CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES
A Division of the Fresno County Department of Public Health

Manual Emergency Medical Services Administrative Policies and Procedures	Policy Number 530.39 Page 1 of 2
Subject Paramedic Treatment Protocols **PEDIATRIC SHOCK (NON-TRAUMATIC)**	
References Title 22, Division 9, Chapter 4 of the California Code of Regulations	Effective Fresno County: 01/15/82 Kings County: 04/10/89 Madera County: 06/15/85 Tulare County: 04/19/05

STANDING ORDERS	
1. Assessment	ABCs
2. Secure Airway	Protect with position, basic airway maneuvers, pharyngeal airway, as needed with a BLS airway, assist respirations as needed, suction as needed.
3. Oxygen	High flow. Refer to EMS Policy #530.02.
4. Transport	Notify Hospital of ETA when enroute.
5. IV/IO Access	LR TKO with Volutrol, 2 large gauge. If unable to start IV on first attempt or no vein immediately visible, and patient is unconscious, initiate IO. Contact Base regarding IO if patient is conscious.
6. Fluid Challenge	20 ml/kg LR. Reassess vital signs. Repeat twice if needed (60cc/kg max).
7. Contact Hospital	Per EMS Policy #530.02.

BASE HOSPITAL ORDERS	
1. IO Access	If unable to start IV, consider IO for conscious patient.

SPECIAL CONSIDERATION AND PRIORITIES

1. Assessment – Airway, vital signs, mental status, mucus membranes, hydration, skin perfusion (cyanosis, decreased capillary refill, mottled skin, cold extremities), neck vein distension, mechanism of injury or volume loss.

2. Delay at scene only to secure airway, stabilize spine, and stop major bleeding. Start IV enroute. If a vein is not visible, or if the initial IV attempt is unsuccessful, contact the Base Hospital to establish an intraosseous line.

Approved By		Revision
EMS Director	**Daniel J. Lynch** (Signature on File at EMS Agency)	**06/01/2018**
EMS Medical Director	**Jim Andrews, M.D.** (Signature on File at EMS Agency)	

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3. Early notification of the Base or Receiving Hospital will allow assembly of resources necessary for resuscitation.

4. Blood volume in children is smaller than adults. Blood loss readily tolerated by an adult may be fatal to a child.

5. Shock is difficult to diagnose in children. Clues include: weak and thready tachycardic pulse; changes in mental status including lethargy, irritability, or confusion; and cold, clammy, cyanotic or mottled skin with poor capillary refill.

   Low blood pressure is a late sign of shock.

6. Consider causes of shock – hypovolemia (trauma, vomiting, diarrhea, and DKA), sepsis, cardiogenic (congenital heart disease), neurogenic (phenobarb OD, intracranial hemorrhage), anaphylaxis (bee sting, penicillin).