Service standards for sexual health

Madam
We fail to understand why Dr Stephen Searle1 feels that implementing the policy had a significant impact on his level of client care. If a service has a clear chaperone policy or protocol then the amount of actual documentation required is minimal. An entry in the case notes ’chaperone: Nurse Smith’ should suffice to indicate adherence with the policy. In Abacus Clinics in Liverpool we established a minimum standard6 for RGN, Dip. Health Education Nursing experience staff have been happy to implement the policy. Although WHOMEC does not provide evidence-based guidance on chaperones, the policy a year after its implementation relating to practical procedures, e.g. fitting an intrauterine device (IUD), may be more time consuming but it is implemented as a medico-legal requirement but for ensuring 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 important, not just for medico-legal reasons, but for ensuring continuity of good clinical care and risk management. The number of publications on this topic is minimal. An entry in the case notes ‘chaperone’ then the amount of actual documentation required should not detract from our level of client care. If a service has a clear chaperone policy or protocol then practice is sufficient to protect all clinician and clinic clients.

Laraine Murray, RGN, Dip. Health Education Nursing Studies
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James T McVicker, BSc(Corp), MFFP
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References
5 Murray L. A review of staff attitudes to the implementation of a chaperone policy. Unpublished MSc report from AMC. Intrareproductive health care service. Unpublished data.

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Letter

UJD insertion following medical TOP

Madam
I 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.1 The reason for the interest of the National Health Service, and for all who work in it, is to provide high-quality, continuously improving, patient-centred care. A recent short space of time when clinical governance has become a pre-eminent tool in enabling this to happen.

Whilst the references on this subject is almost overwhelming, the basic principles applied to clinical practice should ensure the delivery of good care. The service standards are always being reviewed by the Faculty with the object of interpreting national guidance and directives and incorporating these with our own 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 formation 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 comments and suggestions. It is to be hoped that these will inform the refinement of the standards at review thus maximising their usefulness.

Christine Robinson, FRCOG, MFFP
Chair of the Clinical Standards Committee, Faculty of Family Planning and Reproductive Health Care, London, UK

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Letter

Established a minimum standard for intrauterine contraception

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