Bleeding during Endoscopy

In some cases during an endoscopic procedure the Endoscopist may discover or even cause an acute bleed/ haemorrhage.

- Ensure that you stay within the boundaries of your competencies, say no if you are not confident to tackle large polyps/EMR's etc. Someone more experienced can always step in.

- Be prepared :- Before any list starts, the procedure room staff need to check all the equipment is well stocked and the emergency box has all the necessary equipment and that it is in date. Expiry dates for all the drugs should be checked on a weekly basis and when used. Adrenaline 1:10,000, needles, luer lock syringes, clips, water flushes, additional suction bags should all be readily available. After an incident the stock used will need to be replenish immediately.

The bleed will be seen immediately either as a spurt from a vessel or a complete "red out" on the image screen.

1. DO NOT PANIC.....96% of patients who have colonic bleeds survive.

2. Call for back up immediately within the department – an extra pair of hands for checking drugs, drawing up, finding/ unpacking equipment, changing suction, runner, putting up fluids, scribe/ Documentation/drugs chart, will be invaluable.

3. Stabilise the patient - Use clinical assessment to decide how often you monitor the patient, maximum 10 minute intervals, Cannulate (largest bore) if not already done, Volplex/ Gelofusin IV fluids, & oxygen depending on Saturations. **Remember to Document everything – ' If it is not writen it down it did not happen'**

4. Stabilise the bleed – The Endoscopist may be stressed and will want you to react quickly and with precision, they will inform you of what equipment they require. The endoscopist will gauge the severity of the bleed, they will need to improve visualisation of the bleed by suctioning and irrigation. If it is a bleeding vessel then a clip may be appropriate (remember to have at least 10 clips available) If the bleeding is a continuous ooze then injecting adrenaline 1:10,000 may be more appropriate, you will need to prepare and then prime the injection needle with the solution. Other Haemostatic products may be available and the endoscopist will advise. (Always ensure that you draw up whatever you are injecting in a luer lock syringe as this is the correct connection for the injection needles.) Bleeds in the upper GI tract are much more difficult to manage and the patient will require immediate transfer to District General Hospital. You may be asked to draw up Etyhanolamine Oleate this can be drawn up the same as Adrenaline. But must use an Injecting needle to fit a Transnasal scope. If unable to stabilise call 9 999.

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5. Once the bleed is stabilised the endoscopist will give instructions on after care, monitoring the patient, IV fluids, Oxygen. The Endoscopist must remain in the department until the patient is discharged / transferred. If patient is to be transferred then the endoscopist must call the surgical on call team regarding transfer. The patient is to be clinically assessed by the endoscopist for fitness to discharge, ie. Tachycardia, hypotension, pallor, Clamminess, alertness, pain , bleeding. This can be monitored using the (NEWS) National Early Warning chart in the department and / or the continuation sheet.

6. Inform patients relative and ensure that they are kept informed/ updated and the possibility of transfer.

7. Delegated member of staff must contact the ambulance service if for immediate transfer. Use separate Information sheet by telephone or on the resuscitation trolley to ensure that the ambulance service is given the information they require.
    - Post code
    - Address of hospital
    - Telephone number you are calling from or they can call back to you on
    - Patients name & DOB / age
    - Information on patients current condition
    - What the problem is
    - The urgency and stretcher required...to attend at rear entrance of hospital

8. Inform reception / security (depending on the time,) that an ambulance will be arriving shortly at the rear entrance of the hospital. A member of staff should greet the ambulance and direct them to the department.

9. Ensure that all documentation is complete, accurate and legible, signed, dated, timed as per NMC guidelines, InHealth policy and procedure for Record Keeping. Photocopy all of the notes and place in an envelope to go with the patient on transfer.

10. If discharged home ensure the patient is aware of the discharge information, has a copy of their report and the process for reporting any problems.

11. Bleeds are a risk associated with Endoscopic procedures but an Incident form needs to be completed as soon as possible. Clinical Director, Operations Manager and National Operations Manager need to be informed asap. This will be fed back to the Head of Clinical Services for Braintree Community Hospital.

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12. Patient details need to be entered in the colon follow up call book and a comment indicating complication, i.e. bleed, perforation.

13. Staffs involved are to have a de - brief after reflecting on what happened, and actions taken if any lessons learnt, addition equipment required and any requirements for changes to policy and procedure. These are to be entered onto the incident form.

14. Contact hospital that the patient was transferred to the next day to check on the patient's condition. Update incident form with this information.