



Section 2: Adult Airway/Respiratory Protocols

ADULT AIRWAY/RESPIRATORY: RESPIRATORY DISTRESS PROTOCOL

UNIVERSAL PATIENT CARE PROTOCOL
OXYGEN
12 Lead EKG Procedure 1 ST Contact to EKG and Transmission < 10 Min

E	EMT	E
A	AEMT	A
P	PARAMEDIC	P
M	MEDICAL 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
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.
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.
EMT use only with DIRECT Medical Control

METHYLPREDNISOLONE (SOLU – MEDROL) 125 mg IVP
Fever

CPAP PROCEDURE Only if HYPOXIC / not responding to basic oxygenation methods
Hypotension Untreated Vomiting

Consider CPAP PROCEDURE Only if HYPOXIC / not responding to basic oxygenation methods
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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
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 failureHome treatment (oxygen, nebulizer)Medications (Theophylline, steroids, inhalers)Toxic exposure, smoke inhalation	<ul style="list-style-type: none">Shortness of breathPursed lip breathingDecreased ability to speakIncreased respiratory rate and effortWheezing, rhonchiUse of accessory musclesFever, coughTachycardiaTripod position	<ul style="list-style-type: none">AsthmaAnaphylaxisAspirationCOPD (emphysema, bronchitis)Pleural effusionPneumoniaPulmonary embolusPneumothoraxCardiac (MI or CHF)Pericardial tamponadeHyperventilationInhaled 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.