Frequently Asked Questions – HPECD Database – October 24, 2014

Recent updates are marked in red

Registration and Case Activity

How do we generate additional Families First Screening numbers in parent 1's record in the case of multiple concurrent births (e.g., twins, triplets) or sequential births (e.g., someone who had another birth 10 months later)?

There are two ways to do this.

(1) After entering the 'Identifiers' tab select 'Other' in the 'Identifier Value' column and replace it with the letters 'FFS'. It is important that this label is accurately typed because if it is not it will interfere with searching by FFS and also interfere with reporting. Then type in the FFS number in the 'Value' column.

(2) After entering the 'Identifiers' tab press the add button then type the letters 'FFS' in the new row in the 'Identifier Value' column. It is important that this label is accurately typed because if it is not it will interfere with searching by FFS and also interfere with reporting. Then type in the FFS number in the 'Value' column.

It came to light that some clients who were back entered do not have an assigned service provider. This is because some providers were not part of the system at the time of back entry. Should we back enter them?

Yes. Effective client service is based on effective relationships with clients. The intent of noting the current (or past) provider in the database is to create a simple way to identify who a future referral should be assigned to in order to take advantage of, and build on, pre-existing relationships.

Can we eliminate or merge duplicate entries?

We are unable to merge duplicate entries. Please see the user manual for deleting duplicate entries.

Now that there is a field specifically for Ontario and Nunavut health numbers, should we be reentering relevant numbers into those spaces that were previously in the 'Other' field?

Yes, please enter information into the Ontario and Nunavut fields and remove information from the 'Other' field where relevant.

If the client has a new address who is responsible for updating the chart?

Whoever has been informed first - In the event it is central intake they will update the address, it is then the responsibility of the receiving office to validate the address upon receipt of the new referral and notify the service providers as required. If the address update is received at the community office then the client is updated and the other addresses marked as historical.

Do we have to enter the family MFRN on the infant record.

Yes that will assist central intake to not create duplicate charts.

In the circumstance where the mother is deceased following the referral does the mother's record get closed?

Yes the record gets closed and whichever parent is taking over care will become parent 1 and all visit tracking and forms will be generated on their chart as required.

What happens if the mother declined service and we receive an infant referral later?
We assume that any referral we receive was sent with consent. An infant is not normally discharged before the mother. If the situation is that the mother is discharged first, she would usually be registered and case activity would be open on her. If the mother declined service when she was discharged we may have no pre-existing information about her. But now that we have an infant referral we will have some information about the infant and the parent, and open case activity for both. If the infant was discharged a little later than the mother, the case would be registered and case activity would be opened at that time. The referral is associated with the parent that consented to the referral.

If the postpartum referral is received and the infant is already deceased will the admin still register the child and open the case activity. Then immediately mark them as deceased or will this be updated later by the Nurse?
We will not register or open case activity for someone that was never a client (e.g., stillbirth or dead before they left the hospital). However we would create a birth event (postnatal episode) for them. If the referral was made while the child was still alive, we would treat it like any other person. The nurse would mark them as closed and deceased.

Can the PHN chart be closed and have it open to only the FF Home Visitor?
The PHN health record must stay open if the FF Home Visitor health record is open. The family needs to be able to call on a PHN throughout the course of service. The PHN is responsible for completing the Parent Survey and Summary at the end of service with the FF program.

Will the PHIN be required on the infant chart if not enrolled in Families First? Yes, the infant PHIN will be required if the infant is a resident of Manitoba. The Infant PHIN is required for the Families First Screen. See user manual section on closing files.

Is there a checklist for closing a health record?
It has been added to the user manual.

What address should be used for homeless people?
HSHR can use where they are currently staying or where they most recently stayed. It is a temporary address. These clients don't often have a permanent address. I would not use default addresses.

Where are we recording Treaty #?
It is tracked under 'Other'.

Where would "East or West St. Paul" be registered? Would this be under the city category?
East or West St. Paul is a municipality and can be put in the 'city' area.

Is it important to register relationships as part of back entry?
Yes, if we are providing services to more than one client in a family the relationships between them should be noted.

Families First

What should we do if the FFHV is completed their work but the file is going to remain open to a PHN?

Make the FFHV a historical provider. FFHV is to confirm that all visits are current and have been correctly entered. The PHN should merge the two files, or keep them bundled together. The PHN completes entry on all Families First forms and saves and marks them complete.

When do we save and mark complete the FFS and Parent Survey forms?

FF screen should be completed within7 days of discharge. Parent Survey forms should remain in draft until families are discharged.

If a paper FFHV screen was completed and faxed, and now needs to be revised, is it entered into the database?

All Parent 1's health records should have a screening form attached as noted in the current back entry instructions. If the form has been 'Saved and Marked Complete' it will need to be re-opened and the appropriate changes should be made. Include these changes in the Parent Survey and Summary. If the family is now eligible for a Parent Survey a new 'Parent Survey and Summary Worksheet' will need to be initiated in Parent 1's record

Do we need to complete the Parent Survey Forms for late entry if the information was already faxed to Healthy Child?

Yes, Survey's should be transcribed/initiated in the database for program surveillance and program planning purposes.

What are the dates for completing Transition Summary Forms?

Transition Summary forms should be completed with data up to and including June 6 visits by FF Home Visitors.

What are the dates for Screening and Program Tracking Forms that should still be faxed to HCM?

Any FF forms dated with information gathered before June 9 should be sent to HCM as fax forms (e.g., screening, program tracking form).

If a paper FFHV screen was completed and faxed, and now needs to be revised, is it entered into the database?

All Parent 1's health records should have a screening form attached as noted in the back entry instructions. If the form has been 'Saved and Marked Complete' it will need to be re-opened and the appropriate changes should be made. Include these changes in the Parent Survey and Summary. If the family is now eligible for a Parent Survey a new 'Parent Survey and Summary Worksheet' will need to be initiated in the Parent 1 record.

What should I do if I have been unable to complete a screen?

Indicate the reason for no screen and 'Save and Mark Complete'. 'Save and Mark Complete' is a function in the database and does not indicate that all fields in the form were completed.

In whose health record is the FF Screening Number, Parent Survey and Summary found?
FF Screens, Parent Surveys and Summaries for all live births will always be kept in the record of Parent 1, and only Parent 1. A screen may have been started with a birth mother before an apprehension or adoption. The FF number is entered into the infant record if it should be linked such as in an open adoption. An infant with an open adoption may have more than one screening number associated with them.

Why should the Families First Screening Number only be noted in the 'Identifiers' section of health records of live infants?
While the screen does not predict outcomes for children, it is a standardized, validated and objective measure of the data gathered during the nursing assessment/history and is unique for each live birth event. It is the foundation for strength-based support for each live born child.

We screen biological parents whose children have been apprehended. We build relationships with families whose children have been apprehended, as many children may be returned. Beyond determining eligibility for the Parent Survey and possibly Families First, it is a way to standardize assessment and quantify family needs.

The location of FF Screening Numbers is as follows:

- Each live born infant will have a FF Screening Number as one of their "identifiers" in their health record
- If there are multiple births, the FF Screening Number initiated prenatally is entered into the first live-born infant's "Identifiers" section.
- Parents are never an FF Screening Number
- If a screening number was initiated with no live birth, there is no child to register
- For late referrals the relevant year's standardized late entry FF Screening Number should be added to the child's health record in the "Identifiers' section.

What are we doing for late entries? These do not have screening forms so are they still required to keep the Part II Tracking Form?
Late entries DO have a screening form if they were born in Manitoba. If the late entry was born outside of Manitoba, a screening form should be completed to the extent possible. For late entry families the documented FF screening number is the original infant screening number or from the paper 'Program Tracking II Form' if there is no original screening number. If the number on the 'Program Tracking II Form' is being used, it should be kept in the paper record but not faxed to HCM. The Survey and Summary Worksheet replaces the 'Program Tracking II Form' for all children.

How and when should the FF Screening Number be updated, especially in the situation of a Prenatal Referral?

The screening number is retained from Prenatal through Postnatal Services. The exceptions are if the infant is fostered or adopted; in these cases a new screening form and number are generated.

Perinatal Episode

How should we enter LATCHR scores between 1-2?
Enter the lower number.

What is entered in 'Date Discharged (if different)'?
Only enter the date of discharge if different from the mother.

Visit Tracking

Because we do not enter the phone calls that we make to contact and set up home visits, there will not be any entry into the data base for messages left on voicemails to set up initial appointments. Sometimes clients do not call back for 1 or 2 days for one reason or another. Should the contact is not reflected as being made according to PH standards, when it has been?

The HPECD database only captures information related to direct contacts with clients. If a direct contact is made by phone or home visit, that should be entered in the database. Documentation related to direct contacts is entered in to the care map. Indirect contacts are not captured in the database, or in the caremap. The documentation related to direct contacts, indirect contacts and attempted contacts is included in the Progress Notes.

A message left on a personal voice mail, or a letter dropped at a client residence, requesting that the PHN be contacted is an attempt to contact as per the guidelines. When a PHN is unable to contact the family directly, the HB Standard related to Contact # 1 is not met, as "contact" means direct contact was made with the client and PHN services were provided such as assessment and/or health teaching. The information in the HPECD database doesn't mean that the PHN hasn't attempted to meet the standard but rather only that the standard was not met.

The following is copied from the Healthy Beginnings Manual:

Standard 1 Contact #1: The PHN will contact the postpartum family the day after discharge for an initial postpartum assessment. At this time the PHN will articulate the role of the Public Health Nurse and offer a home visit to occur within seven days of discharge.

Clinical Practice Guideline for Initial Contact:
The intent of this initial contact is:
1. To address any immediate concerns of the family
2. To introduce/ review the role of the Public Health Nurse
3. To conduct a thorough assessment, whether initial contact is on the phone or in person

4. To offer a home visit
5. To plan follow-up whether in person or on the telephone
6. To advise the client of the telephone hot-line services

The CNSs will bring this issue for discussion at PHNPC. Please speak with your CNS for further clarification.

In whose health record do I track visits?
For reporting purposes it is essential to track visits to a family in the record of Parent 1. That is the only place from which FF Home Visitor visits can be calculated and reported through the Parent Survey and Summary. Do not track visits in the child's health record even if the purpose of that visit is primarily associated with the health of that child. Do not track the visit with anyone other than the pregnant woman or Parent 1 as noted in the FF Screening Form because it will result in being unable to report service associated with that family.

There are exceptions to the rule of always tracking visits in the record of Parent 1. For children in hotels or temporary shelters there may be no Parent 1 so visits in this exception only can be tracked in the infant's record. There should be no screen or survey in these situations.

Why are we tracking all HPECD visits?

- Healthy Child Manitoba requires information regarding visits completed by Family First Home Visitors.
- We will be able to describe attainment of our first PHN post-partum contact standard following time of hospital discharge.
- For the first time we will be are able to create a baseline for the frequency and quantity of direct service we provide. The database also includes a number of measures of vulnerability. Combined at a population level, the measures of direct service compared to measures of vulnerability will be a powerful tool to use in promoting health equity.

Why are we collecting information on frequency and length of direct services only, and not indirect services?
We believe frequency and total time directly served should be based on a family's vulnerability, where families with higher vulnerability get more direct service. It is assumed that the number and length of indirect contacts would be greater for more vulnerable families.

Once we have described our direct service, we anticipate requesting occasional time-limited audits to confirm that the assumption that indirect contacts are higher for vulnerable families. It was decided not to track frequency and time of all indirect contacts because of the required ongoing work it would require of staff.

Is there an area where emails or texts can be captured for clients?
Emails are not tracked in the system. Emails or texts should never be used to respond to or communicate personal health information.

Service Providers

What is the need for populating the Weekend service provider? What are we doing for the nurses who perform the Triage telephone call and assess the client but then the visiting nurse is actually a different nurse? With both be required in the service provider listing?
Every person who provided service should be listed. Anyone who is not the most current provider of service should be marked as a historical service provider. This will help us determine the level of continuity in client care which is important for developing a relationship. 'Service Providers' is a very quick overview of all those who have provided care to this client. This quick overview may not be as visible in the visit tracking area of the program.

Who is responsible for updating the service providers if these are decided during assignment?
The person who assigns the work assigns the service provider. This task may be delegated but it is still the responsibility of the person who assigned the work that it is completed.

Referral Management

In whose record should I track an 'infant referral'?
Like all other referrals, they should be tracked in the record of parent 1. Please correct all referrals that have been incorrectly entered in the infant file.

What do we need to do for the Breastfeeding hotline reports?
Verify the date is accurate, and demographics as must as possible, route it to the correct service provider and ensure it is entered as a referral.

When adding a referral in the database, can the Date and Time Referred to CA be left blank if the referral was generated in the CA office?
An entry in the "Date Referral Received" field is a required field. You cannot save the referral without completing this field. It refers to the date and time that Central Intake sent the referral to the CA, which is also when the CA received it from Central Intake. However, it is recognized that this field is not relevant when a CA generates a referral. In these situations the date and time in the "Date Referral Received" field should be entered, (as it cannot be left blank), but it can be ignored.

Who should complete the 'Date and Time Referred to PHN" section and when?
The person assigning the PHN to the client should be entering the service provider and time of PHN assignment into the database at the time of assignment. The purpose of tracking this filed is to track the time from the receipt of referral to the time of PHN assignment th the time of first contact. This information will help identify process improvement opportunities.

Who is the referral source in hospitals?
"Referral source" from hospitals is always a nurse, unless explicitly stated otherwise. The hospital nurse offers the client the option of having a PHN visit when at home and then makes the referral to WRHA.

Should we be tracking referrals that have the same information but may come from different sources?
We want to track all referrals in the system except those are identical and have obviously been resent in error. The purpose for doing so is to allow us to improve referral process, especially for prenatal referrals.

Would we also register 2 Infant Referrals and 2 Postpartum Referrals for Twins?
For twins who are sent to us as infant referrals – absolutely if they were sent at different times. Not for twins in a postpartum referral. The reason is that it was one referral with twins – even though it was on two pages.

Breastfeeding Clinics

For a client that was discharged prior to June 9th and has now returned for services in the Breastfeeding Clinic how should we complete their entry?
They will be registered to the best of your ability, without a Birth episode. They would be a self-referral in the referral tab. Their case activity will be opened, their service provider updated; the form opened and then once the form is saved and completed their activity can be closed.

For the Breastfeeding clinic appointments, are the weekend covering staff required to update the form for the visit when they don't have the actual chart or will this be the responsibility of the primary nurse assigned to this client?
Data entry of breastfeeding clinic appointments is the responsibility of the community area administrative staff upon receipt of the paper form. Aggregate information about the clinic that is not client specific continues to be sent to the admin person noted on the form.

Will the Breastfeeding clinic appointment form be used for Healthy Baby groups as well as the drop in "one on one" only consults?
No it will not. Note this as an 'Other Site Visit' in visit tracking.

Miscellaneous

What if we have new or untrained staff needing use of the database?
As soon as possible Managers should request access and submit the relevant documentation to the eHealth HelpDesk. Get the form at http://services.manitoba-ehealth.ca/acctManagement.html

Use of the database is an integral part of the work of all staff. Untrained staff will eventually need formal training from CSIS in use of the database. Monthly training will be posted on the Orientation web page http://www.wrha.mb.ca/extranet/publichealth/orientation.php and registration requests can be emailed to CSIS_support@wrha.mb.ca.

In the meantime, untrained staff should pair up with experienced staff to learn how to use the database to do their work. They should also attend any scheduled training opportunities because we want to ensure that all staff knows how to enter data that is current, accurate and complete.

In the event the new staff member does not have their HPECD database access yet- another staff person can entering data on their behalf. This individual must sign and date an entry describing what they added, deleted or changed in the database within the client's paper chart. It is a requirement of all electronic information systems that the person making all additions, deletions or changes are tracked as well as the time these occurred.

New staff will not be able to select themselves as a Service provider until they have been given access to the database. This will make it impossible to select their name in visit tracking or in any other tab that requires this functionality. ***The staff person is responsible for keeping a list of the items they are unable to complete. They must back-enter it when they receive access to the database.***

What if a previous client whose record was closed before June 9 calls for service?
Open the record as you would have done for any back entry. This time, 'add referral' this is a self-referral. If the client is now in another office use the transfer process previously noted.

Should the location of the FFHV record be noted in the routing note?
Yes, regardless of whether that location is permanent or temporary.

When the charts are placed into storage should the routing note be used to identify the box they are located in?
Yes.

What if staff is unable to enter data into the database on the same day?
The normal standard of data entry into a client record within 24 hours of providing service applies. The only exception is the FF Screen which can be completed within a week, but we encourage that it be completed as soon as reasonably possible.

I am unclear about what to do when there is apprehension/relinquishment and fostering/adoption?
The easiest way to address situations of apprehension/relinquishment and fostering/adoption is to break them into discrete tasks: registration, case activity, birth episode, relationships, referral, and forms. There are a variety of issues that may affect these situations. Adoptions or foster situations can be voluntary or involuntary, open or closed. Foster placements may vary in length.

1. Registration We assume that any referral we receive was sent with consent. We will register every person to whom we provide a service and those whom we have made a reasonable effort to contact with or without success.
2. Case Activity Open case activity on any person to whom we are providing service or whom we are looking for to provide service.
3. Birth Episode The only person for whom a birth episode can be entered is the biological mother. In situations where the child was apprehended or relinquished at birth, we would not create a client from within the birth episode. We would not do this is because we are not providing service to the infant associated with that mother.
4. Relationships It will be important to create and update all relationships that we know about. Sometimes we will be able to link biological mothers to their children where open adoptions have occurred and the biological mother has ongoing involvement with the child.
5. Referral The referral is associated with the parent that consented to the referral.
6. Forms The Families First Screen should be completed to the extent possible for all birth parents. Completing the Families First Screen for temporary foster situations is based on the PHN's discretion. Any new permanent family situations will likely have a Families First Screen associated with it. The person taking most responsibility for parenting will be Parent 1.

Can we run a report that will generate a list of who should be invited to infant feeding classes?
Please see suggestions in the User Manual

Why do clients that were back entered last week do not appear on that report?
There were no referrals entered until June 9. That is why there will not show up in the referral summary document for back entry clients.

If nurses want to see who is open to them, they can run the report in 'search' and identify who is open to them as the provider. For the team overall, you would need to replicate that search for every team member.

General

What should I do if I notice something not working correctly in the database?
If you have checked with the User Manual, the troubleshooting guide and your peers to confirm that what you are experiencing is an error; contact the service desk at servicedesk@manitoba-ehealth.ca or call 204-940-5000.

What should I do if I have some ideas for improvement?
Ideas for improvement are welcome. Please let Horst Backe know of any suggestions you may have. Most changes will require additional funding and time to develop and implement. At this point there is no funding for additional development.

Will we in future be able to remove the prepopulated 'No' identifiers on the Birth Episode for prenatal alcohol, smoking and discharged with mother? This can be inaccurate if the referral did not indicate one or the other options.
We may be able to have this changed in future versions of the software.

Who prints and applies labels in the event a name change is registered to the client?
The responsibility for this task needs to be clearly negotiated between the PHN and Administrative staff. Not completing a timely name change on a health record will cause unacceptable patient safety risks.