

Mom on a Ventilator: Pneumonia, Sepsis, Brain Trauma

Families' FAQ: "Will she recover, and what are our options?" | Quick tip for families in intensive care

A mother admitted with pneumonia has been ventilated since admission. Three days after sedation was stopped she hasn't woken up, her EEG shows signs of brain trauma, and the doctors are asking the family to decide about removing the ventilator. Here is what families in this situation need to know.

Q. What has happened to her body?

Pneumonia (a lung infection) progressed to **sepsis**, where the immune response goes into overdrive and starts damaging the body's own organs, in this case causing **acute kidney injury**. The ventilator is keeping her alive because her lungs couldn't sustain breathing alone while her body fights. This is not unusual with severe pneumonia and sepsis.

Q. Why hasn't she woken up after sedation was stopped?

Two explanations with very different implications. **1. Sedation hangover:** some sedatives, especially in elderly patients or those with kidney or liver impairment, take many days to clear. It looks like unconsciousness but is reversible. **2. Brain injury:** sepsis-associated encephalopathy or hypoxic-ischemic injury from low oxygen or low blood pressure. This is more serious and ranges from fully reversible to permanent. The EEG helps tell them apart.

Q. What does "signs of brain trauma" on an EEG actually mean?

It can mean very different things. **Diffuse slowing** (slower activity across the brain) can come from metabolic disturbance, medications or early injury, and can be reversible. **Burst suppression** (flat periods alternating with bursts) is more serious, suggesting significant injury or very deep sedation. An **isoelectric (flat) EEG** means no brain activity and is the most concerning. Ask for the **written EEG report** and for a neurologist to explain it in plain language.

Q. Will she recover?

Nobody can promise this without her full records. Key factors: the severity and cause of the infection and whether it is resolving; how long her blood pressure was dangerously low before the ICU; the exact EEG and brain imaging findings; whether kidney function is improving; how long since sedation stopped (three days is concerning, but in sepsis-associated encephalopathy some patients have woken after 10 to 14 days); and her health and cognitive baseline before admission. Prognosis is a conversation that needs full information and a neurologist at the table.

Q. Is it really just "continue or withdraw"? What are our options?

There is more nuance. **1. Time-limited trial:** continue for a defined period (e.g. 7 to 14 days), then reassess with a formal neurological review. **2. Full investigations first:** a brain **MRI** (not just CT), formal neurologist review of the EEG, and confirmation that sedatives have fully cleared. **3. Tracheostomy** if she improves neurologically but can't be weaned, opening the door to rehabilitation and possibly home. **4. Palliative care** if investigations confirm no realistic prospect of meaningful recovery: a humane, dignified option, but a decision for the family, with full information, not under pressure.

Q. Should we make a decision now?

Ask: "Where is the urgency?" Withdrawal being raised after only a few days in ICU deserves questioning, and you should ask why all resources aren't being used first. Families often tell us they gave in early and now have second thoughts. **Never make a decision today you could regret in 12 or 24 months.** Slow, informed decisions also give her time to recover. Advocacy can help you buy that time.

Q. Which records should we get?

Everything, not just what the team chooses to show: every nursing note, blood result, the full EEG report, CT and MRI reports, the medication chart and ventilator parameters. You are entitled to them (US, Canada, Australia, UK, Ireland, India and more), and a second opinion is reasonable before any life-or-death decision.

Q. What if she improves but stays ventilator-dependent?

She doesn't have to stay in ICU. **Intensive Care at Home**, the only third-party accredited intensive care at home nursing service, provides 24/7 critical care nursing at home across Australia (all states, territories and remote areas): tracheostomy ventilation, BiPAP/CPAP, tracheostomy without ventilation, home TPN, PEG and nasogastric tubes. Families in the US, UK and Canada are welcome to reach out too.

Q. What can we do at the bedside?

Keep holding her hand and talking to her. There is evidence that familiar voices and human touch can matter for patients with altered consciousness. Alongside love, you also need information and advocacy.

Need independent expert advocacy? Intensive Care Hotline can help.

Patrik Hutzl brings 25 years of critical care nursing experience. We review records, explain them in plain language, speak directly with the ICU team and represent you in family meetings. Book a **free 15-minute consulting call**. intensivecarehotline.com | support@intensivecarehotline.com | intensivecareathome.com

General information for families, not a substitute for advice from your loved one's treating medical team.