



## 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 SpO<sub>2</sub> on room air or baseline O<sub>2</sub> usage
  - Titrate O<sub>2</sub> to main SpO<sub>2</sub> 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 ≥ 8 years old
- ❖ Treat in accordance with suspected condition (Table 2)
- ❖ Transport/Contact Base Station.

**Table 1: Signs of Severe Respiratory Distress**

• ALOC	• low SpO <sub>2</sub> ,
• Sig. accessory muscle use	• poor skin signs
• fatigue	• Elevated ETCO <sub>2</sub>
	• inability to speak

### 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**

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