Palliative Management of Major Haemorrhage in an Adult Patient with Advanced Cancer

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NHSCT/11/409

**Target audience:**
This trust-wide policy is directed to medical, pharmacy and nursing staff working with adult patients in both the hospital and community setting.

**Sources of advice in relation to this document:**
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**NHSCT Mission Statement**

To provide for all, the quality of service we expect for our families, and ourselves.
Guidance on the Palliative Management of Major Haemorrhage in an Adult Patient with Advanced Cancer
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Guidance on the Palliative Management of Major Haemorrhage in an Adult Patient with Advanced Cancer

Introduction

Purpose of the Guidance

1. To enable healthcare professionals, across care settings, to identify adult patients at risk of a life threatening major haemorrhage to allow appropriate planning and management.
2. To promote proactive / sensitive discussions to inform a Palliative Management Plan to meet the needs and wishes of the adult patient with advanced cancer who is at risk of a life-ending major haemorrhage.
3. To reduce distress, anxiety and fear felt by patient, family and healthcare professionals.

Target Audience

This trust-wide policy is directed to medical, pharmacy and nursing staff working with adult patients in both the hospital and community setting.

Responsibilities

Directors
Responsibility is delegated to individual Directors who have responsibility to ensure that this guidance has been disseminated to the clinical staff working within their area of responsibility.

Clinical staff working in hospital and community environment
It is the responsibility of clinical staff working with adult patients in either the hospital or community settings to be aware of the guidance and to implement it when appropriate.

Equality, Human Rights and DDA

The guidance is purely clinical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

Alternative formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English
Sources of advice in relation to this document

The guidance author, responsible Assistant Director or Director as detailed on policy title page should be contacted with regard to any queries on the content of this policy.

Policy Statement

The incidence of major haemorrhage in adult patients with advanced cancer is 6-14%, and for 3-12% this can be a terminal event, which if poorly managed is frightening for the patient and leaves a lasting memory for the family and carers. It is important that health care professionals, across all settings in the NHSCT, can identify adult patients with potential risk of major haemorrhage. This should prompt advance care planning alongside the patient, their family and carers.

Identification of Risk

Major haemorrhage in advanced cancer can occur as a dramatic terminal event secondary to:

1. A carotid artery rupture in 20% of patients with advanced head and neck cancer;
2. Haemoptysis in patients with advanced primary or secondary lung cancer;
3. Haematemesis in patients with advanced primary or secondary upper GI cancer;
4. Bleeding from advanced vascular tumours such as sarcoma;
5. Rectal bleeding in patients with advanced primary or secondary lower GI cancer.

Sensitive Communication - Preparing the patient, family and carers

Major haemorrhage is an extremely frightening event for the patient and family and, if unprepared, could result in greater distress for the patient and family with complex bereavement for family afterwards. However, discussing an event that does not occur can cause unnecessary fear and anxiety for both patient and family. The timing of these discussions is difficult and is best done by a member of the multi-professional team whom the patient and family know and trust. The discussion should clarify the patient’s prognosis, identify end of life goals and develop a treatment plan that is compatible with the patient’s wishes and maximise quality of life. Goals should change from prolonging life at all cost to maximising time with friends and family at home, avoiding hospitalisation and unnecessary procedures, while trying to maintain comfort. These goals could include local measures to control haemorrhage and medication to control pain and anxiety, as well as developing a clear plan for the family/healthcare professionals involved in the care of the patient, in the event of a major haemorrhage (see Flowchart A).

The palliative management plan should only be used when a decision has been made by the lead clinician and multi-professional team that
cardiopulmonary resuscitation and transfer for acute, active management of the haemorrhage would be inappropriate. The stage of illness, treatment options available and patient’s choice should be taken into consideration. It is good practice for these decisions to be made openly and with patient and family involvement, taking into full consideration their expressed wishes. These decisions and discussions should be clearly recorded and information shared with the appropriate healthcare professionals providing in and out of hours care for the patient.

If the patient and clinicians involved feel that active acute management is appropriate then an acute management plan should be in place and communicated to all relevant care providers; this should include appropriate use of analgesics, anxiolytics and support for the patient and family (see Flowchart A).

These advance care decisions, by their very nature, need to be responsive to the evolving clinical situation and the holistic needs of the patient and should therefore be reviewed with the patient and family at times of significant clinical change, and/or when the patient wishes to review previous decisions.

**Palliative Management Plan for Major Haemorrhage in an Adult Patient with Advanced Cancer across all care settings**

In event of massive terminal haemorrhage the patient may be unconscious in minutes and may die very quickly even before medication is administered or has had a chance to work. **Never leave the patient alone.**

**In hospital**

The multi-professional team should assess, discuss and plan for all adult patients with advanced cancer in which life threatening major haemorrhage can be anticipated. The team can include surgeon/oncologist/nursing staff/specialist palliative care team or other relevant professionals. The surgeon and oncologist, whilst working in secondary/tertiary care settings, are still key professionals in the patient’s ongoing management and should be accessible and involved in the decision-making process at this key stage of the patient’s journey. If the decision is made that active treatment is inappropriate, due to stage of disease, lack of appropriate treatment options and/or patient choice, this should be clearly documented and communicated to all relevant healthcare professionals.

The management plan should be clearly understood by the patient and family including CPR status, plans for active or palliative measures and that comfort and alleviation of distress and suffering will be a priority to the team caring for the patient. Information should be communicated to primary care team especially if discharge planned (including ambulance crews and out of hours medical services).
Preparing the environment in anticipation of major haemorrhage

A side room would be appropriate if available for privacy and dignity of patient and to avoid distress of other patients.

The necessary equipment:
- call bell
- suction
- gloves
- personal protective equipment (PPE)
- syringes for cuff inflation of tracheostomy tube if appropriate
- dark disposable drapes
- availability of sedative such as midazolam (see Appendix A/Flowchart B/Flowchart C).

Managing a major haemorrhage

Avoid panic; being calm will help the patient and family.
Apply dark disposable drapes to bleeding site if possible/appropriate. If appropriate use suction and consider inflating the cuffed tracheostomy. Administer IM midazolam 5-10mg and repeat every 10-15 minutes if necessary to achieve adequate sedation.

After event

Time should be taken to prepare the patient’s body and environment to reduce the impact of the event on the family.
Family should be offered time to talk about what happened and provided with support which can include bereavement counselling, spiritual support and a follow-up meeting with the medical team and specialist palliative care team if involved.
Staff should also have an opportunity to reflect on the event and be able to avail of occupational health support, Carecall and counselling.

In community

The multi-professional team should assess, discuss and plan for all adult patients with advanced cancer in which life threatening major haemorrhage can be anticipated. The team can include surgeon/oncologist/general practitioner/district nursing staff/specialist palliative care team/other relevant professionals. If the decision is made that active treatment is inappropriate, due to stage of disease, lack of appropriate treatment options and/or patient choice this should be clearly documented and communicated to all relevant healthcare professionals (including ambulance crews and out of hours medical services).

The management plan should be clearly understood by the patient and family including CPR status, plans for active or palliative measures and that comfort and alleviation of distress and suffering will be a priority to the team caring for the patient.
Support for Patient and Family in the community

The patient and family should be clear about what they should do in the event of a major haemorrhage; this includes in-hours and out-of-hours contact numbers for the primary care team and discussion around use of 999 ambulance service for support only. The general practitioner should liaise with the NHSCT out of hours service and NI ambulance service so that the appropriate management plan is communicated and that up-to-date information is available in the event of an emergency call. Family should be offered advice and training on appropriate positioning of the patient to protect the airway, in the use of the dark towels or disposable drapes and the administration of buccal midazolam (if no healthcare professional available to administer IM midazolam). Practical issues around disposal of soiled linen and the storage of midazolam should be addressed.

The necessary equipment may include:
- Suction (if in situ)
- gloves
- personal protective equipment (PPE)
- dark towels or disposable drapes
- appropriate sedative available and prescribed (midazolam injection 10mg/2mls and/or buccal liquid, see Appendix A)
- waste bags.

Managing a major haemorrhage

Avoid panic; being calm will help the patient and family. Position the patient in best position to reduce the risk of aspiration. Apply dark towels or disposable drapes to bleeding site if possible/appropriate. If appropriate and available use suction and inflate the cuffed tracheostomy. Administer IM midazolam 5-10mg and repeat every 10-15 minutes if necessary to achieve sedation (see Appendix A). If an appropriately qualified healthcare professional is not present, an appropriately trained family member could administer buccal midazolam 10mg as a comfort measure. Call for assistance for support for family/healthcare professional as needed.

After event

Family and staff should be offered support which can include bereavement counselling, spiritual support and a follow-up meeting from the primary care team and the community specialist palliative care team if involved. Staff should also have an opportunity to reflect on the event and be able to avail of occupational health support, Carecall and counselling.
Acknowledgements

This guidance has been developed by the Loughside Palliative Care Development Group in the NHSCT after review of current literature including the work of the British Association of Head and Neck Nurses and a draft document from the Belfast Cancer Centre Specialist Palliative Care Team. The group would like to thank those who supported the guidance development, especially Mrs L. Nevin (NI CaN).

References


Appendix A  Medications for symptom control of pain and distress during a Major Haemorrhage

1. Midazolam—short acting benzodiazepine, rapid onset, used for sedation/easing distress/suffering. If bleeding stops and the patient survives, it may reduce their memory of experience. Ideally it should be prescribed as “emergency use”, and in hospital ordered as a pre-filled syringe in a sealed container, prepared by the Aseptic Unit in pharmacy at Antrim Area Hospital and stored in the patient’s medicine management locker or medicine trolley depending on ward’s medicine management system (See Flowchart B/Flowchart C). Dose depends on patient weight and previous benzodiazepine exposure. Dosage 5-10mg IM may be considered but may need to be titrated until patient is fully sedated (Gagnon et al, 1998; Pereira & Phan, 2004). After a recent NPSA alert all acute trusts have restricted the availability of midazolam 10mg/2ml strength to a named patient requisition. The high strength 10mg/2mls injection of midazolam will therefore need to be ordered immediately the potential for major haemorrhage in a palliative care patient is identified. It is treated as a controlled drug and staff should consult Flowchart B and Flowchart C for safe ordering and storage. Can be stored at room temperature but pre-filled syringes should be replaced weekly in case of instability.

If patient at home could consider buccal midazolam 10mg as alternative if healthcare professional not available to administer parenteral midazolam. This is an unlicensed indication and the buccal liquid requires special ordering; can use midazolam injection solution buccally in interim. Liaise with pharmacy for further advice and support if required.

2. Use of diamorphine is not recommended as first-line medication as pain is rarely reported. Also strict protocols around controlled drug use could cause delays in administration and take staff away from the patient to check and draw up increasing the chance of a frightened dying patient being left alone. It should be considered if patient complains of pain and/or breathlessness. If on opioids regularly use the equivalent dose to their usual 4 hourly breakthrough dose. If opioid naïve use 2.5-5mg diamorphine IM.
Identify patient at risk of major haemorrhage (MD Team)

Discuss with relevant healthcare professionals, patient and family, as appropriate and agree plan of care (including resuscitation decisions)
- document appropriate management plan (acute or palliative)
- communicate to all relevant care providers (especially primary care team/DUC/NI Ambulance service)

Family
- phone nearby
- contact numbers
- dark drapes

Care Provider
- gloves and aprons
- dark drapes
- prescibe midazolam

ACUTE MANAGEMENT PLAN

Stay calm
Assess patient
999 emergency ambulance
Appropriate intervention/resuscitation (including dark drapes, analgesia, anxiolytics as appropriate)
Support patient and family
Inform GP

PALLIATIVE MANAGEMENT PLAN

Stay Calm
Assess patient

- Consider appropriate dressings/pressure, depending on source of bleeding
- Position patient as appropriate
- Dark drapes
- Administer Midazolam IM, if prescribed and appropriate
- Use suction if available/appropriate

Stay with patient as much as possible
Contact appropriate family members/healthcare professionals for support
Support patient and family

MAJOR HAEMORRHAGE OCCURS

After event, offer family and staff support (can include bereavement counselling). Follow-up visit from Primary Care Team and Specialist Palliative Care Team if involved.

Flowchart A
Management of Major Haemorrhage in Adult Patients with Advanced, Progressive Cancer
Midazolam pre-filled syringe required for patient.

Doctor prescribes midazolam pre-filled syringe on kardex in the “once only section”.

Nursing staff place order in ward Controlled Drug requisition book detailing:
- Midazolam 10mg /2ml prefilled syringe x number required, for Emergency Bleed
- State patients name and hospital number.

Nursing staff to contact Aseptics, Pharmacy Department, Antrim Hospital (Tie line: 7555 Ext: 4417) to make them aware of request.

Forward order to Aseptics, Antrim Hospital.

Antrim Site.
- Controlled drug box and requisition to be delivered to pharmacy.

Off Site.
- Requisition to be faxed to Aseptic Unit, Antrim Hospital (02894424276).
- Original requisition to be posted to: Aseptics, Pharmacy Department, Antrim Hospital, 45 Bush Rd, BT41 2RL.

Aseptics manufactures prefilled syringe(s).

Prefilled midazolam syringe(s) supplied to ward as per Flow Chart B.
Flowchart C: Supply and Recording of Midazolam Pre-filled Syringe For Palliative Management of Major Haemorrhage in NHSCT hospitals

Aseptics manufacture prefilled syringe(s), charge to relevant ward and complete all Pharmacy related Controlled Drug Registers.

Aseptics arrange supply to the ward.

Antrim Site.

Aseptic staff will deliver prefilled syringe(s) to the ward in controlled drug box.

Member of ward nursing staff will sign for delivery of controlled drug box.

Off Site.

Aseptic staff will place prefilled syringe(s) in a tamper evident zip bag labelled for the relevant ward, with “confirmation of receipt paperwork”.

Aseptic staff will arrange transport to the relevant ward via taxi / transport.

On delivery of bag ward nursing staff must check number on zip seal tag corresponds to that stated on “confirmation of receipt paperwork” and contents of bag are correct. They must then complete the “confirmation of receipt paperwork” and fax to Aseptics (02894424276) the original should also be posted to Aseptic Unit, Pharmacy, Antrim Hospital, BT412RL, at the earliest convenience.

The ward nursing staff must then register the receipt of the midazolam prefilled syringe in the specific section of the ward controlled drug register as per trust procedures.

Midazolam pre-filled syringe can then be placed in patients bedside locker or drug trolley. While on the ward, the midazolam pre-filled syringe stock must be checked at each nursing staff “hand over” as per trust procedure for controlled drugs.

Patient requires administration.

Record details of administration in controlled drug register in terms of total volume (mls).

Any midazolam remaining in the prefilled syringe post administration should be discarded as per trust procedure for controlled drugs and the volume disposed of recorded in the controlled drugs register.

Patient does not require administration or product expires.

Return pre-filled syringe to pharmacy for destruction as per trust procedure for controlled drugs.
# Emergency Numbers

<table>
<thead>
<tr>
<th>Helper</th>
<th>Usual Number</th>
<th>Out of Hours</th>
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<tbody>
<tr>
<td>GP:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Nurse:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others:</td>
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