Dyspnea Standing Order

**INCLUSION**

All patients complaining of dyspnea, cough, tachypnea, or in respiratory distress

**EXCLUSION**

Standing order should NOT be used on patients with the following symptoms:
- Chest Pain
- Smoke Inhalation
- Absent Breath Sounds
- Dysrhythmia (ACLS)
- Toxic Exposure
- Hemorrhage
- Seizure

Initiate supportive care:

**BLS Care:**
- Assist ventilations if indicated:
  - BVM with 100% O2
- Supplemental O2 to achieve O2 Sat>94%
- Obtain vital signs
- Place patient in position of comfort
- IV Access if permitted

**ALS Care:**
- Follow BLS Interventions
- Cardiac monitor
- If respiratory failure:
  - Consider [Airway Management Protocol](#)

Contact Medical Direction if unclear clinical presentation or patient wishes to refuse and does not meet Refusal Standing Order. Notify receiving facility of incoming patient and/or if CPAP therapy has been initiated.

**SPECIAL NOTE:**
- Other causes of dyspnea include pneumonia, pneumothorax, pulmonary contusion, pulmonary embolism, or toxic ingestion (i.e. aspirin).
- Aspirin ingestions can cause severe tachypnea due to metabolic acidosis: If ETI is performed, ENSURE ventilation rate after ETI matches the patient’s respiratory rate prior to ETI.
- If BVM ventilation or an advanced airway is placed, examine for presence of potential tension pneumothorax and decompress if present.

Effective 4-16-2014
Anaphylaxis/Allergic Reaction Standing Order

**INCLUSION**

**Unstable Allergic Reaction:**
- Signs of: shock, severe respiratory distress or airway compromise

**EXCLUSION**
- If none of the above use Stable Allergic Reaction Inclusion/Order set only.

**INCLUSION**

**Stable Allergic Reaction:**
- Urticaria (Hives)
- Sense of dyspnea
- Sense of oropharyngeal swelling
- Sense of throat tightness

**ORDERS**

For UNSTABLE allergic reaction:

**BLS Care:**
- Administer Epinephrine:
  - via Adult auto-injector IM (wt >30kg)
  - via Pediatric auto-injector IM (wt <30kg)
- Continue with orders outlined in Stable Allergic Reaction.

**ALS Care:**
- Epinephrine 0.01mg/kg to a max of 0.5mg. May repeat every 5 minutes for hypotension or airway edema.
  - 1:1000 solution IM or may substitute age/weight appropriate epinephrine auto-injector
  - 1:10,000 solution IV
- Consider early airway management per Airway Management Protocol
- Continue with orders outlined in Stable Allergic Reaction.

For STABLE allergic reaction OR following the administration of epinephrine:

**BLS Care if respiratory involvement:**
- Albuterol nebulized therapy
  - single unit dose may repeat every five minutes to a max of three doses.

**ALS Care:**
- Albuterol and Ipratropium nebulized therapy
  - May repeat Albuterol every five minutes to a max of three doses.
- IV access and NS/LR fluid bolus:
  - 20ml/kg to a max of 1000ml
- Diphenhydramine
  - 1mg/kg IVP to a max of 50mg
- Methylprednisolone
  - 2mg/kg IVP to a max of 125mg

- Transport to the most appropriate receiving facility. Provide appropriate receiving facility notification.

**SPECIAL NOTE:**
- Multiple diseases may mimic anaphylaxis (i.e. Angioedema, Scombroid Toxicity, Anaphylactoid Reaction, etc).
  Treatment for these diseases is the same as anaphylaxis as outlined above.

Effective 4-16-2014
### Asthma/COPD Dyspnea

#### Standing Order

**INCLUSION**

History of respiratory disease (asthma, COPD), wheezing with increased work of breathing.

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For Presumed **Asthma** and severe respiratory distress unresponsive to initial therapy:

**ALS Care:**

- Epinephrine 0.01mg/kg to a max of 0.5mg
  - 1:1000 solution IM or may substitute age/weight appropriate epinephrine auto-injector
  - 1:10,000 solution IV
- Magnesium Sulfate 50mg/kg up to a maximum dose of 2 grams IV
  - dilute in 50cc bag of D5W and administer over 15 minutes

For Presumed **COPD** and severe respiratory distress unresponsive to initial therapy:

**ALS Care:**

- CPAP
  - Initiated per CPAP protocol
  - Limited to CPAP systems that allow administration of Albuterol and Ipratropium while CPAP is applied

If respiratory failure, support ventilation with BVM. Consider Airway Management Protocol.

Transport to the most appropriate receiving facility. Provide appropriate receiving facility notification.

**SPECIAL NOTE:**

In the management of patients with asthma ETI should be used as a last resort. Following ETI, ventilate slowly (keep respiratory rate to 10/min or less) and with a low tidal volume (6cc/kg ideal body weight).

Effective 4-16-2014
**CHF/Volume Overload Dyspnea Standing Order**

**INCLUSION**

History of volume overload (CHF, Renal Failure) with increased work of breathing or dyspnea.

**For Normotensive** (SBP>90) patients:

**ALS Care:**
- Initiate **CPAP Protocol**
- 12-lead ECG and continuous cardiac monitor
- IV saline lock
- Nitroglycerin
  - 0.4mg SL may repeat every five minutes to a max of three doses. Hold if SBP < 90

**For Hypotensive** (SBP<90) patients:

**ALS Care:**
- Initiate **CPAP Protocol**
- 12-lead ECG & continuous cardiac monitor
- IV saline lock
- Dopamine (If heart rate < 100)*
  - 10-20mcg/kg/min titrate to SBP > 80

**ORDERS**

- If altered mental status or failure to respond to CPAP, support ventilation with BVM. Consider Airway Management Protocol.

Transport to the most appropriate receiving facility. Provide appropriate receiving facility notification.

**SPECIAL NOTE:**

- Furosemide and Morphine are no longer considered appropriate first line prehospital interventions in the management of CHF/Volume overload in the prehospital setting. Should a provider feel that these interventions might be appropriate contact medical direction.

* Infusion of Dopamine for patients with congestive heart failure and a heart rate greater than 100 decreases cardiac output and has been shown to increase mortality and morbidity.

Effective 4-16-2014