Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: TERMINATION OF PREGNANCY – GUIDELINE FOR THE MANAGEMENT OF WOMEN SEEKING TOP

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Evidence Base/ References:	• Best Practice in Abortion Care. RCOG, March 2022 • World Health Organization. Safe Abortion: Technical and Policy Guidance for Health Systems. 2nd ed. Geneva: WHO; 2012 World Health Organization • Clinical Practice Handbook for Safe Abortion. Geneva: WHO; 2014 • Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion. Evidence-based Guideline Number 7. London: RCOG; 2011 • NICE Guideline NG140: Abortion Care; 2019
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Lead Specialty:	Gynaecology
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Sponsor:	Head of Service – Obstetrics and Gynaecology

	Name the documents here or record not applicable
Associated Policy	N/A
Associated Procedure(s)	N/A
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Associated Standard Operating Procedure(s)	N/A
Other associated documents e.g. documentation/ forms	N/A

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CONTENTS

1 INTRODUCTION/ BACKGROUND

Each year, 22 million unsafe abortions are estimated to take place, resulting in the death of approximately 47 000 women. Some 5 million women suffer injury as a result of complications due to unsafe abortion, often leading to chronic disability. Abortion need **not** be unsafe. Safe abortion should be and can be available and accessible for all women, to the full extent that the law allows. Even in countries where legal abortion is severely restricted, in circumstances where it is permitted, such as to save the life of the woman, it should always be done safely.

Abortion is not a complex procedure. A range of providers, including nurses and midwives, have been shown to be competent to deliver abortion services safely in a number of settings. As with many other medical procedures, adherence to best practice standards will ensure that the most effective and the safest services are delivered.

All aspects of abortion care should be delivered in a respectful and sensitive manner that recognises women as decision makers.

2 SCOPE OF DOCUMENT (including Related Trust Documents

This clinical document applies to:

Staff group(s)

- Medical staff
- Nursing staff
- Sonographers

Clinical area(s)

- Clinic 12
- Ward 14
- Ultrasound Department

Related Trust Documents

- Venous Thrombosis Risk Assessment and Management of Thromboprophylaxis in Early Pregnancy Guideline

3 DEFINITIONS/ ABBREVIATIONS

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
TOP	Termination of Pregnancy
BP	blood pressure
mg	milligrams
mcg	micrograms

4 GUIDELINE DETAILS (including Flowcharts)

4.1 Referral

- Women are referred by their GP practice to the Unplanned Pregnancy Clinic (Alternate Tuesday afternoons) via electronic Choose and Book referral

4.2 Out – patient assessment

- Women should be informed about their pregnancy options so that they can make an informed choice about their preferred course of action.
- All women who require more support in deciding whether to continue the pregnancy or have an abortion should be identified and offered further opportunities to discuss their decision.
  If performed in line with best practice, abortion is safer than childbirth
- The following information should be provided to women requesting abortion, with an emphasis on the overall safety of the procedure and in a way that women can understand:

    - the choice of abortion method available and the characteristics of each (see below)
    - the side effects, risks and complications associated with each available abortion method
    - what will be done during and after the abortion
    - symptoms likely to be experienced both during and after the abortion (e.g. menstrual-like cramps, pain and bleeding)
    - how long it will take for the abortion to be completed
    - what pain management will be made available
    - follow-up care, including contraceptive advice and provision
    - the range of emotions commonly experienced after having an abortion

- other services that are available, such as sexually transmitted infection (STI) testing and support for women experiencing sexual coercion or domestic violence

Table 1 What abortion methods entail; adapted from the WHO (2014) Clinical Practice Handbook for Safe Abortion and the NICE (2019) patient decision aids published with the Abortion Care guideline

Medical abortion	Surgical abortion
• avoids surgery • mimics miscarriage controlled by the woman • takes time (hours to days) to complete abortion, and the timing may not be predictable • women experience bleeding and cramping, and potentially some other side effects (nausea, vomiting) • may require more clinic visits than surgical abortion *May be necessary in the following situations:* • for severely obese women • if the woman has uterine malformations, or has had previous cervical surgery • if the woman wants to avoid surgical intervention	• quick procedure • complete abortion is easily verified by evaluation of aspirated products of conception • takes place in a healthcare facility • placement of an intrauterine device (IUD) may be performed at the same time as the procedure • requires instrumentation of the uterus small risk of uterine or cervical injury timing of abortion is controlled by the facility and provider *May be necessary in the following situations:* • if there are contraindications to medical abortion • if there are constraints for the timing of the abortion

- The **pre-abortion consultation** should confirm the woman's decision and should include the following information:

    - Abortion is a safe procedure for which major complications and mortality are rare at all gestations
    - The earlier in pregnancy an abortion is undertaken, the safer it is likely to be
    - Surgical and medical methods of abortion carry a small risk of failure to end the pregnancy (1 or 2 per 100 procedures)
    - There is a small risk (less than 2 in 100 for surgical and 5 in 100 for medical) of the need for further intervention to complete the procedure, i.e. surgical intervention following medical abortion or re-evacuation following surgical abortion

The table below describes the complications/risks associated with each procedure and the absolute risk of them occurring:

Table 2 Complications and risks of abortion; adapted from the NICE (2019) Abortion Care guideline and the RCOG (2011) Care of Women Requesting Induced Abortion guideline

Complication/risk	Medical abortion	Surgical abortion
Continuing pregnancy	1–2 in 100	1 in 1000 Higher in pregnancies <7 weeks
Need for further intervention to complete the procedure	<14 weeks: 70 in 1000 >14 weeks: 13 in 100	<14 weeks: 35 in 1000 >14 weeks: 3 in 100
Infection	Less than 1 in 100	Less than 1 in 100
Severe bleeding requiring transfusion	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000
Cervical injury from dilation and manipulation	-	1 in 100
Uterine perforation	-	1–4 in 1000
Uterine rupture	Less than 1 in 1000 for second trimester medical abortions	-

Medical History

- A general medical history should be sought to exclude serious or relevant acute or chronic medical conditions e.g. asthma, venous thromboembolism, heart disease

Blood Tests

- Pre-TOP assessment should include determination of Rhesus (Rh) blood status and Full Blood Count (FBC) to assess haemoglobin concentration

Determining gestational age

- It is important to assess gestational age to appropriately offer particular methods of TOP
- Prior to being seen in the Unplanned Pregnancy Clinic, a pelvic ultrasound scan should be requested and performed to determine gestational age as well as location of the pregnancy
- If incidental pathology is identified on the pelvic ultrasound scan, the practitioner in clinic will discuss the findings and, if appropriate, follow up that may be required

Sexually Transmitted Infection (STI) Screening

- It is good practice to risk assess all women for STIs and to offer screening if appropriate
- A self-taken vaginal swab to detect chlamydia and gonorrhoea can be offered
- A referral should be made to Genito-Urinary Medicine should a positive swab be detected to allow for partner notification as well as appropriate follow-up

Prevention of infective complications

- Routine prophylactic antibiotics should NOT be used for women undergoing medical termination of pregnancy
- Antibiotic prophylaxis should be offered to women undergoing surgical termination
    - Oral doxycycline 100mg BD for 3 days

Prevention of venous thromboembolism

- For women who need pharmacological thromboprophylaxis, consider low-molecular-weight heparin for at least 7 days after the abortion.
- For women who are at high risk of thrombosis, consider starting low-molecular-weight heparin before the abortion and giving it for longer afterwards.
- See Venous Thrombosis Risk Assessment and Management of Thromboprophylaxis in Early Pregnancy Guideline for supporting risk assessment

Contraception

- Effective methods of contraception should be discussed with women at the initial assessment and a plan agreed, and documented, for contraception after the abortion
- Women should be advised of the greater effectiveness of long-acting reversible methods of contraception (LARC: implants and IUDs) and encouraged (but not coerced) to choose them
- Immediately after surgical abortion is an optimal time for insertion of an IUD
- Contraceptive implants can be provided at any time once the abortion procedure has started

4.3 Methods of Termination and Medication for Pain Management

4.3.1 Surgical abortion

- This should be considered at gestations from **7+0** weeks to **13+0** weeks. There may be individual cases where the operating surgeon will perform a surgical termination at gestations beyond this but this is at their discretion
- Vacuum aspiration should be used to empty the uterus using a suction cannula
- The procedure should not routinely be completed by sharp curettage
- Routine administration of medications containing oxytocin or ergometrine are NOT recommended for prophylaxis to prevent excessive bleeding
- Cervical preparation should be undertaken pre-operatively using **misoprostol 400mcg** PV at least **2 hours before** the procedure is undertaken.

4.3.2 Medical abortion

- These are performed at any gestational age up to **16+6** weeks

- It is undertaken in two stages

- Part 1 – this part takes place in the women's unit on ward 14. The woman is cared for by the specialist registered nurse. The woman should remain on the unit for 1 hour post administration of **the** medication before going home to return 48 hours later. Any concerns over the 48 hour period the woman is advised to immediately contact the gynaecology inpatient ward for advice

- Part 2 – The visit takes place 48 hours post initial visit. The woman is advised to return to the gynaecology inpatient ward for this stage of the process. She will be cared for by the specialist registered nurse. She should be advised that usually she will go home the same day but may require an overnight stay in some circumstances

- At gestations below **10+0** weeks, the prescribed regime is:
- Mifepristone 200mg PO, followed 48 hours later by:
- Misoprostol 800mcg PV followed by 400mcg orally or vaginally 3 hours later if needed

- At gestations between **10+0** and **16+6** weeks the prescribed regime is:
- Mifepristone 200mg PO, followed 48 hours later by:
- Misoprostol 800mcg PV followed by 400mcg orally or vaginally at 3 hourly intervals until the abortion occurs

4.3.3 Medication for pain management

- For both medical and surgical abortions, analgesia (pain relief) should always be offered and provided without delay, if requested.
- In most cases, simple analgesics e.g. nonsteroidal anti-inflammatory drugs (NSAIDS) and paracetamol are sufficient. However opiate based analgesia may be prescribed for inpatient use during the procedure along with antiemetics
- Women should be advised to avoid using NSAIDS following the administration of mifepristone before commencing the second part of a medical abortion

4.4 Information for staff concerned with care after induced abortion

- Healthcare staff involved in post-abortion care should ensure that the woman leaves the abortion service knowing what to expect following the procedure and where to get help if necessary.
- They should also ensure that every woman is able to leave with a method of contraception that she can start immediately.
- Women should be informed of the superior effectiveness of IUDs and implants in preventing unintended pregnancy.

4.4.1 Information to provide

- Before leaving, women should receive instructions about how to care for themselves after they go home, including:
  - how much bleeding to expect in the next few days and weeks
  - how to recognise potential complications, including signs of ongoing pregnancy
  - when they can resume normal activities (including sexual intercourse)
  - how and where to seek help if required.

4.4.2 Contraception

- Before they leave, all women should receive contraceptive information and, if desired, the contraceptive method of their choice
- If the chosen method is not available, they should be referred to a service where the method can be provided
- Women should be advised of the greater effectiveness and duration of LARC methods (implants and IUDs) and of their safety, and healthcare staff should dispel any myths there may be about these methods
- Sterilisation can be safely performed at the time of induced abortion although it can be more likely than interval sterilisation to be associated with regret

4.4.3 Anti-D IgG

- Anti-D prophylaxis should be offered to all women who are rhesus D negative and are having an abortion after 10^{+0} weeks' gestation.
- Do not offer anti-D prophylaxis to women who are having a medical abortion up to and including 10^{+0} weeks' gestation.
- Anti-D prophylaxis should be considered for women who are rhesus D negative and are having a surgical abortion up to and including 10^{+0} weeks' gestation

4.5 Management of post abortion complications

- Incomplete abortion should be suspected when any woman of reproductive age presents with vaginal bleeding and/or abdominal pain after one or more missed menstrual periods.
- Ectopic pregnancy should be suspected if the uterus is small, the cervix closed and/or there is an adnexal mass
- Infection
    - It is vital to identify women who may have an infection and to manage this urgently. Infection is much more likely, and much more likely to be severe, if the abortion has been performed unsafely.
    - Clinical features suggestive of infection include:
        - temperature above 37.5°C
        - localised or general abdominal tenderness, guarding and rebound
        - foul odour or pus visible in the cervical os
        - uterine tenderness
    - Features suggestive of sepsis and indicating the need for urgent intervention include:
        - hypotension
        - tachycardia
        - increased respiratory rate
- Management
    - If an incomplete abortion is suspected without signs of infection, either uterine evacuation or administration of 600mcg misoprostol orally should be considered
    - If there are signs of infection, broad spectrum antibiotics should be considered before either surgical treatment or misoprostol administration are commenced.

4.6 Safeguarding issues/concerns

- In any cases where there are any concerns/suspicions regarding safeguarding children issues and in any cases where the patient is under 13 then the Named Nurse Safeguarding Children should be contacted

- **Issues of vulnerable women should be referred to the appropriate lead for safeguarding vulnerable adults**

- All girls under the age of 13 seeking a TOP are referred to the duty social work team.
- For all girls aged 13-15 seeking a TOP there is a documented assessment of risks and documentation of whether there are any child protection concerns.
- For all cases where there are concerns a referral is made to Social Services.
- For all girls under the age of 16 seeking a TOP their competence to consent is assessed and documented

5 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Termination of Pregnancy			
New or existing service/policy/procedure: Existing			
Date of Assessment: August 2023			
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	N/A	N/A
Gender:	Females only	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A

Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? None
What data or information did you use in support of this EqIA? None
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? None

Level of impact

From the information provided above and following EqIA guidance document, please indicate the perceived level of impact:

Low Level of Impact

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:
Signature: Susie Al-Samarrai
Date: August 2023

6 APPENDICES

Appendix A – Quick Reference Guide: Management of Women Seeking Termination of Pregnancy

Appendix A

Quick Reference Guide: Management of Women Seeking Termination of Pregnancy

OUTPATIENT ASSESSMENT

- Women should be informed about their pregnancy options in order to make an informed choice.
- Further support should be offered if needed.
- Information should be provided regarding the abortion methods available. Including:
  - Choices of abortion methods
  - Side-effects, risks and complications
  - Procedure details
  - Symptoms during and after procedure
  - Pain management
  - Follow-up and contraceptive advice
  - Emotional support
- Obtain a general medical history
- Blood tests – including Rhesus blood status and FBC
- Pelvic ultrasound scan to determine gestation age and location of pregnancy
- Offer STI screening if appropriate
- Prophylactic antibiotics at time of surgical TOP
  - Doxycycline 100mg BD for 3 days

TERMINATION METHODS

SURGICAL ABORTION

- Considered from **7^{+0}** weeks to **13^{+0}** weeks.
- Vacuum aspiration used to empty uterus using suction cannula.
- **400mcg of Misoprostol PV** should be given **at least 2 hours prior** to procedure.

MEDICAL ABORTION

- Performed at any gestational age **up to 16^{+6} weeks**.
- Two stages:
  - Part 1 – takes place on Ward 14. The woman should remain on the unit for 1 hour after administration of the medication.
  - Part 2 – takes place 48 hours after initial visit. Takes place on ward 14 again. The woman would usually go home the same day, unless exceptional circumstances.
- Regimens:
  - **At gestations below 10^{+0} weeks:**
    - Mifepristone 200mg PO
    - 48 hours later: Misoprostol 800mcg PV followed by 400mcg orally or vaginally 3 hours later if needed.

- **At gestations between 10^{+0} and 16^{+6} weeks:**
  - Mifepristone 200mg PO
  - 48 hours later: Misoprostol 800mcg PV followed by 400mcg orally or vaginally at 3 hourly intervals until the abortion occurs.

- Additional information:
  - Analgesia should be offered and provided without delay.
  - Women should be advised to avoid NSAIDs after mifepristone, before commencing second part of medical abortion.

INFORMATION TO PROVIDE

- What to expect following procedure
- Contraception to start immediately if required
- What to expect in terms of symptoms in the coming days and weeks
- How to recognise complications
- When they can resume normal activities
- How and where to seek help

ANTI-D

- Anti-D prophylaxis should be offered to all women who are rhesus D negative and are having an abortion after 10^{+0} weeks' gestation.
- Do not offer anti-D prophylaxis to women who are having a medical abortion up to and including 10^{+0} weeks' gestation.
- Anti-D prophylaxis should be considered for women who are rhesus D negative and are having a surgical abortion up to and including 10^{+0} weeks' gestation

POST ABORTION COMPLICATIONS

- Suspect incomplete abortion if woman presents with vaginal bleeding and/or abdominal pain after one or more missed menstrual periods.
- Ectopic pregnancy should be suspected if the uterus is small, the cervix closed and/or there is an adnexal mass
- Suspect infection if any of the below are present:
  - Temperature above 37.5°C
  - Localised or general abdominal tenderness, guarding and rebound
  - Foul odour or pus visible in the cervical os
  - Uterine tenderness
- In any cases where there are any concerns/suspicions regarding safeguarding children issues and in any cases where the patient is under 13 then the Named Nurse Safeguarding Children should be contacted.
- Issues of vulnerable women should be referred to the appropriate lead for safeguarding vulnerable adults