Clinical Practice Guidelines: Resuscitation/Resuscitation – Post return of spontaneous circulation (ROSC) management

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<table>
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<tr>
<th>Date</th>
<th>May, 2018</th>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of Post return of spontaneous circulation (ROSC) management.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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<td>Information security</td>
<td>This document has been security classified using the Queensland Government Information Security Classification Framework (QGISCF) as UNCLASSIFIED and will be managed according to the requirements of the QGISF.</td>
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There is increasing recognition that systematic post-cardiac arrest care can improve the likelihood of patient survival with a good quality of life.\[^{1,2}\]

Resuscitation continues after a return of spontaneous circulation (ROSC).

- Primary aims after initial resuscitation care include:
  - support circulation, airway and breathing
  - maintain cerebral perfusion
  - manage cardiac dysrhythmias.

- Determine and manage the cause of the cardiac arrest giving consideration to those that are reversible:
  - hypoxia
  - hypo/hyperthermia
  - hypovolaemia
  - hypo/hyperkalaemia
  - hydrogen ion (acidosis)
  - tension pneumothorax
  - tamponade
  - toxins

- All ROSC patients require a 12-Lead ECG.

- Following out of hospital cardiac arrest (suspected to be of cardiac aetiology) patients should, where possible, be transported to a PCI capable facility.
Transport to hospital
Pre-notify as appropriate

Optimise circulation:
- Aim for SBP ≥ 100 mmHg for adults
- Aim for SBP ≥ 80 mmHg for children

Consider:
- Appropriate posturing
- Adrenaline (epinephrine)

Optimise ventilation and oxygenation:
- Maintain SpO₂ ≥ 94%
- Consider advanced airway
- Maintain EtCO₂ of 30–40 mmHg
- If no EtCO₂ ventilate at rate of 8–12 per minute
- Do not hyperventilate

- 12-Lead ECG
- Treat presenting dysrhythmias
- Consider and manage reversible causes

CPG: Paramedic Safety
CPG: Standard Cares