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 ect)_____

_____
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 you're 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: _____

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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: _____

Notes

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:

_____

_____

_____

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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: _____

_____

_____

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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 _____

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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.

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