Royal Cornwall Hospitals
NHS Trust

Surgical Abortion Quality Standards Clinical Guideline

V2.0

August 2023

Summary

This document provides guidance to new nurses, Health Care Assistant's (HCA's), colleagues, locums, or trainees so they can understand how the team works and what standards are expected.

The aim is to reduce variation in quality and ensure that best practice is maintained across the service. These should help to ensure our own quality is maintained- at recruitment, when a candidate applies, when a new trainee joins us with prior experience etc., they can read this and understand how the rest of the team operate and what patients will have been counselled to expect. It is also publicly available to reassure stakeholders of our expectations.

This guidance is available in a format suitable for printing and laminating in Appendix 3 to be given to new nurses, HCAs, colleagues, locums, or trainees so they can understand how the team works and what standards are expected.

In terms of using them, it is suggested that a laminated copy be kept in the treatment room for visitors (student nurses, new HCAs etc.), a copy on the documents library to link any Freedom of Information requests to and for the current consultants to use for new trainees, when talking to candidates looking for posts etc.

1. Aim/Purpose of this Guideline

1.1. This document provides guidance to all staff who are involved with Surgical Abortion at RCHT.

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

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

The Trust has a duty under the Data Protection Act 2018 and 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 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 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

The following guidance is available in a format suitable for printing and laminating in Appendix 3.

2.1. Pre-operative

2.1.1. Prior to the procedure the surgeon must see the woman in a private location (e.g., office or day room) and give her the opportunity to ask any questions and to raise any concerns out of hearing of other patients. The only exceptions are if the surgeon has already obtained consent from the woman and is confident she has no further questions, or where it would be distressing for the woman to move.

2.1.2. Informed consent is essential- this is best achieved where the woman has been able to review the consent form before making her decision, so that she can consider her options and raise and questions or concerns at each consultation. The surgeon must be reassured that:

- The woman understands the procedure.
- She is aware that period-like loss and pain is likely afterwards.
- She has analgesia for use after discharge (usually self-bought ibuprofen and / or paracetamol).

- She has used cervical preparation correctly (if not, misoprostol should be prescribed as buccal or sub-lingual for immediate use).

- Her choice of contraception is actioned.

- That she is safe to use tampons, have baths/ showers and to resume intercourse when she feels comfortable to do so.

2.1.3. For procedures under local anaesthesia, all women should be offered a choice of adjuvants to the main paracervical block. This may include, depending on patient choice, self-administered prilocaine/lidocaine cream 5-10 minutes prior to the procedure, lidocaine 10% spray, methoxyflurane inhalation.

2.1.4. Where LNG-IUD (e.g., “Mirena”) is chosen the woman should be informed that light, irregular bleeding may be experienced for up to a year (but that there should be an improvement in symptoms after six months), and for both LNG-IUD & IUCD that she understands the recommendation for and process of self-check of thread.

2.1.5. Where oral contraception is chosen, confirm that she has a stock to start the next day.

2.2. Procedure

2.2.1. Procedures are offered up to 14 weeks gestation. There is no lower limit but under 6 weeks the surgeon must be confident they have removed the pregnancy (e.g., by pre and post procedure scans).

2.2.2. If procedures are performed prior to 6 weeks or after 14 weeks, or if definite products of conception (POC) are not visualised, ultrasound should be used to confirm the uterus is empty.

2.2.3. Where anti-D is needed this is given intravenously during the procedure whilst under general anaesthetic (GA), or for procedures under local anaesthesia (Manual Vacuum Aspiration - MVAs) at the end of the procedure (usually intra muscular (IM)).

2.2.4. Metronidazole 1g pr is given as the first line prophylactic antibiotic.

2.2.5. Contraceptive implant or injection are administered whilst under GA, or for MVAs immediately after the procedure.

2.2.6. Oxytocin is not routinely administered but should be available if required.

2.3. MVA (Manual Vacuum Aspiration – procedure under local anaesthesia)

2.3.1. Aim to keep the whole process as “office based” as possible so as to create an environment as reassuring as possible to reduce anxiety. It is therefore not necessary formally to recheck the WHO checklist or the

consent form in front of the patient in the treatment room if the surgeon is satisfied safe processes have been followed (and they are following on from having just assessed the patient themselves). Dress/ uniform is at the discretion of each team member with the aim of portraying a caring, professional environment whilst being comfortable (e.g., wearing scrubs, uniform, clinic-based “office” clothes depending on preference).

2.3.2. Ensure the highest standards of professionalism are delivered consistently- e.g., friendly greeting, ensuring everybody introduces themselves, making the privacy, dignity, and comfort of the patient a priority (e.g., privacy for changing, ensuring the pillow is properly positioned and the patient is as comfortable as possible, never leaving the patient unnecessarily exposed, offering support/ drink/ fan/ blanket as appropriate). Whilst the healthcare assistant’s (HCA’s) primary responsibility is to act as the woman’s advocate and to alert the surgeon of any concerns, her role is also to create a friendly environment and to relax the woman by encouraging friendly conversation, unless the woman would prefer not to engage.

2.3.3. In the treatment room, the woman should have a drawer sheet to cover her knees at all times, with further exposure kept to the minimum necessary to perform the procedure.

2.3.4. A heat pad should be offered to all women at the start of the procedure, and inhaled analgesia be available if needed.

2.3.5. A nurse or HCA should act as the patient’s advocate and be empowered to alert the surgeon immediately if there is significant distress or she is concerned about the patient’s wellbeing.

2.3.6. When preparing the equipment, keep the instruments covered and always keep them out of eyesight of the patient.

2.3.7. For operative procedures requiring local anaesthesia, the standard technique is of a four-site paracervical block given deep into the fornices (plus one intracervical for the vulsellum), with sufficient time given for it to be effective. Intrauterine local anaesthesia should be used (e.g., Instillagel).

2.4. Post-operative

2.4.1. All women should be invited to complete a patient-reported outcome form that includes pain score and the NHS standard quality questions- the surgeon should ensure the staff and procedure details are completed correctly. The aim is that reported pain is expected to be equivalent or less than that from natural menstruation.

2.4.2. A written discharge letter is provided to the woman which includes the ongoing contraceptive plan.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with policy.
Lead	Clinical lead for abortion service.
Tool	Patient reported outcome form. Review at staff brief/ de-brief.
Frequency	All patients are invited to complete an outcome form. Results should be used for each clinician's annual appraisal and for rolling audit.
Reporting arrangements	Audit results are presented at departmental governance meeting. Individual clinicians use their own data in their annual appraisal. The standards should be reviewed at each time briefing where a new staff member is present.
Acting on recommendations and Lead(s)	Clinical lead for abortion service. Directorate of obstetrics and gynaecology – governance and directorate meetings.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/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:	Surgical Abortion Quality Standards Clinical Guideline V2.0
This document replaces (exact title of previous version):	Surgical Abortion Quality Standards Clinical Guideline V1.0
Date Issued/Approved:	August 2023
Date Valid From:	August 2023
Date Valid To:	August 2026
Directorate / Department responsible (author/owner):	Mr. Jonathan Lord, Consultant
Contact details:	01872 252730
Brief summary of contents:	Quality Standards for Surgical Abortion
Suggested Keywords:	Abortion, manual vacuum aspiration, MVA, termination of pregnancy, TOP.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology business meeting
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Caroline Amukusana
Links to key external standards:	NICE NG140, NICE QS199, RCOG Best practice in abortion care (Best Practice Paper), WHO abortion care guideline
Related Documents:	Abortion Services Operational Policy

Information Category	Detailed Information
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 No	Summary of Changes	Changes Made by *(Name and Job Title)*
December 2020	V1.0	Initial version	Mr. Jonathan Lord, Consultant
July 2023	V2.0	Minor revisions to reflect changes introduced during the COVID pandemic (e.g. consent process, use of adjuvants) and including NICE quality standard	Mr. Jonathan Lord

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. Initial Equality Impact Assessment Form

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:	Surgical Abortion Quality Standards Clinical Guideline V2.0
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):	Mr. Jonathan Lord, Consultant
Contact details:	01872 252730

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)	To reduce variation in quality and ensure that best practice is maintained across the service.
2. Policy Objectives	Short two-sided guide formatted to be given to new nurses, HCAs, colleagues, locums or trainees so they can understand how the team works and what standards are expected.
3. Policy Intended Outcomes	Improved patient care and experience
4. How will you measure each outcome?	Patient reported outcome measure
5. Who is intended to benefit from the policy?	Patients and staff

Information Category	Detailed Information
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
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gynaecology business meeting. All consultants and clinical staff within the abortion service.
6c. What was the outcome of the consultation?	Approved 04 August 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.

Protected Characteristic	(Yes or No)	Rationale
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 the decision to treat.
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: Mr. Jonathon Lord

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. Guidance in a format suitable for printing and laminating:

See next 3 pages.

Royal Cornwall Hospitals NHS Trust

Quality Standards for Surgical Abortion at RCHT

Guidance for all Team Members

Pre-operative

Prior to the procedure the surgeon must see the woman in a private location (e.g., office or day room) and give her the opportunity to ask any questions and to raise any concerns out of hearing of other patients. The only exceptions are if the surgeon has already obtained consent from the woman and is confident she has no further questions, or where it would be distressing for the woman to move.

Written Informed consent is essential – this is best achieved where the woman has been able to review the consent form before making her decision, so that she can consider her options and raise and questions or concerns at each consultation. The surgeon must be reassured that:

- the woman understands the procedure.
- she is aware that period-like loss and pain is likely afterwards.
- she has analgesia for use after discharge (usually self-bought ibuprofen and / or paracetamol).
- she has used cervical preparation correctly (if not, misoprostol should be prescribed as buccal or sub-lingual for one hour pre-operatively).
- her choice of contraception is actioned.
- that she is safe to use tampons, have baths/ showers and to resume intercourse when she feels comfortable to do so.

For procedures under local anaesthesia, all women should be offered a choice of adjuvants to the main paracervical block. This may include, depending on patient choice, self-administered prilocaine/lidocaine cream 5-10 minutes prior to the procedure, lidocaine 10% spray, methoxyflurane inhalation.

Where LNG-IUD (e.g., “Mirena”) is chosen the woman should be informed that light, irregular bleeding may be experienced for up to a year (but that there should be an improvement in symptoms after six months), and for both LNG-IUD & IUCD that she understands the recommendation for and process of self-check of thread.

Where oral contraception is chosen, confirm that she has a stock to start the next day and provide it if needed.

Procedure

Procedures are offered up to 14 weeks gestation. There is no lower limit but under 6 weeks the surgeon must be confident they have removed the pregnancy (e.g., by pre and post procedure scans)

If procedures are performed prior to 6 weeks or after 14 weeks, or if definite products of conception (POC) are not visualised, ultrasound should be used to confirm the uterus is empty.

Where anti-D is needed this is given intravenously during the procedure whilst under general anaesthetic (GA), or for procedures under local anaesthesia (MVAs) at the end of the procedure (usually IM).

Metronidazole 1g pr is given as the first line prophylactic antibiotic.

Contraceptive implant or injection are administered whilst under GA, or for MVAs immediately after the procedure.

Oxytocin is not routinely administered but should be available if required.

MVA (Manual Vacuum Aspiration – procedure under local anaesthesia)

Aim to keep the whole process as "office based" as achievable so as to create an environment as reassuring as possible to reduce anxiety. It is therefore not necessary formally to recheck the WHO checklist or the consent form in front of the patient in the treatment room if the surgeon is satisfied safe processes have been followed (and they are following on from having just assessed the patient themselves). Dress/ uniform is at the discretion of each team member with the aim of portraying a caring, professional environment whilst being comfortable (e.g., wearing scrubs, uniform, clinic-based "office" clothes depending on preference).

Ensure the highest standards of professionalism are delivered consistently- e.g., friendly greeting, ensuring everybody introduces themselves, making the privacy, dignity and comfort of the patient a priority (e.g., privacy for changing, ensuring the pillow is properly positioned and the patient is as comfortable as possible, never leaving the patient unnecessarily exposed, offering support / drink / fan / blanket as appropriate). Whilst the healthcare assistant's (HCA's) primary responsibility is to act as the woman's advocate and to alert the surgeon of any concerns, her role is also to create a friendly environment and to relax the woman by encouraging friendly conversation, unless the woman would prefer not to engage.

In the treatment room, the woman should have a drawer sheet to cover her knees at all times, with further exposure kept to the minimum necessary to perform the procedure.

A heat pad should be offered to all women at the start of the procedure, and inhaled analgesia (e.g., Penthrox) be available if needed.

A nurse or HCA should act as the patient's advocate and be empowered to alert the surgeon immediately if there is significant distress or she is concerned about the patient's wellbeing.

When preparing the equipment, keep the instruments covered and always keep them out of eyesight of the patient.

For operative procedures requiring local anaesthesia, the standard technique is of a four-site paracervical block given deep into the fornices (plus one intracervical for the vulsellum), with sufficient time (7 minutes) given for it to be effective. Intrauterine local anaesthesia should be used (e.g., Instillagel).

Post-operative

All women should be invited to complete a patient-reported outcome form that includes pain score and the NHS standard quality questions- the surgeon should ensure the staff and procedure details are completed correctly. The aim is that reported pain is expected to be equivalent or less than that from natural menstruation.

A written discharge letter is provided to the woman which includes the ongoing contraceptive plan.