Nursing, EDM & SUR Modules

Abuse/Living Situation Update & Alignment



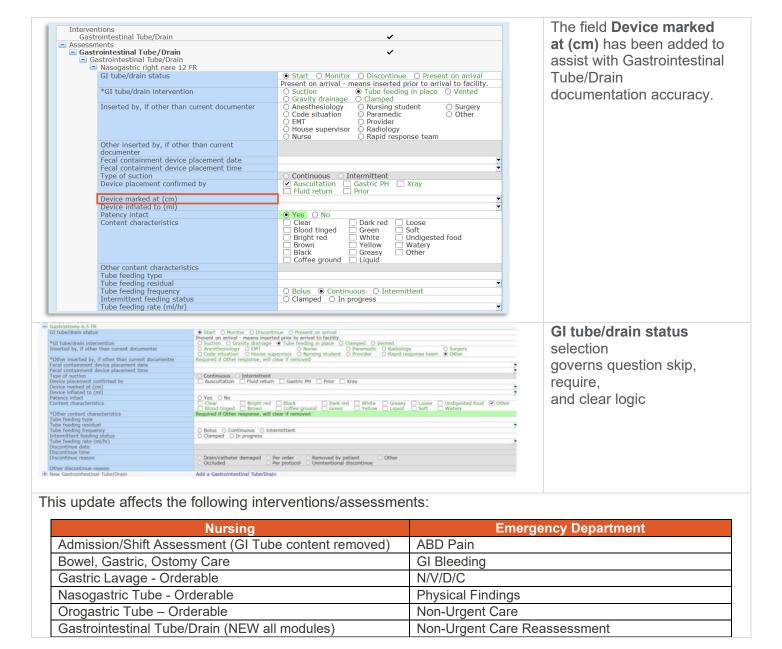
Three queries around Safety / Abuse in the **Health History** assessment need to have an additional group response "Unable to assess" built as this is a regulatory requirement to be captured on every patient. The previous documentation section **Living Situation and Abuse** has been renamed and updated to align with Cloud.

Abuse/Living Situation Abuse/Living Situation Cafety / Abuse	✓ ○ All normal	The Abuse/Living Situation section has
Safety / Abuse Do you feel safe at home, work and/or school/daycare Evidence/suspicion of physical and/or psychological abuse Evidence/suspicion of verbal abuse History consistent with presentation/injury Possible abuse reported to	O All normal O Yes ○ No ○ Unable to assess O Yes ○ No □ Advocate □ Social services	been updated for alignment.
Other possible abuse reported to Safety risk to you or your child	Accord Services Other County social services Other	Default normal functionality has been added to the <i>Safety</i> /
Visitor restriction Living situation	should know about that might place you or your child at a safety risk.	Abuse query. The additional query
Other living situation	○ Group home ○ Jail/prison ○ Home alone ○ Nursing home ○ Home with caregiver ○ Refused to answer ○ Homeless ○ Unable to assess	response 'Unable to assess' has been added to the Safety/Abuse
Barriers in living situation relevant for discharge planning Other barriers in living situation relevant for discharge planning	☐ None ☐ Forensic hold ☐ Other	queries.
		NOTE: The BH Level of Care Assessment and BH Nurse Assessment only contain 2 Safety /
		Abuse updated queries.

Tube Feeding and Gastric Tube Alignment



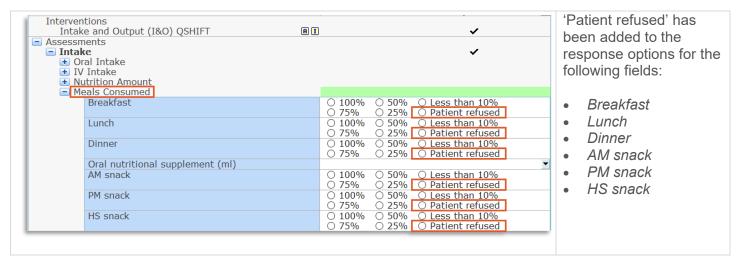
This alignment effort combines tube feeding and gastric tube care documentation into one new instance. This new instance will replace all existing OG/NG tube and tube feeding documentation on the Gastrointestinal body system and EDM GI sections. A new stand alone intervention is available.



Intake – Meals Consumed Update



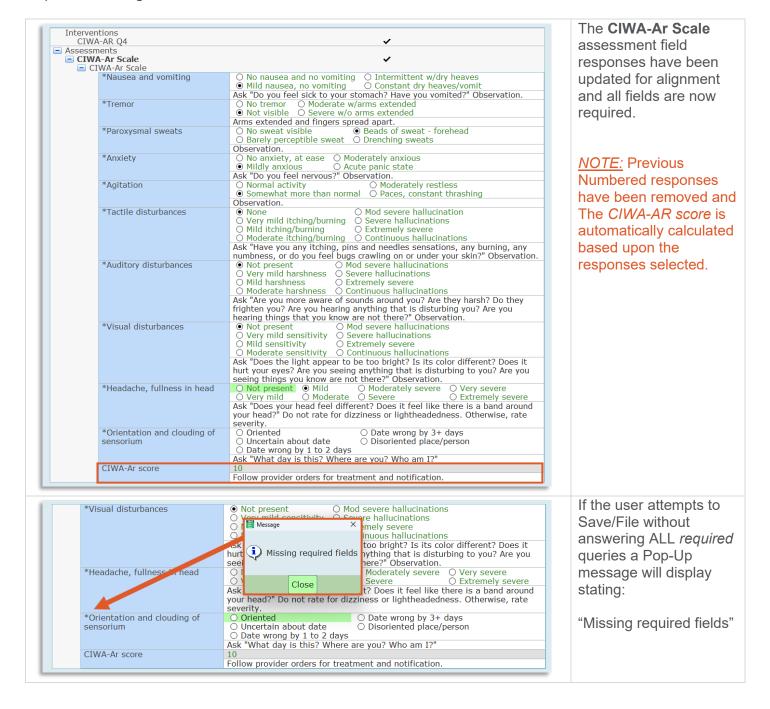
Currently, the clinicians cannot document when a patient refuses a meal or snack as part of **Intake and Output**. Regulatory agencies emphasize the importance of recording why a patient consumes less than 10% of their meal. To address this issue, "Patient refused" has been added as a new option, facilitating instances when a patient refuses a meal or snack. Information regarding patients who are NPO can be found elsewhere in the medical record.



Nursing Module

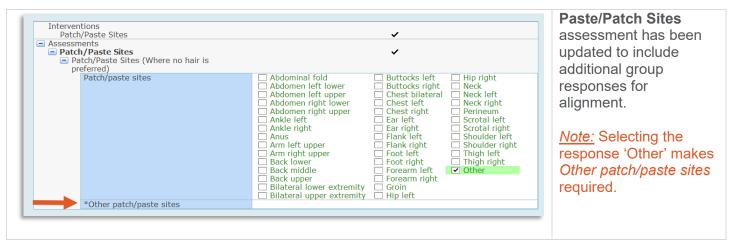
CIWA-Ar Alignment

In Expanse OnPrem, the CIWA-AR assessment used to allow users to skip questions and still populate a score. Updated to make all questions that are used to calculate the CIWA-AR total score required and align content with Cloud.



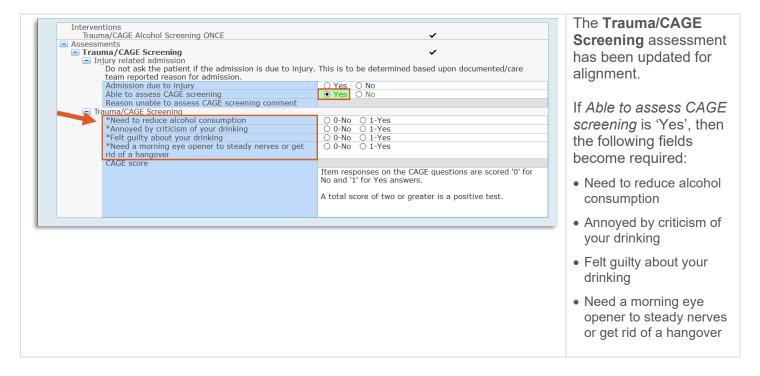
Paste/Patch Sites Alignment

In Expanse OnPrem, some of the sites needed to be able to document patch/paste placement in MAR is unavailable and there is not an 'Other' option which leads to inaccurate documentation. Align the Paste/Patch site group responses in Expanse OnPrem with the same options that are available in Cloud



Trauma/CAGE Screening Alignment

In current state, Trauma/CAGE Screening allows the nurse to skip questions but will still populate a CAGE score. This can result in an inaccurate score calculation. This update adds programming to require all questions that contribute to the CAGE score calculation to align with Cloud and Magic.

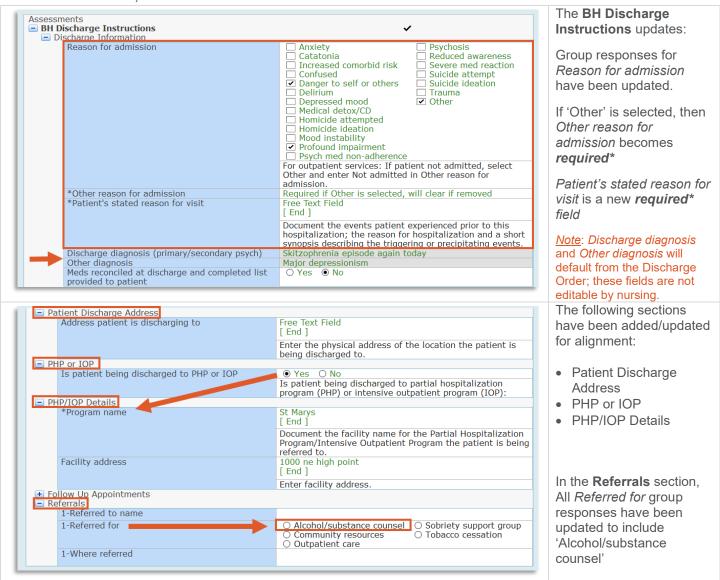


BH Module

BH Discharge Instructions



The BH Discharge Instructions content is being updated to align with Cloud. Several new fields from the updated BH Discharge Instructions that correspond with queries found in other BH interventions will be changed as well. Affected interventions include: BH Psychosocial Assessment, BH Discharge Nurse Assessment, and BH Nurse Assessment.

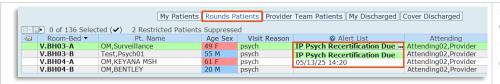


Procedures or Tests		The following sections
Major procedures or tests performed during in stay	patient ☐ None ☐ Lab work ☐ X-rays ☐ CT scans ☑ Metabolic screen ☐ Other	have been added/updated
Stay	Document all specific procedures and tests notewood supporting patient's diagnosis, treatment, or dischedular plan. Examples may include complete blood count	orthy in harge and
Other major procedures or tests performed d	metabolic panel, urinalysis, or radiological imaging	Procedures or Tests
inpatient stay		
Summary of tests, screens, and procedure re-	asdferofij [End]	 Legal Directives
		Designated Caregiver
	Include results of procedures, tests and metabolic screenings.	
Studies pending at discharge	Yes O No	Post Discharge
Comments regarding pending studies		Wellness Check
	Include contact information for obtaining results o	Transition Record
■ Legal Directives	pending at discharge.	
Legal directives	□ None	Attestation
	✓ Healthcare advance direct □ Living will	
	✓ Durable power of attorney	Note: In multi-select group
	☐ Plan of care	
	☐ Psychiatric advance direc Select all that apply.	responses, 'None' cannot
Copy of legal directive(s) on chart	None	be combined with other
	✓ Healthcare advance direct □ Living will	responses. A pop-up
	☐ Durable power of attorney	message will occur
	☐ Plan of care ☐ Psychiatric advance direc	
	Select all that apply.	notifying the user.
In absence of healthcare advance directives,	patient	
	Wishes to receive AD info	Programming has been
In absence of healthcare advance directives of In absence of psychiatric advance directives,		added and additional
in absence of psychiatric advance directives,	O Does not wish to execute	
In absence of psychiatric advance directives	O Wishes to receive AD info	documentation will
Durable power of attorney agent name and p	none	become
 Designated Caregiver 		available/ <i>required</i> * based
Conservator/guardian	● Yes ○ No	
*Conservator/guardian name and phone num Designated caregiver name	Required if Yes is selected, will clear if No is selected. Caregiver	
*Designated caregiver phone number	Required if answer given above, will clear if remov	selected.
Patient/caregiver offered instruction Person/caregiver receiving instructions	● Yes ○ No	
reison/caregiver receiving instructions		
Post Discharge Wellness Check		
☐ Transition Record Attestation Translator used, if applicable	○ Yes ○ No ● Unable to assess	
Translator used, if applicable Transition record discussed and provided to	○ Yes ○ No ● Unable to assess ○ Yes	
Translator used, if applicable Transition record discussed and provided to patient/representative	○ Yes	
Translator used, if applicable Transition record discussed and provided to	○ Yes	
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh	○ Yes	
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable	○ Yes	The BH Psychosocial
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment	○ Yes	The BH Psychosocial Assessment has the
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable	○ Yes	Assessment has the
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment	○ Yes	Assessment has the following updated queries
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems	○ Yes	Assessment has the
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason	○ Yes	Assessment has the following updated queries that match the BH
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason	○ Yes	Assessment has the following updated queries that match the BH Discharge Instructions:
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit	○ Yes end info ② Yes	Assessment has the following updated queries that match the BH Discharge Instructions: • Patient's stated reason
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit	Yes ● Yes • Yes • Yes • Yes	Assessment has the following updated queries that match the BH Discharge Instructions:
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit Do to	Yes ● Yes • Yes • Yes • Yes • Curment the events patient experienced prior this hospitalization; the reason for	Assessment has the following updated queries that match the BH Discharge Instructions: • Patient's stated reason for visit
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit Do to	Yes • Yes	Assessment has the following updated queries that match the BH Discharge Instructions: Patient's stated reason for visit Reason for admission
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit Do to ho	Yes ● Yes • Yes • Yes • Yes • Curment the events patient experienced prior this hospitalization; the reason for	Assessment has the following updated queries that match the BH Discharge Instructions: • Patient's stated reason for visit
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit Do to htte Reason for admission	Yes Ordered info Yes Occument the events patient experienced prior this hospitalization; the reason for spitalization and a short synopsis describing extragering or precipitating events.	Assessment has the following updated queries that match the BH Discharge Instructions: Patient's stated reason for visit Reason for admission
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit Do to ho the Reason for admission	Yes end info	Assessment has the following updated queries that match the BH Discharge Instructions: Patient's stated reason for visit Reason for admission Other reason for
Translator used, if applicable Transition record discussed and provided to patient/representative Patient clinically unstable/unable to compreh and rep unavailable BH Psychosocial Assessment Presenting Problems Patient's stated reason for visit Reason for admission	Yes ocument the events patient experienced prior this hospitalization; the reason for spitalization and a short synopsis describing e triggering or precipitating events. Anxiety □ Trauma □ Catatonia □ Other Increased comorbid risk Confused	Assessment has the following updated queries that match the BH Discharge Instructions: Patient's stated reason for visit Reason for admission Other reason for admission
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Discharge Psych N Discharge Status Discharge di (primary/sec psych) Other diagno Patient com suicidal idea	iagnosis condary osis O Yes otion	○ No narge Order; these fields are not edit	able by	The BH Discharge Nurse Assessment has the following updated queries that match the BH Discharge Instructions: Discharge diagnosis Other diagnosis
nursing.	mi doladic from the Bloom	large Graef, these helds are not early	ubic by	The BH Nurse
 BH Nurse Assessment Inpatient Admission History and Assessment 				Assessment has the
Alerts	None Assaultive to others Assaultive to staff Contraband - substances Contraband - weapons Delirium tremens - DT's Developmentally delayed Elopement attempt Extrapyramidal symptoms Intensive case management MRSA, VRE, C-Diff (MDRO) Neuroleptic malignant Reported violent behavior Self-harm potential Sexual acting out Suicide gestures			following updated queries that match the BH Discharge Instructions: Patient's stated reason for visit All legal directive and conservative queries
Time of arrival to unit Caregiver preference Psychiatric hospitalizations	○ Male ○ Female ○ No prefere	nce		
	Cessation Counseling f Hospitalizations			
Le	gal directives	None Healthcare advance direct Living will Durable power of attorney Plan of care Psychiatric advance direc Select all that apply.		
	py of legal ective(s) on chart	None Healthcare advance direct Diving will Durable power of attorney Plan of care Psychiatric advance direc Select all that apply.		
he dir In he	absence of althcare advance rectives, patient absence of althcare advance rectives comment	Wishes to execute AD Does not wish to execute Wishes to receive AD info		
In ps: dir In ps:	absence of ychiatric advance ectives, patient absence of ychiatric advance	Wishes to execute ADDoes not wish to executeWishes to receive AD info		
Du	rectives comment trable power of corney agent name d phone number			
Co Co na	nservator/guardian nservator/guardian me and phone mber	○ Yes ○ No		

IP Psychiatric Recertification Surveillance Alerts and Order Process

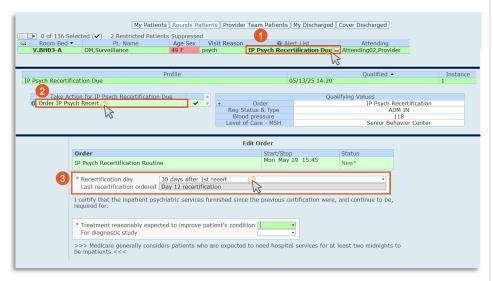
In prior release, the IP Psych Recertification order reminder only included the 12-day recertification surveillance alert. With this release, surveillance alerts have been updated to include 30, 60, 90 and 120 day recertification. The alert will be displayed as **IP Psych Recertification Due**.



Surveillance profiles and watchlists have been created to notify providers of patients who qualify for a 12, 30, 60, 90 and 120 Day Psych Recertification order

Qualifying Criteria for Psych Recertification Alert for 30, 60, 90, and 120 days:

- ADM IN
- Behavioral Health Level of Care service
- Active IP Psych Initial Certification
- No active IP Psych Recertification Order AND:
 - 28-32 days elapsed (30 Day Profile)
 - 58-62 days elapsed (60 Day Profile)
 - 88-92 days elapsed (90 Day Profile)
 - 118-122 days elapsed (120 Day Profile)



Action Steps:

- 1 Select the IP Psych
 Recertification Due from the
 Alert List column of the Rounds
 Patients list.
- 2 Select the **Order IP Psych Recert** from the "Take Action"
- 3 In the *Recertification day* field select the appropriate recertification response.

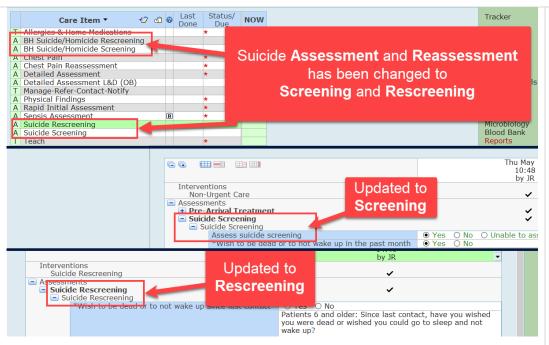
<u>Note</u>: The Last recertification ordered will be displayed under the Recertification day field.



Suicide Screening Update



The naming convention of the Suicide Assessment intervention is inaccurate as the C-SSRS is not an assessment but a screening tool to evaluate the patient's suicide risk level. In the future state, all interventions that have Suicide Assessment within the name will be changed to Suicide Screening.



For all interventions/ assessments, the verbiage "Suicide Assessment" has been updated to **Suicide Screening** as this will be used for required documentation and BH related screenings in accordance with the TJC.

This update affects the following interventions/assessments:

Nursing	Emergency Department
BH Level of Care Assessment	BH Suicide/Homicide Screening
BH Nurse Assessment	BH Suicide/Homicide Rescreening
BH Psychosocial Assessment	Detailed Assessment
BH RN Reassessment	Detailed Assessment L&D (OB)
Suicide Screening	Non-Urgent Care
Suicide Rescreening	Suicide Screening
LD Admission Assessment	Suicide Rescreening