***Administrative Policies and Procedures***

**REFUSAL OF BLOOD PRODUCTS – MEDICAL AND SURGICAL OPTIONS 85.7**

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| **Policy Number:** | 85.7 |
| **Division:** | Patient Care Services |
| **Effective Date:** | 07/2005 |
| **Review Date:** | 07/2011 |
| **Reviewer:** | Becky Pierce |

**POLICY PURPOSE:**

**Consent**

Obtaining consent for blood is a routine part of every hospital admission.  If upon informing the patient of the risks of blood transfusion, the patient decides not to accept this therapy, the HMC form titled “*Informed Consent for Refusal of Blood Components”* should be used for documentation.  For patients refusing blood for religious reasons, the patient may request to speak with an advocate.  Should this occur, contact HMC Social Work at 744-8030.

**POLICY:**

A.    **Patients capable of providing informed consent**

Determine if the patient is refusing blood for fear of infectious disease transmission, or for religious reasons.

i.              Refusal for fear of infectious disease transmission

a.     Explain to the patient that albumin and immune globulins, although human-derived, have been specially treated so that they are very unlikely to transmit infection.

b.    Notify the patient that, should albumin be refused, the option to use erythropoietin will not be possible.

c.     Obtain consent or refusal of albumin and immune globulins. Document on the consent form.

ii.             Patients refusing consent for religious reasons

a.     Patients refusing blood for religious reasons will have individual responses to what they will or will not accept (for example, some patients will agree to receive cryoprecipitate).  It is therefore necessary to ask each individual item on the consent form.

b.    Inform the patient that erythropoietin formulations are made in albumin.

c.     If the patient will need urgent surgery, it is necessary to gain consent/refusal for the following:

-       Intra-operative blood salvage (cell saver)

-       Intra-operative hemodilution (acute normovolemic hemodilution)

-       Blood patch

-       Whether blood collected intraoperatively must be in constant connection to the patient’s circulatory system (if the patient does not know, assume the answer is yes).

B.    **Patients incapable of providing informed consent (including minors)**

i.              An authorized representative (including parents) cannot refuse the emergency provision of blood components to a level necessary to provide optimal patient care for the patient unless a signed copy of a valid court order to the contrary and/or blood refusal card can be immediately produced.  Follow emergency procedures as set forth in HMC/UW Medical Centers consent Manual p. A-5.

ii.             **IF NON-EMERGENT TREATMENT IS DELAYED** based on the preference statement by the patient’s authorized representative, this consent form needs to be signed and the rationale for delay documented in the patient’s medical record (i.e., choice is elective and patient does not constitute an emergency)**.**

iii.            **IF THE PATIENT’S AUTHORIZED REPRESENTATIVE (INCLUDING PARENTS OF A MINOR) REFUSE TO CONSENT TO BLOOD COMPONENTS**, the Medical Center may seek a court order authorizing such treatment if the physician believes that the failure to provide blood components will endanger the patient’s health.  If the situation becomes an emergency, in the opinion of the physician, follow emergency procedures as cited in step 1 above.

iv.            **FOR ASSISTANCE IN OBTAINING A COURT ORDER,** the physician should contact the Administrator-on-Call through the paging operator (HMC:744-3000, UWMC 598-6190) and the Health Sciences Assistant Attorney General’s Division (543-9220 or paging operator after hours).  If the physician believes blood components may be necessary during an evening , weekend or holiday, arrangements should be made during normal business hours whenever possible.

v.             **IF AN ATTEMPT IS MADE TO WITHDRAW THE PATIENT FROM MEDICAL CENTER CARE** to avoid potential provision of blood components, a Medical Center administrator or physician may detain the patient (See “Refusal of Consent/Minors”, Consent Manual cited above p. A-16).  As appropriate, immediately notify Child Protective Services (721-4115) or Adult Protective Services (587-5620).

**A specific person will be assigned to communicate the refusal of blood to the patient care area where the patient will be transferred or will have future surgery.**

**Minimizing Blood Loss**

The following techniques should be used to minimize blood loss:

1.     Minimize blood draws.

2.     Minimize sampling techniques for any blood tests by using microtubules/pediatric tubes.  Call the laboratory if minimum sampling requirements for a specific test are unknown.

3.     During intravenous line insertion, use postphlebotomy digital pressure until bleeding stops.

4.     Ice pack administration following phlebotomy may be used to limit hematoma formation.

5.     For invasive procedures such as dialysis catheter placement or chest tube placement, physicians at the senior resident level or above  should perform the procedure unless the urgency of the situation precludes this.

**Optimizing erythropoiesis and red cell function**

The following therapies should be considered:

1.     Use of oxygen in the setting of anemia

2.     In the setting of anemia or anticipated anemia, administer erythropoietin if the patient has agreed.

3.     Administer vitamin C, B12, and folate

4.     Administer ferrous sulfate (particularly if ferritin levels are low).

**Optimizing hemostasis**

Obtain a hematology consult. In the interim, consider:

1.     Discontinue use of medications that may inhibit platelet function or alter coagulation factor activity.

2.     Avoid hypothermia.

3.     Administer vitamin K.

4.     In uremic patients requiring invasive procedures, consider short-term use of DDAVP in conjuction with the procedure.

5.     In patients with mucosal bleeding, consider Epsilon amino caproic acid (Amicar ,NOTE: generally contraindicted in the setting of renal pelvic hemorrhage).

6.     For external bleeding, consider topical hemostatic agents..

7.     For bleeding in the setting of documented coagulopathy, consider recombinant hemophilia products such as factor VIIa (Novoseven, may be obtained from HMC pharmacy).

8.     Consider use of aprotinin if clinical scenario is appropriate

**Anesthesia and Surgery**

**A.    Pre-operative phase**

i.              Immediate surgery required

a.     Notify the Heme-Onc fellow via the hospital operator

b.    Notify anesthesia and transfusion support of the patient and the refusal of blood.

c.     Inform the anesthesiologist of the specific acceptance and refusals on the consent.

d.    For surgery expected to result in > 500 mL of blood loss, notify the attending surgeon.

e.     Draw an emergency hemorrhage panel (EHP) using a pediatric tube and send it STAT to the laboratory.

ii.             Semi-urgent surgery required

a.     Notify the Heme-Onc fellow via the hospital operator

b.    For current anemia or cases with possible blood loss, administer erythropoietin (600U/kg SC once a week or 300U/kg SC 3 times a week; round to the nearest available vial size) if patient agrees.

c.     If possible, discontinue any medications that may predispose to bleeding.

d.    Check ferritin level. Administer iron until ferritin level is documented to be >100. (SEE MANAGEMENT ORDERS FOR BLOODLESS SURGERY)

e.     Administer vitamin C, B12, K, and folate (SEE MANAGEMENT ORDERS FOR BLOODLESS SURGERY)

f.     Notify anesthesia of the need for surgery and fax the *Refusal of blood consent form* to the anesthesia department.

g.    Draw a PT, PTT, platelet count and hematocrit the day prior to surgery.

iii.            Elective surgery cases

a.     Contact the Heme Infusion Clinic 206-744-6210 and the patient care coordinator for the heme clinic 206-744-6212 (or page Dr. John Harlan at 206-997-6717) as soon as surgery is a consideration for the patient.

b.    A minimum of 3 weeks should be allowed to prepare patient for elective surgery.

c.     Obtain consent using the *Refusal of blood consent* form.

d.    See MANAGEMENT ORDERS FOR BLOODLESS SURGERY, attached.  Arrange for the patient to receive erythropoietin if patient agrees and significant blood loss is expected.

e.     Arrange for subsequent pre-surgery visit to review ferritin results and check hematocrit. **Elective surgery should  be delayed until ferritin level >100.**

f.     Notify anesthesia of the surgery and fax a copy of the patient’s consent form to the anesthesiology department.

**B.    Intraoperative phase**

a.     Anesthesia: refer to bloodless surgery guidelines developed for the anesthesiology dept.

b.    For cases where patient must remain connected to any blood being returned to patient, nursing and anesthesia staff will be notified.

c.     For cases with expected blood loss of >500 mL, the attending surgeon will be present for the entire case.

**C.    Post-operative phase**

i.              Immediate  surgery

a.     For cases with significant blood loss, administer erythropoietin (300U/kg or 600U/kg SC; round to the nearest available vial size) if patient accepts albumin.

b.    Administer iron, Vitamin C, B12, K, folate (see MANAGEMENT ORDERS FOR BLOODLESS SURGERY). Tailor dose according to degree of anemia present and need for subsequent surgery.

c.     Draw microtube for ferritin level.  Discontinue iron if ferritin level is high.

ii.             Semi-urgent  or Elective surgery with significant blood loss

a.     Continue with therapy used to optimize hematocrit and coagulation parameters prior to surgery.

iii.            Any surgery with significant blood loss

a.     Have a low threshold for ICU admission post-operatively.

b.    Monitor hematocrit and coagulation parameters for several hours following surgery. Use available interventions as needed.

**CROSS REFERENCE:**

None

**ATTACHMENT:**

None

**REVIEW/REVISION DATES:**

07/2005, 03/2007, 07/2011 (reviewed)