



- a. Full set of vital signs (pulse, blood pressure, respiratory rate, neurologic status assessment) temperature, and O₂ saturation
- b. Air entry (normal vs. diminished)
- c. Breath sounds (wheezes, crackles, rales, rhonchi, diminished, clear)
- d. Signs of distress (grunting, nasal flaring, retracting, accessory muscle use)
- e. Weak cry or inability to speak full sentences (sign of shortness of breath)
- f. Color (pallor, cyanosis, normal)
- g. Mental status (alert, tired, lethargic, unresponsive)
- h. Hydration status (+/- sunken eyes, delayed capillary refill, mucous membranes (moist vs. tacky), fontanel (flat vs. sunken))

Treatment and Interventions

1. Pulse oximetry and end-tidal capnography (EtCO₂) should be routinely used as an adjunct to other forms of respiratory monitoring
2. Perform EKG only if there are no signs of clinical improvement after treating respiratory distress
3. Airway
 - a. Give supplemental oxygen – escalate from a nasal cannula to a simple face mask to a non-breather mask as needed, to maintain normal oxygenation (goal SpO₂ 94–98%)
 - b. Suction the nose and/or mouth (via bulb or suction catheter) particularly if excessive secretions are present
4. Inhaled medications – nebulized epinephrine 5 mg (5 mL of 1 mg/mL solution) should be administered to children in severe respiratory distress with bronchiolitis in the prehospital setting if other treatments (e.g., suctioning, oxygen) fail to result in clinical improvement; if immediate reassessment after treatment does *not* demonstrate clinical improvement, airway management should be escalated as necessary (*see below* and refer to [Airway Management Guideline](#))
5. Utility of IV placement and fluids. IVs should only be placed in children with respiratory distress for clinical concerns of dehydration, or when administering IV medications. Otherwise, IV access is not routinely needed in bronchiolitis.
6. Steroids are not efficacious and should not be given
7. Improvement of oxygenation and/or respiratory distress with non-invasive airway adjuncts

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| <ol style="list-style-type: none">a. High flow nasal cannula (HFNC) or continuous positive airway pressure (CPAP) can be administered, when available, for severe respiratory distressb. Bag-valve-mask ventilation should be utilized in children with respiratory failure or impending respiratory failure |
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8. Supraglottic devices and intubation
 - a. Supraglottic devices and intubation should be utilized only if bag-valve-mask (BVM) ventilation fails
 - b. The airway should be managed in the least invasive way possible

Patient Safety Considerations

Routine use of lights and sirens is not recommended during transport