EBCD MEDITECH Content Updates – 2024.2
All Modules

Overview

This Pilot 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	Impacted by Women's and Children's
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.

Updated 03/08/2024

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

Summary of Revisions

Date	Revision
02/20/2024	Updated Gastrointestinal Ostomy and Pediatric Weight Source verbiage
02/21/2024	Added Behavioral Health: Level of Care Assessment section to ED and NUR Modules
03/08/2024	Added Health History Update: Social Determinants of Health to NUR Module

Nursing, ORM and EDM Modules

Gastrointestinal Ostomy

The **Gastrointestinal Ostomy** screen has been updated to include *GI stoma size cm* so the stoma size is documented and able to be tracked, indicating proper healing or any possible acute events.

GI stoma size cm is a new field utilizing the keypad function.

Press F1 to see all prior documentation.

Note: The F1 functionality is not applicable in the EDM Module.

This update affects the following interventions/assessments:

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

Pediatric Weight Source Updates

Pediatric weights are essential for weight-based medication dosing, thus estimated weights should not be used for medication dosing.

| Height/Weight Measurement screen | The *Weight source* field has been updated with two new soft stops. |

```
Height/Weight Measurement
Ok   Weight source:
  1  Bed scale            7  Sling scale        - Calculated Value -
  2  Chair scale          8  Standing scale
  3  Estimated            9  Stated/Reported    The equivalent: 18lb, 0.61oz
  4  Infant scale        10  Wheelchair scale
  5  Pediatric emergency tape  11  Not applicable
  6  Refused

                    Height ft:→
                    Height in:→
                    Height cm:
                Height source:→

                    Weight gm:
                    Weight kg:→8.182
                Weight source:→                           *.→

                Weight change gm:
Total weight change since birth gm:
Percent weight change since birth:                        (Next Page)
```

If "Estimated" is selected, an alert will display to the clinician:

```
Error
  ⊗   Estimated should not be used for less than 18 years old.
      An accurate weight must be documented for medication dosing and administration.
                          Ok
```

> Estimated should not be used for less than 18 years old.
>
> An accurate weight must be documented for medication dosing and administration.

After selecting 'Ok' for the alert, the cursor will advance and allow the clinician to correct their weight source response.

```
Rapid Flowsheet
Ok   Weight source:
  1  Bed scale            7  Sling scale        - Calculated Value -
  2  Chair scale          8  Standing scale
✓ 3  Estimated            9  Stated/Reported    The equivalent: 18lb, 0.61oz
  4  Infant scale        10  Wheelchair scale
  5  Pediatric emergency tape  11  Not applicable
  6  Refused

                    Weight gm:
                    Weight kg:→8.182   *
                Weight source:→Estimated                  *

            Head circumference cm:
                BMI calculated: 24.0

       Document orthostatic vital signs:
    Document bilateral blood pressures:
                Glasgow coma scale:
       PEDS non pharmacy daily weight kg:
(Prev Page)                                         (Next Page)
```

Height/Weight Measurement

Click OK or Press Enter to continue.

```
                    Height ft:→
                    Height in:→
                    Height cm:
                 Height source:→

                    Weight gm:
                    Weight kg:→8.182
               Weight source:→Estimated                *.→

                Weight change gm:
  Total weight change since birth gm:
  Percent weight change since birth:                      (Next Page)
```

Note: *Some assessments have additional programming added to prevent the cursor from advancing to the next page after acknowledging the alert.*

Error

Refused should not be used for less than 18 years old.
An accurate weight must be documented for medication dosing and administration.

Ok

If "Refused" is selected, an alert will display to the clinician:

Refused should not be used for less than 18 years old.

An accurate weight must be documented for medication dosing and administration.

After selecting 'Ok' for the alert, the cursor will advance and allow the clinician to correct their weight source response.

Note: *Some assessments have additional programming added to prevent the cursor from advancing to the next page after acknowledging the alert, as noted above.*

Rapid Flowsheet

Weight source:

```
 1  Bed scale              7  Sling scale           – Calculated Value –
 2  Chair scale            8  Standing scale
 3  Estimated              9  Stated/Reported      The equivalent: 18lb, 0.61oz
 4  Infant scale          10  Wheelchair scale
 5  Pediatric emergency tape 11 Not applicable
✓6  Refused

                    Weight gm:
                    Weight kg:→8.182   *
               Weight source:→Refused                  *

           Head circumference cm:
                 BMI calculated: 24.0

      Document orthostatic vital signs:→
      Document bilateral blood pressures:
                 Glasgow coma scale:
      PEDS non pharmacy daily weight kg:
(Prev Page)                                            (Next Page)
```

This update affects the following interventions/assessments:

Nursing	Emergency Department	Surgery
MRI Procedure Screening	Detailed Flowsheet	SURG: Height/Weight Intra-op
Pre-Procedure Checklist	Rapid Flowsheet	SURG: Height/Weight Pre
Six Minute Walk	Rapid Initial Assessment	SURG: MRI Procedure Screening Pre
RT: Six Minute Walk	Triage Reassessment	SURG: Pre-Procedure Checklist, Pre
Vitals/Ht/Wt/Measurements	Pre-Procedure Checklist	SURG: Admission Health History
	Six Minute Walk	
	MRI Procedure Screening	
	Paramedic Intake	
	Disposition-DC/TX/ADM/LPT	

Suicide/Homicide Updates

The Hospital-Based Inpatient Psychiatric Services (HBIPS) regulatory requirements have been updated for the suicide and homicide assessments. Nurses are no longer required to document suicidal and homicidal ideation in the last 6 months.

The following fields have been removed:
- *Wish to be dead or to not wake up in the past 6 months*
- *Non-specific active suicidal thoughts in the past 6 months*
- *Active suicidal ideation with plan and intent in the past 6 months*
- *Active ideation without method, plan or intent in the past 6 months*
- *Active ideation with some intent and without plan in the past 6 months*

```
BH Suicide/Homicide Assessment                                    [x]
[Ok] Homicidal/violent ideation:
  1[ ]Current            Ask: Are you having homicidal or violent thoughts now or
  2[ ]Lifetime           recently?
  3[ ]None currently     Have you had any homicidal or violent thoughts in your
  4[ ]None in lifetime   lifetime?


     Homicidal/violent ideation:→|


    Describe current homicidal/violent thoughts/plans/means/intent:


    Describe homicidal thoughts/plan/means/intent over lifetime:


  (Prev Page) [  ]                            (Next Page) [  ]
```

The *Homicide/violent ideation* field has removed the following response:

- Past six months
- None in past six months

The Yellow Information Box has been updated to reflect the update for the clinicians:

Ask: Are you having homicidal or violent thoughts now or recently? Have you had any homicidal or violent thoughts in your lifetime?

Describe homicidal thoughts/plan/means/intent over past 6 months field has been removed.

This update affects the following interventions/assessments:

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

Nursing and OR Modules

Heart Sounds/Murmur Update

The **Heart Sounds/Murmur** screen has been updated to include the 'LVAD Hum' response. Evidence based practice supports that listening to the 'LVAD hum' is vital to the assessment on an LVAD patient. While the 'hum' should be present, the S1 and S2 can still be heard if the patient is pulsatile with the LVAD. Therefore, having the ability to document the 'LVAD hum' in LVAD patients is the most accurate assessment for these type of patients.

Heart sounds has a new response:

- LVAD Hum

This update affects the following interventions/assessments:

Nursing	Surgery
Admission/Shift Assessment	SURG: Admission Assessment
	SURG: Admission Assessment Int
	SURG: Assessment PAC

Nursing and ED Modules

CRRT

Two new filters have been added to the **CRRT** intervention to aid the clinicians to accurately document which filter is being utilized. This screen has also been updated to align with the **SLED/SCUF** updates.

CRRT treatment status has a new response:

- New order implemented

CRRT filter type has two new responses:

- ST 100
- ST 150

Two responses were removed:

- AN 69 ST
- M 60

ED Module

Behavioral Health: Level of Care Assessment

The **Behavioral Health Assessment** is changing to **BH: Level of Care Assessment**.

Behavior Health Assessment has been renamed **BH Level of Care Assessment**.

For patients in the Emergency Department at the time of the update who have documentation on the **Behavioral Health Assessment** prior to the name change, the documentation will appear in the **Trg/Doc** view as **Behavioral Health Assessment**.

If a clinician selects the **Behavoral Health Assessment** for another entry, it will still appear as **Behavoral Health Assessment**. However, after the update to the name change, if the clinician selects the updated name, **BH Level of Care Assessment,** the documentation will appear as **BH Level of Care Assessment**.

If any new documentation is added <u>after</u> the name change, it will appear as **BH Level of Care Assessment**.

<u>Note</u>: Clinical Review will reflect the assessment name as it appeared during the time of documentation.

Heart Sounds/Murmur Update

The **Heart Sounds/Murmur** screen has been updated to include the 'LVAD Hum' response. Evidence based practice supports that listening to the 'LVAD hum' is vital to the assessment on an LVAD patient. While the 'hum' should be present, the S1 and S2 can still be heard if the patient is pulsatile with the LVAD. Therefore, having the ability to document the 'LVAD hum' in LVAD patients is the most accurate assessment for these type of patients.

Cardiac Related	*Heart sounds* has a new response:
Patient: _____	
Date 01/03/24 Time 1034 User _____	• LVAD Hum
Heart sounds:	
1☐S1 7☐LVAD hum	
2☐S2 8☐Muffled	
3☐S3 9☐Pericardium active	
4☐S4 10☐Quadruple	
5☐Click 11☐Rub	
6☐Irregular 12☐Summation	
Cardiac monitor:→ _____	
Monitored heart rhythm: _____	
Ectopy: _____	
Ectopy frequency: _____	
Heart sounds:→ _____	
Heart Murmurs: _____	
(Prev Page) ___ (Next Page) ___	
OK Cancel	

This update affects the following assessments:

Emergency Department	
Vertigo Dizziness	Vertigo Dizziness Reassessment
Trauma MVC	Trauma MVC Reassessment
Neonatal Physical Findings	Physical Findings
Change Mental/Neuro Status	Change Mental/Neuro Status Reassessment
Cardiac Related	Cardiac Related Reassessment

Point of Care CBC

A new **Point of Care CBC** treatment has been created for clinicians to accurately document appropriate labs being performed at the bedside.

Point of Care Test screen showing Patient, Date 12/19/23, Time 0839, User. Point of care test list: 1 ABG, 2 ABV, 3 BNP, 4 CBC, 5 Cardiomarkers, 6 Chemistry, 7 COVID-19, 8 D dimer, 9 Flu complete, 10 Gastroccul, 11 Glucose, 12 Hemoccult, 13 INR, 14 Lactic acid, 15 Mononucleosis, 16 PT, 17 PTT, 18 or<F9> For More Options. Point of care test:→. Are point of care results critical: [ ]. Lookup window: Select [ ] Options 1 Pregnancy HCG, 2 RSV, 3 Strep, 4 Troponin, 5 Urine <End of list>	*Point of care test* has a new response: • CBC
Point of Care Test screen. Are point of care results critical: 1 Yes, 2 No. Point of care test:→. Are point of care results critical:→. (End) [ ] OK Cancel	*Are point of care results critical* has the following responses: • Yes • No

NUR Module

Behavioral Health: Level of Care Assessment

The **Behavioral Health Assessment** intervention is changing to **BH: Level of Care Assessment**.

Behavior Health Assessment has been renamed **BH Level of Care Assessment**.

When reviewing patients who have been admitted during the update who have had BH: Behavioral Health Assessment documentation in View History, the clinician will select BH: Level of Care Assessment. Prior documentation will appear as BH: Level of Care.

When reviewing the same documentation in Clinical Review, the clinician will see the Assessment name(s) as Behavioral Health Assessment and/or BH: Level of Care Assessment under the Assessments menu.

From the **Assessments** routine in **View Form**, the clinician will see documentation prior to the update as **Behavioral Health Assessment** and documentation after, as **BH: Level of Care Assessment**.

The **Enter Form** routine will display **BH: Level of Care Assessment**.

Health History Update

If the Social Determinants of Health (SDOH) field is selected as 'Unable to access' or the patient is admitted through surgery, the SDOH field can be updated in the **Health History Update**.

The *Assess SDOH* field has the following responses:
- Yes
- No

Select 'Yes" to update the field.

Health History Update 03/06 1552   J00021257116 DEMO,SBINKLEY

Ok **Patient has instability or unmet needs related to:**
1☐None
2☐Food
3☐Living situation
4☐Safety
5☐Transportation
6☐or<F9> For More Options

Select all that apply if the patient is experiencing instability in any of the five social conditions which may impact their health or well-being.
Case Management will be consulted to perform additional screening and potentially identify referrals or other needed services.

Patient has instability or unmet needs related to:>

Patient has instability or unmet needs related to: Lookup

Select [   ]

Options

1   Utility
2   Unable to assess

<End of list>

(Prev Page) [   ]

The *Patient has instability or unmet needs related to* is a new, multi-select field with the following responses:

- None
- Food
- Living situation
- Safety
- Transportation
- Unable to assess
- Utility

The Yellow Information Box guides the clinician to select the appropriate response:

Select all that apply if the patient is experiencing instability in any of the five social conditions which may impact their health or well-being.
Case Management will be consulted to perform additional screening and potentially identify referrals or other needed services.

The nurse will need to file the reflexed order so Case Management will receive the notification.

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