

Cardiac Arrest in Suspected COVID Patients

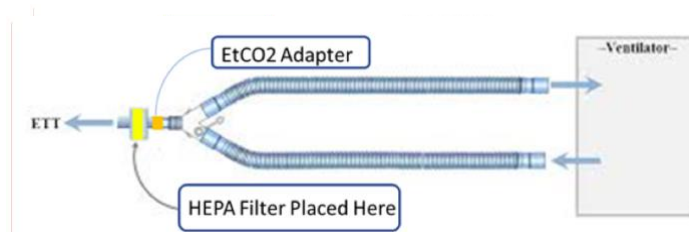
Assume all cardiac arrest patients to be suspected COVID patients unless there was a clear inciting factor AND bystanders can answer the COVID screening for the patient (i.e. respiratory arrest from choking at a family dinner with negative screening).

Basic Life Support

- All personnel should Don full PPE (N95, eye protection, gown, double gloves) prior to physical contact with the patient
- When available, place a clear barrier over the patient (such as a rain coat) to utilize during ventilations and compressions, in order to decrease aerosolization
- Check responsiveness
- Call “Patient Contact/Working code” time to dispatch
- Utilize pit crew approach with as limited personnel as possible
- Open airway, check breathing, and feel for carotid pulse
- If a pulse is not definitely felt within 10 seconds immediately begin chest compressions while preparing to apply AED or Monitor/Defibrillator
- Assist ventilation with minimal interruptions in chest compressions
 - When bagging the patient, be sure to have a very good seal in efforts to decrease exposure. This can be achieved by either utilizing the 2 hand technique or using a CPAP mask in place of the mask for the BVM
 - Use a PEEP valve for the BVM when available
 - Provide ventilations after 30 compressions; do not bag simultaneously with compressions. When not providing ventilations, if feasible, place a surgical mask on the patient. (No more than 3 second pauses of CPR for ventilation).
- 30:2 compression to ventilation ratio for BLS
 - A LUCAS device should be used when available
- Apply AED and follow directions
- If shockable rhythm identified by AED:
 - Administer shock and call “first shock” time to dispatch
 - Resume CPR immediately after shock is delivered for 2 minutes
 - Do not wait for pulse or rhythm check
- Re-analyze rhythm using AED and follow directions

Advanced Life Support

- Advanced airway/ventilatory management
 - When using a BVM, Supraglottic device, or Endotracheal tube, a viral filter must be attached PRIOR TO BAGGING. It has to be attached closest to the patient; proximal to the end tidal device.



- Intubation is preferred over BVM as the definitive airway management. A better seal is achieved with the endotracheal tube, therefore decreasing aerosolization. Although not always the best seal, a Supraglottic device is preferred over intubation as it ultimately allows for less time in the airway=less exposure.
- SGA> INTUBATION> BVM (Most preferred to least preferred)
- Hold compressions during intubation to decrease exposure, but for no more than 10 seconds.
 - If it appears the patient has a difficult airway, proceed directly to Supraglottic rather than intubation, as intubating in difficult circumstances may require more attempts= more exposure.
 - Video laryngoscopy is preferred over direct laryngoscopy as it typically requires less time and allows the operator to be further away from the airway, which translates to less exposure.
- Ventilation rate with the Supraglottic or Endotracheal Tube of 8-10 per minute (avoid hyperventilation)
 - If unwitnessed arrest, immediately begin CPR and continue until ready for rhythm analysis

- Follow algorithm for specific rhythm
- The Lifepack should be as far away from the patient as possible.
- Attempt peripheral IV, if unobtainable proceed to adult intraosseous access
- All medications listed for IV use can be given IO
- For medical arrests, continue high quality cardiac arrest management on scene for 20 minutes. Follow Termination of Resuscitation guidelines.
- After transfer of care or immediately following termination of resuscitation, a brief time out should be performed to identify all equipment used and secure for thorough disinfection. All crew members should carefully doff PPE at this time, under the observation of each other to identify any possible breeches.