

# EBCD MEDITECH Content Updates – 2023.2

## All Modules

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### Overview

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

Inpatient Rehab Facility Enhancements education will be posted separately.

### How to use this guide

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

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

### Impact Legend:

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

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

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

*Click the topic name to be taken to the specific documentation within this update:*

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## Summary of Revisions

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Date	Revision
03/01/2023	Updated ICP Monitoring Interventions
03/02/2023	Updated YIB for Safety/Risk/Regulatory

# Nursing, OR and ED Modules

## Fall Risk Assessment

### CHAMPS Pediatric Fall Risk Assessment

The **CHAMPS Pediatric Fall Risk Assessment** should be completed for all pediatric ages, less than 18 years of age, in the Pediatric areas.

Fall Risk Tool Identifier

Ok Fall risk tool identifier:

1  Adult medical/surg/OB/ED Select all that apply

2  Behavioral health

3  Inpatient rehab

4  Maternal/newborn

5  Pediatric

Fall risk tool identifier:>Pediatric

(End)

For the CHAMPS Pediatric Fall Risk, the Pediatric population is selected in the *Fall risk tool identifier* field.

Once the Pediatric response is selected, the appropriate documentation will populate.

Each following field noted with an asterisk is required.

Pediatric Fall Risk - CHAMPS

Ok Change in mental status:

1 1-Yes

2 0-No

Episodes of disorientation, dizziness, or confusion related to post-op status, medication (high dose of narcotics, rapid weaning of sedation), or illness. Newborn/infant indicators may include irritability, agitation, inconsolability, or nonresponsiveness to auditory, visual or tactile stimuli.

Change in mental status:> \*

History of falls: \*

Age less than 36 months: \*

Mobility impairment: \*

CHAMPS fall score and risk level:

Parental involvement:

Safety interventions:

(End)

The *Change in mental status* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

Episodes of disorientation, dizziness, or confusion related to post-op status, medication (high dose of narcotics, rapid weaning of sedation), or illness. Newborn/infant indicators may include: irritability, agitation, inconsolability, or nonresponsiveness to auditory, visual or tactile stimuli.

Pediatric Fall Risk - CHAMPS

History of falls:

1 1-Yes  
2 0-No

Accidental fall = a developmentally inappropriate fall. Patient has experienced an accidental fall recently.

Change in mental status: 0-No \*

History of falls: 0-No \*

Age less than 36 months: \*

Mobility impairment: \*

CHAMPS fall score and risk level: 0-Low Risk

Parental involvement:

Safety interventions:

(End)

The *History of falls* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

Accidental fall = a developmentally inappropriate fall. Patient has experienced an accidental fall recently.

Pediatric Fall Risk - CHAMPS

Age less than 36 months:

1 1-Yes  
2 0-No

Yes if less than 36 months of age chronologically or developmentally.

Change in mental status: 0-No \*

History of falls: 1-Yes \*

Age less than 36 months: 1-Yes \*

Mobility impairment: \*

CHAMPS fall score and risk level: 1-High Risk

Parental involvement:

Safety interventions:

(End)

The *Age less than 36 months* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

Yes if less than 36 months of age chronologically or developmentally.

**Note:** As you complete the fields, the *CHAMPS score and risk level* is calculated.

Pediatric Fall Risk - CHAMPS

**Mobility impairment:**

1 1-Yes  
2 0-No

Mobility includes ability to get in/out of bed/crib unassisted as well as ability to utilize bathroom without assistance. Yes-patient needs help of furniture/walls to ambulate. Yes-patient needs crutches, walker or other assistive device to ambulate. Yes-patient needs assistance of one or two people to ambulate. Yes-patient is less than one year of age.

Change in mental status: 0-No \*  
History of falls: 1-Yes \*  
Age less than 36 months: 0-No \*  
**Mobility impairment: 0-No \***

CHAMPS fall score and risk level: 1-High Risk

Parental involvement:   
Safety interventions:

(End)

The *Mobility impairment* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

Mobility includes ability to get in/out of bed/crib unassisted as well as ability to utilize bathroom without assistance. Yes-patient needs help of furniture/walls to ambulate. Yes-patient needs crutches, walker or other assistive device to ambulate. Yes-patient needs assistance of one or two people to ambulate. Yes-patient is less than one year of age.

Pediatric Fall Risk - CHAMPS

**CHAMPS fall score and risk level:**

Last documented on Admission History:  
Falls within the past 3 months: No - 09/28/21 at 1850

Last documented on Post Fall Assessment during this admission within the last 3 months:  
Type of fall: No results found

Change in mental status: 0-No \*  
History of falls: 1-Yes \*  
Age less than 36 months: 0-No \*  
Mobility impairment: 0-No \*

**CHAMPS fall score and risk level: 1**

Parental involvement:   
Safety interventions:

(End)

The *CHAMPS score and risk level* field is calculated from the documentation above and is only editable by changing the prior responses.

The Yellow Information Box guides the clinician on previous documented falls:

Last documented on Admission History:  
Falls within the past 3 months: No – MM/DD/YY at HHMM

Last documented on Post Fall Assessment during this admission within the last 3 months:  
Type of fall: No results found

Pediatric Fall Risk - CHAMPS

**Parental involvement:**

1 Yes  
2 No

Change in mental status:  \*

History of falls:  \*

Age less than 36 months:  \*

Mobility impairment:  \*

CHAMPS fall score and risk level:

**Parental involvement:**

Safety interventions:

(End)

The *Parental involvement* field has the following responses:

- Yes
- No

Pediatric Fall Risk - CHAMPS

**Safety interventions: [or free text]**

1  Assistive devices      8  Physical PSA  
2  Bed/chair alarm      9  Slow position changes  
3  Change bed to crib      10  Supervised/assisted ambul  
4  Diversion techniques      11  Supervised toileting  
5  Gait belt      12  Virtual PSA  
6  Low bed      13  Visual aids accessible  
7  Med review/timing optimiz

Change in mental status:  \*

History of falls:  \*

Age less than 36 months:  \*

Mobility impairment:  \*

CHAMPS fall score and risk level:

**Parental involvement:**

**Safety interventions:**

(End)

*Safety interventions* is a multi-select field with the following responses:

- Assistive devices
- Bed/chair alarm
- Change bed to crib
- Diversion techniques
- Gait belt
- Low bed
- Med review/timing optimiz
- Physical PSA
- Slow position changes
- Supervised/assisted ambul
- Supervised toileting
- Virtual PSA
- Visual aids accessible

This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Safety/Risk/Regulatory +	SURG: Safety/Risk/Regulatory +	Fall Risk Assessment
	SURG: Safety/Risk/Regulatory Int +	
	SURG: Safety/Risk/Regulatory PAC +	

# ICP Monitoring



For accuracy of trending for the evaluation of patients, the unit of measure of mmH2O for ICP documentation is inaccurate and has been removed.

The *mmH2O* field has been removed.

This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Vital Signs	SURG: IV Drip Titration PAC + SURG: IV Drip Titration Pre +	Vital Signs
IV Drip Status		Triage Reassessment
Critical Care Flowsheet		IV Drip Status
	Paramedic Intake	
	Detailed Flowsheet	
	Disposition – DC/TX/ADM/LPT	
	ICP Monitoring	
		Newborn Stabilization

# ICP/Ventriculostomy



The location for the ICP level has been updated to remove the numeric options, reducing clinician confusion.

ICP/Ventriculostomy

Ok Ventricular device set at mmHg:  
Enter free text.

Ventricular device: External ventricular \*

Location: Frontal region right \*

Instance list status: Active \*

Ventricular device status: Monitor

Ventricular device set at mmHg:

Ventricular device set at cmH2O:

Drain status:

Level:

(Next Page)

*Ventricular device marked at mmHg has changed to Ventricular device set at mmHg.*

ICP/Ventriculostomy

Ok Ventricular device set at cmH2O:  
Enter free text.

Ventricular device: External ventricular \*

Location: Frontal region right \*

Instance list status: Active \*

Ventricular device status: Monitor

Ventricular device set at mmHg:

Ventricular device set at cmH2O:

Drain status:

Level:

(Next Page)

*Ventricular device marked at cmH2O has changed to Ventricular device set at cmH2O.*

The *Level/* field has removed the numerical responses.

ICP/Ventriculostomy

Level: [for free text]

- 1 Above ext auditory meatus
- 2 At ext auditory meatus
- 3 Below ext auditory meatus

Ventricular device: External ventricular \*

Location: Frontal region right \*

Instance list status: Active \*

Ventricular device status: Monitor

Ventricular device set at mmHg:

Ventricular device set at cmH2O:

Drain status:

Level:

(Next Page)

This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Trig: ICP Ventriculostomy	ICP Ventriculostomy	ICP Ventriculostomy
ICP Ventriculostomy	SURG: Lines, Drains, Airways Pre-op +	Newborn Stabilization
Critical Care Flowsheet	SURG: Lines, Drains, Airways Intra-op +	
Lines/Drains/Airways	SURG: Lines, Drains, Airways PACU +	

# Urinary Catheter



If a **Temporary/indwelling** catheter type has been started previously and no discontinue date and time has been recorded, the Temporary/indwelling catheter insertion information will now default in *Uneditable* until the Discontinue has been filed.

An existing “Temporary/indwelling catheter” type will be the only Urinary catheter type available for documentation until it has been documented as discontinued.

If a clinician selects an existing documented **External/condom** urinary catheter and attempts to change the *Urinary catheter type* to either “Temporary/indwelling” or “Straight”, the defaulted *Insertion date* and *time* will be cleared and a new Start for the new *Urinary catheter type* must be documented.

Urinary Catheter

Indication for urinary catheter:

1 Accurate I/O and crit ill	7 Palliative care	Patient should have specific order for chronic indwelling catheter.
2 Acute retention/obstruct	8 Perioperative procedure	
3 Assist in skin healing	9 Peripartum	
4 Chronic	10 Prolonged immobilization	
5 Gross hematuria/irrigate		
6 Meets removal protocol		

Urinary catheter type: Temporary/indwelling \*

Insertion/applied date: 01/18/23\*

Insertion/applied time: 1110\*

Indication for urinary catheter: \*

Urinary catheter status: \*

External/condom change date: \*

External/condom change time: \*

(Next Page)

Urinary ca Select

Insertion/a

Insertion/a 1 NEW

2 External/condom 12/21/22 1047

Indication for urinary catheter: \*

Urinary catheter status: \*

External/co

External/co

Urinary Catheter

Urinary catheter type:

1 Temporary/indwelling
✓ 2 External/condom
3 Straight

Urinary catheter type: External \*

Insertion/applied date: 01/18/23\*

Insertion/applied time: 1119\*

Indication for urinary catheter: \*

Urinary catheter status: \*

External/condom change date: \*

External/condom change time: \*

(Next Page)

Urinary Catheter

Insertion/applied date:  
 Calendar Del  
 Yesterday  
 Today  
 Tomorrow

Urinary catheter type:→Straight \*

Insertion/applied date:→ \*  
 Insertion/applied time:→ \*

Indication for urinary catheter:→ \*  
 Urinary catheter status:→

External/condom change date:   
 External/condom change time:

(Next Page)

This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Critical Care Flowsheet	Lines/Drains/Airways – Urinary Catheter	Newborn Stabilization
Lines/Drains/Airways – Urinary Catheter		Urinary Catheter

# Nursing and OR Modules

## Fall Risk Tool Identifier Update – Safety/Risk/Regulatory

The **Fall Risk Screening** has been updated to align with the evidence-based HCA standardized fall screening tools based upon the patient's age and location.



Fall Risk Tool Identifier

Ok Fall risk tool identifier: Select all that apply

1 Adult medical/surg/OB/ED  
 2 Behavioral health  
 3 Inpatient rehab  
 4 Maternal/newborn  
 5 Pediatric

Fall risk tool identifier:\*

(End)

The *Fall risk tool identifier* field pops to each corresponding Fall Risk tool when the patient population is selected.

- Adult medical/surg/OB/ED → Morse Fall Scale
- Behavioral health → Wilson Sims Fall Risk
- Inpatient rehab → Fall Risk
- Maternal/newborn → Maternal/newborn Fall Risk
- Pediatric → CHAMPS Fall Risk

This is a multi-select field.

## Wilson Sims Fall Risk Assessment Tool

Fall Risk Tool Identifier

Ok Fall risk tool identifier: Select all that apply

1 Adult medical/surg/OB/ED  
 2 Behavioral health  
 3 Inpatient rehab  
 4 Maternal/newborn  
 5 Pediatric

Fall risk tool identifier: Behavioral health

(End)

For the Wilson Sims Fall Risk, the Behavioral health population is selected in the *Fall risk tool identifier* field.

Once the Behavioral health response is selected, the appropriate documentation will populate.

Each following field noted with an asterisk is required.

BH Fall Risk - Wilson Sims

Age:

- 1 0-18 years to 59 years
- 2 1-60 years to 70 years
- 3 2-71 years or greater

Age: > \*  
 Gender: \*  
 Mental status: \*  
 Physical status: \*  
 Elimination: \*  
 Impairments: \*  
 Gait or balance: \*  
 History of falls in past 6 months: \*  
 Mood stabilizer medications: \*  
 Benzodiazepines: \*  
 Narcotics: \*

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The *Age* field has the following responses:

- 0- 18 years to 59 years
- 1- 60 years to 70 years
- 2- 71 years or greater

BH Fall Risk - Wilson Sims

Gender:

- 1 0-Male
- 2 1-Female

Age: > 0-18 years to 59 years \*  
 Gender: > \*  
 Mental status: \*  
 Physical status: \*  
 Elimination: \*  
 Impairments: \*  
 Gait or balance: \*  
 History of falls in past 6 months: \*  
 Mood stabilizer medications: \*  
 Benzodiazepines: \*  
 Narcotics: \*

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The *Gender* field has the following responses:

- 0- Male
- 1- Female

BH Fall Risk - Wilson Sims

Mental status:

- 1 0-Oriented/cooperative
- 2 1-Oriented/uncooperative
- 3 2-Confused, mem loss, intox

Age: > 0-18 years to 59 years \*  
 Gender: > 1-Female \*  
 Mental status: > \*  
 Physical status: \*  
 Elimination: \*  
 Impairments: \*  
 Gait or balance: \*  
 History of falls in past 6 months: \*  
 Mood stabilizer medications: \*  
 Benzodiazepines: \*  
 Narcotics: \*

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The *Mental status* field has the following responses:

- 0- Oriented/cooperative
- 1- Oriented/uncooperative
- 2- Confused, mem loss, intox

The *Physical status* field has the following responses:

- 0- Healthy
- 1- General muscle weakness
- 2- Dizzy, vertigo, syncope
- 3- Cachexia and wasting

The *Elimination* field has the following responses:

- 0- Independent/continent
- 1- Catheter, ostomy
- 2- Assist/diarrhea/incont
- 3- Indep/incont,urg,freq

The *Impairments* field has the following responses:

- 0- None
- 1- Uncorr vis/hear/speech
- 2- Limb amputation
- 3- Paralysis, paresthesia

BH Fall Risk - Wilson Sims

**Physical status:**

- 1 0-Healthy
- 2 1-General muscle weakness
- 3 2-Dizzy, vertigo, syncope
- 4 3-Cachexia and wasting

Age: >0-18 years to 59 years \*

Gender: >1-Female \*

Mental status: >0-Oriented/cooperative \*

**Physical status: >** \*

Elimination: \*

Impairments: \*

Gait or balance: \*

History of falls in past 6 months: \*

Mood stabilizer medications: \*

Benzodiazepines: \*

Narcotics: \*

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BH Fall Risk - Wilson Sims

**Elimination:**

- 1 0-Independent/continent
- 2 1-Catheter, ostomy
- 3 2-Assist/diarrhea/incont
- 4 3-Indep/incont,urg,freq

Age: >0-18 years to 59 years \*

Gender: >1-Female \*

Mental status: >0-Oriented/cooperative \*

Physical status: >1-General muscle weakness \*

**Elimination: >** \*

Impairments: \*

Gait or balance: \*

History of falls in past 6 months: \*

Mood stabilizer medications: \*

Benzodiazepines: \*

Narcotics: \*

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BH Fall Risk - Wilson Sims

**Impairments:**

- 1 0-None
- 2 1-Uncorr vis/hear/speech
- 3 2-Limb amputation
- 4 3-Paralysis, paresthesia

Age: >0-18 years to 59 years \*

Gender: >1-Female \*

Mental status: >0-Oriented/cooperative \*

Physical status: >1-General muscle weakness \*

Elimination: >0-Independent/continent \*

**Impairments: >** \*

Gait or balance: \*

History of falls in past 6 months: \*

Mood stabilizer medications: \*

Benzodiazepines: \*

Narcotics: \*

(Next Page)

BH Fall Risk - Wilson Sims

**Gait or balance:**

- 1 0-Unassisted/fully ambul
- 2 1-Unable to walk/stand
- 3 2-Walks with cane
- 4 3-Unsteady/walker/crutch

Age:>0-18 years to 59 years \*

Gender:>1-Female \*

Mental status:>0-Oriented/cooperative \*

Physical status:>1-General muscle weakness \*

Elimination:>0-Independent/continent \*

Impairments:>0-None \*

**Gait or balance:>** \*

History of falls in past 6 months: \*

Mood stabilizer medications: \*

Benzodiazepines: \*

Narcotics: \*

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The *Gait or balance* field has the following responses:

- 0- Unassisted/fully ambul
- 1- Unable to walk/stand
- 2- Walks with cane
- 3- Unsteady/walker/crutch

BH Fall Risk - Wilson Sims

**History of falls in past 6 months:**

- 1 0-No history
- 2 1-Near falls/fear of fall
- 3 2-Has fallen 1-2 times
- 4 3-More than 2 falls

Age:>0-18 years to 59 years \*

Gender:>1-Female \*

Mental status:>0-Oriented/cooperative \*

Physical status:>1-General muscle weakness \*

Elimination:>0-Independent/continent \*

Impairments:>0-None \*

Gait or balance:>2-Walks with cane \*

**History of falls in past 6 months:>** \*

Mood stabilizer medications: \*

Benzodiazepines: \*

Narcotics: \*

(Next Page)

The *History of falls in past 6 months* field has the following responses:

- 0- No history
- 1- Near falls/fear of fall
- 2- Has fallen 1-2 times
- 3- More than 2 falls

BH Fall Risk - Wilson Sims

**Mood stabilizer medications:**

- 1 0-Not taking prior to adm
- 2 1-Taking prior to adm
- 3 2-Newly ordered

Age:>0-18 years to 59 years \*

Gender:>1-Female \*

Mental status:>0-Oriented/cooperative \*

Physical status:>1-General muscle weakness \*

Elimination:>0-Independent/continent \*

Impairments:>0-None \*

Gait or balance:>2-Walks with cane \*

History of falls in past 6 months:>1-Near falls/fear of fall \*

**Mood stabilizer medications:>** \*

Benzodiazepines: \*

Narcotics: \*

(Next Page)

The *Mood stabilizer medications* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

BH Fall Risk - Wilson Sims

**Benzodiazepines:**

- 1 0-Not taking prior to adm
- 2 1-Taking prior to adm
- 3 2-Newly ordered

Age: >0-18 years to 59 years \*

Gender: >1-Female \*

Mental status: >0-Oriented/cooperative \*

Physical status: >1-General muscle weakness \*

Elimination: >0-Independent/continent \*

Impairments: >0-None \*

Gait or balance: >2-Walks with cane \*

History of falls in past 6 months: >1-Near falls/fear of fall \*

Mood stabilizer medications: >0-Not taking prior to adm \*

**Benzodiazepines: >** \*

Narcotics: | \_\_\_\_\_ \*

(Next Page)

The *Benzodiazepines* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

BH Fall Risk - Wilson Sims

**Narcotics:**

- 1 0-Not taking prior to adm
- 2 1-Taking prior to adm
- 3 2-Newly ordered

Age: >0-18 years to 59 years \*

Gender: >1-Female \*

Mental status: >0-Oriented/cooperative \*

Physical status: >1-General muscle weakness \*

Elimination: >0-Independent/continent \*

Impairments: >0-None \*

Gait or balance: >2-Walks with cane \*

History of falls in past 6 months: >1-Near falls/fear of fall \*

Mood stabilizer medications: >0-Not taking prior to adm \*

Benzodiazepines: >0-Not taking prior to adm \*

**Narcotics: >** \*

(Next Page)

The *Narcotics* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

BH Fall Risk - Wilson Sims

**Diuretics:**

- 1 0-Not taking prior to adm
- 2 1-Taking prior to adm
- 3 2-Newly ordered

**Diuretics: >** \*

Sedatives/hypnotics: | \_\_\_\_\_ \*

Atypical antipsychotics: | \_\_\_\_\_ \*

? points if on detox protocol: | \_\_\_\_\_ \*

Wilson Sims fall score and risk level: 5 - Low Risk

Fall risk per RN clinical judgement:

Fall risk comments:

(Prev Page)  (End)

The *Diuretics* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

BH Fall Risk - Wilson Sims

**Sedatives/hypnotics:**

- 1 0-Not taking prior to adm
- 2 1-Taking prior to adm
- 3 2-Newly ordered

Diuretics: 0-Not taking prior to adm \*

Sedatives/hypnotics: 0 \*

Atypical antipsychotics: \*

7 points if on detox protocol: \*

Wilson Sims fall score and risk level: 5 - Low Risk

Fall risk per RN clinical judgement:

Fall risk comments:

(Prev Page)  (End)

The *Sedatives/hypnotics* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

**Note:** As you complete the fields, the *Wilson Sims Fall Risk Assessment Tool* score and risk level is calculated.

BH Fall Risk - Wilson Sims

**Atypical antipsychotics:**

- 1 0-Not taking prior to adm
- 2 1-Taking prior to adm
- 3 2-Newly ordered

Diuretics: 0-Not taking prior to adm \*

Sedatives/hypnotics: 0-Not taking prior to adm \*

Atypical antipsychotics: 1 \*

7 points if on detox protocol: \*

Wilson Sims fall score and risk level: 5 - Low Risk

Fall risk per RN clinical judgement:

Fall risk comments:

(Prev Page)  (End)

The *Atypical antipsychotics* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

BH Fall Risk - Wilson Sims

**7 points if on detox protocol:**

- 1 0-Not on detox protocol
- 2 7-On detox protocol

Diuretics: 0-Not taking prior to adm \*

Sedatives/hypnotics: 0-Not taking prior to adm \*

Atypical antipsychotics: 1-Taking prior to adm \*

7 points if on detox protocol: 7 \*

Wilson Sims fall score and risk level: 6 - Low Risk

Fall risk per RN clinical judgement:

Fall risk comments:

(Prev Page)  (End)

The *7 points if on detox protocol* field has the following responses:

- 0- Not on detox protocol
- 7- On detox protocol

BH Fall Risk - Wilson Sims

**Wilson Sims fall score and risk level:**

Last documented on Admission History:  
Falls within the past 3 months: No - 09/28/21 at 1850

Last documented on Post Fall Assessment during this admission within the last 3 months:  
Type of fall: Assisted descent - 01/12/23 at 1218

Diuretics:→0-Not taking prior to adm \*

Sedatives/hypnotics:→0-Not taking prior to adm \*

Atypical antipsychotics:→1-Taking prior to adm \*

7 points if on detox protocol:→0-Not on detox protocol \*

**Wilson Sims fall score and risk level:→6**

Fall risk per RN clinical judgement:

Fall risk comments:

(Prev Page)  (End)

The *Wilson Sims Fall Risk Assessment Tool score and risk level* field is calculated from the documentation above and is only editable by changing the prior responses.

The Yellow Information Box guides the clinician on previous documented falls:

Last documented on Admission History:  
Falls within the past 3 months: No – MM/DD/YY at HHMM

Last documented on Post Fall Assessment during this admission within the last 3 months:  
Type of fall:

BH Fall Risk - Wilson Sims

**Fall risk per RN clinical judgement:**

1 Yes

2 No

Diuretics:→0-Not taking prior to adm \*

Sedatives/hypnotics:→0-Not taking prior to adm \*

Atypical antipsychotics:→1-Taking prior to adm \*

7 points if on detox protocol:→0-Not on detox protocol \*

Wilson Sims fall score and risk level:→6 - Low Risk

**Fall risk per RN clinical judgement:→1**

Fall risk comments:

(Prev Page)  (End)

The *Fall risk (RN clinical judgment)* field has the following responses:

- Yes
- No

The *Fall risk comments* field is a free text enabled field.

**Note:** If the clinician selects “No” in the previous field, the *Fall risk comments* field becomes required.

## Maternal/Newborn Fall Risk – Adult and Pediatric

The **Maternal/Newborn Fall Risk** can be documented on either the mother or newborn’s chart, or both, depending upon the facility’s workflow and policy. For example, facilities that provide couplet care would likely only document this fall risk tool on only one of the patient’s chart.

For the Maternal/Newborn Fall Risk, the Maternal/newborn population is selected in the *Fall risk tool identifier* field.

Once the Maternal/newborn response is selected, the appropriate documentation will populate.

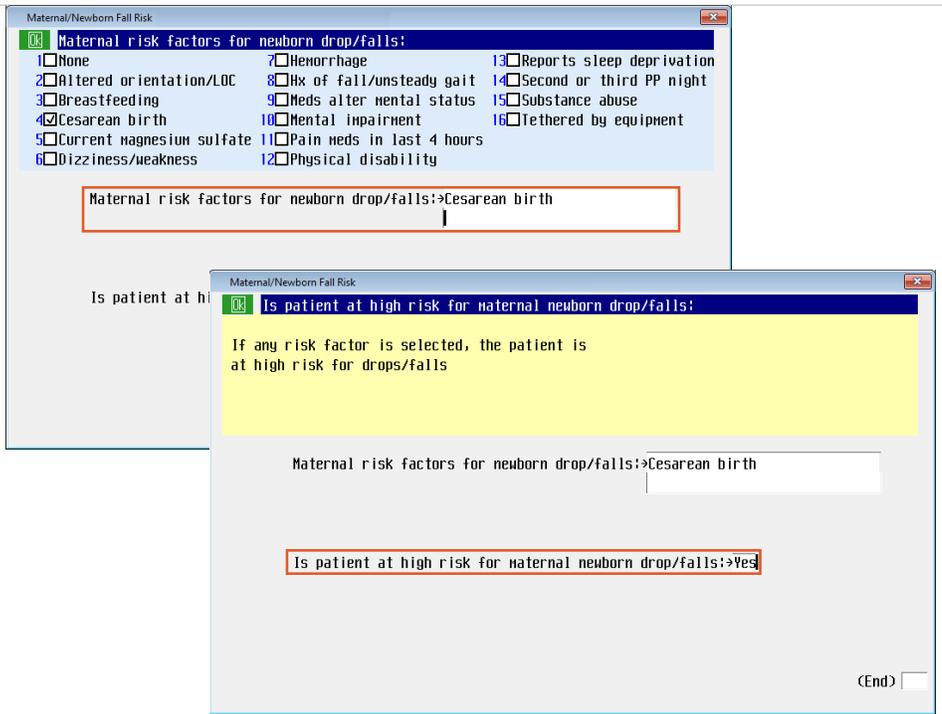
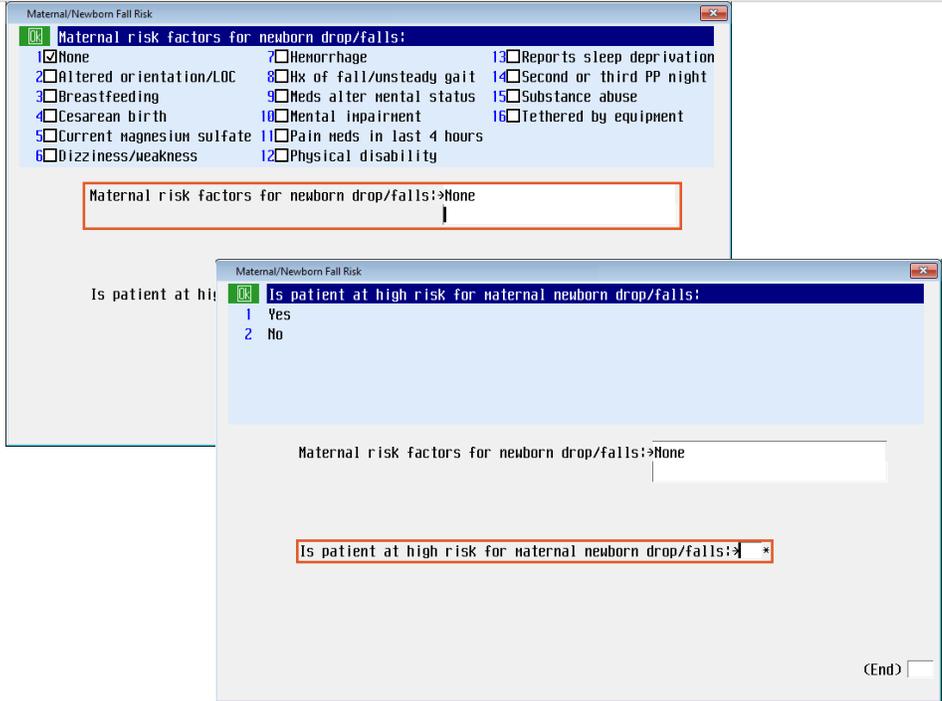
Each following field noted with an asterisk is required.

If “None” is selected in the *Maternal risk factors for newborn drop/falls* field, neither “Yes” or “No” defaults in the *Is patient at high risk for maternal newborn drop/falls* field.

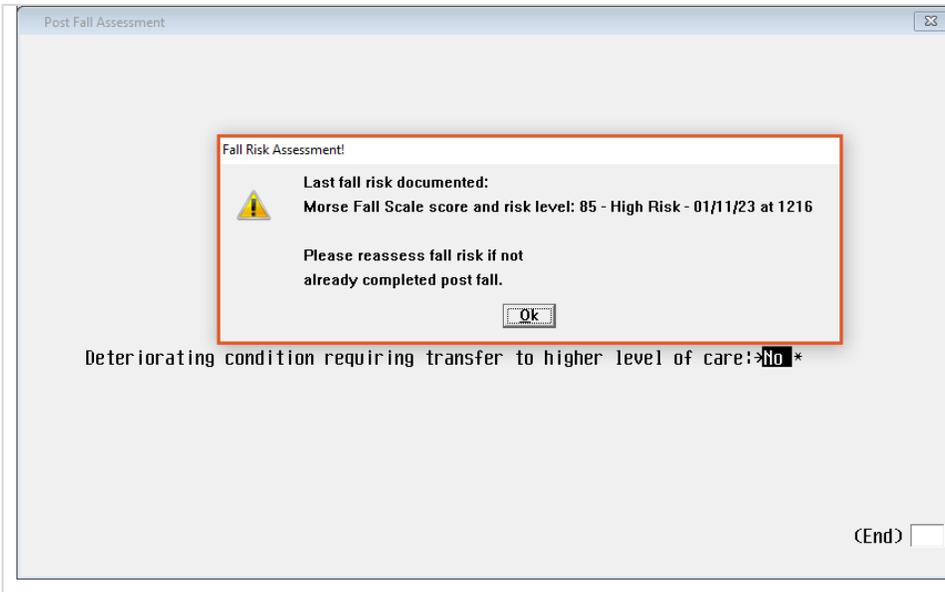
However, if at least one response is selected in the *Maternal risk factors for newborn drop/falls* field, the *Is patient at high risk for maternal newborn drop/falls* field automatically defaults “Yes”.

The Yellow Information Box aids the clinician in understanding the criteria that determines the risk:

If any risk factor is selected, the patient is at high risk for drop/falls.



## Post Fall Assessment Alert

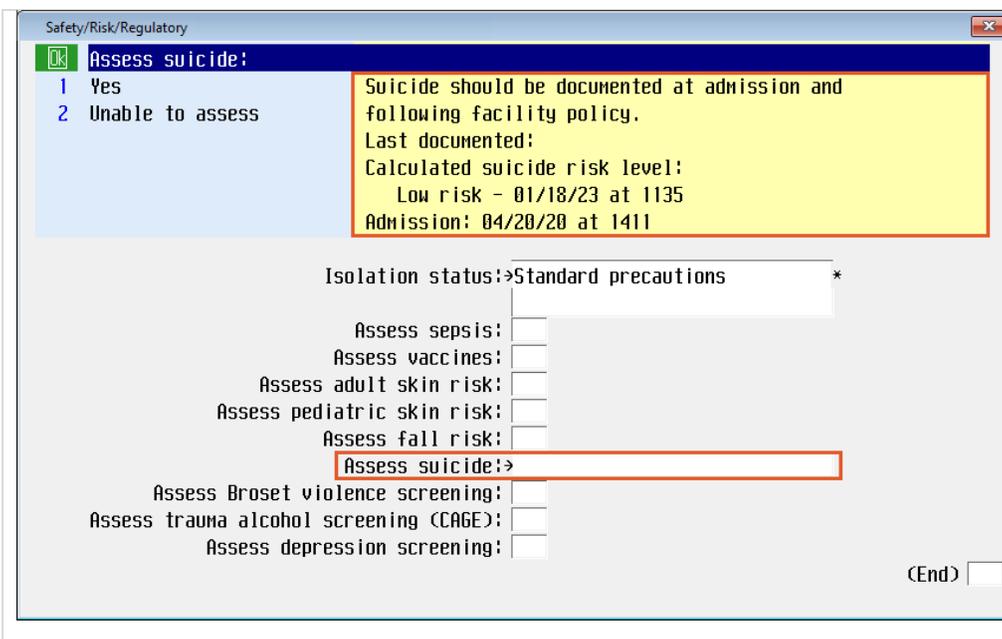


The **Post Fall Assessment** displays the last documented fall risk with the score, risk level, date and time displayed.

## Safety/Risk/Regulatory



The Yellow Information Box has been updated for the *Assess suicide* field in the **Safety/Risk/Regulatory** intervention to include the Admission date and time. This update allows for clinicians to quickly identify whether the suicide assessment was completed in the Emergency Department and needs to be readdressed in Inpatient Nursing.



The Yellow Information Box has been updated and allows the clinician to assess if the suicide assessment has been completed previously:

Suicide should be documented at admission and following facility policy.  
Last documented:  
Calculate suicide risk level:  
Admission: 00/00/00 at 0000

# Nursing and ED Modules

## Height/Weight Measurement



The **Height/Weight Measurement** screens have been updated to alert the clinicians if there is a discrepancy from the last documented weight within the same admission/visit.

The top screenshot shows the 'Height/Weight Measurement' screen with a numeric keypad for weight entry. A dialog box titled 'Yes/No Confirmation' is displayed, containing the text: 'Warning: Weight discrepancy of at least 25% than previous documentation. Would you like to continue?' with 'Yes' and 'No' buttons.

The bottom screenshot shows the 'Detailed Flowsheet' screen with a numeric keypad for weight entry. A dialog box titled 'Yes/No Confirmation' is displayed, containing the text: 'Warning: Weight discrepancy of at least 10% than previous documentation. Would you like to continue?' with 'Yes' and 'No' buttons. The screen also shows fields for 'Height ft:', 'Height in:', 'Height cm:', 'Height source:', 'Weight gm: 5200', and 'Weight kg: 5.200'.

The *weight gm* and *weight kg* fields alert the clinician if the weight has increased or decreased by 10% or 25% or greater.

The 10% discrepancy alert affects the Pediatric population, ages 17 and younger. This affects both fields depending upon the age of the patient.

The 25% discrepancy alert affects the Adult population, ages 18 and older.

If “No” is selected, the field is cleared and the clinician may enter a new weight.

If “Yes” is selected, the clinician is forwarded to the next applicable field.

*Note: This is only for the same admission. For example, if a patient is discharged and returns, the previous weight would not be compared against. The return visit is counted as a new encounter.*

This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
MRI Procedure Screening	SURG: MRI Procedure Screening Preop +	MRI Procedure Screening
Pre-Proc Checklist UP RN Assessment	SURG: Pre-Procedure Checklist, Prep +	Pre-Proc Checklist UP RN Assessment
Six Minute Walk	SURG: Height/Weight Intra-op +	Six Minute Walk
Health History Assessment	SURG: Height/Weight Pre +	Rapid Initial Assessment
Height/Weight Measurement	SURG: Admission Health History +	Rapid Flowsheet
Vital Signs		Height/Weight Measurement
Critical Care Flowsheet		Vital Signs
		Triage Reassessment
	Paramedic Intake	
	Disposition – DC/TX/ADM/LPT	
Critical Care Flowsheet		Newborn Stabilization

# Personal Safety Plan



The **Behavioral Health Personal Safety Plan** has been updated to allow entries to pull forward during the current admission. This allows for a bidirectional flow to and from the Provider note and Nursing documentation to produce a comprehensive Personal Safety Plan.

**Note:** In non-Behavioral Health settings (e.g., ED, Med/Surg), a BH specialist (if available) may complete the EBCD Personal Safety Plan. However, if a BH specialist is not available, the provider is responsible for completing the PSP in provider documentation. For Behavioral Health settings, a BH nurse or specialist completes the EBCD Personal Safety Plan.

Personal Safety Plan

Calming strategies: [or free text]

<input type="checkbox"/> Do artwork (paint, draw)	<input type="checkbox"/> Medication	Indicate 3 activities that help you feel better when you are having a hard time.
<input type="checkbox"/> Drink a beverage	<input checked="" type="checkbox"/> Listen to music	
<input type="checkbox"/> Wrapping in a blanket	<input type="checkbox"/> Pace in the halls	
<input type="checkbox"/> Call friend/family member	<input checked="" type="checkbox"/> Read a book	
<input checked="" type="checkbox"/> Dark room (dimmed lights)	<input type="checkbox"/> Read spiritual material	
<input type="checkbox"/> Exercise	<input type="checkbox"/> or <F9> For More Options	

What makes you angry, upsets you or causes you to go into a crisis:

Physical force \*  
Be forced to do something

Signals of distress (losing control or getting upset):  
Injuring self \*

Calming strategies:  
Listen to music \*  
Readbook ↓

(Next Page)

The following fields have been updated to allow current visit responses to flow between Provider and Nurse documentation:

- *What makes you angry, upsets you or causes you to go into a crisis*
- *Signals of distress (losing control or getting upset)*
- *Calming strategies*

Personal Safety Plan

What makes life worth living/most important to me:  
Enter free text.

People I feel safe calling to help me cope: > spouse \*

People/social settings that provide distraction: > home \*

Strategies for making my environment safe: > Remove sharps \*  
> Remove weapons \*

What makes life worth living/most important to me: > family \*

(Prev Page)  (End)

The following fields have been updated to allow current visit responses to flow between Provider and Nurse documentation:

- *People I feel safe calling to help me cope*
- *People/social settings that provide distraction*
- *Strategies for making my environment safe*
- *What makes life worth living/most important to me*

This update affects the following interventions/assessments:

<b>Emergency Department</b>	
BH Personal Safety Plan	
<b>Nursing</b>	
BH Personal Safety Plan	BH Nurse Assessment (INA)
BH Discharge Nursing Summary	BH Discharge Instructions

## BH Patient Safety Plan Report

The reports below have been updated with the following changes:

- Field labels have been shortened
- Signature lines have been removed to align with other HCA standard reports
- Physician has been changed to Provider

<b>Patient Safety Plan</b> <small>DEMO, SEINKLEY J00021257116/3000442100</small>				
GENERAL MEDICAL CENTER				
<p><b>An important message to the patient and/or patient's loved ones:</b></p> <p>You have been assessed by a provider and their evaluation has determined that you have been cleared from a medical standpoint. Follow up with this plan is recommended for your safety. Your safety plan includes:</p> <p><b>Causes for anger/crisis:</b> Be forced to do something Physical force</p> <p><b>Signs of losing control:</b> Injuring self</p> <p><b>Suicide risks and warning signs - please call for help immediately if you experience the following warning signs:</b></p> <table border="0"> <tr> <td> <ul style="list-style-type: none"> <li>* Acting reckless-seemingly without thinking</li> <li>* Always anxious, agitated, unable to sleep or sleeping all the time</li> <li>* Being rude</li> <li>* Clenching of fists or teeth</li> <li>* Crying</li> <li>* Dramatic mood changes</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>* Excessive Anger</li> <li>* Feeling rage or seeking revenge or uncontrolled anger</li> <li>* Feeling trapped as there is no way out</li> <li>* Feelings of hopelessness</li> <li>* Giving away possessions to others that are of importance to the individual</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>* Hurting others</li> <li>* Increasing alcohol or drug use</li> <li>* Injuring self</li> <li>* Not taking care of self</li> <li>* Not eating</li> <li>* Pacing</li> <li>* Running</li> <li>* Seeking access to guns, pills, other</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>* Seeing no reason for living or having no sense of purpose in life</li> <li>* Talking or writing about death or dying or suicide when out of the ordinary</li> <li>* Withdrawal from family, friends and society</li> </ul> </td> </tr> </table> <p><b>Calming strategies:</b> Dark room (dimmed lights) Listen to music Read a book</p> <p><b>People I can call for help:</b> spouse</p> <p><b>Distractions:</b> home</p> <p><b>Making environment safe:</b> Remove sharps Remove weapons</p> <p><b>Reasons for living:</b> family</p> <p><b>Please know that if you have access to firearms or know your loved one has access to firearms, it is important to secure those safely away from us</b></p> <p><b>Providers and Agencies I can contact during a crisis:</b></p> <ul style="list-style-type: none"> <li>* The national toll-free SUICIDE PREVENTION HOTLINE NUMBER - day, 7 days per week serves English and Spanish speaking</li> <li>* 988 (call or text)</li> <li>* www.988lifeline.org</li> <li>* Spanish + 250 other languages available through live 988</li> <li>* Hard of hearing or blind - dial 711 then 1-800-273-8255</li> </ul>	<ul style="list-style-type: none"> <li>* Acting reckless-seemingly without thinking</li> <li>* Always anxious, agitated, unable to sleep or sleeping all the time</li> <li>* Being rude</li> <li>* Clenching of fists or teeth</li> <li>* Crying</li> <li>* Dramatic mood changes</li> </ul>	<ul style="list-style-type: none"> <li>* Excessive Anger</li> <li>* Feeling rage or seeking revenge or uncontrolled anger</li> <li>* Feeling trapped as there is no way out</li> <li>* Feelings of hopelessness</li> <li>* Giving away possessions to others that are of importance to the individual</li> </ul>	<ul style="list-style-type: none"> <li>* Hurting others</li> <li>* Increasing alcohol or drug use</li> <li>* Injuring self</li> <li>* Not taking care of self</li> <li>* Not eating</li> <li>* Pacing</li> <li>* Running</li> <li>* Seeking access to guns, pills, other</li> </ul>	<ul style="list-style-type: none"> <li>* Seeing no reason for living or having no sense of purpose in life</li> <li>* Talking or writing about death or dying or suicide when out of the ordinary</li> <li>* Withdrawal from family, friends and society</li> </ul>
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<b>Patient Safety Plan</b> <small>DEMO, SEINKLEY J00021257116/3000442100</small>				
<p><b>* Local suicide hotline name and number:</b> TEST SUICIDE HOTLINE TERN 615 555-1212 Another Hotline number 988 another line to call 232 234 2345</p> <p><b>** If you or a loved one notices any of the warning signs mentioned above, please contact one of these providers/agencies, contact 911 or go to the nearest emergency room for assistance. **</b></p>				

These updates affects the following reports:

<b>Nursing</b>	
Patient Safety Plan Report	Behavioral Health Discharge Instructions Report
<b>Emergency Department</b>	
Patient Safety Plan Report	

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