IVF administered, inotrope use, CTs ordered, or need for ICU care of length of stay.

One significant limitation of POCUS is that performance and interpretation of testing is operator-dependent. Familiarity with basic ultrasound techniques and interpretation is now expected in the emergency department and critical care setting. Accordingly, competency standards have been proposed for emergency medicine and critical care providers in both basic and advanced POCUS techniques.

INITIAL TREATMENT OF SHOCK

Because shock can progress rapidly to an irreversible stage, a key principle in shock management is to initiate treatment for circulatory shock simultaneous with efforts to elucidate shock etiology (Table 303-3). If the initial history, physical examination, and laboratory evaluation have identified the shock type or the specific etiology, then therapy is directed to reverse the underlying physiologic abnormality causing the hypoperfusion and reduced oxygen delivery. To expedite care, all members of the multidisciplinary team (providers, nurses, pharmacists, and respiratory therapists) must be involved in the development and delivery of care. Details of the optimal care for the specific disease processes leading to shock may be found in other chapters of this text. As many patients will present with undifferentiated shock, in this section we will discuss treatment directed at the patient with undifferentiated shock. At the conclusion of this section, we will highlight etiologies of shock that require initiation of lifesaving specific therapy.

The development of shock is a medical emergency, and optimal therapy involves the involvement of a multidisciplinary team to allow the evaluation and initiation of therapy to begin simultaneously. Patients must be treated in a setting where adequate resources are available to support frequent reassessments and invasive monitoring. Most patients with shock should be cared for in an ICU setting.

A key early consideration is to ensure adequate intravenous access. Placement of two peripheral venous catheters (16G or 18G) will provide initial access for the aggressive volume resuscitation that