P06: Palliative Care - Secretions

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Introduction

Secretions and respiratory congestion produce noisy breathing as the movement of mucus and phlegm disrupts the flow of air in the upper airway. Patients who are dying, or who have reduced levels of consciousness or profound weakness, often suffer from excessive oral secretions from the salivary glands. These secretions predict death for up to 75% of patients, often within 48 hours of onset. Bronchial secretions can be caused by respiratory pathologies such as lung infections, aspiration, or pulmonary edema.

Secretions are a common, and expected, symptom in the dying patient. Although the sound can be distressing to family and practitioners, there is no evidence that the sound alone is associated with respiratory distress.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team.
- Although the sound of respiratory congestion can be disturbing to hear, determine if the patient is distressed by observing other indications, such as wincing, and provide reassurance to the family.
- If the patient seems distressed from their secretions, start medication early for best effect.
- Positioning is the most effective non-pharmacological intervention. Reposition the patient in a side-lying position with the head of the bed elevated.
- Deep suctioning may not relieve congestion. However, in the event of copious secretions in the oropharynx, gentle anterior suction may be helpful.

Additional Treatment Information

- Oxygen has no known patient benefit for respiratory congestion.
- Anticholinergics may be more effective when started early, as these drugs do not dry up secretions that are already present.

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Care Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway. EMRs are required to contact CliniCall for consultation to proceed with the ASTaR clinical pathway.

Interventions

First Responder

- Provide reassurance
- Positioning (side-lying with the head of the bed elevated) is the most effective non-pharmacological intervention

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team; inform families that noisy breathing may occur as a normal part of the dying process

Primary Care Paramedic – All FR and EMR interventions, plus:

- Assist family with the administration of any medications that are recommended as part of an established care plan

- Paramedics can only administer the patient's own medications where the symptom management plan is clear, they are trained and experienced in the technique of administration, and are operating within BCEHS scope
- CliniCall consultation required prior to initiating treatment.

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- Consider atropine IM
- Consider glycopyrrolate IM
- ACPs may administer a patient's own prescribed medication only if the ACP has completed the appropriate Schedule 2 (4(b)) license endorsement;
- CliniCall consultation required prior to the administration of any out-of-scope medications.

Evidence Based Practice

Secretions

Supportive

Neutral

Against

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]
2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]

Practice Updates

- 2022-01-06: EMRs now authorized to access ASTaR clinical pathway.