Base Hospital Contact: Required for Shock.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn (MCG 1302)
   Continually assess patient's airway and ventilation status

2. Administer Oxygen prn (MCG 1302)
   High flow Oxygen 15 L/min for all patients in shock, regardless of SpO₂ ❶

3. Maintain supine if respiratory status allows ❷

4. Establish vascular access (MCG 1375)
   Large bore catheter (18G or 16G) preferred
   For patients with hypotension and clinical evidence of poor perfusion, establish IO catheter if
   unable to obtain peripheral venous access after 2 attempts

   For IO placement in alert patients administer Lidocaine 2% 40mg (20mg/mL) slow IO push,
   dose per MCG1309, may repeat once for infusion pain at half initial dose

5. Initiate cardiac monitoring (MCG 1308)

6. Apply blanket to keep patient warm ❸

7. Consider etiology ❹
   Perform 12-lead ECG if cardiac ischemia suspected
   For patients with dysrhythmia, treat in conjunction with TP 1212, Cardiac Dysrhythmia-
   Bradycardia or TP 1213, Cardiac Dysrhythmia-Tachycardia
   For patients with traumatic injury, treat per TP 1244, Traumatic Injury
   For concern of overdose or toxic exposure, treat in conjunction with TP 1241, Overdose /
   Poisoning / Ingestion
   For patients with suspected sepsis, treat in conjunction with TP 1204, Fever/Sepsis

8. Normal Saline 1L IV/IO rapid infusion
   Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop
   infusion if pulmonary edema develops

9. CONTACT BASE for shock despite initial fluid resuscitation, and for order of additional Normal
   Saline 1L IV/IO

10. For patients with isolated hypotension without signs of poor perfusion and those who rapidly
    improve with or without the initial Normal Saline 250mL document Hypotension (HOTN) as
    provider impression. For patients with hypotension and poor perfusion, as well as patients with
    poor perfusion who do not respond to an initial Normal Saline 250mL infusion and/or require
    addition Normal Saline beyond 1L or Push-dose Epinephrine, document as Shock (SHOK).

11. If clinical evidence of poor perfusion persists despite fluid infusion or pulmonary edema develops
    requiring cessation of fluid administration: Push-dose Epinephrine – mix 9mL Normal Saline with 1mL
    Epinephrine (0.1mg/mL) IV formulation in a 10mL syringe; administer Push-dose Epinephrine (0.01mg/mL)
    1mL IV/IO every 1-5 minutes as needed to maintain SBP > 90mmHg until hospital arrival ❺
    CONTACT BASE concurrent with initial dose of Push-dose Epinephrine
SPECIAL CONSIDERATIONS

1. Shock is inadequate tissue perfusion, equivalent to poor perfusion for the purposes of this protocol.

2. Maintaining a patient supine improves perfusion to vital organs; raising the lower limbs does not provide additional benefit. However, not all patients will tolerate a supine position, which can further compromise respiratory function and airway patency.

3. Exposure to cold increases the likelihood of bleeding complications.

4. There are many etiologies of shock. The treatment protocols referenced here contain guidance on specific interventions beyond what is contained in this treatment protocol. Consider Base contact if hypotension/shock of unclear etiology.

5. **Push-dose Epinephrine** is appropriate for non-traumatic shock including cardiogenic shock. Additional doses beyond 10mL may need to be prepared for prolonged transports.