



Section 2: Adult Airway/Respiratory Protocols

ADULT AIRWAY/RESPIRATORY: RESPIRATORY DISTRESS PROTOCOL

UNIVERSAL PATIENT CARE PROTOCOL

OXYGEN

12 Lead EKG Procedure
1ST Contact to EKG and Transmission < 10 Min

| | | |
|---|-------------|---|
| E | EMT | E |
| A | AEMT | A |
| P | PARAMEDIC | P |
| M | MED CONTROL | M |

IV PROCEDURE

Mild

Slight wheezing and SOB
Treat with aerosol
DUONEB
(0.5 mg Ipratropium & 2.5 mg Albuterol in 3 ml)
Oxygen as needed

STOP EMT use only with DIRECT Medical Control

Moderate

CAPNOGRAPHY PROCEDURE

Tachypnea wheezing
Treat with aerosol
DUONEB
(0.5 mg Ipratropium & 2.5 mg Albuterol in 3 ml)
Oxygen as needed
Follow up pulse-ox
Repeat **DUONEB** aerosols as needed.

STOP EMT use only with DIRECT Medical Control

Severe

CAPNOGRAPHY PROCEDURE

Tachypnea wheezing
Treat with aerosol
DUONEB
(0.5 mg Ipratropium & 2.5 mg Albuterol in 3 ml)
Oxygen as needed
Follow up pulse-ox
Repeat **DUONEB** aerosols as needed.

STOP EMT use only with DIRECT Medical Control

METHYLPREDNISOLONE (SOLU – MEDROL)
125 mg IVP

STOP Fever

CPAP PROCEDURE
Only if **HYPOXIC** / not responding to basic oxygenation methods

STOP Hypotension
⚠ Untreated Vomiting

Consider **CPAP PROCEDURE**
Only if **HYPOXIC** / not responding to basic oxygenation methods

SEVERE COPD
EPINEPHRINE 1:1000 (ADRENALINE)
0.3 mg IM

⚠ Heart Disease

For Asthma/Known asthmatic
MAGNESIUM SULFATE
2 GM in 100 ml NS over 10 min via minidrip administration set

METHYLPREDNISOLONE (SOLU – MEDROL)
125 mg IVP

STOP Fever

TRANSPORT to appropriate facility **CONTACT** receiving facility **CONSULT** Medical Direction



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ADULT AIRWAY/RESPIRATORY: RESPIRATORY DISTRESS PROTOCOL-cont.

PEARLS and KEY POINTS

| HISTORY | SIGNS AND SYMPTOMS | DIFFERENTIAL DIAGNOSIS |
|--|---|---|
| <ul style="list-style-type: none">• Asthma; COPD -- chronic bronchitis, emphysema, congestive heart failure• Home treatment (oxygen, nebulizer)• Medications (Theophylline, steroids, inhalers)• Toxic exposure, smoke inhalation | <ul style="list-style-type: none">• Shortness of breath• Pursed lip breathing• Decreased ability to speak• Increased respiratory rate and effort• Wheezing, rhonchi• Use of accessory muscles• Fever, cough• Tachycardia• Tripod position | <ul style="list-style-type: none">• Asthma• Anaphylaxis• Aspiration• COPD (emphysema, bronchitis)• Pleural effusion• Pneumonia• Pulmonary embolus• Pneumothorax• Cardiac (MI or CHF)• Pericardial tamponade• Hyperventilation• Inhaled toxin (Carbon monoxide, etc.) |

CPAP should be used as a last resort only in asthmatic patients. Prepare to intubate and ventilate.

SEVERE ASTHMA / STATUS ASTHMATICUS patients not moving air or is not moving the mist from an aerosol treatment give Epinephrine (Adrenaline) 1:1000 0.3 mg IM

Tracheostomy Patient Breathing Management

If the patient is in respiratory distress and has a tracheostomy, suction vigorously with an appropriately sized soft suction catheter using sterile technique. If continued distress, remove and examine the inner cannula of the tracheostomy, if removable, for obstructions. If the tracheostomy and the patient's airway have been suctioned and the catheter passes freely, apply oxygen and / or breathing treatments over the tracheostomy site rather than the patients face.

- Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro
- **Status asthmaticus** - severe prolonged asthma attack unresponsive to therapy - life threatening!
- If the patient is over 50 years of age, has a history of cardiac disease, or if the patient's heart rate is >120 Epinephrine (Adrenaline) may precipitate cardiac ischemia.
- Monitor pulse oximetry continuously during treatment and transport.
- A silent chest in respiratory distress is a pre - respiratory arrest sign.
- Be alert for respiratory depression in COPD patients on prolonged high flow oxygen administration.
- DO NOT withhold oxygen from hypoxic patients.
- If DUONEB is given, monitor the patient's cardiac rhythm and initiate IV.
- Patient with known COPD, asthma and a history of steroid use should receive IV Methylpredisolone (Solu-Medrol). Use with caution in diabetics (hyperglycemia), GI bleeds, and febrile patients (sepsis).
- Assure sufficient expiration time when ventilating COPD or asthma patients to prevent breath stacking and Co2 elimination.
- Albuterol (Proventil) and Ipratropium (Atrovent) can be given down an ETT or Tracheotomy during ventilation if there is evidence of bronchoconstriction.