N.C. Department of Health and Human Services/Division of Public Health
Women's and Children's Health Section Monitoring System
FY 16–17 RECORD AUDIT

Home Visit for Postnatal Assessment and Follow-Up Care

Local Health Department: _____ Date _____

Patient Record Auditors — Name and Title:

_____ _____

_____ _____

_____ _____

Staff Present for Audit — Name and Title:

_____ _____

_____ _____

_____ _____

Patient Records Audit

No.	Patient ID	Patient Initials	Record Compliant		Comments
			Yes	No	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Notes:

Postpartum Home Visit *(not a funding condition, but an encouraged practice)*	1	2	3	4	5	6	7	8	9	10
A. Within two weeks										
B. If client is not seen within two weeks, how many weeks PP time frame?										

Comments

Prenatal History	1	2	3	4	5	6	7	8	9	10
A. Source of Prenatal Care										
B. When Prenatal Care Began (# of weeks completed)										
C. Drug Use:										
1. Tobacco										
2. Alcohol										
3. Illicit Drugs										
4. Prescription/Over-the-Counter										
D. STD/HIV (coded as Y/N)										
E. GBS (coded as Y/N)										
F. Hepatitis (coded as Y/N)										
G. Prenatal complications (coded as Y/N)										
Record Compliant?										

Comments

II. Intrapartum	1	2	3	4	5	6	7	8	9	10
A. Gravida/Parity										
B. Place of Delivery										
C. Type of Delivery (box checked appropriately)										
D. Problems During/After Delivery										
E. Received Immunization(s) as indicated post/delivery (box checked appropriately)										
Record Compliant?										

Comments

III. Interim	1	2	3	4	5	6	7	8	9	10
A. General Wellbeing (subjective)										
B. Physical Activities/Fatigue										
C. Emotional Status										
D. Depression Screening Tool Completed										
Record Compliant?										

Comments

IV. Breastfeeding	1	2	3	4	5	6	7	8	9	10
A. Yes/No										
B. Complications/Concerns										
C. Support Systems/Resources Available										
Record Compliant?										

Comments

V. Home & Social Environment	1	2	3	4	5	6	7	8	9	10
A. Type/Condition of Dwelling (described)										
B. Number in Household (# of adults, # of children)										
C. Water Supply/Plumbing (box checked appropriately)										
D. Basic Family Need of Food & Clothing										
E. Stove and Refrigerator (coded Y/N)										
F. Electricity (coded Y/N)										
G. Environment/Safety Hazard										
H. Smoking—Home and/or Car (coded Y/N)										
I. Smoke/Carbon Monoxide Detectors (coded Y/N)										
J. Other										
Record Compliant?										

Comments *Document type of dwelling and dwelling condition*

VI. Nutrition Status	1	2	3	4	5	6	7	8	9	10
A. Appetite										
B. Vitamin/Mineral Supplement										
C. Adequate Food Supply										
D. Fluid Intake (64 fluid ounces daily)										
Record Compliant?										

Comments

VII. Elimination	1	2	3	4	5	6	7	8	9	10
A. Voiding/Bowel Function										
B. Hemorrhoids										
Record Compliant?										

Comments

VIII. Postpartum Physical Assessment	1	2	3	4	5	6	7	8	9	10
A. General Appearance (objective)—box checked appropriately										
B. T/P/R/BP (specifics of each completed)										
C. Pain Assessment Using VRNS (Patient reported #)										
D. Breast/Nipples										
E Abdomen—Incision(s) box checked appropriately										
F. Uterus (box checked appropriately)										
G. Lochia (box checked appropriately)										
H. Episiotomy/Perineum (box checked appropriately)										
I. Legs/Homan Sign (box checked appropriately)										
J. Other										
Record Compliant?										

Comments

IX. Family Relationships	1	2	3	4	5	6	7	8	9	10
A. Support Person										
B. Maternal-Infant Bonding										
C. Sexual Issues										
D. Domestic Violence										
Record Compliant?										

Comments

X. Contraception	1	2	3	4	5	6	7	8	9	10
A. Current Method										
B. Planned Method										
C. Plans for Spacing Children (box checked appropriately)										
Record Compliant?										

Comments

XI. Referrals (coded Y/N or N/A)	1	2	3	4	5	6	7	8	9	10
A. WIC										
B. Medicaid										
C. Postpartum Exam/Family Planning (elements completed)										
D. Care Coordination for Children (CC4C)										
E. Breastfeeding Support										
F. Parenting Classes										
G. Transportation										
H. *Be Smart* Medicaid for FP Services										
I. Newborn Assessment Completed (box checked appropriately)										
J. Other										
Record Compliant?										

Comments

XII. Coordination of Services	1	2	3	4	5	6	7	8	9	10
A. Collaboration with OBCM (as indicated, box checked appropriately with element completed)										
B. Collaboration with CC4C (box checked appropriately, with element completed)										
C. Other										
Record Compliant?										

Comments