COVID-19 Compassionate Extubation Procedure

**Decision for compassionate extubation has been determined**

**Orders:**
- End of Life Order Set
- To prevent excessive respiratory secretions and discomfort
  - Artificial respiration
  - Sedation (RASS -5)
- Consider communication with pharmacy regarding symptom management; medication administration protocol

**Prior to extubation: Family support considerations**
- Offer information about the family's right to be present with patient, including virtual options
- If family is present during extubation procedure, they should provide appropriate emotional support
- Make sure that they are provided appropriate PPE
- Have family be at least 6 feet away from the head of the bed during the extubation to limit exposure to droplets
- Turn off alarms and monitors
- Remove restraints and unnecessary medical paraphernalia (e.g. SpO2 monitor, venous compression device, BP cuff, etc.)
- Position the patient as much as possible in a supine position (e.g., back bed, EOP bed)

**Prior to extubation:**
- If patient is on paralytic agents:
  - Discontinue and allow medication to wear off
  - Communicate with pharmacy if questions regarding paralytic clearance
- Use Train of Four (TOF) on ulnar or facial nerve

**Discontinue vasopressors prior to premedicating with opioids,**
- Pre-medicate with anticholinergic (e.g., glycopyrrolate), when possible

**Prepare for Extubation Procedure**
- Deep suction through endotracheal tube to assess level of sedation and control of symptoms with stimulation
- Discontinue the patient with a sitting or higher level of sedation, as indicated for anticipatory control of agitation, pain, anxiety, guided by End of Life Order Set

**Note:** Medication dosing should be initiated by the patient's previous medication regimen, supplemented by the End of Life Order Set. For those patients not on ventilator support, a sedation protocol (2-3mg sufentanil) is recommended. For those patients on ventilator support, consider deep sedation (IV push bolus of 1-2mg sufentanil) or a sedation level of -5 on the Richmond Agitation Sedation Scale (RASS) score.

**In patient already on sedation/analgesia: Infusion of opioid and/or benzodiazepine?**
- Yes: Increase infusion by 50-100%.
  - Pre-medicate with bolus dose for acute symptom control
    - Bolus dose will half to one hour dose
    - Observations after stimulation or anticipated level of being uncomfortable
  - Bolus dose titration of opioid and/or benzodiazepine:
    - Mild-moderate symptoms: Increase bolus dose by 25-50%,
    - Moderate-severe symptoms: Increase bolus dose by 50-100%

- No: Initiate bolus dose of opioid and benzodiazepine
  - Weight-continuous infusion of opioid - half of bolus dose/hour (Guided by End of Life Order Set)

**Bulb dose titration of opioid and/or benzodiazepine**
- With medium to severe symptoms, increase bulb dose by 25-50%
- With severe to moderate symptoms, increase bulb dose by 50-100%

**Deep sedation level for ventilator assisted**
- IV push bolus of 1mg fentanyl
- If family present
  - Remove ET tube and NG/OG tube under a towel so that the visualization of the tubes/secretions is minimized to the family
  - Use adhesive removal swabs

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