Mid Essex Hospital Services NHS Trust

DRUG AND ALCOHOL MISUSE IN PREGNANCY	CLINICAL GUIDELINES Register No: 06056 Status: Public

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1.0 Purpose

1.1 As part of a harm reduction philosophy, a multi-disciplinary working party developed these guidelines, advocating shared antenatal and postnatal care for pregnant patients who misuse drugs and alcohol. The guidelines follow The Children Act 2004, which states that the interest of the child is paramount.

1.2 It is hoped that in promoting a positive approach to pregnant patients who substance misuse, pregnant patients will become more confident in reporting and reducing their drug and alcohol use.

1.3 The purpose of this guidance is to ensure that the best possible care is offered to women who are substance abusers and their unborn babies. This will be achieved by working in partnership with the parents-to-be and through multi-agency collaboration.

1.4 Patients should be reassured that they will not be discriminated against as result of drug or alcohol use and that the overall aim in each service is to provide non-judgmental care. This is essential as the engagement of patients is dependent on a feeling of confidence in the services. At all times staff must behave in a culturally sensitive way, endeavouring to take into account cultural beliefs and racial diversity in all aspects of the care pathway process.

1.5 The health worker should discuss the patient's substance misuse throughout her pregnancy to assist in the planning of appropriate care as this can have far reaching implications for her future drug use and the well being of the baby. It is widely acknowledged that pregnancy can be highly motivating for women in terms of exerting some control over drug/alcohol usage.

1.6 Staff should be mindful at all times of the need to maintain appropriate confidentiality and to understand that all sharing of information must be in the best interests of the child. They must be aware that any decision to share may need to be justified at some future point in time. Confidentiality Policy and Data Sharing Policy must be complied with at all times.

2.0 Equality and Diversity

2.1 Mid Essex Hospitals Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Background

3.1 The number of women misusing substances has dramatically increased over the past 30 years, with many being in their child-bearing years (Drug Scope 2005, CEMACE 2011). It is reported by NICE that of the 600,000 pregnancies recorded in the UK each year, 30,000 involve substance abusers (NICE 2010). CEMACE (2011) report that 35 women, who were known to misuse substances in pregnancy and or the following 6 months following delivery, died between 2006 and 2008.

3.2 Research suggests that women, who misuse substances, and their infants, have better outcomes if they access antenatal care early and if they attend treatment programmes consistently throughout pregnancy (CEMACE 2011).

3.3 Pregnancy may motivate some women to access support for substance misuse issues, however some may feel inhibited due to feelings of guilt or fear that their child(ren) will be removed from their care (Scottish Executive 2006).

3.4 Some pregnant women who misuse substances may be anxious about the attitudes of healthcare staff and the potential role of social services. They may also be overwhelmed by the involvement of multiple agencies. These women need supportive and coordinated care during pregnancy. Midwives are ideally placed to identify children and families who require additional support and co-ordinate care of these women in partnership with other agencies.

4.0 Definition of Terms

4.1 Substance Misuse - Regular use of recreational drugs, misuse of over the counter medications, misuse of prescription medications, misuse of alcohol or misuse of volatile sub-stances i.e. solvents or inhalants, to an extent where physical dependence or harm is a risk to the woman and/or her unborn baby (NICE 2010).

4.2 Drug dependency - a cluster of behavioural, cognitive and physiological phenomena that developed after repeated substance use and typically includes:

- Strong desire to take the substance
- A higher priority given to substance use than to other activities and obligations
- Difficulties controlling its use
- Persisting in its use despite harmful consequences
- Increased tolerance to the substance
- A physical withdrawal state
- Hazardous drinking - regular consumption of over 3 units per day/ or more than the recommended weekly limit i.e. 14 units
- Binge Drinking – part of Hazardous drinking, but specifically a pattern of drinking which is defined as excessive consumption of alcohol on any one occasion involving six or more units even though they may not exceed weekly limits
- Harmful drinking - a pattern of drinking that causes damage to physical or mental health. Harmful drinking also includes drinking at levels that may cause substantial harm to others (HM Government 2007)

4.3 **Essex S.T.a.R.S**: Specialist, Treatment and Recovery Service; previously known as North East Essex Drug and Alcohol Service (NEEDAS)

5.0 Aims

5.1 Substance misuse has been defined by the World Health Organisation as:

‘A state, psychic and sometimes physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take a drug on a continuous basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present.’

5.2 The aims of the guideline are as follows:

- Identify risks of significant harm to the unborn child and ensure appropriate action
- Ensure the substance misusing patient is offered appropriate antenatal care

- Establish a comprehensive plan of care to meet the needs of the pregnant substance user and her child and identifies which professional undertakes the responsibility for convening and co-coordinating any meetings
- Ensure that the patient is involved in all aspects of her care planning throughout her pregnancy and in the postnatal period
- Encourage and facilitate the patient and, where appropriate, her partner, to seek help for their substance misuse
- Provide information about HIV, Hepatitis B and C and appropriate risk reduction strategies to pregnant substance users
- Provide a flexible service according to client need with due respect to client individuality and culture
- Establish effective communication between all professionals in order to minimize risks and provide seamless planning of care pathways and safeguarding processes.
- To maximize the opportunities to stabilize the patient on a safe level of drugs or alcohol for the duration of the pregnancy, through appropriate referrals, support and follow-up
- To alert all staff to the other agency roles and responsibilities throughout the processes of these complex pregnancies

6.0 Role of the General Practitioner (GP)

6.1 Contraception and safer sex are topics that should be discussed routinely with all substance misusers.

6.2 Preconceptual care should be discussed routinely wherever possible.

6.3 All patients should be asked about drug and alcohol use as a routine part of antenatal care. The GP may be the first professional to suspect and confirm a substance misuser's pregnancy. The GP's first duty is to inform the client of the potential risks and the services that are available to assist her in substance misuse reduction/stabilization. The GP should undertake the following actions in consultation with the patient:

- The GP should arrange an urgent appointment with the obstetrician registrar/ consultant on call who will become the lead professional for the duration of the pregnancy
- Complete an antenatal booking form recording prescribed drugs, reported levels of other substances and alcohol being used
- Make a referral to the local drug and alcohol service. If the patient refuses this service the obstetric registrar/consultant on call and the midwife must be informed
- The GP should be aware of blood test results and any referral for further care that may be needed as a result of these tests

6.4 If there are any concerns about the patient's behaviour, mental health or social issues which will have an impact on the unborn baby a referral to social care must be made and the patient informed. Procedure in the Child Protection Policy must be followed. (Refer to the 'Identification and management of patients with mental ill health during the perinatal period'. Register number 09090)

6.5 The GP may be involved in substitute prescribing and should liaise with the consultant in the local drugs and alcohol team and inform the lead professional co-coordinating care.

6.6 If there are concerns that the unborn baby is or will be at significant risk of harm a Child Protection Conference may be convened to which the GP must submit a report and

attend if possible.

6.7 A multi-disciplinary partnership meeting should always be convened for any patient who is substance misusing to which the patient and her partner will be invited. The GP will be invited to participate in the meeting where a lead professional will be appointed. A care plan will be formulated and discussed with the patient and the professionals involved.

6.8 A further pre-birth planning meeting will take place as necessary to which the GP will be invited.

6.9 If the GP identifies any further concerns during the course of the pregnancy the coordinator of care must be informed as soon as possible.

7.0 Role of the Community Drug and Alcohol Team

7.1 Professionals should make a referral to their local Substance Misuse Team indicating that the patient is pregnant. Pregnant drug/alcohol users are considered high priority and will be seen as soon as possible and always within 5 working days. A patient can self refer by telephone or letter to:

- **Essex S.T.A.R.S**: Specialist, Treatment and Recovery Service; previously known as North East Essex Drug and Alcohol Service (NEEDAS)

7.2 The drug and alcohol receptionist/or duty worker will ask for brief information and arrange a triage assessment.

7.3 A staff member from the local substance misuse team will carry out a triage assessment.

7.4 A full assessment summary will be made as soon as possible but with no more than two weeks wait. The assessment will include:

- Drug history, past and current
- Nature and frequency of any medication currently prescribed
- GP/ pharmacy substitute prescribing
- Alcohol and tobacco consumption
- Psychiatric, psychological and social history
- General health and medical history
- Treatment plan which identifies whether stabilizing drug use in the pregnancy or offering a ‘detoxification’ programme is appropriate before delivery
- Names and contact numbers of all agencies involved
- Any other concerns

7.5 Where a client first reveals her pregnancy to the Substance Misuse Team, a fast track system referral will be made to the Consultant Obstetrician. Confirmation of the pregnancy should be made by the GP and/or midwifery services

7.6 The patient will be encouraged to access antenatal care as soon as possible (if she has not already booked) to establish the stage of her gestation as this will influence the drug/alcohol treatment plan. The substance misuse worker will telephone maternity services and make direct contact.

7.7 The patient will be informed that the substance misuse team can not take on the role of

the obstetric/midwifery services, but will act in a liaison or advocacy capacity as required.

7.8 Substance misuse practitioners are to contact and share relevant information with other professionals and the client/s informed that other professionals will be involved to ensure that maximum support can be offered and is in the best interests of both mother and unborn baby. These may include: but are not limited to:

- Consultant Obstetrician
- Hospital and Community Midwives
- Health Visitor
- Social Worker
- General Practitioners
- Non statutory organisations such as Open Road/Essex stars
- Probation, Housing and other agencies where appropriate
- Safeguarding Leads
- Other professionals as appropriate

7.9 Contact should be made before 12 weeks of pregnancy possible in line with best practice.

7.10 Various options are open to a pregnant patient who has drug or alcohol problems depending on the stage of pregnancy, past obstetric history, the drugs or alcohol used, and level of care needed for the woman and the unborn baby. An individual care plan will be devised according to the patient's and the unborn child's needs. The child may subsequently be subject to either a 'child in need plan' or a 'child protection plan'; should a child protection conference be convened. The substance misuse worker will provide the patient with information regarding the risks involved to her and her unborn baby as a result of her drug**/**alcohol use and advise her of the need to stabilize, or reduce, in a planned way.

7.11 If any concerns arise about risks to the unborn baby consultation must take place with the named professional for safeguarding children , where consideration will be mad about a referral to social care. Such consultation must be documented (in accordance with MEHT policy with a copy placed in the service user's clinical notes (Lilac folder).

7.12 It may be beneficial to both mother and unborn baby to prescribe, where appropriate, substitute medication as quickly as possible. Risk of sudden withdrawal either in pregnancy or during labour can be very significant i.e. miscarriage, premature labour and fetal distress.

7.13 The substance misuse worker will maintain regular contact with the client throughout pregnancy to include one to one contact and toxicology if needed and attend multi-agency or professional meetings as required. Part of the care plan will include regular drug and alcohol screening to monitor progress.

7.14 Referral to residential drug/alcohol rehabilitation will be made through the local substance misuse team as appropriate.

7.15 The mother and baby's well being will be everyone's primary concern. The drug and alcohol worker has a duty to assist in involving the partner in the patient's care. There will be regular communication with all professionals concerned with the patient's care, including pre-delivery discussion. Where there is conflict, the interests of the unborn

baby are paramount.

8.0 Role of the Midwife

Booking Visit

- Complete routine booking history and assessment.
- In addition;
- Ensure a full history regarding current or past problem drug/alcohol use is recorded on Lorenzo
- It is imperative to ask if partners or any cohabiters are using drugs and or alcohol
- An Alert MUST be flagged up on Lorenzo
- To be booked to see an Obstetric Consultant between 14-20 weeks if the woman admits to substance misuse in this pregnancy
- Identify if the woman is currently accessing the drug dependency service for treatment and is in receipt of prescribed methadone or subutex (buprenorphine).
- Establish and record the current dose taken (may differ from dose prescribed)
- Confirm dosage with GP/drugs agency/dispensing community chemist
- Discuss with woman regarding her wishes for the management of her prescription in pregnancy
- Offer Urine toxicology
- Neo Natal alert to be completed and sent
- Vulnerable alert to be sent to safeguarding, copy to lilac notes
- Referral to social care with Request for Services (RFS) via the portal https://www.essexeffectivesupport.org.uk/request-support/
- Women who misuse substances are known to be of higher risk of domestic abuse ensure that the MEHT screening tool is used and refer to Independent Domestic Violence Advisors (IDVA) services if positive response noted (Refer to the Management of domestic abuse in maternity patients 06040)

8.1 If the GP is aware of substance misuse he or she should have indicated this on the maternity booking form, which is sent to the midwife. All patients should routinely be asked about any use of drugs and/or alcohol when they book care with Midwifery services.

8.2 Patients should be informed about the benefits of antenatal care and encouraged to attend. The midwife must complete a Neonatal Alert to be sent to Consultant Pediatricians' for planning and advice.
(Refer to Appendix F)

8.3 A booking should be completed and a consultant referral made by the 12 weeks of pregnancy if possible. If the patient declines to access maternity care, liaison must take place with social service, the drugs and alcohol service and the patient who must be informed that safeguarding processes will be initiated or informed.
(Refer to Appendix A)

8.4 The patient will be offered consultant care. The pattern of appointments for antenatal care and how this should be shared between professionals should be individually planned and will include high risk care pathway and growth scans.

8.5 An urgent referral should be made to the drugs and alcohol service for an initial assessment of drug use and the formulation of a plan of care.

8.6 Following referral to children's social care a Partnership or Strategy meeting will, in most cases be held where a lead professional will identify risks, maternal support mechanisms and formulate a care plan. The midwife will contribute to the care plan. In the event that social services open a Child Protection case for the unborn, the midwife will participate in safeguarding processes.
(Refer to the 'Trust Safeguarding Children and Young People Policy 0-18 years'; register number 04064)
(Refer to Appendix C)

8.7 The midwifery team will ensure that discussion around antenatal screening includes Hepatitis C, B and HIV. If a positive result ensues referral to sexual health will follow for treatment in consultation with the obstetric registrar/consultant on call.

8.8 The patient will be encouraged to carry her handheld records with her at all times which will contain the history and up-to-date details of reported substance misuse, toxicology and serology reports and any treatment; a further copy should be kept in the hospital records. All conversations and discussions should be documented in the patient's handheld/maternity records.

8.9 A 'birth plan' should be discussed with the patient taking into full account her cultural and religious views. A copy of this should be included in the patient's handheld record and should include the full assessment summary completed at the Community Drug and Alcohol Team or if not available the following:

- Drug history, past and current
- Nature and frequency of any medication currently prescribe
- GP/ pharmacy substitute prescribing
- Urine toxicology assessment
- Alcohol and tobacco consumption
- Names and contact numbers of all agencies involved
- Any other concerns
- Psychiatric, psychological and social history
- General health and medical history
- Treatment plan which identifies whether stabilising drug use in the pregnancy or offering detox is appropriate before delivery

Additionally:

- Management of the drug dependency
- Pain relief during labour
- Infant feeding
- Parent craft classes
- Management of known hepatitis B/C or HIV infection
- The name of the health visitor and GP

8.10 Midwives delivering intrapartum care should ensure that the patient's hospital and handheld records have been read thoroughly; in addition to any other confidential information.

8.11 The midwife should arrange a visit to the neonatal unit and to the labour ward in order to minimise anxiety and enhance the family's trust around services.

8.12 The midwife should ensure that a discussion takes place regarding the mother's feeding intentions by 34 weeks gestation. This will allow time for any specific feeding plans to be developed prior to delivery and is especially important if the mother indicates a desire to breastfeed. Feeding advice and support can be sought from the Specialist Midwife for Infant feeding.

8.13 The midwife should inform the Named Midwife for Safeguarding and the Specialist Midwife for Safeguarding, Vulnerable Women and Teenagers, via the vulnerable alert form, who will forward to the relevant Health Visitor so she can arrange an antenatal contact. (Refer to the 'Identification and management of patients with mental ill health during the Perinatal period'; register number 09090)

8.14 If any concerns arise about risks to the unborn baby consultation should take place with the Named Midwife for Safeguarding, where consideration will be made about referral to social care. The patient should be informed of any referral unless there are compelling reasons why not. These must be documented into the hospital lilac record and social service referral form only. Concerns may include aspects of care, behaviours or poor antenatal attendance. (Refer to the 'Identification and management of patients with mental ill health during the Perinatal period'; register number 09090)

8.15 In the likely event that the unborn child becomes subject to child protection planning, the midwife is responsible for participating fully within the process and ensuring the child protection plan and Perinatal safeguarding birth plan is available in the lilac hospital record prior to birth.

8.16 Depending on the level and type of drug/alcohol abuse during the pregnancy, the baby may require admission to the neonatal unit. This will be indicated in the plan and paediatric input is essential at delivery in all cases. The The Named Midwife for Safeguarding will inform the neonatal unit via a plan placed in the alert folder. In addition any safeguarding cases will be discussed at the psychosocial meeting.

8.17 The newborn will likely require safety planning prior to transfer home via the Discharge Planning Meeting. This is convened by the ward midwife or neonatal nurse and invitees should include CMW, Paediatrician, HV, Social Worker, Ward staff, Drug Worker.

8.18 Patients who have a history of drug abuse are at greater risk of postnatal depression and disorders such as depression and anxiety; and a history of sexual/physical abuse are commonly associated with drug and alcohol dependency. The patient should have an individual management plan formulated and further revisions identified if necessary at the pre-discharge meeting.

8.19 After the birth of the baby care may continue from the midwife for twenty-eight days. The frequency of visiting will be determined at the discharge planning meeting and communicated fully to the community midwifery service. A verbal and written handover will be given to the health visitor and GP.

i. **Triage Attendance (Antenatal):**

- Query drug testing at this point:
- Urine sample for toxicology needs to be obtained (with consent) prior to **any** analgesia being administered to provide an accurate result;

- A supervised sample is the most accurate way of testing the urine to eliminate any false results i.e. a health professional should accompany the client with gained consent until a void is obtained.

ii. **Antenatal Admissions (Including for elective Caesarean section and Induction):**

- Urine toxicology (with informed consent) prior to any analgesia administered;
- Ensure all prescribed medication that woman has brought with her is recorded in the SAMS Controlled Drugs Register;
- Recorded on Patient prescription chart on the front sheet stored in the controlled drug cupboard;
- Liaise with GP/ drugs advisor and or dispensing community chemist:
- To confirm correct dosage of medication prior to any administration
- To possibly cancel prescription whilst inpatient
- Update any changes to dosages on notes and lorenzo
- Inform Midwife for Vulnerable women of admission
- Referral to Social Care if test positive on urine toxicology

iii. **On discharge home:**

- Where a woman has an identified prescriber, at the point of discharge the prescriber, if possible, should be given 24 hours' notice of a planned discharge.
- In the event the woman takes her own discharge at short notice, she should be advised of the potential impact on her prescription; there is a risk that there will not be a community prescription available to her on discharge which may result in drugs related harm to her and the unborn baby
- The discharging midwife should make every reasonable effort to inform the prescriber of the discharge
- Inform the Midwife for Vulnerable women of discharge

iv. **Admission in Labour (including latent phase)**
Intrapartum Care Pathway

- Urine sample for toxicology needs to be obtained (with consent) prior to **any** analgesia being administered to provide an accurate result.
- A supervised sample is the most accurate way of testing the urine to eliminate any false results. i.e. a health professional should accompany and stay in the cubicle with gained consent until a void is obtained
- ALL women known to be substance misusers must be offered urine toxicology on admission

8.20 If poor venous access, consider insertion of cannula at admission:

- Inform the Named Midwife for Safeguarding and the Specialist Midwife for Safeguarding, Vulnerable Women and Teenagers of admission
- Inform NNU of admission and test results
- Inform Social care of admission if appropriate
- Determine which substances have been used and when?
- Should a woman present in labour who is not known to be a substance misuse and staff have concerns consent should be obtained to perform urine toxicology (kits can be found on through the safeguarding team)

- Pain relief in labour should follow the woman's choice. Seek advice from S.T.a.R.S or Biochemistry if the woman has recently taken an illicit drug due to the possible adverse reaction with drugs given in labour.
- Methadone or subutex (buprennorphine) if prescribed should continue through labour. It will not produce a significant analgesic effect and should not replace other forms of pain relief. It should be treated as any other vital medication and its **timely** administration should be a priority. Delayed administration of methadone can lead to withdrawal for both mother and baby.
- Fetal monitoring may be more challenging to interpret due to the effects of opiates on fetal heart rate patterns. There may be reduced baseline, variability, loss of accelerations and intrapartum fetal withdrawal may result in unusual CTG patterns all of which should be considered when undertaking interpretation.
- Opioid analgesics may have reduced efficiency in women who are using prescribed or illicit opiates/opioids. An anaesthetist should be requested to attend for a review if there is difficulty in achieving the appropriate level of analgesia.
- There may be placental insufficiency in pregnancies of drug using women, leading to an increased risk of intrapartum hypoxia, fetal distress and meconium staining.
- Inform Neonatologist to be present at delivery.

8.21 **Postnatal care**

8.21.1 **DO NOT ADMINISTER NALOXONE TO THE NEWBORN**

8.21.2 Methadone usage to be reviewed by the obstetric registrar at the earliest postnatal opportunity to ensure a non-sedating dose is prescribed:

- Following delivery, changes in circulating volume can mean that a woman's normal of prescribed methadone can affect her more than usual. Over sedation may increase the risks of harm to the baby from falling or smothering or the mother may not hear them cry. For some women postnatal haemodilution may have the opposite effect and leave them feeling under prescribed with symptoms of withdrawal (Whittaker 2011).
- Some methadone maintained women may require higher doses of opiate analgesia following caesarean section. If unable to control pain adequately seek a review from the anaesthetic team
- It is important to rule out any other underlying cause of pain prior to discharge and to ensure that any TTO analgesia given will be adequate

8.21.3 Maternal withdrawal may occur around 48 hours post delivery in which case medication may be required.

8.21.4 Drug/alcohol misuse is associated with an increased risk of Sudden Infant Death Syndrome (SIDS) and parents who use drugs should be given advice regarding safe sleeping and bed sharing. (The Lullaby Trust, 2013)

8.21.5 **Postnatal care for babies**

(Refer to the Guideline for the 'Treatment of infants suffering from neonatal abstinence syndrome'; register number 09029)

- Neonatologist to make plan of care for baby;
- A set of baby notes should have been generated and stored on Delivery Suite;

- If the decision has been made to admit baby to Neonatal Unit (NNU) the transfer to NNU must take place in a timely manner depending on the clinical condition of the baby;
- A full set of observations for the neonate must be performed by a Registered Midwife within 20 minutes and recorded on the baby's observation chart
- All known drug and or alcohol dependant women should be advised that they will need to remain in hospital following delivery so that baby can be observed for signs and symptoms of neonatal abstinence syndrome (NAS)
- The baby will commence 4 hourly observations as per NAS scoring chart

8.21.6 **A sample of baby's urine is required for toxicology as soon as is practical following delivery**

- Results are invalid if collected after 72 hours
- Maternal consent is required where possible

- Ensure link safeguarding midwife is aware of delivery and any test results
- Inform the midwife for Vulnerable women
- Inform Social care if appropriate.

8.21.7 **If a referral has been made to Social Care a Pre-discharge meeting will be required.**

8.21.8 **Breastfeeding**

- Breastfeeding should be encouraged for **most** women, even if the mother continues to use substitution therapy

8.21.9 **Exceptions** include women who are:

- Using high-dose benzodiazepines
- Using cocaine/crack
- HIV positive.
- Heavy alcohol use
- Seek specialist advice if the woman is hepatitis C positive
- It is recommended that mothers should breastfeed immediately *before* an opioid dose is taken (to avoid peak concentrations of opioid in breast milk). Infants whose mothers are taking methadone should be monitored to avoid sedation.

9.0 Role of the Consultant Obstetrician

9.1 A named obstetrician consultant will be responsible for the pregnant patient with substance misuse.

9.2 The nominated obstetric consultant will participate in the assessment and the development of the care plan throughout the pregnancy.
(Refer to Appendix A)

9.3 Best practice dictates the first assessment by the consultant should occur by twelve weeks of pregnancy or and then care based upon individual needs.

9.4 The information needed by the obstetric registrar/consultant on call is as follows:

- Drug history, past and current
- Nature and frequency of any medication currently prescribed

- GP/ pharmacy substitute prescribing
- Urine toxicology assessment
- Names and contact numbers of all agencies involved
- Any other concerns
- Alcohol and tobacco consumption
- Psychiatric, psychological and social history
- General health and medical history
- Treatment plan which identifies whether stabilising drug use in the pregnancy or offering detox is appropriate before delivery

And in addition a birth plan with:

- Management of the drug dependency
- Pain relief during labour
- Infant feeding
- Management of known Hepatitis B/C or HIV infection
- The name of the Health Visitor and GP -This should be available from the records.

9.5 All patients will be screened for hepatitis B, C and HIV.

9.6 A partnership meeting with the patient will be called involving all professionals who are and will be involved with the patient. This meeting should include the neonatologist, midwife, GP, HV and social service. Members will:

- Assess risk
- Identify strengths and support within the family
- Evaluate progress
- Identify a care plan which should include the treatment plan
- Pain relief during labour
- Neonatal care Discharge planning.

9.7 The obstetric registrar/consultant on call should:

- Offer safer sex advice throughout pregnancy and promote other risk reduction behaviours
- Arrange anomaly scans at 20 weeks and 4-weekly scans to monitor growth as appropriate
- Obtain results of blood screening tests
- Identify who will give contraceptive and pre-conception counselling after delivery for future pregnancies
- Ensure reviews are undertaken during pregnancy and communicated to the midwife and Substance Misuse Team
- Participate in the organising of Intrapartum drug prescriptions via the drug services in liaison with their Doctor, to be available promptly in order to prevent withdrawal. The woman should not use her own supplies, which have often been ‘amended’.

9.8 In an emergency and where a patient is assessed as needing medication and unable to get a prescription it is the duty of the Obstetric Team to undertake this responsibility.

9.9 Following birth the Obstetric Team should provide information to the Neonatal Unit if the baby is admitted detailing:

- What drugs and alcohol is used or was used by the client
- Time and date of last use
- Length of time of usage of substances by client
- Maternal urinalysis results if appropriate
- Substitute prescriptions being used where applicable
- Name and contact number of Lead Professional

10.0 Neonatal Unit (NNU)

10.1 The neonatal unit (NNU) welcomes antenatal contact with patients who have substance misuse problems, as well as their partners, as a part of their birth plan.

10.2 A visit to the neonatal unit can be arranged by the midwife with the senior nurse in charge of the NNU and will be recorded in the Unit Daily Diary.

10.3 During the visit the senior nurse in charge will:

- Show the client and her partner around the Unit
- Provide an opportunity, in private, to discuss what the parents can expect in terms of her infant's likely physical condition and clinical care following birth
- Explain that the infant's nursing care will be coordinated by a named nurse, who will be introduced to the parents soon after the infant's admission to the NICU. The named nurse per shift will keep them updated on their baby's progress and will liaise with the lead professional accordingly throughout the baby's stay
- Explain that during the infant's stay, both parents will be supported and encouraged to care for their infant as much as possible. Practicalities such as "open visiting" and the use of the "rooming in" accommodation prior to discharge will be discussed. The alert folder on the NNU will be used for communication
- An explanation about the hospital policy on substance misuse on the hospital site will be given to the parents

10.4 The medical and nursing staff will need information held by the midwifery team when the baby is admitted. This will be kept in the alert folder when the baby on admission of the baby.

10.5 At the time of the client's admission to the labour ward, midwifery staff should notify the senior nurse in charge on the NNU and alert the paediatric team. The NNU should obtain the information from the midwifery team.

10.6 The paediatric consultant or registrar will undertake a formal medical assessment of the baby after birth. In most cases, admission to the NNU for observation will follow.

10.7 Information about the birth and admission will be sent to the paediatric liaison nurse within one working day who will inform the named nurse for child protection.

10.8 If the baby is not admitted to the NNU, the infant should remain in the postnatal maternity unit for a minimum of five days following delivery and be assessed in accordance with the 'Guideline for the treatment of infants suffering from neonatal abstinence syndrome'. Register number 09029.

10.9 Prior to discharging the baby appropriate feeding methods should be discussed, observations on parent and child interaction and any other care needs. The lead professional and health visitor should be notified.

10.10 A discharge planning meeting will be convened by the lead professional prior to the baby's discharge.

11.0 Role of the Health Visitor (HV)

11.1 If a Health visitor becomes aware that a patient is pregnant and substance misusing, support and advice should be offered. The mother should be informed of the steps that must be taken to ensure the safety and well being of herself and the unborn baby.

11.2 The Health visitor will contact the midwife to ensure that midwifery care is offered and that appropriate referrals take place to the drugs and alcohol team. It will normally be the responsibility of the midwife to proceed with the referral.

11.3 Health visitors will work in close liaison with the multi disciplinary team to identify those women who are pregnant and substance misusing to assist in the assessment of the client's needs and plan care for the family. The school nurse will be informed if there are school children in the family.

11.4 Health visitors must establish systems for enabling effective communication with the multi-disciplinary team; this involves regular contact and planning arrangements.

11.5 The named nurse, child protection, must be informed of any woman who is substance misusing during pregnancy to support the health visitor in the management of care.

11.6 The health visitor must be involved in the partnership meetings with woman.

11.7 The health visitor will ensure that she liaises with the midwife during the pregnancy and undertakes a contact with the patient to explain the health visiting service.

11.8 The health visitor will be involved in the discharge planning meeting before the baby is discharged from hospital.

11.9 The health visitor will continue to support the patient and her baby following discharge from hospital.

12.0 Members of the Multi Disciplinary Team

General Practitioner
Midwifery Team
Consultant Obstetrician
Neonatal Lead
Social Services
(Refer to Appendix B)
Drug and Alcohol Team
Health Visitor
Neonatologist
Paediatrician
Named and Lead Midwives

13.0 Documentation

(Refer to the 'Guideline for Maternity Record Keeping including Documentation in Handheld Records'. Register number 06036)

13.1 Well-kept records provide an essential underpinning to good professional practice.

13.2 Good record keeping helps to protect the welfare of patients and clients.

13.3 Records should therefore be timely, clear, accessible and comprehensive. Records should provide clear evidence of the care planned, the decisions made the care delivered and the information shared. Where decisions have been jointly taken across agencies or endorsed by a manager this should be made clear.

13.4 Safeguarding and promoting the welfare of mothers and children requires information to be brought together from a number of sources and careful professional judgments to be made on the basis of this information.

14.0 Staffing and Training

14.1 All midwifery and obstetric staff must attend yearly mandatory training which includes safeguarding issues.

14.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

14.3 All staff working with children require Safeguarding Supervision as frequently as necessary as per Safeguarding Supervision Policy (11018)

15.0 Professional Midwifery Advocates

15.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

16.0 Infection Prevention

16.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

17.0 Audit and Monitoring

17.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

17.2 As a minimum the following specific requirements will be audited:

- Management of the newborn of women known to have misused substances in pregnancy. A review of a suitable sample of health records of patients to include the minimum requirements

17.3 A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

17.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

17.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

17.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

18.0 Guideline Management

18.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

18.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

18.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

18.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

19.0 Communication

19.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

19.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

19.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

19.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

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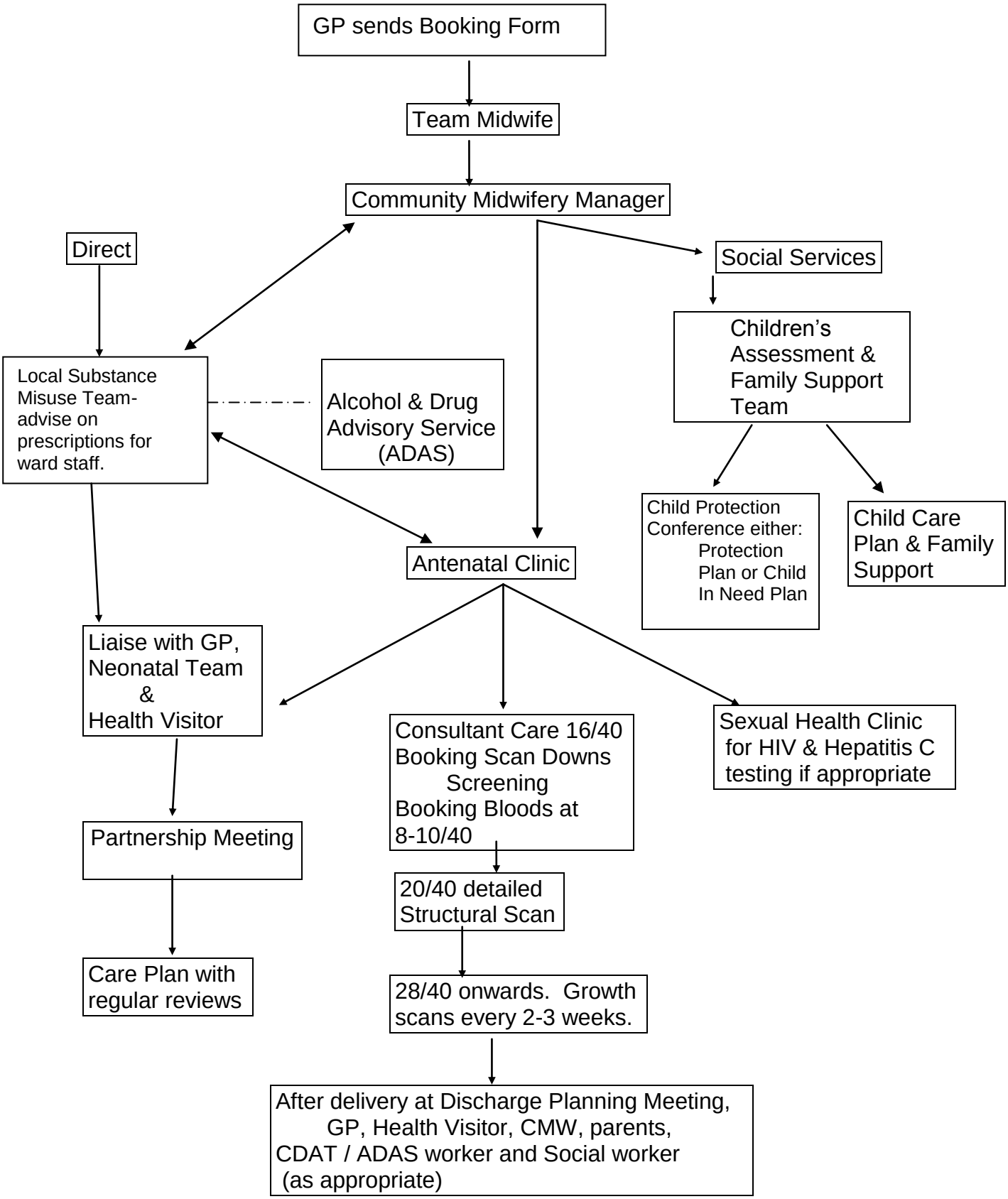
18.0 Appendices

Appendix A	Flowchart for Antenatal Care for Substance Misuse	\\Vfs1-rq8-00001\ UserData\diroberts\D
Appendix B	Mid Essex Contact Numbers	\\Vfs1-rq8-00001\ UserData\diroberts\D
Appendix C	Guidelines for Partnership Meetings	\\Vfs1-rq8-00001\ UserData\diroberts\D
Appendix D	Vulnerable Women Alert Form	Maternity Blank Safeguarding Office F
Appendix E	Discharge Planning Meeting Proforma	Maternity New Pre-Discharge Plannir
Appendix F	Neonatal Alert Proforma	\\Vfs1-rq8-00001\ UserData\diroberts\D
Appendix G	NAS obs chart and guidance to scoring	Neonatal Abstinence Scoring System.docx

Appendix A Flowchart for Antenatal Care for Substance Misuse



Appendix B Mid Essex Contact Numbers

Community Drug & Alcohol Team (Changes)	01245 31858
Essex Stars Specialist, treatment and recovery service previously known as North East Essex drug and Alchohol service (NEEDAS)	01245 315400
Essex Young Peoples Drug and Alcohol Services (EYPDAS) (aged up to 18 years)	01245 493056

Health in Mind 03003305455
Safer places 03301025811

National Drugs Helpline	0800 77 66 00
East Essex, NEEDAS	01206 287551
South Essex, SEPT	01268 583154
Southend, Drug Action Group	01702 345348
Thurrock, Drug Action Group	01375 652972

Named Midwife Safeguarding MEHT Therese Mccarrick-Roe	01245 515167
Specialist Midwives for Safeguarding, Vulnerable Women and Teenagers Gemma Bellhouse/ Rebecca Saltwell	01245 513351
Designated Consultant Paediatrician for Child Protection Dr Manas Datta	01245 513251
Lead Midwife Perinatal Mental Health Nana Onyinah	01245 513251
Named Nurse for Child Protection MEHT Sue Wright (Currently on Sick Leave)	01245514728
Associate Named Nurse for child protection MEHT Jenny Harris	01245 514728

Obstetrician/Gynaecologist	01245
Social Care (referrals)	0345 603 7627 – in hours
Social Services Essex Emergency Duty Team	0845 806 1212 – out of hours
Police Child Protection Abuse Investigation Team	01245 490608 101 ext 180022
Triage Team	
Police Domestic Violence Unit Chelmsford / Maldon	01245 490840
Braintree / Witham	01376 556223
Essex Probation Service	01376 501626
DHSS Benefits Agency	01245 214300
Samaritans	01245 357357
Relate	01245 258680
Victim Support	01245 422660
RELEASE	0207 7299904
Families Anonymous	0207 4984680
Chelmsford Borough Council (Housing)	01245 606606
(Homelessness)	01245 606644

Chelmer Housing	01245 613000
CRUSE - Bereavement Care	0870 1671677
Sexual Health Clinic	01245 513086/513173

Appendix C - Guidelines for Partnership Meetings

Introduction

When there are concerns about a child a meeting may be called to assess the situation. A Partnership meeting will involve the parents and can be used to assess the needs and identify risks. The meeting should involve all relevant professionals.

Any professional can call the meeting and advice can be sought from the designated person in their area of work. That person then becomes responsible for coordinating the meeting.

Professionals do not need to take along a report but should have all relevant records available.

Organising a Meeting

Make a decision on: Date
Time
Venue
Professionals who can contribute to the discussion
Chairperson and Minute Taker
Invitation list
Follow Agenda Format
Record Outcomes
Circulate Action Plan and Minutes

If a parent has been unable to attend a professional must be nominated to discuss the meeting, the minutes and outcomes with them.

Guidance and Agenda Format

Record Attendees and apologies sent
Identify the purpose of the meeting
Identify concerns & risks to children and family members.
Identify strengths in the family, this may include support mechanisms available to them and work already undertaken by family.
Draw up a care plan / action plan with specific, measurable, achievable, time related outcomes. It should be clear to professionals and the family what is expected of them by the end of the meeting
Set a date for the next meeting to review the Action Plan.
Record where copies will be sent, date and sign.

PARTNERSHIP MEETING

Family Name: **Address:**

Children's Names: **DOB:**

Date: Venue:

Present:

Apologies: (If Parents not present – state why)

Purpose of Meeting:

Concerns: (Bullet Points or numbers)

Strengths:

Care Plan:

Action Required	**By Whom**	**By When**
If Parents not present identify who will inform them		

Date of Next Meeting:

Chair Person:

Signature: **Print Name:**

Designation:

Safeguarding	*Lilac folder*	*Community/ Midwife Led Unit folders*	*Perinatal Mental Health Midwife*	***Health Visitor Emails:*** ***Braintree/Witham:*** ***vcl.essexmid-braintreehvadmin@nhs.net*** ***Chelmsford:*** ***vcl.essexmid-chelmsforddv@nhs.net*** ***Maldon:*** ***vcl.essexmid-maldondv@nhs.net***
				Mie-tr.maternitysafeguarding@nhs.net

Appendix D

Mid Essex Hospital Services NHS Trust

WOMEN'S & CHILDREN's DIVISION

Perinatal Mental Health / Safeguarding / Vulnerable Referral

For Advice re referral to social care or for early help

Family Operations Hub (Mon-Thurs 8.45-5.30pm Fri 8.45-4.30pm) Call 0845 603 7627 Out of Hours Tel no: 0845 606 1212

Please fill in as much information as possible and send to Level 4, A404 Safeguarding Team, Broomfield Hospital							
Personal details *(please enter details legibly in block capitals)*							
First name:		Surname:					
Hospital No:		DOB:					
NHS No:							
Address:		Postcode:					
Telephone:		Mobile:					
Preferred language:		Interpreter required?	Yes		No		
Ethnicity:		Nationality:					
Religion:		Marital status:					
Partner:		DOB					
Address:		Postcode:					
Telephone:		Mobile:					
GP details *(please enter details legibly in block capitals)*							
Name**:**							
Address: Postcode:							
Telephone:		Fax:					
Referrer details *(please enter details legibly in block capitals)*							
Name**:**							
Area:							
Telephone:		Fax:					
Obstetric history							
Obstetrician/Named Midwife:				Next appt:			
Date booked:							
EDD:		G		P			
NAME		HOSP NO					
Risk status		High		Low			

Medical history *(✓if yes, **no** if no, **n/k** if not known).Include details of allergies, relevant personal or familymedical history)*					
Medical problems					Details:
Currently taking medication					
Neonatal alert	Yes		No		

Psychiatric history *(✓if Yes, **no** if No, **n/k** if not known)*		
Answered yes to Whooley questions		Details:
Past history of mental illness		
Past history of substance misuse		
Family history of mental illness		
Previous diagnosis		
Bipolar (manic depression)		
Schizophrenia		
Puerperal psychosis		
Depression		
Post-natal depression		
Anxiety disorder		

OTHER CHILDREN IN FAMILY

NAME	**DOB**	**ADDRESS**

Potential social stressors *(detail problems in the areas listed, ✓if yes*		
Employment		Details:
Financial/debts		
Housing/homelessness		
Relationship with partner		
Relationship with family		
Social support (or lack of)		

Formal risk assessment *(detail any evidence of risk in the areas listed, ✓i f yes, **no** if no, **n/k** if not known)*		
Dangerous/risk to others		Details:
Risk of self-harm		
Self-neglect		
Vulnerability		
Safeguarding concerns		

If there is an urgent concern please contact Crisis team if out of hours on 01376 308100

HOSPITAL NO:	NAME:

Vulnerable/safeguarding history

Teenage Pregnancy over 16	Yes		No	
Teenage Pregnancy under 16	Yes		No	
Domestic Abuse	Yes		No	
English not the first Language	Yes		No	
Drug and Alcohol issues	Yes		No	
Disability	Yes		No	
Other				
Family solutions Referral made?	Yes		No	
Has the unborn/child been referred to Child & Family Social Services?	Yes		No	
Is there previous family Social Services involvement	Yes		No	
Children's Centre Referral	Yes		No	

Details including named workers, if yes:

Actions taken to date by midwife:

Reason for referral *(brief summary of problems)*

Mothers comments on referral (mum can write here if she wants/ e.g express what she would want for support)

Is the patient aware of this referral and consented?		**Yes**	No
Signature of referrer:		Date	

Please use for initial referral only. For updates, use communication update form.

HOSPITAL NO: ***NAME:***

COMMUNICATION

DATE	***UPDATE***

Appendix E

MID ESSEX HOSPITAL SERVICES NHS TRUST
Women's & Children's Division

SAFEGUARDING PRE-DISCHARGE MEETING

Each entry must be signed and dated.

<table>
<tr><td colspan="2">Mothers Name
DOB
Record Number
Address</td><td>Newborns Name:
DOB
Birth Weight
Sex</td></tr>
<tr><td colspan="2">Fathers Name
DOB
Address</td><td>Named Midwife:

Team:</td></tr>
<tr><td>Date:</td><td colspan="2">Discharge Planning Meeting
Reason for meeting:
•
•
•
•
•
•

Present:
• Maternity SG Team -
• Ward Midwife -
• Social Worker -
• Health Visitor -
• Mother -
• Father -
• Other -
• Other -
Maternity Safeguarding Team to be informed of the meeting for attendance/advice/support.</td></tr>
</table>

	Meeting Notes: • • • • • • • • • **PLAN** • Community Midwives visit frequency 1st day home, day 3, 5, 7, 10 then weekly to 28 days. • Direct liaison between Community Midwife and Health Visitor • • • • • • Signature and Designation …….. *1 copy to Maternity Safeguarding Team* *1 copy to all present at meeting* *1 copy to HV if not present* *1 copy for patient's main lilac folder.*

DISCHARGE TO FOSTER PLACEMENT

Baby details:
Name:
DOB:
NHS Number:

Additional Information

Carer of baby……..
Social Worker…….
Parents names……
……..
Health visitor……

Appendix F

Mid Essex Hospital Services NHS Trust

Women's & Children's Division

Neonatal Alert Form

Surname: **First Name:**
Hospital number: **NHS No:**
Gestation: **Consultant:**
EDD: **Referral Date:**

Background history & problems summary:

Delivery plans:

Broomfield Hospital ☐ Not decided ☐
Other Hospital ☐ State please ……
GP informed ☐ CMW informed ☐

Neonatal Alert Form Criteria

Please use the neonatal alert form for the following conditions:

- Multiple pregnancy (higher order>2fetus)
- Hepatitis B positive mother
- HIV positive mother
- Previous baby with GBBS sepsis / meningitis
- Significant structural abnormalities diagnosed on ultrasound scan
- All cases that require referral to specialist units for treatment or advice
- Mothers with high antibody titres e.g. Anti D, C and Kell
  - Severe oligohydramnios/IUGR
  - Abnormal dopplers
  - Genetic/hereditary conditions in the immediate family that may affect the fetus
  - Social e.g. drug abuse, alcohol abuse in this pregnancy
  - Any other condition that will require paediatric input at birth

Antenatal neonatal counselling needed	Yes	No	(please circle)
Maternal consent given to telephone (if appropriate)	Yes	No	(please circle)
Contact telephone no:			

Postnatal plan (paediatric)

Name: **Signature**

Date:

Neonatal Abstinence Scoring System

system	Signs and symptoms	Score															
Central nervous system Disturbances	Excessive high pitched (or other) cry < 5mins	2															
	Continuous High pitched (or other) cry > 5 mins	3															
	Sleeps < 1 hour after feeding	3															
	Sleeps <2 hours after feeding	2															
	Sleeps <3 hours after feeding	1															
	Hyperactive Moro Reflex	2															
	Markedly hyperactive Moro reflex	3															
	Mild tremors when disturbed	1															
	Moderate-severe tremors when disturbed	2															
	Mild tremors when undisturbed	3															
	Moderate-severe tremors when undisturbed	4															
	Increased muscle tone	1															
	Excoriation (chin, knees, elbows, toes, nose)	1															
	Myoclonic jerks	3															
	Generalised convulsions	5															
Metabolic/ Vasomotor/ Respiratory Disturbances	Sweating	1															
	Hyperthermia 37.2^{o}C -38.3^{o}C	1															
	Hyperthermia > 38.4 ^{o}C	2															
	Frequent yawning (3-4 times/ scoring interval)	1															
	Mottling	1															
	Nasal stuffiness	1															
	Sneezing (> 3-4 times/scoring interval	1															
	Nasal flaring	2															
	Respiratory rate > 60/min	1															
	Respiratory rate > 60/min with recession	2															
Gastrointestinal Disturbances	Excessive sucking	1															
	Poor feeding (infrequent/ uncoordinated suck)	2															
	Regurgitation (> 2 times during/ post feed)	2															
	Projectile vomiting	3															
	Loose stools	2															
	Watery stools (water ring on nappy round stool)	3															
	Total score																
	Date																
	Time																
	Signature																

Guide to Assessment and Scoring

- **First score should be recorded approx. 2 hours after birth/ admission.**
- **Initially infants should be scored 4 hourly, except when high scores indicate more frequent scoring**
- **If score at any time is greater or equal to 8, increase to 2 hourly and continue for 24hours from last score of 8 or above**
- **Treat with pharmacotherapy if 3 consecutive scores 8 or greater**
- **Scoring is dynamic. All signs and symptoms observed during the scoring period are included in point total for that period**
- **In a term infant scoring should be performed 30 mins to one hour after a feed,modification may be needed for pre term infant**
- **If pharmacotherapy is not needed, infants should be scored for 3 days**

High pitched cry	Score 2 if high-pitched at its peak, 3 if high pitched throughout. Infant scored if crying is prolonged, even if not high pitched
Sleep	This is a scale of increasing severity and an infant should only receive one score from the three levels. Modification will be needed for premature infants
Moro reflex	This is a reflex of young infants and occurs when a sudden noise causes the child to stretch out arms and flex the legs. Score if infant exhibits pronounced jitteriness (rhythmic tremors that are symmetrical and involuntary) of the hands during or at the end of a Moro reflex. Score 3 if jitteriness and clonus (repetitive involuntary jerks? Of the hands and/or arms are present during or after the initiation of the reflex
Tremors	This is a scale of increasing severity and an infant should only receive one score from the four levels. Undisturbed refers to the baby being asleep or at rest in cot
Increased Muscle tone	Score if excessive or above-normal muscle tone or tension observed-muscles become stiff or rigid and the infant shows resistance to passive movement. E.g. no head lag when pulled to sitting position, or tight flexion of infants arms and legs (unable to slightly extend when an attempt is made to extend and release the supine infants limbs
Excoriation	Excoriation (skin abrasions resulting from constant rubbing against a surface that is covered e.g. from bed linen. Score only when excoriations first appear/ increase of appear in new area
Myoclonic jerks	Score if involuntary muscle contractions which are irregular and exceedingly abrupt (usually single muscle group) are observed
Generalised convulsions	Infant seizures or convulsions are most commonly seen as generalised activity involving tonic extension of all limbs, but sometimes limited to one or both limbs on one side. Unusual limb movement may accompany a seizure e.g. in upper limbs these resemble swimming or rowing. In lower limbs they resemble cycling or pedalling. Other signs can include eye staring lip smacking back arching and fist clenching
Sweating	Score if sweating is spontaneous and not due to environment or clothing
Hyperthermia	Axilla temperature should be taken.
Yawning	Score if more than 3yawns in scoring interval
Mottling	Score if mottling (marbled appearance of pink and pale and white areas is present on chest, trunk, arms or legs
Nasal stuffiness	Score if infant sounds congested; mucous may be visible
Sneezing	Score if 3 or more sneezes in scoring interval
Nasal flaring	Score only if repeated dilation of nostrils is observed without other evidence of lung or airway disease
Respiratory rate	Respirations are counted for a whole minute. Score only if rate over 60 with no evidence of lung or airway disease. Score 2 is respiration involved recession
Excessive sucking	score if hyperactive/disorganised sucking, increased rooting reflex or attempts to suck fists or thumbs (more than that of average infant) are observed
Poor Feeding	Score if demonstrated excessive sucking prior to feed, yet sucks infrequently during feed taking a small amount, and/or demonstrates an uncoordinated sucking reflex (difficulty sucking and swallowing). Premature infants should not be scored for poor feeding if requiring NGT feeds due to immaturity
Regurgitation	Score if at least one episode of regurgitation
Loose/ watery stools	Score if loose or watery stools are observed. Check nappy after examination if needed