

Nursing, EDM & SUR Modules

Pressure Support and Airway Tube Size Update



Current documentation workflows for Respiratory Therapists do not include structured fields for documenting pressure support in BiPAP/CPAP interventions or a response option for airway tube sizes greater than 10.5mm for Intubation interventions. This update adds a *Pressure support* field to all **BiPAP/CPAP** interventions and expands the *Airway tube size* responses to include 11mm, 12mm, and free text option for all **Intubation** interventions.

RT BiPAP/CPAP		The <i>Pressure support (cmH2O)</i> has been added to all RT: BiPAP/CPAP interventions.																																										
☐ Pressure support (cmH2O): <table border="1"> <tr><td>7</td><td>8</td><td>9</td><td>Del</td></tr> <tr><td>4</td><td>5</td><td>6</td><td></td></tr> <tr><td>1</td><td>2</td><td>3</td><td></td></tr> <tr><td>-</td><td>0</td><td>.</td><td>Calc</td></tr> </table> Set tidal volume (mL): O2 Liters per minute: O2 mL per minute: FiO2%: Set IPAP (cmH2O): Set EPAP/CPAP (cmH2O): Pressure support (cmH2O): Set rate (bpm): P max (cmH2O):			7	8	9	Del	4	5	6		1	2	3		-	0	.	Calc																										
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1	2mm	8	5.5mm	15	9mm																																							
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Restraint 2026 Phase 2 Strategic Agenda



As part of the ongoing Corporate Responsible Restraint Program, the 2026 initiative focuses on refining policies and clarifying clinical practice expectations to ensure alignment with The Joint Commission (TJC) and CMS requirements. Restraint documentation workflows have been streamlined to remove duplicative, outdated, and non-required elements. These updates reduce documentation burden, improve regulatory compliance, and enhance efficiency in both bedside care and EHR documentation. The revised workflow standardizes restraint documentation to reflect current regulatory requirements while maintaining existing system programming across all restraint episodes.

In **Start** workflow, *Alternatives utilized* has been updated to *Alternatives attempted* and the response options have been streamlined to better align with policy.

The documentation fields on pages 2 and 3 of the **Start** and **Monitor** workflow have been removed to eliminate duplicative documentation.

Restraint Documentation

☒ Restraints are clinically justified:

1 Yes
2 No

- Second tier review -
Click below to default system normal values
DFT Norms
DFT Norms (Go to File)

--- The following must be reviewed with the RN. ---

Restraints clinically justified: ☐ *

Reasons reviewed: ☐ *

Least restrictive type planned: ☐ *

Alternatives attempted, ineffective documented: ☐ *

Cause of patient reviewed: ☐ *

Consideration for vulnerability: ☐ *

Justified for restraint type/device: ☐ *

Assessed restraints were safely and appropriately applied: ☐ *

Patients rights, dignity, and safety have been upheld: ☐ *

(Prev Page) ☐ (Next Page) ☐

The **Second tier review** documentation has been removed in alignment with recent policy updates.

Note: Second tier review has also been removed from the Restraints Report.

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:

(Prev Page) ☐ (Next Page) ☐

Safety/Rights/Dignity documentation is now only available for violent restraint episodes.

Restraint Documentation

☒ Reviewed/attempted ways to help the patient regain control:

1 Yes
2 No

Reviewed/attempted ways to help the patient regain control: ☐ *

Evaluated the patients immediate situation: ☐ *

Evaluated the patients reaction to the intervention: ☐ *

Evaluated the patients medical and behavioral condition: ☐ *

Evaluated the need to continue or terminate restraint/seclusion:
 *

(Prev Page) ☐ (Next Page) ☐

For Violent level of restraints, the one-time **Face to face** documentation has been reduced.

Restraint Documentation

Response to restraint:

1 Tolerant
2 Combative

- Monitor/RN assess -
Click below to
default system normal values
DFT Norms
DFT Norms (Go to File)

Response to restraint: *

Vital signs taken per unit policy or doctors orders: *

Free from injury or pain associated with restraint: *

Free from respiratory/airway compromise associated with restraint: *

Skin under/around restraint verified (when applicable): *

Range of motion done: *

Response to restraint has been added to the **Monitor/RN assess** documentation. Responses continue to allow for selection of 'DFT Norms' and 'DFT Norms (Go to File)'.

Note: *Monitor/RN assess* may be documented as often as necessary/per policy.

Restraint Documentation

Date restraint discontinued:

Calendar Del
Yesterday
Today
Tomorrow

Date restraint discontinued: *

Time restraint discontinued: *

(Prev Page) (End)

The **Restraint Discontinue** workflow has been updated to require documentation of only the date and time the restraint was discontinued for both Violent and Non-violent workflows.

Restraint Debriefing

Circumstances leading to restraint/seclusion incident:

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

Circumstances leading to restraint/seclusion incident:→

Recommendations for future actions:→

Post counseling provided to: *

Debriefing Comment:→

(End)

The **Restraint Debriefing** documentation has been removed from the Violent level of restraint discontinue workflow documentation.

Nursing & EDM Modules

Telemetry Unavailable Optimization

 In 2024, the field *Telemetry Unavailable and patient maintained on continuous monitor* was added to the EDM Telemetry intervention to allow clinicians to document situations where telemetry is ordered, but a telemetry box is not available. This field will now be included in the nursing module. The field has been moved to be the first question to enhance workflow.

Telemetry Application/Discont

Telemetry unavailable and patient maintained on continuous monitor:

Yes

If a telemetry box is unavailable, place the patient on a continuous monitor and validate that the patient is being monitored.

Telemetry unavailable and patient maintained on continuous monitor:>Yes

Telemetry application date:

Telemetry application time:

RUN DATE: 04/07/26

QAIA FACILITY (QAA) **ADMISSIONS**

PAGE 1

RUN TIME: 1511

Patient Handoff Report

RUN USER: QLS8135

Patient:

J000458827 / J00021598925

Admit/Service Date: 07/10/24

DOB: 05/05/05

Age: 20

Sex: F

Room/Bed: J.X2-61

Code status:

Admitting MD: ODOM

Weight (kg):

Attending MD: ODOM

BMI:

Reason for Visit/Chief Complaint: ASD

Brief History:

Allergies: No Known Allergies

Tele unavailable; on continuous monitor: Yes (04/06/26 1038)

Suicide Risk: None Documented

Pain control goal: None Documented

Mold status: None Documented

Pain scale utilized:

Cardiac Monitor: None Documented

Numeric pain scale:

Diet:

Vaccine Collection Mx: Complete, discharging pt

Influenza Vaccine Status: Not a candidate

Provider Review Vaco Mx: None Documented

If telemetry is unavailable and patient is on a continuous monitor, 'Yes' would be documented in the field.

If 'Yes' is documented:
The rest of the queries on the screen will be bypassed.

Telemetry unavailable will display on the SBAR report with the date and time the intervention was filed.

Telemetry Application/Discont

Telemetry box number:

Enter free text.

Telemetry unavailable and patient maintained on continuous monitor:>

Telemetry application date:>04/07/26*

Telemetry application time:>1200*

RUN DATE: 04/07/26

QAIA FACILITY (QAA) **ADMISSIONS**

PAGE 1

RUN TIME: 1557

Patient Handoff Report

RUN USER: QLS8135

Patient:

J000458827 / J00021598925

Admit/Service Date: 07/10/24

DOB: 05/05/05

Age: 20

Sex: F

Room/Bed: J.X2-61

Code status:

Admitting MD: ODOM

Weight (kg):

Attending MD: ODOM

BMI:

Reason for Visit/Chief Complaint: ASD

Brief History:

Allergies: No Known Allergies

Tele application date: 04/07/26

Tele application time: 1200

Suicide Risk: None Documented

Pain control goal: None Documented

Mold status: None Documented

Pain scale utilized:

Cardiac Monitor: None Documented

Numeric pain scale:

Diet:

Vaccine Collection Mx: Complete, discharging pt

Influenza Vaccine Status: Not a candidate

Provider Review Vaco Mx: None Documented

The documented *Telemetry application date and time* will continue to be displayed on the SBAR report.

Note: When the *Telemetry application date and time* are documented, the previous *Telemetry unavailable* response will be automatically removed from the SBAR report.

Telemetry Application/Disconti

Telemetry discontinued date:

Calendar Del
Yesterday
Today
Tomorrow

Telemetry unavailable and patient maintained on continuous monitor:*

Telemetry application date: 04/07/26*

Telemetry application time: 1430*

Telemetry box number: 12345

Telemetry discontinued date: 04/09/26

Telemetry discontinued time: 0800*

PAGE 1

RUN TIME: 1606 Patient Handoff Report

RUN USER: QLS0135

Patient: J000458827 / J00021598925 Admit/Service Date: 07/10/24
DOB: 05/05/05 Age: 20 Sex: F Room/Bed: J.X2-61
Code status:

Admitting MD: ODOM Weight (kg):
Attending MD: ODOM BMI:
Reason for Visit/Chief Complaint: ASD

Brief History:

Allergies: No Known Allergies

Suicide Risk: None Documented Pain control goal: None Documented
Hold status: None Documented Pain scale utilized:
Cardiac Monitor: None Documented Numeric pain scale:
Diet:

Vaccine Collection Hx: Complete, discharging pt
Influenza Vaccine Status: Not a candidate
Provider Review Vacc Hx: None Documented

Once the *Telemetry discontinued date and time* is documented, the telemetry fields will no longer be displayed on the SBAR report.

STANDARD Nurse Tracker- LCoE (SP=LEARNING CENTER OF EXCELLENCE)

Current Patient **Lcoe,Edpatient - 33/M** J00021620333

RM/LOC/PRI	PT Name/RN/MD	Age/Sex/Status	Complaint/Orders	LOS
MAIN12	Lcoe,Edpatient	33 M SUN	Cardiac Re	
MAIN11-1	TROTTER, DYER, TAN	PRE C	MED RAD RN	
holding			TELE holding	
MAIN50	Test, Sarah	51 F TR	GI/Abdomin	
MAIN 3	TROTTER, DR.CPOE	REG E		

ED TRACKER

For ED patients on Inpatient Hold with a Telemetry Initial Order, a TELE indicator displays on the ED Tracker. Click the indicator to open the charting screen. Refer to the *ED INPT HOLD Telemetry Administrator Guide* for additional details.

Nursing Intervention	Emergency Department Treatment
Tele App/Discon *ORDER REQUIRED*	Telemetry Application/Disconti

Nursing & Ancillary Modules

Nutritional Related Diagnosis



The response options for *Nutrition related diagnosis* were not sufficiently defined to meet CMS guidelines. This update introduces more detailed response options to support precise documentation that can be included in provider documentation and ensures CMS compliance.

Nutrition Assessment J00021639878 LCOE,TEST

Nutrition related diagnosis:	
1 Mild malnutrition	7 Obese class I
2 Moderate malnutrition	8 Obese class II
3 Severe malnutrition	9 Obese class III - Morbid
4 Underweight	
5 Normal weight	
6 Overweight	

Nutrition monitoring:→

Nutrition related diagnosis:→

Nutrition diagnosis details:→

Responses for the *Nutrition related diagnosis* field have been updated to include:

- Mild malnutrition
- Moderate malnutrition
- Severe malnutrition
- Underweight
- Normal weight
- Overweight
- Obese class I
- Obese class II
- Obese class III - Morbid

Note: A malnutrition response for adult patients in *Nutrition related diagnosis* will skip the *Nutrition diagnosis details* field.

Nursing

Nutritional Assessment

Alteplase - Alignment with Large Volume IV Pump Library

Alteplase is a high alert medication with risk of bleeding adverse events including intracranial hemorrhage. Multiple indications and multiple dosing strategies pose increased patient safety risk. This enhancement will update v5 adult admin criteria with new screens for alteplase for new indications to align with the IV pump standardization.

The new enhancements consist of the following:

- Two additional screens have been created for Alteplase to treat STEMI and Frostbite.
- The new screens will include dosing calculations using the patient's weight.
- New screens will calculate the amount to waste for doses that are less than 100 mg.

New Screens – Provider View

Alteplase – STEMI

Enter/Edit Rx's Administration Criteria

Administration Criteria: **Alteplase - STEMI ADLT05**

Erase Admin Crit
Save as Favorite

Patient's Weight (kg): 78.93 *

Loading Dose: 15 mg over 1 * minute(s)

Initial Infusion Dose: 0.75 mg/kg = 50 * mg over 30 min

** Initial Infusion maximum dose: 50 mg **

Subsequent Infusion Dose: 0.5 mg/kg = 35 * mg over 60 min

** Subsequent infusion maximum dose: 35 mg **

Total Dose: 100 * mg

** Maximum TOTAL Dose: 100 mg **

Amount to waste: 0 * mg

Dosing calculations using the patient's weight

"Amount to waste" field

Ok Cancel Help Prev Next



Alteplase - IV Frostbite

Enter/Edit Rx's Administration Criteria

Administration Criteria: **Alteplase-IV Frostbite ADLT05**

Erase Admin Crit
Save as Favorite

Patient's Weight (kg): **80.00** *

Loading Dose: 0.15 mg/kg = **12** * mg over 15 min
Infusion Dose: 0.15 mg/kg/hr = **72** * mg over 6 hours

Total Dose: **84** * mg
** Maximum TOTAL Dose: 100 mg **

Amount to waste: **16** mg

"Amount to waste" field

Ok Cancel Help Prev Next

New Screens – Pharmacy View

Alteplase – STEMI

Enter/Edit Admin Criteria

Mnemonic: **hrx.aALT5C** Active: ☒ Description: **Alteplase - STEMI ADLT05**
Display: Type: **CDS**

CDS: **hcarx.ALTEPL05C**

Patient's Weight (kg): **78.93** *

Loading Dose: 15 mg over **1** * minute(s)
Initial Infusion Dose: 0.75 mg/kg = **50** * mg over 30 min
** Initial Infusion maximum dose: 50 mg **
Subsequent Infusion Dose: 0.5 mg/kg = **35** * mg over 60 min
** Subsequent infusion maximum dose: 35 mg **
Total Dose: **100** * mg
** Maximum TOTAL Dose: 100 mg **

Amount to waste: **0** * mg

"Amount to waste" field

Ok Cancel Help Prev Next

Alteplase – IV Frostbite

Enter/Edit Admin Criteria

Mnemonic Active ☒ Description
Display Type

CDS

Patient's Weight (kg): *

Loading Dose: 0.15 mg/kg = * mg over 15 min
Infusion Dose: 0.15 mg/kg/hr = * mg over 6 hours

Total Dose: * mg
** Maximum TOTAL Dose: 100 mg **

Amount to waste: mg

Ok Cancel Help Prev Next

Dosing calculations using the patient's weight

"Amount to waste" field