ECMO DAY _____ CIRCUIT DAY _____

VV ECMO WARD ROUND (VERSION 6)

This checklist can be used for the daily ward round for the ICU patient on VV ECMO. For further details see the Alfred ECMO guideline.

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1. Is ECMO support adequate?

◯ Yes ◯ Does O_2 delivery meet demand (SpO_2 88-94%, cardiac output, Hb)
◯ $PaCO_2$ controlled

◯ No ◯ Can flows be further optimized (fluid bolus, paralysis, positioning)
◯ Can O_2 consumption be reduced (fever control, paralysis)
◯ Pulmonary vasoldilators (NO/PGI_2)
◯ Is high flow configuration required?

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2. Is lung function and recovery optimized?

◯ Lung protective ventilatory stratergy is still required
◯ Do ventilator setting meet lung-protective requirements (VT <6ml/kg, PIP<30 cmH_20, FiO2 <0.6)
◯ RASS -5 +/- paralysis may be required to achieve this

◯ Recovery phase
◯ Spontaneous respiratory effort allowed
◯ Sedation to target RASS -2 to 0

◯ Is specific management required to improve the underlying pathology

◯ Is fluid balance optimized

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3. Which patient complications have developed?

◯ Sepsis (Bacteraemia, devices, VAP etc)
◯ Bleeding (Cannulae, lines, retroperitoneal, intrathoracic)
◯ Barotrauma - Can intervention be avoided? Yes / No
◯ Thrombus (cannulae)
◯ Neurological (Delerium, coma, CVA, ICH)
◯ No complications

Risk of complications increases +++ if
- ECMO >4 days
- MODS/Coagulopathy
- Comorbidities

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4. Have ECMO circuit complications developed?

◯ Problematic recirculation (low SpO_2 sats with pre-oxygenator sats >80%)
◯ Access insufficiency – recurrent episodes during the shift
(kicking, dropping flows, haemolysis, hypovolaemia, high intra-thoracic or intra-abdominal pressures)
◯ Haemolysis
(aim quiet pump, TMP <40mmHg, plasma free Hb <0.1g/L, LDH stable, post-oxygenator PO_2 >200)
◯ Circuit driven fibrinolysis (Rising D-dimers, fibrinogen <1.5 g/L, stable platelets)
◯ Anticoagulation (target bleeding vs thrombosis risk)
◯ Cannulae and tubing (position stable on skin/CXR, secured, no kinks
◯ No complications

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5. Can the patient be safely weaned?

◯ Has the underlying condition improved
(CXR and compliance improving, $PaCO_2$ normal and ventilation safe)
◯ Reduce FGF with adequate respiratory gas exchange
◯ If FGF 0 with good gas exchange consider decannulation

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6. Is the overall plan clear? (DW AIR/CTSx/Home team)

◯ Bridge to recovery ◯ Bridge to transplant ◯ Palliation