St. John Medical Center
Medical Excellence • Compassionate Care
1923 S. Utica Ave. Tulsa, OK 74104-6502

PREVENTION OF VENTILATOR ASSOCIATED PNEUMONIA (VAP)

1. Wean the patient and extubate as rapidly as possible; use the weaning and extubation protocol.
2. Consider the use of noninvasive ventilation (BIPAP) when possible.
3. Head of Bed (HOB) to be kept at 30 - 45 degrees and/or continuous lateral rotation (unless contraindicated).
4. RT should ***NOT*** change the ventilator tubing/HME/suction catheter units routinely. They should ***ONLY*** be changed if grossly contaminated or plugged.
5. Excellent oral/nasal care including tooth brushing and suction of oral secretions.
6. Avoid NG and OG tubes when not necessary. When tubes are used for feeding use small bore tubes placed beyond the pyloric sphincter.
7. The nasal route for tubes should be avoided when possible.
8. Wash hands thoroughly before examining patients.
9. Avoid the unnecessary use of antibiotics.
10. Utilize the most specific antibiotic for known infections.
11. Utilize Continuous Aspiration of Subglottic Secretions (CASS) such as a Mallinckrodt Hi-Lo Evac Endotracheal Tube.

Procedure

1. Assemble suction regulator, canister and tubing designated only for subglottic lumen. Change canister and tubing per policy.
2. Uncap the suction evacuation lumen and connect the continuous suction port to suction tubing.
3. Set the suction regulator at 20 mm Hg and do not exceed 20 mm Hg on continuous suction.
4. Reassess suction lumen every 4 hours. Flush the suction lumen with 4 ml of air while suctioning the hypo-pharynx.
5. Recap suction lumen while not in use to prevent contaminants from entering or secretions from leaking out, i.e. when the patient is in transport.
6. Document flush of suction lumen and the continuous suction pressure every 4 hours.
7. Disconnect continuous suction just prior to deflating cuff and extubating per policy and procedure.
8. Monitor endotracheal tube cuff pressure every shift to ensure an adequate seal.
9. Interventions for thick secretions may include:
   a. injection of 4 ml of air into the continuous suction port, while suctioning the hypo-pharynx with a yankaur, momentarily increase the suction pressure to evacuate thick secretions or;
   b. attach a syringe to the suction port to manually evacuate any remaining secretions.
10. Prior to extubation, effort should be taken to evacuate all material above the cuff, thereby decreasing the risk of aspiration during the procedure.

NOTE:

A. Current data does ***NOT*** support selective decontamination of the digestive tract (SDD).
B. Current data on carafate vs. H2 blockers or PPI's is mixed: there are probably fewer pneumonias with carafate but a higher incidence of UGI bleeding.

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CONFIDENTIAL INFORMATION

VAP SCREENING CRITERIA

ETT > 48 Hours on ________ / ________ / @ ________ Hours

VAP SCREENING CRITERIA							
CRITERIA	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Both of the following:							
1. On ventilator at least 48 hours							
2. New or worsening infiltrate consistent with pneumonia, pleural effusion or empyema							
And 2 of the following 3:							
1. New or worsening leukocytosis or leukopenia (WBC less than 4,000 or greater than 12,000)							
2. New or worsening fever (≥ 38 degrees C)							
3. New or worsening sputum purulence							

VAP MAY BE CONFIRMED BY ANY OF THE FOLLOWING CRITERIA

☐ 1. Positive Blood Cultures X2 with matching Sputum Culture:
Date and Results ____

☐ 2. Positive Pleural Fluid Culture:
Date and Results ____

☐ 3. Positive BAL (≥ 10,000 cfu/ml bacteria)
Date and Results ____

☐ 4. Positive PSB (≥ 1,000 cfu/ml bacteria)
Date and Results ____

NOTIFICATION

VAP confirmed by: ______________________________ Date: ________ / ________ / ________

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IF VAP IS CONFIRMED, FAX THIS FORM TO JUDY AVERILL AT 744-3393

BAL - Bronchial Aveolar Lavage; PSB - Protected Specimen Brush; VAP – Ventilator Associated Pneumonia