

PEDIATRIC POST RESUSCITATION CARE



1. Optimize ventilation and administer **O₂**.
2. Maintain SpO₂ saturation at \geq to 94%. Wean patient, if saturation is 100%.
3. Establish IV/IO access, if not already done.
4. Consider establishing advanced airway (ETT or supraglottic advanced airway) and waveform **capnography**.
5. Assess for and treat persistent shock*. Administer fluid bolus at 20 ml/kg IV/IO. May repeat up to 60 ml/kg as required.
6. Consider need for **dopamine** at 2-20 mcg/kg/minute for fluid refractory shock.†
7. Search for and treat reversible causes.

✓ Hypovolemia	✓ Tamponade, cardiac
✓ Hypoxia	✓ Toxins
✓ Hydrogen Ion (acidosis)	✓ Thrombosis pulmonary
✓ Hypoglycemia	✓ Thrombosis Coronary
✓ Hypo/hyperkalemia	✓ Trauma
✓ Tension pneumothorax	
8. Transport patient ASAP.

*May include significant respiratory difficulty or one or more of the following signs of shock: altered LOC, capillary refill > 2 seconds, rapid pulse, diminished distal pulses, cool extremities, and hypotension.

†If dopamine is unavailable, epinephrine may be substituted at a continuous infusion of 0.1-1 mcg/kg/min.