

APPENDIX A
Virginia Department of Health
Standards of Care

Virginia Department of Health Standards of Care: Maternity

Quality Standard: Clients seeking maternity services through the Virginia Department of Health (VDH) can expect to receive information, diagnostic testing, clinical examinations, ongoing perinatal risk assessment, nutrition counseling and referrals appropriate to their individual needs. The Guidelines for Perinatal Care, 5th Edition, of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists are the basis for the core components of care in the maternity program. The following core components are considered acceptable practice.

Assessment: All clients will complete a VDH Confidential Health History, which includes past and present obstetrical history, medical and family history, psychosocial and occupational information, and substance use history. Clients will receive genetic screening, assessment of physical and laboratory findings, learning needs, and overall nutritional risk assessment done by the provider. Protocols for these assessments are referenced in the Guidelines and the VDH Standards of Care: Maternity Addendum I Periodicity Chart. Normal parameters for physical findings of pregnancy are defined in VDH Standards of Care: Normal Male/Female Adult Exam and the VDH Standards of Care: Normal Pregnant Female Exam. Nutrition assessment will be based on the VDH Division of Chronic Disease Prevention's Nutrition Guide: Nutrition Standards for Documentation by Exception Record System: Maternity.

Intervention: Comprehensive prenatal services are provided in the clinic setting. These interventions include appropriate treatment and/or referral for any diagnosed medical problem, patient/family education designed to meet individual needs and referrals for resources based on client need and community availability. Interventions are referenced in the Guidelines and the VDH Standards of Care: Sexually Transmitted Diseases. Individual health districts are responsible for having written standards for education content and information assessment and interventions appropriate to their practice and the use of printed material to convey that content. Nutrition intervention will be based on the VDH Division of Chronic Disease Prevention's Nutrition Guide: Nutrition Standards for Documentation by Exception Record System: Maternity.

Outcome: Outcome criteria for maternity services will be based on the uncomplicated delivery of a viable infant > 37 weeks gestation with a birth weight of > 2500 grams and a 5-minute APGAR score of 6 or better.

Virginia Department of Health Standards of Care: Normal Pregnant Female Exam

Quality Standard: Maternity clients receiving ongoing medical evaluation in a health department clinic during their pregnancy can expect the following health screening assessment to be performed. Parameters and normal values are based on Physical Examination and Health Assessment by Carolyn Jarvis, W. B. Saunders Co., 3rd Edition, and A Guide to Physical Examination and History taking by Barbara Bates, J.P. Lippincott Co., 1998 and the Guidelines for Perinatal Care, 4th Edition, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology.

Refer to normal parameters already detailed in the VDH Standards of Care: Normal Male/Female Adult Exam. Normal variances due to pregnancy are presented below.

GENERAL SURVEY/SKIN

- Baseline measurement of blood pressure at entry into care within first trimester determines the usual range of normal for the individual client. Hypertension is defined as a sustained blood pressure increase to levels of 140 systolic or 90 diastolic. Baseline weight is that reported by the patient as normal weight prior to pregnancy. A gain or loss of 5 lbs or more in a week indicates a variance from normal.

HEENT

Head

- The mask of pregnancy (chloasma) is normal. This consists of irregular brownish patches around the eyes or across the bridge of the nose.
- Oiliness or dryness of the hair may be noted.
- Generalized minor hair loss may occur.

Nose

- Nasal congestion and nosebleed are common during pregnancy.

Mouth and Throat

- Gingival enlargement with bleeding is common during pregnancy.

Neck

- Symmetrical enlargement of the thyroid is expected in pregnancy.

BREAST/CHEST

- Breast enlargement, tenderness and increased nodularity are normal during pregnancy. The nipples and areola are dark and the venous pattern may be marked. Compression of the nipple may express a normal discharge of colostrum. Inverted nipples are a normal finding, but must be addressed for the client intending to breastfeed.

HEART/LUNGS

Heart

- Soft blowing murmurs are common in pregnancy.

ABDOMEN

- Purplish striae and linea nigra are normal in pregnancy.
- Fetal movements can be felt by the examiner after 24 weeks.
- Palpate the abdomen for organs or masses, fetal movements and measure fundal height if client is 16 weeks or more gestation.
- Auscultate the fetal heart rate using the Doppler at 10 weeks or the fetoscope at 18 weeks. Normal FHT's are 120-160.

GENITOURINARY

- Enlargement of labia and clitoris are normal in pregnancy.
- Frequency of urination may be normal in the absence of infection.
- The cervix is friable and may bleed.
- Check the cervix for any dilatation or effacement. Normal cervical length prior to 34-36 weeks is 1.5 cm to 2 cm.
- The vaginal walls are violet or bluish in color with deep rugae and may have increased white discharge.

MUSCULOSKELETAL

- Physiologic, dependent edema is normal in pregnancy.
- Pretibial edema < 2+ may be normal in the absence of elevated blood pressure.

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Virginia Department of Health Standards of Care: Maternity Addendum I: Minimum Periodicity Chart

The following schedule for diagnostic testing and clinical exams during pregnancy will provide the basis for acceptable medical practice. Individual clinicians may adjust and/or add testing as they deem necessary in their medical judgment.

Physical Exam: Comprehensive exams must be performed on the initial visit and postpartum visit. Record on the appropriate visit record for maternity or family planning services. Other than the designated times in the periodicity chart, cervical checks are to be done at the discretion of the clinician, but should coincide with selected times for repeat or follow-up cervical cultures. The regular schedule of visits will be monthly until twenty-eight weeks, every two weeks from twenty-eight to thirty-six weeks and weekly thereafter until delivery.

Laboratory Testing: Laboratory testing will be performed according to the schedule in the periodicity chart. Other testing may be indicated by psychosocial, medical or cultural assessment. These include urine culture, blood glucose, PPD, Hgb electrophoresis or STD testing not included in the regular testing. A rubella antibody screen must be done if the client does not have a previous antibody titer or documented rubella immunization. Ultrasounds will be ordered by the clinician based upon medical need. Postpartum lab testing will follow the guidelines outlined in the Family Planning protocol. For Nutrition Assessment, refer to Division of Chronic Disease Prevention and Nutrition's Nutrition Guide: Nutrition Standards for Documentation by Exception Record System: Maternity.

The following minimum periodicity schedule may be altered based upon EGA at entry into care, local health department policy, or clinician discretion.

PERINATAL GUIDELINES AND RESOURCES

	Initial Visit/First Trimester	Second Trimester	Third Trimester
Comprehensive P.E.	X		
Cervical Check	X		
Blood group/RH	X		
HBV surface antigen	X		
Atypical. antibody screen	X	X draw at 28 wk visit & give Rhogam as indicated	
HIV antibody	X		
Rubella screen	X		
Hgb/Hct	X	X	X
MSAFP		offer 16-20 wks	
Urinalysis/Culture	As ordered during	any trimester	
Urine protein/glucose ketone/nitrates	q visit X	q visit X	q visit X
Pap Smear	X		
STD testing	X	X or	X (at clinician's discretion)
G.C. culture	X		X
Chlamydia	X		
1 hr. 50 gm glucose		24-28 wks	
Nutrition Assessment	X	X	X
Group B strep			X (prevalence based)

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INSTRUCTIONS: VDH MATERNITY VISIT RECORD

Purpose:

This form will be used to record assessment and intervention data for each prenatal visit. It may also be used for office or home visits if assessing the same parameters.

NOTE: Reference the overall standard plan of care for the patient on the VDH Standard Plan of Care.

Assessment:

Enter client's height and pre-pregnancy weight in spaces at top of record.

Enter the date at each visit. Record assessment data including weight, BP, HGB/ HCT and urine dip in actual values. Record all other critical data gathered in this section of the form using the key at the bottom of the form. A √ means the parameter was assessed and was normal. An * means variance from normal was found and will be noted on the VDH Communication/Exception Record. No entry indicates not required by standard. If required by the standard and not done, an * must be entered and an explanation of the omission placed in the exception notes. The interviewer initials this portion of the assessment upon completion.

Where two parameters share a single box, if either is abnormal, enter an * and make an exception note explaining the abnormality.

Some signs and symptoms are normal in pregnancy. If the client indicates a positive response for nausea, vomiting, headaches, edema, backache, cramping, bleeding, or vaginal pressure or discharge, and these signs or symptoms are a change from what the client has been experiencing, or are significant to the pregnancy, then enter an exception note addressing them as variances from normal.

If client indicates fetal activity prior to 16 weeks or the absence of it after 20 weeks, enter an * and document in exception notes. Otherwise a √ indicates fetal activity was experienced by the client.

The clinician will record assessment data by actual value rather than using the key and initialing upon completion. Name and initials of all providers will be recorded on the VDH Summary of Providers of Care. If an interpreter is used, the Interviewer should place an * beside initials and record that an interpreter and name was used for interview (and exam, if appropriate). Normal parameters for assessing signs and symptoms are found in the VDH Standard of Care: Normal Pregnant Female Exam.

Perform nutrition assessment **at least once each trimester** following the VDH Division of Chronic Disease Prevention and Nutrition's Nutrition Guide: Nutrition Standards for DBE: Maternity. A √ indicates the assessment was performed; an * indicates nutrition assessment was not done or only part was done and will be documented in the exception notes.

Intervention recommended for a dietary deficiency may be documented in exception notes in either case.

History and Dating Criteria:

Record pertinent data requested in these sections.

Orders and Interventions:

This section will be a chronological summary of medications, orders, referrals, and other interventions not in the standards or routine protocols. Medications ordered during clinic visits (such as treatment for UTI or STD) will be written here to serve as the medical record copy of the prescription; therefore, orders must be signed and dated. Referrals and those orders not addressed in the VDH Standards of Care: Maternity (such as ultrasound, 3 hr GTT or Genetics referral) will be written in this section with date and provider signature.

This section is not to be used for routine orders such as MSAFP, 1 Hr. Glucola or FMC, PIH and PTL precautions.

Any other summary data or progress type notes must be entered in Exception notes.

Nurses may initial by an order that it has been done, then initial the posting section when the client has been counseled about her visit.

Significant Findings:

Document present medications, significant risks and cumulative events occurring during pregnancy which have the potential to impact the outcome in this section. If client is on a medication such as an anticonvulsant or antidepressant, document here as a risk. If the clinician orders an antibiotic for UTI, the diagnosis of UTI will be entered here with the medication written in Orders and Interventions.

Breast and Bottle:

Circle infant feeding method selected by the client.

Allergies:

Record allergies in the space provided.

Post-Delivery Contraceptive Method:

Record patient's planned method.

Physical/Pelvic Examination:

The clinician records the initial exam data using the key at the bottom of the form. Describe variances from normal in the Exception Notes Section. Use Form 01-8 Anatomical Supplement for noting significant findings.

Education Information Assessment and Intervention:

Contents of information packets for each trimester must be archived and updated by the district.

The provider may make the determination that the client understands or may give the information or instruction to the client and should date and initial each trimester, or as done if off schedule.

Virginia State Code 32.1-37.2 requires informed consent for HIV antibody testing.

This is indicated by client signature on the HIV Consent Form and does not require entry under teaching topic.

Laboratory/Diagnostic Procedures:

Enter date when done and results when available. Mount lab reports on the lab sheet in the chart.

NOTE: ADDITIONAL ROOM FOR EXCEPTION RECORDING MAY BE FOUND ON THE VDH COMMUNICATION/EXCEPTION RECORD. SHORT ENCOUNTERS, SUCH AS OFFICE VISITS, WILL ALSO BE RECORDED ON THE VDH COMMUNICATION/EXCEPTION RECORD.

When records are forwarded to delivering hospital, note the hospital name and dates of forwarding in the space provided on the bottom of page two of Form 00-M-1.

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**Virginia Department of Health
Standards of Care: Maternity Addendum II:
Education/Information Assessment and Interventions**

QUALITY STANDARD: All clients receiving maternity care will be assessed regarding learning needs in the areas listed below. Provider will use assessment to guide patient education at appropriate time. The information conveyed must be appropriate to learning capability and individualized to clinical course.

Topic:	When to review:
Nutrition/Weight gain	each trimester
STD Risk Reduction	1st trimester
Substance Use Avoidance	1st trimester
Normal Physical Changes	ongoing
Physical Discomforts	ongoing
Danger Signs of Pregnancy	ongoing
Feeding Method	1st and 3rd trimester
Fetal Development	1st trimester and ongoing
Post-Delivery Contraception	3rd trimester
Labor and Delivery	3rd trimester
Preparation for infant (including circumcision for male infant)	3rd trimester
PTL/PIH Precautions	2nd and 3rd trimester
Fetal Movement Count	3rd trimester

The individual health districts are responsible for having written standards for content appropriate to their practice and use of printed material to convey that content.

Education assessment and interventions will be documented on the Maternity Clinic Visit Record, page 2. Each entry is dated and the initials of the provider are to be entered.

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