

**PEORIA AREA EMS SYSTEM
PEDIATRIC PREHOSPITAL CARE MANUAL**

**Pediatric Respiratory
Arrest Protocol**

When the pediatric patient enters respiratory arrest, cardiac arrest (and poor outcome) is sure to follow. Assisted ventilations with a BVM can be the most useful skill in resuscitation of the child in respiratory arrest. Remember – the pediatric patient responds to oxygenation very favorably. Therefore, it is important to try to identify the cause of the respiratory arrest after securing a patent airway and providing proper ventilation.

First Responder Care

First Responder Care should be focused on ensuring a patent airway and proper ventilation.

1. Assess airway. If agonal respirations are present or the child is not breathing at all:
 - a. Perform jaw thrust
 - b. Suction airway
 - c. Oropharyngeal or nasopharyngeal
2. Administer **100% oxygen** using appropriately sized BVM.
3. If chest rise is inadequate:
 - a. Relieve upper airway obstruction.
 - b. Reposition airway.
 - c. Refer to *Basic Airway Management of the Pediatric Patient Protocol*.
4. Refer to *Pediatric Respiratory Distress Protocol* if breathing resumes.
5. If hypoperfusion is present, refer to *Pediatric Shock Protocol*.
6. *Routine Pediatric Care Protocol*.
7. Initiate transport as soon as possible.

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BLS Care

BLS Care should be directed at conducting a thorough patient assessment, ensuring that the child has a patent airway and proper ventilation.

1. BLS Care includes all components of *First Responder Care*.
2. Apply pulse oximetry and document oxygen saturation.
3. Initiate ALS intercept and transport as soon as possible.

ILS Care

ILS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, ensuring a patent airway and proper ventilation.

1. ILS Care includes all components of *First Responder Care/BLS Care*.
2. Consider underlying etiologies and treat according to the appropriate protocol:

- Airway obstruction
- Cardiac dysrhythmias
- CNS injury
- Anaphylaxis
- Poisoning/Overdose
- Suffocation
- Metabolic (refer to *Pediatric ALOC Protocol*)
- Hypovolemia (refer to *Pediatric Shock Protocol*)
- Near drowning
- Carbon monoxide exposure

3. Initiate IV access, if possible.
4. Initiate ALS intercept and transport as soon as possible.

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ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, ensuring a patent airway and proper ventilation.

1. ALS Care includes all components of *FR/BLS/ILS Care*.
2. Refer to *Advanced Airway Control of the Pediatric Patient Protocol* if needed.
3. **Needle chest decompression** on the affected side with a 14g, 16g, or 18g IV catheter if tension pneumothorax is suspected. (**with Medical Control order only**).
4. Transport as soon as possible.

Critical Thinking Elements

- **Studies have shown that BLS management of pediatric airways is just as effective as intubation. Do not spend time on scene with intubation procedures.**
- **Gastric distention is very common in pediatric patients and may cause poor compliance. Ventilating too fast or giving too much tidal volume is the top two reasons for distention. Use proper ventilation techniques and an appropriately sized BVM for the pediatric patient.**