

# HAMILTON-T1

## Operator's Manual

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**HAMILTON**  
**MEDICAL**  
Intelligent Ventilation since 1983



# Operator's Manual

HAMILTON-T1

2019-08-30

10078282/00

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	Preface .....	15
Chapter 1	Safety information .....	19
1.1	Overview.....	20
1.2	Electromagnetic susceptibility.....	20
1.3	Fire and other hazards.....	21
1.4	General operation and setup.....	21
1.4.1	General operation and setup.....	21
1.4.2	Electrical: power and batteries.....	22
1.4.3	Gas supply .....	23
1.4.4	USB ports.....	24
1.4.5	Transport .....	24
1.5	Setting up for ventilation.....	25
1.5.1	Patient breathing circuits, components, and accessories .....	25
1.5.2	Preoperational check and tests .....	26
1.5.3	Humidifier .....	26
1.5.4	CO2 sensor setup and operation .....	26
1.5.5	Nebulization.....	28
1.5.6	Speaking valve .....	28
1.6	Ventilating the patient .....	29
1.6.1	Specifying patient settings.....	29
1.6.2	Neonatal ventilation .....	29
1.6.3	Apnea backup.....	30
1.6.4	Noninvasive ventilation.....	30
1.7	Monitoring and alarms .....	30
1.8	Using the trolley.....	31
1.9	Maintenance.....	31
1.9.1	General maintenance, cleaning, and disinfection.....	31
1.9.2	Preventive maintenance .....	33
1.9.3	O2 sensor .....	33

---

1.10	Service and testing .....	33
<b>Chapter 2</b>	<b>System overview .....</b>	<b>35</b>
2.1	Overview.....	36
2.1.1	Standard features and options .....	36
2.2	Physical descriptions.....	39
2.2.1	About the ventilator.....	39
2.2.2	About the main display .....	44
2.2.3	About the patient breathing circuits.....	45
2.2.4	About the trolley and mounting variations .....	51
2.3	Navigating the windows and controls.....	51
2.3.1	Accessing windows .....	51
2.3.2	Adjusting controls.....	52
2.3.3	Selecting list items.....	52
<b>Chapter 3</b>	<b>Preparing the ventilator.....</b>	<b>53</b>
3.1	Overview.....	54
3.2	Connecting to a power source .....	54
3.2.1	Connecting to DC power .....	54
3.2.2	Using battery power.....	54
3.3	Connecting the oxygen supply .....	56
3.3.1	Using a low-pressure oxygen supply.....	56
3.3.2	Connecting the oxygen supply to the ventilator.....	56
3.3.3	Selecting the oxygen source type .....	56
3.4	Ensuring an adequate oxygen supply for patient transport .....	57
3.4.1	Reviewing current oxygen consumption .....	57
3.4.2	Calculating estimated oxygen consumption.....	58
3.5	Setting up the patient breathing circuit .....	63
3.5.1	Breathing circuit connections on the ventilator .....	63
3.5.2	Working with the expiratory valve set.....	64
3.5.3	Selecting the breathing circuit components.....	64

---

3.5.4	Assembling the patient breathing circuit .....	65
3.5.5	Positioning the breathing circuit .....	67
3.6	Turning the ventilator on and off .....	67
<b>Chapter 4</b>	<b>Setting up external devices and sensors.....</b>	<b>69</b>
4.1	Overview.....	70
4.2	Setting up a humidifier.....	70
4.3	Setting up CO2 monitoring .....	70
4.3.1	Mainstream CO2 measurement.....	71
4.3.2	Sidestream CO2 measurement.....	72
4.4	Setting up SpO2 monitoring.....	73
4.5	Enabling sensors .....	74
4.6	Setting up nebulization .....	74
4.7	Setting up a speaking valve .....	75
4.7.1	Activating speaking valve compatibility.....	75
4.7.2	Connecting a speaking valve to the breathing circuit set .....	76
4.7.3	Deactivating speaking valve compatibility.....	76
4.8	Connecting to an external patient monitor or other device.....	76
<b>Chapter 5</b>	<b>Specifying ventilation settings .....</b>	<b>77</b>
5.1	Process overview .....	78
5.2	Selecting the patient group .....	78
5.2.1	About Quick setups: pre-configured settings .....	79
5.3	Entering patient data .....	79
5.4	Performing the preoperational check, tests, and calibrations .....	80
5.4.1	Performing the preoperational check.....	81
5.4.2	Performing the breathing circuit Tightness test.....	83
5.4.3	Calibrating the adult/pediatric flow sensor .....	84
5.4.4	Calibrating the O2 sensor.....	85
5.4.5	Performing a zero calibration on the CO2 sensor/adaptor .....	86
5.4.6	Testing the alarms.....	87

---

5.5	Selecting the ventilation mode .....	89
5.5.1	Reviewing and adjusting ventilation settings.....	90
5.5.2	About Apnea backup ventilation .....	91
5.6	Setting alarm limits .....	92
5.6.1	About the Oxygen alarm limits .....	94
5.7	Starting ventilation .....	95
5.8	Stopping ventilation .....	95
5.9	About the control parameters .....	95
<b>Chapter 6</b>	<b>Specifying neonatal settings .....</b>	<b>99</b>
6.1	Setting up for neonatal ventilation .....	100
6.1.1	Setting the patient group and weight.....	100
6.1.2	Setting up the patient breathing circuit .....	101
6.2	Performing the preoperational check, tests, and calibrations .....	103
6.2.1	Calibrating the neonatal flow sensor .....	104
6.2.2	Calibrating the neonatal breathing circuit (nCPAP and nCPAP-PC modes) .....	105
6.3	Selecting the ventilation mode .....	106
6.4	Setting the patient weight for ventilation .....	106
6.5	Alarms for neonatal ventilation .....	106
6.6	O2 enrichment for neonates .....	106
<b>Chapter 7</b>	<b>Ventilation modes .....</b>	<b>107</b>
7.1	Overview.....	108
7.1.1	Breath types and timing options.....	108
7.1.2	Ventilation modes .....	108
7.1.3	Ventilation controls and settings .....	110
7.2	Volume-targeted modes, adaptive pressure control .....	112
7.2.1	APVcmv / (S)CMV+ mode.....	113
7.2.2	APVsimv / SIMV+ mode.....	114



---

7.3	Pressure-controlled modes .....	115
7.3.1	PCV+ mode .....	116
7.3.2	PSIMV+ mode .....	117
7.3.3	PSIMV+ mode with PSync .....	118
7.3.4	DuoPAP mode.....	119
7.3.5	APRV mode.....	120
7.3.6	SPONT mode.....	121
7.4	Intelligent Ventilation .....	122
7.4.1	ASV mode.....	122
7.5	Noninvasive modes .....	124
7.5.1	NIV mode.....	125
7.5.2	NIV-ST mode.....	126
7.5.3	The nCPAP modes.....	127
7.6	Special conditions .....	129
7.6.1	Safety ventilation .....	129
7.6.2	Ambient state .....	130
7.7	Working with noninvasive modes.....	130
7.7.1	Required conditions for use.....	130
7.7.2	Contraindications.....	131
7.7.3	Potential adverse reactions.....	131
7.7.4	Control settings in noninvasive ventilation.....	131
7.7.5	Alarms in noninvasive ventilation.....	132
7.7.6	Monitored parameters in noninvasive ventilation.....	132
7.7.7	Additional notes about using noninvasive ventilation.....	133
7.8	Working with ASV .....	133
7.8.1	Clinical workflow with ASV.....	134
7.8.2	Maintaining adequate ventilation .....	135
7.8.3	Reviewing alarm settings.....	135
7.8.4	Monitoring ASV .....	136
7.8.5	Weaning.....	137

---

7.8.6	Functional overview .....	138
<b>Chapter 8</b>	<b>Monitoring ventilation .....</b>	<b>143</b>
8.1	Overview.....	144
8.2	Viewing numeric patient data .....	144
8.2.1	About the main monitoring parameters (MMP) .....	144
8.2.2	Viewing patient data in the Monitoring window .....	145
8.3	Viewing graphical patient data.....	146
8.3.1	Selecting display options .....	146
8.3.2	Working with waveforms.....	147
8.3.3	Working with Trend graphs.....	149
8.3.4	Working with loops.....	150
8.4	Working with Intelligent panels.....	151
8.4.1	Dynamic Lung panel: real-time ventilation status .....	151
8.4.2	Vent Status panel: real-time ventilator dependence status .....	154
8.4.3	ASV Graph panel: real-time patient condition and targets .....	156
8.5	About the monitored parameters .....	156
8.6	Viewing patient ventilation time.....	164
8.7	Viewing device-specific information .....	165
<b>Chapter 9</b>	<b>Responding to alarms .....</b>	<b>167</b>
9.1	Overview.....	168
9.1.1	Alarm limit indicators .....	170
9.1.2	Responding to an alarm .....	171
9.1.3	Temporarily silencing an alarm .....	171
9.2	About the alarm buffer .....	172
9.3	Adjusting alarm loudness (volume).....	173
9.4	Troubleshooting alarms.....	174

<b>Chapter 10</b>	<b>Ventilation settings and functions</b> .....	<b>191</b>
10.1	Overview.....	192
10.2	Accessing settings during ventilation .....	192
10.2.1	Accessing patient data during ventilation .....	192
10.2.2	Accessing settings during ventilation .....	193
10.3	Entering/exiting Standby .....	194
10.4	Oxygen enrichment.....	195
10.4.1	Suctioning maneuver .....	195
10.5	High flow oxygen therapy .....	196
10.5.1	Working with HiFlowO2.....	196
10.6	Manual breath .....	197
10.7	Working with a nebulizer .....	197
10.7.1	Working with a pneumatic nebulizer.....	197
10.8	Working with a speaking valve.....	198
10.8.1	Mode changes that automatically turn off compatibility .....	198
10.8.2	Parameters monitored when compatibility is activated.....	198
10.8.3	Speaking valve-related control settings.....	198
10.8.4	Speaking valve-related alarms .....	199
10.9	Locking and unlocking the touch screen.....	199
10.10	Capturing a screenshot .....	200
10.11	About the Event log .....	200
10.11.1	Copying Event log data .....	201
10.12	Setting display options .....	202
10.12.1	Setting date and time.....	202
10.12.2	Day and night display brightness .....	202
<b>Chapter 11</b>	<b>Maintenance</b> .....	<b>205</b>
11.1	Overview.....	206
11.2	Cleaning, disinfection, and sterilization .....	206
11.3	Preventive maintenance .....	211

11.4	Performing maintenance tasks .....	211
11.4.1	Maintaining the filters .....	212
11.4.2	Replacing the galvanic O2 sensor .....	213
11.4.3	Charging and storing batteries .....	213
11.4.4	Replacing batteries .....	213
11.5	Repacking and shipping .....	214
<b>Chapter 12</b>	<b>Configuration .....</b>	<b>215</b>
12.1	Overview .....	216
12.2	Accessing Configuration mode .....	216
12.3	Configuring general settings .....	216
12.3.1	Selecting the default language .....	216
12.3.2	Selecting the units of measure .....	216
12.3.3	Enabling the communication interface .....	216
12.3.4	Setting the minimum alarm loudness (volume) .....	217
12.4	Selecting breath timing, mode naming, and ASV version .....	217
12.4.1	Setting breath timing options .....	217
12.4.2	Choosing the mode naming convention .....	217
12.4.3	Choosing the ASV version .....	217
12.5	Configuring MMPs .....	218
12.6	Defining Quick setups .....	218
12.6.1	Configuring individual setup settings .....	218
12.6.2	Selecting a default Quick setup .....	219
12.7	Configuring device options .....	219
12.7.1	Reviewing installed options .....	219
12.7.2	Adding software options .....	220
12.7.3	Activating hardware options .....	220
12.7.4	Removing options .....	221
12.8	Copying configuration settings .....	221

---

Chapter 13	Parts and accessories.....	223
13.1	Overview.....	224
Chapter 14	Specifications.....	233
14.1	Physical characteristics.....	234
14.2	Environmental requirements.....	235
14.3	Pneumatic specifications .....	236
14.4	Electrical specifications .....	237
14.5	Control settings .....	239
14.6	Monitored parameters .....	243
14.7	Alarms .....	249
14.8	Configuration .....	252
14.9	ASV technical data .....	254
14.10	Ventilator breathing system specifications .....	256
14.11	Technical performance data .....	257
14.11.1	Accuracy testing.....	261
14.11.2	Essential performance .....	262
14.11.3	Estimated oxygen consumption relative to minute volume.....	262
14.12	Functional description of ventilator system .....	263
14.12.1	Gas supply and delivery.....	264
14.12.2	Gas monitoring with the flow sensor.....	265
14.12.3	Pneumatic diagram .....	266
14.13	Symbols used on device labels and packaging .....	267
14.13.1	Symbols used on the trolley.....	269
14.14	Standards and approvals .....	269
14.15	Disposal and year of manufacture .....	271
14.16	Warranty.....	271
	Glossary.....	273
	Index .....	279



## HAMILTON-T1 Documentation

This guide is part of a documentation suite that includes, among others, the following documents:

Table 1. HAMILTON-T1 documentation suite

Document title	Description
<i>Operator's Manual (this guide)</i>	Provides detailed information about the setup and use of the HAMILTON-T1 ventilator.
<i>Pulse Oximetry Instructions for Use</i>	Provides setup and use information for using SpO2 and related sensors with the ventilator. <sup>1</sup>
<i>Volumetric Capnography User Guide</i>	Provides reference information for CO2 capnography. <sup>1</sup>
<i>Communication Interface User Guide</i>	Provides an overview of the communication interface, including how to connect the ventilator to external devices for data communication and support for nurse call remote alarms.
<i>Service Manual</i>	Provides information about installing and setting up the medical equipment, as well as additional technical and servicing information for the ventilator.
<i>EMC Declarations Guide</i>	Provides emissions and EMC-related safety and use information.

Be sure to read the documentation before using the device or accessories.

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<sup>1</sup> If option is installed.

## Conventions used in this guide

In this manual:

- Button and tab names are shown in a **bold** font.
- The notation **XX > XX** shows the sequence of buttons/tabs to touch to open the associated window.  
For example, the text "Touch **System > Settings**" means touch the **System** button, then touch the **Settings** tab.
- Window names are shown using the sequence of buttons/tabs used to open them.  
For example, "Alarms > Limits 1 window" means the window accessed by touching the **Alarms** button, then the **Limits 1** tab.
- *Software version*: The software version for the ventilator is displayed in the **System > Info** window and should match the version on the title page of this manual.
- The graphics shown in this manual may not exactly match what you see in your environment.
- Not all features are available in all markets.
- *Units of measure*: Pressure is indicated in cmH<sub>2</sub>O, length in cm, and temperature in degrees Celsius (°C). The units of measure for pressure and length are configurable.

Safety messages are displayed as follows:

### WARNING

A **WARNING** alerts the user to the possibility of injury, death, or other serious adverse reactions associated with the use or misuse of the device.

### CAUTION

A **CAUTION** alerts the user to the possibility of a problem with the device associated with its use or misuse, such as device malfunction, device failure, damage to the device, or damage to other property.

### NOTICE

A **NOTICE** emphasizes information of particular importance.

In tables, safety messages are indicated as follows:

 **WARNING!**

 **CAUTION!**

 **NOTICE!**



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## Intended use


The HAMILTON-T1 ventilator is intended to provide positive pressure ventilatory support to adults and pediatrics, and optionally infants and neonates.

Intended areas of use:

- In the intensive care ward, intermediate care ward, emergency ward, long term acute care hospital, or in the recovery room
- For emergency medical care
- During transport within and outside the hospital
- During transfer by rescue vehicles, fixed wing aircraft, helicopter, or ship

The HAMILTON-T1 ventilator is a medical device intended for use by qualified, trained personnel under the direction of a physician and within the limits of its stated technical specifications.

---

 **CAUTION**

*Federal law restricts this device to sale by or on the order of a physician.*

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# 1

## Safety information

1.1	Overview.....	20
1.2	Electromagnetic susceptibility.....	20
1.3	Fire and other hazards.....	21
1.4	General operation and setup.....	21
1.5	Setting up for ventilation.....	25
1.6	Ventilating the patient.....	29
1.7	Monitoring and alarms.....	30
1.8	Using the trolley.....	31
1.9	Maintenance.....	31
1.10	Service and testing.....	33

## 1.1 Overview

This chapter provides safety information related to setting up and operating the ventilator and trolley, as well as providing service.

**Be sure to review this Operator's Manual before using the ventilator and any accessories.**

**Be sure to read the Instructions for Use provided with any devices and accessories used with the ventilator before use.**

**Carefully review all sections of this safety chapter before setting up the ventilator and accessories, and ventilating the patient.**

If you have questions about any of the information in this manual, contact your Hamilton Medical representative or technical service personnel.

## 1.2 Electromagnetic susceptibility

### WARNING

- **MR UNSAFE.** Keep away from magnetic resonance imaging (MRI) equipment. The HAMILTON-T1 poses unacceptable risks to the patient, medical staff, or other persons within the MR environment.
- Correct function of the device may be impaired by the operation of high-frequency surgical equipment, microwaves, shortwaves, or strong magnetic fields in close proximity.
- Follow precautions for electrostatic discharge (ESD) and electromagnetic interference (EMI) to and from the ventilator and any connected devices and accessories.

- Use of accessories, transducers, and cables other than those specified or provided by the manufacturer of this equipment can result in increased electromagnetic emissions or decreased electromagnetic immunity of this equipment, and may result in improper operation.
- Portable RF communications equipment, including peripherals such as antenna cables and external antennas, should be placed no closer than 30 cm (12 in) to any part of the HAMILTON-T1 ventilator, including any cables specified by the manufacturer. Otherwise, degradation of the performance of this equipment can occur.
- The emissions characteristics of this equipment make it suitable for use in industrial areas and hospitals (CISPR 11, class A). If it is used in a residential environment (for which CISPR 11, class B is normally required) this equipment might not offer adequate protection to radio-frequency communication services. The user might need to take mitigation measures, such as relocating or reorienting the equipment.

The HAMILTON-T1 complies with the IEC 60601-1-2 EMC (Electromagnetic Compatibility) Collateral Standard.

The ventilator requires special precautions regarding electromagnetic compatibility (EMC). It must be installed and put into service according to the EMC information provided in the ventilator *EMC Declarations* (PN 10078284).

Portable and mobile RF communications equipment can affect the ventilator and all medical electrical equipment.

## 1.3 Fire and other hazards

### WARNING

- It is *not* permitted to use any of the equipment with flammable gases or anesthetic agents, or in insufficiently ventilated areas. Danger of fire!
- It is *not* permitted to use the ventilator with helium or mixtures of helium.
- Do *not* use the ventilator with any equipment or high-pressure gas hoses that are worn or contaminated with oil or grease.
- Highly compressed oxygen together with flammable sources could lead to spontaneous explosions.
- In case of fire, immediately secure the patient's ventilatory needs, turn off the ventilator, and disconnect it from its gas and electrical sources.
- Do *not* use if primary power source cables are damaged.
- The HAMILTON-T1 can be used in an oxygen-enriched environment. To reduce the risk of fire, use only breathing circuits intended for use in oxygen-enriched environments. Do *not* use antistatic or electrically conductive tubing.

## 1.4 General operation and setup

This section provides the following safety information:

- General operation and setup
- Electrical: power and batteries
- Gas supply
- USB ports
- Transport

### 1.4.1 General operation and setup

#### WARNING

- Modifications to the device and any accessories are *not* permitted.
- An O2 sensor must be installed.
- In case of ventilator failure, the lack of immediate access to appropriate alternative means of ventilation can result in patient death.
- If a fault is detected in the ventilator or its life-support functions are in doubt, disconnect the ventilator from the patient and immediately start ventilation with an alternate device (for example, a resuscitation bag), using PEEP and/or increased oxygen concentration when appropriate. The ventilator *must* be removed from clinical use and serviced by a Hamilton Medical authorized service engineer.
- Use only parts and accessories specified in Chapter 13 and in the product e-catalog, or that are specified as being compatible with this ventilator. Doing so ensures proper ventilation operation, avoids degraded performance, and keeps your warranty in force.
- The use of this equipment is restricted to one patient at a time.
- Only use the ventilator and its components and accessories according to the intended use and as described in the associated *Instructions for Use*.
- Do *not* connect any component or device to the exhaust port of the expiratory valve unless authorized by Hamilton Medical.
- The ventilator must *not* be used in a hyperbaric chamber.

- If there is damage to any part of the ventilator, do *not* use the device. Technical service is required.
- Do *not* simultaneously touch conductive components (for example, the USB port) or conductive parts of the ventilator enclosure and the patient.
- Additional equipment connected to medical electrical equipment must comply with the respective IEC or ISO standards. All configurations must comply with the requirements for medical electrical systems, IEC 60601-1, clause 16.
- Anybody connecting additional equipment to medical electrical equipment configures a medical system and is responsible for ensuring that the system complies with the requirements for medical electrical systems. Local laws take priority over the above-specified requirements.

 **CAUTION**

- *To prevent possible patient injury, do NOT block the holes at the back and side of the ventilator. These holes are vents for the fresh air intake and the cooling fan.*
- *Use in rescue vehicles, fixed wing aircraft, helicopter, or ship may increase the risk of autotriggering. Adjust flow trigger if needed.*


**NOTICE**

- The ventilator provides automatic barometric pressure compensation.
- Due to the ventilator's base flow, the exhaust gas output is larger than the patient's actual exhaled volume.

## 1.4.2 Electrical: power and batteries

 **WARNING**

- To ensure grounding reliability, use a special hospital-grade receptacle.
- Ventilation stops if the battery or batteries are discharged and no external power supply is connected.
- The HAMILTON-T1 does not require protective earth grounding, because it is a class II device, as classified according to IEC 60601-1.
- It is the responsibility of the operator to ensure that the power system of any device connected to the ventilator power outlet complies with the requirements for medical electrical systems as well as local regulations.
- Periodically check or replace the battery.
- Check the battery charge level before ventilating a patient and before unplugging the ventilator for transport or other purposes.
- The batteries will *not* charge if the ambient temperature is above 43°C.

 **CAUTION**

*To electrically isolate the ventilator electrical circuits from all poles of the primary power supply simultaneously, disconnect the power plug.*

**NOTICE**

- Set up the ventilator in a location where the primary power supply is accessible.
- Only authorized service personnel may replace the power cable.
- Battery life indications are approximate. The actual battery life depends on ventilator settings, battery age, and level of battery charge. To ensure maximum battery life, maintain a full charge and minimize the number of complete discharges.
- After power has been interrupted, the device stores the last settings, including any specified alarm limits. Upon reconnection with the power supply, the device resumes ventilation with these stored settings.

## 1.4.2.1 Connecting to DC power

**NOTICE**

- Use only cables supplied by Hamilton Medical.
- Only qualified technicians are allowed to configure the open end of the DC cable that is supplied with open contacts.
- The HAMILTON-T1 DC cables may only be used with the HAMILTON-T1 ventilator.
- The DC cables are for use only with a 12-28 V DC electrical power supply. A 15-amp fuse is included.
- Always check the reliability of the DC outlet. When DC power is connected, the DC symbol on the display shows a frame around it. See Table 3-1.

## 1.4.3 Gas supply

**CAUTION**

*Always check the status of the oxygen cylinders or other supply before using the ventilator during transport.*

**NOTICE**

- To prevent damage to the ventilator, connect only clean, dry medical grade oxygen.
- When the ventilator is not in use, disconnect all gases.

## 1.4.3.1 Low-pressure oxygen supply

**CAUTION**

- *To reduce the risk of fire:*
  - *Do NOT use a low-pressure oxygen source that delivers a flow greater than 15 l/min.*
  - *Ensure adequate ventilation at the rear of the ventilator.*
  - *Turn off the oxygen source when the ventilator is not in operation.*
- *To prevent possible patient injury when using the ventilator with an oxygen concentrator, do not use a humidifier. Any humidifier system supplied with the concentrator must be removed before using the ventilator.*
- *The Oxygen control on the ventilator is not active when low-pressure oxygen is used. It is the operator's responsibility to control the oxygen setting.*

- *To prevent possible patient injury, use low-pressure oxygen only in cases where the low-pressure source can provide an adequate level of oxygenation.*
- *To prevent possible patient injury, ensure that an emergency backup oxygen supply (for example, a cylinder) is available in case the low-pressure oxygen source fails.*
- *To calibrate the O<sub>2</sub> sensor, disconnect all O<sub>2</sub> supplies. Calibration is performed at a concentration of 21%.*
- *To protect the oxygen control system, do not supply both high- and low-pressure oxygen to the ventilator simultaneously.*

#### NOTICE

- Only use low-pressure hoses that comply with EN ISO 5359 to connect the device to the oxygen supply.
- Before starting ventilation, ensure that the selected gas source type, **HPO** or **LPO**, matches the connected gas source.

#### 1.4.4 USB ports

#### WARNING

- During transfer of a ventilated patient, to prevent water intake, the ventilator USB port must be covered.
- Do *not* use the USB port to make a wireless connection of any kind.

#### NOTICE

- Before using the USB port, touch the ventilator to discharge any static electricity.
- The USB port is intended for passive memory devices only.
- The memory device must be USB 1.1 compatible.
- If you remove the USB memory device before files are completely transferred, you must turn the ventilator off and on again to reset the USB port.

#### 1.4.5 Transport

#### CAUTION

- *Ensure that accessories used during transport are adequately protected against water ingress.*
- *During transport, only use humidifiers that are approved for transport operation.*

#### NOTICE

- The HAMILTON-T1 must always be secured during transport.
- In rough environments (for example, aircraft or ambulance), use an oxygen hose with a slow release valve to safeguard against a rapid loss of pressurized O<sub>2</sub>.



## 1.5 Setting up for ventilation

This section provides the following safety information:

- Patient breathing circuits, components, and accessories
- Performing preoperational checks and testing
- Humidifier
- CO2 monitoring setup and operation
- Nebulization
- Speaking valve
- SpO2 monitoring setup and operation  
See the *Pulse Oximetry Instructions for use*.

### 1.5.1 Patient breathing circuits, components, and accessories

In addition to the information provided in this section, carefully review the information in Sections 1.3 and 1.4.

#### WARNING

- **To prevent patient or ventilator contamination, always use a bacteria filter or HMEF between the patient and the inspiratory port. If no bacteria filter is used, the exhaled gas can contaminate the ventilator.**
- Ensure that all of the components of the breathing circuit set, including but *not* limited to flow sensor, humidifier, and other accessories, match the associated intended use for the target patient group.

- Adding attachments or other components/assemblies to a breathing system can change the pressure gradient across the ventilator, which can adversely affect ventilator performance.
- Make sure a HEPA filter is installed by the air intake. See Figure 11-1.
- For each new patient, always use a new or reprocessed breathing circuit to avoid cross contamination.
- During ventilation, regularly check the breathing circuit filter for increased resistance and blockage.

#### NOTICE

- Any bacteria filter, HMEF, or additional accessories in the expiratory limb may substantially increase flow resistance and impair ventilation.
- When adding components to the Hamilton Medical breathing circuit configurations, do *not* exceed the inspiratory and expiratory resistance values of the ventilator breathing system as specified in Section 14.10, as required by ISO 80601-2-12.
- Pressure and volume measurement accuracy may be affected by using a breathing circuit with high resistance. Accuracy was tested with Hamilton Medical devices using the breathing circuits PN 260144 for adults, PN 260189 for pediatrics, and PN 151969 for neonates.
- The flow sensor tubes must be secured with the included clamp.

### 1.5.2 Preoperational check and tests

#### CAUTION

- To prevent possible patient injury, disconnect the patient from the ventilator before running the preoperational tests, and use another source of ventilatory support.
- To ensure the ventilator's safe operation, always run the preoperational check before using the ventilator on a patient.
- Do NOT use the ventilator until necessary repairs are completed and all preoperational tests have passed.

#### NOTICE

- To ensure that all breathing circuit connections are leak-tight, perform the **Tightness** test every time you connect a circuit or change a circuit part.
- If there is a mismatch between the selected patient group and the type of flow sensor connected, the calibration fails. Ensure you are using the correct flow sensor for the patient.

### 1.5.3 Humidifier

#### WARNING

- Before using a humidifier, review the *Instructions for Use* as well as the *Instructions for Use* provided with its accessories.
- To prevent possible patient injury and equipment damage, do *not* turn the humidifier on until the gas flow has started and is regulated. Turn the humidifier off before stopping gas flow.

- Adding attachments or other components/assemblies to a connected humidifier can change the pressure gradient across the ventilator, which can adversely affect ventilator performance.
- Regularly check the water traps and the breathing circuit limbs for water accumulation. Empty as required.

### 1.5.4 CO2 sensor setup and operation

#### WARNING

- Monitor the CO2 waveform (capnogram) on the ventilator display. If it appears abnormal, check the patient, settings, and the breathing circuit components, including the CO2 sensor sampling line. Adjust and replace components as appropriate.
- If the capnogram appears abnormal, inspect the CO2 airway adapter and replace if needed.
- Elevated baseline can be caused by sensor problems or an issue with the patient.
- Do *not* use any CO2 sensor/adapter if they appear to be damaged or if they fail to operate properly. Refer servicing to Hamilton Medical authorized personnel.
- Do *not* use the CO2 components when they are wet or have exterior condensation.
- In NIV and neonatal ventilation with uncuffed tubes, leaks may influence the volumetric capnogram and the measured values.

- Always connect all components securely and check for leaks according to standard clinical procedures. Displacement of the nasal or combined nasal-oral cannulas can cause lower-than-actual CO2 readings.
- Positioning of tubes and cables:
  - Do *not* position the cables or tubing in any manner that may cause patient entanglement or strangulation.
  - Support the tubing to avoid stress on the ET tube.
  - Do *not* apply excessive tension to any cable or tubing.
- During use, a system leak, such as that caused by an uncuffed ET tube or damaged CO2 sensor may significantly affect sensor readings, including flow, volume, pressure, and other respiratory parameters.
- Leakages in the breathing or sampling system may cause the displayed CO2 values to be significantly under-reported (too low).
- Keep all cleaning agents away from the CO2 sensor electrical connections.
- For the CO2 sensor/adaptor, use only cleaning and disinfection agents that are recommended in the *Approved cleaning agents for CO2 components*, available on MyHamilton.
- Periodically check the sensor and tubing for excessive moisture or secretion build-up, and replace if needed. Excessive moisture can affect measurements.
- **LoFlo sidestream CO2 sensor.** Do *not* use with patients who cannot tolerate the removal of 50 ml  $\pm$ 10 ml/min from their total minute volume. In adaptive modes (such as ASV, APVcmv, and APVsimv), the removal is fully compensated.
- **LoFlo sidestream CO2 sensor.** Use of devices containing PVC plasticized with DEHP should be limited to the amount of time treatment is medically necessary, especially for neonates and pregnant or nursing mothers.

### CAUTION

- *All devices are NOT protected against reanimation with a defibrillator. Disconnect the CO2 sensor before using a defibrillator on the patient.*
- *Always use the correct CO2 adapter. In adult patients, smaller geometrics increase airway resistance and induce low tidal volumes and intrinsic PEEP. In neonatal patients, large geometrics impede effective CO2 removal.*
- *Do NOT place the CO2 sensor on the patient. It can burn the skin as the sensor may reach a temperature of 46°C (115°F).*
- *Use during nebulization may influence the CO2 measurements. In addition, the medication can contaminate the sensor windows, causing the sensor to fail prematurely.*
- **LoFlo sidestream CO2 sensor.** *Remove the sampling kit sample cell from the module when not in use.*
- **LoFlo sidestream CO2 sensor.** *Do NOT stick finger into the sample cell receptacle.*

### NOTICE

- Position airway adapters with windows in a vertical, *not* a horizontal, position. This helps keep patient secretions from pooling on the windows. If pooling occurs, remove the adapter, rinse with water, and reconnect.

- Do *not* combine the neonatal CO2 airway adapter and the adult flow sensor. Doing so can increase resistance, create artifact, or lead to hypoventilation, intrinsic PEEP, or overinflation.
- Do *not* place the CO2 sensor/adapter between the ET tube and the elbow, as this may allow patient secretions to enter the tubing and block the adapter windows.
- The CO2 sensors and accessories that have contact with the patient are not made with natural rubber latex.
- Nitrous oxide, elevated levels of oxygen, helium, and halogenated hydrocarbons can influence the CO2 measurement.

### 1.5.5 Nebulization

#### WARNING

- Nebulization of drugs can cause an occlusion and increased resistance of a connected expiratory filter. Check the filter frequently for increased resistance or blockage.
- Connect the nebulizer in the inspiratory limb per your institution's policy and procedures. Connecting the nebulizer between the flow sensor and the endotracheal tube increases dead space and causes incorrect volume measurements.
- Pneumatic nebulization affects the delivered oxygen concentration.
- Nebulization can affect the accuracy of CO2 measurements.

#### CAUTION

*To prevent the expiratory valve from sticking due to nebulized medications, regularly check and clean or replace the expiratory valve membrane and/or the expiratory filter.*

#### NOTICE

- Pneumatic nebulization is disabled:
  - During neonatal ventilation (if needed, use an Aerogen nebulizer<sup>2</sup>)
  - When using HiFlowO2
  - When using LPO
- Only use approved piezo nebulizers with the HAMILTON-T1.

### 1.5.6 Speaking valve

#### CAUTION

- *Do not leave the patient unattended when **SpeakValve** is activated and a speaking valve is connected to the patient.*
- *When compatibility is activated:*
  - *Apnea backup ventilation is disabled. When compatibility is turned off, Apnea backup ventilation returns to its previous setting.*
  - *Some alarm limits are changed and some alarms are disabled. For details, see Section 10.8.4.*
  - *Some changes apply to monitoring parameters. For details, see Section 10.8.2.*

<sup>2</sup> Not available in all markets. Aerogen nebulization is not supported for patients younger than 28 days old in the USA.

## 1.6 Ventilating the patient

This section provides the following safety information:

- Specifying patient settings
- Neonatal ventilation
- Apnea backup
- Noninvasive ventilation

### 1.6.1 Specifying patient settings

#### WARNING

- It is the clinician's responsibility to ensure that all ventilator settings are appropriate, even when "automatic" features, such as ASV, or default settings are used.
- To prevent possible patient injury:
  - Make sure the ventilator is set up for the appropriate patient group with the appropriate breathing circuit components.
  - For each patient group, make sure you select the correct patient sex and height (Adult/Ped) or weight (Neonatal). Correct entries help prevent hyper- or hypo-ventilation.
- The ventilator is a high-flow device that can operate with flows above 60 l/min and with a high oxygen concentration.

### 1.6.2 Neonatal ventilation

In addition to the information provided in this section, carefully review the information in Sections 1.5 and 1.6.

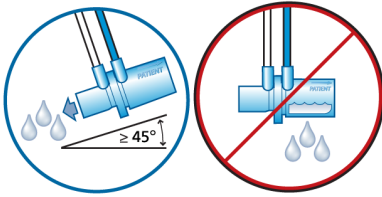
#### WARNING

Prolonged exposure to high oxygen concentrations may cause irreversible blindness and pulmonary fibrosis in preterm neonates. Be especially careful when performing oxygen enrichment.

#### CAUTION

- *Make sure the correct type of expiratory valve for your patient is installed:*
  - *Ensure the Neonatal patient group is selected on the ventilator when using the neonatal expiratory valve. It cannot be used with the Adult/Ped group.*
  - *You must use a neonatal expiratory valve for neonates.*
- *To prevent increased CO<sub>2</sub>, do NOT use an adult airway adapter for neonates as it will increase dead space.*
- *To determine appropriate tidal and minute volumes for neonatal patients, you must consider (anatomic) dead space. Artificial airways (Y-piece, flow sensor, ET tube, CO<sub>2</sub> airway adapter) may increase the dead space.*

- When using active humidification, prevent water accumulation in the flow sensor by ensuring that the flow sensor is positioned at a  $\geq 45^\circ$  angle relative to the floor. Excess water can affect the flow sensor measurements and lead to inaccurate volume delivery, potentially resulting in hypoventilation.



#### NOTICE

When switching between the Adult/Ped to the Neonatal patient groups, you must calibrate the flow sensor and perform the Tightness test.

#### 1.6.2.1 Working with nCPAP modes

#### NOTICE

- In nCPAP and nCPAP-PC modes, starting O<sub>2</sub> enrichment or changing the Oxygen setting sets the flow to 10 l/min for 60 seconds. The flow then returns to its previous setting.
- The Flow sensor calibration needed alarm may be generated when changing to and from nCPAP modes.
- Apnea backup, trigger detection, disconnection detection, and volume measurements are not available in nCPAP modes.

#### 1.6.3 Apnea backup

#### ⚠ CAUTION

We recommend you enable Apnea backup ventilation whenever a mode that allows spontaneous breathing is selected. Apnea backup is enabled by default.

#### 1.6.4 Noninvasive ventilation

#### NOTICE

- As a precaution, you must be prepared to intubate the patient and start invasive ventilation at any time while noninvasive ventilation is in use.
- The use of a mask can increase dead space. Always comply with the mask manufacturer's instructions when using noninvasive ventilation.
- The Inspiratory volume limitation alarm is inactive in noninvasive modes.

### 1.7 Monitoring and alarms

#### ⚠ CAUTION

- To prevent possible patient injury, make sure the alarm limits are appropriately set before you place the patient on the ventilator.
- The HAMILTON-T1 oxygen monitoring function can be disabled. Ensure that an alternative means of oxygen monitoring is always available and enabled.
- To ensure that oxygen monitoring is always fully functional, replace an exhausted or missing O<sub>2</sub> sensor as soon as possible or use an external monitor that complies with ISO 80601-2-55.

- *Ambient temperature < 0°C: The oxygen concentration that is displayed may be inaccurate. Disable O2 monitoring. Ensure that an alternative means of oxygen monitoring is always available and enabled.*

### NOTICE

- The HAMILTON-T1 is *not* intended to be a comprehensive vital sign monitor for patients on life-support equipment. Patients on life-support equipment should be appropriately monitored by qualified medical personnel and suitable monitoring devices.
- The use of an alarm monitoring system does *not* give absolute assurance of warning for every type of issue that may arise with the ventilator. Alarm messages may *not* pinpoint a problem exactly; the exercise of clinical judgment is necessary.
- It is recommended that additional independent monitoring devices, including pulse oximeters measuring SpO<sub>2</sub>, be used during mechanical ventilation. The operator of the ventilator must still maintain full responsibility for proper ventilation and patient safety in all situations.
- Do *not* pause the audible alarm when leaving the patient unattended.
- The **Auto** function is *not* available during neonatal ventilation.

## 1.8 Using the trolley

### WARNING

- To prevent possible personal injury and equipment damage, including tipping:
  - Lock the trolley's wheels when parking the ventilator.
  - Take care when crossing thresholds.
- To prevent accidental extubation, check the patient tubing support arm joints and secure as necessary.

## 1.9 Maintenance

This section provides the following safety information:

- Maintenance, cleaning, and disinfection
- Preventive maintenance
- O<sub>2</sub> sensor

### 1.9.1 General maintenance, cleaning, and disinfection

### WARNING

- Reprocessing of Hamilton Medical single-use products can affect the product properties and may cause injury to the patient. For example, a change to the surface structure during reprocessing may lead to a change in the tear strength or cause actual cracking. Furthermore, an altered surface structure may result in a microbial aggregation of spores, allergens and pyrogens, for example, or cause an increase in the number of particles released as a result of chemical changes in the material properties.

- To reduce the risk of cross-contamination, regularly clean and replace the fan filter. For details, see Table 11-5 and Section 11.4.1.
- To prevent patient exposure to sterilizing agents and to prevent premature deterioration of parts, sterilize parts using only the techniques recommended in Chapter 11 and in any associated *Reprocessing Guide* or *Instructions for Use* provided with each part.
- Hamilton Medical does *not* assume any liability for the proper functioning of single-use items if they are reprocessed and reused by the user.
- Always use caution when handling bacteria filters to minimize the risk of bacterial contamination or physical damage. Dispose of used filters immediately after use. Follow your hospital procedures for disposal.
- Follow the cleaning, disinfection, and sterilization procedures for each component as described in this guide and in the cleaning agent manufacturer's *Instructions for Use*.
- Always disconnect the device and any accessories, including CO2 sensor/ adapter, from electrical power before cleaning and disinfection to reduce the risk of electric shock.
- *To prevent premature deterioration of parts, make sure the disinfecting chemical is compatible with the part material. Use only registered/ approved cleaning and disinfection solutions, as approved by your institution's protocol, after each patient use, according to the cleaning agent manufacturer's recommendations.*
- *Use only EPA-registered/ approved cleaning and disinfection solutions, as approved by your institution's protocol, after each patient use, according to the cleaning agent manufacturer's recommendations.*
- *Intrusion of fluids, or immersing parts in fluids, will damage the device.*
- *Do NOT pour fluids onto the device surfaces.*
- *Do NOT use abrasives materials (for example, steel wool or silver polish), hard brushes, pointed instruments, or rough materials on surfaces.*
- *Thoroughly rinse all patient or airway contact component to ensure removal of residual cleaning/disinfection agents.*
- *Cleaning and disinfection agent residues can cause blemishes or fine cracks, especially on parts exposed to elevated temperatures during sterilization.*

 **CAUTION**

- *Do NOT sterilize or immerse the CO2 sensor in liquids.*
- *Do NOT attempt to sterilize the interior components of the ventilator.*
- *Do NOT attempt to sterilize the entire device with ETO gas.*
- *Incorrect concentrations or residence times of sterilization agents may lead to bacterial resistance.*

**NOTICE**

For specific information on cleaning, disinfecting, and sterilizing autoclavable (reusable) accessories and components, refer to the appropriate *Reprocessing Guide* and *Instructions for Use* provided with each part.



## 1.9.2 Preventive maintenance

### NOTICE

- Dispose of all parts removed from the device according to your institution's protocols. Comply with all local, state, and federal regulations with respect to environmental protection, especially when disposing of the electronic device or parts of it (for example, O<sub>2</sub> sensor).
- We recommend that you document all maintenance procedures.
- It is *not* allowed to perform service or maintenance on the device while a patient is connected.
- If no bacteria (inspiratory) filter is used, the device must be considered contaminated and must be serviced.

## 1.9.3 O<sub>2</sub> sensor

### NOTICE

- Replace the O<sub>2</sub> sensor with a genuine Hamilton Medical O<sub>2</sub> sensor only; otherwise, oxygen measurement will *not* function and permanent oxygen-related alarms may be generated.
- To prevent leakage within the ventilator, make sure an O<sub>2</sub> sensor is installed at all times, even if you use an external monitor or disable oxygen monitoring.

## 1.10 Service and testing

- To ensure proper servicing and to prevent possible physical injury, only Hamilton Medical authorized service personnel may service the ventilator using information provided in the ventilator *Service Manual*. In addition, all accessories and devices must only be serviced by Hamilton Medical authorized service personnel.
- The manufacturer can only be responsible for the safety, reliability, and performance of the ventilator if all of the following requirements are met:
  - Appropriately trained personnel carry out assembly operations, extensions, readjustments, modifications, maintenance, or repairs.
  - The electrical installation of the relevant room complies with the appropriate requirements.
  - The ventilator system is used in accordance with the ventilator *Operator's Manual*.
  - Do *not* attempt service procedures other than those specified in the ventilator *Service Manual*.
- Any attempt to modify the ventilator hardware or software without the express written approval of Hamilton Medical automatically voids all warranties and liabilities.



# 2

## System overview

2.1	Overview.....	36
2.2	Physical descriptions.....	39
2.3	Navigating the windows and controls.....	51

### 2.1 Overview

The HAMILTON-T1 ventilator system comprises the following main components:

- Ergonomic design featuring integrated monitor with touch screen display and alarm lamp
- Ventilation unit for gas mixing and control, and patient breathing circuit for gas delivery and exchange
- Oxygen monitoring using a galvanic sensor
- Optional connections to a humidifier, nebulizer, SpO2 and CO2 sensors, and external data interfaces
- Trolley, carrying case, and a variety of wall, bed, ceiling, and shelf mounts

The ventilator system offers the following main features:

- *Monitoring:* Real-time waveforms, numerical monitoring, trends, loops, and Intelligent panels showing the patient's real-time breathing status, ventilator dependence, and targets, CO2 and SpO2 measurements (when enabled)
- *Alarms:* Adjustable and nonadjustable to ensure patient safety
- Configurable startup settings for each patient group
- Support for pneumatic or Aerogen nebulization
- Support for AC and DC primary power sources

#### 2.1.1 Standard features and options

The ventilator offers a robust set of standard equipment and features, as well as optional modes and features for the supported patient groups.

Table 2-1 lists the standard software configuration and options.

Table 2-2 lists the standard equipment (hardware) and options.

Table 2-1. Standard software configuration and options

Function	Patient group	
	Adult/Ped	Neonatal <sup>3,4</sup>
	Standard: X    Option: O    Not applicable: --	
<b>Patient groups</b>	X	O
<b>Modes</b>		
<b>Intelligent ventilation mode</b>		
ASV <sup>®</sup>	X	--
<b>Volume-targeted, pressure-controlled modes</b>		
APVcmv / (S)CMV+	X	X
APVsimv / SIMV+	X	X
<b>Pressure-controlled modes</b>		
DuoPAP, APRV	O	O
PCV+	X	X
PSIMV+	X	X
SPONT	X	X
<b>Noninvasive modes</b>		
NIV, NIV-ST	O	O
nCPAP, nCPAP-PC	--	O
<b>Other functions</b>		
HiFlowO2	O	O
Suctioning tool <sup>5</sup>	X	--
Flow trigger	X	X
Speak valve compatibility	O	O
Trends/Loops	O	O

<sup>3</sup> Applies only to devices with serial number > 3000.<sup>4</sup> Not available in all markets.<sup>5</sup> Not available during neonatal ventilation.

Table 2-2. Standard equipment (hardware) configuration and options

Functions	HAMILTON-T1
Standard: X    Option: O	
Trolley, carrying case, and a variety of wall, bed, ceiling, and shelf mounts	O
Second battery	O
Communication board: CO2/Nurse Call/COM, CO2/SpO2/COM <sup>6</sup> , or CO2	O
Extended communication ports: USB port, RJ-45 Ethernet connector <sup>7</sup>	X
Communication protocols: Hamilton, Hamilton P2, GALILEO compatible, DrägerTestProtocol, Philips VueLink Open, Hamilton Block protocol	O
Night vision compatibility (NVG) <sup>6</sup>	O
NBC filter compatibility	O

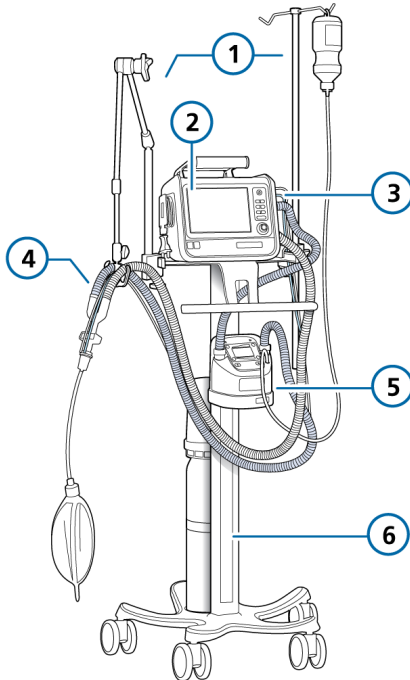
<sup>6</sup> Applies only to devices with serial number > 3000.

<sup>7</sup> For internal use only.

## 2.2 Physical descriptions

This section provides an overview of the ventilator, breathing circuit sets, and trolley.

Figure 2-1. HAMILTON-T1 with accessories

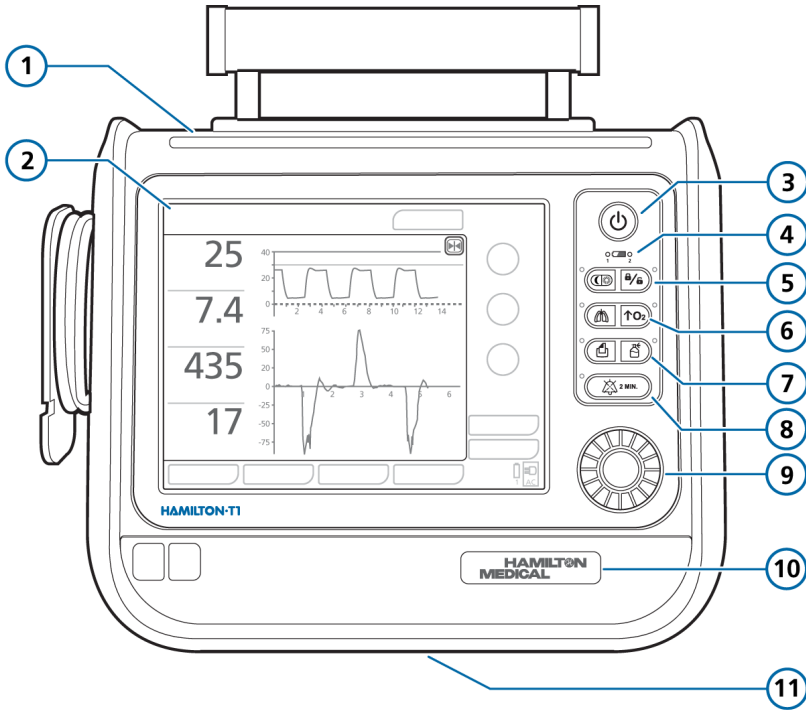


- |                                 |                     |
|---------------------------------|---------------------|
| 1 Support arm and infusion arm  | 4 Breathing circuit |
| 2 Display and controls          | 5 Humidifier        |
| 3 Breathing circuit connections | 6 Trolley           |

### 2.2.1 About the ventilator

Figures 2-2 through 2-5 provide an overview of the device.

Figure 2-2. Front view, ventilator

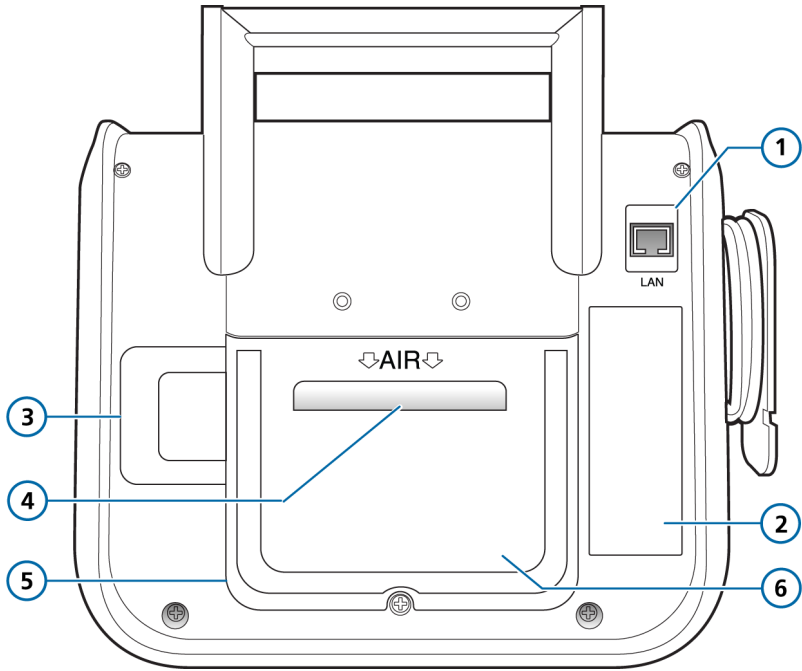


- |   |  |    |  |
|---|--|----|--|
| 1 | Alarm lamp   | 7  | Print screen key<br>Nebulizer key  |
| 2 | Touch screen display                                 | 8  | Audio Pause key  |
| 3 | Power/Standby key                                    | 9  | Press-and-Turn (P&T) knob  |
| 4 | Battery charge indicator                             | 10 | Front cover and battery  |
| 5 | Day/Night key <sup>8</sup><br>Screen lock/unlock key | 11 | Expiratory valve bleed port (under the ventilator)<br><i>Do not obstruct</i> |
| 6 | Manual breath key<br>O2 enrichment key               |    |  |

<sup>8</sup> Applies only to devices with serial number > 3000.

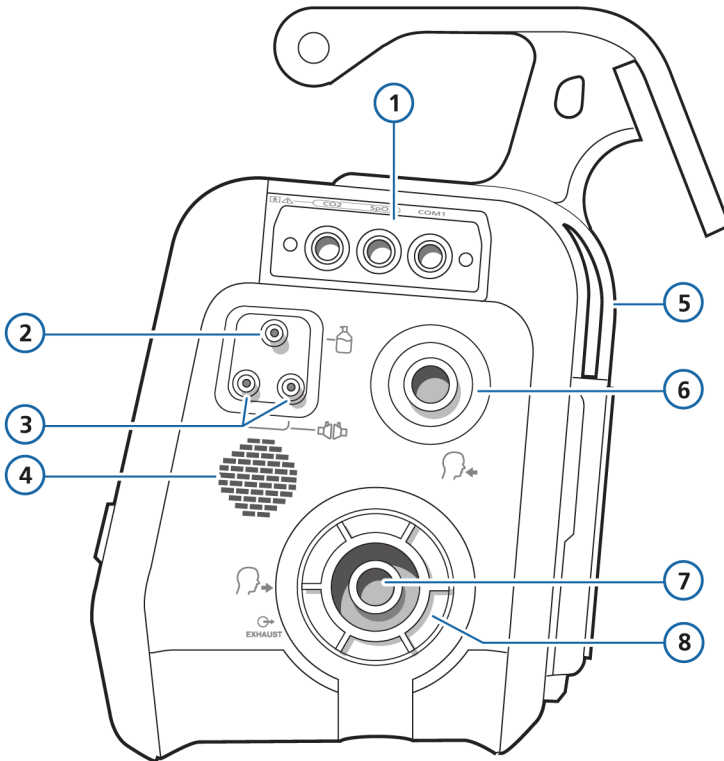


Figure 2-3. Rear view, ventilator



- |   |  |   |  |
|---|--|---|--|
| 1 | RJ-45 Ethernet connector               | 4 | Air intake and dust filter<br><i>Do not obstruct</i> |
| 2 | Label with device-specific information | 5 | Rear cover   |
| 3 | O2 sensor (under the cover)            | 6 | HEPA filter (under the cover)                        |

Figure 2-4. Side view, with breathing circuit connections







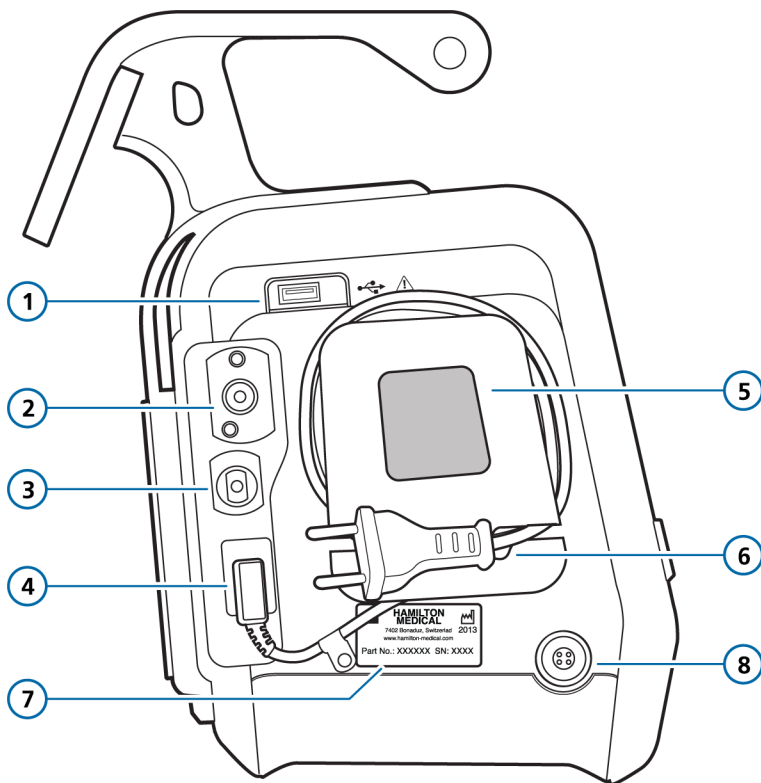
1		Communication board (optional)	5		Cooling air outlet
2		Pneumatic nebulizer port	6		To patient inspiratory port
3		Flow sensor connection ports	7		From patient expiratory port
4		Loudspeaker	8		Expiratory valve set

Figure 2-5. Side view, with gas connections

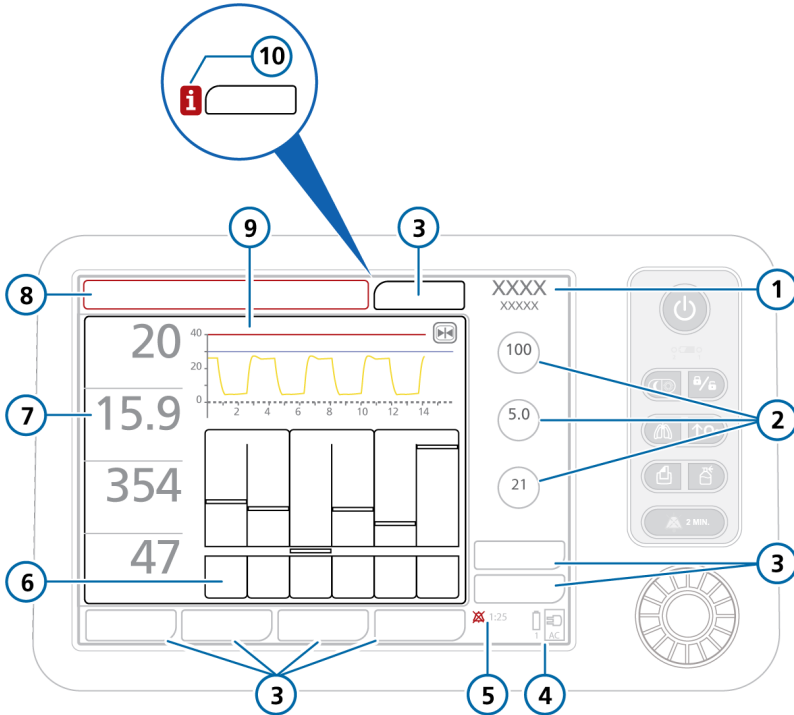


- |   |   |   |                                    |
|---|---|---|------------------------------------|
| 1 | USB port  | 5 | Cooling air intake and dust filter |
| 2 | High-pressure oxygen DISS or NIST inlet fitting | 6 | AC power cord with retaining clip  |
| 3 | Low-pressure oxygen connector                   | 7 | Serial number label                |
| 4 | AC Power socket                                 | 8 | DC power socket                    |

### 2.2.2 About the main display

Directly access all the windows for mode, controls, alarms, and monitoring from the main display during normal ventilation (Figure 2-6).

Figure 2-6. Main display



- |   |  |    |                                  |
|---|--|----|----------------------------------|
| 1 | Active mode and patient group  | 6  | Configurable graphic display     |
| 2 | Main controls for the active mode  | 7  | Main monitoring parameters (MMP) |
| 3 | Window buttons: Modes, Alarms, Controls, Monitoring, Tools, Events, System | 8  | Message bar (color coded)        |
| 4 | Power source   | 9  | Pressure/time waveform           |
| 5 | Audio pause indicator and countdown timer                                  | 10 | i-icon alarm indicator           |

### 2.2.3 About the patient breathing circuits

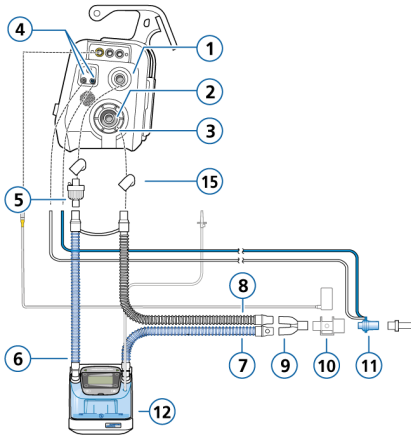
For details about connecting and setting up the breathing circuit, see Section 3.5.

When setting up the patient breathing circuit, keep in mind the following important points:

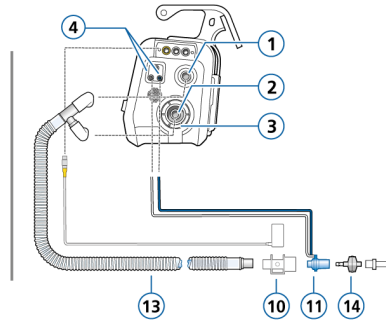
- To prevent patient or ventilator contamination, be sure to connect a bacteria (inspiratory) filter or HMEF between the patient and the **To patient inspiratory port**.
- Connect the CO<sub>2</sub> sensor in front of or behind the flow sensor, according to your institution's protocol.
- During neonatal ventilation with active humidification, prevent water accumulation in the flow sensor by ensuring that the flow sensor is positioned at a  $\geq 45^\circ$  angle relative to the floor.

Figure 2-7. Adult/pediatric breathing circuits

Adult/Ped: Dual limb with humidifier

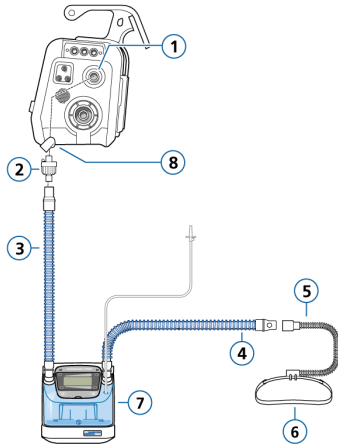


Adult/Ped: Coaxial with HMEF



- |   |   |    |                                     |
|---|---|----|-------------------------------------|
| 1 | To patient inspiratory port                                 | 9  | Y-piece                             |
| 2 | From patient expiratory port                                | 10 | CO2 sensor/adaptor                  |
| 3 | Expiratory valve set  | 11 | Flow sensor                         |
| 4 | Flow sensor connection ports                                | 12 | Humidifier                          |
| 5 | Bacteria filter   | 13 | Coaxial inspiratory/expiratory limb |
| 6 | Inspiratory limb to humidifier                              | 14 | HMEF                                |
| 7 | Heated inspiratory limb with temperature sensor, to patient | 15 | Adapters                            |
| 8 | Heated expiratory limb                                      |    |                                     |

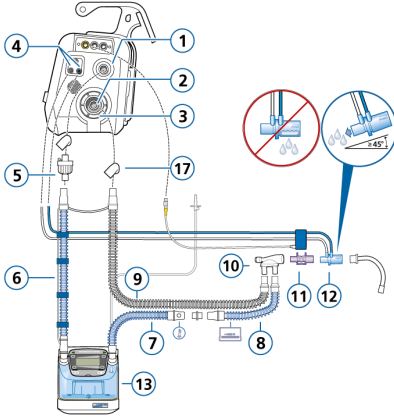
Figure 2-8. Adult/pediatric breathing circuit: high flow oxygen therapy

**Adult/Ped: Single limb, high flow oxygen therapy**

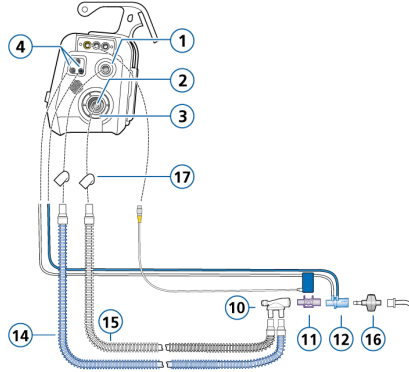
- |   |   |   |                  |
|---|---|---|------------------|
| 1 | To patient inspiratory port                                 | 5 | Nasal cannula    |
| 2 | Bacteria filter   | 6 | Attachment strap |
| 3 | Inspiratory limb to humidifier                              | 7 | Humidifier       |
| 4 | Heated inspiratory limb with temperature sensor, to patient | 8 | Adapter          |

Figure 2-9. Neonatal breathing circuits

Neonatal/pediatric: Dual limb with humidifier



Neonatal/pediatric: Dual limb with HMEF

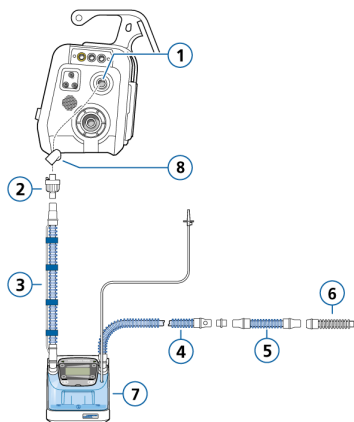


- |   |   |    |                    |
|---|---|----|--------------------|
| 1 | To patient inspiratory port                                 | 10 | Y-piece            |
| 2 | From patient expiratory port                                | 11 | CO2 sensor/adapter |
| 3 | Expiratory valve set  | 12 | Flow sensor        |
| 4 | Flow sensor connection ports                                | 13 | Humidifier         |
| 5 | Bacteria filter   | 14 | Inspiratory limb   |
| 6 | Inspiratory limb to humidifier                              | 15 | Expiratory limb    |
| 7 | Heated inspiratory limb with temperature sensor, to patient | 16 | HMEF               |
| 8 | Unheated inspiratory limb extension, for use in incubator   | 17 | Adapters           |
| 9 | Heated expiratory limb                                      |    |                    |



Figure 2-10. Neonatal breathing circuit: high flow oxygen therapy

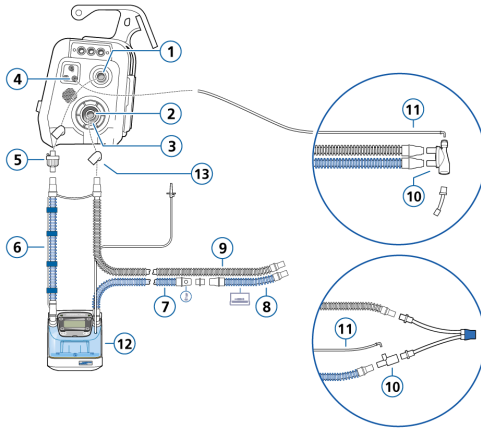
### Neonatal/pediatric: Single limb, high flow oxygen therapy



- |   |   |   |   |
|---|---|---|---|
| 1 | To patient inspiratory port                                 | 5 | Unheated inspiratory limb extension, for use in incubator |
| 2 | Bacteria filter   | 6 | Connection to patient interface (options not shown)       |
| 3 | Inspiratory limb to humidifier                              | 7 | Humidifier  |
| 4 | Heated inspiratory limb with temperature sensor, to patient | 8 | Adapter   |

Figure 2-11. Neonatal breathing circuit: nCPAP, nCPAP-PC

Neonatal: nCPAP, nCPAP-PC



- |   |   |    |   |
|---|---|----|---|
| 1 | To patient inspiratory port                                 | 8  | Unheated inspiratory limb extension, for use in incubator |
| 2 | From patient expiratory port                                | 9  | Heated expiratory limb                                    |
| 3 | Expiratory valve set  | 10 | Y-piece, T-piece  |
| 4 | Pressure line connection port (blue)                        | 11 | Pressure line   |
| 5 | Bacteria filter   | 12 | Humidifier  |
| 6 | Inspiratory limb to humidifier                              | 13 | Adapters  |
| 7 | Heated inspiratory limb with temperature sensor, to patient |    |   |

## 2.2.4 About the trolley and mounting variations

The HAMILTON-T1 can optionally be ordered with a standard trolley, carrying case, or a variety of wall, bed, ceiling, and shelf mount solutions. The trolley has space for one oxygen cylinder.

### 2.2.4.1 Preparing the trolley for intrahospital transport

*Before proceeding, review the safety information in Chapter 1.*

#### WARNING

- Only the components listed in this section are approved for intrahospital transport.
- Use of additional items, such as a patient support arm, can result in the trolley tipping over.
- The ventilator must be attached to the trolley using the locking bolt. Ensure the device is securely attached to the trolley before use.

If using a HAMILTON-T1 trolley, the ventilator and its components, as well as the trolley, **must be** configured and positioned as follows during transport within the hospital:

- The ventilator and oxygen cylinders must be securely attached to the trolley.
- Only the following components are allowed to be connected during transport:
  - Breathing circuit
  - Flow sensor (or pressure line)
  - CO2 sensor (mainstream or side-stream)

- O2 cylinder
- SpO2 sensor, including Masimo adapter

## 2.3 Navigating the windows and controls

Use the touch screen and the Press-and-turn knob (referred to as the *P&T knob*) to access data and specify settings.

You interact with the HAMILTON-T1 user interface as follows:

- Touch elements on the display to open windows and make selections.
- Use the P&T knob to select, specify, and confirm selections. A selected item is highlighted in yellow.

This section describes how to navigate the interface.

### 2.3.1 Accessing windows

#### To open a window

- ▶ Do any of the following to open a window:
  - Touch the button and any needed tabs.
  - Turn the P&T knob to move the cursor to the button or tab, then press the P&T knob.

#### To close a window

- ▶ Do any of the following to close a window:
  - Touch the window button again.
  - Touch the **X** button.
  - Turn the P&T knob to move the cursor to the **X** button, then press the P&T knob.

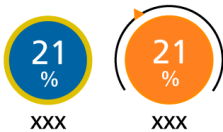
### 2.3.2 Adjusting controls

Specifying settings involves *activating* a control, *setting* a value, and *confirming* the setting.

#### To adjust a control setting

1. **Activate** the control by doing any of the following:
  - Touch the control to select and activate it; the selected control has a yellow outline.
  - Turn the P&T knob to move the cursor to the control, then press the P&T knob to activate it.

The activated control is orange.



2. **Adjust** the value by turning the P&T knob to increase or decrease the value.
3. **Confirm** the setting by doing any of the following:
  - Touch the control again.
  - Press the P&T knob.

The new setting is immediately applied.

### 2.3.3 Selecting list items

Some selections are presented in a scrollable list.

#### To select a list item

1. In a list, touch the scroll bar to select and activate it.
2. Turn the P&T knob to scroll through the list, and when the desired selection is highlighted, press the knob to select it.

# 3

## Preparing the ventilator

3.1	Overview.....	54
3.2	Connecting to a power source .....	54
3.3	Connecting the oxygen supply .....	56
3.4	Ensuring an adequate oxygen supply for patient transport .....	57
3.5	Setting up the patient breathing circuit .....	63
3.6	Turning the ventilator on and off .....	67

### 3.1 Overview

Preparing the ventilator for use comprises the following steps:

To ...	See ...
Connect to a power source.	Section 3.2
Connect the oxygen supply.	Section 3.3
Set up the patient breathing circuit, including performing the preoperational check.	Section 3.5
Connect external devices and sensors.	Chapter 4
Turn on the ventilator.	Section 3.6
Select the patient group, mode, and alarm limits, and enter patient data.	Chapter 5

### 3.2 Connecting to a power source

*Before proceeding, review the safety information in Chapter 1.*

Always check the reliability of the primary power outlet before plugging in the ventilator. When connected to primary power, the associated power symbol (AC or DC) in the bottom right corner of the display shows a frame around it.

#### To connect the ventilator to a primary power supply

- ▶ Connect the ventilator to an outlet that supplies AC or DC power. Make sure the power cord is well seated into the ventilator socket and secured with the power cord retaining clip to prevent unintentional disconnection.

#### 3.2.1 Connecting to DC power

*Before proceeding, review the safety information in Chapter 1.*

The DC cable can be used during transport in ambulances, fixed-wing aircraft, helicopters, and ships that provide an appropriate electrical power supply.

A DC cable kit (referred to as the assembled DC cable) includes a stripped end with two strands. This cable must only be assembled by authorized personnel using a UL-listed plug.

The DC car cable is intended for use during transport in ambulances and other rescue vehicles that are provided with appropriate plug connectors.

For available cables, see Chapter 13.

#### 3.2.2 Using battery power

A mandatory backup battery protects the ventilator from low power or failure of the primary power source.

When the primary power source fails, the ventilator automatically switches to operation on backup battery with no interruption in ventilation. An alarm sounds to signal the switch-over. Silence the alarm to confirm notification of the power system change and reset the alarm.

If battery power is completely lost, a buzzer sounds continuously for at least two minutes.

Batteries are charged whenever the ventilator is connected to primary power (AC or DC), whether or not it is turned on. The battery indicator on the device shows the charge status of the batteries.

The battery and power source symbols in the bottom right corner of the display show the power source in use. See Table 3-1. A frame around a power symbol indicates the current ventilator power source.

An optional second battery is available. It is labeled 2 on the display, and is only shown when installed. When the ventilator is running on battery power, a blue frame indicates which battery is currently in use.

Figure 3-1. Power source indicators on display

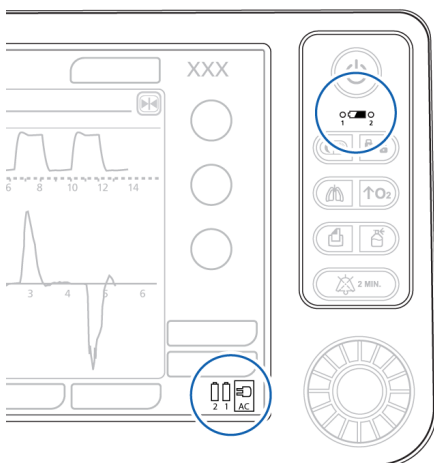


Table 3-1. Battery/power state

Power icon on display	Battery status
	Device is plugged into primary power and the battery is charging.
	Device is running on battery power.
	Battery is fully charged.

Power icon on display	Battery status
	Battery is partially charged.
	Battery has less than 10% charge left.
	Battery is either defective or not installed.

Table 3-2. Battery status indicator on ventilator, overview

Indicator on ventilator	Battery status
	<b>Solid green:</b> The indicated battery (1 shown) is fully charged and the device is connected to primary power, even when the ventilator is turned off.
	<b>Flashing green:</b> Flashes to show that the device is connected to a primary power source and the indicated battery is charging, even when the ventilator is turned off.
	<b>Not lit:</b> Dark to show the indicated battery is not charging (the device is running on battery power and is not connected to a primary power source or the battery is overheated).

If a battery is not fully charged, recharge it by connecting the ventilator to AC or DC power. For details, see Section 14.4.

Chapter 11 describes how to replace the battery.

### 3.3 Connecting the oxygen supply

*Before proceeding, review the safety information in Chapter 1.*

Oxygen for the HAMILTON-T1 can come from a high- or low-pressure source.

High-pressure oxygen, provided by a central gas supply or a gas cylinder, is supplied through DISS or NIST male gas fittings. With the optional cylinder holder, you can mount an oxygen cylinder to the trolley. If you use gases from the cylinder, secure the cylinder to the trolley with the accompanying straps.

Low-pressure oxygen is provided by a concentrator or liquid cylinder.

The selected setting is active until manually changed or the ventilator is restarted.

#### 3.3.1 Using a low-pressure oxygen supply

Using the low-pressure oxygen supply involves two steps:

- Connecting the supply to the ventilator (Section 3.3.2)
- Selecting the source type on the ventilator (Section 3.3.3)

#### 3.3.2 Connecting the oxygen supply to the ventilator

##### To connect the oxygen supply to the ventilator

- ▶ Connect the oxygen hose to the HAMILTON-T1's high-pressure or low-pressure oxygen inlet fitting (Figure 2-5).

See Section 3.3.3 for details on selecting the oxygen source on the device.

#### 3.3.3 Selecting the oxygen source type

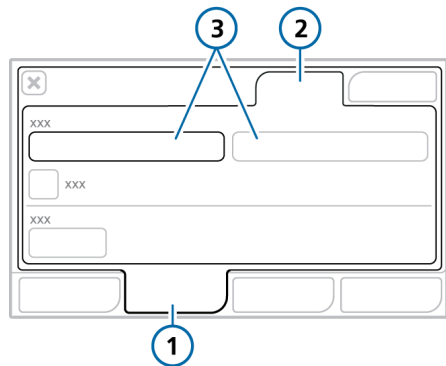
Before starting ventilation, be sure to select the appropriate oxygen source. By default, the ventilator is set to high-pressure oxygen (HPO).

You set the source in **Standby** mode.

##### To select the oxygen source

1. In **Standby** mode, touch **Tools > Utilities**.
2. Touch the appropriate button for the desired oxygen source.
  - Select **HPO mode** for high-pressure oxygen (default).
  - Select **LPO mode** for low-pressure oxygen (see Section 3.3.1).
3. Close the window.

Figure 3-2. Selecting the oxygen source



- |             |                         |
|-------------|-------------------------|
| 1 Tools     | 3 HPO mode,<br>LPO mode |
| 2 Utilities |                         |



### 3.4 Ensuring an adequate oxygen supply for patient transport

#### **WARNING**

Before transporting the patient, ensure an adequate oxygen supply by checking the *O2 consumption* parameter (in the System > Info window) and ensuring it is adequate for your estimated travel time and current oxygen capacity.

Use the appropriate calculation method (see Table 3-3) to estimate total oxygen requirements for the patient.

Before transporting the patient you must ensure that you have enough oxygen for the journey.

Be sure to:

- Review current oxygen consumption (Section 3.4.1)
- Calculate the patient's estimated oxygen requirement (Section 3.4.2)

For neonatal patients, use Method III (Section 3.4.2.3).

For information about estimated oxygen consumption relative to minute volume, see Section 14.11.3.

#### 3.4.1 Reviewing current oxygen consumption

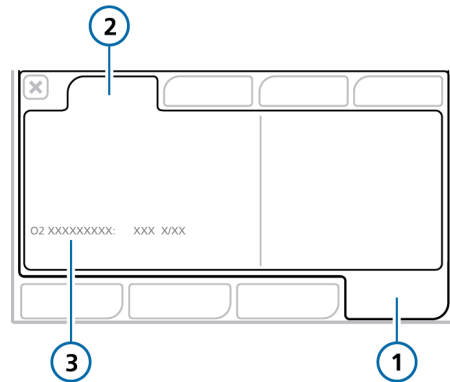
##### **NOTICE**

- O2 consumption data is not available with low-pressure oxygen (LPO).
- When initially starting ventilation, the **O2 consumption** parameter is calculated and displayed after 2.5 minutes.

The current oxygen consumption rate is displayed in the **O2 consumption** parameter in the System > Info window (Figure 3-3).

The O2 consumption rate is updated every breath and shows the average rate over the last five minutes, after the initial 2.5 minutes of ventilation.

Figure 3-3. System > Info window, O2 consumption



1 System

3 O2 consumption

2 Info

### 3.4.2 Calculating estimated oxygen consumption

**WARNING**

The oxygen consumption of a nebulizer attached to the device is not included in the **O2 consumption** parameter value. To calculate it, use Method IV (Section 3.4.2.4).

**NOTICE**

- The oxygen consumption calculation is not intended to affect therapy decisions and should be used solely to estimate the amount of oxygen required for the duration of transport, *before* connecting the ventilator to the patient.
- The calculations provided here are valid only for systems without leaks at the patient end. For systems with leaks (for example, ventilating with a mask), oxygen consumption will be higher.
- The calculations show the result in liters per minute (l/min). You must multiply the result by the planned duration of transport for the final estimate.

The calculation method for estimating oxygen consumption depends on the patient height and weight, and nebulizer use, as listed in the following table.

Table 3-3. Overview of O2 consumption calculation methods

For ...		See ...
Method I	Smaller patients: ≤ 70 cm, IBW ≤ 8 kg	Section 3.4.2.1
Method II	Larger patients: > 70 cm, IBW > 8 kg	Section 3.4.2.2
Method III	Neonates: Patient group on the ventilator is set to <b>Neonatal</b> .	Section 3.4.2.3
Method IV (nebulizer in use)	Additional amount to add to the result of Method I or II to account for the nebulizer oxygen use.	Section 3.4.2.4

All of the methods require the following information for the calculation:

- **ExpMinVol** setting (l/min)
- **Oxygen** setting (%)
- **I:E** setting, if using a nebulizer
- **Planned duration of transport**

The patient height and IBW (or **Weight** for Neonatal patients) determine which of the calculation methods to use (Table 3-3).

### 3.4.2.1 Method I. Overall oxygen consumption for smaller patients

*Method I* is for smaller patients with height  $\leq 70$  cm, IBW  $\leq 8$  kg, in liters per minute (l/min).

For neonatal patients, use *Method III*<sup>9</sup> (Section 3.4.2.3).

### To calculate estimated oxygen consumption using Method I

$$\text{O2 cons.} = \frac{[(\text{ExpMinVol} * 2) + 3 \text{ l/min}] * (\text{FiO}_2 - 20.9)}{79.1}$$

Table 3-4. Calculating O2 consumption using Method I for smaller patients

Calculation	Result and example
1 Replace <i>ExpMinVol</i> and <i>FiO2</i> in the equation with the current patient values.	<i>Example uses:</i> ExpMinVol = 2 l/min Oxygen (FiO2) = 60%
2 Solve the equation. <sup>10</sup>	The result is the estimated oxygen consumption in liters per minute (l/min). <i>Example.</i> O2 consumption = $((2 * 2) + 3) * (60 - 20.9) / 79.1$ O2 consumption = $7 * 0.494$ O2 consumption = 3.5 l/min
3 Multiply the result by the planned duration of transport, in minutes.	The final result is the estimated oxygen requirement, in liters, for the specified length of time. <i>Example.</i> Transport duration = ~60 minutes <i>Example result.</i> Required O2 for transport = $\sim 3.5 * 60 = 210$ liters

<sup>9</sup> If the patient group on the ventilator is set to Neonatal, be sure to use Method III for the calculation. This is important because the base flow is fixed at 4 l/min for neonatal patients and at 3 l/min for adult/pediatric patients.

<sup>10</sup> The \* 2 is to account for compressible volume in the breathing circuit. See Section 14.11.3.

3.4.2.2 Method II. Overall oxygen consumption for larger patients

Method II is for larger patients, with height > 70 cm, IBW > 8 kg in l/min.

To calculate estimated oxygen consumption

$$\text{O2 cons.} = \frac{[(\text{ExpMinVol} + 3 \text{ l/min})] * [\text{FiO}_2 - 20.9]}{79.1}$$

Table 3-5. Calculating O2 consumption using Method II for larger patients

Calculation	Result and example
1 Replace <i>ExpMinVol</i> and <i>FiO2</i> in the equation with the current patient values.	<i>Example uses:</i> ExpMinVol = 2 l/min Oxygen (FiO2) = 60%
2 Solve the equation.	The result is the estimated oxygen consumption in liters per minute (l/min). <i>Example.</i> O2 consumption = ((2 + 3) * (60 - 20.9) / 79.1 O2 consumption = 5 * 0.494 O2 consumption = 2.5 l/min
3 Multiply the result by the planned duration of transport, in minutes.	The final result is the estimated oxygen requirement, in liters, for the specified length of time. <i>Example.</i> Transport duration = ~60 minutes <i>Example result.</i> Required O2 for transport = ~2.5 * 60 = <b>150 liters</b>

### 3.4.2.3 Method III. Overall oxygen consumption for neonatal patients

*Method III* is for neonatal patients. Use this method when the **Neonatal** patient group is selected on the ventilator.

This method is required because the base flow is fixed at 4 liters per minute (l/min) for neonatal patients, and at 3 l/min for adult and pediatric patients.

#### To calculate estimated oxygen consumption using Method III

$$\text{O2 cons.} = \frac{[(\text{ExpMinVol} * 2) + 4 \text{ l/min}] * (\text{FiO}_2 - 20.9)}{79.1}$$

Table 3-6. Calculating O2 consumption using Method III for neonatal patients

Calculation	Result and example
1 Replace <i>ExpMinVol</i> and <i>FiO2</i> in the equation with the current patient values.	<i>Example uses:</i> ExpMinVol = 0.5 l/min Oxygen (FiO2) = 60%
2 Solve the equation <sup>11</sup> .	The result is the estimated oxygen consumption in liters per minute (l/min). <i>Example.</i> O2 consumption = $((0.5 * 2) + 4) * (60 - 20.9) / 79.1$ O2 consumption = $5 * 0.494$ O2 consumption = 2.5 l/min
3 Multiply the result by the planned duration of transport, in minutes.	The final result is the estimated oxygen requirement, in liters, for the specified length of time. <i>Example.</i> Transport duration = ~60 minutes <i>Example result.</i> Required O2 for transport = $\sim 2.5 * 60 = 150$ liters

<sup>11</sup> The \* 2 is to account for compressible volume in the breathing circuit. See Section 14.11.3.

3.4.2.4 Method IV. Nebulizer oxygen consumption

Method IV calculates nebulizer oxygen consumption. The result of this calculation is added to the result of Method I or II.

To calculate estimated oxygen consumption with a nebulizer

$$\text{Neb. O}_2 \text{ cons.} = 8 \text{ l/min} * (\text{Insp time} / \text{total breath time})$$

Table 3-7. Calculating O2 consumption with a nebulizer

Calculation	Result and example
1 Calculate the ventilation oxygen requirement using Method I or II. See Sections 3.4.2.1 and 3.4.2.2.	<p><i>Example uses:</i> Method I ExpMinVol = 2 l/min Oxygen (FiO2) = 60% Transport duration = 30 minutes</p> <p><i>Example result.</i> O2 consumption = 3.5 l/min Required O2 for transport = <math>\sim 3.5 * 30 = 105</math> liters</p>
2 Calculate the nebulizer oxygen requirement.	<p>Replace <i>Insp Time / total breath time</i> with the current patient I:E value.</p> <p><i>Example.</i> I:E = 1:3 The inspiration time is one-quarter (0.25) of the total breath time. Neb. O2 cons. = <math>8 * 0.25 = 2</math> l/min.</p>
3 Multiply the result of step 2 by the planned nebulization duration.	<p>The result is the oxygen requirement for the nebulizer <i>only</i>.</p> <p><i>Example.</i> Neb. O2 cons. = 2 l/min Transport duration = <math>\sim 30</math> minutes</p> <p><i>Example result.</i> Required O2 for nebulizer during transport = <math>\sim 2 * 30 = 60</math> liters</p>
4 Add the results from steps 1 and 3.	<p>This gives you the total estimated oxygen requirement for the duration of transport and the specified nebulization time.</p> <p><i>Example.</i> Required O2 for nebulizer during transport = 60 liters Required O2 for transport = 105 liters</p> <p><i>Example result.</i> Total required O2 for transport = <math>105 + 60 = 165</math> liters</p>

## 3.5 Setting up the patient breathing circuit

Before proceeding, review the safety information in Chapter 1.

Connecting the breathing circuit comprises the following steps.

For neonatal ventilation, see Chapter 6.

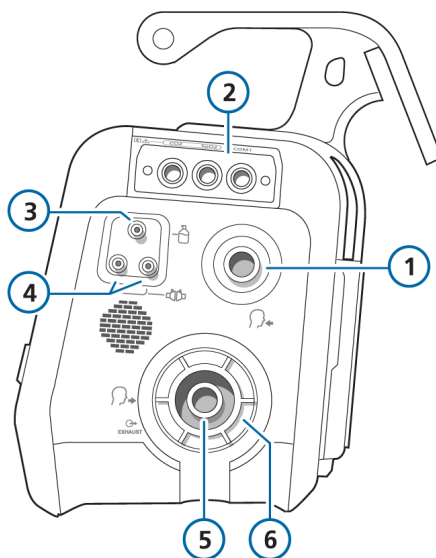
To ...	See ...
Install the expiratory valve.	Section 3.5.2
Select the appropriate breathing circuit and components.	Section 3.5.3
Assemble the breathing circuit.	Section 3.5.4
Adjust the position of the breathing circuit.	Section 3.5.5
Connect external devices and sensors.	Chapter 4
Perform any required tests, calibrations, and the preoperational check.	Chapter 5

### 3.5.1 Breathing circuit connections on the ventilator

Figure 3-4 illustrates the key ports on the ventilator for connecting the breathing circuit set.

For breathing circuit diagrams, see Section 2.2.3.

Figure 3-4. Key connection ports



- |   |                                |
|---|--------------------------------|
| 1 To patient inspiratory port   | 4 Flow sensor connection ports |
| 2 Communication board with CO <sub>2</sub> , SpO <sub>2</sub> ports, if installed | 5 From patient expiratory port |
| 3 Nebulizer port  | 6 Expiratory valve set         |

### 3.5.2 Working with the expiratory valve set

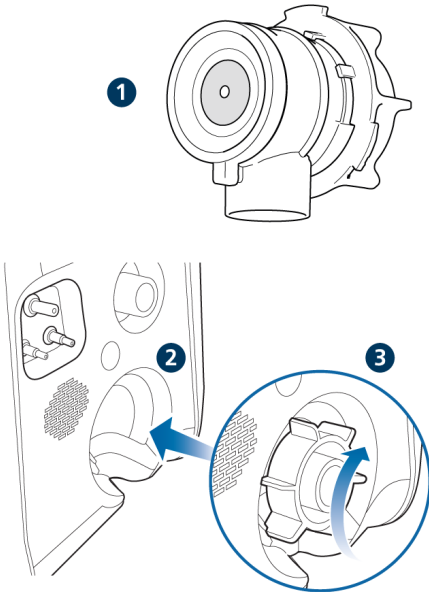
This section describes how to assemble/install, and remove/disassemble the expiratory valve set.

#### To assemble/install the expiratory valve set

Refer to Figure 3-5.

1. Remove the safety cover.
2. Ensure the membrane is properly aligned with the expiratory valve housing and the metal plate faces up (1).
3. Position the expiratory valve set in the expiratory port (2) and twist the locking ring clockwise until it locks into place (3).

Figure 3-5. Installing the expiratory valve set



#### To disassemble and remove the expiratory valve set

1. Remove the expiratory valve set from the expiratory port on the ventilator.
2. Holding the expiratory valve housing, remove the silicone membrane (1 in Figure 3-5) by lifting it up.

### 3.5.3 Selecting the breathing circuit components

Select the correct breathing circuit parts for your patient.

For neonatal ventilation, see Chapter 6.

Table 3-8. Breathing circuit component specifications

Patient data/ Component	Adult	Pediatric
Patient height (cm)	> 130	30 to 150
IBW (kg)	> 30	3 to 48
Tracheal tube ID (mm)	> 4	> 4
Breathing circuit limb ID (mm) <sup>12</sup>	15 to 22	10 to 22
Flow sensor	Adult/Ped	Adult/Ped
CO2 airway adapter	Adult/Ped <sup>13</sup>	Adult/Ped <sup>13</sup>

<sup>12</sup> When using coaxial breathing sets, follow the manufacturer's recommendations for each patient group.

<sup>13</sup> When tracheal tube ID > 4 mm.



### 3.5.3.1 Using a filter in the breathing circuit

*Before proceeding, review the safety information in Chapter 1.*

#### Inspiratory bacteria filter

To prevent patient or ventilator contamination, be sure to connect a bacteria (inspiratory) filter or HMEF between the patient and the inspiratory port.

For neonatal patients, use a neonatal-pediatric bacteria (inspiratory) filter or HMEF.

If no inspiratory filter is used, the exhaled gas can contaminate the ventilator. If you are not using an inspiratory filter, and an exhalation obstructed alarm is generated, the ventilator may be contaminated. Have the ventilator serviced.

#### Expiratory bacteria filter

*Before using an expiratory filter with nebulization, review the safety information in Section 1.5.5.*

An expiratory filter is not required on the HAMILTON-T1, but you may use one according to your institution's protocol. It is not required because the expiratory valve design prevents internal ventilator components from coming into contact with the patient's exhaled gas.

If you use an expiratory filter, place it on the patient side of the expiratory valve cover. Monitor closely for increased expiratory circuit resistance.

An **Exhalation obstructed** alarm may also indicate excessive expiratory circuit resistance. If the **Exhalation obstructed** alarm occurs repeatedly, remove the expiratory filter immediately. If you otherwise suspect

increased expiratory circuit resistance, remove the expiratory filter or replace the filter to eliminate it as a potential cause.

#### Heat and moisture exchanging filter (HMEF)

The HMEF is a passive humidification component used together with a bacteria filter. Use an HMEF when ventilating with a coaxial breathing system.

### 3.5.3.2 Using a speaking valve in the breathing circuit

A speaking valve allows certain tracheostomized adult and pediatric patients to communicate verbally, in addition to numerous other clinical benefits.

Speaking valve compatibility is an option available for **Adult/Ped** invasive ventilation when using any of the following modes: PCV+, PSIMV+, and SPONT.

For setup details, see Section 4.7. For details about working with the speaking valve, see Section 10.8.

### 3.5.4 Assembling the patient breathing circuit

Assemble the appropriate breathing circuit for your patient. Commonly used standard breathing circuit configurations are illustrated in Section 2.2.3.

For neonatal ventilation, see Chapter 6.

### 3.5.4.1 Connecting the flow sensor

#### NOTICE

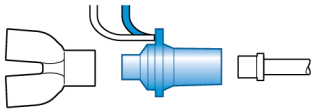
To prevent inaccurate flow sensor readings, make sure the flow sensor is correctly connected.

*Before proceeding, review the safety information in Chapter 1.*

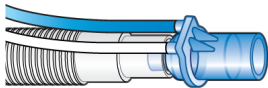
#### To connect a flow sensor to the breathing circuit

1. Insert a flow sensor into the breathing circuit in front of the patient connection.  
See also the breathing circuit diagrams in Section 2.2.3.

Flow sensor connection dual limb circuit, Y-piece



Flow sensor connection coaxial circuit



2. Attach the blue and clear tubes to the flow sensor connection ports on the ventilator (Figure 3-4).  
The blue tube attaches to the blue connection port. The clear tube attaches to the white connection port.
3. Calibrate the flow sensor and perform the Tightness test. See Section 5.4.

### 3.5.4.2 Use of adult/pediatric flow sensor with neonatal/pediatric breathing circuits

#### NOTICE

Only use a neonatal/pediatric breathing circuit with an adult/pediatric flow sensor when the patient IBW is 20 kg or below.

With small pediatric patients whose IBW is below 20 kg, using an adult/pediatric breathing circuit can generate too much dead space, resulting in ineffective ventilation.

For these patients, consider using a neonatal/pediatric breathing circuit with an adult/pediatric flow sensor instead.

#### To use an adult/pediatric flow sensor with a neonatal/pediatric breathing circuit

1. Verify that the Adult/Ped patient group is selected.
2. Verify that the patient IBW is below 20 kg.
3. Set up the ventilator for adult/pediatric ventilation with the adult/pediatric flow sensor, but connect a neonatal/pediatric breathing circuit.
4. Perform the Tightness test, calibrate the flow sensor, and perform other preoperational checks. See Section 5.4.
5. Connect the patient.
6. Start ventilation.

### 3.5.5 Positioning the breathing circuit

#### NOTICE


- To prevent water accumulation in the flow sensor and tubing, position the flow sensor tubing on top of the flow sensor.
- Ensure there is no undue stress placed on any tubing or cables.

After assembly, position the breathing circuit so that the hoses will *not* be pushed, pulled, or kinked as a result of a patient's movement, transport, or other activities, including scanner bed operation and nebulization.

The next step is to perform all required tests, calibrations, and the preoperational check. See Chapter 5.

## 3.6 Turning the ventilator on and off

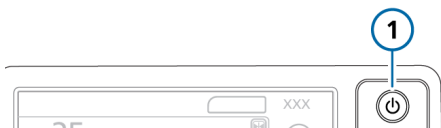
### To turn on the ventilator

- ▶ Press  (Power/Standby).



The ventilator runs a self-test. After a short time, the **Standby** window is displayed.

Proceed with setting up the ventilator and patient, as appropriate.

Figure 3-6. Power/Standby key



### To turn off the ventilator

1. Press  (Power/Standby) to open the **Activate Standby** window during active ventilation.
2. Touch **Activate standby** to confirm.
3. Press and hold  for about 3 seconds to turn off the ventilator.

The ventilator turns off.

### In the event of a technical fault or the device will not turn off

- ▶ Press and hold  for about 10 seconds to turn off the ventilator.



# 4

## Setting up external devices and sensors

4.1	Overview.....	70
4.2	Setting up a humidifier.....	70
4.3	Setting up CO2 monitoring.....	70
4.4	Setting up SpO2 monitoring.....	73
4.5	Enabling sensors.....	74
4.6	Setting up nebulization.....	74
4.7	Setting up a speaking valve.....	75
4.8	Connecting to an external patient monitor or other device.....	76

## 4.1 Overview

The HAMILTON-T1 supports a variety of external devices and sensors for ventilation, including:

- Humidifier
- CO2 monitoring sensors
- Pulse oximetry (SpO2 monitoring) sensors
- Nebulizers

This chapter describes how to set them up for ventilation.

## 4.2 Setting up a humidifier

*Before proceeding, review the safety information in Chapter 1.*

### To set up the humidifier

1. Attach the humidifier to the trolley, if appropriate.
2. Connect a potential equalization cable to the humidifier and to a grounding socket at your facility.
3. Plug the humidifier into primary power.

For additional details about:

- Connecting the humidifier to the breathing circuit, see Section 2.2.3.
- Working with the HAMILTON-H900 humidifier, see the *HAMILTON-H900 Instructions for use*.

## 4.3 Setting up CO2 monitoring

*Before proceeding, review the safety information in Chapter 1.*

CO2 monitoring data is helpful for the assessment of the patient's airway integrity or ensuring proper endotracheal tube placement, among other applications.

Two CO2 measurement options are available: mainstream and sidestream. Which option you use depends on the clinical setting.<sup>14</sup>

Enabling CO2 measurement on the ventilator requires enabling the CO2 hardware (in Configuration) and enabling the sensor.

Table 4-1. CO2 measurement overview

For details about ...	See ...
Mainstream CO2 measurement, connection, and use	Section 4.3.1
Sidestream CO2 measurement, connection, and use	Section 4.3.2
Enabling the CO2 hardware	Section 12.7.3
Enabling the CO2 sensor	Section 4.5

<sup>14</sup> The volumetric capnogram is only available when using a mainstream CO2 sensor.

### 4.3.1 Mainstream CO2 measurement

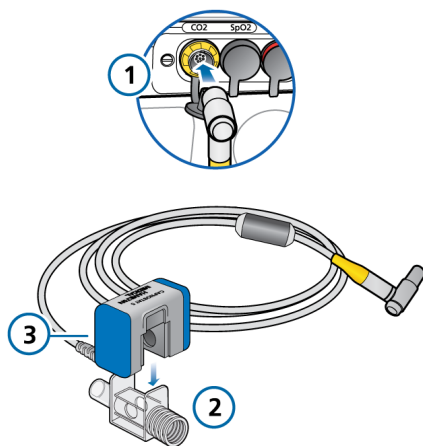
The CO2 monitoring option comprises the following components (shown in Figure 4-1): communication board, airway adapter, and CO2 sensor.

The sensor generates infrared light and beams it through the airway adapter to a detector on the opposite side. CO2 from the patient, flowing through the mainstream airway adapter, absorbs some of this infrared energy.

The system determines the CO2 concentration in the breathing gases by measuring the amount of light absorbed.

The ventilator displays CO2 measurements as numeric values, waveforms, trends, and loops.

Figure 4-1. Mainstream CO2 monitoring components and assembly



- |   |              |
|---|--------------|
| 1 Communications board with CO2 connection port | 3 CO2 sensor |
| 2 Airway adapter                                |              |

#### 4.3.1.1 Connecting the mainstream CO2 sensor

##### ⚠ CAUTION

*When using active humidification, prevent water accumulation in the CO2 adapter/sensor by ensuring that they are positioned at a  $\geq 45^\circ$  angle relative to the floor. Excess water can affect the sensor measurements.*

##### NOTICE

You must use an appropriate adapter to connect the mainstream CO2 sensor to a neonatal flow sensor.

*Before proceeding, review the safety information in Chapter 1.*

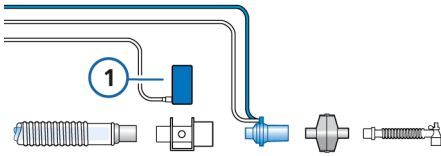
Ensure the CO2 sensor and adapter are clean and dry before connection.

#### To set up mainstream CO2 monitoring

1. Connect the sensor cable to the CO2 connection port (1) on the ventilator (see Figure 4-1).
2. Attach the CO2 sensor (3) to the airway adapter (2), aligning the arrows on both components. Press the components together until they click.
3. When connecting a CO2 sensor for the first time, perform the zero calibration of the sensor/adapter, if needed, as described in Section 5.4.5.

4. Connect the sensor/adaptor to the breathing circuit proximal to the patient, in a vertical position. See Figure 4-2.  
Do *not* place the airway adapter between the ET tube and the elbow, as this may allow patient secretions to accumulate in the adapter.<sup>15</sup>  
The sensor cable should face away from the patient.
5. Secure the sampling line safely out of the way.

Figure 4-2. Connecting CO2 sensor/adaptor (1) to breathing circuit (Adult/Ped shown)



#### To verify the quality of the connection

- ▶ Check the capnogram (CO2 waveform) on the ventilator display.  
If CO2 levels are higher than expected, check the patient condition. If you determine that the patient's condition is not contributing, calibrate the sensor (Section 5.4.5).

#### To remove the sensor cable

- ▶ Pull back on the connector sheath and disengage from the connection port on the ventilator.

### 4.3.2 Sidestream CO2 measurement

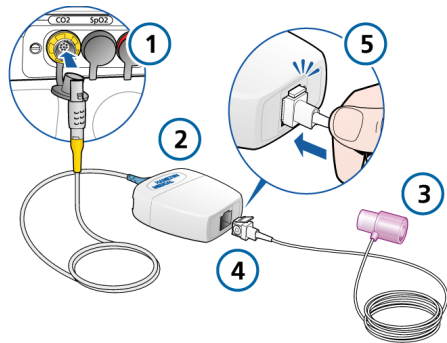
The LoFlo CO2 module is a sidestream CO2 monitoring system comprising the following components: communication board, airway sampling adapter, and CO2 module. See Figure 4-3.

The module generates infrared light and beams it through the sample cell to a detector on the opposite side. CO2 from the patient that is aspirated into the sample cell absorbs some of this energy. The system uses a sampling rate of 50 ml/min.

The system determines CO2 concentration in the breathing gases by measuring the amount of light absorbed by these gases.

The ventilator displays CO2 measurements as numeric values, waveforms, trends, and loops.

Figure 4-3. Sidestream CO2 monitoring components and assembly



- |   |                                      |
|---|--------------------------------------|
| 1 Communications board with CO2 connection port | 4 Sampling cell                      |
| 2 CO2 module                                    | 5 Connecting sampling cell to module |
| 3 Airway adapter                                |                                      |

<sup>15</sup> You can connect the CO2 sensor in front of or behind the flow sensor according to your institution's protocol.



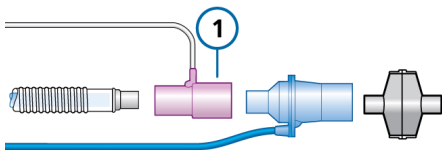
### 4.3.2.1 Connecting the sidestream CO2 sensor

Before proceeding, review the safety information in Chapter 1.

#### To set up CO2 sidestream monitoring

1. Connect the CO2 module cable to the CO2 connection port (1) on the ventilator (see Figure 4-3).
2. Insert the sample cell (4) into the CO2 module (2) as shown in Figure 4-3. It clicks into place.  
Inserting the sample cell into the module automatically starts the sampling pump. Removing the cell turns the pump off.
3. Perform the zero calibration of the adapter, if necessary, as described in Section 5.4.5 before connecting it to the breathing circuit.
4. Connect the adapter between the inspiratory limb and the flow sensor (or between the inspiratory limb and HMEF, if used). See Figure 4-4.  
The sampling line should face away from the patient.
5. Secure the sampling line safely out of the way.

Figure 4-4. Connecting CO2 adapter (1) to the breathing circuit



#### To remove the sample cell

1. Remove the airway adapter from the breathing circuit.
2. Press down on the locking tab and remove the sample cell from the CO2 module.

## 4.4 Setting up SpO2 monitoring

The HAMILTON-T1 supports input of SpO2 and related pulse oximetry data, and provides integrated monitoring and data display.

Enabling SpO2 measurement on the ventilator requires enabling the SpO2 hardware (in Configuration) and enabling the SpO2 sensor.

Table 4-2. SpO2 measurement overview

For details about ...	See ...
Activating the SpO2 hardware	Section 12.7.3
Enabling the SpO2 sensor	Section 4.5
Working with SpO2 data	<i>Pulse Oximetry Instructions for Use</i>

## 4.5 Enabling sensors

Before proceeding, review the safety information in Chapter 1.

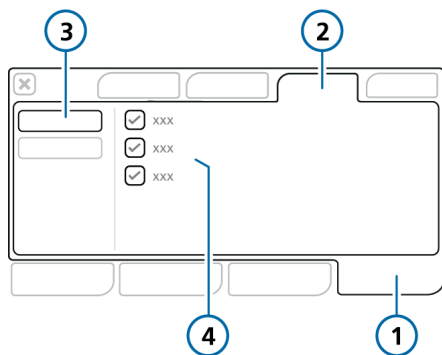
In addition to hardware activation for CO<sub>2</sub> and SpO<sub>2</sub> measurement (Section 12.7.3), the O<sub>2</sub>, CO<sub>2</sub>, and/or SpO<sub>2</sub> sensors must be individually enabled for monitoring data to be available.

### To enable sensor monitoring

1. Touch **System > Sensors > On/Off**.
2. Select the appropriate checkboxes (O<sub>2</sub> sensor, CO<sub>2</sub> sensor, SpO<sub>2</sub> sensor) to enable/disable the monitoring functions, as desired.

The ventilator always enables O<sub>2</sub> monitoring upon restart.

Figure 4-5. System > Sensors > On/Off window



- |           |   |
|-----------|---|
| 1 System  | 3 On/Off  |
| 2 Sensors | 4 O <sub>2</sub> sensor,<br>CO <sub>2</sub> sensor <sup>16</sup> ,<br>SpO <sub>2</sub> sensor <sup>16</sup> |

## 4.6 Setting up nebulization

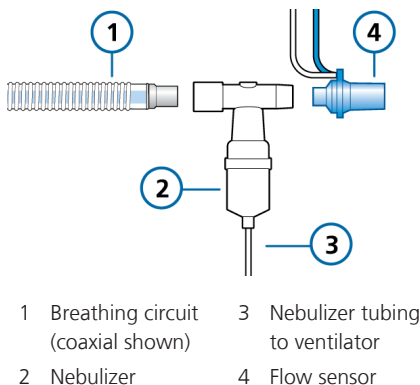
The HAMILTON-T1 supports the use of pneumatic nebulizers for adult and pediatric patients.<sup>17</sup>

For neonatal patients, use an Aerogen nebulizer system<sup>18</sup>. For Aerogen connection and device details, refer to the manufacturer's *Instructions for use*.

### To connect a pneumatic nebulizer to the breathing circuit set

1. Connect the nebulizer to the breathing circuit as shown in Figure 4-6.
2. Connect the nebulizer tubing to the **Nebulizer port** on the ventilator (Figure 2-4).

Figure 4-6. Connecting a pneumatic nebulizer



- |                                     |                                  |
|-------------------------------------|----------------------------------|
| 1 Breathing circuit (coaxial shown) | 3 Nebulizer tubing to ventilator |
| 2 Nebulizer                         | 4 Flow sensor                    |

For additional details, refer to the manufacturer's *Instructions for use*.

For nebulizer details and operation, see Section 10.7.

<sup>16</sup> If the option is installed and activated.

<sup>17</sup> See the Hamilton Medical e-catalog for compatible devices.

<sup>18</sup> Not available in all markets. Aerogen nebulization is not supported for patients younger than 28 days old in the USA.

## 4.7 Setting up a speaking valve

A speaking valve allows certain tracheostomized adult and pediatric patients to communicate verbally, in addition to numerous other clinical benefits.

Table 4-3 describes the steps required to set up the patient for ventilation with a speaking valve.

Table 4-3. Speaking valve patient setup

To ...	See ...
<b>Connect the speaking valve</b>	
Select a compatible mode.	Section 10.8
Activate speaking valve compatibility.	Section 4.7.1
Deflate the tracheostomy cuff.	
Connect the speaking valve to the breathing circuit set and patient.	Section 4.7.2
Review control settings and alarm limits.	Section 10.8.4 and Chapter 5
Start ventilation.	
<b>Remove the speaking valve</b>	
Remove speaking valve from the breathing circuit.	
Deactivate speaking valve compatibility.	Section 4.7.3
Inflate the tracheostomy cuff.	
Review control settings and alarm limits.	Section 10.8.4 and Chapter 5

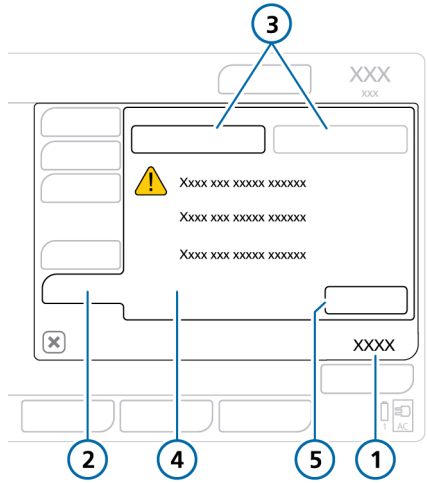
### 4.7.1 Activating speaking valve compatibility

**NOTICE**

If PEEP > 0, auto-triggering can occur while using a speaking valve.

By default, speaking valve compatibility is deactivated (OFF).

Figure 4-7. SpeakValve window



- 1 Controls
- 2 SpeakValve
- 3 SpeakValve ON, SpeakValve OFF
- 4 Important safety information
- 5 Apply

### To activate the use of a speaking valve with the ventilator

1. Touch **Controls** > **SpeakValve**.  
Be sure to carefully read the safety information displayed in the window.
2. Be sure to do the following:
  - Deflate the cuff.
  - Connect a speaking valve.
3. To activate compatibility, touch **Speak-Valve ON**, then touch **Apply**.  
Consider setting PEEP to 0 while compatibility is activated.

As long as compatibility is activated, the message **SpeakValve ON** is active and the following safety messages are shown in the **SpeakValve** window:



The tracheostomy cuff must be completely deflated prior to connecting a speaking valve.

Disconnection alarms and the **Inspiratory limitation** alarm are disabled. The **Vt** alarms are based on **VTI**. The **Exp-MinVol** alarm limits are set to **OFF**.

**Apnea backup** ventilation is disabled.

### 4.7.2 Connecting a speaking valve to the breathing circuit set

Connect the speaking valve between the flow sensor and the patient interface.

Pay careful attention to any safety information and requirements for cuff deflation.

For connection details, refer to the speaking valve manufacturer's *Instructions for use*.

### 4.7.3 Deactivating speaking valve compatibility

In some cases, compatibility is automatically deactivated. See Section 10.8.1.

#### To deactivate speaking valve compatibility

1. Touch **Controls** > **SpeakValve**.
2. Touch **SpeakValve OFF**, then touch **Apply**.
3. Be sure to do the following:
  - Remove the speaking valve.
  - Inflate the cuff.

When compatibility is deactivated (OFF), the following safety messages are shown in the **SpeakValve** window:



Remove the speaking valve, deactivate speaking valve compatibility, and inflate the tracheostomy cuff.

All alarms are enabled. The **Vt** alarms are based on **VTE**.

**Apnea backup** ventilation is enabled.

Upon deactivation, alarms and monitoring parameters return to their previous operation, and the **ExpMinVol** alarm limits are reset based on the patient's **IBW**. For details, see Sections 10.8.2 and 10.8.4.

## 4.8 Connecting to an external patient monitor or other device

You can connect the ventilator to a patient monitor, PDMS, or computer using the communication ports on the communication board, if installed. For details, see the *Communication Board User Guide* and the *Communication Interface User Guide*, available on MyHamilton.

# 5

## Specifying ventilation settings

5.1	Process overview .....	78
5.2	Selecting the patient group .....	78
5.3	Entering patient data .....	79
5.4	Performing the preoperational check, tests, and calibrations .....	80
5.5	Selecting the ventilation mode .....	89
5.6	Setting alarm limits .....	92
5.7	Starting ventilation .....	95
5.8	Stopping ventilation .....	95
5.9	About the control parameters .....	95

## 5.1 Process overview

This section explains how to set up the HAMILTON-T1 for ventilation on an individual patient.

Setting up ventilation generally comprises the following steps, each of which is described in this chapter:

- Selecting the patient group
- Selecting the desired preconfigured settings (Quick setup)
- Specifying patient data
- Performing the preoperational check, including:
  - Performing a breathing circuit tightness test
  - Calibrating the flow sensor, O<sub>2</sub> sensor, and zero calibration of the CO<sub>2</sub> sensor
  - Calibrating the breathing circuit (nCPAP and nCPAP-PC modes)
- Testing alarms
- Selecting the ventilation mode
- Reviewing and adjusting control settings
- Reviewing and adjusting alarm limits

## 5.2 Selecting the patient group

*Before proceeding, review the safety information in Chapter 1.*

The HAMILTON-T1 supports the following patient groups: **Adult/Ped** (adult and pediatric patients) and **Neonatal**.

Table 5-1. Patient groups

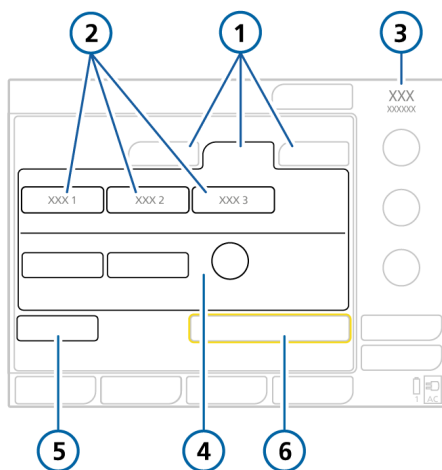
Adult/Ped	Neonatal
Sex: M, F	Weight: 0.2 to 30 kg
Height: 30 to 250 cm	Minimum delivered tidal volume: 2 ml
IBW: 3 to 139 kg	
Minimum delivered tidal volume: 20 ml	

### To select the patient group and initial settings

1. In the **Standby** window (Figure 5-1), touch the desired patient group tab:
  - **Adult/Ped**
  - **Neonatal**
  - **Last patient.** Reuse the last active ventilator parameters. The selected patient group appears under the mode name. (Figure 2-6).
2. For a new patient, touch the desired **Quick setup** button (Section 5.2.1).

The settings saved with the selected **Quick setup** are loaded and displayed, in addition to the default patient sex/height/IBW (**Adult/Ped**) or weight (**Neonatal**).

Figure 5-1. Patient group options in Standby window



- |                                   |  |
|-----------------------------------|--|
| 1 Patient group tabs              | 4 Sex/height/IBW (or Weight for Neonatal) for selected Quick setup |
| 2 Quick setups                    | 5 Preop check  |
| 3 Selected mode and patient group | 6 Start ventilation (when HiFlowO2 is selected: Start therapy)     |

### 5.2.1 About Quick setups: pre-configured settings

For each of the patient groups, you can define up to three different default configurations, referred to as Quick setups.

During patient setup, you can then quickly pre-configure the ventilator per your standard protocols, and modify settings as needed.

Each Quick setup defines a ventilation mode, mode control settings, graphic display selections, alarm limit settings, Vent Status panel settings, and Vt/IBW (Adult/Ped) or Vt/kg (Neonatal).

The Quick setups are defined in Configuration (Chapter 12).

## 5.3 Entering patient data

### **CAUTION**

*Entering the correct patient data ensures safe ventilation settings for start up, Apnea backup, and safety ventilation.*

*Before proceeding, review the safety information in Chapter 1.*

Specifying the correct patient data is particularly important, as the ventilator uses this data as a basis for some calculations and initial mode control settings.

- For the Adult/Ped patient group, the ventilator uses sex and patient height to calculate the ideal body weight (IBW).

The following control settings are based on IBW: Vt, Rate, T high, T low, and TI, and Apnea backup and safety settings.

- For Neonatal patients, the ventilator uses the patient body weight.

The following parameters are set based on Weight: Vt, Rate, T low, T high, TI, and TI max, and Apnea backup and safety settings.

**To enter patient data**

- ▶ In the **Standby** window:
  - **Adult/Ped.** Specify the patient sex and height. The device calculates the patient IBW.
  - **Neonatal.** Specify the patient weight.

### 5.4 Performing the preoperational check, tests, and calibrations

The tests and calibrations described in this section help verify the safety and reliability of the ventilator.

If a test fails, troubleshoot the ventilator as indicated or have the ventilator serviced. Make sure the tests pass before you return the ventilator to clinical use.

The test results are stored in memory, including when the ventilator is turned off. This allows the ventilator to be checked and kept in storage, ready for use.

The audible alarm is paused during calibration, and for 30 seconds thereafter.

Table 5-2. When to perform tests and calibrations

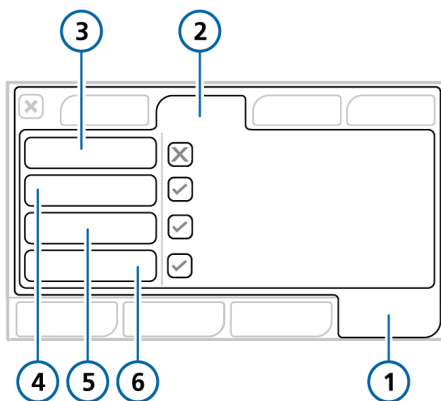
Test or calibration	When to perform
Preoperational check	Before connecting a new patient to the ventilator.
Flow sensor/circuit calibration and tightness test	After connecting a new breathing circuit or component (including a flow sensor or pressure-monitoring line).
O2 sensor calibration, if needed	After installing a new O2 sensor or when a related alarm occurs. Not required with a paramagnetic O2 sensor.
CO2 sensor/adaptor zero calibration (mainstream/sidestream)	Required after connecting a CO2 sensor or when a related alarm occurs. Recommended after switching between different airway adapter types.
Alarm tests	As desired



**To access tests and calibration functions**

1. Do either of the following:
  - Touch **System > Tests & calib.**
  - In the Standby window, touch **Preop check.**
2. Touch the button for the desired operation.

Figure 5-2. System > Tests & calib window



- |                                  |  |
|----------------------------------|--|
| 1 System                         | 4 Circuit or Flow sensor, depending on selected mode |
| 2 Tests & calib                  | 5 O2 sensor  |
| 3 Tightness (shown uncalibrated) | 6 CO2 sensor   |

**5.4.1 Performing the preoperational check**

*Before proceeding, review the safety information in Chapter 1.*

**When to perform**

Before connecting a new patient to the ventilator.

**To perform the preoperational check**

1. Use a setup as described in Table 5-3.
2. Perform all of the steps in Table 5-4.

To ensure that the ventilator functions according to specifications on your patient, we recommend that your test circuit be equivalent to the circuit used for ventilation.

Table 5-3. Test breathing circuit setup

Component	Specification
Breathing circuit	Adult/pediatric, ID10 to ID22 circuit
Flow sensor	Adult/pediatric, with calibration adapter
Test lung	Demonstration lung, 2 liter, with adult ET tube between flow sensor and lung

Table 5-4. Preoperational check, overview

Do or observe...	Verify ...
1 Connect ventilator to primary power and an oxygen supply.	
2 Assemble the patient breathing circuit.	The breathing circuit is assembled correctly.
3 Turn on the ventilator.	During the self test, the alarm lamp flashes yellow and red in sequence and the buzzer sounds briefly. When complete, the alarm lamp flashes yellow again.
4 With the ventilator in Standby, touch <b>Preop check</b> in the Standby window.	The <b>System &gt; Tests &amp; calib</b> window opens.
5 Perform the Tightness test.	The test passes. See Section 5.4.2.
6 Calibrate the flow sensor.	The calibration is successful. See Section 5.4.3.
7 If necessary, run the O2 sensor calibration.	The calibration is successful. See Section 5.4.4.
8 If necessary, run the CO2 sensor zero calibration.	The zero calibration is successful. See Section 5.4.5.

Do or observe...	Verify ...
9 Generate test alarms.	The corresponding alarm message is displayed in the Message bar. See Section 5.4.6.  Note that patient alarms are suppressed in Standby.

**Corrective action**

A checkmark indicates the component is calibrated and ready. A red **X** indicates the calibration was unsuccessful.

If the ventilator does not pass the preoperational check, have it serviced.

## 5.4.2 Performing the breathing circuit Tightness test

Before proceeding, review the safety information in Chapter 1.

This test checks for leakage in the patient breathing circuit.

### When to perform

After installing a new or decontaminated breathing circuit or component (including a flow sensor).

### To perform the Tightness test

1. Set up the ventilator for ventilation, complete with breathing circuit and flow sensor.
2. Touch **System > Tests & calib**.
3. Touch **Tightness**.  
The text **Disconnect patient** is now displayed.
4. Disconnect the breathing circuit at the patient side of the flow sensor. Do not block the open end of the flow sensor.  
The text **Tighten patient system** is now displayed.
5. Block the opening (wearing a glove is recommended).



The text **Connect patient** is now displayed.

6. Connect the patient.
7. When the test is complete, verify that there is a checkmark in the **Tightness** checkbox.

### To cancel the test while it is in progress

- ▶ Touch **Tightness** again.

### In case of test failure

If the test fails, a red **X** is displayed in the **Tightness** checkbox.

Perform the following checks, repeating the **Tightness** test after each one, until the test is successful:

- Check the breathing circuit for a disconnection between the ventilator and the flow sensor, or for other large leaks (for example, breathing circuit, humidifier).
- Check that the flow sensor and expiratory valve set are properly seated.
- If the calibration still fails, replace the flow sensor.
- If the calibration still fails, replace the expiratory valve membrane.
- If the calibration still fails, replace the expiratory valve set.
- If the calibration still fails, replace the breathing circuit.

If the problem still persists, have the ventilator serviced.

### 5.4.3 Calibrating the adult/pediatric flow sensor

This calibration checks and resets the calibration points specific to the flow sensor in use, and measures circuit resistance compensation.

Ensure you are using the correct flow sensor for the selected patient group. If there is a mismatch, calibration fails.

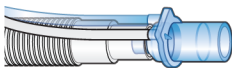
For details about calibrating a neonatal flow sensor, see Section 6.2.1.

#### When to perform

After connecting a breathing circuit or component.

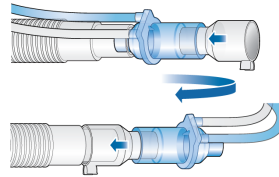
#### To calibrate an adult/pediatric flow sensor

1. Set up the ventilator for ventilation, complete with breathing circuit and flow sensor.
2. Touch **System > Tests & calib.**
3. Touch **Flow sensor.**  
If you have not already disconnected the patient, the message line displays **Disconnect patient.**
4. Disconnect the patient now.

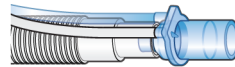


5. When prompted, attach the calibration adapter to the flow sensor and flip them 180° so the adapter is

directly connected to the limb (as shown below).



6. When prompted, flip the flow sensor/adapter 180° again, so the flow sensor is directly connected to the limb, and remove the calibration adapter.



7. When calibration is complete, verify that there is a checkmark in the **Flow sensor** checkbox.
8. When successful, continue with other tests or ventilation.

#### To cancel an ongoing calibration

- ▶ Touch **Flow sensor** again.

#### In case of calibration failure

If the calibration fails, a red **X** is displayed in the **Flow sensor** checkbox.

Perform the following checks, repeating the calibration after each one, until calibration is successful:

- Ensure that the flow sensor is appropriate for the selected patient group.
- Check the breathing circuit for a disconnection between the ventilator and the flow sensor, or for other large leaks (for example, breathing circuit, humidifier).
- Check that the flow sensor and expiratory valve set are properly seated.

- If the calibration still fails, replace the flow sensor.
- If the calibration still fails, replace the expiratory valve membrane.
- If the calibration still fails, replace the expiratory valve set.

If the problem persists, have the ventilator serviced.

#### 5.4.4 Calibrating the O2 sensor

##### NOTICE

When using LPO, be sure to disconnect the oxygen supply during calibration.

The device tests the O2 sensor and resets the calibration points specific to the sensor in use.

Note that as the galvanic O2 sensor requires approx. 30 minutes to reach stable values, and O2 monitoring during this time may be more variable, we recommend running the ventilator for at least 30 minutes before calibrating the O2 sensor.

##### To perform O2 sensor calibration

1. Using the information in Table 5-5, set the **Oxygen** control as appropriate to calibrate the sensor using either 21% or 100% oxygen.  
For example, to calibrate during active ventilation with 100% oxygen, ensure the **Oxygen** control is set to 22% or higher.
2. Touch **System > Tests & calib.**
3. Touch **O2 sensor.**
4. When calibration is complete, verify that there is a checkmark in the **O2 sensor** checkbox.

Table 5-5. Oxygen concentration during O2 sensor calibration

Standby or active ventilation	Gas source connection status	Set Oxygen to ...
<b>100% oxygen calibration<sup>19</sup></b>		
Standby	HPO Connected	> 21%
Active ventilation	HPO Connected	> 21%
<b>21% oxygen calibration</b>		
Standby	HPO Disconnected	any
Standby	HPO Connected	21%
Standby	LPO Disconnected	21%
Active ventilation	HPO Connected	21%
Active ventilation	LPO Disconnected	21%

##### In case of calibration failure

If the calibration fails, a red **X** is displayed in the **O2 sensor** checkbox.

Perform the following checks, repeating the calibration after each one, until calibration is successful:

- Ensure a Hamilton Medical O2 sensor is installed.
- If the second calibration attempt fails, replace the O2 sensor.

If the problem persists, have the ventilator serviced.

<sup>19</sup> Calibrating at 100% improves the stability of measurements at higher oxygen concentrations during use.

### 5.4.5 Performing a zero calibration on the CO2 sensor/adapter

#### CAUTION

- Always perform zero calibration with the CO2 sensor (mainstream) or CO2 module (sidestream) connected to the airway adapter.
- Be sure NOT to cover both ends of the airway adapter with your fingers.

Before proceeding, review the safety information in Chapter 1.

The CO2 adapter zero calibration compensates for optical differences between airway adapters and for sensor drift.

Note that the CO2 sensors are calibrated at the factory; you only need to zero the adapters as described next.

#### Zero calibration requirements for mainstream CO2 sensors

Perform a zero calibration in the following cases:

- With the first use of the sensor
- When changing between airway adapter types (for example, from single use to reusable)
- When the CO2 calibration needed alarm is generated

#### Zero calibration requirements for sidestream CO2 sensors

You only need to perform a zero calibration with sidestream CO2 sensors when the CO2 calibration needed alarm is generated.

Wait at least 20 seconds — and for best results, 2 minutes — to perform the zero calibration after removing the adapter from the patient's airway. This time allows any CO2 remaining in the adapter to dissipate.

#### To perform the zero calibration of the CO2 sensor/adapter (mainstream) and sensor/module (sidestream)

For reference, see Figure 4-1 for the mainstream CO2 assembly and Figure 4-3 for the sidestream assembly.

1. Connect the CO2 sensor (mainstream) or the CO2 module (sidestream) to the ventilator, and ensure CO2 monitoring is enabled.

Once connected, wait approx. 90 seconds for the device to warm up.

2. Disconnect the CO2 adapter from the breathing circuit.
3. Attach the CO2 adapter to the sensor (mainstream) or plug the sample cell into the CO2 module (sidestream).

Place these components away from all sources of CO2 (including the patient's and your own exhaled breath) and the exhaust port of the expiratory valve.

4. Touch **System > Tests & calib.**
5. Touch **CO2 sensor.**

Do not move the components during calibration.

6. When the zero calibration is complete, verify that there is a checkmark in the CO2 sensor checkbox.

### In case of zero calibration failure

If the zero calibration fails, a red **X** is displayed in the CO<sub>2</sub> sensor checkbox.

Perform the following checks, repeating the zero calibration after each one, until it is successful:

- Check the airway adapter and clean if necessary.
- If the zero calibration still fails, ensure there is no source of CO<sub>2</sub> near the airway adapter.
- If the zero calibration still fails, connect a new adapter.
- If the zero calibration still fails, connect a new CO<sub>2</sub> sensor (mainstream) or CO<sub>2</sub> module (sidestream).

If the problem persists, have the ventilator serviced.

### 5.4.6 Testing the alarms

The HAMILTON-T1 performs a self-check that verifies proper alarm function during startup.

We recommend testing the alarms as part of the preoperational check.

For all of the tests, use a demonstration lung assembly as described in Section 5.4.1.

#### 5.4.6.1 High pressure alarm test

1. Touch **Modes**, and select PCV+.
2. Start ventilation.
3. Set the high **Pressure** alarm limit to 15 cmH<sub>2</sub>O above the measured **Ppeak**.
4. Squeeze the demonstration lung hard during inspiration.
5. Verify that the **High pressure** alarm is generated, the ventilator cycles into exhalation, and pressure falls to the **PEEP/CPAP** level.
6. Reset the alarm limit to its previous setting.

#### 5.4.6.2 Low minute volume alarm test

1. Touch **Modes**, and select a mode, for example, PCV+.
2. Start ventilation.
3. Let the ventilator deliver 10 breaths with no alarms.
4. Adjust the low **ExpMinVol** alarm limit so it is higher than the measured value.
5. Verify that the **Low minute volume** alarm is generated.
6. Reset the alarm limit to its previous setting.

### 5.4.6.3 Low oxygen alarm test

#### If using HPO, do the following:

1. Touch **Modes**, and select a mode, for example, PCV+.
2. Start ventilation.
3. Set the **Oxygen** control to 50%.
4. Wait for two minutes.
5. Disconnect the oxygen supply.
6. Verify the following:
  - The oxygen concentration displayed in the **Monitoring** window decreases.
  - The **Low oxygen** alarm is generated.
7. Wait 30 seconds or until the oxygen concentration falls below 40%.
8. Reconnect the oxygen supply.
9. Verify that the **Low oxygen** alarm resets.  
The alarm should reset when the measured oxygen exceeds 45%.

#### If using LPO, do the following:

1. Touch **Modes**, and select a mode, for example, PCV+.
2. Start ventilation.
3. Touch **Alarms > Limits 1**.
4. Set the low **Oxygen** alarm limit to a value above 21%.
5. Verify the **Low oxygen** alarm is generated.
6. Set the low **Oxygen** alarm to a value below 21%.
7. Verify that the **Low oxygen** alarm resets.

### 5.4.6.4 Disconnection on patient side alarm test

1. Disconnect the demonstration lung during active ventilation.
2. Verify that the **Disconnection on patient side** alarm is generated.
3. Reconnect the demonstration lung.
4. Verify that the alarm resets and that the ventilator automatically resumes ventilation.

### 5.4.6.5 Loss of external power alarm test

1. With the ventilator connected to primary power, turn it on.
2. Disconnect the power cord.
3. Verify that the **Loss of external power** alarm is generated and that the ventilator is powered by its backup battery.
4. Reconnect the ventilator to primary power.
5. Verify that the alarm resets and that the ventilator is again powered by primary AC power.

### 5.4.6.6 Exhalation obstructed alarm test

1. Block the expiratory valve exhaust port during active ventilation.
2. Observe the pressure rise.
3. Verify that the **Exhalation obstructed** alarm is activated.



### 5.4.6.7 Apnea alarm test

1. Touch **Modes**, and select **SPONT**.  
Make sure **Apnea backup** ventilation is disabled.
2. Wait for the set apnea time.
3. Verify that the Apnea alarm is generated.
4. Squeeze the demonstration lung twice.
5. Verify that the Apnea alarm resets.

## 5.5 Selecting the ventilation mode

The active ventilation mode is displayed at the top right corner of the display together with the selected patient group.

When first starting to ventilate a patient, the mode associated with the selected **Quick setup** is pre-selected. You can change it, if needed.

For details about each of the modes, see Chapter 7.

### To select a mode

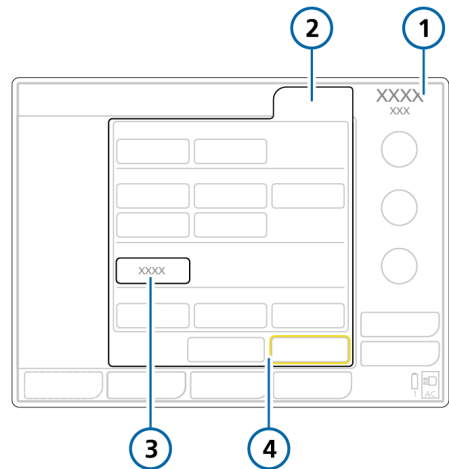
1. Touch **Modes** (1).



2. In the **Modes** window, touch the desired mode, then touch **Confirm**.  
The **Confirm** button is only displayed after you select a different mode in the window.  
The **Controls** window opens.

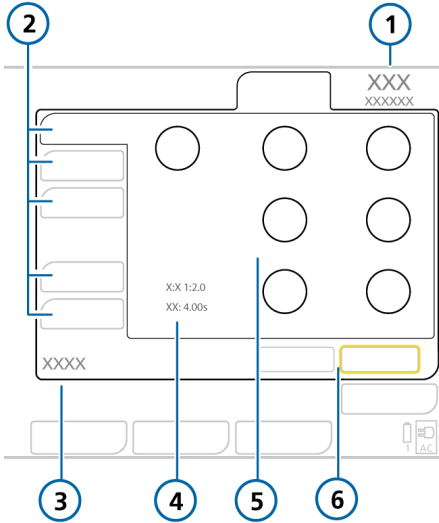
3. Review and, if needed, adjust the control settings (Figure 5-4), then touch **Confirm** to enable the new mode.  
After you touch **Confirm**, the mode changes at the end of the current breath cycle.  
Without confirmation, the window closes after a short time and the currently active mode remains in place.

Figure 5-3. Modes window, changing modes



- |                              |                  |
|------------------------------|------------------|
| 1 Active mode, patient group | 3 New mode       |
| 2 Modes                      | 4 Cancel/Confirm |

Figure 5-4. Controls window, changing modes



- |   |                            |
|---|----------------------------|
| 1 Active mode, patient group                    | 4 Values depending on mode |
| 2 Tabs: Basic, More, Apnea, Patient, SpeakValve | 5 Controls for new mode    |
| 3 New mode                                      | 6 Cancel/Confirm           |

### 5.5.1 Reviewing and adjusting ventilation settings

You specify ventilation settings in the **Controls** window tabs: **Basic**, **More**, **Apnea**. The **Patient** tab provides access to patient data during ventilation.

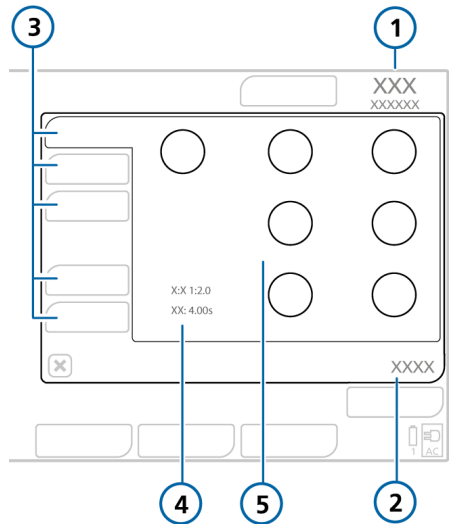
Which tabs are available depends on which mode is selected, as well as whether you are in Standby or active ventilation.

In addition, the window changes slightly depending on whether you are changing settings for the active mode or you are changing modes.

### To change the control settings for the active mode

1. Touch **Controls**, and select and adjust settings as needed. See Figure 5-5. The change takes effect immediately.
2. Touch **More** to enable/disable Sigh, if needed.
3. If applicable, touch **Apnea** and select or deselect **Backup** as needed.
4. If you need to change basic patient data, touch **Patient** and adjust settings as needed. See Section 5.3.

Figure 5-5. Controls window, settings for active mode



- |  |  |
|--|--|
| 1 Active mode, patient group                     | 4 Values depending on mode (I:E, TE, TI) |
| 2 Controls                                       | 5 Mode controls                          |
| 3 Tabs: Basic, More, Apnea, Patient, Speak-Valve |  |

## 5.5.2 About Apnea backup ventilation

Before proceeding, review the safety information in Chapter 1.

The HAMILTON-T1 provides Apnea backup ventilation, a mechanism that minimizes possible patient injury due to apnea or cessation of respiration. Apnea backup is available in the following modes: APVsimv, SPONT, DuoPAP, APRV, and NIV

### Apnea backup ventilation enabled

Apnea backup provides ventilation after the apnea time passes with no breath attempts detected. The apnea time is set in the Alarms window using the Apnea time control.

When this occurs, the ventilator automatically and immediately switches into Apnea backup ventilation.

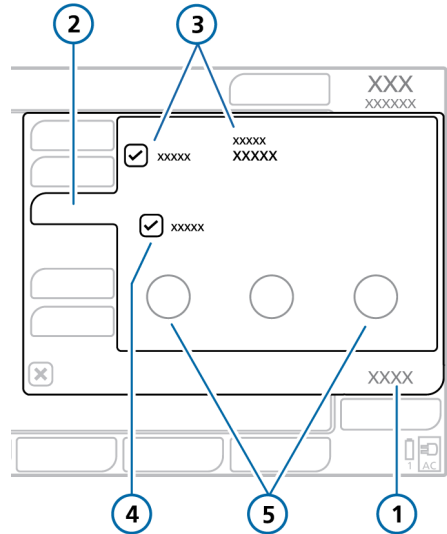
It generates a low-priority alarm, displays the alarm Apnea ventilation, and provides ventilation using the settings specified in Section 7.1.3.

When set to Automatic, the control setting for the Apnea backup mode depends on the IBW (or weight for neonates) of the patient.

### To change the Apnea backup control settings

1. Touch **Controls** > **Apnea**.
2. Clear the **Automatic** checkbox.  
The settings controls are enabled.
3. Change the values as desired.  
The changes take effect immediately.

Figure 5-6. Apnea window, Automatic button



- |                             |  |
|-----------------------------|--|
| 1 Controls                  | 4 Automatic check box                        |
| 2 Apnea                     | 5 Control settings corresponding to the mode |
| 3 Backup check box and mode |  |

If the patient triggers two consecutive breaths, the ventilator reverts to ventilation in the original support mode and at the original settings, and displays the message, Apnea ventilation ended.

Once Apnea backup ventilation is enabled or disabled, it retains this status in all applicable modes. Apnea backup ventilation requires no clinician intervention, although you can freely change the mode during Apnea backup ventilation, either switching to a new mode or accepting the backup mode as the new mode.

**Apnea backup ventilation disabled**

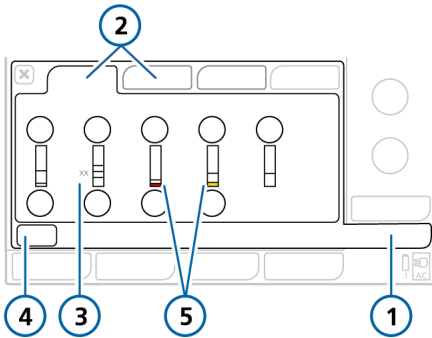
When **Apnea backup** is disabled, the high-priority **Apnea** alarm is generated when apnea occurs and there is no patient trigger within the operator-set interval.

**5.6 Setting alarm limits**

*Before proceeding, review the safety information in Chapter 1.*

You can access the **Alarms** window and change alarm settings at any time, without affecting ventilation.

Figure 5-7. Alarms > Limits 1 window



- 1 Alarms
- 2 Limits 1, 2
- 3 Current monitored value
- 4 Auto
- 5 Red or yellow bar (depending on alarm priority) indicates the monitored value is out of range

**To review and adjust alarms**

1. Touch the **Alarms** button.  
The **Alarms > Limits 1** window is displayed (Figure 5-7).
2. To set an alarm limit individually, touch the alarm control and adjust the value.  
Repeat for any other alarm.
3. Access additional alarm settings by touching the **Limits 2**, and if used, **Limits 3** tabs.  
For details about the Oxygen alarm limits, see Section 5.6.1.
4. To set alarm limits automatically, touch **Auto**<sup>20</sup> in the **Limits 1** window.

Selecting **Auto** automatically sets alarm limits around the current monitoring parameter values except for the **Vt** and **Apnea** alarm limits<sup>21</sup>. These alarm limits remain unchanged, and must be set manually to the desired level.

Note that some automatic settings are not appropriate under all clinical conditions. Check the validity of the settings as soon as possible.

5. Close the window.

The following table briefly describes each of the adjustable ventilator alarms. Additional details are available in Table 14-9.

For SpO2-related alarms, see the *Pulse Oximetry Instructions for use*.

<sup>20</sup> Not available during neonatal ventilation.

<sup>21</sup> SpO2-related alarms are also not automatically set.

Table 5-6. Adjustable alarms

Alarm	Definition
Apnea time	<p>The maximum time allowed from the beginning of one inspiration to the beginning of the next inspiration.</p> <p>If the patient does not trigger a breath during this time:</p> <ul style="list-style-type: none"> <li>• A low-priority alarm sounds if <b>Apnea backup</b> is enabled. Apnea ventilation begins.</li> <li>• A high-priority alarm sounds if <b>Apnea backup</b> is disabled</li> </ul> <p>Not applicable in nCPAP or nCPAP-PC modes.</p>
ExpMinVol (low and high)	<p>Low and high expiratory minute volume. If either limit is reached, a high-priority alarm is generated.</p> <p>Not applicable in nCPAP or nCPAP-PC modes.</p> <p>For alarm details when using a speaking valve, see Table 10-1.</p>
Flow	<p>Only active in nCPAP and nCPAP-PC modes.</p> <p>The <b>High Flow</b> alarm is generated when the limit is reached.</p>
fTotal (low and high)	<p>Low and high monitored total breath rate (fTotal), including both spontaneous and mandatory breaths. If either limit is reached, a medium-priority alarm is generated.</p> <p>Not applicable in nCPAP or nCPAP-PC modes.</p>
Oxygen (low and high)	<p>Low and high monitored oxygen concentration (<b>Oxygen</b>). If either limit is reached, a high-priority alarm is generated.</p> <p>Applies only when low-pressure oxygen is used or the <b>Set Oxygen alarm limits manually</b> checkbox is selected with HPO.</p>
PetCO2 (low and high)	<p>Low and high monitored PetCO2. If either limit is reached, a medium-priority alarm is generated.</p>
Pressure (low and high)	<p>Low and high monitored pressure at the patient airway (<b>Ppeak</b>). If the high <b>Pressure</b> limit is reached or the device fails to reach the low <b>Pressure</b> limit, a high-priority alarm is generated.</p> <p>When pressure reaches the <b>high Pressure limit minus 10 cmH2O</b>, pressure is limited to this setting; the pressure is not increased further.</p> <p>If the delivered pressure is the same as the set high <b>Pressure</b> alarm limit, the device aborts the breath and reduces the pressure to <b>PEEP</b> level.</p> <p>Sigh breaths are an exception to this rule. In this case, the ventilator may apply inspiratory pressure 3 cmH2O below the high <b>Pressure</b> alarm limit (<b>high Pressure limit minus 3 cmH2O</b>).</p>

Alarm	Definition
Vt (low and high)	<p>Low and high expiratory tidal volume, for two consecutive breaths. If either limit is reached, a medium-priority alarm is generated.</p> <p>When the delivered Vt is &gt; 1.5 times the set upper Vt alarm limit, the <b>Inspiratory volume limitation</b> alarm is generated. In this case, the device aborts the breath and reduces the pressure to PEEP level.</p> <p>The APV controls reduce the pressure for the next breath by 3 cmH2O.</p>

### 5.6.1 About the Oxygen alarm limits

How the device sets the **Oxygen** alarm limits depends on the gas source used (LPO or HPO) and associated option settings.

**Oxygen** alarm limits are set as follows:

Table 5-7. Setting Oxygen alarm limits in LPO and HPO modes

Gas source	Setting Oxygen alarm limits
LPO	<p>Always manually. The <b>Oxygen</b> limit controls are enabled in the <b>Alarms</b> window and are manually adjusted, as appropriate.</p>
HPO	<p>By default, automatically. The <b>Oxygen</b> high/low alarms are, by default, automatically set to the current <b>Oxygen</b> setting <math>\pm 5</math> (absolute value). The <b>Oxygen</b> limit controls are disabled in the <b>Alarms</b> window.</p> <p>To set them manually, select the <b>Set Oxygen alarm limits manually</b> option, as described next.</p>

*The minimum lower alarm limit is 18%.*

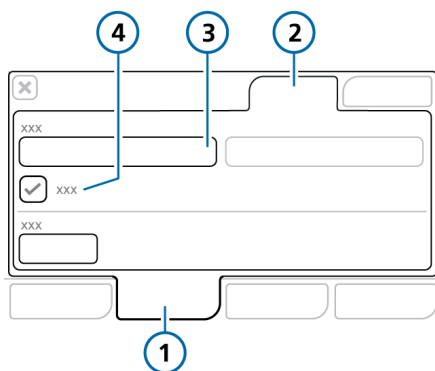
### To enable manual adjustment of Oxygen alarm limits in HPO mode

1. Touch **Tools > Utilities**.
2. Select **HPO mode** as the gas source.
3. To set the Oxygen alarm limits yourself, touch the **Set Oxygen alarm limits manually** checkbox.

When selected, the Oxygen alarm control is enabled in the Alarms window. You can now set the limits as desired.

4. To have the limits set automatically, ensure the checkbox is clear.

Figure 5-8. Setting Oxygen alarm limits manually with HPO



- |             |  |
|-------------|--|
| 1 Tools     | 3 Gas source: HPO mode                               |
| 2 Utilities | 4 Set Oxygen alarm limits manually checkbox selected |

## 5.7 Starting ventilation

Before starting ventilation, review the patient information in the **Standby** window and ensure it is correct.

### To start ventilation

- ▶ Do either of the following:
  - In **Standby**, press the **Power/Standby** key.
  - In **Standby**, touch **Start ventilation**.
  - Using the **P&T** knob, move the cursor to the **Start ventilation** button, and press the **P&T** knob.

Ventilation starts.

## 5.8 Stopping ventilation

### To enter Standby and stop ventilation

1. Press the **Power/Standby** key.
2. In the confirmation window, touch **Activate standby**.

The device enters **Standby** (Figure 5-1). The yellow counter shows the time elapsed in **Standby**.

## 5.9 About the control parameters

Table 5-8 briefly describes each of the ventilator control parameters.

Table 14-5 provides the control parameter ranges and default settings, including accuracy.

Table 5-8. Control parameters, defined

Parameter	Definition
%MinVol	<p>Percentage of minute volume to be delivered in ASV mode. The ventilator uses the %MinVol, Pat. height, and sex settings to calculate the target minute ventilation.</p> <p>Add 20% per degree of body temperature &gt; 38.5°C (101.3°F)</p>
Apnea backup	<p>A function that provides ventilation after the adjustable apnea time passes without breath attempts.</p> <p>If Automatic is enabled, control parameters are calculated based on the patient's IBW.</p> <p>Applies in APVsimv, SPONT, DuoPAP, APRV, and NIV modes.</p> <p><i>Be sure to review the safety information in Chapter 1.</i></p>
ETS	<p>ETS (expiratory trigger sensitivity) is the percent of peak inspiratory flow at which the ventilator cycles from inspiration to exhalation.</p> <p>Increasing the ETS setting results in a shorter inspiratory time, which may be beneficial in patients with obstructive lung disease. The ETS setting lets you match the inspiratory time of pressure-supported breaths to the patient's neural timing.</p> <p>Applies to spontaneous breaths.</p>
Flow trigger	<p>The patient's inspiratory flow that triggers the ventilator to deliver a breath.</p>
Flow	<p>In HiFlowO2, Flow is the continuous and constant flow of medical gas to the patient in liters per minute.</p>
I:E	<p>Ratio of inspiratory time to expiratory time.</p> <p>Applies to mandatory breaths, and in APVsimv/APVcmv and PCV+ modes.</p>
Oxygen	<p>Oxygen concentration to be delivered.</p> <p>Applies to all breaths and during HiFlowO2.</p>
P high	<p>The high pressure setting in APRV and DuoPAP modes. Absolute pressure, including PEEP.</p>
P low	<p>The low pressure setting in APRV mode.</p>
Pasvlimit	<p>The maximum pressure to apply in ASV mode.</p> <p>For the ASV controller to function correctly, Pasvlimit must be at least 15 cmH2O above PEEP/CPAP.</p> <p>Changing Pasvlimit or the Pressure alarm limit automatically changes the other: The Pressure alarm limit is always 10 cmH2O greater than Pasvlimit.</p>



Parameter	Definition
Pat. height	Patient height. It determines the ideal body weight (IBW), used in calculations for ASV and ventilation settings for adult/pediatric patients.
Pcontrol	The pressure (additional to PEEP/CPAP) to apply during the inspiratory phase in PCV+ and PSIMV+ modes.
PEEP/CPAP	Positive end expiratory pressure and continuous positive airway pressure, baseline pressures applied during the expiratory phase. Applies to all breaths, except in APRV mode and during HiFlowO2.
Pinsp	Pressure (additional to PEEP/CPAP) to apply during the inspiratory phase. Applies in PSIMV+ PSync and NIV-ST modes.
P-ramp	Pressure ramp. The rate at which pressure rises to meet the set value. The set Pressure is generally reached after approximately 2 x P-ramp. The P-ramp setting lets you fine-tune the initial flow output during a pressure-controlled or pressure-supported breath to match the ventilator flow to the patient's demand. Applies to all breaths.  Notes: <ul style="list-style-type: none"> <li>• Short P-ramp settings (0 to 50 ms) provide higher initial flow rates and result in faster attainment of the target pressure. This may benefit patients with elevated respiratory drive.</li> <li>• Lower P-ramp values have been correlated with reduced work of breathing in certain patients.</li> <li>• Setting the P-ramp too low, especially in combination with a small ET tube (high resistance), may result in a noticeable pressure overshoot during the early stage of inspiration and generation of a Pressure limitation alarm.</li> <li>• Setting the P-ramp too high may prevent the ventilator from attaining the set inspiratory pressure. A square (rectangular) pressure profile is the goal.</li> </ul>
Psupport	Pressure support for spontaneous breaths in SPONT, NIV, APVsimv, PSIMV+, and DuoPAP modes. It is the pressure (additional to PEEP/CPAP) to apply during the inspiratory phase.  Pressure support helps the patient counteract the flow resistance of the breathing circuit and endotracheal tube. It compensates for the decreasing tidal volume and rising respiratory rate of a spontaneously breathing patient.
Rate	Respiratory frequency or number of breaths per minute.
Sex	Sex of patient. Used to compute ideal body weight (IBW) for adult and pediatric patients.

Parameter	Definition
Sigh	<p>When Sigh is activated, every 50th breath is applied using one of the following settings:</p> <ul style="list-style-type: none"> <li>• In pressure-controlled modes, the pressure delivered is &gt; 10 cmH<sub>2</sub>O above the currently set PControl or P<sub>insp</sub>.</li> <li>• In volume-controlled modes, the tidal volume delivered is 150% of the current tidal volume (V<sub>t</sub>) setting.</li> </ul> <p>During sigh breaths, the Pressure and V<sub>t</sub> alarm limits remain in effect to help protect the patient from excessive pressures and volumes.</p> <p>Not available for neonatal patients, or DuoPAP or APRV modes.</p>
T high	Length of time at the higher pressure level, P high, in DuoPAP and APRV modes.
T low	Length of time at the lower pressure level, P low, in APRV mode.
TI max	<p>Maximum inspiratory time for cycled breaths in NIV, NIV-ST, and SPONT in neonatal modes.</p> <p>For all patient groups, the switchover from inspiration to exhalation in spontaneous breaths is normally controlled by the ETS. If gas leakage is significant, however, the set cycle may never be reached. The TI max setting provides a backup so inspiration can be terminated. The ventilator switches over to exhalation when the set TI max is reached.</p> <p>When speaking valve compatibility is activated (ON), the control setting TI max is available in PSIMV+ and SPONT modes, in the Controls &gt; More window.</p>
TI	<p>Inspiratory time, the length of time to deliver gas for inspiration at the Pcontrol setting. Used with Rate to set the breath cycle time.</p> <p>Applies in PCV+, APVcmv, APVsimv, PSIMV+, and NIV-ST.</p> <p>In PCV+ and APVcmv modes, TI can be controlled by Rate and TI or by the I:E ratio (set in Configuration). All other modes are controlled by Rate and TI.</p>
Vt/kg	Tidal volume per weight.
Vt	Tidal volume delivered during inspiration in APVcmv and APVsimv modes.
Weight	Actual body weight. Used only with neonates.

# 6

## Specifying neonatal settings

6.1	Setting up for neonatal ventilation .....	100
6.2	Performing the preoperational check, tests, and calibrations .....	103
6.3	Selecting the ventilation mode .....	106
6.4	Setting the patient weight for ventilation .....	106
6.5	Alarms for neonatal ventilation .....	106
6.6	O2 enrichment for neonates .....	106

## 6.1 Setting up for neonatal ventilation

Before proceeding, review the safety information in Chapter 1.

Setting up for neonatal ventilation comprises the following steps:

To ...	See ...
On the ventilator, select the patient group and specify weight.	Section 6.1.1
Install the expiratory valve.	Section 3.5.2
Select and assemble the appropriate breathing circuit and components.	Section 6.1.2
Adjust the position of the breathing circuit.	Section 6.1.2.6
Connect external devices.	Chapter 4
Perform the preoperational check and any required tests and calibrations.	Sections 6.2 and 5.4
Select the ventilation mode.	Sections 6.3 and 5.5

### 6.1.1 Setting the patient group and weight

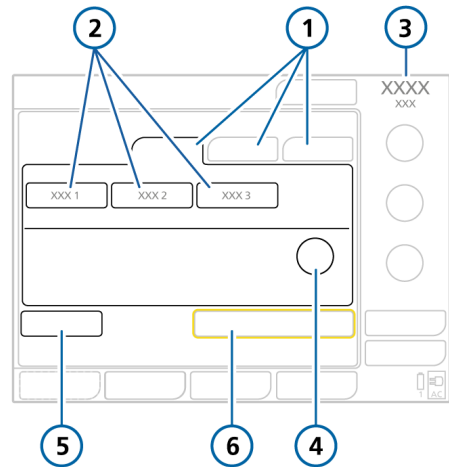
#### ⚠ CAUTION

Entering the correct patient data ensures safe ventilation settings for start up, Apnea backup, and safety ventilation.

You select the patient group and weight in the **Standby** window when first setting up the ventilator for the patient.

You can edit this information during ventilation, if needed, in the **Patient** window.

Figure 6-1. Neonatal Standby window



- |  |  |
|--|--|
| 1 Patient group tabs (Neonatal selected) | 4 Weight   |
| 2 Quick setup buttons                    | 5 Preop check  |
| 3 Selected mode and patient group        | 6 Start ventilation (when HiFlowO2 is selected: Start therapy) |

### To select the patient group

1. In the **Standby** window, touch the **Neonatal** tab. See Figure 6-1.
2. Touch the appropriate **Quick setup** button.  
By default, they are labeled **Neonatal 1**, **Neonatal 2**, and **Neonatal 3**. The **Quick setup** names and settings are defined in Configuration. For details, see Section 5.2.1.
3. Touch the **Weight** control and set the patient's body weight.  
By default, the weight is set to 2 kg.

You can now select the ventilation mode, if the desired mode is not already selected.

### 6.1.2 Setting up the patient breathing circuit

Setting up a neonatal breathing circuit comprises the following steps:

Table 6-1. Assembling the breathing circuit

To ...	See ...
Select the components	Section 6.1.2.1
Connect the breathing circuit	Section 6.1.2.2
Connect the flow sensor	Section 6.1.2.4
Connect the pressure line (nCPAP, nCPAP-PC modes)	Section 6.1.2.5
Position the circuit	Section 6.1.2.6

#### 6.1.2.1 Selecting the breathing circuit components

Select the correct breathing circuit and components for your patient from Table 6-2.

Table 6-2. Neonatal breathing circuit part specifications

Patient group/ component	Specification
Patient group	Neonatal
Weight (kg)	0.2 to 30
Tracheal tube ID (mm)	≤ 4
Breathing circuit tube ID (mm)	10 to 12
Flow sensor	Neonatal
Pressure line	Neonatal
CO2 airway adapter	Neonatal

#### 6.1.2.2 Connecting the neonatal breathing circuit

Figures 2-9 through 2-11 in Chapter 2 show typical neonatal breathing circuit configurations.

#### 6.1.2.3 Working with the expiratory valve

The process is the same as for adult and pediatric patients. See Section 3.5.2.

### 6.1.2.4 Connecting the neonatal flow sensor

Note the following:

- Use a Hamilton Medical neonatal flow sensor to ventilate your neonatal patient.
- Do *not* use an adult/pediatric flow sensor.
- The neonatal flow sensor adds 1.3 ml of dead space.

#### To connect the neonatal flow sensor

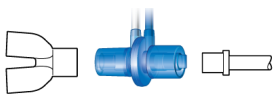
1. For all modes except nCPAP and nCPAP-PC, connect a flow sensor between the Y-piece of the breathing circuit and the patient connection. See Figure 6-2.

When using the nCPAP and nCPAP-PC modes, remove the flow sensor and use the pressure-monitoring line with the breathing circuit (Section 6.1.2.5). Note that during calibration you place the flow sensor proximal to the patient.

HiFlowO2 does not use a flow sensor.

2. Connect the blue and clear tubes to the flow sensor connection ports on the ventilator. The blue tube attaches to the blue connection port. The clear tube attaches to the white connection port.
3. Calibrate the flow sensor and perform the **Tightness test**. See Section 6.2.

Figure 6-2. Connect flow sensor between the Y-piece and patient interface

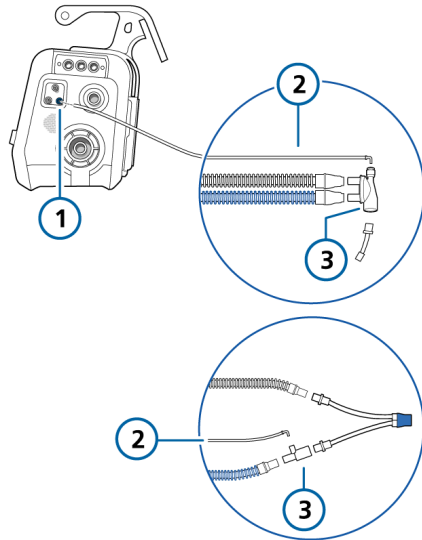


### 6.1.2.5 Connecting the pressure-monitoring line

Use the pressure line with the breathing circuit when using the nCPAP or nCPAP-PC modes. Do *not* use a flow sensor.

The pressure is measured by a built-in T-piece adapter in the inspiratory line, close to the patient, or (if available) over the optional pressure measuring connection at the Y-piece of the breathing circuit.

Figure 6-3. Connecting the pressure line



- 1 Pressure line connection port (blue)
- 2 Pressure line
- 3 T-piece, Y-piece

### To connect the pressure-monitoring line

1. Using an adapter, connect the pressure line to the small inlet at the top of the T- or Y-piece, whichever is used. See Figure 6-3.
2. Connect the pressure line to the blue flow sensor connection port on the ventilator.
3. Calibrate the breathing circuit and perform the **Tightness** test.

#### 6.1.2.6 Positioning the breathing circuit

After assembly, position the breathing circuit so that the hoses will *not* be pushed, pulled, or kinked as a result of a patient's movement, transport, or other activities, including scanner bed operation and nebulization.

## 6.2 Performing the preoperational check, tests, and calibrations

*Before proceeding, review the safety information in Chapter 1.*

The following sections in this chapter provide information that is specific to neonatal ventilation, and is intended as a supplement to the information provided in Chapter 5.

For details about when to perform the tests, and about the full preoperational check process, see Section 5.4.

### When to perform

Before connecting a new patient to the ventilator.

### To perform the preoperational check

1. Use a setup as described in Table 5-3.
2. Perform all of the steps in Table 5-4.

To ensure that the ventilator functions according to specifications on your patient, we recommend that your test circuit be equivalent to the circuit used for ventilation.

Table 6-3. Test breathing circuit setup

Component	Specification
Breathing circuit	Neonatal, ID10 to ID12
Flow sensor	Neonatal, with calibration adapter
Pressure line	For use in nCPAP and nCPAP-PC modes
Test lung	Neonatal, with neonatal ET tube between flow sensor and lung model (an IngMar neonatal lung model is recommended)

Table 6-4. Preoperational check, overview

To ...	See ...
Perform the preoperational check	Section 5.4 in Chapter 5
Perform the <b>Tightness</b> test	Section 5.4.2 in Chapter 5
Calibrate the neonatal flow sensor	Section 6.2.1
In nCPAP modes, calibrate the breathing circuit	Section 6.2.2
Perform other calibrations, as needed	Section 5.4 in Chapter 5

### 6.2.1 Calibrating the neonatal flow sensor

Calibrate the flow sensor after connecting a new flow sensor or whenever the **Flow sensor calibration needed** alarm is generated.

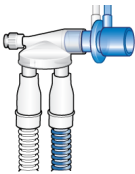
A flow sensor is required for all modes except nCPAP or nCPAP-PC modes or when using HiFlowO2. Before proceeding, ensure you have the calibration adapter available.

#### To calibrate a neonatal/pediatric flow sensor

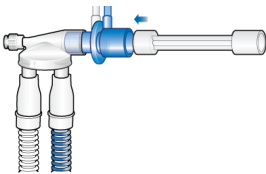
1. Set up the ventilator for ventilation, complete with breathing circuit and neonatal/pediatric flow sensor.
2. Touch **System > Tests & calib.**
3. Touch **Flow sensor.**

If you have not already disconnected the patient, the message line displays **Disconnect patient.**

4. Disconnect the patient now.

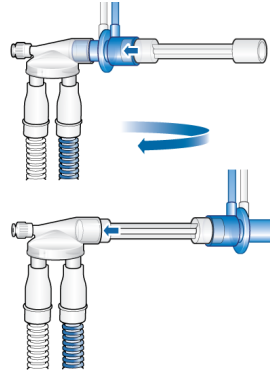


5. When prompted on the display, attach the calibration adapter to the patient end of the flow sensor.

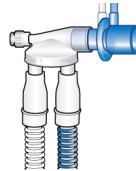


6. When prompted, flip the flow sensor/calibration adapter 180° so the

adapter is directly connected to the Y-piece (as shown below).



7. When prompted to turn the flow sensor again, remove the calibration adapter, and flip the flow sensor 180° back to its starting position.



8. When calibration is complete, verify that there is a checkmark in the **Flow sensor** checkbox.
9. When successful, continue with other tests or ventilation.

#### To cancel an ongoing calibration

- ▶ Touch **Flow sensor** again.

#### In case of calibration failure

If the calibration fails, a red **X** is displayed in the **Flow sensor** checkbox.



Perform the following checks, repeating the calibration after each one, until calibration is successful:

- Ensure that the flow sensor is appropriate for the selected patient group.
- Check the breathing circuit for a disconnection between the ventilator and the flow sensor, or for other large leaks (for example, breathing circuit, humidifier).
- Check that the correct flow sensor is connected, and that the flow sensor and expiratory valve/membrane are properly seated.
- If the calibration still fails, replace the flow sensor.
- If the calibration still fails, replace the expiratory valve membrane.
- If the calibration still fails, replace the expiratory valve set.

If the problem persists, have the ventilator serviced.

### 6.2.2 Calibrating the neonatal breathing circuit (nCPAP and nCPAP-PC modes)

The nCPAP and nCPAP-PC modes use a pressure line in the breathing circuit to measure the inspiratory pressure. Do *not* use a flow sensor.

This calibration ensures that the breathing circuit resistance compensation is accurate.

#### To calibrate the circuit with the pressure line

1. Touch **System > Tests & calib.**
2. Touch **Circuit.**

If you have not already disconnected the patient, the text **Disconnect patient** is displayed.

3. Disconnect patient as follows:
  - If using a Y-piece, disconnect the breathing circuit from the patient.
  - If using a T-piece, disconnect the interface from the patient.
4. Follow the instructions displayed in the message line.
5. When calibration is complete, verify that there is a checkmark in the **Circuit** checkbox.
6. When successful, continue with other tests or ventilation.

#### To cancel an ongoing calibration

- ▶ Touch **Circuit** again.

#### In case of calibration failure

If the calibration fails, a red X is displayed in the **Circuit** checkbox.

Perform the following checks, repeating the calibration after each one, until calibration is successful:

- Check the breathing circuit for a disconnection between the ventilator and the pressure line, or for other large leaks (for example, breathing circuit, humidifier).
- Check that the pressure line and expiratory valve set is properly seated.
- If the calibration fails, replace the pressure line.
- If the calibration still fails, replace the breathing circuit and expiratory valve set.

If the problem persists, have the ventilator serviced.

## 6.3 Selecting the ventilation mode

The neonatal modes available on the ventilator are either pressure controlled or adaptive (pressure regulated and volume targeted) modes.

Note that the ventilator generates a continuous and constant base flow from the inspiratory outlet to the expiratory outlet during the later part of exhalation.

The base flow is set to a fixed 4 l/min for neonatal patients.

For the list of supported modes and details about each one, see Chapter 7.

### To select the ventilation mode

- ▶ See Section 5.5.

## 6.4 Setting the patient weight for ventilation

For neonates, the ventilator uses actual body weight (instead of a calculated **IBW**), set in the **Weight** control.

Specifying the correct weight is particularly important as the ventilator uses this data as the basis for some calculations and mode control settings. By default, neonatal weight is set to 2 kg.

To set up the patient, see Section 6.1.1.

## 6.5 Alarms for neonatal ventilation

Note that the following adjustable alarms use patient **Weight** to set the initial alarm limits:

- Tidal volume, high and low (**Vt**)
- Minute volume, high and low (**ExpMin-Vol**)

Be sure to set the correct patient **Weight** in the **Standby** window before starting ventilation. See Section 6.1.1.

## 6.6 O<sub>2</sub> enrichment for neonates

The applied oxygen concentration during the enrichment maneuver is increased by 25% of the last **Oxygen** setting.

For additional details on performing O<sub>2</sub> enrichment, see Chapter 10.

# 7

## Ventilation modes

7.1	Overview.....	108
7.2	Volume-targeted modes, adaptive pressure control .....	112
7.3	Pressure-controlled modes .....	115
7.4	Intelligent Ventilation .....	122
7.5	Noninvasive modes .....	124
7.6	Special conditions .....	129
7.7	Working with noninvasive modes.....	130
7.8	Working with ASV .....	133

## 7.1 Overview

The HAMILTON-T1 offers a full range of ventilation modes that provide full and partial ventilatory support.

The primary aims of mechanical ventilation are:

- Elimination of CO<sub>2</sub>
- Oxygenation
- Decreased work of breathing
- Patient synchronization

The detailed mode descriptions provided in this chapter illustrate how the controls work to achieve these goals.

### 7.1.1 Breath types and timing options

Hamilton Medical ventilators support two main breathing methods: mandatory breaths and spontaneous breaths.

**Mandatory breaths.** The start of inspiration (triggering) is determined by the ventilator or the patient. The end of inspiration (cycling) is determined by the ventilator.

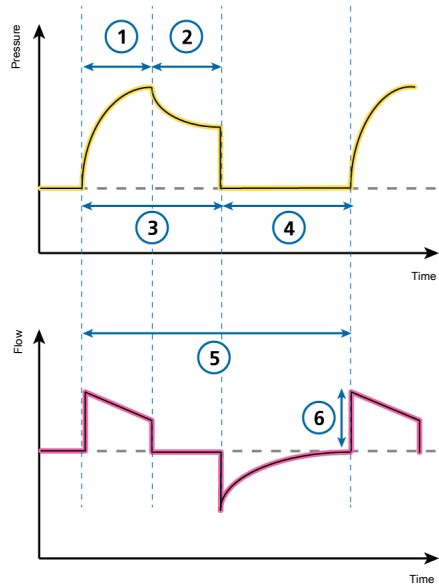
**Spontaneous breaths.** The start of inspiration (triggering) and end of inspiration (cycling) is determined by the patient. The patient breathes independently or receives support from the ventilator.

The ventilator controls mandatory breath timing using a combination of inspiratory time (TI) and Rate.

For some modes, you can set the ventilator to use any of the following combinations to control breath timing: I:E or TI.

To select the breath timing to use, see Section 12.4.1.

Figure 7-1. Breath timing parameters



1	TI or %TI	4	I:E ratio
2	Pause or Tip	5	Rate
3	I:E ratio	6	Peak flow

Note that in the breath patterns shown in this chapter, we show I:E. What is actually displayed on your device depends on the breath timing selection on the ventilator.

### 7.1.2 Ventilation modes

The choice of mode is a medical decision that depends on the patient's CO<sub>2</sub> elimination, oxygenation, activity, and breathing effort.

A ventilation mode combines breath type, breath sequence, and control variables.

Table 7-1. HAMILTON-T1 ventilation modes, description and applicable patient group

Mode name	Patient group	Mode
<b>Volume-targeted modes, adaptive pressure controlled</b>		
APVcmv / (S)CMV+	All	Breaths are volume targeted and mandatory.
APVsimv / SIMV+	All	Volume-targeted mandatory breaths can be alternated with pressure-supported spontaneous breaths.
<b>Pressure-controlled modes</b>		
PCV+	All	All breaths, whether triggered by the patient or the ventilator, are pressure-controlled and mandatory.
PSIMV+	All	Mandatory breaths are pressure controlled. Mandatory breaths can be alternated with pressure-supported spontaneous breaths.
DuoPAP	All	Mandatory breaths are pressure controlled. Spontaneous breaths can be triggered at both pressure levels.
APRV	All	Spontaneous breaths can be continuously triggered. The pressure release between the levels contributes to ventilation.
SPONT	All	Every breath is spontaneous, with or without pressure-supported spontaneous breaths.
<b>Intelligent ventilation</b>		
ASV	Adult/Ped	Operator sets %MinVol, PEEP, and Oxygen. Frequency, tidal volume, pressure, and I:E ratio are based on physiological input from the patient.
<b>Noninvasive modes</b>		
NIV	All	Every breath is spontaneous.
NIV-ST	All	Every breath is spontaneous as long as the patient is breathing above the set rate. A backup rate can be set for mandatory breaths.
nCPAP	Neonatal	Demand flow Nasal Continuous Positive Airway Pressure.
nCPAP-PC	Neonatal	Breaths are pressure controlled and mandatory.

### 7.1.3 Ventilation controls and settings

The table on the following page provides an overview of all of the modes and their control settings.

Mode type	Intelligent Ventilation	Vol targeted, adaptive press. control		Pressure controlled						Noninvasive				
		ASV ***	APV/cmv	APV/simv	PCV+	FSIMV +PSync	FSIMV+	DuoPAP	APRV	SPONT	NIV	NIV-ST	nCPAP**	nCPAP-PC **
Timing	--	Rate	Rate	Rate	Rate	Rate	T low	Rate	T high	--	--	Rate	Rate	Rate
	--	*	TI	TI	*	TI	T high	T high	T high	--	TI	TI	TI	TI
Mandatory breaths	--	Vt	Vt	Vt	Pcontrol	Pcontrol	P high	P high	P high	--	--	Pinsp	Pinsp	Pinsp
	--	--	--	Psupport	Pcontrol	Pcontrol	Psupport	Psupport	Psupport	Psupport	Psupport	Pinsp	Pinsp	Pinsp
Spontaneous breaths	Cycle	--	Cycle	Cycle	--	Cycle	Cycle	Cycle	Cycle	Cycle	Cycle	Cycle	Cycle	Cycle
	--	--	--	--	--	--	--	--	--	TI max	TI max	TI max	TI max	TI max
Baseline press. PEEP/CPAP	X	X	X	X	X	X	P low	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Trigger	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X
P-ramp	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Oxygen	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sex	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pat. height	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mode specific	%MinVol	--	--	--	--	--	--	--	--	--	--	--	--	--
	Pass/limit	--	--	--	--	--	--	--	--	--	--	--	--	--
Sigh***	X	X	X	X	X	X	--	--	--	X	X	X	X	--
	X	X	X	X	X	X	APV/simv	APV/simv	APV/simv	APV/simv	PCV+	APV/simv	APV/simv	PCV+
Apnea backup	--	--	--	--	--	--	--	--	--	--	--	--	--	--
	--	--	--	--	--	--	--	--	--	--	--	--	--	--

\* I.E, TI      \*\* Neonatal only      \*\*\* Adult/Ped only      - N/A      X applies to this mode

## 7.2 Volume-targeted modes, adaptive pressure control

The following modes are volume targeted, with adaptive pressure control:

- APVcmv / (S)CMV+
- APVsimv / SIMV+

In this manual, we refer to these modes using the APVcmv / APVsimv nomenclature. You can select the format to use in Configuration (Section 12.4.2).

### NOTICE

- The minimum inspiratory pressure ( $P_{peak} - PEEP$ ) in APVcmv and APVsimv modes is 5 cmH<sub>2</sub>O. Be aware that a small set tidal volume with high lung compliance may lead to higher-than-expected tidal volumes.
- For adaptive modes, such as APVcmv or APVsimv, be sure the Pressure alarm is set appropriately. This alarm provides a safety pressure limit for the device to appropriately adjust the inspiratory pressure necessary to achieve the target tidal volume.

The maximum available inspiratory pressure is 10 cmH<sub>2</sub>O below the high Pressure limit, indicated by a blue line on the pressure waveform display.

If the Pressure limit is set too low, there may not be enough margin for the device to adjust its inspiratory pressure to deliver the target tidal volume.

---



### 7.2.1 APVcmv / (S)CMV+ mode

APVcmv stands for *adaptive pressure ventilation with controlled mandatory ventilation*. This mode is also called (S)CMV+, which stands for *synchronized controlled mandatory ventilation*.

APVcmv is a volume-targeted pressure-controlled ventilation mode. It functions similarly to the conventional volume-controlled mode of ventilation, (S)CMV, except that pressure is the control variable rather than flow. Pressure is adjusted between breaths to achieve the target tidal volume.

The breath can be triggered by the ventilator or by the patient. If the breath is triggered by the patient, the inspiratory rate may increase.

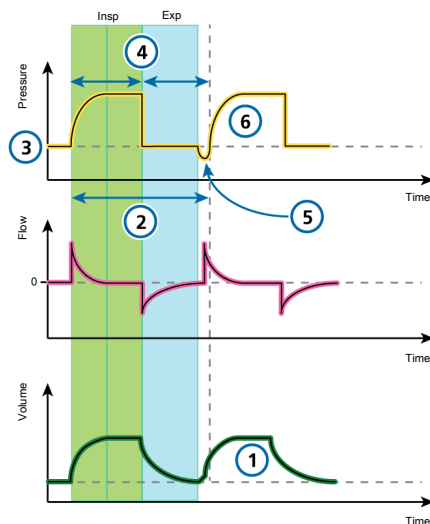
The ventilator uses the high Pressure alarm limit minus 10 cmH<sub>2</sub>O as a safety boundary for its inspiratory pressure adjustment, and does not exceed this value. An exception is sigh breaths, when the ventilator may apply inspiratory pressures 3 cmH<sub>2</sub>O below the high Pressure alarm limit.

Breaths in APVcmv mode are volume-targeted and mandatory, delivered at the lowest possible pressure depending on lung conditions.

The operator sets the target tidal volume (V<sub>t</sub>).

The ventilator delivers the set target volume (V<sub>t</sub>) at a preset rate. The patient can trigger mandatory breaths between preset rate breaths.

Figure 7-2. APVcmv / (S)CMV+: Breathing pattern and controls



#### Ventilator controls

##### CO<sub>2</sub> elimination

- |                  |        |
|------------------|--------|
| 1 V <sub>t</sub> | 2 Rate |
| Sigh (not shown) |        |

##### Oxygenation

- |                    |                     |
|--------------------|---------------------|
| 3 PEEP             | 4 I:E <sup>22</sup> |
| Oxygen (not shown) |                     |

##### Patient synchronization

- |           |          |
|-----------|----------|
| 5 Trigger | 6 P-ramp |
|-----------|----------|

<sup>22</sup> Depending on the selected breath timing philosophy (I:E, TI, or other supported option, if available).

## 7.2.2 APVsimv / SIMV+ mode

APVsimv stands for *adaptive pressure ventilation with synchronized intermittent mandatory ventilation*. This mode is also called SIMV+, *synchronized intermittent mandatory ventilation plus*.

The APVsimv mode combines attributes of the APVcmv and SPONT modes, delivering volume-targeted mandatory breaths or pressure-supported spontaneous (patient-triggered) breaths.

APVsimv mode ensures that the set target volume is delivered during the mandatory breaths.

After the mandatory breath is delivered, the patient is free to take any number of spontaneous breaths for the remainder of the APV breath interval.

The ventilator uses the high **Pressure** limit minus 10 cmH<sub>2</sub>O as a safety boundary for its inspiratory pressure adjustment, and does not exceed this value. An exception is sigh breaths, when the ventilator may apply inspiratory pressures 3 cmH<sub>2</sub>O below the high **Pressure** limit.

Each breath interval includes mandatory time (**Tmand**) and spontaneous time (**Tspont**).

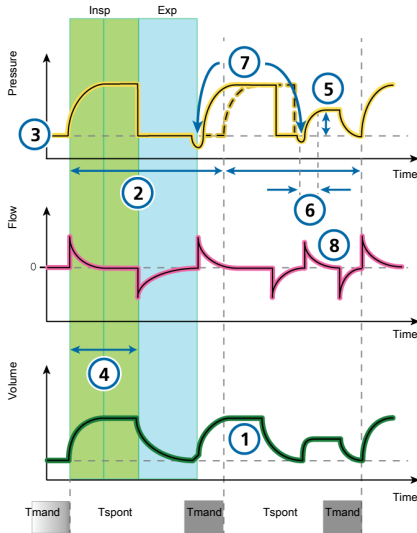
- If the patient triggers a breath during **Tmand**, the ventilator immediately delivers a mandatory breath.
- If the patient triggers a breath during **Tspont**, the ventilator delivers a spontaneous pressure-supported breath.

If the patient does not trigger a breath during **Tspont**, the ventilator automatically delivers a mandatory breath at the end of **Tmand**.

In this mode, parameters for both mandatory and spontaneous breath types are set.

- The tidal volume (**Vt**) setting defines the delivered volume of mandatory breaths.
- **Rate** and **I:E** define the timing of the breath cycle for mandatory breaths.
- For spontaneous breaths, **Psupport** defines the pressure support above PEEP. **ETS** defines the inspiratory timing of the breaths.

Figure 7-3. APVsimv / SIMV+: Breathing pattern and controls



### 7.3 Pressure-controlled modes

The following modes are pressure controlled:

- PCV+
- PSIMV+
- PSIMV+ with PSync
- DuoPAP
- APRV
- SPONT

**Ventilator controls**

**CO2 elimination**

- 1 Vt
- 2 Rate
- Sigh (not shown)

**Oxygenation**

- 3 PEEP
- 5 Psupport
- 4 I:E<sup>23</sup>
- Oxygen (not shown)

**Patient synchronization**

- 6 P-ramp
- 8 ETS
- 7 Trigger

<sup>23</sup> Depending on the selected breath timing philosophy (I:E, TI, or other supported option, if available).

### 7.3.1 PCV+ mode

PCV+ stands for *pressure-controlled ventilation*.

Breaths in PCV+ mode are pressure controlled and mandatory.

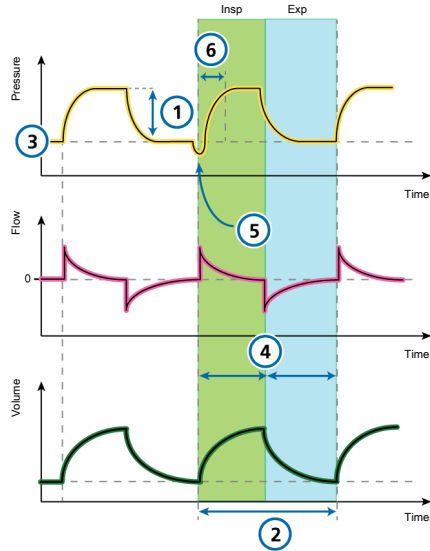
The ventilator delivers a constant level of pressure, so the volume depends on the pressure settings, the inspiration time, and the resistance and compliance of the patient's lungs.

In PCV+ mode, parameters are set only for mandatory breaths.

- The pressure control (Pcontrol) setting defines the applied pressure above PEEP.
- Rate and I:E define the timing of the breath cycle.
- The P-ramp setting controls the speed with which the ventilator arrives at the desired pressure.

This mode is available for use with a speaking valve.

Figure 7-4. PCV+ mode: Breathing pattern and controls



**Ventilator controls**

**CO2 elimination**

- |                  |        |
|------------------|--------|
| 1 Pcontrol       | 2 Rate |
| Sigh (not shown) |        |

**Oxygenation**

- |                    |                     |
|--------------------|---------------------|
| 3 PEEP             | 4 I:E <sup>24</sup> |
| Oxygen (not shown) |                     |

**Patient synchronization**

- |           |          |
|-----------|----------|
| 5 Trigger | 6 P-ramp |
|-----------|----------|

<sup>24</sup> Depending on the selected breath timing philosophy (I:E, TI, or other supported option, if available).

### 7.3.2 PSIMV+ mode

PSIMV+ stands for *pressure-controlled synchronized intermittent mandatory ventilation*.

PSIMV+ mode has two options: with and without PSync. For a description of PSIMV+ with active PSync, see Section 7.3.3.

In PSIMV+ mode, the mandatory breaths are PCV+ breaths. These can be alternated with spontaneous breaths.

Each SIMV breath interval includes mandatory time (T<sub>mand</sub>) and spontaneous time (T<sub>spont</sub>).

- If the patient triggers a breath during T<sub>mand</sub>, the ventilator immediately delivers a mandatory breath.
- If the patient triggers a breath during T<sub>spont</sub>, the ventilator delivers a spontaneous, pressure-supported breath.
- If the patient does not trigger a breath during T<sub>spont</sub>, the ventilator automatically delivers a mandatory breath at the end of T<sub>mand</sub>.

In PSIMV+ mode, parameters for both mandatory and spontaneous breath types are set.

- For mandatory breaths, the pressure control (P<sub>control</sub>) setting defines the applied pressure above PEEP.

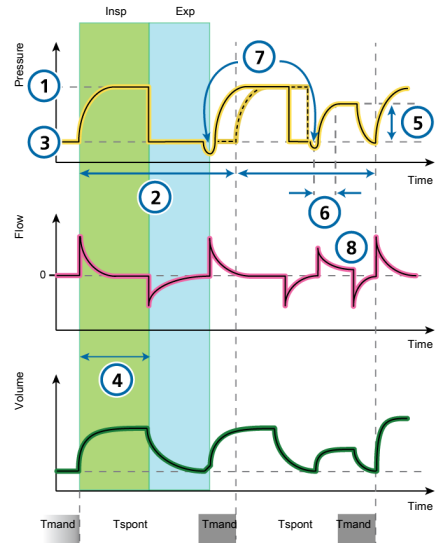
Rate and I:E define the timing of the breath cycle.

- For spontaneous breaths, P<sub>support</sub> defines the pressure support above PEEP.

ETS defines the inspiratory timing of the breaths.

This mode is available for use with a speaking valve.

Figure 7-5. PSIMV+ mode: Breathing pattern and controls



#### Ventilator controls

##### CO<sub>2</sub> elimination

- |            |        |
|------------|--------|
| 1 Pcontrol | 2 Rate |
|------------|--------|

Sigh (not shown)

##### Oxygenation

- |                     |                    |
|---------------------|--------------------|
| 3 PEEP              | 5 Psupport         |
| 4 I:E <sup>25</sup> | Oxygen (not shown) |

##### Patient synchronization

- |           |       |
|-----------|-------|
| 6 P-ramp  | 8 ETS |
| 7 Trigger |       |

<sup>25</sup> Depending on the selected breath timing philosophy (I:E, TI, or other supported option, if available).

### 7.3.3 PSIMV+ mode with PSync

PSIMV+ stands for *pressure-controlled synchronized intermittent mandatory ventilation*.

PSIMV+ mode has two options: with and without PSync. For a description of PSIMV+ without active PSync, see Section 7.3.2.

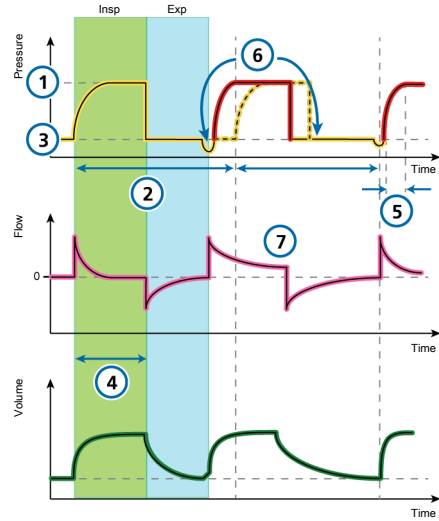
If the patient triggers a breath, the ventilator delivers a breath supported at the P<sub>insp</sub> setting.

If the patient does not trigger a breath, the ventilator automatically delivers a mandatory breath at the P<sub>insp</sub> setting.

In PSIMV+ mode, parameters for both mandatory and spontaneous breath types are set.

- The P<sub>insp</sub> setting defines the applied pressure above PEEP for mandatory and spontaneous breaths.
- Rate and TI define the breath timing for mandatory breaths.
- For spontaneous breaths, ETS defines the inspiratory timing of the breaths.

Figure 7-6. PSIMV+ with PSync mode: Breathing pattern and controls



**Ventilator controls**

**CO2 elimination**

- |                     |        |
|---------------------|--------|
| 1 P <sub>insp</sub> | 2 Rate |
|---------------------|--------|

Sigh (not shown)

**Oxygenation**

- |        |                     |
|--------|---------------------|
| 3 PEEP | 4 I:E <sup>25</sup> |
|--------|---------------------|

Oxygen (not shown)

**Patient synchronization**

- |          |       |
|----------|-------|
| 5 P-ramp | 7 ETS |
|----------|-------|

- |           |
|-----------|
| 6 Trigger |
|-----------|

### 7.3.4 DuoPAP mode

DuoPAP stands for *duo positive airway pressure*.

DuoPAP is a type of pressure ventilation designed to support spontaneous breathing on two alternating levels of CPAP.

In this mode, the ventilator switches automatically and regularly between two operator-selected levels of positive airway pressure or CPAP.

Cycling between the levels is triggered by DuoPAP timing settings or by patient effort.

In DuoPAP, the switch-over between the two levels is defined by the pressure settings, P high and PEEP/CPAP, and the time settings, T high and Rate.

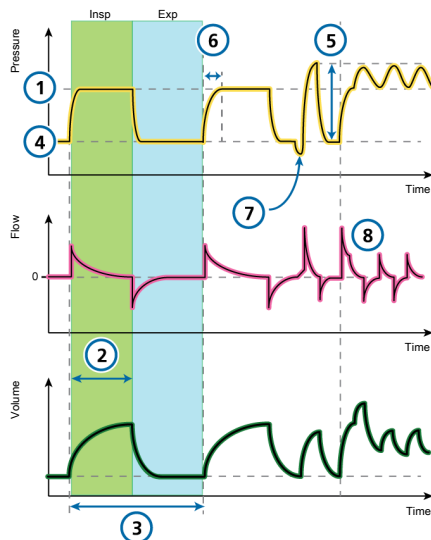
Note the following:

- At conventional settings and in the absence of spontaneous breathing, DuoPAP resembles PCV+.
- As you decrease the rate, keeping T high short relative to the time at the lower pressure level, the mode looks more like PSIMV+, with spontaneous breaths following mandatory breaths.
- If T high is set to almost the breath cycle time with just enough time at the low level to allow full or near-full exhalation, this mode looks like APRV (Section 7.3.5).

Pressure support can be set to assist spontaneous breaths in DuoPAP, whether they occur at the PEEP/CPAP or P high level.

Psupport is set relative to (above) PEEP/CPAP, which means that spontaneous breaths at the P high level are supported only when this target pressure is greater than P high.

Figure 7-7. DuoPAP mode: Breathing pattern and controls



#### Ventilator controls

##### CO2 elimination

- |          |        |
|----------|--------|
| 1 P high | 3 Rate |
| 2 T high |        |

##### Oxygenation

- |                    |            |
|--------------------|------------|
| 4 PEEP/CPAP        | 5 Psupport |
| Oxygen (not shown) |            |

##### Patient synchronization

- |                        |       |
|------------------------|-------|
| 6 P-ramp <sup>26</sup> | 8 ETS |
| 7 Trigger              |       |

<sup>26</sup> Pressure rise time to P high and Psupport.

### 7.3.5 APRV mode

APRV stands for *airway pressure release ventilation*.

Set airway pressure P high is transiently released to a lower level P low, after which it is quickly restored to reinflate the lungs.

For a patient who has no spontaneous breathing efforts, APRV is similar to pressure-controlled inverse ratio ventilation.

APRV allows spontaneous breathing at any time during the respiratory cycle.

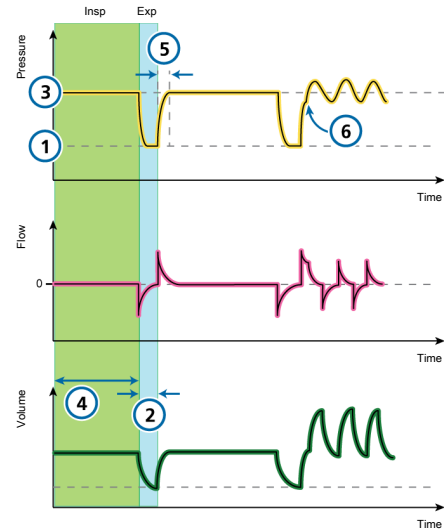
APRV is an independent mode. When changing modes, the pressure and timing settings from any other mode are not transferred to APRV, and vice versa.

When switching to APRV for the first time, the initial timing and pressure settings proposed are based on IBW (Weight for neonatal patients) as shown in the following table.

Table 7-2. Default settings for APRV

IBW / Weight (kg)	P high / P low (cmH2O)	T high (s)	T low (s)
0.2 to 2.99	20 / 5	1.4	0.2
3 to 5.9	20 / 5	1.7	0.3
6 to 8.9	20 / 5	2.1	0.3
9 to 20.9	20 / 5	2.6	0.4
21 to 39	20 / 5	3.5	0.5
40 to 59	20 / 5	4.4	0.6
60 to 89	20 / 5	5.4	0.6
90 to 99	20 / 5	5.4	0.6
> 100	20 / 5	5.4	0.6

Figure 7-8. APRV mode: Breathing pattern and controls



#### Ventilator controls

##### CO2 elimination

- 1 P low
- 2 T low

##### Oxygenation

- 3 P high<sup>27</sup>
- 4 T high

Oxygen (*not shown*)

##### Patient synchronization

- 5 P-ramp (to P high)
- 6 Trigger

<sup>27</sup> With prolonged T high settings and short T low settings, the P high setting in effect becomes the PEEP level.



### 7.3.6 SPONT mode

SPONT stands for *spontaneous mode*.

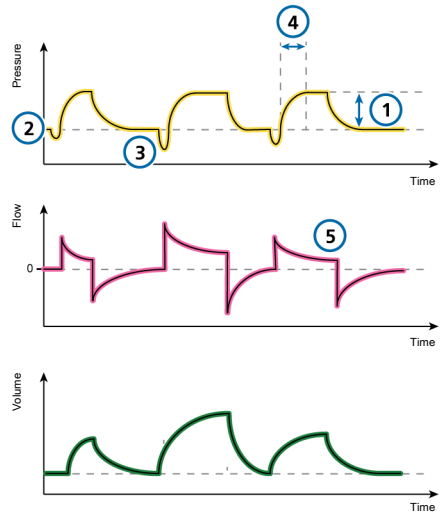
SPONT delivers spontaneous breaths and operator-initiated manual, mandatory breaths.

When pressure support is set to zero, the ventilator functions like a conventional CPAP system.

- The pressure support (**Psupport**) setting defines the applied pressure during inspiration.
- ETS defines the inspiratory timing of the breaths.
- The PEEP setting defines the PEEP applied during expiration.

This mode is available for use with a speaking valve.

Figure 7-9. SPONT mode: Breathing pattern and controls



**Ventilator controls**

**CO2 elimination**

1 Psupport                      Sigh (*not shown*)

**Oxygenation**

2 PEEP                              Oxygen (*not shown*)

**Patient synchronization**

3 Trigger                      5 ETS

4 P-ramp

## 7.4 Intelligent Ventilation

ASV™ is a volume-controlled Intelligent Ventilation mode.

ASV is *not* available for neonatal patients.

### 7.4.1 ASV mode

ASV stands for *Adaptive Support Ventilation*®.

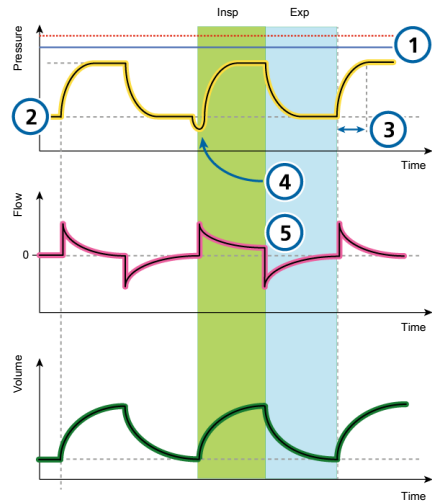
ASV maintains an operator-preset, minimum minute ventilation independent of the patient’s breathing activity.

The target breathing pattern (tidal volume and inspiratory rate) is calculated by the ventilator, based on the assumption that the optimal breath pattern results in the least work of breathing, and the minimal force of breathing also results in the least amount of ventilator-applied inspiratory pressure when there is no patient breathing effort. For initial settings, see Table 7-3.

ASV adjusts inspiratory pressure and machine rate on a breath-by-breath basis taking into account the changing patient condition (resistance, compliance,  $RC_{exp}$ ) and applying lung-protective strategies to meet the targets.

A decrease in pressure limitation will follow with a decrease in tidal volume ( $V_t$ ) and an increase in Rate.

Figure 7-10. ASV mode: Breathing pattern and controls



#### Ventilator controls

##### CO2 elimination

- 1 P<sub>asv</sub>limit                      Sigh (*not shown*)
- %MinVol (*not shown*)

##### Oxygenation

- 2 PEEP/CPAP                      Oxygen (*not shown*)

##### Patient synchronization

- 3 P-ramp                              5 ETS
- 4 Trigger

ASV maintains a **preset minimum minute ventilation**:

- Automatically and smoothly adjusts for changing patient conditions between active and passive states
- Mandatory breaths are pressure controlled
- Spontaneous breaths are pressure supported
- Prevents tachypnea

- Prevents AutoPEEP
- Prevents dead space ventilation
- Does not exceed a P<sub>insp</sub> pressure of **10 cmH<sub>2</sub>O below the upper pressure limit**

The operator sets the %MinVol, PEEP, and Oxygen.

For details about working with ASV, see Section 7.8.

Table 7-3. Initial breath pattern settings

Patient group	IBW (kg)	P <sub>insp</sub> (cmH <sub>2</sub> O)	TI (s)	Initial rate (b/min)
Pediatric	3 to 5	15	0.4	30
	6 to 8	15	0.6	25
	9 to 11	15	0.6	20
	12 to 14	15	0.7	20
	15 to 20	15	0.8	20
	21 to 23	15	0.9	15
	24 to 29	15	1	15
	> 30	15	1	15
Adult	30 to 39	15	1	14
	40 to 59	15	1	12
	60 to 89	15	1	10
	90 to 99	18	1.5	10
	> 100	20	1.5	10

## 7.4.1.1 ASV and ASV 1.1

ASV 1.1 is the default setting for the ASV mode. The previous version of ASV is also available on the device, and can be selected in **Configuration**.

ASV 1.1 extends the use of ASV with the following additional features and changes:

- Increased target rate and reduced tidal volumes for the majority of patients compared to standard ASV.
- In cases of high time constants and high minute volumes,  $V_t$  max is limited to 15 ml/kg.

For details about working with ASV, see Section 7.8.

## 7.5 Noninvasive modes

The following modes are noninvasive:

- NIV
- NIV-ST
- nCPAP
- nCPAP-PC

The NIV and NIV-ST modes are implementations of noninvasive positive pressure ventilation (NPPV).

nCPAP and nCPAP-PC are neonatal modes that offer nasal continuous positive airway pressure - and intermittent positive pressure support through a nasal interface (mask or prongs) for infants and neonates.

For details about working with noninvasive modes, see Section 7.7.

### 7.5.1 NIV mode

NIV stands for *noninvasive ventilation*.

NIV mode delivers spontaneous breaths.

NIV is designed for use with a mask or other noninvasive patient interface.

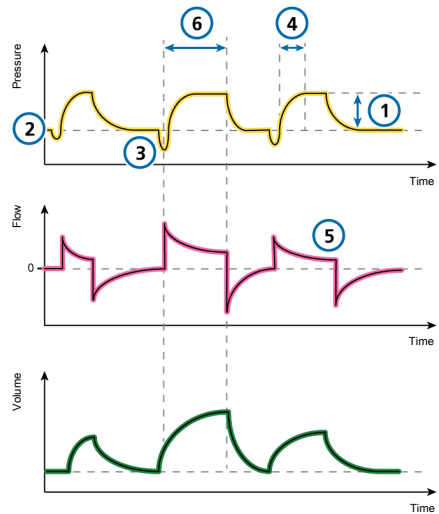
When pressure support is set to zero, the ventilator functions like a conventional CPAP system.

- The pressure support ( $P_{support}$ ) setting defines the applied pressure during inspiration.
- ETS defines the inspiratory timing of the breaths.  
If the ventilator does not detect an expiratory trigger (for example, due to a leak), inspiratory time is limited by TI max.

- The PEEP setting defines the PEEP applied during expiration.

For additional details about working with noninvasive modes, see Section 7.7.

Figure 7-11. NIV mode: Breathing pattern and controls



**Ventilator controls**

**CO2 elimination**

- 1  $P_{support}$  Sigh (*not shown*)

**Oxygenation**

- 2 PEEP Oxygen (*not shown*)

**Patient synchronization**

- 3 Trigger 5 ETS  
4 P-ramp 6 TI max

### 7.5.2 NIV-ST mode

NIV-ST stands for *spontaneous/timed noninvasive ventilation*.

NIV-ST mode delivers time-cycled or flow-cycled breaths. Every patient trigger results in a flow-cycled, pressure-supported breath.

If the rate of patient-triggered breaths falls below the set mandatory Rate, time-cycled breaths are delivered at the set Rate and timing.

If the patient triggers a breath during the breath interval *timv*, the ventilator immediately delivers a spontaneous breath. If the patient does not trigger an inspiration during this time, the ventilator initiates a mandatory breath at the end of *timv*.

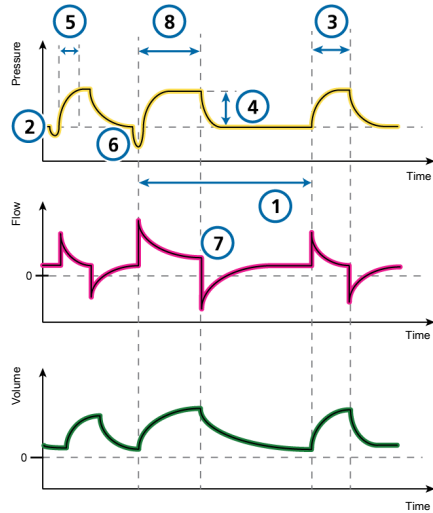
When pressure support is set to zero, the ventilator functions like a conventional CPAP system.

This mode requires that you set the parameters needed for both mandatory and spontaneous breath types.

- The inspiratory pressure setting, *P<sub>insp</sub>*, defines the applied pressure for both mandatory and spontaneous breaths.
- The **Rate** and **TI** (inspiratory time) control settings define the breath timing.
- For spontaneous breaths, the **ETS** setting defines the percentage of peak flow that cycles the device into exhalation.

If the ventilator does not detect an expiratory trigger (for example, due to a leak), inspiratory time is limited by **TI max**.

Figure 7-12. NIV-ST mode: Breathing pattern and controls



**Ventilator controls**

**CO2 elimination**

- |   |      |                           |
|---|------|---------------------------|
| 1 | Rate | Sigh ( <i>not shown</i> ) |
|---|------|---------------------------|

**Oxygenation**

- |   |      |   |    |
|---|------|---|----|
| 2 | PEEP | 3 | TI |
|---|------|---|----|

Oxygen (*not shown*)

**Patient synchronization**

- |   |                         |   |        |
|---|-------------------------|---|--------|
| 4 | <i>P<sub>insp</sub></i> | 7 | ETS    |
| 5 | P-ramp                  | 8 | TI max |
| 6 | Trigger                 |   |        |

### 7.5.3 The nCPAP modes

#### CAUTION

*Be sure to set the Flow alarm limit to an appropriate level above the current monitored peak flow to avoid potential gastric overinflation, and to be able to detect leaks and disconnection of the patient interface.*

nCPAP stands for *nasal continuous positive airway pressure*.

The HAMILTON-T1 offers two nCPAP modes: nCPAP and nCPAP-PC, described in detail in the following sections.

#### About the Flow and Insp Flow parameters

In these modes, the Flow and Insp Flow parameters monitor average and peak flow, respectively, as described in the following table.

Table 7-4. Flow parameters in nCPAP modes

Parameter (unit)	nCPAP mode	nCPAP-PC mode
Flow (l/min)	Average flow, updated every second.	Average flow during expiration, updated each breath.
	Displayed in the Monitoring window.	
Insp Flow (l/min)	Peak flow during inspiration, measured every second.	Insp Flow is a main monitoring parameter (MMP) and is always displayed.

#### About the High Flow alarm

In both modes, the High Flow alarm monitors the inspiratory flow and can help to detect disconnection of the patient interface. When the flow exceeds the set limit, the High Flow alarm is generated and the system reduces the delivered flow. As a result, the delivered pressure may also be reduced.

To minimize the incidence of this alarm, observe the Insp Flow values and set the flow limit to a value above the average Insp Flow reading plus a known minimum leakage.

### 7.5.3.1 nCPAP mode

nCPAP stands for *nasal continuous positive airway pressure*.

This mode applies CPAP over a nasal interface (mask or prongs). Leaks are compensated due to the set **High Flow** limit.

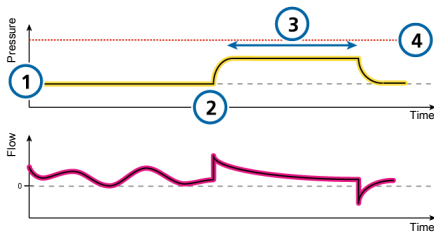
The nCPAP mode works with the following parameters:

- Control settings: PEEP/CPAP and Oxygen
- Monitored parameters: Insp Flow and Flow

For details about the parameters and flow-related alarms, see Sections 7.5.3, 5.9, and 9.4.

When a manual breath is applied, the pressure changes to PEEP + 5 cmH<sub>2</sub>O for a period of 0.4 seconds, or so long as the key is pressed, to a maximum of 15 seconds. When the manual breath is completed, the pressure returns to the set PEEP/CPAP level.

Figure 7-13. nCPAP mode: Breath pattern and controls



- |                 |                             |
|-----------------|-----------------------------|
| 1 PEEP          | 3 Manual breath key pressed |
| 2 Manual breath | 4 Pressure limitation       |
|                 | Oxygen ( <i>not shown</i> ) |

### 7.5.3.2 nCPAP-PC mode

nCPAP-PC stands for nasal continuous positive airway pressure - pressure control.

This mode delivers, in addition to the set CPAP, intermittent, time-cycled, and pressure-controlled breaths. This results in a biphasic breathing pattern.

The patient can also breathe freely at both pressure levels. The inspiratory flow follows the respiratory effort of the patient on both pressure levels. Leaks are compensated due to the set **High Flow** limit.

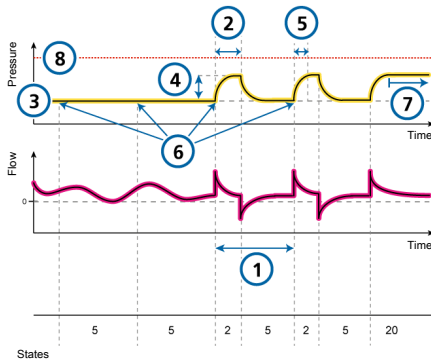
The following parameters are used in the nCPAP-PC mode: Rate, Pcontrol, TI, P-ramp, PEEP/CPAP, Oxygen

When a manual breath is applied, the pressure changes to the Pcontrol setting for the length of time set by the TI (inspiratory time) or so long as the key is pressed, to a maximum of 15 seconds. When the manual breath is completed, the pressure returns to the set PEEP/CPAP level.

For details about the parameters, see Section 5.9.



Figure 7-14. nCPAP-PC mode: Breathing pattern and controls



- |            |                             |
|------------|-----------------------------|
| 1 Rate     | 5 P-ramp                    |
| 2 TI       | 6 Mandatory trigger         |
| 3 PEEP     | 7 Manual breath key pressed |
| 4 Pcontrol | 8 Pressure limitation       |

## 7.6 Special conditions

If the ventilator encounters certain error conditions, it may switch to **Safety ventilation** or other special state until the situation is resolved.

### 7.6.1 Safety ventilation

In the event of certain technical failures, the ventilator switches to **Safety ventilation**. This gives you time to arrange for corrective actions, including organizing a replacement ventilator.

The following conditions apply to ventilation in **Safety ventilation**:

- The ventilator does not monitor patient inputs in **Safety ventilation**.
- The blower runs constantly to create inspiratory pressure (P<sub>insp</sub>) (Table 7-5). If the ventilator switches to **Safety ventilation** during HiFlowO<sub>2</sub>, the blower creates a constant pressure of 5 cmH<sub>2</sub>O at the inspiratory port.
- The expiratory valve switches system pressure levels between PEEP and inspiratory pressure.
- You must turn off ventilator power to exit **Safety ventilation**.

Table 7-5. Safety ventilation settings (Adult/Ped)

IBW (kg)	P <sub>insp</sub> (cmH <sub>2</sub> O)	Rate (b/min)	Oxygen (%)
3 to 5.9	15	30	> 21%
6 to 8.9	15	25	> 21%
9 to 20.9	15	20	> 21%
21 to 29	15	15	> 21%
30 to 39	15	14	> 21%
40 to 59	15	12	> 21%
60 to 89	15	10	> 21%
90 to 99	18	10	> 21%
≥ 100	20	10	> 21%

PEEP is set to the PEEP of the previous mode and the I:E ratio is 1:4.

Table 7-6. Safety ventilation settings (Neonatal)

Weight (kg)	P <sub>insp</sub> (cmH <sub>2</sub> O)	Rate (b/min)	Oxygen (%)
< 1.26	15	60	> 21%
1.26 to 3.0	15	45	> 21%
3.1 to 6.0	15	35	> 21%
6.1 to 9.0	15	30	> 21%
9.1 to 21	15	25	> 21%
> 21	15	20	> 21%

PEEP is set to the PEEP of the previous mode and the I:E ratio is 1:3.

### 7.6.2 Ambient state

If the technical fault alarm is serious enough to possibly compromise safe ventilation, the ventilator enters the **Ambient** state.

The following conditions apply to ventilation in the **Ambient** state:

- The inspiratory channel and expiratory valves are opened, letting the patient breathe room air unassisted.
- Provide alternative ventilation immediately.
- You must turn off ventilator power to exit the **Ambient** state.

## 7.7 Working with noninvasive modes

This section provides an overview of noninvasive ventilation requirements, contraindications for use, and important information about settings and alarms.

When using noninvasive positive pressure ventilation (NPPV), you can use a mask, mouthpiece, or helmet-type patient interface rather than an invasive conduit, such as an endotracheal tube.

### 7.7.1 Required conditions for use

*Before proceeding, review the safety information in Chapter 1.*

The following requirements **must be met** to use noninvasive ventilation:

- The patient must be able to trigger the ventilator and must have regular spontaneous breaths.

Noninvasive ventilation is intended to provide supplemental ventilatory support to patients with regular spontaneous breaths.

- The patient must be conscious.
- The patient must be able to maintain an adequate airway.
- Intubation must be possible at any time.
- The mask or interface is a good fit.

## 7.7.2 Contraindications

### CAUTION

- *If you place an additional component, such as an HMEF, between the flow sensor and the patient, the additional resistance limits the ventilator's ability to identify disconnection at the patient.  
To correctly identify a patient disconnection, be sure to appropriately set the lower limit of the Pressure alarm, as well as the Volume alarm limits, and carefully monitor the patient's SpO2 and, if available, PetCO2 values.*
- *To prevent possible patient injury, do NOT use noninvasive ventilation on patients with no or irregular spontaneous breaths. Noninvasive ventilation is intended to provide supplemental ventilatory support to patients with regular spontaneous breaths.*
- *To prevent possible patient injury, do NOT attempt to use noninvasive ventilation on intubated patients.*

Using noninvasive ventilation is contraindicated if **any** of the following conditions are met:

- The patient does not have the drive to breathe
- Partial or complete airway obstruction
- Gastrointestinal bleeding
- Anatomic or subjective intolerance of NIV interface
- Patient is unable to cooperate or protect airway

## 7.7.3 Potential adverse reactions

The following reactions to noninvasive ventilation are possible:

- Aspiration, gastric insufflation
- Increase of intracranial pressure (ICP)
- Decrease of arterial pressure
- CO2 rebreathing
- Claustrophobia
- Discomfort
- Dyssynchrony
- Skin or conjunctiva lesions

## 7.7.4 Control settings in noninvasive ventilation

### WARNING

- The exhaled volume from the patient can differ from the measured exhaled volume due to leaks around the mask.
- Peak pressures exceeding 33 cmH2O may increase the risk of aspiration due to gastric insufflation. When ventilating with such pressures, consider using an invasive mode.

When a significant leak occurs, the inspiratory flow can never fall below ETS, thereby preventing the ventilator from cycling into exhalation and resulting in endless inspiration. The TI max setting provides an alternate way to cycle into exhalation. When inspiration lasts longer than TI max, the ventilator cycles into exhalation.

Ensure the **TI max** setting is sufficiently long to give **ETS** the chance to cycle the ventilator.

- Adjusting the **TI max** setting increases or decreases the allowable inspiratory time.
- Increasing **ETS** above the default 25% allows the ventilator to cycle to terminate inspiration at a higher flow, to accommodate larger leaks.

Other controls require special attention:

- Carefully observe the patient/ventilator interaction.
- Adjust **Psupport** or **Pinsp** to obtain appropriate tidal volumes.
- The leakage in noninvasive modes can reduce the actual applied **PEEP** and give rise to autotriggering.
- Adjust **PEEP** further, considering oxygenation and **AutoPEEP**.

### 7.7.5 Alarms in noninvasive ventilation

Due to the changing and unpredictable amount of leakage, volume alarms are less meaningful in noninvasive modes than in other modes. Alarms are based on the returned expiratory gas volume measured at the flow sensor; this value can be significantly lower than the delivered tidal volume, because the delivered tidal volume is the sum of the displayed **VTE** and the leakage volume.

To avoid nuisance volume alarms, set the low **Vt** and **ExpMinVol** alarms to a low level.

Because the noninvasive modes are pressure modes, however, do pay attention to the pressure-related alarms. If the defined

**PEEP** and inspiratory pressure can be maintained, the ventilator is compensating the gas leak sufficiently.

### 7.7.6 Monitored parameters in noninvasive ventilation

#### NOTICE

- The following numeric monitoring parameters *cannot* be used for reliable analysis of patient conditions: **ExpMinVol**, **RCexp**, **Rinsp**, **Insp Flow**, **AutoPEEP**, and **Cstat**.
- Continuous monitoring of clinical parameters and patient comfort is critically important.
- The parameters **VTE NIV**, **MinVol NIV**, **MVSpont NIV**, and **MVLeak** are leak compensated, and are used in noninvasive modes. These parameters are estimations and may not reflect exact values.

Due to the leakage at the patient interface, displayed exhaled volumes in the noninvasive modes can be substantially smaller than the delivered volumes.

The flow sensor measures the delivered volume and the exhaled tidal volume; the ventilator displays the difference as **VLeak** in percent (%), and as **MVLeak** in l/min. Use **VLeak** and **MVLeak** to assess the fit of the mask or other noninvasive patient interface.

While a leak at the patient interface influences the tidal volume measurement, leaks in the breathing circuit itself do not influence the tidal volume measurement.

In addition to other clinical parameters, **TI**, **Ppeak**, **PEEP/CPAP**, **I:E**, **fTotal**, **Pmean**, and **fSpont** can be used to assess the patient's ventilatory status.

### 7.7.7 Additional notes about using noninvasive ventilation

Due to some unique characteristics, consider the following points when using noninvasive ventilation.

#### IntelliTrig (intelligent trigger) function

To synchronize, IntelliTrig compensates for leaks and resistance between the ventilator and the patient, and with each breath, it measures the leakage at the patient interface (mask).

With this information, IntelliTrig adjusts the trigger mechanism, reducing the influence of leakage and the changing breath pattern on the operator-set trigger sensitivity.

#### Maintaining PEEP and preventing auto-triggering

Significant leakage can be present in noninvasive ventilation, which can serve to reduce the actual applied PEEP/CPAP and give rise to autotriggering. If you cannot reach the set PEEP/CPAP, check the mask fit.

The Loss of PEEP alarm alerts you to uncompensated leaks (that is, when the measured PEEP/CPAP is 3 cmH<sub>2</sub>O lower than the set PEEP/CPAP).

#### Inspect mask fit and position

Inspect the mask position regularly and adjust as necessary. React promptly and appropriately to any alarms.

The ventilator's VLeak parameter provides one indicator of mask fit.

To verify that the mask fits properly, ensure that the leakage value shown in the Monitoring window (VLeak, MVLeak) is acceptable.

To monitor leakage during ventilation, set the low limit of the Pressure alarm to a value near the set pressure for ventilation (PEEP/CPAP + P<sub>insp</sub>/P<sub>support</sub>). When excessive leaks are present, the ventilator may not be able to reach the set pressure, and generates an alarm.

## 7.8 Working with ASV

### To set up the ventilator using ASV

1. Touch **Modes**.
2. Touch **ASV**, then touch **Confirm**.
3. Set the controls as appropriate:
  - %MinVol: Set a value that results in the same minute volume as a previous mode, if applicable.
  - PEEP, Oxygen, Trigger, ETS, P-ramp: Set according to clinical requirements and the patient condition.
4. Review and adjust alarm limits.
  - Set the high Pressure alarm limit to an appropriate value.
  - The maximum peak pressure delivered in ASV (Pasvlimit) is 10 cmH<sub>2</sub>O below the high Pressure alarm limit or equal to the upper Pasvlimit setting.
  - The maximum peak pressure for ASV can be also set using the Pasvlimit control in the Controls window.
  - Changing the Pasvlimit value also changes the high Pressure limit.
5. Connect the patient to the ventilator and start ventilation.

The ventilator initiates three test breaths.

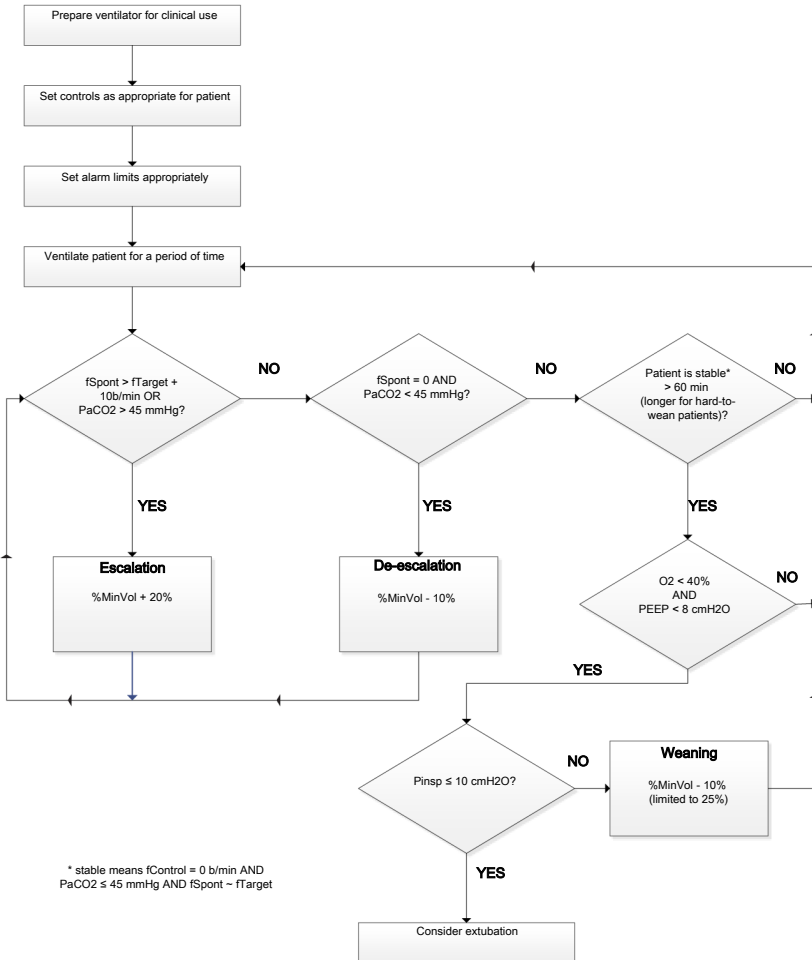
The device automatically selects the values for respiratory rate (f<sub>Total</sub>), inspiratory time (TI), and inspiratory pressure (P<sub>insp</sub>) based on the calculated IBW and as specified in Table 7-3.

### 7.8.1 Clinical workflow with ASV

Figure 7-15 provides an overview of the ASV clinical workflow.

For technical specifications, see Section 14.9.

Figure 7-15. Clinical use of ASV



## 7.8.2 Maintaining adequate ventilation

### WARNING

To change the minute volume setting, always use the %MinVol control. Do *not* manipulate the patient height setting to achieve the desired IBW to control minute volume.

Once ASV is started, the ventilator calculates an optimal breath pattern and associated target values for tidal volume and rate according to the rules in ASV and the set %MinVol to achieve the targets. Depending on whether the patient is passive or actively breathing, the ventilator delivers pressure-controlled or pressure-supported breaths in compliance with a lung-protective strategy. For details, see Section 7.8.6.4.

Once the calculated targets are reached, the result of the ventilation needs to be assessed. All monitored parameters can be used for this purpose.

However, to assess respiratory acid-base status, it is recommended that arterial blood gases be measured and minute ventilation be adjusted accordingly.

Table 7-7 provides examples of how to adjust the %MinVol setting.

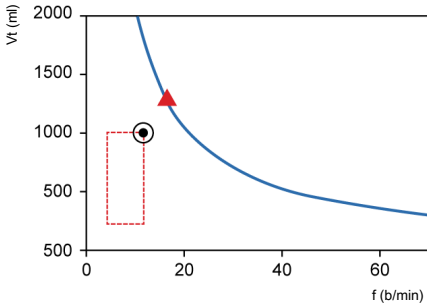
Table 7-7. Blood gas and patient conditions and possible adjustments for ASV

Condition	%MinVol change
Normal arterial blood gases	None
High PetCO <sub>2</sub> or PaCO <sub>2</sub>	Increase %MinVol Pay attention to inspiratory pressures
Low PaCO <sub>2</sub>	Decrease %MinVol Pay attention to mean pressures and oxygenation status
High respiratory drive	Consider increase in %MinVol Consider sedation, analgesia, or other treatments
Low O <sub>2</sub> saturation	None Consider increase in PEEP/CPAP and/or Oxygen

## 7.8.3 Reviewing alarm settings

It is *not* possible to select a %MinVol that is incompatible with the lung-protective rules that govern ASV (for a detailed description, see Section 7.8.6.4). As a consequence, ASV tries to achieve the maximum possible ventilation and activates the ASV: Cannot meet target alarm.

Figure 7-16. Example of high %MinVol setting incompatible with the lung-protective rules strategy



### 7.8.4 Monitoring ASV

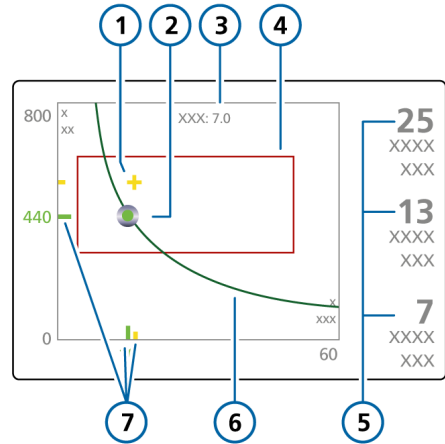
ASV interacts with the patient continuously. Whenever the patient's respiratory mechanics change, ASV adjusts to this change. Whenever the patient's breathing activity changes, ASV adjusts the settings.

The ASV graph, shown in Figure 7-17, provides a real-time graphical view of the patient status relative to the set target. For details about the graph, see Section 8.4.3.

For details on displaying the ASV graph and ASV monitoring values, see Section 8.4.

To monitor progress over time, it is recommended that you plot trends for  $P_{insp}$ ,  $f_{Total}$ , and  $f_{Spont}$ . Review these trends, together with the %MinVol setting to gain insight into the patient's ventilatory status. Table 7-8 provides interpretations of typical ventilatory patterns.

Figure 7-17. ASV Graph panel



- |  |  |
|--|--|
| <p>1 Current measured point: Intersection of measured tidal volume and rate</p> <p>2 Target point: Intersection of target tidal volume and target rate</p> <p>3 Target minute volume</p> <p>4 Safety frame</p> | <p>5 <math>P_{insp}</math>: Inspiratory pressure set by ventilator<br/>fControl: Machine rate<br/>fSpont: Spontaneous breath rate</p> <p>6 Minute volume curve</p> <p>7 Current measured point (in yellow) and target value (in green)</p> |
|--|--|



### 7.8.5 Weaning

Weaning patients from the ventilator is a clinical task that requires experience and involves more than just ventilation issues. This section does not intend to provide clinical information other than that needed to operate the ventilator with ASV.

ASV always allows patients to take spontaneous breaths. Episodes of spontaneous breathing can occur and are supported by ASV even within a period of fully controlled ventilation. In other words, weaning can start with ASV so early that it may go unrecognized clinically. It is therefore important to monitor the spontaneous efforts of the patient over time.

The weaning progress can be monitored in the trends display when inspiratory pressure (**P<sub>insp</sub>**), total rate (**f<sub>Total</sub>**), and spontaneous rate (**f<sub>Spont</sub>**) are plotted.

It may be necessary to reduce the **%MinVol** setting to 70% or even lower to “motivate” the patient to resume spontaneous breathing. If a patient can sustain minutes or even hours with a low **%MinVol** setting, it does not mean that weaning is complete. In fact, the **%MinVol** setting must always be interpreted in conjunction with the level of **P<sub>insp</sub>** needed to achieve the set minute ventilation. Only if **P<sub>insp</sub>** and **f<sub>Control</sub>** are at their minimum values can weaning be assumed to be complete.

Table 7-8. Interpretation of breathing pattern at lower than 100 %MinVol setting

<b>P<sub>insp</sub></b>	<b>f<sub>Control</sub></b>	<b>f<sub>Spont</sub></b>	<b>Interpretation</b>
> 10	> 10	0	<i>Danger of hypoventilation.</i> Check arterial blood gases and consider increasing <b>%MinVol</b> .
> 10	0	Acceptable	<i>Enforced weaning pattern.</i> Check arterial blood gases and patient respiratory effort. Consider decreasing or increasing <b>%MinVol</b> accordingly.
< 8	0	Acceptable	<i>Unsupported breathing.</i> Consider extubation.
> 10	0	High	<i>Dyspnea.</i> Consider increasing <b>%MinVol</b> and other clinical treatments. Check for autotriggering.

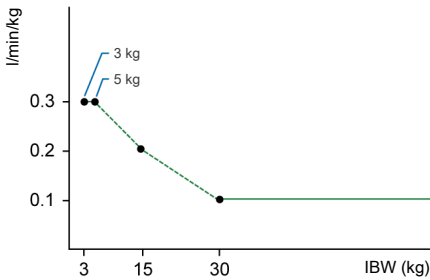
## 7.8.6 Functional overview

The following sections provide a brief overview of how ASV manages ventilation.

### 7.8.6.1 Normal minute ventilation

ASV defines **normal** minute ventilation according to the graph in Figure 7-18.

Figure 7-18. Normal minute ventilation as a function of ideal body weight (IBW)



For patients with an IBW of 30 kg or more, minute ventilation is calculated as  $0.1 \text{ l/kg} * \text{IBW}$  (solid line).

For patients with an IBW below 30 kg, the value is indicated by the dotted line in the previous figure.

Minute ventilation for a 15 kg patient is calculated as

$$0.2 \text{ l/kg} * 15 \text{ kg} = 3 \text{ l/min}$$

For example, for an IBW of 70 kg, **normal** minute ventilation corresponds to 7 l/min.

### 7.8.6.2 Compensation for changes in apparatus dead space

Dead space is calculated as 2.2 ml per kg. This dead space is a nominal value that is valid, on average, for intubated patients whose endotracheal tube is connected to the Y-piece of the ventilator by a standard catheter mount.

Changes in alveolar dead space due to ventilation/perfusion mismatch must be compensated using the %MinVol control.

If this dead space is altered by an artificial airway configuration, such as the use of a heat and moisture exchanging filter (HMEF) or nonstandard tubing, modify the %MinVol setting to take into account the added or removed dead space.

### 7.8.6.3 Targeted minute ventilation

When you choose ASV, you must select an appropriate minute ventilation for the patient. Minute ventilation is set with the %MinVol control, which, together with the patient height, determines the total minute ventilation in liters per minute (l/min).

A %MinVol setting of 100% corresponds to **normal** minute ventilation (Section 7.8.6.1). A setting below or above 100% corresponds to minute ventilation lower or higher than normal.

From the %MinVol, the target minute ventilation (in l/min) is calculated as:

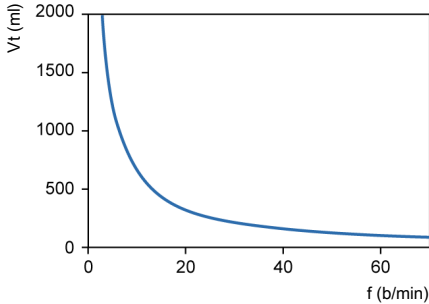
$$\text{Ideal body weight (in kg)} \times \text{NormMinVent (in l/kg/min)} \times (\% \text{MinVol}/100)$$

where **NormMinVent** is the **normal** minute ventilation. See Figure 7-18.

For example, with a %MinVol = 100 and an IBW = 70 kg, a target MinVol of 7 l/min is calculated. This target can be achieved

with a number of combinations of tidal volume ( $V_t$ ) and respiratory rate ( $f$ ). This is shown in Figure 7-19, where all possible combinations of  $V_t$  and  $f$  lie on the bold line, the target minute volume curve.

Figure 7-19. MinVol = 7 l/min



#### 7.8.6.4 Lung-protective strategy

Not all combinations of  $V_t$  and  $f$  shown in Figure 7-19 are safe for the patient. The high tidal volumes will overdistend the lungs, and the small tidal volumes cannot produce alveolar ventilation at all.

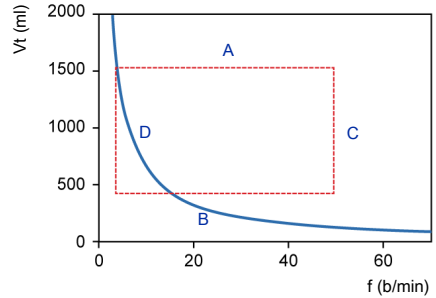
Another risk lies in inadequate respiratory rates. High rates can lead to dynamic hyperinflation or breath stacking, and thus inadvertent PEEP. Low rates can lead to hypoventilation and apnea. Therefore, it is necessary to limit the number of possible combinations of  $V_t$  and  $f$ .

When limits are imposed on the possible combinations of  $V_t$  and  $f$ , ASV uses a double strategy:

- The operator input for ASV determines the absolute boundaries.
- Internal calculations based on patient measurements further narrow the limits to counteract possible operator errors and to follow changes of respiratory system mechanics.

The effect of the strategy is shown in Figure 7-20 and explained in the subsequent sections.

Figure 7-20. Lung-protective rules strategy



#### A: High tidal volume limit

The tidal volume applied by ASV is limited (see A in Figure 7-20) by three operator settings: high Pressure alarm limit, high  $V_t$  alarm limit, and patient height.

Note the following:

- You must set the high Pressure limit before connecting a patient to the ventilator. The maximum pressure applied in the ASV mode is 10 cmH<sub>2</sub>O below the high Pressure alarm limit.
- Additionally, the target volume is limited to 150% of the high  $V_t$  alarm limit, and pressure support is limited such that the inspired volume does not exceed the high  $V_t$  alarm limit in mechanical breaths for more than a few breaths.
- If you set the Pressure alarm limit to a very high pressure, say 60 cmH<sub>2</sub>O, the target volume is limited by the second criterion: 15 ml/kg.
- Check the  $V_t$  high setting to make sure the target minute ventilation can be reached in passive patients.

**B: Low tidal volume limit**

You must use caution with low tidal volumes to avoid insufficient alveolar ventilation.

The determining parameter for alveolar ventilation is dead space ( $VD_{aw}$ ). Tidal volume value must always be greater than the  $VD_{aw}$  value. It is widely accepted that a first approximation of dead space can be obtained by the following simple equation (Radford 1954):

$$VD_{aw} = 2.2 * IBW$$

ASV calculates the lower limit for tidal volume based on the following equation:  $IBW * 4.4 \text{ ml/kg}$ . The multiplying factor is calculated to be at least twice the dead space.

**C: High rate limit**

You derive the maximum rate (C in Figure 7-20) from the operator-set %MinVol and the calculated IBW, which is calculated from the operator-set patient height (Pat. height). The equation used to calculate the maximum rate is:

$$f_{max} = \text{target MinVol} / \text{minimum } V_t$$

However, if you choose an excessively high %MinVol of 350%, the maximum rate becomes 77 b/min. To protect the patient against such high rates, ASV employs a further safety mechanism, which takes into account the patient's ability to exhale.

A measure of the ability to exhale is the expiratory time constant ( $RC_{exp}$ ). To achieve a nearly complete exhalation to the equilibrium point of the respiratory system (90% of the maximum potential volume change), an expiratory time of at least  $2 * RC_{exp}$  is theoretically required.

For this reason, ASV calculates the maximum rate based on the principle of giving a minimum inspiratory time equal to  $1 * RC_{exp}$  and a minimum expiratory time equal to  $2 * RC_{exp}$ , which results in these equations:

$$f_{max} = 60 / (3 * RC_{exp}) = 20 / RC_{exp}$$

$$f_{max} \leq 60 \text{ b/min}$$

This limit applies to the respiratory rate of the ventilator only, *not* to the respiratory rate of the patient.

**D: Low rate limit**

The lowest target rate (see D in Figure 7-20) is predefined according to the IBW. See Table 7-3.

**7.8.6.5 Optimal breath pattern**

Although the lung-protective rules strategy limits possible combinations of  $V_t$  and  $f$ , ASV prescribes an explicit target combination. Using the example in Figure 7-20, this shows considerable room for selection within the dotted rectangle. The selection process is an exclusive feature of ASV.

The device works on the assumption that the optimal breath pattern is identical to the one a totally unsupported patient will choose naturally (assuming the patient is capable of maintaining the pattern).

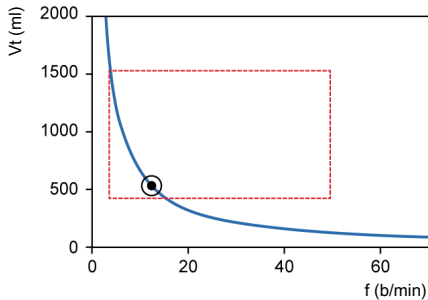
It is common knowledge that the choice of breathing pattern is governed by either work of breathing or the force needed to maintain a pattern. ASV calculates the optimal rate based on the operator-set %MinVol and the calculated IBW, as well as on the measurement of  $RC_{exp}$  (Section 7.4.1).

Once the optimal rate is determined, the target  $V_t$  is calculated as follows:

$$V_t = \text{target MinVol} / \text{optimal rate}$$

Figure 7-21 shows the position of the target breathing pattern as well as the safety limits imposed by the lung-protective rules strategy. The rectangle shows the safety limits; the circle shows the target breath pattern.

Figure 7-21. Anatomy of the ASV target graphics window



#### 7.8.6.6 Initial breaths: How ASV starts

How do you achieve the target values for a given patient if you do not know whether or not the patient can breathe spontaneously? For this purpose, ASV uses a predefined rate according to the calculated IBW. For more information see Table 7-3.

Patient-triggered breaths are pressure supported and flow cycled. If the patient does not trigger the breath, the delivery of the breath is with a preset pressure and time cycled.

The following controls are operator-set (manual):

- PEEP/CPAP
- Oxygen
- P-ramp
- ETS
- Trigger type and sensitivity

This list of controls is adjusted automatically by ASV, and cannot be adjusted by the operator:

- *Mandatory breath rate*: to change total respiratory rate
- *Inspiratory pressure level*: to change inspiratory volume
- *Inspiratory time*: to allow gas flow into the lungs
- Startup breath pattern

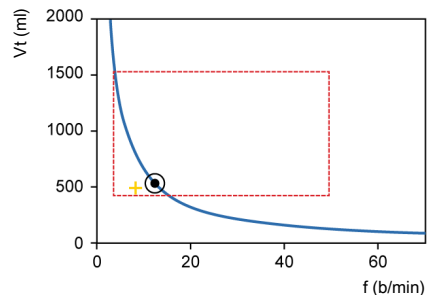
To safely start ASV, you set the patient height and sex, which are then used to calculate the IBW.

Upon starting ventilation, three initial test breaths are delivered. The resulting rate and tidal volume are measured and compared with the target values. ASV then responds to the differences between the current and target tidal volumes, as well as the current and target rates.

#### 7.8.6.7 Approaching the target

Figure 7-22 shows a possible scenario after the three initial test breaths. The current breath pattern, which is plotted as the patient symbol, shows clear deviation from the target. ASV's task is to move the patient symbol as close to the circle as possible.

Figure 7-22. Example after three initial breaths



The patient symbol marks the actual measured value for  $V_t$  and Rate.

To achieve the target, ASV uses the following strategy:

- If actual  $V_t$  < target  $V_t$ , the inspiratory pressure is increased.
- If actual  $V_t$  > target  $V_t$ , the inspiratory pressure is decreased.
- If actual  $V_t$  = target  $V_t$ , the inspiratory pressure is left unchanged.
- If actual rate < target rate, the fControl rate is increased.
- If actual rate > target rate, the fControl rate is decreased.
- If actual rate = target rate, the fControl rate is left unchanged.

As a result, the patient symbol in Figure 7-22 moves toward the circle. The current  $V_t$  is calculated as the average of inspiratory and expiratory volumes. This definition compensates in parts for leaks in the breathing circuit, including the endotracheal tube.

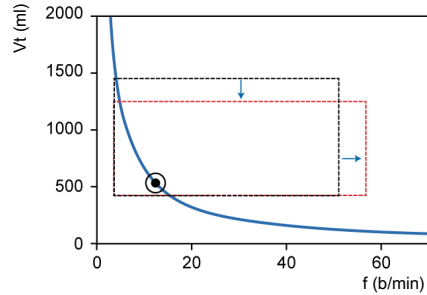
#### 7.8.6.8 Dynamic adjustment of lung protection

The operator preset values are not changed by ASV, and the corresponding safety limits remain as defined in the previous sections. However, if the respiratory system mechanics change, the safety limits change accordingly, as defined in Section 7.8.6.4. The safety limits are updated on a breath-by-breath basis.

For example, if the lungs stiffen, the high  $V_t$  limit is lowered proportionally, and the high rate limit is increased.

This dynamic adjustment ensures that ASV applies a safe breathing pattern at all times. In graphical terms, the dotted rectangle changes as shown in Figure 7-23.

Figure 7-23. Lung-protective limits



Lung-protective limits are changed dynamically and according to the respiratory system mechanics.

However, the limits set by the operator are never violated.

#### 7.8.6.9 Dynamic adjustment of optimal breath pattern

After it is calculated, the optimal breath pattern is revised with each breath according to the  $RC_{exp}$  measurements. A new target breathing pattern is calculated using ASV algorithms. The targets do not change under steady-state conditions. However, if the patient's respiratory system mechanics change, the target values also change.

# 8

## Monitoring ventilation

8.1	Overview.....	144
8.2	Viewing numeric patient data .....	144
8.3	Viewing graphical patient data .....	146
8.4	Working with Intelligent panels .....	151
8.5	About the monitored parameters .....	156
8.6	Viewing patient ventilation time .....	164
8.7	Viewing device-specific information .....	165

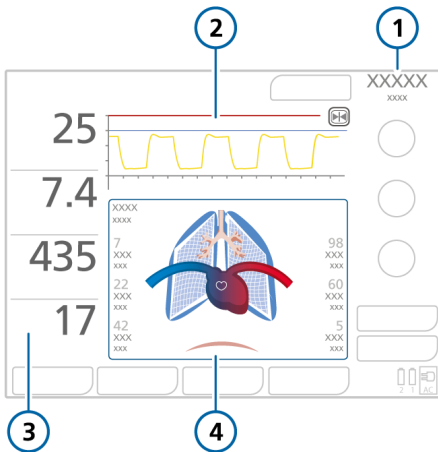
## 8.1 Overview

You can configure how to view patient data during ventilation, including viewing data numerically and graphically in a combination of waveforms, loops, trends, and Intelligent Panel graphics to suit your institution's needs (Figure 8-1).

Data is also available in the **Monitoring** window, which you can access at any time without affecting breath delivery.

For the list of monitored parameters, see Section 8.5.

Figure 8-1. Main display



- |  |  |
|--|--|
| 1 Current mode   | 3 Main monitoring parameters (MMP) (Section 8.2.1) |
| 2 Pressure/time waveform, non-configurable (Section 8.3.2) | 4 Graphic display, configurable (Section 8.3)      |

## 8.2 Viewing numeric patient data

Numeric patient data is readily available as follows:

- The main display prominently shows the configured main monitoring parameters (MMPs). See Section 8.2.1.
- The **Monitoring** window provides access to all of the parameter data. See Section 8.2.2.

### 8.2.1 About the main monitoring parameters (MMP)

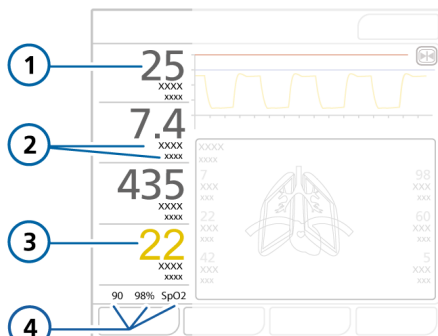
The MMPs are the numerical monitoring parameters shown on the left side of the display. Every displayed parameter shows the following elements: the current value, name, and unit of the monitoring parameter.

The MMPs that are displayed, as well as their sequence on the display, can be changed in **Configuration** (Section 12.5). Any of the monitored parameters can be displayed as an MMP. As a result, MMPs may differ between individual ventilators.

An MMP is normally displayed in white. When directly related to an active alarm, the MMP is shown in yellow or red, corresponding to the alarm priority. After the alarm resets, the affected MMP returns to white.



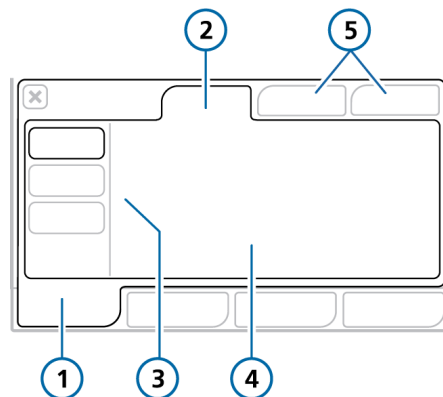
Figure 8-2. MMP components



- |                        |   |
|------------------------|---|
| 1 MMP value            | 3 Parameter associated with an active alarm |
| 2 Parameter name/units | 4 SpO2 lower alarm limit, SpO2 value*       |

\* If SpO2 sensor is enabled and connected

Figure 8-3. Monitoring &gt; General window



- |                   |                             |
|-------------------|-----------------------------|
| 1 Monitoring      | 4 Parameter values          |
| 2 General         | 5 CO2 and SpO2 (if enabled) |
| 3 1, 2, 3 buttons |                             |

## 8.2.2 Viewing patient data in the Monitoring window

The **Monitoring** window provides access to monitored parameter data as follows:

- The **General** tab (Figure 8-3) provides access to ventilation parameter values.
- When enabled, the **CO2** and **SpO2** tabs provide access to CO2- and SpO2-related data, respectively.

### To display the Monitoring > General window

1. Touch **Monitoring**.
2. If not already displayed, touch **General**.

## 8.3 Viewing graphical patient data

The HAMILTON-T1 offers a variety of graphic areas on the display that can show waveforms, as well as graphic and Intelligent panels.

Table 8-1 shows the options for each graphic type.

Table 8-1. Graphical view options

Graphic type	Options	
Waveforms (Data values plotted against time)	<ul style="list-style-type: none"> <li>Flow</li> <li>Volume</li> <li>Off</li> </ul>	<ul style="list-style-type: none"> <li>PCO<sub>2</sub><sup>28</sup></li> <li>FCO<sub>2</sub><sup>28</sup></li> <li>Plethysmogram<sup>29</sup></li> </ul>
Graphics (Intelligent panels)	<ul style="list-style-type: none"> <li>Dynamic Lung<sup>30</sup></li> <li>Vent Status</li> </ul>	<ul style="list-style-type: none"> <li>ASV Graph<sup>31</sup></li> </ul>
Trends	1-, 6-, 12-, 24-, or 72-h <sup>32</sup> trend data for a selected parameter or combination of parameters	
Loops	<ul style="list-style-type: none"> <li>Pressure/Volume</li> <li>Pressure/Flow</li> <li>Volume/Flow</li> </ul>	<ul style="list-style-type: none"> <li>Volume/PCO<sub>2</sub><sup>28</sup></li> <li>Volume/FCO<sub>2</sub><sup>28</sup></li> </ul>

<sup>28</sup> CO<sub>2</sub> option required.

<sup>29</sup> SpO<sub>2</sub> option required.

<sup>30</sup> Only for adult/pediatric patients.

<sup>31</sup> Only in ASV mode.

<sup>32</sup> 72-hour trend not available in all markets.

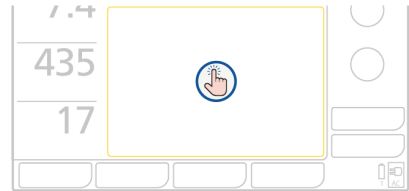
### 8.3.1 Selecting display options

You can change the graphics at any time.

#### To change the contents of a graphic panel or waveform

1. Touch the area of the display to change.

The selected panel is highlighted in yellow.

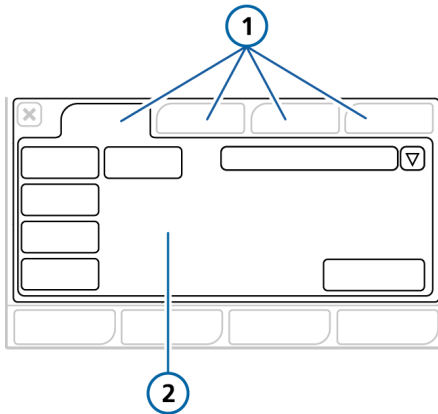


The graphics selection window appears, displaying the current selection (Figure 8-4).

2. Touch the desired option to select it, or touch a tab (**Trends**, **Loops**, **Graphics**, **Waveforms**) to access additional options.

After making a selection, the window closes automatically, and the display adjusts to the new selection.

Figure 8-4. Graphics selection window



- 1 Trends, Loops, Graphics, Waveforms  
2 Available options

### 8.3.2 Working with waveforms

The ventilator can plot pressure, volume, and flow against time, in addition to other data as listed in Table 8-1.

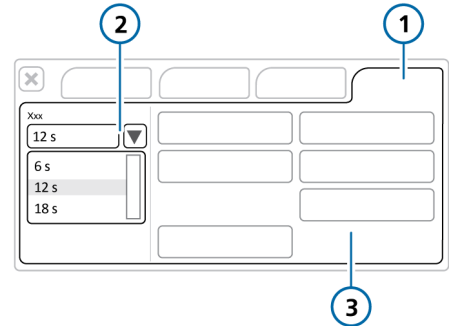
#### 8.3.2.1 Waveform views

You can show up to two waveforms on the display. The **Paw** waveform is always displayed and cannot be configured. You can choose to display a second waveform, if desired. For details, see Section 8.3.2.2.

#### 8.3.2.2 Displaying waveforms

You select options in the **Waveforms** window.

Figure 8-5. Graphics selection &gt; Waveforms window



- 1 Waveforms  
2 Time scale  
3 Available options

#### To select a waveform

1. Touch the area of the display where you wish to show a waveform or touch the waveform to change (Section 8.3.1).

You cannot replace the **Pressure/Time (Paw)** waveform.

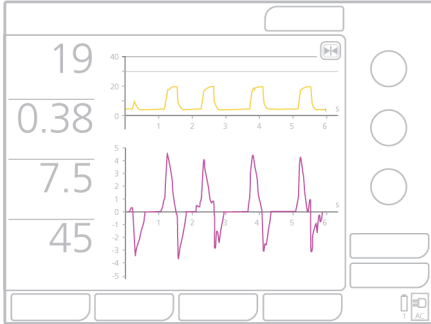
The graphics selection window appears (Figure 8-4).

2. If needed, touch the **Waveforms** tab.
3. If needed, change the time scale to apply to all waveforms.
4. Touch the waveform type to display.

To leave the area blank, touch **Off**.

Once the selection is made, the window closes and the selected waveform is displayed.

Figure 8-6. Waveform display

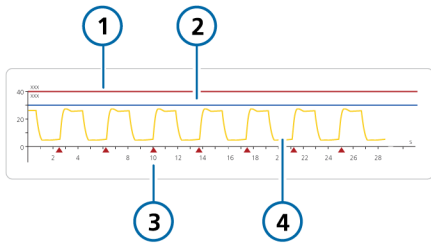


### 8.3.2.3 About the Pressure/time (Paw) graph

By default, the Pressure/time (Paw) graph is shown at the top of the display.

The blue pressure limit line shows the maximum pressure that the ventilator will apply, which is 10 cmH<sub>2</sub>O below the set high Pressure alarm limit. The high Pressure alarm limit is shown as a red line.

Figure 8-7. Pressure/time graph



- |  |                                  |
|--|----------------------------------|
| 1 High Pressure alarm limit  | 3 Patient trigger indicator      |
| 2 Pressure limitation: high Pressure alarm limit – 10 cmH <sub>2</sub> O | 4 Airway pressure (Paw) waveform |

### 8.3.2.4 Changing the waveform time scale

*Scaling* refers to the values of the x- and y-axis of a waveform or a loop. In the waveforms displayed on the ventilator, the x-axis represents time, while the y-axis can represent a variety of parameters, including pressure, flow, or volume.

You can set the time scale (x-axis values) of the waveforms; your selection applies to all displayed waveforms.

A scale value refers to the length of the x-axis. For example, a scale value of 22 means that the x-axis displays the waveform from 0 to 22 seconds.

The HAMILTON-T1 offers the following time scale options, in seconds:

- Adult/Ped: 6, 12, 18, 24, 30
- Neonatal: 3, 6, 12, 18, 24

#### To change the time scale

- ▶ In the Waveforms window, touch the Time scale arrow (Figure 8-5) and select the time scale to use.

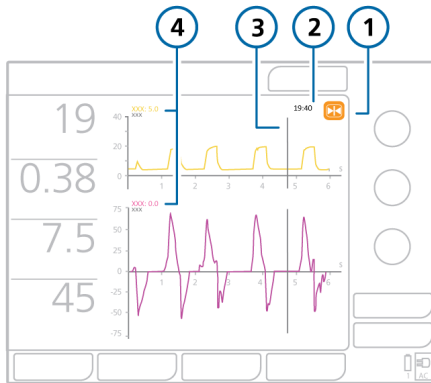
Your selection applies to all displayed waveforms.

### 8.3.2.5 Freezing and reviewing waveforms and trends

You can temporarily freeze the display of waveforms and trends. After 30 seconds of inactivity, they are automatically unfrozen.

When Freeze is enabled, any displayed waveforms and Trend graph are frozen, allowing you to scroll through them for a detailed review. The Freeze function is time-synced across the displayed graphs.

Figure 8-8. Freezing waveforms



- |                  |   |
|------------------|---|
| 1 Freeze button  | 3 Cursor  |
| 2 Time at cursor | 4 Value at cursor<br>(same color as the waveform) |

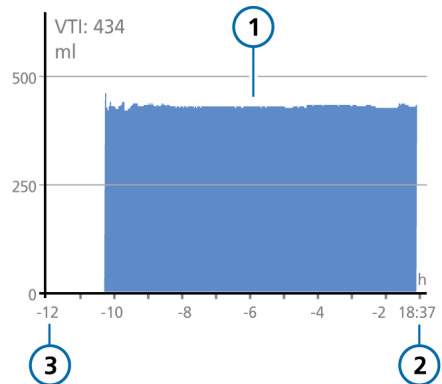
### To freeze waveforms

- Touch the **Freeze** button (1 in Figure 8-8).  
Any displayed waveforms and Trend graph are frozen, and cursor bars are displayed.
- To scroll through the graphics for analysis, turn the P&T knob clockwise or counter-clockwise.  
The cursor bars move to the right and to the left.
- To unfreeze the display and return to displaying real-time data, touch the **Freeze** button again or press the P&T knob.

### 8.3.3 Working with Trend graphs

Trend data includes all data since the ventilator was turned on for a selected parameter for the past 1, 6, 12, 24, or 72 hours.

Figure 8-9. Trend panel



- |                |                                    |
|----------------|------------------------------------|
| 1 Trend graph  | 3 Elapsed time relative to present |
| 2 Current time |                                    |

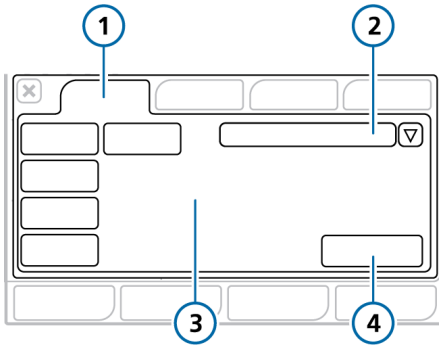
From the time the ventilator is turned on, it continuously stores up to 72 hours of monitored parameter data in its memory, including when in Standby. This data is deleted upon setting up a new patient.

You can also freeze Trend graphs and examine them more closely. When trends are frozen, the panel shows the time and the corresponding value of the monitored parameter.

Most monitoring parameters can be trended. The following parameters are trended in combination: Ppeak/PEEP, Exp-MinVol/MVSpont, fTotal/fControl, VDaw/VTE, VTE/Vtalv, and SpO2/Oxygen and SpO2/FiO2 (if supported on your device).

### 8.3.3.1 Displaying trends

Figure 8-10. Graphics selection > Trends window



- |                  |                        |
|------------------|------------------------|
| 1 Trends         | 3 Trend time, in hours |
| 2 Parameter list | 4 Confirm              |

#### To display trends

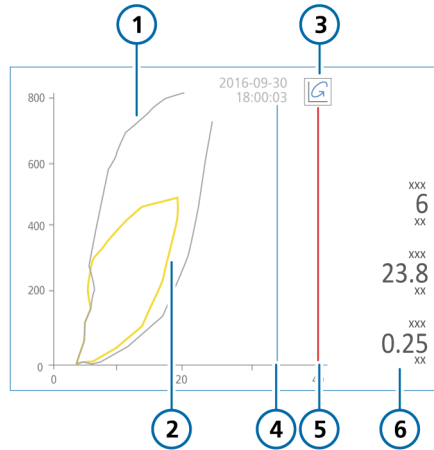
1. Touch the area of the display where you wish to show a trend graph (Section 8.3.1).
2. In the graphics selection window, touch the **Trends** tab (Figure 8-10).
3. Select the parameter(s) to trend.
4. Touch the desired trend time.
5. Touch **Confirm**.

The selected trend information is displayed (Figure 8-9).

### 8.3.4 Working with loops

The HAMILTON-T1 can display a dynamic loop based on the parameter combinations listed in Table 8-1.

Figure 8-11. Loops panel, Pressure/Volume loop displayed

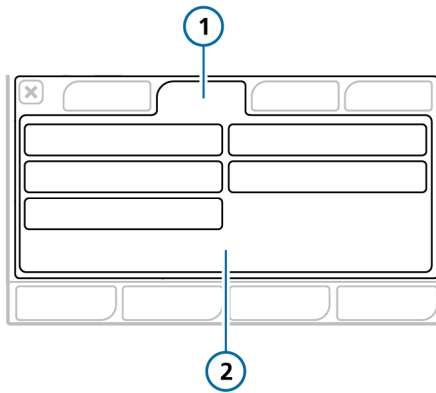


- |                         |  |
|-------------------------|--|
| 1 Stored reference loop | 4 Pressure limitation: high Pressure alarm limit - 10 cmH2O* |
| 2 Current loop          | 5 High Pressure alarm limit*                                 |
| 3 Loop reference button | 6 Key parameters   |

\* Displayed if applicable

### 8.3.4.1 Displaying loops

Figure 8-12. Graphics selection > Loops window



- |         |                     |
|---------|---------------------|
| 1 Loops | 2 Parameter options |
|---------|---------------------|

#### To display loops

1. Touch the area of the display where you wish to show a loop (Section 8.3.1).
2. In the graphics selection window, touch the **Loops** tab.
3. Touch the parameter combination to display.

The selected combination is displayed (Figure 8-11).

### 8.3.4.2 Storing loops

You can store a loop to use as a reference, for comparison purposes.

#### To store a new loop

- ▶ In the Loop display (Figure 8-11), touch the **Loop reference** button to store the loop curve with the current date and time.

The previous and current characteristics are shown. Any previously stored loop is discarded.

## 8.4 Working with Intelligent panels

You can set up the ventilator display to show any of the Intelligent panels:

- Dynamic Lung
- Vent Status
- ASV Graph

The Intelligent panels are all displayed using the graphics selection window **Graphics** tab.

### 8.4.1 Dynamic Lung panel: real-time ventilation status

The **Dynamic Lung**<sup>33</sup> shows an up-to-date visual representation of key ventilation data (Figure 8-13). It visualizes tidal volume, lung compliance, patient triggering, resistance, and cuff pressure in real-time.

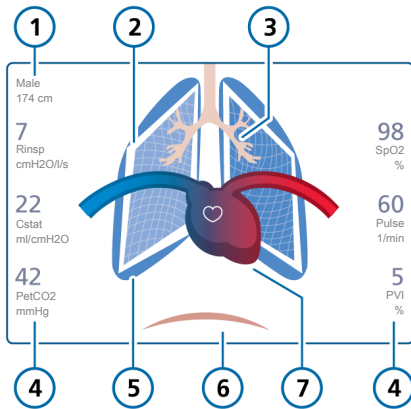
In addition to the graphic representation, the panel shows numeric data for key parameters. If all values are in a normal range, the panel is framed in green.

<sup>33</sup> Only for adult/pediatric patients.

The Dynamic Lung comprises the following components:

- Mechanical breath
- Respiratory compliance
- Airway resistance
- Patient triggering
- SpO2 data (if installed and enabled)

Figure 8-13. Dynamic Lung panel



- |                                       |  |
|---------------------------------------|--|
| 1 Sex, height                         | 5 Representation of breaths and tidal volume |
| 2 Representation of lung compliance   | 6 Patient trigger (diaphragm)                |
| 3 Representation of airway resistance | 7 Heart and pulse display*                   |
| 4 Monitored parameter values          |  |

\* If SpO2 sensor enabled and connected.

### Mechanical breaths, with tidal volume

The mechanical breath is shown as a set of lungs that expand and contract in synchrony with ventilator breath delivery, showing the delivered tidal volume ( $V_t$ ) in real-time. The lung size displayed is relative to the “normal” size for the patient’s height.

A Disconnection alarm is indicated by a deflated lung. An Exhalation obstructed alarm is indicated by an over-inflated lung.

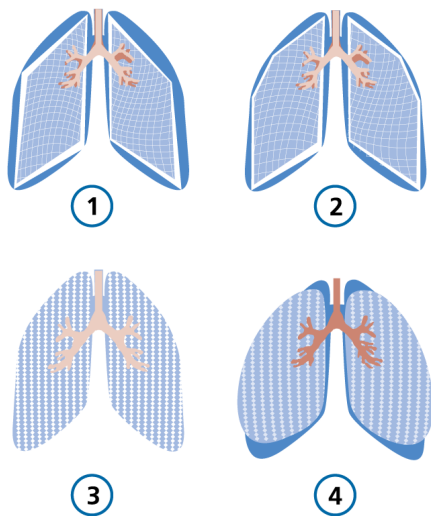
The movement and shape of the lungs allows you to quickly verify that the ventilator is ventilating the patient and at which rate.

### Respiratory compliance

Respiratory compliance is a measure of the lung's ability to stretch and expand. Compliance is illustrated by the contour lines of the lung, as shown in Figure 8-14. The static measurement is provided with the Cstat parameter.



Figure 8-14. Examples of lung compliance (Cstat) illustrated in Dynamic Lung

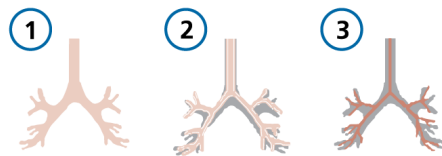


- 1 Very low compliance
- 2 Low compliance
- 3 Normal compliance
- 4 High compliance

### Airway resistance

Airway resistance refers to the total resistance imposed by the patient’s airway as well as the artificial airway, such as an endotracheal tube or tracheostomy tube. Airway resistance is illustrated by the size and color of the tracheobronchial tree, as shown in Figure 8-15. The resistance measurement is provided with the Rinsp parameter.

Figure 8-15. Examples of resistance shown by the bronchial tree of the Dynamic Lung

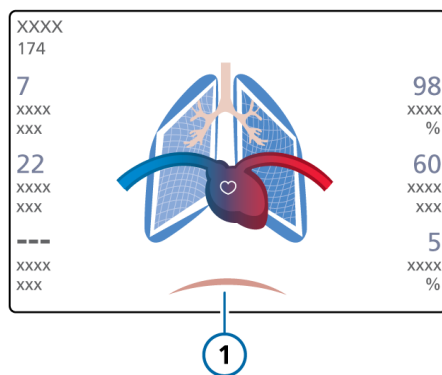


- 1 Normal resistance
- 2 Moderately high resistance
- 3 High resistance

### Patient trigger

If a patient trigger is detected, an illustration of the diaphragmatic muscle appears briefly at the beginning of inspiration, as shown in Figure 8-16. This allows you to quickly see whether the breath is patient triggered.

Figure 8-16. Patient triggering (1) in Dynamic Lung



## SpO2 data

If the SpO2 option is enabled and a sensor is connected, the **Dynamic Lung** panel shows a heart and big vessel illustration superimposed on the lungs. The heart beats in synchrony with the patient's pulse rate.

For details about SpO2 measurement, see the *Pulse Oximetry Instructions for Use*.

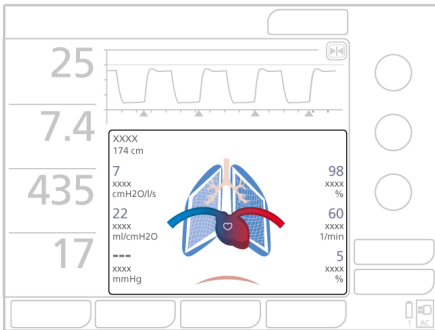
### 8.4.1.1 Displaying the Dynamic Lung

#### To display the Dynamic Lung

1. Touch the graphics area at the bottom half of the display (Section 8.3.1).
2. In the graphics selection window, touch the **Graphics** tab (Figure 8-4).
3. Touch **Dynamic Lung**.

The **Dynamic Lung** panel is displayed (Figure 8-17).

Figure 8-17. Dynamic Lung in display



## 8.4.2 Vent Status panel: real-time ventilator dependence status

The **Vent Status** panel (Figure 8-18) displays six parameters related to the patient's ventilator dependence, in the areas of oxygenation, CO2 elimination, and patient activity.

A floating indicator (floater) moving up and down within the column shows the value for a given parameter.

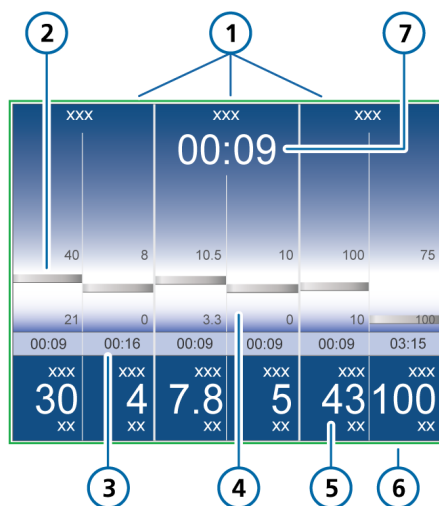
When the indicator is in the light blue (weaning) zone, a timer starts, showing how long that value has been in the weaning zone. When all values are in the weaning zone, the **Vent Status** panel is framed in green, indicating that weaning should be considered. A timer appears, recording the length of time all values have been in the weaning zone (Figure 8-18).

The panel is updated breath by breath.

Table 8-2 describes the parameters shown in the **Vent Status** panel.

You can configure the weaning zone ranges for these parameters in **Configuration**. To set the values, see Section 12.6.1.

Figure 8-18. Vent Status panel



- |   |   |   |   |
|---|---|---|---|
| 1 | Group title                                 | 5 | Monitored value, numeric                                    |
| 2 | Monitored value, graphic (floater)          | 6 | Green outline indicating all values are in the weaning zone |
| 3 | Elapsed time value has been in weaning zone | 7 | Elapsed time all values have been in weaning zone           |
| 4 | Weaning zone with user-configurable limits  |   |   |

Table 8-2. Vent Status parameters

Parameter (unit)	Definition
<i>For additional details, including ranges and accuracy, see Table 14-5.</i>	
Oxygen (%)	Oxygen setting.
PEEP (cmH <sub>2</sub> O)	PEEP/CPAP setting.
MinVol (l/min)	Normal minute ventilation (see Section 7.8).
Pinsp (cmH <sub>2</sub> O)	Inspiratory pressure, the target pressure (additional to PEEP/CPAP) applied during the inspiratory phase.
RSB (1 / (l*min)) <sup>34</sup>	Rapid shallow breathing index. The total breathing frequency (f <sub>Total</sub> ) divided by the exhaled tidal volume (VTE).
%fSpont (%)	Spontaneous breath percentage. The moving average of the percentage of spontaneous breaths over the last 10 total breaths.

#### 8.4.2.1 Displaying the Vent Status panel

##### To display the Vent Status panel

1. Touch the area of the display where you wish to show the Vent Status panel (Section 8.3.1).
2. In the graphics selection window, touch the **Graphics** tab (Figure 8-4).
3. Touch **Vent Status**.

The Vent Status panel is displayed (Figure 8-18).

<sup>34</sup> Weaning zone defaults are based on normal values < 100 / (l\*min) for adult patients. Default values can be changed in Configuration.

### 8.4.3 ASV Graph panel: real-time patient condition and targets

Available in ASV<sup>35</sup> mode, the ASV Graph shows how the adaptive lung controller moves toward its targets. The graph shows both the target and real-time patient data for tidal volume, frequency, pressure, and minute ventilation.

Figure 7-17 in Chapter 7 describes the graph in detail.

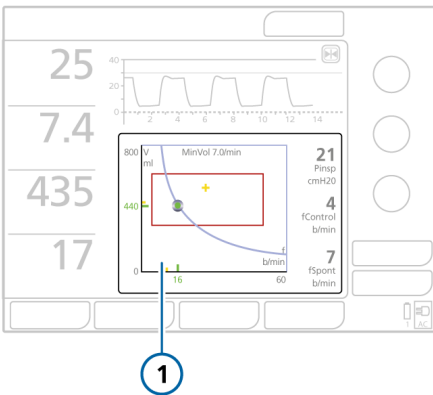
#### 8.4.3.1 Displaying the ASV Graph

##### To display the ASV Graph

1. Touch the area of the display where you wish to show the ASV Graph (Section 8.3.1).
2. In the graphics selection window, touch the **Graphics** tab (Figure 8-4).
3. Touch **ASV Graph**.

The ASV Graph is displayed (Figure 8-19).

Figure 8-19. ASV Graph panel (1)



### 8.5 About the monitored parameters

The following table is an alphabetical list of the ventilator's monitored parameters.

You can review all parameter values in the **Monitoring** window (Section 8.2.2). The display of monitored parameters is updated every breath or is time driven.

See Section 14.6 for parameter specifications.

For details about SpO2-related parameters, see the *Pulse Oximetry Instructions for Use*.

<sup>35</sup> Only for adult/pediatric patients.

Table 8-3. Monitored parameters

Parameter (unit)	Definition
<b>Pressure</b>	
AutoPEEP (cmH <sub>2</sub> O)	<p>The difference between the set PEEP and the calculated total PEEP within the lungs.</p> <p>AutoPEEP is the abnormal pressure generated by air “trapped” in the alveoli due to inadequate lung emptying. Ideally, it should be zero. AutoPEEP is calculated using the LSF method applied to the entire breath.</p> <p>Actively breathing patients can create artifacts or noise, which can affect the accuracy of these measurements.</p> <p>When AutoPEEP is present, volutrauma or barotrauma might develop. In active patients, AutoPEEP may present an extra workload to the patient.</p> <p>AutoPEEP or air trapping may result from an expiratory phase that is too short, which may be observed under the following conditions:</p> <ul style="list-style-type: none"> <li>• Delivered tidal volume too large</li> <li>• Expiratory time too short or respiratory rate too high</li> <li>• Circuit impedance too high or expiratory airway obstruction</li> <li>• Peak expiratory flow too low</li> </ul>
PEEP/CPAP (cmH <sub>2</sub> O)	<p>Monitored PEEP/CPAP. The airway pressure at the end of exhalation.</p> <p>Measured PEEP/CPAP may differ slightly from the set PEEP/CPAP, especially in spontaneously breathing patients.</p>
P <sub>insp</sub> (cmH <sub>2</sub> O)	<p>Inspiratory pressure, the automatically calculated target pressure (additional to PEEP) applied during the inspiratory phase.</p> <p>Also displayed in the Vent Status panel.</p> <p>Not all modes use the P<sub>insp</sub> parameter. Rather, this target pressure is set using the following parameters, depending on the selected mode:</p> <ul style="list-style-type: none"> <li>• APVcmv, APVsimv, ASV: Automatically calculated target pressure</li> <li>• PCV+: Pcontrol setting</li> <li>• PSIMV+, NIV-ST: P<sub>insp</sub> setting</li> <li>• SPONT, NIV: P<sub>support</sub> setting</li> <li>• APRV, DuoPAP: P high setting</li> </ul>
P <sub>mean</sub> (cmH <sub>2</sub> O)	<p>Mean airway pressure. The absolute pressure, averaged over the breath cycle.</p> <p>P<sub>mean</sub> is an important indicator of the possible impact of applied positive pressure on hemodynamics and surrounding organs.</p>

Parameter (unit)	Definition
Ppeak (cmH2O)	<p>Peak airway pressure. The highest pressure during the previous breath cycle.</p> <p>It is influenced by airway resistance and compliance. Ppeak may differ noticeably from alveolar pressure if airway resistance is high. This value is always displayed.</p>
Pplateau (cmH2O)	<p>Plateau or end-inspiratory pressure. The pressure measured at the end of inspiration when flow is at or close to zero.</p> <p>Used as a rough representation of alveolar pressure. Pplateau is displayed for mandatory and time-cycled breaths.</p>
<b>Flow</b>	
Control Flow (l/min)	The set flow of gas to the patient during HiFlowO2.
Exp Flow (l/min)	Peak expiratory flow.
Flow (l/min)	<p>Only active in nCPAP and nCPAP-PC modes.</p> <p>Displays the current flow as follows:</p> <ul style="list-style-type: none"> <li>• In nCPAP mode, this value is the average flow, updated every second.</li> <li>• In nCPAP-PC mode, this value is the average flow during expiration, updated every breath.</li> </ul> <p>Displayed in the <b>Monitoring</b> window.</p> <p>Flow is affected by the setting of the <b>Flow</b> alarm. See Chapter 9.</p>
Insp Flow (l/min)	Peak inspiratory flow, spontaneous or mandatory. Measured every breath.
<b>Volume</b>	
ExpMinVol MinVol NIV (l/min)	Expiratory minute volume. The moving average of the monitored expiratory volume per minute over the last 8 breaths. ExpMinVol changes to MinVol NIV in noninvasive modes. MinVol NIV is an adjusted parameter taking leakage into account.
MVSpont MVSpont NIV (l/min)	<p>Spontaneous expiratory minute volume.</p> <p>The moving average of the monitored expiratory volume per minute for spontaneous breaths, over the last 8 mandatory and spontaneous breaths.</p> <p>In noninvasive ventilation modes, MVSpont is replaced by MVSpont NIV. MVSpont NIV is an adjusted parameter taking leakage into account.</p>

Parameter (unit)	Definition
VLeak (%) MVLeak (l/min)	<p>Due to the leakage at the patient interface, displayed exhaled volumes in the noninvasive modes can be substantially smaller than the delivered volumes.</p> <p>The flow sensor measures the delivered volume and the exhaled tidal volume; the ventilator displays the difference as VLeak in % and as MVLeak in l/min, averaged over the past 8 breaths.</p> <p>VLeak/MVLeak can indicate leaks on the patient side of the flow sensor. They do not include leakage between the ventilator and the flow sensor.</p> <p>Use VLeak and MVLeak to assess the fit of the mask or other noninvasive patient interface.</p>
VTE VTE NIV (ml)	<p>Expiratory tidal volume, the volume exhaled by the patient.</p> <p>It is determined from the flow sensor measurement, so it does not show any volume added due to compression or lost due to leaks in the breathing circuit.</p> <p>If there is a gas leak on the patient side, the displayed VTE may be less than the tidal volume the patient actually receives.</p> <p>In noninvasive ventilation modes, VTE is replaced by VTE NIV. VTE NIV is an adjusted parameter taking leakage into account</p>
VTEspont (ml)	<p>Spontaneous expiratory tidal volume, the volume exhaled by the patient.</p> <p>If there is a gas leak on the patient side, the displayed VTEspont may be less than the tidal volume the patient actually receives.</p> <p>Only displayed for spontaneous breaths.</p>
VTI (ml)	<p>Inspiratory tidal volume, the volume delivered to the patient, determined from the flow sensor measurement.</p> <p>If there is a gas leak on the patient side, the displayed VTI may be larger than the displayed VTE.</p>
Vt/IBW Vt/Weight (kg)	<p>Tidal volume is calculated according to ideal body weight (IBW) for adult/pediatric patients and according to the actual body weight for neonatal patients.</p>
<b>Time</b>	
fControl (b/min)	<p>Mandatory breath frequency. The moving average of machine-delivered breaths per minute over the last 8 total breaths.</p>
fSpont (b/min)	<p>Spontaneous breath frequency.</p> <p>The moving average of spontaneous breaths per minute over the last 8 total breaths.</p>

Parameter (unit)	Definition
fTotal (b/min)	Total breathing frequency. The moving average of the patient's total breathing frequency over the last 8 breaths, including both mandatory and spontaneous breaths. When the patient triggers a breath or the operator initiates a breath, fTotal may be higher than the Rate setting.
I:E	Inspiratory:expiratory ratio. Ratio of the patient's inspiratory time to expiratory time for every breath cycle. This includes both mandatory and spontaneous breaths. I:E may differ from the set I:E ratio if the patient breathes spontaneously.
TE (s)	Expiratory time. In mandatory breaths, TE is measured from the start of exhalation until the set time has elapsed for the switch to inspiration. In spontaneous breaths, TE is measured from the start of exhalation, as dictated by the ETS setting, until the patient triggers the next inspiration. TE may differ from the set expiratory time if the patient breathes spontaneously.
TI (s)	Inspiratory time. In mandatory breaths, TI is measured from the start of breath delivery until the set time has elapsed for the switch to exhalation. In spontaneous breaths, TI is measured from the patient trigger until the flow falls to the ETS setting for the switch to exhalation. TI may differ from the set inspiratory time if the patient breathes spontaneously.
<b>Other calculated and displayed parameters</b>	
Cstat (ml/cmH2O)	Static compliance of the respiratory system, including lung and chest wall compliances, calculated using the LSF method. Cstat can help diagnose changes in elastic characteristics of the patient's lungs. Actively breathing patients can create artifact or noise, which can affect the accuracy of these measurements.
IBW (kg)	Ideal body weight. A calculated value using height and sex, for adult and pediatric patients.
Oxygen (%)	Oxygen concentration of the delivered gas. It is measured by an O2 sensor in the inspiratory pneumatics. This parameter is not displayed if the O2 sensor is not installed, is defective, is not a genuine Hamilton Medical part, or if oxygen monitoring is disabled.



Parameter (unit)	Definition
P0.1 (cmH <sub>2</sub> O)	<p>Airway occlusion pressure. The pressure drop during the first 100 ms when a breath is triggered. P0.1 indicates the patient's respiratory drive and patient inspiration effort.</p> <p>P0.1 applies only to patient-triggered breaths.</p> <p>A P0.1 value of -3 cmH<sub>2</sub>O indicates a strong inspiratory effort, and a value of -5 cmH<sub>2</sub>O indicates an excessive effort, possibly because the patient is "air hungry" (peak inspiratory flow or total ventilatory support is inadequate) or has an excessive drive.</p> <p>If P0.1 is below -3 cmH<sub>2</sub>O:</p> <ul style="list-style-type: none"> <li>• Increase pressure or volume settings (depending on mode)</li> <li>• Increase %MinVol (ASV mode only)</li> <li>• Shorten P-ramp</li> </ul>
PTP (cmH <sub>2</sub> O*s)	<p>Inspiratory pressure time product.</p> <p>The measured pressure drop required to trigger the breath multiplied by the time interval until the PEEP/CPAP level is reached at the beginning of inspiration.</p> <p>PTP is valid for patient-initiated breaths only, and indicates work by the patient to trigger the breath. The work depends on:</p> <ul style="list-style-type: none"> <li>• The intensity of the patient's effort</li> <li>• The trigger sensitivity</li> <li>• The volume and resistance of the breathing circuit</li> </ul> <p>PTP does not indicate total patient work but is a good indicator of how well the ventilator is adjusted for the patient.</p> <p>If PTP values increase, do the following:</p> <ul style="list-style-type: none"> <li>• Increase trigger sensitivity</li> <li>• Decrease P-ramp</li> </ul>

Parameter (unit)	Definition										
RCexp (s)	<p>Expiratory time constant. The rate at which the lungs empty, as follows:</p> <table border="0"> <tr> <td>Actual TE</td> <td>% emptying</td> </tr> <tr> <td>1 x RCexp</td> <td>63%</td> </tr> <tr> <td>2 x RCexp</td> <td>86.5%</td> </tr> <tr> <td>3 x RCexp</td> <td>95%</td> </tr> <tr> <td>4 x RCexp</td> <td>98%</td> </tr> </table> <p>RCexp is calculated as the ratio between VTE and flow at 75% of the VTE.</p> <p>Normal values in intubated adult patients:</p> <ul style="list-style-type: none"> <li>• Short, &lt; 0.6 seconds: restrictive disease (ARDS, atelectasis, chest wall stiffness)</li> <li>• Normal, 0.6 to 0.9 seconds: normal compliance and resistance, or combined decreased compliance and increased resistance</li> <li>• Long, &gt; 0.9 seconds: obstructive disease (COPD, asthma), bronchospasm, ET tube obstruction, or incorrect positioning</li> </ul> <p>Use RCexp to set the optimum TE (Goal: TE ≥ 3 x RCexp):</p> <ul style="list-style-type: none"> <li>• <i>With passive patients:</i> Adjust <b>Rate</b> and I:E</li> <li>• <i>With active patients:</i> Increase <b>Psupport</b> and/or <b>ETS</b> to achieve a longer TE</li> </ul> <p>These actions may reduce the incidence of AutoPEEP.</p>	Actual TE	% emptying	1 x RCexp	63%	2 x RCexp	86.5%	3 x RCexp	95%	4 x RCexp	98%
Actual TE	% emptying										
1 x RCexp	63%										
2 x RCexp	86.5%										
3 x RCexp	95%										
4 x RCexp	98%										
Rinsp (cmH2O / (l/s))	<p>Resistance to inspiratory flow caused by the endotracheal tube and the patient's airways during inspiration.</p> <p>It is calculated using the LSF method applied to the inspiratory phase. Also displayed in the <b>Dynamic Lung</b> panel.</p> <p>Actively breathing patients can create artifact or noise, which can affect the accuracy of these measurements.</p>										
RSB (1 / (l*min))	<p>Rapid shallow breathing index.</p> <p>The total breathing frequency (fTotal) divided by the exhaled tidal volume (VTE).</p> <p>Because a patient with dyspnea typically takes faster and shallower breaths than a non-dyspnoeic patient, RSB is high in the dyspnoeic patient and low in the non-dyspnoeic patient.</p> <p>RSB is often used clinically as an indicator of a ventilated patient's readiness for weaning.</p> <p>RSB is only significant for spontaneously breathing patients weighing more than 40 kg and is only shown if 80% of the last 25 breaths were spontaneous.</p>										

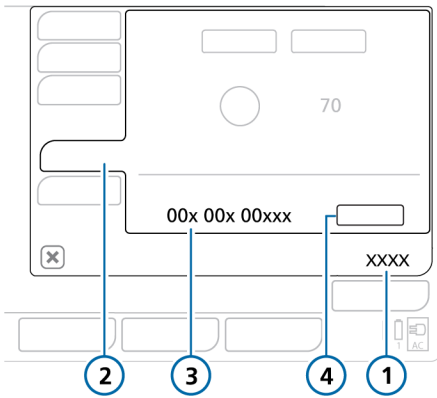
Parameter (unit)	Definition
Ventilation time	Displayed in the <b>Controls &gt; Patient</b> window, shows how long the patient has been ventilated. For details, see Section 8.6.
<b>CO2 related</b>	
FetCO2 (%)	Fractional end-tidal CO2 concentration. Permits assessment of PaCO2 (arterial CO2). Note that it is inaccurate in pulmonary embolism. Available when a CO2 sensor is connected and enabled.
PetCO2 (mmHg)	End-tidal CO2 pressure. The maximum partial pressure of CO2 exhaled during a tidal breath (just before the start of inspiration). It represents the final portion of air that was involved in the exchange of gases in the alveolar area, thus providing a reliable index of CO2 partial pressure in the arterial blood under certain circumstances. <b>PetCO2</b> does not reflect PaCO2 in the case of a pulmonary embolism. Available when a CO2 sensor is connected and enabled.
slopeCO2 (%CO2/l)	Slope of the alveolar plateau in the <b>PetCO2</b> curve, indicating the volume/flow status of the lungs. Available when a CO2 mainstream sensor is connected and enabled.
V'alv (ml/min)	Alveolar minute ventilation. Permits assessment of actual alveolar ventilation (as opposed to minute ventilation). $V_{alv} * f$ (normalized to 1 min) Available when a CO2 mainstream sensor is connected and enabled.
V'CO2 (ml/min)	CO2 elimination. Net exhaled volume of CO2 per minute. Permits assessment of metabolic rate (for example, it is high with sepsis) and treatment progress. Available when a CO2 mainstream sensor is connected and enabled.
VDaw (ml)	Airway dead space. Gives an effective, in-vivo measure of volume lost in the conducting airways. A relative increase in dead space points to a rise in respiratory insufficiency and can be regarded as an indicator of the current patient situation. Patients with high dead space values are at particular risk if the muscles also show signs of fatigue. Available when a CO2 mainstream sensor is connected and enabled.
VDaw/VTE (%)	Airway dead space fraction at the airway opening. Available when a CO2 mainstream sensor is connected and enabled.

Parameter (unit)	Definition
VeCO2 (ml)	Exhaled CO2 volume, updated breath by breath. Available when a CO2 mainstream sensor is connected and enabled.
ViCO2 (ml)	Inspired CO2 volume, updated breath by breath. Available when a CO2 mainstream sensor is connected and enabled.
Vtalv (ml)	Alveolar tidal ventilation. VTE - VDaw Available when a CO2 mainstream sensor is connected and enabled.

## 8.6 Viewing patient ventilation time

The **Controls > Patient** window displays a timer that shows how long the patient has been ventilated.

Figure 8-20. Ventilation time



- |            |   |
|------------|---|
| 1 Controls | 3 Ventilation time (days, hours, minutes) |
| 2 Patient  | 4 Reset                                   |

The timer records time as follows:

- The timer starts when you start ventilation.
- When you enter **Standby**, the timer pauses. It picks up again from the last value when you exit **Standby** and return to active ventilation.
- When you set up a new patient in the **Standby** window, and start ventilation, the timer resets to 0.
- When you select **Last patient** in the **Standby** window, the timer continues from the last total time recorded.
- When you touch **Reset**, the timer resets to 0.

When the timer is reset, an entry is made to the **Event** log recording the time of the reset, as well as how long the ventilator had been running prior to the reset.

### To reset the timer to 0

1. Touch **Controls**.
2. In the **Controls** window, touch the **Patient** tab.
3. Touch **Reset**.

The timer starts again at 00d 00h 00min.

## 8.7 Viewing device-specific information

The **System > Info** window displays device-specific information including serial number, model, operating hours, hours since startup, time to next service, battery capacity, oxygen consumption, software version, and installed options.

### To view device-specific information

1. Touch **System**.
2. If needed, touch the **Info** tab.



# 9

## Responding to alarms

9.1	Overview.....	168
9.2	About the alarm buffer .....	172
9.3	Adjusting alarm loudness (volume) .....	173
9.4	Troubleshooting alarms.....	174

## 9.1 Overview

Operator-adjustable and nonadjustable alarms together with a visual alarm indicator notify you of conditions that require your attention.

These alarms are categorized as high, medium, or low priority, as described in Table 9-1. Figure 9-1 shows the ventilator's visual alarm indications.

Additional alarms conditions are associated with technical fault and technical note alarms, as well as informational messages.

You can view active alarms in the **alarm buffer** (Figure 9-2). Information about the alarm is also stored in the **Event log**.

Alarms are indicated in the color associated with the alarm priority as follows:

- The alarm lamp on top of the ventilator lights and flashes.
- The alarm text is shown in color in the **Message bar** on the ventilator display.
- An MMP associated with an active alarm is shown in color.
- In the **Monitoring** window, a parameter associated with an active alarm is shown in the associated color.
- Any affected parameter shown in the **Dynamic Lung** is shown in color.
- The alarm text is displayed in the **alarm buffer**.

When an alarm condition is serious enough to possibly compromise safe ventilation, the device defaults to the **Ambient** state (Section 7.6). The inspiratory valve closes, and the ambient and expiratory valves are opened, letting the patient breathe room air unassisted.

For details on setting alarm limits, see Section 5.6.

Table 9-1 describes the audio and visual characteristics of these types of alarms and provides guidance on how to respond.

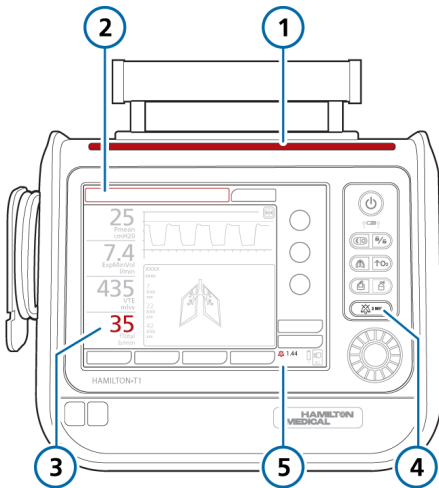


Table 9-1. Alarm indicators

Alarm type	Message bar	Alarm lamp / Alarm status indicator	Audio	Action required
High priority	Red, with alarm message	Red, flashing	A sequence of 5 beeps, repeated until the alarm is reset. If the audible alarm is not silenced during the first minute, the continuous-tone buzzer also sounds.	The patient's safety is compromised. The problem needs immediate attention.
Medium priority	Yellow, with alarm message	Yellow, flashing	A sequence of 3 beeps, repeated periodically.	The patient needs prompt attention.
Low priority	Yellow, with alarm message	Yellow, solid	Two sequences of beeps. This is not repeated.	Operator awareness is required.
Technical fault	Red, with the text, <i>Safety ventilation, or Technical fault: xxxxxx</i>	Red, flashing	Same as for high-priority alarm, if technically possible. At a minimum, a continuous buzzer tone. The buzzer cannot be silenced.	The ventilator enters Safety ventilation, or, if it cannot safely ventilate, the Ambient state. <ul style="list-style-type: none"> <li>• Provide alternative ventilation.</li> <li>• Turn off the ventilator.</li> <li>• Have the ventilator serviced.</li> </ul>
Technical event	Depends on severity of the event. Can be low, medium, or high.	Same as the associated alarm level	Same as the associated alarm level.	A technical alarm cannot typically be corrected by the operator. Ventilation continues. Have the ventilator serviced.

Alarm type	Message bar	Alarm lamp / Alarm status indicator	Audio	Action required
Technical note	Provides technical information about a hardware or software issue, displayed only in the Event log.	--	--	No action is required.

Figure 9-1. Visual alarm indications



- 1 Alarm lamp
- 2 Message bar
- 3 MMP associated with alarm
- 4 Audio Pause key
- 5 Audio Pause indicator and countdown

### 9.1.1 Alarm limit indicators

Alarm limits are shown in the Alarms > Limits windows.

## 9.1.2 Responding to an alarm

### WARNING

When an **Audio pause** is active, the following critical alarms still generate an audible alarm:

- Apnea
- External power loss
- Oxygen supply failed
- Technical events: 231003, 243001, 243002, 283007, 284003, and 285003
- All technical faults

### CAUTION

*Carefully set alarm limits according to the patient's condition. Setting limits too high or too low defeats the purpose of the alarm system.*

Alarms may result from either a clinical condition or an equipment issue. In addition, a single alarm condition can generate multiple alarms.

Your search for the causes of the alarm condition should be assisted by, but not limited to, the alarm messages displayed.

### To respond to an alarm

1. Approach the patient immediately.
2. Secure sufficient and effective ventilation for the patient.


You can pause the audible alarm, if appropriate and available. See Section 9.1.3.

3. Correct the alarm condition from the alarm messages. See Section 9.4.  
For a technical fault, remove the ventilator from use, note the fault code, and have the ventilator serviced.
4. If appropriate, readjust the alarm limit.

## 9.1.3 Temporarily silencing an alarm

One component of an alarm is the audible alarm sound. With most alarms, you can pause (silence) the alarm sound for two minutes at a time.

### To temporarily silence an alarm

- ▶ Press  (**Audio pause**) on the front of the ventilator (Figure 10-2).

The audible ventilator alarm is muted for two minutes. Pressing the key a second time cancels the **Audio pause**.

The indicator light next to the **Audio pause** key is continuously lit red while an **Audio pause** is active.

The display also indicates an **Audio pause** is engaged as follows (Figure 9-1):

- The **Audio Pause** indicator is displayed.
- A countdown timer on the main display shows the remaining time for the **Audio pause**.

When the time expires and the issue has not yet been resolved, an audible alarm sounds again.

## 9.2 About the alarm buffer

The **alarm buffer** shows up to 4 active alarm messages or up to 6 inactive alarm messages:

- The **alarm buffer** shows active alarms as they are generated (Figure 9-2). The alarm messages also alternate in the **Message bar**. Active alarms are shown in wide color-coded boxes.
- If no alarms are active, the **alarm buffer** shows the most recent inactive alarms (Figure 9-3). Inactive alarms are shown in narrow color-coded boxes. In addition, the **i**-icon is visible on the display.

### To view alarms

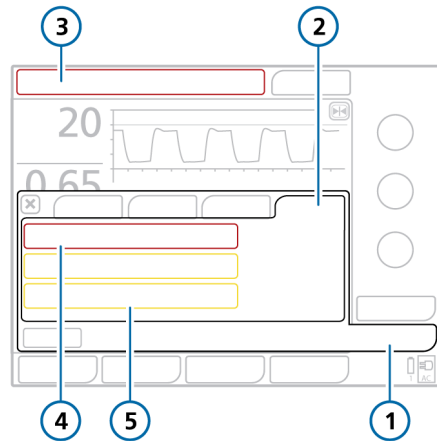
- ▶ Open the **Alarms > Buffer** window by doing one of the following:
  - Touch an active alarm in the **Message bar** at the top of the display (Figure 9-2).
  - Touch the inactive alarm indicator (the **i**-icon) (Figure 9-3).
  - Touch **Alarms > Buffer**.

The most recent alarm is at the top of the list.

### To clear the list of inactive alarms

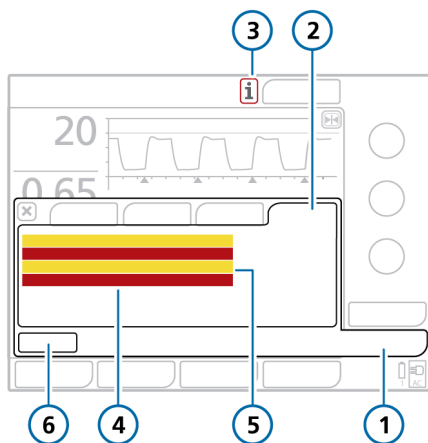
- ▶ Touch the **Reset** button (Figure 9-3). Closing the **alarm buffer** does not erase its contents.

Figure 9-2. Alarm buffer with active alarms



- |                             |  |
|-----------------------------|--|
| 1 Alarms                    | 4 High-priority alarm (red)              |
| 2 Buffer                    | 5 Low- or medium-priority alarm (yellow) |
| 3 Alarm text in Message bar |  |

Figure 9-3. Alarm buffer with inactive alarms



- |          |   |
|----------|---|
| 1 Alarms | 4 Inactive high-priority alarm (red)              |
| 2 Buffer | 5 Inactive low- or medium-priority alarm (yellow) |
| 3 i-icon | 6 Reset   |

## 9.3 Adjusting alarm loudness (volume)

### WARNING

Be sure to set the auditory alarm loudness above the ambient sound level. Failure to do so can prevent you from hearing and recognizing alarm conditions.

You can set the loudness of the audible alarm.

By default, the loudness is set to 5 (Adult/Ped) or 3 (Neonatal).

If you set the loudness below the default value during a patient session, the value is reset to the default upon:

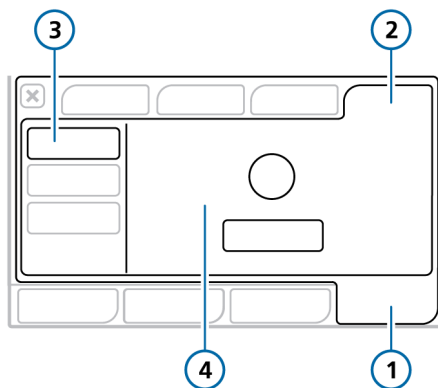
- Setting up a new patient
- Turning the ventilator off and on again

You cannot set the loudness below the minimum level configured for the device (Chapter 12).

### To adjust the alarm loudness

1. Touch **System > Settings**.
2. Touch the **Loudness** button if the **Loudness** window is not already displayed.
3. Activate and adjust the **Loudness** control, as needed.
4. Touch **Test** to check the loudness level.  
Ensure the loudness level is above the ambient sound level.
5. Repeat the process as required, and close the window.

Figure 9-4. Alarm loudness control



- |            |                                    |
|------------|------------------------------------|
| 1 System   | 3 Loudness                         |
| 2 Settings | 4 Loudness control and Test button |

## 9.4 Troubleshooting alarms

Table 9-2 is an alphabetical list of the alarm messages displayed by the HAMILTON-T1, along with their definitions and suggested corrective actions.

These corrective actions are sequenced to correct the most probable issue or to present the most efficient corrective action first. The proposed actions, however, may not always correct the particular problem.

Table 9-2. Alarms and other messages

Alarm	Definition	Action needed
Ambient state	The inspiratory and expiratory channels are opened, letting the patient breathe room air unassisted. See Section 7.6.	Provide alternative ventilation immediately.
Apnea ventilation ended	<i>Low priority.</i> Backup mode was reset, and ventilator is again ventilating in its original support (pre-apnea) mode.	No action required.
Apnea ventilation	<i>Low priority.</i> Apnea backup ventilation has started. No breath delivered for the operator-set apnea time. Apnea backup ventilation is on.	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check trigger sensitivity.</li> <li>• Check the control settings for the backup mode.</li> <li>• Consider changing the mode.</li> </ul>
Apnea	<i>High priority.</i> No patient trigger within the operator-set apnea time in APVsimv, SPONT, DuoPAP, APRV, or NIV mode. Apnea backup is off.	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check trigger sensitivity.</li> <li>• Consider changing the mode.</li> </ul>
ASV: Cannot meet the target	<i>Low priority.</i> The operator-set %MinVol cannot be delivered, possibly due to setting conflicts or lung-protective rules.	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the Pasvlimit setting and adjust if appropriate.</li> <li>• Consider a mode change. However, be aware that other modes may not enforce lung-protective rules.</li> </ul>

If your issue is not resolved after performing the recommended tasks, contact your Hamilton Medical authorized service personnel.

For SpO<sub>2</sub>-related alarms, see the *Pulse Oximetry Instructions for Use*.

Alarm	Definition	Action needed
Battery 1, 2: Calibration required	<i>Low priority.</i> The battery requires calibration. You may continue to use the battery.	Replace the battery with a properly calibrated battery to continue ventilation.
Battery 1, 2: Defective	<i>High priority.</i> Battery defective. Ventilation continues if an alternative power source is connected.	<ul style="list-style-type: none"> <li>• Replace battery.</li> <li>• Prepare alternative ventilation.</li> <li>• If the problem still persists, have the ventilator serviced.</li> </ul>
Battery 1, 2: Replacement required	<i>Low priority.</i> Battery capacity is insufficient for reliable operation and must be replaced immediately.	<ul style="list-style-type: none"> <li>• Connect the ventilator to primary power (AC or DC).</li> <li>• Replace the battery.</li> <li>• If a replacement is not available, provide alternative ventilation until the issue is resolved.</li> <li>• If the problem still persists, have the ventilator serviced.</li> </ul>
Battery 1, 2: Temperature high	<i>High priority.</i> The battery temperature is higher than expected.	<ul style="list-style-type: none"> <li>• Remove the ventilator from the sun or other heat source.</li> <li>• Replace the battery.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• If the problem still persists, have the ventilator serviced.</li> </ul>
Battery 1, 2: Wrong battery	<i>Low priority.</i> The battery in use is not the correct battery for this ventilator.	<ul style="list-style-type: none"> <li>• Replace the battery.</li> <li>• Connect the ventilator to primary power (AC or DC).</li> <li>• Provide alternative ventilation until the issue is resolved.</li> </ul>
Battery communication error	<i>High priority.</i> Battery data is not available. Ventilation continues.	<ul style="list-style-type: none"> <li>• Check the battery connectors and that the battery is installed correctly.</li> <li>• Make sure the battery lock is properly closed.</li> <li>• If the problem persists, replace the battery.</li> <li>• If the problem still persists, have the ventilator serviced.</li> </ul>

Alarm	Definition	Action needed
<p>Battery low</p>	<p>The low battery alarm has different levels of priority depending on battery age and condition. The alarm priority levels are defined as follows:</p> <p><b>High priority.</b> The ventilator is running on battery power, and the battery charge is critically low. You have a minimum of 5 minutes operating time left.</p> <p>If the high-priority <b>Battery low</b> alarm occurs when starting up the ventilator, you may have less than 5 minutes of operating time remaining.</p> <p><b>Medium priority.</b> The ventilator is running on battery power and the battery charge is low.</p> <p><b>Low priority.</b> The ventilator is running on primary power and the battery charge is low.</p>	<ul style="list-style-type: none"> <li>• Connect the ventilator to a primary power source.</li> <li>• Install charged battery.</li> <li>• If necessary, be prepared to provide alternative ventilation.</li> </ul>
<p>Battery power loss</p>	<p><i>High priority.</i> No battery is present.</p>	<ul style="list-style-type: none"> <li>• Connect the ventilator to primary power (AC or DC).</li> <li>• Insert a battery.</li> </ul>
<p>Battery totally discharged</p>	<p><i>High priority.</i> The battery charge level is below 5%. The ventilator switches to the <b>Ambient</b> state.</p>	<ul style="list-style-type: none"> <li>• Connect the ventilator to primary power (AC or DC). Connecting to primary power also charges the battery.</li> <li>• Immediately provide alternative ventilation until the issue is resolved.</li> <li>• If the problem still persists, have the ventilator serviced.</li> </ul>
<p>Blower fault</p>	<p><i>High priority.</i> A blower malfunction was detected. A technical alarm cannot typically be corrected by the operator. The ventilator switches to the <b>Ambient</b> state.</p>	<ul style="list-style-type: none"> <li>• Immediately provide alternative ventilation.</li> <li>• Have the ventilator serviced.</li> </ul>
<p>Blower service required</p>	<p><i>Low priority.</i> Blower has reached the end of its lifespan.</p>	<p>Have the ventilator serviced.</p>



Alarm	Definition	Action needed
Buzzer defective	<i>High priority.</i> A buzzer malfunction was detected. A technical alarm cannot typically be corrected by the operator.	<ul style="list-style-type: none"> <li>Restart device.</li> <li>Provide alternative ventilation until the issue is resolved.</li> <li>If the problem persists, have the ventilator serviced.</li> </ul>
Check CO2 sensor airway adapter	<i>Low priority.</i> Adapter disconnection, optical block, or adapter type changed.	<ul style="list-style-type: none"> <li>Check patient condition.</li> <li>Check the airway adapter for excess moisture accumulation /contamination by secretions.</li> <li>Replace / perform zero calibration on airway adapter.</li> </ul>
Check CO2 sensor sampling line	<i>Low priority.</i> The CO2 sidestream sensor sampling line is occluded by water.	<ul style="list-style-type: none"> <li>Check patient condition.</li> <li>Replace sampling line.</li> </ul>
Check flow sensor tubing	<p><i>High priority.</i> The flow sensor tubes are disconnected or occluded.</p> <p>The ventilator switches to PCV+ mode and displays the internal ventilator pressure (Pvent) instead of airway pressure (Paw).</p> <p>The ventilator returns to the previous mode when measurements are within the expected range.</p>	<ul style="list-style-type: none"> <li>Check the flow sensor connection to the ventilator.</li> <li>Connect and calibrate a new flow sensor.</li> </ul>
Check flow sensor	<p><i>High priority.</i> Flow sensor measurements are out of expected range.</p> <p>The ventilator changes to PCV+ mode and displays the internal ventilator pressure (Pvent) instead of airway pressure (Paw).</p> <p>The ventilator returns to the previous mode when measurements are within the expected range.</p>	<ul style="list-style-type: none"> <li>Make sure the flow sensor is the correct type for the patient (Adult/ Ped or Neonatal).</li> <li>Check the flow sensor connection to the ventilator.</li> <li>Connect and calibrate a new flow sensor.</li> </ul>

Alarm	Definition	Action needed
Check patient interface	<p><i>High priority.</i> Internal pressure is too high in HiFlowO2. Flow cannot be delivered to the patient.</p> <p>For alarm details when using a speaking valve, see Table 10-1.</p>	<ul style="list-style-type: none"> <li>• Observe the patient</li> <li>• Check patient interface for blockage.</li> </ul> <p>If no blockage is observed, consider reducing the flow to decrease back pressure.</p> <ul style="list-style-type: none"> <li>• Check breathing circuit limbs and tubing for kinks.</li> </ul>
Check settings	<p><i>Low priority.</i> A change to a control or alarm setting was not saved.</p>	<p>Check and confirm settings, including alarms.</p>
Circuit calibration needed	<p><i>Medium priority, Low after silence.</i> The ventilator does not have correct calibration data.</p> <p>Only active in nCPAP and nCPAP-PC modes.</p>	<p>Calibrate the neonatal breathing circuit (Section 6.2.2).</p>
CO2 calibration needed	<p><i>Low priority.</i> A previous sensor zero calibration failed.</p>	<p>Perform the following checks, repeating the calibration after each one, until calibration is successful:</p> <ul style="list-style-type: none"> <li>• Clean or replace airway adapter.</li> <li>• Perform a zero calibration of the sensor, making sure there is no source of CO2 near the airway adapter.</li> <li>• Replace the airway adapter.</li> <li>• Replace the CO2 sensor.</li> <li>• If the problem persists, have the ventilator serviced.</li> </ul>
CO2 sensor defect	<p><i>Low priority.</i> The CO2 sensor signal indicates a hardware error or a third-party sensor is installed.</p>	<ul style="list-style-type: none"> <li>• Disconnect the sensor from the CO2 module. Wait a few seconds, and reconnect.</li> <li>• Perform a zero calibration of the sensor. Ensure the sensor is attached to the airway adapter during zero calibration.</li> <li>• Replace the CO2 sensor. Make sure the sensor is a genuine Hamilton Medical part.</li> </ul>

Alarm	Definition	Action needed
CO2 sensor disconnected	<i>Low priority.</i> The CO2 module is installed, but there is no signal from the CO2 sensor. CO2 monitoring is enabled.	<ul style="list-style-type: none"> <li>• Make sure a CO2 sensor is connected.</li> <li>• Check CO2 sensor connections (CO2 sensor cable to module, CO2 module to ventilator).</li> <li>• If the problem persists, have the ventilator serviced.</li> </ul>
CO2 sensor over temperature	<i>Low priority.</i> The temperature at the CO2 sensor is too high.	<ul style="list-style-type: none"> <li>• Check whether the sensor is affected by an external heating source.</li> <li>• Remove the sensor from the airway, and disconnect the sensor from the CO2 module. Reconnect.</li> <li>• Verify that system is running within the specified environmental conditions. Check for excessive airway temperature, which could be caused by defective humidifier, heater wire, or probe.</li> </ul>
CO2 sensor warmup	<i>Low priority.</i> The CO2 operating temperature has not yet been reached or is unstable.	Wait for sensor to warm up.
Device temperature high	<i>High priority.</i> The internal temperature of the ventilator is higher than expected.	<ul style="list-style-type: none"> <li>• Remove the ventilator from the sun or other heat source.</li> <li>• Check the cooling fan filter and fan.</li> <li>• Prepare alternative ventilation.</li> <li>• Have the ventilator serviced.</li> </ul>
Disconnection on patient side	<p><i>High priority.</i> VTE is less than one-eighth of the delivered VTI, and delivered VTI exceeds 50 ml.</p> <p>Applicable in invasive modes. For APRV and DuoPAP modes, only applicable during the pressure phase.</p> <p>For alarm details when using a speaking valve, see Table 10-1.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the breathing circuit for a disconnection between the patient and the flow sensor, or for other large leaks (for example, ET tube).</li> </ul>

Alarm	Definition	Action needed
<p>Disconnection on ventilator side</p>	<p><i>High priority.</i> Measured VTI at the flow sensor is less than one-half of the delivered VTI, and delivered VTI exceeds 50 ml.</p> <p>For alarm details when using a speaking valve, see Table 10-1.</p>	<ul style="list-style-type: none"> <li>• Check the expiratory valve:               <ul style="list-style-type: none"> <li>– Check the condition of the expiratory valve set. If anything is defective, replace.</li> <li>– Check whether the expiratory valve is affected by any nebulizing agent.</li> <li>– Make sure that the expiratory valve is properly installed.</li> <li>– Check whether there is a disconnection at the expiratory valve.</li> </ul> </li> <li>• Replace the expiratory valve.</li> <li>• Check the flow sensor. If needed, replace the flow sensor.</li> </ul>
<p>Exhalation obstructed</p>	<p><i>High priority.</i> Either the end-expiratory pressure is too high or the end-expiratory flow is too low.</p> <p>Note that you must use an inspiratory filter to prevent contamination. The ventilator may be contaminated if no inspiratory filter is used.</p> <p>Not active in HiFlowO2.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the expiratory limb for occlusion.</li> <li>• Check the expiratory valve set. Replace if needed.</li> <li>• Check the flow sensor tubes for occlusion.</li> <li>• Adjust breath timing controls to increase the expiratory time.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced.</li> </ul>
<p>External flow sensor failed</p>	<p><i>High priority.</i> The external flow sensor does not work properly.</p>	<ul style="list-style-type: none"> <li>• Check flow sensor for excessive secretions and/or water accumulation.</li> <li>• Provide alternative ventilation and clean the flow sensor with sterile water.</li> <li>• Connect and calibrate a new flow sensor.</li> </ul>

Alarm	Definition	Action needed
Fan failure	<i>Medium priority.</i> There is a problem with the cooling fan.	<ul style="list-style-type: none"> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Disconnect the ventilator from the patient.</li> <li>• Have the ventilator serviced.</li> </ul>
Flow sensor calibration needed	<i>High priority.</i> The ventilator does not have correct calibration data or automatic recalibration of the flow sensor is impossible.	<ul style="list-style-type: none"> <li>• Calibrate the flow sensor as soon as possible.</li> <li>• Flow, volume, and pressure readings are less accurate with an uncalibrated flow sensor.</li> </ul>
Function key not operational	<i>Medium priority.</i> Function key is defective. Ventilation continues.	<ul style="list-style-type: none"> <li>• Turn off the ventilator using the <b>Power/Standby</b> button on the back of the device.</li> <li>• Have the ventilator serviced.</li> </ul>
High Flow	<i>Medium priority, Low after silence.</i> Flow has reached the set limit. Only active in nCPAP and nCPAP-PC modes.	<ul style="list-style-type: none"> <li>• Check the patient interface and breathing circuit for disconnection or excessive leakage.</li> <li>• Check ventilator settings and alarm limits.</li> </ul>
High frequency	<i>Medium priority.</i> The measured <b>fTotal</b> exceeds the set alarm limit.	<ul style="list-style-type: none"> <li>• Check the patient for adequate ventilation (VTE).</li> <li>• Check alarm limits.</li> <li>• Check the trigger sensitivity.</li> <li>• If the ventilator is in ASV mode, see Section 7.8.</li> </ul>
High minute volume	<i>High priority.</i> The measured <b>Exp-MinVol</b> exceeds the set alarm limit.	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check and confirm settings, including alarms.</li> </ul>

Alarm	Definition	Action needed
High oxygen	<p><i>High priority.</i></p> <p>One of the following has occurred:</p> <ul style="list-style-type: none"> <li>• If the <b>Oxygen</b> alarm limits are set automatically, the measured oxygen is more than 5% (absolute) above the current <b>Oxygen</b> control setting.</li> <li>• If the <b>Set Oxygen</b> alarm limits manually checkbox is selected, the measured oxygen is above the set upper limit.</li> </ul>	<ul style="list-style-type: none"> <li>• Calibrate the O2 sensor.</li> <li>• Install a new O2 sensor.</li> <li>• Check alarm limits (if set manually).</li> </ul>
High PEEP	<p><i>Medium priority.</i> Monitored PEEP exceeds (set PEEP + 5 cmH2O) for two consecutive breaths.</p> <p><i>For DuoPAP and APRV only:</i> Alarm applies to both <b>P high</b> and <b>P low</b> settings. The alarm sounds when the monitored <b>P high</b> exceeds (set <b>P high</b> + 5 cmH2O) or monitored <b>P low</b> exceeds (set <b>P low</b> + 5 cmH2O) for two consecutive breaths.</p> <p>If <b>T low</b> is set to &lt; 3 seconds, the <b>High PEEP</b> alarm is disabled for <b>P low</b> settings. This reduces the incidence of false positive alarms.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check and confirm settings, including alarms.</li> <li>• Check the expiratory valve set for possible obstructions.</li> <li>• Check for obstructions in the expiratory limb.</li> </ul>

Alarm	Definition	Action needed
High pressure <i>Audio pause is disabled for this alarm.</i>	<p><i>High priority.</i> The measured inspiratory pressure exceeds the set high Pressure alarm limit. The ventilator immediately closes the inspiratory valve to stop gas flow to the patient and opens the expiratory valve to reduce pressure to the PEEP/CPAP level.</p> <p>If the pressure reaches 15 cmH<sub>2</sub>O above the high Pressure alarm limit for longer than 5 seconds, the ventilator opens the release valve.</p> <p>If the pressure reaches 15 cmH<sub>2</sub>O above the high Pressure alarm limit for longer than 7 seconds, the ventilator enters the Ambient state.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Adjust the Pressure alarm limit.</li> <li>• Check the artificial airway of the patient for kinks and occlusions.</li> <li>• Check the breathing circuit limbs and flow sensor tubes for kinks and occlusions.</li> <li>• Provide alternative ventilation once the ventilator enters the Ambient state.</li> </ul>
High pressure during sigh	<p><i>High priority.</i> A sigh cannot be fully delivered because excessive inspiratory pressure would be required. The sigh is partially delivered.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the artificial airway of the patient for kinks and occlusions.</li> <li>• Check the breathing circuit limbs and flow sensor tubes for kinks and occlusions.</li> <li>• Consider disabling the Sigh function.</li> </ul>
Inspiratory volume limitation	<p><i>Medium priority.</i> The delivered V<sub>t</sub> is more than 1.5 times the set high V<sub>t</sub> alarm limit. Pressure is reduced to PEEP level.</p> <p>The APV controls reduce the pressure for the next breath by 3 cmH<sub>2</sub>O.</p> <p>Disabled in noninvasive modes.</p> <p>For alarm details when using a speaking valve, see Table 10-1.</p>	<ul style="list-style-type: none"> <li>• Reduce the P<sub>support</sub> setting.</li> <li>• Adjust the high V<sub>t</sub> alarm limit.</li> </ul>
Invalid communication board	<p><i>Low priority.</i> The installed communication board is invalid.</p>	<ul style="list-style-type: none"> <li>• Contact your Hamilton Medical technical representative.</li> <li>• Have the ventilator serviced.</li> </ul>

Alarm	Definition	Action needed
IRV	<p><i>Low priority.</i> The set I:E ratio is above 1:1, leading to inverse ratio ventilation.</p> <p>Does not apply in APRV mode.</p>	<p>Check the timing control settings.</p>
Loss of external power	<p><i>Low priority.</i> The ventilator is running on battery power due to loss of a primary power source.</p>	<ul style="list-style-type: none"> <li>• Silence the alarm.</li> <li>• Check integrity of connection to primary power source.</li> <li>• Check battery status.</li> <li>• Prepare for possible power loss.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> </ul>
Loss of PEEP	<p><i>Medium priority.</i> One of the following conditions is in effect:</p> <ul style="list-style-type: none"> <li>• Pressure during exhalation is below (set PEEP/CPAP – 3 cmH<sub>2</sub>O) for more than 10 seconds</li> <li>• Measured end-expiratory pressure is below (set PEEP/CPAP – 3 cmH<sub>2</sub>O) for two consecutive breaths</li> </ul>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the breathing circuit for leaks. Replace the breathing circuit, if necessary.</li> <li>• Check the condition of the expiratory valve set. If anything is defective, replace.</li> </ul>
Loudspeaker defective	<p><i>High priority.</i> A loudspeaker malfunction was detected. A technical alarm cannot typically be corrected by the operator. Ventilation continues.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced.</li> </ul>
Low frequency	<p><i>Medium priority.</i> Measured f<sub>Total</sub> is below the set alarm limit.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Adjust the low f<sub>Total</sub> alarm limit.</li> </ul>
Low minute volume	<p><i>High priority.</i> Measured ExpMinVol is below the set alarm limit.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the breathing circuit and artificial airway of the patient for leaks and/or disconnection.</li> <li>• Check and confirm settings, including alarms.</li> </ul>



Alarm	Definition	Action needed
Low oxygen	<p><i>High priority.</i></p> <p>One of the following has occurred:</p> <ul style="list-style-type: none"> <li>• If the <b>Oxygen</b> alarm limits are set automatically, the measured oxygen is more than 5% (absolute) below the current <b>Oxygen</b> control setting.</li> <li>• If the <b>Set Oxygen</b> alarm limits manually checkbox is selected, the measured oxygen is below the set lower limit.</li> </ul>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the oxygen supply. Provide an alternative source of oxygen, if necessary.</li> <li>• Calibrate the O2 sensor.</li> <li>• Provide alternative ventilation and install a new O2 sensor.</li> </ul>
Low pressure	<p><i>High priority.</i> The set pressure during inspiration was not reached.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the breathing circuit for a disconnection between the patient and the flow sensor, or for other large leaks.</li> </ul>
Maximum leak compensation	<p><i>Low priority.</i> A leak cannot be fully compensated.</p> <p>In APVsimv and APVcmv modes only.</p>	<ul style="list-style-type: none"> <li>• Inspect the system for leaks.</li> <li>• Suction the patient, if needed.</li> <li>• Ensure the high <b>Pressure</b> limit is appropriate.</li> <li>• Switch to a different ventilation mode.</li> </ul>
O2 sensor calibration needed	<p><i>Low priority.</i> O2 sensor calibration data is not within expected range, or sensor is new and requires calibration.</p>	<ul style="list-style-type: none"> <li>• Calibrate the O2 sensor.</li> <li>• Verify temperature settings are within environmental specifications.</li> <li>• Replace O2 sensor if required.</li> <li>• Have the ventilator serviced.</li> </ul>
O2 sensor defective	<p><i>Low priority.</i> The O2 sensor is depleted.</p>	<ul style="list-style-type: none"> <li>• Install a new O2 sensor.</li> </ul>
O2 sensor missing	<p><i>Low priority.</i> There is no signal from the O2 sensor.</p>	<ul style="list-style-type: none"> <li>• Install an O2 sensor or use an external monitor, according to ISO 80601-2-55.</li> </ul>
O2 sensor not system compatible	<p><i>Low priority.</i> The incorrect type of O2 sensor is installed.</p>	<p>Ensure a Hamilton Medical O2 sensor is used and it is properly installed.</p>

Alarm	Definition	Action needed
Obstruction	<p><i>High priority.</i> End-expiratory pressure &gt; set PEEP/CPAP + 5, or Flow &lt; 1 l/min.</p> <p>Only active in nCPAP and nCPAP-PC modes.</p>	<ul style="list-style-type: none"> <li>• Check the patient.</li> <li>• Check the expiratory limb for occlusion.</li> <li>• Check the expiratory valve set.</li> <li>• Check the pressure line for occlusion.</li> <li>• Adjust breath timing controls to increase the expiratory time.</li> <li>• Have the ventilator serviced.</li> </ul>
Options not found	<p><i>High priority.</i> Options were not found during startup.</p>	<ul style="list-style-type: none"> <li>• Restart device.</li> <li>• If the problem persists, have the ventilator serviced.</li> </ul>
Oxygen supply failed	<p><i>High priority.</i> Oxygen source flow is lower than expected.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the oxygen supply. Provide an alternative source of oxygen, if necessary.</li> <li>• Check the oxygen source/supply for potential leakage.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> </ul>
Performance limited by high altitude	<p><i>Medium priority, Low after silence.</i> The airway pressure cannot be reached at the current altitude.</p> <p>As long as the device remains above the altitude limit, the pressure cannot be reached, and the alarm is active.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• If at all possible, consider lowering altitude to reach the target performance.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> </ul>
PetCO <sub>2</sub> high	<p><i>Medium priority.</i> PetCO<sub>2</sub> exceeds the set alarm limit.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check and confirm settings, including alarms.</li> </ul>
PetCO <sub>2</sub> low	<p><i>Medium priority.</i> PetCO<sub>2</sub> is below the set alarm limit.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check the breathing circuit and flow sensor/artificial airway of the patient for leaks.</li> <li>• Check and confirm settings, including alarms.</li> </ul>

Alarm	Definition	Action needed
Pressure limit has changed	<i>Low priority.</i> Applies in ASV mode. The <b>Pasvlimit</b> was changed. When this setting is changed, the device automatically adjusts the high <b>Pressure</b> alarm limit to 10 cmH <sub>2</sub> O above the specified <b>Pasvlimit</b> setting.	Make sure the pressure limit is high enough so that sufficient pressure can be applied for adequate breath delivery.
Pressure limitation	<i>Medium priority, Low after silence.</i> Inspiratory pressure, including PEEP/CPAP, is 10 cmH <sub>2</sub> O below <b>Pressure</b> . The ventilator limits applied pressure, so the target pressure or volume may not be achieved.	<ul style="list-style-type: none"> <li>• Check the patient for adequate ventilation.</li> <li>• Check and confirm settings, including alarms.</li> </ul>
Pressure not released	<i>High priority.</i> Airway pressure has exceeded the <b>Pressure</b> limit, and the pressure was not released via the expiratory valve after 5 seconds. The ventilator enters the <b>Ambient</b> state.	<ul style="list-style-type: none"> <li>• Check expiratory valve and breathing circuit for kinks and occlusions.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced.</li> </ul>
Preventive maintenance required	<i>Low priority.</i> According to its operating hours, the ventilator requires preventive maintenance.	Have the ventilator serviced as soon as possible.
Real-time clock failure	<i>Medium priority.</i> The date and time are not set.	Set the date and time ( <b>System &gt; Settings</b> window).
Release valve defective	<i>Low priority.</i> During the routine check of the ambient valve during a <b>Tightness</b> test, the valve was found to be defective.  The alarm is reset when a tightness test is successfully passed.  Ventilation is not necessarily affected.	If the problem still persists, have the ventilator serviced as soon as possible.
Replace HEPA filter	<i>Low priority.</i> The air inlet HEPA filter shows increased resistance.	Replace the HEPA filter as soon as possible.

Alarm	Definition	Action needed
Replace O2 sensor	<i>High priority.</i> Communication error, O2 sensor is defective. Ventilation is not necessarily affected. Oxygen concentration should not be affected by this issue. Ventilation can continue.	<ul style="list-style-type: none"> <li>• Replace O2 sensor.</li> <li>• If you cannot replace the O2 sensor, consider disabling it.</li> </ul>
Safety ventilation	<i>Technical fault.</i> A hardware or software issue was detected. The ventilator switches to <b>Safety</b> ventilation.	<ul style="list-style-type: none"> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced.</li> </ul>
Self test failed	<i>High priority.</i> The self test failed during startup. The <b>Start ventilation</b> button is unavailable. Note that if this error occurs when the device is restarting from a complete power loss, the device enters the <b>Ambient</b> state.	<ul style="list-style-type: none"> <li>• Restart device.</li> <li>• If the problem persists, have the ventilator serviced.</li> <li>• If the device enters the <b>Ambient</b> state, provide alternative ventilation and have the ventilator serviced.</li> </ul>
Suctioning maneuver	<i>Low priority.</i> Ventilation suppression is active, and ventilator settings are being maintained, although the ventilator is not delivering breaths.	Resume ventilation when desired by first reconnecting the patient.
Technical event: xxxxxx	<i>Low, medium, or high priority.</i> A hardware or software issue was detected. A technical alarm cannot typically be corrected by the operator. Ventilation continues.	Have the ventilator serviced.
Technical fault: xxxxxx	<i>Technical fault.</i> A hardware or software issue was detected. The ventilator switches to the <b>Ambient</b> state or to <b>Safety</b> ventilation.	<ul style="list-style-type: none"> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced.</li> </ul>
Technical state failed	There is a problem with the hardware configuration. Ventilation is not possible.	Have the ventilator serviced.
Touch not functional	<i>Low priority.</i> The touch screen is defective.	<ul style="list-style-type: none"> <li>• Turn the ventilator off and on again.</li> <li>• If the problem persists, have the ventilator serviced.</li> </ul>

Alarm	Definition	Action needed
Turn flow sensor	<p><i>Medium priority.</i> Either the flow sensor is connected to the breathing circuit facing the wrong direction or the flow sensor connections to the ventilator are reversed.</p> <p>Ventilation continues, but the ventilator corrects for the reversed signal.</p>	<ul style="list-style-type: none"> <li>• Check the flow sensor. The end marked <b>PATIENT</b> faces the patient.</li> <li>• Reverse the flow sensor tube connections on the ventilator.</li> <li>• The blue tube attaches to the blue connector. The clear tube attaches to the white connector.</li> </ul>
Unknown part number	<p><i>Technical fault.</i> A hardware or software issue was detected. The ventilator switches to the <b>Ambient</b> state.</p>	<ul style="list-style-type: none"> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced.</li> </ul>
Vent outlet temperature high	<p><i>High priority.</i> Inspiratory temperature is too high.</p> <p>Ventilation continues, but if temperature stays high, the ventilator may enter the <b>Ambient</b> state.</p>	<ul style="list-style-type: none"> <li>• Check whether the room temperature exceeds the ventilator's operating temperature limit.</li> <li>• Check that the air intake on the device is not obstructed.</li> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Have the ventilator serviced if temperature cannot be reduced.</li> </ul>
Ventilation canceled	<p><i>Technical fault.</i> A hardware or software issue was detected. The ventilator switches to the <b>Ambient</b> state.</p>	<ul style="list-style-type: none"> <li>• Provide alternative ventilation until the issue is resolved.</li> <li>• Contact your Hamilton Medical representative.</li> <li>• Have the ventilator serviced.</li> </ul>
Vt high	<p><i>Medium priority.</i> Measured VTE exceeds the set limit for 2 consecutive breaths.</p> <p>In invasive modes, if the delivered tidal volume exceeds 150% of the Vt high limit (<math>V_t &gt; 1.5 \times \text{high } V_t \text{ limit}</math>), the <b>Inspiratory volume limitation</b> alarm is generated.</p>	<ul style="list-style-type: none"> <li>• Check the pressure and volume settings for potential leaks and/or disconnections.</li> <li>• Check and confirm settings, including alarms.</li> </ul>

Alarm	Definition	Action needed
Vt low	<p><i>Medium priority.</i> Measured VTE is below the set limit for 2 consecutive breaths.</p> <p>For alarm details when using a speaking valve, see Table 10-1.</p>	<ul style="list-style-type: none"> <li>• Check patient condition.</li> <li>• Check and confirm settings, including alarms.</li> <li>• Check the breathing circuit and artificial airway of the patient for leaks, kinked limbs or tubing, or disconnection.</li> </ul>
Wrong expiratory valve <sup>36</sup>	<p><i>Medium priority, Low after silence.</i> The type of expiratory valve installed does not match the selected patient group, or no expiratory valve is installed.</p> <p>In addition to the alarm message, after attempting to start ventilation, the device displays a dialog box describing the risks of proceeding with the wrong valve.</p> <p>The alarm is recorded in the Events log and remains in the alarm buffer.</p>	<p>Install the appropriate expiratory valve.</p> <p>To start ventilating the patient, you must confirm that you are aware of the issue by selecting either <b>Accept</b> or <b>Decline</b> in the dialog box.</p> <ul style="list-style-type: none"> <li>• By selecting <b>Accept</b>, you accept the risks associated with using the wrong valve for selected patient. Ventilation starts after touching <b>Accept</b>.</li> </ul> <p>This option is only to be used in emergency cases, where the appropriate expiratory valve for the patient group is not available and mechanical ventilation must be delivered.</p> <ul style="list-style-type: none"> <li>• By selecting <b>Decline</b>, the dialog box closes and you remain in standby.</li> </ul> <p>The selection you make (Accept or Decline) is recorded with the alarm in the Events log.</p>
Wrong flow sensor	<p><i>High priority.</i> The type of flow sensor connected does not match the selected patient group.</p>	<ul style="list-style-type: none"> <li>• Check the patient group selection.</li> <li>• Connect and calibrate the correct flow sensor.</li> </ul>

<sup>36</sup> Applies only to devices with serial number > 3000.

# 10

## Ventilation settings and functions

10.1	Overview.....	192
10.2	Accessing settings during ventilation .....	192
10.3	Entering/exiting Standby .....	194
10.4	Oxygen enrichment.....	195
10.5	High flow oxygen therapy .....	196
10.6	Manual breath .....	197
10.7	Working with a nebulizer .....	197
10.8	Working with a speaking valve.....	198
10.9	Locking and unlocking the touch screen.....	199
10.10	Capturing a screenshot .....	200
10.11	About the Event log .....	200
10.12	Setting display options .....	202

## 10.1 Overview

This chapter describes changing ventilation settings during active ventilation, as well as how to perform special functions on the ventilator.

*Before proceeding, review the safety information in Chapter 1.*

## 10.2 Accessing settings during ventilation

You can change patient data and ventilation control settings during ventilation, as needed.

### 10.2.1 Accessing patient data during ventilation

#### NOTICE

Changing the patient height automatically adjusts the following settings based on the recalculated IBW:

- Apnea backup setting (when set to Automatic)
- Safety ventilation startup values

Other settings and alarm limits are not adjusted.

During ventilation, the **Controls > Patient** window displays the basic patient profile, including sex, height, and ventilation time (Section 5.2).

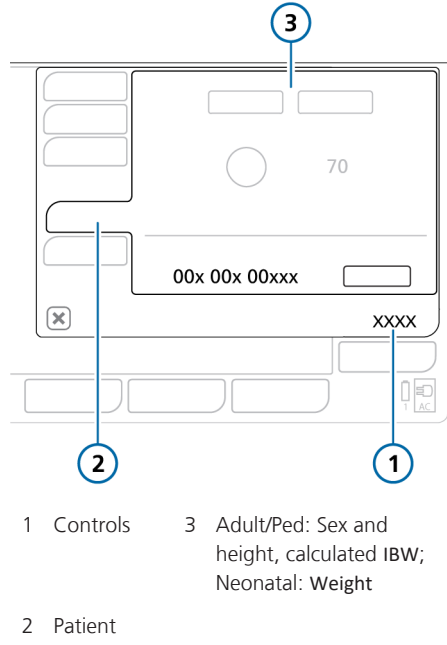
When the ventilator is in **Standby**, the patient controls are accessible in the **Standby** window.

Note that if you are ventilating using the **Last patient** setup, these controls are greyed out and unavailable.

### To change patient data during ventilation

- ▶ Touch **Controls**, then touch the **Patient** button, and adjust settings as needed.

Figure 10-1. Controls > Patient window (Adult/Ped shown)





## 10.2.2 Accessing settings during ventilation

At any time during ventilation, you can adjust settings, as needed. Changes are applied immediately.

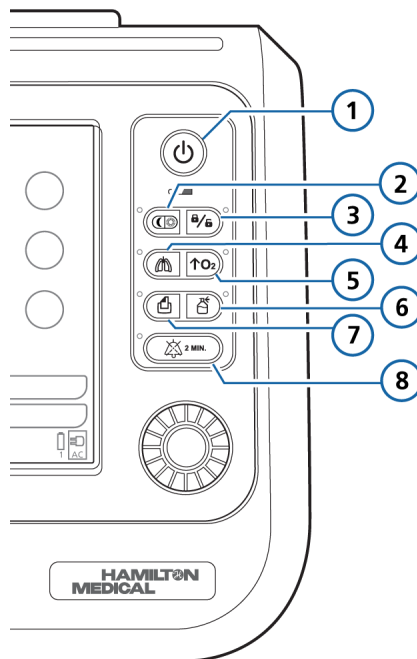
- Touch **Alarms** to access the alarm limit controls.
- Touch **Controls** to access the mode controls. Some controls are also available on the right side of the main display.
- Touch the **Modes** button to change the selected ventilation mode.  
Note that you can only select the nCPAP and nCPAP-PC modes when in Standby.
- Touch **Controls > Patient** to access patient settings.

The ventilator also provides access to key functions.

Keys on the front of the ventilator provide access to important functions, including entering **Standby** mode and pausing the audible alarm.

When a selected function is active, the indicator light next to the key is lit.

Figure 10-2. Function keys



1 Power/Standby	5 O2 enrichment
2 Day/Night <sup>37</sup>	6 Nebulizer
3 Screen lock/unlock	7 Print screen
4 Manual breath	8 Audio Pause

<sup>37</sup> Applies only to devices with serial number > 3000.

### 10.3 Entering/exiting Standby

**⚠ WARNING**

When in **Standby**, the ventilator does *not* automatically resume ventilation when the patient is reconnected. You must manually restart ventilation.

**NOTICE**

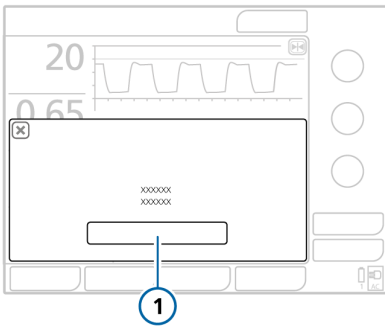
- Patient alarms are suppressed in **Standby**.
- Acoustic patient alarms are suppressed for 1 minute after starting ventilation from **Standby**.

Standby is a waiting mode that lets you maintain ventilator settings while the ventilator is not performing any ventilatory functions.

**To put the ventilator into Standby**

1. Press and quickly release **⏻** (**Power/Standby**) while the ventilator is turned on (Figure 10-2).

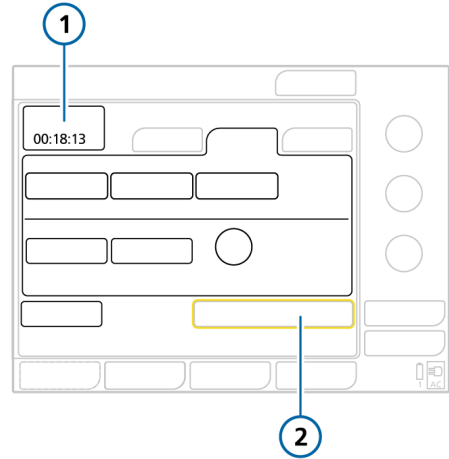
The **Activate Standby** window (1) opens.



2. Touch **Activate standby**.  
The **Standby** window opens (Figure 10-3).

While in **Standby**, the window shows the elapsed time the ventilator has been in **Standby**.

Figure 10-3. Standby window



- |                           |  |
|---------------------------|--|
| 1 Elapsed time in Standby | 2 Start ventilation (When HiFlowO2 is selected: Start therapy) |
|---------------------------|--|

**To end Standby and start ventilation**

- ▶ Do either of the following:
  - Touch **Start ventilation**.
  - Press and quickly release **⏻**.

Ventilation resumes with the previous settings.

## 10.4 Oxygen enrichment

### NOTICE


- Oxygen alarms are suppressed while O2 enrichment is active.
- O2 enrichment is not available when using low-pressure oxygen.

Oxygen enrichment is useful before or after tracheal/endotracheal suctioning or for other clinical applications.

The device delivers the following oxygen concentration for 2 minutes depending on the selected patient group:

- **Adult/Ped.** 100% oxygen
- **Neonatal.** 125% of the current **Oxygen** setting

### To start oxygen enrichment


- ▶ Press  (O2 enrichment) (Figure 10-2).  
After a short time, the ventilator starts delivering increased oxygen (see above).

When active, the indicator light next to the key is green. The **Oxygen** control turns green and displays the currently applied concentration, with a countdown timer.



When finished, the ventilator resets the concentration to the previous operator-set value.

### To stop O2 enrichment manually

- ▶ Do either of the following:
  - Press .  
Ventilation resumes at the previous operator-set oxygen concentration.
  - Change the O2 concentration using the **Oxygen** control.  
Ventilation resumes at the set oxygen concentration.

### 10.4.1 Suctioning maneuver


Note that suctioning is disabled:

- During HiFlowO2
- When using NIV or NIV-ST modes
- With LPO
- During neonatal ventilation

The suctioning maneuver is intended to withdraw an excess of tracheal and/or bronchial secretions in the patient's airways while protecting the operator from possible contamination, as well as ensuring the patient's safety during the suctioning maneuver. This section describes an open-suctioning maneuver.<sup>38</sup>

Suctioning may affect measured values.


### To perform the suctioning maneuver

1. Press  (O2 enrichment) for pre-oxygenation.
2. Disconnect the patient.  
Disconnecting the patient stops ventilation so that no gases are blown through the breathing circuit. All alarms are suppressed for one minute.
3. Use a suctioning catheter (not included) to suction all secretions out of the patient's airway.

<sup>38</sup> A closed-suctioning maneuver is not described here since there is no breathing system disconnection.

4. Reconnect the patient to the ventilator.  
Post-oxygenation starts and all acoustic alarms are again suppressed for one minute. Alarm messages and alarm lamp are still active.

### To stop the maneuver manually

- ▶ Press  again.

## 10.5 High flow oxygen therapy

### WARNING

Excessive high flows through the nasal cannula could lead to adverse clinical events such as barotrauma or pneumothorax.

High flow oxygen therapy (HiFlowO2<sup>39</sup>) continuously delivers an air/gas mixture to the patient and monitors the delivered oxygen concentration.

HiFlowO2 is indicated for adult, pediatric, infant, and neonatal patients who can breathe spontaneously. HiFlowO2 is not intended to be life-supporting.

The operator sets the oxygen concentration and flow rate. The set flow can vary from 2 to 60 l/min for adult and pediatric patients, and 2 to 12 l/min for neonatal patients.

When using HiFlowO2, the following parameters are monitored: Oxygen and Control flow (in trend and as an MMP), as well as SpO2, if enabled. If a flow sensor is connected, PEEP is monitored.

Pressure is measured at the ventilator's pressure release valve. If pressure exceeds the high pressure limit of 50 cmH2O, the flow stops and the **Check patient interface** alarm is generated. Flow resumes shortly after the pressure is released.

Note that during HiFlowO2, disconnection and apnea alarms are inactive.

### 10.5.1 Working with HiFlowO2

You must be in Standby to select HiFlowO2.

#### To deliver HiFlowO2

1. Place the ventilator into **Standby**.
2. Touch **Modes**.
3. Touch **HiFlowO2**, then touch **Confirm**.  
The **Controls** window opens. Be sure to read the safety information.
4. Set the desired values for **Oxygen** and **Flow**, then touch **Confirm**.  
You can change these settings any-time.
5. Touch **Start therapy**.

The HiFlowO2 Trend graphs and plethysmogram (if SpO2 is enabled) are displayed.

<sup>39</sup> HiFlowO2 may also be referred to as cFlow (continuous flow).

## 10.6 Manual breath

You can prolong inspiration as well as deliver a manually triggered breath.

When active, the indicator light next to the **Manual breath** key is green.

Note that manual breath is disabled in HiFlowO2.

### To deliver a manual breath

- ▶ Press and release  (**Manual breath**) during exhalation (Figure 10-2).

The manual breath uses the mandatory breath settings (standard or operator set).

If you try to initiate a manual breath during the early stage of inspiration or the early stage of exhalation, the breath will not be delivered.

### To deliver a prolonged inspiration

- ▶ Press and hold  (**Manual breath**) during any breath phase.

If the ventilator is in exhalation, the device applies a minimum exhalation phase and then switches to inspiration. The device maintains the inspiration pressure until you release the key, or for a maximum of 15 seconds.

## 10.7 Working with a nebulizer

The ventilator supports the use of pneumatic nebulizers for adult and pediatric patients.<sup>40</sup>

For neonatal patients, use an Aerogen nebulizer system.<sup>41</sup> For Aerogen connection and device details, refer to the manufacturer's instructions for use.

### 10.7.1 Working with a pneumatic nebulizer

*Before proceeding, review the safety information in Chapter 1.*

Nebulization with a pneumatic nebulizer is available in all ventilation modes *except* during neonatal ventilation or when using HiFlowO2.

You can use a standard inline nebulizer for delivery of prescribed medications in the ventilator circuit. The ventilator provides a stable pressure source to power a pneumatic nebulizer connected to the **Nebulizer** port, optimally specified for a flow of approximately 8 l/min.

The ventilator automatically compensates the additional volume provided by the pneumatic nebulizer to deliver the set tidal volume.

For effective nebulization, use a pneumatic nebulizer jar.


For additional information about nebulizer use, including adding medication, refer to the manufacturer's *Instructions for use*. For connection and setup details, see Section 4.6.

### To start and stop nebulization

1. Press  (**Nebulizer**) (Figure 10-2).

When active, the indicator light next to the key is green.

The fixed nebulizer flow, using 100% O<sub>2</sub>, is synchronized with the inspiratory phase of each breath for 30 minutes.

2. To stop nebulization at any time, press  again.

<sup>40</sup> See the Hamilton Medical e-catalog for compatible devices.

<sup>41</sup> Not available in all markets. Aerogen nebulization is not supported for patients younger than 28 days old in the USA.

## 10.8 Working with a speaking valve

Speaking valve compatibility is an option available for **Adult/Ped** invasive ventilation when using any of the following modes: **PCV+**, **PSIMV+**, and **SPONT**.

For setup details, see Section 4.7.

### 10.8.1 Mode changes that automatically turn off compatibility

The following actions automatically deactivate speaking valve compatibility:

- Entering **Standby**.  
You must manually reactivate compatibility when restarting ventilation, if desired.
- Selecting a mode that does not support use of a speaking valve.
- Entering **Safety** ventilation or **Ambient** mode.

Note that upon automatic deactivation, the message **SpeakValve OFF** appears in the ventilator **Message bar**<sup>42</sup>. See Table 10-1.

### 10.8.2 Parameters monitored when compatibility is activated

When speaking valve compatibility is *activated*, the following parameter changes are in effect:

- The following monitoring parameters are invalid and show dashes (---):

AutoPEEP	PTP
Cstat	RCexp
Exp Flow	Rinsp
ExpMinVol	VLeak
MVLeak	VTE
P0.1	VTEspont
Pmean	Vt/IBW
Pplateau	

- If **VTE** is set as a main monitoring parameter (**MMP**), **VTI** is displayed instead.  
If *both* **VTI** and **VTE** are selected as **MMPs**, upon activation, the **VTE** value shows dashes (---).
- **Apnea backup** ventilation is disabled.

Once compatibility is deactivated, **Apnea backup** ventilation returns to its previous setting, and the parameters listed above, including **VTE**, are again actively monitored.

### 10.8.3 Speaking valve-related control settings

In **PSIMV+** and **SPONT** modes, the control setting **TI max** is available in the **Controls > More** window when speaking valve compatibility is activated (**ON**).

When speaking valve compatibility is deactivated (**OFF**), **TI max** is unavailable in these modes.

<sup>42</sup> Except in **Safety** or **Ambient** mode.

### 10.8.4 Speaking valve-related alarms

The alarms listed in the table below are related to speaking valve compatibility.

Table 10-1. Speaking valve-related alarm conditions

Alarm	Status
<b>SpeakValve ON</b>	
SpeakValve ON <i>Low priority</i>	Always displayed as long as compatibility is activated.
Vt low <i>High priority when Speak-Valve is ON</i>	Based on delivered volume instead of exhaled volume; alarm is generated when VTI is below the limit.  This alarm can indicate that the cuff is still inflated.
Check patient interface <i>High priority</i>	Generated when the Vt low or Low pressure alarm is active.  Check for: <ul style="list-style-type: none"> <li>• Disconnection</li> <li>• Whether cuff is fully deflated</li> <li>• Upper airway occlusion</li> <li>• Speaking valve is operating properly</li> </ul>
ExpMinVol low ExpMinVol high	Automatically set to OFF.
Disconnection on patient side Disconnection on ventilator side	Suppressed. If the lower Pressure limit is appropriately set, when a disconnection occurs, a <b>Low pressure</b> alarm is generated.

Alarm	Status
Inspiratory volume limitation	Suppressed.
<b>SpeakValve OFF (after being enabled)</b>	
Volume related, including low and high Exp-MinVol limits	Upon deactivation, all volume-related alarm limits are reset based on the patient's IBW.
SpeakValve OFF <i>Low priority</i>	Displayed when compatibility has been automatically deactivated.  Confirm the change in status by pressing the <b>Audio Pause</b> key.

### 10.9 Locking and unlocking the touch screen


You can lock the touch screen to prevent inadvertent entries.

When screen lock is active:

- The indicator light next to the key is lit green.
- Touching the screen generates an audible beep and the message, **Screen is locked!**, is displayed.
- Some device controls remain available, while others are disabled, as follows:
  - **Active controls.** Audio pause, Manual breath, O2 enrichment, Nebulizer, Day/Night<sup>43</sup>
  - **Inactive controls.** Touch screen, Standby/Power, Print screen, P&T knob


<sup>43</sup> Applies only to devices with serial number > 3000.

**To lock or unlock the screen**


- ▶ Press  (Screen lock/unlock) (Figure 10-2).

## 10.10 Capturing a screenshot

*Before using a USB memory device with the ventilator, review the safety information in Chapter 1.*

The  (Print screen) key saves a JPG file of the current ventilator display to a USB memory drive.

**To capture a screenshot of the display**

1. Insert a USB memory drive into the USB port (Figure 2-5).
2. Press  (Figure 10-2) when the desired display is shown.

The device saves the image to the **screenshots** folder on the memory drive. The indicator light next to the key is lit green while the device saves the image.

The filename uses the following format:

screenshot\_yyyy-mm-dd\_hh-mm-ss.jpg

where:

- yyyy is the year
- mm is the month
- dd is the date
- hh is the hour (in 24-hour format)
- mm is the minute
- ss is the second

## 10.11 About the Event log

Once the ventilator is turned on, event logs collect data about clinically relevant ventilator activities, including alarms, technical notes, setting changes, calibrations, maneuvers, and special functions.

The date, time, and a unique identification reference (ID) for event classification is included.

Alarms are shown in color, depending on priority level (yellow for low or medium, red for high).

A more extensive log including technical and configuration details is available to service engineers.

When setting up a new patient:

- Data is appended to the existing event log when you select the **Last patient** tab.
- The event log is cleared and starts again when you select a different patient group tab (**Adult/Ped** or **Neonatal**).

Event log data persists after shutting off the ventilator or in the event of a power loss. When a log buffer is full, new events overwrite the oldest log entries.

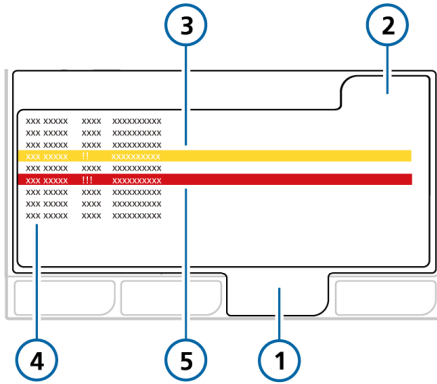
You can copy Event log data. See Section 10.11.1.

**To display the Event log**

- ▶ Touch **Events**.



Figure 10-4. Events window



- 1 Events
- 2 All
- 3 Low-/medium-priority alarm (yellow)
- 4 Informational message
- 5 High-priority alarm (red)

### 10.11.1 Copying Event log data

Before using a USB memory device with the ventilator, review the safety information in Section 1.4.4.

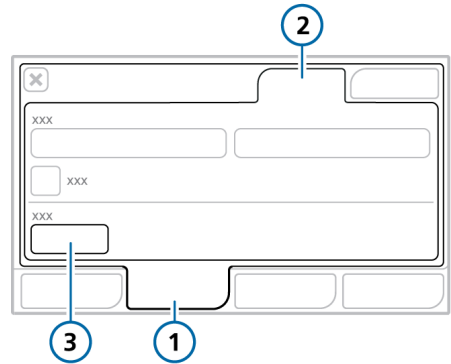
You can save the Event and Service logs to a USB memory device. The device must have a FAT or FAT32 format and it must *not* have an operating system or a security system installed.

### To copy the log

1. Place the ventilator into **Standby** and insert a memory device into the USB port (Figure 2-5).
2. Touch **Tools** > **Utilities** (Figure 10-5).
3. Touch **Export Logs**.
4. Remove the memory device when the text **Export successful** is displayed.

A folder named T1-sn<serial number> is created on the memory device containing all Event and Service log files.

Figure 10-5. Data transfer window



- 1 Tools
- 2 Utilities
- 3 Export Logs

## 10.12 Setting display options

You can set the day and night display brightness, as well as the device date and time.

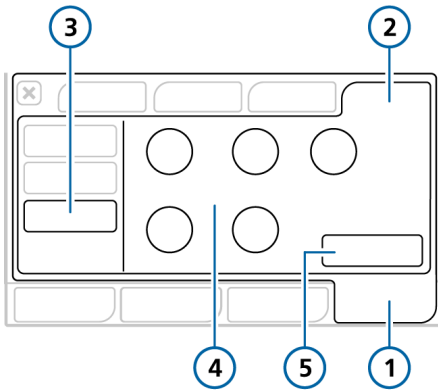
### 10.12.1 Setting date and time

You set the date and time for the ventilator in the **System > Settings** window. Ensure the date and time are set correctly so that event log entries have accurate time and date stamps.

#### To set the date and time

1. Touch **System > Settings** (Figure 10-6).
2. Touch **Date & Time**.
3. Adjust the day and time, then touch **Apply** to save the changes.

Figure 10-6. Date & Time settings



- |               |                          |
|---------------|--------------------------|
| 1 System      | 4 Date and time settings |
| 2 Settings    | 5 Apply                  |
| 3 Date & Time |                          |

### 10.12.2 Day and night display brightness

Use these settings to set the brightness of the display for use during the day and night.

#### To set the display brightness

1. Touch **System > Settings** (Figure 10-7).
2. Touch **Day & Night**.
3. To select **Day** mode with a bright display, touch the **Day** button. To select **Night** mode with a dimmer display, touch the **Night** button.
4. Adjust the brightness of the display in each mode using the **Brightness** control. The setting you choose becomes the new default for that mode.
5. To have the device control the brightness based on ambient light, touch the **Automatic** button.

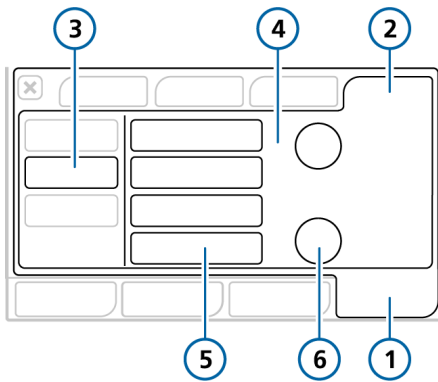
The device continuously senses the available light and dynamically adjusts the display brightness settings.

If the NVG option is installed, you can set the display brightness for use with night vision goggles.

### To set the display brightness with NVG

1. Touch **System** > **Settings** (Figure 10-7).
2. Touch **NVG**.  
The NVG Brightness control is enabled.
3. Adjust the brightness of the display in NVG using the **Brightness** control. The setting you choose becomes the new default for the mode.


Figure 10-7. Day & Night window



- |               |  |
|---------------|--|
| 1 System      | 4 Day, Night, Automatic, Brightness settings |
| 2 Settings    | 5 NVG  |
| 3 Day & Night | 6 NVG Brightness setting                     |

Table 10-2. Day and Night settings

Setting	Brightness range	Default
Day	10% to 100%	80%
Night	10% to 100%	40%
NVG	1 to 10	5

The  (Day/Night) key<sup>44</sup> allows you to quickly switch the display between defined Day and Night settings. When the Night setting is active, the green indicator light next to the key is lit.

If the NVG option is installed on the ventilator, the Day/Night key switches between the Night and NVG settings. When the NVG setting is active, the green indicator light next to the key is lit.

### To change the display brightness to the defined Day or Night setting

- ▶ Press  (Figure 10-2).

<sup>44</sup> Applies only to devices with serial number > 3000.



# 11

## Maintenance

11.1	Overview.....	206
11.2	Cleaning, disinfection, and sterilization .....	206
11.3	Preventive maintenance .....	211
11.4	Performing maintenance tasks .....	211
11.5	Repacking and shipping .....	214

## 11.1 Overview

### NOTICE

(USA only) Only use EPA-registered and approved surface cleaning/disinfection agents.

*Before proceeding, review the safety information in Chapter 1.*

This chapter provides information about ventilator maintenance procedures and schedule, as well as cleaning and disinfection instructions.

All of the procedures in this chapter are to be performed by the operator.

For additional maintenance requirements, contact your Hamilton Medical service representative. Any documents referenced in this chapter are available on the MyHamilton website: <https://www.hamilton-medical.com/MyHamilton>

## 11.2 Cleaning, disinfection, and sterilization

Ventilator components must be regularly cleaned and disinfected, using the cleaning methods and solutions specific to the individual components.

It is important that you use the appropriate method and materials when cleaning and disinfecting the ventilator and its components, not only to avoid damaging the equipment, but also to avoid cross-contamination.

Cleaning and disinfection information is presented as follows:

- Table 11-1 lists the applicable ventilator-related components, and indicates which cleaning and disinfection methods can be used for each one, the frequency with which the component must be cleaned/disinfected, and any other relevant information.
- Table 11-2 lists the supported cleaning and disinfection agents, as well as the concentration to be used for the ventilator.
- Table 11-3 lists the supported cleaning and disinfection agents for the CO<sub>2</sub> sensors.
- Table 11-4 provides cleaning and disinfection information for ventilator-compatible external devices and sensors.

When working with the ventilator components, cleaning methods, and cleaning agents, keep the following in mind:

- Do *not* attempt decontamination procedures unless specified by Hamilton Medical or the original manufacturer.
- While we provide guidelines for agents and concentrations to use, if you have specific questions about the use of a particular cleaning or disinfection agent, contact the manufacturer of the agent.
- After cleaning and decontaminating parts, be sure to perform any required tests and calibrations described in Chapter 5.

Table 11-1. Ventilator cleaning and disinfection methods

Part	Frequency	Cleaning/disinfection method	Remarks
<i>For supported cleaning and disinfection agents, see Table 11-2.</i>			
Ventilator exterior including: <ul style="list-style-type: none"> <li>• Housing</li> <li>• Power cables</li> <li>• Gas supply hoses</li> <li>• Mounting systems</li> </ul>	After each patient use or as needed.	Wipe with a damp cloth using a registered and approved cleaning/disinfection solution.	Do not clean the ventilator interior to avoid damaging internal components.
Touch screen	After each patient use or as needed.	Wipe with a damp cloth using a registered and approved cleaning/disinfection solution or a nonabrasive glass cleaner.	<ul style="list-style-type: none"> <li>• Lock the touch screen before cleaning. See Section 10.9.</li> <li>• Do not use any vinegar based solutions.</li> <li>• Avoid using a gritty cloth.</li> </ul>
Trolley-related accessories including: <ul style="list-style-type: none"> <li>• Trolley</li> <li>• Basket</li> <li>• O2 cylinder holding system</li> </ul>	After each patient use or as needed.	Wipe with a damp cloth using a registered and approved cleaning/disinfection solution.	
Autoclavable expiratory valve	After each patient use or as needed.	Clean and sterilize according to the instructions in the <i>Expiratory Valve Reprocessing Guide</i> (PN 624591).	For details about assembly, installation, and disassembly of the expiratory valve, see Section 3.5.2.

Part	Frequency	Cleaning/disinfection method	Remarks
CO2 sensors	After each patient use or as needed.	Wipe with a damp cloth using a registered and approved cleaning/disinfection solution (Table 11-3). Dry before use.	<ul style="list-style-type: none"> <li>• Ensure that the module/sensor is disconnected and cooled to room temperature before cleaning.</li> <li>• Do not immerse the module/sensor in liquid.</li> </ul>

Table 11-2. Cleaning/disinfection agents for the ventilator

Cleaning/disinfection agent	Concentration
<b>EPA-registered cleaning/disinfection agents</b>	
Sani-Cloth Active wipes	n/a
<b>Approved cleaning/disinfection agents</b>	
Mikrobac Tissues wipes	n/a
mikrozid sensitive wipes	n/a
mikrozid AF liquid	Ready for use
Bacillol 30 Foam	Ready for use
Ethanol	--
Incidin Foam	Ready for use
Incidin Pro	0.25% to 4%
Incidin Rapid	0.25% to 2%
Isopropyl alcohol	--
Mikrobac forte	0.25% to 4%
perform	3%
terralin protect	2%



Table 11-3. Cleaning/disinfection agents for CO2 sensors

Cleaning/disinfection agent	LoFlo (side-stream)	CAPNO-STAT 5 (main-stream)
<b>EPA-registered cleaning/disinfection agents</b>		
Steris Coverage <sup>§</sup> Spray	X	X
PDI Sani Cloth Bleach <sup>§</sup>		X
PDI Sani Cloth AF <sup>§</sup>		X
<b>Approved cleaning/disinfection agents</b>		
Ammonia	X	
2% gluteraldehyde solution	X	
Isopropyl alcohol 70%	X	X
A 10% aqueous solution of chlorine bleach	X	X
Clinell Wipes <sup>§</sup>		X
Speedy Clean <sup>§</sup>		X
Tuffie <sup>§</sup>		X
Tuffie 5 <sup>§</sup>		X
WIP Anios <sup>§</sup>		X

Table 11-4. Cleaning and disinfection methods for external devices

Device	Frequency	Remarks
IntelliCuff	After each patient use or as needed.	Refer to the <i>IntelliCuff Instructions for Use</i> .
HAMILTON-H900 humidifier	After each patient use or as needed.	Refer to the <i>HAMILTON-H900 Instructions for Use</i> .
Third-party humidifiers	After each patient use or as needed.	Refer to the humidifier <i>Instructions for Use</i> .
SpO2 sensors	After each patient use or as needed.	Refer to the <i>Pulse Oximetry Instructions for Use</i> and the sensor manufacturer's <i>Instructions for Use</i> .

## 11.3 Preventive maintenance

Perform preventive maintenance on your ventilator according to the schedule shown in Table 11-5.

The System > Info window shows the number of hours the ventilator has been in operation.

Table 11-5. Preventive maintenance schedule

Interval	Part/accessory	Procedure
Between patients and according to hospital policy	Breathing circuit (including mask, inspiratory or expiratory filter, flow sensor, nebulizer jar, expiratory valve set)	Replace with sterilized or new single-patient use parts.
	Entire ventilator	Run the preoperational checks (Section 5.4).
Every month (or more often if required)	Fan filters (rear panel), air intake filters (white filters on outside of HEPA filter)	Check for dust and lint. If needed, replace. See Section 11.4.1.
Every 6 months	Batteries	Recharge batteries by plugging the ventilator into a primary power source for at least 4 hours.
Yearly or as necessary	Galvanic O2 sensor	Replace if depleted. See Section 11.4.2.
	Air intake HEPA filter	Replace. See Section 11.4.1.
	Ventilator	Perform service-related preventive maintenance. <sup>45</sup>
	CO2 sensor	If the CO2 option is installed, have a CO2 accuracy check performed. <sup>45</sup>

## 11.4 Performing maintenance tasks

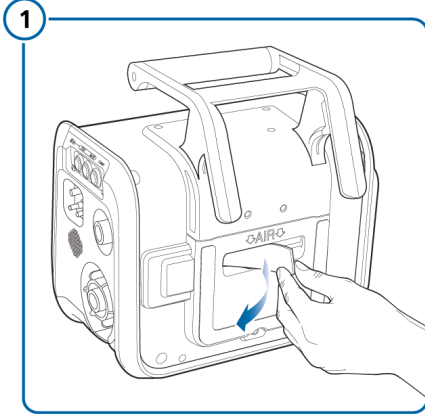
The following sections describe how to clean and replace filters, batteries, and a galvanic O2 sensor.

<sup>45</sup> Must be performed by Hamilton Medical authorized service personnel according to instructions in the *Service Manual*.

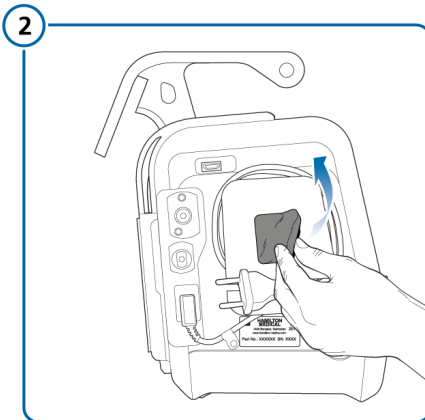
### 11.4.1 Maintaining the filters

Figure 11-1 summarizes the steps to exchange the HEPA and fan filters in the back of the ventilator.

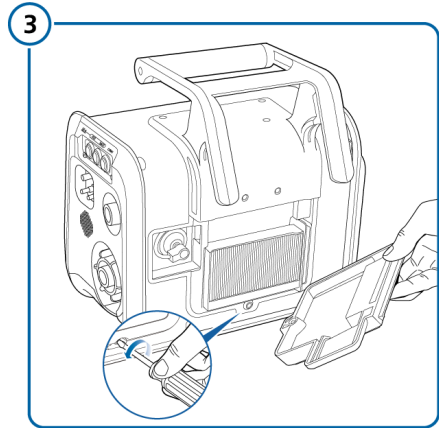
Figure 11-1. Replacing air and HEPA filters



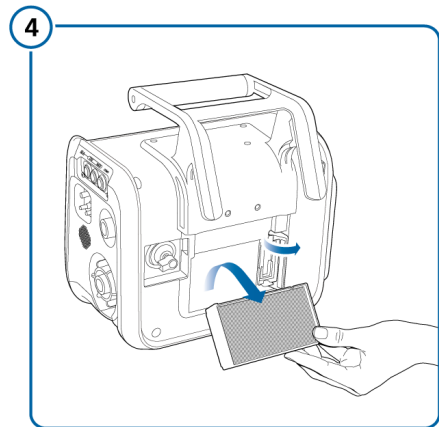
Remove and replace air filter.



Remove and replace fan filter.



Remove back panel.



Remove and replace HEPA filter.  
Replace back cover when finished.

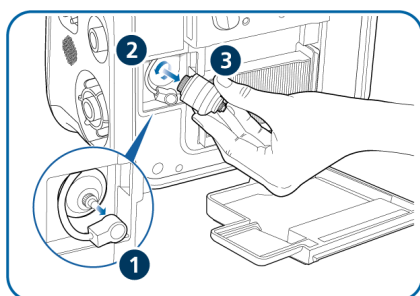
### 11.4.2 Replacing the galvanic O2 sensor

Before proceeding, review the safety information in Chapter 1.

Figure 11-2 summarizes the steps to remove a galvanic O2 sensor. To replace the sensor, reverse the steps.

Remove the back cover first.

Figure 11-2. Replacing the O2 sensor



Remove connection cable (1).  
Unscrew the sensor counterclockwise (2) and remove (3).

### 11.4.3 Charging and storing batteries

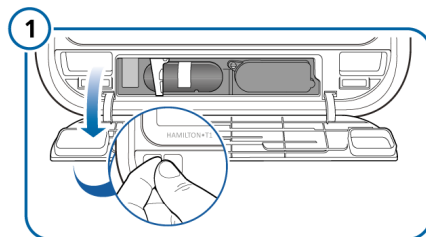
To maintain the battery charge and to prolong the life of the battery, keep the ventilator connected to its primary power source.

Have the battery recharged every 6 months, depending on storage conditions. For details, see Section 14.4.

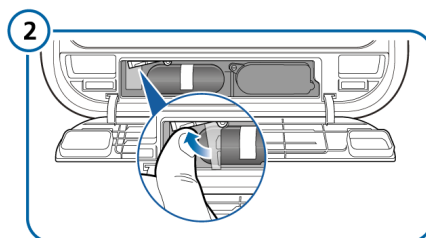
### 11.4.4 Replacing batteries

Figure 11-3 summarizes the steps to replace a battery.

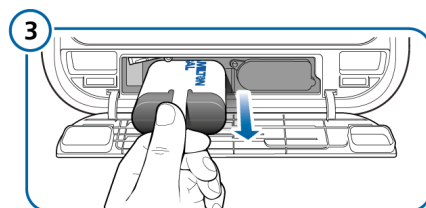
Figure 11-3. Replacing a battery



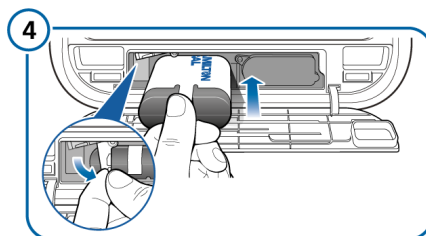
Pull the cover open.



Turn metal clip to the left and up.




Pull white tab to remove battery.



Insert new battery, then turn clip to the right and down.

## 11.5 Repacking and shipping

 **CAUTION**

*Inform Hamilton Medical if you are shipping a contaminated (nonsterilized and nondisinfected) device for service.*

---

If you must ship the ventilator, use the original packing materials. If these materials are not available, contact your Hamilton Medical representative for replacement materials.

# 12

## Configuration

12.1	Overview.....	216
12.2	Accessing Configuration mode.....	216
12.3	Configuring general settings .....	216
12.4	Selecting breath timing, mode naming, and ASV version.....	217
12.5	Configuring MMPs.....	218
12.6	Defining Quick setups .....	218
12.7	Configuring device options .....	219
12.8	Copying configuration settings.....	221

## 12.1 Overview

During configuration, you set up the ventilator with a default language, main monitoring parameter display, startup settings for a new patient, and units of measure, among other settings.

## 12.2 Accessing Configuration mode

You can access all Configuration mode settings when the ventilator is in **Standby**. Access requires a configuration code; contact your administrator.

### To access Configuration mode

1. Touch **Tools > Configuration**.
2. Using the keys on the onscreen keypad, type the configuration code; then touch **Enter**.  
The **Configuration** button is enabled.

3. Touch **Configuration**.

The **Configuration** window appears, displaying the **Language** window.

You can now define settings and add options.

## 12.3 Configuring general settings

You can configure some general default settings for the ventilator, including language, units of measure, communication interface to use, and minimum loudness for alarms.

### 12.3.1 Selecting the default language

#### To select the user interface language

- ▶ Touch **General > Language** and select the desired language.

### 12.3.2 Selecting the units of measure

#### To select the units of measure

- ▶ Touch **General > Units** and select the unit of measure for pressure, length, and CO<sub>2</sub>.

### 12.3.3 Enabling the communication interface

You can connect external devices to the ventilator using the communication interface. For a list of the communication protocols, see Table 2-2.

#### To select the communication protocol

- ▶ Touch **General > More** and select the desired protocol for use, then restart the ventilator.

The ventilator must be restarted to establish communication using the selected protocol.

For setup and configuration details, see the *Communication Interface User Guide*, available on MyHamilton.



### 12.3.4 Setting the minimum alarm loudness (volume)

You can specify a minimum alarm loudness (volume) setting for the ventilator. Once set, the ventilator operator cannot set the alarm volume below the value set here in **Configuration**.

#### To set the minimum alarm loudness

1. Touch **General** > **More**.
2. Touch the **Min. loudness** button and choose the minimum alarm volume to allow on the device.

The setting is applied to the ventilator. Note that if the new minimum is greater than the currently set alarm volume, the alarm volume is reset to the new minimum level.

To verify the setting, check the **Loudness** value in the **System** > **Settings** window.

## 12.4 Selecting breath timing, mode naming, and ASV version

You can set the following:

- Mandatory breath timing philosophy to use for PCV+ and APVcmv modes
- Naming convention for volume-controlled, pressure-adaptive modes
- ASV version

### 12.4.1 Setting breath timing options

The ventilator controls mandatory breath timing using a combination of inspiratory time (TI) and **Rate**.

For the modes PCV+ and APVcmv, you can set the ventilator to use either of the following to control breath timing: I:E or TI

#### To change the breath timing selection

- ▶ In the **Modes** > **General** > **Philosophy** window, touch the desired breath timing option.

### 12.4.2 Choosing the mode naming convention

You can select the naming convention used for adaptive modes: *APVcmv* / *APVsimv* or *(S)CMV+* / *SIMV+*.

By default, *(S)CMV+* / *SIMV+* are used.

#### To select the mode naming convention

- ▶ In the **Modes** > **General** > **Philosophy** window, select the desired option.

### 12.4.3 Choosing the ASV version

By default, the device uses ASV version 1.1.

#### To select the ASV version

- ▶ In the **Modes** > **General** > **Philosophy** window, select the desired version.

## 12.5 Configuring MMPs

You can specify which MMPs to always display on the ventilator.

The list of entries in the **Configuration** window is shown in the same order as the MMPs appear on the main display.

### To select the MMPs to display

1. In **Configuration**, touch **Graphics**, then the **MMP** tab.
2. In each dropdown list, select the desired parameter to show in that position in the MMP list on the main display.

## 12.6 Defining Quick setups

A *Quick setup* refers to a group of settings you define, including patient characteristics, mode selection and control settings, alarm limit settings, and weaning zone limits.

The settings saved with a **Quick setup** are automatically applied when the setup is selected in the **Standby** window.

For each patient group, you can configure up to three **Quick setups**, and can specify a setup to be selected by default when the ventilator is turned on.

### 12.6.1 Configuring individual setup settings

#### To configure a Quick setup

1. In **Standby** mode, configure the ventilator with the parameters you will save as a **Quick setup**.

Select:

- Patient group and sex/height (**Adult/Ped**) or weight (**Neonatal**)
- Ventilation mode
- Mode control settings
- Alarm limits

2. Touch **Start ventilation** and select the desired graphic layout and graphics to display. See Section 8.3.

3. Return to **Standby**.

4. Access **Configuration** mode.

5. In the **Configuration** window, touch **Setups**, and then touch the button (1, 2, or 3, or your custom-defined labels) for the setup to configure.

The **General setup configuration** window is displayed. Note that the buttons in the left panel now change to provide access to the setup options.

6. Touch **Rename setup** to give the setup a meaningful name.

You must define a name as it is used as the **Quick setup** button label in **Standby**, as well as in this **Configuration** window.

7. Select the configuration settings to apply to this setup by touching the appropriate button:

- To apply the ventilator settings you selected in step 1, touch **Use current settings**.

- To apply factory settings, touch **Use factory settings**.

8. Touch **ModeCtrls > Controls** to review patient parameter settings.

Some parameters are not displayed, as they are based on weight:

- The following parameters are set based on ideal body weight (IBW) (Adult/Ped): Vt, Rate, T high, T low, and TI.

- The following parameters are set based on body weight (Neonatal): Vt, Rate, T low, T high, TI, and TI max.

9. Touch **Vt/IBW (Adult/Ped)** or **Vt/Weight (Neonatal)** to set the tidal volume per IBW or weight, respectively.

The ventilator uses the Vt/IBW or Vt/Weight setting in calculations for the following:

- To set the initial delivered Vt in volume-controlled modes
- To set the initial high and low alarm limits for Vt and ExpMinVol

10. Review the alarm settings in the Alarms window.
11. In **Vent status**, set patient parameters manually.  
The **Vent Status** window allows you to configure the weaning zone ranges shown in the **Vent Status** panel according to your institution's protocol.
12. Touch the **Back** button to return to the **Default setup** window.

Configuration of the **Quick setup** is complete.

## 12.6.2 Selecting a default Quick setup

A **Default setup** comprises a group of settings that are automatically loaded when turning on the ventilator.

After you have configured one or more **Quick setups**, select the default to use.

### To set a Quick setup as the default

- ▶ In **Configuration**, touch **Setups** and select the setup to use as the default.

## 12.7 Configuring device options

Before use, you must enable any installed hardware options (for example, CO<sub>2</sub> and SpO<sub>2</sub>), and add and enable software options.

### 12.7.1 Reviewing installed options

#### To view installed options

1. In **Configuration**, touch **Options**.
2. Touch **SW options** for software or **HW options** for hardware.
3. Scroll through the options to review, as needed.

## 12.7.2 Adding software options

Software options are added using license keys.

Trial versions of software options may be available. Trial options expire and are automatically deactivated after 30 days.

Have all required keys available before proceeding.

### To add a software option

1. In Configuration, touch **Options**.
2. In the Options window, touch **SW options**.
3. Touch **Add options**.
4. Type the activation code exactly as provided into the field and touch **Enter**.

If the message *Option code invalid!* appears, re-enter the code.

The message *Option valid* indicates the code is correct and the option has been added.

5. Repeat until all desired software options are added.
6. Touch the **X** to close the window.
7. Restart the ventilator to enable the options.

Upon turning on the ventilator, the added options are available for use.

## 12.7.3 Activating hardware options

Communication board-related functions (CO<sub>2</sub>, SpO<sub>2</sub>) are activated at two levels:

- The hardware itself must be activated in configuration to make the functionality available to the user, described in this section.
- Sensors that plug into the hardware are individually enabled by the user, as needed, in the System window. See Chapter 4.

### To activate hardware options in Configuration

1. Touch **Options**.
2. In the Options window, touch the **HW options** tab.

The window lists hardware that requires activation.

3. Select the checkbox for options to activate.  
A checkmark indicates the option is activated.

Upon exiting Configuration, the activated hardware is available for use.

SpO<sub>2</sub> and CO<sub>2</sub> sensors require an additional step, and must also be enabled in the System window.

### 12.7.4 Removing options

Note the following:

- Trial options are automatically removed at the end of the trial period.
- Selecting **Clear options** removes *all* non-trial options.
- The patient groups on the ventilator, **Adult/Ped** and **Neonatal**, are also treated as options. Clearing options removes them and the associated ventilation modes. You must re-add them before using the ventilator on a patient.

#### To remove software options

You can remove all non-trial software options from the ventilator.

1. In the **SW options** window, touch **Clear options**.  
You are prompted to confirm deletion of all non-trial options. See the previous notes.
2. Touch **Clear options** to remove the options.  
Touch **Cancel** to leave the options installed.
3. Restart the ventilator.  
Once you restart the ventilator, all options (including patient groups) listed in the window are cleared.
4. To re-add the patient groups and any other desired options, re-enter **Configuration** mode.
5. Add software options (including the patient groups), as appropriate.

#### 12.7.4.1 Disabling hardware options

##### To disable hardware options

- ▶ In the **HW options** window, clear the checkboxes to disable the hardware.

## 12.8 Copying configuration settings

*Before proceeding, review the safety information in Chapter 1.*

You can copy the configuration settings to a USB memory device and quickly transfer the settings to other HAMILTON-T1 devices.

If you remove the USB drive before the files are successfully transferred, you must start over and repeat the export.

#### To copy configuration settings to a memory device

1. Insert a USB drive into the USB port on the side of the ventilator. See Figure 2-5.
2. In **Configuration**, touch **Transfer**.
3. In the **Transfer** window, touch **Import** or **Export** to transfer configuration data to or from a USB drive.



# 13

## Parts and accessories

13.1	Overview.....	224
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### 13.1 Overview

This chapter lists the parts available for the HAMILTON-T1 ventilator. Note that not all parts are available in all markets.

For additional parts and accessories and ordering information, refer to the e-catalog on the Hamilton Medical website or contact your Hamilton Medical representative.

Figure 13-1. Ventilator parts and accessories

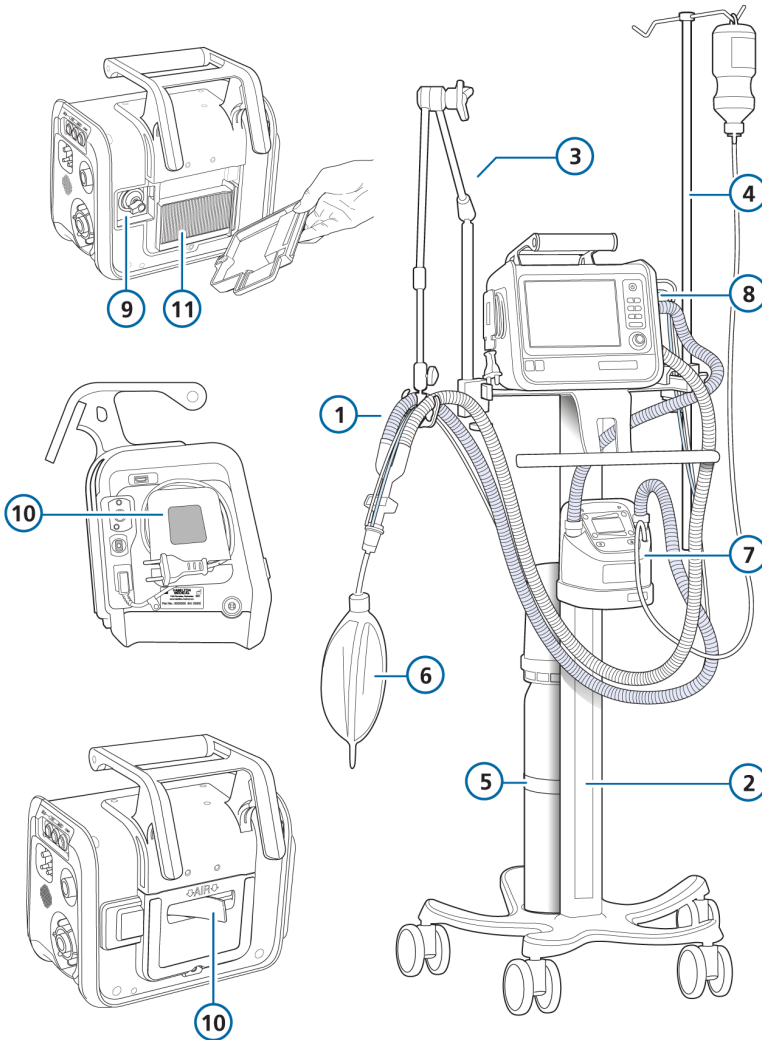




Table 13-1. Ventilator parts and accessories

Item no. (ref to Fig 13-1)	Description	PN
<b>1</b>	<b>HAMILTON-H900 breathing circuit set, adult/pediatric</b>	
	Breathing circuit set BC8022, dual limb, single use, preassembled, box of 15	260161
	Breathing circuit set BC8022-A, dual limb, autoclavable, pre-assembled, box of 1	260188
	Breathing circuit set BC4022, single limb, single use, preassembled, box of 15	260186
	<b>HAMILTON-H900 breathing circuit set, neonatal</b>	
	Breathing circuit set BC8010, dual limb, single use, preassembled, box of 15	260185
	Breathing circuit set BC8010-A, dual limb, autoclavable, pre-assembled, box of 1	260189
	Breathing circuit set BC4010, single limb, single use, preassembled, box of 15	260187
<b>1</b>	<b>Breathing circuit set, coaxial, single use, adult/pediatric</b>	
	length 1.80 m, box of 20	260206
	Preassembled with flow sensor, length 1.80 m, box of 20	260207
	length 2.40 m, box of 10	260239
	Preassembled, with flow sensor, length 2.40 m, box of 10	260240
	Preassembled, with expiratory valve set, flow sensor, and elbow adapter, length 2.40 m, box of 10	260127
	Preassembled, with expiratory valve set, flow sensor, and elbow adapter, length 1.80 m, box of 20	260128
	Preassembled, with expiratory valve set, flow sensor, and elbow adapter, length 3.0 m, box of 10	260167
	Preassembled, with expiratory valve set, flow sensor, and elbow adapter, length 4.80 m, box of 8	260168
	Preassembled, with flow sensor and elbow adapter, length 1.80 m, box of 20	260087
	Preassembled, with flow sensor and elbow adapter, length 2.40 m, box of 10	260094

Item no. (ref to Fig 13-1)	Description	PN
1	Preassembled, with flow sensor and elbow adapter, length 3.0 m, box of 10	260145
	Preassembled, with flow sensor and elbow adapter, length 4.80 m, box of 8	260144
1	<b>Breathing circuit sets, dual limb, single use, neonatal</b>	
	With Y-piece, flow sensor, flow sensor calibration adapter, and pressure line with T-piece connectors, length 1.50 m, box of 20	260180
	With Y-piece, flow sensor, flow sensor calibration adapter, and pressure line with T-piece connectors, length 3.0 m, box of 10	260182
	With expiratory valve set, Y-piece, flow sensor, flow sensor calibration adapter, and pressure line with T-piece connectors, length 1.50 m, box of 20	260170
	With expiratory valve set, Y-piece, flow sensor, flow sensor calibration adapter, and pressure line with T-piece connectors, length 3.0 m, box of 10	260169
1	<b>Breathing circuit sets, autoclavable</b> <i>See the online Hamilton Medical e-catalog.</i>	
1	<b>Flow sensors, adult/pediatric</b>	
	Flow sensor, single use, adult/pediatric, 1.88 m, box of 10	281637
	Flow sensor, single use, adult/pediatric, 2.60 m, box of 10	282049
	Flow sensor, autoclavable, adult/pediatric, 1.88 m, box of 1	950185
	Flow sensor calibration adapter, single use, adult/pediatric, box of 10	279937
	Flow sensor calibration adapter, autoclavable, adult/pediatric, box of 10	282323
1	<b>Flow sensors, neonatal</b>	
	Flow sensor, single use, neonatal, 1.60 m, box of 10	260177
	Flow sensor, single use, neonatal, 1.88 m, box of 10	155500
	Flow sensor, single use, neonatal, 3.10 m, box of 10	260179
	Flow sensor calibration adapter, single use, neonatal, box of 10	279964

Item no. (ref to Fig 13-1)	Description	PN
<b>8</b>	<b>Expiratory valve</b>	
	Expiratory valve set, autoclavable, adult/pediatric, box of 1	161175
	Membrane, expiratory valve, autoclavable, adult/pediatric, box of 5	161390
	Expiratory valve set, single use, adult/pediatric, box of 10	161186
	Expiratory valve set, autoclavable, neonatal (incl. membrane, expiratory valve)	161188
	Membrane, expiratory valve, autoclavable, neonatal, box of 5	161169
	Expiratory valve set, single use, neonatal, box of 10	161189
<i>not shown</i>	<b>Pressure-monitoring line (for nCPAP, nCPAP-PC modes)</b>	
	Pressure line, single use, neonatal/pediatric, 1.60 m, box of 10	260174
	Pressure line, single use, neonatal/pediatric, 3.10 m, box of 10	260176
	Luerlock adapter kit for nCPAP/nCPAP-PC with breathing set, single use, neonatal, box of 50	279971
<i>not shown</i>	<b>Nasal cannulas (adult and adult/pediatric)</b>	
	Size S, box of 10	282495
	Size M, box of 10	282496
	Size L, box of 10	282497
	Size S, box of 20	282714
	Size M, box of 20	282715
	Size L, box of 20	282716
	Tracheostomy direct connection, OD22, box of 20	282717
<i>not shown</i>	<b>Nasal cannulas (neonatal and pediatric)</b>	
	Size S, box of 10	10072354
	Size M, box of 10	10072355
	Size L, box of 10	10072356
	Size XL, box of 10	10072357
	Nasal fixation patch, size S, box of 10	10072358
	Nasal fixation patch, size L, box of 10	10072359

Item no. (ref to Fig 13-1)	Description	PN
<i>not shown</i>	<b>Nasal cannula adapter</b>	
	Adapter, ID22/ID22, box of 30	282509
<i>not shown</i>	<b>Masks and accessories, adult/pediatric</b> <i>See the Hamilton Medical e-catalog.</i>	
<i>not shown</i>	<b>Masks and accessories, neonatal</b>	
	nCPAP Starter kit, large (10 sets, incl. mask, prongs, and bonnets)	281975
	nCPAP Starter kit, small (1 set, incl. mask, prongs, and bonnets)	282330
<i>not shown</i>	<b>Ventilation hose protective sleeve</b>	
	Protective sleeve, 1.70 m	161435
	Protective sleeve, 2.30 m	161436
<i>not shown</i>	<b>CO2 mainstream measurement</b>	
	HAMILTON CAPNOSTAT-5 CO2 sensor (90° angled)	282157
	CO2 mainstream airway adapter, single use, adult/pediatric, box of 10	281719
	CO2 mainstream airway adapter, single use, neonatal, box of 10	281720
	CO2 mainstream airway adapter, autoclavable, adult/pediatric, box of 1	281721
	CO2 mainstream airway adapter, autoclavable, neonatal, box of 1	281722
	OD15/ID15 adapter, single use, neonatal, box of 25	281803
<i>not shown</i>	<b>CO2 sidestream measurement</b>	
	HAMILTON LoFlo sidestream CO2 sensor	281928
	CO2 sidestream adapter, single use, adult/pediatric, box of 10	281929
	CO2 sidestream adapter, single use, adult/pediatric, box of 10	281931
	CO2 sidestream adapter, single use, neonatal/pediatric, box of 10	281930
	CO2 sidestream adapter, single use, neonatal, box of 10	281932
<b>7</b>	<b>Humidifier</b>	
	HAMILTON-H900 humidifier <i>See the Hamilton Medical e-catalog.</i>	

Item no. (ref to Fig 13-1)	Description	PN
	<b>Trolley</b>	
2	Trolley (incl. humidifier support)	161150
3	Support arm, quick positioning, basic	281671
4	Water bottle holder with quick lock (max. 1 kg per side)	160162
5	Cylinder holder	161152
6	<b>Demonstration lung</b>	
	IntelliLung, maximum 1 liter	281869
	Demonstration lung assembly with endotracheal tube, adult, 2 liter, with OD15 connector	151815
	Demonstration lung assembly with endotracheal tube, 0.5 liter, with OD15/OD22 connector (pediatric)	151816
	Demonstration lung, neonatal, OD15 <i>A passive lung simulator with two independent compartments for simulating neonatal patients.</i>	R53353
10	<b>Filter</b>	
	Filter set <i>Includes 5 sets. Each set includes 1 air intake dust filter and 1 fan filter.</i>	161275
11	Filter, air intake (HEPA)	161236
<i>not shown</i>	<b>Patient filter</b>	
	HME filter (HMEF), single use, adult/pediatric	279963
	HME filter (HMEF), single use, adult/pediatric	279974
	Expiratory bacteria filter	279204
	Inspiratory bacteria filter	279211
<i>not shown</i>	<b>Power cord</b>	
	Power cord with US plug, 2-pin, 3.0 m	355198
	Power cord with British angled plug, 3.0 m	355199
	Power cord with continental European plug, 2-pin, 3.0 m	355200
	Power cord with Chinese plug, 3.0 m	355308

Item no. (ref to Fig 13-1)	Description	PN
<i>not shown</i>	<b>DC input cables</b>	
	DC cable, metal (with MIL standard connector)	161624
	DC cable open, metal (for individual assembly)	161622
	Car cable, metal (for cigarette lighter)	161623
<b>9</b>	<b>Oxygen sensor</b>	
	Galvanic O2 sensor	396200
<i>not shown</i>	<b>Communication</b>	
	Extended communication board CO2, Nurse call, COM1	161535
	Extended communication board CO2	161537
	Extended communication board CO2, SpO2, COM1	161535
	Cable to COM1, 26 cm	161545
	Cable to COM1, 50 cm	161650
	Cable, Nurse Call	160166
<i>not shown</i>	<b>Battery</b>	
	Li-Ion battery	369108
<i>not shown</i>	Battery charger/calibrator	369104
<i>not shown</i>	<b>High-pressure oxygen connector</b>	
	DISS – diameter index safety standard	160470
	NIST – no interchangeable screw thread	160471
<i>not shown</i>	<b>Gas supply hoses and parts</b>	
	Coupling insert for low pressure O2 inlet, 4.8 mm ID	279913
<i>not shown</i>	<b>SpO2 sensors and accessories (Masimo)</b> <i>See the Hamilton Medical e-catalog.</i>	
	<b>SpO2 sensors and accessories (Nihon Kohden)</b> <i>See the Hamilton Medical e-catalog.</i>	
<i>not shown</i>	<b>Nebulizer and accessories</b> <i>See the Hamilton Medical e-catalog.</i>	
<i>not shown</i>	<b>Tools and test equipment</b> <i>See the Hamilton Medical e-catalog.</i>	

Item no. (ref to Fig 13-1)	Description	PN
<i>not shown</i>	<b>Ventilator hardware and mounting options</b> <i>See the Hamilton-T1 System Integration brochure, available on myHamilton.</i>	
	<b>Language kit</b>	
	English	161030
	German	161031
	Spanish	161032
	French	161033
	Italian	161037
	Russian	161034
	Chinese	161035
	Portuguese	161036
	<b>Extended warranty</b>	
	Extended warranty of 1 year	700403
	Extended warranty of 2 years	700404
	Extended warranty of 3 years	700405





# 14

## Specifications

14.1	Physical characteristics.....	234
14.2	Environmental requirements.....	235
14.3	Pneumatic specifications .....	236
14.4	Electrical specifications .....	237
14.5	Control settings .....	239
14.6	Monitored parameters .....	243
14.7	Alarms .....	249
14.8	Configuration .....	252
14.9	ASV technical data .....	254
14.10	Ventilator breathing system specifications .....	256
14.11	Technical performance data .....	257
14.12	Functional description of ventilator system .....	263
14.13	Symbols used on device labels and packaging .....	267
14.14	Standards and approvals .....	269
14.15	Disposal and year of manufacture .....	271
14.16	Warranty.....	271

## 14.1 Physical characteristics

Table 14-1. Physical characteristics

Dimension	Specifications
Weight	6.5 kg (14.3 lb) 18.5 kg (40.8 lb) with trolley The trolley can accommodate a maximum safe working load of 44 kg (97 lb). <sup>46</sup>
Dimensions	See Figure 14-1.

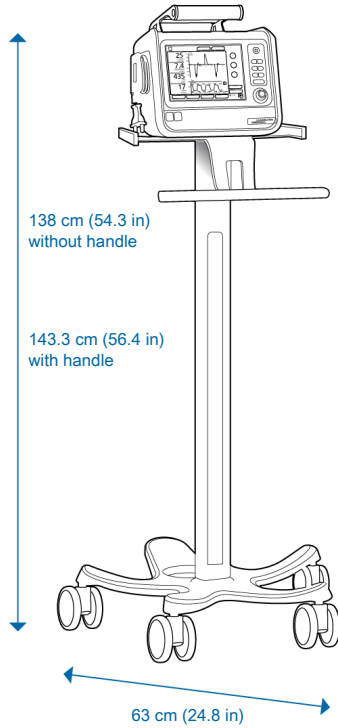
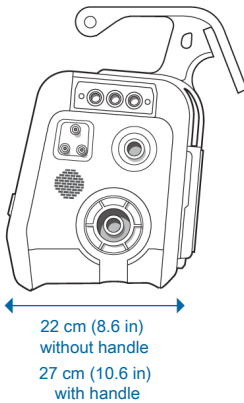
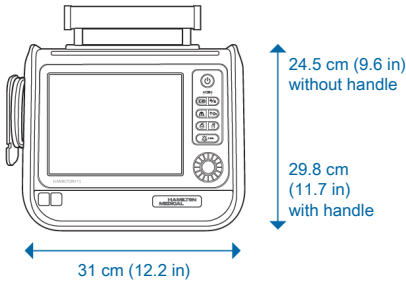


Figure 14-1. HAMILTON-T1 dimensions



<sup>46</sup> The maximum safe working load applies to a stationary, properly load-balanced trolley.

## 14.2 Environmental requirements

Table 14-2. Environmental requirements

Environment		Specifications
Temperature	Operation:	Adult/Ped: -15°C to 50°C (5°F to 122°F) <sup>47</sup> Neonatal: -15°C to 40°C (5°F to 104°F)
	Storage:	-20°C to 60°C (-4°F to 140°F), in original packaging
Altitude	Operation and storage:	Adult/Ped: -650 to 7620 m (-2,132 to 25,000 ft) <sup>47</sup> Neonatal: -650 to 4000 m (-2,132 to 13,123 ft) Note that at higher altitudes the ventilator performance may be limited. The <b>Performance limited by high altitude</b> alarm is generated and a message is shown on the display. See Table 9-2. Above 4000 m, supported only with DC power or battery operation.
	Operation and storage:	Adult/Ped: 376 to 1100 hPa <sup>47</sup> Neonatal: 620 to 1100 hPa
Relative humidity	Operation:	5% to 95%, noncondensing
	Storage:	10% to 95%, noncondensing
Water protection		IP24

<sup>47</sup> Only valid for devices with serial number > 3000. For devices with a lower serial number, the maximum operating temperature for Adult/Ped use is 40°C (104°F) up to an altitude of 4600 m (15,091 ft) and a minimum atmospheric pressure of 570 hPa.

### 14.3 Pneumatic specifications

Table 14-3. Pneumatic specifications

Component	Specifications	
High-pressure oxygen inlet	Pressure:	2.8 to 6 bar / 41 to 87 psi
	Flow:	Maximum of 200 l/min
	Connector:	DISS (CGA 1240) or NIST
Low-pressure oxygen inlet	Peak pressure:	Maximum 6 bar / 87 psi
	Flow:	≤ 15 l/min
	Connector:	Quick-coupling system, compatible with Colder Products Company (CPC) PMC series
Air supply	Integrated blower	
Gas mixing system	Delivered flow:	<ul style="list-style-type: none"> <li>• &gt; 260 l/min ±10% against ambient pressure (at sea level)</li> <li>• &gt; 200 l/min with 100% oxygen</li> </ul>
	Delivered pressure:	Adult/Ped: 0 to 60 cmH2O
		Neonatal: 0 to 45 cmH2O
	Flow accuracy:	±10% or ±300 ml/min (whichever is greater)
Inspiratory outlet (To patient port)	Connector:	ISO ID15/OD22 conical
Expiratory outlet (From patient port)	Connector (on expiratory valve):	ISO ID15/OD22 conical

## 14.4 Electrical specifications

Table 14-4. Electrical specifications

Element	Specifications
Input power	100 to 240 VAC $\pm$ 10%, 50/60 Hz 12 to 28 VDC (total range 10.2 to 30.3 VDC) <sup>48</sup>
Power consumption	50 VA typical, 150 VA maximum
Battery	Hamilton Medical provides a high-capacity <sup>49</sup> battery. An optional second battery is available.
Electrical specifications:	10.8 V DC, 6.7 Ah, 72 Wh, 50 W typical, 150 W maximum
Type:	Lithium-ion, supplied by Hamilton Medical only
Recharge time:	While ventilator is connected to primary power, approximately 3.25 h to fully recharge one battery, approximately 6.25 h to fully recharge two batteries.
Storage:	-20°C to 60°C, $\leq$ 85% relative humidity. The storage location should be free from vibration, dust, direct sunlight, moisture, and corrosive gases, and with a recommended temperature range < 21°C. Extended exposure to temperatures above 45°C can degrade battery performance and life.

<sup>48</sup> When the current exceeds 34 VDC, the device automatically switches to battery power, and continues ventilation as set.

<sup>49</sup> PN 369108, revision 4 and later.

Element	Specifications	
Battery	Normal operating time:	<p>Typically 4 hours with one battery, 8 hours with two batteries.</p> <p>Operating times are measured with one or two fully charged batteries, the blower in use, without communication board, and with the following settings: Mode = PCV+, Rate = 10 b/min, Pcontrol = 10 cmH<sub>2</sub>O, I:E = 1:4, PEEP = 5 cmH<sub>2</sub>O, Flow trigger = 5 l/min, FiO<sub>2</sub> = 40%.</p> <p>Approximate operating times under these conditions are as follows:</p> <ul style="list-style-type: none"> <li>• One battery, display brightness = 80%: 4 h</li> <li>• One battery, display brightness = 20%: 4.5 h</li> <li>• Two batteries, display brightness = 80%: 8 h</li> <li>• Two batteries, display brightness = 20%: 9.25 h</li> </ul> <p>This operating time applies to new, fully charged Li-ion batteries not exposed to extreme temperatures. The actual operating time depends on battery age and on how the battery is used and recharged.</p>

## 14.5 Control settings

Table 14-5. Control settings, ranges, and accuracy

Parameter or setting (unit)	Range:	Range:	Default settings: Adult/Ped	Default settings: Neonatal	Accuracy <sup>50</sup>
	Adult/Ped	Neonatal			
%MinVol <sup>51</sup> (%)	25 to 350	--	100	--	--
Apnea back-up	On, Off	On, Off	On	On	--
ETS <sup>52, 53</sup> (%)	5 to 80	5 to 80	25 <i>In noninvasive modes:</i> 35	25 <i>In noninvasive modes:</i> 35	--
Flow <sup>54</sup> (l/min)	2 to 60	2 to 12	15	2	±10% or ±1 l/min, whichever is greater
I:E <sup>55</sup>	1:9 to 4:1	1:9 to 4:1	1:4	1:3	
IBW (kg)	3 to 139	--	70	--	--
Oxygen (%)	21 to 100	21 to 100	50	40	± (volume fraction of 2.5% + 2.5% gas level)
Pasvlimit <sup>51</sup> (cmH <sub>2</sub> O)	5 to 60	--	30	--	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
Pat. height (cm) (in)	30 to 250 12 to 98	-- --	174 69	-- --	-- --

<sup>50</sup> The stated accuracy includes the tolerance interval for each measurement.

<sup>51</sup> Only in ASV mode.

<sup>52</sup> Expiratory trigger sensitivity, in % of inspiratory peak flow.

<sup>53</sup> When selecting a noninvasive mode, the device uses the ETS value used in the previous mode, if available. If the previous mode did not use ETS, the device sets ETS to default values.

<sup>54</sup> Only for HiFlowO2.

<sup>55</sup> In PCV+, (S)CMV, and APVcmv modes, mandatory breath timing can be controlled by using a combination of inspiratory time (TI) and rate, or by the I:E ratio; set the method in Configuration. All other modes are controlled by using a combination of inspiratory time (TI) and rate.

Parameter or setting (unit)	Range:		Default settings: Adult/Ped	Default settings: Neonatal	Accuracy <sup>50</sup>
	Adult/Ped	Neonatal			
Pcontrol <sup>56</sup> (cmH <sub>2</sub> O)	5 to 60	3 to 45 nCPAP-PC: 0 to 45	15	15	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
PEEP/CPAP (cmH <sub>2</sub> O)	0 to 35	3 to 25	5	5	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
Phigh APRV (cmH <sub>2</sub> O)	0 to 60	0 to 45	20 startup setting = PEEP + 15	20 startup setting = PEEP + 15	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
Phigh DuoPAP (cmH <sub>2</sub> O)	0 to 60	3 to 45	20	20	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
Pinsp <sup>57</sup> (cmH <sub>2</sub> O)	3 to 60	3 to 45	15	15	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
Plow APRV (cmH <sub>2</sub> O)	0 to 35	0 to 25	5	5	±5% or ±1 cmH <sub>2</sub> O, whichever is greater
P-ramp <sup>58</sup> (ms)	0 to 2000 ASV, NIV, NIV-ST, SPONT: max = 200	0 to 600 NIV, NIV-ST, SPONT, nCPAP-PC: max = 200	100	50	±10 ms
Psupport <sup>59</sup> (cmH <sub>2</sub> O)	0 to 60	0 to 45	15	15	±5% or ±1 cmH <sub>2</sub> O, whichever is greater

<sup>56</sup> Control pressure, added to PEEP/CPAP.

<sup>57</sup> Inspiratory pressure, added to PEEP/CPAP.

<sup>58</sup> P-ramp is limited to one-third (1/3) of TI time. Adjustment of TI time can override the P-ramp setting. Limitation in ASV, SPONT, NIV, NIV-ST, nCPAP-PC: max 200 ms.

<sup>59</sup> Pressure support, added to PEEP/CPAP.



Parameter or setting (unit)	Range:	Range:	Default settings:	Default settings:	Accuracy <sup>50</sup>
	Adult/Ped	Neonatal	Adult/Ped	Neonatal	
Rate <sup>60</sup> (b/min)	1 to 80 APVcmv, PCV+: 4 to 80 PSIMV+, NIV- ST: 5 to 80	1 to 80 APVcmv, PCV +, PSIMV +Psync, NIV-ST, APVsimv + Apnea Backup: 15 to 80 nCPAP-PC: 10 to 80 PSIMV+: 5 to 80	38 (3.0 to 5.8 IBW) 32 (5.9 to 8.0 IBW) 25 (8.1 to 20.0 IBW) 19 (20.1 to 29.9 IBW) 17 (30 to 39 IBW) 15 (40 to 59 IBW) 12 (60 to 200 IBW)	60 (0.2 to 1.25 kg) 45 (1.26 to 3.0 kg) 35 (3.1 to 5.9 kg) 30 (6.0 to 8.9 kg) 25 (9.0 to 20.5 kg) 20 (21 to 30 kg)	±1
Sex	Male, Female	--	Male	--	--
Sigh <sup>61</sup>	On, Off	--	Off	--	--
SpeakValve compatibility	On, Off	--	Off	--	--
Thigh APRV <sup>60</sup> (s)	0.1 to 40	0.1 to 40	Based on rate (IBW)	Based on rate (Weight)	±0.01
Thigh DuoPAP <sup>60</sup> (s)	0.1 to 40	0.1 to 40	Based on rate (IBW)	Based on rate (Weight)	±0.01
Tl max <sup>62</sup> (s)	1 to 3	0.25 to 3	1.5	1.0 (≤ 10 kg) 1.5 (> 10 kg)	±0.1
Tl <sup>60, 55, 63</sup> (s)	0.1 to 12	0.1 to 12	Based on rate (IBW)	Based on rate (Weight)	±0.01
Tlow APRV (s)	0.2 to 40	0.2 to 40	Based on rate (IBW)	Based on rate (Weight)	±0.01
Trigger, flow <sup>64</sup> (l/min)	1 to 20 APVcmv, PCV +: 1 to 20 / Off	0.1 to 5 APVcmv, PCV+: 0.1 to 5.0 / Off	5	0.5	±10%

<sup>60</sup> Startup setting derived from IBW (adult/pediatric), body weight setting (neonatal). Does not apply in ASV mode.

<sup>61</sup> Sigh is disabled in DuoPAP and APRV modes, when using HiFlowO2, and for neonates.

<sup>62</sup> Maximum inspiratory time for spontaneous breaths during noninvasive ventilation.

<sup>63</sup> Inspiratory time; used with Rate to set the breath cycle time.

<sup>64</sup> Flow trigger is leak compensated.

Parameter or setting (unit)	Range:	Range:	Default settings:	Default settings:	Accuracy <sup>65</sup>
	Adult/Ped	Neonatal	Adult/Ped	Neonatal	
Vt/IBW <sup>65</sup> Vt/wt (ml/kg)	5 to 12	5 to 12	8	5	--
Vt <sup>60</sup> (ml)	20 to 2000	2 to 300	Based on IBW	Based on Weight	Adult/Ped: ±10% or ±10 ml, whichever is greater Neo: ±10% or ±2 ml, whichever is greater
Weight <sup>65</sup> (kg)	--	0.2 to 30	--	2.0	--

<sup>65</sup> Set in configuration. IBW is calculated using height and sex, and is used for adult and pediatric patients. Actual body weight is used for neonates.

## 14.6 Monitored parameters

Table 14-6 provides monitored parameter details. Tables 14-7 and 14-8 list the ranges of the real-time curves and loops.

Pressure, flow, and volume measurements are based on readings from the flow sensor, and are expressed in BTPS (body temperature and pressure saturated).

Table 14-6. Monitored parameters, ranges, and accuracy

Parameter (units)	Range: Adult/Ped	Range: Neonatal	Accuracy <sup>66</sup>
<b>Pressure</b>			
AutoPEEP <sup>67</sup> (cmH <sub>2</sub> O)	0 to 80	0 to 80	±2 cmH <sub>2</sub> O + 4% of the actual reading
PEEP/CPAP (cmH <sub>2</sub> O)	0 to 80	0 to 80	±2 cmH <sub>2</sub> O + 4% of the actual reading
Pinsp <sup>68</sup> (cmH <sub>2</sub> O)	0 to 50	--	±2 cmH <sub>2</sub> O + 4% of the actual reading
Pmean (cmH <sub>2</sub> O)	0 to 80	0 to 80	±2 cmH <sub>2</sub> O + 4% of the actual reading
Ppeak (cmH <sub>2</sub> O)	0 to 80	0 to 80	±2 cmH <sub>2</sub> O + 4% of the actual reading
Pplateau (cmH <sub>2</sub> O)	0 to 80	0 to 80	±2 cmH <sub>2</sub> O + 4% of the actual reading
<b>Flow</b>			
Insp Flow (peak) (l/min)	0 to 260	0 to 260	Adult/Ped: ±10% or ±20 ml/s, whichever is greater  Neo: ±10% or ±2 ml/s, whichever is greater
Exp Flow (peak) <sup>69</sup> (l/min)	0 to 260	0 to 260	Adult/Ped: ±10% or ±20 ml/s, whichever is greater  Neo: ±10% or ±2 ml/s, whichever is greater

<sup>66</sup> The stated accuracy includes the tolerance interval for each measurement, except for measurements displayed from external sensors (CO<sub>2</sub>). See Section 14.11.1 for details.

<sup>67</sup> Not available in nCPAP, nCPAP-PC modes.

<sup>68</sup> Inspiratory pressure displayed in the Vent Status panel.

<sup>69</sup> Not available in HiFlowO<sub>2</sub> or if SpeakValve is active.

Parameter (units)	Range: Adult/Ped	Range: Neonatal	Accuracy <sup>66</sup>
Control Flow <sup>70</sup> (l/min)	2 to 80	2 to 12	--
Flow <sup>71</sup> (l/min)	--	0 to 30	±10% or ±20 ml/s whichever is greater
<b>Volume</b>			
ExpMinVol <sup>72, 67</sup> MinVol NIV <sup>73, 67</sup> (l/min)	0 to 99.9	0 to 99.9	±10% or ±0.3 l/min, whichever is greater
MVSpont <sup>72, 67</sup> MVSpont NIV <sup>73, 67</sup> (l/min)	0 to 99.9	0 to 99.9	±10% or ±0.3 l/min, whichever is greater
VTE <sup>72, 67</sup> VTE NIV <sup>73, 67</sup> (ml)	0 to 9000	0 to 9000	Adult/Ped: ±10% or ±10 ml, whichever is greater  Neo: ±10% or ±2 ml, whichever is greater
VTESpont <sup>67</sup> (ml)	0 to 9000	0 to 9000	±10% or ±10 ml, whichever is greater
VTI <sup>67</sup> (ml)	0 to 9000	0 to 9000	Adult/Ped: ±10% or ±10 ml, whichever is greater  Neo: ±10% or ±2 ml, whichever is greater
Vt/IBW (ml/kg)	2 to 20	--	--
Vt/Weight (ml/kg)	--	2 to 20	--
VLeak <sup>67</sup> (%)	0 to 100	0 to 100	±10% (VLeak > 100 ml and < 2000 ml)

<sup>70</sup> Only in HiFlowO2.<sup>71</sup> Only in nCPAP, nCPAP-PC modes.<sup>72</sup> Only for invasive modes.<sup>73</sup> NIV is used with noninvasive modes.

Parameter (units)	Range: Adult/Ped	Range: Neonatal	Accuracy <sup>66</sup>
MVLeak <sup>67</sup> (l/min)	0 to 99.9	0 to 99.9	±10% or ±0.3 l/min whichever is greater
<b>Time</b>			
I:E	9.9:1 to 1:99	9.9:1 to 1:99	--
fControl (b/min)	0 to 999	0 to 999	±1 b/min
fSpont <sup>67</sup> (b/min)	0 to 999	0 to 999	±1 b/min
fTotal (b/min)	0 to 999	0 to 999	±1 b/min
TI (s)	0 to 60	0 to 60	±100 ms
TE (s)	0 to 60	0 to 60	±100 ms
<b>Other calculated and displayed parameters</b>			
Cstat <sup>67</sup> (ml/cmH2O)	0 to 300	0 to 300	--
Oxygen (%)	18 to 105	18 to 105	± (volume fraction of 2.5% + 2.5% gas level)
Oxygen consumption <sup>74</sup> (l/min)	0 to 99.9	0 to 99.9	±10% or ±0.3 l/min, whichever is greater
P0.1 <sup>67</sup> (cmH2O)	-99 to 0	-99 to 0	--
PTP <sup>67</sup> (cmH2O*s)	0 to 99	0 to 99	--
RCexp <sup>75, 67</sup> (s)	0 to 99.9	0 to 99.9	--
Rinsp <sup>67</sup> (cmH2O / (l/s))	0 to 999	0 to 999	--
Trigger	Yes or No	Yes or No	--
RSB (1 / (l*min))	0 to 400	0 to 400	--

<sup>74</sup> If option is installed.<sup>75</sup> Least square fit method.

Parameter (units)	Range: Adult/Ped	Range: Neonatal	Accuracy <sup>66</sup>
Ventilation counter (days/hours/minutes)	0 to 999	0 to 999	0 to 999
<b>CO2 related<sup>76</sup></b>			
FetCO2 (%)	0 to 20	0 to 20	CO2 (BTPS): 0 to 40 mmHg: ±2 mmHg 41 to 70 mmHg: ±5% of reading 71 to 100 mmHg: ±8% of reading 101 to 150 mmHg: ±10% of reading For sidestream CO2 sensor above 80 b/min: ±12% of reading
PetCO2 (mmHg)	0 to 150	0 to 150	
slopeCO2 <sup>77</sup> (%CO2/l)	0 to 99.9	0 to 99.9	--
Vtalv <sup>77</sup> (ml)	0 to 9999	0 to 9999	--
V'alv <sup>77</sup> (l/min)	0 to 20	0 to 20	--
V'CO2 <sup>77</sup> (ml/min)	50 to 9999	50 to 9999	--
VDaw <sup>77</sup> (ml)	0 to 999	0 to 999	--
VDaw/VTE <sup>77</sup> (%)	0 to 100	0 to 100	--
VeCO2 <sup>77</sup> (ml)	0 to 999	0 to 999	--
ViCO2 <sup>77</sup> (ml)	0 to 999	0 to 999	--

<sup>76</sup> Only available if the CO2 communication board is installed and the CO2 sensor is enabled.

<sup>77</sup> Only for mainstream CO2.

Table 14-7. Real-time waveforms

Parameter	Range	Y-axis scale
<i>All waveforms show time on the x-axis. Adult/Ped Full-screen waveforms: Auto, 12, 18, 24, 30; Adult/Ped Half-screen waveforms: 6, 12, 18, 24; Neonatal waveforms: 3, 6, 12, 18, 24</i>		
Volume <sup>78, 79</sup> (V) (ml) / time (s)	0 to 3200	0 to 5, 0 to 10, 0 to 25, 0 to 50 ( <i>Neonatal default</i> ), 0 to 100, 0 to 200, 0 to 400, 0 to 800 ( <i>Adult/Ped default</i> ), 0 to 1600, 0 to 3200
Flow <sup>78, 79</sup> (l/min) / time (s)	-300 to 300	±2.5, ±5, ±10 ( <i>Neonatal default</i> ), ±15, ±25, ±45, ±75 ( <i>Adult/Ped default</i> ), ±150, ±300
Airway pressure (Paw) (cmH <sub>2</sub> O) / time (s)	-10 to 80	-10 to 20, -10 to 40 ( <i>default</i> ), -10 to 80
FetCO <sub>2</sub> <sup>80</sup> (%) / time (s)	0 to 10	0 to 6 ( <i>default</i> ), 0 to 10
PetCO <sub>2</sub> <sup>80</sup> (mmHg) / time (s)	0 to 100	0 to 60 ( <i>default</i> ), 0 to 100

<sup>78</sup> Scaled automatically. Not leak compensated.<sup>79</sup> Not applicable in nCPAP and nCPAP-PC modes.<sup>80</sup> Available with CO<sub>2</sub> option.

Table 14-8. Real-time graphics and loops

Parameter	X-axis scale	Y-axis scale
<b>ASV graphs</b>		
ASV target graphics: Vt/Rate x-axis: b/min y-axis: ml	0 to 60	0 to 5, 0 to 10, 0 to 25, 0 to 50, 0 to 100, 0 to 200, 0 to 400, 0 to 800 ( <i>default</i> ), 0 to 1600, 0 to 3200
<b>Loops</b>		
Pressure/Volume x-axis: cmH2O y-axis: ml	-10 to 80	0 to 3200
Volume/Flow x-axis: ml y-axis: l/min	0 to 3200	-300 to 300
Pressure/Flow x-axis: cmH2O y-axis: l/min	-10 to 80	-300 to 300
Volume/PCO2 <sup>81</sup> x-axis: ml y-axis: mmHg	0 to 3200	0 to 100
Volume/FCO2 <sup>81</sup> x-axis: ml y-axis: %	0 to 3200	0 to 10

<sup>81</sup> Available with CO2 option.

<sup>82</sup> Not applicable in nCPAP and nCPAP-PC modes.

<sup>83</sup> Startup setting derived from IBW (adult/pediatric), body weight setting (neonatal). Does not apply in ASV mode.

<sup>84</sup> Only active in nCPAP and nCPAP-PC modes.

<sup>85</sup> Active only when O2 monitoring (O2 sensor) is enabled.

<sup>86</sup> The high and low oxygen alarm limits are automatically set in relation to the current oxygen setting: O2 setting + 5 (high Oxygen limit) and O2 setting - 5 (low Oxygen limit). For example, if the Oxygen setting is 70%, the high Oxygen limit is set to 75 and the low limit is set to 65.

<sup>87</sup> CO2 option required.

<sup>88</sup> Can also be adjusted using Psvlimit. Pressure limitation is always 10 cmH2O below the pressure high limit.

<sup>89</sup> In ASV mode, this alarm only applies for spontaneous breaths.



## 14.7 Alarms

Table 14-9. Adjustable alarm priority, range, defaults, and resolution

Alarm (units)	Priority	Range:	Range:	Default:	Default:	Resolution
		Adult/Ped	Neo	Adult/ Ped	Neo	
Apnea time <sup>82</sup> (s)	High	15 to 60	5 to 60	20	5	<i>Adult/Ped:</i> 5 <i>Neonatal:</i> 1 (< 15) 5 (≥ 15)
ExpMinVol (high) <sup>83,82</sup> (l/min)	High	0.1 to 50 NIV, NIV-ST: 0.1 to 50 / Off	0.03 to 10 / Off	Based on Rate and Vt  1.5 * Rate * Vt	Based on Rate and Vt  1.5 * Rate * Vt	<i>Adult/Ped:</i> 0.1 (< 1) 0.5 (≥ 1) 1 (≥ 10) <i>Neonatal:</i> 0.01 (< 1) 0.1 (≥ 1)
ExpMinVol (low) <sup>83,82</sup> (l/min)	High	0.1 to 50 NIV, NIV-ST: Off / 0.1 to 50	Off / 0.01 to 10	Based on Rate and Vt  0.6 * Rate * Vt	Based on Rate and Vt  0.6 * Rate * Vt	<i>Adult/Ped:</i> 0.1 (< 1) 0.5 (≥ 1) 2 (≥ 10) <i>Neonatal:</i> 0.01 (< 1) 0.1 (≥ 1)
Flow (high) <sup>84</sup> (l/min)	Medium	--	8 to 30	--	15	1
fTotal (high) (b/min)	Medium	0 to 99	2 to 210	40	70	1
fTotal (Low) (b/min)	Medium	0 to 99	0 to 200	0	0	1
Oxygen (high) <sup>85,86</sup> (%)	High	18 to 105	18 to 105	55 or +5 % of the current setting	55 or +5 % of the current setting	--

Alarm (units)	Priority	Range:	Range:	Default:	Default:	Resolution
		Adult/Ped	Neo	Adult/Ped	Neo	
Oxygen (low) <sup>85,86</sup> (%)	High	18 to 97	18 to 97	45 or -5% of the current setting	45 or -5% of the current setting	--
PetCO2 (high) <sup>87</sup> (mmHg)	Medium	1 to 100	1 to 100	60	60	1
PetCO2 (low) <sup>87</sup> (mmHg)	Medium	Off / 0 to 100	Off / 0 to 100	30	30	1
Pressure (high) (Pmax) (cmH2O)	High	15 to 70	18 to 55 nCPAP: (Pcontrol + PEEP + 5) to 55 nCPAP-PC: 10 to 55 APRV: 15 to 55	40	40 nCPAP/ nCPAP-PC: 15	1
Pressure (low) (cmH2O)	High	4 to 60	4 to 55 nCPAP, nCPAP-PC: 2 to 55	PEEP	PEEP nCPAP: 3, nCPAP-PC: 5	1
Pressure limitation <sup>88</sup> (cmH2O)	Medium, Low after silence	5 to 60	8 to 45 nCPAP, nCPAP-PC: 8 to Pmax	Pmax -10	Pmax -10	1

Alarm (units)	Priority	Range:		Default:		Resolution
		Adult/Ped	Neo	Adult/Ped	Neo	
Vt, high <sup>89</sup> (ml)	Medium	10 to 3000 / Off	0.1 to 300 / Off	Vt is based on IBW $1.5 * Vt$	Vt is based on Weight $1.5 * Vt$	<i>Adult/Ped:</i> Off 5 (< 100) 10 (< 500) 50 ( $\geq$ 500) <i>Neonatal:</i> Off 0.1 (< 10) 1 ( $\geq$ 10) 5 ( $\geq$ 100)
Vt, low <sup>89</sup> (ml)	Medium	Off / 10 to 3000	Off / 0.1 to 300	Vt is based on IBW $0.5 * Vt$	Vt is based on Weight $0.5 * Vt$	<i>Adult/Ped:</i> Off 5 (< 100) 10 (< 500) 50 ( $\geq$ 500) <i>Neonatal:</i> Off 0.1 (< 10) 2 ( $\geq$ 10) 6 ( $\geq$ 100)

## 14.8 Configuration

Table 14-10. Configuration specifications

Parameter	Configuration range	Default setting
<b>General</b>		
Language	English, US English, Chinese, Croatian, Czech, Danish, Dutch, Finnish, French, German, Greek, Hungarian, Indonesian, Italian, Japanese, Korean, Norwegian, Polish, Portuguese, Romanian, Russian, Serbian, Slovak, Spanish, Swedish, Turkish	English
Units	Pressure: hPa, mbar, cmH2O CO2: mmHg, Torr, kPa Length: cm, in	cmH2O mmHg cm
More	Communication protocol: Hamilton, GALILEO compatible, Hamilton P2, Philips VueLink Open, DrägerTestProtocol, Hamilton Block Protocol	GALILEO
	Min. loudness	1
<b>Modes</b>		
Philosophy	Inspiratory time philosophy: I:E, TI Mode label: APVcmv/APVsimv or (S)CMV+/SIMV+ ASV: ASV, ASV 1.1	I:E (S)CMV+/SIMV+ ASV 1.1
<b>Graphics</b>		
Main monitoring parameters (MMP) <sup>90</sup>	MMP 1 to 4: Pmean, PEEP/CPAP, Ppeak, ExpMinVol, VTI, VTE, VLeak, fTotal, fSpont, Oxygen, Cstat, Rinsp, I:E, TI, TE, MVSpont, AutoPEEP, P0.1, PTP, RCexp, Pplateau, VTESpont, MVLeak, Insp Flow, Exp Flow, Vt/BW, Vt/Weight	Ppeak <sup>91</sup> , ExpMinVol, VTE, fTotal
Settings	For all mode, control, and alarm settings, see the appropriate tables in this chapter.	
Setups	This information applies to the default adult Quick setup configurations. You can also specify default neonatal settings.	

<sup>90</sup> Additional parameters available when the CO2 or SpO2 options are installed.

<sup>91</sup> The default setting is configurable.

Parameter	Configuration range	Default setting
<b>Mode Ctrl</b>	Vt/IBW (Adult/Ped): 5 to 12 ml/kg Vt/Weight (Neonatal): 5 to 12 ml/kg	Adult/Ped: 8 ml/kg Neonatal: 5 ml/kg
<b>Vent Status</b>		
Oxygen <sup>92</sup> (%)	22 to 80	40
PEEP <sup>93</sup> (cmH <sub>2</sub> O)	1 to 20	8
Pinsp (cmH <sub>2</sub> O)	1 to 50	10
%MinVol high (%)	100 to 250	150
%MinVol low (%)	25 to 99	50
RSB high (1 / (l*min))	50 to 150	100
RSB low (1 / (l*min))	0 to 49	10
%fSpont <sup>94</sup> (%)	0 to 99	75

<sup>92</sup> The low Oxygen setting is always 21%.

<sup>93</sup> The low PEEP setting is always 0 cmH<sub>2</sub>O.

<sup>94</sup> The high %fSpont setting is always 100%.

## 14.9 ASV technical data

Table 14-11. ASV technical data

ASV-related data	Specifications
<b>ASV-related operator settings</b>	
%MinVol	25% to 350%
Patient height	Adults: 130 to 250 cm / 50 to 100 in Pediatric: 30 to 150 cm / 12 to 60 in
<b>Internal calculations</b>	
IBW	In kg, calculated based on patient height and sex (see Section 5.3)
MinVol (target)	In l/min, target minute volume is calculated as: $IBW \text{ (in kg)} \times \text{NormMinVent (in l/kg/min)} \times \%MinVol/100$ where NormMinVent is the normal minute ventilation from Figure 7-18.
fTotal	In b/min
VDaw	2.2 ml/kg IBW
Vt (target)	MinVol/ f(target)
<b>ASV monitor</b>	
Target values (numerical)	MinVol, Vt, fTotal
Current achieved values (numerical)	MinVol, Vt, fTotal, $Vt = (VTI+VTE)/2$
Status of patient (numerical)	fSpont, fControl, PInsp
Graphics display (curve)	fTotal versus Vt, target value, current value, safety boundaries
<b>Alarms</b>	
All alarms are functional except apnea alarms	See Chapter 9
Special	ASV: Cannot meet the target alarm

ASV-related data	Specifications
<b>Performance specifications</b>	
Response time (90% of steady state)	< 1 min (typical)
Overshoot/undershoot	< 25%
Maximum pressure change per breath	2 cmH <sub>2</sub> O
Settling time	< 120 seconds
Steady state deviation	< 10%
<b>Lung-protective rules</b>	
Minimum V <sub>t</sub>	4.4 ml/kg x IBW
Maximum V <sub>t</sub> depends on	<ul style="list-style-type: none"> <li>• High Pressure alarm limit</li> <li>• Volume/ pressure ratio (V/P)</li> <li>• Always &lt; 15 ml/kg x IBW<sup>95</sup></li> <li>• Limited to 1.5 x high V<sub>t</sub> limit</li> </ul>
Maximum machine rate	<p>The maximum rate in ASV is the smallest value of the following conditions:</p> <ul style="list-style-type: none"> <li>• 60 b/min</li> <li>• 23 b/min * %MinVol/100 / (IBW = 30 kg)</li> <li>• 23 b/min * %MinVol/ (0.5 to 100 depending on IBW) (IBW &lt; 30 kg)</li> <li>• 20/RC<sub>exp</sub></li> </ul>
Minimum target rate	5 to 15 b/min (depending on IBW)
Minimum P <sub>insp</sub>	5 cmH <sub>2</sub> O above PEEP/CPAP
Maximum P <sub>insp</sub>	High Pressure alarm limit - 10 cmH <sub>2</sub> O - PEEP
Minimum inspiratory time (T <sub>I</sub> )	0.5 s or RC <sub>exp</sub> , whichever is longer
Maximum inspiratory time (T <sub>I</sub> )	IBW = 30 kg: 2 seconds IBW < 30 kg: 1.5 seconds
Minimum expiratory time (T <sub>e</sub> )	0.5 s or 2 x RC <sub>exp</sub> , whichever is longer
Maximum expiratory time (T <sub>e</sub> )	12 seconds
I:E range	1:4 to 1:1

<sup>95</sup> Only applicable to ASV 1.1.

## 14.10 Ventilator breathing system specifications

Table 14-12. Ventilator breathing system specifications

Parameter	Specification	
Resistance <sup>96</sup>	Adult/Ped circuit (ID15 to ID22, flow of 30 l/min)	≤ 0.06 cmH2O/l/min
	Adult/Ped circuit (ID12 to ID15, flow of 15 l/min)	≤ 0.12 cmH2O/l/min
	Neonatal circuit (ID09 to ID12, flow of 15 l/min)	≤ 0.12 cmH2O/l/min
Compliance <sup>96</sup>	Adult/Ped circuit (ID15 to ID22)	≤ 4.0 ml/cmH2O at 60 cmH2O ± 3 cmH2O
	Adult/Ped circuit (ID12 to ID15)	≤ 4.0 ml/cmH2O at 60 cmH2O ± 3 cmH2O
	Neonatal circuit (ID09 to ID12)	≤ 1.5 ml/cmH2O at 60 cmH2O ± 3 cmH2O
Volume <sup>96</sup>	Adult circuit (ID19)	2.4 l
	Neonatal circuit (ID10)	~ 0.9 l
Bacteria filter	Particle size	Captures particles of 0.3 mm (micron) with > 99.99% efficiency
	Resistance	< 2.0 cmH2O at 60 l/min
Flow sensor dead space	Adult/pediatric	< 9 ml (single use)
		< 11 ml (reusable)
	Neonatal	< 1.3 ml

<sup>96</sup> As tested, the inspiratory limb includes ambient valve, flow sensor, inspiratory filter, inspiratory tubes, and humidifier. It does not include the heating wire. The expiratory limb includes expiratory tubes, water trap, expiratory valve, and flow sensor.

<sup>97</sup> Actual patient weight can be much greater (e.g., 300 kg or 661 lb).

<sup>98</sup> Neither humidity (noncondensing) nor cyclical pressures have any effect on the stated accuracy of the device.

<sup>99</sup> Volume at 1 meter distance from ventilator. A setting of 1 = 62 dB(A), 5 = 76 dB(A), and 10 = 85 dB(A), with accuracy of ±3 dB(A).

<sup>100</sup> Per ISO 80601-2-12.



## 14.11 Technical performance data

Table 14-13. Technical performance data

Description	Specification
Patient ideal body weight (IBW, determined from Pat. height setting)	3 to 139 kg (6.6 to 306 lb) <sup>97</sup>
Weight (used for neonatal patients)	0.2 to 30 kg (0.44 to 66 lb)
Inspiratory pressure	0 to 60 cmH <sub>2</sub> O
Maximum limited pressure	60 cmH <sub>2</sub> O
Maximum working pressure	<i>Adult/Ped.</i> 60 cmH <sub>2</sub> O (PEEP/CPAP + P <sub>insp</sub> ). Ensured through pressure limiting. <i>Neonatal.</i> 45 cmH <sub>2</sub> O (limitation depending on frequency).
Maximum inspiratory flow	260 l/min (120 l/min with 100% O <sub>2</sub> )
Tidal volume/target tidal volume	<i>Adult/Ped.</i> 20 to 2000 ml <i>Neonatal.</i> 2 to 300 ml
Minute volume capability	Up to 60 l/min
Inspiratory time (spontaneous breaths)	0.2 to 3 seconds
Minimum expiratory time	20% of cycle time; 0.2 to 0.8 seconds
Automatic expiratory base flow	<i>Adult/Ped.</i> Fixed at 3 l/min <i>Neonatal.</i> Fixed at 4 l/min
Means of inspiratory triggering	Flow trigger control
Oxygen mixer accuracy	± (volume fraction of 2.5% + 2.5% of actual reading)

Description	Specification	
<b>Measuring devices</b>		
Continuous oxygen measurement	The delivered oxygen concentration is continuously measured when an O2 sensor is enabled.	
	<i>Type of sensor: Galvanic O2 sensor</i>	
	Sensing position:	Inspiratory pneumatics
	Measurement, delivered oxygen concentration, range:	18% to 105%
	Response time:	< 45 seconds to reach 90% of final oxygen concentration
	Initialization time (time from turning on device to operating performance):	< 40 seconds
	Drift:	≤ 2.5% at 60% Oxygen over 6 hours
	Storage temperature:	To maximize the shelf life of unused galvanic O2 sensors, store them between 5°C and 15°C (41°F and 59°F).
Pressure and volume measurements	Type:	Differential pressure transducer, variable orifice
	Sensing position:	Patient y-piece
	Measurements:	See Table 14-6

Description	Specification	
CO2 measurement	Two types of CO2 sensors are supported: CAPNOSTAT-5 (mainstream) and LoFlo (sidestream)	
	<i>Type: CAPNOSTAT 5</i>	
	Sensing position:	Mainstream
	Principle of operation:	Nondispersive infrared (NDIR) technology
	Measurements:	See Table 14-6
	Rise time:	< 60 ms
	Initialization time:	Capnogram displayed in < 15 seconds at an ambient temperature of 25°C, full specifications within 2 minutes
	Sampling frequency:	100 Hz
	CO2 calculation method:	BTPS
	CO2 stability <sup>98</sup> :	Short-term drift: ≤ 0.8 mmHg over 4 hours Long-term drift: Accuracy specification maintained over 120 hours
	CO2 noise (rms):	≤ 0.25 mmHg at 7.5% CO2
	Operating temperature:	0°C to 45°C (32°F to 113°F)
	Storage temperature:	-40°C to 70°C (-40°F to 158°F)

Description	Specification	
CO2 measurement	<i>Type: LoFlo</i>	
	Sensing position:	Sidestream
	Principle of operation:	Nondispersive infrared (NDIR) technology
	Measurements:	See Table 14-6
	Rise time:	200 ms for on-airway adapter kits Additional 30 ms for sidestream sampling can- nulas. Additional 80 ms for extension line and dehu- midification tubing.
	Initialization time:	Capnogram displayed in < 20 seconds at an ambient temperature of 25°C, full specifica- tions within 2 minutes
	Sampling frequency:	100 Hz
	Gas sampling rate:	50 ml/min ±10 ml/min
	CO2 calculation method:	Actual, corrected for temperature and pressure in the sample cell
	CO2 stability <sup>98</sup> :	Short-term drift: ≤ 0.8 mmHg over 4 hours Long-term drift: Accuracy specification main- tained over 120 hours
	CO2 noise (rms):	≤ 0.25 mmHg at 5% CO2
	Sensing position:	Inside ventilator
	Measurements:	See Table 14-6
	Operating tempera- ture:	0°C to 40°C (32°F to 104°F)
	Storage temperature:	-40°C to 70°C (-40°F to 158°F)
Tests and special functions	Tightness test, flow sensor/circuit/O2 sensor/CO2 sensor zero calibra- tion, O2 enrichment, manual breath, inspiratory hold maneuver, nebuli- zation, leak compensation, communication interface, compensation of breathing circuit resistance and compliance	
Display device	Display of settings, alarms, and monitored data: Type: Color TFT Size: 640 x 480 pixels, 8.4 in (214 mm) diagonal	

Description	Specification
Brightness setting for display	The range is 10% to 100% brightness. By default, <b>Day</b> = 80%; <b>Night</b> = 40%.
Brightness with NVG option	The range is 1 to 10. The default is 5.
Alarm volume (Loudness <sup>99</sup> )	The range is 1 to 10. <i>Adult/Ped</i> : 5 (default); <i>Neonatal</i> : 3 (default)
Sound power level <sup>100</sup>	51 dB(A) $\pm$ 3 dB(A)
Sound pressure level <sup>100</sup>	43 dB(A) $\pm$ 3 dB(A)

### 14.11.1 Accuracy testing

The ventilator's parameter and measurement accuracy is tested using an IMT FlowAnalyser<sup>5</sup>. The tolerance intervals for the data generated by the FlowAnalyser are as specified below, and are included in the accuracy information provided in this manual.

Table 14-14. Tolerance intervals for accuracy testing

Parameter type	Tolerance interval of measurement
Volume	$\leq 50$ ml: $\pm 1\%$ $> 50$ ml: $\pm 1.75\%$
Pressure	$\pm 0.75\%$ or $\pm 0.1$ cmH <sub>2</sub> O, whichever is greater
Flow	$\pm 1.75\%$ or $\pm 0.5$ l/min, whichever is greater
O <sub>2</sub>	$\pm 1\%$

### 14.11.2 Essential performance

Table 14-15. Essential performance

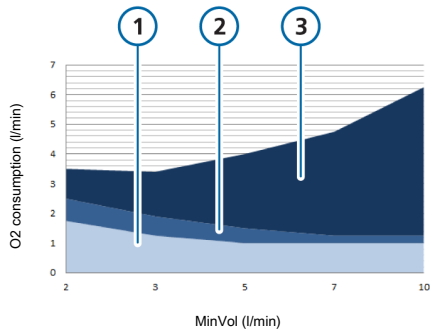
Component	Requirement
Gas supply failure	Gas supply failure must be detected and the operator informed.
Oxygen level alarm condition	If O <sub>2</sub> is higher or lower than the set alarm limits, this must be detected and the operator informed through an alarm.
CO <sub>2</sub> level alarm condition <sup>101</sup>	If CO <sub>2</sub> is higher or lower than the set alarm limits, this must be detected and the operator informed through an alarm.
SpO <sub>2</sub> level alarm condition <sup>101</sup>	If SpO <sub>2</sub> is higher or lower than the set alarm limits, this must be detected and the operator informed through an alarm.
Pressure	The airway pressure must be monitored. If it is higher or lower than the set alarm limits, this must be detected and the operator informed through an alarm.
Volume	The applied and expired volumes must be monitored. If they are higher or lower than the set alarm limits, this must be detected and the operator informed through an alarm.
Electrical supply failure	An electrical supply failure must be detected and the operator informed.

Component	Requirement
Internal electrical power source nears depletion	The remaining battery capacity must be monitored and qualitatively indicated. At least 5 min prior to depletion, an alarm must be issued.

### 14.11.3 Estimated oxygen consumption relative to minute volume

The following graphs show oxygen consumption as a function of minute volume.

Figure 14-2. Oxygen consumption as a function of minute volume, oxygen set to 60%



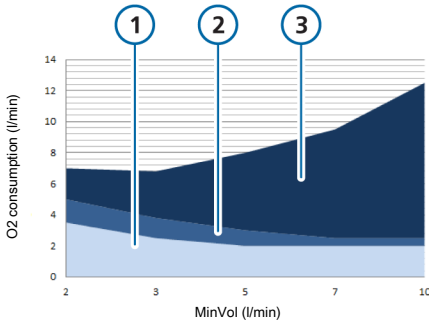
- 1 Oxygen consumption of the device. This accounts for base flow
- 2 Compressible volume in the breathing circuit.

The compressible volume is a significant factor that must be taken into account for smaller patients due to smaller tidal volumes. See Section 3.4.2.1.

- 3 Oxygen volume delivered to patient.

<sup>101</sup> If option is installed.

Figure 14-3. Oxygen consumption as a function of minute volume, oxygen set to 100%



- 1 Oxygen consumption of the device. This accounts for base flow
- 2 Compressible volume in the breathing circuit.  
The compressible volume is a significant factor that must be taken into account for smaller patients due to smaller tidal volumes. See Section 3.4.2.1.
- 3 Oxygen volume delivered to patient.

## 14.12 Functional description of ventilator system

The HAMILTON-T1 is an electronically controlled pneumatic ventilation system with an integrated air compressing system. It runs on AC or DC power with battery backup to protect against power failure or unstable power and to facilitate intra-hospital transport.

The user provides inputs to the HAMILTON-T1 microprocessor system through a touch screen, keys, and a press-and-turn knob. These inputs become instructions for the HAMILTON-T1's pneumatics to deliver a precisely controlled gas mixture to the patient. The ventilator receives inputs from the proximal flow sensor and other sensors within the venti-

lator. Based on this monitored data, the ventilator adjusts gas delivery to the patient. Monitored data is also displayed by the graphic user interface.

The ventilator's microprocessor system controls gas delivery and monitors the patient. The gas delivery and monitoring functions are cross-checked by an alarm controller. This cross-checking helps minimize the possible hazards of software failure.

A comprehensive system of visual and audible alarms helps ensure the patient's safety. Clinical alarms can indicate an abnormal physiological condition. Technical alarms, triggered by the ventilator's self-tests including ongoing background checks, can indicate a hardware or software failure. In the case of some technical alarms, a special safety ventilation ensures basic minute ventilation while giving the operator time for corrective actions.

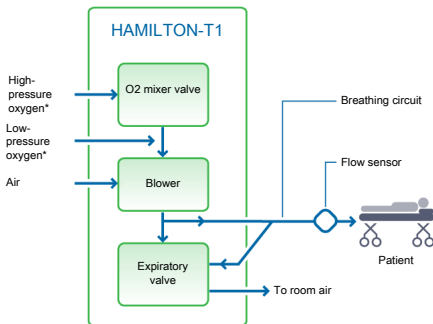
When a condition is critical enough to possibly compromise safe ventilation, the HAMILTON-T1 is placed into the Ambient state. The inspiratory channel and expiratory valves are opened, letting the patient inspire room air through the inspiratory channel and exhale through the expiratory valve.

The HAMILTON-T1 has several means to ensure that safe patient or respiratory pressures are maintained. The maximum working pressure is ensured by the high pressure alarm limit. If the set high pressure limit is reached, the ventilator cycles into exhalation. The ventilator pressure cannot exceed 60 cmH<sub>2</sub>O.

### 14.12.1 Gas supply and delivery

The HAMILTON-T1 uses room air and high- or low-pressure oxygen (Figure 14-4). The use of medical oxygen is mandatory. Air enters through a fresh gas intake port and is compressed together with the oxygen by the blower. Oxygen enters through a high<sup>102</sup>- or low<sup>103</sup>-pressure inlet.

Figure 14-4. Gas delivery in the HAMILTON-T1



\* only one oxygen source required

Within the ventilator, the gas enters the ventilator's pneumatic system. If high-pressure oxygen is supplied, a mixer valve provides for the operator-set concentration. If low-pressure oxygen is supplied, the delivered oxygen concentration is determined by the flow of the oxygen source.

Gas is supplied to the patient via the blower. The microprocessor controls the speed of the blower and the length of time it runs to meet the user settings.

The ventilator delivers gas to the patient through the inspiratory limb breathing circuit parts, which may include one or more of the following: inspiratory filter, flex tubes, humidification system, water traps, Y-piece, and flow sensor. An internal pneumatic nebulizer supplies the nebulizer flow.

Gas exhaled by the patient passes through the expiratory limb breathing circuit parts, which includes one or more of the following: flex tubes, flow sensor, Y-piece, and expiratory valve set. Gas is vented through the expiratory valve housing such that no exhaled gas comes into contact with any internal components of the ventilator. The expiratory valve is heated to reduce the possibility of rainout in the expiratory limb.

Measurements taken at the flow sensor are used in the pressure, flow, and volume measurements.

The ventilator monitors the oxygen concentration of the gas to be delivered to the patient using a galvanic O<sub>2</sub> sensor. The galvanic O<sub>2</sub> sensor generates a voltage proportional to the partial pressure of oxygen in the delivered gas.

The operations of the blower and expiratory valve are coordinated to maintain system pressure levels.

<sup>102</sup> High-pressure oxygen: Maximum allowed pressure is 600 kPa.

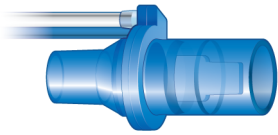
<sup>103</sup> Low-pressure oxygen: Maximum allowed pressure is 600 kPa, maximum allowed flow 15 l/min.



### 14.12.2 Gas monitoring with the flow sensor

The HAMILTON-T1 accurately measures flow, volume, and pressure in the patient's airway with the Hamilton Medical flow sensor. This proximal flow sensor lets the ventilator sense even weak patient breathing efforts. Between its highly sensitive flow trigger and fast response time, the ventilator helps minimize the patient's work of breathing.

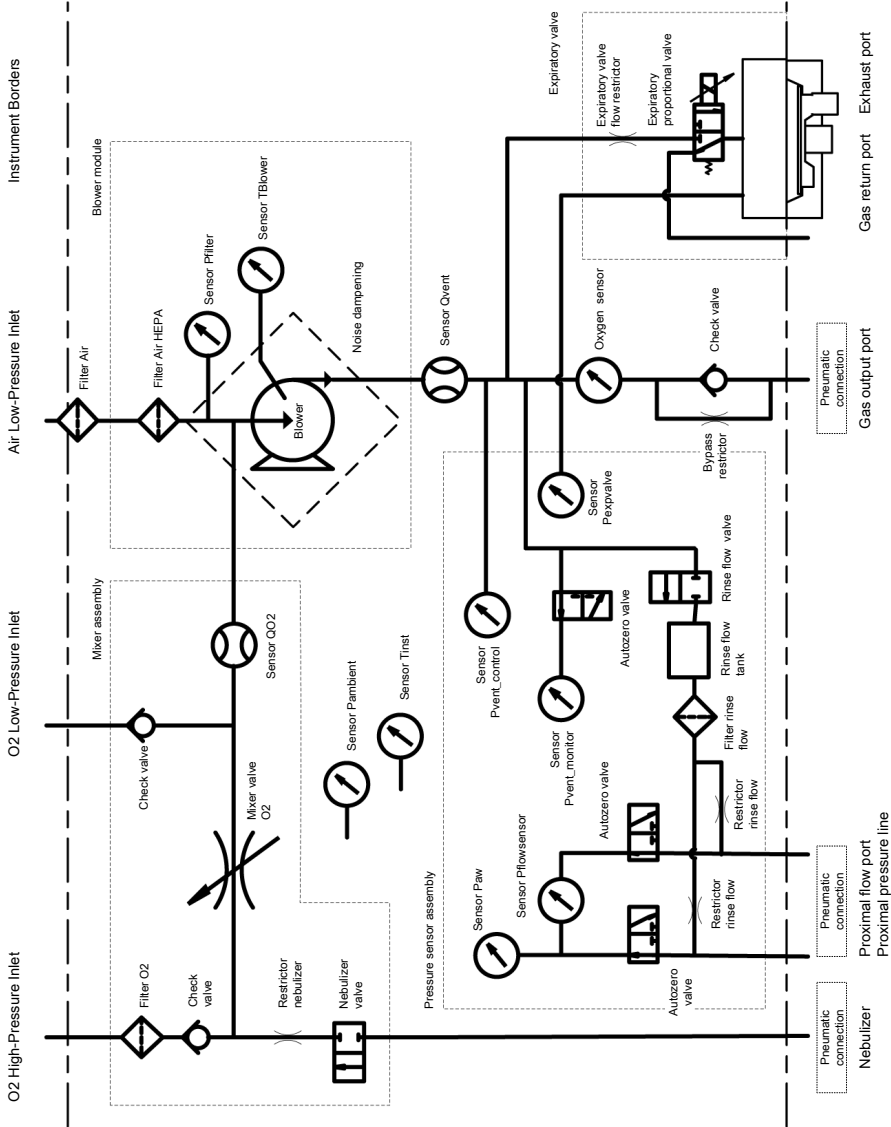
The flow sensor contains a thin membrane within the outer housing and has a pressure port on either side. The membrane allows bidirectional flow through its variable orifice.



The area of the orifice changes depending on the flow rate. It opens progressively as the flow increases, creating a pressure drop across the orifice. The pressure difference is measured by a high-precision differential pressure sensor inside the ventilator. The pressure difference varies with flow (relationship determined during flow sensor calibration), so the patient's flow is determined from the pressure drop. The ventilator calculates volume from the flow measurements.








The flow sensor is highly accurate even in the presence of secretions, moisture, and nebulized medications. The ventilator flushes the sensing tubes with mixed gases (rinse flow) to prevent blockage.











14.12.3 Pneumatic diagram















## 14.13 Symbols used on device labels and packaging

Table 14-16. Symbols used on device, device labels, and packaging

Symbol	Definition
	Power/Standby key
	Manufacturer
	Date of manufacture
	Refer to the operator's manual for complete information.
	Symbol for "Caution". Applied parts not protected against defibrillation.
<b>CE 0197</b>	CE Marking of Conformity, seal of approval guaranteeing that the device is in conformance with the Council Directive 93/42/EEC concerning medical devices
	The TÜV NRTL mark with the indicators "C" and "US" means that the product complies with Canadian requirements and the requirements of US authorities for safety.
	Dispose according to Council Directive 2002/96/EC or WEEE (Waste Electrical and Electronic Equipment)
<b>SN</b>	Serial number





Symbol	Definition
	This way up at transport and storage
	Fragile, handle with care at transport and storage
	Keep dry at transport and storage
	Temperature limitations at transport and storage
	Humidity limitations at transport and storage
	Atmospheric pressure limitations at transport and storage
	Stacking limitations at transport and storage
	Recyclable material
	Mass
	Single use

Symbol	Definition
	<p>Autoclavable.</p> <p>Autoclavable parts can be used inside an autoclave (for example, a steam autoclave) without damage. These parts withstand temperatures up to approximately 134°C. The correct way to reprocess autoclavable parts is described in the <i>Reprocessing Guide</i> provided by the manufacturer.</p> <p>Parts that Hamilton Medical terms as <i>autoclavable</i> can undergo autoclaving with steam sterilization without damage.</p>
	<p>Reusable.</p> <p>A reusable part is a medical device or part of a medical device that can be reused if it undergoes some sort of reprocessing between use on different patients. The correct way to reprocess reusable parts is described in the <i>Reprocessing Guide</i> provided by the manufacturer.</p> <p>Parts that Hamilton Medical terms as <i>reusable</i> cannot be autoclaved with steam sterilization.</p>
	<p>Type B applied part (classification of medical electrical equipment, type B, as specified by IEC 60601-1)</p>
	<p>Type BF applied part (classification of medical electrical equipment, type BF, as specified by IEC 60601-1)</p>

Symbol	Definition
	<p>Applicable to neonatal patient group</p>
	<p>Applicable to pediatric patient group</p>
	<p>Applicable to adult patient group</p>
	<p>Applicable to neonatal/pediatric patient groups</p>
	<p>Applicable to pediatric/adult patient groups</p>
	<p>Applicable to all patient groups</p>
	<p>Indicates the degree of protection against electric shock according to IEC 60601-1. Class II devices have double or reinforced insulation, as they have no provision for protective grounding.</p>
<b>IP24</b>	<p>Protected against splashing water and solid particles larger than 12.5 mm.</p>
	<p>HAMILTON-T1 poses unacceptable risks to the patient, medical staff, or other persons within the MR environment.</p>

### 14.13.1 Symbols used on the trolley

Table 14-17. HAMILTON-T1 trolley warning labels

Label	Description
	Make sure the wheel brakes are unlocked when moving the trolley.
	Do not lean on the trolley.
	Do not park the trolley on an incline greater than 5 degrees.
	<p>Weight</p> <p>The maximum safe working load applies to a stationary properly load-balanced trolley.</p>

## 14.14 Standards and approvals

The HAMILTON-T1 was developed in accordance with pertinent international standards and FDA guidelines.

The ventilator is manufactured within an EN ISO 13485 and EN ISO 9001, Council Directive 93/42/EEC, Annex II, Article 3 certified quality management system.

The ventilator meets the Essential Requirements of Council Directive 93/42/EEC, Annex I.

Where standards are mentioned, the HAMILTON-T1 complies with the versions listed in Table 14-19.

The ventilator meets relevant parts of the following standards, listed in Table 14-18.

Table 14-18. Standards

IEC 60601-1	<p>Medical electrical equipment, Part 1: General requirements for basic safety and essential performance. The device classification is: Class II, Type B applied part (ventilator breathing system, VBS), type BF applied part (CO2 sensor including CO2 module connector, and SpO2 sensor including SpO2 adapter), continuous operation</p>
IEC 60601-1-2	<p>Medical electrical equipment - Part 1-2: General requirements for basic safety and essential performance.</p> <ul style="list-style-type: none"> <li>• Collateral standard: Electromagnetic disturbances</li> <li>• Requirements and tests</li> </ul>
ISO 80601-2-12	<p>Medical electrical equipment - Part 2-12: Particular requirements for the basic safety and essential performance of critical care ventilators</p>
CAN/CSA-C22.2 No. 60601.1	<p>Medical electrical equipment: General requirements for safety</p>
ANSI/AAMI ES 60601-1	<p>Medical electrical equipment - Part 1: General requirements for basic safety and essential performance</p>

EN ISO 5356-1	Anaesthetic and respiratory equipment - conical connectors - Part 1: Cones and sockets	IEC 61000-4-3:2006 + A1:2007+A2:2010 IEC 61000-4-4:2004 IEC 61000-4-5:2005
EN ISO 5359	Low-pressure hose assemblies for use with medical gases	IEC 61000-4-6:2003+A1:2004+A2:2006 IEC 61000-4-8:2009
EN ISO 80601- 2-55	Medical electrical equipment - Part 2-55: Particular requirements for the basic safety and essential performance of respiratory gas monitors	IEC 61000-4-11:2004 EN ISO 5359:2008 + A1: 2011 EN ISO 13485:2012/AC:2012 IEC 60950-1:2013
MIL-STD-461F	Control of electromagnetic interference	ISO 15883-1:2006+A1:2014 ISO 15883-2:2006
MIL-STD-810G	Low pressure (altitude)	ISO 15883-3: 2006 ISO 15883-4:2008
EN 1789	Medical vehicles and their equipment - Road ambulances	ISO 11607-1: 2006 + AMD1:2014 EN ISO 9001:2008
EN 794-3	Lung ventilators - Part 3: Particular requirements for emergency and transport ventilators	EN ISO 5356-1:2015 ISO 4135:2001 EN 794-3:1998 + A2:2009 EN 1789:2007 + A1:2010
Table 14-19. Standards and approvals, valid versions		MIL-STD-461F MIL-STD-810G
IEC 60601-1:2005/A1:2012		
ANSI/AAMI ES60601-1:2005(R)2012		
CAN/CSA-C22.2 No. 60601-1:14		
IEC 60601-1-2:2014		
ISO 80601-2-12:2011 + Cor.:2011		
ISO 80601-2-55:2011		
IEC 61000-3-2:2005		
IEC 61000-3-3:2008		
IEC 61000-4-2:2008		

## 14.15 Disposal and year of manufacture

### Disposal

The device must be disposed of according to your institution's protocols and Directive 2002/96/EC.

All parts removed from the device must be considered contaminated, and pose infection risk.

Dispose of all parts removed from the device according to your institution's protocol. Follow all local, state, and federal regulations with respect to environmental protection, especially when disposing of the electronic device or parts of it (for example, O<sub>2</sub> sensor, batteries).

### Year of manufacture

The year of manufacture is shown on the serial number label on the HAMILTON-T1 ventilation unit.

## 14.16 Warranty

### LIMITED WARRANTY

THE WARRANTY DESCRIBED IN THIS AGREEMENT IS IN LIEU OF ANY AND ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. HOWEVER, IMPLIED WARRANTIES ARE NOT DISCLAIMED DURING THE PERIOD OF THIS LIMITED WARRANTY.

Hamilton Medical guarantees its products to be shipped free from defects in material and workmanship.

The warranty does not include disposable items. Disposable items and consumable products are considered to be of single use or of limited use only and must be replaced regularly as required for proper operation of the product following the operator's manual.

Hamilton Medical shall have no obligations nor liabilities in connection with the product other than what is specified herein, including without limitation, obligations and/ or liabilities for alleged negligence, or for strict liability.

In no event shall the company be liable for incidental or consequential damages, either direct or contingent.

This Limited Warranty shall be void and not apply:

1. If the product has not been installed and connected by an authorized local representative of Hamilton Medical in accordance with the instructions furnished by Hamilton Medical and by a Hamilton Medical representative.
2. If replacements and/or repairs have not been performed by authorized or properly trained personnel.
3. If no evidence is present that the occurrence of damage/ repair happened within the certified warranty period.
4. If the serial number has been altered, effaced or removed and there is no bill of sale or evidence to verify the product's purchase date.
5. If the defects arise from misuse, negligence, or accidents or from repair, adjustment, modification or replacement made outside Hamilton Medical's factories or other than an authorized service center or authorized service representative.
6. If the product has been modified, or in any nature altered without prior written authorization from Hamilton Medical.
7. If yearly maintenance is not performed.
8. If the product is or has been used in any way that is not specified under "Intended Use" (see "General cautions and notes").
9. If the product has been used by anyone but properly trained personnel under the supervision of a physician. Replacements and/or repairs furnished under this Limited Warranty do not carry a new warranty, but carry only the unexpired portion of the original Limited Warranty. The warranty of repaired and/or replaced components does not exceed the Limited Warranty of the device.

To obtain service under this Limited Warranty, claimant must promptly notify the country's sales partner of Hamilton Medical regarding the nature of the problem, serial number and the date of purchase of the Product.

Except as stated above, Hamilton Medical shall not be liable for any damages, claims or liabilities including, but not limited to, personal bodily injury, or incidental, consequential, or special damages. Nor will Hamilton Medical be liable for any damages, claims or liabilities including, but not limited to, personal bodily injury, or incidental, consequential, or special damages resulting from misuse of the device or failure to comply with any of the provisions made in this manual.

The general terms and conditions of Hamilton Medical shall be applicable. This agreement shall be governed by and construed in accordance with the laws of Switzerland and may be enforced by either party under the jurisdiction of the court of Chur, Switzerland.



**%MinVol**

Percentage of minute ventilation, a control setting in ASV mode

**(S)CMV+**

See APVcmv

**alarm lamp**

Lamp on top of the ventilator that lights in the color corresponding to the active alarm

**ambient state**

An emergency state in which the ventilator opens the inspiratory channel and expiratory valve; this allows the patient breathe room air unassisted by the ventilator

**apnea**

Cessation of breathing

**Apnea time**

The maximum time allowed without a breath trigger, an alarm setting

**APRV**

Airway pressure release ventilation, a ventilation mode

**APVcmv**

Adaptive pressure ventilation with controlled mandatory ventilation, a ventilation mode; can also be shown as (S)CMV+ (configurable)

**APVsimv**

Adaptive pressure ventilation with synchronized intermittent mandatory ventilation, a ventilation mode; can also be shown as SIMV+ (configurable)

**ASV**

Adaptive support ventilation mode. ASV adjusts pressure and rate on a breath-by-breath basis, taking into

account changing patient conditions and applying lung-protective strategies to meet the targets.

**ASV Graph**

An Intelligent panel that shows ASV target and patient data graphically, available in ASV mode

**AutoPEEP**

Unintended positive end-expiratory pressure, a monitored parameter

**b/min**

Breaths per minute

**backup**

Apnea backup ventilation

**backup buzzer**

A buzzer that sounds for at least 2 minutes in certain conditions; also functions as a backup for the ventilator loudspeaker

**base flow**

A continuous and constant gas flow from the inspiratory outlet to the expiratory outlet

**breathing circuit**

Breathing limbs and components used to deliver respiratory gases to the patient

**BTPS**

Body temperature, barometric pressure at sea level, saturated with water vapor

**CE**

A certification mark that indicates compliance with the Medical Device Directive, 93/42/EEC

**cmH2O**

Centimeters of water; 1 cmH2O is approximately equal to 1 mbar, which equals 1 hPa

**CSA**

Canadian Standards Association

**Cstat**

Static compliance, a monitored parameter

**DuoPAP**

Duo positive airway pressure, a ventilation mode

**Dynamic Lung**

Intelligent panel that graphically represents tidal volume, lung compliance, patient triggering, and resistance in real time

**EMC**

Electromagnetic compatibility

**EMI**

Electromagnetic interference

**EN**

European norm, a European standard

**ETS**

Expiratory trigger sensitivity, a control setting

**event log**

A record of clinically relevant ventilator occurrences, including alarms, settings changes, calibrations, maneuvers, and special function uses that have occurred since the ventilator was turned on

**Exp Flow**

Peak expiratory flow, a monitored parameter

**ExpMinVol**

Expiratory minute volume, a monitored parameter and alarm setting; in the Vent Status panel, ExpMinVol is the percentage of normal minute ventilation based on IBW

**f**

Respiratory rate

**fControl**

Mandatory breath frequency, a monitored parameter

**FDA**

United States Food and Drug Administration

**FetCO<sub>2</sub>**

Fractional end-tidal CO<sub>2</sub> concentration, a monitored parameter

**Flow (parameter)**

In the neonatal nCPAP and nCPAP-PC modes, monitored parameter that measures and displays the current flow; the upper (high) limit is controlled by the Flow alarm

**fSpont**

Spontaneous breathing frequency, a monitored parameter

**fTotal**

Total breathing frequency, a monitored parameter and alarm setting

**HEPA**

High efficiency particle air filter

**HiFlowO<sub>2</sub>**

High flow oxygen therapy, a ventilation mode

**HME, HMEF**

Heat and moisture exchanger (artificial nose), heat and moisture exchanging filter

**HPO**

High-pressure oxygen

**I:E**

Ratio of inspiratory time to expiratory time, a setting, timing parameter, and monitored parameter

**IBW**

Ideal body weight, a calculated value for adult and pediatric patients based on the patient's sex and height; used as the basis for initial settings of various parameters

**ID**

Inner diameter

**IEC**

International Electrotechnical Commission

**Insp Flow**

Peak inspiratory flow, a monitored parameter

**Intelligent Panel**

A type of graphic display on the ventilator

**IntelliTrig**

Intelligent trigger, a feature that ensures that the set trigger sensitivity can trigger a breath independent from leakage and breath pattern

**IRV**

Inverse ratio ventilation

**ISO**

International Organization for Standardization

**loudness**

Sets the volume for the audible ventilator alarms

**LPO**

Low-pressure oxygen

**LSF**

Least squares fitting method; a mathematical procedure for finding the best fitting curve for a given set of points by minimizing the sum of the squares of the offsets of the points from the curve

**mandatory breath**

The start of inspiration (triggering) is determined by the ventilator or the patient. The end of inspiration (cycling) is determined by the ventilator.

**manual breath**

A user-triggered mandatory breath started by pressing the Manual breath key

**MinVol**

Minute volume, a calculated and monitored parameter used in ASV mode; based on the operator-set %MinVol, the ventilator calculates the target MinVol in l/min, then measures and displays this value in the ASV Graph

**MVLeak**

Total minute volume leakage; MVLeak shows  $V_{Leak} \times \text{frequency}$  (respiratory rate)

**MVSpont**

Spontaneous expiratory minute volume, a monitored parameter

**nCPAP**

Neonatal-only ventilation mode that applies CPAP over a nasal interface (mask or prongs)

**nCPAP-PC**

Neonatal-only ventilation mode that delivers, in addition to the set CPAP, intermittent, time-cycled, and pressure-controlled breaths

**NIST**

Noninterchangeable screw thread, a standard for high-pressure gas inlet fittings

**NIV**

Noninvasive ventilation, a ventilation mode

**NIV-ST**

Spontaneous/timed noninvasive ventilation, a ventilation mode

**NPPV**

Noninvasive positive pressure ventilation

**OD**

Outer diameter

**Oxygen**

Oxygen concentration of the delivered gas, a control setting and a monitored parameter

**P high**

High pressure in APRV and DuoPAP modes

**P low**

Low pressure setting in APRV mode

**P0.1**

Airway occlusion pressure, a monitored parameter

**Pasvlimit**

Maximum pressure to be applied in ASV, a control setting

**Pat. height**

Patient height; a control setting used to compute the patient's ideal body weight (IBW) in calculations for ASV and startup settings

**patient group**

A control setting used to define initial startup settings for the patient; options are Adult/Ped (adult and pediatric patients) and Neonatal

**Pcontrol**

Pressure control, a control setting in PCV+ and PSIMV+ modes; pressure (additional to PEEP/CPAP) to be applied during the inspiratory phase

**PCV+**

Pressure controlled ventilation, a ventilation mode

**PEEP/CPAP**

PEEP (positive end-expiratory pressure) and CPAP (continuous positive airway pressure), a control setting and monitored parameter; PEEP and CPAP are constant pressures applied during both the inspiratory and expiratory phases

**PetCO<sub>2</sub>**

Partial pressure of end-tidal CO<sub>2</sub>, the measure of CO<sub>2</sub> present in the exhaled air

**Pinsp**

Inspiratory pressure, the target pressure (additional to PEEP/CPAP) to be applied during the inspiratory phase. Set by the operator in the PSIMV +PSync and NIV-ST modes; displayed in the Vent Status panel and the ASV Graph.

**Pmean**

Mean airway pressure, a monitored parameter

**PN**

Part number

**Ppeak**

Peak airway pressure, a monitored parameter

**Pplateau**

Plateau or end-inspiratory pressure

**P-ramp**

Pressure ramp, a control setting

**Press-and-turn knob**

See P&T knob

**pressure control**

Maintenance of a consistent transrespiratory pressure waveform despite changing respiratory system mechanics

**PSIMV+**

Pressure-controlled synchronized intermittent mandatory ventilation, a ventilation mode

**Psupport**

Pressure support, a control setting valid during spontaneous breaths in SPONT, SIMV+, APVsimv, PSIMV +PSync, DuoPAP, and NIV modes. Psupport is pressure (additional to PEEP/CPAP) to be applied during the inspiratory phase.

**PTP**

Inspiratory pressure time product, a monitored parameter

**Rate**

Breath frequency or number of breaths per minute, a control setting

**RCexp**

Expiratory time constant, a monitored parameter

**Rinsp**

Inspiratory flow resistance, a monitored parameter

**RSB**

Rapid shallow breathing index, a monitored parameter

**Sex**

Sex of patient, a control setting

**sigh**

Breaths delivered to deliberately increase tidal volume at a regular interval. If enabled, a sigh breath with an additional 10 cmH<sub>2</sub>O is delivered every 50 breaths. Note that in

volume-controlled modes, a sigh breath delivering 150% of the set tidal volume is delivered every 50 breaths.

**SIMV+**

See APVsimv

**slopeCO<sub>2</sub>**

Slope of the alveolar plateau in the PetCO<sub>2</sub> curve, a monitored parameter

**SPONT**

Spontaneous (pressure support) mode of ventilation, a ventilation mode

**spontaneous breath**

A breath for which both the inspiratory and expiratory triggers are controlled by the patient; the patient both triggers and cycles the breath

**Standby**

The ventilator is in a waiting state; there is no breath delivery

**T high**

Set time interval for the high pressure level in the APRV and DuoPAP modes

**T low**

Set time interval for the low pressure level in APRV mode

**TE**

Expiratory time, a monitored parameter

**technical fault**

A type of alarm generated when the ventilator's ability to safely ventilate the patient may be at risk

**TI**

Inspiratory time, a control setting and monitored parameter

**TI max**

Maximum inspiratory time, a control setting

**touch screen**

The glass portion of the monitor that you touch to interact with the display elements

**Trends**

A special graphic type

**V'alv**

Alveolar minute ventilation, a monitored parameter

**V'CO<sub>2</sub>**

Net exhaled volume of CO<sub>2</sub>, a monitored parameter

**VDaw**

Airway dead space

**VDaw/VTE**

Airway dead space fraction at the airway opening, a monitored parameter

**VeCO<sub>2</sub>**

Expiratory CO<sub>2</sub> volume, a monitored parameter

**Vent Status panel**

An Intelligent Panel that illustrates six parameters related to the patient's ventilator dependence, including oxygenation and patient activity

**ventilator breathing system (VBS)**

A breathing system bounded by the low-pressure gas input port(s), the gas intake port(s), and the patient connection port, together with the fresh-gas inlet and exhaust port(s), if fresh-gas inlet or exhaust ports are provided, as described in ISO 4135

**ViCO<sub>2</sub>**

Inspiratory CO<sub>2</sub> volume, a monitored parameter

**VLeak**

Leakage percent, a monitored parameter

**Vt**

Tidal volume; a control setting, alarm setting, and monitored parameter

**Vt/IBW**

Tidal volume calculated according to ideal body weight, used for adult/pediatric patients; a monitored parameter

**Vt/Weight**

Tidal volume calculated according to actual body weight, used for neonatal patients; a monitored parameter

**Vtalv**

Alveolar tidal ventilation, a monitored parameter

**VTE**

Expiratory tidal volume, a monitored parameter; it is the integral of all negative flow measurements during exhalation

**VTESpont**

Spontaneous expiratory tidal volume, a monitored parameter

**VTI**

Inspiratory tidal volume, a monitored parameter

**Waveforms**

A special graphic type

## Icons

- %MinVol parameter 96, 239
- (S)CMV+ / APVcmv ventilation mode 113

## A

- accessories, list of 224
- air/dust filters, replacing 212
- alarm tests
  - about 87
  - apnea alarm 89
  - disconnection on patient side alarm 88
  - exhalation obstructed alarm 88
  - high pressure alarm 87
  - loss of external power alarm 88
  - low minute volume alarm 87
  - low oxygen alarm 88
- alarms
  - about 168
  - active, viewing 172
  - audio pause, enabling 171
  - buffer, about 172
  - i-icon (alarm buffer) 173
  - inactive, viewing 172
  - indicators, about 168, 169
  - limits, setting 92
  - limits, where shown 170
  - list of 174
  - loudness, setting 173
  - responding to 171
  - silencing (audio pause) 171
  - troubleshooting 174
- alarms, adjustable
  - about 92
  - Apnea time 93
  - ExpMinVol 93
  - Flow (nCPAP, nCPAP-PC only) 93
  - fTotal 93
  - limits, setting 92
  - Oxygen 93
  - PetCO<sub>2</sub> 93
  - Pressure 93
  - Vt 94
- Ambient state 130
- Apnea backup 91, 96, 239
- Apnea time alarm 93, 249
- APRV ventilation mode 110, 120

- APVcmv / (S)CMV+ ventilation mode 110, 113
- APVsimv / SIMV+ ventilation mode 110, 114
- ASV Graph
  - about 156
  - displaying 156
- ASV ventilation mode 110, 122
  - functional overview 138
  - maintaining adequate ventilation 135
  - monitoring ventilation 136
  - weaning, overview 137
  - working with 133
- audio pause (alarm silence)
  - alarms not affected 171
  - enabling 171
- AutoPEEP parameter 157, 243

## B

- batteries
  - about 54
  - power states, about 55
  - status indicator on ventilator 55
  - storage 213
- breath timing options 108
  - selecting 217
- breath types 108
- breathing circuit diagrams (Adult/Ped)
  - coaxial with HMEF 46
  - dual limb with humidifier 46
- breathing circuit diagrams (adult/pediatric)
  - HiFlowO<sub>2</sub> 47
- breathing circuit diagrams (Neo)
  - HiFlowO<sub>2</sub> 49
  - nCPAP, nCPAP-PC 50
  - with HMEF 48
  - with humidifier 48
- breathing circuits
  - connection diagrams 45
  - connection overview 63
  - expiratory valve, installing 64
  - filters, using in 65
  - flow sensor, connecting 66
  - key connection ports on ventilator 63
  - positioning 67, 103
  - pressure line, connecting 102
  - selecting components for (adult/pediatric) 64

- selecting components for (Neo) 101
- speaking valve compatibility 65
- buffer, alarm 172

## C

- calibration
  - breathing circuit (pressure line) 105
  - CO2 sensor/adaptor 86
  - flow sensor 84, 104
  - O2 sensor 85
  - Tests & calibs window, accessing 81
- cleaning components and ventilator
  - agents for touch screen 209
  - cleaning agents 208
  - general guidelines 206
- CO2 alarms 93, 249
- CO2 measurement
  - activating option 220
  - CO2-related parameters 163, 246
  - enabling 74
  - mainstream monitoring, about 71
  - overview 70
  - sidestream monitoring, about 72
  - zero calibration, performing 86
- communication (COM) interface, selecting 216
- configuration
  - alarm loudness, setting minimum 217
  - breath timing options, selecting 217
  - CO2, activating option 220
  - communication (COM interface, selecting) 216
  - Configuration mode, accessing 216
  - copying configuration settings to other devices 221
  - hardware options, activating/deactivating 220
  - hardware options, enabling/disabling 221
  - language, selecting 216
  - MMPs, selecting what to show 218
  - mode naming, selecting 217
  - options, reviewing installed 219
  - Quick setups, defining 218
  - software options, activating 220
  - software options, removing 221
  - SpO2, activating option 220
  - units of measure, selecting 216
- Control Flow parameter 158, 244

- control parameters
  - adjusting 51
  - defined 95
  - settings, changing 52, 193
- Controls window 90
  - opening 90
  - settings for ventilation, adjusting 90
- Cstat parameter 160, 245
  - in Dynamic Lung 152

## D

- data transfer, copying configuration settings 221
- date/time, setting 202
- device information, viewing 165
- disinfecting components
  - general guidelines 206
- display
  - brightness, setting 202
  - navigating 51
- documentation
  - conventions used in manual 16
  - manuals for ventilator, list of 15
- DuoPAP ventilation mode 110, 119
- Dynamic Lung
  - about 151
  - airway resistance (Rinsp) 153
  - compliance (Cstat) 152
  - displaying 154
  - patient trigger 153
  - SpO2 data 154

## E

- EMC-related safety information 20
- ETS parameter 96, 239
- Event log
  - about 200
  - copying 201
  - viewing 200
- Exp Flow parameter 158, 243
- expiratory valve, installing 64
- ExpMinVol parameter 158, 244



**F**

- fControl parameter 159, 245
- FetCO<sub>2</sub> parameter 163, 246
- filters, using in breathing circuit 65
- Flow 244
- flow alarms 93, 249
- Flow parameter 96, 158, 239
- flow sensor
  - calibration 84, 104
  - connecting 66
  - connecting (Neo) 102
- flow-related parameters 158, 243
- fSpont parameter 159, 245
- fTotal parameter 160, 245
- function keys on front of ventilator, about 193

**G**

- gas source
  - selecting HPO/LPO 56
- gas supply
  - connecting 56
  - functional description of 264
  - LPO, connecting 56
  - LPO, overview 56
  - selecting HPO/LPO 56
- graphics on display
  - Intelligent panels, about 151
  - loops 150
  - trends 149
  - types of 146
  - waveform view options 147

**H**

- Hamilton Medical College website 15
- hardware options
  - reviewing installed 219
- HEPA filter
  - replacing 212

**HiFlowO<sub>2</sub>**

- about 196
- breathing circuit diagrams (adult/pediatric) 47
- breathing circuit diagrams (Neo) 49
- working with 196
- humidifier
  - connecting 70

**I**

- I:E parameter 96, 160, 239, 245
- IBW parameter 160, 239
- i-icon (alarm buffer), about 173
- Insp Flow parameter 158, 243
- Intelligent panels
  - about 151
  - ASV Graph 156
  - Dynamic Lung 151
  - types of 146
  - Vent Status 154

**K**

- keys on front of ventilator, about 193

**L**

- language, setting 216
- leak alarms 93, 249
- Leak parameter 159
- list items, selecting 52
- loops
  - about 150
  - displaying 151
  - storing 151
  - types of 146
- loudness, setting for alarms 173
- LPO (low-pressure oxygen)
  - connecting 56
  - overview 56
  - selecting gas source 56

**M**

- main display, overview of 44
- main monitoring parameters (MMPs)
  - selecting what to show 218
  - viewing 144
- mainstream CO2 measurement
  - about 71
  - setting up 71
- maintenance
  - air/dust filters, replacing 212
  - battery, storage 213
  - HEPA filter, replacing 212
  - O2 sensor (galvanic), replacing 213
  - preventive 211
- manual breath, delivering 197
- MinVol NIV parameter 158, 244
- modes
  - naming convention, selecting 217
- monitored parameters 243
  - defined 157
  - specifications for 243
- monitoring ventilation
  - about 144
  - main monitoring parameters (MMPs) 144
  - parameter values, viewing graphically 146
  - parameter values, viewing numeric 144
- MVLeak 245
- MVLeak parameter 159
- MVSpont NIV parameter 158, 244
- MVSpont parameter 158, 244
- MyHamilton website 15

**N**

- navigating the display 51
- nCPAP ventilation mode 110, 127, 128
- nCPAP/nCPAP-PC
  - breathing circuit diagram 50
- nCPAP-PC ventilation mode 110, 127, 128

**nebulizer**

- pneumatic, setting up 74
  - setting up 74
- starting/stopping 197
- using 197

**neonatal ventilation**

- breathing circuit diagrams 48, 49, 50
- breathing circuit, setting up 101
- flow sensor, connecting 102
- patient data, entering 100
- preoperational check, overview 103
- setting up for 100

**NIV ventilation mode 110, 125****NIV-ST ventilation mode 110, 126**

- noninvasive (NIV) ventilation
  - alarms during 132
  - conditions for use 130
  - contraindications for use 131
  - notes for use 133
  - working with 130

**O**

- O2 consumption parameter 245
- O2 enrichment, delivering 195
- O2 sensor
  - calibrating 85
  - enabling 74
  - replacing 213
- options
  - hardware, activating/deactivating 220
  - hardware, enabling/disabling 221
  - removing software 221
- oxygen alarms 93, 249
- Oxygen parameter 96, 160, 239, 245
  - alarm 94
- oxygen supply
  - connecting 56

**P**

- P high parameter 96, 240
- P low parameter 96, 240
- PO.1 parameter 161, 245
- parts, list of 224
- Pasvlimit parameter 96, 239
- Pat. height parameter 97, 239

- patient data
    - changing 192
    - entering 79
    - main monitoring parameters (MMPs) 144
    - viewing graphically 146
    - viewing numeric data 144
  - patient setup
    - entering patient data 78, 100
    - overview of 78
    - Quick setups, about 79
  - Paw (pressure/time) waveform, about 148
  - Pcontrol parameter 97, 240
  - PCV+ ventilation mode 110, 116
  - PEEP/CPAP parameter 97, 157, 240, 243
  - PetCO<sub>2</sub> parameter 163, 246
  - Pinsp parameter 97, 157, 240, 243
  - Pmean parameter 157, 243
  - power supply
    - batteries, about 54
    - power states, about 55
    - primary power, connecting to 54
  - Ppeak parameter 158, 243
  - Pplateau parameter 158, 243
  - P-ramp parameter 97, 240
  - preconfigured settings (Quick setups), about 79
  - preoperational check
    - flow sensor calibration, performing 84, 104
    - overview 82
    - overview of 80, 103
    - performing 81, 103
    - test breathing circuit setup (adult/pediatric) 81
    - test breathing circuit setup (Neo) 103
    - testing alarms 87
    - Tests & calibs window, accessing 81
    - Tightness test, performing 83
  - preparing for ventilation, overview 54
  - pressure alarms 93, 249
  - pressure line, connecting 102
  - pressure-related parameters 157, 243
  - PSIMV + PSync ventilation mode 110, 118
  - PSIMV+ ventilation mode 110, 117
  - Psupport parameter 97, 240
  - PTP parameter 161, 245
  - Pulse oximetry, about 73
- Q**
- Quick setups
    - about 79
    - defining 218
- R**
- rate alarms 93, 249
  - Rate parameter 97, 241
  - RCexp parameter 162, 245
  - Rinsp parameter 162, 245
    - in Dynamic Lung 153
  - RSB parameter 162, 245
- S**
- safety information 20
    - alarms 30
    - apnea backup 30
    - breathing circuits and accessories 25
    - CO<sub>2</sub> sensors 26
    - electrical 22
    - EMC 20
    - fire/hazards 21
    - gas supply 23
    - general operation and setup 21
    - humidifiers 26
    - maintenance and cleaning/disinfection 31
    - maintenance, cleaning/disinfection 31
    - monitoring 30
    - nebulization 28
    - neonatal ventilation 29
    - noninvasive ventilation 30
    - O<sub>2</sub> sensor 33
    - patient settings 29
    - power and batteries 22
    - preoperational checks 26
    - preventive maintenance 33
    - service and testing 33
    - trolley 31
    - USB port 24
  - Safety ventilation 129
  - screenshot of display, capturing 200

- sensors, enabling 74
  - setting up for ventilation, overview 54
  - Setups button, Configuration 218
  - sex 241
  - Sex parameter 97
  - sidestream CO2 measurement
    - about 72
    - setting up 73
  - Sigh parameter 98, 241
  - SIMV+ / APVsimv ventilation mode 114
  - slopeCO2 parameter 163, 246
  - software options
    - removing 221
    - reviewing installed 219
  - software options, activating on ventilator 220
  - software version, viewing 165
  - speaking valve
    - about 75
    - activating 75
    - compatibility 65
    - connecting to breathing circuit 76
    - deactivating 76
    - SpeakValve control 241
  - specifications
    - accuracy testing 261
    - adjustable alarms 249
    - ASV technical data 254
    - breathing system 256
    - configuration 252
    - dimensions 234
    - disposal 271
    - electrical 237
    - environmental 235
    - essential performance 262
    - functional description of system 263
    - gas monitoring description 265
    - gas supply/delivery description 264
    - monitored parameters 243
    - pneumatic 236
    - pneumatic diagram 266
    - standards/approvals 269
    - symbols used on labels 269
    - technical performance data 257
    - year of disposal 271
  - SpO2
    - activating option 220
  - SpO2 measurement
    - about 73
    - activating option 220
    - data displayed in Dynamic Lung 154
    - enabling 74
  - SPONT ventilation mode 110, 121
  - standards, compliance with 20, 269
  - Standby
    - entering 95
    - entering/exiting 194
  - starting/stopping ventilation 95
  - suctioning, performing 195
  - System Info window, viewing device info 165
- ## T
- T high parameter 98, 241
  - T low parameter 98, 241
  - TE parameter 160, 245
  - TI max parameter 98, 241
  - TI parameter 98, 160, 241, 245
  - Tightness test, performing 83
  - time scale of waveforms, changing 148
  - time/date, setting 202
  - time-related parameters 159, 245
  - touch screen
    - cleaning agents for 209
    - locking/unlocking 199
  - transfer configuration settings 221
  - transport, preparing trolley for 51
  - trends
    - about 149
    - displaying 150
    - freezing 148
  - Trigger parameter 241, 245
    - Flow, defined 96
  - trolley, preparing for intrahospital transport 51
  - troubleshooting
    - alarms 174
    - CO2 sensor zero calibration failure 87
    - flow sensor calibration failure 84
    - O2 sensor calibration 85
    - tightness test failure 83
  - turning the ventilator on/off 67

## V

- V'alv parameter 163, 246
- V'CO<sub>2</sub> parameter 163, 246
- VDaw parameter 163, 246
- VDaw/VTE parameter 163, 246
- VeCO<sub>2</sub> parameter 164, 246
- Vent Status panel
  - about 154
  - displaying 155
  - weaning zone, configuring 219
- ventilation
  - alarms, working with 168
  - changing patient data during 192
  - control parameters, defined 95
  - monitored parameters, list of 156
  - monitoring, overview 144
  - neonatal, setting up for 100
  - preparing for, overview 54
  - settings, changing 193
  - Standby, entering/exiting 194
  - starting/stopping 95
- Ventilation counter 246
- ventilation modes
  - ASV, working with 133
  - changing 89
  - control settings overview 110
  - control settings, adjusting 90
  - modes, list of 109
  - noninvasive ventilation, working with 130
  - overview 108
  - selecting 89
- ventilation modes, list of
  - Ambient state 130
  - APRV 120
  - APVcmv 113
  - APVsimv (SIMV+) 114
  - ASV 122
  - DuoPAP 119
  - nCPAP 128
  - nCPAP-PC 128
  - NIV 125
  - NIV-ST 126
  - PCV+ 116
  - PSIMV+ 117
  - PSIMV+PSync 118
  - Safety ventilation 129
  - SPONT 121
- ventilation parameters
  - control settings 95
  - monitored 157, 243
- ventilation settings
  - entering patient data 78, 100
  - how to adjust 52
  - preconfigured settings (Quick setup), about 79
- ventilation time 163
- ventilation timer
  - about 164
  - resetting 164
- ventilator
  - cleaning agents for 208
  - controls, how to use 52
  - features/options, overview of 36, 37
  - front view 40
  - hardware options, overview of 38
  - intended use 17
  - main display, overview of 44
  - navigating the display 51
  - patient setup, overview 78
  - physical characteristics 39
  - rear view 41
  - side view (gas connections) 43
  - side view (patient ports) 42
  - turning on/off 67
- ViCO<sub>2</sub> parameter 164, 246
- VLeak parameter 159, 244
- volume alarms 93, 249
- volume-related parameters 158, 244
- Vt parameter 98, 242
- Vt/IBW parameter 159, 244
- Vt/kg parameter 98, 242
- Vt/Weight parameter 159, 242, 244
- Vtalv parameter 164, 246
- VTE NIV parameter 159, 244
- VTE parameter 159, 244
- VTESpont parameter 159, 244
- VTI parameter 159, 244

## W

- warranty 271
- waveforms
  - display options 147
  - displaying 147
  - freezing 148
  - Pressure/time (Paw), about 148
  - time scale, changing 148
  - types of 146
- Weight parameter 98, 242

## Z

- zero calibration
  - performing for CO2 sensor/adapter 86
  - Tests & calibs window, accessing 81





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