Management of catastrophic haemorrhage in palliative care

This guideline is intended to assist healthcare professionals involved in the care of patients who are at risk of and/or suffer from a major haemorrhage. These are to be used only when it is clear that the patient is not to receive cardiopulmonary resuscitation (CPR) due to advanced, untreatable diagnosis, and the goal of management of the event must be to minimize anxiety, ease suffering and ensure death with dignity providing a calm, reassuring and caring atmosphere.

When it occurs, catastrophic haemorrhage results in the patient's rapid deterioration and death usually occurs within minutes. It is a feared complication, but is actually rare.

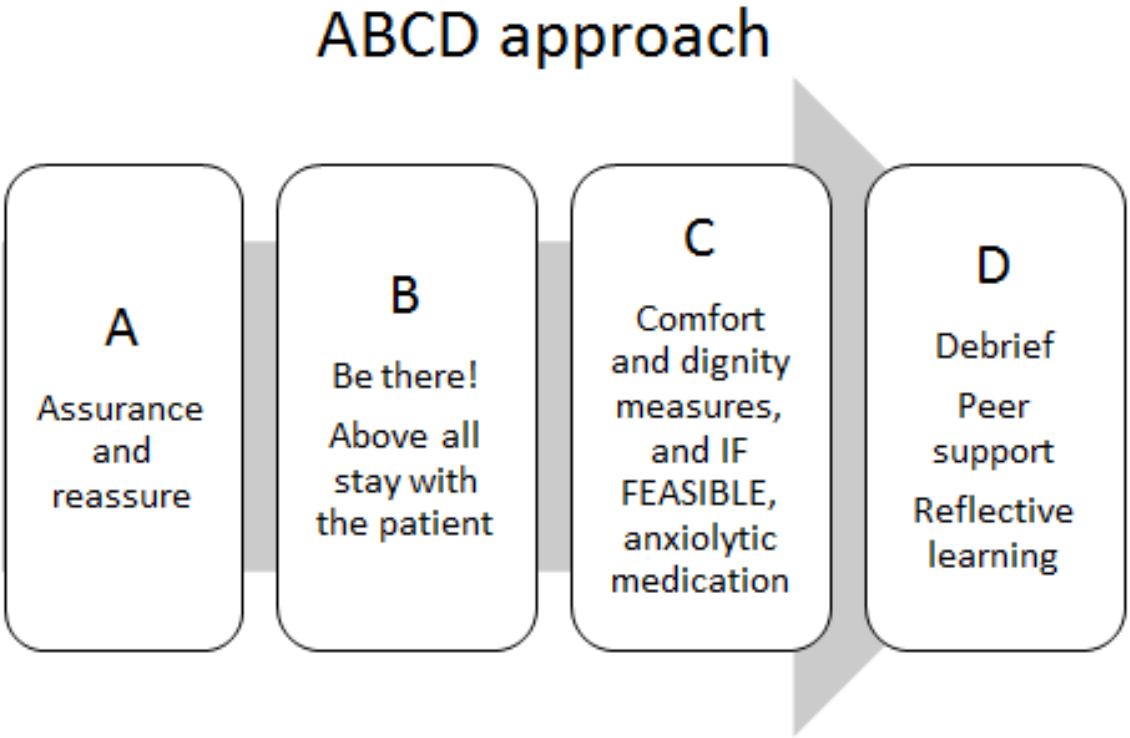
Preparation when a patient who is considered to be at high risk of catastrophic haemorrhage:

- Decide as a multidisciplinary team who will discuss this risk with the patient and their family. The palliative intent of management and DNAPCR decision must also be conveyed
- Stop anticoagulants and antiplatelet drugs where possible
- The identified risk and management plan must be highlighted at each nursing and medical handover
- For patients with head and neck cancer, ensure the emergency equipment bag/box to manage a bleed is adequately stocked and at the bedside (discuss with Max Fac/Oncology ward manager if uncertain)
- Patients deemed to be at very high risk of bleeding who need to leave the ward (e.g. essential radiology investigation) must be accompanied by an appropriately briefed trained member of nursing staff (who takes the emergency bag/box with them)
- If a patient is receiving palliative radiotherapy or chemotherapy ensure the chemotherapy team, outpatients manager and radiotherapy manager are aware of the bleeding risk
- Consider the patients preferred place of care and the available level of care. Arrange a side room if possible
- Ensure crisis medication is prescribed and prepared.
    - Stat doses of opioids are not required for haemorrhage
    - Stat doses of midazolam, 10mg IM/IV are most appropriate for use if medication is required. As a benzodiazepine, it will provide sedation. It has a rapid onset, short duration of action and produces amnesia. Thus if this is a herald bleed and the patient recovers from this event, then it is hoped that the patient will have little memory of the event
    - The midazolam should be drawn up in advance and kept in the controlled drug cupboard ready for use. The syringe will need to be replaced with a freshly drawn up ampoule every 24 hours. The syringe must be clearly labeled with drug name, dose and date / time drawn up and recorded in line with local policy in the controlled drugs (CDs) register. The balance in the register will remain the same until the syringe is used or destroyed. In the event the midazolam is used, the dose administered will be recorded in the CD register as usual and the stock balance adjusted accordingly. In addition, each day when an old unused vial and syringe is discarded, this will be recorded as "destroyed" in the controlled drug register and the balance adjusted to reflect the reduction of one ampoule from the total*. Please note: Destruction must be witnessed by a Pharmacist, Doctor or other qualified practitioner in accordance with the Policy for Safe and Secure Handling of Medicines.*
- If a patient is to be discharged home, the MDT will need to consider communication with community health and social care professionals. The specific management if a bleed occurs during ambulance transfer and ambulance crew briefing must be arranged by the MDT. Further planning for equipment, medication (i.e. which medication will be used, by which route and who will administer it) and clean up will need to be considered and arranged as well as where the family will be offered support and debrief. Buccal midazolam should be included on the TTO as shown below and the carer advised on how to administer this:

  Midazolam Buccal Solution 10mg in 2ml pre-filled syringe. Give the entire contents of the syringe when required. Please supply 2 (TWO) pre-filled syringes.

What to do when a major haemorrhage occurs:

- Ensure someone stays with the patient at **ALL** times
- Ensure another member of the ward nursing team moves other patients away from the bay (or clinical area) if the patient is not already in a side room
- Be respectful of the patient/family wishes of whether they stay at the bedside. Ensure support is given to the family during this time if they are present
- Stem/disguise bleeding with dark towels/blankets
- If bleeding from external wound, apply pressure to external wound if possible.
- Administer midazolam. Repeat after 10 minutes if needed. The subcutaneous route is not recommended in this situation due to peripheral shut down and poor systemic absorption. **Staying with the patient is the most important thing. Not giving medication may be the only practical option if there are delays with getting help to obtain/draw up medication**
- If the event occurs off the ward, call 2222 for support and assistance
- In an extreme emergency, it may be acceptable to deviate from usual manual handling practice (e.g. may need to roll and move patient on a folded blanket)
- **If a patient does not die immediately, it is likely they will require a midazolam infusion for continued symptom control. Call the specialist palliative care team for advice on x 3012**
- Such an event will be is likely to be distressing to family and friends (as well as staff) which may raise issues and concerns of a spiritual / religious nature. Do contact the Chaplaincy Team who can offer support
- Follow the ABCD approach detailed below:



Reference: Ubogagu E , Harris DG. Guideline for the management of terminal haemorrhage in palliative care patients with advanced cancer discharged home for end-of-life care. BMJ Supportive & Palliative Care 20102 doi:10.1136/bmjspcare-2012-000253