Withdrawal of Life Sustaining Therapies: End of Life Care in the Critical Care Setting

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Principle Statement:

- The withdrawal of life sustaining therapies is part of the transitioning process from a curative to palliative model of care.
- Palliative or comfort care places priority on patient and family education, support with compassionate, and meticulous attention to dignity and comfort above all else.
Why do we need a Policy for Withdrawal of Life Sustaining Therapies in Critical Care?

- The traditional goals of critical care have centered around curing and saving patients, and on preventing death.
- With advancements in technology and an aging population, people are living longer with more co-morbidities.
- As many as 20% of hospital deaths occur in ICU therefore critical care is an environment that both supports cure / life saving treatments, and also provides palliative / comfort care.
What is Palliative Care?

- It is the practice of preventing / relieving pain and suffering for those at the end of life.
- It focuses on providing quality of life to those patients that are facing life – threatening or life – limiting illnesses and injuries.
- Palliative care emphasizes the prevention and control of pain and other symptoms, while attending to the patient & family’s psychological, social, and spiritual needs.
Life Sustaining Therapies

- Are initiated and maintained when there is a likelihood of a patient benefit (e.g. recovery, cure, or preservation of quality of life)

- Life sustaining therapies include anything that prolongs life, including: mechanical ventilation, inotropic or vasoactive medications, dialysis, antibiotics, etc. . .
What is withdrawal of life sustaining therapy?

- It is the active removal (withdrawal) or the conscious decision not to implement (withhold) technology & medications that are artificially sustaining life once the decision has been made to transition a patient’s care from cure to comfort.

- When a patient’s prognosis changes & death is the expected outcome, life sustaining therapies are no longer indicated or justified as they pose no patient benefit and are likely to cause undo suffering and prolong a natural death.
Withdrawal of life sustaining therapy is NOT the withdrawal of care. It is a change in the type of care that is being provided.
End of Life Care

- Is the active and total care of patients’ whose disease process or illness is no longer responsive to curative treatment.
- It is based on the understanding that death is inevitable and a natural process of life.
- Good end of life care provides & maintains comfort and the quality of life to a person who is understood to be dying.
Withdrawal of Life Sustaining Therapies: How do we do it?

- In order to support our staff across all sites, a regional clinical practice guideline “Withdrawal of Life Sustaining Therapies and Establishment of Palliative / Comfort Care in Critical Care” was created (still in draft form), as well as an updated preprinted order set, and a bedside checklist.

- The following slides highlight the key points of the clinical practice guideline and provide some background rationale.
Withdrawal of Life Sustaining Therapies: How do we do it?

- The multidisciplinary team must first reach a consensus on changing the patient care goals from curative to comfort.
- A patient / family meeting must occur to reach a mutual consensus between staff and family that the goal of care is comfort.
Tips for Conducting Effective Family Conferences:

- Find a private location
- Ensure all necessary family members, patient (if able to participate), and any additional supports (social worker, spiritual support, translator, etc…) are present
- Ensure enough time available to listen to family
  - Use VALUE mnemonic
    - Value statements made by family members
    - Acknowledge emotions
    - Listen to family members
    - Understand who the patient is as a person
    - Elicit questions from family members
Tips for Conducting Effective Family Conferences:

- Assure family that the patient will not suffer
- Provide explicit support for the decisions made by the family
  - Provide family with time to make decisions
  - Do not rush or pressure family to make decisions
- During the family meeting:
  - Clarify patient / family understanding & concerns about diagnosis, prognosis, and possible outcomes
  - **Focus the family on what the PATIENT would want, not what they family wants**
  - Use language that is understandable and less likely to cause misinterpretations
  - Emphasize life sustaining therapies cannot reverse underlying disease process & withdrawal of these allows the natural course of death.
Withdrawing Life Sustaining therapies:

- Ensure updated Medical Orders for Scope of Treatment (MOST) form is on the patient’s chart
- Ensure doctor’s orders for withdrawal of life sustaining therapies signed (pre-printed order form available)
Preparing the Family

- Educate family about what will likely happen after life-sustaining therapies are withdrawn
- Allow family as much time as needed with the patient prior to withdrawing life-sustaining therapies
  - This includes anyone that the patient would like to see, including family, friends, colleagues, and pets
  - Ask family if there is anything special they want to bring for the patient (e.g. favorite blanket, music, etc...)
- Ask family if there are any special religious / cultural practices or other special requests to be followed prior to, during, or at the time of death.
In Preparation:

- Move patient to a private room if possible
- Ensure patient is clean and comfortable
  - Allow family to participate in care where appropriate
- Prepare the room:
  - Remove as much technology / equipment from room as possible
  - Ensure adequate number of chairs
  - Ensure tissues available for family members
  - Dim the lights
In Preparation:

- Discontinue bedside monitoring and alarms (e.g. ECG, O2 sat, blood pressure,)
  - If needed may monitor ECG from central station as appropriate
  - The presence of alarms can be stressful and distracting to both the patient & family. The goal of care at this point is strictly comfort and monitoring does not serve any comfort purpose and therefore should be stopped.
In Preparation:

- Discontinue all therapies (medication and other) not directly related to providing comfort to the patient, including:
  - Gastric or enteral feeding
  - Oral or gastric tubes, post-pyloric tubes
  - Arterial lines
  - Blood products
  - All blood work, x-rays, or other diagnostic testing
  - Intravenous fluids
  - All medications not directly related to comfort
    - Continue all analgesics, sedatives, anti anxiety medications
Maintain existing analgesics and sedatives, or if not previously receiving any, initiate infusions and boluses as ordered to meet comfort goals.

No patient should have to suffer pain or anxiety during the end of life process. Therefore withholding comforting drugs such as analgesia, sedation, or anti anxiety medications in fear of hastening death is neither in the patient’s best interest nor in best practice. Palliative care is about enabling patients to die peacefully with dignity.
Comfort

- Assess patient frequently and as needed for comfort and adjust medications as indicated:
  - Analgesic goal:
    - Verbal pain score as stated by patient or
    - Critical – care observation tool score 0 to 1
  - Sedative goal: RASS 0 to -2 or as ordered
Comfort

- If at anytime an increase in infusions is being considered due to re-emergence of signs & symptoms of suffering or discomfort, a bolus intravenous dose should be given concurrently to achieve a rapid return to comfort.

- As well as monitoring the patient for comfort, also assess family’s perception of patient’s level of comfort and treat as indicated.
Comfort

- Nurses / clinicians must clearly verbalize and document their intentions to relieve pain and suffering of the patient and the clinical signs and symptoms that justify the administration of additional medications.
Discontinuation of Mechanical Ventilation

- Once comfort has been achieved, discontinue mechanical ventilation as ordered, by:
  - Immediate extubation to room air
    - If the patient is on a noninvasive form of ventilatory support (e.g. bipap) removal of the mask to room air
  - Or continue to ventilate patient using the most comfortable mode of ventilation, and wean either the respiratory rate and / or PEEP slowly over 1 – 2 hours to induce hypercarbia, then extubate to room air
    - If patient has an endotracheal tube it will be removed, if the patient has a tracheostomy it will remain in situ and just disconnect the patient from the ventilator.
On Going Care:

- Once all life sustaining therapies have been removed provide the patient and family with privacy. Ensure the patient and family are aware that nurse will be checking frequently to ensure patient’s comfort (and will treat as needed), and is available for assistance at any time.
Additional Information:

- See the Clinical Practice Guidelines: Withdrawal of Life Sustaining Therapies and Establishment of Palliative / Comfort Care in Critical Care
- See the Critical Care Withdrawal of Life Sustaining Therapies Bedside Nursing Checklist
- [https://ccrs.vch.ca](https://ccrs.vch.ca) for palliative care courses offered through Fraser Heath
- [http://www.capc.org/ipal/](http://www.capc.org/ipal/) (improving palliative care in ICU project)
- [http://www.aacn.org/WD/ELEarning/content/palliative/palliative.pcms?menu=ELEarning&lastmenu=divHeader_Courses](http://www.aacn.org/WD/ELEarning/content/palliative/palliative.pcms?menu=ELEarning&lastmenu=divHeader_Courses) (American Association of Critical Care Nurses palliative e-learning site)
Questions / Comments?

- Please feel free to contact me directly at:

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