

GUIDANCE FOR HEALTHCARE STAFF FOR MANAGING CATASTROPHIC HAEMORRHAGE

CATASTROPHIC HAEMORRHAGE IS VERY, VERY RARE. This is both a comfort (unlikely to happen) and a challenge (What do I do if it does?)

As far as anyone can ascertain death from catastrophic haemorrhage is PAIN FREE and often there is no time for fear.

However, it can be very distressing to watch for healthcare staff and family.

PATIENTS POTENTIALLY AT RISK INCLUDE:

- Head and neck cancer (see also national guideline on www.bahnon.co.uk)
- Haematological malignancies
- Any cancer around a major artery
- Bone marrow failure where platelets < 15
- Disseminated intravascular coagulation

FOR THESE PATIENTS STOP AND THINK:

- Might this patient be at risk?
- Robust Multi Disciplinary Team (MDT) assessment is recommended liaising closely with the diagnostic team to assess risk.
- Stop any therapy predisposing to haemorrhage eg aspirin, heparin or warfarin.
- If patient is assessed as HIGH RISK of haemorrhage **PLAN AHEAD.**

* Careplans need to be individualised according to individuals needs and patient and family wishes. *

1. FORWARD PLANNING

With MDT decide:

1.1 Who needs to be informed:

- Patient?
- Family members? Which ones?
- Primary health care team members (nursing and medical)?
- Out of hours service providers (nursing and medical)?
- Acute services (nursing and medical)?

1.2 Risk assessment and risk management plan to consider potentially hazardous activities/individual social situation.

1.3 Failsafe mechanism for transfer of information and agreed care plan across care boundaries (eg following admission to inpatient unit).

1.4 What action to consider regarding:

- Care Setting
- Level of care available/needed
- Pro's and con's of crisis medication (not always possible/appropriate :see below)
- Telephone numbers available for emergency assistance
- Plan for who will clean up afterwards and how to get hold of them
- Equipment Needed (as close as is practical to the patient, ideally in the house or next to the bed in an inpatient unit):
 - Dark sheets.
 - Dark towels (green, blue or multi-coloured).
 - Gloves.
 - Aprons.
 - Plastic sheet or inco pad.
 - Clinical waste disposal system (including clinical waste bags).
 - Wipes.

(a box containing the above will be available at each out of hours provider base, clearly labelled "crisis box")

2. **MANAGING THE EVENT IF IT HAPPENS**

- Stay calm (or if on the telephone encourage family member/carer to stay calm)
- Priority is to stay with the patient and stem or disguise the bleeding with dark towels.
- If possible, calmly summon assistance.
- Administer medication only if applicable, as decided at MDT meeting. (See Appendix 2).

3. **AFTER THE EVENT**

- Offer debriefing (remember the whole team, including the cleaners).
- Ongoing support as necessary for relatives **and** staff.
- Staff may wish to seek support from a health care professional of their choice.
- Dispose of clinical waste appropriately.

APPENDIX 1

Crisis medication for catastrophic haemorrhage

DON'T FORGET :
A CALM AND REASSURING PRESENCE IS MORE IMPORTANT THAN GIVING CRISIS MEDICATION.
CARE AND SUPPORT OF THE PATIENT AND FAMILY IS THE PRIORITY.
IN PRACTICE ADMINISTERING CRISIS MEDICATION IS RARELY ACHIEVABLE.

If medication is felt to be appropriate, it needs to be:

- Rapid in onset (2-5 mins).
- Kept close to the patient.
- Already drawn up in a formulation which can be administered by the nearest carer, ideally, as there is rarely time to prepare an injection or calmly measure a sublingual dose.

The crisis management guidelines group recommends:

If nursing staff available quickly (within minutes) 24h/day:			
Drug	Route	Dose	Speed of onset
Midazolam (pre-drawn up injection if possible)	I/V injection	10mg	2-3 mins ²
	I/M injection (deltoid may be quicker than gluteal ¹)	10mg	5-15 mins ³
Domiciliary setting or nursing staff not available quickly:			
Lorazepam (pre-drawn up dose in syringe if possible)	Sublingual	4mg (1ml)	5 mins ⁴

The subcutaneous route is inappropriate (peripheral shutdown and unpredictable absorption).

¹ Lazebnik N. Kuhnert BR. Carr PC. Brashear WT. Syracuse CD. Mann LI. Intravenous, deltoid, or gluteus administration of meperidine during labor?. American Journal of Obstetrics & Gynecology. 160(5 Pt 1):1184-9, 1989

² PCF2 Twycross, Wilcock, Charlesworth, Dickman (2002) Radcliffe medical Press

³ British Association of Head and neck oncology guidelines for carotid artery rupture (1999)

⁴ PCF2 Twycross, Wilcock, Charlesworth, Dickman (2002) Radcliffe medical Press

APPENDIX 2

Cleaning up policies/resources (for spills of blood and other body fluids)

HOSPITAL

Refer to hospital policy across the Acute Trust and PCT (available on all wards and departments).

COMMUNITY

Soiled linen if not washed may be disposed of in the normal household waste. Soiled waste may be disposed of in the normal household waste. If you would like help cleaning up there are local specialist cleaning firms who will provide this service for a charge. Details are available in the yellow pages under cleaning and maintenance services.