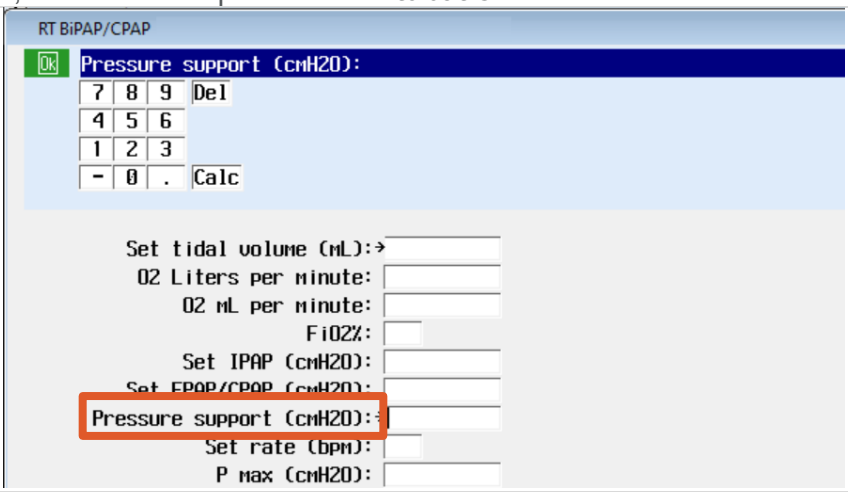
Nursing, EDM & SUR Modules

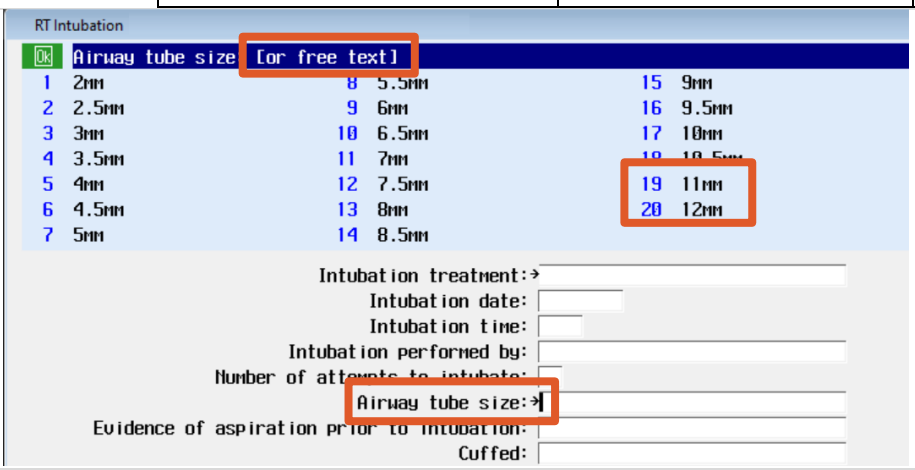
Pressure Support and Airway Tube Size Update

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.



The *Pressure support (cmH20)* has been added to all **RT: BiPAP/CPAP** interventions.

Nursing		Emergency Department
RT: BiPAP/CPAP Initial	RT PED: BiPAP/CPAP Initial	RT: BiPAP/CPAP
RT: BiPAP/CPAP Subsequent	RT PED: BiPAP/CPAP Subsequent	
RT: BiPAP/CPAP		



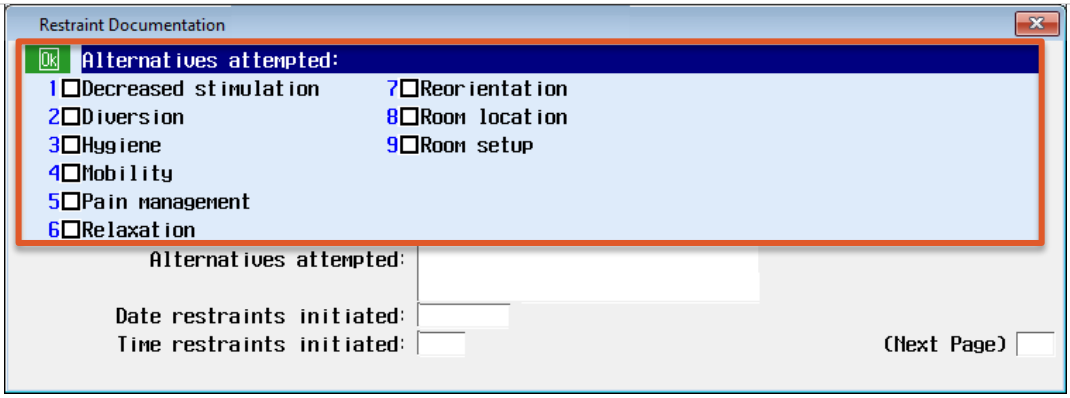
Additional responses have been added to the *Airway tube size* field within all **RT: Intubation** interventions:

- Free text
- 11mm
- 12mm

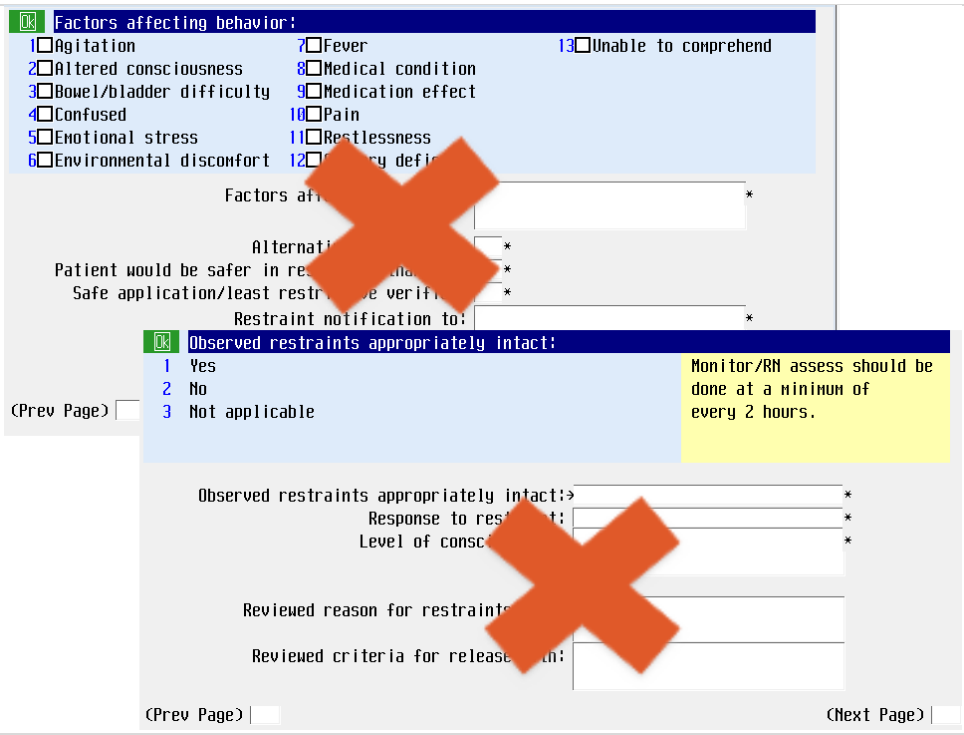
Nursing		Emergency Department	Surg
Lines/Drains/Airways	RT: Intubation Assist- Inpatient	Intubation	SURG: Lines/Drains/Airways Intra-op
Critical Care Flowsheet	RT: Intubation Assist- Outpatient	Newborn Stabilization	SURG: Lines/Drains/Airways PACU
RT: Intubation- Inpatient	RT PED: Intubation Assist- Inpatient	RT: Intubation Assist- Output	SURG: Lines/Drains/Airways Pre-op
RT: Intubation- Outpatient	RT PED: Intubation Assist- Outpatient	RT: Intubation- Output	
RT PED: Intubation- Outpatient	RT: Ventilator Flowsheet	RT: Neonatal Intubation	
RT: Neonatal Intubation	RT PED: Ventilator Flowsheet	RT: Ventilator Flowsheet	
RT PED: Neonatal Intubation			

Restraint 2026 Phase 2 Strategic Agenda

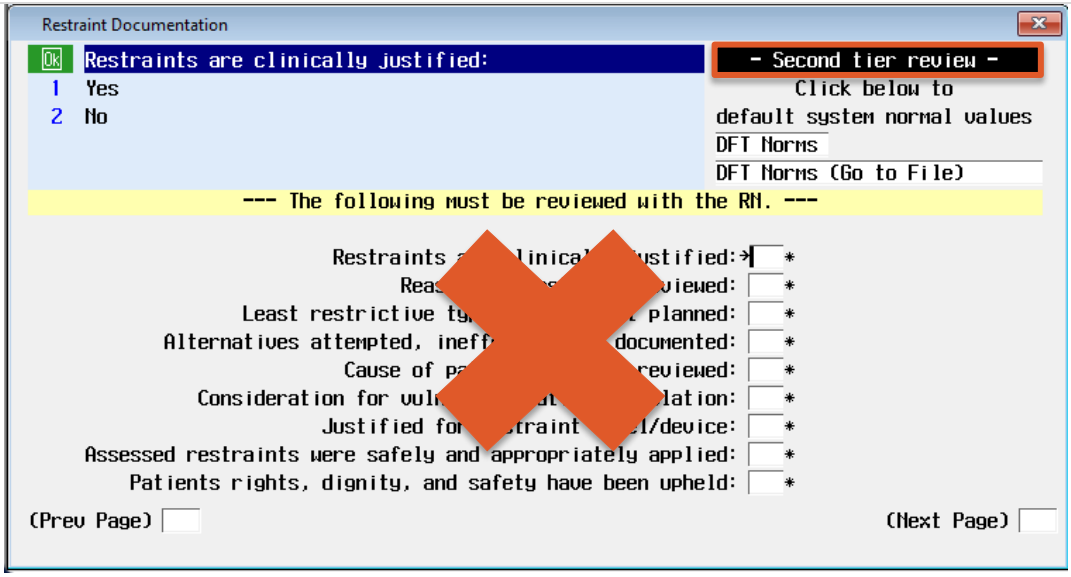
As part of the ongoing Corporate Responsible Restraint Program, the 2026 initiative focuses on refining policies and clarifying clinical practice expectations to ensure alignment with The Joint Commission (TJC) and CMS requirements. Restraint documentation workflows have been streamlined to remove duplicative, 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.

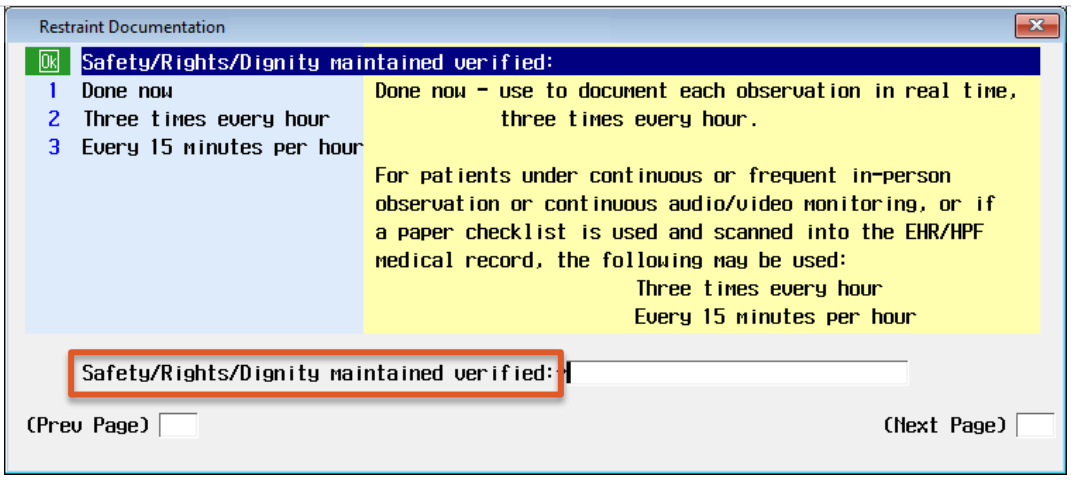


The documentation fields on pages 2 and 3 of the **Start** and **Monitor** workflow have been removed to eliminate duplicative documentation.

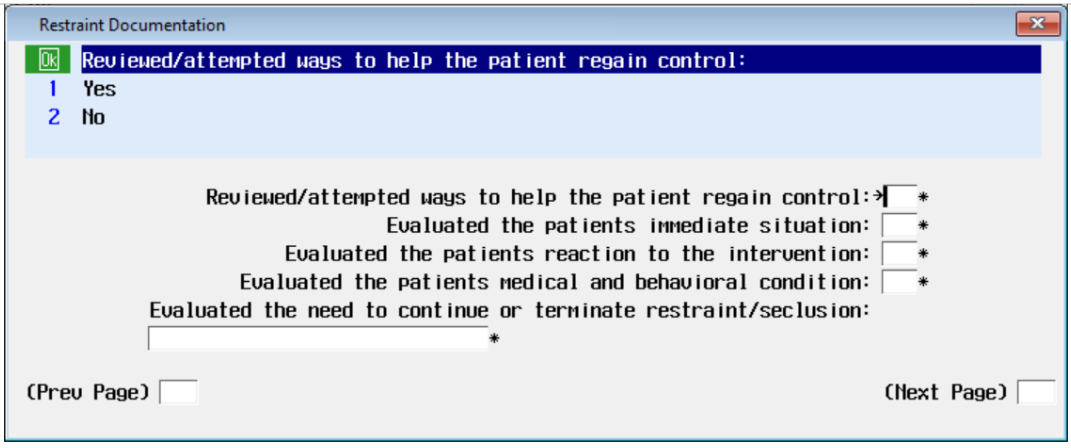


The **Second tier review** documentation has been removed in alignment with recent policy updates.

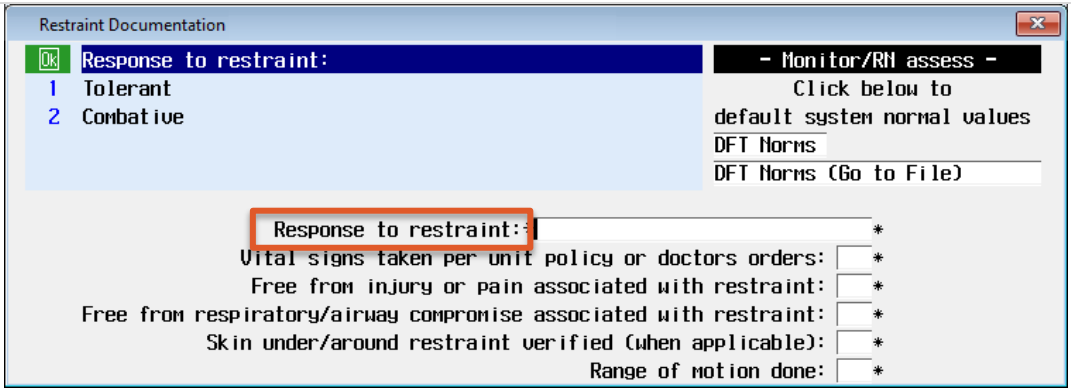
Note: Second tier review has also been removed from the Restraints Report.



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

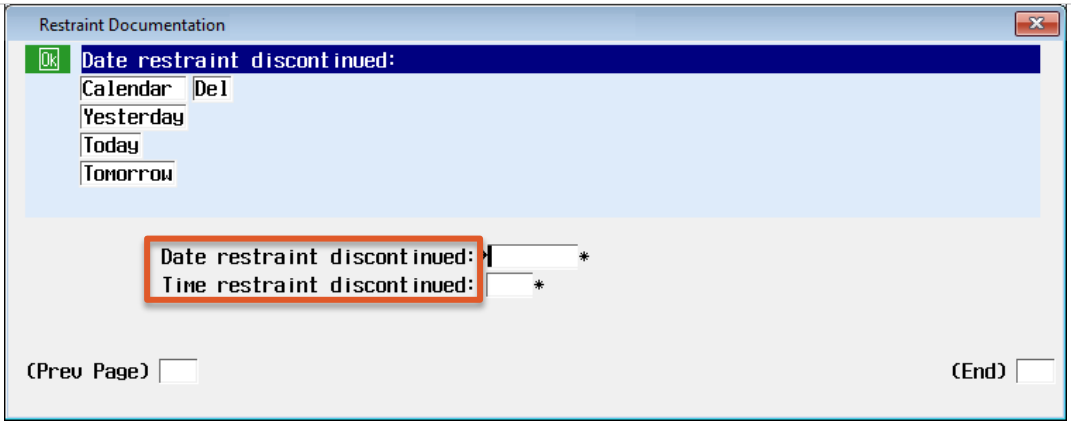


For Violent level of restraints, the one-time **Face to face** documentation has been reduced.

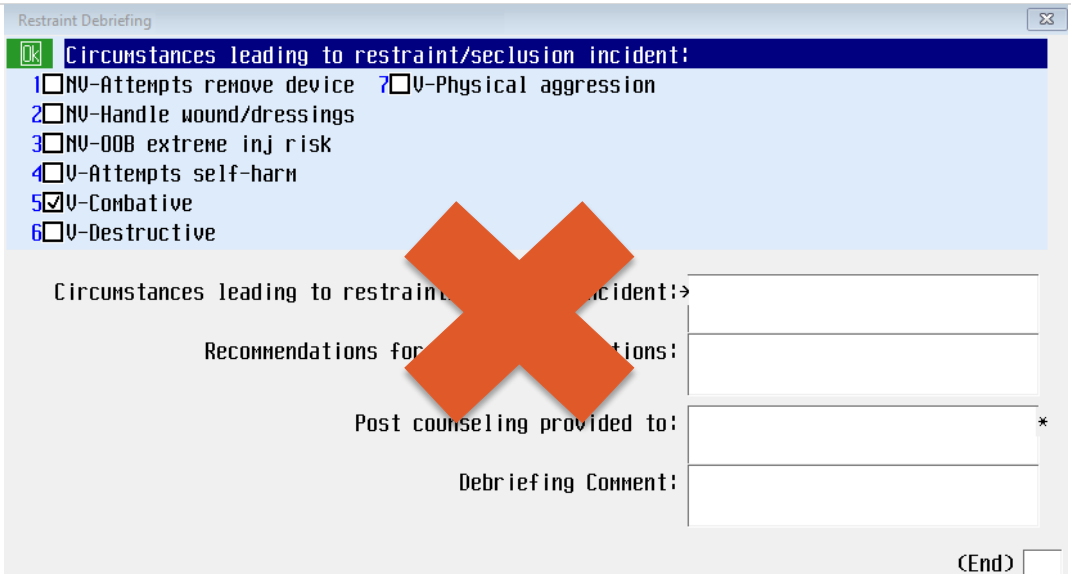


Response to restraint has been added to the **Monitor/RN assess** documentation. Responses continue to allow for selection of 'DFT Norms' and 'DFT Norms (Go to File)'.

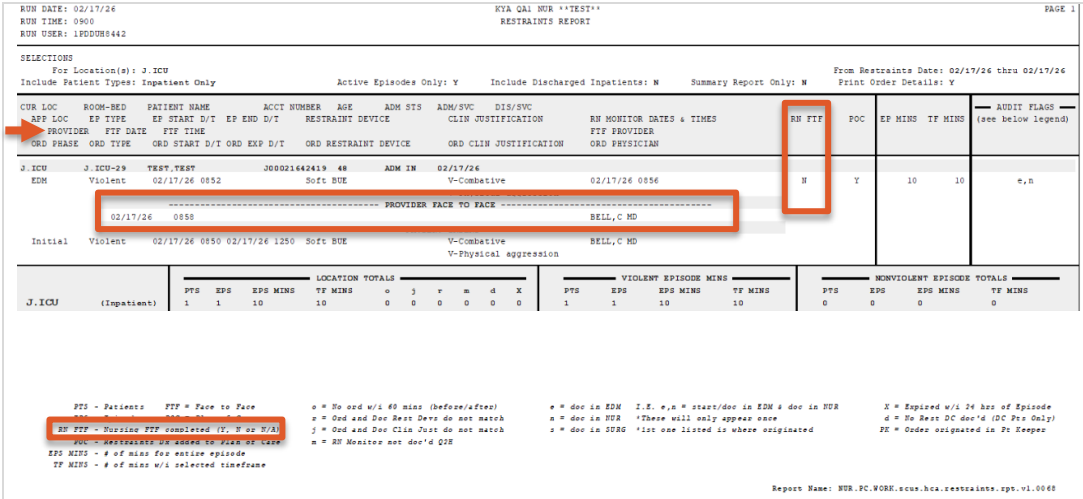
Note: *Monitor/RN assess* may be documented as often as necessary/per policy.



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.



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



RUN DATE: 02/17/26
RUN TIME: 0900
RUN USER: 1PDDUH8442

KYA QA1 NUR **TEST**
RESTRAINTS REPORT

PAGE 1

SELECTIONS
For Location(s): J.ICU
Include Patient Types: Inpatient Only
Active Episodes Only: Y
Include Discharged Inpatients: N
Summary Report Only: N
From Restraints Date: 02/17/26 thru 02/17/26
Print Order Details: Y

CUR LOC / APP LOC / PROVIDER / ORD PHASE	ROOM-BED / EP TYPE / FTF DATE / ORD TYPE	PATIENT NAME / EP START D/T / FTF TIME / ORD START D/T	ACCT NUMBER / EP END D/T / ORD EXP D/T	AGE / RESTRAINT DEVICE / ORD RESTRAINT DEVICE	ADM STS / CLIN JUSTIFICATION / ORD CLIN JUSTIFICATION	ADM/SVC / RN MONITOR DATES & TIMES / FTF PROVIDER / ORD PHYSICIAN	DIS/SVC	RN FTF	POC	EP MINS	TF MINS	AUDIT FLAGS (see below legend)
J.ICU / EDM	J.ICU-29 / Violent	TEST,TEST / 02/17/26 0852	J00021642419 /	48 / Soft BUE	ADM IN / V-Combative	02/17/26 / 02/17/26 0856		N	Y	10	10	e,n
		PROVIDER FACE TO FACE										
		02/17/26 0858				BELL,C MD						
Initial	Violent	02/17/26 0850	02/17/26 1250	Soft BUE	V-Combative V-Physical aggression	BELL,C MD						

	LOCATION TOTALS									VIOLENT EPISODE MINS				NONVIOLENT EPISODE TOTALS			
	PTS	EPS	EPS MINS	TF MINS	o	j	r	m	d	X	PTS	EPS	EPS MINS	TF MINS	PTS	EPS	EPS MINS	TF MINS
J.ICU (Inpatient)	1	1	10	10	0	0	0	0	0	0	1	1	10	10	0	0	0	0

PTS - Patients
FTF = Face to Face
RN FTF - Nursing FTF completed (Y, N or N/A)
POC - Restraints DX added to Plan of Care
EPS MINS - # of mins for entire episode
TF MINS - # of mins w/i selected timeframe

o = No ord w/i 60 mins (before/after)
r = Ord and Doc Rest Devs do not match
j = Ord and Doc Clin Just do not match
m = RN Monitor not doc'd Q2H

e = doc in EDM I.E. e,n = start/doc in EDM & doc in NUR
n = doc in NUR *These will only appear once
s = doc in SURG *1st one listed is where originated

X = Expired w/i 24 hrs of Episode
d = No Rest DC doc'd (DC Pts Only)
PK = Order originated in Pt Keeper

Report Name: NUR.PC.WORK.ncus.hca.restraints.rpt.v1.0068

Note: RN FTF has been added to the legend.

The Restraints Report has been updated with the following changes:

- Face to face column has been updated to RN FTF.
- A new header and row have been added to indicate when the Face-to-face was completed by a provider. It will display the provider's name along with the date and time documented. If the documentation is completed using PK, then that will be displayed in lieu of the provider's name.

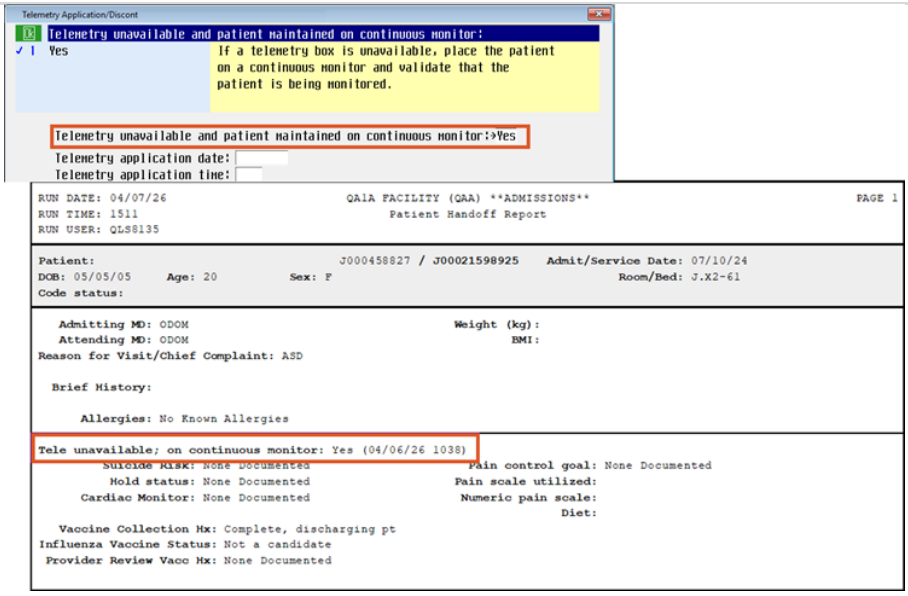
This update affects the following interventions:

Nursing	Emergency Department	Surgery
Restraint Documentation +	Restraint Documentation	SURG: Restraints Documentation Pre-op +
		SURG: Restraints Documentation Intra-op+
		SURG: Restraints Documentation PACU +

Nursing & EDM Modules

Telemetry Unavailable Optimization

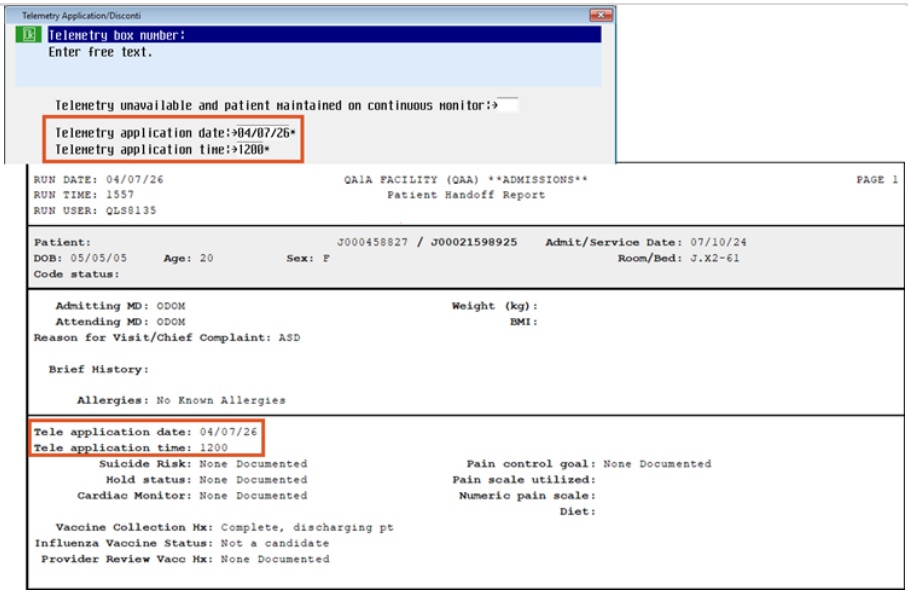
In 2024, the field *Telemetry Unavailable and patient maintained on continuous monitor* was added to the EDM Telemetry intervention to allow clinicians to document situations where telemetry is ordered, but a telemetry box is not available. This field will now be included in the nursing module. The field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



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

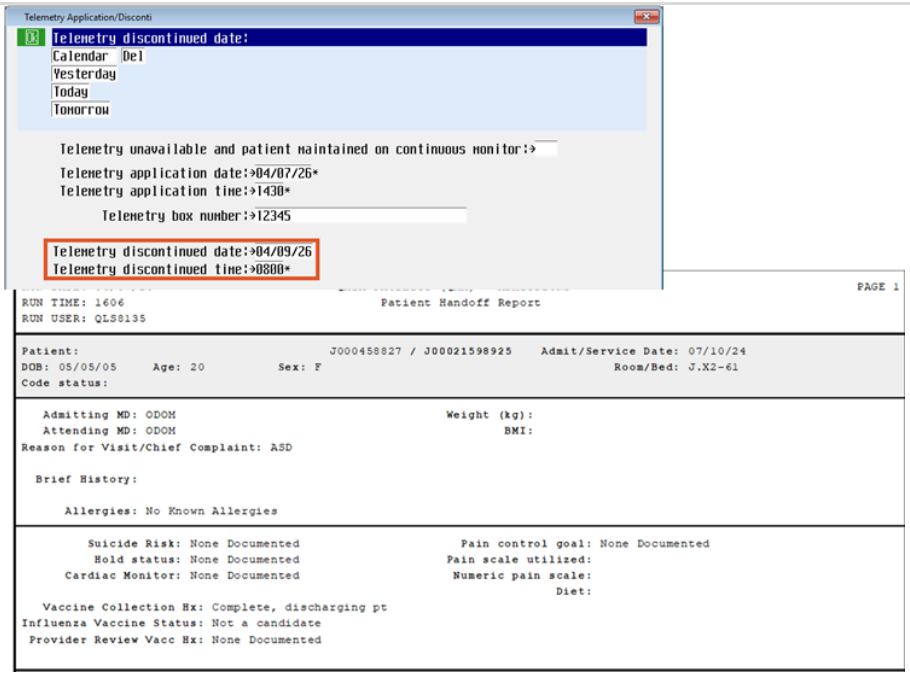
If 'Yes' is documented:
The rest of the queries on the screen will be bypassed.

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

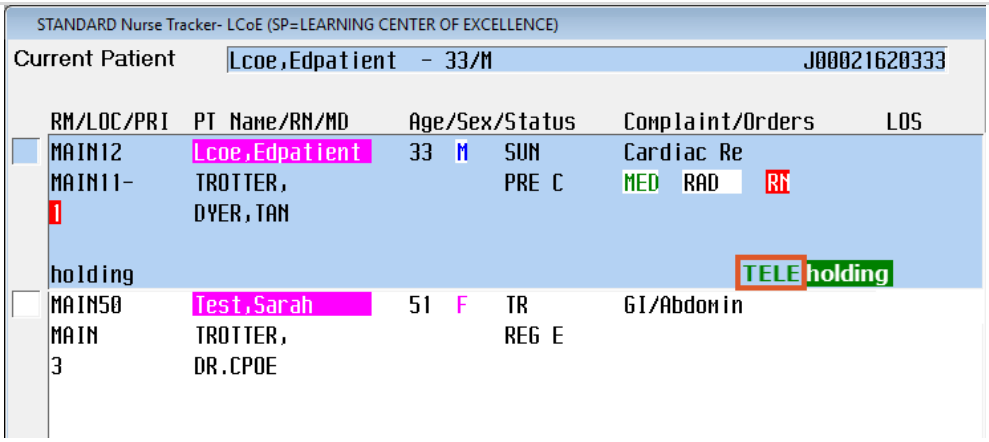


The documented T*elemetry application date and time* will continue to be displayed on the SBAR report.

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



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



ED TRACKER

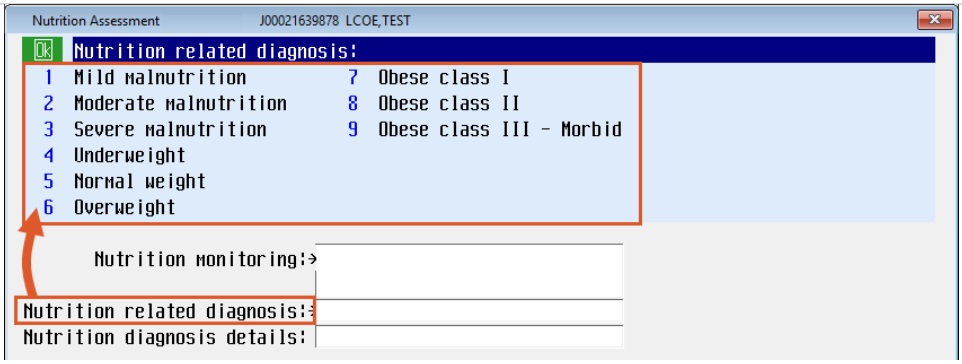
For ED patients on Inpatient Hold with a Telemetry Initial Order, a TELE indicator displays on the ED Tracker. Click the indicator to open the charting screen. Refer to the *ED INPT HOLD Telemetry Administrator Guide* for additional details.

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.



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

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

Nursing
Nutritional Assessment

Alteplase - Alignment with Large Volume IV Pump Library

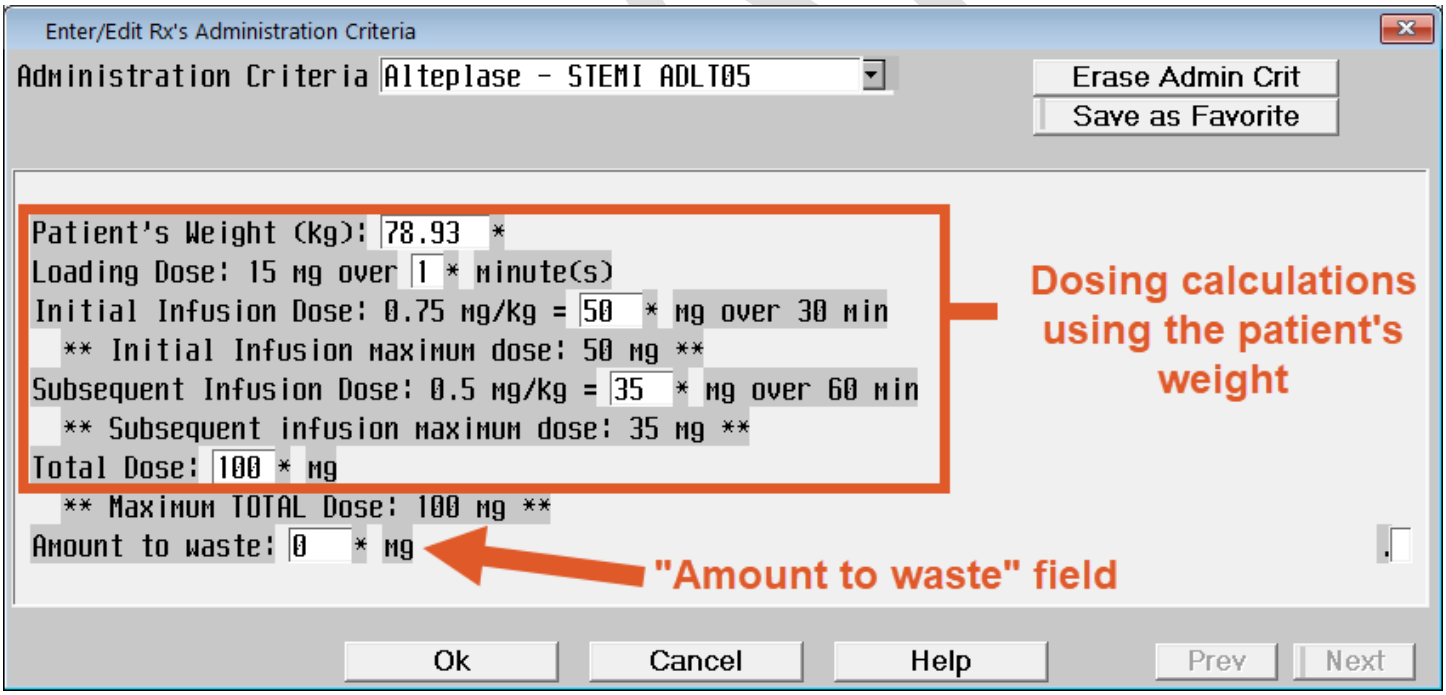
Alteplase is a high alert medication with risk of bleeding adverse events including intracranial hemorrhage. Multiple indications and multiple dosing strategies pose increased patient safety risk. This enhancement will update v5 adult admin criteria with new screens for alteplase for new indications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

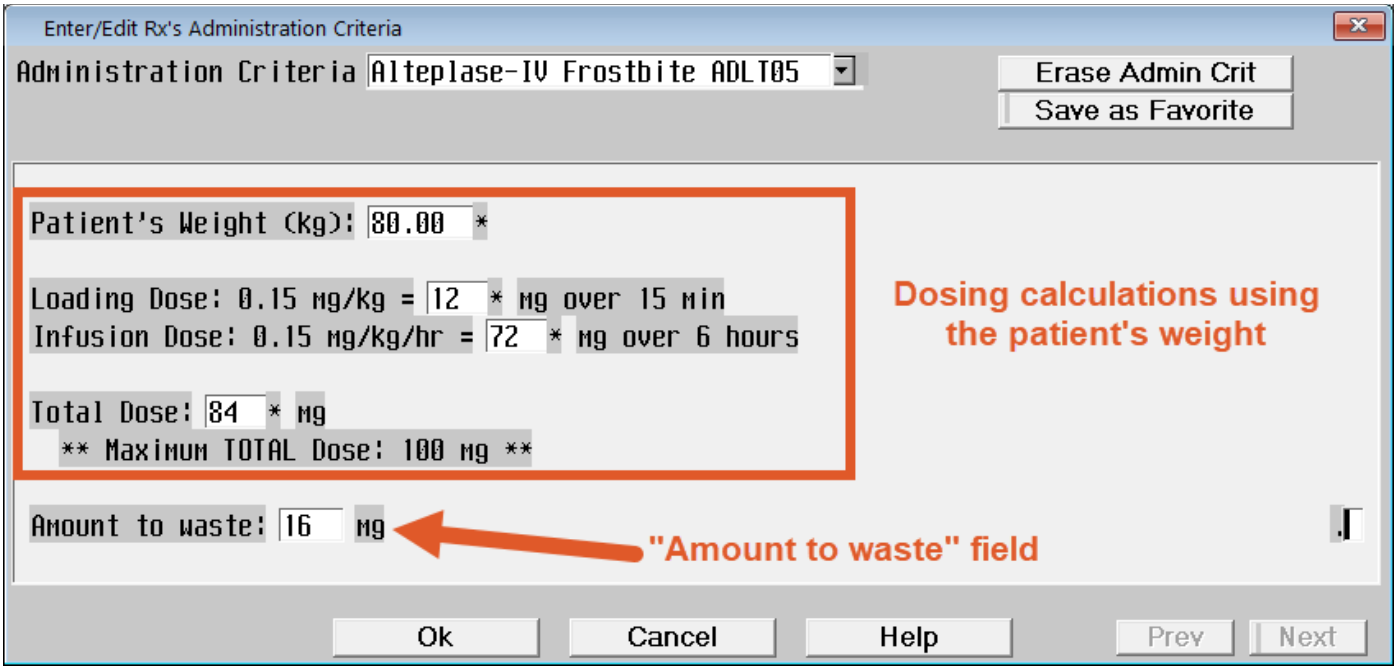
New Screens – Provider View

Alteplase – STEMI



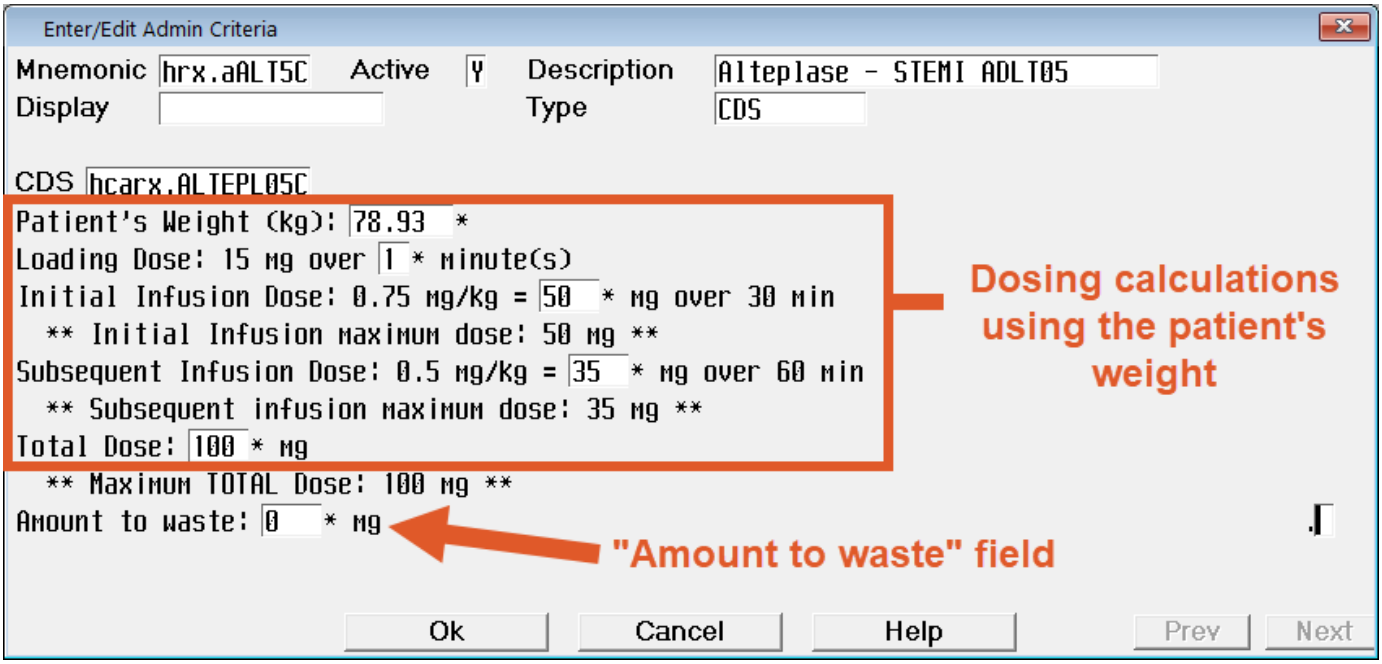
CORP.PharmacyTeam@HCAHealthcare.com

Alteplase - IV Frostbite



New Screens – Pharmacy View

Alteplase – STEMI



Alteplase – IV Frostbite