

The role of each provider is discussed.

Floor Nurses, LVNs, etc: Perform chest compressions prior to code team arrival; call for help. When additional help becomes available, get the crash cart into the room and perform bag mask ventilation at a 30 compression: 2 shallow breath ratio. Do your best to keep these nurses in the room; they typically possess knowledge about the patient that others may lack.

The following are members of the code team who carry pagers.

Medical Interns. Two interns carry pagers:

- (1) one of the on-call interns and
- (2) one of the ICU interns.

Interns need to get the backboard attached to the back of the code cart and perform CPR. They should give each other breaks without interruptions in chest compressions and should NOT BE DOING ANYTHING ELSE BESIDES PERFORMING CPR. Non-code team interns who may also be present are “extras.” The **medical resident** leader should decide what to do with the extra interns. They are likely most effective doing one of the following:

- locating and keeping hand on pulse
- assist leader by looking at cognitive aids and other materials
- joining the CPR effort

ICU Nurses: Confirm proper attachment of defibrillator pads to patient. Develop expertise in all functions of defibrillator including end-tidal CO₂ and CPR feedback. Charge, shock and pace as directed. Assess patency of IV and establish port for drug infusion. Hang one-liter of crystalloid solution for drugs and fluid resuscitation. Recruit floor RN to spike bags, flush lines, etc. Push drugs when needed and requested. Double-check labeling and dose of drug. Announce any drug and dose given.

Pharmacist. Draw up drugs appropriate for the situation at hand. Label all syringes clearly. Do not wait to be asked to prepare epinephrine or vasopressin for injection if CPR is in progress.

Medical Resident on Call (carrying code pager).

Observe team and provide guidance
Make brief survey of teams in operation; redirect personnel as needed.
Ask for help when other personnel for diagnostic or procedural help are needed.

Anesthesia, RT. Airway team. Perform mask ventilation, airway insertion, intubation as needed. Remember, the team leader needs to request the patient to be intubated. Unless the situation is really clear-cut, most anesthesiologists will not walk into a room and just intubate a patient. Be prepared to discuss airway management with the anesthesiologist and arrive at a decision on how to manage the airway. Anesthesiologists can also provide valuable input on line placement, drug selection, preparation, and dosing.

ICU fellow and attending

These people are instructed to run the code if it is not being run properly by the Medical Resident. Ideally, the medical resident will be doing a fabulous job running the ACLS algorithms and the fellow can work on understanding why the arrest occurred and what type of underlying conditions need to be addressed if the patient regains a spontaneous circulation. The Fellow or attending should also be communicating needs with the ICU and planning the next stages of resuscitation (cooling, cath lab, surgery, endoscopy,, etc), and coordinating procedures with other services. The attending should be able to fill in any unmet need per the fellow or medicine resident's request. The ICU fellows and or attending should conduct debriefings where appropriate. With the fellows being more and more skilled with TTE, performance of intermittent echo exams is an evolving role of the fellow. One can envision that an echocardiographic exam of the heart can augment resuscitation by more rapidly differentiating causes of PEA arrest, and may also help define clearer end points for cessation of efforts.

ICU advanced practice nurse (RNP)

Perform procedures, assist with monitoring and transport and coordination of advanced care with ICU fellow and attending.