Mechanical Ventilation

Purpose
Mechanical Artificial Ventilation refers to any methods to deliver volumes of gas into a patient's lungs over an extended period of time to remove metabolically produced carbon dioxide. It is used to provide the pulmonary system with the mechanical power to maintain physiologic ventilation, to manipulate the ventilatory pattern and airway pressures for purposes of improving the efficiency of ventilation and/or oxygenation, and to decrease myocardial work by decreasing the work of breathing.

Scope
Outlines the procedure of instituting mechanical ventilation and monitoring.

Accountability
- Mechanical Ventilation may be instituted by a qualified licensed Respirator Care Practitioner (RCP).
- To be qualified the practitioner must complete a competency based check off on the ventilator to be used.
- The RCP will have an understanding of the age specific requirements of the patient.

Physician's Order
Initial orders for therapy must include a mode (i.e. mandatory Ventilation/Assist/Control, pressure control etc., a Rate, a Tidal Volume, and an Oxygen concentration and should include a desired level of Positive End Expiratory Pressure, and Pressure Support if applicable.

Pressure modes will include inspiratory time and level of pressure control.

In the absence of a complete follow up order reflecting new ventilator changes, the original ventilator settings will be maintained in compliance with last order until physician is contacted and the order is clarified.

Indications
Mechanical Ventilation is generally indicated in cases of acute alveolar hypoventilation due to any cause, acute respiratory failure due to any cause, and as a prophylactic post-op in certain patients.

If a patient’s spontaneous ventilation is clinically adequate, mechanical ventilation may not be indicated.

Procedure

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<th>Step</th>
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**Mechanical Ventilation**

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<tr>
<th>Step</th>
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<tr>
<td>1</td>
<td>Verify physicians order.</td>
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<tr>
<td>2</td>
<td>Set up ventilator with an appropriate circuit based on patient requirements (neonatal, pediatric, or adult).</td>
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| 3    | Check ventilator for proper operation of all systems:  
  • No leaks in circuit.  
  • Proper documented EST test  
  • Humidifier  
  • Refer to policy 7.4.11.  
  • Alarms functional and audible |
| 4    | Make sure proper size of resuscitator bag and mask are at bedside attached to O₂ source. |
| 5    | Explain procedure to patient or family if possible. |
| 6    | Connect circuit to patient airway and monitor patient and ventilator to assure adequate ventilator and patient tolerance. |
| 7    | Complete a ventilator check and patient assessment and document results in Epic. |
| 8    | Once patient is stable, assess patient and ventilator settings as per unit standard and after each parameter change. |
| 9    | Circuits will be changed as needed in adult patients and every fourteen days in neonatal and pediatric patients. |

**Undesirable Side Effects**

The complications of Mechanical Ventilation can be broken into four categories:

**Pulmonary Barotrauma**
- Tension Pneumothorax
- Pulmonary Interstitial Emphysema
- Pneumomediastinum
- Pneumopericardium □ Pneumoperitoneum

**Cardiovascular Effects**
- Decreased Venous Return
- Decreased Cardiac Output
- Increased Pulmonary Vascular Resistance
Removal of natural defense mechanisms with intubation:
- Contamination of ventilator circuits
- Contamination through suctioning

Psychological Effects
- Inability to communicate (See Patient Teaching)
- Psychological dependency on ventilator

**Assessment** □ Arterial and Mixed Venous Blood Gas Values

**Outcome** □ Pulmonary Function Studies
- Chest X-Rays
- Auscultation
- Work of Breathing Evaluation
- Sputum: culture, amount, color, consistency
- Patient Temperature

**Patient/ Family Teaching**
Patients on mechanical ventilators require considerable emotional support.

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<td>1</td>
<td>Explain the reason that for receiving mechanical ventilation. Relate it to disease or injury state.</td>
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<td>2</td>
<td>Encourage patient to relax and allow the ventilator to work for the patient.</td>
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<tr>
<td>3</td>
<td>Explain the alarms and their function. Reinforce to patient that the alarms do not mean that the ventilator is not working, but that the ventilator needs some readjustment so that breathing will be easier.</td>
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<td>4</td>
<td>Use reality orientation technique with patient (ask what day it is, what time it is, etc. (Inform patient if not known). Try to locate a clock that patient can see.</td>
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<td>5</td>
<td>Teach patient communication techniques. It is very frustrating for a patient not to be able to communicate. Have the patient answer questions yes or no by shaking/nodding head. Provide patient with a tablet and pen for writing. If patient cannot write, draw the alphabet on a piece of paper or cardboard for spelling out communication by pointing to the letters. Above all let patient know that some kind of communication will be provided.</td>
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### Infection Control


### Safety

- Alarms on ventilator will be activated at all times (Note: In certain instances the Exhaled Minute Ventilation and/or Exhaled Tidal Volume alarm may be set to 0 in the presence of significant leak).
- Anesthesia gases will not be administered through ventilator.

### Corresponding Policies

- Respiratory Care Services Policy # 7.4.11; Operating Instructions For Adult Microprocessor Controlled Ventilators

### References

- AARC Clinical Practice Guidelines; Patient-Ventilator System Checks, Respiratory Care; 1992; 37: 882-886
- AARC Clinical Practice Guidelines; Humidification During Mechanical Ventilation, Respiratory Care; 1992; 37: 887-890
- Dean Hess, Robert Kacmarek, Essentials of Mechanical Ventilation,
<table>
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<tr>
<th>Mechanical Ventilation</th>
<th>Formulated: 11/78</th>
<th>Effective: 10/26/95</th>
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