

THE INFANT OF AN ADDICTED MOTHER

Although abuse of alcohol, heroin, and marijuana has remained relatively stable, cocaine and crack use is growing dramatically, affecting approximately 1 in 10 pregnancies (higher in urban areas). In addition to alcohol and illicit drugs, abuse of prescription medications also occurs and use of multiple substances is common. From 80%–90% of infants born to addicted mothers are physiologically addicted and experience passive signs of drug withdrawal, commonly referred to as neonatal withdrawal syndrome or neonatal abstinence syndrome. It is estimated that cocaine use alone impacts 30,000–50,000 infants born annually. An additional 3000–5000 infants yearly are determined to be suffering from FAS. This plan of care is to be used in conjunction with the previous newborn plans of care. Refer also to CPs: The Preterm Infant and Deviations in Growth Patterns, as appropriate.

NEONATAL ASSESSMENT DATA BASE

Severity and time of onset of symptoms are related to substance(s) abused, duration of use, and maternal drug level at birth.

Activity/Rest

High-pitched cry, wakefulness, short or unquiet sleep patterns, yawning
Difficulty maintaining alert states

Circulation

Tachycardia
Hypertension

Ego Integrity

Poor state organization (cocaine use)

Elimination

Diarrhea
Hyperactive bowel sounds (hypermotility)

Food/Fluid

May be LBW or SGA infant; may have IUGR (maternal use of heroin, alcohol, or cocaine, or maternal malnutrition); or may be higher-birth-weight/LGA infant (maternal use of methadone)
Poor feeding with uncoordinated frantic sucking, hyperphagia, drooling, hiccups, possible cleft lip
Weight decrease or failure to gain weight
Vomiting/regurgitation
Dry mucous membranes, poor skin turgor, sunken fontanelles
Abdominal distension, changes in bowel sounds, dilation of bowel (paralytic ileus, NEC)

Neurosensory

Apgar score may be low (e.g., intrauterine asphyxia or medication given to mother during intrapartur period).
Small head circumference/SGA (nicotine); microcephaly (FAS, cocaine use, toxic vapor abuse); facial abnormalities (FAS, toxic vapor abuse).
Hyperirritability (including increased startle response), hyperactivity, poor state organization; hypertonicity may be present.
Hyperacusis (abnormal sensitivity to sound), difficulty attending to/actively engaging in auditory and visual stimuli.
Tremors, persistent or rhythmic myoclonic jerks, or seizure activity may be noted.
Increased or exaggerated reflexes (e.g., gag, sucking, rooting, deep tendon, and Moro reflex) may be noted; absent or poor reflexes; poor muscle tone/limpness (perinatal infarcts).
Dilated/tortuous vessels of the iris.

Respiration

Periods of apnea (cocaine), transient tachypnea (heroin).
Increased tearing, rhinorrhea, stuffy nose, yawning, or sneezing may be present.
Signs of respiratory distress; green-tinged mucus (meconium aspiration) (heroin).
Tracheoepiglottal abnormalities (FAS).

Safety

Temperature variations.
Sweating, mottling, and flushing may be seen.
Rub marks on face and knees related to constant “mouthing/crawling” motions pressure-point abrasions.
Sclera, skin may be jaundiced.
Congenital anomalies (associated with cardiovascular or genitourinary systems) may be present.
Signs of infection or sepsis (acquired in utero), history of premature rupture of membrane, impaired immunologic mechanisms (marijuana).

Social Interaction

May exhibit poor tolerance for being held, decreased interactive behavior (difficulty responding to human voice/face, environmental stimuli), gaze aversion.

Sexuality

Female more commonly affected, ratio 2:1 (FAS)
Genital abnormalities in females (FAS)

Teaching/Learning

May be premature.
Mother may have received no prenatal care (literature suggests that 75% of women who abuse drugs during pregnancy do not seek prenatal care until the onset of labor), or may report prenatal problems associated with preterm labor, abruptio placentae, or placenta previa (placental insufficiency/fetal asphyxia); infections such as pneumonia, endocarditis, STD, or hepatitis; PIH; and anemia.

Diagnostic Studies

Toxicology or Drug Screen (maternal/infant blood and urine, and fetal meconium): Identifies current substance exposure. Cocaine metabolites may persist in urine for 4–7 days after use, or even longer in infant.

Serum Electrolytes: Vomiting/diarrhea resulting in electrolyte imbalances.

Serum Glucose: May be decreased (increased metabolic rate, poor feeding, limited nutritional reserves [FAS]).

CBCD and Blood Cultures: For differential diagnosis associated with sepsis. GBS is becoming one of the most insidious and lethal infections of the newborn.

Platelet Count: May be decreased (tranquilizers or infectious process).

Serologic Tests: Determine presence of STDs, e.g., syphilis, hepatitis B, HIV.

Bilirubin Levels: Increased risk of jaundice (especially in infant of methadone user).

Electroencephalogram (EEG): May be abnormal, demonstrating cerebral irritation, in cocaine-exposed infant.
Normalization of EEG noted by 3–12 mo of age.

Lumbar Puncture: Determines presence of white cells/bacteria, specific GBS antigens.

NURSING PRIORITIES

1. Facilitate and support drug withdrawal in infant.
2. Detection of infectious process.
3. Prevent injury, and reduce risk of short- and long-term complications.
4. Foster parent-infant interaction and attachment.
5. Provide information and support to parent(s) during rehabilitation process.

DISCHARGE GOALS

1. Gaining weight appropriately.
2. Free of injury, complications resolving.
3. Parent-infant interactions progressing satisfactorily.
4. Parent(s)/caregiver understand infant's present condition, prognosis, and needs.
5. Parent(s)/caregiver participate in care and use available resources.
6. Plan in place to meet ongoing needs after discharge.

NURSING DIAGNOSIS:**INJURY, risk for CNS damage****Risk Factors May Include:**

Prematurity, hypoxia, effects of medications/substance use and/or withdrawal, possible exposure to infectious processes (perinatal/intrapartal)

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION

Be free from injury and complications.

CRITERIA—NEONATE WILL:

Display reduced periods of hyperactivity or irritability; free of seizure activity.

Display CNS function WNL.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Determine maternal history of addiction, noting duration, type of drug(s) used (including alcohol), and time and strength of last dose before delivery.

Degree of infant narcosis and withdrawal is related to the amount of mother's regular drug intake, the length of time mother has been addicted to drug(s), and the drug level at time of delivery. The closer the drug ingestion is to the time of delivery, the longer it takes for the infant to develop withdrawal and the more severe the manifestations may be. Note: An addicted mother frequently uses more than one substance, e.g., alcohol, cocaine, heroin, and phencyclidine (PCP).

Review prenatal/intrapartal record, and note any anesthesia or analgesia administered during intrapartal period.

The newborn is susceptible to possible long-term effects from fetal asphyxia associated with placental insufficiency, fetal drug withdrawal in utero (secondary to maternal withdrawal), and increased incidence of strokes and intracerebral hemorrhage. Medications administered to the mother during the intrapartal period, acidosis, and hypoxia associated with meconium aspiration may also contribute to temporary or permanent alterations in CNS function.

Observe infant for initial signs of acute withdrawal (e.g., tremors, restlessness, hyperactive reflexes, sneezing, high-pitched shrill cry, and hypertonicity).

Monitor withdrawal using an evaluative tool or a seizure withdrawal chart (e.g., Neonatal Abstinence Score).

Place infant on abdomen. Provide pacifier/allow hand-to-mouth contact.

Swaddle infant in prone fetal (flexed) or side-lying position. Provide quiet, dimly lit area and scheduled periods of uninterrupted sleep.

Observe sleep patterns and degree and timing of irritability. (Refer to CP: The Preterm Infant; ND: Infant Behavior, risk for disorganized.)

Place baby in infant carrier, play soft music, and provide gentle rocking during periods of arousal.

Monitor effects of handling; decrease handling, as indicated.

Monitor vital signs and neurological status.

Observe infant for change in withdrawal signs and/or for side effects of drug therapy.

Observe infant for signs of seizure activity, such as twitching (rhythmic movements not decreased when limbs are held), rigidity, arching of back, nystagmus, and tongue thrusting or sucking motions. Institute seizure precautions.

Although these signs may appear soon after delivery (6–24 hr), the mean is 72 hr after birth, with delay of onset for as long as 10–14 days following delivery, especially if mother was on methadone maintenance during prenatal period. Note: Frequency of withdrawal signs is significantly less if methadone dose at time of delivery was 20 mg.

Consistent use of an objective tool provides a cumulative record that is useful in judging progress of withdrawal and/or effectiveness of supportive care and in determining need to institute or alter pharmacological therapy. Early identification of infants requiring medical or pharmacological intervention decreases incidence of mortality and morbidity. Subacute effects of narcotic drug withdrawal may last 4–6 mo.

Facilitates quieting and behavior organization. May reduce tension levels, decrease crying and irritability, and may actually reduce amount of drug treatment needed.

Decreases external stimuli, reducing CNS stimulation. Note: Infant may need to be positioned on side when risk of vomiting or regurgitation is present.

Excessive jitteriness and irritability interrupt sleep cycle, possibly necessitating initiation or alteration of pharmacological therapy. Withdrawal prevents adequate periods of deep sleep, but therapy promotes REM and deep sleep cycles.

Mimics intrauterine posture, helps soothe infant; provides body closeness.

Holding infant and providing close contact usually reduces hyperactivity and quiets child, although some infants become more irritable when they are held.

Early detection and treatment of potential complications such as meningitis, intracranial hemorrhage, and pyrexia reduce risk of long-term sequelae. Prematurity and liver immaturity, especially when associated with use of methadone, increase the risk of jaundice and kernicterus.

Changes in withdrawal signs may necessitate alteration in medication dosage to produce the best effect at the lowest dose without the side effects of excessive CNS depression, impaired sucking, or delayed bonding. Note: The greater the number and severity of withdrawal signs, the higher the probability of infant mortality or morbidity.

Newborns experiencing passive withdrawal from addiction are subject to convulsions associated with CNS stimulation, which increases risk of injury.

Suction airway, and provide resuscitative measures, as indicated.

Maintains airway patency and supports vital functions.

Collaborative

Monitor laboratory values, as indicated:

Glucose;

Useful in differentiating signs of withdrawal from those of hypoglycemia. Note: Increased risk of hypoglycemia exists in FAS infants, who are often SGA with limited nutritional reserves.

ABGs;

Hypoxia and acidosis may develop, requiring prompt intervention.

CBCD, sodium, calcium, and blood cultures.

Alterations in electrolytes and presence of sepsis or meningitis can produce signs similar to those of withdrawal.

Administer medications, as indicated:

Note: Infant experiencing cocaine withdrawal usually does not require pharmacological support.

Paregoric (administered orally);

Paregoric is the drug of choice for pharmacological management of drug withdrawal in the infant because of its sedative effect and lack of adverse effects.

Phenobarbital;

Sedatives may prevent or control seizure activity and modify hyperactive movement by depressing cerebrum, reducing CNS stimuli, and controlling irritability and insomnia.

Lorazepam (Ativan);

Often used for sedation by itself or with denatured tincture of opium (DTO). May decrease amount of DTO needed. Respiratory depression is main adverse effect, especially when used with other anticonvulsants.

Chlorpromazine (Thorazine);

While these drugs are generally not recommended, Thorazine may be used to control CNS and GI effects of withdrawal, but may be associated with prolonged excretion time and hypothermia.

Diazepam (Valium).

Valium can rapidly suppress narcotic withdrawal effects, but is poorly metabolized and excreted by infant and may require as long as 1 mo for total elimination. Parenteral administration may displace bilirubin and is contraindicated in jaundiced or premature infant.

Administer supplemental oxygen, as needed.

Corrects hypoxia and may prevent associated CNS damage.

Refer to foster care or child protection agency. (Refer to ND: Parenting, risk for altered.)

Psychosocial environment of home setting may predispose infant to neglect, addiction, or personality problems in later life. Some state laws require that all addicted mothers be reported to a child protection agency.

NURSING DIAGNOSIS:

AIRWAY CLEARANCE, ineffective/GAS EXCHANGE, impaired

May Be Related To:

Excess production of mucus, depression of cough reflex and respiratory center, intrauterine asphyxia

Possibly Evidenced By:

Tachypnea, tachycardia, cyanosis, nasal flaring, grunting respirations, hypoxia, acidosis

DESIRED OUTCOMES/EVALUATION CRITERIA—NEONATE WILL:

Display ABGs and respiratory rate WNL, with pink mucous membranes.

Be free of signs of respiratory distress.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note respiratory rate and effort, color, heart rate, presence of cough reflex, and signs of respiratory distress.

Narcotic may depress respiratory center and cough reflex. Transient tachypnea (>60 respirations per min) secondary to excess fluid reabsorption in the lungs may occur. Tachycardia, cyanosis, nasal flaring, or grunting indicates hypoxia and respiratory failure. Mottling may occur as a vasomotor response during withdrawal and may be unrelated to peripheral oxygenation.

Review and record fetal status during prenatal and intrapartal periods, and at delivery, for evidence of stress, hypoxia, or meconium-stained amniotic fluid.

Provides data about infant’s respiratory status and indicates occurrence and degree of hypoxic insults.

Place infant on side or in semi-Fowler’s position.

Reduces risk of aspiration.

Note nasal stuffiness; suction prior to feedings, as indicated.

Increased nasal stuffiness and production of mucus interfere with breathing, especially during feedings.

Monitor infant’s temperature. Control environment to promote cooling if infant’s temperature is elevated.

Pyrexia associated with CNS stimulation increases metabolic rate and oxygen needs.

Collaborative

Monitor and graph serial ABGs.

Drug withdrawal causes an increase in oxygen consumption. In addition, respiratory depression or failure may result in hypoxia and acidosis. Although narcotic-addicted infants are usually delivered prematurely, chronic intrauterine stress, especially when associated with heroin addiction, can increase surfactant production, thereby reducing risk of RDS.

Administer supplemental oxygen, if indicated.

Increased oxygen demands and respiratory depression are associated with withdrawal and may compromise respiratory function, causing hypoxia and respiratory acidosis and alkalosis.

Avoid use of narcotic antagonists, such as naloxone hydrochloride (Narcan) and naltrexone hydrochloride (Trexan).

These drugs are contraindicated in narcotic-addicted infants because they may precipitate acute withdrawal.

Place infant on cardiopulmonary monitor and pulse oximeter. Initiate resuscitative measures, as appropriate.

May be necessary in cases of severe respiratory interference. Note: Increased incidence of SIDS has been reported in cocaine-exposed infants, possibly because of altered neurotransmitter content and disruption of brain structures regulating respiration.

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

INFECTION, risk for

Maternal cultures positive for GBS or any STDs

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]Display no signs of infection as evidenced by normal CBCD, stable vital signs; afebrile, negative blood culture.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Identify maternal immune status and blood culture results; note prolonged rupture of membranes, infant's birth weight.

Infant may acquire STDs/GBS, either during intrapartum stage or during parturition. Transmission may also occur in the nursery. GBS is the single most common cause of fatal bacterial infection during the first 2 mo of life. It occurs most frequently in LBW infants and with prolonged rupture of membranes.

Monitor vital signs closely and assess respiratory status (rate and effort).

Respiratory-distress-like syndrome characterizes the infection. It then progresses to apnea, shock, and respiratory failure.

Inspect conjunctiva and eyelids.

Herpes simplex virus, gonococcal ophthalmia, and *Chlamydia* infections present with thick yellow eye discharge, accompanied by eyelid edema. These infections can progress to pneumonia and superficial corneal vascularization and blindness from scarring.

Note skin lesions, e.g., vesicles, pustules, petechiae.

Herpes simplex virus lesions appear in groups of small vesicles, which evolve into pustules with crust. Frequently found around the face, mouth, and on the scalp.

Collaborative

Review laboratory/diagnostic studies, e.g.:

CBCD, platelet count;

Development of septicemia (as evidenced by shift of differential to left, decreased platelets) is a high index of suspicion.

Gram's stain and cultures;

Identifies specific agent(s) involved to determine appropriate therapy.

Giemsa-stained smear;

Identifies herpes simplex virus (obtained from a smear from the base of a vesicular lesion), *Chlamydia* (obtained from lower conjunctival scrapings).

Lumbar puncture with CSF for bacteria, protein and glucose; cell count and differential; Viral culture, liver function tests (LFTs);

CSF analysis helps to detect specific GBS antigens.

Optional testing for viral sepsis may be indicated if tachycardia and/or hepatosplenomegaly or liver function abnormalities are present. Viral organisms may include CMV, herpes, enteroviruses (coxsackie, echo), and rubella.

Chest x-ray.	Presentation on x-ray can vary and may include asymmetrical densities, pleural effusion, or pulmonary granularity (often associated with GBS).
Administer antibiotics as indicated, e.g.:	Dosage and schedule may vary with gestational and postnatal age.
Ampicillin;	May be indicated in early sepsis;
Vancomycin (Vancocin);	May be used.
Gentamicin (Garamycin);	May be effective in early or late sepsis. Note: Check drug levels before and after third dose and adjust accordingly.
Acyclovir (Zovirax);	Indicated in herpes exposure.
Ocular medications, such as vidarabine (Vira-A).	Prevents eye infections.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION

CRITERIA—NEONATE WILL:

NUTRITION: altered, less than body requirements

Inability to ingest/digest/absorb adequate nutrients to meet metabolic needs (e.g., poor/uncoordinated sucking and swallowing, frequent GI irritation with vomiting, diarrhea, and repeated regurgitation; frequent hyperactivity)

Failure to gain weight or weight loss, decreased adipose tissue

Tolerate feedings, free of aspiration.

Maintain adequate nutritional intake as evidenced by normal weight gain and customary stool cycle.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine infant's gestational age. Note maternal prenatal nutritional state and evidence of maternal prenatal care.

IUGR and delivery of LBW infant can result from heroin use, which decreases cellular multiplication and growth hormone production in utero. Many addicted mothers are malnourished throughout the pregnancy, leading to birth of a preterm SGA/LBW infant having low protein, iron, and glucose stores. Approximately 75% of women who abuse drugs during pregnancy do not seek prenatal care until labor begins.

Monitor strength and coordination of sucking and swallowing reflexes.

CNS hyperactivity may negatively affect feeding behaviors and oral intake of nutrients.

Assess infant for nasal congestion, stuffiness, or sneezing. Use bulb suction prior to feedings as indicated.

Clears respiratory passage of excess mucus, allowing newborn to breathe more easily while eating, which may improve oral intake.

Encourage mother to feed infant, and assist her with activity as appropriate. Note effects of drugs and withdrawal syndrome on infant's feeding behaviors.

Hyperactive or sedated newborn is difficult to feed and put to the breast. In addition, FAS infants may display feeding problems and persistent vomiting for 6–7 mo and have difficulty adjusting to solid foods.

Provide small, slow, or frequent feedings. Use high-calorie formula, as appropriate. Encourage mother to avoid overfeeding.

Position infant on right side; do not disturb after feedings.

Monitor infant's intake and output, including frequency and consistency of stools.

Weigh infant as indicated. Graph weight gains and losses.

Institute a calorie count.

Note dryness of skin and mucous membranes, sunken fontanel, poor skin turgor, fever, diaphoresis, and increased urine specific gravity.

Provide pacifier between feedings, position to facilitate hand-to-mouth activity.

Reduce external stimuli, and swaddle infant. (Refer to ND: Injury, risk for CNS damage.)

Test stool for presence of reducing substances.

Collaborative

Monitor laboratory studies, as indicated:

Hb/Hct;
WBC count with differential, blood cultures;
Serum glucose;

Serum electrolytes.

Administer supplemental fluids parenterally, as appropriate.

Reduces risk of abdominal distension with resultant regurgitation. Slow feedings may allow infant to coordinate sucking and swallowing reflexes, improving intake. High-calorie formulas maximize nutrients available for energy production. In many cases, mothers overfeed, offering milk whenever the newborn cries, which may actually prolong the GI dysfunction. Note: If mother chooses to breastfeed infant, addition of HMF to pumped milk may be indicated.

Facilitates emptying of stomach; promotes absorption. Disturbances may increase likelihood of regurgitation.

Identifies imbalances, permitting early intervention. GI irritability is associated with frequent loose or watery stools, vomiting, and regurgitation, with resultant dehydration and malnutrition.

Excessive or steady weight loss may indicate that caloric intake is inadequate for amount of energy being expended.

Inadequate weight gain may require use of higher-calorie formula and supplements, especially in LBW/SGA infant.

Dehydration can occur quickly in newborns because of fluid/electrolyte losses through diarrhea, vomiting, fever, and sweating.

Satisfies infant's need for sucking, promotes self-quieting, and may decrease metabolic demands.

Reduces activity level, metabolic needs, and energy expenditure.

Identifies possible lactose intolerance or poor nutritional state, necessitating use of soy-based formula.

Identifies anemia.

Infection/sepsis may be acquired in utero. Hypoglycemia may develop as a result of poor feeding, hyperactivity with increased metabolic demands, or GI disturbances resulting in faulty utilization of formula.

Electrolyte imbalances may result from profuse diaphoresis, diarrhea, and inadequate fluid and nutrient intake.

May be necessary to prevent dehydration and to correct fluid and electrolyte imbalances associated with diarrhea, sweating, and vomiting.

Provide gavage feedings as indicated.

Conserves energy and decreases risk of regurgitation and aspiration. Gavage may be necessary if sucking and swallowing reflexes are ineffectual or uncoordinated and result in slower, difficult feedings, or if tachypnea or respiratory distress is present.

Administer antispasmodics (e.g., paregoric, tincture of opium) between feedings, as indicated.

Reduces GI irritation, controls loose or watery stools, and helps prevent dehydration.

NURSING DIAGNOSIS:**SKIN INTEGRITY, risk for impaired****Risk Factors May Include:**

Mechanical factors (continual rubbing of face and knees against bedding, scratching of the face with hands), presence of excretions

Possibly Evidenced By:

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

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

Maintain intact skin.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Inspect skin for abrasion or excoriation, especially on face, nose, knees, elbows, and shoulders, and under buttocks.

Changes in tissue color and integrity indicate increased irritation and need for intervention.

Provide soft bedding or sheepskin; cover hands with mitts.

Decreases risk of dermal injury.

Reposition infant at least every 2 hr.

Avoids prolonged pressure on body parts.

Swaddle infant; place in infant carrier.

Provides sense of containment, decreases external stimuli, reducing activity level and risk of dermal irritation.

Provide skin care and meticulous cleansing of diaper area.

Prevents breakdown in diaper area, which is more susceptible to excoriation because of loose excretions/moisture and lack of air circulation.

Collaborative

Apply zinc oxide cream; nystatin medicated cream (Micronazole).

Forms a barrier between skin and irritants. Used to treat fungal infections of the buttocks. Note: *Candida* organisms gravitate to warm, moist areas such as buttocks or groin.

NURSING DIAGNOSIS:**PARENTING, altered****May Be Related To:**

Lack of available or ineffective role model, lack of support between/from significant other(s), unmet emotional maturation needs

Possibly Evidenced By:

of parent, interruption in bonding process, lack of knowledge, lack of appropriate response of child to relationship

Verbalization of role inadequacy, inability to care for infant, inattention to infant needs, inappropriate caretaking behaviors, lack of parental attachment behaviors

DESIRED OUTCOMES/EVALUATION

Demonstrate appropriate attachment behaviors.

CRITERIA—PARENT(S) WILL:

Verbalize realistic perception of the maternal/parental role.

Verbalize insight into own dependency needs.

Contact/use support resources effectively.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Evaluate mother's prenatal and current physical and emotional status. Assess family stressors. Note mother's involvement in prenatal care, childbirth classes, and drug or alcohol rehabilitation programs.

Provides data necessary to evaluate parenting capabilities and the family/home situation. Because of her own emotional state, the addicted mother is often unable to assume the overwhelming task of unselfish giving and nurturing, so that the potential for infant abuse or neglect exists.

Discuss mother's perception of herself, noting realistic and unrealistic appraisals and her desire to change. Maintain nonjudgmental attitude.

Fosters mother's desire to provide data about drug dependence, to discuss her emotional status, and to look realistically at her own ability to cope with the stress of childrearing and with the infant's withdrawal behaviors. The drug-addicted mother is usually dependent and depressed, and has low self-esteem and inadequate support systems stemming from an inability to form lasting intimate/mutually supportive relationships. Her drug dependence has resulted from her inadequate coping skills. Fear and guilt associated with her observation of infant's physiological withdrawal may reinforce her negative self-image and may negatively affect her ability to cope and care for the infant.

Encourage mother to express anxieties, fears, and anger. Discuss ways to release frustrations and manage stress (e.g., stating concern directly or use of physical exercise).

Helps mother to ventilate her concerns. Abusive behavior, guilt, and fear may reinforce feelings of incompetence.

Discuss current status of substance abuse. Initiate plans for enrollment in drug or alcohol rehabilitation program.

Mother's insight into her dependency needs and her ability to use resources to promote change may affect the decision regarding newborn placement with parent(s) or in foster care.

Ascertain maternal/paternal perceptions of parenting role and state of the family.

Provides realistic appraisal of parenting capabilities. Aids in predicting the amount of follow-up needed, and influences decisions regarding custody of newborn.

Encourage frequent visits/telephone contact as appropriate.

Recommend bringing infant to eye contact gradually while speaking slowly and softly.

Observe attachment behaviors and quality of parent-infant interaction.

Assess parent's ability and desire to keep child.

Support parents' efforts to understand and care for child.

Encourage performance of infant care tasks by mother and father.

Provide information about the signs of acute newborn withdrawal, anticipated behaviors, and the therapeutic measures to be employed. Let parents know that these signs are usually temporary; however, infants with FAS can have subacute or long-term withdrawal effects, as well as mental retardation.

Provide names, phone numbers, and addresses of supportive resources providing 24-hr availability. Encourage use of these resources.

Schedule home visit within 7–10 days of infant's discharge from hospital.

Collaborative

Refer parents to community resources, such as addiction counselor, social service, visiting nurse services, or peer/support group.

Minimizes separation between mother and newborn if infant is confined to the nursery, reducing interruption in bonding process. (Refer to CP: The Parents of a Child with Special Needs; ND: Parent/Infant Attachment, risk for altered.)

May limit infant irritability and enhance interactive behavior. Note: Limited ability to tolerate visual activity may result in infant's taking a time-out by averting eyes after only 30–60 sec of interaction. Parent may erroneously interpret this as rejection by the infant.

Previous lifestyles, a potential lack of knowledge regarding child care and the needs of a growing infant, and the possibility of the infant's experiencing problems of withdrawal can interfere with the attachment process. Poor maternal interactional capabilities increase risk for a disturbed mother-child relationship. Furthermore, separation related to the infant's withdrawal, treatment, and hospitalization of the infant required after discharge of the mother may negatively affect the acquaintance process.

Subtle cues of parental anxiety may be apparent in parents' behavior or in the expression of their concerns. The child may need to be placed in foster care if the mother/couple is unable to care for infant for a protracted period of time.

Many parents require constant emotional support to build confidence.

Fosters positive adaptation to parenting role; facilitates the parent-newborn acquaintance process.

Prepares parents for management of withdrawal. Information about therapy may help relieve feelings of guilt, fear, and ambivalence. Feeding problems, excessive crying, irritability, inconsolability, and sleep disturbances may further reinforce parents' low self-esteem, may create potential negative feedback patterns (e.g., avoidance or rough handling of infant), and may interfere with or prevent positive attachment.

Allows parents to obtain help and information to help them to cope with stressful situations.

Helps to monitor home setting and to assess the possibility of substance abuse, poor parenting, and infant neglect or abuse.

Ongoing support and assistance in a protective or therapeutic environment such as a halfway house or the use of ongoing services in the home may help parents develop appropriate parenting skills and promote well-being of the infant.

Make appropriate referral to foster care or child care agency.

Some state laws require notification of such agencies if mother is a known substance abuser. Maternal maturation may be insufficient to meet increasing demands of infant care. Note: Studies show an increased incidence of illness in the offspring of substance abusers believed to be directly related to poor parenting.

Refer mother to drug assistance program, as indicated (e.g., Narcotics Anonymous or Alcoholics Anonymous).

Mother needs to take care of herself before she can assume responsibility for another person.

NURSING DIAGNOSIS:

KNOWLEDGE deficit [Learning Need], regarding infant condition, prognosis, and care

May Be Related To:

Lack of exposure/unfamiliarity with information resources, misinterpretation, lack of recall, lack of interest in learning

Possibly Evidenced By:

Request for information, statement of misconceptions, inaccurate follow-through of instructions, inappropriate behaviors

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

List behaviors/signs associated with substance withdrawal.

Verbalize/demonstrate appropriate infant care activities.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Provide information to parents about infant's behavior and physiological signs of withdrawal. Discuss rationale of treatment plan.

Fosters cooperation and understanding of interventions; promotes safety of infant. Encourages informed decision making.

Review altered responses of infant during withdrawal (increased sensitivity to auditory stimuli, depressed visual orientation and response, increased lability, and reduced alertness). Encourage mother to provide early visual input and pattern stimulation.

Information helps parent(s) understand infant's needs, optimizing infant's capabilities and interactional qualities, which can increase parents' self-esteem and provide reinforcement for efforts. Note: Long-term effects, particularly associated with cocaine, include behavior lability and inability to express strong feelings.

Identify long-term physiological effects of addiction on infant.

Discuss passage of drugs (e.g., nicotine, narcotic, or alcohol) through breast milk.

Provide information about infant's needs following discharge (e.g., food, clothing, and equipment) and verify availability of resources. (Refer to CPs: The Neonate at 1 Week Following Discharge; and The Infant at 4 Weeks Following Birth; ND: Knowledge deficit [Learning Need].)

Recommend that parent(s) learn infant cardiopulmonary resuscitation (CPR).

Stress importance of continued medical monitoring and periodic reevaluation.

Although most infants are free of withdrawal signs by 10 days of age, mild patterns of irritability may persist for 3–4 mo, and sleep problems may persist for as long as 1 yr, creating stress for parents. Use of opiates, methadone, and possibly other drugs has been correlated with SIDS, feeding problems (FTT), hyperactivity, and brief attention span (which may be manifested with apparent long-term growth retardation and disturbed behavior patterns, especially in the FAS infant). In addition, smaller head size associated with cocaine use can lead to neurological impairment and difficulties with language skills as the infant matures.

Alternative feeding method may need to be considered if maternal withdrawal program includes prescribed pharmacological agents. Mother needs to be aware that any drugs she takes can be passed on to the infant. Note: Cocaine may remain in breast milk for up to 60 hr following maternal use.

Helps ensure that parent(s) have necessary supplies in the home to care for the child.

Research suggests a fivefold increased incidence of SIDS in cocaine-exposed infants.

Once withdrawal is complete, infant/child may be asymptomatic until school age, at which time some limitations in general intelligence may be noted (FAS). In addition, lack of early diagnosis/timely intervention increases risk of behavioral problems.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

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

FAMILY COPING, ineffective: disabling

Significant person with chronically unexpressed feelings of guilt, anxiety, hostility, despair, and so forth; dissonant discrepancy of coping styles for dealing with adaptive tasks by/among significant person(s)

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

Verbalize realistic understanding and expectations of family members.

Participate positively in care of infant, within limits of family's abilities.

Express feelings and expectations openly and honestly, as appropriate.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Discuss parents' expectations of themselves and of infant, noting realistic and unrealistic perceptions.

Assess family stressors, history, and situation, and available support systems. Involve other family members in plan of care, if appropriate.

Observe parent-infant interaction and child care skills. Evaluate parents' level of knowledge and decision-making skills in regard to keeping and raising the infant. (Refer to ND: Parenting, risk for altered.)

Ascertain long-range plans and mother's commitment to seeking assistance and making necessary lifestyle changes to achieve and maintain drug-free life.

Collaborative

Provide referrals, as indicated, to meet physical, emotional, and financial needs (e.g., visiting nurse services, group homes, halfway houses, drug programs, and counseling or psychotherapy).

Increases parents' awareness of common problems that may arise and helps them to have a more realistic view of parenting.

A stable relationship, the presence in the home of adults who are not substance abusers, and previous success in childrearing increase chance of positive outcome for infant. Family disorganization and disruption, with absence of strong, consistent father figure, or a history of sexual abuse of female who is addicted, may negatively affect mothering qualities.

Identifies areas of weakness or misunderstanding. Anxiety, depression, low self-esteem and self-confidence, and poor interpersonal skills typically render parents ineffective as primary caregivers and may foster intergenerational problems of child abuse or child neglect and predispose family members to substance abuse.

Mother's drug problem and treatment status, together with her poor coping skills and lack of family support, may interfere with integration of infant into the family, necessitating alternative placement.

May be necessary to provide ongoing care, to reduce incidence of recidivism, and to foster optimal growth and development of parent(s) and infant.