Health
Justice Health &
Forensic Mental Health Network

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Management of Pregnant Women in Custody

Policy Number 1.430

Policy Function Continuum of Care

Issue Date 7 December 2017

Summary This policy provides Justice Health and Forensic Mental Health Network (JH&FMHN) staff with the appropriate direction for identifying the pregnancy status of women of childbearing age entering custody; and guidelines for providing antenatal and postnatal care for pregnant women in custody.

Responsible Officer Executive Director Clinical Operations

Applicable Sites

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

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

Change Summary

- Alignment with the Guidelines for the Management of Pregnant and Postnatal Women in Custody
- Inclusion of the Perinatal & Infant Mental Health Service (PIMHS) CNC role being responsible for co-ordinating the mental health care of pregnant women in custody with a particular emphasis on the parent-infant relationship.
- Update to reflect requirements of pregnancy testing at reception and associated follow up.
- Addition of the Antenatal Checklist. JUS060.456
- Addition of Maternal Venous Thromboembolism (VTE) risk assessment.
- Inclusion of Legal Education and Advice in Prison (LEAP)

TRIM Reference POLJH/1430

Authorised by Chief Executive, Justice Health & Forensic Mental Health Network

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, which is comparable to care available in the community. Justice Health and Forensic Mental Health Network (JH&FMHN) staff aim to follow best practice guidelines to assist in providing pregnant and early postnatal women in custody with the best possible maternity care.

Women entering custody, including young females in Adolescent Health, often have complex health co-morbidities which include drug and alcohol misuse, complex obstetric histories, mental health issues and/or existing medical conditions. JH&FMHN provides women-centred midwifery care and delivers this care with equality, respect and professionalism. The women are supported to make informed decisions about their care for themselves and their baby in partnership with the JH&FMHN Midwife Program (hereafter the Midwives) and other health care professionals.

This policy applies to all custodial centres where women are accommodated within JH&FMHN, including Juvenile Justice Centres (JJC).

For pregnancy care of women in the Forensic and Long Bay Hospital see JH&FMHN policy 1.316 *Pregnancy Care Forensic Hospital and Long Bay Hospital*.

2. Policy Content

2.1 Mandatory Requirements

- All women of child bearing age entering custody must be offered testing for pregnancy via a beta human chorionic gonadotropin (BHCG) urine test. This is done at the time of reception. If the woman refuses a BHCG urine test, counselling must be offered and this must be documented in the patients' health record.
- All women of child bearing age must have the BHCG offered 28 days after entering custody 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 the patient's health record.
- This policy requires that the pregnant women in custody have a comprehensive primary health care assessment and history is collected on drug and alcohol misuse, obstetric, medical and psychosocial history.
- All clinical staff working with the pregnant women in custody must refer to JH&FMHN *Guidelines for the Management of Pregnant Women in Custody*
- This policy requires that all maternity care provided refers to the Australian College of Midwives (ACM) *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, if risk factors arise in pregnancy. As per NSW MoH PD2010_022 *Maternity - National Midwifery Guidelines for Consultation and Referral*.
- It is critical that all pregnant women who enter custody are discussed within four hours with the Drug and Alcohol ROAMS because of the potential risks a withdrawal episode can have on the unborn baby. Drug and Alcohol services provide 24 hour clinical consultation across the state via the on-call telephone service.

Phone: 1300 076 267 or 13000 ROAMS.

2.2 Implementation - Roles & Responsibilities

Operations Manager Primary Care – Clinical is responsible for providing strategic and operational oversight of this policy.

JH&FMHN Midwives are responsible for the management of the antenatal and postnatal care of the women including adolescents and those located at the Forensic and Long Bay Hospital.

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

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

3. Procedure Content

3.1 Reception to the Custodial System

JH&FMHN aims:

- To provide staff with a clinical pathway to determine pregnancy status and referral pathways.
- To define the process for the management of pregnant women in the custodial environment.
- To provide up to date information regarding choices relating to the care of the woman and her baby.
- To provide continuity of antenatal and postnatal care for pregnant women in custody.
- To provide culturally competent health care to all patients
- To liaise with all relevant stakeholders for consultation and referral.

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

- Notification of pregnancy status on Justice Health electronic Health System (JHeHS) via adding the health condition 'pregnant'.
- Referral to the Midwives via the waiting list on Patient Administration System (PAS).
- Knowledge of the effects of substance use on the woman and her baby. Prompt assessment and referral to the On Call Drug and Alcohol ROAMS.
- The Midwives have a comprehensive understanding of normal pregnancy, labour and birth and the postnatal period with the knowledge to recognise deviations from this process.
- Appropriate and timely consultation and referral pathways.
- Mandatory reporter guidelines are accessible, if notification to Family and Community Services (FACS) is required.

3.1.1 Legal Education and Advice in Prison (LEAP)

The Legal Education and Advice in Prison (LEAP) program for women has been operating since 2009 in Silverwater Women's, Emu Plains and Dillwynia Correctional Centres. Women's Legal Service (WLS) also works with young women in Reiby JJC on a case by case basis. LEAP is a joint project of WLS, Wirringa Baiya Aboriginal Women's Legal Centre (WB) and Western Sydney Community Legal Centre (WS).

LEAP provides free legal advice and representation for women in prison on family violence, sexual assault, family law, child protection, victim support and other human rights issues impacting women in custody. LEAP provide both a trauma informed and culturally appropriate service e.g. only female solicitors and casework support from Aboriginal and Torres Strait Islander community access workers. Also both WLS and WB are state wise services and can continue to represent the women after their release from custody.

The WLS and other community legal centres provide legal advice and casework services for pregnant women in custody. WLS can provide early legal advice for pregnant women in custody, particularly when they have had previous contact with FACS, as a child in need of care and protection themselves and/or had other children notified, removed etc.

The three local centres provide monthly outreach clinics to Silverwater Women's (SWCC), Dillwynia (DCC) and Emu Plains (EPCC) correctional centres, with referrals from women directly or via Corrective Services NSW (CSNSW) or JH&FMHN clinical staff.

3.1.2 Assessment of Pregnancy

To facilitate prompt implementation of a management plan, it is important that confirmation of pregnancy, assessment and referral are made as soon as possible following admission to custody.

The possibility of pregnancy must be considered for all women entering custody. Assessment should include urinalysis for Beta human Chorionic Gonadotropin (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 offered 28 days later. A PAS wait list entry must be made to schedule the 28 day second pregnancy test by the nurse conducting the Reception Screening Assessment (RSA)/ Adolescent Health Initial Assessment.

3.1.3 Pregnancy Confirmed

All pregnant women in custody are considered women with complexities. This is due to co-morbidities such as poor health status, a high incidence of drug and alcohol misuse and/or mental health issues. To facilitate timely and coordinated care upon confirmation of pregnancy the following must be considered in providing antenatal care:

- Effects of substance use on the woman and her unborn baby, e.g. intoxication or withdrawal, and adjustments of methadone dosing in pregnancy require prompt referral to Drug and Alcohol clinicians. ROAMS Drug and Alcohol must be contacted for advice within four hours of all positive pregnancy tests.
- Regarding medications and complementary therapies used in the pregnancy. Information can be obtained via JH&FMHN Pharmacy Department on 9700 3888 and/or refer to the Mothersafe Drugs in Pregnancy and Breastfeeding website. MotherSafe is a free telephone service for 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, street drugs, infections, radiation and occupational exposure.
- Review current immunisation status and recommend vaccination as required.
- Referral to the CSNSW Mothers' and Children's Program, this is generated automatically via the 'pregnant'' alert generated in JHeHS.

The Nurse Manager Adolescent Health will be notified of all pregnant young females admitted to JJCs by the clinic staff.

A comprehensive primary health assessment must assess all aspects of health and well-being including a systematic exploration of all health domains:

- physical health
- stolen generation experiences
- previous involvement with child removal services
- medical and obstetric history
- family structure
- relationships
- support networks
- recent major stresses
- family strengths
- current and history of mental illness, substance use, child protection issues, domestic violence, physical, sexual or emotional abuse
- psychosocial issues

This assessment is the responsibility of all JH&FMHN clinical staff.

3.2 Pregnant Women in Rural Correctional/Detention Centres

The Nursing Unit Manager (NUM) is responsible for the co-ordination of antenatal and postnatal care of pregnant women who are received into adult correctional centres in the rural regions. The NUM is responsible for liaison with the Midwives when pregnancy is confirmed. The Midwives must be notified of all pregnant women in custody throughout NSW.

Where possible, attempts must be made to transfer pregnant women to the Sydney metropolitan region as soon as possible; this includes returning after court in regional and rural areas.

Pregnant women in custody are usually accommodated at Silverwater Women's Correctional Centre, Dillwynia Correctional Centre or Emu Plains Correctional Centre. Adolescent females are located at Reiby JJC.

3.3 Pregnancy Choices

Pregnant women in custody have the same rights to choice 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 will be assessed in a supportive and non-judgemental manner whilst maintaining strict confidentiality and professional attitudes. This request for a termination of pregnancy should be facilitated in accordance with NSW MoH PD2014_022 *Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*.

First trimester terminations of pregnancy up to 12 weeks since Last Menstrual Period (LMP) can be arranged through the Local Health District (LHD) public hospital.

Limitations may apply to termination of pregnancy sought during the second trimester (week 12 – 19+6) due to public hospital policy. Termination of pregnancy may be accommodated at private clinics on a fee-for-service basis. When this option is chosen, JH&FMHN may agree to pay costs, in consultation with the Clinical

Director Primary Care, the Midwives and/or GP or the Nurse Manager Adolescent Health. Payment is approved by the Service Director Primary Care.

On occasions, accessing a publicly funded termination of pregnancy in the first trimester is restricted. Privately funded termination of pregnancy can be considered on an individual basis.

All women requesting a termination of pregnancy will receive counselling from the Midwife and/or GP. The women may be offered an appointment with the Perinatal Infant Mental Health Service (PIMHS) Clinical Nurse Consultant (CNC).

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 FACS. Consider parental or legal guardian consent for females less than 16 years of age. See JH&FMHN policy 1.085 *Consent to Medical Treatment – Patient Information*.

3.4 Perinatal and Infant Mental Health Service (PIMHS)

PIMHS co-ordinates the mental health care of pregnant women in custody 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 the Safe Start guidelines. Refer to NSW MoH PD2010_016 *SAFE START Strategic Policy* GL2010_004 GL2010_004 *SAFE START Guidelines: Improving Mental Health Outcomes.*

PIMHS follows up all pregnant women throughout their pregnancy, 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 JH&FMHN and with LHD Social Work services and FACS in the community.

If a woman is identified as receiving any psychotropic medication including antipsychotics, mood stabilisers, antidepressants or sedatives, she should be assessed as a matter of urgency by a psychiatrist/psychiatry registrar for the specific consideration of the risks and benefits of continuing on her prescribed medication and for an assessment of her current mental health needs.

Untreated and unstable mental illness is a serious adverse risk factor in pregnancy. Pregnancy alone can exacerbate or trigger a relapse of a pre-existing mental illness. The risks and benefits of evidence-based treatment in pregnancy need to be carefully considered by a psychiatrist and discussed with the pregnant woman.

3.5 Substance Use Assessment

Women entering custody in NSW have a very high incidence of substance misuse, estimated as follows:

- 40% of women are drinking at harmful levels
- 78% are using illicit substances
- Levels of prescription opioid analgesic and benzodiazepine dependence increasing.

All pregnant women must be discussed with the Drug and 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 and Alcohol specialist should be undertaken within four hours of a positive pregnancy test.

Drug and Alcohol services provide 24 hour clinical consultation across the state via the on-call telephone service. Phone: 1300 076 267 or 13000 ROAMS.

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 health-care practitioners in NSW working with pregnant women who are using substances during pregnancy and the postnatal period. Substances discussed in these guidelines include the licit substances, alcohol and tobacco; illicit substances such as opioids, amphetamine-type stimulants (ATS), cocaine, cannabis and inhalants; and prescription medication which can be used illicitly or illicitly.

3.6 Documentation of Observations

The recording of clinical observations for all pregnant women in custody must be documented onto the *Standard Maternity Observation Chart* (SMOC). The SMOC (**SMR110.013** available on ePOD) contains calling 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. The *Standard Adult General Observations* (SAGO) or the Standard Paediatric Observational Chart (SPOC) must not be used for pregnant women in custody.

The SMOC is not used for routine antenatal care provided by the Midwives. Routine antenatal care (including observations) will continue to be documented on the *NSW Health Antenatal Care Record* (also referred to as the 'yellow card') which is kept with the health record. The *NSW Health Antenatal Care Record* is sent with the woman to all external appointments at hospitals. Should a woman's clinical observations deviate from the norm during the antenatal period, the Midwives will commence documenting the observations onto the SMOC and provide a clinical care plan.

3.7 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 CSNSW of any matters related to a woman's pregnancy other than routine notification. A ROI from pregnant women must be completed and sent to previous health care providers as soon as possible. Refer to JH&FMHN policy 4.030 *Requesting and Disclosing Health Information* and JH&FMHN Guidelines on the Use and Disclosure of Inmate/Patient Medical Records and Other Health Information.

With the consent of the pregnant woman only, staff may maintain ongoing engagement with the designated carer and/or family and significant others, where appropriate. Staff must comply with section 3.1.3 of JH&FMHN policy 2.010 *Code of Conduct*.

3.8 Identification of a Child at Risk - Family and Community Services (FACS)

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

Staff can refer to the Mandatory Reporters Guide to assess if a report is required and the FACS 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 MoH

PD2013_007 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* or the JH&FMHN policy 5.015 *Child Protection*.

3.9 Transport of Pregnant Women in Custody

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 Midwives and/or Medical Officer.

3.10 Pregnant Women Transfer to and Returning from Hospital procedure

3.10.1 Transfer to Hospital

The main reasons why a pregnant or postnatal woman requires transfer to hospital are listed below:

- Labour
- Hypertension
- Vaginal bleeding in pregnancy
- Spontaneous rupture of membranes
- Abdominal pain or threatened premature labour
- Decreased or no baby movements
- Abdominal trauma i.e. falls or assault
- Generally feeling unwell
- Febrile
- Secondary postpartum haemorrhage (after 24 hours)

The nurse on duty when a woman presents at the clinic, must complete an assessment and arrange for transfer to hospital, if required.

The Midwives must be contacted during business hours or ROAMS GP (13000 76267 or 13000 ROAMS) during out of hours for notification and further advice.

Key details for nursing staff to ask when assessing a pregnant woman include:

- Gestational age – how many weeks pregnant?
- Any headaches and/or visual disturbances?
- Any nausea and/or vomiting?
- 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 (blood pressure, temperature and pulse).

In the event of transferring pregnant women to hospital, Nursing staff must:

- Provide comfort and reassurance to the woman.

- Contact the receiving hospital's birthing unit and provide verbal handover including:
    - Woman's name, date of birth, gestational age etc.;
    - Brief history of current events e.g. abdominal pain, vaginal loss, etc.;
    - Maternal baseline observations (blood pressure, temperature and pulse).
- Send a copy of the Antenatal Folder (this contains the women's antenatal record (yellow card) and copies of ultrasound results with the woman to hospital.
- Complete the *Clinical Summary/Transfer to External Hospital* eform in JHeHS to accompany the women to hospital.
- Document in the woman's health record and log 'transfer out' on PAS.

3.10.2 Returning from Hospital

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

- Review any documentation from the hospital and ensure this is uploaded onto JHeHS;
- Perform maternal baseline observations (blood pressure, temperature and pulse) and document these on the SMOC chart.
- Document in woman's health record and log 'transfer in' on PAS;
- Make appropriate follow up appointments via the PAS waiting lists (i.e. Midwife, GP, Nursing staff etc.).
- Notify the Midwives and After Hours Nurse Manager via ROAMS (13000 76267).

It is important that the Midwives are notified of **ALL** (metropolitan and rural health centres) pregnant or postpartum women transferring to or returning from hospital by either:

Pager: (02) 9937 2506 (during business hours)

Or

Email: .Midwife@justicehealth.nsw.gov.au

3.11 Antenatal Care

Continuity of midwifery care is provided by the Midwives, for all pregnant women in custody including pregnant females in Reiby JJC, and the Forensic and Long Bay Hospitals, within the Sydney metropolitan area.

In rural centres, if the woman needs to remain there for a period of time, care is coordinated by the NUM in consultation with the Midwives and the GP.

Medical and obstetric history and current obstetric review is risk assessed by using the Australian College of Midwives National Midwifery Guidelines for Consultation and Referral 3rd Edition, Issue 2, published 23rd February, 2015. Refer to NSW MoH PD2010_022 *Maternity - National Midwifery Guidelines for Consultation and Referral.*

Care is provided by a multi-disciplinary team approach, this includes the Midwives, GP and nursing staff, together with LHD obstetricians, paediatricians, midwives and social workers.

JH&FMHN and Nepean Public Hospital have a collaborative arrangement that provides an Obstetricians Clinic at Dillwynia Correctional Centre. This agreement includes a visiting obstetrician and social worker. Pregnant women from Emu Plains and Dillwynia Correctional Centres attend this clinic.

Clinical information regarding the pregnant women must be recorded by the midwives on the *NSW Health Antenatal Record*, (the yellow card) and the health record or ObstetriX/eMaternity, this documentation is printed out and filed in the health record.

The *Antenatal Checklist* JUS060.465 is a guideline for all clinical staff to use as the antenatal care schedule.

3.12 National Evidence-Based Antenatal Care Guidelines

The National Antenatal 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, general practitioners, obstetricians, maternal and child health nurses, Aboriginal and Torres Strait Islander health practitioners, Aboriginal and Torres Strait Islander health workers, multicultural health workers, practice nurses, sonographers and allied health professionals. The recommendations in the Guidelines cover a wide range of care including routine physical examinations, screening tests and social and lifestyle advice for women with an uncomplicated pregnancy. By providing a summary of the currently available evidence on many aspects of antenatal care, the Guidelines aim to promote consistency of care and improve the experience and outcomes of antenatal care for all families.

3.13 Vitamin Supplements for Pregnant Women

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

- Iodine (Elivet which also contains folic acid) 150mcg once daily.
- Vitamin C 500mg once daily.
- Iron & Vitamin D (as required, only when antenatal pathology results indicate deficiency).

3.14 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 or DVT). These blood clots may become dislodged and then obstruct the pulmonary artery or one of its branches (pulmonary embolism or PE). All pregnant women must undergo VTE risk assessment as soon as practicable during the antenatal period. This is undertaken by a midwife or GP if a midwife not available.

The Maternal Venous Thromboembolism (VTE) Risk Assessment Tool is used for the pregnant woman to assess VTE risk to identify all pregnant and postpartum women at risk of VTE. The decision to commence pharmacological and/or mechanical prophylaxis must be referred for an obstetric consultant. For more information please refer to MoH PD2014_032 *Prevention of Venous Thromboembolism* policy directive.

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 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 blood 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 at 28 weeks.

3.15.1. Antenatal Prophylaxis

All Rh D negative **women who do not have preformed anti-D antibodies** are given 625 IU Rh D immunoglobulin at 28 and 34 weeks gestation.

3.15.2. Potentially Sensitising Events

- ectopic pregnancy
- miscarriage
- termination of pregnancy
- ultrasound guided procedures such as chorionic villus sampling, amniocentesis, cordocentesis and foetoscopy
- abdominal trauma considered sufficient to cause feto maternal haemorrhage (FMH)
- 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:

In the first trimester (less than 12 weeks):

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

In the second and third trimester:

- 625 IU Rh D immunoglobulin should be administered with additional doses as indicated from the results of assessment of the extent of fetomaternal haemorrhage (FMH).

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 FMH. Additional doses of Rh D immunoglobulin should be administered as indicated from the results of testing.

3.15.3. Administration of Rh D immunoglobulin

All pregnant women, both Rh D positive and Rh D negative, should be tested in the first trimester for blood group and clinically significant red cell antibodies.

Repeat testing of Rh D negative women at 28 weeks gestation **prior** to administering Rh D immunoprophylaxis is recommended. Repeating this test at 34 weeks gestation is **not** required, the second prophylaxis Rh D immunoprophylaxis is given at 34 weeks.

Before administration of Rh D immunoglobulin, the midwife, registered nurse or medical practitioner should check against the pathology result to confirm the mother's blood group and red cell antibody status i.e. that there were no preformed anti-D antibodies. Findings should be documented and placed on the women's health record.

Rh D immunoglobulin should be administered at weeks 28 and 34 only if the mother is Rh negative and had no preformed anti-D antibodies. If Rh D immunoglobulin was given for a potentially sensitising event, antenatal prophylaxis doses should still be given.

3.15.4. Contraindications to the administration of Rh D immunoglobulin

Rh D immunoglobulin should not be given to individuals:

- With preformed anti-D antibodies, except where the preformed antibodies are due to antenatal administration of Rh D immunoglobulin.
- Who are Rh D positive.
- Who are immunoglobulin A deficient, unless they have been tested and shown not to have circulating anti-IgA antibodies; or
- With a history of anaphylactic or other severe systemic reaction to immunoglobulins. For individuals with severe thrombocytopenia or a coagulation disorder that contraindicates intramuscular injection, the intravenous preparation of Rh D immunoglobulin should be used.

3.15.5. 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.

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 or recently pregnant, staff should refer to NSW MoH GL2015_011 *Maternity – Rh (D) Immunoglobulin (Anti D)*.

3.16 Antenatal and Perinatal Loss

Staff should refer to NSW MoH PD2012_022 *Maternity – Management of Early Pregnancy Complications* for guidance relating to the clinical and psychological management of early pregnancy loss, defined as loss within the first 12 completed weeks of pregnancy.

NSW MoH PD2007_005 *Stillbirth – Management and Investigation* provides advice on the clinical and psychological management of late pregnancy and perinatal loss. The Sids and Kids website also offers extensive bereavement support services to parents and families who have experienced the sudden and unexpected death of a baby or child, during pregnancy, birth or infancy. These include counselling, parent and family support, group activities, annual memorial services, telephone counselling and a national 24 free call bereavement support line on 1300 308 307.

3.17 Pregnant Women Drug and Alcohol Diversion Programs

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.

3.18 Release Planning

When pregnant women are released prior to giving birth, they require a comprehensive handover of antenatal care to community providers such as LHD 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 on JHeHS by generating a *Release Summary and Transfer of Care* eform.

For women on OST, 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 issues/ Opioid Substitute Treatment (OST) must be referred to the Connections Program or the Community Integration Team (CIT).

On occasions, women are released unexpectedly and there is little time for release planning. The Midwives and Drug and Alcohol office must be notified about their release ASAP to arrange community follow up.

3.19 Intrapartum Management

3.19.1 Sydney Metropolitan area

At the onset of labour, pregnant women are transferred to either Westmead Public Hospital for women from Silverwater Women's Correctional Centre or Nepean Public Hospital for women from either Emu Plains or Dillwynia Correctional Centre. Campbelltown Hospital will be used in the case of pregnant females located at Reiby JJC. The care of the women during labour and birth is provided by the local public hospital.

Health centre staff must ensure that 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:

- Antenatal Records - NSW Health Antenatal Record (yellow card)
- Copies of ultrasound results
- Comprehensive list of current medications

3.19.2 Rural Areas

At the onset of labour, pregnant women in custody are transferred to the closest hospital that provides maternity services. The care of the women during labour and birth is provided by public hospital staff.

The NUM or Nurse in Charge (NiC) must notify the Midwives on when a woman is in labour and has been transferred to hospital. When possible, the Midwives will offer support to the woman during labour at the hospital.

3.20 Postnatal Care

Continuity of postnatal midwifery care is provided by the Midwives in conjunction with the GP, primary and/or women's health nursing staff, within the Sydney metropolitan area. Midwifery care is finalised at 4-6 weeks postnatal depending on the women's individual circumstances, and the woman's care is handed over to Primary Care services.

Wherever possible, staff will provide opportunities to maintain and support the attachment and relationship between the mother and baby. This is especially important if it is expected that the mother will be reunited with her baby, and/or become the primary carer at a future time. Staff must collaborate with other agencies such as FACS, and, where applicable, the woman's partner, designated carer, family and any other significant persons.

At 6-12 weeks postnatal, the women may require a Pap smear and/or contraception advice. The Midwives will wait list the women's health nurse and/or GP to provide this appointment. In rural centres, the NUM must ensure this follow up postnatal appointment is booked.

3.20.1 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 MoH PD2011_042 *Breastfeeding in NSW: Promotion, Protection and Support.*

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

Women who choose to express breast milk will be provided with a breast pump and encouraged and supported to express breast milk.

Breastfeeding is encouraged for women on a stable OST program; however breast feeding is not recommended where there is ongoing poly drug 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. Breastfeeding is contraindicated for women who are HIV positive.

JH&FMHN does not take responsibility for the transportation of EBM. The women can take EBM into the hospital while the baby is an inpatient. Nursing staff must liaise with CSNSW to facilitate the transport of the women to the hospital as often as possible while the baby is an inpatient. When the baby is discharged from the hospital and living in the community, transport of EBM is arranged by the woman's family or significant others.

For further information and instructions on EBM, refer to the JH&FMHN Guidelines for the Management of Pregnant and Postnatal Women in Custody.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

Women in custody

Applies to all women in JH&FMNH adult centres, adolescent centres and police cells.

5. Legislation and Related Documents

NSW Ministry of Health Policy Directives and Guidelines

GL2008_001 *Nursing & Midwifery Clinical Guidelines – Identifying & Responding to Drug & Alcohol Issues*

GL2008_009 *Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines*

GL2008_011 *Drug and Alcohol Withdrawal Clinical Practice Guidelines - NSW*

GL2010_004 SAFE START Guideline: Improving Mental Health Outcomes for Parents & Infants

GL2011_012 *Maternity – Decreased Fetal Movements in the Third Trimester*

GL2014_015 *Maternity – Management of Pregnancy Beyond 41 Weeks Gestation*

GL2014_016 *Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation/ Cutting*

GL 2015_011 *Maternity – Rh D Immunoglobulin (Anti –D)*

GL2016_001 *Maternity – Fetal Heart Rate Monitoring*

GL2016_015 *Maternity – Timing of Planned or Pre-Labour Caesarean Section at Term*

GL2017_007 *Maternity – External Cephalic Version*

GL2017_008 *Maternity – Supporting Women Planning a Vaginal Breech Birth*

GL2017-002 *Maternity – Maternal Group B Streptococcus (GBS) and minimisation of neonatal early- onset GBS Sepsis*

PD2005_406 *Consent to Medical Treatment – Patient Information*

PD2007_025 *Stillbirth – Management and Investigation*

PD2009_003 *Maternity – Clinical Risk Management Program*

PD2010_016 *SAFE START Strategic Policy*

PD2010_017 *Maternal & Child Health Primary Healthcare Policy*

PD2010_019 *Maternity – Breastmilk: Safe Management*

PD2010_022 *Maternity – National Midwifery Guidelines for Consultation and Referral*

PD2010_045 *Maternity – Towards Normal Birth in NSW*

PD2010_062 *Antenatal Maternal Referral/Transfer: Known Congenital Structural Malformations - Early Surgery*

	PD2011_042 *Breastfeeding in NSW: Promotion Protection and Support*
	PD2011_064 *Maternity – Management of Hypertensive Disorders of Pregnancy*
	PD2012_022 *Maternity – Management of Early Pregnancy Complications*
	PD2013_007 *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*
	PD2013_049 *Recognition and Management of Patients Who Are Clinically Deteriorating*
	PD2014_004 *Maternity – Supporting Women in their Next Birth After Caesarean Section*
	PD2014_022 *Pregnancy – Framework for Terminations in New South Wales Public Health Organisations*
	PD2016_015 *Maternity – Newborn Bloodspot Screening*
	PD2016_018 *NSW Maternity and Neonatal Services Capability Framework*
JH&FMHN Policies	1.036 *Health Assessment (Adolescents)*
	1.040 *Drug and Alcohol Service Provision*
	1.085 *Consent to Medical Treatment – Patient Information*
	1.395 *Transfer and Transport of Patients*
	4.030 *Requesting and Disclosing Health Information*
	5.015 *Child Protection*
	1.141 *Release Planning and Transfer of Care Policy – Adult to External Providers*
	1.245 *Immunisation of Patients*
	1.316 *Pregnancy Care Forensic Hospital and Long Bay Hospital*
	Guidelines for the management of pregnant and postnatal women in custody
JH&FMHN Forms	JUS110.450 *Antenatal Checklist*
	SMR020.060 Rh(D) Immunoglobulin Patient Consent
External Sources	Maternity Services – NSW Health Australian government http://www.health.gov.au/maternity
	Antenatal Care Guidelines Module 1
	Antenatal Care Guidelines Module 2
	CSNSW - Mothers and Children Program
	DAWN – Drug and Alcohol Withdrawal Now
	Mother safe Drugs in Pregnancy and Breastfeeding
	National clinical guidelines for the management of drug use during pregnancy, birth

and the early development years of the newborn.

National Health and Medical Research Council (NHMRC)