EBCD MEDITECH Content Updates – 2025.3 All Modules

Overview

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

Inpatient Rehab Facility Enhancements education will be posted separately.

How to use this guide

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

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

Impact Legend:

Safety/Regulatory	Clinical Initiative	Women's and Children's
	T.	
Reimbursement/Billing	Enhancements/Wins	

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

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

Reviewed/Revised: 08/05/2025

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

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Summary of Revisions	

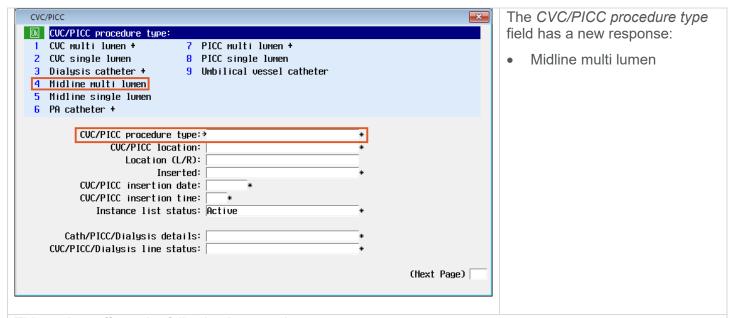
Date	Revision

Nursing, EDM & SUR Modules

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.

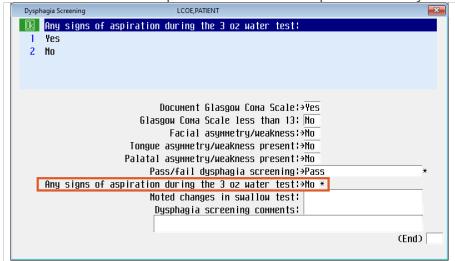


Nursing	Emergency Department	Surgery
Critical Care Flow Record	CVC/PICC	SURG: Lines, Drains, Airways Intra-op
Lines/Drains/Airways	Newborn Stabilization	SURG: Lines, Drains, Airways Pre-op
		SURG: Lines, Drains, Airways PACU

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.

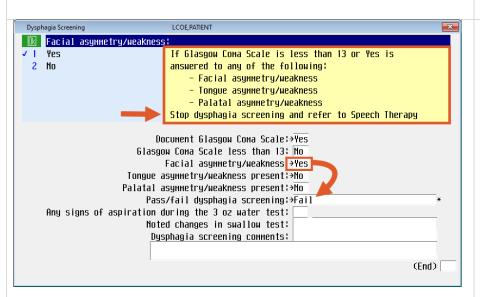


If "No" is answered for:

- 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.



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

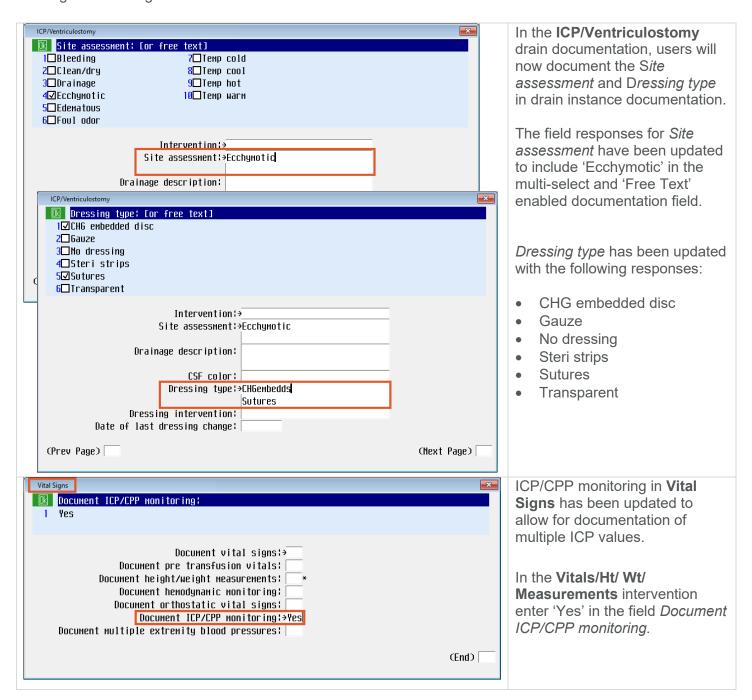
Then patient *Fails* the dysphagia screening and needs to be referred to Speech Therapy.

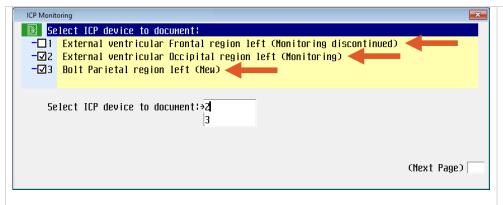
Nursing	Emergency Department	Surgery
Dysphagia Screening +	Dysphagia Screening	SURG: Dysphagia Screening PAC +
Neuro Checks +		

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.

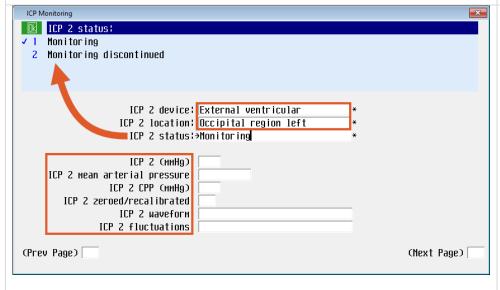




Select ICP device to document is a multi-select response field. A list of devices documented in **Drains** will automatically populate.

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

- New
- Monitoring
- Monitoring discontinued



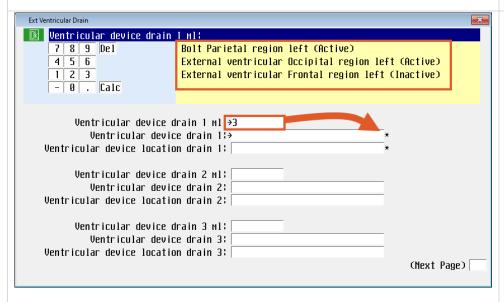
ICP device and ICP location will pre-populate to ensure consistent documentation:

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

- Monitoring
- Monitoring discontinued

<u>Note:</u> The following fields have been added for each instance:

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



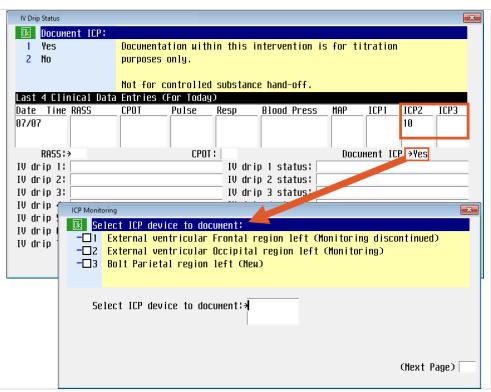
Ventricular Drain output will be documented in the **Intake and Output** intervention.

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

- Ventricular device
- Ventricular device location

<u>Note:</u> 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.



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.

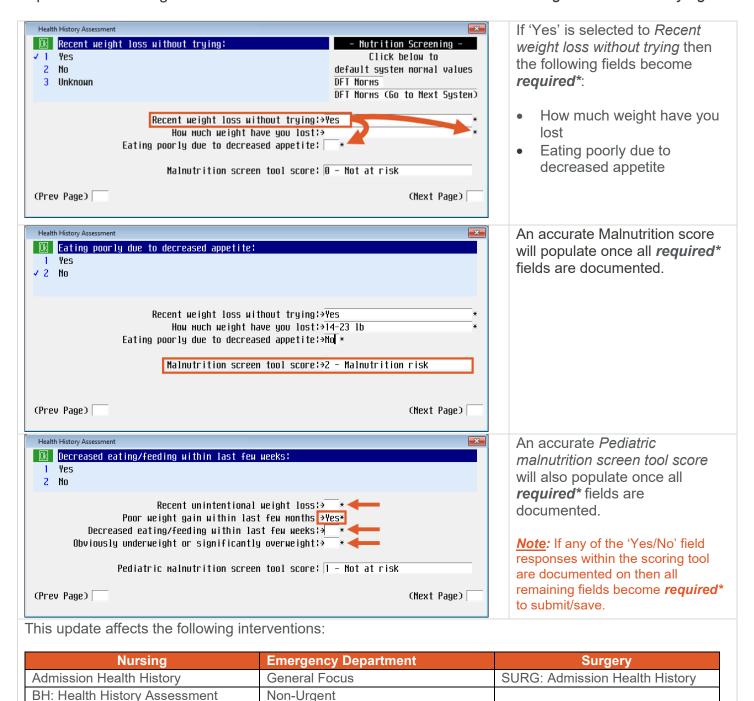
Note: A list of documented devices will automatically populate with the ICP drain status in the Yellow comment box.

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	

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*.



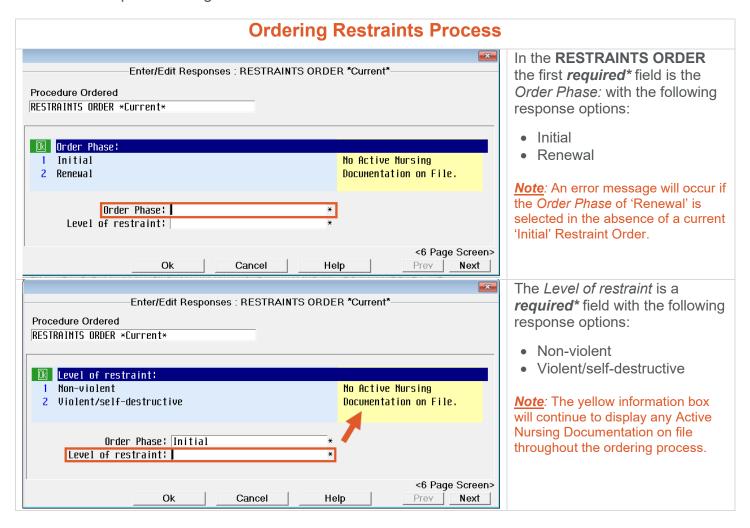
Paramedic Intake

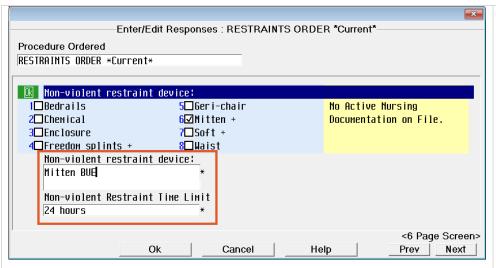
BH: Outpatient Nutrition Assessment

Restraints Initiative Update

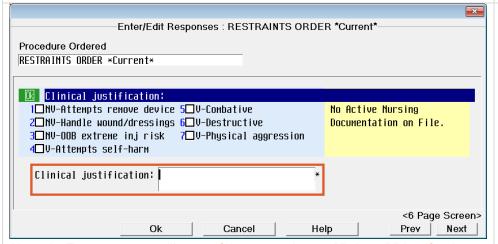


Inappropriate restraint utilization has heightened regulatory risk with inconsistent practices and outcomes for managing restraints effectively. As part of the 2025 Strategic Priorities, we have identified ways to drive appropriate restraint utilization by optimizing both the ordering of restraints and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





Enter/Edit Responses: RESTRAINTS ORDER *Current* Procedure Ordered RESTRAINTS ORDER *Current* ■ Violent restraint device: 1**☑**Chemical 5□Seclusion No Active Nursing 2□Enclosure 6□Soft + Documentation on File. 3□Physical holding <mark>7</mark>□Synthetic + 4□Restrictive positioning Violent restraint device: Chemical Violent Restraint Time Limit 4 hours <6 Page Screen> Ok Next Cancel Help Prev



<u>Note</u>: 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**.

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.

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.

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

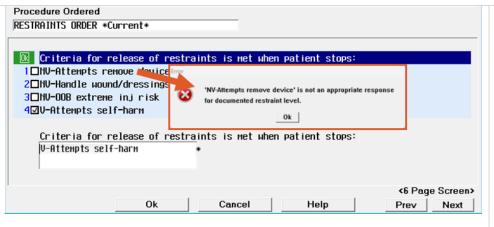
Clinical justification is a required field.

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:

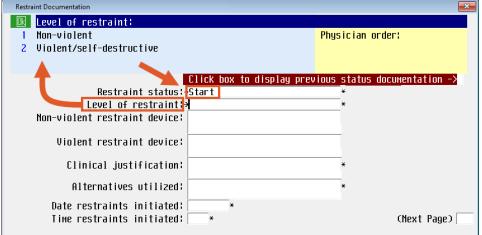
- V-Attempts self-harm
- V-Combative
- V-Destructive
- V-Physical aggression



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.

NURSING DOCUMENTATION



In the **Restraint Documentation +** intervention,

Level of restraint will become a

required* field when 'Start' is
selected for the Restraint status.

The available *Level of restraint* responses are:

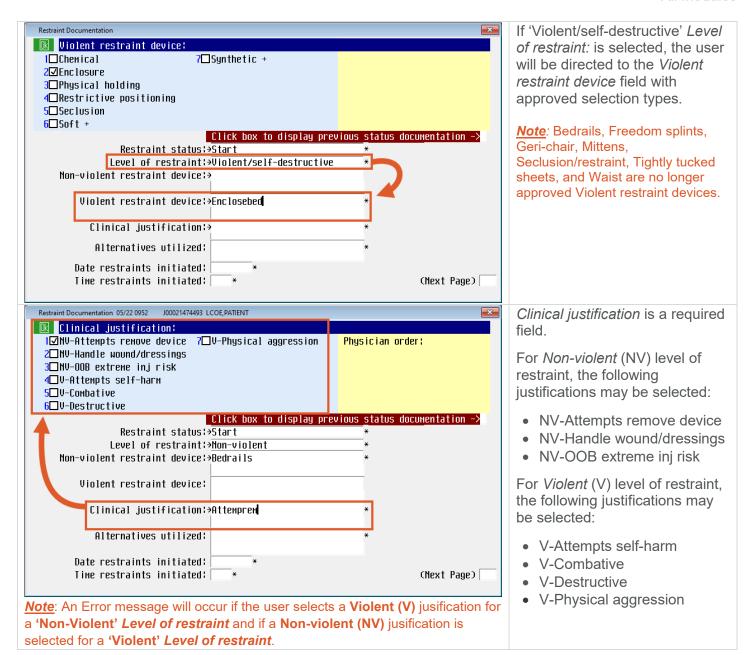
- Non-violent
- Violent/self-destructive

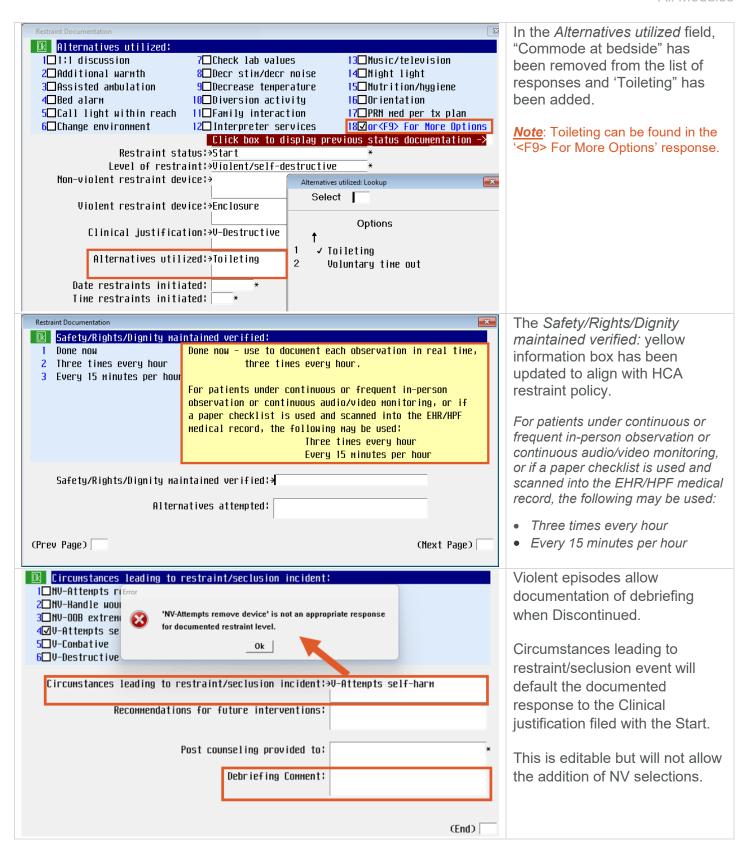
Restraint Documentation Mon-violent restraint device: 1☑Bedrails 7□Soft + Physician order from 2□Chemical 8□Waist 05/22/25 at 0606: 3□Enclosure Bedrails 4□Freedom splints + 5□Geri-chair 6□Mitten + Click box to display previous status documentation -> Restraint status:>Start Level of restraint:→Non-violent Non-violent restraint device:→Bedrails Violent restraint device: Clinical instification: 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.

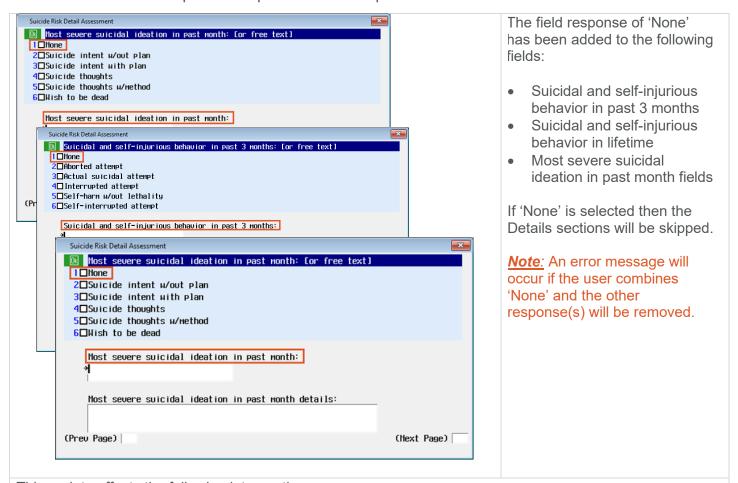




Suicide Risk Detail Assessment (SRDA) Field Updates



To support regulatory documentation requirements, the Suicide Risk Detailed Assessment (SRDA) has been updated to include 'None' in several field response options. This update will reduce the need for free text and improve compliance with completion.

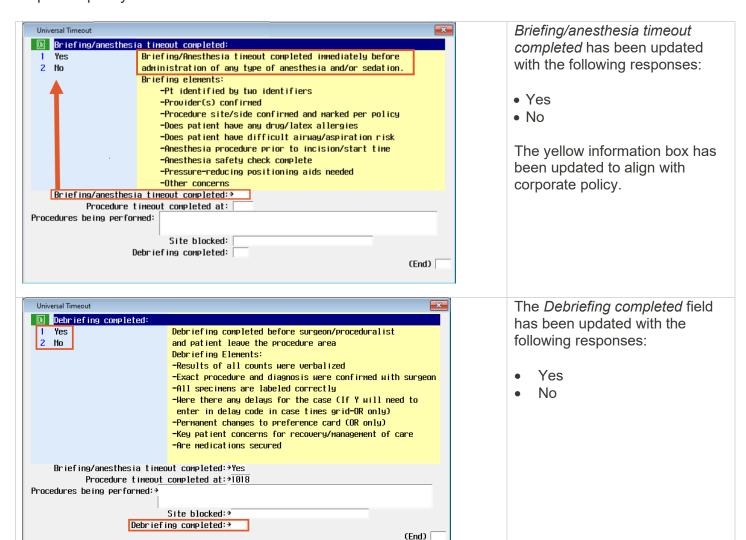


Nursing	Emergency Department	Surgery
BH: Level of Care Assessment +	Detailed Risk Assessment	SURG: Safety/Risk/Regulatory +
BH: Initial Nurse Assessment (INA) +	BH Level of Care Assessment	SURG: Safety/Risk/Regulatory Int +
BH: Psychosocial Assessment (PSA) +	Suicide Risk Detail Assessment	SURG: Safety/Risk/Regulatory PAC +
BH: RN Reassessment +	Suicide/Homicide Screening	
BH: Suicide/Homicide Screen +	Suicide/Homicide Rescreening	
BH: Outpatient Initial Nurse Assessment+		
BH: Suicide Risk Detail Assessment +		
Safety/Risk/Regulatory		

Universal Timeout Updates



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



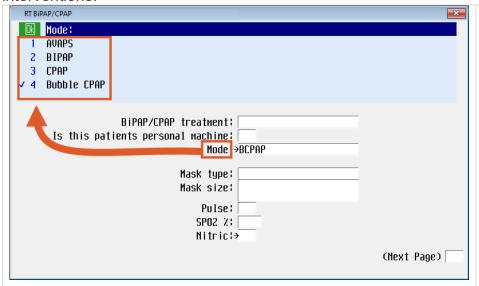
Nursing	Emergency Department	Surgery
Universal Timeout	Universal Timeout	SURG: Universal Timeout Intra-op
Moderate Sedation	Moderate Sedation	SURG: Universal Timeout PACU
Lines, Drains, Airways	Lines, Drains, & Airways	SURG: Universal Timeout Pre-op
OB: OR Record	Temporary Pacemaker	SURG: Moderate Sedation 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

Nursing & EDM Modules

Respiratory Therapy Intervention Updates

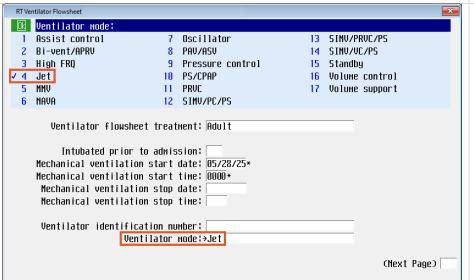


Current RT EBCD Intervention templates lack sufficient fields that lead to decreased efficiency and missing data values for respiratory patients. Updates will include a new Bubble CPAP field response, additional fields in the Jet Mode section, and other fields to allow for adequate documentation of RT interventions.



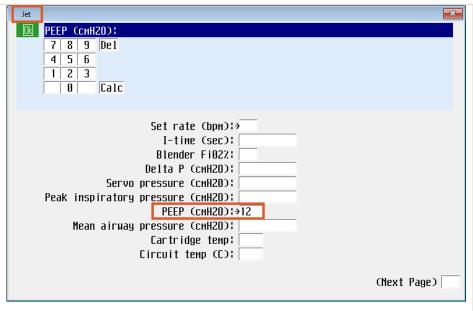
'Bubble CPAP' has been added to the Mode field response options documenting **RT BiPAP/CPAP**.

Note: This update has been added to the **RT BiPAP/CPAP Initial** and the **RT BiPAP/CPAP Subsequent** interventions.

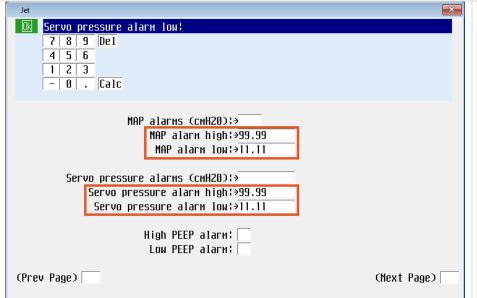


In the RT Ventilator Flowsheet, the following fields have been added when the response 'Jet' is selected for the *Ventilator mode* field:

- PEEP
- High & Low MAP
- Servo Pressure Alarms
- Backup Rate
- Backup PIP
- Backup inspiratory pressure
- Backup I-time

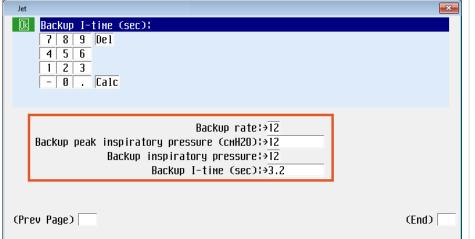


PEEP (cmH2O) has been added to page 2 of **Jet Ventilator Mode** screen and supports a response up to 2-digits.



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

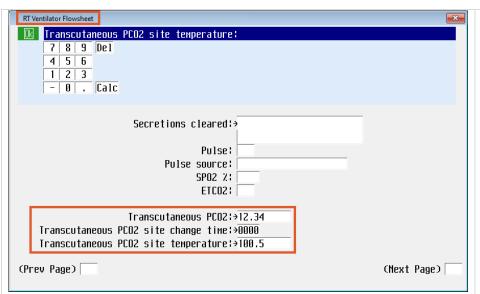
- MAP alarm high
- MAP alarm low
- Servo pressure alarm high
- Servo pressure alarm low



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)

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



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:

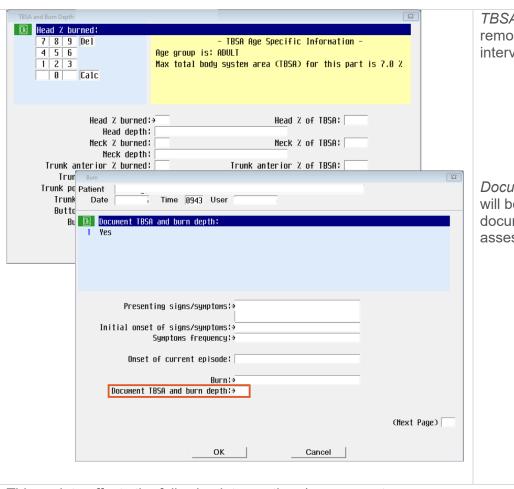
Nursing	Emergency Department
RT: Ventilator Flowsheet	RT: Ventilator Flowsheet
RT: PEDS Ventilator Flowsheet	RT: BiPAP/CPAP Initial
RT: BiPAP/CPAP Initial	RT: BiPAP/CPAP
RT: BiPAP/CPAP Subsequent	
RT: BiPAP/CPAP	
RT PEDS: BiPAP/CPAP Initial	
RT PEDS: BiPAP/CPAP	

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

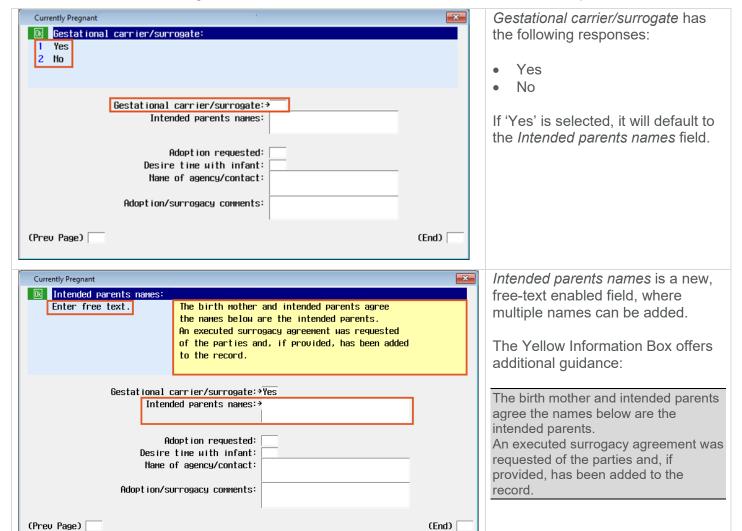
Nursing & SUR Modules

Admission Health History: Currently Pregnant Updates



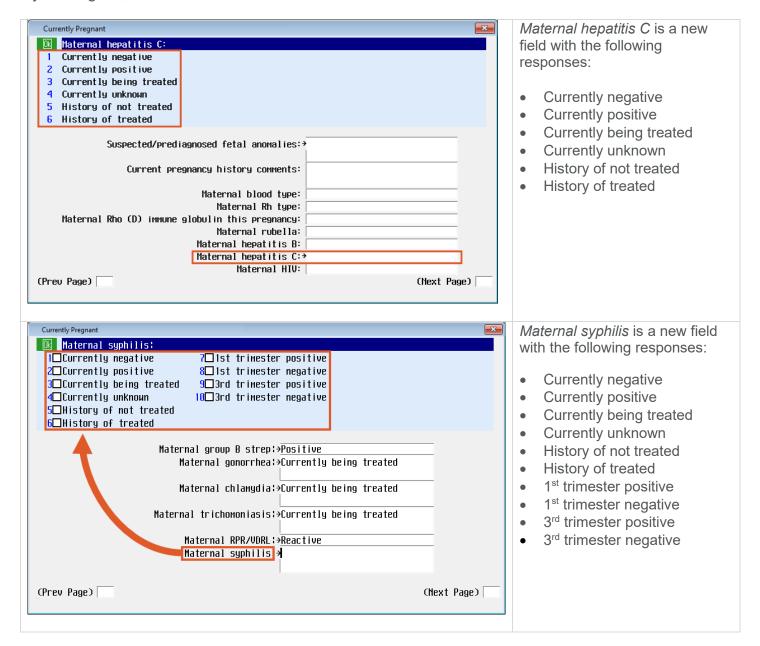
Surrogacy Updates

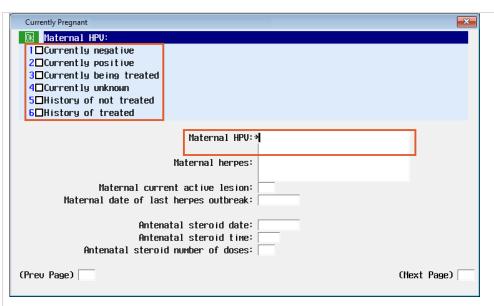
Currently, the **Admission Health History** form does not have a space to list the names of the intended parents for a gestational carrier or surrogate. Under the domain of surrogacy, proper documentation of the intended parents supports patient safety and the validation of parentage under the terms 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.



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.





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

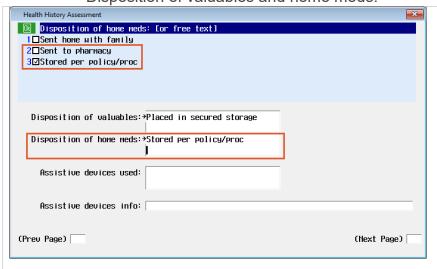
These updates affect the following interventions/assessments:

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

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 <u>Discharge Instructions</u> update for information regarding the alert for Disposition of valuables and home meds.



Disposition of home meds has a new response:

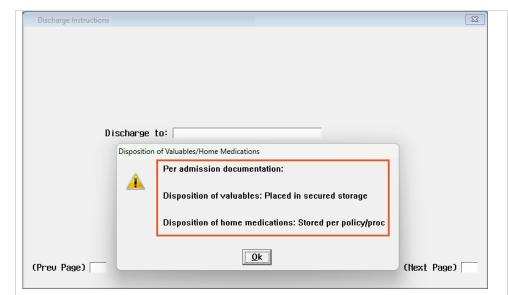
Stored per policy/proc

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.



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.

<u>Note</u>: 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

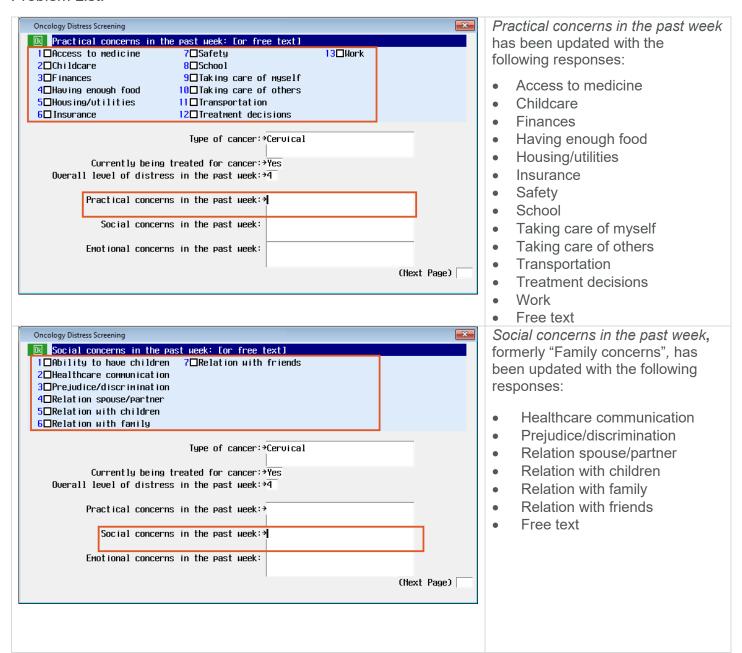
Discharge Instructions

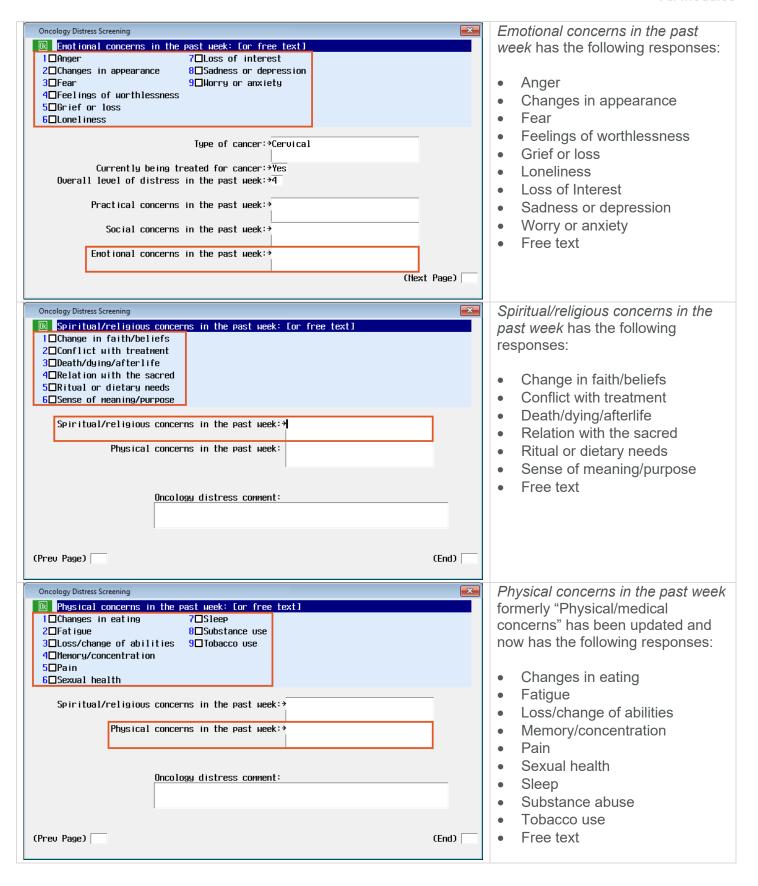
BH: Discharge Instructions Home

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 continued

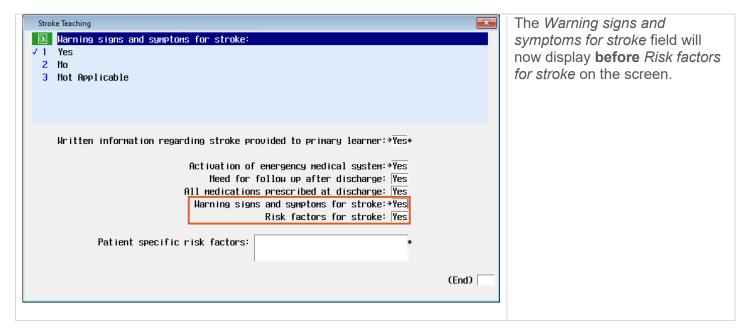
This update affects the following interventions/assessments:

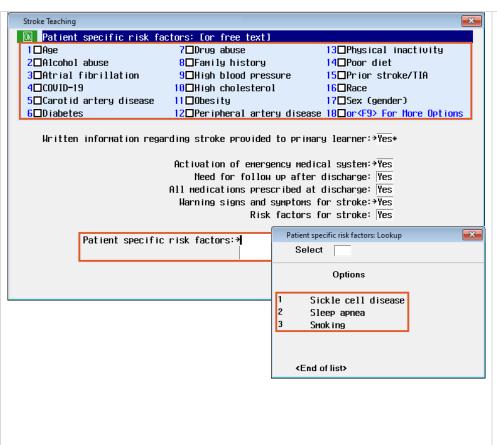
Nursing	Emergency Department	Surgery
Oncology Distress	Detailed Assessment	SURG: Admission Health History
BH: Health History Assessment	Non-urgent General Focus	
Admission Health History	Paramedic Intake	

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.





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

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

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

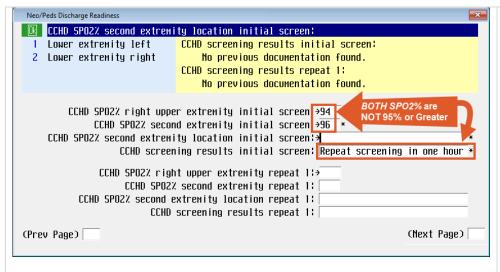
Nursing Modules

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.



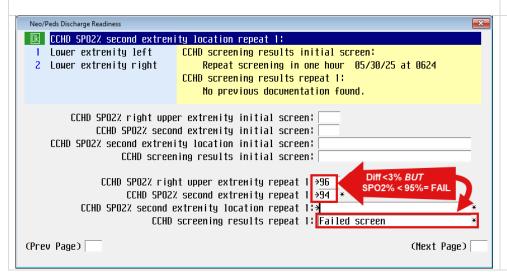
The CCHD screening results has been updated to align with the new screening algorithm.

<u>Note:</u> 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.



Repeat Screening

There is now only one retest following an indeterminate measurement

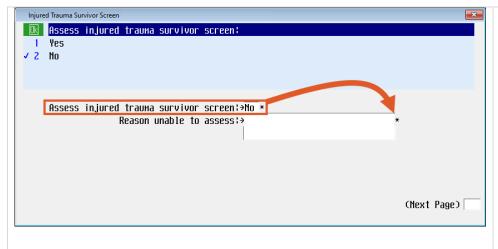
In current state: this would result in a passed screen.

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

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.

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

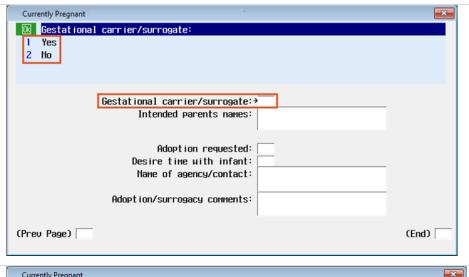
BH Module

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:

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)

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

The Yellow Information Box offers additional guidance:

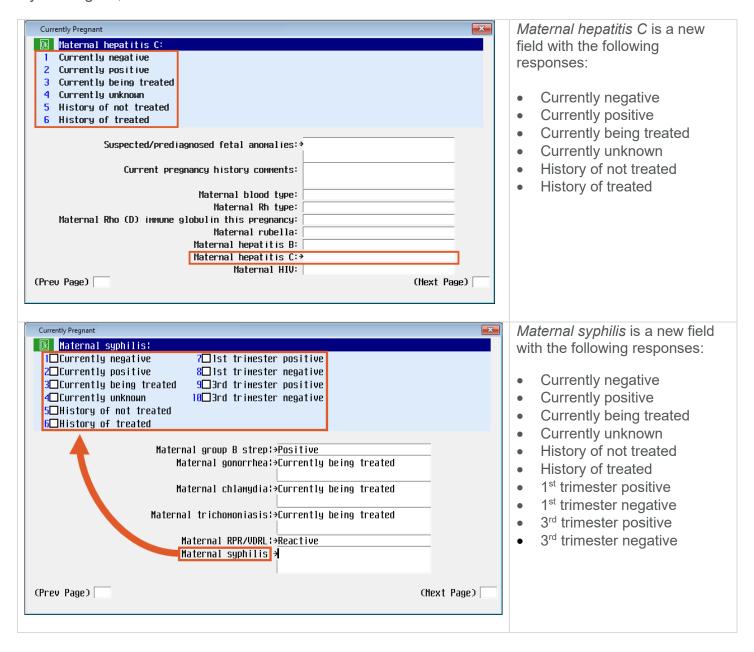
The birth mother and intended parents agree the names below are the intended parents.

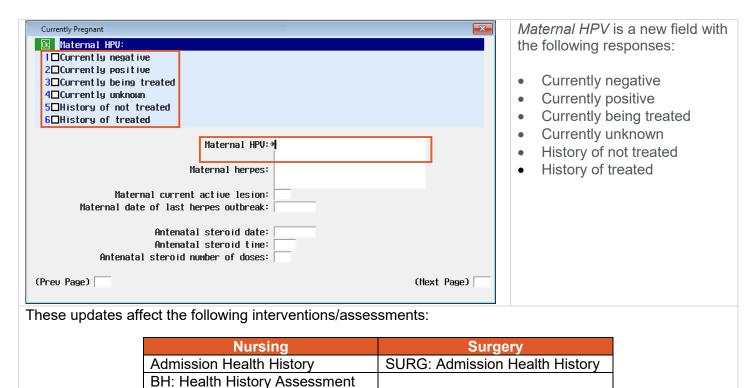
An executed surrogacy agreement was

An executed surrogacy agreement was requested of the parties and, if provided, has been added to the record.

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.





Disposition of Home Meds



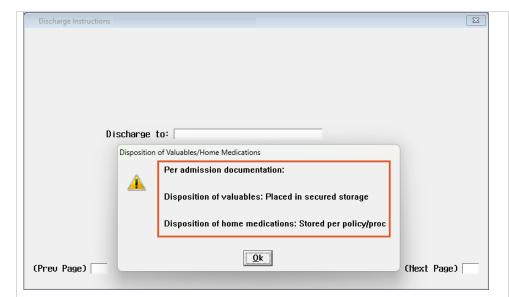
The **Health History Assessment** has been updated to provide a new response option to document that a patient's home medications were secured or stored during the admission process. See the Discharge Instructions update for information regarding the alert for Disposition of valuables and home meds.



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.



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

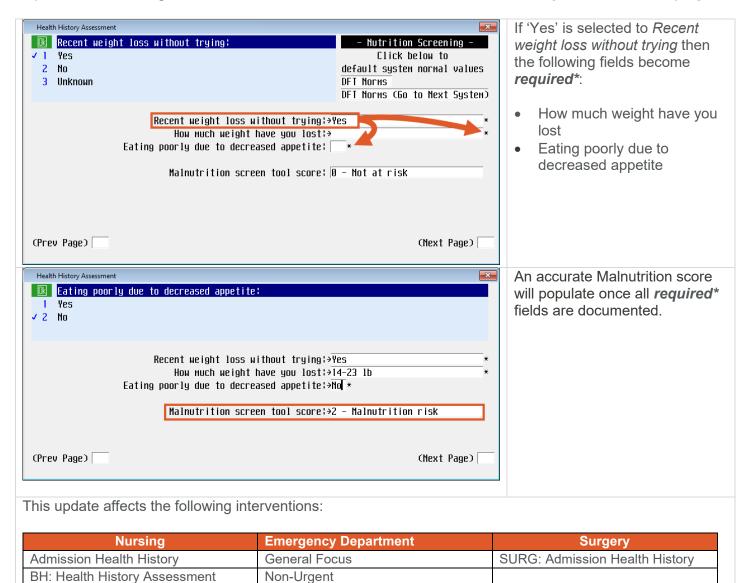
Discharge Instructions

BH: Discharge Instructions Home

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*.



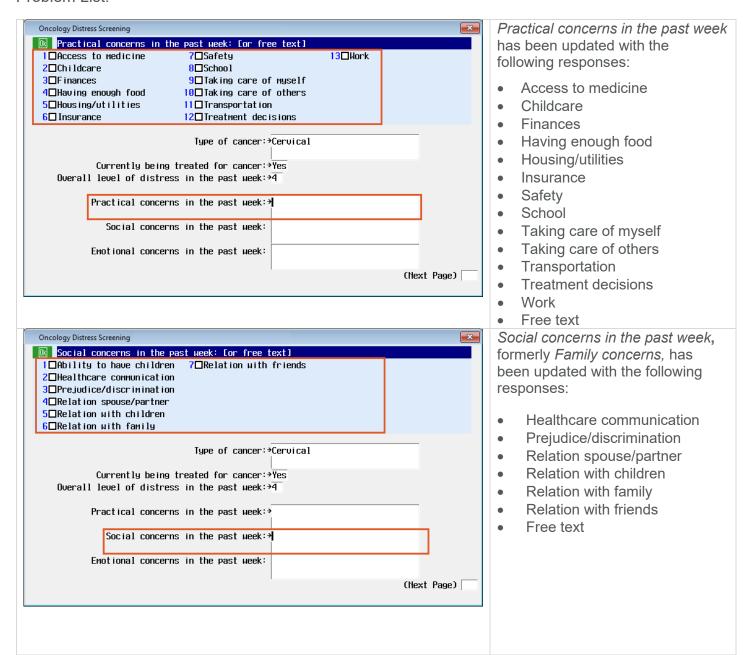
Paramedic Intake

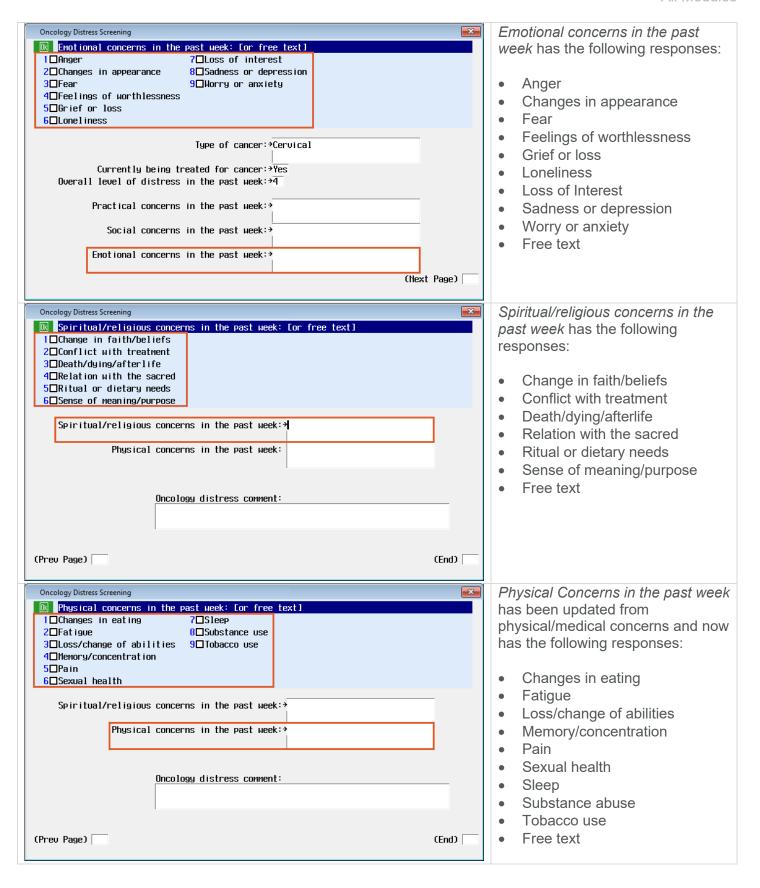
BH: Outpatient Nutrition Assessment

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 continued

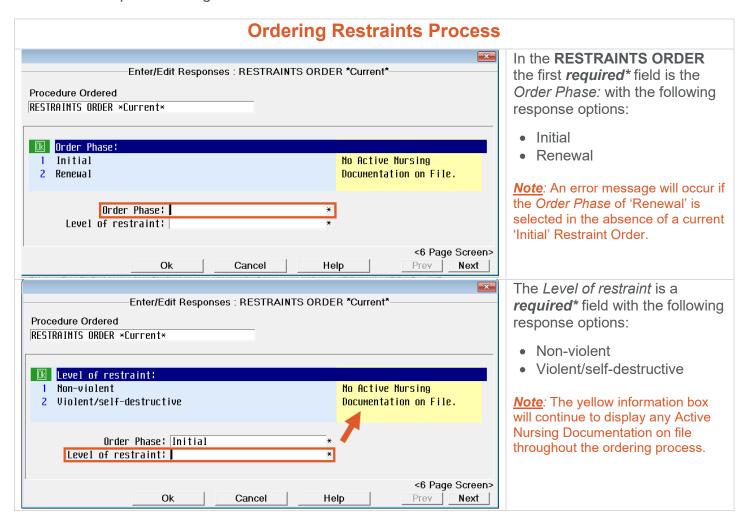
This update affects the following interventions/assessments:

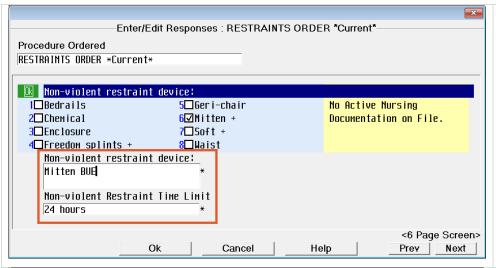
Nursing	Emergency Department	Surgery
Oncology Distress	Detailed Assessment	SURG: Admission Health History
BH: Health History Assessment	Non-urgent General Focus	
Admission Health History	Paramedic Intake	

Restraints Initiative Update

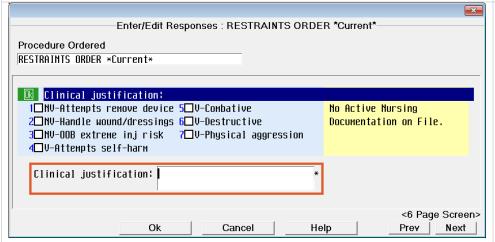


Inappropriate restraint utilization has heightened regulatory risk with inconsistent practices and outcomes for managing restraints effectively. As part of the 2025 Strategic Priorities, we have identified ways to drive appropriate restraint utilization by optimizing both the ordering of restraints and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





Enter/Edit Responses: RESTRAINTS ORDER *Current* Procedure Ordered RESTRAINTS ORDER *Current* ■ Violent restraint device: 1**☑**Chemical 5□Seclusion No Active Nursing 2□Enclosure 6□Soft + Documentation on File. 3□Physical holding <mark>7</mark>□Synthetic + 4□Restrictive positioning Violent restraint device: Chemical Violent Restraint Time Limit 4 hours <6 Page Screen> Ok Next Cancel Help Prev



<u>Note</u>: 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**.

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.

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.

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

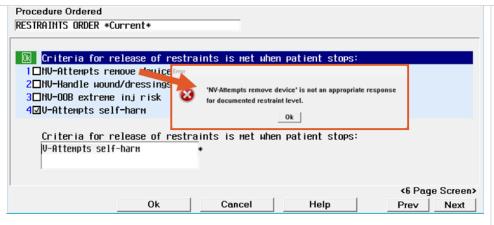
Clinical justification is a required field.

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:

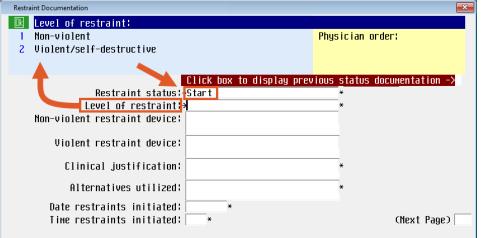
- V-Attempts self-harm
- V-Combative
- V-Destructive
- V-Physical aggression



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.

NURSING DOCUMENTATION



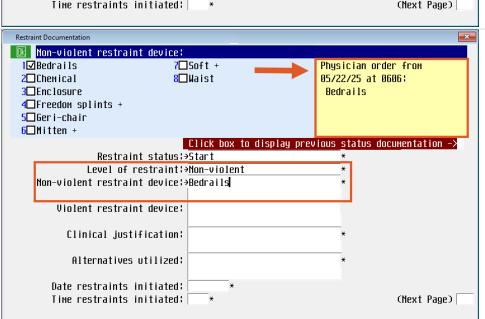
In the **Restraint Documentation +** intervention,

Level of restraint will become a

required* field when 'Start' is
selected for the Restraint status.

The available *Level of restraint* responses are:

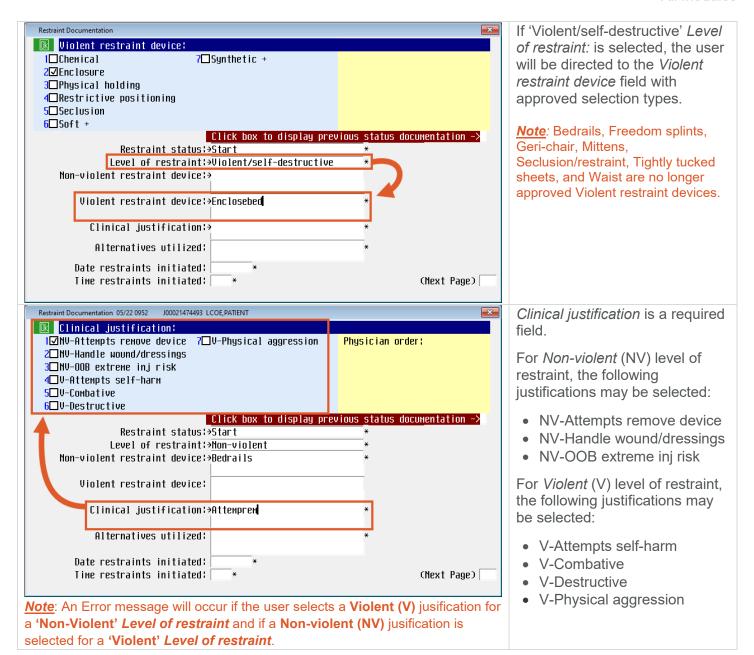
- Non-violent
- Violent/self-destructive

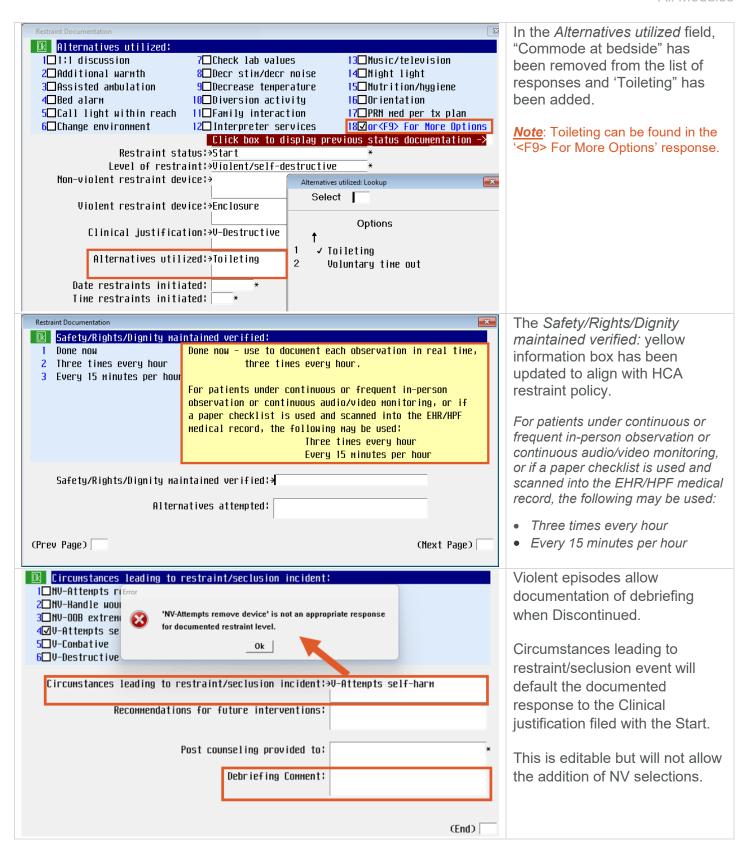


If 'Non-violent' Level of restraint is selected, the user will be directed to the Non-violent restraint device field with approved selection types.

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.

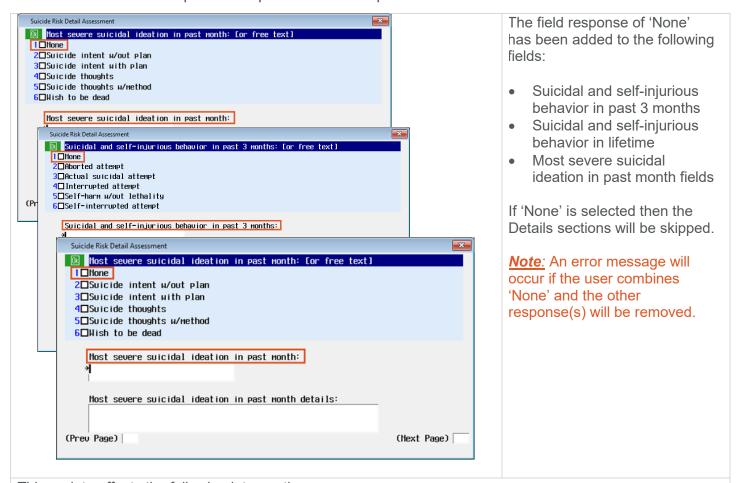




Suicide Risk Detail Assessment (SRDA) Field Updates



To support regulatory documentation requirements, the Suicide Risk Detailed Assessment (SRDA) has been updated to include 'None' in several field response options. This update will reduce the need for free text and improve compliance with completion.



Nursing	Emergency Department	Surgery
BH: Level of Care Assessment +	Detailed Risk Assessment	SURG: Safety/Risk/Regulatory +
BH: Initial Nurse Assessment (INA) +	BH Level of Care Assessment	SURG: Safety/Risk/Regulatory Int +
BH: Psychosocial Assessment (PSA) +	Suicide Risk Detail Assessment	SURG: Safety/Risk/Regulatory PAC +
BH: RN Reassessment +	Suicide/Homicide Screening	
BH: Suicide/Homicide Screen +	Suicide/Homicide Rescreening	
BH: Outpatient Initial Nurse Assessment+		
BH: Suicide Risk Detail Assessment +		
Safety/Risk/Regulatory		