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Preterm infant developmental care Initial assessment

Child Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Clinical assessment

Subjective: Caregiver asks how to participate in care and feeding.

Objective findings and required checks: Immature feeding and temperature regulation; cardiorespiratory stability requires monitoring.

Physical examination and investigations: Assess temperature, breathing, glucose, growth and feeding readiness according to the neonatal plan.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Preterm infant developmental care: Prematurity limits physiological reserves and coordinated feeding and thermoregulation.

Medical / surgical management

Provide thermoregulation, minimal-stress handling, infection prevention and supported skin-to-skin care when appropriate.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed expressed-milk or nutrition plan	Support growth safely	Monitor tolerance and the ordered route
prescribed neonatal supplements	Meet specific needs	Verify gestation/weight-related orders and monitoring.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about feed frequency, pain, infant behaviour and caregiver concerns. Assess: Observe an entire feed when possible and assess weight, output and clinical stability.	Feeding difficulties affecting infant or caregiver well-being. Possible factors: ineffective attachment, fatigue or a clinical feeding barrier. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: A safe, supported feeding plan is demonstrated during the observation period. Longer-term: Before the clinically approved transition or agreed follow-up: Caregiver describes feeding cues, intake indicators and when to seek help.	1. Assess both infant stability and caregiver comfort before recommending changes. Rationale: Feeding difficulty can have medical as well as technique-related causes. 2. Support positioning and attachment or the prescribed alternative feeding method. Rationale: Individual support can improve comfort and effective milk transfer. 3. Arrange weight or feeding review and escalate poor intake or dehydration. Rationale: Follow-up helps identify inadequate intake early. 4. Provide thermoregulation, minimal-stress handling, infection prevention and supported skin-to-skin care when appropriate. Rationale: Prematurity limits physiological reserves and coordinated feeding and thermoregulation. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask the caregiver about feeding, behaviour and thermal-care concerns. Assess: Monitor temperature using the neonatal method, environment, skin condition, glucose and clinical stability.	Temperature instability in a vulnerable infant. Possible factors: immature temperature regulation and environmental heat loss. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Temperature remains within the prescribed neonatal range at the documented review. Longer-term: Before the clinically approved transition or agreed follow-up: Caregiver demonstrates the agreed thermal-care and follow-up plan.	1. Monitor temperature and reassess the environment and infant after any change. Rationale: Trends identify inadequate thermal support and possible illness. 2. Provide prescribed thermal support and supported skin-to-skin care when clinically appropriate. Rationale: Controlled thermal care reduces heat loss while preserving safe monitoring. 3. Escalate persistent temperature instability and review feeding, glucose and infection concerns. Rationale: Temperature changes may indicate metabolic stress or infection.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about exposure, wound symptoms and recent invasive devices. Assess: Inspect relevant sites and monitor systemic findings and investigation trends.	Vulnerability to infection or worsening infection. Possible factors: disrupted barriers, exposure or reduced host defence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Aseptic care is maintained and any new signs of infection are escalated promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates relevant hygiene and explains the infection-prevention plan.	1. Use hand hygiene and risk-based standard or transmission precautions. Rationale: Interrupting transmission protects the patient, staff and other patients. 2. Review invasive device need with the team and maintain indicated aseptic care. Rationale: Unnecessary devices and barrier breaks increase infection exposure. 3. Monitor for systemic deterioration and administer prescribed antimicrobials on schedule. Rationale: Early escalation and timely indicated treatment reduce avoidable harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach safe participation, hand hygiene, feeding cues, thermal care and neonatal follow-up. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach safe participation, hand hygiene, feeding cues, thermal care and neonatal follow-up.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Apnea, temperature instability, poor perfusion, abdominal changes or reduced responsiveness needs urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Prematurity limits physiological reserves and coordinated feeding and thermoregulation.

- Priority concerns: Feeding difficulties affecting infant or caregiver well-being; Temperature instability in a vulnerable infant; Vulnerability to infection or worsening infection; Learning needs about the condition and care plan.

- Apnea, temperature instability, poor perfusion, abdominal changes or reduced responsiveness needs urgent review.

- Teach safe participation, hand hygiene, feeding cues, thermal care and neonatal follow-up.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Health conditions A to Z: external further reading - NHS
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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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