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Management and Care of Pregnant and Postnatal Women

Policy Number 1.430

Policy Function Continuum of Care

Issue Date 9 September 2022

Summary This policy provides Justice Health and Forensic Mental Health Network staff the appropriate direction in identifying the pregnancy status of women entering custody or the Forensic Hospital; and guidelines for providing antenatal and postnatal care for pregnant and postnatal women in custody and the Forensic Hospital.

Responsible Officer Executive Director Clinical Operations

Applicable Sites
☐ Administration Centres
☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
☒ Health Centres (Adult Correctional Centres or Police Cells)
☒ Health Centres (Youth Justice Centres)
☒ Long Bay Hospital
☒ The Forensic Hospital

Previous Issue(s) Policy 1.430 (Dec 2017, May 2014, Mar 2009)

Change Summary

- Comprehensive review and update of document to align with NSW Health and the Network policies and procedures
- Inclusion of private correctional centres for the management and care of pregnant and postnatal women in their care
- Inclusion of Aboriginal Health Worker in management of Aboriginal and/or Torres Strait Islander women or women who are giving birth to Aboriginal and/or Torres Strait Islander babies

TRIM Reference POLJH/1430

Authorised by Chair, Policy Steering Committee

1. Preface

Pregnancy, labour, birth and parenting are significant and meaningful life events and women have the right to access comprehensive maternity care whilst in custody or the Forensic Hospital. Justice Health and Forensic Mental Health Network (the Network) staff aim to follow best practice guidelines to assist in providing pregnant and early postnatal women with the best possible midwifery-led maternity care.

Women entering custody or the Forensic Hospital often have complex health co-morbidities which include drug and alcohol misuse, complex obstetric history, mental health issues and/or pre-existing medical conditions. The Network provides women-centred, midwifery-led maternity care and delivers this care with equality, respect and professionalism. Women are supported to make informed decisions about their care for themselves and their babies in partnership with the Network Midwifery Program (hereafter the Midwives) and other health care professionals, both internal to the Network and external stakeholders.

This policy applies to the Forensic Hospital (FH), Long Bay Hospital (LBH) and all custodial centres including Youth Justice Centres (YJC) where women are accommodated within the Network and privately operated correctional centres.

2. Policy Content

2.1 Mandatory Requirements

- All women entering custody or the FH must be offered testing for pregnancy via a beta human chorionic gonadotropin (BHCG) urine test at the time of reception screening. If the woman refuses a BHCG urine test, counselling must be offered and this must be documented in Justice Health electronic Health System (JHeHS).
- All women must have the BHCG urine test offered 28 days after entering custody or the FH to ensure that all false negative results are checked. If the woman refuses this BHCG test, counselling must be offered and this must be documented in JHeHS.
- This policy requires that all pregnant women to have a comprehensive primary health care assessment including medical, obstetric, psychosocial, sexual health, and drug and alcohol history, consistent with the SAFE START model as mandated by NSW Health PD2010_017 *Maternal and Child Health Primary Health Care Policy*.
- All pregnant women are discussed within four hours of entering custody or FH with the Remote On-Call Afterhours Medical Service (ROAMS) – Drug and Alcohol on **1300 076 267** (13000 ROAMS) due to the potential risks that substance withdrawal may have on the unborn baby. Drug and Alcohol service provides 24 hour clinical consultation across the state via the ROAMS.
- On-call Adolescent Psychiatrist (During Business Hours) or ROAMS – Psychiatry (After Hours) provide Drug and Alcohol service for adolescents entering YJC and must be contacted for advice within four hours of Adolescent Health Initial Assessment/Update for all positive pregnancies (Staff must check roster of on-call adolescent psychiatrist for preferred mode of contact).
- This policy requires that all maternity care provided refers to the Australian College of Midwives (ACM) *National Midwifery Guidelines for Consultation and Referral* as per NSW Health

PD2020_008 *Maternity - National Midwifery Guidelines for Consultation and Referral*. The use of these guidelines informs clinical decision-making and supports the Midwives to make appropriate referrals for consultation to other clinicians and allied health staff for pre-existing and/or new co-morbidities that may develop in pregnancy.

2.2 Implementation - Roles & Responsibilities

Nurse Manager Adolescent and Maternal Services is responsible for providing strategic and operational oversight of this policy.

Midwives are responsible for the management and care of the antenatal and postnatal women including adolescents and those located at the FH and LBH.

Clinical Director Primary Care is responsible for ensuring that all Primary Care clinicians comply with this policy.

Nurse Managers/Nursing Unit Managers (NM/NUM) are responsible for ensuring that all nursing staff comply with this policy.

All clinical staff are responsible for awareness of and compliance with this policy.

Clinical Director Forensic and Long Bay Hospitals (CDFLBH) is the 'medical superintendent' of the FH and LBH (by appointment under s111 of the MH Act) for the purposes of the MH Act and the MHFP Act, and is responsible for ensuring that all medical staff comply with this policy.

3. Procedure Content

The Network aims to:

- Provide staff with a clinical pathway to determine pregnancy status and referral process.
- Define the process for the care of pregnant and postnatal women in custodial and forensic environment.
- Provide up to date information regarding choices relating to the care of the woman and her baby.
- Provide midwifery-led continuity of care for the pregnant and postnatal women.
- Provide culturally appropriate, evidence based maternity care to all pregnant and postnatal women.
- Liaise with all relevant stakeholders for consultation and referral.

3.1 Reception to the Custodial System or admission to the FH

All women entering custody or the FH must be tested for pregnancy via urine BHCG pregnancy test. This should be done within 24 hours for adults and 48 hours for adolescents wherever possible in accord with the Network Policy 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* and Policy 1.036 *Health Assessments (Adolescents)*.

The Reception Screening Assessment (RSA) / Adolescent Health Initial Assessment in JHeHS is undertaken to obtain an initial history and to identify current and past medical conditions. This includes assessments for pregnancy, substance use including alcohol or other drugs, mental health,

women's health, sexual health and infectious diseases. Any recent medications including opioid agonist therapy (OAT) should be noted and relevant stakeholders contacted to review ongoing prescribing.

Clinical procedures that must be considered in pregnancy and postnatal care are:

- Notification of pregnancy status in JHeHS via adding the health condition 'pregnant'.
- Prompt assessment and referral to Drug and Alcohol service, this is provided by the ROAMS – Drug and Alcohol for adults and On-call Adolescent Psychiatrist (During Business Hours) or the ROAMS – Psychiatry (After Hours) for adolescents.
- Referral to the Midwives via waitlist on Patient Administration System (PAS) & email JHFMHN-Midwife@health.nsw.gov.au
- Identify consultation and referral pathways relevant to women's physical and mental health.
- Mandatory reporter guide are accessible, if notification to the Department of Communities and Justice (DCJ) formally known as Family and Community Services (FaCS) is required.

3.1.1 Assessment of Pregnancy

To facilitate prompt implementation of a management plan, it is important that assessment of pregnancy and referrals are made as soon as practicable following admission to custody or the FH.

- The possibility of pregnancy must be considered for all women entering custody or the FH. Assessment should include urinalysis for BHCG, consider requirement for BHCG blood test and supporting documentation sought from community health providers.
- If the initial pregnancy test is negative, a second pregnancy test must be completed 28 days later. A PAS wait list entry must be made to schedule the 28 day second pregnancy test by the nurse conducting the RSA/ Adolescent Health Initial Assessment.

3.1.2 Confirmed pregnancy

All pregnant women in custody or the FH are considered women with complexities. This is due to the co-morbidities such as poor health status, a high incidence of alcohol and other drug use, complex social situations and/or mental health history.

To facilitate timely and coordinated care upon confirmation of pregnancy the following must be considered in providing antenatal care:

- Notification of pregnancy status must be logged as a 'pregnant' health condition in JHeHS for all pregnant women.
- Drug and Alcohol service must be contacted for advice within four hours of all positive pregnancy tests. This is provided by the ROAMS – Drug and Alcohol for adults and On-Call Adolescent Psychiatrist (During Business Hours) or ROAMS – Psychiatry (After Hours) for adolescents. Prompt referral to Drug & Alcohol service is required to assess effects of substance use on the woman and her unborn baby, e.g. substance intoxication or withdrawal, and commence/adjust OAT.
- The Midwives must be notified of all pregnant women in custody throughout NSW and the FH. The Midwives have a comprehensive understanding of normal pregnancy, labour, birth and postnatal period with the knowledge to recognise deviations from normal.

- For the medications and complementary therapies used in pregnancy, information can be obtained via the Network Pharmacy Department on 9700 3888 and/or MotherSafe. MotherSafe is a free telephone service for the women in NSW. It provides a comprehensive counselling service for women and their healthcare providers concerned about exposure during pregnancy and breastfeeding including prescription drugs, over-the-counter medications, non-prescribed substances (e.g. illicit drugs), infections, radiation and occupational exposure.
- Review current immunisation status and recommend vaccination as required.
- Referral to the Corrective Services New South Wales (CSNSW) Mothers and Children's Program; this is generated automatically once the 'pregnant' alert is added into JHeHS.
- Primary health care assessment must include a systematic exploration of all health domains including, but not limited to:
    - Physical health
    - Medical and obstetric history
    - Substance use
    - Mental health history
    - Child protection history
    - Domestic violence
    - Support networks
    - Stolen generation experiences

3.2 Pregnant Women in Rural Correctional Centres

In rural centres, the Midwives are responsible for the co-ordination of antenatal care of pregnant women in consultation with the NUM.

The Midwives must be notified of all pregnant women in custody throughout NSW. The NUM/delegate is responsible for liaison with the Midwives when pregnancy is confirmed by email JHFMHN-Midwife@health.nsw.gov.au

Arrangements for transfer to a metropolitan correctional centre in Sydney should start as soon as practicable after reception and the women must be transferred by 20 weeks pregnant.

For women entering custody after 20 weeks pregnant, transfer must happen as soon as practicable.

If the woman needs to remain in the rural centre for upcoming court dates then the care is coordinated by the Midwives or General Practitioner (GP) if the Midwives are unavailable, in consultation with the NUM/delegate.

Handover must occur to the Midwives for all pregnant women transferring to the metropolitan correctional centres in Sydney from the rural centres using the Midwives generic email JHFMHN-Midwife@health.nsw.gov.au

If a pregnant woman goes into labour while still in the rural centre, then she must be transferred to the nearest hospital that provides maternity services. The care of the woman during labour and birth is provided by the hospital staff.

The NUM/delegate must notify the Midwives when a woman is in labour and has been transferred to hospital via email.

Note: From 20 weeks pregnant onwards, staff must complete a special transport form and place an alert on PAS (see Transport of Pregnant Women)

3.3 Pregnant Women in the Forensic Hospital and Long Bay Hospital

The Midwives must be notified of any pregnant women admitted to the FH and LBH via PAS waitlist. In addition to the mandated PAS referral pathway, the NUM/delegate should also refer directly to the Midwives by email JHFMHN-Midwife@health.nsw.gov.au

The Midwives are responsible for the co-ordination of antenatal care of pregnant women who are admitted to the FH and LBH in consultation with the NUM/delegate.

In the FH, CDFLBH, Director of Nursing, Deputy Director of Nursing within office hours and After Hours Nurse Manager outside business hours must be notified by the NUM/delegate of all pregnant females as soon as practicable after admission or subsequent confirmation of pregnancy.

In the LBH, CDFLBH and Operational Nurse Manager must be informed by the NUM/delegate.

3.4 Pregnant Women in Private Correctional Centres

The Network do not take responsibility of the management and care of the pregnant and postnatal women received into custody in private correctional centres. The care is provided by the private correctional centre and follows the Network policy for the management and care of pregnant and postnatal women.

All pregnant women must be transferred to a Sydney metropolitan correctional centre as per the women's classification. Arrangements for transfer to a metropolitan correctional centre in Sydney should start as soon as practicable after reception and the women must be transferred by 20 weeks pregnant.

For women entering custody after 20 weeks pregnant, transfer must happen as soon as practicable.

Handover must occur to the Network Midwives for all pregnant women transferring to metropolitan correctional centres in Sydney from private correctional centres using generic email JHFMHN-Midwife@health.nsw.gov.au

Note: From 20 weeks pregnant onwards, staff must complete a special transport form and place an alert on PAS (see Transport of Pregnant Women)

3.5 Release of Information

The 'pregnant' health condition in JHeHS is automatically transferred to the Offender Incident Management System (OIMS) and the Client Incident Management System (CIMS).

A signed consent for release of information (ROI) is required prior to notifying the CSNSW and Youth Justice New South Wales (YJNSW) of any matters related to pregnancy other than routine notification.

A ROI from pregnant women must be completed and sent to previous health care providers as soon as practicable. Refer to the Network Policy 4.030 *Requesting and Disclosing Health Information* and *Guidelines on the use and disclosure of inmate/patient medical records and other health information.*

With the consent of the pregnant woman, staff may maintain ongoing engagement with the designated carer and/or family and significant others, where appropriate. Staff must comply with section 3.1 of the Network Policy 2.010 *Code of Conduct*.

3.6 Antenatal Care

Pregnant women in custody are usually accommodated at Silverwater Women's Correctional Centre (SWCC), Dillwynia Correctional Centre (DCC) or Emu Plains Correctional Centre (EPCC) and adolescent females at Reiby Youth Justice Centre (YJC).

Continuity of midwifery care is provided by the Midwives for all pregnant women in custody within Sydney metropolitan area, including Reiby YJC, and the FH and LBH.

In rural centres, the Midwives are responsible for the co-ordination of the antenatal care in consultation with the NUM/delegate.

Women's medical and obstetric history is assessed using the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* as per NSW Health PD2020_008 *Maternity - National Midwifery Guidelines for Consultation and Referral*.

Care is provided in a midwifery-led multidisciplinary team approach, this includes the Network Midwives, GPs, drug and alcohol clinicians, mental health clinicians, primary health nursing staff and relevant other speciality clinicians together with obstetricians, paediatricians, midwives and social workers from the hospital where women are booked for pregnancy care.

The Network has collaborative arrangements with the participating public hospitals to provide care for the pregnant women for medical episodes, obstetric consultation, and care for the birth and immediate postnatal period.

- Pregnant women from **Silverwater Women CC** are to be transferred to the **Westmead Hospital**
- Pregnant women from **Emu Plains CC** and **Dillwynia CC** are to be transferred to the **Nepean Hospital**.
- Adolescent pregnant female from **Reiby YJC** are to be transferred to the **Campbelltown Hospital**.
- Pregnant Women from the **Forensic Hospital** and **Long Bay Hospital** are to be transferred to the **Royal Hospital for Women**

3.7 Routine Antenatal Care Schedule

3.7.1 Antenatal Appointment Schedule

Gestational Period	Appointment Frequency	Roles and Responsibilities
Up to 28 weeks	Monthly appointments	Appointments with the Midwives or local hospital's Antenatal Clinic
28 – 36 weeks	Fortnightly appointments	
After 36 weeks	Weekly appointments	

3.7.2 Pathology Schedule

Gestational Period	Pathology		Roles and Responsibilities
Initial Pathology	• Blood group (BG) and antibodies (Ab) • Full Blood Count (FBC) • Hepatitis B, Hepatitis C and HIV (*if known Hep C positive include:* Hep C RNA*)* • Rubella and Syphilis • Liver function test • Vitamin D level • Iron Studies • MSU for asymptomatic bacteriuria • Urine PCR for Gonorrhoea and Chlamydia		The Midwives and GP to order and review the pathology (to order in JHeHS choose Organisational Order Set – Pregnancy: Initial screening and add Miscellaneous test for BG and Ab) Must use Pink Blood Bank Form for BG and Ab and hand write on the Pink tube
	• GTT/Fasting BGL and Hba1C (if unable to obtain GTT)		The Midwives or GP to assess for GDM risk
	• Nuchal Translucency (NT) Pathology: Optimal timing of screening is 10-11 weeks, otherwise before the NT ultrasound. — PAPP-A — BHCG		Woman's weight and gestational age at collection to be written on the NT form (Add Miscellaneous test for PAPP-A)
	• High Vaginal Swab (HVS): (Only for women with a previous preterm birth)		HVS is to be collected by the Women's Health Nurse Practitioner, GP or clinical staff that have undergone training.
24 – 28 Weeks	• Antibody screen (for Rh negative women only) • FBC • GTT/Fasting BGL and Hba1C (if unable to obtain GTT) • Iron Studies if low at first pathology or if symptomatic	Anti D is given to women who are Rh negative at 28 & 34 weeks.	The Midwives or GP to order and review the pathology (to order in JHeHS choose Organisational Order Set – Pregnancy: 24-28 Weeks Test and add Miscellaneous test for Ab) Must use Pink Blood Bank Form for BG and Ab and hand write on the Pink tube
36 weeks	• Low vaginal swab for Group B Strep		Self-collected with instruction from the Midwives.

3.7.3 Ultrasound Schedule

Gestational Period	Ultrasound Type	Roles and Responsibilities
First visit	Dating ultrasound	Referrals made by the Midwives or GP. The Midwives and GP to review ultrasound report.
11 – 13+6 Weeks	Nuchal Translucency ultrasound	
18 – 20 weeks	Morphology ultrasound	
32 – 34 weeks	Fetal Wellbeing ultrasound	

3.8 Pregnancy Care Guidelines

The Pregnancy Care Guidelines are designed to support Australian maternity services to provide high-quality, evidence-based antenatal care to healthy pregnant women. They are intended as a standard reference for health professionals who contribute to antenatal care, including midwives, obstetricians, general practitioners, Aboriginal and Torres Strait Islander health workers and allied health professionals.

The recommendations in this guidelines cover a wide range of care including routine physical examinations, screening tests and social and lifestyle advice for pregnant women with uncomplicated pregnancies.

3.9 Pregnancy Choices

Pregnant women in custody and the FH have the same right to choices as they would have in the community. It is essential to recognise that many women are likely to be in an emotional crisis at the time of incarceration. Where possible they should be given opportunity to liaise with their partner, family and/or a counsellor.

A request for termination of pregnancy must be assessed in a supportive and non-judgemental manner whilst maintaining strict confidentiality and a high level of professionalism. The request for termination of pregnancy should be facilitated in accordance with NSW Health PD2021_018 *Framework for Termination of Pregnancy in New South Wales*. All women requesting a termination of pregnancy should be reviewed by the Midwives and/or GP as priority to discuss and facilitate the request. A PAS appointment with the Perinatal Infant Mental Health Service (PIMHS) Clinical Nurse Consultant (CNC) or mental health clinician should be booked. The Midwives must continue to support the women as part of the multidisciplinary team.

Parental or legal guardian consent for a termination of pregnancy needs to be obtained if the pregnant adolescent is less than 14 years of age, or under the care of DCJ. Consider parental or legal guardian consent for females less than 16 years of age. See the Network Policy 1.085 *Consent to Medical Treatment – Patient Information* & NSW Health IB2020_010 *Consent to Medical and Healthcare Treatment Manual*.

In NSW, women can request a termination of pregnancy up until 22 weeks of pregnancy (unless medically indicated thereafter). On occasions, accessing a publicly funded termination of pregnancy is restricted, privately funded termination of pregnancy can be considered on an individual basis. The Network may agree to pay for the privately funded termination of pregnancy in consultation with the relevant stakeholders such as the Midwives, GP, NUM, NM Adolescent Health and Maternal Services and CDFLBH.

The Network doesn't support termination of pregnancy requested solely for the purpose of sex selection, unless not performing the termination will cause significant risk to the woman's health or safety in accordance with NSW Health GL2021_008 *Prevention of Termination of Pregnancy for the Sole Purpose of Sex Selection*. Before or after a referral for the termination of pregnancy is made, it may be disclosed by the woman that her reason for the request is for the sole purpose of sex selection. If this is the reason for the request, the staff who collected this information must notify the NUM immediately. The NUM must discuss this with the Midwives and arrange an urgent review before the planned termination date. Any decision either to support or refuse a termination should be made in consultation with the relevant stakeholders such as the Midwives, GP, PIMHS, NUM, NM Adolescent Health and Maternal Services and CDFLBH. When a termination for the sole purpose of sex selection is refused, the woman must be offered additional support and referral to counselling or other relevant services.

When transferring women out for termination of pregnancy procedure, nursing staff must:

- Provide comfort and appropriate compassion
- Advise the women to take clean underwear and warm socks
- Provide women with sanitary pads

Following a termination of pregnancy appointment, the Network clinician must follow aftercare instruction provided by the service provider. This may include post procedure written instructions and a list of telephone numbers that the women can call for ongoing support if required. It is important that this information is provided to and received by the women and that they are aware of the support services they can access. Nursing staff must request this information from the external service provider if it is not already sent with the women.

After the termination of pregnancy, PAS appointments are booked for primary health nurses to access each day for 5 days to check on the women's physical and psychological wellbeing in addition to instruction provided by the service provider. The NUM/delegate is responsible to ensure this follow up happens and women are offered post termination support and counselling. If the women refuse this service it must be clearly documented in JHeHS.

The Midwives must follow up with the women after the procedure and waitlist the women to the GP to hand back to primary care as they are now no longer pregnant. The Midwives may also create a waitlist to Women's Health Nurse Practitioner for adult women for counselling, cervical screening and contraception if needed.

3.10 Early Pregnancy Loss

In an event of suspected spontaneous pregnancy loss under 20 weeks, women may be transferred to the Emergency Department of local public hospital after consultation with the Midwives or GP. Symptoms of potential pregnancy loss may include:

- Fluid, blood or tissue passing from the vagina and/or
- Period like pain in the lower abdomen or lower back

The Midwives and/or ROAMS – Primary health must be contacted for notification and further advice.

For additional information, staff may refer to NSW Health PD2012_022 *Maternity – Management of Early Pregnancy Complications* for guidance relating to the clinical and psychological management of early pregnancy loss.

Possibility of ectopic pregnancy must be considered for all women who present with pain and bleeding in early pregnancy where location of pregnancy is unknown. Pregnancy of unknown location can be defined when serum BHCG is positive i.e. > 5 IU/L and transvaginal ultrasound indicates no sign of either intra or extra uterine gestation or evidence of retained products of conception.

Consideration needs to be given to a lower threshold for admission to hospital for pregnant women who present with pregnancy complication in second trimester to ensure that such clinical and psychological needs can be met.

After a diagnosis of early pregnancy loss, PAS appointments are booked for primary health nurses to access each day for 5 days to check on the women's physical and psychological wellbeing in addition to any instruction provided by the hospital if the woman was transferred to hospital. The NUM/delegate is responsible to ensure this follow up happens and women are offered appropriate support and counselling. If the women refuse counselling it must be clearly documented in JHeHS.

The Midwives must follow up with the women after the early pregnancy loss and waitlist the women to the GP to hand back to primary care as they are now no longer pregnant. The Midwives may also create a waitlist to Women's Health Nurse Practitioner for adult women for counselling, cervical screening and contraception if needed.

3.11 Documentation of Observations

In the Network, general observations for a maternity woman must be recorded on the NSW Health *Standard Maternity Observation Chart* (SMOC) for all women of 20 weeks gestation and over, up to 6 weeks (42 days), post-partum. The SMOC contains criteria for early recognition of the deteriorating pregnant women as a 'safety net' to protect them from ongoing deterioration and to ensure they receive appropriate and timely care if and when required.

- For all 'Red Zone' observations, women may be transferred to an acute care facility via ambulance
- For all 'Yellow Zone' observations, it must be escalated the ROAMS – Primary health for immediate advice and the Midwives by email JHFMHN-Midwife@health.nsw.gov.au
- Document in JHeHS contemporaneously and log on PAS

The *Standard Adult General Observations* (SAGO) or the *Standard Paediatric Observational Chart* (SPOC) must not be used for pregnant women.

The SMOC is not used for the routine antenatal care provided by the Midwives. Routine antenatal care (including observations) will continue to be documented in JHeHS and on the *NSW Health Antenatal Care Record* (also referred to as the 'Yellow Card') which is kept with the health record.

Primary Health Staff need to complete routine weekly observations and document on SMOC for pregnant women over 35 weeks.

3.12 Vitamin Supplements for Pregnant Women

Vitamin supplements are important for pregnant women due to the dietary limitations associated with being in a custodial environment. The following supplements must be charted as soon as practicable:

- Folic acid 500mcg once daily up to 14 weeks pregnant (Elevit which also contains folic acid)
- Iodine 150mcg once daily (Elevit which also contains iodine)
- Vitamin C 500mg once daily
- Iron & Vitamin D (as required, only when antenatal pathology results indicate deficiency)

3.13 Prevention of Venous Thromboembolism

Venous thromboembolism (VTE) involves the formation of a blood clot within the deep veins, most commonly of the legs or pelvis (deep venous thrombosis i.e. DVT). These blood clots may become dislodged and then obstruct the pulmonary artery or one of its branches (pulmonary embolism). All pregnant women must undergo VTE risk assessment as soon as practicable during the antenatal period. This is undertaken by the Midwives or the hospital women are booked for pregnancy care.

The VTE Risk Assessment Tool is used to assess and identify all pregnant women at risk of VTE. If the woman is at intermediate or high risk of VTE, she must be referred to the obstetric clinic at the local hospital for thromboprophylaxis. For more information please refer to NSW Health PD2019_057 *Prevention of Venous Thromboembolism.*

3.14 Vaccinations during Pregnancy

The need for vaccination during pregnancy should be assessed as part of the routine antenatal assessment undertaken during the antenatal period. Seasonal Influenza and dTpa (diphtheria – tetanus-acellular pertussis) are the only vaccines to be given routinely during pregnancy.

The influenza vaccine is recommended in every pregnancy and can safely be given at any stage during pregnancy. It is best given before the influenza season starts, however, it can be given at any time during the year. This will provide protection to the mother and baby when it is born.

Whooping cough (pertussis) vaccine is recommended as a single dose between 20 and 32 weeks in each pregnancy.

Hepatitis B vaccine can be offered to pregnant women who are non-immune and are at an increased risk of exposure to Hepatitis B.

mRNA COVID-19 vaccines (Pfizer or Moderna) are the recommended vaccines in pregnancy. There are substantial data on their safe use in pregnancy.

Refer to The Australian Immunisation Handbook for more information.

Prior to administering any vaccinations to pregnant women, staff should refer to the Network Policy 1.245 *Immunisation of Patients* for procedures on serological screening, immunity of pregnant women and post-delivery vaccination.

3.15 Rh negative pregnant women & Rh D Immunoglobulin (Anti-D)

Rh D immunoglobulin is used to protect against Haemolytic Disease of the Newborn, which can potentially occur in babies born to women with rhesus (Rh) (D) negative blood. Rh (D) Immunoglobulin is used as a prophylaxis treatment and/or treatment for potential sensitising events for Rh (D) negative women who are pregnant or recently pregnant (up to 10 days post pregnancy cessation).

1. All pregnant women should be typed for ABO and Rh (D) as early as possible during each pregnancy and preferably at the first antenatal appointment
2. All Rh (D) negative women should have an antibody screen around 28 weeks prior to administering Rh D immunoprophylaxis

3.15.1 Antenatal Prophylaxis

All Rh (D) negative women (who have not actively formed their own anti-D antibodies) are given 625 IU Rh D immunoglobulin at weeks 28 and 34 weeks gestation.

If Rh D immunoglobulin was given for a potentially sensitising event, antenatal prophylaxis doses should still be given.

In the event of potentially sensitising events –

In the first trimester (less than 12 weeks):

- Single pregnancies: 250 IU Rh D immunoglobulin.
- Multiple pregnancies (i.e. Twins): 625 IU Rh D immunoglobulin.

In the second and third trimester:

- 625 IU Rh D immunoglobulin with additional doses as indicated from the results of assessment of the extent of fetomaternal haemorrhage

3.15.2 Potentially Sensitising Events

- ectopic pregnancy
- miscarriage
- termination of pregnancy
- ultrasound guided procedures such as chorionic villus sampling, amniocentesis, cordocentesis and fetoscopy
- abdominal trauma considered sufficient to cause fetomaternal haemorrhage
- external cephalic version
- antepartum haemorrhage (PV bleeding during pregnancy)
- birth

In the event of potentially sensitising events during the first trimester of pregnancy, Rh D immunoglobulin should be administered as soon as possible after the sensitising event and always within 72 hours. If Rh D immunoglobulin has not been offered within 72 hours, a dose offered within 9-10 days may provide protection.

In the event of potentially sensitising events that occur after the first trimester, blood should be taken prior to the administration of Rh D immunoglobulin to determine the extent of possible fetomaternal haemorrhage. Additional doses of Rh D immunoglobulin should be administered as indicated from the results of testing.

3.15.3 Consent or decline to the administration of Rh D immunoglobulin

Informed consent for medical treatment including a clear explanation of the risks and benefits when receiving Rh D immunoglobulin must be obtained using the NSW Health consent form. The same form is used if the woman declines the Rh D immunoglobulin.

See the Network Policy 1.085 *Consent to Medical Treatment – Patient Information* & NSW Health IB2020_010 *Consent to Medical and Healthcare Treatment Manual*.

All Rh negative women must be given the pamphlet: You & Your Baby: Important information for Rh (D) Negative Women.

For further guidance on the management of Rh negative women who are pregnant, staff should refer to NSW Health GL2015_011 *Maternity – Rh (D) Immunoglobulin (Anti D).*

3.16 Release Planning

When pregnant women are released prior to giving birth, they require a comprehensive handover of antenatal care to community providers such as hospital antenatal clinics, Aboriginal Medical Services (AMS), Aboriginal Maternal & Infant Health Services (AMIHS) and GP's. Within Sydney metro, this is done by the Midwives. In rural centres, this is the responsibility of the NUM in consultation with the Midwives.

Release plans are recorded in JHeHS by generating a *Release Summary and Transfer of Care* eform.

For women on OAT, a community dosing point and prescriber must be found prior to their release. Women with Drug and Alcohol issues need to be linked into Drugs in Pregnancy Services. Sentenced women with substance use disorder and on OAT must be referred to the Connections Program or the Community Integration Team (CIT). This is the responsibility of Substance Use in Pregnancy Coordinator (SUPC). Patients on OAT should be offered take home naloxone (Nyxoid nasal spray) prior to release.

On occasions, pregnant women are released unexpectedly and there is little time for release planning. The Midwives and SUPC must be notified of their release to arrange community follow up.

3.17 Transport of Pregnant Women

Transport arrangements must be suitable for the individual pregnant woman.

From 20 weeks pregnant onwards, staff must complete a special transport form and place an alert on PAS.

Air transport may be restricted after 36 weeks gestation; this restriction and alternatives are considered in conjunction with the Network Midwives and/or GP.

Note: Pregnant women >20 weeks must not be transported in a CSNSW/YJNSW truck and must have special transport arrangements for any travel needs.

3.18 Escalation, Transfer to and Return from Hospital procedure

The Midwives or On-Call ROAMS – Primary health (if Midwives unavailable) must be contacted for notification and further advice for **ALL** pregnant and postnatal women requiring escalation, transfer to and return from hospital (metropolitan and rural health centres).

The Midwives can be contacted by email JHFMHN-Midwife@health.nsw.gov.au and ROAMS – Primary health by telephone on 13000 ROAMS

After Hours NM must be notified of all transfers to and returns from hospital.

Note: Any pregnant women from **20 weeks** gestation must travel in special transport vehicles.

3.18.1 Escalation to the Midwives / ROAMS – Primary health

Unless it is an emergency, care of pregnant and postnatal women require escalation to the Midwives or On-Call ROAMS (if Midwives unavailable) for following presentations:

- Nausea and Vomiting of Pregnancy
- Vaginal bleeding in pregnancy
- Abdominal pain or threatened premature labour (labour under 37 weeks pregnant)
- Hypertension – Refer to *Standard Maternity Observation Chart* (SMOC)
- Spontaneous rupture of membranes
- Decreased or no baby movements
- Abdominal trauma i.e. falls or assault
- Labour
- Abnormal observation on SMOC
- Postpartum haemorrhage (heavy bleeding up to 6 weeks after birth)

Prior to the escalation an assessment must include:

- Gestational age – how many weeks pregnant?
- Any headaches and/or visual disturbances?
- Baby movements – are they the same or has there been any changes?
- Any vaginal loss – blood or fluid (what colour and estimate loss amount, if any)?
- Any abdominal pain (intermittent or continuous)?
- Check baseline observations and document on SMOC

3.18.2 Transfer to Hospital

When a decision is made for pregnant or postnatal woman to transfer to hospital, nursing staff must:

- Provide comfort and reassurance to the woman
- Provide woman with sanitary pads if any vaginal loss
- Contact the receiving hospital's birthing unit and provide verbal handover if applicable

- Send a copy of the Network Antenatal Record Folder i.e. Blue Folder (this contains the women's Antenatal Care Record commonly referred to as the 'Yellow Card' and copies of external bloods and ultrasound results)
- Complete the Clinical Summary/Transfer to External Hospital eform in JHeHS to accompany the woman to hospital
- Document in JHeHS and log 'transfer out' on PAS

3.18.3 Return from Hospital

All pregnant or postpartum women must be assessed by nursing staff on return from hospital. When conducting an assessment, the nurse must:

- Review any documentation from the hospital and ensure this is uploaded into JHeHS
- Check baseline observations and document on SMOC
- Review the woman on return and contact the Midwives or ROAMS – Primary Care for any health concerns or Drug and Alcohol for any substance related concerns
- Make appropriate follow up appointments via PAS Waiting Lists (i.e. the Midwives and/or GP and relevant others)
- Document in JHeHS and log 'transfer in' on PAS

3.19 Intrapartum Management (Care during Birth)

The care of the women during labour and birth is provided by the public hospital. The NUM/delegate must notify the Midwives when a woman is in labour and has been transferred to hospital and must follow Escalation, Transfer to and Return from Hospital procedure.

Where possible, the Midwives will offer support to the woman during labour and birth, and the early postnatal period at the hospital.

Health centre staff must ensure that the relevant pregnancy and general health information is available to hospital staff at the time of admission.

The following information should be copied and forwarded to the hospital of birth at the time of transfer:

- Yellow Card
- Copies of bloods and ultrasound results
- Comprehensive list of current medications
- *Clinical Summary/Transfer to External Hospital* eform in JHeHS

3.20 Postnatal Care

On return from hospital, nursing staff must complete a PAS Waitlist for the Midwives (or the GP in rural centres). The postnatal women must be assessed by nursing staff on return from hospital.

Ongoing assessment must be performed daily by nursing staff for a minimum of 5 days to check on the women's physical and psychological wellbeing in addition to the instruction provided by the

hospital. Below is a postnatal care assessment guide for nursing staff to use when assessing the women:

- Become familiar with the woman's birth history
- Ask how she is feeling mentally and physically
- Complete clinical observations on SMOC
- Ask about her breasts - Are they firm, soft, is she expressing etc.
- Ask about vaginal loss - Is the colour changing from red to pink or brown? Is the amount decreasing/increasing? Has she passed any clots?
- Ask about elimination – Is she passing urine and moving bowels without problems?
- Ask about mobilising – Is she comfortable moving around? Discuss importance of gentle exercise for reducing incidence of DVT.
- Ask about Perineal or Caesarean section wound comfort - Basic wound care may be required.
- Document the assessment in JHeHS and contact the Midwives or ROAMS – Primary health for any concerns

Continuity of postnatal midwifery care is provided by the Midwives in conjunction with the GP and/or Women's Health Nurse Practitioner, and primary health nursing staff, within Sydney metropolitan area. Midwifery care is finalised at 4-6 weeks postnatal depending on the women's individual circumstances. After this, the woman's care is handed over to Primary Care and the Midwives should create a wait list for the Women's Health Nurse Practitioner or GP for postnatal check, cervical screening and contraception advice. In rural centres, the NUM/delegate must ensure this follow up is booked. Arrange review by Drug and Alcohol if on OAT in the initial postnatal period as a dose adjustment may be required.

Wherever possible, staff will provide opportunities to maintain and support the attachment and relationship between the mother and baby. Staff must collaborate with other agencies such as CSNSW, YJNSW, DCJ, etc. and, where applicable, the woman's partner, designated carer, family and any other significant persons.

3.21 Breastfeeding and Expressed Breast Milk (EBM)

There is compelling evidence that breastfeeding is protective against a wide range of short and longer term health problems in infants and mothers. Breastfeeding is universally recommended as the most beneficial method for feeding infants by authoritative organisations such as the World Health Organisation, Australia's National Health and Medical Research Council, Australian College of Midwives, Royal Australasian College of Physicians and International Confederation of Midwives, among many others. Please refer to the NSW Health PD2018_034 *Breastfeeding in NSW: Promotion, Protection and Support.*

The Network promotes and supports breastfeeding and/or expressing breast milk depending on the women's individual circumstances. Women who have their babies with them on the Mother and Children's Program are encouraged and supported to breastfeed.

Breastfeeding is encouraged for women on a stable OAT program; however breast feeding is not recommended where there is ongoing polysubstance use, or alcohol use.

Women who are Hepatitis B and/or Hepatitis C positive and wish to breastfeed are encouraged and educated about transmission and safe practices. Specialist advice needed for women who are HIV positive and wish to breastfeed.

Women who choose to express breastmilk should be provided with a breast pump and instruction on expressing and storing breastmilk if safe to do so. For adolescents, this has to be consulted with relevant stakeholders.

3.21.1 Cleaning Expressing Equipment

The women must be advised to wash any pumping equipment, such as bottles, valves and breast shields, that has been in contact with the breasts or milk and then dry thoroughly so they're ready for your next session, after every expressing. Nursing staff or the Midwives should provide the following instructions to the women on how to clean the expressing equipment:

- First, take the breast pump kit apart, and separate all pieces.
- Rinse off the pumping equipment with drinking-quality water (at around 20 °C/68 °F), to remove any grease, milk and dirt left behind.
- Then wash all parts with warm water (approximately 30 °C/86 °F) and washing-up liquid.
- Rinse the parts again with drinking-quality water for 15 to 20 seconds.
- Drain kit, bottles and containers upside-down on new paper towels or clean tea towel and cover with either a paper towel or clean tea towel while they air dry.
- Store the dry kit in a new plastic bag, plastic wrap, paper towels, clean tea towel or covered container until next use.
- If not being used frequently, expressing equipment must be cleaned once a day.

3.21.2 Storage and transportation of EBM

EBM must be stored in a designated freezer in each health centre. Women can express breastmilk in their cell, store in the fridge of the unit immediately after expressing and bring to health centre at least daily to put in the freezer.

EBM must be labelled with woman's name, date and time of expressing. The Midwives can be contacted for further advice if needed regarding expressing and storing EBM.

The Network does not take responsibility for the transportation of EBM. The women may be able to take EBM to the hospital while the baby is an inpatient. Nursing staff must liaise with CSNSW/YJNSW to facilitate the transfer of the women to the hospital as often as possible while the baby is an inpatient.

When the baby is discharged from hospital and living in the community, transport of EBM is arranged by the woman's family or significant others, this include organising the cooler bag with freezer bricks or similar to keep milk frozen during transport.

Refer to the below table for detailed instructions EBM storage.

Breastmilk status	Room Temperature (26 ºC or lower)	Refrigerator (4 ºC or lower)	Freezer
Freshly expressed into a closed container	6 – 8 hours If refrigeration is available store milk there	No more than 72 hours Store at back, where it is coldest	2 weeks in freezer compartment inside refrigerator (–15°C) 3 months in freezer section of refrigerator with separate door (–18°C) 6–12 months in deep freeze (–20°C)
Previously frozen—thawed in refrigerator but not warmed	4 hours or less – that is, the next feeding	Store in refrigerator for max. 24 hours	Do not refreeze
Thawed outside refrigerator in warm water	For completion of feeding	Hold for 4 hours or until next feeding	Do not refreeze
Infant has begun feeding	Only for completion of feeding – Discard after feed	Discard	Discard

For more information on expressing and storing breastmilk and cleaning of expressing equipment, please refer to Australian Breastfeeding Association – Expressing and Storing Breastmilk

3.22 Other Relevant Perinatal Support Services

3.22.1 Perinatal and Infant Mental Health Service (PIMHS)

PIMHS co-ordinates the mental health care of pregnant women in custody and FH with a particular emphasis on the parent-infant relationship. All pregnant women are seen and assessed by the service for psychosocial and mental health vulnerabilities as per NSW Health Safe Start guidelines PD2010_016 *SAFE START Strategic Policy* and GL2010_004 *SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants.*

PIMHS follow up all pregnant women and provides continuity of care, support, counselling, therapeutic interventions and referral to Psychiatric services as required. PIMHS works closely with the Midwifery, Mental Health and Drug and Alcohol services within the Network, and Social Work Services of the public hospital and DCJ in the community.

3.22.2 Drug and Alcohol Services

All women who are newly identified as pregnant must be discussed with the Drug & Alcohol ROAMS because of the potential risks a withdrawal episode can have on the unborn baby. Prompt referral to and assessment by the relevant Drug & Alcohol specialist should be undertaken within 4 hours of a positive pregnancy test.

Women entering custody in NSW have a very high incidence of substance misuse. Withdrawal from drugs and alcohol for these women is an urgent situation which must be prevented and managed as soon as possible to reduce the risk of harm to the unborn baby.

The NSW Health GL2014_022 *Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period* is intended for use by all healthcare practitioners in NSW working with pregnant women who are using substances during pregnancy and the postnatal period. Substances discussed in these guidelines include alcohol and tobacco; illicit substances such as opioids, amphetamine-type stimulants (ATS), cocaine, cannabis and inhalants; and prescription medication which can be used licitly or illicitly.

Drug and Alcohol services is provided by the ROAMS – Drug and Alcohol for adults and On-call Adolescent Psychiatrist (During Business Hours) or ROAMS – Psychiatry (After Hours) for adolescents.

3.22.3 Substance Use in Pregnancy Coordinator (SUPC)

The Substance Use in Pregnancy Coordinator (SUPC), the role is developed and managed within the Network's Drug and Alcohol Services and the service is available to all pregnant women in custody with current substance use issues.

The SUPC works closely with the Network's Midwives, Primary Care Services, Mental Health Services, Operations and Nursing Services as well as with the external agencies such as CSNSW, DCJ, public hospital Social Work Services, and the Drug and Alcohol Service's release planning teams to ensure a smooth transition to community based antenatal and Drug and Alcohol services is in place for each of these women.

This service provides pregnant women with information and education about the best strategies to reduce the harms associated with alcohol and drug use in pregnancy. The program is supporting pregnant women with substance use issues through early engagement, integrated multidisciplinary team care, assertive follow up and community linkages.

3.22.4 Drug and Alcohol Diversion Program – Drug Court Program

Women on the Drug Court Program may be pregnant at the time of entering the program or become pregnant during the program. These women are court ordered to attend Drug and Alcohol programs in the community.

The Drug Court Program team can make recommendations to the court to include antenatal care and where appropriate parenting classes as part of their treatment plan.

3.22.5 Antenatal and Parenting Coordinator

The Antenatal and Parenting Coordinator works in collaboration with the Midwives to provide education, guidance and support to young parents throughout their antenatal and postnatal periods. The Antenatal and Parenting Coordinator role also embodies child and family health, with a focus on working in partnership with the parent to promote a nuturing and supportive environment in which children can thrive and grow.

3.22.6 Department of Communities and Justice (DCJ)

Department of Communities and Justice (DCJ) notification via the Mandatory Reporting process regarding pregnant women in custody is undertaken by the Midwives within the Sydney metropolitan area. If a woman is in a rural centre or additional information arises that meets mandatory reporting requirements, it is the responsibility of all health care professionals to make a mandatory DCJ

notification. Adolescent Health staff will make the mandatory notification for young females, as required.

Staff can refer to the Mandatory Reporter Guide to assess if a report is required in the DCJ website when making a mandatory notification. The completed notification report must be printed and filed in the health record and the notification reference number documented in the progress notes. Further information can be found in NSW Health PD2013_007 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* or the Network Policy 5.015 *Child Protection.*

3.22.7 Aboriginal Health Worker (AHW)

Aboriginal and/or Torres Strait Islander women or women who are giving birth to Aboriginal and/or Torres Strait Islander babies who have a confirmed pregnancy are to be referred to the women's Aboriginal Health Worker (AHW). The women's AHW covers all of the Metro women's centres, and can provide advice and support to the health workers in regional and remote centres, or to women in these centres via telehealth. The woman's AHW is able to provide clinicians coordinating the care of pregnant women with advice to ensure that care aligns with cultural practices and traditions as much as practical in the custodial setting.

Woman can also be referred to AHW via the PAS waiting list for support following any stressful event such as admission to hospital, as a visit to hospital can be traumatic for Aboriginal and/or Torres Strait Islander people. The AHW should be consulted in the event of Antenatal and Perinatal loss to ensure the woman is supported, and to ensure cultural practices applicable to the loss of life are followed where possible.

Including the AHW in release planning will ensure that culturally appropriate arrangements can be made for the woman being released into community to encourage engagement and participation in ongoing antenatal care leading up to the birth of the baby. The AHW can also provide insight into additional support services available, inclusive of Aboriginal and/or Torres Strait Islander women's groups and mums and bubs groups. Linking the woman in with the Aboriginal Health Worker (AHW)-Aboriginal Maternal & Infant Health Strategy (AHMIS) in community if she wants to participate may also assist in ensuring the women stay with the health service post release.

Aboriginal and/or Torres Strait Islander pregnant women with chronic or complex health conditions (cardiovascular issues, kidney disease, asthma, diabetes, cancer etc.) can be referred to the Integrated Care Service who can also assist with appointment management and release planning if required.

3.22.8 Mothers and Children's Program – Emu Plains Correctional Centre

The full time residential program provides pre-school age children the opportunity to reside with their mother or primary carer in Jacaranda Cottages at Emu Plains Correctional Centre. All eligible pregnant women in adult custody and adolescent pregnant women in youth justice centres are referred to this program. This referral is auto-generated from the 'pregnant' alert in JHeHS. After referral the case is assessed by the Mother and Children's Program Committee led by CSNSW officer. Each woman is assessed on a case to case basis by the Mother and Children's Program Committee with its member input.

4. Definitions

Must

Indicates a mandatory action that must be complied with.

Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

5. Legislation and Related Documents

NSW Health Policy Directives and Guidelines	Breastfeeding in NSW - Promotion, Protection and Support (PD2018_034) Care Pathway for Women Concerned About Fetal Movements (GL2021_019) Child Wellbeing and Child Protection Policies and Procedures for NSW Health (PD2013_007) Consent to Medical and Healthcare Treatment Manual (IB2020_010) Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW (GL2008_011) Framework for Termination of Pregnancy in New South Wales (PD2021_018) Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period (GL2014_022) NSW Clinical Guidelines: Treatment of Opioid Dependence 2018 Maternal & Child Health Primary Health Care Policy (PD2010_017) Maternity - Breast Milk: Safe Management (PD2010_019) Maternity - Clinical Risk Management Program (PD2009_003) Maternity - Fetal heart rate monitoring (GL2018_025) Maternity - Management of Early Pregnancy Complications (PD2012_022) Maternity - Management of Hypertensive Disorders of Pregnancy (PD2011_064)

	Maternity - Management of Pregnancy Beyond 41 Weeks Gestation (GL2014_015)
	Maternity - Maternal Group B Streptococcus (GBS) and minimisation of neonatal early-onset GBS Sepsis (GL2017-002)
	Maternity - National Midwifery Guidelines for Consultation and Referral (PD2020_008)
	Maternity - Newborn Bloodspot Screening (PD2016_015)
	Maternity - Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation / Cutting (GL2014_016)
	Maternity - Rh D Immunoglobulin (Anti-D) (GL 2015_011)
	Maternity - Supporting Women in their Next Birth After Caesarean Section (GL2014_004)
	Maternity - Towards Normal Birth in NSW (PD2010_045)
	Maternal & Child Health Primary Health Care Policy (PD2010_017)
	NSW Maternity and Neonatal Service Capability Framework (GL2016_018)
	Postpartum Haemorrhage (PPH) GL2021_017
	Prevention of Termination of Pregnancy for the Sole Purpose of Sex Selection (GL2021_008)
	Prevention of Venous Thromboembolism (PD2019_057)
	Recognition and management of patients who are deteriorating (PD2020_018)
	SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants (GL2010_004)
	SAFE START Strategic Policy (PD2010_016)
	Stillbirth - Management and Investigation (PD2007_025)
Network Policies	5.015 *Child Protection* 1.075 *Clinical Handover* 2.010 *Code of Conduct* 1.085 *Consent to Medical Treatment - Patient Information*

	1.040 *Drug and Alcohol Services* 1.036 *Health Assessments (Adolescents)* 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* 1.245 *Immunisation of Patients* 1.141 *Release Planning and Transfer of Care Policy – Adult to External Providers* 4.030 *Requesting and Disclosing Health Information* 1.395 *Transfer and Transport of Patients* Guidelines on the use and disclosure of inmate/patient medical records and other health information

External Sources	Australian Breastfeeding Association – Expressing and Storing Breastmilk Australian College of Midwives link to National Midwifery Guidelines for Consultation and Referral Australian Red Cross Blood Service – You & Your Baby: Important information for Rh (D) Negative Women CEC – Safer Baby Bundle CEC – NSW Health Observation Charts Communities and Justice – Mandatory reporters: How to make a child protection report Communities and Justice – Mandatory reporter guide Mothersafe CSNCW – Programs for women offenders Department of Health – Maternity Services and Stillbirth Prevention Department of Health – Pregnancy Care Guidelines Department of Health – The Australian Immunisation Handbook Royal Hospital for Women - Mothersafe