Standard of Care for
The Patient undergoing Mechanical Ventilation

Objectives:
1. To promote adequate perfusion/ventilation.
2. To maintain a patent airway.
3. To prevent complications of respiratory dysfunction.
4. To teach awareness of needs/limitations.
5. To prevent ventilator associated pneumonia.

Process Standards:
1. The patient’s baseline respiratory status will be assessed and documented for: rate, depth, signs of respiratory distress, breath sounds and evidence of respiratory effort.
2. Any changes in baseline assessment will be documented with notification of MD.
3. Arterial blood gases will be obtained as ordered with notification of MD for any abnormal finding.
4. The ventilator settings will be documented at the beginning of every shift and with changes:
   a. Tidal Volume
   b. FIO₂
   c. Mode
      i. Intermittent Mandatory Ventilation
      ii. Assist Control
      iii. Inverse Ratio Ventilation
      iv. Pressure Regulated Volume Control
      v. Pressure Control (PC, PC-IMV-PS)
      vi. Continuous Positive Pressure
      vii. Pressure Support
      viii. Volume Support
      ix. High Frequency Oscillatory Ventilation
   d. Rate
   e. Positive End Expiratory Pressure
   f. Inspiratory Time
   g. Peak Inspiratory Pressure
   h. Pause
      i. Mean
5. The patient will be positioned for comfort and optimal oxygenation/ventilation.
   a. Hypoxic patients may be placed in the prone position until oxygenation plateaus.
   b. The head of Bed will be maintained in the supine patient at least 30 – 45 degrees. (AACN practice alert)
6. The patient will be repositioned at least every two hours.
7. The patient shall have their sedation and pain level assessed at least every 4 hours using the RASS and CPOT.
8. As the patient begins to be weaned from ventilator, Daily Awakening Trials (DAT’s) may be ordered. If ordered, DAT’s shall be performed.
9. The endotracheal, nasotracheal, or trach tube will be secured properly and placement will be verified per CXR daily.
10. The patient will be suctioned to maintain a patent airway as needed with sterile technique. Secretions’ quantity, color, and consistency will be documented.
11. Pulse oximetry will be monitored continuously and documented at least hourly. MD will be notified when saturation below acceptable limit.
12. The nurses shall have the head of bed elevated 30 - 40 degrees unless otherwise ordered.
13. The nurses shall ensure deep vein thrombosis and peptic ulcer prophylaxis.
14. An ambu bag will be at the bedside and connected to continuously flowing oxygen at all times.
15. The patient will be assessed routinely for signs of discomfort and appropriate intervention will be performed to enhance comfort. MDs will be notified of discomfort.
16. If paralytic agents are being used sedation will also be continuously given until paralytics discontinued.
17. Complications will be assessed for, documented and a physician will be notified.
18. The patient/family will be educated regarding need for a procedures related to and including mechanical ventilation.

Outcome Standards:
At the time of discontinuing mechanical ventilation the patient will:
1. Be able to maintain a patent airway without assistance.
2. Be able to adequately ventilate.
3. Show effectiveness of medical therapy.
4. Be free of ventilator associated pneumonia.

Reference: