Brighton and Sussex University Hospitals NHS Trust

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Checking Pregnancy before Surgery

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Name of responsible committee/individual:	Clinical Policies and Guidelines Group
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Review date:	
Target audience:	All staff in contact with women undergoing a surgical procedure or any other procedure involving an anaesthetic
Accessibility	This document is available in electronic format only.

Contents

Introduction

This policy is based on the recommendations of the NPSA (1) alert 2011 after a number of spontaneous abortions of pregnancy following surgical procedures where the woman and staff caring for her were unaware of her pregnancy.

1.2.1 This policy refers to all patients who have started menstruating regardless of age and who are not more than 1 year post-menopausal. Patients who are using contraceptives, those who have had surgical procedures to prevent pregnancy and patients who are not sexually active will be included.

1.2.2 It is worth noting that an estimated 0·5 to 2·0 per cent of pregnant women undergo anaesthetic or surgical procedures at some point during their pregnancy and the incidence of previously undiagnosed pregnancy ranges from 0·15 to 2·2 per cent (Wingfield and McMenamin 2014).

1.3 For advice about pregnancy testing children under the age of 16, contact the child protection team based in the Royal Alexandra Children's Hospital (RACH) or the bleep holder for the hospital out of hours. Please also refer to the policy document "Local Guidelines for Pre-Procedure Pregnancy Testing in premenarchal Females at the RACH and The Royal College of Paediatrics and Child Health (RCPCH) guidance for pregnancy testing is available at www.rcpch.ac.uk/pregnancychecks.
Advice on the duty of confidentiality towards young people are included in 'Service standards on confidentiality' (Royal College of Obstetrics & Gynaecology (RCOG)); 'Best practice guidance for doctors and health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health' (Department of Health (DOH)).

1.4 Refer to the BSUH Mental Capacity Act Policy for any person who lacks capacity or requires support in making their own decisions

2. Purpose

2.1 This policy provides clear guidelines to identify pregnancy and the potential risks to the mother and foetus by undergoing surgery and anaesthetics and ensuring all parties make an informed choice regarding the treatment plan. 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.

2.2 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.

2.3 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.

3. Definitions

- Pregnancy tests refer to Human Chorionic Gonadotrophin (HcG) urine pregnancy testing sticks.
- HcG is the key hormone in pregnancy normally detected higher than 5 m units/ml in pregnant patients.
- LMP refers to Last Menstrual Period

4. Responsibilities, Accountabilities and Duties

4.1 Chief Executive

The Chief Executive will be aware of their legal duties as the responsible person for meeting the requirements of pregnancy testing and implementing NPSA alert recommendations. They will be aware of the performance of the Trust in meeting all regulations and recommendations and will ensure that adequate resource is provided for appropriate action to be taken.

4.2 Responsibility of all management

- Ensure the policy is implemented, compliance monitored and regularly reviewed as required in line with Trust and national recommendations.
- Ensure this document is available to all staff caring for patients in the clinical setting.
- Ensure all staff are competent in the use of urinary pregnancy tests and understand their responsibilities.
- Pregnancy tests are available for use as required and stored as manufacturer's guidelines.
- Ensure any lapses in guidelines are investigated and remedial actions are implemented immediately.

4.3 Responsibilities for health care professionals preparing the patient for surgery and any other procedure involving anaesthesia or sedation

- To access, read, understand and follow this policy.
- To use their professional judgement in application of this policy to protect any patient or foetus from potential harm.
- To act accordingly and involve the multi-disciplinary team if pregnancy is detected prior to elective and emergency surgical procedures or investigations involving sedation.
- To protect the patient's privacy and dignity.
- To follow the manufacturer's guidelines when using the pregnancy test. Two individuals must interpret the pregnancy test, and one of those individuals must be a registered practitioner. All staff undertaking pregnancy testing must be assessed as competent in the skill, and understand their limitations.

Policy

5.1 BSUH clinical staff should routinely ask patients for the date of their last period at preoperative assessment, and again on admission for their procedure during completion of the preoperative/procedure check list.

5.2 All BSUH staff should emphasise that pregnancy testing is routine for all female patients with a history of a LMP, who require an anaesthetic or sedation for their procedure. 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.

5.3 Asking patients about their menstrual cycle and potential pregnancy is complex. Reliance on history alone is problematic because the menstrual cycle length is erratic in 72 per cent of normal women (median 28–29 (range 19–60) days), with greatest variability in the years leading up to menopause. Many women will not know the date of their LMP or the precise frequency of their cycle, and their assessment of their chances of being pregnant has been shown to be unreliable (Wingfield and McMenamin 2014). This is why we should routinely carry out a pregnancy test on all women with a history of a last menstrual period.

5.4 Staff should explain to patients that urine pregnancy tests are designed to be accurate from the first day of a missed period, and so may not detect very early pregnancies. Therefore, it is possible that a very early pregnancy may not give a positive result when urine is tested before the expected date of the next period. (Wingfield and McMenamin 2014).

5.5 The preoperative assessment staff should explain that a pregnancy test will be performed on the day of surgery and ensure the patient understands the risks of surgery, anaesthesia or sedation to the foetus.

5.6 A patient may have made it clear at initial contact at preoperative assessment that there is no risk of pregnancy. However pregnancy status may have changed in the intervening time prior to surgery, so patients should have a routine pregnancy test carried out and documented on the preoperative check list on the day of surgery.

5.7 All staff working in operating theatres must check that a pregnancy test has been performed whenever necessary and documentation must be completed prior to anaesthesia as part of the theatre checklist within the Theatre Pathway documentation: including that they have either:

- Performed a pregnancy test with the patient's consent, including the result, batch number and expiry date of the test documented.
- Not performed a pregnancy test due the patient withholding their consent.

5.8 If a patient does not consent for pregnancy testing, this should be documented in the medical notes and theatre check list. The surgeon and anaesthetist should also be informed, because they may decide not to operate or anaesthetise if there is a risk of harm to the with a potentially undiagnosed pregnancy.

5.9 Some patients may refuse a pregnancy test for personal reasons, such as their sexual orientation, and this should be respected. The refusal of consent should be documented and the surgeon and anaesthetist informed.

5.10 Staff should be sensitive to circumstances when the question of possible pregnancy should not be asked e.g. patients undergoing surgery for surgical management of miscarriage or for the treatment of an ectopic pregnancy. A pregnancy test should have been carried out for these patients on admission and documented in their medical records.

5.11 If a pregnancy is detected a registered member of staff (doctor, nurse or operating department practitioner ODP) should inform the patient of any unexpected positive pregnancy result and involve the consultant providing her care. Nursing staff should inform a member of both the anaesthetic and surgical teams caring for the patient and escalate to the consultant from each speciality (if not already involved).

5.12 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 sending a serum sample for testing.

5.13 The risks and benefits of surgery should be discussed with the patient and may be postponed or anaesthetic and surgical approaches modified if necessary. In emergency situations, confirmation of pregnancy should not delay treatment and should be judged within clinical assessment of risk.

5.14 A named nurse should support the patient throughout the process. The named nurse should also help with a referral to local ante-natal care, normally through the patient's GP surgery.

5.15 Chaplaincy support can be provided for anyone having difficulty coming to terms with their pregnancy or alternatives (contact can be made through switchboard). Counselling is available at: http://www.pregnancychoicesdirectory.com/

5.16 The registered practitioner should record the positive result and the actions taken within the patient's notes.

6. Training Implications

Only those staff who have completed a competency assessment for pregnancy testing should perform pregnancy tests.

7. Monitoring Arrangements

Measurable Policy Objective	Monitoring / Audit Method	Frequency	Responsibility for performing monitoring	Where is monitoring reported & what groups/committees Are responsible for progressing & reviewing action plans
A preoperative pregnancy test is carried out on patients as indicated above	Paper audit	Monthly	Theatre managers	Perioperative Standards Forum which reports to the Nursing Midwifery Management Board

8. Due Regard Assessment Screening

As an NHS organisation, BSUH is under a statutory duty to set out arrangements to assess and consult on whether their policy and function impact on equality with regard to race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, marriage and civil partnership status, pregnancy and maternity status and disability. A review of the assessed impact of this policy against these criteria can be seen (Appendix 1).

9. Number Links to other Trust policies

- Consent to Examination or Treatment Policy
- Teenage Pregnancy Protocol
- Early Pregnancy Assessment Unit Guidelines
- Mental Capacity Act Policy
- Local Guidelines for pre-procedure pregnancy testing in pre-menarchal females at the RACH.

10. Associated documentation

Theatre and Recovery Integrated Care Pathway

11. References

- NICE. 2016: Routine preoperative tests for elective surgery
- Available at: https://www.nice.org.uk/guidance/NG45
- NPSA 2011: Checking Pregnancy before Surgery: Patient Safety. http://www.nrls.npsa.nhs.uk/resources/?EntryId45=73838
- RCOG 2015: Obtaining Valid Consent. Clinical Governance Advice no.6
- RCPCH 2012: Pre-procedure Pregnancy Checking for Under-16s. http://www.rcpch.ac.uk/pregnancychecks
- Wingfield M. and M. McMenamin 2014: Preoperative pregnancy testing *The British Journal of Surgery* 101: (1488-1490)

Appendix 1 Due Regard 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:**		
	• Age	No	
	• Disability	No	
	• Gender	Yes	Pregnancy related so affects those who were born female
	• Gender identity	Yes	May affect trans gender individuals – sensitivity needs to be applied
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	Yes	
	• Race	Yes	Delicacy is needed in discussions surrounding pregnancy with mixed sex clinicians
	• Religion or belief	Yes	Same comments as per Race
	• Sexual orientation, including lesbian, gay and bisexual people	No	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	No	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	n/a	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**	n/a	
6.	**What alternative is there to achieving the document/guidance without the impact?**	n/a	
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?**	n/a	
8.	**Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)**	No	

If you have identified a potential discriminatory impact of this policy, please refer it to Directorate Lead Nurse – Perioperative together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Directorate Lead Nurse – Perioperative.