RESPIRATORY STATUS AND PERFUSION ASSESSMENT

	NORMAL	RESPIRATORY DISTRESS (#)
General appearance	Calm Quiet Not anxious	Distressed Anxious Obviously fighting for breath Exhausted Decreased level of consciousness
Speech	Normal sentences, with no difficulty	Short sentences → phrases → words only → none
Respiratory noises (heard without a stethoscope)	Quiet No noises	Cough Audible wheeze on exhalation "Crackly" moist sounds Inspiratory stridor
Chest auscultation	Quiet No wheeze or crackles	Wheeze – expiratory, occasionally inspiratory Crackles – fine → coarse – initially bases → mid zone → full field Silent chest – one side or bilateral
Respiratory rate	Adults: 12 – 16/min Kids: 15 – 25/min Babies: 20 – 40/min	Tachypnoea: - adults >24/min - kids >35/min - babies >50/min
Respiratory effort	Minimal apparent effort Small chest / abdo movement	Marked chest / abdo movement Use of accessory muscles Intercostal recession Sternal retraction Tracheal tug (NOTE: chest movements may be minimal with some conditions)
Pulse rate	Adults: 60 – 80/min Kids: 80 – 120/min Babies: 100 – 140/min	(*) tachycardia - adults >100/min - kids >130/min - babies >150/min (slow pulse rate is a late sign in severe cases)
Skin	Pink, normal	Sweaty Sometimes pale May be flushed Cyanosis is a late sign
Conscious state	Alert Orientated	Altered
Oximetry	≥96% on room air	90 – 95% on room air <90% = serious hypoxia

NOTE: this assessment applies to patients with respiratory distress from any cause.

(**#**) – any of these features *may* indicate respiratory distress. The more that are present, the greater the degree of respiratory distress.

(*) – some patients, especially older patients, may be on medication that prevents the development of tachycardia