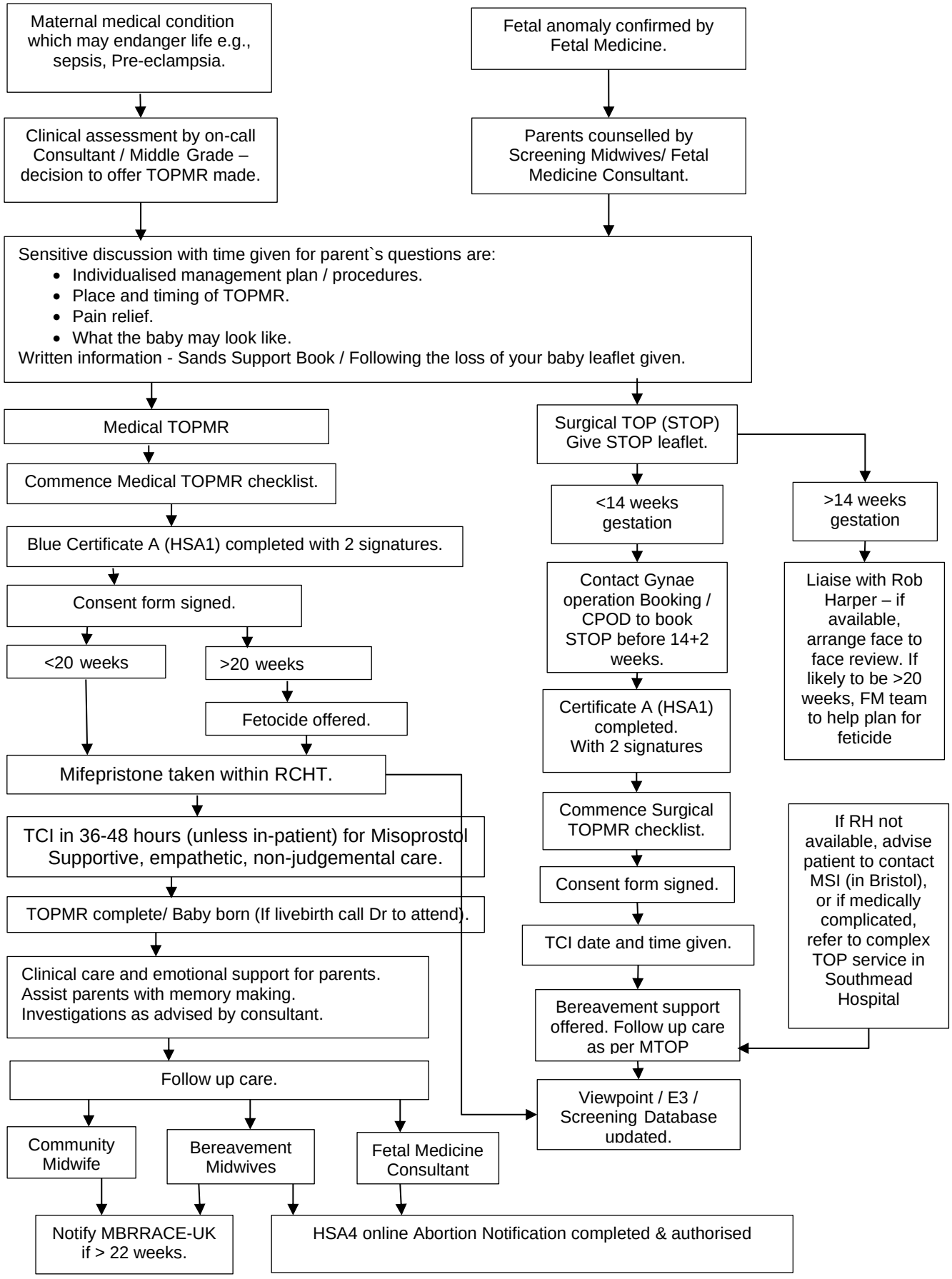
Royal Cornwall Hospitals
NHS Trust

Termination of Pregnancy for Medical Reasons (TOPMR) Clinical Guideline

V2.2

September 2024

Summary


Maternal medical condition which may endanger life e.g., sepsis, Pre-eclampsia.
Fetal anomaly confirmed by Fetal Medicine.
Clinical assessment by on-call Consultant / Middle Grade – decision to offer TOPMR made.
Parents counselled by Screening Midwives/ Fetal Medicine Consultant.
Sensitive discussion with time given for parent`s questions are:
Individualised management plan / procedures.
Place and timing of TOPMR.
Pain relief.
What the baby may look like.
Written information - Sands Support Book / Following the loss of your baby leaflet given.
Medical TOPMR
Commence Medical TOPMR checklist.
Blue Certificate A (HSA1) completed with 2 signatures.
Consent form signed.
<20 weeks
>20 weeks
Fetocide offered.
Mifepristone taken within RCHT.
TCI in 36-48 hours (unless in-patient) for Misoprostol Supportive, empathetic, non-judgemental care.
TOPMR complete/ Baby born (If livebirth call Dr to attend).
Clinical care and emotional support for parents.
Assist parents with memory making.
Investigations as advised by consultant.
Follow up care.
Community Midwife
Bereavement Midwives
Fetal Medicine Consultant
Notify MBRRACE-UK if > 22 weeks.
Surgical TOP (STOP) Give STOP leaflet.
<14 weeks gestation
>14 weeks gestation
Contact Gynae operation Booking / CPOD to book STOP before 14+2 weeks.
Liaise with Rob Harper – if available, arrange face to face review. If likely to be >20 weeks, FM team to help plan for feticide
Certificate A (HSA1) completed.
With 2 signatures
Commence Surgical TOPMR checklist.
Consent form signed.
TCI date and time given.
If RH not available, advise patient to contact MSI (in Bristol), or if medically complicated, refer to complex TOP service in Southmead Hospital
Bereavement support offered. Follow up care as per MTOP
Viewpoint / E3 / Screening Database updated.
HSA4 online Abortion Notification completed & authorised

1. Aim/Purpose of this Guideline

1.1. The decision to end a pregnancy after a prenatal diagnosis is traumatic for the parents, who deserve to be cared for with empathy and compassion. This guideline is intended to be used in conjunction with the Termination of Pregnancy for Fetal Anomaly National Bereavement Care Pathway and the RCHT TOPMR Checklist to provide best practice recommendations for staff providing care and support to women at any gestation who have chosen medical termination of pregnancy for fetal anomaly. The guideline is also relevant to situations where maternal well-being is compromised, and delivery indicated before 24 weeks gestation.

1.2. Wherever possible, managers should support staff with a conscientious objection to opt out of providing care before and after the termination procedure to ensure that parents receive the best care possible.

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

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

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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.

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

2. The Guidance

2.1. **Best practice in bereavement care**

2.1.1. Staff should acknowledge the difficulty for parents who are planning a termination for a much-wanted baby.

2.1.2. Parents should be listened to and given time, information, and support to make informed decisions relating to their care.

2.1.3. Communication with parents should be clear, sensitive, and honest. Use the terminology used by the parents e.g., fetus or baby.

2.1.4. Good communication is required between all professionals to ensure that parents do not have to repeatedly explain their situation. Continuity and consistency of care are important.

2.1.5. Assumptions should not be made about how an individual will feel about their loss.

2.1.6. A partner's needs for support should be recognised and met.

2.1.7. Care should meet the personal cultural and religious needs of the parent's babies.

2.1.8. Women and their partners should have their care coordinated by staff who are trained in bereavement care and in an environment appropriate to their circumstances. All staff that care for parents before, during or after TOPMR should have opportunities to develop and update their skills in bereavement care.

2.1.9. All bereaved parents should be offered opportunities to create memories.

2.1.10. The bodies of babies should be treated with respect at all times and at all gestations.

2.1.11. Staff should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the termination of pregnancy will be shared with healthcare professionals not directly involved in their care.

2.2. **Diagnosis and delivering news of fetal anomaly**

2.2.1. Staff who give parents screening results should also be well informed about the significance and implications of the results before discussions with parents. The information provided to parents about a fetal anomaly and the woman's options must be as complete as possible, accurate, up-to-date, and impartial. The possible severity and impact of a fetal anomaly should be neither exaggerated nor understated.

2.2.2. It is important that parents receive supportive, empathetic non-judgmental care and information from staff so that parents can make decisions that are right for them. Parents may experience additional distress if they perceive staff to be unsupportive or disapproving of their decision to terminate the pregnancy.

2.2.3. It should not be assumed that, even in the presence of an obviously fatal fetal condition such as anencephaly, a woman will choose to have a termination. A decision to decline the offer of termination must be fully supported.

2.2.4. Parents should be offered information about medical and surgical options for termination of the pregnancy. If the pregnancy is approaching 24 weeks' gestation, the woman also needs to know how her gestation affects her options (e.g. surgical TOP only available up to 23+6, Clause C TOP only legal up to 23+6).

2.2.5. When parents do not agree with each other about the decision, they may appreciate it if a trained member of staff offers to support them while exploring their options so they can attempt to reach a joint decision.

2.3. **Care once decision to terminate pregnancy has been made**

2.3.1. Timing should be discussed with women to find out what is appropriate for each woman as some women may experience additional distress if there are delays for referral and others may be more upset if they feel rushed.

2.3.2. Staff should sensitively offer to discuss parent`s options for seeing, touching, holding and / or creating memories with their baby and normalize these choices when speaking to parents.

2.3.3. If parents have decided not to tell family members and friends about the termination, it is extremely important that staff are aware of this decision and reassure parents that complete confidentiality is maintained.

2.3.4. Viewpoint and the Fetal Medicine TOPMR Database should be updated.

2.3.5. Add a Patient Note to the woman's electronic record.

2.3.6. Cancel any outstanding clinic and/or scan appointments.

2.4. **Legal requirements for performing a termination of pregnancy for medical reasons**

2.4.1. Two doctors will need to verify that the conditions for termination have been met (except in an emergency) using the Certificate A (Abortion Act) form HSA1. (Clause E in cases of fetal anomaly).

2.4.2. Legislation does not impose a gestational limit for terminations that satisfy the necessary criteria after 24 weeks' gestation.

2.4.3. The Chief Medical Officer at the Department of Health needs to be notified via the online Abortion Notification System

2.4.4. Details of the TOPMR may be added by staff with administrative access rights (Screening Midwives / Screening Administrator) online.

2.4.5. The terminating medical practitioner must authorise the form at Section 1, which enables the information to be released to the Chief Medical Officer. Contact DHSA by email: HSA4@dhsc.gov.uk or telephone 020 7972 5541 to obtain passwords.

2.4.6. In cases where the medical practitioner does not have the required login and authorisation passwords a paper HSA4 form may be used. To reduce the risk to patient confidentiality, DHSC request that patient identity stickers are not used on paper forms sent by post.

2.4.7. For medical terminations, where more than one doctor may have seen the patient, the terminating practitioner is the doctor taking responsibility for the abortion, usually this will be the practitioner prescribing the Mifepristone.

2.4.8. In the case of medical terminations, the form must be signed even if the practitioner has been unable to confirm that the pregnancy has been terminated.

2.4.9. Patient stickers should not be placed in the address box on page two as they slow down the processing system. In addition, the amount of information included on these stickers (e.g., patient's name and full address, GP name and address) is not required by the Department of Health and inclusion of this information increases the risk to patient confidentiality.

2.5. **Surgical Termination of Pregnancy for Fetal Anomaly (NEW 2024)**

2.5.1. The routine NHS surgical Termination of Pregnancy (TOP) pathway closes at 14 weeks +2 days. These cases should be discussed with the Abortion service – (in person in the booking office or rcht.top@nhs.net).

2.5.2. After 14+2, staff should liaise with Rob Harper to see if a timely date can be arranged for a face-to-face review (and an operation date, either on an elective list if there is free space, or on CEPOD (emergency theatre list).

2.5.3. At the face-to-face review, the surgeon and screening midwife should:

- Discuss medical and surgical history, with anaesthetic review if necessary.
- Sign consent form, discuss the logistics of the day, and inform on-call team.

  Discuss arrangements for momento's (limited but hand/footprints may be possible), genetic samples and tissue disposal.
- Confirm arrangements for Anti-D, antibiotics, contraception (if appropriate) Provide patient information and emergency contact details (e.g. if bleeding prior to the procedure).

- Arrange cervical preparation. Regime:
    - All cases: Mifepristone200mg 24-48h before surgery.
    - >19w: 3-5 Dilapan rods placed in cervix the day before surgery.
    - >20w: Feticide the day before surgery.
- Discuss plan for bereavement support and aftercare.

2.5.4. Surgical guidance for procedures >14 weeks:

- Most cases are performed on CEPOD, with the possibility of using elective lists, including WCH / SASH. In emergencies, maternity theatre 2 may be used with the agreement of maternity staff.
- Tranexamic acid and oxytocin 5iu IV are recommended.
- US guidance is mandatory.
- Tissues should be delivered directly into a disposal bag, then placed in the sample box by the surgeon. Theatre staff should not be expected to help with these arrangements.
- 1g Metronidazole PR and 100mg diclofenac PR are administered
- The surgeon should take and send samples for cytogenetics / and arrange momento's as needed.
- Complete operation note, tissue disposal forms and discharge summary.

2.5.5. If the surgeon is not available in a timely fashion, screening Midwives may also refer women to the independent sector through MSI until 24 weeks gestation. These procedures are performed in Bristol and parents need to be made aware that onward emotional support can be limited. MSI do not perform procedures for medically complex women, who would need to be referred to the complex TOP service in Southmead, via the refer a patient online system.

2.5.6. Discuss with parents how place of care (independent sector, West Cornwall Hospital theatres or Maternity) may affect treatment options.

2.5.7. Let the woman know that she may be alongside women ending unwanted pregnancies or having unrelated procedures.

2.5.8. Inform parents sensitively about the surgical procedure i.e., if the baby is not removed intact that there will not be a baby to see or hold following the procedure.

2.5.9. Give parents clear information and discuss their individualised care plan.

2.5.10. Provide parents with the time to take in information and ask as many questions as necessary.

2.5.11. Inform parents that a postmortem will not be possible, but that genetic testing may be possible if eligible.

2.5.12. Explain to the woman what she can expect regarding pain and bleeding after the procedure.

2.5.13. Sensitively discuss reducing infection risks and barrier contraception methods.

2.5.14. Inform parents that they can change their mind about their management option and let them know who to contact.

2.5.15. Be aware that some women may want to take the fetal remains away with them. This must be pre-arranged by the team organizing the TOPMR.

2.5.16. Ensure all staff seeing parents before, during and after the procedure are aware of the baby`s death and communicate sensitively. Place a Sands sticker on the woman`s medical notes.

2.5.17. Screening Midwives to use the required paperwork and Surgical TOP for Fetal Anomaly Checklist.

2.5.18. Women should be offered referral to Bereavement Midwives and contact details given.

2.5.19. A memory box specifically for early gestation loss may be offered.

2.5.20. RCHT Remembrance Service, entry to Baby Book of Remembrance and leaf on Baby Memory Tree should also be offered.

2.5.21. Women should be offered details of relevant support groups/ counselling.

2.6. **Medical termination of pregnancy**

2.6.1. Although it is important not to overload the parents with too much detail initially it is good practice to have an early discussion about what they should expect in terms of the termination process, analgesia, delivery, appearance of baby, and memory making.

2.6.2. Written consent should be taken prior to commencing termination of pregnancy.

2.6.3. The obstetrician leading care should document in the checklist which further investigations, if any, are recommended.

2.6.4. Give parents the Sands Bereavement Support Book, RCHT leaflet: Following the loss of your baby and Bereavement Midwives / ward contact details card. Discuss the content of leaflets with parents as they may be too overwhelmed to read the information they need. Parents may prefer to use the Sands App for their phone or tablet.

2.6.5. As soon as practically possible involve a Bereavement Midwife to provide ongoing support.

2.6.6. Use the required paperwork and TOPMR Checklist in “TOPMR” ring binder found in the satellite mortuary/ nursery on Wheal Rose. Please file forms as they are completed in the medical notes and do not leave in the ring binder (Data Protection).

2.6.7. Mifepristone is an anti-progesterone steroid used as a pre-treatment. It facilitates uterine response to subsequent administration of prostaglandin and takes time to work so is given before prostaglandin. This drug must only be administered in an approved place (i.e., within RCHT). Contraindications include uncontrolled asthma, chronic renal, liver, or adrenal failure and acute porphyria.

2.6.8. In the absence of an obstetric complication that necessitates close observation; oral Mifepristone 200mg should be given at a time to suit the parents, with a view to the woman going home and returning to the Bereavement Suite in 36-48 hours to termination of pregnancy with Misoprostol.

2.6.9. Women should be made aware that they may experience modest bleeding and abdominal cramps following Mifepristone. Women should be advised to take simple analgesia, but to avoid those containing ibuprofen. Headaches, nausea, and skin rashes may also occasionally.

2.6.10. Complete the pre-admission sections of the TOPMR Checklist before the parents leave the hospital. Individual items should be signed and dated by the doctor or midwife who provides that care. The checklist should be filed in the medical notes.

2.6.11. Unless the woman declines, the updated handheld notes should be returned to the woman to ensure that clinical information is available if required prior to admission to hospital.

2.6.12. Inform the Community Midwife, Named Consultant and Bereavement Midwives of the diagnosis and management plan.

2.6.13. Cancel any outstanding appointments.

2.7. **Fetocide**

2.7.1. It is uncommon for a baby to be born alive following medical termination however women should be prepared for this possibility. To avoid the situation the Fetal Medicine Team will discuss the option of feticide from 18 weeks gestation with the importance of this increasing in gestations >21+6 weeks. The RCOG recommends that feticide is used for terminations that take place after 21+6 weeks gestation. However, it is not a legal requirement, and women should not be pressurised to have this procedure.

2.7.2. When feticide is discussed, it is important that the woman is told what the procedure involves and what she may feel during and after the procedure.

2.7.3. Offer anti-D prophylaxis to women who are having feticide and are rhesus D negative. Women with known rhesus negative babies do not need Anti-D.

2.7.4. Feticide should always be performed if termination is planned after 24 weeks gestation.

2.7.5. Women who decline feticide should be informed that it is possible that their baby may be born with signs of life when a doctor would be called to see the baby and palliative comfort care would be offered. Parents should also be made aware that if their baby is born alive that the law requires the birth and death to be registered and an individual funeral to be held.

2.7.6. Parents should be told that they can see, touch, and hold their baby if they wish, regardless of whether the baby is born dead or alive.

2.7.7. If the baby is born alive palliative comfort care should be offered. A doctor should be called to see the baby so that a Cause of Death Certificate (Neonatal Death Certificate) can be completed without delay.

2.7.8. If a baby is born alive, Coroner should be contacted by the Consultant for further guidance so that a Cause of Death Certificate can be completed without delay.

2.8. **Termination of Pregnancy Medication Regimen**

No Scar	**Up to 26+6 weeks**	**> TOP 27 weeks**	**Stillbirth >27**
Day 1	200 mg Mifepristone	200 mg Mifepristone	200mg Mifepristone
Day 2			
Day 3 (Readmission)	200mcg Misoprostol PV/SL/PO 4 hourly	100mcg misoprostol. 6 hourly PV/SL/PO.	25mcg Misoprostol PO 2 hourly. (Full course Miso completed in 10 hours). 12-hour rest following. NB With obstetric Review Misoprostol can be increased to 50mcg if no uterine activity.
Third Stage	Further doses of Misoprostol can be given if the placenta has not delivered within an hour. If the placenta has not been delivered within an hour of Misoprostol administration medical review and consideration of surgical management must occur.		

With Scar	**< 24 weeks**	**Stillbirth or TOP 24-26+6**	**Stillbirth or TOP >27**
Day 1	200 mg Mifepristone	200 mg Mifepristone	600 mg Mifepristone
Day 2			600 mg Mifepristone (must be undertaken in hospital and witnessed by RM).
Day 3 (Readmission)	200mcg Misoprostol PV / SL/PO 4 hourly	100mcg misoprostol. 4 hourly PV/SL/PO.	Cervical balloon / ARM +/- 10 IU oxytocin infusion monitoring contractions carefully. (See Oxytocin in the First and Second Stage of labour clinical guideline).
Third Stage	Further doses of Misoprostol can be given if the placenta has not delivered within an hour. If the placenta has not been delivered within an hour of Misoprostol administration medical review and consideration of surgical management must occur.		

Following 5 doses of Misoprostol request Obstetric review for an on-going individualised plan of care.

2.9. Route of administration

2.9.1. PV administration has higher efficiency unless vaginal bleeding.

2.9.2. Sublingual administration may be more effective than oral, recommend the tablet is held under her tongue for 15 minutes, then after 15 minutes swallow the remaining fragments.

2.10. Support during admission

2.10.1. Women should be able to have their partner and / or another supporter with them at all times.

2.10.2. In the absence of co-existing complications, women having medical termination of pregnancy regardless of gestation should be cared for ideally in the Daisy Bereavement Suite. If the Daisy Suite is already in use, an individualised assessment should be made as to the most appropriate place of care and the Birth Centre may be considered.

2.10.3. Women having termination of pregnancy for maternal conditions may require higher level care on Delivery Suite. All women require regular reassessment for appropriate place of care and seniority of carer throughout admission which must be documented in the notes.

2.10.4. If a room other than the Bereavement Suite is used display a laminated “Daisy” sign on door to ensure that all staff are aware that the room is being used by bereaved parents and are sensitive to noise/ inappropriate comments.

2.10.5. Ensure continuity of carer whenever possible.

2.10.6. Ensure that all staff seeing parents during labour and birth are aware of the pregnancy loss and communicate sensitively.

2.10.7. The partner / supporter should be kept fully informed and involved (with woman`s consent). A partner’s grief can be as profound as that of the mother; their needs for support should be recognised and met.

2.11. Pain management

2.11.1. A range of analgesia and anti-emetics should be prescribed. All women should be given appropriate information regarding pain relief options including advantages and disadvantages.

2.11.2. Options include, water therapy, TENS machine, Patient controlled analgesia (PCA), oral analgesia, diamorphine/pethidine.

2.12. 3rd stage of labour

2.12.1. The 3rd stage of labour should be actively managed. Cases of retained placenta should be managed as per Retained Placenta Diagnosis and Management Clinical Guideline V3.0 (cornwall.nhs.uk).

2.12.2. Women should be informed that there is a higher incidence of retained products of conception compared to first trimester miscarriage. A low threshold for evacuation of retained products should be adopted.

2.12.3. If there is any concern that the placenta is not complete on examination arrange a follow up appointment for the Emergency Gynae Unit (EGU). This may be an out- patient appointment.

2.13. Caring for the baby

2.13.1. Labelling a baby

2.13.1.1. At delivery label the baby with a name band in accordance with the RCHT Newborn Identification and Labelling Clinical Guideline (cornwall.nhs.uk) (2023). At earlier gestations place the Name band around the baby`s abdomen.

2.13.1.2. At very early gestations (<14 weeks) it may be appropriate to place fetal remains in formalin in a labelled histology pot.

2.13.1.3. Once the baby is ready to go to the mortuary replace this name band with a mortuary identification label which should have 3 points of reference: - “baby of” (mother`s full name), date and time of birth, and Baby`s CR if a registerable birth. Write firmly on the mortuary band and peel off paper layer. This will ensure identification details are smudge proof. Offer the original name band to parents.

2.13.1.4. Put “red sticker” identifier on deceased baby care record, Termination of Pregnancy due to Fetal Anomaly (TOPFA) checklist, and postmortem consent form if appropriate.

2.13.2. Cuddle cot cold mattress

Caring for the baby on a cold mattress allows the family to spend more time with their baby. The appropriate size cold mattress should be set up to operate at a temperature between 8-13 degrees Celsius. Cold mattress guidance and temperature record are included in the TOPMR Checklist.

2.13.3. Seeing and holding the baby

2.13.3.1. Depending on the condition of the baby / fetal remains discuss with parents seeing and / or holding their baby / fetal remains while respecting that some parents may decline this offer. It is essential to offer genuine choice and not to steer parents towards a particular course of action in the belief that it will help them.

2.13.3.2. The parents should be aware that they can change their mind at any time.

2.13.3.3. The condition of the baby should be considered when discussing memory making with parents. Parents should be sensitively informed of how their baby may look when born considering gestation, known abnormality, macerated or severely hydropic babies.

2.14. Creating Memories

2.14.1. All staff should use the baby's name if one has been given.

2.14.2. Do not make assumptions about what parents may want based on the gestation of their pregnancy.

2.14.3. It can be difficult for staff to know whether or not to offer to take photographs of a miscarried baby or pregnancy remains. Some women/couples will appreciate the offer of a photograph being taken of their baby or the pregnancy remains even in a very early loss, while others might find the suggestion distressing, unacceptable or not needed even with a later loss.

2.14.4. If parents are undecided regarding photos, offer to take photos and give the SD memory card to the parents without printing photographs.

2.14.5. Offer a memory box (A 4Louis miscarriage memory box or for later gestations use a Sands memory box) with:

- Scan photos.
- Hand and footprint.
- Cot card.
- Certificate of Acknowledgement of Loss.
- Teddy bear.
- Blanket.

2.14.6. Not all of the above list will be possible or appropriate in early gestations. The memory box does not need to be filled as it is designed for the parents to add their own memories.

2.14.7. Offer parents a leaf engraved with their baby`s name to be added to the Memory Tree situated in the Baby Memorial Garden and the option of having their baby`s name entered in the hospital Book of Remembrance in the Chapel. Complete and forward the relevant request forms as directed.

2.15. Pastoral Care

2.15.1. Staff should be aware of, and open to, different personal, religious, and cultural needs. Assumptions should not be made, however, about what any individual will want on the basis of their heritage or religion.

2.15.2. Discuss with parents whether they wish to speak with the hospital Chaplain.

2.15.3. Parents should be informed that the Chaplaincy Team will be able to put them in touch with a representative of their faith, wherever possible.

2.15.4. Offer a Blessing / Naming ceremony. The on-call Hospital Chaplain may be contacted day or night via Switchboard.

2.15.5. Inform parents of the RCHT annual Service of Remembrance in October and give information / consent for invitation form.

2.16. Legal Requirements

2.16.1. There is no legal requirement for registration of babies born deceased before 24 weeks gestation. An alternative Acknowledgement of Loss Certificate should be completed and offered to parents in lieu of a Stillbirth Certificate.

2.16.2. The Crematorium Committee Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains form should be completed by a doctor or registered midwife who has examined the baby. This form should accompany the baby to the mortuary or funeral director.

2.17. Investigations on the baby and placenta

2.17.1. Where there is fetal malformation, and the cause known investigations should be advised by the Consultant managing the case.

2.17.2. If postmortem is to be offered written information, should also be given and it is good practice to have a detailed discussion at least twice with the family.

2.17.3. It should be explained to the parents that different types of postmortem are available e.g., full, limited, or external.

2.17.4. Parents should be advised that even with full investigation, new information may not be found.

2.17.5. Consent should be sought by a member of staff who has received training in seeking postmortem examination consent and the process and who has a good understanding of the procedures for which they are seeking consent (Appendix 4 Sands Guide for consent takers). It is a process that should involve careful listening and discussion.

2.17.6. If postmortem is to be performed the placenta should be placed in formalin and sent to the mortuary with the baby to be transferred to Bristol for histopathological investigations.

2.17.7. Cytogenetic tests may be offered in some circumstances. Samples of umbilical cord (tissue sample at very early gestations) and placenta should be taken in the Bereavement Nursery (satellite mortuary) in accordance with guidance: Cytogenetics Samples after Pregnancy Loss.

2.18. Taking the baby out/home

2.18.1. There are no legal reasons to prevent parents from taking their baby home. Parents should be offered the opportunity to take their baby home or out of the hospital. This discussion should be recorded in the TOPMR Checklist.

2.18.2. There is no legal reason to inform the police if parents take their baby's body home or out of the hospital. However, for the protection of the parents and to prevent misunderstandings, a form for parents who take their baby`s body home should be given to the parents confirming that the body has been released to the parents and that they will be taking it back to the hospital or making their own funeral arrangements.

2.18.3. Parents can take the baby home by car in a Moses basket or in a suitable casket. Small lined wooden caskets are provided by charities for very early gestations.

2.18.4. A Cuddlecot cold mattress should be offered on loan to the parents.

2.19. Sensitive Disposal / Funerals

2.19.1. Provide information for parents about what happens to the baby/ fetal remains and complete the Sensitive disposal option form "What happens to our baby" (CHA4628).

2.19.2. There is no legal requirement for a funeral for babies / fetal remains below 24 weeks gestation, but parents should be given the opportunity to discuss and make choices about their available options for the disposal of fetal remains.

2.19.3. RCHT offers collective cremation for fetal remains / babies < 24 weeks gestation. Parents should be informed that this service takes place on a monthly basis at Penmount Crematorium. Parents are not able to attend the service and individual ashes will not be available.

2.19.4. Individual cremation is possible for fetal remains and babies born dead before 24 weeks' gestation in Cornwall, if funded by the family. Parents should be aware that while there is no guarantee that ashes will be recovered from early gestation (< 24 weeks gestation).

2.19.5. Staff should be aware that some cultures and religions do not traditionally hold funerals or other ceremonies for babies born before 20 weeks' gestation. It should not be assumed however that this will be the case, and all parents should be offered information.

2.19.6. Some women may decline information about these options or involvement in decision-making processes regarding the disposal of fetal remains and this should be respected. If they have not made a decision prior to transfer home, ensure that parents are aware that collective cremation will be arranged if the parents do not contact RCHT Bereavement Services (Tel: 01872 252713) after 4 weeks. The parents will not be informed of the cremation details.

2.20. Psychological Support

2.20.1. All parents should be offered bereavement support. Involve the Bereavement Midwives as soon as practically possible to provide ongoing support.

2.20.2. Ensure that the parents have information on local and national support groups including contact details.

2.20.3. With consent ensure handover of care to GP for the partner as well as the woman.

2.20.4. If the woman has ongoing psychological concerns the GP should be made aware.

2.21. Lactation suppression

Suppression of lactation should be discussed. Offer Cabergoline 1mg as a single dose from 18 weeks gestation unless contra-indicated or there is maternal hypertension or puerperal psychosis.

2.22. Discharge from hospital

2.22.1. Perform a full postnatal examination including maternal observations, VTE assessment, and contraceptive advice before discharge.

2.22.2. Ensure that the TOPMR Checklist is complete before the parents go home.

2.22.3. Ensure that the woman has the RCHT leaflet ‘Following the loss of your baby’ for information about what to expect in the postnatal period and knows how to contact her community midwife / Bereavement Midwives.

2.22.4. Signpost the parents to local and national support group and give contact numbers/ websites addresses.

2.22.5. Ensure that parents are aware that they may return to see their baby if they wish. Parents should be advised to contact RCHT Bereavement Services office during office hours to make arrangement. Telephone: 01872 252713.

2.22.6. The community midwife should contact the woman within 24 hours and offer a postnatal visit. The woman should not be asked to attend a clinical area for a postnatal check.

2.22.7. Seek consent for the parent`s participation in the Maternity Bereavement Experience Measure (MBEM) feedback in approximately six - twelve months. Document if this is declined.

2.23. Transport of the baby and placenta

2.23.1. When the parents have been discharged / said their final goodbyes, the baby is wrapped in a blanket and placed in a casket lined with a plastic backed absorbent sheet. The baby is then transferred to the mortuary by a porter. Record the porter`s name on the Deceased Baby Care Record.

2.23.2. The placenta, in Formalin, is also sent to the mortuary in a red transport box lined with an absorbent pad in accordance with COSHH requirements.

2.23.3. The Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains (cremation form), Sensitive Disposal “What happens to our baby” form, Deceased Baby Record and postmortem request and consent forms (if applicable) go with the baby to the mortuary.

2.24. Aftercare

2.24.1. Bereavement midwives to provide on-going bereavement support as required.

2.24.2. Bereavement Midwives to collate investigation results and report > 22-week (20 weeks if the TOPMR results in a live birth) gestation cases to MBRRACE-UK.

2.24.3. Bereavement Midwives to inform Consultant (Area Consultant if TOP for maternal reasons and / or premature rupture of membranes and Fetal Medicine Consultant when TOP is for fetal abnormality) and request debrief / investigation feedback once all investigation results are available.

2.24.4. If parents give consent to participate in giving feedback, Bereavement Midwives to send the Maternity Bereavement Experience Measure (MBEM) by post or e-mail in approximately six months (www.bit.ly/2DQ3Mjz).

2.25. Conscientious objection and support for staff

2.25.1. Staff who have a conscientious objection to termination of pregnancy must inform their employer at the earliest opportunity. They should be supported not to participate in care scenarios that may lead to conflict with their religious or moral beliefs. However, Midwives have a professional responsibility to act with integrity and ensure that their personal views do not affect or influence the care of the woman and cannot refuse to provide care for women before or after termination. The same applies to doctors who have a duty to act in acute situations which compromise maternal health.

2.25.2. In accordance with the National Bereavement Care Pathway, Midwives should receive appropriate education and annual in-service training to feel confident in the care they provide and to reduce stress in distressing and emotional situations. Bereavement care training should be given to new Doctors during their induction.

2.25.3. The hospital Pastoral Care Team and Bereavement Midwives can provide mechanisms of support for staff involved in the care of women who have termination of pregnancy if required. Midwives may also seek support from Professional Midwifery Advocates.

2.25.4. Antenatal Results and Choices (ARC) and Sands provide telephone support for Healthcare Professionals.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. Parents offered bereavement support. 2. MBRRACE-UK notification > 22 weeks gestation (20 weeks if live birth).
Lead	1. Bereavement Midwives. 2. Screening Midwives (<14 weeks) Bereavement Midwives > 14 weeks gestation).
Tool	1. TOPMR checklist. 2. TOPMR Checklist / Bereavement Database / electronic record. 3. MBRRACE-UK Register.
Frequency	Each case checked individually.
Reporting arrangements	Governance Group. Documented in meeting minutes.
Acting on recommendations and Lead(s)	Any deficiencies identified will be discussed at the Maternity. forum / Clinical Audit Forum and an action plan developed. Action leads will be identified and a time frame for the action to be completed. The action plan will be monitored by Maternity Forum/ Clinical Audit Forum.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within six months. A lead member of the Fetal Medicine or Bereavement 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:	Termination of Pregnancy for Medical Reasons (TOPMR) Clinical Guideline V2.2
This document replaces (exact title of previous version):	Termination of Pregnancy for Medical Reasons (TOPMR) Clinical Guideline V2.1
Date Issued/Approved:	September 2024
Date Valid From:	September 2024
Date Valid To:	February 2027
Directorate / Department responsible (author/owner):	Karen Stoyles / Claire Moors, Bereavement Midwives
Contact details:	01872 25 2879
Brief summary of contents:	To provide midwives, obstetricians, and support workers with guidance in the provision of emotional support and clinical care when parents decide to end pregnancy due to fetal anomaly or maternal medical condition.
Suggested Keywords:	Termination of Pregnancy, Bereavement, Antenatal screening.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Director
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Tamara Thirlby
Links to key external standards:	1. Termination of Pregnancy Due to Fetal Anomaly (TOPFA) Bereavement Care Pathway. (2022) National Bereavement Care Pathway. www.nbcpathway.org.uk

Information Category	Detailed Information
	2. House of Commons, Abortion Act 1967 updated 1990 (London: HMSO, 1990). 3. The Abortion Act 1967: Approval of a Class of Places (2020). Department of Health and Social Care. 4. Guide for consent takers. Seeking consent/authorisation for the post mortem of a baby. (Sands / HTA 2013). 5. Sands, London www.sands.org.uk 4. Hunter A., Schott J., Henley A., Kohner N., (2016) Pregnancy loss and the death of a baby: Guidelines for Professionals. Sands www.sands.org.uk 6. Code A: Guiding principles and the fundamental principle of consent (2020) Human Tissue Authority. www.hta.gov.uk 7. When a Patient Dies: Advice on Developing Bereavement Services in the NHS (2005) Department of Health When a patient dies - Advice on developing bereavement services in the NHS (hscni.net) 8. Learning from Deaths: Guidance for NHS Trusts on working with bereaved families (2018). 9. Department of Health: Guidance note for completing the abortion notification form HSA4 for abortions performed in England and Wales (2022). Gov.uk/abortion-notification-forms-for-england-and-wales 10. The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates. (NMC 2020) Conscientious objection - The Nursing and Midwifery Council (nmc.org.uk) 11. Government Response to the Independent Pregnancy Loss Review: care and support when baby loss occurs before 24 weeks gestation. (2023) https://www.gov.uk/government/publications/government-response-to-the-independent-pregnancy-loss-review/government-response-to-the-independent-pregnancy-loss-review-care-and-support-when-baby-loss-occurs-before-24-weeks-gestation

Information Category	Detailed Information
	12. Chief Coroner Guidance No.45: Stillbirth, and livebirth following termination of pregnancy (2023) https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy/
Related Documents:	Termination of Pregnancy Due to Fetal Anomaly (TOPFA) Bereavement Care Pathway. (2022) National Bereavement Care Pathway. www.nbcpathway.org.uk
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
February 2021	V1.0	Initial version.	Karen Stoyles and Claire Moors, Bereavement Team
July 2023	V1.1	Update to 2.8, Misoprostol Regime.	Karen Stoyles and Claire Moors, Bereavement Team
November 2023	V1.2	Update to table 'With Scar' with dosage time.	Catherine Wills Maternity Guidelines Midwife
February 2024	V2.0	Full update including: Update to 2.4.3. Legal requirements. 2.5.19 Support groups for surgical TOPMR. 2.6.7 Mifepristone to be administered in an approved location at all gestations. 2.7.8 Coroner guidance. 2.14.4 Creating memories.	Karen Stoyles and Claire Moors, Bereavement Midwives

Date	Version Number	Summary of Changes	Changes Made by
August 2024	V.2.1	2.24 Parents viewing their baby after discharge	Karen Stoyles, Bereavement Midwife Sophie Haynes, Obstetric Bereavement Lead Consultant
September 2024	V2.2	Addition of 2.5 and updates to flowchart regarding surgical TOP	Rob Harper, Consultant Obstetrician

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:	Termination of Pregnancy for Medical Reasons (TOPMR) Clinical Guideline V2.2
Directorate and service area:	Obstetrics and 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):	Karen Stoyles, Bereavement Midwife.
Contact details:	01872 252879

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 provide guidance to all staff members who care for birthing person and their partner who are having a Termination of Pregnancy for Medical Reasons (TOPMR).
2. Policy Objectives	To ensure that parents receive appropriate care and support before, during and after a TOPMR.
3. Policy Intended Outcomes	To ensure consistent, high-quality care and support before, during and after a TOPMR.
4. How will you measure each outcome?	Against the audit tool. By reviewing feedback from the birthing person and their partner.
5. Who is intended to benefit from the policy?	Bereaved parents following a TOPMR.

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:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Guideline Agreed
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	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
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: Catherine Wills, Maternity Guidelines Midwife.

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