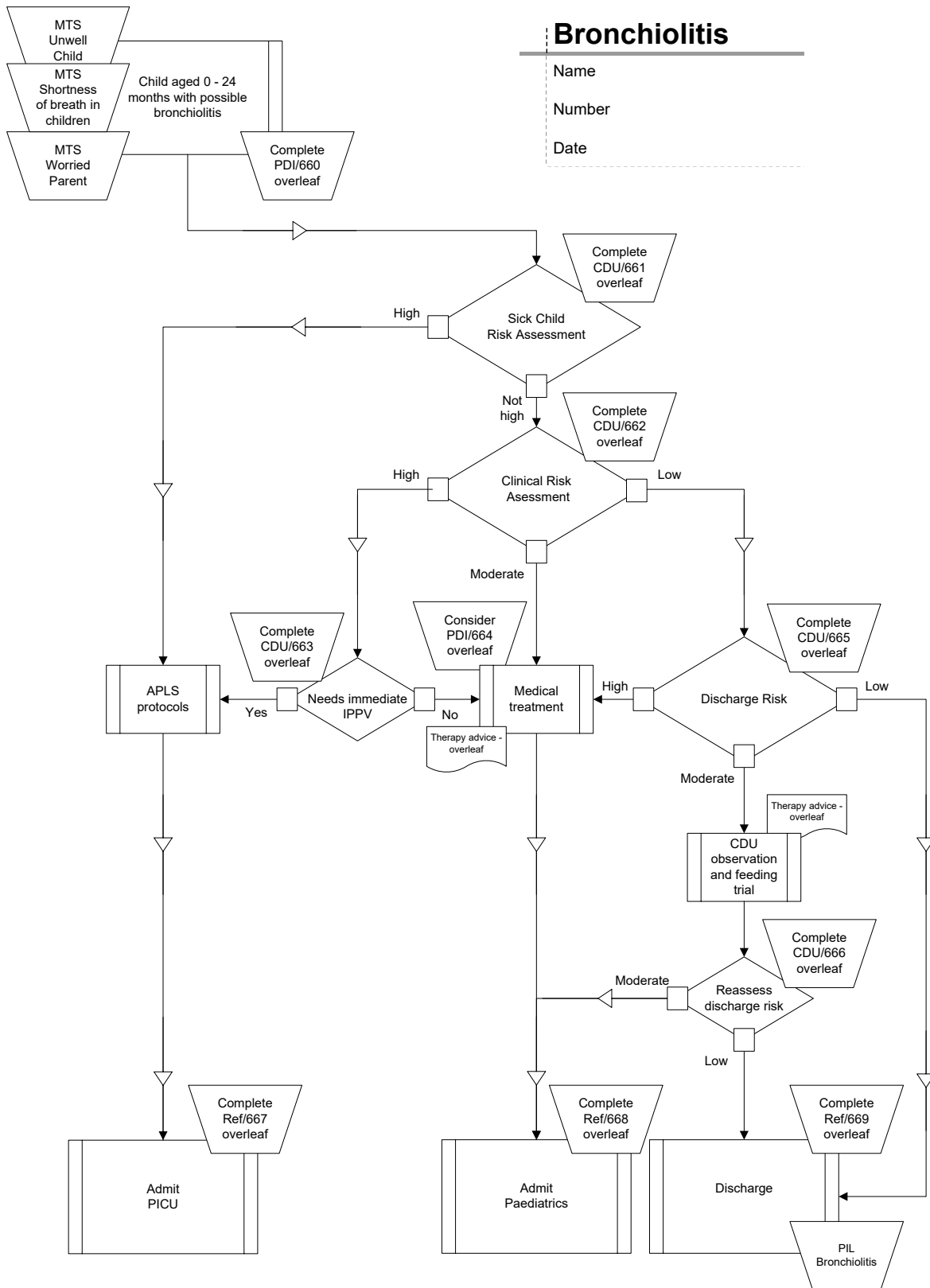


Bronchiolitis

Name

Number

Date



Produced By:	Dan Horner and Catherine Williams	Protocol number	2009-51 v 2.1
Authorised By:	Consultants Emergency Department	Date of issue	18/06/2009
Approved By:	Lead Clinician Children's Emergency Medicine	Date of review	17/06/2012

PDI/660: SUITABILITY FOR PROTOCOL DRIVEN INVESTIGATION (ALL YES)

24 months or less	Yes	No
Possible bronchiolitis (preceding coryzal illness, nasal discharge, wheezy cough)	Yes	No
Order: T, P, BP, RR, S _a O ₂ , Weight		

CDU/661: SICK CHILD ASSESSMENT (ANY YES)

Airway compromise / stridor / drooling	Yes	No
Inadequate breathing	Yes	No
Shock	Yes	No
Altered conscious level / Fails to react to parent	Yes	No
Floppy	Yes	No

Any Y = High

CDU/662: CLINICAL RISK ASSESSMENT OF BRONCHIOLITIS

	0	1	2	3
Wheezing	None	End expiration / on auscultation	All expiration / audible	Insp and exp audible
Retractions	None	Intercostal	Tracheosternal	Severe with flaring
General appearance	None			Irritable, lethargic, poor feeding effort
Respiratory rate	< 31	31 - 44	45 - 60	> 60

Risk is high if 9 - 12, moderate if 5 - 8 and low if 0 - 4

CDU/663: NEED FOR IMMEDIATE IPPV (ANY YES)

Apnoeic periods with desaturation	Yes	No
SaO ₂ < 80%	Yes	No
Respiratory rate over 70 or less than 20	Yes	No
Obvious exhaustion or deteriorating respiratory effort	Yes	No

PDI/664: INVESTIGATIONS PRIOR TO ADMISSION

Order CXR if T > 39°, NPA for RSV, Ametop

CDU/665: DISCHARGERISK

	H	M	L
Delivered < 34/40, or aged < 8 weeks, or congenital heart / lung disease			
Social concerns			
SaO ₂ not consistently > 95%			
Feeding < 50% normal			
Abnormal respiratory rate for age			
None of the above			

CDU/666: REASSESSMENT OF DISCHARGE RISK (ANY YES)

	M	L
SaO ₂ not consistently > 95%	Yes	No
Feeding < 50% normal	Yes	No
Persistent abnormal respiratory rate for age	Yes	No
Deterioration during the observation period	Yes	No

Any Y = Moderate

MEDICAL THERAPY ADVICE

Medical therapy: Oxygen should be given to keep SaO₂ > 95%. Nasal suction should be undertaken regularly. Oral feeding should be attempted, if this is not possible then a NGT should be placed and maintenance feeds given. 4ml 3% hypertonic saline should be nebulised every 8 hours with salbutamol 2.5mg for patients who have moderate or high clinical risk.

Ref/677: Referral to PICU agreed	
Ref/668: Admission to paediatric ward agreed	
Ref/669: Discharge to GP agreed. Safety net in place	

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