



Document ID: MATY100	Version: 1.1
Facilitated by: CMM	Last reviewed: August 2019
Approved by: Maternity Quality Committee	Review date: August 2023

Management of Women who Decline Blood Products & Jehovah's Witness in Pregnancy Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Background

- Some women may decline transfusion of blood or its components, based on religious or personal beliefs. These women are at increased risk of obstetric morbidity and mortality. Observational studies suggest that refusal of transfusion in major PPH may be associated with a 44-fold risk of mortality compared to the general obstetric population.
- Blood transfusion may be unavailable when a woman has complex antibodies or a rare blood group.
- Careful planning is required to reduce morbidity and maximise these women's care.
- The antenatal period provides the opportunity to optimise a woman's health status and to form a clear plan of care.

Antenatal

- Identify women in this community at booking.
- LMC to refer Woman to the antenatal clinic and it is recommended that she be seen at the beginning of the second trimester
- Baseline bloods: FBC, iron studies, B12 & folate, vitamin D if indicated. Treatment of any haematinic deficiency. Anaemia in pregnancy should be avoided and corrected.
- Routine iron supplementation for all Jehovah's Witness Women. Please see algorithm one -pathway for iron supplementation for pregnant Jehovah's Witnesses from the first trimester until 28 weeks.
- Haemoglobin & ferritin should be rechecked at 28 and 36 weeks. Please see algorithm two (pathway for iron supplementation for pregnant Jehovah's witnesses from 28 weeks) for further iron replacement information.
- If anaemia unresponsive to oral and intravenous iron, hospital obstetrician will discuss erythropoietin with haematologist. An unresponsive anaemia is an increase of $<15\text{g/L}$ in 4 weeks.
- Avoidance of antiplatelet drugs such as aspirin prior to birth where possible. If there is an indication for aspirin or anticoagulation the risks and benefits need to be weighed up on a case by case basis and a senior clinician involved in the decision. Non-prescription drugs and supplements which may affect anticoagulation status such as garlic, ginger, ginkgo biloba and ginseng should be avoided.

- Women should be counselled so that they can make decisions as to which products and treatments are acceptable. These discussions should be recorded clearly in the antenatal notes.
- Women must be advised that the inability to administer blood products may increase her risk of death or disability following major haemorrhage and that even with optimal care and the implementation on non-blood management strategies these risks remain.
- Women should be counselled at least once in the absence of any family members or acquaintances.
- An Advance Care Directive must be copied and stored in the notes.
- A woman's decision is final and to administer blood against her express views could be regarded as assault. In the severely ill, incompetent patient, these views still stand if her wishes were made clear prior to her becoming incompetent. Women need to be aware that in this situation, her family cannot override her previously stated wishes.
- Women should be advised that in the event of haemorrhage, there would be a lower threshold for definitive intervention. A hysterectomy may be required to control bleeding.
- Plan for third stage management. Recommend active management. If this is declined by woman, careful documentation required that this has been recommended.

Anaesthetic consult (third trimester)

- Discuss cell-saver availability in Wellington but not Hutt DHB. Cell saver systems allow for free blood in the abdomen to be aspirated, filtered and then reinfused into the patient peri-operatively as an intra-operative autologous transfusion. They are acceptable to some Jehovah's Witnesses. The cell-saver is not always available in an emergency situation but may be beneficial in a planned setting such as elective caesarean section. The availability of the cell-saver in Wellington, as well as its limitations, should be discussed antenatally and women provided with the option of birthing at Wellington Hospital.
- Women at increased risk of bleeding (e.g. Grade IV placenta praevia) may be advised to deliver in Wellington even if she will decline blood products and a cell saver. This needs to be reviewed on a case by case basis and will be an SMO decision made by anaesthetic & obstetric SMO and documented as such.
- There is significant variation among Jehovah's Witnesses as to which products may be acceptable. A woman who is well-informed about her options can decide what she wants done in the event of life threatening haemorrhage.
- Women will be provided with verbal and written information on blood components. Products that are deemed acceptable and unacceptable by the patient will be documented in the Women's medical notes.
- A clear plan needs to be documented on the front page (yellow sheet) of woman's antenatal notes.

Intrapartum

- On admission to labour ward, obstetric RMO to be notified. Obstetric SMO to be notified when woman in labour. Duty anaesthetist to be notified.
- 16G IV access, avoid over hydration with intravenous fluids
- Active third stage. Low threshold for oxytocin infusion and further oxytocic's.
- Careful documentation of any blood loss, including accurate measurement (weight or volume) of blood loss where possible.
- If transfer to theatre is required, obstetric and anaesthetic SMO must be present in theatre.
- Rapid and definitive management of any obstetric bleeding (oxytocics and uterotonics, EUA, balloon tamponade, B-Lynch sutures, uterine artery ligation & hysterectomy). The decision to proceed to laparotomy should be taken earlier than usual.
- Consider use of Tranexamic acid in management of haemorrhage. Aim to avoid hypothermia, acidosis, hypocalcaemia which are all factors that can worsen a coagulopathy
- A woman is entitled to change her mind at any time, from any previously agreed treatment plan. Care should be taken to give any products that the woman accepts in a private manner, with assurance of confidentiality. For this reason, Jehovah's Witnesses should still have a Group & Hold specimen taken for the usual obstetric indications e.g. pre-epidural, pre theatre, PPH.

Management of Postpartum Anaemia

- Optimise haematinic status
- Optimise oxygenation
- Minimise blood tests (consider using paediatric tubes)
- Consider iron infusion if Hb<80 or PPH > 1.5 L. Ferritin is not a useful test postnatally as it is an acute phase reactant.
- Consider transfer to HDU if PPH > 1.5L

References:

- Considerations in the management of pregnant women who refuse blood and blood products. Queensland maternal and perinatal control council.
- Management of women who refuse blood components and / or blood products, including Jehovah's Witnesses. King Edward Memorial Hospital Clinical Guidelines.
- Gyamfi, C; Mirza, F.G, Management of pregnancy in the Jehovah's Witness. Contemporary Obstetrics-Gynecology & Women's Health. Dec 2010.
- Gyamfi, C, Berkowitz, RL. Management of pregnancy in a Jehovah's Witness. Obstet Gynecol Clin North Am. 2007 Sep;34(3):357-65
- Singla, A.K., Lapinski, R.H. et al. Are women who are Jehovah's Witnesses at increased risk of maternal death. Am J Obstet Gynecol 2001;185: 893-5
- Murphy, NC, Hayes, NE et al. Jehovah's Witness patients presenting with ruptured ectopic pregnancies: two case reports. Journal of medical Case Reports 2014 8:312.
- Kidson-Gerber, G, Kerridge, I et al. Caring for pregnant women for whom transfusion is not an option. A national review to assist in patient care. Aust N Z J Obst Gynecol. 2015 Nov 17. doi: 10.1111/ajo.12420

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

CHECKLIST FOR WOMEN DECLINING BLOOD PRODUCTS

Booking

- Check baseline FBC, iron studies, B12 & folate, vitamin D levels
- Commence ferrous fumarate (ferro-tab) 200mg once daily, follow pathway for iron supplementation for pregnant Jehovah's Witnesses from the first trimester until 28 weeks.
- Secondary Care referral
- Ask if on any herbal remedies, aspirin, anticoagulants

Second trimester

- Obstetric review

Third trimester

- Check Hb & ferritin at 28/40, follow pathway for iron supplementation for pregnant Jehovah's witnesses from 28 weeks
- Anaesthetic review
- Ensure advance care directive in notes
- Ensure documentation of labour care plan in notes
- Ensure acceptability of different blood products & cell saver documented
- Advise for active third stage
If this is declined, document has been discussed
- Recheck Hb & ferritin at 36/40, refer to follow pathway for iron supplementation for pregnant Jehovah's witnesses from 28 weeks

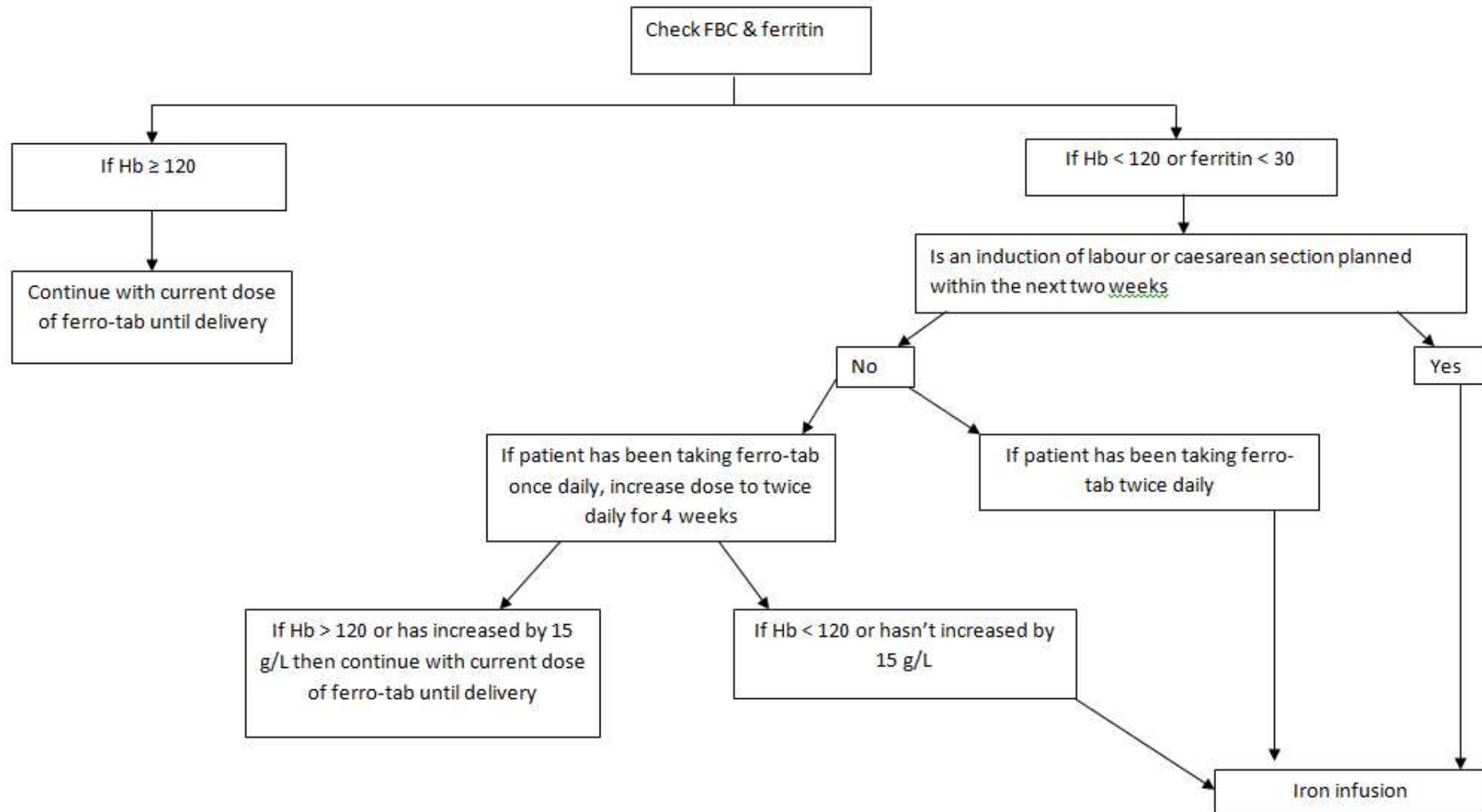
Intrapartum

- Notify obstetric RMO & SMO, duty anaesthetist
- 16G IV access
- Group & Hold for usual obstetric indications
- Active third stage
- Documentation & measurement of any blood loss



Document ID: MATY100a	Version: 1.0
Facilitated by: Jo McMullan, CMM	Issue Date: August 2016
Approved by: Maternity Quality Committee	Review date: August 2018

Appendix 1: Pathway for Iron Supplementation for pregnant Jehovah's Witnesses from 28 weeks





Document ID: MATY100b	Version: 1.0
Facilitated by: Jo McMullan, CMM	Issue Date: August 2016
Approved by: Maternity Quality Committee	Review date: August 2018

Appendix 2:

Pathway for Iron Supplementation for pregnant Jehovah's Witnesses from the first trimester until 28 weeks

