

Decision agreed & communicated with patient and/or family to withdraw HFNT

Non-pharmacological adjuncts before withdrawal

- Calm, reassuring environment
- Family presence if appropriate
- Fan directed at face
- Upright positioning

Highly dependent

Consider early CSCI*

20-30 mg morphine & 20-30 mg midazolam over 24 hours

OR

Give STAT doses†

IV: 5-10 mg morphine & 2.5-5 mg midazolam

SC: 10-15 mg morphine & 5-10 mg midazolam

Moderately dependent

Give STAT doses

IV: 2.5-5 mg morphine & 2.5-5 mg midazolam

SC: 5-10 mg morphine & 5-10 mg midazolam

Administer medication and reassess

Wait 20-30 minutes‡

Begin stepwise withdrawal

Reduce FiO₂ and/or flow rate by ~25-50%, or introduce a gradual leak at the interface

Keep HFNT interface on initially

Avoid repeated replacement of the interface

Distress at any stage

Return to previous tolerated settings

Give rescue medication

Consider escalating/initiating CSCI

Continue reduction if comfortable

Consider PRN doses every 10-15 min

Start/increase CSCI if repeated PRNs or prolonged withdrawal

Sustained post-withdrawal care

If patient continues to deteriorate

CSCI for symptom control if needed

PRN medication as required

Provide support to family and carers

If patient stabilises

Reassess care goals with MDT/family

Reassess appropriateness of further respiratory support

After death: consider bereavement support for family and carers and debrief for clinical teams

Optimise comfort

Assess dependency

Assess and withdraw

Manage ongoing care

*Continuous subcutaneous infusion; aim for comfort, with proportionate sedation to relieve distress

†Morphine is typically used unless contraindicated or on another opioid; doses may need adjustment in context of regular opioid/benzodiazepine use, frailty, and renal/liver dysfunction - seek specialist palliative care input if needed

‡Following CSCI initiation, allow 3-4 hours before attempts at withdrawal where possible