The Shrewsbury and Telford Hospital NHS Trust

Pregnancy Testing Prior to Treatment

Version 4

Lead Clinician	**:**	Mr. Andrew Tapp – Consultant Gynaecologist
Care Group	**:**	Women and Children's
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This guideline should be read in conjunction with the following guidance:
Consent Policy SaTH NHS.
Radiology Protocol For Identifying Women Whom May Be Pregnant.SaTH NHS
SaTH NHS Paediatric Department local guidelines.

Version	Implementation Date	History	Ratified By	Full Review Date
1	April 2005			
2	July 2011			July 2014
3	30th April 2014			April 2017
3.1	30th July 2015	Addition of process for patients admitted to ITU	Gynae Governance 30.6.2015	April 2017
3.2	16th October 2019		Guideline EPAS Lead Nurse confirmed no changes	16 Oct 2024
4	October 2025	Reviewed, no changes required	Confirmed by Mr M Wood	October 2028

1.0 Introduction

1.1 Through the clinical risk system in the Trust is has become apparent that on occasion a fetus in utero has been put at risk because the mother has been treated without knowledge that she is pregnant.
There is evidence that some treatments carry significant risks of spontaneous abortion, prematurity and intrauterine growth retardation.

1.2 It has also been found that there is an increased risk of death 7 days after birth in offspring of women who have been anaesthetised in early pregnancy.

1.3 The risks of the fetus from exposure to x-rays during early pregnancy are also documented. Pregnancy testing will allow feto-maternal risks of any planned treatment to be considered.

1.4 Patient history of menstrual period, contraception, sexual activity and possibility of pregnancy in post menarche patients presenting for treatment is known to be often unreliable. Following extensive discussions at Trust and Clinical Governance meetings it was felt on balance that all female patients capable of reproduction should be routinely offered pregnancy testing in the 24 hours preceding invasive or surgical therapy. Likewise patients admitted to the medical ward either acutely or electively should be offered pregnancy testing before commencing investigations or treatment that could potentially jeopardise fetal health. In practice the universal policy of offering pregnancy testing on admission to hospital for at risk patients would seem appropriate.
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2.0 Aim

To minimise the risk of a fetus being unknowingly exposed to factors that may be potentially harmful.

3.0 Objective

To offer all women of child bearing age to menopause, pregnancy testing immediately prior to treatment/investigation.

4.0 Definition

4.1 Consent:
It must be explicit that patients have a choice as to whether or not to accept pregnancy testing. Verbal consent should be taken from all competent patients and this consent recorded. Where patients decline they must receive full information as to the risks and a record made.

4.2 When patients are not competent, doctors will need to decide if the test is in the patient's best interest. Where possible, consultation should be with the main carer or next of kin.

5.0 Process

- For patients under 16 please seek advice from the Paediatric Department.
- For patients admitted to an intensive care setting see section 5.2
- The x-ray department currently have their own arrangements

5.1 Pregnancy testing will be undertaken on a fresh urine sample from the patient with near patient testing. Near patient testing has a false negative rate in the order of 0.3% and can occasionally be confounded by very dilute urine. Urinary pregnancy tests may become positive 2 to 3 days before the date of the missed period.

5.1.1 A negative pregnancy:
A negative pregnancy test should be documented in the urine results in the medical records and should be clearly visible to everyone caring for the patient.

5.1.2 A positive test:
The senior member of the team responsible for the care and management of the patient or the operating surgeon should be notified of the positive result. The result should be given to the patient. A positive result does not mean

automatic cancellation of the proposed surgery/procedure, but the significance of the positive pregnancy test and the pros and cons of proceeding with the proposed operation/procedure should then be discussed with the patient by the senior member of the team caring for the patient/operating surgeon/anaesthetist. The result should be documented in the notes in a clearly visible manner with a record of the doctor informed of the positive result. NB. It is advisable for departments to use a result stamp.

5.1.3 A declined test:

A declined test would not result in the automatic cancellation of operation/procedure. A senior member of the team responsible for the care and management of the patient or operating surgeon would confirm with the patient that she wished to proceed with her operation / treatment in the absence of information with regards pregnancy. The declined test and the reason for decline would be documented in the medical records.

5.2 Patients admitted to ITU

Knowledge of pregnancy status of female ITU patients is vital for the safe treatment of the patient (and fetus) and to ensure sound decision making.

5.2.1 For patients admitted to ITU electively following surgery this policy process will apply and pregnancy testing will have been offered as part of the workup for surgery.

5.2.2 For **female patients between 16 and 55 years of age admitted to ITU as emergency admissions alternative arrangements** are necessary. The vast majority of these patients will not have capacity to consent and many will be anuric or polyuric making urinary pregnancy tests unsuitable.

All these patients should have a serum beta HCG test performed on admission to the ITU. In the event of a positive test it may be appropriate to involve an obstetrician and confirm the result with an ultrasound of the uterus before discussing the result with the patient (when capacity regained) or the patient's family.

6.0 Training

6.1 Minimal training for the technique of pregnancy testing is required.

6.2 There should be agreement within directorates with regards to appropriateness of testing in the outpatients setting.

6.3 Those testing should be informed of the importance of sensitivities surrounding the issue of requesting the test and supplying the result.

6.4 Those testing the patient should be able to give the patient a clear explanation as to why the test has been performed.

6.5 Consent will be verbal.

6.6 Patients testing should be aware of potential compounding factors including dilute urine, contaminated urine, hormone-producing tumours and occasionally hormone based drug treatment.

6.7 Prior to commencing the test, staff need to be aware of the manufacturer's instructions for completing an accurate pregnancy test and correctly interpreting the results. This policy would not apply to the Paediatric Ward.

7.0 References

Bastian-L-A, Piscitelli-J-T ***Is this patient pregnant? Can you reliably rule in or rule out early pregnancy by clinical examination*** .JAMA, {JAMA}, 20 Aug 1997, vol. 278, no. 7, p. 586-91, 21 refs, ISSN: 0098-7484.

CEMACH (2004) ***Why Mothers Die 2000 – 2002*** CEMACH, page 106.

NICE (June 2003) ***Clinical Guideline 3 – The use of routine preoperative tests for elective surgery.***

Appendix 1

Routine Pregnancy Testing Flow Chart (For non ITU patients)

Women of childbearing age 16 – menopause (exclude only patient post hysterectomy within this age group).