# WLSM policy

###### Withdrawal of life-sustaining measures (WLSM)

The inter-professional team’s primary responsibility is to ensure that decisions are being made in the best interests of the patient which should be guided by the following principles:

* to honor the patient’s wishes at end-of-life;
* to offer care that is collaborative with a shared-decision making model;
* to support family/substitute decision maker (SDM) during the difficult decision-making process;
* to align evidence-based interventions with the patient and family’s values, beliefs and goals;
* to alleviate suffering and prevent harm; and
* to communicate clearly and respectfully with the patient, family and inter-professional team.

Prior to WLSM, an inter-professional care plan should be created for each patient focusing on symptom management, order and pace of withdrawal, and family support. Referral to an organ and tissue donation program, if appropriate, should also be initiated.

WLSM should be carried out in accordance with the 2016 Canadian Critical Care Society’s Guidelines, and applied in accordance with the following principles, while respecting the needs and wishes of patients and their families.

The principles of expert inter-professional critical care must foster a seamless transition into end-of-life care. It is imperative that end-of-life care in the critically ill be of the highest quality, in all circumstances, including that of organ and tissue donation.

High quality end-of-life care:

* maintains dignity, respect and compassion;
* explores the wishes and voices of the patient and family/SDM;
* respects cultural, spiritual values and observances;
* continues to support and partner with patients, families/SDM and health care team members throughout the death experience;
* is consistent with guidelines for WLSM;
* focuses on alleviating pain, distress and providing comfort;
* adheres to the existing medicolegal framework that includes respect for the dead donor rule and precludes intentional hastening of death (notwithstanding medical assistance in dying legislation);
* avoids unnecessary prolongation of the dying process; and
* preserves the opportunity to donate organs and tissues.

These principles of person-centered care in the intensive care unit must be maintained throughout conversations, assessments, and procedures involved in organ and tissue donation. While it is acknowledged that individual WLSM plans may be subject to variability in response to patient/family/SDM priorities, these principles of high quality care must be maintained.

###### Symptom management

1. Objective signs of pain, shortness of breath, agitation, and delirium should be used to guide symptomatic treatment. Neuromuscular blocking agents should be discontinued before withdrawal of life support to aid in symptom assessment.
2. Medications should be used both to treat current symptoms and in anticipation of symptoms that are likely to arise. The rationale for giving any comfort medication should be documented.
3. A specific titration schedule for opioid and sedative medications should be utilized and medications should be titrated to symptoms with no dose limit.
4. Pain and dyspnea should be treated with opioids before employing the use of sedatives for anxiety or agitation.
5. Medications to alleviate other symptoms such as excessive secretions, post-extubation stridor, and nausea should also be included in the care plan.

###### Discontinuation of treatment

1. Liberalized family visiting should be offered and where possible, a space for the family to gather privately should be arranged. The approach to monitoring should be reviewed with the family/SDM and the healthcare team. An unobtrusive signal should be displayed outside to alert members of the health care team that WLSM is occurring.
2. The pace and order of withdrawal should be individualized to the needs of the patient. However, consideration should be given to withdrawing vasopressors and inotropes first, followed by mechanical ventilation and the artificial airway.
3. All non-comfort focused medications and interventions should be discontinued including dialysis, transfusions, parenteral feeding, enteral tube feeding, intravenous fluids, blood work, and imaging studies.
4. Providing that the patient is comfortable, mechanical ventilation should be withdrawn as quickly as possible. In the absence of contraindications, the patient should be extubated to room air and non-invasive ventilation or supplemental oxygen should not be provided except for comfort.
5. Implantable cardiac defibrillators should be deactivated prior to WLSM, and consideration should be given to discontinuing or disabling transvenous or permanent pacemakers.

**Family/substitute decision maker support**

1. Family/SDM should be involved in shared-decision making.
2. Family/SDM should be invited to be present at the time of withdrawal and assist in patient care. This can include helping to provide comfort to the patient and assisting in symptom assessments.
3. Family/SDM should be offered spiritual and bereavement supports and efforts should be made to accommodate any religious or cultural rituals, including involvement of their own religious leaders.
4. Following the death of their loved one, family members should receive information on community bereavement resources along with a letter of condolence.
5. To facilitate excellent bereavement support, inter-professional team members should receive education on the grieving process and how to provide acute support.
6. Physicians should be available as needed for family/SDM and staff once life support has been withdrawn to answer questions and offer additional support.

**Case audit and review**

1. Debriefing with the inter-professional team should be considered after each WLSM case.
2. Case audits should be performed after each case to ensure that protocols were followed and to identify opportunities for improvement.

**Donation after circulatory determination of death (cDCDD)**

1. Patients should be referred to the provincial organ and tissue donation agency when there is a plan in place to WLSM.
2. The decision to proceed with WLSM should not be influenced by any member of the organ or tissue donation team. The patient and/or family/SDM should not be approached to discuss donation until after the decision to WLSM has been made by the patient or SDM and the treating team.
3. The principles of care during WLSM should be the same regardless of whether or not the patient is a candidate for organ donation, although the treatment plan may differ slightly in terms of symptom management and comfort medications. The orders for WLSM should be written by a member of the ICU team without input from the organ donation team.
4. Explicit consent should be obtained for the administration of any medications that are being prescribed to optimize the chances of organ donation, but are not normally part of WLSM, such as unfractionated heparin.
5. If the dying process is prolonged and the patient is no longer a candidate for organ donation, symptomatic management and family/SDM support will proceed as per the protocol outlined above. Tissue donation may still be appropriate and feasible in these situations.

*For further details regarding organ and tissue donation after death by circulatory criteria, please consult your institutional organ and tissue donation policy.*