GUIDELINE FOR MANAGEMENT OF THE ACTIVELY/IMMINENTLY DYING PATIENT IN THE ED:

Introduction: A patient may be considered "actively/imminently dying" within the hours and days preceding death during which time the patient's physiologic functions wane and the process is unlikely to be arrested by medical care. These patients and their families often require intensive nursing care and psychosocial and spiritual support at the end of their life.

Management of Symptoms: Symptoms commonly encountered at the end of life include:

- Pain
- Dyspnea/Respiratory distress
- Terminal secretions
- Altered mental status [terminal agitation or delirium]

Recognize that other clinical conditions, including intractable vomiting or care for advanced open or bleeding wounds, may also need to be addressed.

Disposition: While planning for disposition, initiate and continue care in the ED.

General considerations:

- If possible, ensure a private space, preferably a single room for the patient and family.
- Encourage family access to the bedside, providing chairs as available.
- Respect family/patient wishes, beliefs, and/or rituals at the end of life, as feasible.

Physicians:

- Communicate with family about the expected prognosis, timeline, and what to expect as part of the end-of-life or dying process.
- Consult palliative care team to assist in family and patient support.
- Contact social worker for hospice enrollment, if appropriate
- Contact family support/chaplain/bereavement counselor for family bereavement services
- Contact chaplain for spiritual support
- Provide adequate documentation for services:
    - Document clinical findings, discussion with families/surrogates, and goals of care.
    - Place order for DNR, if applicable.
- Effective communication with primary care providers and transitioning team.
- Medical Management:
    - Discontinue life-sustaining treatments or invasive non-essential tests such as (but not limited to):

        - Pressors
        - All blood draws
        - Artificial nutrition
        - Dialysis
        - All I&O and weights
        - Inactivate AICD if present
        - See ventilator withdrawal guidelines, if appropriate.
    - May complete medication administration however, is not recommended to restart:
        - IV Fluids
        - Antibiotics

Nursing:

- Maintain intravenous or subcutaneous access for administration of medications as needed. Remove all monitoring devices. Remove restraints if possible.
- For patient comfort, prioritize nasal cannula and medical management for dyspnea, if possible, over obstructive masks.
- Settings:
    - If a patient is intubated, ensure that respiratory therapy or nursing staff sets parameters to override alarms that cannot be turned off.
    - Turn off and remove all monitors and alarms from patient (pulse oximetry, blood pressure cuff or monitor leads)

Admitting:

- Request general medicine/surgery bed
- If no general medicine/surgery inpatient bed is immediate available, patient will be placed at the front of the holding cue for inpatient beds

Case manager:

- Inform bed management about patient
- If no general medicine/surgery inpatient bed is immediate available, patient will be placed at the front of the holding cue for inpatient beds
- Social worker should be contacted for hospice enrollment when appropriate

PALLIATIVE VENTILATOR WEANING PROTOCOL

Introduction: For a ventilator-dependent patient, discussing ventilator withdrawal is never easy for family members, providers, nurses, or other staff. Members of a patient's care team should be involved in the decision-making process and have the opportunity to discuss the plan of care. For ventilator withdrawal, clinician's and patient's comfort and the family's perceptions should influence the choice on how to proceed. Ideally, palliative extubation should not occur in the Emergency Department, and all attempts should be made for the patient to be moved to an inpatient bed prior to weaning.

Prior to extubation:

1. Documentation:
    a. Document clinical findings, discussion with families/surrogates, and goals of care.
    b. Document health care proxy/surrogate decision maker
    c. Place order for DNR

2. Consult:
    a. Palliative care service for supportive care
    b. Social worker for hospice enrollment or family bereavement services
    c. Respiratory therapy to assist in ventilator withdrawal
    d. Chaplain care as per family request [vs bereavement?]

3. Setting:
    a. Admit to floor for palliative extubation or move to private room within the ED
    b. Turn off and remove all monitors and alarms from patient (pulse oximetry, blood pressure cuff or monitor leads)
    c. Override alarms that cannot be turned off such as ventilator alarms
    d. Remove restraints if possible

4. Families:
    a. Counsel families on potential outcomes following withdrawal such as symptoms, possible time frames such as minutes to hours or hours to days for death to occur.
    b. Clear a space for family access to the bedside. Invite family into the room if they wish to be present. If the patient is an infant or child, offer to have the parent hold the child.
    c. Encourage family if desired to have music, rituals, or other support during and following extubation.
    d. Tell staff no visitation limits after extubation
5. Nursing:
    a. Maintain intravenous or subcutaneous access for administration of medications.
    b. Have towels and nasal cannula connected to humidified air or oxygen for after intubation

6. Medical Management: To maintain patient's comfort after extubation, have adequate symptom control instituted prior to weaning and extubation. The most useful intervention will be bolus doses of medications such as opioids and benzodiazepines, with subsequent adjustment of drips.
    a. Turn off blood pressure support and paralytic medications; discontinue other life-sustaining treatments or intrusive orders:
        i. Pressors
        ii. All labs and X-ray orders
        iii. Artificial nutrition
        iv. Dialysis
        v. All I&O and Weights
        vi. Inactivate AICD if present
    b. May complete medication administration however, is not recommended to restart:
        i. IV Fluids
        ii. Antibiotics

Medication Management

Medication Management	
Pain *when applicable, use single agent for overlapping indications and titrate as per symptoms *Note that pain may be demonstrated by verbalized complaints or non-verbal vocalizations (e.g., moaning, groaning, crying, or sighs), facial grimacing, or restlessness.*	**Scheduled** Convert home pain medication dose to morphine dose (see conversion table)
	● Morphine* (Roxanol) 15-30 mg ORAL every 4 hours ● Morphine* (Roxanol) 2-10 mg IV or SQ every 4 hours ** Hold and re-evaluate if morphine has been given for dyspnea management in the past 5 minutes.*
	AND/OR Ketamine 0.3 mg/kg in NS 100mL IVPB
	PRN Breakthrough
	● Morphine* (Roxanol) 15-30 mg ORAL every 30 mins PRN for breakthrough pain ● Morphine* (Roxanol) 2-10 mg IV or SQ every 30 mins PRN for breakthrough pain
Dyspnea	● Morphine* (Roxanol) 4 mg ORAL every 1-4 hours as needed for dyspnea ● Morphine* (Roxanol) 2 mg IV or SQ 1-4 hours as needed **Hold if morphine for dyspnea/pain has been administered within the past 5 mins*
	AND/OR Oxygen via Nasal Canula
Antipyretic	● Acetaminophen (Tylenol) tablet 650 mg oral, NGT or rectal every 4 hours as needed for temperature greater than 100.4F
Anxiety	● Lorazepam (Ativan) 2 mg ORAL every 4 hours as needed for anxiety

	• Lorazepam (Ativan) 2 mg SQ or IV every 4 hours as needed for anxiety
Nausea/Vomiting/Delirium	• Haloperidol (Haldol) 0.5 mg ORAL liquid every 30 mins as needed for delirium, nausea, or vomiting • Haloperidol (Haldol) 0.5 mg SQ or IV every 30 mins as needed for delirium, nausea, or vomiting
Secretions	• Atropine (Isopto Atropine) 1% eye drops, 2 drops SUBLINGUAL every 2 hours as needed • Glycopyrrolate (Robinul) 0.2 mg IV or SQ every 4 hours as needed
Oral Care	• Chlorhexidine (Peridex) 15 mL oral rinse every 12 hours

Opioid Conversion Table

Opioid Conversion Table			
Opioid	Home Dose	Morphine IR PO Dose	Morphine IV Dose
Oxycodone PO	5 mg	15 mg	4 mg
	10 mg	30 mg	8 mg
Hydromorphone PO	2 mg	15 mg	4 mg
	4 mg	30 mg	8 mg
Morphine PO	15 mg	15 mg	7 mg
Unknown home regimen	N/A	15 mg	0.2 mg/kg (max 16 mg)

7. Respiratory:
    a. During palliative extubation, people can be terminal weaned off the ventilator. In terminal weaning, the ventilator rate, positive end-expiratory pressure (PEEP), and oxygen levels are decreased while the endotracheal tube is left in place. Terminal weaning may be carried out over a period of as little as 30 to 60 minutes. Remember: Some patients might not survive the terminal weaning process.
    b. Begin terminal weaning while observing for signs of respiratory distress and adjusting medication as needed before further proceeding:
        i. *Mode*: If on more controlled modes such as Assist-Control (AC) or Pressure Regulated Volume Control (PRVC) while maintaining the same rate, change ventilator mode to support or combined mode to support patient breaths such as Synchronized Intermediate Mechanical Ventilation (SIMV) or Pressure Support (PS)
        ii. *Tidal Volume (TV):* same as previous setting
        iii. *Rate*: Decrease Intermittent Mandatory Ventilation (IMV) rate by 30-50% every 20-60 minutes until no mandatory breaths are delivered.
        iv. *Pressure Support*: If applicable, decrease PS by 5 cm H2O every 20- 60 minutes until PS equals 5 cm H2O. PS to achieve spontaneous TV approximately 67% of set TV.

v. *PEEP*: Decrease to 5 cm H2O
vi. *FiO2*: Decrease FiO2 every 10-20 minutes until 21%
vii. Attempt 1-5 minutes of "no assist" ventilation before the ET tube is removed to help gauge the degree of symptoms a patient might exhibit once extubated

At the time of extubation:

1. Staff:
    a. A nurse or respiratory therapist should be positioned at the head of the patient's bed, across from the patient's family member, with a washcloth and oral suction catheter

2. Medication:
    a. Have a syringe of an additional sedating medication at the bedside in case distressing tachypnea or other effects occur and give boluses as needed
    b. If patient on sedation drip, after extubation infusion rates can be increased to maintain relief, but changes might have a delayed effect and boluses are often needed:
        i. Morphine 2-10 mg IV q10min or Fentanyl IV 25-100 mcg q5min (Warning: Fentanyl is shorter acting and will need more frequent redosing)
        ii. Midazolam 2-5 mg or Lorazepam 1-2 mg q10min

3. Procedure:
    a. Suction both superficial and deep
    b. If the patient appears comfortable, deflate the ET tube cuff
    c. Once the cuff is deflated, remove the ET tube under a clean towel which collects most of the secretions and keep the ET tube covered with the towel

After extubation:

1. Documentation:
    a. Initiate palliative care order set in EPIC with goal of symptom relief over specific dosages

2. Medical management:
    a. Suction excessive oropharyngeal secretions immediately.
    b. Reassess patient q20 min for any perceived distress and administer comfort medications as needed
    c. Check respiratory rate and manual pulse with each patient reassessment
    d. Goal of respiratory rate < 30

e. Titrate medications to eliminate grimacing, agitation, and labored respirations with bolus doses of morphine or benzodiazepines as needed.

Remember
Orders such as “morphine drip 1-20 mg/hr, titrate as needed” are inappropriate as they will likely result in mismanagement the acute symptoms of distress and place undue burden on the bedside nurse to make clinical management decisions

3. Nursing:
   a. Give humidified air or oxygen via nasal cannula to prevent the airway from drying, avoid masks such as non-rebreather mask that limit interface between patient and family

4. Families:
   a. The family and the nurse should have tissues for extra secretions, and for any family or caregivers at bedside.
   b. The family should be encouraged to hold the patient’s hand and speak to their loved one if they believe the patient would desire it.
   c. After death occurs, encourage the family to spend as much time at the bedside as they require; provide acute grief support ,and follow-up bereavement support or chaplain
   d. Be prepared to spend additional time with the family discussing questions and concerns.

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