5.7 Withdrawing Ventilation Support

Key Points

1. We never withdraw care from patients at Life's End. However, we may withdraw a therapy (e.g., mechanical ventilation) and increase other forms of care when the burdens of therapy outweigh its benefits.

2. Mechanical ventilation therapy is a bridge of support until improvement allows patient to be off ventilator. When mechanical ventilation no longer bridges to recovery, it is no longer supporting Goals of Care.

   Use available criteria to help assess whether a patient can successfully wean off ventilator support. A decision to withdraw the therapy is appropriate in an incurable or irreversible illness when it no longer advances the Goals of Care.

3. Conduct a family conference to share the prognosis, select reasonable Goals of Care, and prepare family for outcome of withdrawing ventilation.
   - Discuss patient's status in simple language
   - Explain why patient is unlikely to improve
   - Discuss options. Review any Advance Directive for guidance
   - Has patient ever discussed treatment preferences for Life's End?
   - What would patient choose if he knew he had an illness that man cannot cure?

4. Be prepared for symptoms and have a plan to control them. Have a plan for care outside of the unit if patient is stable after ventilator removed. (See "Last Hours of Life.")

5. Provide maximal support for the family during and after withdrawal.

   Offer calm, supportive presence; schedule daytime withdrawal for maximal interdisciplinary support. Meet with family after patient dies; offer to be available for questions. Consider moving patient to a private room to support family time.

6. Monitor patient frequently.

   Turn off monitors if allowable and use physical signs (e.g., respiratory rate) to guide treatment. Family and staff have tendency to stare at monitors instead of interacting and attending to patient.

Withdrawing Ventilation Support

The Palliative Response

Care versus Therapy

- We never withdraw care from patients at Life's End
- The burden of a particular type of therapy (e.g., mechanical ventilation) may outweigh the benefits
- The patient, family, and medical team may make a decision to withdraw mechanical ventilation therapy while increasing other forms of caring

Mechanical Ventilation as a Bridge

- Supports patient until he improves sufficiently to be off ventilator
- An aggressive, invasive, and potentially life-saving therapy
- Use criteria to help assess whether a patient can successfully wean off ventilator support

When Ventilation Is No Longer a Bridge

- Incurable or irreversible illnesses
- Therapy is no longer bridging to a time when patient can live without ventilator support

Clinical Considerations

Ask:

- What are the Goals of Care?
- Does ventilator support accomplish Goals of Care?

It is appropriate to withdraw ventilation therapy when Goals of Care cannot be accomplished by ventilator support.

Mechanical-Ventilator Support

Experience of Patient's Family

- One of the most stressful events in family's life
- Fatigued and overwhelmed
- Fear, guilt, and anger are common
- Usually faced with making decisions because their loved one has lost capacity
- Sometimes arguing/unable to reach consensus

Family Conference

Sharing Bad News

- Identify family members/ relationships
- Include patient if has some capacity
- Share the bad news

  Simple language

  Explain why patient is unlikely to improve

  Discuss options of care (e.g., palliative care and hospice, as appropriate)

Help Family Select Reasonable Goals of Care

- More time with family
- Transfer from ICU
- Removal of uncomfortable and nonbeneficial treatment
- Potential of conversation with patient after ventilator withdrawal, if this is a reasonable goal

Discussing Patient Preferences for Care

"Did loved one have Advance Directive?"

- Yes—Review document for guidance
- No—Do not make family feel as if you ask them to "pull the plug." Use questions such as:

  "Did patient discuss treatment preferences?"

  "What would patient choose if could speak?"

  "Would patient choose this therapy or a different kind of care if he knew he had an illness man cannot cure?"

Protocol for Withdrawal

Prepare family for outcome

- Some patients die almost immediately
- Some live a few hours to days
- A small minority has a prolonged survival

Preparation

- Determine whether family wants to be with patient during removal of support
- Be prepared for symptoms and have a plan to control them

Protocol for Withdrawal

Timing: morning is usually best

- Give family time to prepare
- Availability of pastoral and social work support

Staff support is important

- Colleagues: Important to have their support
- Nursing staff: Discuss plan and rationale

Document carefully

- Discussion
- Decisions

Protocol for Withdrawal

Alternative care plan

- Have a care plan outside ICU if patient stabilizes

Gather supplies

- Scopolamine patch overnight or several hours before withdrawal may reduce secretions
- Open face mask with moist oxygen support
- Moist wash cloth for face after removal of tube
- Suction for secretions in oropharynx after tube removed

Protocol for Withdrawal

Procedural Preparations

- IV access with flowing IV
- Draw up morphine for IV infusion
- Draw up lorazepam for IV infusion
- Turn off tube feeding 4–6 hours in advance
- Elevate head of bed
- Remove nasogastric (NG) tube and restraints
- Remove telemetry or other devises if possible

Turn off all alarms and monitors

Protocol for Withdrawal

Procedure

- Premedicate patient with morphine 2–5mg IV for dyspnea and lorazepam 1–2mg for anxiety
- Deflate cuff completely
- Remove endotracheal tube
- Suction mouth and oropharynx
- Wipe and clean face and neck
- Place open face mask for humidity
- Monitor and titrate morphine and lorazepam for comfort

Post-Procedural Measures

Family

- Invite to stay with patient if not already present

Comfort

- Use physical signs to guide treatment

  e.g., respiratory rate (RR) as guide for medication such as RR>16–20 morphine 2–5mg IV q1hr

- Do not use ABG, oxygen saturation or other monitoring to guide treatment

Post-Procedural Measures

Turn monitors off if policy allows

- Family and staff have tendency to stare at monitors instead of interacting and attending to patient

Consider private room

- To provide more time and privacy for patient and family

Protocol for Withdrawal

Assess

- Assess patient frequently after extubation

Support

- Be a calm and supportive presence to family
- Garner support for the family from other sources: pastoral care, social work, nursing and community
- Meet with family after patient dies
- Refer for bereavement support as needed
- Offer to be in contact with family for questions

Mechanical Ventilation

Selected Readings

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