**Trust Policy**

Plymouth Hospitals NHS
NHS Trust

# Management of Substance Use during Pregnancy and the Postnatal Period

| Date | Version |
|---|---|
| July 2014 | Version 3 |

## Purpose

The purpose of this policy is to provide clear guidance for healthcare professionals regarding their role and responsibilities in ensuring a suitable care is available and provided in order to provide safe, effective care.

## Who should read this document?

All staff. This policy applies to all trust employees, including locum, bank and agency staff working on behalf of the trust and involved in the direct care of patients.

## Key messages

Plymouth NHS Trust attaches the highest importance to ensuring a culture that values high standards of patient care exists within the organisation. This policy is intended to safeguard the position of patients and staff throughout consultation, examination, treatment and care.

## Core accountabilities

| | |
|---|---|
| **Production** | Specialist Midwife |
| **Review and approval** | Clinical Effectiveness Committee |
| **Ratification** | Director of Nursing |
| **Dissemination** | Specialist Midwife |
| **Compliance** | Specialist Midwife |

## Links to other policies and procedures

This policy must be applied to all Trust policies and procedures.

## Version History

| | | |
|---|---|---|
| **1** | May-June 2012 | Summary framework agreed and cascaded. |
| **2** | August 2012 | Full framework updated and draft presented to RARG. |
| **3** | July 2014 | Document review completed |

| Last Approval | Due for Review |
|---|---|
| July 2014 | July 2017 |

*The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.*

**An electronic version of this document is available on the Trust Documents. Larger text, Braille and Audio versions can be made available upon request.**

# Contents

## 1 Introduction

Substance misuse makes a significant contribution to maternal mortality, psychiatric causes of maternal death in particular. In the CMACE Report (2006-2008) Saving Mothers' Lives, 53 deaths within this triennium were related to substance misuse.

Substance misuse was present in 44% of women who received no care at all (or who missed 3 or more antenatal appointments). This group is often socially isolated and presents a challenge to the midwifery services.

At Derriford Maternity Unit the women in this client group are referred to as JASMIN patients (**J**oint **A**gency **S**ubstance **M**isuse **IN** pregnancy). Documenting the name JASMIN on their pregnancy notes provides a subtle form of identifying their current or past substance use. This helps staff care appropriately for these women given the potential impact on their pregnancy/baby.

Substance misuse has increased substantially among women over the past 30 years. 2-3% of children in England and Wales have a parent with drug/alcohol problems.

Parenting ability can be dramatically affected by substance misuse. Two thirds of drug using women entering drug-treatments are mothers, but only half of them have custody of their own children.

Information sharing between GP, Midwife and Addictive Services is essential. Many women will conceal or minimise the nature and extent of their substance misuse fearing Child Protection involvement, so it is important to ascertain factual circumstances through multi-agency working.

## 2 Effects and risks of some illicit/prescribed drugs and alcohol during pregnancy

**Opiates** (Heroin, Methadone, DF118's, Co-codamol)
May result in:

- Pre-term labour
- Placental insufficiency
- IUGR
- Placental abruption
- Miscarriage
- Intrauterine death
- No evidence of teratogenic effects

**Stimulants** (Amphetamines, ecstasy, mephradone)
May result in:

- Pre-term labour
- IUGR
- Placental Abruption
- Miscarriage

- High levels of amphetamine misuse can slightly increase the risk of fetal abnormality.

**Depressants** (Diazepam, Temazepam)
May result in:

- Miscarriage
- Mother may convulse
- Increased risk of cleft lip and palate malformations

**Cannabis**
May result in:

- Associated maternal psychiatric disturbances
- Inherent risk of smoking/IUGR

**Alcohol**
May result in:

- Pre-term labour
- Potentially liver disease and poor diet (with excess use)
- Fetal Alcohol Spectrum Disorder which includes Fetal Alcohol Syndrome, Alcohol-Related Neurodevelopment Disorders and Alcohol-Related Birth Defects,

**Baby may exhibit withdrawal symptoms from some substances (medically known as Neonatal Abstinence Syndrome) immediately following birth, up to several weeks following delivery. Methadone withdrawal typically occurs after 48-72 hours following birth.**

## 3 | Antenatal care – first community booking

- If current or past misuse of substances (including alcohol) are identified the Drug Liaison Midwife (DLMW) should be sent a copy of the Pregnancy Booking Summary Form. The antenatal clinic staff will make a JASMIN clinic appointment if this is indicated on the booking form.
- If illicit drug use is disclosed, screening for Hepatitis C, alongside routine antenatal serology should be offered. Obtaining blood samples may be difficult and may need to be taken by an anaesthetist.
- In cases of excessive alcohol use, consider taking bloods for liver function tests.
- If the mother has other children a brief history should be obtained which includes their dates of birth and whether they have a social worker. Check if these children are in the care of the patient or subject to residency orders, fostering or adoption.
- The 'vulnerable family pathway' needs to be followed (see Antenatal Guidelines for the Safeguarding pathway).
- Refer to Day Assessment Ward for Clexane if previous DVT/PE (frequently seen in current or previous IV drug-users).

## 4 First contact with drug liaison midwife (DLMW)

- Full drugs/alcohol use history taken (information also recorded on antenatal summary card - held in the JASMIN folder in DLMW's office antenatally, then filed in mother's medical notes postnatally)
- Mother informed of the effects substances will have on her unborn baby.
- If Hepatitis B or C positive refer to Hepatology.
- Serial growth scans booked if indicated.
- Consider referral to Children's Social Care or initiating the CAF process.
- Referral to the Drug & Alcohol Service (if indicated).
- Ensure patient has relevant contact telephone numbers.

## 5 Ongoing antenatal care

Liaising with other professionals involved is essential;

- GP (letters sent from DLMW with update after scan/clinic appointments)
- Community midwife (receives copies of GP letters)
- Drug/Alcohol worker (receives copies of GP letters)
- Social worker - if involved (receives copies of GP letters)
- Health Visitor (receives copies of GP letters)
- Neonatologists (if seen by them also receives a copy of GP letter)
- Hepatology specialist nurse – if involved (receives copies of GP letters)
- Probation Officer - if involved (receives copies of GP letters)
- Community Psychiatric Nurse – if involved (receives copies of GP letters)
- Any other agencies involved e.g. community support worker, Learning Disabilities Team, Prison service etc.

  If a patient is likely to lose/misplace their pregnancy hand-held notes, any admission paperwork should be photocopied and kept in the patient's hospital clinical records.

Antenatal summary sheet should contain the following information;

- Full drugs/alcohol history
- Current prescription and/or illicit use/alcohol intake
- Name of prescriber and pharmacist for collection of methadone/subutex
- Investigation results (including Hepatitis C)
- Dates of scans booked
- Ongoing social issues
- Home visit by midwife (risk assessment needed prior to this)
- Neonatal alert form being completed (file copy of this in unborn baby notes)
- Discussion of safe storage of methadone/other medications

- Any referrals made (if applicable) to Drug & Alcohol Service, Anaesthetist for venous access, Children's Social Care, Learning Disabilities Team, Hepatology, Day Assessment Ward (for Clexane management)
- Attendance or failure to attend appointments

If possible, during the pregnancy the mother should meet with a neonatologist to discuss the clinical plan for her baby. This will include treatment of withdrawal, breastfeeding, infection risks and immunisations.

Postnatal/neonatal care plans including Hepatitis B vaccination paperwork for baby's notes can be prepared antenatally.

If Hepatitis positive add 'alert' stickers to maternal and baby notes, ensure neonatal alert form completed. Refer to hepatitis B and C protocol. Offer support and advice to patient.

Continue with advice and guidance to the patient about illicit drug/alcohol/prescribed drug use.

Maintain safeguarding chronology (in unborn baby notes) including attendance/failure to attend appointments, and physical and emotional appearance of patient (and partner if present).

In cases of non-engagement with midwifery services, a referral to Children's Social Care should be considered. If a referral is made, follow up the outcome, document the agreed action plan and follow the Safeguarding pathway.

## 6 Treatment of opiate users

Since 1990 the treatment choice for the opiate-dependent pregnant woman has been methadone. Subutex (buprenorphine) is an alternative but cannot be started in pregnancy due to licensing regulations, however if the mother is already on an existing prescription and becomes pregnant, this can continue.

Pregnant IV drug users will have risk of blood borne viruses, DVTs, endocarditis. Further associated risks include anaemia, premature labor and placental abruption. The pregnant drug user may also suffer from psychological and social problems of low self-esteem, depression, anxiety, poverty, homelessness, legal problems and domestic violence. Poor diet, little rest and lack of antenatal care will also increase the risk to mother and fetus.

Many women present late in pregnancy. Some may have experienced amenorrhoea for many years (due to a low Body Mass Index) so do not recognise signs of pregnancy. Some mistake signs and symptoms of pregnancy (nausea fatigue etc) as withdrawal symptoms or "dirty drugs". Others may have had previous contact with "Social Services" and be afraid to disclose the pregnancy so deliberately conceal it.

## 7 Advantages for methadone

- It replaces illicit opiates with a stable/safe alternative (reduces the risks associated with injecting/inhaling drugs, e.g. blood-borne viruses, DVTs, injection site abscesses, septicaemia, lung damage, risk of placental abruption).
- Those on methadone programmes generally access essential antenatal care
- It relieves the fetus of the peaks/troughs association with illicit heroin use.
- There is no longer a need for the woman to fund her drug habit (reduced criminal activity/street work).
- Heroin is an appetite suppressant so is associated with malnutrition and risk of IUGR for the baby. Methadone does not affect the appetite.

Use of methadone in combination with good antenatal care improves the outcome of the pregnancy.

## 8 Prescribing methadone in pregnancy

If a mother is on a methadone prescription whilst pregnant, the following needs to be considered:

- Regular liaison between Harbour, the prescriber and maternity services.
- Changes in prescription dose should be documented in maternal obstetric notes.
- For any antenatal admissions ensure methadone prescription is cancelled in the community by contacting Harbour who will notify the prescribing doctor/GP. At weekends the mother's pharmacy has be contacted directly.
- The prescription will need to be re-instated in the community prior to discharge from hospital (this will have to be done via Harbour or the prescribing GP)
- It is important that no prescriptions are missed as maternal withdrawal and subsequent fetal distress could ensue.

## 9 Labour and the drug-dependent mother

- Any women with substance misuse (e.g. chaotic lifestyle) and SROM should be admitted and induced when indicated. She must not be sent home to await events.
- Check serology results. It not available, treat as potentially HIV, Hep B or C positive and act accordingly.
- If hepatitis C positive, avoid ARM, FSE and FBS. Ensure hepatitis alert sticker is placed inside baby notes (which recommends skin cleansing before giving IM Konakion)
- Analgesia is often a problem and advice should be sought from an anaesthetist. Higher doses of opiates are usually required
- Assess suitability for venous access.
- Analgesia should be given as necessary (her methadone should not be regarded as analgesia and needs to be given when it is usually taken).
- Epidural is the best form of analgesia but IV access may be difficult.

- On admission, try to obtain a history of recent drug use and with her consent, send a urine drug screen for amphetamines, benzodiazepines, cocaine, methadone and opiates.
- Inform Social worker if Children's Social care is involved.
- At delivery if baby has respiratory depression, Naloxone must **never** be given to infants as withdrawal could be precipitated and seizures may occur.
- It is not necessary to have a neonatologist present for delivery unless other indications are present.
- Monitoring in labour as per CDS guidelines
- It may be worth noting that abdominal cramps from drug withdrawal can be misinterpreted as premature labour.

## 10 Clinical advice when caring for babies born to drug-dependent mothers

- Baby will need observation for withdrawal symptoms. The length of stay will be decided according to what type of drugs the mother has been taking.
- Commence Neonatal Abstinence scoring chart (if appropriate) – see appendix 1.
- Ascertain maternal Hepatitis B, C and HIV status
- If positive to any of the above, ensure follow-up is arranged.
- Hepatitis B vaccination programme should be offered for the baby
- In cases of long hospital stays, the mother can go out for agreed periods of time
- Discuss with the parents all aspects of withdrawal symptoms in their baby
- Strongly advise mother against co-sleeping with baby
- Extra help and support with parenting may be needed. Intervene as necessary.
- Liaise with social worker (if allocated)
- If poor parenting causes concern, refer to Children's Social Care
- Obtain urine for drug screen with patient's consent (labour/postnatal analgesia opiates will be present in system for 72 hr after being given)
- Maintain confidentiality - do not openly discuss drug use/methadone prescription in the presence of other patients. Give medication in privacy. Ascertain whether family/friends are aware of the situation
- In instances of suspected illicit drug use or concerning behaviour, the mother should be asked to leave the hospital. The baby will have to stay. Social worker to be informed (out of hours duty worker tel 346894)

## 11 Care of the neonate

Providing care and treatment with Neonatal Abstinence Syndrome working towards a reduction in symptoms

<u>Difficulty sleeping / maintaining sleep state</u>

- ♦ Keep room quiet and dimly lit.
- ♦ Swaddle using a soft or cotton sheet – if pyrexia dress baby in nappy only.

- Try “nesting” by placing rolled up sheet or blanket each side and round head in cot – ensure padding is in contact with extremities.
- Organise care to reduce handling.
- Pacify by use of dummy
- Soft talk to baby.

Generally irritable

- Avoid positioning baby’s cot directly under fluorescent lights which will be highly irritating and cause visual discomfort to the baby
- Try sitting baby up facing you and if able, swaddle baby.
- Hold closely and try to keep arms and legs flexed.
- If baby makes eye contact – talk softly whilst baby is looking

Limb tremor or stiffness or hyper-tonicity

- Handle slowly and gently
- Use warm baths (avoid bath-products e.g. ‘bubble-bath –which can irritate the skin)
- Reduce tonicity by encouraging side lying, bringing knees and hips forward to bring baby out of hyper-tonicity.
- Place a soft towel between knees to abduct legs and help reduce muscle tone.
- Help to control trembling by holding the hands across chest. Shoulders forward.
- Reduce environment stimuli
- Place hands within line of vision to promote eye / hand awareness.

Panicked awakening when disturbed

- Approach calmly and quietly.
- Gently stroke baby and talk softly.
- Slowly unwrap, initially holding limbs and then slowly releasing to help prevent agitation.

When capable of moderate periods of invested alertness

- Encourage parents to take advantage of these periods and interact with baby.
- Adopt face to face position, eye to eye contact with soft talking.
- Be aware not to over stimulate – baby may only tolerate one stimulus at a time.
- May need swaddling and / or use of dummy to maintain alertness.

## 12 Postnatal stay and discharge of mother and baby

- Ensure Methadone is prescribed. Without this she will have withdrawal symptoms. Prescription dose should be recorded in maternal notes. If any doubt contact drug service (Harbour office hours tel. 434343).
- Weekdays – contact mother’s Drug Service to cancel community prescription (at weekends contact Pharmacy – the mother will know who dispenses).
- A smaller dose may be required postnatally (decreased blood volume, therefore higher concentration levels of methadone present)
- Baby can be roomed in with mother unless risks present (e.g. recent illicit use)

- Women taking methadone should not be discouraged from breastfeeding. This is the best form of milk for their baby and can help settle baby.
- Baby may breastfed unless contraindicated with other medication. If any illicit drug use is occurring breastfeeding should be avoided.
- In cases of suspected illicit use, request a urine drug screen from the mother.
- Ensure social worker (if involved) is aware of delivery.
- Ascertain whether a Multi-disciplinary pre-discharge meeting is needed
- Ensure mother's Drug Service is aware of planned discharge date so community prescription can be recommenced.
- On discharge ensure community midwife or health visitor are notified DIRECTLY to ensure they are aware of history/current circumstances.
- Close community follow-up for late onset withdrawal
- Neonatology review may be arranged, e.g. if mother Hepatitis C positive.
- A Symptom Scoring Chart should go home with the baby so community staff are aware of signs indicating later onset indications and can record these appropriately
- Unless the baby is still in hospital, he/she should be weighed on Day 7 and Day 10 (weight loss is an indicator of NAS).

## 13 Breastfeeding and the drug/alcohol-dependent mother

The advantages generally outweigh the disadvantages. Women should be advised that if breastfeeding becomes established and they later choose to stop, the baby must be gradually weaned off the breast or there will be a risk of late onset withdrawal symptoms.

Methadone Dependency
Methadone passes through the breast milk in very small amounts. This can reduce the degree of opiate withdrawal symptoms in the neonate.

Heroin Dependency
Breastfeeding not recommended. Quantity in breast milk would be uncertain and heroin will pass freely into breastmilk.

Stimulant Dependency
If very chaotic use this should be discouraged.

Sedative Dependency
Benzodiazepines will be distributed in breast milk. If using more than 40-60mgs daily this can cause lethargy, poor feeding, and weight loss in the neonate. Close monitoring of baby is advised.

Alcohol Dependency
This should be discouraged. Alcohol will freely pass through into the breast milk.

Hepatitis Positive
Breastfeeding should be encouraged. Lipases in human breast milk induce damage to the Hepatitis virus which will render the milk non-infectious.

HIV Positive

Transmission through breast-milk is 10-15% therefore formula feeding is advised

## 14 Examples of some drugs which when used by the mother can result in neonatal abstinence syndrome (NAS)

| Opioids | CNS stimulants | CNS depressants | Hallucinogens |
|---|---|---|---|
| Morphine<br>Heroin<br>Methadone<br>Codeine<br>Pentazocine<br>Buprenorphine<br>Fentanyl | Amphetamines<br>Methyl Phenidate<br>Cocaine<br>Crack cocaine | Alcohol<br>Barbiturates<br>Benzodiazepines<br>Cannabinoids<br>Hypnotics | Lysergic acid diethylamide (LSD)<br>Mescaline<br>Inhalants |

## 15 Typical symptoms, timing of onset and pharmacological management

| CNS | GIT | Autonomic | Other |
|---|---|---|---|
| Wakefulness<br>Irritability<br>Tremors<br>High pitched cry<br>Increased tone<br>Brisk reflexes<br>Seizures | Poor feeding<br>Vomiting<br>Diarrhoea<br>Poor weight gain | Yawning<br>Sneezing<br>Fever<br>Hiccoughs<br>Sweating | Tachypnoea<br>Apnoea<br>Skin excoriation |

Clinical features may vary with the type of drug, amount taken and timing of last antenatal use. Maternal and infant metabolism and excretion will also vary.

IMPORTANT – consider other diagnoses, e.g. infection, hypoxic-ischemic encephalopathy, electrolyte imbalance, hypoglycemia, intracranial bleed.

**Timing of onset of symptoms**

| | |
|---|---|
| **Early** (3 – 72 hrs) | **Late** (1-21days) |

| | |
|---|---|
| Alcohol<br>Heroin<br>Morphine | Methadone<br>Benzodiazepines<br>Barbiturates |

**Pharmacological Management**

Initial drug treatment is oral morphine. Infants of polydrug users may require additional medication. Phenobarbitone is the preferred second-line treatment (if morphine alone is insufficient to control symptoms).

**Medications available**

| Drug | Dosing | Comments |
|---|---|---|
| **Morphine** | 40 mcg/kg/dose 4 hourly<br>Maximum 125mcg for first 2 doses | Increase dose by 25 to 50 mcg every 8-12 hours if required until symptoms controlled. |
| **Phenobarbitone** | Loading dose 20 mg/kg oral or intravenously.<br><br>Maintenance 2.5mg/kg<br>12 hourly | |
| **Chlorpromazine** | 500 mcg/kg 6 hourly | This dose can also be increased |

Controlled drug prescriptions should be written in words as well as figures.

**Discuss all other drugs for potential use with consultant in charge**

## 16 Weaning

- Once symptoms have been controlled on the same dose for 48-72 hours, begin to wean treatment.
- Wean by decreasing the dose **not** by increasing the dose interval.
- Decrease dose by 10-15% **of the maximum dose** that the infant has received, every 48-72 hours. If symptoms recur this interval may be prolonged – Consultant or tier two decision only.

## 17 Actions to take if there is a suspicion of illicit drug use or dealing taking place in hospital

If there is suspicion/confirmation of illicit drug use/dealing taking place in the hospital;

- This matter should be dealt with by the Police, not hospital Security Staff.
- Call 999 requesting Police attendance.
- Arrange with the Police for a member of Ward staff to meet them at Derriford Main Entrance NOT the maternity reception area where their presence could alert the suspect to be informed by others (giving them opportunity to dispose of illicit substances)
- Inform Hospital Security of the situation - tel 53942 (daytime hours) or bleep them via Switchboard
- It is essential the Police use discretion when entering the Ward to minimise knowledge of their presence to the 'suspect'.
- The patient has to be present if the Police search her belongings.
- If illicit substances are found, the Police will escort the patient/visitor off the premises.
- The baby will need to remain on the Ward
- Children's Social Care need to be informed and appropriate arrangements made for the baby.

## 18 Review and Approval

The review and approval checklist has been completed at Appendix 3, 4 and 5.

## 19 References


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CMACE Report (2006-2008)

Drug Misuse Motherhood Hilary Klee, Marcia Jackson and Susan Lewis 2002

Parental Substance Misuse and Child Welfare Brynna Kroll, Andy Taylor 2003

The South London and Maudsley NHS Trust, Oxleas NHS Trust prescribing guidelines 8th edition 2005-2006. David Taylor, Carole Paton, Robert Kerwin

## NAS chart | Appendix 1

### Symptom scoring chart (tick symptoms present)

| **Date:** | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Time**: | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Mild Symptoms** | | | | | | | | | | | | | | | | | | |
| Tremors when disturbed | | | | | | | | | | | | | | | | | | |
| Respiratory Rate >60/min<br>Sneezing/Snuffles | | | | | | | | | | | | | | | | | | |
| Unexplained Fever/Sweating | | | | | | | | | | | | | | | | | | |
| Frequent Yawning | | | | | | | | | | | | | | | | | | |
| Poor feeding, Regurgitation, Frantic<br>Sucking or Rooting | | | | | | | | | | | | | | | | | | |
| Loose stools | | | | | | | | | | | | | | | | | | |
| **Severe Symptoms** | | | | | | | | | | | | | | | | | | |
| Tremors when undisturbed | | | | | | | | | | | | | | | | | | |
| Non-stop high pitched cry | | | | | | | | | | | | | | | | | | |
| Sleeping for less than1hr after feed | | | | | | | | | | | | | | | | | | |
| Excessive and Watery stools | | | | | | | | | | | | | | | | | | |
| Need for tube feeding | | | | | | | | | | | | | | | | | | |
| Convulsions | | | | | | | | | | | | | | | | | | |
| Severe weight loss | | | | | | | | | | | | | | | | | | |
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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Number of Mild Symptoms** | | | | | | | | | | | | | | | | | |
| **Number of SevereSymptoms** | | | | | | | | | | | | | | | | | |
| **Morphine Dose (mcg)** | | | | | | | | | | | | | | | | | |

**Treatment**: Supportive management should be employed initially (including swaddling, holding, rocking, feeding frequently and nursing in a quiet environment).

With persisting severe symptoms discuss with Consultant in charge. **Oral morphine** solution may need to be commenced. This is given at **40mcg/kg 4hrly up to 125mcg 4hrly for the initial 2 doses** before increasing in 25-50 mcg increments if necessary.

When stable, review the dose after 48 hours. If symptoms allow, aim to reduce by 10-15% and leave for a further 48 hours before reviewing again. When a dose of 100mcg is reached the dose can be reduced by 20mcg every 48 hours if symptoms allow. Other drugs may be required e.g. Phenobarbitone for seizures.

## Post-operative pain management for JASMIN women | Appendix 2

**Caesarean Section under Regional Anaesthesia**

Neuraxial diamorphine dose should be increased

- Epidural 4-5 mg
- Intrathecal 0.3-0.5 mg
- iii.Consider using preservative free morphine (epidural 4-5 mg intrathecal
- 0.2- 0.3 mg – remember to add fentanyl for intra-operative analgesia)

Consider using a CSE rather than single shot spinal, so more opiate and/or local anaesthetic can be given in recovery for poorly controlled pain

Ondansetron 4 mg IV for n/v and pruritus prophylaxis

Usual paracetamol and diclofenac (if not contraindicated)

Analgesia in recovery:

Oromorph 20 – 30 mg *(if narcotic users, consider giving 1$^{st}$ dose on arrival in recovery regardless of pain score)* and monitor vitals (HR, BP, SpO2) every 30 min for 2 hrs after each dose

Ward management:

- Regular paracetamol and Naproxen
- Oromorph 20 – 30 mg orally 2 – 3 hourly. Monitor vitals (HR, BP, SpO2) every 30 min for 2 hrs after each dose
- If this is not adequate consider using a PCA

Consider adding benzodiazepine at night for all, but more regularly for those women who use(d) cocaine

Continue methadone treatment

1. **Caesarean Section under General Anaesthesia**
    a. Load intra-operatively with morphine
    b. Paracetamol and diclofenac IV / PR if not contraindicated
    c. Ondansetron 4 mg for n/v prophylaxis
    d. Consider Dexamethasone 4-8 mg IV for n/v prophylaxis

e. Regular diclofenac and paracetamol
f. PCA commenced in recovery
g. May need additional Oromorph
h. Consider adding benzodiazepine at night for all, but more regularly for those women who use(d) cocaine
i. Continue methadone treatment
j. Wound infiltration with local anesthetic/ bilateral ilioinguinal blocks.

***Consider giving oral Oromorph regularly in the first 24 hours if patient is not on methadone treatment to prevent acute withdrawal***

***For help / advice on methadone prescribing contact either the Harbour centre (4) 34343, or Dr Charlie Lowe Consultant Psychiatrist (4) 35222***

## Consultation and Dissemination Plan | Appendix 3

| Core Information | |
|---|---|
| **Document Title** | Management of Substance Use during Pregnancy and the Postnatal Period |
| **Date Finalised** | July 2014 |
| **Dissemination Lead** | Specialist Midwife |
| **Previous Documents** | |
| **Previous document in use?** | Yes, electronic version on StaffNET |
| **Action to retrieve old copies** | To be managed by the Information Governance Team. |
| **Consultation** | |
| **Trust Clinical Executive (TCE)** | Summary framework presented on X. |
| **HMSC** | Summary framework presented on X. |
| **Chief Executive's Briefing** | Summary framework presented on X. |
| **Team Brief** | Summary framework presented on X. |

**Dissemination Plan**

| Recipient(s) | When | How | Responsibility | Progress update |
|---|---|---|---|---|
| All Trust staff | July 2014 | Vital Signs | Information Governance Team | |

# Equalities and Human Rights Impact Assessment | Appendix 4

| Core Information | |
|---|---|
| **Manager** | Director of Governance |
| **Date** | July 2014 |
| **Title** | Management of Substance Use during Pregnancy and the Postnatal Period |

| Scope of the assessment |
|---|
| The document has been circulated with the accompanying Equality Impact Assessment to all Executive Directors, Directors and Heads of Department. The document has been compiled in line with CQC and NHSLA requirements. |

| Collecting data | |
|---|---|
| **Race** | The document has no impact in this area. |
| **Religion** | The document has no impact in this area. |
| **Disability** | The document has no impact in this area. |
| **Sex** | The document has no impact in this area. |
| **Gender Identity** | The document has no impact in this area. |
| **Sexual Orientation** | The document has no impact in this area. |
| **Age** | The document has no impact in this area. |
| **Socio-Economic** | The document has no impact in this area. |
| **Human Rights** | The document has no impact in this area. |
| **What are the overall trends/patterns in the above data?** | There are no trends/patterns in this data. |
| **Specific issues and data gaps that may need to be addressed through consultation or further research** | Trust wide documents can be made available in a number of different formats and languages if requested. No further research is required as there are no further equality issues. |

| Involving and consulting stakeholders | |
|---|---|
| **Internal involvement and consultation** | This policy has been compiled by the Director of Governance. The policy has been circulated for consultation to members of the Risk & Assurance Review Group. |
| **External involvement and consultation** | This policy has been developed with reference to the practices of other NHS Trusts and the 2012/13 NHSLA Risk Management Standards for NHS Trusts. |

| Impact Assessment | |
|---|---|
| **Overall assessment and analysis of the evidence** | This assessment has shown that there is no anticipated impact on race or disability groups. |

**Action Plan**

| Action | Owner | Risks | Completion Date | Progress update |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| None | - | - | - | - |

## Review and approval checklist — Appendix 5

| Review | | |
|---|---|---|
| **Title** | Is the title clear and unambiguous? | Yes |
| | Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP? | Yes |
| | Does the style & format comply? | Yes |
| **Rationale** | Are reasons for development of the document stated? | Yes |
| **Development Process** | Is the method described in brief? | Yes |
| | Are people involved in the development identified? | Yes |
| | Has a reasonable attempt has been made to ensure relevant expertise has been used? | Yes |
| | Is there evidence of consultation with stakeholders and users? | Yes |
| **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 |
| **Evidence Base** | Is the type of evidence to support the document identified explicitly? | Yes |
| | Are key references cited and in full? | Yes |
| | Are supporting documents referenced? | Yes |
| **Approval** | Does the document identify which committee/group will review it? | Yes |
| | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | Yes |
| | Does the document identify which Executive Director will ratify it? | Yes |
| **Dissemination & 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 |
| **Document Control** | Does the document identify where it will be held? | Yes |
| | Have archiving arrangements for superseded documents been addressed? | Yes |
| **Monitoring Compliance & 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 |
| **Review Date** | Is the review date identified? | Yes |
| | Is the frequency of review identified? If so is it acceptable? | Yes |
| **Overall Responsibility** | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document? | Yes |