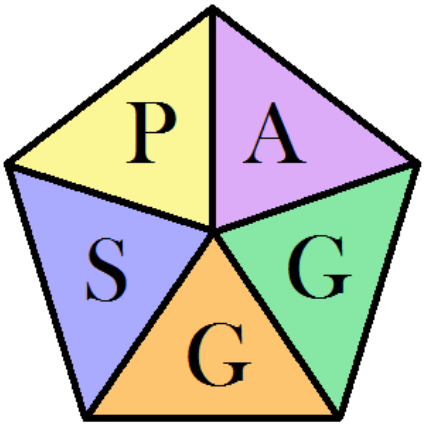

Specialist Palliative Care
Audit and Guidelines Group

Specialist Palliative Care Audit and Guidelines Group (SPAGG)

Clinical Guideline and Community Care plan for the Management of a Major Catastrophic Bleed

Version 2.0

Document Title	Clinical Guideline and Community Care plan for the Management of a Major Catastrophic Bleed
Document Date	September 2018
Document Purpose and Intended Audience	This guideline has been produced to provide a clear framework to ensure the safe and effective care of a patient who suffers a catastrophic bleed in both an inpatient and community setting. It includes the inpatient guidance complied by St Giles Hospice, and the existing SPAGG community care plan. For use by palliative medicine specialists and community teams
Authors	St Giles Hospice (Dr Nial McCarron, Katie Taroni, Toni Flanafan, Jane Mogford) Dr Brenda Ward
References	See St Giles Document reference section
Consultation Process	Endorsed and approved by SPAGG
Review Date (must be within three years)	September 2021
Approval Signatures: SPAGG chair SPAGG deputy chair SPAGG secretary	 L. Seager C. Radcliffe M. Turley and S. Rayner

Date Approved by SPAGG: September 2018

Date submitted to Area Prescribing Committee:

Version	Date	Summary of change/ process
1	September 2015	Endorsed and approved by SPAGG
2	September 2018	Fuller inpatient guidance added to existing community care plan, creating a care booklet
3		

S052

Management of a major catastrophic bleed in advanced cancer patients

Objective

To provide a clear framework to ensure the safe and effective care of a patient who suffers a catastrophic bleed due to advanced cancer in an inpatient setting.

Scope

1. Introduction
2. Risk assessment
3. Advance care plan
4. Action in event of acute bleed
5. Crisis medication
6. Crisis pack
7. Management of bleeding wounds

Overall Responsibility

All registered nursing and medical staff are responsible for ensuring this SOP is adhered to, handing over any concerns to the senior nursing team.

Process stages

1. **Introduction**

   The following clinical guidelines are written for the situation when a major bleed may be expected due to identified risk factors, signs and symptoms. These guidelines are to be used only when it is clear that the patient is not to be resuscitated due to advanced, untreatable, malignancy.

   The goal of management of the event must be to minimise anxiety, ease suffering and ensure death with dignity providing a calm, reassuring and caring atmosphere.

   Midazolam is a benzodiazepine which is an appropriate drug to use in providing sedation and thus ease of anxiety and suffering. It has a rapid onset, a short duration of action and produces amnesia. It is important that there is immediate access to Midazolam. For information on the use of emergency drug boxes please see P064 Safe Management and Administration of Medicines Policy and Standard Operating Procedures.

   Please see appendix 1 for management of a major catastrophic bleed in advanced cancer patients

2. **Risk Assessment**
   - Site of cancer with fungating/malignant ulceration e.g. head and neck, haematological, breast, penile cancer.

- Presentation with bleeding e.g. haemoptysis in lung cancer, melaena
- Co-existing disease e.g. gastrointestinal bleeding, oesophageal varices
- Smaller warning (Herald) bleeds
- Local infection at the tumour site
- Clotting abnormalities (including Liver failure)
- Drugs that inhibit coagulation

3. **Advanced Care Plan**
   - Medical review and stop anticoagulants and antiplatelet drugs where possible

   Consider:
   - Preferred care setting – available level of care
   - Prepare equipment: dark towels, face shields (where available), gloves, aprons, plastic sheet or pads, clinical waste bags
   - Prescription and preparation of crisis medication
   - Use of an emergency drug box within room

   The medic accompanied by a Ward Nurse will discuss the likely occurrence of a catastrophic bleed and its implications to the patient and if the patient consents their family and or carers. The information should ensure that patients/relatives have a clear plan of care and are aware that **NO** resuscitation will take place; this must then be documented as per DNACPR guidelines. Patients and their relatives may require further opportunities to discuss what was said at the initial meeting as they may not have taken in all that was said or may have further questions.

   If the patient is at risk of catastrophic bleed this must be communicated at each nursing handover. If a bleed occurs it is important that staff debrief after the event. An opportunity to have a reflective meeting can also be arranged.

4. **Action in event of catastrophic bleed**
   - Stay calm and if possible summon assistance
   - Ensure that someone is with the patient **at all times**
   - If possible nurse in recovery position to keep airway clear
   - Stem / disguise bleeding with dark towels
   - Apply pressure to the area if bleeding from external wound with haemostatic dressings/gauze or adrenaline soaks if available
   - Administer crisis medication if prescribed which can be repeated after 10 minutes if needed

   It is important to remember, however, that in the event of a massive, terminal bleed the patient may be unconscious within minutes and may die very quickly, even before the sedation has had a chance to work. Thus it is important to remember that whilst sedation is important, **never leave the patient alone**, and stay with them at all times.

5. **Crisis Medication**

   If nursing staff are available quickly (within minutes) 24 h/day:

Drug	Route & Onset of effect	Dose *	Frequency
MIDAZOLAM	IV 2-3 minutes IM 5 – 15 minutes (preferably deltoid)	10 mg 10 mg	Repeat after 10 minutes if needed Repeat after 10 minutes if needed

The subcutaneous route is inappropriate due to peripheral shut down and unpredictable absorption.
* If the patient is already on large background doses of midazolam or other benzodiazepines, but still not adequately sedated during catastrophic bleeding they may need larger doses of midazolam in proportion with the background dose.

6. **Emergency Drug Box**
   - 1 amp midazolam
   - 3 syringes
   - 3 needles green
   - 3 needles blue
   - 10mL Tranexamic acid injection (500mg/5mL)
   - 10mL Adrenaline 1:1000 (1mg/mL) injection
   - 5 x gauze swabs (10x10cm)
   - 1 x Haemostatic dressing
   - 1 x Haemostatic Granules

   Once required, Midazolam is to be checked out of CD cupboard for a specific patient as per policy.

   The Midazolam is checked into patient specific POD register in designated emergency drug box. This is to be kept in the patient's room; all trained staff will be issued with the emergency drug box specific key on each shift to ensure no delay in the administration of Midazolam.

7. **Management of Bleeding Wounds**
   Consider antibiotics if signs or symptoms of infection as infected wounds are more likely to bleed. Also if there is increase in pain, odour and exudate from the wound, consider infection.

   For all patients consider the appropriateness of radiotherapy, chemotherapy, cauterisation or embolization.

   1. Minimise trauma during dressing changes by cleaning gently with irrigation and using non-adherent dressings

   2. Some brands of alginate (kaltostat, sorbsan) claim to have haemostatic properties that can be used to control minor bleeding. Alginate dressings are manufactured from the calcium salt of an alginic acid polymer derived from brown seaweed. It is claimed that calcium ions that are released into the wound from the dressing activate platelets, which results in haemostasis. However, these dressings are not licensed as haemostatic dressings.

   3. To control profuse bleeding, where available apply Haemostatic Gauze (such as Celox™ or Haemostatic granules (Such as CELOX™ granules). (See Appendix 2)

   4. If Haemostatic gauze/granules are unavailable, soak 5-10mL of Adrenaline soaked 1 in 1000 (1mg in 1ml) on to gauze and apply with pressure for 10-20 minutes. This causes local vasoconstriction, but may also cause 'rebound' bleeding once these effects wear off. Care should be taken to avoid ischaemic necrosis.

      An alternative is Tranexamic acid Injection 500mg in 5 ml, apply 5-10mL (500-1000mg)

soaked into gauze and applied with pressure for 10-20 minutes – (if patient already on Tranexamic acid – use Celox or adrenaline soaks).

5. Consider oral Tranexamic acid 1.5g stat (and then 1g QDS - or as per PCF guidance – see contra-indications and warnings.) This can be reduced to 500mg TDS (likely to be required indefinitely) or discontinued 1 week to 10 days after bleeding stops or. Restart if bleeding recurs.

Validation date	Review date	Authors
18th September 2012 Reviewed May 2015 Reviewed December 2017	December 2020	Dr Nial McCarron, Consultant Palliative Medicine Katie Taroni, Nursing Director Toni Flanagan, Clinical Educator Jane Mogford, Ward Manager

Management of a major catastrophic bleed in advanced cancer patients

Appendix 1

Risk Assessment

Patients potentially as risk include:

- Site of cancer with fungating/malignant ulceration e.g. head and neck, haematological, breast, penile cancer.
- Presentation with bleeding e.g. haemoptysis in lung cancer, melaena
- Co-existing disease e.g. gastrointestinal bleeding, oesophageal varices
- Smaller warning (Herald) bleeds
- Local infection at the tumour site
- Clotting abnormalities (including Liver failure)
- Drugs that inhibit coagulation

Is the patient at risk of a major life-threatening bleed?

Yes ↓

No ↓

Reassess as appropriate

Advance Care Plan

- Medical review and consider stopping anticoagulants and antiplatelet drugs, including SSRIs where possible
- Review all medications that may increase risk of bleeding
- Consider Stopping anti-hypertensives and consider stopping diuretics

Consider:

- Who needs to be aware of risk? – Patient, family, carers, other healthcare professionals?
- Preferred care setting – available level of care
- Prepare equipment: Haemostatic Gauze/ Granules for bleeding wounds
- Dark towels, surgical face shields (where available), gloves, aprons, plastic sheet or pads, clinical waste bags
- Prescription and preparation of crisis medication and emergency drug box

IN THE EVENT OF AN ACUTE BLEED:

- Stay calm and if possible summon assistance
- Use personal protective equipment, face shields where available
- Ensure that someone is with the patient at all times
- If possible nurse in recovery position to keep airway clear
- Stem / disguise bleeding with dark towels
- Apply pressure to the area if bleeding from external wound with Haemostatic Gauze or granules, or with adrenaline soaks/Tranexamic acid soaks if available
- Administer crisis medication MIDAZOLAM if available which can be repeated after 10 minutes if needed

REMEMBER – patient support and non-drug interventions may be more important than crisis medication

After the event

- Offer de-briefing to the whole team
- Ongoing support as necessary for relatives / staff members
- Disposal of clinical waste appropriately
- Inform ward manager if need to re-order any haemostatic dressings/gauze

Appendix 2

Haemostatic Gauze can be used on any open wound when haemorrhage cannot be controlled by application of direct pressure alone, or wounds with soft tissue loss. It is of particular value in controlling haemorrhage at junctional areas where a tourniquet cannot be applied such as the groin, axilla and neck.

It is suitable for arterial and venous bleeding. It is effective at clotting blood containing anti-coagulants.

There are no special storage instructions.

Celox™ gauze does not require cutting, it can easily be torn to the required size

When used on facial wounds, care must be taken to avoid contact with eyes.

Haemostatic gauze dressings or Haemostatic granules should be used to pack the wound at the point of haemorrhaging. Cavities should be packed with gauze down to the wound bed. It should not be blindly inserted into thorax or abdomen if the terminal point of bleeding cannot be visualised.

Once in place, compression should be maintained, if possible with a pressure dressing, which should be applied circumferentially to the outer part of the gauze to assist in the application of pressure to hold the gauze in situ.

Direct pressure should be applied for at least 3 minutes to allow a stable clot to form. Continued direct significant pressure may be required to control bleeding after application of haemostatic gauze dressings.

The dressing should be re-checked after moving the patient.

References: accessed 10/10/2017

- Introducing Palliative care 5th Edition
- Drugs In Palliative Care 3rd Edition
- Palliative Care Formulary 5th Edition (PDF Version)
- South Western ambulance service NHS Foundation Trust: Clinical Guideline – CG!$ Major Haemorrhage - http://www.swast.nhs.uk/Downloads/Clinical%20Guidelines%20SWASFT%20staff/CG14_Major_Haemorrhage.pdf
- http://www.celoxmedical.com/wp-content/uploads/Celox-Granular.pdf
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- https://docs.wixstatic.com/ugd/511737_9f711ff8d3b2400387d7b25e69144de8.pdf
- https://www.traumasurvivalkits.com/haemostatic-gauze - provides video links on how to use.
- https://www.spservices.co.uk/item/CELOX_CeloxHaemostaticAgent-35gSachet-Single_0_70_3498_1.html
- http://www.library.wmuh.nhs.uk/wp/library/wp-content/uploads/sites/2/2017/01/Results-2.pdf

PLAN FOR HEALTH CARE PROFESSIONALS IN THE EVENT OF MAJOR BLEEDING IN A PALLIATIVE CARE PATIENT IN THE COMMUNITY

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PATIENT NAME:
ADDRESS:
DOB:
NHS NUMBER:

This person is at risk of bleeding from.....

No further medical intervention is possible to stop the bleeding.

The aim of treatment in the event of a bleed is to keep the patient calm and comfortable.

The following plan describes the actions to take if the person experiences a major (very heavy) bleed. The goal of this plan is to ensure the person is comfortable and their carer well supported.

Experiencing a sudden large bleed may be frightening for the person and their family. It may also be distressing for professionals involved.

Priority: Ensure someone remains with the patient to provide reassurance

Actions

- Call for help. Support from the paramedic service may be very helpful. *Calling for ambulance assistance does not mean the person has to be taken to hospital*
- DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION
- Ensure 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form is located in the house)
- Keep calm, reassure the patient
- Use dark towels and sheets to help absorb the blood

- Have gloves, aprons and clinical waste bags at hand
- Support family who may also be distressed

Medications (see prescription chart for doses)

Symptoms of:

- Anxiety/distress/ breathlessness: Give Midazolam intra-muscular/buccal/subcutaneously
- Pain/ breathlessness: Give strong opioid subcutaneously

Other symptoms may sometimes occur such as:

- Troublesome oral/lung secretions: Give Hyoscine Butylbromide subcutaneously
- Nausea/vomiting: Give antiemetic subcutaneously

Actions after the bleed

- If the patient survives the bleed, aim to relieve any symptoms. Medical input and the need for medication via a subcutaneous syringe driver should be considered
- A hospice admission may be appropriate if person/carer is in agreement and a bed available
- Should the person be transported to the Emergency Department, staff there may contact the hospice
- Continue to offer reassurance to the patient if conscious
- Support family who are likely to be distressed
- Staff present should consider a debrief session after the event

Plan Written by:

Professional ……..…….
Signature…….
Title……..…. Date…….

For plan review: Yes / No

Date for review if applicable …….

Telephone for further advice if needed
Hospice ……
Telephone Number ……