1. Attending Physician: ___________________________ Resident/Fellow ___________________________

Indications:
- Presence of carbonaceous sputum with suctioning
- Intraoral or pharyngeal burns
- Upper airway edema, erythema, mucosal blisters
- Inhalation injury confirmed by bronchoscopy
- Evidence of smoke inhalation
- PaO2/FiO2<200
- History of fire in an enclosed space
- Carboxyhemoglobin value>10

Initiate protocol immediately if any of the above indications are noted

**Intubated Patient**

- Lung Protective Strategy Modality Including: ARDSnet, APRV, or PRVC
- Aerosolize: 2.5mg Albuterol/3ml 20% Mucomyst alternating with 5000 units of Heparin/3ml NS every 4 hours
  - Start with 2.5mg Albuterol/3ml 20% Mucomyst then in 4 hours aerosolize 5000 Units of Heparin/3ml NS then 4 hours later 2.5mg Albuterol/3ml 20% Mucomyst etc...
  - Example: 7:00 - 2.5mg Albuterol/3ml 20% Mucomyst
  - 11:00 - 5000 Units of Heparin/3ml NS
  - 3:00 - 2.5mg Albuterol/3ml 20% Mucomyst
  - 7:00 - 5000 Units of Heparin/3ml NS
- Deliver aerosolized therapy for 7 days
- CPT/Wrap Q4 X 10 minutes
- HZ 10-14 (as tolerated)
- Pressure 1-4 (as tolerated)
- After completing 5 min. of therapy, pause therapy and suction patient, repeat in 5 min.
- Sputum cultures every Monday, Wednesday, and Fridays

**Non-Intubated Patient**

- Humidified O2 Keeping Sats >90%
- IS Q2 hours
- Aerosolize: 2.5mg Albuterol/3ml 20% Mucomyst alternating with 5000 units of Heparin/3ml NS every 4 hours
  - Start with 2.5mg Albuterol/3ml 20% Mucomyst then in 4 hours aerosolize 5000 Units of Heparin/3ml NS then 4 hours later 2.5mg Albuterol/3ml 20% Mucomyst etc...
  - Example: 7:00 - 2.5mg Albuterol/3ml 20% Mucomyst
  - 11:00 - 5000 Units of Heparin/3ml NS
  - 3:00 - 2.5mg Albuterol/3ml 20% Mucomyst
  - 7:00 - 5000 Units of Heparin/3ml NS
- Deliver aerosolized therapy for 7 days
- CPT/Wrap Q4 X 10 min
- HZ 10-14 (as tolerated) Pressure 1-4 (as tolerated)
- After completing 5 min. of therapy, pause therapy have the patient cough or NT suction patient, repeat in 5 min.
- Sputum cultures every Monday, Wednesday, and Fridays

☐ TO  ☐ Read back
Order taken by Signature: ___________________________ Date/Time: ___________________________

Physician Signature ___________________________ Date/Time ___________________________