

CF OPERATING PROCEDURE
NO. 155-57

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, March 1, 2021

Mental Health/Substance Abuse

CARE OF PREGNANT FEMALES IN STATE MENTAL HEALTH TREATMENT FACILITIES

1. Purpose. This operating procedure describes Departmental procedures and guidelines to safeguard the health of pregnant females and their unborn infant(s) while in the care of a state mental health treatment facility.

2. Scope. This operating procedure applies to state mental health treatment facilities that serve female residents, whether operated by the Department of Children and Families (DCF) or by contract with private entities.

3. References.

- a. [Guidelines for Perinatal Care, Current Edition](#);
- b. [American Academy of Pediatrics](#);
- c. [American College of Obstetricians and Gynecologists](#);
- d. DCF Operating Procedure [155-26](#), Safe and Supportive Observations of Residents;
- e. DCF Operating Procedure [155-4](#), Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Screening and Treatment in State Mental Health Treatment Facilities;
- f. Chapter 394, Florida Statutes (F.S.), [Part I](#), Florida Mental Health Act;
- g. Chapter [916](#), F.S., Mentally Deficient and Mentally Ill Defendants;
- h. Chapters [458](#) and [459](#), F.S., Regulation of Professions and Occupations;
- i. Chapter 464, F.S., [Part I](#), Nursing Practice Act; and,
- j. Chapter 39, F.S. [Part II](#), Reporting Child Abuse and [Part III](#), Protective Investigations.

4. Definitions.

a. Clinician. A Physician licensed pursuant to Chapter 458 or Chapter 459, F.S.; Advanced Registered Nurse Practitioner (ARNP) licensed pursuant to Chapter 464, F.S.; or Physician Assistant licensed pursuant to Chapter 458, F.S.

b. Close Observation (CO). This level of observation requires that staff monitor a person's condition, location, and/or behavior every 15 minutes. Close observation will occur in settings residents generally occupy such as bedrooms, wards, pods, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to buildings. Authorization for Close Observation is by clinician order, which must be reviewed and renewed at least every seven (7) days and include a face-to-face examination by a clinician. The clinician will document whether changes have occurred, note additional

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concerns, if any, write a new order and document justification for continuation or discontinuation of an order.

c. Group Observation (GO).

(1) This level of observation requires a staff member to remain within visual contact and in close proximity of up to three (3) designated residents, in order for the physical, medical, emotional or security needs of the residents to be met. The assigned staff maintains visual contact with the assigned residents at all times. Should a resident need to separate from the group observation for medical care or the bathroom, additional staff assistance will be called to maintain the required observation. Documentation of behavior, activity, and location is required every 15 minutes. Authorization for GO is by clinician order and must be reviewed and renewed at least every seven (7) days and include a face-to-face examination by a clinician. The clinician will document whether changes have occurred, note additional concerns, if any, write a new order and document justification for continuation or discontinuation of an order.

(2) Residents who have been determined by a clinician to be at risk for suicide, significant resident injury, or significant injury to staff resulting from resident to staff altercations shall not be placed on GO. When assessing this risk, the clinician will review the resident's recent history of such behavior.

d. Guardian. A person who has been appointed by the Court to act on behalf of a resident or property, or both.

e. One-to-One (1:1) Observation. This level of observation requires one staff member to maintain uninterrupted visual contact of a resident while remaining within arm's length at all times. If it is determined by a clinician that "within arm's length" creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. The clinician will document justification for the variance. Staff assigned this coverage cannot be assigned to more than one resident at a time. One-to-one observation requires documentation at least every 15 minutes. Authorization for One-to-One Observation is by clinician order and must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician. The clinician will document whether changes have occurred, note additional concerns, if any, write a new order and document justification for continuation or discontinuation of an order.

f. Resident. Person who receives mental health treatment services in a mental health treatment facility operated by the state or via a contract with a provider. The term is synonymous with "client", "consumer", "individual", "patient", or "person served".

g. Recovery Plan. A written plan developed within 30 calendar days of admission by the resident and his or her recovery team (also referred to as the "plan"). This plan is based on assessment data, identifying the resident's clinical, rehabilitative and quality of life/enrichment service or recovery needs, the strategy for meeting those needs, documented treatment and recovery goals and objectives, criteria for terminating the specified interventions, and documented progress in meeting specified goals and objectives. The recovery plan is reviewed at least every 30 calendar days during the first 24 months the resident is in the facility, and at least every 60 calendar days when the resident's length of stay exceeds 24 months.

h. Recovery Team. An assigned group of individuals with specific responsibilities identified on the recovery plan including the resident, psychiatrist, guardian/guardian advocate (if resident has a guardian/guardian advocate), community case manager, family member and other treatment professionals as determined by the resident's needs, goals, and preferences.

i. Routine Observation. This level of observation consists of visual observation which is not the result of a special written order in a resident's medical record. It involves at least thirty (30) minute face checks completed by direct care staff in settings which residents generally occupy such as bedrooms, wards, pods, restrooms, dining rooms, activity rooms, classrooms, and enclosed yards attached to buildings.

j. State Mental Health Treatment Facility (SMHTF). A facility operated by the Department of Children and Families or by a private provider under contract with the Department to serve individuals committed pursuant to Chapter 394, F.S., or Chapter 916, F.S.

k. Two-to-One (2:1) Observation. This level of observation requires two staff members to maintain uninterrupted visual contact of a resident while remaining within arm's length at all times. If it is determined by a clinician that "within arm's length" creates a danger to staff members or is not therapeutic for the resident, the clinician may write an order indicating a variance from this requirement. The clinician will document justification for the variance. Staff assigned this coverage cannot be assigned to more than one resident at a time. Two-to-one observation requires documentation at least every 15 minutes. Authorization for two-to-one observation is from a clinician's order and must be reviewed and renewed at least every 24 hours and include a face-to-face examination by a clinician. The clinician will document whether changes have occurred, note additional concerns, if any, write a new order and document justification for continuation or discontinuation of an order.

5. Policy. It is the policy of the Department to provide the best possible care for pregnant female residents and their unborn infant(s) while in the SMHTF. Medical care provided should follow the American Academy of Pediatrics, American College of Obstetricians and Gynecologists and Guidelines for Perinatal Care as guided by the consulting Obstetrician. All reasonable efforts shall be made to obtain resident consent to medical treatment as appropriate.

a. All female residents of childbearing age will be tested upon admission (if confirmation of pregnancy has not already been established) and monitored at regular monthly intervals thereafter to detect pregnancy at the earliest possible date. Upon confirmation of a positive pregnancy test or once a pregnant female is admitted:

(1) The Clinician will:

(a) If not already done, order Hepatitis B Profile on all women that are confirmed pregnant to determine if Hepatitis B vaccination is indicated.

(b) Test for human immunodeficiency virus (HIV) to prevent perinatal HIV transmission. Where indicated, referrals will be made to infectious disease specialists. CFOP 155-4 provides complete guidelines for HIV/AIDS testing and treatment in the SMHTFs.

(c) Complete an external consultation request for obstetrician care at the appropriate external medical facility.

(2) Develop an individualized prenatal care treatment plan for each pregnant woman in conjunction with the individual's Obstetrician recommendations, which will be incorporated into the Recovery Plan.

(a) Decisions on medication should be based on each woman's needs and circumstances, and selected based on available scientific research.

(b) All psychotropic medications should be prescribed in consultation with a pharmacist/consultant pharmacist and Obstetrics-Gynecology specialist.

b. Each Facility will develop procedures for the daily care of the resident and the unborn infant(s) consistent with the Obstetrics-Gynecology Specialist's treatment plan, including:

- (1) Use of mechanical restraints;
- (2) Dietary staff responsibilities;
- (3) Social Service staff responsibilities;
- (4) Nursing Service staff responsibilities; and,
- (5) Emergency procedures related to pregnancy.

c. Safe and Supportive Observations.

(1) Observation and precautions may be ordered for medical, psychiatric, or behavioral concerns following face-to-face examination based on facility specific policies and procedures, which include routine, close, group, or one-to-one observations.

(2) Orders for special observations and precautions are generally provided after a clinical assessment, and to the extent possible, assessment should involve members of the recovery team. The assessment should consider risk of harm to the mother, the unborn infant(s) and medical risk factors.

(3) Pregnant residents will be transferred to a facility medical unit or placed on a one-to-one observation a minimum of two weeks prior to the scheduled delivery date unless an assessment by the treating physician determines the special observation could be contra-indicated. Documentation of such an assessment will be placed in the resident's medical record.

d. If the resident will not be discharged prior to delivery:

(1) Information will be obtained from the resident regarding the father of the infant(s), support systems, placement of the infant(s) and potential discharge placement. This information will be documented in the resident's recovery plan. Appropriate person(s) will be contacted regarding the resident's plan for assistance with the infant.

(2) Prior to one month of due date, telephone contact will be made with the local Department of Children and Families' Child Welfare Services and followed up in writing with a brief social history, potential placement plans for the infant(s), case manager contact information and projected discharge of resident.

(3) SMHTF staff will coordinate visits and assist in interviews of resident, if requested, by Child Welfare Services to complete temporary plans for the infant(s). This may include the father or family members picking up the newborn at the designated community hospital, placing him/her in foster care under temporary custody of the Department of Children and Families, adoption of infant, etc.

(4) Within one month of due date, SMHTF staff will attempt to contact the Pediatric Social Worker at the designated community hospital explaining the proposed date of delivery, condition of the resident, the need for involvement of Child Welfare Services and the Abuse Hotline notification, and provide contact information for the resident's current attending medical doctor and psychiatrist and current medications.

(5) When the resident is transported to the designated community hospital for delivery, SMHTF staff will notify Child Welfare Services, the hospital Pediatric Social Worker, and with consent of resident, the father, family members, next of kin, and/or first representative.

(6) If, at the time of birth, no family or first representative is identified, and placement for the infant(s) cannot be arranged, staff will contact the Abuse Hotline as required by section 39.201, F.S.

6. Training. The Medical Executive Director is responsible for coordinating training on this operating procedure for appropriate professional and paraprofessional staff working in direct contact with residents.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

JACQUELINE A. YOUNG
Director, Policy and Programs

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

References in paragraph 3 updated. No other substantive changes were made.