PROTOCOL FOR: **Emergency Care for Lethal Dysrhythmias**

POLICY: In the absence of an MD/LIP, RNs in the ICU/CSDU may perform the following interventions in the specified situation while waiting for the physician to arrive and provide further medical treatment.

DESIRED PATIENT OUTCOME:

1. Patient will achieve hemodynamic stability, ie, SBP > 90 mmHG.
2. Patient will maintain cerebral perfusion.
3. ECG will demonstrate a rhythm with which the patient is stable.

CLINICAL ASSESSMENT AND CARE:

1. Premature Ventricular Contractions (PVC's):

   a. Obtain vital signs and assessment to determine stability of patient.

   b. For PVC's occurring at the frequency of 6/min, in couplets, or in salvos of 3 or more, notify the house officer and then proceed as per MD/LIP's order.

   c. If indicated (ie. the patient becomes unstable, with serious signs or symptoms or fails to respond to recommended treatment), activate the Rapid Response Team (RRT).

2. Ventricular Tachycardia (VT) with a pulse:

   a. If ventricular tachycardia (VT) occurs and the patient is hemodynamically stable: contact MD/LIP for specific orders.

   b. If the patient is symptomatic (ie. hypotensive with systolic BP < 80 mm Hg, angina, dizzy, breathless):

      1. Administer Amiodarone 300 mg IV push (over 3-5 minutes).
      2. If there is no response, give another dose of Amiodarone, 150mg over 3-5 minutes (once only).
      3. Monitor the patient's B/P closely while delivering severe hypotension occurs, lower the HOB/elevate legs.
      4. Notify MD/LIP and consider activating RRT if no response.

   c. If VT occurs and the patient is severely symptomatic (ie, losing consciousness), but still has a pulse:

      1. Activate a Code Blue.
      2. As soon as defibrillator is available, immediately deliver synchronized countershock (cardiovert)at

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100 J (biphasic).
3. If still in VT with a pulse, resynchronize defibrillator and repeat synchronize countershock (cardiovert) at 200 J (biphasic).

3. Pulseless Ventricular Tachycardia (VT)/ Ventricular Fibrillation (VF):

a. Call a Code Blue / initiate CPR
b. As soon as defibrillator is available, immediately deliver an unsynchronized shock (defibrillate) at 200 J (biphasic).
c. Follow shock with 2 minutes of CPR.
d. If patient remains in pulseless VT / VF rhythm after 2 minutes of CPR, and the code team MD/LIP has not yet arrived, administer a second unsynchronized (defibrillation) shock at 300 J (biphasic) and follow with CPR.

4. Brady-Dysrhythmias:

a. For sinus bradycardia with a rate less than 50, associated with hypotension or related symptoms (i.e., lightheadedness, dizziness, N/V):
   1. Administer 0.5 mg of atropine IV push.
   2. Repeat this dose every 3-5 minutes if no response, up to a total of 3 mg.

b. For other symptomatic bradycardic rhythms (ie. slow atrial fibrillation, 2nd or 3rd degree heart block): Apply the external pacemaker, and attempt to pace the patient by setting the pacer rate to 80, and adjusting (increasing) MA (milliamps) until electrical and mechanical capture is obtained.

(* If patient has epicardial or transvenous pacemaker wires, refer to #6 below.)

5. Asystole or PEA:

a. Initiate CPR / Call a Code Blue

(* If patient has epicardial or transvenous pacemaker wires, refer to #6 below.)

6. Treatment of bradycardia / asystole in patient with epicardial or transvenous pacemaker wires:

a. For symptomatic sinus bradycardia with MAP < 60mm Hg, pace with available wires as appropriate:

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1) If atrial wires only, attach atrial wires to pacer box and pace at rate of 80, MA of 10. Increase MA as needed until capture.
2) If ventricular wires only, attach ventricular wires to pacer box and pace at rate of 80, MA of 10. Increase MA if needed until capture.

3) If both atrial and ventricular wires, use either of the above, or pace both chambers with A-V sequential pacer at rate of 80, MA of 10, increasing if needed for capture.

b. For 2nd or 3rd degree heart block with MAP < 60mm Hg, pace with ventricular wires at same settings as above. (Note: If only atrial wires are present, pacing atrially will not assure ventricular capture. In this case, apply the external pacemaker as in step 4b. to provide for emergent ventricular pacing.)

c. For asystole: pace with either atrial or ventricular wires, or both. Pace at same settings as above: Rate 80, MA 10, adjusted for capture.

e. Notify the MD/LIP on call for any of the above situations, and procure specific orders for pacemaker rate, MA and sensitivity.

7. For any rhythm abnormality, monitor the patient with frequent VS based on assessment of the rhythm and patient condition after treatment.

DOCUMENTATION:

1. Initiate an RRT or code sheet, if appropriate.
2. Post rhythm strips and document rhythm changes on flow sheet or progress note.
3. Enter medication order for meds given “per protocol”.
4. Document all medications given on MAR (unless code record was used).
5. Document summary of data/actions/response (DAR) in progress note.

APPROVAL: Nursing Standards Committee
ICU Standards Committee (4/07)

EFFECTIVE DATE: 8/84

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REVISION DATE: 12/85, 1/92, 1/93, 11/94, 3/96, 5/97, 8/97, 8/00, 10/03, 3/04, 4/07, 10/09