Termination of Pregnancy and Abortion Care

Clinical guidance

CLINICAL PROFESSIONAL RESOURCE

Acknowledgements

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Notes

The RCN recognises that services are provided and supported by registered nurses and midwives nursing associates and health care support workers, and nursing and midwifery students, and trainee nursing associates. For ease of reading, the generic terms 'nurse', 'nursing' and 'nurses' are often used throughout this publication.

As a gender diverse society this guidance can be used by and/or applied to people who identify as non-binary, transgender or gender fluid. Equally not all those who become pregnant will identify as women, and where relevant this has been acknowledged.

This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact corporate.communications@rcn.org.uk

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Contents

Introduction 4

Professional development, nurse-led services and support 4

Nurse-led services and advancing nursing practice 5

Legal considerations 9

Background to legislation 9

Conscientious objection 11

Consent 12

Confidentiality 13

Service provision and practice considerations 15

Access and referral 15

Pregnancy options 15

Whose decision is it? 15

Pre-abortion assessment 16

Pregnancy termination methods 17

Practice considerations 17

Congenital/fetal anomaly 18

Post-termination of pregnancy care 19

Special considerations and safety 22

Safeguarding adults 22

Safeguarding children 22

Language issues 23

LGBTQI+ 23

Physical disabilities, learning disabilities and mental wellbeing 23

Difficulties with vaginal examinations 24

Safety in practice for nurses and patients 26

Conclusion 28

References and further reading 29

Useful organisations/support 33

1. Introduction

The Royal College of Nursing (RCN) first published guidance in 2008, to support registered nurses and midwives fulfil their role in caring for those undergoing termination of pregnancy across the UK. Following changes in the law and the introduction of new medical techniques, the RCN regularly reviews and updates its guidance to keep pace with legislative changes around this area of practice.

This updated guidance builds on previous work and incorporates expert and evidence-based practice. It has been produced to support registered nurses and midwives working within the NHS and independent sectors, and is relevant across England, Scotland, Wales and Northern Ireland.

The RCN is committed to providing guidance for nurses and midwives who choose to work in termination of pregnancy services/abortion care*, to ensure they can provide safe effective high-quality care, whilst acknowledging and respecting those who have a conscientious objection to participation in termination of pregnancy.

*__Terminology__: the term termination of pregnancy is interchangeable with the term abortion, used in this guidance to discuss induced abortion, as opposed to spontaneous abortion, also identified as miscarriage. Both terms are in common use.

Professional development, nurse-led services and support

There are a range of professional skills, knowledge and competencies required to enable nurses to plan, deliver, develop and evaluate abortion services within their scope of practice and within the limits of the current legislation. Nursing care is dynamic and responds to the changing needs of the UK population. Nurses and midwives have developed new roles, are working across traditional boundaries, and have been instrumental in developing new services to meet health needs in a variety of health settings which now includes digital care within a woman's own home.

In 2019, the RCN Women's Health Forum Committee conducted research on education provision and abortion care, and it made recommendations on access to education on abortion for all nursing teams, not just for specialist staff (RCN, 2019).

Recent and future developments in abortion care will continue to provide both challenges and opportunities for nurses practising at every level in this area of health care. The need for organisational support and robust clinical governance mechanisms is fundamental to assist professional practice.

The current climate of change in health care provides an opportunity for health care leaders to shape the way services are provided in the future. The development of a designated role to achieve this – for example, consultant nurse, clinical nurse specialist and advanced nurse practitioner roles can shape local, regional and national practice in relation to caring for women undergoing a termination of pregnancy. All nurses have an opportunity to lead service provision and developments whilst influencing change in ensuring improved services for women within the current legal framework.

Nurse-led services and advancing nursing practice

Since the late 1960s, the authorisation and provision of termination of pregnancy has been the legal responsibility of a registered medical practitioner, and the requirements were set out in the Abortion Act 1967. Historically, the role of the nurse was to provide general nursing care. Recent advances in termination of pregnancy methods, particularly telemedicine and early medical abortion, have led to the development of new nursing roles allowing for a more holistic provision of nursing care.

Under the supervision of a registered medical practitioner, nurses now triage, assess, plan, lead and manage most of the care for women undergoing medical termination of pregnancy. The role of the nurse in abortion care has developed in response to a number of internal and external drivers. Re-organisation of the NHS and changes in commissioning, the changes in service delivery in response to the COVID-19 pandemic, as well as developments in the role of health professionals within the NHS, has provided a backdrop for professional and service development.

At present, the current legal requirements of the Abortion Act 1967 for England, Scotland and Wales do not allow nurses to authorise a termination of pregnancy, and the current need for two doctors' involvement can limit the extent of nursing activity in termination of pregnancy. The legislation in Northen Ireland is less restrictive and this role can be undertaken by registered nurses and midwives, as laid out in The Abortion (Northern Ireland) Regulations 2020.

In abortion care, the nursing profession endeavours to provide more responsive woman-centred services, and opportunities for nurses have developed to take a more proactive role in enhancing services across the UK. In addition, early medical abortion lends itself to nurse-led provision and now represents 87% of all abortions (Office of Health Improvements and Disparities (OHID), 2023) and this has led to further opportunities for enhanced and advanced nursing role development.

The principles of role development should focus on clinical need with nurses developing their knowledge and skills for the benefit of the care of women, rather than the acquisition of technical skills or the inappropriate delegation of tasks by other professional groups.

The identification of local service provision as well as consideration of organisational sustainability, are important factors when determining role development. Working in partnership with commissioners and higher education institutions is well recognised as enabling robust service and practice development. Role purpose and responsibilities must be clearly specified.

Individual registrants must ensure that competencies, including additional skills required are identified, and appropriate education, assessment and continuing support/ supervision are available, especially for those expanding their practice into advanced practice roles.

Further information can be found in the RCN *Standards for Advanced Nurse Practitioners* (RCN, 2018) at: **rcn.org.uk/Professional-Development/Advanced-Practice-Standards** and information on opportunities for RCN credentialling (which enable nurses to demonstrate advancing skills and knowledge) information can be found at: **rcn.org.uk/Professional-Development/Professional-services/Credentialing**

The RCN has published specific guidance on advanced practice roles in gynaecology (RCN, 2023) which is available at: **rcn.rcn.org.uk/publications** (due to be published December 2023).

Examples of role development

Clinical skills:

- pre-abortion assessment
- pre- and post-termination of pregnancy discussion and/or counselling
- obtaining consent for a termination of pregnancy procedure
- administration of abortifacient drugs
- vaginal and speculum examination
- screening, testing and treating sexually transmitted infections.
- ultrasound assessment of gestational age, implantation site and viability
- insertion of osmotic cervical dilators such as Dilapan
- assessment and provision of contraception – including via nurse independent prescribing or patient group directions (PGDs)
- discharge following medical and surgical procedure
- post-abortion assessment
- specialist care for vulnerable women
- leading on service and practice development
- provision of manual vacuum aspiration (MVA)*

- developing political awareness, advocacy and influencing skills
- education
- policy and service developments
- research.

Note: *At this time (November 2023) nurses can perform MVA for termination of pregnancy in Northern Ireland, however in other parts of the UK, despite nurses and midwives performing MVA for miscarriage and retained products following abortion, it is yet to be confirmed whether nurses in England, Wales and Scotland can lawfully perform MVA for induced abortions. The law is difficult to interpret in relation to this area of practice. It has been suggested in a paper by Sheldon and Fletcher (2017) that it would be legal for nurses to do so, providing a registered medical practitioner has

overall responsibility for the care of the woman throughout the care pathway. Further clarification is required in relation to the interpretation of the law.

To develop such roles nurses need to:

- be accountable for their own practice
- have a sound knowledge base and appropriate education and training
- be up-to-date with evidence-based practice in abortion care
- identify a champion who shares the vision and supervises and supports the nursing team, including management teams
- have robust competency assessment, ensuring confidence in performing practical skills (for example, ultrasound scanning)
- have an understanding and implementation of the principles of risk management
- have opportunities to develop and practise leadership, mentoring and supervisory skills
- engage in research opportunities to extend the evidence base in termination of pregnancy care
- undertake service development evaluations.

Nurses also need to have:

- access to restorative clinical supervision
- access to leadership and development programmes
- a complete understanding of the law on termination of pregnancy.

In England, Scotland and Wales nurses work within the provisions of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990), providing they are carrying out treatment in accordance with delegated instructions from a registered medical practitioner. The medical practitioner remains responsible for care throughout any treatment (RCN v DHSS [1981] 1 All ER 545) (National Library of Medicine, 1981).

In Northern Ireland, abortion care is provided under a different framework allowing it to be medically managed within that legal framework. This has enabled nurses to use their skills such as prescribing abortion medication and undertaking MVA for surgical abortion.

Supervision and support for nurses

Nurses have a professional responsibility to act with integrity and ensure that their personal views do not affect or influence the care of the woman (NMC, 2018). Clinical supervision is recognised as 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.

The RCN is committed to enabling nurses, as a graduate workforce, to critically reflect on, in and for action relating to nursing practice and continues to work towards embedding clinical supervision as a fundamental attribute of professional nursing. Visit: **rcn.org.uk/About-us/Our-Influencing-work/Position-statements/rcn-position-on-clinical-supervision**

The RCN Women's Health Forum has a UK-wide network of members and webpage as well as an active Facebook page and Twitter community. It provides updates on a wide range of issues and evidence-based guidance.

rcn.org.uk/Get-Involved/Forums/Womens-Health-Forum

RCN members can seek individual advice by accessing RCN Direct online advice guides at: rcn.org.uk/contact

2. Legal considerations

Background to legislation

Nurses who are involved in a termination of pregnancy must be familiar with the legal requirements of the legislation and policies applicable locally. This guidance gives a brief overview of the main provisions and recommendations. Further reading can be found at the end of this document. Where a nurse is in any doubt, they must seek advice from a senior colleague, an employer or a professional organisation before proceeding further.

The Abortion Act 1967 (Gov.UK 1967) (amended by the Human Fertilisation and Embryology Act 1990 (Gov.UK 1990)) defines the grounds upon which a termination of pregnancy can take place legally. This Act covers England, Scotland and Wales but does not apply to Northern Ireland.

On 1 April 2020, the legislation in Northern Ireland relating to termination of pregnancy changed, and further details can be found in The Abortion (Northern Ireland) Regulations 2020.

The current legislation for England, Scotland and Wales allows termination on any of the following grounds:

- that the pregnancy has not exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family
- that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman
- that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated
- that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped

In Northern Ireland, abortion is allowed in the following circumstances:

- prior to 12 weeks on a woman's request and with the certification of a registered health care professional such as a doctor, nurse, or midwife, in line with the Republic of Ireland in good faith
- between 12-24 weeks on the same grounds as in the rest of the UK – that continuing with the pregnancy would involve a risk of injury to the physical or mental health of the woman greater than if the pregnancy was terminated. This must be certified by two registered health care professionals
- beyond 24 weeks along the same lines as the rest of the UK – if the life or health of the woman is in serious danger, or if there has been a diagnosis of severe or fatal fetal abnormality. This must be certified by two registered health care professionals.

It is critical for nurses to have a sound understanding of the legislation. In England, Scotland and Wales, authorisation for the termination of pregnancy can usually only take place when two registered medical practitioners are of the opinion, formed in good faith, that one of the grounds for a lawful termination of pregnancy exists, confirming this by signing a form called an HSA1. In an emergency, and only when the life of the woman is

at risk, then one signature is required. Every abortion must be legally certified by at least one health care professional and must be notified to the chief medical officer.

The legislation in England, Scotland and Wales does not give any scope for nurses or midwives to be signatories on the HSA1, however nurses do have a legal authority to be involved in activity surrounding termination of pregnancy as long as a registered medical practitioner has overall responsibility for the care of the woman throughout the care pathway. This clarification of Section 1(1) of the Abortion Act 1967 was set out by the House of Lords in RCN v DHSS [1981] 1 All ER 545 (National Library of Medicine, 1981).

In Northern Ireland, before 12 weeks gestation, authorisation for the termination of pregnancy can be undertaken by one registered practitioner. After 12 weeks it must be certified by two registered practitioners. In all cases this must be notified to the chief medical officer in writing. This is clarified in The Abortion (Northern Ireland) Regulations 2020.

In England and Wales, 98% of pregnancy terminations are carried out because of risk to the mental or physical health of the woman or her existing children under the grounds allowed by Section 1(1) (a) of the Abortion Act 1967 (DH, 2021). Further statistics can be found on the Office for National Statistics website at: **ons.gov.uk**

The requirements of the Abortion Act are unaffected by the method of a termination of pregnancy, whether medical or surgical. In England, Scotland and Wales, terminations of pregnancy must take place on registered premises, such as NHS hospitals or registered abortion clinics. However, in 2021 the Secretary of State gave permission in England for the early medical abortion medications to be taken at home rather than in a clinic or hospital setting before 10 weeks gestation,

In Scotland, in 2020, a legislation change allowed both early medical abortion medication to be taken at home up to 11 weeks and six days gestation. Further to this in 2023, in Scotland, mifepristone can be taken in the woman's home as the first stage of a medical abortion, at all gestations up to the legal limit, when decided that it is clinically appropriate to do so. This new approval applies when the pregnant woman has:

a) either attended an in-person consultation, or, where the consultation is carried out remotely, an in-person appointment, where she will normally be expected to have had an ultrasound scan or other appropriate pre-abortion tests and

b) will return to the hospital or clinic to take misoprostol and pass the pregnancy.

The aim of this approval is to allow patients to avoid making an unnecessary extra trip to a clinic where this is only required in order for them to take their mifepristone.

In Northern Ireland, medical and surgical abortions must take place at an HSC (Northern Ireland NHS) site or premises registered for the purpose by the Northern Ireland Department of Health. For medical abortions up to nine weeks and six days gestation the first medication must be taken in the registered premises with the rest of the medications permitted to be taken at home.

Conscientious objection

Section 4 of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) provides a right of conscientious objection which allows health care professionals to decline to participate in a termination of pregnancy.

This right is limited only to the active participation in the termination of pregnancy where there is no emergency in relation to the physical or mental health of the pregnant woman.

This was clarified further in the case of Greater Glasgow Health Board v Doogan and another [2014] UKSC 68 (Supreme Court 2014). The Supreme Court held that the meaning of 'to participate in' a termination of pregnancy should be given a narrow meaning 'taking part in a 'hands-on' capacity'.

As the Abortion Act does not apply in Northern Ireland, the right of conscientious objection contained within it, is also not applicable. In Northern Ireland it is covered in Section 12 of The Abortion (Northern Ireland) Regulations 2020.

Nurses, midwives and other health care workers who have a conscientious objection must inform their employer at the earliest opportunity. Under the 1990 legislation, nurses cannot refuse to provide nursing care for women before or after the termination of the pregnancy (RCN, 2020). It is equally important to acknowledge that where nurses may have an objection to terminating a pregnancy, they should be afforded respect for their decision and supported not to participate in care scenarios that may lead to conflict.

Information on conscientious objection

Nursing and Midwifery Council (2023) Conscientious Objection by Nurses, Midwives and Nursing Associates. **nmc.org.uk/standards/code/conscientious-objection-by-nurses-and-midwives**

RCN (2020) *Conscientious objection (termination of pregnancy) position statement*. **rcn.org.uk/publications**

What nurses cannot do within the current legislation

The current legislation clearly sets out what nurses and midwives cannot do:

- sign the regulatory forms in England, Scotland and Wales
- prescribe abortifacient drugs for use in medical termination of pregnancy in England, Scotland and Wales, including via the use of Patient Group Directions (PGDs)
- provide a termination of pregnancy service alone without a doctor remaining responsible for the woman in England, Scotland and Wales
- currently nurses can prescribe abortion medication and provide perform MVA for surgical termination of pregnancy in Northern Ireland
- at the time of publication, in England, Wales and Scotland it is yet to be confirmed whether nurses can lawfully perform MVA for induced abortions as the law is difficult to interpret with regards to this area of practice (Sheldon and Fletcher, 2017).

The penalties for any person failing to follow the provisions of the Abortion Act could be through both criminal and civil law.

Consent

As with any form of health care treatment or procedure, women undergoing a termination of pregnancy procedure should consent to the procedure, which should include a signed consent for surgical procedures to evidence the consent process.

To ensure informed decision making, the consent process should include details of:

- the process and the procedure to be undertaken
- alternative options
- the benefits and risks of the range of methods available
- the potential complications that may occur as a result of the procedure, as well as any other procedures that might need to be undertaken as a result of complications occurring (NICE, 2019).

The competence of a woman to consent to the procedure should also be assessed.

- Does the woman demonstrate a reasonable capacity to make a choice about her requested course of action?
- Does she know and understand the risks, benefits and alternatives discussed with her?
- Does she understand that her informed decision making must be voluntary?
- Does she understand that her consent can be withdrawn at any time?

In England and Wales women aged 16 and 17 years are presumed competent to give consent under the provisions of the Mental Capacity Act 2005.

In Scotland, a person of or over the age of 16 years has legal capacity (Age of Legal Capacity (Scotland) Act 1991) the effect is the same in that women aged 16 and above are presumed competent.

In Northern Ireland, The Age of Majority Act (Northern Ireland) 1969 provides that a person who is 16 or over may consent to treatment without acquiring consent by the parent(s) or guardian(s).

This Act does not remove the right of parents or guardians to consent on behalf of a 16- or 17-year-old. In each UK country 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 nurses should encourage the involvement of a parent or guardian where applicable (DH, 2001; NICE, 2019).

The legal principle for consent to treatment by those under 16 years of age was given in the House of Lords ruling on Gillick v West Norfolk and Wisbech HA [1986] AC 112 (Gillick v West Norfolk and Wisbech, 1986). This legal principle, sometimes known as the Gillick Competence or Fraser Guidelines test of competence, has provided an objective test of competence for young people under 16 years of age. If the young person 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 action, then they will be deemed competent to consent to the medical treatment.

This ruling was applied on 23 January 2006 in the case of Regina (Axon) v Secretary of State for Health (Regina (Axon) v Secretary of State for Health, 2006), when the High Court rejected Axon's claim that the Department of Health's 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.

Confidentiality

Everyone (including those under 18 years of age) seeking a termination of pregnancy has a right to confidentiality from all health care professionals. Only in exceptional circumstances (for example, where the health, welfare or safety of the woman, a minor or other person is at risk) should a third party be informed where the woman refuses to give her consent to disclosure (NICE, 2019). If information is disclosed without consent, there should be clarity and transparency about how the decision to do so was reached, and the decision should be demonstrably in the best interests of those concerned.

These principles were also upheld in relation to protecting the confidentiality of advice given to those aged under 16 years of age in Regina (Axon) v Secretary of State for Health (2006).

Data on all women undergoing a termination of pregnancy is collected via the HSA4 form and notified to the Department of Health/Scottish Government and women must be informed of this.

- In Scotland, doctors have a legal requirement to notify the Chief Medical Officer of all terminations carried out.

- In England and Wales, the forms are held securely and only individuals authorised by the Chief Medical Officer have access.
- In Northern Ireland every abortion must be legally certified by at least one health care professional and must be notified to the Chief Medical Officer in writing.

Further guidance is available at: **rcn.org.uk/Get-Help/RCN-advice/confidentiality**

3. Service provision and practice

Access and referral

All women in England, Wales and Scotland can access a termination of pregnancy if two doctors determine in good faith that their circumstances meet the terms of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). Termination services should therefore be easily accessible and should allow both direct referrals as well as referrals from health professionals.

The legislation for Northern Ireland permits terminations on request in the first 12 weeks of pregnancy, and beyond that in other cases including no term limit in cases of fatal fetal abnormality, where there is a substantial risk that the fetus would die or, if born, would suffer a severe mental or physical impairment.

Providers of termination services should be committed to ensuring that women can access services as early as possible to reduce the possibility of associated physical and mental health risks. This should include the option of a remote service provision where practicable (NICE, 2019).

Pregnancy options

Many women who request termination of pregnancy have already made the decision to end the pregnancy by the time they present to the service (NICE, 2019). Abortions are common, safe and approximately 80% of terminations are because the pregnancy was unintended and tends to be completed before 10 weeks gestation (NICE, 2019).

Pregnancy may not be a straightforward event for a woman, whatever her social realities, and it can bring with it significant physiological, emotional and psychological changes which can make decision making increasingly difficult, particularly as the pregnancy progresses.

Evidence suggests that there are many reasons as to why some people present at a late gestation for abortions (Lee and Ingham, 2010), it is therefore imperative that women are provided with a non-judgemental approach when they do present to services (NICE, 2019). Some women will be unsure about continuing with a pregnancy and must have access to confidential, free, non-directive and non-judgemental discussion and/or counselling, at the earliest opportunity.

Women should be able to choose whether to have counselling or not (NICE, 2019). Where required expert counselling (such as that delivered by abortion providers) should be available. A wide range of health professionals and organisations currently provide help and support with the decision-making process. Organisations/groups should always be researched beforehand as they do not always provide an impartial view. Systems should be in place to rapidly refer women for pregnancy options, discussion and counselling when required.

Whose decision is it?

While the opinion and feelings of others will often form part of the process, the decision remains with the pregnant woman. She should be enabled to make her own decision; therefore, it is important to see or speak to the woman on her own initially (whatever her

age or social situation) to ensure there is no coercion in the decision and to allow space to disclose any personal safety issues. Women should never be coerced into continuing with or ending a pregnancy.

It may then be appropriate for a woman to involve a partner or family member, or carer, in the decision-making process, should she wish to. For young women, under 16 years of age, part of this process will be concerned with issues of consent and support, the advantages and disadvantages of confiding in a parent/guardian 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 and referred to the designated person for safeguarding.

Pre-abortion assessment

Registered nurses and midwives who are appropriately trained and assessed as competent in line with local guidance or protocols may undertake pre-assessment for abortion (ensuring that abortion legislation is adhered to, depending on location).

It is important to speak to or see the woman (regardless of her age) on her own at some point to allow her to give accurate answers and freely express her thoughts and feelings and assess safeguarding risk.

The role of pre-termination assessment is holistic, multi-faceted and should include:

- developing an understanding of the circumstances leading to a woman requesting a termination and offering options, discussion and/or counselling
- an assessment of risk from a safeguarding perspective
- where required, a medical and physical assessment, in line with recommendations from NICE quality standards (NICE, 2021) and the RCOG guidelines (2022), including estimation of gestational age, recording of medical and social history, and referral for physical observations (such as blood tests) if required
- a choice of medical or surgical procedures and an assessment within one week of her request (these may be dependent on gestational age and local policy), which should include the risk of potential complications (including local risk percentages), including the risks of continuing a pregnancy; written information should be available and accessible consent for the chosen procedure, including assessment of competence to consent in the case of a child under 16 years of age
- an offer of a discussion on future contraceptive needs to include all available methods, and promotion of the commencement of contraception at the time of a termination of pregnancy or immediately afterwards
- an offer of sexually transmitted infection (STI) testing, treatment and partner notification
- appropriate and speedy referral to other agencies as appropriate
- ensuring that legal obligations are fulfilled before any treatment is commenced
- maintaining accurate records of all care provided

BACK TO CONTENTS

- clearly setting out women's rights relating to their own sexual and reproductive health, as well as their general health
- undertaking a referral to a specialist placements service for pre-existing medical conditions that contraindicate certain treatments or the need for inpatient services.

Pregnancy termination methods

The RCOG best practice guidelines (2022) provide an extensive review of methods and procedures.

- Telemedicine can be used for consultations and allows the woman the choice of being in their own environment and may be more convenient overall. Following a thorough assessment, they may not need to be seen in person.
- A medical termination of pregnancy involves the woman taking an anti-progestogenic steroid, followed by a prostaglandin. The anti-progestogenic steroid blocks the action of progesterone. and facilitates the process of medical termination by sensitising the uterus to the prostaglandin analogue, which induces uterine contractions and softens and dilates the cervix.
- An early medical abortion (EMA) is generally considered to be when the pregnancy has not exceeded the first trimester, however there are differing gestational limits in legislation and/or clinical guidance. In England, Scotland and Wales all stages of treatment can be carried out at home if preferred, however in Northern Ireland the first stage must be taken in a clinical setting.
- The surgical termination of pregnancy involves the physical removal of the pregnancy from the uterus. The surgical procedure method is determined by the gestation of the pregnancy, and cervical preparation is recommended at all gestations to reduce the risk of complications.

Analgesia should always be offered, regardless of method. Non-steroidal anti-inflammatory methods are recommended either prophylactically or as needed. Opioid analgesics may also be required.

In the UK, termination of a pregnancy is a safe procedure for which major complications and mortality is rare at all gestations, however, morbidity and mortality increase for every week of gestation, thus earlier abortions are safer than later ones (NICE, 2021).

Practice considerations

Environment for termination of pregnancy/abortion services

In England, Scotland and Wales, terminations of pregnancy take place in approved premises, such as NHS hospitals or registered abortion clinics. Following recent changes to the legislation, women can now access EMA, and all elements of the process from their own home, using telemedicine services which can be used for consultations and allows the woman the choice of being in their own environment.

In England, Scotland and Wales abortifacients (Mifepristone and misoprostol when used for abortion) can only be prescribed by a doctor or supplied and/or administered

following a Patient Specific Direction (PSD) for a named individual from a doctor. Patient Group Directions (PGDs) are not permissible for abortifacients as this route removes the personal oversight of the procedure from the medical practitioner.

In Northern Ireland, abortions must take place at an HSC (Northern Ireland NHS) site or premises registered for the purpose by the Northern Ireland Department of Health. Currently there is no allowance for mifepristone to be taken at home, and pharmacies and services take additional precautions with the drug Mifepristone, meaning the woman must attend a maternity unit, and not a specialist centre for terminations, for administration of the mifepristone (McKeown et al., 2013).

Congenital/fetal anomaly

Some terminations are carried out due to a congenital or fetal abnormality. Most of these abnormalities are identified at routine ultrasound. All women are offered a mid-pregnancy ultrasound scan as part of the NHS Fetal Anomaly Screening Programme. The main purpose is to look for fetal abnormalities or anomalies. Further information about the screening tests, advice and care pathways regarding fetal anomaly can be found at: gov.uk/guidance/fetal-anomaly-screening-programme-overview .

Further information can also be found on the website of Antenatal Results and Choices, a charity, which supports those affected by fetal anomalies. Its website can be found at: arc-uk.org

Multiple pregnancy

Multiple births have increased over the past few decades, in part due to increasing positive results from fertility treatment (although in recent years the UK has a one at a time policy (Human Fertilisation and Embryology Authority, 2022), whereas fertility treatment abroad may not have similar policies). Other contributory factors include women are choosing to have their families when they are older and are more likely to have a multiple pregnancy, as well as the significant advances in obstetric and neonatal care so more multiple birth babies are surviving. However, multiple births are not without its risks and one option is reductive feticide.

Fetal reduction (sometimes referred to as embryo reduction or selective reduction) is usually discussed if a woman has a triplet or higher order pregnancy as there is a higher risk of mortality and morbidity for the mother and babies. A selective termination (selective feticide) would be discussed if a baby in a multiple pregnancy had a serious anomaly or severe growth restriction, and the pregnant woman should be referred to a specialist fetal medicine centre to discuss these procedures.

Fetus delivered showing signs of life following termination of pregnancy

In later stage termination of pregnancy there is the possibility that the fetus could be delivered showing signs of life. This can be extremely traumatic for the woman undergoing the termination and challenging for the health care professionals providing treatment and care. Appropriate local policies should be in place to deal with the management of later medical terminations of pregnancy, with RCOG (2011) recommending that feticide should be performed before medical abortion after 21 weeks and six days of gestation to ensure that there is no risk of a live birth.

Local protocols should be clear about the role of the health care professional in the event of the fetus showing signs of life. A neonate born alive must be registered as such by law. The subject of termination of pregnancy is a sensitive one, and the law as it applies to coronial investigations in England must be applied (Chief Coroners Guidance No 45, 2023).

Where a fetus shows signs of life or appears to be beyond 24 weeks gestation at delivery, if the woman has accessed an abortion believing she was under 24 weeks, which was agreed and signed by two medical practitioners in good faith that the gestation of the pregnancy had not exceeded 24 weeks, police notification from the health care provider is not required. If the police contact a provider to request information, advice should be sought from the Caldicott Guardian or legal team before sharing any information.

Post-termination of pregnancy care

General advice and support after a termination of pregnancy is aimed at enabling a healthy recovery, minimising risk, and initiating early intervention or treatment, if indicated. Each woman should be given information, in a language she understands and a 24-hour contact telephone number.

Routine follow up after surgical or medical termination where successful completion has been confirmed is not clinically recommended, however if a woman undertakes EMA at home, a low-sensitivity pregnancy test should be performed at least two weeks after treatment (RCOG, 2022). If there are indications that the abortion is incomplete, further assessment and management will be necessary (RCOG, 2022).

A contraception discussion should be offered, with contraception supplied as appropriate. All termination of pregnancy providers should be promoting the benefits of long-acting reversible contraceptives (LARCs) and should have access to fit or provide a full range of contraceptive methods or have clear and timely pathways to refer for these methods. Not all women will want to discuss contraception and should be offered information on options available to them (RCOG, 2022).

Anti-D and rhesus prophylaxis

Anti-D IgG should be offered intramuscularly to all non-sensitised RhD negative women who have an abortion after 12+0 weeks' gestation, and within 72 hours of the procedure (RCOG, 2022) however, NICE (2019) currently recommend from 10 weeks.

Disposal of pregnancy remains

Disposal of pregnancy remains is an area that providers of termination of pregnancy services should consider. Guidance has been published by the Human Tissue Authority (HTA) in 2015 and 2021 and the RCN (2021), which provides detail of the current requirements across the UK. The primary message here is that all those involved must consider the personal wishes expressed by the woman in relation to the disposal of pregnancy remains. Options for disposal recommended by the HTA are burial, cremation or incineration. In Scotland, the options are collective burial or cremation, incineration is not an option.

Guidance was also published by the Scottish Government in 2012 which included

that all women should be offered information on the available methods for disposing of pregnancy remains in a sensitive and appropriate manner, including the options available should they have specific wishes. Information leaflets regarding termination of pregnancy should include information regarding disposal.

Health care professionals should ensure that the woman knows, before the termination of pregnancy, what her options are with regard to disposal of the pregnancy remains, as the type of procedure can have a bearing on how the remains are collected.

If a woman prefers not to decide about disposal, she should be informed which method will be used. Where a woman does not want to engage in any discussion about disposal, her position should be respected and recorded, and she should be made aware that information is available should she so wish.

It should be clearly recorded in the woman's medical notes that she has been provided with appropriate information about the options for disposal and what, if any, decision she has made. It should also be recorded if a woman declines the offer of information and chooses not to decide.

The HTA (2015) recommends that if a woman does not make a decision, the remains should be kept for no more than 12 weeks before disposal. The woman should be made aware of the local timeframe and that if no decision has been expressed within that time, the remains will be disposed of. Ideally, this information should be provided both verbally and in writing.

Service providers should ensure that safe and acceptable systems for disposal are in place and can respond appropriately to questions raised about methods of disposal. This should include how to approach the subject of choice of disposal, in line with HTA guidance (HTA, 2015).

Sometimes women/parents do not recognise their loss at the time and may return months or years later to enquire about disposal arrangements. It is therefore important that any discussions and information provided are well-documented, along with the details of the disposal (HTA, 2021).

Women may 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. Further guidance on this issue can be found in the RCN's *Managing the Disposal of Pregnancy Remains guidance* (2021). Systems should also be in place to advise where a woman requests individual cremation/ burial of the fetal remains.

General aftercare advice

Recent studies have highlighted the need for clear advice to be given to the women of what to expect post abortion (Baraister et al., 2022 and Lohr et al., 2021).

This should include information such as the following detail.

- Vaginal bleeding (with or without clots) can last until the next period which can take four-six weeks after treatment and can be affected by hormonal contraception. The bleeding should decrease as the weeks go on. Should the woman experience

continuous and heavy bleeding (for example, soaking two or more sanitary pads for two consecutive hours) she should contact the service provider or seek medical attention urgently.

- It is advisable to use sanitary towels instead of tampons or menstrual cups until the pregnancy has passed.
- Over the counter analgesia such as ibuprofen and/or paracetamol can be used prophylactically, or when cramping or pain start. Hot pads or hot water bottles might also afford some relief. Service providers can offer stronger analgesia.
- The woman should be advised who to contact if she experiences lasting pain, signs of fever, malaise, offensive vaginal discharge, abdominal tenderness, continuing signs of pregnancy or other unusual signs or symptoms.
- The woman should also contact the service provider if she has less than the expected amount of pain and bleeding or does not feel she has passed the pregnancy.
- Breast discomfort can persist for seven to 10 days, and a well supporting bra and analgesia can provide some relief. Some women may lactate at later gestations, and should be advised not to express the milk, which stimulates further production.
- Normal activities can be resumed when the woman feels able.
- After a termination there is no right or wrong way to feel. The most common emotion felt is relief, but some may also feel emotional discomfort, such as sadness or guilt. Women should be advised how to access counselling and support should they need it.
- Pregnancy-related symptoms of nausea, vomiting and tiredness usually improve within three days of a termination.
- It is recommended that sexual intercourse is resumed when the woman feels ready.
- Women should be advised that fertility can return almost immediately (a woman may ovulate as soon as 10 days post-termination), so reliable contraception should be initiated immediately if she wishes to avoid pregnancy (NICE, 2019). All available methods of contraception, including long-acting reversible contraceptives, should be offered (NICE, 2019).
- Women should also be advised that high sensitivity urine pregnancy tests may remain positive for up to six weeks post-termination.
- Women who intend to travel long distances or take a flight soon after their termination should be advised to ensure that they have appropriate sanitary wear, remain well hydrated and if appropriate follow standard in-flight guidance regarding exercises.
- The next menstrual period will begin four to six weeks after treatment. If the woman has not had a period six weeks post-treatment, she should do a pregnancy test or contact the service provider.

4. Special considerations and safety

Safeguarding adults

Special consideration should be given to individuals and groups of women who may be considered as vulnerable, either physically, psychologically, socially or economically. These could include women who are under 18, survivors and/or victims of abuse, those who misuse drugs or alcohol, those with learning difficulties and sex workers.

All women should be treated as individuals with respect and dignity, regardless of their vulnerabilities. This should include being sensitive to social and ethnic, or religious consideration, whilst respecting individual needs, including sexuality and gender.

Women should be offered the option of being examined by a female practitioner and the decision should be respected. If an appropriate practitioner is unavailable, alternative arrangements may have to be made. In emergency situations, where no one is available to perform the termination of pregnancy, health professionals should work in partnership with the woman to identify the best course of action including referrals/liaison with other agencies such as the NHS.

Safeguarding children

A safeguarding risk assessment should always be completed for anyone accessing termination of pregnancy service when they are under 18. Where there is an indication that a child or young person seeking an abortion is a child in need of protection, or at risk of harm, practitioners should follow local child protection procedures and make a safeguarding referral immediately.

Nurses should be familiar with the key safeguarding issues relating to young women who are under 18 years of age.

Where there is an indication that a child or young person seeking an abortion is in need of protection, or at risk of harm, practitioners should follow local child protection procedures and make a safeguarding referral immediately.

Health care professionals and those in enhanced safeguarding roles should be familiar with the key safeguarding issues relating to children and young people who present for abortion care, including children in foster care, looked after care or care experienced. This should also include consideration of those subjected to grooming, exploitation, and sexual abuse.

Health care professionals have a duty of care to safeguard children and young people (Children's Act 1989 and 2004). This includes:

- children/young people known to adult patients such as their own children or siblings
- children/young people in the wider community, for example abuse being heard or seen whilst in a clinic
- children/young people at risk from people in position of trust, for example knowledge of a perpetrator who is a youth worker.

Language issues

Women who prefer to communicate in their first language (or where a health professional considers that an interpreter is necessary) will require a professional independent interpreter.

Due to the confidential nature of abortion a family member or friend is not appropriate to assist with the translation, particularly during the discussion of pregnancy options and the obtaining of consent to treatment. If translated, written information should be made available and provided prior to the examination. Practitioners are advised to follow local protocols in relation to the use of independent interpreters.

LGBTQI+

Nursing is committed to safe, accessible, and inclusive care and Bowler et al., (2023), in their systematic review reported that LGBTIQA+ people face significant barriers to accessing abortion. Consequently, nurses need to meet the needs of all their patients, and make appropriate adjustments. Women and other patients who identify as LGBTQI+ may require services from abortion care providers. Nurses should understand the needs of all their patients and may be required to adjust service provision, such as referring to patients as they wish to be referred, ensuring case notes allow for the use of he, they and Mr, and adjusting surgical services to allow for privacy and dignity.

Physical disabilities, learning disabilities and mental wellbeing

Services should be safe and accessible, provide appropriate levels of communication and information, and offer an equal level of service for all women regardless of ability. Services should be flexible, creative and innovative in meeting the needs of women who have a disability.

Careful consideration should be given to women with temporary or permanent learning disabilities or mental illness as to whether they have the capacity to consent to any proposed examinations or procedures. Guidance regarding this issue is available from the Department of Health (2009).

If a woman appears to lack competence and concerns are expressed about her capacity to consent, care needs to be sensitive to this, and clear documentation should be kept of how and when this was assessed. It is good practice to keep such records in all cases where consent is discussed. In certain cases, a procedure may be carried out in her best interest and legal advice should always be sought in such cases.

Where a woman does not have capacity to consent and an abortion is not clinically considered to be in her best interests, legal advice must be sought, whilst working in partnership with medical and other colleagues to identify the most appropriate course of action. Further legal advice should be sought on the appropriate course of action if there is any doubt or lack of consensus.

Difficulties with vaginal examinations

Some women will have a history of traumatic experiences with previous vaginal examinations or may have experienced physical, sexual abuse or rape in the past. Women who disclose this (recognising that some may not) should be given the opportunity to discuss any underlying sexual, or trauma-related issues. Any discussion should take place when the woman is dressed and not on the examination couch. They should be cared for with compassion and sensitivity, considering the need to make further appointments, as may be required. Women should be offered counselling and referral to specialist services.

For more information on related issues see the RCN's guidance on *Genital Examination in Women: resource for skills development and assessment* (RCN, 2023).

Rape and sexual assault

If a woman is pregnant because of rape or sexual assault and has chosen to have police involvement, then fetal samples may be required for forensic analysis. The woman should consent to this prior to liaising with the local police department. In the case of an unreported rape, the nurse or midwife should be aware of the referral pathway to the local rape assessment unit or alternative management pathways and the need to protect any potential evidence. Any disclosure should be documented in the woman's medical records for access in the event of legal action.

Female genital mutilation (FGM)

Female genital mutilation (FGM) or female cutting, is a violent and abusive act carried out on girls and women in some communities across the globe, and all registrants should be aware of the latest guidance, particularly from the Department of Health (2017), RCOG (2017) and the RCN (2023).

Since October 2015, registered health care professionals, including nurses, midwives and nursing associates, have a mandatory duty to report cases of FGM to the police non-emergency number 101 in cases where a girl under 18 either discloses that she has had FGM or the professional observes physical signs of FGM.

Survivors/victims of FGM should be treated with great sensitivity and referred to specialist services where appropriate for ongoing treatment and support. For some women, deinfibulation (a surgical procedure carried out to re-open the vaginal introitus, to enable access to the uterus) may need to take place before the abortion can be performed to enable insertion of the speculum and the products of a medical abortion to be expelled.

Further information is available at: rcn.org.uk/clinical-topics/female-genital-mutilation

Hymenoplasty and virginity testing

Hymenoplasty, defined as the surgical reconstruction of the hymen and the practice of virginity testing were made illegal in 2022 as part of the strategy to tackle violence against women and girls. Such practices are recognised to be part of so called honour-based violence and subject women to harm. Since the publication of the Health and Care Act 2022, it is illegal to carry out, offer or aid and abet virginity testing or hymenoplasty

in any part of the UK. Nurses and midwives have a responsibility to recognise and safeguard patients at risk, and further information can be found at: gov.uk/government/publications/virginity-testing-and-hymenoplasty-multi-agency-guidance

Domestic abuse

Routine enquiry into domestic abuse should be carried out in all health settings, including women requesting an abortion. Women should routinely be asked a question relating to their experience of domestic abuse, such as Do you feel safe at home?

If a woman discloses that she has been subject to domestic abuse, it is important to ensure that information is provided 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 take appropriate action based on local agreements/protocols.

The woman may choose not to take further action (note: children may be at risk of harm from domestic abuse, including witnessing domestic abuse, and this may require a referral to the Multi-Agency Safeguarding Hub (MASH) or equivalent, using local safeguarding processes) but may wish to refer to her medical records at a later date for evidence in a court case.

- RCN guidance and web resources on domestic abuse can be found at: rcn.org.uk/clinical-topics/domestic-violence-and-abuse
- Department of Health guidance (2017) provides relevant information and a practical toolkit for frontline practitioners at: gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

Forced marriages and so called honour based violence

'A forced marriage is a marriage where one or both people do not (or in the case of some people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used.' Forced Marriage Unit, Foreign and Commonwealth Office (2017).

Women and girls at risk of forced marriages are at high risk of other forms of so called honour-based violence.

Further information from the Foreign and Commonwealth Office can be found at: gov.uk/guidance/forced-marriage and government.nl/topics/honour-based-violence/question-and-answer/what-forms-of-honour-based-violence-are-there provides information on so called honour-based violence.

Human trafficking and modern slavery

The UN Office on Drugs and Crime describes human trafficking as '...the acquisition of people by improper means such as force, fraud or deception, with the aim of exploiting them' (2013).

It is important that nurses and other health care workers learn to recognise the signs of trafficking. Signs to consider would include someone who is afraid to speak to a health care professional or is reluctant or unable to explain their current circumstances or how they came to be pregnant.

- Identifying and Supporting Victims of Modern Slavery guidance for Health Staff is available at: gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff/identifying-and-supporting-victims-of-modern-slavery-guidance-for-health-staff
- The RCN has developed guidance for nurses and midwives on identifying and best supporting victims of modern slavery which is available at: rcn.org.uk/clinical-topics/Modern-slavery-and-human-trafficking

Safety in practice for nurses and patients

Nurses and patents have a right to practice safely and without fear. Over the last 10 years there has been growing concern over the increasing rise in protests outside abortion centres that have resulted in distress to service users and staff. Although it is recognised that the public have a right to peaceful protest, service users have a right to access care without fear, harassment or intimidation. One solution to this intimidation is to create buffer zones around clinics, to enable staff and patients' safer access to the service.

In May 2023, the Public Order Bill came into force which introduces a safe access zone around abortion clinics in England and Wales. It is now an offence to interfere with any person's decision to access, provide or facilitate the provision of abortion services within a 150m zone although, at the time of publication (December 2023), this has not yet been fully implemented. Those prosecuted for breaching this law, now face an unlimited fine and a criminal record. In Northern Ireland buffer zones between 100m and 250m are provided for under the Abortion services (Safe Access Zones) Act (Northern Ireland) 2023, and in Scotland the proposed Abortion Services Safe Access Bill will also legislate for a buffer zone of 200 metres.

Another growing area of concern is unregulated pregnancy option centres in the UK, which may be operating without formal oversight or regulation. These clinics often present themselves as pregnancy advice centres or crisis pregnancy centres, but they usually do not adhere to the same standards and regulations as licensed medical facilities.

They may offer services such as pregnancy testing, counselling, and information on pregnancy options, including abortion, adoption, and parenting. Unlike regulated clinics, unregulated pregnancy clinics are not subject to the same requirements for medical supervision, professional qualifications, and transparency. As a result, they may provide biased, inaccurate, or misleading information to women seeking reproductive health advice.

The lack of regulation surrounding these clinics raises concerns about the quality of care provided and the potential risks to women's health and autonomy.

To protect themselves against unregulated pregnancy clinics in the UK, nurses should:

- familiarise themselves with regulations and licenced clinics
- verify the credentials and licensing of clinics and staff
- provide evidence-based information for patients
- maintain detailed documentation of interactions

- report any concerns to regulatory authorities
- engage in continuous professional development
- seek support from colleagues and professional organisations
- ensure that they have personal professional indemnity.

Being vigilant, well informed, and proactive in advocating for patient safety and evidence-based care can help nurses safeguard themselves.

Conclusion

The care of women who are considering or undergoing a termination of pregnancy is a sensitive area of practice that requires appropriate skill, knowledge and compassion. It is an area of practice that has become more common, as evidence suggests that a third of women will have one or more abortions (NICE, 2019) during their reproductive life, which sets the care of these women firmly within the context of women's health.

It is essential that nurses working in the area of abortion have a good understanding of the legislation applicable to this area of practice and understand what the law does and does not allow them to undertake.

It is important that nurses also understand the potential complexity of decision making around a woman's decision to terminate her pregnancy. It is equally important to consider the requirements and needs of the wider family or social group, if a woman wishes.

Nurses working in this specialist area should have access to appropriate continuing professional development to enable them to provide high quality, evidence-based care. Nursing care in this arena of practice also provides opportunities for nurses to develop new skills, for example ultrasound scanning.

Good nursing leadership in this specialty will be invaluable to support best practice across the range of issues which may still arise. It is a critical opportunity to advocate for women and nurses around improving women's health. It is equally important to encourage nurse leaders and all nurses to become more politically aware, so that as nursing practice expands and more evidence becomes available, care around termination of pregnancy could be further extended for nurses.

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Useful organisations/support

Abortion Talk abortiontalk.com

Antenatal Results and Choices (ARC) charity arc-uk.org

British Association for Sexual Health and HIV bashh.org

British Society Abortion Care Providers bsacp.org.uk

British Pregnancy Advisory Services bpas.org

Faculty of Sexual and Reproductive Health fsrh.org/home

Family Planning Association fpa.org.uk

NHS Fetal Anomaly Screening Programme gov.uk/guidance/fetal-anomaly-screening-programme-overview

Marie Stopes International msichoices.org

National Unplanned Pregnancy Advisory Service nupas.co.uk

Northern Ireland Abortion and Contraception Task Group (NIACT) niact.taskgroup@gmail.com

SANDS – Saving babies' lives. Supporting bereaved families sands.org.uk

Scottish Abortion Care Providers (SACP) Network

The Elizabeth Bryan Multiple Births Centre bcu.ac.uk/health-sciences/research/centre-for-social-care-health-and-related-research/research-clusters/ebmbc

RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This updated guidance incorporates expert and evidence-based practice. It has been produced to support registered nurses and midwives working within the NHS and independent sectors, across the UK. It considers the legislative frameworks in place across the UK, alongside clinical guidance for those working in termination of pregnancy services.

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The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact **publications.feedback@rcn.org.uk**

Evaluation

The authors would value any feedback you have about this publication. Please contact **publications.feedback@rcn.org.uk** clearly stating which publication you are commenting on.

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