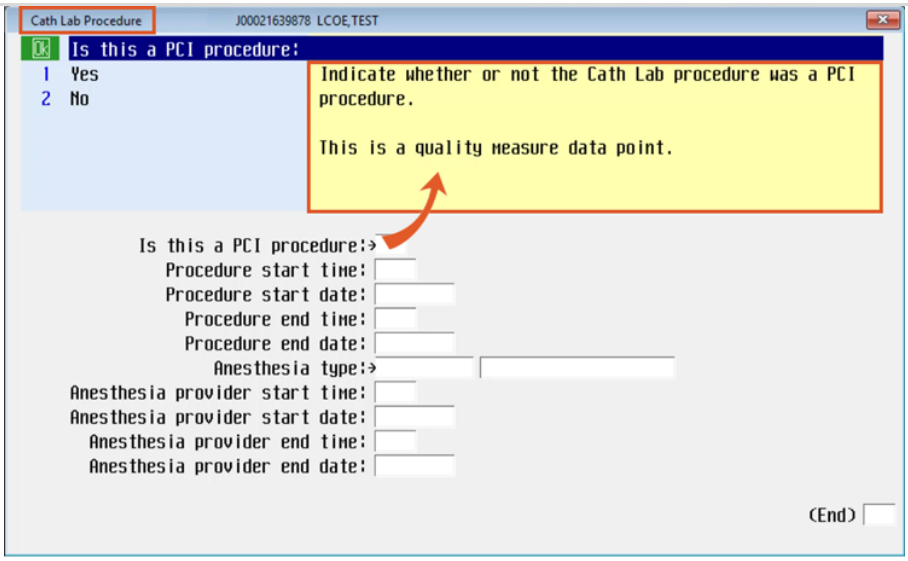
SUR Module

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.

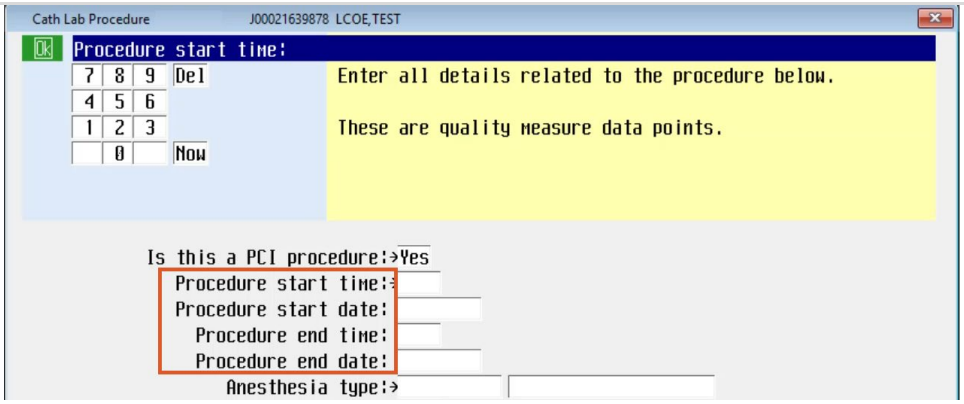
Procedural and PACU staff play a critical role in this process by documenting the required intervention in Meditech. Accurate and timely documentation ensures the procedural context is clearly defined, enabling reliable eCQM measurement and reporting.



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

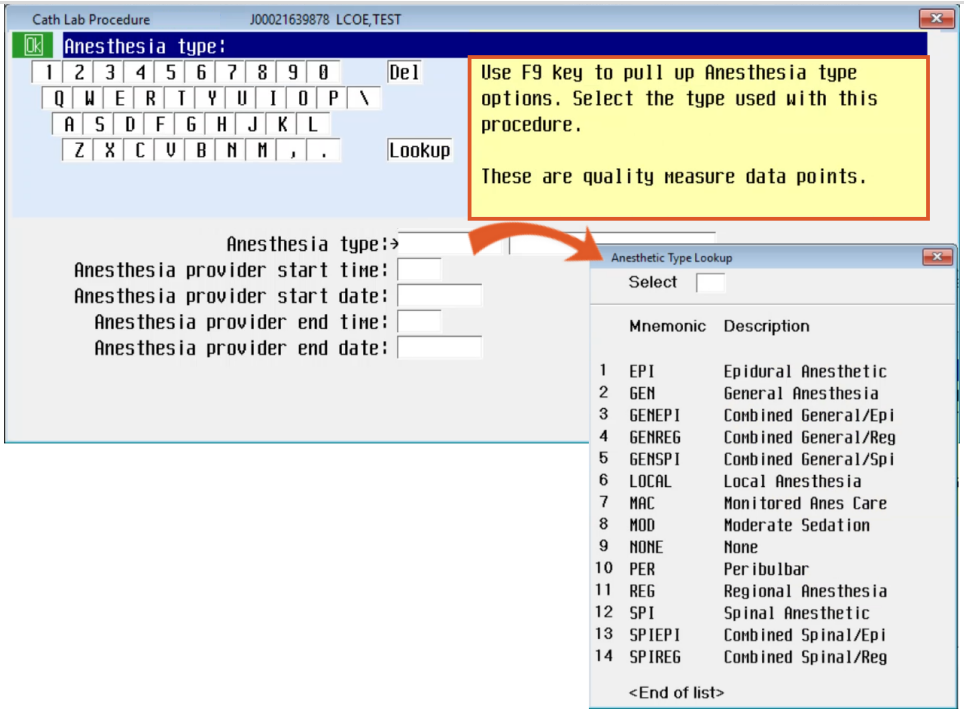
Is this a PCI procedure has a 'Yes' or 'No' response.

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



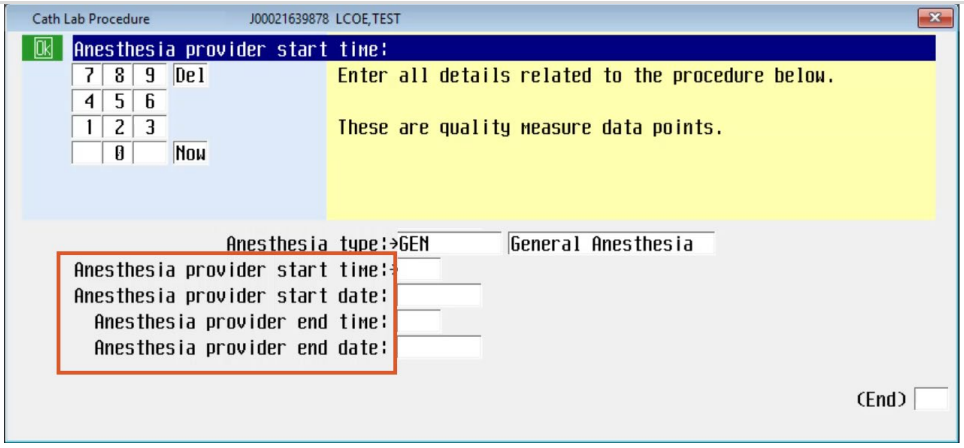
The following fields are time and date related responses for:

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



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



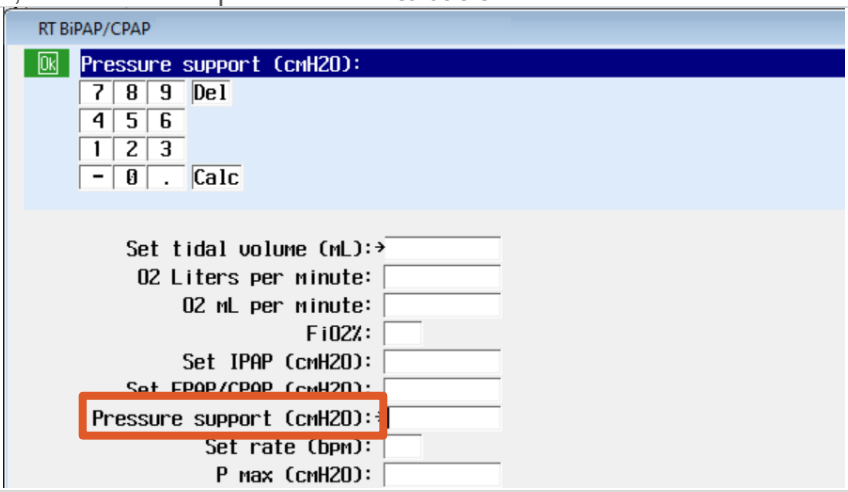
The following fields are time and date related responses for:

- 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

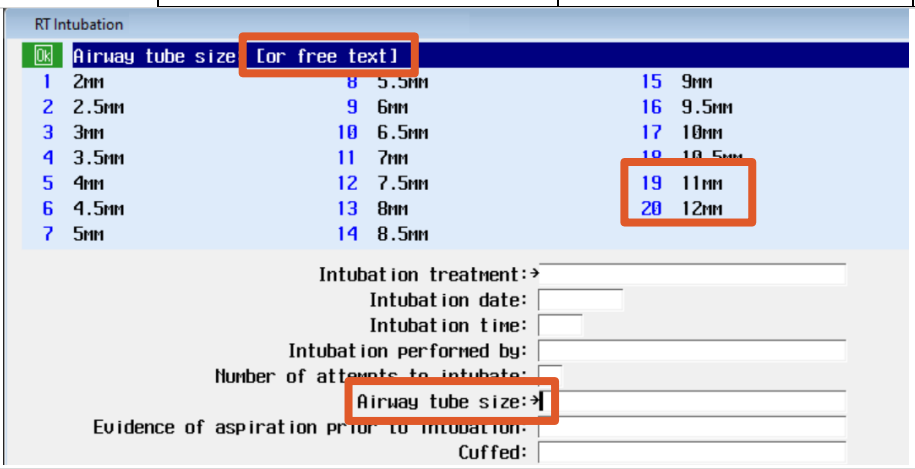
Pressure Support and Airway Tube Size Update

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.



The *Pressure support (cmH20)* 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		



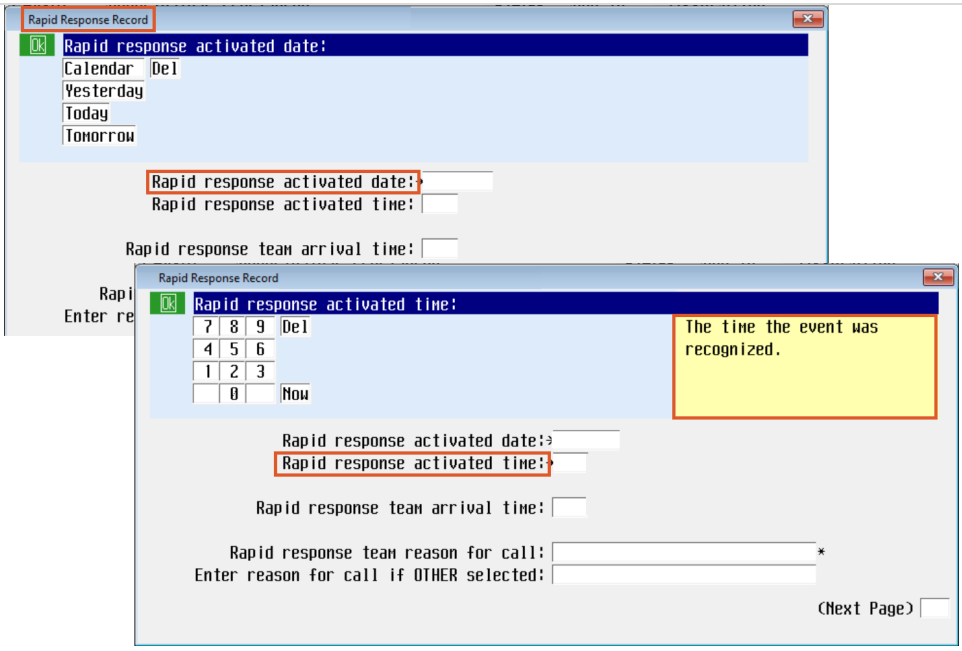
Additional responses have been added to the *Airway tube size* field within all **RT: Intubation** interventions:

- 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			

Rapid Response Update

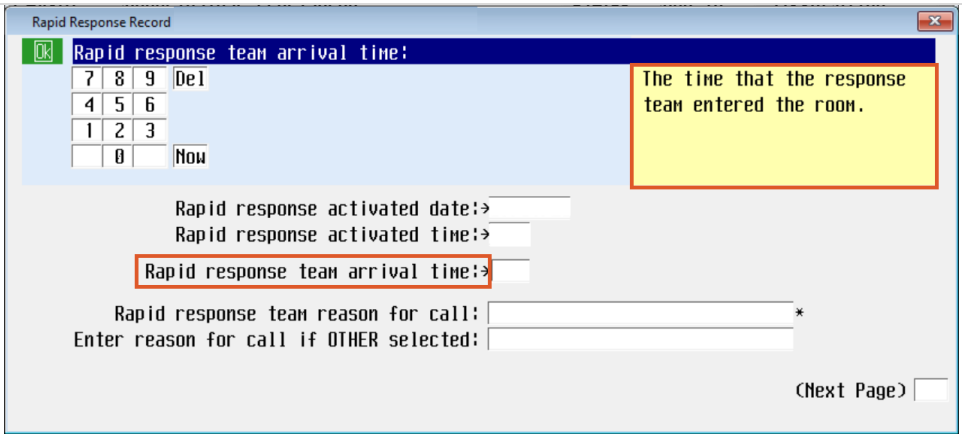
The current **Rapid Response/Code Record** combines Rapid Response and Code Blue documentation into a single intervention, leading to confusion, inconsistent documentation, and incomplete data capture. The updated workflow separates these processes by renaming the intervention to **Rapid Response Event 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.

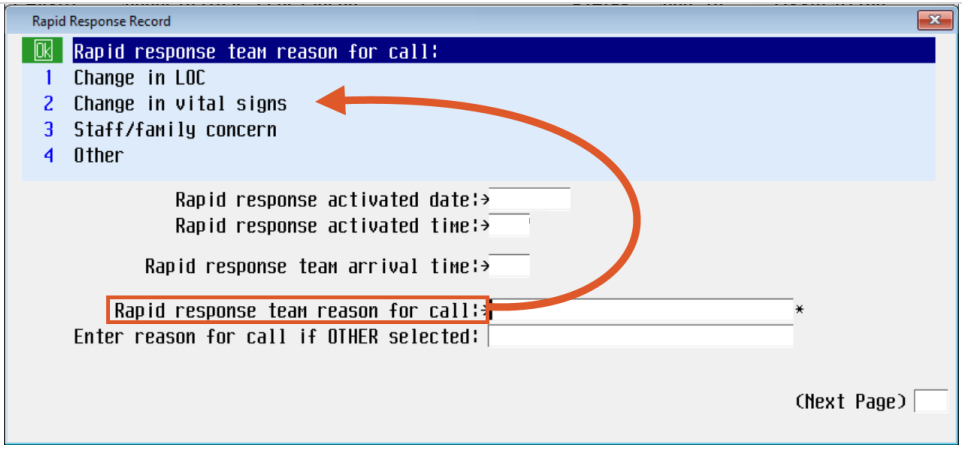
- Rapid Response Activated Date
- Rapid Response Activated Time

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



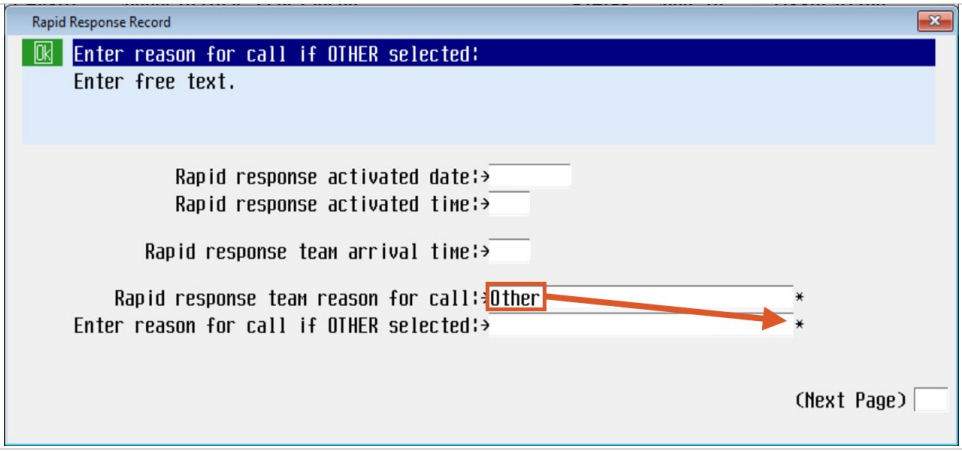
Document the time the response team entered the room in *Rapid response team arrival time* field.

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



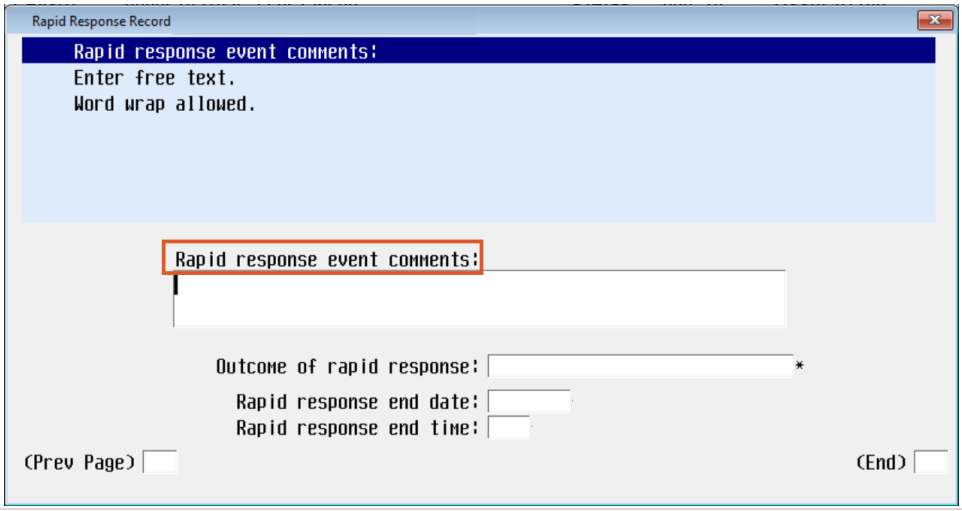
Rapid response team reason for call is required and has the following responses:

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

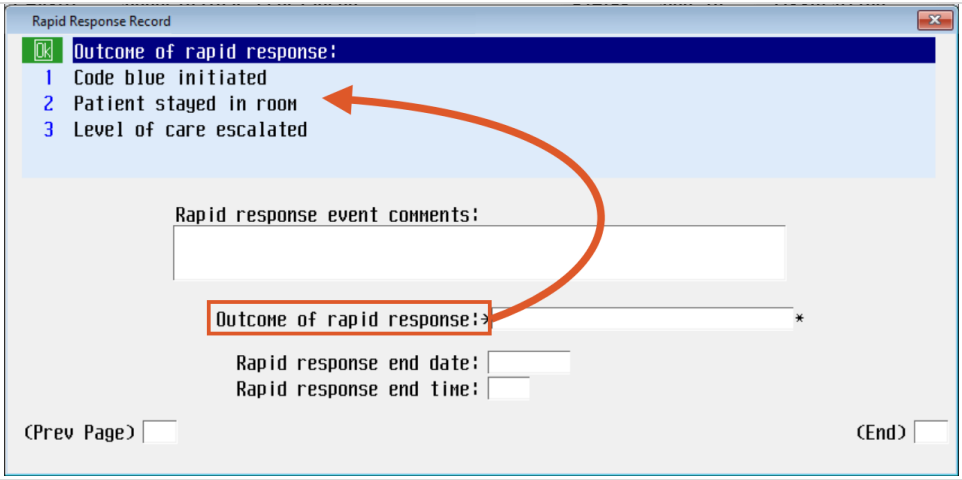


When 'Other' is selected for *Rapid response team reason for call*, *Enter reason for call* field becomes required.

The field allows for free text entry.

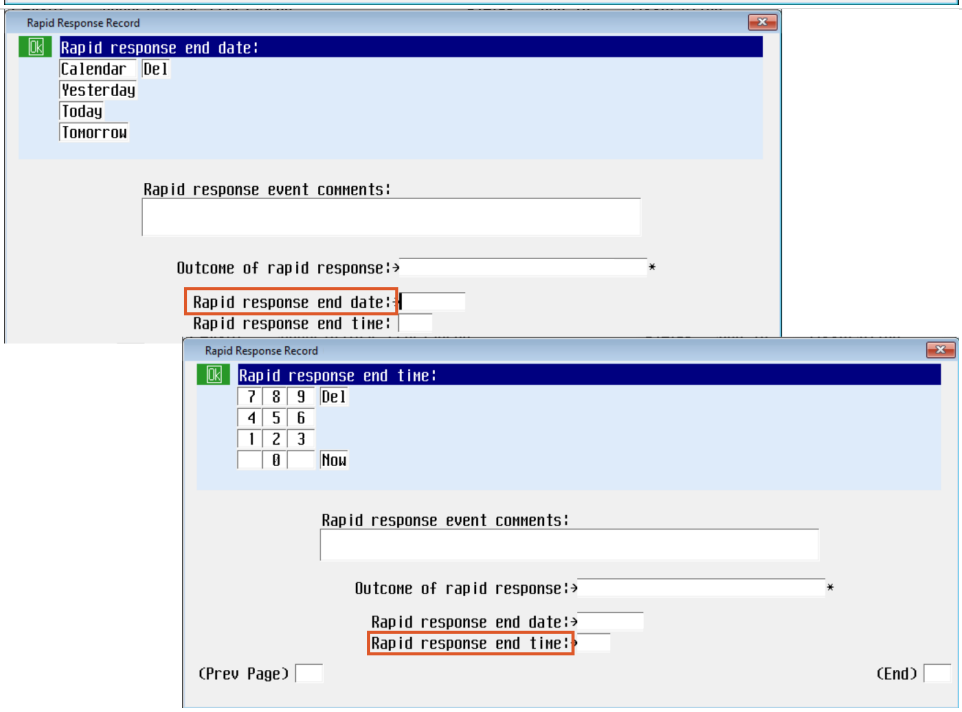


Use the field **Rapid Response Event Comments** to document additional clinical details that are not captured elsewhere.



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

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

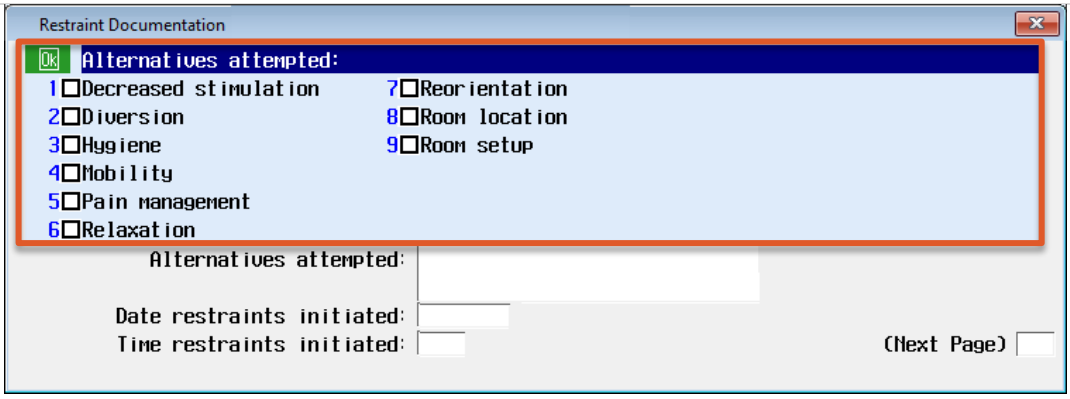


The *Rapid response end date* and *Rapid response end time* fields allow for documentation of the end date and time of the rapid response.

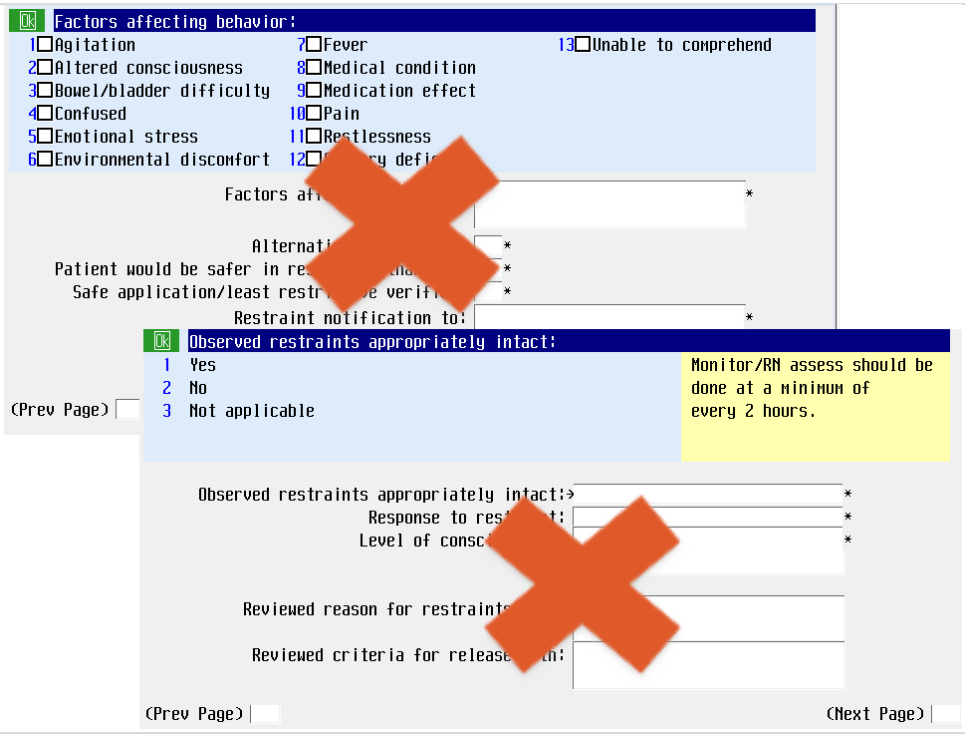
Nursing	Surgery
Rapid Response Event Outcome	SURG: Rapid Response Event Outcome Pre+
	SURG: Rapid Response Event Outcome Int+
	SURG: Rapid Response Event Outcome PAC+

Restraint 2026 Phase 2 Strategic Agenda

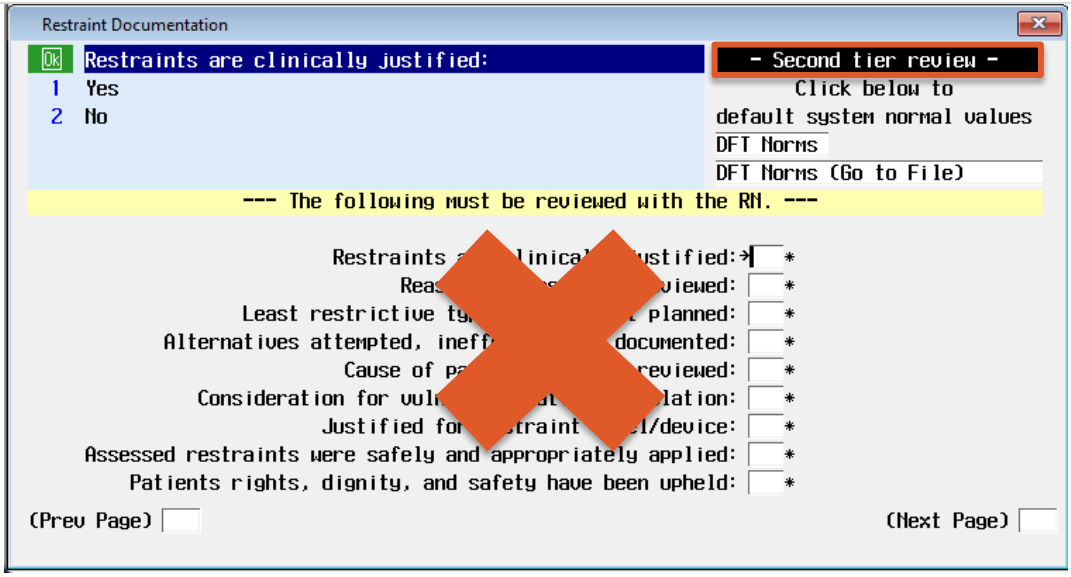
As part of the ongoing Corporate Responsible Restraint Program, the 2026 initiative focuses on refining policies and clarifying clinical practice expectations to ensure alignment with The Joint Commission (TJC) and CMS requirements. Restraint documentation workflows have been streamlined to remove duplicative, 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.



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

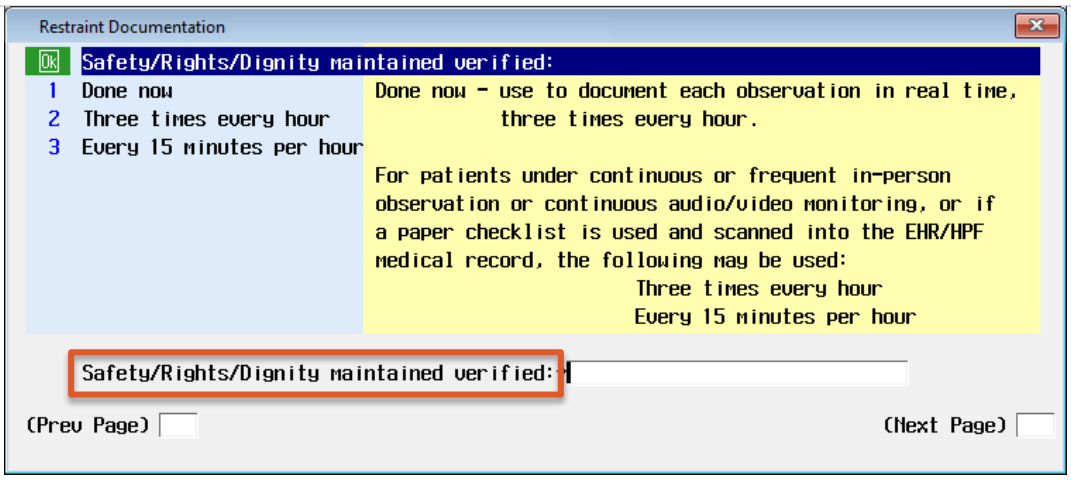


The documentation fields on pages 2 and 3 of the **Start** and **Monitor** workflow have been removed to eliminate duplicative documentation.

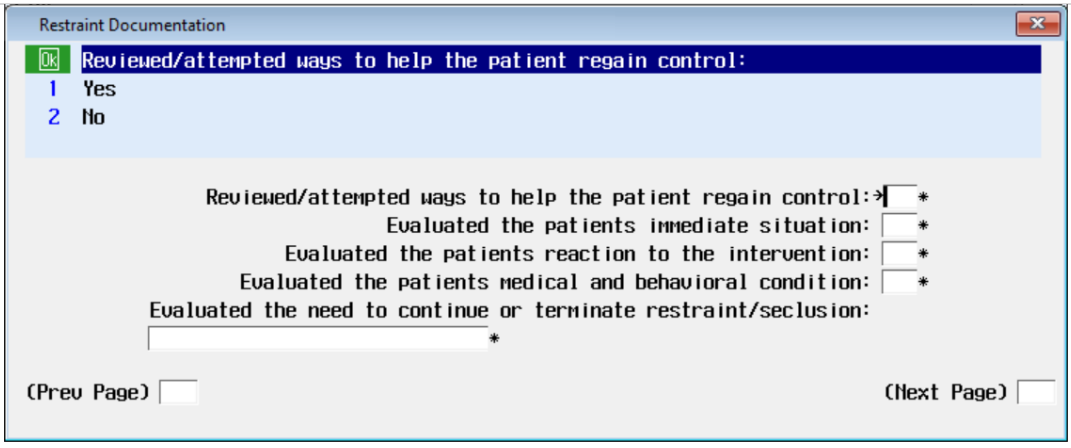


The **Second tier review** documentation has been removed in alignment with recent policy updates.

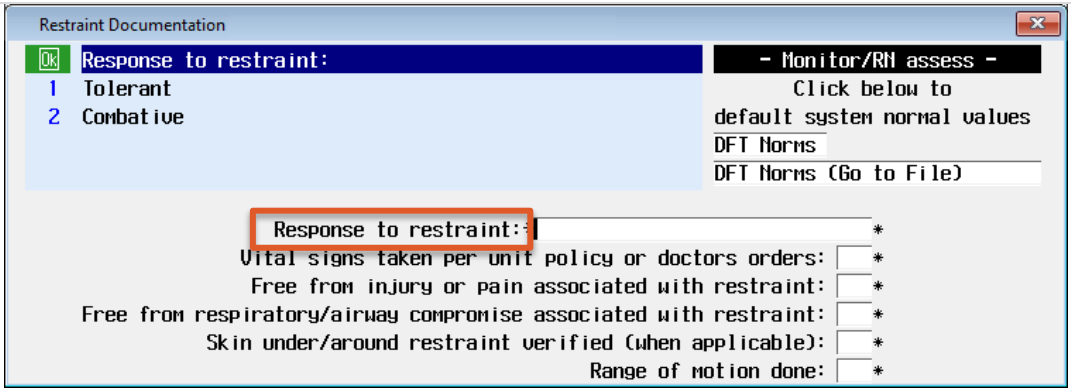
Note: Second tier review has also been removed from the Restraints Report.



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

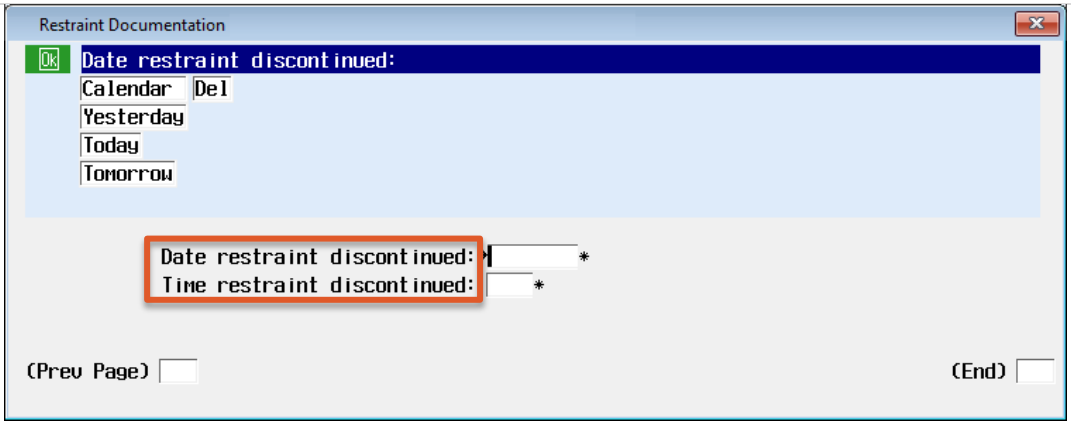


For Violent level of restraints, the one-time **Face to face** documentation has been reduced.

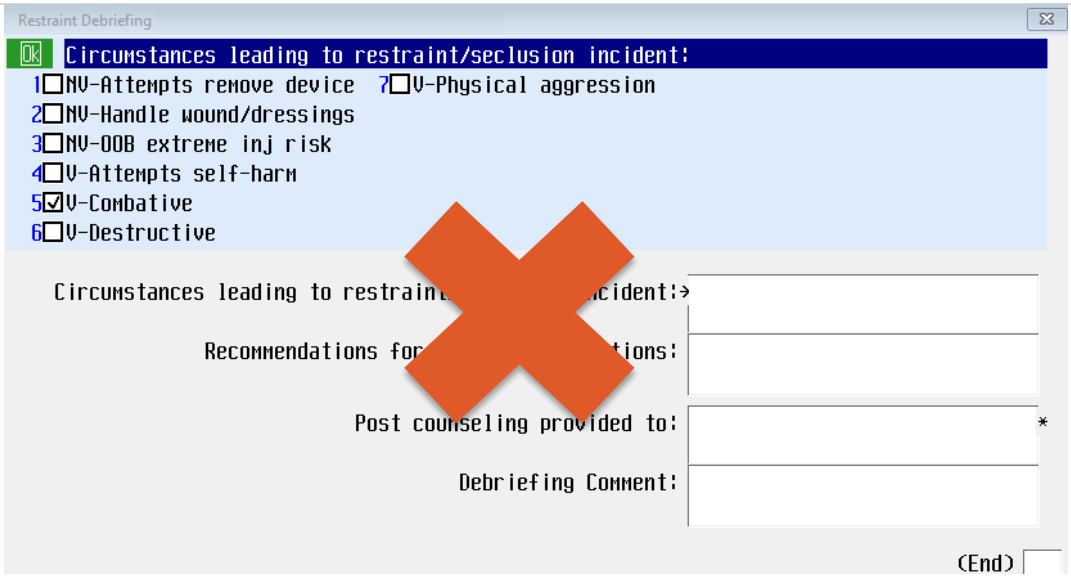


Response to restraint has been added to the **Monitor/RN assess** documentation. Responses continue to allow for selection of 'DFT Norms' and 'DFT Norms (Go to File)'.

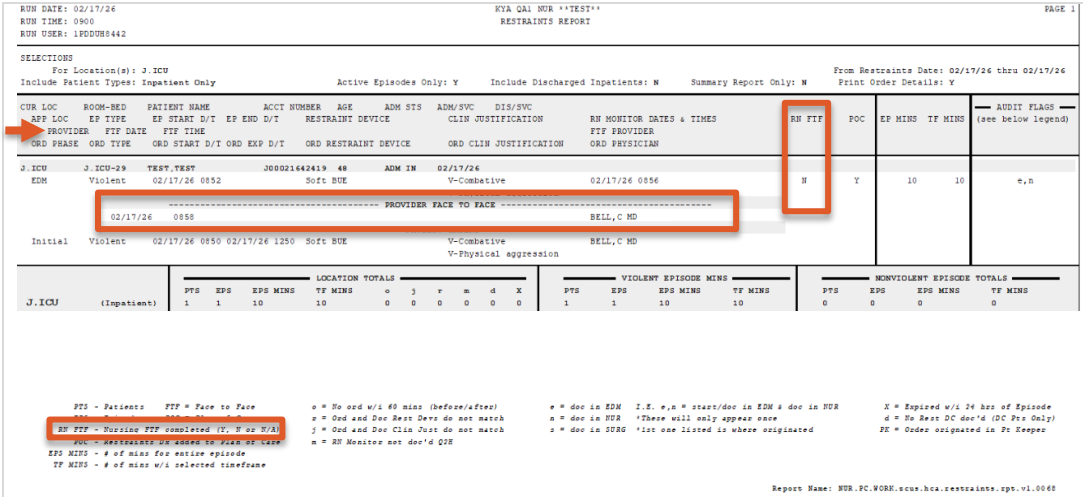
Note: *Monitor/RN assess* may be documented as often as necessary/per policy.



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.



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: 1PDDUH8442

KYA QA1 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 / APP LOC / PROVIDER / ORD PHASE	ROOM-BED / EP TYPE / FTF DATE / ORD TYPE	PATIENT NAME / EP START D/T / FTF TIME / ORD START D/T	ACCT NUMBER / EP END D/T / ORD EXP D/T	AGE / RESTRAINT DEVICE / ORD RESTRAINT DEVICE	ADM STS / CLIN JUSTIFICATION / ORD CLIN JUSTIFICATION	ADM/SVC / RN MONITOR DATES & TIMES / FTF PROVIDER / ORD PHYSICIAN	DIS/SVC	RN FTF	POC	EP MINS	TF MINS	AUDIT FLAGS (see below legend)
J.ICU / EDM	J.ICU-29 / Violent	TEST,TEST / 02/17/26 0852	J00021642419 /	48 / Soft BUE	ADM IN / V-Combative	02/17/26 / 02/17/26 0856		N	Y	10	10	e,n
		PROVIDER FACE TO FACE										
		02/17/26 0858				BELL,C MD						
Initial	Violent	02/17/26 0850	02/17/26 1250	Soft BUE	V-Combative V-Physical aggression	BELL,C MD						

	LOCATION TOTALS									VIOLENT EPISODE MINS				NONVIOLENT EPISODE TOTALS			
	PTS	EPS	EPS MINS	TF MINS	o	j	r	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	0	1	1	10	10	0	0	0	0

PTS - Patients
FTF = Face to Face
RN FTF - Nursing FTF completed (Y, N or N/A)
POC - Restraints DX added to Plan of Care
EPS MINS - # of mins for entire episode
TF MINS - # of mins w/i selected timeframe

o = No ord w/i 60 mins (before/after)
r = Ord and Doc Rest Devs do not match
j = Ord and Doc Clin Just do not match
m = RN Monitor not doc'd Q2H

e = doc in EDM I.E. e,n = start/doc in EDM & doc in NUR
n = doc in NUR *These will only appear once
s = doc in SURG *1st one listed is where originated

X = Expired w/i 24 hrs of Episode
d = No Rest DC doc'd (DC Pts Only)
PK = Order originated in Pt Keeper

Report Name: NUR.PC.WORK.ncus.hca.restraints.rpt.v1.0068

Note: RN FTF has been added to the legend.

The Restraints Report has been updated with the following changes:

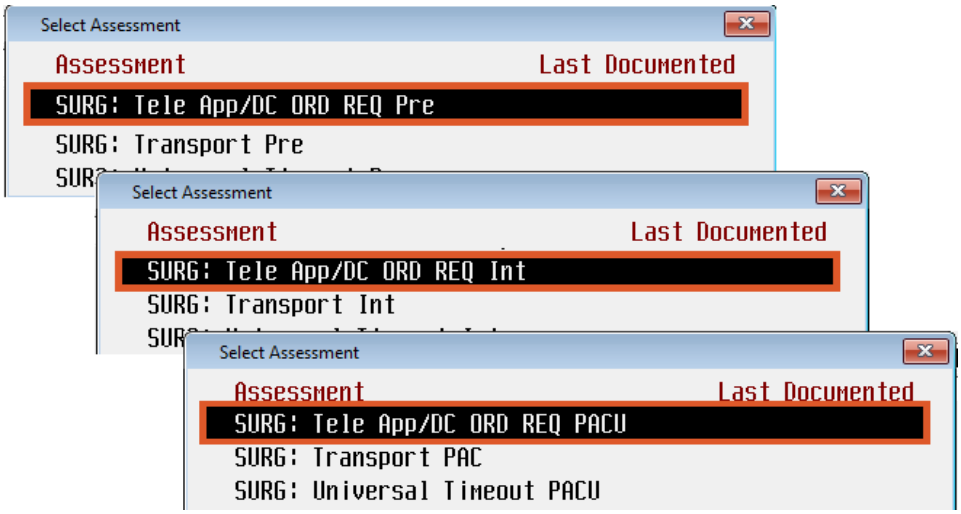
- Face to face column has been updated to RN FTF.
- A new header and row have been added to indicate when the Face-to-face was completed by a provider. It will display the provider's name along with the date and time documented. If the documentation is completed using PK, then that will be displayed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

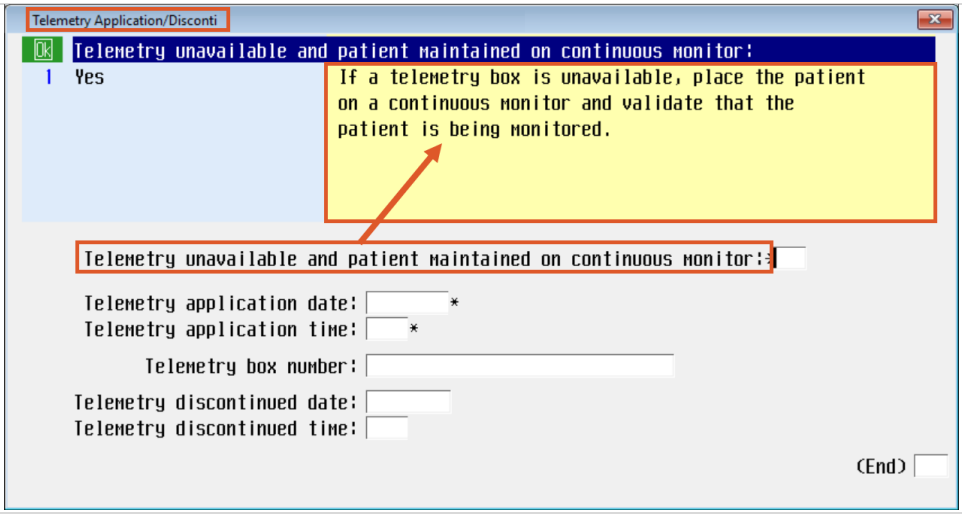
The SUR module currently lacks an assessment for documenting the application or discontinuation of telemetry for patients with an active order. This update will add the **Tele App/DC ORD REQ** assessment to all phases of the Surgical Profile to support required documentation. Note that telemetry is when a patient is being remotely monitored by a central monitoring unit via a portable telemetry box. Continuous cardiac monitoring that is watched, monitored, and acted upon by the nurse does not constitute telemetry.



Note: A provider order is required before documentation of the telemetry application.

After the provider enters a Telemetry order and the order is acknowledged, documentation of telemetry is completed using the **Tele App/DC ORD REQ** assessment in each phase of care in the Surgical Profile.

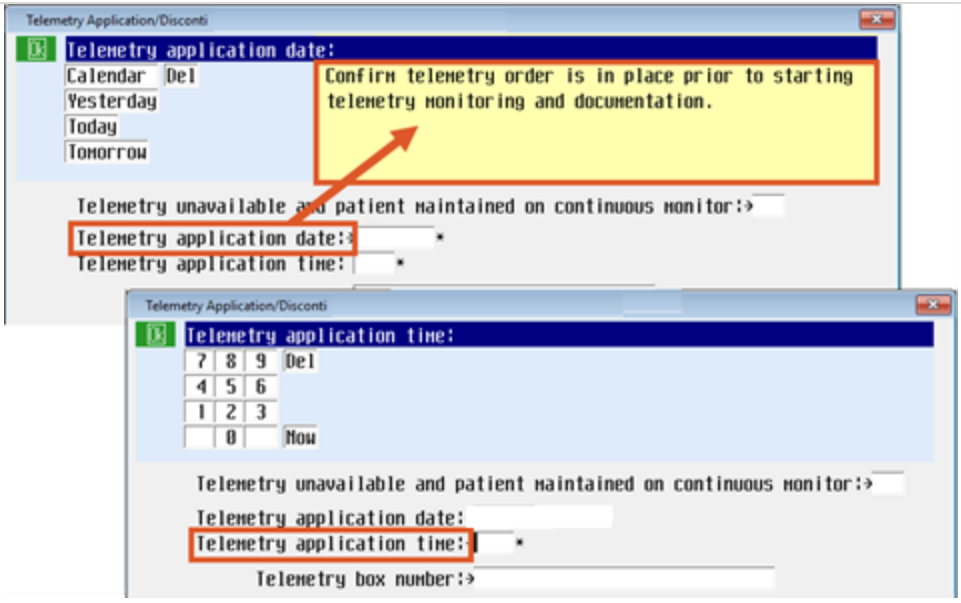
Select the appropriate Phase of Care. From Page 1, select Assessments then Enter Forms. Select **SURG: Tele App/DC ORD REQ**.



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

The remainder of the fields on the screen will be bypassed.

Note: The highlighted information box states, 'If a telemetry box is unavailable, place the patient on a continuous monitor and validate that the patient is being monitored.'



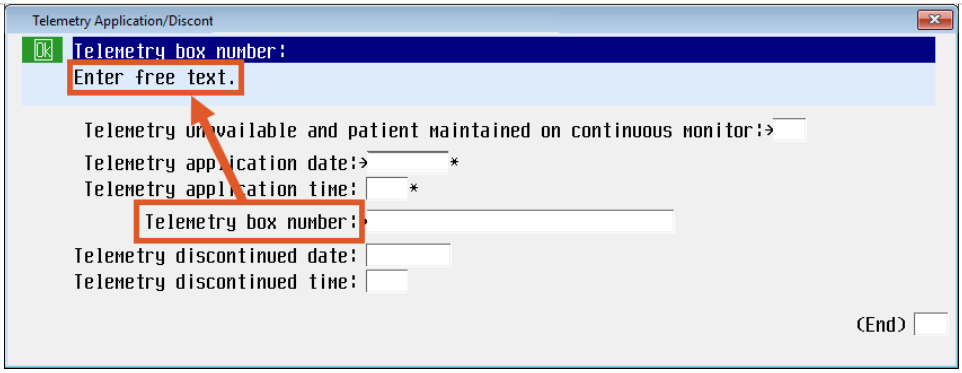
The *Telemetry application date* is a reqiured field utilizing the calendar function.

The highlighted information box states:

Confirm telemetry order is in place prior to starting telemetry monitoring and documentation.

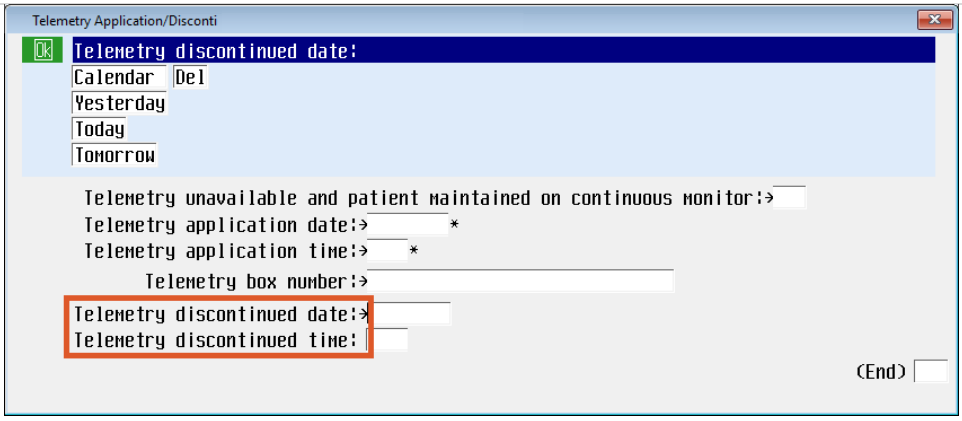
The *Telemetry application time* is also a required field using the keypad numeric function.

Note: The date and time will auto-populate on subsequent entries to the intervention until a discontinuation is entered.

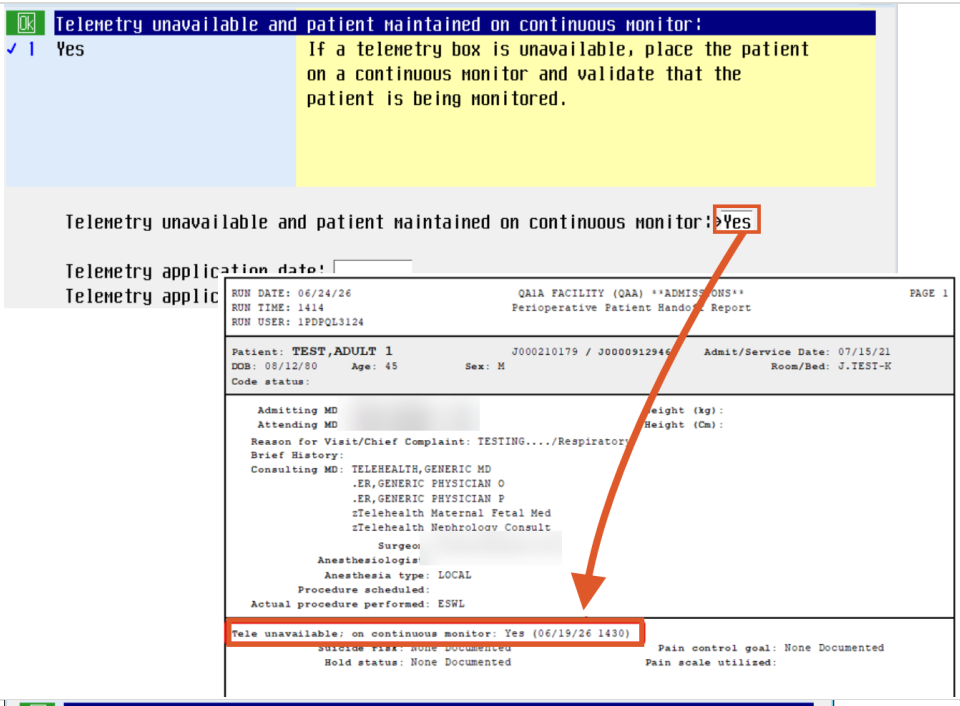


Telemetry box number allows for free text entry of alpha-numeric characters. The field can be edited in subsequent entries as needed.

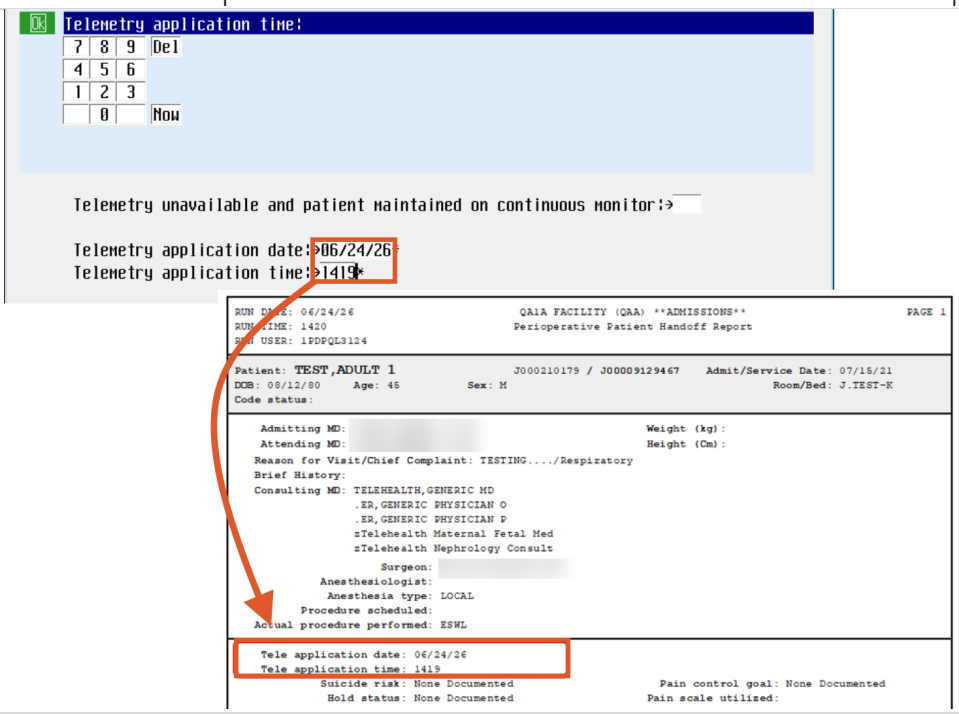
Note: The *Telemetry discontinue date* and *Telemetry discontinued time* should be skipped upon telemetry application documentation.



For discontinuation, once the Telemetry Discontinuation order has been entered and acknowledged, document in the *Telemetry discontinuation date* and *Telemetry application time* fields.



The Tele unavailable; on continuous monitor is documented in SUR will display on the Perioperative Patient Handoff Report.



The Tele application date and time documented in SUR will display on the Perioperative Patient Handoff Report.

Surgery
SURG: Telemetry Application/DC Pre
SURG: Telemetry Application/DC Int
SURG: Telemetry Application/DC PACU