Ref:MM184a

# Termination of Pregnancy Protocol

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**Definition of Protocol**

These are detailed descriptions of the steps taken to deliver care or treatment to a patient and are sometimes called the "integrated care pathway". They are designed at local level to implement the national standards and determine care provision by using the best evidence if national standards are not available

**Minor Amendments**

If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

| Type of change | Why change made | Page number | Date of change | Version 1 to 1.1 | Name of responsible person |
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# 1. Introduction

This is a protocol for the delivery of the Termination of Pregnancy Service policy. The Protocol applies to Rhondda, Cynon, Taf and Merthyr Localities. The Bridgend Locality currently have a Service Level Agreement (SLA) with Swansea Bay University Health Board for this service which will be reviewed by 1st April 2020. The use of this protocol within the Bridgend locality will be reviewed in line with the review of the SLA.

# 2. Definition

This protocol is to be used by all staff involved in the Termination of Pregnancy Service (TOP) within Cwm Taf Morgannwg University Health Board (CTMUHB).

The purpose of this protocol is to provide a step by step guide to ensure that where women meet the criteria for TOP, the needs of the woman are met where possible.

# 3. Assessment Criteria

The criteria below are designed to help health professionals identify women who are suitable for either home, medical or surgical termination of pregnancy. Medical termination can be completed at home or within Health Board premises depending on gestation and choice. (1) The home assessment criteria allows healthcare professionals to identify women who are suitable for the option of home termination and minimise potential risk factors related to the process. The information gained forms the basis of clinical decision-making.

**Young People less than 16 years old**

All young people should be encouraged to confide in a parent or guardian (2);

'The House of Lords ruling in the Gillick case was followed by the issuing of guidance by the DH in the form of a Health Circular [HC (FP) (86)1]. The legal position was stated as 'any competent young person, regardless of age, can give valid consent to medical treatment'.

The same working test for assessing capacity as described in relation to the adult with capacity should be applied.

Although a young person may have the capacity to give consent, this is only valid if it is given voluntarily. To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person to either accept or refuse treatment.

Lord Fraser provided the Fraser Criteria to guide doctors asked to provide contraception for girls aged under 16 years who refuse to involve their parents.

A doctor or clinician is justified in proceeding without the parents' consent or knowledge if:

• The young person will understand the advice
• She cannot be persuaded to inform her parents or to allow the doctor/clinician to inform her parents that she is seeking an abortion.
• She cannot be persuaded to inform her parents or to allow the doctor/clinician to inform her parents that she is seeking contraceptive advice.
• She is likely to begin or to continue having sexual intercourse with or without contraceptive advice.
• Unless she receives contraceptive advice or treatment, her physical or mental health, or both, is likely to suffer.
• Her best interests require the clinician/doctor to give her contraceptive advice, treatment or both without parental consent.

The case of Axon vs The Secretary of State for Health confirmed that the Gillick judgement also extends to cover abortion.

Doctors have an obligation to encourage a young person to involve her parent(s) or another adult (such as another family member or a specialist youth worker) but generally should not override the patient's views. Further guidance is contained in Working Together to Safeguard Children.

Any issues should be discussed with the doctor at the time of the consultation and where necessary the Lead for Child Protection

Adequate contraception and advice should be provided on the day of the procedure.

## 4. Cervical Cytology

Women who have not had cervical cytology screening within the recommended interval should be offered screening within the abortion service, or advised on when and where to obtain it.(2)

## 5. Protocol Procedures

A detailed history must be undertaken to ascertain any complications that could occur or the suitability of the patient for the preferred procedure.

**For all terminations the complications and sequelae associated with the procedures should be discussed with the patient.**

**Medical TOP– Home/ In-patient**

- Procedure explained
- Leaflet given
- Appropriate consent taken

**Surgical TOP/ MVA**

- Procedure explained
- Leaflet given (Day Surgery or TOP clinic)
- Appropriate consent taken

### 5.1.1 Disposal of fetal remains

The woman can take responsibility for disposal of pregnancy tissue at home if they desire, however CTUHB will take responsibility for disposal of pregnancy tissue if that is the woman's preference. This **MUST** be discussed, and options provided and clearly documented in the notes.(3)

### 5.1.2 Ultrasound scan findings

If there is not an intra uterine pregnancy on ultrasound scan (USS) a serum human Chorionic Gonadotrophin (hCG) level must be performed.(2)

- If this is negative; < 5IU/Litre. This confirms that there is no pregnancy and appropriate contraception should be given.
- If this positive; > 5IU/Litre, then a repeat test should be performed after 48 hours and followed up appropriately

Where a woman has an increase in serum hCG concentration greater than 63% after 48 hours:

- Inform her that she is likely to have a developing intrauterine pregnancy (although the possibility of an ectopic pregnancy cannot be excluded).
- A repeat USS should be performed as necessary to confirm an intrauterine pregnancy.

### 5.1.3 STI screening and treatment

For all women it is best practice to undertake a risk assessment for STIs (i.e. HIV, syphilis, chlamydia, gonorrhoea) and to screen for them if appropriate with consent prior to the termination.(2)

Women with a positive STI result should be followed up and treated accordingly as per current CTUHB guidelines. Individual regimens can be found at;

https://viewer.microguide.global/CWMTAF/SECONDARYCARE/#content,3970db5f-4e09-4164-8050-e1ddb3d32dd6

Where a positive result for syphilis or HIV has been obtained the patient should be referred to specialist sexual health services

If any contraindications to treatment with the recommended regimens exist e.g. allergy, then second line options must be discussed with the consultant microbiologist.

The partners of women who test positive for STI's should also be informed and advised about treatment. A system of partner notification and follow up/ referral to sexual health service should be in place.

Information should also be available about prevention of STI's, and condoms offered.

## 5.1.4 Early medical TOP at HOME

Defined as up to 9 weeks +6 days/69 days gestation

### 5.1.4.1 **Home medical TOP (4)**

**Selection criteria**

1. **Essential criteria**

**Women MUST:-**

- Be a resident in Wales
- Fulfil the criteria set out in the Abortion Act 1967 and subsequent amendments
- Be less than 69 days (9+6 weeks) on ultrasound scan date for the *first* part of the procedure
- Be age 18 years or above (primipara and multipara).
- Be 16+ with parental/guardian support (primipara and multipara).
- Younger women please liaise with Consultant
- Be certain of the decision to have the TOP at home and wish to pass the pregnancy at home
- Consent to the procedure to be completed at home
- Have no contra-indications to the medication used in the procedure (see below)
- Have no serious health, social or emotional problems which make treatment at home inappropriate

- Be able to understand all information given and communicate satisfactorily with clinical staff
- Have a responsible adult for support at home
- Not offer cause for concern regarding wellbeing at home i.e. safeguarding and social circumstances are satisfactory
- Provide a reliable telephone number
- Have transport readily available and A & E facilities within 30 minutes or aware of access to emergency service via 999 if required
- Understand the need to confirm the success of the procedure in line with local protocols

## 2. Home TOP contraindications

Home TOP **MUST NOT** be chosen if any of the following apply:

- Previous allergic reaction to one of the drugs involved
- Inherited porphyria
- Chronic adrenal failure
- Known or suspected ectopic pregnancy
- Uncontrolled severe asthma

## 3. Possible Home TOP contraindications

Home TOP **may be considered** in the following circumstances only following consultation and discussion with a doctor.

- Long-term corticosteroid therapy
- Asthma (avoid if severe)
- Haemorrhagic disorder (or current anti-coagulation)
- Prosthetic heart valve or history of endocarditis
- Severe anaemia (Hb < 100g/L)
- Pre-existing symptomatic heart disease or multiple risk factors (e.g. hypertension, smoking >15/day or hyperlipidaemia)
- Hepatic or renal impairment
- Severe inflammatory bowel disease e.g. Crohn's disease
- Uterine surgery for myomectomy or correction of congenital abnormalities
- IUCD in place (remove pre procedure)

## HOME TOP PROCEDURE

The following information is specific to the procedure to be followed for a home TOP and will form the home TOP pathway to be maintained as evidence of care (Appendix 1)

**Part 1: Assessment of patient and home TOP procedure-**

- USS confirmation of gestation sac with definite yolk sac / fetal pole (Fetal heart not necessary)
- Assessment by specifically trained nurse/midwife or doctor
- Is the patient certain of their decision to proceed with abortion at home?
- Ensure support is available during the procedure at home (transport is available if unwell) and childcare has been arranged
- Discuss all appropriate contraceptive options and provide method prior to discharge in line with national guidelines.(2)
- Undertake a risk assessment for STIs (i.e. HIV, syphilis, chlamydia, gonorrhoea) and screen for them if appropriate with consent prior to the termination
- Take bloods to check Group & Save (G&S) if blood group not known, Full blood count (FBC) when clinically indicated (i.e recent pregnancy, history of anaemia etc), STI screen (HIV/Syphilis), HCG (Human Chorionic Gonadotrophin) if required.
- Self-taken vaginal swab to screen for chlamydia/gonorrhoea
- Agree contact if positive STI result
- Ensure HSA1 form signed x 2; if this is not the case this must be discussed in clinic in order to proceed
- Ensure home TOP consent form has been signed and witnessed
- Apply full requirements of the Human Tissue Authority Legislation and discuss disposal of fetal remains and obtain relevant consent
- Ensure medication chart has been completed and signed by the prescriber

- Advise to use regular analgesia at home or provide a prescription for analgesia as required

- Provide misoprostol 800micrograms, vaginal applicator, and written instructions of how to administer the misoprostol 24 – 48hrs later (5,6)and ensure the patient understands Misoprostol is unlicensed for TOP, and has signed the disclaimer.

- For Rhesus D-negative women explain the need to administer Anti-D prior to discharge if blood group known. If blood group not known, women to return to the service within 72 hours following the home administration of misoprostol for anti-D immunoglobulin.(7) Ensure disclaimer is signed.

- Provide pregnancy test to be performed at home, 3 weeks following home administration of misoprostol 800micrograms, and provide leaflet / or blood form for repeat HCG. Ensure disclaimer has been signed and patient is aware of responsibility to contact the service if there is a positive result.

- Give mifepristone 200 mg orally with water. Keep the patient in clinic for 30 minutes post medication. Advise the patient to return for a repeat dose if they vomit within 2 hours of taking mifepristone.

- Discuss the possibility of bleeding/ pain before the 2nd part of the home TOP procedure.

- Give written information leaflet for Home TOP and BODYWISE/Pregnancy Advisory Service/ emergency contact number. Advise the patient to contact the service if no pain or bleeding within 24hrs following misoprostol and to access A&E if experiencing excessive bleeding/collapse.

    - Pregnancy Advisory Service (PAS) 01685 728721
    - Ward 8 Prince Charles Hospital (PCH) 01685 728608 (24 hours)
    - BODYWISE 01443 443192/ 07810500763

**Part 2:- 3 weeks later**

- Pregnancy test to be performed at home. Patient to ring service with pregnancy test result and arrange follow up appointment if positive result or still bleeding/ any other concerns

- Agree further management as required – HCG/ USS as clinically indicated

  Record HCG result if taken, if < 50% drop, follow up appointment to be arranged

- If result is HCG negative and bleeding has stopped, patient can be discharged

- Check STI result and organise treatment as required

- Complete audit in 6 months

#### 5.1.4.2 Inpatient Medical TOP (MTOP)

**Inpatient MTOP- up to 9 weeks +6 days/69 days gestation (2)**

**Part 1: Assessment of patient**

- Assessment by specifically trained nurse/midwife or doctor

- Complete under 16's risk assessment as necessary

- If USS, confirmation of gestation sac with definite yolk sac / fetal pole (Fetal heart not necessary).

- Undertake a risk assessment for STIs (i.e. HIV, syphilis, chlamydia, gonorrhoea) and screen for them if appropriate with consent prior to the termination

- Take bloods for Group & Save (G&S), Full blood count (FBC) when clinically indicated (i.e recent pregnancy, history of anaemia, etc) STI screen (HIV/Syphilis), HCG (Human Chorionic Gonadotrophin) if required.

- Self-taken vaginal swab to screen for chlamydia/gonorrhoea

- Agree contact if positive STI result

- Ensure HSA1 form signed x 2; if this is not the case must be discussed in clinic in order to proceed

- Ensure consent form has been signed and witnessed

- Ensure medication chart has been completed and signed by the prescriber
- Discussion on possibility of bleeding/pain before 2nd visit
- Given written information and contact help-line number
    - Pregnancy Advisory Service (PAS) 01685 728721
    - Ward 8 Prince Charles Hospital (PCH) 01685 728608 (24 hours)
    - BODYWISE 01443 443192 / 07810500763
- Discussion of all appropriate contraceptive methods. Plan agreed contraception for following the TOP

**Part 2: MTOP inpatient procedure**

If the procedure is to be completed as an inpatient, ward staff must be given adequate notice of admission date following administration of mifepristone.

- Give mifepristone 200 mg orally with water. Keep the patient in clinic for 30 minutes post medication. Advise the patient to return for a repeat dose if they vomit within 2 hours of taking mifepristone.
- Ensure adequate analgesia and anti-emetics are prescribed
- Give specific advice to attend the ward /clinic 24-48 hours later for insertion of misoprostol (5,6) as arranged at appointment in order to complete the second stage of the procedure.
- Ensure full requirements of the Human Tissue Legislation are met.
- Ensure sensitive disposal of fetal remains, consent taken and documented (3)
- Products of conception do **NOT** go for routine histology (3)
- 24 - 48 hours after mifepristone 200mg has been given, administer misoprostol 800micrograms vaginally (5,6)
- Rhesus negative women: Give Anti D – 500 micrograms intra muscularly within 72 hours of abortion regardless of gestation (7)
- Discuss all appropriate contraceptive options and provide method prior to discharge in line with national guidelines.(2)

**If products of conception not passed after 4 hours as inpatient (2)**

- Administer further dose of misoprostol 400micrograms orally or vaginally
- If after a further 4 hours, products of conception have still not passed – Discuss with on call registrar/consultant for further plan of care.
- Consider further medical management until products have passed.
- Ultrasound scan (USS) should only be performed if clinically indicated following medical review
- If Rhesus negative: carry out administration of Anti D with consent as if products had passed

**At discharge**

- Women **must** be given advice regarding potential side effects and complications together with the appropriate telephone contact details
- Advise patient to attend A&E if there is heavy bleeding or pain
- Contraception to be given on day of procedure in line with national recommendations. Where possible Long Acting Reversible Contraception (LARC) should be encouraged.(2)

Following discharge if NO products of conception have been passed on Ward 8, women should be advised by ward staff to contact Bodywise / PAS for a follow up appointment. A follow up HCG / pregnancy test /Ultrasound Scan should be performed as clinically indicated in BW/PAS.

## 5.1.5 Late medical TOP (2)

Defined as 10-15 weeks +6 days/70 - 111 days gestation

Women undergoing a late termination of pregnancy should be no more than 15 weeks + 4 days at the time of the consultation appointment. Women outside of

this should be referred to the British Pregnancy Advisory Service (BPAS) or discuss with the consultant concerned.

During the consultation women must have the procedure explained fully

The date for admission must be agreed with the ward prior to administration of medication

**In Patient Procedure**

- Give mifepristone 200 mg orally with water. Keep the patient in clinic for 30 minutes post medication. Repeat the dose if the patient vomits within 2 hours of taking mifepristone.

- 24 - 48 hours after mifepristone 200mg has been given, administer misoprostol 800micrograms vaginally (5,6)

- If after a further 4 hours, products of conception have still not passed, give misoprostol 400micrograms orally or vaginally every 3 hours to a maximum of 4 doses (2)

- Ensure adequate analgesia and anti- emetics are prescribed

**If products of conception are passed:**

- Syntometrine 1ml to be given intramuscularly if clinically indicated and prescribed

- Rhesus negative women are to be given Anti D 500 micrograms intra muscularly within 72 hours of abortion (7)

- Ensure full compliance with the Human Tissue Authority Legislation

- Ensure sensitive disposal of fetal remains, consent has been taken and documented (3)

- Discharge the patient and follow up if necessary

**If products of conception are not passed:**

Discuss with on call registrar or consultant for further plan of care

Patient is NOT to be discharged until the products of conception are passed and the process completed

Contraception to be given on day of procedure in line with national recommendations. Where possible Long Acting Reversible Contraception (LARC) should be encouraged.(2)

**Documentation**

- Ensure inpatient medication chart is completed, signed and dated by the prescriber
- Ensure any products of conception passed are documented in the patient's medical record
- Record any follow up appointments in the patient's medical record and ward staff to notify PAS / BW if urgent follow up required.

## 5.1.6 Manual vacuum aspiration (MVA)

Up to 9 weeks/63 days gestation.

Please refer to separate MVA guidelines for the MVA procedure, to be read in conjunction with the CTUHB Termination of Pregnancy (TOP) Service Policy

## 5.1.7 Surgical termination

Up to 12 weeks +6 days/90 days gestation

- This procedure will be carried out only following an in depth discussion with the medical practitioner and **NOT** as routine. Patient choice should be considered

- Appropriate consent must be obtained and all the complications/sequelae explained to the patient and documented in the medical notes

- Arrangements for admission will be via the day surgical ward at RGH

- Appropriate advice, contact details and any other appropriate information must be given to the patient

- Apply full requirements of the Human Tissue Authority Legislation and discuss disposal of fetal remains and obtain relevant consent

- Contraception needs to be discussed and arranged at the time of appointment and can be commenced on the day of the procedure

- Appropriate medication to be prescribed by the medical practitioner

- Antibiotic prophylaxis is to be prescribed as per current CTUHB antimicrobial surgical prophylaxis guidelines.

https://viewer.microguide.global/CWMTAF/SECONDARYCARE/#content,b98946c8-aa26-45ae-bb71-7b2f46d13f02

### 5.1.8 Twin Pregnancy

Relevant procedure to be followed as above – discuss with medical practitioner and document in medical records

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## Appendix 1: Home TOP Care Pathway

This pathway details the care of a woman assessed as suitable for HTOP. It is supplementary to the recognised longstanding assessment processes undertaken within the CTUHB Termination of Pregnancy Service.

| **PART 1: First contact, assessment, support and follow up for HOME TOP** | | |
|---|---|---|
| **Actions** | **Y** | **N** |
| • USS confirmation of gestation sac with definite yolk sac / fetal pole (Fetal heart not necessary)<br>• Assessment by specifically trained nurse/midwife or doctor<br>• Is the patient certain of their decision to proceed with abortion at home?<br>• Is support available during the procedure at home (transport is available if unwell)?<br>• Childcare has been arranged, where appropriate?<br>• Discuss all appropriate contraceptive options and provide method prior to discharge in line with national guidelines<br>• Risk assessment for STIs (i.e. HIV, syphilis, chlamydia, and gonorrhoea) and screen for them if appropriate with consent prior to the termination<br>• Bloods taken for Group & Save (G&S), Full blood count (FBC) where clinically indicated, STI screen (HIV/Syphilis), HCG **if required**<br>• Where the woman has self-taken a swab for chlamydia/gonorrhoea contact if positive STI result agreed<br>• HSA1 form signed x 2; if this is not the case this must be discussed in clinic in order to proceed<br>• Ensured inpatient medication chart has been signed<br>• Home TOP consent form has been signed and witnessed<br>• Discussed disposal of fetal remains and obtained relevant consent<br>• Provide pregnancy test to be performed at home 3 weeks following home administration of misoprostol 800mcg, and provide leaflet / or blood form for repeat HCG. Ensure disclaimer has been signed and patient is aware of responsibility to contact the service if there is a positive result. | | |

| **PART 1: First contact, assessment, support and follow up for HOME TOP** | | |
|---|---|---|
| **Actions** | **Y** | **N** |
| • Advise to use regular analgesia at home or provide a prescription for analgesia as required<br><br>• Provide misoprostol 800micrograms, vaginal applicator, and written instructions on how and when (24 – 48hrs later) to administer it and ensure the patient is aware misoprostol is unlicensed for TOP and has signed the disclaimer.<br><br>• Give written information leaflet for Home TOP and Bodywise /Pregnancy Advisory Service/ emergency contact number. Advise the patient to contact the service if no pain or bleeding within 24hrs following misoprostol and to access A&E if experiencing excessive bleeding/collapse.<br><br>• For Rhesus negative women explain the need to administer Anti-D - 500 micrograms intra muscularly prior to discharge if blood group known. If blood group not known, women to return to the service within 72 hours following the home administration of misoprostol for anti-D immunoglobulin.(7) Ensure disclaimer is signed.<br><br>• Give mifepristone 200 mg orally with water. Keep the patient in clinic for 30 minutes post medication. Advise the patient to return for a repeat dose if they vomit within 2 hours of taking mifepristone.<br><br>• Discuss the possibility of bleeding/ pain before the 2nd part of the home TOP procedure. | | |

| ***PART 2: Follow up post Home TOP*** |
|---|

| | Y | N |
|---|---|---|
| **1 – 3 weeks later**<br>• Record Pregnancy test result in diary<br>• If result Positive, offer follow up appointment for bloods/ USS as clinically indicated<br>• Chase follow up BHCG result if taken<br>• If < 50% drop follow up appointment to be arranged<br>• Check STI result and organise treatment as required<br>• Contact women if any problems<br>• Offer follow-up appointment if any issues for discussion post TOP. | | |
| • Complete audit in 6 months | | |

Signature……

Print name……..……..

Date ……...…….