

WEST MICHIGAN REGIONAL PROTOCOL

RESPIRATORY DISTRESS PROTOCOL

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Purpose: To provide the process for the assessment and management of patients experiencing respiratory distress.

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I. Assessment Information

A. History:

1. Past Medical History: chronic lung or heart problems, known diagnosis, medications, home oxygen, past allergic reactions, recent surgery, immobility.
2. Current History: onset sudden or gradual, trauma, fever, associated chest pain, itching, paresthesia of mouth or hands

B. Specific Objective Findings:

1. Vital Signs, level of consciousness
2. Cyanosis, poor color
3. Evidence of upper airway obstruction: hoarseness, drooling, coughing, stridor
4. Breath Sounds: present, wet, and wheezing
(Note: on inspiration or exhalation)
5. Signs of Congestive Failure: distended neck veins when upright, peripheral edema (chronic), labored respirations, rales, no fever.
6. Hives, facial swelling
7. Evidence of trauma
8. Retractions, grunting, tracheal tug, other signs respiratory distress.
9. Presence of fever

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II. Management

- A. Utilize universal precautions
- B. Allow patient a position of comfort.
- C. Establish and maintain airway, provide oxygenation and support ventilation as needed.

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D. Determine the type of respiratory problem involved:

1. Upper Airway Obstruction

a. Complete Obstruction:

- 1) Go to Obstructed Airway Procedure.
- 2) Transport

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b. Partial Obstruction: croup, epiglottitis, foreign body, and anaphylaxis:

- 1) Also see Obstructed Airway Protocol.
- 2) In suspected epiglottitis, minimize agitation.
- 3) Consider anaphylaxis (see Allergic Reaction/ Anaphylaxis Protocol).

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- 4) In croup cases, **provide oxygen with nebulized normal saline.**

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- 5) Transport in position of comfort.

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6) Possible orders post radio contact:

- a) Administration of fluids and medications by physician order only.

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2. Breath Sounds: (adequate tidal volume must be present to determine breath sounds.)

a. Clear (hyperventilation, metabolic problems, MI, pulmonary embolus)

- 1) Monitor EKG if appropriate.
- 2) Transport

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P</p> <p>S P</p> <p>P</p> | <p>b. Crackles (rales): differentiate between the following by history, time course, medications, fever, etc.</p> <p>1) Pneumonia</p> <p>a) Sit patient upright.</p> <p>b) Monitor EKG.</p> <p>c) Obtain vascular access.</p> <p>d) Transport</p> <p>2) Pulmonary Edema</p> <p>a) Sit patient upright.</p> <p>b) Monitor EKG.</p> <p>c) Obtain vascular access.</p> <p>d) Consider CPAP per procedure</p> <p>e) NTG 1/150 gr. (0.4 mg) SL</p> <p>i) May repeat every three to five minutes, to a total of 6 doses.</p> <p>ii) Do not administer if patient is, or becomes hypotensive (systolic BP <90), or has taken erectile dysfunction medications within the previous 48 hours, or in pediatric pt.</p> <p>f) Furosemide 40 mg, slow IVP (1 mg/kg in peds) (Contact Med Control Prior to giving in Peds)</p> <p>g) Transport</p> <p>h) If wheezing, consider albuterol 2.5 mg, may be repeated at 2.5 mg if no improvement. (Peds < 5 years old, 1.25 mg, may be repeated at 1.25mg if no improvement)</p> <p>i) Not given without Medical Control permission when pulse is over 140.</p> <p>j) Consider morphine 2-10mg IVP</p> <p>k) Possible orders post radio contact:</p> <p>i) Additional NTG SL</p> <p>ii) Additional furosemide</p> <p>iii) Additional albuterol</p> <p>c. Wheezes: differentiate by history if possible.</p> <p>1) Consider foreign body, especially in children.</p> <p>2) Anaphylactic reaction: see Allergic Reaction/ Anaphylaxis Protocol.</p> <p>3) Asthma</p> <p>a) Sit patient upright.</p> <p>b) Transport</p> <p>c) Consider albuterol/Atrovent 2.5 mg/0.5mg may repeat albuterol at 2.5 mg if no improvement. (Peds < 5 years old albuterol/atrovent 1.25 mg/0.25 mg, may repeat albuterol at 1.25 mg if no improvement)</p> <p>i) Not given without Medical Control permission when pulse is over 140.</p> <p>d) If patient remains unstable, consider establishing vascular access</p> <p>e) Possible orders post radio contact:</p> <p>i) Consider epinephrine 1:1,000 SQ. (0.3 mg in adults; 0.01 mg/kg in peds)</p> |
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- ii) Consider **magnesium sulfate** 2gms slow IVP in refractory Status Asthmaticus.
- iii) Consider **albuterol**, initial or repeat.
- 4) **Chronic Obstructive Pulmonary Disease**
- a) Sit patient upright.
- b) In mild to moderate distress, use low flow oxygen (2 lpm). In severe respiratory distress, administer oxygen at 6 lpm via nasal cannula or 10-15 lpm via mask or other airway adjuncts as appropriate. Watch for respiratory depression.
- c) Monitor EKG
- d) Consider CPAP per procedure
- e) Transport
- f) Consider **albuterol/Atrovent** 2.5 mg/0.5mg may repeat albuterol at 2.5 mg if no improvement. (Peds < 5 years old albuterol/atrovent 1.25 mg/0.25 mg, may repeat albuterol at 1.25 mg if no improvement)
- i) Not given without Medical Control permission when pulse is over 140.
- g) Obtain vascular access
- h) **Possible orders post radio contact:**
- i) Consider additional albuterol
- d. **Asymmetrical breath sounds** (spontaneous pneumothorax)
- 1) Obtain vascular access.
- 2) Transport
- 3) **Possible orders post radio contact:**
- a) If evidence of tension pneumothorax and respiratory arrest appears imminent, consider decompression (see Pleural Decompression Procedure).

IV. Specific Precautions

- A. If you are unable to differentiate the cause of the respiratory distress, the proper course is to administer oxygen and transport. When in doubt and the patient is in severe distress, administer oxygen and support ventilations. You must discuss your alternatives with the medical control physician.
- B. Wheezing may be cardiac in origin. Consider pulmonary edema.
- C. Children with croup, epiglottitis, or laryngeal edema usually have respiratory arrest due to exhaustion or spasm. You will still be able to ventilate with mouth-to-mask or BVM technique. Intubation is appropriate if above techniques do not provide adequate ventilation.
- D. Since albuterol treatments are nebulized with 100% O₂, they may cause respiratory depression in COPD patients