NEONATAL ABSTINENCE SYNDROME (NAS) CLINICAL PRACTICE GUIDELINES

Revised: November 25, 2016

Please note that this guideline is for information purposes only. These recommendations reflect the information available as of the date it was issued/revised. Please use your own clinical judgment when applying any management strategies documented in this resource.

SUMMARY OF CLINICAL PRACTICE RECOMMENDATIONS

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NAS Maternal Guidelines: Antenatal, Intrapartum and Postpartum Care	
1	Health care providers should routinely screen all pregnant women for use of opioids and other licit and illicit substances.
2	Every pregnant opioid using woman should be offered comprehensive care, including obstetrical care, addiction care, community care, and psychosocial counselling and support.
3	Every pregnant opioid using woman and her partner and family should receive written material explaining NAS, hospital stay expectations, the role of the parent, and resource contacts, in order to prepare and educate the opioid using woman and her support persons.
4	Methadone Maintenance Treatment (MMT) is the standard of care for the management of opioid use disorders in women during pregnancy.
5	Buprenorphine Maintenance Treatment (BMT) may be considered as an alternative to methadone for the management of opioid use disorders in women during pregnancy.
6	If methadone or buprenorphine are not available, other sustained-release preparations may be considered for the management of opioid use disorders in pregnancy.
7	Referral to Child Protection Services (CPS) should be considered on a case-by-case basis.
8	During labour and delivery, the pregnant woman should continue to take her daily dose of opioid agonist treatment to avoid withdrawal.
9	Additional pain management (i.e. analgesia) may be required for women on opioid agonist treatment.
10	Narcotic antagonists (e.g. Naloxone, Nubain) should be avoided as they are contraindicated for women with opioid use disorder.
11	Implement a partnership plan that focuses on all aspects of infant care, including feeding, handling, skin- to-skin care, rooming-in, and the frequency of follow-up visits after the mother is discharged, in order to enhance communication between care providers and parents, and to support the parents' involvement in the care of their infant.

NAS Neonatal Guidelines: Newborn Screening and Assessment	
12	Identification of infants with NAS should be based on the mother's antenatal history and the care provider's clinical assessment/ suspicion.
13	A Standardized NAS Scoring Tool is recommended to assess suspected or known cases of in utero opioid exposure: a) In cases of exposure to short-acting preparations of opioids, infants should be scored for a minimum of 72 hours. b) In cases of exposure to sustained-release preparations of opioids, infants should be observed for 120 hours, since onset of withdrawal may be delayed. *(Follow-up can occur in hospital for the first 72 hours, with close follow-up in the community for the next 48 hours. If close follow-up in the community is not possible, then the infant should remain in the hospital for the entirety of the observation period.)* c) Infants should be scored with each care interaction, typically every 2-4 hours.
14	Mother-baby dyad care, including rooming-in or care-by-parent, should be promoted.
NAS Neonatal Guidelines: Newborn Treatment • *Non-pharmacological interventions should be utilized for all infants with NAS.* • *Pharmacological interventions should be considered for the treatment of NAS when non-pharmacological measures fail to adequately ameliorate the signs of withdrawal.* ○ *Medication is indicated when 3 consecutive scores are ≥8 on the Standardized NAS Scoring Tool or when the average of 2 scores or the scores for 2 consecutive intervals is ≥12.*	
15	The baby's environment should be modified to reduce sensory stimulation, including limiting visitors, minimizing overhead lighting, and decreasing noise.
16	Soothing behaviours, positional support, swaddling, gentle handling, kangaroo care, and frequent, hypercaloric, smaller volume feedings are beneficial and should be considered in the treatment of newborns with NAS, both in the hospital and the home environment.
17	Breastfeeding should be recommended and supported in methadone/ buprenorphine-maintained mothers, assuming absence of absolute contraindications.
18	Preventive skin care should be initiated at birth to prevent excoriation.
19	Cardio-respiratory monitoring is recommended for all infants started on morphine and continued for 4 days and/or until the dose is reduced. Further monitoring should then be at the discretion of the physician in charge.
20	Morphine should be considered the first line pharmacological treatment of NAS when supportive measures fail to adequately ameliorate the signs of withdrawal.
21	Infants whose signs of withdrawal are difficult to control on morphine may require an additional medication such as clonidine or phenobarbital.
NAS Discharge Planning Guidelines	
22	A primary health care provider who is comfortable following a baby with NAS should be confirmed prior to discharge.
23	Discharging the infant home on morphine should only be undertaken if the clinical team is confident that the social risk is low, the infant is stable, there is a clear and comprehensive plan for weaning the infant, and a designated supervisor of that plan is identified, who will follow the infant with, at minimum, a weekly visit. Following consultation with the clinical team, the final decision to discharge an infant on pharmacological treatment is at the discretion of the physician.
24	Every baby exposed to opioid agonists and other substances should be offered ongoing developmental assessments by a clinical expert.