Clinical Practice Guideline for Bronchiolitis Management: Urgent Care

FINAL 10.4.18

Infants presenting with signs and symptoms of upper respiratory infection progressing to lower respiratory symptoms[1]

Blue shaded area represents **Caregiver Initiated Protocol for Bronchiolitis 6.04**

Score → Suction → Rescore

Place in room immediately and notify physician of O_2 sats if less than or equal to 90%

For temperature ≥38 C, also refer to **Fever Guideline** for appropriate age group

Mild CRS 0-2

Moderate CRS 3-6

Severe CRS ≥7 *Notify physician

Continue to evaluate & suction PRN Assess hydration[3]

At risk for Asthma[2]? — YES → Consider One Time Trial Albuterol

*If positive response, then Off Guideline and Consider **Asthma Guideline** for Further Management*

NO

MODERATE — SEVERE

Suction PRN

Suction PRN *Consider:* Racemic Epinephrine

Reevaluate Assess Hydration[3]

Reevaluate Assess Hydration[3]

Meets Discharge Criteria[4]

NO

YES

Patient/Family Education[5]

Discharge

Admit[6]

Literature shows the following are not beneficial routinely: CBC, CXR, RSV labs, antibiotics, serial aerosols, steroids and/or chest percussion

[1]Inclusion Criteria

- Previously healthy infant
- 1-18 months of age
- Suspicion of diagnosis of bronchiolitis: upper respiratory symptoms such as rhinitis, coughing; lower respiratory signs such as wheezing, crackles, tachypnea, that may result in difficulty breathing and/or difficulty feeding

Exclusion Criteria:

- Toxic Appearance
- CLD (Chronic Lung Disease)
- Cardiac disease requiring baseline medications

Isolation Standard

- Per CDC/HICPAC Guidelines: Contact Droplet Isolation for the duration of the illness

[2]Risk for Asthma

Patient may be at increased risk for asthma if >12mo old:

- with wheeze plus history of atopy OR
- strong family history of atopy or asthma

Respiratory

- Suctioning: Oral, Bulb tip, or NP suctioning as needed; Wean to bulb suctioning
- Oxygen PRN to maintain Sats ≥90% while awake (≥88% while asleep) or If severe respiratory distress

[3]Feeding/Hydration

- PO feeding preferred if respiratory rate <60
- Intake of 75% maintenance fluid needs is adequate unless dehydrated
- D5NS or D5LR are preferred maintenance IV fluids. If giving IVF, avoid hypotonic solution (D5¼ and D5½) due to risk of SIADH induced hyponatremia.
- *NG feedings preferred to IVF unless contraindicated or physician order. While NG feedings are not routinely available in Urgent Care, patient may receive in ED or Inpatient.* ***Refer to NG policy: PC 19-02, HS-PC 19-02***

[4]Discharge Criteria

Patient must meet all discharge criteria

- Room air sats consistently ≥ 90% while awake or ≥88% while asleep
- Able to handle secretions or bulb suctioning only
- Adequate activity & hydration
- Home care needs arranged
- Parent verbalizes/demonstrates understanding of: Natural history of the disease, bulb suctioning, and medications if indicated
- Parents able to follow-up with PCP within 48 hours or access emergency care if needed

[5]Patient/Family Education

- Nasal suctioning
- Signs/symptoms of respiratory distress
- Guidelines for feeding
- Review bronchiolitis teaching sheet
- No smoking in home & avoidance of other environmental pollutants

[6]Transfer to Emergency Department

- Persistent Significant work of breathing
- O_2 requirement to keep sats ≥90%, consistently
- Unable to handle secretions with bulb suctioning
- Poor Feeding
- Consider if history of apneic episode

Consider Air Transport IF:

- Multiple episodes of apnea (>1) or any episode requiring bagging
- CRS ≥ 9
- FiO_2 ≥ 50%
- PEWS =7 or score of 3 in any of categories Airway, Circulation, or Disability
- Use Air Transport or call 911 as appropriate

CRS=Clinical Respiratory Score