From MEDICAL ASSESSMENT

Ensure oxygenation

Exclude tension pneumo
- Establish vascular access
- Establish cardiac monitor
- Consider causes of shock

If SBP > 100 mmHg:
- Consider 12/15 Lead ECG

If SBP = < 100 mmHg or suspicion of shock:
- Monitor for volume overload
- Administer fluid by bolus

If Volume overload:
- Maintain / reduce IVF @ TKVO

If SBP correcting or shock improving:

TRANSPORT
INDICATIONS:
- Any patient with hypotension, or suspected or confirmed shock, not due to injury or a traumatic incident

CONTRAINDICATIONS:
- None

NOTES:
- Transport the patient in the supine position. Do not elevate the legs. Patients in cardiogenic shock may not tolerate the supine position (due to pulmonary vascular congestion) and should be transported in the position they find most comfortable regardless of blood pressure.
- Providers with the appropriate delegation should initiate needle decompression as soon as tension pneumothorax is suspected.
- Providers with the appropriate delegation should consider IO device insertion if IV access cannot be established, patient condition is critical, and transport time is anticipated to be longer than the time required establishing IO access.
- Appendix A lists the various causes of shock and the primary prehospital interventions available.
- Providers with the appropriate delegation should obtain an ECG providing it does not delay emergent transport. Evidence of STEMI on ECG will require emergent transport, even if the patient is pain free.
- Certain types of shock may be present with a normal SBP and certain patients may be in compensated shock and still register a normal SBP.
- Total volume and rate of administration will be determined by patient condition and response.
- Continuously monitor for signs of pulmonary volume overload, especially in the elderly and patients with cardiogenic shock. If volume overload develops, reduce the rate of fluid administration to TKVO (regardless of the SBP) and initiate emergent transport.

**IV Fluid:**
- NS or RL by bolus
- 20 ml/kg (to a maximum of 1000 ml per bolus)
- Repeat as required
- Consider smaller boluses (5 – 10 ml/kg) if age > 75 yr or cardiac dysfunction known / suspected
### APPENDIX A:
Causes of Shock in Adults

<table>
<thead>
<tr>
<th>Cause</th>
<th>BP</th>
<th>Prehospital Intervention</th>
<th>Associated Care Map(s) or Procedure(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenal insufficiency</td>
<td>↓</td>
<td>- Fluid administration</td>
<td></td>
</tr>
<tr>
<td>Anaphylaxis</td>
<td>↓ / ↔</td>
<td>- Fluid administration</td>
<td>- Anaphylaxis Care Map</td>
</tr>
<tr>
<td>Cardiogenic</td>
<td>↓</td>
<td>- Cautious fluid administration</td>
<td>- Acute Coronary Syndrome Care Map</td>
</tr>
<tr>
<td>Hemorrhagic</td>
<td>↓</td>
<td>- Fluid administration</td>
<td></td>
</tr>
<tr>
<td>Hypovolemic</td>
<td>↓</td>
<td>- Fluid administration</td>
<td></td>
</tr>
<tr>
<td>Obstructive *</td>
<td>↓</td>
<td>- Fluid administration</td>
<td>- Needle Decompression Procedure</td>
</tr>
<tr>
<td>Sepsis</td>
<td>↓ / ↔</td>
<td>- Fluid administration</td>
<td></td>
</tr>
<tr>
<td>Neurogenic</td>
<td>↓ / ↔</td>
<td>- Fluid administration</td>
<td></td>
</tr>
</tbody>
</table>

* Obstructive shock may be due to tension pneumothorax, cardiac tamponade or pulmonary embolism