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**Critical Care Guidelines**

**FOR CRITICAL CARE USE ONLY**

## 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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