EL DORADO COUNTY EMS AGENCY
PREHOSPITAL PROTOCOLS

Effective: January 2012
Reviewed: July 2021
Revised: May 2022
Scope: ALS – Adult/Pediatric

EMS Agency Medical Director

BRADYCARDIA - ADULT

PROTOCOL PROCEDURE: *Flow of protocol presumes that bradycardia is continuing. If response or condition changes, refer to appropriate protocol. If at any time a stable patient becomes unstable, go to the unstable section of this protocol. If patient is in severe distress, immediate,* rapid *transport is preferred with treatment performed en route.*

ABCs / ROUTINE MEDICAL CARE –

- Assess airway and support ventilation with appropriate airway adjuncts as indicated.
- HP-CPR as indicated
- Apply oxygen if pulse oximetry <94% or signs of hypoperfusion or respiratory distress Place patient in position of comfort.
- Obtain and transmit 12 lead EKG (Do not delay therapy).

STABLE ***HR < 50; SBP > 90; GCS 15; NO CHEST DISCOMFORT / DYSPNEA or CHANGE IN MENTAL STATUS***	**UNSTABLE - SYMPTOMATIC** ***Fluids, atropine and/or TCP for the patient with: HR < 50; SBP<90 and signs of hypoperfusion including any: Acutely Altered Mental Status, Signs of shock, Chest Discomfort, or Acute Heart Failure***
Cardiac Monitor Vascular Access: IV/IO. Rate as indicated. ↓ Move to unstable section if condition deteriorates	Consider 2nd IV or IO if difficult access ↓ Consider 500 mL Fluid Bolus ↓ Atropine IV/IO: 1 mg q 3-5 min (Max 3 mg) (Go directly to TCP for patients with wide complex rhythms) ↓ **If Atropine is ineffective or if delay in IV/IO Begin TCP at 80 bpm** Do not delay if high degree block is present ↓ Refer to Pain Management Protocol
	CONTACT BASE Dopamine or epinephrine infusion may be ordered for hypotension. Titrate to patient response.

References: Prehospital Formulary, Transcutaneous Pacing Procedure,12 Lead EKG Procedure

BRADYCARDIA

BRADYCARDIA – PEDIATRIC

ABCs / ROUTINE MEDICAL CARE –

- Assess airway and support ventilation with appropriate airway adjuncts as indicated
- Apply oxygen if pulse oximetry <94% or signs of hypoperfusion or respiratory distress
- Place patient in position of comfort.
- Obtain and transmit 12 lead EKG (Do not delay therapy).

STABLE ***NO HYPOTENSION, NO DELAYED CRT, NO CHEST PAIN/DYSPNEA***	**UNSTABLE OR SYMPTOMATIC** ***ALOC, DELAYED CRT, HYPOTENSION CHEST PAIN, DYSPNEA, SHOCK***
Cardiac Monitor ↓ Vascular Access – - IV/IO. Rate as indicated. ↓ Move to unstable section if condition deteriorates	**Begin Ventilation with BVM if HR<60; if no improvement in 1 minute begin HP-CPR** If HR < 60 Perform CPR ↓ Consider 2nd IV or IO if difficult access ↓ **Epinephrine 1:10,000 (0.1mg/mL)** 0.01 mg/kg IV/IO Repeat every 3 – 5 min. ↓ **Atropine** 0.02 mg/kg IV/IO Repeat q 5 min prn. Minimum dose 0.1mg. Max. total dose 1 mg. ↓ **Consider TCP** at 80 bpm **Do Not** delay if high degree block is present Refer to Pain Management Protocol ↓ Treat underlying causes ↓ Contact Base Dopamine or epinephrine infusion may be ordered for hypotension. Titrate to patient response.