

RN Protocol: Respiratory Distress (Non-traumatic)

I. POLICY

- A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients in respiratory distress.

- B. Circumstances under which the RN may perform:
 - 1. Setting: Outpatient clinic and triage and treatment area.
 - 2. Supervision: None required.

II. PROTOCOL

This protocol may be used for patients in respiratory distress who do not have a known history of asthma. If the patient has a history of asthma use the RN Protocol: Asthma/Bronchospasm. If the patient appears to be having an allergic reaction use the RN Protocol for Allergic Reactions.

- A. Definition: Subjective difficulty or distress in breathing usually associated with disease of the heart or lungs; occurs normally during intense physical exertion or at high altitude. Signs and symptoms of respiratory distress include dyspnea, tachypnea, stridor, wheezing, and cyanosis.

- B. Subjective:
 - 1. Chief complaint (document in the patient's own words).
 - 2. Date and time of onset.
 - 3. What activity was the patient engaged in when the symptoms began?
 - 4. Is the shortness of breath accompanied by chest pain?
 - 5. Has the patient been exposed recently to dust, fumes, or chemicals?
 - 6. History of smoking.
 - 7. Past medical history (e.g., recent upper respiratory infection, asthma, bronchitis, chronic obstructive pulmonary disease, tuberculosis, heart disease, travel >4 hours, etc.).
 - 8. Allergies.
 - 9. Current medications.

- C. Objective:
 - 1. Airway, breathing and circulation
 - 2. Vital signs
 - 3. Observe patient for the following signs and symptoms:
 - a. Shortness of breath
 - b. Dyspnea
 - c. Tachypnea
 - d. Unable to speak in sentences

- e. Stridor
 - f. Nasal flaring
 - g. Signs of choking
 - h. Use of accessory muscles
 - i. Restlessness
 - j. Pallor
 - k. Diaphoresis
4. Evaluate neck for JVD, tracheal deviation.
 5. Percuss for dullness, asymmetry.
 6. Auscultate breath sounds bilaterally (clear, wheezes, crackles, diminished, absent).
 7. Obtain pulse oximetry reading.
 8. After the patient has stabilized obtain peak expiratory flow rate.
- D. Assessment:
- Ineffective breathing pattern related to/evidenced by:
 - Impaired gas exchange related to/evidenced by:
 - Inability to sustain spontaneous ventilation related to/evidenced by:
- E. Plan:
1. Notify physician **STAT**.
 2. Ensure a patent airway and assist ventilation as indicated. Place patient in high-Fowler's position.
 2. Place on pulse oximeter. Administer O₂ at 2-6 L/minute via nasal cannula or 15L/minute via mask to maintain oxygen saturation ≥ 90%.
 3. Monitor cardiac rate and rhythm with EKG machine or cardiac monitor.
 4. Insert intravenous line and infuse Sodium Chloride Intravenous Solution (0.9%) at TKO.
 5. Monitor vital signs, level of consciousness, and pulse oximeter readings every five minutes until transferred to outside facility.
 6. Prepare to transfer to outside facility or admit to a facility capable of providing a higher level of care.
 7. Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to receiving facility.
- F. Patient Education:
1. Assess patient's potential for understanding the health information to be provided.
 2. Provide patient education consistent with the assessment of the condition.
 3. Document the education provided and the patient's level of understanding on the emergency care flow sheet.
 4. Refer patient to other resources as needed. Document all referrals on the emergency care flow sheet.
 5. Advise patient to utilize urgent/emergent process to access medical care if symptoms recur.

G. Documentation:

All information related to the patient's complaint shall be documented on the emergency care flow sheet. The flow sheet shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

- A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients in respiratory distress and achieve a minimum score of 80% on the written posttest examination.
- B. Experience: None.
- C. Certification: None
- D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstration. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include, but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

- E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurses authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____

REVISION DATE: _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

Chief Nurse Executive/Director of Nursing

DATE: _____

Chief Medical Executive

DATE: _____