# REFUSAL OF TRANSFUSION OF BLOOD AND BLOOD COMPONENTS POLICY

**POLICY**

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|---|---|---|---|
| **Reference** | CPG-TW-RoB | | |
| **Approving Body** | Hospital Transfusion Committee (HTC) | | |
| **Date Approved** | 24/04/2024 | | |
| **For publication to external SFH website** | **Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:** | | |
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| | X | | |
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| **Sponsor (Position)** | Medical Director | | |
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| **Lead Division/ Directorate** | Clinical Support, Therapies and Outpatients (CSTO) | | |
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| **Position of Person able to provide Further Guidance/Information** | Hospital Transfusion Committee Chair,<br>Dr Lisa Milligan | | |

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# CONTENTS

## 1.0 INTRODUCTION

Every competent adult patient is entitled to refuse to consent to medical treatment for good reason, bad reason, or no reason (1). The Mental Capacity Act (2005) formalises, in law, the right of people with capacity to define in advance which medical treatments that they will and will not consent to at a time when they have become incapable of making and communicating a decision.

A fundamental belief of the Jehovah's Witness Christian movement is the rejection of transfusions of whole blood, or any of its four primary components, namely, red cells, plasma, platelets, and white cells. Fractions of any of the four primary components may be acceptable but are a matter of individual patient choice. Such beliefs should be acknowledged and respected. However, it should be remembered that the declining of blood components is not just limited to Jehovah's Witness patients and there are some people who may decline blood components on the grounds of other religious or personal beliefs.

Patients who decline treatment using blood components or products remain entitled to the highest standards of medical care and full use of modern medical technology (2).

When agreement cannot be reached between the doctor and the patient, referral for a second opinion should be considered. When the patient is a child, the same strategy should be used but on occasion the clinical team may have to obtain legal help.

## 2.0 POLICY STATEMENT

In order to ensure a high standard of medical care it is essential that individual cases are reviewed in a timely way by consultant leads for the speciality, haematology and anaesthesia. This policy describes the standards in practice required and applies to:

**Staff group(s)**

- all staff who treat patients who may refuse a blood or blood component transfusion
- Blood bank staff

**Clinical area(s)**

- All clinical areas
- Blood bank

**Patient group(s)**

- All patients who refuse the administration of blood or blood components (see section 5 regarding paediatric patients)

**Exclusions**

- All patients who consent to the administration of blood or blood components (see section 5 regarding paediatric patients)

**The policy should be read in conjunction with the Code of Conduct relevant to each professional body, i.e.**

- The General Medical Council
- The Nursing and Midwifery Council
- The Health professions Council

## 3.0 DEFINITIONS/ ABBREVIATIONS

| | |
|---|---|
| **Trust** | Sherwood Forest Hospitals NHS Foundation Trust |
| **SFHT** | Sherwood Forest Hospitals NHS Foundation Trust |
| **Staff** | All employers of the Trust including those managed by a third party on behalf of the Trust |
| **ADRT*** | Advance decision to refuse treatment |
| **FBC** | Full blood count |
| **NSAID** | Non-steroidal anti-inflammatory drug |
| **MCA** | Mental Capacity Act |
| **HLC** | (Jehovah's Witness) Hospital Liaison Committee |
| **ODP** | Operating department practitioner |

***N.B. For the purpose of this document, where the wording "advance decision document" is used, this should also be taken to mean Living Will, Advance Directive, or Advance Statement. Good practice is now to refer to all advance statements to refuse treatment as "Advance Decisions Documents" in line with terminology in the Mental Capacity Act 2005.**

## 4.0 ROLES AND RESPONSIBILITIES

### 4.1 Medical Staff

- Medical staff are responsible for discussing the care and treatment options and transfusion alternatives with the patient.
- Medical staff are responsible for obtaining consent where the patient has capacity. This should involve the most senior doctor available, preferably a consultant and ideally the Consultant responsible for the patient's care.
- The discussion and consent must be recorded in the patient health record. This must in turn be communicated to those delivering care to the patient, especially in the Operating Theatre or similar environment.
- Where the patient does not have capacity but has an ADRT (advance decision to refuse treatment), this must be respected and communicated to all members of the care team and documented in the patient health record.
- In the case of Jehovah's Witness patients, medical staff have a responsibility to ensure that the Local Hospital Liaison Group (HLC,) where relevant, is involved in all discussions and documentation.
- Medical staff have the right to refuse to treat patients in elective situations but should attempt to refer to suitably qualified colleagues who are prepared to undertake treatment. In an emergency medical staff are obliged to provide care and must respect the patient's competently expressed views (1).

### 4.2 Consultant Haematologists

The haematology medical team, led by the Consultant Haematologists, will provide support for the clinical teams involved in caring for patients who may refuse transfusion.

### 4.3 Registered nurse / midwife, Registered Operating Department Practitioners (ODPs), healthcare assistants

All staff are responsible for:

- Ensuring that the beliefs and concerns of any patient who refuses transfusion of blood components or products, and/or their derivatives, are acknowledged and always respected.
- Complying with the Policy and bringing to the attention of their immediate manager any difficulties they encounter using this policy.
- Ensuring a patient's decision is communicated to all relevant staff & recorded in the patient's health records. This is particularly important when transferring patients for invasive procedures (e.g. Operating Theatres).
- Ensuring that they can provide information and contact details of local Jehovah's Witness HLC.

### 4.4 Laboratory (Blood Bank) staff

In situations whereby blood bank staff are informed that a patient is a Jehovah's Witness the flag 'This patient is a Jehovah's Witness' will be selected.

### 4.5 The Hospital Liaison Committee

The local Jehovah's Witness Hospital Liaison Committee (HLC) will give advice regarding transfusion issues for Jehovah's Witness patients. Their aim is to support the patient and doctor, assisting understanding on both sides avoid confrontation and to help find alternative treatment options (See appendix 1 for further information ).

### 4.6 Trust Solicitor

The Trust Solicitor can be contacted over 24/7 via switchboard and will advise regarding treatment decisions, where there are issues regarding consent, particularly with the care of children.

### 4.7 Hospital Transfusion Committee

The Hospital Transfusion Committee is responsible for the development and management of the policy.

## 5.0 APPROVAL

Following consultation this policy (v3.0) has been approved by the Trust's Hospital Transfusion Committee.

## 6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

### 6.1 Consent and legal matters

#### 6.1.1 Adults (18 years and older)

Any competent adult patient, including those who are Jehovah's Witnesses, is entitled to refuse any aspect of medical treatment. They can consent to a surgery but exclude specifically certain aspects of management, such as a blood transfusion. Many Jehovah's Witness patients will carry an "Advance Directive" document detailing which blood components/products, derivatives, and techniques they refuse to accept. Such documents, if properly signed and witnessed, should be respected unless there is some reason to think the patient may have changed their views since the directive was executed. To transfuse a patient who has steadfastly refused to accept it either by the provision of an advance directive or by its exclusion in a consent form is unlawful, ethically unacceptable and may lead to criminal and/or civil proceedings.

A patient does not need to give a reason for refusing consent, but where refusal may lead to a loss of life or serious harm; it is good practice to ensure that there is specific documentation, both fact of refusal and of the patient's awareness of its potential consequences. The Doctor should also consider whether there is any indication that the patient's refusal is the result of coercion or undue pressure from any other person. However, they should equally be careful not to seek to influence a patient to take a course of action which is not in keeping with the patient's wishes and values. The anaesthetic induction room or the operating theatre is not the appropriate venue for discussing consent in the elective situation.

In an emergency, the clinician is obliged to provide care and must respect the patient's competently expressed views.

Where adult patients lack capacity to decide for themselves (for example, the patient is unconscious following a head injury or severe trauma, or they are sedated in intensive care), an assessment of the benefits, burdens and risks, and the acceptability of proposed treatment must be made in their behalf by the doctor, taking into account of their wishes, where they are known. This cannot be done effectively without information about the patient which those close to the patient will be best placed to know (9). Therefore, if time permits the views of the patient's relatives or representatives should be taken into consideration. Relatives must be invited to produce evidence of an advance directive to refuse treatment. Many Jehovah's Witness patients will have previously lodged a copy of an advance directive with their GP, so if time permits, they should be contacted. see Appendix 1 for further information specific to Jehovah's Witness patients

A previously completed, SFHT 'Checklist for patients refusing blood and blood components' (appendix 2) may be used to help identify the patient's wishes, however this will depend upon the circumstances, such as time interval since it was completed. In such circumstances, this document would not be binding.

If the healthcare personnel are satisfied that an advance decision is valid and applies to the proposed treatment, they would not be protected from liability if they then give a treatment which goes against the documented advance decision. However, they would be protected from liability if they did not know about an advance decision, or they are not satisfied that the advance decision is valid and applies in the current circumstances (4)

Where a patient's wishes are not known it is the doctor's responsibility to decide what is in the patient's best interests and this may include the transfusion of blood components/products if this is lifesaving.

In the case of emergency patients identified as Jehovah's Witnesses but *without documentation*, every effort should be made to avoid the use of blood and blood products in the perioperative period. However, in serious or life-threatening situations the use of blood and blood products should be based on the judgement of the clinician responsible for the patient. (11)

Where a patient's wishes are not known it is the doctor's responsibility to decide what is in the patient's best interests and this may include the transfusion of blood components/products if this is lifesaving.

### 6.1.2 Children

Young adults of sound mind aged 16-18 years have a statutory right in England and Wales to consent to procedures on their own account and there is no legal requirement to obtain additional consent from a parent or guardian. The patient's consent takes precedence over parental objections; however, the law expressly states that this does not invalidate the right of others to consent on their behalf. If the patient is in an acute emergency, it will be lawful to proceed based on the consent of either parent. Where time permits, the court should be asked to resolve the position (2, 5, 8).

In England and Wales children younger than 16 years may be competent to give their own consent if they demonstrate a clear grasp of the proposed treatment and the risks, benefits or consequences of acceptance or rejection of a proposed treatment. This is referred to as 'Gillick-competence'. However, this is likely only to apply to children above the age of 12 years but could for more minor procedures apply much younger.

Even though a child of 16 or 17 may give consent to medical treatment, his refusal will not be binding. If the treatment is in the child's 'best interests' such a refusal may be over-ridden by someone with parental responsibility or by the Court. Should a child under 16 refuse to consent this may still be over-ridden by anyone with parental responsibility. However, practitioners will often wish to obtain a court order before seeking to impose medical treatment on an unwilling teenager solely based on parental consent (9).

A situation could be envisaged where a child under the age of 16 years consented to an elective blood transfusion in the face of parental opposition. Consent in this situation would be sound provided that the child could show evidence of 'Gillick competence'. Although those with parental responsibility can give consent to treatment on a child's behalf, they cannot veto treatment if it is in the child's best interests. It may be necessary to treat a child against his parents' wishes. In such circumstances, and if time permits, a Court declaration should be sought as to the child's best interests (9). In an emergency where there is no time to apply to Court any doubts should be resolved in favour of the preservation of life (6,7,9).

If the family are Jehovah's Witnesses, the Jehovah's Witness Hospital Liaison Committee is available to help with advice and guidance. These discussions along with the parents at ward level can often resolve difficulties and avoid costly court referral. Doctors have a legal and ethical responsibility to ensure the wellbeing of the child under their care and this must always be their first consideration; however, every effort must be made to respect the beliefs of the family and avoid the use of blood or blood products wherever possible (11).

Further advice in a situation which is proving challenging can be obtained from the Jehovah Witnesses as they have an international database of clinicians that can offer advice. Contact details for Hospital Information Desk, Great Britain, and Ireland headquarters: daytime telephone: 020 8371 3415 (24 h service); email: hid.gb@jw.org. International details: https://www.jw.org/en/medical-library/hospital-liaison-committee-hlc-contacts.

### 6.2 Care Planning

When a patient refusing blood and blood components presents for treatment, the staff responsible will discuss with them their treatment choices. This will include a plan of care and treatment by consultants and nursing/midwifery staff, which will be communicated to all clinical staff likely to be involved in the treatment of the patient.

Alternative treatment modalities that are available, in particular, interventional or surgical procedures known to be associated with comparatively low blood loss, should be offered e.g., Cell salvage. Cell salvage can be set up as a 'closed system' if the witness requests (a continuous connection from the patient to the CS system and back to the patient)

Discussions will need to occur with service planners, and medical and theatre staff, when alternatives and cell salvage are to be used. This must be documented and communicated to all members of the Multi-Disciplinary Team.

In elective and urgent cases, when blood transfusions may be standard treatment, the following actions will be considered:

1. Review of non-blood transfusion alternatives.
2. Consultation with other doctors experienced in non-blood management and treatment without using allogeneic (homologous) blood.
3. Transfer of the patient's care to a doctor or to a facility willing to treat the patient without blood before the patient's condition deteriorates.
4. Given the difficulties which may arise during surgical or other invasive procedures, consideration should be given to such procedures being performed by consultant grade staff.
5. Consult the local Hospital Liaison Committee (HLC) of Jehovah's Witnesses (if appropriate).

### 6.3 Clinical management of patients who refuse transfusion

- **Surgical patients**

#### 6.3.1 pre-operative preparation

A patient's views about blood and blood components/products should be sought as soon as the need for a procedure with an attendant risk of blood loss is identified. A full and frank discussion of the proposed treatment and its risks and benefits should take place. This must include the possibility that declining blood components/products could result in a threat to life or even death. This review should not, however, be intended to influence the patient to take a course of action that is not in keeping with their values and their wishes (11).

**Those patients who refuse transfusion of blood and blood components/products should be identified and have the appropriate discussions as soon as possible (at the time of consent).**

The treating Consultant must be made aware of the patient's decision at the earliest opportunity and the risks and benefits of the proposed intervention should be carefully evaluated. Non-surgical or less invasive treatment options should be considered.

Consultants from anaesthesia and haematology must be involved at the earliest opportunity, and a multi-disciplinary management plan should be formulated and documented.

The patient should be given the opportunity to read the National Blood Service patient information booklets (Will I need a Blood Transfusion / Patient Blood Management) and the SFHT Cell Salvage Patient Information Leaflet.

The patient's relatives and/or religious advisor should not be allowed to coerce or pressurise the patient into a particular course of action, or to impede discussion about the acceptability of certain treatments (2).

### 6.3.2 Pre – Operative Management Plan

Pre-operative assessment and relevant investigations should be carried out as early as possible. The patient's condition should be optimised where possible, especially with regard to haemoglobin level and cardio-respiratory fitness (appendix 3)

- Review of proposed date of surgery to enable time for effective preparation of the patient
- Consideration of non surgical or less invasive treatment
- History of anaemia, bleeding disorders, renal/hepatic disease, and allergies should be specifically noted, including family history.
- Relevant investigations include full blood count (FBC); B12 and folate; iron studies (ferritin and transferrin saturations); clotting screen; and fibrinogen At least 6 weeks before surgery (may not be possible in elective cancer surgery).
- If iron deficiency (absolute or functional), low iron stores or iron sequestration is diagnosed, iron treatment is indicated. Oral iron may be considered; in which case the patient's Hb should be re-checked 4 weeks after starting treatment.
- Results must be viewed by the pre-operative department nursing staff as soon as possible following initial patient contact
- Optimisation of the patient's pre-operative haemoglobin level if less than 130 g/l (see (appendix 3)
- Assessment and optimisation of any anti-coagulant and anti-platelet medications, including warfarin, heparins, other direct-acting oral anti-coagulants, aspirin, clopidogrel, NSAIDs, etc.
- Intra-operative cell salvage if appropriate arrangements should be made to ensure that both a machine and trained operators are available on the day of surgery
- Advise on dietary intake

### 6.3.3 Documentation of treatment discussions

It is essential that treatment discussions are recorded in order that clear instructions are available in the event of an emergency where life sustaining treatment is required.

The SFHT 'Checklist for patients refusing blood and blood components' (appendix 2) must be completed, along with the SFHT consent form 1 (FKIN030290), including Section 16.

Originals must then be filed in the patient's medical record and a copy given to the patient. It is essential that patients complete the checklist and consent form with the speciality consultant in charge of their care.

A copy of this policy should also be printed out and filed in the patient's medical notes (at the front of the notes in the "Red Alert" section), so that it can be referred to at any time.

### 6.3.4 Advance Decisions

If presented by the patient, the Advance Decision to Refuse Treatment (ADTR) should be reviewed by the consultant in charge of care and a copy placed in medical records along with a completed 'Checklist for patients refusing blood and blood components' and NHS consent form.

Any additional information should be recorded in the medical records and signed by the patient and speciality consultant in charge of care (4).

These documents should be filed in the "Red Alert" section at the front of the medical notes.

### 6.3.5 On admission to hospital

It is essential that the speciality consultant in charge of care re-confirms the treatment plan with the patient and makes a contemporaneous entry, signed, timed and dated on both the 'Checklist for patients refusing blood and blood components 'and NHS Consent form.
The patient should have the opportunity to reconsider their treatment decision(s) (2).

Should a patient disclose on the day of admission that they would decline blood or blood components for a procedure where there is a risk of bleeding; consideration should be given to rescheduling the procedure to allow adequate preparation and discussion.

### 6.3.6 Intra operative management

All relevant issues should be highlighted at the time of the team brief and during the surgical safety checklist before the start of anaesthesia.

Tranexamic acid should be administered intravenously if not contraindicated and Cell Salvage considered for all surgical procedures if blood loss >500 ml is possible/likely.

The treatment or intervention should be supervised by the surgical specialty Consultant and Consultant Anaesthetist in charge of the patient's care. In the event of heavy bleeding, immediate guidance from a Consultant Haematologist should be sought. Early pre-operative consideration should be given by consultants for the speciality, anaesthesia, and haematology to one or more of a number of techniques to reduce intra operative blood loss (2).

This may include: -

- Patient positioning, which can influence the amount of pressure and subsequent blood loss from the operative area.
- Techniques to maintain or restore normothermia, e.g., fluid warmers and heated mattresses.
- *Controlled hypotension may be considered*
- Maximising tissue oxygen delivery by maintaining:
  - intravascular volume
  - cardiovascular support
  - ventilation and oxygenation
  - use of nitrous oxide and hypercapnia may increase the risk of bleeding

- Minimising oxygen consumption using:
  - Adequate and appropriate analgesia
  - Sedation
  - Mechanical ventilation
- Employing surgical techniques which help prevent blood loss:
  - Use of minimally invasive techniques if possible
  - Use of electrocautery, laser, or ultrasonic dissection to minimise blood loss
  - Extra vigilance and lower tolerance for bleeding during procedure
  - Meticulous surgical haemostasis
  - Staged surgery for complex procedures
- Careful estimation and measurement of blood loss during the procedure, and careful recording and documentation of volumes
- Use of intraoperative cell salvage if appropriate (closed system for Jehovah's Witnesses)
- A Surgical specialty Consultant and Consultant Anaesthetist should oversee the patient's care and should directly supervise or carry out the treatment/intervention

**In the event of heavy bleeding, immediate guidance from a Consultant Haematologist should be sought**

The administration of fresh frozen plasma or platelet concentrate is not normally accepted by Jehovah's Witness patients, but cryoprecipitate may be acceptable. Other potentially acceptable therapeutic options include prothrombin complex concentrate, which contains factors 2, 7, 9 and 10, and fibrinogen concentrate. Raising the fibrinogen concentration with fibrinogen concentrate or cryoprecipitate can partially compensate for the effect of a low platelet count on haemostasis. Desmopressin 0.3 lg.kg_1 intravenously may also improve haemostasis by increasing large vWF multimers, and possibly improving procoagulant platelet activity. Recombinant factor 7 should only be considered as a 'last resort' treatment due to the excess of prothrombotic events.

If after consideration and/or use of the intraoperative techniques described above, bleeding cannot be stopped despite all best efforts, the patient should be stabilised as far as possible with fluids and coagulants, and then the patient should be returned to the ward for symptom control.

The patient's family/friends should be made aware of the patient's condition, and they should be invited to be with their loved one in the event of there being a high likelihood of death.

### 6.3.7 Post-Operative Management

A comprehensive verbal and written handover of the patient to recovery, critical care and/or ward staff is essential. They should be made aware of any adverse intra-operative events and should understand and respect the wishes of the patient that have been discussed before the procedure.

Management must include regular routine post-operative observations and action taken appropriately, as well as careful, close monitoring and documentation of post-operative blood loss. Following surgical procedures that employed a tourniquet intra-operatively there may be excessive blood loss after its release that may continue into the postoperative period. Abnormal bleeding must be reported immediately to the surgical team. A postoperative dose of intravenous Tranexamic acid (1 g) should be considered.

- Maintain strict fluid balance chart
- Restrict phlebotomy to prevent iatrogenic blood loss but careful monitoring of the patient's haematological status must not be neglected (consider use of paediatric sample bottles)
- Avoid and promptly treat infections to reduce secondary postoperative haemorrhage
- 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 (appendix 4)

There should be close adherence to any additional surgical, anaesthetic, or haematological instructions which should be documented as part of the management plan in the clinical notes.

- **Medical patients**

### 6.3.8 Patients with anaemia who refuse transfusion

In anaemic medical patients the aim is to maintain a haemoglobin level that achieves the maximum benefit, not just physiologically, but in terms of energy levels and quality of life.
All cases of anaemia should be investigated and treated with appropriate haematinic replacement therapy if a deficiency is discovered.

In haematological conditions seek advice from a Consultant Haematologist and refer Jehovah's Witnesses to the local Hospital Liaison Committee member if the patient wishes.

A plan should be drawn up between the patient and their consultant to cover the range of possible outcomes during day-to-day treatment.

### 6.3.9 Medical emergencies (haemorrhage)

Early involvement of the medical consultant responsible for the patient to determine the management plan is essential. Active intervention to investigate and stop bleeding should be considered at an early stage.

The checklist, (appendix 2) should be consulted to determine the patient's wishes. If this has been completed at hospital admission, check with the patient (if possible) that they still refuse transfusion, and confer with the on-call Consultant Haematologist for advice at the earliest opportunity.

Extra vigilance should be exercised to quantify any abnormal bleeding/coagulopathy due to underlying medical conditions or medications, and to detect complications, as promptly as possible. A Consultant Haematologist should be involved immediately after abnormal bleeding has been detected.

Intravenous crystalloid and artificial plasma expanders should be used for fluid replacement. Consideration should be given to the use of tranexamic acid.

The patient and family must be kept informed about the situation and they should be given information in a professional manner and their wishes always respected.

Where a patient lacks capacity and is unable to give/withhold consent to transfusion doctors should act in their best interests, taking into consideration the advice in section 5.1 relating to advance directives.

- **Obstetric Patients**

Pregnant women who are Jehovah's Witnesses, or who refuse transfusion of blood components or blood products for whatever reason, should be identified early, ideally when they first present to antenatal services. Pregnant women should be asked at the time of their booking appointment whether they would accept the transfusion of blood components or products (including anti-D). If they decline, they should be referred for Maternity Team care and a detailed discussion will need to take place regarding options and risks. The woman will be classified as "high risk" and a Consultant Obstetrician, and a Consultant Anaesthetist should be involved and an individual management plan developed. It is recommended that these women give birth in a consultant-led unit.

The same legal principles as apply to the general population regarding consent for transfusion are applicable to pregnant women over the age of 18 years, and for those under 18 years of age, the principles described in section 5.1.2 apply. There is no special consideration given in English law to "the rights of the foetus" in these circumstances. Detailed management guidance is given in the SFHT document "Management of women in pregnancy who decline blood and blood products guideline"

- **Neonates**

The legal principles that are applicable to children who are too young to give informed consent will also apply to neonates (see section 5.1.2). If the baby's parents object to it receiving a transfusion and time permits, medical staff should apply via the courts to resolve the issue. In a life-threatening emergency, doctors must provide treatment in the neonate's best interests, which may include giving a blood component/product transfusion even if this is against the wishes of the parent(s).

If the family are Jehovah's Witnesses, the Jehovah's Witness Hospital Liaison Committee is available to help with advice and guidance. These discussions along with the parents at ward level can often resolve difficulties and avoid costly court referral.

## 6.4 Other considerations

### 6.4.1 Stress and anxiety for staff

Doctors, nurses, and midwives have an obligation to do the best for their patients. It can be difficult and stressful when the use of treatments which could reduce morbidity or even save the patient's life is limited because of conflict with the patient's wishes or religious beliefs. It can be especially difficult when these limitations contribute to a death which might otherwise have been avoidable.

A clinician may refuse to participate in an elective procedure if he or she feels that the patient's request is unreasonable or inappropriate. The reasons should be explained to the patient. An attempt should be made to refer the patient to a suitably qualified colleague
When a patient death or near death occurs, the effect on staff members may be profound. Full briefing of all members of the expanded team can avoid feelings of frustration and anger which may be directed at the patient, their relatives, or representatives. Counselling may be required for staff who may feel that, because of adhering to the patients expressed wishes,

they have been unable to provide an optimal level of care that has resulted in a significant morbidity or even death during their care (2).

### 6.4.2 Ethical Dilemmas

Working within restrictions imposed by patients who refuse blood or blood products can result in diversion of hospital resources from other patients who have a medically indicated need for them. Examples are significant periods in ITU or HDU, or temporary dialysis. (2)

### **6.5** Contacting **the local Jehovah's Witness Hospital Liaison Committee**

The local Hospital Liaison Committee is contactable over 24 hours and will advise on all issues relating to the care and treatment of a patient who is a Jehovah's Witness.

See appendix 1 for further information and contact telephone numbers

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

| **WHAT**<br>**element of compliance or effectiveness within the procedural document will be monitored** | **WHO**<br>**is going to monitor this element (job title of person/ group responsible)** | **HOW**<br>**will this element be monitored (method used)** | **WHEN**<br>**will this element be monitored (frequency/ how often)** | **REPORTING**<br>**Which committee/ group will the resultant report and action plan be reported to and monitored by (report should include any areas of good practice/ organisational learning)** |
|---|---|---|---|---|
| Demonstrate that patient care reflects individual needs as directed by the policy | Hospital transfusion team | Documentation audit | Annually | Results will be presented to the HTC<br><br>A summary report will be presented to the PSB |
| A clear record of the patient's management plan when a blood transfusion is refused | Hospital transfusion team | Documentation audit | Annually | Results will be presented to the HTC<br><br>A summary report will be presented to the PSB |
| Analysis of incidents where there has been a failure to follow procedure | Hospital transfusion team | Datix reports | Quarterly | A summary report will be presented to the HTC and PSB |

## 8.0 TRAINING AND IMPLEMENTATION

This policy will be disseminated via the Trust intranet.

Education and training with regard to the policy will be covered during mandatory Blood Components Training.

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 5
- This document is not subject to an Environmental Impact Assessment

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

**Evidence Base:**

1. Re T. (1992). *Adult Refusal of Medical Treatment.* 4 All ER 649, 9 BMLR 46, CA

2. The Association of Anaesthetists of Great Britain and Ireland (2005) Management of Anaesthesia for Jehovah's Witnesses. The Association of Anaesthetists of Great Britain and Ireland Nov 2005: 2nd Edition

3. Bevan.D.H. (2002) Haematological Care of a Jehovah's Witness Patient. British Journal of Haematology, 119, 25-37

4. Department of Constitutional Affairs Mental Capacity Act 2005 .Crown Copyright 2005 Available from http://www.dca.gov.uk/menincap/legis.htm

5. Department of Health (2003) Reference Guide to Consent for Examination or Treatment. Crown Copyright. Available from www.doh.gov.uk/consent

6. Department of Health (2001) Consent –what you have a right to expect. A guide for parents Crown Copyright. Available from www.doh.gov.uk/consent

7. Department of Health (2001) Seeking Consent – Working with children Crown Copyright. Available from www.doh.gov.uk/consent

8. Sherwood Forest Hospitals NHS Foundation Trust Consent to examination, treatment and care policy

9. Hempsons (2007) Consent to treatment –A brief guide for the NHS. Second Edition

10. GMC (2009) Withholding and withdrawing life-prolonging treatments: Good practice in decision-making .Available from www.gmc.uk.org

11. Royal College of Surgeons (2016) - Caring for patients who refuse blood: a guide to good practice for surgical management of Jehovah's Witness and other patients who decline transfusion.
Available from
https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/caring-for-patients-who-refuse-blood/

12. Association of Anaesthetists (July 2018) – Guidelines : Anaesthesia and peri-operative care for Jehovah's Witness and patients Who refuse blood.

**Related SFHFT Documents:**

- Trust Transfusion Policy
- Trust Consent to examination, treatment and care policy
- Trust "Guideline for the management of women in pregnancy who decline blood and blood products"

## 11.0 KEYWORDS

Jehovah's Witness; Advance directive; Red cells; Fresh frozen plasma; Platelets; Cryoprecipitate; Cell salvage

## 12.0 APPENDICES

| | |
|---|---|
| Appendix 1 | Further information for Jehovah's Witness patients' and Jehovah's Witness Hospital Liaison Committee (HLC) contacts |
| Appendix 2 | Checklist for any patient refusing blood component/product support |
| Appendix 3 | Care pathway for pre-operative anaemia management of adults refusing blood and blood component transfusions |
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| Appendix 5 | Equality Impact Assessment |

## Appendix 1 – Further information for Jehovah's Witness patients' and Jehovah's Witness Hospital Liaison Committee (HLC) contacts

The majority of this policy, including ethical, legal, and clinical guidance is applicable to Jehovah's Witnesses. However, the following key information should be carefully noted when determining and working with their treatment choices:

For Jehovah's Witnesses, the refusal of whole blood and blood components (red cells, white cells, platelets, and plasma [FFP]) is a more than a treatment choice; it is a deeply-held core value.

Each one of Jehovah's Witnesses will make a personal decision regarding:
all plasma derivatives (these may be referred to by Jehovah's Witnesses as "fractions")
all autologous procedures (with the exception of pre-donation, which is unacceptable).

Jehovah's Witnesses generally complete and carry an Advance Decision to Refuse Specified Medical Treatment document which records their wishes. When correctly completed this document is legally binding. This document may also be filed with their GP and/or Summary Care Record.

Jehovah's Witnesses have established a support network for Witnesses facing medical treatment, particularly when this involves their treatment choices regarding blood transfusion.

These are known as Hospital Liaison Committees (HLC). This arrangement also exists to assist clinicians who are providing care to Jehovah's Witnesses.

The 24/7 contact details for the local HLC are:

The HLC emergency 24/7 contact number is: 07894 984493
Michael Deans: 07967 563565
Gerald Thoburn: 07810 753445
Simon Etches: 07736 109561

The 24/7 contact details for Hospital Information Services for Jehovah's Witnesses (UK) are:
020 8731 3415 his.gb@jw.org

Jehovah's Witnesses recognise that there are significant clinical and legal challenges when it comes to the treatment of minors who are Jehovah's Witnesses or are the children of Jehovah's Witnesses. In such situations it is important—with consent—to involve the HLC, either via the details above or by contacting Hospital Information Services.

Jehovah's Witnesses maintain a section of their website which contains citations of peer-reviewed articles from leading medical journals, as well as downloadable resources, on the subject of non-blood management:

## Appendix 2– Checklist for any patient refusing transfusion

Patient's Name: _____ Consultant: _____

Hospital number: _____ Department:__ _____

Date of birth: _____ Today's Date: _____

**Does the patient have an Advance Decision covering refusal of blood components? YES / NO.**
**(If so place a copy in the patients' medical notes behind the red alert notification page)**

| Treatment | Action | Further information |
|---|---|---|
| Is your patient taking: aspirin, NSAIDs, warfarin, other anticoagulants/antiplatelet agents, e.g.clopidogrel, prasugrel, dabigatran, apixaban, edoxaban or rivaroxaban? | YES / NO / N/A | Date to stop: |
| Have you corrected any anaemia pre-operatively, e.g. with iron, B12, folic acid (if appropriate)? | YES / NO / N/A | |
| Have you started patient on Tranexamic Acid? | YES / NO / N/A | |
| Has Consultant Anaesthetist been informed? | YES / NO / N/A | |
| Has Consultant Haematologist been informed? | YES / NO / N/A | |

| | I accept | | | | I accept | | |
|---|---|---|---|---|---|---|---|
| | YES | NO | Not Discussed | | YES | NO | Not Discussed |
| **Red blood cells** | | | | **Acute Normovolaemic Haemodilution** | | | |
| **Platelets** | | | | **Intra-op Cell Salvage** | | | |
| **Fresh Frozen Plasma** | | | | **Post-op Cell Salvage** | | | |
| **Cryoprecipitate** | | | | **Fibrin glues and sealants (human)** | | | |
| **Albumin** | | | | **Fibrin glues and sealants (non-human)** | | | |
| **Recombinant clotting factors (rVIIa)** | | | | **Anti-D** | | | |
| **Prothrombin Complex Concentrate (PCC)** | | | | **Other treatment (specify):** | | | |
| **Fibrinogen concentrate** | | | | | | | |

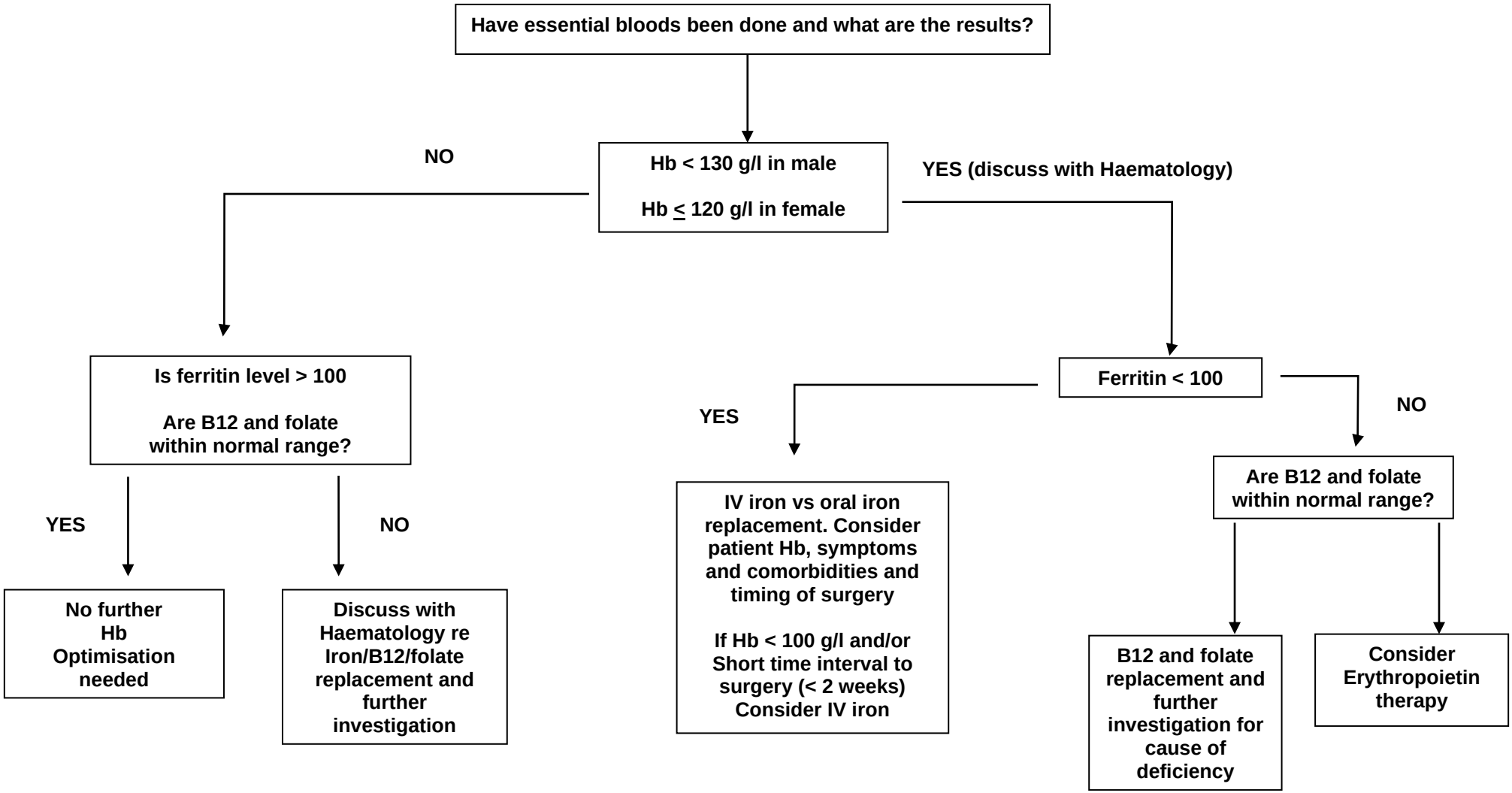
| **If required to save my life:** | |
|---|---|
| **Red Cells:** | **YES / NO** |
| **Platelets:** | **YES / NO** |
| **Fresh Frozen Plasma (FFP):** | **YES / NO** |
| **Cryoprecipitate:** | **YES / NO** |

- The patient (parent/guardian) has confirmed understanding and agreement with all the statements made above.
- The patient (parent/guardian) has also confirmed understanding that this document will remain in force and binding to all those involved in his/her care until he/she personally revokes it either verbally or in writing.
- The patient (parent/guardian) is signing the relevant document of his/her own free will.

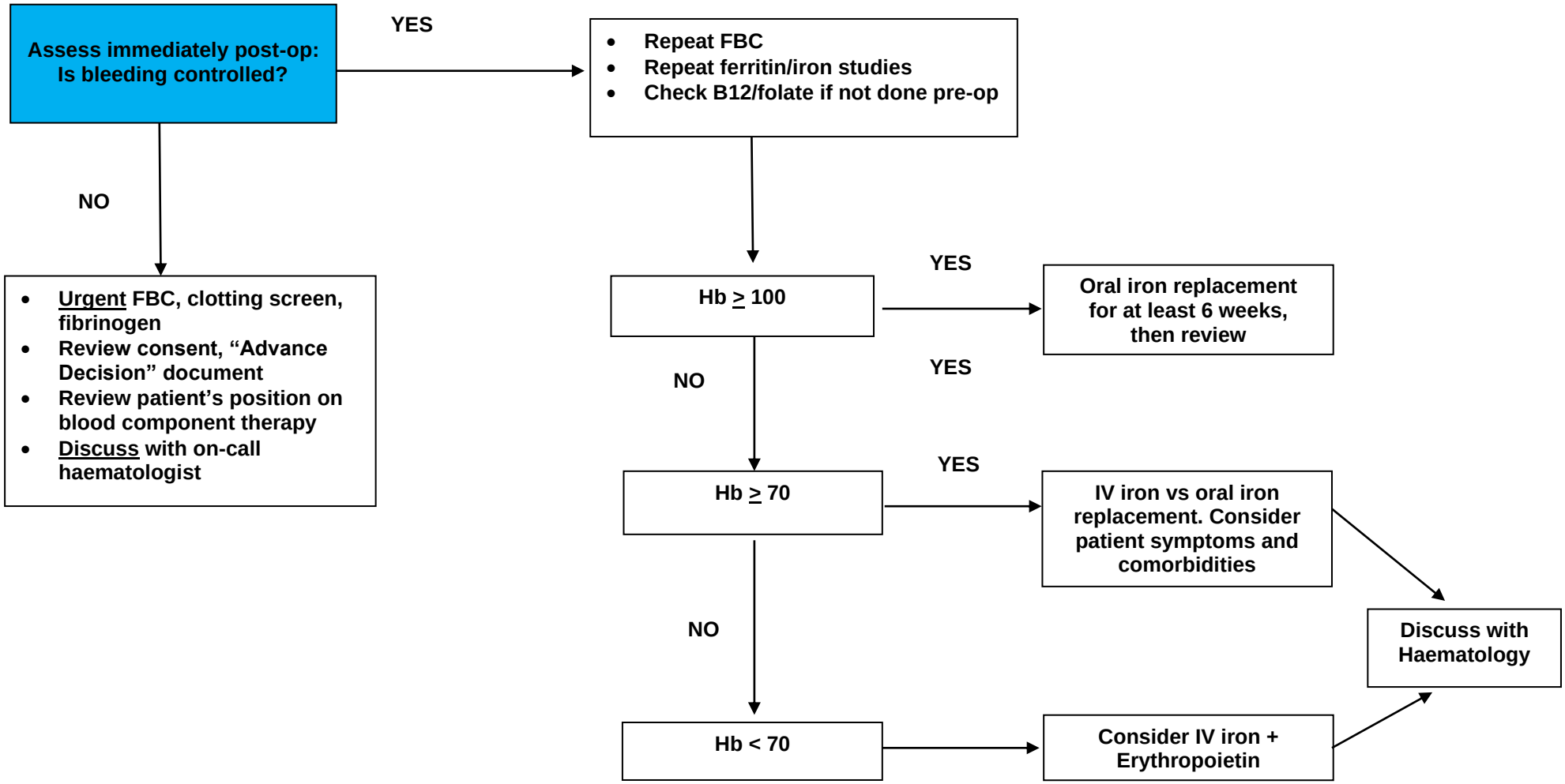
**Patient (parent/guardian) signature** _____ **Name** _____ **Date**_____
Document author: Specialist Transfusion Practitioner Version: 20171025

# Appendix 3

## Pathway for pre-operative anaemia management of adults refusing blood and blood component transfusions



## Appendix 4 – Pathway for post-operative anaemia management of adults refusing blood or blood component transfusions



## APPENDIX 5 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

| | | | |
|---|---|---|---|
| Name of service/policy/procedure being reviewed: Policy for refusal of transfusion of blood and blood components | | | |
| New or existing service/policy/procedure: Existing | | | |
| Date of Assessment: 16.04.2024 | | | |
| For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas) | | | |
| Protected Characteristic | a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider? | b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening? | c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality |
| The area of policy or its implementation being assessed: | | | |
| Race and Ethnicity | None | None | None |
| Gender | None | None | None |
| Age | None | None | None |
| Religion | None | None | None |
| Disability | None | None | None |
| Sexuality | None | None | None |
| Pregnancy and Maternity | Not covered in policy | Already a Trust guideline for the management of women in pregnancy who decline blood and blood products | None |
| Gender Reassignment | None | None | None |
| Marriage and Civil Partnership | None | None | None |
| Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation) | None | None | None |

| |
|---|
| What consultation with protected characteristic groups including patient groups have you carried out?<br>• Consultation has occurred with the local hospital Jehovah's witness representatives. |
| What data or information did you use in support of this EqIA?<br>• |
| As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?<br>• No |

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

**Low Level of Impact** *(Delete as appropriate)*

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

| |
|---|
| Name of Responsible Person undertaking this assessment<br>Leanne Hostler, Specialist Transfusion Practitioner |
| Signature: |
| Date:<br>16th April 2024 |