**[insert hospital name here]**

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| **Guideline for Immediate Postpartum IUD & Implant Placement** |
| **Policy #:** | [insert policy # designated] |
| **Issued:** | [insert date issued] |
| **Reviewed/Revised:** | [insert reviewing committee] |
| **Section:** | [insert section of hospital. Ex: Maternal Child Health] |

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| **Purpose:** |
| This policy is designed to provide specific guidelines for the safe provision of postpartum Long-Acting Reversible Contraceptive (LARC) devices, including intrauterine devices (IUDs) and contraceptive implants. |

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| **Guideline Statement:** |
| 1. Prenatal care practitioners should counsel all pregnant patients prior to delivery hospitalization on all contraceptive options for which the patient is eligible. Counseling should include risks and benefits of all options discussed. While the patient is in labor, such counseling should not occur to avoid coercion.
2. An IUD or contraceptive implant order and consent form will be completed prior to delivery, either prior to admission or during the delivery admission.
3. A time out will be performed following the [Universal Protocol (TimeOut)](https://bostonmedicalcenter.policytech.com/docview/?docid=1441) both IUD and contraceptive implant placement.
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| **Application:** |
| Insertion of IUDs and contraceptive implants performed inpatient following vaginal or cesarean delivery. |

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| **Exceptions:** |
| Contraindications to immediate postpartum (IPP) IUD placement include:* Chorioamniotis (defined as antibiotics given for fever/other symptoms in labor or post-delivery for suspected uterine infection)
* Hemorrhage at the time of delivery
	+ A patient may experience a hemorrhage precluding IUD placement within 10 minutes of placental delivery. If the hemorrhage resolves, and there is no further concern about bleeding, they may then receive a delayed postpartum IUD during hospitalization.
* Routine contraindications to IUD placement
	+ Untreated infection with gonorrhea or chlamydia or no test of cure
	+ Uterine malformation
	+ Fibroids causing distortion of the uterus
	+ Severe anemia (for the copper IUD)
	+ Wilson’s disease (for the copper IUD)
	+ Breast cancer (for the levonorgestrel IUDs)
	+ Systemic lupus with positive or unknown antibodies (for the levonorgestrel IUDs)
	+ Cervical cancer
	+ Pelvic tuberculosis
	+ AIDS and clinically unwell on ARVs (due to risk of pelvic infections)
	+ Malignant or benign trophoblastic disease
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| **Equipment** |
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| **Instruments/Equipment for IUD placement** | **Quantity** |
| Sponge forceps (one should be Kelly/ovum/placental forceps) | 2 |
| Sims speculum or a bivalve speculum | 1 |
| Sterile scissors | 1 |
| Bowl or cup and Betadine | 1 |
| Gauze pads | 1 box |
| IUD, in its sterile package and placed near the sterile tray | 1 |
| Sterile gloves | 1 pair |
| Ultrasound |  |

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| **Instruments/Equipment for Implant/Nexplanon placement**  | **Quantity** |
| Marking pen | 1 |
| Alcohol swabs | 1 |
| Betadine swabs | 3 |
| Nexplanon device/inserter | 1 |
| 4X4 gauze | 1 |
| Band-aid & 2X2 gauze | 1 each |
| Conforming stretch gauze bandage & tape | 1 |

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| **Procedure:** |
| **LABOR AND DELIVERY PROCEDURES**1. Upon patient admission to L&D, practitioners should check the problem list/supervision of pregnancy notes for contraception plan. Verify that the patient wants an immediate postpartum device if eligible, and document this contraceptive plan in the admission note. Order the LARC device at the time of the admission orders (under Medication).
2. The RN will confirm the order for an in-hospital LARC device. For IUDs, the device should be retrieved from the L&D Pyxis, a patient sticker affixed to the box, and the device kept at the patient bedside. For implants, the device should be retrieved when the patient is postpartum from the partpartum Pyxis.
3. If the patient has not been previously counseled about the option of IPP LARC, they should not be counseled while they are in labor, to avoid the possibility of coercion. The practitioner team may consider LARC counseling on postpartum day 1.

**CONTRACEPTIVE IMPLANT INSERTION PROCEDURES**The technique for implant placement in the immediate postpartum period does not differ from that for interval insertion. The implant can be placed at any time during the patient’s inpatient postpartum stay using standard insertion techniques. **IUD INSERTION PROCEDURES**Immediate postpartum IUD placement differs from interval insertion technique. Best practice for immediate postpartum IUD insertion is to insert the IUD into the uterus while the patient is in the delivery room, within 10 minutes of placental delivery in vaginal and cesarean births. However, the IUD may be placed at any time during the patient’s inpatient postpartum admission.**PROCEDURE FOR IMMEDIATE POSTPLACENTAL IUD INSERTION DURING VAGINAL DELIVERY**1. Immediately prior to delivery, confirm that the patient still wants the IUD placed.
2. The vaginal delivery should be performed per routine practice of the operating clinician(s) until delivery of the placenta. This includes administration of the usual uterotonics (including oxytocin, misoprostol).
3. Following routine care after delivery of the placenta (removal of membranes, control of bleeding, etc.), ensure that adequate hemostasis has been attained and that the uterus is not atonic. Perineal lacerations that are actively bleeding may need repair prior to IUD placement. Consideration should be given to performing IUD insertion prior to laceration repair when feasible.
4. The RN will open the IUD packaging. Because it is packaged sterilely, the device and inserter can be placed directly on to the delivery tray. (Waiting until this point in the procedure avoids opening it until it is sure to be placed, so it is not wasted if unable to be placed for any reason.)
5. The practitioner will change gloves, then place a bivalve or Sims speculum into the patient’s vagina to expose the cervix and cleanse the cervix and vagina with Betadine.
6. Ultrasound guidance **must** be used for insertion.
7. **For Liletta/Kyleena/Skyla insertion the practitioner will:**
	* Slide back the flange (ring) all the way to the handle.
	* Choose whether to bend the inserter at the base of the sheath just above the handle to facilitate insertion.
	* Pass the inserter into the lower uterine segment under ultrasound guidance, and pull back the slider until the top of the slider reaches the mark (raised horizontal line on the handle).
	* Wait 10 seconds, then advance the inserter to the uterine fundus.
	* Pull the slider all the way back, releasing the IUD at the fundus, then carefully remove the inserter from the uterus.
	* If the inserter is defective, or is too short (as may be the case with obese patients), the IUD may also be inserted using ring or ovum forceps, as outlined below.
8. **For Paragard insertion the practitioner will:**
	* Remove the IUD from the inserter.
	* Grasp both the stem and the arm of the IUD with a ring or ovum forceps.
	* Place the IUD at the fundus of the uterus under ultrasound guidance.
	* Open the forceps, allowing the IUD to remain at the fundus.
	* Remove the forceps carefully, by gliding the forceps against the uterine side wall, keeping them open so as to not inadvertently grasp the strings or the IUD.
	* Trim the strings of the IUD at the level of the cervix.
9. Careful attention should be paid when performing any adjustments that the IUD is not inadvertently removed.
10. Uterine (abdominal) massage is permitted; do NOT manually express the uterus of clots after the IUD is placed. Uterotonics may be given as medically indicated.
11. A ring forceps may act as a tenaculum on the cervical anterior lip, if assistance is needed in placing the inserter through the lower uterine segment.

**PROCEDURE FOR IMMEDIATE POSTPLACENTAL IUD PLACEMENT AFTER CESAREAN SECTION**1. The IUD should be taken into the operating room with the patient and stay in its sterile packaging until the decision has been made to place it. No extra instruments or set up is required.
2. Immediately prior to delivery, confirm that the patient still wants the IUD placed.
3. The cesarean delivery should be performed per routine practice of the operating physician(s) until delivery of the placenta. This includes administration of the usual prophylactic antibiotics and uterotonic agents (oxytocin, methylergonovine).
4. Following routine care after delivery of the placenta (removal of membranes, control of bleeding, etc.), the hysterotomy closure should be initiated.
5. If there is not excessive bleeding, the IUD should be passed onto the field in a sterile fashion. Because it is packaged sterilely, the device and inserter can be placed directly on to the operating field. (Waiting until this point in the procedure avoids opening it until it is sure to be placed, so it is not wasted if unable to be placed for any reason.)
6. **For Liletta/Kyleena/Skyla insertion:**
	* The inserter is used to place the IUD at the uterine fundus, in a similar fashion to standard transcervical insertion.
	* The surgeon will place the tip of the inserter at fundus via hysterotomy site, pull back 2cm, move slider on inserter handle back to mark on handle, wait for 10 seconds then push the inserter to fundus.
	* The assistant will place their finger on the IUD at the fundus and hold the IUD at the fundus until all insertion steps are complete.
	* The surgeon will then move the slider on the inserter all the way back to release strings, and finally remove the inserter from the uterus.
		+ The assistant continues to hold the IUD in place with a finger when the inserter is being removed, in order to ensure that the IUD stays at the fundus.
		+ The surgeon can place their non-dominant hand on the exterior of the fundus to stabilize the uterus and guide placement.
	* After the inserter has been removed, the assistant will continue to hold the IUD in place with a finger and confirm correct placement (fundal and longitudinal) digitally. If incorrectly positioned, adjustments can be made manually.
		+ Careful attention should be paid when performing digital confirmation (and adjustment) such that removal of the finger or hand does not displace the IUD.
	* With the finger of the assistant *still* on the IUD at the fundus, the surgeon will grasp the strings at the distal tip with a ring forceps and then insert them into the lower uterine segment (can place through the cervix into the vagina if the cervix was previously dilated).
	* The surgeon will open the ring forceps as much as possible before pulling back up through the cervix to avoid pulling the strings back up with it. The ring forceps should then be removed from the sterile field.
7. **For Paragard insertion:**
	* The surgeon will load the IUD into the inserter per the usual method. The strings should not be trimmed.
	* The inserter is used to place the IUD at the uterine fundus, in a similar fashion to standard transcervical insertion.
	* The surgeon will place the tip of the inserter at the fundus via hysterotomy site, then pull back slightly.
	* Holding the white rod, the insertion tube is pulled back, allowing deployment of the arms of the IUD.
	* The assistant will place their finger on the IUD at the fundus and hold the IUD at the fundus until all insertion steps are complete.
	* The inserter tube and rod are removed from the uterus.
		+ The assistant will hold the IUD in place with a finger when the inserter is being removed, in order to ensure that the IUD stays at the fundus.
		+ The surgeon can place their non-dominant hand on the exterior of the fundus to stabilize the uterus and guide placement.
	* After the inserter has been removed, the assistant will continue to hold the IUD in place with a finger and confirm correct placement (fundal and longitudinal) digitally. If incorrectly positioned, adjustments can be made manually.
		+ Careful attention should be paid when performing digital confirmation (and adjustment) such that removal of the finger or hand does not displace the IUD.
	* With the finger of the assistant *still* on the IUD at the fundus, the surgeon grasps the strings at the distal tip with a ring forceps and then inserts through the cervix into the vagina from above, via the hysterotomy site.
	* The surgeon will open the ring forceps as much as possible before pulling back up through the cervix to avoid pulling the strings back up with it. The ring forceps should then be removed from the sterile field.
8. The cesarean delivery should then be completed per the routine of the operating physician.
9. Uterine (abdominal) massage is permitted; do NOT manually express the uterus of clots after the cesarean. Uterotonics may be given as medically indicated.

**PROCEDURE FOR DELAYED POSTPARTUM INSERTION OF THE IUD FOLLOWING VAGINAL OR CESAREAN DELIVERY**1. The Non-OR Universal Protocol is followed for IUD and Implant placements, refer to [Universal Protocol (TimeOut)](https://bostonmedicalcenter.policytech.com/docview/?docid=1441) .
2. The patient should be offered a dose of their postpartum pain medication one hour before the time of insertion.
3. The patient should void prior to the insertion process.
4. The practitioner will:
	* Confirm that the cervix is sufficiently dilated for postpartum insertion.
	* Place a bivalve speculum into the patient’s vagina to expose the cervix.
	* Place the IUD into the cervix under ultrasound guidance to confirm cervical dilation.
	* Set up and insert the IUD in the manner described above for immediate postplacental insertion following vaginal delivery.
	* Trim the strings of the IUD at the level of the cervix.
5. Careful attention should be paid when performing any adjustments that the IUD is not inadvertently removed.
6. Uterine (abdominal) massage is permitted; do NOT manually express the uterus after the IUD is placed. Uterotonics may be given as medically indicated.

**POSTPARTUM CONTRACEPTIVE DEVICE IMPLANT PROCEDURES**1. As the patient is being transferred to the postpartum unit, the order for the LARC device should remain active as the orders are reconciled. The order should remain active until the administration has been documented.
2. The RN will utilize an L&D stretcher with stirrups for IUD placement, or transfer the patient to Triage.
3. The RN will document the Non-OR Universal Protocol in the electronic medical record for IUD and contraceptive implant placements.
4. Practitioners should document the device insertion in a procedure note in the electronic medical record.
	1. If IUD or contraceptive implant is placed at time of delivery, place procedure note within the delivery note.
	2. If IUD or contraceptive implant is placed apart from delivery, write a separate procedure note on the day of service.
	3. Can use SmartPhrases .XXXOBIUD or .XXXOBIMPLANT
5. The Practitioner will bill for the device insertion in the electronic medical record at the time of writing the note.
6. The RN will document device insertion under the order in the Medications tab in the electronic medical record. Include lot number and expiration date in the free text field.
7. Do not manually express the uterus, though uterotonic agents can be used as needed.

**INDICATIONS FOR REMOVAL OF IUD PLACED IN THE POSTPARTUM TIME PERIOD*** Delayed infection
	+ If the IUD has been placed, and the patient becomes febrile or has other signs of chorioamnionitis after placement, treat them with routine antibiotics as indicated.
	+ The IUD should only be removed if the patient does not show clinical improvement after 48 hours of treatment.
* Delayed hemorrhage
	+ Treat hemorrhage medically with uterotonic agents as indicated.
	+ The IUD should be removed if D&C or Bakri balloon placement is to be performed.
	+ The IUD does not have to be removed in the setting of embolization.
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| **Responsibility:** |
| All physicians, NPs, CNMs, RNs involved in patient care. |

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| **Clinical Information:** |
| Nearly one half of all pregnancies in the United States are unintended. Many barriers exist that contribute to this pregnancy rate, notably the difficulty in obtaining effective birth control in the postpartum period. In addition to prenatally, it is at the six-week postpartum visit where patients receive birth control counseling. Unfortunately, many patients do not present to their follow up visits and do not receive contraceptive counseling. Additionally, many patients have become sexually active by their follow-up visit, and if they are not exclusively breastfeeding, may become pregnant.Immediate postpartum LARC refers to LARC initiation in the immediate postpartum period, before hospital discharge. Intrauterine device placement while still in the delivery room is referred to as postplacental insertion. Multiple studies attest to the safety, efficacy, and cost-effectiveness of immediate postpartum IUD and implant placement (1-3). The Centers for Disease Control and Prevention’s 2010 U.S. Medical Eligibility Criteria for Contraceptive Use (MEC) has been endorsed by ACOG and provides guidance about the safety of postpartum contraceptive use. Immediate postpartum initiation of IUDs and implants are classified as Category 1 (no restriction for use) or Category 2 (advantages generally outweigh theoretical or proven risks) (4). |

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| **Forms:** |
| [insert consent form name for IUD insertion][insert consent form for implant insertion] |

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| **Other Related Policies:** |
| [insert any other related policies] |

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| **Initiated by:** |
| Obstetrics |

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| **Reviewed by:** |
| [insert reviewing committee] |

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| **References:** |
| (1) Gariepy AM, Duffy JY, Xu X. Cost-effectiveness of immediate compared with delayed postpartum etonogestrel implant insertion. Obstet Gynecol 2015;126:47–55.(2) Washington CI, Jamshidi R, Thung SF, Nayeri UA, Caughey AB, Werner EF. Timing of postpartum intrauterine device placement: a cost-effectiveness analysis. Fertil Steril 2015;103:131–7.(3) Rodriguez MI, Caughey AB, Edelman A, Darney PD, Foster DG. Cost-benefit analysis of state- and hospital-funded postpartum intrauterine contraception at a university hospital for recent immigrants to the United States. Contraception 2010;81:304–8.(4) Update to CDC’s U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep 2011;60:878–83. |

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| **Approval Date** | **Committee** |
| [insert date approved] | [insert reviewing committee] |





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