PARALYSIS PROTOCOL

Who: up to 4 patients who meet inclusion criteria:

- Age <75
- Few comorbidities
- **Double triggering (if RR > set rate) and/or O2 sat <88% despite PEEP of 20 and FiO2 100% on vent**
- Approved by EHC pulm/crit fellow and A4 PCCM attending

Staffed by: A/B/C/D teams, one additional NP dedicated to these patients, A4 assist
Limitations: no HD on unit, no train of fours

PARALYSIS PROTOCOL (adapted from ACURASYS trial, pubmed ID: 20843245)

- Ensure adequate sedation (RASS -4) before administering paralysis
    - Note: double triggering the vent =/= inadequate sedation. Use RASS score to assess sedation.
- Start continuous nimbex (cisatracurium) gtt vs Roc (rocuronium) Q40 min; NO TRAIN OF FOUR MONITORING REQUIRED
    - Nimbex dosing: 3mL rapid IV infusion of 15mg, followed by 37.5mg/hr x 48 hours
    - Roc dosing: 1mg/kg q40-60m
    - Monitor patient's RR to ensure same as set goal on vent; if not synchronous check on patient and breathing pattern to increase sedation and/or paralytic
- FIRST ABG 30 minutes after paralysis to make sure CO2 reasonable (not becoming more hypercarbic)
- RASS Q4H; goal -4
- Oxygenation goal: SpO2 88-92 or PaO2 55-80 on ABG Continuous pulse ox monitoring
    - Follow high PEEP ladder
- MUST have foley, strict I/Os Q8 hours, gases q8h (ideally ABGs)
- Daily assessment to determine if paralysis can be weaned (based on saturation, vent synchrony, gas exchange / decreasing FiO2 and PEEP requirement per high PEEP ladder)