Service standards for sexual health

Madam

We fail to understand why Dr Stephen Searle1 feels that implementing the Faculty’s Service Standards should be the province of level of 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 Council3 and the Royal College of Obstetricians and Gynaecologists.4 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 chaperone as a purely gender issue. The staff would not always be present and there were no medical-legal implications. Some felt that the offer of a chaperone would alarm clients and make them suspicious of the clinician. There were concerns about how this would cause 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 later showed that the majority of staff felt that less than 5% of clients accepted a chaperone when offered. It was felt that the role of 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. The 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.

Documentation relating to practical procedures, e.g. fitting an intrauterine device (IUD), may be more time consuming but it is important to keep a record of these-legal reasons, 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 and what is not essential documentation. Following an audit5 of relevant case notes within our service, carried out in 2000, we established a minimum standard6 for documentation relating to IUD insertion acceptable to all our clinicians. In our experience, all staff have been happy to implement these standards, accepting them as a useful aid in maintaining good clinical care. Standards established by consensus should serve to protect both client and clinician.

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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 of etre of the National Health Service, and for all who work in it, is to provide high quality, continuously improving, patient-centred care. The new service standards of the FFPRHC Clinical Standards Committee have short space of time to become a pre-eminent tool in enabling this to happen.

Whilst the many publications 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 updated by the Faculty with the object of interpreting 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 or for poor practice, is surely to miss the point. Rather, good documentation is a fundamental part of each episode of patient care.

Clearly formalisation of standards is a rapidly developing area. The documents produced by the FFPRHC Clinical Standards Committee have short review cycles so that views can be included commensurate with this progression. Further, the committee are actively seeking 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

IUD insertion following medical TOP

Madam

We found the FFPCHRIC Guidance on ‘The copper intrauterine device as long-term contraception’ most informative but were surprised by the lack of data relating to intrauterine device (IUD) insertion following medical termination of pregnancy (TOP) (Section 26). It is important that more than 300 medical TOPs annually up to 83 days’ gestation. All women are screened for sexually transmitted infections and there is a 96% complete miscarriage rate.3 A proportion of cases of abortion occurs or completes at home in the first few days following the administration of misoprostol. If not achieved in hospital, the contra-ception such as oral contraceptives or Depo-Provera® is commenced immediately by the nursing staff. Women are then reviewed in a weekly staffed family planning clinic approximately 7–10 days after their termination procedure. This review ensures that the termination is complete and allows the patient’s physical and emotional status to be assessed. IUDs or implants are inserted at this visit. Occasionally at this visit the appointment is not kept and further misoprostol is required to expel all products of conception. Another appointment is then made 1 week later for the IUD fitting. Since January 2000, 55 copper IUDs have been inserted between 4 and 30 (average, 11) days following medical TOP. The majority were Gyne-T380® or Nuvaring®. There were also two Flexi-T380® IUDs in 2000 and two Flexi-T380® IUDs in 2003. The two women whose copper IUDs were fitted at 29 days post-TOP had had a continued problems with bleeding and required further doses of misoprostol. Thirty Mines® intrauterine systems (IUS) were also inserted 6–16 (average, 10) days after a first medical TOP. There have been no difficulties or immediate complications with insertions using this policy. In 2001, a Mines IUS was partially expelled 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 respectively. The first trimester postabortal uterus does not appear to behave like a postpartum uterus. In practice many women would not wish to be examined within the first 48 hours when the bleeding may be heavier and in some women the uterus may not be 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.

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Reply

Madam

The FFPCHRIC Clinical Effectiveness Unit (CEU) provides evidence-based Guidance documents on individual contraceptive and reproductive health topics. The recent Guidance document ‘The intrauterine device as long-term contraception’ was developed using best available evidence from a systematic literature review, and is the first to incorporate 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 clear advantages. The insertion of intrauterine contraception at the time of surgical abortion is practical and safe.7 The World Health Organization (WHO) Material of 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 WHO recommends 14 days after abortion. Full contraindications and benefits still outweigh the risks (WHO 2).9 Although WHOMEC does not provide recommendations regarding insertion of intrauterine contraception, evidence from case–control studies showed low perforation rates with insertion within 30 days of abortion.

References
2 Kasliwal AP, Webb AMC. Intrauterine device insertions: a chaperone policy in a large community-based contraception service on September 13, 2023 by guest. Protected by copyright. http://jfprhc.bmj.com/ J Fam Plann Reprod Health Care: first published as 10.1783/1471189041261438 on 1 July 2004. Downloaded from

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This relatively new journal is primarily aimed at pharmaceutical physicians, but its Editor-in-Chief, Professor Ronald M of papers, it will also be useful to clinicians. Each issue is devoted to examining a single drug, with the intention of doing an expedient and comprehensive manner. The Editor-in-Chief writes an ‘executive summary’ derived from the review articles on the basis of their extensive clinical experience, but are professionals who are not directly or indirectly associated with the manufacturer in a way that would be considered a conflict of interest. A declaration of ‘conflict of interest’ is required to be signed by each author.

so The definition for a systematic review was given in an article in the journal in January 2004:1

‘A critical synthesis of research evidence, which involves analysis of all available and relevant evidence in a systematic, objective and robust manner.’ However, this article is not so much a systematic review as a monograph, the definition of which is ‘a scholarly book, article or pamphlet on a specific and usually narrow subject’. In many ways it demonstrates the reasons why having specified guidelines is a good idea.

What is the research question?

This is not stated explicitly. It could be to answer the question: ‘Is this contraceptive method acceptable, effective and safe?’ If so, then to a large degree the question is answered, but the answers need to be extracted from a large mass of data. The question might be ‘What is known so far about this method of contraception?’; then again most of the answers are there, but see the Caveats highlighted below.

Why was the review needed?

The last review of Implanon that I could find was in 1999, so another is due. This paper is cited twice in this journal (references 29 and 56). The average total cost was US$2817 in the LNG-IUS group and US$4460 in the hysterectomy group, a difference of 40% less. When hysterectomy costs are placed at 20% or placed higher than USA costs, the LNG-IUS costs were still considerably less.

References

3 French R, et al. Placing devices (subdermal implants and hormonally impregnated systems) versus other forms of reversible contraceptives as effective methods of preventing pregnancy’, so a systematic review will be available in due course.

This study is from all five university hospitals of Finland. In some countries the levonorgestrel-releasing intrauterine system (LNG-IUS) is licensed and/or being used to treat menorrhagia. The commonest indication for hysterectomy is menorrhagia, so it is important to consider whether possible alternatives to surgery are effective and cost-effective in the early premenopausal period. The LNG-IUS is because there has never been a systematic review (of several randomized trials of the LNG-IUS versus placebo, of which course can never occur.


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