experience at IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures.

Do any readers know of anyone else who is struggling to manage the IV administration. Perhaps we are unusual in that so many of our nurses do so many procedures. 

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Nurse training and the need for IUD fitters to have expertise in resuscitation


Royal College of Nursing (RCN) Statement. 

Reply

I would like to thank Drs Hollingworth and Mansour for their letters about nurse training and the need for intrauterine device (IUD) fitters to have expertise in resuscitation.1,2 This is a question that I am being increasingly asked by clinicians around the country as they become aware of the implications of the recent guidance on this topic. Not only is it unrealistic to expect all the clinicians involved to undertake the extra training and regular practice to comply with the guidance – looking at the British Resuscitation Council guidelines,3,4 this is needed in order to attend the training and regular practice to comply with the guidance. The British Resuscitation Council guidelines,3,4 this is needed in order to attend the training and regular practice to comply with the guidance. 

As I understand it, the original guidance from the RCN,5 which was directed at nurses fitting devices rather than assisting other clinicians and was based on discussions with the RCN legal team, recommended that resuscitation should be carried out only if the nurse had participated in regular practice of the techniques – it also implied that such services can be delivered not just by nurses but by doctors too. Nurses will feel it is unworkable. Those that have tried, like Dr Hollingworth, to ask the Royal College of Nursing (RCN) to be referred to the Faculty guidance,4 and the Faculty rightly feel that they were following advice from the RCN. As I understand it, the original guidance from the RCN,5 which was directed at nurses fitting devices rather than assisting other clinicians and was based on discussions with the RCN legal team, recommended that resuscitation should be carried out only if the nurse had participated in regular practice of the techniques – it also implied that such services can be delivered not just by nurses but by doctors too. 

We have also had local community nurse-based clinics fitting intrauterine contraceptives in general practice premises suspended because ‘doctor cover’ by the general practitioners [who can administer intravenous (IV) drugs] has been withdrawn. Faculty guidance in Service Standards for Resuscitation in Sexual Health and any untreated infections in pregnancy can carry serious consequences.

One of the key issues in the current guidance is the need for the nurse to have expertise in resuscitation procedures. If a woman had rushed in and had not eaten for hours, and so on? Perhaps the way forward would be for one or more groups of nurse practitioners to produce guidelines for use by all clinicians to follow in such circumstances. This would reflect the multidisciplinary aspect of the work and recognise that this could apply to either doctors or nurses, both groups having highlighted that this is an area where few currently feel able to undertake the actions suggested in the current guidance. If this guidance could be produced following discussion with experts in the field of resuscitation it would then hopefully be realistic, as well as being practical, and would reflect current evidence-based best practice.

Shelley Mehigan, RCN Nurse Specialist (Contraception), Berkshire East Community Health Services, Sexual Health, Upton Hospital, Slough, UK.
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References

1 Mehigan S, Moore W, Hayes L. Nurse training in resuscitation. Correspondent article1 in the April issue of the Journal. The second point made is that “if either partner has a sexually transmitted infection (STI), they should use protection...”. If one of a couple has an STI then it is generally recommended that for the treatable infection a couple cease completely from having any penetrative sex until treatment of both partners is complete. Condoms do not provide 100% protection against any STI and any untreated infections in pregnancy can carry serious consequences.

I am uncertain why protected anal sex should be “avoided altogether”. If the couple exercises good hygiene practice is there any other concern about advising against pregnancy? I could not find anything in the article to explain this advice.

Susan Young, BSc, MNLP Freelance Writer, Broadcaster and Agony Aunt, Cambridge, UK.
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Reply

First, I wish to thank Dr Young for reading my article1 so carefully and for responding to it so thoughtfully in her letter.2 Dr Young is, of course, correct that if either partner in a couple has a sexually transmitted infection (STI) they should ideally not have sex at all until after treatment. However, in practice this advice is frequently ignored – particularly during pregnancy when partners want to reinforce their bond and reflect their closeness – so I was being practical in advising against pregnancy. Similarly, Dr Young is correct in saying that in ideal circumstances, anal sex is safe. But in the ‘real life’ situations I hear about, hygiene practices around anal sex are often far from perfect and so, again pragmatically, during pregnancy in particular I generally advise abstinence.

Finally, the aim of my article, and the substance of the main body of my text, was to promote sex in pregnancy and ask professionals to encourage it. I didn’t aim to give detailed information about risks – such information is covered fully in many other sources. Hence the guidance provided in the summary boxes gives headlines only rather than explaining in full the medical background.

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References


Safe sex during pregnancy

As a consultant in gynaecological medicine, I wish to comment on Box 1 entitled ‘It is safe to have sex...? in Susan Quilliam’s Consumers Correspondent article1 in the April issue of the Journal.

I agree that ‘it is safe to have sex in the first two trimesters...’ is the guidance which is confusing in the Journal. The second point made is that “if either partner has a sexually transmitted infection (STI), they should use protection...”. If one of a couple has an STI then it is generally recommended that for the treatable infection a couple cease completely from having any penetrative sex until treatment of both partners is complete. Condoms do not provide 100% protection against any STI and any untreated infections in pregnancy can carry serious consequences.

I am uncertain why protected anal sex should be “avoided altogether”. If the couple exercises good hygiene practice is there any other concern about advising against pregnancy? I could not find anything in the article to explain this advice.

Susan Young, BSc, MNLP Freelance Writer, Broadcaster and Agony Aunt, Cambridge, UK.
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References


e-SRH e-Learning

As an Instructing Doctor for the Faculty of Sexual and Reproductive Health Care (FSRH), I have enjoyed completing this online training2 at www.e-lfh.org.uk.

This is an excellent course, and the animations, including the physiology of the...
Nurse training and the need for IUD fitters to have expertise in resuscitation

Diana Mansour

*J Fam Plann Reprod Health Care* 2010 36: 180
doi: 10.1783/147118910791749290

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