



# Neonatal Drug Withdrawal: Lipsitz Scoring Tool

**The Lipsitz Scoring Tool is an alternative method for screening newborn infants for possible drug exposure. It has only 11 items to score and is less resource intensive, a consideration for nurseries without the resources to maintain staff competencies for the more complex Finnegan Scoring System. It is also useful for those nurseries that routinely transfer babies to a higher level of care for treatment.**

***There is a reported 77% sensitivity using a value of >4 as an indication of significant signs of withdrawal.*** (MCN, 2013; Western Australian Centre for Evidence Based Nursing & Midwifery, 2007; AAP, 1998)

## **Instructions:**

- Label the tool in the upper right hand corner with the infant identifying information (name, DOB, MR#) as appropriate for your nursery.
- At the beginning of each 24 hour period, fill in the date and infant's day of life spaces.  
***Remember the infant's date of birth is considered DOL #1.***
- It is recommended that each sheet start with the beginning of the new day (after midnight)
- Each staff member utilizing the tool should enter his/her name and initials at the bottom of the document for identification purposes.
- Enter the initial time the infant is scored for that day. Enter subsequent intervals as the infant receives additional scores.
- ***The infant should be scored at least every 3 hours.***
- All staff who will be using the tool should receive standardized training on use of the tool, definition or terms, as well as practice to assure some level of consistency across scorers.
- If there is not enough room for comments-Use an asterisk and continue notes on the back of the scoring tool. Documentation of all non-pharmacologic interventions is extremely important for staff at the receiving nursery to know.

For each time interval, select the highest score the infant demonstrates. Score the infant every 3 hours for the first 72 hours (if exposed to narcotics or opiates) or for the first 96 hours (if exposed to Methadone or Suboxone).

***Please remember: A total score of 4 is recommended for initiation of pharmacologic treatment***

## **SIGNS:**

### **Tremors (muscle activity of limbs)**

Tremors are involuntary movements that are rhythmical in nature and generally of equal amplitude. Seizures, while the incidence is rare, should be reported immediately.

### **Irritability (excessive crying)**

While all infants will occasionally cry, normally they can self-soothe within 15-20 seconds or be consoled by a caregiver via rocking, holding, or offering a pacifier. Look for a high pitched cry with no apparent cause. The infant can appear inconsolable even after normal comforting measures.

### **Reflexes**

A typical newborn will exhibit a startle reflex. In infants withdrawing from drugs the Moro reflex is exaggerated. The infant should be evaluated at rest and with gentle handling, not when crying or over-stimulated.

**Stools**

Note any loose, watery stools, frequent in number, which may also be explosive, with or without a water ring. (These are NOT ‘breast milk’ stools)

**Muscle Tone**

Infants in withdrawal will demonstrate varying degrees of stiffness or rigidity.

**Skin Abrasions**

Rub marks may or may not be present since most infants are now placed on their backs in a ‘safe sleep’ position. When extremities are frequently rubbed against bed linens, excoriation and abrasions may occur. If there is any skin breakdown on elbows, heels or other pressure points, this should be scored. (Diaper rash is not scored).

**Respiratory Rate**

Measure breaths per minute (bpm) and note if infant is tachypneic or if breathing is labored or retractions are present. Respirations should be counted for a full minute when the infant is calm or asleep by touch or direct visualization of the chest and/or abdomen.

**Repetitive Sneezing**

If the infants sneezes several times in a row this can be a sign of autonomic nervous system dysregulation. This item is scored as either yes or no.

**Repetitive Yawning**

If the infant yawns excessively, this can represent alterations in autonomic nervous system regulation. This is scored as either yes or no.

**Forceful Vomiting**

Score yes if vomiting is observed that is not necessarily related to burping and occurs frequently during feeding. Note particularly if vomiting is forceful and projectile during or right after the baby is fed. This is scored as either yes or no.

**Fever >38°C or >100.4°F**

Score utilizing an axillary temperature. Make sure that the baby is not bundled too warmly to ascertain if the fever is indeed due to withdrawal and not because the baby is overheated due to being dressed in clothing that is too heavy or because of an infection. This item is scored as either yes or no.

**TOTAL SCORE**

Add the column to obtain the “total score” for that time interval. A total score of 4 is recommended for initiation of pharmacologic treatment.

**Recommendations:**

- All babies suspected of being exposed to narcotics or opiates should receive Non-Pharmacologic management
- Do not wake up a baby to perform the scoring. Clinical judgment should be used should a fussy baby have just gone to sleep.
- If a baby receives a score of 4, confirm that all possible non-pharmacologic interventions have been implemented and rescore the infant in an hour. If the score remains at 4 or higher, the infant should be transferred to a higher level of care.