Subject: PEDIATRIC RESPIRATORY DISTRESS

General

A. Establish and maintain airway. Treat any airway obstructions as per AHA protocol for obstructed airway.

B. Administer O_2 @ 12-15 lpm per non-rebreather mask. If not tolerated, administer blow-by oxygen. Allow the child to assume a position of comfort.

C. If decreased LOC, assist ventilations with BVM as indicated.

D. If patient unresponsive to BVM ventilation, consider endotracheal intubation.

E. In the unconscious or slow to respond patient, establish peripheral IV access with Normal Saline @ TKO. Consider intraosseous route if, indicated.

F. Establish cardiac monitor.

Asthma

A. Consider **albuterol**, 2.5 mg in 2-3 cc normal saline, per nebulizer mask. May give up to two additional times. Continue, if no theophylline preparation being taken by patient.

B. Transport ASAP, and monitor status.

C. Establish cardiac monitor.

Croup

A. Administer **albuterol**, 2.5 mg in 2-3 cc normal saline, per nebulizer mask. May repeat q 20 minutes up to two additional times.

B. Transport ASAP, and monitor status.

Epiglottis

A. In a conscious child with suspected epiglottitis, avoid invasive procedures that may cause agitation.

B. If child loses consciousness, or develops periods of apnea and/or respiratory depression, ventilate with BVM and supplemental O_2 @ 12-15 lpm.

Effective Date: October 20, 2004

Medical Program Director:

C. If BVM ventilation unsuccessful, perform endotracheal intubation using ET tube one size smaller than normal for age.

D. If attempts at ET intubation unsuccessful, consider needle cricothyroidotomy.

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