Written Case 3 Rating Key

- 40-week healthy baby boy born by c-section after failure to progress.
- Mom is 31 years old, in buprenorphine treatment for 3 years, doing well in recovery. Mom on Zoloft for depression. No other medication or substance exposure present.
- All assessments being performed every 3 hours.

Day of Life (DOL) 1

- Baby has problems staying latched. Does not seem interested in feeding increased tone and difficulty sleeping for more than one hour due to tremors when disturbed.
- Since last assessment, taking ~15 minutes to calm with swaddling and holding. Being passed around between both grandparents (very excited about baby's birth today). They talk a little loudly due to hearing problems. One family member holding baby at all times; baby swaddled in blanket.

DOL 2

- Mom on her own keeping baby with her in a calm and quiet room. Dad now at work and grandparents left per staff recommendations. Baby no longer spitting up.
- RN performed vital signs, ESC assessment, and exam 4 hours after last assessment. Vital signs and exam within normal limits, including tone and reflexes.
- Baby awoke approximately 3 hours after last assessment and was very fussy but able to calm after a few minutes of STS contact. He was able to latch within a few minutes and breastfed well for 20 minutes. Mom swaddled baby using RN tips from DOL 1.
- Baby slept for approx. 3 hours in bassinet after feeding. Mom able to get a nap in also.

DOL 3

- Mom waking baby every 2 hours after placing baby STS and doing breast massage/hand expression as recommended.
- On last assessment 3 hours ago, baby took approximately 5-7 min to latch on but then able to bf well x 10 min. Baby noted to have tremors when disturbed, increased tone, and difficulties sleeping for more than 30 min due to increased startle with any noise or movement. Taking 15-20 min to console despite parents' and LNA's best efforts.
- Parents calm but a little stressed about how baby is feeling. Baby now having undisturbed tremors, crying lots, and having a harder time consoling.
- Continuously rooming-in, in a calm room. No visitors, holding baby STS all the time, except when swaddled effectively and safely for sleep in bassinet. Using gentle jiggling movements. Parents taking turns napping/going for walks while other parent cares for baby but still getting tired. No one else can cuddle baby (including staff/cuddler).
- On this assessment, baby taking 20 minutes to calm despite parents' (and lactation consultant's) best efforts. Baby unable to latch within 30 minutes of mom trying. Only able to stay latched on for 5 min due to excessive rooting and tremors. Mom STS with baby for last few hours, offering a breastfeed every 1.5-2 hours to avoid him getting too hungry. Lactation consultant using colostrum on finger to help calm baby and organize suck prior to helping mom latch baby. Baby did not sleep in last 3 hours – startling lots.

Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment	Day 1	Day 2	Day 3
NOWS/NAS ASSESSMENT			
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	Y		
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	N		
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	Y		
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	N		
EATING			
Takes > 10 min to coordinate feeding *or* **breastfeeds < 10 min** *or* **feeds < 10 mL** (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** *Day 1: Spitty from c-sxn, sx of w/d are from Prozac*	N		
SLEEPING			
Sleeps < 1 hr due to NOWS/NAS? *Day 1: Tremors, difficulty sleeping are from Prozac*	N		
CONSOLING			
Takes > 10 min to console (*or* **cannot stay consoled for** *at least* **10 min) due to NOWS/NAS?** *Day 1 – Prozac w/d, GPs too loud*	N		
Consoling Support Needed **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	3		
CARE PLAN			
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? Yes / No	Y		
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed? Yes / No	N		
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea)) – please list medication(s) initiated **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	a		
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT			
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	>3		
NON-PHARM CARE INTERVENTIONS (I = Increase Now, **R** = Reinforce, **E** = Educate for Future, **NA** = Not Applicable/Available)			
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	R		
Parent/caregiver presence to help calm and care for infant	R		
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	R/I		
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	R		
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	R/E		
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	I		
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger – *Day 1: NA as baby spitty*	NA		
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	I		
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	I		
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member) – *Day 3: Consider RN expert help*	R/E		
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	I		
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	E		
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	E		
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	I		

Rating Key DOL 1

Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment	Day 1	Day 2	Day 3
NOWS/NAS ASSESSMENT			
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	Y		
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	N		
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	Y		
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	N		
EATING			
Takes > 10 min to coordinate feeding *or* breastfeeds < 10 min *or* feeds < 10 mL (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** *Day 1: Spitty from c-sxn, sx of w/d are from Prozac*	N		
SLEEPING			
Sleeps < 1 hr due to NOWS/NAS? *Day 1: Tremors, difficulty sleeping are from Prozac*	N		
CONSOLING			
Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) due to NOWS/NAS? *Day 1 – Prozac w/d, GPs too loud*	N		
Consoling Support Needed **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	3		
CARE PLAN			
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? Yes / No	Y		
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed? Yes / No	N		
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea)) – please list medication(s) initiated **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	a		
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT			
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	>3		
NON-PHARM CARE INTERVENTIONS (I = Increase Now, **R** = Reinforce, **E** = Educate for Future, **NA** = Not Applicable/Available)			
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	R		
Parent/caregiver presence to help calm and care for infant	R		
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	R/I		
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	R		
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	R/E		
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	I		
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger – *Day 1: NA as baby spitty*	NA		
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	I		
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	I		
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member) – *Day 3: Consider RN expert help*	R/E		
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	I		
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	E		
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	E		
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	I		

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DOL 2

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DOL 3

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- Parents calm but a little stressed about how baby is feeling. Baby now having undisturbed tremors, crying lots, and having a harder time consoling.
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Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment	Day 1	Day 2	Day 3
NOWS/NAS ASSESSMENT			
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	Y	N	
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	N		
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	Y		
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	N	N	
EATING			
Takes > 10 min to coordinate feeding *or* **breastfeeds < 10 min** *or* **feeds < 10 mL** (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** *Day 1: Spitty from c-sxn, sx of w/d are from Prozac*	N	N	
SLEEPING			
Sleeps < 1 hr due to NOWS/NAS? *Day 1: Tremors, difficulty sleeping are from Prozac*	N	N	
CONSOLING			
Takes > 10 min to console (*or* **cannot stay consoled for** *at least* **10 min) due to NOWS/NAS?** *Day 1 – Prozac w/d, GPs too loud*	N	N	
Consoling Support Needed **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	3	2	
CARE PLAN			
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? Yes / No	Y	N	
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed? Yes / No	N	N	
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea)) – please list medication(s) initiated **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	a	a	
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT			
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	>3	>3	
NON-PHARM CARE INTERVENTIONS (I = Increase Now, **R** = Reinforce, **E** = Educate for Future, **NA** = Not Applicable/Available)			
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	R	R	
Parent/caregiver presence to help calm and care for infant	R	R	
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	R/I	R/I	
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	R	E	
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	R/E	R	
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	I	R/I	
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger – *Day 1: NA as baby spitty*	NA	E	
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	I	R	
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	I	E	
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member) – *Day 3: Consider RN expert help*	R/E	I	
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	I	R/E	
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	E	E	
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	E	R/E	
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	I	R/I	

Rating Key DOL 2

Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment	Day 1	Day 2	Day 3
NOWS/NAS ASSESSMENT			
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	Y	N	
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	N		
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	Y		
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	N	N	
EATING			
Takes > 10 min to coordinate feeding *or* breastfeeds < 10 min *or* feeds < 10 mL (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** ***Day 1: Spitty from c-sxn, sx of w/d are from Prozac***	N	N	
SLEEPING			
Sleeps < 1 hr due to NOWS/NAS? ***Day 1: Tremors, difficulty sleeping are from Prozac***	N	N	
CONSOLING			
Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) due to NOWS/NAS? ***Day 1 – Prozac w/d, GPs too loud***	N	N	
Consoling Support Needed **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	3	2	
CARE PLAN			
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? Yes / No	Y	N	
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed? Yes / No	N	N	
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea)) – please list medication(s) initiated **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	a	a	
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT			
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	>3	>3	
NON-PHARM CARE INTERVENTIONS (I = Increase Now, **R** = Reinforce, **E** = Educate for Future, **NA** = Not Applicable/Available)			
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	R	R	
Parent/caregiver presence to help calm and care for infant	R	R	
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	R/I	R/I	
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	R	E	
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	R/E	R	
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	I	R/I	
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger – ***Day 1: NA as baby spitty***	NA	E	
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	I	R	
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	I	E	
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member) – ***Day 3: Consider RN expert help***	R/E	I	
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	I	R/E	
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	E	E	
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	E	R/E	
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	I	R/I	

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DOL 2

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- Baby slept for approx. 3 hours in bassinet after feeding. Mom also able to nap.

DOL 3

- Mom waking baby every 2 hours after placing baby STS and doing breast massage/hand expression as recommended.
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Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment	Day 1	Day 2	Day 3
NOWS/NAS ASSESSMENT			
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	Y	N	Y
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	N		Y
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	Y		N
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	N	N	Y
EATING			
Takes > 10 min to coordinate feeding *or* **breastfeeds < 10 min** *or* **feeds < 10 mL** (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** *Day 1: Spitty from c-sxn, sx of w/d are from Prozac*	N	N	Y
SLEEPING			
Sleeps < 1 hr due to NOWS/NAS? *Day 1: Tremors, difficulty sleeping are from Prozac*	N	N	Y
CONSOLING			
Takes > 10 min to console (*or* **cannot stay consoled for** *at least* **10 min) due to NOWS/NAS?** *Day 1 – Prozac w/d, GPs too loud*	N	N	Y
Consoling Support Needed **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	3	2	3
CARE PLAN			
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? *Indicate NA as Parent/Caregiver is formally included in the Full Care Team Huddle*	Y	N	NA
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed? Yes / No	N	N	Y
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea)) – please list medication(s) initiated **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	a	a	a + b
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT			
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	>3	>3	>3
NON-PHARM CARE INTERVENTIONS (I = Increase Now, **R** = Reinforce, **E** = Educate for Future, **NA** = Not Applicable/Available)			
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	R	R	R
Parent/caregiver presence to help calm and care for infant	R	R	R
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	R/I	R/I	R
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	R	E	R
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	R/E	R	R
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	I	R/I	R
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger – *Day 1: NA as baby spitty*	NA	E	R
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	I	R	R
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	I	E	R
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member) – *Day 3: Consider RN expert help*	R/E	I	R/I
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	I	R/E	R
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	E	E	R
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	E	R/E	R
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	I	R/I	R/I

Rating Key DOL 3

Perform assessment of ESC behaviors, signs of withdrawal, and NPIs for time period since last ESC assessment	Day 1	Day 2	Day 3
NOWS/NAS ASSESSMENT			
Are signs of withdrawal present? (e.g., hyperactive moro, tremors/jitteriness, increased tone, excessive/disorganized suck) Yes / No	Y	N	Y
If Yes, is timing of withdrawal consistent with known opioid exposure? Yes / No / Unsure	N		Y
Are co-exposures present that may be contributing to signs of withdrawal? Yes / No / Unsure (please list co-exposures)	Y		N
Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes / No / Unsure	N	N	Y
EATING			
Takes > 10 min to coordinate feeding *or* breastfeeds < 10 min *or* feeds < 10 mL (*or* other age-appropriate duration/volume) **due to NOWS/NAS?** *Day 1: Spitty from c-sxn, sx of w/d are from Prozac*	N	N	Y
SLEEPING			
Sleeps < 1 hr due to NOWS/NAS? *Day 1: Tremors, difficulty sleeping are from Prozac*	N	N	Y
CONSOLING			
Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) due to NOWS/NAS? *Day 1 – Prozac w/d, GPs too loud*	N	N	Y
Consoling Support Needed **1:** Able to console on own **2:** Able to console within (and stay consoled for) 10 min with caregiver support **3:** Takes > 10 min to console (*or* cannot stay consoled for *at least* 10 min) despite caregiver's best efforts	3	2	3
CARE PLAN			
Formal Parent/Caregiver Huddle Performed to formally review NPIs to be increased further? ***Indicate NA as Parent/Caregiver is formally included in the Full Care Team Huddle***	Y	N	NA
Full Care Team Huddle Performed to formally consider all possible etiologies for symptoms, re-assess if NPIs are maximized to fullest extent possible, and determine if NOWS/NAS medication treatment is needed? Yes / No	N	N	Y
Management Decision **a: Continue/Optimize NPIs** **b: Initiate NOWS/NAS Medication Treatment** (e.g., if baby's symptoms & timing of symptoms are consistent with mother's particular opioid *and* NPIs are maximized to fullest extent possible in infant's clinical setting, *OR* other significant NOWS/NAS concerns are present (e.g., seizures, apnea)) – please list medication(s) initiated **c: Continue NOWS/NAS Medication Treatment** **d: Other** (please describe – e.g., Start 2nd Pharmacologic Agent (indicate name); Wean or Discontinue Medication Treatment)	a	a	a + b
PARENT/CAREGIVER PRESENCE SINCE LAST ASSESSMENT			
> 3 hours (includes if parent/caregiver present entire time), **2-3 hours**, **1-2 hours**, **< 1 hour**, **0 hours** (no parent/caregiver present)	>3	>3	>3
NON-PHARM CARE INTERVENTIONS (I = Increase Now, R = Reinforce, E = Educate for Future, NA = Not Applicable/Available)			
Rooming-in (i.e., caring for infant in their own room with earlier caregiver response to infant stress or hunger cues)	R	R	R
Parent/caregiver presence to help calm and care for infant	R	R	R
Skin-to-skin contact when caregiver fully awake/alert to help organize infant feeding behaviors, calming & sleep	R/I	R/I	R
Holding by parent/caregiver/cuddler to help calm infant & aid in sleep (with caregiver fully awake/alert)	R	E	R
Safe & effective swaddling (e.g., extremities swaddled in flexed position, blanket snug, no extra blanket around baby's face)	R/E	R	R
Optimal feeding (e.g., baby offered feedings when showing hunger cues & fed till content)	I	R/I	R
Non-nutritive sucking with infant's hand, pacifier, adult caregiver's washed or gloved finger – ***Day 1: NA as baby spitty***	NA	E	R
Quiet, low light environment to help limit overstimulation of infant (e.g., tv volume down, quiet "white noise" machine or phone app)	I	R	R
Rhythmic movement provided by parent/caregiver or infant calming device (e.g., "jiggling" or infant swing in presence of alert adult)	I	E	R
Additional help/support in room (e.g., other parent, family member, friend, cuddler, staff member) – ***Day 3: Consider RN expert help***	R/E	I	R/I
Limiting # of visitors & duration of visit(s) to minimize disruptions in infant's care environment & sleep	I	R/E	R
Clustering care & assessments with infant's awake times (e.g., RN & infant provider perform assessment together after infant feedings)	E	E	R
Safe sleep/fall prevention (e.g., infant sleeps on back, safely swaddled, in own sleep space)	E	R/E	R
Parent/caregiver self-care & rest (e.g., identifying another adult to care for infant so parent can rest or take a walk/break)	I	R/I	R/I

Written Case 3 Teaching Script

DAY OF LIFE 1

NOWS/NAS Assessment

Are symptoms (sx) of withdrawal (w/d) present? Yes – Increased tone, difficulty sleeping, tremors when disturbed.

Is timing consistent with opioid exposure? No – Baby is 1-day old and was exposed to buprenorphine. Sx are unlikely secondary to NOWS unless mom missed dose day prior or her dose was close to 24 hrs. before delivery.

Are co-exposures present that may contribute to w/d sx? Yes – Baby's sx are most likely due to to prenatal Zoloft SSRI exposure.

Are non-pharm care interventions (NPIs) maximized to fullest extent possible in infant's clinical setting? No – Grandparents are loud.

Eating, Sleeping, Consoling (ESC) Assessment

All ESC answers will be No as timing is not likely consistent with mom's buprenorphine.

Eating: No – Problems staying latched and poor eating likely due to spitting up retained amniotic fluid after c-section.

Sleeping: No – Baby having a hard time sleeping for more than 1 hr. due to tremors when disturbed; however, sx are most likely 2/2 to Zoloft w/d (and grandparents talking loudly).

Consoling: No – Taking > 10 minutes to console - likely due to Zoloft and excessive noise in the room.

Consoling Support Needed: 3 – Taking >10 min to calm with swaddling and holding. Though consoling support needed is 3, consoling is No because baby's sx are from Zoloft and not due to NOWS.

Care Plan

Formal Parent/Caregiver Huddle: Yes – Since baby received a 3 for consoling support needed and NPIs can be optimized further, a Formal Parent Caregiver Huddle is recommended to teach family ways to help baby effectively sleep and calm, and to help prevent escalation of w/d symptoms from Zoloft and potentially buprenorphine over the next few days.

Full Care Team Huddle: No – NPIs can be maximized further and no other significant concerns are present at this time.

Management Decision: a

Parent/Caregiver Presence

>3 hrs. – Family member present entire time, holding baby.

Non-Pharm Care Interventions (NPIs)

Reinforce: Rooming-in, parent/caregiver presence, skin-to-skin (STS) contact, holding, swaddling, and additional support.

Increase: STS contact as potentially more effective way to calm baby. Discuss that STS will also help promote stable blood sugars in baby and stimulate mom's milk production while baby not interested in feeding. Recommend a **quieter environment** and **limiting visitors** to only one set of calm, quiet grandparents at a time. Promote **optimal feeding** by having mom hand/electronically express colostrum and provide drops to baby (as tolerated based on spitting up), and/or save for later if supplementation is required. Teach families to use **rhythmic movement** to help calm baby (e.g., up & down or "jiggling" movement), and to use in a gentle manner to avoid increasing baby's spitting up. Due to mom's prolonged labor and failure to progress, leading to c-section, *and* baby's difficulties latching and spottiness, leading to limited feedings in first day, instruct parents to **increase parent/caregiver self-care and rest** (e.g., taking naps). This is in anticipation of baby's likely cluster feeding overnight and parents awake and alert to respond to baby's cues/needs and to reduce chance of unsafe sleep/infant falls.

Educate for Future: Provide education re: **safe & effective swaddling**, using parents' demonstrated method of swaddling with additional tips/tricks for safety/efficacy as needed. Anticipate ways to **optimize feeding** by educating family re: why baby is not interested in feeding at this time but likely will be by 24 hrs. and in middle of night. Encourage asking grandparents for **additional help/support** during day while parents resting and/or at night when baby potentially fussier as per usual baby patterns & parents possibly sleepier with higher risk for infant drops or unsafe sleep. Teach family to avoid passing baby around a lot as this may overstimulate baby, and to call out after baby done feeding to **cluster RN/Infant Provider assessments with infant's awake time**.

Not Applicable: As baby is spitting up, it is unlikely that baby will want to suck on a pacifier or finger.

DAY 2

NOWS/NAS Assessment

Are sx of w/d present? No – Tone and reflexes are within normal limits.

Is timing consistent with opioid exposure? No answer needed as sx of w/d are absent.

Are co-exposures present that may contribute to w/d sx? No answer needed as sx of w/d are absent. If sx were present, they could be from Zoloft.

Are NPIs maximized to fullest extent possible in infant's clinical setting? No – See below for NPIs that can be increased further.

Eating, Sleeping, Consoling (ESC) Assessment

Eating: No – Able to latch within a few minutes and then breastfeed well for 20 minutes.

Sleeping: No – Baby slept for approximately 3 hrs. in bassinet.

Consoling: No – Baby awoke very fussy but able to calm within a few minutes.

Consoling Support Needed: 2 – Baby very fussy when awoke approximately 3 hrs. after last feeding but able to calm down after a few minutes of STS contact.

Teaching Point: If infant did have any ESC difficulties, the answer would be **Yes** for that particular difficulty because timing is consistent w/mom's buprenorphine dose (even though sx could also be due to Zoloft). At most, this would prompt a Formal Parent/Caregiver Huddle to review NPIs that can be optimized further at this time.

Care Plan

Formal Parent/Caregiver Huddle: No – A Formal Parent/Caregiver Huddle is not needed at this time as baby is eating, sleeping, and consoling well. Staff are still encouraged to reinforce parents/caregivers for all NPIs they are implementing well, and increase/educate about NPIs that could benefit the mother-infant dyad now or in the future.

Full Care Team Huddle: No – Not needed at this time. As time allows, can teach mom when a Full Care Team Huddle may be needed in future.

Management Decision: a – Continue/Optimize NPIs as discussed below.

Parent/Caregiver Presence

>3 hrs. – Mom present entire time.

Non-Pharm Care Interventions (NPIs)

Reinforce: Rooming-in, parental presence, STS contact, swaddling (complimenting mom on safety & efficacy of her swaddle), **optimal feeding**, **quiet/low light environment**, **limiting number of visitors and duration of visit**, **safe sleep/fall prevention** (mom having baby sleep in safe swaddle in bassinet after feeding), **parent self-care and rest** (reinforcing mom's taking a nap while baby slept).

Increase: STS contact (consider putting baby STS at breast at approximately 2.5 hrs. next time as baby woke very fussy at approximately 3 hrs.). **Optimal feeding** (teach mom to massage breasts/hand express a little milk before feeding to help calm baby/latch since baby woke very fussy). **Additional help/support in room** to help **increase parent self-care and rest** (for both mom and dad, who has to work). All support has now left, coach parents to ask for one grandparent/or set of grandparents to return and help care for baby/provide support for parent(s).

Educate for Future: Holding, **non-nutritive sucking**, **rhythmic movement**, **limiting number of visitors and duration of visit** (in this case, review with mom that presence of visitors is too limited!), and **clustering care** (e.g., encourage mom to call RN after baby's feedings to perform ESC assessment, vital signs assessment, and exam). Provide additional education to mom about the **importance of continuing to get sufficient rest/sleep** since baby will likely need increased caregiver support during next 1-2 days. NOWS sx may increase during this time, and mom is likely to become sleepier if she is the only one caring for her baby. Stress importance of **safe sleep/fall prevention** in setting of anticipated increased caregiver fatigue.

Reminder: 'Increase Now' includes education for future (e.g., importance of getting sufficient rest/sleep in this case).

DAY 3

NOWS/NAS Assessment

Are sx of w/d present? Yes – Tremors when disturbed and undisturbed, increased tone, excessive crying, and difficulty eating, sleeping and consoling.

Is timing consistent with opioid exposure? Yes – Baby is 3 days old and was prenatally exposed to buprenorphine.

Are co-exposures present that may contribute to w/d sx? No – Baby does not have w/d sx on DOL 2, so Zoloft w/d likely resolved by now.

Are NPIs maximized to fullest extent possible in infant's clinical setting? Yes with possible exception of care by expert RN in room as parent's stress level may be exacerbating baby's sx.

Eating Sleeping Consoling (ESC) Assessment

Eating: Yes – Having problems staying latched due to excessive rooting and tremors.

Sleeping: Yes – Did not sleep > 30 min. in past 3 hrs. Having difficulties sleeping due to frequent startling.

Consoling: Yes – Taking > 10 min. (20 min.) to console despite parents' & LNA's best efforts.

Consoling Support Needed: 3 – as per Consoling above.

Care Plan

Formal Parent/Caregiver Huddle: Staff can either skip question or indicate a **Yes**. As below, a Formal Parent/Caregiver Huddle is recommended, and this automatically includes the Parent/Caregiver (as available in person, by phone, Skype, Zoom, etc.).

Full Care Team Huddle: Yes – A Full Care Team Huddle is indicated due to baby's ESC difficulties with baby receiving a **2nd Yes in a row for sleeping and consoling**, and a **2nd 3 for consoling support needed** despite **maximal NPIs;** baby also now has **eating difficulties**. It is recommended to perform a **Full Care Team Huddle** with **parent/caregiver**, **infant RN** *and* **physician or associate provider** to discuss the following items.

- **Consider all potential etiologies** for symptoms
- **Re-assess if NPIs** are **maximized** to fullest extent possible in infant's clinical setting
- **Determine if NOWS/NAS medication treatment is needed** while continuing to **maximize all NPIs and closely monitor infant**

Management Decision: a + b – Medication is likely to be beneficial at this time in addition to continuing optimizing NPIs. It is also reasonable to consider trialing care provided by an RN expert in caring for infants with NOWS-related ESC difficulties to see if additional advanced-level care techniques can effectively decrease baby's sx. If baby's sx continue despite this expert level of care, medication is recommended.

Parent/Caregiver Presence

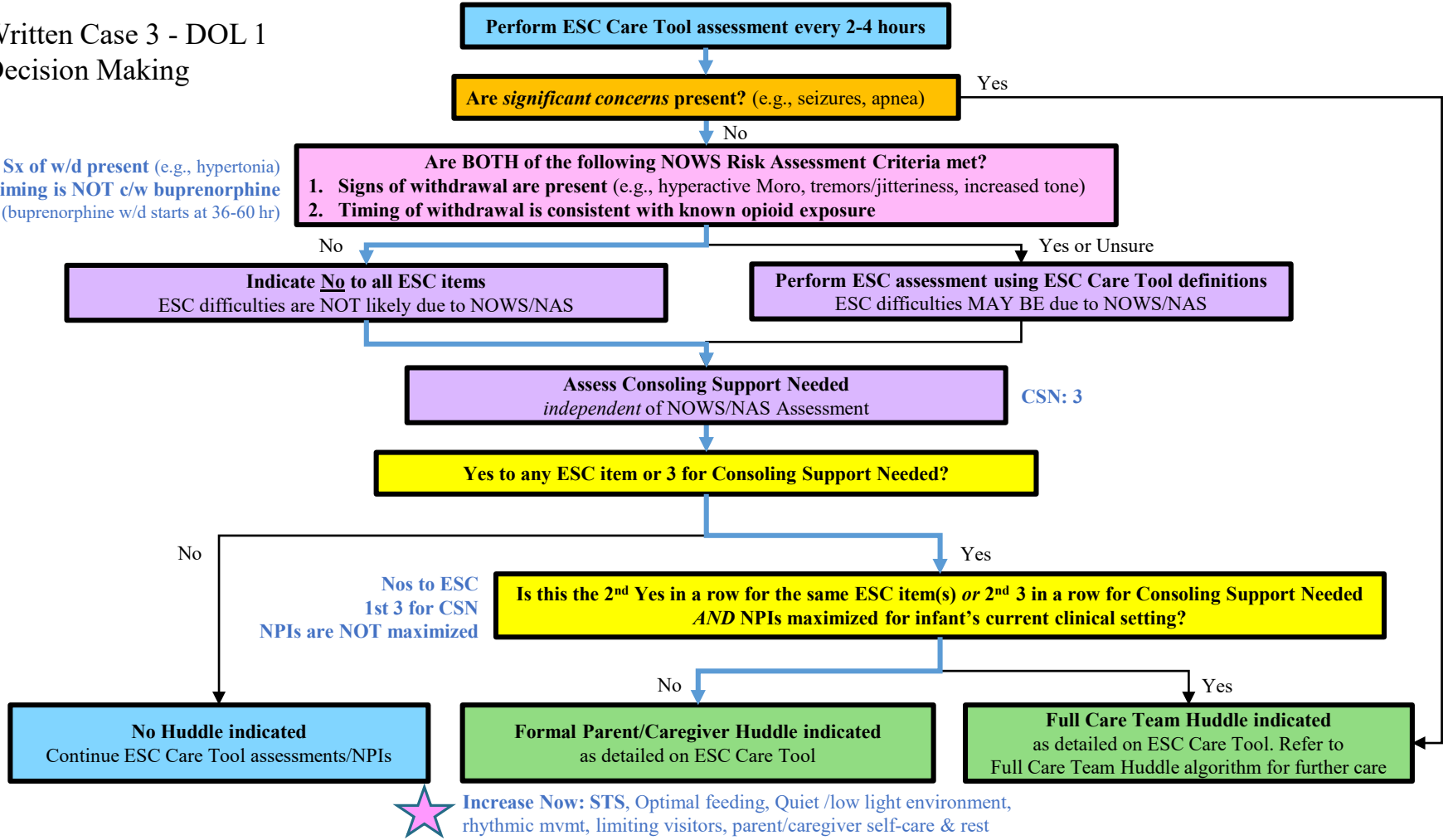
>3 hrs – Parents present entire time.

Non-Pharm Care Interventions (NPIs)

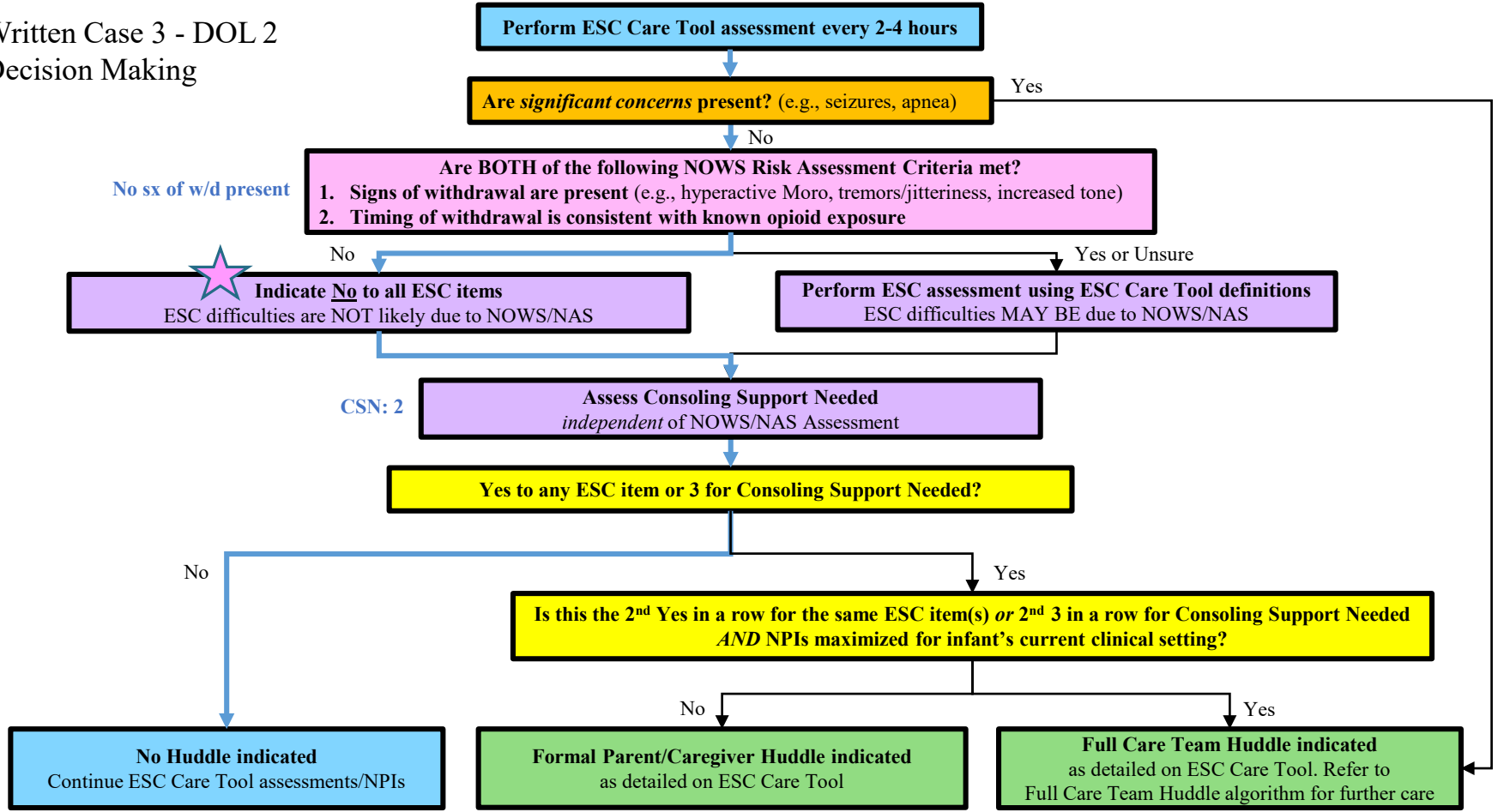
Reinforce: Reinforce that all parent/caregiver-led NPIs are being implemented as best possible by parents, and that parents are accepting of **additional help/support in room** provided by LNA and lactation consultant.

Increase: Increase **additional help/support in room** through trial of increased nursing support with demonstration/modeling for holding, swaddling, optimal feeding, and rhythmic movement. Brainstorm additional cuddler support (e.g., medical or nursing student) to help increase **parent/caregiver self-care and rest** since they are getting tired, despite taking turns with naps/walk breaks. Provide emotional support for parents as they are becoming a little stressed about how baby is feeling. Discuss that some babies require medication treatment for NOWS despite all best efforts with non-pharm care, and this does not reflect poorly on mom's need for medication-assisted treatment or on parents' attempts to help baby.

Written Case 3 - DOL 1
Decision Making

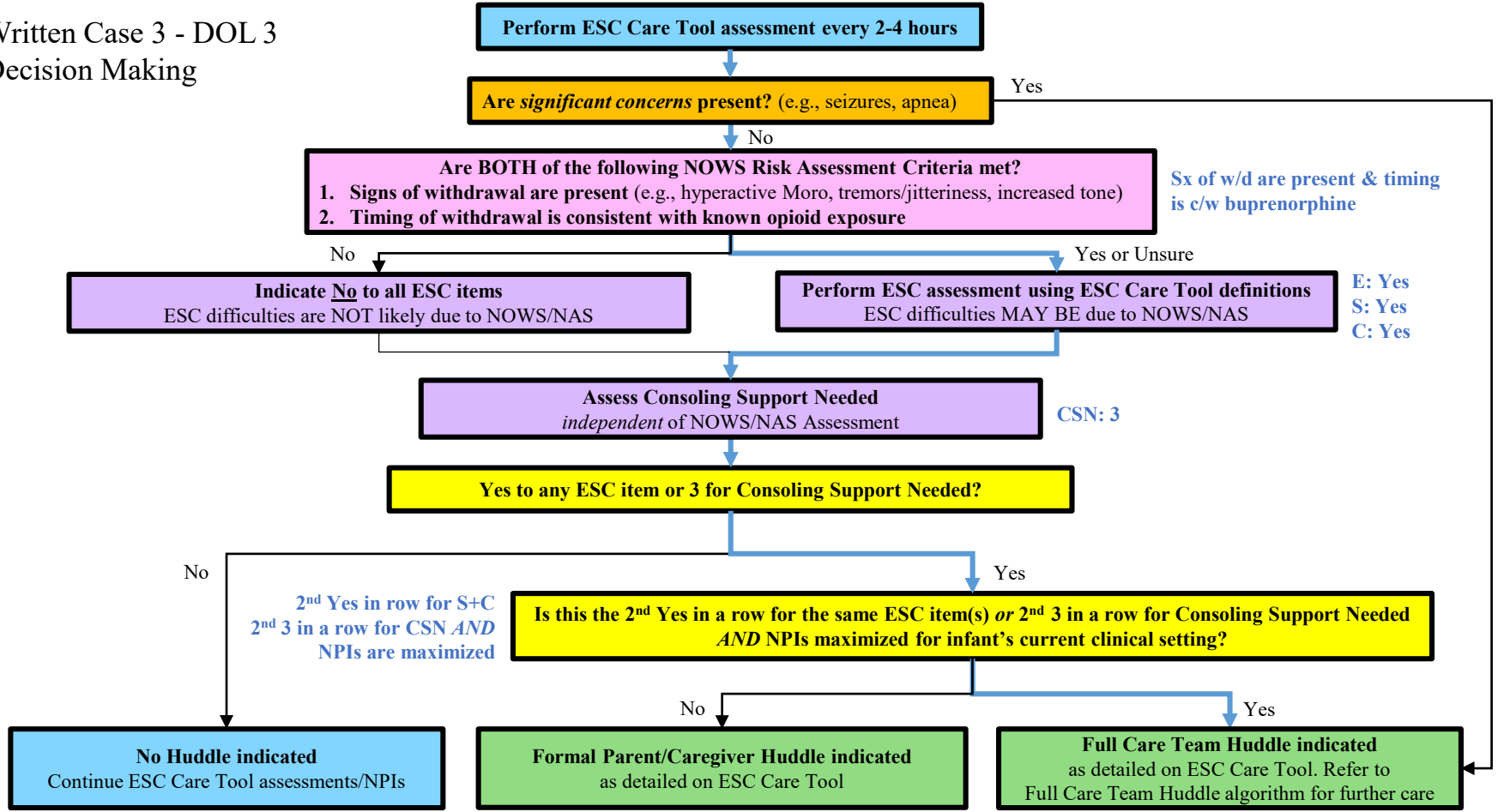


Written Case 3 - DOL 2
Decision Making



Recommend Increasing Now: STS, Optimal feeding, Quiet environment, rhythmic mvmt, limiting visitors, parent/caregiver self-care & rest

Written Case 3 - DOL 3
Decision Making



Written Case 3 - DOL 3
Full Care Team Decision Making