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|  | <b>Department Name<br/>Address</b> | <b>ALS</b>                       | <b>Paramedic</b> |
|   |                                    | <b>Revision #</b>                |                  |
|   |                                    | <b>Implementation Date</b>       |                  |
| <b>Protocol</b>   | <b>2.1.6 Asystole</b>              | <b>Last Reviewed/Update Date</b> |                  |
| <b>Author / Owner</b>   |                                    | <b>Medical Director</b>          |                  |

This protocol must be used in conjunction with other associated protocols: Cardiac Arrest, Baseline Care Standards, and Airway Management protocol. The primary goal is conversion of asystole to another cardiac rhythm, with or without a pulse. Change to another appropriate protocol based on any ECG change. Early recognition, continuous CPR, intubation, and rapid pharmaceutical interventions, give the greatest chance of resuscitation.

1. Baseline care standards.
2. Cardiac arrest management per protocol.
3. Manage airway per protocol.
4. Verify asystole in two leads.
5. Administer:
  - *Epinephrine (1:10,000) 1mg IV (2mg via ETT). Repeat every 3 – 5 minutes for duration of pulselessness.*
  - *Atropine 1mg IV (2mg via ETT). Repeat every 3 – 5 minutes up to a maximum dose of 0.04 mg/kg or 3mg.*
6. After maximum atropine dose or with known metabolic acidosis, administer:
  - *Sodium Bicarbonate (8.4%) 1 mEq/kg IV.*
7. Apply external pacer:
  - Rate of 80 bpm.
  - Begin at 100 ma and decrease to lowest power setting with capture.
8. Early contact to the receiving Emergency Department and Medical control.
9. After 30 minutes of ALS interventions, consider implementing the “Withholding or discontinuing resuscitation” protocol.

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*Medical Director's Signature*

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*Date*

**Disclaimer:**

The protocols have been developed by the North Dakota Department of Health are meant to be used as general guidance for developing protocols for individual emergency medical services agencies. These sample protocols are not meant to be medical or legal advice; nor do they establish standards of care. Each emergency medical services agency must tailor protocols based on their specific needs or capabilities. Local medical directors must be consulted with and approve any protocol(s) prior to becoming operational in an emergency medical services agency. directors must be consulted with and approve any protocol(s) prior to becoming operational in an emergency medical services agency. The North Dakota Department of Health make no representation on the accuracy of information contained herein and accepts no liability for any loss or damage arising from any content error or omission.