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 Care Manager to assess any medical problems that would require further discussion or a referral during the visit.

If patient is non-English speaking, it would be preferred to have an agency approved interpreter present during the visit. 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	Areas for additional focus or attention	Nursing Process
I. Prenatal History			B. Document by weeks/days when Prenatal Care (PNC) began. Assess by record. C. Review and/or asking patient specific use of: Tobacco, products, electronic nicotine devices/vaping, alcohol, illegal drugs, prescription and over the counter (OTC) drug or herbal supplements/remedies. D. Sexual transmitted infections (STI) and Human Immunodeficiency Virus (HIV) E. Group B Streptococcus (GBS) - if patient was GBS positive, document treatment F. Hepatitis - if patient was positive, was referral made for patient's follow up and document infant's receipt of HBIG if applicable G. PN complications - if yes, explain
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 (MMR), Tetanus, Diphtheria, and Pertussis vaccine (Tdap), and Varicella

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III. Interim	Patient states and/or demonstrates time for her personal self	- Pre-existing mental illness or intellectual disability - Previous postpartum depression. Infant loss, birth defect, prematurity or adoption may modify a patient's postpartum emotional reaction. - Other issues, which may affect adaption 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 regarding: A. General wellbeing (subjective) B. Physical activity/fatigue; support person(s) in place, rest she is receiving, diet, exercise C. Emotional status; feeling regarding parenthood, affect and interaction with infant D. Blues/Depression; PHQ9 or EDPS screening performed, scored, documented, and referral made if indicated. 1. Postpartum blues a. Lasts 3-7 days b. Due to hormonal changes, discomfort, or fatigue c. Usually temporary
IV. Infant Feeding	Patient is breastfeeding comfortably, if applicable, or bottle-feeding as appropriate. Nursing at least every 2-3 hours during the day/night.		Assess by record review and/or asking patient specifics regarding: C. Complications/concerns: Is the 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. If bottle feeding, note any issues with formula preparation, feeding and/or need for referral. D. Support/resources available: -Ensure that patient has written breastfeeding references. -Inform patient of breastfeeding support available in the community (peer/ lactation counselors, support groups, and telephone help).
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. - Family can meet basic needs.		Assess by observation and/or asking patient specifics regarding: B. Number in household: Overcrowding? C. Adequate source of income D. Water supply/plumbing: Access indoor and/or outdoor? E. Basic family needs for clothing met? F. Stove and refrigerator: If equipment is present and in proper working condition. G. Electricity: Is it available/turned on? H. Environment/Safety hazard(s): Home environment has physical hazards? I. Smoking: Is the patient a smoker or anyone in the infant's home? Do they smoke inside the home or car? J. Smoke/Carbon Monoxide detectors: Present and in compliance with the square footage of home? May need multiple units.

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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 regarding: A. How is the patient's appetite? Report on how many meals/snacks the patient consumes in a day in relation to the amount she ate before her pregnancy. B. Recommend continuing prenatal vitamins through postpartum and possibly beyond if breastfeeding. C. If applicable, inquire with the patient when the next WIC appointment is and assist with scheduling if needed. Provide other resources for food assistance. D. Recommend intake of 64 ounces daily of fluid water (preferably water). Provide counseling during home visit if area(s) of need are identified. If more significant issues are identified, refer to public health nutritionist and/ or pregnancy care manager.
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 regarding: 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 for a 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 that she is progressing 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 healed by day 7. - Rubra lochia has ceased by one week. - Patient has increased her activities of daily living (ADL) gradually guided by her level of tolerance. Patient will perform appropriate postpartum exercises daily.	Pre-existing medical condition Delivery was vaginal If Cesarean delivery and Tubal ligation, follow Provider's guidance for beginning to engage in exercise.	Note: Please indicate whether significant problem or no significant problem was identified for each component. Assess physical status: A. General Appearance B. Take full set of vital signs (VS) and record. Compare pre-pregnancy or PN baseline BP to current findings. Inquire and inspect: C. Breast/nipples D. Abdomen (surgical incision) E. Uterus (location) F. Lochia (color, amount, odor) G. Perineum/episiotomy (healing, swelling) H. Legs (edema, pain) I. Other Instruct patient regarding: - Cleansing 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 - Abdominal Pain - Burning with urination Assess and instruct patient in regard 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 with partner. - Interpersonal Violence is identified, and resources shared with patient.	- Stillbirth/miscarriage or baby up for adoption (BUFA). - Other issues in parent-infant interaction may be in part to infant with special medical or developmentally anticipated needs. i.e., Neonatal intensive care unit (NICU) admission; congenital anomaly, chromosomal abnormality. - If perineum has not yet healed. - Privacy for open discussion.	Assess by observation and/or asking patient specifics regarding: A. Those persons 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 regarding: C. Sexual issues - Advise avoiding intercourse until postpartum exam. Advise that coital, side lying, or female superior positions are those in which the woman has control of the depth of penile penetration. - Instruct on Kegel exercises to help strengthen the vaginal and bladder muscles. - Vaginal dryness may occur, and a lubricant might be needed (water soluble gel, contraceptive cream) D. Interpersonal Violence; observe behavior of patient and others in her 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 regarding: A. Current method; patient and partner'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 with plans to receive method if didn't receive one prior to hospital discharge. C. Plans for future pregnancies - Assess patient's knowledge: 1. Regarding reasons for family planning (FP) including physical, emotional, financial, and social aspects. 2. Of birth control methods, while assisting in future planning. 3. The potential impact of FP methods on lactation (if applicable). 4. Encourage discussion of FP methods with partner 5. Review the choices of both temporary and permanent methods.
XI. Referrals	Patient recognizes need for preventative care for herself.		Assess by asking patient's specifics regarding: - Already planned or needed appointments. - Needing information about program(s).
XII. Coordination of Services	Collaboration and information sharing with pregnancy care manager and care management for children care manager as indicated.	- Patient not receiving care management services. - No needs identified by care managers. - Patient declines care management referral(s) for identified need(s).	Review Division of Medical Assistance (DMA) Clinical Coverage Policy No.: 1M-5 Home Visit for Postnatal Assessment and Follow-up Care F If patient and/or infant are currently receiving care management services, coordinate care to avoid duplication of services: - Prior to visit, discuss past and present medical history (Hx) of patient and infant with care managers. - Discuss, develop and/or revise care plan(s) with care managers as applicable. - Following the visit; document findings in both patient and infant's medical record. - Discuss visit observations/concerns with care manager as applicable.

Abbreviations:

Baby Up For Adoption (BUFA)
Blood Pressure (BP)
Division of Medical Assistance (DMA)
Family Planning (FP)
Group B Streptococcus (GBS)
History (Hx)
Human Immunodeficiency Virus (HIV)
Neonatal Intensive Care Unit (NICU)
Over the Counter (OTC)
Prenatal (PN)
Prenatal Care (PNC)
Sexual Transmitted Infection (STI)
Within Normal Limits (WNL)
Human Papilloma Virus (HPV)
Vital Signs (VS)
Family Planning (FP)
Tetanus, Diphtheria, and Pertussis Vaccine (Tdap)