Substance Misuse in Pregnancy Guideline

Guideline information

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Summary of document:
To guide all professionals in identifying women / birthing persons who misuse alcohol and drugs in pregnancy and manage their care appropriately, optimising outcomes for the neonate and the parent.

Scope:
For Healthcare professionals to identify, refer and manage those women/birthing persons who misuse drugs and alcohol in pregnancy.

To be read in conjunction with:
https://nhswales365.sharepoint.com/sites/HDD_Corporate_Governance/SitePages/Policy%20pages/All%20Policies,%20Procedures%20and%20Guidelines/All-Policies,-Proceduresand-Guidelines.aspx#:~:text=868,Wales%20Safeguarding%20Procedure (opens in new tab)

NICE Guideline for Pregnancy and Complex Social Factors: a model for service provision for pregnant women with complex social factors 2010
www.nice.org.uk/guideance/cg110 (opens in new tab)
1089 - Infant Safe Sleeping Guideline (opens in new tab)
868 - All Wales Safeguarding Procedures (opens in new tab)
607 - Sharing Information in Pregnancy Procedure (Safeguarding Children) (opens in new tab)
629 - Promotion of Safety and Prevention of Abduction of Babies Guideline (opens in new tab)
502 - Acute Pain Management - Patients Taking Strong Opioids Guideline (opens in new tab)
795 - Management of Acute Pain in the Acute Hospital Setting Guideline (opens in new tab)
337 - Epidural Analgesia Guideline (opens in new tab)

Neonatal Network Guideline on the Management of Neonatal Abstinence Syndrome Wales, http://www.walesneonatalnetwork.wales.nhs.uk/sitesplus/documents/1034/Neonatal%20Abstinence%20Syndrome%20All%20Wales%20Oct%202017%20final.pdf

Patient information:
Include links to Patient Information Library

Owning group:
Obstetric Guideline, Audit and Research Group
28/06/2023

Reviews and updates:
1.0 – New Guideline

Keywords
Alcohol, Buprenorphine, Methadone, Substance Misuse

Glossary of terms

APH	Antepartum Haemorrhage
ASW	Antenatal Screening Wales
ARM	Artificial Rupture of Membranes
BBV	Blood Borne Virus
CDAT	Community Drug and Alcohol Team
CNS	Central Nervous System

CTG	Cardiotocography (electronic fetal monitoring)
CSE	Combined Spinal Epidural
DDAS	Dyfed Drug and Alcohol Service
FSE	Fetal Scalp Electrode
GP	General Practitioner
IOL	Induction of labour
IM	Intramuscular
NAS	Neonatal abstinence scoring
NCMW	Named Community Midwife
NSMW	Named Safeguarding Midwife
NSP	New Psychoactive substances
MARF	Multi-Agency Referral Form
MDT	Multi-Disciplinary Team
MG	Milligram
NIPE	Newborn and Infant Physical Examination
OST	Opiate Substitute Therapy
POM	Prescription Only Medication
PPROM	Pre-term, prelabour rupture of membranes
RID	Relative infant dose
SGA	Small for Gestational Age
SIP	Sharing of Information P
SROM	Spontaneous rupture of membranes
TAP	Transversus Abdominal Place
UBB	Unborn Baby

Contents

Scope

This guideline applies to all multi-Disciplinary professionals caring for women/birthing person who misuse, or has recently misused, substances such as drugs (both legal and illegal) and alcohol in the perinatal period, to enable appropriate care for them and their baby.

Aim

Substance misuse can be defined as the regular use of recreational drugs, misuse of over-the-counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile substances (such as solvents or inhalants) to an extent whereby physical dependence or harm is a risk to the birthing person/woman and/or the unborn baby. This guideline will outline procedures and referrals for healthcare professionals to appropriately manage the care of women/ birthing people who are at risk of substance misuse of alcohol, illegal substances, and misuse of prescription drugs. It will promote a collaborative approach, ensuring good communication between the multi-disciplinary teams and other professional services involved in caring for the woman/ birthing person.

Objectives

Substance misuse in pregnancy may lead to multiple health problems such as poor fetal development, low birth weight, prematurity, fetal alcohol syndrome, miscarriage, and stillbirth. Following birth, substance abuse can affect the parent-baby bonding process and parental functioning. It can also trigger gender-based and domestic violence, which may impact the physical, emotional, and mental development of the child (RCoG,2017)

The aim of this document will be achieved by the following objectives:

- All professionals use a planned co-operative, non-judgemental approach that encourages women/ birthing people to accept care for themselves and their baby (Maternity Health Care in Wales 2019).
- The advice given to women/ birthing person during pregnancy, from all professionals involved, is consistent, up to date and in line with National/All Wales guidelines, (Working Together to Reduce Harm – Revised Guidance for Substance Misuse 2017),
- All women/ birthing people with complex social circumstances should be treated with dignity and respect.
- Women /birthing persons with substance misuse complexities will be involved in the planning of their care from the earliest opportunity.
- The normalisation of antenatal, intrapartum, and postnatal care as much as possible.
- Guidance and communication with Hywel Dda's safeguarding team to identify any concerns and ongoing assessments relating to safeguarding that may need further involvement of social services.

Referral Criteria for Substance Misuse Service

Referrals for ≥ 18 years

The 2 main agencies that support clients with substance misuse problems are the Community Drug and Alcohol Team (CDAT) and Dyfed Drug and Alcohol Services (DDAS).

DDAS are an initial point of contact for all 3 counties for self-referrals to services. They can support people with low threshold substance misuse issues and provide advice and support around harm reduction (for example needle exchange).

CDAT provide care planned interventions including opiate substitute therapy (OST), alcohol detox, psychosocial interventions, and recovery support.

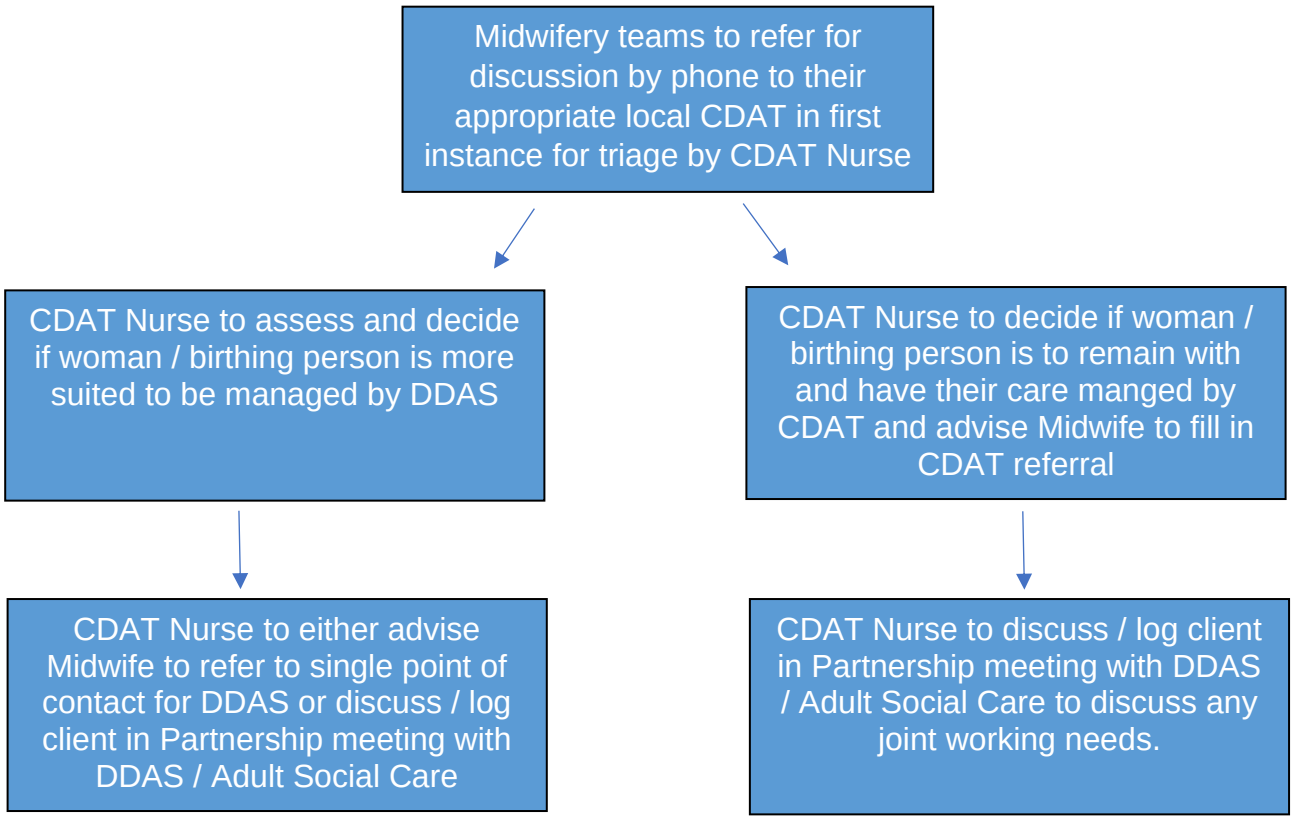
Referrals for < 18 years
CHOICES are a specialist young person substance misuse service. They work in conjunction with DDAS/CDAT and the other core members of the Substance Misuse Partnership. They provide specialist support for young people (and their families) who misuse substances.
Point of Contact telephone number for referrals (following discussion with CDAT) is **01554755779**

Social Care Substance Misuse Teams
Social Care Substance Misuse Teams (Carmarthenshire, Ceredigion, Pembrokeshire) are core members of the Substance Misuse Partnership. They receive referrals through Choices, DDAS & CCDAT Services.

In relation to parental substance misuse The Social Care Substance Misuse Teams provide consultation to partner agencies regarding associated risks, current and previous involvement with local authority, safeguarding pathways and collaborative working.

They also provide care management of complex needs arising from substance misuse through Tier 3 pathways and specialist Tier 4 treatment referral pathways that include exploration of generic, gender specific and mother & baby residential rehabilitation providers.

Flowchart for Referral Process



CDAT contact numbers

Carmarthenshire: **01267 244442**

Pembrokeshire: **01437 774141**

Ceredigion: **01970 636340**

Once a referral has been submitted a plan will be provided by the service who will be supporting the pregnant person which will be uploaded by the NCMW to the Maternity Safeguarding Database

Potential Substances of Maternity Safeguarding DatabaseMisuse (NB this list in not exhaustive)

- Alcohol
- Amphetamines
- Benzodiazepines (e.g., diazepam / temazepam / oxazepam)
- Cannabis
- Cocaine / Crack cocaine
- Hallucinogens
- Heroin
- Prescription/OTC opioids (eg tramadol / codeine)
- Gabapentin / Pregabalin
- Mephedrone (MCAT)
- Methadone
- New Pschyoactive Substances (NPS) previously known as 'legal highs' (e.g., Spice)
- Solvents
- Buprenorphine (Subutex / Espranor / Buvidal)
- Any Prescription Only Medicine that is being misused

Prenatal Care

Persons who wish to become pregnant should be given advice regarding the use of alcohol, illegal or misused legal drugs and smoking in pregnancy.

Those persons on prescription medication should have a medication review with their GP in preparation for pregnancy.

Advice should be given on taking folic acid and vitamin D supplements and the importance of healthy lifestyles.

Persons with a history of or have an increased risk of a blood born virus should be offered testing.

Antenatal Care

Initial contact appointment with the midwife

During the booking assessment, all women/ birthing persons should be asked in a non-judgemental way about their current and historic alcohol and substance use (prescribed and non-prescribed). This should be undertaken as early in pregnancy as possible. Emphasis should be on supporting and working with the woman collaboratively, shared care, guidance, and encouragement.

Midwives are to inform women/birthing persons that the safest approach is not to drink alcohol or use illicit substances during pregnancy due to the increased risks to the unborn.

If required, midwives should use the alcohol brief advice discussions and the F.A.S.T. alcohol questionnaire (see link below).
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684828/Fast_alcohol_use_screening_test__FAST__.pdf

Recording of information regarding alcohol, drugs and medication should be undertaken in The All-Wales Maternity Record* (please see notes below regarding documentation) and on the Welsh PAS clinical reporting system.

For those women/persons who disclose misuse of substances and/or alcohol, midwives are to discuss a referral for support by CDAT (see section 5). The following actions should be carried out in addition to the routine care and risk assessments made at the booking appointment by the Named Community Midwife (NCMW) who will be responsible for the woman/birthing person's care:

- Refer for named consultant-led care
- Contact CDAT for initial telephone consultation and then complete relevant referral proforma (see appendix1.) and upload the proforma onto the maternity safeguarding database. Attach a copy of the CDAT/ DDAS (or Choices if appropriate) referral proforma with the routine information sent when arranging consultant-led-care.
- Assess social circumstances including the routine enquiry for domestic abuse, complete and upload a SIP 2 onto the HDUHB Maternity safeguarding database.
- Risk Asses for and adult child safeguarding concerns and consult with the Named Safeguarding Midwife (NSMW) / HDUHB safeguarding team if there are any concerns or advice required. Inform the women/ birthing person of the importance of information sharing providing reassurance of confidentiality.
- Include screening for Hepatitis C screening along with other routine screening bloods as per Antenatal Screening Wales with appropriate counselling and referral to further specialist services as required.
- Refer to Perinatal Mental Health Team if required.
- Refer to smoking cessation Service if required.

***Documentation about substance and alcohol use should be discussed with the woman, and an agreement reached regarding where it will be documented. It may not be appropriate to document substance use in handheld maternity notes and if this is the case, the midwife should document that other important sensitive information is available on the Welsh PAS system and on the HDUHB Safeguarding Maternity database.**

Document the following on the Welsh Pas recording system (in the antenatal notes section) in the All-Wales Maternity Record hand-hand notes (if appropriate) and on the HDUHB Maternity Safeguarding database:

- The name of the drug use, drug history, past and current.
- Nature and frequency of any medication currently prescribed.
- GP/ pharmacy responsible for substitute medication prescribing.
- Names and contact numbers of all agencies involved.

If a woman/ birthing person discloses that their partner or a household member is using illicit substances or misusing alcohol, to encourage woman/ person to get them to engage with DDAS and discuss the woman/ birthing person and their circumstances with the Named Safeguarding Midwife (NSMW)/ HDUHB Safeguarding Team and consider completing a MARF referral for the UBB. Complete SIP 2 on the HDUHB Safeguarding Maternity Database.

If a woman/birthing person discloses exposure to drugs or alcohol during pregnancy that she is no longer using, the booking midwife should still book for consultant-led care for an obstetric opinion and for a plan of care. A referral to the CDAT / DDAS may also be appropriate still in terms of support around relapse prevention.

Initial appointment with the named consultant
Consultant responsibilities
A Named Obstetric Consultant will be the responsible clinician for the care of a pregnant woman/ person with current or recent history of substance misuse. This care plan should be based on the individual needs of the woman/ birthing person and include their preferences. The consultant plan should ensure good communication with all members of the multi-disciplinary team and other agencies, to ensure a holistic, person-focussed approach.

The first assessment by the consultant should occur as early as possible and no later than sixteen weeks of pregnancy.

In addition to routine risk assessments, the named consultant will participate in the assessment and development of an individualised obstetric care plan throughout the pregnancy, liaising with drug and alcohol support if required at any point.

- Growth scans as required, consideration for fetal medicine referral depending on the substance and dosage used.
- Monitor drug use and screening as required. Toxicology testing will only be required if the woman/ birthing person is not undergoing regular toxicology screening by the CDAT/DDAS/ Ch's service, or there is a suspicion that the woman / birthing person has or is using substances outside of the CDAT/DDAS/Ch's plan
- Paediatric referral from 28/40 for plan of care for the neonate following birth
- Documentation of the plan of care in the All-Wales-Maternity Record (if appropriate) and completion of the obstetric antenatal proforma
- Generate a referral to the anaesthetic team for an individualised plan of care 14
- If BBV then refer to BBV specialist for plan of care
- Update the HDUHB Maternity Safeguarding database with changes of the plan of care

Further antenatal care
Due to the complexities surrounding social misuse it is important that the woman/ birthing person is cared for by both the named community midwife care and consultant. Continuity of care is important in both the obstetric and midwifery service.

The NCMW should provide appointments alongside obstetric care. This may mean that the woman/ birthing person may require extra appointments. Therefore, where possible, these appointments should be provided in a setting of the woman's/ birthing person's choice.

The named CDAT/DDAS/Ch's worker responsible for care will inform and email the individualised plan of care to the NCMW, this will include any prescribed medication from CDAT for example methadone / buprenorphine.

The NCMW will be responsible for uploading the CDAT/DDAS/Ch's plan onto the HDUHB Safeguarding Maternity Database as soon as it is received.

The NCMW will take responsibility for uploading any plans, changes of plan, or other communications from and to outside agencies onto the maternity safeguarding database system. They will ensure that safeguarding notes and substance misuse notes will be available on safeguarding maternity database to anyone with access. All Midwives have a responsibility

to update the HDUHB safeguarding Maternity database including if the woman/birthing person is admitted to hospital.

28-week gestation

In addition, to routine care and ultrasound scans, the obstetrician/ ANC team will undertake:

- A referral to the paediatric team using the generic email account: paediatric.referralAccount@wales.nhs.uk and provide information regarding complexities of pregnancy, substances used at booking, current substance misuse and CDAT plan of care. This will enable the paediatric team to make an individualised assessment and an initial plan of care for the baby following birth. This should include a preliminary time length plan for abstinence scoring.
- A complex anaesthetic review with the woman/birthing person should be undertaken regarding IV access and options for analgesia in labour. Analgesia options for the 15 postnatal period should also be included. Any contraindications for opiate-based pain-relief should be sensitively documented in the 'All-Wales Maternity Record' on the considerations for intrapartum/ postnatal care pages, a letter should be uploaded onto the Welsh PAS recoding system.

32-week gestation

An individualised multi-disciplinary and multi-agency team meeting will be held to plan for the labour, birth, and the postnatal period. This plan should be made in conjunction with, and in regard of, the service user. If the woman/ birthing person finds this overwhelming their wishes should be voiced by the community midwife /CDAT worker and taken into consideration. The NCMW will feed back the outcomes of the meeting to the woman/ birthing person.

The multi-disciplinary / multi-agency team will consist of the CDAT worker, the NSMW, the Named Consultant, a representative from the paediatric team, and a representative from hospital pharmacy. Other members such as representatives from the perinatal mental health team and anaesthetics, and social worker should be included as required. This list is not exhaustive.

The individualised care plan should include:

- A recommendation for the safest place of birth. For some women a midwifery led birth setting may be appropriate depending on intrapartum risk factors, the level of neonatal care and monitoring required, and the Local Authority safeguarding plan for the UBB. If the woman/ person requests a home birth, then consideration should also include the suitability of the venue.
- A plan for pharmacology required including medications and expected dosage when admitted.
- A plan of care for the handover of therapeutic medications from and to the community pharmacy pre and post planned admission.
- Paediatric care plan for the neonate which includes:
    - Toxicology screening if required.
    - Vaccination plan if required.
    - Plan for abstinence scoring as per Welsh Neonatal Network Guidelines and should include time length and frequency of neonatal observations (this should be made on an individual basis based on the substance used, dosage and circumstances).
    - Plan for infant feeding following birth.
- Safeguarding and plan for both labour and the postnatal period (if required) (The Local Authority safeguarding plan for the UBB should be completed by 32 weeks).
- Analgesia requirements and contraindications.
- Mental health issues and plan of care (if required). 16

- Maternal toxicology screening plan if required (a summary of urine tests will be provided by the CDAT team.

The NCMW will provide the health visitor with a copy of this MDT care plan.

Where a pregnant person chooses to birth outside guidance then the NCMW should undertake an SBAR outlining the risks and the MSMW should be notified. The Consultant midwife can support the decision-making with the woman/birthing person and community team who will provide the intrapartum care.

Should the clinical, or social circumstances change following 32/40 the maternity safeguarding database is to be updated and the named midwife/obstetrician, NSMW, and paediatrician informed. If necessary, a further MDT review and new plan should be made. All parties are to be informed of the new care plan as soon as possible. This updated care plan along with the updated Local Authority birth plan for the UBB should be uploaded to the HDUHB Safeguarding Maternity database by the NCMW or NSMW at the earliest opportunity.

Inpatient admission

Any women/persons with complex substance misuse reporting a suspected SROM should attend and on confirmation be admitted and induced when indicated.

If HIV, Hepatitis B or C positive then avoid undertaking an ARM or using an FSE or birth by forceps or ventouse.

It may be worth noting that abdominal cramps from drug withdrawal can be misinterpreted as premature labour therefore a partosure/amnisure or equivalent point-of-care testing should be considered.

Admission when plan in place

- Inform the NSMW of any admission during office hours or leave a message.
- Inform CDAT (in working hours) on admission or the next working day
- Access the HDUHB Safeguarding Maternity database and download the SIP 2, The Local Authority Birth plan for the UBB and the MDT care. Inform SCBU of the admission to hospital
- All screening blood results should be accessed and known as soon as possible, and the labour managed according to relevant guidelines.
- Ask the woman /birthing person if their birth partner/relatives are aware of their history and current use of a script to maintain the woman's confidentiality.
- Methadone/ buprenorphine prescribing must continue in parallel to any other analgesia in labour. Sudden opiate withdrawal has been shown to possibly cause fetal distress.

    - Confirm dose and when last dose was taken with local pharmacy/ CDAT (if at the weekend / bank holidays and current does cannot be verified, and the 32-week plan does not state time and dosage of OST, then medication should not be given. If the woman/ person is symptomatic of opiate withdrawal, then see the Emergency Stabilisation guide below.
    - Prescribe the methadone/buprenorphine on the regular prescriptions part of the inpatient chart and ensure that timely administration of OST.

- Commence admission checklist (see appendices) and if being discharged antenatally, complete discharge part and inform community midwife, hospital pharmacy (and confirm date and time of last dose of OST), CDAT worker, and the NSMW. If CDAT are not able to be contacted, contact pharmacy to inform community pharmacy to recommence prescription. If out of normal working hours, then discuss with the on-call pharmacist for a plan for OST until community pharmacy can recommence administration. Avoid using TTO's unless there is no alternative. The daily dose of OST should be given on the ward before discharge.
  Do not give TTO's from stock.
- Access and update the SIP 2 of admission and outcome on the HDUHB Safeguarding Maternity database.

Admission / with no MDT plan in place / not known to substance misuse service

If actively withdrawing from opioid use, then follow the Emergency stabilisation for pregnant inpatients experiencing opioid withdrawal guide below

- Ask the woman / birthing person when alone if their birth partner/relatives are aware of her history and current use of a script to maintain the woman's confidentiality.
- Urgent review with anaesthetist and discussion with the woman regarding analgesia and intravenous access.
- If no antenatal screening undertaken, then take bloods and include HEP 'C' and send as urgent.
- Check HDUHB Safeguarding Maternity database for plan. Contact duty social worker, initiate a SIP 2, and complete a MARF for the unborn baby and submitted within 24 18 hours of the phone call. Contact the NSMW for advice (email / leave message if out of office hours). Email a copy of the MARF to the NSMW.
- Contact the CDAT service and complete a referral.
- Inform SCBU and Paediatricians of admission, complete paediatric referral. If birth is imminent, then urgent paediatric review of notes and MDT discussion and plan of care is required.

Intrapartum Care

Intrapartum care when substance misuse is managed and MDT plan in place

All women/ pregnant persons should be offered analgesia in labour.

All women/ birthing persons who have been under the care of CDAT should have a personalised plan of care for analgesia made by the anaesthetist and the pregnant person. This should be uploaded onto the HDUHB Safeguarding Maternity database. Should further analgesia be required then a discussion should be held with the woman/person, the midwife caring for her, and the on-call anaesthetist.

- If HIV, Hepatitis B or C positive then avoid undertaking an ARM or using an FSE or n assisted birth.
- Routine continuous electronic fetal monitoring in an otherwise low risk pregnancy is not required. Follow the MDT plan for fetal monitoring in labour.
- If there is a suspicion that the person has misused a substance prior to, or during labour, or if the woman/birthing person is symptomatic of withdrawal, then continuous CTG monitoring should be performed. This should be documented on The HDUHB Safeguarding Maternity database.

- If there has been poor compliance with drug-testing in pregnancy, or a suspicion that further substances have been used which are outside of the care plan or taken after the MDT plan, then continuous electronic fetal monitoring should be considered. This should be documented on The HDUHB Safeguarding Maternity database.
- If the woman/ birthing person is on a methadone script, intravenous cyclizine antiemetic can exacerbate the depression of the CNS, therefore alternatives such as stemitil / ondansetron could be considered as an alternative line of therapy.
- Paediatric team should be informed of the admission along with SCBU. If the baby has respiratory depression following their birth, then caution should be given to the use of naloxone. If possible, a discussion with a senior neonatologist should take place before administration due to the precipitation of withdrawal and associated risk of seizures.
- Following the birth of the baby a neonatal observation chart should be commenced as per the Paediatric plan made at 32 weeks, any subsequent monitoring will be based on an individual basis at the request of the paediatrician. See the All Wales Neonatal Network guidance on Neonatal Abstinence Syndrome (NAS). All Wales Guideline on the Management of Neonatal Abstinence Syndrome_Issue 1.pdf

The named community midwife will take responsibility for uploading any plans, changes of plan, or other communications from and to outside agencies onto the maternity safeguarding database system. They will ensure that safeguarding notes and substance misuse notes will be available on safeguarding database to anyone with access. All Midwives have a responsibility to update the HDUHB safeguarding Maternity database during the pregnancy, intrapartum and postnatal period.

Intrapartum care when no plan in place
Urgent review with anaesthetist and discussion with the woman regarding analgesia and intravenous access.

- Continuous fetal monitoring should be undertaken as withdrawal can lead to fetal distress.
- Avoid FSE, ARM, and assisted birth if a blood borne virus is suspected.
- Inform the neonatal team for an urgent plan of care, which includes the need for their presence at the birth, postnatal care plan, toxicology screening and neonatal urine toxicology, the need for cord blood samples etc.
- At delivery if baby has respiratory depression, caution should be given to the use of naloxone and discussion with a senior neonatologist should take place before administration due to the precipitation of withdrawal and associated risk of seizures.
- The baby should have a timely review following birth and a plan of care made for abstinence scoring (including frequency and time scale) in discussion with the mother. Evaluate the need for vaccinations.
- NB. If Hepatitis positive then ensure to clean the
- skin of the neonate with alcohol wipes thoroughly before administering the vaccine/ Vit K injection.

However, if a woman/birthing person chooses to birth at home, midwives have a duty to provide midwifery care if called in labour. Ideally, two midwives should attend. Any immediate safeguarding concerns will be managed in line with the Wales Safeguarding Procedures 2019 and Local Authority policies and the police where necessary.

Analgesia

All women/ birthing persons should be offered analgesia in labour all options are available for women including waterbirth, TENs machine, Entonox, pethidine, remifentanil, and epidural.

Women/ birthing persons who are not opiate-naive will require higher doses of opioids to achieve the same clinical effect. If high doses are required and given to manage pain effectively then consideration should be given for further monitoring with one-to-one care (either antenatally or postnatally) in the Enhanced Monitoring Unit on labour ward due to the unpredictability of effects with high doses.

It is not recommended to alter the bolus dose if a remifentanil PCA is used for analgesia in labour.

Women/ birthing persons who are on buprenorphine, methadone or heroin will still experience pain in labour.

If a woman / birthing person is already prescribed OST by the CDAT, their regular daily dose should not be used / assumed to be a substitute for analgesia in labour, please see the guide below.

Management of Pain relief in Maternity Inpatients Prescribed Methadone or using Heroin or Other

(Not Buprenorphine (Subutex))

Methadone is a long-acting full opioid agonist and is a medication used to treat Opioid Use Disorder (OUD)

Those service users on methadone should be offered standard analgesia in labour and should be encouraged to take their methadone at the usual times.

Women/ Birthing persons on methadone may become distressed if the methadone is delayed or omitted as they may start to go into withdrawals. Therefore, ensuring the medication is prescribed and available should be prioritised.

The main issues from methadone occur when established doses need to be adjusted, most commonly after birth as doses are titrated back to pre-pregnancy levels.

Venous Access

- If there is a potential problem with venous access due to current or previous injecting drug use, the client should have an anaesthetic review in the antenatal period. Please check birth plan for any specific requirements.
- **Epidural for women/birthing persons on methadone or heroin**
- Epidural / spinal analgesia remains the best method of analgesia for these patients. It will often be appropriate to continue with epidural analgesia post operatively following a discussion with a senior anaesthetist.
- Epidurals containing fentanyl are not contraindicated. If pain remains a problem despite an adequate block, then consider plain levo/bupivacaine at a higher concentration (0.25%). This might not be possible as an infusion, due to stock; therefore, manual boluses may be required. The on-call anaesthetist should be contacted early if this is felt to be required.

- A higher dose of local anaesthetic may be associated with an increased incidence of motor block.
- An epidural cannot be given without good IV access. Central lines may be used in exceptional circumstances, but this should have been discussed in the antenatal period or discussed in labour with a Senior Anaesthetist.
- Trans Abdominal Plane (TAP) block can also be considered as an additional analgesic option for a caesarean birth.

Post Operative birth analgesia for women/birthing person on methadone or heroin

- Consideration can be given for continuation of epidural PCEA if used for operative analgesia in discussion with the senior anaesthetist.
- For all women/birthing persons on opiates (i.e., heroin, methadone): Paracetamol and Ibuprofen/ diclofenac should be considered as first line analgesia. Where possible avoid the use of further opioid analgesia such as Codeine (i.e., co-dydramol, co-codamol) in women who are already on opioid substitute medication.
- Buprenorphine is contraindicated for women / birthing persons using heroin or prescribed methadone as it is a partial opioid antagonist and can bring on precipitated withdrawals if administered with other opioids still in the system.
- If further analgesia is required, then a senior anaesthetist should consult the on-call pharmacist for advice around options.

Other drugs

Cocaine is especially hazardous in association with anaesthesia (especially general anaesthesia) therefore an anaesthetic review should be undertaken if no plan made in the antenatal period or dosage has changed.

Enquire re. maternal use about the drug/s used if any anaesthetic required. Again, this should have been discussed in the antenatal period.

If in doubt, please call the on-call anaesthetist

Management of Pain Relief for Maternity Inpatients Prescribed Buprenorphine

Buprenorphine is used in the treatment of opioid dependence to substances such as heroin or codeine. Buprenorphine can be prescribed in varying forms. Most commonly this will be a sublingual tablet. This daily dose is known as a ‘maintenance dose’. Buprenorphine can also be prescribed as Espranor (an oral lysophiliate that dissolves rapidly on the tongue) or administered as a weekly or monthly subcutaneous depot injection. The management of OST is undertaken by HDUHB CDAT.

Buprenorphine acts as a partial agonist/antagonist, particularly in large doses. The degree of opioid receptor occupancy by buprenorphine is not only dependent upon the maintenance dose of buprenorphine but also individual variation. Therefore, when pure/full opioid agonists (e.g., morphine) are given to a mother already on buprenorphine, then the full agonist effect will be blocked by the buprenorphine to varying degrees.

The mother/birthing person will not have an adverse effect, but the degree of analgesia will be unpredictable. The danger of giving a full opioid agonist (e.g., morphine) in this 23 circumstance is that

there will be initially poor analgesia. It is still possible that overuse of an opioid agonist can still result in respiratory depression.

When a long-acting pure opioid agonist (e.g., morphine) is given for analgesia followed by another dose of buprenorphine then a withdrawal phenomenon can occur because of the partial antagonist effect of the buprenorphine. It is therefore best not to give a long-acting full agonist so that the mother can be rapidly returned to her usual buprenorphine regime.

Buprenorphine is a good analgesic in its own right and will be used as part of the analgesic regime however, the regular dosage should not be used routinely for analgesia in labour.

Antenatal
Mothers/ birthing persons on maintenance buprenorphine will be regularly seen by the Prescribers and Nurses at CDAT who will inform the community midwife of the woman's/ birthing person's care plan. This will be stored on the maternity safeguarding database and updated with any changes.

Analgesia will be discussed with the mother by the anaesthetist during the anaesthetic review. The agreed plan for analgesia should be recorded in the mother's/ birthing person's notes in the event that the woman/person delivers outside of the Health Board. The plan for analgesia should also be included in the 32/40 individualised MDT plan of care, this should be stored on the maternity safeguarding database.

Women / birthing persons on buprenorphine 4mg or less

Labour analgesia
Avoid opioid analgesia where possible. In labour, consider immersion in water, TENS, mobilisation, and relaxation techniques as alternatives to pharmacological analgesia. Entonox may be used in women/ birthing persons using buprenorphine.

Mothers/ birthing persons on buprenorphine 4mg or less can be treated with usual delivery suite analgesia protocols. This can include IM pethidine, Remefentanil PCA, and usual epidural mixtures of bupivacaine and Fentanyl.

Higher dosages of full opioid agonists (e.g., morphine/ pethidine) may still be needed to achieve satisfactory analgesia. This is subject to individual variation and is also dependent upon the dosage of buprenorphine and the time interval from the last dose of buprenorphine.

Epidural top-up for Caesarean or assisted birth

- Women/ birthing person on less than buprenorphine 4mg can be treated with usual delivery suite analgesia protocols.
- Higher dosages of full opioid agonists (e.g.,morphine) may still be needed to achieve satisfactory analgesia. This is subject to individual variation and is also dependent upon the dosage of buprenorphine and the time interval from the last dose of buprenorphine.

Spinal block for Caesarean or assisted birth

- Women on less than buprenorphine 4mg can be treated with usual delivery suite analgesia protocols.

- Higher dosages of full opioid agonists (e.g., morphine) may still be needed to achieve satisfactory analgesia. This is subject to individual variation and is also dependent upon the dosage of buprenorphine and the time interval from the last dose of buprenorphine.

General anaesthesia
Women/ birthing persons on less than buprenorphine 4mg can be treated with usual delivery suite analgesia protocols.

Post-birth management
- Write up the woman's/ Birthing person's usual dose of buprenorphine on the regular prescription.
- Write up anti-emetic and naloxone.
- Write paracetamol and diclofenac as usual on the regular prescriptions.
- If analgesia is a problem, remember that paracetamol IV and diclofenac given PR can be more effective.
- On the PRN prescription chart write up buprenorphine 2mg to be given as required not more than every hour. A small supply of 2mg buprenorphine will be kept as a controlled drug on the delivery suite and on the postnatal ward. This should be written up in the PRN side of the prescription chart and in addition to the usual dose of buprenorphine that is prescribed on the regular prescription.
- This can be repeated hourly with careful evaluation of pain-relief. The maximum dose of buprenorphine in a 24-hour period should not exceed 32mgs (inclusive of regular or 'maintenance' daily dose)
- Always put the usual dose of buprenorphine on the regular prescription and supplementary buprenorphine on the PRN prescription

Post Caesarean birth analgesia
Women/ Birthing person on buprenorphine 4mg or less can be treated with usual delivery suite analgesia protocols. This can include intrathecal or epidural diamorphine, or IM or subcutaneous morphine after a GA (General Anaesthesia) Caesarean birth. Higher dosages of full opioid agonists may still be needed to achieve satisfactory analgesia. This is subject to individual variation and is also dependent upon the dosage of buprenorphine and the time interval from the last dose of buprenorphine.

If required, additional analgesia can be provided using buprenorphine, see above.

Women / birthing persons on buprenorphine 4-16mg

Labour analgesia
- Avoid opioid analgesia where possible. In labour, consider immersion in water, TENS, mobilisation and relaxation techniques as alternatives to pharmacological analgesia. Entonox may be used in women on buprenorphine.
- In doses above 4mg, because of the high receptor site occupancy, a reduced effect of IM pethidine is anticipated.
- Please note that IM pethidine will result in potentially inadequate analgesia if the woman / birthing person is prescribed regular buprenorphine.
- Usual epidural regime can be used initially, and analgesia assessed regularly.
- If analgesia is poor and the block is inadequate, then increase the concentration of bupivacaine to 0.125% or 0.25% rather than increase the dose of Fentanyl.

- PCA fentanyl or remifentanil can be used if an epidural is not wanted or contraindicated

Epidural top-up for Caesarean or assisted birth
In women/birthing person on doses of Subutex 4 - 16mg, use100micrograms fentanyl (because of the potential resistance to pure agonist) but DO NOT give epidural diamorphine.

Spinal block for Caesarean or assisted birth
In women on doses of Subutex 4 - 16mg, give intrathecal fentanyl 20 micrograms but DO NOT give intrathecal diamorphine.

General anaesthesia
In women on doses of Subutex 4 - 16mg, give fentanyl 100micrograms IV but DO NOT give morphine. Consider the use of TAP blocks or local infiltration into the wound.

Post-birth management
- Write up the mother/ birthing person for their usual dose of buprenorphine on the regular prescription.
- Write up anti-emetics and Naloxone
- Write paracetamol and diclofenac as usual on the regular prescriptions.
- If analgesia is a problem, remember that paracetamol IV and diclofenac given PR can be more effective.
- On the PRN prescription chart write up buprenorphine 2mg to be given as required not more than every hour. A small supply of 2mg Subutex will be kept as a controlled drug on the labour suite and on the postnatal ward.
- This can be repeated hourly with careful evaluation of pain-relief. The maximum dose of buprenorphine in a 24-hour period should not exceed 32mgs (inclusive of regular or 'maintenance' daily dose).
- Always put the mother's/ birthing person's usual dose of buprenorphine on the regular prescription and supplementary buprenorphine on the PRN prescription.

Post Caesarean birth analgesia
- In recovery the mother/ birthing person can be given buprenorphine 2mg sublingually and analgesia noted after one hour.
- This can be repeated hourly with careful evaluation of pain-relief. The maximum dose of buprenorphine in a 24-hour period should not exceed 32 mgs (inc. of regular dose).
- Always put the mother's usual dose of buprenorphine on the regular prescription and supplementary buprenorphine on the PRN prescription.
- The mother should be cared for in the enhanced monitoring unit for a minimum of 6 hours after a caesarean birth to ensure her analgesia is effectively managed prior to transfer to the postnatal ward.

Women / birthing persons using over 16mg buprenorphine

At doses greater than buprenorphine 16mg, most of the opioid receptors will be blocked. Analgesia from pure opioids is more unpredictable and the mother/parent is more likely to get a sudden on-set of respiratory depression as a large dose of a pure opioid may be required to get opioid induced analgesia.

Labour analgesia

- In labour, consider immersion in water, TENS, mobilisation, and relaxation techniques as alternatives to pharmacological analgesia. Entonox may be used in women/ birthing person on buprenorphine.
    - Please note that IM pethidine will result in potentially inadequate analgesia if the woman / birthing person is prescribed regular buprenorphine
    - Usual epidural regime can be used initially, and analgesia assessed regularly.
    - If analgesia is poor and the block is inadequate, then increase the concentration of bupivacaine to 0.125% or 0.25% rather than increase the dose of Fentanyl.
    - PCA fentanyl or remifentanil can be used if an epidural is not wanted or contraindicated

Epidural top-up for Caesarean or assisted birth

- In women on doses of buprenorphine16mg or above, give intrathecal fentanyl 20mcg but DO NOT give diamorphine.
- If Caesarean birth is carried out under CSE, leave the epidural catheter in place and if analgesia fails, a bupivacaine infusion can be run for the first 24 hours post-birth.

Spinal bock for Caesarean or assisted birth

- In women on doses of buprenorphine 16mg or above, give intrathecal fentanyl 20 micrograms but DO NOT given diamorphine.
- If Caesarean birth is carried out under CSE, leave the epidural catheter in place and if analgesia fails, a bupivacaine infusion can be run for the first 24 hours post-delivery.

General anaesthesia

- In women on doses of buprenorphine 16mg or above, give fentanyl 100micrograms IV but DO NOT give morphine.
- Consider the use of TAP block or local infiltration into the wound.

Post-birth management

- Write up the mother for her usual dose of buprenorphine on the regular prescription.
- Anti-emetics and naloxone should be prescribed.
- Write paracetamol and diclofenac as usual on the regular prescriptions.
- If analgesia is a problem, remember that paracetamol IV and diclofenac given PR can be more effective.
- On the PRN prescription chart write up buprenorphine 2mg to be given as required not more than every hour. A small supply of 2mg buprenorphine will be kept as a controlled drug on the delivery suite and on the postnatal ward.
- This can be repeated hourly with very careful evaluation of pain-relief. **The maximum dose of buprenorphine in a 24-hour period should not exceed 32mgs (inclusive of regular or 'maintenance' daily dose)**
  Always put the mother's/ birthing persons usual dose of buprenorphine on the regular prescription and supplementary buprenorphine on the PRN prescription

Post Caesarean section analgesia

- At doses greater than buprenorphine 16mg, most of the opioid receptors will be blocked.
- Analgesia from pure opioids (e.g., morphine) is more unpredictable and the mother is more likely to get a sudden on-set of respiratory depression as a very large dose of a pure opioid may be required to get opioid induced analgesia.

- These mothers/birthing persons should have an analgesia regime prescribed as above but if they have a Caesarean birth under epidural analgesia or CSE then the epidural should be left in place and if analgesia fails, a bupivacaine infusion can be run for the first 24 hours post-delivery.
- If an epidural infusion is used the mother will need appropriate monitoring and one- to - one care in the EMU.

General Points
Most post-delivery analgesia problems can be dealt with by the usual paracetamol/diclofenac regimes and increasing the dose of buprenorphine. All post-delivery analgesia problems (including after a normal vaginal delivery) should be referred to the obstetric anaesthetist and discussed with the covering obstetric anaesthetic consultant if problems persist.

The buprenorphine dose should be returned to the regular maintenance dose prior to discharge. Any increase in regular dosage needs to be discussed with the community Prescriber prior to discharge.

Postnatal Care

Where there has been Local Authority involvement, then follow the Local Authority birth plan and document on the HDUHB Safeguarding Maternity database. Where there is no plan in place contact the named social worker or duty social worker and inform them of the birth of the baby, request an immediate birth plan and attach to the HDUHB Safeguarding Maternity database. Document all conversations and proposed actions on the' Record of Contact 'on the Safeguarding Maternity database.

Consider postnatal pain management and seek support from anaesthetic team if required. **Remember that opiate-based pain relief for women who are using buprenorphine will not work as effectively as it is an opiate blocker. See above post-birth analgesia for buprenorphine users.**

Maintain confidentiality in front of other patients do not openly discuss drug use or social services involvement and provide methadone prescription in a private place.

- Ensure methadone / buprenorphine is prescribed in a timely manner and available each day at the time specified on the drug chart. The prescription dose should be recorded in hand-held pregnancy notes (if appropriate) and on the CDAT plan found in the HDUHB Safeguarding Maternity database. If any doubt, contact the CDAT worker (see previous numbers).

- If the patient appears to be over sedated following OST consumption, consider a dose reduction as there will be reversed haemodilution which results in higher concentration levels of the drug. CDAT can advise about how this can be managed during weekdays. Out of hours please contact the on-call Anaesthetist to review.

- Breastfeeding should be encouraged if appropriate where clients are stable on OST. **Please note that breastfeeding is contraindicated for both cocaine / crack cocaine and high doses of diazepam and codeine, which are both commonly misused substances.** For other substances, decisions must be made on an individualised basis. Most drugs of misuse do not pass into breast milk in sufficient quantities to have a major effect on the baby. The Relative Infant Dose (RID) is a method for estimating risk to the baby from exposure to medication taken by the mother in breast milk. The RID of the vast majority of drugs is < 1%. The (RID) of each

medication is found on the LactMed website Drugs and Lactation Database (LactMed®) - NCBI Bookshelf (nih.gov) (opens in new tab). Any drugs have limited data on the effect on the neonate. Please see appendix. Contact Infant Feeding Lead, Paediatrician, and hospital pharmacist for advice.

- A postnatal drug screens should be considered (see MDT plan) especially if substance misuse is disclosed in labour or neonate displays unexpected withdrawal symptoms.

- If the mother/birthing person is obviously under the influence of substances, the midwife should seek advice from the corporate safeguarding team/ NSMW and inform senior midwifery managers for support. It may be necessary for the mother/ birthing person to leave the maternity unit. In this scenario, the baby would need to stay if NAS observations and treatments are ongoing. Social care would also need to be informed of the situation.

- Ascertain whether a multi-disciplinary pre-discharge meeting is needed.

- Ensure the CDAT is aware of planned discharge date so community prescription can be recommenced. If CDAT not able to be contacted, contact pharmacy to inform community pharmacy to recommence prescription. Out of hours then discuss with on-call pharmacist for plan for OST until community pharmacy can recommence 31 administration. Avoid using TTO's unless there is no alternative. The daily dose of OST should be given on the ward before discharge. **Do not give TTO's from stock.**

- When the woman/ birthing person has been discharged but stays in the hospital with the baby when admitted to SCBU, the pharmacy should be contacted and informed of the situation and plan made as to where the OST will be administered. This should be documented on the HDUHB Safeguarding Maternity database. CDAT should be informed.

- On discharge, ensure the NCMW/community midwife or health visitor are contacted to ensure they are aware of history/current circumstances and the plan of care.

- Paediatric review for NIPE and plan of further care e.g such as vaccinations.

- Strongly advise mother of the risks of co-sleeping with baby and follow the safe sleeping policy.
- Discuss with the parents all aspects of withdrawal symptoms in their baby, that extra help may be required for parents of babies that withdraw and where to seek help. If community staff are concerned that the baby is exhibiting increased symptoms of NAS after discharge, then a paediatric a review should be requested. NAS (Neonatal Abstinence Syndrome) may occur immediately after birth or up to several weeks later.

- The baby should be weighed in the community on Day 3, 5, 7 and Day 10 (weight loss is an indicator of NAS) whether in hospital or in the community. The baby should not be discharged from the maternity services' care until it has regained birth weight or > 28 days.

- A full handover of care to the health visitor should be done face-to-face/virtually and should involve the CDAT team if possible. Documentation of the handover of care and on-going care plan by CDAT team should be recorded on the HDUHB Safeguarding Maternity Database and a

completion of SIP 3 in line with the Sharing of Information in Pregnancy procedure should be undertaken.

Care to the neonate that may help reduce Neonatal Abstinence Syndrome symptoms

Breastfeeding and skin-to-skin are very important in supporting babies with NAS

Difficulty sleeping / maintaining sleep state

- Keep room quiet and dimly lit.
- Swaddle using a soft or cotton sheet – if pyrexia dress baby in nappy only.
- Organize care to reduce handling.
- Pacify by use of dummy.
- Soft talk to baby.

General irritability

- Avoid positioning baby's cot directly under fluorescent lights that 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
- Help to control trembling by holding the hands across chest. Shoulders forward.
- Reduce environment stimuli.

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 baby is alert

- 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.

Management of withdrawal from opiate use

If a woman / birthing person is admitted and found to be in opioid withdrawals, CDAT should be contacted in the first instance to advise around management of this in terms of starting / titrating onto OST (methadone or buprenorphine). If CDAT are unavailable, please consider one of the hospital pharmacists with knowledge of this speciality. If this occurs out of hours or there is likely to be a delay in this communication, consider the following guidance in terms of symptomatic relief of opioid withdrawals.

Prescribing symptomatically can reduce some of the physical effects of withdrawal. Care is needed concerning the risks of multiple drug use and an appropriate medical review should be sought.

The following list of medications used in symptomatic relief of opioid withdrawals is as advised in the Drug misuse and dependence - UK guidelines on clinical management (Department of Health and Social care 2017.)

- Diarrhoea – loperamide 4mg immediately followed by 2mg after each loose stool for up to five days; usual dose 6-8mg daily, maximum 16mg daily.
- Nausea, vomiting, may also be useful for stomach cramps – metoclopramide 10mg eight-hourly (for a maximum of five days to minimise neurological and other adverse reactions) or prochlorperazine 5mg three times a day or 12.5mg intramuscularly 12- hourly.
- Stomach cramps – mebeverine 135mg three times a day.
- Agitation and anxiety, sleeplessness – diazepam (oral) up to 5-10mg three times daily when required (or zopiclone 7.5mg at bedtime for patients who have been dependent on benzodiazepines). In severe cases of anxiety and agitation, obtain suitable psychiatric advice from an addiction psychiatrist or the on-call duty psychiatrist.
- Muscular pains and headaches – paracetamol, aspirin and other non-steroidal
- anti-inflammatory drugs. Topical rubefacients can be helpful for relieving muscle pain associated with methadone withdrawal.

Medication used to manage opioid withdrawals should be offered for approximately 3-5 days and should not be continued on discharge. Patients should be advised of this when medication is initiated.

Management of overdose from opiate use

Signs and symptoms

Drowsiness reduced respiratory rate and force, confusion, slurred speech, pinpoint pupils, leading to coma and respiratory arrest. Note that it is still possible, although less likely to overdose, or suffer a respiratory arrest on buprenorphine (as opposed to an opioid agonist such as methadone) due to its partial antagonistic properties. see

NB - a benzodiazepine overdose can cause drowsiness and respiratory arrest but is not characterises by pinpoint pupils as found in an opioid overdose.

Treatment

1. General supportive care
2. Try to verify overdose from patient or other independent source
3. Give Naloxone 400mg injection intramuscularly / intravenously (if access available)
4. If they respond temporarily to IM Naloxone consider IV infusion

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

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

1. Staff should seek support from the corporate safeguarding team / Named Safeguarding Midwife and the senior midwifery managers. At the weekends, the on-call manager for maternity should be requested to attend.
2. Should there be a strong suspicion then this matter should be dealt with by the Police, not hospital staff.
3. Call 999 requesting Police attendance and arrange with the Police for a member of Ward staff to meet them at the hospital main entrance rather than the maternity ward/reception area.
4. Inform Hospital porters of the situation - or bleep via Switchboard.
5. The Police should be encouraged to use discretion entering the ward to minimize knowledge of their presence and to minimise distress to the woman/birthing person and other people on the ward.
6. The patient has to be present if the Police search her belongings. If illicit substances are found, the Police will decide on course of action. If required, the woman/birthing person will be escorted off the premises. The baby will need to remain on the Ward.
7. The Duty Social worker should be contacted and informed, a MARF should be completed for the UBB / neonate, and a SIP 2 should be completed on the HDUHB Safeguarding Maternity database. Emergency Local Authority birth plans should be uploaded onto the HDUHB Safeguarding Maternity database and all conversations regarding safeguarding should be documented on the ‘ Record of Contact’ on the Safeguarding Maternity database.

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Hywel Dda/CDAT Maternity Substance Misuse Referral

To be sent following initial telephone call with local CDAT

Dyfed Drug and Alcohol Service (DDAS): 0330 3639997

Community Drug and Alcohol Team (CDAT) contact numbers:

Carmarthenshire: 01267 244442 **Pembrokeshire:** 01437 774141 **Ceredigion:** 01970 636340

Date of referral:	**Pre referral discussion CDAT worder (name and date):**	
Mothers name:	**Date of Birth:**	
Hospital / NHS number:	**Gravida:**	**Para:**
Partners name:	**EDD:**	
Referring midwife:	**Midwifery tram / contact number:**	
GP name / practice:	**GP address:**	
SIP 2 YES / NO	**MARF YES / NO**	**Safeguarding database completed/updated YES / NO**

Safeguarding midwife:	**Data informed:**
Perinatal MH Midwife:	**Data informed:**
Consultant Obstetrician:	**Data informed:**
Other:	**Data informed:**

Current agency involvement

Agency:	**Current / historic**	**Key Worker**	**Contact Tel No:**
CDAT / DDAS			
Community Mental Health Team / Crisis team			
Perinatal Mental Health Team			
Social Services			

Other (e.g., Housing, Probation)			

Substance:	**Current / historic**	**Frequency / How often**	**Dose / amount / units**
Alcohol			
Amphetamine			
Benzodiazepines (e.g. Valium)			
Cannabis			
Cocaine / Crack Cocaine			
Codeine			
Ecstasy / NPS / MDNA			
Heroin			
Methadone			
Buprenorphine (Buvidal / Subutex, Suboxone, Temgesic)			
Other / non prescribed medication E.G: Codeine / Pregabalin			

Supplementary Information

Inpatient checklist for OST use

To be filed in main notes following discharge and documented on the maternity safeguarding database. Refer to full guidelines

Patient Identification Sticker	CDAT Worker name: CDAT Tel: Community Pharmacy: Tel: Named Community Midwife:

Admission Date				
Access Safeguarding Maternity Database for CDAT and Local Authority plan of care, input admission in the 'Record of Contact' section.				
Inform Prescriber & Community Pharmacy of admission and pending prescription requirements if on OST				
Inform Local Authority (if required).				
Drs to prescribe usual dose of OST				
Send request form to pharmacy ASAP				
Check OST stock arrived and available on ward (document in OST in inpatient CD book; 2 people to sign).				
Inform CDAT of admission				
Inform Named Safeguarding Midwife /Safeguarding team of admission				
Discharge Date				
Inform hospital and community Pharmacy of discharge and dose of OST				
Confirm dose of OST on discharge				
Inform CDAT of discharge				
Inform Local Authority / Safeguarding team of discharge and follow up plan				
Update Safeguarding Maternity database in the 'Record of Contact' with follow up plan of care.				
Inform Safeguarding team of discharge and F/U plan				
Inform Named Community Midwife of discharge				

Clinical Opiate Withdrawal Scale substance misuse

Give score that best describes the patient's signs or symptom.
Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:								
Reason for this assessment (should not be undertaken routinely):								
Date:								
Time								
Runny nose or tearing (in the absence of a cold/hayfever)								
Not present	0							
Nasal stuffiness or unusually moist eyes	1							
Nose running or tearing	2							
Nose constantly running or tears streaming down cheeks	4							
Pulse rate:								
pulse rate 80 or below	0							
pulse rate 81-100	1							
pulse rate 101-120	2							
pulse >120	4							
Sweating: over past ½ hour not accounted for by room temperature or patient activity								
no report of chills or flushing	0							
subjective report of chills or flushing	1							
flushed or observable moistness on face	2							
Beads of sweat on brow or face	3							
Sweat streaming on face	4							
Restlessness Observation during assessment								
Able to sit still	0							
Sits still but patient reports difficulty	1							
Frequent shifting of extraneous movements of legs/arms	3							
Unable to sit still for more than a few seconds	5							
Pupils								
Normal for room light	0							
Larger than normal for room light	1							
Moderately dilated	2							
Dilated that only rim of iris is visible	5							

Gastric / Intestines Upset: over last ½ hour								
No G.I. symptoms	0							
Stomach cramps	1							
Nausea/ loose stools	2							
Vomiting/ diarrhoea	3							
Multiple episodes of Vomiting/ diarrhoea	5							
Tremor (observation of outstretched hands)								
No tremor	0							
Tremor felt but not visible	1							
Slight tremor	2							
Gross tremor, muscle twitching	4							
Anxiety or Irritability								
None	0							
Patient reports increasing irritability or anxiousness	1							
Patient obviously anxious/ irritable	2							
patient so irritable or anxious that participation in the assessment is difficult	4							
Gooseflesh skin								
Skin is smooth	0							
Goosebumps of skin can be felt or hairs standing up on arms	1							
Prominent goosebumps	5							
Yawning during the observation period								
No yawning	0							
1-2 times	1							
3+	2							
Excessive yawning over a 1-minute period	4							
TOTAL SCORE (add each section score together)								
Completed by (Initial)								

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal (: Wesson and Ling 2003)

Flow chart for women / birthing person using Buprenorphine

Maternity inpatient taking buprenorphine (Subutex)

<4mg

Follow usual protocols

4mg-16mg

Epidural Top up for C/B
- 20-30ML L-bupivacaine 0.5%
- 100mcg Fentanyl
- No epidural diamorphine

>16mg

Epidural Top up for C/B
- 20-30ML L-bupivacaine 0.5%
- 20mcg Fentanyl
- No epidural diamorphine

Labour analgesia
- Non-pharmacological methods & Entonox
- IM pethidine safe if >6hrs to next subutex dose
- Usual epidural mix
- Consider 0125% - 025% if inadequate, no extra boluses of fentanyl
- Remifentanil PCA

Spinal Anaesthesia
- Usual dose heavy bupivacaine + 20mcg fentanyl
- No intrathecal diamorphine
- Consider CSE & post op epidural infusion for analgesia

General Anaesthesia
- Usual induction + 100mcg fentanyl
- No iv Morphine
- IV Paracetamol 1g post delivery
- Consider local infiltration of wound or ilio-inguinal nerve blocks / TAP block

Post birth analgesia for all patients taking buprenorphine

- Prescribe on 'regular' sid,e of prescription chart: Paracetamol, Diclofenac plus, maintenance buprenorphine dose.

  Consider Iv paracetamol and PR diclofenac for better analgesia.

- If pain not managed as above: Prescribe on 'PRN' side of prescription chart: Buprenorphine 2mg hourly (in addition to normal maintenance dose) with careful of pain and assessment, strict hourly observations, plus anti-emetics and naloxone as usual.

N.B. Maximum daily dose of 32mg buprenorphine inclusive of maintenance dose

THIS IS INTENDED AS A GUIDE ONLY. IF THERE ARE ANY QUERIES, PLEASE REFER TO THE MAIN DOCUMENT OR CONTACT A SENIOR ANAESTHETIST

Neonatal Abstinence Scoring Chart

This table is for guidance only, some durations of observation may be shortened or lengthened depending on the substance, the dose, and the circumstances. In all cases, decisions must be reached by reviewing mother's history, notes, and any individual care plan outlined in the MDT review unless there has been a change of circumstances.

DRUG/MEDICATIONS	EFFECTS	SCORING: Frequency and time length	Breastfeeding Guidance Advice
Alcohol	Use in pregnancy associated with Fetal Alcohol Syndrome and withdrawal in newborn infants (irritability, unstable temperature, poor feeding, wakefulness)	If there has been regular and frequent alcohol intake **during late pregnancy,** examine for dysmorphic features and observe infant for **48** hours for signs of withdrawal.	Evidence of disturbed sleep pattern and impaired motor development. **Breastfeeding not advisable within 8 hours of drinking alcohol**[1]
Anti-Depressants/SSRIs/Tricyclics, SNRI's, Anti-psychotics, any other medications prescribed for Mental Health issues	**PLEASE REFER TO THE PNAS GUIDELINE:** Psychotropic Medication - Babies Born to Mothers.pdf Psychotropic Medication - Appendix 1 - Drug Specific Guidence.pdf		
Amphetamines (nonprescribed): Phet, Powder, Speed, Whiz	Irritability, hyperstimulated, unstable temperature, overfeeding.	5 days	**Not advisable**. the Department of Health recommend not breastfeeding if using large/high doses of amphetamines
Benzodiazepines: e.g., Valium (diazepam) **≥30mgs daily**	Hypotonic, hypothermic, lethargy, poor feeding	5 days	**Not advisable** If using more than 3060mgs daily this can cause lethargy, poor feeding, and weight loss in the neonate.

Benzodiazepines: <30mgs daily	Possibly slow to feed	24 hours	**Yes,** only If stable on current dose lower than 30 mg then, breast feeding may be considered on a benefit and outweigh risks basis
Beta blockers; e.g**.** Propranolol	Irritability, hypoglycaemia	See hypoglycaemia pathway	**Yes**

Cannabis	Possibly shorter feeds and lethargy.	None	**Yes,** although limited Data available. Effects of Tobacco smoke and nicotine with SIDS should also be discussed.
Cocaine /Crack Cocaine	Effects highly variable - irritability, poor feeding, hyper-alert state, excessive sleeping	5 days	**Not advisable**. Women who have a regular heavy/high use of cocaine should be advised not to breastfeed due to the immaturity of the new-born's ability to metabolise cocaine via breast milk. Women who intermittently use cocaine should be advised to be abstinent for 24 hours prior to Breastfeeding.

Codeine	Small risk of NAS. Ultrafast metabolisers (up to 1 in 10 of population, up to 1 in 4 of African ethnic background) will convert codeine to morphine with subsequent risk of sedation and apnoea in the new-born infant	48 hours	**Not advisable especially with high doses.** Discussion with mothers of risks of excessive sleepiness/apnoea. Any symptoms should prompt urgent medical attention. Consider suspending breastfeeding until the cause of the baby's symptoms can be identified. For consultation with paediatricians
Heroin	Neonatal Abstinence Syndrome (NAS)	5 days	**Not Advisable.** The Department of Health advises that if a woman is a chaotic heroin user or is injecting that breastfeeding should be avoided.
MCAT (mephedrone) Meow Meow; Bonsai; Bubbles; Bounce	See Amphetamines	5 days	**Not Advisable**
Methadone	NAS	5 days	**Yes** Methadone passes through the breast milk in very small amounts. This can reduce the degree of withdrawal symptoms in the neonate.
Morphine based analgesics: MST, Oramorph	NAS	2 to 5 days depending on dose and circumstances.	**Yes**

NPS (New Psychoactive Substances) **Formerly 'Legal Highs'** Genesis, Terminator, Clockwork Orange	See Amphetamines	5 days	**Not Advisable.** Little data known on the effects on the neonate
Buprenorphine (Subutex)	NAS	5 days	**Yes**
Tramadol	Rapid onset of NAS, within 24-48 hours Drowsiness and feeding issues	2 to 5 days depending on dose and circumstances	**Yes, although limited data available.** Stop f showing signs of NAS and paediatric review.
Pregablin/ Gabapentin	Some case studies report effects of loose stools, drowsiness, and feeding issues such as poor sucking reflex . Withdrawal symptoms may be exacerbated when combined with opioid use.	48 hours	**Yes, although limited data available.**

Risk of breastfeeding should be weighed against its benefits. If in doubt, advice from a senior member of the neonatal team/l should be sought or infant feeding lead midwives.

When there is insufficient data to guide management, a pragmatic approach may be taken in which the baby can be observed for between 2 and 5 days depending on dose and circumstances (eg parenting skills, social concerns). At discharge the midwife/clinician should advise the mother on potential risks and inform her what symptoms to look out for. This should then be documented in the notes

Pathway Summary for Pregnancy Service Users Identified with Substance Misuse (to be used alongside routine care)

The NCMW will be responsible for uploading all plan of care/ correspondence form outside agencies onto the maternity safeguarding database including the initial substance misuse team's management plan

Booking appointment with Community midwife at earliest opportunity

In addition to routine care

- Refer for named consultant led care
- Refer to Community Drug and Alcohol Team (CDAT) **in the first instance. CDAT will ascertain as to which agency (CDAT / DDAS) is best placed to support the client. This can be done as a telephone conversation initially.**
- If appropriate, complete the CDAT/ DDAS referral proforma and upload the proforma onto the maternity safeguarding database. (Copies to consultant and handheld record)
- Assess social circumstances including the routine enquiry for domestic abuse, complete and upload a SIP 2 onto the maternity safeguarding database.
- Risk Asses for child protection issues and consult with safeguarding team if any concerns. Inform the women/birthing person of the importance of information sharing providing reassurance of confidentiality.
- Consider Hep C BBV screening along with ASW routine screening.
- Refer to Perinatal Mental Health Team if required.
- Refer to smoking cessation Service if required.

All appointments should be offered in addition to consultant appointments and in a place of the service users' choice

Initial consultant appointment

- Growth scans as required, consideration for fetal medicine referral depending on the substance and dosage used.
- Monitor drug use and screening as required. Toxicology testing will only be required if the woman/ birthing person is not undergoing regular toxicology screening by the CDAT service, or there is a suspicion that the woman / birthing person has or is using substances outside of the CDAT plan.
- Paediatric referral from 28/40 for plan of care following delivery.
- Documentation of the plan of care in the All-Wales Maternity Record and completion of the obstetric antenatal proforma.
- Generate a referral to the anaesthetic team for an individualised plan of care
- If blood BBV positive refer to BBV specialist for plan of care

28 weeks gestation

- Appointment with anaesthetist to discuss analgesia options for labour and all modes of birth, assessment for IV access.

- Paediatric referral for plan of care following birth to include frequency and time scale for abstinence scoring paediatric.referralAccount@wales.nhs.uk based on All Wales NAS Guidance

An individualised multi-disciplinary and multi-agency team meeting will be made to plan for the labour and the postnatal period. This plan should be made in conjunction with, and in regard of, the service user. It should include obstetric, midwifery, paediatric, pharmacist, safeguarding and CDAT input. It may require social service, perinatal mental health representatives. Plan should include:

- A recommendation for the safest place of birth.
- A plan for pharmacology required including medications and expected dosage when admitted.
- A plan of care for the handover of therapeutic medications from and to the community pharmacy pre and post planned admission.
- Paediatric care plan for the neonate which includes:
    - toxicology screening if required.
    - vaccination plan if required.
    - Plan for abstinence scoring including time length and frequency of neonatal observations.
- Safeguarding and plan for both labour and the postnatal period (if required).
- Analgesia requirements and contraindications.
- Mental health issues and plan of care (if required).
- Maternal toxicology screening plan, (determined on the summary of urine tests will be provided by the CDAT team).

The completed plan must be uploaded onto the HDUHB Safeguarding Maternity database and recorded in the hand-held record in the intrapartum and postnatal sections (with consent)

Plan should be forwarded to health visitor

Intrapartum care / admission for all women / persons with plan of care in place

- All women /persons with SROM should not be sent home to await events following confirmation of rupture of membranes.
- If HIV, Hepatitis B or C positive then avoid undertaking an ARM or using an FSE or birth by forceps /ventouse.
- Inform the Safeguarding Midwives of any admission during office hours or leave a message.
- Check the maternity safeguarding database for the MDT intrapartum care plan and Safeguarding plans of care for both the mother and the neonate.
- Check All screening blood results and care provision and PPE as appropriate.
- Ascertain and ensure confidentiality regarding substance misuse and pharmacotherapy.
- Methadone/Subutex prescribing and administration to be given throughout labour, contact pharmacy for methadone/ buprenorphine prescription for inpatient care.
- Follow the MDT plan for fetal monitoring in labour. If there is a suspicion that the woman has misused a substance or alcohol just prior to, or during labour, then continuous CTG monitoring should be performed.
- Pain relief during labour should be as the anaesthetic plan. It is not acceptable to withhold analgesia in labour unless it is contraindicated. See analgesia section for women using opiates/OST and discuss with anaesthetist.

- if Women are on a buprenorphine prescription, most opiates may not be effective due to the blocking effect of the buprenorphine and as such they **should not** be offered an opiate based analgesia, an epidural is therefore the preferred alternative.
- Avoid cyclizine as a first line anti-emetic, offer alternatives such as stemitil/ondansetron
- Neonatal respiratory distress -naloxone should be given with caution.

Unplanned birth at home, midwives have a duty to provide midwifery care if called in labour. Any immediate safeguarding concerns will be managed in line with social services and the police where necessary.

Admission/Intrapartum care with no MDT plan in place / not known to substance misuse service

- Ask the woman / pregnant person if her birth partner/relatives are aware of her history and current use of a script to maintain the woman's confidentiality.
- Urgent review with anaesthetist and discussion with the woman regarding analgesia and intravenous access. For women using opiates or OST please see analgesia section in main part.
- If no antenatal screening undertaken, then take booking bloods and include HEP 'C' and send as urgent. Avoid FSE, ARM and instrumental delivery if blood borne virus is suspected.
- Check Safeguarding database for plan. Contact duty social worker, initiate a SIP 2, and complete a MARF. Contact the safeguarding midwife for advice.
- Contact the CDAT service and complete a referral to the appropriate substance misuse team as advised.
- Continuous fetal monitoring should be undertaken as withdrawal can lead to fetal distress.
- Following birth if baby has respiratory depression, neonatal naloxone should be given with caution as withdrawals could be precipitated, and seizures may occur.
- Inform the neonatal team for an urgent plan of care, which includes the need for their presence at delivery, postnatal care plan, toxicology screening and neonatal urine toxicology and need for cord blood samples etc.
- The baby should have an immediate review following birth and a plan of care for abstinence scoring (including frequency and time) in discussion with the mother. Evaluate the need for vaccinations

Unplanned birth at home, midwives have a duty to provide midwifery care if called in labour. Transfer to the Maternity Unit following birth to the unit for care of the mother/ parent and the neonate. Any immediate safeguarding concerns should be managed with social services and the police where necessary.

Postnatal Care

- Commence NAS scoring as MDT/Paediatric plan within the 1st hour of birth following birth.
- Follow safeguarding plan of care. When there is no plan of care in place contact duty social worker to inform of birth of the baby and plan for discharge.
- Document conversations on safeguarding database, contact the safeguarding team.
- Ensure patient confidentiality re: safeguarding concerns and drug use.
- Ensure Methadone/ buprenorphine is prescribed in a timely manner and available each day at the specific time.
- Analgesia as required and as outlined by anaesthetist plan.
- Liaise with CDAT, community pharmacy, and hospital pharmacy regarding cancelling and initiating community prescription.
- Paediatric review for NIPE and plan of further care e.g., such as vaccinations toxicology screening results.
- Discuss with the parents all aspects of withdrawal symptoms in their baby, extra help may be required for parents of babies that withdraw and where to seek help.
- Discuss with the parent on the risks to the baby when co-sleeping, especially with risks of substance misuse and other allied factors. document conversation in postnatal notes. Follow the safe sleeping policy, signpost to HDUHB's Maternity safe sleeping video, and the Lullaby Trust's Safe Sleeping Information.
- Ascertain whether a multi-disciplinary pre-discharge meeting is needed.
- On discharge, ensure community midwife /health visitor are aware of history.
- Weight on Days 3,5 7 and 10 regardless of mode of feeding. Do not discharge from service until ≥ birth weight or day 28.
- Full hand over of care of Health Visitors with CDAT worker involvement.
- Complete the SIP 3.