Ratified February 2019

Review due February 2022

Standard Operating Procedure for the Management of Women Who Refuse Blood Products

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Prepared by: Mike Pearson

Version: SOP 1

Effective: 11/02/19

Review: 11/02/22

CARE PLAN FOR WOMEN IN LABOUR REFUSING A BLOOD TRANSFUSION

(As referred to in the RCOG News (October 2000) of the Royal college of Obstetricians and Gynaecologists)

Please ensure that the consultant obstetrician is aware when a women who is refusing blood products is being admitted in labour.

All such patients should have the third stage of labour actively managed with Oxytocin drugs together with early cord clamping and controlled cord traction after placental separation. Do not leave the patient alone for the first hour after delivery

Risk factors predisposing to postpartum haemorrhage

If the patient has any of the risk factors below, an IV infusion of Syntocinon should be considered after delivery of the baby:

Previous history of bleeding, post or antepartum haemorrhage

Multiple pregnancy	More than 3 children
Large baby (>3.5kg)	Maternal obesity
Fibroid or myomectomy scars	Maternal age >40 yrs

Polyhydramnios

Prolonged labour (especially when augmented with Syntocinon)

Difficult operative delivery

Actively haemorrhaging

First Steps: establish IV colloid infusion e.g. **Haemaccel or Gelofusine**. Give oxygen. Consider CVP line. Catheterise and monitor urine output. Give **Oxytocin drugs first, then exclude retained products of conception or trauma** (this could save time). Proceed with **bimanual uterine compression**. A useful emergency measure to but time is **aortic**

Recombinant factor VIIa (Novoseven) 90µg/kg, provides site specific thrombin generation. Successfully used to treat 5 reported cases of uncontrollable bleeding associated with DIC, in one case following caesarean section. Experience with this drug is limited. Should only be used in life-threatening bleeding under consultant guidance. Expert advice available from local Haemophilia Comprehensive Care Centre or Novo Nordisk 24-hour medical advice line: 0845 600 5055 (with emergency delivery).

Uterine packing or intrauterine balloon catheter. Purpose-designed 500 ml J-SOS Bakri balloon available (Cook [UK] Ltd Ted. 01462 473100). Embolisation or ligation of internal iliac artery or bilateral mass ligation of uterine arteries and veins

B-Lynch brace suture. Simple surgical technique to control massive haemorrhage. Has been used to avoid hysterectomy.

Hysterectomy, subtotal hysterectomy can be just as effective, also quicker and safer Consider **blood salvage** if surgical blood loss anticipated **(blood salvage with leucocyte depletion fillers also** reported as potential life-saving technique during caesaean section).

Post haemorrhage

For severe anaemia, give oxygen and use erythropoietin 300 U/kg x 3 per week subcutaneously, without delay. Shortens lag period of erythropoiesis and accelerates haemoglobin recovery. Dosage for renal anaemia (50 U/kg), ineffective for severe blood loss anaemia

Iron supplementation essential. Oral iron is slow and unreliable, use **IV iron sucrose (Venofer)** which is not associated with anaphylaxis, 200mg x 3 per week. Augment with vitamin B-12 and folic acid. Consider elective ventilation on intensive care unit.

Hyperbaric oxygen therapy is an option in life-threatening anaemia– contact Hospital Information Services for Jehovah's Witnesses Tel: 020 8906 2211 (his@wtbts.org.uk)

NB: Many women who refuse blood products carry a care plan in their notes and may present it when admitted in labour, a sample of which is shown below.

This care plan does not necessarily reflect the care that we give and is for information purposes ONLY

1 BACKGROUND

Massive obstetric haemorrhage is often unpredictable and can threaten life in a short time. Very few women will refuse transfusion in these circumstances but if it is thought likely that they may do so, the management of massive haemorrhage should be considered in advance.

2 PURPOSE

This document provides guidance on caring for woman who decline blood products.

3 SCOPE

This document is for use by all obstetricians, anaesthetists and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

4 COURSE OF ACTION:

4.1 Booking

- Women who may decline blood products will be identified at the booking appointment. They should be seen as early as possible in their pregnancy to ascertain their views on blood transfusion and other blood products such as Anti-D or albumin.
- At this appointment the community midwife will offer and discuss the leaflet 'Information for pregnant women that decline blood products'
- Women who decide against receiving blood under any circumstances should be booked for an appointment between 12-20 weeks gestation, with a consultant obstetrician and an individual plan of care documented in her notes.

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4.2 Antenatal care

- All information about the risks of refusing transfusion should be given in a non-confrontational manner.
- A detailed account of the woman's wishes should be documented following discussion of the options.
- An advance directive form should be completed by the woman and filed in her notes.
- An appointment for the anaesthetic antenatal clinic should be given.
- Routine antenatal blood screening should be undertaken throughout the pregnancy.
- Oral iron supplements should be considered throughout the pregnancy to maximise iron stores.
- If any complications occur antenatally the consultant should be informed.
- For elective surgery it may be possible to store blood in advance for auto transfusion. This may be acceptable to some women.

4.3 Labour

- The registrar or consultant on call must be made aware when a woman who refuses blood transfusion is admitted in labour.
- The labour should be managed routinely by experienced midwives.
- The 3rd stage of labour should be actively managed and the woman should not be left alone for at least an hour after delivery.
- If caesarean section is necessary the consultant should perform this if possible and the anaesthetic given by an experienced anaesthetist and the consultant anaesthetist on call should be informed

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4.4 Postnatal

- Women should be advised to report promptly if they have concerns about heavy bleeding.
- Senior staff should be informed of readmission, Consultant obstetrician and consultant anaesthetist

4.5 IF HAEMORRHAGE OCCURS

The most important aspect of management is to avoid delay therefore rapid decision-making may be necessary.

- The threshold for intervention should be lower than in other women.
- Extra vigilance should be exercised to quantify any abnormal bleeding and to detect complications such as clotting abnormalities promptly.
- If abnormal bleeding occurs antenatally, in labour or the puerperium the consultant obstetrician should be informed and the standard management commenced. (Please see guidelines for obstetric haemorrhage)
- The on-call anaesthetist and the consultant haematologist should be notified.
- IV fluids - intravenous crystalloid and artificial plasma expanders such as Gelofusine should be used.
- In cases of severe bleeding the following drugs should be considered after discussion with the consultant haematologist.
    - Vitamin K 10mg should be given intravenously slowly.
    - Desmopressin 0.3microgrammes/kg IV or subcutaneously (over 30 mins)
    - Fibrinolytic inhibitors such as aprotinin 1,000,000 units. It is preferable to give a test dose of 1ml (10,000U) at least 10 mins prior to the remainder of the dose due to the risk of anaphylactic reaction
    - Tranexamic acid 1gram x3 daily, IV or orally

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- The use of cell saver devices can be considered.
- The woman should be kept fully informed about what is happening. The information should be given in a professional way by someone she knows and trusts.
- If standard treatment is not controlling the bleeding she should be advised that blood transfusion is strongly recommended.
- If she maintains her refusal to accept blood or blood products her wishes should be respected. The legal position is that any person who is considered competent under the Frazier ruling is entitled to refuse treatment even if it is likely that refusal will end in death. No other person is legally able to consent to treatment for that adult or to refuse treatment on that person's behalf.
- Staff should maintain a professional attitude and must not lose the trust of the patient as further decisions e.g. hysterectomy may need to be made.
- Hysterectomy is usually a last resort in treatment of obstetric haemorrhage but with these women delay may increase the risk. The woman's life may be saved by timely hysterectomy, although even this may not guarantee success. 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, and may be quicker and safer. In some cases there may be a place for internal iliac artery ligation. The timing of hysterectomy is a decision for the consultant obstetrician present at the time.
- Further management - If the woman survives the acute episode and is transferred to an intensive care unit, the management should include erythropoietin, parenteral iron therapy and adequate protein for haemoglobin synthesis.

If the woman dies in spite of all efforts the relatives need support like any other bereaved family. Such a death is very distressing for the staff involved who may also need support.

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4.6 Further Information

Hospital Information Services for Jehovah's Witnesses

Tel: 02089062211 (24 hour)

e-mail: his@wbts.org.uk

5 IMPLEMENTATION/TRAINING/AWARENESS:

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter.

6 AUDITABLE STANDARDS

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Consultant Obstetrician & Consultant Anaesthetist appointment between 12/20 weeks gestation	Patients notes	Identified on E3 - Yearly	All women that refuse blood products	Audit Midwife	LW meeting/ Audit meeting
Is a clear LW care plan documented in the notes by consultant and anaesthetist	Patients notes	Identified on E3 - Yearly	All women that refuse blood products	Audit Midwife	LW meeting/ Audit meeting
Lead midwife, obstetric team and anaesthetic team informed of woman's admission in labour documented	Patients notes	Identified on E3 - Yearly	All women that refuse blood products	Audit Midwife	LW meeting/ Audit meeting

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7 REFERENCES

RCOG News October 2000
Care plan for women in labour refusing a blood transfusion January 2002

CEMACH 1991-1993 –
The treatment of obstetric haemorrhage in women who refuse blood transfusion

As Alok et al 1996
Tranexamic acid in the management of post partum haemorrhage Br J Obs gynecol 103: 1250-1251

Breymann et al 2000
Effectiveness of recombinant erythropoetin and iron sucrose vs iron therapy only in patients with postpartum anaemia and blunted erythropoiesis Europ J Clin Invest 30: 154-161.

Busuttil Copplestone 1995
Management of blood loss in Jehovah's Witnesses Br Med J 311: 1115-1116

McLoughlin et al 1999
Hyperbaric oxygen therapy in the management of severe acute anaemia in a Jehovah's Witness Anaesthesia 54: 891-895

Valentine et al 1993
Reduction of acute haemorrhage with aprotonin. Anaesthesia 48: 405-406

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8 LINKS TO OTHER POLICIES/DOCUMENTS

- Policy for the transfusion of blood and blood products (Trust Policy)
- Guideline for the management of antepartum haemorrhage
- Guideline for the management of Post partum haemorrhage
- Guideline for the Management of Maternal Death
- Patient Information Leaflet- Information for pregnant women that decline blood products'

9 DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
Nov 2006	1.0	Dec 2009	Nov 2006		
Dec 2009	2.0	Dec 2011	Dec 2009		Maternity CSG
2nd January 2012	3.0	2nd January 2015	2nd January 2012		No changes. Agreed within department and with Transfusion Practitioner
February 2016	4.0	10th February 2019	10th February 2016	Clinical Director of SWCH	Reviewed with no changes. Agreed with Maternity CSG members
February 2019	1.0 SOP	11th February 2022	11th February 2019		Reviewed & Agreed by Maternity CSG members

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Appendix A

IMPACT ASSESSMENT ON DOCUMENT IMPLEMENTATION
Summary of Impact Assessment (see next page for details)

Document title	**Guidelines for the management of women who refuse a blood transfusion**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**0**	**0**	**0**
Training Staff	**0**	**0**	**0**
Equipment & Provision of resources	**0**	**0**	**0**

Summary of Impact:

None

Risk Management Issues

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES /
- Are there any reported equality issues? NO

If "YES" please specify:

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Use additional sheets if necessary

IMPACT ASSESSMENT ON POLICY IMPLEMENTATION

Please include all associated costs where an impact on implementing this document has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	0	0	0
Additional staffing required - by affected areas / departments:	0	0	0
Totals:	0	0	0

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Affected areas / departments	0	0
e.g. 10 staff for 2 days		
Totals:	0	0

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Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed	0	0
Building alterations (extensions/new)	0	0
IT Hardware / software / licences	0	0
Medical equipment	0	0
Stationery / publicity	0	0
Travel costs	0	0
Utilities e.g. telephones	0	0
Process change	0	0
Rolling replacement of equipment	0	0
Equipment maintenance	0	0
Marketing – booklets/posters/handouts, etc	0	0
Totals:	0	0

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

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Appendix B

Impact on Equality Assessment Form

Title/Subject: Guidelines for the management of women who refuse a blood transfusion

Name: - Amanda Pearson	Date:-

What are the intended outcomes of the protocol? This document provides guidance on caring for woman who decline blood products
Who will be affected? E.g. staff, patients, service users etc Patients

Evidence	
List the main sources of data, research and other sources of evidence you have reviewed.	
	What evidence have you considered?
Disability	□
Sex	□
Race	□

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Age	☐
Gender reassignment	☐
Sexual orientation	☐
Religion and belief	☐
Pregnancy and maternity	☐
Carers	☐
Other groups e.g. socio-economic , are inequalities, income	☐

Summary of Analysis	
Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive	
	What evidence have you considered?
Eliminate discrimination, harassment and victimisation	
Advance equal opportunity and promotes good relationships between groups	

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Please select **one** of each of the following categories that apply to your protocol:-

EQUALITY GROUPING	
Patient Safety	□
Patient Experience	
Quality & Clinical Effectiveness	
Governance & Compliance	

TRUST OBJECTIVES	
Quality	□
Innovation	
Productivity	
Prevention	
Reform	

Please select **as many** of the following that apply to your protocol:-

Health & Safety Issue	□
Infection Control Issue	□
Quality Issue	□
Attitude or Behavioural Issue	□

Signed:…… Name in full:……..……
Title/Grade:……

Protocol Agreed at: Maternity CSG

Date:

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