In most long-term care settings, patients typically have tubes designed to facilitate suction of subglottic secretions. These tubes include a separate integrated port (suction lumen), and are usually balloon-cuffed endotracheal and tracheal tubes, which are typically used for patients intubated with tracheostomy tubes who require mechanical ventilation, and for other dysphagic patients. Patients with neurological, traumatic or medical disorders such as stroke, TBI, or cancer, may require mechanical ventilation, and are at high risk of pneumonia if any pooled secretions aspirate into the lungs. Suboptimal SSD therefore occurs around the stoma as a result of a buildup of secretions, which frequently causes coughing, sometimes severe, and an increase in treatment costs. For example, more than 25% of patients who are intubated with tracheostomy tubes have had previous tracheostomy tube blockages.

VAP Reduction Across Methodologies in SSD

VAP has been defined as the presence of new or progressive infiltrates on a chest radiograph, with a positive respiratory pathogen aspirate. The incidence of VAP varies considerably among institutions, and is significantly reduced when respiratory secretions are properly managed. In most cases, VAP is the result of aspiration of subglottic secretions. Preventing aspiration of subglottic secretions, therefore, is an important step in the prevention of VAP.

The AARC recommends that VAP be diagnosed by a Gram stain and culture of the aspirate, and that the aspirate be obtained by means of manual or automated intermittent suctioning. VAP is treated with a combination of antibiotics and non-pharmacological interventions, such as nutrition, hydration, and rehabilitation. Patients with VAP are at high risk of mortality.

In conclusion, automated intermittent subglottic aspiration is a promising method for reducing the risk of VAP, in patients who need mechanical ventilation. Automated intermittent subglottic aspiration has been shown to be effective in reducing VAP, and improving patient outcomes. However, further research is needed to determine the optimal settings for automated intermittent subglottic aspiration, and to compare its effectiveness to other methods of VAP prevention.


does automated intermittent aspiration make your job easier?

The clinic nurses were asked the following questions:

1. In your opinion, is the automated intermittent aspiration system a time saver?

2. Does automated intermittent aspiration make your job easier?

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The initial VAE protocol had a moderate impact. The initial VAE rate dropped from 18% to 12%, with a hospital transition rate of 7%. This was a significant improvement, but we feel that the rate could be much lower.

Subglottic Suction Technique

In September, 2014, we decided to switch all tracheostomy tubes to subglottic suction models. We did this in anticipation of the VAE care center to reduce the overall frequency of respiratory secretions.

We installed the subglottic suction models to our tracheostomy tubes at the Respiratory Therapists’ and anesthesiologist’s request. The subglottic suction models had a history of clinical success.

We have many patients that sit up in their wheelchairs and/or Geri chairs at greater than 60° angles. From our initial observations, the subglottic suction was more effective at patient angles of 70°. When the patient remains at an 80° less angle, the suction gust is effective. We will immediately check the subglottic secretion drainage. Respiratory Therapy. 2015; 10:4:27-28.

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21 Helmut Fendler, RN, Katja Fain, SLP, and Jerry Gentile, BSRT, BSHA, MBA, EdD(c), RT, RRT

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