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 **Obstructed 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. 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.

SPECIALIST/PARAMEDIC

13. If wheezing is present, refer to the **Pediatric Bronchospasm Protocol**.
14. 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. Refer to the **Emergency Airway Procedure**.