**Advanced Skills Module (ASM)**

**Safe Practice in Abortion Care (2018)**

**Aim**

To prepare the clinician to provide abortion care based upon best practice.

**Prerequisites**

This is an optional ASM that may be taken as part of the Acute Gynaecology and Early Pregnancy ATSM.

**Key components**

The Safe Practice in Abortion Care Module comprises of only 1 ASM and covers medical and surgical methods of termination up to 23+6 weeks’ gestation. The surgical skills, however, may be undertaken to one of three thresholds, 13+6 weeks, 18+6 weeks or 23+6 weeks. **It follows that some of the surgical skills listed will not be required for the earlier gestations.**

In order to plan the delivery and location of the ASM the trainee must register at the outset the gestational age to which they are developing their surgical skills. If adequate training time remains (12 months) this threshold may be modified with trainer support. The final RCOG ASM certification will include the surgical threshold reached, for example, ‘Safe Practice in Abortion Care (surgical skills to 23+6 weeks)’.

**Educational Support**

Attendance at the BSACP/RCOG/FSRH Safe Practice in Abortion Care course or equivalent prospectively approved by your Regional Preceptor is mandatory. Attendance at the course must be after registering for the ASM and no more than **three** years prior to completing the module. TOG, STRATOG and e-portfolio support is also provided by the RCOG.

**Clinical Support**

The ASM requires an identified Consultant supervisor, who must be in a position to directly supervise and assess competence as well as approve appropriate professionals to train for the wider curriculum components.

Although the ASM does not attract its own work intensity score an average of least **one** session per week is typically required to work towards the targets.

**Work intensity**

The ASM is included as part of the Acute Gynaecology & Early Pregnancy ATSM which has a work intensity score of **2.0**.

| Clinical competency | GMP | Knowledge criteria | **GMP** | **Professional skills and attitudes** | GMP | Training support | Evidence/assessment |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1.01 Demonstrate a thorough working knowledge of the legal aspects of abortion care in the UK. |  | (1.01) Full understanding of the Abortion Act (1967) and the role of the doctor in completion of the necessary forms for authorisation and notification of abortion.  Abortion Act 1967. London: HMSO. [www.legislation.gov.uk/ukpga/1967/87/contents](http://www.legislation.gov.uk/ukpga/1967/87/contents)  Statutory Instrument 2002 No. 887. The Abortion (Amendment) (England) Regulations 2002. London: HMSO (2002) [www.legislation.gov.uk/uksi/2002/887/made](http://www.legislation.gov.uk/uksi/2002/887/made)  Department of Health. Abortion Notification Forms [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_4063863](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4063863) |  | (1.01) Demonstrate awareness of BMA/GMC guidance for doctors with conscientious objection to abortion/GMC ‘Good Medical Practice’ duties of a doctor.  Identifies client reason for consultation. Allows client to elaborate, presenting problem fully. |  | (1.01) The British Society of Abortion Care Providers (BSACP) [www.bsacp.org.uk](http://www.bsacp.org.uk)  RCOG: Comprehensive Abortion Care, Best Practice Paper No. 2. (2015). | Completion of RCOG STRATOG e-learning Abortion Care. |
| 1.02 Provide accurate and non-judgmental decision-making support; identify when referral for counselling is indicated.  1.03 Should termination of pregnancy be chosen, provide accurate and non-judgmental information on the appropriate methods for termination of pregnancy for the gestational age. |  | (1.02 -1.03) Understand the benefits, risks and alternatives for surgical and medical methods including manual vacuum aspiration (MVA) outside of a theatre setting, for appropriate to the gestational age, medical and social history..  (1.03) Understand how these options change after 12 weeks and after approximately 19 weeks, depending on local policies. |  | (1.02 -1.03) Non-directive counselling, sensitive to all options and associated health issues. To include: support for continuation of the pregnancy, adoption, as well as the medical and surgical methods for termination of pregnancy.  Explain clearly and openly treatment regimes, potential side effects of drugs and complications of procedures. |  | (1.01-1.03) The Care of Women Requesting Induced Abortion RCOG Evidence-based CG No.7 (2011)  (1.03) Medical versus surgical methods for first trimester termination of pregnancy. Cochrane Database Syst Rev 2005;(1):CD003037 | Completion of RCOG STRATOG e-learning Abortion Care.  Mini-CEX, CBD. |
| 1.04 Communicate and construct an appropriate management plan based upon shared decision-making. |  | (1.04) Familiarity with local and national guidelines. |  | (1.04) Phrases questions simply and clearly. Deals sensitively with embarrassing and/or disturbing topics. Structures interview in logical sequence.  Involves others as appropriate, respects and observes confidentiality, displays tact, empathy, respect and concern for the patient.  Discuss potential consequences of not completing treatment regime. |  | (1.04) General Medical Council. Consent guidance: patients and doctors making decisions together. (2008)  RCOG Presenting Information on risk. Clinical Governance Advice No. 7. (2008)  RCOG: Patient leaflet: Information about abortion care (2012) | OSAT |
| 1.05 Apply local pathways of care for protected groups including any safeguarding issues.  1.06 Identify if multidisciplinary input or high dependency care is required. Plan management and liaise accordingly. |  | (1.05-1.06) Thorough working knowledge of the local pathways of care for high risk and for protected groups including any safeguarding issues |  | (1.05-1.06) Ascertain social support, encouraging parental involvement where patient under 16 years’ old.  Respect religious and cultural diversity and beliefs.  Shows appreciation and acceptance of the range of human sexuality, lifestyles and culture. Appreciate how this may reflect in their presentation and impact on their management.  Check patient/carer aware of procedure, analgesia requirements, support, and expected course of recovery. Ensure everyone knows what constitutes abnormal signs and symptoms after abortion including who to contact in an emergency.  (1.06) Appreciate own limitations and the role of the MDT for high-risk situations. |  | (1.05) Pregnancy and complex social factors. Clinical guideline CG110. London: NICE (2010).  RCOG STRATOG, eLearning Abortion Care •Lecture 1: Historical, public health and legal issues. •﻿Lecture 2: The package of care (abortion methods and complications). •Lecture 3: What constitutes a good service? •Lecture 4: The client perspective. | (1.05-1.06) CBD, OSAT focused on counselling skills. |
| 1.07 Discuss and document a plan for STI screening, post-abortion contraception, indications for and availability of a post-abortion follow-up care. |  | (1.07) Department of Health. Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. (2004) |  | (1.07) Prescribe contraception and provide sexual health advice appropriate to the circumstances. |  |  | (1.07) Min-CEX, CBD. |
| 1.08 Perform ultrasound dating of the pregnancy.  1.09 Recognise abnormal uterine anatomy or pathology and identify a low-lying placenta.  1.10 Identify the endocervical canal and its instrumentation during dilatation of the cervix.  1.11 Perform evacuation of the uterus under ultrasound guidance.  1.12 Direct others to provide effective ultrasound guidance during uterine evacuation  1.13 Confirm complete evacuation of products using ultrasound. |  | (1.08 -1.10) Familiarity with the use of ultrasound dating based upon CRL or from 14 weeks HC, AC and FL. Recognition of cervical uterine and placental anatomy.  (1.09-1.13) Understand the ultrasound feature of normal and abnormal uterine anatomy and implantation (e.g., cervical or scar pregnancy). Familiarity with the ultrasound appearances during termination of pregnancy and recognition of successful completion of the procedure. |  | (1.08) Able to explain the need to accurately date the pregnancy.  (1.08-1.09) Able to produce a suitable report demonstrating the findings. |  | (1.08-1.12) RCOG Basic gynaecology and obstetric ultrasound modules. | (1.08-1.10) OSATs for Ultrasound component.  (1.11-1.13) OSATs for procedure. |
| 1.14 Appropriate prescribing for medical abortion, including abortifacients and analgesia.  1.15 Appropriate prescribing for cervical priming before surgical abortion.  1.16 Appropriate prescribing to minimise the risk of complications (e.g., infection, haemorrhage, alloimmunisation).  1.17 Appropriately identify indications for and demonstrate ability to safely insert and remove osmotic cervical dilators. |  | (1.14 -1.17) Know the indications, contra-indications and cautions for the use of mifepristone and/or misoprostol or other prostaglandin analogue (e.g., Gemeprost).  (1.16) Full knowledge of evidence-based recommendations for the prescribing of antibiotics, uterotonics and Rhesus anti-D immunoglobulin.  (1.17) Know the indications, contra-indications and cautions for the use of osmotic cervical dilators. [Not required for Surgical skills to 13+6 weeks]. |  | (1.14-1.17) Clearly explain the process of cervical preparation and dilatation, and aftercare advice including pain management and indications for seeking emergency out of hours care for procedures undertaken over two or more days.  (1.17) Insert osmotic dilators correctly and taking account of any allergies to materials used (e.g., latex), client comfort (e.g, vocal local, need for cervical anaesthesia), and use of no-touch technique.  Identify and manage immediate complications with insertion of osmotic cervical dilators (e.g., vasovagal, false passage) or removal (e.g. hourglassing). |  | (1.16) RCOG The Use of Anti-D Immunoglobulin for Rhesus D Prophylaxis, Green-top Guideline No. 22 (2011) | (1.14-1.17) Min-CEX, CBD. |
| 1.18 Safe and adequate mechanical dilatation of the cervix.  1.19 Effective and safe manual vacuum aspiration (MVA).  1.20 Effective and safe electric vacuum aspiration (EVA).  1.21 Effective and safe dilatation and evacuation (D&E)**.** |  | (1.18) Know best practice: Pain control in first trimester surgical abortion. Cochrane Database Syst Rev 2009;(2): CD006712  (1.19) Understand the pain management options for MVA (local cervical anaesthesia and oral analgesia, mild-moderate (conscious) sedation).  Know the environmental, staffing, and supplies required to safely and effectively provide office-based (1.19) or theatre (1.20-1.21) based uterine evacuation and acute management of complications.  (1.20-1.21) Knowledge of the theatre set up patient positioning and necessary equipment. |  | (1.18) Undertake assessment of adequacy of cervical preparation.  (1.18-1.21) Identify and manage inadequate cervical preparation or difficult cervical dilatation.  Choose appropriate instruments for the gestational age. Be able to recognise complications of abortion such as cervical false passage, uterine perforation, retained products of conception.  Work as a team and liaise with all staff.  Recognise and verbalise any personal difficulties encountered. |  |  | (1.1.18-1.21) Recorded within OSATs for the whole procedure across appropriate gestational ages. |
| 1.22 Confirm complete evacuation of products on inspection of the products.  1.23 Safe and sensitive disposal of fetal tissue.  1.24 Arrange investigations as indicated in cases of fetal anomaly or placental anomaly. |  | (1.22-1.24) Familiarity with the Human Tissue Authority Guidance on the disposal of pregnancy remains following pregnancy loss or termination (2015).  Completion of necessary documentation (1.24) Understand the indications for post mortem examination and karyotyping in the context of termination for fetal anomaly. Understand documentation and follow up for gestational trophoblastic disease. |  | (1.22-1.23) Give discharge instructions. Explain what is normal and abnormal (signs and symptoms) following abortion; how and when to contact the provider for advice/review.  (1.24) Obtain valid consent for post mortem, placental histology and for karyotyping if indicated. |  | (1.24) Termination of Pregnancy for Fetal Abnormality in England, Scotland & Wales. Report of a Working Party. RCOG (2010) [www.rcog.org.uk/termination-pregnancy-fetal-abnormality-england-scotland-and-wales](http://www.rcog.org.uk/termination-pregnancy-fetal-abnormality-england-scotland-and-wales) | (1.22-1.24) Recorded within OSAT of the whole procedure. |
| 1.25 Correct placement of intrauterine contraceptive device if indicated. |  | (1.25) Know best practice including: Immediate postabortal insertion of intrauterine devices. Cochrane Database Syst Rev 2010;(6): CD001777.  Department of Health. Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. (2004) |  | (1.25) Prescribe contraception and provide sexual health advice appropriate to the circumstances. |  | Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit. Clinical Guidance. Intrauterine contraception. (2007) [www.fsrh.org/news/new-fsrh-guideline--contraception-after-pregnancy/](http://www.fsrh.org/news/new-fsrh-guideline--contraception-after-pregnancy/) | (1.25) OSAT for the procedure |
| 1.26 Recognise cervical trauma and manage appropriately.  1.27 Recognise uterine trauma and manage appropriately.  1.28 Manage post-abortion haemorrhage and collapse  1.29 Manages complex cases requiring medical or surgical abortion. Recognise when a transcervical approach is not feasible and referral for hysterectomy or hysterotomy should be considered. |  | (1.26-1.27) Recognise and manage immediate complications of surgical abortion (e.g., cervical laceration, uterine perforation, acute haemorrhage, vasovagal episode) and medical abortion (e.g., retained placenta, acute haemorrhage, uterine rupture).  (1.28) Recognise and manage delayed complications of medical and surgical abortion (e.g., endometritis, incomplete abortion/retained products of conception, emotional difficulties)  (1.29) For example, women with medical comorbidities, uterine or placental anomalies. |  | (1.26-1.29) Know when to call for assistance.  Excellent communication skills and effective practical skills in acute situations requiring MDT approach. |  |  | (1.26-1.28) Note that any sign-off under ‘other methodology’ requires skills drill if no direct exposure.  (1.29) This requires evidence based upon actual clinical caseload. OSAT, CBD, Reflective Practice. |

## Recommended further reading

1. Rowlands S, ed. Abortion Care. Cambridge: Cambridge University Press, 2014
2. Paul M, Lichtenberg S, Borgatta L, et al. eds. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care. 2nd ed. Chichester: WIley-Blackwell, 2009.
3. Kelly T, Suddes J, Howel D, Hewison J, Robson S. Comparing medical versus surgical termination of pregnancy at 13-20 weeks of gestation: a randomised controlled trial. BJOG. 2010 Nov;117(12):1512-20.
4. Grimes DA. The choice of second trimester abortion method: evolution, evidence and ethics. Reprod Health Matters. 2008 May;16(31 Suppl):183-8.
5. Harris LH. Second trimester abortion provision: breaking the silence and changing the discourse. Reprod Health Matters. 2008 May;16(31 Suppl):74-81.
6. Kerns J, Steinauer J. Management of postabortion hemorrhage: release date November 2012 SFP Guideline #20131. Contraception. 2013 Mar;87(3):331-42.
7. Fox MC, Krajewski CM. Cervical preparation for second-trimester surgical abortion prior to 20 weeks' gestation: SFP Guideline #2013-4. Contraception. 2014;89:75-84.
8. Newmann S, Dalve-Endres A, Drey EA; Society of Family Planning. Clinical guidelines. Cervical preparation for surgical abortion from 20 to 24 weeks' gestation. Contraception. 2008;77:308-14.
9. Goldberg AB, Fortin JA, Drey EA, Dean G, Lichtenberg ES, Bednarek PH, Chen BA, Dutton C, McKetta S, Maurer R, Winikoff B, Fitzmaurice GM. Cervical Preparation Before Dilation and Evacuation Using Adjunctive Misoprostol or Mifepristone Compared With Overnight Osmotic Dilators Alone: A Randomized Controlled Trial. Obstet Gynecol. 2015 Sep;126(3):599-609.
10. Lichtenberg ES. Complications of osmotic dilators. Obstet Gynecol Surv. 2004 Jul;59(7):528-36.
11. Darney PD, Sweet RL. Routine intraoperative ultrasonography for second trimester abortion reduces incidence of uterine perforation. J Ultrasound Med. 1989 Feb;8(2):71-5.
12. Kerns J, Steinauer J. Management of postabortion hemorrhage: November 2012 SFP Guideline #20131. Contraception. 2013 Mar;87(3):331-42.

| **ASM 1 Safe Practice in Abortion Care.** | **Competence Level** | | | | | |
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| **Level 1** | | **Level 2** | | **Level 3** | |
|  | **Date** | **Signature** | **Date** | **Signature** | **Date** | **Signature** |
| **Communication and Governance Skills** | | | | | | |
| 1.01 Demonstrate a thorough working knowledge of the legal aspects of abortion care in the UK. |  |  |  |  |  |  |
| 1.02 Provide accurate and non-judgmental decision-making support for all pregnancy options; identify when referral for counselling is indicated. |  |  |  |  |  |  |
| 1.03 Should termination of pregnancy be chosen, provide accurate and non-judgmental information on appropriate methods for the gestational age, medical, and social history. |  |  |  |  |  |  |
| 1.04 Communicate and construct an appropriate management plan based upon shared decision-making. |  |  |  |  |  |  |
| 1.05 Apply local pathways of care for protected groups including any safeguarding issues. |  |  |  |  |  |  |
| 1.06 Identify if multidisciplinary input or high dependency care is required. Plan management and liaise accordingly. |  |  |  |  |  |  |
| 1.07 Discuss and document a plan for STI screening, post-abortion contraception, indications for and availability of a post-abortion follow-up care. |  |  |  |  |  |  |
| **Ultrasound Skills** | | | | | | |
| 1.08 Perform ultrasound dating of the pregnancy. |  |  |  |  |  |  |
| 1.09 Recognise abnormal uterine anatomy or pathology and identify a low-lying placenta. |  |  |  |  |  |  |
| 1.10 Identify the endocervical canal and its instrumentation during dilatation of the cervix. |  |  |  |  |  |  |
| 1.11 Perform evacuation of the uterus under ultrasound guidance. |  |  |  |  |  |  |
| 1.12 Direct others to provide effective ultrasound guidance during uterine evacuation. |  |  |  |  |  |  |
| 1.13 Confirm complete evacuation of products using ultrasound. |  |  |  |  |  |  |
| **Procedural Skills** | | | | | | |
| 1.14 Appropriate prescribing for medical abortion, including abortifacients and analgesia. . |  |  |  |  |  |  |
| 1.15 Appropriate prescribing for cervical priming before surgical abortion. |  |  |  |  |  |  |
| 1.16 Appropriate prescribing to minimise the risk of complications (e.g., infection, haemorrhage, alloimmunisation). |  |  |  |  |  |  |
| 1.17 Appropriately identify indications for and demonstrate ability to safely insert and remove osmotic cervical dilators. |  |  |  |  |  |  |
| 1.18 Safe and adequate mechanical dilatation of the cervix. |  |  |  |  |  |  |
| 1.19 Effective and safe manual vacuum aspiration (MVA). |  |  |  |  |  |  |
| 1.20Effective and safe electric vacuum aspiration (EVA). |  |  |  |  |  |  |
| 1.21 Effective and safe dilatation and evacuation**.** |  |  |  |  |  |  |
| 1.22 Confirm complete evacuation of products on inspection of the products. |  |  |  |  |  |  |
| 1.23 Safe and sensitive disposal of fetal tissue. |  |  |  |  |  |  |
| 1.24 Arrange investigations as indicated in case of fetal anomaly or placental anomaly. |  |  |  |  |  |  |
| 1.25 Correct placement of intrauterine contraceptive device if indicated. |  |  |  |  |  |  |
| **Management of associated complications ( \* Sign-off under ‘other methodology’ requires skills drill if no direct exposure)** | | | | | | |
| 1.26 Recognise cervical trauma and manage appropriately. **\*** |  |  |  |  |  |  |
| 1.27 Recognise uterine trauma and manage appropriately. **\*** |  |  |  |  |  |  |
| 1.28 Manage post-abortion haemorrhage and collapse. **\*** |  |  |  |  |  |  |
| 1.29 Manages complex cases requiring medical or surgical abortion. Recognise when a transcervical approach is not feasible and referral for hysterectomy or hysterotomy should be considered. |  |  |  |  |  |  |

| **Completion of ASM Safe Practice in Abortion Care.**  **PLEASE COMPLETE ONE OF THE FOLLOWING:** | **Date** | **Supervisor Signature** |
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| I confirm that the candidate has completed the ASM requirements for Safe Practice in Abortion Care. Surgical skills have been achieved up to **13+6 weeks’ gestation.** |  |  |
| I confirm that the candidate has completed the ASM requirements for Safe Practice in Abortion Care. Surgical skills have been achieved up to **18+6 weeks’ gestation.** |  |  |
| I confirm that the candidate has completed the ASM requirements for Safe Practice in Abortion Care. Surgical skills have been achieved up to **23+6 weeks’ gestation.** |  |  |

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| Training Courses or sessions | | |
| Title | Signature of educational supervisor | **Date** |
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| **Authorisation of signatures (to be completed by the clinical trainers)** | |
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| **Name of clinical trainer (please print)** | **Signature of clinical trainer** |
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| **COMPLETION OF Safe Practice in Abortion Care ASM**  **I confirm that all components of the module have been successfully completed:** | | |
| **Date** | **Name of educational supervisor** | **Signature of educational supervisor** |
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