

Mobility Nursing Strategic Agenda Enhancements



This update will enhance documentation in the **Routine Daily Care** to standardize capture of patient activity/mobility and level of assistance, improving multidisciplinary communication, visibility into functional status, and correlation with outcomes including length of stay, falls, NVHAP, CAUTI/CLABSI, restraint use, and pressure injuries.

Routine Daily Care J00021631632 LCOE,Sarah

Activity/Mobility: [or free text]

- 1 ☐ Active range of motion
- 2 ☐ Ambulate
- 3 ☐ Bed in chair position
- 4 ☐ Chair/commode
- 5 ☐ Dangle
- 6 ☐ Marching
- 7 ☐ None/bedrest
- 8 ☐ Passive range of motion
- 9 ☐ Stand
- 10 ☐ Turn

Activity/Mobility:

Level of assistance:

The *Activity* field has been modified to *Activity/Mobility* and the group responses have been updated to include:

- Active range of motion
- Ambulate
- Bed in chair position
- Chair/commode
- Dangle
- Marching
- None/bedrest
- Passive range of motion
- Stand
- Turn
- Free text

Note: The yellow information box has been updated to document only what the patient actually did, not what the patient is capable of doing.

Routine Daily Care J00021639878 LCOE,TEST

Level of assistance: [or free text]

- 1 None
- 2 Dependent/total assist
- 3 Independent/mod independ
- 4 Maximal assist
- 5 Min to moderate assist
- 6 Set up/clean up only
- 7 Supv/contact guard assist

Activity/Mobility:

Level of assistance:

Assistive devices:

Duration out of bed (minutes):

Ambulation distance (feet):

(Next Page)

For *Level of assistance*, the group responses have been updated to include the following:

- None
- Dependent/total assist
- Independent/mod independ
- Maximal assist
- Min to moderate assist
- Set up/clean up only
- Supv/contact guard assist
- Free text

Note: The yellow information box defines levels of assistance.

Routine Daily Care J00021639878 LCOE,TEST

Duration out of bed (minutes):

7 8 9 Del

4 5 6

1 2 3

0 Calc

Activity/Mobility:

Level of assistance:

Assistive devices:

Duration out of bed (minutes):

Ambulation distance (feet):

(Next Page)

A new field for *Duration out of bed (minutes)* has been added in place of *Ambulation duration (minutes)*.

Nursing

Routine Daily Care

Nutritional Related Diagnosis



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

Nutrition Assessment J00021639878 LCOE,TEST

Nutrition related diagnosis:

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

Nutrition monitoring: >

Nutrition related diagnosis: >

Nutrition diagnosis details: >

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

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

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

Nursing
Nutritional Assessment

Standard Diet Orders Update

MEDITECH CPOE Update

EHR
2026.2
Update

Standard Diet Order Updates: Modifiers/Supplements

Updates have been made to the Standard Diet Orders, Modifiers, and Supplements to more accurately capture patient nutrition needs.

Diet Modifiers

The following standardized diet orders has been updated with the new 'No pork' modifier field response:

- Bariatric Diet
- Cardiac/Heart Healthy Diet
- Clear Liquid Diet
- Consistent Carb/Diabetic Diet
- Dysphagia/IDDSI Diet
- Fiber Restricted Diet
- Full Liquid Diet
- Low Fat Diet
- Low Sodium Diet
- Pediatric Diet
- Regular Diet
- Renal Diet
- Adult tube feeding
- Pediatric tube feeding

In addition, the 'Wired jaw' modifier field response has been added to **Regular Diet** only.



CORP.AdvClinicalContent@HCAHealthcare.com

TF Formula: Lookup

Select Options

↑

1	Osmolite 1.5 cal RTH
2	Pediasure 1 cal
3	Pediasure 1.5 cal
4	Pediasure FBR 1 cal 8oz
5	Pediasure FBR 1 cal RTH
6	Pediasure FBR 1.5 cal 8oz
7	Pediasure FBR 1.5 cal RTH
8	Pediasure harvest
9	Pediasure PEP 1 cal 8oz
10	Pediasure PEP 1 cal RTH
11	Pediasure PEP 1.5 cal 8oz
12	Pediasure PEP 1.5 cal RTH
13	Pulmocare 1.5 cal 8oz

Procedure Ordered
Pediatric Tube Feeding

TF Formula: (Or Fr)

1 Alfamino Jr
2 EleCare infant
3 EleCare Jr unflav
4 Ensure harvest

TF Formula:
Route:
Modular #1:
Modular #2:
Modular #3:

Tube Feeding Orders

'Pediasure FBR 1.5 cal RTH' has been added to the **Pediatric Tube Feeding** formula list.

'Prosource TF' and 'Prosource TF20' have been added to both **Adult and Pediatric Tube Feeding Modulares**. <see below>

Enter/Edit Responses : Pediatric Tube Feeding

Procedure Ordered
Pediatric Tube Feeding

Modular #1:

1	Banatot
2	Beneprotein
3	Juven
4	Liquacel
5	Promod liq pro 10 gm
6	Promod liq pro 20 gm
7	Prosource TF
8	Prosource TF20

TF Formula: Pediasure FBR 1.5 cal RTH* Administration Type:
Route:

Modular #1:
Modular #2:
Modular #3:

Error

Prosource TF and Prosource TF20 are intended only for patients 4 years old and older.

Ok

An "Age-Appropriate" **Error Message** has been added to 'Prosource TF' and 'Prosource TF20' that will prohibit ordering these items for patients who are under 4 years of age.

Prosource TF and Prosource TF20 are intended only for patients 4 years old and older.

Enter/Edit Responses : Adult Tube Feeding

Procedure Ordered
Adult Tube Feeding

Diet Modifiers:

1	NPO	5	Clear liquid	9	Finger foods
2	Bariatric	6	Consistent carb	10	Full liquid
3	Cardiac/heart healthy	7	Dysphagia/IDDSI	11	Fundoplication clear
4	Chyle leak	8	Fiber restricted	12	or<F9> For More Options

Diet Modifiers: * Fluid Restriction:
Safety: Adaptive Feeding:

To order supplements see next page

Ok Cancel Help Prev Next

<14 Page Screen>

The *Diet Modifiers* field is now **required*** on both **Adult** and **Pediatric Tube Feeding** orders

Enter/Edit Responses : Pediatric Tube Feeding

Procedure Ordered
Pediatric Tube Feeding

Diet Modifiers:

1 ☒ NPO	5 ☒ Clear liquid	9 ☐ Finger foods
2 ☐ Regular	6 ☐ Consistent carb	10 ☐ Full liquid
3 ☐ Cardiac/heart healthy	7 ☐ Dysphagia/IDDSI	11 ☐ Fundoplication clear
4 ☐ Chyle leak	8 ☐ Fiber restricted	12 ☐ or <F9> For More Options

Diet Modifiers: NPO * Fluid Restriction:

Safety: Adaptive Feeding:

To order supplements see next page

Enter/Edit Responses : Pediatric Tube Feeding

Procedure Ordered
Pediatric Tube Feeding

Supplement 1:

- Banatrof
- Healthy shot
- Banatrof TF
- Hone Regimen

Supplement 1:

Hone Regimen 1: Hone Regimen 2:

Frequency 1: Frequency 2:

Quantity 1: Quantity 2:

For additional supplement see next page

Ok Cancel Help

<15 Page Screen> Prev Next

Supplements

Order Rule Logic has been added to all 'Supplement' fields. If 'NPO', 'Clear liquid', 'Fundoplication clear' or 'Bariatric clear liquid' (*Adults Only*) is entered as a 'Diet Modifiers' and inappropriate supplements are selected, the following **Error Message** will display:

Any Gelatein, Magic cup or Thrive ice cream supplements are not appropriate with NPO or any Clear liquid diet modifiers.

Supplements Added

The following New supplements/flavors have been added and are available for selection if appropriate:

- Juven pineapple coconut
- Magic cup van redu sugar
- Prosource no carb

Note: If the supplement is not appropriate for the ordered diet it will be unavailable in Look-Ups.

Supplements Removed

The following supplements have been removed from **ALL** supplement selections:

- Ensure plus HP Butter Pecan
- Prosource TF

Pressure Support and Airway Tube Size Update



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

RT BiPAP/CPAP Pressure support (cmH2O): 7 8 9 Del 4 5 6 1 2 3 - 0 . Calc Set tidal volume (mL):> O2 Liters per minute: > O2 mL per minute: > FiO2%: > Set IPAP (cmH2O): > Set EPAP/CPAP (cmH2O): > Pressure support (cmH2O): > Set rate (bpm): > P max (cmH2O): >	The <i>Pressure support</i> (cmH2O) has been added to all RT: BiPAP/CPAP interventions.																															
<table border="1"> <thead> <tr> <th colspan="2">Nursing</th> <th>Emergency Department</th> </tr> </thead> <tbody> <tr> <td>RT: BiPAP/CPAP Initial</td> <td>RT PED: BiPAP/CPAP Initial</td> <td>RT: BiPAP/CPAP</td> </tr> <tr> <td>RT: BiPAP/CPAP Subsequent</td> <td>RT PED: BiPAP/CPAP Subsequent</td> <td></td> </tr> <tr> <td>RT: BiPAP/CPAP</td> <td></td> <td></td> </tr> </tbody> </table>		Nursing		Emergency Department	RT: BiPAP/CPAP Initial	RT PED: BiPAP/CPAP Initial	RT: BiPAP/CPAP	RT: BiPAP/CPAP Subsequent	RT PED: BiPAP/CPAP Subsequent		RT: BiPAP/CPAP																					
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Rapid Response Update



The current **Rapid Response/Code Record** combines Rapid Response and Code Blue documentation into a single intervention, leading to confusion, inconsistent documentation, and incomplete data capture. The updated workflow separates these processes by renaming the intervention to **Rapid Response Event Outcome** and removing Code Blue documentation. This change improves documentation consistency, increases visibility into rapid response events, and supports quality improvement initiatives.

The following fields represent when the event was identified, not when the response team arrived.

- Rapid Response Activated Date
- Rapid Response Activated Time

Note: The highlighted box for *Rapid response activated time* instructing to enter 'The time the event was recognized.'

Document the time the response team entered the room in *Rapid response team arrival time* field.

Note: The highlighted information box stating to enter 'The time that the response team entered the room.'

Rapid Response Record

Rapid response activated date:

Calendar Del
Yesterday
Today
Tomorrow

Rapid response activated date:

Rapid response activated time:

Rapid response team arrival time:

Rapid Response Record

Rapid response activated time:

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

The time the event was recognized.

Rapid response activated date:

Rapid response activated time:

Rapid response team arrival time:

Rapid response team reason for call: *

Enter reason for call if OTHER selected:

(Next Page)

Rapid Response Record

Rapid response team arrival time:

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

The time that the response team entered the room.

Rapid response activated date:

Rapid response activated time:

Rapid response team arrival time:

Rapid response team reason for call: *

Enter reason for call if OTHER selected:

(Next Page)

Rapid response team reason for call is required and has the following responses:

- Change in LOC
- Change in vital signs
- Staff/family concern
- Other

When 'Other' is selected for *Rapid response team reason for call*, *Enter reason for call* field becomes required.

The field allows for free text entry.

Use the field **Rapid Response Event Comments** to document additional clinical details that are not captured elsewhere.

Rapid Response Record

Rapid response team reason for call:

- 1 Change in LOC
- 2 Change in vital signs
- 3 Staff/family concern
- 4 Other

Rapid response activated date:>

Rapid response activated time:>

Rapid response team arrival time:>

Rapid response team reason for call: *

Enter reason for call if OTHER selected:

(Next Page) ☐

Rapid Response Record

Enter reason for call if OTHER selected:

Enter free text.

Rapid response activated date:>

Rapid response activated time:>

Rapid response team arrival time:>

Rapid response team reason for call: **Other** *

Enter reason for call if OTHER selected:>

(Next Page) ☐

Rapid Response Record

Rapid response event comments:

Enter free text.
Word wrap allowed.

Rapid response event comments:

Outcome of rapid response:

Rapid response end date:

Rapid response end time:

(Prev Page) ☐ (End) ☐

Rapid Response Record

Outcome of rapid response:

- 1 Code blue initiated
- 2 Patient stayed in room
- 3 Level of care escalated

Rapid response event comments:

Outcome of rapid response:→ *

Rapid response end date:

Rapid response end time:

(Prev Page)

(End)

Outcome of rapid response is a required field and has the following responses:

- Code blue initiated
- Patient stayed in room
- Level of care escalated

Rapid Response Record

Rapid response end date:

Calendar Del

Yesterday

Today

Tomorrow

Rapid response event comments:

Outcome of rapid response:→ *

Rapid response end date:→

Rapid response end time:

The *Rapid response end date* and *Rapid response end time* fields allow for documentation of the end date and time of the rapid response.

Rapid Response Record

Rapid response end time:

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

Rapid response event comments:

Outcome of rapid response:→ *

Rapid response end date:→

Rapid response end time:→

(Prev Page)

(End)

Nursing	Surgery
Rapid Response Event Outcome	SURG: Rapid Response Event Outcome Pre+
	SURG: Rapid Response Event Outcome Int+
	SURG: Rapid Response Event Outcome PAC+

Restraint 2026 Phase 2 Strategic Agenda



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

Restraint Documentation

Alternatives attempted:

- 1 ☐ Decreased stimulation
- 2 ☐ Diversion
- 3 ☐ Hygiene
- 4 ☐ Mobility
- 5 ☐ Pain management
- 6 ☐ Relaxation
- 7 ☐ Reorientation
- 8 ☐ Room location
- 9 ☐ Room setup
- 10 ☐
- 11 ☐
- 12 ☐
- 13 ☐

Alternatives attempted: _____

Date restraints initiated: _____

Time restraints initiated: _____

(Next Page)

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

Factors affecting behavior:

- 1 ☐ Agitation
- 2 ☐ Altered consciousness
- 3 ☐ Bowel/bladder difficulty
- 4 ☐ Confused
- 5 ☐ Emotional stress
- 6 ☐ Environmental discomfort
- 7 ☐ Fever
- 8 ☐ Medical condition
- 9 ☐ Medication effect
- 10 ☐ Pain
- 11 ☐ Restlessness
- 12 ☐ Sensory deficit
- 13 ☐ Unable to comprehend

Factors affecting behavior: _____ *

Alternatives attempted: _____ *

Patient would be safer in restraint: _____ *

Safe application/least restrictive restraint verified: _____ *

Restraint notification to: _____ *

Observed restraints appropriately intact:

- 1 ☐ Yes
- 2 ☐ No
- 3 ☐ Not applicable

Monitor/RN assess should be done at a minimum of every 2 hours.

Observed restraints appropriately intact: _____ *

Response to restraint: _____ *

Level of consciousness: _____ *

Reviewed reason for restraints: _____

Reviewed criteria for release/reassessment: _____

(Prev Page) (Next Page)

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

Restraint Documentation

☒ Restraints are clinically justified:

1 Yes
2 No

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

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

Restraints clinically justified: ☐ *

Reasons reviewed: ☐ *

Least restrictive type planned: ☐ *

Alternatives attempted, ineffective documented: ☐ *

Cause of patient reviewed: ☐ *

Consideration for vulnerability: ☐ *

Justified for restraint type/device: ☐ *

Assessed restraints were safely and appropriately applied: ☐ *

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

(Prev Page) ☐ (Next Page) ☐

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

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

Restraint Documentation

☒ Safety/Rights/Dignity maintained verified:

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

Done now - use to document each observation in real time, three times every hour.

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

Safety/Rights/Dignity maintained verified:

(Prev Page) ☐ (Next Page) ☐

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

Restraint Documentation

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

1 Yes
2 No

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

Evaluated the patients immediate situation: ☐ *

Evaluated the patients reaction to the intervention: ☐ *

Evaluated the patients medical and behavioral condition: ☐ *

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

(Prev Page) ☐ (Next Page) ☐

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

Restraint Documentation

Response to restraint:

1 Tolerant
2 Combative

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

Response to restraint: *

Vital signs taken per unit policy or doctors orders: *

Free from injury or pain associated with restraint: *

Free from respiratory/airway compromise associated with restraint: *

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

Range of motion done: *

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

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

Restraint Documentation

Date restraint discontinued:

Calendar Del
Yesterday
Today
Tomorrow

Date restraint discontinued: *

Time restraint discontinued: *

(Prev Page) (End)

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

Restraint Debriefing

Circumstances leading to restraint/seclusion incident:

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

Circumstances leading to restraint/seclusion incident:→

Recommendations for future actions:→

Post counseling provided to: *

Debriefing Comment:→

(End)

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

RUN DATE: 02/17/26
 RUN TIME: 0900
 RUN USER: LPD008442

KYA QAI NUR **TEST**
 RESTRAINTS REPORT

PAGE 1

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

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

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

PPS - Patients
 FTF - Face to Face
 RN FTF - Nursing FTF completed (Y, N or N/A)
 POC - Restraints RN added to plan at time
 EPS MINS - # of mins for entire episode
 TF MINS - # of mins w/ selected timeframe

o = No end w/ 60 mins (before/after)
 s = Ord and Doc Rest Devs do not match
 j = Ord and Doc Clin Just do not match
 n = RN Monitor not doc'd QIR

e = doc in EDM I.E. e,n = start/doc in EDM & doc in NUR
 n = doc in NUR *There will only appear once
 s = doc in SDRG *Loc one listed is where originated

X = Expired w/ 24 hrs of Episode
 d = To Spec DC doc'd (DC For Only)
 PK = Order originated in Pt Keeper

Report Name: WDR_PC_VGRH.scus.hca.restraints.rpt.v1.0008

Note: RN FTF has been added to the legend.

The Restraints Report has been updated with the following changes:

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

This update affects the following interventions:

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

Telemetry Unavailable Optimization



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

Telemetry Application/Discont

13 Telemetry unavailable and patient maintained on continuous monitor:

☒ Yes

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

Telemetry unavailable and patient maintained on continuous monitor:>Yes

Telemetry application date:

Telemetry application time:

RUN DATE: 04/07/26 QAIA FACILITY (QAA) **ADMISSIONS** PAGE 1
 RUN TIME: 1511 Patient Handoff Report
 RUN USER: QLS8135

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

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

Brief History:

Allergies: No Known Allergies

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

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

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

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

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

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

Telemetry Application/Discont

13 Telemetry box number:

Enter free text.

Telemetry unavailable and patient maintained on continuous monitor:>

Telemetry application date:>04/07/26*
 Telemetry application time:>1200*

RUN DATE: 04/07/26 QAIA FACILITY (QAA) **ADMISSIONS** PAGE 1
 RUN TIME: 1557 Patient Handoff Report
 RUN USER: QLS8135

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

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

Brief History:

Allergies: No Known Allergies

Tele application date: 04/07/26
 Tele application time: 1200

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

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

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

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

Telemetry Application/Disconti

Telemetry discontinued date:

Calendar Del
Yesterday
Today
Tomorrow

Telemetry unavailable and patient maintained on continuous monitor:*

Telemetry application date: 04/07/26*

Telemetry application time: 1430*

Telemetry box number: 12345

Telemetry discontinued date: 04/09/26

Telemetry discontinued time: 0800*

PAGE 1

RUN TIME: 1606 Patient Handoff Report

RUN USER: QLS0135

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

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

Brief History:

Allergies: No Known Allergies

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

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

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

STANDARD Nurse Tracker- LCoE (SP=LEARNING CENTER OF EXCELLENCE)					
Current Patient		Lcoe,Edpatient - 33/M			J00021620333
RM/LOC/PRI	PT Name/RN/MD	Age/Sex/Status		Complaint/Orders	LOS
MAIN12	Lcoe,Edpatient	33	M	SUN	Cardiac Re
MAIN11-1	TROTTER, DYER, TAN			PRE C	MED RAD RN
holding					TELE holding
MAIN50	Test, Sarah	51	F	TR	GI/Abdomin
MAIN3	TROTTER, DR.CPOE			REG E	

ED TRACKER

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

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

BH Module

Mobility Nursing Strategic Agenda Enhancements



This update will enhance documentation in the **BH: Activity Assessment** to standardize capture of patient activity/mobility and level of assistance, improving multidisciplinary communication, visibility into functional status, and correlation with outcomes including length of stay, falls, NVHAP, CAUTI/CLABSI, restraint use, and pressure injuries.

Activity Assessment J00021639878 LCOE,TEST

Level of assistance: [or free text]	
1 None	Supervision/contact guard assist: Supervision, verbal cues or touching assistance such as holding gait belt loosely.
2 Dependent/total assist	Minimal to moderate assist: Patient completes 50% or more of total task/effort with physical assistance.
3 Independent/mod independ	
4 Maximal assist	
5 Min to moderate assist	Maximal assist: Patient contributes, but completes less than 50% of total task/effort with physical assistance.
6 Set up/clean up only	
7 Supv/contact guard assist	Dependent/total assist: Patient does not contribute to completion of task or requires assistance of two helpers.

Level of assistance: >

Development delays:

Activity restrictions:

Group responses for the *Level of Assistance* field in the **BH: Activity Assessment** have been updated to the following:

- None
- Dependent/total assist
- Independent/mod independ
- Maximal assist
- Min to moderate assist
- Set up/clean up only
- Supv/contact guard assist
- Free text

Note: The yellow information box defines levels of assistance.

Behavioral Health

BH: Activity Assessment