Royal College of Nursing

Termination of Pregnancy

An RCN nursing framework

CLINICAL PROFESSIONAL RESOURCE

Royal College of Nursing

Acknowledgements

Project Team

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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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 guidance 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.

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The Nine Quality Standards

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Evaluation

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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, 1997 and again in 2013.

Following the publication of *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 continued to be a contemporary framework for nursing practice. Note: the RCOG document is due for review during 2017.

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
- 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.

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 which aims to provide clarity on the law regarding termination of pregnancy in Northern Ireland was published in March 2016 by the Department of Health in Northern Ireland (DH NI). It is available at: **www.health-ni.gov.uk/news/health-minister-welcomes-executive-agreement-termination-pregnancy-guidance-and-provides-update**

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 for nurses to have a sound understanding of the legislation, depending on where they practise.

* 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. DH NI has published guidance for nurses and other HSC professionals on their responsibilities under the current law in Northern Ireland (DH NI).

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 to assist nurses in their 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 resource to achieve this – for example, consultant nurse, clinical nurse specialist and advanced nurse practitioner roles shape can 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. Re-organisation of the NHS and changes in commissioning, as well as developments in the role of health professionals within the NHS, 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.

In the termination of pregnancy practice field, the nursing profession endeavours to develop more responsive woman-centred services. Opportunities for nurses have developed in recent years, in conjunction with medical colleagues, to take a far more proactive role in developing services across England, Scotland and Wales. 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 on clinical need and on 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) and opportunities for RCN Credentialing (RCN, 2016).

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 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 procedures
- post-early medical abortion assessment
- providing 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 assessmen, ensuring confidence in performing practical skills (for example, ultrasound scanning)
- understanding and implementation of the principles of risk management
- opportunities to develop and practise 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 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).

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, 2015). 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 as well as an active Facebook page. It provides updates on a wide range of issues affecting women's health. Members can seek individual advice by accessing RCN Direct online advice guides on the RCN website at: **www.rcn.org.uk/advice**

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 recommendations for 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 (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 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 termination of pregnancy exists. However, this is not required 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
- 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% 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. This was clarified further in the case of Greater Glasgow Health Board v Doogan and another [2014] UKSC 68. The Supreme Court held that the meaning of 'to participate in' a termination of pregnancy should be given a narrow meaning, ie, '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. Information on conscientious objection for nurses and midwives can be found on the Nursing and Midwifery Council's website at: **www.nmc-uk.org**

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, they should be 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.

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; RCN 2017).

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 and Wales women aged 16 and 17 years are presumed competent to give consent under the provisions of the Mental Capacity Act 2015. In Scotland, legal capacity has 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 Northern Ireland, The Age of Majority Act (NI) 1969 provides that a person who is 16 or over may consent to treatment without acquiring consent by parent/s or guardian/s. However, this Act does not remove the right of the parent/s or guardian/s 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 (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 judgment can be found online on the British and Irish Legal Information Institute website at: **www.bailii.org**

Confidentiality

All women (including those under 18 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 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 and Wales, 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.

In 2011, the Royal College of Obstetricians and Gynaecologists (RCOG) published extensive guidance and it is recommended that *The Care of Women requesting Induced Abortion: Evidence-based Clinical Guideline number 7* (RCOG, 2011) is considered alongside these updated RCN guidelines. The RCOG guidelines are due for review during 2017.

3 Service provision and practice considerations

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

Registered 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
- ensuring that medical assessment has been completed
- ensuring that the HSA1 form (and drugs prescribed) has been signed by a medical practitioner and before any treatment is commenced
- maintaining accurate records of all care provided
- clearly setting out women's rights relating to their own sexual and reproductive health – as well as their general health.

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 a pregnancy is a safe procedure for which major complications and mortality is rare at all gestations. There is some evidence that the earlier in pregnancy 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 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 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.

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 5% for triplets, 8% for quadruplets and 11% 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. 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 an 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 (see page 16).

Anti-D and rhesus prophylaxis

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

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 in 2015 and RCN 2015, which provides detail of the current requirements across the UK. The primary message contained here is that all those involved must consider the personal wishes expressed by the woman in relation to the disposal of pregnancy remains. Guidance was also published by the Scottish Government in 2012. 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 in this regard. Information leaflets regarding termination of pregnancy should include information regarding disposal.

It is important for the nurse to ensure that the woman knows, before the termination of pregnancy, what her options are with regard to disposal of the pregnancy remains, as termination procedure type can have a bearing on how the remains are collected. Options for disposal recommended by the HTA are burial, cremation or incineration. In Scotland, the minimum options are collective burial or cremation.

If a woman prefers not to make a decision about disposal, she should be informed what method of disposal will be used. Where a woman does not want to engage in any discussion about disposal, her position should be respected but she should be made aware that information is available to access should she so wish.

It should be clearly recorded in the woman's medical notes that she has been given 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 make a decision.

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. This should include how to approach the subject of choice of disposal, in line with HTA guidance (HTA, 2015).

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 in the RCN's *Managing the Disposal of Pregnancy Remains (2015)*. Systems should also be in place if a woman requests individual cremation/burial of the fetal remains 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 particularly 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 individuals with respect and dignity, regardless of their vulnerabilities. This should include being sensitive to social and ethnic, or religious consideration, whist respecting individual needs.

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.

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.

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 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 independent interpreters.

Female genital mutilation

Female genital mutilation (FGM) affects the lives and health of an estimated 200 million girls and women living in countries where the practice is prevalent (UNICEF, 2016). FGM is child abuse and the practice is illegal in the UK. Nurses and midwives should be aware of the latest guidance on FGM, particularly from the Department of Health (2016), the RCN (2016) and RCOG (2015).

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 pregnancy remains to be expelled (RCOG, 2015).

As FGM is a form of child abuse, professionals have a statutory obligation under national safeguarding protocols to protect girls and women at risk of FGM. Since October 2015 registered health professionals, including nurses and midwives, have 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 (known as the mandatory reporting duty). Those working in the NHS also have data reporting responsibilities. For further information please visit: **www.gov.uk/government/collections/female-genital-mutilation-fgm-guidance-for-healthcare-staff** and **www.rcn.org.uk/clinical-topics/female-genital-mutilation**

Physical disabilities, learning disabilities and mental illness

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 examination(s) or procedures. Guidance regarding this issue is available from the Department of Health and the NMC.

If a woman appears to lack competence 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, 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 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. Further information and guidance on how to protect and collect forensic evidence is available at: **www.careandevidence.org**

Domestic abuse

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 to the Multi-Agency Safeguarding Hub (MASH) or equivalent, using local safeguarding processes) 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?". Routine enquiry into domestic abuse is carried out in all women's health settings, including women requesting a termination of pregnancy. RCN pocket guides and webpage resources on domestic abuse can be found at: **www.rcn.org.uk/clinical-topics/domestic-violence-and-abuse**. NICE 2015 and The Department of Health guidance (published in 2017) provides relevant information and a practical toolkit for frontline 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 (2017)

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, 2015).

Human trafficking/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 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 Modern Slavery. Guidance for Health Staff* is available at: **www.gov.uk** and an e-learning module is available at: **www.e-lfh.org.uk/programmes/modern-slavery/more-information**

The RCN has developed guidance for nurses and midwives on identifying and best supporting victims of modern slavery, which is available at: **www.rcn.org.uk/publications** (publication code: 005 984) and at: **www.rcn.org.uk/clinical-topics/modern-slavery**

4 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 (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 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. 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 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 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). 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 and further reading

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Royal College of Obstetricians and Gynaecologists (RCOG) (2015) *Female Genital Mutilation and its Management*. Green-top Guideline No. 53.

Legislation

Age of Majority Act (NI) 1969

FGM and Serious Crime Act 2015

Mental Capacity Act 2016

Mental Health (NI) Order 1986)

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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