

# EBCD MEDITECH Content Updates – 2025.2

## ED Module

### Overview

This document is a high-level overview for end user education purposes about significant changes within the Nursing, ED, and OR Module screens, including Behavioral Health routines. Additional enhancements may be seen in the [EHR Maintenance Release Section](#) of the [EHR Optimization SharePoint](#).






Inpatient Rehab Facility Enhancements education will be posted separately.

### How to use this guide

The enhancements are listed by intervention. They include which module(s) are affected along with the impact associated with the intervention.

The enhancements are listed in alphabetical order and provide a rationale behind the change and screenshot example(s). This document focuses on end user enhancements designated as high and medium impact.

### Impact Legend:

Safety/Regulatory 	Clinical Initiative 	Women's and Children's 
Reimbursement/Billing 	Enhancements/Wins 	

Be aware the enhancements may not be in your test environment at the time this document is published. Your facility/IT Division support team will notify you when the updates will be available in your software.

Please read the MEDITECH selected prompts and follow the yellow information boxes onscreen as you become aware of changes in the documentation.

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## Summary of Revisions

Date	Revision

# eMAR Updates

## eMAR Admin of Nurse Compounded Balfaxar



Current documentation does not prompt nurses to review incorrect number of units entered for Balfaxar, which can lead to incorrect dosage documentation within the medical record. Future documentation for Balfaxar orders will include a pop-up to the nurse if the field units entered for a vial are less than 400 or more than 640 units, as a 500-unit vial can contain between 400-640 units.

Administration Queries

Balfaxar Admin      Number of vials (Kits): 2

Document Factor IX Units, Lot and Exp from Balfaxar vials

Vial #	Units	Lot	Exp
Vial #1	Units: <input type="text"/> *	Lot: <input type="text"/> *	Exp: <input type="text"/> *
Vial #2	Units: <input type="text"/> *	Lot: <input type="text"/> *	Exp: <input type="text"/> *
Vial #3	Units: <input type="text"/> *	Lot: <input type="text"/> *	Exp: <input type="text"/> *
Vial #4	Units: <input type="text"/> *	Lot: <input type="text"/> *	Exp: <input type="text"/> *
Cumulative Total: <input type="text"/> *units			

The number of vials (kits) will automatically populate from Admin Criteria.

Required fields include:

- Units
- Lot
- Exp

Error

**Verify vial actually contains 500 units. Vials can contain from 400 to 640 units**

Ok

If 500 units is entered by the nurse, a soft-stop alert will appear asking the nurse to verify units is correct. If the vial is not exactly 500 units, the nurse should return to the Units field and enter the correct value.

Error

**Each 500 unit vial contains 400 to 640 units of Balfaxar. Verify units in vial.**

Ok

If less than 400 or greater than 640 units are entered by the nurse, a hard-stop alert will appear asking the nurse to verify total units in vial. The nurse must return to the Units to enter the correct value.

Administration Queries

Balfaxar Admin      Number of vials (Kits): 2

Document Factor IX Units, Lot and Exp from Balfaxar vials

Vial #1	Units: 584 *	Lot: LOT NO *	Exp: 03/31/25*
Vial #2	Units: 584 *	Lot: LOT NO *	Exp: 03/31/25*
Vial #3	Units: * *	Lot: * *	Exp: * *
Vial #4	Units: * *	Lot: * *	Exp: * *

Cumulative Total: 1168 units


Record cumulative total units in eMAR as administered dose

\*\*\*Cumulative total units may not equal ordered dose\*\*\*

The message to record total units in eMAR will display at the end of the screen. The nurse will document the Cumulative Total units from the MAR Admin CDS as the dose.

If the documentation does not match the cumulative total, then the MAR Dose rule displays a hard-stop alert which contains the Cumulative Total dose on the screen.

Error

 Cumulative dose is 1168 units. Change Dose to match.

Ok

The nurse should acknowledge the pop-up and update the dose to match the Cumulative Total. There will not be a hard-stop alert if documenting as "Not-Given."

# ED Module

## First Point of Contact



The existing documentation within the First Point of Contact does not address scenarios where patients refuse to wear masks or whether patients are isolated and the receiving unit/department is notified. This gap in documentation can lead to inconsistencies in patient management and communication between departments. The new updates will introduce additional fields at the end of the screening process to account for these circumstances.

First Point of Contact/MRSA 01/15 1452

Mask applied:

- 1 Yes
- 2 No
- 3 Patient refused

Point of entry screening status: Positive Respiratory Risk  
Negative TB Risk  
Negative C difficile Risk

Mask applied: \*

Patient isolated and receiving unit/dept notified: \*

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First Point of Contact/MRSA 01/15 1459

Patient isolated and receiving unit/dept notified:

- 1 Yes
- 2 No

Point of entry screening status: Positive Respiratory Risk  
Negative TB Risk  
Negative C difficile Risk

Mask applied: Yes \*

Patient isolated and receiving unit/dept notified: \*

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*Mask applied* will have 3 responses:

- Yes
- No
- Patient refused

*Patient isolated and receiving unit/dept notified* will be a Yes/No response field only.

Note: These fields become required if the patient screens positive for Respiratory and/or TB risk.

First Point of Contact - Onc 04/17/1259 J00021620333 LCOE,EDPATIENT

**Mask applied and patient isolated and receiving unit/department notified:**

1 Yes  
2 No

Recent oncology history:>

Has patient received chemotherapy in the past 6 weeks: >

Has patient had a stem cell transplant in the past 6 months: >

Point of entry screening status: Positive Respiratory Risk  
Negative TB Risk  
Negative C difficile Risk

Mask appl

Point of entry screening is positive, are you sure?

Yes No

(Prev Page) (End)

*Note: The soft stop alert has been removed, as new documentation allows for the patient to refuse to be masked.*

This update affects the following interventions/assessments:

Emergency Department
First Point of Contact – Onc
Paramedic Intake
Recept MOA 1 <sup>st</sup> POC
Rapid Initial Assessment

# Meals Consumed Intake



Currently, clinicians cannot document when a patient refuses a meal or snack as part of **Intake and Output**. To address this issue, “Patient refused” has been added as a new option, facilitating instances when a patient refuses a meal or snack offered. Information regarding patients who are NPO can be found elsewhere in the medical record.

The top screenshot shows the 'Meals Consumed Intake' form with the 'Amount taken:' dropdown menu open. The options are: 1 100%, 2 75%, 3 50%, 4 25%, 5 Less than 10%, and 6 Patient refused (selected). The 'Meal:' field is set to 'Breakfast' and the 'Amount taken:' field is set to 'Patient refused'. The 'Oral nutritional supplement ml:' field is empty.

The bottom screenshot shows the 'Meals Consumed Intake' form with the 'AM snack:' dropdown menu open. The options are: 1 100%, 2 75%, 3 50%, 4 25%, 5 Less than 10%, and 6 Patient refused (selected). The 'Meal:' field is set to 'Breakfast' and the 'Amount taken:' field is set to 'Patient refused'. The 'Oral nutritional supplement ml:' field is empty. Below the dropdown menu, there are three fields for 'AM snack:', 'PM snack:', and 'HS snack:', all of which are empty.

‘Patient refused’ has been added to the response options for the following fields:

- Amount taken
- AM snack
- PM snack
- HS snack

This update affects the following interventions/assessments:

Emergency Department
Intake and Output
Newborn Stabilization
Disposition- DC/TX/ADM/LPT

# Newborn Resuscitation Efforts



Current documentation for newborns does not allow for nurses to enter CPAP within resuscitation or stabilization efforts. Fields have now been added to include CPAP to accurately reflect care provided.

	<p>The Newborn Stabilization intervention in <b>EDM</b> has new queries related to newborn resuscitation.</p>
	<p>The following fields have been added when documenting <i>Newborn Resuscitation</i>:</p> <ul style="list-style-type: none"> <li>• CPAP Given</li> <li>• Time started CPAP</li> <li>• Time CPAP Complete</li> </ul> <p><i>Note: If 'CPAP Given' response is "No" or blank, the other CPAP related fields will be skipped.</i></p>



Neonatal Intervention 02/21 1533 J00021618000 DC,PLAN

**Infant delivery:**

1 Yes  
2 No

Infant delivery should only be utilized by NICU/nursery staff present and assisting with delivery. If infant delivery documented in OB Intervention on maternal record, it should not be addressed on this intervention.

Click box to display maternal documentation ->  
Click box to display delivery documentation ->  
Click box to display Apgar documentation ->

Gestational age in weeks: ☐  
Gestational age in days: ☐  
Corrected gestational age in weeks: ☐  
Corrected gestational age in days: ☐  
Infant delivery: ☐  
Admission history: ☐  
Safety/security: ☐  
Environmental care: ☐  
Developmental care: ☐

(End) ☐

OB and Neonatal interventions for **inpatients** have an updated field for CPAP inside the infant delivery screens.

*Note: Only facilities without another newborn documentation solution besides Meditech utilize these interventions.*

**Infant stabilization interventions: [or free text]**

1 ☐ None  
2 ☒ CPAP  
3 ☐ Chest compressions  
4 ☐ Infant warmer  
5 ☐ Intubation  
6 ☐ Oxygen  
7 ☐ Positive pressure  
8 ☐ Skin to skin contact  
9 ☐ Suction  
10 ☐ Umbilical catheter  
11 ☐ Volume expansion

Infant stabilization interventions:

Suction method:

Amniotic fluid description:

Meconium description:

Infant voided in delivery room: ☐  
Infant stoolled in delivery room: ☐

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The addition of CPAP is available from the group responses when documenting infant stabilization interventions.

*Note: Only facilities without another newborn documentation solution besides Meditech utilize these interventions.*

This update affects the following interventions/assessments:

<b>Emergency Department</b>
Newborn Stabilization

# Restraint Documentation



Current documentation allows for the selection of “Quick Release Synthetic” options when non-violent restraints have been ordered. Quick release synthetic restraints should be reserved for violent restraint use only. Future documentation will remove all “Quick Release Synthetic” options from the Non-violent restraint device field.

Restraint Documentation 01/16 0937

**Non-violent restraint device:**

<input type="checkbox"/> 1 Bedrails	<input type="checkbox"/> 7 Restrictive positioning
<input type="checkbox"/> 2 Chemical	<input type="checkbox"/> 8 Soft +
<input type="checkbox"/> 3 Enclosure	<input type="checkbox"/> 9 Tightly tucked sheets
<input type="checkbox"/> 4 Freedom splints +	<input type="checkbox"/> 10 Waist
<input type="checkbox"/> 5 Geri-chair	
<input type="checkbox"/> 6 Mitten +	

----- No previous documentation found. -----

Restraint status: Start \*

Clinical justification: Attempts to remove device \*

Alternatives utilized: Change environment \*

Level of restraint: Non-violent

Non-violent restraint device: \*

Violent restraint device:

Date restraints initiated: \*

Time restraints initiated: \*

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The “Quick Release Synthetic” options are no longer available when documenting Non-violent restraint device.

This update affects the following interventions/assessments:

Emergency Department
RESTRAINT Restraint Documentation

# RT Ventilator Flowsheet



The Servo Pressure, Servo Pressure Alarms and Delta P fields have been updated to allow for accurate capture of these values by the end user; especially in the NICU population.

RT Ventilator Flowsheet

**Ventilator mode:**

1 Assist control	7 Oscillator	13 SIMU/PRUC/PS
2 Bi-vent/APRV	8 PAV/ASV	14 SIMU/UC/PS
3 High FRQ	9 Pressure control	15 Standby
4 <b>Jet</b>	10 PS/CPAP	16 Volume control
5 MMV	11 PRUC	17 Volume support
6 NAVA	12 SIMU/PC/PS	

Ventilator flowsheet treatment: Neonatal

Intubated prior to admission: No

Mechanical ventilation start date: 01/15/25\*

Mechanical ventilation start time: 1233\*

Mechanical ventilation stop date: \*

Mechanical ventilation stop time: \*

Ventilator identification number: 2203456

Ventilator mode: \*

**Jet**

**Delta P (cmH2O):**

7	8	9	Del
4	5	6	
1	2	3	
-	0	.	Calc

Set rate (bpm): \*

I-time (sec): \*

Blender FiO2: \*

**Delta P (cmH2O): \***

**Servo pressure (cmH2O): \***

Peak inspiratory pressure (cmH2O): \*

Mean airway pressure (cmH2O): \*

Cartridge temp: \*

Circuit temp (C): \*

MAP alarms (cmH2O): \*

**Servo pressure alarms (cmH2O): \***

(Next Page) \*

Within the *Ventilator mode* field, selecting the 'Jet' response now allows for documentation of decimal values in the following fields:

- Delta P (cmH2O)
- Servo pressure (cmH2O)
- Servo pressure alarms (cmH2O)

This update affects the following interventions:

Emergency Department
RT Ventilator Flowsheet

# Suicide Screening



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.

**Suicide Screening**

Patient:

Date: 01/22/25 Time: 1433 User: TEDDPI7485

**1 Wish to be dead or to not wake up in the past month:**

1 Yes In the past month, have you wished you were dead or wished you could go to sleep and not wake up?

2 No

Wish to be dead or to not wake up in the past month: ☐ \*

Wish to be dead or to not wake up in your lifetime: ☐ \*

Non-specific active suicidal thoughts in the past month: ☐ \*

Non-specific active suicidal thoughts in your lifetime: ☐ \*

(Next Page) ☐

OK Cancel

*Suicide Screening* will be the new verbiage used for required documentation and BH related screenings.

This update affects the following interventions/assessments:

Emergency Department
Suicide Screening - ED
Suicide Rescreening - ED
Detailed Assessment
BH Level of Care Assessment
BH Suicide/Homicide Screening
BH Suicide/Homicide Rescreen
Non-Urgent General Focus