Preconception counselling at long-acting contraception (LARC) removals

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Key Messages:

- Access to preconception care can improve health outcomes.
- Preconception advice can be quick and easy to deliver at LARC removals.
- Educating sexual health clinic staff on preconception health and having built-in templates for preconception advice can increase delivery of preconception advice.

Why was change needed?

Evidence shows that health before pregnancy has strong links to maternal and child health outcomes. Preconception health encompasses diet and nutrition, lifestyle (e.g. smoking/alcohol consumption) as well as awareness of vaccination and chronic health conditions in pregnancy, and wider issues such as domestic violence[1]. Access to preconception care when attending sexual and reproductive health (SRH) services is a key goal in the Faulty of Sexual and Reproductive Health's Hatfield Vision[2]. The Hatfield Vision is a framework which aims to improve women and girls' reproductive health in the United Kingdom of tackle the inequalities that they face in their reproductive outcomes. Working towards 2030, the Hatfield Vision sets out 16 goals and a series of actions to support those goals. Goal nine is that 'all women are offered comprehensive preconception care when they attend their contraception appointments in general practice, specialist SRH services and community gynaecology services'.

This intervention took place in a sexual health clinic in a large city which already had a built in 'preconception counselling' section in the patient record system (Figure 1). We wanted to ascertain whether staff were aware of it and the extent to which it was being used.

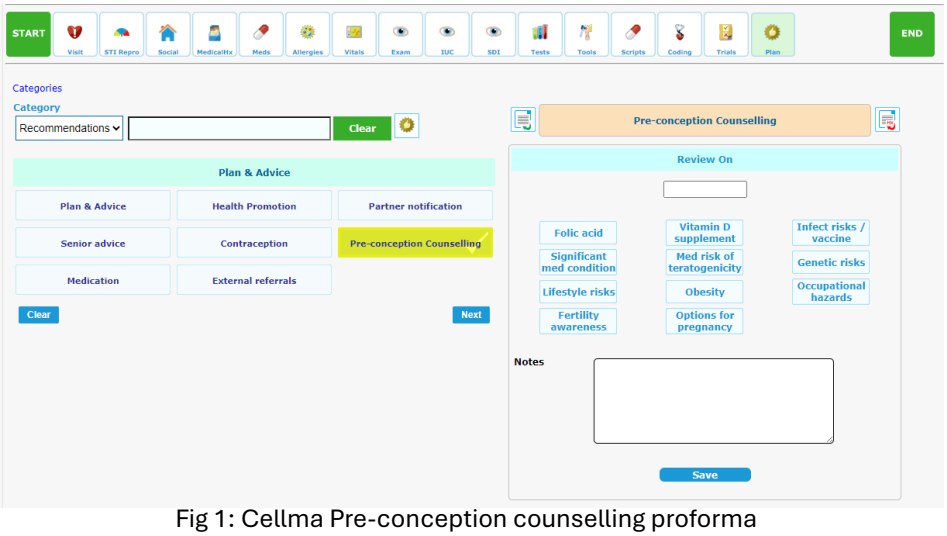


Fig 1: Cellma Pre-conception counselling proforma

An audit was undertaken over a two-month period (September-October 2022) looking at long-active reversible contraception (LARC) removals without reinsertion (levonorgestrel or copper intrauterine devices (IUD) and sub-dermal implants (SDI)). We reviewed 60 patients aiming for about 50% removing for conception and 50% for other reasons. The age range of the audited sample was 19-52 years old, and ethnicity was 48% white, 20% missing data, and 12% black. Of the 60 patients audited, 26 were removing LARC because they wanted to become pregnant and 34 were having it removed for other reasons.

Of the 26 wanting to conceive, 73% (n=19) had some record of preconception advice. In just over half of these (53%, n=10) this was written as free text in the record and in 47% (n=9) the template was used. Free text most commonly stated that a link had been sent to NHS pregnancy planning advice and did not detail the advice given in the consultation. When the template was used, on average three items were ticked (range two to four items); in all cases folic acid was selected.

Of the 34 patients removing LARC for other reasons, none had any record of preconception advice. Twenty of these patients went on to have no contraception or took condoms, 10 moved onto a short-acting contraceptive, three chose to switch to a different LARC. Two of these patients who switched to condoms, or a short-acting contraception were taking teratogenic medications.

How did you implement change?

To support an increase in preconception counselling at LARC removal all clinical staff were invited to attend a 20-minute talk followed by questions on preconception health and how to ask about pregnancy intention by an expert in the field in November 2022.

During this talk it was discussed that women attending sexual health clinics are usually open to being asked about pregnancy preferences and that preconception advice can be delivered during initial consultation or during LARC removal – this can be tailored to each consultation. For example, Hough et al discuss sensitively questioning around pregnancy intention and giving preconception health advice at LARC removal in their clinical consultations article. They describe the standard package of preconception care, as per the National Institute for Health and Care Excellence (NICE), as consisting of “diet and lifestyle advice, low-dose (400 µg/day)

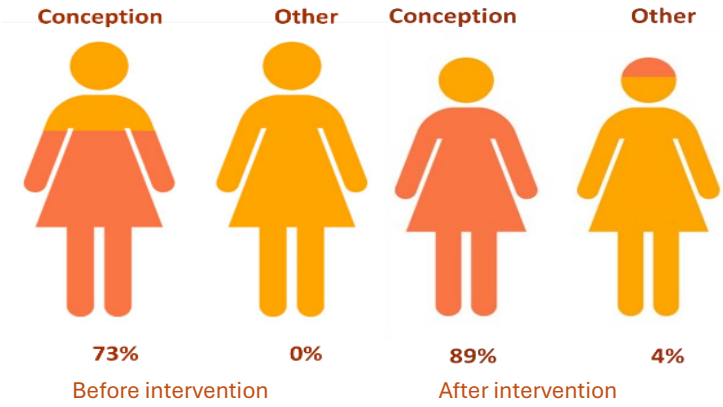
folic acid supplementation, discussion of interpregnancy intervals, and advising unprotected sexual intercourse every 2–3 days"[3,4]. Clinicians should also screen for significant medical conditions, medications or characteristics that require higher dose folic acid (5mg/day) or require GP or specialist preconception review as outlined in the NICE guidance[4]. If a review is required it would be advisable for the clinician to continue contraceptive cover until then, especially if the patient is taking teratogenic medications[3,4].

Staff were also given a demonstration of the use of the built-in template (Figure 1) on patient record system to serve as reminder for what to discuss when delivering preconception counselling in clinic. The built-in template makes it easier for clinicians to accurately document discussions and serves as a prompt to discuss all relevant preconception health topics with the patient.

Outcome of change:

We repeated the audit after the intervention for the period of January-March 2023. A further 60 patients were reviewed with 29 removing LARC for conception. Results showed an improvement (Figure 2), with to 89% of those 29 having documented preconception advice at LARC removal. Of those with documented advice 8% (n=2) were free text and 92% (n=24) used the template. This was a significant increase in template use from 47% to 92% ($p<0.001$). Furthermore, on average 3.5 items were ticked (range 1-10 items) suggesting an increase in the comprehensiveness of advice given.

Fig 2: Percentage of patients having LARC removals who received pre-conception counselling.



Post-intervention there was also one patient of the 31 having LARC removal for other reasons than conception who had preconception advice given. Of these 31 patients 17 moved on to no contraception or took condoms, 9 moved onto a short-acting contraceptive, five switched to an alternative LARC. Again, two patients who switched to condoms or short acting methods were on teratogenic medications.

While we did not audit individual clinician's practice, in both audit and re-audit periods most consultations (65-73%) were conducted by nurses (Bands 5-7) and the remainder by doctors (registrars, consultants, clinical fellows or Speciality and Associate Specialist (SAS) doctors). By

comparison, the clinics' staff distribution has Band 5-7 nurses making up roughly 53% of clinicians and the rest doctors.

Advice for those implementing change:

- Create a template for preconception advice in your patient record if possible.
- Deliver teaching sessions on preconception care, especially for those who will be removing LARCs or doing contraception clinics.
- Include advice on how to incorporate this counselling into clinic sessions.

In conclusion, using the template led to an increase in and more complete documentation of preconception advice. These findings were presented to the whole clinic again in December 2023 and it was suggested that preconception teaching and information about the template should be included in induction for all new clinical staff. Staff were also encouraged to consider how to incorporate preconception advice into other contraception appointments and were made aware of online resources to direct patients to (see Box) and of the NICE Clinical Knowledge Summary on Preconception Health[4].

https://www.tommys.org/pregnancy-information/planning-a-pregnancy

https://www.contraceptionchoices.org/did-you-know/thinking-having-baby

https://www.nhs.uk/pregnancy/trying-for-a-baby/planning-your-pregnancy/

Box 1: Useful preconception resources for patients

References:

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2. FSRH (2022) Faculty of Sexual and Reproductive Healthcare Hatfield Vision: A Framework to Improve Women and Girls' Reproductive Health Outcomes url:https://www.fsrh.org/documents/fsrh-hatfield-vision-july-2022/
3. Hough, A., Kavanagh, J. and Pathak, N. (2024) 'Sexual and reproductive health clinical consultations: Preconception Care', BMJ Sexual & Reproductive Health [Preprint]. doi:10.1136/bmjsrh-2024-202361.
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