Palliative extubation/discontinuation of invasive ventilatory support - Guide for bedspace nursing staff

As part of End of Life Care, the patient may be planned to undergo a palliative extubation, as per the steps below.

Prior to extubation/discontinuation of invasive ventilatory support, ensure the following have been planned (refer to full *NHS Lothian End of Life Care Guidance for Critical Care* p7, for detailed guidance)

- ☐ Monitoring- removal of
- ☐ Instructions for prescribed medications
- ☐ Nutritional support and IV fluids

If the patient is proceeding to DCD organ donation, liaise with the duty SNOD for any specific instructions (e.g., timeline and environment).

Palliative extubation

- ☐ Ensure medical staff have fully documented plan in medical notes
- ☐ Ensure family understand the process.
    - Explain that airway obstruction, airway noises and airway soiling (secretions or vomitus) may occur and provide reassurance that the patient will be unaware of this and not distressed.
- ☐ Stop NG feed, ideally 4 hrs pre-extubation, (but this should not delay extubation if this has not been performed)
- ☐ Attempt to establish on spontaneous mode of invasive ventilation
- ☐ Reduce FiO2 to 0.21
- ☐ Establish appropriate analgesia and sedation regimen and ensure symptom relief is adequate prior to extubation.
- ☐ Consider antisialogogue (medication which deceases secretion/saliva production) prior to extubation e.g., buscopan
- ☐ Aspirate NG tube immediately prior to extubation
- ☐ Perform endotracheal and oropharyngeal suction
- ☐ If family wish to leave (majority of cases), ask them to wait outside
- ☐ Turn off ventilator and monitor alarms
- ☐ Extubate (ensure oropharyngeal suction is to hand)
- ☐ If significant mechanical airway obstruction then nurse the patient onto their side with head of the bed up and the chin tilted slightly.
- ☐ Avoid use of airway adjuncts (OPA, NPA) post extubation

Discontinuation of ventilation with ET tube in situ (consider when risk of airway soiling is v high e.g., active upper Gi haemorrhage, small bowel obstruction)

- ☐ As per initial pre-extubation steps above
- ☐ Discontinue ventilator support and disconnect ventilator
- ☐ Consider use of Swedish nose with no tubing, to avoid an open ended ET tube (as some families find this distressing)

Reduction in ventilatory support, whilst the patient remains intubated e.g. where the patient is on multi-organ support

- ☐ Ensure family understand the process (family usually prefer to remain present in this circumstance and death may be very rapid).
- ☐ Turn-off apnoea ventilation and alarms
- ☐ Withdraw other forms of organ support
- ☐ Decrease ventilatory support as directed by clinicians e.g. FiO2 of 0.21

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