

Asthma Orders

for use only in the Emergency Department

Draw a line through, initial and date all changes.
If generically equivalent medication is not acceptable, then write "brand necessary."

Circles: mark one and only one.
Squares: mark one, many or none.

Beta-agonist therapy as per *DEM Initial Bronchodilator Treatment Guidelines*

Administer supplemental oxygen to maintain SpO2 >92%

Continuous pulse oximetry during bronchodilator continuous nebulization

Does patient need an oral/IM/IV steroids?

Yes →

No

prednisone PO mg
2 mg/kg; maximum 60 mg

prednisolone liquid PO mg
2 mg/kg; maximum 60 mg

SOLU-MEDROL (methylprednisolone) IV mg
2 mg/kg; maximum 125 mg

DECADRON (dexamethasone) PO mg
for those with prednisone intolerance; may give IV form
PO in formula/juice; 0.6 mg/kg; maximum 10 mg

DECADRON (dexamethasone) IM mg
0.6 mg/kg; maximum 10 mg

Resident/PA/CRNP

Print Last Name:

Date:

Sign:

Time:

ED Attending physician (required):

Print Last Name:

Date:

Sign:

Time:

Triage nurse/charge nurse to notify DEM therapist via pager 1488 that an asthma patient is in the department of emergency medicine. RN or Respiratory Therapist to initiate bronchodilator therapy

Initial assessment PEF or PI score
History, physical examination (auscultation, use of accessory muscles, heart rate, respiratory rate,) oxygen saturation, clinical symptoms.

Mild

PEF > 80 and patient is symptomatic or has history of high risk for acute exacerbation
Or PI score \leq 8

-2.5mg albuterol < 30 kg
5mg albuterol > 30 kg

Moderate-Severe

PEF < 80% or
PI score \geq 8

• Inhaled high dose beta₂- agonist and anticholinergic by nebulizer every 20 minutes or continuously for 1 hour.

Adult -5mg albuterol Q 20 minutes for 3 doses or 15 mg/hr continuous, for \geq 30 kg (10mg/hr < 30 kg)

Atrovent -1mg added to 1st dose of beta₂- agonist or continuous

- Oxygen to achieve saturation \geq 92%
- Continuous pulse oximetry
- Oral or IV corticosteroids as ordered by a physician.
- Consider HELIOX as driving gas source for bronchodilators

Repeat assessment PEF and/or PI score
Physical examination (auscultation, use of accessory muscles, heart rate, respiratory rate,) ,oxygen saturation, clinical symptoms

Discharge home RCP

- Patient education
- Review medicine use
- Review/initiate asthma action plan

Physician recommendation

- Recommend close medical follow-up
- Continue treatment with inhaled beta₂-agonist
- Continue course of oral systemic steroids

Incomplete Response

Mild Exacerbation

- PEF > 80%
- Symptoms persist
- Add oral steroid or double current inhaled steroid
- Repeat bronchodilator up to 3 times

Good/complete response to therapy Good response

- PEF \geq 80%
- Response sustained after last treatment
- No distress
- Physical exam normal

Moderate exacerbation

PEF > 50% predicted but < 80%
Physical exam moderate symptoms

- Initial short acting beta₂-agonist every 60 minutes
- Continue treatment q1-3 hours, provided there is improvement. Consider continuous 8 hour dosing.
- abg

Severe exacerbation

PEF < 50% predicted
Physical exam sever symptoms at rest
History-high risk patient

- Consider noninvasive ventilation
- Consider HELIOX as driving gas source for bronchodilators
- Inhaled short acting beta₂-agonist hourly or continuously with inhaled anticholinergic
- abg

Admit to hospital ward (recommended)

- Inhaled beta₂-agonist + inhaled anticholinergic
- Systemic (oral or IV corticosteroid)
- Oxygen
- Monitor PEF, O₂ saturation, pulse
- Consider HELIOX as driving gas source for bronchodilators if not already on

Admit to hospital intensive care (recommended)

- Inhaled beta₂-agonist hourly or continuously + inhaled anticholinergic
- IV corticosteroid
- Oxygen
- Consider invasive or noninvasive ventilation
- Consider HELIOX as driving gas source for bronchodilators if not already on