As needed in line suction catheter changes were as safe as and less expensive than daily scheduled catheter changes during mechanical ventilation


Question
How safe are, and what are the costs of, daily scheduled changes (v as needed changes) on in line suction catheters for patients who receive mechanical ventilation?

Design
Randomised controlled trial.

Setting
A university teaching hospital in St Louis, Missouri, USA.

Patients
521 patients (mean age 58 y, 54% men, 66% white) who were > 18 years old and required mechanical ventilation for > 12 hours while in the intensive care unit (ICU). Exclusion criteria were mechanical ventilation in another hospital, heart or lung transplantation, or massive haemoptysis.

Intervention
263 patients were allocated to receive changes of in line suction catheters every 24 hours. 258 patients were allocated to receive non-scheduled changes of suction catheters indicated by mechanical failure of the device or visible soiling of the catheter. Routine nursing and respiratory treatment suctioning practices were done for all patients. Standard commercial equipment was used and metered dose inhalers and attached chamber devices were used to deliver medication dispersed in an aerosol.

Main outcome measures
The main outcome was ventilator associated pneumonia (VAP). Secondary outcomes were duration of mechanical ventilation, length of ICU and hospital stay, number of acquired organ system derangements (Organ System Failure Index), hospital mortality, mortality associated with VAP, and total costs for catheter changes.

Main results
Patients who received scheduled changes had a mean of 4.7 changes compared with 0.4 changes per person in the as needed group (p < 0.001). The groups did not differ for any other outcome including VAP (14.7% for as needed changes v 14.8% for scheduled changes, p = 0.97), episodes of VAP/1000 ventilator days (25.8 v 27.5, p = 0.8), VAP in patients who needed mechanical ventilation for > 7 days (50% v 63%, p = 0.2), duration of mechanical ventilation (5.7 v 5.4 d, p = 0.7), length of ICU stay (6.9 v 7.0 d, p = 0.9), length of hospital stay (14.4 v 14.7 d, p = 0.8), acquired organ system derangements (1.2 v 1.1, p = 0.3), hospital mortality (26% v 24.3%, p = 0.7) and mortality attributed to VAP (1.9% v 1.5%, p = 0.7). Total costs were $US11 016 for the scheduled group and $837 for the as needed group. Characteristics that predicted VAP were being a man (p = 0.01), black race (p = 0.02), low premorbid lifestyle score (p = 0.02), high Acute Physiology and Chronic Health Evaluation II (APACHE) score (p = 0.01), low P O2/Fio2 (p = 0.009), previous intubation during same hospital stay (p = 0.001), receipt of sucralfate (p = 0.004), receipt of medication dispersed in an aerosol (p < 0.001), receipt of previous antibiotic treatment (p = 0.03), and having had a tracheostomy (p < 0.001).

Conclusion
As needed in line suction catheter changes during mechanical ventilation were as safe as scheduled daily changes for ventilator associated pneumonia and costs were much less.

Commentary
Endotracheal suctioning is an important supportive treatment for patients requiring mechanical ventilation. Traditionally, in line suction catheters are changed every 24 hours to prevent the development of VAP.

A paucity of research exists on the use of in line suction catheters and the optimal time to prevent the development of VAP.

As needed in line suction catheter changes were mechanical ventilation in another hospital, heart or lung transplantation, or massive haemoptysis.

This study has important implications for nursing practice in the ICU. Changing in line suction catheters as needed minimises the number of manipulations of the ventilator circuitry, reducing the risk of cross contamination and the risk of VAP.

The importance of effective hand hygiene and the use of protective clothing such as gloves and aprons cannot be overemphasised.

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