St. Joseph Health
St. Joseph Hospital

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Owner:	*Corrinne Volta: Dir, Nursing*
Policy Area:	*Childbirth Center*
References:	
Applicability:	*CA - St. Joseph Hospital - Eureka*

Care of the Opiate Exposed Infant- Eat, Sleep, Console Method

PURPOSE:

To outline the nursing responsibilities and management of the opiate exposed Infant, while using a comprehensive family-centered non-pharmacologic care approach.

POLICY:

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Neonatal Abstinence Syndrome (NAS) secondary to in-utero opioid exposure has increased 5-fold in the United States between 2000 and 2012 and now affects 5 per 1000 live births nationally. NAS typically refers to an opioid withdrawal syndrome characterized by behavioral dysregulation that occurs within 2-3 days of birth for infants exposed chronically to opioids in-utero. Signs and symptoms include altered sleep, high muscle tone, tremors, irritability, poor feeding, vomiting and diarrhea, sweating, tachypnea, fevers, and other autonomic nervous system disturbances. All opioids can cause withdrawal symptoms, including methadone, buprenorphine (Subutex, Suboxone), and short-acting agents such as oxycodone, heroin, and fentanyl, but the severity of these symptoms vary greatly. All infants should be treated first with non-pharmacologic (non-pharm) care. Some infants may also receive replacement opioids. All opioid-exposed infants should be monitored in the hospital for 4-7 days for signs of withdrawal that may require pharmacologic treatment according to the American Academy of Pediatrics. Without medication, symptoms typically resolve within 1-2 weeks. Withdrawal can also occur after in-utero exposure to non-opioid agents such as benzodiazepines, selective serotonin re-uptake inhibitors (SSRIs), and nicotine.

ASSESSMENT:

A. Complete physical exam with special consideration to birth weight, length, and head circumference. Each parameter may be lower than unexposed infants of the same gestational age.Obtain a complete maternal substance use history to ensure proper monitoring and pharmacologic treatment if needed. History should include: dose of medications or substances used, prescribed or illicit

B. Document time last dose taken or used.

C. Send urine toxicology screen.

D. Determine risk for HIV, Hep B, Hep C, HSV, CMV, Syphilis, Chlamydia, and GC. This may include maternal prenatal screening and/or testing the infant post-delivery.

E. Complete Newborn Risk summary. Contact Social Worker. The social worker will complete appropriate

DHHS notifications. If Social Worker unavailable RN will need to make appropriate referrals

EAT, SLEEP, CONSOLE ASSESSMENTS:

A. Eat, Sleep, Console (ESC) care assessments should be performed every 4 hours at the time of other routine infant care, such as with feedings and vital signs. Assessments should be initiated within 4-6 hours of birth, and should continue for 4-7 days for infants exposed to Opioids. Assessments should reflect the entire 3-4 hour interval since the last ESC assessment, and should incorporate input from all infant caregivers (mother/other parent, nurse) who interacted with the infant during this time period.

B. Infants should be assessed in their own room and do not need to be removed from their mother (or other parent/caregiver). Recommend use the Newborn Care Diary to keep track of their infant's ESC behaviors and for staff to incorporate these observations into the ESC assessment. ESC assessments should be documented on the ESC flow sheet on paper or in the electronic medical record.

C. Interventions should first be initiated and documented in the medical record prior to considering pharmacologic treatment. Non-pharmacological care significantly reduces an infant's likelihood of needing pharmacologic treatment and reduces pharmacologic treatment duration. We encourage a consistent approach to non-pharm care focusing on the parent as the primary caregiver. Non-pharm care interventions should be reviewed with families prenatally and in the newborn setting, in addition to the Consoling Support Interventions (CSI).

NON-PHARM CARE:

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A. Rooming-in with parent throughout the hospital stay

B. Ensuring parental presence at the bedside as often as possible during the hospital stay

C. Encouraging skin-to-skin contact

D. Encouraging holding / gentle rocking / swaying by a caregiver

E. Swaddling / flexed positioning

F. Ensuring optimal feeding quality including encouraging breastfeeding for mothers without concerns for continued concerning substance use or other medical contraindication (e.g., HIV)

G. Non-nutritive sucking with pacifier or finger (ensuring baby is well fed first)

H. Ensuring a quiet environment with low light stimulation in the room Limiting visitors to one at a time (and to those that will be quiet / supportive)

I. Providing uninterrupted periods of sleep / clustering infant's care

BREASTFEEDING AND NEONATAL ABSTINENCE SYNDROME:

A. The AAP Committee on Drugs list methadone and buprenorphine as maternal medications compatible with breastfeeding. However, breastfeeding is not recommended for mothers using illicit drugs or multiple drugs and should be made on a case by case basis. If Breastfeeding, consult lactation within the first 24 hours. If there are signs of withdrawal or an increased caloric requirement consider a higher calorie formula or breast milk fortification.

ECS DEFINITIONS (SCORE EVERY 3 TO 4 HOURS):

A. **EATING:**The first component of the ESC Care Tool is infant feeding:

1. **POOR FEEDING:**
    a. Baby is unable to coordinate feeding within 10 minutes of showing hunger cues AND/OR is unable to sustain feeding for 10 minutes at breast or is unable to eat amount appropriate for age by finger, cup, SNS, or bottle due to NAS symptoms (e.g., fussiness, tremors, uncoordinated or excessive suck).
        i. Special Note: Do not indicate "Yes" for poor eating if it is clearly due to non-NAS related factors (e.g., prematurity, transitional sleepiness or spittiness in the first 24 hours of life, or inability to latch due to infant / maternal anatomical factors). If it is not clear if the poor feeding is due to NAS, indicate "Yes" on the flow sheet and continue to monitor the infant closely while optimizing all non-pharm interventions.
    b. Frequent feedings. Refrain, if possible, from waking between feedings.
    c. If there are signs of withdrawal or an increased caloric requirement consider a higher calorie formula or breast milk fortification.
2. **OPTIMAL FEEDING:**
    a. Feeds are cue based, feeds until content, no limit placed on duration or volume of feeding.
    b. Breastfeeding: Baby latching deeply with comfortable latch for mother, and sustained active suckling for baby with only brief pauses noted. Lactation consult to assist directly with breastfeeding to achieve more optimal latch/position.
    c. Bottle feeding: Baby effectively coordinating suck and swallow without gagging or excessive spitting up; modify position of bottle or flow of nipple if any concerns.

B. **SLEEPING:**
1. **Sleeps < 1 hour due to NAS:**
    a. Baby unable to sleep for more than an hour after feeding due to NAS symptoms (e.g., fussiness, restlessness, increased startle, tremors).
        i. Special Note: Do not indicate "Yes" if sleep < 1 hour is clearly due to non-NAS related factors (e.g., physiologic cluster feeding, interruptions in sleep for routine newborn testing, symptoms in first day likely due to nicotine or SSRI withdrawal).
    b. If it is not clear if sleep < 1 hour is due to NAS, indicate "Yes" on the flow sheet and continue to monitor the infant closely while optimizing all non-pharm interventions.

C. **CONSOLING:** *The final symptom component of the ESC Care Tool is infant consoling: Is the infant unable to be consoled within 10 minutes due to NAS – Yes/No?*
1. **Unable to console within 10 minutes due to NAS:**
2. Baby unable to be consoled within 10 minutes by infant caregiver effectively providing recommended Consoling Support Interventions.
    a. Special Note: Do not indicate "Yes" if infant's inability to be consoled is due to infant hunger, difficulty feeding or other non NAS sources of discomfort. If it is unclear if the inability to console within 10 minutes is due to NAS, please indicate "Yes" and continue to monitor the infant closely while optimizing all non-pharm interventions.

CONSOLING SUPPORT INTERVENTIONS (CSIs):

A. Caregiver begins softly and slowly talking to infant and uses his/her voice to calm infant.

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B. Caregiver looks for hand-to-mouth movements and facilitates by gently bringing infant's hand to mouth.

C. Caregiver continues talking to infant and places care giver's hand firmly but gently on infant's abdomen.

D. Caregiver continues softly talking to infant bringing baby's arms and legs to the center of body.

E. Picks up infant, holds skin-to-skin or swaddled in a blanket, and gently rocks or sways infant.

F. Offers a finger or pacifier for infant to suck, or a feeding if infant showing hunger cues.

SOOTHING SUPPORT USED TO CONSOLE INFANT IS SCORED USING A 1-3 SCALE:

A. Soothes with little support:

1. Consistently self-soothes or is easily soothed with one of first 4 CSIs above.

B. Soothes with some support:

1. Soothes fairly easily with: skin-to-skin contact, being held clothed or swaddled, rocking or swaying, sucking on finger or pacifier, or feeding.

C. Soothes with maximum support or does not soothe in 10 minutes:

1. Has difficulty responding to all caregiver efforts to help infant stop crying OR does not soothe within 10 minutes, never self-soothes.

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EVALUATION OF ESC SCORE:

A. A Team Huddle is recommended if the infant has a "Yes" response to any ESC item OR if the infant consistently receives "3s" for "Soothing Support Used to Console Infant". Just one "Yes" is sufficient to consider a Team Huddle. The Team Huddle, at minimum, should include the baby's mother/parent if possible and bedside nurse. If the infant scores "Yes" on any ESC item more than once despite optimal non-pharm care OR other significant concerns are present, the Team Huddle should include the mother/parent if possible, the bedside nurse, AND physician. Include social worker as needed to facilitate parental presence / engagement.

1. **The Team Huddle should include discussion of:**

   a. Ways to further optimize non-pharm care including ensuring the presence of a caregiver.

   b. Infant's response to and efficacy of Consoling Support Interventions implemented.

   c. Efforts to improve feeding (when needed)

   d. Assessment of the infant's environment. All efforts should be made to encourage the parent or other caregiver to be present at all times to provide comfort measures for the infant. If non-pharm care has been optimized and infant continues to have poor eating, sleeping, or consoling, then medication treatment should be considered.

MORPHINE INITIATION ON MOTHER-BABY UNIT (ROOMING IN, NON-MONITORED)

Consider initiating oral morphine after a full team huddle if:

A. Continues with "Yes" to any ESC item or "3s" for "Consoling Support" AND

1. Non-pharmacological care optimized to greatest extent AND
2. Non-NAS causes excluded (e.g., cluster feeding, SSRI, nicotine withdrawal in first 24 hours)

B. Starting dose of neonatal morphine oral solution on Mother–Baby unit remains in room with mother (no monitors)
   1. 0.05 mg Q 3hrs PO x 2 doses
   2. Reassess ESC every 3-4 hours to determine if infant requires scheduled Morphine dosing as below:
   3. 2 doses maximum to be given on mother baby unit.

C. If a full team huddle (parent/caregiver, RN and MD) determines the infant:
   1. Continues with "Yes" to any Esc item or "3s" for "Soothing Support" AND
   2. Non-pharmacological care optimized to greatest extent AND
   3. Non-NAS causes excluded (e.g., cluster feeding, SSRI, nicotine withdrawal in first 24 hours)

D. 2 rescue doses of Morphine (as above) have been given while rooming in with mother/caregiver.

E. Contact Pediatrician for transfer to the NICU for scheduled Morphine dosing.

MORPHINE NICU DOSING (per provider order)

A. Admit to NICU with continuous oximetry monitoring

B. Administer Morphine 0.05mg/kg Q3hrs. Continue to use ESC non-pharm soothing methods and scoring tool Q3hrs.

C. Begin weaning after 8 doses or 24hrs.

D. Wean by Morphine 0.04mg every 24hrs using ESC non pharm support and ESC scoring tool as weaning guide.

E. Discontinue Morphine when dose has weaned to 0.01mg/kg

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REPLACES:

Care of the Opiate Exposed Infant

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Dan Kelly: Interim Chief Nursing Officer	7/13/2019
	Deepak Stokes, MD: CBC/NICU Physician [AS]	7/11/2019
	Karen Lewis: Area Director of Nursing	7/10/2019

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