

| | |
|--|--|
| MANAGEMENT OF PREGNANT AND POSTNATAL PATIENTS REFUSING BLOOD PRODUCTS | CLINICAL GUIDELINES Register No: 07040 Status: Public |
|--|--|

| | |
|----------------------------|---|
| Developed in response to: | Intrapartum NICE Guidelines RCOG guideline |
| CQC Fundamental Standards: | 9, 11, 12 |

| Consulted With: | Post/Committee/Group: | Date: |
|---|--|----------------|
| Anita Rao/Alison Cuthbertson Miss Dutta Sam Brayshaw Shereen Elshazly Alison Cuthbertson Paula Hollis Chris Berner Wendy Patarou Nick Sheppard Claire Fitzgerald Deborah Lepley | Clinical Director for Women's and Children's Division Consultant for Obstetrics and Gynaecology Consultant Anaesthetist Consultant Haematologist Head of Midwifery Lead Midwife Acute Inpatient Services Lead Midwife Clinical Governance Team Leader Labour Ward Blood Bank Manager Pharmacy Senior Librarian, Warner Library | September 2017 |

| Professionally Approved By: | | |
|-----------------------------|--|----------------|
| Anita Rao | Lead Consultant for Obstetrics & Gynaecology | September 2017 |

| | |
|---------------------------------|---|
| Version Number | 5.0 |
| Issuing Directorate | Women's and Children's |
| Ratified By | DRAG Chairmans Action |
| Ratified On | 22 nd November 2017 |
| Implemented on: | 11 th December 2017 |
| Executive Board Date | December 2017/ January 2018 |
| Next Review Date | October 2020 |
| Author | Sarah Moon, Lead Midwife for Guidelines and Audit |
| Policy to be followed by | Midwives, Obstetricians, Paediatricians |
| Distribution Method | Intranet & Website. Notified on Staff Focus |
| Related Trust Policies | 04071 Standard Infection Prevention 04072 Hand Hygiene 10120 Privacy and Dignity Policy 04080 Consent Policy 06036 Guideline for Maternity Record Keeping 07072 Guideline for the Management of a patient reporting an Antepartum Haemorrhage 04234 Guideline for the Management of a Postpartum Haemorrhage 04184 Trust Blood Transfusion Policy 09079 Management of normal labour and prolonged labour in low risk patients Maternity Care 08011 Iron Deficiency Anaemia in pregnancy 04272 Maternity Care 13012 Major Haemorrhage Policy |

Document History Review:

| Version No: | Reviewed by | Active Date |
|-------------|--|------------------|
| 1.0 | Julie Bishop | January 2003 |
| 2.1 | Liz Stewart | |
| 2.2 | Equality and diversity; audit and monitoring update. Clarify point 5.3 | January 2010 |
| 2.3 | Sarah Moon - review of guideline | April 2011 |
| 3.0 | Sarah Moon | August 2012 |
| 3.1 | Sarah Moon – clarification to point 6.1 | December 2012 |
| 4.0 | Sarah Moon | September 2014 |
| 5.0 | Sarah Moon | 11 December 2017 |

INDEX

- 1. Purpose**
- 2. Equality and Diversity**
- 3. Introduction**
- 4. Advance Management**
- 5. Booking Appointment**
- 6. Antenatal Care**
- 7. Management in Labour**
- 8. Haemorrhage**
- 9. Staff and Training**
- 10. Professional Midwifery Advocates**
- 11. Infection Prevention**
- 12. Audit and Monitoring**
- 13. Guideline Management**
- 14. Communication**
- 15. References**
- 16. Appendix**
 - A. Appendix A - Consent to Medical Treatment by Patient who refuses to have a Blood Transfusion

1.0 Purpose

- 1.1 The purpose of the guideline is to provide guidance to staff on prediction, early detection and management of massive haemorrhage in the event that a pregnant/postnatal patient refuses blood products.

2.0 Equality and Diversity

- 2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Introduction

- 3.1 Massive obstetric haemorrhage is often unpredictable and can become life threatening in a short time. In most cases blood transfusion can save the woman's life and very few women refuse blood transfusion in these circumstances. If it is thought likely that a patient will do so, the management of massive haemorrhage should be considered in advance.

4.0 Advance Management

- 4.1 Refer to consultant team for discussion and record clearly in the patient's healthcare records. If the patient is at any risk of an antepartum haemorrhage (APH) or postpartum haemorrhage (PPH), the case must be discussed with her obstetric consultant. (Refer to the Guideline for the management of a patient reporting an antepartum haemorrhage', register number 07072; and the 'Guideline for the management of a postpartum haemorrhage'; register number 04234).
- 4.2 Document the patient's wishes regarding the possible requirement for a blood transfusion and/or the use of blood products with particular reference to life threatening circumstances. Any documentary evidence such as a Refusal of Treatment Certificate (in the form of Schedule 1 to the Medical Treatment Act 1998) should be requested from relatives of the patient and examined. A copy should be placed in the patient's lilac medical records and its contents respected.
- 4.3 Offer the patient a patient information leaflet entitled 'Refusing blood products' for further reading and offer explanations as required or provide a contact number for any further clarification i.e. the Antenatal Clinic on 01245 362305.
- 4.4 Advise her about the risk of postpartum haemorrhage (PPH) and strongly recommend the option for an active 3rd stage and the use of syntometrine.
- 4.5. The obstetric registrar/ consultant on call must be informed of the patient's admission in labour and the obstetric consultant on call must be informed about haemorrhage at the earliest opportunity.
- 4.6. An alert sticker should be placed on the front cover of the patient's lilac medical records folder and a record made in the box on the inside front cover signed and dated by a midwife or obstetric registrar/ consultant on call.

5.0 Booking Appointment

- 5.1 At the booking clinic the midwife should ascertain the patient's religious beliefs and the midwife should also enquire if they have any objections to a blood transfusion. If a patient is a Jehovah's Witness or likely to refuse blood transfusion for other reasons, this should be documented in the patient's healthcare records. The patient should be asked if she is willing to receive blood transfusion if necessary and her reply should be duly documented in the patient's healthcare (maternity) records and an alert sticker should be placed in the patient's lilac medical records with the appropriate entry made on the inside front cover (refer to point 4.6)
- 5.2 If the patient asks about the risks of refusing blood transfusion, the patient should be given all the relevant information. This should be done in a non-confrontational manner. The patient should be advised that if massive haemorrhage occurs there is an increased risk that hysterectomy will be required and the patient and her partner should be offered the opportunity to read and discuss the treatment guidelines.
- 5.3 In the absence of any other risk factors the patient could be booked for a delivery at the birth centre as long as all staff are aware on admission of her choice and ensure prompt transfer if she bleeds. In the event of this situation arising, this should be agreed by the patient's obstetric consultant in the antenatal period to add support to this notion.
- 5.4 Iron and folic acid supplementation should be offered throughout pregnancy as well as regular blood tests to check the woman's haemoglobin (blood count) is above 12g/dl. If the woman's haemoglobin remains low despite taking supplements and following review by the obstetric registrar/ consultant on call; intravenous iron therapy may be offered as an alternative treatment.
(Refer to guidelines entitled 'Iron Deficiency Anaemia in pregnancy; register number 08011; Maternity Care; register number 04272)
- 5.5 All women at 28 weeks gestation require a blood test to ascertain haemoglobin levels. If the haemoglobin results are between 85 to 105 g/l, the woman should be treated with the appropriate iron therapy.
(Refer to the guideline entitled 'Iron deficiency anaemia in pregnancy'; register number 08011)
- 5.6 The woman's haemoglobin levels should be repeated at 36 weeks gestation to review the bloods levels and ascertain whether the iron therapy has been effective.
(Refer to the guideline entitled 'Iron deficiency anaemia in pregnancy'; register number 08011)

6.0 Antenatal Management

- 6.1 The patient should have an antenatal appointment arranged to see her obstetric consultant at 18 weeks gestation for the purpose of formulating an individual care pathway, which complies with the patient's wishes and beliefs; and this information should be documented in the patient's healthcare records. In addition, the proposed delivery and possible complications that may result in bleeding should be discussed by the patient's obstetric consultant.
- 6.2 The obstetric registrar/consultant on call should ensure that a 'refusing blood transfusion' proforma is signed by the patient and completed.
(Refer to Appendix A)

- 6.3 The midwife should ensure that a copy of the 'refusing blood transfusion' proforma should be retained in the patient's lilac medical records folder.
(Refer to Appendix A)
- 6.4 The patient should be managed by a team including the consultant obstetrician, anaesthetist and haematologist.
- 6.5 The patient should have an anaesthetic appointment arranged to see the anaesthetic registrar/ consultant at 24 weeks gestation. The anaesthetist should document what the patient is prepared to accept in terms of blood or products and what the patient specifically wishes to avoid. The anaesthetist should ensure that a copy of the anaesthetic notes is placed in the patient's lilac medical record folder.
- 6.6 The anaesthetist should outline techniques used to avoid transfusion and will obtain and document consent for these.
- 6.7 The anaesthetist should enquire what action the patient will sanction if unconscious or unable to communicate and dying of unexpected blood loss, this information should be documented in the anaesthetic pages of the patient's healthcare records.
- 6.8 The Consultant/ Registrar Anaesthetist will ascertain which therapeutic agents are acceptable to the patient for support of blood volume.
- 6.9 The Consultant/ Registrar Anaesthetist will consider enhancement of pre-operative haemoglobin with recombinant human erythropoietin if appropriate.
- 6.10 The patient's blood group and antibody status should be checked in the usual way and the haemoglobin and serum ferritin should be checked regularly. Haematinics should be given throughout pregnancy to maximise iron stores.
- 6.11 All appointments and communications should be documented contemporaneously in the patient's healthcare records and patient's lilac medical records folder.
- 6.12 Discussion should include which of the minor blood fractions are acceptable to the patient i.e. Rhesus immunoglobulin (anti-D).
- 6.13 An ultrasound scan should be carried out to identify the placental site.
- 6.14 There are well-described procedures for elective surgery in Jehovah's Witnesses: such as intra-operative cell salvage.
- 6.15 If any complication is noted during the antenatal period the obstetric consultant should be informed.

7.0 Management in Labour

- 7.1. The obstetric registrar and on call anaesthetist should be informed when a patient who will refuse a blood transfusion is admitted in labour. Consultants in other specialities need not be alerted unless complications occur. At this point in time if the woman has consented to cell salvage; ensure that the anaesthetic team has been informed and that they have a team available from the outset.

- 7.2 A full blood count should be taken on admission. If the patient is termed 'low risk', the labour should be managed routinely, by experienced staff. If the haemoglobin level is below 10 g/dl, an intravenous line should be inserted. The obstetric consultant on call and the haematologist should be informed.
(Refer to the guideline for 'Management of normal labour and prolonged labour in low risk patients (09079)
- 7.3 Oxytocics should be given when the baby is delivered. The patient should not be left alone for at least an hour after delivery. If the haemoglobin is below 10 g/dl run a syntocinon infusion via IVAC pump of 40 intravenous syntocinon in 1000 ml Hartmanns at 125ml/hour for 2 hours or as prescribed by the obstetric registrar/consultant on call.
- 7.4 If a caesarean section is necessary it should be carried out by the obstetric consultant on call.
- 7.5 The great majority of pregnancies will end without serious haemorrhage. When the woman is discharged from hospital, she should be advised to report promptly if she has any concerns about bleeding during the puerperium.

8.0 Haemorrhage

(Refer to the Guideline for the management of a patient reporting an antepartum haemorrhage', register number 07072; and the 'Guideline for the management of a postpartum haemorrhage'; register number 04234)

- 8.1 The principle of management of haemorrhage in these cases is to avoid delay. Rapid decision-making may be necessary, particularly with regard to surgical intervention.
- 8.2 If unusual bleeding occurs at any time during pregnancy, labour or in the puerperium the consultant obstetrician should be called early and the standard management should be commenced promptly. The threshold for intervention should be lower than in other patients. Extra vigilance should be exercised to quantify any abnormal bleeding and to detect complications, such as clotting abnormalities, as promptly as possible.
- 8.3 Consultants in other specialities, particularly anaesthetists and haematology, are involved in the treatment of massive haemorrhage. If the patient has refused a blood transfusion the consultant anaesthetist should be notified after any abnormal bleeding has been detected, even though the options for treatment may be severely limited.
- 8.4 Intravenous crystalloid and artificial plasma expanders such as gelofusine should be used for fluid replacement. Dextran should be avoided because of its possible effects on haemostasis.
- 8.5 In cases of severe bleeding, vitamin K should be given to the patient intravenously. Early use of tranexamic acid should be considered. The advice of the haematologist should be sought before considering the use of heparin to combat disseminated intra vascular coagulation.
- 8.6 The patient should be kept fully informed about what is happening. Information should be given in a professional way, ideally by someone she knows and trusts. If standard treatment is not controlling the bleeding, she should be advised that a blood transfusion is strongly recommended. Any woman is entitled to change her mind about previously agreed treatment plan.

- 8.7 The obstetric registrar/consultant on call should be satisfied that the patient is not being subjected to pressure from others. It is reasonable to ask the accompanying persons to leave the room for a while so that the obstetric registrar/consultant (with midwife or other colleague) can ask her whether she is making her decision of her own free will.
- 8.8 If she maintains her refusal to accept blood or blood products, her wishes should be respected. The legal position is that any adult patient (i.e. 18 years or over) who has the necessary mental capacity to do so is entitled to refuse treatment, even if it is likely that refusal will result in the patient's death. No other person is legally able to consent to treatment for that adult or to refuse treatment on that person's behalf.
- 8.9 The staff must maintain a professional attitude. They should not lose the trust of the patient or her partner as further decisions regarding hysterectomy may have to be made.
- 8.10 Massive obstetric haemorrhage usually occurs in the form of postpartum 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.
- 8.11 Hysterectomy is normally the last resort in the treatment of obstetric haemorrhage, but with such patients delay may increase the risk. The patient's life may be saved by timely hysterectomy, though even this does not guarantee success.
- 8.12 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. The timing of hysterectomy is a decision for the obstetric consultant on call.
- 8.13 If a patient survives the acute episode and is transferred to an intensive care unit, the management there should include erythropoietin parenteral iron therapy and adequate protein for haemoglobin synthesis.
- 8.14 If, in spite of all care, the patient dies, her relatives require support and information to assist with funeral arrangements.
- 8.15 It is very distressing for staff to have to watch a patient bleed to death while refusing effective treatment. Support and counsel should be available for staff in these circumstances. The Professional Midwifery Advocates' should be made aware of the situation and inform all relevant personnel as per policy.

9.0 Staffing and Training

- 9.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training, maternal resuscitation and early recognition of the ill patient. (Refer to 'Mandatory training policy for Maternity Services (incorporating training need analysis. Register number 09062)
- 9.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

10.0 Professional Midwifery Advocates

10.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

11.0 Infection Prevention

11.1 All staff should follow Trust guidelines on infection control by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

11.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

12.0 Audit and Monitoring

12.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

12.2 As a minimum the following specific requirements will be monitored:

- To document an individual management plan in the health records of women who decline blood products
- Current arrangements for the use of intraoperative cell salvage
- Current arrangements for the use of interventional radiology
- Process for continuous audit, multidisciplinary review of audit results and subsequent monitoring of action plans

12.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 12.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

12.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

12.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

12.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

12.7 Key findings and learning points will be disseminated to relevant staff.

13.0 Guideline Management

13.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

13.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

13.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

13.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

14.0 Communication

14.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

14.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

14.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

14.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

15.0 References

Walker, I & Grise, E. (2008). Safe Births: Everybody's business - Independent Inquiry into the Safety of Maternity Services in England. London: King's Fund.
www.kingsfund.org.uk

Knight M, Nair M, Tuffnell D, Kenyon S, Shakespeare J, Brocklehurst P, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2016.

Catling, S. (2007) Blood Conservation techniques in obstetrics: UK perspective. International Journal of Obstetric Anesthesia, 16(3): 241-249.

www.clinicalkey.com

Davies, K. and Rucklidge, M. (2007). Management of Obstetric Haemorrhage.
www.anaesthesiauk.com

Healthcare Commission. (2006). Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005. London: Commission for Healthcare Audit and Inspection.
www.cqc.org.uk

National Institute for Health and Clinical Excellence. (2005). Intraoperative blood cell salvage in obstetrics. Interventional procedures guidance [IPG144] London: NICE.
www.nice.org.uk

National Institute for Health and Clinical Excellence. (2007). Intrapartum care: Care of healthy women and their babies during childbirth. Clinical Guideline (CG 190). Updated 2017. London: NICE. Available at:
www.nice.org.uk

**Consent to Medical Treatment by a Patient who refuses to have a
Blood Product or Blood Component Transfusion**

I acknowledge that I have been informed that I am suffering from:
and that I require, or may require, treatment, the nature of:
which has been explained by Dr/Mr/Mrs/Miss/Ms

I hereby give my consent to the administration of such treatment as the physician considers necessary, **except** that although it has been explained to me in the course of the said treatment it may be necessary to give me a transfusion of a blood product/component so as to enhance the effectiveness of any treatment.

If there are any blood products or components that you would accept please tick here:

- Red Blood Cells (Blood)
- Platelets
- Fresh Frozen Plasma (FFP)
- Cryoprecipitate
- Albumin
- PCC (Beriplex)
- Anti D
- Other
- Intraoperative Cell Salvation
- (please state below)

.....

Signed (patient)..... Print Name.....

I hereby expressly withhold my consent to and forbid the administration to me of a blood or blood component/product transfusion, in any circumstances or for any reason whatsoever (except as stated above), and I accordingly absolve the physician, the hospital and every member of the medical staff concerned, from all responsibility, and from any liability to me, or to my estate, or to my dependents, for any damage or injury which may be caused to me or to my estate or to my dependents in any way, arising out of, or connected with this my refusal to consent to any such blood/blood product transfusion.

Hospital Number: DOB: Date:

Signed (patient) :.....Print Name:

Doctor providing information and witnessing refusal:

Signed: Print Name:

Job Title: Date: