Clinical Practice Guideline for Bronchiolitis Management: Inpatient

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Admission to hospital with suspicion for bronchiolitis [1]

Initiate guideline order set

Review Prior Outpatient therapy

Score → Suction → Rescore

Mild
CRS 0-2

Assessment q3-4 hours
Suction prn
PO feeding as tolerated[2]

Moderate
CRS 3-6

Assessment q3-4 hours
Suction prn
Assess hydration
Consider NG feeds or IVF[2]

Severe
CRS ≥7 or WOB 2
Notify Physician

- Assessment and suction q 1-2 hours x3
- Continuous pulse ox
- Assess hydration /Consider NPO with NG or IVF[2]

The following are not routinely indicated. Perform only if results are expected to change management:

- High Flow Nasal Cannula
- Blood gas
- Racemic Epinephrine

Reassess and Rescore
Continue current treatment
With patient status change, rescore and evaluate level of treatment

Clinically Improving?

NO → Assess for PICU admission

YES

- Continue reassessment and suction q3-4 hours and prn
- Wean HFNC per guideline
- If patient deteriorates notify physician

Patient/Family Education[3]
Wean to Room Air
Advance Feeds as Tolerated

Meets Discharge Criteria[4]?

NO → Reassess and Rescore

YES → Discharge Home

Literature shows the following are not beneficial routinely: CBC, CXR, RSV labs, antibiotics, serial aerosols, steroids, and/or chest percussion

CRS: Clinical Respiratory Score
HFNC: High Flow Nasal Cannula

[1]Inclusion Criteria

- Previously healthy infant
- 1-18 months of age
- Suspicion of bronchiolitis: upper respiratory symptoms such as rhinitis, coughing OR lower respiratory symptoms such as wheezing, crackles, tachypnea
- Exclusion Criteria:
  - Toxic Appearance
  - CLD (Chronic Lung Disease)
  - Cardiac disease requiring baseline medications

Isolation Standard

- Per CDC/HICPAC Guidelines: Contact Droplet Isolation for the duration of the illness

Oxygenation and Monitoring

- Wean to room air if sats maintained at ≥90% while awake or ≥88% while asleep (brief desats < 88% are expected & acceptable)
- Continuous pulse ox if on oxygen or severe illness
- Discontinue continuous pulse oximetry monitoring if on room air

Respiratory

- Suctioning: Oral, Bulb tip, or NP suctioning as needed; Wean to bulb suctioning

Risk for Asthma

Patient may be at increased risk for asthma if >12 months old:

- with wheeze plus history of atopy OR
- strong family history of atopy or asthma

*Consider **Asthma Guideline** for further management*

[2]Feeding/Hydration

- PO feeding preferred if respiratory rate <60
- Intake of 75% maintenance fluid needs is adequate unless dehydrated
- NG feedings preferred to IV fluids unless contraindicated or physician order. **Refer to NG policy: PC 19-02, HS-PC 19-02**
- If giving IVF, avoid hypotonic solution (D5¼ and D5½) due to risk of SIADH induced hyponatremia. D5NS or D5LR are preferred maintenance fluids.

[3]Patient/Family Education

- Nasal suctioning (teach back)
- Signs/symptoms of respiratory distress
- Guidelines for feeding
- Review bronchiolitis teaching sheet
- No smoking in home & avoidance of other environmental pollutants

PICU Criteria

Consider:

- Multiple episodes of apnea (>1) or any episode requiring bagging
- PCO_2 > 55, 30-60 minutes after initiation HFNC
- CRS ≥ 9 despite initiation HFNC
- HFNC Max: Less than 3 kg- PICU
  - **>3 kg, see campus specific HFNC Guidelines**

[4]Discharge Criteria

Patient must meet all discharge criteria

- On room air at least 4 hours
- Sats ≥90% while awake, ≥88% while asleep
- Able to handle secretions or bulb suctioning only
- Adequate activity & hydration
- Parent verbalizes/demonstrates understanding of: course of illness and bulb suction
- Parents able to follow-up with PCP within 48 hours or access emergency care if needed
- Administer influenza vaccine, unless contraindicated, refused, or already given.