

# Dysphagia Screening – Water Test



Currently in the **Dysphagia Screening** assessment, the field “Any signs of aspiration during 3 oz water test” can be bypassed and the screening will still auto populate a ‘Pass’. With this update, the 3 oz water test will be required to evaluate the patient's ability to swallow if applicable.

Dysphagia Screening LCOE, PATIENT

☒ Any signs of aspiration during the 3 oz water test:

1 Yes  
2 No

Document Glasgow Coma Scale: Yes  
Glasgow Coma Scale less than 13: No  
Facial asymmetry/weakness: No  
Tongue asymmetry/weakness present: No  
Palatal asymmetry/weakness present: No  
Pass/fail dysphagia screening: Pass \*

**Any signs of aspiration during the 3 oz water test: No \***

Noted changes in swallow test:  
Dysphagia screening comments:

(End)

If “No” is answered for:

- Glasgow Coma Scale less than 13
- Facial asymmetry/weakness
- Tongue asymmetry/weakness
- Palatal asymmetry/weakness

Then *Any signs of aspiration during the 3 oz water test* becomes **Required** to complete the **Dysphagia Screening**.

Once the 3 oz water test is performed and there are no signs of aspiration, the patient passes the dysphagia screening.

Dysphagia Screening LCOE, PATIENT

☒ Noted changes in swallow test:

1 ☒ Throat clearing If throat clearing, coughing or change in vocal quality noted refer to Speech Therapy.  
2 ☒ Cough If patient fails dysphagia screening, maintain NPO per facility protocol.  
3 ☐ Change in vocal quality If patient passes dysphagia screening, start diet per order.

Document Glasgow Coma Scale: Yes  
Glasgow Coma Scale less than 13: No  
Facial asymmetry/weakness: No  
Tongue asymmetry/weakness present: No  
Palatal asymmetry/weakness present: No  
Pass/fail dysphagia screening: Fail \*

Any signs of aspiration during the 3 oz water test: Yes \*

Noted changes in swallow test: Throat clearing \*

Dysphagia screening comments: Cough

(End)

If ‘Yes’ is answered for *Any signs of aspiration during the 3 oz water test* then *Noted changes in swallow test* becomes **required\*** and the patient will **Fail** the test.

**Note:** In this scenario, the *Pass/fail dysphagia screening* programming response will change when the user goes to the next field (*Dysphagia screening comments*) or upon filling after all **required\*** fields have been answered.

Dysphagia Screening LCOE, PATIENT

**Facial asymmetry/weakness:**

✓ 1 Yes  
2 No

If Glasgow Coma Scale is less than 13 or Yes is answered to any of the following:

- Facial asymmetry/weakness
- Tongue asymmetry/weakness
- Palatal asymmetry/weakness

Stop dysphagia screening and refer to Speech Therapy

Document Glasgow Coma Scale: > Yes  
Glasgow Coma Scale less than 13: No  
Facial asymmetry/weakness: > Yes  
Tongue asymmetry/weakness present: > No  
Palatal asymmetry/weakness present: > No  
Pass/fail dysphagia screening: > Fail \*  
Any signs of aspiration during the 3 oz water test: ☐  
Noted changes in swallow test: ☐  
Dysphagia screening comments:   
(End) ☐

If 'Yes' is answered for any of the following fields:

- Glasgow Coma Scale less than 13
- Facial asymmetry/weakness
- Tongue asymmetry/weakness
- Palatal asymmetry/weakness

Then patient **Fails** the dysphagia screening and needs to be referred to Speech Therapy.

This update affects the following interventions:

| Nursing               | Emergency Department | Surgery                         |
|-----------------------|----------------------|---------------------------------|
| Dysphagia Screening + | Dysphagia Screening  | SURG: Dysphagia Screening PAC + |
| Neuro Checks +        |                      |                                 |

# Malnutrition Screening Updates



Currently, the Malnutrition Screening allows users to bypass remaining screening questions after answering 'Yes' to *Recent weight loss without trying*. This results in inaccurate and incomplete malnutrition screening, potentially missing patients that may need further evaluation. The update will require the remaining fields be answered if a 'Yes' is entered for *Recent weight loss without trying*.

Health History Assessment

**Recent weight loss without trying:**

1 Yes  
2 No  
3 Unknown

**- Nutrition Screening -**  
Click below to default system normal values  
OFT Norms  
OFT Norms (Go to Next System)

Recent weight loss without trying: Yes \*

How much weight have you lost: \*

Eating poorly due to decreased appetite: \*

Malnutrition screen tool score: 0 - Not at risk

(Prev Page) (Next Page)

If 'Yes' is selected to *Recent weight loss without trying* then the following fields become **required\***:

- How much weight have you lost
- Eating poorly due to decreased appetite

Health History Assessment

**Eating poorly due to decreased appetite:**

1 Yes  
2 No

Recent weight loss without trying: Yes \*

How much weight have you lost: 14-23 lb \*

Eating poorly due to decreased appetite: No \*

Malnutrition screen tool score: 2 - Malnutrition risk

(Prev Page) (Next Page)

An accurate Malnutrition score will populate once all **required\*** fields are documented.

Health History Assessment

**Decreased eating/feeding within last few weeks:**

1 Yes  
2 No

Recent unintentional weight loss: \*

Poor weight gain within last few months: Yes \*

Decreased eating/feeding within last few weeks: \*

Obviously underweight or significantly overweight: \*

Pediatric malnutrition screen tool score: 1 - Not at risk

(Prev Page) (Next Page)

An accurate *Pediatric malnutrition screen tool score* will also populate once all **required\*** fields are documented.

**Note:** If any of the 'Yes/No' field responses within the scoring tool are documented on then all remaining fields become **required\*** to submit/save.

This update affects the following interventions:

| Nursing                             | Emergency Department | Surgery                        |
|-------------------------------------|----------------------|--------------------------------|
| Admission Health History            | General Focus        | SURG: Admission Health History |
| BH: Health History Assessment       | Non-Urgent           |                                |
| BH: Outpatient Nutrition Assessment | Paramedic Intake     |                                |

# EDM Module

## CVC/PICC: Midline Multi Lumen Update



The CVC/PICC screen has been updated and now includes a new option to accurately document midlines and clearly differentiate between single and multiple lumens.

CVC/PICC

CVC/PICC procedure type:

- 1 CVC multi lumen +
- 2 CVC single lumen
- 3 Dialysis catheter +
- 4 Midline multi lumen
- 5 Midline single lumen
- 6 PA catheter +
- 7 PICC multi lumen +
- 8 PICC single lumen
- 9 Umbilical vessel catheter

CVC/PICC procedure type: \*

CVC/PICC location: \*

Location (L/R): \*

Inserted: \*

CVC/PICC insertion date: \*

CVC/PICC insertion time: \*

Instance list status: Active \*

Cath/PICC/Dialysis details: \*

CVC/PICC/Dialysis line status: \*

(Next Page) ☐

The CVC/PICC procedure type field has a new response:

- Midline multi lumen

This update affects the following interventions:

| Nursing                   | Emergency Department  | Surgery                               |
|---------------------------|-----------------------|---------------------------------------|
| Critical Care Flow Record | CVC/PICC              | SURG: Lines, Drains, Airways Intra-op |
| Lines/Drains/Airways      | Newborn Stabilization | SURG: Lines, Drains, Airways Pre-op   |
|                           |                       | SURG: Lines, Drains, Airways PACU     |

# ICP Monitoring: External Ventricular Device



Currently, if a patient has multiple EVD drains, nurses may need to monitor two ICP values. The EHR does not allow users to capture two discrete ICP values within the hemodynamic screen, preventing clinicians from tracking and trending these results.

ICP/Ventriculostomy

Site assessment: [or free text]

☐ Bleeding  
☐ Clean/dry  
☐ Drainage  
☒ Ecchymotic  
☐ Edematous  
☐ Foul odor

☐ Temp cold  
☐ Temp cool  
☐ Temp hot  
☐ Temp warm

Intervention: >

Site assessment: >Ecchymotic

Drainage description:

ICP/Ventriculostomy

Dressing type: [or free text]

☒ CHG embedded disc  
☐ Gauze  
☐ No dressing  
☐ Steri strips  
☒ Sutures  
☐ Transparent

Intervention: >

Site assessment: >Ecchymotic

Drainage description:

CSF color:

Dressing type: >CHG embedded disc  
Sutures

Dressing intervention:

Date of last dressing change:

(Prev Page) (Next Page)

Vital Signs

Document ICP/CPP monitoring:

Yes

Document vital signs: >

Document pre transfusion vitals: >

Document height/weight measurements: > \*

Document hemodynamic monitoring: >

Document orthostatic vital signs: >

Document ICP/CPP monitoring: > Yes

Document multiple extremity blood pressures: >

(End)

In the **ICP/Ventriculostomy** drain documentation, users will now document the *Site assessment* and *Dressing type* in drain instance documentation.

The field responses for *Site assessment* have been updated to include 'Ecchymotic' in the multi-select and 'Free Text' enabled documentation field.

*Dressing type* has been updated with the following responses:

- CHG embedded disc
- Gauze
- No dressing
- Steri strips
- Sutures
- Transparent

ICP/CPP monitoring in **Vital Signs** has been updated to allow for documentation of multiple ICP values.

In the **Vitals/Ht/ Wt/ Measurements** intervention enter 'Yes' in the field *Document ICP/CPP monitoring*.

ICP Monitoring

Select ICP device to document:

- ☐ 1 External ventricular Frontal region left (Monitoring discontinued)
- ☒ 2 External ventricular Occipital region left (Monitoring)
- ☒ 3 Bolt Parietal region left (New)

Select ICP device to document: 3

(Next Page)

Select ICP device to document is a multi-select response field. A list of devices documented in **Drains** will automatically populate.

**Note:** The ICP drain status will populate in the Yellow comment box. The possible responses are:

- New
- Monitoring
- Monitoring discontinued

ICP Monitoring

ICP 2 status:

- ✓ 1 Monitoring
- 2 Monitoring discontinued

ICP 2 device: External ventricular \*

ICP 2 location: Occipital region left \*

ICP 2 status: Monitoring \*

ICP 2 (mmHg)

ICP 2 mean arterial pressure

ICP 2 CPP (mmHg)

ICP 2 zeroed/recalibrated

ICP 2 waveform

ICP 2 fluctuations

(Prev Page) (Next Page)

ICP device and ICP location will pre-populate to ensure consistent documentation:

ICP status is a new **required\*** field on every device monitoring instance with the following responses:

- Monitoring
- Monitoring discontinued

**Note:** The following fields have been added for each instance:

- ICP (mmHg)
- Mean Arterial Pressure
- CPP (mmHg)
- Zeroed/recalibrated
- Waveform
- Fluctuations

Ext Ventricular Drain

Ventricular device drain 1 ml:

7 8 9 Del

4 5 6

1 2 3

- 0 . Calc

Bolt Parietal region left (Active)

External ventricular Occipital region left (Active)

External ventricular Frontal region left (Inactive)

Ventricular device drain 1 ml: 3

Ventricular device drain 1: \*

Ventricular device location drain 1: \*

Ventricular device drain 2 ml:

Ventricular device drain 2:

Ventricular device location drain 2:

Ventricular device drain 3 ml:

Ventricular device drain 3:

Ventricular device location drain 3:

(Next Page)

Ventricular Drain output will be documented in the **Intake and Output** intervention.

If a numerical response is entered in the *Ventricular device ml* field then the following responses become **required\***:

- Ventricular device
- Ventricular device location

**Note:** The Yellow information box will display the list of documented drains in **Alphabetical Order** starting with **Active** drains followed by **Inactive** drains.

**Please ensure the appropriate output is documented on the correct drain.**

IV Drip Status

☒ Document ICP:

1 Yes Documentation within this intervention is for titration purposes only.

2 No Not for controlled substance hand-off.

Last 4 Clinical Data Entries (For Today)

| Date  | Time | RASS | CPOT | Pulse | Resp | Blood Press | MAP | ICP1 | ICP2 | ICP3 |
|-------|------|------|------|-------|------|-------------|-----|------|------|------|
| 07/07 |      |      |      |       |      |             |     |      | 10   |      |

RASS: CPOT: Document ICP: ☒ Yes

IV drip 1: IV drip 1 status:

IV drip 2: IV drip 2 status:

IV drip 3: IV drip 3 status:

IV drip

IV drip

IV drip

IV drip

IV drip

IV drip

ICP Monitoring

☒ Select ICP device to document:

☐ 1 External ventricular Frontal region left (Monitoring discontinued)

☐ 2 External ventricular Occipital region left (Monitoring)

☐ 3 Bolt Parietal region left (New)

Select ICP device to document:

(Next Page) ☐

The **IV Drip Titration +** intervention has been updated to include additional ICP drain documentation values.

If 'Yes' is answered for *Document ICP* the user will be directed to the *ICP Monitoring* documentation section listed in the **Vitals/Ht/ Wt/ Measurements** intervention.

**Note:** A list of documented devices will automatically populate with the ICP drain status in the Yellow comment box.

This update affects the following interventions:

| Nursing                   | Emergency Department  | Surgery                               |
|---------------------------|-----------------------|---------------------------------------|
| Lines/Drains/Airways      | Disposition           | SURG: Lines, Drains, Airways Intra-op |
| Critical Care Flow Record | Flowsheet             | SURG: Intake and Output Intra         |
| Intake & Output           | ICP/Ventriculostomy   | SURG: Lines, Drains, Airways PACU     |
| Vitals/Ht/Wt/Measurements | ICP Monitoring        | SURG: Intake and Output PACU          |
| IV Drip Titration         | Intake and Output     | SURG: Intake and Output Pre-op        |
|                           | IV Drip Titration     | SURG: IV Drip Titration PAC           |
|                           | Newborn Stabilization | SURG: IV Drip Titration Pre           |
|                           | Paramedic Intake      |                                       |
|                           | Triage Reassessment   |                                       |

# Respiratory Therapy Intervention Updates



Current RT EBCD Intervention templates lack sufficient fields that lead to decreased efficiency and missing data values for respiratory patients. Updates will include a new Bubble CPAP field response, additional fields in the Jet Mode section, and other fields to allow for adequate documentation of RT interventions.

RT BiPAP/CPAP

Mode:

- 1 AVAPS
- 2 BiPAP
- 3 CPAP
- ✓ 4 Bubble CPAP

BIPAP/CPAP treatment:

Is this patient's personal machine:

Mode:

Mask type:

Mask size:

Pulse:

SpO2 %:

Nitric:

(Next Page)

'Bubble CPAP' has been added to the Mode field response options documenting **RT BiPAP/CPAP**.

**Note:** This update has been added to the **RT BiPAP/CPAP Initial** and the **RT BiPAP/CPAP Subsequent** interventions.

RT Ventilator Flowsheet

Ventilator mode:

|                  |                    |                   |
|------------------|--------------------|-------------------|
| 1 Assist control | 7 Oscillator       | 13 SIMV/PRVC/PS   |
| 2 Bi-vent/APRV   | 8 PAV/ASV          | 14 SIMV/VC/PS     |
| 3 High FRQ       | 9 Pressure control | 15 Standby        |
| ✓ 4 Jet          | 10 PS/CPAP         | 16 Volume control |
| 5 MMV            | 11 PRVC            | 17 Volume support |
| 6 NAVA           | 12 SIMV/PC/PS      |                   |

Ventilator flowsheet treatment:

Intubated prior to admission:

Mechanical ventilation start date:

Mechanical ventilation start time:

Mechanical ventilation stop date:

Mechanical ventilation stop time:

Ventilator identification number:

Ventilator mode:

(Next Page)

In the **RT Ventilator Flowsheet**, the following fields have been added when the response 'Jet' is selected for the *Ventilator mode* field:

- PEEP
- High & Low MAP Alarms
- Servo Pressure Alarms
- Backup Rate
- Backup PIP
- Backup inspiratory pressure
- Backup I-time



Jet

PEEP (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):>

PEEP (cmH2O):>12

Mean airway pressure (cmH2O):>

Cartridge temp:>

Circuit temp (C):>

(Next Page) <input type="checkbox"/>

PEEP (cmH2O) has been added to page 2 of **Jet Ventilator Mode** screen and supports a response up to 2-digits.

Jet

Servo pressure alarm low:

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

MAP alarms (cmH2O):>

MAP alarm high:>99.99

MAP alarm low:>11.11

Servo pressure alarms (cmH2O):>

Servo pressure alarm high:>99.99

Servo pressure alarm low:>11.11

High PEEP alarm: <input type="checkbox"/>

Low PEEP alarm: <input type="checkbox"/>

(Prev Page) <input type="checkbox"/>

(Next Page) <input type="checkbox"/>

The new alarms fields have been added and support the use of 5-digits including a decimal point:

- MAP alarm high
- MAP alarm low
- Servo pressure alarm high
- Servo pressure alarm low

Jet

Backup I-time (sec):

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

Backup rate:>12

Backup peak inspiratory pressure (cmH2O):>12

Backup inspiratory pressure:>12

Backup I-time (sec):>3.2

(Prev Page) <input type="checkbox"/>

(End) <input type="checkbox"/>

Four additional new fields have been added and support a response up to 2 digits:

- Backup rate
- Backup peak inspiratory pressure (cmH2O)
- Backup inspiratory pressure
- Backup I-time (sec)

*Note:* The *Backup I-time (sec)* field supports 3-digit responses, including a decimal point.

RT Ventilator Flowsheet

Transcutaneous PCO2 site temperature:

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

Secretions cleared:

Pulse:

Pulse source:

SpO2 %:

ETCO2:

Transcutaneous PCO2:

Transcutaneous PCO2 site change time:

Transcutaneous PCO2 site temperature:

(Prev Page)

(Next Page)

On the **RT Ventilator Flowsheet** intervention, the following fields have been added:

- Transcutaneous PCO2
- Transcutaneous PCO2 site change time
- Transcutaneous PCO2 site temperature

This update affects the following interventions/assessments:

| Nursing                       | Emergency Department     |
|-------------------------------|--------------------------|
| RT: Ventilator Flowsheet      | RT: Ventilator Flowsheet |
| RT: PEDS Ventilator Flowsheet | RT: BiPAP/CPAP Initial   |
| RT: BiPAP/CPAP Initial        | RT: BiPAP/CPAP           |
| RT: BiPAP/CPAP Subsequent     |                          |
| RT: BiPAP/CPAP                |                          |
| RT PEDS: BiPAP/CPAP Initial   |                          |
| RT PEDS: BiPAP/CPAP           |                          |

# Restraints Initiative Update



Inappropriate restraint utilization has heightened regulatory risk with inconsistent practices and outcomes for managing restraints effectively. As part of the 2025 Strategic Priorities, we have identified ways to drive appropriate restraint utilization by optimizing both the ordering of restraints and the subsequent nursing documentation.

## Ordering Restraints Process

Enter/Edit Responses : RESTRAINTS ORDER \*Current\*

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Order Phase:**

- 1 Initial
- 2 Renewal

No Active Nursing Documentation on File.

Order Phase: \*

Level of restraint: \*

<6 Page Screen>

Ok Cancel Help Prev Next

In the **RESTRAINTS ORDER** the first **required\*** field is the **Order Phase:** with the following response options:

- Initial
- Renewal

**Note:** An error message will occur if the **Order Phase** of 'Renewal' is selected in the absence of a current 'Initial' Restraint Order.

Enter/Edit Responses : RESTRAINTS ORDER \*Current\*

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Level of restraint:**

- 1 Non-violent
- 2 Violent/self-destructive

No Active Nursing Documentation on File.

Order Phase: Initial \*

Level of restraint: \*

<6 Page Screen>

Ok Cancel Help Prev Next

The **Level of restraint** is a **required\*** field with the following response options:

- Non-violent
- Violent/self-destructive

**Note:** The yellow information box will continue to display any Active Nursing Documentation on file throughout the ordering process.

Enter/Edit Responses : RESTRAINTS ORDER \*Current\*

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Non-violent restraint device:**

- 1 ☐ Bedrails
- 2 ☐ Chemical
- 3 ☐ Enclosure
- 4 ☐ Freedom splints +
- 5 ☐ Geri-chair
- 6 ☒ Mitten +
- 7 ☐ Soft +
- 8 ☐ Waist

No Active Nursing Documentation on File.

Non-violent restraint device: \*

Mitten BLUE

Non-violent Restraint Time Limit \*

24 hours

<6 Page Screen>

Ok Cancel Help Prev Next

If 'Non-Violent' **Level of restraint** is selected, the user will be directed to the approved **Non-violent restraint device** selection types.

**Non-violent Restraint Time Limit** will pre-populate 24 hours for Order Phase of Initial and 1 Calendar Day for Order Phase of Renewal.

**Note:** Restrictive positioning and Tightly tucked sheets are no longer approved Non-violent restraint devices.

Enter/Edit Responses : RESTRAINTS ORDER \*Current\*

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Violent restraint device:**

|  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> 1 Chemical     | <input type="checkbox"/> 5 Seclusion   | No Active Nursing<br>Documentation on File. |
| <input type="checkbox"/> 2 Enclosure               | <input type="checkbox"/> 6 Soft +      |   |
| <input type="checkbox"/> 3 Physical holding        | <input type="checkbox"/> 7 Synthetic + |   |
| <input type="checkbox"/> 4 Restrictive positioning |  |   |

Violent restraint device:  
Chemical \*

Violent Restraint Time Limit  
4 hours \*

Ok Cancel Help <6 Page Screen> Prev Next

If 'Violent/self-destructive' *Level of restraint* is selected, the user will be directed to the approved *Violent restraint device* selection types.

*Violent Restraint Time Limit* will pre-populate 4 hours for both the Order Phase of Initial and Order Phase of Renewal for adult patients.

**Note:** Bedrails, Freedom splints, Geri-chair, Mittens, Seclusion/restraint, Tightly tucked sheets, and Waist are no longer approved Violent restraint devices.

*Clinical justification* is a required field.

For *Non-violent* (NV) level of restraint, the following justifications may be selected:

- NV-Attempts remove device
- NV-Handle wound/dressings
- NV-OOB extreme inj risk

For *Violent* (V) level of restraint, the following justifications may be selected:

- V-Attempts self-harm
- V-Combative
- V-Destructive
- V-Physical aggression

The response entered for *Clinical Justification* will default into the *Criteria for release of restraints is met when patient stops* response field.

Additional responses can be selected; however, an Error message will occur if the user selects a Violent (V) Criteria for a Non-Violent Level of restraint and if a Non-violent (NV) Criteria is selected for a Violent Level of restraint.

Enter/Edit Responses : RESTRAINTS ORDER \*Current\*

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Clinical justification:**

|  |  |   |
|--|--|---|
| <input type="checkbox"/> 1 NV-Attempts remove device | <input type="checkbox"/> 5 V-Combative           | No Active Nursing<br>Documentation on File. |
| <input type="checkbox"/> 2 NV-Handle wound/dressings | <input type="checkbox"/> 6 V-Destructive         |   |
| <input type="checkbox"/> 3 NV-OOB extreme inj risk   | <input type="checkbox"/> 7 V-Physical aggression |   |
| <input type="checkbox"/> 4 V-Attempts self-harm      |  |   |

Clinical justification: \*

Ok Cancel Help <6 Page Screen> Prev Next

**Note:** An Error message will occur if the user selects a **Violent (V)** justification for a **Non-Violent Level of restraint** and if a **Non-violent (NV)** justification is selected for a **Violent Level of restraint**.

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Criteria for release of restraints is met when patient stops:**

|  |  |
|--|--|
| <input type="checkbox"/> 1 NV-Attempts remove device       |  |
| <input type="checkbox"/> 2 NV-Handle wound/dressings       |  |
| <input type="checkbox"/> 3 NV-OOB extreme inj risk         |  |
| <input checked="" type="checkbox"/> 4 V-Attempts self-harm |  |

Criteria for release of restraints is met when patient stops:  
V-Attempts self-harm \*

Ok Cancel Help <6 Page Screen> Prev Next

## NURSING DOCUMENTATION

Restraint Documentation

Level of restraint:

1 Non-violent

2 Violent/self-destructive

Physician order:

Click box to display previous status documentation ->

Restraint status: Start \*

Level of restraint: \*

Non-violent restraint device: \*

Violent restraint device: \*

Clinical justification: \*

Alternatives utilized: \*

Date restraints initiated: \*

Time restraints initiated: \*

(Next Page) ☐

In the **Restraint Documentation +** intervention, Restraint status and *Level of restraint* are **required\*** fields.

The available *Level of restraint* responses are:

- Non-violent
- Violent/self-destructive

Restraint Documentation

Non-violent restraint device:

1 ☒ Bedrails

2 ☐ Chemical

3 ☐ Enclosure

4 ☐ Freedom splints +

5 ☐ Geri-chair

6 ☐ Mitten +

7 ☐ Soft +

8 ☐ Waist

Physician order from 05/22/25 at 0606: Bedrails

Click box to display previous status documentation ->

Restraint status: Start \*

Level of restraint: Non-violent \*

Non-violent restraint device: Bedrails \*

Violent restraint device: \*

Clinical justification: \*

Alternatives utilized: \*

Date restraints initiated: \*

Time restraints initiated: \*

(Next Page) ☐

If 'Non-violent' *Level of restraint* is selected, the user will be directed to the *Non-violent restraint device* field with approved selection types.

The yellow information box will continue to display any Physician order information throughout the documentation process.

**Note:** Restrictive positioning and Tightly tucked sheets are no longer approved Non-violent restraint devices.

Restraint Documentation

Violent restraint device:

1 ☐ Chemical

2 ☒ Enclosure

3 ☐ Physical holding

4 ☐ Restrictive positioning

5 ☐ Seclusion

6 ☐ Soft +

7 ☐ Synthetic +

Click box to display previous status documentation ->

Restraint status: Start \*

Level of restraint: Violent/self-destructive \*

Non-violent restraint device: \*

Violent restraint device: Enclosed \*

Clinical justification: \*

Alternatives utilized: \*

Date restraints initiated: \*

Time restraints initiated: \*

(Next Page) ☐

If 'Violent/self-destructive' *Level of restraint* is selected, the user will be directed to the *Violent restraint device* field with approved selection types.

**Note:** Bedrails, Freedom splints, Geri-chair, Mittens, Seclusion/restraint, Tightly tucked sheets, and Waist are no longer approved Violent restraint devices.

Restraint Documentation 05/22 0952 J00021474493 LCOE,PATIENT

**Clinical justification:**

1 ☒ NV-Attempts remove device 7 ☐ V-Physical aggression  
 2 ☐ NV-Handle wound/dressings  
 3 ☐ NV-OOB extreme inj risk  
 4 ☐ V-Attempts self-harm  
 5 ☐ V-Combative  
 6 ☐ V-Destructive

Physician order:

Click box to display previous status documentation ->

Restraint status:>Start \*  
 Level of restraint:>Non-violent \*  
 Non-violent restraint device:>Bedrails \*  
 Violent restraint device:  
 Clinical justification:>Attempt remove \*  
 Alternatives utilized:  
 Date restraints initiated: \*  
 Time restraints initiated: \*

(Next Page) ☐

**Note:** An Error message will occur if the user selects a **Violent (V)** justification for a **'Non-Violent' Level of restraint** and if a **Non-violent (NV)** justification is selected for a **'Violent' Level of restraint**.

*Clinical justification* is a required field.

For *Non-violent (NV)* level of restraint, the following justifications may be selected:

- NV-Attempts remove device
- NV-Handle wound/dressings
- NV-OOB extreme inj risk

For *Violent (V)* level of restraint, the following justifications may be selected:

- V-Attempts self-harm
- V-Combative
- V-Destructive
- V-Physical aggression

Restraint Documentation

**Alternatives utilized:**

1 ☐ 1:1 discussion 7 ☐ Check lab values 13 ☐ Music/television  
 2 ☐ Additional warmth 8 ☐ Decr stim/decr noise 14 ☐ Night light  
 3 ☐ Assisted ambulation 9 ☐ Decrease temperature 15 ☐ Nutrition/hygiene  
 4 ☐ Bed alarm 10 ☐ Diversion activity 16 ☐ Orientation  
 5 ☐ Call light within reach 11 ☐ Family interaction 17 ☐ PRN med per tx plan  
 6 ☐ Change environment 12 ☐ Interpreter services 18 ☒ or <F9> For More Options

Click box to display previous status documentation ->

Restraint status:>Start \*  
 Level of restraint:>Violent/self-destructive \*  
 Non-violent restraint device:>  
 Violent restraint device:>Enclosure  
 Clinical justification:>V-Destructive  
 Alternatives utilized:>Toileting  
 Date restraints initiated: \*  
 Time restraints initiated: \*

Alternatives utilized: Lookup

Select ☐

Options

1 ☒ Toileting  
 2 ☐ Voluntary time out

In the *Alternatives utilized* field, "Commode at bedside" has been removed from the list of responses and 'Toileting' has been added.

**Note:** Toileting can be found in the '<F9> For More Options' response.

Restraint Documentation

**Safety/Rights/Dignity maintained verified:**

1 Done now  
 2 Three times every hour  
 3 Every 15 minutes per hour

Done now - use to document each observation in real time, three times every hour.  
 For patients under continuous or frequent in-person observation or continuous audio/video monitoring, or if a paper checklist is used and scanned into the EHR/HPF medical record, the following may be used:  
 Three times every hour  
 Every 15 minutes per hour

Safety/Rights/Dignity maintained verified:>  
 Alternatives attempted:

(Prev Page) ☐ (Next Page) ☐

The *Safety/Rights/Dignity maintained verified*: yellow information box has been updated to align with HCA restraint policy.

For patients under continuous or frequent in-person observation or continuous audio/video monitoring, or if a paper checklist is used and scanned into the EHR/HPF medical record, the following may be used:

- Three times every hour
- Every 15 minutes per hour

**Circumstances leading to restraint/seclusion incident:**

- 1 ☐ NV-Attempts remove device
- 2 ☐ NV-Handle wound
- 3 ☐ NV-OOB extreme
- 4 ☒ U-Attempts self-harm
- 5 ☐ U-Combative
- 6 ☐ U-Destructive

**Circumstances leading to restraint/seclusion incident:** U-Attempts self-harm

Recommendations for future interventions:

Post counseling provided to: \*

Debriefing Comment:

(End) ☐

Violent episodes allow documentation of debriefing when Discontinued.

Circumstances leading to restraint/seclusion event will default the documented response to the Clinical justification filed with the Start.

This is editable but will not allow the addition of NV selections.

# Suicide Screening Functionality Update



Currently, if the clinician exits the suicide screening without completing documentation, it appears as if the screening was completed, as it retains 'Yes' in the *Assess suicide screening* field. This results in no-risk level being assigned or reported to the provider and is a potential safety concern for patients.

To reduce the potential safety concerns, if the clinician exits the Suicide Screening/Rescreening screen without completing documentation, nothing will display in the field.

The screenshot displays two overlapping windows. The top window, titled 'Safety/Risk/Regulatory', contains a section for 'Assess suicide screening:' with a dropdown menu showing '1 Yes' and '2 Unable to assess'. Below this are various assessment fields including 'Isolation status', 'Assess sepsis', 'Assess vaccines', 'Assess adult skin risk', 'Assess pediatric skin risk', 'Assess fall risk', and 'Assess suicide screening:'. The 'Assess suicide screening:' field is highlighted with a red box. The bottom window, titled 'BH Suicide/Homicide Screening', contains a section for 'Non-specific active suicidal thoughts in the past month:' with a dropdown menu showing '1 Yes' and '2 No'. Below this are various assessment fields including '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', and 'Non-specific active suicidal thoughts in your lifetime'. A red arrow points to the 'Exit and Erase' button in the 'Erasing Documentation Alert' dialog.

Selecting 'Yes' to the *Assess suicide screening* field will direct the user to the **BH Suicide/Homicide Screening** documentation screen.

If the clinician decides to exit the suicide screening prior to completing the documentation, an alert will appear to 'Exit and Erase' to return to the main screen or "Return to Screen" to complete required documentation.



Safety/Risk/Regulatory

Assess Broset violence screening:

1 Yes

Isolation status: Standard precautions \*

Assess sepsis: ☐

Assess vaccines: ☐

Assess adult skin risk: ☐

Assess pediatric skin risk: ☐

Assess fall risk: ☐

Assess suicide screening: ☐

Assess Broset violence screening: ☐

Assess trauma alcohol screening (CAGE): ☐

Assess depression screening: ☐

(End) ☐

The *Assess suicide screening* field will now be blank and the system will move the cursor to the next field if the clinician exits the screening prior to completing the screening.

This update affects the following interventions:

| Nursing                              | Emergency Department        | Surgery                            |
|--------------------------------------|-----------------------------|------------------------------------|
| BH: OP Initial Nurse Assessment+     | Detailed Assessment         | SURG: Safety/Risk/Regulatory PAC + |
| BH: Initial Nurse Assessment (INA) + | BH Level of Care Assessment | SURG: Safety/Risk/Regulatory +     |
| BH: Nursing Reassessment             | Non-Urgent General Focus    | SURG: Safety/Risk/Regulatory Int + |
| BH: Psychosocial Assessment (PSA) +  |                             |                                    |
| BH: Level of Care Assessment +       |                             |                                    |
| Safety/Risk/Regulatory +             |                             |                                    |

## TBSA and Burn Depth Removal Update



TBSA and burn depth will be removed from Nursing documentation and will be completed by the Burn physician using the Lund and Browder chart. Determination of TBSA with the use of Lund and Browder is a diagnosis and not within the nurse's scope. Nursing integumentary assessments will be documented within the following assessments/interventions:

- Admission/Shift Assessment: Skin Alteration
- Burn Assessment/Reassessment (for ED)

*TBSA and burn depth will be removed nursing documentation interventions.*

*Document TBSA and burn depth will be removed from EDM documentation within the Burn assessment/reassessment*

This update affects the following interventions/assessments:

| Nursing             | Emergency Department |
|---------------------|----------------------|
| TBSA and Burn Depth | Burn Assessment      |
|                     | Burn Reassessment    |

# Universal Timeout Updates



In the **Universal Timeout** intervention, the Briefing information field has been updated to align with corporate policy.

Universal Timeout

**Briefing/anesthesia timeout completed:**

1 Yes  
2 No

Briefing/Anesthesia timeout completed immediately before administration of any type of anesthesia and/or sedation.

Briefing elements:

- Pt identified by two identifiers
- Provider(s) confirmed
- Procedure site/side confirmed and marked per policy
- Does patient have any drug/latex allergies
- Does patient have difficult airway/aspiration risk
- Anesthesia procedure prior to incision/start time
- Anesthesia safety check complete
- Pressure-reducing positioning aids needed
- Other concerns

Briefing/anesthesia timeout completed:→

Procedure timeout completed at:

Procedures being performed:

Site blocked:

Debriefing completed:

(End) ☐

*Briefing/anesthesia timeout completed* has been updated with the following responses:

- Yes
- No

The yellow information box has been updated to align with corporate policy.

Universal Timeout

**Debriefing completed:**

1 Yes  
2 No

Debriefing completed before surgeon/proceduralist and patient leave the procedure area

Debriefing Elements:

- Results of all counts were verbalized
- Exact procedure and diagnosis were confirmed with surgeon
- All specimens are labeled correctly
- Were there any delays for the case (If Y will need to enter in delay code in case times grid-OR only)
- Permanent changes to preference card (OR only)
- Key patient concerns for recovery/management of care
- Are medications secured

Briefing/anesthesia timeout completed:→Yes

Procedure timeout completed at:→1018

Procedures being performed:→

Site blocked:→

Debriefing completed:→

(End) ☐

The *Debriefing completed* field has been updated with the following responses:

- Yes
- No

This update affects the following interventions:

| Nursing                   | Emergency Department     | Surgery                               |
|---------------------------|--------------------------|---------------------------------------|
| Universal Timeout         | Universal Timeout        | SURG: Universal Timeout Intra-op      |
| Moderate Sedation         | Moderate Sedation        | SURG: Universal Timeout PACU          |
| Lines, Drains, Airways    | Lines, Drains, & Airways | SURG: Universal Timeout Pre-op        |
| OB: OR Record             | Temporary Pacemaker      | SURG: Moderate Sedation Intra-op      |
| Critical Care Flow Record | Newborn Stabilization    | SURG: Moderate Sedation PAC           |
|                           |                          | SURG: Moderate Sedation Pre           |
|                           |                          | SURG: Lines, Drains, Airways Intra-op |
|                           |                          | SURG: Lines, Drains, Airways PACU     |
|                           |                          | SURG: Lines, Drains, Airways Pre-op   |
|                           |                          | Post Procedure Doc (Profile Screens)  |

## EDM Module Updates

Current documentation does not allow the capture of a cell phone number in the EDM Recept or Check-In screen. Future documentation will allow a cell phone number to be entered upon patient arrival during the Recept function.

The image displays two screenshots of the 'Patient Reception' form, illustrating the difference in cell phone number capture between two scenarios.

**Scenario 1 (Top Screenshot):** The form is for a patient named 'RECEPT, TESTING CELL'. The 'Cell Phone' field is empty and highlighted with a red box. Other fields include: Patient: NEW, Arrival Date: 05/13/25, Arrival Time: 1548, Sex: F, Birthdate: 08/12/87, Age: 37, Zip Code: 37066, Stated Complaint: headache, Chief Complaint: ZHEADPAIN Head Pain/Injury, Priority: 3, ED Location: J.OBED, Wait List: [empty], Wait No.: [empty].

**Scenario 2 (Bottom Screenshot):** The form is for a patient named 'HT, CELL'. The 'Cell Phone' field is filled with '(214)879-2170' and highlighted with a red box. Other fields include: Patient: NEW, Arrival Date: 05/13/25, Arrival Time: 1550, Sex: F, Birthdate: 08/12/19, Age: 5Y 09M, Zip Code: 38507, Stated Complaint: stomachache, Chief Complaint: Z61ABD GI/Abdominal Pain, Priority: 3, ED Location: J.OBED, Wait List: [empty], Wait No.: [empty]. The bottom section includes PCP: DR.ATHD01, Comment: ATTENDING01, PROVIDER, INTEG, Preferred Pharmacy: No Pharmacy Entered, and buttons for Edit, Ack, OK, and Cancel.

### Walk-in Recept

Scenario 1: Cell phone number is not entered at time of Recept.

Scenario 2: Cell phone has been entered at time of Recept.

## Call-In Reception

Scenario 3: Call-In Receipt is used; all fields will be entered apart from the Cell Phone and Arrival Date/Time.

Upon patient arrival, complete the Check-In process including documenting patient cell phone number.

The 'Call In Reception' form contains the following fields and values:

- Patient: CHECK IN
- Name: TEST, HAY I
- Call Date: 05/01/25
- Call Time: 0808
- Priority: 3
- Age: 19
- Birthdate: 05/05/05
- Sex: F
- Zip Code: 38057
- Cell Phone: (highlighted in red)
- Stated Complaint: headache
- Assessment: ZRECEPTOR
- ETA (minutes): 10
- ETA Date: 05/01/25
- ETA Time: 0818
- Arrival Date: (empty)
- Arrival Time: (empty)
- Location: J. OBED
- Room: (empty)
- PCP: (empty)
- Comment: CALL IN RECEIPT TEST
- Preferred Pharmacy: No Pharmacy Entered

## EMS Recept

EMS Recept is used by the Transfer Center. All fields will be entered apart from the Cell Phone and Arrival Date/Time.

Once the patient arrives, Cell Phone field can be documented.

The 'EMS Recept' form contains the following fields and values:

- Patient: (empty)
- Ambulance Company: abc
- Ambulance ID: hayl
- Call Date: 05/01/25
- Call Time: 0807
- Priority: 3
- Age: 21
- Birthdate: (empty)
- Sex: F
- Zip Code: (empty)
- Cell Phone: (highlighted in red)
- Stated Complaint: headache
- Assessment: ZRECEPTOR
- ETA (minutes): 10
- ETA Date: 05/01/25
- ETA Time: 0817
- Arrival Date: (empty)
- Arrival Time: (empty)
- Name: abc, hayl
- Location: J. OBED
- Room: (empty)
- PCP: (empty)
- Comment: EMS Recept Test
- Preferred Pharmacy: No Pharmacy Entered