Critical Care Goals

MAP	> 65 mmHg	• First assess if fluid responsive with passive leg raise or bolus LR 500 mL to see if MAP raises > 65 mmHg • Start norepinephrine @ 5 mcg/min (up-titrate to 10 mcg/min) for MAP < 65 mmHg • Ensure CEFM if GA > 24 weeks
SpO$_2$	> 94%	• Increase PEEP to 10-24 cm H$_2$0 • Consider VC+ modality • Consider prone positioning • Ensure finger is warm or place monitor on forehead
PaO$_2$	> 80 mmHg	• Increase PEEP to 10-24 cm H$_2$O • Increase I:E ratio • Consider prone positioning
PaCo$_2$	< 40 mmHg	• Increase ventilatory / respiratory rate to 20-25 bpm • Consider higher tidal volume than 6 ml/kg ideal body weight • Ensure no "auto-PEEP" – keep plateau pressure < 35 cmH$_2$0
pH	7.3-7.5	• First assess if acidemic or alkalemic • Then assess which is more out-of-range (PO$_2$ or PCO$_2$) • If metabolic acidosis, assess anion gap & ensure appropriate ventilatory compensation (Bicarb x 1.5) + 8 = PCO$_2$
Bicarb	16-22 mmHg	• Consider addition of IV bicarb if low AND pH is < 7.1
Anion Gap	6-15	• Correct for hypoalbuminemia (add 2.5 to gap for every 1 g/dl albumin below level of 2.5 g/dl)
PiP	< 35 mmHg	• Check peak inspiratory pressure on vent & ensure < 40 cm H$_2$O • Consider VC+ modality
UOP	> 20 ml/kg/hr	• Place foley and ensure strict Is/Os + daily weights
Skin	No break-down	• Evaluate skin front & back daily (esp under fetal monitors)
VTE	prophylaxis	• Consider institution of Heparin 7,500 U BID in 2nd trimester & 10,000 U BID in 3rd trimester if delivery is not imminent
Peptic Ulcer	prophylaxis	• Consider H2 blockade
CEFM	Category 1-2	• Delivery for category 3 if GA > 28 weeks • Worsening category 2 may signal worsening maternal status
Sedation	Lowest achievable	• Goal is to achieve RASS of 0 (alert & calm) while on mechanical ventilation • May need to increase sedation with propofol, fentanyl, & midazolam • May need paralytic (cisatracurium) esp when proning