Walsall Healthcare NHS
NHS Trust

| Document Title |
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| **Substance Misuse in pregnancy and subsequent care of the Newborn** |

| Document Description | |
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| Document Type | **Guideline** |
| Service Application | **Maternity Services** |
| Version | **3** |

| Lead Author(s) | |
|---|---|
| Name | Job Title |
| Mrs Mulay | Clinical Director |
| Mrs Sharma | Obstetric consultant |
| Women's, Children's and Clinical Support services Policy and Procedures Group | |
| | |

| Change History- Version Control | | |
|---|---|---|
| Version | Date | Comments |
| 1 | Nov 2009 | New Guideline formulation |
| 2 | July 2013 | Reformat required and full review this year |
| 3 | May 2017 | Full review |

| Links with External Standards | |
|---|---|
| Advisory Council on the Misuse of Drugs. (2003). *Hidden Harm.* Retrieved 07 2008, from Department of Health: http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm | BMA Publications. (2006). *Fetal alcohol spectrum disorders-a guide for healthcare professionals.* London: British Medical Association. |
| Confidential Enquiry Into Maternal Deaths. (2006). *Saving Mothers' Lives 2003-2005.* CEMACH Publications. | RCOG. (2006, March). *Statement No. 5; Alcohol consumption and the outcomes of pregnancy.* Retrieved 07 2008, from http://www.rcog.org.uk/index.asp?PageID=1477 |
| The Highland Council, S. (2006, 06). *Women, Substance abuse and Pregnancy.* Retrieved 07 2008, from The Highland Council: http://www.highland.gov.uk/NR/rdonlyres/F370D4D0-34D9-4450-AD19-0FA2FFCC50CB/0/cyp22Women.pdf | Dryden C, Young D, Hepburn M, Mactier H. Maternal methadone use in pregnancy: factors associated with the development of neonatal abstinence syndrome and implications for healthcare resources. BJOG 2008; DOI: 10.1111/j.1471-0528.2008.02073.x. |

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| **Key Dates** | **DATE** |
| Ratification Date | Team of Five Meeting, 6 June 2017 |
| Review Date | June 2020 |

| **Executive Summary Sheet** | | |
|---|---|---|
| Document Title: | **Substance Misuse in pregnancy and subsequent care of the newborn** | |
| | | |
| **Please Tick (☑) as appropriate** | This is a new document within the Trust | |
| | This is a revised Document within the Trust | √ |

**What is the purpose of this document?**

To provide written guidelines for Walsall Hospitals NHS Trust staff to ensure the correct procedures can be followed when caring for women who misuse drugs during pregnancy, intrapartum and postpartum period.

**What key issues does this document explore?**

- Antenatal care including booking, confidentiality, domestic abuse, screening for blood-borne viruses, unbooked patients and DNA's.
- Specific substances including alcohol, cannabis, cocaine/crack, heroin/methadone/other opiates, Subutex, Benzodiazepines and amphetamines.
- Maternal inpatient care including admission and labour/pain relief.
- Postnatal care including Neonatal Abstinence Programme, Infant feeding, discharge planning.

**Who is this document aimed at?**

The multidisciplinary team at Walsall Hospitals NHS Trust involved with the care of women and babies of the women who misuse drugs during pregnancy, intrapartum or postnatal periods.

**What other policies, guidance and directives should this document be read in conjunction with?**

Antenatal Access Pathway
Antenatal Default Appointments
Antenatal Screening Tests
Communicating Test Results
Hepatitis B
HIV Positive Mother
Induction of Labour
Newborn Feeding
Abstinence (Neonatal Network Guideline)
Neonatal Alert

**How and when will this document be reviewed?**

Three years following publication date or earlier in the light of new evidence or Recommendations.

**CONTRIBUTION LIST**

**Key individuals involved in developing the document**

| Name | Designation |
|---|---|
| Mrs Sharma | Consultant |
| | |

**Circulated to the following for consultation**

| Name/Committee/Group/ | Designation |
|---|---|
| All Obstetric consultants | |
| All Matrons | |
| Ward Managers | |
| Jane Henley | ANNP |
| Ann Sargent | Named Midwife for Safeguarding Children |
| Catherine Akinwale | Anaesthetic lead |
| Community Midwife Team leaders | |
| Delivery Suite Team Leaders | |
| All Paediatric Consultants | |

**Version Control Summary**

**Significant or Substantive Changes from Previous Version**
A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

When a document is reviewed the changes should using the tracking tool in order to clearly show areas of change for the consultation process.

| Version | Date | Comments on Changes | Author |
|---|---|---|---|
| 2 | July 2013 | Full review of guideline and reformat | Leanne York |
| 3 | May 2017 | Full review of guideline | Sushma Sharma |

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| **1.0** | **Introduction** |
| | Parental problem drug use can and does cause serious harm to children from conception to adulthood. Effective treatment of the mother can have major benefits for the baby, and requires a coordinated approach from the multidisciplinary team caring for mothers and their babies. These key recommendations were published in a document entitled "Hidden Harm" produced for the Department of Health by the Advisory Council on the Misuse of Drugs (2003).<br><br>Problem drug use in the UK is characterised by the use of multiple drugs, often by injection, and is strongly linked to social deprivation. This often results in a typically chaotic and unpredictable lifestyle, often resulting in chronic poor maternal health and precarious domestic conditions.<br><br>Maternal drug use in pregnancy can seriously affect fetal growth, but when multiple drugs are being taken against a background of other adverse social conditions, poor nutrition, smoking and alcohol use, fetal outcome can be very poor. Many drugs (opiates, benzodiazepines) can cause severe neonatal withdrawal symptoms. In addition, maternal drug injecting carries the risk of mother-to-child transmission of HIV and viral hepatitis (B & C). After birth, the baby may be exposed to many hazards as a result of sustained parental drug use, and it is essential that a robust plan of social care is in place prior to the baby being discharged.<br><br>A further key recommendation of the Advisory Council on the Misuse of Drugs is that **"problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic in a way that respects privacy and confidentiality but both enables accurate assessment of the individual (or family)"**. Every maternity unit should provide a service that is accessible to and non-judgmental of pregnant problem drug users, and should be able to offer high quality care aimed at minimizing the impact of the mother's drug use on the pregnancy and the baby. |
| **2.0** | **Scope** |
| | To provide written guidelines for Walsall Hospitals NHS Trust staff to ensure the correct procedures can be followed when caring for women who misuse drugs during pregnancy, intrapartum and postpartum period. |
| **3.0** | **Statement of Intent** |
| | This guideline has been developed to enable streamlined and effective multidisciplinary care of women who disclose that they are misusing substances during pregnancy. This includes care of the woman during the antenatal, intrapartum and postnatal periods and care of the baby following birth.<br><br>There is an overriding imperative to ensure that problems secondary to substance misuse that arise during pregnancy are communicated to both Neonatal practitioners and the Social Care teams that will be involved in the care of the infant after delivery and on discharge. |
| **4.0** | **Definitions** |

| ABBREVIATION | DEFINITION |
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| | | HIV | Human Immunodeficiency Virus |
| | | MARF | Multi Agency Referral Form |
| | | NAS | Neonatal Abstinence Syndrome |
| | | CMW | Community midwife |
| **5.0** | **Roles and responsibilities** | | |
| **5.1** | **Women's, Children's and Clinical Support Services Divisional Director** | | |
| | The Women's Children's and clinical support services Divisional Director has responsibilities for ensuring that robust systems and are in place within Maternity services for the Consultation, Ratification and implementation of polices and guidelines. | | |
| **5.2** | **Obstetric Clinical Director** | | |
| | The Clinical Director for Obstetrics lead director for all Polices and guidelines ratified in the Maternity Service and attend the Women's, children's and Clinical Support Services Divisional Quality Team meeting to oversee ratification of such guidelines/Polices. | | |
| **5.3** | **Divisional Director of Midwifery, Gynaecology and Sexual Health** | | |
| | The Divisional Director of Midwifery, Gynaecology and Sexual Health's responsibility is to ensure that a robust system for the monitoring and control of all policies and guidelines is implemented across the maternity service. She will also ensures that a dedicated team is in place to ensure all clinical guidelines and polices within maternity services are current, evidence based and reflects best practice. | | |
| **5.4** | **Guideline Lead** | | |
| | The policy Lead/ Author of the policy responsibilities include:.<br>•Ensure the guideline follows the Maternity services process as described within the maternity services in relation to the document formulation, review, consultation and ratification of polices and guidelines.<br>•To ensure that Guidelines are presented in the correct format, is accurate, up to date and adheres to Best Practice Evidences and National Guidelines.<br>•To ensure this Guideline has been circulated to all relevant groups across the maternity service relevant to the guideline being formulated or reviewed for information and comments prior to ratification.<br>•Forwards the guideline to the Trust Governance team for uploading on to the trusts 'Policy for Comments' page prior to ratification.<br>•Is Responsible for amendments to the guideline following the consultation process<br>•Is Responsible and for the presentation of this guideline to the Womens, Childrens and clinical support services Divisional Quality Board for ratification.<br>•Forwards any ratified guidelines to the Trust Governance deaprtment for uploading on to the trusts Intranet site, maternity guidelines page and adds to the guidelines' folder on the shared Maternity 'P' drive<br>•Ensure the Guideline is audited within three years of publication date and any minor reviews are undertaken in the light of new evidence/ recommendation are undertaken.<br>•To ensure previous versions of this guideline are within the Family Health Policy and Guidelines Group archiving system. | | |
| **5.5** | **Senior Midwives and Matrons within Maternity services** | | |
| | All senior midwives/matrons are responsible for the day to day implementation of this | | |

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| | guideline within the maternity service.<br><br>They are also responsible for ensuring that they :<br>Provide Comments when requested on maternity polices and guidelines circulated within maternity services.<br>Be aware of their own roles within the maternity services polices and guidelines.<br>Ensure electronic access to this and all other polices and guidelines are provided for staff in their clinical area/department for all staff within the maternity service.<br>Ensure staff are aware of how to access trust wide polices and guidelines via the intranet link.<br>Ensures that appropriate equipment for the implementation of this guideline is readily available in the clinical area.<br>Providing opportunity to attend mandatory training and or Address training needs.<br>Promote the completion of incident reports and issues relating to this guideline used within the maternity service using the Trust wide Adverse Incidents/ Near Miss reporting system- Safeguard. |
| **5.6** | **All Medical, Midwifery and Nursing Staff within Maternity Services** |
| | All medical Midwifery and Nursing staff are responsible for the day to day implementation of this guideline within the maternity service. They are also responsible for ensuring that they :<br>Provide Comments when requested on maternity polices and guidelines circulated within maternity services.<br>Electronically they are aware how to access the contents of this guideline in their clinical area/department.<br>Assume responsibility for the completion of incident reports and issues relating to this or any current polices and guidelines within the maternity service using the trust wide incident reporting system- Safeguard.<br>To highlight any gaps in training that are required to implement this guideline to their immediate line manager and subsequently access and complete relevant training. |
| **6.0** | **Main body of guideline** |
| 6.1 | **Antenatal Care** |
| 6.1.1 | **Booking**<br>• All mothers at booking should be asked routinely and sensitively about all substance misuse, including the use of alcohol and prescribed or illicit drugs.<br>• Mothers who disclose substance misuse should be told about the benefits of antenatal care and encouraged to attend early in pregnancy. They will be booked under consultant care to facilitate planning of maternity, neonatal and social care within a multidisciplinary team. Mothers whose babies are at risk of Neonatal Abstinence Syndrome (NAS) should not deliver on the Midwifery Led Unit.<br>• All pregnant women who substance misuse should be notified to Social Services via a MARF form.<br>• The woman will be assigned to the appropriate Community Drug Team (The Beacon) if not already in contact with these services by the Midwife.<br>• The Midwife/drug worker will provide education to the woman and any appropriate family members of the effects that Neonatal Abstinence Syndrome may have on the baby and the plan of care involved. |

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| | • Women using opiates who are not already in a drug treatment programme should be encouraged to accept referral to specialist services so that there can be an in-depth assessment of substance use, drug screening to confirm present use, ongoing counselling and support with stabilising use through substitute prescribing (methadone).<br>• Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment rather than attempt opioid detoxification.<br>• A thorough assessment of the mother's social circumstances must also be made in order to guide need for referral for social care and health planning.<br>• A NNA form will be completed on Badgernet.<br>Initial contact between women and maternity services is likely to influence their subsequent uptake of care. Non-judgmental care from maternity unit staff encourages regular attendance by the mother, which in turn improves antenatal care, detection of fetal growth restriction, neonatal care, communication between members of the multiagency team, and discharge planning. |
| 6.1.2 | **Confidentiality**<br>All professionals should be aware that although the maternal hand-held antenatal notes are marked confidential, anything written therein is often read by others. Ensure that mothers agree before recording explicit details of substance misuse in this record and ensure all electronic data is presented in a confidential way where possible. |
| 6.1.3 | **Domestic Violence**<br>Substance misuse may be associated with current or past experiences of abuse, which staff should be aware of. It is well recognised that domestic abuse often escalates during pregnancy.<br><br>If injuries are noticed, women should be asked sympathetically, but directly, about these injuries and healthcare professionals should be prepared to follow this up with advice, support and information as needed.<br><br>It is also recommended that family/friends are not used as interpreters, but that the appropriate Trust approved interpretation services should be used in order to facilitate disclosure.<br><br>It is essential that routine enquiries are made about domestic abuse. This should be done at booking and at 28 weeks. Whenever possible, all women should be seen alone at least once during the antenatal period to enable disclosure more easily if they wish. (Refer to Antenatal Access Guideline). |
| 6.1.4 | **Screening for blood-borne viruses**<br>All women booking for antenatal care are routinely asked if they wish to be screened for Hepatitis B and HIV (in addition to syphilis). Hepatitis C in the UK is most frequently found in intravenous substance misusers. Chronic carriers of Hepatitis C have a lifetime risk of up to 20% of developing cirrhosis. Currently there is no way of preventing mother-to-child transmission but there are obvious benefits to both mother and baby for long-term health surveillance.<br><br>Mothers who are found to be HIV positive will be referred to Dr Acharya, Consultant |

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| | GU medicine. Mothers found to be chronic carriers of Hepatitis B will be identified by the antenatal screening co-coordinating specialist midwives so that their baby can be immunized after birth.<br>**Mothers who are found to be carriers of Hepatitis C should be referred to Dr Amanda Hughes, Consultant Gastroenterologist**. |
| 6.1.5 | **Plan for Antenatal Care**<br>All women will be offered consultant led care.<br>The schedule for antenatal care will follow that detailed in Appendix 1. |
| 6.1.6 | **Un-booked women**<br>Mothers who do not engage with maternity services (who deliver within the Trust) need:<br>• Ascertain current substance use<br>• Ideally take urine sample (may take some time to process)<br>• Detailed multi-agency discharge planning.<br>• All antenatal bloods are taken on admission or after delivery if this is imminent. Urgent screening for blood-borne viruses is essential, in order to better plan neonatal care.<br>• Referral to social services via MARF. |
| 6.1.7 | **Women who DNA appointments**<br>There is a local guideline (See Antenatal default appointments) for the follow-up of mothers who do not attend scheduled antenatal clinic appointments, involving home visits by community midwives. It is also necessary to inform the mother's specialist drug worker or team that the mother is failing to attend antenatal clinic. They may have additional opportunities to engage with the mother on a non-hospital setting and encourage attendance. |
| 6.2 | **Specific Substances** |
| 6.2.1 | **Cannabis**<br>Cannabis can be taken both by smoking and by mouth. The main adverse effects are thought to be due to associated heavy tobacco smoking although this has not been demonstrated conclusively. Smoking tobacco has a wide range of adverse effects including fetal growth restriction, preterm labour, stillbirth and sudden infant death.<br>• Smoking cessation should be encouraged<br>• Consider a growth scan at 28, 34 and 37 weeks taking into account previous obstetric history |
| 6.2.2 | **Alcohol**<br>The current UK government recommendation regarding alcohol consumption during pregnancy is to avoid alcohol completely (May 2007). There is no good evidence to suggest that drinking 1-2 units of alcohol per week causes harm to the developing fetus (RCOG Statement, 2006) but a greater alcohol intake than this does carry excess risks to the pregnancy. This includes binge-drinking in early pregnancy.<br><br>There is evidence that alcohol can damage the fetus throughout pregnancy. The following risks of excessive alcohol consumption in pregnancy have been identified:<br>• Increased risk of first trimester miscarriage |

- Increased risk of major structural congenital anomalies
- Increased risk of second trimester miscarriage
- Pre-term labour
- Fetal growth restriction (<10th centile)
- Fetal alcohol syndrome (facial abnormalities, fetal growth restriction, neurodevelopment abnormality)

All women are questioned routinely about alcohol intake during pregnancy, but often underreport and underestimate their true intake. The table below can help to give a more realistic estimate of alcohol consumption.

| Beer, cider and Alco pops | Measure (Number of Units) | | | | |
|---|---|---|---|---|---|
| | Half pint | Pint | 330ml | 500ml | 1 Litre |
| Ordinary strength beer, lager or cider | 1 | 2 | 1.5 | 2 | - |
| Export strength beer, lager or cider (e.g. Stella, Strongbow) | 1.25 | 2.5 | 2.0 | 3.0 | - |
| Extra strong beer (e.g. Special Brew, Diamond White) | 2.5 | 5 | 3 | 5.5 | 11 |
| Alco pops | - | - | 1.7 | - | - |

| **Wines and spirits** | Small glass/pub measure | Wine glass | Bottle (750ml) |
|---|---|---|---|
| Table wine | | 1.5 | 9 |
| Sherry/Martini | 0.8 | 2-3 | 14 |
| Sprits | 1 | - | 30 |

**Table 1. Modified and reproduced from RCOG Statement 5 (2006), Alcohol consumption and the outcomes of pregnancy**

The following actions are recommended for mothers drinking excessive alcohol;

- Advise the mother that her alcohol consumption may cause significant harm to her unborn child and that she should urgently consider stopping. In the case of women who are drinking heavily, stopping suddenly may be hazardous for the woman and her baby, so specialist advice should always be sought. Check liver function tests at booking. Consider liver scan of markedly abnormal
- Fetal anomaly scan with Consultant or Senior Radiographer at 20 -22 weeks
- Growth scan at 28, 34 and 37 weeks
- Refer for expert help if considering withdrawal
- Antabuse® (disulfiram) is contraindicated in pregnancy and breastfeeding

6.2.3 **Cocaine/Crack**

Cocaine is a potent vasoconstrictor, which causes miscarriage, fetal structural anomalies, fetal growth restriction, abruption, intrauterine death, preterm

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| | labour/delivery, SIDS, low Apgar scores, meconium staining, fetal death, microcephaly, neurodevelopmental delay and structural/congenital anomalies, especially involving the gastrointestinal and renal systems. Babies are at risk of neonatal abstinence syndrome. For these patients the following is suggested;<br>• Detailed scan (abdominal wall defects) at 20-22 weeks<br>• Serial growth scans at 28, 34 and 37 weeks as minimum. |
| 6.2.4 | **Heroin/Methadone/Other Opiates**<br>Heroin is misused via a variety of routes of administration including injecting, smoking, snorting and inhaling its vapours. Injecting heroin carries the risk of acquiring blood-borne viruses (HIV, Hepatitis B and C). Neonatal abstinence syndrome is also common in the babies of mothers who misuse opiates.<br><br>**Women should be encouraged to enter into a methadone maintenance programme which allows engagement with Drug Treatment services which include counselling, health promotion and help with social care support.**<br>Women already engaged in a methadone programme should be offered care by the Specialist Drug Workers associated with the antenatal clinic, but may choose to continue with their existing Drug Team.<br><br>The antenatal plan of care for mothers misusing heroin and other opiates should be as follows;<br>• Aim to stabilize on methadone on adequate dose to discourage other drug use<br>• Avoid injecting<br>• Screen for HIV, Hepatitis B& C<br>• Growth scans at 28, 34 and 37 weeks as minimum, taking into account other substance misuse and past obstetric history<br><br>For those mothers already being prescribed methadone, in addition to the above;<br>• Maintain mothers on an adequate dose to discourage other drug use<br>• The dose of Methadone or drug used to be kept updated in the woman's notes by the Drug Liaison team/Obstetric Team<br>• Methadone dose may need to be increased in the third trimester (plasma concentrations may decrease as gestation increases). This increase will need to be reversed in the post-partum period.<br>• Only reduce dose if mother is highly motivated |
| 6.2.5 | **Buprenorphine (Subutex)**<br>Buprenorphine (a partial opioid agonist, administered sublingually) is used as substitution therapy for patients with moderate opioid dependence. There is very little published evidence on its use in pregnancy but it is well known to cause neonatal abstinence syndrome. It is not recommended that mothers already stabilized on buprenorphine be switched to methadone. The prescription of buprenorphine should be continued during admission, labour, and in the postnatal period.<br><br>The antenatal plan of care for mothers maintained on buprenorphine should be as follows;<br>• Screen for HIV, Hepatitis B&C<br>• Growth scans at 28, 34 and 37 weeks as minimum, taking into account other |

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| | substance misuse and past obstetric history<br>Arrange an Anaesthetic opinion at 34 weeks. Opioid analgesics may be less effective in labour because of the high affinity of buprenorphine for central opioid receptors. Regional anaesthesia should be discussed. |
| 6.2.6 | **Benzodiazepines (Diazepam, Temazepam)**<br>Maternal benzodiazepine dependence is associated with neonatal abstinence syndrome, sometimes prolonged, but is not associated with any other adverse pregnancy outcomes *per se*. Sudden withdrawal from benzodiazepines can precipitate severe anxiety, hallucinations and seizures. Benzodiazepine misuse is commonly associated with other substance misuse. It is essential to consider this when formulating an antenatal plan of care.<br>• Avoid abrupt withdrawal |
| 6.2.7 | **Amphetamine**<br>Amphetamine (Speed) is often injected and hence is associated with the transmission of blood-borne viruses. It is often used in conjunction with other drugs so little evidence is available of its effects when it is the only substance being used.<br><br>The antenatal plan of care for mothers misusing amphetamine should be as follows;<br>• Screen for HIV, Hepatitis B&C<br><br>Growth scan at 34 weeks taking into account other substance misuse and past obstetric history. |
| 6.3 | **Maternal Inpatient Care** |
| 6.3.1 | **Admission**<br>• When a mother is admitted to hospital and is unable to collect her usual methadone prescription, the community dispensary will cancel that prescription after a set number of days. It is essential that the patient's drug workers be informed of the admission to allow arrangements to be made to avoid discharge with no prescription in place.<br>• Clarify the dose of any prescribed medications (methadone, benzodiazepines) with her specialist drug worker/team and get these prescribed on an inpatient drug chart correctly. The Beacon should be contacted during working hours and out of hours by to discuss and decide on the appropriate Methadone dose to be given. (The Beacon offers a 24 hour service).<br>• Methadone prescription should be flexible and allow for specific needs. Timing of administration should follow the mother's normal pattern.<br>• Subutex® (buprenorphine) prescription should also continue in hospital. The dose will need checking with the mother's specialist drug worker/team unless it is clearly written in the hospital notes.<br>• Prior to discharge, the mother's specialist drug worker/team will need to be notified to allow for her script to be restarted in the community.<br>• Please **anticipate weekend discharges** so a mother's community script can be planned. A mother discharged on a Friday without a planned script will be much more likely to obtain opiates illegally in this situation. |
| 6.3.2 | **Labour and Pain Relief**<br>• Inform the mother's specialist drug worker team. |

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| | • Give her usual dose of methadone during labour at the usual time<br>• Standard opiate analgesia in labour can safely be given. Methadone will not be adequate for analgesia in labour.<br>• Adequate pain relief during labour can be difficult for Subutex® (buprenorphine) users, as it can reduce the effects of opioid analgesics (due to the high affinity of buprenorphine for mu opiate receptors). Morphine and pethidine may be inadequate for labour analgesia in labour; regional analgesia may be preferable. Involve the on-call anaesthetist early.<br>• Paediatricians should be informed when delivery is imminent but do not need to attend routinely unless there are other indications.<br>• It is important that **NO NALOXONE** is given to baby as this has a major risk of respiratory depression and risk of seizures, both of which may be counteracted by use of morphine. |
| 6.4 | **Postnatal Care** |
| 6.4.1 | **Neonatal Abstinence Syndrome**<br>Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs including opioids, benzodiazepines, alcohol and barbiturates. It is characterised by central nervous system irritability, gastrointestinal problems and autonomic hyperactivity. The symptoms normally present within the first 24 – 72 hours after birth, but may present up to a week later. There appears to be little correlation between the amount of maternal drug use and the severity of NAS, and practitioners should be aware of the signs and symptoms of NAS, as not all maternal drug use may have been reported.<br>It is very important that signs and symptoms of NAS are discussed with the pregnant women well before her baby is due as these babies are often born prematurely.<br>• All mothers and babies should be transferred to the post-natal ward unless there is a medical reason for admission to NNU and separation should be avoided whenever possible.<br>• Mothers should be notified they will be advised and encouraged to stay in hospital for a minimum of 72 hours following the birth. Their baby will be observed for signs of neonatal abstinence syndrome during this period. This is within paediatric plan of care. Non- compliance must be shared with Social Services and Child Protection issues reassessed.<br>• The woman to be encouraged to participate in the assessment of her baby.<br>• The use of the Neonatal drug withdrawal observation chart should be fully explained to the mother in the antenatal period and she should be involved in the scoring process. These forms should be kept in the ward office for reasons of confidentiality.<br>• Babies should be assessed for signs of withdrawal at 6 hours of age and 4 hourly intervals after that, always POST FEEDING.<br>• They should be scored for behaviour noted during the four hour period and not just at time recording are made.<br>• If two consecutive total scores of 6 are documented, the paediatrician should be informed and the treatment must be considered following the NNU protocol.<br>• The Ward staff to notify the appropriate Community Drug Team 24hrs prior to the transfer of the woman to community care. On transfer of the woman and her baby to community care the Community Midwife will continue to offer support. |

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| | Further reference can be gained from the Neonatal Network Guideline on Abstinence. |
| 6.4.2 | **Infant Feeding**<br>• Breastfeeding should be encouraged as outlined in the trust policy.<br>• The exceptions to promotion of breastfeeding are:<br>• If a woman is HIV positive<br>• If she is using large quantities of stimulant drugs such as cocaine, “crack” or amphetamines, because of vasoconstriction effects.<br>• If drinking heavily or taking large amount of non-prescribed benzodiazepines, because of potential sedative effects. |
| 6.4.3 | **Discharge Planning**<br><br>Mothers who do not engage with maternity services (i.e. non-booked patients who deliver within the Trust) also need detailed multi-agency discharge planning.<br>No babies will be discharged without a Discharge Care Meeting Plan.<br>After birth, the baby may be exposed to many hazards as a result of sustained parental drug use, and it is essential that a robust plan of social care is in place prior to the baby being discharged (National Institute on Drug Abuse 2011).<br><br>The discharge should be planned as follows<br><br>**Neonate- be aware of the following**<br>• Late neonatal abstinence syndrome (>72 hours)<br>• BDZ longer withdrawal period<br>• Advise mothers of the symptoms and signs of neonatal abstinence syndrome<br>• Need to give mothers a way to come back with their babies if worried (fast track, symptom awareness). Provide contact number for community midwife.<br>• Advocate CMW visit as appropriate.<br>There is an increased risk of neurodevelopment problems, infant mortality and care proceedings. There is a follow up clinic in place for these babies. All babies needing admission to the NNU and treatment will be followed up at the baby clinic. Duration and frequency of follow- up will be individualised.<br><br>**Mother-arrange the following**<br>• Inform Patient’s Specialist Drug worker of discharge<br>• Multi-professional discussion/meeting with Social Care.<br>• Plan for the issuing of scripts after in-patient stay for mothers. The mother’s specialist drug worker/team will be able to arrange this.<br>• Avoid discharging a mother prior to a weekend without ensuring her script is active with a community dispensary |
| 6.5 | **Documentation requirements** |
| | Ensure all relevant documentation is completed and stored within the Maternal record. Ensure documentation complies with NMC guidelines Standards for record keeping and local approved abbreviation list. |
| 6.6 | **Risk Management** |
| | Any adverse/near miss incident in relation to this guidance will initiate the completion of a clinical incident report using the trusts system for incident reporting, Safeguard. All |

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| | incidents will follow the review as described in the local guideline for the management of clinical Near/miss actual Incident reporting. |

| **7.0 Monitoring and Audit arrangements** | |
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| **Monitoring Process** | **Requirements** |
| Who | Postnatal ward manager/Allocated midwife |
| Standards Monitored | Management of the newborn of women known to have misused substances in pregnancy. |
| When | Annually |
| How | Retrospective Audit |
| Evidence and Action plan presented to | Antenatal/Postnatal Forum |
| Monitored by | Postnatal ward manager |
| Completion/Exception reported to | Maternity Risk Group |

| **8.0** | **References** |
|---|---|
| | Advisory Council on the Misuse of Drugs. (2003). *Hidden Harm.* Retrieved 07 2008, from Department of Health: http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm<br><br>BMA Publications. (2006). *Fetal alcohol spectrum disorders-a guide for healthcare professionals.* London: British Medical Association.<br><br>Confitential Enquiry Into Maternal Deaths. (2006). *Saving Mothers' Lives 2003-2005.* CEMACH Publications.<br><br>Dryden C, Young D, Hepburn M, Mactier H. *Maternal methadone use in pregnancy: factors associated with the development of neonatal abstinence syndrome and implications for healthcare resources*. BJOG 2008; DOI: 10.1111/j.1471-0528.2008.02073.x.<br><br>NICE (2008) Antenatal Care: *Routine Care for the Healthy Pregnant Woman.* London:NICE<br><br>RCOG. (2006, March). *Statement No. 5; Alcohol consumption and the outcomes of pregnancy.* Retrieved 07 2008, from http://www.rcog.org.uk/index.asp?PageID=1477<br><br>The Highland Council, S. (2006, 06). *Women, Substance abuse and Pregnancy.* Retrieved 07 2008, from The Highland Council: http://www.highland.gov.uk/NR/rdonlyres/F370D4D0-34D9-4450-AD19-0FA2FFCC50CB/0/cyp22Women.pdf<br><br>Wilson, J, Thorp, Jr., J, *Glob. libr. women's med*., *(ISSN: 1756-2228)* 2008; DOI 10.3843/GLOWM.10115 |

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| | Marx JA, Hockberger RS, Wall RM (eds): Rosen's emergency medicine: *concepts and clinical practice.* pp 2396, 2400 5th ed.. St. Louis, CV Mosby, 2002<br><br>National Institute on Drug Misuse (2011) *Prenatal exposure to drugs of abuse. The science of drug abuse and addiction.*<br><br>Guidelines for the identification and management of substance use and substance use disorders in pregnancy. World Health Organisation 2014 |
| **9.0** | **Appendices** |
| | **Appendix One- Antenatal Care flow chart** |

**Appendix 1 – Antenatal Care Flowchart**

| Gestation (as a guide) | Actions | Rationale |
|---|---|---|
| At first disclosure | • Consultant led ANC.<br>• Complete a MARF.<br>• | Early access to antenatal care |
| Booking | • Drug history, past and current<br>• Determine exactly what substances are being used and in what quantities<br>• Who Is prescribing her medications<br>• Ensure mother has FU with Specialist Drug Workers<br>• H/O Alcohol and tobacco consumption<br>• Psychiatric, psychological and social history<br>• Booking blood tests (Blood group and antibodies), FBC, U&E, LFT, non-fasting serum glucose, HIV, Hepatitis B & C, Syphilis) Dating scan<br>• Discuss Screening for Downs syndrome, Edward's and Patau's syndrome<br>• Complete a Neonatal Alert Form<br>• Plan subsequent antenatal visits with CMW/ ANC | Screen for major infections affecting antenatal care and pregnancy. Allows neonate to be immunised against Hep B. |
| 20 weeks | • Mid trimester anomaly scan | |
| 28 weeks | • Growth scan<br>• Repeat NBS bloods, FBC, non-fasting serum glucose | |
| 32-36 weeks | • Ensure Pre-birth plan (WSCB4) for baby is in place, if appropriate<br>• Review need for Social Care and Health involvement | |

| | | |
|---|---|---|
| 34 weeks | • Growth scan<br>• FBC | |
| 37 weeks | • Growth scan | |
| 41 weeks | • Induction of labour for Obstetric reasons | |

**Equality Analysis Form**

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

## Service Overview & Improvement Action Plan: Equality Analysis Form

| | |
|---|---|
| **Title:**<br>Substance Misuse in Pregnancy and Subsequent Care of the Newborn | **What are the intended outcomes of this work?**<br>To provide written guidelines for Walsall Hospitals NHS Trust staff to ensure the correct procedures can be followed when caring for women who misuse drugs during pregnancy, intrapartum and postpartum period<br>To provide appropriate guidance regarding:<br>• Antenatal care including booking, confidentiality, domestic abuse, screening for blood-borne viruses, unbooked patients and DNA's<br>• Specific substances including alcohol, cannabis, cocaine/crack, heroin/methadone/other opiates, Subutex, Benzodiazepines and amphetamines<br>• Maternal inpatient care including admission and labour/pain relief<br>• Postnatal care including Neonatal Abstinence Programme, Infant feeding, discharge planning. |
| **Who will be affected?**<br>Pregnant Women | **Evidence:**<br>Advisory Council on the Misuse of Drugs. (2003). *Hidden Harm.* Retrieved 07 2008, from Department of Health: http://drugs.homeoffice.gov.uk/publicationsearch/acmd/hidden-harm<br>BMA Publications. (2006). *Fetal alcohol spectrum disorders-a guide for healthcare professionals.* London: British Medical Association.<br>Confidential Enquiry Into Maternal Deaths. (2006). *Saving Mothers' Lives 2003-2005.* CEMACH Publications.<br>Dryden C, Young D, Hepburn M, Mactier H. Maternal methadone use in pregnancy: factors associated with the development of neonatal abstinence syndrome and implications for healthcare resources. BJOG 2008; DOI: 10.1111/j.1471-0528.2008.02073.x.<br>NICE (2008) Antenatal Care: Routine Care for the Healthy Pregnant Woman. London:NICE<br>RCOG. (2006, March). *Statement No. 5; Alcohol consumption and the outcomes of pregnancy.* |

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|---|---|
| | Retrieved 07 2008, from http://www.rcog.org.uk/index.asp?PageID=1477<br>The Highland Council, S. (2006, 06). *Women, Substance abuse and Pregnancy.* Retrieved 07 2008, from The Highland Council: http://www.highland.gov.uk/NR/rdonlyres/F370D4D0-34D9-4450-AD19-0FA2FFCC50CB/0/cyp22Women.pdf |

| ANALYSIS SUMMARY: considering the above evidence, please summarise the impact of the work based on the Public Sector equality duty outcomes against the 9 Protected characteristics | | | |
|---|---|---|---|
| *Public Sector Duty*<br>*Protected Characteristics* (highlight as appropriate) | **Eliminate discrimination, harassment and victimisation** | **Advance equality of opportunity** | **Promote good relations between groups** |
| AGE / DISABILITY/ RACE | | | |
| SEX (Gender)/ GENDER REASSIGNMENT | | | |
| RELIGION or BELIEF/ SEXUAL ORIENTATION | | | |
| PREGNANCY & MATERNITY | | | |
| MARRIAGE & CIVIL PARTNERSHIP | | *Not applicable at present* | *Not applicable at present* |
| What is the overall impact?(you need to consider whether there are different levels of access experienced, what the needs are for each group, whether there are barriers to engagement and what is the overall combined impact?) | | | |

| |
|---|
| Any action required on the impact on equalities? *(Please give a broad outline on what actions will be taken to address any inequalities (gaps, challenges or opportunities)identified through the evidence- this could be in the form of an action plan Include here any or all of the following, based on your assessment*<br>• *Plans already under way or in development to address the challenges and priorities identified.*<br>• *Arrangements for continued engagement of stakeholders.*<br>• *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*<br>• *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*<br>• *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*<br>• *Arrangements for making information accessible to staff, patients, service users and the public*<br>*Arrangements to make sure the assessment contributes to reviews of strategic equality objectives)* |

| | | | |
|---|---|---|---|
| **Name of person completing analysis** | *The person who is completing this form- it may be the same person who has written the document to be analysed* | **Date completed** | *The date the document is completed.* |
| **Name of responsible Director** | *From the Directorate responsible for the document or could be Chief Executive/Divisional Director* | | |
| **Signature** | *Signature of person above who is accountable for the document* | | |

Walsall Healthcare NHS
NHS Trust

**Checklist for the Review and Approval of Procedural Document**

To be completed and attached to any procedural document that requires ratification

| | Title of document being reviewed: | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Title Substance Misuse** | | |
| | Is the title clear and unambiguous? It should not start with the word policy. | Yes | |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes | |
| **2.** | **Rationale** | | |
| | Are reasons for development of the document stated? This should be in the purpose section. | Yes | |
| **3.** | **Development Process** | | |
| | Is the method described in brief? This should be in the introduction or purpose. | Yes | |
| | Are people involved in the development identified? | Yes | |
| | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | Yes | |
| | Is there evidence of consultation with stakeholders and users? | Yes | |
| **4.** | **Content** | | |
| | Is the objective of the document clear? | Yes | |
| | Is the target population clear and unambiguous? | Yes | |
| | Are the intended outcomes described? | Yes | |
| | Are the statements clear and unambiguous? | Yes | |
| **5.** | **Evidence Base** | | |
| | Is the type of evidence to support the document identified explicitly? | Yes | |
| | Are key references cited? | Yes | |
| | Are the references cited in full? | Yes | |
| | Are supporting documents referenced? | Yes | |
| **6.** | **Approval** | | |
| | Does the document identify which committee/group will approve it? | Yes | |

| | Title of document being reviewed: | Yes/No | Comments |
|---|---|---|---|
| | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | Yes | |
| **7.** | **Dissemination and Implementation** | | |
| | Is there an outline/plan to identify how this will be done? | Yes | |
| | Does the plan include the necessary training/support to ensure compliance? | Yes | |
| **8.** | **Document Control** | | |
| | Does the document identify where it will be held? | Yes | |
| | Have archiving arrangements for superseded documents been addressed? | Yes | |
| **9.** | **Process to Monitor Compliance and Effectiveness** | | |
| | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | Yes | |
| | Is there a plan to review or audit compliance with the document? | Yes | |
| **10.** | **Review Date** | | |
| | Is the review date identified? | Yes | |
| | Is the frequency of review identified? If so is it acceptable? | Yes | |
| **11.** | **Overall Responsibility for the Document** | | |
| | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation? | Yes | |

| **Lead Director** | | | |
|---|---|---|---|
| If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date it and forward to the chair of the committee for ratification. | | | |
| Name | Karen Palmer | Date | |
| Signature | | Approving Committee | |
| **Ratification Committee Approval** | | | |
| If the committee is in agreement to ratify this document, can the Chair sign and date it and forward to the Risk & Assurance Team | | | |

| | | | |
|---|---|---|---|
| Name | | Date | |
| Signature | | | |