



Protocol 700-R1-P: Respiratory Distress

Revision 5/22/18
Effective 8/1/18

BLS Treatment

- ❖ Treat life threats. (See Procedure 701 *Life Threats*)
- ❖ Place patient in position of comfort.
- ❖ Observe for signs of severe respiratory distress (Table 1)
 - **Epinephrine** Auto-injector (See Procedure 715 *Epinephrine Auto-Injector*)
 - For draw and inject **Epinephrine** see Special Considerations below
- ❖ Keep patient and family calm.
 - Remember to keep the child in the lap of a caregiver whenever possible on scene. This will keep the child calmer, help to prevent further worsening of symptoms, and allow for better evaluation of the child's respiratory status.
- ❖ Prepare for transport/transfer of care.

ALS Treatment

- ❖ Treat life threats. (See Procedure 701 *Life Threats*)
- ❖ Cardiac Monitor and determine rhythm
- ❖ Obtain baseline SpO₂ on room air or baseline O₂ usage
 - Titrate O₂ to main SpO₂ above 94%
- ❖ If child presents with symptoms consistent with croup (history of upper respiratory infection, fever, "seal bark" cough, or stridor) consider blow by nebulized NS to cool inflamed subglottic tissues.
- ❖ Consider CPAP if \geq 8 years old
- ❖ Treat in accordance with suspected condition (Table 2)
- ❖ Transport/Contact Base Station.

Table 1: Signs of Severe Respiratory Distress

<ul style="list-style-type: none">• ALOC• Sig. accessory muscle use• fatigue	<ul style="list-style-type: none">• low SpO₂,• poor skin signs• Elevated ETCO₂• inability to speak
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Special Considerations

- ❖ An increased work of breathing - typified by retractions, grunting, head bobbing, and nasal flaring is the most specific indicator of respiratory distress.
- ❖ Fatigue is the most specific indicator for impending respiratory failure.
- ❖ Respiratory failure is the number one cause of pediatric cardiac arrest. Bradycardia is almost always caused by hypoxia in children and is an ominous and late finding.
- ❖ EMTs accredited for Optional Scope of Practice per Policy 208 *EMS Responder Scope of Practice* may draw and inject epinephrine in accordance with ALS procedures



Table 2: Treatment Protocols for Respiratory Distress

Suspected Croup (Stridor)	Bronchospasm (Diffuse Wheezing)
<ul style="list-style-type: none">• Normal saline via nebulizer	<ul style="list-style-type: none">• Albuterol: 2.5 mg via nebulizer• Repeat Albuterol as needed• Obtain base contact if HR >180• If the patient is in severe distress and his/her tidal volume decreased,• administer Albuterol via in-line CPAP or BVM• If, after all other interventions, the patient's condition remains the same or worsens, consider• Epinephrine 0.01 mg/kg (1: 1,000) 1mg/1ml: 0.3 mg IM every 3-5 minutes to a max of 0.6mg.
Allergic Reaction/ Anaphylaxis	
<ul style="list-style-type: none">• See Policy <i>M2 - Allergic Reaction</i>	
Smoke Inhalation	
<ul style="list-style-type: none">• See Policy <i>R2 – Smoke Inhalation</i>	