Intrauterine device insertions: Setting our standards

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bstract

Objective. *To determine if the documentation for intrauterine device (IUD) insertions was satisfactory and to agree minimum standards for practice.*

Method. A *list was drawn up with minimum standards for documentation in the case notes. These were agreed at the clinical audit meeting. A retrospective analysis of case notes was done and a list completed for each IUD insertion.*

Setting and participants. *IUD fittings at all the Abacus clinics from 1 September 1999 to 31 October 1999.*

Results. *Of the 232 IUD insertions, the gold standard for documentation was met in 20%, however documentation of essential criteria was met 93% and all criteria 83% of the time. Each doctor received individual, confidential, comparative feedback.*

Conclusion. *We were able to agree a minimum standard for documentation to enhance adequate counselling, safe insertion, communication with colleagues and risk management.*

Context

Intrauterine device (IUD) insertion is a common procedure in our clinics with over 100 insertions each month. A recent Medical Defence Union (MDU) survey showed that it is one of the two areas of contraceptive provision with the maximum litigation.[1] It is important not only to follow procedure guidelines for counselling and insertion but also to document these in the notes. This is helpful for subsequent follow-up as well as for risk management.

Objective

The objective was to determine if the documentation for IUD insertion was satisfactory and to agree minimum standards for practice.

Design

The IUD insertion protocol and IUD manufacturers' suggestions were looked at and a literature search done in order to draw up a list with minimum standards for documentation in the case notes. These were discussed at the clinical audit meeting and three essential criteria (pelvic examination, sound length and chlamydia risk assessment) agreed.

A retrospective analysis of case notes was done and each item on the documentation list was checked against the notes for each IUD insertion. All IUD inserters were given confidential, individual and comparative anonymised feedback. Those doctors achieving scores below 90% for essential criteria documentation and 80% for overall documentation were asked to reflect and feed back to the lead clinician. A clearer list of counselling and documentation points was then agreed for future use.

Setting and participants

The study surveyed IUD fittings at all Abacus clinics from 1 September 1999 to 31 October 1999, and included all the doctors responsible for IUD insertions.

Results

A total of 232 clients had an IUD insertion in the study period by 18 doctors. The gold standard (mention of all of the agreed criteria) was met in 46 (20%) of the case notes. Overall, 93% of essential criteria and 83% of all criteria were recorded. Seven doctors always recorded all essential criteria but no-one recorded all criteria every time. Six doctors who between them fitted 37 IUDs did not achieve the set acceptable level of 90% for essential criteria. Eight doctors who between them fitted 107 IUDs did not achieve the set acceptable level of 80% recording for all criteria.

Discussion

It was very useful to discuss the documentation as it made us think of what we do and why we do it. Our note-

Table 1 *Standard documentation for an IUD insertion covering the three main areas of pre-insertion, procedure and post-insertion*

Area of documentation	Criteria
Pre-insertion	
History	Previous contraception used Parity, mode of delivery, ectopic pregnancies Usual cycle Stability/length of relationship PID with details of diagnosis and treatment Smear status and cervical surgery Cardiac lesions Allergy to local anaesthetic Discussion of all contraceptive options
Counselling	Efficacy and duration Effects on the menstrual cycle Insertion procedure Thread check: expulsion, thread moving up, perforation Testing for *C. trachomatis* advised if at any risk
Procedure	Bimanual examination Local anaesthetic if used Chlamydia/smear if done Uterocervical length Technique: acceptable terms include 'no touch', 'easily/with no problems', 'routine' Comments: if any problems, documented together with any actions taken Type of IUD, batch number and expiry date
Post-insertion	Special instructions, e.g. for Gynefix Patient information leaflet ± *fpa* leaflet Follow-up: 'see if any problems' is acceptable Letter to GP sent/not sent, depending on client's consent

fpa, Family Planning Association; GP, general practitioner; PID, pelvic inflammatory disease.

keeping meant different things to different clinicians. Explicit documentation criteria make communication clearer for follow-up as well as risk management. Taking into account the World Health Organization (WHO) eligibility criteria,[2] the Cochrane Database,[3] the Royal College of Obstetricians and Gynaecologists (RCOG) recommendations[4] and known frequency and seriousness of complications,[5] we agreed a standard of documentation for an IUD insertion in our service. A balance needed to be struck between recording sufficient information to adequately reflect the consultation but not so much that it was unmanageable. The agreed documentation included three main areas – pre-insertion, procedure and post-insertion – see Table 1.

The agreed recommendations for standards of documentation were incorporated into the IUD clinical protocols and distributed to all clinicians in the service. The individual, confidential comparative feedback allowed staff to reflect on their strengths and areas for improvement in a non-threatening manner. We plan to re-audit to ensure standards are being maintained.

Conclusion

This audit clarifies what we should do, why we should do it, and how we should record it to enhance communication and reduce risk. We were able to agree a minimum standard for practice to enhance adequate counselling, safe insertion, communication with colleagues and risk management.

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Revisiting 'Fraser ruling competence' for under 16s in the UK

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One-quarter of women and nearly one-third of men have sex under the age of 16 years but the average age at first sexual intercourse is 16 for both sexes, according to the recent *National Survey of Sexual Attitudes and Lifestyles.*[1] Two in five men and four in five women in their late teens and early twenties who first had sex at the age of 13 and 14 wished they had waited longer, so there is no doubt that young people under the age of 16 need to be able to discuss sexual matters with a health professional. They will be given accurate information, which helps them to make informed choices as to when they start sexual activity and how to lead a healthy sexual lifestyle.

The Sexual Health Research Unit at the University of Southampton recently found that over 50% of boys get their information from television and magazines; one-third of the young men said that they would like more information from doctors (R Ingham, personal communication, 2001). Young women also rated magazines highly as a source of information, but 40% said that they also saw the doctor or nurse as a source of information. Young people, especially those aged under 16, still have reservations about approaching general practitioners (GPs) and family planning clinics for advice about contraception, although it is 16 years since the case of whether or not doctors could advise and prescribe for under 16-year-olds without parental consent or knowledge. A test case[2] went through the legal system and ultimately to appeal in the House of Lords. The final ruling was made by Lord Fraser, who stated that the doctor should always encourage the young person to share their need for contraception with a parent or allow the doctor to do so. If the young person explained to the doctor it was not desirable or possible to discuss these matters at home, given the family relationships or circumstances, then the doctor takes on the responsibility for helping the young person without parental consent.

The doctor needs to discuss the sexual relationship or proposed relationship with the young person to help the young person to decide whether they are comfortable and are in no way being pressurised or abused. The young woman is asked if she intends to continue her present relationship and the doctor assesses her need for contraception and whether her physical or mental health would be damaged by lack of advice or prescription. When the decision is made to prescribe for the young person the doctor must feel confident that the patient is mature enough to understand the decision she is making. The doctor should explain the method in detail and allow the young person to ask any questions.

The decision is then made by the doctor whether it is in the best interests of the under 16-year-old to prescribe for her in order to protect her against unintended pregnancy or sexually transmitted infections (STIs). Previously the assessment of the young person's maturity was called 'Gillick competence'; the current terminology is 'Fraser ruling competence', after Lord Fraser who was one of the Law Lords who ruled in the test case.

GP practices and community clinics should put in their practice/clinic leaflets, and any other relevant information materials, that they offer a confidential service for those under 16. It is particularly important to display this information in reception areas, so that young people are made aware of this. This should encourage more young people to consult doctors and nurses, so that they can be given accurate information on sexual health in an open and non-judgmental way.

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