LEARNING OBJECTIVES

- Compare community-based health care and community health (population- or aggregate-focused) care.
- Identify key components of the community assessment process.
- List indicators of community health status and their relevance to perinatal health.
- Describe data sources and methods for obtaining information about community health status.
- Identify predisposing factors and characteristics of vulnerable populations.
- List the potential advantages and disadvantages of home visits.
- Explore telephonic nursing care options in perinatal nursing.
- Describe how home care fits into the maternity continuum of care.
- Identify and define common perinatal conditions amenable to home care.
- Discuss safety and infection control principles as they apply to the care of patients in their homes.
- Describe the nurse’s role in perinatal home care.

KEY TERMS AND DEFINITIONS

continuum of care: Range of clinical services provided for an individual or group that reflects care given during a single hospitalization or care for multiple conditions over a lifetime.

home health care: Care that is provided within the home.

key informants: Individuals in positions of leadership who can provide information about a situation.

levels of prevention: Consists of three levels: primary prevention is promoting general health and well-being; secondary prevention involves early detection of health problems so that treatment can begin before significant disability occurs; tertiary prevention is the treatment and rehabilitation of persons who have developed disease.

telephonic nursing: Services such as “warm lines,” nurse advice lines, and telephonic nursing assessments.

vulnerable populations: Groups who are at higher risk of developing physical, mental, or social health problems or who are more likely to have worse outcomes from these health problems than the population as a whole.

walking survey: Using one’s senses while traveling through a community to obtain information about sociocultural characteristics and the environment, housing, transportation, and local community agencies.

ELECTRONIC RESOURCES

Additional information related to the content in Chapter 3 can be found on the companion website at http://evolve.elsevier.com/Lowdermilk/Maternity/ or on the interactive companion CD:

- NCLEX Review Questions
- Critical Thinking Exercies—Community Resources for Families
- Plan of Care—Community and Home Care
Health care in the United States has evolved rapidly in recent years, with notable shifts in both the nature of health priorities and the ways that health care is delivered to populations, families, and individuals. Greater emphasis is placed on the prevention of disease and disability, rather than the curative focus of past decades. Most health care for women occurs outside the acute care setting. The movement to reduce health care costs has shortened hospitalization time and led to an increase of home- and community-based options for the provision of care. The increased emphasis on brief hospital stays reduces the financial burden for individuals, agencies, and insurance carriers. Hospital stays after childbirth may be abbreviated. By minimizing inpatient length of stay, much of acute care nursing has been transferred to home-based nursing services in local communities.

The U.S. national health objectives in Healthy People 2010 focus attention on the unequal distribution of disease and disability and the need to reach out to vulnerable populations not being adequately served by the current health system (U.S. Department of Health and Human Services [USDHHS], 2000a). Hospital-based nurses are increasingly involved in follow-up of patients and families after discharge.

Trends in maternal and infant health in the United States reveal that progress has been made in relation to reduced infant and fetal deaths, use of prenatal care, and rates of cesarean births (see Chapter 1), but notable gaps remain in many other target areas. Some critical measures, such as low birth weight (LBW) and very low birth weight (VLBW), have increased, with significant disparities in infant mortality rates between Caucasians and other racial and ethnic groups in the United States. Despite favorable trends in early prenatal care and cesarean births, maternal mortality has not decreased significantly since 1982, with disproportionate rates among African-American and Hispanic women (Martin, Kochanek, Strobino, Guyer, & MacDorman, 2005; Minino et al., 2002). That many of these outcomes are preventable through access to prenatal care and use of preventive health practices clearly demonstrates the need for comprehensive, community-based care for mothers, infants, and families.

Changing demands on the community-based nurse evolve out of these societal, economic, and health-related trends. Acuity of illness of home care patients may be far greater than in the past, requiring the community nurse to become more adept in maternal assessment, direct care, and teaching. Assessment of the neonate requires knowledge of parameters for measuring the health of a newborn within the first days of life. Skill in assisting with breastfeeding is essential. Knowledge of an ever-widening array of diverse family traditions, beliefs, and expectations related to childbearing becomes even more critical for the nurse to facilitate effectively the transition required when a family moves through the stages of incorporating a new family member. Community and family cannot be considered separately. Furthermore, as population demographics change, nurses are assuming greater roles in assessing community health status and providing health promotion and disease prevention interventions across the perinatal health continuum. Chapter 2 contains an overview of family and cultural theory and assessment. This chapter discusses the integration of community and home care within the context of family-focused nursing in relation to Healthy People 2010 and perinatal health outcomes. Methods of community assessment and the special perinatal health needs of vulnerable aggregates in the population are discussed.

HEALTH AND WELLNESS IN THE COMMUNITY

In the context of community-based health care, both the aggregate (group of people who have shared characteristics) and the population become the focus of intervention. Health professionals are required not only to determine health priorities but also to develop successful plans of care to be delivered in the health clinic, the community health center, or the patient’s home.

Public Health Services

Public health services are essential to provide for the needs of the community, especially for those who do not have the resources to access needed health care. Communities must do assessments to determine the needs of the populations they serve. Basic and essential services are listed in Box 3-1. Individual communities may identify other needs.

**Box 3-1**

**Essential Public Health Services**

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Enforce laws and regulations that protect health and ensure safety.
4. Inform, educate, and empower people about health issues.
5. Mobilize community partnerships to identify and solve health problems.
6. (a) Link people to needed personal health services and (b) assure the provision of health care when otherwise unavailable.
7. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
8. Assure a competent public health and personal health care workforce.
9. Develop policies and plans that support individual and community health efforts.
10. Research for new insights and innovative solutions to health problems.

Community Health Status Indicators

The data collected about communities can be compared with state or national standards to assess the well-being of the population as a whole and answer questions such as the following: Do most women begin prenatal care in the first trimester? What are the fetal and infant mortality rates?

Box 3-2 displays a set of community health status indicators developed by a committee of experts from many community health-related organizations. Infant mortality, because it is affected by the preconceptional health and prenatal and intrapartal care of the mother, as well as living conditions for the infant after birth, is a statistic widely used to compare the health status of different populations. Three of the five indicators of risk (i.e., incidence of low birth, adolescent pregnancy, and early prenatal care) refer to maternal-infant health. Poverty and a high percentage of young children in a community are strongly associated with significant community health needs.

Vulnerable Populations

Several broad categories of high risk or vulnerable populations, i.e., those more likely to develop health problems or who are more likely to have worse outcomes from these health problems than the population as a whole, are of special interest to perinatal nurses working in the community. These include the categories discussed in the following sections.

Women

One of the primary factors compromising women’s health is lack of access to acceptable-quality health care, which may take many forms: lack of health insurance, living in a medically underserved area, or an inability to obtain needed services, particularly basic services such as prenatal care. For example, some rural areas have few obstetricians, pediatricians, and nurse-midwives; women may have to travel hundreds of miles for this kind of care. Women often have lower incomes and less education and are therefore considered at high risk. Infant mortality is nearly two times higher for mothers without a high school education (USDHHS, 2000b).

Within the larger group of vulnerable women, a number of subgroups present challenges to the community-based perinatal nurse.

Adolescent girls

Youths and adults younger than 24 years of age are the least medically served of all age groups in the United States. Lifestyle choices related to substance use, sexually transmitted infections, and human immunodeficiency virus (HIV) represent high risk behaviors with both immediate and long-term health consequences. Many engage in “survival sex,” exchanging sexual favors for food, clothing, and shelter, making them vulnerable to sexually transmitted infections and unintended pregnancies. Young women, particularly African-Americans and Hispanics, are less likely to have access to routine care and often fail to seek care because of inability to pay, lack of transportation, or confidentiality issues.

Minority women

In the United States, disparities continue to exist in health and health care. Higher infant and maternal mortality rates are evident in African-American and Hispanic women and among some Native American and Alaskan Native communities. Women with underlying health conditions are at especially high risk for poor obstetric outcomes for both themselves and their infants. They have high rates of preterm labor and gestational hypertension and often have intrauterine growth restriction resulting in the birth of infants who are small for gestational age. These are the patients for which perinatal nurses are best equipped to care.
whom the community-based perinatal nurse will be providing care, and their needs are complex, demanding expertise and high levels of skill.

Women and poverty

In 2002, 13.5 million women were living with incomes below the federal poverty level, with a 19.5% poverty rate reported for women aged 18 to 24 years (Health Resources and Services Administration [HRSA], 2004). Because these are also the years of greatest childbearing, many women and their infants have unmet needs. A significant proportion of women are underinsured or uninsured.

Homeless women

An estimated 2.5 to 3.5 million people are homeless nationally, with 6.5% of adults reporting homelessness each year. This includes increasing numbers of women, children, and adolescents who are disenfranchised from their homes, families, and services for various reasons, resulting in a 17% increase in the demand for family assistance (Bureau of Primary Health Care, 2001). Depending on the cause of homelessness and the availability of services, a person may be homeless for weeks or months, intermittently, or on a prolonged basis.

The most significant causes of homelessness in the United States relate to mental illness (approximately 50%) and substance use (nearly 75% among homeless men). Violent relationships and a history of abuse are significant contributing factors to homelessness for women. Although the homeless population is generally higher in urban areas, a growing number of the homeless are found in rural agricultural, mining, and fishing regions, where they seek temporary employment. Often these families remain hidden within the community. Sometimes the family stays in a local hotel (paying on a daily basis while they work), lives out of a car, resides in an unoccupied building, or camps in a national park. Couples with children form the largest group among rural homeless. Lack of visibility and community resources in rural areas frequently results in longer periods of poverty and homelessness for these families (Bushy, 2000).

Health issues among the homeless are numerous, including mental illness, substance use, and relationship violence. Health issues are related to specific factors including poor nutrition, stressful environments, limited access to health care, and low levels of education, language and cultural barriers, and limited access to health and social services. Immigration and Naturalization Services prevents many undocumented workers from seeking care. Incarceration is an important factor for many homeless individuals, including young adults who are more likely to become homeless after incarceration (HRSA, 2004). Because these factors are complex, demanding expertise and high levels of skill.

Migrant women

An estimated 3 to 5 million people, 21% of whom are women, are classified as migrant farm workers in the United States (Economic Research Service, 2003). Migrant laborers establish temporary residence in various areas on a seasonal basis to obtain employment. Although many acquire temporary housing for at least 6 months, others move continuously throughout the year. Diverse ethnic groups are represented among migrants: African-Americans, European-Americans, Hispanics, Haitians, and Southeast Asians. Migrant laborers and their families face many problems, including financial instability, child labor, poor housing, lack of education, language and cultural barriers, and limited access to health and social services (McGuire, 2002). Poor dental health, diabetes, hypertension, malnutrition, tuberculosis, and parasitic infections are common health issues among migrant populations. The average life expectancy for migrant laborers is 49 years (as compared with 79 years for the population as a whole). Substance abuse and domestic violence are significant problems. Numerous reproductive health issues exist for migrant women, including less consistent use of contraception and increased rates of sexually transmitted infections. Migrants are less likely to receive early prenatal care and have a greater incidence of inadequate weight gain during pregnancy than do other poor women. The infant mortality rate among migrant workers is estimated to be 25 times higher than the national average (Murray, Zentner, & Samiezade-Yazd, 2001). Federally funded migrant health centers have been established in many regions of the United States, but they are unable to meet the demands of the 3 to 5 million migrants. Many seek care at local hospitals and clinics in the areas in which they work, but access is limited by lack of time and financial constraints. Even if services are free, the loss of wages incurred in leaving the field is a deterrent to preventive care. Lack of trust or fear of being reported to the Immigration and Naturalization Services prevents many undocumented workers from seeking care.

Incarcerated women

In 2002 there were 165,800 women incarcerated in the United States. Non-Hispanic black women aged 30 to 34 years experience the highest rate of incarceration (HRSA, 2004). Mental illness and HIV infection are significant health problems among female inmates, with 23.6% of female inmates mentally ill and more than 5% infected with HIV.

Rural versus Urban Community Settings

Rural refers to a town or community area that has a population of less than 2500 or to a county with fewer than 50,000 people. Approximately 21% of the population live in rural areas (HRSA, 2004). A number of common characteristics define rural groups: they lack anonymity, are isolated, and tend to be content to live independently (Bushy, 2000; Murray, Zentner, & Samiezade-Yazd, 2001). They are more
Critical Thinking Exercise

Health Needs of a Migrant Worker

The home care agency receives a referral for a home visit to a 16-year-old Vietnamese-speaking mother, Linh, who is a migrant worker. She has a 2-week-old infant and is expected to return to the fields to work. Before visiting Linh, the nurse establishes as priorities to promote breastfeeding, encourage use of birth control, and involve the father of the baby in child care.

1. Evidence—Is there sufficient evidence to draw conclusions about the appropriateness of the nurse’s plan of care?
2. Assumptions—What assumptions can be made about the needs of this mother and baby in regard to the following issues?
   a. The priorities for care
   b. Conditions for effective breastfeeding
   c. Feasibility of maintaining breastfeeding while working in the field
   d. Cultural relevancy of involving the father
3. What implications and priorities for nursing care can be drawn at this time?
4. Does the evidence objectively support your conclusion?
5. Are there alternative perspectives to your conclusion?

Refugees and Immigrants

Refugees are defined as those who are displaced suddenly or forced to leave their country of origin because of persecution, civil unrest, or war. Families are thus forced from their own homes to seek residence and employment elsewhere (Murray, Zentner, & Samierzade-Yard, 2001). Often these groups are extremely impoverished and face extreme physical and emotional stress when they arrive in the United States. Some refugees have a history of arrival in a new country by precarious means, such as crossing wide oceans in fragile boats. Many survivors of such journeys have memories of related events that were familiar and comforting.

Many have profound grief over the loss of loved ones, their homelands, and all they owned. Both refugees and immigrants are saddened by the knowledge that it will be difficult or impossible to go “home” to the people, traditions, and customs that were familiar and comforting.

Along with their profound resilience and determination, refugees and immigrants have brought rich diversity to the United States in several important dimensions, including cultural heritage and customs, economic productivity, and enhanced national vitality. At the same time, multiple challenges accompany the dramatic influx of individuals and families from other countries.

In general, refugees are more likely to live in poverty than are immigrants (Murray, Zentner, & Samierzade-Yard, 2001). Over time, measures of health and well-being actually decline for the immigrant population as they become part of American society (National Academy Press [NAP], 2002). Many of the conditions or illnesses that they acquire contribute to the persistence of disparities in maternal and neonatal health outcomes for both immigrants and refugees.

Implications for Nursing

Working in the community or in the home with the full spectrum of family organizational styles, vulnerable populations, and cultural groups presents challenges for the nurse. Whether it involves prenatal care focused on women and their newborns, or women’s health care directed toward treatment and prevention of other health conditions such as communicable diseases and sexually transmitted infections, nursing must be accomplished with a high degree of professionalism. Cultural sensitivity, compassion, and a critical awareness of family dynamics and social stressors that will affect health-related decision making are critical components in developing an effective plan of care.

Although the long-term consequences of contemporary immigration for U.S. society are unclear, the successful incorporation of immigrant families depends on the resources, benefits, and policies that ensure their healthy development and successful social adjustment. Culturally competent health care and involvement of the immigrant community in health care programs are recommended strategies for improving the access to and effectiveness of health care for this population (NAP, 2002).

The use of camp volunteers, known as “romatoras,” has been effective in assisting families living in migrant worker camps to obtain prenatal, postpartum, and infant care (see Resources at the end of the chapter). Working in partnership with health professionals such as nurses, lay camp aides have been used effectively for outreach and health education; however, more strategies are needed to link traditional practices with the formal health care system. Guidance and information about other health resources are available to health care providers through the National Migrant Resource Program and the Migrant Clinicians Network.

Nurses working with homeless women and families are challenged to treat them with dignity and respect to establish a therapeutic relationship. Case management is recommended to coordinate the services and disciplines that may be involved in meeting the complex needs of these families. Whenever possible, health services must be provided when the women seeks treatment, as this may be the only opportunity to provide health information and intervention. Building on existing coping strategies and strengths, the health care provider helps the woman and her family to reconnect with a social support system. Nurses also have an important role in advocating for funding to enhance these efforts.
support homeless health services and to improve access to preventive care for all homeless populations.

Women who are incarcerated are exposed to stress and violence and have limited access to health care, especially for treatment for mental disorders. Nurses who work in prisons and jails must be creative in their approaches to providing health care for this vulnerable group of women.

Nurses have established and maintained a variety of clinics where the homeless, migrants, immigrants, and those living in poverty have access to care. Outreach must continue, as women who are eligible for services often do not access the services for a variety of reasons.

**ASSESSING THE COMMUNITIES IN WHICH FAMILIES LIVE**

Mothers assume much of the health-related decision making for their families, with up to 83% of them having sole or shared responsibility for financial decisions affecting family health. A significant link exists between the maternal roles of health care provider and decision maker and family health behavior. The health and well-being of women and children will be in jeopardy as long as the communities in which they live are ill prepared to provide the quantity and quality of services they need.

Important measures of community health include access to care, level of provider services available, and other social and economic factors. For women and infants, access to a consistent source of care is critical. Those with a regular source of care are more likely to use preventive services and receive timely treatment for illness and injury, but 13.9% of women are uninsured (9% of non-Hispanic white, 17.9% of Black, 18.0% of Asian/Pacific Islander, and 29.5% of Hispanic female) (HRSA, 2004). More Medicaid-covered women as compared with privately insured women lack access to a usual source of care or rely primarily on emergency services. Consequently, many of these women have unmet health or dental needs. In 2002, 12% of women reported not having seen a dentist for 5 years or having never seen one (HRSA, 2004).

**Methods of Community Assessment**

Community, in its broadest definition, refers to a geographically defined area; its residents; their cultural, religious, and ethnic characteristics; and the activities or functions through which the needs of the residents are met. The health of individuals or groups is inextricably linked to the health status of each community.

With the community as the focus of perinatal health care, the nurse must become familiar with the neighborhoods and resources that influence patients. Community assessment is a complex although well-defined process through which the unique characteristics of the populations and their special needs are identified to plan and evaluate health services for the community as a whole. The desired outcome of this process is identification of direct service, as well as advocacy needs of the targeted aggregate or group and improved health for the community as a whole (Kuehnert, 2002).

**Data Collection and Sources of Community Health Data**

A community assessment framework or model provides criteria for conducting a community assessment, identifies types and methods of data collection, and organizes the data of a community assessment (Ervin, 2002) (Fig. 3-1).

Data collection is often the most time-consuming phase of the community assessment process, but it provides an important definition and description of the community (Ervin, 2002). A broad range of health information is available for nurses in conducting a community assessment. The most critical indicators of perinatal health in a community are related to access to health care; maternal mortality; infant mortality; low birth weight; first trimester prenatal care; and rates for mammography, Papanicolaou tests, and other similar screening tests. Nurses may use these indicators as a reflection of access, quality, and continuity of health care in a community.

The U.S. government censuses provides data on population size, age ranges, sex, racial and ethnic distribution, socioeconomic status, educational level, employment, and housing characteristics. Summary data are available for most large metropolitan areas, arranged by zip code and census tract, which usually corresponds to a neighborhood (approximately 3000 to 6000 people). Looking at individual census tracts within a community helps to identify subpopulations or aggregates whose needs may differ from those of the larger community. For example, women at high risk for inadequate prenatal care according to age, race, and ethnic or cultural group may be readily identified, and outreach activities may be appropriately targeted.

City, county, and state health departments provide annual reports of births and deaths. Maternal and infant death rates are particularly important, as they reflect health outcomes that may be preventable (McDevitt & Wilbur, 2002). Local health departments also compile extensive statistics about the birth complications, causes of death, and leading causes of morbidity and mortality for each age group. The National Health Survey, which describes national health trends, is published annually by the National Center for Health Statistics.

Other sources of useful information are hospitals and voluntary health agencies. The March of Dimes Birth Defects Foundation, for example, has supported perinatal needs assessments in many communities across the United States. Other community health resources include health care providers or administrators, government officials, religious leaders, and representatives of voluntary health agencies. Community or county health councils exist in many areas, with oversight of specific health initiatives or programs for that region. These key informants often provide a unique perspective that may be inaccessible through other sources.
The perinatal health nurse also may explore community health program reports, records of preventive health screenings, and other informal data. Established programs often provide good indicators of the health promotion and disease prevention characteristics of the population.

Professional publications are a rich and readily accessible source of information for all nurses. In addition to nursing and public health journals, behavioral and social science literature offers diverse perspectives on community health status for specific populations and subgroups. The Internet has increased the availability and accessibility of national, state, and local health data as well. Use of Web-based resources for health information requires some caution, however, as the reliability and the validity of the data are difficult to verify. Some guidelines for evaluation of Internet health resources can be found at the Health on the Net Web site at www.hon.org. Additional health websites are identified at the end of the chapter.

Data collection methods may be either qualitative or quantitative, including visual surveys that can be completed by walking through a community, participant observation, interviews, focus groups, and analysis of existing data. Potential patients and health care consumers may be asked to participate in focus groups or community forums to present their views on needed community services and programs. Formal surveys, conducted by mail, by telephone, or by face-to-face interviews, can be a valuable source of information not available from national databases or other secondary sources. Several drawbacks exist with this method: surveys are generally expensive to develop and time consuming to administer. In addition to the cost of such surveys, poor response rates often preclude a sufficiently representative response on which to base nursing interventions.

A walking survey is generally conducted by a walk-through observation of the community (Box 3-3), taking note of specific characteristics of the population, economic and social environment, transportation, health care services, and other resources. This method allows the nurse to collect subjective data and may facilitate other aspects of the assessment (Ervin, 2002). Fig. 3-2 is an example of an
at this point. The chapter also describes the types of interventions used to prevent tobacco use and focuses on the health benefits of taking action toward prevention. Finally, population-based care is discussed in terms of community assessment. Nurses play a critical role in the community assessment process.

Community Assessment

Community assessment is a vital process that allows nurses to identify potential health problems and to plan interventions to prevent illness and promote health. Community assessment involves gathering data about the community, identifying needs, and planning interventions to improve health outcomes. Community assessment can be conducted at various levels, including the local, state, and national levels. At the local level, nurses work with community leaders and residents to identify health issues and develop strategies to address them. At the state and national levels, nurses may work with state and national organizations to identify health trends and develop policies and interventions to promote health.

Community assessment is a dynamic process that involves ongoing evaluation and adaptation. Nurses must be able to recognize and respond to changing conditions in the community. This may involve adjusting intervention strategies or developing new strategies to address emerging health issues.

Community Assessment Process

Community assessment involves several steps: identifying the community, collecting data, analyzing data, and planning interventions. The process begins with identifying the community to be assessed. This involves determining the boundaries of the community and the population to be included. The next step is to collect data about the community. This may involve gathering information through surveys, interviews, and other methods. The data collected should include information about the social and economic conditions of the community, as well as health risks and priorities.

Once the data have been collected, they are analyzed to identify trends and patterns. This involves examining the data for correlations and relationships, and identifying areas of concern. The results of the analysis are used to plan interventions that are designed to address identified health issues.

Community Assessment Tools

Community assessment tools are used to collect data about the community. These tools may include surveys, interviews, focus groups, and other methods. The data collected through these tools should be used to identify health priorities and to plan interventions to address identified issues. Community assessment tools should be designed to be inclusive, so that all members of the community are represented in the assessment process.

Community Assessment Resources

Community assessment resources are available to support nurses in the community assessment process. These resources may include community health assessment guides, data sources, and training materials. Community assessment resources should be used to support nurses in identifying health priorities and planning interventions to address identified issues.

Community Assessment Outcomes

Community assessment outcomes are the results of the assessment process. These outcomes may include identified health priorities, planned interventions, and other findings. Community assessment outcomes should be used to guide nurses in identifying target populations, planning interventions, and evaluating the effectiveness of interventions. Community assessment outcomes should be communicated to all stakeholders, including community leaders, health care providers, and other members of the community.

Community Assessment Challenges

Community assessment challenges include limited resources, lack of data, and resistance to change. These challenges require nurses to be creative in their approach to assessment and to use a variety of methods to collect data. Community assessment challenges can be overcome by involving a range of stakeholders, using community-based approaches, and collecting data in a way that is culturally sensitive.

Community Assessment for Maternity Nursing

Community assessment is a critical component of maternity care. Nurses working with pregnant women and their families should be involved in the community assessment process. This allows nurses to identify potential health issues and to plan interventions to address them. Community assessment can be conducted at various levels, including the local, state, and national levels. At the local level, nurses work with community leaders and residents to identify health issues and develop strategies to address them. At the state and national levels, nurses may work with state and national organizations to identify health trends and develop policies and interventions to promote health.

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level, various methods of health screening and testing facilitate early treatment of the pathologic process. The goal is to shorten disease duration and severity, thus enabling an individual to return to normal function as quickly as possible (Murray, Zentner, & Samiezade-Yazd, 2001).

Tertiary prevention follows the occurrence of a defect or disability that is permanent and irreversible. Persons who have developed disease are provided with treatment and rehabilitation to prevent complications and further deterioration and to maintain their optimal level of function.

Primordial prevention is a form of early intervention designed to prevent the development of risk factors. It is the promotion of healthy behaviors to preclude susceptibility to disease.

Because most women are healthy during pregnancy, maternal-newborn nursing emphasizes primary and secondary prevention activities regardless of where care is provided. Tertiary prevention is frequently the focus for the ill patient at home or in the hospital. Nurses can emphasize primordial prevention through anticipatory guidance and other forms of health teaching. Good nutrition and exercise are important components of primordial prevention.

COMMUNITY HEALTH PROMOTION

The emphasis on community-based health promotion has grown in recent years, with recognition that many health issues require the collaborative efforts of a diverse community network to achieve public health goals. Pender, Murdaugh, and Parsons (2002) noted the benefits of community-based, coordinated health promotion programs with the potential for widespread change in community health status. These efforts are particularly relevant in relation to maternal-newborn health, which encompasses multiple public health issues; lack of health insurance, teen pregnancy, substance abuse, and the consequences of inadequate prenatal care.

Health promotion efforts for childbearing families are primarily focused on early intervention through prenatal care and prevention of complications during the perinatal period. Often this early exposure to health information sets the stage for a successful birth and positive outcomes for mother and baby. Involving expectant mothers and fathers in identification of their learning needs is an essential first step to securing their participation in the health promotion process.

A wide variety of strategies have been used to disseminate health information to women in the community. Prenatal classes are well-established mechanisms for increasing awareness of healthy behaviors during pregnancy and preparing parents for the care of themselves and their newborn during the postpartum period. Mass media efforts such as those presented by the March of Dimes “Baby Your Baby” advertisements are clear, consumer-friendly messages designed to reach a large target audience. Other venues include public health education in newspapers and magazines and health department programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which offers a variety of health education and written information to mothers. The Association of Women’s Health, Obstetric and Neonatal Nurses’ (AWHONN’s) 2004 education guide, Every Woman: The Essential Guide for Healthy Living, is an evidence-based practice guide distributed to women by their nurses.

Many communities have organized coalitions to address specific health promotion agendas related to sharing information, educating community members, or advocating for health policies around maternal and child health issues. An example of this is Healthy Start, a community-based initiative to reduce infant mortality and improve the health and well-being of women, children, and families. Smoking presents major health risks for women, fetuses, and infants. There are major smoking cessation efforts directed toward pregnant women (Fig. 3-3). Adolescent health is another important component of primordial prevention through anticipatory guidance and other forms of health teaching. Good nutrition and exercise are important components of primordial prevention.

Fig. 3-3  Billboard illustrating the hazards of smoking. (Courtesy Joan R. Vogel, Boca Raton, FL.)

Program for Women, Infants, and Children (WIC), which offers a variety of health education and written information to mothers. The Association of Women’s Health, Obstetric and Neonatal Nurses’ (AWHONN’s) 2004 education guide, Every Woman: The Essential Guide for Healthy Living, is an evidence-based practice guide distributed to women by their nurses.

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Within the community, perinatal care is provided on a continuum. A continuum of care is defined as a range of clinical services provided for an individual or group that reflects...
EVIDENCE-BASED PRACTICE
Parenting Groups for Teenage Parents

BACKGROUND
- In the developed world, teen pregnancy is highest in the United States (55 per 1000 women age 15 to 19 years), followed by New Zealand (33 per 1000) and Canada (25 per 1000). The United Kingdom (33 per 1000) has the highest rate in Europe. Where deprivation and poverty are high, so is teen pregnancy. There is evidence that teen mothers have lower aspirations for themselves and come from family backgrounds of low educational expectations. Early parenthood brings the needs of the still-developing teen in direct competition with the needs of the fetus and baby and usually truncates the mother’s opportunities. Younger parents may lack realistic expectations of child development and parenting and disciplinary skills. They may experience stress, depression, low self-esteem, and socioeconomic deprivation. Infants of teen mothers may have developmental delays, behavioral problems, intellectual deficits, and lower educational achievement. Child abuse may be present for all these reasons, rather than young parental age alone. The prevention of teen pregnancy remains the primary intervention to prevent these vulnerabilities. After birth, however, early interventions such as parenting programs show promise as a way to compensate for a lack of life exposure and perspective in the immature and inexperienced parent.

OBJECTIVES
- The reviewers’ goal was to assess the impact of parenting skills education on the health and well-being of teen parents and their infants. The reviews found that parenting programs show promise as a way to compensate for a lack of life exposure and perspective in the immature and inexperienced parent.

METHODS
Search Strategy
- The authors searched Cochrane, MEDLINE, EMBASE, CINAHL, Psyclit, Sociofile, Social Science Citation Index, and reference lists. Search keywords included parent, program, train, education, promotion, health, adolescent, mother, teen, father, pregnancy, and combinations of these words.
- Four randomized, controlled trials were selected, for a subject pool of 247 teen mothers who volunteered for a parenting program. The studies were published between 1977 and 1999 and were all from the United States. The trials used a variety of settings, including a school, a health setting, a residential maternity home, community health clinics, and family support centers.

Statistical Analysis
- The reviewer calculated a treatment effect for each available and reliable outcome. This enabled assessment of how strongly the intervention was associated with the outcomes.

FINDINGS
- When compared with the controls, the parenting intervention showed a significant increase in maternal sensitivity, identity as a mother, parenting knowledge, maternal-child interaction, and communication, and cognitive growth fostering capacities. There were trends toward improvement in maternal self-confidence and motivation, but not to the level of statistical significance. Infants whose mothers were receiving the parenting intervention had nonsignificant trends toward responsiveness to parent, clearer interaction, and language scores, up to 2 years of age.

LIMITATIONS
- The small number of studies, and the fact that they were all from the same country, limits generalizability of the results. Some of the data were collected with tools that had no reported reliability or validity. The treatment effects may have seemed stronger than they actually were, because of the statistical handling of cluster randomization (groups in a school who were divided into groups by classroom), dropouts, and subjects lost to follow-up. Dropout rates were marked in one study (33%) but remarkably low in the other three studies, considering that dropout rates are usually increased with teenagers, low socioeconomic status, and ethnic minorities.
- There were no data on fathers. All the subjects were volunteers, and so may have self-selected for motivation, the maturity to identify their own deficits, self-esteem, or some other confounding influence. A strength of the review was the variety of settings in which pregnant teens were seen.

CONCLUSIONS
- Interventions facilitating parenting skills for vulnerable teen parents foster improved outcomes for both the mother and (probably) the child.

IMPLICATIONS FOR PRACTICE
- Interventions to foster parenting skills should be provided for teen parents. Health care providers need to give some thought to which setting might maximize the effects of which interventions. Some coordination among various providers is required. Teen fathers, often absent because of lack of commitment, mistrust in the services, illiteracy, and personality, need interventions tailored to their special needs as teens and parents.

IMPLICATIONS FOR FURTHER RESEARCH
- More trials are needed, with attention to large numbers, minimizing dropouts, and statistical rigor for confounding effects. Some methods to recruit and randomize nonvolunteers would improve the generalizability of the results. Of particular interest are the influences of peers in the group. The skill of the facilitator is critical to the process and tone of the group, but none of the studies discussed this variable. Data on the long-term outcomes of the children are needed.
care given during a single hospitalization or care for multiple conditions over a lifetime. Home care is one delivery component available along the perinatal continuum of care (Fig. 3-4). This continuum begins with family planning and continues with preconception care, prenatal care, intrapartum care, postpartum care, newborn care, interconception care, and infant care until the infant is 1 year old. Independent self-care, ambulatory care, home care, low risk hospitalization, or specialized intensive care may be appropriate at different points along this continuum.

Clinical integration of services can improve services. The goals of clinical integration are improved coordination of care and care outcomes; better communication among health care providers; increased patient, payer, and provider satisfaction; and reduced cost. With clinical integration, the focus changes from illness to health, from the individual to the population, and from care provided in one setting to care across the continuum. The following factors make home care an important area in perinatal services:

- Interest in family birthing alternatives
- Shortened hospital stays
- New technologies that allow sophisticated assessments and treatments to be performed in the home
- Reimbursement by third-party payers

Modern home care nursing has its foundation in public health nursing, which provided comprehensive care to sick and well patients in their own homes. Specialized maternity home care nursing services began in the 1980s, when public health maternity nursing services were limited and services had not kept pace with the changing practices of high risk obstetrics and emerging technology. Lengthy antepartal hospitalizations for such conditions as preterm labor and gestational hypertension created nursing care challenges for staff members of inpatient units. Many women expressed their concern for the negative effect of antepartal hospitalizations on the family. Although clinical indications showed that a new nursing care approach was needed, home health care did not become a viable alternative until third-party payers (i.e., public or private organizations or employer groups that pay for health care) pushed for cost containment in maternity services.

**COMMUNICATION TO BRIDGE THE CONTINUUM**

As maternity care continues to consist of frequent and brief contacts with health care providers throughout the prenatal and postpartum periods, services that link maternity patients throughout the perinatal continuum of care have assumed increasing importance. These services include critical pathways, telephonic nursing assessments, discharge planning, specialized education programs, patient support groups, home visiting programs, nurse advice lines, and perinatal home care. Some hospitals provide cross-training for hospital-based nurses to make postpartum home visits or to staff outpatient centers for postpartum follow-up.

**Telephonic Nursing Care**

Telephonic nursing care through services such as warm lines, nurse advice lines, and telephonic nursing assessments is a valuable means of managing health care problems and bridging the gaps among acute, outpatient, and home care services. Some providers are using the Internet to communicate with patients who have an Internet service provider (ISP). Nursing care that occurs by telephone is interactive and responsive to immediate health care questions about particular health care needs. Warm lines are telephone lines that are offered as a community service to provide new parents with support, encouragement, and basic parenting education. Nurse advice lines, or toll-free nurse consultation services, often are supported by third-party payers or nurse care managers employed by health

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**Fig. 3-4** Perinatal continuum of care.
A wide range of professional health care services and technology can be delivered or used in the home with technology and telecommunication. For example, telehealth and telemedicine make it possible for patients in the home to be interviewed and assessed by a specialist located hundreds of miles away. Some view home health care as an extension of in-hospital care. Essentially, the primary difference between health care in a hospital and home care is the absence of the continuous presence of professional health care providers in a patient’s home. Generally, but not always, home health care entails intermittent care by a professional who visits the patient’s home for a particular reason and/or provides care on site for fewer than 4 hours at a time. The home health care agency maintains on-call professional staff to assist home care patients who have questions about their care and in emergencies, such as equipment failure.

**GUIDELINES FOR NURSING PRACTICE**

Although the home care industry continues to grow rapidly, perinatal home care nursing practice is still emerging. AWHONN (1998) defined *home care* as the provision of technical, psychologic, and other therapeutic support in the patient’s home rather than in an institution. The scope of nursing care delivered in the home is necessarily limited to practices deemed safe and appropriate to be carried out in an environment that is physically separated from a health care institution and its resources... Nursing practice at home is consistent with federal and state regulations... that direct home care practice. The nurse demonstrates practice competence through formalized orientation and ongoing clinical education and performance evaluation in the respective home care agency. Standards for practice from key specialty organizations such as AWHONN, the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the Intravenous Nursing Society (INS) provide the basis for clinical protocols and pathways and organizational programs in home care practice. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) provides criteria for home care operations based on Centers for Medicare and Medicaid Services regulations.

AWHONN (1994) developed standards of practice and identified essential knowledge and skills to provide safe perinatal home care. Health care agencies and individuals can use these to assess the nurse’s skills and learning needs.

Home care agencies are subject to regulation by governmental and professional organizations. They provide interdisciplinary services including social work, nutrition, and occupational and physical therapy. Increasingly their case loads are made up of patients who require high-technology care, such as infusions or home monitoring. Although the home health nurse develops the care plan, all care must be ordered by a physician. Additionally, interventions must meet the insurer’s
Patient Selection and Referral

The office- or hospital-based nurse is often the key person in making effective referrals to home care. When a referral to home care is considered, the following factors are evaluated:

- Health status of mother and fetus or infant: Is the condition serious enough to warrant home care? Is it stable enough for intermittent observation to be sufficient?
- Availability of professionals to provide the needed services within the patient’s community
- Family resources, including psychosocial, social, and economic resources: Will the family be able to provide care between nursing visits? Are relationships supportive? Is third-party reimbursement available, or can it be negotiated with the insurer?
- Cost-effectiveness: Is it more reasonable for the patient to receive these services at home or to go to a local outpatient facility to receive them?

Community referrals should not be limited to women with physiologic complications of pregnancy that require medical treatment. Patients at risk (e.g., young adolescents, families with a history of abuse, members of vulnerable population groups, developmentally disabled individuals) may need follow-up care at home. In consultation with the social worker, the hospital-based nurse should become familiar with agencies in the community that accept such referrals. When the patient lives in a rural area, hospital-based nurses should familiarize themselves with available formal and informal resources in that community, as these may be different from those in a more populated setting (Bushy, 2000).

Standardized referral forms simplify the referral process and ensure that all needed information will be forwarded to the home health agency. The nursing assessment should include the woman’s physical and psychologic status, her level of knowledge about self-care activities, her willingness to learn, the availability of caregivers and social support in the home, and her level of comfort with home care. If the referral is for a mother and infant home care visit, the nursing assessment should include data about the newborn.

High technology home care requires additional information to be collected from the medical record and consultation with the referring physician and other members of the health care team before a home care referral is made. Additional data include the medical diagnosis, medical prognosis, prescribed therapies, medication history, drug-dosing information, potential ancillary supplies, type of infusion access device, and the available systems of social support for the patient and family. The nursing assessment and therapies data provide baseline information for the home care nurse and other types of health care providers involved in the care plan.

Whenever a referral is called in to a home health care agency, a member of the nursing or admission staff determines the agency’s ability to accept the patient for service. The use of telecommunication such as fax machines, cellular phones, and the Internet to transmit information has eliminated delays in initiating home care services, even in more remote rural areas.

Preparing for the Home Visit

The home care nurse reviews the available clinical data, demographic information, and completed plan of care form and consults with the referring physician and other members of the health care team before a home care referral is made. Additional data include the medical diagnosis, medical prognosis, prescribed therapies, medication history, drug-dosing information, potential ancillary supplies, type of infusion access device, and the available systems of social support for the patient and family.

Before going on a home visit, the nurse contacts the woman to make necessary arrangements and obtain detailed instructions on the location of the home. Contact by telephone has several goals besides establishing a convenient time to visit and exact directions; it also sets the stage for the first home care visit.

The nurse identifies himself or herself by name, title, and agency. He or she then explains who referred the woman to the agency for home care and the purpose of the home care visit. Whenever a referral is called in to a home health care agency, a member of the nursing or admission staff determines the agency’s ability to accept the patient for service. The use of telecommunication such as fax machines, cellular phones, and the Internet to transmit information has eliminated delays in initiating home care services, even in more remote rural areas.

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UNIT ONE
INTRODUCTION TO MATERNITY NURSING

Protocol for Perinatal Home Visits

PREVISIT INTERVENTIONS
1. Contact family to arrange details for home visit.
   a. Identify self, credentials, and agency role.
   b. Review purpose of home visit follow-up.
   c. Schedule convenient time for visit.
   d. Confirm address and route to family home.
2. Review and clarify appropriate data.
   a. Review all available assessment data for mother and fetus or infant (e.g., referral forms, hospital discharge summaries, family-identified learning needs).
   b. Review records of any previous nursing contacts.
   c. Contact other professional caregivers as necessary to clarify data (e.g., obstetrician, nurse-midwife, pediatrician, referring nurse).
3. Identify community resources and teaching materials appropriate to meet needs already identified.
4. Plan the visit, and prepare bag with equipment, supplies, and materials necessary for assessments of mother and fetus or infant, actual care anticipated, and teaching.

IN-HOME INTERVENTIONS: ESTABLISHING A RELATIONSHIP
1. Reintroduce self and establish purpose of visit for mother, infant, and family; offer family opportunity to clarify their expectations of contact.
2. Spend brief time socially interacting with family to become acquainted and establish trusting relationship.

IN-HOME INTERVENTIONS: WORKING WITH FAMILY
1. Conduct systematic assessment of mother and fetus or newborn to determine physiologic adjustment and any existing complications.
2. Throughout visit, collect data to assess the emotional adjustment of individual family members to pregnancy or birth and lifestyle changes. Note evidence of family-newborn bonding and sibling rivalry; note relationships among mother, father, children, and grandparents.
3. Determine adequacy of support system.
   a. To what extent does someone help with cooking, cleaning, and other home management tasks?
   b. To what extent is help being provided in caring for the newborn and any other children?
   c. Are support persons encouraging the new mother to care for herself and get adequate rest?
   d. Who is providing helpful information? Emotional support?
4. Throughout the visit, observe home environment for adequacy of resources:
   a. Space: privacy, safe play of children, sleeping
   b. Overall cleanliness and state of repair
   c. Number of steps pregnant woman/new mother must climb
   d. Adequacy of cooking arrangements
   e. Adequacy of refrigeration and other food storage areas
   f. Adequacy of bathing, toilet, and laundry facilities
   g. Arrangements in home for newborn: sleeping, bathing, formula preparation (if needed), layette items, and diapers
5. Throughout the visit, observe home environment for overall state of repair and existence of safety hazards:
   a. Storage of medications, household cleaners, and other substances hazardous to children
   b. Presence of peeling paint on furniture, walls, or pipes
   c. Factors that contribute to falls, such as dim lighting, broken steps, scatter rugs
   d. Presence of vermin
   e. Use of crib or playpen that fails to meet safety guidelines
   f. Existence of emergency plan in case of fire; fire alarm or extinguisher
6. Provide care to mother, newborn, or both as prescribed by their respective primary care provider or in accord with agency protocol.
7. Provide teaching on basis of previously identified needs.
8. Refer family to appropriate community agencies or resources, such as warm lines and support groups.
9. Ascertain that woman knows potential problems to watch for and whom to call if they occur.
10. Ensure that used disposable items have been handled appropriately and that reusable items are cleaned and repacked appropriately in the nurse’s bag.

IN-HOME INTERVENTIONS: ENDING THE VISIT
1. Summarize the activities and main points of the visit.
2. Clarify future expectations, including schedule of next visit.
3. Review teaching plan and provide major points in writing.
4. Provide information about reaching the nurse or agency if needed before the next scheduled visit.

POSTVISIT INTERVENTIONS
1. Document the visit thoroughly, using the necessary agency forms to serve as a legal record of the visit and to allow third-party reimbursement, as possible.
2. Initiate the plan of care on which the next encounter with the woman and family will be based.
3. Communicate appropriately (by telephone, letter, progress notes, or referral form) with primary care provider, other health professionals, or referral agencies on behalf of woman and family.
First Home Care Visit

Making the first home care visit can be stressful for the nurse and the woman. The home care nurse is faced with an unknown environment controlled by the woman and her family. The woman and her family also experience feelings about the unknown, such as anxiety about the way the nurse will treat them or what the nurse will do during the visit. The challenge for the home care nurse is to establish a nurse-patient relationship and provide the prescribed home care services within the time provided for the initial home visit. One of the most important roles of the home care nurse is modeling health-related behaviors for the patient and others who are in the home during the visit.

Introductions generally begin the visit; the nurse identifies herself or himself and the home care agency. The woman introduces herself and the other family members who are present. Sometimes the woman may feel uncertain of her role or be uncomfortable in taking the lead in introductions, so other people in the home may not be introduced to the nurse. In these situations the nurse can politely ask about other people in the home and their relationship to the woman.

During the first visit to the home, the home care nurse completes extensive documentation with the patient (Fig. 3-5). Before performing any services, the nurse must obtain written agreement and consent for the home health care services. This consent-for-care serves two major purposes: agreement for care and authorization to release medical information.

Many third-party payers require written documentation of the services provided; therefore the agency obtains authorization from the woman to give information to her physician and any individual or company involved in payment for the services. Agencies that bill third-party payers for the rendered services will include agreement language for assignment of benefits and financial remuneration. By agreeing to assign insurance benefits to the agency, the woman allows her insurance company to pay the home health care agency directly.

All patients have the right to participate actively in their plan of care. These patient rights and responsibilities should begin the discussion about the nurse and patient roles during this initial visit.

Assessment and Nursing Diagnoses

The primary goals of the assessment phase are to develop a trusting relationship and collect data by various methods to obtain a comprehensive patient profile. It may not be feasible or appropriate to collect in-depth information about all areas of assessment during the first visit. In many instances, however, the nurse may be limited to one visit and must obtain information pertinent to the current situation in that hour.

The establishment of a trusting relationship begins with the previsit telephone call. An interview style that reflects sensitivity; a nonjudgmental, accepting attitude; and respect for the woman’s rights facilitates the development of that trusting relationship. A skillful interviewer avoids barriers to communication such as false reassurance, advice giving, excessive talking, and the showing of approval or disapproval. This nurse-patient relationship continues to develop over the course of home visits.

The nurse is a guest in the woman’s home and should show respect for her and her belongings. Some adaptation of the home visit schedule may be made if numerous distractions interrupt a visit, such as caring for the needs of small children. The nurse may ask to have the volume of the television reduced or suggest moving to another room where it is more quiet and private.

The major areas of the assessment are demographics, medical history, general health history, medication history, sociocultural assessment, home and community environment, and physical assessment. Some of this information can be obtained from patient records sent to the home care agency at the time of referral or from the previsit interview. These data will be used to develop the nursing care plan and complete the plan of care, which is required for many licensed home health care agencies. Two areas requiring further discussion are the social assessment and the home environment assessment.

Social assessment includes information regarding the number of people in the family, the roles of each household member, which family members or individuals have taken on the roles of caregivers, and the woman’s social support network (Box 3-5). Identifying the roles of each member is helpful for developing the plan of care.

Physical assessment of the home environment is an essential element of the home care assessment. The major areas of the home environment assessment include physical features of the home, access to the home, sanitary conditions, the presence of utilities (e.g., indoor plumbing, telephone, electricity), safety features, and access to transportation and emergency support. Although some of this information can be collected during an interview, physically
Psychosocial Assessment

**LANGUAGE**
- Identify the primary language spoken in the home.
- Assess whether there are any language barriers to receiving support.

**COMMUNITY RESOURCES AND ACCESS TO CARE**
- Identify primary and secondary means of transportation.
- Identify community agencies the family currently uses for health care and support.
- Assess cultural and psychosocial barriers to receiving care.

**SOCIAL SUPPORT**
- Determine the people living with the pregnant woman.
- Identify who assists with household chores.
- Identify who assists with child care and parenting activities.
- Identify to whom the pregnant woman turns when problems occur or during a crisis.

**INTERPERSONAL RELATIONSHIP**
- Identify the way decisions are made in the family.
- Identify the family’s perception of the need for home care.
- Identify roles of adults in caring for family members.

**CAREGIVER**
- Identify the primary caregiver for home care treatments.
- Identify other caregivers and their roles.
- Identify potential strain from the caregiver role.

**STRESS AND COPING**
- Identify what the woman perceives as lifestyle changes and their impact on her and her family.
- Identify the changes she and her family have made to adjust to her health condition and home health care treatments.

Box 3-5

**Psychosocial Assessment**

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**CAREGIVER**
- Identify the primary caregiver for home care treatments.
- Identify other caregivers and their roles.
- Assess the caregiver’s knowledge of treatments and care process.
- Identify potential strain from the caregiver role.

**STRESS AND COPING**
- Identify what the woman perceives as lifestyle changes and their impact on her and her family.
- Identify the changes she and her family have made to adjust to her health condition and home health care treatments.

Box 3-5

Inspecting many areas of the home essential to care is a critical part of developing an accurate nursing plan of care. Before any physical inspection, the home care nurse should ask the woman or the caregiver for permission and assistance in identifying areas in the home that will be involved in the caregiving activities. During the physical inspection, careful consideration should be taken to avoid moving personal belongings that are not affected by the care.

Each plan of care has a different emphasis in the home environment. For example, women receiving infusion therapy for hyperemesis gravidarum need a safe place to store medications and infusion supplies that is out of reach of small children living in the home. The home care nurse should incorporate the agency policies and procedures for the storage and handling of infusion supplies into her walk-through inspection. During the walk-through, the home care nurse looks at the potential storage areas that are dry, that are clean, and where the temperature can be maintained. The home care nurse should include an inspection of work areas, such as countertops, tabletops, sinks, and trash areas, that the woman or caregiver may use for mixing medications, changing infusion tubing, handling supplies, or disposing of used equipment and supplies.

The homes of patients using electronic home health care equipment, such as phototherapy equipment or infusion pumps, require physical inspection of electrical outlets, electrical cords, and extension cords that will be used. Homes with faulty electrical wiring may place the patient at risk for being involved in an electrical fire. Faulty wiring may require inspection and repair by a professional electrician before electronic devices are used. Findings from the assessment are incorporated into the plan of care.

Nursing diagnoses are derived from the data collected at the first home visit. Nursing diagnoses for perinatal home health care patients include the following:

- **Deficient knowledge related to**
  - therapeutic regimen management (e.g., nausea and vomiting, preterm labor, gestational diabetes)
  - newborn care and feeding
- **Compromised family coping related to**
  - lack of child care while mother is on bed rest
  - care of newborn receiving oxygen therapy
- **Impaired home maintenance, deficient diversional activity related to**
  - prolonged bed rest at home or in the hospital
- **Impaired parenting related to**
  - maternal immaturity and lack of family support

**Expected Outcomes of Care**

Examples of expected outcomes for perinatal patients include that the woman and/or her family will do the following:

- **Verbalize understanding of treatments**
- **Use support systems to cope effectively with problems** (e.g., pregnancy complications, newborn complications or treatments)
- **Perform procedures accurately** (e.g., blood glucose monitoring) as evidenced by return demonstration
- **Verbalize decreased role strain**

**Plan of Care and Interventions**

The nursing plan of care is developed in collaboration with the patient, based on the health care needs of the individual. Home care nurses working in home health care agencies regulated by the Centers for Medicare and Medicaid Services use a plan of care that includes patient demographics, the health care provider’s orders, home care goals, and the level of functioning. This document is initiated at the time of
referral to the home care agency and must be updated every 60 days or as specified by state regulations.

The frequency of the skilled nursing visit may vary with the individual plan of care and reimbursement criteria established by the third-party payers (Plan of Care).

Nurse safety and infection control are two important aspects specific to home care.

**Safety issues for the home care nurse**

The nurse should be fully aware of the home environment and neighborhood in which the home care is being provided. Unlike hospitals, in which the environment is more predictable and controlled, the patient’s neighborhood and home have the potential for uncertainty. Home care nurses should take necessary safety precautions and avoid dangerous areas. Agencies that serve patients in high crime areas may conduct a violence potential assessment by telephone before the visit and enlist the patient’s cooperation in minimizing risk. Others have hired full-time security personnel to accompany nurses on their visits. Personal strategies recommended for nurses visiting families with a history of violence or substance abuse include (1) self-awareness; (2) environmental assessment; (3) using listening and observation skills with patients to be aware of behavioral changes indicating aggression or lack of impulse control; (4) planning for dealing with aggressive behavior (e.g., allowing personal space and taking a nonaggressive stance); (5) making visits in pairs; and (6) having access to a cellular phone at all times.

**Personal safety.** The home care nurse must be aware of personal safety behaviors before going on a home visit. Dress should be casual but professional in appearance, with a name identification tag. Limited jewelry should be worn. Valuable personal items, such as an expensive purse or coat, should not be worn on a visit. Carrying an extra set of car keys in the nursing home care bag saves time and frustration if the nurse becomes locked out of the automobile. Automobile keys spread between the fingers with sharp ends outward can be used as a weapon if necessary.

The same commonsense behaviors and precautions that guide a person’s behavior when alone in any setting should be followed by home care nurses.

The agency should have a copy of the nurse’s home care itinerary, including contact telephone numbers if a patient needs assistance.

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**NURSING DIAGNOSIS: Ineffective community management of therapeutic regimen**

**Expected Outcome:** The community will develop programs to meet the needs of new members of the community.

**Nursing Interventions/Rationales:**

- Conduct a needs assessment of the community to identify priority needs for new members of the community.

- Initiate health education programs based on topics identified in the needs assessment to meet the needs of members of the community.

- Prepare patient education materials in a variety of languages to enhance understanding of community members.

- Identify the risk in the community of infectious diseases.

- Develop a monitoring or surveillance system to ensure that progress will continue and new problems will be identified.

**NURSING DIAGNOSIS: Ineffective community coping**

**Expected Outcome:** Health status of the community will improve.

**Nursing Interventions/Rationales:**

- Initiate health screening programs for community members to identify effects of environmental hazards in the community.

- Work with politicians and policy makers to develop the community to provide a safe environment with means of economic survival for community members.

- Initiate programs such as Block Watch, Safe Houses, and Neighborhood Watch to enhance the safety of the environment.

- Work with community leaders to develop or clean up playgrounds to provide a safe place for children to play.

- Identify sites of lead exposure to decrease the potential for lead poisoning in children.

- Participate in immunization or vaccination clinics to reduce the risk in the community of infectious diseases.
does not have a telephone and information on the nurse’s car (make, model, color, and license plate number). Many home care nurses carry agency-provided pagers or cellular telephones that allow the agency to contact the nurse throughout the day to give information about patient updates, changes in orders or services, schedule changes, and new patients who require an initial visit. The telephone also is useful to notify patients when the nurse is delayed.

The automobile used for the home care visits, whether a personal or an agency-owned vehicle, should have regular preventive maintenance checks, an adequate fuel level, and road safety items stored in the trunk. Items to carry in the vehicle include change for telephone calls and tolls, maps, emergency telephone numbers, a flashlight, a first aid kit, flares, a blanket, and equipment for inclement weather conditions. When a visit is made to a patient in a more remote rural setting, other travel considerations may be needed, as well as additional supplies or medication to be taken to the patient (Busby, 2003).

Home care nurses should park and lock their cars in a safe place that is visible from the street and the patient’s home and away from hidden alleys. While driving to the patient’s home, the nurse should assess the neighborhood for safety, especially if the neighborhood is unfamiliar. All valuable items should be stored out of sight before the nurse leaves the office. While walking to the patient’s home, nurses should not walk near groups of strangers hanging out in doorways or alleys, enter into vacant buildings, or enter a yard surrounded by a barbed wire fence. The home or building should not be entered if the nurse has any safety concerns. Responsibility for safety of home care staff is the responsibility of the agency (McPhaul, 2004). All home care agencies should have policies to follow in such situations.

Unsafe situations in the patient’s home. Once inside the woman’s home, the nurse may encounter unsafe situations such as the presence of weapons, abusive behavior, or health hazards. Each potentially hazardous situation must be dealt with according to agency policies and procedures. If abuse or neglect is reasonably suspected, the home care nurse should follow home care agency and state and federal regulations for reporting and documenting the situation. Nurses should maintain their own safety first and act accordingly throughout the visit.

Infection control

The nurse carries the necessary supplies and equipment to provide nursing care to the woman. Home care bags should contain infection control supplies, such as personal protection equipment; disposable nonsterile, sterile, and utility gloves; disinfectants; disposable cardiopulmonary resuscitation (CPR) masks; gowns; shoe covers; caps; leakproof and puncture-resistant specimen containers; sharps container; dry hand disinfectants; and leakproof barriers. Proper infection control techniques should be used in stocking, storing, handling, and transporting this bag. When a procedure is to be performed, the nurse should set up a clean area for necessary supplies. A “dirty” area is designated with a trash bag for the collection of soiled equipment and supplies. Hands are washed before all supplies and equipment for the visit are removed from the bag and placed in a clean area.

Standard Precautions should be used whenever a treatment is performed because it is difficult to determine which patients have a communicable disease (see Box 6-5). Handwashing remains the single most important infection control procedure, and the caregiver is in a position to educate about the importance of this practice in preventing disease. Hands should be washed thoroughly for 15 to 20 seconds before and after each patient contact. Wearing gloves does not eliminate the necessity for handwashing. If running water or clean facilities are unavailable, the hands can be cleaned with a self-drying antiseptic solution.

Using gloves reduces the incidence of exposure to bloodborne pathogens. Gloves should be selected according to the nursing activity to be performed. Nonsterile latex or vinyl gloves should be worn for each procedure that has the potential for contact with bodily substances (e.g., performing venipunctures, heel sticks on the newborn, perineal care). Sterile gloves should be worn for clinical procedures requiring sterile technique, such as insertion of peripherally inserted central lines and certain dressing changes. General purpose utility gloves should be used for housekeeping activities, such as cleaning equipment or spills. Nonsterile and sterile gloves should be discarded after each use in a leak-resistant waste receptacle. Utility gloves may be disinfected and reused.

Disposable personal protection equipment should be removed after each use and discarded in a plastic trash container. Safety glasses or goggles can be cleaned with soap and water after each use.

Whenever specimens are collected, Standard Precautions should be used. Any specimen of bodily fluids should be placed in a leakproof bag and secured in a puncture-proof container. The outside of the container is washed off, if it was soiled, before the container is transported. Specimens should be labeled with the woman’s or infant’s name and additional identifying information according to the home health care agency or laboratory policies. If specimens are being transported, they should be placed in a container on a flat surface in the vehicle. An insulated container may be used to keep specimens cool in transit. The nurse should be aware of the time-sensitive nature of laboratory procedures for certain types of specimens.

Sharps containers are puncture-proof and leakproof containers labeled with a biohazard sign on the outside and should be used to collect needles and sharp objects (Fig. 3-4). Patients are instructed to fill containers between two thirds
The nurse inquires about any other medications that the woman might be taking concurrently. Over-the-counter drugs or herbal supplements may not be considered medications by the women and not mentioned unless such information is specifically asked for. Even more important is ensuring that the patient and her caregivers fully understand the information that they are exposed to by health care providers. High-technology home care involves many diagnostic and therapeutic procedures. A focused physical assessment is always part of the visit. Nurses involved in perinatal home care must be skilled in prenatal, postpartal, and newborn assessment. Many women require additional diagnostic tests. The nurse may need to collect blood or other specimens. Portable fetal monitoring equipment or even ultrasound can be used in the home for fetal assessment. Home infusion for women with hyperemesis gravidarum often replaces hospitalization. Women with preterm labor may receive parenteral tocolytic therapy. Phototherapy or apnea monitors can be provided in the home for newborns. The power supply and wiring must be reliable. Family members may need to be taught to monitor equipment between nurse visits and to prevent accidental damage.

Medical emergencies may occur during or between the nurse’s visits to the home. Prior planning and education can reduce the risk of problems. All parents of newborns should know infant CPR. There should be immediate telephone access to call for emergency medical assistance. Women and their families should be taught to recognize danger signs related to their condition. For example, women at risk for preterm labor should learn to palpate the uterus and recognize contractions in the absence of pain; women with diabetes must learn the signs of hypoglycemia and what to do if it occurs; women with preeclampsia must know the danger signs that indicate worsening of their condition and to notify the health care provider immediately. In a more remote rural community that does not have an obstetrician in the region, the nurse may need to assist the patient’s family to arrange for “boarding” somewhere that is closer to a medical specialist.

Patient and family education in home care includes information about the specific high risk condition(s) involved, implications for pregnancy outcome, and measures for self-monitoring. Verbal explanations should be supplemented with clearly written instructions. General information to promote well-being, such as about nutrition and common discomforts of pregnancy, also should be included. The need for preparation for childbirth can be addressed by using books or videos that are supplemented by individual teaching at home. Coping with bed rest or other limitation of activity is a problem for many women with high risk pregnancies. The nurse may share strategies that others have used, help with time management, and provide information about support services. Teaching about infant care or the special needs of the preterm infant may be appropriate during the prenatal period.

Fig. 3-6 Sharp container. (Courtesy Shannon Perry, Phoenix, AZ.)

and three fourths full to prevent spillage of their contents. As part of the patient teaching process, information about storage and handling is covered by the home care nurse. When the container reaches its maximal capacity, it should be returned to the home health care agency and replaced. Medical waste, such as urine and secretions, can be discarded through the sewer or septic system. Contaminated dressings and disposable supplies should be placed in a leakproof plastic bag and securely fastened for disposal at the patient’s home. The patient should be instructed regarding the proper disposal of medical waste in the home. Agency policies and procedures and local waste management ordinances should be consulted before the patient is instructed.

Nursing Considerations

In home care the woman or family members are responsible for administration of medications in the absence of the nurse. A careful medication history should be obtained to see if the woman is taking her medications correctly and understands the desired action and potential side effects. Sometimes when orders are changed, women continue to take both the old and new prescriptions, which can lead to dangerous overdoses or medication interactions. The nurse ensures that there is an adequate supply and a safe place for proper storage of medications to prevent deterioration or accidental ingestion by children or pets. The nurse
Clear documentation of assessments, problems identified, treatments and interventions performed, and the patient’s responses is essential. Third-party payers base reimbursement on the nurse’s written record of providing skilled nursing care and assessments that support the woman’s continuing need for those services. The nurse must promptly inform the health care provider by telephone or facsimile of any significant changes. When new orders are transmitted by telephone, a written copy must be sent for the physician’s signature.

The home care nurse continually reassesses the patient’s condition and response to the interventions during every home visit and revises the nursing diagnoses and plan of care. Nursing documentation should reflect an objective description of the nursing assessment data collected at each visit. Statements such as “no change” or “same as last visit” do not accurately reflect the monitoring of the patient condition that occurred during the skilled nursing visit. Once the home care outcomes are achieved and the patient is discharged from the home care agency, documentation should include information about the patient’s status at the time of discharge, progress toward attaining health care goals, and plans for follow-up care.

Key Points
- A community is defined as a locality-based entity composed of systems of societal institutions, informal groups, and aggregates that are interdependent and whose function is to meet a wide variety of collective needs.
- Of necessity, most changes aimed at improving community health involve partnerships among community residents and health workers.
- Methods of collecting data useful to the nurse working in the community include walking surveys, analysis of existing data, informant interviews, and participant observation.
- Vulnerable populations are groups who are at higher risk for developing physical, mental, or social health problems.
- Perinatal home care is a unique nursing practice that incorporates knowledge from community health nursing, acute care nursing, family therapy, health promotion, and patient education.

Social and economic factors affect the scope of perinatal nursing practice.
- Perinatal home care can be provided for women and infants throughout the perinatal period, beginning before conception and ending in the postpartum period.
- Perinatal home care nurses should incorporate personal safety and infection control practices in the nursing plan of care.
- Telephonic nurse advice lines, telephonic nursing assessments, and warm lines are low-cost health care services that facilitate continuous patient education, support, and health care decision making, even though health care is delivered in multiple sites.
- Communication protocols among members of the home health care team are critical to diminish fragmentation and duplication of health care services.

Evaluation
Evaluation is based on the expected outcomes of care. The plan is revised as necessary.

IDENTIFY AT LEAST TWO CULTURAL GROUPS IN YOUR COMMUNITY. READ YOUR LOCAL NEWSPAPER AND IDENTIFY ARTICLES DESCRIBING HEALTH NEEDS OF VULNERABLE POPULATIONS WITHIN THESE TWO GROUPS IN YOUR COMMUNITY. CONSULT THE YELLOW PAGES OF THE TELEPHONE BOOK. ARE THERE AGENCIES IN YOUR AREA THAT SPECIFICALLY DEAL WITH MEETING THOSE NEEDS? IF YOU ENCOUNTERED A PATIENT WITH ONE OF THE NEEDS, TO WHOM WOULD YOU REFER HER?

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Answer Guidelines to Critical Thinking Exercise
Health Needs of a Migrant Worker
1. No, there is not sufficient evidence. The nurse needs to establish baseline data and understanding of the mother within her culture and perform an assessment before mutual goal setting.
2. a. The goals must be realistic, not just idealistic.
   b. Both mother and infant need adequate nutrition and rest.
   c. Maintaining breastfeeding while working long hours in the field is difficult if not impossible.
   d. Including other family members in the care of the infant will assist the mother. Including the father may be neither culturally appropriate nor possible given his work hours.
Priority for care is to ensure that the infant and mother obtain adequate nutrition. If the mother cannot breastfeed, a safe source of nutrition must be provided. Refrigeration must be available, as well as a source of safe water. WIC may be a source of formula for the infant and food for the mother. In this setting, powdered formula may be the safest form of milk because each feeding can be prepared at the time of feeding.

Yes. Standards of care dictate that the mother and infant need adequate nutrition, as well as sleep and rest.

There are no data to indicate whether or not the father of the baby is involved or that his involvement is culturally appropriate. Because the mother is Vietnamese speaking, a nurse who speaks Vietnamese or an interpreter must be involved. There also may be need for a bed and clothing and other supplies for the infant. Sources of family support should be ascertained. Whether there are other community agencies or groups that can provide assistance should be ascertained.

Resources


Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244-1850
www.cms.hhs.gov

Community Health Status Indicators
Public Health Foundation
1300 L. St., NW, Suite 800
Washington, DC 20005
www.phf.org

National Association of County and City Health Officials
1100 17th St., NW, Second Floor
Washington, DC 20036
202-783-1550
202-783-1583 (fax)
www.naccho.org

The Children’s Partnership
2000 P. St., NW, Suite 330
Washington, DC 20006
202-429-0033
202-429-0974 (fax)
www.childrenspartnership.org

References


