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HC Operational Procedure/HCDOM Supplement Approval Coversheet

California Institution for Women

Instructions: Complete the summary below and attach HC Operational Procedure/HCDOM Supplement with attachments (if any). Please complete this form for all CIW HCDOM Supplements and Operational Procedures assigned to you.

THIS FORM IS TO BE COMPLETED BY THE DEPARMENT HEAD PRIOR TO PCPC SO THAT THE COMMITTEE ONLY NEEDS TO MAKE MINOR ADJUSTMENTS, IF NEEDED.

CIW HCDOM Supplement and Operational Procedure Information
HCDOM Supplement and Operational Procedure Name: Please include the numbering convention and title of the supplement/operational procedure.
HCDOM 3.1.16 Patient Care During Pregnancy and Childbirth Supplement
Purpose: What is the purpose for the implementation of this HCDOM Supplement/Operational Procedure? This information will be displayed in the LMS Course Announcement Memorandum.
To ensure health care concerns are met for the pregnant patient population both pre and post-partum and for the birth of children at local hospitals.

Submitted By:	Michelle Torres, HPSI
Date Submitted:	4/23/2021
Responsible Parties:	CME, CNE, SD, HPMIII

Audience: Which areas, classifications (**be specific**), or departments need to be trained on this material?		
1. Medical Providers	11.	21.
2. Dental Providers	12.	22.
3. Licensed Nursing Staff	13.	23.
4.	14.	24.
5.	15.	25.
6.	16.	26.
7.	17.	27.
8.	18.	28.
9.	19.	29.
10.	20.	30.

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Summary of Changes: Please provide a summary of all changes made to this Health Care DOM Supplement/HC Operational Procedure. Please provide sufficient information to ensure staff can easily grasp the content being provided.

Annual review, suggestions for Statewide policy changes include:

Page 1 (3)(B)4. Provision of social and educational services pertaining to pregnancy, childbirth, and health promotion ADDED: to include safer sexual practices.

Page 4, (7)(A) Postpartum patients shall not be discharged from hospital, until they are medically stable. Patients who deliver a child via cesarean section shall ADDED: be offered admission to the OHU or CTC via the TTA upon return to the institution. ADDED: If patient refuses, document in EHRS and they shall have appropriate OB follow up.

Local Governing Body Decision:	Approved:	YES	NO

Reviewed and Approved By:

DocuSigned by:
James Elliot
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5/3/2021

James K. Elliot
Chief Executive Officer

Approval Date:

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3.1.16 Patient Care during Pregnancy and Childbirth

(a) Policy

(1) California Correctional Health Care Services (CCHCS) staff shall provide health care for the pregnant patient population. CCHCS provides comprehensive and coordinated health care services to female patients commensurate with each patient's risk level and complexity, based on the Complete Care Model.

(2) Every institution housing women shall provide obstetrical services, to include care for women with high-risk pregnancies. The California Institution for Women (CIW) is the designated institution for management of pregnancy and childbirth. All newly identified pregnant patients shall be referred for transfer to CIW.

(b) Purpose

To ensure health care concerns are met for the pregnant patient population both pre and post-partum and for the birth of children at local hospitals.

(c) Responsibility

(1) Statewide

CDCR and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place; and appropriate tools, training, technical assistance, and levels of resources are available so that care teams can successfully implement this procedure at all institutions housing female inmates.

(2) Regional

Regional Health Care Executives shall implement this procedure at the subset of institutions within an assigned region.

(3) Institutional

(A) The Chief Executive Officer (CEO), or designee, is responsible for the implementation, monitoring, and evaluation of this policy.

(B) The CEO shall implement and manage a system to administer this procedure. The CEO shall delegate decision making authority to designated institutional health care executives for daily operations of the health care delivery system and ensure adequate resources are deployed to support the required elements of care:

1. Provision of obstetrical (OB) services 24 hours per day.
2. Emergency treatment and management of preterm and/or precipitous delivery 24 hours per day.
3. Provision of hospital, surgical, and neonatal services.
4. Provision of social and educational services pertaining to pregnancy, childbirth, and health promotion to include safer sexual practices.

(C) The CEO and all members of the institution leadership team shall ensure all necessary resources are in place to support the successful implementation of this procedure at all levels; including, but not limited to:

1. Institution level
2. Patient panel level
3. Patient level

(D) The CEO and all members of the institution leadership team shall ensure access to and utilization of equipment, supplies, health information systems, patient registries and summaries, and evidence-based guidelines, to ensure coordinated and integrated management of pregnancy and childbirth.

(d) Local Operating Procedure

Each CDCR institution shall maintain a Local Operating Procedure to implement the statewide procedure.

(e) Procedure

(1) General Requirements

(A) CCHCS staff shall conduct a health screening, including a pregnancy screening, for all female inmates upon reception into CDCR per Health Care Department Operations Manual (HCDOM), Section 3.1.8, Reception Center.

(B) The Primary Care Provider (PCP) shall evaluate patients within seven calendar days of self-reporting a suspected pregnancy or when pregnancy is suggested by the patient's physical appearance, and/or signs and symptoms of pregnancy are present.

(C) CCHCS staff shall obtain diagnostic studies within three business days of evaluation by the PCP.

(D) Upon confirmation of pregnancy, the Primary Care Team (PCT) shall provide and/or coordinate OB and health care services to include a written plan of care.

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1. A patient may request to receive medical services from the physician and surgeon of her choice who is credentialed and trained in obstetrics.
2. Any expenses incurred by the services of a non CDCR/CCHCS physician and surgeon of the patient's choice shall be the responsibility of the patient.

(E) Patients with health care conditions that increase the risk of, or cause a high-risk pregnancy shall be identified, monitored, and referred to the appropriate level of care as indicated by health care needs of the patient.

(F) The PCT shall ensure communication with the receiving institution and other health care providers, regarding the patient's status and treatment plans to ensure continuity and coordination of services.

(G) Transfer shall occur in accordance with the procedure outlined in HCDOM, Section 3.1.9, Health Care Transfer. Special consideration shall be given to ensure that the appropriate mode of transportation is selected and communicated.

(2) Care of Pregnant Patients

(A) Pregnant patients shall be provided the following:

1. An initial OB visit scheduled to occur within seven calendar days of pregnancy diagnosis.
2. Diagnostic studies; ordered as medically necessary.
3. The option to be tested for human immunodeficiency virus (HIV).
4. Education by the PCP or Obstetrician, in conjunction with a Mental Health Clinician when appropriate, regarding the patient's choice of pregnancy options such as:
   a. Continuing pregnancy and childcare plans.
   b. Adoption.
   c. Termination services. (A Referral for Services shall be submitted for the PCP or Obstetrician)
   d. Emergency contraceptives.
   e. Obtaining pregnancy information pamphlets or other pertinent educational material.
5. CCHCS staff shall document the provision of this education in the health record.

(B) Pregnant patients shall be prescribed or issued:

1. Prenatal vitamins (which contain iron and folic acid).
2. Dietary supplementation to include:
   a. Two extra cartons of milk,
   b. Two extra servings of fresh fruit, and
   c. Two extra servings of fresh vegetables daily.
   d. Additional nutrients or supplements and/or referral to a Dietitian as necessary.
3. A CDCR 1845, Disability Placement Program Verification, CDCR 7410 Comprehensive Accommodation Chrono and Medical Classification Chrono, for lower bunk and lower tier housing if housed in a multi-tier housing unit and any other necessary medical clearances or restrictions in their third trimester or earlier, if medically indicated.
4. A referral to the dentist on a priority basis, as early in the second trimester of gestation as possible, for a comprehensive dental examination, periodontal evaluation, and the necessary treatment in order to maintain periodontal health during gestation period. To establish protocols which prevent or treat gingivitis/periodontitis during pregnancy.
   a) Diagnosis of Periodontal Disease
      1. Pregnant patients shall receive a comprehensive full mouth periodontal examination, charting and classification to determine the periodontal condition and an appropriate treatment plan.
      2. Pregnant patients shall have their plaque index score determined and recorded on a Clinical Note in the Electronic Dental Record System (EDRS).
   b) Treatment of Periodontal Disease
      1. Education: Methods and procedures to control periodontal disease shall be taught and demonstrated to pregnant patients by dental staff.

(C) The PCP shall prepare a CDCR 7252, Request for Authorization of Temporary Removal for Medical Treatment, for all pregnant patients within 30 calendar days prior to the estimated delivery date. This form shall be taken to the Watch Commander's office in advance by the OB PCT to enable custody staff to prepare the patient for transportation to an outside facility in a timely manner.

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(D) Unless otherwise indicated by the Obstetrician, pregnant patients shall be scheduled for their OB visits as follows:
1. Every four weeks in the first trimester and up to 24-26 weeks gestation.
2. Every three weeks up to 30 weeks gestation.
3. Every two weeks up to 36 weeks gestation.
4. Weekly after 36 weeks gestation up to delivery.

(E) Pregnant patients shall be provided additional health care services as medically indicated.

(F) Every pregnant patient electing to continue her pregnancy shall be referred to a Medical Social Worker for case management to discuss placement of her child and options available for placement and care of the child after delivery.
1. A Medical Social Worker shall assist the pregnant patient to contact relatives regarding newborn placement, even while still in process of reception.
2. The Medical Social Worker shall initiate and oversee the management of all newborn placements.

(G) If clinically appropriate, patients shall be provided opioid maintenance therapy during pregnancy.

(3) Outside Consultation or Non-Emergent Labor and Delivery

(A) Transportation shall occur in accordance with the procedure outlined in the HCDOM, Section 3.1.9, Health Care Transfer. Special consideration shall be given to ensure that the appropriate mode of transportation is selected and communicated.

(B) Copies of all prenatal forms and the completed CDC 7243, Health Care Services Physician Request for Services, shall accompany the pregnant patient when she is sent for medical treatment or consultation to an outside facility, and when the patient is transported for labor and delivery.

(C) When a patient returns, the Registered Nurse (RN) on duty in the Triage and Treatment Area (TTA), Outpatient Housing Unit (OHU), or Correctional Treatment Center (CTC), or Psychiatric Inpatient Program (PIP) shall receive the patient's paperwork from the outside facility. The receiving nurse shall notify the PCP or Obstetrician of the patient's return, medical status, recommendations from the outside consultant, and ensure the documents are filed in the health record.

(4) After-Hours Procedure

(A) All pregnant patients presenting for care after hours shall be referred to the on call medical provider trained in OB Services.

(B) A Medical Provider trained in OB Services shall be on call after regular business hours.

(C) All pregnant patients requiring urgent/emergent services shall be directed to TTA.

(D) Designated Nursing staff shall contact the on call Medical Provider trained in OB Services to report a comprehensive assessment, which can include the following:
1. Age
2. Gravidity/Parity
3. Gestational age
4. Chief Complaint
5. History of Present Illness
6. OB History
7. Medical and Mental Health history
8. Vital Signs/Pain Assessment
9. Fetal Heart Tones
10. Frequency of Contractions
    a. by Toco or palpation
11. Urine Dip
12. Vaginal Discharge/Bleeding
13. Other presenting sign and symptoms/other pertinent information

(E) Additional orders shall be given by the on call medical provider trained in OB services as clinically indicated and nursing shall ensure all orders are carried out immediately.

(F) All fetal diagnostic results shall be interpreted by the designated provider on call for OB.

(G) No patient shall be discharged back to their housing without an order from the designated provider on call for OB.

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(5) Precipitous Delivery

(A) A Precipitous Delivery kit is available in the Triage and Treatment Area (TTA), OB Clinic, and ambulance.

(B) In the absence of a provider, an RN may need to assist the patient in birthing, if delivery is imminent. A Precipitous Delivery Quick User Guide (Attachment A) is available in the Precipitous Delivery kit.

(C) Any staff can call 911 if delivery is imminent.

(6) Emergency Transport

(A) A pregnant patient in labor shall be treated as an emergency and be transported immediately via ambulance. In the event of an emergency transport for the delivery of a baby, the Obstetrician or PCP shall be immediately notified and provide appropriate assistance and/or orders.

(B) Application of restraint gear and physical restraints shall be in accordance with California Penal Code, Sections 3407 and 3423, and the Department Operations Manual, Sections 54045.1 and 54045.11. If handcuffs are applied, the patient's arms shall be brought to the front of her body for application.

(7) Postpartum Care

(A) Postpartum patients shall not be discharged from hospital, until they are medically stable. Postpartum patients who deliver a child via cesarean section shall be offered admission to the OHU or CTC via the TTA upon return to the institution. If patient refuses, document in EHRS and patient shall have appropriate OB follow up.

(B) All postpartum patients who deliver a child vaginally shall be assessed by the TTA RN who shall review discharge orders and initiate postpartum care following communication and receipt of orders with the PCP or Physician-on-call and determine appropriate housing.

1. All postpartum patients assigned to PIP shall be admitted straight to PIP.
2. All postpartum patients assigned to OHU shall be admitted straight to OHU during 2nd Watch, and via TTA during 1st and 3rd Watch.

(C) Postpartum patients shall be seen within the following intervals:

1. Five calendar days upon return from Higher Level of Care, per 3.1.5 Scheduling and Access to Care.
2. At six weeks postpartum. At the postpartum check-up, the OB Provider shall articulate treatment plans and determine whether the patient may be cleared for full duty or if medical restrictions are still warranted.

(D) CCHCS staff shall schedule follow-up appointments, articulate treatment plans, and determine the need for continued limited duty, for all postpartum patients.

(E) Patients shall be afforded family planning services if their release and/or parole date falls within 12 to 16 weeks after delivery.

(8) **Lactation Program**

(A) The CIW has a program to support postpartum patients who desire to breastfeed, should the patient qualify. The Lactation Program is facilitated through Custody; specifically, the Clinical Social Worker/Family Services Coordinator, per CIW DOM Supplement 54045.19 Breastfeeding.

(9) Required Training

(A) Orientation to patient care during pregnancy and precipitous delivery shall be included in the onboarding process for all nursing staff and annually or upon revision of this policy, thereafter or as indicated.

(10) Local Oversight - Designated Standing Improvement Committee

(A) The Medical Program Subcommittee shall be the designated oversight committee reporting to the local Quality Management Committee for oversight of the systems and processes dedicated to the health care management of pregnant patients.

(B) Tracking and monitoring activities shall be performed to identify trends and opportunities for improvement.

Attachments

- Attachment A – Precipitous Delivery Quick User Guide

References

- Code of Federal Regulations, Title 42, Chapter 1, Subchapter A, Part 8, Subpart B, Section 8.12(f)(3), Federal Opioid Treatment Standards
- California Penal Code, Part 3, Title 2, Chapter 3, Sections 3406-3407
- California Penal Code, Part 3, Title 2, Chapter 3, Section 3409
- California Penal Code, Part 3, Title 2, Chapter 4, Section 3423
- California Code of Regulations, Title 9, Division 4, Chapter 4, Subsection 5, Article 3, Section 10360, Additional

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Requirements for Pregnant Patients

- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 2, Article 7, Section 3170-3182, Visiting
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 7, Section 3337, Classification Hearing of Administrative Segregation Placements
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 8, Section 3355.2, Treatment for Pregnant Inmates
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.1, Complete Care Model
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.8, Reception Center
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.9, Health Care Transfer
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.10, Specialized Health Care Housing
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.12, Outpatient Dietary Intervention
- Health Care Department Operations Manual, Chapter 3, Article 2, Section 3.2.1, Medication Management
- California Department of Corrections and Rehabilitation, Department Operations Manual, Article 45, Sections 54045.1 and 54045.11

Revision History
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Precipitous Delivery Quick User Guide

(Attachment A)

1) **Stay calm**, reassure mother
2) Notify Watch, Control and EMA team to prepare for transport
3) Prepare for eminent delivery by:
   a) Turn on infant warmer
   b) Open delivery pack on clean surface between mother's legs
   c) Put on protective equipment
   d) Prep perineum
      i) Pour sterile water or normal saline over perineum
      ii) Wipe once top to bottom with 4X4s
4) If possible:
   a) Place on fetal monitor
   b) Place mother on Oxygen
   c) Start IV of 0.9 Normal Saline at 125cc/hour rate
5) Control delivery:
   a) Have mother pant during contractions
   b) Control delivery (place gloved hand on presenting part without pressure)
   c) Once head delivered *Check neck for umbilical cord.
      i) If cord around neck attempt to slip it over baby's head.
      ii) If tight and can't be removed cord must be doubled clamped and cut.
   d) Once head presented bulb suction immediately (don't wait for entire body to be delivered)
      i) Suction mouth then nose
   e) Allow delivery to proceed at own rate. Do not pull or to prevent delivery.
   f) Deliver shoulders:
      i) Steady, gentle downward pressure to allow anterior shoulder to slip under pubis
      ii) Smooth upward guidance to deliver posterior shoulder
   g) Once baby delivered:
      i) Suction, dry, and stimulate infant to cry (rub back, flick baby's feet)
      ii) Double clamp and cut cord
      iii) Keep infant warm, with skin to skin with mother or on infant warmer
      iv) Preform 1-minute and 5-minute Apgar Score
   h) Deliver placenta **ONLY** if it separates spontaneously, and place in red bag for transport with mother. (can take up to thirty minutes after delivery)
6) Prepare mom and baby for transport, give report to paramedics and phone hospital report.
7) Documentation