# Actionable Patient Safety Solution (APSS) #2D:
VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

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Executive Summary Checklist

In order to implement a program to reduce ventilator-associated pneumonia (VAP) the following implementation plan will require these actionable steps. The following checklist was adapted from the prevention strategies recommended by the California Department of Public Health (CDPH):¹

- Commitment from hospital leadership to support a program to eliminate VAP
- Implement evidence-based guidelines to prevent the occurrence of VAP
  - Prevent aspiration of secretions
    - Maintain elevation of head of bed (HOB) (30-45 degrees)
    - Avoid gastric over-distention
    - Avoid unplanned extubation and re-intubation
    - Use cuffed endotracheal tube with in-line or subglottic suctioning
    - Encourage early mobilization of patients with physical/occupational therapy
  - Reduce duration of ventilation
    - Conduct “sedation vacations”
    - Assess readiness to wean from ventilator daily
    - Conduct spontaneous breathing trials
  - Reduce colonization of aero-digestive tract
    - Use non-invasive ventilation methods when possible (i.e. CPAP, BiPap)
    - Use oro-tracheal over naso-tracheal intubation
    - Use cuffed Endotracheal Tube (ETT) with inline or subglottic suctioning
    - Perform regular oral care with an antiseptic agent
    - Reduce opportunities to introduce pathogens into the airway
  - Prevent exposure to contaminated equipment
    - Use sterile water to rinse reusable respiratory equipment
    - Remove condensation from ventilator circuits
    - Change ventilator circuit only when malfunctioning or visibly soiled
    - Store and disinfect respiratory equipment effectively
  - Measure adherence to VAP prevention practices and consider monitoring compliance
    - Hand Hygiene
    - Daily sedation vacation/interruption and assessment of readiness to wean
    - Regular antiseptic oral care
    - Semi-recumbent position of all eligible patients
  - Monitor ventilated patients for: positive cultures, temperature chart/log, pharmacy reports of antimicrobial use, and change in respiratory secretions
    - When complications exist, raise them on top of the patient’s EHR problem list.

- Develop an education plan for attendings, residents and nurses to cover key curriculum pertaining to the prevention of VAP.
- Encourage continuous process improvement through the implementation of quality process measures and metrics and a monthly display through a dashboard

The Performance Gap

Ventilator-associated pneumonia (VAP) is an infection that appears in the lungs when a patient is mechanically ventilated. Mechanically ventilated hospital patients are typically critically ill and treated in an intensive care unit (ICU). The infection develops after 48 hours or more of mechanical ventilation and is caused when bacteria reaches the lower respiratory tract via the endotracheal tube or tracheostomy; in addition, when airways are not properly maintained intubation may allow oral and gastric secretions to enter the lower airways.²

VAP is the leading cause of death associated with healthcare-associated infections (HAIs).³ In the US, over 40,000 cases of VAP occur each year leading to around 6,000 deaths.⁴ As many as 28% of all patients who receive mechanical ventilation in the hospital will develop VAP and the incidence increases with the duration of mechanical ventilation.⁵ The crude mortality rate for VAP is between 20% and 60%; and incidence ranges from 4% to 48%.⁶⁷ Depending on the type of pneumonia the mortality rate may vary; Pseudomonas and Acinetobacter are associated with higher mortality rates than other strains of bacteria.⁸ It is believed that when antibiotic therapy is delayed or improperly dosed, mortality also increases. These factors are largely preventable.

Patients who acquire VAP have significantly longer durations of mechanical ventilation, length of ICU stay as well as hospital stay.⁹ In addition, the development of VAP is associated with significant increase in hospital costs and poor economic outcomes. VAP is associated with greater than $40,000 in mean hospital charges per patient.

It is estimated that the use of process change and technology to reduce VAP can save up to $1.5 billion per year while significantly improving quality and safety.¹⁰ Closing the performance gap will require hospitals and healthcare systems to commit to action in the form of specific leadership, practice, and technology plans, examples of which are delineated below for utilization or reference. This is provided to assist hospitals in prioritizing their efforts at designing and implementing evidence-based bundles for VAP reduction.

² http://emedicine.medscape.com/article/304836-overview
⁵ http://emedicine.medscape.com/article/304836-overview#a2
¹⁰ Scott R. The direct medical costs of healthcare-associated infections in U.S hospitals and the benefits of prevention: Centers for Disease Control and Prevention; 2009.
Leadership Plan

- Hospital governance and senior administrative leadership must champion efforts in raising awareness to prevent and manage VAP infections safely.
- Healthcare leadership should support the design and implementation of an antimicrobial stewardship program.
- Senior leadership will need to integrate oversee surveillance and metrics to ensure prevention measures are being followed.
- Leadership commitment and action are required at all levels for successful process improvement.

Practice Plan

Establish and consistently implement VAP prevention guidelines that focus on surveillance, minimization of ventilator patient days, prevention of aspiration and gastric distention, equipment cleansing, oral hygiene and avoidance of unintended extubation and reintubation. An example of an evidence-based bundle is the Institute for Healthcare Improvement’s How-to Guide: Prevent Ventilator Associated Pneumonia. This Guide can be accessed online through the Institute for Healthcare Improvement (IHI).

We have also listed the key components here:

- Elevate the Head of the Bed to between 30 and 45 degrees
- Daily Sedative Interruption and Daily Assessment of Readiness to Extubate
- Peptic Ulcer Disease (PUD) Prophylaxis
- Deep Venous Thrombosis (DVT) Prophylaxis
- Daily Oral Care with Chlorhexidine
- Check the patient’s ability to breathe on his/her own every day so the patient can be taken off the ventilator as soon as possible.
- Before and after touching the patient, ensure that healthcare providers are following hand hygiene procedures.

Technology Plan

Suggested practices and technologies are limited to those proven to show benefit or are the only known technologies with a particular capability. As other options may exist, please send information on any additional technologies, along with appropriate evidence, to info@patientsafetysummit.org.

- Implement endotracheal tubes designed to drain subglottic secretions
  - Such as Kimberly-Clark® KIMVENT MICROCUFF Subglottic Suctioning Endotracheal Tube, Teleflex® ISIS HVT, or Mallinckrodt® SealGuard Evac Endotracheal Tube
- Implement electronic surveillance technologies that support antimicrobial stewardship (in late onset cases of VAP bacteria is often multi-drug resistant, and can have great clinical and economic challenges)

Metrics

Topic:

Ventilator-associated Pneumonia Rate (VAP)

Rate of patients on a ventilator for more than 48 hours who develop pneumonia while on the ventilator or within 1 day of ventilator removal per 1,000 ventilator-days

Outcome Measure Formula:

Numerator: Ventilator-associated Pneumonia infections based on CDC NHSN definitions for all inpatient units\(^14\)
Denominator: Total number of ventilator-days for all patients on a ventilator in all tracked units

* Rate is typically displayed as VAP/1000 ventilator days

Metric Recommendations:

Indirect Impact:
All patients with conditions that lead to temporary or permanent ventilation

Direct Impact:
All patients that require invasive ventilation.

Lives Spared Harm:

\[
\text{Lives} = (VAP \text{ Rate}_{\text{baseline}} - VAP \text{ Rate}_{\text{measurement}}) \times \text{Ventilator days}_{\text{baseline}}
\]

Notes:

To meet the NHSN definitions, infections must be validated using the hospital acquired infection (HAI) standards.\(^15\) Infection rates can be stratified by unit types further defined by CDC.\(^16\) Infections that were


present on admission (POA) are not considered HAI\'s and not counted.

Data Collection:
VAP and ventilator-days can be collected through surveillance (at least once per month) or gathered through electronic documentation. Denominators documented electronically must match manual counts (+/- 5\%) for a 3 month validation period.

Mortality:
The PSMF, when available, will use the mortality rates associated with Hospital Acquired Conditions targeted in the Partnership for Patient\’s grant funded Hospital Engagement Networks (HEN). The program targeted 10 hospital acquired conditions to reduce medical harm and costs of care. “At the outset of the PFP initiative, HHS agencies contributed their expertise to developing a measurement strategy by which to track national progress in patient safety—both in general and specifically related to the preventable HAC\'s being addressed by the PFP. In conjunction with CMS\’s overall leadership of the PFP, AHRQ has helped coordinate development and use of the national measurement strategy. The results using this national measurement strategy have been referred to as the “AHRQ National Scorecard,” which provides summary data on the national HAC rate.17

Workgroup

Chair:
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Revision History

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<th>Primary Author(s)</th>
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<tbody>
<tr>
<td>Version 1</td>
<td>Paul Jansen</td>
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<tr>
<td>Version 3</td>
<td>Peter Cox, Michael Ramsay, Ariana Longley, Joe Kiani</td>
<td>Executive Review</td>
<td>April 2016</td>
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