

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
- Trauma
- Hemorrhage
- Seizure

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

[Anaphylaxis](#)

Dyspnea SO

[Asthma / COPD](#)

Dyspnea SO

[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.

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

ORDER

For UNSTABLE allergic reaction:

BLS Care:

- Administer Epinephrine:
 - via Adult auto-injector (wt >30kg)
 - via Pediatric auto-injector (wt <30kg)
 - Epinephrine anaphylaxis prepared kit may be used (if authorized)
- Continue with orders outlined in Stable Allergic Reaction.

ALS Care:

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

ORDER

For STABLE allergic reaction

OR

following the administration of epinephrine:

BLS Care if respiratory involvement:

- Albuterol nebulized therapy
- Ipratropium nebulized therapy (if available)
 - Single unit dose. May repeat albuterol every five minutes to a max of three doses.

ALS Care:

- IV access and NS/LR fluid bolus:
 - 20ml/kg to a max of 1000ml
- Diphenhydramine
 - 1mg/kg IVP to a max of 50 mg
- 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



Asthma/COPD Standing Order

INCLUSION

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

ORDERS

Initial BLS Care:

- Albuterol nebulized therapy
 - Ipratropium nebulized therapy (if available)
 - Single unit doses.
- May repeat Albuterol 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:

BLS/ALS Care:

- CPAP (if authorized for BLS provider)
 - 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



CHF/Volume Overload Standing Order

INCLUSION

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

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

BLS Care:

- Initiate CPAP Protocol (If authorized)
- IV saline lock (if authorized)

ALS Care:

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



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

BLS Care:

- IV saline lock (if authorized)

ALS Care:

- 12-lead ECG and continuous cardiac monitor
- Initiate CPAP Protocol with pressor support
- Dopamine (If heart rate < 100)*
 - 2-20mcg/kg/min titrate to SBP>80 to a max dose of 20mcg/kg/min



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- 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.

