

# Florida Perinatal Quality Collaborative



Partnering to Improve Health Care Quality  
for Mothers and Babies

## ACCESS LARC

INCREASING ACCESS TO IMMEDIATE POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION

### Chapter Five: Provider and Staff Training on Clinical Procedures

#### Overview

Clinical and support staff should receive training for immediate postpartum IUD and implant insertion in the delivery room or OB operating room, and in identifying and treating any difficulties or complications that arise. This chapter outlines clinical procedures for post-placental IUD insertion and postpartum subdermal implant insertion.

Clinical staff in the obstetrical service (antepartum, labor and delivery, postpartum) should also be trained in comprehensive contraceptive counseling (see Chapter 6). Additionally, appropriate hospital staff should be trained in ordering and acquisition of LARC devices according to the protocol established by the hospital, to ensure the device is immediately available to the practitioner when needed.

**Staff in labor and delivery** should be trained in setting up and assisting with IUD and/or subdermal contraceptive implant insertion, with attention to sterile technique as well as care for the patient before, during and after the procedure according to hospital policy.

**Staff in the postpartum unit** should be trained in setting up and assisting with subdermal contraceptive implant insertion, with attention to sterile technique as well as care for the patient before, during and after the procedure according to hospital policy.

To ensure providers are adequately trained, please contact FPQC to set up a training session. The ACOG LARC Program's Postpartum Contraceptive Access Initiative (PCAI) also provides additional training and support for immediate postpartum LARC implementation.

#### Post-Placental IUD Insertion Procedures

The technique for placing an IUD during the immediate postpartum period is different than during interval IUD insertion. There are several variations of techniques used to place a postpartum IUD, including manual placement and forceps placement, as well as inserter placement when used at the time of cesarean delivery. Additionally, an ultrasound may be used to confirm proper placement, but is not necessary. Individual hospitals may choose whether or not to recommend any specific technique, as well as whether or not they will be able to ensure access to an ultrasound.

This chapter outlines the techniques used to place postpartum IUDs. Prior to actually placing postpartum IUDs, providers should undergo training, which the Florida Perinatal Quality Collaborative can help arrange. After completing a training session, provider may begin placing postpartum IUDs. There is no proctoring required, or minimum amount of training necessary prior to placing IUDs.

Before delivery, obtain informed consent for the procedure and review the following:

- ✓ expulsion risk,
- ✓ possibility of not being able to place due to obstetric complications,
- ✓ more difficult removal if strings not visible,
- ✓ duration of efficacy,
- ✓ bleeding profile of device,
- ✓ infection and perforation risk,
- ✓ efficacy, and risk of ectopic pregnancy should pregnancy occur with LARC method in place.

### Vaginal Delivery

1. Following placental delivery, review contraindications for immediate post placental insertion including chorioamnionitis and ongoing postpartum hemorrhage
2. Place IUD within 10 minutes of placental delivery. An IUD may be placed beyond this period if patient accepts the potential increased risk of expulsion
3. Perform uterine massage and administration of uterotonic medications as clinically indicated. If bleeding from laceration is not heavy, insertion should occur before perineal repair.
4. Gather appropriate supplies (Figure 1):
  - 2 Ring forceps or 1 ring forceps and one Kelly placental forceps
  - Speculum or retractor
  - 4x4 sterile gauze or cotton swabs
  - Antiseptic solution (Betadine or Hibiclens)
  - IUD device
  - Sterile gloves
  - Sterile gown
  - Sterile towels/drape
  - Scissors
  - Ultrasound readily available is useful but not required for placement
5. Palpate the uterus to evaluate fundal height.
6. Cleanse the external genitalia with antiseptic.
7. Insert retractor or speculum into vagina and visualize cervix.
8. Cleanse the cervix and vagina with antiseptic using sponge stick or cotton swab.
9. Gently grasp the anterior lip of cervix with ring forceps.



Figure 1

### Using Forceps:

#### 10. Open the IUD packaging:

- i. For the copper IUD open the bottom of the IUD package and remove the plastic applicator leaving only the IUD inside.
- ii. For the LNG IUD remove inserter from packing and grasp the IUD directly from the tip of the inserter.



Figure 2a: Grasping the IUD from the tip of the inserter



Figure 2b: grasping the Copper IUD within the packaging

- iii. Using the placental forceps or the ring forceps grasp the arm of the stem of the IUD and remove it from the package or inserter. **Do NOT click down or lock** as this can disrupt the copper or levonorgestrel containing plastic.
- iv. Using sterile gloves adjust the IUD placement in the ring forceps. The IUD should be held by its vertical arms; the horizontal arms should be slightly out of the ring (Figure 2a and 2b).
- v. Apply gentle traction on the anterior lip of the cervix and insert the forceps holding the IUD through the cervix into the lower uterine segment. Avoid touching the vagina with the IUD.
- vi. Release the hand that is holding the cervix-holding ring forceps. Move this hand to the abdomen placing it over the uterine fundus.
- vii. With the abdominal hand, stabilize the uterus and apply firm downward pressure.
- viii. Direct the IUD-holding forceps in an upward motion toward the fundus. The lower uterine segment might be contracted and slight pressure might be necessary to achieve fundal placement. Confirm the tip of the forceps are at the fundus with the abdominal hand.
- ix. Open the forceps wide to release the IUD. Sweep the forceps slightly laterally to avoid entanglement with the string.
- x. Slowly retract the forceps from the uterine cavity. If the IUD becomes dislodged during placement, the IUD should be removed, re-grasped sterilely and immediately reinserted.
- xi. Consider use of ultrasound to verify fundal location of IUD.
- xii. Cut the strings of the IUD flush against the cervical os.

The Paragard strings are shorter than the LNG IUDs and will unlikely be visible at the cervical os after insertion.

### Manual Insertion:

11. Change into sterile gloves
12. Remove the IUD from packaging and inserter and place between index and middle finger
13. Place the other hand on the abdomen to externally stabilize the uterus and apply downward pressure.
14. Insert the hand holding the IUD through cervix and place the IUD arms at the top of the uterine fundus.
15. As the internal hand is removed, rotate it about 15 degrees to avoid dislodging the IUD.
16. Consider use of ultrasound to verify fundal location of IUD.
17. Cut the strings of the IUD flush against the cervical os.

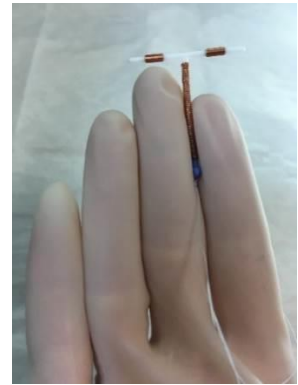


Figure 3: correct positioning for manual insertion

The Paragard strings are shorter than the LNG IUDs and will unlikely be visible at the cervical os after insertion.

### **Cesarean Delivery**

1. Review contraindications for immediate post placental insertion including chorioamnionitis and ongoing postpartum hemorrhage
2. The IUD can be placed with package inserter, ring forceps or manually

### Package Inserter:

- i. For the LNG IUD, position the IUD in inserter so the arms of the IUD are out. Cut the LNG IUD strings to 10cm. (Figure 4a)
- ii. For the ParaGard, position IUD so arms are out of the clear plastic tube, the white plunger is not needed (Figure 4b). The strings are shorter and do not need to be cut.
- iii. Place the device through the hysterotomy and place at uterine fundus.
- iv. For the LNG IUD slide the slider down to carefully deploy the IUD. For the ParaGard remove the tube inserter leaving the IUD at the fundus.

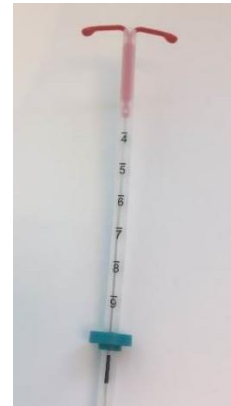


Figure 4a



Figure 4b

### Ring Forceps:

- i. Grasp the stem of the IUD and remove it from the package or inserter. **Do NOT click down or lock.** The IUD should be held by its vertical arms; the horizontal arms should be slightly out of the ring (Figures 2a-2b).

- ii. Place the device through the hysterotomy and place at uterine fundus.
- iii. Open the forceps wide to release the IUD.

#### Manual Insertion:

- i. Remove IUD from packaging and inserter and place between index and middle finger (Figure 3).
  - ii. With the IUD arms out place the device through the hysterotomy and place at uterine fundus.
3. Once IUD placed at fundus, assistant places hand on exterior of uterus to stabilize IUD in place at fundus.
  4. While the assistant continues to stabilize the IUD externally use a ring forceps to guide the IUD strings into the cervix. If the cervix is closed, dilate from above with ring forceps before passing strings. The ring forceps should then be removed from the sterile field.
  5. Prior to closing the hysterectomy confirm fundal IUD placement, incorrectly positioned, adjustments can be made manually.
  6. Complete the cesarean per routine.
  7. Abdominal fundal massage is permitted; do not manually express the uterus of clots after the cesarean. Uterotonics may be given as medically indicated.

An instructional video by ACOG can be found here for both vaginal and cesarean delivery

[https://cfweb.acog.org/district\\_ii/larc/section4.html](https://cfweb.acog.org/district_ii/larc/section4.html)

### **Postpartum Subdural Implant Insertion Protocol**

Prior to placing any Nexplanons, either postpartum or interval, Merck requires that providers complete a 2-hour in-person training course. Individual courses can be requested from the Merck website at <https://www.nexplanontraining.com/request-clinical-training/in-person-training/>. Additionally, please contact FPQC for a list of your local Merck representative, who can set up a training for your providers.

Unlike an IUD, which must be placed within 10 minutes following delivery of the placenta, a contraceptive implant device can be inserted any time after delivery and prior to patient's discharge from the hospital. The insertion can be done on L&D or on the postpartum floor.

Prior to insertion, verify insurance coverage, obtain informed consent for the procedure and review the risks and potential side effects after insertion, such as:

- ✓ Risks include:
  - pain, irritation, swelling or bruising at the insertion site,
  - scar tissue may develop around the implant,
  - if you become pregnant there is a slightly increased chance of having an ectopic pregnancy than in women who do not use birth control.
- ✓ Side effects include:
  - longer or shorter bleeding during periods,
  - absence of periods, spotting between periods, and varying amounts of time between periods
  - implant migration, making it difficult to be removed. (Consult the Nexplanon consent form for full details of risks.)

## Procedure

1. Collect all necessary supplies for insertion (Figure 5):
  - i. Sterile gloves
  - ii. Nexplanon device
  - iii. Local anesthetic (1% Lidocaine with or without Epinephrine)
  - iv. 2 mL syringe
  - v. 18 gauge needle (for drawing up anesthetic)
  - vi. 25 gauge-1.5cm needle (for administering anesthetic)
  - vii. Antiseptic solution: Povidone Iodine/Betadine (Chlorhexidine if patient is allergic)
  - viii. Sterile cup
  - ix. 4x4 sterile gauze
  - x. A sterile marking pen (to mark insertion site)
  - xi. Sterile towels/drape
  - xii. Adhesive dressing (Steri-strips)
  - xiii. Pressure dressing (Kerlex)



Figure 5

2. Set up sterile field on stand or table using sterile towels or sterile drapes:
  - i. Sterilely lay drape/towel on field
  - ii. Using sterile gloves place supplies on sterile field
  - iii. Use sterile cup to hold antiseptic solution
  - iv. Sterilely draw up 1-2mL of 1% lidocaine with or without epi into the 2 mL syringe with the 18 gauge needle
  - v. Remove the 18 gauge needle and dispose of it in the sharps container
  - vi. Place the 25 gauge-1.5cm needle on the syringe with the lidocaine
  - vii. Remove sterile gloves and discard



3. Position patient on bed in the supine position with her non-dominant arm flexed so that her hand lies next to her head with her palm facing the ceiling.

4. Place a towel or drape under the patient's arm in case blood or antiseptic solution runs down the patient's arm.

5. Put on sterile gloves and clean the insertion site with antiseptic solution and 4x4 sterile gauze

6. Using the sterile marking pen, mark the insertion site (Figure 7). The implant should be inserted 8-10cm (3-4inches) above the medial epicondyle of the humerus. Insert subdermally avoiding the sulcus between the biceps and triceps muscles. When inserting the implant, avoid inserting directly through the pen mark as to avoid tattooing the skin.



Figure 6

7. Remove the Nexplanon from its sterile packing and hold the applicator between the thumb and forefingers on the textured area of the device
8. Slide the transparent protection cap horizontally away from the device
9. The implant can be visualized by looking at the needle tip
10. The insertion of the implant is best done while sitting to have better visualization of the applicator from the side
11. Use counter-traction with your free hand as you insert the needle at a 30° angle (Figure 7).

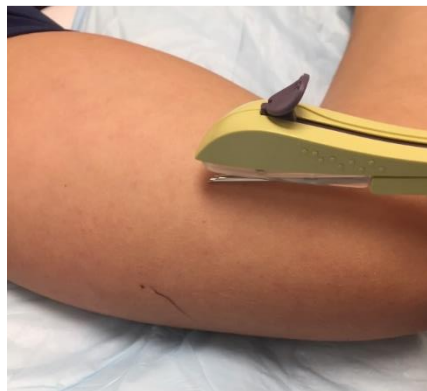


Figure 7

12. Once the needle has punctured the skin, hold the applicator horizontal to the skin and tent the skin upward with the applicator as the rest of the needle is inserted into the subdermal space
13. Hold the applicator in place and using your index finger unlock the purple slider by pushing the slider downward and backward until it locks in place
14. The implant is now inserted and the applicator needle should be checked to ensure the implant is no longer in the device
15. Palpate the implant to ensure proper placement
16. Place adhesive dressing over the insertion site
17. Clean excess antiseptic solution and blood from patient's arm
18. Have the patient feel the implant prior to placing pressure dressing

19. Place pressure dressing around the arm over the insertion site
20. Instruct patient to wear the pressure dressing for 24 hours and to wear a small adhesive bandage for 3-5 days after the pressure dressing is removed
21. Instruct the patient to return to clinic if she is unable to feel her implant, it has broken under the skin, or it is more painful than it should be

### **Additional Resources**

Florida Perinatal Quality Collaborative Access LARC Online Toolbox for Hospital Implementation:

<http://health.usf.edu/publichealth/chiles/fpqc/larc/toolbox>

ACOG LARC Program Help Desk: [www.acog.org/LARC/helpdesk](http://www.acog.org/LARC/helpdesk)

Postpartum Contraceptive Access Initiative: <https://pcainitiative.org/>

ACOG District II: Long-Acting Reversible Contraception – A Hospital-Based Physician Initiative Video Series:

<https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Long-Acting-Reversible-Contraception-LARC>

ACQUIRE Project Postpartum IUD Curriculum (supported by USAID):

<http://www.acquireproject.org/archive/html/10-training-curricula-and-materials/resources.html>

CARDEA Inserting LARC Immediately After Childbirth eLearning Course:

<http://www.cardeaservices.org/resourcecenter/inserting-long-acting-reversible-contraception-larc-immediately-after-childbirth>

Stanford Program for International Reproductive Education and Services (SPIRES) Postpartum IUD Insertion Model and Technique Demonstration: <https://www.youtube.com/watch?v=uMcTuf8XxQ>