Royal Cornwall Hospitals
NHS Trust

Management of Miscarriage Clinical Guideline

V5.0

November 2023

1. Aim/Purpose of this Guideline

1.1. All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of miscarriages.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Introduction

Miscarriage occurs in 10-20% of clinical pregnancies. Traditionally most miscarriages were managed surgically, however non-surgical management (expectant or medical) options are safe but should only be offered in units where women can access 24 hour telephone advice and emergency admission if required.

When the diagnosis of miscarriage is made, the woman can be counselled about the different options of management and given the RCHT (Royal Cornwall Hospitals NHS Trusts) patient information leaflet No 968 ‘Managing your Miscarriage. Your choices explained’.

Choices are:

- Expectant management.
- Medical management (at home).
- Surgical management.
  - Under local anaesthetic (Manual vacuum aspiration).
  - Under general anaesthetic (ERPC (evacuation of retained products of conception)).
- Use expectant management for 7-14 days as the first line

management strategy with a confirmed diagnosis of miscarriage. Explore management options other than expectant if:

- The woman is at increased risk of haemorrhage (e.g., late in first trimester) **or**
- She has previous adverse and/ or traumatic experience associated with pregnancy (for example, stillbirth, miscarriage, or antepartum haemorrhage) **or**
- She is at increased risk from the effects of haemorrhage (for example, if she has coagulopathies or is unable to have a blood transfusion) **or**
- There is evidence of infection **or**
- This is not acceptable to the woman.

Offer medical or surgical management with a confirmed diagnosis of miscarriage if expectant management is not acceptable to the woman.

2.2. Expectant management of miscarriage

Up to 70% of women choose expectant management of miscarriage if given the choice. The timescale is variable and can take weeks (80-90% success rate within 2-6 weeks with incomplete miscarriage; 65-75% success rate within 2-6 weeks with non-viable intrauterine or anembryonic pregnancy).

Expectant management can be continued so long as the woman is willing and there are no signs of infection.

Before discharge ensure:

- Given the RCHT patient information leaflet No. 989 ‘Expectant management of your miscarriage’.
- Give miscarriage association leaflet.
- Advised to expect pain and bleeding.
- Has adequate analgesia at home- give prepacks of paracetamol/ Ibuprofen (PGD (Patient Group Directive) in place) if not.
- To contact the Gynaecology ward or EPU (Early Pregnancy Unit) (numbers in leaflet and on viewpoint report / discharge letter) if severe pain or bleeding or changes mind about management.
- Follow up is made in EPU in 2 weeks until miscarriage complete/ alternative plan decided.
- We have her contact numbers in the notes (we will contact her if she doesn’t attend follow up).
- Discharge letter/ viewpoint report completed- 1 copy given to patient

and 1 copy filed in notes.

- Cancel any booked routine scans by calling the fetal medicine ward clerk on extension 2682.

- Check woman cancelled from Euroking (E3), and community midwife informed by emailing the relevant team and completing pregnancy loss checklist.

- Advise to check pregnancy test 10 days after bleeding stops and contact EGU (Emergency Gynaecology Unit) if still positive.

There is no need to offer Rh negative women anti D who chose expectant management of miscarriage <12 weeks gestation.

2.3. Medical management of miscarriage

Medical management of miscarriage is widely practiced in the UK (United Kingdom) and whilst the drugs used are unlicensed for this indication, they have a good safety record.

- **Mifepristone** is an antiprogestogenic steroid, sensitises the myometrium to prostaglandin induced contractions and softens and dilates the cervix.

- **Misoprostol** (cytotec) is a synthetic prostaglandin analogue = antisecretory and protective properties promoting the healing of gastric and duodenal ulcers.

If there is a gestation sac present (early fetal demise), the success of medical management is increased by prior administration of mifepristone 36-48 hours before the misoprostol. If there is no gestation sac, but a thickened endometrium (incomplete miscarriage), the use of mifepristone is unnecessary, and they can be managed with misoprostol alone.

Women who choose medical management of miscarriage undertake this at home. They must be given full counselling, encouraged to have support with them during the process, have ‘open access’ to the ward and have all the numbers to call for advice/ help if necessary. Women have the option of bringing in the pregnancy tissue for histological evaluation if they wish.

2.4. Doctor’s responsibility EGU/ on ward pre-procedure

2.4.1. **Full history** on EGU history sheet. Include any medical problems, previous anaesthetic problems, medication history and allergies.

2.4.2. Get **written, informed consent**. Use the pre-filled RCHT standard consent forms only. Available in EGU or on the shared drive, (see appendix 3). Issues that need to be raised include:

- Use of misoprostol in management of miscarriage is an unlicensed indication but has been widely used with a good safety record and the dose of mifepristone (200mg (milligram)) in this regimen is less than that licensed but is

widely accepted.

- If has mifepristone, may miscarry at home before the misoprostol (1 in 10).
- Side effects of medication- pain, bleeding, diarrhoea, vomiting, shivering, flatulence, rashes, dizziness.
- Risk of incomplete miscarriage needing surgical evacuation (1 in 10).
- Issues of tissue disposal if they decide to bring the tissue into hospital (see appendix 6).

2.4.3. **Bloods** No need to take FBC (full blood count) unless clinically indicated. Group and save sample not indicated routinely.

2.4.4. Check no contraindications to medical management - rare, but include:

- Severe asthma.
- Cardiovascular disease or hypertension (bp (blood pressure)>160/100).
- Chronic renal, hepatic, or adrenal failure.
- Porphyria or haemorrhagic disorders.
- Drugs- long term corticosteroid, anticoagulant or NSAID (non- steroidal anti-inflammatory drugs) therapy.
- Heavy smokers (>20/ day) if aged >35 years.
- Known allergy to mifepristone or misoprostol.

2.4.5. **Prescribe** regimen – on JAC (JAC Medicines Management)

- Mifepristone 200mg orally- omit if ‘incomplete miscarriage’.
- VAGINAL misoprostol 800 mcg (micrograms) (administer the tablets vaginally high in the posterior fornix - this can be given buccally if refuse PV or bleeding).
- After 3 hours if the bleeding is not as heavy as a menstrual bleed, then to take 400mcg misoprostol buccally/ sub lingually.
- Print off a copy so the mifepristone can be signed to say given by the nursing staff and added to the patient notes.

2.4.6. **Prescribe analgesia if the woman doesn’t have her own supply.**

Usually prepacked paracetamol 1g (gram) qds (four times a day) PRN

(pro re nata)- pack 16 x 500mg tablets and Ibuprofen 400mg tds (three times a day) PRN- pack 24 tablets (check contraindications to ibuprofen including severe maternal asthma and history of previous or active peptic ulceration).

Complete a discharge letter, including the open access contact numbers.

2.5. Nurse's responsibility pre-procedure in EGU / on ward

2.5.1. **Offer Chlamydia screening** to all women. Women can be instructed to take a low vaginal swab themselves and we can request the sample via maxims.

2.5.2. Give **RCHT patient information leaflet** No 969 'Medical management of your miscarriage' with emergency contact numbers.

2.5.3. Give **miscarriage association leaflet**.

2.5.4. Give **patient instruction leaflet** on how to take misoprostol medication.

2.5.5. Give prepacked misoprostol +/- prepacks of analgesia.

2.5.6. Cancel any booked routine scans by call fetal medicine ward clerk on extension 2682.

2.5.7. Check woman cancelled from Euroking (E3) and community midwife informed by emailing the community team responsible. Complete pregnancy loss checklist proforma.

2.5.8. Complete proforma.

2.5.9. Give patient a copy of discharge letter with emergency contact numbers on.

2.5.10. Establish whether the woman wants to bring in the tissue for histological evaluation and if so, make the necessary arrangements.

2.5.11. Give patient urine pregnancy test (with instructions) to perform 10 days after bleeding settled.

2.5.12. Administer Mifepristone 200mg orally (to be taken in front of you)- unless incomplete miscarriage- and allow home.

There is no need to offer Rh (rhesus) negative women anti D who chose medical management of miscarriage <12 weeks gestation.

In some instances, it may be considered to use the Daisy Suite for patients less than 14/40 gestation for medical management. In these cases, the case needs to be discussed with the maternity manager on call via switchboard. The patient needs to be added to E3, to enable clear communication between departments.

Priority will always be given to those above 14/40 if the Daisy Suite is required.

Therefore, careful consideration of counselling these patients needs to be considered in line with the Maternity manager and the Daisy suite workload/ requirements.

2.6. Surgical management of miscarriage

When a woman has been counselled and has chosen surgical management of miscarriage, she needs to be seen by a nurse and doctor in the emergency gynaecology unit and preparations for admission made. Phone EGU (2686) to make appointment for woman to be seen by nurse and doctor.

If a woman chooses surgical management of miscarriage, she should be offered:

- Manual Vacuum Aspiration (MVA) in a clinic setting under local anaesthetic.
- Surgical evacuation (ERPC) in theatre under a general anaesthetic.

2.7. Doctor's responsibility on ward / EGU pre-operatively

2.7.1. **Full history** on EGU history sheet. Include any medical problems, previous anaesthetic problems, medication history and allergies. Inform duty anaesthetist of any concerns.

2.7.2. **Examination** You do not need to do a speculum / vaginal examination unless they have severe pain / bleeding.

2.7.3. **Get written, informed consent**. Use the pre-filled RCHT standard consent forms only. Available in EGU or on the shared drive (see Appendix 5). Obtain written consent for collective cremation of pregnancy tissue / make other arrangements via the bereavement office (see appendix 6 and 7).

2.7.4. **Bloods**: Not necessary unless clinical suspicion of anaemia or Rhesus status unknown

2.7.5. **Prescribe cervical ripening agent** to ALL women (400mcg Misoprostol vaginally or buccally 06.00 morning of surgery) on JAC. Contraindications to misoprostol:

- Severe maternal asthma.
- Maternal adrenal insufficiency disease.
- Ischaemic heart disease.
- Sickle cell disease.

2.7.6. **Prescribe analgesia for discharge home** if unable to obtain own supply. Usually prepacked paracetamol 1g qds PRN – pack 16 x 500mg tablets and Ibuprofen 400mg tds PRN – pack 24 tablets (check contraindications to ibuprofen including severe maternal asthma and history of previous or active peptic ulceration).

2.7.7. **Complete a discharge summary.**

2.7.8. **File all your paperwork** in the patient notes**.**

2.7.9. **Nurse's responsibility pre-operatively on ward / EGU.**

2.7.10. Ensure **theatre slot booked on appropriate list** or appointment in EGU for MVA.

2.7.11. Email the consultant, registrar, and previous night SHO (Senior House Officer), when the patient is due to come in, so the patient is expected. SHO is to then add to Nervecentre on arrival.

2.7.12. Add to ward list as a TCI (to come in).

2.7.13. **Offer Chlamydia screening** to all women. Women can be instructed to take a low vaginal swab themselves and the Chlamydia request form filled in, getting them to fill in the contact details.

2.7.14. **Dispense misoprostol and analgesia** (if required) prescribed from stock cupboard.

2.7.15. **Give RCHT patient information leaflet** No 970 'Surgical management of your miscarriage' with admission date, time and location of where to come on day of procedure and emergency contact numbers.

2.7.16. Give **miscarriage association leaflet.**

2.7.17. Check woman cancelled from Euroking (E3) and community midwife informed by emailing the relevant community team. Cancel any routine booked scans by leaving a message for the ward clerk in fetal medicine dept (2682) and complete pregnancy loss checklist.

2.7.18. Check any further EPU appointments have been cancelled.

2.8. Manual Vacuum Aspiration (See separate MVA Guideline)

2.8.1. Provide information leaflet titled 'Surgical Management of your miscarriage under local anaesthetic' RCHT1249.

2.8.2. The procedure, risks and alternatives should be explained to the patient and all questions answered.

2.8.3. Pain control during the procedure should be discussed.

The woman may be advised to take an analgesic 1 hour prior to her appointment at the clinic/unit. Suitable options include:

- Paracetamol 1g AND Ibuprofen 400mg **or**
- Cocodamol 8mg/500mg (1-2 Tablets).
- Alternatively oral Ibuprofen can be provided at the treatment unit.

- Entonox or Penthrox will be available to the patient throughout the procedure.

- Para-cervical local anaesthetic will be provided unless patient has an allergy or declines.

2.8.4. The woman should be advised that a health professional will be at her side during the procedure providing reassurance and support.

2.8.5. Informed consent must be obtained on pre-printed approved consent form (Appendix 4) to include disposal consent for sensitive disposal of pregnancy tissue.

2.8.6. Prescribe Misoprostol 400 micrograms to be taken vaginally 3 hours before the procedure or buccally / sublingually one hour prior to procedure.

2.8.7. **Medical history, physical examination and Laboratory evaluation.**

2.8.7.1. Complete EGU proforma.

2.8.7.2. Any patient with a complex medical history, where suitability is not clear, should have her case reviewed by a consultant.

2.8.7.3. Pre-procedure blood testing is NOT typically undertaken prior to MVA unless:

- There is a significant history of anaemia or concern about anaemia based on clinical signs and symptoms.

- Rhesus status is unknown.

2.8.8. **Treatment**

2.8.8.1. Patient Preparation

- Before the treatment begins, the woman should be introduced to the staff, the procedure should be reviewed with her, including the use and benefits of entonox or penthrox and any questions she has should be answered.

- The treatment practitioner should review the woman's medical history, gestational age dating (i.e., ultrasound) and confirm consent.

- The woman should be asked to void shortly before the procedure; urinary bladder catheterisation is not recommended.

- WHO checklist should be completed.

- The woman should be allowed some privacy to

remove her underwear, undress from the 'waist down' or be provided with a gown, whichever is her preference.

- The woman should be assisted onto the treatment couch and her legs put into the supports. The hips should be flexed to about 45° and care should be taken in maintaining symmetry of leg positions.

- The woman should be kept covered until the practitioner is ready to proceed.

- An Entonox or penthrox mouthpiece should be offered to the woman and instructions on its use provided.

2.8.8.2. Uterine Evacuation

- A bimanual pelvic examination can be performed to assess the uterine size and position or the USS (ultrasound scan) reviewed to gain this information.

- In cases of known uterine anomaly, large fibroids, or an ante-retroflexed uterus, the use of continuous transabdominal ultrasound guidance during the procedure may be helpful.

- After introduction of a vaginal speculum, the vagina and cervix should be cleaned with a non-spirit based preparation.

- A tenaculum may be placed on the cervix to stabilise and align the cervical canal and uterine cavity during the procedure. Injection of 1% Prilocaine at the site where the tenaculum will be placed can reduce discomfort from applying the instrument.

- A deep para-cervical block (see training slides in EGU) of 1% Prilocaine (Citanest) or equivalent is recommended: instillation of intra-uterine Lidocaine gel is recommended.

- The appropriate cannula and aspirator should be chosen.

MVA cannulas are made of rigid plastic and come in a range of sizes up to 12mm in diameter. Typically, the size of the cannula used would match the gestational age in weeks. However, practitioners are often able to successfully and completely evacuate the uterus with cannula of smaller diameter: this may avoid the need for cervical dilation and may be more comfortable for the woman.

- If dilatation is necessary, the cervix should be dilated to the minimum necessary to insert a cannula of the appropriate size.

- Insert the cannula gently through the cervix into the uterine cavity, just passed the internal os; rotating the cannula with gentle pressure often helps ease insertion.

- Attach the charged 60ml self-locking syringe to the cannula. Make sure that the cannula does not move forward into the uterus as you attach the syringe. Alternatively, the cannula could be attached to the charged syringe before inserting the cannula into the cervical os.

- Never grasp the syringe by the plunger arms after the syringe has been charged.

- Advance the cannula until it gently touches the fundus and then withdraw it slightly.

- Open the valve(s) so that the vacuum is applied to the uterine cavity.

- Move the cannula gently back and forth from the fundus to the internal cervical os while rotating it to aspirate all sections of the uterus.

- Withdrawing the cannula apertures beyond the cervical os will cause the vacuum to be lost. If the cannula becomes clogged and must be removed or if it passes the os accidentally, the aspirator must be emptied and ‘recharged’.

- The aspiration process is complete when no further tissue is seen passing through the cannula. Other signs of complete aspiration are when pinkish foam is seen passing through the cannula, a gritty sensation is felt as the cannula passes over the surface of the evacuated uterus, and the uterus contracts around the cannula.

- Typically, the vaginal speculum will be removed prior to examination of the aspirate. If there is any concern regarding completion of the aspiration, the woman should remain in the treatment room until the products have been examined.

- A transabdominal or transvaginal scan should now be performed and documentation of endometrial appearance and thickness made. To be deemed a success, the absence of a gestation sac (if previously

seen) and endometrial thickness of <15mm would be expected.

2.8.8.3. Tissue Examination

- The evacuated tissue must be examined.
- Empty the contents of the evacuation into an appropriate container by removing the cannula, releasing the buttons if not depressed, and gently pushing the plunger completely into the cylinder. Do not push aspirated contents through the cannula.
- Tissue may only be viewed directly in the container into which it was emptied.
- All tissue is sent for histological evaluation (unless woman declines) and MUST be accompanied by a signed cremation form, unless she is postnatal – in which case this needs to be clearly stated on the histology request. (Appendix 7).

2.8.8.4. Post-procedure Care

- As a minimum, one set of post-procedure observations should be recorded in the case notes.
- Refreshment is offered to the woman at an appropriate time.
- Check woman's Rhesus status and if non-sensitised Rhesus negative, administer Anti D.
- When the patient is fully recovered, she can be discharged by the nurse.

2.8.9. **Duration of Stay in the Clinic/Unit**

Procedure duration is typically 10-15 minutes and recovery time 15-20 minutes.

2.8.10. **Anti-biotic Prophylaxis**

Anti-biotic prophylaxis should be provided to all clients undergoing MVA. 400mg oral metronidazole or 1g rectal metronidazole or three days of oral doxycycline 100mg bd (prescribe on an outpatient prescription)

2.8.11. **Aftercare**

A routine follow up appointment is not necessary after an uncomplicated procedure. A pregnancy test at 3 weeks is not recommended after MVA.

2.8.12. **Persistent Bleeding following Discharge**

Persistent bleeding and/or cramping post-procedure may be a sign of retained products of conception or another complication. The patient should return for evaluation.

2.9. Surgical Evacuation under GA (general anaesthetic)

2.9.1. **Surgeon's responsibility on day of operation**

2.9.1.1. **See woman pre-operatively** on the ward- check indication, consent, that took her misoprostol that morning. Sign 'confirmation to consent' part of consent form and complete relevant section of perioperative document.

2.9.1.2. **Ensure that she is listed on NerveCentre** and that you've attended the morning CEPOD (Confidential Enquiries into Perioperative Deaths) meeting or contacted CEPOD theatres and anaesthetists on call.

2.9.1.3. Evacuation of the uterus should be performed by suction curettage (Grade A RCOG (Royal College of Obstetrics and Gynaecology) Recommendation).

2.9.1.4. At end of procedure, give PR (per rectum) Metronidazole.

2.9.1.5. Send products of conception for **histological analysis**. The tissue needs to be accompanied by a **signed 'cremation' form** so that it can be disposed of appropriately (Appendix 7).

2.9.1.6. Write clear operation notes- include:

- Size of uterus (in weeks).
- Degree of dilation of cervix and whether any difficulty was encountered.
- Confirm products of conception seen and sent for histology.
- Confirm cavity felt to be empty.
- Estimated blood loss.
- Metronidazole given (and sign drug chart).

2.9.1.7. **Check Rhesus status** and prescribe Anti D 1500 IU if Rhesus negative.

2.9.1.8. Complete the **discharge letter** on Maxims. As the surgeon, this is your responsibility **DO NOT** leave this for the 'ward' SHO to do. Document on letter to expect bleeding for up to 3 weeks and if it becomes heavy /

offensive to see GP.

2.9.2. **Nurses responsibility on day of operation**

2.9.2.1. Check patient details correct and **admission complete.**

2.9.2.2. **Baseline observations** (temperature, pulse, blood pressure).

2.9.2.3. Ensure **pre-operative checklist** completed.

2.9.2.4. Advise woman to **dress for theatre.**

2.9.2.5. Routine **post-operative observations** every ½ hour three times or as clinical condition indicates:

- Temperature.
- Pulse.
- Blood pressure.
- Oxygen saturations.
- PV (per vaginum) loss.

2.9.2.6. Before discharge home ensure:

- Diet and fluids tolerated.
- Woman passed urine.
- Venflons removed.
- Rhesus status checked and anti-D given if required.
- PV loss not excessive.

2.9.2.7. **Discharge letter** correctly distributed:

- One copy with patient for their records.
- One copy filed in notes.

2.10. Emergency admission with heavy bleeding / shock during miscarriage

Occasionally, women can bleed very heavily during a miscarriage (expectant / medical) or experience shock (hypotension / tachycardia) requiring emergency admission to hospital / attendance at the Emergency Department (ED). Pregnancy tissue (POC) stuck in the cervical os can cause a significant vagal response in some women, leading to shock.

If this occurs:

- Medical staff should be summoned.

- Resuscitate in accordance with Trust policy.
- An early speculum should be performed to detect POC (products of conception) in the cervical canal. If found, remove with sponge holding forceps.
- If bleeding heavily, give ergometrine 500mcg IV/ IM (intra muscular) or syntometrine 1 vial IM (contraindicated if history of hypertension) or syntocinon 5-10 units IV/ IM. Consider bimanual compression.
- If bleeding settles, arrange an ultrasound scan before discharge home.
- If heavy bleeding continues, immediate assessment by senior medical staff and consider surgical evacuation.

2.11. Disposal of Products of Conception

It is very important that you know what happens to the pregnancy tissue once it goes to the lab. Pregnancy tissue has to be disposed of in a sensitive manner. The routine is for all pregnancy tissue to be taken to Penmount crematorium and undergo collective cremation at regular intervals. You must obtain written consent for this and there is a section on the pre-printed consent forms which covers this and reads:

> "Following the procedure, tissue samples may be taken for analysis and kept as part of your patient record. We will treat all samples with dignity and respect. The hospital will arrange for a collective cremation at Penmount Crematorium together with other tissue of conception only. I understand there will be no ashes and that a non-denominational service is held in the Chapel."

There is a paragraph in the patient information leaflet which reads:

> **"What happens to the pregnancy tissue?**
>
> It is usual for any pregnancy tissue to be sent to the laboratory for analysis. We take the utmost care to treat the tissue with respect and dignity. Some of the pregnancy tissue (sometimes all) is then kept as part of your medical records. With your written consent, any remaining pregnancy tissue will be taken to Penmount crematorium for collective cremation with other pregnancy tissue. If you would like to consider a more personal option, such as burial please discuss this with the hospital staff. The hospital chaplain regularly gives a non-denominational blessing in the chapel on behalf of all those who have suffered a pregnancy loss.

If the woman doesn't want collective cremation, contact the bereavement office (via switchboard) and they will advise. Complete the relevant section in the 'Consent form for funeral arrangements after pregnancy loss'.

2.12. Follow Up Pregnancy Tests

All women who have a medical and expectant management of miscarriage should be given a pregnancy testing kit and advised to do a urine pregnancy test 10 days after the bleeding has stopped. If this is still positive, they should be advised to ring EGU.

They should be asked about symptoms of pain/ bleeding and if they are asymptomatic, advised to repeat the test in a week. If this is still positive, then they should be advised to come in for a serum bHCG ((beta- human chorionic gonadotropin) and senior review.

If they still have pain and bleeding, they should be advised to come in for a scan and serum bHCG and senior review.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	To audit the outcome and success of different managements of miscarriage.
Lead	Miss Lisa Verity, Consultant Obstetrics and Gynaecology Sarah Eddy ANP GOPD (Advanced Nurse Practitioner Gynaecology Outpatient Department).
Tool	Miscarriage database and Gynaecology dashboard on Q drive.
Frequency	Annually.
Reporting arrangements	EGU / EPU MDT (multi disciplinary team).
Acting on recommendations and Lead(s)	EGU and EPU MDT
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Management of Miscarriage Clinical Guideline V5.0
This document replaces (exact title of previous version):	Management of Miscarriage Clinical Guideline V4.2
Date Issued/Approved:	November 2023
Date Valid From:	November 2023
Date Valid To:	November 2026
Directorate / Department responsible (author/owner):	Sarah Eddy; Advanced Nurse Practitioner, Gynaecology Outpatients Department.
Contact details:	01872 252686
Brief summary of contents:	All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of miscarriages
Suggested Keywords:	Miscarriage. MVA. ERPC. Bleeding. Early pregnancy. Misoprostol.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology Specialty Meetings
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Melanie Gilbert

Information Category	Detailed Information
Links to key external standards:	Ectopic pregnancy and miscarriage: Diagnosis and initial management NICE clinical guideline 126. April 2019 Last updated: 23 August 2023
Related Documents:	Ectopic pregnancy and miscarriage: Diagnosis and initial management NICE clinical guideline 126. April 2019
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Gynaecology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
11 Jun 14	V1.0	Initial Issue	Lee Azancot; Data Administrator
16 Mar 15	V2.0	Mifepristone inclusion	Lisa Verity; Obs/ Gynae Consultant
11/04/2017	V3.0	Minor changes	Lisa Verity; Obs/ Gynae Consultant
08/07/2020	V4.0	Full review. Formatting updated. Section 2.10 updated in line with the MVA guideline.	Miss Lisa Verity; Consultant O and G

Date	Version Number	Summary of Changes	Changes Made by
11 Feb 21	V4.1	Point removed – previously point number 2.8.7 – 2.8.7. Prescribe prophylactic Antibiotics. Azithromycin 1g orally – pre-packed TTO to take that day.	Sarah Eddy; Advanced Nurse Practitioner
14 Sept 23	V5.0	Medical management regime updated: To include second dose of misoprostol. Updated nursing responsibilities in all choices. MVA patient preparation added: WHO checklist completed	Sarah Eddy; Advanced Nurse Practitioner

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Management of Miscarriage Clinical Guideline V5.0
Directorate and service area:	Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Miss Lisa Verity; Consultant Obstetrics and Gynaecology
Contact details:	01872 252686

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of miscarriages.
2. Policy Objectives	As above
3. Policy Intended Outcomes	As above
4. How will you measure each outcome?	See section 3
5. Who is intended to benefit from the policy?	All obstetric and gynaecology patients
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Obstetric and Gynaecology Specialty Meetings
6c. What was the outcome of the consultation?	Approved- 28 November 2023
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the patient's needs- i.e., available in different languages if required/ access to an interpreter if required
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patients with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on treatment.

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Miss Lisa Verity, Consultant Obstetrics and Gynaecology

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Consent Form 1- Medical Management of Miscarriage

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Forms/FormsToPrint/Specialty/Gynaecology/CHA4530ConsentForm1MedicalManagementOfMiscarriage.pdf

Appendix 4. Consent Form 1- Manual Vacuum Aspiration

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Forms/ConsentForms/ProcedureSpecificConsentForms/Gynaecology/AbortionManualVacuumAspirationOfPregnancyConsentCHA3280.pdf

Appendix 5. Consent Form 1- Surgical Evacuation of the Uterus

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Forms/FormsToPrint/Specialty/Gynaecology/CHA4532ConsentForm1SurgicalEvacuationOfTheUterus.pdf

Appendix 6. Consent Form for Funeral Arrangements After Pregnancy Loss (for 14-24 weeks gestations)

http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Forms/FormsToPrint/Specialty/MidwiferyAndObstetrics/CHA4628FuneralConsentFormForParentsAfterPregnancyLoss14To24WeeksGestations.pdf

Appendix 7. Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains

Histology Case Number	Collective Number
Crematorium Number	

CORNWALL COUNCIL

Cornwall Council
PENMOUNT CREMATORIUM, TRURO
Tel 01872 272871

CERTIFICATE OF MEDICAL PRACTITIONER OR MIDWIFE IN RESPECT OF FETAL REMAINS

(The products of conception expelled from the uterus before 24 weeks gestation which showed no visible signs of life)

I hereby certify that I have examined the fetal remains whose details are shown below:

Delivered on.....(Date) at.....am/pm of .....weeks gestation and which at no time showed any visible signs of life. Place of delivery .....

I have no reason to suspect that the duration of pregnancy was shortened by violence, poison or any unlawful act and I know of no reason why any further examination or enquiry should be made.

Tick one box

I confirm that informed written consent for collective cremation has been obtained. ☐
(Complete sections **A & B**)

I confirm that informed written consent for a private funeral has been obtained. ☐
The mother/parents understand that they may contact the Hospital Bereavement Office to discuss the options available and/or any financial concerns they may have.

(Complete sections **A & C**)

A) Doctor/Midwife details

Print Name..... Signature.....

Registered qualifications..... Date.....

Workplace ..... Tel.....

(Mother's details to be removed by bereavement office if remains are for collective cremation)

Funeral Arrangements

As explained these are the options available to you, please indicate your preference below:

B) The mother/parents would like the hospital to arrange collective cremation by means of a monthly collective cremation together with other tissue of conception only. ☐

C) The mother/parents would like to make private funeral arrangements. They will instruct a funeral director and advise the bereavement office accordingly within one month. ☐

Affix Patient Label