

Respiratory Distress / Respiratory Failure (Pediatric)

CRITERIA

- This protocol is for patients who have respiratory distress or respiratory failure from an unclear etiology or who have persistent respiratory distress or respiratory failure despite treatment under other existing protocols
- Patients with respiratory distress or respiratory failure due to specific reasons (e.g. obstructed airway, anaphylaxis/severe allergic reaction) should be treated accordingly

CFR and All Provider Levels

1. ABCs and vital signs
2. Use airway adjuncts as needed and administer oxygen as follows:
 - For respiratory distress, administer oxygen and allow the patient to maintain a position of comfort
 - For respiratory failure, assist ventilations at a rate of 20-30 breaths/min with supplemental oxygen
3. Assess and treat for an overdose as needed

CFR STOP

EMT

4. Request ALS assistance
5. Transport

EMT STOP

Paramedic

6. Perform advanced airway management if unable to provide effective bag valve mask ventilations
7. Assess and treat for a tension pneumothorax as needed (Appendix M: Needle Decompression of a Tension Pneumothorax)
8. Begin cardiac monitoring
9. Obtain intravascular access as needed

Paramedic STOP

Medical Control Options

Key Points / Considerations

- Respiratory distress is characterized by increased respiratory effort (work of breathing) WITHOUT central cyanosis, including anxiety, nasal flaring, elevated respiratory rate, use of accessory muscles of respiration (e.g. retractions)
- Respiratory failure is characterized by:
 - Ineffective respiratory effort and symptoms of respiratory distress WITH central cyanosis, including agitation, lethargy, severe dyspnea, labored breathing, head bobbing, grunting, or significant suprasternal, substernal, intercostal and/or parasternal retractions, bradypnea leading to ineffective oxygenation or ventilation
 - Presence of hypoxia and/or hypercapnia
- Monitor breathing continuously and assess for signs of hypoxia and/or increasing respiratory distress
- Bradycardia is an ominous sign that indicates hypoxic cardiac arrest may be imminent
- High concentration oxygen should always be used in pediatric patients
- Do not allow the mask to press against the eyes
- Chest rise is the best indication of adequate ventilation in pediatric patients
- Do not overinflate the lungs when assisting ventilations
- Do not hyperextend the neck
- Blow-by oxygen is an inadequate method of oxygenation. Use the closest age or size-appropriate oxygen delivery mechanism (e.g. nasal cannula, facemask, bag valve mask)
- Effective bag valve mask ventilation is a reasonable alternative to advanced airway interventions (endotracheal intubation or use of a supraglottic airway) in the management of pediatric patients with severe respiratory distress or respiratory failure
- For the tachypneic child with abnormal respirations, consider a glucose check to evaluate for hyperglycemia
- Tension pneumothorax in a pediatric patient in respiratory arrest may develop after resuscitative efforts have begun