VENTILATOR SUPPORT PLAN

Goals

- ☐ To ensure effective delivery of oxygen as prescribed
- ☐ Maintain skin integrity on face
- ☐ Prevent infection
- ☐ Promote participant comfort
- ☐ Ensure equipment safety and effectiveness
- ☐ Other: _____

Identified need for support

Ventilation required secondary to:

- ☐ Trauma
- ☐ Respiratory Failure
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Obstructive Sleep Apnoea
- ☐ Bronchitis
- ☐ Asthma
- ☐ Positive Airways Pressure (CPAP)
- ☐ Participant is unable to self-manage and requires full assistance of support worker
- ☐ Other: _____

Evidenced by

- ☐ Medical Notes
- ☐ Progress Notes
- ☐ Health Care Directive Date: _____
- ☐ Other: _____

Interventions

Non-Invasive Ventilation (NIV)

- ☐ Confirm need for ventilation
- ☐ Follow personal hygiene and infection control procedures
- ☐ Assemble and connect ventilation equipment as per instructions
- ☐ Prepare ventilator for operation as per instructions
- ☐ Fit Breathing mask
- ☐ Start ventilator and monitor effectiveness
- ☐ Respond to alarms as per trouble shooting procedures
- ☐ Maintain clean equipment
- ☐ Other participant specific interventions: _____

Invasive Ventilation with Tracheostomy

- ☐ Follow personal hygiene and infection control procedures

Stoma Care

- ☐ Check and clean skin around tracheostomy tube and stoma with saline daily
- ☐ Apply dry gauze dressing to prevent irritation
- ☐ Do not apply powders or cream unless prescribed
- ☐ Observe and report any abnormal changes, infection, or inflammation to health practitioner

Supplementary Oxygen

	Regime ☐ Continuous ☐ Intermittent/PRN Flow Rate: _____ Litres/Min **Via:** ☐ Concentrator ☐ Portable cylinder size: _____ ☐ Nasal cannula ☐ Face Mask ☐ Other: _____ ☐ Encourage adequate fluid intake ☐ Check for nasal congestion daily ☐ Oral hygiene daily (mouth and lip care) ☐ Position mask, nasal prongs ☐ Observe for elastic strap causing tissue damage around the ears ☐ Adjust straps and pad if necessary ☐ Use water-based lubrication only. Do not use petroleum jelly ☐ Clean mask (frequency): _____ ☐ Change tubing (frequency): _____ ☐ Replace mask/nasal prongs (frequency): _____ **Positive Airways Pressure** ☐ CPAP ☐ BiPAP **Via:** ☐ Nasal mask ☐ Face mask ☐ Apply mask before sleeping ☐ Adjust mask, tubing straps and headgear ☐ Make sure the mask is a good fit ☐ Use a saline nasal spray to ease mild nasal congestion ☐ Use a humidifier or gel for dry mouth, throat or nose ☐ Clean mask (frequency): _____ ☐ Change tubing (frequency): _____ ☐ Replace mask/nasal prongs (frequency): _____

Other participants specific interventions:

_____

Risk / Response:

- ☐ Wind or distended abdomen
- ☐ Facial sores from NIV interface
- ☐ Eye soreness from NIV interface, air leakage
- ☐ Dry Mouth
- ☐ Nasal Congestion
- ☐ Other: _____

Refer to Health Practitioner or transfer to hospital if any of the above risks occur to ensure participants well-being.

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Ventilator Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Progress Chart

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

Evaluation Chart

Date	Evaluation	Name / Signature / Delegation

Ventilator Support Directive
Specialist / Medical Practitioner / Consultant

Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

Version No.	Issue Date	Document Owner
1	09/01/2025	Elizabeth Bradshaw
Version History		
Version No.	**Review Date**	**Revision Description**