PROMOTE SAFETY ACROSS THE BOARD

>>>

DATE OF LAST VAE:

Ventilator-Associated Events (VAE) Top Ten Checklist

- Include all elements of the bundle in charge nurse rounds and nurse-to-charge-nurse reports.
- Enlist a multidisciplinary approach. Nurses, physicians and respiratory therapy staff need to work together to ensure bundle items such as head of bed (HOB), spontaneous awakening trials (SAT), spontaneous breathing trials (SBT) and oral care are done according to recommendations.
- Elevate HOB to between 30-45 degrees (use visual cues, designate one person to check for HOB every one to two hours).
- Establish a process to perform routine oral care every two hours with antiseptic mouthwash and Chlorhexidine 0.12 percent every 12 hours (create visual cues, partner with respiratory therapy in performing oral care). Make the above oral care part of the ventilator order set as an automatic order that requires the physician to actively exclude it.
- Include peptic ulcer disease prophylaxis (PUD) on ICU admission and ventilator order sets as an automatic order that requires the physician to actively exclude it.
- Include venous thromboembolism (VTE) prophylaxis on ICU admission and ventilator order sets as an automatic order that would require the physician to actively exclude it.
- Invite families to participate in care by encouraging them to ask if prevention efforts have been completed, such as oral care and HOB elevation. Educate families on the risk of VAE, preventive measures put in place and what they can do to help (e.g., perform oral care or passive range of motion exercises if willing).
- Perform and coordinate SAT and SBT to maximize weaning opportunities when patient sedation is minimal. Coordinate between nursing and respiratory therapy to manage SAT and SBT, perform daily assessment or readiness to wean and extubate.
- Establish a process for timely physical and occupational therapy evaluation for patients on ventilator support to establish a plan for progressive mobility.
- Manage delirium by assessing patients for delirium at least once daily. Sedation should be goal-oriented and should be administered, as ordered, by the physician according to a scale such as Richmond Agitation Sedation Scale (RASS).