Caring Connections

POSC
PLAN OF SAFE CARE
PRENATAL, DELIVERY AND POST NATAL

Purpose: Plan of Safe Care (POSC) – A communication plan that will help you and your support team, coordinate necessary services to prevent possible negative outcomes associated with pre-natal and post-natal substance misuse. This plan includes goals specific to the you, your baby and your family. Dealing with Substance Misuse and/or Mental Health issues is hard enough – but to do this while pregnant requires help. We will be with you through all the stages of your pregnancy, your delivery and your transition home. We know you want the best possible outcomes for your newborn and your family – and we can help get you there.
POSC Prenatal Information

Mother Name: ___________________________________________

Father Name: ___________________________________________

Is Father willing to participate in POSC? Yes: ____ No:____

If no, why not? ____________________________________________

Are there any other family or support member you want to participate?

________________________________________________________

Do you have any Transportation needs?________________________

Who is your OB/GYN? ______________________________________

Contact Information? ________________________________________

What Trimester did you start Prenatal Care? __________________

Do you have any medical conditions, and if so, are you currently taking any medications for these conditions? (blood pressure, gestational diabetes etc)____________________

Have you been participating in WIC? __________________________

What are the issues that you are most concerned about at this time?

________________________________________________________________

________________________________________________________________

________________________________________________________________

Have you been involved with any treatment agencies in the past? Yes:_____ No:____

If yes, who and were your needs met? ____________________________

If no, why? __________________________________________________

Is there anything else you want us to know about you and your situation?:________

________________________________________________________________

________________________________________________________________

________________________________________________________________

What are your Strengths? _____________________________________

________________________________________________________________

________________________________________________________________

What are your Weaknesses? ____________________________

________________________________________________________________

________________________________________________________________
Substance Misuse Treatment Provider involved in your POSC

Treatment Provider/Agency: ________________________________

Name of coordinator/case manager: ________________________________

Contact information: ________________________________

Start Date with provider: ________________________________

When are your appointments? ________________________________

Is this a Medication Assisted Treatment? Yes: _____  No:______

If yes, medication and dosage: ________________________________

Has MAT medical staff contacted your OB/GYN to coordinate your care and discuss prescribed medication? ________________________________

Marchman Acts: Yes:_______  No:________

Objectives of service:

1. ________________________________
   ________________________________
   ________________________________
   Completion date: ________________

2. ________________________________
   ________________________________
   ________________________________
   Completion date: ________________

3. ________________________________
   ________________________________
   ________________________________
   Completion date: ________________
Mental Health Treatment Provider involved in your POSC

Treatment Provider/Agency: ______________________________________________________

Name of counselor: ____________________________________________________________

Contact information: ____________________________________________________________

Start Date with provider: _______________________________________________________

Baker Acts: Yes: _____ No: ______
If yes, Please provide dates and brief description: ____________________________________

Were you prescribed medication? If yes, What are your medications and dosage:
____________________________________________________________________________
____________________________________________________________________________

Has your Mental Health counselor contacted your OB/GYN to coordinate your care and
discuss prescribed medication? ________________________________________________

Objectives of service:
1. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   Completion date: ______________________

2. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   Completion date: ______________________
Substance Misuse Care Coordination Service Provider involved in your POSC

In-home service provider agency: __________________________________________________________

Name of coordinator/case manager: ________________________________________________________

Contact information: _________________________________________________________________

Objectives of service:
1. __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   Completion date: __________________

2. __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   Completion date: __________________

3. __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________
   Completion date: __________________

Resources and information provided to the family:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
In- Home Service Provider involved in your POSC

In-home provider agency: ________________________________

Name of coordinator/case manager: ________________________

Contact information: ________________________________

Objectives of service:

1. _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________

2. Completion date: __________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   Completion date: __________________

3. _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   _______________________________________________________________________________________________________
   Completion date: __________________

Resources provided to the Family: ________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________
POSC Pre-Delivery Information

Do you have transportation to the hospital planned? ________________________________

Name of Hospital where you expect to deliver: ____________________________________

Expected due date: ____________________________________________________________

Who will be a part of your support system when you take the child home and have you discussed a schedule with them, (examples so you can sleep, go to appointments etc.)? ____________________________________________________________________________

What is your plan to return to Treatment/receive your methadone while in the hospital? ____________________________________________________________________________

Please list most current medications below (or take a picture of the bottles) to provide hospital staff at intake: ____________________________________________________________

Do you have a car seat for your newborn and did you need to have it checked by a certified car seat Inspector? Yes _______ No ________ Your fire department can inspect for proper installation.

Do you have a safe place for your newborn to sleep? Yes _____ NO ________

Do you have the supplies needed for you and your newborn? Yes _____ No _____

If no, what do you still need? ____________________________________________________________________________

Do you or your doctor expect your new born to be substance dependent? Yes____ No_______

If yes, do you have a place to stay (close to hospital) if your newborn is in the NICU? Yes_____ No_______

Have you been provided a copy of “Signs and Symptoms of Neonatal Abstinence Syndrome (NAS)” What you need to know?

Have you contacted Connect CI&R in your county of record for in home service visits for your newborn after release from NICU? Yes _________ No________

(If no, Ask the hospital social worker for contact information so that a referral can be made to your local in-home nursing program.)

What are your long-term birth control plans post-delivery? Discuss options with OB/GYN ________________________________
POSC Delivery

Name of Baby: ___________________________  Date of Birth: _____________
Weight: _______________  Length: _______________  Sex: ________
Name of Hospital where you delivered: _______________________________________

Location of NICU - If newborn was transported: _______________________________

Name of doctor that delivered newborn: _______________________________________

Mode of Delivery: Vaginal ________ C-Section ____________

Pain Medications provided during delivery: _________________________

Drug Screen for Mother: Date: _______  Negative: _______  Positive, if yes for what substances? ____________________________
Drug Screen for Newborn: Date: _______  Negative: _______  Positive, if yes for what substance? ____________________________

Infant observation – 5 day: Yes ________ No _________
Newborn Symptoms and/or complications and Treatment: _________________________
_________________________________________________________________________

Newborns length of stay: ____________________________________________________
Breast Feeding or Bottle Feeding: __________________________

Discharge -Follow – up instructions
Newborn: __________________________
CI&R Referral Completed on: ____/__ /_____

1st Pediatric Appointment: Doctor: __________________________ Date:___________________
Mothers: __________________________
Follow-up appointment: Doctor:_________________________ Date ______________________

PLACE A COPY OF HOSPITAL POST-NATAL DISCHARGE INSTRUCTIONS FOR YOU
AND YOUR NEWBORN IN YOUR POSC FOLDER TO REFER TO AFTER YOU LEAVE
THE HOSPITAL
Once You Are Home

What is your plan for returning to your substance misuse program?:
________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Try to develop consistent eating and sleeping routines for the infant- NAS infants may take more time eating or falling asleep than non-opioid exposed infants. Who do you have helping you to care for the infant during the early weeks after you return home?

Has someone reviewed safe sleep measures with you to ensure your newborn has the safest sleeping environment possible? Yes___/No___ If no – Have your In-Home service provider discuss the latest research and the ABCs of safe sleep.

**Remember!!!** It is very possible that the Department of Children and Families will be called if you are participating in an MAT program. This is not meant to be punitive – it is to ensure the safety and well-being of your infant. So **Let them know that you are participating in a Plan of Safe Care.** Allow them time to review the plan and share with them any other resources you may be involved with. **Be proud of your sobriety** and **Celebrate what you have accomplished** during your pregnancy. You and your newborn will benefit from all of your hard work.