

Table 24-5: Protocol for Ventilator Withdrawal at End of Life

Step	Specific Actions
Prepare the family and patient (if conscious)	Hear concerns, address fears, establish informed consent, explain procedure so they are prepared, give family a place at the patient's bedside if they wish.
Appropriate setting and monitoring	Provide privacy to the greatest degree possible in the ICU setting. Turn off all monitors. Remove tubes, drains, and associated machinery if possible without compromising comfort. Liberalize visitation as much as possible.
Ensure adequate sedation	Establish continuous infusions of analgesia and antianxiety medications; provide wide latitude in drug dosing to nurses who have experience in evaluating suffering in patients who cannot talk.
Reduce inspired oxygen to 21% (air)	This should be done in steps, with adequate time to ensure that any dyspnea or air hunger is controlled with the morphine infusion; if the infusion is increased, bolus doses should be given to rapidly establish the new steady state.
Remove positive end expiratory pressure (PEEP)	Air hunger must be relieved before proceeding with morphine.
Set ventilator to IMV or PS level to fully meet patient's ventilatory needs	This provides another period to establish patient comfort before proceeding.
Observe and modify sedatives while gradually reducing IMV rate or PS level to 5	This process may take 15 to 30 minutes. Family may wish to be present, but should be warned of the possibility of transient increases in agitation or respiratory rate as sedation is being titrated. Ventilator alarms must be disabled so they are not triggered by terminal hypoventilation.
Extubate or leave on humidified air by T-piece	Offer the family the possibility of private time with the patient if feasible, or support from any staff members they wish to have present. Rituals devised by the family or performed by clergy may have an important role.