HOW DO WE CONSENT FOR TRANSFUSION IN PREGNANCY?

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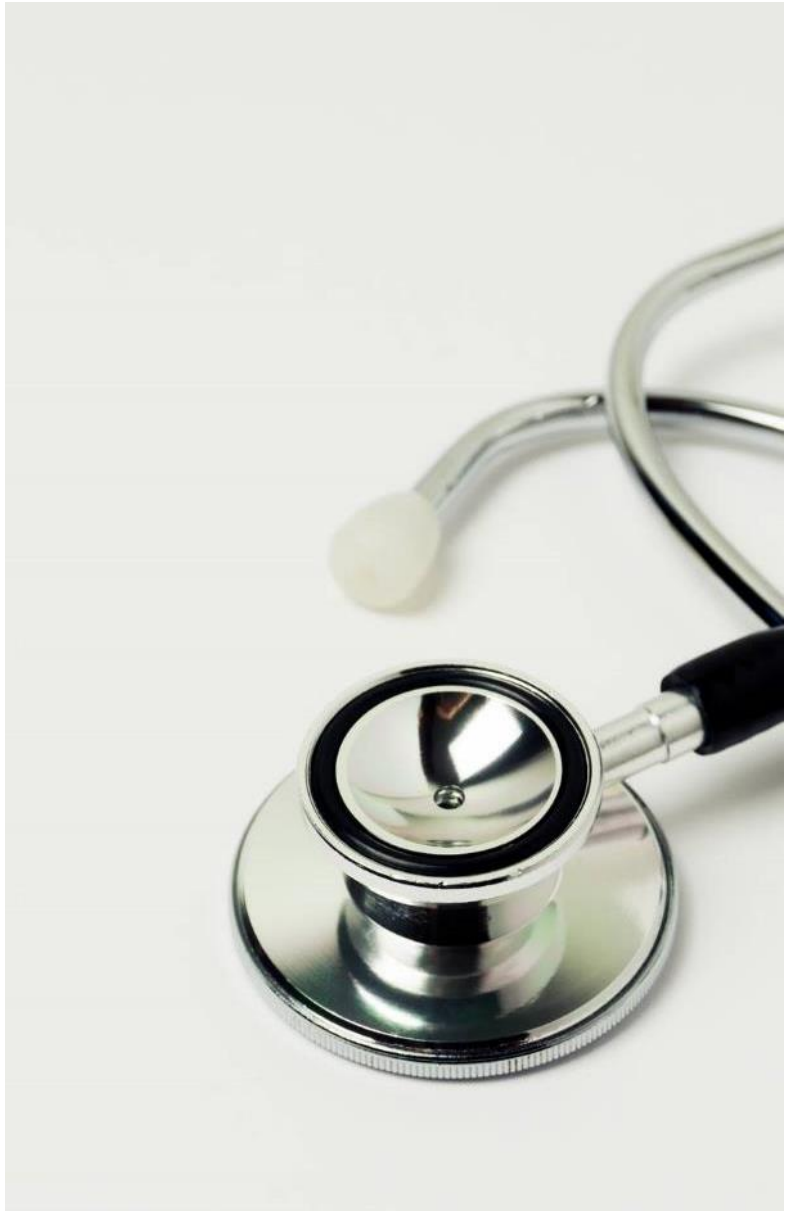
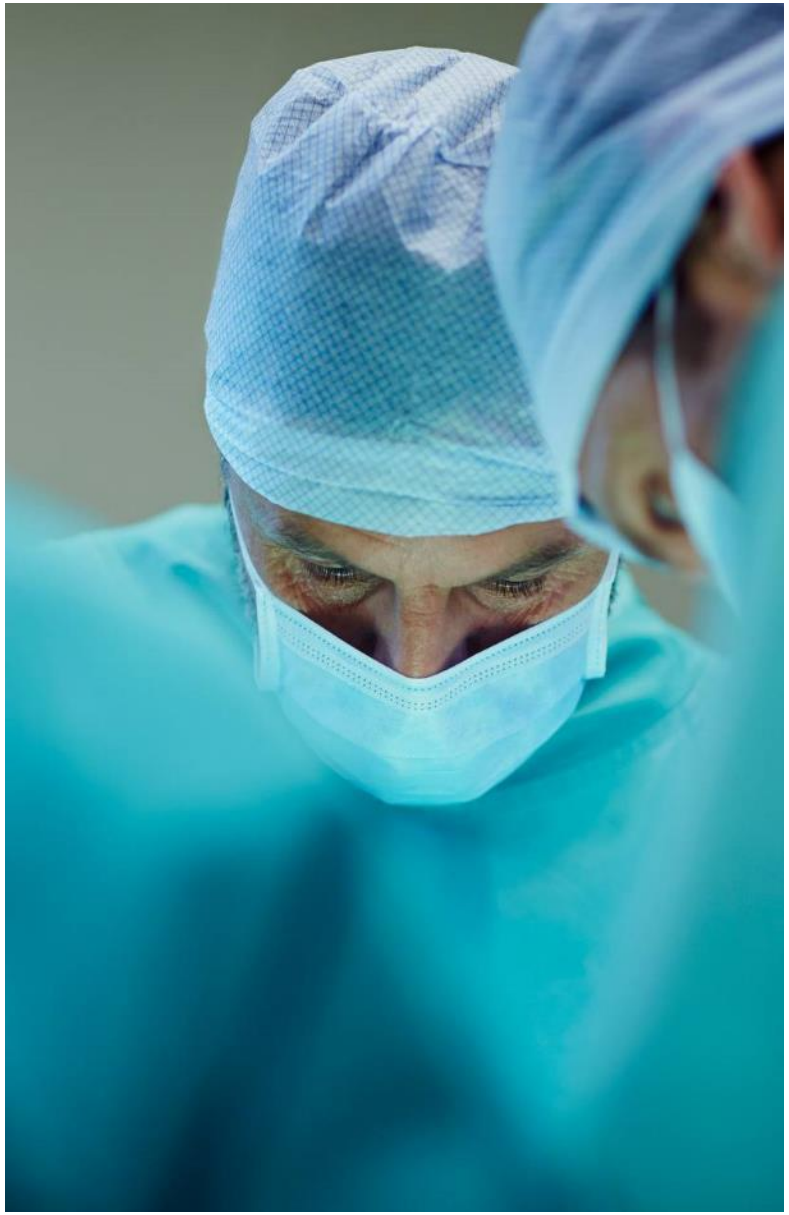
West Suffolk Hospital

CONSENT

- Principles
- Pregnancy specifics
- Practicalities





INTRODUCTION

- It is a general legal and ethical principle that valid consent should be obtained from a patient before they are treated.
- In 2020: SaBTO published "Patient Consent for Blood Transfusion" which updates the 2011 recommendations and includes the following:
  - Valid consent should be obtained and documented in the patient's clinical record by the healthcare professional
  - Patients who were given a blood transfusion and were not able to give informed and valid consent prior to the transfusion are informed of the transfusion prior to discharge and provided with paper or electronic information
  - There should be a modified form of consent for long term multi-transfused patients, and this should be detailed in your organisation's consent policy

CASE ONE

29 year old, G1 P1

- Day 1 postpartum
- Forceps delivery for prolonged second stage with traumatic blood loss, 3rd degree tear
- EBL 1.9L
- Hb post delivery 73 g/L
- No pre-existing iron/haematinic deficiency
- Planning to breast feed
- Aiming for home today

Issues to consider?

- Elective 'top up' transfusion
- Risks?
- Alternatives?

PRACTICALITIES:
WHAT DO WE NEED TO KNOW TO TAKE INFORMED CONSENT?

Benefits

Risks

Alternatives

PRACTICALITIES:
WHAT DO WE NEED TO KNOW TO TAKE INFORMED CONSENT?

Benefits

- Management of acute blood loss
- May be life saving
- Relieve symptoms of anaemia
- Improve recovery
- Support successful breast feeding

Risks

- Transfusion reactions
- Infections
- Fluid overload (TACO)
- Transfusion related acute lung injury (TRALI)
- Antibody formation
- Ineligible for blood donation

Alternatives

- Cell salvage
- Tranexamic acid
- Oral iron replacement
- Intravenous iron
- B12/folate replacement
- (Erythropoietin)

CASE TWO

36 year old, G3 P2

- Low lying placenta in this pregnancy
- Pre-existing iron deficiency, ferritin 10
- Poorly tolerant of oral iron (GI effects)
- US at 32/40 shows placenta praevia, and this is confirmed at 36/40
- Delivery by Caesarean section is recommended

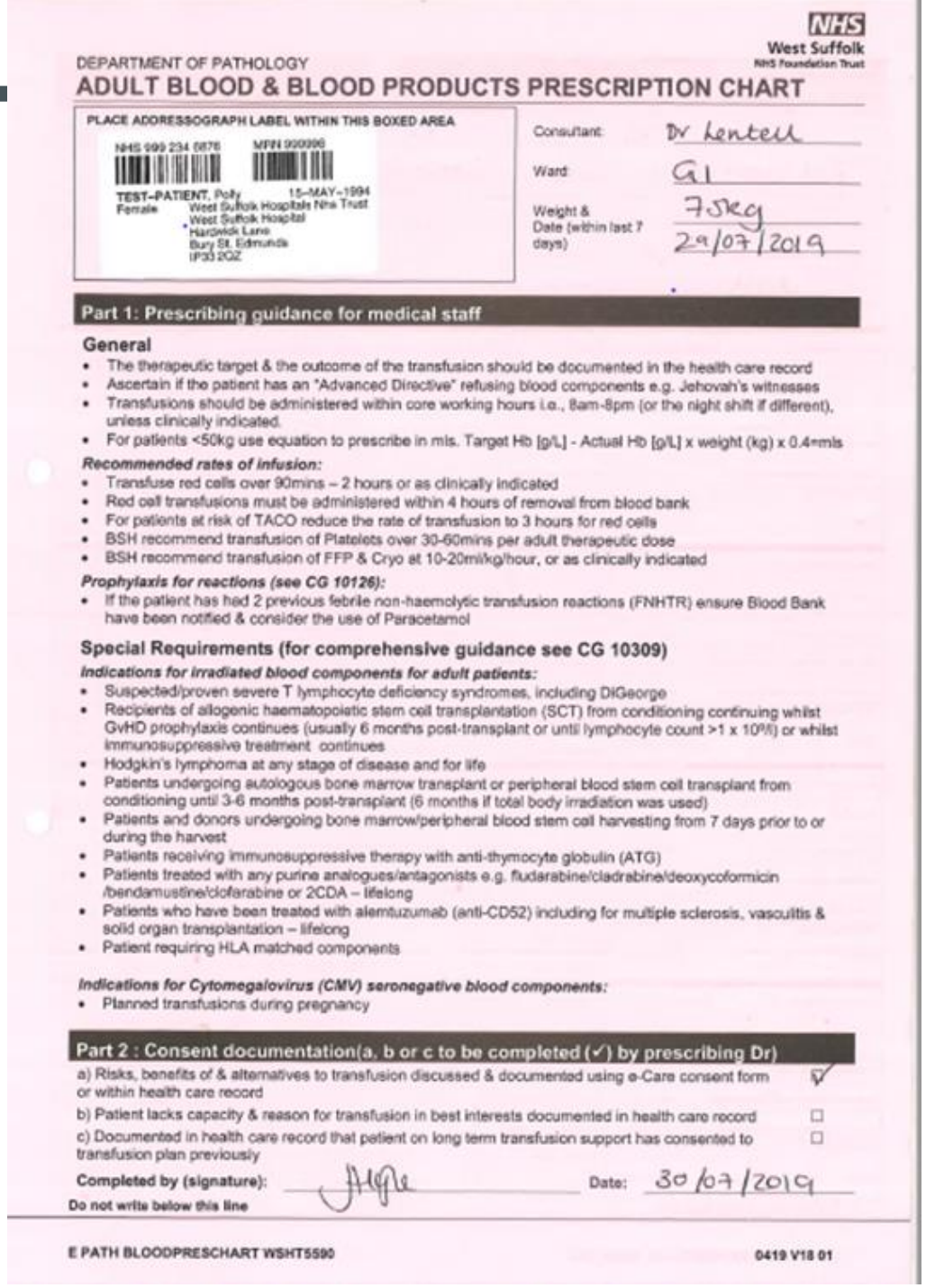
Issues to consider?

- Treatment of iron deficiency
- IV iron
- Increased likelihood of requiring transfusion during delivery
- Time to take consent in advance and provide written/electronic information
- Ensure blood is crossmatched and available for theatre

INFECTION RISK

- UK has one of the safest blood supplies in the world
- About 2 million units transfused in the UK each year
- Transfusion-transmitted Infection (TTI) is extremely rare (frequency varies but most are <1/million)
- Bacterial risk reduction: ANTT, temperature controlled storage, adherence to expiry date/time, bacterial monitoring (platelets)
- Viral risk reduction: Donor health screen, donor screening for HIV, HBV, HCV, syphilis, HTLV and HEV
- Last 10 years: 0-5 TTI per year
- SHOT report 2023: 1 confirmed malaria, 1 confirmed TTI (hepatitis A), 1 probable HEV cleared with treatment, 1 probable HBV likely lifelong treatment.

WSFT BLOOD PRESCRIPTION FRONT PAGE



NHS
West Suffolk
NHS Foundation Trust

DEPARTMENT OF PATHOLOGY

ADULT BLOOD & BLOOD PRODUCTS PRESCRIPTION CHART

PLACE ADDRESSOGRAPH LABEL WITHIN THIS BOXED AREA

NHS 999 234 5876 MRN 000000

TEST-PATIENT, Polly 15-MAY-1994
Female
West Suffolk Hospitals Nhs Trust
West Suffolk Hospital
Hardwick Lane
Bury St. Edmunds
IP33 2QZ

Consultant: Dr Lentell

Ward: G1

Weight & Date (within last 7 days): 75kg 29/07/2019

Part 1: Prescribing guidance for medical staff

General

- The therapeutic target & the outcome of the transfusion should be documented in the health care record
- Ascertain if the patient has an "Advanced Directive" refusing blood components e.g. Jehovah's witnesses
- Transfusions should be administered within core working hours i.e., 8am-8pm (or the night shift if different), unless clinically indicated.
- For patients <50kg use equation to prescribe in mls. Target Hb [g/L] - Actual Hb [g/L] x weight (kg) x 0.4=mls

Recommended rates of infusion:

- Transfuse red cells over 90mins – 2 hours or as clinically indicated
- Red cell transfusions must be administered within 4 hours of removal from blood bank
- For patients at risk of TACO reduce the rate of transfusion to 3 hours for red cells
- BSH recommend transfusion of Platelets over 30-60mins per adult therapeutic dose
- BSH recommend transfusion of FFP & Cryo at 10-20ml/kg/hour, or as clinically indicated

Prophylaxis for reactions (see CG 10126):

- If the patient has had 2 previous febrile non-haemolytic transfusion reactions (FNHTR) ensure Blood Bank have been notified & consider the use of Paracetamol

Special Requirements (for comprehensive guidance see CG 10309)

Indications for irradiated blood components for adult patients:

- Suspected/proven severe T lymphocyte deficiency syndromes, including DiGeorge
- Recipients of allogenic haematopoietic stem cell transplantation (SCT) from conditioning continuing whilst GvHD prophylaxis continues (usually 6 months post-transplant or until lymphocyte count >1 x 10^9/l) or whilst immunosuppressive treatment continues
- Hodgkin's lymphoma at any stage of disease and for life
- Patients undergoing autologous bone marrow transplant or peripheral blood stem cell transplant from conditioning until 3-6 months post-transplant (6 months if total body irradiation was used)
- Patients and donors undergoing bone marrow/peripheral blood stem cell harvesting from 7 days prior to or during the harvest
- Patients receiving immunosuppressive therapy with anti-thymocyte globulin (ATG)
- Patients treated with any purine analogues/antagonists e.g. fludarabine/cladrabine/deoxycoformicin /bendamustine/clofarabine or 2CDA – lifelong
- Patients who have been treated with alemtuzumab (anti-CD52) including for multiple sclerosis, vasculitis & solid organ transplantation – lifelong
- Patient requiring HLA matched components

Indications for Cytomegalovirus (CMV) seronegative blood components:

- Planned transfusions during pregnancy

Part 2 : Consent documentation(a, b or c to be completed (✓) by prescribing Dr)

a) Risks, benefits of & alternatives to transfusion discussed & documented using e-Care consent form or within health care record ☑

b) Patient lacks capacity & reason for transfusion in best interests documented in health care record ☐

c) Documented in health care record that patient on long term transfusion support has consented to transfusion plan previously ☐

Completed by (signature): JHyde Date: 30/07/2019

Do not write below this line

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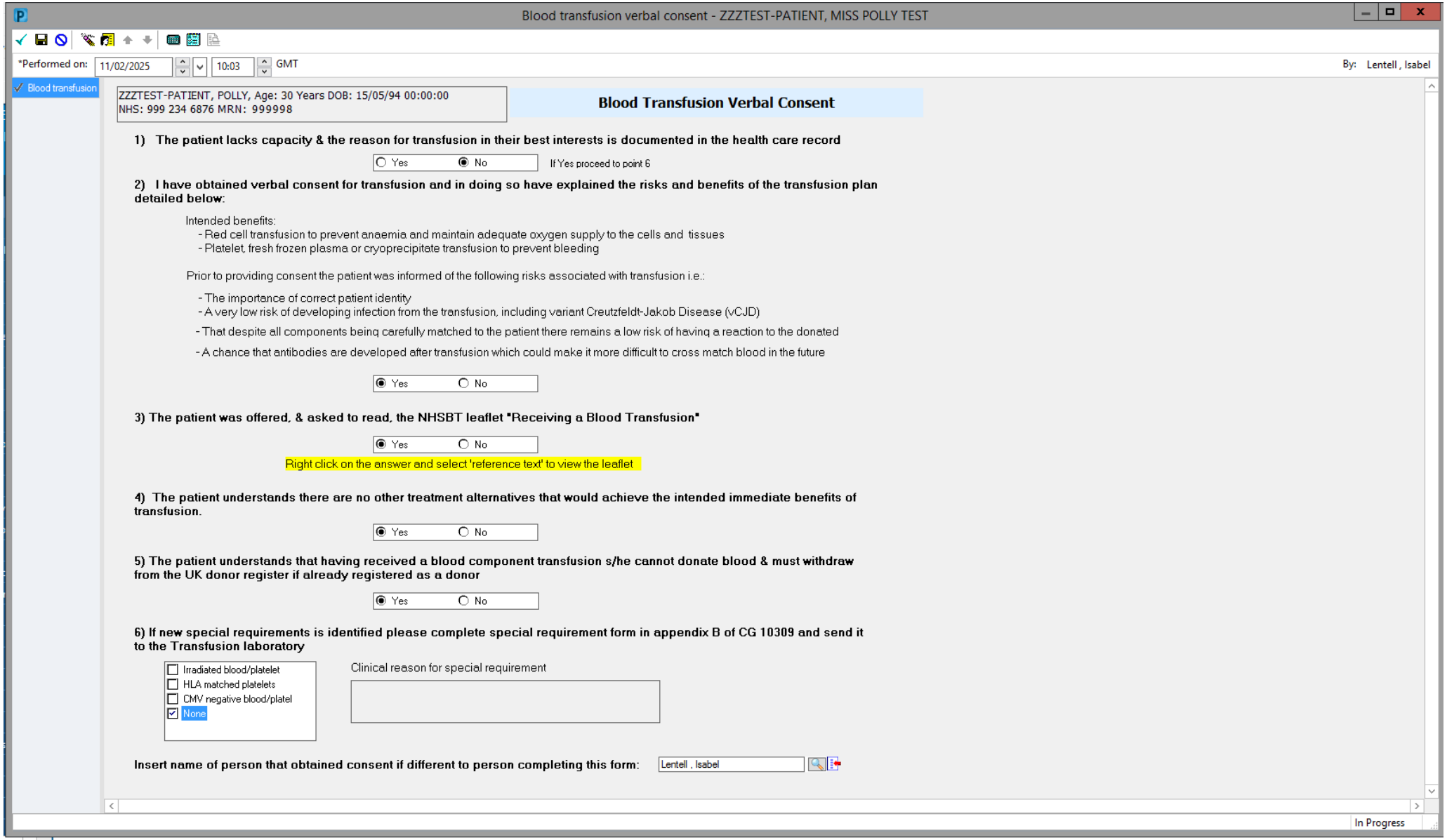
WEST SUFFOLK ECARE CONSENT FORM



CASE THREE

25 year old, G0 P1

- Currently 16/40 in first pregnancy
- Jehovah's Witness
- No iron or haematinic deficiency
- Does not yet have an Advance Decision to Refuse Medical Treatment in place
- Offered a review in the Haematology clinic to discuss options for delivery in more detail
- Has already decided she will decline red cell and platelet transfusion

Issues to consider?

- Cellular vs non cellular products
- Avoiding anaemia in pregnancy, oral iron/folate
- Cell salvage, TXA, active management of 3rd stage
- Considering use of erythropoietin if required
- Documenting decision and sharing Advance Decision to Refuse Medical Treatment

WEST SUFFOLK REFERRAL FORM FOR PATIENT DECLINING BLOOD

- For adult patients who have an "Advance Decision to Refuse Specific Medical Treatment" in place
- Referral form to Haematologist completed
- Plan is documented, and signed by patient
- File/scan into patient record
- Complete request for electronic flag to be placed in health records, signed by patient

Appendix 10: Referral form for patient declining blood

Diagnosis:

Referring Consultant:

Advanced directive alert already on e-Care or added? ☐

Addressograph label

Planned procedure/EDD (if appropriate):

Relevant medical history (bleeding tendencies):

Date of procedure (if appropriate):

Anaesthetist (if relevant):

Estimated blood loss:

Is patient taking anticoagulant/anti-platelet medications/LMWH? **Yes** ☐ **No** ☐

If yes what & why?

'Advance Decision to Refuse Specific Medical Treatment' document available? **Yes** ☐ **No** ☐

Indicate if patient willing/ not willing to accept the components/products below:

Status	Product/ Procedure accepted by patient:	Acceptable?
NOT accepted	Whole blood	Yes / No
	Red Cells	Yes / No
	White cells	Yes / No
	Plasma (FFP)	Yes / No
	Platelets	Yes / No
	Autologous pre-deposit	Yes / No
Accepted	Saline / Hartmann's	Yes / No
	Gelofusin	Yes / No
For personal decision	Cryoprecipitate	Yes / No
	Albumin	Yes / No
	Plasma derived coagulation factors	Yes / No
	Globulins including immunoglobulins and anti D	Yes / No
	Interferons / Interleukins	Yes / No
	Routine syntometrine at delivery	Yes / No
	Post-natal syntocinon infusion	Yes / No
	Intra-operative cell salvage - with continuous connectivity	Yes / No
	Intra-operative cell salvage - without continuous connectivity	Yes / No
	Postoperative cell salvage (not a continuous circuit)	Yes / No
	Acute normovolaemic haemodilution	Yes / No
	Haemodialysis	Yes / No
	Cardiopulmonary bypass	Yes / No
	Recombinant products Factors VIIa, VIII, IX	Yes/No

I refuse the use of the products indicated above, even if it puts my life at risk:

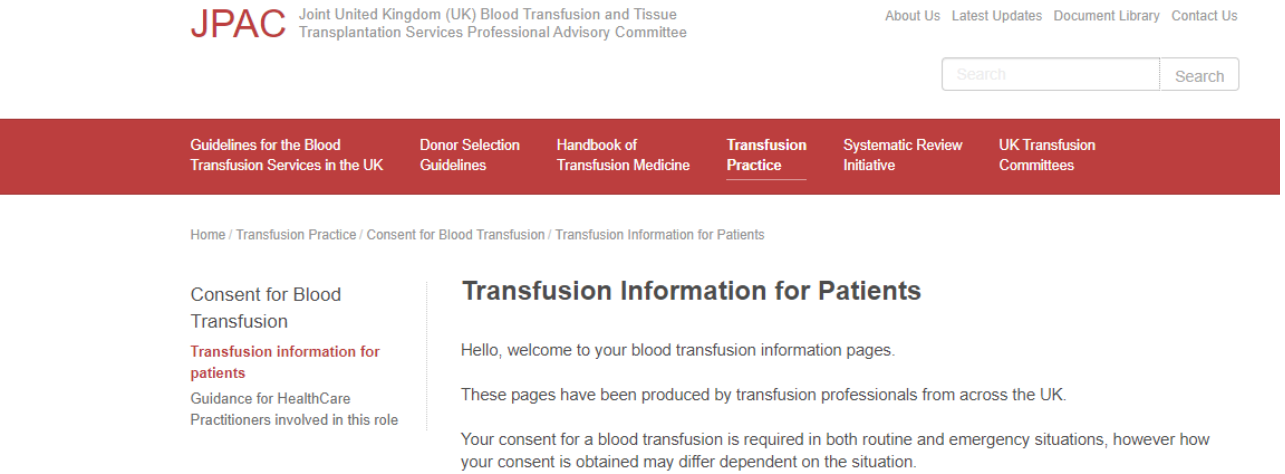
Patient's signature: **Date:**

Clinician's signature: **Date:**

Essential bloods taken:
FBC & reticulocyte count ☐
B12 & folate ☐
Others (state) ☐

Date sent to lab:
Iron studies (ferritin & transferrin saturations) ☐
Clotting screen & fibrinogen ☐
CRP ☐
Group & screen ☐

RESOURCES



- JPAC Transfusion Information for Patients
- NHSBT Patient information leaflets - Hospitals and Science
- RCOG Blood transfusion, pregnancy and birth | RCOG

Receiving a Blood Transfusion leaflet

Receiving a Blood Transfusion
(audio version)

Easy read “HAVING A BLOOD TRANSFUSION” leaflet

Translations of “Receiving a Blood Transfusion”

Receiving a Blood Transfusion
(text compatible with screen reader software)

THANK YOU!

ANY QUESTIONS?

With thanks to:

- West Suffolk Hospital Transfusion Team
- Gilda Bass & Joanne Hoyle, WSH TNS's