## Diagnosis and management of acute bronchiolitis in the non-ICU hospital setting

## Goals: Patient admitted to hospital · Deliver high-quality, evidence-based care with diagnosis of acute bronchiolitis and exam consistent with bronchiolitis · Reduce unnecessary interventions that may cause harm, increase cost and increase length Provide education regarding best practices Not recommended for routine across the continuum of pediatric care care of bronchiolitis: Begin education with family: **Exclusion criteria:** Chest X-ray When and how to use nasal suction Viral testing, unless concern for flu device · Children younger than 2 months or older than 2 years CBC Signs of dehydration Congenital heart disease Blood culture Signs of respiratory distress Anatomic airway abnormality Chest physiotherapy (CPT) Antibiotics Chronic lung disease Nebulized hypertonic saline Immunodeficiency Steroids Neuromuscular disease Albuterol · Racemic epinephrine History of wheezing in the absence of a viral illness Continuous pulse ox, if spot check Gestational age < 35 weeks Prior history requiring respiratory support (ventilator, Assess disease severitv CPAP, BiPAP, HFNC) Severe co-morbid disease Concern for sepsis Mild: Interventions: Severe: Moderate: Alert, active · Alert, consoles easily Ensure family has Fussy, difficult to received nasal console Feeding well · Feeding decreased, suction device but patient can Poor feeding None or minimal Continue to maintain hydration retractions Poor air movement suction before Mild to moderate RR < 60 Severe retractions feeds and with retractions distress Stable, on room air **RR > 70** RR 60-69 · Wean IV fluids or Escalating oxygen • Stable, on room air or NG feeds. requirement current oxygen level as tolerated Patient should not be on continuous pulse ox Interventions to consider: • Suction before feeds and with distress Reposition Interventions: Adjust oxygen level, as needed, for Discharge home · Suction before feeds and hypoxemia with parent with distress education and Hold feeds if significantly increased RR Reposition or work of breathing PCP follow-up PO challenge and wean Initiate NG feeds or start isotonic IV fluid, IV fluids or NG feeds, as such as D5-NS Continue to tolerated Suggested discharge criteria: Obtain blood gas if worsening clinical reassess response to Wean oxygen, as tolerated RR < 60 therapy and Consider transition to spot Off oxygen > six hours (can be Trial of racemic epinephrine if poor air clinical check pulse ox movement despite other interventions status adjusted based on age) · No apneic episodes for at least 12-24 hours Feeding well enough to maintain



hydration

Teach about safe sleep and smoking

cessation (if applicable)