



Royal College
of Nursing

Abortion care

*RCN guidance for nurses, midwives
and specialist community public
health nurses*



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Abortion care

RCN guidance for nurses, midwives and specialist community public health nurses

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Introduction

The Royal College of Nursing (RCN) first published guidance concerning nurses and abortion in 1980. Following changes in the law and the introduction of new methods of abortion, the RCN updated its guidance in 1992 (RCN guidance document No. 11, *Nurses and abortion*) and again in 1997 (RCN, 1997). As a result of changes in practice and the advancing role of nurses in providing abortion services, the RCN Nurses working within the Termination of Pregnancy Network considered it appropriate to further revise this guidance.

Building on previous work and incorporating expert and evidence-based practice, this guidance has been produced to support registered nurses, midwives and specialist community public health nurses working in the National Health Service (NHS) and private sector providers who care for women undergoing abortion.

It considers the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act 1990, and the Human Fertilisation and Embryology Bill 2008. The guidance covers England, Scotland and Wales.

The guidance is mainly related to women undergoing abortion under section 1(1)(c) Abortion Act 1967, which allows a termination on the grounds: “*That the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated*”. But the guidance is relevant for all women undergoing abortion under all sections of the Act.

(http://www.opsi.gov.uk/acts/acts1967/PDF/ukpga_19670087_en.pdf)

We recognise that abortion services are provided by doctors and nurses, midwives and specialist community public health nurses in a wide range of settings. For ease of reading, we have used the generic terms of ‘nurse’, ‘nursing’, ‘nurses’ throughout the document to indicate the roles and contributions of nurses, midwives and specialist community public health nurses.

This guidance aims:

- ◆ to provide accurate and current information for nurses
- ◆ to improve the knowledge base about abortion and abortion care for nurses
- ◆ to promote best practice
- ◆ to empower nurses to develop their roles in abortion care
- ◆ to protect the public by identifying relevant legislation and standards of care.

1

Nurse led services, professional development and support

Professional development within abortion services

There are many professional components required in enabling nurses to plan, deliver, develop and evaluate abortion services within their scope of practice, and within the limits of the Abortion Act 1967. Nursing needs to be dynamic and respond to the changing needs of the UK. Nurses have developed new roles, are working across traditional boundaries, and have been instrumental in setting up new services to meet health needs in a variety of health settings (DH, 2006).

Recent and anticipated future developments in abortion services will continue to provide both challenges and opportunities for nurses practising at every level. The need for organisational support and robust clinical governance mechanisms is fundamental (RCN, 2003) to assist nurses who are individually accountable for their professional practice and to ensure their legal duty of care to patients and clients is fulfilled (NMC, 2008).

The current climate of change in health care provides an ideal opportunity for clinical leaders to shape the way abortion services are provided in the future. The development of a designated resource to achieve this (for example, consultant nurse, clinical nurse specialist and nurse practitioner roles) has been successful in shaping local, regional and national nursing practice in caring for women undergoing abortion. All nurses have an opportunity to lead from a clinical perspective and can be empowered to influence change in service provision and practice development, ensuring improved services for women undergoing abortion within the legal framework

Nurse led services – advancing nursing roles

Since the late 1960s, the authorisation and provision of abortion has been the legal responsibility of a registered medical practitioner, and the strict requirements are set out in the Abortion Act 1967. The role of the nurse was historically to provide general nursing care.

However, recent advances in abortion methods, particularly medical abortion (abortion stimulated by drugs rather than surgical removal), have led to the development of innovative nursing roles and a more holistic provision of nursing care. Nurses are now planning, leading, and managing a significant proportion of care for women undergoing medical abortion, under the guidance of a registered medical practitioner. The requirements of the Abortion Act 1967 mean that in this guidance, the phrase 'Nurse led' means that nurses are taking delegated responsibility from a registered medical practitioner.

The role of nurses in abortion services has developed in response to a number of internal and external drivers. The political drive to reorganise the NHS, while modernising and developing the role of health professionals within it, provides an ideal backdrop for professional and service development (DH, 2000). The legal requirements of the Abortion Act 1967 do not allow nurses to authorise an abortion and the need for a doctor's involvement will limit the extent of nursing activity in abortion services.

The RCN consulted members who work in abortion services to inform its submission to the Commons Science and Technology Committee Inquiry in August 2007. The inquiry looked into scientific developments relating to the Abortion Act 1967. The inquiry was completely focused on scientific developments and did not look at ethical or moral arguments. While the RCN acknowledges and respects those nurses who have a conscientious objection to providing abortion care, the organisation is committed to providing support to those nurses who do work in abortion to provide safe and quality care.

Following this consultation it was clear that those RCN members who worked in this clinical field felt the law on abortion required modernisation. These members saw both the requirement for two doctors to agree that a woman can have an abortion and the law that prohibits nurses and midwives from performing early medical and early surgical abortions as outdated. Amendments to modernise abortion law were to be debated under the Human Fertilisation and Embryology Bill in October

2008, however due to time restrictions this did not happen and the Abortion Act 1967 remains unchanged for the time being.

The nursing profession endeavours to develop more responsive, patient-centred services. Opportunities for nurses, in conjunction with medical colleagues, to take a far more proactive role in developing abortion services across England, Scotland and Wales have been created as a result of the European Working Time Directive (RCOG, 2004a). In addition, the increasing number of doctors 'opting out' of providing abortion services has resulted in gaps in service provision, which has led to further opportunities for enhanced development nursing roles in providing medical termination of pregnancy.

The principles of role development should be focused upon clinical need. They should empower nurses to develop their knowledge and skills for the benefit of patient care, rather than involve the ad hoc acquisition of technical skills or the inappropriate delegation of unpleasant or unwanted tasks by other professional groups. Role development should occur after a health care provider has identified the need for, and potential benefits from, development, and should be given organisational support and built into planning for sustainability. Providers should work in partnership with commissioners and institutes of higher education to enable robust service and practice development (DH, 2000, RCN, 2004, and Ball, 2005).

Employers must ensure that role, purpose and responsibilities are clearly specified. Individuals should ensure that they identify the professional competencies, additional knowledge and skills they will need, and that they have access to appropriate education, training, competency assessment and continuing support/supervision. Once they have achieved competency, nurses should be able to practise within agreed protocols and under the guidance of a registered medical practitioner (DH, 1999).

Examples of role development to date may include:

- ◆ performing a pregnancy test and communicating the results to the woman
 - ◆ pre-admission assessment
 - ◆ pre- and post-abortion counselling
 - ◆ participation in the process of obtaining consent for abortion procedures (DH, 2001a)
 - ◆ administration of abortifacient drugs (within the context of RCN v DHSS [1981] 1 All ER 545)
 - ◆ vaginal and speculum examination
 - ◆ screening or testing for sexually transmitted infections
 - ◆ ultrasound assessment of gestational age, implantation site and viability (via a CASE accredited training programme: www.bmus.org)
 - ◆ insertion of osmotic cervical dilators such as Dilapan
 - ◆ assessment and provision of contraception via nurse independent prescribing or patient group directions (PGDs)
 - ◆ discharge following medical and surgical procedures
 - ◆ ability to make an assessment and take appropriate action based upon the assessment framework for children in need and use of domestic abuse pathways
 - ◆ provision of care for the mature minor/vulnerable woman
 - ◆ leading on service and practice development
 - ◆ developing political awareness, advocacy and influencing skills.
- To develop such roles, nurses need:
- ◆ to be accountable for their own practice
 - ◆ to identify a medical champion who shares the "vision" and supervises and supports the nursing team
 - ◆ a sound knowledge base and be appropriately educated and trained. (This may include undertaking an accredited training course e.g. sonography, counselling, Practice of Family Planning and Sexual Health course, Faculty of Sexual and Reproductive Health (FSRH) abortion modules)
 - ◆ up-to-date knowledge of evidence based practice
 - ◆ robust competency assessment ensuring confidence in performing practical skills (e.g. pelvic examination)
 - ◆ understanding and implementation of the principles of risk management

- ◆ opportunities to develop and practice leadership, mentoring and supervisory skills
- ◆ thorough working knowledge of the law on abortion.

Nurses will be working lawfully in the limits of the Abortion Act 1967 providing they are carrying out treatment in accordance with delegated instructions from a registered medical practitioner. The medical practitioner must remain responsible for patient care throughout any treatment ([RCN v DHSS [1981] 1 All ER 545).

Supervision and support for nurses

Caring for a woman with an unwanted pregnancy is a demanding yet rewarding area of nursing. Nurses have a professional responsibility to act with integrity and ensure that their personal views do not affect or influence the care of the patient or client (NMC, 2008).

Sources of support and supervision include:

- ◆ clinical supervision

Clinical supervision (NMC, 2006a) is a formal process of professional support and learning which enables nurses to assume responsibility for their own practice and reflect upon personal beliefs and bias.

- ◆ local groups

Setting up local support groups is an excellent way of sharing and learning from experiences of peers.

- ◆ RCN forums

The RCN Gynaecology Nursing Forum Sub-group 'Nurses working in Termination of Pregnancy' was established in 1998 in response to a tangible and widespread need for nurses requesting support and advice from their peers including front-line nurses working in this specialised field of nursing. The steering group comprises of nurses from across England, Scotland and Wales working in abortion services in both the NHS and independent sector. The steering group acknowledges the emotional, ethical and legal and clinical challenges faced by nurses caring for women at all stages of the abortion care process.

The RCN Gynaecology Nursing Forum and its specialist sub-group offer a nationwide network of members sharing the same area of interest. Its bi-annual

newsletter provides an update from a steering group member. Members can seek individual advice through accessing the RCN Gynaecology Nursing Forum Community on the RCN website (www.rcn.org.uk). There is also a discussion zone which is a useful way of engaging fellow professionals in a dialogue in a safe environment. Regional and national seminars, publicised through the website, are held bi-annually to share local initiatives, policies, guidelines, best practice and to debate the political agenda. Networking at these events is invaluable in fostering liaisons with other professionals who share common experiences. There are also regional email networks to facilitate networking amongst members.

2

Legal considerations

Background to legislation

Nurses who are involved in abortion must be familiar with the legal requirements of the Abortion Act 1967, as amended 1990. Here is a brief overview of the main provisions – you will find recommendations for further reading at the end of the document. Where you are in any doubt about a legal or ethical issue, you must seek advice from a senior colleague, an employer or a professional organisation before proceeding further.

The Abortion Act 1967 (with some provisions amended by the Human Fertilisation and Embryology Act 1990) defines the grounds upon which an abortion can take place in a lawful manner. The Act covers England, Scotland and Wales but does not apply to Northern Ireland, where the Offences Against the Person's Act 1861 applies. It is critical for nurses to have a sound understanding of the legislation: it is the provisions of the Abortion Act that make some abortions lawful only in certain circumstances.

Essentially, authorisation for any abortion can only take place when two registered medical practitioners are of the opinion formed in good faith that one of the grounds for a lawful abortion exists – this is a critical element under s.1 (1) Abortion Act 1967. The legislation does not give any scope for nurses to be signatories on the form, known as HSA1, which confirms that the terms of the Abortion Act 1967 have been met.

Nurses do have legal authority to be involved in activity that induces an abortion, as long as a registered medical practitioner is on call and responsible for the care of the woman throughout the abortion. This clarification of s.1(1) Abortion Act 1967 was set out in the House of Lords case *RCN v DHSS* [1981] 1 All ER 545.

Conscientious objection

The Abortion Act 1967 provides a right of conscientious objection in Section 4 which allows nurses to decline to participate in an abortion. This right is limited only to the active participation in an abortion where there is no emergency with regard to the physical or mental health of the pregnant woman. More information about this is provided in the Nursing and Midwifery Council advice sheet *Conscientious Objection* (NMC, 2006b). Nurses who have a conscientious objection must inform their

employer at the earliest opportunity. Nurses cannot refuse to provide nursing care for these women.

What nurses cannot do within the current legislation:

- ◆ sign the Abortion Act forms (HSA1 and HSA4)
- ◆ prescribe the abortifacient drugs for use in medical abortions or to prime the cervix prior to surgical abortion
- ◆ provide abortion services alone without a doctor being on call and remaining responsible for the woman
- ◆ perform surgical abortions.

The penalties for any person in failing to follow the provisions of the Abortion Act are criminal. Vicarious liability (the principle whereby an employer is held responsible for the acts or omissions of its employees) is not engaged as this is not a matter of negligence, but of a criminal act. RCN indemnity insurance does not provide cover for nurses who are prosecuted for unlawful activity.

Consent

All women undergoing an abortion procedure need to sign a written consent form. The consent form should include:

- ◆ the procedure to be undertaken
- ◆ the potential complications that could occur as result of the procedure
- ◆ any other procedures that might need to be undertaken as a result of complications occurring (DH, 2001a, RCOG, 2004).

In England, Wales and Northern Ireland, young women aged 16 and 17 years of age are presumed to be competent to give consent under the provisions of the Family Law Reform Act 1969. The legislation is slightly different in Scotland where adulthood has now been defined at 16 years not 18 years (Age of Legal Capacity (Scotland) Act, 1991).

In all UK countries, young people under 16 years of age can give consent if they fully understand what is

involved – parental involvement is not a legal requirement, although ideally nurses should encourage the young woman to involve a parent or guardian (DH, 2001b; RCOG, 2004).

The legal principle for consent to treatment by those aged under 16 was given in the House of Lords ruling in *Gillick v West Norfolk and Wisbech HA [1986] AC 112*. This legal principle, known as the test for Gillick competence, has provided clinicians with an objective test of competence. This identifies young people under 16 years of age who have the legal capacity to consent to medical examination and treatment, providing they can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of the proposed treatment, including the risks and alternative courses of actions. The guidance is commonly known as the Fraser Guidelines/ Criteria (DH, 2004a; FFPRHC, 2004). Although specifically relating to contraception, this guidance is widely used in abortion services. This ruling was upheld on 23 January 2006 in the case of *The Queen on the Application of Sue Axon (claimant) –v- The Secretary of State for Health (Defendant) and The Family Planning Association (Intervener)* when the High Court rejected Sue Axon's claim that the Department of Health's document *Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under sixteen on Contraception, Sexual and Reproductive Health* was unlawful (<http://www.bailii.org/ew/cases/EWHC/Admin/2006/37.html> 09/01/08).

Confidentiality

All women (including those under 16 years of age) seeking an abortion have a right to confidentiality from all health care and ancillary staff. Only in exceptional circumstances (for example, where the health, welfare or safety of the woman, a minor or other people is at risk) should a third party be informed (RCOG, 2004b). Data on all women undergoing an abortion is collected via the HSA4 form and notified to the Department of Health/ Scottish Executive. The forms are held securely and only individuals authorised by the Chief Medical Officer have access.

These principles were also upheld in relation to protecting the confidentiality of advice given to those aged under 16 years of age in the case R (on the application of Sue Axon) v Secretary of State for Health (EWCA 37, 2006)

Gillick case in the House of Lords- Lord Fraser's legal criteria for contraceptive advice:

A doctor [now taken to include other health care professionals] is justified in proceeding with treatment on a young person under the age of 16, including abortion, without the parent or guardian's consent or knowledge if:

- ◆ the young person understands the advice being given
- ◆ the clinician cannot persuade the young person to involve parents/carers or allow the clinician to do so on their behalf
- ◆ it is likely the young person will begin or to continue having sexual intercourse with, or without, contraceptive advice
- ◆ unless he/she receives contraceptive advice or treatment their physical or mental health, or both, are likely to suffer
- ◆ the young person's best interests require contraceptive advice, treatment, or supplies to be given without parental consent.

N.B While not a legal requirement, assessing the need for parental involvement is a key principle of the Fraser/ Gillick assessment.

Safeguarding issues

For information on safeguarding please see The abortion decision on page 11, and Vulnerable groups and special considerations (safeguarding children) on page 14.

3

Service provision and clinical considerations

The abortion care pathway (Appendix 1 – page 17) provides a reference guide of best practice for access and referral to abortion services, pre-abortion assessment, abortion methods and post-abortion care.

Access and referral

All women in England, Wales and Scotland can access an abortion if their circumstances fulfil the terms of the Abortion Act 1967. Abortion services should therefore be easily accessible and allow direct referral as well as referral from health professionals. Health care providers of abortion services should be committed to ensuring that women can access abortion services as early as possible in the pregnancy to reduce the possibility of associated health risks (See RCOG, (2004b) www.rcog.org.uk, MedFASH (2005) www.medfash.org.uk, and QIS (2008) guidelines www.nhshealthquality.org).

Pre-abortion assessment – the nursing role

Nurses who are appropriately trained and assessed as competent in line with local guidance or protocols may undertake pre-abortion assessment (ensuring that two doctors have agreed that the abortion is justified under the grounds of the Abortion Act 1967). Because this consultation is a sensitive one, it is good practice to see the woman (regardless of her age) on her own initially, so that she can give accurate answers and express her thoughts and feelings freely without being inhibited by the presence of other family members/partners.

The role of pre-abortion assessment is holistic and multi-faceted. It should include:

1. Developing a full picture of the circumstances leading up to the woman's request for an abortion (see The abortion decision – page 11). The woman should be offered pregnancy counselling if required (see Appendix 2 – page 18).
2. A detailed medical assessment to include:
 - ◆ date of last menstrual period (LMP) and menstrual history
 - ◆ past gynaecological, obstetric history and sexual health history
 - ◆ currently breastfeeding – if 'yes' and considering medical abortion, refer to the current British National Formulary appendix on breast-feeding
 - ◆ past and current medical history
 - ◆ current medication
 - ◆ awareness of any allergies – including assessment of contraindications to abortifacient drugs
 - ◆ use of substances such as nicotine/ alcohol/ recreational drugs.
3. Physical assessment to include:
 - ◆ confirmation of pregnancy by urine pregnancy test
 - ◆ assessment of gestational age, ideally by ultrasound scan otherwise by bi-manual examination (RCOG, 2004b)
 - ◆ prevention of post-abortion sepsis – ideally services should offer screening for chlamydia and gonorrhoea (either via urine, endo-cervical swabs or self obtained swabs). Currently not all areas offer screening for gonorrhoea. As a minimum standard all women should be given antibiotic prophylaxis (RCOG, 2004b). Good practice would suggest links to local Genito Urinary Medicine services are in place to allow partner notification when a positive result occurs (MedFASH 2005, SIGN 2000, Welsh Assembly Government 2006, QIS 2008)
 - ◆ obtaining blood for haemoglobin concentration/ studies, blood group and rhesus status.
4. Referral for medical assessment as appropriate.
5. Explanation of methods of abortion which are available dependent upon gestational age and local policy. This should include a full explanation of the risk of potential complications (including local risk

percentages). Written information should be available.

6. Obtain consent for chosen procedure including assessment of competence to consent in the case of a child under 16 years of age.
7. Assessment and discussion of future contraceptive needs to include all available methods, and promotion of commencing contraception at the time of abortion or immediately afterwards.
8. Appropriate and speedy referral to other agencies as appropriate.
9. Ensure medical assessment has been completed (signed HSA1 form and drugs prescribed) before any treatment is commenced.

The abortion decision

Unwanted pregnancy may involve complicated and ambivalent feelings. A decision to continue or not with a pregnancy is an important life event that needs careful consideration. Pregnancy is rarely a straightforward event for a woman whatever her social realities. Pregnancy brings with it enormous physiological, emotional and psychological changes which can make decision-making difficult, and increasingly so as the pregnancy progresses.

It is important to give women the opportunity to consider the issues in a confidential and non-judgemental environment. A wide range of health professionals and organisations currently provide help and support with the decision-making process. Systems should be in place to refer women rapidly for pregnancy counselling when this is required (see Appendix 2 – page 18).

Whose decision is it?

While the opinion and feelings of others will often form part of the picture for each woman, the decision remains hers alone. It is important that the woman acknowledges the implications and responsibility of the decision. Once you have seen the woman on her own, it may be equally appropriate for the woman to involve a partner or family member in making her decision.

For young women under 16 years of age, part of this process will be concerned with issues of consent and support, the pros and cons of confiding in a parent or another responsible adult, and an exploration of 'ways to

tell'. If there are concerns regarding child protection, sexual abuse or exploitation then the case should be discussed or referred to the designated person for safeguarding children (DH, 2003; Scottish Executive, 2004).

Methods of abortion

In Britain 98% of abortions in Britain are carried out because of risk to the mental or physical health of the woman or her children under the ground allowed by section 1(1) (a) of the Abortion Act 1967 (DH 2007).

Abortion can be carried out up to the legal limit of 24 weeks' gestation by medical or surgical means under grounds allowed under s.1(1) (b) and (c) Abortion Act 1967. There is no time limit for induced abortion under s 1(1) (d) Abortion Act 1967. The earlier in pregnancy that an abortion is performed, the lower the risk of complications (RCOG, 2004b). The Abortion Act 1967 does not distinguish in the method of abortion between medical and surgical.

Medical abortion

Medical abortion involves the woman taking oral medication – currently an antiprogesterone steroid (for example, mifepristone), followed some time later by a prostaglandin (for example, misoprostol). The antiprogesterone steroid effectively blocks the action of progesterone, preventing the pregnancy from progressing. It also facilitates the process of medical abortion by sensitising the uterus to the prostaglandin, which induces uterine contractions and also by softening and dilating the cervix (BMA and RPS, Sept 2005). The use of an antiprogesterone steroid means that medical abortions complete more quickly and with a lower dose of prostaglandin (BMA and RPS, Sept 2005). There is a table showing the RCOG (2004b) recommended drug regimes for medical abortion in Appendix 3 (page 19).

Surgical abortion

Surgical abortion involves the physical removal of the fetus from the uterus. The method of surgical procedure is determined by the gestation of the pregnancy.

- ◆ **Up to 15 weeks gestation:** abortion can be by suction aspiration (electric or manual) under local or general anaesthetic. This involves emptying the

uterus of its contents via a suction curette attached to a suction machine or a manual vacuum aspiration syringe. Local anaesthetic (with or without conscious sedation) can be used up to 12 weeks gestation (service provision varies widely and will be dependent upon local policy. Some providers do not offer this, while others may only offer local anaesthetic up to eight weeks gestation). Failure rates for electric suction abortion below seven weeks gestation are higher than for electric suction abortion carried out beyond seven weeks and may also be higher than medical abortion below seven weeks gestation (RCOG, 2004b). Manual vacuum aspiration is most commonly carried out under local anaesthetic, with or without conscious sedation.

- ◆ **15 weeks gestation and above:** for 15 weeks gestation and above, dilatation and evacuation is used. This involves the removal of the fetus with forceps, through the cervix. Cervical preparation approximately three hours prior to the surgical procedure with a prostaglandin is recommended for surgical abortion beyond 10 weeks gestation and for women aged under 18 years (RCOG, 2004b).
- ◆ **19 weeks gestation and above:** osmotic dilators are used to dilate the cervix prior to the evacuation of the uterus. Beyond 21 weeks and 6 days gestation, some abortion providers inject intra-amniotic medication (for example, potassium) the day before a surgical abortion. It is suggested that the autolysis of the fetus that occurs during the intervening time enables an easier evacuation, but this is not a practice undertaken by all providers and is not described in the latest RCOG (2004b) guidelines.

Specialised service considerations

Although not relevant to all abortion providers, nurses need to be aware of the circumstances in this section.

Fetus delivered showing signs of life following abortion

There is a possibility that a late stage abortion may be performed where the fetus could be delivered showing signs of life. This can be extremely traumatic for the woman undergoing the abortion and challenging for the health care professionals providing treatment and care.

In order to ensure compliance with the Abortion Act 1967 and to avoid any potential crime of inducing a miscarriage under s.58 Offences Against the Person Act 1861, it is necessary in later stage abortions (after 21 weeks and 6 days) to ensure that the fetus is born dead (RCOG, 2001). The Royal College of Obstetricians and Gynaecologists (RCOG) recommends that for medical terminations after 21 weeks and 6 days, foeticide should be carried out to ensure fetal demise prior to delivery (RCOG, 2001). Intracardiac potassium chloride is the recommended method to induce foeticide (RCOG, 2001). You will find further guidance in the NMC document *The care of babies born alive at the threshold of viability* (NMC, 15 January 2007, 03/NMC circular). Surgical abortion, by its nature, ensures that the fetus will not be born alive.

Selective fetal reduction

Multi-fetal pregnancy reduction can be considered when a higher order multiple pregnancy is diagnosed. Triplets or higher numbers have a significantly higher risk of fetal demise, pre-term birth and increased risk of mortality and morbidity. Professionals should also consider the psychosocial implications of multiple births for the woman and family. The evidence for lower maternal complications and infant mortality and morbidity for triplets reduced to twins is more controversial, but it is usually agreed that a reduction results in better medical outcomes for higher order births.

The usual practice is to refer the woman to a fetal medicine unit as early as possible for specialist assessment, information, counselling and management of each individual case. The risk of losing the pregnancy after the procedure is about five percent for triplets, eight percent for quadruplets and 11 percent for quintuplets. It is an immensely difficult and individual decision. You should provide the woman with as much information as possible about the potential outcomes and give her the opportunity to discuss the risks and advantages and emotional, psychological and social issues.

Fetal reduction involves inserting a needle through the woman's abdomen using ultrasound guidance, and injecting potassium chloride into the fetal heart so that it stops. The reduction from higher order multiple pregnancies is usually to a twin pregnancy and is normally carried out at 11-14 weeks gestation, because up to this point in pregnancy there may be a

spontaneous reduction. The decision regarding which fetus(es) to reduce is based on clinical information about which fetal sac is most easily accessible, thus reducing the risk of miscarriage. It is also usually possible by this stage of a pregnancy to measure nuchal translucency and detect gross structural fetal anomalies and some indications of aneuploidy (Kilby et al, 2006). Chorionicity is an important factor to take into account.

Selective reduction may be considered if a serious anomaly is diagnosed in one twin. Factors to consider include whether the child is likely to die at or soon after birth or survive with a severe disability. As the diagnosis of the abnormality is often not made until later in the pregnancy, selective reduction is usually performed in the second trimester, although it may be earlier. The safety of the unaffected fetus is also an important consideration. The Abortion Act 1967 allows this procedure to be performed after 24 weeks under the ground set out in s.1(1) (e). This offers less risk to the co-twin from premature labour and delivery. This can be a very difficult concept for the woman and information must be provided about the risks and clinical aspects of the procedure as well as counselling about the emotional and psychological effects for the parents and surviving child. Whenever fetal reduction is performed, short- and long-term support and counselling should be available.

Congenital/fetal anomaly

Methods for abortion used in cases of diagnosed congenital or fetal anomaly are covered in the methods of abortion section. You can find advice and care pathways for fetal anomaly screening and care by visiting: <http://www.fetalanomaly.screening.nhs.uk>. Further information is also given in the SANDS guidelines (Schott et al, 2007), and at the Ante-natal Results and Choices website (<http://www.arc-uk.org/>)

Post-abortion care

General advice and support

The advice and support you provide after an abortion is aimed at enabling the woman to achieve a healthy recovery, to minimise risk and to initiate early intervention or treatment if indicated. You should give each woman a written information leaflet and a 24-hour contact telephone number. Contraception should be

discussed and supplied as appropriate. Abortion providers should be promoting the use of long-acting reversible contraceptives (LARC) and should have access to fit or provide a full range of contraceptive methods including LARC, or have clear and timely pathways to refer to other providers for these methods. Appendix 4 (page 20) contains an example of abortion aftercare advice.

Psychological sequelae of induced abortion

The incidence of psychological sequelae (a psychological disorder possibly caused by the abortion process) following induced abortion is difficult to assess. The RCOG undertook a review of the available evidence and states that:

“Some studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared with women who give birth and to non-pregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions.” (RCOG, 2004b)

It is important that those women who do experience psychological difficulties after abortion and in the long term have access to appropriate counselling (RCOG, 2004b). The RCOG (2004b) suggests that there are certain factors that might be helpful in identifying those women at particular risk:

- ◆ ambivalence prior to the abortion
- ◆ absence of a supportive partner
- ◆ psychiatric history
- ◆ membership of a cultural group that believes abortion to be wrong.

Sensitive disposal of fetal remains

Sensitive disposal of fetal remains is an area that abortion providers should consider. Guidance has been published by the Department of Health (2004), RCOG (2005), Human Tissue Authority (2006) and the RCN (2007). There are web links at the end of this document for these publications. Providers should fully inform women about the method of disposal of fetal tissue, what their options are, and that they may not have to undergo specific written consent for cremation. This will depend on local arrangements. Patient information leaflets regarding abortion should include information regarding sensitive disposal.

Where abortion services are sited in a health setting that also provides gynaecology or maternity services it may be helpful to link with disposal processes that are already in place. Independent abortion providers may find this more problematic, but should still ensure that safe, acceptable systems are in place and that all staff are aware of the methods used so that they can respond to an enquiry from a woman. Women may occasionally ask to take their fetal remains home. Whilst there is no legislation that prevents this, the woman will need support to decide if this is the most appropriate course of action, and what she can do with the remains. You will find further guidance on this issue in the SANDS publication *Pregnancy Loss and the Death of a Baby: Guidelines for professionals* (Schott et al., 2007).

Providers should also have systems in place so that if a woman requests individual cremation/ burial of the fetal remains (where this is not the usual option) that staff are able to give advice and offer support.

Vulnerable groups and special considerations

When you are providing advice and assessment for abortion, you will need to give special consideration to vulnerable groups and to ethical and social issues.

Safeguarding children

- ◆ Where there is an indication that a child or young person seeking an abortion is a 'child in need' or a 'child in need of protection', practitioners should follow local child protection procedures and refer the case immediately.
- ◆ Only appropriately experienced and competent nurses and midwives should examine young women under 16 once they have established the young woman's capacity to consent to examination. The practitioner must be fully aware of the laws regarding consent (see page 8).
- ◆ The Department for Education and Skills (DfES, 2005) outlined a common core of skills and knowledge that everyone working with children and young people in England must attain. All health care practitioners who may come into contact with a child or young person under the age of 19 (age of 16 in Scotland in line with the Age of Legal Capacity (Scotland) Act 1991) are advised to undertake a self-

assessment against the requirements and to seek relevant additional training as required.

- ◆ Nurses should be familiar with the key safeguarding issues relating to young women under 16 years of age who are sexually active.

Ethnic and cultural issues

- ◆ Women whose first language is not English and who prefer to communicate in that language (or where a health professional considers that an interpreter is necessary) will require a recognised interpreter. Due to the sensitive nature of abortion, a family member or friend is not appropriate to assist with translation. Written information should be provided in translation if possible, before the woman is examined. Practitioners are advised to follow local protocols in relation to the use of interpreters.
- ◆ Nurses should be aware that women who have cultural links to African countries, parts of the Middle East and South East Asia may have undergone female genital mutilation (FGM). It may be appropriate to ask if they have been circumcised or closed. Where necessary, de-infibulation must be performed before or at the time of the abortion, because the vaginal opening needs to be of sufficient size to allow the passing of a speculum and, in the case of medical abortion, for the products of conception (POC) to leave the body (NICE, 2003). It is a criminal offence to re-close the vulva. For more information see the RCN publication *Female Genital Mutilation* (RCN, 2006a).
- ◆ Some women will request to be examined only by a female practitioner, and this should be respected if possible. If a female doctor or nurse has been requested but is unavailable, alternative arrangements may have to be made. In emergency situations, where no female doctors are available to perform the abortion, health professionals should work in partnership with the woman to identify the best course of action.

Physical disabilities, learning disabilities and mental illness

- ◆ Services should be accessible, provide appropriate levels of communication and information, and offer an equal level of service for all women regardless of disability. Services should be flexible, creative and innovative in meeting the needs of disabled women (RCN, 2007).

- ◆ Careful consideration should be given when a woman has temporary or permanent learning disabilities or mental illness about whether they have the capacity to consent to any proposed examination(s) or procedures. You will find more guidance about this issue from the Department of Health (2001c), the NMC (2005) and the Mental Capacity Act 2005. If a woman has capacity to consent, it is important that you keep clear documentation of how and when consent was assessed. Where a woman does not have capacity to consent and an abortion is indicated, the provider must seek legal advice, working in partnership with medical and other colleagues to identify the most appropriate course of action.
- ◆ If the woman does not have capacity to consent, you should refer her to the designated registered medical practitioner for the abortion service.

Rape and sexual assault

- ◆ Some women will have a history of traumatic experiences with previous vaginal examinations or may have experienced sexual abuse, physical abuse or rape in the past. This may become evident to you during history taking. You must give the woman an opportunity to discuss this. Any discussion should take place when the woman is dressed and not on the examination couch. Referral for counselling may be appropriate, and you should advise this in all cases.
- ◆ If a woman is pregnant as a result of rape or sexual assault and has chosen to have police involvement, then fetal samples may be required for DNA analysis. You must obtain the woman's consent to this before liaison with the local police department. In the case of an unreported rape, you should be aware of the referral pathway to the local rape assessment unit or its equivalent, or to alternative management pathways, and of the need to protect any potential 'evidence'. You must document any disclosure of rape or sexual assault in the woman's medical records for access in the event of legal action. For information on how to protect forensic evidence when sexual assault has been reported, a CD-ROM is available from: www.careandevidence.org

Domestic abuse:

- ◆ If a woman discloses that she has been subject to domestic abuse, it is important to ensure that you

provide information to enable her to contact a local or national helpline. It is also the responsibility of the nurse to record any disclosure and any physical signs of abuse and to take appropriate action based on local agreements/protocols. The woman may choose not to take further action at the time, but may wish to refer back to her medical records at a later date for evidence in a court case. In Wales, routine enquiry into domestic abuse is carried out in all women's health settings including when women request abortion (further information is available from: <http://www.wales.nhs.uk/sites3/home.cfm?orgid=699>).

Forced marriages

- ◆ Forced marriage is becoming an increasing concern and can involve child and sexual abuse including abduction, violence, rape, enforced pregnancy and enforced abortion. For further information see new guidance from the Foreign and Commonwealth Office on forced marriages: www.fco.gov.uk/forcedmarriage.

Difficulties with vaginal examinations

- ◆ Women who experience difficulty with vaginal examination should be given the opportunity to discuss any underlying sexual, marital or trauma related issues. These discussions should take place when the woman is dressed and not during examination (RCOG, 2002). Some women may experience distress without any underlying history of sexual abuse or difficulties.
- ◆ Some women may find vaginal and pelvic examination extremely difficult, because they experience vaginismus. This could be related to a previous vaginal examination, previous sexual abuse or reasons of unknown origin. Referral to a psychosexual counsellor may be necessary. You should not proceed with the examination if it will cause further distress to the woman (RCOG, 2002).
- ◆ If the woman is reluctant to be examined or has not had a vaginal or pelvic examination before, it may be appropriate to discuss the examination/procedure with her, considering all of the above as this may affect her choice of abortion method. You could consider an ultrasound scan should be performed to assess gestational age and screening for infection using urine or self-taken vulval swabs. If infection screening is not undertaken, then the woman should be given prophylactic antibiotics.

- ◆ Explain to the woman that following a vaginal examination, slight bleeding may occur.
- ◆ If a woman refuses or withdraws consent to the examination or procedure at any time, then you must stop the examination/procedure.
- ◆ You should not proceed with a vaginal examination if the woman:
 - ◆ is unduly stressed or upset
 - ◆ has had previous vasovagal reactions
 - ◆ has an imperforate hymen
 - ◆ has a full rectum
 - ◆ has a clinical condition which prevents examination.

For more information see the RCN guidance: *Vaginal and Pelvic Examination* (RCN, 2006b).

Appendix 1

Abortion care pathway

Best practice guidance

Overarching Aim – To enable women to have prompt access to abortion services and to reduce the risk of complications or negative outcomes arising from abortion (MedFASH, 2005)



Appendix 2

Pregnancy counselling

What is the aim of pregnancy counselling?

Pregnancy counselling aims to provide women with the opportunity to consider their situation, work through emotional issues, think through the possible consequences of their actions, explore options and to make an informed choice about the outcome of their pregnancy. It is crucial to give women the opportunity to consider the issues in a confidential, non-judgemental environment which allows feelings of ambivalence to be explored without the fear that this may jeopardise their decision to access abortion services. All women facing a decision about an unwanted pregnancy may benefit from counselling, but counselling is clearly of particular use to women who:

- ◆ are struggling with ambivalent feelings
- ◆ cannot reach a decision
- ◆ feel very anxious about a decision they have made
- ◆ have very little or no support from the people around them
- ◆ are under the age of 16 years.

You should also provide information on alternatives to abortion so that the woman can access appropriate services.

Who provides this service?

Counselling should be undertaken by someone who is a trained counsellor, is familiar with the issues surrounding unwanted pregnancy, has no vested interest in the pregnancy outcome and who is receiving regular professional supervisory support.

Issues to cover in counselling

Listed below are examples of the areas that might be explored during pregnancy counselling. Some of these may also be covered in the pre-abortion assessment process, according to individual needs.

- ◆ Is the gestation known? Is the woman aware that the length they have already been pregnant may limit the method of abortion available to her?
- ◆ Is this a single or multiple pregnancy? Do these issues make a difference to her decision?
- ◆ Was the pregnancy the result of failed contraception/non compliance?

- ◆ Is the pregnancy the result of sexual assault?
- ◆ How is the pregnancy conceptualised by the woman? A 'clot of blood', a 'baby'? How emotionally 'attached' to the pregnancy is the woman?
- ◆ What were her feelings about abortion before she was faced with the decision herself? Does she have any religious, social, moral beliefs that would make abortion a difficult option?
- ◆ Who else is aware of the pregnancy? Who has she told? What is her support network? What other emotional support is there for her?
- ◆ What does she know about the process of abortion? Does she understand the medical risks of the different abortion methods available to her and of continuing with the pregnancy?
- ◆ How does she imagine she will cope post-abortion? Explore levels of relief, guilt, shame, loss and grief. Any other experiences of loss/bereavement in her life that might be re-awakened by her current situation?
- ◆ Does the woman have any special needs/ learning difficulty?
- ◆ If she is less than 16 years old, explore issues of consent and encourage the young woman to confide in a parent/adult she can trust. What are the implications of keeping the pregnancy secret? Are there child protection issues involved which may need discussion with the Designated Child Protection Officer? If she is less than 13 years of age, the Sexual Offences Act 2003 (www.opsi.gov.uk/acts/acts2003/20030042.htm) would apply in England and Wales. The Children (Scotland) Act, 1995 applies in Scotland.
- ◆ Is the woman aware of other options such as adoption or continuing with the pregnancy? If the woman is considering continuing with the pregnancy, explore the realities of caring for a baby and child. Identify what kind of support she would want from extended family or whether she is seeking independence. Discuss the financial and other practical realities (e.g. housing, continuing work/education, childcare etc).
- ◆ Has she informed her GP or organised ante-natal care? Make appropriate referrals. If the woman is considering adoption, refer her to the appropriate local social work department.

Appendix 3

Recommended drug regimes for medical abortion

The table shows the RCOG (2004b) recommended drug regimes for medical abortion.

Gestation	RCOG recommended drugs	Time gap between antiprogestogen and prostaglandin	Repeat doses
Up to 9 weeks (63 days)	Mifepristone 200mg orally followed by Misoprostol 800 micrograms vaginally 48 hours later	1-3 days	At 49-63 days gestation, second dose of misoprostol 800 micrograms vaginally or orally can be given if abortion has not occurred within 4 hours
	Mifepristone 600mg orally followed by Gemeprost 1mg vaginally 48 hours later	36-48 hours	
9 to 13 weeks	Mifepristone 200mg orally followed by Misoprostol 800 micrograms vaginally 48 hours later	36-48 hours	Misoprostol 400 micrograms vaginally or orally at 3-hourly intervals up to a maximum of four further doses
13 to 24 abortion (mid-trimester)	Mifepristone 200mg orally followed by Misoprostol 800 micrograms vaginally 48 hours later	36-48 hours	Misoprostol 400 micrograms vaginally or orally at 3-hourly intervals up to a maximum of four further doses
	Mifepristone 600mg orally followed by Gemeprost 1mg vaginally 48 hours later	36-48 hours	Gemeprost 1mg vaginally every 3 hours to a maximum of five pessaries

Appendix 4

Aftercare advice following abortion

Practitioners should give after care advice to women who have had an abortion which includes the following points:

- ◆ vaginal bleeding (with or without clots) can last for up to two weeks after a surgical abortion and longer after a medical abortion. The bleeding should decrease in amount over these weeks. Should the woman experience continuous and heavy bleeding (for example to soak three or more pads in an hour while resting), she should contact the abortion provider or seek medical attention urgently
- ◆ sanitary towels should be used instead of tampons during this post-treatment bleeding to limit the risk of infection
- ◆ over-the-counter pain medicines (analgesia) such as paracetamol and/or ibuprofen can be used to relieve any abdominal pain or cramping. Hot pads or hot water bottles might also give some relief
- ◆ the woman should contact her abortion provider or GP if she experiences signs of fever, malaise, offensive vaginal discharge, continuing signs of pregnancy or other unusual signs or symptoms
- ◆ the possibility of ectopic pregnancy should be discussed with women who have an abortion at an earlier gestation (particularly Early Medical Abortion) if the pregnancy site has not been confirmed by ultrasound scan before the procedure. Women should be advised of the signs and symptoms to watch out for and what to do should they experience any of them. You should give written information to support your verbal explanation
- ◆ breast discomfort can persist for two weeks (especially after a mid-trimester TOP) and a well-supporting bra and pain relief medicine can provide some relief. Some women (at later gestations) can lactate. They should be advised not to express the milk because this can stimulate further production
- ◆ normal day-to-day activities can be resumed when the woman feels able
- ◆ sexual intercourse should be avoided after the procedure while the woman is still bleeding, to limit the risk of infection. Condoms should be recommended when sexual intercourse is resumed, to reduce the risk of infection and protect against sexually transmitted infections
- ◆ fertility can return immediately (first ovulation post-abortion can be within two weeks) so reliable contraception should be initiated immediately if she is having sexual intercourse, to avoid a further pregnancy (RCOG, 2004b). All women should be advised of all available methods of contraception, including long-acting reversible contraceptives (NICE 2005, QIS 2008). There is helpful information for professionals available from the Faculty of Sexual and Reproductive Healthcare: www.ffprhc.org.uk
- ◆ urine pregnancy tests are not reliable until at least 4-6 weeks post-abortion, because human chorionic gonadotropin (HCG) levels may still be discernable and distort the test results
- ◆ women who intend to travel long distances or take a flight soon after their abortion should be advised to ensure that they have appropriate sanitary wear, remain well hydrated by drinking lots of water, and if appropriate, should follow standard in-flight guidance regarding travel related deep vein thrombosis
- ◆ although there is no evidence that the risk of infection is increased, some health care professionals advise against swimming whilst still bleeding after an abortion
- ◆ the woman's next menstrual period may start as early as three weeks post-treatment, but in some cases it can take up to nine weeks for her next period to arrive. Factors that influence this are the woman's normal menstrual cycle, contraception choice and gestation at abortion. If the woman has not had a period at 4-6 weeks post-treatment, she should do a pregnancy test or contact the abortion provider.

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The Mental Capacity Act 2005, available at: <http://www.dca.gov.uk/menincap/legis.htm> .

The Sexual Offences Act 2003, available at: <http://www.uk-legislation.hmso.gov.uk/acts/acts2003/20030042.htm> .

Useful websites

Ante-natal Results and Choices

<http://www.arc-uk.org>

British Association for Sexual Health & HIV

<http://www.bashh.org>

bpas (formerly British Pregnancy Advisory Service)

<http://www.bpas.org>

Department of Health

<http://www.dh.gov.uk>

Faculty of Sexual and Reproductive Health (formerly Faculty of Family Planning and Reproductive Health Care, FFPRHC)

<http://www.fsrh.org.uk>

Family Planning Association

<http://www.fpa.org.uk>

Fetal Anomaly Screening Programme

<http://www.fetalanomaly.screening.nhs.uk>

Genito-Urinary Nurses Association (GUNA)

<http://www.guna.org.uk>

Irish Family Planning Association (for information on abortion in Southern Ireland)

<http://www.ifpa.ie>

Marie Stopes International (MSI)

<http://www.mariestopes.org.uk>

Medical Foundation for Aids & Sexual Health

<http://www.medfash.org.uk>

Multiple Births Foundation

<http://www.multiplebirths.org.uk>

NHS Quality Improvement Scotland

<http://www.nhshealthquality.org/nhsqis/43.144.140.html>

Nursing and Midwifery Council

<http://www.nmc-uk.org>

Office of Public Sector Information

<http://www.opsi.gov.uk>

Royal College of Obstetricians & Gynaecologists

<http://www.rcog.org.uk>

Royal College of Nursing

<http://www.rcn.org.uk>

UK National Screening Committee

<http://www.screening.nhs.uk/fetalanomaly/home.htm>



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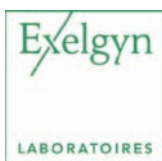
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