Trust-wide Document

Great Western Hospitals NHS Foundation Trust

Management of Bleeding Malignant Fungating Wounds in Palliative Care Patients in the Hospital and Community Guideline

Document No	UC - 00056	**Version No**	1.0
Approved by	Policy Governance Group	**Date Approved**	20/01/2023
Ratified by	Medicines Assurance Committee	**Date Ratified**	01/12/2022
Date implemented (made live for use)	20/01/2023	**Next Review Date**	01/12/2025
Status	LIVE		
Target Audience- who does the document apply to and <u>who should be using it</u>. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	Health Care Professionals working in the Swindon area; • Great Western Hospital. • Swindon Community Health services. • All Health Care providers within Swindon. • Prospect Hospice		
Special Cases	*This document does not apply when a patient declines treatment*		
Accountable Director	*Director of Nursing*		
Author/originator – Any Comments on this document should be addressed to the author	*Clinical lead for End of Life and Consultant in Palliative Medicine*		
Division and Department	*Swindon Community Health Services & Palliative Partnership Working Group*		
Implementation Lead	*Associate Director of Nursing*		
If developed in partnership with another agency ratification details of the relevant agency	*Prospect Hospice.*		
Regulatory Position	*CQC* *NMC* *GMC*		
Review period. This document will be fully reviewed every 3 years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

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1 Introduction & Purpose

1.1 Introduction & Purpose

The aim of this document is to support evidenced best practice for healthcare professionals working in Great Western Hospital Foundation Trust and Swindon Community healthcare providers managing Malignant Fungating Wounds (MFWs) prone to bleeding.

Wound bleeding or haemorrhage may be a frequent and significant problem in patients with MFWs, and can cause distress for patients, their families and those managing the wounds in both an acute or community setting. There may be systemic factors contributing to bleeding such as disturbed clotting or the use of antiplatelets or anticoagulants. Bleeding occurs when blood vessels erode tumour cells due to the local stimulation of vascular endothelial growth factor and reduced platelet function within the tumour.

Bleeding can also occur from trauma such as scratching due to pruritus or wound dressings adhering to the wound surface. Localised antimicrobial loading which occurs in fungating tissue may also cause superficial bleeding Depending on the location of the tumour, there is a risk of major haemorrhage if the tumour erodes into a large blood vessel, and this may result in death, though this is rare.

Most of the pharmaceutical interventions will be being used off-licence and should be issued by the patient's GP with support from Prospect Hospice, Palliative Care Teams and Tissue Viability following a discussion with the patient.

For further information please refer to the Palliative Care Formulary- available via the intranet - and the practical guidance for management of the wound as per associated documents.

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

CQC	Care Quality Commission
CVA	Cerebrovascular event
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
EIA	Equality Impact Assessment
GMC	General Medical Council
GPC	General Pharmaceutical Council
HCP	Health care professional
IP&C	Infection Prevention and Control
MFW	Malignant Fungating Wounds
NHS	National Health Service
NMC	Nursing and Midwifery Council
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
TEP	Treatment Escalation Plan
TV	Tissue Viability
VTE	Venous Thombo-embolism

2 Main Document Requirements

2.1 Prevention of Bleeding.

Trauma should be minimised during dressing changes by gently irrigating and soaking adhered dressings, prior to attempting removal. MFWs should be dressed with non-adherent dressings that maintain a moist wound environment and may include an anti-microbial element to lessen the risk of bacterial loading and odour. *See Appendix C 'Topical Fungating Wound Management'.*

Pruritus, which can result in traumatic bleeding, is caused by irritation of the nerve endings due to stretching of the skin, or exudate in prolonged contact with the surrounding skin. Unfortunately, anti-histamines are often ineffective. Skin irritation from exudate may be managed and prevented with the use of topical agents. *See Appendix C 'Topical Fungating Wound Management'.*
For problematic pruritus relating to the MFW contact the TV team or for generalised Pruritis contact the Palliative care team.

Exudate
If exudate is a particular problem and is not being managed with absorbent dressings, and infection has been excluded/treated, specialist advice from the tissue viability nurses should be sought.

2.2 Management of Minor Bleeding

Minor bleeding/capillary ooze from a MFW can be achieved through the use of alginate/hydrofiber dressings which have haemostat properties. *See Appendix C 'Topical Fungating Wound Management'.*

1st line Systemic treatment
The use of oral Tranexamic acid should be considered to stop bleeding:

- initial dose of 1g orally followed thereafter by 500mg-1g three times daily
- if not settling after 3 days, increase to 1g three times daily
- reduce or discontinue 1 week to 10 days after bleeding stops; restart if recurs.

It is contraindicated in patients with haematuria as it can cause clot retention. Side effects include diarrhoea, nausea and vomiting, if these side effects occur reducing the dose may help. There is a potential increase in the risk of venous thromboembolism in people taking systemic tranexamic acid. Do not give this drug if the risk is thought to outweigh the benefit.

2nd line
Consider parenteral tranexamic acid if in an appropriate setting. Discuss with the palliative care team.

3rd line
See Appendix B 'Topical applications to bleeding wounds'.

If the MFW bleeds through the dressing, and the patient is in the community, the patient should be instructed to apply a second dressing over the dressing and to call the Single Point of Access 01793 646436 to request a Community Nurse to visit. If no dressing is available a sanitary towel can be used or failing that any clean cloth such as a towel.

2.3 Management of Profuse Bleeding

Control of profuse bleeding can be achieved through the use of Adrenaline soaked gauze. Adrenaline 1 in 1000 (1mg in 1ml) is applied to a pad of gauze and applied with pressure for 10 minutes. This results in local vasoconstriction but may also cause 'rebound' bleeding once these effects wear off. Care should also be taken to avoid ischaemic necrosis which can result from prolonged exposure.

Alternatively, Tranexamic acid 500mg in 5ml can be applied to gauze and applied with pressure for 5 minutes. The tranexamic acid soaks can be left in situ with a dressing on top. Alternatively, a tranexamic

acid paste (4 x 500mg tablets crushed in 60g base such as hydrophilic soft paraffin or instillagel) can be applied up to twice daily under dressings.

For advice regarding quantities of adrenaline and tranexamic acid to be used please contact Palliative Care for specialist advice.

2.4 Management of Anaemia and Medication

Multiple episodes of profuse bleeding or prolonged periods of minor bleeding may result in anaemia or may be being exacerbated by an underlying clotting disorder. Following discussion with the patient's treating doctor or GP it may be recommended to arrange for some baseline bloods including a Full Blood Count, Ferritin and Clotting Screen to be taken.

A medication review should be undertaken and drugs which predispose to bleeding, such as antiplatelets and anticoagulants should be identified. Stopping these drugs should be discussed with the patients as well as any adverse outcomes that may result such as VTE or CVA depending on the indication for the original prescription.

If the patient is anaemic early identification and treatment with oral iron may avoid the need for iron infusions or transfusions. Oral iron is frequently associated with gastrointestinal side effects such as diarrhoea or constipation as well as nausea, these can be minimised by taking on an empty stomach and not eating for 1 hour. There is growing evidence that the use of lower dosage regimes such as Ferrous sulphate 200mg once a day or on alternative days is just as effective in correcting anaemia as higher dose regimes and is associated with a lower incidence and severity of side effects.

Depending on where the patient is in their illness journey, profound and symptomatic anaemia may need to be corrected by a blood transfusion and may have a dramatic effect on the quality of life the patient experiences and should be considered after a discussion with the patient and their treating doctor This is often not a straightforward decision and it may be helpful to involve the palliative care team.

2.5 Management of Catastrophic Bleeding

If haemorrhage is anticipated, from an arterial bleed, then this could be fatal, and should be discussed with the patient when completing the ReSPECT form. Catastrophic bleeds are rare, but head and neck wounds that are adjacent to carotid arteries, or those in the groin adjacent to the femoral arteries are most likely to haemorrhage. Midazolam should be available to treat the patient's distress in the event of a catastrophic bleed, and a medication review should take place stopping anticoagulants and antiplatelets where possible.

Midazolam injection administered by the buccal route at a dose of 10mg, repeated after 10 minutes if needed should be prescribed, as this will enable the family to administer in the case of sudden haemorrhage, especially if it occurs in the in the out of hours period. It is also advisable to have a supply of dark coloured towels available to soak up and disguise the extent of the haemorrhage

In the event of an acute 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/sheets
- Apply pressure to the area if bleeding from external wound with adrenaline soaks if available

Administer 10mg Midazolam via the buccal route, subcutaneous or IM route as appropriate. This can be repeated after 10 minutes if required.

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

Following a catastrophic bleed professional cleaning services may be required, and this should be included when developing a care plan for the patient. A catastrophic bleed can be distressing for family and bereavement support can be invaluable in managing the psychological repercussions.

There is a leaflet available for patients and the loved ones of those for whom a large bleed can be anticipated. It talks about what to potentially expect and how to mitigate possible complications in the domestic setting. It can be found in trust wide documents, Patient Information leaflets titled *Palliative care patients at risk of bleeding. Information for families and carers.*

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be take if gaps are identified
All patients at risk of bleeding have careplan on EOL ICR	Audit	EOL/TVN teams	Annual	EOLA	Education and training

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Nursing Managers and Matrons

All Nursing Managers and Matrons must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.3 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

Ref. No.	Document Title	Document Location
1	Scottish Palliative Care Guidelines - Bleeding	https://www.palliativecareguidelines.scot.nhs.uk/guidelines/palliative-emergencies/Bleeding.aspx
2	Palliative Care Guidelines Plus (pallcare.info)	https://book.pallcare.info/index.php?tid=78&searchstring=tranexamic%20acid
3	Palliative Care Formulary	Palliative Care Formulary | MedicinesComplete

Ref. No.	Document Title	Document Location
4	Palliative care patients at risk of bleeding Information for families and carers	Trust wide documents/Leaflets/live/ integrated and community care

5.2 Consultation Process

The document was discussed with the members of staff detailed below and further discussion held at a Medicines Management Meeting.

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department.	Date Consultee Agreed Document Contents
Associate Director of Nursing – Sarah Latham	17.11.22
Consultant of Palliative Medicine Dr Natasha Wiggins	08.09.22
Community Tissue Viability Lead Eva Harris & Laura Deville	12.09.22
Band 6 Community Nurse – Lisa Cannell	08.03.22
Lead Community Pharmacist – Sophie Khan	07.11.22
End of Life Nurse – Jenna Butcher	13.09.22

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A.

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? **Management of Bleeding Malignant Fungating Wounds in Palliative Care Patients in the Hospital and Community Guideline**		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? **The aim of this document is to support best practice for nursing staff managing Malignant Fungating Wounds (MFWs) prone to bleeding.**		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?	**Yes**	**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?	**Yes**	**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**Yes**	**No**

Signed by the manager undertaking the assessment	Dr Natasha Wiggins
Date completed	08.09.22
Job Title	Clinical lead for End of Life and Consultant in Palliative Medicine

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

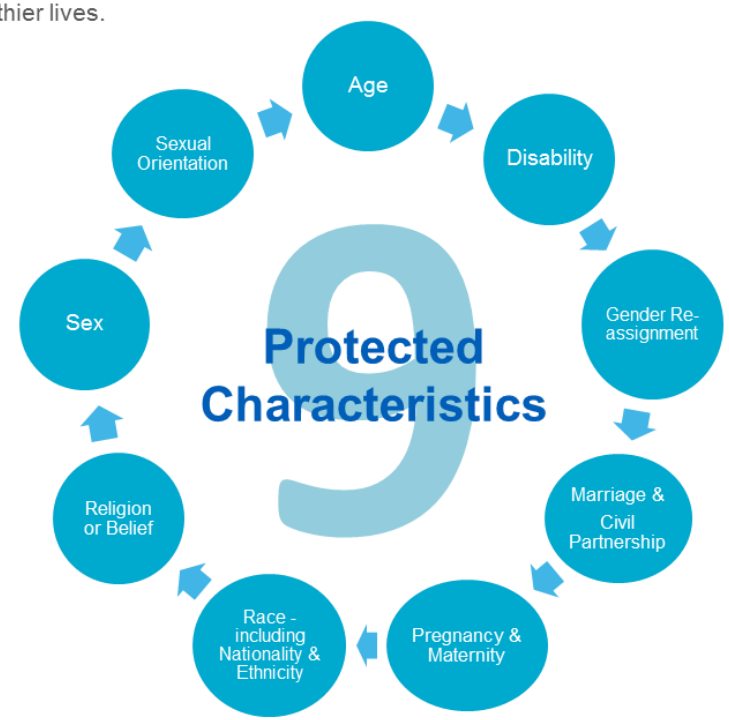
Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.



Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Appendix B - Topical applications to bleeding wounds

Practical guidance for the Management of Catastrophic Bleed(s)			
Management Aim	**Product**	**Name of Product**	**Advice**
Cessation of bleeding & absorbency of blood loss	Soft absorbent pad	Zetuvit E 10x20cm 20x20cm 20x40cm	Apply gentle pressure with numerous pads to stem bleeding but reduce trauma from pressure.
Application of topical medication	Sterile Gauze	10x10cm close woven swab/gauze	Use as carrier of topical medicaments
Stem acute bleeding 1st line	Topical Antifibrinolytic	Tranexamic Acid 100mg/1ml	Can be used to control bleeding and can remain under a dressing. *Gain advice from specialists re volume and application.
Stem acute bleeding 2nd line. Alternative to 1st Line. *Do not use in combination*	Topical Antifibrinolytic	Adrenaline 1:100	*Use for 15 minutes max, do not leave in place. Be aware of the potential for rebound bleeding or Tissue necrosis.
If bleeding has stabilised apply dressing	See Fungating wound guidelines for further guidance and management.		

Appendix C - Topical Fungating Wound Management

Practical guidance for managing fungating wounds		
Before dressing/product selection is made identify the purpose and aim of the proposed treatment as healing may not be a realistic option. **The goal of care being to maintain and improve quality of life through symptom control.** ***The tissue in fungating tumours is very friable – simple measures may reduce risk of bleeding.**		
Management aims	**Product / Dressing category**	**Name of dressings / product**
Protect surrounding skin **(see MASD Pathway)**	**Skin barrier products**	**Cavilon Film (Spray or 1ml / 3ml applicators** Application: Each dressing change **Cavilon Advanced 0.7 & 2.7 mls** (Twice weekly).
Trauma reduction if adhesive dressings are used.	**Medical Adhesive remover**	**Appeel adhesive remover.** How to use: Loosen a corner of adhesive dressing - apply Appeel between dressing and skin to loosen adhesion. Continue until all the adhesive layer has been soaked in Appeel and enables safe removal. Applications: 1 ml applicators (Recommended) 5mls sachets & 100 ml spray
Prevent bleeding and wound trauma	**Non adherent dressings**	Wound Contact Layer: **Urgotul all relevant sizes** Largest 15 x 20 cm Application: Apply directly to the wound bed.
Prevention of infection	**Anti – microbial**	Wound Contact Layer: **Urgotul Ag, - largest size 15 x 20cm** Application: Apply directly to the wound bed
Absorption	**Superabsorbers**	**Kerramax care** – all sizes

		Application: use with contact layer to reduce potential adhesion to wound bed.
Mask Odour	**Odour Control**	**Clinisorb** 15 x 25 cm Advise not applying directly to the wound – requires a contact layer first.
Pain / Comfort management	**Medicated dressings** *do not use in conjunction with hypochlorite	**Polymem foam – non adhesive** – With Humectant & surfactant. Largest size(s) 10 x 61 cm & 20 x 60 cm rolls. Application: Apply directly to the wound Requires wound to be wet - if dry add water to foam before application. **Biatian Ibu - (non-adhesive)** Ibuprofen - 0.5mg per cm^2 Largest size: 20 x 20cms

- Please seek Tissue Viability advice for further dressing regimes if the current recommendations are not suitable.
- Please see catastrophic bleeding wounds guidance for wounds that bleed easily. Appendix B