Approved by Quality & Patient Safety Committee
21 February 2013

TERMINATION OF PREGNANCY (TOP) - FRAMEWORK

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

- **AIM**
  - Termination of pregnancy occurs within the New South Wales department of health framework

- **PATIENT**
  - All women (public and private) admitted for termination of pregnancy

- **STAFF**
  - Registered Midwives
  - Student Midwives
  - Registered Nurses
  - Medical Staff
  - Social Workers

- **EQUIPMENT**
  - Nil

- **CLINICAL PRACTICE**

1. Pre-procedure issues

1.1 Counselling

- 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:

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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.

Beyond 20 weeks Gestation
The request for termination must be reviewed by a Termination Review Committee. This is convened as per the Royal Hospital for Women Termination review committee terms of reference (Appendix A).

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 Mifepristone, Cervagem and Misoprostol medical termination procedures and these are to be followed at all times.

Medical and nursing staff are not required to administer Cervagem or Misoprostol if they do not wish to. 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.

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TERMINATION OF PREGNANCY (TOP) – FRAMEWORK cont'd

3. Post Procedure

3.1 Woman

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.

Counselling 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.

ROYAL HOSPITAL FOR WOMEN

LOCAL OPERATING PROCEDURE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

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TERMINATION OF PREGNANCY (TOP) – FRAMEWORK 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.

- **DOCUMENTATION**
  - Medication Chart
  - Integrated Clinical Notes
  - Birth Registration Papers

- **EDUCATIONAL NOTES**
  - Nil

- **RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP**
  - NSW Department of Health Policy Directive 2005-587 *Framework for terminations in New South Wales Public Health Organisations*.

- **REFERENCES**
  Nil

REVISION & APPROVAL HISTORY
Approved Quality Council 17/3/03
Reviewed January 2007 by Executive Clinical Director RHW
Approved Clinical Performance & Quality Committee 19/2/07
Reviewed Maternity Services LOPs August 2011

Attachment A

ROYAL HOSPITAL FOR WOMEN
TERMS OF REFERENCE
Termination Review Committee

16th July 2012

1. The Termination Review Committee (TRC) is convened when a woman requests a termination of pregnancy after 20 weeks gestation. Between 20 and 24 weeks gestation in non-controversial cases, the committee may convene by email communication. After 24 weeks gestation or in controversial cases the committee will convene in person.

2. The constitution of the TRC accords with NSW Policy Directive PD2005-587, section 3.2 Assessment of Need : "The multidisciplinary team may include experts in the areas of psychiatry or specialist mental health, fetal medicine, neonatology and any other specialty relevant to the woman's and fetus's medical condition".

3. The Head of Department of Maternal-Fetal Medicine is responsible for the governance of this committee, and in turn reports to the Co-Directors of Maternity and Executive Clinical Director.

4. The committee will usually be chaired by a Maternal Fetal Medicine Specialist. If this is not possible (for example when there is medical leave and the sole Specialist available is presenting the case), the Clinical Midwife Consultant High Risk Pregnancy will chair the meeting. In both cases this will be in an administrative non-voting role.

5. An expert in mental health always forms part of the TRC, this may be a Social Worker, Psychologist or Psychiatrist depending on the specific psychosocial needs of the patient.

6. Other clinicians as applicable who have been involved in the case may be invited to attend according to which staff members are most relevant to the case.

7. The Treating Medical Practitioner makes an initial submission to convene the TRC. This submission is written on the RHW Individual TOP Committee Proforma including a list of all members of the multi-disciplinary team consulted.

8. The Treating Medical Practitioner or the Fellow in Maternal Fetal Medicine presents the case at the TRC.

9. The Administrative Officer of Maternal-Fetal Medicine contacts members of the TRC by email or telephone to decide whether the meeting can be conducted by email consultation, or to arrange a suitable time and venue for the TRC to convene.

10. When the meeting is conducted by email consultation, copies of the relevant emails will be stored with the TRC documentation as minutes.

11. All relevant minutes and information pertaining to the case under review will be collated by the Administrative Officer of Maternal-Fetal Medicine and sent to the Administrative Officer of the Co-Directors of the Maternity Services Division for safe filing.

12. Members of the multi-disciplinary team who have consulted with the patient may make a written submission to the TRC, particularly if they are unable to be present. Social work / psychiatry should provide the TRC with a written report regardless of whether they are attending the meeting.

13. The patient and/or her family may make a written submission to the TRC.

14. The TRC should aim to convene within 2 business days of the request for termination of pregnancy.

15. Members of the multi-disciplinary team may participate in the TRC by teleconferencing.

16. Members of the TRC with voting rights should include those who form part of the multi-disciplinary team relevant to the woman's clinical condition.

17. The decision of the TRC is made by a majority vote. Abstentions are permitted. In the case of inability to reach a clear decision, or if the committee requests further input or information, the chair may delay the decision and organise further specialist consultation or advice.

Members of the committee:

- A Maternal-Fetal Medicine Specialist or Clinical Midwife Consultant High Risk Pregnancy will chair the Termination Review Committee. The Chairperson has a non voting role (responsible for maintaining records).
- Treating Medical Practitioner
- If over 26 weeks gestation a psychiatric review is highly recommended.

Specialists involved in consultations as relevant (at least 2):

- Maternal Fetal Medicine Specialist
- Expert in paediatric outcomes relevant to this case (e.g. neonatologist, paediatrician, geneticist or specialised paediatric physician or surgeon)
- Obstetric Physician

Mental Health (at least 1):

- Social Work
- Psychiatry
- Psychologist

Midwifery:

- Midwifery Manager, Birthing Services
- Primary Midwife, Midwifery Group Practice (if relevant)
- Maternal Fetal Medicine Midwife (if relevant)

Other – if relevant:

- Genetic Counsellor
- Maternal Fetal Medicine Fellow – non voting

Developed: Submitted to Clinical Operations Committee by Medical Clinical Co-Director, Maternity Services Division- approved
Implemented– Maternity Services Division

Reviewed: 27 June 2012 – Medical Clinical Co-Director and Midwifery Clinical Co-Director, Maternity Services Division