Brighton and Sussex University Hospitals NHS Trust

Local Guidelines for Pre-Procedure Pregnancy Testing in Postmenarchal Females at the Royal Alexandra Children's Hospital.

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Name of responsible committee/ individual:	
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Contents

Section

Appendices:

1 Introduction:

1.1 In the UK, the 2012 incidence of pregnancy in under 16 year olds was 5.6 per 1000 (total conceptions = 5432) and in under 14 year olds was 0.8 per 1000 (total conceptions 253)[1]. Onset of menarche varies widely. In a study of 81606 women the mean age of menarche was 12.7 years (range 7-20 years). Significantly 4.8% of this population experienced menarche under the age of 11.[2] While the risk of pregnancy under 13 is very low (1 per 10,000[3]), pregnancies have been reported in females under 12.[4] NICE and the HPA advocate determining the pregnancy status of females of "childbearing age" prior to elective and radiological procedures with a suggested age range of 12 – 55.

1.2 The risks associated with performing procedures on patients with undisclosed or undetected pregnancy depend on the foetal gestation and the type of surgery and can be divided into risks to the patient and risks to the pregnancy and foetus.

1.2.1 Risks to the patient include increased rates of difficult intubation, increased oxygen consumption, more rapid desaturation, increased risk of aspiration and changes to the distribution and metabolism of drugs.

1.2.2 Risks to the foetus include spontaneous miscarriage, premature birth and low-birth weight with certain procedures defined as high-risk e.g. lower abdominal surgery and those involving perioperative x-ray screening.[5)]

1.3 In November 2012 the Royal College of Paediatrics and Child Health produced a guidance document[4] for clinicians covering the process of pre-procedure pregnancy testing in female patients under the age of 16, but also recommended all paediatric departments agree a local protocol for questioning and urine testing. The national guidelines suggest clear documentation of decision making regarding questioning or testing, propose the involvement of safeguarding teams particularly in all patients under 13 and suggest compliance with the guidelines should be subject to regular audit.

2 Purpose:

2.1 To provide clear local guidelines for pre-procedure pregnancy testing, for elective procedures, in female patients less than 19 years of age at the RACH.

2.2 To explain the correct course of action in the event of a positive pregnancy test.

2.3 To act as a reference for referral pathways in cases where safeguarding concerns are raised.

2.4 To provide a clear local standard against which practice can be regularly audited.

3 Responsibilities, Accountability and Duties:

3.1 Responsibility of departmental managers:

3.1.1 Ensure the policy is implemented, compliance monitored and regularly reviewed as required in line with Trust and national recommendations.
3.1.2 Ensure this document is available to all relevant staff.
3.1.3 Ensure pregnancy tests are available for use as required and staff are trained in their use.

3.2 Responsibilities for all health care professionals preparing the patients for surgery.

3.2.1 To access, read, understand and follow this policy.
3.2.2 To use their professional judgment in the application of this protocol.
3.2.3 To protect the patient's privacy and dignity.

4 Policy:

Please reference Appendix A, a flow chart of testing procedures.

4.1 Which Patients and which Procedures?

4.1.1 The recommended standard is consented urine pregnancy testing of all post menarchal female patients less than 16 years of age, prior to all elective surgery or elective procedure under general anaesthesia. The policy is for consented testing of all children, acting in the best interests of the child undergoing anaesthesia. Within the RACH we care for patients with severe disabilities and at times have patients up to 19 years of age and these patients are included in these guidelines.
4.1.2 All patients should be assessed for competency to make decisions. Competent patients or their legal guardians should be consented for urine pregnancy testing on the day of surgery. In the case of refusal to give consent, this should be documented in the notes and the responsible clinician must be informed. It is the clinicians' responsibility to establish the benefit of proceeding in the absence of a pregnancy test and this should be clearly documented in the theatre care plan.
4.1.4 For emergency procedures it may be impossible or inappropriate to delay care to establish pregnancy status. If there is a chance the patient could be pregnant the lead clinician should consider the balance of risk and benefit. Whether or not enquiry or testing is carried out this should be clearly documented in the theatre care plan.

4.2 Preparation

4.2.1 Pre-admission females aged 10 and above, should be given the RACH leaflet "Why am I being asked about pregnancy? Information for girls."
4.2.2 At preadmission all girls should be asked about the onset of periods. If they are post-menarche then this should be followed by an explanation

that all post menarchal girls will be routinely tested for pregnancy on the day of surgery.

4.2.3 When booking female patients for surgery it is good practice for the surgical team to explain to the patient and parents/carers that excluding pregnancy is a standard part of theatre preparation.

4.3 Confidentiality:

4.3.1 All young people should be offered the opportunity the consultation to be in private, without their parents/carers present.

4.3.2 Patient confidentiality should always be maintained unless there are overriding safeguarding considerations. However, given the responsibility that parents/carers have for their child's welfare, we should encourage the patient to share information where it is safe to do so.

4.3.3 Decisions to involve patient's parents or carers should be taken using professional judgement based on age, maturity, Gillick Competence, and the implication/risk involved. Where there is doubt this decision should be escalated to a senior member of the surgical/nursing team.

4.4 Ward based Urinary Pregnancy Testing:

4.4.1 A urine sample must only be used for pregnancy testing with the patient's knowledge and specific consent. Verbal consent is sufficient and should be documented in the theatre care plan.

4.4.2 Urinary testing should be offered to all post menarchal females on the day of surgery. See Appendix C for information on urinary pregnancy tests.

4.4.3 The patient must be informed of the result, positive or negative, and the result documented in the theatre care plan.

4.4.4 If consent is not given to urinary testing, the surgical/anaesthetic team should be informed and must decide whether it is in the patient's best interest to proceed with an unconfirmed pregnancy status. The risks involved in proceeding should be explained to the patient and their parents/carer if appropriate, to enable them to reach an informed decision.

4.5 Action to be taken in the event of a positive test:

4.5.1 In the event of a positive pregnancy test nursing staff should inform a member of both the anaesthetic and surgical teams caring for the patient, with the result then escalated to the consultant from each speciality prior to notification of the patient.

4.5.2 A named nurse should support the patient.

4.5.3 Action should be taken to substantiate the result by either:

Repeating the ward based urinary test
Sending the urine sample for laboratory testing
With patient consent send a serum sample for testing.

4.5.4 The possibility of a false positive test should be considered (e.g. early miscarriage or rare medical causes of elevated hCG levels)

4.5.5 The surgical and nursing teams should meet with the patient to discuss the result, implications for the planned procedure and on-going care/referrals.

4.5.6 Parents/carers should only be present when the competent patient has given consent, or if the patient lacks capacity.

4.5.7 If the proposed procedure is to go ahead the anaesthetist should be involved in the risk/benefit discussions with the patient.

4.5.8 Consider referral to the teenage pregnancy liaison midwife based at the Royal Sussex County Hospital, Mitch Denny, for ongoing support.

5 Safeguarding:

5.1 Children under the age of 13 in England and Wales are by law[6] unable to consent to sexual intercourse. Any disclosure of sexual activity in this age group must prompt a referral to the safeguarding team.

5.2 The legal age of sexual consent in England and Wales is 16[6], but for female patients aged 13 to 16 the situation can be complicated. Disclosure of sexual activity in this age group should be discussed with senior members of the multidisciplinary team. Evidence of coercion, sexual activity with an older partner or any indication of abuse should prompt a referral to the safeguarding team.

5.3 Local arrangements are set in place to protect the safety and wellbeing of female patients under 16 and in the case of pregnancy, their unborn babies:

The lead safeguarding nurse for RACH is Debi Fillery
The lead safeguarding doctor for RACH is Dr Leonie Perera
The teenage pregnancy liaison midwife, based at the Royal Sussex County Hospital is Mitch Denny

6 Staff Training:

6.1 Once the new policy is instigated, all staff involved in the preoperative assessment of patients, preadmission process and surgical pathway will be invited to a training session outlining the new policy and patient information sheets.

6.2 All new medical, nursing and ward auxiliary staff should be made aware of the policy as part of their mandatory trust induction process.

7 Monitoring Arrangements:

7.1 The compliance with this policy will be monitored through regular audit.

8 Equality impact assessment

8.1 As an NHS organisation, BSUH is under a statutory duty to set out arrangements to assess and consult on whether this policy and function impacts on equality.

8.2 The policy author will be responsible for completing an Equality Impact Assessment on this document in accordance with Trust guidance, and for liaising with the Equality, Diversity and Human Rights team with regards to any findings and subsequent action plan. This policy does not discriminate against any groups on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, disability, gender identity, marriage/civil partnership status, pregnancy and maternity (See Appendix D below).

9 Relevant trustwide policies

9.1 C047 Safeguarding Children and Young People Policy; May 2013

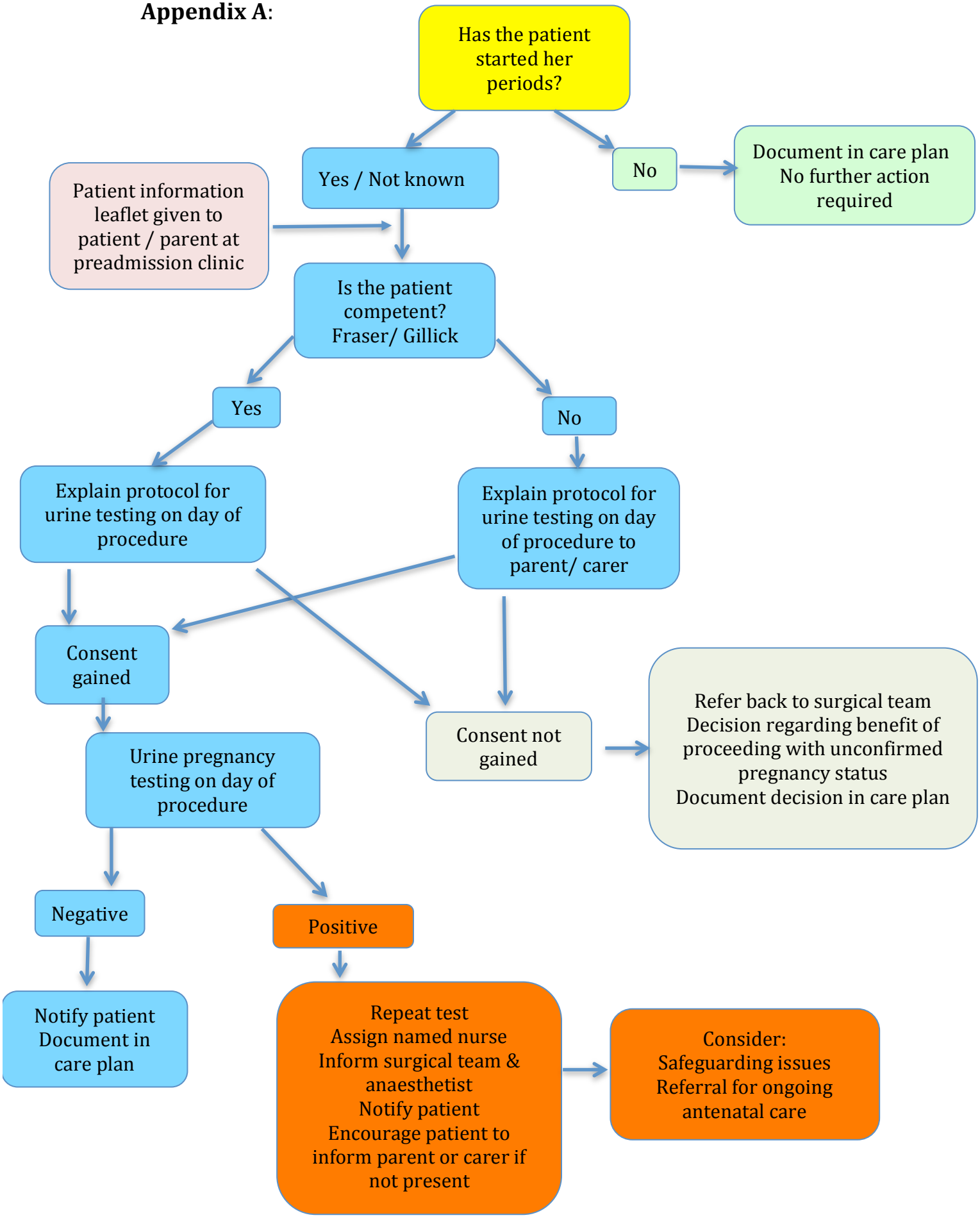
9.2 C039 Checking Pregnancy before Surgery, Anaesthesia and any Procedure Performed Under Sedation Policy; September 2012

9.3 MP016 Teenage Pregnancy; March 2011

10 References

1. Office for National Statistics, 2012
2. Determinants of age at menarche in the UK: analyses from the Breakthrough Generations Study; Morris DH et al; Br J Cancer; 2010; 103:1760 – 1764
3. Sexual initiation, contraceptive use and pregnancy among young adolescents; Finer LB et al; Paediatrics; 2013; 131:886-91
4. Pre-procedure Pregnancy Checking in Under 16s: Guidance for Clinicians; Royal College of Paediatrics and Child Health; November 2012
5. Risks associated with anaesthesia and surgery in early pregnancy; Short J; Royal College of Paediatrics and Child Health; 2012
6. The Sexual Offences Act, 2003 (c.42), The Stationery Office Limited, Crown copyright 2003: www.legislation.gov.uk/ukpga/2003/42/pdfs/ukpga_20030042_en.pdf

Appendix A:


Has the patient started her periods?
Yes / Not known
No
Document in care plan
No further action required
Patient information leaflet given to patient / parent at preadmission clinic
Is the patient competent? Fraser/ Gillick
Yes
No
Explain protocol for urine testing on day of procedure
Explain protocol for urine testing on day of procedure to parent/ carer
Consent gained
Consent not gained
Refer back to surgical team
Decision regarding benefit of proceeding with unconfirmed pregnancy status
Document decision in care plan
Urine pregnancy testing on day of procedure
Negative
Positive
Notify patient
Document in care plan
Repeat test
Assign named nurse
Inform surgical team & anaesthetist
Notify patient
Encourage patient to inform parent or carer if not present
Consider:
Safeguarding issues
Referral for ongoing antenatal care

Appendix B: Suggested Documentation

Documentation of Pre-procedure Pregnancy Testing for Patients at the RACH.

Is the patient post menarche:	Yes/No
Information given	Yes/No
Consent given for urinary pregnancy test?	Yes/No/Not indicated
Result of urinary pregnancy test?	Negative/Positive
Further action taken?	

Appendix C:

Information regarding urinary pregnancy tests:

- Urinary pregnancy tests detect the presence of urine human chorionic gonadotropin, hCG a hormone produced by the synctiotrophoblast of the placenta.
- Urine tests can detect hCG within days of implantation of the embryo, which occurs 6 to 12 days after fertilisation.
- A result is available within 60 seconds.
- False positive results occur with incorrect application of the test, early miscarriage, use of drugs containing the hCG molecule, medical use of the hCG hormone itself and medical conditions producing elevated hCG.
- False negative results can occur if testing occurs after fertilisation of the ova but before implantation in the endometrial lining.

Appendix D:

Equality Impact Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/ No	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	• Race		
	• Ethnic origins (including gypsies and travellers)		
	• Nationality		
	• Gender		
	• Culture		
	• Religion or belief		
	• Sexual orientation including lesbian, gay and bisexual people		
	• Age		
	• Gender Identity		
	• Marriage and Civil Partnership Status		
	• Pregnancy and Maternity Status		
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems		
2.	Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?		
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
4.	Is the impact of the document/guidance likely to be negative?		
5.	If so, can the impact be avoided?		
6.	What alternative is there to achieving the document/guidance without the impact?		
7.	Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?		