Home Visit for Postnatal Assessment and Follow-up Care Protocol

Prior to visit the following should be completed:
1. Complete demographic information required.
2. Review of prenatal (PN) and Intrapartum history (Hx)
3. Contact Pregnancy Care Manager (OBCM) to assess any medical problems that would require a further discussion or a referral during the appointment.

If patient is non-English speaking, it would be preferred to have an agency approved interpreter present during the appointment. If an interpreter's presence is not possible, please note who performed the interpreting.

NOTE: Medicaid requires that form codes be used under the form's code column section.

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
I. Prenatal History			B. Document by weeks when Prenatal Care (PNC) began. Assess by record review and/or asking patient specific use of: C. Tobacco, electronic nicotine device, alcohol, illegal drugs, prescription and over-the-counter (OTC) drug use. D. Sexual transmitted infection (STI) and Human Immunodeficiency Virus (HIV) E. Group B Streptococcus (GBS) F. Hepatitis G. PN complications
II. Intrapartum	Patient had an uneventful/positive experience intrapartum		A. Gravida: record total number of pregnancies. Parity: First entry is number of Term pregnancies (37 weeks or greater of gestation); second entry is number of Preterm pregnancies (36 6/7 weeks or less of gestation); third entry is number of miscarriages and/or spontaneous/therapeutic abortions; fourth entry is number of current living children. D. Assess by record review and/or asking patient specifics of intrapartum and postpartum course of care. E. Immunization(s) received post-delivery. (i.e., Influenza, Rubella, Tetanus, Diphtheria, and Pertussis vaccine (Tdap), and Varicella)
III. Interim	Patient states and/or demonstrates time for personal self	– Pre-existing mental illness or intellectual disability – Previous postpartum depression. Infant loss, birth defect, prematurity or adoption may modify patient's postpartum emotional reaction. – Other issues, which may affect adaptation to role include: unwanted pregnancy, difficult intrapartum course, poor support system, Cesarean section, drug use during and/or after pregnancy.	Assess by record review and/or asking patient specifics in regards to: A. General wellbeing (subjective) B. Physical activity/fatigue; support person(s) in place, intervals of rest patient is receiving, diet, exercise C. Emotional status; feeling regarding motherhood, affect and interaction with infant D. Depression Screening Tool completed (please attach copy to assessment); 1. Postpartum blues a. Lasts 3–7 days b. Due to hormonal changes, discomfort or fatigue c. Usually temporary – Edinburgh is a 30-point scale screening tool, can be used in English or Spanish. – The scoring is up to 30. Any score under 9 is considered negative. – Score 9–12 is borderline, so in the case of home visiting, that score could prompt a recommendation for follow-up. Above 12 is a positive screen and needs to be assessed by a medical provider. The higher the score the more concerned the provider of the screen should be. – There is no cut off for emergency care but there is one question about suicidal thoughts that leads to an immediate provider contact.

Parameters of Assessment	Outcome Criteria	Constraints	Nursing Process
IV. Breastfeeding	Patient is breastfeeding comfortably. Nursing at least every 2–3 hours during the day/ night. No routine supplemental formula or water is given for the first 3 weeks of life.	Not breastfeeding	Assess by record review and/or asking patient specifics in regards to: B. Complications/concerns: Is patient having any problems with sore nipples, engorgement, pumping or any other concerns? Inquire about frequency of feedings, and/or supplemental formula. Observe a feeding to determine the following: correct positioning of infant, latch-on, strength of suck and swallow. Ensure proper preparation/storage of breastmilk. C. Support/resources available: Ensure that patient has written breastfeeding references titled “Breastfeeding: a Mother’s Gift” or a book from Women, Infants and Children (WIC) lending library. – Inform patient of breastfeeding support available in the community (peer/ lactation counselors, support groups, and telephone help) – If bottle feeding, note any issues with formula preparation, feeding and/or need for referral
V. Home Environment	– Family is living in a home that is adequate in space, cleanliness and repair. – Family has adequate equipment to safely prepare and store food.		Assess by observation and/or asking patient specifics in regards to: B. Number in household: Overcrowding? C. Water supply/plumbing: Access indoor and/or outdoor? D. Basic family needs of food and clothing E. Stove and refrigerator: If equipment is present and in proper working condition. F. Electricity: Is it available? G. Environment/Safety hazard(s): Home environment has physical hazards? H. Smoking: Is the patient a smoker or anyone in the infant’s home and/or car? I. Smoke/Carbon Monoxide detectors: Present and in compliance with the square footage of home? May need multiple units.
VI. Nutritional Status	– Patient’s appetite is normal – Family has access to an adequate and safe food supply.		Assess by observation and/or asking patient specifics in regards to: A. Report on how many meals/snacks patient consumes in a day in relation to the amount consumed before reported knowledge of the pregnancy. C. If applicable, inquire with the patient when the next WIC appointment is schedule, as well as obtaining WIC certification. D. The recommended 64 fluid ounces daily of water (preferably). Provide counseling during home visit if area(s) of need are identified. Significant issues identified refer to public health nutritionist and/or OBCM.
VII. Elimination	Patient is voiding and bowel pattern are within normal limits (WNL) with little to no discomfort.		Assess by record review and/or asking patient specifics in regards to: A. Voiding/Bowel function; determine adequacy of fiber and fluid intake. Note: if constipation is an issue, provide counseling that suggests increasing fiber and fluid intake. B. Hemorrhoids; If hemorrhoids are present suggest sitz baths 2–3x daily. Contact provider for a prescription stool softener and witch hazel pads to be applied to the affected area.

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VIII. Postpartum Physical Assessment	– Patient demonstrates or states progression through the postpartum period WNL. – Little to no edema is present. – Blood pressure (BP) has returned to pre-pregnancy or PN baseline reading. – Breasts have little to no engorgement and/or tenderness by three weeks. – Cesarean incision has healed by 7 days. – Rubra lochia has ceased by one week. – Patient has increased her activities of daily living (ADL) gradually guided by her level of tolerance.	Pre-existing medical condition Delivery was vaginal	Note: Please indicate WNL where appropriate as it helps in-house staff to identify more quickly what part of the exam was as expected. Assess physical status: A. General well-being (objective) B. Take full set of vital signs (VS) and record. Compare pre-pregnancy or PN baseline BP to current findings. C. Pain assessment; using the verbal numeric rating scale (VNRS) rate pain, onset, location and duration. Has the patient taken any medication to relieve it and if so, what, dosage and how often. RN should complete the assessment as prescribed, making sure that sufficient education of the use of VNRS is completed initially. If patient's response is a (6 or greater), this warrants notification of the provider accompanied by clear documentation of findings and actions to follow. Inquire and/or inspect: D. Breast/nipples E. Abdomen—surgical incision(s) F. Uterus (location) G. Lochia (color, amount, odor) H. Perineum/episiotomy (healing, swelling) I. Legs/Homans sign Assess by observation and/or asking patient specifics in regards to: – Cleanse perineum well, front-to-back after each toileting with peri pad changes. – Keeping bladder empty assists with decreased bleeding and cramping. – Lying in a prone position helps to ease cramping – If not breastfeeding wear supportive bra continuously. Ice pack(s) may help to relieve breast engorgement discomfort. Avoid stimulation of nipples. Provider referral: – Leg edema beyond one week – Pain in leg(s) – A temperature of 99.0°F or 37.2°C or greater – BP elevated ≥ 20% of pre-pregnancy or PN baseline findings – Painful lump(s) in breast(s) – Signs of infection – Excessive bleeding with/without clots beyond one week. – Foul smelling discharge – Severe (VNRS scale 6–10) abdominal pain – Burning with urination
	Patient will perform appropriate postpartum exercises daily.	If Cesarean delivery and Tubal ligation, follow Provider's guidance for beginning to engage in exercise.	Assess by asking patient specifics in regards to: – Knowledge of the benefits of daily postpartum physical exercise 1. Promotes healing 2. Enhances circulation 3. Assists with return to pre-pregnancy weight 4. Enhances physical recovery during involution of the uterus. 5. Improves self-esteem and attitude

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			– Exercises 1. Kegel exercises may be started immediately after birth regardless of the type of delivery. *2. Pelvic rock *3. Modified sit ups *4. Bent leg lifts * Begin slowly and build up to maximum repetitions by 6th week.
IX. Family Relationships	– Patient moving toward a satisfying, comfortable relationship with infant and if applicable significant other (SO). – Resumption of sexual relations with SO and without discomfort – Intimate partner violence (IPV) is identified and resources shared with patient.	– Stillbirth/miscarriage of baby up for adoption (BUFA). – Other issues in parent-infant interaction may be in part to infant with special medical or developmental anticipated needs. i.e., Neonatal intensive care unit (NICU) admission; congenital anomaly, chromosomal abnormality. – Not having sexual relations. – If perineum has not yet healed. – Privacy for open discussion.	Assess by observation and/or asking patient specifics in regards to: A. Those person(s) assisting patient in caring for infant B. Maternal-Infant bonding: – Demonstrate, if needed – how to interact with infant: 1. Establish eye contact 2. Hold closely, touch, stroke and rock gently 3. Talk and/or sing to infant – Identify to patient where infant is in developmental growth, and perhaps what is in the near future (milestones to look for). Assess by asking patient specifics in regards to: C. Sexual issues; A coital, side lying or female superior positions are those in which the woman has control of the depth of penile penetration are often recommended regardless of the type of delivery experienced. – If some vaginal tenderness is present, the SO can be instructed to insert one or more clean, lubricated fingers in to the vagina and rotate them within it to facilitate relaxation of the muscle while possible identifying areas of discomfort. – Kegel exercises assist with vaginal perception and response during intercourse. – Vaginal dryness may occur and a lubricant might be needed (water soluble gel, contraceptive cream) D. IPV; observe behavior of patient and others in the environment. Inquire about safety issues and provide resources if appropriate.

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X. Contraception	– Patient is able to articulate use of chosen method of contraception. – Patient does not experience an unplanned pregnancy. – Any future pregnancies are planned.	– No method chosen; bilateral tubal ligation. – No contraceptive method is acceptable. – Lack of resources and not using effective method of birth control.	Assess by asking patient specifics in regards to: A. Current method; patient and SO's (if applicable) understanding and use of selected method of contraception. Provide information as needed. B. Planned method; patient has postpartum examination within 4-6 weeks of delivery. – Patient's knowledge: 1. Regarding reasons for family planning (FP) including physical, emotional, financial and social aspects. 2. Birth control methods, while assisting in future planning. 3. The potential impact of FP methods on lactation (if applicable). 4. Encourage to discuss FP methods with SO 5. Review the choices of both temporary and permanent methods.
XI. Referrals	Patient recognizes need for preventative care for herself.		Assess by asking patient specifics in regards to: – Obtain specifics regarding already planned or needed appointments. – Needing information about particular program.
XII. Coordination of Services	Collaboration and information sharing with OBCM and Care Coordinators for Children (CC4C) as indicated.	– Patient not receiving OBCM or CC4C services. – No needs identified by OBCM or CC4C. – Patient declines OBCM or CC4C referral(s) for identified need(s).	Review Division of Medical Assistance (DMA) Clinical Coverage Policy No.: 1E-5 (Amended: October 1, 2015 or latest revision), 7.0 Additional requirements. – Prior to visit, discuss past and present medical history (Hx) of both patient and infant with OBCM and/or CC4C. – Develop, discuss and/or revise care plan(s) with OBCM/CC4C coordinators, if services are currently being provided. – Following the visit; document findings in both patient and infant's medical record (as applicable). – Discuss observations made with patient by both OBCM and CC4C coordinators

Abbreviations:

Baby Up For Adoption (BUFA)
Blood Pressure (BP)
Care Coordinator For Children (CC4C)
Division of Medical Assistance (DMA)
Family Planning (FP)
Group Beta Streptococcus (GBS)
History (Hx)
Human Immunodeficiency Virus (HIV)
Intimate Partner Violence (IPV)
Neonatal Intensive Care Unit (NICU)
Over-the-Counter (OTC)
Pregnancy Care Manager (OBCM)
Prenatal (PN)
Prenatal Care (PNC)
Sexual Transmitted Infection (STI)
Significant Other (SO)
Tetanus, Diphtheria, and Pertussis Vaccine (Tdap)
Verbal Numeric Rating Scale (VNRS)
Vital Signs (VS)
Within Normal Limits (WNL)