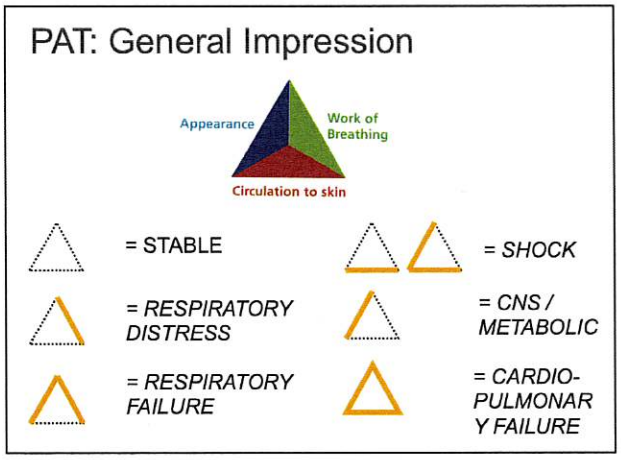
SHOCK (POOR PERFUSION)

BASE GUIDELINES

1. Determine ALS Standing Order treatments/procedures rendered prior to base hospital contact. Use ALS standing order as guidelines for treatments/procedures not initiated prior to base hospital contact.

2. Symptomatic hypotension/shock is manifested by low blood pressure (≤ 80 systolic), poor skin signs, altered mental status, tachycardia, poorly palpable pulses.

3. Causes:
   - There are multiple causes for shock, most common in the field is hypovolemia but consider anaphylaxis and respiratory failure with hypoxia.
   - Shock can be caused by diabetic ketoacidosis, if ketoacidosis suspected consider normal saline bolus of 20 mL/kg.
   - Children with occult trauma can develop shock from internal hemorrhage, assure field personnel have assessed scene and situation for possible injury and if suspected direct transport to a Trauma Center.



ALS STANDING ORDER

1. Cardiac monitor and document rhythm: treat bradycardia using appropriate cardiac SO.

2. Pulse oximetry, if room air oxygen saturation less than 95%, provide:

   ► *High-flow Oxygen by mask or nasal cannula 6 L/min flow rate (direct or blow-by) as tolerated.*

3. IV access, if unresponsive consider IO if peripheral IV cannot be established:

   ► *Administer normal saline 20 mL/kg (maximum 250 mL) IV/IO bolus and make BH contact (CCERC preferred).*

   ► *May repeat twice for total of 3 boluses as a standing order.*

4. Obtain blood glucose and document finding, if blood glucose equal to or less than 60, administer one of:

   ► *Oral glucose preparation, if tolerated and airway reflexes are intact.*
   ► *10% Dextrose 5 mL/kg IV (maximum dose 250 mL).*
   ► *Glucagon 0.5 mg IM if unable to establish IV.*

   Note: IO access may be used for dextrose administration when patient is unconscious with blood glucose less than 60, unable to establish IV and there is no response to glucagon.

5. If no improvement in blood pressure after first fluid bolus, continue with fluid resuscitation and request base hospital order for push dose epinephrine per PR-205.

6. ALS escort to appropriate ERC.

Approved: Carl Schultz, MD

Reviewed: 4/2013; 9/2017; 8/2024; 4/2025
Final Date for Implementation: 4/24/2025

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BASE GUIDELINES

4. If patient is unresponsive to NS bolus, consider push dose epinephrine.
   See PR-205

   Mixing Instructions:
   - Take the epinephrine preparation of 1mg in 10mL (0.1 mg/mL – cardiac epinephrine) and waste 9 mL of the epinephrine solution.
   - Into that syringe, withdraw 9 mL of normal saline from the patient's IV bag. Shake well.
   - Mixture now provides 10 mL of epinephrine at a 10 mcg/mL concentration.

   Push Dose:
   - 0.1 mL/kg of above solution (0.001 mg/kg) IV/IO
   - Maximum single dose 1 mL of above solution (10 mcg)
   - May repeat dose every 3 minutes
   - Titrate to a SBP >70 + age in years X 2 for age up to 10 years.
   - For ages of 10 or more, titrate to a SBP >90

5. Pediatric GCS (Procedure B-02):

Variable	Description	Score
Eye Opening	Eyes opening spontaneously	4
	Eyes opening to sound	3
	Eyes opening in response to painful stimulus	2
	No eye opening	1
Verbal Response	Smiles, oriented to sounds, follows objects, interacts, coos	5
	Irritable cries and inappropriate interactions	4
	Cries in response to pain	3
	Inconsolable and moans in response to pain	2
	No verbal response	1
Motor Response	Infant moves spontaneously or purposefully	6
	Infant withdraws form touch	5
	Infant withdraws from pan	4
	Abnormal flexion to pain for an infant (decorticate response)	3
	Extension to pain (decerebrate response)	2
	No motor response	1
Maximum Score		15

ALS STANDING ORDER

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