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
- Dysrhythmia (ACLS)
- Hemorrhage
- Smoke Inhalation
- Toxic Exposure
- Seizure
- Absent Breath Sounds
- Trauma

Initiate supportive care:

BLS Care:

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

ALS Care:

- Follow BLS Interventions
- Cardiac monitor
- If respiratory failure:
  - Consider Airway Management Protocol

Dyspnea SO	Dyspnea SO	Dyspnea SO
Anaphylaxis	Asthma / COPD	CHF / Volume Overload

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. Consider Critical Pediatrics Triage Criteria

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.

Approved: 1/19/16

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 (wt >30kg)
  - via Pediatric auto-injector (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 (preferred)* 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.

ORDERS

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 25mg
- Methylprednisolone
  - 2mg/kg IVP to a max of 125mg

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.
- *Administration of IV epinephrine can result in significant tachycardia / hypertension and complications such as heart attack and stroke

Approved: 1/19/16

Asthma/COPD Dyspnea
Standing Order

INCLUSION

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

ORDERS

Initial BLS Care:
- Albuterol nebulized therapy
  - Single unit dose. May repeat every five minutes to a max of three doses.

Initial 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
- Methylprednisolone
  - 2mg/kg IVP to a max of 125mg

ORDERS

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 (preferred)* or may substitute age/weight appropriate epinephrine auto-injector
  - 1:10,000 solution IV
- Magnesium Sulfate 25mg/kg to max of 2 grams IV
  - dilute in 50cc bag of crystalloid and administer over 15 minutes

ORDERS

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

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)).
- *Administration of IV epinephrine can result in significant tachycardia / hypertension and complications such as heart attack & stroke

Approved: 1/19/16

CHF/Volume Overload Dyspnea
Standing Order

INCLUSION

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

ORDERS

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

ALS Care:

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

ORDERS

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

ALS Care:

- Initiate CPAP Protocol
- 12-lead ECG and continuous cardiac monitor
- IV saline lock
- Dopamine (If heart rate < 100)*
  - 10-20mcg/kg/min titrate to SBP>80 to a max dose of 20mcg/kg/min

ORDERS

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

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.

Approved: 1/19/16