Respiratory Distress – Respiratory Therapy Medical Directive

Medical Advisory Committee Approved: 23MAR2021

☑ Harmonized

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Authorizing Prescribers

LHO	-	Lakeridge Health Oshawa Physicians
LHAP	-	Lakeridge Health Ajax-Pickering Physicians
LHB	-	Lakeridge Health Bowmanville Physicians
LHPP	-	Lakeridge Health Port Perry Physicians

Authorized to Whom

Registered Respiratory Therapists (RRT) that have the knowledge, skill, and judgment, have successfully attained certification and participated in Didactic and Simulation education, and have successfully passed examinations for the Lakeridge Health Respiratory Distress medical directive.

Co-implementers: Medical Radiation Technologist (R) (MRT(R)) employed at LH who have the knowledge, skill and judgement. The MRT (R) providing diagnostic imaging for whom the RRT has selected a chest X-ray from the orders table under this directive, as a co-implementer, will proceed with the chest x- ray as selected by the RRT. Refer to order table form.

Patient Description/Population

Patients over 16 years of age who present with signs and symptoms of respiratory distress in an adult patient care unit.

Order and/or Procedure

- Review patient's history and diagnosis
- Initiate any appropriate orders from the Order Table Form.
- Contact Most Responsible Practitioner (MRP) and Consult Critical Care Outreach Team (CCOT), if available on site.

Indications to the Implementation of the Directive

Any admitted patient with indications for respiratory distress originating from metabolic or cardiorespiratory imbalance. See order table for specific indications.

Contraindications to the Implementation of the Directive

The directive must not be implemented in any of the following circumstances:

- The patient refuses to consent to the procedure
- Patient's advanced care plan does not support initiating or continuing with Medical Directive procedures.
- Existence of procedure specific contraindications as noted in the Order Table Form.

Note: If a person or substitute decision maker (SDM) refuses treatment, contact the Most Responsible Practitioner (MRP) immediately to determine plan of care.

Consent

The RRT implementing the medical directive must obtain consent, if the patient is capable of providing it. In an emergency situation, if the patient is not capable of providing consent, the RRT may administer treatment without consent if, in his or her opinion, all of the following are true:

- the patient is incapable with respect to the treatment;
- the patient is experiencing severe suffering or is at risk, if the treatment is not administered promptly, of suffering serious bodily harm; and
- it is not reasonably possible to obtain a consent or refusal on the person's behalf, or the delay required to do so will prolong the suffering that the patient is experiencing or will put the patient at risk of suffering serious bodily harm

Documentation Requirements

In addition to standard documentation practices, the RRT implementing this directive must document the following in the patient's health record:

- The name of this medical directive
- The procedure and orders that were completed
- The name of the implementer
- The date and time
- Legible signature of implementer including credential
- MRT (R) (co-implementer) will document in the patients' health record as per standard documentation practices.

Review/Evaluation Process

This medical directive is to be reviewed every 2 years by the Critical Care Program.

References

Government of Ontario (2017). Regulated health professions act, 1991S.O. 1992, chapter 18. Retrieved from https://www.ontario.ca/laws/statute/91r18

Institute for Safe Medication Practices (ISMP) Canada (2016*).* Changes in expression of strength: Elimination of ratios on single-entity injectable products. Volume 16 Issue 2. Retrieved from https://www.ismp-canada.org/download/safetyBulletins/2016/ISMPCSB2016-02_ChangesInExpressionStrength.pdf

Chojecki, D., & Moga, C. (2016). Oxygen therapy in acute care settings. *Institute of Health Economics Report.* Alberta:ON. Retrieved from: https://www.ihe.ca.download/oxygen_therapy_in_acute_care_settings.pd

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This table must **not** be used independently apart from the Medical Directive

Order Table Form

Order	Indication	Contraindication	Notes
Oxygen therapy to maintain saturation: • Adult patients to maintain SpO2 above or equal to 92%. • Adult patients with a known history of COPD to achieve SpO2 of 88-92%	The patient complaints of respiratory distress or presents with symptoms such as: • Shortness of breath • Tachypnea • Dyspnea • Orthopnea • Cyanosis • Accessory muscle use • Stridor • Crackles/wheezes	The patient's symptoms are not suggestive of respiratory distress.	Ensure MRP is aware of the treatment initiated. Explained to the patient and/or family, and/or SDM when possible.
Arterial Blood Gases (ABG) by puncture or via arterial line STAT or i-STAT ABG (pH, PO2, and pCO2)	• Decreased LOC • Hypoxia • Suspected Diabetic Ketoacidosis	• Patient refusal • No collateral circulation	Explained to the patient and/or family, and/or SDM when possible.
Stat portable chest X-ray (upright if possible)	If on auscultation: • Wheezing • Silent chest • Crackles	• Patient refusal	Review patients history and diagnosis. Explained to the patient and/or family, and/or SDM when possible.
Salbutamol 100mcg/puff 4-8 puffs inhaled q15 minutes up to 3 times	If on auscultation: • Wheezing • Silent chest • Crackles	Do not administer if there is a documented salbutamol allergy	Explained to the patient and/or family, and/or SDM when possible. Position patient is Semi to High Fowlers
Ipratropium 20 mcg/puff 4 – 8 puffs inhaled q15 minutes up to 3 times	If on auscultation: • Wheezing • Silent chest • Crackles	Do not administer if there is a documented ipratropium allergy	Explained to the patient and/or family, and/or SDM when possible. Position patient is Semi to High Fowlers
Initiate CPAP at 5 cm H20 and increase by 5 cm H20 to maximum 15 cm H20 as required	CPAP: Respiratory rate greater than 30 and/or oxygen saturation less than 90% on 100% oxygen by non-rebreather or high-flow nasal cannula, to relieve symptoms/ hypoxia	CPAP • SBP less than 90 mmHg • Suspected pneumothorax • Decrease in level of consciousness leading to airway compromise • Inability to sit upright	Patients who require CPAP must be transferred to Critical Care Unit Explained to the patient and/or family, and/or SDM when possible.