Tri State
Clinical Guideline

Bronchiolitis – Paediatric

Clinical Guideline Link: https://www.rch.org.au/clinicalguide/guideline_index/Bronchiolitis
Intended Audience: Paediatric Units/Paediatric Beds and Emergency Departments - Registered Nurses, Enrolled Nurses and Medical Officers
Context: HNE LHD has endorsed the Paediatric Improvement Collaborative Tristate clinical guideline for the management of Bronchiolitis within HNELHD. Compliance is mandatory: where a variation is warranted; the reason must be clearly documented.
HNE LHD variance: Suitable for use across HNE LHD

PURPOSE AND RISKS:

This document should be used as a guide and does not replace the need for clinical judgement in each individual presentation.

- Bronchiolitis is a clinical diagnosis
- No Investigations should be routinely performed
- Management includes supporting feeding and oxygenation as required
- No medication should be routinely administered

Risk Category: Clinical Care & Patient Safety

CHANGES TO PRACTICE WITH THIS GUIDELINE:

- Oxygen Therapy: should only be administered when oxygen saturations are persistently below 90%. Begin with nasal prong oxygen. Oxygen should be discontinued when oxygen saturations are persistently above 90%.
- Respiratory Support: High flow nasal prong cannula (HFNC) to be used ***only*** if nasal prong oxygen has failed.
- Hydration/Nutrition: When non-oral hydration is required nasogastric (NG) hydration in the route of choice.

COVID-19 Considerations

Use of Humidified High Flow Nasal Cannula (HFNC) for Bronchiolitis during the COVID-19 pandemic.

https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/Documents/guide- bronchiolitis-HFNC.PDF

This guideline has been endorsed by the Paediatric Improvement Collaborative

ONE PAGE ALGORITHM

See Appendix 1

EDUCATION RESOURCES

https://www.hnekidshealth.nsw.gov.au/aboutus/professionals/education_videos

IMPLEMENTATION, MONITORING AND AUDIT

- Timeframe (implemented across all HNE LHD sites within 4 weeks)
- Education strategy: see link above to education PPP
- Systems for monitoring compliance: Audits /IMS+

APROVALS AND CONTACT OFFICER

Position responsible for Clinical Guideline	Clinical Guideline contact officer	Date authorised	Approval gained from HNE Quality Use of Medicines Committee on
Paul Craven Executive Director, CYPFS	Rhonda Winskill	June 2021	N/A

REGISTRATION NUMBER AND DATES

Date Issued	Document and Version Number	Review date
January 2018	GL2018_001	Rescinded November 2020
6 July 2021 (Adopted PIC Clinical Guideline)	Version One	6 July 2024

Appendix 1: Bronchiolitis Algorithm

Initial Assessment: This table is meant to provide guidance in order to stratify severity. The more symptoms the infant has in the moderate – severe categories, the more likely they are to develop severe disease.

Symptoms	Mild	Moderate	Severe
Behaviour	Normal	Some/intermittent irritability	Increasing irritability and/or lethargy/fatigue
Respiratory Rate	Normal - mildly increased respiratory rate	Increased respiratory rate	Marked increase or decrease in respiratory rate
Use of accessory muscles	Nil - mild chest wall retractions	Moderate chest wall retractions. Suprasternal retraction.	Marked chest wall retractions Marked suprasternal retraction Marked nasal flaring
Oxygen saturations/ Oxygen requirements	Oxygen saturations >92% (in room air)	Oxygen saturations 90-92% (in room air)	Oxygen saturations <90% (in room air) Hypoxemia may not be corrected by oxygen
Apnoeic episodes	None	May have brief apnoea	May have increasingly frequent or prolonged apnoea
Feeding	Normal	May have difficulty with feeding or reduced feeding	Reluctant or unable to feed
Management			
Likelihood of admission	Suitable for discharge Consider admission if risk factors present	Likely admission may be able to discharge after a period of observation. Discuss admission with a paediatrician	Requires admission and consider need for transfer to an appropriate children's facility/PICU. CERS response
Observations: Vital signs Respiratory rate, heart rate, oxygen saturations, temperature.	Adequate assessment in ED prior to discharge – minimum of two recorded measurements or every four hours.	1-2 hourly (not continuous) Once improving and not requiring oxygen for 2 hours discontinue oxygen saturation monitoring	Hourly with continuous cardiorespiratory (including oximetry) monitoring and close nursing observation
Hydration/nutrition	Small frequent feeds	If not feeding adequately (< 50% over 12 hours) administer NG hydration	If not feeding adequately (< 50% over 12 hours), or unable to feed administer NG hydration
Oxygen saturations/oxygen requirement	Nil requirement	If oxygen saturations fall below 90% administer oxygen to maintain saturations ≥ 90 %	Administer oxygen to maintain saturations ≥ 90 %
Respiratory support		Begin with nasal prong oxygen High flow nasal cannula (HFNC) to be used only if nasal prong oxygen has failed	Consider HFNC or continuous positive airway pressure (CPAP)
Disposition/escalation	Consider further medical review if early in the illness and any risk factors are present **or** if risk factors are present **or** if infant develops increasing severity after discharge	Decision to admit should be supported by clinical assessment, (including risk factors) social and geographical factors and phase of illness	Requires admission or transfer, escalate as per **CERS if :** Severity does not improve Persistent desaturations Significant or recurrent apnoeas with desaturations Has risk factors
Parent Factsheet http://www.hnekidshealth.nsw.gov.au/site/content.cfm?page_id=680390&current_category_code=16117		**If no improvement consult NETS 1300 36 2500**	