

Restraint 2026 Phase 2 Strategic Agenda



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 Restraint documentation workflows have been streamlined to remove duplicative, outdated, and non-required elements.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

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

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

Restraint Documentation

☒ Restraints are clinically justified:

1 Yes
2 No

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

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

Restraints clinically justified: ☐ *

Reasons reviewed: ☐ *

Least restrictive type planned: ☐ *

Alternatives attempted, ineffective documented: ☐ *

Cause of patient reviewed: ☐ *

Consideration for vulnerability: ☐ *

Justified for restraint type/device: ☐ *

Assessed restraints were safely and appropriately applied: ☐ *

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

(Prev Page) ☐ (Next Page) ☐

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

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

Restraint Documentation

☒ Safety/Rights/Dignity maintained verified:

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

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

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

Safety/Rights/Dignity maintained verified:

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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:
 *

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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.

[illegible]

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 +

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.



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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 Modulators**. <see below>

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.

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

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: []

Route: []

Modular #1: []

Modular #2: []

Modular #3: []

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

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	☐ For More Options

Diet Modifiers: NPO Clear liquid

Fluid Restriction: []

Safety: []

Adaptive Feeding: []

To order supplements see next page

Error

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

Ok

Supplement 1:

1	Banatot
2	Healthy shot
3	Banatot TF
4	Home Regimen

Home Regimen 1: []

Frequency 1: []

Quantity 1: []

Home Regimen 2: []

Frequency 2: []

Quantity 2: []

For additional supplement see next page

Ok Cancel Help

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Supplements Added	Supplements Removed
The following <u>New</u> supplements/flavors have been added and are available for selection if appropriate: • Juven pineapple coconut • Magic cup van redu sugar • Prosource no carb Note: <i>If the supplement is not appropriate for the ordered diet it will be unavailable in Look-Ups.</i>	The following supplements have been removed from ALL supplement selections: • Ensure plus HP • Prosource TF

Nursing, EDM & SUR Modules

Pressure Support and Airway Tube Size Update



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

RT BiPAP/CPAP

☐ **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 *Pressure support (cmH2O)* has been added to all **RT: BiPAP/CPAP** interventions.

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

RT Intubation

☐ **Airway tube size** [or free text]

1	2mm	8	5.5mm	15	9mm
2	2.5mm	9	6mm	16	9.5mm
3	3mm	10	6.5mm	17	10mm
4	3.5mm	11	7mm	18	10.5mm
5	4mm	12	7.5mm	19	11mm
6	4.5mm	13	8mm	20	12mm
7	5mm	14	8.5mm		

Intubation treatment:

Intubation date:

Intubation time:

Intubation performed by:

Number of attempts to intubate:

Airway tube size:

Evidence of aspiration prior to intubation:

Cuffed:

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

- Free text
- 11mm
- 12mm

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

Nursing & EDM Modules

Telemetry Unavailable Optimization



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

Telemetry Application/Discontinuation

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 QALIA 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 Vaco Mx: None Documented

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

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

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

Telemetry Application/Discontinuation

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 QALIA 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 Vaco Mx: None Documented

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

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

Telemetry Application/Disconti

Telemetry discontinued date:

Calendar Del
Yesterday
Today
Tomorrow

Telemetry unavailable and patient maintained on continuous monitor:*

Telemetry application date:04/07/26*

Telemetry application time:1430*

Telemetry box number:12345

Telemetry discontinued date:04/09/26

Telemetry discontinued time:0800*

PAGE 1

RUN TIME: 1606 Patient Handoff Report

RUN USER: QLS0135

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

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

Brief History:

Allergies: No Known Allergies

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

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

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

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

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

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

ED TRACKER

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

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

Alteplase - Alignment with Large Volume IV Pump Library

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

The new enhancements consist of the following:

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

New Screens – Provider View

Alteplase – STEMI

Enter/Edit Rx's Administration Criteria

Administration Criteria: **Alteplase - STEMI ADLT05**

Erase Admin Crit
Save as Favorite

Patient's Weight (kg): 78.93 *

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

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

** Initial Infusion maximum dose: 50 mg **

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

** Subsequent infusion maximum dose: 35 mg **

Total Dose: 100 * mg

** Maximum TOTAL Dose: 100 mg **

Amount to waste: 0 * mg

Dosing calculations using the patient's weight

"Amount to waste" field

Ok Cancel Help Prev Next



Alteplase - IV Frostbite

Enter/Edit Rx's Administration Criteria

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

Erase Admin Crit
Save as Favorite

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

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

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

Amount to waste: **16** mg

"Amount to waste" field

Ok Cancel Help Prev Next

New Screens – Pharmacy View

Alteplase – STEMI

Enter/Edit Admin Criteria

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

CDS: **hcarx.ALTEPL05C**

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

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

Amount to waste: **0** * mg

"Amount to waste" field

Ok Cancel Help Prev Next

Alteplase – IV Frostbite

Enter/Edit Admin Criteria

Mnemonic Active ☒ Description
Display Type

CDS

Patient's Weight (kg): *

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

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

Amount to waste: mg

Ok Cancel Help Prev Next

Dosing calculations using the patient's weight

"Amount to waste" field

Nursing & SUR Modules

2026 eCQM HH-PRF (Hospital Harm Postoperative Respiratory Failure)



Currently, identification of Cath Lab patients who receive anesthesia and subsequently experience postoperative respiratory failure during the same hospitalization relies on non-standardized procedural data sources from third-party applications. These complications, including unplanned intubation or delayed extubation occurring outside of the procedural or surgical setting, are difficult to consistently capture without a clear indication of when the patient was in a procedural area.

This update will establish a standardized, EHR-based approach within Meditech to capture procedural timing and related anesthesia events at the point of care. By clearly identifying when a patient is in a procedural setting, Quality teams can more reliably identify, track, and analyze postoperative respiratory failure events, supporting improved clinical oversight, quality monitoring, and eCQM reporting.

Procedural and PACU staff play a critical role in this process by documenting the required intervention in Meditech. Accurate and timely documentation ensures the procedural context is clearly defined, enabling reliable eCQM measurement and reporting.

The new intervention, **Cath Lab Procedure +**, will replace the **PCI Procedure** intervention.

Is this a PCI procedure has a 'Yes' or 'No' response.

Note: The yellow information box stating, "This is a quality measure data point," is available on most fields in this intervention.

Cath Lab Procedure J00021639878 LCOE,TEST

Procedure start time:

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

Enter all details related to the procedure below.

These are quality measure data points.

Is this a PCI procedure: ☐ Yes

Procedure start time:

Procedure start date:

Procedure end time:

Procedure end date:

Anesthesia type:

The following fields are time and date related responses for:

- Procedure start time
- Procedure start date
- Procedure end time
- Procedure end date

Cath Lab Procedure J00021639878 LCOE,TEST

Anesthesia type:

1	2	3	4	5	6	7	8	9	0	Del
Q	W	E	R	T	Y	U	I	O	P	\
A	S	D	F	G	H	J	K	L		
Z	X	C	V	B	N	M	,	.		

Lookup

Use F9 key to pull up Anesthesia type options. Select the type used with this procedure.

These are quality measure data points.

Anesthesia type:

Anesthesia provider start time:

Anesthesia provider start date:

Anesthesia provider end time:

Anesthesia provider end date:

Anesthetic Type Lookup

Select

Mnemonic	Description
1	EPI Epidural Anesthetic
2	GEN General Anesthesia
3	GENEPI Combined General/Epi
4	GENREG Combined General/Reg
5	GENSPI Combined General/Spi
6	LOCAL Local Anesthesia
7	MAC Monitored Anes Care
8	MOD Moderate Sedation
9	NONE None
10	PER Peribulbar
11	REG Regional Anesthesia
12	SPI Spinal Anesthetic
13	SPIEPI Combined Spinal/Epi
14	SPIREG Combined Spinal/Reg

<End of list>

Anesthesia type will look up into the facility specific Anesthesia Types available. Below is an example of responses:

- Epidural Anesthetic
- General Anesthesia
- Combined General/Epi
- Combined General/Reg
- Combined General/Spi
- Local Anesthesia
- Monitored Anes Care
- Moderate Sedation
- None
- Peribulbar
- Regional Anesthesia
- Spinal Anesthesia
- Combined Spinal/Epi
- Combined Spinal/Reg

Cath Lab Procedure J00021639878 LCOE,TEST

Anesthesia provider start time:

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

Enter all details related to the procedure below.

These are quality measure data points.

Anesthesia type: GEN General Anesthesia

Anesthesia provider start time:

Anesthesia provider start date:

Anesthesia provider end time:

Anesthesia provider end date:

(End)

The following fields are time and date related responses for:

- Anesthesia provider start time
- Anesthesia provider start date
- Anesthesia provider end time
- Anesthesia provider end date

Nursing	SURG
Cath Lab Procedures +	SURG: Cath Lab Procedure Intra-op+ & PACU

Nursing & Ancillary Modules

Nutritional Related Diagnosis



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

Nutrition Assessment J00021639878 LCOE,TEST

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

Nutrition monitoring:→

Nutrition related diagnosis:→

Nutrition diagnosis details:→

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

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

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

Nursing

Nutritional Assessment

Nursing Module

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:

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

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

Routine Daily Care

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

Supervision/contact guard assist: Supervision, verbal cues or touching assistance such as holding gait belt loosely.

Minimal to moderate assist: Patient completes 50% or more of total task/effort with physical assistance.

Maximal assist: Patient contributes, but completes less than 50% of total task/effort with physical assistance.

Dependent/total assist: Patient does not contribute to completion of task or requires assistance of two helpers.

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