N.C. Department of Health and Human Services Division of Public Health

Women, Infant, and Community Wellness Section

Home Visit for Postnatal Assessment/Follow-Up Care Audit Tool

Local Health Department: Patient Record Auditors — Name and Title:

Date County

Patient Records Audit

|  |  |  |
| --- | --- | --- |
| **No.** | **Patient Generic Identifier** | **Comments** |
|
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |

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| --- |
| **Postpartum Home Visit** |
| (not a funding condition, but an encouraged practice) | **1** | **2** | **3** | **4** | **5** |
| A. | Visit was done within two-three weeks from discharge |  |  |  |  |  |

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| --- |
| **I. Prenatal History** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Prenatal Care |  |  |  |  |  |
| B. | When Prenatal Care Began (weeks/days gestation at initiation of prenatal care) |  |  |  |  |  |
| C. | Substance Use |  |  |  |  |  |
| D. | STI/HIV  |  |  |  |  |  |
| E. | GBS  |  |  |  |  |  |
| F. | Hepatitis  |  |  |  |  |  |
| G. | Prenatal complications  |  |  |  |  |  |

**Comments:**

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| **II. Intrapartum** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Gravida/Parity (GTPAL) |  |  |  |  |  |
| B. | Place of Delivery |  |  |  |  |  |
| C. | Type of Delivery |  |  |  |  |  |
| D. | Problems During/After Delivery |  |  |  |  |  |
| E. | Received Immunization(s) as indicated post/delivery |  |  |  |  |  |

**Comments:**

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| --- |
| **III. Interim** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | General Wellbeing (subjective) |  |  |  |  |  |
| B. | Physical Activities/Fatigue |  |  |  |  |  |
| C. | Emotional Status |  |  |  |  |  |
| D. | Depression Screening Tool Completed, Scored, and Referral if indicated (PHQ9 or EDPS) |  |  |  |  |  |

**Comments:**

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| --- |
| **IV. Infant Feeding** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Breastfeeding  |  |  |  |  |  |
| B. | Other Infant Feeding |  |  |  |  |  |
| C. | Complications/Concerns  |  |  |  |  |  |
| D. | Support Systems/Resources Available |  |  |  |  |  |

**Comments:**

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| --- |
| **V. Home & Social Environment** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Type/Condition of Dwelling (described) |  |  |  |  |  |
| B. | Number in Household (# of adults, # of children) |  |  |  |  |  |
| C. | Water Supply/Plumbing |  |  |  |  |  |
| D. | Basic Family Need of Clothing Met  |  |  |  |  |  |
| E. | Working Stove and Refrigerator  |  |  |  |  |  |
| F. | Electricity |  |  |  |  |  |
| G. | Environment/Safety Hazard |  |  |  |  |  |
| H. | Smoking—Home and/or Car  |  |  |  |  |  |
| I. | Smoke/Carbon Monoxide Detectors  |  |  |  |  |  |
|  |  |  |

**Comments:**

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| --- |
| **VI. Nutrition Status** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Appetite |  |  |  |  |  |
| B. | Vitamin/Mineral Supplement |  |  |  |  |  |
| C. | Adequate Food Supply |  |  |  |  |  |
| D. | Fluid Intake (64 fluid ounces daily) |  |  |  |  |  |

**Comments:**

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| **VII. Elimination** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Voiding/Bowel Function |  |  |  |  |  |
| B. | Hemorrhoids |  |  |  |  |  |

**Comments:**

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| **VIII. Postpartum Physical Assessment** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | General Appearance |  |  |  |  |  |
| B. | T/P/R/BP (documentation of each) |  |  |  |  |  |
| C. | Breast/Nipples |  |  |  |  |  |
| D. | Abdomen—Incision(s)  |  |  |  |  |  |
| E. | Uterus  |  |  |  |  |  |
| F. | Lochia  |  |  |  |  |  |
| G. | Episiotomy/Perineum  |  |  |  |  |  |
| H. | Legs  |  |  |  |  |  |
|  |  |  |

**Comments:**

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| --- |
| **IX. Family Relationships** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Support Person |  |  |  |  |  |
| B. | Maternal-Infant Bonding |  |  |  |  |  |
| C. | Sexual Issues |  |  |  |  |  |
| D. | Interpersonal Violence |  |  |  |  |  |

**Comments:**

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| --- |
| **X. Contraception** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Current Method |  |  |  |  |  |
| B. | Planned Method |  |  |  |  |  |
| C. | Plans for future pregnancy  |  |  |  |  |  |

**Comments:**

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| --- |
| **XI. Referrals** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | WIC |  |  |  |  |  |
| B. | Medicaid for FP Services |  |  |  |  |  |
| C. | Postpartum Exam/Family Planning |  |  |  |  |  |
| D. | Care Management for Children |  |  |  |  |  |
| E. | Breastfeeding Support |  |  |  |  |  |
| F. | Parenting Classes |  |  |  |  |  |
| G. | Transportation |  |  |  |  |  |
| H. | Newborn Assessment Completed |  |  |  |  |  |
| I. | Primary Care Provider |  |

**Comments:**

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| --- |
| **XII. Coordination of Services** |
|  | **1** | **2** | **3** | **4** | **5** |
| A. | Collaboration Pregnancy Care Manager |  |  |  |  |  |
| B. | Collaboration with Care Management for Children |  |  |  |  |  |
|  |  |  |

**Comments:**