Return of Spontaneous Circulation (ROSC)
This protocol should be followed for all cardiac arrests with ROSC. If an arrest is of a known traumatic origin, refer to the Traumatic Arrest Protocol and MCA Transport Protocol. If it is unknown whether the arrest is traumatic or medical, consider other treatable causes. Initiate ALS response if available.

1. If ventilation assistance is required, ventilate at 10-12 breaths per minute. Do not hyperventilate.
2. Reassess patient, if patient becomes pulseless
   a. Begin CPR
   b. Follow Adult or Pediatric Cardiac Arrest General Protocol.
3. Monitor vital signs.
4. Check blood glucose (MFR, if MCA approved).
5. Start an IV/IO NS KVO.
6. Treat hypotension (SBP less than 90 mm/Hg) with an IV/IO fluid bolus consistent with Shock Protocol.
7. Perform 12-lead ECG (Per MCA selection, may be BLS skill per 12 Lead ECG Procedure).
8. If ventilation assistance is required, target ETCO2 of 35-40 mm Hg.
9. Consider Transport to a facility capable of Percutaneous Coronary Intervention (PCI) per MCA protocol.
10. If hypotension persists after IV/IO fluid bolus, administer Epinephrine by push dose (dilute boluses).
   a. Prepare (10 mcg/mL) by adding 1mL of 1mg/10mL Epinephrine in 9mL NS, then
   b. Adults
      i. Administer 10-20 mcg (1-2 mL Epinephrine 10 mcg/mL)
      ii. Repeat every 3 to 5 minutes
      iii. Titrate to SBP greater than 90 mm/Hg
   c. Pediatrics
      i. Administer 1 mcg/kg (0.1 mL/kg Epinephrine 10 mcg/mL)
      ii. Maximum dose 10 mcg (1 mL)
      iii. Repeat every 3-5 minutes
11. If patient is agitated with advanced airway in place, refer to Patient Sedation Protocol.

Notes:
1. If a mechanical ventilator is available or there are spontaneous respirations in the non-intubated patient, titrate inspired oxygen on the basis of monitored oxyhemoglobin saturation to maintain a saturation of ≥94% but <100%. Titrate ETCO2 between 34-45 mmHg.
2. Consider extubation only if wide awake, following commands, and unable to tolerate endotracheal tube.