This Patient Group Direction (PGD) must only be used by registered healthcare professionals who have been named and authorised by their organisation to practice under it. The most recent and in date final signed version of the PGD should be used.

PATIENT GROUP DIRECTION (PGD)

Administration of intramuscular (IM) medroxyprogesterone acetate (DMPA) injection

BrisDoc Healthcare Services

Version Number 2.1

Change History	
Version and Date	**Change details**
Version 1.0 August 2020	New template
Version 1.1 November 2020	Minor rewording and highlighting of contents caution section relating to individuals for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan. Acute porphyria and hypertension with vascular disease added as exclusion criteria.
Version 2.0 April 2023	Updated template (no clinical changes to expired V1.1)
Version 2.1 September 2023	Reworded section on cervical and breast cancer risk, in line with updated FSRH guidance. Updated references.

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PGD DEVELOPMENT GROUP

Date PGD template comes into effect:	August 2023
Review date	February 2026
Expiry date:	July 2026

This PGD template has been peer reviewed by the Reproductive Health PGDs Short Life Working Group in accordance with their Terms of Reference. It has been approved by the Faculty for Sexual and Reproductive Health (FSRH) in January 2023.

This section MUST REMAIN when a PGD is adopted by an organisation.

Name	Designation
Dr Cindy Farmer	Vice President General Training FSRH
Michelle Jenkins	Advanced Nurse Practitioner, Clinical Standards Committee FSRH
Vicky Garner	Deputy Chief Midwife British Pregnancy Advisory Service (BPAS)
Gail Rowley	Quality Matron British Pregnancy Advisory Service (BPAS)
Katie Girling	British Pregnancy Advisory Service (BPAS)
Sim Sesane	CASH Nurse Consultant MSI Reproductive Choices
Kate Devonport	National Unplanned Pregnancy Association (NUPAS)
Chetna Parmar	Pharmacist adviser Umbrella
Heather Randle	Royal College of Nursing (RCN)
Carmel Lloyd	Royal College of Midwives (RCM)
Clare Livingstone	Royal College of Midwives (RCM)
Kirsty Armstrong	National Pharmacy Integration Lead, NHS England
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Emma Anderson	Centre for Postgraduate Pharmacy Education (CPPE)
Dr Kathy French	Specialist Nurse
Dr Sarah Pillai	Consultant
Alison Crompton	Community pharmacist
Andrea Smith	Community pharmacist
Lisa Knight	Community Health Services pharmacist
Bola Sotubo	NHS North East London ICB pharmacist
Tracy Rogers	Director, Medicines Use and Safety, Specialist Pharmacy Service
Sandra Wolper	Associate Director Specialist Pharmacy Service
Jo Jenkins (Working Group Co-ordinator)	Lead Pharmacist PGDs and Medicine Mechanisms Specialist Pharmacy Service

ORGANISATIONAL AUTHORISATIONS

Name	Job title and organisation	Signature	Date
Senior doctor	Medical Director		
Senior pharmacist	Lead Pharmacist		31/10/2024
Senior representative of professional group using the PGD	Director of Nursing, Allied Health Professionals and Governance		31/10/2024
Person signing on behalf of authorising body	Medical Director		25/10/2024

1. Characteristics of staff

Qualifications and professional registration	Current contract of employment within a Local Authority /or NHS commissioned service or an NHS Trust/organisation. Registered healthcare professional listed in the legislation as able to practice under Patient Group Directions.
Initial training	The registered healthcare professional authorised to operate under this PGD must have undertaken appropriate education and training and successfully completed the competencies to undertake clinical assessment of patients ensuring safe provision of the medicines listed in accordance with local policy. Recommended requirement for training would be successful completion of a relevant contraception module/course accredited or endorsed by the FSRH, CPPE or a university or as advised in the RCN training directory. Individual has undertaken appropriate training for working under PGDs for the supply and administration of medicines. Recommended training - eLfH PGD elearning programme The healthcare professional has completed locally required training (including updates) in safeguarding children and vulnerable adults or level 2 safeguarding or the equivalent.
Competency assessment	• Individuals operating under this PGD must be assessed as competent (see Appendix A) or complete a self-declaration of competence for contraception administration. • Staff operating under this PGD are encouraged to review their competency using the NICE Competency Framework for health professionals using patient group directions
Ongoing training and competency	• Individuals operating under this PGD are personally responsible for ensuring they remain up to date with the use of all medicines and guidance included in the PGD - if any training needs are identified these should be addressed and further training provided as required. • Organisational PGD and/or medication training as required by employing Trust/organisation.
The decision to administer any medication rests with the individual registered health professional who must abide by the PGD and any associated organisational policies.	

2. Clinical condition or situation to which this PGD applies

Clinical condition or situation to which this PGD applies	Contraception
Criteria for inclusion	• Individual (age from menarche to 50 years) presenting for contraception. • Informed consent given.
Criteria for exclusion	• Informed consent not given. • Individuals under 16 years of age and assessed as not competent using Fraser Guidelines. • Individuals 16 years of age and over and assessed as lacking capacity to consent. • Established pregnancy. Note - risk of pregnancy with a negative pregnancy test is not an absolute exclusion • Known hypersensitivity to the active ingredient or to any constituent of the product - see Summary of Product Characteristics. • Unexplained vaginal bleeding suspicious of a serious medical condition. • Acute porphyria **Cardiovascular Disease** • Current or past history of ischemic heart disease, vascular disease, stroke or transient ischemic attack. • Individuals with multiple risk factors for cardio-vascular disease (such as smoking, diabetes, hypertension, obesity and dyslipidemias) • Hypertension with vascular disease. **Cancers** • Current or past history of breast cancer. • Malignant liver tumour (hepatocellular carcinoma). **Gastro-intestinal conditions** • Severe decompensated cirrhosis. • Benign liver tumour (hepatocellular adenoma).
Cautions including any relevant action to be taken	• If the individual is less than 16 years of age an assessment based on Fraser guidelines must be made and documented. • If the individual is less than 13 years of age the healthcare professional should speak to local safeguarding lead and follow the local safeguarding policy. • Discuss with appropriate medical/independent non-medical prescriber any medical condition or medication of which the healthcare professional is unsure or uncertain. • Individuals aged under 18 years, should not use IM DMPA first

	line for contraception because of its effect on bone mineral density. IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable.
	• Individuals of any age with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of IM DPMA – IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include:
	  ○ Alcohol abuse and/or tobacco use
	  ○ Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids
	  ○ Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia
	  ○ Previous low trauma fracture
	  ○ Family history of osteoporosis
	• **Offer Long Acting Reversible Contraception (LARC) to all individuals in particular those with medical conditions for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan.**
	• **If an individual is known to be taking a medication which is known to be harmful to pregnancy a highly effective form of contraception is recommended. Highly effective methods include the LARC methods: IUD, IUS and implant. If a LARC method is unacceptable/unsuitable and an IM-DPMA is chosen then an additional barrier method of contraception is advised. See FSRH advice.**

Action to be taken if the individual is excluded or declines treatment	• Explain the reasons for exclusion to the individual and document in the consultation record. • Record reason for decline in the consultation record. • Where required refer the individual to a suitable health service provider if appropriate and/or provide them with information about further options.

3. Description of treatment

Name, strength & formulation of drug	Medroxyprogesterone Acetate 150 mg in 1 mL Injection (vial/pre-filled syringe)
Legal category	POM
Route of administration	Intramuscular injection (IM) **Advice for administration:** • Follow manufacturers' guidance for administration • Shake the syringe/vial vigorously before administration. • Deep intramuscular injection into the gluteal (preferred) or deltoid muscle • Ensure that the full contents of the syringe/vial is administered

	• Do not massage the site after the administration of the injection.
Off label use	Best practice advice is given by the FSRH and is used for guidance in this PGD and may vary from the Summary of Product Characteristics (SPC). This PGD specifically includes inclusion criteria and dosage regimens which are outside the market authorisation for the available products but which are included within FSRH guidance: • Can be administered after day 5 of a cycle • Can be administered between 10-14 weeks. Refer to FSRH guidance for administration after 14 weeks. • Administration after five days postpartum if not breast feeding/before six weeks postpartum if breast feeding. FSRH guidance supports the use of IM DMPA any time after childbirth for both breastfeeding and non-breastfeeding individuals. Medicines should be stored according to the conditions detailed in the Storage section below. However, in the event of an inadvertent or unavoidable deviation of these conditions the local pharmacy or Medicines Management team must be consulted. Where medicines have been assessed by pharmacy/Medicines Management in accordance with national or specific product recommendations as appropriate for continued use this would constitute off-label administration under this PGD. The responsibility for the decision to release the affected medicines for use lies with pharmacy/Medicines Management. Where a medicine is recommended off-label consider, as part of the consent process, informing the individual/parent/carer that the medicine is being offered in accordance with national guidance but that this is outside the product licence.
Dose and frequency of administration	• Single IM injection (150mg/1ml) on day 1-5 of the menstrual cycle with no need for additional protection. • IM DMPA can be started at any time after day 5 if it is reasonably certain that the individual is not pregnant. Additional precautions are then required for 7 days after starting and advise to have follow up pregnancy test at 21 days after last UPSI. • When starting or restarting IM DMPA as quick start after levonorgestrel emergency contraception, additional contraception is required for 7 days and follow up pregnancy test at 21 days after last UPSI is required. • In line with FSRH guidance, individuals should delay starting or restarting hormonal contraception for 5 days

	following use of ulipristal acetate for emergency contraception. Avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised for a further 7 days and follow up pregnancy test at 21 days after last UPSI is required. • IM DMPA dose should be repeated 13 weeks after the last injection. • If required a repeat injection can be given up to 14 weeks after the previous dose with no additional contraceptive precautions. • If required on an occasional basis, IM DMPA injection may be repeated as early as 10 weeks after the last injection. • If the interval from the preceding injection is greater than 14 weeks the injection may be administered/supplied - the professional administering the injection should refer to FSRH current guidelines for advice on the need for additional contraception and pregnancy testing. • For guidance on changing from one contraceptive method to another, and when to start after an abortion and postpartum, refer to the Faculty of Sexual and Reproductive Healthcare (FSRH) guidelines.
Duration of treatment	For as long as individual requires IM DMPA and has no contraindications to its use. **Note** - In individuals of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use every 2 years. In particular, in individuals with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of IM DPMA – IM DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include: • Alcohol abuse and/or tobacco use • Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids • Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia • Previous low trauma fracture • Family history of osteoporosis **If no risks are identified then it is safe to continue IM DMPA for longer than 2 years until the age of 50.**
Quantity to be supplied	Single dose is to be administered per episode of care.
Storage	Medicines must be stored securely according to national guidelines.
Drug interactions	The efficacy of IM DMPA is **not** reduced with concurrent use of enzyme-inducing drugs.

	All concomitant medications should be checked for interactions. A detailed list of drug interactions is available in the individual product SPC, which is available from the electronic Medicines Compendium website www.medicines.org.uk the BNF www.bnf.org and FSRH CEU Guidance: Drug Interactions with Hormonal Contraception https://www.fsrh.org/standards-and-guidance/documents/ceu-clinical-guidance-drug-interactions-with-hormonal/ Refer to a prescriber if any concern of a clinically significant drug interaction.
Identification & management of adverse reactions	A detailed list of adverse reactions is available in the SPC, which is available from the electronic Medicines Compendium website: www.medicines.org.uk and BNF www.bnf.org The following possible adverse effects are commonly reported with IM DMPA (but may not reflect all reported adverse effects): • Headache, dizziness • Disturbance of bleeding patterns • Changes in mood • Weight change • Breast tenderness • Loss of libido • Abdominal discomfort or distension, nausea • Alopecia, acne, rash • Genitourinary tract infection • Association with a small loss of bone mineral density which is recovered after discontinuation of the injection • The available evidence suggests a possible association between current or recent use of hormonal contraception (including progestogen-only injectables) and a small increase in risk of breast cancer; absolute risk remains very small. • There is a weak association between cervical cancer and use of DMPA for 5 years or longer. Any increased risk appears to reduce with time after stopping and could be due to confounding factors.
Additional facilities and supplies	• Access to working telephone • Suitable waste disposal facilities • Immediate access to in-date anaphylaxis kit (IM adrenaline 1:1000)
Management of and reporting procedure for adverse reactions	• Healthcare professionals and patients/carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory

	Agency (MHRA) using the Yellow Card reporting scheme on: http://yellowcard.mhra.gov.uk • Record all adverse drug reactions (ADRs) in the patient's medical record. • Report via organisation incident policy.
Written information and further advice to be given to individual	• Provide patient information leaflet (PIL) provided with the original pack. • Explain mode of action, side effects, risks and benefits of the medicine • Offer condoms and advice on safer sex practices and possible need for screening for sexually transmitted infections (STIs) • Ensure the individual has contact details of local service/sexual health services.
Advice / follow up treatment	• The individual should be advised to seek medical advice in the event of an adverse reaction. • Individual to seek further advice if they has any concerns.

Records	**Record:**
	• The consent of the individual and
	  ○ If individual is under 13 years of age record action taken
	  ○ If individual is under 16 years of age document capacity using Fraser guidelines. If not competent record action taken.
	  ○ If individual over 16 years of age and not competent, record action taken
	• The consent of the individual and if individual not competent to consent record action taken
	• Name of individual, address, date of birth
	• GP contact details where appropriate
	• Relevant past and present medical history, including medication and family history.
	• Any known allergies
	• Name of registered health professional
	• Name of medication supplied/administered
	• Date of administration
	• Dose administered and site of administration
	• Batch number and expiry date of administered product in line with local procedures
	• Advice given, including if excluded or declines treatment
	• Individual has been advised on the date/s for next appointment as required.
	• Details of any adverse drug reactions and actions taken
	• Advice given about the medication including side effects, benefits, and when and what to do if any concerns
	• Any referral arrangements made

	• Any administration outside the terms of the product marketing authorisation • Recorded that administration is via Patient Group Direction (PGD) Records should be signed and dated (or a password-controlled e-records) and securely kept for a defined period in line with local policy. All records should be clear, legible and contemporaneous. A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with local policy.

4. Key references

Key references (accessed January 2023 and July 2023)	• Electronic Medicines Compendium http://www.medicines.org.uk/ • Electronic BNF https://bnf.nice.org.uk/ • NICE Medicines practice guideline "Patient Group Directions" https://www.nice.org.uk/guidance/mpg2 • Faculty of Sexual and Reproductive Health Clinical Guidance: Progestogen-only Injectable Contraception (December 2014, amended July 2023) https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-injectables-dec-2014/ • Faculty of Sexual and Reproductive Health Drug Interactions with Hormonal Contraception – May 2022 https://www.fsrh.org/documents/ceu-clinical-guidance-drug-interactions-with-hormonal/ • Faculty of Sexual and Reproductive Healthcare (2016) UK Medical Eligibility Criteria for Contraceptive Use. https://www.fsrh.org/documents/ukmec-2016/ • Faculty of Sexual and Reproductive Healthcare (2016 Clinical Guideline: Quick Starting Contraception (April 2017) https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/quick-starting-contraception/