VENTILATOR ASSOCIATED PNEUMONIA (VAP) CHECKLIST

This form should be completed when a patient is mechanically ventilated in the critical care unit.

Patient Name: ______________________________ MRN: _________________________

☐ Patient Ventilated > 48 hours

Date Ventilation Initiated: ____ ____ ____ (dd mm yy)

FOR EACH DATE SPECIFIED, INDICATE WHETHER THE PATIENT MET ANY OF THE FOLLOWING CRITERIA. **VAP IS PRESENT IF ALL CRITERIA (I – V) HAVE BEEN MET.**

DIAGNOSTIC CRITERIA	**DATE** ___ ___ ___ **dd mm yy**	**DATE** ___ ___ ___ **dd mm yy**	**DATE** ___ ___ ___ **dd mm yy**	**DATE** ___ ___ ___ **dd mm yy**	**DATE** ___ ___ ___ **dd mm yy**	**DATE** ___ ___ ___ **dd mm yy**	**DATE** ___ ___ ___ **dd mm yy**
I. Patient has new, worsening or persistent infiltrate consolidation or cavitation on CXR compatible with pneumonia	☐	☐	☐	☐	☐	☐	☐
II. Patient has WBC ≥ 12,000 or < 4,000 **OR** Patient temperature greater than 38 degrees Celsius or less than 36 degrees Celsius with no other recognized cause	☐	☐	☐	☐	☐	☐	☐
III. Patient has new onset of purulent sputum, or change in character of sputum, or increase in respiratory secretions or increase in suctioning requirements	☐	☐	☐	☐	☐	☐	☐
IV. Patient has worsening gas exchange (e.g., increasing oxygen requirements, worsening PaO_2/FiO_2 ratio, increasing in minute ventilation)	☐	☐	☐	☐	☐	☐	☐
V. The patient is being treated with antibiotics for VAP	☐	☐	☐	☐	☐	☐	☐

☐ CHECK IF VAP IS DIAGNOSED. IF VAP IS DIAGNOSED PLEASE REASSESS THE PATIENT FOR RESOLUTION OF VAP OR SUBSEQUENT INCIDENT OF VAP BASED ON CURRENT CLINICAL PRACTICE.

Ontario