Ventilator-Associated Events (VAE) Top Ten Checklist

TOP TEN EVIDENCE BASED INTERVENTIONS				
PROCESS CHANGE	**IN PLACE**	**NOT DONE**	**WILL ADOPT**	**NOTES (RESPONSIBLE AND BY WHEN?)**
Include all elements of the bundle in charge nurse rounds and nurse to charge nurse reports.	☐	☐	☐	
Multi-disciplinary approach is key – nurses, physicians, and respiratory therapy staff can work together to ensure bundle items such as head of bed, spontaneous awakening trials (SAT), spontaneous breathing trials (SBT), and oral care are done according to recommendations.	☐	☐	☐	
Elevate Head of the Bed to between 30-45 degrees (use visual cues, designate one person to check for HOB every one to two hours). Involve family and loved ones by educating on the risk of VAE, preventive measures in place, and what they can do to help, e.g. remind staff to raise head of bed.	☐	☐	☐	
Oral Care — routine oral care every 2 hours with antiseptic mouthwash and Chlorhexidine 0.12% every 12 hours (create visual cues, partner with Respiratory Therapy in performing oral care by making in a join the nurse and respiratory therapy function). Make the above oral care part of the ventilator order set as an automatic order that requires the physician to actively exclude it.	☐	☐	☐	
Peptic ulcer disease prophylaxis — include on ICU admission and ventilator order sets as an automatic order that requires the physician to actively exclude it.	☐	☐	☐	
Venous Thromboembolism (VTE) prophylaxis — Include on ICU admission and ventilator order sets as an automatic order that would require the physician to actively exclude it.	☐	☐	☐	
Spontaneous awakening and breathing trials (SAT/SBT) — designate one time of day for the SAT and SBT to be attempted.	☐	☐	☐	
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 assessments of readiness to wean and extubate.	☐	☐	☐	
SAT and SBT should be included in the nurse to nurse handoffs, nurse to charge nurse reports, and charge nurse to charge nurse reports.	☐	☐	☐	
Delirium management — assess for delirium at least daily. Sedation should be goal oriented — administer sedation as ordered by the physician according to a scale such as a Richmond Agitation Sedation Scale (RASS).	☐	☐	☐	

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