POLICY & PROCEDURE

TITLE: RESPIRATIONS				
Scope/Purpose: To create a standard process for assessing breathing and oxygenation. To ensure protocols are followed when breathing effectiveness appears impaired/inadequate.				
Division/Department: All Clinics		**Policy/Procedure #:**		
Original Date: July 6, 2015		**_x__New ___Replacement for:**		
Date Reviewed:	**Date Revised:**	**Implementation:**	**CPIC Approved:**	**Board Approved:**
			07/22/2015	
Responsible Party: Director of Nursing				

DEFINITIONS: The function of the respiratory system is to supply adequate oxygen to tissues in the body and remove waste carbon dioxide. This is achieved with inspiration and expiration of air (breathing).

POLICY: It is the policy that all HealthPoint employees assess and document patient's respirations at all clinic provider visits. While assessment and documentation of respiratory rate assessment are not required for "Lab only" or "Immunization only" visits, staff obtaining labs or performing immunizations/vaccines shall observe the patient's ease with breathing and follow guidelines outlined in "***Standing Delegation Order – Urgent Assessment***" should the patient have any trouble breathing.

PROCEDURE:

A. GUIDELINES:
1. Respirations rate is the number of breaths a person takes a minute.
2. The rate is measured by counting the number of breaths (meaning, count how many times the chest rises) a person takes for one minute.
3. Respiratory rates vary with age and gender. Normal resting respiratory rates are as follows:
    a. Adults/Children 6 years and older: 12-20 breaths per minute
    b. Children 1 year to 6 years: 20-30 breaths per minute
    c. Infants: 6 months to 12 months: 24-30 breaths per minute
    d. Newborns to 6 months old: 30-60 breaths per minute
4. When measuring and recording respirations, staff should note:
    a. Rate of respiration; breathing should be regular with a pause between breaths
    b. Ease of breathing; 'mouth breathing', 'nasal flaring', 'pursing the lips' on expiration (exhaling) can indicate respiratory problems; cyanosis or

discoloration around a patient's lips, or in nailbeds are additional signs of respiratory problems.

B. PROCEDURE:

1. Visually count the how many times the patient's chest rises in one minute.
2. If visual observation of the patient's chest rising is difficult to ascertain, one can:
    a. Position the patients arm in such a way that you can feel the rise of the chest/abdomen when taking the pulse, and count respirations once pulse is taken.
    b. Listen for breaths using a stethoscope over the heart area of patient's chest.
3. If a patient displays difficulty breathing, however patient is alert and still breathing; follow procedure outlined in ***Standing Delegation Order – Urgent Assessment:***
    a. Remain with the patient
    b. Obtain pulse oximetry reading
    c. Call for another staff to obtain oxygen tank?
    d. Notify Provider
    e. Call CODE BLUE if patient has diminished alertness or unresponsiveness
4. If a patient is unable to breath or has stopped breathing; follow procedure outlined in ***Standing Delegation Order – Emergency Assessment***:
    a. Remain with patient
    b. Call CODE BLUE
    c. Initiate rescue breathing or CPR as appropriate
    d. Call 911

RELATED POLICY:

Standing Delegation Order – Urgent Assessment
Standing Delegation Order – Emergency Assessment

REFERENCES:

www.hopkinsmedicine.org/healthlibrary

REQUIRED BY:

ATTACHMENTS/ENCLOSURES:

POLICY/PROCEDURE TRACKING FORM

TITLE: Respiratory Rate				
Scope/Purpose: To create a standard process for assessing breathing and oxygenation. To ensure protocols are followed when breathing effectiveness appears impaired/inadequate.				
Division/Department: All HealthPoint Clinics			**Policy/Procedure #:**	
Original Date: July 6, 2015			**_X_New ___Replacement for:**	
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Date of Revision	**Description of Changes**