1. **Introduction**

- This guideline is intended for use by all clinicians providing antepartum, intrapartum and postpartum care to women who refuse transfusion of blood products and/or Anti-D injections. Increasing knowledge and understanding, may improve communication between clinicians and women.

- People in the UK may refuse blood component transfusion for many reasons such as fear of errors, infection transmission or because of religious beliefs. The main group of women who may refuse for religious reasons are Jehovah’s Witnesses.

- The aim of this policy is to:
  - ensure that these patients’ beliefs are acknowledged and respected
  - to provide information to clinicians about the management of these patients
  - to facilitate and expedite non-blood medical management for these patients

When “blood products” are referred to in this document they may include:

- Whole blood
- Red blood cells
- Platelets
- Granulocytes
- Fresh frozen plasma
- Albumin
- Immunoglobulin
- Antithrombin III concentrate
- Drotrecogin Alfa (Activated)
- Factor VIIa (Recombinant)
- Factor VIII fraction, dried
- Factor VIII inhibitor bypassing fractions
- Dried factor IX fraction
- Factor XIII dried
- Protein C concentrate
2. **Staff responsibilities**

Midwifery Staff must:
- refer all women who at booking disclose that they would decline any blood products during their obstetric care to consultant led obstetric care and to the antenatal anaesthetic clinic
- inform obstetric and anaesthetic staff when a woman who has indicated she will decline blood products is admitted to the maternity unit

Labour ward co-ordinator must:
- inform the obstetric and anaesthetic staff when a woman who has indicated she will decline blood products is admitted in labour

Consultant Obstetrician must:
- personally review the woman at her first consultant appointment
- discuss all relevant risks and give advice, appropriately counsel the woman and establish which products the woman declines or would accept and ensure the woman understands the availability of treatments at Derriford
- document an individual management plan of care in the health care records
- complete the Advance Decision to Refuse Specified Medical Treatment Form and file a copy in the health care records
- offer support to staff when the woman presents on Labour ward
- liaise with the consultant anaesthetist and consultant haematologist as required

Consultant Anaesthetist must:
- review the woman who has declared that she would decline blood product in the obstetric anaesthetic clinic in the antenatal period, formulate a management plan and insert an alert sticker in the healthcare records.
- review the woman when admitted to the hospital as requested by the obstetric team

3. **Jehovah’s witnesses position on medical treatment and related matters**

Each patient who is a Jehovah Witness will, as a matter of personal, individual choice, decide whether he/she wishes to accept the following: **It is therefore important to discuss with each patient whether or not these are acceptable.**

- **Autologous transfusion procedures**
  While machines, systems, and arrangements vary, each patient will make a personal decision as to whether or not to accept perioperative/intraoperative blood salvage (cell saver)

- **Blood Products**
  Derivatives of primary blood components (albumin, coagulation factors, immunoglobulins, etc).

**Acceptable Medical Treatment**
Jehovah’s Witnesses accept most medical treatments, surgical and anaesthetic procedures, devices and techniques, as well as haemostatic and therapeutic agents that do not contain blood. For example, they accept:
- Non-blood volume expanders such as crystalloids (e.g. saline, Hartmann’s and dextrose) and colloids (e.g. gelatine, hydroxyethylstarch)
• Agents such as Erythropoiesis Stimulating Agents (ESAs), Desmopressin, vasoconstrictors and recombinant clotting factors

**Usually Unacceptable Medical Treatment**

- Transfusions of whole blood, packed red cells, white cells, plasma and platelets.
- Pre-operative autologous blood collection and storage for later transfusion (not available in Plymouth).

Some patients will refuse all blood derivatives whilst others may consent to some but refuse others. It is important to make a record of the treatment the patient will or will not accept.

**Advance Directives and Patient Identification**

Most Jehovah’s Witnesses will carry an Advance Directive in the format specified in the Mental Capacity Act, 2005 to communicate their refusal of whole blood, packed red cells, white cells, platelets and plasma and their individual choice regarding acceptance or refusal of autologous procedures and ‘fractions’ of plasma or cellular components. This document is entitled Advance Decision to Refuse Specified Medical Treatment.

- Some Witness patients may wish to provide and wear their own ‘No Blood’ wristband. The NPSA (National Patient Safety Agency) Safer Practice Notice No.24 (3 July 2007) states: ‘Patients who wish to wear their own wristbands in hospital should be permitted to do so, but advised of the dangers of confusion for staff.’
- Blood sampling must be kept to a minimum but careful monitoring of the patient’s haematological status must not be neglected.

4. **Booking appointment**

- At the booking the midwife must enquire about religious beliefs and if the woman has any objections to blood transfusions or other blood products (e.g. Anti-D). If the woman is noted to be a Jehovah’s Witness or is likely to refuse blood for other reasons, this must be recorded in the hand held pregnancy notes and on the antenatal referral form.

- If the patient has completed an *Advance Decision to Refuse Specified Medical Treatment (Example - Appendix 2)* this should be included in the case notes.

- All Jehovah’s Witness pregnant women must be referred to the consultant antenatal clinic for discussion about management of pregnancy and delivery.

- The mother should be referred to the anaesthetic clinic early in the antenatal period.
5. Consultant appointment

The woman must be given all relevant information, including benefits and risks of receiving or refusing a blood transfusion or other blood products. This must be done in a non-confrontational manner.

- The woman must be advised that if major haemorrhage occurs there is an increased risk that hysterectomy will be required.

- The woman (and her partner) should be offered the opportunity to read and discuss the “Care Plan for Women in Labour Refusing a Blood Transfusion” and file a copy in the healthcare records (Appendix 1).

- Some Jehovah’s Witnesses will accept the use of ‘fractions’ of plasma or cellular components (e.g. prophylactic anti-D, albumin, immunoglobulins, clotting factors, Cryoprecipitate. This should be discussed and the patient’s choice documented clearly in the notes (hand held and hospital).

- A discussion of cell salvage should also be documented, clearly stating that the mother realises that the circuit is not complete.

- A ‘Form To Be Completed For All Obstetric Patients Who Refuse Consent For Blood and Blood Product Administration, Including Jehovah’s Witnesses’ (Appendix 3) must be completed and a copy filed in the woman’s pregnancy hand held records and in the healthcare records. The original is retained by and is the property of the woman.

- The extent of the patient’s personal beliefs and wishes must be established including their wishes in case of emergency and whether they fully understand the potential implications of their refusal of blood components.

- A discussion about what products the mother will and won’t accept should be documented, including a statement that the mother realises and accepts the risk of:
  - death
  - disability
  - lengthy recovery
  - for herself and/or her child as a result of her refusal of blood products.

- Discussions should be signed and dated by both the clinician and the mother. A copy should be entered into the hand held and main hospital notes.

- Rhesus negative mothers may be advised to have intramuscular (IM) injections of Anti-D following a suspected feto-maternal haemorrhage incident or as a prophylactic dose at 28 weeks. Women, who refuse Anti-D against medical advice, must be counselled by the Obstetrician, with regards to the risks posed to the baby and the effect that it may have on future pregnancies, should isoimmunisation occur. All discussions must be documented in the healthcare records.

6. Antenatal care

- The woman’s blood group, antibody status, haemoglobin and serum ferritin must be checked as the clinical condition dictates.
- Iron tablets should be given throughout pregnancy if required and tolerated, especially if the haemoglobin is less than 10.5g/dl to maximise iron stores.

- A mid trimester ultrasound scan must be carried out, with consent, to identify the placental site.

- The woman must be reviewed by a consultant obstetrician and anaesthetist during the antenatal period in order to develop an individual management plan together with the woman, her husband and family, and, if necessary, religious advisors.

- If any significant complications are noted during the antenatal period, the Consultant obstetrician must be informed.

### 7. Intrapartum care
- The woman must be actively encouraged to deliver at the hospital, not at home or in the community.

- The Advance Decision to Refuse Specified Medical Treatment Form must be NOTED and CONFIRMED whenever the woman is admitted to the hospital

- The obstetric and anaesthetic staff on duty must be informed by the labour ward co-ordinator when a woman who refuses blood products is admitted in labour. The obstetric consultants should then be informed and an individual plan of care for labour documented in the healthcare records.

- The third stage of labour must be actively managed, with consent. An intravenous solution of oxytocin (40 Units in 500 mls at 125mls/hr) should be considered after the delivery of the baby if the patient has any of the following risk factors:
  - previous history of bleeding or post or ante partum haemorrhage
  - prolonged labour
  - increased maternal age (>40 years) and/or maternal obesity
  - multiple pregnancy and/or >4 children
  - difficult operative delivery
  - abnormal placentation/retained products
  - >3.5kg baby
  - polyhydramnios
  - fibroids

- If a Caesarean section is necessary it should be discussed with the on-call consultant obstetrician and carried out by the most experienced surgeon available, paying attention to meticulous haemostasis.

### 8. Haemorrhage
- The key to management of haemorrhage in these cases is to AVOID DELAY and ensure senior assistance. Rapid decision making may be necessary, particularly with regard to surgical intervention.
• Extra vigilance must be exercised to quantify any abnormal bleeding and detect complications such as clotting abnormalities as promptly as possible.

• Please refer to intrapartum guideline 18: Obstetric haemorrhage and postnatal guideline 9: Postpartum haemorrhage, AND:

• If unusual bleeding occurs at any time during pregnancy, labour or the puerperium the consultant obstetrician must be informed and standard management for obstetric haemorrhage must be commenced promptly. The threshold for prompt surgical intervention (e.g. hysterectomy) should be lower in women who decline blood products.

  **Ergometrine** with **oxytocin (Syntometrine)** marginally more effective than oxytocin alone. If patient is hypertensive, use **oxytocin** 10U (not 5U) by slow IV injection (In PPH, benefits of the higher dose outweigh the risks)

  **Carboprost (Hemabate)** 250μg/ml IM, can be repeated after 15 min. Direct intra-myometrial injection is faster (less hazardous at open operation). If not available use 1 or 2 **Gemeprost** pessaries in the uterus.

  **Rectal or Oral misoprostol** 800μg (4 tablets) – can be used used when unresponsive to oxytocin and ergometrine. **Intrauterine misoprostol** 800μg (4 tablets), can be used during caesarean section. (Misoprostol does not cause hypertension)

  **Recombinant factor Vlla (rFVlla; NovoSeven)** 90μg/kg, provides site specific thrombin generation. Increasingly used to successfully treat uncontrollable haemorrhage in placenta accreta/percreta, ruptured uterus, uterine atony and HELLP syndrome (Has to be discussed with Consultant Haematologist)

  In cases of severe bleeding, give **intravenous Vitamin K** and consider antifibrinolytics such as **tranexamic acid** 1g 6 hourly orally or 1g intravenously 5 hourly. **Desmopressin** has also been recommended.

  **Intrauterine balloon tamponade**

  **B-Lynch brace suture** - Simple suture technique to control massive haemorrhage. Can be combined with intrauterine balloon catheter if bleeding persists

  **Hysterectomy**

  • The consultant anaesthetist and haematologist must be notified as soon as possible in the presence of abnormal heavy bleeding.

  • The woman must be kept fully informed about her condition in a professional manner, ideally by someone she knows and trusts. If standard treatment is not controlling the haemorrhage, blood transfusion must be strongly recommended.

  • Hysterectomy is normally the last resort in the treatment of obstetric haemorrhage, but with women who decline blood products timely hysterectomy may be life saving. The timing and type of hysterectomy (sub-total or total) is a decision for the Consultant Obstetrician where possible. During hysterectomy
the uterine arteries must be clamped as early as possible. In some cases there may be a place for internal iliac artery ligation.

- In the event of an emergency, the Hospital Liaison Committee Network for Jehovah’s Witnesses may be contacted for advice and support on 020 8906 2211 (24-hour).

- If the woman survives the acute episode and is transferred to the ITU, amongst the treatments to be considered are:
  - mechanical ventilation
  - high dose ESAs with intravenous iron supplementation (e.g. Cosmofer) with adequate protein intake for Haemoglobin synthesis.

9. Legal issues

- Where the woman maintains her refusal to accept blood products, her wishes must be respected. The legal position is that any adult patient (i.e. 18 years old 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.

- Some women may change their mind about a previously agreed treatment plan. If this is the case and they agree to receive blood products this MUST be documented in the medical records and signed by two witnessing healthcare professionals.

- The witnessing healthcare professionals must be satisfied that the woman is not being subjected to pressure from others. It is reasonable to ask the accompanying persons to leave the room temporarily so that the obstetrician and/or anaesthetist can confirm that the woman is making the decision of her own free will.

- If the woman is unconscious and there is no evidence of an Advance Statement in the notes or she is not wearing a MedicAlert bracelet all efforts should be made to halt the haemorrhage. Blood and blood products may be given unless the family can provide clear proof that the woman would refuse such treatment.

10. Postnatal care

- When the woman is discharged, she must be advised to report immediately if she has any concerns about bleeding during the puerperium.

- The great majority of pregnancies will end without serious haemorrhage. When the mother is discharged from hospital, she must be advised to report promptly to the Midwife or the General Practitioner, if she has any concerns about bleeding during the puerperium.

There is a Hospital Liaison Service for Jehovah’s Witnesses and their contact number is 02089062211. This is a 24hr service to provide guidance to Jehovah’s Witness patients and staff alike.

11. Patient information and discussion

Women must be afforded a documented discussion re: risks and benefits of refusal of blood and blood products and be given an information booklet as soon as possible in order to assist them in making the decision that is best for them. Where there are communication or language support needs assistance can be obtained via patient service and interpretation services.
12. Record keeping and documentation
It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the date and time together with signature and printed name.

13. Appendices

Appendix 1 – Care Plan for Women in Labour Refusing a Blood Transfusion

Appendix 2 – An Example of Advance Decision to Refuse Specified Medical Treatment Form

Appendix 3: Form To Be Completed For All Obstetric Patients Who Refuse Consent For Blood and Blood Product Administration, Including Jehovah’s Witnesses
Appendix 1 – Care Plan for Women in Labour Refusing a Blood Transfusion

CARE PLAN FOR WOMEN IN LABOUR REFUSING A BLOOD TRANSFUSION

(As referred to in the RCOG News of the Royal College of Obstetricians & Gynaecologists)

This document is an aid for medical staff and midwives managing a Jehovah’s Witness or other patient who declines blood. Autologous procedures such as blood salvage and the use of plasma-derived products such as clotting agents are a matter of personal choice for each woman. Most will carry an advance decision document expressing their wishes. Please check with the patient.

Risk management

- All Jehovah’s Witnesses or those declining a blood transfusion should be seen in a consultant clinic.
- Clinicians should plan in advance for blood loss. If the Hb is < 10.5g/L use ferrous sulphate 200mg tds and folic acid — with systemic measures. Consider giving iron, if there is no iron deficiency anemia, use IV iron which provides iron stores faster and more effectively than oral iron. A single total dose IV iron preparation may be more acceptable to the patient than repeat infusions. Addition of recombinant human erythropoietin (EPO), which does not cross the placenta and is reportedly safe, is used in pregnancy, enhances Hb response.
- High-risk patients should be booked into antenatal clinics with facilities such as interventional radiology, blood salvage and surgical expertise.
- All elective surgery must be planned as far in advance as possible.
- For high-risk caesarean section, e.g. abnormal presentation, consider invasional radiologist’s elective insertion of catheters for uterine artery embolisation immediately pre-operatively and arrange blood salvage.
- The team of obstetricians, anaesthetists and midwives should be aware that a Jehovah’s Witness has been admitted.
- The third stage of labour should be actively managed with oxytocics with consideration of prophylactic syntocinon infusion.
- Consider delayed cord clamping 1-2 min for pre-term infants to maximise Hb, with controlled cord traction after placental separation.
- Check patient’s vital signs and evidence of uterine contractions every 15 min for 1 to 2 hours after delivery.
- Contact the hospital liaison committee for Jehovah’s Witnesses in an emergency (contact details over page).

Management of active haemorrhage

First step: AVOID DELAY. Involve obstetric, anaesthetic and haematology consultants. Establish IV infusion, along with uterine massage (every 15 min for 1 hour to reduce blood loss). Give oxytocics first, then excise retained products of conception or tissued (shave, if safe and feasible). Proceed with bimanual uterine compression. Give oxygen. Catherise and maintain urine output (Consider CVP line). Slow, but persistent blood loss requires action. Anticipate coagulation problems. Keep patient fully informed. Proceed with follow-up strategies of bleeding continues:

Oxytocics: Fenoterol with oxytocin (Syntocinon): Marginally more effective than oxytocin alone. If patient is hypotensive, use oxytocin 10U (not 5U) slow IV injection (in serious PHF the benefits of higher dose outweigh the risks). Carboprost (Hemabate) 250mcg in 250ml normal saline over 1hour. If not effective, IM desmopressin (DDAVP), 0.3mcg/kg in 100ml Lactated Ringer’s solution. Mepivacaine (Carbocaine): Useful as an option in atomic PHF where first-line treatment has failed. Can be given either by sub-lingual (600-800mcg) or rectally (100-1000mcg) or intravenous route (800mcg). Control of haemorrhage reported for rectal and intravenous routes when non-possible to oxytocin, ergometrine and carboprost.

Intravenous balloon tamponade: Have available purpose-designed 500 ml Balloon tamponade balloon (Cook medical). Drainage of blood and evacuation of bleeding can be observed via the catheter drainage shaft. Continue oxytocics. Expulsion of balloon can be prevented by vaginal packing. To minimise bleeding risk during removal, use graduated deflation or slowly deflate to half volume and observe; if no bleeding, continue deflation; if bleeding starts, reinflate. Alternatively, stomach balloon of Sengstaken-Blakemore oesophageal catheter has controlled bleeding in 64/435 cases (62 studies), in the majority of successful cases bleeding was due to uterine atony and/or end of the basal second should be cut off to reduce risk of occlusion or perforation. Indwell time of balloon averaged 24 hours. Balloon also used to control PHF due to vaginal lacerations.

Non-inflatable tamponade: Recently developed neoprene Velcro-fastened garment (moonsage.com) can be applied in 2 min and allows perineal access for obstetric procedures. Can reduce blood loss and reverse hypovolaemic shock within minutes by the transfer of 0.5 to 1.5 litres of blood from the lower body and abdomen to the vital organs. Can stabilise the patient and gain time while awaiting senior staff input. Successfull trials have been conducted with > 400 women experiencing PHF in developing countries.

Recombinant factor VIIa (Novo Seven): Increasing evidence of effectiveness for control of PHF unresponsive to standard therapies. This product and the following haemostatic agents should be used under consultant guidance. 90mcg/kg provides safe, specific thrombin generation, repeat if necessary. Successfully used to stop or reduce bleeding in 88% of 118 massive PHF cases. Also to control bleeding in 17 anecdotally PHF cases complicated by DIC. (Novo Nordisk have 24-hour emergency distribution for UK-wide delivery [01888 565652] or a small stock can be held to avoid delivery delay.) Occasional failure of FVIIa has been attributed to a low fibrinogen level. The fibrinogen concentrate Hemospermat (a plasma derived alternative to cryoprecipitate) available on a named-patient basis within 24 hours from CSL Behring, 01444 474400 can enhance clot strength and normalise clotting in the presence of FVIIa.

Other haemostatic agents: Prothrombin in complex concentrates (PCCs) such as Beriplex and Octaplex (plasma-derived), are used as substitutes for fresh frozen plasma and are widely prescribed as such in Europe. Beriplex reported to achieve control of bleeding in cardiac and other surgery. Tranexamic acid (Cyklokapron): anti-fibrinolytic agent well established for controlling haemorrhage, use 1gm IV x 5ths, slowly. Fibrin sealants: Flowflect used to arrest massive bleeding in surgical bed following hysterectomy; Tissueal has controlled bleeding from complicated vaginal and perineal lacerations when surgery haemostasis is failed due to tissue friability. Also consider IV vitamin K.

B-Lynch uterine compression suture: The B-Lynch brace suture can also be combined with intravenous balloon catheter if bleeding persists. Prophylactic insertion of this suture has been used in high-risk caesarean sections. The Hayman technique: may be a simpler procedure and quicker to apply in the lower uterine segment in not opened.

Embolisation/ligation of internal sac arteries or embolisation/lateralisation of uterine vessels: Angioplasty balloon catheters can be used for emergency temporary occlusion in theatre, with transf for the angiography suite for definitive embolisation.

Hysterectomy and care in theatre: Subtotal hysterectomy can be just as effective, also quicker and safer. Use Floretox or Endoloop to decrease risk of DVT. Avoid hypothermia (impairs coagulation), use fluid warmer, warmer gowns, hats etc. Avoid unnecessary over-vigour. Have blood salvage and experienced operator on hand (see below).

Intrauterine balloon catheter: Endorsed by NICU (2005) and RCOG (2008) guidelines, should be set up whenever possible (check if acceptable). Either single lumen or dual lumen catheter can be used for collection. However, to maximise blood recovery, there is good evidence that single sucker is a safer procedure. Suck with swab also increases RBC recovery. 'A bottle only' set-up of the collection system will enable blood salvage to begin within minutes. Conventionally, a leukocyte filter has been used to remove them, though in an emergency situation the filter may be removed to maximise the flow rate, prior to availability of filters to avoid adverse events were reported. There are clinical decisions based on the balance of benefit/risk.

Management of postpartum anaemia—continued over page
Management of postpartum anaemia

IV iron should be considered for severe anaemia as oral iron is known to be slow and unreliable. In a randomised controlled trial of 64 women with postpartum anaemia, significantly higher mean haemoglobin and ferritin levels from baseline were achieved for patients on IV iron (200 mg x 2, 48 hours apart) in comparison to those on oral iron (mean Hb day 5: IV vs oral iron 2.5 ± 0.7 g/dL vs 1.4 ± 0.3 g/dL, p < 0.001 for both periods). Comparable results for IV iron were reported in 2 similar trials (mean Hb 2.8 ± 0.3, 3.1, both day 14). These increases in Hb from baseline with IV iron exceed the expected rise after 2 U blood transfusion. The level of life-threatening anaemia is a consequence of unusually high rates of uterine iron preparations is now very low, varying from 0.6 to 3.3 percent, depending on the iron preparation (FDA, 2004). Erythropoietin-stimulating agents (ESA) should be administered together with IV iron in life-threatening anaemia to further accelerate erythropoesis. A once weekly EPO dosage of 300 IU/kg subcutaneously (e.g. 40,000 IU/for a 66 kg patient) is being increasingly used and found to be satisfactory in critically ill anaemic patients. An EPO dosage of 200 IU/kg x 3 weekly together with IV iron (200 mg x 3 weekly) has also proved effective for postpartum anaemia—augmentation with vitamin B12 and folic acid.

Check oxygen saturation: Give 100% oxygen if necessary (no oxygen limitations for 48-72 hours of use). Use microsampling techniques to conserve blood (e.g. Hemocue), as well as paediatric sample tubes. Ibf leading continues until reassuringly increased urinary output.

Hyperbaric oxygen therapy: Option in life-threatening anaemia. (0.15-0.6 bar 8000 [24 hr] for suitable and available centers.)

References:

### Appendix 2 – An Example of Advance Decision to Refuse Specified Medical Treatment Form

**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 ministered 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
   - ____ 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):

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

Name

Occupation

Address

Signature of witness

Name

Occupation

Address

Telephone

Mobile

Telephone

Mobile

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)
Appendix 3

Form To Be Completed For All Obstetric Patients Who Refuse Consent For Blood and Blood Product Administration, Including Jehovah’s Witnesses

This form must only be used for the refusal of blood products by adults, who have capacity to consent or refuse treatment.

To be completed by the patient

(Please read carefully before completing and signing form and ask any questions you may have of the health care professional reviewing this form with you)

Please clearly tick where applicable:

☐ I am a Jehovah’s Witness

☐ I carry a Health Care Advance Directive. I have discussed this with the health care professional completing the Blood Product Refusal Form with me

☐ I am not a Jehovah’s Witness and I have chosen to refuse blood product transfusion or products

Please sign and date in the appropriate box below (I will accept/I will not accept) for every product listed. If you have any questions, see the reverse of this form or ask your doctor or midwife.

<table>
<thead>
<tr>
<th>Blood (packed Red Cells)</th>
<th>I will accept</th>
<th>I will NOT Accept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh Frozen Plasma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cryoprecipitate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Albumin Solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell salvaged blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(not a continuous circuit).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor VII (7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(NovoSeven)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient’s declaration

I confirm that I have been informed about the available alternatives to blood/blood product transfusion and/or blood conservation methods, if applicable to the clinical situation, including their effectiveness and the risks. I understand the information that I have been given.

I withhold my consent to the blood-related options indicated above in relation to all operations, investigations or treatment that I may undergo until I withdraw my refusal either by completing the box at the end of the form, or by expressing this wish orally to a Health care professional. The implications of this have been explained to me and I understand them.

My refusal of blood and any blood components stated above will remain in force even if I become unconscious and/or affected by medication, or any condition rendering me incapable of expressing my wishes and consent to treatment options.

I intend to refuse blood and blood components stated above even if the clinician/s treating me consider them NECESSARY TO SAVE MY LIFE.

I understand and accept that by refusing the products as signed above, I risk SERIOUS LONG TERM INJURY AND DEATH, that might be avoided by the administration of blood and/or blood products.

I intend to refuse blood and blood components stated above even if the clinician/s treating me consider them NECESSARY TO SAVE THE LIFE OF MY BABY.

I understand and accept that by refusing the products as signed above, I risk SERIOUS LONG TERM INJURY AND DEATH TO MY BABY, that might be avoided by the administration of blood and/or blood products.

I fully understand the implications of my position, and the implications for my baby, regarding blood/ blood component transfusion and am exercising my own choice, free from any external influence.

Signature of patient: ........................................................... Date: ........................................

Name (print): ..........................................................

To be completed by health care professional

I confirm that I am a health care professional with sufficient knowledge about the issue and implications of consent to blood products to properly inform the patient about the matters contained in this form. A full note of the discussions with the patient has been made in their medical records, clearly giving a date and time of the explanation, including details of the person giving it.
I confirm that I have considered the patient’s capacity and I am satisfied that they have the capacity to refuse blood and any blood components.

I have confirmed with the patient that they have no further questions and that they understand the implications of signing this refusal form to their life, and to the life of their baby.

Signature of Health Care Professional: ………………………….. Date: ………………………………
Name and Title (print): ………………………………………………………

If the patient later decides to withdraw refusal and decides to accept blood and/or blood component transfusion:

Patient sign and date (unless oral consent given): ……………………………………………………………
Health Care professional sign and date: …………………………………………………………………………………

Explanation of Products

Blood (Packed Red Cells)
This is human blood with most of the cells (white blood cells, platelets, clotting factors) removed and a nutritive solution added. Red blood cells carry oxygen around your body. A transfusion can be lifesaving.

Fresh Frozen Plasma
This is a part of human blood which is separated from the red cells and contains clotting factors. A transfusion can help significantly with controlling bleeding and can therefore be lifesaving.

Platelets
These are small bits of cells taken from whole human blood. They help with clotting. A transfusion can help significantly with controlling bleeding and can therefore be lifesaving.

Cryoprecipitate
This is a part of human blood that contains clotting factors. A transfusion can help significantly with controlling bleeding and can therefore be lifesaving.

Human Albumin Solution
Albumin is a protein found in blood. It is taken from whole blood and given to a patient with very low albumin. In very sick patients, albumin can be a helpful treatment.

Cell Salvage
When surgery creates bleeding, this blood can be sucked up from the surgical site, washed and transfused back to the patient through a vein. The blood is yours and does not leave the room. A continuous circuit between yourself and the suction machine can be attempted in a planned procedure, but not be guaranteed in an emergency.

Recombinant Factor VII (NovoSeven)
Factor VII is an important clotting factor that helps stop bleeding. It is made in a laboratory and is not taken directly from blood, nor does it contain blood products. The DNA code that is used to make it was originally taken from human cells.
Monitoring and Audit

**Audit standards:**
Please refer to audit tool, location: ‘Maternity on cl2-file11’, Guidelines

**Reports to:**
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Directorate Clinical Governance & Risk Management Committee

**Frequency of audit:**
Annual

**Responsible person:**
Senior midwife

Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping
Antenatal Guideline 35 - Risk assessment of low- and high-risk antenatal care pathways
Antenatal Guideline 44 - Guideline development within the Maternity Services
Intrapartum Guideline 18 - Obstetric haemorrhage
Postnatal Guideline 9 - Postpartum haemorrhage

Hospital Transfusion Policy – Derriford Hospital

References


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