

Caring for the Mechanically Ventilated Patient

Mechanical ventilation is utilized in intensive care and long-term care settings to assist patients who require additional respiratory support. This handy reference guide provides critical patient care essentials, tips for trouble-shooting ventilator alarms, and potential complications.

Care Essentials for Patients on Mechanical Ventilation

- Maintain a patent airway. Per policy, note endotracheal (ET) tube position (centimeters) and confirm that it is secure. If the patient has a tracheostomy, check that the ties or Velcro straps are secure and that the stoma appears healthy.
- Assess oxygen saturation, bilateral breath sounds for adequate air movement, and respiratory rate per policy.
- Check vital signs per policy, particularly blood pressure after a ventilator setting is changed. Mechanical ventilation increases intrathoracic pressure, which could affect blood pressure and cardiac output.
- Assess patient's pain, anxiety and sedation needs and medicate as ordered.
- Complete bedside check: ensure suction equipment, bag-valve mask and artificial airway are functional and present at bedside. Verify ventilator settings with the prescribed orders.
- Suction patient only as needed, per facility policy; hyperoxygenate the patient before and after suctioning and do not instill normal saline in the ET or tracheostomy tube; explain procedure to patient; suction for the shortest time possible and use the lowest pressure required to remove secretions. Monitor for upper airway trauma as evidenced by new blood in secretions.
- Monitor pulse oximetry and [arterial blood gas \(ABG\)](#) after adjustments are made to ventilator settings and during weaning to ensure adequate oxygenation and acid-base balance.
- To minimize the risk for ventilator-associated pneumonia (VAP), implement best practices such as strict handwashing; aseptic technique with suctioning; elevating head of bed 30-45 degrees (unless contraindicated); providing sedation vacations and assessing patient's readiness to extubate; providing peptic ulcer disease prophylaxis; providing deep vein thrombosis prophylaxis; and performing oral care with chlorhexidine, per your facility policy.
- For awake patients, provide writing tools or a communication board to facilitate communication. Ask yes or no questions so that the patient can respond by nodding their head.
- The use of an evidence-based bundled approach to managing pain and agitation, and promoting early mobility has been shown to decrease ventilator days and the incidence of delirium (Devlin et al, 2018).

Ventilator Alarms		
Alarm	Potential Causes	Interventions
High peak inspiratory pressure (PIP)	<ul style="list-style-type: none"> • Blockage of ET tube (secretions, food, kinked tubing, patient biting on ET tube) • Coughing • Bronchospasm • Lower airway obstruction 	<ul style="list-style-type: none"> • Assess lung sounds. • Suction airway for secretions. • Insert bite block or administer sedation per orders if patient is agitated or biting on ET tube. • Assess breath sounds for increased consolidation, wheezing, and

	<ul style="list-style-type: none"> • Pulmonary edema • Pneumothorax • Ventilator/patient dyssynchrony 	<p>bronchospasm; treat as ordered.</p> <ul style="list-style-type: none"> • Assess for tachypnea, pain or anxiety, which are factors that may cause dyssynchrony. Notify provider if existing sedation orders are inadequate or ineffective.
Low pressure alarm	<ul style="list-style-type: none"> • Air leak in ventilator circuit or in the ET tube or tracheostomy tube cuff 	<ul style="list-style-type: none"> • Locate leak in ventilator system. • Check pilot balloon as an indicator of tube cuff failure. • Replace tubing as needed, per policy.
Low minute ventilation (V_E)	<ul style="list-style-type: none"> • Low air exchange due to shallow breathing or too few respirations 	<ul style="list-style-type: none"> • Check for disconnection or leak in the system. • Assess patient for decreased respiratory effort; consider decreasing sedative dosage or increasing the set respiratory rate or tidal volume.
Low O_2 saturation (SpO_2)	<ul style="list-style-type: none"> • Worsening of clinical condition • Common causes of hypoxia: <ul style="list-style-type: none"> ○ Pulmonary edema ○ Pneumonia ○ Pneumothorax ○ Pulmonary embolus ○ Mucus plugging ○ Atelectasis • Pulse oximeter malpositioned • SpO_2 cable unplugged • Connective tissue disorder, such as Raynaud's disease or scleroderma • Hypoperfusion, such as with vasopressor use or shock states 	<ul style="list-style-type: none"> • Ensure ventilator oxygen supply is connected. • Observe pulse oximeter waveform on the monitor. If the waveform is poor, consider applying monitor to a different location on the patient. • Ensure pulse oximeter is positioned correctly. • Verify all cables are plugged in. • Auscultate for presence of breath sounds, worsening adventitious breath sounds or respiratory distress. • Assess perfusion.
Apnea	<ul style="list-style-type: none"> • Breaths are not being taken by the patient or triggered on the ventilator 	<ul style="list-style-type: none"> • Assess patient effort and SpO_2. • Immediately adjust ventilator settings to provide controlled breathing assistance. • Check system for disconnections. • Check patient for change in mental status (oversedation or acute neurologic condition such as stroke may cause central apnea).

Complications Related to Mechanical Ventilation		
Complication	Potential Causes	Interventions
Cardiovascular issues	<ul style="list-style-type: none"> Decrease in venous return to the heart due to positive pressure applied to the lungs. 	<ul style="list-style-type: none"> Assess for adequate volume status by checking heart rate, blood pressure, central venous pressure and urine output. Assess patient for increasing autopeep, which can increase risk for cardiac tamponade.
Barotrauma/pneumothorax	<ul style="list-style-type: none"> Positive pressure applied to lungs Elevated mean airway pressures may rupture alveoli 	<ul style="list-style-type: none"> Notify healthcare provider of any signs of pneumothorax, such as unequal breath sounds, elevated peak airway pressures, respiratory distress, drop in oxygen saturation, tracheal deviation and hypotension. Prepare patient for possible chest tube insertion. Avoid high pressure settings for patients with chronic obstructive pulmonary disease (COPD), asthma, acute respiratory distress syndrome (ARDS), or history of pneumothorax.
Infection	<ul style="list-style-type: none"> Breaks in ventilator circuit Decreased mobility Impaired cough reflex Aspiration of subglottic secretions 	<ul style="list-style-type: none"> Use aseptic technique. Keep head of bed elevated 30 degrees. Consider use of subglottic secretion drainage endotracheal tube. Provide frequent mouth care with chlorhexidine. Stress ulcer prophylaxis. Support proper nutritional status.

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