

Intervention	Recommendation Quality of Evidence	In place	Needs Improvement	Follow up Action Items
<b>I. Basic Practices</b>	A II			
<b>A. Education of staff about epidemiology</b>				
Risk Factors	A II			
Patient Outcomes	A II			
Education of clinicians who care for patients undergoing ventilation about non invasive ventilatory strategies	B III			
<b>B.Surveillance of VAP</b>	B III			
1. Direct Observation of Compliance with VAP specific process measures				
Hand Hygiene				
Bed Position				
Daily Sedation Vacation				
Assessment of readiness to Wean				
Regular oral care				
Use structured tools at regularly scheduled intervals				
2. Active Surveillance for VAP				
Active surveillance for VAP patients who are known or suspected to be at high risk, based on assessment ( Ventilator days)	A II			
<b>C. Practice</b>				
1. Disinfection, maintenance of respiratory equipment	A II			
2. Ensure that patients are maintained in a recumbant position( except for contraindications)	B II			
3. Regular Antiseptic Oral Care	A I			
4. Provide easy access to non invasive ventilation equipment and institute protocols to promote them	B III			
<b>II. Special Approches to VAP Prevention( high rates despite implementation of basic practices</b>				
1. Endotrachial tube with in-line suctioning	B II			
2. Ensure that ICU beds have a built in tool to provide continuous monitoring of the angle of incline	B III			
<b>III.Ventilators- Cleaning and Disinfection</b>				
<b>General Measures-</b>				
a. Thoroughly clean all RT equipement to be sterilized or disinfected	Category 1A			
b. Use Steam sterilization or high- level disinfection by wet heat pasteurization, follow mfr directions	Category 1A			
c. Use sterile water to rinse reusable semicritical when required	Category 1B			
<b>Mechanical ventilators</b>				
Do not routinely sterilize the internal machinery	Category II			

Breathing Circuits, humidifiers and heat moisture exchanges				
a. Do not change circuits on the basis of duration, Change when visibly soiled or malfunctioning	Category 1A			
b. periodically drain and discard condensate that collects in tubing	Category 1B			
c. wear gloves to do the above	Category 1B			
d. perform Hand Hygiene prior to performing the above	Category 1A			
e. Use sterile water in humidifiers	Category II			
f. Change the heat-moisture exchanger when it malfunctions or becomes visibly soiled	Category II			
g. Do not routinely change more frequently than Q48 houts heat-moisture exchanger that is in use by the patient	Category II			
Obtain sputum specimen within 4 hours of intubation				
BAL(bronchoalveolar lavage)				
Dedicated therapists for ICU				
EVS- disinfect and cleaning in the ICU				
<b>IV. Approches that Should not be considered a routine part of VAP Prevention</b>				
1. Routinely administering IGG, whit-cell- stimulating factors, or chest physiotherapy	A III			
2. Do not routinely use rotational therapy with kinetic or continuous rotational therapy	B II			
3. Do not routinely use systemic prophylactic aerosolized or systemic antimicrobials	B III			
<b>E. Accountability</b>				
1. Senior Management support of Infection Prevention Program				
2. Trained people are assigned to the IC program				
3. Competence of staff to perform responsibilities				
4. Direct healthcare providers are responsible for ensuring that appropriate infection prevention and control practices are used at all times				
5. Hospitl and unit leaders are responsible for holding their personel accountable for their actions				
6. The Infection Prevention and Control program is responsible for ensuring an active program to identify VAP is implemented to improve quality and evidence based practices are implemented				

7. Healthcare personnel and Patient education are accountable for ensuring appropriate training and programs are developed and presented to personnel, staff and families				
8. Personel from infection prevention and control, laboratory, and information technology ensure that systems are in place to support the program				