

# Department of Public Safety and Correctional Services

## Clinical Services & Inmate Health



### Operations Manuals

Administration	Medical Records
Chronic Disease Management	Pharmacy Services
Infection Control	Pregnancy Management
Infirmatory Care	Sick Call
Inmate Deaths	Substance Abuse
Medical Evaluations	

By signing this cover page, DPSCS officials responsible for the care and treatment of persons confined to their facilities give approval that the policies and procedures, reviewed and updated as needed annually and found herein, formally establish these processes to be acceptable to DPSCS.

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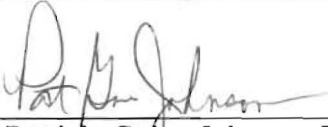
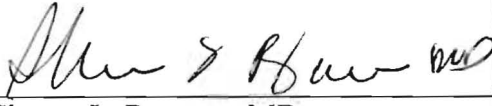
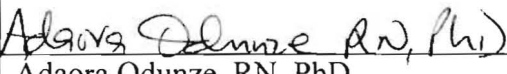
# Department of Public Safety and Correctional Services

## Clinical Services & Inmate Health



## Pregnancy Management Manual

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
PREGNANCY MANAGEMENT MANUAL

Chapter 1

SEVEN DAY PHYSICAL EXAM FOR PREGNANT WOMEN

- I. Policy: All female detainees and inmates of childbearing age (12 to 65) shall be queried about and tested promptly for pregnancy upon entry into the facility by healthcare personnel. Immediately upon determination of pregnancy, both the detainee/inmate and DPSCS: Services shall be promptly notified and the detainee/inmate shall be immediately enrolled into the prenatal program.
- II. Procedure:
  - A. A female providing a positive response on the IMMS to the “pregnancy” question and/or the pregnancy test shall be referred immediately to medical for a focused pregnancy evaluation by a provider. This evaluation shall include but not limited to an inquiry regarding:
    1. History of last menstrual period with date
    2. Nausea
    3. Vomiting
    4. Diarrhea
    5. Bleeding/Vaginal discharge
    6. Cramping
    7. Abdominal/back pain
    8. Fetal movement (after 22 weeks)
    9. Substance abuse during the pregnancy (alcohol, illicit drugs) as well as exposure to STDs and other infections during pre-incarceration.
    10. Vital signs (i.e.: temperature, blood pressure, pulse, respirations, height, and weight).

11. Fetal heart reading and documentations in EMR for gestational ages appropriate to fetal heart tones via Doppler/feta scope. (If applicable by gestation.)
  12. Most recent drug usage.
  13. History consistent with American College of Obstetrics and Gynecology.
- B. If any of the questionnaire responses are positive or if the vital signs are abnormal, the provider shall immediately call the physician-on-call for orders and discussions of care, or refer if onsite, to the OB/GYN specialist/nurse practitioners at UMMS Labor and Delivery.
- C. All pregnant females with a history of opiate abuse will be assessed by a physician and the appropriate treatment plan initiated.
1. All pregnant females currently addicted to opiates and who have never received methadone treatments will be assessed by a physician and methadone shall be initiated and maintained at appropriate dosages following DPSCS policy and procedure as outlined in the Substance Abuse Manual.
  2. All pregnant females previously receiving methadone maintenance during pre-incarceration will be assessed by a physician and shall be maintained on methadone at appropriate dosages. The community based methadone clinic shall be contacted for verification of enrollment and dosages provided consistent with the DPSCS Methadone Maintenance Program.
  3. All of the above information shall be documented in the EMR, on the Problem List, and the Obstetrics Flow Sheet as approved by the DPSCS: Clinical Services.
- D. As part of the Intake process, the seven day physical examination of all pregnant or suspect pregnant detainees/inmates of childbearing age shall receive a complete exam, including a breast exam, a bimanual examination and pelvic examination to evaluate gestational age (unless contraindicated). At no time shall the initial examination of a suspected or documented pregnant inmate exceed 10 working days. If contraindicated, the reason must be documented in EMR and the Obstetrics Flow Sheet. The detainees/inmates shall receive the following tests/services:

1. Urine pregnancy testing if not already completed. (Note: Pregnancy tests are to be performed at the initial screening of detainees/inmates at the Sally port).
2. PAP Smear
3. Serum HcG
4. Pregnancy profile, Hepatitis profile, RPR, HIV, Gonorrhea, Chlamydia and Sickle Cell testing, blood typing to determine Rh factor.
5. Consideration for appropriate immunizations shall be done including Hepatitis A, B, and C
6. Counseling related to HCV, HIV and Syphilis risk factors
7. Urinalysis
8. Prenatal Diet
9. Prenatal Vitamins
10. Enrollment and registration in the Prenatal Care program with discussion related to nutrition and exercise within corrections should be documented.
11. Appropriate housing
12. Appropriate activity level
13. Onsite OB consultant referral
14. Social Work referral as needed
15. Written educational brochure about prenatal services and delivery appropriate for the facility
16. Consideration for a discussion on breast feeding
17. Information on Interruption of Pregnancy should be documented in the medical record to include, but not limited to, the presentation of factual information about risks associated with either the decision to continue or interrupt the pregnancy. Terminations of pregnancy are restricted to the first trimester only. Considerations for termination of pregnancy outside of the first trimester will not be done without a life threatening event. Recommendations for second trimester abortions must be brought to the attention of the DPSCS Chief Medical Officer for review/discussion.
18. Request for all previous medical records within 24 hours and release of information form completion shall be documented in EMR.

- E. The prenatal Check off List shall be initiated and maintained in the EMR.
- F. The above required services shall be completed in a timely manner, consistent with good patient care but not to exceed seven days from the date of Intake Screening (date of arrest).
- G. If an inmate in her first trimester is identified as being Diabetic, they shall be followed per DPSCS Diabetic Clinic management plan, which includes a comprehensive eye exam during the first trimester.

III. References:

- A. NCCHC: P.G. -07
- B. Clinical Practice in Correctional Medicine, Puisis, M., 2<sup>nd</sup> Revised Edition; Mosby, St. Louis, 2006
- C. MD DPSCSD #130-100 Section 134
- D. American College of Obstetrical and Gynecology, 7<sup>th</sup> Edition, 2012

IV. Rescissions: MD DPSCSD #130-100 Section 134

- V. Date Issued: September 15, 2007
- Date Revised: September 21, 2009  
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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
OFFICE OF CLINICAL SERVICES/INMATE HEALTH  
PREGNANCY MANAGEMENT MANUAL

Chapter 2

CONTINUING CARE

- I. Policy: All pregnant detainees and inmates shall receive timely and appropriate prenatal care by qualified health care practitioners. Clinicians who are recognized specialists in obstetrical care shall provide prenatal care, either onsite or offsite. The care shall conform to community standards and the American College of Obstetrics and Gynecology standards 2010 edition. Care shall be consistent and scheduled on a regular basis per those standards and shall include but not limited to examinations, screening for concurrent disease and infection, advice on activity, nutrition, housing recommendations, safety precautions, exercise and counseling. Patient education, continuity of care, and social services as needed, shall be integrated into the prenatal services program.
- II. Procedure:
  - A. There shall be a designated medical primary care prenatal provider for all pregnant patients in addition to a provider whose credentials include highly specialized training in obstetrical and gynecological conditions.
    1. This shall be a M.D., PA, NP or Midwife who shall be the primary care provider for the patient and shall provide medically necessary services exclusive of those deemed the responsibility of the OB clinician.
    2. The OB/GYN clinician shall have documentation of specialized training specific to the monitoring of high risk Obstetrical patients and familiarity with complications of pregnancy in this population including substance abuse and HIV care.

- B. Documentation of OB visit shall be made in the EMR (Electronic Medical Record) consistent with the scheduled visits and assessments and documentation of care outlined by the American College of Obstetrics and Gynecology (ACOG).
- C. Consultation with OB/GYN specialty consultant is mandatory and will be documented on DPSCS consultant form even if the provider is onsite.
- D. The attempt to contact previous providers and signed release of information will be documented in the EMR (Electronic Medical Record).
- E. There shall be a designated service coordinator for the special needs population program. This LPN/RN responsibilities shall include but not limited to:
  - 1. Coordinate the completion of appointments and ancillary services as required in DPSCS/CS policies and manuals. Coordinate notification to the specialist of abnormal lab sonograms, x-rays, and follow-up tests, etc.
  - 2. Coordinate the completion of services as required by the check-off list.
  - 3. Coordinate the acquisition of lab reports, consultation reports, sonogram and non-stress tests etc. for the clinicians. This is to include a tracking system to ensure that all ordered labs are obtained or initiated within 24-72 hours unless ordered as STAT.
  - 4. Assist the clinicians and patients in service delivery.
  - 5. Be an information source for the patients.
  - 6. Specialized in-service training on care of the pregnant.
  - 7. Facilitate the generation of reports for DPSCS.
- F. Labs
  - 1. All labs shall be cleared identified by the addition of the prefix "OB" before the patient's surname.
  - 2. All labs shall be time and date stamped
  - 3. The primary care clinician upon receipt shall promptly review all labs and document the review as part of EMR/progress note.
  - 4. All abnormal labs shall have a progress note by the clinician, either primary care or an OB provider and the lab form initialed and dated if it is a paper format. Reviews of abnormal labs should be brought to the attention of the



- provider immediately, if grossly abnormal. Within the shift hours, if urgent and within 48-72 hours if abnormal lab values are slightly elevated.
5. All labs shall be made available to the OB provider at the time of the clinic visit. Progress note documentation of all shall be done.

G. Referrals:

1. If no significant problems are found at the time of the Intake Exam, the detainee/inmate shall receive a referral to the OB Specialist, for the next available slot, not to exceed 10 days.
  2. If an urgent or emergent problem is found, the detainee/inmate shall be referred immediately to an OB/GYN specialist for care. If not available, the patient should be sent to UMMS labor and delivery or the ER. Documentation of the referral per DPSCS policy will be done by the referring provider in EMR. Clinical situations that are non-life threatening but require evaluations outside of the usual cycle shall be referred within the week of the referral request date.
  3. All detainees/inmates shall have available to them, the services of the Social Work department. Social work may be asked to address issues of:
    - a. Continuity of prenatal care upon release
    - b. Newborn custody and
    - c. Other social issues for the patient including breast feeding
  4. All patients shall be registered with the hospital for labor and delivery services.
  5. A copy of the ACOG compliant Obstetrics Flow sheet shall be faxed to the delivering hospital upon enrollment into the prenatal program and within two weeks of the expected date of confinement.
- H. At the time of transfer to another region, the transferring region shall enter the following information on the Transfer Screening Form in the EMR (Electronic Medical Record).
1. RPR, HIV, Hepatitis screen, sickle cell date and results. (Note: Infectious Disease staff shall be notified for all positive ID results).
  2. PPD Date and results

3. Ultrasound date
4. Last OB visit
5. Next OB visit
6. Gestational Weeks
7. Any complications or problems of pregnancy
8. Medications

I. OB Clinic:

1. The OB specialist shall provide regularly scheduled prenatal care to the detainee/inmate as referenced by contact and community standards and ACOG.
2. Visits shall be scheduled consistent with community standards/ACOG for high risk pregnancy.
3. The OB Flow Sheet shall be used and maintained in the detainees/inmates EMR (Electronic Medical Record).

J. Patient Education:

1. The OB Clinic nurse shall document patient education for each visit, including, but not limited to:
  - a. Signs of toxemia
  - b. Fetal distress
  - c. Vaginal bleeding and vaginal discharge
  - d. Continuity of care upon release
2. Diet, nutrition and exercise options compatible with prenatal pre-conditioning (i.e.: walking or low impact movement in cell or ward).
3. Breast care and breast feeding support if the neonate is to be maintained by family and detainee/inmate request opportunity.

K. Housing:

1. Individuals in their third trimester of pregnancy shall be housed in the infirmary as an admitted patient for the last two weeks prior to their EDC (Estimated Date of Confinement). If the individuals are overdue, she will continue to be housed in the infirmary as an admitted infirmary patient until

active labor begins or until the OB consultant has made other housing and care recommendations.

2. Individuals of any trimester who are deemed to need Infirmiry Care shall be admitted to the Infirmiry on order of the primary care/Nurse Practitioner or OB physician.
3. Upon admission to the infirmiry the following shall be performed:
  - a. A medical evaluation including a physical examination will be performed by a physician's assistant, nurse practitioner, or physician within twelve (12) hours of admission.
  - b. A physician who is qualified to do an examination on high risk obstetrical patients will provide an assessment of the status of the gestation and a treatment plan within 48-72 hours of admission.
  - c. Baseline vital signs shall be obtained, which includes but not limited to height, weight, blood pressure, pulse, respiration, temperature, fetal heart rate, and fetal position. The detainees/inmates condition shall be documented in the patients EMR (i.e.: good, fair, poor, etc.).
  - d. Infirmiry admission laboratory data will include at a minimum, CBC, fasting blood sugar, urinalysis, chemical profile indication, liver function, renal status and any other medically indicated tests.
  - e. The detainee/inmate shall be weighed daily and vital signs including fetal heart sounds shall be obtained and recorded every shift. Blood glucose shall be measured and recorded weekly. Indications of edema, proteinuria, and elevation in blood pressure will be noted at each encounter with the detainee/inmate. Any signs or symptoms of toxemia should be noted and a call made to the provider for instructions.
  - f. Nursing staff should examine the detainee/inmate for bloody show when indicated. All bleeding shall be reported to a provider immediately and documented as mild, moderate etc. Clinician should also note the number of pads used /shift and any back ache, cramping, etc.



6. The detainee/inmate shall be transferred to the hospital if regular contractions occur, active labor begins, hemorrhage or rupture of membranes occurs, or other signs of fetal maternal distress.

III. References:

- A. NCCHC: P.G. -07, 2008
- B. Clinical Practice in Correctional Medicine, Puisis, M., et.al. 2<sup>nd</sup> Revised Edition  
Mosby, St. Louis, 2006
- C. MD DPSCSD #130-100 Section 134
- D. American College of Obstetrical and Gynecology, 6<sup>th</sup> Edition, 2010

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# DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

## OFFICE OF CLINICAL SERVICES/INMATE HEALTH

### PREGNANCY MANAGEMENT MANUAL

#### Chapter 3

#### HIGH RISK PREGNANCY

- I. Policy: Special attention will be given to the detainee/inmate experiencing a high-risk pregnancy defined as one in which the mother or fetus has a significantly increased risk of mortality or morbidity before, during, or after birth. Women identified as high-risk obstetrical patients include those women who have a history of incarceration. Other factors that may constitute a high risk pregnancy includes:
  - Multiple pregnancies, >30 years of age or <19 years of age
  - Precipitous onset of labor
  - Multiple abortions (spontaneous and/or therapeutic)
  - Previous ectopic pregnancies
  - Teenage pregnancy, (Current)
  - Inadequate pre-natal care
  - Diabetes mellitus, asthma, seizure, chronic condition, sickle cell or systemic conditions
  - Drug abuse
  - HIV infection
  - Syphilis
  - Hepatitis
- II. Procedure:
  - A. The OB specialist in consultation with the primary care provider shall identify higher-risk patients and the EMR (Electronic Medical Record) will reflect that designation.
  - B. HIV-Positive Patients

1. All HIV-Positive patients shall be managed in conjunction with the Obstetrics department at the University of Maryland Hospital or a board certified OB/GYN consultant who is managing the patient in consultation with HIV specialist or infectious disease.
  2. A referral to the University of Maryland or a board certified OB/GYN specialist shall be made immediately upon confirmation of HIV status. The primary care physician shall ensure that this referral is made and document the disposition in the record.
  3. A CD4 count and Viral Load must be obtained and noted in the EMR within 24-48 hours of receiving positive results.
  4. Tele-medical consultation with HIV specialist shall be scheduled and managed by primary care provider.
  5. All HIV-positive patients shall receive ante-partum, intra-partum and post-partum anti-retroviral medications to minimize transmission to the fetus per community and infectious disease standards. Record status on the monthly OB census report to DPSCS.
- C. A serology on all pregnant individuals shall be obtained within five (5) days of Intake.
1. All positive serology shall be treated in a manner appropriate to the stage of syphilis and consistent with community and current CDC recommendations.
    - a. Infection Control shall be notified of all positive serology results as well as a line listing provided on the Infectious Control report and submitted to DPSCS monthly.
    - b. This treatment shall be initiated within 48-72 hours of notification and shall be documented in the EMR and in consultation with the ID or OB specialist. Treatment plan shall also be included on the Infectious Control report as a line listed and provided to DPSCS monthly.
    - c. The primary care physician shall ensure that treatment is completed on all patients for whom it is indicated and documentation of completed treatment shall be included on the Infectious Control report and sent to DPSCS monthly.

2. If the OB specialist so determines, higher-risk patients shall be promptly referred to the University of Maryland OB services for management.

D. Identified higher-risk patients require close care and monitoring during the prenatal and labor period. Any of the following complaints will be reported to a physician immediately;

1. Persistent nausea or vomiting
2. Dizziness
3. Headaches
4. Visual disturbances
5. Lower abdominal pain or cramps
6. Vaginal bleeding
7. Rupture of membranes
8. Excessive swelling of hands or feet
9. Diminished urinary output
10. Urinary tract infections
11. Polyuria, polydipsia, nocturia
12. Elevated blood pressure
13. Hyperactive reflexes
14. Open wounds, boils, suspicious of MRSA, etc.

E. Consultation provided by the attending physician at the community hospital regarding high-risk pregnancies should be documented in the medical record.

F. Special orders for management should be instituted after consultation with the facility physician and the community hospital.

### III. References:

A. NCCHC;P.G. -.07, 2008

B. Clinical Practice in Correctional Medicine, Puisis, M., et.al., 2<sup>nd</sup> Revised Edition; Mosby, St. Louis , 2006

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PREGNANCY MANAGEMENT MANUAL

Chapter 4

LABOR AND DELIVERY

- I. Policy: All pregnant detainees and inmates shall receive timely and appropriate labor and delivery services by qualified health care practitioners in a safe environment with all necessary emergency equipment available.
- II. Procedure:
  - A. Normal Labor
    1. At the onset of active labor, regular contractions, or the spontaneous rupture of membranes, a physician shall be notified.
    2. Transportation to the hospital will be initiated.
      - a. If delivery is progressing rapidly and/or signs of fetal distress are evident (fetal heart rate above 170 or meconium staining), staff will call 911.
      - b. If hemorrhaging occurs or the life of the mother or fetus is at risk, call 911.
    3. The patient shall be transported to the designated hospital for labor and delivery.
    4. The Obstetrics Flow sheet and all other relevant clinical information shall accompany the patient.
    5. Detainees/inmates in the process of labor and delivery shall not have physical restraints used during that process.
  - B. Spontaneous Abortion
    1. Detainees/inmates experiencing spontaneous abortion shall be transported to the health care unit (along with the products of conception, if available).
      - a. Upon arrival at the health care unit, complete vital signs shall be obtained, a physician notified and emergency orders initiated.
      - b. The individual shall be transported by 911 to the hospital for evaluation.

- c. The products of conception, if available, shall be transported along with the individual to the hospital
- C. Post-Partum Management
- 1. Following discharge from the hospital and return to the facility, the detainee/inmate shall be admitted to the infirmary for post-partum care until discharge by the facility physician.
  - 2. Vital signs, pad counts, bleeding, discharge and other observation shall be documented for each shift.
  - 3. The physician shall be immediately notified of
    - a. Abnormal vital signs
    - b. Excessive bleeding or pain
    - c. Signs of infection
    - d. Other signs of unusual distress

III. References:

- A. NCCHC;P.G. -.07, 2008
- B. Clinical Practice in Correctional Medicine, Puisis, m., et.al., 2<sup>nd</sup> Revised Edition; Mosby, St. Louis , 2006
- C. MD. DPSCSD #130-100 Section 134

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
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PREGNANCY MANAGEMENT MANUAL

Chapter 5

STAFF CONTINUING EDUCATION

- I. Policy: Staff working with pregnant inmates will receive the training necessary to assure the delivery of the best possible care for these individuals and their babies.
- II. Procedure:
  - A. The OB specialist shall provide one in-service per month to the clinical staff on topics pertinent to the care of the pregnant patient.
  - B. Topics to be included, but not limited to, are:
    1. Vaginal bleeding
    2. Pain, normal and abnormal
    3. Fetal heart tones and fetal distress
    4. Pre-eclampsia and Eclampsia
    5. Post-partum care
    6. Breast feeding
    7. Other topics deemed to be of importance to staff or found to be necessary in the event of special concerns, such as an infectious disease outbreak
  - C. The contracted medical vendor shall maintain records of date, topic, and attendees and submit them to the agency ACOM (Area Contract Operations Manager) in conjunction to DPSCS submission on the monthly in-service report.
- III. References:
  - A. NCCHC;P.G. -.07, 2014
  - B. Clinical Practice in Correctional Medicine, Puisis, m., et.al., 2<sup>nd</sup> Revised Edition; Mosby, St. Louis , 2006
  - C. MD. DPSCSD #130-100 Section 134
- IV. Rescissions: MD DPCSCD #130-100 Section 134

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

PREGNANCY MANAGEMENT MANUAL

Chapter 6

USE OF RESTRAINTS DURING PREGNANCY

- I. Policy: All pregnant inmates from 1<sup>st</sup> Trimester until postpartum should not be placed in restraints unless there is a security determined threat of harm of self, staff or others.
- II. Procedure: If custody determines there is a threat of any harm and restraints are required for safety, then restraint of the pregnant inmates should be done by the least restrictive means necessary and in a way that mitigates adverse clinical consequences and only if necessary due to serious threat of harm to self, staff or others.

**Pre-partum**—Restraint should be done by the least restrictive means necessary and in a way that mitigates adverse clinical consequences and only if necessary due to serious threat of harm to self, staff or others.

**Abdominal Restraints** that directly constricts the area of pregnancy should not be used

**Facedown position or in Four-point Restraints** Pregnant inmates **should not** be placed in a face down position or in four point restraint at any time during pregnancy.

**Leg and ankle restraints should not** be used once a pregnancy is suspected or confirmed

**Wheel Chair Transport** is preferred with wrist restraint *only if flight risk or identified as violent hostile and in the most minimal manner to protect the safety of the public, infant and inmate*

**Partum** Restraints during transport to the hospital or during labor should not be used, except where necessary due to serious threat of harm to self, staff, or others

**Labor No Restraint** recommended during labor. Necessary bed rest and rapid response to medical emergencies should also be taken into account, particularly for cesarean section (also known as a C-section) births.

If restraints are required during labor *due to serious threat of harm to self, staff, or others*, they should allow for the mother's safe handling of her infant or mother-infant bonding, which is beneficial and very strong during the postpartum period.

**Postpartum** Restraints **should be avoided if possible** during the immediate postpartum period while hospitalized. Upon return to the facility, restraints may be applied. Labor and delivery can result in exhaustion, dehydration, difficulty in urination or defecation, and complications such as hemorrhage, they should allow for the mother's safe handling of her infant and mother-infant bonding, which is beneficial and very strong during the postpartum period.

Adopted by the National Commission on Correctional Health Care Board of Directors October 10, 2010

- III. References: Clinical Practice in Correctional Medicine, Puisis, M., et al. 2<sup>nd</sup> Revised Edition Mosby, St Louis , 2006.
- IV. Rescissions: MD DPSCSD #130-100 Section 134
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