

# NUR Module

## Admission Health History: Currently Pregnant Updates



### Surrogacy Updates

Currently, the **Admission Health History** form does not have a space to list the names of the intended parents for a gestational carrier or surrogate. Under the domain of surrogacy, proper documentation of the intended parents supports patient safety and the validation of parentage under the terms of a gestational agreement. With this change, a new field has been added to the **Admission Health History** intervention to document the names of the intended parents.

*Gestational carrier/surrogate* has the following responses:

- Yes
- No

If 'Yes' is selected, it will default to the *Intended parents names* field.

*Intended parents names* is a new, free-text enabled field, where multiple names can be added.

The Yellow Information Box offers additional guidance:

The birth mother and intended parents agree the names below are the intended parents.  
An executed surrogacy agreement was requested of the parties and, if provided, has been added to the record.

Currently Pregnant

Ok Gestational carrier/surrogate:

1 Yes

2 No

Gestational carrier/surrogate:→

Intended parents names:

Adoption requested:

Desire time with infant:

Name of agency/contact:

Adoption/surrogacy comments:

(Prev Page) (End)

Currently Pregnant

Ok Intended parents names:

Enter free text.

The birth mother and intended parents agree the names below are the intended parents.  
An executed surrogacy agreement was requested of the parties and, if provided, has been added to the record.

Gestational carrier/surrogate:→Yes

Intended parents names:→

Adoption requested:

Desire time with infant:

Name of agency/contact:

Adoption/surrogacy comments:

(Prev Page) (End)

## Maternal Status Updates

Currently, Maternal hepatitis C results, Maternal syphilis result & testing trimester and Maternal HPV results are not documented. With recommendation from the American Obstetricians and Gynecologists, these fields are now available for documentation.

Currently Pregnant

**Maternal hepatitis C:**

- 1 ☐ Currently negative
- 2 ☐ Currently positive
- 3 ☐ Currently being treated
- 4 ☐ Currently unknown
- 5 ☐ History of not treated
- 6 ☐ History of treated

Suspected/prediagnosed fetal anomalies:→

Current pregnancy history comments:

Maternal blood type:

Maternal Rh type:

Maternal Rho (D) immune globulin this pregnancy:

Maternal rubella:

Maternal hepatitis B:

**Maternal hepatitis C:→**

Maternal HIV:

(Prev Page) ☐ (Next Page) ☐

*Maternal hepatitis C* is a new field with the following responses:

- Currently negative
- Currently positive
- Currently being treated
- Currently unknown
- History of not treated
- History of treated

Currently Pregnant

**Maternal syphilis:**

1 <input type="checkbox"/> Currently negative	7 <input type="checkbox"/> 1st trimester positive
2 <input type="checkbox"/> Currently positive	8 <input type="checkbox"/> 1st trimester negative
3 <input type="checkbox"/> Currently being treated	9 <input type="checkbox"/> 3rd trimester positive
4 <input type="checkbox"/> Currently unknown	10 <input type="checkbox"/> 3rd trimester negative
5 <input type="checkbox"/> History of not treated	
6 <input type="checkbox"/> History of treated	

Maternal group B strep:→Positive

Maternal gonorrhea:→Currently being treated

Maternal chlamydia:→Currently being treated

Maternal trichomoniasis:→Currently being treated

Maternal RPR/VDRL:→Reactive

**Maternal syphilis:→**

(Prev Page) ☐ (Next Page) ☐

*Maternal syphilis* is a new field with the following responses:

- Currently negative
- Currently positive
- Currently being treated
- Currently unknown
- History of not treated
- History of treated
- 1<sup>st</sup> trimester positive
- 1<sup>st</sup> trimester negative
- 3<sup>rd</sup> trimester positive
- 3<sup>rd</sup> trimester negative

Currently Pregnant

**Maternal HPV:**

- 1 ☐ Currently negative
- 2 ☐ Currently positive
- 3 ☐ Currently being treated
- 4 ☐ Currently unknown
- 5 ☐ History of not treated
- 6 ☐ History of treated

Maternal HPV:

Maternal herpes:

Maternal current active lesion:

Maternal date of last herpes outbreak:

Antenatal steroid date:

Antenatal steroid time:

Antenatal steroid number of doses:

(Prev Page)  (Next Page)

*Maternal HPV* is a new field with the following responses:

- Currently negative
- Currently positive
- Currently being treated
- Currently unknown
- History of not treated
- History of treated

These updates affect the following interventions/assessments:

Nursing	Surgery
Admission Health History	SURG: Admission Health History
BH: Health History Assessment	

# Restraints Initiative Update

## MEDITECH CPOE Update

EHR

2025.3

Update

## 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.

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.

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Order Phase:**

- 1 Initial
- 2 Renewal

No Active Nursing Documentation on File.

Order Phase: \*  
Level of restraint: \*

Ok Cancel Help Prev Next

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Level of restraint:**

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

No Active Nursing Documentation on File.

Order Phase: Initial \*  
Level of restraint: \*

Ok Cancel Help Prev Next

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Non-violent restraint device:**

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

No Active Nursing Documentation on File.

Non-violent restraint device: \*  
Mitten BUE \*  
Non-violent Restraint Time Limit \*  
24 hours \*

Ok Cancel Help Prev Next



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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Violent restraint device:**

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

Violent restraint device:  
Chemical \*

Violent Restraint Time Limit  
4 hours \*

<6 Page Screen>

Ok Cancel Help Prev Next

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

*Violent Restraint Time Limit* will pre-populate 4 hours for both the Order Phase of Initial and Order Phase of Renewal for adult patients. Pediatric patients will default to 1 hour or 2 hours depending on the patient's age and the time does not increase for renewal orders.

**Note:** Physical holding will pre-populate 15 minutes for both the order phase of Initial and Renew

*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

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Clinical justification:**

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

Clinical justification: \*


<6 Page Screen>

Ok Cancel Help Prev Next

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

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

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

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

<6 Page Screen>

Ok Cancel Help Prev Next

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.

# Critical Congenital Heart Disease Screening Update



The Critical Congenital Heart Disease (CCHD) content on the **Neonatal/Peds Discharge Readiness** intervention has been updated to align with a new simplified screening algorithm endorsed by the American Academy of Pediatrics. There are two important changes. The measurement in the right hand and one foot must **BOTH** be 95% or greater and the difference between the measurements must be three or less to pass. Additionally, there will only be one retest for an indeterminate result instead of two.

Neo/Peds Discharge Readiness

**CCHD SPO2% second extremity location initial screen:**

1 Lower extremity left CCHD screening results initial screen:  
No previous documentation found.

2 Lower extremity right CCHD screening results repeat 1:  
No previous documentation found.

CCHD SPO2% right upper extremity initial screen: >94

CCHD SPO2% second extremity initial screen: >96 \*

CCHD SPO2% second extremity location initial screen: \*

CCHD screening results initial screen: Repeat screening in one hour \*

CCHD SPO2% right upper extremity repeat 1:

CCHD SPO2% second extremity repeat 1:

CCHD SPO2% second extremity location repeat 1:

CCHD screening results repeat 1:

(Prev Page)

(Next Page)

The CCHD screening results has been updated to align with the new screening algorithm.

*Note:* If CCHD SPO2% right upper extremity is answered then the CCHD SPO2% second extremity value and location become **required\*** for **Initial** and **Repeat** screening.

## Initial Screening

**In current state:** this would result in a passed screen.

**Now:** These measurements will require a 'Repeat screening in one hour' since **BOTH** measurements are not 95% or greater.

Neo/Peds Discharge Readiness

**CCHD SPO2% second extremity location repeat 1:**

1 Lower extremity left CCHD screening results initial screen:  
Repeat screening in one hour 05/30/25 at 0624

2 Lower extremity right CCHD screening results repeat 1:  
No previous documentation found.

CCHD SPO2% right upper extremity initial screen:

CCHD SPO2% second extremity initial screen:

CCHD SPO2% second extremity location initial screen:

CCHD screening results initial screen:

CCHD SPO2% right upper extremity repeat 1: >96

CCHD SPO2% second extremity repeat 1: >94 \*

CCHD SPO2% second extremity location repeat 1: \*

CCHD screening results repeat 1: Failed screen \*

(Prev Page)

(Next Page)

## Repeat Screening

There is now only one retest following an indeterminate measurement.

**In current state:** this would result in a passed screen.

**Now:** These measurements will result in a **FAIL** since **BOTH** measurements are not 95% or greater.

# CVC/PICC: Midline Multi Lumen Update



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

CVC/PICC

**CVC/PICC procedure type:**

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

CVC/PICC procedure type: \*

CVC/PICC location: \*

Location (L/R): \*

Inserted: \*

CVC/PICC insertion date: \*

CVC/PICC insertion time: \*

Instance list status: Active \*

Cath/PICC/Dialysis details: \*

CVC/PICC/Dialysis line status: \*

(Next Page) ☐

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

- Midline multi lumen

This update affects the following interventions:

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

## Disposition of Home Meds



The **Health History Assessment** has been updated to provide a new response option to document that a patient's home medications were secured or stored during the admission process. See the Discharge Instructions update for information regarding the alert for Disposition of valuables and home meds.

*Disposition of home meds* has a new response:

- Stored per policy/proc

This update affects the following interventions:

Nursing	Surgery
Admission Health History	SURG: Admission Health History
BH: Health History Assessment	

# Discharge Instructions: Disposition of Valuables and/or Home Medications Alert



Currently, there is not an efficient way for discharging staff to know that a patient's valuables and/or home medications were secured on admission. Based on responses to valuables and/or home medications, the **Discharge Instructions** will display an alert to provide awareness that there may be items to return to the patient.

The screenshot shows a 'Discharge Instructions' window. At the top, there is a 'Discharge to:' field. Below it, a modal dialog box titled 'Disposition of Valuables/Home Medications' is displayed. The dialog contains a yellow warning icon and the following text:

**Per admission documentation:**

Disposition of valuables: Placed in secured storage

Disposition of home medications: Stored per policy/proc

At the bottom of the dialog is an 'Ok' button. The main window also has '(Prev Page)' and '(Next Page)' buttons at the bottom.

An alert will display if the following responses were selected for the *Disposition of valuables* and/or *Home medications*:

- Placed in secured storage
- Sent to pharmacy
- Stored per policy/proc

This will alert the clinician to items that may need to be returned to the patient.

**Note:** If free text was entered in addition to one of the above group response options, the 'Free Text' will also be displayed. If only 'Free Text' was entered on admission, no alert will display.

This update affects the following interventions/assessments:

Nursing
Discharge Instructions
BH: Discharge Instructions Home

# Dysphagia Screening – Water Test



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

Dysphagia Screening LCOE,PATIENT

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

1 Yes  
2 No

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

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

Noted changes in swallow test:  
Dysphagia screening comments:

(End)

If “No” is answered for:

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

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

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

Dysphagia Screening LCOE,PATIENT

☒ Noted changes in swallow test:

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

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

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

Noted changes in swallow test:→Throat clearing \*

Dysphagia screening comments: Cough

(End)

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

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

Dysphagia Screening LCOE, PATIENT

**Facial asymmetry/weakness:**

✓ 1 Yes  
2 No

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

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

Stop dysphagia screening and refer to Speech Therapy

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

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

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

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

This update affects the following interventions:

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

# 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/CPM 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/CPM monitoring*.

ICP/Ventriculostomy

Site assessment: [or free text]

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

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

Intervention: >

Site assessment: >Ecchymotic

Drainage description:

ICP/Ventriculostomy

Dressing type: [or free text]

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

Intervention: >

Site assessment: >Ecchymotic

Drainage description:

CSF color:

Dressing type: >CHG embedded disc

Sutures

Dressing intervention:

Date of last dressing change:

(Prev Page) (Next Page)

Vital Signs

Document ICP/CPM monitoring:

Yes

Document vital signs: >

Document pre transfusion vitals: >

Document height/weight measurements: > \*

Document hemodynamic monitoring: >

Document orthostatic vital signs: >

Document ICP/CPM monitoring: > Yes

Document multiple extremity blood pressures: >

(End)

ICP Monitoring

Select ICP device to document:

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

Select ICP device to document: 3

(Next Page)

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

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

- New
- Monitoring
- Monitoring discontinued

ICP Monitoring

ICP 2 status:

- ✓ 1 Monitoring
- 2 Monitoring discontinued

ICP 2 device: External ventricular \*

ICP 2 location: Occipital region left \*

ICP 2 status: Monitoring \*

ICP 2 (mmHg)

ICP 2 mean arterial pressure

ICP 2 CPP (mmHg)

ICP 2 zeroed/recalibrated

ICP 2 waveform

ICP 2 fluctuations

(Prev Page) (Next Page)

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

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

- Monitoring
- Monitoring discontinued

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

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

Ext Ventricular Drain

Ventricular device drain 1 ml:

- Bolt Parietal region left (Active)
- External ventricular Occipital region left (Active)
- External ventricular Frontal region left (Inactive)

Ventricular device drain 1 ml: 3

Ventricular device drain 1:

Ventricular device location drain 1:

Ventricular device drain 2 ml:

Ventricular device drain 2:

Ventricular device location drain 2:

Ventricular device drain 3 ml:

Ventricular device drain 3:

Ventricular device location drain 3:

(Next Page)

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

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

- Ventricular device
- Ventricular device location

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

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

IV Drip Status

☒ Document ICP:

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

2 No Not for controlled substance hand-off.

Last 4 Clinical Data Entries (For Today)

Date	Time	RASS	CPOT	Pulse	Resp	Blood Press	MAP	ICP1	ICP2	ICP3
07/07									18	

RASS: CPOT: Document ICP: ☒ Yes

IV drip 1: IV drip 1 status:

IV drip 2: IV drip 2 status:

IV drip 3: IV drip 3 status:

IV drip

IV drip

IV drip

IV drip

IV drip

IV drip

ICP Monitoring

☒ Select ICP device to document:

☐ 1 External ventricular Frontal region left (Monitoring discontinued)

☐ 2 External ventricular Occipital region left (Monitoring)

☐ 3 Bolt Parietal region left (New)

Select ICP device to document:

(Next Page) ☐

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

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

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

This update affects the following interventions:

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

# Injured Trauma Survivor Screening Update



A new field has been added to the **Injured Trauma Survivor Screen (ITSS)** intervention to comply with the American College of Surgeons (ACS) standards for Level One Trauma Centers. This addition enables documentation of instances where the screening process cannot be completed.

*Assess injured trauma survivor screen* is a required field and has been updated to include the following responses:

- Yes
- No

If 'No' is selected, the *Reason unable to assess* field will be required.

**Note:** If 'Yes' is selected the clinician will be directed to the **Injured Trauma Survivor Screen** documentation.

# Malnutrition Screening Updates



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

Health History Assessment

**Recent weight loss without trying:**

1 Yes  
2 No  
3 Unknown

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

Recent weight loss without trying: Yes \*

How much weight have you lost: \*

Eating poorly due to decreased appetite: \*

Malnutrition screen tool score: 0 - Not at risk

(Prev Page) (Next Page)

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

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

Health History Assessment

**Eating poorly due to decreased appetite:**

1 Yes  
2 No

Recent weight loss without trying: Yes \*

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

Eating poorly due to decreased appetite: No \*

Malnutrition screen tool score: 2 - Malnutrition risk

(Prev Page) (Next Page)

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

Health History Assessment

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

1 Yes  
2 No

Recent unintentional weight loss: \*

Poor weight gain within last few months: Yes \*

Decreased eating/feeding within last few weeks: \*

Obviously underweight or significantly overweight: \*

Pediatric malnutrition screen tool score: 1 - Not at risk

(Prev Page) (Next Page)

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

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

This update affects the following interventions:

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

# Oncology Distress Screening



The **Oncology Distress Screening** intervention is outdated and being updated to align with the current version of the National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List.

Oncology Distress Screening

**Practical concerns in the past week: [for free text]**

1 <input type="checkbox"/> Access to medicine	7 <input type="checkbox"/> Safety	13 <input type="checkbox"/> Work
2 <input type="checkbox"/> Childcare	8 <input type="checkbox"/> School	
3 <input type="checkbox"/> Finances	9 <input type="checkbox"/> Taking care of myself	
4 <input type="checkbox"/> Having enough food	10 <input type="checkbox"/> Taking care of others	
5 <input type="checkbox"/> Housing/utilities	11 <input type="checkbox"/> Transportation	
6 <input type="checkbox"/> Insurance	12 <input type="checkbox"/> Treatment decisions	

Type of cancer: → Cervical

Currently being treated for cancer: → Yes

Overall level of distress in the past week: → 4

Practical concerns in the past week: →

Social concerns in the past week: →

Emotional concerns in the past week: →

(Next Page) ☐

*Practical concerns in the past week* has been updated with the following responses:

- Access to medicine
- Childcare
- Finances
- Having enough food
- Housing/utilities
- Insurance
- Safety
- School
- Taking care of myself
- Taking care of others
- Transportation
- Treatment decisions
- Work
- Free text

Oncology Distress Screening

**Social concerns in the past week: [for free text]**

1 <input type="checkbox"/> Ability to have children	7 <input type="checkbox"/> Relation with friends
2 <input type="checkbox"/> Healthcare communication	
3 <input type="checkbox"/> Prejudice/discrimination	
4 <input type="checkbox"/> Relation spouse/partner	
5 <input type="checkbox"/> Relation with children	
6 <input type="checkbox"/> Relation with family	

Type of cancer: → Cervical

Currently being treated for cancer: → Yes

Overall level of distress in the past week: → 4

Practical concerns in the past week: →

Social concerns in the past week: →

Emotional concerns in the past week: →

(Next Page) ☐

*Social concerns in the past week*, formerly “Family concerns”, has been updated with the following responses:

- Ability to have children
- Healthcare communication
- Prejudice/discrimination
- Relation spouse/partner
- Relation with children
- Relation with family
- Relation with friends
- Free text

Oncology Distress Screening

**Emotional concerns in the past week: [or free text]**

1 <input type="checkbox"/> Anger	7 <input type="checkbox"/> Loss of interest
2 <input type="checkbox"/> Changes in appearance	8 <input type="checkbox"/> Sadness or depression
3 <input type="checkbox"/> Fear	9 <input type="checkbox"/> Worry or anxiety
4 <input type="checkbox"/> Feelings of worthlessness	
5 <input type="checkbox"/> Grief or loss	
6 <input type="checkbox"/> Loneliness	

Type of cancer: → Cervical

Currently being treated for cancer: → Yes

Overall level of distress in the past week: → 4

Practical concerns in the past week: →

Social concerns in the past week: →

Emotional concerns in the past week: →

(Next Page) ☐

*Emotional concerns in the past week* has the following responses:

- Anger
- Changes in appearance
- Fear
- Feelings of worthlessness
- Grief or loss
- Loneliness
- Loss of Interest
- Sadness or depression
- Worry or anxiety
- Free text

Oncology Distress Screening

**Spiritual/religious concerns in the past week: [or free text]**

1 <input type="checkbox"/> Change in faith/beliefs
2 <input type="checkbox"/> Conflict with treatment
3 <input type="checkbox"/> Death/dying/afterlife
4 <input type="checkbox"/> Relation with the sacred
5 <input type="checkbox"/> Ritual or dietary needs
6 <input type="checkbox"/> Sense of meaning/purpose

Spiritual/religious concerns in the past week: →

Physical concerns in the past week: →

Oncology distress comment:

(Prev Page) ☐ (End) ☐

*Spiritual/religious concerns in the past week* has the following responses:

- Change in faith/beliefs
- Conflict with treatment
- Death/dying/afterlife
- Relation with the sacred
- Ritual or dietary needs
- Sense of meaning/purpose
- Free text

Oncology Distress Screening

**Physical concerns in the past week: [or free text]**

1 <input type="checkbox"/> Changes in eating	7 <input type="checkbox"/> Sleep
2 <input type="checkbox"/> Fatigue	8 <input type="checkbox"/> Substance use
3 <input type="checkbox"/> Loss/change of abilities	9 <input type="checkbox"/> Tobacco use
4 <input type="checkbox"/> Memory/concentration	
5 <input type="checkbox"/> Pain	
6 <input type="checkbox"/> Sexual health	

Spiritual/religious concerns in the past week: →

Physical concerns in the past week: →

Oncology distress comment:

(Prev Page) ☐ (End) ☐

*Physical concerns in the past week* formerly “Physical/medical concerns” has been updated and now has the following responses:

- Changes in eating
- Fatigue
- Loss/change of abilities
- Memory/concentration
- Pain
- Sexual health
- Sleep
- Substance use
- Tobacco use
- Free text

**Oncology Distress Screening** continued

This update affects the following interventions/assessments:

Nursing	Emergency Department	Surgery
Oncology Distress	Detailed Assessment	SURG: Admission Health History
BH: Health History Assessment	Non-urgent General Focus	
Admission Health History	Paramedic Intake	

## 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

Jet

PEEP (cmH2O):

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

Set rate (bpm):>

I-time (sec):>

Blender FiO2:>

Delta P (cmH2O):>

Servo pressure (cmH2O):>

Peak inspiratory pressure (cmH2O):>

PEEP (cmH2O):>12

Mean airway pressure (cmH2O):>

Cartridge temp:>

Circuit temp (C):>

(Next Page)

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

Jet

Servo pressure alarm low:

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

MAP alarms (cmH2O):>

MAP alarm high:>99.99

MAP alarm low:>11.11

Servo pressure alarms (cmH2O):>

Servo pressure alarm high:>99.99

Servo pressure alarm low:>11.11

High PEEP alarm: ☐

Low PEEP alarm: ☐

(Prev Page)  (Next Page)

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

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

Jet

Backup I-time (sec):

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

Backup rate:>12

Backup peak inspiratory pressure (cmH2O):>12

Backup inspiratory pressure:>12

Backup I-time (sec):>3.2

(Prev Page)  (End)

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

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

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

RT Ventilator Flowsheet

Transcutaneous PCO2 site temperature:

7 8 9 Del

4 5 6

1 2 3

- 0 . Calc

Secretions cleared:

Pulse:

Pulse source:

SpO2 %:

ETCO2:

Transcutaneous PCO2: 12.34

Transcutaneous PCO2 site change time: 0000

Transcutaneous PCO2 site temperature: 100.5

(Prev Page)

(Next Page)

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

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

This update affects the following interventions/assessments:

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

# Restraints Initiative Update



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

## Ordering Restraints Process

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Order Phase:**

- 1 Initial
- 2 Renewal

No Active Nursing Documentation on File.

Order Phase:  \*

Level of restraint:  \*

<6 Page Screen>

Ok Cancel Help Prev Next

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

- Initial
- Renewal

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

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Level of restraint:**

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

No Active Nursing Documentation on File.

Order Phase: Initial \*

Level of restraint:  \*

<6 Page Screen>

Ok Cancel Help Prev Next

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

- Non-violent
- Violent/self-destructive

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

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Non-violent restraint device:**

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

No Active Nursing Documentation on File.

Non-violent restraint device:  \*

Non-violent Restraint Time Limit  \*

24 hours

<6 Page Screen>

Ok Cancel Help Prev Next

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

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

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

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Violent restraint device:**

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

Violent restraint device:  
Chemical \*

Violent Restraint Time Limit  
4 hours \*

Ok Cancel Help <6 Page Screen> Prev Next

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

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

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

*Clinical justification* is a required field.

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

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

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

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

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

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

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

**Clinical justification:**

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

Clinical justification: \*

Ok Cancel Help <6 Page Screen> Prev Next

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

Procedure Ordered  
RESTRAINTS ORDER \*Current\*

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

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

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

Ok Cancel Help <6 Page Screen> Prev Next

## NURSING DOCUMENTATION

Restraint Documentation

Level of restraint:

1 Non-violent

2 Violent/self-destructive

Physician order:

Click box to display previous status documentation ->

Restraint status: Start \*

Level of restraint: \*

Non-violent restraint device: \*

Violent restraint device: \*

Clinical justification: \*

Alternatives utilized: \*

Date restraints initiated: \*

Time restraints initiated: \*

(Next Page)

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

The available *Level of restraint* responses are:

- Non-violent
- Violent/self-destructive

Restraint Documentation

Non-violent restraint device:

1 ☒ Bedrails

2 ☐ Chemical

3 ☐ Enclosure

4 ☐ Freedom splints +

5 ☐ Geri-chair

6 ☐ Mitten +

7 ☐ Soft +

8 ☐ Waist

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

Click box to display previous status documentation ->

Restraint status: Start \*

Level of restraint: Non-violent \*

Non-violent restraint device: Bedrails \*

Violent restraint device: \*

Clinical justification: \*

Alternatives utilized: \*

Date restraints initiated: \*

Time restraints initiated: \*

(Next Page)

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

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

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

Restraint Documentation

Violent restraint device:

1 ☐ Chemical

2 ☒ Enclosure

3 ☐ Physical holding

4 ☐ Restrictive positioning

5 ☐ Seclusion

6 ☐ Soft +

7 ☐ Synthetic +

Physician order:

Click box to display previous status documentation ->

Restraint status: Start \*

Level of restraint: Violent/self-destructive \*

Non-violent restraint device: \*

Violent restraint device: Enclosed \*

Clinical justification: \*

Alternatives utilized: \*

Date restraints initiated: \*

Time restraints initiated: \*

(Next Page)

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

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

Restraint Documentation 05/22 0952 J00021474493 LCOE,PATIENT

**Clinical justification:**

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

Physician order:

Click box to display previous status documentation ->

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

(Next Page) ☐

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

*Clinical justification* is a required field.

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

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

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

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

Restraint Documentation

**Alternatives utilized:**

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

Click box to display previous status documentation ->

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

Alternatives utilized: Lookup

Select ☐

Options

1 ☒ Toileting  
 2 ☐ Voluntary time out

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

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

Restraint Documentation

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

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

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

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

(Prev Page) ☐ (Next Page) ☐

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

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

- Three times every hour
- Every 15 minutes per hour

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

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

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

Recommendations for future interventions:

Post counseling provided to:

Debriefing Comment:

(End) ☐

Violent episodes allow documentation of debriefing when Discontinued.

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

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

# Suicide Screening Functionality Update



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

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

The screenshot shows two overlapping windows. The top window, titled 'Safety/Risk/Regulatory', contains the 'Assess suicide screening' form. It has a dropdown menu with options '1 Yes' and '2 Unable to assess'. Below this are several assessment fields: 'Isolation status: Standard precautions', 'Assess sepsis:', 'Assess vaccines:', 'Assess adult skin risk:', 'Assess pediatric skin risk:', 'Assess fall risk:', 'Assess suicide screening:', and 'Assess Broset violence screening:'. The 'Assess suicide screening' field is highlighted with a red box. The bottom window, titled 'BH Suicide/Homicide Screening', contains a dropdown menu with options '1 Yes' and '2 No'. It also has several assessment fields: 'Wish to be dead or to not wake up in the past month: Yes\*', 'Wish to be dead or to not wake up in your lifetime: Yes\*', 'Non-specific active suicidal thoughts in the past month: \*', and 'Non-specific active suicidal thoughts in your lifetime: \*'. A red arrow points to the 'Exit and Erase' button in the 'Erasing Documentation Alert' dialog box, which is overlaid on the bottom window. The dialog box contains the text: '\*\*\* ATTENTION \*\*\*', '\*\*\* Erasing Documentation Alert \*\*\*', 'Exiting from this screen will cause the values of any questions you have answered on this screen to be erased', and 'Are you sure you want to exit this screen?'. The 'Exit and Erase' button is highlighted with a red box.

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

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

Safety/Risk/Regulatory

Assess Broset violence screening:  
1 Yes

Isolation status: Standard precautions \*

Assess sepsis: ☐

Assess vaccines: ☐

Assess adult skin risk: ☐

Assess pediatric skin risk: ☐

Assess fall risk: ☐

Assess suicide screening: ☐

Assess Broset violence screening: ☐

Assess trauma alcohol screening (CAGE): ☐

Assess depression screening: ☐

(End) ☐

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

This update affects the following interventions:

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

## TBSA and Burn Depth Removal Update



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

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

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

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

This update affects the following interventions/assessments:

Nursing	Emergency Department
TBSA and Burn Depth	Burn Assessment
	Burn Reassessment

## Teach/Educate Update - Stroke Risk Factors



In the **Teach/Educate** intervention, the nurse is unable to document which specific stroke risk factor(s) the patient is being educated on in the Stroke Teaching screen. A new field for patient specific risk factors has been added to the Stroke Teaching screen within the Teach/Educate intervention to align with requirements for Stroke Certification compliance.

Stroke Teaching

Warning signs and symptoms for stroke:

✓ 1 Yes  
2 No  
3 Not Applicable

Written information regarding stroke provided to primary learner: Yes\*

Activation of emergency medical system: Yes  
Need for follow up after discharge: Yes  
All medications prescribed at discharge: Yes  
Warning signs and symptoms for stroke: Yes  
Risk factors for stroke: Yes

Patient specific risk factors: \*

(End)

The *Warning signs and symptoms for stroke* field will now display **before** *Risk factors for stroke* on the screen.

Stroke Teaching

Patient specific risk factors: [or free text]

1 ☐ Age  
2 ☐ Alcohol abuse  
3 ☐ Atrial fibrillation  
4 ☐ COVID-19  
5 ☐ Carotid artery disease  
6 ☐ Diabetes  
7 ☐ Drug abuse  
8 ☐ Family history  
9 ☐ High blood pressure  
10 ☐ High cholesterol  
11 ☐ Obesity  
12 ☐ Peripheral artery disease  
13 ☐ Physical inactivity  
14 ☐ Poor diet  
15 ☐ Prior stroke/TIA  
16 ☐ Race  
17 ☐ Sex (gender)  
18 ☐ or <F9> For More Options

Written information regarding stroke provided to primary learner: Yes\*

Activation of emergency medical system: Yes  
Need for follow up after discharge: Yes  
All medications prescribed at discharge: Yes  
Warning signs and symptoms for stroke: Yes  
Risk factors for stroke: Yes

Patient specific risk factors: \*

Patient specific risk factors: Lookup

Select ☐

Options

1 Sickle cell disease  
2 Sleep apnea  
3 Smoking

<End of list>

*Patient specific risk factors* is a new, multi-select field with the following responses:

- Age
- Alcohol abuse
- Atrial fibrillation
- COVID-19
- Carotid artery disease
- Diabetes
- Drug abuse
- Family history
- High blood pressure
- High cholesterol
- Obesity
- Peripheral artery disease
- Physical inactivity
- Poor diet
- Prior stroke/TIA
- Race
- Sex (gender)
- Sickle cell disease
- Sleep apnea
- Smoking

**Note:** The clinician will be required to document a response to the new field if *Risk factors for stroke* is answered 'Yes'.

This update affects the following interventions:

Nursing	Surgery
Teach/Educate +	SURG: Teach/Educate Pre-op +
	SURG: Teach/Educate Intra-op +
	SURG: Teach/Educate PACU +

## Universal Timeout Updates



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

Universal Timeout

Ok Briefing/anesthesia timeout completed:

1 Yes

2 No

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

Briefing elements:

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

Briefing/anesthesia timeout completed:>

Procedure timeout completed at:

Procedures being performed:

Site blocked:

Debriefing completed:

(End)

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

- Yes
- No

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

Universal Timeout

Ok Debriefing completed:

1 Yes

2 No

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

Debriefing Elements:

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

Briefing/anesthesia timeout completed:>Yes

Procedure timeout completed at:>1010

Procedures being performed:>

Site blocked:>

Debriefing completed:>

(End)

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

- Yes
- No

This update affects the following interventions:

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