Service standards for sexual health

Madam

We fail to understand why Dr Stephen Searle1 feels that implementing the Faculty’s Service Standards should be a rank-level client care. If a service has a clear chaperone policy or protocol then the amount of actual documentation required is minimal. In the case notes ‘chaperone declined’ or ‘chaperone: Nurse Smith’ should suffice to indicate adherence with the policy.

In Abacus Clinics in Liverpool we established a chaperone policy in 2001 in response to guidance from the General Medical Council and the Royal College of Obstetricians and Gynaecologists.2 This followed a lengthy in-house discussion and required a significant ‘culture change’ for a predominantly female staff who previously viewed the offer of a chaperon as a weekly issue with medico-legal implications. Some felt that the offer of a chaperone would alarm clients and make them suspicious of the clinician. There were concerns about the chaos that would ensue in busy clinics if all clients wanted a chaperone. In the event, these fears were unfounded. A review of staff perspectives on the policy a year after its introduction showed that the majority of staff felt that less than 5% of clients accepted a chaperone when offered. It was felt that the reason for requesting a chaperone had more to do with relieving the client’s anxiety about the examination rather than about unprofessional behaviour by the clinician. Whilst only 18% of staff members stated that they always offered a chaperone, up to 80% usually or sometimes did so. The main reason given for not offering a chaperone was that they simply forgot to do so because it was a change to their previous routine practice. Those who did offer documented the offer on most occasions. There was no evidence to suggest that implementing the policy had a significant detrimental effect on clinic times or workload.

Referring to practical procedures, e.g. fitting an intrauterine device (IUD), may be more time consuming but it is important that such procedural protocol is documented to ensure continuity of good clinical care and risk management. Perhaps the devil is in the detail. It is up to us as clinicians to decide what is and what is not essential documentation. Following an audit5 of relevant case notes within our service, carried out in 2000, we established a minimum standard2 for documentation relating to IUD insertion acceptable to all our clinicians. In our experience it has been happy to implement these standards, accepting them as a useful aid to maintaining good clinical care.

Staff involvement by consensus should serve to protect both client and clinician.

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References


20 days after insertion and a new IUS was refitted without incident. Two women have conceived with copper IUDs in situ for 4 and 6 months after insertion. One subsequent IUD 2004; 30(3): 139–141.

Letters

UFD insertion following medical TOP

Madam

We would like to respond to the letter by Stephen Searle in the April 2004 issue of the Journal on behalf of the Clinical Standards Committee of the Faculty. The reason d’etre of the National Health Service, and for all who work in it, is to provide high-quality, continuously improving, patient-centred care. The Faculty with the object of integrating national guidance and directives and incorporating these with core clinical governance principles to provide specialty-specific standards. They are intended to aid clinicians in patient care. Clear record keeping is fundamental to, and an integral part of, patient care. To view it as reactive bureaucracy, which is only necessary to protect in cases of legal action for poor practice, is surely to miss the point. Rather, good record keeping is a fundamental part of each episode of patient care.

Clearly formalization of standards is a rapidly developing area. The documents produced by the Clinical Standards Committee have short review cycles so that views can be included commensurate with this progression. Further, the ‘committee asks for feedback comments and suggestions. It is to be hoped that these will inform the refinement of the standards at review thus maximising their usefulness.

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References

2 MRCGP, MFFP
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References


Reply

Madam

The FFPFRHC Clinical Effectiveness Unit (CEU) provides evidence-based Guidance documents on contraception and reproductive health topics. The recent Guidance document ‘The intrauterine device as long-term contraception’ was developed using best available evidence from a systematic review of professional knowledge of the multidisciplinary expert group and subsequent peer review. Despite a large number of medical abortions performed each year in England, Wales and Scotland, there is a lack of published evidence on the timing of intrauterine contraceptive insertion following medical abortion.

The insertion of intrauterine contraception immediately following abortion clearly has advantages. The insertion of intrauterine contraception at the time of surgical abortion is practical and safe.7 The World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use (WHOMEC)8 recommends that intrauterine contraception can be inserted immediately following induced or spontaneous first trimester abortion (WHO 1: unrestricted use). Although the risk of expulsion of an intrauterine device (IUD) following second-trimester abortion is increased,2 WHOMEC recommends that benefits still outweigh the risks (WHO 2:3).

Although WHOMEC does not provide recommendations regarding insertion of intrauterine contraception immediately following abortion; evidence from case-control studies showed low perforation rates with insertion within 30 days of abortion.

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T380® or Nova T380® IUDs but included two Flexi-T300® IUDs in 2000 and two Flexi-T300® IUDs in 2000 and two

Since January 2000, 55 copper IUDs have been inserted between 4 and 30 (average, 11) days following medical TOP. The majority were GyneFix® IUDs in 2000 and two Flexi-T300® IUDs in 2003. The two women whose copper IUDs were not completely empty. Waiting for 4 weeks (presumably until after the next menses) requires women to arrange a further appointment that they may have difficulty keeping and also denies them efficient contraception for the first month after TOP.

We suggest that a review appointment, usually at 7–10 days post-medical TOP, allows safe insertion of both copper IUDs and Mirena IUS and should be promoted.

References


3 Murray L. A review of staff attitudes to the implementation of a chaperone policy within a family planning and reproductive health care service. Unpublished MSc thesis submitted to the University of Ulster. 2001. Available from the Abacus Institute for Sexual Health, P.O. Box 4, Larkfield, Ayr, Scotland.


3 Murray L. A review of staff attitudes to the implementation of a chaperone policy within a family planning and reproductive health care service. Unpublished MSc thesis submitted to the University of Ulster. 2001. Available from the Abacus Institute for Sexual Health, P.O. Box 4, Larkfield, Ayr, Scotland.
IUD insertion following medical TOP

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