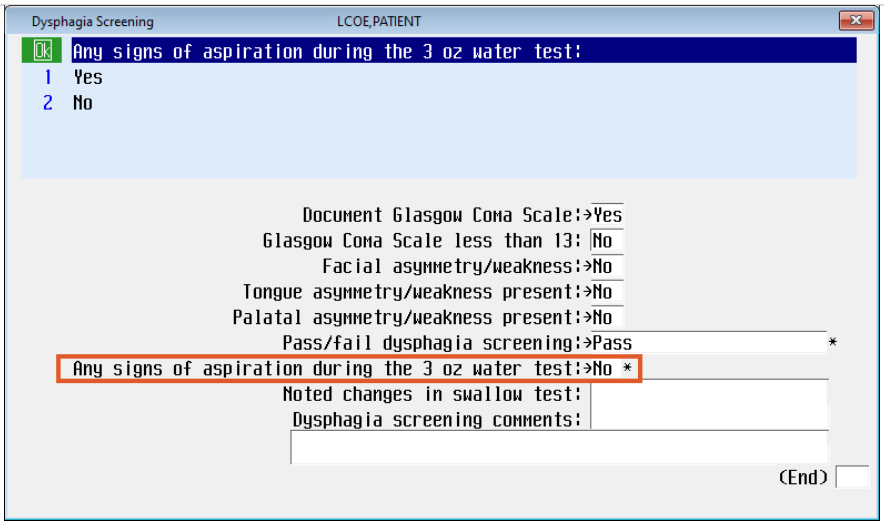
Dysphagia Screening – Water Test

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.

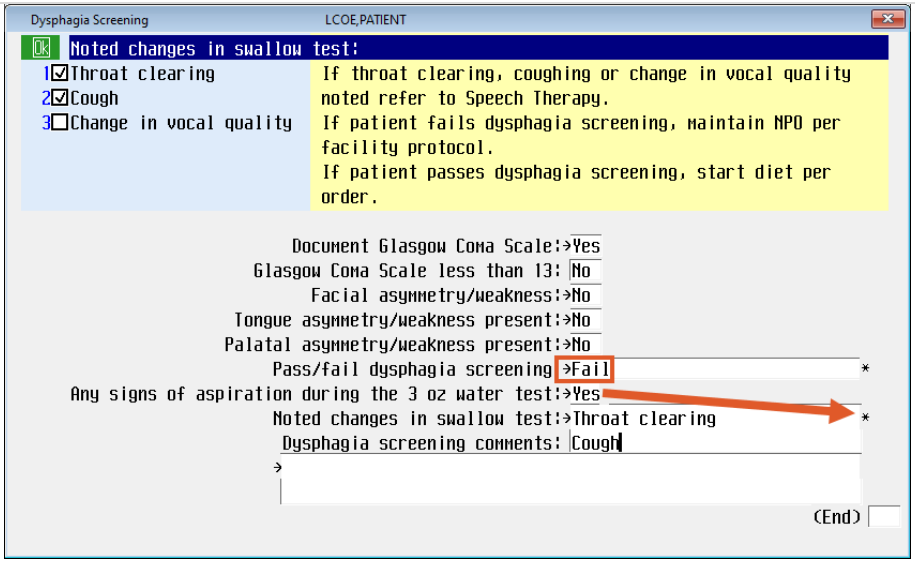


If “No” is answered for:

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

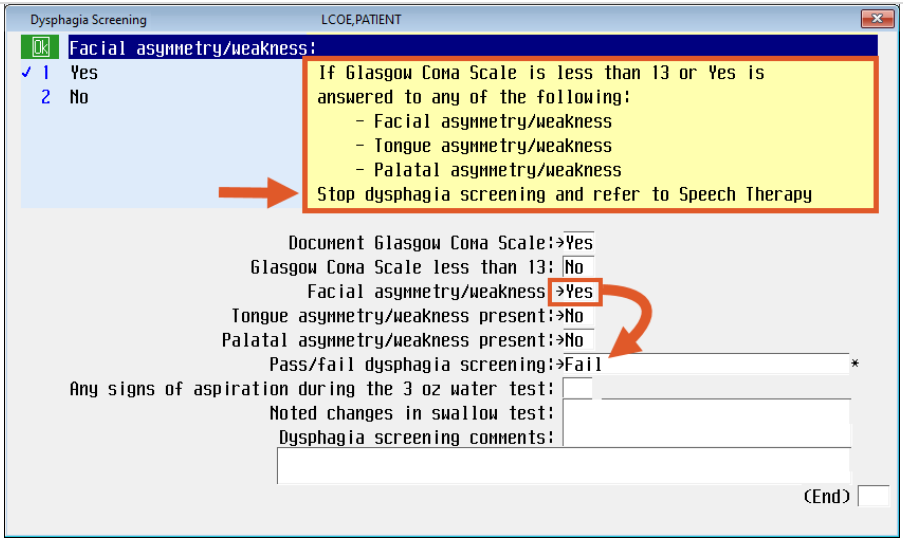
Then *Any signs of aspiration during the 3 oz water test* becomes ***Required*** to complete the **Dysphagia Screening.**

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



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 filing after all ***required**** fields have been answered.



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

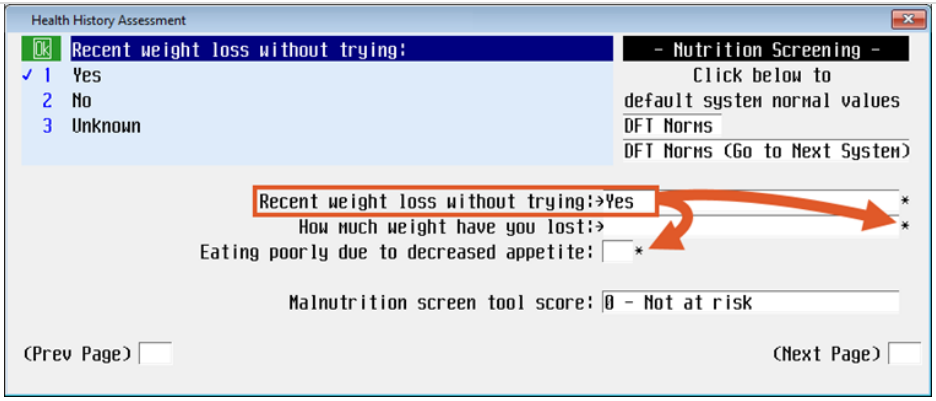
Then patient ***Fails*** the dysphagia screening and needs to be referred to Speech Therapy.

This update affects the following interventions:

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

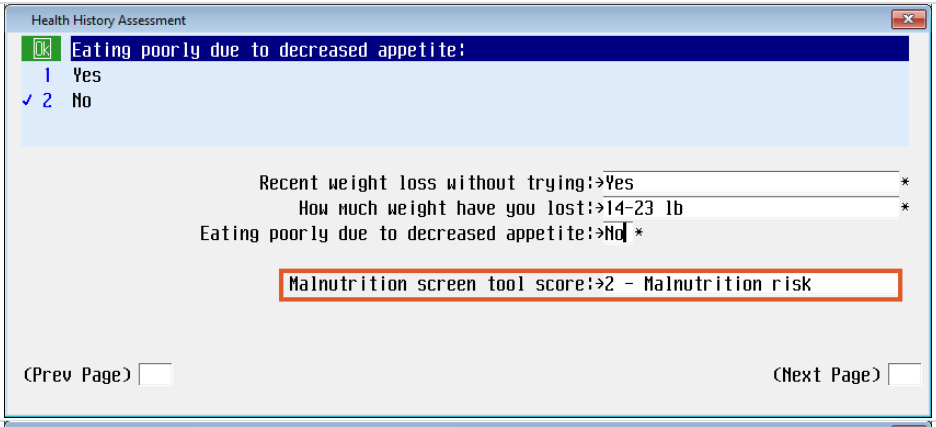
Malnutrition Screening Updates

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*.

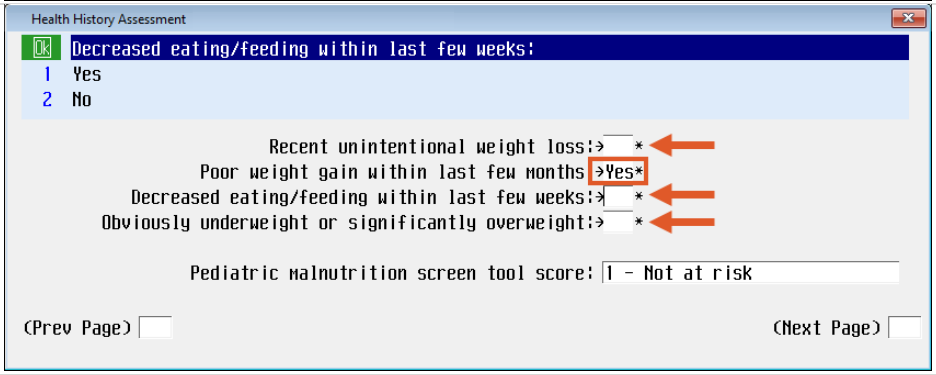


If 'Yes' is selected to *Recent weight loss without trying* then the following fields become ***required****:

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



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



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.

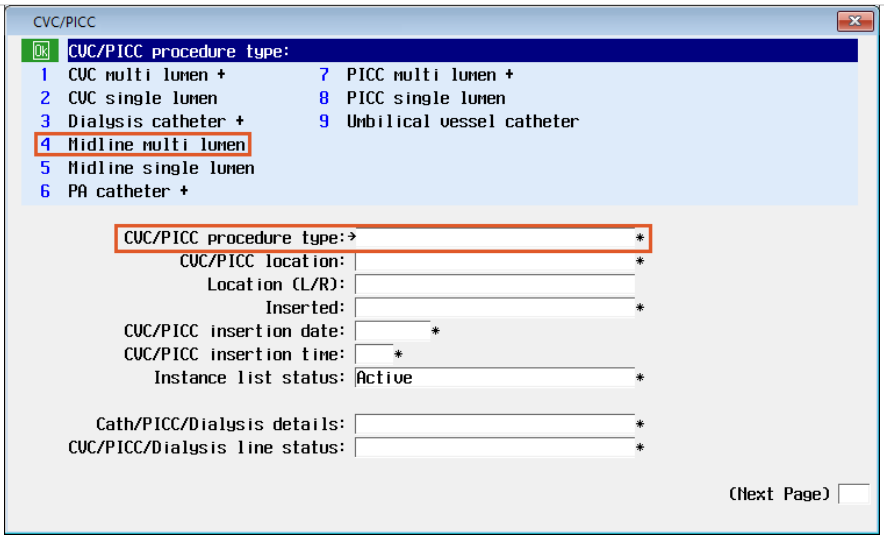
This update affects the following interventions:

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.



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

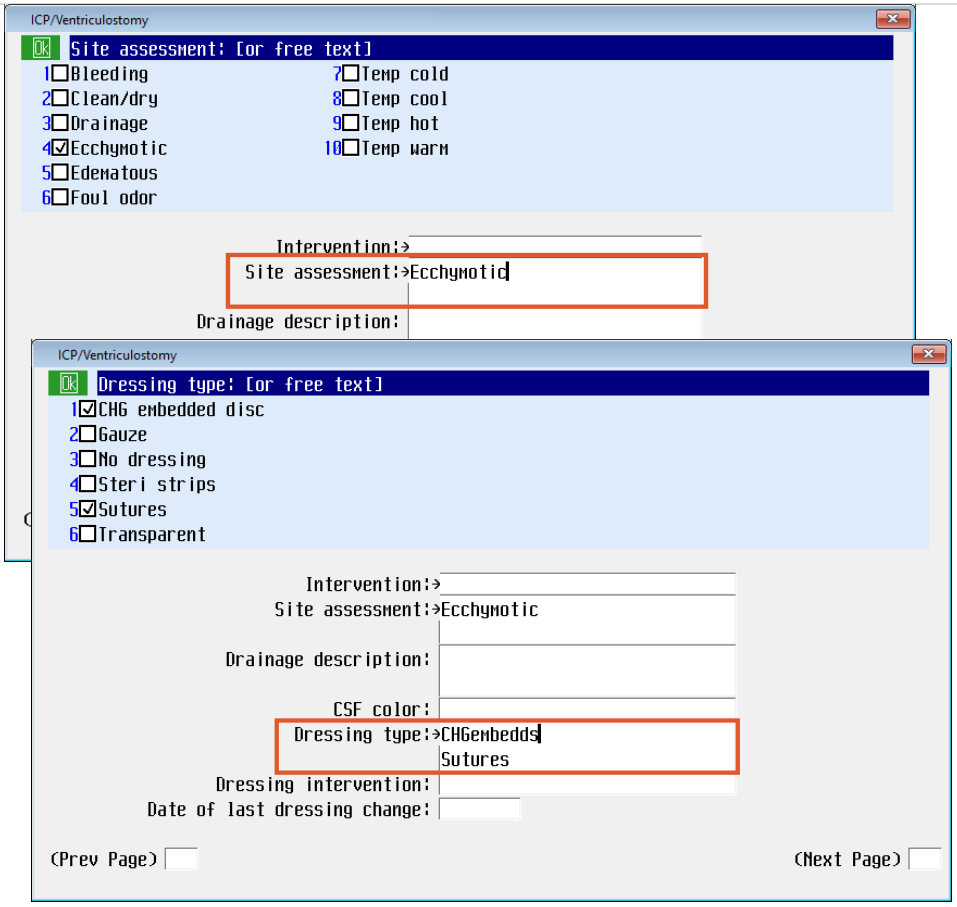
- Midline multi lumen

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.

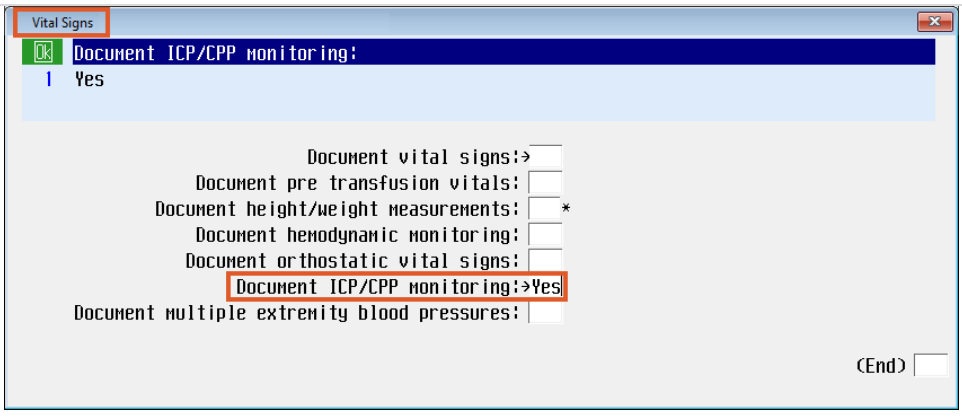


In the **ICP/Ventriculostomy** drain documentation, users will now document the *Site assessment* and *Dressing type* in drain instance documentation.

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

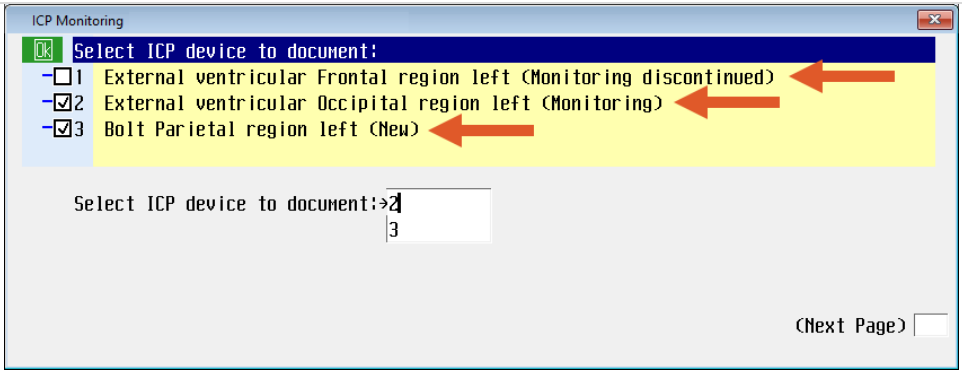
Dressing type has been updated with the following responses:

- 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.

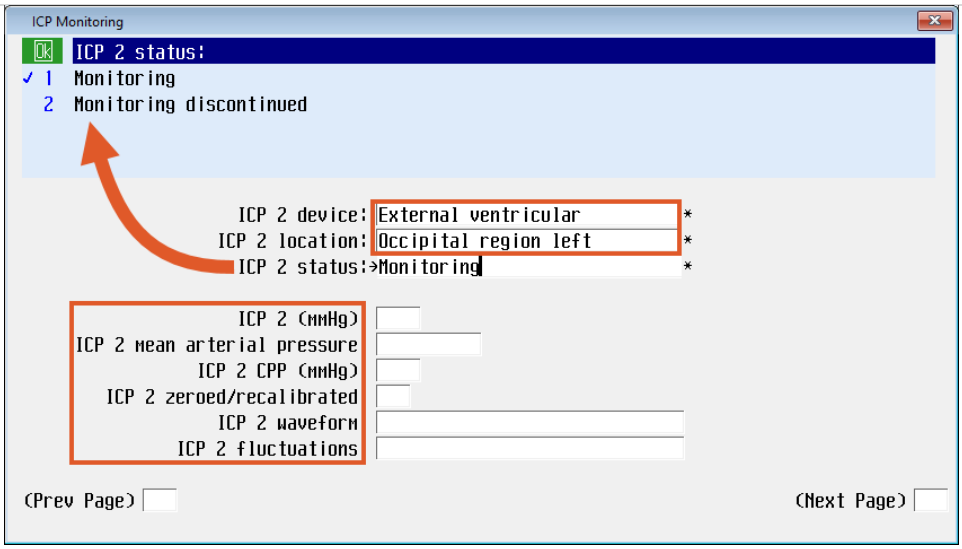
In the **Vitals/Ht/ Wt/ Measurements** intervention enter 'Yes' in the field *Document ICP/CPP monitoring.*



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*



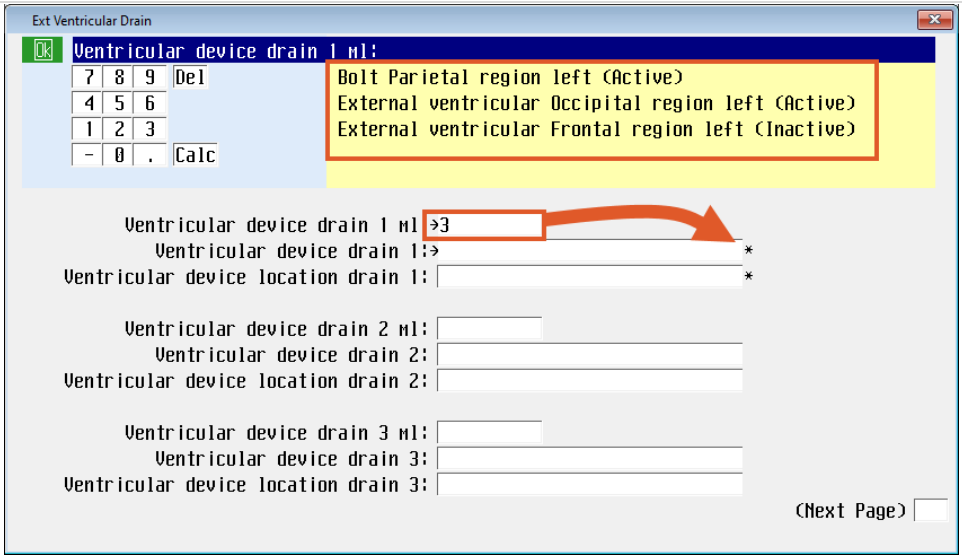
ICP device and *ICP location* will pre-populate to ensure consistent documentation:

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*



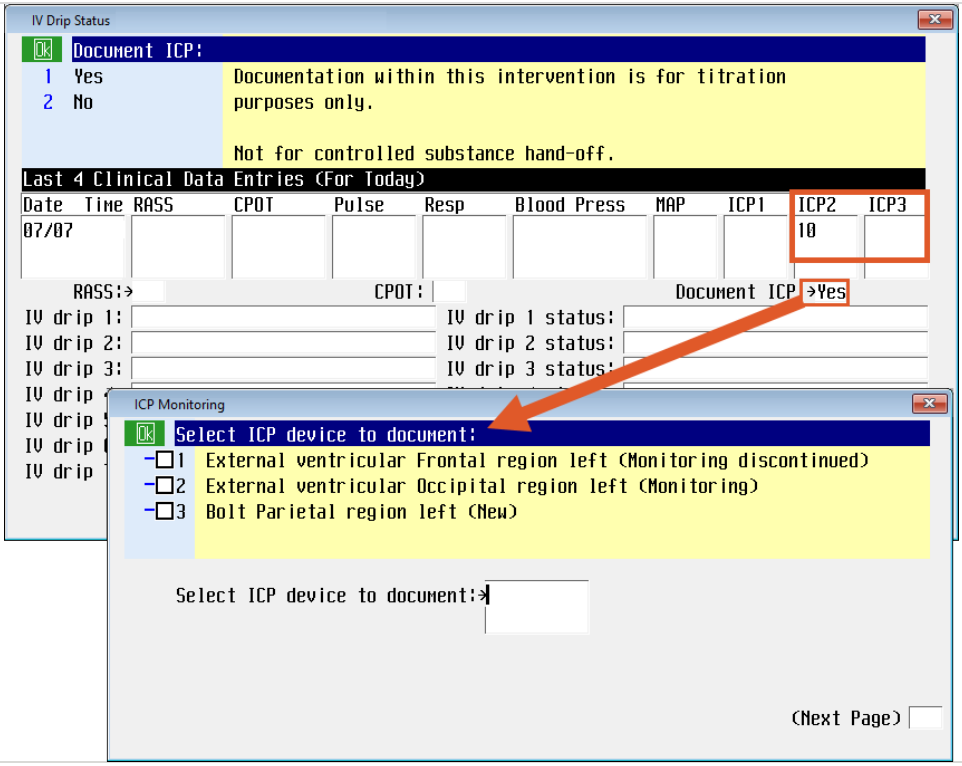
Ventricular Drain output will be documented in the **Intake and Output** intervention.

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.



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.

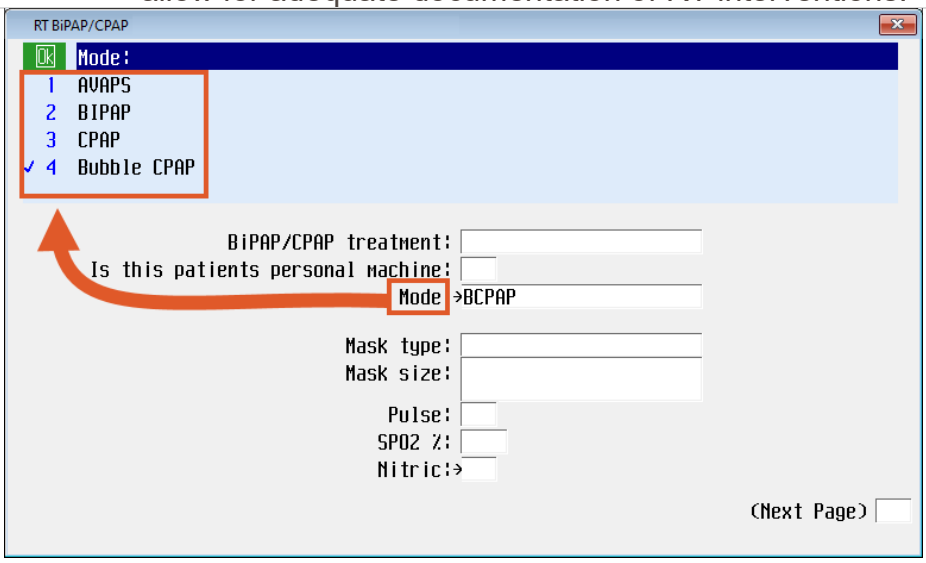
Note: A list of documented devices will automatically populate with the ICP drain status in the Yellow comment box.

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	

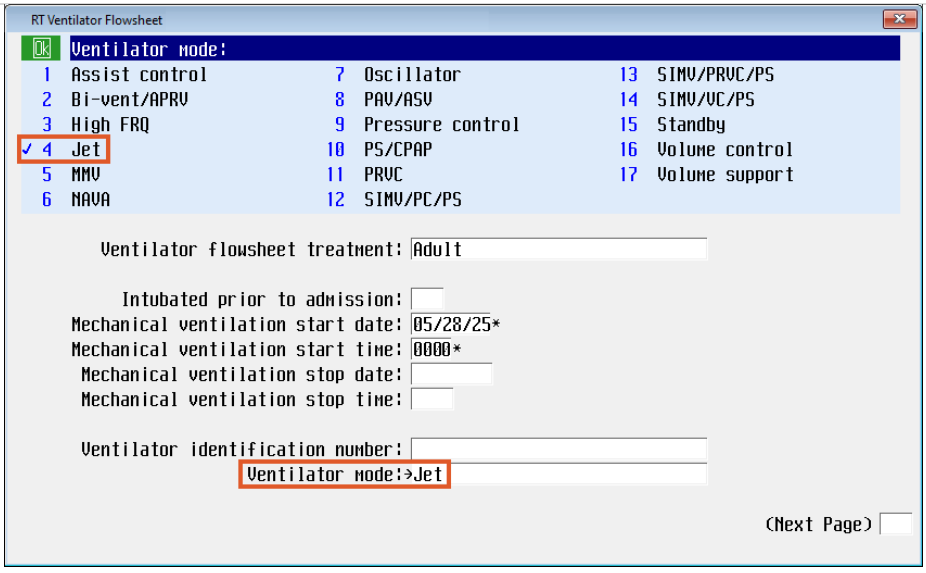
Respiratory Therapy Intervention Updates

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.



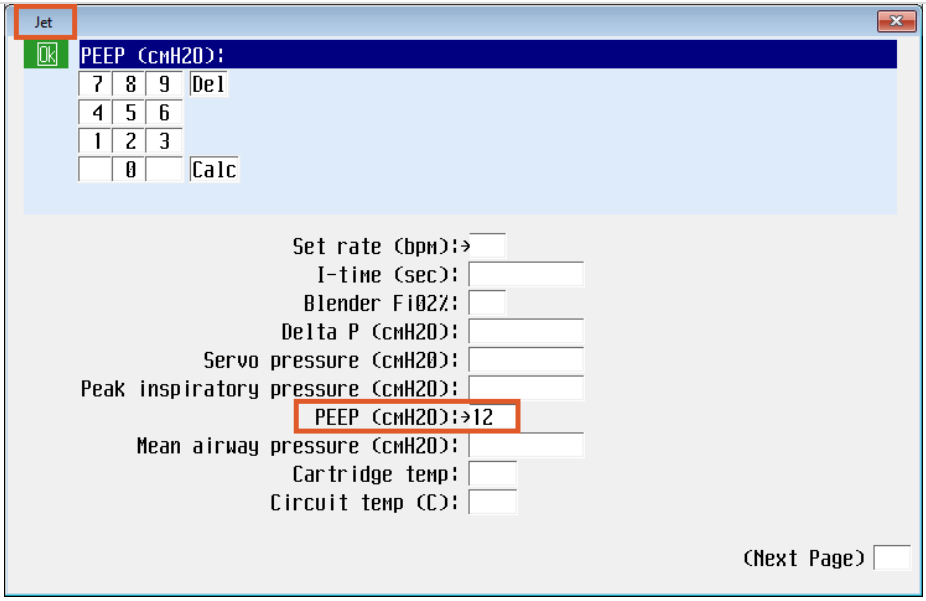
'Bubble CPAP' has been added to the Mode field response options documenting **RT BiPAP/CPAP**.

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

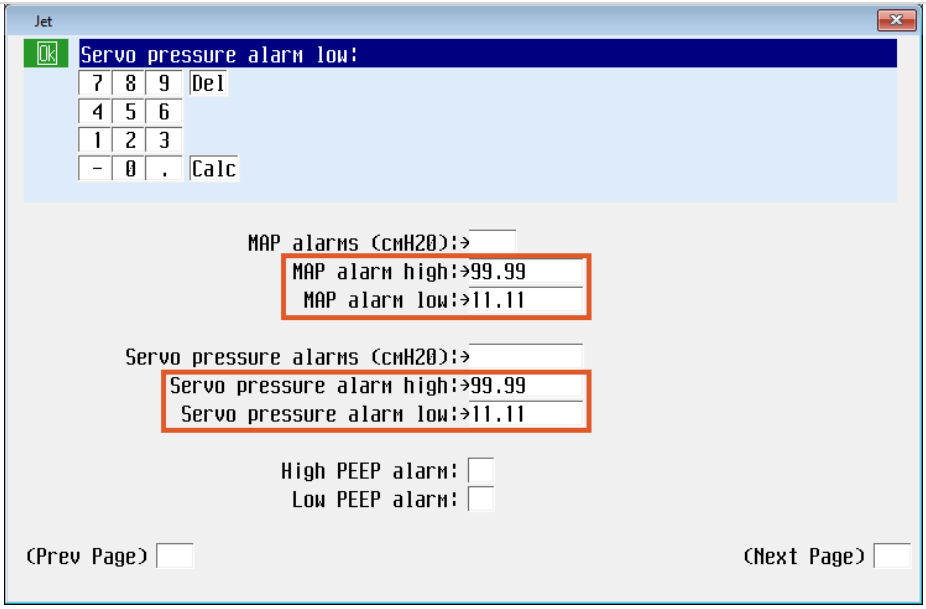


In the **RT Ventilator Flowsheet**, the following fields have been added when the response 'Jet' is selected for the *Ventilator mode* field:

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

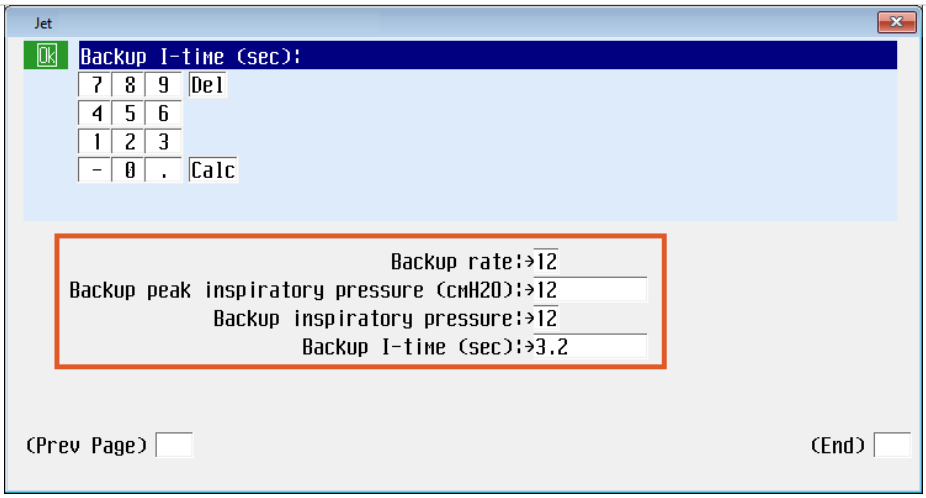


PEEP (cmH2O) has been added to page 2 of **Jet Ventilator Mode** screen and supports a response up to 2-digits.



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

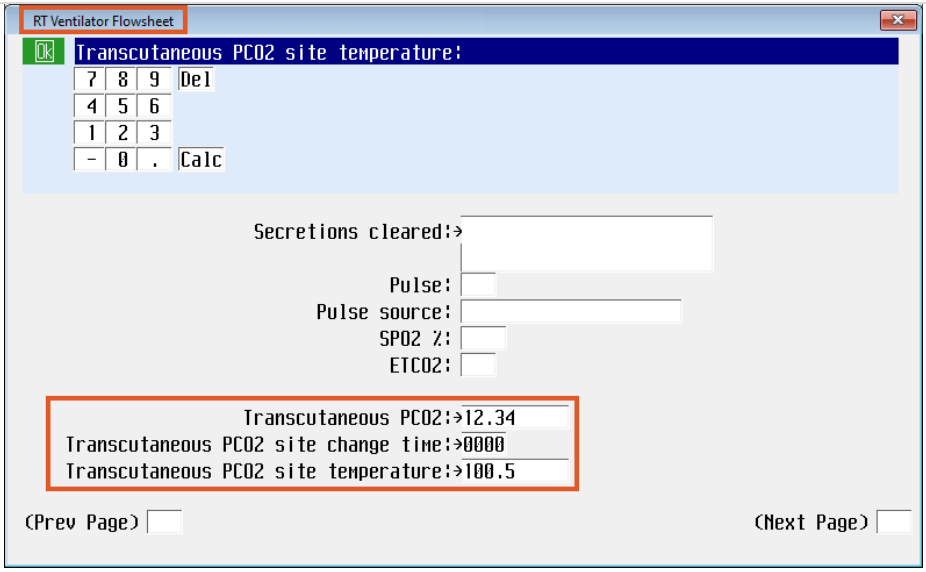
- MAP alarm high
- MAP alarm low
- Servo pressure alarm high
- Servo pressure alarm low



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.



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

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

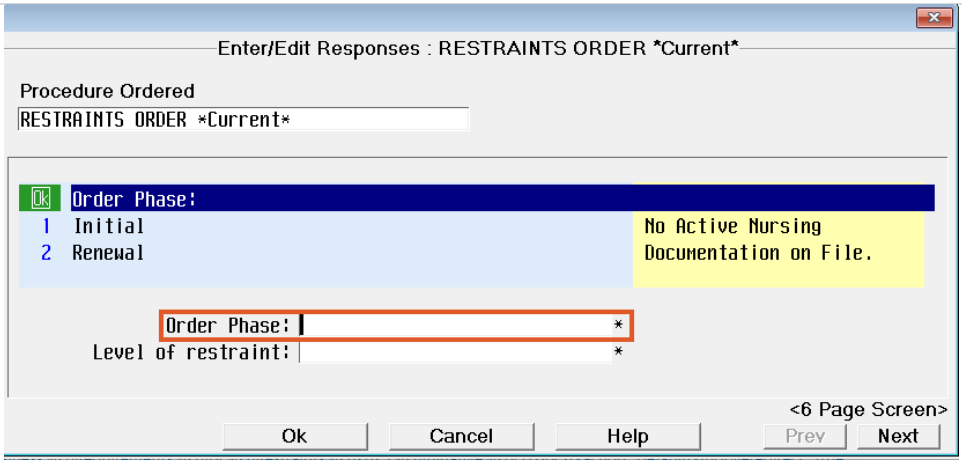
This update affects the following interventions/assessments:

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.

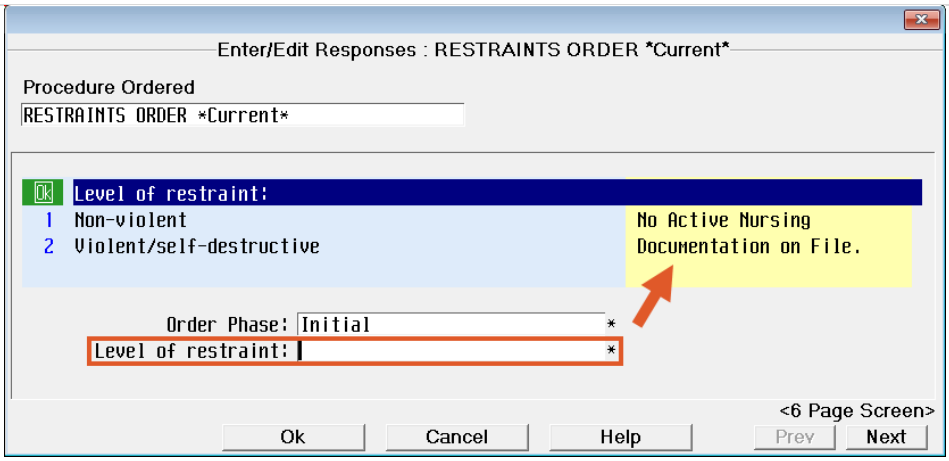
Ordering Restraints Process



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

- Initial
- Renewal

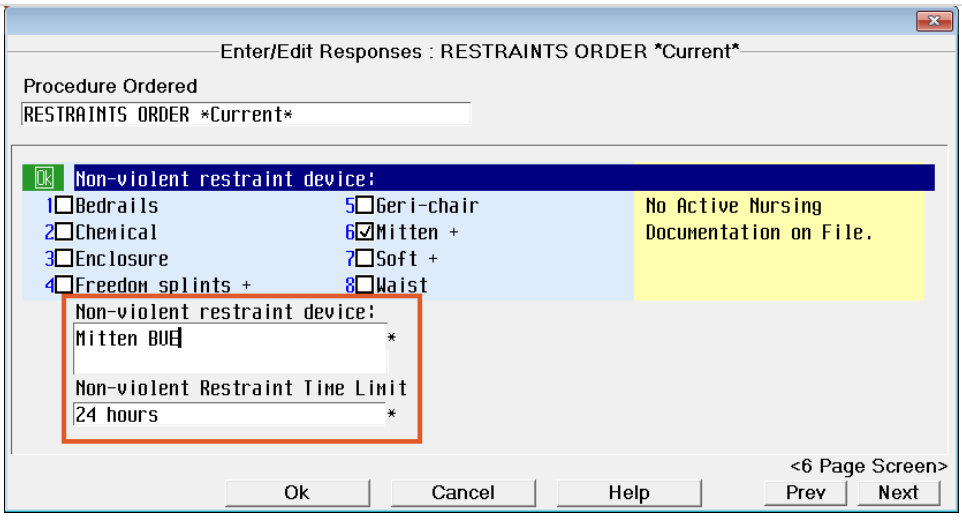
Note: An error message will occur if the *Order Phase* of 'Renewal' is selected in the absence of a current 'Initial' Restraint Order.



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

- Non-violent
- Violent/self-destructive

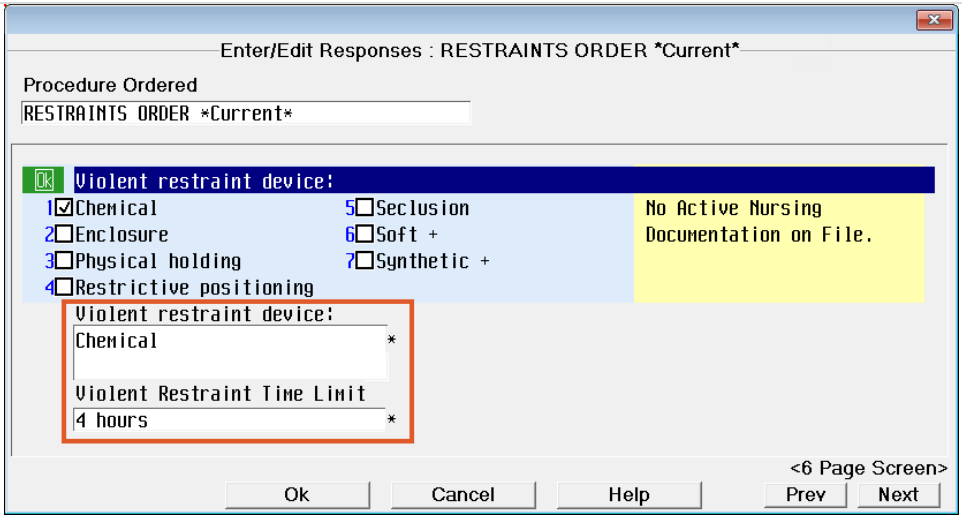
Note: The yellow information box will continue to display any Active Nursing Documentation on file throughout the ordering process.



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.

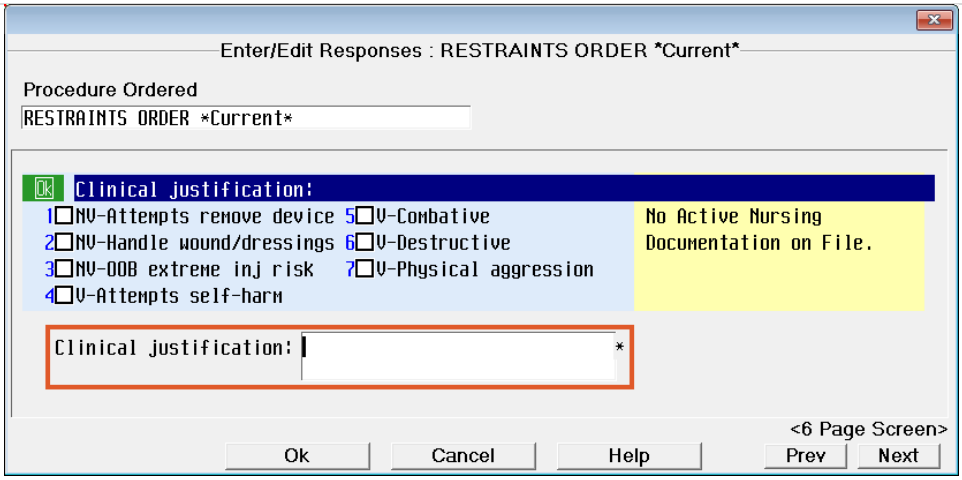
Note: Restrictive positioning and Tightly tucked sheets are no longer approved Non-violent restraint devices.



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.



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**.

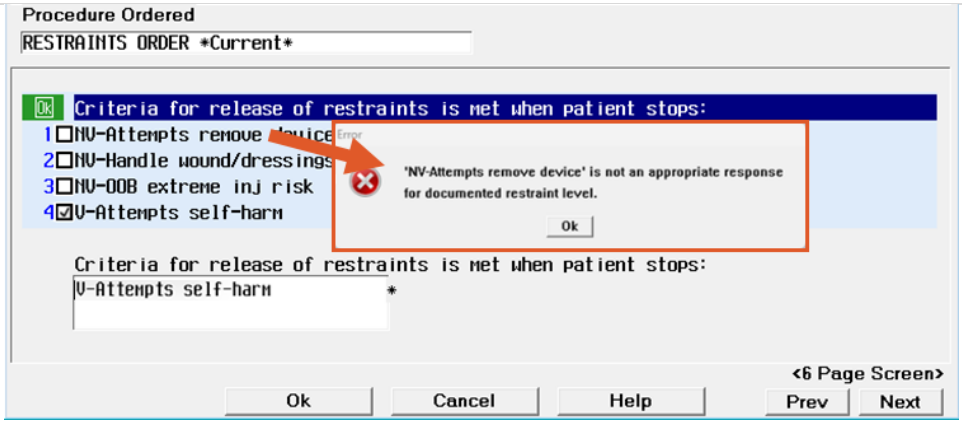
Clinical justification is a required field.

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:

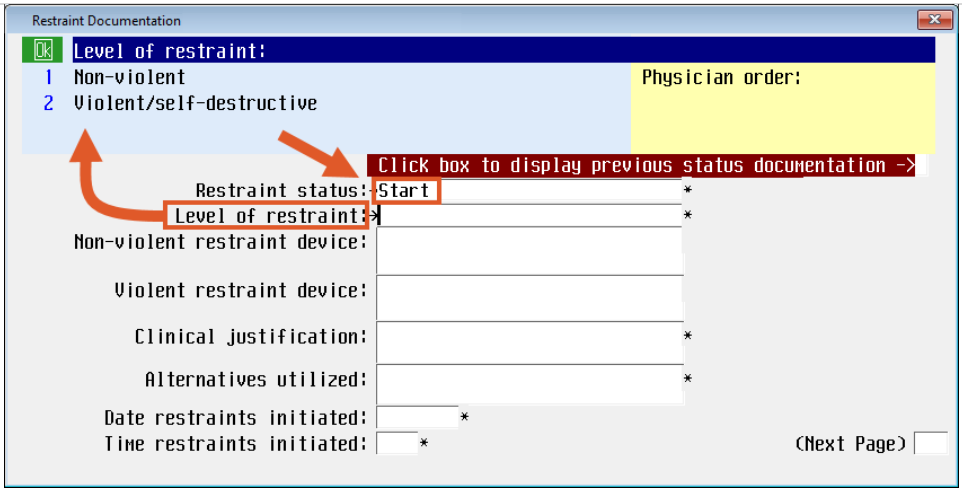
- V-Attempts self-harm
- V-Combative
- V-Destructive
- V-Physical aggression



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.

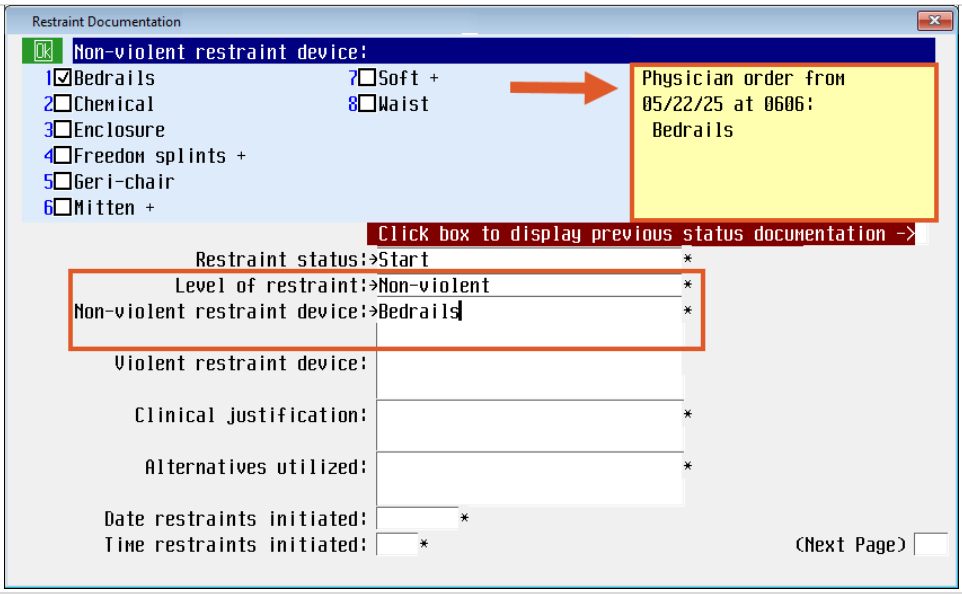
NURSING DOCUMENTATION



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

The available *Level of restraint* responses are:

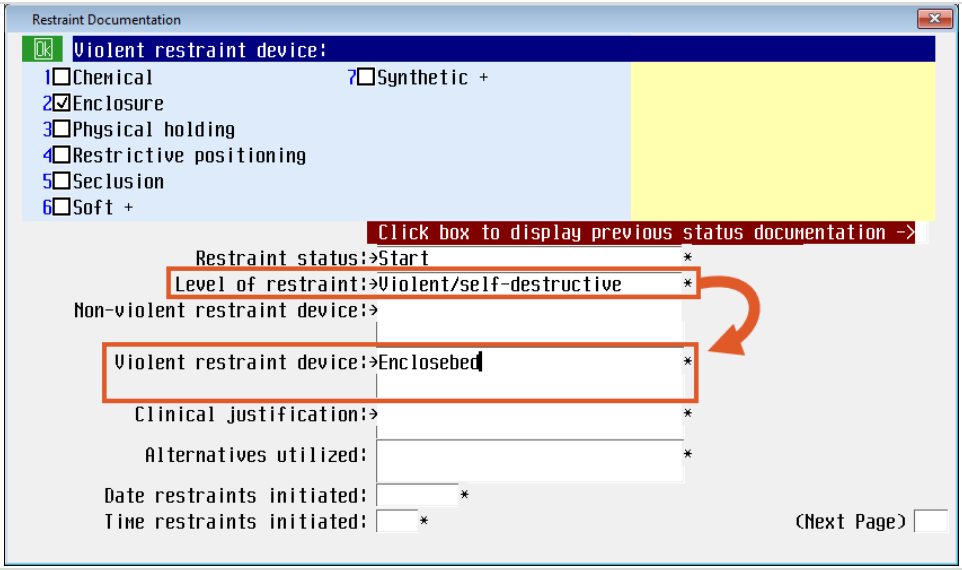
- Non-violent
- Violent/self-destructive



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

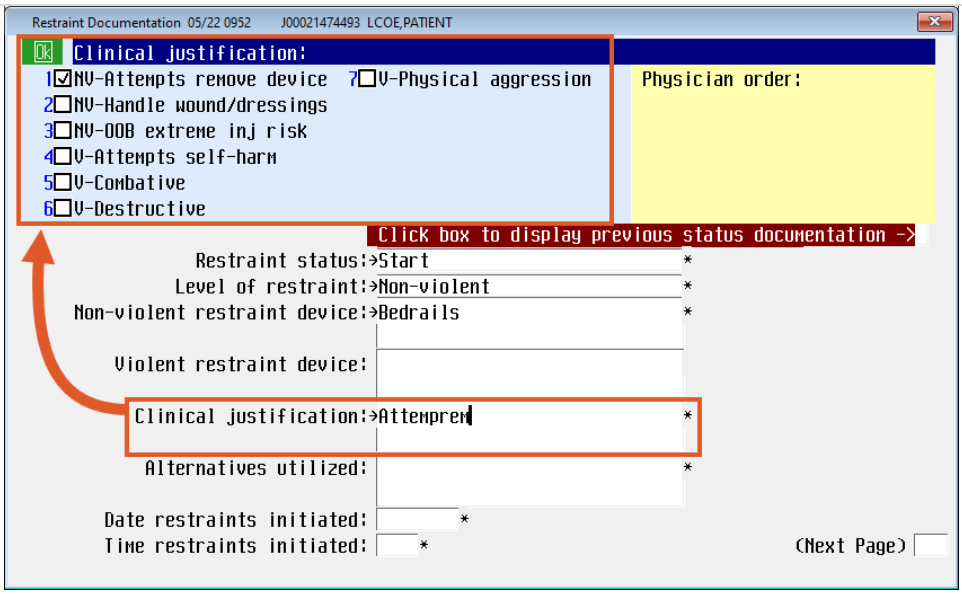
The yellow information box will continue to display any Physician order information throughout the documentation process.

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



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.



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

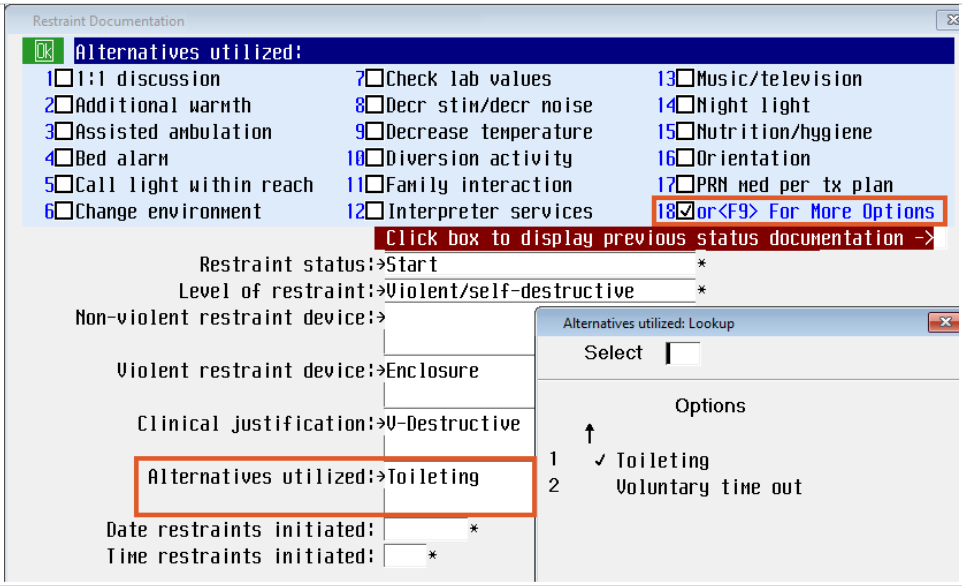
Clinical justification is a required field.

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

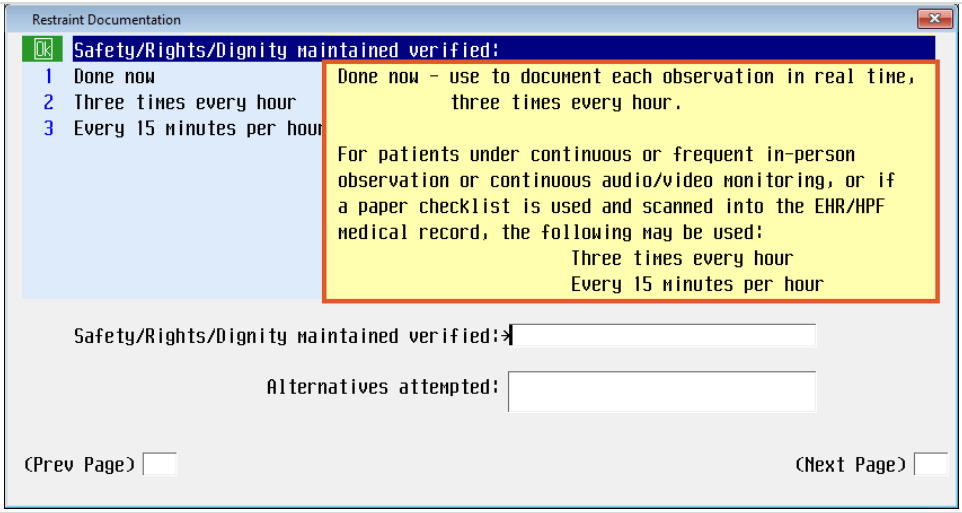
For *Violent* (V) level of restraint, the following justifications may be selected:

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



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

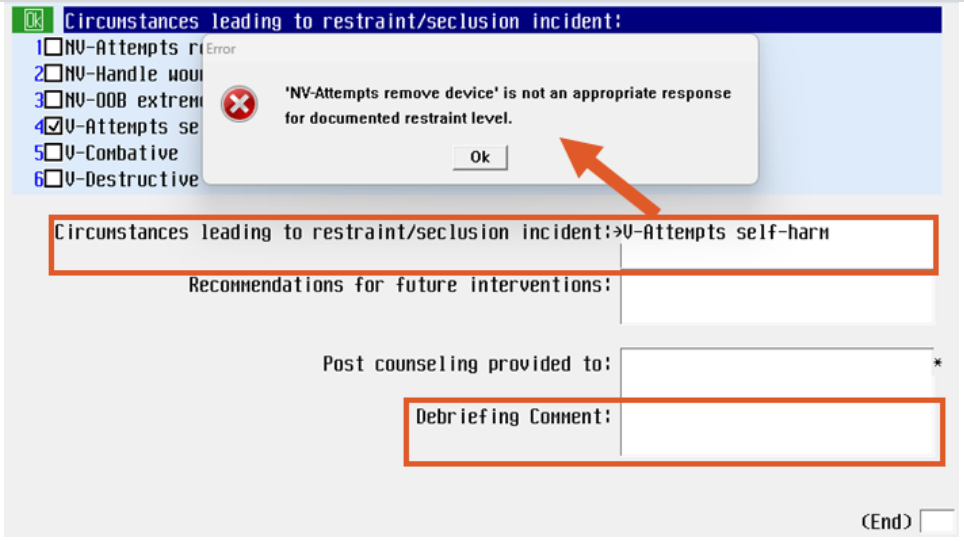
Note: Toileting can be found in the '<F9> For More Options' response.



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*



Violent episodes allow documentation of debriefing when Discontinued.

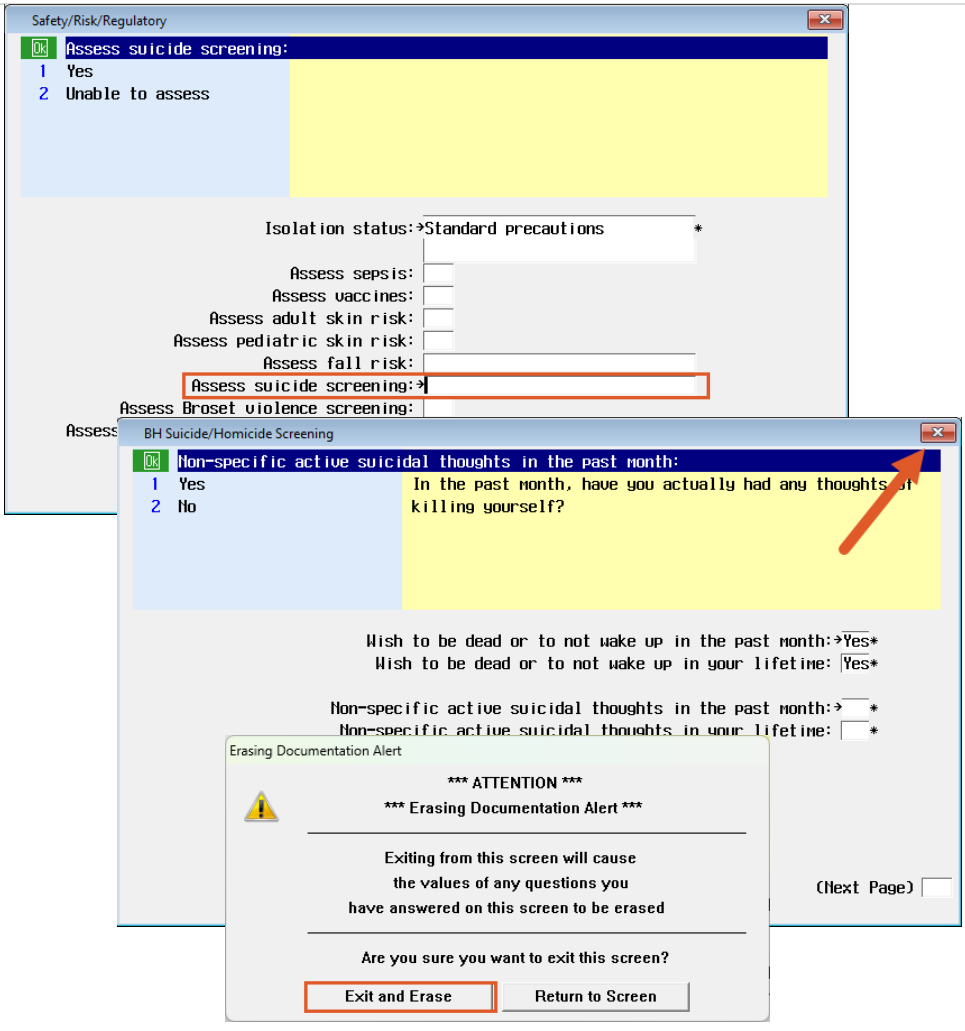
Circumstances leading to restraint/seclusion event will default the documented response to the Clinical justification filed with the Start.

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

Suicide Screening Functionality Update

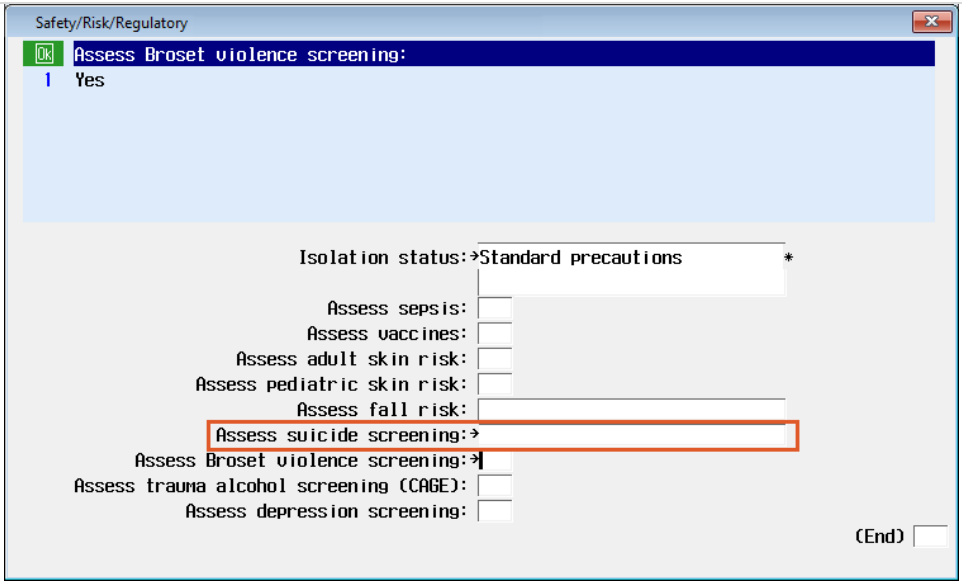
Currently, if the clinician exits the suicide screening without completing documentation, it appears as if the screening was completed, as it retains 'Yes' in the *Assess suicide screening* field. This results in no-risk level being assigned or reported to the provider and is a potential safety concern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



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.



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.

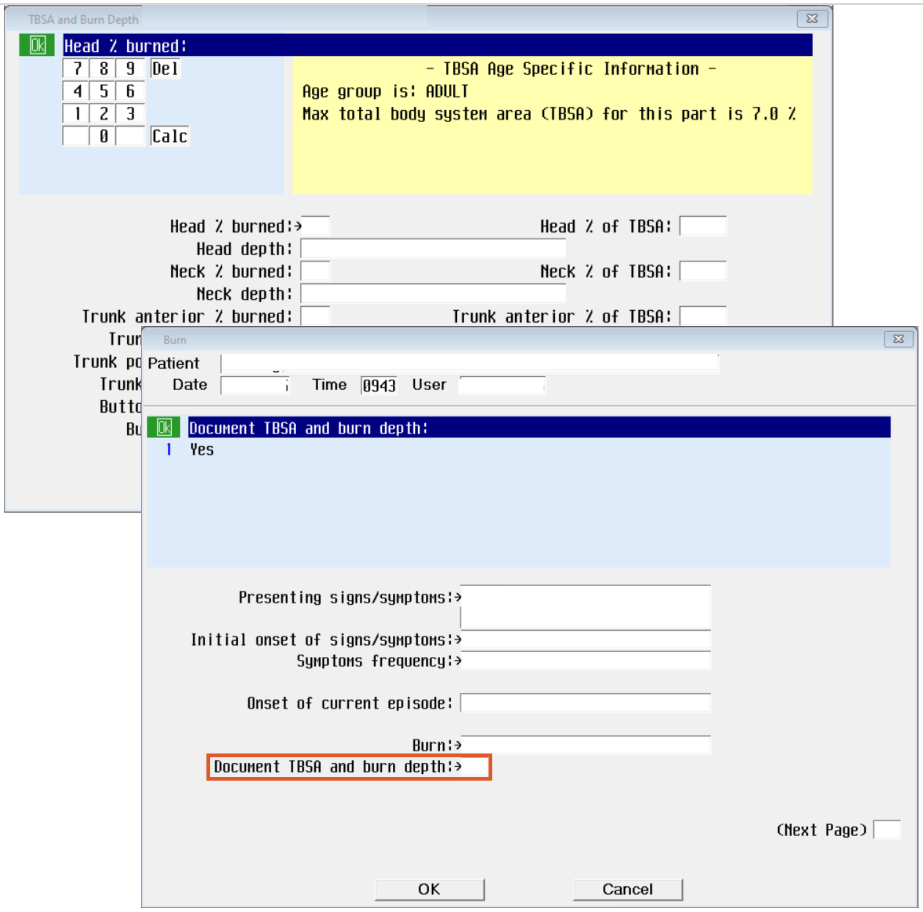
This update affects the following interventions:

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.

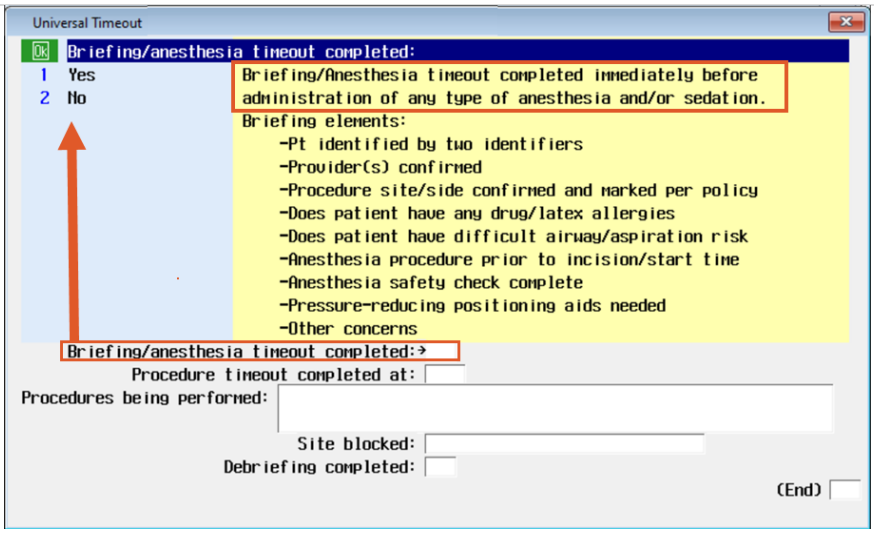
Document TBSA and burn depth will be removed from EDM documentation within the Burn assessment/reassessment

This update affects the following interventions/assessments:

Nursing	Emergency Department
TBSA and Burn Depth	Burn Assessment
	Burn Reassessment

Universal Timeout Updates

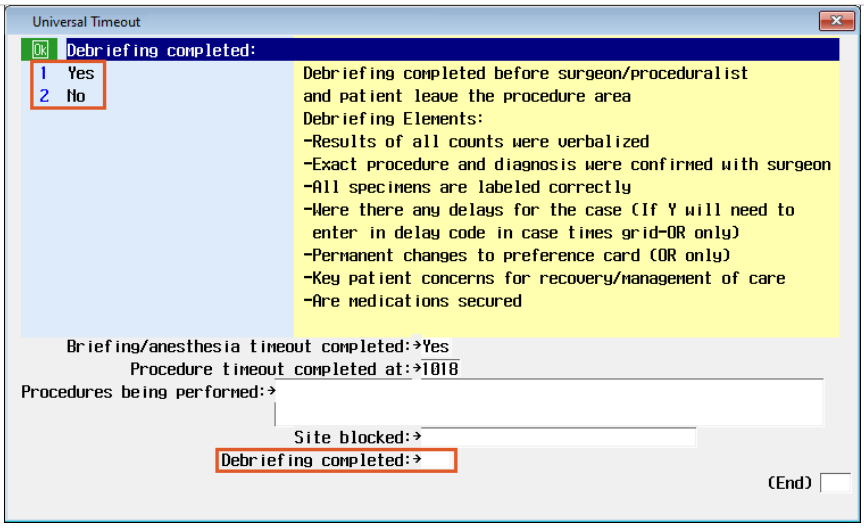
In the **Universal Timeout** intervention, the Briefing information field has been updated to align with corporate policy.



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.



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

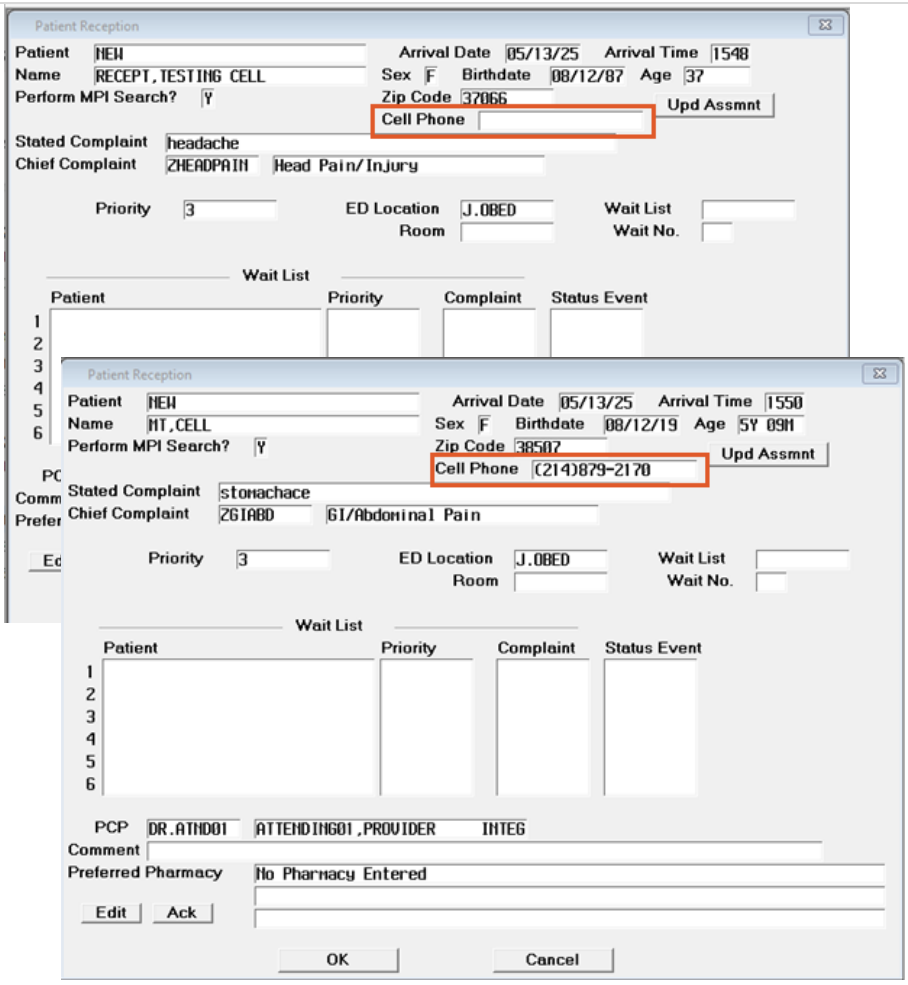
- Yes
- No

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.



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.

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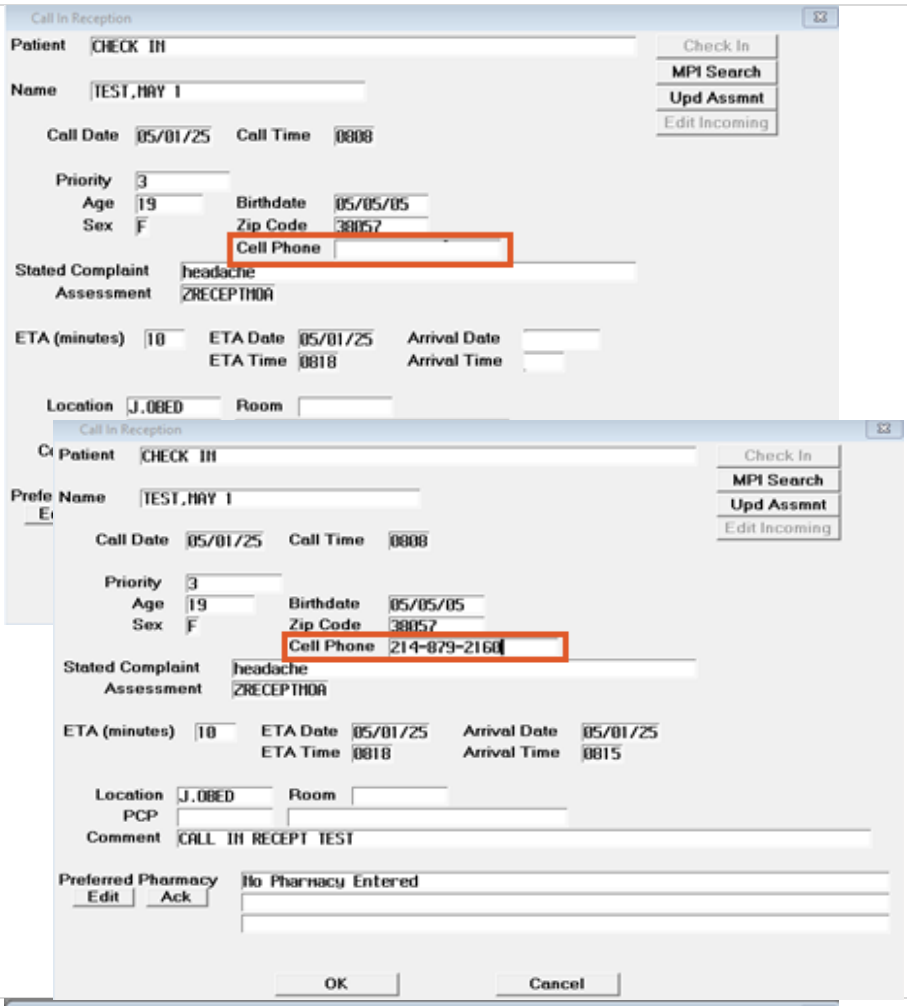
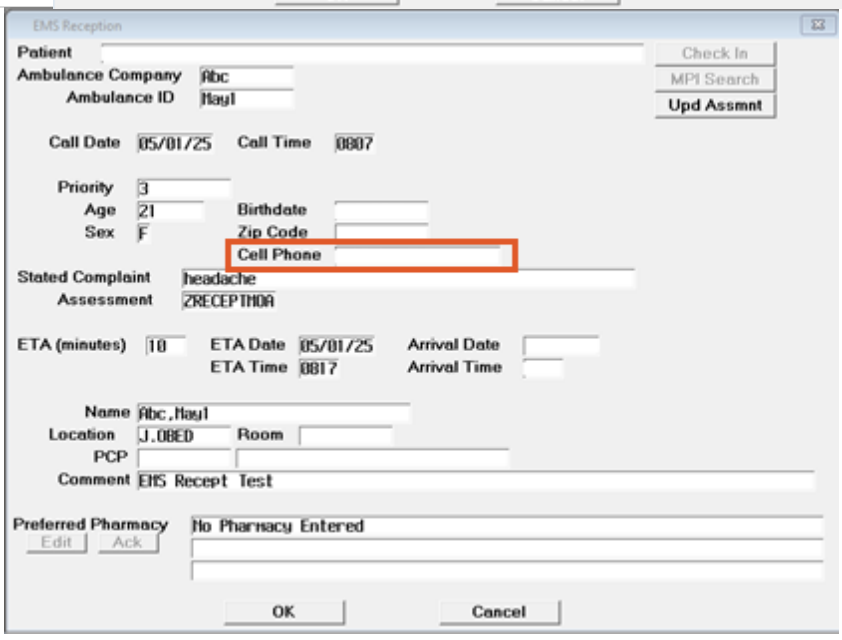


Call-In Reception

Scenario 3: Call-In Recept 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.



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.