

POST-ROSC CARE

AIMS

- Support oxygenation, ventilation, cardiac output
- Leadership promoting non-technical skills.
- Consider analgesia/sedation
- Senior-decision making

TEAM BRIEF:

- Allocate tasks
- Plan if patient re-arrests
- Extrication strategy
- Consider family

CHECK	CONSIDER										
<p>A -PATENT</p>	<p>-SUCTION</p> <p>-A well-functioning iGel does not routinely require replacement with ETT; evaluate ETCO₂ trace, chest rise and airway noise.</p> <p>-Consider need for PHEA (HEMS).</p> <p>-If prolonged downtime/no ↑ GCS, a “cold intubation” may be indicated.</p>										
<p>B -RR: if <10:</p> <p>-SpO₂: if <94%:</p> <p>-ETCO₂</p>	<p>-BVM/MAPELSON/VENTILATOR SUPPORT: Tv 6ml/kg/RR 12-14/PEEP start at 5cm H₂O unless bronchospasm/hypotension (increase in increments of 2.5 cm H₂O as required, max 20cm H₂O) Aim for normocarbida and normoxia (unless asthmatic); adjust frequency in the first instance. Titrate FiO₂ to SpO₂.</p> <p>-O₂ CYLINDER ON/FULL? ↑PEEP, consider PS (Start at 5cm H₂O, max 20 cm H₂O , sit patient upright, NG tube.</p> <p>-TRACE ON-VENTILATION APPROPRIATE?</p>										
<p>C -HR:</p> <p>-NIBP (cycle on 3 mins)</p> <p>-12-LEAD ECG</p>	<p>-Consider underlying cause;</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #f08080;"> <th style="width: 50%; text-align: center;">BRADYCARDIA</th> <th style="width: 50%; text-align: center;">TACHYCARDIA</th> </tr> </thead> <tbody> <tr> <td style="background-color: #f08080;">Cardiac (MI, arrhythmia)</td> <td style="background-color: #add8e6;">Cardiac (MI, arrhythmia)</td> </tr> <tr> <td style="background-color: #f08080;">Non-cardiac: Hypoxia (Rx O₂) Hyperkalaemia (Rx Calcium Chloride, Sodium Bicarbonate) Hypothermia</td> <td style="background-color: #add8e6;">Non-cardiac: Hypoxia (Rx O₂) Hyperkalaemia (Rx Calcium Chloride, Sodium Bicarbonate) Hypovolaemia/Sepsis (Rx Fluids,ADR) Pain (Rx sedation +/- paralysis)</td> </tr> <tr> <td style="background-color: #f08080;">Drug-induced: Beta or Calcium Channel Blockade (Rx Calcium Chloride)</td> <td style="background-color: #add8e6;">Drug induced: TCA (Rx Sodium Bicarbonate) Cocaine (Rx Midazolam)</td> </tr> <tr> <td style="background-color: #f08080;">Consider ATROPINE /ADRENALINE/PACING if ↓ BP</td> <td style="background-color: #add8e6;">Consider CARDIOVERSION/AMIODARONE</td> </tr> </tbody> </table> <p>-MAP < 65mmHg= 250ml FLUID BOLUS +/-ADRENALINE (50mcg (0.5ml of 1:10,000 PFS))</p> <p>-Consider ADRENALINE INFUSION; start at 5ml/hr, titrate to BP (PGD CCA)</p> <p>-Wait until at least 5 minutes post-ROSC before recording. STEMI? → PPCI</p>	BRADYCARDIA	TACHYCARDIA	Cardiac (MI, arrhythmia)	Cardiac (MI, arrhythmia)	Non-cardiac: Hypoxia (Rx O ₂) Hyperkalaemia (Rx Calcium Chloride, Sodium Bicarbonate) Hypothermia	Non-cardiac: Hypoxia (Rx O ₂) Hyperkalaemia (Rx Calcium Chloride, Sodium Bicarbonate) Hypovolaemia/Sepsis (Rx Fluids,ADR) Pain (Rx sedation +/- paralysis)	Drug-induced: Beta or Calcium Channel Blockade (Rx Calcium Chloride)	Drug induced: TCA (Rx Sodium Bicarbonate) Cocaine (Rx Midazolam)	Consider ATROPINE /ADRENALINE/PACING if ↓ BP	Consider CARDIOVERSION/AMIODARONE
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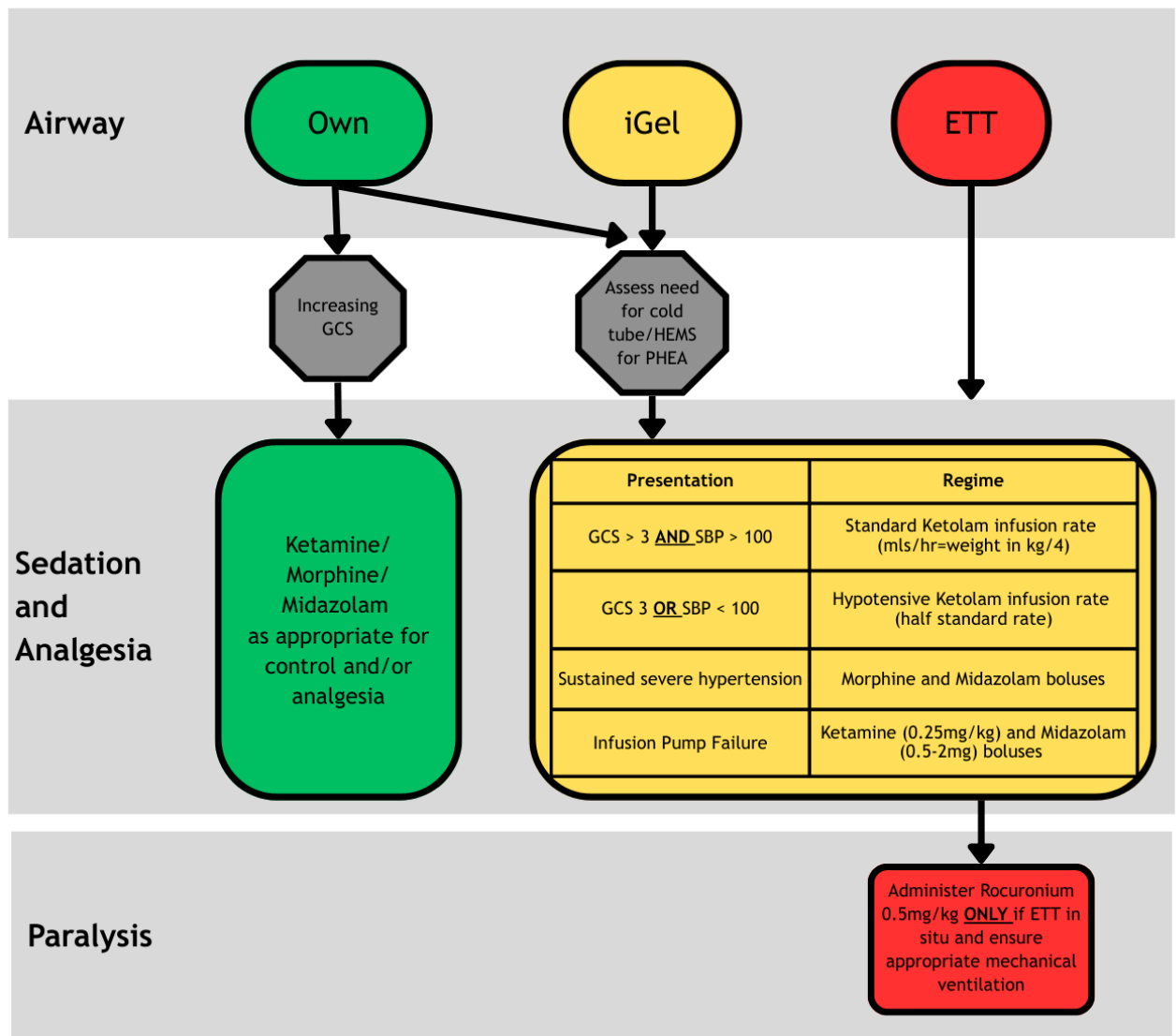
D -GCS

-AGITATION: **SAFE TO TRANSPORT?**

-SEDATION: assess for signs of cerebral perfusion and awareness.

In most patients, maintenance of anaesthesia should be by means of an infusion. This has the benefit of:

1. Reducing the cognitive burden of repeat bolus dosing techniques
2. Provides a consistent level of sedation throughout transfer: bolus dosing creates peaks and troughs which risks labile haemodynamics or potential awareness for the patient. In cases where this is felt to be clinically inappropriate, the rationale for this decision should be well described in the patient notes. Use the following decision making tool:



-CHECK BM

-Aim for normoglycaemia

E -TEMPERATURE

-PACKAGING; SUPPORT NORMOTHERMIA (in hyperthermia aim for early and rapid cooling: 2L sodium chloride IV, ice packs in neck/groin/axillae.

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