Policy for the Treatment of Patients who Decline Blood and Blood Components

Classification:	Policy
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Authors Division:	Core Clinical
Departments/Group this Document applies to:	All clinicians and practitioners involved in the care of the patient declining blood or blood components

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Policy to be followed by (target staff): Doctors, Nurses, Midwives, Allied Health Professionals

To be read in conjunction with the following documents:

Milton Keynes University Hospital NHS Foundation Trust (2022) Advance Care Planning Policy for Patients Approaching the End of Life, PALCAR/GL/04, Version 1.2 [Online] Available at: https://mkuhcloud.sharepoint.com/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/End%20Of%20Life%20Care/EOLC%20Polices%20and%20guidelines/Advance%20Care%20Planning%20for%20Patients%20Approaching%20End%20of%20Life.pdf [Accessed 27 January 2023]

Milton Keynes University Hospital NHS Foundation Trust (2022) Blood Transfusion Policy for Administration of Blood, Blood Components and Blood Components and the Management of Transfused Patients. PATH/GL/03, Version 10 [Online] Available at: https://mkuhcloud.sharepoint.com/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Blood%20transfusion/Blood%20transfusion%20policies%20and%20guidelines/Blood%20Transfusion%20Policy.pdf [Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust (2020) Major Haemorrhage Management. PATH/GL/05. Version 8.2 [Online] Available at: https://mkuhcloud.sharepoint.com/:b:/r/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Pathology/Pathology%20Polices%20and%20Guidelines/Major%20H

aemorrhage%20Management.pdf [Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust (2019) Mental Capacity & Deprivation of Liberty Safeguarding (DoLS) Policy, ORG/GL/55, Version 2.0 [Online] Available at: https://mkuhcloud.sharepoint.com/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Safeguarding/Mental%20Capacity%20amd%20Deprivation%20of%20Liberty%20Safeguarding%20(DoLS)%20Policy.pdf
[Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust (2021) Paediatric Blood Transfusion Guideline (for the Administration of Blood & Blood Components and the Management of Transfused Patients. PATH/GL/20. Version 5 [Online] Available at: https://mkuhcloud.sharepoint.com/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Pathology/Pathology%20Polices%20and%20Guidelines/Paediatric%20Blood%20Transfusion%20.pdf [Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust. Policy & Guidelines for Consent to Examination or Treatment (2020) DOC82, Version 11 [Online] Available at: https://mkuhcloud.sharepoint.com/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Consent/Policy%20and%20Guidelines%20for%20Consent%20to%20Examination%20or%20Treatment%20amended%20for%20blood%20transfusion.pdf [Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust (2022) Risk management framework. RM/GL/11. Version 9 [Online] Available at: https://mkuhcloud.sharepoint.com/:b:/r/sites/TrustDocumentation/Non%20Clinical%20Documentation/Risk%20Management/Risk%20Management%20Polices%20and%20Guidelines/Risk%20Management%20Framework.pdf?csf=1&web=1&e=ZLlf5P
[Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust. Safeguarding Adults Policy (2019) ORG/GL/51. Version 4.2 [Online] Available at: https://mkuhcloud.sharepoint.com/:b:/r/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Safeguarding/Safeguarding%20Adults%20Policy.pdf?csf=1&web=1&e=poM6y4 [Accessed 30 January 2023]

Milton Keynes University Hospital NHS Foundation Trust. Safeguarding Children Policy and Procedures (2019) ORG/GL/25. Version 11 [Online] Available at: https://mkuhcloud.sharepoint.com/:b:/r/sites/TrustDocumentation/Trust%20Documentation%20%20policies%20guideslines%20patient/Safeguarding/Safeguarding%20Children%20Policy%20.pdf?csf=1&web=1&e=wUrgEz [Accessed 30 January 2023]

Caring for patients who refuse blood - a guide to good practice — Royal College of Surgeons (rcseng.ac.uk)

CQC Fundamental standards:
Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 17 – Good governance

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the policy, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Policy Statement

This document has been produced to ensure that MKUH NHS Foundation Trust supports all patients with cultural, spiritual or personal beliefs which impact on their willingness to receive blood components (i.e. red cells, white cells, platelets, plasma).

It should be recognised that the guidance offered within this document is equally applicable to groups or patients (other than Jehovah's Witnesses) and should be considered in the management of other patient groups or individual patients.

To support and provide information to nurses/midwives and clinicians about the management of those patients declining blood/blood components.

At present, there is no legal requirement in the UK to gain formal written consent from the patient for a transfusion. It is however, good clinical practice to discuss treatment options with the patient before reaching a decision to prescribe blood components and to document this discussion in the patient medical records. The Advisory Committee on the Safety of Blood, Tissue and Organs (SaBTO, 2011, p2) recommend that valid consent for transfusion should be obtained and documented in the patient's clinical records by the healthcare professional. The GMC standard for consent also applies.

Jehovah's Witnesses are a religious denomination that believes that the transfusion of blood or its major components is prohibited by scripture. When a Jehovah's Witness presents for treatment, staff concerned should discuss with them their individual wishes and beliefs and their relevance to the proposed treatment and of the non-blood, medical alternatives to transfusion that may be applicable. Jehovah's Witnesses are encouraged to carry a signed Advance Decision to Refuse Specified Medical Treatment (ADRT) (see Appendix 3) at all times which details their wishes about medical care in the event of being incapacitated. It may also be that they are happy to receive some blood components.
Please be aware that it is not only Jehovah's Witnesses who may decline blood components for transfusion, it could be anyone for any reason at any time. Christian Scientists are another religious group who may decline blood /blood components. Whatever the views of the clinicians involved, if a patient being of sound mind declines to consent to a blood/blood component transfusion their beliefs should be respected and upheld.

'Every patient has the right to be treated with respect and staff must be sensitive to their individual needs, acknowledge their values, beliefs and cultural background. Some patients, their family members or friends are very worried about the risks of blood transfusion, especially transfusion transmitted infection, based on reports in the media or anecdotal experience. Others decline transfusion of certain blood components based in their religious beliefs' (*JPAC Transfusion Handbook, Section 12*)

It should be remembered that Jehovah's Witnesses and any patient declining blood components have the same right as any other person who makes an advance decision or declines treatment – i.e. they are able to withdraw or alter it at any time they have the capacity to do so. Should their wishes change, this should be documented and witnessed.

Abbreviations used

ADRTD – Advance Decision Document
BMS – Biomedical Scientist
DoLS - Deprivation of Liberty Safeguards
HLC Hospital Liaison Committee for
Jehovah's Witness
MCA - Mental Capacity Act (2005)
SOP – Standard Operating Procedure
SNOMED - Systematized Nomenclature Of Medicine – code used in e-care to record clinical information

Definitions

Advance Decision - This is a decision to decline specific medical treatment in advance. This is valid if made voluntarily by an appropriately informed adult with capacity. It must be in writing, and if the advance decision is to apply to life sustaining treatment, it must specifically say so and it must be in writing, signed and witnessed. It must also be applicable to the specific treatment proposed. The decision can be revoked by the patient at any time whilst the patient retains capacity to do so. The Mental Capacity Act (2005) (Sections 24-26) and its accompanying Code of Practice (Chapter 9) sets out the requirements of an Advance Decision.

Autologous Blood - Patient's own blood collected for re-infusion (e.g. Bellovac ABT)

Allogeneic Blood - Blood donated from another individual, which is typically stored and then provided through a transfusion.

1.0 Roles and Responsibilities:

All clinical staff must ensure the policy is followed whenever a patient declines a blood/blood component transfusion as part of their treatment.

Blood Transfusion Team
The Consultant Haematologist, Blood Transfusion Manager, Transfusion Practitioner (TP), as a whole, provide information and support for the clinical team involved with patients declining blood or blood components. The Blood Transfusion Team will, when made aware by the clinical team (via email - bloodtransfusion@mkuh.nhs.uk) of a patient declining blood and in receipt of appropriate documentation, place an alert on the Blood Bank computer system.
The Blood Transfusion Team will provide education to trust staff on procedures to follow should a patient decline blood/blood component transfusion.
Contact details **Appendix 1**

On Call Duty Consultant Haematologist
The On Call Duty Haematologist provides a 24 hour advisory service and can be contacted via the hospital switchboard.

Pre-assessment Unit Staff
The Pre-assessment Unit Staff will review all pre-op patients and will identify patients that wish to decline blood. They will e-mail the Blood Transfusion Team with the patient details, including date of surgery if available. **(Appendix 4a**) A copy of this form will be scanned to the patient's electronic record along with the pre- op assessment and the ADRT if available at the time.

They will place a notification on eCare by adding the required SNOMED code to the Problem list on eCare chosen from the following -
Administration of blood component declined or Transfusion of blood component declined for religious reason.
A flag of Patient Preference should be added under Classification and further details can be added in the comments box and more information added as a clinical note if required. (See Appendix 10 of this document)

Pre-op staff will offer the patient a "no blood" bracelet (refer to Appendix 9) if there is an ADRT.

They will also make the Consultant treating the patient aware of the patient's refusal of blood/blood components.

Medical Staff
Medical Staff will be responsible for explaining the risks and benefits of blood / blood component transfusion to patients, the indication for blood transfusion and for acknowledging the patient's right to decline to receive it.

Where appropriate, the Medical Staff will also need to give the patient information about alternatives to blood / blood component transfusion.
A record of this discussion should be documented in the patients' medical record. Medical Staff will ensure that a copy of the ADRT is available in the patient's medical notes/electronic record.
Place a notification on eCare by adding the required SNOMED code to the Problem list on eCare then choosing one of the following -
Administration of blood component declined or Transfusion of blood component declined for religious reason. A flag of Patient Preference must be added under Classification and further details can be added in the comments box and more information added as a clinical note if required.' (See Appendix 10 of this document)

Inform blood bank and ensure that this is highlighted in any handovers.
It is the Medical Staff's responsibility to complete the Consent Form and Checklist for All Patient's Declining Blood (PATH/FM26) Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) in this document whether or not a valid ADRT is available.
This form must be completed for each admission and is only for use for patients aged 18 or over.

Consultant
The Consultant of the patient needs to be aware that the patient is declining blood components as early as possible in the plan of care. They should be confident in their ability to treat the patient under these circumstances or refer them immediately to a Clinician/Anaesthetist who has specialist knowledge of this area. The Consultant treating the patient is responsible for completing the Patient Declining Blood/Blood Components Document (PATH/FM/26) Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) in this document) whether or not an ADRT is available. This form must be completed for each admission and is only for use for patients aged 18 or over. Check that a copy of the patient's ADRT is available in the patient's electronic record.
Place a notification on eCare by adding the required SNOMED code to the Problem list on eCare then choosing one of the following -
Administration of blood/blood component declined or Transfusion of blood/blood component declined for religious reason. A flag of Patient Preference must be added under Classification and further details can be added in the comments box and more information added as a clinical note if required.' (See Appendix 10 of this document)

For maternity service users an antenatal clinic appointment should be made to ensure the service user completes Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26).

Anaesthetist
If the patient is coming for surgery the Anaesthetist must allow for adequate planning and discussion with the patient and relevant teams

All Care Practitioners
All care practitioners are to make medical staff aware if a patient is declining a blood / blood component transfusion.
Nursing Staff will ensure that a copy of the ADRT and the Consent Form and Checklist for All patient's Declining Blood (PATH/FM/26) is put in the patient's electronic record and ensure the blood bank is informed of the patient's refusal of blood via email (bloodtransfusion@mkuh.nhs.uk)
The Nursing Staff will offer the patient a "no blood" bracelet (refer to Appendix 9) if either of these forms have been completed.

Biomedical Scientist (BMS)
The BMS will, when made aware by the clinical team of a patient declining blood, and in receipt of appropriate documentation, place an alert on the Blood Bank computer system.
The BMS will bring to the attention of Medical Staff requests from the clinical team for blood for patients with an alert indication stating "No Blood".

Patient's Declining Blood and Blood Components
Jehovah's Witness patients should carry with them an Advance Decision to Refuse Specified Medical Treatment (ADRT) or "blood card", which is legally binding if completed correctly **(Appendix 3).** In any event the Consent Form and Checklist for All Patients Declining Blood must be completed (PATH/FM/26)

It should be remembered that Jehovah's Witnesses and any patient declining blood components have the same right as any other person who makes an advance decision or declines treatment – i.e. they are able to withdraw or alter it at any time they have the capacity to do so. Should their wishes change this should be documented and witnessed.

See **Appendix 8** for the patient information leaflet "Patients declining blood/blood components"

Hospital Liaison Committee for Jehovah's Witnesses (HLC)

The HLC can be contacted 24/7 via switchboard, with the patient's permission, for support in assisting to manage Jehovah's Witnesses **(Appendix 2).**

The HLC can provide medical articles and information about the latest developments in both bloodless surgery, and medical management. They can provide a contact list of Consultants and physicians willing to work with Jehovah Witnesses without the use of blood components. In addition, the HLC can liaise between clinicians in order to share the benefit of experience and good practice. They also act as a resource for information regarding the beliefs and practices of Jehovah witnesses.

N.B. Staff should not give information to the HLC about an individual patient without obtaining the patient's prior consent for disclosure.

2.0 Implementation and dissemination of document

This document will be published on the Trust Intranet.

A copy of this policy will be sent to the Jehovah's Witness Hospital Liaison Committee to share with their members and reassure them that at Milton Keynes University Hospital NHS Foundation Trust, we are well prepared to support them in their choices. It is also made available to any patient wishing to decline blood and blood components as part of their outpatients/consultation pathway.

Management of patients who wish to decline blood is incorporated into the education for all clinical and nursing staff through the mandatory e-learning packages on ESR.

3.0 Processes and procedures

If any patient is identified as likely to require blood / blood components (i.e., their treatment requires a group and antibody screen), check with the patient if they have any objections about receiving a blood / blood components transfusion prior to taking the group and saving the sample.

Also refer to roles and responsibilities section 1.0 above

(Refer to Appendix 10 Refusal of Blood and Blood Components Flow Chart)

3.1 Management of Adults aged 18 or over

3.1.1 Elective cases

- During the outpatient consultation Jehovah's Witness patients or patients declining blood/blood components will be identified and a discussion will take place between the Consultant and the patient, regarding surgery and blood requirements.

- Jehovah's Witness are encouraged to carry a signed **"Advanced Decision to Refuse Specified Medical Treatment"** which should help the clinician understand the patients' decisions surrounding blood and blood components. Signed and dated copies should be kept in the patient's medical notes, as this document is legally binding if completed correctly **(Appendix 3).** A copy should also be sent to the Blood Bank or emailed to the Blood Transfusion Team to allow an alert to be entered on the pathology computer system.

- Patients with a valid ADRTD will also be required to complete Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) on which they can indicate which treatments they would be willing to accept.

- Patients with a **valid** ADRT and/or having completed Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) may wish to wear an orange "NO BLOOD" bracelet, which is available from the Transfusion Practitioners, Blood Bank, Pre-op assessment team or the site office.

- If identified as likely to require blood (i.e. their operation requires a group and antibody screen), a referral document notifying the Blood Transfusion Team of the patient's planned admission to the Trust must be completed and sent by email to the Transfusion Team which includes the Consultant Haematologist, Blood Bank Manager,

The Transfusion Practitioner and to the Consultant lead for the pre-assessment team and Anaesthetist (**Appendix 4a).**

- If the patient does not have an ADRT and is declining Blood/Blood components, irrelevant of their religious position, the Consultant will elicit the individual views of the patient and complete a Consent Form and Checklist for All Patient's Declining Blood (PATH/FM/26) A copy will be placed in the medical notes and a copy given to the patient (**Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26)**). A copy should also be sent to Blood Bank to allow an alert to be entered on the pathology computer system

Refer to **Appendix 5** flow chart for planned surgery

- The Consultant treating the patient needs to be aware of, and document clearly, the circumstances in which the patient would accept blood. If the patient wishes to place certain parameters around the acceptance of blood / blood components there should be clear discussion and this needs to be documented on form Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26)).

For those patients where pre-operative optimization of haemoglobin is key, please refer to the Pre-operative Care section of this policy **(Appendix 6).**
More information regarding pre-operative optimization can be found in in *Caring for patients who decline blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion* (Royal College of Surgeons of England, 2016)

https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/caring-for-patients-who-refuse- blood/

- All alternatives to allogeneic blood transfusion should be considered and discussed with the patient as appropriate.

A summary of alternatives can be found in (Appendix 7).

Note MKUH currently does not offer intra-operative cell salvage. Other hospitals may be able to offer other suitable alternatives.

3.1.2 Urgent elective cases

- In urgent elective cases the pre-assessment team will request an ADRTD and the patient's consultant will need to complete the Consent Form and Checklist for All Patient's Declining Blood (PATH/FM/26) Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26).
- In addition, the Duty Consultant Haematologist can be contacted for advice via the switchboard.

3.2. Gynaecology appointment

At a gynaecology consultation where there is a noted risk of hemorrhage or increased risk of anaemia due to current condition or planned procedure, the discussion of consent for blood and or blood components should be had. If the service user is declining blood and/or blood components please

complete appendix 3 and 4b and provide the patient information leaflet (appendix 8). Documentation on eCare for no blood alert needs to be completed see appendix 10. The service user should be offered on admission the chance to wear a no blood bracelet (see appendix 9).

In gynaecological cases such as surgical management of miscarriage, consideration should be given to giving timely and even prophylactic therapeutic measures such as ergometrine, haemobate, misoprostol.

3.2.1 Antenatal Booking Appointment

At booking the midwife will ask all service users if they are willing to accept blood/blood components and if they decline tick consultant led care on the antenatal booking referral form and arrange an urgent consultant care appointment.

- Discuss with the service user, that consultant led care is to ensure personalised antenatal care to assess risk factors for hemorrhage and plan for place of birth dependent on medical factors.
- Provide the service user with the patient information leaflet Information for adult patients who may wish to decline the use of blood/blood components (see appendix 8)
- Encourage supplementation of folic acid and vitamin D as per antenatal care pathway.
- Booking bloods are discussed with the service user - the blood group and antibody screen are for screening testing, all bloods require informed consent.
- At booking for all service users who are declining blood and/or blood components offer ferritin level test. If below 30µg/l will need early supplementation to prevent anaemia in pregnancy before birth. Result should be checked within 10 working days of the booking request by midwife.
- The full blood count result (to be checked within 10 working days of obtaining sample) if below 110g/l should have early supplementation and further testing for haematinics (ferritin, vit B12, folate, this can be performed by the midwife and review by GP/obstetric team within 10 working days, midwife to chase review).
- Maternity service users who have sickle cell disease should be offered folic acid 5mg dose along with iron supplementation as required and multidisciplinary approach to care with their named haematology consultant.
- Ensure if any ADRT, send a copy to EDM and clearly document that the ADRT has been seen.

3.2.2 Antenatal Care

Consultant led care for all service users who decline blood/ blood components.
Consultant appointment before 20 weeks gestation. The following should be completed.

- Complete Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) and add the alert to e-care (see appendix 10)
- Ensure service user has been given the patient information leaflet Information for adult patients who may wish to decline the use of blood/blood components (appendix 8)
- Advise regarding diet for improving iron levels within pregnancy
- Review Hb and ferritin and any current supplementation
- Only supplement if Hb below 110g/L in first trimester and 105g/L in second and third trimester.
- Offer regular Hb level checks at 28, 34 and 38 weeks gestation, if below 105g/l supplementation to commence and test haematinics (ferritin, vit B12, folate)
- Refer to anaesthetist for anaesthetic alert
- Assess risk factors for haemorrhage:

Antenatal risk factors for haemorrhage include:

Previous PPH	Fibroids/uterine abnormalities
Previous MROP	Placenta Praevia
Any APH	Placenta Accreta/ invasive placenta
BMI >35	Known bleeding disorders
Multiple pregnancy	Polyhydramnios
LGA over 95th centile	Previous major abdominal surgery

This list is not exhaustive please see obstetric haemorrhage guideline, and please note that not all service users who have a major obstetric haemorrhage will have risk factors.

It can occur with no risk factors

Known risk factors should be discussed and have an advised hospital birth, where access to medication and surgical intervention for haemorrhage is quicker and readily available compared to home environments.
If the maternity service user would like to birth outside of guidance, please refer to the people who choose care outside of guidance SOP.

Subject to the service user's consent, if they wish to consult local Hospital Liaison Committee for Jehovah's Witnesses, regarding alternative care and/or locating co-operative doctors at other facilities – ask haematologist or blood bank for the contact names/numbers

- Document plan for arrival for delivery this is to include:
  - Notifying the obstetric team when service user arrives and of any ADRT
  - If the service user is declining blood/blood components, irrelevant of their religious position or procession of an ARDT, the consultant/senior obstetrician/gynaecologist will elicit the individual views of the woman and complete Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26). A copy will be placed in the maternal records and given to the woman.
  - Inform the anaesthetic team of arrival and any ADRT.
  - Offer the service user a "no blood" wrist band
  - Identify any risk factors for haemorrhage – see obstetric haemorrhage guideline for list.
  - Active management of third stage recommended and needs to be discussed antenatally and
  - consent obtained.
  - Consider prophylactic oxytocin infusion following birth if any risk factors for haemorrhage had been identified.
  - If birth by caesarean section this should be performed by an experienced obstetrician with the consultant present in theatre.

If the service user would like to birth outside of guidance please refer to the people who choose care outside of guidance SOP.
If no medical/obstetric risk factors discuss the service user's intended place of birth, can be offered homebirth if no risk factors.

3.2.3 Intrapartum Care

- Notify the registrar of admission to maternity. In turn, the consultant obstetrician and anaesthetist should be made aware that a maternity service user who does not wish blood or blood components has been admitted in labour.
- It is essential that any risk factors that could pre-dispose to postpartum haemorrhage are identified. See Obstetric Haemorrhage Guideline for risk factors.
- If the service user is declining blood/blood components, irrelevant of their religious position or procession of an ARDT, the consultant/senior obstetrician/gynaecologist will elicit the individual

views of the woman and complete Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26). A copy will be sent to EDM and given to the service user.

- Active management of the third stage of labour is advised. The maternity service user should be cared for as per routine postnatal care as defined in postnatal care pathway.
- Consider prophylactic oxytocin infusion following birth if any risk factors for hemorrhage are present; refer to Obstetric Haemorrhage Guideline in respect of initial management.
- If a caesarean section is necessary this should be performed by an experienced obstetrician with the consultant obstetrician present in theatre.

- In elective and urgent cases when blood transfusion might be possible or likely, the following actions should be considered:

➢ Review non-blood medical alternatives and treat without using allogeneic blood

➢ Consult with other doctors experienced in non-blood management and treat without using allogeneic blood

➢ If necessary, transfer the service user to a doctor or facility before the service user's condition deteriorates, ie interventional radiology or transfer to a unit with tertiary level care dependent on the potential level of need required.

➢ Subject to the service user's consent if they wish to consult local Hospital Liaison Committee for Jehovah's Witnesses, regarding alternative care and/or locating co-operative doctors at other facilities – ask haematologist or blood bank for the contact names/numbers.

➢ In a life threatening emergency, the above actions should be followed whenever possible. If for any reason, this is not possible; the service user's wishes, if known to the medical or midwifery staff involved, are to be honoured. It is normal for Jehovah's Witnesses to carry an ADRT stating their views.

This document, if valid and applicable, is recognised as legally binding. An ADRT to or refusal of specific treatment is valid and applicable if made voluntarily by an appropriately informed person with capacity. The advice of the maternity unit manager, lead on call or clinical site manager can be sought out of hours, if necessary.

The above should also be considered in the management of retained placenta, third degree tears etc.

3.3 Emergency Surgery

- If a patient presents as an emergency admission requiring a blood transfusion, avoid delay and ensure a senior member of staff is contacted for assistance. The duty Consultant Anaesthetist and Haematologist must be notified (via the switchboard See appendix 1).
- In a life threatening emergency, the patient's view, if known to the medical or nursing /midwifery staff involved, should be honored. It is normal for a Jehovah's Witness to carry an "Advanced Decision Document to Decline Specified Medical Treatment" (ADRT) stating their views. The ADRT document is legally binding if completed correctly. If available, a copy, must be secured in the patient's medical record. A clearly signed, dated and timed entry outlining the patient's wishes must be documented in the patient's medical record
- The advice of the Duty Manager should be sought if necessary see appendix 1 for contact details
- If no ADRT is in existence, and the patient is conscious with mental capacity, and able to indicate verbally that they do not wish to have blood components, then their wishes must be respected and alternatives to allogenic blood should be considered. The patient's Consultant should be informed and they should complete Consent Form and Checklist for All Patient's Declining Blood (PATH/FM/26)
- If the clinician feels unable to successfully treat the patient without the use of blood components, then the patient should be notified of this fact immediately and of the fact that he/she may die without the administration of blood / blood components.
- The patient should, if possible, be transferred to the care of another Consultant who can provide alternative cover before his/her condition deteriorates or if appropriate and safe the patient may be referred to another hospital which can offer such care.
- In an emergency, a clinician is obliged to care for a patient in accordance with the patient's wishes
- Information on "Consideration of Alternative Procedures" can be found in Appendix 7 of this Policy. There is a link with further information on alternative strategies and procedures to establish optimum care.
- The advice of the Consultant Haematologist may be accessed via switchboard and asking for the on-call Consultant Haematologist (see Appendix 1).
- If the views of the patient are NOT known the medical staff must act in the best interests of the patient, which may include a transfusion with blood/blood components.
- Clinicians must consult with family members to ascertain whether the patient objects to blood / blood components transfusions and whether the patient has an advance decision in place or if there is a lasting power of attorney. The Mental Capacity Act 2005 must be followed if the patient lacks capacity.

3.4 For the unconscious patient

- If an unconscious patient presents requiring a blood transfusion and is found to carry an appropriately completed ADRT confirming that he/she specifically declines consent to the use of blood components, then blood components should not be used.
- This document releases the clinician from any liability for the possible consequences of refusal if the ADRT is found on the patient or produced by relatives. It must be respected as it is legally binding.
- If available, the ADRT, or a copy, must be placed in the patient's medical notes. A clearly signed, dated and timed entry outlining the patient's wishes must be documented in the medical notes accordingly
- If a patient is unconscious and has no written material on him/her to suggest that he/she specifically declines consent to the use of blood components, a transfusion should be avoided or postponed for as long as possible without compromising the life of the patient.
- Thoroughly check the patient's medical notes for evidence of an ADRT, specifically declining blood/blood components.
- During this time the clinician should ask those claiming that the patient is a Jehovah's Witness to furnish documentary evidence of the patient's refusal of blood components, if such exists. It is not uncommon for Jehovah's Witnesses to lodge a copy of their advance decision with their GP, their local congregation, witnesses to the signing of the ADRT, or the Hospital Liaison Committee for Jehovah's Witnesses (HLC) who should also be contacted. Contact details can be found in Appendix 2 of this policy or via the switchboard.

Where the patient is stable, reasonable enquiries must be made of whether an ADRT or Lasting Power of Attorney (LPA) is in force and applicable, whilst ensuring the wellbeing of the patient as much as possible. If no such ADRT is available, or the views of the patient are unknown, the clinician must act in the best interests of the patient. Treatment that is necessary to preserve life, health or well-being may be given without consent, which may involve giving blood/blood components if there is no ADRT or LPA present.
Emergency Surgery is covered in Section 3.2 above.

See section 3.6 in this document and MKUH *Mental Capacity & Deprivation of Liberty Safeguarding (DoLS) Policy* (ORG/GL/55)).

Wherever possible the relatives or associates should be kept informed of the steps being taken and these must be clearly documented in the patient's medical notes.

The relatives or associates of a patient aged 18 or over have no legal right to decline treatment on the patient's behalf in the absence of a signed ADRT, unless a personal welfare Lasting Power of Attorney (LPA) is in force and the attorney is authorised to make the particular decision in accordance with the Mental Capacity Act 2005 (as amended) and Code of Practice.

3.5 Children / Young Persons

Children under the age of 16 years may consent to treatment (including blood transfusions) if "the child has sufficient maturity, understanding and intelligence to enable him/her to fully understand the treatment proposed." These patients are known as "*Gillick* competent". Competence must be assessed on a continual basis.

For a young person under the age of 16 to be competent he / she should have

- The ability to understand that there is a choice and choices have consequences;
- The ability to weigh the information and arrive at a decision;
- A willingness to make a choice;
- An understanding of the nature and purpose of the proposed intervention;
- An understanding of the risks and side effects;
- An understanding of the alternatives and the risks attached to them;
- Freedom from undue pressure.

Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can, in some circumstances be overridden by a parent, someone with parental responsibility or a court.

The relevant section of GMC guidance on consent (Making decisions - ethical guidance - GMC (gmc-uk.org) says:

24. You must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having the treatment. Only if they are able to understand, retain use and weigh this information, and communicate their decision to others can they consent to that investigation or treatment. That means you must make sure that all relevant information has been provided and thoroughly discussed before deciding whether or not a child or young person has the capacity to consent.

25. The capacity to consent depends more on young people`s ability to understand and weigh up options than on age. When assessing a young person`s capacity to consent, you should bear in mind that:

a) At 16 a young person can be presumed to have capacity to consent
b) A young person under 16 may have the capacity to consent, depending on their maturity and ability to understand what is involved.

26. It is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision made. You should remember that a young person who has the capacity to consent to straight forward relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risk or serious consequences. The capacity to consent can also be affected by their physical and emotional development and by changes in their health and treatment'

Documentation to support the consent must be recorded in the medical notes.

Although it should be noted that if the young person themselves is expressing the view that they do not want a blood transfusion or blood components given to them, support from an independent child advocate should be sought. This will ensure they have a voice in the care they are receiving.

If a patient under 16 years is seen in pre-assessment and identified as a Jehovah's Witness, the Pre-assessment Team will liaise with the patient's consultant and complete form 4a once surgery is confirmed. A copy will also be sent to the transfusion team

The pre –op team must also make the Safeguarding Children Team aware of the young person and when they are being admitted for surgery (see Appendix 1 for all contact details).

The following plan will be adopted in caring for any child or neonate whose parents are Jehovah's Witnesses.

The paediatric team will fully explore options for utilising bloodless medicine and surgery in order to treat without recourse to allogeneic blood components. This must include careful assessment of the benefits and risks of all management options followed by detailed discussion with the parents.

If elective or urgent treatment for a child with blood or blood components is felt essential by medical staff, against the wishes of parents or guardians, the following questions should be addressed:

- Have the risks of using blood been fully considered?
- Have all non-blood medical management options been fully explored?
- Has the Hospital Liaison Committee for Jehovah's Witness been asked for assistance (if applicable)?
- Is there another Hospital willing to treat without blood?
- Has the voice of the child been considered?
- Is there an urgent requirement for blood?

The parents and the child must receive comprehensive counselling by the medical staff concerning the immediate or anticipated transfusion requirement. All communication must be clearly documented in the notes.

If the person with parental responsibility of an incompetent child is firmly opposed to the giving of blood or blood components and the clinical team believes that giving the blood or blood components is necessary, in the child's best interests, an application to the High Court for a Specific Issue Order in accordance with Section 8 of The Children Act 1989 should be sought. The Trust's solicitors will normally carry this out and the Trust Litigation Department should be contacted as soon as possible once this scenario arises.

- Before this step is taken, two doctors of Consultant status should make an unambiguous, clear and signed entry in the medical records that the blood transfusion is essential, or likely to become so, to save life or prevent serious permanent harm.
- A statement will be prepared by a Consultant and sent to the Trust solicitors.
- It needs to be proven that the child's need for treatment is so overwhelmingly for his/her welfare that the parents' wishes and young person's wishes must be overridden.
- The parents must be kept fully informed and offered as much support and information as required to support the decision making process, recognising clinical factors that may impact on the condition of the child.
- The Children's Social Care must be made aware of the situation. Ring the MASH in normal working hours 01908 253169 and out of hours 01908 265545 (see Appendix 1).
- In normal working hours the safeguarding team should be contacted for support (see Appendix 1).
- To help a young person get their views and wishes across to make an informed decision, Coram Voice advocate for young people in Milton Keynes. Their contact details are Tel 0808 800 5792 Text 07758 670 369 E-mail help@coramvoice.org.uk (see Appendix 1).

Jehovah's Witnesses has medical information relating to

paediatrics for clinicians at: https://www.jw.org/en/medical-

library/neonatal-pediatric-medicine-bloodless/

Note: The clinician only needs the consent of one person with parental responsibility and both parents do not have to agree. However, if a parent with parental responsibility objects to treatment with blood/ blood components, an application to the Family Division of the High Court may be required. Legal advice should be obtained from the Trust's Litigation Department.

Paras 12-18 Law in a recent judgment [2019] EWHC 1671 (Fam)* should be helpful in reviewing the above, citing as it does previous cases. [2019] EWHC 1671 (Fam) was an urgent application to the High Court "to decide on an urgent basis whether it is in T's best interests to be treated by way of blood transfusion in circumstances where consent for such treatment is not forthcoming from his mother, who is a committed and conscientious Jehovah's Witness." ([2019] EWHC 1671 (Fam), 1)
* *Cardiff and Vale University Health Board v T (A Minor) (Urgent Blood Transfusion) [2019] EWHC 1671 (Fam) (21 June 2019)*
http://www.bailii.org/ew/cases/EWHC/Fam/2019/1671.html

Contact MKUH Litigation Department for further

information/assistance via the switchboard or Clinical Governance (See Appendix 1).

Further information can be found in Safeguarding Children Policy

3.6 Emergency or life-threatening situation with a child

If, in an exceptional and imminently life-threatening circumstance, it is felt that a delay in treatment with blood or blood components might be fatal, a decision to proceed with treatment, against the wishes of parents or guardians, should be made by two practitioners of Consultant status who are fully informed of the situation and appropriately aware of alternative forms of treatment. The clinician may face criminal prosecution if a child comes to harm because treatment was deliberately withheld.

In such circumstances the details should be comprehensively documented and the Trust Litigation Department informed as early as possible.

Further information can be found in Safeguarding Children Policy

3.7 Patients Lacking Mental Capacity

(Also see section 3.3 in this document the unconscious patient)

If the treating clinicians think that a patient lacks capacity to consent to declining blood and blood components, you should refer to Mental Capacity Act 2005 (MCA (2005)) and the Mental Capacity Act Code of Practice. (Department for Constitutional Affairs, 2007).

Also refer to:

Safeguarding
Adults Policy
Safeguarding
Children Policy

If the patient is deemed to lack capacity to make an informed decision about receiving blood and blood components but already has a valid and applicable ADRT made at an earlier time when they had capacity, the content of the Advance Decision MUST be respected.

Capacity is decision specific. If the patient is found to lack capacity to consent to receiving blood and blood components, reasonable efforts should be made to determine if an advance decision document exists. This includes discussions with the next of kin. The patient may have appointed a personal welfare Lasting Power of Attorney (LPA) to make healthcare decisions for them when they became unable to do so. It is important to see the registered LPA form if this is the case.

If the LPA was made after an Advance Decision, the attorney can override the Advance Decision, unless the LPA says otherwise (*see Mental Capacity Act 2005 Code of Practice Chapter 7 – in reference list*).
If person does not have any family or close friends, an Independent Mental Capacity Advocate (IMCA) will be required. *Refer to MCA (2005) & DOL'S Policy*.

If treatment is felt to be in the best interests of the patient, then the following questions should be answered beforehand.

- Have the risks of using blood been fully considered?
- Have all non-blood medical management options been fully explored?
- Has the Hospital Liaison Committee for Jehovah's Witnesses been asked for assistance (if applicable)?
- Is there another hospital willing to treat without blood?
- Has the mental incapacity of the patient been fully documented?
- Is there an urgent requirement of blood transfusion?

All communication with the patient, relatives and representatives must be clearly documented in the medical notes.

3.8 Management of Medical patients declining blood components

Since the presentation of medical patients can be so varied, the management of medical patients declining blood components will be dependent on the symptoms and diagnosis of each individual case.
Doctors should be aware that all patients have a right to clinically appropriate treatment, and in some cases, if patients decline blood components this can pose challenging situations.
All doctors are advised to contact the Consultant Haematologist at the earliest opportunity to clarify what treatments may be available for each individual patient dependent on their individual problems and requirements.

3.9 Post-operative Management

The key to effective management is vigilance:

- Observe patient closely for any signs of bleeding and employ early intervention as necessary;
- Maintain strict fluid balance;
- Consider intensive therapy/high dependency care if close observation is required;
- Maintain oxygenation;
- Restrict phlebotomy to prevent iatrogenic blood loss;
- Continue iron therapy and stimulation of red cell production if required. It is recommended that iron therapy be maintained for a minimum of three months from restoration of normal haemoglobin values;
- Avoid and promptly treat infections to reduce secondary postoperative haemorrhage;

- Ensure prompt consultation with specialists experienced in non-blood management if complications arise and, consider transferring a stabilised patient, to a major centre before the patient's condition deteriorates

Further information can be found in Caring for patients who decline blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion (Royal College of Surgeons of England, 2016)
https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/caring-for-patients-who-decline- blood/

3.10 Jehovah's Witnesses Position on Medical Treatment

Acceptable Medical Treatments

Jehovah's Witnesses generally accept most medical treatments, surgical and anaesthetic procedures, devices and techniques, as well as haemostatic and therapeutic agents that do not contain blood:

- Non-blood volume expanders such as crystalloids (e.g. Saline, Hartmann's, Dextrose) and colloids (e.g. Gelatin, Dextran, Hetastarch).
- Techniques such as Hypotensive Anaesthesia, meticulous haemostasis and diathermy.
- Agents such as Erythropoietin (e.g Eprex and Neorocormon), Aprotinin, Desmopressin, Vasoconstrictors and Recombinant Factor VIIa.

Although this is generally recognised to be acceptable to most Jehovah's Witnesses, these should be discussed with the patient on an individual basis.

Matters of patient choice

Each Jehovah's Witness will decide whether he or she wishes to accept the following as a matter of personal choice. It is essential therefore to discuss the acceptability of the following procedures with each individual patient:

- (Autologous procedures) Intra-operative and post-operative cell salvage and haemodialysis.
- Plasma components (e.g. albumin, immunoglobulins, anti-D, clotting factors, vaccines).

Unacceptable Medical Treatments
The following treatments are unacceptable to Jehovah's Witnesses, although this should be ascertained on an individual basis:

Transfusions of whole blood, packed red cells, white cells, plasma (FFP) and platelets.
See **Appendix 7** of this Policy for alternatives to blood transfusion

Blood test for Group and Screen - consider using paediatric sample bottle if the patient is very anaemic

4.0 Statement of evidence/references

Statement of evidence:

Association of Anaesthetists [2019] Anaesthesia and peri-operative care for Jehovah's Witnesses and patients who decline blood: online supporting information. [Online]. Available from: https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/full/10.1111/anae.14441 [Accessed 27 January 2023]

British Medical Association (2021) Assessing competence. In: British Medical Association Children and young people ethics tool kit. [Online]. Available from: https://www.bma.org.uk/media/4666/bma-children-and-young-people-ethics-toolkit-oct-2021.pdf [Accessed 30 January 2023]

Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice. [Online]. London: TSO. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf [Accessed 30 January 2023]

Department of Health and Social Care (2020) Independent report. Blood transfusion: patient consent. Recommendations from the advisory committee on the Safety of Blood, Tissues and Organs (SaBTO) on patient consent for blood transfusion [Online]. Available from: https://www.gov.uk/government/publications/blood-transfusion-patient-consent [Accessed 30 January 2023]

Doberne JW, et al (2022) Bloodless HeartMate 3 explantation and orthotopic heart transplant in a heart failure patient refusing blood products, *Journal of Heart and Lung Transplantation* [Online]. Available from: https://www.clinicalkey.com/#!/content/journal/1-s2.0-S1053249822020721 [Accessed 30 January 2023]

General Medical Council (2020) Guidance on professional standards and ethics for doctors: Decision making and consent [Online]. Available from: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent [Accessed 30 January 2023]

General Medical Council (2018) 0–18 years: guidance for all doctors https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years (accessed 20 February 2023)

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Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) (2014) Transfusion handbook. [Online]. 5th ed, web version. Available from: https://www.transfusionguidelines.org/transfusion-handbook [Accessed 30 January 2023]

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) (2014) 6: Alternatives and adjuncts to blood transfusion. In: JPAC Transfusion handbook. [Online]. 5th ed, web version. Available from: https://www.transfusionguidelines.org/transfusion-handbook/6-alternatives-and-adjuncts-to-blood-transfusion [Accessed 30 January 2023]

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) (2014) 12: Management of patients who do not accept transfusion. In: JPAC Transfusion handbook. [Online]. 5th ed., web version. Available from: https://www.transfusionguidelines.org/transfusion-handbook/12-management-of-patients-who-do-not-accept-transfusion [Accessed 30 January 2023]

Jung J, et al (2022) Patient blood management when blood is not an option: a report of two cases. *Annals of palliative medicine*, Vol. 11, Iss. 8 [Online]. Available from: https://apm.amegroups.com/article/viewFile/87988/pdf [Accessed 30 January 2023]

National Institute for Health and Care Excellence (2015) Blood transfusion. [NICE guideline NG24]. [Online]. Available from: https://www.nice.org.uk/guidance/NG24 [Accessed 30 January 2023]

National Institute for Health and Care Excellence (2016) Blood transfusion. [Quality standard QS138]. [Online]. Available from: https://www.nice.org.uk/guidance/QS138 [Accessed 30 January 2023]

NHS Blood and Transplant (2021) Information for patients and their families, carers and guardians. Receiving a Blood Transfusion. [Online]. Available from: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/24640/receiving-a-blood-transfusion-leaflet-1.pdf [Accessed 30 January 2023]

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Shander A, Goodnough LT (2018) Management of anemia in patients who decline blood transfusion. *American journal of hematology*, Vol. 93, Iss. 9, (September 2018): 1183-1191. [Online]. Available from: https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/ajh.25167 [Accessed 30 January 2023]

Stevenson J, et al (2022) Characteristics and outcomes of pediatric oncology patients at risk for guardians declining transfusion of blood components. *Cancer reports (Hoboken, N.J.)*
Preview publication details (July 6, 2022): e1665 [Online]. Available from: https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/cnr2.1665 [Accessed 30 January 2023]

Legislation
Note re: links to legislation.gov.uk website. Versions may be revised, annotated or original as enacted. A 'List of all changes' made by subsequent legislation affecting the statute or statutory instrument may be viewed by opening the statute or statutory instrument on the legislation.gov.uk website and clicking the 'More Resources' tab.

Children Act 1989. (c. 41). [Online]. Available from: http://www.legislation.gov.uk/ukpga/1989/41/contents [Accessed 30 January 2023]

Mental Capacity (Amendment) Act 2019. (c. 18). [Online]. Available from: http://www.legislation.gov.uk/ukpga/2019/18/contents [Accessed 30 January 2023]

Mental Capacity Act 2005. (c. 9). [Online]. Available from: http://www.legislation.gov.uk/ukpga/2005/9/contents [Accessed 30 January 2023]

Case Law:

Cardiff and Vale University Health Board v T (A Minor) (Urgent Blood Transfusion) [2019] EWHC 1671 (Fam) (21 June 2019) [Online]. Available from: http://www.bailii.org/ew/cases/EWHC/Fam/2019/1671.html [Accessed 30 January 2023]

Gillick v West Norfolk and Wisbech AHA [1986] AC 112, [1985] UKHL 7 [Online]. Available from: https://www.bailii.org/uk/cases/UKHL/1985/7.html [Accessed 30 January 2023][Online].Available from:

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1.0	12/2002	Dr Elizabeth Miller – Haematology Consultant	Development of new policy
2.0	10/9/2006	Claire Sambridge – Transfusion practitioner	New information to improve the care for patients.
3.0	12/2009	Dr Elizabeth Miller – Haematology Consultant. Sarah Morey – Transfusion Practitioner	Review date extended whilst full review takes place
4.0	07/2010	Sarah Morey – Transfusion practitioner	Response to a root cause analysis
4.1	12/2011	Cheryl Hasell – Transfusion practitioner	Minor update to contact details
4.2	02/07/2012	Dr Mitra – Hematology Consultant Cheryl Hasell – Transfusion Practitioner	Full document review including minor amendments to pages 14 – contact details, 17 – flow chart for planned surgery and 18 – laboratory assessment/screening.
4.3	10/12/2012	Cheryl Hasell – Transfusion practitioner	Changes to policy title, minor wording in body amended and appendix 8b as a result of an incident. No procedural changes only amended to ensure that the policy is clear. Policy also updated into new trust template.
5	27/01/2014	Alison Wright – Transfusion practitioner	Minor update to contact details. Policy updated to new trust template. Renumbering of appendices and update of policy wording related to such.
5.1	15/09/2015	Caroline Lowe -Transfusion practitioner	Update to contact details for HLC
6.0	01/07/2016	Dr Mitra – Haematology Consultant. Caroline Lowe – Transfusion Practitioner Tanya Bancroft –Blood Bank Manager	Full document review
7.0	12/12 /2019	Dr Mitra – Haematology Consultant. Caroline Lowe – Transfusion Practitioner Terrie Perry Transfusion Practitioner	Full document review. Redesign of Appendix 4a Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) for use in all patients declining and redesigned Appendix 10 removed
7.1	19/10/2020	HTC	Agreed SNOMED code and how to put the 'no blood 'alert on eCare addition of appendix 10
7.2	16/11/2020	Caroline Lowe and Terrie Perry	Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26) amended to make clear it is for single admission use only

7.3	02/06/2021	Mr Ghaly Hanna- Consultant Obstetrician and Gynaecology	Addition of 2 sections in 3.1 2 relating to care of the pregnant woman in the antenatal period
7.4	Nov 2021	Erica Puri- Audit and guideline midwife	and 3.1.3- relating to appendix 11 flow chart for obstetrics patients who decline transfusion of blood components.
7.5	Jun 2022	Leanne Andrews - Audit and Guideline Lead Midwife, Ghaly Hanna – Consultant Obs and Gynae	Review and updated obstetric and gynaecology section.
8.0	Jan 2023	Audit and guideline lead midwife, Mr Hanna, HTC	Full review

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Safeguarding Team	Adult and Children safeguarding	Oct 2022	Oct 2022	None	Yes
Laura Crump	CNIO	Oct 2022	Oct 2022	None	Yes
Tina Worth	Head of Risk and clinical Governance	Oct 2022	Oct 2022	Legal review not required	Yes
Dr I Reckless	Medical Director	Oct 2022	Oct 2022	No Comments	Yes
Dr C Lindesay	CSU Lead General Medicine	Oct 2022	Oct 2022	No Comments	Yes
Dr H Manji	Divisional Director Surgery	Oct 2022	Oct 2022	No Comments	Yes
Dr Z Gawlowski	Clinical Director Paediatric Services	Oct 2022	Oct 2022	Out of hours process	Yes
Dr Wasim Shamsuddin	CSU Lead Anesthetics	Oct 2022	Oct 2022	No Comments	Yes
Mr S. Ray-Chaudhuri	CSU Lead Theatres	Oct 2022	Oct 2022	No Comments	Yes
Julie Preston	Safeguarding Adults Lead Nurse	Oct 2022	Oct 2022	No Comments	Yes
Ben Jagger	Specialist Safeguarding Nurse	Oct 2022	Oct 2022	Agreed JWHLC comments	Yes

Rebecca Juffs Nicola Fairgrieve	Practice Development Midwives	July 2022	July 2022	Word changes, confirm email process in maternity, review early cord clamping, review postnatal hb if no other indicators.	Yes
Anja Johansen-Bibby	Consultant Obstetrician	Aug 2022	Aug 2022	Addition to antenatal care regarding liaison committee, clarification of transfer if condition deteriorates in labour care. To change decline to decline throughout document	Yes Yes
Emma Mitchener	Deputy Head of Midwifery	Aug 2022	Aug 2022	To change decline to decline throughout document Make leaflet clearer. Make it clear we do not have cell salvage at this hospital. Jehovah Witness – clarity on phrasing. Check that safeguarding aspects are up to date.	Yes Yes Yes
Katie Selby	Maternity Governance and Quality Lead	Aug 2022	Aug 2022	To change refuse to decline throughout document Phrasing in consent for Jehovah Witness. Move gynae comments into gynae paragraph. Postnatal care to be clarified.	Yes Yes Yes
Maria Panourgia		Oct 2022	Oct 2022	None	Yes
Emma Codrington		Oct 2022	Oct 2022	None	Yes

Elizabeth Winter		Oct 2022	Oct 2022	None	Yes
Hospital Liaison Committee (JW)	HLC	Oct 2022	Oct 2022	Minor comments , contact updates	Yes
HTC	Hospital Transfusion Committee	Jan 2023	Jan 2023	None	Yes
Pathology CIG	Pathology Governance	Feb 2023	Feb 2023	None	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Referred cases sent to the transfusion team will be evaluated & measured against policy to ensure correct decision making process was applied, to optimise care and to implement changes to future care appropriately	Pre assessment referral form (appendix 4a)	Transfusion Practitioner	Yearly	Hospital Transfusion Committee
Obstetric cases will be evaluated & measured against policy to ensure correct decision making process was applied, to optimise care and to implement changes to future care appropriately	Appendix 4b and Appendix 11	Obstetric Lead	Case by Case	Women's Health

5.4 Equality Impact Assessment

As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified.

Division	Pathology Core Clinical	Department	Blood Transfusion
Equality Impact Assessment			
the EqIA			
Others involved:	Hospital Transfusion Team	Date of assessment:	06/01/2023
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Staff
If staff, how many/which groups will be effected?	All staff

Protected characteristic	**Any impact?**	**Comments**
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	YES	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	Document sent out for consultation to women's health, surgery, ED, medicine Paeds and the JWHLC
How are the changes/amendments to the policies/services communicated?	To be included in all blood transfusion mandatory education

What future actions need to be taken to overcome any barriers or discrimination?

Who will lead this?	Who will lead this?	Who will lead this?	Who will lead this?
Review date of EqIA			

Appendix 1: Contact List

	Phone Ext	Bleep
Consultant Haematologist	Via switchboard	Contact via switch/ through mobile
Email: subir.mitra@mkuh.nhs.uk		
Blood Transfusion Manager	85832	
Email: bloodtransfusion@mkuh.nhs.uk		
Blood Transfusion Laboratory Email: bloodtransfusion@mkuh.nhs.uk	85776/85774	1412
Transfusion Practitioners (TP)	85798	1644
Email: Caroline.lowe@mkuh.nhs.uk Terrie.perry@mkuh.nhs.uk		
On Call Duty Consultant Haematologist **24 hour contact**	Via switchboard	
On Call Duty Consultant Anaesthetist	Via Switchboard	
Duty Hospital Manager	Via switchboard	
CORAM VOICE	Tel 0808 800 5792 Text 07758 670 369 E-mail help@coramvoice.org.uk	
Children's Social Care	01908 253169 Out of hours 01908 265545	
Safeguarding Team		1329 and 1091
Hospital Litigation Department	Via switchboard	

Appendix 2: Jehovah's Witness Liaison Committee (updated October 2022)

Peter Marriott

Telephone: 01908 550780
Mobile: 07941466049

Email: swisspeat20@gmail.com

Gareth Ingerfield

Mobile: 07557 344476

Email: gareth.ingerfield@sky.com

Hospital Information Services UK (London)

(Can offer assistance when local contacts unavailable)

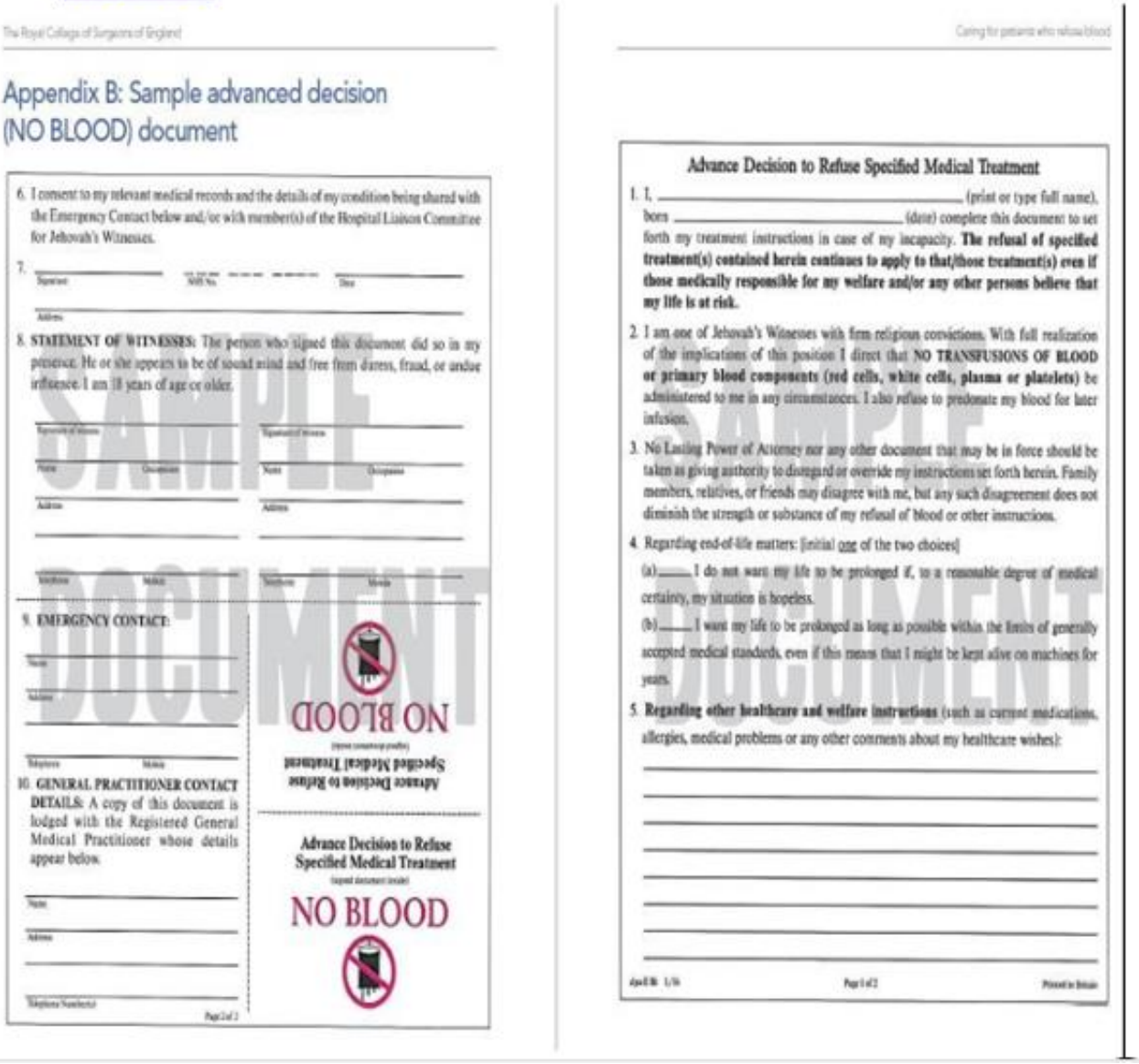
Telephone: 020 8371 3415

Appendix 3 Advance Decision (NO BLOOD) document sample

Appendix 3: Advanced Decision to refuse blood/ blood products

A sample 'Advanced Decision (NO BLOOD) document' is provided in *Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion* (Royal College of Surgeons of England, 2016, pp.30-31 Appendix B)

https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/caring-for-patients-who-refuse-blood/



The Royal College of Surgeons of England

Appendix B: Sample advanced decision (NO BLOOD) document

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 ____ Name (PRINT) ____ 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.

Witness ____ Witness ____

Name ____ Occupation ____ Name ____ Occupation ____

Address ____ 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) ____

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NO BLOOD

Advance Decision to Refuse Specified Medical Treatment

(signed document inside)

NO BLOOD

Caring for patients who refuse blood

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. No Lasting Power of Attorney nor any other document that may be in force should be taken as giving authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

4. Regarding end-of-life matters: [initial one of the two choices]

(a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

(b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

5. **Regarding other healthcare and welfare instructions** (such as current medications, allergies, medical problems or any other comments about my healthcare wishes):

_____

_____

_____

_____

_____

_____

_____

_____

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SAMPLE DOCUMENT

Appendix 4a Pre-op Assessment Form for Patients Declining Blood/Blood Components: (PATH/FM/25)

Surname _____

First Names _____

D.O.B. _____

Hospital No _____

Consultant: _____

Speciality: _____

Planned Operation: _____

Planned Date (if known): _____

Pre Op Hb _____

Advanced Decision Available? **YES/NO**

Copy of ADRT in patient's notes? **YES/NO**

Copy of ADRT sent to Blood Bank? **YES/NO**

If yes to all the above has a 'No blood' Bracelet been issued to patient? **YES/NO**

Medications and Dosage

Blood Tests to be taken only on adults who are booked for high risk procedures (i.e. those procedures that would normally indicate a group and save to be taken). Also to include in the 'high risk' procedures: Tonsillectomy and/or Adenoidectomy and Circumcision

Please request the following Tests

Full blood count , Serum Ferritin, Folate, B12 , Renal function, Liver Function, Clotting Screen

Pre assessment Nurse	Bleep	**Date**

This document needs to be completed at pre-assessment. The completed document must be emailed to Caroline Lowe, Terrie Perry, Jasmine MBeharry, Dr Subir Mitra, patient's consultant, pre-assessment Lead Nurse and Deputy and Transfusion Team (bloodtransfusion@mkuh.nhs.uk)

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Appendix 4b Consent Form and Checklist for All Patients Declining Blood (PATH/FM/26)

I…… …… Hospital No ……..
Date of Birth …… …… have given my consent for a procedure/investigation/operation on the Hospital standard Consent Form (Patient Agreement to Investigation or Treatment), the nature and purpose of which have been explained to me by Dr/Mr. .....and to the administration of general, local or other anaesthetic.
It has been explained to me that in the course of or by reason of the said operation/procedure it may be necessary to give me a blood transfusion (red cells, white cells, plasma or platelets) so as to render the operation/procedure successful, or to prevent injury to my health, or even death .**I hereby expressly withhold my consent to and forbid the administration to me of a blood transfusion/blood components (unless indicated by my signature below) in any circumstances or for any reason whatsoever** and I accordingly acknowledge the surgeon, the hospital and the medical staff will not be responsible or liable for any damage or injury which may be caused to me by reason of my decision to decline to consent to blood transfusion or components . I acknowledge that in declining to consent to a blood transfusion or blood components (as indicated below) during this operation/ procedure, this may result in death.

	I accept (where clinically indicated)				**I accept (where clinically indicated)**		
	Yes	**No**	**Not Discussed**		**Yes**	**No**	**Not Discussed**
Red Blood Cells				**Acute Normovolaemic Haemodiluition**			
Fresh Frozen Plasma				**Intraoperative Cell salvage**			
Platelets				**Fibrin glues and sealants**			
Cryoprecipitate				**Other (specify)**			
Albumin				**Other (Specify)**			
Recombinant Clotting Factors				**Other (Specify)**			
Prothrombin Complex Concentrate				**Other (Specify)**			
Fibrinogen Concentrate				**Other (Specify)**			

If required to save my life I will accept (circle the desired response and sign)		
Fresh Frozen Plasma	**Yes**	**No**
Red Cells	**Yes**	**No**
Platelets	**Yes**	**No**

Statement of The patient
I have read and understood the above information and here by confirm my refusal to receive blood transfusion or blood components as indicated above.

Signed (Patient) …… Print Name …… Date ……

Signed (Consultant)…… Print Name …… Date ……

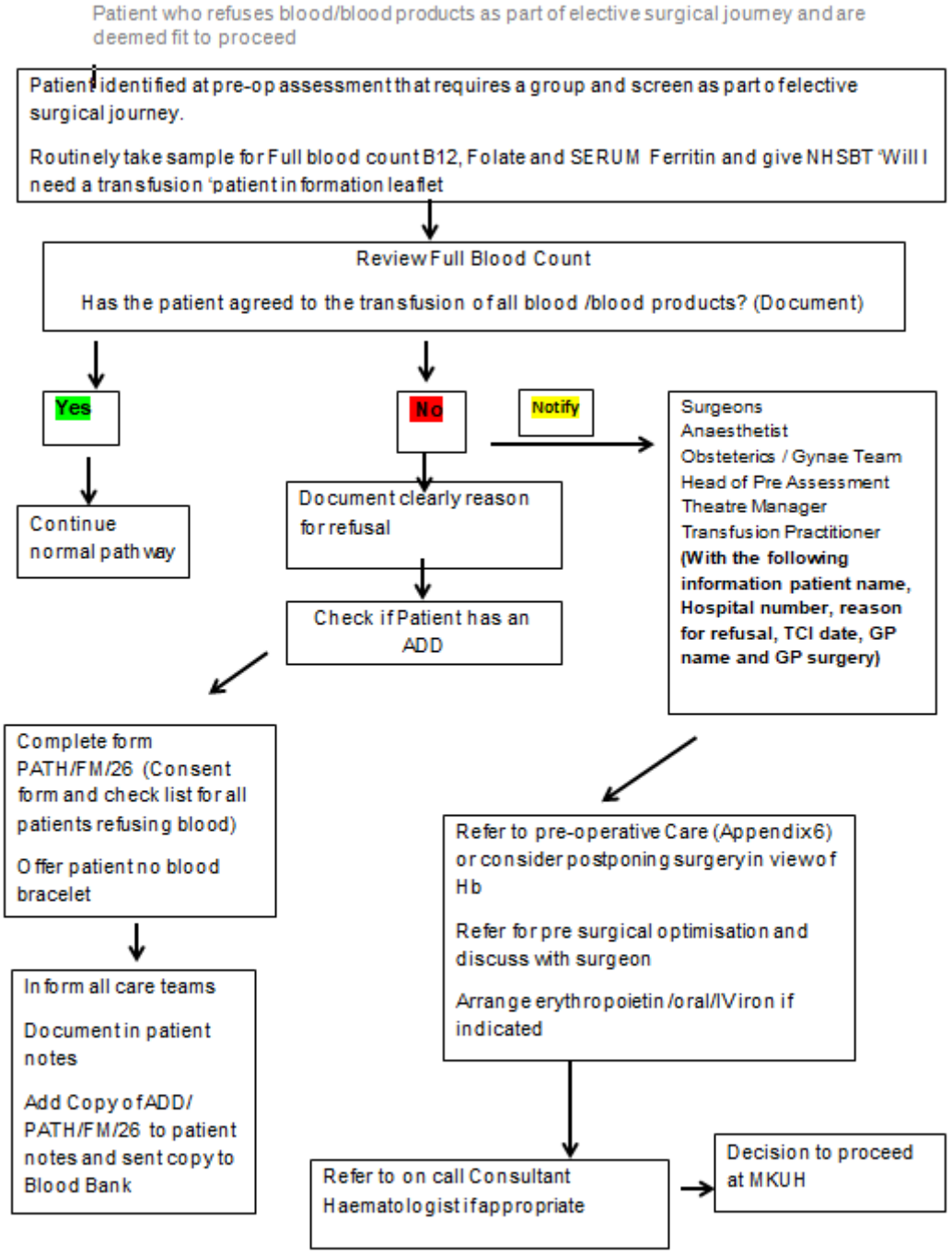
Witness to both signatures. ..... Print Name …….. Date.....

PHOTOCOPY ACCEPTED BY PATIENT: YES / NO (PLEASE CIRCLE)

This form must be completed for each admission and is only for use for patients aged 18 or over.

This document needs to be completed by the Consultant and placed in the patient's medical record. A copy must be sent to Blood Bank

Appendix 5: Flow Chart for Planned Surgery



Appendix 6: Pre-Operative Care to minimize need for Blood Transfusion

Pre-operative planning to minimise the need for blood transfusion should start far in advance of anticipated surgery. This will involve a thorough assessment of the patient, involving the surgical Consultant, Anaesthetist and patient or guardian; the wider multidisciplinary team will also be consulted to develop a comprehensive, individualised plan of care and treatment for the patient This should be at least 2 months before the date of surgery.

Medical History and Physical Examination

Pre-operative predictors will identify potential risks of patient needing a blood transfusion -

- Personal and family history
- Weight and height
- History of bleeding disorders (personal or family)
- Identify medications that may adversely affect haemostasis (e.g. aspirin, NSAIDS, anticoagulants, platelet aggregation inhibitors, antibiotics, dietary supplements)
- Physical examination
- Type of surgery

Laboratory Assessment / Screening

Establish baseline haematic parameters, including;

- Full blood count
- Serum ferritin
- Serum folate
- Serum B_{12}
- Renal function
- Liver function
- Clotting

Management of Bleeding Risk/Therapy for Coexisting Disease.

Careful planning will be required.
Make sure the patient avoids over the counter cold and flu remedies which may contain aspirin.

Appendix 7: Consideration of Alternative Procedures

Alternative strategies and procedures will need to be discussed with the patient at the earliest opportunity to establish optimum care

See link below to access further information.

Further information is available from:

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) (2014) 6: Alternatives and adjuncts to blood transfusion. In: JPAC *Transfusion handbook*. [Online]. 5th ed., web version. Available from: https://www.transfusionguidelines.org/transfusion-handbook/6-alternatives-and-adjuncts-to-blood-transfusion [Accessed 3 February 2023]

Jehovah's Witnesses has medical information for clinicians at https://www.jw.org/en/medical-library/
Royal College of Surgeons of England (2016) *Caring for patients who decline blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion.* [Online]. London: RCS. Available from: https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/caring-for-patients-who-decline-blood/ [Accessed 3 February 2023)

Note: MKUH currently does not offer intra -operative Cell salvage. Other hospitals may be able to offer other suitable alternatives.

Appendix 8 Patients who decline blood and blood components leaflet

The patient information leaflet *Information for Adult patients who may wish to decline the use of Blood / Blood Components* (PATHOLOGY/PI/5) is available in Trust Documentation

Appendix 9 No Blood Bracelet

No Blood Bracelet

For patients with a valid ADRT and /or completed Consent Form and Checklist for all Patients Declining Blood (PATH/FM/26)

These bracelets may only be issued to patients with a valid advance directive (ADRT) and/or Consent Form and Checklist for all Patients Declining Blood (PATH/FM/26)

This bracelet is supplied by the Jehovah Witness HLC and supplies are held with the Pre-op assessment Team, Transfusion Practitioners, Blood Bank and the Site office.

If the Patient is requesting a No Blood Bracelet and a valid ADRT and/or Consent Form and Checklist for all Patients Declining Blood (PATH/FM/26) is available-

- Document the patients' full name, hospital number and date of birth on the bracelet prior to securing to the patient.
- It should be remembered that Jehovah's Witnesses and any patient declining blood components have the same right as any other person who makes an advance refusal – i.e. to withdraw or alter it at any time they have the capacity to do so. Should their wishes change this should be documented and witnessed and the bracelet removed.

Appendix 10 Instructions on adding 'No Blood' alert to eCare

Add the required SNOMED code to the Problem and Diagnosis list on eCare;

Choose either -

"Administration of blood component declined" or "Transfusion of blood component declined for religious reasons"
Add a flag of Patient Preference under Classification

Some details can be added in the comments box and more information added to a clinical note if required.

*If unsure of how to add the alert eCare guides have instructions