# DST-900 Contraceptive Management: Assessment

A comprehensive contraceptive management assessment is client-centred and includes obtaining informed consent, taking a health history and completing physical assessment components. When assessing the type of contraception that best meets a client's needs, the RN(C)[1] takes into consideration the individual's clinical judgment and assessment along with the preferences of the client. Selection of an appropriate contraceptive method is based on best practice (eg. effectiveness, contraindications, side effects, non-contraceptive benefits), availability, costs, and the desires and prior experience of the client. No single regime is most effective; a variety of regimes can be provided based on client/provider preference.

## MANAGEMENT AND INTERVENTIONS

NOTE: For the purpose of this DST, initiation of hormonal contraception is when no hormonal contraception has been used within the last three months or the client is switching from a combined hormonal contraception (CHC) to a progestin only hormonal contraception (POHC) or from a POHC to a CHC.

### Intended Client Outcomes

- Client receives safe and effective contraception.
- Unintended pregnancies are prevented through the provision of safe and effective contraception.
- Sexual health education is provided to enhance the client's capacity to manage their sexual and reproductive health care.

## INDICATIONS

RN(C)s practice autonomously to dispense and or administer hormonal contraception for the purpose of contraception when indicated for a client who is seeking a reliable, reversible, coitally-independent method of contraception.

Hormonal contraception is further indicated for a number of menstrual-related problems and the non-contraceptive benefits that they confer. However, clients seeking or using hormonal contraception for purposes other than contraception—see example below—must be referred to a physician or nurse practitioner for a patient specific order or transfer of care.

Other benefits of hormonal contraception include, but are not limited to:

- Decreased acne
- Improvement in some menstrual related conditions such as primary dysmenorrhea, ovarian cysts and premenstrual syndrome
- Decreased risk of ovarian and uterine cancer
- Decreased risk of iron deficiency anemia
- Reduction of ectopic pregnancies

In the absence of contraindications, and with precautions in mind, the choice of contraception is based on client preferences. The RN(C) can assist the client by asking the following sample questions:

- How important is it that you do not get pregnant (efficacy)?
- Which method do you think you would like to use or try?
- How convenient do you want the method to be?
- Do you want to use your contraception daily, weekly, monthly or longer?
- Will you be able to use the method as intended (e.g., take the pills daily, return for regular injection)?
- How important is it to have a discreet method of birth control?
- Are you comfortable touching your own genitals (e.g., ring, female condom)?
- Can you afford the method you wish to use or can you access a program to assist with the cost (pharmacare, extended health benefits)?

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[1] Note: RN(C) is an authorized title recommended by BCCNP that refers to BCCNP-certified RNs, and is used throughout this Decision Support Tool (DST).

- Are you or will you be using a birth control method that provides protection against sexually transmitted infections (STIs)?
- How quickly do you want to be able to return to fertility?

### Relative and Absolute Contraindications

RN (C)s dispense medications autonomously based on individual client assessment and within the US Medical Eligibility Criteria (US MEC) categories 1 & 2. US MEC categories 3 & 4 require a consult and/or referral.

For complete guidance, see Centers for Disease Control and Prevention. (2016). *U.S. medical eligibility criteria for contraceptive use, 2016. Morbidity and Mortality Weekly Report*, *65*(3), 1-106.

### Informed Consent Specific to Contraceptive Management

RNs follow the BCCNP *Consent* practice standard when assessing informed consent with clients who want to access contraception which included the following:

- Assess the client's ability to provide consent for hormonal contraception
- Understand the legal requirements for determining if a minor can provide valid consent.
- Know who may give consent if your minor client cannot.

Know your organization's policies about any relevant legislation related to consent. When policies are inadequate or inappropriate, participate in refining and strengthening them.

### Health History

Before initiating or continuing a hormonal contraceptive, a thorough medical history is taken or reviewed that includes:

- Potential contraindications - medical conditions, medication use, allergies, smoking, breast/chest feeding
- Assess for strong family history consistent with inherited thrombophilia, such as unprovoked venous thromboembolism (VTE) in a first or second degree relative under the age of 50.
- Assessment of menstrual patterns that might assist in determining possible benefits of hormonal contraceptive use
- Last menstrual period
- Current or past use of contraception (and any difficulties using the method and or side effects)
- Potential for existing pregnancy and need for pregnancy testing
- Assessment of unexplained vaginal bleeding, including recommendations for additional investigations or referrals
- Assessment of sexual activity (risk factors for STIs and potential need for emergency contraception.

### Physical Assessment

The physical assessment includes:

- Initial blood pressure measurement for initiation of all hormonal contraception and at least annually thereafter
- Cervical Cancer Screening, STI Screening, breast/chest exams although important for overall reproductive health, are **not** mandatory for provision of hormonal contraception and should not be a requirement to receive contraception.

### Diagnostic Testing/Investigations

- No specific diagnostic tests or investigations are required for initiation of hormonal contraception.
- Urine pregnancy testing may be indicated if the client is considered at risk for an existing pregnancy.

## PRECAUTIONS AND CONSIDERATIONS

Timing of administration is important for effective contraception.

- **Quickstart** of a hormonal contraceptive is recommended as it demonstrates improved compliance (especially in youth). Delaying initiation of hormonal contraception (e.g., Sunday start or start with next menstrual period) could increase the risk that a client forgets to start, chooses not to start or becomes pregnant while awaiting initiation.
- Inconsistent use of hormonal contraception can result in unintended pregnancy.

- Consider use of back-up method(s) and/or emergency contraception (Leonogesterol or Ulipristal acetate) when initiating hormonal contraception and in situations of missed or late doses. Counsel patient around other options including EC IUD.
- Expense and accessibility can affect a person's ability to use hormonal contraception effectively.
- Hormonal contraception does not offer protection from STIs
- Youth have been shown to be less tolerant of medication side effects and, therefore, tend to have higher discontinuation rates. As such, proper education and counseling at the time of initiation and follow up of hormonal contraception may help address youth specific needs. This may include more frequent follow up visits (such as at 3 months).

## CLIENT EDUCATION

Use of hormonal contraception is more likely to be successful when client education includes:

- How the method works to prevent pregnancy.
- How to use the method(s) of hormonal contraception.
- Initiation of hormonal contraceptive method and time for onset of contraception (recommend quickstart, first day of next menstrual period).
- Estimated return to fertility after discontinuing hormonal contraception.
- Storage of hormonal contraceptive products.
- Use of appropriate back-up method(s) and emergency contraception.
- Drug-drug interactions and the need to consult with a health care provider when taking other medications.
- Discussion that hormonal contraception is a medication and should be disclosed to health care providers when asked.
- Hormonal contraceptive methods do not protect against STIs.
- Recognizing and taking appropriate action for:
  - transitional and ongoing side effects
  - possible serious side effects (e.g., ACHES: abdominal pain, chest pain, headache, eye problems and severe leg pain)
  - method failure
  - missed or late doses (including vomiting within two hours of ingestion of a contraceptive pill might require repeat doses)
- Accessing the hormonal contraception (e.g., ability to return to clinic or purchase at pharmacy).
- Planned follow up:
  - as per Combined Hormonal Contraceptive (CHC) or Progestin-only Hormonal Contraceptive (POHC) DSTs
  - such that the client can contact the clinic/health care provider or return with any questions
  - as needed by the client

## BREAST/ CHEST FEEDING

Hormonal Contraceptives can be started when the person is medically eligible to use the method and if it is reasonably certain that they are not pregnant, see CHC and POHC DSTs for more information regarding intiation oc contraception during the postpartum period.

Estrogen and progestin are excreted in breastmilk in small quantities, but are unlikely to have an effect on the baby.

## DISPENSING AND ADMINISTRATION

The dispensed hormonal contraceptive medication should be labelled with a client-specific label. Labels can be pre-printed, but must be client specific and include the information as outlined in the BCCNP Dispensing Medications Practice Standard.

For specific criteria about the administration of DMPA, please refer to the POHC DST.

### Expiry dates

- When expiry dates note only the month and year, the date is interpreted as the last day of the noted month.
- The expiry date is the date by which the client should finish the medication in that package.
- When dispensing contraception, the RN(C) must calculate the number of doses required to ensure that the dispensed method, if used as directed, will be completed prior to the stated expiry date.

## DOCUMENTATION

Document on the client's health record as per agency policy and as per the BCCNP Dispensing Medications Practice Standard.

## MONITORING AND FOLLOW UP

- Advise a client to return at any time to discuss side effects or other problems or if they want to change the method being used. No routine follow-up visit is required.
- To improve continuation rates and enhance a client's abilities to obtain contraception when needed, health care providers should prescribe up to a 1- or 2-year supply of COCs at the initial and return visits

## IDENTIFYING AND MANAGING SIDE EFFECTS

To manage common side effects, the RN(C) may refer to the following recommended resources:

- SOGC Canadian Contraception Consensus (Part 3 and 4):
  - Chapter 8  Progestin-Only Contraception
  - Chapter 9: Combined Hormonal Contraception
- Hatcher, R.A., Trussell, J., Nelson, A.L., Cates, W., Stewart, F., & Kowal, D. (2018). *Contraceptive technology* (21st Rev. ED.). New York: Ardent Media Inc.
- Zieman, M., Hatcher, R. A., Allen, A. Z., Lathrop, E. & Haddad, L.  (2018). *Managing contraception on the go* (14th ed). Atlanta, GA: Bridging the Gap Communications.
- RX files https://www.rxfiles.ca/RxFiles/home.aspx (requires subscription))
- Consult with another health care provider for questions [e.g., RN(C), physician, nurse practitioner, pharmacist]

## REFERENCES

More recent editions of any of the items in the Reference List may have been published since this DST was published. If you have a newer version, please use it.

Centers for Disease Control and Prevention. (2016). *U.S. medical eligibility criteria for contraceptive use, 2016. Morbidity and Mortality Weekly Report*, *65*(3), 1-106.

British Columbia College of Nursing Professionals. (2017). *Dispensing Medications*: Practice standard for registered nurses and nurse practitioners*.* Vancouver, BC: Author.

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Culwell, K. (2011). WHO *Immediate start of hormonal contraceptives for contraception: RHL commentary*. Geneva: World Health Organization: WHO Reproductive Health Library.

Dickey, R. P. (2014). *Managing contraceptive pill patients* (15th ed.). Fort Collins, CO: E. M. I. S. Medical Publishing.

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Society of Obstetricians and Gynaecologists of Canada. (2015). *SOGC Clinical practice guidelines: Canadian contraception consensus (Part 1 of 4).* Retrieved from http://sogc.org/wp-content/uploads/2015/11/gui329Pt1CPG1510E.pdf

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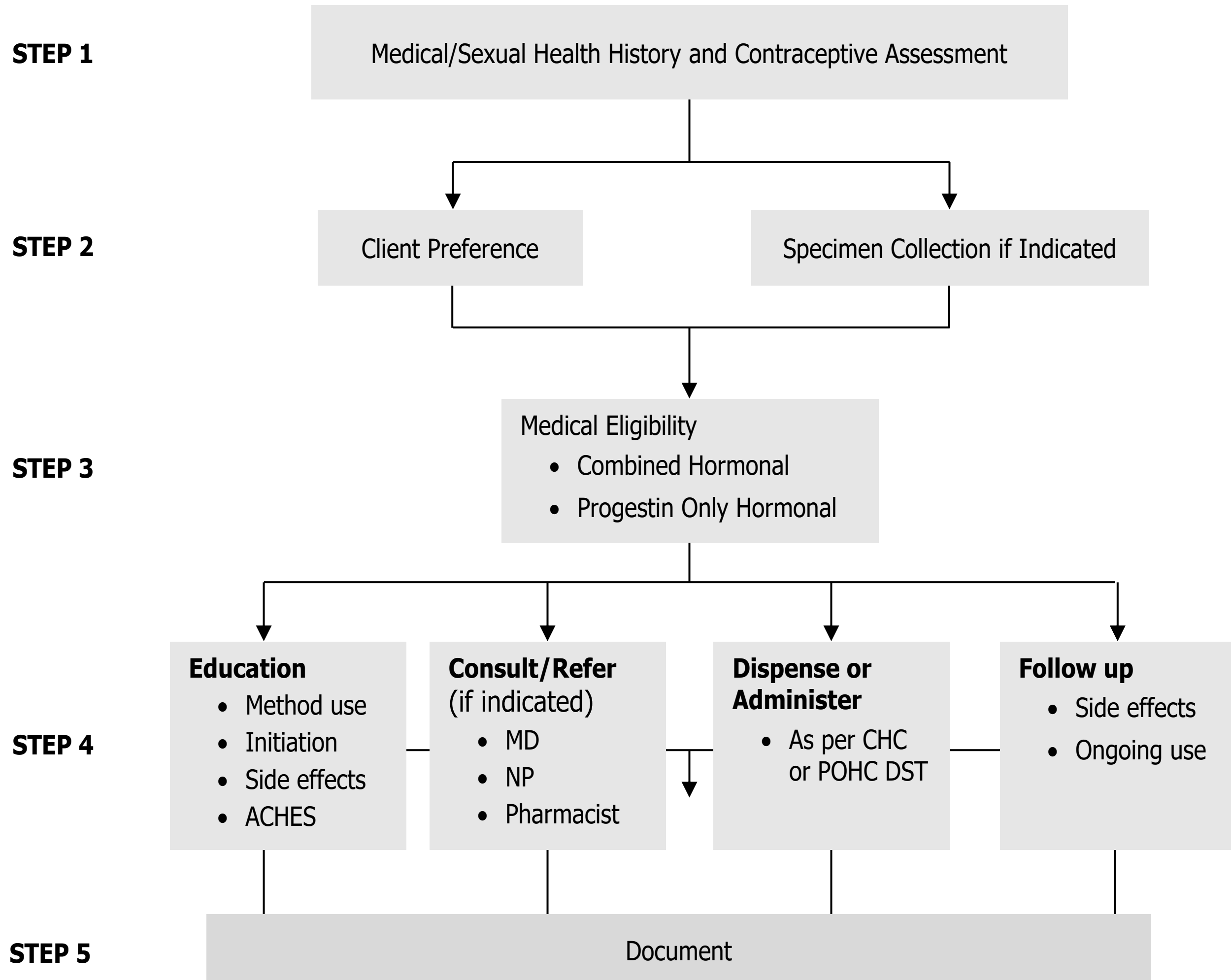
## APPENDIX 1




## APPENDIX 2

The following link provides a summary chart as a quick reference guide to the classifications for hormonal contraceptive methods and intrauterine contraception to compare classifications across these methods. Retrieved from https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1_appendix.htm

For complete guidance, see the 2016 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC) (Curtis KM, Tepper NK, Jatlaoui TC, et al. U.S. medical eligibility criteria for contraceptive use, 2016. MMWR Recomm Rep 2016;65[No. RR-3])