All ventilated patients will be seen by a pulmonology consult if available.

1. Elevate the head of the patient’s bed greater than or equal to 30°
   - Yes
   - No, if no, please state reason: ______________

2. Daily Sedation Vacation
   - Yes
     - Hold all sedation daily at 0600 or at ______________
     - Restart at ½ previous rate when RASS score is greater than 0; titrate to ordered RASS score
   - No, if no, please state reason: ______________
   - Other: ______________

3. Respiratory Therapist will conduct daily “Readiness Assessment” per weaning protocol during Sedation Vacation
   - Yes, initiation time: ______________
   - No, if no, please state reason: ______________

4. ICU Delirium
   - Baseline QTc interval ________ msec, date _______
   - Contact ordering physician if QTc > 450 msec
   - Haloperidol (Haldol) ________ mg slow IVP every ________ hours prn agitation
   - Quetiapine (Seroquel)
     - 25mg PO / NGT / OGT every ________ hours
     - ________ mg PO / NGT / OGT every ________ hours

5. RESPIRATORY MEDICATIONS
   - Nebulizer Solutions
     - Albuterol 0.083% (2mg/3mL) via nebulizer every _____ hours
       - scheduled
     - Ipratropium 0.02% (0.5mg/2.5mL) via nebulizer every _____ hours
       - scheduled
   - MDI Inhalers
     - Albuterol 17gm MDI ________ INH every _____ hours
       - scheduled
     - Ipratropium 14gm MDI ________ INH every _____ hours
       - scheduled

Physician Initial: ______________

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Mechanical Invasive Ventilator Bundle Order Set
Guam Memorial Hospital Authority
Page 1 of 3
Revised: 4/10/16 Approved Clin Services 3/8/16 SCC 3/8/16
Form # CPOE-021
6. SEDATION (use RASS score below):

<table>
<thead>
<tr>
<th>RICHMOND AGITATION-SEDATION SCALE (RASS) ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
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<tr>
<td>+3</td>
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<tr>
<td>-3</td>
</tr>
<tr>
<td>-4</td>
</tr>
<tr>
<td>-5</td>
</tr>
</tbody>
</table>

**SEDATIVE DRIPS**

- **Versed (Midazolam) 1mg/mL continuous infusion:**
  - Maintenance dose _____ mg/hr continuous infusion and titrate to target RASS _____ to ______.
  - Maximum rate: ______ mg/hr

- **Propofol (Diprivan) 10mg/mL continuous infusion:**
  - Maintenance dose _____ mcg/kg/min continuous infusion and titrate to target RASS _____ to ______.
  - Maximum rate: 50mcg/kg/min

- **Dexmedetomidine (Precedex) 4mcg/mL continuous infusion:**
  - Maintenance dose _____ mcg/kg/hr continuous infusion and titrate to target RASS _____ to ______.
  - Maximum rate: _____ mcg/kg/hr

- **Other:** ______________ bolus ______ mg IVP every _____ hours prn _____________

7. ANALGESIA

Choose analgesic and check box to maintain Pain Intensity Rating Score (FACES) less than _____ or equal to _____.

**ANALGESIC DRIPS**

- **Fentanyl (Sublimaze) 10mcg/mL continuous infusion:**
  - Maintenance dose _____ mcg/hr continuous infusion and titrate to pain relief.
  - Maximum rate: 200mcg/hr

- **Morphine 1mg/mL continuous infusion:**
  - Loading dose: _____ mg IVP; may repeat times ______
  - Maintenance dose _____ mg/hr continuous infusion and titrate to pain relief
  - Maximum rate: _____ mg/hr

- **Other:** ______________ bolus _____ mg IVP every _____ hours prn pain scale _____ to ______.

Physician initial ________________
8. Peptic Ulcer Disease Prophylaxis (please choose one):
If no prophylaxis chosen, please state reason: _______________________
☐ Omeprazole (Prilosec) 20mg PO / NGT / OGT daily
☐ Pantoprazole (Protonix) 40mg Q24H ☐ IV ☐ PO
☐ Sucralfate (Carafate) 1mg PO QID
☐ Other: _______________________ (dose) _________ (route) _________ (frequency) ____________

9. Deep Vein Thrombosis (DVT) Prophylaxis (please choose one):
If no prophylaxis chosen, please state reason: _______________________
☐ Enoxaparin (Lovenox)
  ☐ 40mg SC every 24 hours
  ☐ 40mg SC twice daily
  ☐ 30mg SC every 24 hours (recommended for low body weight)
  ☐ Other: _______________________
☐ Heparin
  ☐ 5,000 units SC every 8 hours
  ☐ 5,000 units SC every 12 hours
  ☐ 2,500 units SC every 12 hours (recommended for low body weight)
  ☐ Other: _______________________
☐ Pneumatic Compression Device / Sequential Compression Device (SCD)
  (Needs to be on the patient continuously while in bed)
  ☐____________________________________
  ☐____________________________________
  ☐____________________________________

Physician: ________________________________

Date: _______________ Time: _______________