



Royal College
of Nursing

Termination of pregnancy

An RCN nursing framework



Acknowledgements

This publication updates the RCN's original publication *Abortion care: RCN guidance for nurses, midwives and specialist community public health nurses* (2008), the production of which was led by Joanne Fletcher on behalf of the RCN's Gynaecological Nurses' Forum and other key stakeholders.

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This review was conducted by the RCN Women's Health Forum and was led by:

Debby Holloway, Consultant Nurse, The McNair Centre, Guy's and St Thomas' NHS Foundation Trust

Dianne Crowe, Advanced Nurse Practitioner, Hexham General Hospital

Mandy Myers, Director of Nursing, British Pregnancy Advisory Service

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Introduction

The Royal College of Nursing (RCN) first published guidance in relation to nurses and abortion in 1980. Following changes in the law and the introduction of new medical techniques, the RCN updated its guidance in 1992 and again in 1997.

Following the publication of 2011 *The care of women requesting induced abortion: evidence-based clinical guideline number 7* by the Royal College of Obstetricians in 2011, the RCN took the decision to update its guidance to ensure it continues to be a contemporary framework for nursing practice.

This 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. It considers the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act 1990 and is mainly related to the care of women undergoing termination of pregnancy under section 1(1)(a) of the Abortion Act 1967 which allows termination on the following grounds:

- that the pregnancy has not exceeded its twenty-fourth 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; or
- that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
- that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
- 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.

This framework aims to:

- provide accurate and current information
- improve the knowledge base about termination of pregnancy care

- promote best practice
- empower nurses and health care professionals to develop their roles within termination of pregnancy care
- protect the public by identifying relevant legislation and standards of care.

This framework covers England, Scotland and Wales. Guidance relating to termination of pregnancy in Northern Ireland is currently under review.

A primary principle in termination of pregnancy care is to ensure that a woman should always be given as much information as possible about available options, and the opportunity to discuss the risks and benefits as well as the emotional, psychological and social issues of continuing or not continuing her pregnancy.

The current legislation, which governs the issues of how a termination of pregnancy is allowed, comes from the Abortion Act 1967, which was revised and updated in the Human Fertilisation and Embryology Act 1990. The act covers England, Scotland and Wales but does not apply to Northern Ireland*. These and other related legislation and regulations can be found at www.legislation.gov.uk and on the Department of Health's website at www.gov.uk. It is critical therefore for nurses to have a sound understanding of the legislation, depending on where they practice.

* In Northern Ireland, the law relating to the termination of pregnancy is contained in sections 58 and 59 of the Offences Against the Person Act 1861, and in section 25 of the Criminal Justice Act (Northern Ireland) 1945 as those provisions have been interpreted to date by the courts. The *Department of Health, Social Services and Public Safety Northern Ireland* (DHSSPSNI) has useful information on the current situation with the legislation in Northern Ireland - *Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland* available at www.dhsspsni.gov.uk/showconsultations?txtid=43372 In April 2013, the DHSSPSNI issued a consultation on The limited circumstances for a lawful termination of pregnancy in Northern Ireland : a guidance document for health and social care professionals on law and clinical practice available at www.dhsspsni.gov.uk/guidance-limited-circumstances-termination-pregnancy-april-2013.pdf

Note

It is recognised that termination of pregnancy services are provided by doctors and nurses, midwives and specialist community public health nurses in a wide range of settings. For ease of reading, the generic terms 'nurse', 'nursing' and 'nurses' are used throughout this document to indicate the roles and contributions of nurses, midwives and specialist community public health nurses. It is also acknowledged that 'abortion' and 'termination of pregnancy' are terms that are used interchangeably. In this text, the term 'termination of pregnancy' is used throughout. The requirements of the Abortion Act 1967 mean that in this guidance the phrase 'nurse-led' relates to nurses taking delegated responsibility from a registered medical practitioner.

1 Professional development, nurse-led services and support

Professional development within services

There are many professional components required in enabling nurses to plan, deliver, develop and evaluate termination of pregnancy services within their scope of practice and within the limits of the Abortion Act 1967. The need for nursing to be dynamic and respond to the changing needs of the UK population is recognised. Nurses 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.

Recent and future developments in termination of pregnancy services 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 (RCN, 2003) to assist nurses who are individually accountable for their professional practice and to ensure their legal duty of care is fulfilled (NMC, 2008).

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 resource to achieve this – for example, consultant nurse, clinical nurse specialist and advanced nurse practitioner roles – has been successful in shaping local, regional and national nursing practice in relation to caring for women undergoing a termination of pregnancy. All nurses have an opportunity to lead service provision and development, and can be empowered to influence change in ensuring improved services for women within the current legal framework.

Nurse-led services - 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 medical methods, have led to the development of new nursing roles and a

more holistic provision of nursing care. Under the supervision of a registered medical practitioner, nurses now plan, lead and manage a significant proportion of care for women undergoing medical termination of pregnancy.

The role of the nurse in termination of pregnancy services has developed in response to a number of internal and external drivers. The recent drive to reorganise the NHS, while modernising and developing the role of health professionals within it, has provided a backdrop for professional and service development. However, the legal requirements of the Abortion Act 1967 do not allow nurses to authorise a termination of pregnancy, and the need for two doctors' involvement may limit the extent of nursing activity in termination of pregnancy services.

While the RCN acknowledges and respects those nurses who have a conscientious objection to delivering termination of pregnancy services, it is committed to providing support to nurses who choose to work in these services to ensure they can provide safe and quality care.

Ahead of its August 2007 submission to the Commons Science and Technology Committee inquiry – which explored scientific developments relating to the Abortion Act 1967 only, and not ethical or moral issues - the RCN consulted with members working in termination of pregnancy services.

Following this consultation it was clear that for those who worked in this clinical field, the law required modernisation. The requirement for two doctors to agree that a woman meets the grounds of the Abortion Act 1967, and the prohibition on nurses and midwives prescribing early medical abortion drugs or performing early surgical termination of pregnancy were seen as outdated and in need of future consideration.

In the termination of pregnancy practice field, the nursing profession endeavours to develop more responsive woman-centred services. Opportunities for nurses, in conjunction with medical colleagues, to take a far more proactive role in developing services across England, Scotland and Wales have been created as a result of the European Working Time Directive (RCOG, 2004). In addition, early medical abortion particularly lends itself to nurse-led provision and the steady increase in the numbers of women

choosing early medical abortion (DH, 2012) has led to further opportunities for enhanced nursing role development.

The principles of role development should be focused upon clinical need and by empowering nurses to develop 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 need, as well as consideration of organisational sustainability are important factors when determining role development for nurses. 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. Individuals should ensure that the professional competencies, additional knowledge and skills required are identified, and appropriate education, training, competency 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 competences for advanced nurse practitioners (RCN, 2012).

Examples of role development may include:

- pre-admission assessment
- pre- and post-termination of pregnancy discussion and/or counselling
- obtaining consent for a termination of pregnancy procedures
- administration of abortifacient drugs
- vaginal and speculum examination
- screening, testing, 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 procedures
- post early medical abortion assessment
- provide specialist care for vulnerable women
- 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
- a sound knowledge base and appropriate education and training
- up-to-date knowledge of evidence based practice
- to identify a champion who shares the ‘vision’ and supervises and supports the nursing team, including management teams
- robust competency assessment ensuring confidence in performing practical skills (for example, ultrasound scanning)
- understanding and implementation of the principles of risk management
- opportunities to develop and practice leadership, mentoring and supervisory skills
- to engage in research opportunities to extend the evidence base in termination of pregnancy care
- thorough working knowledge of the law on termination of pregnancy.

Nurses continue to work within the limits 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].

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, 2008). 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. Setting up local support groups is an excellent way of sharing and learning from the experience of peers.

The RCN Women’s Health Forum also offers a UK-wide network of members and a community webpage. It issues regular newsletters which provide updates from forum committee members on a wide range of issues affecting women’s health, including those around pregnancy termination. Members can seek individual advice by accessing RCN Direct online advice guides on the RCN website at www.rcn.org.uk

2 Legal considerations

Background to legislation

Nurses who are involved in a termination of pregnancy must be familiar with the legal requirements of the Abortion Act 1967, as amended in 1990. This guidance gives a brief overview of the main provisions and you will find recommendations for further reading 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 (amended by the Human Fertilisation and Embryology Act 1990) defines the grounds upon which a termination of pregnancy 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 Act 1861 applies (alongside more recent case law). It is critical therefore for nurses to have a sound understanding of the legislation.

Essentially, authorisation for the termination of pregnancy 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 a termination of pregnancy exists. This is not required however, where termination is on the following grounds:

- that the termination is necessary to prevent grave permanent injury to physical or mental health of the woman, or
- that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated.

In other words, single practitioners may operate on their own initiative in these two circumstances. The legislation does not give any scope for nurses to be signatories on the HSA1 (the form which confirms the terms of the Abortion Act 1967 have been met).

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.

In England and Wales, 98 per cent 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,

2012). Further relevant statistics can be found on the Office for National Statistics website at www.ons.gov.uk

The requirements of the Abortion Act are unaffected by the method of a termination of pregnancy, whether medical or surgical.

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 with regard to the physical or mental health of the pregnant woman. As the Abortion Act does not apply in Northern Ireland, the right of conscientious objection contained within it is also not applicable. Information on conscientious objection for nurses and midwives can be found on the Nursing and Midwifery Council's website www.nmc-uk.org. The RCN has also published guidance on conscientious objection, which is available to members at https://www.rcn.org.uk/support/rcn_direct_online_advice

Nurses and midwives 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.

It is equally important to acknowledge that where nurses may have an objection to terminating a pregnancy, that they are afforded respect for their decision and supported not to participate in care scenarios that may lead to conflict.

What nurses cannot do within the current legislation

The current legislation clearly sets out what nurses cannot do:

- sign the regulatory forms (HSA1 and HSA4)
- prescribe abortifacient drugs for use in medical termination of pregnancy
- provide a termination of pregnancy service alone without a doctor remaining responsible for the woman
- perform surgical termination of pregnancy.

The penalties for any person failing to follow the provisions of the Abortion Act are criminal. Vicarious liability (where an employer is held responsible for the acts or omissions of its employee) does not apply as this is not a matter of negligence. The RCN indemnity scheme does not provide protection against a clinical negligence claim made against nurses or midwives who have committed a criminal act.

Consent

As with any form of health care treatment or procedure, women undergoing a termination of pregnancy procedure should first sign a written consent form. To ensure informed decision making, the consent process should include details of:

- the process and the procedure to be undertaken
- 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 (DH, 2001; RCOG, 2011).

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?
- can she articulate 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, Wales and Northern Ireland women aged 16 and 17 years are presumed competent to give consent under the provisions of the Family Law Reform Act 1969. Although the legislation is different in Scotland, where legal capacity has now been defined at 16 years and not 18 years of age (Age of Legal Capacity (Scotland) Act, 1991) the effect is the same in that women aged 16 and above are presumed competent.

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 (DH 2001; RCOG, 2011).

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. This legal principle, sometimes known as the Gillick or Fraser 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 she will be competent to give her 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*, when the High Court rejected Sue 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. A full transcript of the judgement can be found online on the British and Irish Legal Information Institute website at www.bailii.org.

Confidentiality

All women (including those under 16 years of age) seeking a termination of pregnancy have a right to confidentiality from all health care staff. 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 her to give her consent to disclosure (RCOG, 2011). Data on all women undergoing a termination of pregnancy is collected via the HSA4 form and notified to the Department of Health/Scottish Government. In Scotland, doctors have a legal requirement to notify the Chief Medical Officer of all terminations carried out. In England, 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 *Regina (Axon) v Secretary of State for Health* mentioned above.

3 Service provision and practice considerations

In 2011 the Royal College of Obstetricians and Gynaecologists (RCOG) published extensive guidance and it is recommended that the *The care of women requesting induced abortion: evidence-based clinical guideline number 7* (RCOG, 2011) is considered alongside these updated RCN guidelines.

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). However, as mentioned above, in exceptional circumstances the act allows that only one doctor may initiate treatment. Termination services should therefore be easily accessible, and should allow both direct referrals as well as referrals from health professionals. Providers of termination services should be committed to ensuring that women can access services as early as possible to reduce the possibility of associated health risks (RCOG, 2011).

Pregnancy options

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. Many women who request termination of pregnancy have already made the decision to end the pregnancy by the time they present to the service (RCOG, 2011).

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 who are certain of their decision should be able to choose to have counselling or not (RCOG, 2011). A wide range of health professionals and organisations currently provide help and support with the decision-making process. Systems should be in place to rapidly refer women for pregnancy options, discussion and/or counselling when required.

Whose decision is it?

While the opinion and feelings of others will often form part of the picture for each woman, the decision remains with the woman who is pregnant. It is important that the woman is enabled to

acknowledge the implications and responsibility of her decision.

It is therefore important to see the woman on her own initially (whatever her age or social situation) to ensure there is no coercion in the abortion decision and to allow the woman space to disclose any personal safety issues, should there be a need. It may then be entirely appropriate for a woman to involve a partner or family member 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 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.

Pre-assessment – the nursing role

Nurses who are appropriately trained and assessed as competent in line with local guidance or protocols may undertake pre-termination of pregnancy assessment (ensuring that it is two doctors who agree that the termination of pregnancy is justified under the grounds of the Abortion Act 1967, as described above).

It is important to 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.

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
- a medical and physical assessment, in line with recommendations from the RCOG guidelines (RCOG, 2011), including estimation of gestational age
- referral for medical assessment as appropriate
- a review and explanation of all methods and available services (these may be dependent on gestational age and local policy) which should include the risk of potential complications (including local risk percentages); 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 assessment and discussion of 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
- STI testing, treatment, partner notification
- appropriate and speedy referral to other agencies as appropriate
- ensure medical assessment has been completed
- ensure the HSA1 form (and drugs prescribed) has been signed by a medical practitioner and before any treatment is commenced
- it is essential that accurate records are maintained of all care provided, in line with NMC record keeping guidance (NMC, 2010)
- women's rights relating to their own sexual and reproductive health – as well as their general health—should be clearly set out.

Pregnancy termination methods

The RCOG 2011 guidelines provide an extensive review of methods and procedures.

The medical termination of pregnancy involves the woman taking an anti-progestogenic steroid, followed some time later by a prostaglandin. The anti-progestogenic steroid effectively blocks the action of progesterone, preventing the pregnancy from progressing. It also facilitates the process of medical termination by sensitising the uterus to the prostaglandin, which induces uterine contractions and softens and dilates the cervix.

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.

In the UK the termination of pregnancy is a safe procedure for which major complications and mortality are rare at all gestations. There is some evidence that the earlier in pregnancy that a termination is performed, the lower the risk of complications (RCOG, 2011).

Specialised service considerations

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 live (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.

The RCOG guidelines (2011) state that feticide should be performed before medical abortion after 21 weeks and 6 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 neonate showing signs of life. The neonate should be kept warm and comfortable and, offered oral nutrition.

A neonate born alive must be registered as such by law.

Fetal reduction and selective fetal reduction

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.

One at a time policy: the Human Fertilisation and Embryo Authority (HFEA) policy is to reduce all multiple births, including twins, because of the risk to the health of the mother and babies. All centres providing in vitro fertilisation (IVF) services are required by the HFEA to have a multiple births minimisation strategy which includes single embryo transfer for women who meet the criteria. For more information visit the website www.oneatatime.org.uk

Multiple pregnancy: the RCOG statement on multiple pregnancy recommends that multiple pregnancies resulting from infertility treatments should be strenuously avoided. When a woman has a triplet or higher order pregnancy, all the issues associated with fetal reduction should be discussed in depth to ensure she is able to make a fully informed decision.

The Multiple Births Foundation (www.multiplebirths.org.uk) provides more information on this point. The procedure should be carried out in a specialist fetal medicine unit. It is vital that both parents are offered counselling, long term support and appropriate midwifery care for the pregnancy and postnatally.

Selective feticide: if a fetus in a multiple pregnancy has major abnormalities then the option of selective feticide may be suggested to the mother and her partner. This raises many complex emotional issues for parents as well as risks for the other healthy baby/babies. Professionals should be aware of these risks and trained to give the information and support required, including independent counselling. Long-term support should be available. The Multiple Births Foundation and the Antenatal Results and Choices (ARC) organisation (www.arc-uk.org) can provide information to expectant and bereaved parents throughout and after the antenatal screening and testing process.

Fetal reduction: the procedure 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 risk of losing the pregnancy after the procedure is about five per cent for triplets, eight per cent for quadruplets and 11 per cent for quintuplets. It is an immensely difficult and individual decision. The woman should be given as much information as possible about the outcomes and the opportunity to discuss the risks and advantages as well as emotional, psychological and social issues.

Congenital/fetal anomaly

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. For further information about the screening tests, advice and care pathways regarding fetal anomaly can be found at the NHS fetal anomaly screening programme resource section at www.fetalanomaly.screening.nhs.uk which contains useful guidance.

Further information can also be found on the website of Sands, the stillbirth and neonatal death charity, which supports those affected by the death of a baby. Its website can be found at www.uk-sands.org

Post-termination of pregnancy care

General advice and support

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 a written information leaflet and a 24-hour contact telephone number. Routine follow up after surgical or medical termination where successful completion has been confirmed is not clinically necessary. Where successful completion has not been confirmed women should be offered a follow up appointment to rule out a continuing pregnancy (RCOG, 2011).

Contraception should be discussed and supplied as appropriate. 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 including a LARC, or have clear and timely pathways to refer for these methods.

Appendix 1 expands on some of the details of the advice to be provided following a termination of pregnancy.

Anti-D and rhesus prophylaxis

Anti-D IgG should be given, intramuscularly to all non-sensitised RhD negative women within 72 hours following abortion termination, whether by surgical or medical methods.

Sensitive disposal of fetal remains

Sensitive disposal of fetal remains is an area that providers of a termination of pregnancy should consider. Guidance has been published by the Department of Health (2004), RCOG (2011) and the RCN (2007a). Women should be offered information on the method of disposal of fetal tissue, including the options available should they have specific wishes in this regard. Information leaflets regarding termination of pregnancy should include information regarding sensitive disposal.

Where termination of pregnancy services are in an area that also provides gynaecology or maternity services, it may be helpful to link with existing processes that are in place. Independent termination of pregnancy service providers should also ensure that safe and acceptable systems for

disposal are in place and that staff can respond appropriately to questions raised about methods of disposal.

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. Further guidance on this issue can be found on the Sand website www.uk-sands.org. Systems should also be in place if a woman requests individual cremation/burial of the fetal remains (where this is not the usual option) and staff must be able to give advice and offer support with this.

Vulnerable groups and special considerations

Special consideration should be given to individuals and groups of women who may be considered to be vulnerable, either physically, psychologically, socially or economically. These could include women who misuse drugs or alcohol, and sex workers. All women should be treated as unique individuals with respect and dignity, regardless of their vulnerabilities.

You will also need to give special consideration to other vulnerable groups, and be sensitive to ethical and social issues.

Safeguarding children

Where there is an indication that a child or young person seeking a termination of pregnancy is a child in need of protection or at risk of harm, practitioners should follow local child protection procedures and refer immediately. Nurses should be familiar with the key safeguarding issues relating to young women who are under 18 years of age in England and Wales and under 16 years of age in Scotland, and who are sexually active.

Ethnic and cultural 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 interpreter.

Due to the sensitive nature of a termination of pregnancy, 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 forms of written information are available these should be provided prior to the examination. 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 termination of pregnancy, as the vaginal opening needs to be of sufficient size to allow the passing of a speculum and in the case of medical termination, the products of conception to leave the body (NICE, 2003).

It is a criminal offence to re-close the vulva. For more information, see the RCN guidance on female genital mutilation (RCN, 2006).

Some women will request to only be examined by a female and this should be respected if possible. If a female doctor or nurse 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.

Physical disabilities, learning disabilities and mental illness

Services should be safe, 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 (RCN, 2007b).

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 examination(s) or procedures. Guidance regarding this issue is available from the Department of Health, the NMC and is contained in the Mental Capacity Act 2005.

If a woman appears to be within the remit of the Mental Capacity Act and concerns are expressed about her capacity to consent, it is important that clear documentation is kept of how and when this was assessed. It is good practice to keep such records in all cases where consent is discussed. Where a woman does not have capacity to consent and termination of pregnancy is not clearly and unequivocally within her best interests (see the Mental Capacity Act 2005), legal advice must be sought, whilst working in partnership with medical and other colleagues to identify the most appropriate course of action. In any case, legal advice should be sought on the appropriate course of action if there is any doubt or lack of consensus.

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 during history taking or examination. Any discussion should take place when the woman is dressed and not on the examination couch. Referral for counselling may be appropriate and should be offered 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. 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. For information on how to protect forensic evidence when sexual assault has been reported, a CD-ROM is available from www.careandevidence.org

Domestic violence

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 violence, including witnessing domestic violence and this may require a referral to Children's Services) but may wish to refer back to her medical records at a later date for evidence in a court case. Some termination providers use an approach of routine enquiry into domestic abuse (women are routinely asked a question relating to their experience of domestic abuse, such as "Do you feel safe at home?"). In some geographical areas, such as Wales, routine enquiry into domestic abuse is carried out in all women's health settings, including women requesting a termination of pregnancy. The Department of Health guidance *Improving safety, reducing harm: children, young people and domestic violence* (DH, 2009) provides relevant information and a practical toolkit for front-line practitioners.

Forced marriages

"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*

Forced marriage is becoming an increasing concern as it can involve children. It can also involve sexual abuse including abduction, violence, rape, enforced pregnancy and enforced termination of pregnancy.

For further information see the new guidance from the Foreign and Commonwealth Office on forced marriages which is available at 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. They should be cared for with compassion and sensitivity, considering the need to make further appointments, as may be required.

For more information on related issues see the RCN guidance on *Genital examination in women: a resource for skills development and assessment* (RCN, 2013).

Human trafficking

The UN Office on Drugs and Crime defines trafficking in persons as the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs" UNODC www.unodc.org/unodc/en/human-trafficking (UNODC 2013).

It is important that nurses and other health care workers learn to recognise the signs of trafficking. Platform 51, with the support of the DH, has recently published two new tools to facilitate health care workers to identify and appropriately support people who may have been illegally trafficked. Signs to consider would

4 Conclusion

include someone who is afraid to speak to a nurse or doctor, or is reluctant to explain their current circumstances or how they came to be pregnant. A victim may also be vague when providing personal details or be with someone who insists on speaking for them. *Identifying and supporting victims of human trafficking, guidance for health staff* is available online at: www.gov.uk/government/publications, with an e-learning module available via the introduction to the guidance, or by using this link: www.e-lfh.org.uk/projects/human-trafficking-e-learning

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 (RCOG, 2011) during their reproductive life, which sets the care of these women firmly within the context of women's health.

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

The needs of nurses should also be a consideration. Nurses working in this specialist area need 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. The need for more nurse-led research into related topics to extend the evidence base for care should be encouraged.

Good nursing leadership in the speciality 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 to nurses.

Appendix 1 General aftercare advice

- Vaginal bleeding (with or without clots) can last for up to two weeks after a surgical procedure and longer after a medical procedure. The bleeding should decrease in amount over these weeks. 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.
- Sanitary towels should be used instead of tampons during this post-treatment bleeding to limit the risk of infection.
- Over the counter 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 afford some relief.
- 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.
- Breast discomfort can persist for seven to 10 days and a well supporting bra and analgesia can provide some relief. Some women can lactate. They 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 most women feel relieved but some may also feel emotional distress, 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 stop within three days of a termination.
- It is recommended that sexual intercourse is avoided for a week after the procedure. Condoms should be recommended when sexual intercourse is resumed. In addition, the woman 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 in the absence of abstinence to avoid a further pregnancy (RCOG, 2011). All women should be advised of all available methods of contraception, including long-acting reversible contraceptives (NICE, 2005; QIS, 2008).
- 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.

References, further reading and useful resources

Department of Health (2001) *Good practice in consent implementation guide: consent to examination or treatment*, London: DH.

Department of Health (2004) *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*, London: DH.

Department of Health (2006) *Modernising nursing careers – setting the direction*, London: DH.

Department of Health (2009) *Improving safety, reducing harm: children, young people and domestic violence*, London: DH.

Department of Health (2012) *Abortion statistics, England and Wales: 2011*, London: DH.

Department of Health (2012) *Interim procedures for the approval of independent sector places for the termination of pregnancy (abortion)*, London: DH.

Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit (2010) *Contraceptive choices for young people*, London: RCOG.

Office of National Statistics (2011) *Conceptions in England and Wales 2009*, Statistical Bulletin issued 22 February 2011, Newport: ONS.

Nursing and Midwifery Council (2008) *The Code: standards of conduct, performance and ethics for nurses and midwives*, London: NMC.

Nursing and Midwifery Council (2010) *Record keeping: guidance for nurses and midwives*, London: NMC.

Royal College of Obstetricians and Gynaecologists (2004) *The European working time directive and maternity services*, London: RCOG.

Royal College of Obstetricians and Gynaecologists (2011) *The care of women requesting induced abortion: evidence-based clinical guideline number 7*, London: RCOG. Available at www.rcog.org.uk/womenshealth (accessed 22 April 2013).

Royal College of Nursing (2003) *Clinical governance: an RCN resource guide*, London: RCN. Available at www.rcn.org.uk/publications (accessed 3 June 2013).

Royal College of Nursing (2006) *Female genital mutilation: an RCN educational resource for nursing and midwifery staff*, London: RCN. Available at www.rcn.org.uk/publications (accessed 3 June 2013).

Royal College of Nursing (2007a) *Sensitive disposal of all fetal remains: guidance for nurses and midwives*, London: RCN. Available at www.rcn.org.uk/publications (accessed 3 June 2013).

Royal College of Nursing (2007b) *Pregnancy and disability: RCN guidance for midwives and nurses*, London: RCN. Available at www.rcn.org.uk/publications (accessed 3 June 2013).

Royal College of Nursing (2012) *RCN competences for advanced nurse practitioners*, London: RCN. Available at www.rcn.org.uk/publications (accessed 3 June 2013).

Royal College of Nursing (2013) *Genital examination in women: a resource for skills development and assessment* London: RCN. Available at www.rcn.org.uk/publications (accessed 3 June 2013).

Further reading

Dimond B (2011) *Legal aspects of nursing* (sixth edition), London: Pearson Education.

Legislation

The Abortion Act 1967

The Age of Legal Capacity (Scotland) Act 1991

The Children (Scotland) Act 1995

The Human Fertilisation and Embryology Act 1990

Legislation can be reviewed at www.opsi.gov.uk

Useful websites

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

British Association for Sexual Health and HIV www.bashh.org

bpas (formerly the British Pregnancy Advisory Service) www.bpas.org

Department of Health www.dh.gov.uk

Faculty of Sexual and Reproductive Health www.fsrh.org

Family Planning Association www.fpa.org.uk

NHS Fetal Anomaly Screening Programme www.fetalanomaly.screening.nhs.uk

Marie Stopes International (MSI) www.mariestopes.org.uk

The Multiple Births Foundation (MBF) www.multiplebirths.org.uk

National Institute for Health and Clinical Excellence www.nice.org.uk

Nursing and Midwifery Council www.nmc-uk.org

Royal College of Obstetricians and Gynaecologists www.rcog.org.uk



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