Worcestershire Acute Hospitals NHS Trust

Management of women who refuse the transfusion of blood products in pregnancy and postnatal period

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Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by

Introduction

Pregnant women who decline treatment with blood products should be reviewed by an obstetrician and an anaesthetist as soon as this preference has been identified. If, after discussing the potential requirement for blood product transfusion and the risks/benefits of this as well as alternatives, the woman still refuses blood product transfusion this fact should be clearly documented in the notes. A clear management plan should be kept in hospital (EZ notes) and hand held medical records.
If the patient has already signed a consent form in the antenatal period, but then changes her mind, you and the patient should note this in both patient and hospital notes (EZ notes).
Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

Antenatal

1. Women who refuse blood transfusion should be seen and counselled by a senior obstetrician (preferably a consultant) in the antenatal period.
2. The patient should be referred to Consultant Anaesthetist antenatally to discuss other alternative treatments
3. If a woman refuses any blood products, this should be noted and an individualised management plan kept in her hospital held records with a copy in her hand held records.
4. **Advance Directives:** Jehovah's Witnesses should have been pre-counselled ante-natally. At this time a copy of their Advanced Directive (an Advance Medical Decision document to refuse Specified Medical Treatment) should be discussed. This document should state clearly which blood products are unacceptable under any circumstances and which, if any, would be. This document legally releases medical practitioners/ hospitals of responsibility for any damages that might be caused by their refusal of blood." See Example of Jehovah's Witness Advance Directive- Appendix 1.

   An Advance Decision may be revoked at any time while a patient retains capacity to do so. If a patient holds an Advance Directive it should be highlighted to the multidisciplinary team. The advance directive should be photocopied and filed inside the front of the hospital held records with a copy in her hand-held records. The alert box located on the front of the notes should be ticked and alert card inside patient notes should be completed; there should also be a copy available in EZ notes.

5. **The consent** form for the acceptability of individual blood products must be completed and signed antenatally and kept in woman's hospital held records/EZ notes with a copy in her hand held records. See appendix 2

6. **For the basic legal position** in relation to an adult patient who refuses blood products and neonate of a mother who refuses blood and blood product refer to and Management of patients who refuse blood transfusion WAHT-KD-001.

7. If the patient asks about the risks of refusing blood transfusion, she should be given all relevant information. This must be done in a non-confrontational manner. The patient would be advised that if massive haemorrhage occurs there is an increased risk that hysterectomy will be required or haemorrhage could be life threatening and the woman and her partner should be offered the opportunity to discuss the treatment guidelines.

8. If the patient decides against accepting blood product transfusion in any circumstances and declines intra operative cell salvage, she should be booked under consultant care for delivery in a hospital which has all the facilities for prompt management of haemorrhage, including hysterectomy.

9. If the patient decides against accepting blood/ blood product transfusion in any circumstances and agrees to intra-operative cell salvage (IOCS) she should be booked for delivery in Worcester Royal Hospital. Intra-operative cell salvage uses involves collection and processing of blood shed in the operative field. The collected blood is citrated, filtered, washed with saline, concentrated and returned to the patient. The acceptability of IOCS should be documented clearly on the appropriate form (appendix 2).

   If the decision to use Cell salvage for planned delivery then the Obstetric consultant in charge of her care should inform the Maternity Theatre team leader and delivery suite matron in good time. The provision of adequately trained theatre staff to deliver IOCS in and out of hours is most likely but not 100% guaranteed and this must be conveyed to patient at consent discussion. The woman's blood group and antibody status should be checked as routine antenatal test.

10. The woman should be advised to take Haematinics throughout pregnancy to maximise iron stores. In addition to routine FBC in antenatal period, FBC and serum ferritin should be checked at 36 weeks. Prophylactic Ferinject infusion should be considered in cases of low or borderline Hb and serum iron. Refer to guideline for administration of Ferinject.

11. If a new risk for haemorrhage emerges in antenatal period (e.g. large for dates, polyhydramnios, placenta previa, PET etc.) the named consultant obstetrician must be informed.

Labour

12. The on-call consultant obstetrician and the on-call anaesthetist should be informed when a woman who is at risk of haemorrhage and known to refuse blood transfusion is admitted in labour. Consultants in other specialities need not be alerted unless complications occur.

13. The consent form for patients objecting to the use of blood product must be completed and signed antenatally and checked again when admitted in labour.

14. Active management of third stage is recommended.

15. The woman should not be left alone for at least an hour after delivery.

16. If Caesarean Section is necessary it should be carried out by an experienced obstetrician preferably a consultant.

17. The great majority of pregnancies will end without serious haemorrhage. When the mother is discharged from hospital, the patient should be advised to report promptly if the patient has any concerns about bleeding during the puerperium.

18. Un-booked women refusing blood product transfusion or booked women who are not known to refuse blood transfusion prior to admission should be seen by the on-call obstetrician and anaesthetist. If the consent form for patients objecting to the use of blood product is not completed and signed antenatally it should be done by the obstetrician on-call. The management should be as explained above.

Obstetric Haemorrhage

- Consultant Obstetrician must be informed and they should attend theatre. A Consultant Anaesthetist should be informed and may attend as appropriate.
- The standard management of haemorrhage should commence promptly.
- Extra vigilance should be exercised to quantify any abnormal bleeding and to detect complications, such as trauma /clotting abnormalities, as promptly as possible
- The principle of management of haemorrhage in these cases is to avoid delay. Rapid decision making is vital, particularly with regard to surgical intervention. The threshold for intervention should be lower than in other patients.
- Replace volume with fluid acceptable to patient
- Try to stop bleeding by acceptable and available pharmacological and surgical means. An initial intravenous bolus dose of 1g Tranexamic acid is safe and prudent if there is any suggestion of increased blood loss.
- Consultant haematologist must be involved at the earliest opportunity in the treatment of massive haemorrhage.
- In the case of life-threatening antepartum haemorrhage in which the baby is still alive, the baby should be delivered promptly by caesarean section if necessary
- In cases of PPH woman's life may be saved by timely hysterectomy. When hysterectomy is performed the uterine arteries should be clamped as early as possible in the procedure. Subtotal hysterectomy can be just as effective as total hysterectomy, as well as being quicker and safer. In some cases there may be a place for internal iliac artery ligation or uterine artery embolization – discuss with Radiologist at the time.
- Pharmacological options: In cases of severe bleeding (in addition to oxytocics and other drugs used to improve uterine tone). Fibrinolytic inhibitors such as tranexamic acid should be considered and after discussion with the consultant obstetrician, anaesthetist and haematologist consider phytomenadione - vitamin K (10mg should be given to the woman as a slow IV bolus over 3-5 minutes) and Desmopressin; the doses and administration of these drugs should be confirmed on individual basis. Activated factor VII should be considered early in consultation with the consultant haematologist

Debriefing & Counselling

Patient & partner: The doctor must be satisfied that the woman is not being subjected to pressure from others.

Most patients delivering by Caesarean section will be awake, with their partners present in theatre. They should be kept fully informed about what is happening. Information must be given in a professional way, ideally by someone the patient knows and trusts. If standard treatment is not

controlling the bleeding, the patient should be advised that blood transfusion be strongly recommended. Any patient is entitled to change her mind about a previously agreed treatment plan. Consultant obstetrician should arrange for a further debriefing session with the patient and or partner & family

Staff: It is very distressing for staff to have to watch a woman bleed to death while refusing effective treatment. Support should be promptly available for staff in these circumstances

Remember

- Discuss the situation fully with the woman and establish her views
- Inform the on-call consultant if you consider her to be at particular risk of haemorrhage or for any other reason
- Seek advice from the haematologist and anaesthetist early
- Discuss the use of alternative blood substitutes/products with the patient
- Check maternal haemoglobin unless a recent result is available
- Alert the paediatrician if the baby is likely to need blood – eg preterm/maternal antibodies
- If haemorrhage occurs manage aggressively and inform the consultant obstetrician, anaesthetist and haematologist

APPENDIX 1

Advance Decision to Refuse Specified Medical Treatment

1. I, _____ (print or type full name), born _____ (date) complete this document to set forth my treatment instructions in case of my incapacity. **The refusal of specified treatment(s) contained herein continues to apply to that/those treatment(s) even if those medically responsible for my welfare and/or any other persons believe that my life is at risk.**
2. I am one of Jehovah's Witnesses with firm religious convictions. With full realization of the implications of this position I direct that **NO TRANSFUSIONS OF BLOOD or primary blood components (red cells, white cells, plasma or platelets)** be administered to me in any circumstances. I also refuse to predonate my blood for later infusion.
3. **Regarding minor fractions of blood** (for example: albumin, coagulation factors, immunoglobulins): [Initial **one** of the three choices below.]
   (a) _____ I refuse all
   (b) _____ I accept all
   (c) _____ I want to qualify either (3a) or (3b) above and my treatment choices are as follows:
   _____
   _____
4. **Regarding autologous procedures** (involving my own blood, for example: haemodilution, heart bypass, dialysis, intraoperative and postoperative blood salvage):
   [Initial **one** of the three choices below.]
   (a) _____ I refuse all such procedures or therapies
   (b) _____ I am prepared to accept any such procedure
   (c) _____ I want to qualify either (4a) or (4b) above and my treatment choices are as follows:
   _____
   _____

   I am prepared to accept diagnostic procedures, such as blood samples for testing.
5. **Regarding other welfare instructions** (such as current medications, allergies, and medical problems):
   _____
   _____
   _____

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6. I consent to my relevant medical records and the details of my condition being shared with the Emergency Contact below and/or with member(s) of the Hospital Liaison Committee for Jehovah's Witnesses.

7. _____ _____
Signature Date

_____
Address

8. **STATEMENT OF WITNESSES:** The person who signed this document did so in my presence. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older.

_____ _____
Signature of witness Signature of witness

_____ _____
Name Occupation Name Occupation

_____ _____
Address Address

_____ _____

_____ _____
Telephone Mobile Telephone Mobile

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9. **EMERGENCY CONTACT:**

_____
Name

_____
Address

_____

_____
Telephone Mobile

10. **GENERAL PRACTITIONER CONTACT DETAILS:** A copy of this document is lodged with the Registered General Medical Practitioner whose details appear below.

_____
Name

_____
Address

_____

_____
Telephone Number(s)

NO BLOOD

(signed document inside)

Advance Decision to Refuse Specified Medical Treatment

Advance Decision to Refuse Specified Medical Treatment

(signed document inside)

NO BLOOD

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APPENDIX 2

Worcestershire NHS
Acute Hospitals NHS Trust

Please attach patient sticker here or record:

Name:……

NHS No: | | | | | | | | | | |

Unit No: | | | | | | | | | | |

D.O.B: ……

ACCEPTIBILITY OF BLOOD PRODUCTS FORM

Having discussed the risks of refusing blood product transfusion when clinically indicated in pregnancy and labour to both mother and baby, the following acceptability conclusions have been confirmed and agreed:

Blood / Blood Product	**Patient to indicate Yes/ No**
Packed Red Blood Cells	
Fresh Frozen Plasma	
Platelets	
Cryoprecipitate	
Intra-operative Cell Salvage	
Anti-D Immunoglobulin (recombinant)	
Epidural blood patch (if offered to treat Dural puncture headache)	

Patient Signature…… Clinician Signature…….

Patient Name …… Clinician Name ……..……..

Date ……. Clinician Grade ……

Date …….