Treatment Protocols **Date: 07/01/2023**

Respiratory Distress or Failure - Pediatric **Policy #9170P**

Stable Systolic blood pressure appropriate for age	**Unstable** Systolic blood pressure low for age, and/or signs of poor perfusion
Pediatric BLS Standing Orders	
• **Universal Patient Protocol** • Ensure patent airway, give oxygen and/or ventilate PRN per **Airway Policy** • Maintain O2 saturation > 95% • Suction aggressively as needed • For adult-sized pediatric patients, can consider **NIPPV – see NIPPV procedure** • Consider early **BHP contact** **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** • Maintain O2 saturation > 95% • Suction aggressively as needed • For adult-sized pediatric patients, can consider **NIPPV – see NIPPV procedure** • Consider early **BHP contact** **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
Pediatric LALS Standing Order Protocol	
• Establish IV access PRN **SUSPECTED BRONCHOSPASM** (Suspected asthma) • Albuterol via nebulizer per ped dosing chart	• Establish IV **HYPOTENSION IF CARDIAC CAUSE NOT SUSPECTED** • 10-20 mL/kg NS IV bolus; titrated to age-appropriate systolic BP MR x1, if patient is without rales and there is no evidence of heart failure **SUSPECTED BRONCHOSPASM** (Suspected Asthma) • Albuterol via nebulizer per pediatric dosing chart **If severe respiratory distress with bronchospasm or inadequate response to Albuterol/Atrovent, consider** • Epinephrine 1:1,000 per drug chart IM SO. MR x 2 q5minutes **Respiratory Distress with stridor at rest** • Epi 1:1,000 per drug chart via nebulizer, MR x1 **Reassess following IM epinephrine. If no improvement in 2 minutes, consider:** • Epi 1:1,000 per drug chart IM. MR x2 q5 minutes

Pediatric ALS Standing Orders	
• Monitor EKG • Establish IV/IO • Capnography • 12 Lead if cardiac source considered **SUSPECTED BRONCHOSPASM** • Albuterol weight based • Ipratropium weight based • Consider NIPPV PRN – See **NIPPV Procedure** (for adult sized pediatric patients only) **CROUP / SUSPECTED CROUP** • NS or Sterile Water 5 mL, via nebulizer mask, MR prn	• Monitor EKG • Establish IV/IO • Capnography • 12 Lead if cardiac source considered **HYPOTENSION IF CARDIAC CAUSE NOT SUSPECTED** • 10-20 mL/kg NS IV/IO bolus; titrated to age-appropriate systolic BP MR x1, if patient is without rales and there is no evidence of heart failure **SUSPECTED BRONCHOSPASM** • Albuterol weight based • Ipratropium weight based • Consider NIPPV PRN – See **NIPPV Procedure** (for adult sized pediatric patients only) **CROUP / SUSPECTED CROUP** • NS or Sterile Water 5 mL, via nebulizer, MR prn
Pediatric Base Hospital Orders	
EPIGLOTTITIS/ SUSPECTED EPIGLOTITIS W/ STRIDOR • **BHP – Epinephrine 1:1,000 weight based** via nebulizer, monitor ECG during administration	**EPIGLOTTITIS/ SUSPECTED EPIGLOTITIS W/ STRIDOR** • **BHP – Epinephrine 1:1,000 weight based** via nebulizer, monitor ECG during administration
Notes:	
• **Not all wheezing is from bronchospasm. A cardiac wheeze can occur from heart failure. If a pediatric patient has known cardiac history (congenital heart abnormality or Kawasaki's disease for example) consider early Base Station contact and NIPPV.** • **If a pediatric 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
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