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Field Treatment

1. Basic airway
2. Oxygen/Pulse oximetry
3. Cardiac monitor/document rhythm and attach EKG/ECG strip ①
4. Perform a 12-lead KG if suspected cardiac event
5. Shock position prn
6. Advanced airway prn
7. Venous access prn

Perfusing

8. Continuous monitoring enroute, assess for signs of poor perfusion

Poor Perfusion

8. **Atropine 0.5mg** IVP administer while preparing Transcutaneous Pacing (TCP) or if TCP not available ②

9. Transcutaneous Pacing – if available

10. If TCP is utilized in the awake patient, consider administering sedation **or** analgesia for discomfort ❶ ❷

11. Consider fluid challenge ③

12. Consider dopamine 400mg/500ml NS IVPB, start at 30mcgtts/minute ❹ ④

Drug Considerations

Midazolam for sedation:
❶ Titrate **1-2mg slow** IVP, may repeat every 5 minutes to maximum of 10mg. If unable to obtain venous access, may administer 2.5mg IM or IN, may repeat once in 5 minutes

Morphine for pain**:**
❷ Titrate **2-12mg slow** IVP for analgesia, maximum adult dose 20mg or if unable to establish IV, administer 4mg IM (single dose)

Atropine
❸ May repeat in increments q 3-5 minutes to maximum dose 3mg

Dopamine
❹ Titrate to SBP 90-100 and signs of adequate perfusion or to maximum of 120mcgtts/minute

Special Considerations

① In the acute MI, bradycardia may reflect a protective cardiac mechanism

② **Immediate TCP for patients in 2nd degree (type II) HB or 3rd degree HB – do not delay for IV access**. Recommend setting initial rate at 70 bpm/0 mA**,** slowly increase mA's until capture is achieved

③ Ensure absence of rales

④ Consider initiating dopamine before maximum dose of atropine or if hypotension is unresponsive to atropine and TCP