

Immediate Postpartum LARC

The Role of Nursing

Suzanne McMurtry Baird, DNP, RN
TIPQC Maternal Quality
Improvement Specialist

Thank You



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS



Disclosures

- I have no relevant disclosures associated with this presentation
- All health care providers who perform implant insertions and removals must receive training from the manufacturer. Therefore, the insertion process is deferred to the manufacturer and not covered in this presentation.

Objectives

1. Describe the importance of and identify resources for woman-centered contraceptive counseling
2. Explore operational barriers to IPP LARC provision
3. Discuss the role of nursing in IPP LARC provision and identify resources for support

Definitions

- **Unintended pregnancy:** pregnancy that was either mistimed (occurred earlier than desired) or unwanted (occurred when no children, or no more children were desired).
- **Intended pregnancy:** pregnancy that was desired at the time it occurred or sooner. (Guttenmacher, 2016)
- **Immediate postpartum period:** during the delivery “hospitalization”.
- **Birth spacing:** the time from one child’s birth until the next pregnancy (also known as interpregnancy interval) (March of Dimes)

Case Study

A 25 y/o G6P0101 presents to your OB Triage at 36 weeks by stated EGA in early labor, her contractions subside and she will be discharged home. No prenatal care. Her youngest child is 12 months old. She says this was not an intended pregnancy and would like to do something to avoid having another pregnancy so soon. She did not follow-up with a postpartum visit in her prior pregnancy.

Plan: discharge home

Case Study

A 25 y/o G6P0101 presents to your OB Triage at 36 weeks by stated EGA in early labor, her contractions subside and she will be discharged home. No prenatal care. Her youngest child is 10 months old. She says this was not an intended pregnancy and would like to do something to avoid having another pregnancy so soon. She did not follow-up for a postpartum visit in her prior pregnancy.

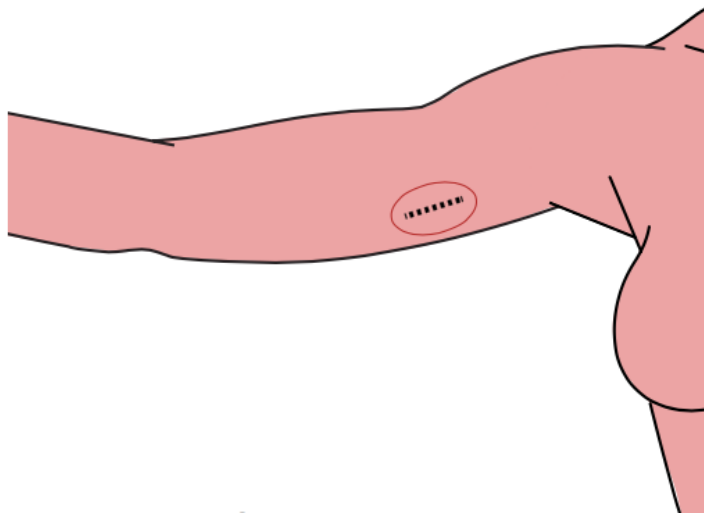
Ideal time for counseling and consent

Plan: discharge home

What is Immediate Postpartum LARC?

When LARC methods are available to women in the hospital after a delivery before discharge

LARC Implant



Nexplanon

- Effective for 3 years
- Approved for women regardless of parity

Potential Side Effects

- Inter-menstrual spotting in the early months.
- Hormone-related: headaches, nausea, breast tenderness, depression, ovarian cyst formation

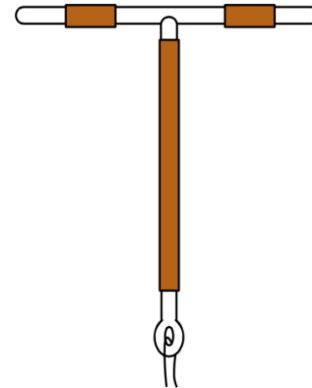
LARC Copper IUD

ParaGard Copper T

- Approved for women regardless of parity
- Can be used as emergency contraception

Potential Side Effects

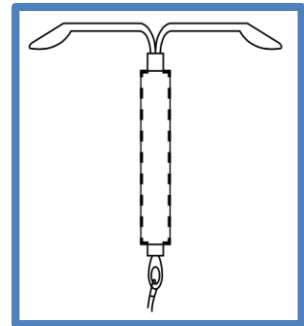
- Abnormal, heavier menstrual bleeding
- Higher frequency or intensity of cramps/discomfort



Hormonal IUDs

- Inter-menstrual spotting in the early months
- Reduces menstrual blood loss significantly
- Hormone related: Headaches, nausea, breast tenderness, depression, ovarian cyst formation – all rare

NOTE: all currently available hormonal IUDs use levonorgestrel (LNG) and have the same side effect profile



Device	Available Since	Years Effective	Use
Mirena	2000	5 years	Approved only in parous women, but available to all women regardless of parity.* Approved for treatment of anemia in women desiring contraception
Skyla	2013	3 years	Approved for women regardless of parity. Smaller “T” and insertor than Mirena and Liletta
Liletta	2015	4 years	Approved for women regardless of parity.
Kyleena	2017	5 years	Approved for women regardless of parity. Smaller “T” and insertor than Mirena or Liletta Less LNG daily dose than Mirena and Liletta

*In 2005, the package label for the ParaGard IUD changed. The new label no longer contains language that suggests the IUD is appropriate only for women with one or more children. However, the Mirena label has not yet undergone a similar change (ACOG, 2011).

ACOG Committee Opinion #670, IPP LARC

- Immediate postpartum LARC can reduce unintended pregnancy & lengthen interpregnancy intervals



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WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 670 • August 2016

Committee on Obstetric Practice

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Immediate Postpartum Long-Acting Reversible Contraception

ABSTRACT: Immediate postpartum long-acting reversible contraception (LARC) has the potential to reduce unintended and short-interval pregnancy. Women should be counseled about all forms of postpartum contraception in a context that allows informed decision making. Immediate postpartum LARC should be offered as an effective option for postpartum contraception; there are few contraindications to postpartum intrauterine devices and implants. Obstetrician-gynecologists and other obstetric care providers should discuss LARC during the antepartum period and counsel all pregnant women about options for immediate postpartum initiation. Education and institutional protocols are needed to raise clinician awareness and to improve access to immediate postpartum LARC insertion. Obstetrician-gynecologists and other obstetric care providers should incorporate immediate postpartum LARC into their practices, counsel women appropriately about advantages and risks, and advocate for institutional and payment policy changes to support provision.

Recommendations

The American College of Obstetricians and Gynecologists (the College) recommends the following strategies for immediate postpartum long-acting reversible contraception (LARC):

- Optimally, women should be counseled prenatally about the option of immediate postpartum LARC. Counseling should include advantages, risks of intrauterine device (IUD) expulsion, contraindications, and alternatives to allow for informed decision making.
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reducing unintended pregnancy and lengthening interpregnancy intervals.

- Obstetrician-gynecologists and other obstetric care providers should include in their contraceptive counseling the increased risk of expulsion, including unrecognized expulsion, with immediate postpartum IUD insertion compared with interval IUD insertion.
- Systems should be in place to ensure that women who desire LARC can receive it during the comprehensive postpartum visit if immediate postpartum placement was not undertaken.
- Obstetrician-gynecologists, other obstetric care providers, and institutions should develop the resources, processes, and infrastructure, including stocking LARC devices in the labor and delivery unit and coding and reimbursement strategies, to support immediate LARC placement after vaginal and cesarean births.

Pregnancy Interval / Birth Spacing

Newborn

- Congenital anomalies
- Preterm birth
- Low birth weight infant
- Small for gestational age
- Fetal, neonatal, infant death

Maternal

- Anemia
- Preterm, premature rupture of membranes
- Preeclampsia
- Maternal death
- Uterine rupture at TOLAC

NOTE: Studies vary re. birth spacing timeline

LARC and Birth Spacing

- Women who used LARC had almost 4 times the odds of achieving an optimal birth interval compared with women who used less contraceptive effective methods
- Associated with longer interpregnancy interval in adolescents compared with less effective methods.

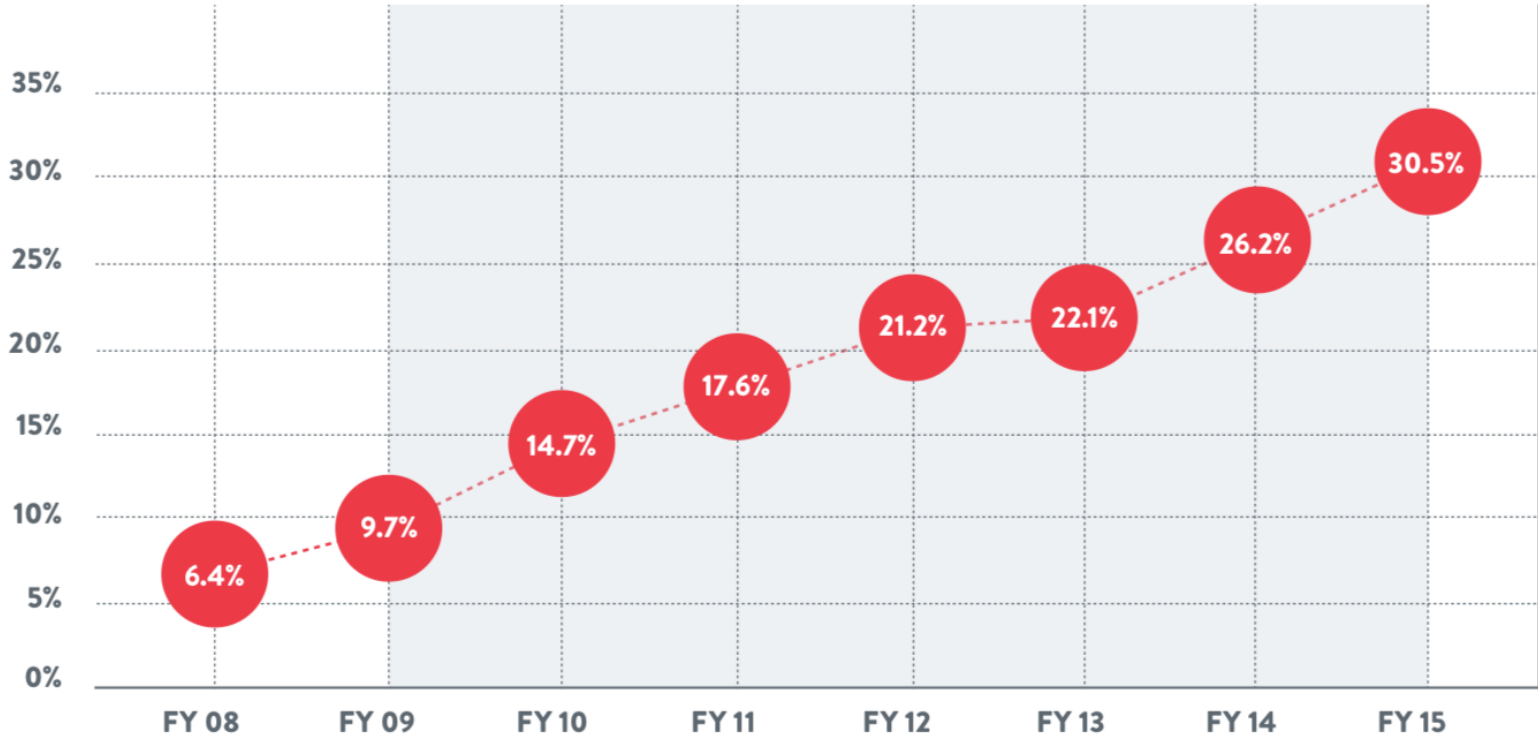
Thiel de Bocanegra H, Chang R, Howell M, et al. Interpregnancy intervals: impact of postpartum contraceptive effectiveness and coverage. *Am J Obstet Gynecol* 2014;210:311.e1-8.
Baldwin M, Edelman A. The effect of long-acting reversible contraception in rapid repeat pregnancy in adolescents: A review. *J Adolesc Health*. 2013;52:S47-S53.

Colorado Data

- Since 2009, the state has provided contraceptive implants or intrauterine devices (IUDs) at low or no cost
- Described as “Seismic impact”
- **Estimated savings for CO of \$70 million** in health-care expenditures associated with teen births.

https://www.colorado.gov/pacific/sites/default/files/PSD_TitleX3_CFPI-Report.pdf

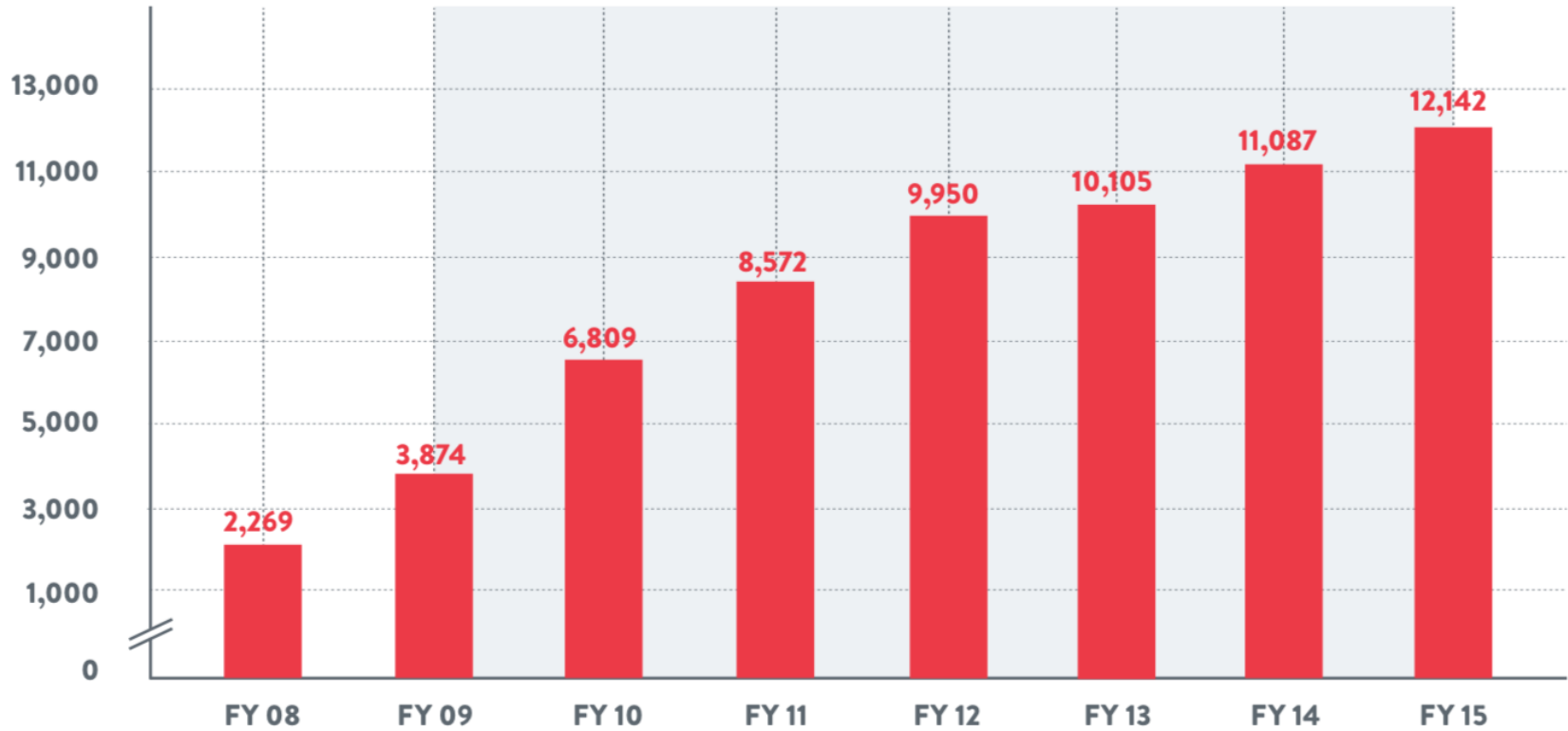
**FIGURE 2:
PERCENT OF TITLE X CLINIC CONTRACEPTORS USING LARC METHODS, COLORADO, FY 2008–FY 2015**



■ *The Colorado Family Planning Initiative began in 2009.*

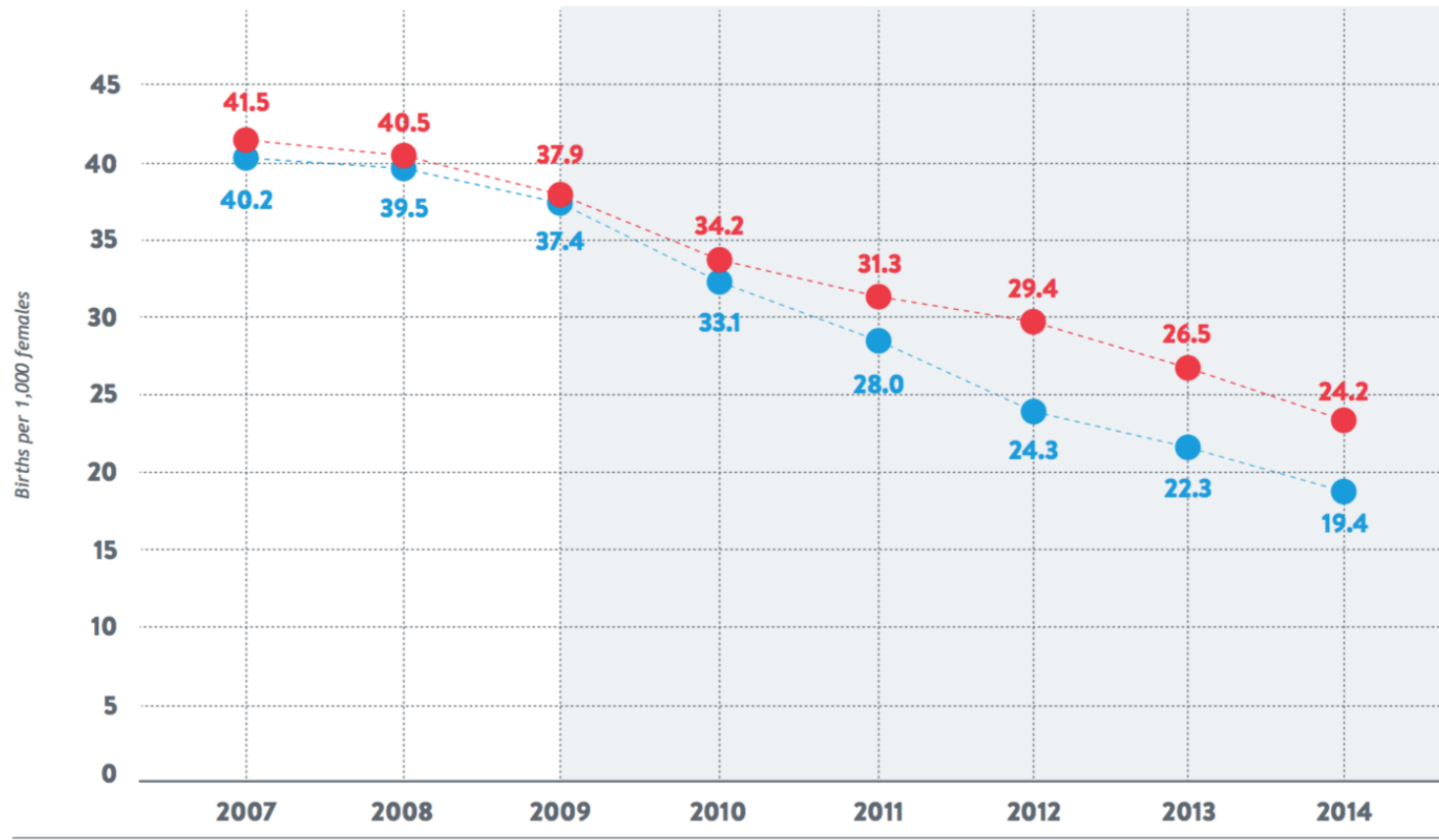


FIGURE 3:
NUMBER OF LARC USERS IN TITLE X CLINICS, COLORADO, FY 2008–FY 2015



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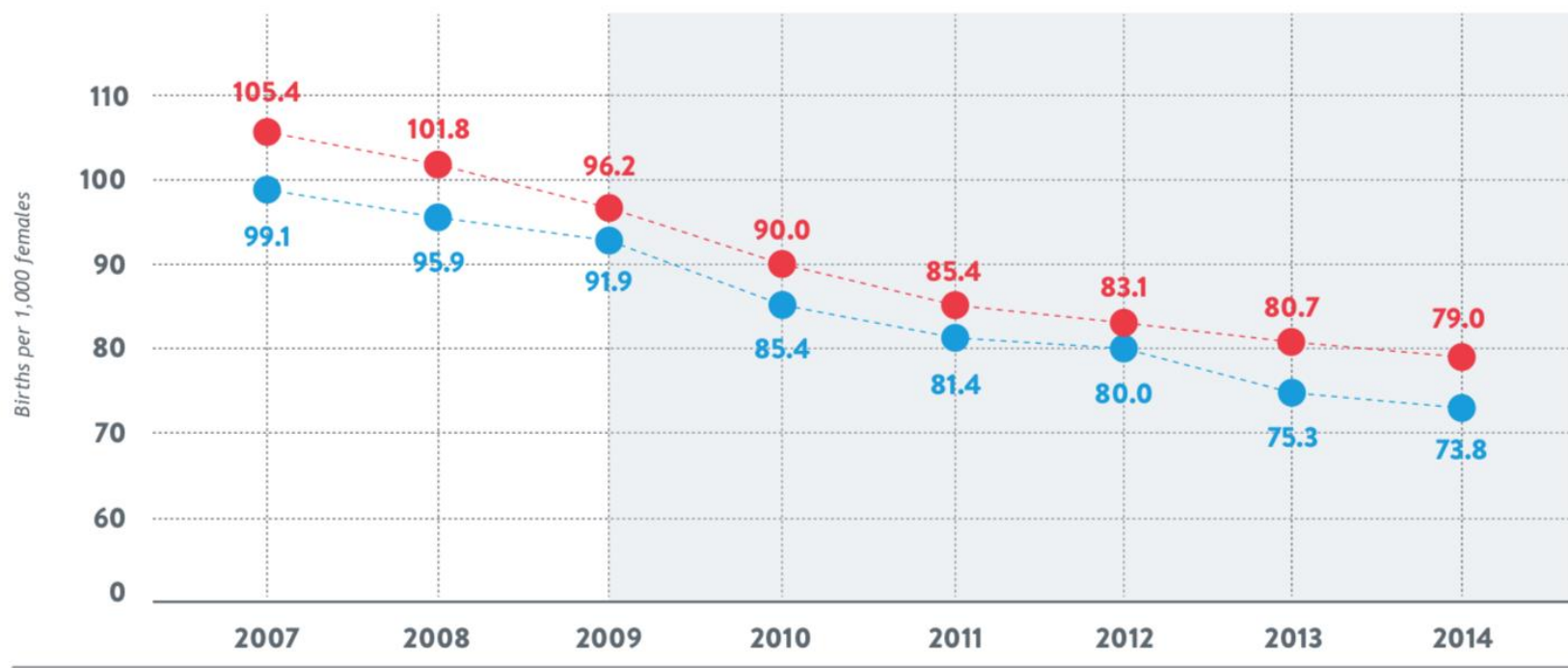
FIGURE 6:
U.S. AND COLORADO FERTILITY RATES, AGES 15–19, 2007–2014



■ The Colorado Family Planning Initiative began in 2009.

● U.S. ● Colorado

FIGURE 9:
U.S. AND COLORADO FERTILITY RATES, AGES 20-24, 2007-2014

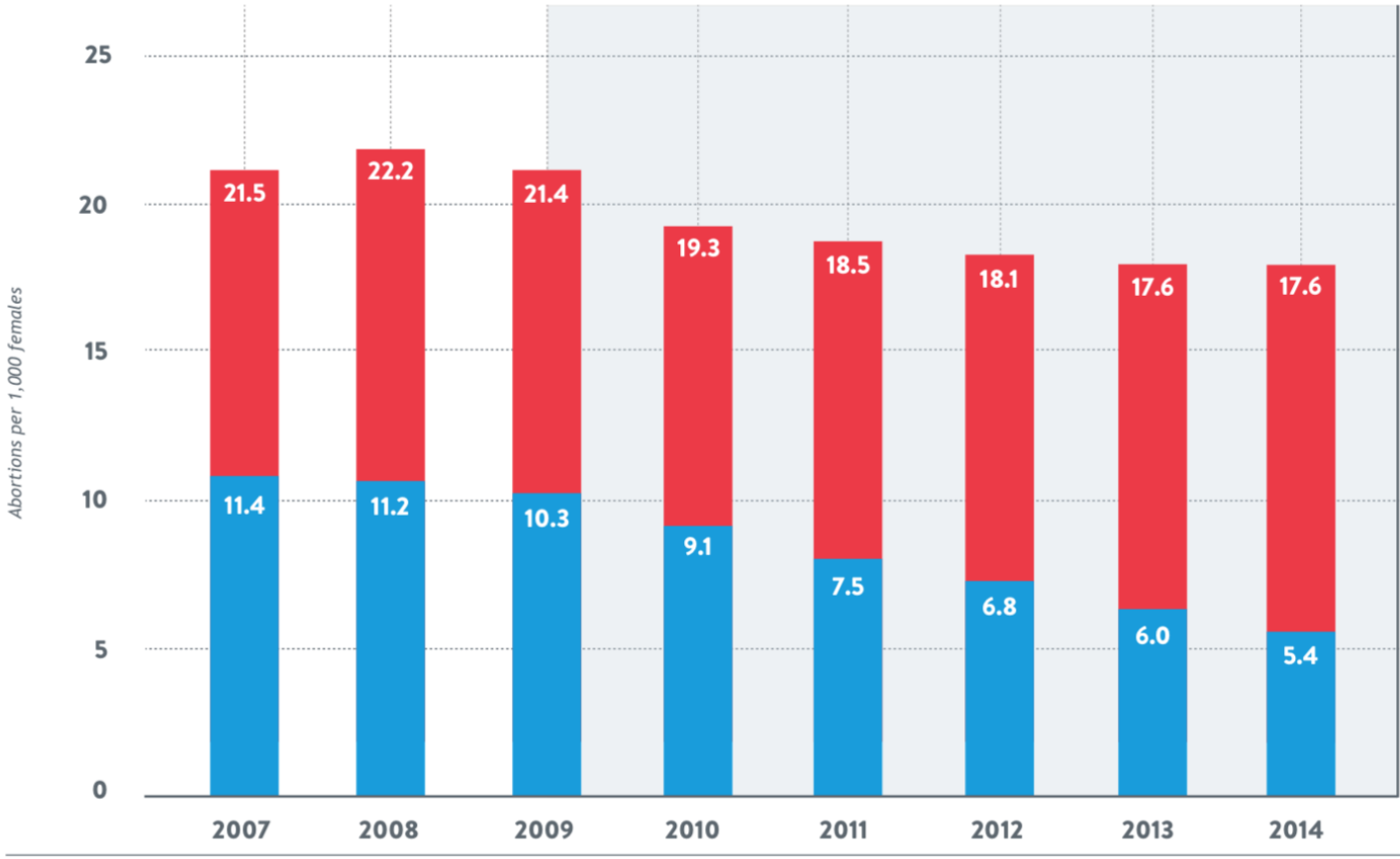


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● U.S.

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FIGURE 10:
ABORTION RATES IN COLORADO, AGES 15-19 AND AGES 20-24, 2007-2014

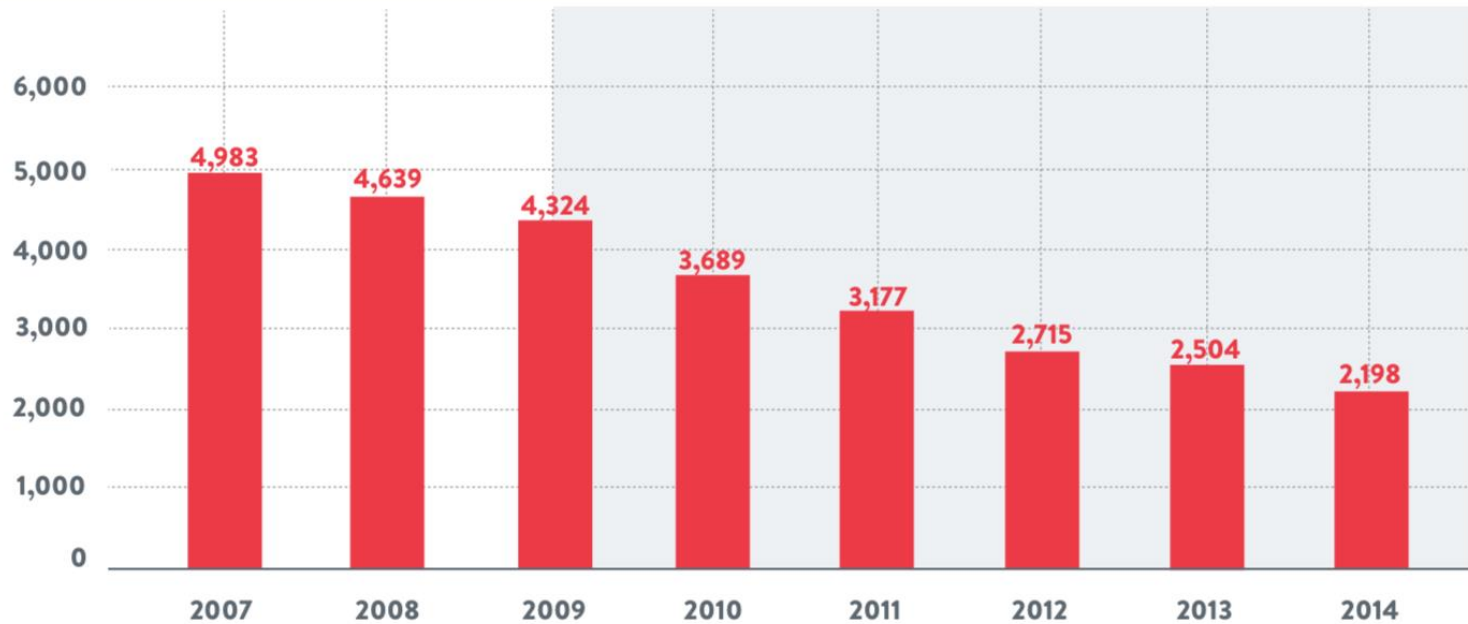


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● Ages 15-19

● Ages 20-24

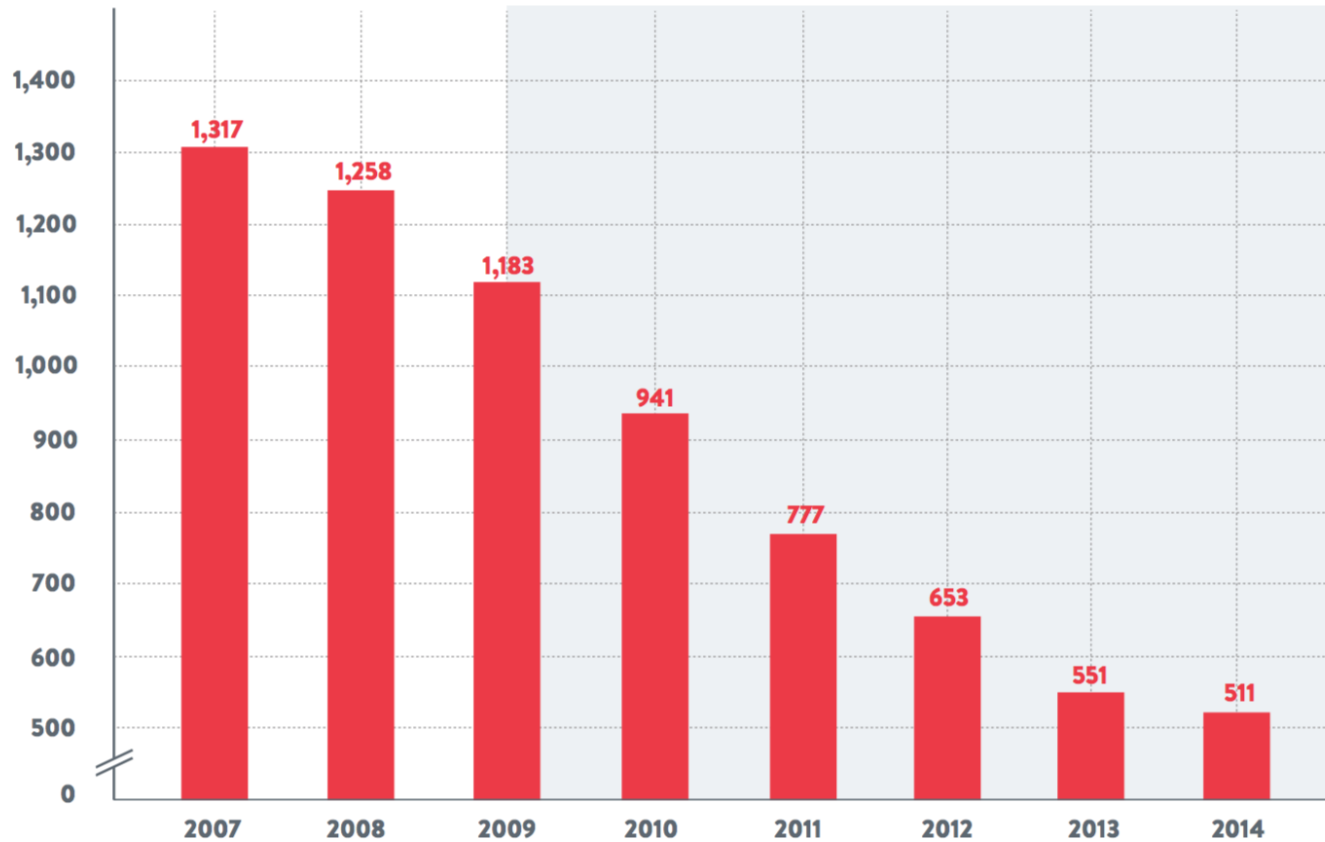
**FIGURE 15:
NUMBER OF HIGH-RISK BIRTHS*, COLORADO, 2007-2014**



■ The Colorado Family Planning Initiative began in 2009.

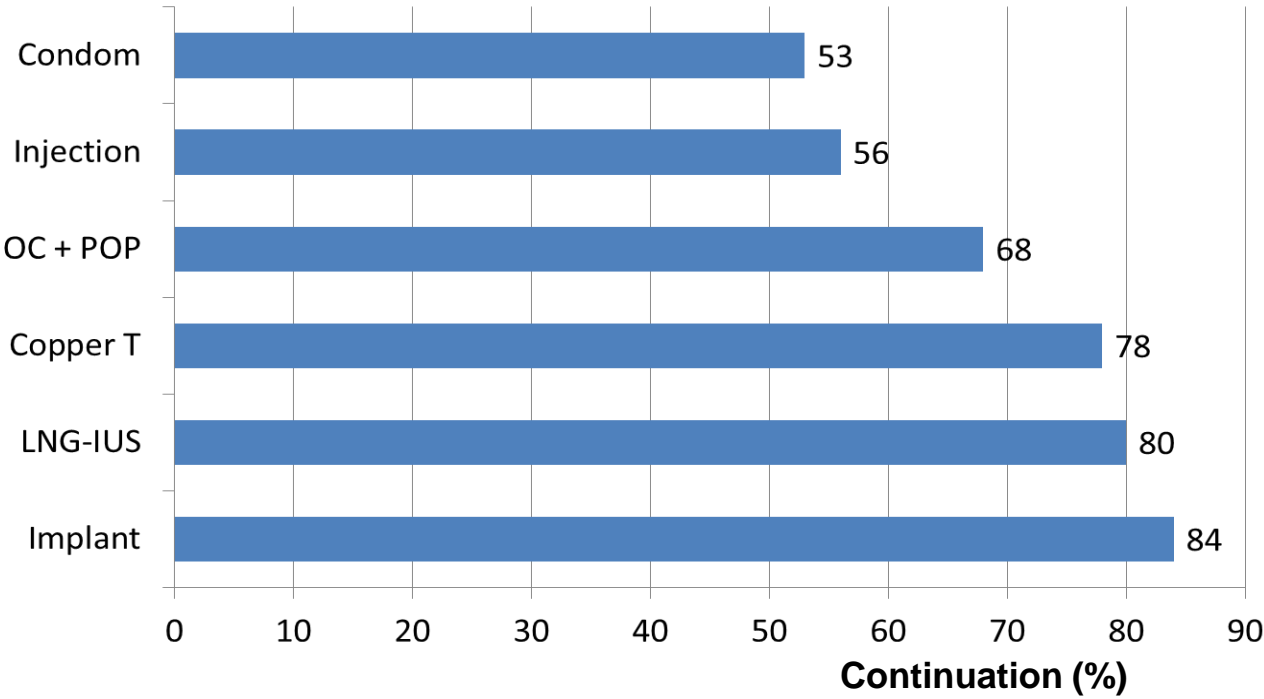
**High risk birth is defined as a mother who is younger than 25, unmarried and does not have at least 12 years of education.*

FIGURE 17:
NUMBER OF SECOND AND HIGHER ORDER BIRTHS, AGES 15-19, COLORADO, 2007-2014



■ The Colorado Family Planning Initiative began in 2009.

LARC Continuation Rates Are the Highest of All Reversible Methods



One year continuation rates

Trussell J in Hatcher R et al. *Contraceptive Technology*. 2007.



ACOG Committee Opinion #670, IPP LARC

- Women's health care providers should support IPP LARC placement after vaginal and cesarean births



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Recommendations

The American College of Obstetricians and Gynecologists (the College) recommends the following strategies for immediate postpartum long-acting reversible contraception (LARC):

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ACOG Committee Opinion #670, IPP LARC

- Women should be counseled prenatally about the option of IPP LARC, including its convenience, effectiveness, and increased IUD expulsion rates



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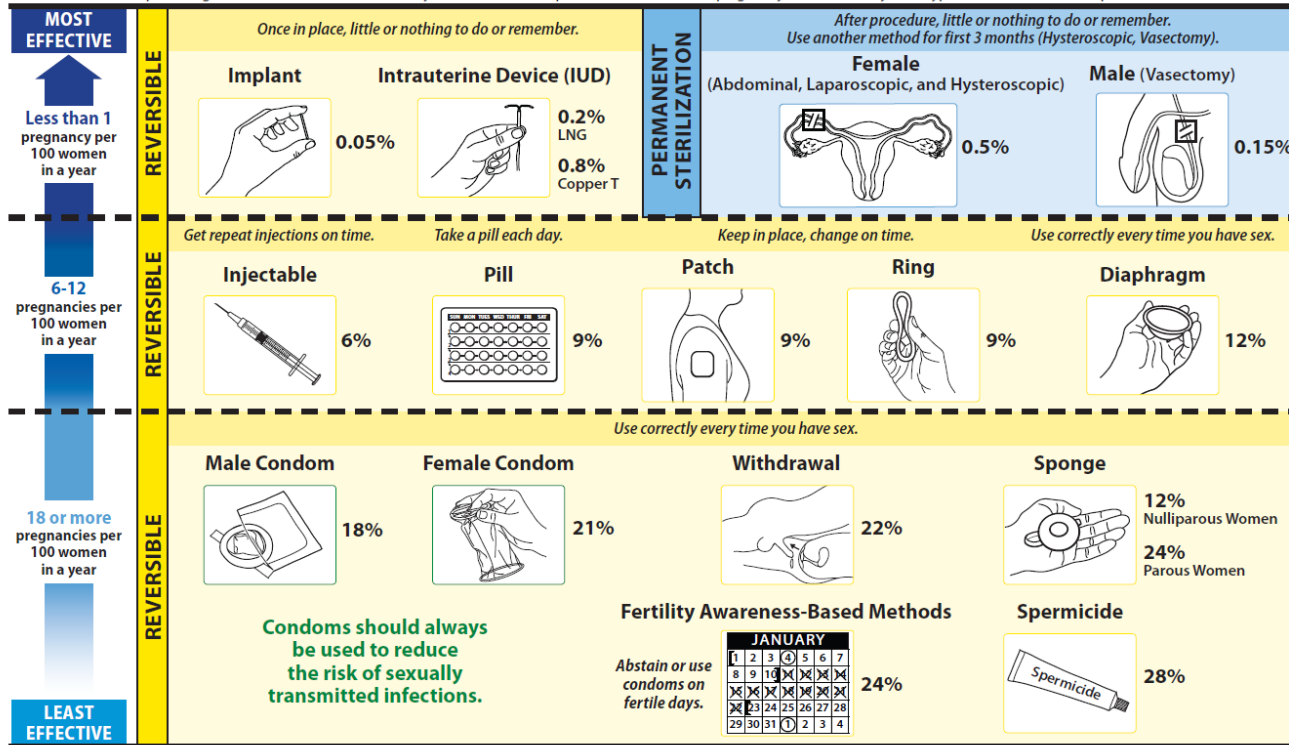
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EFFECTIVENESS OF FAMILY PLANNING METHODS*

*The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.



Other Methods of Contraception: (1) Lactational Amenorrhea Method (LAM); is a highly effective, temporary method of contraception; and (2) Emergency Contraception: emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy. Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. *Contraception* 2011;83:397-404.



HOW WELL DOES BIRTH CONTROL WORK?

Really, really well



Works, hassle-free, for up to...

				
The Implant (Nexplanon)	IUD (Skyla)	IUD (Mirena)	IUD (ParaGard)	Sterilization, for men and women
3 years	3 years	5 years	12 years	Forever

No hormones

What is your chance of getting pregnant?

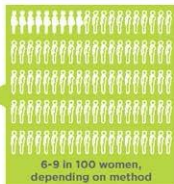


Okay



For it to work best, use it...

			
The Pill	The Patch	The Ring	The Shot (Depo-Provera)
Every. Single. Day.	Every week	Every month	Every 3 months



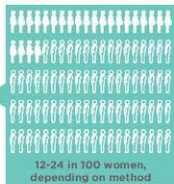
Not so well



For each of these methods to work, you or your partner have to use it every single time you have sex.

			
Withdrawal	Diaphragm	Fertility Awareness	Condoms, for men and women

Needed for STI protection
Use with any other method



FYI, without birth control, over 90 in 100 young women get pregnant in a year.

U. S. Medical Eligibility Criteria Wheel For Contraceptive Use

June 2012

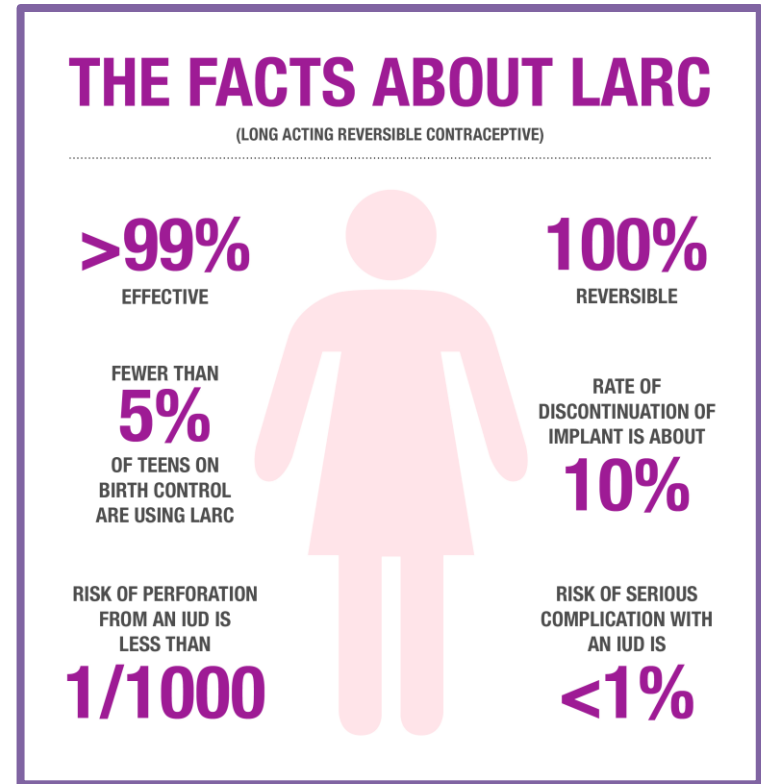
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



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Choice of Contraception

- Patient preference
- Risk/benefit/alternatives



When to Start Using Specific Contraceptive Methods

KEY POINT:
 Provider is reasonably certain woman is not pregnant.

<https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/summary.html>

Contraceptive method	When to start (if the provider is reasonably certain that the woman is not pregnant)	Additional contraception (i.e., back up) needed	Examinations or tests needed before initiation ¹
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection ²
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection ²
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

US MEC (Medical Eligibility Criteria)

1	Can use the method	No restrictions
2	Can use the method	Advantages generally outweigh theoretical or proven risks.
3	Should not use method unless no other method is appropriate	Theoretical or proven risks generally outweigh advantages
4	Should not use method	Unacceptable health risk

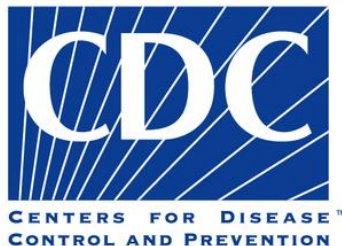
Postpartum Use	LNG IUD	Copper IUD	Implant
Non-breastfeeding, starting <21 days			1
Breastfeeding, <30 days			2
Breastfeeding, >30 days			1
IUD Use, with or without breastfeeding			
<10 minutes after placenta	2	1	
10 minutes to 4 weeks	2	2	
≥ 4 weeks	1	1	
Puerperal Sepsis	4	4	

IPP LARC & Breastfeeding

The implant can be inserted at any time following delivery.

Advantages generally outweigh real or theoretical risks if placed < 1 month post-partum, and there is no restriction if placed > 1 month post-partum

Observational studies of progestin-only contraceptives suggest they have no effect either on a woman's ability to successfully initiate and continue breastfeeding, or an infant's growth and development.



CDC MMWR June 21, 2013



IPP LARC & Breastfeeding

ACOG Practice Bulletin #121, LARC: Implants & IUDs

“Although data is limited, observational studies of progestin-only contraceptives suggest no effect either on the ability to successfully initiate & continue breastfeeding or on an infant's growth and development.”

IPP LARC & Breastfeeding

ACOG Committee Opinion #670, IPP LARC

IPP placement of the levonorgestrel IUD and implant are rated as MEC Category 2 for women who are breastfeeding

There are theoretical concerns that exogenous progesterone could prevent lactogenesis, but observational studies of progestin-only contraceptives suggest no effect on successful initiation and continuation of breastfeeding or on infant growth and development

IPP LARC & Breastfeeding

ACOG Practice Bulletin #121, LARC: Implants & IUDs

- A RTC PP insertion of the etonogestrel contraceptive implant at 1–3 days with standard insertion at 4–8 weeks postpartum
 - The study reported no differences in breastfeeding outcomes between groups, including lactogenesis and the risk of lactation failure

IPP LARC & Breastfeeding

ACOG Practice Bulletin #121, LARC: Implants & IUDs

A prospective nonrandomized comparative study examined breast milk composition using the contraceptive implant v a non-hormonal IUD, initiated at least 28–56 days after childbirth.

- Neither breast milk quantity nor composition differed between the groups
- At 3-year follow-up, there was no difference in neonatal body length, biparietal head circumference, or body weight between the groups

IPP LARC & Breastfeeding

- The Copper IUD lacks hormones, which avoids any theoretical effect on breastfeeding, and is classified as MEC Category 1 (no restriction on use) for women who are breastfeeding

ACOG Committee Opinion #670, IPP LARC

“Given available evidence, women considering immediate postpartum hormonal LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on actual breastfeeding outcomes.”

IPP LARC & Breastfeeding

Patient Counseling

- Review future child-bearing intentions
 - Review safety and high user satisfaction
 - Discuss theoretical risk of LARC methods, but that this has not been observed in clinical practice
 - Review potential rapid return to fertility after delivery
-
- If the woman desires IPP LARC, it's provision should be supported in the hospital setting

NURSING CARE: GETTING PREPARED FOR IPP LARC

Establish Policy/Procedure for IPP LARC

- Interprofessional team
- Outline counseling procedure
- Procedure for teen consent
- Contraindication language
- Pain management options
- Equipment and supply needs
- Timing of placement
- Process if expulsion occurs
- Documentation
- Communication
- Simulation

Informed Consent

- Provider required to obtain informed consent
 - Risks, benefits, alternatives to procedure
- Nursing
 - Determine if consented during prenatal care
 - Witnesses consent
 - Verifies consent
 - Answer questions



Device Availability

- Where will devices be stored?
 - Pharmacy/Medication System
- Who is responsible for getting them to the bedside?
- Who is responsible for restocking?
- Which LARC devices will you stock?

Education

- Providers
 - Determine credentialing requirements
- Nursing
- Lactation Consultants
- Surgical Technicians



Patient Education

- Culturally sensitive materials
- Non-English speaking process/materials
- Interprofessional team review materials
- Coordination between inpatient and outpatient providers
- Have LARC samples available for demonstration

NOTE: There is no current validated patient education tool specific to IPP LARC



Healthy Mom&Baby / Long-term birth control choices

Getting Pregnant & Infertility

Healthy Moms

Women's Health

Long-term birth control choices

By [Susan Peck, MSN, APN](#)



Have you thought about long-term birth control choices? When you think about birth control, do you think about pills or condoms—or getting your “tubes tied?” Hey, it’s 2016! There are many other effective options.

Whether you want to delay or space your pregnancies or you just aren’t ready to do something permanent with your fertility, consider long-acting reversible contraception, or LARC.

Intrauterine devices (IUDs) and implants are LARCs. Most health insurance plans cover LARC

and permanent birth control. In some states, a LARC can be inserted following your baby’s birth before you leave the hospital or birthing center; in most states, providers wait 6 weeks or more after a birth before inserting this contraceptive. LARCs are safe while nursing; your milk won’t be affected.

With so many choices, picking the best one may feel difficult. Learning about each method may help to make your decision easier.

<http://www.health4mom.org/long-term-birth-control-choices/>



Patient Education

- Consider talking points
 - **Effective:** more effective than the pill, patch, or ring
 - Low or no **hormones**
 - **Safe:** safe, easy to remove, and won't effect future fertility
 - **Easy to use:** don't have to remember to do anything for it to work
 - **Reversible:** can be removed anytime; can get pregnant right away after removal
 - **Long lasting:** effective for 3, 5, or 10 years

Coding, Billing, Reimbursement

- Determine appropriate billing codes (See toolkit)
- Test billing codes and processes
- Ensure all IT billing systems are in place
- Track reimbursement
- Determine process for opened, but not used devices and implants
- Provider order sets and billing forms

Anticipate Barriers

Overcoming Goal Setting Barriers of Organization

- Resistance to new policies = **CHANGE**
- Lack of support or champions
- Concern re. costs and reimbursement
- Time constraints or staffing concerns
- Counseling and/or informed consent not provided
- Concern re. interfering with immediate postpartum care needs



Anticipate Barriers



Concern re. potential complications

- Maternal vasovagal reaction
- Pain/discomfort
- Uterine perforation
 - Rate 0.3 – 2.6 per 1000 insertions of hormonal IUDs (Heinemann et al, 2015)
 - Rate 0.3 – 2.2 per 1000 insertions of copper IUDs (Heinemann et al, 2015)

- Concern re. expulsion

	C-Section	Vaginal
Expulsion	11-14%	16-19%
Removal for bleeding/pain	11%	12%

Kapp *Contraception*, 2009

NURSING CARE: ASSISTING WITH LARC INSERTION

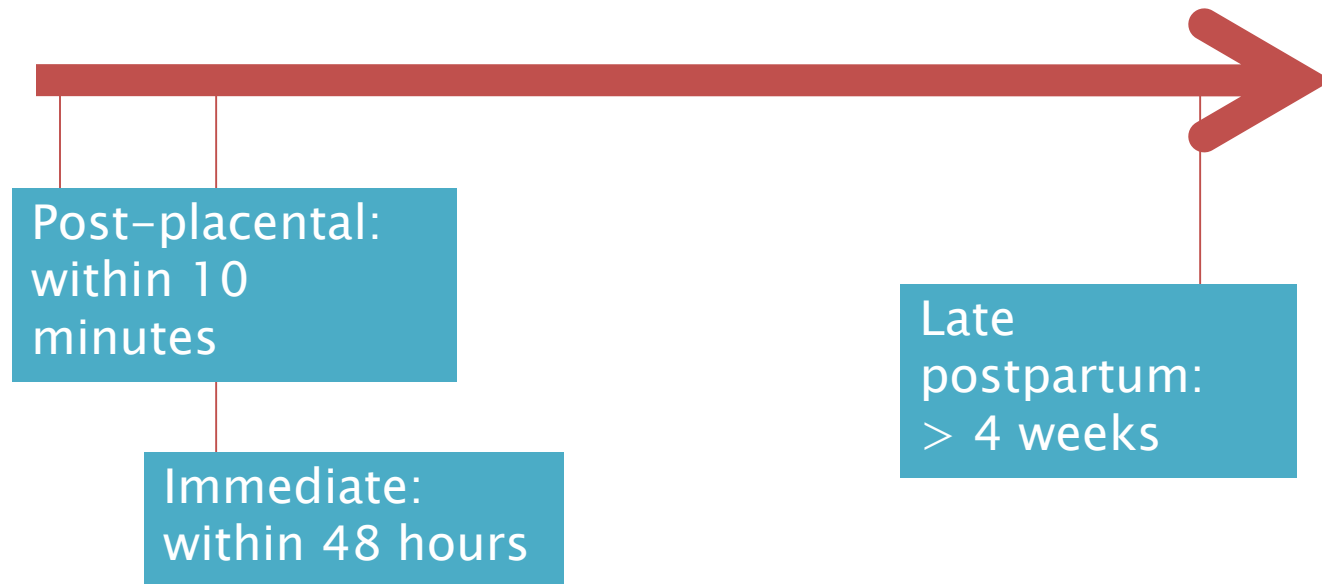
Case Study

The woman is counseled about PP LARC at the triage visit and would like placement IPP copper IUD.

She then comes in 24 hours later at 6 cm and quickly delivers vaginally with no complications. Unfortunately the chart is not consulted in time and there is no IUD available.

30 minutes later the IUD arrives from the pharmacy, should you place the IUD?

Timing of IUD Insertion



Eligibility Criteria

- Healthy women of any reproductive age, desiring highly effective and reversible contraception
- If placing an intrauterine device (IUD), the woman:
 - Has not been ruptured for greater than 18 hours
 - Has no evidence of Triple I or other uterine infections
 - Has normal anatomic uterine cavity (same criteria as when placed unrelated to pregnancy)

Routine Contraindications

- Uterine anomaly or fibroids
 - ○ Dependent on severity of anomaly and/or fibroids
- Active gynecologic malignancy
- Allergy to any component of the IUD
- Severe anemia or Wilson's disease (for copper IUD)
- Breast cancer (for LNG IUS)
- Pelvic tuberculosis

Contraindications for IPP LARC IUD

1. Triple I diagnosis at time of birth, endometritis, and/or puerperal sepsis
2. Uncontrolled postpartum hemorrhage (defined as greater than 1000 mL blood loss for vaginal or cesarean birth with risk of continued bleeding)

Triple I

- **Intrauterine inflammation, infection or both**
- Diagnostic criteria: maternal fever and 1 or more of the following:
 - Fetal tachycardia
 - Maternal WBC greater than 15,000 in the absence of corticosteroids
 - Purulent fluid from the cervical os (cloudy or yellowish thick discharge confirmed visually on speculum examination to be coming from the cervical os)
 - Biochemical or microbiologic amniotic fluid results consistent with microbial invasion of the amniotic cavity.

Higgins, R.D., et al. (2016) Evaluation and management of women and newborns with maternal diagnosis of chorioamnionitis. *Obstetrics & Gynecology*, 127(3), 426-436.

IUD Insertion Following Vaginal Birth

- Management of 3rd and 4th stages of Labor
 - Uterine massage and assessments Q15
 - Administration of oxytocin per protocol
- No additional anesthesia required
 - Considerations if birth w/out anesthesia
- Skin to skin may continue
- Initiation of breastfeeding within 1 hour
- Laceration repair after IUD insertion
- No evidence of need for antibiotic administration



IPP IUD Placement Checklist

Procedure Checklist

- IUD availability
- Consent signed and witnessed
- Instruments available
- Considerations for pain management as indicated
- Confirm no contraindications to placement

IUD Instruments and Supplies

- Ultrasound
- Ring forceps and/or Kelly clamp
- Scissors
- Speculum
- Radiopaque surgical sponge(s)
- Light source

IUD Insertion at Time of Cesarean Birth

- Placement prior to uterine closure
- Change gloves
- IUD manually inserted to the fundus and carefully release
 - Can also use inserter or ring
 - No need to suture
- IUD strings placed at the internal cervical os
 - Trim LNG IUD strings
 - Some describe pushing strings through the cervix with a ring forceps

Postpartum Implant Procedure

Procedure Checklist

- Implant availability
- Consent signed and witnessed
- Instruments available

Instrument Checklist

- Instrument Checklist
 - 1% lidocaine, 3-5 mL
 - Betadine
 - Band-aid or steri-strips
 - Kerlex

Documentation

- Provider and nurse document procedure
- Lot # and expiration date
- If implant, right or left arm
- Any complications
- Patient tolerance of procedure

Potential Barriers

- Woman
 - Doesn't want a LARC and/or isn't sure = don't pressure, just give information
 - Wants more information = where will you get it from?
- Provider
 - Doesn't want to place the device = advocate for the woman if she wants IPP LARC
 - Is someone else available and trained?
- Device and supplies not available
 - Plan
 - Restocking device plan

NURSING CARE: POST-INSERTION

Postpartum Care

MATERNAL AND CHILD HEALTH NURSING

NURSING MNEMONICS & TIPS

POST-PARTUM ASSESSMENT

"BUBBLE HE"

- B** BREAST
- U** UTERUS
- B** BOWEL
- B** BLADDER
- L** LOCHIA
- E** EPISIOTOMY
- H** HOMAN'S SIGN
- E** EMOTIONAL STATUS

LEARN MORE: [POST-PARTUM ASSESSMENT](#)

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Nurses need to be aware of the normal physiologic and psychological changes that take place in women's bodies and minds in order to provide comprehensive care during this period. The postpartum period covers the time period from birth until approximately six weeks after delivery. So it is important to remember the mnemonic BUBBLE-HE to denote the components of the postpartum maternal nursing assessment.

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SEE ALL MNEMONICS AND TIPS AT:
<http://nurseslabs.com/mnemonics>

- Routine postpartum care
- Mild cramping normal
- Assessment for expulsion

Postpartum IUD Instructions

- Postpartum visit within 2 weeks (offer, but not necessary)
 - Strings will lengthen with uterine involution and may need to be trimmed
 - Instruct not to mess with strings
- If woman experiences unusual bleeding accompanied by cramping different from afterbirth pains, see provider for possible partial expulsion
 - Inspect pads for expulsion

Postpartum IUD Instructions

- Instruct woman to remind her provider that an IUD was placed postpartum and to notify a provider if she has:
 - Fevers, chills, severe abdominal pain, or temperature > 100.4°F
 - Heavy bleeding
 - Expulsion of the device

Postpartum Implant Instructions

- Bruising and soreness around the insertion site is normal and should resolve within 1-2 weeks after placement
- Notify provider:
 - Redness, swelling or drainage near the implant site
 - Cannot feel the implant under their skin
- A woman should always remind their provider that they had an implant placed postpartum

NURSING: Take Home Points

- Program cannot be successful without your help! Offering IPP LARC requires a team approach
- Nursing is crucial in helping women understand benefits and risk of IPP LARC
- You are at their bedside frequently – women trust you and listen to what you say

NURSING: Take Home Points

- Women should be counseled prenatally about all postpartum contraceptive options, including IPP LARC
 - Present choices
 - Should include benefits and limitations of IPP LARC

NURSING: Take Home Points

- IPP LARC should be offered as a safe and effective option for postpartum contraception
- LARC methods have few contraindications, and almost all women are eligible

NURSING: Take Home Points

- Despite higher expulsion rates, evidence from clinical trials and from cost-benefit analyses strongly suggest the superiority of immediate placement in reduction of unintended pregnancy
- Women considering IPP LARC should be counseled about the theoretical risk of reduced duration of breastfeeding, but that preponderance of the evidence has not shown a negative effect on breastfeeding outcomes

Additional Resources

- The LARC Program at the American College of Obstetricians and Gynecologists
 - www.acog.org/larc
 - www.pcainitiative.org
- CDC
- <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6504.pdf>