Treatment Protocols **Date: 07/01/2025**

Respiratory Distress or Failure - Adult **Policy #9170A**

Stable Systolic blood pressure >90 mmHg	**Unstable** Systolic blood pressure low for age, and/or signs of poor perfusion
Adult BLS Standing Orders	
• Universal Patient Protocol • Ensure patent airway, give oxygen and/or ventilate PRN per **Airway Policy** • Consider NIPPV – **See NIPPV Procedure** • Maintain O2 saturation > 95% • Capnography • Suction aggressively as needed **RESPIRATORY DISTRESS WITH SUSPECTED BRONCHOSPASM** • May assist patient with prescribed albuterol inhaler **SUSPECTED ACUTE STRESSOR/ HYPERVENTILATION SYNDROME** • Remove from any causative environment • Coaching / reassurance • Do not utilize bag or mask rebreathing	• Universal Patient Protocol • Ensure patent airway, give oxygen and/or ventilate PRN per Airway Policy • Consider NIPPV – See NIPPV Procedure • Maintain O2 saturation > 95% • Capnography • Suction aggressively as needed **RESPIRATORY DISTRESS WITH SUSPECTED BRONCHOSPASM** • May assist patient with prescribed albuterol inhaler **SUSPECTED ACUTE STRESSOR/ HYPERVENTILATION SYNDROME** • Remove from any causative environment • Coaching / reassurance • Do not utilize bag or mask rebreathing
Adult LALS Standing Order Protocol	
• Establish IV access PRN • Capnography **SUSPECTED BRONCHOSPASM** (Suspected asthma or COPD) • Albuterol – 2.5 via nebulizer (5 mg if in severe distress) **SUSPECTED CARDIAC ETIOLOGY (CHF)** • Nitroglycerin 0.4 mg SL if SBP ≥ 100 mmHg MR x2 q5 min • Nitroglycerin 0.8 mg SL if SBP ≥ 150 mmHg MR x1 q5 min with persistently elevated SBP • Repeat vital signs between doses of nitroglycerin. Maximum dose 1.6 mg.	• Establish IV • Capnography **HYPOTENSION** • 250 mL NS IV MR to a max of 1,000 mL to maintain a SBP of ≥ 90 mmHg if patient is without rales and there is no evidence of heart failure **SUSPECTED BRONCHOSPASM** (Suspected Asthma, COPD) • Albuterol 2.5 mg via nebulizer (5 mg if in severe distress) **If severe respiratory distress with bronchospasm or inadequate response to Albuterol/Atrovent, consider** • Epinephrine 1:1,000 0.3 mg IM SO. MR x2 q5minutes Respiratory Distress with stridor at rest: • Epinephrine 1:1,000 5 ml via nebulizer SO. May repeat x1 PRN stridor **Reassess following IM epinephrine. If no improvement in 2 minutes, consider**

	• Epinephrine 1:1,000 0.3 mg IM. MR x2 q5minutes PRN for respiratory distress
Adult ALS Standing Orders	
• Monitor EKG • Establish IV/IO • Capnography • Perform 12 Lead EKG PRN **SUSPECTED BRONCHOSPASM** (Suspected asthma, COPD) • Albuterol – 2.5 via nebulizer (5 mg if in severe distress) • Ipratropium – 2.5 mL added to first dose of albuterol via nebulizer • Consider NIPPV – See **NIPPV Procedure** **SUSPECTED CARDIAC ETIOLOGY (CHF)** • Nitroglycerin 0.4 mg SL if SBP > 100 mmHg MR x2 q5 min • Nitroglycerin 0.8 mg SL if SBP > 150 mmHg, MR x1 q5 min • Nitroglycerin paste, 2%, 1 inch if SBP > 150 mmHg • Repeat vital signs between doses (and types) of nitroglycerin. Maximum total dose 1.6 mg. • Consider NIPPV – See **NIPPV Procedure**	• Monitor EKG • Establish IV/IO • Capnography • Perform 12 Lead EKG PRN **HYPOTENSION IF CARDIAC CAUSE NOT SUSPECTED** • 250 mL NS IV MR to a max of 1,000 mL to maintain a SBP of ≥ 90 mmHg if patient is without rales and there is no evidence of heart failure **SUSPECTED BRONCHOSPASM** (Suspected asthma, COPD) • Albuterol 2.5 mg via nebulizer (5 mg if in severe distress) • Ipratropium– 2.5 mL added to first dose of albuterol via nebulizer **If severe respiratory distress with bronchospasm or inadequate response to Albuterol/Atrovent, consider** • Epinephrine 1:1,000 0.3 mg IM SO. MR x 2 q5minutes **Respiratory Distress with stridor at rest:** • Epinephrine 1:1,000 5 ml via nebulizer SO. May repeat x1 PRN stridor **Reassess following IM epinephrine. If no improvement in 2 minutes, consider:** • Epinephrine 1:1,000 0.3 mg IM. MR x 2 q5minutes PRN for respiratory distress • Consider NIPPV – See **NIPPV Procedure** **SUSPECTED CARDIAC ETIOLOGY (CHF)** • Consider NIPPV – See **NIPPV Procedure**
Adult Base Hospital Orders	
SUSPECTED BRONCHOSPASM (Suspected Asthma, COPD) **Asthma only: Patients without improvement with nebulizer** • BH – Epinephrine – 1:1,000 – 0.3 mg IM (Use with caution in patients over 40 yrs, heart disease, or BP > 150 mmHg systolic) **SUSPECTED CARDIAC ETIOLOGY (CHF)**	**SUSPECTED BRONCHOSPASM** (Suspected Asthma, COPD) **Asthma only: Patients without improvement with nebulizer** • BH – Epinephrine – 1:1,000 – 0.3 mg IM (Use with caution in patients over 40 yrs, heart disease, or BP > 150 mmHg systolic) • BHP – Push dose epinephrine for hypotension **SUSPECTED CARDIAC ETIOLOGY (CHF)**

• BH – Nitroglycerin – 0.4 mg SL q 5min if BP <100 mmHg or maximum total dose > 1.6 mg	• BH – Dopamine – 400 mg/ 250 mL NS - 10-20 mcg/kg/min indicate by BP < 90 mmHg systolic. Titrate to BP of 90-100 mmHg systolic

Notes:

- If any patient has taken an erectile dysfunction medication such as Viagra, Cialis, Levitra within 48 hours, NTG is contraindicated
- May encounter patients taking similar medication for pulmonary hypertension (Revatio, Flolan, Veletri). NTG is contraindicated in these patients as well
- Not all wheezing is from bronchospasm. A cardiac wheeze can occur from heart failure. If a patient does not have known COPD or asthma, albuterol may not help the patient and may be harmful. If they have pedal edema, and/or heart disease without COPD or asthma, and new wheezing, consider NIPPV in these patients
- If a pediatric or elderly demented patient presents with stridor or significant upper airway noise, consider foreign body ingestion/aspiration as source of distress
- NIPPV can increase intrathoracic pressure and drop a patient's blood pressure. Perform frequent BP rechecks, and do not use in profound or refractory hypotension

APPROVED:
SIGNATURE ON FILE – 07/01/25
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