

EBCD MEDITECH Content Updates – 2025.1

All Modules

Overview

This document is a high-level overview for end user education purposes about significant changes within the ED Module screens. 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.

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

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Summary of Revisions

Date	Revision

eMAR Updates

Metformin Contrast Media Alert



Within eMAR, nurses will now only receive an alert upon documentation for Metformin-containing medications if IV Contrast Media has been administered to the patient within the last 47 hours and the patient has an eGFR <30ml/min.

Note: Radiology guidelines no longer recommend that Metformin-containing products are held or discontinued by nursing if the patient has an eGFR value of >= 30ml/min and has received IV Contrast Media.

	<p>When administering a medication that contains Metformin, the nurse will receive the following alert if the patient has received contrast media in the past 47 hours and their eGFR is < 30 mL/min.</p> <p><i>Note: Only the most recent eGFR value over the last 7 days of the current admission will be considered. If there is NO eGFR value available, the alert will not display.</i></p>
	<p>Document the medication as <i>Not Given</i> with the <i>Reason Code</i> as 'N CONTRAST'.</p>

EDM Module

ECMO Documentation Update



The **ECMO Documentation** intervention has been updated to separate the ECMO strategy and the new ECMO mode documentation. In addition, two ECMO SVO2 fields were added to the ECMO Pump Details Screen for trending.

ECMO Documentation

ECMO strategy:

- 1 Central
- 2 Peripheral

----- No previous documentation found. -----

ECMO phase:→Start *

ECMO strategy:→ *

ECMO mode: *

ECMO start date: *

ECMO start time: *

ECMO day: 0 days 0 hours *

ECMO patient physical location: *

ECMO pump details:

ECMO oxygenator details:

ECMO safety checks:

ECMO heater/cooler details:

(Next Page)

ECMO Strategy remains as a required field and has two new responses:

- Central
- Peripheral

Note: For cutover only, the FIRST documentation in the new ECMO strategy field will not default the last filed response and will be blank.

ECMO Documentation

ECMO mode: [or free text]

- 1 V-PA
- 2 VA
- 3 VAV
- 4 VV
- 5 VVA

----- No previous documentation found. -----

ECMO phase:→Start *

ECMO strategy:→Central *

ECMO mode:→ *

ECMO start date: *

ECMO start time: *

ECMO day: 0 days 0 hours *

ECMO patient physical location: *

ECMO pump details:

ECMO oxygenator details:

ECMO safety checks:

ECMO heater/cooler details:

(Next Page)

ECMO mode is a new required field and has the following responses:

- V-PA
- VA
- VAV
- VV
- VVA

Note: Both "ECMO strategy" and "ECMO mode" fields will default the last filed response but can still be edited.

The image displays two screenshots of the 'ECMO Pump Details' software interface. The top screenshot is for 'ECMO SVO2 1: Primary pump'. It features a numeric keypad (7-9, 4-6, 1-3, 0, ., Calc) and a table titled 'Last 4 Clinical Data Entries (Past 2 days)'. The table has columns for Date, Time, Flow (lpm) 1, RPM 1, P venous 1, P arterial 1, P internal 1, Delta P 1, and SVO2 1. Below the table are input fields for ECMO flow (lpm) 1, ECMO RPM 1, ECMO P venous 1, ECMO P arterial 1, ECMO P internal 1, and ECMO delta P 1. The 'ECMO SVO2 1:' field is highlighted with a red box. A '(Next Page)' button is visible at the bottom right of this window.

The bottom screenshot is for 'ECMO SVO2 2: Secondary pump'. It has a similar layout with a numeric keypad and a table titled 'Last 4 Clinical Data Value Entries (Past 2 days)'. The table columns are Date, Time, Flow (lpm) 2, RPM 2, P venous 2, P arterial 2, P internal 2, Delta P 2, and SVO2 2. Input fields below include ECMO P internal 2, ECMO delta P 2, and ECMO SVO2 2 (highlighted with a red box). There are also fields for 'ECMO pump 2 stop date:' and 'ECMO pump 2 stop time:'. Navigation buttons '(Prev Page)' and '(End)' are at the bottom.

The *ECMO Pump Details* screen has been updated to add new documentation of ECMO SVO2 for both the Primary and Secondary pumps.

This information has also been added to the PCI query group to display past documentations.

MAP Autocalculation



Currently, when vital signs are manually entered on the Vital Signs screen, the Mean arterial pressure (MAP) is auto-calculated based on the systolic and diastolic blood pressure values. The monitor or vital sign machine uses a different formula to calculate MAP, which results in a variation. The value displayed on the monitor being used to guide clinical decisions is the value that must be entered/saved in the EHR. With this change, the *Mean arterial pressure* field will no longer populate an auto-calculated value. The nurse must manually enter the value from the vital sign machine or monitor.

Note: This change primarily affects nurses in clinical areas without a monitor integration. In settings with an integration, the Blood pressure and Mean arterial pressure values will interface directly from the monitor to the EHR for validation.

Vital Signs 09/19 0854

Mean arterial pressure:

7	8	9	Del
4	5	6	
1	2	3	
-	0	.	Calc

Last 4 Vital Sign Entries (Past 2 days)

Date	Time	Temp F	Temp C	Pulse	Resp	BP	SpO2%

Respiratory rate: →

Respiratory source:

Vital signs position: →

Vital signs comment: →

Blood pressure: → 120/80

Blood pressure location: →

Blood pressure source:

(Prev Page) **Mean arterial pressure: →** (Next Page)

This update affects the following assessments:

Emergency Department
Triage Reassessment
Paramedic Intake
Newborn Stabilization
Rapid Flowsheet
Fetal Heart/Vitals
Disposition-DC/TX/ADM/LPT
Detailed Flowsheet
Controlled Substance

PEWS Update



Current documentation within the **PEWS** intervention does not display corporate, evidence-based standards for normal heart and respiratory rate. Reference ranges are used to designate the cardiovascular and respiratory sub scores which impact overall score. Future state will reflect appropriate reference ranges in the Cardiovascular and Respiratory fields.

Cardiovascular:

- 0 - Pink OR cap refill 1-2 secs
- 1 - Pale OR cap refill 3 sec
- 2 - Grey OR cap refill 4 sec
- OR tachycardia of 20 above normal rate
- 3 - Grey and mottled
- OR cap refill > 5 sec
- OR tachycardia - 30 above normal OR bradycardia

Normal awake rates (bpm)

- 0 - 27 days.....100-205
- 28 - 364 days.....100-180
- 1yr to <3 yrs.....98-140
- 3yrs to <6yrs.....80-120
- 6yrs to <12yrs.....75-118
- 12yrs to <18yrs....68-100

Respiratory:

- 0 - RR within normal OR No retracts
- 1 - RR >10 above normal
- OR use of accessory muscles
- OR >30% FiO2 OR 3+L/min
- 2 - RR >20 above normal OR retracts
- OR >40% FiO2 OR 6+L/min
- 3 - RR 5 below normal w/retracts
- OR Grunting
- OR 50% FiO2 OR 8+L/min

New documentation reflects evidence-based standard for Cardiovascular and Respiratory ranges.

This update affects the following assessments:

Emergency Department
PEWS
Disposition-DC/TX/ADM/LPT

Point of Care Test Update



Current documentation does not have the option for “other” when documenting Point of Care tests. New state will allow a free text response for instances when the test performed is not listed.

Point of Care Test

Patient

Date 09/13/24 Time 0823 User

Point of care test: [or free text]

1	ABG	7	COVID-19	13	INR
2	ABU	8	D dimer	14	Lactic acid
3	BNP	9	Flu complete	15	Mononucleosis
4	CBC	10	Gastrocult	16	PT
5	Cardiomarkers	11	Glucose	17	PTT
6	Chemistry	12	Hemocult	18	or<F9> For More Options

Point of care test:

Are point of care results critical:

(End)

OK Cancel

The *Point of Care test* field has been updated to include free text capabilities.

Pre-Arrival Antibiotics Administered by EMS



Current documentation shows antibiotics administered prior to arrival being documented on the EDM run sheet, which is not captured as part of Sepsis metrics. Future documentation will allow Antibiotics administered by EMS to be documented in the **Rapid Initial Assessment**.

Rapid Initial Assessment

Patient: _____
 Date: 09/10/24 Time: 1053 User: _____

Medications/treatments prior to arrival: [or free text]

<input type="checkbox"/> 1 None	<input type="checkbox"/> 7 Antivenom	<input type="checkbox"/> 13 O50
<input type="checkbox"/> 2 Antibiotics pre arrival	<input type="checkbox"/> 8 Aspirin	<input type="checkbox"/> 14 Direct pressure
<input type="checkbox"/> 3 ACLS drugs	<input type="checkbox"/> 9 CPR	<input type="checkbox"/> 15 Dressing
<input type="checkbox"/> 4 Ace wrap	<input type="checkbox"/> 10 Cardiac monitor	<input type="checkbox"/> 16 Fingerstick blood glucose
<input type="checkbox"/> 5 Analgesics	<input type="checkbox"/> 11 C collar	<input type="checkbox"/> 17 Fluids pre arrival
<input type="checkbox"/> 6 Antipyretics	<input type="checkbox"/> 12 Cooling measures	<input type="checkbox"/> 18 or <F9> For More Options

Link to RFID: Yes
 First Point of Contact: Yes
 Enter/Edit Allergies: Yes*
 Currently enrolled in CA program: Yes
 CA program reason: Narcotic and
 Arrived by: AMB *
 EMS service: MUSIC CITY*MI
 Other EMS service:

Medications/treatments prior to arrival:

OK

Medications/treatments prior to arrival: Lookup

Select:

Options

1	IO
2	IV
3	Ice pack
4	Immobilization
5	Intubated
6	Irrigation - ear
7	KED
8	Long spine board
9	Meds per EMS
10	Morphine
11	Nebulized treatment
12	Nitroglycerin
13	Oxygen
14	Sling
15	Tourniquet
16	Wound care

<End of list>

Medications/treatments prior to arrival has been updated with the following response:

- Antibiotics pre arrival

'Irrigation – ear' will now be found by utilizing the F9 (more options) response on this screen.

This update affects the following assessments:

Emergency Department
Rapid Initial Assessment
Non Urgent General Focus
EMS Pre-Arrival Assessment
Detailed Assessment

RT Medication Titration



Respiratory Therapists are currently utilizing notes for documenting titration. To improve communication and aid in determining the last rate and dose, a new intervention has been created to make titration documentation more efficient.

RT Medication Titration

RT titratable medication:

- 1 Albuterol
- 2 Ipratropium and albuterol
- 3 Epoprostenol

RT titratable medication:

Current dose:

Current rate:

New dose:

New rate:

Parameter for change:

Parameter value:

(Next Page)

The *RT titratable medication* field has the following responses:

- Albuterol
- Ipratropium and albuterol
- Epoprostenol

Note: The field does not allow for free text.

RT Medication Titration

Current dose:

Enter free text.

RT titratable medication: Albuterol

Current dose:

Current rate:

New dose:

New rate:

Parameter for change:

Parameter value:

(Next Page)

Current dose and Current rate are free text enabled.

RT Medication Titration

New dose:
Enter free text.

RT titratable medication: Albuterol

Current dose: 2.5mg
Current rate: 6 lpm

New dose:
New rate:

Parameter for change:
Parameter value:

(Next Page)

New dose and New rate are free text enabled.

RT Medication Titration

Parameter for change: [or free text]

1	Accessory muscles	7	Peak expiratory flow
2	Cardiac index	8	Pediatric Asthma Score
3	Clinical Resp Score	9	Respiratory rate
4	Mean PAP	10	SpO2
5	P/F ratio	11	SvO2
6	PaO2	12	Wheezing

RT titratable medication: Albuterol

Current dose: 2.5mg
Current rate: 6 lpm
New dose: 5mg
New rate: 7 lpm

Parameter for change:
Parameter value:

(Next Page)

The *Parameter for change* field has the following responses:

- Accessory muscles
- Cardiac index
- Clinical Resp Score
- Mean PAP
- P/F ratio
- PaO2
- Peak expiratory flow
- Pediatric Asthma Score
- Respiratory rate
- SpO2
- SvO2
- Wheezing
- Free text

The *Parameter value* field is free text enabled.

RT Medication Titration

Parameter value:
Enter free text.

RT titratable medication: Albuterol

Current dose: 2.5mg

Current rate: 6 lpm

New dose: 5mg

New rate: 7 lpm

Parameter for change: Accessory muscles

Parameter value: *

(Next Page)

The co-signature feature is available depending on the facility's policy.

If no medications require a co-signature, these fields will be skipped.

The *RT titratable medication comment* field is available for additional comments.

RT Medication Titration

RT titratable medication comment:
Enter free text.

Cosign:

Password:

RT titratable medication comment:
→

(Prev Page)

(End)

EDM and NUR Modules

MEDITECH EBCD Update

EHR

2025.1

Update

Telemetry EDM Documentation and Workflow

To support consistent documentation of the date and time of telemetry application, for Inpatient Holds, the workflow has been updated. Nurses will now be able to document the application of telemetry monitoring for Inpatient Holds.

Overview of workflow: Once the provider submits the Telemetry Initial order, a red TELE indicator is presented on the ED Tracker, alerting the nurse an action is needed. Once a tele box is placed on the confirmed patient, the nurse will validate the patient, waveform and tele box number with the monitor tech. The nurse will document the application date and time within the Telemetry treatment. This information will auto-populate into the Inpatient telemetry documentation.

The screenshot shows two overlapping windows from the MEDITECH EBCD system. The top window, titled 'Review Patient's Orders', displays a table of orders. The bottom window, titled 'Standard Nurse Tracker w/OBED (SP=ED ALL PATIENTS)', shows a list of patients. A red 'TELE' indicator is visible in the CMT column of the patient list, with an orange arrow pointing to it.

Category	Orders	Pri	Date/Time	Status	Stop	My
+ Nursing (2)						
- Other (1)						
Telemetry initial (TELE)			09/12 0818	Active		*
Review by date: 09/14/24						
Review by time: 0818						

ROOM	NAME	CC	CMT
119:6	Sample, DEP	BACKPATH	RN 03:26
		Doctor	TX
			HCG Unco1
			TEST
602:3	MAIN50 OBS	RECEPT	00:19
		PROVIDER	
			HCG Unco1
			TELE

Upon admission, the provider will enter a Telemetry Initial order.

Once the provider enters the Telemetry Initial order, the ED tracker will display a red TELE indicator, notifying the nurse of an action.

Note: Once telemetry documentation is complete, the TELE indicator will turn green.



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Patient Triage/Documentation

Chief Complaint

Allergies/ADRs (1)
No Known Allergies

Assessments (9)
 Rapid Initial Assessment (Required for CARDIAC)
 Detailed Assessment (Required for CARDIAC)
 Cardiac Related (Required for CARDIAC)
 Cardiac Related Reassessment
 Glasgow Coma Scale
 Pain Assessment/Reassessment (Required for CARDIAC)
 Physical Findings (Required for CARDIAC)
 Teaching Education (Required for CARDIAC)
 Triage Reassessment

Treatments (3)
 Cardiac Monitor
 Detailed Flowsheet
Tele App/Discon ORDER REQUIRED (Ordered by Physician)

Notes (0)

Triaged

Telemetry Application/Disconti

Patient
 Date Time User

Telemetry box number:
Enter free text.

Telemetry application date:→09/12/24
 Telemetry application time:→0908

Telemetry box number:→12A45

Telemetry discontinued date:→
 Telemetry discontinued time:

Telemetry unavailable and patient maintained on continuous monitor:→

(End)

Confirm the patient identifier, waveform and tele box with the monitor tech.

The nurse will document the Tele App/Discon ORDER REQUIRED intervention once the telemetry box is applied and validated.

Telemetry Application/Disconti

Patient
 Date Time User

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 application date:→09/12/24
 Telemetry application time:→0908

Telemetry box number:→12A45

Telemetry discontinued date:→
 Telemetry discontinued time:

Telemetry unavailable and patient maintained on continuous monitor:→

(End)

Telemetry unavailable and patient maintained on continuous monitor has a response of 'Yes'.

Use this field if a telemetry box is unavailable. Ensure the patient is placed on an alternative cardiac monitor and continue to document in the Cardiac Monitor treatment screen until a box is available and applied to the patient.

Note: If the 'Telemetry unavailable and patient maintained on continuous monitor' is completed, the TELE indicator will turn green.

Process Care Items

Current Date/Time SB I: 0/ of 1

Document View Order Add Allergy Change Change ≥More
 Now History Detail Interv Link Directions Level

Patient TESTING,BINK Status PRE ER Room
 RESUSCITATION STATUS Admit Bed
 Attend Dr DR.TERESA Age/Sex 38 F Loc J.ER
 Start Date 07/16/24 at 0000 End Date 07/16/24 at 2359 Med Edit Unit#
 Include A AS,CP,MO,OE,PS 1:99 3L ALL INT Acuity

Care Items	Sts	Frequency	OD	Doc	Src	D	C/N	KI	Prt
Routine Care									
-Tele App/Discon *ORDER REQUIRED* +	f	[2024.3]			OE				

Once the patient is assigned an inpatient bed, follow hospital process for SBAR handoff, as the Tele application date and time documented in the ED will be shown on the ED and Inpatient SBAR reports.

The Inpatient nurse will be able to view the ED nurse's previous documentation. The telemetry start date and time will not need to be edited.

Note: The inpatient nurse will confirm the patient identifier, waveform and tele box number with the monitor tech.

Admitting MD: Weight (kg):
 Attending MD: EMI:
 Reason for Visit/CC: BONE FRACTURE

Brief History:

Allergies: No Known Allergies

Tele application date:
 Tele application time:

Cardiac Monitor: None Documented
 Suicide Risk: None Documented
 Pain control goal: None Documented
 Pain scale utilized:
 Diet:

The ED and Inpatient SBAR reports will display the last documented Tele application date and time.

If no documentation has been entered for the Telemetry application date and time, the fields will display as blank on the report.