Protocol for Medical Termination of Pregnancy from 70 days (10 weeks) Gestation

Document Control:

For Use In:	Norfolk and Norwich University Hospitals NHS Foundation Trust		
	Gynaecology Services, Cley Gynaecology Ward		
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Ratified By:	NMCP Board		
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Implementation Date:	As above		
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Version History:

Version	Date	Author	Reason/Change
3.1	March 2020	Chief of Service	Due to coronavirus there is currently no time to review this document. Clinical information is still correct, but a year's review date has been given to allow for a thorough review in the future.
4	July 2020	Consultant – Obstetrics and Gynaecology	Reviewed and changes made to author and timeframes.
5	December 2023	Consultant – Obstetrics and Gynaecology	Transferred onto Procedural Document Template

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:
Gautam Raje, Chief of Service (Document Author's Line Manager)

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospitals NHS Foundation Trust; please refer to local Trust's procedural documents for further guidance.

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1. Introduction

1.1. Rationale

Termination of pregnancy is commonly performed medically, with a combination of Mifepristone and a Prostaglandin. Mifepristone is a synthetic steroid with potent anti progesterone activity. Misoprostol is a prostaglandin that, although unlicensed for this indication, has been widely used in induction of abortion in the UK. Its use has been endorsed by the Royal College of Obstetricians and Gynaecologists. This guideline is to enable the service to be offered by suitably trained nurses and doctors on Cley Ward.

1.2. Objective/s

This clinical protocol will enable the abortion service to be offered by suitably trained nurses in Cley Gynaecology Ward in addition to medical staff.

The objective of the protocol is to: provide guidance to staff involved in the care of women having a medical termination of pregnancy from 10 weeks. This protocol aims to ensure standardisation of care for patients having a medical termination of pregnancy from 10 weeks.

1.3. Scope

This protocol covers only medical termination of pregnancy from 10 weeks of gestation. It does not cover medical termination of pregnancy under 10 weeks nor does it cover surgical terminations.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
RGN	Registered general nurse
TOP	Termination of pregnancy
MTOP	Medical termination of pregnancy
SROM	Spontaneous rupture of membranes
GUM	Genitourinary medicine
IV	Intravenous
GP	General Practitioner
PO	Orally / by mouth
EIA	Equality Impact Assessment

2. Responsibilities

It is the responsibility of the Consultant – Obstetrics and Gynaecology, to review and update this document.

3. Protocol

3.1. Day 1 (First Visit)

The patient will have been assessed at the TOP Clinic. A decision for termination will have been made, gestation assessed, swabs taken if appropriate and consent

obtained. A patient information leaflet will have been given.

The nurse will:

- Check the patient's personal details, discharge arrangements, and next of kin.
- Ensure the consent form has been signed by the patient.
- Ensure the Abortion Act 1967 Certificate A HSA1 has been signed by 2 doctors.
- Ensure that the gestation has been confirmed by ultrasound.
- Obtain the results of chlamydia swabs, blood group and haemoglobin and record them on the proforma.
- Confirm that the patient wishes to proceed with the termination.
- Check the details on the TOP2 form regarding allergies, past medical history and drug therapy.
- Administer Mifepristone orally at the prescribed dose – usually 200mg.
- Advise the patient to contact the ward if she vomits within the next two hours. In this eventuality, a further dose of Mifepristone 200 mg with an antiemetic can be administered.
- Advise the patient to contact Cley ward if she experiences heavy bleeding or significant pain, and that a small number of women will abort at home following the Mifepristone.
- Ensure that she has a patient information leaflet and contact number (Cley ward).
- Ensure she is fully aware of the arrangements for the second visit.
- Discharge the patient.

3.2. Second Visit (Day 3 or 4)

The patient will be asked to contact Cley Ward at 08.00am on the day of the second visit, to arrange an arrival time.
The nurse will:

- Complete a nursing readmission sheet and provide the patient with an ID bracelet.
- Check baseline observations.
- Check haemoglobin, chlamydia and blood group are recorded.
- Ensure prescription of anti D if patient is Rhesus negative.
- Assess patient for any adverse reaction to Mifepristone, bleeding or passage of products of conception since administration, and record on the proforma.
- Refer to doctor if adverse reaction to Mifepristone.
- Ensure that the patient is aware of the procedure:
    - The administration of vaginal and oral abortifacients

  - The availability of analgesia including rectal diclofenac
  - That she will experience pain and bleeding
  - That tissue passed needs to be examined
  - That women often will have aborted within 12 hours, but some take longer
  - That some women will need a vaginal examination during the procedure to remove the fetus or placenta or removal of placenta under general anaesthesia
- Ensure **I.V. access with a large bore cannula** if gestation is greater than 13 weeks + 6 days.
- Administer vaginal misoprostol, and subsequent doses of oral misoprostol. (Use discretion in deciding misoprostol dosage schedule in women with high risk factors in second trimester eg. previous multiple caesarean sections).
- Administer analgesia as required.
- Be aware that a vaginal examination may be indicated in certain clinical situations(SROM, cessation of uterine activity, passage of products) and inform a doctor if needed.
- Check rhesus status and administer anti D if appropriate.
- Administer antibiotics.
- Arrange and document referral to GUM in the case of a positive chlamydia / gonorrhoea result.
- Check blood pressure and pulse when clinically indicated (eg. severe pain or heavy bleeding).
- Administer prescribed antiemetic and analgesia as required and assess effectiveness.
- Assist patient with elimination needs and observe for any products of conception.
- Inform the medical staff if the placenta is retained one hour after delivery of the fetus, if the abortion is incomplete after 12 hours, or significant bleeding. (Consideration should be given if the abortion is incomplete to repeating the Misoprostol the following day as above.(800mcg pv followed by 400 mcg PO up to four occasions 3 hours apart). If the abortion does not occur on the second day, consider Cervagem 1mg 3 hourly up to a maximum of 5 doses.

Under these circumstances consider the possibility of the pregnancy being extrauterine or an anatomical abnormality of the uterus.

- Examine the conceptus for completeness and document in the notes. If there is concern about completeness a speculum examination may be performed and products removed.

Prior to discharge the nurse will:

- Ensure that the patient is not bleeding significantly and is fit for discharge.

- Give contraception and advice as necessary.
- Ensure antibiotics supplied appropriately.
- Arrange GUM appointment if desired or indicated.
- Complete the discharge letter for the GP, complete the EDL, photocopy the MTOP proforma and send with discharge letter to GP, retaining originals in gynaecology notes.
- Discharge the patient home.
- Ensure that the notes are returned to the Consultant for follow up and appropriate investigations are performed in the case of fetal abnormality.

4. Training and Competencies

Required Qualifications and Experience for Nursing Staff using this Guideline

To administer vaginal abortifacients, nurses must be:

- RGN (Level 1), Band 5 and above;
- Qualified for at least 12 months;
- Have worked for at least 6 months in the ward environment caring for women undergoing termination of pregnancy.

Training and assessment of nurses will be conducted by a senior nurse deemed competent in vaginal administration of drugs and examination of pregnancy remains. Only nurses who have been assessed as competent will perform this procedure.

5. Monitoring Compliance

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
The efficacy of medical termination of pregnancy, with reference to complete abortion, day case rates, surgical intervention and readmission rates.	Review of patient notes	Gynaecology ward staff nurse	Gynaecology Governance committee	Annual
All Rhesus negative women at risk should receive anti D immunoglobulin.	Review of patient notes	Gynaecology ward staff nurse	Gynaecology Governance committee	Annual

The audit results are to be discussed at relevant governance meetings to review the results and recommendations for further action. Then sent to Gynaecology Governance who will ensure that the actions and recommendations are suitable and sufficient.

6. References

https://www.nice.org.uk/guidance/ng140/chapter/Recommendations NICE guideline on Abortion care – Sept 2019

https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf **The Care of Women Requesting Induced Abortion** RCOG Guidelines Summary 2011

Ashok PW and Templeton A : Non surgical termination of pregnancy: a review of 55 consecutive cases BJOG 1999 106 706 - 710

7. Appendices

There are no appendices for this document.

8. Equality Impact Assessment (EIA)

Type of function or policy	Existing (remove which does not apply)

Division	OG	**Department**	Gynaecology
Name of person completing form	P.S.Arunakumari	**Date**	08.08.2024

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race			n/a	No
Pregnancy & Maternity			n/a	No
Disability			n/a	No
Religion and beliefs			n/a	No
Sex			n/a	No
Gender reassignment			n/a	No
Sexual Orientation			n/a	No
Age			n/a	No
Marriage & Civil Partnership			n/a	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.