Respiratory Distress, Failure or Arrest

Pre-Radio

MRF/EMT/SPECIALIST/PARAMEDIC

1. Refer to **General 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:

    - absent breath sounds
    - tachypnea
    - intercostal retractions
    - stridor or drooling
    - choking
    - bradycardia
    - cyanosis

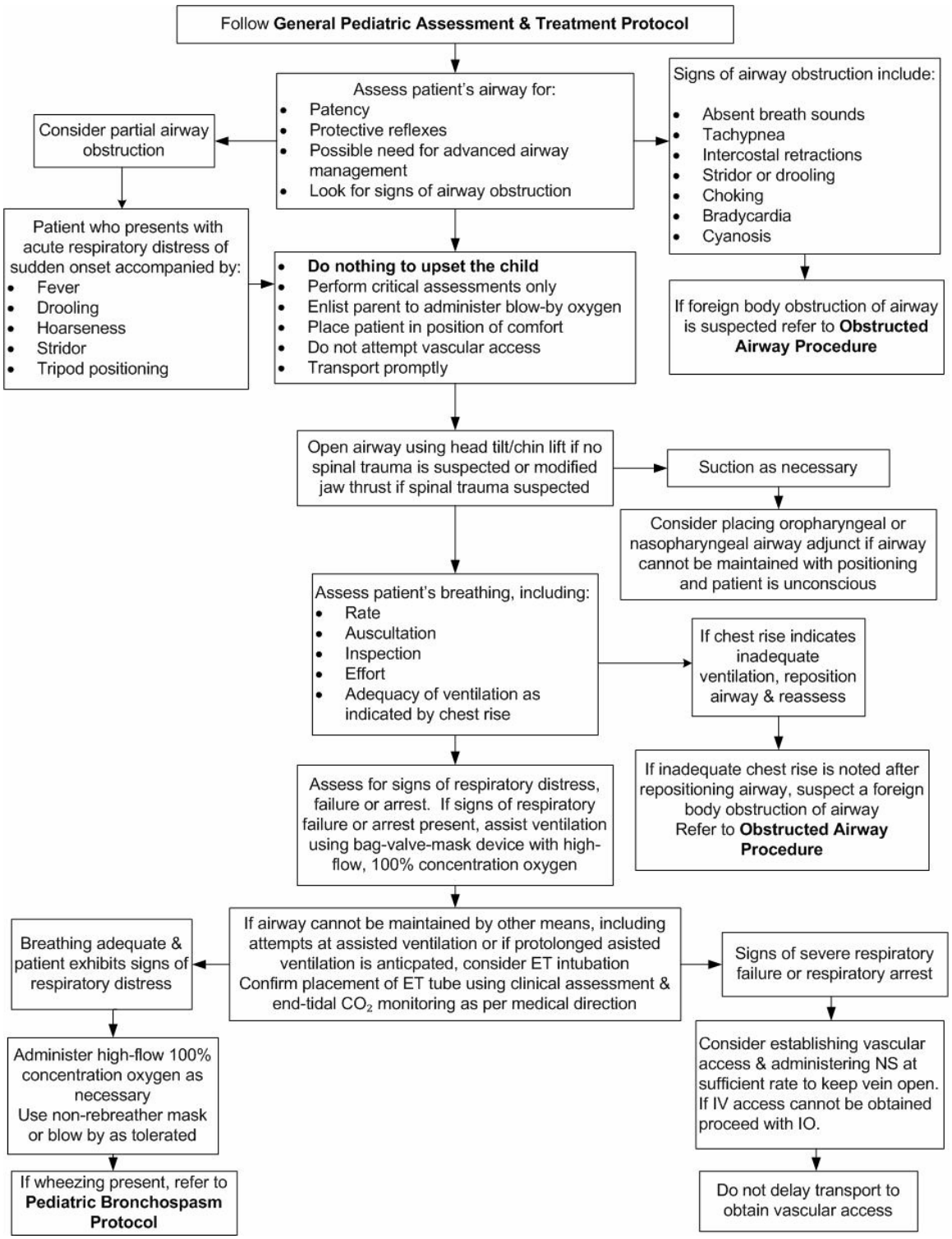
3. If foreign body obstruction of the airway is suspected, refer to the **Obstruction Airway Procedure.**

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 **Obstructed Airway Procedure.**

11. 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.
12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, consider endotracheal intubation. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO_2 monitoring as per medical direction.
13. If breathing is adequate and patient exhibits signs of respiratory distress, administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. If wheezing is present, refer to the **Pediatric Bronchospasm Protocol**.
15. If the patient shows signs of severe respiratory failure or respiratory arrest, consider establishing vascular access and administering normal saline at a sufficient rate to keep the vein open. If intravenous access cannot be obtained, consider intraosseous access. Do not delay transport to obtain vascular access.


Follow **General Pediatric Assessment & Treatment Protocol**
Assess patient's airway for:
• Patency
• Protective reflexes
• Possible need for advanced airway management
• Look for signs of airway obstruction
Signs of airway obstruction include:
• Absent breath sounds
• Tachypnea
• Intercostal retractions
• Stridor or drooling
• Choking
• Bradycardia
• Cyanosis
Consider partial airway obstruction
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
If foreign body obstruction of airway is suspected refer to **Obstructed Airway Procedure**
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 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 **Obstructed 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 airway cannot be maintained by other means, including attempts at assisted ventilation or if protolonged asisted ventilation is anticpated, consider ET intubation
Confirm placement of ET tube using clinical assessment & end-tidal CO_2 monitoring as per medical direction
Breathing adequate & patient exhibits signs of respiratory distress
Signs of severe respiratory failure or respiratory arrest
Administer high-flow 100% concentration oxygen as necessary
Use non-rebreather mask or blow by as tolerated
Consider establishing vascular access & administering NS at sufficient rate to keep vein open. If IV access cannot be obtained proceed with IO.
If wheezing present, refer to **Pediatric Bronchospasm Protocol**
Do not delay transport to obtain vascular access