NON-TRAUMATIC SHOCK/HYPOTENSION (A40)

History may include: GI bleeding, vomiting, diarrhea, allergic reaction, septicemia, antihypertensive medication overdose.

Physical signs may include: collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse, pale/cold/clammy/mottled skin, rapid respirations, and anxiety. Signs of compensation may be absent in the elderly or patients taking beta-blocker or alpha-blocker medications.

NOTE: a decreased blood pressure is a late sign of shock.

	F	E	O	P	D
ASSESSMENT	X	X	X	X	
BODY TEMPERATURE	X	X	X	X	
PULSE OXIMETRY: apply and monitor.		X	X	X	
CAPNOGRAPHY: apply and monitor.				X	
OXYGEN: if pulse oximetry <94% or signs of hypoperfusion or respiratory distress	X	X	X	X	
ECG MONITOR: lead placement may be delegated. Treat as indicated.				X	
12-LEAD ECG				X	
VASCULAR ACCESS: IV/IO, 2 large bore.				X	
FLUID BOLUS: If patient has a systolic BP < 90, administer 250 mL NS bolus as indicated. Reassess after each bolus. Maximum fluid 2 liters.				X	
POSITION: Trendelenburg position as tolerated. Place on left side if pregnant.	X	X	X	X	
PUSH DOSE EPINEPHRINE: for hypotension – titrate to SBP ≥ 90 • Mix 1 mL of Epi 1:10,000 (0.1 mg/mL) with 9 mL of NS = concentration of 1:100,000 (0.01 mg/mL) • Label syringe “epinephrine 10 mcg/mL” • 0.5 – 1 mL (5-10 mcg) IVP every 1-5 minutes If SBP does not stabilize ≥ 90 after two doses, consider epinephrine drip. Refer to Epinephrine Drip Chart (TCEMSA Rx Guidelines)				X	
BASE CONTACT: if blood pressure remains hypotensive.					X