Worcestershire Acute Hospitals NHS Trust

Alcohol and Illicit Drug User

Key Document code:	WAHT-TP- 094	
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Approved by:	Maternity Governance Meeting	
Date of Approval:	15th November 2019	
Date of review:	15th November 2022	

Key Amendments

Date	Amendments	Approved by

Introduction

Alcohol/ drug abuse in pregnancy is associated with significant maternal and fetal morbidity. This is often further complicated by associated legal, social and environmental problems that can interfere with both provision of care and patients ability to care for her child after delivery. Therefore multidisciplinary team involvement is essential in management of this at risk and vulnerable group. The aim of multidisciplinary team working is to provide an environment that is non-judgemental and supportive to minimize the risk, achieve optimal pregnancy, birth and parenting outcomes for each women and her infant, which can be achieved by

- An effective system which clearly identifies the main case worker and lead consultant.
- Individualised care plan made in consultation with the women
- Timely and accurate documentation and communication
- Seamless referral system

This clinical guideline is intended to support a range of health care workers who care for pregnant women with drug and alcohol use issues. The guidelines are based on the best currently available evidence and local consensus.

Confidentiality

Women should be reassured that they will receive a confidential service. However the information relevant to the pregnancy and treatment will be discussed within the MDT. A woman's permission will be sought before speaking to anyone else, unless doing so would put the unborn baby or other children at risk.

A woman with drug misuse problem should not be automatically referred to the Adult & Community Services/Children's Services. However if the MDT members involved with the case, have concerns about the following issues we are obliged to refer the case on to Adult & Community Services/Children's Services for assessment, which does not necessarily lead to case conference:

- Concerns about child care provision
- Non-compliance with Worcestershire Pathways to Recovery (WPTR) or antenatal care
- Concerns about life style issues on top of chaotic drug misuse e.g. no fixed abode, nutritional issues
- Unwanted pregnancy or other vulnerability such as learning disability or mental health issues etc.

If referral to Children's Services is decided the woman should be informed first whenever possible, unless doing so would put the unborn baby or other children at risk.

Social workers may also be able to offer supportive and practical role around housing, benefits and other social difficulties.

Please refer to the Trust Child Protection Policy for further information regarding the safeguarding of children.

Antenatal Care

1. All pregnant women should be asked about personal history of drug/ alcohol misuse and **of their partner** at the booking visit. Patients disclosing substance misuse problem for the first time in pregnancy and requesting help should be referred to WPTR for full comprehensive assessment unless the woman is already known to substance misuse service. GP may refer the women to the drug worker in the surgery for initial assessment and then refer to WPTR.

2. Women with current history of alcohol abuse should be referred to Alcohol Liaison service by a midwife or other health care professionals (see below for contact numbers). Women who independently wish to address their alcohol use can self-refer or be referred by their GP. Women attending antenatal clinic at WRH can be triage assessed and referred to Community Alcohol Team by contacting the Alcohol Liaison Nurse on bleep 565 at WRH or bleep 0340 at the Alexandra Hospital, provided woman has given her consent.

3. If woman discloses illicit drug use/alcohol abuse, ask what they are using, the quantity used how often, by which route, when they last used and about financing and how much is their weekly spend on substances.

4. A specific leaflet detailing support for the woman with drug/alcohol misuse in pregnancy and its effects on pregnancy and her baby are offered by the WPTR.

5. Women who are identified as an illicit drug users should be asked for their consent and urine specimen should be checked each visit, weekly till stable and then fortnightly (by WPTR) in order to confirm or exclude the presence of illicit drugs and or Methadone.

6. WPTR offers a priority appointment to these women where they receive comprehensive assessment to ascertain whether the woman is drug dependant and informing her about options for specialist care, counselling and treatment.

7. **Multidisciplinary team approach** is ideal to provide care for the alcohol/ drug dependant pregnant woman. The Specialist Midwife will be care coordinator on most occasions. **Multidisciplinary-maternity team (MDT**) should include GP, Specialist Midwife, obstetrician, neonatologist and WPTR. MDT may also involve Alcohol Liaison Nurse Service, Children's Services and other relevant authorities if needed. MDT members should liaise on regular basis.

   - Early referral should be made for consultant booking clinic so the patient can be seen by the consultant AT THE LATEST by 16 weeks. Late referral may delay consultant review due to non-availability of urgent appointment.

   - Clear plan of care should be formulated and documented in patient hand held green notes and also in hospital notes as chaotic users may not present with their green notes so it is readily available to other health workers particularly if a woman presents out of hours. The plan should be regularly reviewed with the woman.

   - Paediatric referral should be made at time of booking and may need to be repeated with any new relevant information later in pregnancy.

   - Specialist Midwife should work closely together with WPTR to ensure relevant information is shared at the earliest opportunity.

- The Community Midwife should continue to assess the potential parenting capacity of the woman and her partner and identify any concerns/risks.

- Record of every appointment / DNA should be made in green hand held notes.

- The Specialist Midwife & WPTR will be notified if the woman does not attend for Antenatal visit.

8.Women should be seen regularly by their community midwife in order to build trust and rapport.

9. A letter from the professional supplying the Methadone script should be issued to be filed in the woman's notes. This information is necessary to prescribe Methadone/ Buprenorphine for the woman as an inpatient.

10. Psychosocial assessment should be performed at the booking and antenatal visit and it should include
    - Financial issues
    - Housing
    - Domestic violence
    - Sexual abuse / relationship issues
    - Legal issues
    - Past history of child protection issues
    - History of mental illness (see below)

11. **Child protection issues**. Consideration should be given for an early referral to Children's Services for assessment of parenting capacity and risk to unborn child, as well as any need for support services.

    If MDT members involved with the case, have concerns about childcare provision or any other child has been on child protection register Children's Services should be involved to look at the particular circumstances. If a team member learns that a child is at risk or potentially at risk of significant harm as a result of neglect, or emotional, physical or sexual abuse – then there is clear obligation to act. Unless such discussion may add further risk to the child, the woman will be apprised of the team's concern and given the opportunity to discuss the issues. All procedures should also be explained to the woman. **If there are any Child Protection concerns, a pre-birth planning meeting will be arranged**.

12. Co-ordinated support plans may need to be considered in cases of where issues identified through psychosocial or child protection assessment, taking into account Common Assessment Framework (CAF), Child in need plan or Child Protection plan, and where there is the possibility of legal proceedings/placement with substitute carer following discharge. Ideally this should be done by 36 weeks of pregnancy and documented within the records. In cases of unbooked patients or where this has not been done antenatally the above planning needs to be done as part of the discharge planning.

13. **Infection Screening:** In addition to routine antenatal screening, screening should be offered in the first and third trimester for Hepatitis C. Also consider retesting for HIV during the third trimester for high risk women as there is a risk of seroconversion. Screening for sexually transmitted infection (STI) should be offered for the woman and her partner.

14. The woman and her partner should be offered a visit around Transitional Care Unit.

15. The Specialist Midwife should discuss with the woman the length of stay required postnatally (at least 3-5 days). This should be documented in the woman's hand held notes.

16. **Ultrasound scan**: A dating scan should be offered between 8 – 12 weeks, followed by a mid-trimester detailed anomaly scan.

17. **Monitoring fetal growth:** There is increased risk of IUGR in women who use illicit drugs and abuse alcohol. If there are risk factors like smoking and low BMI serial growth scan and Doppler should be offered in addition to routine measurement of symphysis-fundal height.

18. **Coexisting mental health** problems are common in drug and alcohol users. All health care workers involved in pregnancy care must be able to recognise signs of serious mental health problems e.g. anxiety, depression, psychosis, suicidal or self harming ideation. Mental health questionnaire should be filled at booking and the situation assessed regularly in the antenatal period and, if felt appropriate, referral made urgently to a psychiatrist. Ensure woman is safe while awaiting consultation.

19. **Oral health:** There is some evidence that periodontal disease may increase the risk of preterm birth. Oral/ nasal hygiene should be encouraged and dental infection should be treated aggressively in pregnancy.

20. **Late Bookers.** Women who present for the first time in third trimester or in labour are at a high risk of complications as a result of inadequate antenatal care and should be seen by a senior obstetrician. IMMEDIATE SUPPORT CAN ALSO BE ACCESSED FROM THE FAMILY SERVICES PROJECT AT WPTR. CONTACT CDT/ALCOHOL LIAISION SERVICE ASAP.

21. **Anaesthetic** assessment should be considered antenatally to discuss venous access and optimum mode of analgesia for labour, birth and postpartum period.

22. **Ongoing assessment and treatment planning** should be performed at each antenatal visit and management plan updated in green notes. The following issues must be reviewed:

    - Compliance with care and counselling
    - Maternal and fetal wellbeing
    - Drug, alcohol, and tobacco use (self and of partner)
    - Socioeconomic circumstances and psychosocial issues
    - Mental health
    - (If relevant) withdrawal symptoms and dose of drugs used

23. **Out of hours emergency presentation** – It is not unusual for pregnant women who use drugs or alcohol to present to emergency services after hours, either **intoxicated, or** in **withdrawal or** for social reasons such as **violence**. There are risks to maternal and fetal health from all of the above and therefore after initial assessment , delivery suite/ on-call obstetric registrar should be informed.

    (See guideline on Management of adult opiate dependant patients for initial assessment, consent, screening and prescription.)

- Obstetric/antenatal assessment of the patient should be made by obstetric staff either in A&E or if fit to be transferred in delivery suite.
- Fetal heart should be monitored by performing CTG.
- If there is history of abdominal trauma a Kleihauer test should be performed and in Rhesus negative woman prophylactic Anti-D should be considered.
- Ultrasound scan for fetal assessment may be required if clinically indicated.
- If alcohol abuse is suspected bloods should be taken for LFT. Observe for alcohol withdrawal.
- The obstetric consultant in-charge of her care should be informed (message left with the secretary along with the notes for review) of the admission so that women are not lost to follow up.
- Where the family is already known to Children's Services ensure they are informed of the incident.
- Where family are not yet known to Children's Services refer for assessment of risk to unborn child and existing children in the family.

Induction of Labour (IOL)

IOL is indicated only for obstetric or medical reasons. If IOL is planned, preferably arrange for this to occur early in the day at the beginning of the week. This will ensure that infant is observed closely for signs of neonatal abstinence syndrome during the week, rather than on the weekend when experienced staff and neonatal specialist may not be readily available.

Intrapartum Care

A letter from the professional supplying the methadone/buprenorphine script will be requested antenatally and filed in the woman's notes. This information is necessary to prescribe methadone/buprenorphine for the woman as an inpatient. A copy should also be forwarded to the Child Protection Lead for filing in the appropriate Child Protection folders.

1. Once the woman is an inpatient, the Professional supplying the prescription of methadone/buprenorphine will be notified, to ensure that the woman is only receiving Methadone/buprenorphine from one source. Methadone/buprenorphine prescription must be cancelled in the community.

2. Women who are unbooked and disclose current history of illicit drug/ alcohol abuse should be seen by a senior obstetrician. Immediate support can also be accessed from the Family Services Project at WPTR. Contact WPTR/Alcohol Liaison Nurse as soon as possible.

3. If there are any Child Protection Concerns, the bleep holder of Maternity Unit, and the on-call Social Worker should be notified as soon as the woman is in labour. Midwife can obtain support from the on-call supervisor of midwives for any concerns in practice.

4. **Analgesia in Labour:** Women on methadone maintenance program will require additional analgesia for pain relief and pain must be assessed as a separate issue. Methadone should be given at the usual time and dose. Any analgesia can be offered to women who are receiving a Methadone script. Dose of analgesic should de titrated to response, bearing in mind the tolerance to opioid developed during methadone maintenance programme. Pethidine may be

ineffective in women who are on opioid or cocaine dependant, due to changes in opioid receptors. Therefore regional anaesthetic may be more appropriate and should be discussed with the anaesthetist on-call.

- **Women receiving buprenorphine maintenance** should be managed as for those on methadone maintenance. Please inform the anaesthetist on admission to delivery suite. Pain relief in patients on buprenorphine can be quite difficult and should be tailored for a specific patient according to their response. They will probably require higher doses of opiates to obtain adequate pain relief. The maintenance dose of buprenorphine must be given: If stopped abruptly the woman will be more sensitive to sedation and respiratory depression from other opiates.

- **Women taking buprenorphine should be referred for an anaesthetic opinion and plan regarding analgesia prior to delivery.**

5. **Alcohol abuse and labour/ Delivery:** These patients may require high levels of opiate analgesics in labour. There may also be problems with anaesthetics because of induced liver enzymes and cross tolerance to benzodiazepines.

6. Benzodiazepines as anxiolytic / night sedation should not to be used if the woman is prescribed Methadone, due to the drug interactions.

7. **Management of Vomiting in labour in women on Methadone** is a serious concern. Vomiting of methadone dose may lead to withdrawal in both mother and fetus. Withdrawal symptoms can cause fetal distress and should be avoided. It is preferable that staff have observed the vomiting, if there is doubt she should be assessed within 4-6 hours after vomiting to determine if additional small dose is required.

   - Consider Antiemetics - Cyclizine / Prochlorperazine / Metoclopramide are commonly used in pregnancy.

   - If Methadone is vomited within 10 minutes of dosing – consider giving repeat dose

   - Within 10-60min of dosing consider giving half a repeat dose

   - > 60 min after dosing –consider half a repeat dose if withdrawal symptoms occur.

   If vomiting persists other causes of vomiting should be excluded and anti-emetics prescribed.

8. **Venous access:** Assess venous access on admission. If known IV drug user or poor veins obtain venous access early in labour as poor venous access may cause problems in emergency and take blood for a Group and save.

9. **Fetal monitoring**: Continuous fetal monitoring is recommended in established labour. CTG interpretation may be difficult due to effect of opiates on fetus.

10. Avoid FSE & fetal blood sampling if HIV & or Hep C positive or if infection status unknown.

11. Routine infection control procedures should be followed.

12. Water birth / birthing pool are not recommended as alcohol / opiate and other illicit drugs slows maternal response and reflexes. Continuous fetal heart monitoring is not possible in birthing pool.

13. Not suitable for early discharge.

14. Paediatrician presence at delivery depends upon any clinical/ obstetric indication.

15. Naloxone (Narcan) should not be given to neonates of women receiving Methadone as it may induce sudden infant withdrawal.

16. Neonate should be transferred to TCU with the mother unless clinical/ medical reason for transfer to NICU.

Postnatal Care

1. Mother and baby should be transferred toTCU. The woman and her baby do not necessarily require side room/separate toilet facilities. This may be considered for confidentiality purposes.

2. Methadone is given as prescribed, and should be as near to time taken when at home. The Methadone should be administered in the office to maintain confidentiality. A glass of fruit juice/milk should be given following administration to ensure ingestion of Methadone.

3. The woman should be advised antenatally that she will be expected to remain in Hospital, with her baby, for approximately 5 days. This will be extended by 48 hours, if the mother is using Benzodiazepines and even longer if any other existing maternal or neonatal complication. This will ensure that any signs/symptoms of neonatal withdrawal can be monitored.

4. After 5 days, if the full-term baby has shown no major signs of withdrawal, then he/she will not now withdraw. If however, the baby becomes ill after this time, treat as an ill baby, **not** as withdrawing.

5. WPTR should be informed after delivery ASAP.

6. **Suspected / confirmed use of illicit drugs while in-patient:** Contact WPTR for advice on how to manage the situation and to kick start the referral process to WPTR. Urine screen the woman to confirm the use of illicit drugs, look for withdrawal symptoms and symptomatic relief to manage withdrawal symptoms whilst waiting for assessment and management plan from WPTR. Inform the woman that illicit drug use or dealing may be picked up on trust CCTV and police action may be instigated. This advice should be documented to protect the trust from difficulties with section 8 of the Misuse of Drugs Act.

7. **Discharge planning:** A timely and thorough written discharge plan, initiated in pregnancy must be reviewed with the woman and care providers before discharge. This should link with any co-ordinated support plans already in place, e.g. CAF, Child in Need Plan, or Child Protection Plan.

   A Methadone prescription should be requested from WPTR / woman's GP and started the day following discharge. A prescription for Methadone or buprenorphine on TTO is not normally considered unless in very special circumstances where one or two days supply may be prescribed to tide a patient over until their regular prescription can be restarted.

   The discharge plan must take into account assessments commenced in antenatal period:
   - parenting ability
   - psychosocial issues

- mental health
- child protection issue
- SUBSTANCE MISUSE TREATMENT PLAN

A discharge form will be completed by hospital Midwives, to ensure that relevant Professionals including Health Visitor are informed and can give on-going support. The Community Midwife must visit following discharge regardless of age at discharge. Copies of the discharge plan should be kept in woman's hospital notes, postnatal notes, neonatal notes and a copy given to the woman. It needs to include the appointment dates and contact details, which are given to the woman and forwarded to community providers.

8. **Contraception** advice should be offered on discharge.

Care of Infant

1. The baby will be transferred to TCU with mother.

   The baby to be admitted to NICU if clinically necessary.

2. **Breastfeeding**

- If the mother is stable on methadone, is not supplementing with street drugs and is HIV negative, breast feeding should be encouraged. The secretion of **methadone** in breast milk is variable but it may help to reduce withdrawal symptoms. Baby should be monitored for sedation and for symptoms of excessive opiate ingestion. It is important to keep methadone dose as low as possible.

- The safety of buprenorphine is not clearly established in breast feeding. However, the amount of buprenorphine in breast milk is small and considered to be clinically insignificant. BNF recommends avoid unless essential and also it might inhibit lactation.

- However if mother is still **injecting heroin** and or is using other street drugs (e.g. **cocaine)** or is **HIV positive** breast feeding is not advisable.

- If the woman is **Hepatitis C positive**, it will depend upon her viral load at time of delivery and hence discuss with Virology Department. The virus does appear in breast milk but there is not enough evidence that breast feeding increases the transmission of hepatitis C. It is essential that the woman makes an informed decision. The woman should be advised to discard the breast milk if it may be contaminated with blood such as by cracked/ bleeding nipples.

- If **alcohol abuse** continues after delivery, breast feeding should be discouraged. Alcohol abuse can cause drowsiness in the baby and may aggravate existing nutritional problems.

  Women who are breast feeding their infant are advised to consider not drinking at all or if she wishes to drink alcohol to breast feed before drinking and then wait 3- 4 hours before breast feeding again. Although there is not much evidence about the effect of alcohol on the infant even low levels may reduce the milk secretion and cause poor feeding with irritability and sleep disturbances. Women are advised not to bed share with the baby if taking alcohol, (leaflets to be given).

- Women **abusing other drugs** who wish to breast feed need to be reviewed by a paediatrician to discuss the potential effects on the infant and to make an informed decision. Advice on the effects of illicit drugs on breast feeding can be obtained from Medicines Information on 30235.

3. All infants of dependant drug users must have observations commenced from birth using Neonatal Drug Withdrawal Chart (Appendix B). Instructions for treatment – see Guidance for Management.

4. Support mother to help with baby's minor symptoms e.g. use of pacifiers.

5. Discuss with lead Paediatric Consultant need for infant Hepatitis B immunisation programme. Any blood-borne virus test will need informed consent from mother.

6. Babies of pregnant dependent drug/alcohol users may be offered a follow up appointment by Lead Consultant Paediatrician depending on individual needs.

7. NEONATAL DRUG WITHDRAWAL CHARTS WILL BE KEPT IN BABY'S NOTES (NOT AT END OF COT).

The provision of Methadone to opiate dependant pregnant women
The following information gives guidance to Midwives and prescribers on the correct method of dealing with a woman's own supply of Methadone on admission or discharge, or the provision of Methadone to a woman admitted without a supply of this drug. Antenatally the woman will be advised not to bring in any drug.

This information addresses the legal category of Methadone and that supply made to registered drug users is strictly controlled.

On Admission:
As soon as is possible, the Professional supplying the Methadone prescription should be notified that the woman is an inpatient, so that the woman obtains her daily pick-up from only one source.

Women admitted with own supply of Methadone
Request that drug be retained on ward in Controlled Drugs Cupboard. N.B. This is the property of the woman.

Estimate volume of supply (two Midwives) and enter in back of Controlled Drugs Register. This should be retained in Drugs Cupboard unused until discharge. After consultation with drug agency, the disposal of a woman's own supply of Methadone may be advised. A pharmacist should handle the return to Pharmacy for destruction. Seek advice from Supervisor of Midwives if needed. A new supply will need to be dispensed for discharge as cannot be sure what 'own drugs' contain.

Use ward supply of Methadone once the dose has been prescribed by Doctor. Notification of Methadone dose, from professional supplying script in the Community, will be found in the woman's notes and child protection folder.

Women admitted without a supply of Methadone
Dose, once prescribed, should be given from ward stock.

Urine drug screen should be performed to confirm the use of methadone and confirmation from WPTR regarding methadone maintenance program and care plan associated with it.

Inform the Community Pharmacy which has Methadone prescription details.

Women not registered with Worcestershire Pathways to recovery GP
a) Women who are registered elsewhere

Liaise with their local Drug programmme regarding ongoing management of care.

b) *Women not registered with a* drug programme

Ascertain: Method of Administration
Drug being used
Quantity used daily
Time/s of administration.
Where obtained

During office hours contact WPTR for advice.

Outside office hours, clinical decision by doctors on-call and to seek advice as soon as possible from WPTR.

These women may need to be prescribed either symptomatic relief or opioid substitute medication for the duration of their stay in hospital. **However, no patient should be discharged on such medication <u>unless</u> arrangements have been made with the Substance Misuse Service requesting otherwise.** Unless there are urgent risk factors that would compromise patient recovery (if they were to return to using street drugs) access to specialist prescribing may be subject to waiting lists. Patients should be reassured that their symptoms will be treated promptly and appropriately, but that Methadone will only be prescribed according to the protocol.

i. Wait **<u>up to</u>** 24 hours (or until confirmation available) so that assessment confirming objective signs of opiate withdrawal can take place i.e. yawning, lacrimation, sneezing, runny nose, raised BP/pulse, dilated pupils, diarrhoea, nausea, fine muscle tremor, clammy skin. If the patient is using heroin, withdrawal can start 4-6 hrs after last administration. Methadone can take 24 hrs or longer.

ii. Take appropriate screen for opiates as above (including relevant consent).

iii. **If withdrawals are mild, prescribe symptomatic relief only as follows**: (See separate guidance regarding management of pregnant women as above). Treatment of withdrawals is similar for all opiates including withdrawals from methadone and buprenorphine. Withdrawal symptoms are milder for buprenorphine when compared to methadone.

Loperamide (diarrhoea) 4mg stat followed by 2mg after each loose stool (max 16mg daily)
Metoclopramide (nausea/vomiting) 10mg tds or Prochlorperazine 5mg tds or 12.5mg IM 12 hourly.
Hyoscine butylbromide (stomach cramps) 10-20mg orally up to qds
Diazepam (agitation/anxiety) 5-10mg tds.
Temazepam (sleep) 10mg nocte **(consider if necessary if diazepam already prescribed).**
Paracetamol, (muscular pains/ headaches) 500mg–1g 4-6 hourly up to 4g in 24 hours.

These medications should be used during admission only and not prescribed for discharge.

(See WAHT Guideline for management of adult opiate dependent patients in the acute hospital setting.)

Guidance for the management of mothers presenting with Methadone overdose whilst in Hospital

Women who are suspected to have developed methadone overdose on admission to the obstetric ward or following childbirth should be assessed and managed carefully.

1. Symptoms of methadone overdose

The symptoms of methadone overdose are outlined in the following table:

Drowsiness
Reduced ability to maintain self care
Reduced ability to nurse the newborn

Low attention and concentration
Changes in papillary size
Low pulse rate and blood pressure
Lower respiratory rate
Low body temperature
Reduced level of consciousness

Please note:

Continuous drowsiness / unresponsiveness are the most likely indicators of possible overdosing and that methadone and Heroin overdosing are very similar in nature. Hence, unless after being sensitively asked the mother admits illicit Heroin use or there is objective evidence of drug use [paraphernalia, injecting sites etc] then consideration should be given to assessing for methadone overdosing and therefore reduction.

Furthermore, some of the indicators listed above could be a typical reaction to a mother who has recently undergone delivery.

2. Contributory factors

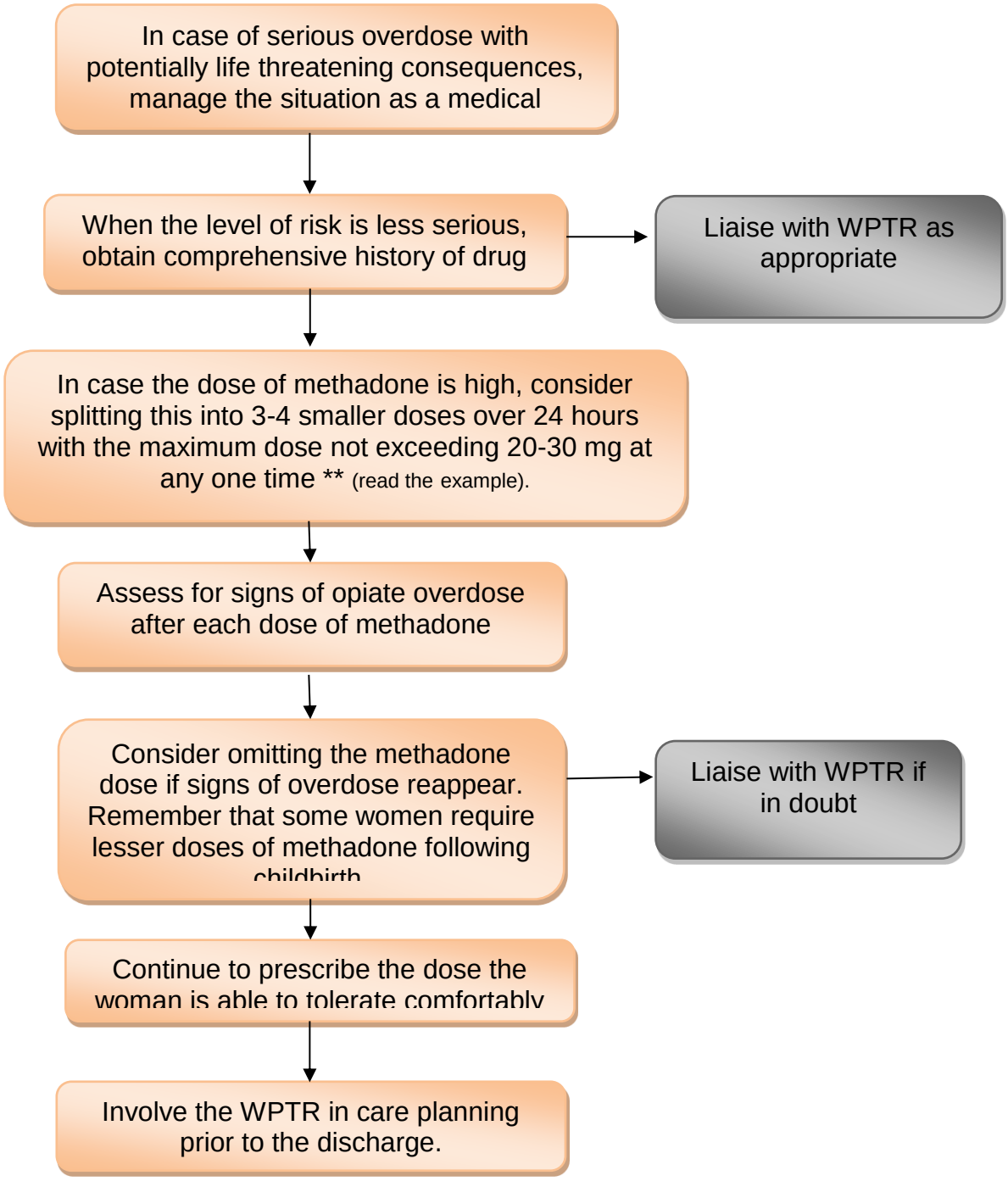
The factors which typically contribute to methadone overdose in these situations are -

- Lower levels of tolerance due to loss of fluids and physiological changes following delivery.
- Woman being poorly compliant with methadone therapy prior to childbirth.
- Changes in the level of tolerance to opiates on admission to the ward due to changes in environment.
- Use of illicit opiates, alcohol and licit/illicit use of medications such as sedative/hypnotics over and above the prescribed methadone program.
- Lack of accurate and clear account of the extent of their illicit drugs or other prescription drugs use.
- Some women may have required a rise in methadone dose in the last trimester due to several factors including increased body fluids, increased metabolism by placenta and fetus and increased clearance by kidneys.

See flowchart for Management of overdose situations below

3. Management of overdose situations

The following flowchart provides a framework to manage situations related to overdose of methadone:



** For example, if a woman is on methadone maintenance dose of 90mgs once daily then this could be prescribed in 30mgs three times daily. If after the first dose of 30mgs methadone woman presents with opiate overdose signs and symptoms then the second daily dose to be skipped and woman could receive the third evening dose. This indicates that the daily dose of methadone maintenance for this individual is 60mgs rather than 90mgs. This prescription schedule of 30mgs twice daily should be continued for the period of their stay on the ward and then during discharge time it could be switched to once daily dosage.

On Discharge
(Refer to guideline on management of adult opiate dependent patients – section vi under prescription details).

Before discharge the recommencement of the patient's methadone prescription needs to be organised with WPTR or prescribing GP. A TTO for methadone is only considered in exceptional circumstances to cover one or two days until the regular supply can be restarted. **Patients should never be discharged with methadone or buprenorphine unless such arrangements have been made.** If there are any problems in relation to arranging Methadone as to take home, contact one of the services below (page 16).

Important Note
Stocks of Controlled Drugs should be obtained from Pharmacy. If Pharmacy is closed and there is an urgent need to obtain a Controlled Drug then the advice in the Medicines Policy SOP for Controlled Drugs should be followed (see Trust intranet or Medicines Policy folder on ward). Women **cannot be** discharged with supplies of Methadone from ward stock.

Monitoring and treating Neonatal drug withdrawal (Neonatal Abstinence Syndrome)
The aims of managing an infant who is at risk of Neonatal Abstinence Syndrome (NAS) are to maintain normal temperature, ensure adequate sleep pattern, reduce hyperactivity, excessive crying and motor instability and to ensure adequate weight gain. Infants assessed for signs of drug withdrawal by a scoring system are less likely to be inappropriately treated with drugs and may have a shorter hospital stay. However, assessing signs of drug withdrawal involves an element of subjectivity. The assessment chart used aims to reduce distress and control potentially dangerous signs. Treatment should be considered after other causes have been excluded; if the infant has profuse watery stools or profuse vomiting or requires tube feeding due to incoordinate sucking, if the infant has been persistently distressed and has been inconsolable with standard comfort measures (cuddling, swaddling or using a pacifier) since the last feed, treatment may be considered. Withdrawal with opiates may occur early (under 24 hours), withdrawal from opioids may occur 3-4 days after birth and poly-drug use may be associated with a delay or a biphasic pattern of drug withdrawal. Buprenorphine use has been increasing in recent years in opiate dependence and many studies show mild neonatal withdrawal symptoms and peak of withdrawal might be delayed when compared to methadone due to longer duration of action and some studies suggest that it might take up to 70hrs to reach the peak.

There is little objective evidence to support the use of any individual drug for the treatment of NAS. A number of randomised trials have been performed attempting to assess the use of various drugs in the treatment of NAS. When an opiate or opioid was used, a morphine derivative seems to be the most effective at controlling signs. When there is poly-drug usage, phenobarbital may be more effective.

Chloral Hydrate may be used on an as-required basis to ease the infant's distress over the withdrawal period. With Benzodiazepine use, later withdrawal may occur and there has been anecdotal success with the use of clonazepam to treat this.

For the management of Neonatal drug withdrawal
Monitor infants at risk of NAS by using the standard assessment chart.

(Guidelines for management appear with the standard assessment chart)

- Minor signs do not require treatment, e.g. sneezing.
- Withdrawal from opiates may occur less than 24 hours after birth (e.g. heroin)
- Withdrawal from opioids may occur 3-4 days after birth (e.g. methadone)
- Polydrug use may delay or skew withdrawal signs.

Aim of treatment: Comfort not sedation
Infant is reviewed daily by paediatric staff

Treatment plan: Level 4
40 microgram/kg morphine sulphate
oral preparation given 4 hourly

Level 3
30 microgram//kg morphine sulphate
oral preparation given 4 hourly

Level 2
20 microgram//kg morphine sulphate
oral preparation given 4 hourly

Level 1
10 microgram//kg morphine sulphate
oral preparation given 4 hourly

Level reduced every 24 hours, if the infant is feeding well and settling better between feeds.

An oral mixture of morphine 100microgram in 1ml must be used. It is available either in ready made vials or as a special made by Pharmacy.

If the feeding and settling does not improve or profuse watery stools and profuse vomiting continue – discuss with senior paediatrician.

Other medication may be required e.g. clonazepam for benzodiazepine use or chloral hydrate.

If pharmaceutical treatment not required – the mother will still require support to help her comfort her baby – cuddling and swaddling is helpful.

An infant pacifier (dummy) may be necessary.

Alcohol/drugs misuse and their effects in pregnancy

Alcohol

- No completely safe level of alcohol consumption has been determined for the fetus.
- Women should be informed to limit use of alcohol to <1 standard drink (I UK unit/12gms) per day and if possible not to drink at all in first three months of pregnancy
- Alcohol is known to have teratogenic effects
- Binge drinking (>5 alcohol units at one occasion) may be particularly harmful to the fetus.
- Advice in DoH publication, Pregnancy and Alcohol (2006): No more than 1- 2 units of alcohol once or twice a week
- Advice in Safe, Sensible, Social HM govt.(2007) is: "Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1-2 units of Alcohol once or twice a week and should not get drunk"

- Most effects are dose dependant and most studies have not shown any substantial effect on child development with low alcohol intake, there are concerns about long term neuro-development of the offspring.
- Pregnant women identified as consuming risky levels of alcohol should have priority access to Alcohol Liaison Services.
- Miscarriage in first trimester is associated with any level of alcohol consumption early in first trimester.
- Excessive use of Alcohol is linked with Foetal Alcohol Spectrum disorder and major congenital cardiac defects
- Alcohol withdrawal occurs after 48 hours and may be a problem postnatally. Appropriate sedation can be used with vitamin particularly thiamine supplementation. Woman may appear agitated and have difficulty caring for the neonate.
- Alcohol abuse reduces milk secretion and problem feeding in infant
- There is a risk of intellectual impairment in children of mothers who abused alcohol in pregnancy

Opiates

- Opiates are not teratogenic.
- Sudden withdrawal may lead to fetal distress.
- There is risk of intra-uterine growth restriction and preterm delivery.
- There is higher incidence of fetal distress in labour and admission to NICU.
- Risk of deficit in cognitive development of the child and behavioural problems.
- Increased risk if Sudden infant death (SIDS).
- Opiate use in pregnancy leads to neonatal abstinence syndrome (NAS).
- Limited data is available on safety of buprenorphine in pregnancy and breast feeding. However the risk of ongoing heroin use outweighs the risk of buprenorpnine maintenance. Services should engage with women in discussion regarding the risks and benefits. It is preferable to go for methadone as first choice, but if its not possible and for those who are already on buprenorhine continue that treatment rather than run a risk of relapsing into heroin use.

Cocaine

No substitute drug is available to help with stabilization in pregnancy.

However, sudden cessation is not associated with adverse fetal effects.

If cocaine use is stopped at anytime during pregnancy it improves the outcome.

Use of cocaine in pregnancy is associated with risk of:

- Fetal abnormalities: GU anomalies, abdominal wall defects
- Placental abruption, PPROM, Meconium stained liquor, preterm delivery, IUGR & resuscitation at birth.
- Prolong postnatal stay

- Newborn shows signs of irritability, poor feeding and abnormal sleep patterns.

Cannabis

- There is no evidence that Cannabis itself is teratogenic.
- Cannabis is often mixed with tobacco and smoked which is harmful for the developing fetus.

Benzodiazipines

- Benzodiazipine use should be discouraged in pregnancy and patient should be stabilized on lowest levels tolerated.
- Stopping suddenly is safe for the baby but may cause maternal convulsions
- There is some non-conclusive evidence of cleft lip/palate in the fetus with long term use.
- Newborn can experience withdrawal symptoms.
- Can cause hypotonia and feeding problems in neonate if taken immediately before delivery.
- Excreted in milk in low levels, there are some case reports of lethargy and poor feeding, it needs to be determined on case by case basis.

Amphetamines

- Teratogenecity is not well documented but it appears to be associated with cleft palate.
- It causes hypertension and there is increased risk of pre-eclapmsia, IUGR and still birth.
- There is no drug substitute and these women should be encouraged to stop its use in pregnancy.
- Can cause withdrawal in neonate.
- Women abusing Amphetamines can be problematic and very difficult to treat.

Barbiturates

- No evidence of teratogenicity.
- Fetal dependence is a problem.
- Acute withdrawal in pregnancy can affect the fetus and is not recommended. Gradual withdrawal can be achieved.
- Can cause neonatal withdrawal.

Medicines Information can be contacted for more detailed advice on drugs of abuse in pregnancy.

Services that can be used for Information and Advice

Worcestershire Pathways to Recovery (WPTR)

Malvern	01684 578 368
Redditch	01527 610 10

Worcester (Castle House)	01905 721 020
Kidderminster	01562 823 211
Evesham	01386 444 380

Pharmacist

WRH	019057 63333 ext 30235
Alexandra Hospital	01527 512067
Medicines Information	01905 760611 or ext 30235

Consultant Obstetrician

Worcester & Kidderminster	01905 763333 ext 30486 (Sec)
Redditch	01527 503030 ext 42003 (Sec)

Consultant Substance Misuse Services WAHT
01905 681416

Alcohol Liaison Nurse
01905 763333 Bleep 565 (WRH)
01527 503030 Bleep 0340 (Alexandra Hosp.)

Child Protection
Trust Lead Nurse for Safeguarding Children
Direct dial: 01905 733871 / Ext 39149 / Page via switchboard / Mobile 07501 482 064

WAHT Child Protection Contact Midwives
AH

Specialist Midwife Redditch and Bromsgrove		07717530360
KH	–Specialist Midwife Kidderminster	
	Antenatal Clinic	01562 513223 Ext 55438
WRH	Specialist Midwife Worcester and Malvern	07786431798
	Specialist Midwife Droitwich and Evesham	07919598304
	TCU Midwife	01905 760663 or 763333 Ext. 30120

Appendix A

CDT (COMMUNITY DRUG TEAM) TRANSITIONAL CARE LIAISON FORM

Name: DOB:	Address:
GP:	Community Midwife: EDD:
Current prescribed medication:	Pharmacy details:
Social services involvement YES/NO If yes please give social worker contact detail: Name: Office Base:	
Any other relevant information (i.e. other professionals involved, significant other	
Named worker CDT: Contact Number: Date:	

Please inform named key worker or relevant CDT link worker of impending discharge.

Worcestershire Acute Hospitals NHS Trust

APPENDIX B

NEONATAL DRUG WITHDRAWAL ASSESSMENT CHART

Name:___________________________ DOB: _____/____/_______ Time of birth: ____:____hrs

Hosp No:_________________________ NHS No:___________________________

Minor signs eg. jitters, sweating, yawning do not require treatment.

The aim of treatment is to reduce distress and control potentially dangerous signs.

Consider treatment (after other cases excluded) if there is: profuse vomiting, profuse watery diarrhoea, a requirement for tube feeds or the infant has been inconsolable after two consecutive feeds (see below).

Has the baby been inconsolable with standard comfort measures (cuddling, swaddling, or using a pacifier) at all since the last feed?

Place a tick in the yes or no box (do not indicate any other signs in the boxes)

Date						
Time	04:00	08:00	12:00	16:00	20:00	24:00
Yes						
No						

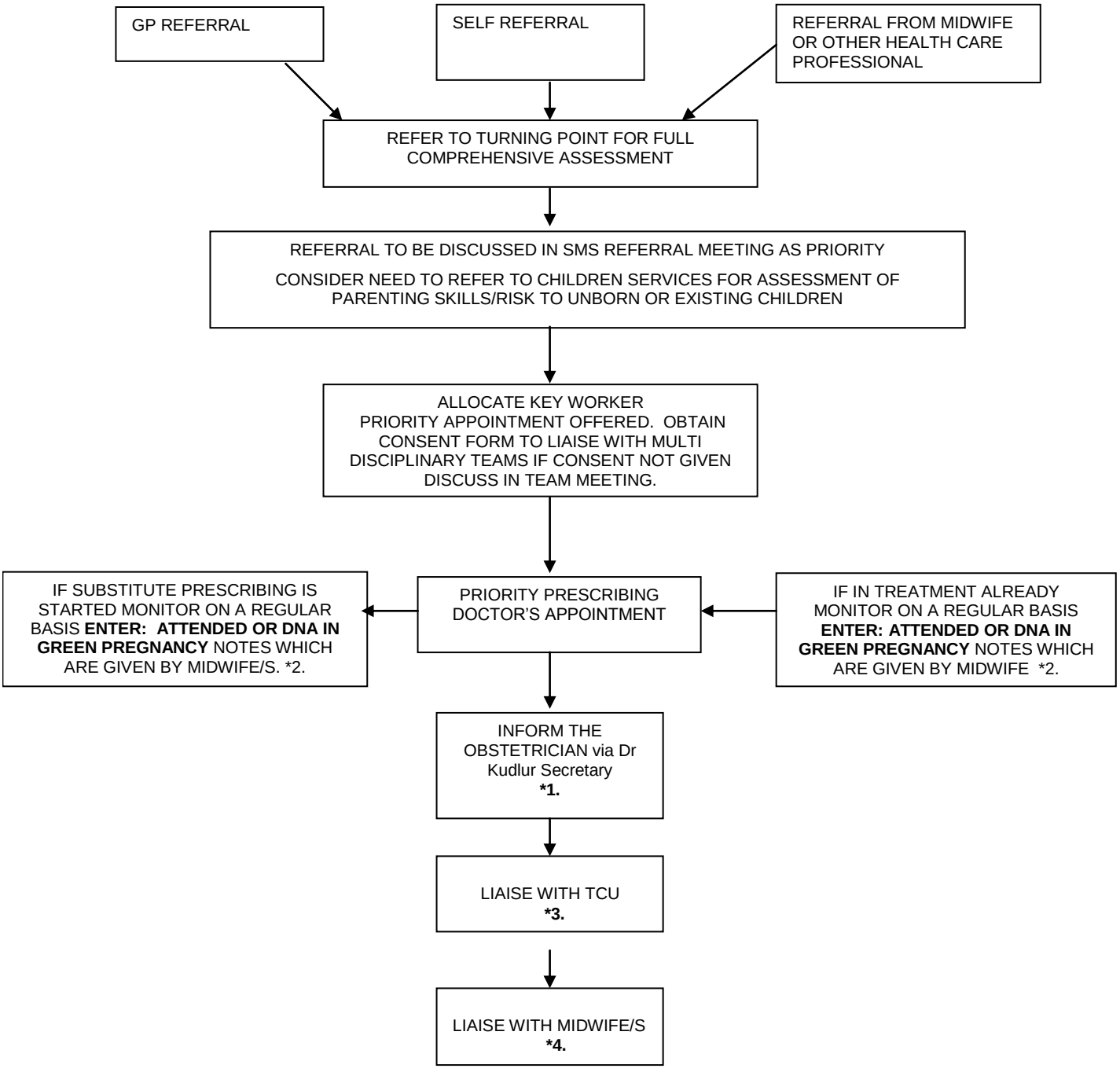
Date						
Time	04:00	08:00	12:00	16:00	20:00	24:00
Yes						
No						

Date						
Time	04:00	08:00	12:00	16:00	20:00	24:00
Yes						
No						

Date						
Time	04:00	08:00	12:00	16:00	20:00	24:00
Yes						
No						

Appendix C

CARE PATHWAY FOR PREGNANT DRUG USERS



1. Obstetrician-
   Worcester Royal Hospital & Kidderminster Treatment centre - Ms.Rabia Imtiaz
   Alexandra Hospital: Individual Consultant Obstetrician the woman is booked under.
2. All pregnant women are issued with green notes from the Midwife. Enter in notes if client attends or DNA'S, nothing more due to confidentiality issues. It is important to liaise with the Midwife and green pregnancy notes issued to individual service users by the midwifery service.
3. **TCU** Transitional Care Unit.
4. It is important to liaise with the allocated midwife/s

APPENDIX D

Guidelines for Treatment of Opiate Dependant Patients in the Acute Hospital Setting

Presentation at A & E or MAU

Treat any Emergency or acute problem *[note: if patient pregnant, opiate withdrawal could cause miscarriage / premature labour. See separate guidance*]

Patient discloses dependence on opiates (illicit or prescribed)

Assessment:
- dosage
- route of admission
- time last used
- check for IV sites

Confirm use with rapid urine screen

Patient discloses that they are on a Methadone /Buprenorphine prescription

Confirm treatment: Ask who provides medication. Contact SMS / GP accordingly. Alternatively, dispensing pharmacy may verify

Note time and date med last taken
Confirm use with rapid urine screen

Confirmation established?

No

Yes

Liaise with named SMS worker re: prescribing for duration of admission. If methadone, prescribe Methadone SF 1mg/1ml Mixture. ***Do not prescribe in any other form.***

Symptomatic relief or opiate substitute may be necessary depending on length of admission.
Assess objective signs of opiate withdrawal: yawning, lacrimation, sneezing, runny nose, raised BP/pulse, dilated pupils, diarrhoea, nausea, fine muscle tremor, clammy skin.
[NB: heroin withdrawal can start 4-6 hrs after last dose, methadone can take 24hrs or longer]

Yes *Severe withdrawal symptoms?* No

If possible, contact Substance Misuse Services and take their advice. If not possible SHO to consider prescribing:
***Methadone**: 10 – 20mg orally (as Methadone SF 1mg/1ml Mixture). Give additional 5-10mg dose at 4 hrly intervals for first 8hrs if objective withdrawal symptoms persist. For next 2 days give previous day's total dose as a single dose each morning (supervised).*
No more than 50mg should be prescribed without specialist advice from SMS.
Subutex (Buprenorphine): (suited to milder dependence / non injectors and less sedating than methadone). Day One: 2mg bd or tds **sublingual** Day Two: increase by 2-4mg depending on response; give total as a single daily dose. Consult SMS for advice on further increases.

Symptomatic relief only:
- Loperamide (diarrhoea) 4mg stat, then 2mg after each loose stool (max 16mg daily)
- Metoclopramide (nausea / vomiting) 10mg tds or
- Prochlorperazine 5mg tds / 12.5mg IM 12 hourly
- Hyoscine Butylbromide (stomach cramps) 10-20mg up to qds
-Diazepam (agitation/anxiety/sleep) 5-10mg tds or Temazepam 10mg nocte
- Paracetamol (muscular pains/headaches)

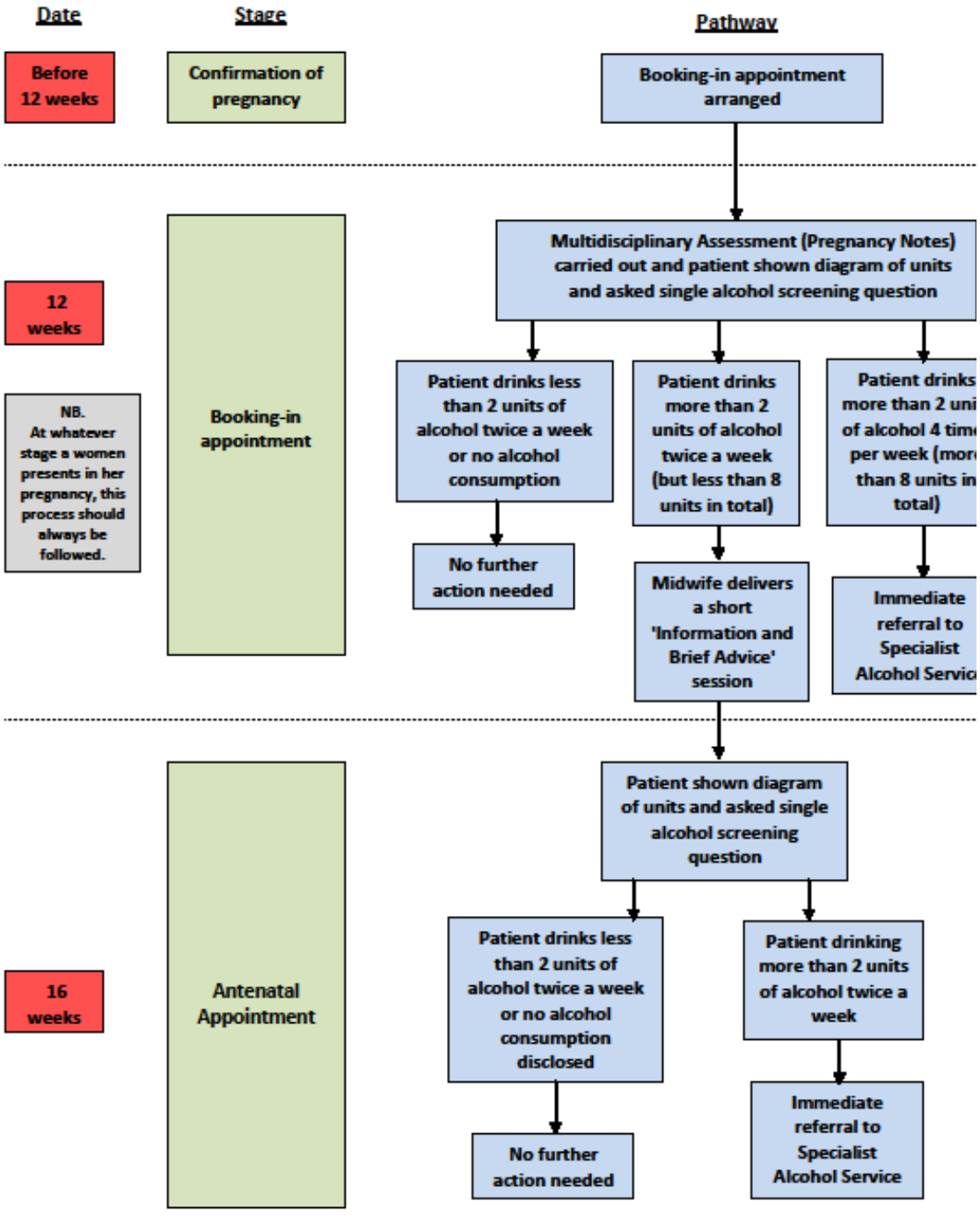
Withdrawal symptoms not effectively managed

Maintain contact with SMS worker

Discharge: It should not normally be necessary to discharge with TTO. Named nurse to contact SMS worker prior to discharge to ensure 'script available / continuation of treatment (24hrs notice needed, and service available Mon – Fri only).
Patients should never be discharged with Methadone or Buprenorphine unless such arrangements have been made.

Discharge: Contact SMS to discuss further access to specialist prescribing. This may be subject to a waiting list, unless there are urgent risk factors (e.g. returning to using street drugs), which may compromise patient recovery

Care Pathway: Alcohol Misuse in Pregnancy



Care Pathway: Alcohol Misuse in Pregnancy – 06.09.2010

Referral information for Midwives: Community Alcohol Treatment

If a midwife needs to make a referral to alcohol treatment, the following procedure should be followed.

If a client is over-18, please complete the attached referral form and post/fax to:

Worcestershire Community Alcohol Team
Rutland House,
25 The Tything,
Worcester,
WR1 1JL
Fax: 01905 616517

Or:

Call and make a telephone referral:

Tel: 01905 729400

If the client is under-18, please make a telephone referral to:

SPACE
0800 169 6064

Referral Form: Worcestershire Community Alcohol Team

II Initial data collected by: ***Office use only***	Date:	WCAT ID No: ***Office use only***
Project Worker: ***Office use only***		
Forenames:		
Surname:	Type of contact: ***Office use only*** Telephone Letter Face To Face	
Address: Postcode:	Telephone No:	
	Permission to contact Yes/ No	
	Area: Droitwich Bromsgrove Kidderminster Redditch Worcester Malvern Evesham	
DOB: Age:	NDTMS No: ***Office use only*** New Client? Y/N	
Gender Male Female	Housing: NK Secure Insecure Traveller Homeless Institution	
Ethnic Origins: W British Irish Other White W-B Carib. W-B Africa. W-Asian Other Mix Indian Pakistani Bangladeshi Other Asian B Carib. B African Other Black Chinese Other		
If client uses drugs, please state which:		
Disabled? Yes/ No If yes, specify:	Heard about WCAT from?	
Language/ Communication Difficulty? Yes/ No If interpreter required what language?	Past Client Y/N: Counsellor:	
Referrers Name: Organisation: Address: Tel:	GP Registered? Yes/ No GP Name: GP Surgery: Tel:	
Number of Children under 16 living or staying with you?	Tier 2 Tier 3 Tier 4 ***Office use only***	

In order to provide you with a confidential service, WCAT has in place a strict Confidentiality and data Protection Policy. These are designed to ensure that information about you remains confidential and that your rights as an individual are protected while you are on WCAT's premises.

- I understand that any information collected about me is protected by both the WCAT Confidentiality Policy and the Data Protection Act 1998.