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Contributors

UCHealth COVID-19 Compassionate Extubation Procedure

Decision for compassionate extubation has been determined

Order:

- End of Life Order Set
- To prevent excessive respiratory secretions and discomfort discontinue:
 - Artificial nutrition, AND
 - Hydration AND/OR IV fluids
- Consider communication with pharmacy regarding symptom management medication availability

Prior to extubation: Family support considerations

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- Offer alternative ways for family to connect with patient, including virtual options (<u>Suggested Language</u>)
- IF family is present during extubation procedure, then:
 - Provide appropriate education on risks of exposure to aerosolized COVID-19 environment (<u>Suggested Language</u>), **AND**
 - Make sure that they are provided appropriate PPE, AND
 - Have them be at least 6 feet away from the head of bed during
 - the extubation to limit immediate exposure to droplets, **AND** Turn off alarms and monitors, **AND**
 - Remove restraints and unnecessary medical paraphernalia (e.g. SpO2 monitor, venous compression device, BP cuff), AND
 - Cover lines and tubes as much as feasible (e.g., foley, central line, ICP bolt).

Prior to extubation:

- IF patient is on paralytic agents:
- Discontinue and allow medication to wear off, AND
- Communicate with pharmacy if questions regarding paralytic clearance, AND
- Use Train of Four (TOF) on ulnar or facial nerve , AND
- Discontinue vasopressors prior to premedicating with opioids, AND
 Pre-medicate with anticholinergic (e.g., glycopyrrolate), when
- possible (<u>clinical note</u>)

Prepare for Extubation Procedure

- Deep suction through endotracheal tube (ET) tube to assess level of sedation and control of symptoms with stimulation.
- Pre-medicate the patient with bolus dosing of opioid and benzodiazepine as indicated for anticipatory control of dyspnea, pain, anxiety (guided by End of Life Order Set).

Note: Medication dosing is guided by the patient's recent medication dosing history and desired level of sedation. These patients are often sedated to a deep sedation (-4) or unarousable (-5) Richmond Agitation Sedation Scale (RASS) score.

Is patient already on continuous infusion(s) of opioid and/or benzodiazepine?

Increase infusion rate by 50-100%.

Pre-medicate with bolus dose(s) for acute symptom control:

 Bolus dose with half to twice the same dose as the hourly infusion dose, based on patient appearance of agitation after stimulation or anticipated level of being uncomfortable post-extubation (Guided by End of Life Order Set)

Initiate bolus dose of opioid and benzodiazepine based on prior usage

 Begin continuous infusion of opioid - at least half of bolus dose/hour (Guided by End of Life Order Set)

No

Respiratory Therapist (RT):

Yes

- Turn FIO2 to 21%, AND
- Turn PEEP to zero

Assess and Manage EOL Symptoms

 Rebolus opioid and/or benzodiazepine every 10 minutes (including deep suctioning) or as needed for control of symptoms.

Bolus dose titration of opioid and/or benzodiazepine:

- Mild-moderate symptoms: Increase bolus dose by 25-50%, **OR**Maderate symptoms: Increase bolus dose by 25-50%, **OR**
- Moderate-severe symptoms: Increase bolus dose by 50-100%

Once desired level of comforted achieved

- RT to extubate to room air, ANDIF 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,
- Remove remaining adhesive from patient's face with adhesive removal swabs.

RT:

 Remove ventilator from patient's room per infection control protocol.

Assess and Manage EOL Symptoms

 Rebolus opioid and/or benzodiazepine every 10 minutes per End of Life Order Set, or as needed for control of symptoms.