



ASSESSMENT OF THE INFANT WITH NEONATAL ABSTINENCE SYNDROME USING THE NEONATAL ABSTINENCE SCORING CHART (MR495)

- The **scoring interval** is the entire period between when you are scoring the infant and when the last score was assigned (i.e 4 hours if the previous score was less than 8 or 2 hours if the previous score was greater than 8). Document all scores.
- The NAS scoring system is dynamic rather than static. That is, scores should reflect all symptoms observed over the **entire** scoring interval, rather than at one set point in time.
- If the infant is unsettled at the time of scoring, efforts should be made to settle the infant prior to scoring symptoms observed during the scoring interval.
- **Do not** wake a sleeping infant for the purpose of assessment. Instead, schedule assessments to occur after feeding at 2 – 4 hourly intervals.
- Parents are to be familiarised with the scoring tool and be encouraged to participate in scoring of their infants.

SUGGESTED NON-PHARMALOGICAL SUPPORTIVE MEASURES:

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

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

Excoriation: Place a sheepskin under sheet. Apply protective skin barriers (e.g Comfeel) to affected areas.

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

Nasal flaring/Tachypnoea: Refer to Medical staff. Avoid swaddling so that respiratory rate can be closely observed. Nurse supine unless continuously monitored in SCN.

Excessive sucking of fists: Apply mittens, keep hands clean, and consult with parents about the use of a dummy.

Poor feeding: Feed to demand, offer small frequent feeds, and allow to rest between sucking. Reduce environmental stimuli during feeds and assess coordination of suck swallow reflex. Refer to Lactation Consultation as required. Weigh and assess hydration daily and refer to Medical staff if infant does not achieve required fluid intake or has excessive weight loss.

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

Peri-anal excoriation due to loose stools/diarrhoea: Change nappy with every feed. Discuss the use of appropriate barrier creams, it may be necessary to initiate a nappy care plan.

