THE PARENTS OF A CHILD WITH SPECIAL NEEDS

The birth of a child with special needs, regardless of whether the condition is temporary or permanent, creates unique concerns for the family, who mourns the loss of a normal, healthy child. Conditions range from prematurity, growth deviations, and infections to gross anomalies. Although each case is individual and varies in degree of involvement, many similarities are observed in the parents' responses to their child.

(This plan of care is to be used in conjunction with the routine postpartal plans of care.)

CLIENT ASSESSMENT DATA BASE

(Refer to Client Assessment Data Base in CPs: The Client at 4 Hours to 2 Days Postpartum; Care Following Ceasarean Birth (4 Hours to 3 Days Postpartum); The Client at 24 Hours Following Early Discharge; The Client at 1 Week Following Discharge; and The Client at 4 to 6 Weeks Following Delivery.)

Ego Integrity

Varied emotional responses (e.g., calm, withdrawal, irritability, restlessness, weeping, anger)
History of postpartal depression or psychosis

Safety

History of exposure to teratogenic factors
Presence of infectious agents (including HIV), premature rupture of membranes

Sexuality

Unexpected intrapartal event (e.g., dysfunctional labor, hemorrhage)
History of birth of a child with special needs and/or perinatal loss

Teaching/Learning

History of substance use/abuse

DIAGNOSTIC STUDIES

Genetic Studies/Chromosomal Analysis: Helps determine presence of syndromes/inherited disorders, general prognosis, and future expectations.
Other Testing: Dependent on specific findings and individual risk factors.

NURSING PRIORITIES

1. Facilitate grieving and positive coping.
2. Provide appropriate information related to short- and long-term implications of child's illness or anomaly.
3. Facilitate learning of parenting role and participation in infant care tasks.

DISCHARGE CRITERIA

1. Demonstrate progress in dealing with grief at own pace.
2. Display appropriate attachment/bonding behaviors.
3. Participate in infant care; develop mastery of therapeutic regimen.
4. Have plan in place to meet needs after discharge.

NURSING DIAGNOSIS:	**GRIEVING [expected], related to**
May Be Related To:	Perceived loss of the perfect child/ pregnancy/delivery, alterations of future expectations

Possibly Evidenced By:	Expression of distress at loss, sorrow, guilt, anger; choked feelings; reliving of pregnancy events; interference with life activities; crying
DESIRED OUTCOMES/EVALUATION—CLIENT/COUPLE WILL:	Verbalize feelings freely/effectively. Demonstrate expected grief responses. Look forward/plan for future one day at a time.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Promote trusting relationship with parents and significant other(s). Encourage verbalization of feelings through listening and an unhurried attitude.	Facilitates sharing of feelings, fears, and concerns. Helps parents to focus on reality of the situation and examine their emotional responses. Grieving for the loss of the perfect child must be completed before parents can establish a positive relationship with their offspring. Staff needs to remain available, even if client seems self-sufficient or withdrawn.
Facilitate the grief process, even if the newborn's problem is temporary or surgically correctable.	The amount of grief the parents experience is independent of the severity/permanency of the infant's problem.
Determine parents' religious orientation, and contact appropriate support, if they desire it.	Many couples lean heavily on their faith as a source of strength during crisis resolution. Note: Perception of situation/condition and individual's response will also be affected by religious beliefs.
Assess for usual grieving responses (e.g., initial shock, disbelief, and denial, then anger, guilt, sadness, and negative self-evaluation/questioning, followed by acceptance) based on cultural/religious practices. Let parents know that these responses are normal.	Grief is the anticipated, healthy emotional response to the profound experience of giving birth to a special needs child, and it involves mourning the loss of the idealized perfect newborn.
Note the stage of grief being expressed. Discuss the individual nature of movement through the stages of grief; let parents know that delays in the grief process or relapses of grief are normal.	The process of grieving is not usually a fluid progression through the stages to resolution; more often the individual fluctuates between the stages, possibly skipping one or more. Understanding that grieving is individual helps the couple let each other grieve at her or his own pace.
Accept use of defense mechanisms (e.g., denial, anger, or silence). Encourage expression of angry feelings, setting limits on unacceptable acting-out behavior.	Use of defense mechanisms at this time may be the best way for parents to deal productively with the situation. However, continued use of defense mechanisms may impair resolution of grief. In addition, preventing destructive behavior is important to the maintenance of the client's self-esteem.
Provide information about extreme mood swings, which may be hormonally induced in the postpartal period.	Usual hormonal adjustments of postpartal period can trigger labile responses and may require further evaluation/treatment.

Offer objective feedback, without judgment, on how behavior is being perceived.

When behavior is unacceptable, gentle statements about angry or withdrawn actions can help the individual cope more effectively with the situation.

Avoid “personalizing” statements made by the parents.

Parents may use the nurse as a sounding board and means of ventilating their feelings. Their statements, although spoken to the individual nurse, are usually directed at the situation in general.

Ascertain parents’ perceptions of infant’s special needs and condition.

The parents’ emotional responses are associated with the perceived loss of the perfect child, in addition to concerns about the infant’s well-being/life expectancy. They may occur regardless of whether the defect appears to healthcare professionals to be relatively minor and/or reparable, or major and life-threatening.

Ask parents what helps them most in dealing with the affected child. Observe nonverbal signals, such as anguished tone of voice, looking down, or crying.

Parents may have a hard time handling the crisis and may have difficulty identifying means of facilitating coping.

Encourage parents to see, hold, and help care for the child.

Interacting with the child as he/she is helps parents to work toward the acceptance phase of the grief process.

Instruct parents in caring for the infant. (Refer to ND: Knowledge deficit [Learning Need].)

Grieving may increase the parents’ fear of caring for the child; in many cases, they feel overwhelmed initially.

Prepare parents for/role-play difficult situations such as discharge from the hospital and other people’s thoughtless comments, questions, and stares.

Parents can develop plan of action to lessen discomfort before actual confrontation with difficult situations.

Evaluate parents for abnormal grief responses, such as inappropriate humor; lack of interest in infant; continued denial of, or failure to recognize, infant’s problem; poor eye contact; continual crying, excessive or vague complaints; inability to carry out self-care activities; or use of distancing in interactions with child (e.g., holding child at arm’s length instead of cuddling).

Inappropriate initial responses may result in long-term emotional dysfunction and lack of resolution of grief. Thus, the grief process may be left open-ended, and the parents’ unresolved feelings continually resurface. Early identification of problems and prompt intervention facilitates individual growth and coping abilities. Note: Parents may be afraid of becoming emotionally attached if they believe that the child might die.

Collaborative

Refer for appropriate individual or family counseling.

Counseling may be necessary for resolution of grief and maintenance of family unity.

NURSING DIAGNOSIS: **PARENT/INFANT ATTACHMENT, risk for altered**

Risk Factors May Include: Delay/interruption in bonding process (separation, physical barriers), perceived threat to infant’s survival, presence of stress (financial, family needs), lack of appropriate response of newborn, lack of support between/from significant other(s)

Possibly Evidenced By: [Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

DESIRED OUTCOMES/EVALUATION CRITERIA—PARENT(S) WILL:	
	Demonstrate beginning attachment behaviors.
	Verbalize acceptance of situation.
	Develop realistic plans for care of the infant.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Provide information honestly about newborn's appearance and condition at birth, encouraging an optimistic perspective (e.g., let parents know the potential for survival or recovery) as appropriate. Describe appearance and show pictures of newborn if initial interaction is delayed and/or following surgery.	The child's appearance may be incongruent with the parents' idealized picture of the perfect infant. Helps prepare parents psychologically for interaction with newborn and reduces the shock associated with initial viewing of infant. Aids in developing parents' trust and in giving them accurate information with which to make decisions. Optimistic perspective helps encourage parents to develop an attachment, although the infant may be unable to participate actively in the interactional process because of illness and/or need for technologic assistance. Note: Based on severity of infant's condition, family may choose to engage in cultural rituals, e.g., Native-Americans may desire to conduct a naming ceremony.
Facilitate communication between parents and nursery staff through use of telephone and letters, especially if infant is transferred to a high-risk facility. Suggest that parents provide tapes, photographs, and personal items for use in infant's environment.	Maintains open channel for exchange of information and clarification of concerns. Fosters continued acquaintance process; helps parents to feel an integral part of infant care and growth. Parents can talk, sign, or tell stories into tape recorder, which can be played for infant, providing audio stimulation and voice recognition of parents.
Encourage verbalization of feelings regarding prenatal/intrapartal and postpartal periods and perceptions of the financial and emotional burdens created by the birth of special needs infant.	Unresolved anticipatory anger and excessive threats to self-esteem and to financial status may predispose parents to subconscious or overt rejection of infant.
Discuss normalcy of feelings related to the grief response (e.g., shock, disbelief, anger, guilt, and sadness).	Parents need to identify and cope with their own grief response before they can begin to bond emotionally with the newborn.
Provide anticipatory and ongoing emotional support to client/couple.	Helps couple whose infant's prognosis is grave to bond with, and then let go of, infant, if death ensues. Parental anticipatory grieving, which begins during the intrapartal period and lasts until the infant dies or shows signs of improvement, may result in a withdrawal from bonding as a protective mechanism. (Refer to CP: Perinatal Loss.)
Determine parents' understanding of infant's condition and needs. Review and clarify questions, and provide opportunity for discussion about the condition and its short- and long-term implications as early as possible after birth.	Initial denial, shock, and disbelief may interfere with understanding and processing of information. Parents may cling to unrealistic expectations or goals if they are not psychologically ready to accept the situation. Review of information helps dispel fantasies, initiate the grief process, and mobilize internal and external support.

Provide information regarding physical and personality characteristics appropriate for gestational age when child is preterm, rather than the characteristics of a full-term infant.	Allows appropriate comparisons for helping parents identify parenting behaviors and activities appropriate for their infant.
Assist parents in identifying familial characteristics, personality traits, positive attributes, and normal behaviors in the infant.	Emphasizes the infant's value as a person and facilitates recognition of individual capabilities and personality traits. Initiates process of attachment and bonding, and allows parents to see similarities between their infant and a normal newborn. Note: Some parents, regardless of how minor the defect is, may have difficulty accepting a baby who is not "perfect."
Promote early parent-infant interaction. Assess parents' perception of infant.	Helps couple acknowledge the reality of the situation and begin to work through appropriate psychologic tasks; determines parents' readiness for involvement in infant care tasks.
Provide privacy for parents to interact with baby.	Parents may want to talk or sing to infant but may not feel comfortable with an "audience."
Review couple's parenting experience and preparation, and previous coping skills. (Refer to ND: Family Coping, ineffective: risk for compromised.)	Provides indications of emotional readiness to adopt parenting roles and responsibilities. Such readiness varies considerably, depending on coping skills and past experiences.
Assess parents for development of attachment behaviors while in the hospital (e.g., talking to, holding, and naming infant; asking appropriate questions regarding infant's condition and needs).	Indicates development of positive parent-infant ties, which help foster optimal growth and development of infant.
Note parental cues indicating readiness for involvement in infant's care and future planning. Encourage parental involvement in planning care and making decisions.	Readiness for parental involvement indicates that client/couple is attaching emotionally to infant, is becoming increasingly concerned for the infant's welfare, and is feeling emotionally able to begin to assume responsibility for infant's care. Parental involvement may enhance feelings of control, promote self-esteem, and reduce anxiety.
Demonstrate special infant care techniques, positions for holding and feeding infant, and ways of talking to infant. Assess parents' need to have staff remain with them or to be left alone with infant.	The nurse acts as a role model in caring for the infant at a time when the parents are acutely aware of others' responses and identify with those responses. Anxiety associated with a new parenting role may be minimized by participation in newborn care.
Encourage appropriate parental participation in infant care.	Reduces anxiety, improves parental self-esteem, and facilitates development of positive parent-infant attachment, which helps to assure appropriate continuity of physical and emotional care necessary for the infant's optimal development.
Identify newborn's responses and behavioral cues.	Aids parents in determining when to interact with infant, what behaviors are appropriate, and when to modify their approach based on infant's tolerance for stimulation.
Provide positive feedback as parents accomplish tasks. Inform staff of parents' capabilities.	Increases sense of self-worth and self-confidence in providing infant's care. Staff coordination provides consistency in approach and helps prevent misunderstandings.

Actions/Interventions	Rationale
Arrange for meeting with other parents who have faced the same or a similar problem.	May aid couple in realistically identifying infant's specific needs and abilities.
Monitor client's/couple's behaviors following client's discharge; e.g., continued visits or telephone calls, and preparation for infant's discharge, or lack of physical contact, failure to name infant or change of name from original choice, negative comments about infant, expressed concerns about adequacy in caring for infant, and failure to visit or communicate with professionals.	Involved behaviors demonstrate continued concern for child's comfort and indicate increasing strength of attachment. Although withdrawal behaviors may represent a normal response to prevent attachment to an infant who may not survive, they may also indicate potential problems, including high-risk parenting (emotional or physical abuse) following discharge, so that further evaluation and/or interventions may be needed. (Refer to CPs: Infant of an Addicted Mother; and The Infant of an HIV-Positive Mother.)
Evaluate appropriateness of discharge planning/ preparation.	Realistic preparation indicates client's readiness for parenting following infant's discharge.
Discuss alternatives to taking baby home (e.g., foster care, institutionalization, adoption), as indicated. Be supportive of final decision; assist parents in evaluating long-term implications of decision.	Parents who choose not (or are unable) to cope with the long-term commitment of raising a child with special needs will need to seek alternative care.

Collaborative

Actions/Interventions	Rationale
Schedule team conference. Identify acute care and community resources for infant and parents (e.g., public health nurse, home care agencies, charitable organizations [such as Easter Seals], and support groups).	Coordinated multidisciplinary planning for discharge can ease the transition from hospital to home and reduce anxiety associated with increased parental responsibilities following discharge.
Refer for counseling or parenting classes, as indicated.	May be necessary if attachment behaviors are incomplete or absent.

NURSING DIAGNOSIS:	**FAMILY COPING, ineffective: risk for compromised**
Risk Factors May Include:	Situational crises, temporary preoccupation by a significant person who is trying to manage emotional conflicts and personal suffering and is unable to perceive or act effectively in regard to client's needs, temporary family disorganization/role changes
Possibly Evidenced By:	[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]
DESIRED OUTCOMES/EVALUATION CRITERIA—FAMILY WILL:	Participate in problem solving and use resources appropriately. Demonstrate integration of infant into family unit.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Evaluate usual family coping mechanisms and relationships among family members. Note history of high-risk behaviors (e.g., substance abuse) or presence of chronic illness.	Helps in identifying strengths and weaknesses and availability of support systems. Individual issues/limitations may overtax family's ability to be involved with client or care for infant.
Identify cultural influences relative to support systems/family involvement, including family spokesperson.	Different family members may assume leadership roles (e.g., family spokesperson/intermediary between healthcare providers and parents based on cultural dictates). For example, in Vietnamese and Iranian cultures, the father is consulted first, whereas in Puerto Rican and Russian cultures the client (mother) is consulted first. The maternal grandmother is the intermediary in Haitian families, whereas the paternal grandmother may take this role in the Hmong culture.
Provide calm, supportive environment and role modeling for parents.	External stressors may interfere with incorporation of therapeutic interventions by parents. Psychosocial needs of parents may be met through positive role modeling by healthcare providers.
Provide emotional support by allowing time, privacy, and opportunity for open discussion. Provide information honestly; keep client/couple informed regarding infant's condition.	Helps client/couple to identify and clarify fears and concerns, and to correct misconceptions.
Determine parental concerns, emotions, and degree of anxiety. Review past experiences with stress and past coping mechanisms and support systems.	Past experience with stress or crisis influences current stress response and management, resulting in either functional or dysfunctional behavior.
Encourage verbalization of fears, and initiate discussion of opportunities.	Parents may be hesitant to share concerns with staff. Fears may go unaddressed unless staff conscientiously creates opportunities for discussion during their client/infant care activities.
Provide parents with realistic responses and reinforcement, giving consideration to their capacity to process information and their knowledge of the situation.	Lack of knowledge contributes to increased anxiety, which interferes with the ability to cope. However, anxiety needs to be minimized for parents to process information. Repetition of explanations enhances understanding.
Encourage parents to express their own dependency needs and to focus on themselves and their own discomfort.	Both parents may need to devote time and energy to understanding and dealing with their own feelings prior to directing their concern to the infant.
Assess individual and collective responses of family members to infant's condition/appearance. Encourage family to verbalize their perceptions of the impact of the infant's illness or condition on the family.	Parental feelings toward the infant are critical, because feelings that are related to physical appearance and capabilities are internalized in the infant as development occurs.
Use role-playing techniques or play therapy with siblings. Demonstrate these techniques for parents to use. Provide information about age-appropriate discussions with siblings.	Helps young children express feelings about infant. Using words and expressions appropriate to the age of the other children helps the parents in talking with them about the new baby.

Evaluate and help parents recognize signs of ineffective coping in siblings (e.g., interpersonal problems, excessive quarreling, psychosomatic illnesses, school problems, regressive behaviors).	Early recognition allows the family to take steps to correct these problems and to seek professional help if necessary.
Encourage client/couple to arrange sibling visits and to allow older siblings the opportunity to participate in infant care, if possible.	Helps siblings to realize that they are an important part of infant care, which may eliminate feelings of abandonment and increase feelings of self-worth.
Place family photos in isolette or crib; encourage siblings to talk to infant, to make tape recordings, or to give gifts (e.g., pick out a small toy, draw a picture).	Provides sense of family unity and includes siblings in activities.
Recommend that client/couple spend special time alone with siblings.	Caring for an infant with special needs is so time-consuming that little time is left for siblings, who may feel abandoned, replaced, ignored, angry, and jealous.
Offer opportunity for contact with couples facing similar problems.	Provides peer support helpful in nurturing the couple; promotes positive behaviors and provides opportunity for sharing ideas and interventions that have been successful.
Provide 24-hr contact phone number. Initiate follow-up phone calls and/or home visits.	Provides continuity of care and a continued source of emotional support.
Be supportive of couple's decision to take infant home or to use institutional help or assistance. Help couple look at long-term effects of decision. Note cultural meaning of condition/birth anomaly.	Such decisions are difficult and may have cultural implications. To avoid increasing their guilt and confusion, make the parents aware of options, give support for their decision without judgment, and let them know that they may change their minds.
Encourage parents to maintain or re-establish good communication between themselves and to take time out from child care for time alone together. Encourage use of resources, such as respite care.	Facilitates rapport between parents, helps maintain healthy relationship, and fosters coping and family growth.
Encourage each partner to allow time for herself or himself, apart from the other.	Helps foster individual coping mechanisms, which can ultimately foster a stronger family.

Collaborative

Refer to community or social services, as appropriate. Identify available respite services. Provide additional referrals, including parent support groups, clergy, and psychiatric services, as indicated.	A coordinated and consistent network of multidisciplinary support enhances management of parental anxiety and assists in development of effective coping skills required by the short- and long-term complications related to the child's special needs.
Encourage couple to seek genetic counseling if appropriate. (Refer to CP: Genetic Counseling.)	Thorough evaluation of genetic factors may provide answers to some of the couple's questions.
Suggest that couple attend marital support group or seek marital counseling, as indicated.	May help couple cope with a crisis that can potentially strengthen or destroy the relationship. Family disintegration is often a consequence of the birth of an infant with a disorder or anomaly. Such disintegration is a direct response to the intense emotional and physical demands created by the infant's long-term health problems, which have a cumulative effect with preexisting stressors.

Support client/family involvement in rehabilitation programs (e.g., Alcoholics/Narcotics Anonymous; Alanon).	May not be able to adequately assume responsibility for newborn until preexisting problems impacting family are dealt with/resolved.

NURSING DIAGNOSIS:	**KNOWLEDGE deficit [LEARNING NEED], regarding infant care**
May Be Related To:	Lack of/unfamiliarity with information resources, misinterpretation, lack of recall
Possibly Evidenced By:	Verbalization of problems, concerns, misconceptions, inaccurate follow-through of instructions, hesitancy or inadequate performance of activities, inappropriate/aggravated behaviors (e.g., agitated, apathetic)
DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/COUPLE WILL:	Verbalize understanding of infant's behaviors, physical status, and care needs. Participate in infant's care. Demonstrate mastery of infant care/treatment activities. Plan appropriately for discharge, home management, and use of available resources.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Keep parents informed about changes in infant's physiological status.	Helps parents to acknowledge possible positive or negative outcomes regarding infant's potential for survival and growth.
Explain plan of care for infant, including rationale for associated tests, procedures, and treatment. Discuss infant's response to treatment. Let parents know when tests are to be performed.	Promotes understanding, clarifies misconceptions, and reduces anxiety. Parents may choose not to visit infant when testing is scheduled or may desire to provide comfort following procedures.
Review normal behavior for infant's gestational age based on Dubowitz or Ballard evaluation.	Provides information to promote understanding of behaviors and motor characteristics typical for gestational age.
Discuss infant's personality traits and individual differences noted from comparison with other infants of same gestational age. Provide information about appropriate stimulation for infant.	Allows couple to gain skill in recognizing responses of infant, acknowledging individual differences, and developing methods for dealing with them.
Introduce client/couple to parent of a baby (in the nursery if possible) with the same or similar special need.	Sharing concerns with another parent can foster acceptance of the situation.
Encourage optimal participation in infant care. Reinforce the idea that infant belongs to the parents, not the nursery. Talk about the infant by name, noting attractive features and other attributes.	Fosters attachment process. Allows parents to demonstrate newly learned behaviors, increasing comfort in handling and caring for the infant. Reminds parents that child is a living being, not a disease or condition.

Encourage questions, provide answers clearly and concisely, and reinforce information as needed. Assess parents' readiness to receive information. Encourage parents to verbalize concerns.	Helps identify learning needs and clarify misconceptions. Denial used initially as a coping mechanism may interfere with learning. Repetition enhances comprehension. Verbalization of concerns promotes atmosphere of trust and is conducive to learning.
Set short-term, measurable goals with parents.	Learning to adjust to problems step by step, one day at a time, helps parents see that progress is being made and reduces the overwhelming stress of the total situation.
Provide encouragement for each task accomplished.	Increases parents' self-confidence in their ability to care for infant.
Review assessment of gestational age, expected potential, immediate and long-term prognosis, and discharge of infant. Be realistic, but positive. Keep parents informed, be honest, and let parents know whether answers are available.	Parents need to know the expectations they can have of their child. Infant may be at risk for neuromuscular disorders, developmental delays, behavior problems, or learning disabilities that may be directly associated with gestational age at birth. Honesty maintains trust between nurse and parents and promotes realistic hope.
Discuss results of ophthalmologic examination when performed prior to infant discharge. Provide information to parents about importance of scheduling reevaluations.	In the preterm infant, retinal scar tissue formation may persist for as long as 5 mo, resulting in varying degrees of visual impairment.
Review results of other routine tests, such as hearing testing and B-mode ultrasonography of the head. appropriate interventions.	These tests are performed for early identification of significant problems (presence and extent of hearing loss, intraventricular hemorrhage) and for provision of
Provide information related to home care of infant. Encourage family to read available literature.	Helps parents gain competence and comfort in caring for infant after discharge.
Discuss purpose and availability of early intervention programs and community resources.	Provides guidance for long-term planning to optimize affective, cognitive, and social development of infant.
Encourage other members of family to learn to care for infant.	Eases the parents' burden of caring for infant and promotes a sense of family unity.
Recommend parents contact other parents of children with similar needs (e.g., Down syndrome, muscular dystrophy, or cerebral palsy groups; or Parents Encouraging Parents).	Provides support and promotes the realization that parents are not alone in their struggle.
Refer to social service agencies or community resources, including national foundations (e.g., Easter Seal centers, Shriners for orthopedic defects), public assistance groups, and Medicaid, as appropriate. Discuss need to notify insurance company immediately after birth.	Couple may be unaware of available financial assistance or free services and may be overwhelmed by incurred or future expenses. Referrals help ensure continuation of support from healthcare agencies. Clarification of available insurance coverage may affect choice of treatment options. Note: Infant may not be covered by insurance if notification is not made within time period specified by third-party payor.
Provide 24-hr contact phone number, schedule follow-up phone calls and/or home visits.	Aids in adjustment of care for home environment. Lets couple know that someone cares and is available should difficulties arise.

NURSING DIAGNOSIS:	SOCIAL ISOLATION, risk for
Risk Factors May Include:	Perceived situational crisis, assuming sole/full-time responsibility for infant's care, lack of resources or inappropriate use of resources
Possibly Evidenced By:	[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]
DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/COUPLE WILL:	Verbalize awareness of potential problems. Identify resources available for assistance. Develop plans to resume social activities.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Discuss situation with couple and determine their perceptions of how they will manage care.	Identifies problem areas and helps with planning interventions for appropriate care. After discharge, the parents quickly become consumed, both emotionally and physically, in child's care, and they may withdraw from usual social interactions and activities.
Listen to parents' expressions of feelings of inadequacy or guilt that may accompany the birth of a child with special needs. Help the couple cope with feelings that are expressed. (Refer to ND: Family Coping, ineffective: risk for compromised.)	Parents may withdraw from society or social interaction because of feelings of shame or a sense of failure as parents. They may also have fears that the child will die or will receive substandard care from others. Unresolved guilt may be responsible for overindulgent behaviors and unwillingness to let others care for the child. Resolution of guilt may promote development of effective parenting skills.
Assist couple with plans for responsible, skilled adults to care for child. Such adults may be relatives, friends, or trained caregivers, such as "mother's helpers."	The couple needs time away from child's constant demands to maintain their own relationship and to keep the situation in perspective. Reduces risk of developing impaired ability to perform family caregiver role.
Discuss plans for resumption of activities engaged in before the birth (e.g., hobbies, employment), if possible.	Returning to normal routines fosters self-esteem and sense of self-worth; however, child's condition may significantly alter the family's previous patterns so that reduction or elimination of outside work or some leisure activities may be necessary. Note: Support from parents sharing similar situation provides opportunity for creative problem solving and continuation of activities.
Prepare parents for/role-play responses to possible reactions by the public.	Preparation helps couple identify possible actions or ways of managing uncomfortable social situations and eliminates the need for isolating themselves from social contacts as a protective mechanism.
Encourage parents to plan family outings such as trips to beach, picnics, walks, and movies.	Helps meet individual and collective needs for social experiences.

Collaborative

Provide social service and public health referrals before discharge.	Maintains continuity of support network from the hospital to the home.
Assist couple in contacting appropriate support groups.	A support group serves as a social outlet, provides role models, and may be a resource for sharing child care.