UCHealth Compassionate Extubation Resource

1. Patient receiving comfort-focused care approach and on End of Life Order Set; intent is to relieve suffering during the dying process.
2. Discontinue artificial nutrition/hydration and/or IV fluids toprevent excessive respiratory secretions and discomfort at end of life once decision for compassionate extubation has been determined.
3. Communicate with pharmacy regarding symptommanagement medication supplies.
4. If patient on paralytic agents, discontinue and allow medication to wear off prior to extubation; consult with thepharmacist regarding time for paralytics to wear off.

a. Use Train of Four (TOF) on ulnar or facial nerve as anobjective measure of neuromuscular blockade to determine when the paralytic has worn off; 3-4/4 indicating under-paralyzed or no paralysis.

5. Turn off vasopressors prior to premedicating with opioids.
6. Pre-medicate with anticholinergic (e.g., glycopyrrolate) prior to extubation when possible, for control of excessiverespiratory secretions associated with end of life ventilator withdrawal.
7. Make a plan around family visiting, either in-person or virtual.
8. If patient is on aerosol or droplet precautions and family is present during extubation procedure, then:
    a. Provide appropriate education on risks of exposure to aerosolized or droplet environment.
    b. Make sure they are provided appropriate PPE.
    c. Have them be at least 6 feet away from the head of bed during the extubation to limit immediate exposure.
9. Turn off alarms and monitors.
10. Remove restraints and unnecessary medical paraphernalia (e.g., SpO2 monitor, venous compression device, BP cuff).
11. Cover lines and tubes as much as feasible (e.g., foley,central line, ICP bolt).
12. Deep suction through endotracheal tube (ET) tube to assess level of sedation and control of symptoms with stimulation.

13. 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).
    a. 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.
14. If patient is already on continuous infusion(s) of opioid and/or benzodiazepine:
    a. Consider increasing infusion rate by 50-100%.
    b. Premedicate with bolus dose(s) for acute symptom control:
        i. 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.
15. If patient is not on continuous infusion(s) of opioid and/or benzodiazepine:
    a. Initiate bolus dose of opioid and benzodiazepine based on prior usage.
    b. Consider continuous infusion of opioid: at least half of bolus dose/hour.
16. Respiratory Therapist (RT) to turn FIO2 to 21% and PEEP to zero.
17. Rebolus opioid and/or benzodiazepine every 10 minutes as needed (including deep suctioning) until symptom control is achieved.
18. Dose titration of opioid and/or benzodiazepine:
    a. Increase dose by 25-50% for mild-moderate symptoms.
    b. Increase dose by 50-100% for moderate-severe symptoms.
19. Once desired level of comforted achieved, RT to extubate to room air.
    a. 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.
        i. Remove remaining adhesive from patient's face with adhesive removal swabs.
20. RT to remove ventilator from patient's room per infection control protocol.
21. Rebolus opioid and/or benzodiazepine every 10 minutes per End of Life Order Set as needed for control of symptoms.