Management of Terminal Haemorrhage in Advanced Malignancy including Carotid Artery Rupture (Adult)

Guidance

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Applies to	All patients suffering terminal haemorrhage in advanced malignancy within Somerset.		**Exclusions**	Paediatric Patients

CONTENTS

1.0 INTRODUCTION

1.1 Background:

Cancer is an infiltrative process which can damage vessel structure. Cancer sites such as the head and neck may be near large and high-pressure vessels. It is possible, rarely, to have damage to the vessel wall and have a sudden and life-threatening bleed.

Persistent bleeding may lead to the death of the patient within minutes of onset. It may include massive haemorrhage or complete airway obstruction. Patients experiencing terminal events will need rapid effective management to minimise the distress of their imminent death.
Terminal bleeding is a rare event in palliative medicine and current statistics suggest that this may happen in 3-12% of patients with an advanced cancer (Ubogagu, E and Harris, D. 2012)
Staff must be supported to assist with the management of uncontrollable bleeding and provided with appropriate support from senior colleagues afterwards.

High risk factors include:

- Cancer patients with tumours close to major arteries or airways
- Haematology Patients
- Upper GI bleeds
- Recent radiotherapy to tumour sites which are close to major arteries.

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

1.2 Scope

All staff involved in caring for patients at risk of a terminal haemorrhage. This includes staff in primary and secondary care, Hospice care and Community Care.

2.0 DEFINITIONS

2.1 PPE – Personal protective equipment. Aprons, Gloves, Masks, Visors or Goggles

CNS – Clinical Nurse Specialist.

CPCNS – Community Palliative Care Nurse Specialist

DNs- District Nurses

3.0 PREPARATION

When planning for a terminal haemorrhage event, the healthcare team should use their professional judgment regarding the level of discussion that should be had with a patient and/or family based on:

- The likelihood that a terminal haemorrhage will occur
- The patient/family's understanding and acceptance of the diagnosis and prognosis
- The information needs of the patient and family
- The patient/family's desired level of participation in decisions about their care
- The patient/ family's coping strategies
- Where the patient is being cared for (e.g. acute hospital setting or community setting)

3.1 All patients 'at risk' of terminal haemorrhage, to be identified. This must be in conjunction with review of scans to ensure correct identification of risk and establish a clear clinical indication.

3.2 Open and honest conversation with the identified patient and those important to the patient/involved in their care. A clear plan of care to be discussed and it must be clear that NO resuscitation will take place in the event of uncontrolled bleeding. These discussions must be recorded in the patients notes as per Somerset Treatment Escalation Plan (STEP) guidance.

3.3 STEP form to be completed at this point. It must be updated on admission to hospital and 'Just in Case' medication to be prescribed (Midazolam 10mg). Original STEP form to be sent with patient to community setting (Hospice, Community Hospital, Home). If STEP form completed by community teams or GP – Acute teams to be made aware and hospital systems to be updated.

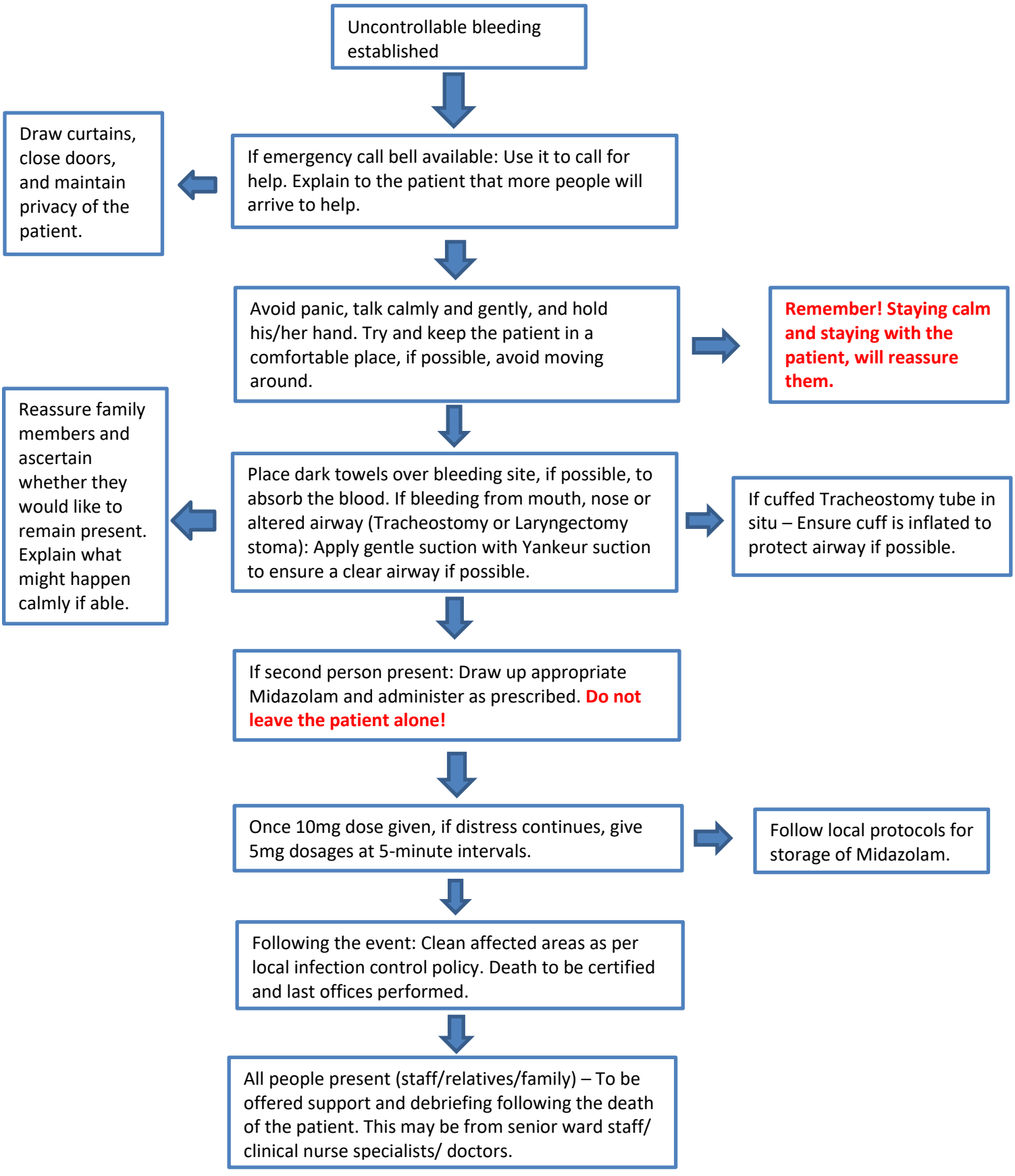
3.4

	Acute Hospital Environment (MPH/YDH)	**Community Hospital**	**Hospice Inpatient Unit**	**Nursing Home**	**Home Environment**
Midazolam 10mg	IM	IM/BUCCAL	IM/BUCCAL	IM/BUCCAL	BUCCAL (Ideally Pre-Loaded Syringes) – Just in Case Box
Dark Towels	At bedside or close by.	At bedside or close by.	Within bedspace or room.	Within resident's room environment.	Within the home – Easily accessible and

	Some areas will have the 'Red Bag'.				known to carers/family.
Alert	Handover, Patient notes on electronic system and Paper notes	At handovers and documented in the notes.	At handovers and within patient notes Cross care digital system updated	Within residents notes and at handovers.	GP, DNs, CPCNS, Family members and household members. In event of bleeding – To contact District nurse or hospice team for support. See template for 999 support.
Suction	Walled with Yankeur at bedside	Walled or Portable near by	Walled or Portable suction near by	Portable suction if available	If available: Within easy reach

4.0 PROCESS AND FLOW CHART

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



Home Environment – Guidance for family in the event of uncontrollable bleeding:

1. Give 10mg of Buccal Midazolam (1 dose). Place between the gums and cheek.
2. Call for help – Call District Nurse team or Hospice Team to attend as soon as possible.
3. You can call 999 for support also but please state as below to the call handler to ensure the situation is managed appropriately:

"This is anticipated bleeding and (Name) is not for resuscitation. I have given 10mg of Midazolam as per the management plan, but I would like some support from a paramedic please. The district nurses/ hospice team have been informed".

5.0 ROLES and RESPONSIBILITIES

5.1 Service Managers - To ensure staff awareness.

5.2 Specialist Nurse Teams – To ensure staff feel competent in managing this event and provide debrief if required.

5.3 Ward managers/ Senior nursing staff – To ensure staff awareness. Liaise with Palliative Care.

5.4 Team Leaders - To ensure emergency protocol is followed.

5.5 All staff involved in caring for 'At risk' patients should familiarise themselves with this guideline and be familiar with departmental/local area guidance on where to store/obtain equipment.

5.6 The decision regarding resuscitation should be clearly documented on the Somerset Treatment Escalation Plan (STEP) form and may include contingencies for resuscitation to occur for events other than a terminal haemorrhage, dependant on relevant patient and tumour factors at the time of that decision.

5.7 Clinical / Medical Oncologists/ GP/ Consultant to pre-prescribe Midazolam (10mg), as a "just in case" medication. Buccal Midazolam to be considered for community settings.

5.8 Nursing team to administer drugs in the event if there is time and staff available.

6.0 PROCESS DESCRIPTION

6.1 **Equipment and Documentation**:
It is important that the following equipment is available in the event of a bleeding, (in close proximity to the patient where possible).

Outpatients/ community patients: 'Just in Case' medications box stored in an accessible place.

Inpatients: If 'Red Bag' available (some inpatient departments), this should be accessible.

- Suction access (If possible)
- Bowls
- Gloves, Plastic apron, eye protector/face shield (PPE)
- Dark coloured towels / blankets
- Most important for a member of staff to remain with the patient. If a second person is available, then Midazolam prescription can be obtained, and dosage administered appropriately.
- Midazolam stored according to Trust policy for both community and inpatient.

6.2 **Process within Home Environment**:

- Ensure all members of household aware of where 'Just In Case' medications are stored and to highlight this to any care staff/ district nurse teams/ GPs/ Hospice teams etc.
- Ensure carers/family are aware how to administer Buccal Midazolam in the event it is required. Ensure the carer understands indication for Midazolam to be administered.
- Provide patient/carers/family with an emergency contact for support in the event of bleeding. Reassure family/carers that the most important action they can take is to stay with the patient and do not leave their side. If second person available- to administer the medication.

7.0 TRAINING/COMPETENCE REQUIREMENTS

All relevant staff will be made aware of this work instruction. Senior staff who are competent in to ensure relevant staff are updated and familiar with the process as per this guidance. This is to include Oncologists, Consultants, CNS, Ward Sisters, District Nurse Lead, GPs.

8.0 MONITORING

Element of Policy for Monitoring	Section	Monitoring Method – Information source (e.g. audit/measure/performance standard	Item Lead	Monitoring Frequency/ reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
Drug Storage	4.0	Audit against trust policy	Authors for each clinical area	Annually	Liaise with Pharmacy
Review of an events within the trust setting	5.0	Case review of any terminal haemorrhage events that occur within the Trust	Jo Greedy	After first 3 events and then review process for effectiveness	Refer to authors and ratification process team for review of policy
Training/ competence	7.0	Audit of staff in relevant working areas for knowledge and understanding of policy	Authors for each clinical area	Annually	Highlight training needs to senior staff for action.

9.0 REFERENCES

9.1 The management of carotid artery rupture related to the terminal care of the head and neck cancer patient – Potter, E. 2005 (2nd ed).

Policy, procedure & guidelines for the management of carotid artery rupture related to the terminal care of the head & neck cancer patient – MacKay, F and Cook, C. (Royal United Hospital, Bath). 2011

9.2 Other Documentation:

Trust policy for infection control – Taunton and Somerset NHS FT/ Somerset Partnership/ St Margaret's Hospice

Standard precautions policy – Taunton and Somerset NHS FT/ Somerset Partnership/ St Margaret's Hospice

Body fluid spillage procedure – Available on Q Pulse, RT08