Pediatric Respiratory Distress, Failure or Arrest

Pre-Medical Control
MRF/EMT/SPECIALIST/PARAMEDIC

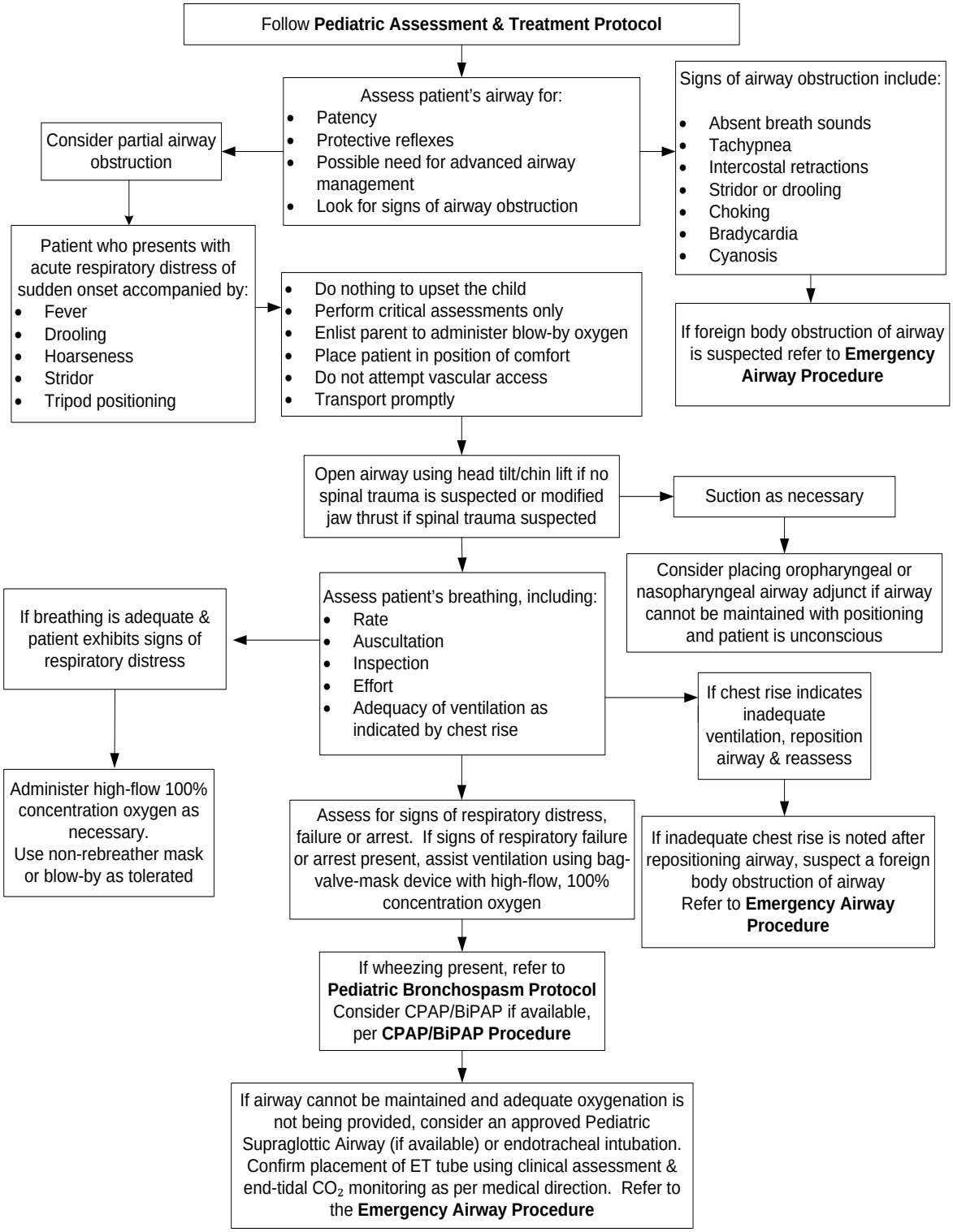
1. Follow **Pediatric Assessment and Treatment Protocol.**
2. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction. Signs include:
   A. absent breath sounds
   B. tachypnea
   C. intercostal retractions
   D. stridor or drooling
   E. choking
   F. bradycardia
   G. cyanosis
3. If foreign body obstruction of the airway is suspected, refer to the **Emergency Airway Procedure.**
4. Consider partial airway obstruction in a patient who presents with acute respiratory distress of sudden onset accompanied by fever, drooling, hoarseness, stridor, and tripod positioning.
   A. Do nothing to upset the child.
   B. Perform critical assessments only.
   C. Enlist the parent to administer blow-by oxygen.
   D. Place the patient in a position of comfort.
   E. Do not attempt vascular access.
   F. Transport promptly
5. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
6. Suction as necessary.
7. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
8. Assess the patient's breathing, including rate, auscultation, inspection, effort, and adequacy of ventilation as indicated by chest rise.
9. If chest rise indicates inadequate ventilation, reposition airway and reassess.
10. If inadequate chest rise is noted after repositioning airway, suspect a foreign body obstruction of the airway. Refer to the **Emergency Airway Procedure.**
11. If breathing is adequate and patient exhibits signs of respiratory distress, administer high-flow, 100% concentration oxygen as necessary. Use a non-rebreather mask or blow-by as tolerated.
12. Assess for signs of respiratory distress, failure, or arrest. If signs of respiratory failure or arrest are present, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen.

EMT/SPECIALIST

13. If wheezing is present, refer to the **Pediatric Bronchospasm Protocol**.
14. Consider CPAP if available, per **CPAP/BiPAP Procedure**.
15. If the airway cannot be maintained and adequate oxygenation is not being provided, consider an approved Pediatric Supraglottic Airway, if available. Refer to the **Emergency Airway Procedure**.

PARAMEDIC

16. If wheezing is present, refer to the **Pediatric Bronchospasm Protocol**.
17. Consider CPAP/BiPAP if available, per **CPAP/BiPAP Procedure**.
18. If the airway cannot be maintained and adequate oxygenation is not being provided, consider an approved Pediatric Supraglottic Airway, if available or endotracheal intubation.
19. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO_2 monitoring, if available. Refer to the **Emergency Airway Procedure**.


Follow **Pediatric Assessment & Treatment Protocol**
Assess patient's airway for:
• Patency
• Protective reflexes
• Possible need for advanced airway management
• Look for signs of airway obstruction
Consider partial airway obstruction
Signs of airway obstruction include:
• Absent breath sounds
• Tachypnea
• Intercostal retractions
• Stridor or drooling
• Choking
• Bradycardia
• Cyanosis
If foreign body obstruction of airway is suspected refer to **Emergency Airway Procedure**
Patient who presents with acute respiratory distress of sudden onset accompanied by:
• Fever
• Drooling
• Hoarseness
• Stridor
• Tripod positioning
• Do nothing to upset the child
• Perform critical assessments only
• Enlist parent to administer blow-by oxygen
• Place patient in position of comfort
• Do not attempt vascular access
• Transport promptly
Open airway using head tilt/chin lift if no spinal trauma is suspected or modified jaw thrust if spinal trauma suspected
Suction as necessary
Consider placing oropharyngeal or nasopharyngeal airway adjunct if airway cannot be maintained with positioning and patient is unconscious
Assess patient's breathing, including:
• Rate
• Auscultation
• Inspection
• Effort
• Adequacy of ventilation as indicated by chest rise
If breathing is adequate & patient exhibits signs of respiratory distress
Administer high-flow 100% concentration oxygen as necessary.
Use non-rebreather mask or blow-by as tolerated
If chest rise indicates inadequate ventilation, reposition airway & reassess
If inadequate chest rise is noted after repositioning airway, suspect a foreign body obstruction of airway
Refer to **Emergency Airway Procedure**
Assess for signs of respiratory distress, failure or arrest. If signs of respiratory failure or arrest present, assist ventilation using bag-valve-mask device with high-flow, 100% concentration oxygen
If wheezing present, refer to **Pediatric Bronchospasm Protocol**
Consider CPAP/BiPAP if available, per **CPAP/BiPAP Procedure**
If airway cannot be maintained and adequate oxygenation is not being provided, consider an approved Pediatric Supraglottic Airway (if available) or endotracheal intubation. Confirm placement of ET tube using clinical assessment & end-tidal CO_2 monitoring as per medical direction. Refer to the **Emergency Airway Procedure**