

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

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Medical Director

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PEDIATRIC RESPIRATORY DISTRESS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

STANDING ORDERS

ABC's

~~**SECURE AIRWAY**~~ ~~As appropriate. Confirm tube placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. Monitor intubated patients with continuous waveform capnography if available.~~

POSITION Place patient in position of comfort, usually in parent's lap or arms. Minimize handling and examination to prevent crying and agitation. Avoid laying the patient down. A parent should be allowed to accompany the child to the hospital in order to ease the child's fears.

OXYGEN

MONITOR Treat rhythm as appropriate.

Epiglottitis

History of upper respiratory infection. Tends to occur in patients age 3 to 6, but some cases occur in children less than 2 years of age. Hx and PE: high fever, sore throat, and pain on swallowing, shallow breathing, dyspnea, inspiratory stridor, drooling, and a red swollen epiglottis: (**Do Not** attempt to visualize airway. If the patient is crying, the epiglottis may be visible posterior to the base of the tongue).

COMPLETE OBSTRUCTION

VENTILATE With bag valve mask or approved ventilator and 100% oxygen.

If unable to ventilate (no rise and fall of the chest), then intubation is high risk procedure that should be attempted after repositioning of head. Notify Emergency Department of possible surgical candidate.

~~**SECURE AIRWAY/
INTUBATE**~~ ~~Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation only if unable to establish adequate ventilation and oxygenation using a BVM. Confirm placement, if intubated, with end-tidal CO₂ detector. Continuous waveform capnography should be used in all intubated patients, if available.~~ Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation while en route. Confirm placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. **Continuous waveform capnography should be used in all intubated patients, if available.**

Asthma - Bronchiolitis - Croup

Asthma:
Asthma: Patient or family history of asthma or reactive airway disease. Age usually greater than 1 year; tachypnea; patient sitting up and leaning forward; ~~non~~productive cough, accessory respiratory muscle usage and wheezing (wheezing may not be present if the patient has insufficient air movement).

Bronchiolitis: Age generally less than 1 year, prominent expiratory wheezing and crackles; history of recent upper respiratory infection and fever.

Bronchiolitis:

Croup: Occurs mostly at night during the fall and winter months. History: Mild cold or other infection. Age between 6 months and 4 years, harsh - barking cough, inspiratory stridor.

Croup:

ALBUTEROL 3.0 ml of 0.5% solution in 15 ml saline (or 6 unit-dose vials) via nebulizer over 1 hour or until symptoms improve. If patient intubated, administer dose through aerosol holding chamber. Repeat as needed.

CONSIDER

SALINE NEBULIZER For croup patients.

BASE PHYSICIAN ORDERS

EPINEPHRINE

0.01 mg/kg of 1:1000 SQ, (max. dose 0.5 mg) for wheezing or stridor, if patient is not a neonate. May repeat once in 20 minutes.