GUIDELINES FOR TERMINATION OF PREGNANCY

The following guidelines apply to all patients (public & private) admitted for termination of pregnancy.

1. Pre-procedure issues

1.1 Counseling

All women seeking termination of pregnancy are to be offered counselling. Evidence of pre-operative counselling from either a medical practitioner, social worker or genetic counsellor must be documented in the medical record and be available to the treating medical practitioner.

Women who have reached or are over 14 weeks gestation who do not present via Maternal Fetal Medicine must receive counselling from a social worker before being seen in the Gynaecology clinic and a statement regarding this must be included with admission information.

1.2 Assessment of need

For all proposed terminations the following criteria should be considered and documented in the medical record:

- Patient’s physical and psychological condition
- Assessment of gestational age
- In cases of birth defect diagnostic probability
- In cases of birth defect prognosis for the fetus.

Except where there is an imminent threat to the life or physical health of a woman necessitating a termination as a matter of urgency the following process is to be followed:

Pre – 20 weeks gestation

The assessment of need is to be undertaken by the attending medical practitioner in consultation with the patient after appropriate testing and counselling has occurred, and results/reports provided to the attending medical practitioner. Other relevant medical specialists may need to be consulted by the attending medical practitioner as part of the assessment of need for termination of pregnancy.

20 – 25 weeks gestation

A multidisciplinary Termination Review Committee will review the case presented by the attending medical practitioner and undertake the assessment of need for termination of the pregnancy.

The Committee will be convened and chaired by the Director of Clinical Services and will have the following membership:-

- the Director of Clinical Services (or Senior Medical Staff nominee) - Chair
- the Attending Medical Practitioner
- a Maternal Fetal Medicine Specialist (or the Director of Obstetrics)
- a Neonatologist
- the Director of Nursing and Midwifery ( or the Nursing & Midwifery Clinical Operations Manager)
- the Nurse Manager of Birthing Services (or Deputy)
- a Social Worker

cont’d ..../2
This Committee of 7 health professionals may need to be augmented by one or more of the following specialists depending upon the nature of the case.

- A Psychiatrist
  - when the pregnant women has a psychiatric illness
  - when the termination of pregnancy is being recommended on grounds of the adverse effects on maternal health continuation of the pregnancy is likely to produce
  - when the indication for termination of pregnancy is primarily for adverse socio-economic circumstances and their effects on the mental health of the mother

- A Medical Geneticist – particularly when the grounds for termination include fetal malformations or other fetal disorders.

- A Specialist Physician – when the grounds for termination include maternal physical disease of any kind.

**Decision**
The Committee will reach a decision about the need for termination of pregnancy by consensus if possible: if not, the decision will be reached by voting such that a majority of all but one member of the Committee in favour of termination of pregnancy will be required if the need for this procedure is deemed necessary.

**26 – 40 weeks Gestation**
For all patients referred for Termination of Pregnancy at or beyond 26 weeks, there is a mandatory requirement that the 20 – 25 weeks Termination of Pregnancy Committee constituted as described above will be augmented by:

- a Psychiatrist – irrespective of the grounds for termination
- the Director of Obstetrics
- the Executive Clinical Director

**Decision**
The assessment of need to proceed with termination of pregnancy will require a unanimous decision of the augmented Committee.

*The attached information (Appendix) provides an overview of the legal position regarding termination of pregnancy in NSW. This should be considered in all decisions relating to termination of pregnancy.*

**1.3 Patient information/Consent**
Written consent is to be obtained by the treating medical practitioner before a pregnancy termination is performed. Terminations may be either surgical or medical. This is to be discussed with the woman concerned.

Where applicable the patient is to be informed, by the treating medical practitioner, of the potential for the infant to be born exhibiting signs of life and the ramifications should this occur.
The woman’s wishes regarding contact with the fetus/child following termination are to be documented to ensure appropriate arrangements are made.

1.4 Booking
All terminations are to be booked through the Bed Manager who will ensure the relevant pre-admission procedures have been completed and will arrange bed allocation.

If a patient’s medical condition requires additional care she will be nursed in the Acute Care Unit.

Terminations at weekends should be avoided, as there is less support staff available for both patients and staff.

2. Procedure

2.1 Clinical protocols
Clinical protocols are in place for cervagem and misoprostol termination procedures and these are to be followed at all times.

Nursing and junior medical staff are not required to administer cervagem or misoprostol. Oral misoprostol may be administered by nursing staff and is to be checked by two registered nurses prior to administration. If at any time there is not a member of nursing or medical staff on duty who is willing to administer misoprostol the Nurse Manager on duty is to be contacted. The Nurse Manager will organise for the medication to be administered.

Counselling is available for all staff. If you require this please contact your Department or Divisional Head or the Employee Assistance Program (EAP).

2.2 Conscientious objection
Staff are not required to participate in terminations of pregnancy or administer any abortifacient agents. Any staff who have concerns should contact their Department or Divisional Head.

3. Post Procedure

3.1 Woman
Refer to clinical guidelines regarding immediate postnatal care. Dostinex should be prescribed to suppress lactation when the termination is performed at 16 weeks or later gestation.

The medical practitioner responsible for the care of the patient is to be informed of the completion of the procedure, the condition of the woman and, where relevant, the child.

The woman should receive appropriate post procedure information.
GUIDELINES FOR TERMINATION OF PREGNANCY  cont’d

The woman’s wishes regarding the fetus are to be respected and arrangements for viewing and handling of the fetus should be arranged by Social Work or nursing staff. If an autopsy is considered appropriate the woman’s consent is to be sought by the attending medical practitioner or Registrar.

A Social Worker is to see the woman where appropriate to discuss and provide assistance with any further requirements that may be necessary, e.g. Funeral arrangements and birth registration.

Counseling is to be offered to the mother and family after the procedure and parents are to be informed of support services available.

A discharge plan is to be documented and implemented by nursing and medical staff.

3.2 Fetus/child

3.2.1 Examination and Care

Examination of the fetus/child should occur immediately upon delivery.

Where a medical termination of pregnancy results in a fetus/child showing signs of life it is important that staff involved are aware of their responsibilities and duty of care toward the child. This includes assessment of the condition of the child at birth, and any abnormalities present. If upon examination the condition of the child warrants further specialist examination staff should immediately consult a neonatologist.

If it is considered that no benefit would be conferred on the child by medical treatment, whether it is because of pre-viability of the child, his/her prematurity or the effect of a disease or condition, staff are under no duty to render futile treatment. If it is considered that benefit would be conferred on the child by medical treatment, there is an obligation to render life saving medical treatment.

Any child born with signs of life as a result of termination of pregnancy, irrespective of gestation or condition, must be afforded the right of dignity, maintenance of privacy and physical comfort while signs of life exist. Parents should be encouraged to be part of this care where appropriate.

3.2.2 Registration Requirements

All terminations where the fetus is of greater than 20 weeks gestation are to be registered. Those that show signs of life are to be registered as a neonatal death otherwise it will be registered as a stillbirth.

In the case of a stillbirth where it is unclear whether the gestational age is less than 20 weeks at the time of delivery the fetus is to be weighed. If the weight is 400 grams or greater the fetus must be registered as a stillbirth.

If a fetus of less than 20 weeks shows signs of life it is to be registered as a neonatal death.
GUIDELINES FOR TERMINATION OF PREGNANCY  cont’d

3.2.3 Appropriate disposal/transfer

Refer to RHW Clinical Policies and Procedures: Protocol to be followed after stillbirths. 
Neonatal death and fetal deaths.

3.2.4 Notification to Department of Health

Birth, perinatal death and birth defects are category 1 conditions under the Public Health Act 1991 requiring notification to the Department of Health.

4. Records Management

In addition to routine clinical notes concerning the care and treatment of the patient the following information should also be documented:

- Gestational age/weight
  Gestational age is to be recorded where known. The method used to calculate the gestational age should be documented. If appropriate, weight should be recorded.
- Signs of life following a medical termination
  Where a medical termination is performed the extent and duration of any signs of life should be recorded, and actions taken.

IN THE SECOND TRIMESTER

INDICATION

To induce cervical dilatation and uterine contractions for termination of pregnancy in the second trimester.

ADMISSION

The woman is allocated a single room for her stay.

The Social Work Department is to be notified of the woman's admission, and the reason for termination. The social worker must see the woman prior to the commencement of the procedure. (Most women having terminations are seen by the social worker prior to admission).

The wishes of the woman regarding the fetus should be documented to ensure that arrangements are made for viewing and handling of the fetus, or for photographs to be taken.

A full medical admission must be attended and consent form signed
Nursing/midwifery admission is attended.

Consent:

Informed written consent must be obtained from the patient for termination of pregnancy and possible surgical uterine evacuation.
MISOPROSTOL

CONTRAINDICATIONS
- Any contraindication to a vaginal delivery
- Known hypersensitivity to any Prostaglandin.
- Severe asthma.
- Acute pelvic inflammatory disease

USE WITH CAUTION
- Uncontrolled severe epilepsy
- Inflammatory bowel disease
- Mild/moderate asthma
- Previous uterine scar
- Grand multiparity

ADVERSE EFFECTS
- Gastrointestinal e.g. nausea, vomiting, diarrhoea 14-40%,
- Pyrexia

DRUG INTERACTIONS
(i) Indomethacin (20-60% reduction in steady state)

PATIENT CARE

Procedure:
IV cannula should be inserted and blood taken for full blood count and group and hold
Explain the procedure to the patient. Ensure that her privacy is maintained
When used vaginally this drug should be given by medical staff.
The patient is advised to remain in bed for 30 minutes following insertion
The patient needs to be observed for side-effects (as listed)
After membrane rupture, continue with Misoprostol protocol (or intravenous oxytocin may be commenced).

Administration:
Initially, Misoprostol in a dose of 200 mcg (one tablet) is either given orally or placed in the posterior vaginal fornix
Subsequently, and in the absence of significant side-effects, Misoprostol 400 mcg (two tablets) is given either orally or into the posterior vaginal fornix four hourly.
Dosage may be decreased at the discretion of the member of the medical staff once active labour is established.
CERVAGEM

EQUIPMENT:
Cervagem pessary (removed from freezer 30 minutes before use).
Sterile gloves, Kidney dish/dressing pack, Water soluble lubricant (e.g. KY jelly)
Medication orders: For Cervagem - 1 pessary p.v. q 3 hourly, (maximum 5 pessaries)
Observation charts and patient records.

CONTRAINDICATIONS:
The use of Cervagem is contraindicated in the third trimester of pregnancy (whether or not
the fetus is alive) and to women with known hypersensitivity to prostaglandins.

PRECAUTIONS:
Cervagem should be used with caution in patients with obstructive airways disease,
cardiovascular insufficiency, elevated intra-ocular pressure, cervicitis or vaginitis.

PATIENT CARE

Procedure:
A Medical Officer should perform the procedure.
An IV cannula is inserted and blood taken for full blood count and group and hold.
Explain procedure to patient. Ensure privacy is maintained.
Instruct patient to remain in bed for at least 30 minutes in order to allow pessary to melt
around cervix.
Up to 5 pessaries may be necessary, especially for nulliparous women. After 5 pessaries,
the patient is reviewed and further pessaries may be indicated if appropriate. This should be
discussed with the consultant in charge. Occasionally Cervagem termination procedures
take more than 24 hours to complete.

Further information
Onset of Action: These figures are average figures and apply when no prior treatment has
occurred.

- Onset of abdominal pain: 3 hours
- Onset of bleeding: 4 hours
- Onset of expulsion of uterine contents: 10-13 hours
- Procedure complete within 24 hours
- Maximum dilatation and softening occurs at 6-9 hours

STORAGE:
Store below 10 degrees C (deep freeze) in the original pack.
Remove only sufficient pessaries from freezer for immediate use.
Any pessaries removed from freezer should not be refrozen.
Once the foil has been opened, any pessary not used within 24 hours should be destroyed.

cont’d ..../8
CARE OF THE WOMAN:

Monitoring
Vital signs: Record BP, pulse, respiratory rate and vaginal loss four hourly
Labour progress: Vaginal examinations four hourly

Further care:

Patient may get out of bed and take light refreshment up until the commencement of contractions.
Once labour is established, the woman should remain in bed and be nil by mouth.

Medication
- Pethidine 50-100 mg IMI 3-4 hourly
- Maxalon or Stemetil 10 mgs intramuscularly 3-4 hourly
- Ativan 1 mg orally 6 hourly prn
If IV oxytocin is required, standard hospital protocol should be followed
Inform medical staff if bleeding increasing or patient’s temperature exceeds 38°C
Nausea, vomiting and pain are common reactions. The RMO must be notified of hypotension, tachycardia, palpitations or dyspnoea.
If patient is Rh negative ensure 1 ml (1 vial) of IMI Rhesus Immunoglobulin is given after delivery and send a sample of maternal blood for a Kleihauer-Betke test
Premedication is not usually required but may be given at the discretion of the staff.
Record dates and times of medications, amount of vaginal loss and passage of products of conception.
A cervical assessment is recorded at each administration of Cervagem or Misoprostol.

BIRTH REGISTRATION

A baby that shows signs of life, regardless of gestation is to be registered as a birth. The documentation associated with the birth details must be completed.

AFTER DELIVERY
- When the fetus is expelled, clamp the cord with plastic cord clamps and cut with scissors. Examine fetus, placenta and membranes
- The mother should be offered the opportunity to see and hold her fetus for as long as she deems appropriate.
- Specimens for karyotyping (cord, placenta, connective tissue) are saved in normal saline (never in formalin).
- All paperwork is to be completed as necessary and consent for autopsy signed.
- Observe patient for signs of placental separation
- If placental separation and delivery has not occurred within three hours or if there is heavy bleeding before this time, then surgical removal of the placenta (curettage) should be undertaken forthwith.
- Inform the medical officer responsible for the care of the woman of the completion of the procedure.

cont’d ..../9
GUIDELINES FOR TERMINATION OF PREGNANCY    cont’d

Observations following delivery
The fundus, lochia and maternal pulse and blood pressure are checked every 15 minutes for the first hour and then 4th hourly unless otherwise indicated.

Discharge planning
The woman is to be advised regarding post-procedural care. This may include:
Breast care and the use of Dostinex
Pain relief
Vaginal bleeding
Social work support
DMP if requested by the woman