

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

PURPOSE: To delineate the educational needs for self assessment, crisis intervention, and active participation in the care of the addicted client.

SUPPORTIVE DATA: Pregnancy, childbirth and parenting are major crises events in a woman's life. For most women, with the support and assistance of family, significant others and their own inherent resources, these events are positive, healthy experiences. But, for the addicted pregnant woman, pregnancy and parenthood are more often overwhelming stressors in their already unstable life. It is estimated that the overall incidence of illicit substance abuse during pregnancy nationwide is 11%. The addicted woman is often ambivalent about the pregnancy. They often feel guilty, are fearful of recrimination, or do not possess the resources necessary to care for themselves and their baby.

For some addicted women, pregnancy may be the first time that they are shown positive concern for their well being. It may be the first time attention has been placed on them. Many women care deeply for their unborn child and fantasize, as many women do, that having a baby will change their lives for the better.

This teaching plan addresses the education and self knowledge needed for the pregnant client to responsibly participate in her plan of care.

DESIRED PATIENT
OUTCOMES:

Patient will verbalize understanding of:

1. The risk factors inherent in the use of drugs during pregnancy, to herself and her fetus.
2. The signs and symptoms of complications of pregnancy with emphasis on those that are drug related.
3. The actions to take if symptoms occur.
4. The necessity for prenatal care and accurate reporting of symptomatology.
5. Resources available to her during her pregnancy and postpartum.

The goal is to maintain the pregnancy to term, ensure a safe delivery and provide a basic understanding of newborn care.

ASSOCIATED
STANDARDS:

Protocols and/or teaching plans outlined in the specific care plan under which the patient has been admitted.

ASSESSMENT:

1. Assess the ability to understand information given: reading ability, language barrier, disabling mental/emotional capacity and/or age (adolescence).
2. Assess previous history/experience with pregnancy, childbirth and parenting.

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

3. Assess for indicators of impaired coping ability, and/or lack of support systems.
4. Assess need for ADATC and/or OB/GYN Consultation Services.

INTERVENTIONS:

1. Initiate appropriate MTP on admission and Patient and Family Teaching Record when teaching begins.
2. Instruct client in an environment free of distractions.
3. Instruct client using lay terms.
4. Reinforce verbal instructions using pamphlets, videos, etc.
5. Remain calm and non-judgmental when instructing and/or providing support.
6. Reinforce instructions/teaching prn.

PATIENT EDUCATION:

The nurse is responsible for identifying the learning needs of the client who is pregnant and addicted and providing basic education using the guidelines that follow:

1. It is known that whatever a woman is exposed to during pregnancy, her fetus is exposed to as well. The amount of exposure to the fetus depends on many factors: the ability of the substance to pass through the placenta, the amount of the substance ingested/exposed, and the rate of occurrence of the substance. Review the following with the client:
 - a. A woman is often 8 weeks pregnant before she realizes that she is pregnant. A fetus is most susceptible to developmental damage during this time. Teratogenic events can occur, such as heart malformations, limb deformities, and neurological damage. Also during the first eight weeks, there is an increased risk for spontaneous miscarriage.
 - b. After the 12th-14th week of gestation, if the pregnancy continues, the chance for central nervous system damage such as microcephaly and mental retardation or developmental delay can occur. It is important to tell the patient that the fetal brain continues to grow and therefore can be susceptible to insult throughout the pregnancy.
 - c. Due to the immaturity of fetal organs, a fetus does not have the ability to break down drugs as an adult would. The fetus' liver is immature. This means that the fetus stays exposed to the active form of the drug longer, sometimes, as in the case of maternal cocaine ingestion, up to four days.
 - d. Drugs, used over time, can often alter and even stop menstruation. This makes it difficult for a woman to determine if she is pregnant and therefore, to seek prenatal care.

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

2. Although it is difficult to determine the exact effect of each drug on pregnancy outcome, it is known that a woman who uses drugs is at greater risk for pregnancy/delivery complications. There is also a higher risk of injury, directly or indirectly, to her baby. Review with the patient the following:

a. MARIJUANA: Chronic use has been shown to cause:

Maternal:

- 1) Disrupted menstrual cycles.
- 2) Increased risk for spontaneous abortion.
- 3) Prolonged labors or labors that stop prior to full cervical dilation.
- 4) Because marijuana is generally smoked, there is decreased oxygen supply to both mother and fetus that can cause respiratory complications to the mother.

Fetal:

- 1) Increased incidence of meconium aspiration and neonatal resuscitation.
- 2) Neurobehavioral abnormalities (cat-like cry, inability to self quiet).

b. HEROIN/METHADONE: Causes CNS depression. Maternal-fetal effects may include:

Maternal:

- 1) Amenorrhea - the cessation of menstrual periods.
- 2) Placenta Previa & Abruptio - Poor implantation and possible separation of the placenta from the uterine wall can result from decreased placental blood flow.
- 3) Malpresentation - A greater % of breech presentations.
- 4) Hypertensive disorders - 3 times greater chance of PIH (Pregnancy Induced Hypertension) due to the toxic effect of heroin on maternal kidneys.
- 5) Premature Rupture of Membranes.
- 6) Premature Spontaneous Onset of Labor.
- 7) Infections - Increased risk for STD's and hepatitis.
- 8) Increased risk of stillbirth due to the hyperactivity of the fetus during periods of fetal withdrawal which requires an increase in O₂ needs.

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

Fetal:

- 1) Neonatal withdrawal: May start during the first 12-24 hours of life. Can take up to 3-4 days for symptoms to appear. Usually peaks by the 14th day but symptoms can last for months.
- 2) Physical appearance at birth - decreased birth weight and length, smaller head circumference.
- 3) CNS abnormalities - irritability, shrill cry, tremors, inability to self quiet, increased REM sleep, seizures, decreased resting sleep, difficulty to console.
- 4) Autonomic Abnormalities - Exaggerated sucking and rooting reflex (but poor nutritive sucking and swallowing coordination). Also, excessive sneezing, sweating, nasal secretions, apnea (cessation of spontaneous breathing).
- 5) GI symptoms - N/V, dehydration and electrolyte imbalances.

* NOTE: Babies whose mothers are using methadone maintenance have less withdrawal symptoms if doses are less than 20 mg per day.

- c. COCAINE: Stimulates the central and peripheral nervous system causing vasoconstriction and neurological changes. Maternal-fetal effects may include:

Maternal:

- 1) Placenta Previa and Abruptio due to constriction of placental vessels. This can result in a life threatening situation to mother and fetus.
- 2) Maternal hypertensive state - tachycardia, palpitations, increased BP's, heart rate and temperature.
- 3) Premature Spontaneous Onset of Labor.
- 4) Increased rate of spontaneous abortions.
- 5) Malnutrition - result of decreased appetite while using cocaine.
- 6) Increased STD's are the result of heightened sexual excitement and prostitution common in female addicts.

Fetal:

- 1) Indirect effect of decreased placental blood flow can cause:
 - a) Stillbirth
 - b) IUGR (Intrauterine growth retardation)

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

- c) Microcephaly - decreased brain growth
 - d) Increased incidence of SIDS (Sudden Infant Death Syndrome).
 - e) Increased chance of intracranial bleeding
- 2) Direct effects of cocaine to the fetal CNS can cause:
- a) Fetal tachycardia
 - b) Fetal hyperactivity
 - c) Tremors (especially in upper torso)
 - d) GI problems - poor eaters and failure to thrive
- 3) Studies are showing that children exposed to cocaine in utero have difficulty developing social skills.
- d. ALCOHOL: Maternal metabolism of alcohol requires increased oxygen consumption by the liver. This can result in decreased oxygen and collapse of the umbilical vasculature. Maternal-fetal effects may include:

Maternal:

- 1) Placenta Previa and Abruptio
- 2) Antenatal bleeding
- 3) Maternal Anemia
- 4) Stillbirth - evidence is still inconclusive as to the pattern of drinking and pregnancy outcome. Studies show that third trimester exposure to alcohol of an already compromised fetus can lead to fetal death.

Fetal: FAS - Fetal Alcohol Syndrome is recognized in infants who exhibit at least one of the characteristics in each of the categories below:

- 1) Prenatal or postnatal growth retardation less than 10%.
- 2) Characteristic facial anomalies:
 - a) Microcephaly
 - b) Wide set eyes
 - c) Broad, high forehead
 - d) Epicanthal folds
 - e) Lengthening of the philtrum (area between nose and upper lip)
 - f) Curvature of the fifth finger

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

3) CNS effects:

- a) Poor coordination
- b) Irritability/hyperactivity
- c) Retardation (average IQ 65)

* NOTE: Documentation of maternal drinking is necessary to complete the diagnosis.

Infants can also present with characteristics which collectively are called fetal alcohol effects, i.e. eye & hearing problems, increase in cleft lip and/or palate as well as any of the above symptoms.

3. A major concern for health care providers is the high percentage of addicted pregnant women who do not seek prenatal care until late in the pregnancy or until an acute medical emergency arises. It is of the utmost importance to review with the client the following symptoms that require medical attention:
- a. Vaginal bleeding: Any bleeding from the vagina regardless of amount or time of occurrence.
 - b. Abdominal tightenings, pain, and/or tenderness
 - 1) Can be associated with vaginal bleeding.
 - 2) Can be related to an infectious process.
 - 3) Can be a result of trauma.
 - 4) Can be the initiation of labor either at term or prematurely.
 - c. Premature Labor - signs and symptoms can be subtle and may include:
 - 1) Uterine contractions.
 - 2) Menstrual-like cramps.
 - 3) Abdominal cramps.
 - 4) Low backache.
 - 5) Pelvic pressure.
 - 6) Change in vaginal discharge.
 - d. Fluid from the vagina:
 - 1) Can either present as a large gush or a slow trickle.
 - 2) Can occur spontaneously or in conjunction with uterine contractions.

TEACHING PLAN FOR: Addicted Pregnant Patient: Care of the

e. Changes in fetal activity:

- 1) Decreased fetal movement (less than the fetus' normal behavior pattern).
- 2) An episode of fetal hyperactivity followed by no movement.
- 3) Changes in fetal position - increased vaginal or rectal pressure. Feelings that the "baby has dropped".

f. Changes in Maternal condition:

- 1) Headaches, vision changes, swelling of hands, feet and/or face, and weight gain (symptoms of developing PIH).
- 2) Elevated temperature, "flu-like" symptoms, abdominal tenderness, foul smelling vaginal discharge (symptoms of developing infection).
- 3) Dizziness, weakness, pallor, palpitations, (symptoms of malnutrition and/or anemia).

* NOTE: Any symptoms of overdose or withdrawal should be reported immediately to medical personnel as these events can be life threatening to both the woman and her fetus.

REPORTABLE

- CONDITIONS:
1. Inability of patient to comprehend written and/or verbal instruction.
 2. Conditions requiring interventions by obstetrical personnel.
 3. Patient unwilling to report and/or perform directions given.
 4. Suspicion of substance abuse while in outpatient detoxification program..

- DOCUMENTATION:
1. Initiate and maintain Treatment Plan appropriate for admission diagnosis.
 2. Document patient response as per documentation standards, Department of Nursing.

REFERENCES: Nursing Standards Committee

CREDENTIALS: RN

EFFECTIVE DATE:

REVIEWED DATES: 9/08