

HPECD Database Record Closure Checklist

To minimize errors, use this checklist to validate data and ensure saved for each record (each family member).

Roles: The PHN closes the file. FF Home Visitors involved with the family need to review their entries. Admin confirms case activity is closed in the HPECD database.

Demographics:

- PHIN and name inputted for all permanent residents of MB.
 - PHINs for newborns may take up to 8 weeks.
 - To update a client's birth date remove the "Unknown" flag prior to selecting the calendar icon.
 - To update a client's estimated birthdate remove the "Estimated" flag and set the birth date.
- DOB and sex for each child.
 - To update a client's birth date remove the "Unknown" flag prior to selecting the calendar icon.
 - To update a client's estimated birthdate remove the "Estimated" flag and set the birth date.
- Ensure all addresses are updated, including postal codes. Use staging PC if unknown: p.15 user manual.
- Save and mark complete**

Birth episode (found under perinatal episode tab):

- Delivery mode, Gravida, Status, Birth weight, Gestational age.
- Date of discharge [all hospital and birth centre births].
- BF at time of d/c --all live births. [May not apply: apprehension or extended hospital stay].
- Save and mark complete**

File activity:

- Ensure files with no activity in last 3 months are closed. [FF program—min quarterly PHN contact]
- Date and time referred to: Central Intake, CA, PHN and referral received.
- Active providers:
 - All are listed in the Service Providers tab.
 - There is only 1 active PHN (occasionally 2—PT PHNs).
- Any providers not the primary / current are marked historical.
- No active providers for closed files.
- All routing notes completed.
- Save and mark complete**

PH services:

- BF level at first PH contact documented.
- FFS form number documented under 'identifiers tab' for every live infant.
 - It should never be registered in the identifiers section of the parent's health record
 - Screening: see FFS tip sheet for more details.*
- Screen and survey forms are filled in completely.**
 - No screen? Document reason (mandatory).
 - FFS score: Child's file only (or clinical positive or reason for no screen), date, completed by, name of parent one.
 - Clinical positives:** Screen positive? Score <3. Survey clinical positive? — total score < 25
- Date enrolled to FF documented.
- Visits:
 - Note all FFHV visits: Ensure service level is documented.
 - Visit length >0
 - Visit details complete
- Disposition, Discharge:
 - Disposition noted and date of disposition (all disposition types)—mandatory
 - Date of discharge.
 - Level of service at discharge.
 - Postal code at date of discharge.
 - Reason for d/c (if reason=other, fill in other notes).
- Save and mark complete**

Save and mark complete to prevent errors