**NCCU CLINICAL GUIDELINES**
**SECTION: 17**

# NEONATAL ABSTINENCE SYNDROME

Section: 17 Neonatal abstinence syndrome
Assessment and care after birth
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## ASSESSMENT AND CARE AFTER BIRTH

### INFANT RESUSCITATION

Naloxone is not to be used in infants of opiate-dependent mothers as it has the potential to cause withdrawal symptoms including seizures. Initially the infant may be observed in the postnatal ward. Mothers need to be forewarned, if this has not already been addressed antenatally, that the infant will need to be in hospital for at least five to seven days and the infant's stay can sometimes be as long as several weeks.

NAS is likely to be more severe in infants that have been antenatally exposed to methadone, heroin or multiple substances. Therefore, these infants should be regularly assessed for symptoms of NAS from birth to the fourth day of life.

### NAS SCORING

Given the vagueness of NAS symptoms in infants, it may be difficult to determine when they are in need of treatment. For this reason the **Neonatal Abstinence Scoring System** devised by Finnegan is used. Read NEONATAL ABSTINENCE SCORING CHART (MR 495) in conjunction with this guideline. The NAS scoring system is a guide and not a precise measure of the infant's clinical course.

Infants on the postnatal wards should be considered for transfer to the neonatal unit if the NAS score $\geq$8 for 3 consecutive scores, or $\geq$12 for 2 consecutive scores. Further scoring is usually appropriate to confirm that high scores are due to NAS. Infants should also be admitted if there is severe irritability. The infant can be transferred back to the postnatal wards/peripheral units when stabilised (i.e. scores <8 for 24 hours). NAS can produce a major disruption to mother-infant attachment. Unnecessary separation of mother and infant should be avoided.

The scoring interval is the entire period between scores (i.e. 4 hours if the previous score was less than 8, or 2 hours if the previous score was greater than 8). Scores should therefore reflect all symptoms observed over the entire scoring interval rather than at one set point in time. The medical staff will use the NAS scores to determine if pharmacological treatment of infants with NAS is required.

If the infant is unsettled at the time of scoring, efforts should be made to settle the infant prior to scoring symptoms observed over the period of assessment. The progression of NAS symptoms, and response to medication should always be documented.

### NON-PHARMALOGICAL INTERVENTIONS

Non-pharmalogical interventions can assist in settling and may reduce symptoms in infants with NAS.

**HIGH PITCHED / EXCESSIVE CRY**

- Soothe infant with swaddling, talk quietly, hold infant firmly to body, rock gently.
- Reduce environmental stimuli (slow movements, reduce lighting and noise level, cover head end of cot).

**SLEEPLESSNESS**

- Reduce environmental stimuli. Swaddle infant, minimise handling, rock gently and encourage skin-to-skin cuddles.

**EXCORIATION**

- Place a sheepskin under sheet. Apply protective skin barriers (eg. Comfeel) to affected areas.

**HYPERTHERMIA**

- Dress in light clothing and use lightweight, soft fabric to swaddle. Nurse in an open cot with adequate ventilation. Avoid using a Perspex cot.

**NASAL FLARING/TACHYPNOEA**

- Refer to Medical staff. Avoid swaddling so that respiratory rate can be closely observed.

**EXCESSIVE SUCKING OF FISTS**

- Apply mittens, keep hands clean, and consult with parents about the use of a dummy.

**POOR FEEDING**

- Feed to demand, offer small frequent feeds, and allow to rest between sucking. Reduce
- Environmental stimuli during feeds and assess coordination of suck swallow reflex. Refer to Lactation Consultant as required. Weigh and assess hydration daily and refer to Medical staff if infant doesn't achieve required fluid intake or has excessive weight loss.

**VOMITING**

- Wind infant regularly when he/she stops sucking and at the end of the feed.

**PERI-ANAL EXCORIATION DUE TO LOOSE STOOLS/DIARRHOEA**

- Change infants' nappy with every feed. Discuss the use of appropriate barrier creams with medical staff, and it may be necessary to expose the buttocks to air to dry.

## PARENT EDUCATION

**1.** Mothers' are to be given the option of keeping the scoring sheet at the infant's bedside, or held in the nursing coordinators handover file (so as not to compromise the confidentiality of the mother's substance use). NAS scores should be documented in consultation with the mother and father if appropriate.

2. Parents are to be familiarised with the scoring tool and be encouraged to participate in scoring of their infants. Daily assessment of withdrawal symptoms, adequacy of feeding, adequacy of weight gain (or severity of weight loss) and non-pharmalogical interventions. This will enable recognition and appropriate response to NAS symptoms and assist in the ongoing management.

3. Encourage breastfeeding if the mother is stable on methadone. Harm minimisation in relation to breastfeeding should be discussed if the mother is on heroin or other sedatives and stimulants.
4. Liaise between medical, nursing and social work/WANDAS team concerning the family's social situation, parenting skills/abilities, visiting schedules and whether there are any indications for involvement of Department of Child Protection/DCP.
5. Hepatitis B vaccine before discharge, or hepatitis B vaccine and immunoglobulin within 72 hours of birth if HepBsAg positive. Hepatitis C is not a contraindication to breast- feeding (See Hepititis C and Breastfeeding and women with Hepatitis B may breast feed once their infant is vaccinated and given immunoglobulin.