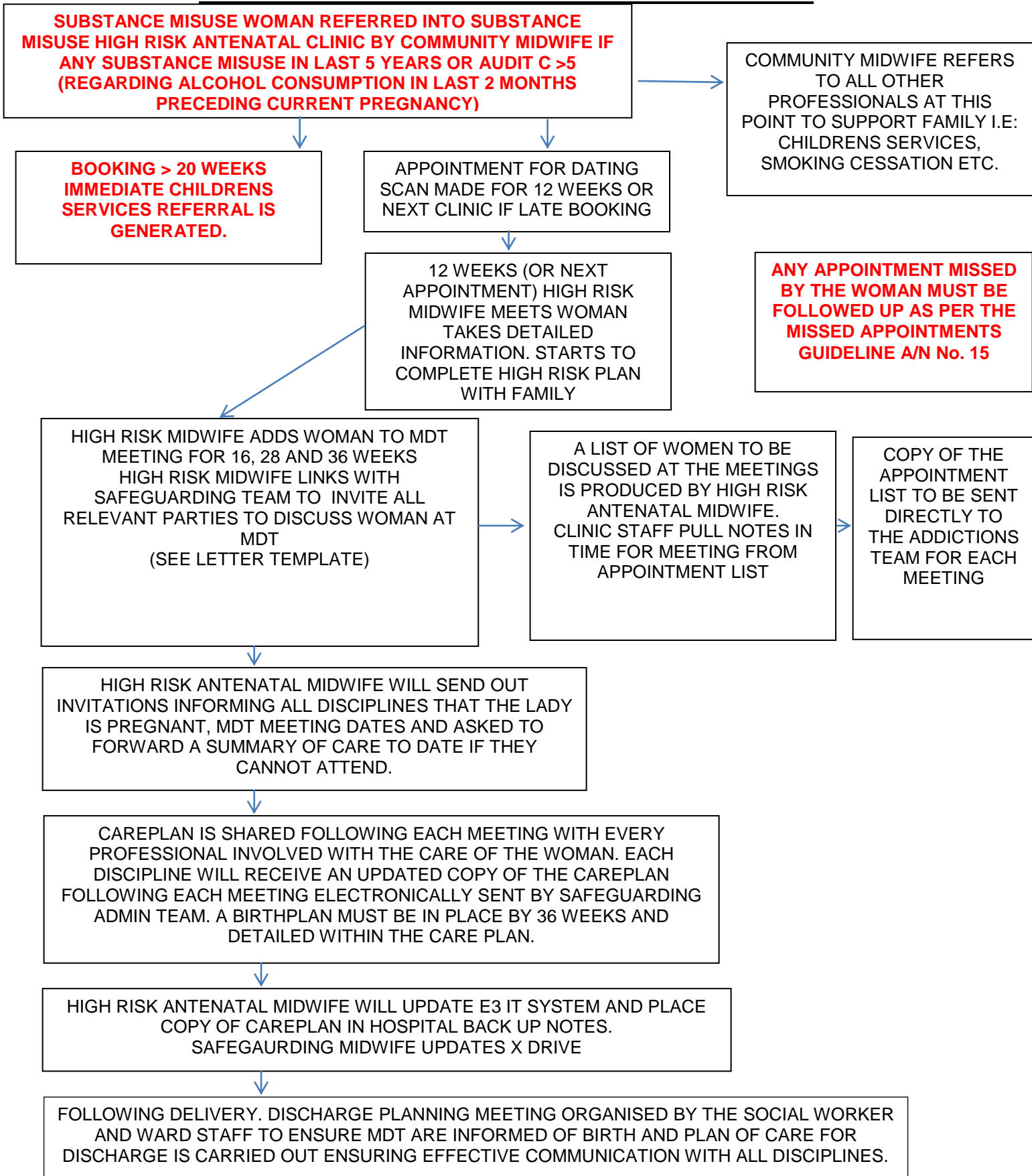


Management of Women Who Misuse Substances In Pregnancy

Document Type: Clinical Guidance
Issue No: 7
Scope: All women in the Antenatal,
Intrapartum and Postnatal Period
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Antenatal Midwife, Guideline group NHCT
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Postnatal 5
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Governance Group
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SUBSTANCE MISUSE MDT MEETING REFERRAL PATHWAY



booking midwives responsibility to organise all appropriate referrals. Utilise the Unborn Thresholds document to inform referral to children's services as appropriate.

The community midwife is pivotal in communicating with all health professionals the care for these women and ensuring documentation of any Safeguarding issues or child protection plans are stored in the hospital medical back up notes. They are also pivotal in keeping the Addictions team up to date with any changes.

The Community midwife must liaise closely with the multi-disciplinary team and ensure that the GP and Health Visitor are included in any discussion around the family. The substance misuse midwife who works alongside the specialist obstetrician to support these women offers extra support and advice; however, it is the community midwives responsibility to write any reports with the substance misuse midwife offering extra information if required.

NOTE: All midwives and Doctors involved in the care of these women must keep accurate and contemporaneous records ensuring copies of any plans for delivery or care are stored in the medical back up notes and use the E3 IT system to log hospital contacts. All records/reports/and concerns need to be distributed to all members of the integrated team.

3. Multi-disciplinary Team meetings.

Multi-Disciplinary Team working around the family

- Comprehensive assessment of all pregnant women with possible drug and alcohol problems, this including all non-prescribed drugs as well as prescribed drugs.
- Identification of children who need to be safeguarded
- Thresholds for referral to children and family services to be clarified
- Pathways of care to be defined and implemented
- Regular review and care planning at strategic points
- Effective joint working arrangements

There are MDT monthly meetings to discuss all patients involved with the Addictions team and obstetric substance misuse team. All members are invited to attend as per Appendix 1 Terms of reference guidance and are invited using the template letter Appendix 4. The high risk antenatal midwife, the Consultant Obstetrician, the Consultant Psychiatrist in Addictions, the clinical lead Northumberland Recovery Partnership are the core members of the team. The key addictions workers, social workers. Community midwives for each woman will be invited to attend for specific discussions including the GP and health visitor.

NOTE: Where the high risk antenatal midwife is unavailable to attend the MDT meeting or any care team meeting to which she is invited. She will organise a deputy with either the named midwife safeguarding or midwifery management team.

It is the role of the high risk antenatal midwife to arrange the meetings, identify the women to be discussed, get their backup notes and invite appropriate other health professionals. This to be arranged in advance to ensure timely discussions and with all appropriate professionals involved.

A care plan for each woman will be documented in her backup notes on the template following each meeting and will be shared with the addictions team and other colleagues involved in the patient care e.g. GPs and social workers. Appendix 5. The template will be completed following MDT meeting by the substance misuse midwife containing any plans and emerging information around the family and referrals made.

A delivery plan and a provisional discharge plan for each patient will be completed by 36 weeks gestation to include all child protection/ children's social care plans and stored in the backup medical records by the substance misuse midwife. All members of the team will have this plan for their own agency records.

NOTE: Any mail addressed for the substance misuse midwife is directed to the Obstetrics & Gynaecology Secretary, opened and actioned ensuring no delay in service provision.

4. Management of Antenatal care:

The Community Midwife will follow the NICE High Risk antenatal Schedule for all Substance Misusing Women regardless of her parity (See Appendix 8). All pregnant women should have assessment of any use of drugs and alcohol at first assessment by the midwife. This should be both past use and current use. It should include illicit drugs, Novel psychoactive substances (NPS/legal highs'), misuse/abuse of prescribed drugs, amount and frequency of all of these drugs and alcohol including alcohol (Appendix 5). Ensure PAS form completed and send to relevant clinic.

Blood tests at booking should be taken with consent as per all pregnant women (See Guideline Booking Appointment)

4.1 Screening at this point must also include:

- Hep C Screening.
- For Alcohol Users LFT's and Gamma GT levels should be taken.
- A urine sample should be sent to the lab with consent marked for 'full drug screen'. This sample should be requested from the woman at the appointment.

"Full drug screen" includes:

- Amphetamine
- Benzodiazepine
- Cannabis
- Cocaine
- EDDP
- Opiates

If positive for Amphetamines or Opiates further confirmation screening is performed for:

- Morphine
- Codeine
- Dihydrocodeine
- 6AC morphine
- Amphetamine
- Ecstasy

NOTE: If the community midwife is unable to obtain blood specimens at booking due to poor venous access, the midwife should refer the woman to PAU requesting that bloods should be taken in the hospital.

A urine sample at booking is important so that the results are available at the first specialist antenatal clinic.

4.2 Alcohol – referral for comprehensive assessment

- Current AUDIT C > 5 should be the threshold for referral to this obstetric clinic. There is not clear evidence from the UK to guide us on this referral, with much variation of what are “acceptable levels”
- Past or current history of excessive use
- Past or current dependence

NOTE: At booking Audit C should be based upon alcohol consumption in the last 2 months prior to positive pregnancy test.

4.3 Thresholds for drug use referral to specialist substance misuse clinic

All should have screened questions about drug use, past and current and include partner history. This should be of:

- Use of all illicit drugs
- NPS / Legal highs
- Use and abuse of prescribed medications, own or others (e.g. slimming tablets/energy drinks)
- Dependence on any drugs including polydrug use and alcohol
- The questions should include quantity and frequency of drugs taken

5. ASSESSMENT AT SPECIALIST CLINIC

Specialist obstetric clinic – as part of the integrated team:

Northumbria Specialist clinics

5.1 Assessment following initial Midwife referral

Comprehensive assessment required as of NICE 2012 for drugs and alcohol with all issues of past and current drug and alcohol use, comorbidity, other factors - eg social, past history of treatment, family assessment and support, safeguarding, violence etc. This assessment will be conducted by the specialist midwife for substance use.

5.2 Assessment

- Comprehensive as per NICE 2012

- Tools: APQ, SADQ, AUDIT
- Toxicology

A urine sample should be obtained in clinic and sent for toxicology with consent and marked 'full drugs screen'. Individualised tests may be added on abuse prescription drugs, such as:

- Gabapentin
- Pregabalin
- Tramadol
- Zopiclone
- Mertzapine

Anaesthetic alert should be generated for all patients with poor venous access.

Hep B & C Positive patients need appropriate onward referral to the gastroenterologists as per national screening guidelines. This information will be shared with the whole integrated team.

All assessments include alcohol and drugs but also a broad assessment of safeguarding, partner and family support, and all advice and information from all parties/agencies involved. Then the case is discussed within the MDT with then clarity of expectation from all agencies with a care plan agreed. This may be of discharge to midwife care only, or/and continuation within team with involvement of more agencies as appropriate. An agreed care plan will be discussed and documented and sent to all agencies following the MDT.

The woman should attend the high risk antenatal schedule with the community midwife and additionally attend any appointments considered necessary by the specialist hospital based team.

4.3 Schedule of antenatal care appointments

<u>Community Midwife appointments & Scans</u>	<u>Specialist clinic appointments and MDT meetings</u>
Booked with community midwife risk assessment/history taken referral into services	
12 weeks dating scan with/without screening	12 weeks Appointment at Substance misuse clinic for further assessment review of blood and urine tests.
16 weeks community midwife appointment	Discuss at MDT meeting
20 weeks anomaly scan	20 weeks Appointment at substance misuse clinic
25 weeks community midwife	
27 weeks community midwife appointments routine blood tests to include LFT's/GGT	
	28 weeks Antenatal Substance misuse clinic. <ul style="list-style-type: none"> • Fetal growth assessment. • Complete Plan of care. • Pregnancy review at MDT • Management of addictions problems • Outcomes of toxicology • Attendance & engagement • Wider social issues housing etc. • Safeguarding issues plans of care

	<ul style="list-style-type: none"> • Parenting issues • Share/discuss care plan with MDT
	32 weeks Antenatal Substance misuse clinic. <ul style="list-style-type: none"> • Fetal growth assessment • MDT Planning meeting to discuss on going care
34 weeks community midwife	34 weeks maybe required to attend Antenatal substance misuse clinic also for intensive monitoring
	36 weeks Antenatal Substance Misuse Clinic. <ul style="list-style-type: none"> • Review pregnancy plan for delivery • Review management of addictions • Attendance & Engagement • Wider issues e.g. housing • Safeguarding issues i.e. Birth plan in place • Pain in labour management • Risk assessment • Review care plan share with all agencies • Involvement of neonatal team • Anaesthetic alert • Discussed MDT
38 weeks Community Midwife	38 weeks maybe antenatal substance misuse clinic or community depending on need
	40 weeks antenatal substance misuse clinic <ul style="list-style-type: none"> • Plan for delivery • Offer membrane sweep if appropriate
41 weeks Community Midwife <ul style="list-style-type: none"> • Offer and perform membrane sweep • Book Induction of labour 	

Substance misuse without evidence of fetal compromise is not a reason for routine induction.

These are the minimum number of visits required. More frequent assessment and monitoring maybe required depending on individual maternal and/or fetal concerns.

Note: At any point in the schedule of care a referral to children’s services can be made and a strategy meeting convened, however, not all women require this extra support and consideration should be given to lifestyle and individualised care provided. Any multi-disciplinary team meetings can be convened at any point during the pregnancy.

6. Drug Use & prescription Management

- 5.1 If the woman is already on a prescription and treatment programme at addiction services this prescription will continue to be prescribed and assessed at addictions throughout pregnancy, with involvement of the MDT.

- Addictions service will encourage and facilitate early access and engagement with midwife and primary care and work with the integrated team.
- It is the responsibility of the addictions team to bring details of the case to the MDT and facilitate discussion and engagement
- All details of prescription and progress will be shared with the MDT

If the woman has only disclosed substance misuse at booking with the midwife, she will be referred for comprehensive assessment to the obstetric clinic. If urgent e.g. IV use, dependence, the specialist midwife will contact the clinical lead in addictions for urgent assessment. This will be done within 24 hours.

5.2 For all who are on prescription for addiction treatment (usually opioid management e.g. buprenorphine or methadone)

- The addictions team will continue to prescribe all medication (eg methadone and BDZ or other psychotropic drug) and will discuss with the integrated team
- All care plans to all agencies will contain the medication, the dose, the pharmacist and the dispensing arrangements.
- These will be updated at each strategic MDT meeting and all agencies informed
- The addictions team will be responsible for the clinical decisions about the medication with careful involvement of all agencies
- The prescription will be organised and arranged only from the addictions service unless patient is admitted into hospital for obstetric care.
- Any decision to admit the person for obstetric reasons will be made by the obstetric specialist
- If there is consideration of admission to ensure or assess stability of drug and alcohol use, this will be discussed with the addictions team including the consultant prior to discussion with mother and high risk antenatal midwife
- On admission at any time, the ward will inform the addictions keyworker and the pharmacist to stop any community dispensing. Inform high risk antenatal midwife of all substance misuse women.
- The senior nurse on the ward will check with the dispensing pharmacy whether the dose on the day of admission has been dispensed or not.
- If on weekly pick up and not supervised, this must be discussed with the key worker to ensure stability in order to continue prescription. This concern of stability should be documented in the records as it will have been discussed at each MDT meeting. A urine test should be taken on admission and prior to prescription.
- Consultant in addictions will be available during the week for advice
- Adaptations – increase or decrease of dose of drugs such as methadone while an inpatient will be written up by the obstetric team but should be discussed with the addictions team and the MDT
- If admitted for other drugs eg amphetamines. Benzodiazepines (BDZ) this is similar to opiates and must be discussed with consultant obstetrician and addictions team.

- In the event of premature discharge by the person from a ward, the ward will dispense on that day but will not give further until discussions are had with the addictions keyworker.
- On discharge, the ward will dispense medication on the day of discharge.
- The ward will contact the keyworker and addictions will organise subsequent prescriptions at her local chemist for collection.
- The community pharmacist should also be notified of the patient's discharge and prescription details.
- If over a weekend and premature discharge, the ward will ensure dispensing until the first working day – Monday - and then ensure communication with addictions team
- At all times primary care must be informed.

6. Intrapartum Care:

The vast majority of labours and deliveries are trouble free in drug and alcohol using women therefore their care should be similar to any other woman.

On admission inform the Consultant Obstetrician on call and the specialist substance misuse obstetrician if available, Neonatal Practitioner, Anaesthetist, Substance Misuse Midwife if available, Addictions key worker and Named Nurse Child Protection (if appropriate) and Social Worker should be notified. The Community midwife and substance misuse midwife must ensure the hospital notes contain any child protection plans and minutes from MDT meetings including a birth plan.

The woman's Hep B, Hep C or HIV status must be recorded with consent on baby notes. If not checked (refused) this needs to be documented also

Women who are Hepatitis B and C positive should not have FBS samples taken or an FSE applied.

Continuous electronic fetal monitoring is required.

There may be placental insufficiency in pregnancies of drug using women, leading to increased risks of intrapartum hypoxia, foetal distress and meconium stained liquor.

Prescribed methadone (or other variants e.g. buprenorphine) should be continued at the current dose in labour and postnatally.

These women should not be given other opiates such as oromorph, codeine, pethidine or diamorphine/morphine unless deemed necessary by a Consultant.

Epidural/Spinal analgesia can be used.

NOTE: The midwife caring for the woman must contact the Community pharmacist and addictions key worker to inform them of her admission so outpatient prescriptions can be withheld for the duration of her admission. The community pharmacist will be able to advise if the patient has had their daily dose of opiate replacement therapy. The woman will know where she collects her prescription and switchboard have all the contact numbers.

This information will be available in the medical back up notes following 36 weeks MDT meeting.

If the woman has her own supply of methadone this should be taken from her and stored in the CD cupboard. A hospital Kardex should be written up for appropriate dosage.

CAUTION – Naloxone given to the neonate may precipitate acute withdrawal and is contraindicated.

7. Neonatal Care:

Please refer to Transitional care guideline No 6 Neonatal Abstinence Syndrome NAS

8. Postpartum Care:

Separation of mother and baby should only be done for legal or medical reasons. It is expected that mother and baby will be an inpatient for five days. This is to observe for neonatal withdrawal and mother should undertake all care of the baby.

Whilst on the postnatal ward the mother will be supported in looking after her baby and her parenting skills assessed.

9. Discharge Requirements:

There must be a discharge planning meeting for all women who misuse substances.

A discharge planning meeting **MUST** occur for all substance misuse women with or without safeguarding concerns. The ward midwife will inform the social worker of the pending discharge date. The social worker will then arrange a date for the meeting and invite all members of the MDT to attend.

The ward midwife must inform the following Key professionals;

- Community Midwife
- Specialist Consultant Obstetrician
- Named Nurse Child Protection
- Addictions Key Worker (CPN)
- Health Visitor
- Social Worker
- Antenatal high risk midwife
- G.P
- Neonatologist
- Anyone else involved in the patients care

Ward staff will dispense medication on day of discharge and will then ensure the addictions service and key worker has taken over prescribing and has a

prescription available at her local chemist for collection. The community pharmacist should also be notified of the patient's discharge and prescription details.

Note: It may not be advisable to discharge some of these patients over the weekend when limited support is available, however, a discharge planning meeting may have already been held and plans in place for discharge. Any urgent prescriptions written by the obstetric team must be clearly documented eg dose, pick up arrangements and communicated to the addictions worker on first working day. If a woman insists on being discharged home against advice then inform the duty safeguarding team if there are concerns and do not allow the baby to be taken from the hospital.

Methadone should be administered on day of discharge as normal. No doses must be given to the patient to take home.

A follow up appointment for 6 weeks postnatal at the antenatal substance misuse clinic should be made for all women who are on prescribed drugs at the time of discharge or are known to be still using illicit drugs or drinking alcohol at the time of delivery.

10. Contraception

Prior to discharge discuss contraception and sexual health needs of the woman. Suitable contraception should be administered. Nexplanon and Depo-provera can be given prior to discharge.

11. Community Midwifery Postnatal care

On transfer of care from hospital to community the midwife will attend the family the following day. Accurate and detailed record keeping of this home assessment is vital to support the family. Daily visiting schedule is required with all substance misusing women until handover to health visitor at Day 10. It is not appropriate for these women to attend a postnatal drop-in clinic as they have a higher rate of non-attendance and it may be difficult for her to access the clinic in a timely manner.

If the midwife is unable to access the property or contact the mother postnatally she must inform childrens social care and other members of the multi-disciplinary team to gain access to assess the mother and baby.

Handover of care to the health Visitor must be documented clearly in the notes, community midwife handover to health visitor letter completed and the mothers hand held notes retrieved from the home and filed in the hospital medical back up notes, this will occur between 10 postnatal days or may be up to 28 postnatal days following delivery depending on the needs of the family. The discharge letter from the hospital will include communication with the GP to continue providing on going care.

References

NICE (2010) Pregnancy & Complex Social factors. org.UK

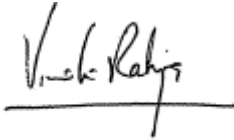
NICE (2007) Antenatal and Postnatal Mental Health. org.uk

DH (2010a) A smokefree future, DoH.otg.uk

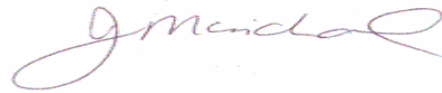
Cochrane review (2009) Routine pre-pregnancy health promotion for improving pregnancy outcomes, Whitworth and Dowswell (in evid based nursing 2010)

www.CMACE.otg.uk Saving Mothers Lives

Authorised by:



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Clinical Director



Miss J McNichol
Head of Midwifery

Appendix 1

Obstetric & Gynaecology Service

OBSTETRIC & GYNAECOLOGY SUBSTANCE MISUSE MDT

TERMS OF REFERENCE

1. Membership

Membership of this group includes:

- High risk midwife (Chair)
- Consultant Obstetrician
- Neonatal services
- Northumberland recovery Partnership
- Safeguarding lead midwife (Vice Chair)
- Community midwife
- Key addictions worker
- Social workers
- Health Visitor
- GP

2. Quorum

The group is quorate when 3 people, including Chair (or deputy) are present.

3. Accountability

The group is accountable to Trust Safeguarding Board

4. Terms of Reference

- 4.1 It is the responsibility of the high risk antenatal midwife to co-ordinate each meeting. The high risk midwife will ensure that all women to be discussed are placed on the agenda and that all parties involved with the woman are invited to attend to discuss each case.

- 4.2 The high risk midwife will ensure that addictions service receive a list of women to be discussed at each MDT.
- 4.3 The high risk midwife will confirm with antenatal clinic a list of women whose medical back up notes are required for discussion at the MDT.
- 4.4 The MDT is responsible for the coordination and seamless care of all women who misuse substances. To ensure that information is shared regularly and appropriately between all parties involved in the care of the woman.
- 4.5 The MDT will actively plan and coordinate care around the woman throughout pregnancy, delivery and postnatal discharge into the community.
- 4.6 There will be at a minimum 3 opportunities to discuss the family at 16 weeks, 28 weeks and 36 weeks pregnant where all partners will attend to update the care plan in time for birth. Additional meetings will be organised if concerns arise.
- 4.7 The Group will formally consider the findings from each discipline to support the family and develop a specific care plan for each woman which will be shared with each discipline involved in the patient care.
- 4.8 Following delivery all substance misuse women with or without child protection concerns will have a discharge planning meeting with all members of the MDT invited to attend to ensure seamless care into the community.

5. **Frequency/schedule of meetings**

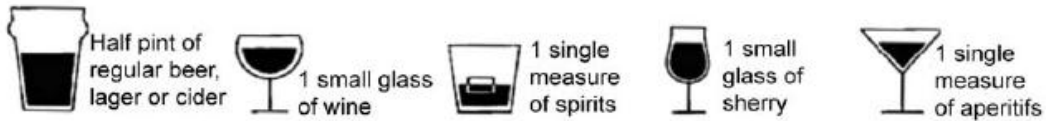
Monthly

7. **Review**

These terms of reference will be reviewed annually.

AUDIT – C

This is one unit of alcohol...



...and each of these is more than one unit



Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
						Your score
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
<p>Score from AUDIT- C</p> <p>Scoring:</p> <p>A total of 5+ indicates increasing or higher risk drinking.</p> <p>An overall total score of 5 or above is AUDIT-C positive.</p> <p>Proceed as per referral flowchart.</p>						



APPENDIX 3



MaternityNorthumbria

Antenatal PAS Booking Form

Low risk booking High risk booking Home Delivery Consultant booking appointment needed
Consultant appointment within 2 weeks of booking due to high risk of VTE Smoking Scan clinic
Which hospital attending Consultant appointment: ALN BER HGH NTGH WGH Other
Which hospital attending USS: ALN BER HGH NTGH WGH Other
HOSPITAL FOR DELIVERY: ALN BER HGH NTGH WGH Other

Patient Details: NHS No.: Surname: Forenames: Address: Postcode: Date of Birth: Telephone No: Mobile:
GP Details: GP: Address: Postcode: Practice Midwife:
Current Body Mass Index: Height (cm): Weight (kg): BMI:
Downs Syndrome Screening: Yes / No / Undecided
Next of Kin: Name: Address: Telephone No.:
Ethnicity and Language: Religion: Ethnic Category code (as defined by client) Interpreter required Yes / No Language:
Current Medication: Drug Name: Dosage: Indication: Drug name: Dosage: Indication:
Gestation at booking: Parity: Date booking referred: LMP: EDD: Unknown:
Over 12 weeks reason: New to area Late presentation Miscalculation of LMP No appointment available Other

HIGH RISK FACTORS:

Current Factors: N/A Maternal age <16 Maternal age >40 Maternal weight (BMI >=35, <18) Learning disabilities Physical disabilities Substance misuse Alcohol misuse Do you drink alcohol in pregnancy If yes, brief intervention / advice given
Medical Factors: N/A Diagnostic BP >90mmHg at booking HIV Rhesus Isoimmunisation Clotting disorder / Thrombophilia Inherited disorder Epilepsy Neurology Sexual health problems Anaesthetic problems Smoker
Medical History: N/A Renal disease Diabetes / Endocrine disorder Cardiac disease Haematological disorder Cancer Thromboembolic disorder Autoimmune disease Mental health problems Hepatitis B Hepatitis C Hypertension Respiratory disease

Current Pregnancy: N/A Multiple pregnancy Musculoskeletal / pelvic pain Previous LLETZ or cone biopsy Other (all antibodies, proteinuria ++, low placenta >32 weeks)
Previous Obstetric History: N/A Eclampsia Severe pre-eclampsia Fetal loss (12-24 weeks) HELLP Puerperal psychosis Intrauterine growth Preterm delivery (< 34 weeks) Placental Accreta Low weight baby (<2.8kg from 37 weeks onwards) High weight baby (> 4.5kg) Previous fetal abnormality Previous fetal abnormality req. specialist fetal medicine 3+ consecutive miscarriages Stillbirth Neonatal death Difficult delivery Previous uterine surgery

Complex Social Factors: Homeless Domestic abuse Adult safeguarding issues Recent migrant (last 12 months) Unable to speak English Child protection concerns Refugee / asylum seeker Unable to understand English

Comments:
Signed (Booking Midwife): Print Name: Form Date:

Post to ANC or Fax: NTGH (0191) 293 2594. HGH (01434) 65347. WGH (01670) 564143.
Top copy to ANC at local hospital. Second copy retain in hand held notes.
Third copy to GP / HV.
Date entered on to database: Signature:

LP44228 - v4

Antenatal Clinic
Wansbeck General Hospital
Woodhorn Lane
Ashington
NE63 9JJ
Fax: 01670 564143

Dear

.....is pregnant and being seen within our Antenatal Services due to a history of substance misuse.

They will be discussed within our Multi-Disciplinary Team meeting on:

Date:

Time:

Venue:

You are invited to attend. If you are unable to attend, then please can you provide any relevant information your agency may hold regarding this woman at least 24 hours prior to the meeting. A template is enclosed which can be completed and returned to the above address.

Kind Regards

Sign:

Print:

Date:

Copies:

High Risk Midwife

Safeguarding Midwife

Information shared from

.....
.....

.....

.....

(Please include agency name and address here)

Relevant Medical Information: (i.e. medical conditions, current prescriptions or agencies that are working with the woman)

Relevant Safeguarding Information:

Sign:

Print:

Date:

Attach Patient ID Label

Substance Misuse MDT Pregnancy Care Plan

<p>Mother's Name:</p> <p>Date of Birth:</p> <p>Address:</p> <p>Telephone Numbers:</p> <p>Hospital No: NHS No:</p> <p>EDD: Parity:</p>	<p>Partner's Name:</p> <p>Father of Unborn(if different to above):</p> <p>Date of Birth:</p> <p>Address:</p> <p>Telephone Numbers:</p> <p>Addictions Services Key Worker (if applicable):</p> <p>Any Involvement with Other Agencies:</p>
<p>Professionals involved in woman's care and contact telephone number</p>	
<p>GP Surgery:</p> <p>Tel:</p> <p>Community Midwife: Tel:</p> <p>Health Visitor: Tel:</p> <p>Maternity Unit: (Antenatal Care and Delivery) Tel:</p> <p>Consultant Obstetrician:</p> <p>Addictions Consultant:</p>	<p>High Risk Midwife: Tel:</p> <p>Addictions Services Key Worker: Tel:</p> <p>Social Worker or District Office: Tel:</p> <p>Date of Referral to Children's Services:</p> <p>Any other professional involved with the woman or family (i.e. CPN/FNP) and their contact no:</p>

Substance Use in the last 12 Months: Client				
Drugs: (please highlight those used where drugs are grouped together)	Prescribed or Illicit	Last Used	Current Amount	Route
Amphetamine				
Cannabis				
Heroin				
Opiates (e.g. Morphine, Codeine, Tramadol)				
Temazepam/Diazepam				
Buprenorphine				
Methadone				
Alcohol -/AUDIT Score				
Smoking – Tobacco or e-cigarette				
Pegablin/Gabapentin				
Cathinones/Cocaine/Crack/Ecstasy/Ketamine/LSD/Magic Mushrooms				
Amyl/Buty/Nitrate				
New Psychoactive Substances (e.g. EBL/GHB/Nitrous Oxide/Piperazines(BZP)/Spice)				
Any other substance recently used example slimming tablets and caffeine energy drinks				
Any other prescribed tablets				

Prescription details at booking from all agencies currently involved with the woman (NTW and Obstetrics)

Mother

	YES	NO	Further Information
History of police/probation/youth offender team involvement or any violent history			

Any social care involvement i.e. child protection or child in need			
Mental Health Issues including her family history regarding Mental Health			
Any other relevant information			

Partner/ Father or Unborn

	YES	NO	Further Information
Substance Misuse; is the partner misusing any substances			
Any Alcohol			

History of police/probation/youth offender team involvement or any violent history			
Any child protection issues			
Mental Health Issues			
Any other relevant information			

Any Children of the Mother and/or Partner

Child's Name (identify if different father to current partner)	Date of Birth	Where they live	Who has Parental Responsibility

16 Weeks Multi-Disciplinary Team Meeting

Date:

Attendees and Apologies:

Current Concerns/Risks Identified by MDT: (attendance/DNA's/illicit misuse/child protection)

Prescription Details at 16 Weeks:

Plan of Care and Professional Responsible:

E3 updated:

Next MDT Meeting Date:

Care Plan to be shared within 5 working days to all agencies/professionals involved with woman's care:

28 Weeks Multi-Disciplinary Team Meeting

Date:

Attendees and Apologies:

Current Concerns/Risks Identified by MDT: (attendance/DNA's/illicit misuse/child protection)

Prescription Details at 28 Weeks:

Plan of Care and Professional Responsible:

E3 updated:

Next MDT Meeting Date:

Care Plan to be shared within 5 working days to all agencies/professionals involved with woman's care:

36 Weeks Multi-Disciplinary Team Meeting

Date:

Attendees and Apologies:

Current Concerns/Risks Identified by MDT: (attendance/DNA's/illicit misuse/child protection)

Prescription Details at 36 Weeks:

Is there a Birth Plan in place and outline plan. Pre-discharge template must be completed at the pre-discharge meeting:

Plan of Care and Professional Responsible:

E3 updated:

Next MDT Meeting Date:

Care Plan to be shared within 5 working days to all agencies/professionals involved with woman's care:

Name, D.O.B, discharge address of baby:-

Date of pre-discharge meeting and those in attendance:-

Has safe sleeping been discussed with parents/carers and information provided?

Provision of basic care: (Any health concerns for mother or baby, feeding & any concerns around this, are cares being carried out safely, is there emotional warmth)

Family: (Is partner present, supportive, controlling, any concerns, what family and friend support has there been)

Concerns & Risk: Any concerns observed, highlighted, documented, what you may be worried about)

Discharge plan for baby: Note professional's plan of care and visiting pattern for baby once discharged. Parents/carers and professionals all to be aware of the vulnerability of baby when drawing up a plan of care.

Date of next core group or care team meeting:

Additional Substance Misuse MDT Pregnancy Care Plan

Multi-Disciplinary Team Meeting

Date:

Attendees and Apologies:

Current Concerns/Risks Identified by MDT: (attendance/DNA's/illicit misuse/child protection)

Prescription Details:

Is there a Birth Plan in place and outline plan:

Plan of Care and Professional Responsible:

E3 updated:

Next MDT Meeting Date:

Care Plan to be shared within 5 working days to all agencies/professionals involved with woman's care:

COMMON PRINCIPLES

1. Professionals delivering care will have appropriate skills and knowledge to deal with substance misuse in pregnancy.
2. There must be a Multi-Disciplinary Team (MDT) approach to the management of high risk pregnancies involving substance misuse.
3. Pregnant women with substance misuse problems must receive the same quality of care, respect and dignity as presumed by any other woman.
4. There will be a clear understanding of professional roles and responsibilities to ensure quality of care throughout the Pathway.
5. There will be a single plan of care agreed by the multi-disciplinary team.
6. The addiction service will undertake an assessment and following this will become the main prescriber throughout the pregnancy and following the birth with regard to substance misuse related treatment
7. The addictions service will communicate with other agencies which drugs they intend to prescribe and which drugs will be prescribed by other agencies for example GP/ Obstetrician.
8. The safety of the child will be paramount.
9. There will be effective communication and integrated working between the following:
 - Addictions service,
 - NHCFT's midwifery service including the maternity ante-natal substance misuse service.
 - GP.
 - GPWSI (GP with Special Interest).
 - Neonatologist where involved.
10. All agencies will have an understanding of Neonatal Abstinence Syndrome (NAS) and the risks in relation to the administration and storage of Oromorph (morphine) medication.
11. A birth plan will ALWAYS be drawn up for child protection, child in need cases

ANTE NATAL PRINCIPLES:

The common principles (see above) in addition to the following:

1. There must be early identification of high risk pregnancies and referral to specialist services, as per referral pathway.
2. All pregnant women will be offered a named doctor and midwife.
3. A birth plan will always be drawn-up and this will be the responsibility of the community midwife and key social worker as per the agreed North of Tyne protocol (LSCB Safeguarding policies and procedures).
4. Prior to all admissions of the pregnant woman for titration, there must be discussion and agreement between NHCFT antenatal substance misuse service and the addictions service.

ON ADMISSION PRINCIPLES:

The common principles (see above) in addition to the following:

1. The inpatient maternity team must notify the MDT as per the birth plan including the pharmacist for the pregnant woman

POST NATAL PERIOD PRINCIPLES:

The common principles (see above) in addition to the following:

1. There must be a pre-discharge planning meeting.
2. There will be a robust safe plan for discharge. This must include:
 - An assessment and evaluation of risks and safety measures regarding mother / parents taking baby home with the responsibility to administer Oromorph and store safely.
 - The Neonatologists must always be included in the risk assessment.
 - The plan must clearly document the arrangements for treatment and prescribing with regard to mother's substance misuse.
3. All services must be notified verbally by the hospital midwife of the discharge date as soon as agreed and ensure a written is provided.
4. Following discharge, the community midwife will be the key worker and must undertake daily visits to support and monitor mother and baby.
5. At the point of transfer of care the community midwife must provide a verbal and written handover of care to the named health visitor for ongoing support and monitoring visits.