

Important respiratory care protocols you need to be aware of!

- Ventilator Liberation Protocol alert
 - Alerts that a patient can undergo a spontaneous breathing trial BUT is oversedated. Your job is to find out whether or not sedation is clinically indicated and to consult with your fellow/attending.
- Post-intubation order set and extubation risk assessment
 - The purpose is to make sure that multiple important orders are immediately placed to provide a safe transition to MV. This includes vent and sedation orders, CXR, ABG, and sputum if indicated. Extubation risk should also be documented

ABC Dash/Alert

- **ABC Pilot**
 - We will shorten the time patients spend on MV by using an electronic surveillance system to more promptly detect patient readiness for weaning and send automated alerts to bedside providers to initiate weaning trials of both vent and sedation support (when appropriate).
 - **ABC Dashboard**
 - Used to determine which patients are SBT-Ready. This dash can be used at anytime to discuss patients status to promote weaning of FIO2/PEEP, pressors, & sedation.
 - **SBT/Sedation Alert**
 - 24hr surveillance system that will send a text to RT, RN, and provider when patients meet SBT criteria.
 - A second alert will be sent to the Charge RN and Provider if RASS <0 and if patient is also getting an IV drip sedative or analgesic suggesting to reassess sedation needs
- **Residents**
 - **The GOLD and GREEN team phones will receive a text alert. Expectation is to assess the need for sedation: can sedatives be stopped to improve the likelihood a patient passes their SBT and is ready sooner for extubation?**
 - **RT**
 - **Will receive a text alert that patient is SBT-Ready. Expectation is to go to the bedside within 30min to place on SBT if appropriate and complete a short survey attached in the alert**
 - **Charge RN**
 - **Will receive the alert via cureatr and forward that message to the bedside RN. Expectation for bedside RN is to go and assess if patients sedation can be discontinued**

MICU B 13 MICU A 12 MICU All 22 Task List: ABC Dashboard

Click patient name for details. Click a cell to toggle. Includes Medicine HUP, MICU A1 Medicine HUP, MICU A2 Medicine HUP, MICU A3 Medicine HUP, MICU A4 Medicine HUP, MICU B1 Medicine HUP, MICU B2 Medicine HUP, MICU B3 Medicine HUP, MICU B4

| | SBT eligible? | O2/PEEP sufficiently weaned? If not SBT ready, notify if SpO2 > 04 (stable 4 hrs) and (FIO2 > 50% or PEEP > 8) | Pressors weaned? If not SBT ready, notify if MAP > 70 (stable 1 hr) and pressors ON | Sedation minimized? This does not affect SBT readiness, but may impact SBT success or extubation readiness. |
|------------|--|---|--|--|
| | Not vented or is trached | - | - | - |
| MICA 0960A | Not SBT-ready due to Oxygenation Criteria, Hemodynamic Stability, Physiological Stability, >n 12 Hours (vented 2 hr) | Wcan FIO2 ac tolerated. SpO2 100 -> 96 -> 93 -> 90 -> 91 -> 91. Params to? 70, peep 5 | Consider weaning pressors now. Norepinephrine: 4, Vasopressin: 0. MAP 65 -> 70 -> 79 | Heavily sedated (RASS -5) Fentanyl: 25 |
| MICA 0961A | Not vented or is trached | - | - | - |
| MICA 0962A | Not vented or is trached | - | - | - |
| MICA 0963A | SBT-ready (vented 20 hr) | ✓ | ✓ | SBT-ready but moderately sedated (RASS -3) Fentanyl: 25, Propofol: 15 |



Post-intubations orderset

For Orders/Practices in All Pt's Who Are
Intubated & Mechanical Ventilated

Includes Ext Risk Screening!

This Program Has 2 Components

- **The Post-Intubation Order set:**
 - ICU Providers complete this for all MV pt's (regardless of when intubated)
 - Many essential orders to prevent/reduce risk of complications, e.g. ventilation, sedation, and STAT tests to order
- **Extubation Risk Screening:**
 - All intubated patients MUST have an Extubation Risk Screen completed
 - In most, screen completed post-intubation by Anesth, ICU, or ED team
 - Intubated OSH ICU admissions are screened by ICU providers
 - Criteria self explanatory; identify conditions for complicated re-intubation

Post-Intubation Order Set

(Also Used For New Admits Already on MV/I)

POST INTUBATION ORDER SET Manage My Version

General Collapse

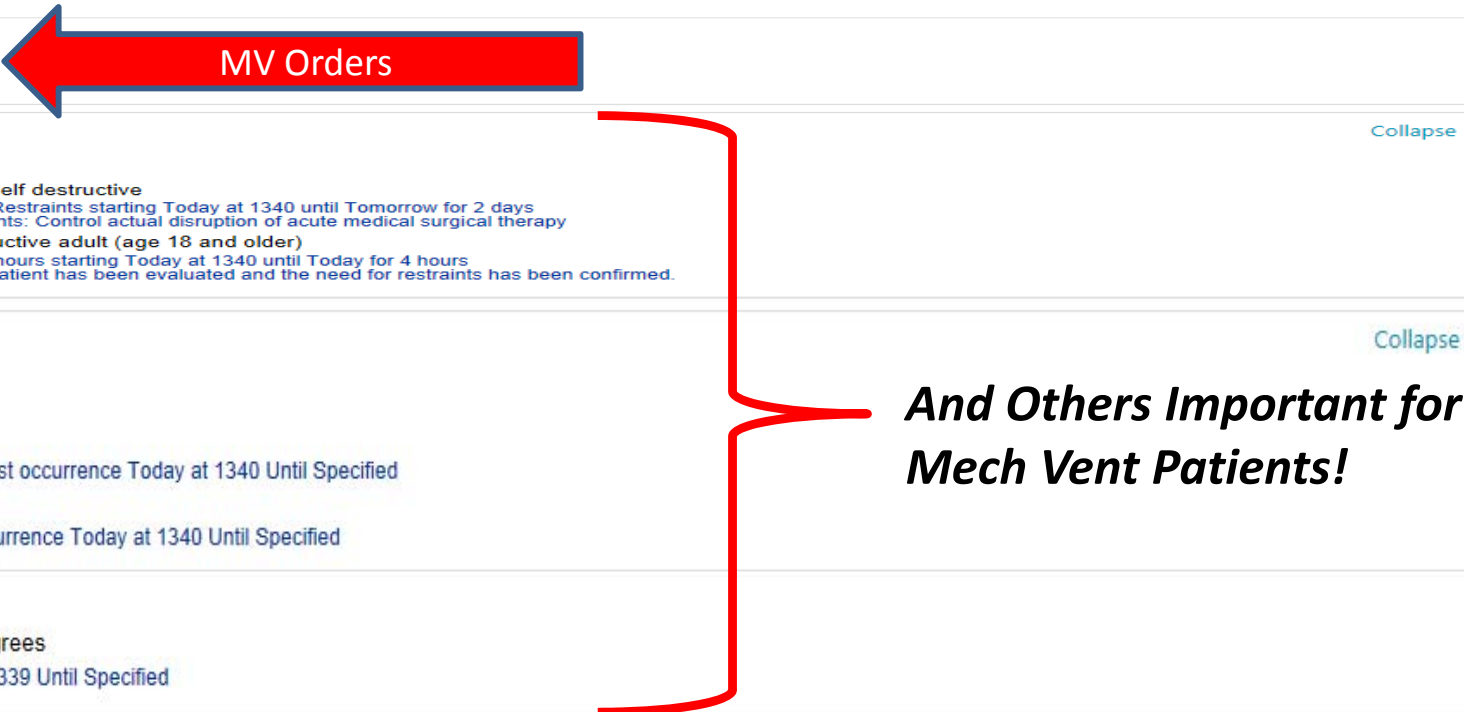
- Bed Request
 - HOSPITAL BED REQUEST
Details
- Respiratory Care
 - Mechanical Ventilation
Details

Restraints Collapse

- Restraints
 - Restrains non-violent or non-self destructive
Routine, Continuous for Restrains starting Today at 1340 until Tomorrow for 2 days
Clinical reason for restraints: Control actual disruption of acute medical surgical therapy
 - Restrains violent or self-destructive adult (age 18 and older)
Routine, Continuous x 4 hours starting Today at 1340 until Today for 4 hours
Assessment of Patient: Patient has been evaluated and the need for restraints has been confirmed.

Nursing Collapse

- Nursing Assessments
 - CAM- ICU
Routine, Every 12 Hours First occurrence Today at 1340 Until Specified
 - RASS and BPS/NPS
STAT, Every 4 Hours First occurrence Today at 1340 Until Specified
- Nursing Interventions
 - Elevate Head of Bed > 30 Degrees
Routine, starting Today at 1339 Until Specified



And Others Important for Mech Vent Patients!

Includes Sedation Orders For Post-Intubation Paralysis!

Medications

Collapse

▼ Sedation

midazolam 2 MG/2ML injection 2 mg

2 mg, intraVENOUS, Every 15 minutes*, 2 doses with the First Dose Today at 1345, Last dose Today at 1400
Consider patient weight, current hemodynamic status, and previous GABA agonist history (EtOH/BZD history) when selecting dose and frequency. HIGH ALERT MEDICATION

midazolam

- ↑ Single dose of 2 mg exceeds recommended maximum of 1.5 mg, over by 34%
- ↑ Daily dose of 4 mg (2 mg Every 15 minutes*) exceeds recommended maximum of 3.5 mg, over by 15%

midazolam 2 MG/2ML injection 2 mg

2 mg, intraVENOUS, Once PRN starting Today at 1339 until Today at 1438, If still paralyzed 1 hour after intubation
HIGH ALERT MEDICATION

midazolam

Missing Weight for dose checking

propofol 1000 mg in 100 mL infusion premix

5-80 mcg/kg/min, intraVENOUS, Continuous starting Today at 1345 Until Discontinued
Titrate by 5 MICROgram/Kg/Min every 10-15 minutes to achieve sedation. Shake well before using. HIGH ALERT MEDICATION

fentanyl bolus INTERMITTENT

fentaNYL (PF) (SUBLIMAZE) 100 MCG/2ML injection 25 mcg

25 mcg, intraVENOUS, Every 10 minutes PRN, 4 doses starting Today at 1339 Until Discontinued, target RASS of -1 to +1 and BPS less than 6
INITIATION dose HIGH ALERT MEDICATION

And

fentaNYL (PF) (SUBLIMAZE) 100 MCG/2ML injection 25-300 mcg

25-300 mcg, intraVENOUS, Every 1 hour PRN starting Today at 1339 until Mon 3/6 at 2359, target RASS of -1 to +1 and BPS less than 6
MAINTENANCE dose - start at 25 mcg Increase by 50 mcg every 1 hour PRN to MAX single bolus of 300 mcg every 1 hour to maintain RASS and or BPS. Contact MD/PA/NP if reach max
single dose of 300 mcg and still not at goal for RASS and or BPS. HIGH ALERT MEDICATION

fentaNYL (SUBLIMAZE) bolus & infusion

fentaNYL (PF) (SUBLIMAZE) 100 MCG/2ML injection

- ↑ intraVENOUS, Once, 1 dose Today at 1345
- ↑ Intravenous administration of up to 200 mcg should be given over 1-2 mins. HIGH ALERT MEDICATION

fentaNYL 16 mcg/mL bolus from bag 12.5-250 mcg

12.5-250 mcg, intraVENOUS, Every 10 minutes PRN starting Today at 1343 until Mon 3/6 at 2359, severe pain (7-10), to target RASS and/or BPS goal
Bolus up to 4 times (using 10 minute intervals) with 50% of infusion rate, then increase infusion per protocol. HIGH ALERT MEDICATION

fentaNYL 16 mcg/mL

- ↑ Single dose of 12.5-250 mcg exceeds recommended maximum of 100 mcg, over by 150%
- ↑ Daily dose of 1,800-36,000 mcg (12.5-250 mcg Every 10 minutes PRN) exceeds recommended maximum of 2,400 mcg, over by 1,400%
- ↑ Frequency of 144 doses/day exceeds recommended maximum of 24 doses/day

fentaNYL (PF) 4,000 mcg in NSS 250 mL (16 mcg/mL) infusion

12.5-500 mcg/hr (0.7813-31.25 mL/hr, rounded to 0.78-31.25 mL/hr), intraVENOUS, Continuous starting Today at 1345 until Mon 3/6 at 2359
Initiate at 25 microgram/hour If not within target RASS and/or BPS goal to follow bolus protocol, then increase infusion by 25 MICROgram/Hour to a MAX infusion rate of 500 mcg/Hr.
Contact MD/NP/PA if at 500 mcg/Hr. HIGH ALERT MEDICATION
Parameter: Titrate to
Parameter 2: BPS
Parameter 3: less than
Parameter 4: 6 and maintain RASS of -1 to +1

And Other Important Time-Sensitive Orders

Note: Perform CXR/POC ABG within 15

Labs Collapse

- ▼ Labs-Microbiology
 - Tracheal Aspirate Routine Culture
🚨 Once First occurrence Today at 1340, Routine
 - R/O MRSA CULTURE
Once First occurrence Today at 1340, Routine, NARES
- ▼ Labs-Blood Gases
 - Capillary Blood Gas
Once First occurrence Today at 1340 Routine BLOOD
 - POC ABG
STAT, Once First occurrence Today at 1340

Imaging Collapse

- ▼ Imaging
 - XR Chest 1 View
🚨 STAT, 1 time imaging First occurrence Today at 1340

Consults Collapse

- ▼ Ancillary Consults
 - Physical Therapy Evaluation and Treatment
 - Inpatient Consult to PT
🚨 Details
 - PT Follow-up Order
Details


Precautions Collapse

- ▼ Isolation and Precautions
 - Isolation
 - Precautions

🔍 Ad-hoc Orders (Type to search) Collapse

You can search for an order by typing in the header of this section.

Don't Forget They all *Need H2 Blockers!*
And a *Changed Route* For all PO meds to OG tube!



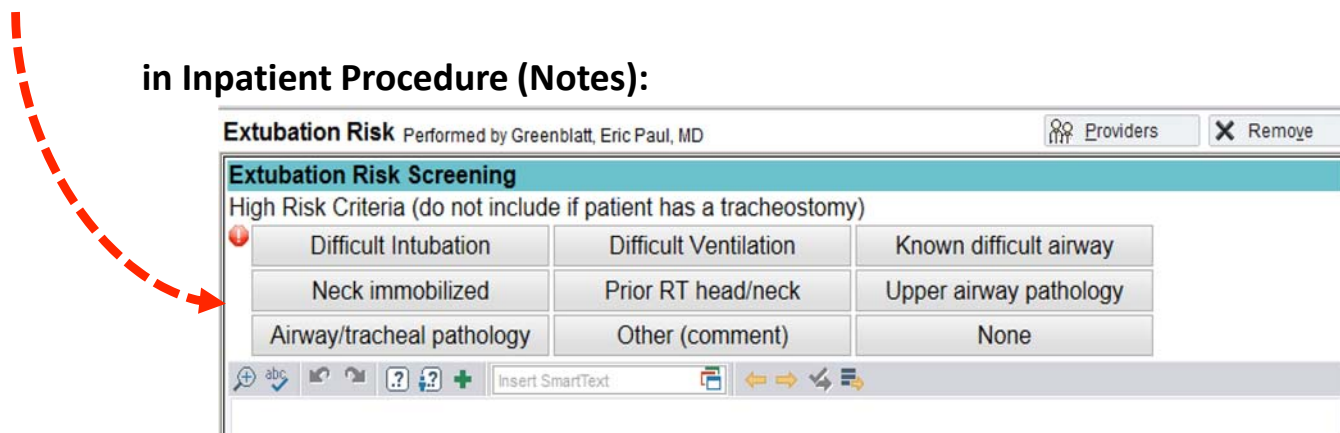
How Do You Enter the Extubation Risk Screen?

Select Procedure----> +Create Note

The screenshot displays the Epic EMR interface for patient Testpah, Scmseven. The left sidebar contains a navigation menu with the following items: Summary, Chart Review, MedView, Results Review, Intake/Output, Problem List, Notes, Orders, Admission, Transfer, Discharge, Procedure (highlighted with a red box), ACP, and FYI. The main content area shows the 'Procedure' section with sub-items: BEDSIDE PROCEDURES, Procedure Notes, and Consent. The 'Procedure Notes' section includes a '+ Create Note' button, a 'Go to Notes' button, and a 'Refresh' button. Below this, it states 'No notes of this type filed.' The 'Consents (Scanning)' section shows a lock icon and the text 'Consents is currently read-only. Could not locate surgical contact.'

Under *New Procedures* Select → *Extubation Risk*
Then Select Risk Based on History/Chart Documentation

in Inpatient Procedure (Notes):



Extubation Risk Performed by Greenblatt, Eric Paul, MD Providers Remove

Extubation Risk Screening

High Risk Criteria (do not include if patient has a tracheostomy)

| | | |
|--|--|---|
| <input type="checkbox"/> Difficult Intubation | <input type="checkbox"/> Difficult Ventilation | <input type="checkbox"/> Known difficult airway |
| <input type="checkbox"/> Neck immobilized | <input type="checkbox"/> Prior RT head/neck | <input type="checkbox"/> Upper airway pathology |
| <input type="checkbox"/> Airway/tracheal pathology | <input type="checkbox"/> Other (comment) | <input type="checkbox"/> None |

abc ? ? + Insert SmartText

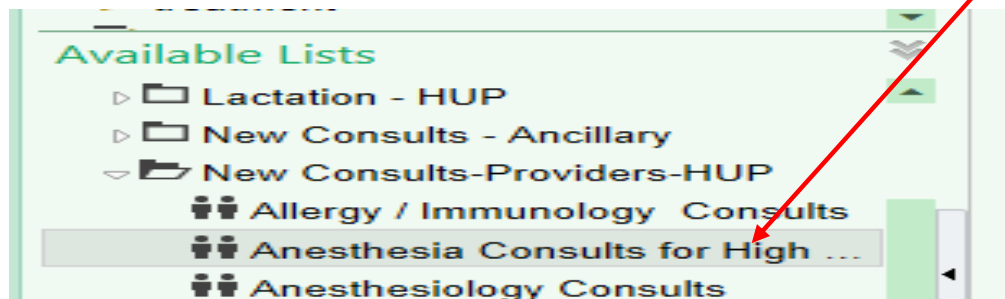
Note: At least one button **MUST** be clicked to complete the Risk Screen.

Select either one (or more) of the High Risk Criteria, as applicable.

Otherwise, if none of the criteria are met you must click 'None'.

* For patients with no risk factors, the process is complete.

Patient is Placed on Anesthesia's High Extubation Risk Patient List!



- **Within 24 hrs Anesthesia will Assess Pt & if Confirmed Enter Extubation Plan!**

Prior to Any Extubation, Always Review Extubation Risk.....

- If High Risk - there are multiple reminders (representing a robust safety net) including Banner, BPA, Wall Card, Sticker, to ensure extubation occurs safely
 - Review Extubation Plan and implement prior to extubation
- If Low Risk – patient may be extubated without preparation with a low risk of complications