PREGNANCY CHECKS BEFORE SURGERY

An NPSA Rapid Response Report outlines how to ensure that women do not undergo surgical procedures when they are unaware that they are pregnant.

Nursing in any surgical area will be familiar with routine preoperative safety checks, such as checking when the patient last ate or drank. However, establishing whether a woman is pregnant before she undergoes anaesthesia/surgery is less consistent. Preoperative assessment often takes place weeks in advance of surgery and pregnancy status may change in the intervening time. While the practice of checking for pregnancy is well established in areas such as gynaecology, surgery and before procedures involving ionising radiation, there appears to be less awareness of the need for routine testing in other areas.

Between October 2003 and November 2009, the National Patient Safety Agency received 42 reports of patients undergoing a planned procedure without having a documented pregnancy test in the preoperative period, in three cases, the patient suffered a spontaneous abortion following the procedure.

These incidents led the NPSA to issue a Rapid Response Report in April 2010 to remind organisations that the possibility of pregnancy should be considered in all relevant female patients prior to surgery that may pose a risk to the woman or the foetus.

Organisations will need to consider the definition of ‘relevant female patient’. This may include all women who have started menstruating, regardless of age. Age needs consideration, and this has been interpreted as between 12 and 55 years.

Although no specific guidance was found on confirming pregnancy status in the immediate preoperative period, other relevant guidance is available: the National Institute for Health and Clinical Excellence issued guidelines on this topic in 2003, recommending pregnancy testing for women who say they may be pregnant. The Royal College of Obstetricians and Gynaecologists have guidance on obtaining valid consent and recommends that ‘all reasonable steps should be taken to exclude pregnancy before embarking upon any surgical procedure’.

If a pregnancy is detected, a discussion should take place between the clinicians and the patient about the risks and benefits of the surgery; the pregnancy will not necessarily result in the surgery being cancelled but it enables a clinical assessment of risk and the procedure may be postponed or the anaesthetic technique modified.

In emergencies, confirmation of pregnancy should not delay treatment but, again, require a clinical assessment of the risk.

Examples of text from incident reports:

- Patient had laparoscopy, during procedure patient found to be pregnant. Failed to do pregnancy test prior to procedure. Patient went on to miscarriage.
- Patient consented for abdominal hysterectomy. On opening the patient and examining the patient surgeon noticed the uterus was soft and bulky.

He performed a pregnancy test which was positive and an ultrasound which confirmed a positive pregnancy. Procedure was therefore abandoned and the wound closed. The pregnancy was subsequently lost.

Patient informed me that she had been admitted post-op with vaginal bleeding and a miscarriage diagnosed, therefore pregnant during surgery. Subsequent complaint raised.

No pre-operative pregnancy test. No mention in notes re: questions to patient about pregnancy.

Michael Surrkutt-Parr, clinical reviewer, NPSA

HOW TO USE THE RAPID RESPONSE REPORT TO CHANGE PRACTICE

Lindsay Egginton, clinical nurse specialist, surgery, at East Sussex Hospitals Trust, believes the NPSA Rapid Response Report helps to highlight this often overlooked issue.

“When the RRR was published, it officially highlighted an issue that I’d already identified as a potential risk and supported me in starting a trust policy on it. Although we have strict, written guidelines where radiology is concerned, there is nothing in black and white for general surgical procedures.

‘Trusts have to protect staff and patients, and balance that against expediency. But this must be balanced against patient responsibility. If you say to a patient, ‘Do you think you are pregnant?’ they say ‘no’ and you want to test them anyway – you are treading a difficult line.

‘We had a lady undergoing a gynaecology procedure [hysterectomy] and asked her the date of her last menstrual period. She said she was having her period that day. The team started the investigation, but were immediately suspicious and stopped proceedings; the patient was pregnant and her bleeding pregnancyrelated.

‘In high risk areas such as gynaecology or radiology, pre-op pregnancy checks are very effective. We have had incidents where patients were convinced they could not be pregnant as they were having their procedure to investigate infertility, but they were. These pregnancies were picked up through pre-op procedures and the operations cancelled.

‘The RRR states there were 42 cases between October 2003 and November 2009 – not vast numbers but, for those patients, it will have been a huge deal. If we can reduce the number of incidents to zero, we must aspire to that.

‘Patients may not have thought about it, so we have to think about it for them. Many will not be aware of the risks.

‘Some medical experts would prefer that all women of childbearing age were pregnancy tested before procedures but the cost would be astronomical, not to mention the impact on patient confidentiality and privacy. You have to take a common sense approach and this is what the RRR outlines.

‘We used to have different documentation for different areas. Now we have core documentation with additions for specialties, and questions about pregnancy are in every piece of documentation. When was the date of the last menstrual period? And could you be pregnant? are all on preoperative assessment documentation and checklists. If a patient insists there is no way she could be pregnant, we have to respect that but make sure that we document it.

‘The RRR has provided supporting evidence for my policy and, as it is from the NPSA, you can’t get much better than that. It is based on the most up to date literature search on this topic, which is very useful as it is not a topic that gets reviewed very often.’

We give patients so much preoperative information, some much of all, some don’t. Information on the risks of surgery while pregnant might go unread because the patient is so focused on the time and day of their operation.

‘With short stay surgery, there is a huge throughput of patients in a short time. And we handle every type of procedure. You have to have the issue of [pregnancy check] at the forefront of your mind and believe that having a policy in place helps this to happen.

‘Some medical experts would prefer that all women of childbearing age were pregnancy tested before

Find the Rapid Response Report and supporting information on the NPSA website at tinyurl.com/RRR-pregnancycheck

DID YOU KNOW?

- You can add the issue of the check for pregnancy to local preoperative documentation if it is not already there, and could consider adding it to the surgical safety checklist carried out in theatre before an operation is started.

- Guidance on the duty of confidentiality towards young people is available from the Department of Health (see tinyurl.com/reproductive-guidance) and the Royal College of Obstetricians and Gynaecologists (see tinyurl.com/consent-guidance).

- A Health Protection Agency guidance on how and when to present or reassure asymptomatic initial exposure to ionising radiation includes establishing the pregnancy status of all women of reproductive potential (see tinyurl.com/HPA-radiation).

- Consent should be obtained from the patient prior to carrying out a pregnancy test.