Treatment Protocol: SHOCK / HYPOTENSION **Ref. No. 1207**

Base Hospital Contact Required.

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 SpO_2 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 *(MCG 1355)*, 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 *MCG 1317.23*, 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**

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SPECIAL CONSIDERATIONS

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

❷ 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.

❸ Exposure to cold increases the likelihood of bleeding complications.

❹ 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.

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