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## **CONTRACEPTIVE MANAGEMENT: ASSESSMENT**

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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)\* takes into consideration his or her clinical judgment and assessment along with the preferences of the client. Selection of an appropriate contraceptive method is based on availability, effectiveness, contraindications, side effects, non-contraceptive benefits, 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 vice versa.

#### **Intended Client Outcomes**

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

### **INDICATIONS**

RN(C)s can make an independent decision to dispense and or administer hormonal contraception without an order for the purpose of contraception when indicated for a woman 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 a

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

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The DSTs are not intended to replace the RN(C)'s professional responsibility to exercise independent clinical judgment and use evidence to support competent, ethical care. The RN(C) must consult with or refer to a physician or nurse practitioner as appropriate, or whenever a course of action deviates from the DST.

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sole purpose other than contraception (see examples below) must be referred to a physician or nurse practitioner for an 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 hormonal contraception is based on client preferences. The RN(C) can assist the client by asking the following sample questions:

- 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?
- Will you be using a birth control method that provides protection against sexually transmitted infections (STIs)?
- How important is it that you do not get pregnant (efficacy)?
- How quickly do you want to be able to return to fertility?

### **Informed Consent Specific to Contraceptive Management**

Assess the client's ability to provide consent for hormonal contraception.

- The Infants Act addresses several issues, including consent to health care for infants. Infants are defined as individuals under 19 years of age. The Act imposes certain obligations on nurses to obtain valid consent from an infant. In the circumstances described in the Act, an infant may give valid consent and it is not then necessary to obtain consent from the infant's parent or legal guardian.
- An infant's consent to health care is valid only if the health care provider has:

- explained to the infant and is satisfied that he or she understands the nature and consequences of the health care as well as the reasonably foreseeable benefits and risks; and
- made reasonable efforts to determine, and has concluded, that the health care is in the infant's best interests.

## 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, breastfeeding
- Assessment of menstrual patterns that might assist in determining possible benefits of hormonal contraceptive use
- Last normal 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 and the 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 (see Medical Eligibility in Appendix 2 for specific blood pressure measurement criteria).
- Blood pressure measurements should be repeated between 3-6 months following initiation of a combined hormonal contraceptive (CHC) and then at least annually thereafter (see Medical Eligibility in Appendix 2 for specific blood pressure measurement criteria).
- Blood pressure measurements should be evaluated at initiation of a POHC and then at least annually thereafter.
- A pelvic exam and a pap smear, 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 when initiating hormonal contraception and in situations of missed or late doses.
- Expense and accessibility can affect a woman's ability to use hormonal contraception effectively.
- Hormonal contraception does not offer protection from STIs or HIV/AIDS.
- 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.

## 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 (quickstart, Sunday start or 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., abdominal pain, chest pain, headache, eye problems and severe leg pain (ACHES))
  - method failure
  - hormonal contraceptive method problems
  - 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

## **BREASTFEEDING**

Progestin-only hormonal contraception is preferred for women who are breastfeeding. Estrogen and progestin are excreted in breastmilk in small quantities, but are unlikely to have an effect on the baby. If a combined hormonal contraceptive method is preferred, review the CHC DST.

## **DISPENSING AND ADMINISTRATION**

The dispensed hormonal contraceptive medication should be labelled with a patient-specific label. Labels can be pre-printed, but must be client specific and include the information as outlined in the [CRNBC Dispensing 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 CRNBC [Dispensing Practice Standard](#).

## **MONITORING AND FOLLOW UP**

- Recommend a follow-up visit between 3 – 6 months and annually after initiation or change in a hormonal contraceptive. This provides an opportunity to re-assess the client (for indicated BP measurements, client satisfaction, compliance, side effects, etc).

## **MANAGING SIDE EFFECTS**

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

- SOGC Clinical Practice Guidelines: Canadian Contraception Consensus (No. 143) (2004)
- Managing Contraception for Your Pocket (Zieman et al, 2012)
- Contraceptive Technology (20th ed.) (Hatcher et al, 2011)
- Consult with another health care provider for questions [e.g., RN(C), physician, nurse practitioner, pharmacist]

## REFERENCES

For help obtaining any of the items on this list, please contact CRNBC Helen Randal Library at [circdesk@crnbc.ca](mailto:circdesk@crnbc.ca)

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.

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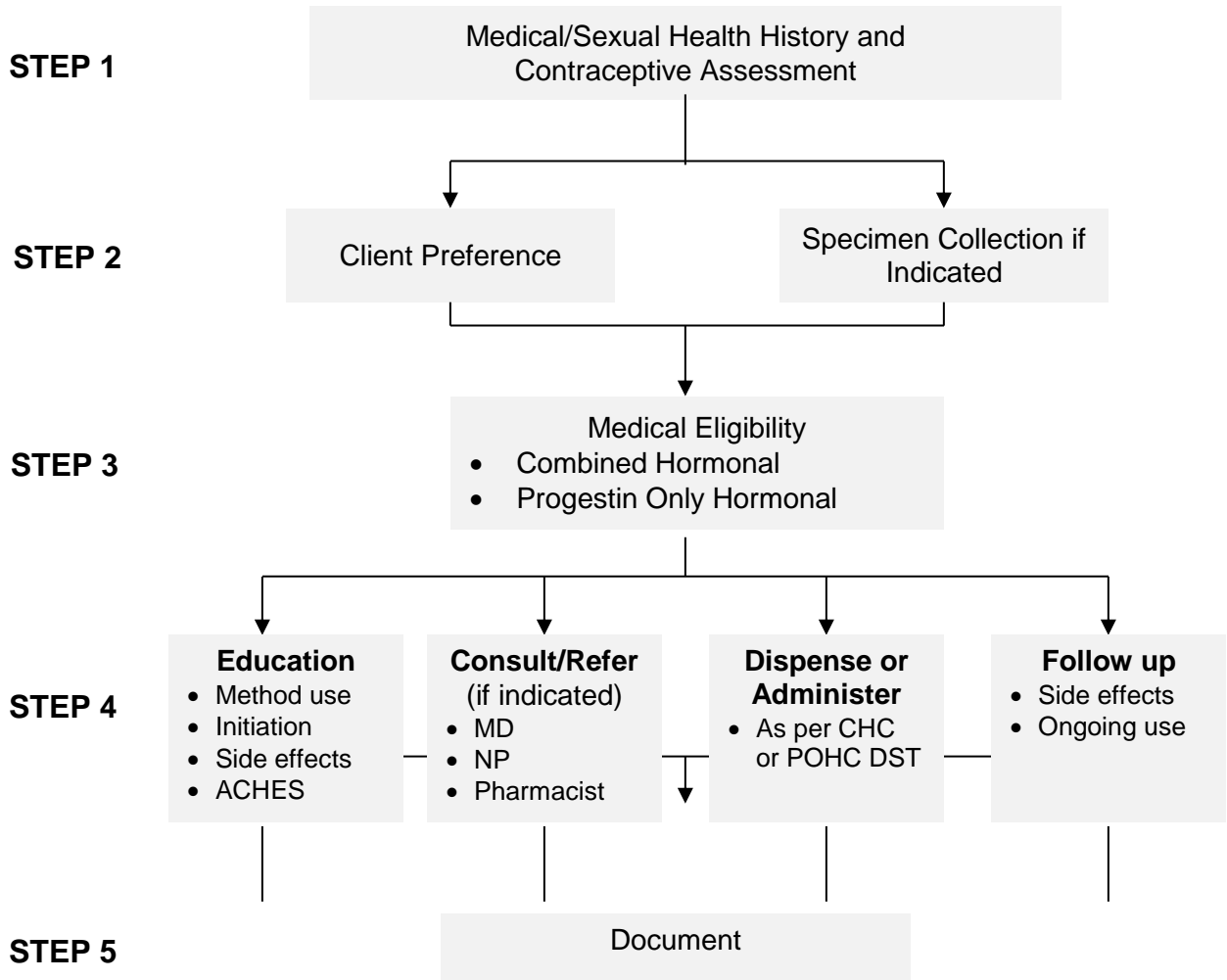
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- U.S. Centers for Disease Control and Prevention. (2010). *U.S. medical eligibility criteria for contraceptive use, 2010. Morbidity and Mortality Weekly Report*, 59(RR-4), 1-86. Retrieved from [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s\\_cid=rr5904a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s_cid=rr5904a1_w)
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**APPENDIX 1**

**Decision-Making Pathway for CM Certified Nursing Practice**



## **APPENDIX 2**

The chart provided on the next two pages is summary excerpt from the extensive United States Medical Eligibility Criteria for Contraceptive Use, 2010 (US MEC). Please access the following link for the complete and current information:

<http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm>



Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG-IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Inflammatory bowel disease	(Ulcerative colitis, Crohn's disease)	2/3*		2		2		1		1		1	
Ischemic heart disease‡	Current and history of	4		2	3	3		2	3	2	3	1	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	2		2		2		2		2		1	
	ii) Hepatocellular adenoma‡	4		3		3		3		3		1	
	b) Malignant‡	4		3		3		3		3		1	
Malaria		1		1		1		1		1		1	
Multiple risk factors for arterial cardiovascular disease	(such as older age, smoking, diabetes and hypertension)	3/4*		2*		3*		2*		2		1	
Obesity	a) ≥30 kg/m² body mass index (BMI)	2		1		1		1		1		1	
	b) Menarche to < 18 years and ≥ 30 kg/m² BMI	2		1		2		1		1		1	
Ovarian cancer‡		1		1		1		1		1		1	
Parity	a) Nulliparous	1		1		1		1		2		2	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		2		1		1		1		1	
Pelvic inflammatory disease	a) Past, (assuming no current risk factors of STIs)												
	(i) with subsequent pregnancy	1		1		1		1		1		1	
	(ii) without subsequent pregnancy	1		1		1		2		2		2	
	b) Current	1		1		1		4		2*		4	
Peripartum cardiomyopathy‡	a) Normal or mildly impaired cardiac function												
	(i) < 6 months	4		1		1		1		2		2	
	(ii) ≥ 6 months	3		1		1		1		2		2	
	b) Moderately or severely impaired cardiac function	4		2		2		2		2		2	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	1*		1*		1*		2		2		2	
	c) Immediately post-septic abortion	1*		1*		1*		4		4		4	
Postpartum (see also Breastfeeding)	a) < 21 days	4		1		1							
	b) 21 days to 42 days												
	(i) with other risk factors for VTE	3*		1		1		1					
	(ii) without other risk factors for VTE	2		1		1		1					
	c) > 42 days	1		1		1		1					
Postpartum (in breastfeeding or non-breastfeeding women, including post-cesarean section)	a) < 10 minutes after delivery of the placenta							2		2		1	
	b) 10 minutes after delivery of the placenta to < 4 weeks							2		2		2	
	c) ≥ 4 weeks							1		1		1	
	d) Puerperal sepsis							4		4		4	
Pregnancy			NA*		NA*		NA*		NA*		4*		
Rheumatoid arthritis	a) On immunosuppressive therapy	2		1		2/3*		1		2		1	
	b) Not on immunosuppressive therapy	2		1		2		1		1		1	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver‡	1		1		1		1		1		1	
Severe dysmenorrhea		1		1		1		1		1		2	
Sexually transmitted infections (STIs)	a) Current purulent cervicitis or chlamydial infection or gonorrhea	1		1		1		1		4		2*	
	b) Other STIs (excluding HIV and hepatitis)	1		1		1		1		2		2	

Condition	Sub-condition	Combined pill, patch, ring		Progestin-only pill		Injection		Implant		LNG-IUD		Copper-IUD	
		I	C	I	C	I	C	I	C	I	C	I	C
Sexually transmitted infections (cont.)	c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1		1		1		1		2		2	
	d) Increased risk of STIs	1		1		1		1		2/3*		2	
Smoking	a) Age < 35	2		1		1		1		1		1	
	b) Age ≥ 35, < 15 cigarettes/day	3		1		1		1		1		1	
	c) Age ≥ 35, ≥ 15 cigarettes/day	4		1		1		1		1		1	
Solid organ transplantation‡	a) Complicated	4		2		2		2		3		2	
	b) Uncomplicated	2*		2		2		2		2		2	
Stroke‡	History of cerebrovascular accident	4		2		3		3		2		3	
Superficial venous thrombosis	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial thrombophlebitis	2		1		1		1		1		1	
Systemic lupus erythematosus‡	a) Positive (or unknown) antiphospholipid antibodies	4		3		3		3		3		3	
	b) Severe thrombocytopenia	2		2		2		2		2*		3*	
	c) Immunosuppressive treatment	2		2		2		2		2		2	
	d) None of the above	2		2		2		2		2		1	
Thrombogenic mutations‡		4*		2*		2*		2*		2*		1*	
Thyroid disorders	Simple goiter/hyperthyroid/hypothyroid	1		1		1		1		1		1	
	a) Non-pelvic	1*		1*		1*		1*		1		1	
Tuberculosis‡ (see also Drug Interactions)	b) Pelvic	1*		1*		1*		1*		4		3	
										4		4	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	2*		2*		3*		3*		4*		2*	
Uterine fibroids		1		1		1		1		2		2	
Valvular heart disease	a) Uncomplicated	2		1		1		1		1		1	
	b) Complicated‡	4		1		1		1		1		1	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		2		2		2		1		1	
	b) Heavy or prolonged bleeding	1*		2*		2*		2*		1*		2*	
Viral hepatitis	a) Acute or flare	3/4*		2		1		1		1		1	
	b) Carrier/Chronic	1		1		1		1		1		1	

**Drug Interactions**

Antiretroviral therapy	a) Nucleoside reverse transcriptase inhibitors	1*		1		1		1		2/3*		2*	
	b) Non-nucleoside reverse transcriptase inhibitors	2*		2*		1		2*		2/3*		2*	
	c) Ritonavir-boosted protease inhibitors	3*		3*		1		2*		2/3*		2*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*		3*		1		2*		1		1	
	b) Lamotrigine	3*		1		1		1		1		1	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampicin or rifabutin therapy	3*		3*		1		2*		1		1	

I = initiation of contraceptive method; C = continuation of contraceptive method; NA = Not applicable

\* Please see the complete guidance for a clarification to this classification: [www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm](http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm)

‡ Condition that exposes a woman to increased risk as a result of unintended pregnancy.