MANAGEMENT OF MISCARRIAGE - CLINICAL GUIDELINE

1. Aim/Purpose of this Guideline

All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of miscarriages

2. The Guidance

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 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)
- 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 (eg 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.

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 in place) if not

To contact the Gynaecology ward or EPU (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 one copy filed in notes

Check woman cancelled from STORK and community midwife informed by leaving a message for the ward clerk in fetal medicine dept (2682)

Advise to check pregnancy test 3 weeks after miscarriage and return if still positive

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

Medical management of miscarriage

Medical management of miscarriage is widely practised in the UK 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 & 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.

Doctor’s responsibility EGU / on ward pre-procedure

1. Full history on EGU history sheet. Include any medical problems, previous anaesthetic problems, medication history and allergies.
2. Get written, informed consent. Use the pre-filled RCHT standard consent forms only. Available in EGU or on the shared drive, (see appendix 1). 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) 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 1)

3. **Bloods** No need to take FBC unless clinically indicated. Group and hold sample not indicated routinely

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

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

5. **Prescribe** regimen

   - Mifepristone 200mg orally – omit if ‘incomplete miscarriage’
   - VAGINAL misoprostol 800 mcg (administer the tablets vaginally high in the posterior fornix - this can be given orally if refuse PV or bleeding)

6. **Prescribe analgesia.** Usually prepacked paracetamol 1g qds PRN – pack 16 x 500mg tablets (if patient hasn’t got own supply at home) and Ibuprofen 400mg tds PRN – pack 24 tablets (check contraindications to brufen including severe maternal asthma and history of previous or active peptic ulceration).

   Complete a **discharge letter** with the open access contact numbers in the ‘comments’ section

**Nurse’s responsibility pre-procedure in EGU / on ward**

1. **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. **Give RCHT patient information leaflet** No 969 ‘Medical management of your miscarriage’ with emergency contact numbers.

3. **Give miscarriage association leaflet**

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

5. Give prepacked misoprostol and prepacks of analgesia

6. Check woman cancelled from STORK and community midwife informed by leaving a message for the ward clerk in fetal medicine dept (2682)

7. Complete proforma and ensure have patients contact details for follow up telephone consultation

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

9. Establish whether the woman wants to bring in the tissue for histological evaluation and if so, make the necessary arrangements.
10. Book in EGU diary for telephone follow up consultation for the next working day following misoprostol.
11. Give patient urine pregnancy test (with instructions) to perform 3 weeks after miscarriage.
12. Administer Mifepristone 200mg orally (to be taken in front of you) – unless incomplete miscarriage – and allow home.

Follow up Telephone consultation day following procedure:

1. Ensure woman gives a good account of miscarriage – ie heavy bleeding giving description of passing clots & ‘tissue’. If ANY doubt – offer follow up scan in EGU.
2. Complete proforma.
3. Advise to do urine pregnancy test 3 weeks after miscarriage and to phone EGU if still positive.
4. Complete discharge letter and send a copy to patient. In comments ‘Telephone consultation undertaken today following medical management of miscarriage at home. Woman gives good account of miscarriage and she has been advised that bleeding may last for up to 3 weeks. If at any point it gets heavier / smelly / offensive or she is feeling unwell, she should see her doctor for consideration of antibiotics (eg. Augmentin) or referral back to EGU. Woman has been advised to do a urine pregnancy test 3 weeks after miscarriage and if still positive she should contact EGU (01872 252686).

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

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 & 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

Doctor's responsibility on ward / EGU pre-operatively

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. Examination You do not need to do a speculum / vaginal examination unless they have severe pain / bleeding.
3. Get written, informed consent. Use the pre-filled RCHT standard consent forms only. Available in EGU or on the shared drive (see Appendix 2). Obtain written consent for collective cremation of pregnancy tissue / make other arrangements via the bereavement office (see Appendix 1).
4. Bloods: FBC / G&H – ensure results are written in notes before theatre.
5. **Prescribe cervical ripening agent** to ALL women (400mcg Misoprostol orally 06.00 morning of surgery) on a TTO prescription. Contraindications to misoprostol:
   - severe maternal asthma
   - maternal adrenal insufficiency disease
   - Ischaemic heart disease
   - Sickle cell disease

6. **Prescribe analgesia for discharge home.** Usually prepacked paracetamol 1g qds PRN – pack 16 x 500mg tablets (if patient hasn’t got own supply at home) and Ibuprofen 400mg tds PRN – pack 24 tablets (check contraindications to brufen including severe maternal asthma and history of previous or active peptic ulceration)

7. **Prescribe prophylactic Antibiotics.** Azithromycin 1g orally – pre-packed TTO to take that day. Metronidazole 1g PR on front of drug chart to be given in theatre with patient’s consent.

8. **Prescribe Anti D to all Rhesus negative women** on hospital prescription chart.

9. **Complete a discharge summary**

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

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

1. Ensure **theatre slot booked on appropriate list** or appointment in EGU for MVA
2. 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.
3. Complete **admission on day case profile**
4. Dispense **misoprostol and analgesia and azithromycin** prescribed from stock cupboard or send patient to hospital pharmacy to collect out patient prescription.
5. 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.
6. Give **miscarriage association leaflet**
7. Check woman cancelled from STORK and community midwife informed by leaving a message for the ward clerk in fetal medicine dept (2682)
8. Check any further EPU appointments have been cancelled

**Manual Vacuum Aspiration (See separate MVA Guideline)**

1. Patient Preparation
   - Before the treatment begins, the woman should be introduced to the nurse/assistant and doctor, the procedure should be reviewed with her, including the use and benefits of entonox and any questions she has should be answered.
   - The treatment doctor should review the woman’s medical history, gestational age dating (i.e. ultrasound).
   - An initial set of observations (pulse and blood pressure) should be taken and recorded in the case notes.
   - The woman should be asked to void shortly before the procedure; urinary bladder catheterisation is not recommended.
• 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 doctor is ready to proceed.
• An entonox mask or mouthpiece should be offered to the woman and instructions on its use provided.

2. Uterine evacuation

• A bimanual pelvic examination should be performed to assess the uterine size and position or the USS 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 should 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.
• Intra or para cervical infiltration of 1% Prilocaine (Citanest) or equivalent is recommended: instillation of intra-cervical Lidocaine gel is an option.
• 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, treatment doctors may attach the charged syringe to the cannula 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’. It is sometimes more efficient to have more than one ‘charged’ aspirator available for use, particularly at higher gestations.
• 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.

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.
• If the sac is not identified, perform a vaginal ultrasound. If no sac is seen in the uterus, send tissue for histology and refer client immediately for evaluation of possible ectopic pregnancy. If a sac is seen, reaspirate. Consider continuous ultrasound guidance throughout aspiration.
• If MVA has been performed for retained products of conception or haemotometra, a gestational sac may not be seen. Documentation of what was visualised should occur. Post-procedure ultrasound may also be helpful to document that the aspiration was complete.
• All tissue is sent for histological evaluation (unless woman declines) and MUST be accompanies by a signed cremation form. (Appendix 5)

4. Post-procedure care

• When the treatment doctor confirms that the treatment is complete, the woman is assisted from the couch, allowed to rest and taken from to a recliner chair to recover.
• As a minimum, one set of post-procedure observations should be recorded in the case notes.
• Check woman’s Rhesus status and if non-sensitised Rhesus negative, administer Anti D
• Refreshment is offered to the woman at an appropriate time
• When the patient is fully recovered, she can be discharged by the nurse.

Duration of stay in the clinic/unit

• Procedure duration is typically 10-15 minutes and recovery time 30-45 minutes.

Anti-biotic prophylaxis
Ant-biotic prophylaxis should be provided to all clients prior to MVA. 1g oral azithromycin and 400mg oral metronidazole

**Aftercare**

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

**Surgical Evacuation under GA**

**Surgeon’s responsibility on day of operation**

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. Evacuation of the uterus should be performed by **suction curettage** (Grade A RCOG Recommendation).
3. At end of procedure, give PR Metronidazole
4. 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 5).
5. **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)
6. **Check Rhesus status** and prescribe Anti D 1500 IU if Rhesus negative
7. Complete the **discharge letter** on Maxim’s. 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

**Nurses responsibility on day of operation**

1. Check patient details correct and **admission complete**
2. **Baseline observations** (temperature, pulse, blood pressure)
3. Ensure **pre-operative checklist** completed
4. Advise woman to **dress for theatre**
5. Routine **post operative observations** every ½ hour three times or as clinical condition indicates.
   - Temperature
   - Pulse
   - blood pressure
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
7. Discharge letter correctly distributed
   - One copy with patient for their records
   - One copy filed in notes
8. Check woman cancelled from STORK and community midwife informed by leaving a message the ward clerk in the fetal medicine dept (2682)
9. Check any further EPU appointments have been cancelled

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 A&E. 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 in the cervical canal. If found, remove with sponge holding forceps
   - If bleeding heavily, give ergometrine 500mcg IV/IM or syntometrine 1 vial IM (contraindicated if history of hypertension) or syntocinon 5-10 units IV / IM
   - If bleeding settles, arrange an ultrasound scan before discharge home
   - If heavy bleeding continues, immediate assessment by senior medical staff and consider surgical evacuation.

Reference: Ectopic pregnancy & miscarriage: Diagnosis and initial management. NICE clinical guideline 154. Dec 2012
CONSENT FORM 1 (Patient copy)
Procedure Specific Patient Agreement

Medical Management of Miscarriage

To treat miscarriage using tablets

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:

- To treat miscarriage using tablets and performing a pregnancy test after two to three weeks to ensure that miscarriage is complete

Significant, unavoidable or frequently occurring risks:

- Pain, bleeding similar to heavy period. Rarely this can require a blood transfusion or surgery
- Infection
- Side effects of misoprostol (vomiting, diarrhoea, shivering, flatulence, rashes, dizziness)
- Failure to work or incomplete miscarriage needing surgical evacuation (1 in 10)

Uncommon but more serious risks:

- [ ]

Any extra procedures which may become necessary during the procedure:

- Blood transfusion - Rarely - only if particularly heavy bleeding
- Other procedure (please specify):

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA969, along with a copy of this consent

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:
- General and/or regional anaesthesia [x]
- Local anaesthesia [ ]
- Sedation [ ]

Health Professional signature: _____________________________ Date: _____________________________

Name (PRINT): _____________________________ Job title: _____________________________

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: _____________________________ Name (PRINT): _____________________________ Date: _____________________________
# Medical Management of Miscarriage

## STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment describe on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaeasthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand that tissue samples will only be taken in relation to the procedure explained to me. No samples will be taken for quality control, clinical education or research purposes.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA969 which forms part of this document.

Patient signature: __________________________ Name (PRINT): __________________________ Date: __________

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

Witness signature: __________________________ Name (PRINT): __________________________ Date: __________

## CONFIRMATION OF CONSENT

(to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: __________________________ Date: __________

Name (PRINT): __________________________ Job title: __________________________

## Important notes (tick if applicable):

- [ ] See advance decision to refuse treatment
- [ ] Patient has withdrawn consent (ask patient to sign/date here)

Patient signature: __________________________ Name (PRINT): __________________________ Date: __________
CONSENT FORM 1 (File copy)
Procedure Specific Patient Agreement

Medical Management of Miscarriage

To treat miscarriage using tablets

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:

* To treat miscarriage using tablets and performing a pregnancy test after two to three weeks to ensure that miscarriage is complete

Significant, unavoidable or frequently occurring risks:

* pain, bleeding similar to heavy period. Rarely this can require a blood transfusion or surgery infection

Side effects of misoprostol (vomiting, diarrhoea, shivering, flatulence, rashes, dizziness)

Failure to work or incomplete miscarriage needing surgical evacuation (1 in 10)

Uncommon but more serious risks:

* Any extra procedures which may become necessary during the procedure:

  * Blood transfusion  Rarely - only if particularly heavy bleeding
  * Other procedure (please specify):

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA969, along with a copy of this consent.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:

General and/or regional anaesthesia  Local anaesthesia  Sedation

Health Professional signature:  Date:

Name (PRINT):  Job title:

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature:  Name (PRINT):  Date:
CONSENT FORM 1 (File copy)
Procedure Specific Patient Agreement

Medical Management of Miscarriage

STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment.

If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand that tissue samples will only be taken in relation to the procedure explained to me.

No samples will be taken for quality control, clinical education or research purposes.

I have been told about additional procedures which may become necessary during my treatment.

I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information Leaflet CHA369 which forms part of this document.

Patient signature: __________ Name (PRINT): __________ Date: __________

A witness should sign below if this patient is unable to sign but has indicated his or her consent.

Young people/children may also like a parent to sign here (see guidance notes).

Witness signature: __________ Name (PRINT): __________ Date: __________

CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: __________ Job title: __________ Date: __________

Important notes (tick if applicable):

☐ See advance decision to refuse treatment

☐ Patient has withdrawn consent (ask patient to sign/date here)

Patient signature: __________ Name (PRINT): __________ Date: __________
Manual Vacuum Aspiration 'MVA'

operation to remove pregnancy tissue from within the womb, under local anaesthetic

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:

- To treat miscarriage

Significant, unavoidable or frequently occurring risks:

- infection (may require antibiotics 3 in 100 women)
- Bleeding (usually a little heavier and more prolonged than a period would be, heavy bleeding uncommon 1-2 in 1000 women)
- Repeat operation (if all the pregnancy tissue not removed 5 in 100 women)
- Feeling faint

Uncommon but more serious risks:

- reaction to local anaesthetic
- surgical complications (eg perforation of womb up to 5 in 1000 which may very rarely lead to damage of internal organs), trauma to cervix

Any extra procedures which may become necessary during the procedure:

- Blood transfusion - rarely required - only if particularly heavy bleeding
- Other procedure (please specify): Rarely during the operation a hole can be made in the womb. If this happened, a laparoscopy (keyhole surgery) or laparotomy (open operation) may be required to repair any injury.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA1249, along with a copy of this consent.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:

- General and/or regional anaesthesia
- Local anaesthesia [X]
- Sedation [ ]

Health Professional signature: [ ]

Name (PRINT): [ ]

Job title: [ ]

Date: [ ]

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: [ ]

Name (PRINT): [ ]

Date: [ ]
**Manual Vacuum Aspiration 'MVA'**

**STATEMENT OF PATIENT**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment describe on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand tissue samples may be taken for analysis and kept as part of my patient record. Any sample arising from a pregnancy will be treated with dignity and respect. The hospital will arrange for collective cremation of the products of conception (unless otherwise indicated here that a separate consent has been taken □)

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA1249 which forms part of this document.

Patient signature: __________________________ Name (PRINT): __________________________ Date: ____________

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

Witness signature: __________________________ Name (PRINT): __________________________ Date: ____________

**CONFIRMATION OF CONSENT** (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: __________________________ Date: ____________

Name (PRINT): __________________________ Job title: __________________________

Important notes (tick if applicable - ask patient to sign/date here):

☐ See advance decision to refuse treatment ☐ Patient has withdrawn consent

Patient signature: __________________________ Name (PRINT): __________________________ Date: ____________
Manual Vacuum Aspiration 'MVA'

operation to remove pregnancy tissue from within the womb, under local anaesthetic

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:

- To treat miscarriage
- Significant, unavoidable or frequently occurring risks:
  - Infection (may require antibiotics 3 in 100 women)
  - Bleeding (usually a little heavier and more prolonged than a period would be, heavy bleeding uncommon 1-2 in 1000 women)
  - Repeat operation (if all the pregnancy tissue not removed 5 in 100 women)
  - Feeling faint
- Uncommon but more serious risks:
  - Reaction to local anaesthetic
  - Surgical complications (e.g., perforation of womb up to 5 in 1000 which may very rarely lead to damage of internal organs), trauma to cervix
- Any extra procedures which may become necessary during the procedure:
  - Blood transfusion rarely required - only if particularly heavy bleeding
  - Other procedure (please specify): Rarely during the operation a hole can be made in the womb. If this happened, a laparoscopy (keyhole surgery) or laparotomy (open operation) may be required to repair any injury.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA1249, along with a copy of this consent.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:

- General and/or regional anaesthesia
- Local anaesthesia
- Sedation

Health Professional signature: ___________________________ Date: ____________

Name (PRINT): ___________________________ Job title: ___________________________

STATEMENT OF INTERPRETER (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: ___________________________ Name (PRINT): ___________________________ Date: ____________
STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand tissue samples may be taken for analysis and kept as part of my patient record. Any sample arising from a pregnancy will be treated with dignity and respect. The hospital will arrange for collective cremation of the products of conception (unless otherwise indicated here that a separate consent has been taken)

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA1249 which forms part of this document.

Patient signature: ___________________________ Name (PRINT): ___________________________ Date: ___________________________

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

Witness signature: ___________________________ Name (PRINT): ___________________________ Date: ___________________________

CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: ___________________________ Job title: ___________________________ Date: ___________________________

Important notes (tick if applicable - ask patient to sign/date here):

☐ See advance decision to refuse treatment ❑ Patient has withdrawn consent

Patient signature: ___________________________ Name (PRINT): ___________________________ Date: ___________________________
CONSENT FORM 1 (Patient copy)
Procedure Specific Patient Agreement

Surgical evacuation of the uterus
(operation to remove pregnancy tissue from within the womb)

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:
• To treat miscarriage

Significant, unavoidable or frequently occurring risks:
• Infection (may require antibiotics - 3 in 100 women)
  Bleeding (usually a little heavier and more prolonged than a period would be, heavy bleeding uncommon 1-2 in 1000 women)
  Repeat operation (if all pregnancy tissue not removed up to 5 in 100 women)

Uncommon but more serious risks:
• Anaesthetic problems
  Surgical complications (e.g. perforation of womb up to 5 in 1000 women which may very rarely lead to damage of internal organs, trauma to cervix

Any extra procedures which may become necessary during the procedure:
• Blood transfusion Rarely required - only if particularly heavy bleeding
• Other procedure (please specify): Rarely during the operation a hole can be made in the womb. If this happens, a laparoscopy (keyhole surgery) or laparotomy (open operation) may be required to repair any injury to internal organs (e.g. bowel surgery).

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA970, along with a copy of this consent

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:
General and/or regional anaesthesia ☒ Local anaesthesia ☐ Sedation ☐

Health Professional signature: __________________________ Date: ______________

Name (PRINT): __________________________ Job title: __________________________

STATEMENT OF INTERPRETER (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: __________________________ Name (PRINT): __________________________ Date: ______________
Surgical evacuation of the uterus

**STATEMENT OF PATIENT**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment describe on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand tissue samples may be taken for analysis and kept as part of my patient record. Any sample arising from a pregnancy will be treated with dignity and respect. The hospital will arrange for collective cremation of the products of conception (unless otherwise indicated here that a separate consent has been taken)

☐

I have been told about additional procedures which may become necessary during my treatment.

I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA970 which forms part of this document.

Patient signature:  

Name (PRINT):  

Date:

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

Witness signature:  

Name (PRINT):  

Date:

**CONFIRMATION OF CONSENT** (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature:  

Date:

Name (PRINT):  

Job title:

Important notes (tick if applicable - ask patient to sign/date here):

☐ See advance decision to refuse treatment  

☐ Patient has withdrawn consent

Patient signature:  

Name (PRINT):  

Date
CONSENT FORM 1 (Final copy)
Procedure Specific Patient Agreement

Surgical evacuation of the uterus
(operation to remove pregnancy tissue from within the womb)

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:
- To treat miscarriage

Significant, unavoidable or frequently occurring risks:
- Infection (may require antibiotics - 3 in 100 women)
  Bleeding (usually a little heavier and more prolonged than a period would be, heavy bleeding uncommon 1-2 in 1000 women)
  Repeat operation (if all pregnancy tissue not removed up to 5 in 100 women)

Uncommon but more serious risks:
- Anaesthetic problems
  Surgical complications (e.g. perforation of womb up to 5 in 1000 women which may very rarely lead to damage of internal organs), trauma to cervix

Any extra procedures which may become necessary during the procedure:
- Blood transfusion  Rarely required - only if particularly heavy bleeding
- Other procedure (please specify):  Rarely during the operation a hole can be made in the womb. If this happens, a laparoscopy (keyhole surgery) or laparotomy (open operation) may be required to repair any injury to internal organs (e.g. bowel surgery).

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA970, along with a copy of this consent

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:
General and/or regional anaesthesia  ✔  Local anaesthesia  ❑  Sedation ❑

Health Professional signature:  
Name (PRINT):  Date:
Job title:

STATEMENT OF INTERPRETER (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature:  Name (PRINT):  Date:
CONSENT FORM 1 (File copy)  
Procedure Specific Patient Agreement  

Surgical evacuation of the uterus

### STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand tissue samples may be taken for analysis and kept as part of my patient record. Any sample arising from a pregnancy will be treated with dignity and respect. The hospital will arrange for collective cremation of the products of conception (unless otherwise indicated here that a separate consent has been taken) ☐

I have been told about additional procedures which may become necessary during my treatment.

I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA970 which forms part of this document.

<table>
<thead>
<tr>
<th>Patient signature:</th>
<th>Name (PRINT):</th>
<th>Date:</th>
</tr>
</thead>
</table>

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

<table>
<thead>
<tr>
<th>Witness signature:</th>
<th>Name (PRINT):</th>
<th>Date:</th>
</tr>
</thead>
</table>

### CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

<table>
<thead>
<tr>
<th>Health Professional signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name (PRINT):</th>
<th>Job title:</th>
</tr>
</thead>
</table>

Important notes (tick if applicable - ask patient to sign/date here):

- ☐ See advance decision to refuse treatment
- ☐ Patient has withdrawn consent

<table>
<thead>
<tr>
<th>Patient signature:</th>
<th>Name (PRINT):</th>
<th>Date:</th>
</tr>
</thead>
</table>
Appendix 3

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?
As a routine, the samples we remove at the operation are sent to the laboratory for tests. We all take the utmost care to treat the tissue with respect and dignity. Once the tests are complete, the pregnancy tissue will be taken to Penmount crematorium for cremation. The hospital chaplain regularly gives a non-denominational blessing in the chapel on behalf of all those who have suffered a miscarriage. We may store a tiny bit of tissue in wax and on a slide as part of your medical record; this will be about the size of a 50p coin. We will need to obtain your written consent for this. If you do not wish this to happen / want to discuss alternatives, please discuss with nurses / doctors who will put you in contact with the bereavement officers.

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’.

Appendix 4
Follow up pregnancy tests
All women who have a medical & expectant management of miscarriage should be given a pregnancy testing kit and advised to do a urine pregnancy test a week 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 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

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>To audit the outcome &amp; success of different managements of miscarriage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Miss Lisa Verity, Consultant O&amp;G</td>
</tr>
<tr>
<td>Tool</td>
<td>Miscarriage database &amp; Gynaecology dashboard on Q drive</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>EGU / EPU MDT</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>EGU &amp; EPU MDT</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>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</td>
</tr>
</tbody>
</table>

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 & Human Rights 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

<table>
<thead>
<tr>
<th>Document Title</th>
<th>MANAGEMENT OF MISCARRIAGE - CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>11/04/2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>08/06/2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>08/06/2020</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Miss Lisa Verity Consultant O&amp;G</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252685</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>All clinical staff working in the Division of women, children &amp; sexual health to provide evidence based guidance in the management of miscarriages</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Miscarriage MVA ERPC bleeding early pregnancy misoprostol</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>11/04/2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>MANAGEMENT OF MISCARRIAGE - CLINICAL GUIDELINE</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Obstetric &amp; Gynaecology Directorate meeting</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Gynae</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>Ectopic pregnancy &amp; miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy &amp; miscarriage. NICE clinical guideline 154. Dec 2012</td>
</tr>
</tbody>
</table>
Related Documents:
Ectopic pregnancy & miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy & miscarriage. NICE clinical guideline 154. Dec 2012
List other guidelines & hyperlink guidelines in document library

Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Jun 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Lee Azancot Data Administrator</td>
</tr>
<tr>
<td>16 Mar 15</td>
<td>V2.0</td>
<td>Mifepristone inclusion</td>
<td>Lisa Verity Obs/Gynae Consultant</td>
</tr>
<tr>
<td>11/04/2017</td>
<td>V3.0</td>
<td>Minor changes</td>
<td>Lisa Verity Obs/Gynae Consultant</td>
</tr>
</tbody>
</table>

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

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as <em>policy</em>) (Provide brief description): MANAGEMENT OF MISCARRIAGE - CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong> Gynaecology</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong> Miss Lisa Verity</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - Who is the strategy / policy / proposal / service function aimed at?
   - All clinical staff working in the Division of women, children & sexual health 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 the outcome?**
   - See section 3

5. **Who is intended to benefit from the policy?**
   - All obs & gynae patients

6a) **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**
   - No

   b) If yes, have these *groups been consulted?*

   C). Please list any groups who have been consulted about this procedure.

**7. The Impact**

Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical Guideline Template

Page 26 of 30
### Sex (male, female, transgender / gender reassignment)

- **Yes**

### Race / Ethnic communities /groups

- **Yes**

### Disability -
- learning
disability, physical
disability, sensory
impairment and
mental health
problems

- **Yes**

### Religion / other beliefs

- **Yes**

### Marriage and civil partnership

- **Yes**

### Pregnancy and maternity

- **Yes**

### Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian

- **Yes**

---

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. **or**
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

9. If you are not recommending a Full Impact assessment please explain why.

---

Signature of policy developer / lead manager / director

Date of completion and submission

Names and signatures of members carrying out the Screening Assessment

1. Miss Lisa Verity
2.

---

**Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD**

A summary of the results will be published on the Trust’s web site.

Signed ____________________________

Date ____________________________
Appendix 4. Consent form for funeral arrangements after pregnancy loss (for 14-24 weeks gestation)

Royal Cornwall Hospitals NHS
NHS Trust

What happens to our baby?

As explained in the leaflet you have been given, there are some options available to you. Please indicate which you would prefer

I would like the hospital to arrange cremation
I understand that the hospital will dispose of my baby sensitively by means of a monthly 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. I understand that it will not be possible for me to attend the cremation.

☐

I would like to make private arrangements for a funeral
I would like to make my own arrangements for a private funeral and I will instruct a Funeral Director at my own expense.

☐

I would like to arrange a home burial
I would like to take my baby for burial at home.
I understand I am required to contact my County Council for advice.

☐

I have not yet made a decision regarding these arrangements
I understand I have up to one month to make a decision and I will make contact with the Hospital Bereavement Office in that time.
I understand that if I don't make contact within that time the hospital will arrange cremation on my behalf. This is a collective cremation with other pregnancy losses conducted monthly at Penmount Crematorium. I understand the hospital will NOT contact me with details.

☐

I understand that I may contact the Hospital Bereavement Office to discuss the options available and/or any financial concerns I may have.

Patient Label

Print name Signature

Options explained and consent from parent obtained by

Print name Signature Date

Procedure for the sensitive disposal of pre-24 week fetal tissue
Appendix 5

Appendix 5. Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains

Histology Case Number

Crematorium Number

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

Procedure for the sensitive disposal of pre-24 week fetal tissue

Page 16 of 48