Standard Operating Procedure for the Insertion of an Intrauterine Device by Nurses
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1. **AIM**

This Standard Operating Procedure (SOP) represents current, recommended good practice and will ensure the proper action to take in the clinical assessment, counselling, pre-insertion procedures and insertion procedures for the insertion of Intrauterine contraception (copper-bearing (IUD) and the Levonorgestrel-releasing intrauterine system (LNG-IUS - Mirena®))

2. **SCOPE**

This SOP is intended for Nurses who hold a recognised qualification in the practice of Sexual and Reproductive Health and have an essential role in the provision of Long Acting Reversible Contraception (i.e. IUD or IUS (Mirena®)).

All nurses need to undertake the training as stated by the Faculty of Sexual and Reproductive Healthcare – Intrauterine

The nurses have signed the Patient Group Direction (PGD) for the supply and administration of emergency medication by Contraception and Sexual Health (CaSH) Nurses and agree to adhere to it.

Audit of the insertion of devices will be carried out annually.

Nurses are accountable for their own practice.

Training needs and competences will be discussed with the Advanced Practitioner /Nurse Consultant and will be on-going.

3. **LINKS TO OVERARCHING POLICY and/or PROCEDURE**

- Policy for Consent to Examination or Treatment
- Chaperoning Policy
- Provision of access to, and use of Interpreters for patients/service users
- Community Contraception and Sexual Health Service (CaSH) Policy Handbook

4. **PROCEDURE**

4.1 **Confidentiality**

- The service will abide by the confidentiality agreement.
- All clients under 16 years of age will be assessed for Fraser competency.
- Information will be passed on to other parties only with the permission of the young person. However, instances when confidentiality cannot be maintained, the young person will be informed of this for their own protection.
4.2 Informed consent

Informed consent should be given by women prior to insertion or removal of Intrauterine Devices (IUD) and documented in the case notes.

4.3 Chaperone

A chaperone should be offered to all women undergoing the procedure of either an insertion or removal of an Intrauterine device. The outcome should be recorded within the clinical records.

4.4 General Details:

A clinical history (including sexual history) should be taken before providing intrauterine conception.

- The healthcare professional should be aware of the contra-indications to any Intrauterine contraception.
- A sexual history should identify women at risk of sexually transmitted infections. A routine screening of all women is offered for Chlamydia and Gonorrhoea.
- Women should be informed how the copper intrauterine device (Cu-IUD) and the Mirena (LNG-IUS) works.
- Women should be advised of low failure rates for intrauterine contraception.
- The duration of use, of the type of device should be discussed with the woman.
- Women should be informed that uterine perforation associated with intrauterine contraception is up to 2 per 1000 insertions.
- The risk of expulsion with intrauterine contraception is around 1 in 20 and is most common in the first year of use.
- Women should be informed that the overall risk of ectopic pregnancy is reduced with use of intrauterine conception when compared to using no contraception.
- Women may be advised that there is no delay in return to fertility after removal of intrauterine contraception.
- Women should be advised there may be an increased risk of pelvic infection in the 20 days following insertion of intrauterine contraception but the risk is the same as the non-IUD-using population thereafter.
- Women should be informed that spotting, light bleeding, heavier or prolonged bleeding is common in the first 3-6 months of Cu-IUD use.
- Women should be informed that irregular bleeding and spotting is common in the first 6 months after insertion of the LNG-IUS but by 1 year amenorrhoea or light bleeding is usual.
- Women considering the LNG-IUS can be informed that systemic absorption of progestogen occurs, however rates of discontinuation due to side-effects (such as acne and headaches) are not significantly different from Cu-IUD users.
- Women may be informed that although ovarian cysts may occur when
using the LNG-IUS they are rarely a clinical problem.

- The LNG-IUS can be used in the management of menorrhagia and/or to provide endometrial protection in conjunction with oestrogen therapy.
- Discomfort during and/or after intrauterine contraception insertion should be discussed with women during counselling.
- Health care professional should enable women to choose an intrauterine method based on medical eligibility and the woman’s preference.
- If women choose a Cu-IUD, the T380 is recommended as it is the cost effective and has the longest duration of use.

4.5 When can intrauterine contraception be safely inserted?

The LNG-IUS can be inserted at any time in the menstrual cycle, if it is reasonably certain the woman is not pregnant and the clinician is reasonably certain there has been no risk of conception. Condoms should be advised for 7 days after inserting the LNG-IUS unless inserted in the first 7 days of the menstrual cycle.

Post-partum – Intrauterine contraception can be inserted from 4 weeks
Following abortion – Ideally insert at the time of a first or second trimester surgical abortion for immediate contraceptive effect. Following medical or surgical abortion ideally insert within the first 48 hours or delay until 4 weeks postpartum.

Switching from another method of contraception – Can be inserted at any time if the other method has been used consistently and correctly. The Cu-IUD is effective immediately. Condoms may be needed for 7 days after inserting the LNG-IUS.

4.6 Pain relief

The need for pain relief during insertion of intrauterine contraception should be discussed with the woman in advance and administered when appropriate

4.7 Emergency management for problems at intrauterine device insertion

Emergency equipment must be available in all settings where intrauterine contraception is being inserted and local referral protocols must be in place for women who require further medical input. (See Appendix A)

4.8 Insertion Technique

- An appropriately trained assistant should be present during insertion procedure
- A bimanual pelvic examination should be performed on all women before inserting intrauterine contraception
- Cleansing the ectocervix prior to insertion of intrauterine contraception has no proven benefit
- A "no-touch" technique should be used when sounding the uterine cavity and inserting intrauterine contraception. Sterile gloves are not required if
this technique is used but non-sterile gloves must be worn.
- During insertion of intrauterine contraception, clinicians should stabilise the cervix with forceps and assess the length of the uterine cavity to facilitate fundal placement and reduce the risk of perforation
- The manufacturer’s instructions should be followed depending on the device inserted.
- Documentation should be made in the case notes to record appropriate pre and post-insertion counselling, the insertion procedure and the type of device inserted.
- All medical equipment should be disposed of correctly. If re-useable equipment, then it should be placed within the correct bag and return to the sterilizing unit at Doncaster Hospital for re-sterilization. If disposable equipment, it should be placed within the correct sharp container.
- All blood stained equipment should be placed within the correct waste disposal bin. All paper equipment should be placed within the black disposal bin.
- Women should be given information (oral and written) about the device inserted and the expected duration of use.
- Women should be offered instruction on how to check for the intrauterine contraceptive and its threads and advised that if they are unable to feel them it may be that the device has been expelled.
- Women should be advised to seek medical assistance at any time if they develop symptoms of pelvic infection, pain, persistent menstrual abnormalities, missed period, non-palpable threads or can feel the stem of the intrauterine device.
- A routine follow-up visit should be advised after the first menses following insertion of intrauterine contraception or 3-6 weeks later.

4.9 Managing problems associated with intrauterine contraception

Suspected perforation at the time of insertion – the procedure should be stopped and vital signs (BP and pulse) and level of discomfort monitored until stable. An ultrasound scan and/or plain abdominal x-ray to locate the device if it has been left *in situ* should be arranged as soon as possible

“Lost threads” – Advise women to use another method of contraception until confirmation that device is in situ. If no threads are seen, an ultrasound scan should be arranged to locate the device. If an ultrasound scan cannot locate device and there is no definite evidence of expulsion, a plain abdominal x-ray should be arranged to identify an extra uterine device.

Abnormal bleeding - pregnancy, gynaecological pathology and infections should be excluded if abnormal bleeding persists beyond the first 6 months following insertion.

Pregnancy - Ectopic pregnancy must be excluded. Women who become pregnant with an intrauterine device in situ should be informed of the increased risks of 2\(^{nd}\) trimester miscarriage, preterm delivery and infection if the device is left in situ. Removal of the device is also associated with a small risk of miscarriage. The device should be removed, if the threads are easily
seen, up to 12 weeks gestation. The device should be sought at delivery / Termination of Pregnancy (TOP) if it wasn't expelled prior to pregnancy. A plain abdominal x-ray should be arranged to determine if the intrauterine method is extra uterine.

Suspected pelvic infection - If women have signs and symptoms suggestive of pelvic infection, appropriate antibiotics should be started. There is no need to remove the device unless symptoms fail to resolve within 72 hours or unless the woman wishes removal. All women with confirmed or suspected Pelvic Inflammatory Disease (PID) should be followed up to ensure: resolution of symptoms and signs, their partner has also been treated, completion of the course of antibiotics, Sexually Transmitted Infection (STI) assessment and counselling regarding safer sex.

Presence of actinomyces-like organisms (ALO) - Intrauterine contraceptive users with ALO detected on a swab who have no symptoms should be advised there is no reason to remove the device unless signs or symptoms of infection occur. There is no indication for follow-up screening. If symptoms of pelvic pain occur, women should be advised to seek medical advice.

4.10 Timing the removal of intrauterine contraception

- For a planned pregnancy - Remove at any time in the menstrual cycle
- When removal and replacement is at the end of the licensed duration of use - remove at any time in the menstrual cycle. Avoid sexual intercourse for at least 7 days before the procedure.

4.11 Removal of Intrauterine device:

- Gloves should be worn for this procedure.
- A speculum should be inserted so that the cervix and threads of the device can be visualised.
- The threads should be held tightly using either artery forceps or sponge holders.
- The device should then be removed by pulling on the threads.
- Some post removal bleeding may occur and the client should be informed.
- Removal of the device should be documented within the clinical records.
- All blood stained equipment should be disposed within the correct clinical waste disposal bin.
- All paper equipment should be disposed within the black waste bin.

5. APPENDICES

Appendix A - Adverse Reaction Protocol for Insertion of Intrauterine Devices.
Appendix A

Adverse Reaction Protocol for Insertion of Intrauterine Devices

Baseline observations taken Intrauterine device insertion
Pulse and BP monitored throughout procedure

Adverse features:
Pulse rate <40 per min (or 20% drop if pulse rate normally 40 or less)
BP - 90 systolic (or 20% drop if systolic 90 or less normally)
Oxygen sat level - < 90%SP02
Chest pain
Respiratory distress
Shock

Remove Intrauterine Device –
Pulse rate increases to normal level of client

YES              Dial 999
Monitor client until ambulance arrives

No

Dial 999
Give oxygen therapy
Give IM atropine 600mcg in 1ml IM
Pulse rate increases to pre insertion level + oxygen stat normal within 10 mins

YES
Monitor client until ambulance arrives

NO
Repeat Atropine injection 600mcg in 1ml IM
Monitor client until ambulance arrives
Commence CPR if necessary
**Insertion of an Intrauterine Device by Nurses SOP**

Area: .................................................................

Please insert the names of all applicable staff

I have signed to say that I have read the procedure and understand its implications.

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