

# THE INFANT AT 4 WEEKS FOLLOWING BIRTH

## INFANT ASSESSMENT DATA BASE

Review prior assessments for identified risk factors.

### Activity/Rest

Infant sleep pattern well-established

### Circulation

Heart rate ranges from 80–150 bpm at rest, with average rate of 120 bpm.

BP obtained by using flush technique at wrist ranges from 48–90 mm Hg, with a mean of 67 mm Hg; at ankle, 38–56 mm Hg, with a mean of 61 mm Hg.

### Ego Integrity

Regards faces, especially parents' faces, intently; may demonstrate beginning of social smile

### Elimination

Urine pale or straw-colored, with output of 6–10 wet diapers per day

Abdomen soft, nondistended with bowel sounds present

Individual bowel elimination pattern established, dependent on type of feeding

### Food/Fluid

Makes comfort noises during feeding, or may make small, throaty noises

Feeding generally 5–8 times per 24-hr period

Height gain 2.5 cm (1 in) monthly for first 6 mo

Weight gain of 3–5 oz/wk for first 6 mo

Drooling absent until 2–3 mo of age, when salivary glands begin to function

### Neurosensory

Beginning to differentiate cry in relation to pain, discomfort, or hunger; uses cry to signal needs; quiets when picked up.

Head circumference increases 1.5 cm (½ in) monthly for first 6 mo.

Fontanels palpable and soft; posterior fontanel closes at 6 wk of age.

Tears present, with tear glands beginning to function at 2–4 wk of age.

Primitive reflexes present with strong, bilaterally equal responses.

Doll's eye and dance reflexes fading.

Crawling movements when prone.

Lifts head momentarily from bed while on abdomen, turns head from side to side when prone.

Demonstrates tonic neck reflex when supine.

Marked head lag when pulled from lying to sitting position (back is uniformly rounded); absence of head control in sitting position.

Strong grasp reflex: Hand closes on contact with object.

Responds to environmental stimuli: Bright objects (which are best viewed 8–12 in from face), sound, and touch.

### Pain/Discomfort

Continuation of pain and cramping associated with colic may be reported.

### Respiration

Signs of aspiration (continued regurgitation associated with reverse peristalsis and immature or relaxed cardiac sphincter)

## Safety

Axillary temperature stable between 97.7°F–98.6°F (36.5°C–37.0°C)  
Perineal area clean and free of rashes

## DIAGNOSTIC STUDIES

Testing dependent on individual findings, risk factors.

**Urine Specific Gravity:** 1.008.

## NURSING PRIORITIES

1. Promote infant's growth and development.
2. Provide information appropriate to parents' learning needs.
3. Enhance home environment to promote infant's safety, stimulation, and rest.

## DISCHARGE GOALS

1. Various indicators of growth and development show progression WNL.
2. Parent(s) understand individual needs of infant.
3. Parent(s) demonstrate proficiency in infant care activities.
4. Plan in place to meet ongoing health monitoring/wellness needs.

---

**NURSING DIAGNOSIS:****Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—NEONATE WILL:**

---

**NUTRITION: altered, risk for less than body requirements**

Failure to ingest/digest/absorb adequate calories; e.g., biologic (insufficient intake, malabsorption, congenital problem, or neglect [failure to thrive]) or psychological factors (emotional abuse)

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Display physical growth and weight gain appropriate for age and developmental stage.

---

---

**ACTIONS/INTERVENTIONS****RATIONALE**

---

**Independent**

Measure infant's height and weight, and compare with measurements at birth and at 1 wk of age.  
Review growth history.

Nutrients for infants are based on body weight. Most full-term, AGA infants regain birth weight within 10–14 days following birth. Weight gain should be 3–5 oz/wk for first 6 mo and may be as much as 1 oz/day in bottle-fed infant. Gains of less than 3–5 oz/wk may result in lifelong nutritional risks with potentially negative effects on infant development.

Assess infant for possible failure to thrive (FTT).

Determine amount, type, and frequency of oral intake over last 24 hr.

Note status of fontanel, production of mucus, skin turgor, and number of wet diapers per day.

Obtain 24-hr dietary recall in lactating mother. Note presence of illness, infection, or dietary inadequacies. Provide dietary teaching, as appropriate, noting cultural/religious practices. Identify adequate sources of calcium and protein; suggest supplementing maternal diet with brewer's yeast as appropriate.

Evaluate lactating mother's sleep and rest, noting excess fatigue, family demands, and work or social commitments. Discuss individual needs and options to meet these needs.

Evaluate effectiveness of let-down reflex in lactating mother. If mother smokes, suggest that she refrain or light cigarette after infant is sucking vigorously, rather than prior to feeding. Assist mother in evaluating stressors and using creative problem solving.

Review techniques used in formula preparation and storage. Confirm that parents follow instructions for making powdered or concentrated formulas. Discourage home preparations of evaporated milk formula and bacterial contamination.

A breastfed infant who continues to lose weight after 10 days of life does not regain the weight by 3 wk of age, or gains weight at rate below 10th percentile after 1 mo is probably an FTT infant and requires prompt evaluation relative to issues of lactation and infant capabilities. In the bottle-fed infant, formula preparation and appropriateness (tolerance) are evaluated. Finally, concerns regarding possible neglect must be addressed. Timely intervention and resolution may prevent permanent deficits.

Infants require about 115 kcal/kg for first 6 mo of life, or 54 kcal/lb. Fluid needs are approximately 530 ml/day. One-third of energy is used for growth. Inadequate caloric and fluid intake results in nutritional inadequacies and poor weight gains. Note: Adequate protein intake is critically important to provide brain growth during the hyperplasia and hypertrophy phase in the first 6 mo of life. Inadequate protein ingestion during this phase can result in developmental delays.

Inadequate fluid intake results in dehydration, manifested by depressed fontanel, reduced urine output, poor skin turgor, and dryness of mucous membranes. Note: Cases of hypernatremic dehydration have been associated with use of cow's milk feedings.

Illness, infection, or marginal diet may affect mother's ability to nourish the infant adequately. Factual information may help correct myths/faulty beliefs resulting in inadvertent or deliberate food restrictions. Supplementing diet with brewer's yeast improves milk production significantly more than simply adding similar nutrients.

Inadequate sleep, resulting in excess fatigue, is most common cause of inadequate milk supply, especially during 1st mo, when milk supply is being established.

Smoking and psychological stress may inhibit let-down reflex. While abstinence is preferred, the reality is that cessation of smoking may not occur and achievable goals, such as reduction in frequency/number of cigarettes may still be beneficial.

Many infant nutritional inadequacies are related to overdilution of commercial formulas, which results in inadequate calories, nutrients, and FTT. Use of home-prepared evaporated milk formulas has been linked to problems associated with improper measurement

Encourage continued use of formula for first 12 mo of life. Discourage substitution of skim or whole cow's milk.

Inspect infant for lesions; note swollen parotid glands.

Determine color, frequency, consistency, and odor of stool.

Auscultate bowel sounds; palpate abdomen. Note presence of loose stools, cramping, crying, reports of vomiting, or chronic blood loss in GI tract.

Assess infant's color, gestational age, and weight at birth, and current weight gains.

Auscultate apical pulse and count respirations as indicated.

Note excessive or forceful vomiting of nonbilious, possibly blood-tinged emesis; visible gastric waves moving right to left across epigastrium; and palpable olive-shaped mass in epigastric region.

### **Collaborative**

Provide information as needed about prescribed alternatives to milk, such as soy milk formulas or hydrolyzed protein and amino acid mixtures.

Refer to social services or WIC program, as indicated.

Instruct in addition to human milk fortifiers (HMF), as indicated, to breast milk, which is pumped and stored for feedings.

Refer parents to pediatric nurse for assistance with surgical preparation and care if pyloric stenosis is confirmed.

Skim milk contains about half the number of calories in breast or commercial formulas; may not meet the infant's energy needs; and may cause deficiencies in iron, vitamin C, and fatty acids. Use of whole milk in the first 12 mo may place the infant at risk for iron, vitamin C, and copper deficiencies.

May indicate poor nutritional state, affect oral intake.

Altered elimination pattern may suggest problem with digestion and absorption. Foul-smelling stool suggests parasitic infection. Diarrhea may reflect milk intolerance or ingestion of cathartics in lactating mother.

Abdominal distension and gas accumulation may be associated with ingestion of gas-producing foods in lactating mother or with milk intolerance. Immaturity of the intestinal tract increases permeability to inadequately catabolized proteins, which produces an allergic response or milk intolerance in 1%–2% of infants.

Iron stores are usually adequate until infant weight increases by 2½ times. Pallor and inadequate weight gain, however, may indicate anemia.

Persistent tachycardia >160–200 bpm associated with increased respiratory rate suggests anemia.

May indicate hypertrophic pyloric stenosis, especially if infant appears alert and hungry, fails to gain weight, and has a history of recurrent vomiting.

Alternative formulas relieve symptoms associated with cow's milk intolerance.

Additional assistance may be needed to meet infant/maternal nutritional needs if financial resources are limited.

FTT infants who are breastfed may benefit from having the mother bottlefeed breast milk supplemented with extra calories until the infant is gaining weight appropriately on a consistent basis. Note: The morning and evening feeding may be from the breast in order to support the maternal breastfeeding experience.

Surgical management or pyloromyotomy is the standard treatment for hypertrophic pyloric stenosis; prognosis is excellent, and mortality is low.

**Risk Factors May Include:**

Obesity in one or both parents, rapid transition across growth percentiles in infant

**Possibly Evidenced By:**

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

**DESIRED OUTCOMES/EVALUATION CRITERIA—PARENT(S) WILL:**

Identify and adopt appropriate infant feeding practices.

Explain factors that promote excess weight gains and eating problems.

**ACTIONS/INTERVENTIONS**

**RATIONALE**

**Independent**

Assess measurement of infant’s weight/height for age and sex. Determine anthropometric assessment.

Weight greater than the 85th percentile in relation to height, age, sex, and body build is considered obese. Although anthropometric assessment is most accurate, serial weight and height measurements in relation to age are fairly good predictors of obesity or excess weight gain.

Review parental weight history.

Heredity and family feeding practices contribute to obesity. There is an 80% probability that if parents are obese, the child will also be obese. If parents are not obese, this probability is only 7%.

Note type of infant feeding (i.e., breast or bottle).

Breastfed infants are less likely to be obese than bottlefed infants, because the breastfed infant regulates the feeding based on hunger needs. In a desire to empty the bottle, parents may overfeed the bottle-fed infant by continuing to feed even after satiation has been reached.

Determine amount and frequency of infant feedings.

Feedings in excess of infant caloric needs relative to energy expenditures result in excess weight gains, possibly leading to obesity.

Provide information about infant’s energy requirements; encourage mother to let infant regulate intake based on hunger needs.

Reduces likelihood of overeating.

Encourage mother to avoid introduction of solid foods until infant is at least 4–6 mo of age.

Early addition of solid foods contributes to development of poor eating habits, excess food consumption, and infantile obesity. Mother may mistakenly think that addition of solids enhances infant’s chances of sleeping through the night, but such practices have been found to have no effect on infant sleep patterns.

Encourage mother to restrict the use of infant seat during waking hours and to allow infant to spend time on mat on floor.

Enhances activity and energy expenditure.

Discuss mother’s feeding of infant for emotional upsets or distress signals.

Inappropriate use of food in response to newborn’s distress encourages infant to associate food with emotional gratification rather than with hunger.

Discourage substitution of skim or whole milk for commercially prepared formula for first 12 mo of life.

Discuss possible lifelong risks associated with overeating.

Review family eating patterns.

Such substitution may increase renal solute load as a result of excess protein and mineral ingestion. Use of whole milk may result in increased plasma osmolality, hyperphosphatemia, and hypernatremia.

Overeating increases risk of health problems related to cardiovascular system, hypertension, and diabetes.

Healthy eating habits and selection of appropriate amounts and types of foods can ultimately affect nutrition of the growing child.

---

**NURSING DIAGNOSIS:**

**May Be Related To:**

**Possibly Evidenced By:**

**DESIRED OUTCOMES/EVALUATION**

**CRITERIA—PARENT(S) WILL:**

---

**KNOWLEDGE deficit [Learning Need], regarding infant care**

Lack of exposure/recall, misinterpretation, unfamiliarity with resources

Verbalization of problem/concern or misconceptions, inaccurate follow-through of instructions, development of preventable complications

Provide appropriate nutritional intake.

Create safe, stimulating/restful infant environment.

Identify signs/symptoms requiring medical follow-up.

Use healthcare system appropriately.

Plan for short- and long-term child care.

---

---

**ACTIONS/INTERVENTIONS****Independent**

Reinforce or provide appropriate information about infant's nutritional needs for next few months.

Provide information about role of iron in body and the need for supplementation.

---

**RATIONALE**

Helps ensure normal growth patterns in height and weight, and may prevent overfeeding through too early introduction of solid foods.

American Academy of Pediatrics recommends 1 mg of iron per kg of body weight per day for full-term infants, starting no later than 4 mo of age. Iron-fortified commercial formula for bottle-fed infant offers most constant and predictable iron ingestion. By 4–6 mo of age, breastfed infant should have supplemental iron in form of iron-fortified cereal or oral iron drops.

Discuss role of fluoride in body and in tooth development. Encourage parents to obtain fluoride supplements if appropriate.

Review information for lactating mother, as needed, including increased infant appetite and caloric needs during growth spurts at about 6 wk and 3 mo of age.

Determine how long mother plans to breast-feed. Discuss techniques of weaning from breast when desired and the process of introducing solids between 4 and 6 mo of age. (Refer to NDs: Nutrition: altered, risk for less than body requirements; Nutrition: altered, risk for more than body requirements.)

Review signs of milk sensitivities, especially if lactating mother plans to wean infant to a bottle when she returns to work.

Discuss mother's plans for possible return to work and plans for child care and feeding practices. Provide anticipatory guidance for lactating mother to allow her to continue with breastfeeding and to maintain milk supply.

Identify factors to be considered and resources available when choosing child care. Stress importance of ongoing monitoring of care provided.

Provide oral or written anticipatory guidance related to infant safety, including discussion of potential accidental injury caused by suffocation, falls, burns, motor vehicle accidents, or bodily trauma. (Refer to NDs: Suffocation/Trauma, risk for.)

Provide information about importance of recommended primary schedule for immunization.

Fluoride helps reduce incidence of tooth decay and improves quality of tooth enamel, making it more resistant to caries, if fluoride is ingested before eruption of teeth. Breastfed infants consume little or no water and should receive 0.25 mg of fluoride per 24 hr for 1st yr of life. Although commercial formulas have minimal amounts of fluoride, supplementation is not necessary if home/bottled water supply used in formula preparation contains 0.3 parts per million (ppm) fluoride.

The "reward period" for the breastfeeding mother may not occur until 6 wk after delivery, and she may need further encouragement and information to continue. Note: Infant may need to nurse more frequently during periods of rapid growth.

Anticipatory guidance related to the individual situation provides for anticipatory problem solving and enhances optimal outcome.

If milk sensitivity is present, infant may require use of soy or other formulas. (Refer to ND: Nutrition: altered, risk for less than body requirements.)

Allows mother to anticipate and plan for problems that may arise. Breastfeeding can be continued with adequate planning and management. Note: Some employers have an area where breastfeeding/breast pumping can be done.

Placing infant in care of others can be difficult for parents relative to issues of trust and child well-being. Informed choice and vigilance enhance parent(s) level of comfort and promote optimal outcomes.

Helps parent(s) to recognize potential safety hazards and reduce risk of injury. Crawling reflex (which propels infant forward), rolling over, increasing eye-hand coordination, and voluntary grasp reflex increase risk of accidents in first 4 mo of life.

Immunizations begin in infancy to reduce incidence of infectious disease (diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, and hepatitis B). Although recommendations are to begin immunizations at 2 mo of age, current discussion varies as to whether immunizations should begin at birth or after the 1st yr to avoid possible untoward responses.

Discuss timing and importance of infant's regularly scheduled well-baby visits to physician or nurse practitioner.

Discuss infant's physical, emotional, and developmental needs. Provide oral or written/pictorial information about anticipated monthly progression of physical (gross and fine motor) development, sensory development, and vocalization and socialization.

Evaluate environment for its ability to provide appropriate infant stimulation and rest. Assist parents as needed in planning for and providing appropriate visual, auditory, tactile, and kinetic stimulation as well as quiet ideas for sleep. Discuss changing needs of infant play as development progresses during the 1st yr. (Refer to ND: Sensory/Perceptual alterations, risk for.)

Review infant's sleep-wake patterns. Suggest ways to promote sleep through provision of warm, nonstimulating environment, position changes, and sleeping arrangements separate from parents' room.

Reassess parent-infant interaction. Discuss methods to foster mutually satisfying interactions and development of infant's trust.

Encourage parents to pay attention to infant cues and to provide gratification soon after need is identified.

Offer anticipatory guidance, as appropriate, regarding teething, shoes, use of pacifiers, thumb sucking, and so forth.

Helps detect any deviations from normal growth and development and ensure early intervention if deviations are identified.

Allows parents to monitor infant's growth and development during infancy. May help reduce parental anxiety relative to individual infant variations.

Helps parents recognize the balance between play and rest and to provide optimal environment for infant play, rest, and development. At 1 mo of age, placing bright hanging objects 8–12 inches from infant's face or looking at infant from close range provides visual stimulation. Talking to or singing to infant, or playing music box or radio, provides auditory stimulation. Holding, cuddling, and providing warmth offer tactile stimulation. Rocking infant in chair or cradle and using carriage provide kinetic stimulation.

Rest periods/naps, usually after meals, are essential for continued growth. Intervals of sleep at night range from 4–10 hr with frequent naps and increased periods of wakefulness without crying. By 3 mo of age most infants have developed a nocturnal pattern.

Ongoing quality of emotional care is an important aspect in promoting optimal infant growth and development. Mutually satisfying parent-infant relationship fosters development of a sense of trust in newborn.

Allowing infant to feel physically comfortable, warm, emotionally loved, and secure aids in development of mutual trust and fosters development of healthy ego in the infant. Delayed gratification and/or meeting needs before infant signals them can lead to development of a sense of mistrust.

During 1st yr of infant's life, both new and experienced parents may have concerns or questions, which if addressed early can foster positive coping, reduce anxiety, and increase problem-solving skills.

---

**NURSING DIAGNOSIS:**

**Risk Factors May Include:**

**Possibly Evidenced By:**

**INFECTION, risk for**

Immature immunologic response, increased environmental exposure

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

**DESIRED OUTCOMES/EVALUATION CRITERIA—NEONATE WILL:**

Be free of infection.

**PARENT(S) WILL:**

Identify individual risk factors and appropriate interventions.

List signs requiring medical intervention.

---

**ACTIONS/INTERVENTIONS**

**RATIONALE**

---

**Independent**

Discuss newborn development and individual risk factors.

By 4 wk of age, the infant is usually out in public more often or may even be cared for outside the home. The infant is particularly susceptible to coryza, or the common cold, which is most frequently caused by a rhinovirus and an immature immunologic response. Because the infant has been an obligatory nose breather and is only beginning to learn to open the mouth in response to an increase in mucus production and edema of nasal mucosa, respiratory problems and an increase in airway resistance may result. Possible complications such as otitis media, sinusitis, or lower respiratory tract infection may also develop.

Review signs of upper respiratory infection (e.g., poor feeding, breathing difficulty, cough, and nasal congestion) with parents.

Reinforces parental learning to assist them in identification of infant's respiratory problems.

Suggest elevating infant's head/shoulders by raising crib mattress to 30-degree angle when infant has trouble breathing.

Increases vertical chest capacity and lung expansion with descent of diaphragm. Facilitates drainage of mucus into stomach.

Recommend observing stool for passage of mucus.

Because infant cannot blow nose, excess mucus is excreted through the GI tract with the stool.

Observe parent(s) technique for using bulb suction to clear mouth/nose of excess mucus.

Bulb suctioning of mouth first, then nose second avoids introduction of microorganisms colonized in nose into oral cavity/pharynx.

Review proper handling/cleaning of syringe.

Bulb should be cleaned with hot water and allowed to dry after each use.

Encourage giving infant sterile warm water between regular feedings twice a day, as appropriate.

Promotes hydration to help liquefy secretions.

Provide information about benefits of humidified air.

Liquefies secretions and provides moisture for mucous membranes, reducing risk of excessive dryness/cracking.

Show parents how to inspect pharynx and to distinguish between viral and bacterial causative agent if area is reddened or inflamed. Discuss appropriate response.

Enlarged lymphoidal tissue and appearance of erythema (suggesting viral cause) or white exudate (indicating bacterial or streptococcal cause) characterize pharyngitis and tonsillitis. Viral infections may resolve with only palliative measures, whereas bacterial infections usually require medication.

Review methods for monitoring temperature.

Discuss signs indicating a deterioration in newborn's status and necessitating evaluation by healthcare provider, such as pulling at ear (as child gets older), croupy cough, elevated temperature, cyanosis, and wheezing.

Instruct parents not to medicate infant without discussing such action with healthcare provider.

Demonstrate medication administration (e.g., antibiotics, ear or nose drops).

Digital pacifier or rectal are both acceptable techniques for obtaining infant's temperature with rectal result approximately 0.5°F (0.28°C) higher. Note: Some healthcare providers prefer rectal measurements.

Involvement of lower respiratory structures or respiratory compromise requires further evaluation and treatment. Infant is prone to development of otitis media because of short, distensible eustachian tubes, which open inappropriately; an immature humoral defense system; and pooling of fluid in pharyngeal cavity when infant is in recumbent position.

Information about administration of medications, when to use them and when not to use them, helps parents know when to ask for assistance.

Enables parents to provide optimal care for infant's individual needs. For example, saline nose drops instilled 15 min before feedings may improve oral intake at mealtime. Note: Use of nose drops in newborn is somewhat controversial, because drops may lead to aspiration if they are improperly administered.

## Collaborative

Provide referral for laboratory studies (e.g., complete blood count with differential [CBCD], throat culture) if needed.

Helps confirm infectious process and identify pathogens, especially when causative organism may be beta-hemolytic streptococci.

---

### **NURSING DIAGNOSIS:**

#### **Risk Factors May Include:**

#### **Possibly Evidenced By:**

#### **DESIRED OUTCOMES/EVALUATION CRITERIA—NEONATE WILL:**

#### **PARENT(S) WILL:**

---

### **SUFFOCATION/TRAUMA, risk for**

Lack of ability to protect self (infant), lack of awareness of hazards (caregivers)

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Be free of injury.

Institute appropriate environmental adaptations or precautions to prevent accidental injury.

Demonstrate concern for infant's well-being by responding to crying with soothing techniques, reacting appropriately during interactions with infant, and raising appropriate questions and concerns.

---

## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

---

### **Independent**

Provide oral or written/pictorial information about infant's motor development between 1 and 4 mo of age, its effect on mobility, and the increased risk of injury.

Allows parents to focus on age-appropriate safety measures. The major developmental changes that occur between birth and 4 mo of age are increased eye-hand coordination, development of voluntary grasp, ability to roll over, and increased possibility of movement associated with crawling and with Moro's reflex.

Review environmental factors that place infant at risk for suffocation.

Improper storage and use of plastic bags, loose-fitting sheets or soft mattress/pillows, opportunities for drowning, and strings around pacifiers/bibs (especially if they are worn at nap time or at night) place infant at risk for suffocation.

Discuss dangers associated with aspiration and proper use and storage of baby powder.

Aspiration dangers at 1 mo are most often related to baby powder container, which because of its shape may be held like a bottle, thereby creating risk of inhalation, aspiration, and possibly fatal asphyxiation.

Provide anticipatory guidance regarding necessity of burping infant before placing in bed, proper positioning, keeping small objects out of infant's reach, avoiding use of clothing with buttons, avoiding balloons or toys with removable parts.

Regurgitation associated with reverse peristalsis and immature or relaxed cardiac sphincter increases risk of aspiration. As infant's coordination and strength increase, potential exists for infant's pulling toys and decorations apart and putting small pieces in mouth.

Reassess and discuss other home safety factors, including precautions for home layout and furniture used for infant care, cigarettes and second-hand smoke, hot liquids, and motor vehicles.

Reminds parents of situations that may present danger for their infant; provides opportunity for problem-solving individual needs.

Reevaluate parents' understanding and practices related to the potential for bodily harm to infant. Provide information as needed.

Keeping diaper pins closed and out of infant's reach and carefully putting away scissors, knives, and razors reduce risks associated with bodily injury from sharp or jagged-edged objects as infant matures and becomes more active.

Assess emotional tone and quality of parent-infant interaction. Note response to infant's crying and nature of adjectives used to describe infant.

Failure of parent to have fun, talk, and make eye contact with infant; anger or frustration in response to crying episodes; and repeated use of negative adjectives to describe infant indicate a negative emotional bond with infant, which may lead to emotional or physical abuse.

Evaluate infant for physical evidence of abuse.

Excessive bruising, pinch marks, handprints, lacerations, abrasions, malnutrition, FTT, or lack of subcutaneous fat indicates possible child abuse/neglect.

### **Collaborative**

Make appropriate referrals to healthcare provider, community agencies, and support groups.

May be necessary to help parents develop positive parenting skills and reduce possibility of physical or emotional harm to infant.

Report suspected abuse to physician and appropriate social or child-care agency.

Suspected child abuse may warrant further investigation before permanent injury or death occurs. Note: Most states have statutory guidelines requiring reporting of suspected child abuse/neglect.

---

**NURSING DIAGNOSIS:****Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION  
CRITERIA—NEONATE WILL:****PARENT(S) WILL:**

---

**PAIN [acute], risk for**

Accumulation of gas in a confined space with cramping of intestinal musculature

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Be free of, or display less frequent, crying spells and episodes of colic.

Identify/demonstrate appropriate techniques to relieve newborn anxiety and tension.

---

---

**ACTIONS/INTERVENTIONS**

---

**RATIONALE**

---

**Independent**

Evaluate infant's behavior.

Helps differentiate cause of problem. For example, colicky infant typically cries loudly, draws legs up to abdomen in pain, clenches fists, and sucks vigorously. Infant with otitis media may pull at affected ear.

Determine what parents have done previously and success of those interventions.

Assists in determining interventions that may be helpful at this time.

Reassess diet of lactating mother and infant feeding/formula preparation procedures.

Helps identify specific foods or errors in feeding process that may be causing discomfort.

Discuss physical condition and infant's well-being.

Gastric acidity reduces within 1st wk of life, affecting digestion and development of colic, which often resolves within 2–3 mo. Despite colic attacks, infant normally thrives, gains weight, and tolerates feedings.

For additional interventions, refer to CP: One Week Following Discharge; ND: Pain [acute], risk for.

---

**NURSING DIAGNOSIS:****Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION  
CRITERIA—PARENT(S) WILL:**

---

**SENSORY/PERCEPTUAL, risk for alterations**

Immature development of sensory organs, inappropriate/inadequate environmental stimuli; effects of disease, trauma, drugs

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis.]

Provide adequate/age-appropriate stimulation.

Identify impairments.

Initiate appropriate interventions.

---

## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

---

### **Independent**

Repeat the Brazelton Neonatal Assessment Scale as appropriate, and compare with previous testing.

Measures cerebral and neurological functioning and assesses interactive behavior. Although testing is usually done at 3 days of age, prolonged effects of intrapartal events/birth stress may affect initial results. Reevaluation provides opportunity for comparison and to verify appropriateness and progression of responses.

Observe responses to visual, auditory, or tactile stimuli; note motor function and reflexes.

The adequacy of sensory modes (e.g., visual, auditory, and tactile) in a 4-wk-old infant is determined by eliciting responses and evaluating the age-specific response. Causes of deviations in sensory perception may be related to vascular or traumatic injury that develops over a period of hours; toxic, infectious, or electrolyte imbalances that peak in several days; or congenital or degenerative injuries that develop or worsen insidiously over days, weeks, and months.

Determine occurrence of recent illnesses of infant or family members, prenatal or intrapartal complications and postnatal course.

Helps detect environmental infection and illness; may rule out mechanical causes of alteration.

Assess parents' behaviors and responses to infant using such measures as Cropley's Critical Attachment Tasks, Maternal Tasks, Mother-Infant Screening Tool (MIST), and Reiser Fathering Assessment Tool.

Helps identify possible inadequacies in parent-infant interaction and establishes them as causative factors in infant's unresponsiveness to surroundings.

Encourage parents to stroke infant gently from head to toe with hand, washcloth, or cotton, and to hold, caress, cuddle, and swaddle infant.

Stimulates sense of touch; conveys feelings of warmth and protection.

Suggest parents place mobiles or bright, shiny objects within 8–12 in of infant's face, to look at infant en face (face-to-face) at close range, and to decrease intensity of light and move objects slowly.

Stimulates visual development. At 4 wk of age, infant can see shadows and outlines, showing preference for circular shapes, intricate patterns, and human faces.

Discuss placing ticking clock or radio playing soft music near infant, playing tape of parent reading a story, talking or singing to infant, and playing music box.

Provides auditory stimulation and may be soothing to infant; e.g., clock may stimulate human heartbeat.

Encourage parents to rock infant, place infant in swing, gently cradle infant in arms, and take infant for walks in carriage or in backpack placed close to back or chest.

Provides kinetic stimulation.

Assess strength of muscles, finger grasp, limb recoil, and stretching. Institute age-appropriate exercises.

Provides parents with information about the infant's ability for reciprocal behavior. Specific exercises stimulate sensory development.

**Collaborative**

Refer to other resources (e.g., physician, nurse practitioner, physical therapy clinic, parenting classes and support groups) as indicated.

May be necessary for follow-up care and evaluation of identified problems. (Provides role models, facilitates role transition and skill acquisition.)