BEST PRACTICES IN ABORTION CARE

Guidelines for British Columbia

July 2004
EXECUTIVE SUMMARY

The purpose of Best Practices for Abortion Care: Guidelines for British Columbia are:

- To assist those providing any aspect of abortion care in the province in achieving or maintaining optimum standards of care, while acknowledging that there are often factors challenging this concept, beyond the control of many providers.

- To assist in the planning and development of additional abortion services throughout the province of BC.

- To promote the concept of woman-centered care in the provision of abortion services.

The initiative for this project arose from concerns raised in the Abortion Services Working Group meetings regarding a lack of standards and guidelines in key aspects of abortion care in the province. The goal of this document is to fill in those gaps by presenting a set of principles and strategies on which abortion service providers can base their care practices.

Divided into three sections, the document tackles the main practice issues facing abortion service providers in B.C. today:

- **Section One (pages 1-1 to 3-2)**
  Focuses on the legal and ethical aspects of abortion

- **Section Two (pages 4-1 to 6-3)**
  Offers guidelines for abortion and related services such as pregnancy diagnosis and counselling.

- **Section Three (pages 7-1 to 11-2)**
  Focuses on clinical practice guidelines, covering protocols for the provision of both surgical and medical abortion care.

While not meant to be an exhaustive review of all aspects of abortion-related care, the hope is that these guidelines can assist providers throughout the province in improving service quality, and gain a broader understanding of better practices in abortion care.
# TABLE OF CONTENTS

EXECUTIVE SUMMARY

1. INTRODUCTION

2. BACKGROUND

   2.1. BACKGROUND
   2.2. STANDARDS OF CARE
   2.3. PATIENT SATISFACTION
   2.4. RECOMMENDATIONS FROM THE REPORT
   2.5. ESTABLISHING STANDARDS

3. LEGAL AND ETHICAL ASPECTS OF ABORTION CARE

   3.1. THE LEGAL HISTORY OF ABORTION IN CANADA
   3.2. CONSCIENTIOUS OBJECTION TO PROVISION OF ABORTION CARE
   3.3. SEX SELECTION

4. PROVIDERS & PREGNANCY DIAGNOSIS

   4.1. ABORTION PROVIDERS
   4.2. PREGNANCY DIAGNOSIS

5. COUNSELLING

   5.1. DECISION-MAKING COUNSELLING
   5.2. SUPPORTIVE COUNSELLING
   5.3. CONTRACEPTIVE COUNSELLING
   5.4. COUNSELLING AND CARE FOR WOMEN WITH A HISTORY OF SEXUAL ABUSE
   5.5. PROVIDING COUNSELLING AND CARE FOR RELATIONSHIP VIOLENCE
   5.6. GENERAL PRINCIPLES OF CARE
      5.6.1. Build Trust
      5.6.2. Focus on Empowering Women
      5.6.3. Create a Clear and Safe Opportunity for Discussion
      5.6.4. Respond When Abuse is Disclosed
   5.7. ADDICTION SENSITIVE COUNSELLING AND CARE

6. CONSENT, CONFIDENTIALITY & DOCUMENTATION

   6.1. INFORMED CONSENT
      6.1.1. Age of Consent
   6.2. DOCUMENTATION
   6.3. CONFIDENTIALITY: SPECIAL CONSIDERATIONS

7. PRE-PROCEDURE CARE GUIDELINES

   7.1. ROUTINE PROPHYLACTIC ANTIBIOTICS
      7.1.1. Routine Prophylactic Antibiotics Prior to Laminaria Insertion
7.1.2. Prevention of Bacterial Endocarditis: Prophylactic Antibiotic Treatment for Women with Cardiac Conditions ......................................................... 7-1
7.2. LABORATORY TESTING .................................................................................. 7-2
7.3. SEXUALLY TRANSMITTED DISEASE SCREENING, TREATMENT AND FOLLOW UP .................. 7-3
7.4. ULTRASOUND ................................................................................................. 7-3
7.5. MANAGEMENT OF SUSPECTED ECTOPIC PREGNANCY .................................. 7-4
8. INTRA-PROCEDURE CARE GUIDELINES ....................................................... 8-1
  8.1. MEDICAL ABORTION ......................................................................................... 8-1
  8.2. SURGICAL ABORTION PROCEDURAL GUIDELINES ................................... 8-2
    8.2.1. Patient Preparation ..................................................................................... 8-2
    8.2.2. Pain Management Options ........................................................................ 8-3
    8.2.3. Cleansing the Perineum, Vulva and Vagina .................................................. 8-3
  8.3. FIRST TRIMESTER ABORTION ...................................................................... 8-4
    8.3.1. Recommended Equipment and Supplies ...................................................... 8-4
    8.3.2. Technique .................................................................................................. 8-4
  8.4. SECOND TRIMESTER ABORTION .................................................................. 8-5
    8.4.1. Recommended Equipment/ Supplies ............................................................ 8-5
    8.4.2. Technique .................................................................................................. 8-5
  8.5. EXAMINATION OF TISSUE .......................................................................... 8-6
  8.6. INTRA-OPERATIVE ULTRASOUND .............................................................. 8-6
  8.7. RH IMMUNE GLOBULIN .............................................................................. 8-6
9. FOLLOW-UP & .................................................................................................... 9-1
  EMERGENCY PROTOCOL GUIDELINES .......................................................... 9-1
  9.1. POST ABORTION FOLLOW UP CARE ......................................................... 9-1
  9.2. EMERGENCY PROTOCOLS .......................................................................... 9-1
10. SECURITY .......................................................................................................... 10-1
  10.1. CLINICAL AREAS .......................................................................................... 10-1
  10.2. PROVIDERS .................................................................................................. 10-1
  10.3. CLINIC WORKERS ....................................................................................... 10-1
11. QUALITY ASSURANCE ............................................................................... 11-1
  11.1. UTILIZATION ............................................................................................... 11-1
  11.2. DOCUMENTATION REVIEW ....................................................................... 11-1
  11.3. REVIEW OF COMPLICATIONS .................................................................. 11-2
  11.4. PATIENT SATISFACTION ............................................................................ 11-2
APPENDIXES

APPENDIX A - EMERGENCY CONTRACEPTION
APPENDIX B - ROUTINE PROPHYLACTIC ANTIBIOTICS
APPENDIX C - LAMINARIA INSERTION: ROUTINE PROPHYLACTIC ANTIBIOTICS
APPENDIX D - ENDOCARDITIS PROPHYLAXIS: HIGH RISK
APPENDIX E - ENDOCARDITIS PROPHYLAXIS: MODERATE RISK
APPENDIX F - ECTOPIC PREGNANCY: PATIENT INFORMATION
APPENDIX G - MEDICAL ABORTION PROTOCOL
APPENDIX H - SAMPLE CONSENT FORM: MEDICAL ABORTION
APPENDIX I - MEDICAL ABORTION: PATIENT INFORMATION
APPENDIX J - PROTOCOL FOR MISOPROSTOL USE
APPENDIX K - RH IMMUNOGLOBULIN: PATIENT INFORMATION, CONSENT & WAIVER
APPENDIX L - INTERVENTIONS FOR CRITICAL INCIDENTS
APPENDIX M - NATIONAL ABORTION FEDERATION COMPLICATION RATES
APPENDIX N - ASSESSMENT FRAMEWORK FOR BEST PRACTICE GUIDELINES
APPENDIX O - ACKNOWLEDGEMENTS
This document offers best practice guidelines for providers of abortion services throughout British Columbia. Its purpose is to:

- Assist those providing any aspect of abortion care in the province in achieving or maintaining optimum standards of care, while acknowledging that there are often factors challenging this concept, beyond the control of many providers.

- Assist in the planning and development of additional abortion services throughout the province of BC.

- Promote the concept of woman-centered care in the provision of abortion services.

Separated into three parts, the document covers a range of issues and practice concerns:

- **Part One**: Legal and Ethical Aspects of Abortion

- **Part Two**: Guidelines for Abortion and Related Services

- **Part Three**: Clinical Practice Guidelines

The impetus for the development of a set of guidelines on best practices in abortion services resulted from a recognition that B.C. lacked standards and guiding principles in key aspects of abortion care. The goal of this document is to fill in those gaps by presenting a set of principles and strategies on which abortion service providers can base their care practices. While not meant to be an exhaustive review of all aspects of abortion-related care, the hope is that these guidelines can assist providers throughout the province in improving service quality, and gaining a broader understanding of better practices in abortion care.

The guiding principles of *Best Practices in Abortion Care* are as follows:

1. Reproductive health is vital to the well-being of women and their families. Quality reproductive health services, including reproductive health screening and treatment, contraceptive information and methods, and abortion, are core components of the health care system in British Columbia.

2. Access to the full range of reproductive health services, including abortion, must be available for women regardless of where they live in the province.
3. The planning and provision of abortion services for women must take place within a woman-centered care model that recognizes and respects the rights of women to control their reproductive lives and to make decisions that are based on their personal knowledge and experiences.

4. Although abortion procedures are not complicated from a medical or technical point of view, the “elective” nature of abortion requires that it be provided with particular care to ensure the future reproductive health of women is not compromised.
2. BACKGROUND

2.1. Background

The initiative for this project arose from concerns raised in the Abortion Services Working Group meetings regarding a lack of standards and guidelines in key aspects of abortion care in the province. A student was hired by the Office of the Special Advisor, Womens’ and Seniors’ Health, Ministry of Health Planning during the summer of 2002 to “gather background information on best practices in abortion care to help set up targets and goals for improving service quality, identify gaps in the existing information for future research, and to gain understanding of the various quality issues to provide input for the patient satisfaction survey project”.

As a result of the student’s work, the Ministry produced a document entitled “Abortion and Quality Assurance Project: Summary of Findings Related to Standards of Abortion Care” (August 2002). The recommendations of the report were based on two important concepts:

- standards of care
- patient satisfaction

2.2. Standards of Care

A comprehensive literature review using CINAHL, PubMed and Ministry of Health databases revealed that information regarding abortion practices and standards are “virtually non-existent” and the majority of the literature focused instead on the experiences and levels of satisfaction of women obtaining these services in Canada and the United States.

Most of the community based abortion clinics in Canada maintain membership in, and utilize Clinical Policy Guidelines developed by the National Abortion Federation (NAF), based in Washington, D.C. These clinics also participate in an annual collection of comprehensive data which includes utilization, parameters of practice, and reporting of complications. NAF utilizes the data collected from throughout the US and Canada to establish benchmarks against which individual abortion clinics may measure their performance.

2.3. **Patient Satisfaction**

A review of the literature found a number of common factors that influenced the quality of women’s experiences of abortion care. These factors include whether or not women were enabled to make an informed choice regarding the type of procedure (medical compared to surgical, in those situations where the gestational age is appropriate for such a choice) along with a comparison of women’s actual experiences of these two options; and whether or not health care providers (primarily physicians) offered options and support to women seeking abortions. Some women commented that their access to information and services was often hampered by physicians who were unhelpful and/or considered themselves “pro-life”.

2.4. **Recommendations from the Report**

Recommendations from the report are summarized as follows:

- Existing guidelines can be modified and adapted to be suitable for hospital-based abortion services. All hospitals providing abortion services should provide the range of services provided in clinics (pregnancy testing, ultrasound, decision-making and supportive counselling, the option of conscious sedation rather than general anaesthesia, etc.).

- Comprehensive counselling must be provided to enable the woman to make an informed decision and be fully informed regarding the details of the procedure. The literature shows that when women receive adequate counselling and support prior to and during their abortion, they show a much higher level of satisfaction post-procedure.

- Nursing and other staff working in abortion services in a general hospital setting should be provided with special education in sexual and reproductive health, abortion and contraception.

- NAF’s Clinical Policy Guidelines should be adapted for the acute care setting, utilizing the most current recommendations.³

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³ The reporter has made an assumption that medical abortions are not provided in hospital settings.
Commentary on the Recommendations

The Summary of Findings presented a helpful but incomplete picture of the issues that must be addressed if women in British Columbia are to receive an optimal level of care.

The Advisory Committee for this project advised that the guidelines should include the full range of abortion-related services and be sufficiently flexible to be applicable in either a community clinic or a hospital facility.

2.5. Establishing Standards

A working paper entitled “Finding a Fit: Establishing Standards Using a Women’s Centred Approach” produced by Penny Dowedoff for the Violence Against Women Provincial Health Care Initiative in 2001, provides an excellent guide to assist organizations in establishing standards that can be used throughout the province.

The paper points out the difficulty in defining standards versus guidelines as there appears to be a wide variation in how these terms are used. Dowedoff’s interview respondents noted that the term “standards” is used for everything from specific rules and regulations to general guidelines and principles (page 4).

The following table is a brief summary of some noted differences between standards and guidelines according to Dowedoff:

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Table I

<table>
<thead>
<tr>
<th>Standards</th>
<th>Guidelines</th>
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<tbody>
<tr>
<td>Established, measurable, achievable statements describing a desired level of performance against which performance can be measured.</td>
<td>A suggestion or set of suggestions that guides or directs action</td>
</tr>
<tr>
<td>Are implemented and enforced by a regulatory body which has the authority to penalize or sanction those who do not meet the standards.</td>
<td>Are flexible and voluntary</td>
</tr>
<tr>
<td>Statements describing the outcome which is expected to occur in response to the provision of a specific component of service.</td>
<td>Outline the general steps to be followed in a particular organization, should it choose to implement and use the guidelines.</td>
</tr>
<tr>
<td>Practice standards describe a required level of performance that can range from the optimal best practice to the minimal level of practice. In other words, standards may describe baseline practice that must be achieved, or may describe best practice or the ideal to be achieved (this may depend on available resources).</td>
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Dowedoff describes guidelines and standards as a continuum where there are varying degrees of flexibility and enforceability and where the diversity of health care settings and resources need to be acknowledged. It is important to note that establishment of “standards” implies that a regulatory or accreditation body exists to ensure compliance. With respect to abortion procedures, in British Columbia provision of services is either through a hospital service (under the auspices of Canadian Council on Health Services Accreditation, which is a generalized accreditation) or a community-based clinic (accredited by NAF). The likelihood of establishing a regulatory body specific to abortion services in B.C. is very remote, and it seems that the approach with the greatest likelihood of success would be to develop and promote evidence-based “guidelines for care” that would ensure the best possible level of care wherever that care is being provided.

In order to ensure that the guidelines reflect a woman-centered care model, it is vital that desired outcomes are described in terms of the woman’s experience of abortion when the guidelines are adhered to. For example in decision-making counselling, the best practice would be to assist the woman to examine her available options and consider each one in the context of her particular circumstances, to provide information about all of the options, including adoption, single parenthood, and abortion, and to support the woman when she has made a decision. When this
process has been followed, the woman’s experience would include a process of informed decision making, and a sense that she is supported and in control of her situation. Research has shown that women at the greatest risk of problems post abortion are those who have pre-existing mental health issues, those who have unresolved conflicts regarding their pregnancy (related to relationships, religion, history of sexual or other abuse), and those whose life situation has resulted in vulnerability to coercion. Further research that would correlate optimal emotional health outcomes with the quality of pre-abortion counselling is needed.

Preliminary data from a project which examined access to abortion in the province (May 2003) revealed that abortion services are provided in at least one community in each Health Authority, but that women living in remote communities in poverty were particularly unable to access either contraceptive choices, pregnancy counselling, or abortion services. There were five barriers to access to abortion services most frequently identified. These barriers are outlined in Table 2.

Table 2

<table>
<thead>
<tr>
<th>Access Barriers to Abortion Services</th>
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<tbody>
<tr>
<td>Scarcity of providers</td>
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<tr>
<td>Scarcity of facilities</td>
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<tr>
<td>Lack of funding for women to enable travel to another community</td>
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<tr>
<td>Lack of information about options (possibly a reflection of a lack of counselling)</td>
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<tr>
<td>Concerns about confidentiality</td>
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</table>

A web search for abortion care guidelines disclosed a document entitled “The Care of Women Requesting Induced Abortion”, developed by the Clinical Effectiveness Support Unit of the Royal College of Obstetricians and Gynaecologists in the UK. These guidelines were developed by a multidisciplinary group following an extensive literature search. They were intended for use by physicians and other health care disciplines involved in abortion care, as well as those involved in planning or development of abortion services. The guidelines were developed in relation to abortion legislation and available resources in England, Wales and Scotland. Although these aspects of the document are not relevant in other jurisdictions, the format, ethical considerations, and most of the core clinical practices guidelines are universal in application, and form a useful model for the development of guidelines for British Columbia.

SECTION ONE

LEGAL AND ETHICAL ASPECTS OF ABORTION CARE
3. LEGAL AND ETHICAL
ASPECTS OF ABORTION CARE

3.1. The Legal History of Abortion in Canada

Until 1969 the Criminal Code of Canada stated that abortion was a criminal act except in cases where the life of the woman was in danger. These statutes also declared that it was illegal to teach about or provide any methods of contraception.

Bill C-52 laid out new guidelines under which the provision of abortion would not be a criminal act; that is, if performed by a licensed physician in an accredited hospital which must have a therapeutic abortion committee of not less than three physicians, and to save the life or health of the woman. Bill C-52 did not provide an interpretation of the word “health”. This latitude resulted in improvements in access to abortion in those areas of Canada where the World Health Organization’s broad definition of “health” was applied. Unfortunately, in many other areas, access to safe abortions remained problematic, especially for women of limited income and/or unable to travel to centres where services were available.

In 1988, a landmark Supreme Court decision declared Bill C-52 to be unconstitutional under the Canadian Charter of Rights (Dr Henry Morgantaler v. the Crown) and for the first time in Canada, abortion became a decision between a woman and her physician. An attempt in 1990 to reinstate a law governing abortion was narrowly defeated in a Senate vote, and to date, the provision of abortion falls within the realm of medical practice standards.

In British Columbia, access to abortion in any community is determined by the availability of physicians who provide abortions and the availability of hospital or clinic facilities in which they may be performed. The Ministry of Health has made a commitment to maintain access to abortion as a core aspect of health care services.
3.2. Conscientious Objection to Provision of Abortion Care

Comfort levels related to abortion are greatly influenced by personal values. A requirement to provide abortions may contravene the personal values held by a health care provider. Therefore there is a need for flexibility in this regard and for accommodation of a health care provider’s choice to not participate in abortion procedures. This is congruent with statements from the Registered Nurses Association of British Columbia\(^6\) and the College of Physicians and Surgeons of British Columbia\(^7\), both of which support the right of an individual health care professional to choose whether or not to participate in the provision of abortion services.

It is also important to recognize the obligation of health care providers to provide appropriate care in emergency situations and to facilitate a woman’s access to information about abortion and services as requested. It follows that all health care workers would contribute to creating an atmosphere of caring and respect for the choices of women, their families, and the choices of colleagues with respect to this issue.

3.3. Sex Selection

After more than a decade of discussion and debate, Bill C-13: An Act Respecting Assisted Human Reproduction was proposed and passed through Parliament in November 2003. Prior to its introduction to the Senate for the final vote, that session of Parliament was prorogued, incidentally preventing passage of Bill C-13. The legislation was reintroduced as Bill C-6 and was passed by the Senate in March 2004. Bill C-6 creates two broad categories of activities related to assisted human reproductive practices, those that are prohibited and must not be carried out under any circumstances (Clause 5), and controlled activities which must be carried out in accordance with the legislation and the regulations stipulated in Bill C-13. The list of prohibited activities includes “sex selection, except for preventing, diagnosing or treating sex-linked disorders or disease”. (Clause 5(1)(e)\(^8\)).

The Society of Obstetricians & Gynaecologists of Canada Policy statement on gender selection condemns any medical techniques that perpetuate discrimination on the basis of gender. These include selective implantation of embryos, selective abortion of healthy fetuses after amniocentesis, or infanticide. The Policy states that the only exceptions are procedures that minimize the genetic (sex-linked) transmission of diseases\(^9\).

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\(^{8}\) www.parl.gc.ca/common/Bills

\(^{9}\) Society of Obstetricians and Gynaecologists of Canada (December 1994), No.32. SOGC policy statement on gender selection.
Women in Canada have the right to choose termination of a pregnancy, and are not required to justify their reasons for doing so. In general, the upper gestational age at which abortion (other than in cases of fetal anomaly) is available in Canada is around 20 weeks in some locations. When a woman discloses that sex selection is her reason for the abortion, a provider may face a dilemma related to his/her personal (emotional) response to gender selection; the evolving legislation and professional guidelines which are very specific on this topic; and the knowledge that in general abortion may be selected for a variety of reasons that are no more nor less compelling. When faced with this dilemma it may be helpful to consider the request from a variety of perspectives. If viewed from a cultural context, a preference for one gender (most commonly male) may have its origins in the socio-economic history of that culture, where male children are valued for their future potential to provide financial support to the family, while females may be viewed as an economic liability. The decision to terminate a pregnancy prior to 20 weeks because of the sex of the fetus, will most likely have been based on information of dubious accuracy (an “out of regulation ultrasound”), or folk (traditional) methods, or there may be a desire to achieve “gender balance” while still limiting family size.

In either case, it is possible that a woman may be under intense pressure from others to terminate her pregnancy, may not necessarily wish to do so, but may not perceive that she has any voice at all in the matter. If she is in a dependant, vulnerable position within her family, she may feel that she must choose either to comply with the wishes of others or suffer serious personal consequences. It is recommended that these complex issues be taken into consideration, any incorrect beliefs or misinformation be addressed, and that the provider would take necessary steps to ensure that the woman’s life or health is not placed in jeopardy if she is denied a safe abortion or by her failure to comply with her family’s wishes.
SECTION TWO
GUIDELINES FOR
ABORTION AND
RELATED SERVICES
4. PROVIDERS & PREGNANCY DIAGNOSIS

4.1. ABORTION PROVIDERS

Abortion is the most commonly performed surgical procedure in developed countries and is a safe option for women with unintended pregnancies, when it is performed by a competent well-trained provider. Provision of Dilatation & Curettage (D&C) procedures for incomplete spontaneous abortion or as a diagnostic procedure does not adequately qualify a physician to be an abortion provider. It is important that a potential abortion provider receives hands-on training during a structured training program or from an experienced colleague and is able to access information about new developments in this field. When providers are aware of limitations in either their skills or in the facility in which they work, it is advisable that they consult with or refer to more experienced colleagues.

4.2. PREGNANCY DIAGNOSIS

Establishing a diagnosis of pregnancy and gestational age are essential aspects of the clinical evaluation when a woman is requesting an abortion. Clinical evaluation includes medical history, physical examination, urinary or serum hCG levels, and/or ultrasonographic examination. An accurate estimate of gestational age will assist the woman in reviewing her options and making an appropriate decision regarding the pregnancy.\textsuperscript{10} \textsuperscript{11}

Although pregnancy testing kits available in pharmacies are theoretically highly accurate, the actual accuracy is dependant upon the ability of the user to follow printed instructions. The false-negative rate in home pregnancy tests ranges from 10 to 50%. A self-administered pregnancy test result should always be confirmed by a combination of either serum or urinary hCG, pelvic examination, and possibly ultrasonography.

\textsuperscript{10} NAF Clinical Policy Guidelines. P. 11
5. COUNSELLING

The quality of the counselling a woman receives when faced with an unintended pregnancy can have a major impact on her ability to make appropriate decisions regarding the pregnancy and her future use of contraception. It is essential that each woman is provided with the level of counselling that she requires, which may range from information only about methods of abortion to an in depth discussion of her perceptions of the advantages and disadvantages of the available options (raising the child in a family unit, single parenthood, adoption, foster care, etc) within the context of her value system and the realities of her life. The main components of pregnancy-related counselling include:

- Decision-making counselling
- Supportive counselling and informed consent
- Contraceptive counselling
- Follow up counselling and/or referrals to other resources for:
  o Abuse/assault
  o Violence
  o Addiction

5.1. Decision-Making Counselling

The decision-making counselling model is based on the principles of short-term crisis counselling with the following characteristics outlined in Table 3.
### Table 3

<table>
<thead>
<tr>
<th>Characteristics of Decision Making Counselling</th>
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<tbody>
<tr>
<td>1. Unintended pregnancy occurs within the context of a woman’s life. Therefore, her feelings regarding the pregnancy and her decision-making process will be influenced by many factors including the relationship or involvement with her partner, her personal support systems and family, age, level of education, financial situation, previous experiences with pregnancy, and her religious or moral views.</td>
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<tr>
<td>2. The relatively limited amount of time available for decision-making requires that the overall direction of the discussion is toward the identification of issues, exploration of alternatives, and making a decision.</td>
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<td>3. Women need accurate, evidence-based information regarding abortion procedures, including possible risks and how these risks are minimized.</td>
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<tr>
<td>4. The emotional intensity experienced by some women during this process can interfere with the ability to deal with the pressure. A supportive atmosphere will promote exploration and expression of feelings.</td>
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<tr>
<td>5. Most people facing a medical or surgical procedure experience some degree of anxiety or ambivalence. It is important to identify the source of ambivalence and deal with it accordingly (if related primarily to terminating a pregnancy, the woman will need to work on how to deal with those feelings, or further explore the options other than abortion).</td>
</tr>
<tr>
<td>6. Women need to be reassured that their decision may be changed up to a certain point (that is, prior to insertion of osmotic dilators. If dilators are removed without an abortion procedure, there is an increased risk of infection and/or miscarriage), or up until an injection of methotrexate or administration of oral misoprostol, or up to the time mechanical dilation of the cervix is started. If the decision is to continue the pregnancy, the woman needs to be aware of the gestational age beyond which abortion would no longer be available.</td>
</tr>
<tr>
<td>7. The decision must be the woman’s, free of coercion or influence from others.</td>
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</table>
5.2. Supportive Counselling

Supportive counselling applies when a woman has clearly explored her options and feels certain that abortion is her best option. The usual process is to briefly review how the decision was reached, identify sources of emotional support, provide information about the procedure, and explore options for contraception.

5.3. Contraceptive Counselling

Contraceptive counselling involves an exploration of prior contraceptive knowledge and practices. Thus, any information provided will either correct misinformation or add new information for the woman to consider. It is important to recognize that ongoing, consistent use of contraception is dependant on personal motivation, therefore, the more involved a woman is in choosing her method of contraception, the more likely she is to use the method consistently and correctly. Any discussion of contraception should also include a discussion of safer sex practices and approaches to prevention of sexually transmitted diseases.

Many abortion providers and clinics provide women with one dose of Emergency Contraception medication along with instructions, plus a prescription for further ECP treatments. (See Appendix A: Provision of Emergency Contraception).

5.4. Counselling and Care for Women with a History of Sexual Abuse

At least 1 in 5 women are survivors of childhood sexual abuse. Although the long term effects on these survivors can be quite varied, for many women the abuse is traumatic and a violation of the body, personal boundaries, and trust, and leads to ongoing physical and mental difficulties.

In these cases, women seeking medical attention may exhibit feelings or behaviours that tend to interfere with the treatment process, and may include a degree of fear or distrust, unexpected reactions to painful treatments, a need to feel “in control”, discomfort with male medical personnel, and difficulty in caring about bodily wellbeing. When women are seeking abortion care, they may exhibit these same feelings or behaviours whether or not the current pregnancy is the result of an assault.

A Health Canada publication, The Handbook of Sensitive Practice for Health Professionals: Lessons From Women Survivors of Childhood Sexual Abuse describes “Principles of Sensitive Practice”, outlining the importance of helping the “client” feel safe in a medical setting. These
Best Practices in Abortion Care

Guidelines can assist providers of abortion services to provide optimal care for women who have a history of sexual abuse or assault\(^\text{12}\). In situations where the woman discloses that the pregnancy she is terminating was the result of sexual assault, it is important to ascertain whether she has had access to the immediate necessary care (counselling, information regarding criminal charges, Sexually Transmitted Infection screening, etc.). If forensic evidence was not collected following the assault, but the woman wishes to pursue criminal charges at the time of the abortion, it is possible that fetal tissue retrieved during the termination could be used to prove the identity of the alleged perpetrator. This process requires involvement of police and careful handling of the fetal tissue as evidence.

5.5. Providing Counselling and Care For Relationship Violence

According to the Canadian Violence Against Women Survey, 51% of women over the age of 16 reported at least one episode of physical or sexual assault, and approximately 15% reported abuse by their intimate partners. Lifetime rates were reported as 25% to 30% in Canadian and American studies.

Twenty one percent of the Canadian women who reported intimate partner abuse stated that they were abused during pregnancy, and 40% of those women reported that the abuse began during the pregnancy.

The broad spectrum of overtly abusive acts includes:

- Mental
- Emotional
- Sexual
- Physical
- Social
- Financial
- Spiritual
- Cultural

However, it is increasingly being recognized, that in abusive relationships, one partner is essentially exercising control over the other. This exercise of control seriously restricts the freedom and autonomy of the abused woman, and limits her ability to make decisions and take actions without fear of retaliation from her abusive partner.

As the relationship between violence and health becomes better understood, health care providers are beginning to consider the impact of potential intimate partner violence on the health of all

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female patients. With respect to reproductive health, the impact can include a lack of control in reproductive decision-making, such as safer sex practices and contraception. Bruising of the breasts or genital area, frequent urinary tract infections, sexually transmitted diseases, incontinence and unintended pregnancy are some of the consequences. Multiple pregnancies or terminations or unexplained pregnancy losses could be indicators of abuse. In a pregnancy that continues, abuse can increase the risk of maternal or fetal death due to trauma or from complications of pregnancy and childbirth.

A woman’s attempt to access health services or to follow prescribed treatments may be controlled by an abusive partner. For example:

- Her partner minimizes her health concerns,
- The woman has learned to ignore or devalue her own needs and doesn’t seek health care when it is necessary,
- Her partner may refuse to leave her alone with the health practitioner,
- The woman may defer decisions to her partner,
- She may be late for or miss appointments,
- She may be visiting health care providers with increasing frequency and severity of concerns,
- She may have difficulty following recommended treatment, has a slower recovery from injury, illness, labour or surgery. Treatment provided may not yield expected outcomes.

This apparent ‘lack of concern or compliance’ regarding her health may lead health care providers to erroneously draw conclusions about the woman. Rather than recognizing these as possible indicators of abuse, health care providers may mistakenly describe her as high maintenance, ‘hormonal’, high risk, needy, emotional, resistant, vague or unreliable.

For a woman seeking an abortion who has been abused, routine medical practices and procedures could have a re-traumatizing effect. For example, health professionals are accustomed to performing procedures that women experience as uncomfortable, invasive and sometime degrading. For a woman who is being abused, these procedures can compound the trauma of her relationship. Some procedures require women to be physically restricted and could be experienced as entrapment or containment by a victim of abuse. Many abused women describe a loss of control, autonomy and power during their health care encounters, which replicate the dynamics of an abusive relationship.

When providers of abortion care recognize the complex interplay of violence and health, they are more likely to provide care that is responsive to the context of a woman’s life and the dynamics of her relationships. This will enable decision-making counselling that will establish a sense of trust and will promote the woman’s sense of control over her situation, with recognition that her safety is of paramount importance.

Any health care encounter is an opportunity for women to make the link between abuse and her health concerns. Ideally health care providers will have received adequate training to assist them to make the link between clinical and behavioural signs that a woman may be experiencing abuse.
and her health concerns. Making this connection will enable health care providers to assess her health issues and respond appropriately. Understanding the sequelae of health issues, utilization issues and behavioural adaptations that abused women may present with will assist practitioners to provide clinical interventions and treatments that decrease the risks of re-traumatization for patients.

While it is good practice to ask women relevant questions about abuse, relatively few women answer yes to questions of abuse. Identification itself does not increase women’s safety or improve women’s health care. It is important to understand why an abused woman may not acknowledge being abused, even when asked directly.

Research documents many negative consequences of disclosing abuse:

- Disclosing abuse may increase women’s sense of vulnerability and be re-traumatizing, thus working against the objective of reducing trauma,
- An abused woman may be concerned about police and child protection involvement,
- A woman may fear that disclosure of abuse may escalate abuse by her partner, and fear for her safety if her partner discovers she has told someone
- A woman may be afraid that her health professional will breach privacy and confidentiality by discussing or documenting abuse.

It is not helpful for the health care provider or the woman to conclude that she is “in denial” about the abuse. She has learned to protect herself by her silence. Whether or not a woman reveals her circumstances, focusing on her safety is paramount.

Because many abused women will not answer ‘yes’ when asked about abuse, routine health care practices need to be adapted to avoid re-traumatizing women. Adopting a perspective that shifts the approach from understanding behaviours as “psychiatric symptoms and disorders” to adaptive coping or undertaking safety mechanisms 18 or the impacts of abuse (e.g. low self-esteem, insecure, passive) can result in greater empathy for the woman and lead to more accurate assessments of her healthcare and safety needs.

Changes in practice can be guided by the following questions:

- Has our care increased women’s safety?
- Has a link been made between abuse, women’s health and treatment approaches?
- Have women been asked about the health impacts of abuse or ‘stressful relationships’?
- Are recommended treatments safe when considered within the context of a controlling and threatening relationship?
At the very least, posters and other information displayed in patient washrooms and examination rooms can convey to women that violence against women is a major health issue and that the setting is one in which it is safe to talk about intimate partner violence. Information about community resources including the legal system should be available, again with discretion.

The following exhibit describes key health care principles and practices that focus on the dual objectives of improving women’s experience of the health care encounter and improving health outcomes. While this approach represents best practices for all women, it is even more critical when providing care for abused women who face immediate safety concerns.

Exhibit 1

General Principles of Care

- Build Trust
- Focus on Empowering Women
- Create a Clear and Safe Opportunity for Discussion
- Respond When Abuse is Disclosed

5.6. General Principles of Care

5.6.1. Build Trust

Assure confidentiality and privacy, listen non-judgmentally, validate her experience and believe her - even when a woman chooses not to disclose abuse, or leaves and returns to the abusive relationship several times.\textsuperscript{17,18,42,47,84-92} This approach will facilitate an increase in trust and will decrease the barriers to women accessing health care services. “The quality of the relationship itself [with the caregiver] is central to any reparative process. In relationships where autonomy and decision-making are taken away, feeling free to make choices without risking retaliation is crucial to regaining a sense of control.”\textsuperscript{18}
5.6.2. Focus on Empowering Women

Recognize and reduce the power imbalances between you as a provider and a woman seeking care. Empowerment strategies include:

- Receive explicit and informed consent for all consultation and referrals.
- Provide information and ensure that she is able to make informed decisions without risk of judgment.
- Take steps to ensure that she remains in control of the information and the process
- Ensure confidentiality and privacy.
- Acknowledge women’s expertise in knowing what is best for her safety and the safety of her children.
- Be aware of the diversity among women. Health-care providers can avoid stereotyping by understanding the complexity of abuse, the many ways that abusive partners assert power and control over women and how gender, race, class, sexual orientation, age and physical or mental ability can shape women's experiences.
- Be knowledgeable about the dynamics and consequences of violence against women and share this information with women.
- Be aware of appropriate resources.

It is important to remember that abuse is about power and control. Because abuse is about power and control being exerted over a woman in her intimate relationship, power and control being exerted over her in a health-care setting may potentially exacerbate or perpetuate her problem.

5.6.3. Create a Clear and Safe Opportunity for Discussion

All women should be provided with a safe and confidential opportunity to discuss abuse by an intimate partner and the health impact of that abuse with their health-care provider. In order for women to talk to a health care provider about abuse, they must perceive that the practitioner can be entrusted with this information and can respond appropriately to such disclosures.

- Demonstrate that you and your agency are aware of the issue of intimate partner violence by having posters and resource materials on woman abuse available in waiting rooms and patient bathrooms.
• Ensure that you, as the care provider, have some time alone with the woman in case she needs to talk to you in confidence.

• If the woman’s partner is reluctant to leave her alone, then consider this a sign that she may be at risk for abuse. Avoid confrontation with the partner but consider other ways to provide assistance to the woman.

• Demonstrate that you are comfortable and knowledgeable about the issue of abuse. For example, wearing a button related to abuse, asking questions, and/or by providing information that is readily accessible, such as a resource card or information brochure.

• When recommending a treatment, ask what is feasible within her situation to keep herself and her children safe from harm e.g. bed rest must not add to the stress and negative outcomes for her and her children.

• Ask if she can afford the cost of prescriptions, and whether she has access to funds to make purchases without her partner’s approval.

• If a woman reports being unable to sleep, is this assessed as part of ‘normal’ pregnancy or is abuse explored. Ask if she feels safe at night when she is in her bed, or if her partner ever disturbs her sleep.

• Ensure that by bringing forward a discussion about violence in a woman’s life that you are not inadvertently placing her at risk. The discussion needs to be private and confidential.
 Potential Questions to Ask

HAVE YOU:

- Had arguments with your partner where you were threatened, insulted or verbally attacked?
- Felt afraid of your partner’s behaviour such as reckless driving, use of drugs and alcohol, or threatening behaviour?
- Been physically hurt by your partner?
- Been prevented from seeing your friends or family, getting a job, going to school?
- Felt afraid in your relationship for fear of your partner’s reaction?
- Been frequently woken or kept up in the night by your partner to continue an argument?
- Been constantly criticized by your partner for how you look or what you wear?
- Had to justify all your purchases, or all your financial decisions?
- Been told you are to blame for all the problems in your relationship?
- Have been made to have sex when or in ways that you didn’t want?
- Feel hopeless that nothing you do seems to change your partner’s behaviour?
5.6.4. Respond When Abuse is Disclosed

The goal of any contact between a woman who is in an abusive relationship and a health care provider is to reduce the harm caused by the abuse. Providing support that recognizes her need for privacy, safety, confidentiality and respect will increase the possibility of her seeking health care, thereby reducing the impact of intimate partner violence13 14.

- In addition to listening and validating the woman’s disclosure, it is important to reassure her regarding confidentiality.
- Assess what type of support is available to her and ensure that she has information regarding community support services.
- Follow the directives of the woman with regard to involvement of the police. If there are children in the home, contact with child protection services should only be made if there is risk of harm to a child.
- Assist the woman in developing a safety plan, which would include having a safety kit stored outside of the home, with a change of clothing for the woman and any children, extra car and house keys, medications, cash and personal papers. The woman should have a plan detailing who she would call or where she would go in order to avoid violence at any time of day, and have the 24 hour crisis lines available.

5.7. Addiction Sensitive Counselling and Care

Women with addictions can be found in all segments of society and the addictions from which they suffer may include alcohol, street drugs, and/or prescription medications. When a woman has disclosed or is known to have an addiction, she may be expecting a very negative experience when she seeks any medical care, including an abortion. However, if the treatment and approach to her care is supportive and non-judgmental regarding both her decision to terminate the pregnancy and her life style, she may be receptive to a discussion about alternatives to her addiction. As in intimate partner violence, the issue should be approached in a supportive, sensitive manner that avoids causing additional emotional distress.

Women with addictions, particularly to narcotics, may have differences in how they experience pain or in their response to conscious sedation or other analgesics (they may require higher dosages of these medications due to increased tolerance).

Resources can be offered as immediate or future opportunities for the woman to begin to deal with her addiction.

**RESOURCES**

- Alcohol and Drug Information and Referral Service (Toll-free number: 1-800-663-1441)
- Narcotics Anonymous
- Alcoholics Anonymous
- Aurora Centre at BC Women’s Hospital & Health Centre
SECTION THREE

CLINICAL PRACTICE GUIDELINES
6. CONSENT, CONFIDENTIALITY & DOCUMENTATION

6.1. Informed Consent

The Health Association of BC Policy Guidelines for Health Care Consent (January 2000) state that valid consent is obtained if:

a) The consent is specific to the proposed health care;
b) The consent is given voluntarily;
c) The consent is not obtained through misrepresentation or by fraudulent means;
d) The adult is capable of making a decision about whether to receive or refuse the proposed health care;
e) The health care provider informs the adult by providing the information that a reasonable person would require to understand the proposed health care and to make a decision, including information about:
   i. The condition for which the health care is proposed,
   ii. The nature of the proposed health care,
   iii. The risks and benefits of the proposed health care that a reasonable person would expect to be told about,
   iv. Alternative courses of health care, (the likely consequences of no treatment should be explained, when indicated), and
f) The adult has an opportunity to ask questions and receive answers about the proposed health care\textsuperscript{15}.

\textsuperscript{15} Health Association of British Columbia. (2002) HABC policy template for health care consent.
6.1.1. Age of Consent

Legislation in B.C. no longer identifies a minimum age to give consent to medical treatment. A person under the age of 19 in BC (referred to as “infant”) may consent to treatment if the following conditions are met:

The health care provider providing the health care:

a) Has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care; and,

b) Has made reasonable efforts to determine and has concluded that the health care is in the infant’s best interests.

If these conditions are met, it is not necessary to obtain consent from the infant’s parent or guardian, and, in fact it would be a breach of confidentiality to advise or involve the parent or guardian unless the minor agrees to that disclosure.

Please refer to the Health Association of BC Policy Template for Health Care Consent (January 2000) for further guidelines regarding Capability to Consent, Substitute Decision Maker, and other consent issues.

With respect to consent for abortion, the following aspects should be considered:

- Ensure that the consent process is geared to the woman’s situation. For example, if English is her second language, or she has a hearing deficit, it is important to ensure that she has full comprehension of the risks and benefits, methods of abortion, pain management options, and future contraception. This may require the involvement of a professional, non-related interpreter.

- Anti-abortion propaganda is geared to frighten women about the safety of abortion. Many women will have been exposed to claims that abortion will lead to breast cancer, or sterility, etc, but may be reluctant to voice their fears. The consenting process is a good opportunity to address these fears, whether expressed or not.

- In situations involving a very young woman who is reluctant to involve her parents, it may be helpful to gently (but not insistently) explore whether it would be possible to involve one parent or an alternative adult who could provide support through the process.
6.2. **Documentation**

All guidelines for Health Records must be followed regardless of venue. Health Records are subject to Freedom of Information Legislation.

Health care providers need to be aware that Health Records are frequently subpoenaed for legal proceedings. References to partner abuse, substance use, etc in a clinical record could compromise the outcome for women involved in legal proceedings.

If Health Records pertaining to abortion are subpoenaed, it is crucial to block out names of all staff involved in provision of these services, in order to protect the anonymity of staff.

6.3. **Confidentiality: Special Considerations**

All patient-related information is subject to confidentiality guidelines. However, past experience has shown that women seeking abortion services are at risk of being targeted by members of anti-choice groups, if their personal information is not treated with the highest degree of care. For example, if a surgical slate is posted in a busy area of the OR Suite, authorized hospital staff such as cleaners or lab personnel may have access to patient names and procedures.

No information confirming that a woman is about to or has undergone an abortion procedure is provided to a second party (including parents, partners or other next of kin).

All paper with patient or staff-related information must not be placed in regular recycling bins, but must be shredded using a cross-hatch shredder.
7. PRE-PROCEDURE CARE GUIDELINES

7.1. Routine Prophylactic Antibiotics

Where possible, optimal treatment will include screening for STD’s and particularly for Bacterial Vaginosis in the days prior to the procedure. In this case, women with positive results should be treated preoperatively or peri-operatively. When, as may often be the case, women access services only on the day of the procedure, such women will receive prophylactic antibiotic treatment after review of medical history and verification of allergy and breast feeding status. The timing of the doses may be adjusted in the presence of severe nausea and vomiting\(^{16}\). See Appendix B: Routine Prophylactic Antibiotics

7.1.1. Routine Prophylactic Antibiotics Prior to Laminaria Insertion

All women not previously screened will receive prophylactic antibiotic treatment after review of medical history and verification of allergy and breast feeding status. The timing of the doses may be adjusted in the presence of severe nausea and vomiting. See Appendix C: Routine Prophylactic Antibiotics Prior to Laminaria Insertion.

7.1.2. Prevention of Bacterial Endocarditis: Prophylactic Antibiotic Treatment for Women with Cardiac Conditions

**PATIENTS AT HIGH RISK:**

Pre-procedure antibiotic prophylaxis is **required** for both laminaria insertion and abortion in patients at high risk for endocarditis.

<table>
<thead>
<tr>
<th>Patients at High Risk are those with:</th>
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<tbody>
<tr>
<td>- Prosthetic heart valves</td>
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<tr>
<td>- Previous history of endocarditis</td>
</tr>
<tr>
<td>- Surgically constructed systemic pulmonary shunts or conduits</td>
</tr>
</tbody>
</table>

See Appendix D: Endocarditis Prophylaxis: HIGH RISK

PATIENTS AT MODERATE RISK:

Pre-procedure antibiotic prophylaxis is required for both laminaria insertion and abortion in the presence of infection in patients at moderate risk for bacterial endocarditis.

In the absence of infection, antibiotic prophylaxis is optional.

<table>
<thead>
<tr>
<th>Patients at Moderate Risk are those with:</th>
</tr>
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<tbody>
<tr>
<td>- Congenital cardiac malformations</td>
</tr>
<tr>
<td>- Rheumatic and other acquired valvular dysfunction, even after valvular surgery</td>
</tr>
<tr>
<td>- Hypertrophic cardiomyopathy</td>
</tr>
<tr>
<td>- Mitral valve prolapse with valvular regurgitation</td>
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</tbody>
</table>

See Appendix E: Endocarditis Prophylaxis: MODERATE RISK

Endocarditis prophylaxis is not recommended at the time of therapeutic abortion, in the absence of infection, or in patients with low risk conditions such as:

- Atrial-septal defect
- Mitral valve prolapse without valvular regurgitation

7.2. Laboratory Testing

- All patients must have a documented positive pregnancy test prior to their abortion procedure. This test may be performed by a laboratory, community clinic, or a physician's office. A home test alone is not acceptable.
- All patients must have a documented Rh status.
- Haemoglobin testing may be performed when the patient's history and physical exam suggests anaemia.
7.2.1. Sexually Transmitted Disease Screening, Treatment, Follow Up

- All patients will have cultures taken for gonorrhea and chlamydia prior to the insertion of laminaria, or, if laminaria will not be used, prior to the abortion procedure. Optimally, cultures should be taken at a pre-procedure screening appointment so that appropriate treatment can be initiated. If this is not possible, cultures will be obtained just prior to the procedure. Results of cultures will be available within 48 to 72 hours.

- Arrangements for contacting the patient in a confidential manner to inform her of a positive result need to be in place. Treatment will be as outlined by the BC Centre for Disease Control and the Canadian Guidelines for Prevention, Diagnosis, Management and Treatment of Sexually Transmitted Diseases.\(^\text{17}\)

7.3. Ultrasound

- The use of pre-procedure ultrasound will assist in confirming gestational age in situations where the LMP is uncertain or unknown, and in pregnancies greater than 12 weeks will help prevent inadvertent second trimester procedures.

- Pre-procedure ultrasound is recommended in the following:
  - Previous history of, or suspected ectopic pregnancy
  - Suspected significant abnormality of the uterus, tubes or ovaries.
  - Obesity that may preclude accurate clinical dating (BMI >26).
  - Uncertain gestational age dating due to history (recent Depo Provera injection, no menstrual period since OCP discontinued or IUD removed, unknown LMP, or irregular cycles).\(^\text{18}\)

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\(^{18}\) BC Women’s Hospital & Health Centre CARE Program. Guidelines for care.
7.4. Management of Suspected Ectopic Pregnancy

In all cases where no gestational sac is seen on ultrasound, the management will be as follows:

- Confirmation of pregnancy with quantitative serum BHCG. Arrangements will be made to communicate the results to the patient. While awaiting results, all patients will receive verbal and written ectopic pregnancy information. (See Appendix F: Patient Information on Ectopic Pregnancy.)

- For all BHCG values greater than 1700, an urgent referral to a gynecologist will be arranged for evaluation for ectopic pregnancy.

- For all BHCG values less than 1700, a repeat Quantitative BHCG will be arranged for 48 hours following the first measurement. The patient will then be managed appropriately.
8. INTRA-PROCEDURE CARE GUIDELINES

8.1. MEDICAL ABORTION

Medical abortion, using medications that interfere with early pregnancy development, allows women to choose a safe, effective approach to abortion without an invasive surgical procedure. One of the regimes is Methotrexate in combination with misoprostol (prostaglandin) which, if administered up to the 49th day of gestation, successfully induces abortion in approximately 80 to 90% of cases. See Appendix G: Methotrexate Abortion Protocol.

The other regime, Mifepristone (formerly known as RU 486) combined with misoprostol, is unfortunately not available at this time in Canada in spite of extensive study and widespread well-documented successful use in many developed countries around the world.

In theory medical abortion should, and in some areas of the country does, increase access to abortion. The key elements to a successful outcome of a medical abortion include appropriate screening and a thorough informed consent process. Patient satisfaction surveys have provided an overview of the factors that are of the greatest importance to women who are considering their abortion options. Some of these include:

- intensity and duration of pain
- length of time required to complete the procedure
- cost
- efficacy
- safety
- amount and duration of bleeding
- number of office visits
- privacy
- seeing or not seeing the products of conception
- being an active participant in the abortion versus undergoing a procedure19.

Due to the teratogenic effects of Methotrexate, in cases where a medical abortion has failed, access to a facility where a surgical abortion can be performed is crucial.

The main barriers to provision of medical abortion appear to be provider-based. The current fee for service structure barely allows for adequate compensation for those providers who spend the required amount of time on counselling, procedures and follow up, and have the requisite access to ultrasound.

19 Paul et al.
8.2. Surgical Abortion Procedural Guidelines

8.2.1. Patient Preparation

- Obtain and document pertinent medical history, including confirmation of pregnancy and verification of gestational age.

- Comfort Measures: If using conscious sedation, could include:
  - Presence of support person, music, soft lights, and personnel comfortable with providing emotional support.
  - Pre operative anti-prostaglandins (such as Naproxen or Ibuprofen) will aid in decreasing discomfort during and after the procedure.

- Laminaria insertion/removal: The use of laminaria is usually determined by physician preference.
  - In general. Laminaria are not required for gestational age of 11 weeks or under.
  - Laminaria or misoprostol is recommended when gestational age is 12 weeks or more.

- Misoprostol for cervical softening: Misoprostol is an effective agent for cervical pretreatment prior to surgical abortion.
  - Further indications include use of Misoprostol to aid in expulsion of a non-viable pregnancy or missed abortion, or retained products following medical or spontaneous abortions.

Please see Appendix H: Protocol for Misoprostol Use.
8.2.2. Pain Management Options

Surgical procedures are usually painful, and abortion is no exception. The perception of pain by an individual is influenced by a number of factors such as prior experience, personality, mood state, attitudes, spiritual beliefs, level of knowledge about the procedure, comfort with the decision to have an abortion, and expectations about the experience.

In free-standing clinics, surgical abortions are performed under local anaesthesia with or without intravenous sedation, whereas, in hospital settings, general anaesthesia is more likely to be used. Ideally, the approach to pain management will be tailored to the needs of the woman, with optimal patient safety and comfort as the primary goal.

In general this procedure is very well tolerated under paracervical block with or without IV sedation. This approach has the added advantage of a shorter more comfortable recovery process for women, many of whom will not have shared their decision to those at home or at work.

The various approaches to pain management for abortion include the following:
- Paracervical Block
- Anxiolytics
- Narcotics
- Intravenous (conscious) sedation
- General Anaesthesia
- Anti-prostaglandins
- Non-pharmacological method:
  - positive suggestion
  - relaxation
  - guided imagery

8.2.3. Cleansing the Perineum, Vulva and Vagina

Cleansing of the perineum and vagina is not commonly performed prior to abortion procedures (this would preclude testing for STD’s). Most clinicians do cleanse the cervix with one piece of gauze soaked in an antiseptic solution. There is no evidence available to support the need for this, and, due to the low incidence of post operative infection, a randomized trial would be nearly impossible. Some experienced clinicians forego cervical cleansing.
8.3. First Trimester Abortion

8.3.1. Recommended Equipment and Supplies

<table>
<thead>
<tr>
<th>Recommended Equipment &amp; Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Vacuum Aspirator that rapidly attains 55 to 60 mm of negative</td>
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<tr>
<td>pressure (with back up power supply or available manual aspirator)</td>
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<tr>
<td>2. Graves or modified Graves Speculum, medium and small Pederson</td>
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<tr>
<td>specula</td>
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<tr>
<td>3. Single-toothed and multi-toothed tenacula</td>
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<tr>
<td>4. Set of Pratt or Denniston dilators</td>
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<tr>
<td>5. Disposable plastic suction cannulas (most providers prefer</td>
</tr>
<tr>
<td>curved rigid cannulas available in 1 mm increments from 6 mm to</td>
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<tr>
<td>16 mm for procedures at 6 to 12 weeks)</td>
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<tr>
<td>6. Ring-type forceps</td>
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<tr>
<td>7. Luer Lock syringe 10 cc</td>
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<tr>
<td>8. Needle extender or spinal needle</td>
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</tbody>
</table>

8.3.2. Technique

Surgical abortion procedures require adherence to aseptic technique. Although gloves and instruments used in the procedure are sterile prior to use, once they are in contact with the patient’s body, this is no longer the case. Therefore, most providers use the “no touch” technique in which the provider avoids touching those portions of instruments that will be inserted into the uterus. They also avoid re-inserting an instrument once it has been removed from the uterine cavity.

One of the desired outcomes of abortion care is the preservation of future child-bearing capacity. This can be assisted by avoiding trauma to the tissues of the vagina and cervix, and the avoidance of complications such as infection or hemorrhage.
8.4. Second Trimester Abortion

8.4.1. Recommended Equipment/ Supplies

<table>
<thead>
<tr>
<th>Recommended Equipment &amp; Supplies (in addition to 1st Trimester Supply List)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Osmotic dilators (laminaria, Dilapan)</td>
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<tr>
<td>2. Modified Graves speculum</td>
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<tr>
<td>3. Vulsellum or double-toothed tenacula</td>
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<tr>
<td>4. Sopher or Bierer forceps</td>
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<tr>
<td>5. Oxytocin</td>
</tr>
<tr>
<td>6. Vasopressin added to cervical block</td>
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</tbody>
</table>

8.4.2. Technique

Dilatation and Evacuation (D&E) procedures in the second trimester have been in use in North America since the early 1970’s. D&E was introduced as a much safer alternative to labour induction methods. The procedure was further refined in the 1980’s with the introduction of osmotic dilators for more gradual dilation of the cervix. As the risk of complications increases in tandem with gestational age, providers and their supporting staff must be adequately trained in order to ensure the safety of women undergoing second trimester abortion.20

8.5. Examination of tissue

Examination of evacuated tissue will allow the provider to confirm the presence of placental tissue and fetal parts appropriate for gestational age. If no products of conception are obtained, or are of insufficient quantity, immediate clinical action should include repeat aspiration, or an ultrasound to investigate the possibility of ectopic pregnancy or continued pregnancy. Serial quantitative bHCG may also be indicated.

In cases where fetal tissue appears abnormal, or there are cystic or hydropic changes in placental tissue, the entire specimen should be submitted to the Pathology Department along with a requisition detailing relevant clinical history, including gestational age and the concern of the submitting physician. Baseline post operative bHCG should be performed. If molar pregnancy is confirmed, appropriate treatment and follow up protocols must be followed. 

8.6. Intra-operative Ultrasound

Patients must be informed as part of the informed consent process that the purpose of intra-operative ultrasound is limited to confirmation of intra-uterine pregnancy and establishing gestational age and does not provide a full Ob/Gyn examination. It can assist with location and evacuation of the conceptus, evaluation of the presence or absence of retained products of conception, and confirmation of successful removal of the gestational sac.

Documentation of the ultrasound is included in the patient’s health record along with a copy of the ultrasound image.

8.7. Rh Immune Globulin

Rh alloimmunization is considered to be a significant health risk to women who are Rh negative and undergoing abortion. This problem can be avoided by ensuring that all women undergoing abortion procedures have their Rh status identified and documented and that all women who are Rh negative are offered Rh immune globulin at the time of the abortion procedure, following an appropriate informed consent process (Recommendations of the Krever Commission, 1995). If Rh Immune globulin is refused by the women, a Refusal to Consent Form must be completed and included as a permanent part of the patient’s health record. (Please see Appendix I: Patient Information and sample consent and waiver forms)

21 BC Women’s CARE Program. Guidelines for care.
22 Ibid.
9. FOLLOW-UP & EMERGENCY PROTOCOL GUIDELINES

9.1. Post Abortion Follow up Care

Follow up examination: Although abortion is a low-risk procedure, a follow up visit 2 to 3 weeks after the procedure can ensure that recovery is uneventful and allow the provider an opportunity both to assess the woman’s physical and mental health as well as confirm her plans for contraception. This visit may be conducted by the woman’s family physician or an alternate, and the results should be communicated to the physician who performed the abortion.

9.2. Emergency Protocols

Although many critical incidents related to patient care within a hospital setting will be managed according to existing hospital protocols, it is possible that hospitals would not have in place protocols that are specific to complications that can occur during or following an abortion procedure.

Community-based abortion services must have such protocols to facilitate a rapid and appropriate response in emergent situations. The following list includes emergent situations that can arise in abortion care along with suggested interventions that would assure high standards of care in both hospital and community clinic settings:
## Critical Intervention Protocol

<table>
<thead>
<tr>
<th>A.</th>
<th><strong>Anticipate</strong> potential problems from patient's history.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td><strong>Monitor and record pulse</strong>, blood pressure, respiratory rate, oximetry and significant parameters at intervals that reflect the patient's responses.</td>
</tr>
</tbody>
</table>
| C. | As observations dictate:  
  - Maintain O₂ sat above 94%  
  - Medication/treatment as per physician's order |
| D. | **Complete the documentation** of all parameters including signatures of all staff involved in the incident. |
| E. | If transfer arranged to acute care setting, **communicate relevant details** to ambulance, receiving hospital Emergency department, attending physicians and patient's emergency contact. |
| F. | **Ensure patient aware of incident** and any pertinent long-term implications. |

See **Appendix J** for specific interventions for the following situations:

- Acute anxiety reaction
- Hyperventilation
- Vasovagal reaction
- Allergic reactions and anaphylaxis
- Inadvertent intravascular injection of local anaesthetic
- Acute asthma attack
- Uterine perforation
- Moderate or sever haemorrhage after procedure
- Post Abortion Syndrome (Acute Hematometra)
- Narcotic Overdose
- Epileptic Seizure
- Hypoglycaemia
10. SECURITY

10.1. Clinical Areas

It is advisable for any hospital or community-based clinic providing abortions to undergo a review of all aspects of security performed by a specialist in the area of abortion security. The safety of patients and staff is of paramount importance and can be significantly enhanced through the installation and monitoring of the following possible measures:

- Intrusion alarms
- Duress alarms
- Electronic access control
- Closed circuit video monitoring
- Staff Training re personal and work place security
- Involvement of hospital security personnel and local police departments.

10.2. Providers

The following measures can enhance the security and personal safety of abortion providers and their families:

- A review of security requirements at home, in the office, and/or other places of work performed by a recommended specialist in abortion provider security.
- Install and institute security measures as advised.
- Follow procedures that decrease vulnerability to attack (unlisted home telephone, vary routes traveled every day, vary parking locations if parking area is not secure, etc.)
- Register your home and office telephone number with your local emergency response centre as a “potentially high risk” location. This alerts police that a rapid response is needed.

10.3. Clinic Workers

Every effort must be made to ensure the security and safety of abortion clinic or hospital employees who work in areas where abortions are performed. This would include ensuring that names and home addresses are protected, that the work place is as secure as possible and personal safety training is provided on a regular basis.
11. QUALITY ASSURANCE

The purpose of a continuous quality assurance process is to provide a regular review of pertinent aspects of an abortion service to ensure that all possible risks to women undergoing abortion procedures are minimized. This review covers four main aspects of the service:

- utilization
- documentation review
- review of complications
- patient satisfaction.

11.1. Utilization

In clinical settings, measurement of utilization could include the number of visits with and without a surgical procedure (ie: counselling only, IUD insertion, follow up visit etc.), patient demographics (age, area of residence, etc), and gestational age. This data would provide some indicators about access to abortion and assist with program planning. In clinic and hospital settings, data is reported to government data bases on a regular basis.

11.2. Documentation Review

Legal medical documentation requirements must be met, as well as any requirements of specific settings where abortions are provided. In many cases, this process involves ensuring that documentation had been completed, included requisite signatures.
11.3. Review of Complications

Published abortion complication rates tend to reflect the fact that abortion, the most common surgical procedure performed in North America, is also a low-risk procedure, if providers are adequately trained and appropriate guidelines for care are followed. It is helpful for practitioners to maintain a record of complications for comparison with the published rates. This would raise awareness of the need for changes in practice, and further enhance patient safety. (See Appendix K: NAF Complication Rates)

11.4. Patient Satisfaction

Ideally, feedback from patients would be collected on a bi-annual basis using an anonymous, retrospective process, such as a questionnaire. In communities where a significant portion of patients would be non-English-speaking, translated questionnaires allow for input from women who are often not able to participate in these processes. A “suggestion box” placed in a strategic location can also produce valuable ideas for improvements. (See Appendix L: Framework for Assessment Using Best Practices Guidelines)
Emergency contraception (EC) is any method of contraception that is used after unprotected intercourse and before implantation. These methods are not considered to be abortifacients as they work prior to implantation. Methods of EC include hormonal methods and insertion of an IUCD postcoitally. The most commonly used hormonal method is the Yuzpe Method which consists of 100 mcg ethinyl estradiol (EE) and 500 mcg levonorgestrel (LNG) (Ovral) two doses 12 hours apart, initiated within 72 hours of unprotected intercourse. Other substitutions include:

<table>
<thead>
<tr>
<th>Brand</th>
<th>Pills/Dose</th>
<th>EE (mcg) Dose</th>
<th>LNG (mcg) Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alesse</td>
<td>5</td>
<td>100</td>
<td>500</td>
</tr>
<tr>
<td>Triphasil</td>
<td>4 yellow</td>
<td>120</td>
<td>500</td>
</tr>
<tr>
<td>Triquilar</td>
<td>4 yellow</td>
<td>120</td>
<td>500</td>
</tr>
<tr>
<td>Minovral</td>
<td>4</td>
<td>120</td>
<td>600</td>
</tr>
</tbody>
</table>

In February 2000, Plan B which consists of 750 mcg of LNG, was approved by Health Canada.

The mechanism of action for hormonal methods of postcoital contraception includes the suppression or delay of ovulation, ovarian steroid changes leading to corpus luteum disruption, and endometrial asynchrony. In terms of efficacy, the Yuzpe Method prevents about 75 percent of the pregnancies which would have occurred were EC not used. Plan B has been found to prevent 85 percent of expected pregnancies. Although hormonal EC may be effective up to 72 hours after unprotected intercourse, the earlier it is started, the more effective it is. Delaying the first dose from 12 to 24 hours after intercourse increases the odds of pregnancy by up to 50 percent. This provides support for provision of hormonal EC in advance of need in order to prevent delay in treatment. In this case it is also important to provide clear instructions regarding appropriate use of hormonal EC.

Emergency hormonal contraception should be considered for any women wishing to avoid pregnancy who has had unprotected intercourse within the 72 hour time frame. EC should also be considered for pregnancy risks that result from multiple missed birth control pills (see table below), failure of a barrier method of birth control, ejaculation on the external genitalia, and sexual assault. Breastfeeding is not a contraindication to hormonal EC use.
### Missed Pills

<table>
<thead>
<tr>
<th>Missed Pills</th>
<th>Provide EC</th>
<th>Resume OCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; than 2 pills in first 7 days</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>&gt; than 4 pills b/n days 8-14</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>&gt; than 2 pills after day 14</td>
<td>No</td>
<td>Start new pack on Sunday or after a 7 day pill-free interval</td>
</tr>
</tbody>
</table>

(Ward Morgan & Deneris 1997)

As long as the woman is not pregnant, neither the total number of unprotected acts of intercourse, nor the cycle day(s) of exposure is relevant to the decision to use EC. Hormonal EC will not affect an already established pregnancy and it is not teratogenic. Hormonal EC may be somewhat effective past the 72-hour window, up to 5 days after unprotected intercourse, and may be considered where there are contraindications to IUCD use. Repeated use of hormonal EC poses no health risks and should not be denied for this reason, but should not be used as an ongoing method of contraception because of its failure rate.

No substantial increased risk for developing venous thromboembolism (VTE) has been found with hormonal EC. Any theoretical risk associated with estrogen does not apply to the LNG (Plan B) regimen.

Before giving hormonal EC, determine the date of the last normal menstrual period and if any previous unprotected acts of intercourse occurred in the cycle, in order to establish whether an existing pregnancy is a possibility. Rarely will a urine pregnancy test be needed. It is important to discuss other sexual health issues, for example, whether the sexual act was consensual, risks for STDs, and need for ongoing birth control. Women should be advised that hormonal EC will not protect against conception in the days or weeks following treatment and a barrier method should be used for the remainder of her cycle. A different method may be started at the beginning of her next cycle if the woman desires. If she wishes to use oral contraceptives, she may start a new pack after hormonal EC treatment is completed (Hatcher, Trussell, F. Stewart, Cates, G. Stewart, Guest, Kowal, 1998). Women need to be aware that a pregnancy test needs to be done if they do not have any menstrual bleeding by the 21st day after treatment. If STDs are a concern, testing can be done 1-2 weeks after exposure.

The main side effect of hormonal methods of EC is nausea. Taking each dose with food and using anti-nausea medications, such as dimenhydrinate 50 mg, thirty minutes before the dose, may reduce nausea. Since the pills are completely absorbed within one hour it is not necessary to replace the dose if vomiting occurs after this time. The LNG method is significantly better tolerated, with less nausea and vomiting than the combined method. Most women have their next menstrual period on time or slightly early, with some experiencing spotting.

Women at risk for pregnancy, and their partners, need to be aware of EC before they need it and informed of how to access it. Improved access can be achieved by giving a prescription in advance of need with instructions for use. Hormonal EC may also be obtained at Health Unit clinics or after hours at local emergency departments.
A copper-bearing IUCD can be used up to seven days after unprotected intercourse in women with no contraindications to IUCD use and may remain in place for ongoing contraception. The failure rate of the postcoital insertion of the IUCD did not exceed 0.1 percent in all studies. The IUCD is unsuitable for women with a history of recent PID, or multiple partners, especially during the exposure period in question. Endocervical cultures should be done at the time of insertion and consideration given to prophylactic use of antibiotics.

References:

All women will receive prophylactic antibiotic treatment after review of medical history and verification of allergy and breast feeding status. The timing of the doses may be changed in the presence of severe nausea and vomiting.

**Routine Prophylactic Antibiotics**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Type of Prophylactic Antibiotic</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients who have not had laminaria insertion</td>
<td>Metronidazole</td>
<td>2 grams orally (as early as possible prior to procedure)</td>
</tr>
<tr>
<td>Patients breastfeeding or allergic to Metronidazole</td>
<td>Clindamycin</td>
<td>300 mg orally for 2 doses (first dose to be given as early as possible prior to procedure; 2nd dose to be given prior to discharge from clinic)</td>
</tr>
<tr>
<td>Patients at high risk* for sexually transmitted diseases ADD</td>
<td>Azithromycin</td>
<td>1.0-1.2 grams orally (immediately post procedure)</td>
</tr>
<tr>
<td>Patients allergic to Azithromycin, erythromycin or other macrolide antibiotics</td>
<td>Doxycycline</td>
<td>100 mg orally bid x 7 days (Begin immediately post procedure)</td>
</tr>
<tr>
<td>Patients unable to take oral medication</td>
<td>Cefazolin</td>
<td>1 gram IV in 50 to 100ml normal saline, administered over 30 minutes, pre-procedure</td>
</tr>
</tbody>
</table>

* HIGH RISK Patients are defined as those with:
  a. Past history of STD other than genital warts
  b. Past history of PID
  c. Three or more sexual partners in the past year
  d. Clinically apparent mucopurulent cervicitis
  e. Age 20 and under
  f. Current partner at high risk for STD
All women will receive prophylactic antibiotic treatment after review of medical history and verification of allergy and breast feeding status. The timing of the doses may be changed in the presence of severe nausea and vomiting.

**Routine Prophylactic Antibiotics: Laminaria Insertion**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Type of Prophylactic Antibiotic</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients to receive</td>
<td>Metronidazole</td>
<td>500 mg orally, bid x 4 doses (to begin as early as possible prior to laminaria insertion)</td>
</tr>
<tr>
<td>Patients breastfeeding or allergic to Metronidazole</td>
<td>Clindamycin</td>
<td>300 mg orally, bid x 4 doses (to begin as early as possible prior to laminaria insertion)</td>
</tr>
<tr>
<td>Patients at high risk* for sexually transmitted diseases ADD</td>
<td>Azithromycin</td>
<td>1.0-1.2 grams orally (1 hour prior to laminaria insertion)</td>
</tr>
<tr>
<td>Patients allergic to Azithromycin, Erythromycin or other Macrolide antibiotics</td>
<td>Doxycycline</td>
<td>100 mg orally bid x 7 days (First dose prior to laminaria insertion, approximately 1 hour pre-procedure)</td>
</tr>
<tr>
<td>Patients unable to take oral medication, or at high risk for infection</td>
<td>Cefazolin</td>
<td>1 gram IV in 50 to 100ml normal saline, administered over 30 minutes, pre-procedure.</td>
</tr>
</tbody>
</table>

**Post Procedure**

Patients who receive Azithromycin or Cefazolin pre-procedure do not require a post-procedure dose of medication.

Post-procedure medication is required for those patients at high risk or breastfeeding who received Doxycycline or Erythromycin.
**Post-Procedure Antibiotics**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Type of Prophylactic Antibiotic</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients who received this medication prior to procedure</td>
<td>Azithromycin, Cefazolin</td>
<td>No post-procedure dose required.</td>
</tr>
<tr>
<td>Patients breastfeeding</td>
<td>Erythromycin</td>
<td>500 mg p.o q6h x 7 days</td>
</tr>
<tr>
<td>Patients at high risk who received Doxycycline or Erythromycin pre-procedure</td>
<td>Doxycycline</td>
<td>100 mg, p.o. bid x 7 days</td>
</tr>
</tbody>
</table>

*HIGH RISK Patients are patients with:

- A past history of std other than genital warts
- A past history of PID
- Three or more sexual partners in the past year
- Clinically apparent mucopurulent cervicitis
- Age 20 and under
- Current partner at high risk for STD
APPENDIX D -
ENDOCARDITIS PROPHYLAXIS: HIGH RISK

A. HIGH RISK NON-PENICILLIN-ALLERGIC PATIENTS

<table>
<thead>
<tr>
<th>Time</th>
<th>Prophylaxis</th>
<th>Dose</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-laminaria insertion &amp; Pre-abortion</td>
<td>Gentamycin</td>
<td>1.5 mg/kg of body weight to a maximum dose of 120 mg</td>
<td>IV in 50-100 ml normal saline over 30-45 minutes</td>
</tr>
<tr>
<td></td>
<td>AND</td>
<td>2 g</td>
<td>IM or IV in 50-100 ml normal saline over 30-45 minutes, within 30 minutes of starting the procedure</td>
</tr>
<tr>
<td></td>
<td>Ampicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-laminaria insertion &amp; post-abortion</td>
<td><strong>Regimen A:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amoxicillin</td>
<td>1 g</td>
<td>Orally</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Regimen B:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ampicillin</td>
<td>1 g</td>
<td>IV in 50-100 ml normal saline following Gentamycin</td>
</tr>
</tbody>
</table>
### B. HIGH RISK PENICILLIN-ALLERGIC PATIENTS

<table>
<thead>
<tr>
<th>Time</th>
<th>Prophylaxis</th>
<th>Dose</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-laminaria insertion &amp; pPre-abortion</td>
<td>Vancomycin AND Gentamycin</td>
<td>1 g 1.5 mg/kg of body weight to a maximum dose of 120mg administered</td>
<td>IV in 100 ml normal saline over a minimum of 1 hour IM or IV in 50-100 ml normal saline over 30-45 minutes. Complete the infusion/injection within 30 minutes of starting the procedure</td>
</tr>
</tbody>
</table>
## APPENDIX E - ENDOCARDITIS PROPHYLAXIS: MODERATE RISK

### A. MODERATE RISK NON-Penicillin-ALLERGIC PATIENTS

<table>
<thead>
<tr>
<th>Time</th>
<th>Prophylaxis</th>
<th>Dose</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-laminaria insertion &amp; pre-abortion</td>
<td>Amoxicillin</td>
<td>2 g</td>
<td>Orally 1 hour pre-procedure</td>
</tr>
<tr>
<td></td>
<td>OR Ampicillin</td>
<td>2 g</td>
<td>I.M. or I.V. in 50-100ml normal saline within 30 minutes of starting the procedure</td>
</tr>
</tbody>
</table>

### B. MODERATE RISK Penicillin-ALLERGIC PATIENTS

<table>
<thead>
<tr>
<th>Time</th>
<th>Prophylaxis</th>
<th>Dose</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-laminaria insertion &amp; pre-abortion</td>
<td>Vancomycin</td>
<td>1 g</td>
<td>I.V. in 100 ml normal saline over a minimum of 1 hour. Complete the infusion within 30 minutes of starting the procedure</td>
</tr>
</tbody>
</table>
An ectopic pregnancy is a pregnancy that develops outside of the uterus (womb). This kind of pregnancy may occur in the fallopian tube ("tubal pregnancy"), the ovary, or the abdomen. The exact cause of an ectopic pregnancy is not always known, but medical conditions such as Pelvic Inflammatory Disease (PID) or endometriosis that causes narrowing in the fallopian tubes make the chance of an ectopic pregnancy greater.

There are a few reasons why it can be difficult to recognize an ectopic pregnancy:

- The uterus gets larger just as it would with a normal pregnancy
- The fertilized egg and placenta are growing and making the pregnancy hormone, HCG which means that a urine pregnancy test will be positive
- Women may experience the usual symptoms of pregnancy such as nausea, tiredness, breast tenderness or swelling, etc.

As an ectopic pregnancy grows, it will stretch the thin wall of the fallopian tube. If the pregnancy is discovered early, medical treatment (with methotrexate) to stop further development may be possible. If the pregnancy continues to grow, the wall of the tube may rupture or burst and bleed. This can be extremely serious and life-threatening because of the internal bleeding and needs immediate medical attention.

### POSSIBLE SYMPTOMS OF AN ECTOPIC PREGNANCY

- Pain: Sudden and severe abdominal pain often on one side at the place of the rupture. The pain then might spread around the abdomen or move to the shoulder and neck or the area under the rib cage (diaphragm)
- Severe weakness or fainting
- Dizziness, hot or cold flashes, rapid heart beat

If one or more of the above symptoms occur, you must see a doctor or go to an emergency room immediately and tell them you may have an ectopic pregnancy.
When you see a doctor, an ultrasound examination may reveal the ectopic pregnancy. It may be necessary to look inside the woman’s abdomen with a small instrument called a laparoscope (this procedure is called a laparoscopy). If the ectopic pregnancy has grown past a certain size, or has caused a rupture, surgery will be needed to remove the pregnancy and repair the tube. Most women will still be able to get pregnant in the future (with the repaired tube, or with the undamaged tube on the other side).

Care Plan

A. Blood tests:  *Quantitative BHCG x 2*  
   Dates:  
   Location:  

B. Ultrasound:  
   Date  
   Location:  

Please call us at __________ the day after your tests, for the results.
APPENDIX G - MEDICAL ABORTION PROTOCOL

APPENDIX G: MEDICAL ABORTION PROTOCOL USING METHOTREXATE AND MISOPROSTOL

DAY ONE:
Administer Methotrexate: 50 mg. I.M. to body surface I.M. or P.O.

SCREENING PROCESS
1. Gestational Age 49 days or less
2. Normal hepatic and renal function
3. Able to do informed consent

Day 4 to 7:
Patient inserts Misoprostol 600 mcg P.V.; repeat in 24 hours if bleeding < normal period

DAY 8:
ULTRASOUND (E.V.)

Gestational Sac Present?
YES

TREATMENT IS COMPLETE

Day 15:
ULTRASOUND (E.V.)

Gestational Sac Present?
YES

Repeat Misoprostol

NO

Fetal Heart Activity?
YES

Surgical Abortion

NO

DAY 36
REPEAT ULTRASOUND

Gestational Sac Present?
YES

TREATMENT IS COMPLETE

NO

Surgical Abortion

N.B. METHOTREXATE WILL CAUSE SERIOUS MALFORMATIONS AND ALL PREGNANCIES THAT HAVE BEEN EXPOSED TO THIS PROTOCOL MUST BE FOLLOWED UNTIL THE ABORTION IS COMPLETE.

MEDICAL ABORTION USING METHOTREXATE AND MISOPROSTOL

I hereby authorize Dr. ______________________ to perform a non-surgical abortion using methotrexate and misoprostol.

I understand that medical abortions using methotrexate and misoprostol have been provided around the world for several years and, in British Columbia alone over 10,000 women have had this treatment. In over 90% of cases, the abortion is completed after the treatment with methotrexate and misoprostol. There is about a 6% chance that I will require a D&C because of pain or bleeding, or because the pregnancy tissue has not been passed. Studies have shown this to be a safe and effective method for early abortion.

I understand that I am less than 7 weeks pregnant. I have decided to have an abortion using methotrexate® and misoprostol®, which will cause me to have bleeding from my vagina that will be like a very heavy menstrual period. I understand that I will have blood tests to ensure that my liver and kidneys are healthy, and to find out whether I am Rh negative or positive.

Methotrexate is a drug that is already used in the treatment of some types of cancer, arthritis, and ectopic (tubal) pregnancy. I understand that when used in early pregnancy, it works by stopping the development of the fetus. Although only a low dose of methotrexate is used, side effects may include nausea, vomiting, diarrhea, mouth sores, and a feeling of warmth. Methotrexate is given by an injection.

Misoprostol is a drug that is commonly used to prevent stomach ulcers. At certain dosages, it causes smooth muscle (such as the muscle of the uterus (womb)) to contract. When used a few days after an injection of methotrexate, it causes the pregnancy tissue to be expelled usually with cramping and fairly heavy bleeding. Other side effects may include nausea, vomiting, diarrhea, and/or a feeling of warmth. I will be inserting the misoprostol tablets into my vagina at home a few days after the injection.

I will be prescribed medications such as gravol®, tylenol®, and/or ibuprofen® that will help control these side effects.

I understand that the use of these medications may not cause all of the pregnancy tissue to come out of my uterus, and that I may require further treatment with misoprostol, or a dilation and curettage (D&C) procedure. I also understand that if I have very heavy bleeding and dizziness, a D&C procedure may be necessary to stop the bleeding. A D&C procedure has some risks, which
include hemorrhage, infection, a perforation (hole) in the uterus, and failure to remove all of the tissue.

Methotrexate and misoprostol have both been reported to cause birth defects when taken in early pregnancy. **I understand that it is strongly recommended that I consent to have a surgical abortion if I change my mind about having a medical abortion after the methotrexate/misoprostol have been given, or if the medication does not cause an abortion.**

I have been given an information sheet which explains the procedure step by step.

I am aware of all of the options available for me to deal with my pregnancy and have decided that an early termination is my preferred method. I understand that there are side effects of methotrexate and misoprostol that can be treated with medications. I understand, that, should the treatment fail to induce an abortion, I will be asked to consent to a surgical procedure (D&C).

I have had an opportunity to discuss any and all questions I may have regarding the treatment I may receive, and have read and understand the information on this consent form. I have received a copy of the consent for my records.

_____________________________   _______________________
Print Name      Date

______________________________  ________________________
Signature       Date

______________________________  ________________________
Witness       Date

______________________________  ________________________
Interpreter Signature (if applicable)   Date
APPENDIX I -
MEDICAL ABORTION:
PATIENT INFORMATION

You will be given a copy of the consent form which explains how the medications work, the possible side effects, and possible risks associated with an early abortion using methotrexate and misoprostol.

The process will involve at least two or three office visits, and, if the abortion is not completed, at least two more visits, and possibly a surgical procedure.

The following is a guide to help you take care of yourself and to get the proper care when you need it:

1. You will probably have been instructed to have some blood tests before your first visit. The first visit will involve counselling to make sure you have made an informed decision regarding ending your pregnancy. The doctor will review your medical history, the blood test results and will perform a vaginal ultrasound to confirm that the pregnancy is less than 7 weeks. After the doctor has reviewed the information in the consent form and answered any questions you may have, you will be asked to sign the form. You will then receive an injection of methotrexate. This is DAY ONE of the procedure. You will receive two packets of 3 misoprostol pills each to take home, plus a prescription for Tylenol or ibuprofen, and you should ensure that you have some gravol on hand.

2. You may choose the most suitable day between DAY FOUR TO SEVEN, preferably a day when you can be at home and able to relax, to insert the three misoprostol tablets. Wash your hands, dampen the tablets with water, then use your finger to place them, one at a time as high up into the vagina as possible. After 2 to 3 hours, you will begin to have some bleeding or cramping, and for most women the pregnancy ends in 1 to 12 hours. You may have very heavy bleeding with some clots, and you may have chills, nausea and vomiting. You may use gravol for the nausea (gravol suppositories if vomiting), and tylenol or ibuprofen for the pain.

3. Twenty four hours after the first dose of misoprostol, if you do not have any bleeding, if the bleeding was less than a normal period or if it stopped after a few hours, wash your hands, dampen the second set of three tablets and again insert them high up into your vagina. If you do not bleed after the second dose of misoprostol, you are having a delayed reaction.

4. DAY EIGHT: During your office visit, the doctor will review your progress, and perform a vaginal ultrasound. If the uterus is empty, your abortion is complete. You may continue to bleed for a week or 10 days. If the abortion is not complete the doctor will
place another 3 tablets of misoprostol in your vagina and you will be asked to return after one week.

5. **DAY FIFTEEN:** Another vaginal ultrasound will be done. If the pregnancy is still growing, you will be advised to have a surgical abortion. If it has stopped growing, you may then wait to see if your body expels the tissue.

6. **DAY THIRTY SIX:** Another vaginal ultrasound will be done. If there are no signs of pregnancy tissue in the uterus, the abortion is complete. If there is still pregnancy tissue remaining in the uterus, you will be offered a surgical abortion.

**OTHER INSTRUCTIONS**

1. If you are taking vitamins which contain folic acid, you will need to stop taking them until one week after you receive the methotrexate injection. Folic acid may lower the effectiveness of the methotrexate.

2. In order to avoid infection, you should not have intercourse, have a tub bath, go swimming, use tampons, or douche from the time of the methotrexate injection until the bleeding has stopped and you know the abortion is complete.

3. It is important to discuss your plans for contraception with your doctor. If you choose oral contraceptives (the Pill), you will be able to start taking them within the first week after your abortion is complete.

4. Emergency Contraception (E.C.) is a highly effective way to avoid pregnancy in situations where unexpected sexual intercourse has taken place or when a contraceptive method may not be effective (such as discovery of a hole in a condom after intercourse). E.C. is available through some pharmacies without a doctor’s prescription, through hospital Emergency departments, and Planned Parenthood Clinics. It is most effective when taken within 72 hours of the unprotected intercourse. Many women ask their doctors for a prescription for E.C. and keep a treatment handy.

**Contact Numbers**

Doctor’s Office: ____________________________

Others:
Misoprostol is an effective agent for cervical pre-treatment prior to surgical abortion. Further indications include use to assist in the expulsion of a non viable pregnancy or retained products after medical or spontaneous abortions, and to minimize post abortion blood loss.

Misoprostol has been used since 1973 as a gastric cytoprotective agent for use with NSAIDs. Side effects are dose related and generally occur in less than 25 % of women for doses of up to 800 mcg. Usual side effects include shivering, abdominal cramping, with occasional diarrhea or loose stools. Occasionally women will begin to spontaneously abort within an hour of misoprostol administration and may notice onset of vaginal bleeding.

Buccal administration appears to be the most effective and practical for preoperative use and appears to reach maximal clinical effectiveness at 90 minutes. The tasteless medication will be absorbed off the methylcellulose base within 10 to 20 minutes although the base may persist in the buccal space and may be spit out after a half hour if desired.

1. **Preoperative cervical preparation for women up to 12 weeks EGA**
   
   At the discretion of the attending surgeon 400 mcg may be given bucally any time as soon as possible after the consent has been signed.

2. **Preoperative cervical preparation for women over 12 weeks EGA**
   
   On physician’s order 600 mcg may be given bucally 90 minutes prior to procedure (400 mcg if the woman has had laminaria inserted). The medication should not be given at the same time or within half an hour before oral pills or liquids will be administered. Once administered the woman should wait in the recovery area. (Note that all patients will have had preoperative ultrasound as per booking protocol when gestational age is >12 weeks)

3. **Prevention of Postoperative Bleeding**
   
   On physician’s order 200 mcg t.i.d. for three days should be given to women to take home, and may be taken orally or bucally as they prefer.
PATIENT INFORMATION
Rh(D) Immune Globulin

What is the Rh factor?
Rh is one of the inherited factors in red blood cells. If your blood cells have this factor, you are Rh positive. If you do not have the factor, you are Rh negative.

Why is Rh status important during pregnancy?
If you are Rh negative, your body can make antibodies against Rh Positive blood. If the fetus is Rh positive, blood cells from the fetus can get into your blood stream, causing antibodies to form. This can happen at the time of an abortion, miscarriage, or if the pregnancy continues, at the time of delivery. Once your body has made these antibodies, they remain in your blood and can damage a future fetus that is Rh positive.

What would happen to the fetus/baby?
The amount of damage to a developing fetus depends on the amount of antibodies that pass from the woman to her fetus. This condition is called Hemolytic Disease of the Newborn and may range from mild symptoms which require no treatment to severe damage to the blood cells causing the fetus to die before or shortly after it is born.

What is Rh(D) Immune Globulin?
Immune Globulin is the scientific word for antibody. Antibodies are produced by white blood cells usually in response to something foreign which has entered the body, such as a virus or bacteria. If you are Rh negative, your white blood cells will recognize Rh positive red blood cells as foreign and will respond by producing antibodies. Rh(D) Immune globulin is produced by separating out the immune globulins from human plasma that contains antibodies to Rh positive blood.

How does Rh(D) Immune Globulin work?
If Rh(D) Immune Globulin is given to an Rh negative woman after she is exposed to Rh positive blood (after abortion, miscarriage, amniocentesis, childbirth, etc) it will destroy any Rh positive blood cells that may have leaked into the woman’s circulation, and prevent the woman’s blood from making antibodies. This ensures that future pregnancies will not be harmed by antibodies.
Are there any risks if I receive Rho (D) Immune Globulin?
Rho (D) Immune Globulin is a highly purified blood product. Special detergent treatment and virus filtration is used to remove all types of viruses including HIV, and Hepatitis A, B and C. The possibility of transmission of infection from any of these viruses is very unlikely. An unknown but potential risk of transmitting presently unrecognized infectious particles, such as those that may cause Creutzfeldt Jakob Disease (similar to Mad Cow Disease) may also exist.

Are there any bad reactions to Rho (D) Immune Globulin?
Reactions to Rho (D) Immune Globulin are very rare but may include discomfort and slight swelling at the site of injection and a slight elevation in temperature. There is also a very remote chance of an allergic reaction.
Rho (D) immune Globulin Consent Form
(Patient Medical Record Copy)

Authorization

I acknowledge that I have discussed Rh₀ (D) Immune Globulin with my health care provider, that I have read and understand this consent and information form, and that I am aware of the potential risks and benefits of receiving Rh₀ (D) Immune Globulin.

Printed Name

Signature Date

Witness Signature Date
WAIVER: Refusal of Rh Immune Globulin

I, ____________________________, attest that I am aware that
        (please print full name)
my blood type is Rh negative and do hereby refuse to accept the Rh Immune Globulin
which has been recommended by the physician. I have read and understood an
information pamphlet which explains the significance of the Rh factor and why Rh
Immune Globulin is used. I understand that my refusal of the Rh Immune Globulin could
lead to adverse reactions to future emergency blood transfusions. I also understand that
there is a risk that in future pregnancies the red blood cells of the fetus could be
destroyed, leading to Hemolytic Disease of the Newborn.

________________________________   _________________
Print Name       Date

________________________________
Signature

________________________________
Witness Signature
APPENDIX L -
INTERVENTIONS FOR CRITICAL INCIDENTS

A. ACUTE ANXIETY REACTION

<table>
<thead>
<tr>
<th>Response Techniques</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consider all anti-anxiety techniques:</td>
<td>If requested:</td>
</tr>
<tr>
<td>▪ Reassurance</td>
<td>Ativan, 1-2 mg s.l. or p.o. (allow 30-45 minutes for effect)</td>
</tr>
<tr>
<td>▪ Relaxation</td>
<td></td>
</tr>
<tr>
<td>▪ Distraction</td>
<td></td>
</tr>
<tr>
<td>2. If necessary, stop the procedure until the patient indicates she is ready to continue</td>
<td></td>
</tr>
<tr>
<td>3. Consider need for pain control.</td>
<td></td>
</tr>
</tbody>
</table>

B. HYPERVENTILATION

Hyperventilation may be caused by factors such as pain and anxiety.

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms (as a result of respiratory alkalosis)</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Feeling of anxiety, agitation, panic, dizziness, weakness, altered state of consciousness, heightened auditory sense, may progress to unconsciousness.</td>
<td>Encourage patient to slow down breathing. If not effective:</td>
</tr>
<tr>
<td>▪ Tingling around mouth and extremities, may progress to carpopedal spasm if cycle is not broken.</td>
<td>a. Have patient breathe in brown bag until symptoms abate.</td>
</tr>
<tr>
<td>▪ Feeling of suffocation.</td>
<td>b. Consider interventions as in anxiety above.</td>
</tr>
</tbody>
</table>
C. VASOVAGAL REACTION

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Bradycardia from vagal stimulation evidenced by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Pallor, cold moist skin (particularly extremities)</td>
</tr>
<tr>
<td></td>
<td>- Dizziness, nausea, anxiety, superficial respirations, restlessness.</td>
</tr>
<tr>
<td></td>
<td>Further progression of vasovagal reaction:</td>
</tr>
<tr>
<td></td>
<td>- Vomiting</td>
</tr>
<tr>
<td></td>
<td>- Drowsiness</td>
</tr>
<tr>
<td></td>
<td>- Loss of consciousness</td>
</tr>
</tbody>
</table>

| Interventions | Check pulse, B.P., O2 sat. as frequently as patient response indicates. |
|              | Encourage coughing to maintain O2 sat. |
|              | If unable to maintain O2 sat. at 94% give Oxygen by mask |

| If persistent symptomatic Bradicardia/ Hypotension | Administer 500 mL N/S IV. |
|                                                   | Atropine 0.6 mg IV. (Repeat q3 - 5 minutes to maximum of 2 mg (0.04mg/kg) |

| Nursing Considerations | Cold cloth to forehead. |
|                       | Explanation and reassurance. |
D. ALLERGIC REACTIONS AND ANAPHYLAXIS

<table>
<thead>
<tr>
<th>Mild to moderate reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signs &amp; Symptoms</strong></td>
</tr>
<tr>
<td>▪ <strong>Skin:</strong> Urticaria, hives, wheals, rash, angioedema</td>
</tr>
<tr>
<td>▪ <strong>Respiratory:</strong> Mild chest tightness, bronchospasm</td>
</tr>
<tr>
<td>▪ <strong>Cardiovascular:</strong> Hypertension, tachycardia</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
</tr>
<tr>
<td>▪ Monitor pulse, B.P., respirations, breath sounds, O2 sat.</td>
</tr>
<tr>
<td>▪ Benadryl 50 mg p.o. or, if nauseated, 50 mg IV over 2 minutes, or 50 mg IM.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If condition severe, worsening, or no response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signs &amp; Symptoms</strong></td>
</tr>
<tr>
<td>▪ <strong>Skin:</strong> Angioedema more diffuse on hands, eyelids, lips, mucous membranes</td>
</tr>
<tr>
<td>▪ <strong>Respiratory:</strong> Laryngospasm/laryngeal oedema (crowing), bronchospasm (wheezing)</td>
</tr>
<tr>
<td>▪ <strong>Cardiovascular:</strong> Hypotension, tachycardia; If extreme, cardiovascular collapse</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
</tr>
<tr>
<td>▪ Establish IV: N/S</td>
</tr>
<tr>
<td>▪ Oxygen to maintain O2 sat. above 94%</td>
</tr>
<tr>
<td>▪ Epinephrine 1:1000, 0.3 to 0.5 ml (3 to 5 mg) SC q15 minutes prn</td>
</tr>
<tr>
<td>▪ Salbutamol 2.5 mg in N/S by nebulizer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If condition severe and life-threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions</strong></td>
</tr>
<tr>
<td>▪ Epinephrine 1:10000 3 to 5 ml (0.3 to 0.5 mg) IV q3 to 5 minutes</td>
</tr>
</tbody>
</table>
E. TOXIC SYSTEMIC REACTION TO LOCAL ANAESTHETIC

Toxic hypersensitivity to local anaesthetics is rare.

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Inflammation, burning, oedema, erythematous macules, papules.</td>
<td>AS PER ALLERGIC REACTION GUIDELINES.</td>
</tr>
<tr>
<td>▪ Hypotension</td>
<td></td>
</tr>
<tr>
<td>▪ Dyspnoea, laryngeal, pharyngeal oedema, bronchospasm, asthma.</td>
<td></td>
</tr>
</tbody>
</table>

F. INADVERTENT INTRAVASCULAR INJECTION OF LOCAL ANAESTHETIC

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Agitation, disorientation, apprehension, lethargy, convulsions.</td>
<td>Treat symptomatically.</td>
</tr>
<tr>
<td>▪ Myocardial depression, hypotension.</td>
<td></td>
</tr>
</tbody>
</table>
G. ACUTE ASTHMATIC ATTACK

Anticipate in any patient who has a history of stress induced asthma. Ensure patient has her own inhaler with her and encourage use if chest tightness or wheezing develops.

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing wheezing confirmed by chest auscultation, and increased efforts to breathe.</td>
<td>Monitor 02 sat. and give oxygen if below 94%, no relief from own inhaler:</td>
</tr>
<tr>
<td>Increasing patient distress</td>
<td>▪ Salbutamol 2.5 mg in N/S by nebulizer over 10 minutes.</td>
</tr>
<tr>
<td>Blood pressure and pulse increased.</td>
<td><strong>If no response:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Epinephrine 1:1000 0.3 - 0.5 ml (0.3 - 0.5 mg) s.c. q 15 minutes.</td>
</tr>
<tr>
<td></td>
<td><strong>In severe distress:</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Epinephrine 1:10000 0.3 - 0.5 ml (0.3 - 0.5 mg) IV.</td>
</tr>
</tbody>
</table>

H. UTERINE PERFORATION

There are three possible sites for uterine perforation:

- Median: fundus, isthmus.
- High lateral, in broad ligament
- Low lateral in the cardinal ligament
### Uterine Perforation

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pain: Abdominal or shoulder tip from diaphragmatic-peritoneal irritation</td>
<td><strong>Stop the procedure</strong></td>
</tr>
<tr>
<td>- Vagal reaction</td>
<td>- Oxytocin 20u in 500 ml N/S and run at rate ordered by physician</td>
</tr>
<tr>
<td>- Sensation of rectal pressure</td>
<td>- Ensure appropriate further care - may require surgical referral for bowel</td>
</tr>
<tr>
<td>- Instrument passes further than expected and no sensation of hitting wall of</td>
<td>repair. If no perforation of bowel evidenced, may only require in-</td>
</tr>
<tr>
<td>uterus</td>
<td>hospital observation for 24 hours.</td>
</tr>
<tr>
<td>- Presence of abdominal tissue or fat in the vacurette or the vagina</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Interventions</strong></td>
</tr>
<tr>
<td></td>
<td>- Ensure that the uterus is completely evacuated</td>
</tr>
<tr>
<td></td>
<td>- Massage the uterus</td>
</tr>
<tr>
<td></td>
<td>- Blood volume replacement with N/S if condition dictates</td>
</tr>
</tbody>
</table>

#### I. MODERATE OR SEVERE HAEMORRHAGE AFTER PROCEDURE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Haemorrhage</td>
<td>- Oxytocin 5 to 10 U. IM</td>
</tr>
<tr>
<td></td>
<td>- Ergometrine 0.25 mg IM</td>
</tr>
<tr>
<td>Moderate Haemorrhage</td>
<td></td>
</tr>
<tr>
<td>Severe Haemorrhage</td>
<td>- Oxytocin 20 U in 500 ml N/S and run according to Physician order</td>
</tr>
</tbody>
</table>
J. POST ABORTION SYNDROME (HEMATOMETRA)

| Risk Factors          |   Cervical stenosis  
|                      |   Past history of cervical surgery  
|                      |   Previous history of post abortion syndrome  |

| Signs & Symptoms      |   May present several minutes to hours after the procedure  
|                      |   Bleeding may be moderate or absent  
|                      |   Pain will be supra-pubic, severe, and cramping  
|                      |   Uterus will be larger in volume compared to immediately following the procedure  
|                      |   Fever may be present  |

| Interventions         |   Re-evacuate the uterus  
|                      |   Volume replacement with N/S if evidence of postural hypotension  
|                      |   Oxytocin 20 U in 500 N/S IV, rate according to physician's order.  |

K. NARCOTIC OVERDOSE

| Signs & Symptoms      |   Respiratory depression - rate will slow, may progress to apnea  
|                      |   Drowsy, but will breathe on command, may progress to unconsciousness  
|                      |   Myosis  
|                      |   Pulse rate and blood pressure may drop initially, but increase if condition untreated and hypercapnes and hypoxia develop  |

| Interventions         |   Stimulate patient, encourage deep breathing and coughing  
|                      |   Oxygen if indicated by oximetry (O2 sat. less than 94%)  
|                      |   Naloxone (Narcan) 0.1 to 0.2 mg IV q2 to 3 min. until respiratory depression reversed  |
## L. EPILEPTIC SEIZURE

**Epileptic Seizure**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient poorly controlled with medication, severe nausea and vomiting due to pregnancy, leading to loss of medication; non-compliance</td>
<td></td>
</tr>
<tr>
<td>Lack of sleep prior to day of procedure</td>
<td></td>
</tr>
<tr>
<td>Hyperventilation during procedure</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>Convulsive crisis</td>
<td></td>
</tr>
<tr>
<td>Primary clonic phase</td>
<td></td>
</tr>
<tr>
<td>Secondary clonic phase</td>
<td></td>
</tr>
<tr>
<td>Flaccid phase</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect patient from harm during clonic phase</td>
<td></td>
</tr>
<tr>
<td>Diazepam 5 to 10 mg IV slowly at 2 mg per min.</td>
<td></td>
</tr>
</tbody>
</table>

## M. HYPOGLYCAEMIA

**Hypoglycaemia**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin-dependant diabetes (check blood sugar with glucometer if concerned re: blood glucose level)</td>
<td></td>
</tr>
<tr>
<td>History of episodes of hypoglycaemia (provide snack prior to procedure)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If conscious, provide snack, or if condition warrants, 5% D/W IV</td>
<td></td>
</tr>
<tr>
<td>If unable to eat, 1 tube Instaglucose into mouth provides 25 Gm CHO</td>
<td></td>
</tr>
<tr>
<td>If unconscious establish IV and give 50 ml 50% glucose as specified.</td>
<td></td>
</tr>
</tbody>
</table>
Surgical abortion is the most common surgical procedure performed in North America and is one of the safest types of procedures. The incidence of complications from first trimester abortions is considerably less than that associated with full term births, and serious complications arising from abortions performed before 13 weeks are rare.

Data from the United States indicate that about 88% of the women who obtain abortions are less than 13 weeks pregnant. Of these women, 97% report no complications; 2.5% have minor complications that can be handled at the medical office or abortion facility; and less than 0.5% have more serious complications that require some additional surgical procedure and/or hospitalization. Complication rates are somewhat higher for abortions performed between 13 and 24 weeks. General anesthesia, which is sometimes used in abortion procedures, obviously carries its own risks.

For further detailed discussion about the safety of abortion please refer to the National Abortion Federation website: [http://www.prochoice.org/Facts/Factsheets/FS3.htm](http://www.prochoice.org/Facts/Factsheets/FS3.htm)

---


## Summary of Annual Abortion Statistics 2002: All Reporting Facilities

<table>
<thead>
<tr>
<th>Total Abortions reported *</th>
<th>192,653</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number with follow up</td>
<td>54,656</td>
</tr>
<tr>
<td></td>
<td>28.37%</td>
</tr>
</tbody>
</table>

### Breakdown of Total abortions by LMP Gestation**

<table>
<thead>
<tr>
<th>Gestation</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td>167,204</td>
<td>86.79%</td>
</tr>
<tr>
<td>13-15 Weeks LMP</td>
<td>11,959</td>
<td>6.21%</td>
</tr>
<tr>
<td>16 – 20 weeks LMP</td>
<td>7,623</td>
<td>3.96%</td>
</tr>
<tr>
<td>Over 20 weeks LMP</td>
<td>2,888</td>
<td>1.50%</td>
</tr>
</tbody>
</table>

### Complications

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mis-estimations/Failures</td>
<td>309</td>
<td>0.16%</td>
</tr>
<tr>
<td>Retained Tissue</td>
<td>656</td>
<td>0.34%</td>
</tr>
<tr>
<td>Unrecognized Ectopic</td>
<td>17</td>
<td>0.01%</td>
</tr>
<tr>
<td>Infection</td>
<td>37</td>
<td>0.02%</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>30</td>
<td>0.02%</td>
</tr>
<tr>
<td>Uterine Injury</td>
<td>37</td>
<td>0.02%</td>
</tr>
<tr>
<td>Embolism</td>
<td>2</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other</td>
<td>52</td>
<td>0.03%</td>
</tr>
<tr>
<td>Postabortal Hematometra</td>
<td>46</td>
<td>0.02%</td>
</tr>
</tbody>
</table>

### Management of Complications

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>133</td>
<td>0.07%</td>
</tr>
<tr>
<td>Laparoscopy</td>
<td>13</td>
<td>0.01%</td>
</tr>
<tr>
<td>Laparotomy</td>
<td>17</td>
<td>0.01%</td>
</tr>
<tr>
<td>Resuction</td>
<td>876</td>
<td>0.45%</td>
</tr>
<tr>
<td>Transfusion</td>
<td>17</td>
<td>0.01%</td>
</tr>
<tr>
<td>Other</td>
<td>117</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

* Totals include medical and surgical abortions as reported by NAF members annually. Please note that not all NAF members reported.

** Some members did not report totals by LMP Gestation, so totals will not add up.
## APPENDIX N - ASSESSMENT FRAMEWORK FOR BEST PRACTICE GUIDELINES

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>STANDARD</th>
<th>ACHIEVED</th>
<th>NOT ACHIEVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Women with unintended pregnancies have access to information about the full range of options available</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abortion services are available within ____ hours travel from home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abortion services timely and at lowest possible gestational age.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Training</td>
<td>Prospective providers trained under guidance of a recognized abortion provider, until deemed capable of competent abortion care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsellor Training</td>
<td>Requires qualifications in clinical social work or psychology plus additional training under the supervision of a qualified counsellor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Standards</td>
<td>Woman-centered care and confidentiality assured</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Universal precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Security measures in pace to ensure safety of patients and staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling Standards</td>
<td>Non-judgmental, crisis intervention model of counselling offered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Procedural/consent counselling includes risks, benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post abortion counselling offered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Standards</td>
<td>Guidelines followed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complications monitored</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow up Care</td>
<td>Physical and emotional status assessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contraceptive plans discussed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX O - ACKNOWLEDGEMENTS

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- The Abortion Services Working Group
- BC Women’s Hospital & Health Centre CARE Program (Comprehensive Abortion & Reproductive Education)
- Elizabeth Bagshaw Women’s Clinic
- Everywoman’s Health Centre
- Physicians (abortion providers throughout BC)
- BC Women’s Hospital & Health Centre Sexual Assault Service
- BC Women’s Hospital & Health Centre Woman Abuse Response Program
- Provincial Health Services Authority and BC Women’s Hospital & Health Centre Leadership.