

Treatment Protocols**Date: 07/01/2023****Respiratory Distress or Failure - Adult****Policy #9170A**

Stable Systolic blood pressure >90 mmHg	Unstable Systolic blood pressure <90 mmHg, and/or signs of poor perfusion
Adult BLS Standing Orders	
<ul style="list-style-type: none"> • Universal Patient Protocol • Ensure patent airway, give oxygen and/or ventilate PRN per Airway Policy • Consider NIPPV – See NIPPV Procedure • Maintain O2 saturation > 95% • Suction aggressively as needed <p><u>RESPIRATORY DISTRESS WITH SUSPECTED BRONCHOSPASM</u></p> <ul style="list-style-type: none"> • May assist patient with prescribed albuterol inhaler <p><u>SUSPECTED ACUTE STRESSOR/HYPERVENTILATION SYNDROME</u></p> <ul style="list-style-type: none"> • Remove from any causative environment • Coaching / reassurance • Do not utilize paper bag or mask rebreathing 	<ul style="list-style-type: none"> • Universal Patient Protocol • Ensure patent airway, give oxygen and/or ventilate PRN per Airway Policy • Consider NIPPV – See NIPPV Procedure • Maintain O2 saturation > 95% • Suction aggressively as needed <p><u>RESPIRATORY DISTRESS WITH SUSPECTED BRONCHOSPASM</u></p> <ul style="list-style-type: none"> • May assist patient with prescribed albuterol inhaler <p><u>SUSPECTED ACUTE STRESSOR/HYPERVENTILATION SYNDROME</u></p> <ul style="list-style-type: none"> • Remove from any causative environment • Coaching / reassurance • Do not utilize paper bag or mask rebreathing
Adult LALS Standing Order Protocol	
<ul style="list-style-type: none"> • Establish IV PRN <p><u>SUSPECTED BRONCHOSPASM</u> (Suspected asthma or COPD)</p> <ul style="list-style-type: none"> • Albuterol – 2.5 via nebulizer (5 mg if in severe distress) <p><u>SUSPECTED CARDIAC ETIOLOGY (CHF)</u></p> <ul style="list-style-type: none"> • Nitroglycerin 0.4 mg SL if SBP \geq 100 mmHg MR x2 q5 min • Nitroglycerin 0.8 mg SL if SBP \geq 150 mmHg MR x1 q5 min with persistently elevated SBP • Repeat vital signs between doses of nitroglycerin. Maximum dose 1.6 mg. 	<ul style="list-style-type: none"> • Establish IV <p><u>HYPOTENSION</u></p> <ul style="list-style-type: none"> • 250 mL NS IV MR to a max of 1,000 mL to maintain a SBP of \geq 90 mmHg if patient is without rales and there is no evidence of heart failure <p><u>SUSPECTED BRONCHOSPASM</u> (Suspected Asthma, COPD)</p> <ul style="list-style-type: none"> • Albuterol 2.5 mg via nebulizer (5 mg if in severe distress) <p>If severe respiratory distress with bronchospasm or inadequate response to Albuterol/Atrovent, consider</p> <ul style="list-style-type: none"> • Epinephrine 1:1,000 0.3 mg IM SO. MR x2 q5minutes <p>Respiratory Distress with stridor at rest:</p> <ul style="list-style-type: none"> • Epinephrine 1:1,000 5 ml via nebulizer SO. May repeat x1 PRN stridor

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	<p>Reassess following IM epinephrine. If no improvement in 2 minutes, consider</p> <ul style="list-style-type: none"> Epinephrine 1:1,000 0.3 mg IM. MR x2 q5minutes PRN for respiratory distress
Adult ALS Standing Order Protocol	
<ul style="list-style-type: none"> Monitor EKG Establish IV/IO PRN Capnography Perform 12 Lead EKG PRN <p><u>SUSPECTED BRONCHOSPASM</u> (Suspected asthma, COPD)</p> <ul style="list-style-type: none"> 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 <p><u>SUSPECTED CARDIAC ETIOLOGY (CHF)</u></p> <ul style="list-style-type: none"> Nitroglycerin 0.4 mg SL if SBP \geq 100 mmHg MR x2 q5 min Nitroglycerin 0.8 mg SL if SBP \geq 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 	<ul style="list-style-type: none"> Monitor EKG Establish IV/IO Capnography Perform 12 Lead EKG <p><u>HYPOTENSION IF CARDIAC CAUSE NOT SUSPECTED</u></p> <ul style="list-style-type: none"> 250 mL NS IV MR to a max of 1,000 mL to maintain a SBP of \geq 90 mmHg if patient is without rales and there is no evidence of heart failure <p><u>SUSPECTED BRONCHOSPASM</u> (Suspected asthma, COPD)</p> <ul style="list-style-type: none"> Albuterol 2.5 mg via nebulizer (5 mg if in severe distress) Ipratropium– 2.5 mL added to first dose of albuterol via nebulizer <p>If severe respiratory distress with bronchospasm or inadequate response to Albuterol/Atrovent, consider</p> <ul style="list-style-type: none"> 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 <p>Reassess following IM epinephrine. If no improvement in 2 minutes, consider</p> <ul style="list-style-type: none"> Epinephrine 1:1,000 0.3 mg IM. MR x 2 q5minutes PRN for respiratory distress Consider NIPPV – See NIPPV Procedure <p><u>SUSPECTED CARDIAC ETIOLOGY (CHF)</u></p> <ul style="list-style-type: none"> Consider NIPPV – See NIPPV Procedure

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Adult Base Hospital Orders	
<p><u>SUSPECTED BRONCHOSPASM</u> (Suspected Asthma, COPD)</p> <p><u>Asthma only: Patients without improvement with nebulizer</u></p> <ul style="list-style-type: none"> BH – Epinephrine – 1:1,000 – 0.3 mg IM (Use with caution in patients over 40 yrs, heart disease, or BP > 150 mmHg systolic) <p><u>SUSPECTED CARDIAC ETIOLOGY (CHF)</u></p> <ul style="list-style-type: none"> BH – Nitroglycerin – 0.4 mg SL q 5min if BP <100 mmHg or maximum total dose > 1.6 mg 	<p><u>SUSPECTED BRONCHOSPASM</u> (Suspected Asthma, COPD)</p> <p><u>Asthma only: Patients without improvement with nebulizer</u></p> <ul style="list-style-type: none"> 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 <p><u>SUSPECTED CARDIAC ETIOLOGY (CHF)</u></p> <ul style="list-style-type: none"> 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
<p>Notes:</p> <ul style="list-style-type: none"> 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

Katherine Staats, M.D. FACEP

EMS Medical Director