

Pre-procedure Pregnancy Checking in Under 16s:
Guidance for Clinicians

November 2012



RCPCH

Royal College of
Paediatrics and Child Health

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Report of an expert working group convened by:

Royal College of Paediatrics and Child Health
Association of Paediatric Anaesthetists of Great Britain and Ireland
Children's Surgical Forum
British Association of Paediatric Surgeons

And supported by:

Royal College of Nursing



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Foreword

This project has brought together a wide range of specialist groups, faculties and Royal Colleges and we are indebted to them for their patience, openness and support in bringing this document through much iteration to this final report. We hope it will be implemented widely to ensure the safety and welfare of young women and their babies.

Please note:

- *The term 'young female patients aged under 16 years' has been agreed by the working group to be the term used throughout this document.*
- *Additional supporting information is available on the RCPCH website:
www.rcpch.ac.uk/pregnancychecks*

1. Introduction

- 1.1** Significant numbers of children and young people (C&YP) undergo elective and emergency surgical, radiological, anaesthetic and some medical procedures in the United Kingdom each year. If the patient is pregnant there is a small but recognised risk to the patient and her pregnancy/fetus and potentially a need to modify the technique or delay the procedure. A number of authorities, including NICE and the Health Protection Agency, stipulate that pregnancy status must be ascertained before a procedure is undertaken, usually recommending verbal questioning, or, if in doubt, a voluntary consented pregnancy test.
- 1.2** For female patients, particularly those under the age of 16, who may be attending a consultation or preoperative checks with their parents, there are a number of sensitivities around verbal questioning about pregnancy and sexual activity, and/or consenting for testing. Combined with the relatively low prevalence of pregnancy in this age group and often insufficient training or support for clinicians in sensitive enquiry there is evidence that pregnancy status in younger women is often not recorded effectively prior to treatment.

The aim of this document and associated webpages is to:

- provide an evidence-based resource to support a consistent approach by clinicians to determining pregnancy status for those under 16.
- propose a clear standard for all units to achieve
- provide information about risk and prevalence, and sources of further advice and data
- suggest practical supporting materials to facilitate implementation and local dialogue
- demonstrate national intercollegiate agreement to support local teams

- 1.3** This guidance was written with the involvement of young people and carers. We expect clinical teams to agree local arrangements to best protect the safety and wellbeing of the female patients in their care and, where applicable, their unborn babies.
- 1.4** This document concentrates mainly on recommendations for patients having elective surgery. For emergency situations, please refer to section 6.

2. Recommendation

- 2.1 All organisations performing procedures that require determination of pregnancy status should have a clear, locally agreed and audited procedure for ensuring documented compliance with statutory and professional guidance in this area, including specifically for females under the age of 16 years¹. This may for certain procedures involve consented testing of all post menarchal female patients under 16 years.
- 2.2 The local procedure should be communicated to all relevant staff, and set out clearly the criteria for enquiry or consented testing, what information is provided to patients, how pregnancy status is recorded and the procedures for management of consent and disclosure.
- 2.3 The agreed policy should consider the locations and staff groups (eg surgical and nursing staff) who would be involved and ensure that they are appropriately trained and resourced to carry out enquiries and, where relevant, consented testing.
- 2.4 A flowchart to assist hospitals in developing guidance is provided in section 4.

3. Policy context

- 3.1 Various clinical procedures are subject to regulations or guidelines which require females 'of childbearing age' to have pregnancy status checked before treatment including, for example, NICE clinical Guideline 3ⁱ for elective surgery and several for radiological protection from IR(ME)Rⁱⁱ, HPA/RCR and SoRⁱⁱⁱ ^{iv}.
- 3.2 These policies and guidelines refer to a suggested age range for determining pregnancy status of 12-55 years but NICE notes '... the sensitive and important issue of assessing the pregnancy status of 13-16 year olds.'^v
- 3.3 The Ionising Radiation (Medical Exposure) Regulation 2000ⁱⁱ states that the employer must have written procedures for making enquiries of females of childbearing age to establish whether the individual is or may be pregnant or breastfeeding. It is also the responsibility of the appropriately entitled referrer, practitioner and operator to check on the pregnancy status.
- 3.4 Clinicians express concern about establishing pregnancy status for females under 16 (the legal age of consent to sexual activity) who may be attending the preoperative assessment with their parents and who may feel uncomfortable discussing or disclosing possible sexual activity.

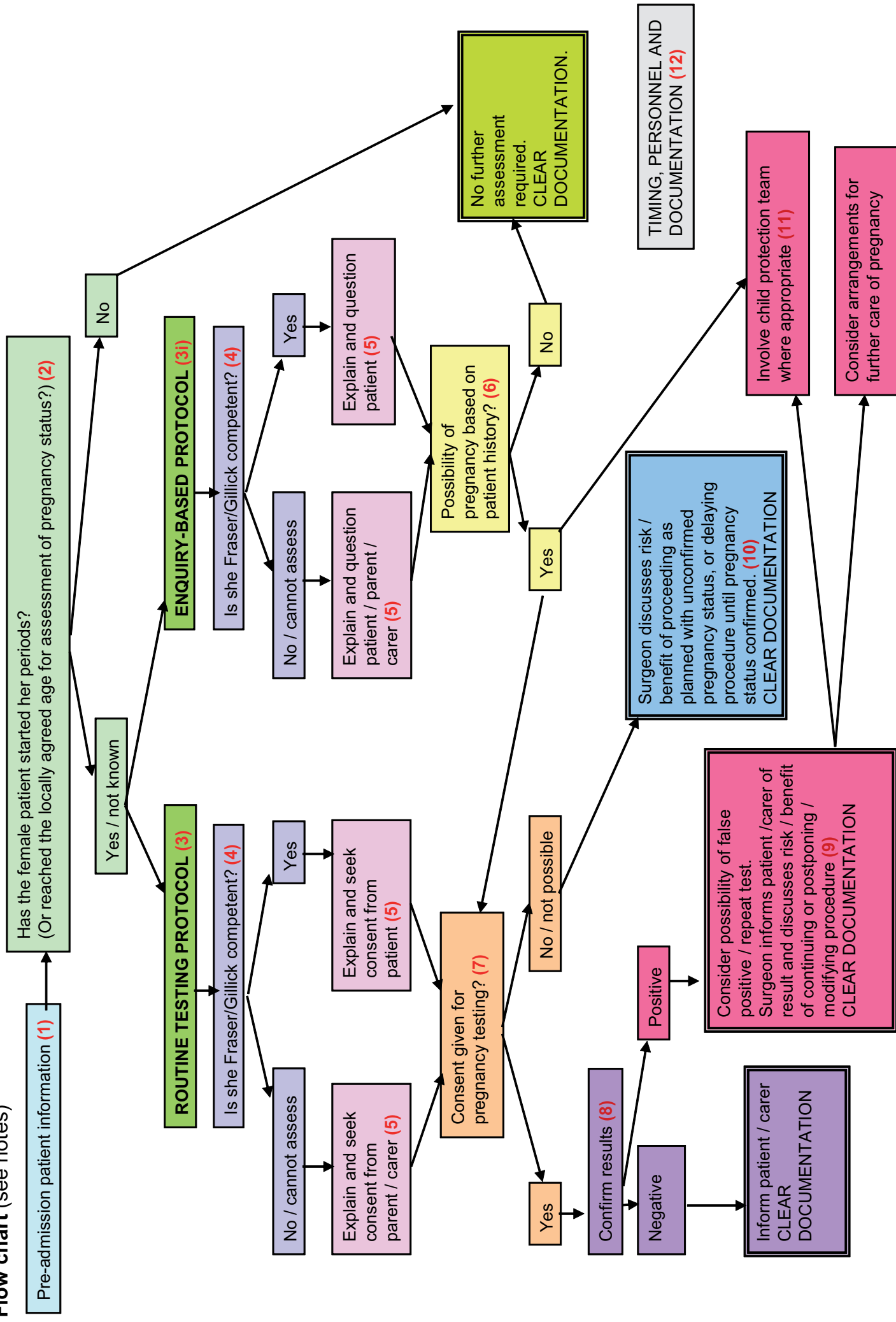
¹ Note the age of 16 was chosen for this guidance since that is the legal age of consensual sexual activity in the UK; many of the references are relevant to all children, ie up to 18 years or may be helpful for older patients where there may be issues around competency to consent.

- 3.5** In these situations it is acknowledged that a balance may be required between:
- the importance of having definitive pregnancy status and formal compliance with guidance
 - inappropriate questioning about sexual activity, or consented testing where pregnancy is statistically and ‘instinctively’ unlikely (see point 5 pages 8-9)
 - the likelihood of an accurate answer to enquiry
 - the potential harm to the pregnant patient and/or fetus of the proposed treatment.
- 3.6** There is some evidence^{vi} from the US that females under the age of 16 are not always able to respond accurately to questioning about their sexual activity or possible pregnancy status for a range of reasons including:
- hesitancy to disclose sexual activity when parents may be present
 - fear of authority if engaging in under-age sexual activity
 - unaware that they may be pregnant
 - the menstrual cycle can be erratic in adolescence and recall of dates of most recent menstrual period may be inaccurate.
- 3.7** Local policies need to reflect the balance of risks and be agreed by the clinicians carrying out the procedures and the checks. For example, they may propose that for those procedures where there may be significant risk to a pregnant patient or fetus, consented testing should be carried out, and for those procedures where the risk of unknown pregnancy is relatively small, consented or even a selective enquiry-based check may be a more suitable approach. Some units offer young people the opportunity for at least part of the consultation to be in private (without parents/carers) which is good practice.

4. Flowchart for development of policies

The following flowchart and subsequent notes provide a step-by-step guide to consideration of the issues required within a local policy, including parental involvement, consent, safeguarding and actions/decisions required. A similar flowchart specifically for radiological enquiries is in Appendix 2, and considerations relating to emergency procedures are detailed in chapter 5.

Flow chart (see notes)



Notes to the flowchart

Numbers refer to the boxes in the chart

1 Pre-admission patient information, written appropriately for female patients under 16 and their carers, will aid greatly in reducing elements of embarrassment and sensitivity during subsequent questioning about pregnancy on admission. Examples of information for display or leaflets and key elements to include can be found on www.rcpch.ac.uk/pregnancychecks.

2 A wide variance in the onset of menarche is reported (7-17 years) and pregnancies have been reported in females aged less than 12 years.^{vii,viii} Whincup et al. report nearly 1% will have their first menstrual period before their tenth birthday and this increases to over 21% by their twelfth birthday.^{ix} However, prevalence data indicates that the likelihood of pregnancy in those under 13 years presenting for clinical diagnosis or treatment is negligible.

3 There are two possible options for ascertaining pregnancy status in female patients presenting for surgery or investigation – directed enquiry or consented urine testing. In adult practice, directed enquiry is usual, with consented testing as appropriate in circumstances where pregnancy status is uncertain. Directed enquiry in females under 16 years may not however reveal all pregnancies for the reasons detailed in section 3.6.

In general, the likelihood of pregnancy in female patients under 15 years is low and the risks associated with most types of procedure are also low. However there may be certain procedures that would be considered particularly high risk to an undisclosed pregnancy, such as surgery to the lower abdomen, or that involving per-operative x-ray screening to the lower abdomen or pelvis, such as scoliosis or hip surgery. In such cases, consented testing of urine to exclude pregnancy may be considered appropriate by local teams. A suggested (and not-exhaustive) list of some of these potentially high-risk procedures is given on the RCPCH website: www.rcpch.ac.uk/pregnancychecks.

4 Decisions to involve parents and carers in discussions on sexual activity and the need for pregnancy testing must be taken using professional judgement and consideration of relevant guidelines such as around Gillick Competence and the Department of Health. Decisions will be based on the patient's age, maturity and ability to appreciate what is involved in terms of the implications and risks to themselves. A judgement may already have been made regarding a young person's competence to give their own consent to the planned procedure, but it is known that competence to make one decision does not necessarily indicate competence to make all decisions. The differing legal elements of determination of competence within the UK also must be taken into account.

5 Female patients under 16 years who may be pregnant have a right to be asked about pregnancy in confidence separately from their parent/carer, and any information disclosed

should be used in confidence unless there are overriding safeguarding considerations. It is sometimes difficult to contrive a way to separate patients from their parents to ask sensitive questions, but it may be enough to suggest that as the patient is nearly an adult, there are a couple of questions they may like to answer by themselves in private. The parents may then be asked to leave the room, or the patient given the opportunity to move to a private space with the healthcare professional. Given the responsibility that parents have for the conduct and welfare of their children, professionals should encourage the patient, at all points, to share information with their parents and carers wherever safe to do so.

In the case of a young patient with severe disability (eg severe cerebral palsy), the clinician caring for the patient may consider the possibility of pregnancy to be so remote that neither enquiry nor testing are necessary. This decision should however be documented (see page 12).

- 6** Patients should be questioned sensitively about whether they have started their periods, and if so, when was the date of their last period. If this was more than 30 days before the proposed procedure, they should be asked if there is any possibility they could be pregnant, qualifying this by asking if they are sexually active in a way which could result in pregnancy. They might also be asked at this stage whether they are taking oral contraceptive medication. If the patient reveals a possibility of pregnancy, as yet undetected or undisclosed, she should be asked if she will provide a urine sample and her consent gained for a pregnancy test. If questioning reveals pregnancy is unlikely, no further intervention is necessary and this should be documented appropriately.
- 7** Consent must be overtly obtained for pregnancy testing following specific questioning and provision of any explanation necessary. Sensitive handling of the discussion is required particularly where the age of the patient or indications of cultural sensitivity around premarital or under-age sexual activity are considerations. Surgical consent forms may specifically include mention of the need to ascertain pregnancy status as part of the consent process. A minimum requirement should be that verbal consent to pregnancy testing is recorded in the admission documentation, preferably as part of the patient's integrated care plan.

Whilst generalising or making assumptions about the beliefs of individual patients or their families is wholly inappropriate, development of a protocol locally should involve consideration and involvement of any prevalent groups who may find discussion of pregnancy with females under 16 years and their families a particularly sensitive issue. Furthermore it is essential to have a professional interpreter, or independent advocate if this helps the family or patient to make decisions. The GMC guidance on personal beliefs and medical practice provides further information.

A sample of urine obtained for standard urinalysis should not be used for pregnancy testing without the patient's knowledge and consent.

The legal framework on consent and confidentiality with particular relevance to children

and young people is covered by the General Medical Council publication '0-18 years: guidance for all doctors'^{xi}. This should be referred to for full references which include England, Wales, Scotland and Northern Ireland, and more detailed explanation.

- 8** Ward-based consented urine tests, which detect presence of urine human chorionic gonadotropin (urine hCG) within a few days of implantation of an embryo, are used routinely in day case units and surgical wards prior to elective procedures. These tests are commercially available to the general public and are extremely easy to use with a swift result (60 seconds). The purchase cost is under £2 each and the test can be conducted as part of pre-operative procedures thus requiring minimal additional staff resource. Laboratory-based urine analysis may be required where the result of a ward-based test is in doubt, or for confirmation of a positive result. Routine use of laboratory-based tests may introduce inconvenient delays in service provision where patients are admitted on the day of surgery, and systems should be in place to conduct these tests as a clinical priority.
- 9** Where a ward-based urine test proves positive, it may be prudent to repeat the test and/or organise a laboratory-based urine or serum test to confirm the pregnancy. The possibility of a false positive test should also be considered; causes include failed implantation (early miscarriage) and rare conditions causing elevated HCG levels.

The surgeon should be informed immediately of a positive test and should meet with the patient, with the support of her named nurse, to discuss the result and the implications for the proposed procedure. With the permission of the competent patient, and for patients not considered competent, parents/carers may be asked to join in these discussions.

Based on an analysis of the risk to the pregnancy compared with the anticipated benefits of the surgery, a decision must be made on an individual basis whether to proceed or postpone the surgery. If there is a possibility that the planned surgery will proceed, the anaesthetist should be involved in the risk/benefit discussions with the patient.

The clinical team caring for the patient must also make a judgement about the need to involve the local safeguarding team in the patient's ongoing care and make sure that appropriate advice is given regarding pregnancy management. This would usually involve the patient's general practitioner.

- 10** In cases where consent for pregnancy testing is denied, the surgeon and clinical team must discuss whether they are willing to proceed with the proposed surgery with unconfirmed pregnancy status, or whether the procedure should be postponed. The risks of proceeding should be explained to the patient and her parents/carers, where appropriate, and an effort made to quantify this risk so that the patient/parent can make an informed decision. On an individual basis, the surgeon may offer the option to consent to the surgery, acknowledging and documenting the risks of unconfirmed pregnancy status. It would be very difficult to quantify any anaesthetic risk in these circumstances. In situations where the risk to an undetected fetus would be considered unacceptable, the surgeon is justified in refusing to undertake the procedure.

11 Children under the age of 13 are considered by law in England and Wales^{xii} as unable to consent to sexual intercourse, and disclosure of sexual activity would usually require clinicians to take action under child protection criteria or the Gillick ruling^{xiii}. Advice should be sought from the safeguarding team with local procedures and contacts in place. The situation is more complicated for girls between 13 and 16 years of age, but any disclosure of coercion, sexual activity with a partner aged over 18 or indications of abuse should prompt discussion with the local safeguarding team.

More detailed information around consent, confidentiality and disclosure relating to sexual activity in those under 16 can be found in helpful guidance from a range of organisations including the RCOG Faculty of Sexual and Reproductive Healthcare^{xiv,xv}, the British Association for Sexual Health and HIV (BASHH)^{xvi}, Department of Health^{xvii} and RCGP^{xviii}.

Development and implementation of local protocols for pre-procedure pregnancy testing must involve the named safeguarding nurse and/or doctor to ensure that accurate safeguarding advice is available at all times to staff seeking consent and conducting the tests. It needs to be recognised that this advice may not be available from on-site personnel. Staff involved with determining the pregnancy status of females under 16 should feel confident in handling enquiries and responses around sexual activity and be aware of the legal and safeguarding issues. They should have received safeguarding training in accordance with intercollegiate guidance^{xix} and follow local procedures should a referral be indicated.

The ultimate responsibility for these discussions is with the senior surgeon in the team. In the case of contentious situations surrounding consent or when a positive pregnancy test is obtained, a senior member of the surgical team must be involved in leading the discussion and subsequent response.

12 Timing and personnel

Pregnancy status should ideally be ascertained within hours of the planned procedure. Information should be provided pre-operatively, at an outpatient visit or pre-assessment clinic, where there is also an opportunity for the need for questions and/or testing to be mentioned by the surgical team as part of the consent process for surgery. The responsibility for ascertaining pregnancy status on the day of procedure will remain with the surgical team. Local protocol may allow the actual questioning and/or testing to be carried out by a registered nurse admitting the patient to the ward providing the lead surgeon has gained and documented consent and should be done early in admission process to avoid delays. The patient's pregnancy status should therefore be known prior to the start of the operating list and form an essential part of the pre-operative documentation. Clear documentation will also avoid the need for further sensitive discussions in the anaesthetic room, where parents may be present.

13 Documentation

Having sought consent for pregnancy testing, it is good practice to inform the patient, and her parents/carers where appropriate, of a negative result. There should be clear documentation of the consent, the testing and the result. Where a result has proved positive, there should be extensive documentation in the medical notes of the clinical and safeguarding actions taken in light of the result.

Suggested minimum documentation in the integrated care plan:

For female patients of child-bearing age:

Any possibility of pregnancy on questioning?	Yes/No/Unknown
Consent given for pregnancy test?	Yes/No/N/A
Result of urine test?	Negative/Positive
Action taken:	Proceed/Postpone/Referral
Clinical decision that questioning/testing not appropriate:	<input type="checkbox"/>

5. Clinical emergencies and long-term conditions

- 5.1** When dealing with major trauma or a clinical emergency it may be impossible or inappropriate to determine pregnancy status through enquiry or consented testing prior to dealing urgently with the patient's condition. Where there is a chance that a patient may be pregnant the lead clinician should consider the radiological or clinical approach and relative balance of risks. For example, acute abdominal pain could be due to an ectopic pregnancy for which a pregnancy test is a necessary diagnostic test. Whether or not enquiry or testing was carried out should be clearly documented with reasons if appropriate.
- 5.2** Post-procedural testing should only be carried out if ongoing treatment would be affected by the patient's pregnancy status.
- 5.3** Where a patient is undergoing a long-term course of treatment such as chemotherapy, or for young female patients with multiple disabilities, it is expected that the clinician will make a judgement from his/her involvement with the patient whether ascertaining pregnancy status at each visit is appropriate. This decision should however always be documented.

6. Conclusion

- 6.1 This document aims to provide clinicians and hospital managers with clear guidance on determining pregnancy status of females under 16 prior to undergoing clinical procedures where there may be risks if they are pregnant. It provides evidence and references to enable local clinicians to determine and implement a legally-compliant and appropriate policy for minimising risk to patients and their children, to enable compliance with NICE and other guidance.

More information, suggested literature wording and examples of policies can be found on the webpage: www.rcpch.ac.uk/pregnancychecks

Appendix 1: Membership of the working group

Dr David Shortland, RCPCH Vice President, Health Services (Chair)

Dr Carol Ewing, RCPCH Workforce Officer

Mr Robert Wheeler, RCPCH Ethics Committee Chair

Dr Amanda Thomas, RCPCH Officer for Child Protection

Dr Hannah Spiers, RCPCH Trainee Representative

Mrs Ann Seymour, Parent-Carer Representative

Miss SuAnna Boddy, Chair, Children's Surgical Forum

Mr Gordon McKinlay, President, British Association of Paediatric Surgeons

Dr Judith Short, Association of Paediatric Anaesthetists

Katie Bagstaff, Royal College of Nursing

Dr Susan King, Royal College of Radiologists

Dr Tim Hillard, Royal College of Obstetricians and Gynaecologists

Kevin Tucker, Society and College of Radiographers

Maria Murray, Society and College of Radiographers

Elizabeth O'Sullivan, British Society of Paediatric Dentistry

Richard Wellbury, British Society of Paediatric Dentistry

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Rita Ranmal, RCPCH Clinical Standards Manager

Sue Eardley, RCPCH Head of Health Policy

Bharti Mevani, RCPCH Participation Manager

RCPCH Children and Young People's Forum

With contributions from:

RCOG Faculty of Sexual and Reproductive Healthcare

British Society of Paediatric and Adolescent Gynaecology

Royal College of Anaesthetists

Association of Anaesthetists of Great Britain and Ireland

Royal College of Physicians - adolescent health group

British Society of Paediatric Radiology

Association of Paediatric Emergency Medicine

Royal College of Midwives

Royal College of General Practitioners

Scottish Colleges' Committee on Children's Surgical Services

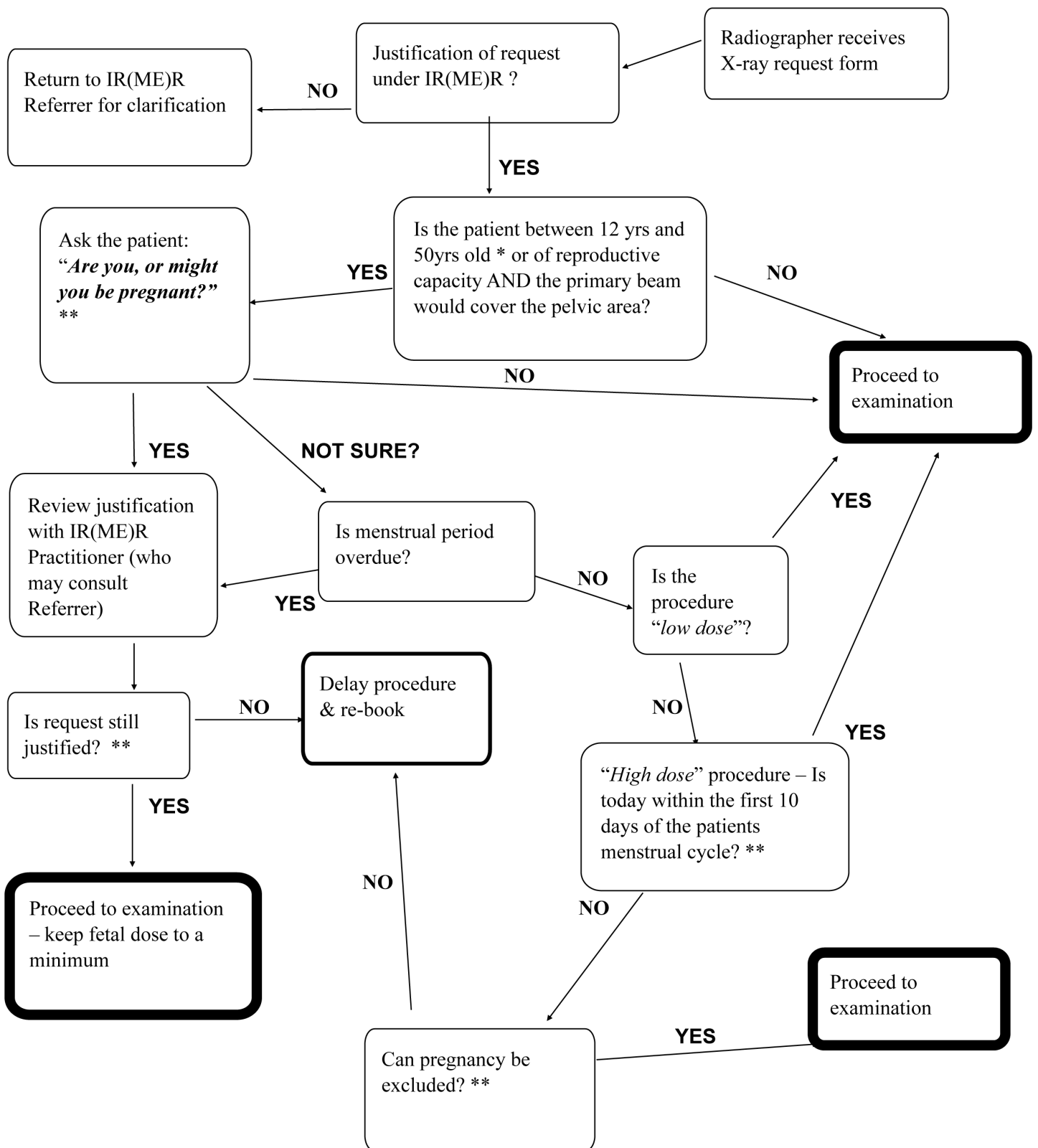
Appendix 2: Society and College of Radiographers sample decision flowchart (conscious patient) for radiological procedures

The Ionising Radiation (Medical Exposure) Regulation 2000ⁱⁱ requires employers to have written procedures for enquiring of females of childbearing age to establish whether the individual is or may be pregnant or breastfeeding. It is also the responsibility of the appropriately entitled referrer, practitioner and operator to check on the pregnancy status. Flowchart courtesy of Maria Murray, Society and College of Radiographers (MariaM@sor.org).

The flowchart has been designed to aid in the decision making process of checking the pregnancy status in women of reproductive capacity who attend for diagnostic medical exposure to ionizing radiations. The flowchart, with its subsequent decisions, mirrors the practical guidance given in the newly published (March 2009) guidance documentⁱⁱⁱ.

Radiographers are strongly advised to make themselves aware of the both the scientific and practical guidance within the publication before adopting the flowchart within local departments.

Sample flow chart for checking pregnancy status in women of reproductive capacity who attend for diagnostic medical exposure to ionizing radiations (conscious patient).



* - age range by local agreement and reviewed regularly

** - Record patient responses according to local procedure

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- iv** Advice on exposure to Ionising radiation during pregnancy in children (due for review)
www.rcr.ac.uk/docs/radiology/pdf/Guidance_diagnosticmedicalexposure_April07.pdf
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- xiv** Contraceptive Choices for Young People, RCOH FSRH Clinical Effectiveness Unit, March 2010: www.fsrh.org/pdfs/ceuGuidanceYoungPeople2010.pdf
- xv** Faculty of Reproductive and Sexual Health Service Standards on Confidentiality www.fsrh.org/pdfs/ServiceStandardsConfidentiality.pdf
- xvi** United Kingdom National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People, BASHH 2010: www.bashh.org/guidelines
- xvii** Best practice guidance to doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual or reproductive health. 2004 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086914.pdf
- xviii** Confidentiality and young people toolkit, RCGP 2011: www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and-adolescent-health.aspx
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