



Revised-ACLS-script - script

MEDICINE (Our Lady of Fatima University)



Scan to open on Studocu

VOMIT SCRIPT

Pre-Arrest / ACLS Survey

VISUALIZE

The team leader will arrive and assess the patient.
(Describe how the patient appears.)

Team Leader: “Assessing what is going on. Assessing done. The patient is sweating profusely and has agonal breathing and cyanosis.”

VERBALIZE

The team leader will tap the patient and ask:

Team Leader: “Sir, can you state your name?”

(CI will state name)

Team Leader: “I am Nurse (name). Are you alright? Can you tell me how are you feeling? Is everything okay?”

The patient will respond.

VITAL SIGNS

Team Leader: “I will now take the following vital signs: Temp, Pulse Rate, RR, o2 Sat, and BP.”

The CI will provide the vital signs.

Team Leader: “Oxygen Saturation is low. Will provide oxygen therapy.”

OXYGEN SATURATION

Nasal Cannula: 2 to 4 liters per unit
Face Mask: 6 to 10 liters per unit
NRM: 11 to 15 liters per unit

(Act as though you are doing what you are saying.)

Team Leader: “Gathering supplies. Nasal Cannula is available. Connecting Nasal Cannula tubing to the flow meter. Setting oxygen flow at prescribed rate which is 2 to 4 liters per unit. Placing the prongs into the patient’s nares. Fitting the tubing around the patient’s ears.”

Team Leader: “Gathering supplies. Nasal Cannula is not available. Will use face mask instead. Connecting tubing to the flow meter.

Setting oxygen flow at prescribed rate which is 6 to 10 liters per unit. Placing the mask over the patient’s mouth and nose. Securing a firm seal.

Tightening the straps around the head.”

Team Leader: “Gathering supplies. Nasal Cannula and face mask is not available. Will use non-rebreather mask instead. Connecting tubing to the flow meter. Setting oxygen flow at prescribed rate which is 11 to 15 liters per unit. Partially inflating the reservoir bag. Placing the mask over the patient’s mouth and nose. Securing a firm seal. Placing the patient in an upright position as clinically appropriate.”

MONITORING

Team Leader: “Establishing cardiac monitoring using (3-lead ECG or 5-lead ECG).”

3-Lead: White on the right. Smoke over fire.
5-Lead: White on the right. Smoke over fire.
Snow over grass and let’s melt some chocolates.

IV/IO ESTABLISH

IV: Intravenous. On the vein.
IO: Intraosseous. On the bone.
Use IO after 3 FAILED attempts of IV.

Team Leader: “I am going to establish IV line. Gathering supplies such as IV fluid, IV catheter, IV tubing, tourniquet, tape, and antiseptic. Putting gloves on. Connecting IV tubing to the bag. Flushing. Choosing vein on the crook of the left arm. Applying the tourniquet snugly 20-25 cm above insertion site. Feeling the vein. Disinfecting the insertion site with alcohol pad in the direction of the venous flow. Skin has dried. Pulling skin taut to stabilize the vein. Inserting the catheter 15- to 30-degree angle right on top of the vein. Bevel up. Insertion done. Untying the tourniquet. Sliding the needle slightly. Backflow confirmed. Needle out. Pressing a finger over the inserted catheter.

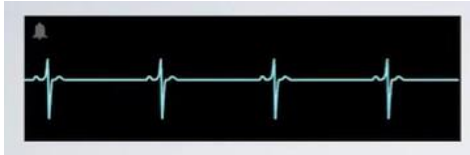
Connecting tubing. Securing the catheter.
Loosening the clamp. Beginning infusion.”

TREATMENT

Treatment will depend on what is flashed on the cardiac monitor (Slow/Fast Cardiac Rate).

Slow Rhythm: Sinus Bradycardia

A: Atropine (1mg every 3-5 minutes)
T: transcutaneous Pacing (Electric pulse)
D: dopamine Infusion (400mg + 250mL PNSS)
E: pinephrine Infusion (1mg + 500mL PNSS)



Team Leader: “Based on the cardiac monitor, the patient is under Sinus Bradycardia. To increase heart rate, I am going to give 1mg of Atropine every 3 to 5 minutes as needed. Atropine given.”

If CI said, “Atropine ineffective. What are the second-line drugs?”

Team Leader: “If bradycardia is unresponsive to Atropine, equally effective alternatives are:

1. Transcutaneous pacing: delivery of small electrical current to temporarily restore electrical activity of the heart (demand mode – common)
2. Dopamine: ideally 1mg
 - renal: 2mcg/kg/min
 - cardiac: 5mcg/kg/min
 - vasopressin: 10 mcg/kg/min
3. Epinephrine: 2-10 mcg q 3-5 mins (1-5 doses)-titrate to response

Fast Rhythm: Supra Ventricular Tachycardia

NARROW COMPLEX TACHYCARDIA

P: Vagal Maneuver (Carotid Massage + cough)

P: Adenosine (1st 6mg 2nd 12 mg)

S: Sedate

S: Synchronized Cardioversion



NOTE: Patient can be considered STABLE if the BP is 90 and above. Below 90 UNSTABLE. Check the cardiac monitor first.

If patient is STABLE

Team Leader: “Patient’s BP is (*state BP that you see on the monitor*). Patient is stable. Giving physiologic treatment first which is Vagal Maneuver Carotid Massage. Extending patient’s neck toward the opposite side. Ensuring there is no carotid bruit. (*Place stethoscope on patient’s neck. Check for whooshing sound.*) Applying firm pressure on carotid sinus. (*Count 1001-1009*). Carotid Massage done. Sir, can you cough? (Patient cannot.)”

Team Leader: “I will proceed to pharmacologic treatment. I am going to give 1st dose of Adenosine 6mg rapid IV push followed by PNSS flush. If second dose is required, I will give Adenosine 12mg IV rapid push. Adenosine given.”

If patient is UNSTABLE:

Team Leader: “I will proceed to sedation. I am going to give 5mg of Diazepam. If unavailable, I can also Midazolam 5 mg or use Demerol at 50mg.”

Team Leader: “After sedating the patient, I will now proceed to synchronized cardioversion.

Engaging synchronization mode. (*Press sync button*).

V-tach: 100 J

Supra v-tach: 50 J

Atrial Fibrillation: 120 J

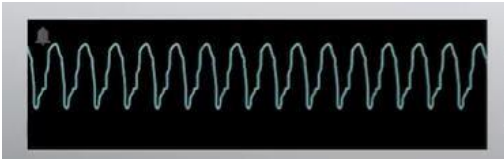
Team Leader: That being said, I will set the charge of defib at 50 joules. Charge. (*Press charge button.*) Initiating shock in 3. 1 2 3. (*Press shock button.*) Shock delivered.

WIDE COMPLEX TACHYCARDIA (V-TACH)

P: Amiodarone (150mg over 10 mins)

S: Sedate

S: Synchronized Cardioversion



Team Leader: “Patient’s BP is (state BP that you see on the monitor). Patient is unstable. I will give Amiodarone 150 mg over 10 minutes. If VTACH recurs, follow by maintenance infusion of 1mg/min for the first 6 hours. Amiodarone given.”

Team Leader: “I will proceed to sedation. I am going to give 5mg of Diazepam. If unavailable, I can also Midazolam 5 mg or use Demerol at 50mg.”

Team Leader: “After sedating the patient, I will now proceed to synchronized cardioversion.

Engaging synchronization mode. (*Press sync button.*)

V-tach: 100 J

Supra v-tach: 50 J

Atrial Fibrillation: 120 J

That being said, I will set the charge of defib at 100 joules. Charge. (*Press charge button.*) Initiating shock in 3. 1 2 3. (*Press shock button.*) Shock delivered

THE PATIENT IS STILL UNSTABLE.

Arrest: BLS Survey 30:2

Team Leader: “Patient is unconscious. Proceeding to basic life support.”

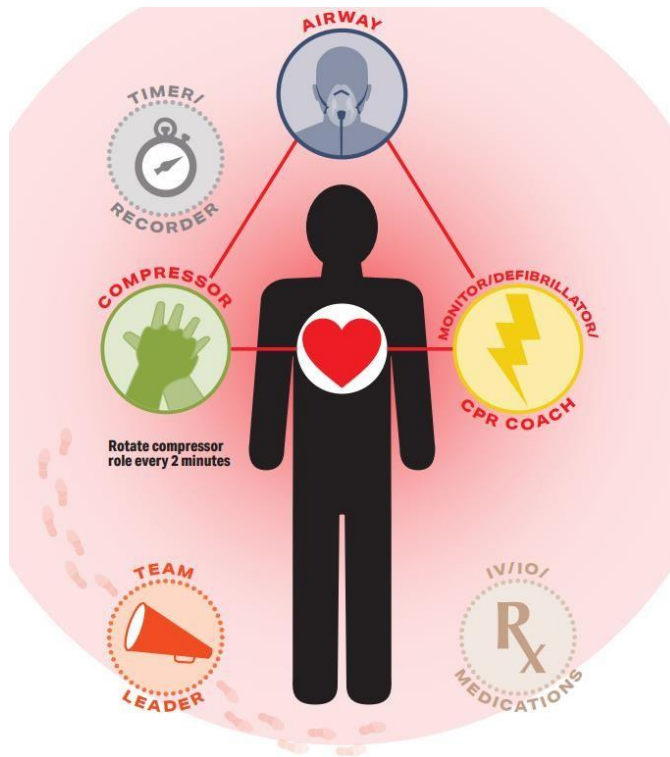
BLS TAP AND SHOUT.

Team Leader: “Hey hey hey. Are you okay? Hey hey hey. Are you alright? No response. Check for pulse and breathing. (Carotid pulse 1001-1009 and rise and fall of chest). No pulse. No breathing. (Push button to call rescue team.) CODE BLUE! CODE BLUE! Room 204! I’ll do high quality compression now.”

- Start 30 compressions 2 rescue breaths.
- PUSH HARD PUSH FAST. Complete chest recoil. Interruption <10secs. Avoid excessive ventilation.
- CI will signal the rescue team to enter the scene.

RESCUE TEAM ARRIVED.

Team Leader: “Patient has gone into Vfib. (Name) start the compressions! (Compressor will start the 30:2 compressions right away). (Name) you’ll be on defibrillator! (Name) you’ll be recording! (Name) you’ll manage the airway! (Ambu bag) (Name) establish an IV access.”



SHOCKABLE
VFIB/ PULSELESS VT
NON-SHOCKABLE
ASYSTOLE/ PEA

At this point, compressor is doing the compressions. Airway is giving rescue breaths through ambu bag. Defib activating the ECG Simulator. IV/IO establishing IV access on crook of left arm. Observer take note of the time always and medications given with dosage and infusion rate.

Team Leader: “(Name of defib), please charge 360 joules.”

Defib: “Charging at 360 joules. Stop touching the patient. Is everybody clear? (CLEAR!) Shocking in 3. 1 2 3. Shocking. Shock delivered.”

Team Leader: “Continue high quality CPR.”

Team Leader: (Name of IV/IO) Do we have IV access now?

IV/IO: “I have (IV/IO) access now.”

Team Leader: “Great. We’ll continue high quality CPR for 2 minutes and evaluate the need for

additional defib. (Name of Observer) I’ll rely on you to monitor the quality of the chest compressions. (Name of IV/IO) If the arrest persists, we’ll continue to drug therapy.” Please prepare 1 mg epinephrine then 20 cc PNSS for flushing.

IV/IO: “Preparing 1 mg of Epinephrine then 20 cc PNSS for flushing.”

2 MINS 1st CYCLE

Team Leader: “Okay. Let’s analyze. Switch roles.”

Switch roles: Defib and Compressor. Start HQCPR.

(CI will announce if “still in V-fib.”)

Team Leader: “Patient is still in V-fib. As per protocol, let’s shock again at 360 joules.” (Name of defib), please charge 360 joules.”

Defib: “Charging at 360 joules. Stop touching the patient. Is everybody clear? (CLEAR!) Shocking in 3. 1 2 3. Shocking. Shock delivered.”

Team Leader: “Continue high quality CPR. (Name of IV/IO), please give 1mg of Epinephrine then 20 cc PNSS for flushing. Make sure to elevate the hand of the patient”

IV/IO: “Giving 1mg of Epinephrine and then flushing with 20 cc PNSS. Epinephrine given.”
Hand of patient elevated.

(OBSERVER. Take note of the time each medication is given.)

Team Leader: “Great. We’ve given 2 shocks and 1mg of Epinephrine. The next medication to consider is Amiodarone. (Name of IV/IO), please prepare 300 mg of Amiodarone then 20 cc for PNSS flushing.”
Do not administer until I say so.

IV/IO: “Preparing 300 mg of Amiodarone and then 20 cc PNSS for flushing.”

Team Leader: “(Name of airway), are you getting good chest rise?”

Airway: “Yes. I am being careful not to deliver ventilations too quickly or forcefully.”

Team Leader: “Okay, great! Let’s continue there.”

2 MINS 2ND CYCLE

Team Leader: “Okay. Let’s analyze. Switch roles.”

Switch roles: Defib and Compressor. Start HQCPR.

(CI will announce if “still in V-fib.”)

Team Leader: “Patient is in persistent Vfib. As per protocol, (Name of Defib) let’s shock again at 360 joules.”

Defib: “Charging at 360 joules. Stop touching the patient. Is everybody clear? (CLEAR!) Shocking in 3. 1 2 3. Shocking. Shock delivered.”

Team Leader: “Continue high quality CPR.”

(OBSERVER. Take note of the time each medication is given.)

Team Leader: We can give Amiodarone now. (Name of IV/IO), please give 300 mg of Amiodarone then 20 cc PNSS for flushing.”

IV/IO: “Giving 300 mg of Amiodarone and then flushing with 20 cc PNSS. Amiodarone given.”

(OBSERVER. Take note of the time each medication is given)

Team Leader: “We’ve given 3 shocks. After the 2nd shock we’ve given 1mg of Epinephrine. And we’ve just administered 300 mg of Amiodarone. We’ll again administer Epinephrine. (Name of IV/IO), please prepare 1 mg of Epinephrine. Do not administer until I say so”

IV/IO: “Preparing 1 mg of Epinephrine.”

2 MINS 3RD CYCLE

Team Leader: “Okay. Let’s analyze. Switch roles.”

Switch roles: Defib and Compressor. Start HQCPR.

CI will announce if status.

Team Leader: “Okay. The monitor shows (what is the ECG reading). Do we have a pulse? (Airway check for pulse)”

NOTE:

NON-SHOCKABLE ASYSTOLE/ PEA Class 1: HQCPR Class 2: Epinephrine q3-5mins

Airway: “I don’t feel a pulse.”

Team Leader: “Continue chest compressions. (Name of observer), how long has it been since the last dose of epinephrine?”

(OBSERVER. Count how many minutes have passed since your record of the last dose of Epi has been given.)

Observer: “____ minutes.”

Team Leader: “Okay, (Name of IV/IO). Let’s go ahead and give 1 mg of Epinephrine then 20 cc PNSS for flushing. Make sure to elevate the hand of the patient.”

IV/IO: Giving 1mg of Epinephrine and then flushing with 20 cc PNSS. Epinephrine given.”
Hand of patient elevated.

(OBSERVER. Take note of the time each medication is given.)

OBSERVER: “(Name of CURRENT compressor), your compressions are slowing down. Can you pick up the pace a bit?”

2 MINS 4TH CYCLE

Team Leader: “Okay. Let’s analyze. Switch roles.”

Switch roles: Defib and Compressor. Start HQCPR.

Team Leader: “Okay. The monitor shows (what is the ECG reading). Do we have a pulse? (Airway check for pulse)”

Airway: “I don’t feel a pulse.”

Team Leader: “Continue chest compressions. (Name of IV/IO). Let’s go ahead and give 150 mg of Amiodarone and 20 cc PNSS for flushing.”

IV/IO: “Giving 150 mg of Amiodarone then flushing with 20 cc PNSS. Amiodarone given.”

Team Leader: “Let’s review any reversible causes considering the Hs and Ts.”

IV/IO: “What about hypervolemia?”

Team Leader: “That’s a good thought. We have IV access established but no obvious signs of internal or external bleeding. Any other suggestions?”

Defib: “What about hypoxia?”

Team Leader: “(Name of airway), is the airway still patent?”

Airway: “Still getting the chest rise.”

POST-ARREST: ROSC

Team Leader: “Okay. Let’s analyze. Switch roles.”

Switch roles: Defib and Compressor. Start HQCPR.

(CI will announce if status).

Team Leader: “Okay. The monitor shows (what is the ECG reading). Do we have a pulse? (Airway check for pulse).”

Airway: “I can feel a rapid quick pulse.”

Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

Shock Energy for Defibrillation

- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- **Monophasic:** 360 J

CPR Quality

- Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.
- Minimize interruptions in compressions.
- Avoid excessive ventilation.
- Change compressor every 2 minutes, or sooner if fatigued.
- If no advanced airway, 30:2 compression-ventilation ratio.
- Quantitative waveform capnography
 - If PETCO₂ <10 mm Hg, attempt to improve CPR quality.
- Intra-arterial pressure
 - If relaxation phase (diastolic) pressure <20 mm Hg, attempt to improve CPR quality.

Team Leader: “Okay great. Let’s initiate immediate post-cardiac arrest care. (Name of IV/IO), get vitals BP, pulse and PETCO.

(IV/IO: *Declare the BP, pulse and PETCO (35-45 mmHg)*

Team Leader: "Checking for patency. Will do 5- point auscultation. "

If BP is stable and no congestion, administer fluid

- PNSS/PLRS (1-2 L)

C- BP unstable

- PNSS/PLRS (1-2 L)
- Airway: 4-point auscultation (for checking if there is normal rhythm/pattern)

Airway: "Negative, negative, negative, negative, still not breathing."

(If all negative proceed to advance airway but recite first the meds)

- Dopamine: 10 mcg/kg
- Epinephrine: 2-10 mcg
- Norepinephrine: 2-10 mcg

If the patient can breathe alone, you can provide oxygen therapy with the use of nasal cannula

AB – No Breathing

- Advanced Airway (Intubation)
 - intubation set, gloves, laryngoscope, ambu bag, wire guide (sterile), syringe, leukoplast tape (anchor)
 - **endotracheal tube:**
 - ✓ adult: 7-8mm
 - ✓ pedia: 4-4.5mm
 - ✓ neonate: 2-2.5mm (uncuff)
 - ✓ geria: 5-6mm

Team Leader: "(Name of Airway) please prepare for intubation."

Airway: "Starting intubation. Tilting the patient's head back. Inserting laryngoscope to mouth. Raising epiglottis. Advancing tip of device into larynx and then into trachea. Inflating balloon (5-10 ml air). Removing laryngoscope. Tubes in."

- 4 positive sound, negative gurgling sound= **INTACT**
- 4 positive sound, 1 gurgling sound – **ADJUST** (Deflate, aspirate, retract at least 1 inch, then reinsert, do another 5-point auscultation)

PETCO2 (Partial-End Tidal Co2)

Qualitative- Yellow

Quantitative- 35-40

D- Disability

- GCS/ Neurovital signs

Behaviour	Response
 Eye Opening Response	4. Spontaneously 3. To speech 2. To pain 1. No response
 Verbal Response	5. Oriented to time, person and place 4. Confused 3. Inappropriate words 2. Incomprehensible sounds 1. No response
 Motor Response	6. Obeys command 5. Moves to localised pain 4. Flex to withdraw from pain 3. Abnormal flexion 2. Abnormal extension 1. No response

Team Leader: (Compressor's name), please check for the GCS

Compressor: (Hold patient's hands) "Ma'am/Sir, can you squeeze my fingers? No eye opening. No verbal response. No motor response. Still unresponsive. GCS is 3.

- Therapeutic hypothermia

- ✓ PNSS/PLRS, 30cc/kg ,4 degrees Celsius
- ✓ 12-24 hours infusion
- ✓ Core body temperature: 32-34 degrees Celsius

Check for the cardiac monitor

Team Leader: “Okay the patient is hypotensive. Let’s start with (computation: 30cc/kg) PNSS. Since we started with hypothermia, let’s use cold PNSS for the bolus at 4 degrees Celsius.”

▪ **Sign of the cross**

- ✓ NGT (for decompression)
- ✓ Foley Catheter
- ✓ 12 Lead ECG
- ✓ Xray (to r/o chest fracture an verify ET tube), CVP

Team Leader: Please transfer patient to ICU for continuous monitoring.”

