EBCD MEDITECH Content Updates – 2023.2
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.

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

Summary of Revisions

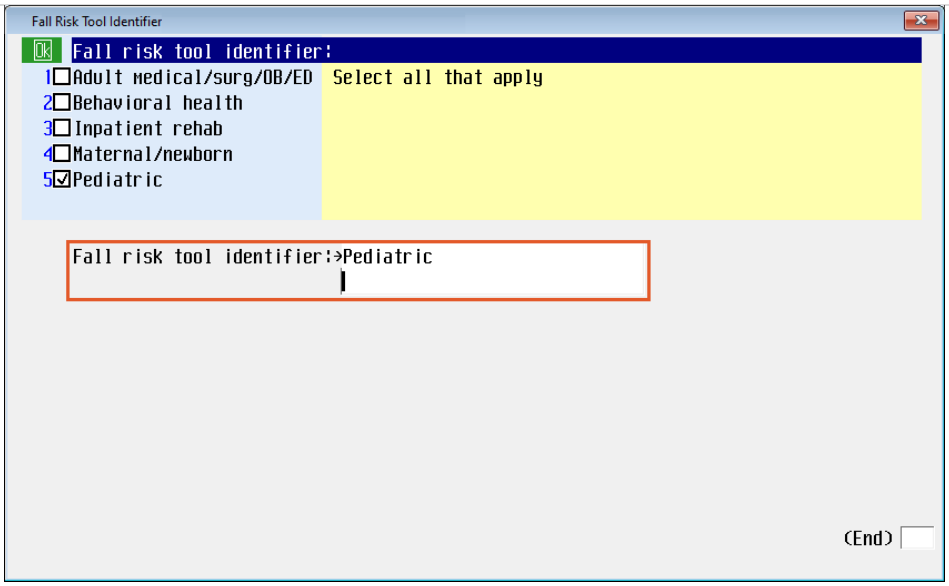
Date	Revision
03/01/2023	Updated ICP Monitoring Interventions
03/02/2023	Updated YIB for Safety/Risk/Regulatory

Nursing, OR and ED Modules

Fall Risk Assessment

CHAMPS Pediatric Fall Risk Assessment

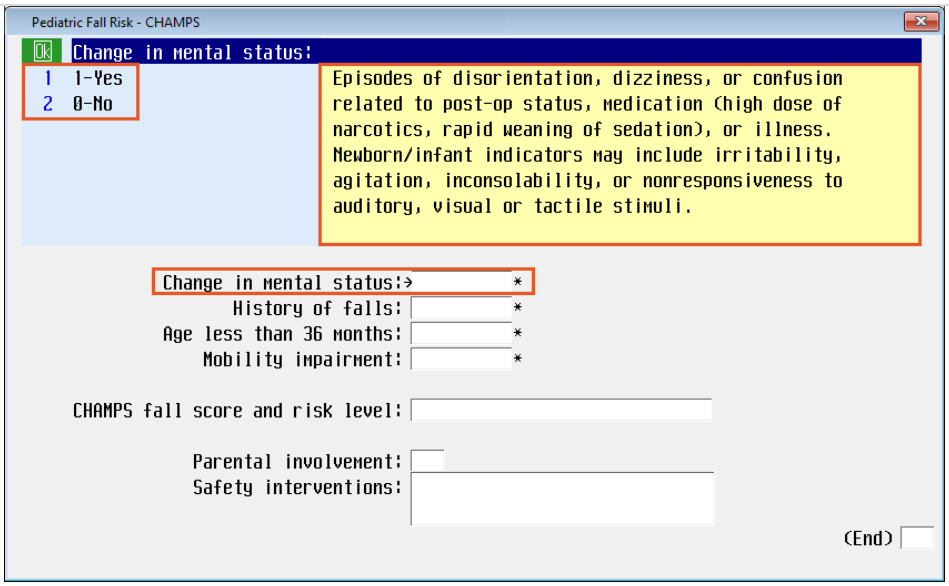
The **CHAMPS Pediatric Fall Risk Assessment** should be completed for all pediatric ages, less than 18 years of age, in the Pediatric areas.



For the CHAMPS Pediatric Fall Risk, the Pediatric population is selected in the *Fall risk tool identifier* field.

Once the Pediatric response is selected, the appropriate documentation will populate.

Each following field noted with an asterisk is required.

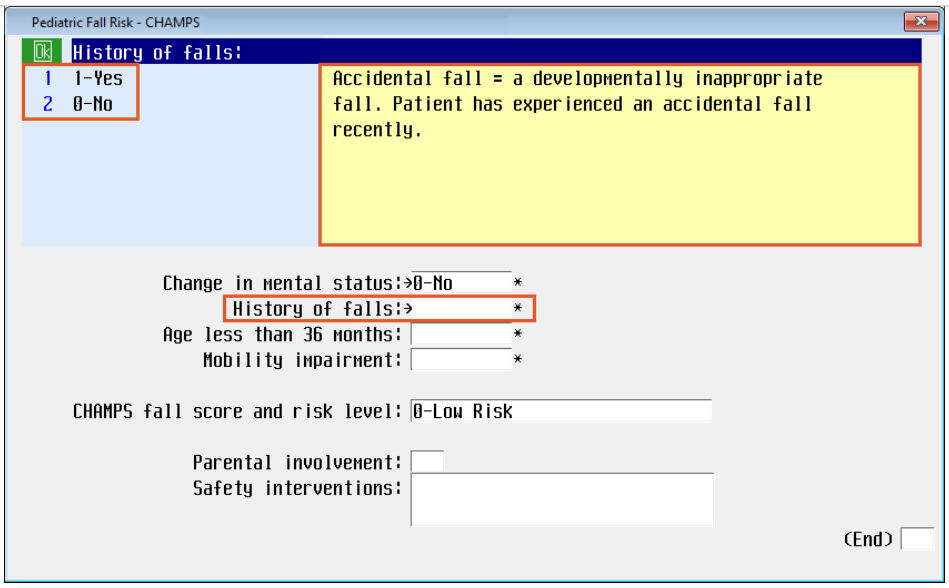


The *Change in mental status* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

> Episodes of disorientation, dizziness, or confusion related to post-op status, medication (high dose of narcotics, rapid weaning of sedation), or illness. Newborn/infant indicators may include: irritability, agitation, inconsolability, or nonresponsiveness to auditory, visual or tactile stimuli.

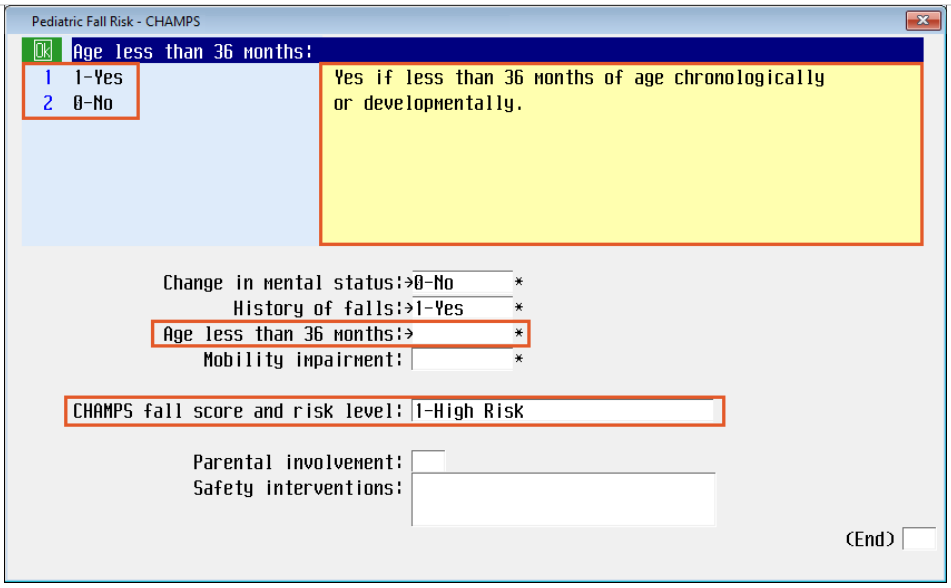


The *History of falls* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

> Accidental fall = a developmentally inappropriate fall. Patient has experienced an accidental fall recently.



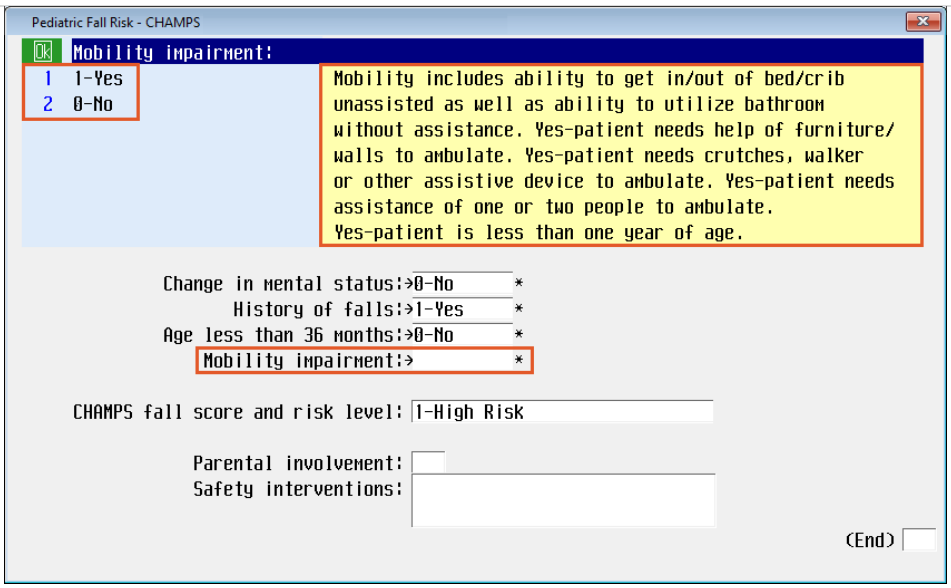
The *Age less than 36 months* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

> Yes if less than 36 months of age chronologically or developmentally.

Note: As you complete the fields, the *CHAMPS score and risk level* is calculated.

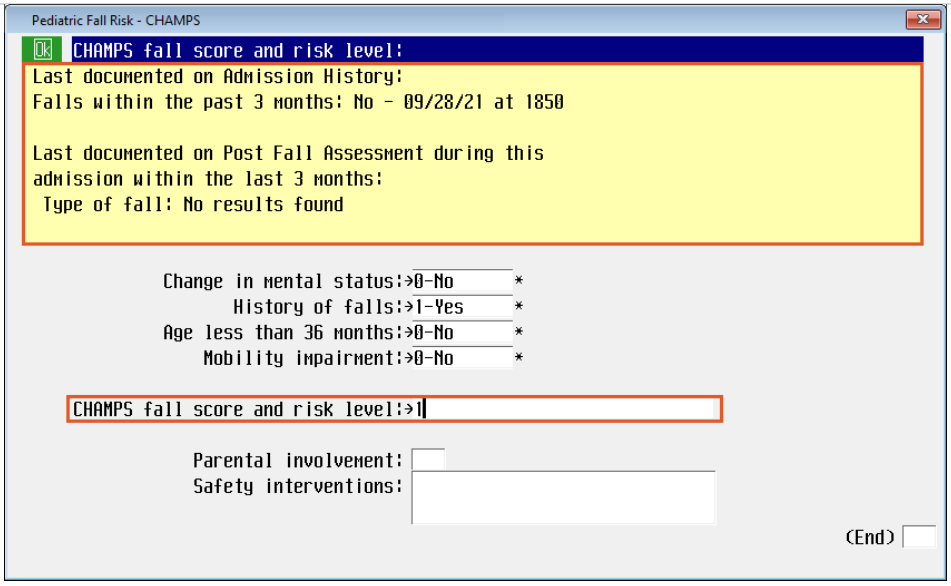


The *Mobility impairment* field has the following responses:

- 1- Yes
- 0- No

The Yellow Information Box guides the clinician in correctly selecting the response:

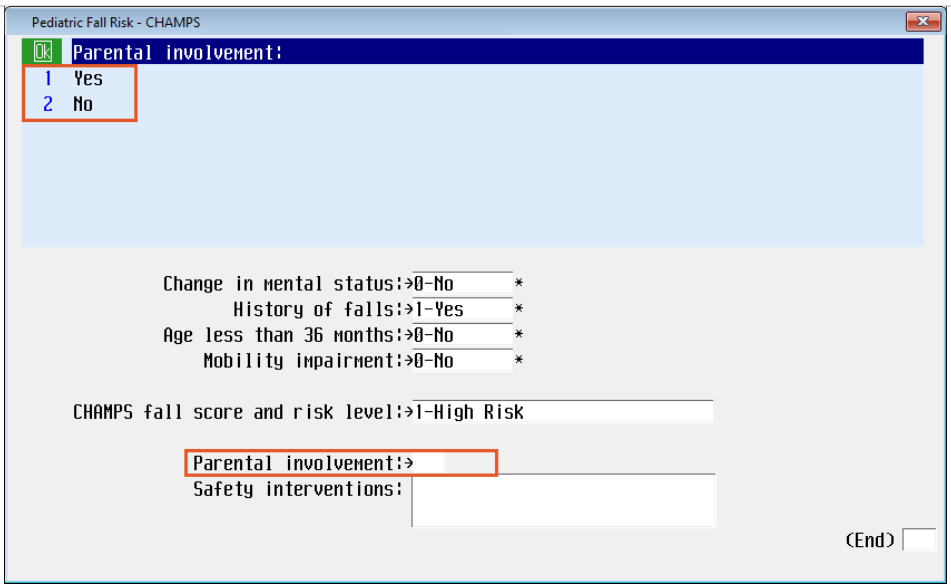
> Mobility includes ability to get in/out of bed/crib unassisted as well as ability to utilize bathroom without assistance. Yes-patient needs help of furniture/walls to ambulate. Yes-patient needs crutches, walker or other assistive device to ambulate. Yes-patient needs assistance of one or two people to ambulate. Yes-patient is less than one year of age.



The *CHAMPS score and risk level* field is calculated from the documentation above and is only editable by changing the prior responses.

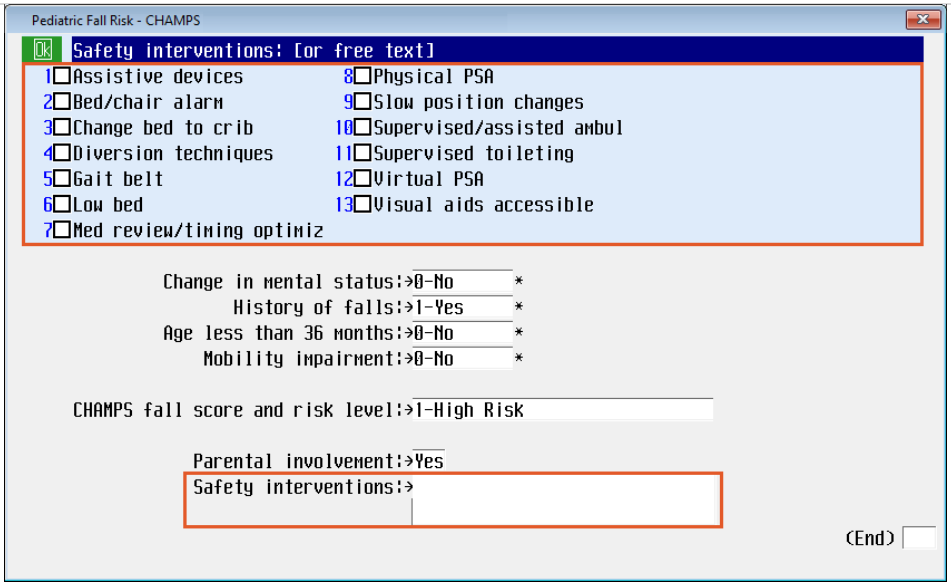
The Yellow Information Box guides the clinician on previous documented falls:

> Last documented on Admission History:
> Falls within the past 3 months: No – MM/DD/YY at HHMM
>
> Last documented on Post Fall Assessment during this admission within the last 3 months:
> Type of fall: No results found



The *Parental involvement* field has the following responses:

- Yes
- No



Safety interventions is a multi-select field with the following responses:

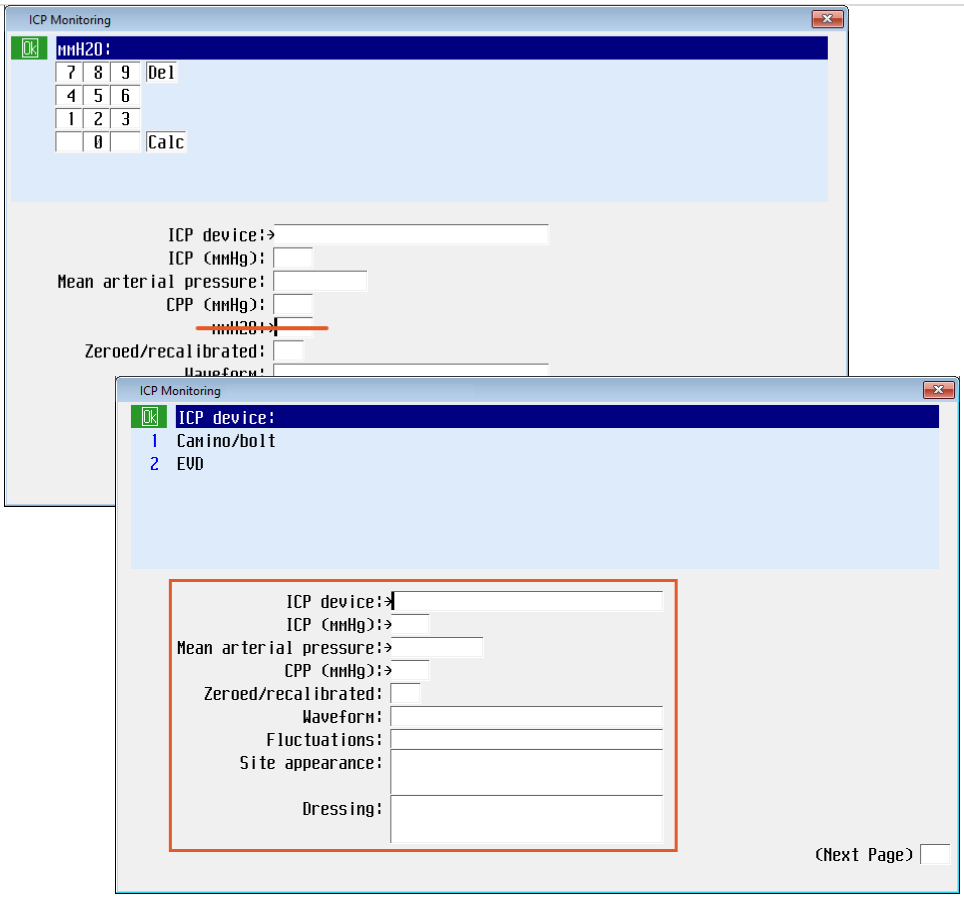
- Assistive devices
- Bed/chair alarm
- Change bed to crib
- Diversion techniques
- Gait belt
- Low bed
- Med review/timing optimiz
- Physical PSA
- Slow position changes
- Supervised/assisted ambul
- Supervised toileting
- Virtual PSA
- Visual aids accessible

This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Safety/Risk/Regulatory +	SURG: Safety/Risk/Regulatory +	Fall Risk Assessment
	SURG: Safety/Risk/Regulatory Int +	
	SURG: Safety/Risk/Regulatory PAC +	

ICP Monitoring

For accuracy of trending for the evaluation of patients, the unit of measure of mmH2O for ICP documentation is inaccurate and has been removed.



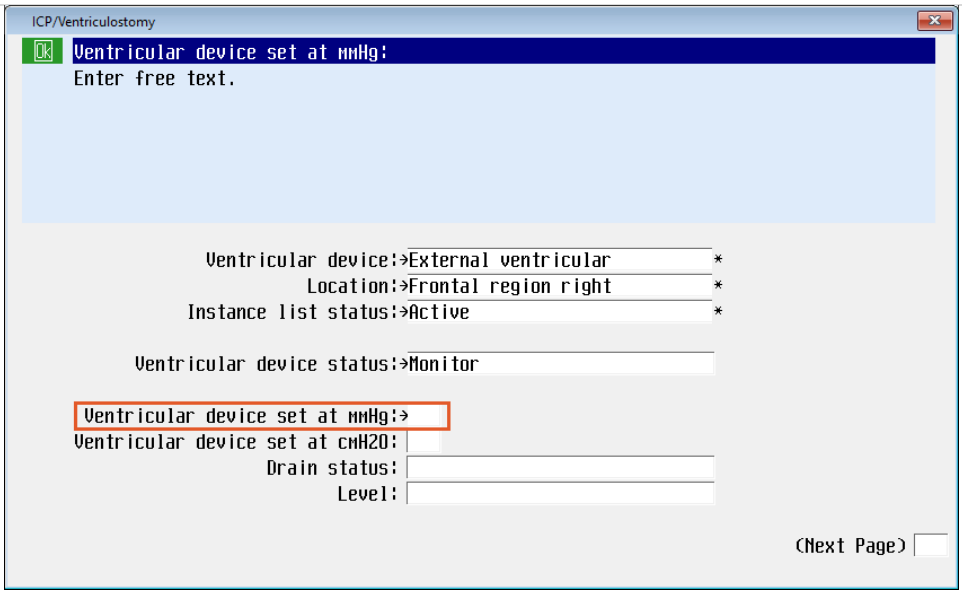
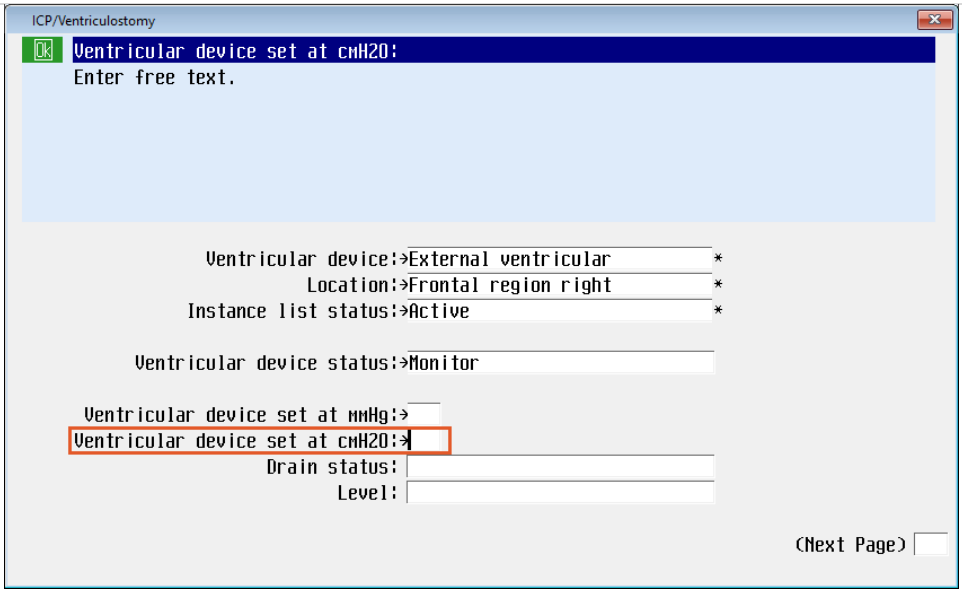
The *mmH20* field has been removed.

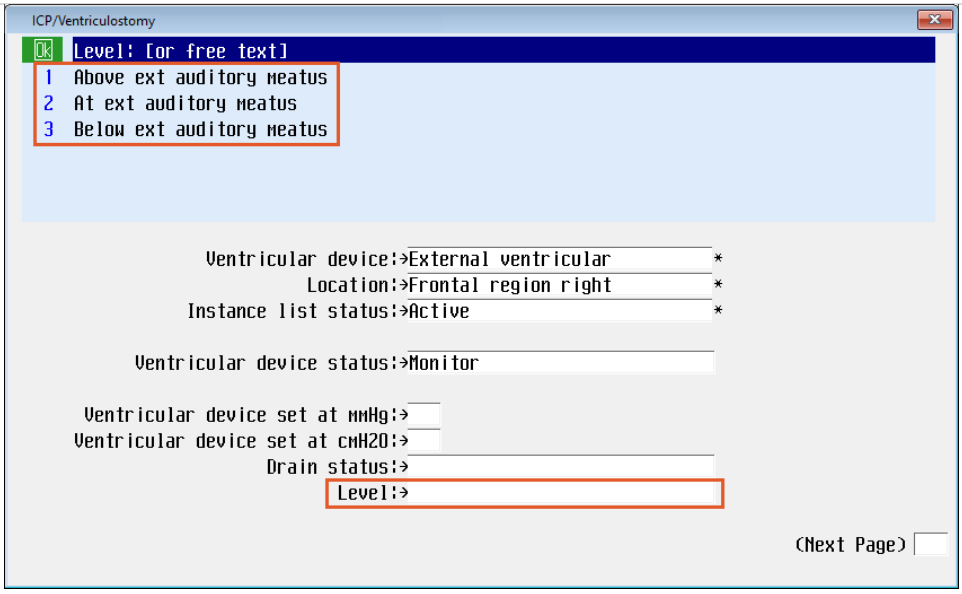
This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Vital Signs	SURG: IV Drip Titration PAC +	Vital Signs
IV Drip Status	SURG: IV Drip Titration Pre +	Triage Reassessment
Critical Care Flowsheet		IV Drip Status
		Paramedic Intake
		Detailed Flowsheet
		Disposition – DC/TX/ADM/LPT
		ICP Monitoring
		Newborn Stabilization

ICP/Ventriculostomy

The location for the ICP level has been updated to remove the numeric options, reducing clinician confusion.

	*Ventricular device marked at mmHg* has changed to *Ventricular device set at mmHg.*
	*Ventricular device marked at cmH2O* has changed to *Ventricular device set at cmH20.*

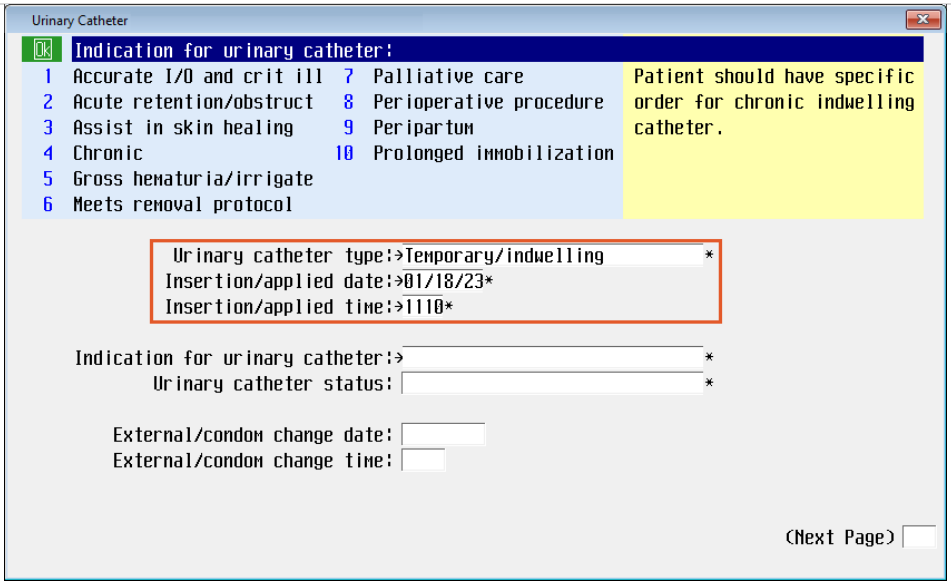


The *Level* field has removed the numerical responses.

This change affects the following assessments and interventions:

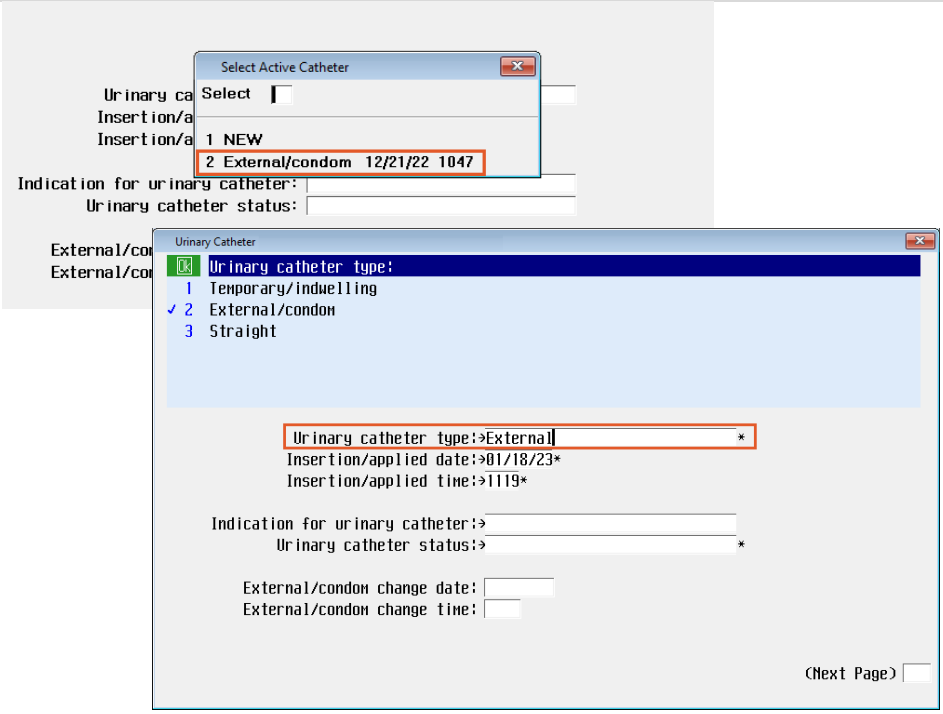
Nursing	Surgery	Emergency Department
Trig: ICP Ventriculostomy	ICP Ventriculostomy	ICP Ventriculostomy
ICP Ventriculostomy	SURG: Lines, Drains, Airways Pre-op +	Newborn Stablilization
Critical Care Flowsheet	SURG: Lines, Drains, Airways Intra-op +	
Lines/Drains/Airways	SURG: Lines, Drains, Airways PACU +	

Urinary Catheter

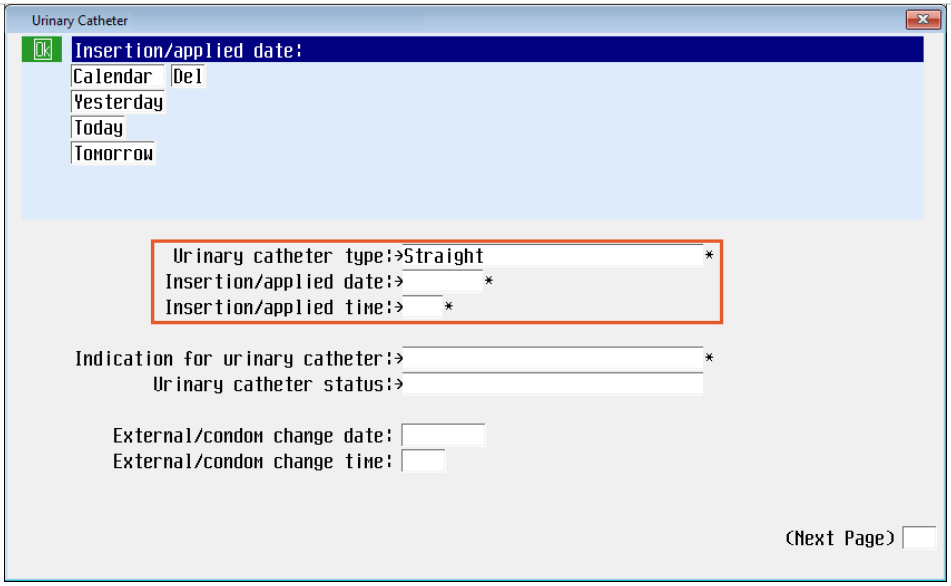


If a **Temporary/indwelling** catheter type has been started previously and no discontinue date and time has been recorded, the Temporary/indwelling catheter insertion information will now default in *Uneditable* until the Discontinue has been filed.

An existing "Temporary/indwelling catheter" type will be the only Urinary catheter type available for documentation until it has been documented as discontinued.



If a clinician selects an existing documented **External/condom** urinary catheter and attempts to change the *Urinary catheter type* to either "Temporary/indwelling" or "Straight", the defaulted *Insertion date* and *time* will be cleared and a new Start for the new *Urinary catheter type* must be documented.



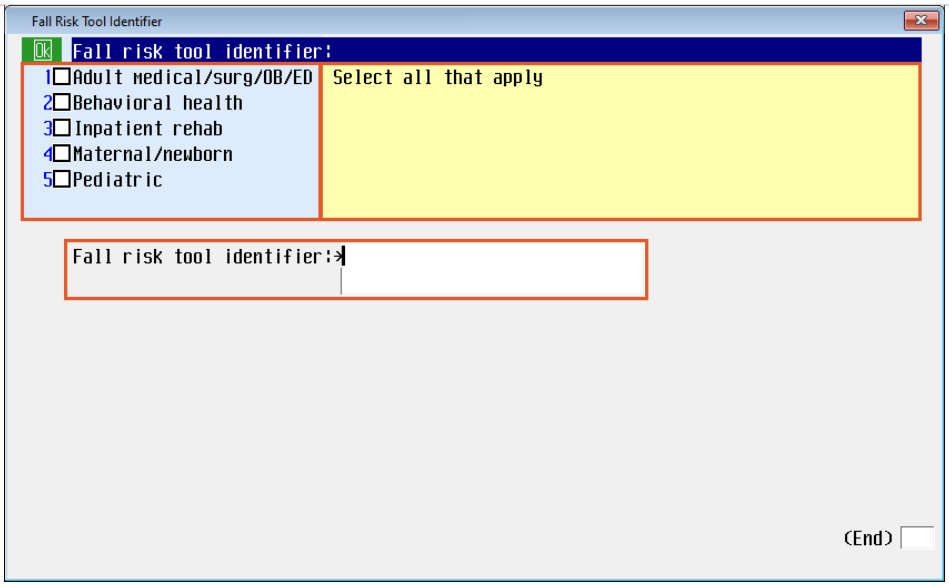
This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
Critical Care Flowsheet	Lines/Drains/Airways – Urinary Catheter	Newborn Stabilization
Lines/Drains/Airways – Urinary Catheter		Urinary Catheter

Nursing and OR Modules

Fall Risk Tool Identifier Update – Safety/Risk/Regulatory

The **Fall Risk Screening** has been updated to align with the evidence-based HCA standardized fall screening tools based upon the patient's age and location.

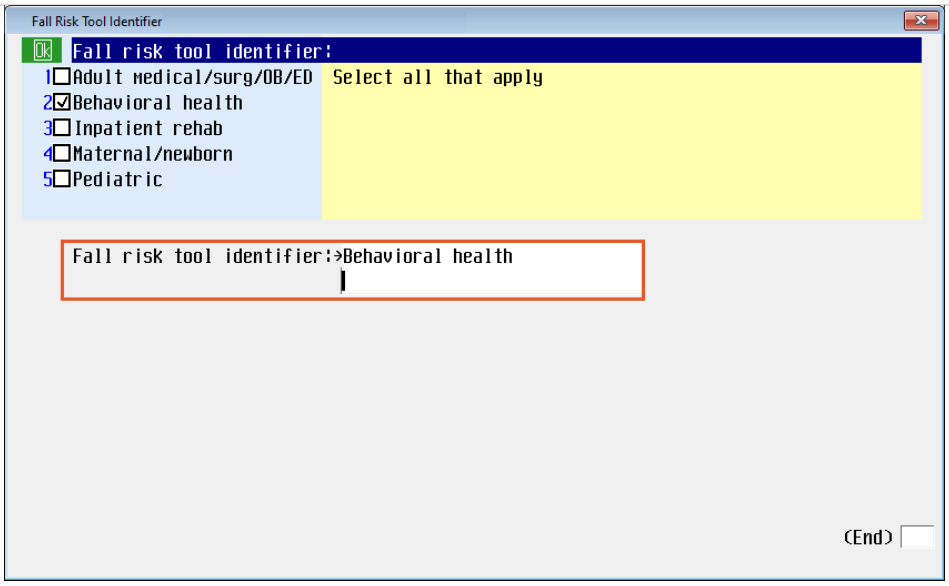


The *Fall risk tool identifier* field pops to each corresponding Fall Risk tool when the patient population is selected.

- Adult medical/surg/OB/ED → Morse Fall Scale
- Behavioral health → Wilson Sims Fall Risk
- Inpatient rehab → Fall Risk
- Maternal/newborn → Maternal/newborn Fall Risk
- Pediatric → CHAMPS Fall Risk

This is a multi-select field.

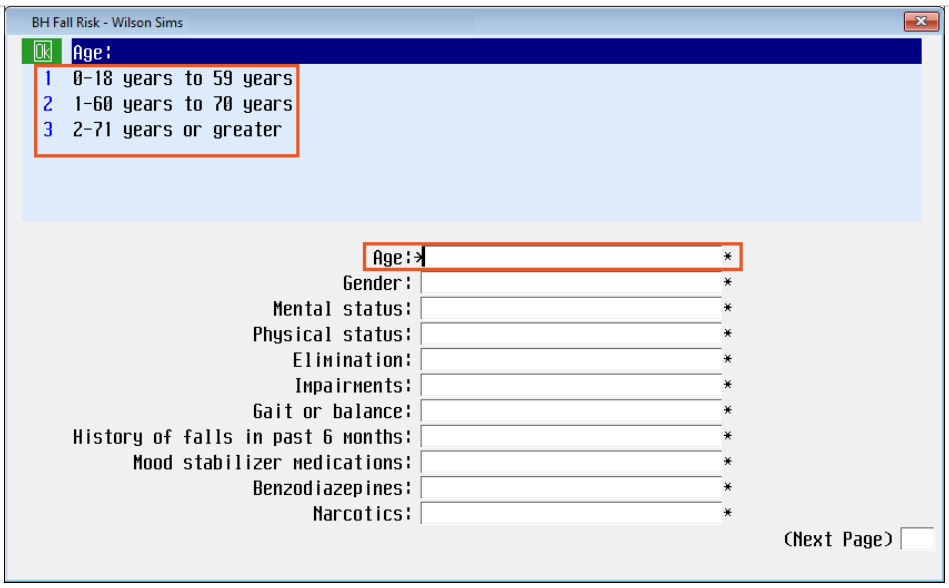
Wilson Sims Fall Risk Assessment Tool



For the Wilson Sims Fall Risk, the Behavioral health population is selected in the *Fall risk tool identifier* field.

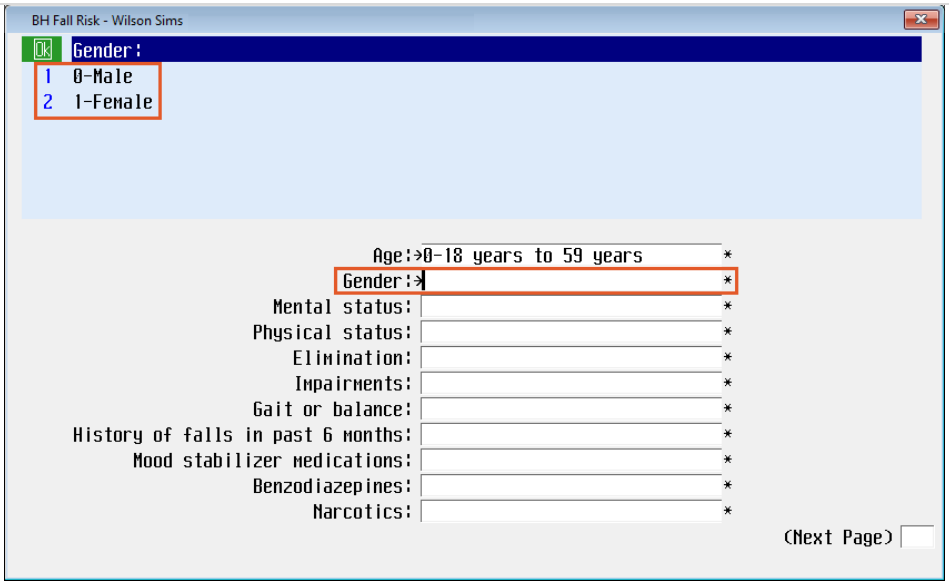
Once the Behavioral health response is selected, the appropriate documentation will populate.

Each following field noted with an asterisk is required.



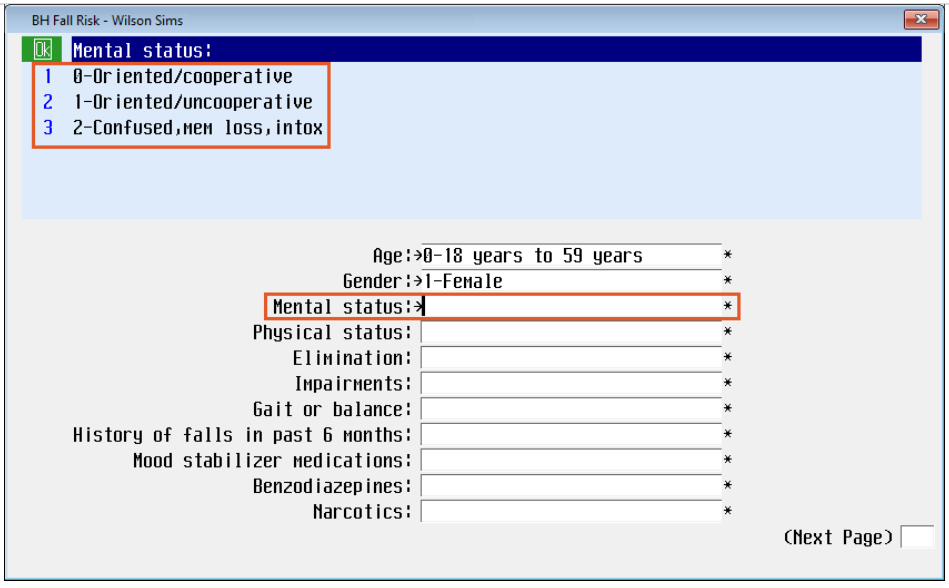
The *Age* field has the following responses:

- 0- 18 years to 59 years
- 1- 60 years to 70 years
- 2- 71 years or greater



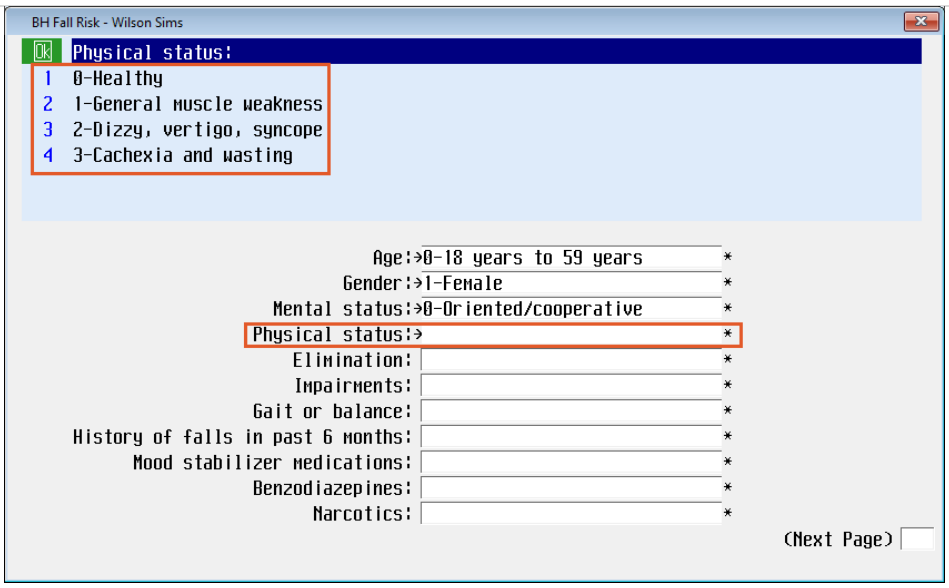
The *Gender* field has the following responses:

- 0- Male
- 1- Female



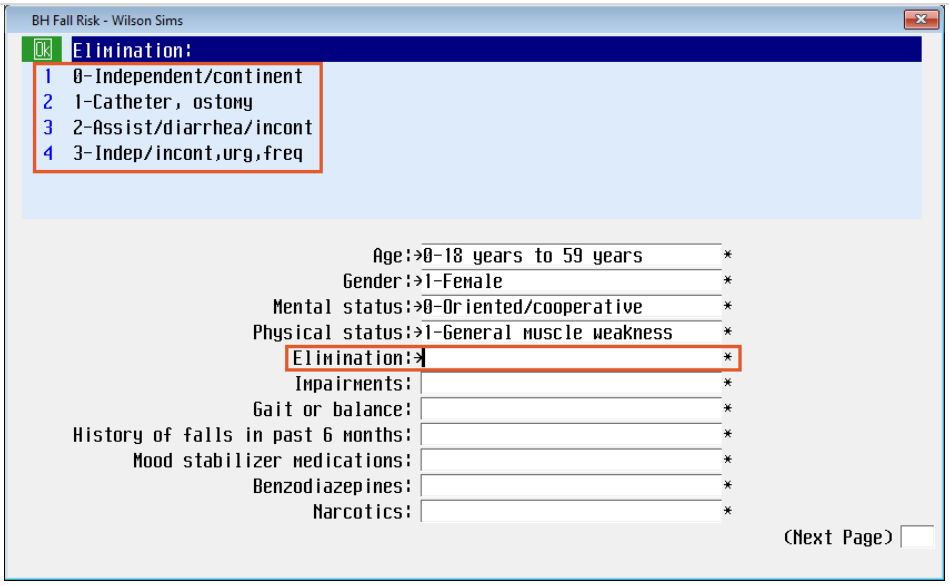
The *Mental status* field has the following responses:

- 0- Oriented/cooperative
- 1- Oriented/uncooperative
- 2- Confused, mem loss, intox



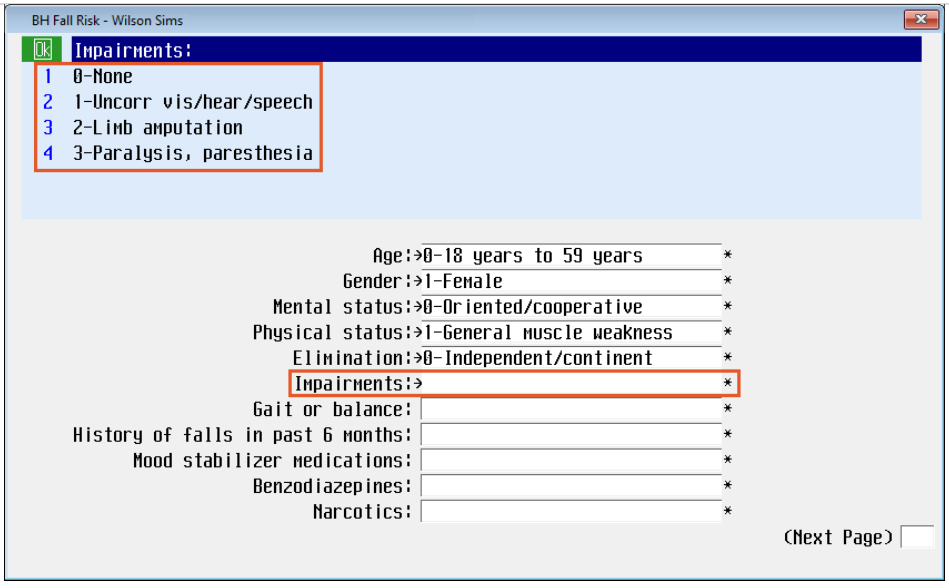
The *Physical status* field has the following responses:

- 0- Healthy
- 1- General muscle weakness
- 2- Dizzy, vertigo, syncope
- 3- Cachexia and wasting



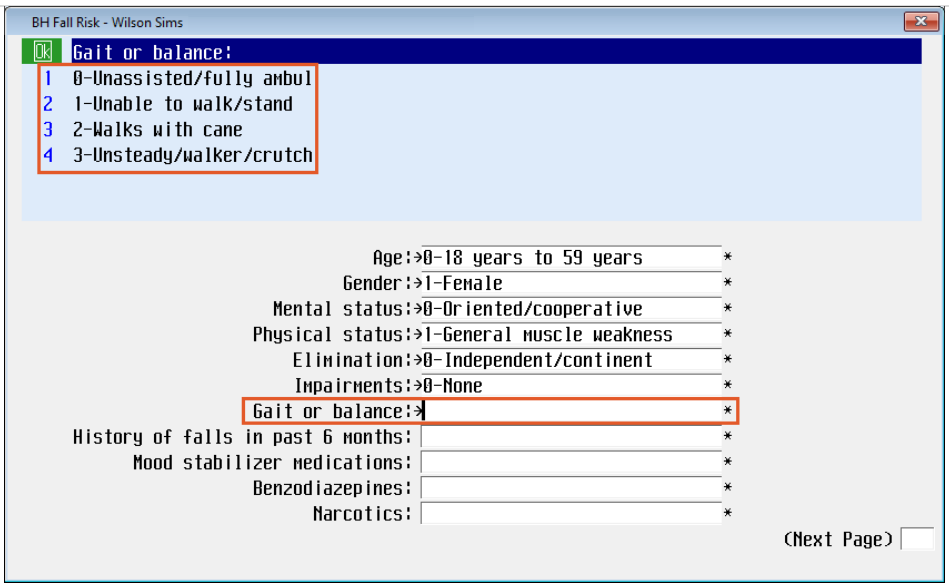
The *Elimination* field has the following responses:

- 0- Independent/continent
- 1- Catheter, ostomy
- 2- Assist/diarrhea/incont
- 3- Indep/incont,urg,freq



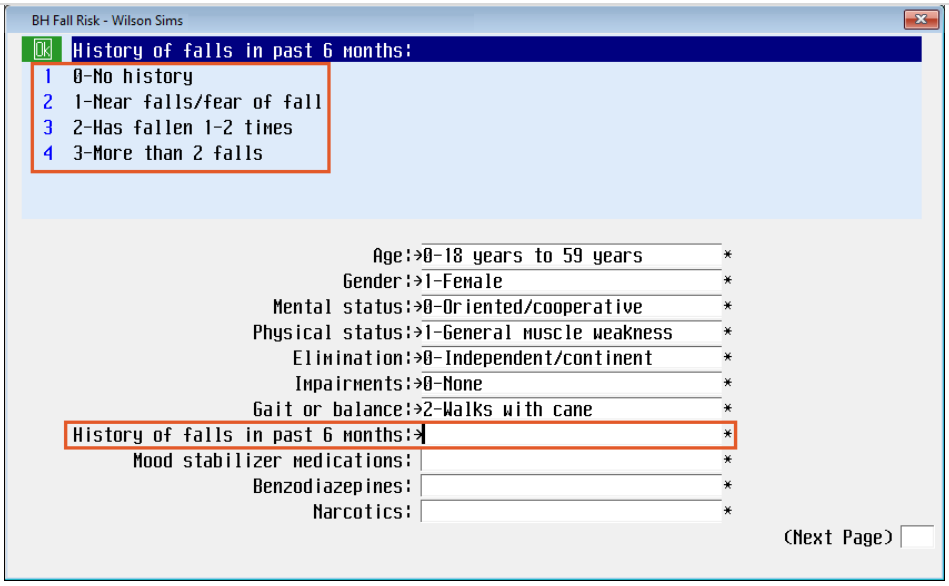
The *Impairments* field has the following responses:

- 0- None
- 1- Uncorr vis/hear/speech
- 2- Limb amputation
- 3- Paralysis, paresthesia



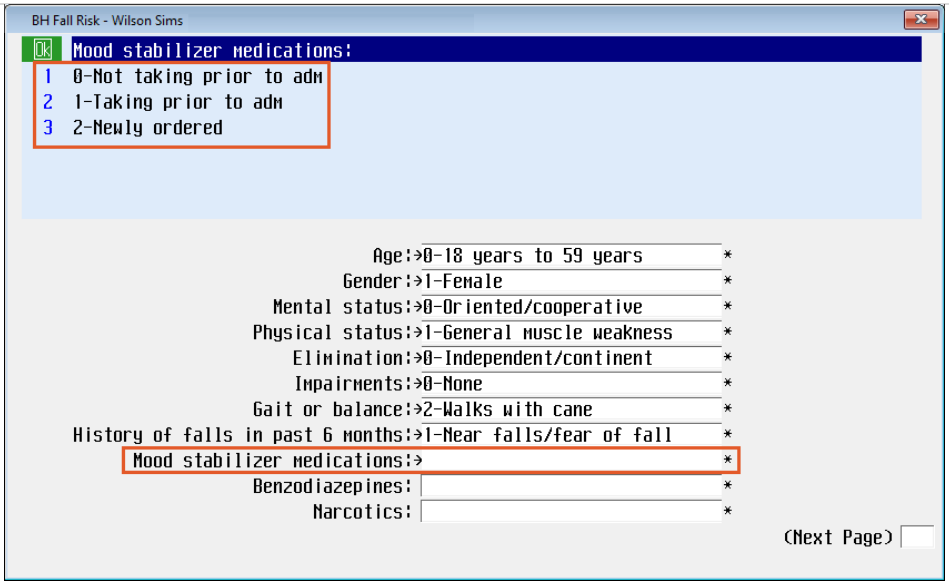
The *Gait or balance* field has the following responses:

- 0- Unassisted/fully ambul
- 1- Unable to walk/stand
- 2- Walks with cane
- 3- Unsteady/walker/crutch



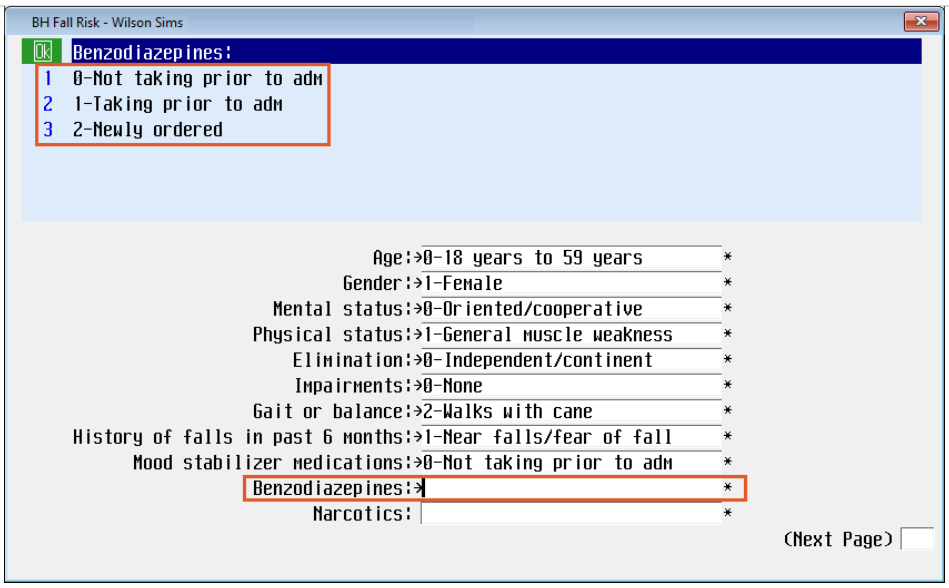
The *History of falls in past 6 months* field has the following responses:

- 0- No history
- 1- Near falls/fear of fall
- 2- Has fallen 1-2 times
- 3- More than 2 falls



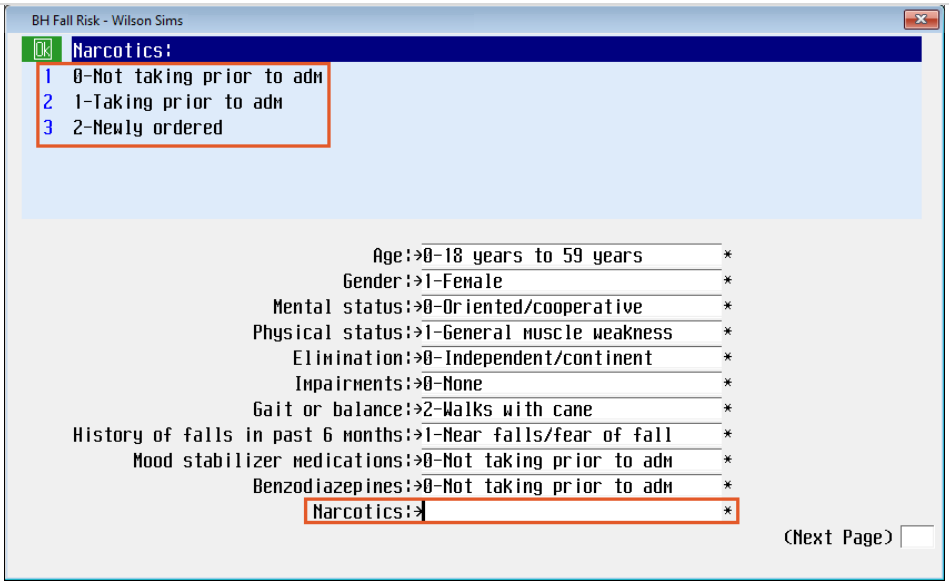
The *Mood stabilizer medications* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered



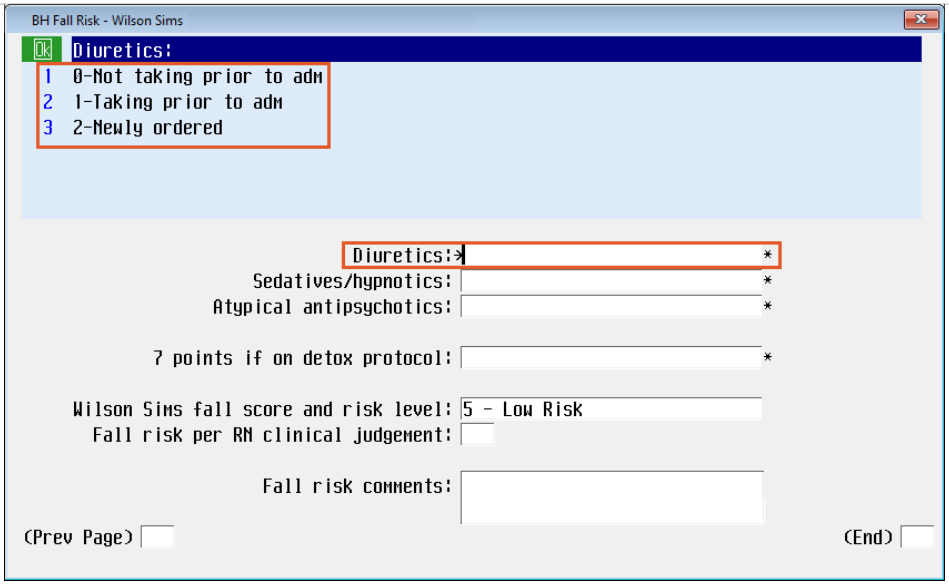
The *Benzodiazepines* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered



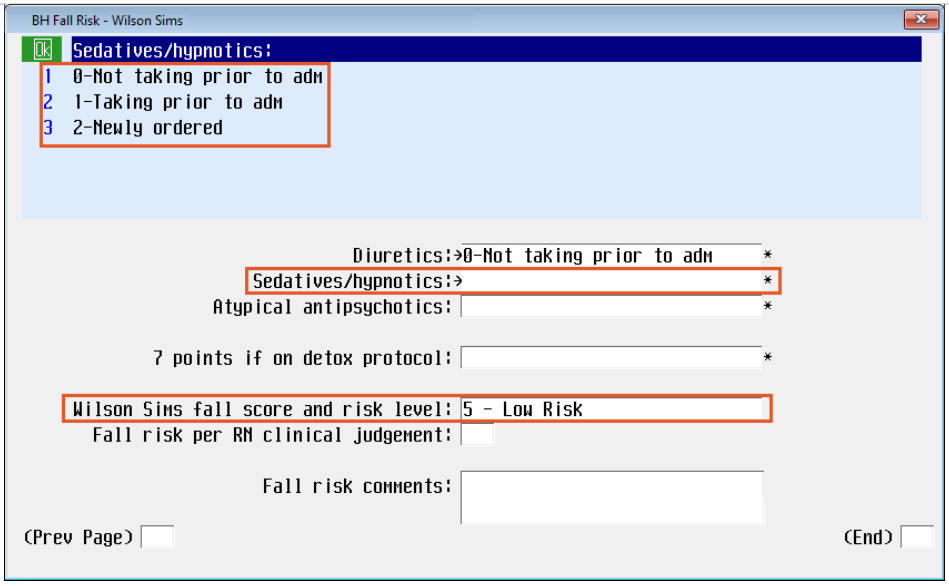
The *Narcotics* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered



The *Diuretics* field has the following responses:

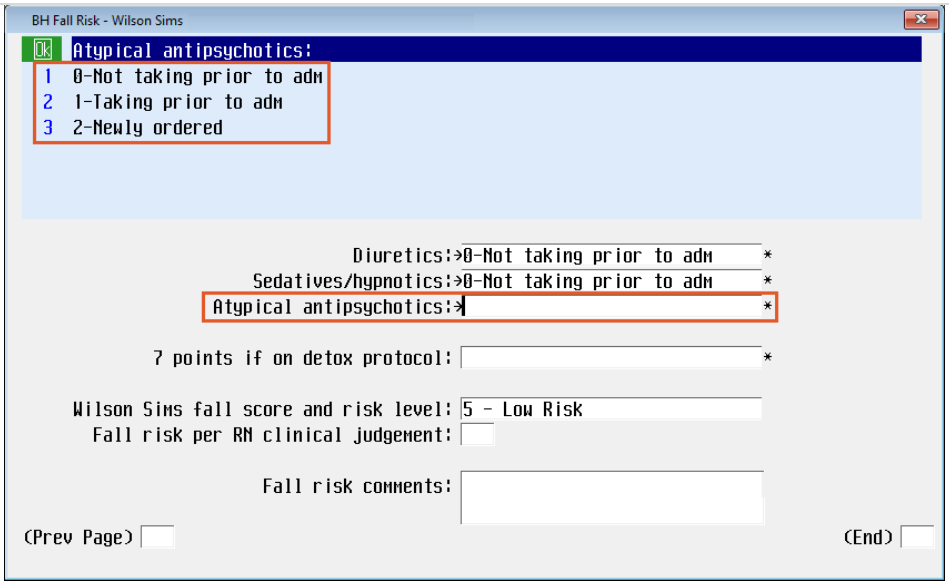
- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered



The *Sedatives/hypnotics* field has the following responses:

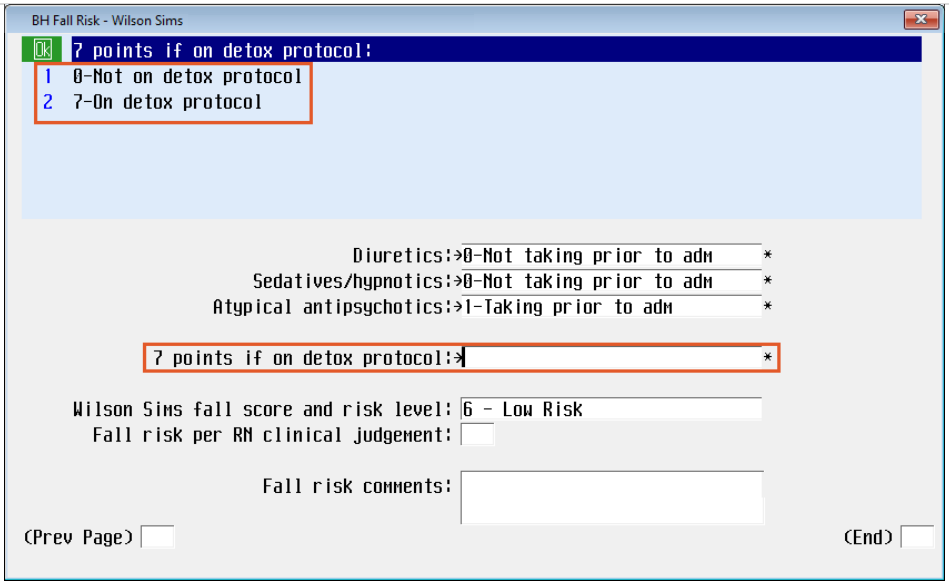
- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered

Note: As you complete the fields, the *Wilson Sims Fall Risk Assessment Tool score and risk level* is calculated.



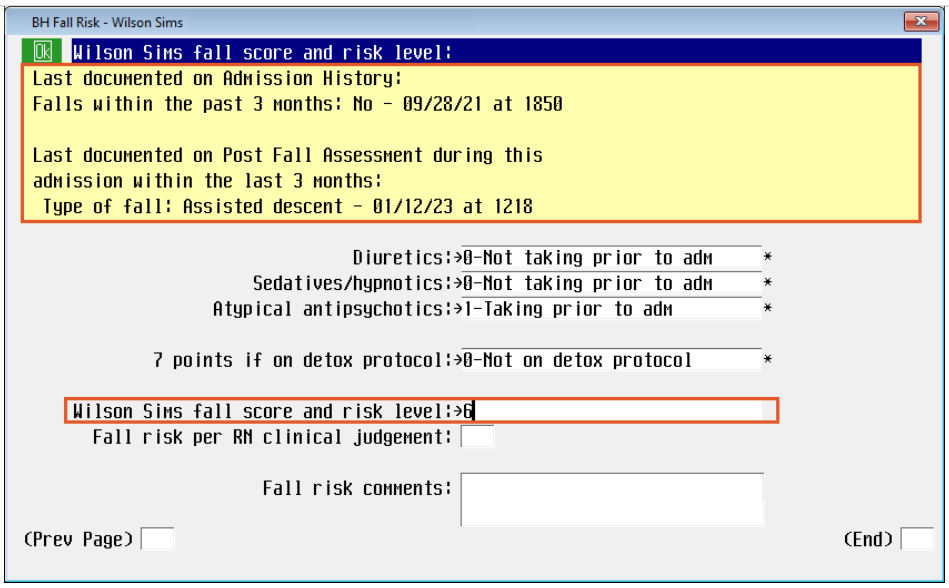
The *Atypical antipsychotics* field has the following responses:

- 0- Not taking prior to adm
- 1- Taking prior to adm
- 2- Newly ordered



The *7 points if on detox protocol* field has the following responses:

- 0- Not on detox protocol
- 7- On detox protocol

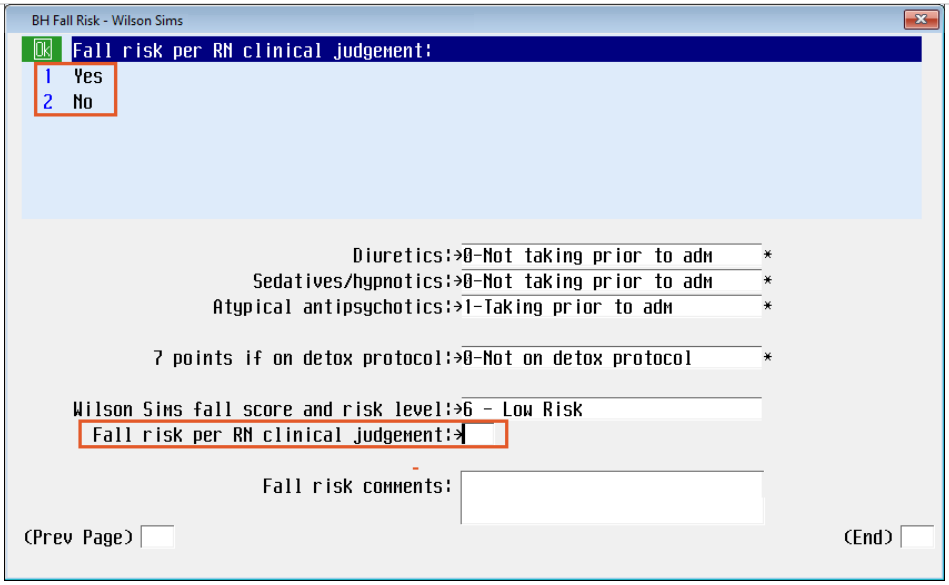


The *Wilson Sims Fall Risk Assessment Tool score and risk level* field is calculated from the documentation above and is only editable by changing the prior responses.

The Yellow Information Box guides the clinician on previous documented falls:

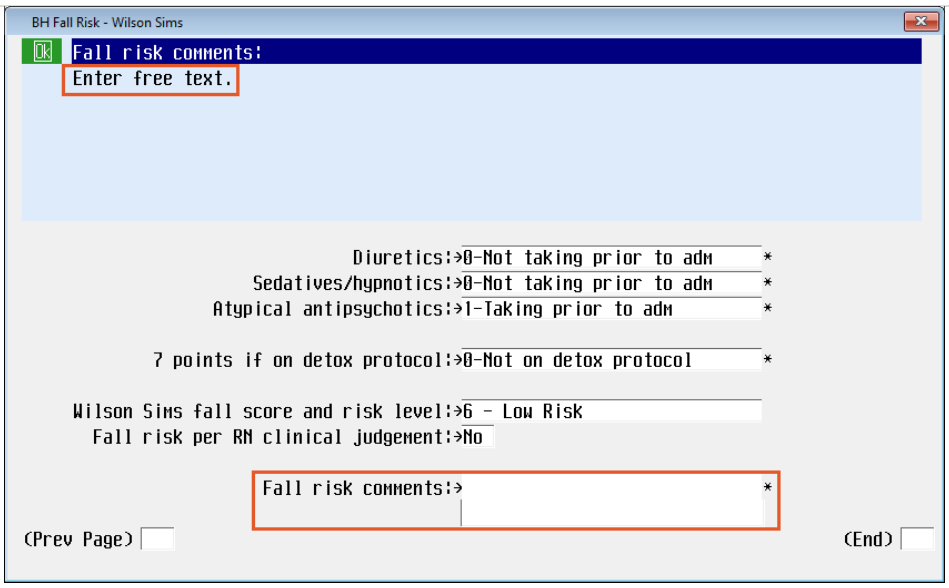
Last documented on Admission History:
Falls within the past 3 months: No – MM/DD/YY at HHMM

Last documented on Post Fall Assessment during this admission within the last 3 months:
Type of fall:



The *Fall risk (RN clinical judgment)* field has the following responses:

- Yes
- No

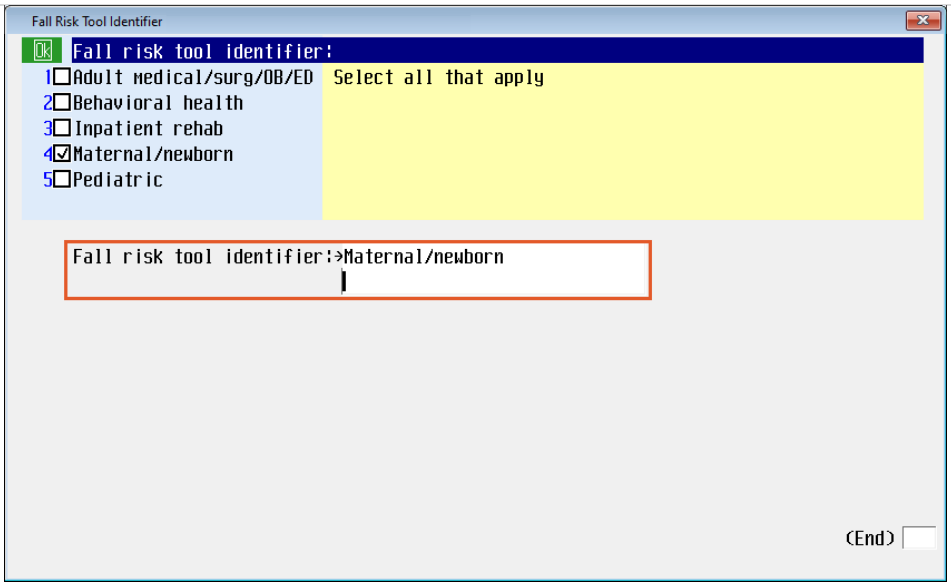


The *Fall risk comments* field is a free text enabled field.

Note: If the clinician selects "No" in the previous field, the *Fall risk comments* field becomes required.

Maternal/Newborn Fall Risk – Adult and Pediatric

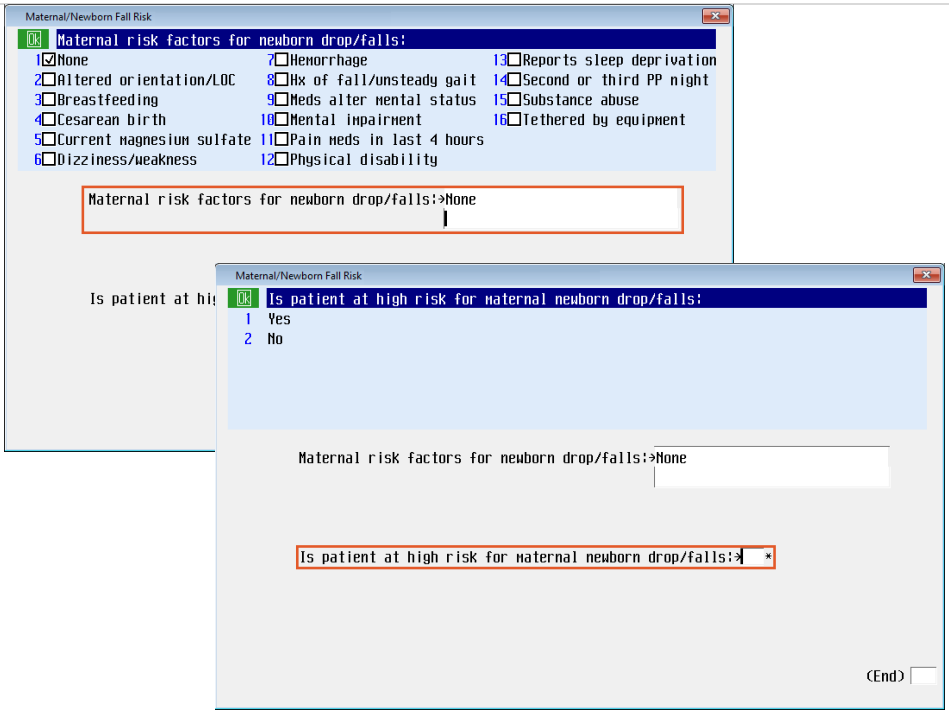
The **Maternal/Newborn Fall Risk** can be documented on either the mother or newborn's chart, or both, depending upon the facility's workflow and policy. For example, facilities that provide couplet care would likely only document this fall risk tool on only one of the patient's chart.



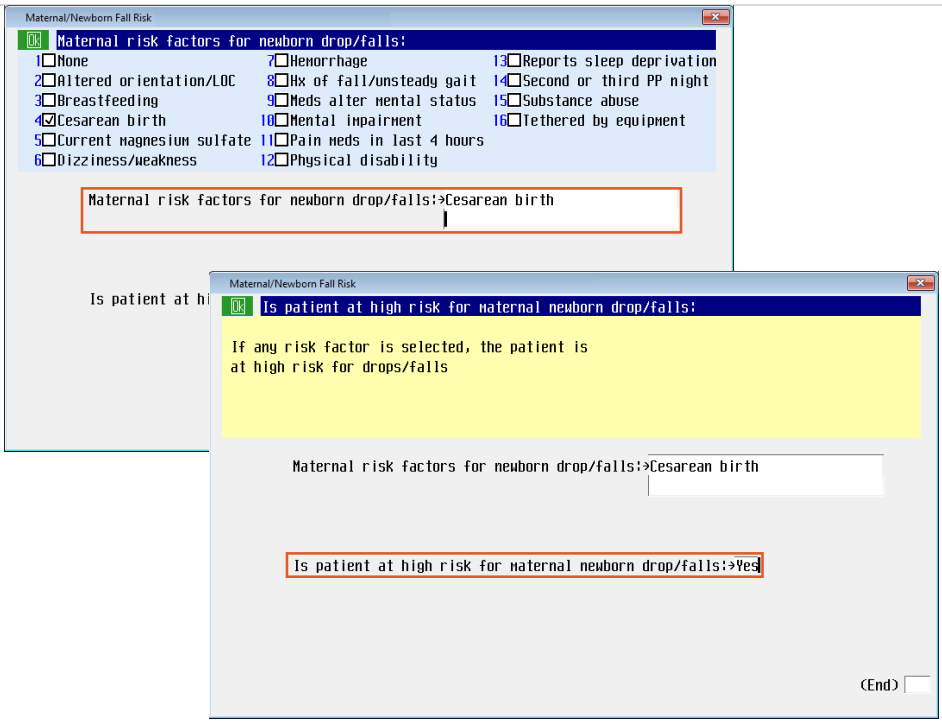
For the Maternal/Newborn Fall Risk, the Maternal/newborn population is selected in the *Fall risk tool identifier* field.

Once the Maternal/newborn response is selected, the appropriate documentation will populate.

Each following field noted with an asterisk is required.



If “None” is selected in the *Maternal risk factors for newborn drop/falls* field, neither “Yes” or “No” defaults in the *Is patient at high risk for maternal newborn drop/falls* field.

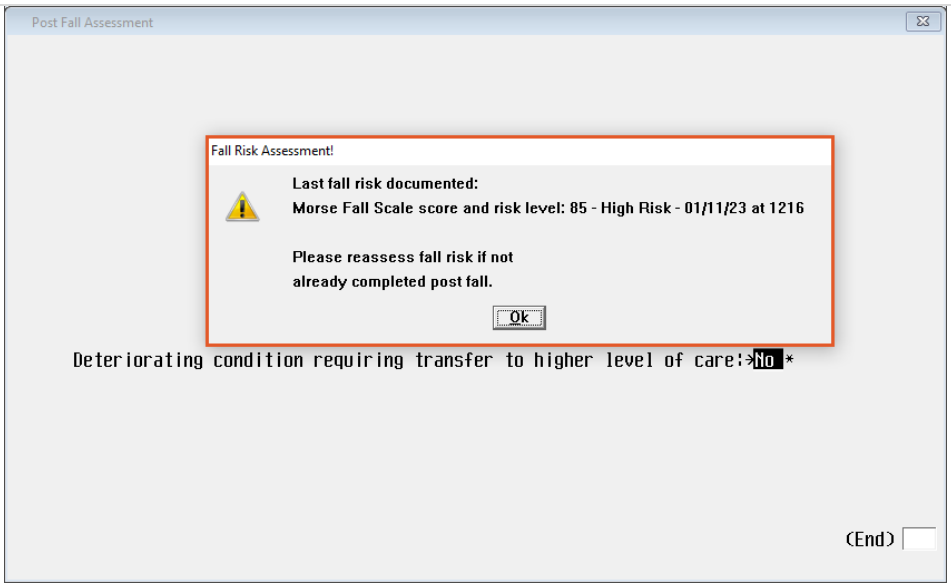


However, if at least one response is selected in the *Maternal risk factors for newborn drop/falls* field, the *Is patient at high risk for maternal newborn drop/falls* field automatically defaults “Yes”.

The Yellow Information Box aids the clinician in understanding the criteria that determines the risk:

> If any risk factor is selected, the patient is at high risk for drop/falls.

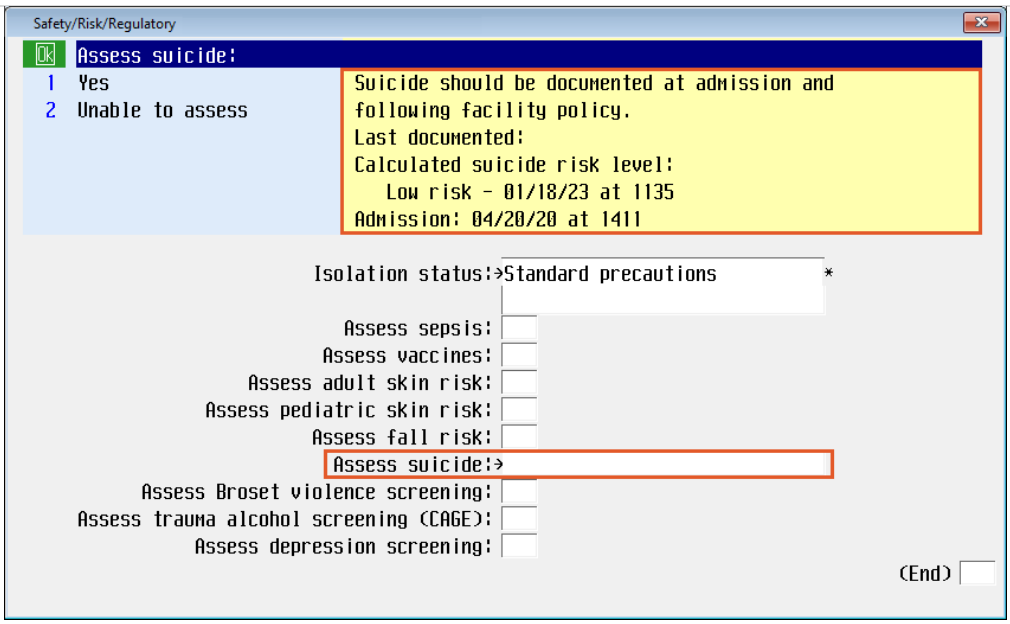
Post Fall Assessment Alert



The **Post Fall Assessment** displays the last documented fall risk with the score, risk level, date and time displayed.

Safety/Risk/Regulatory

The Yellow Information Box has been updated for the *Assess suicide* field in the **Safety/Risk/Regulatory** intervention to include the Admission date and time. This update allows for clinicians to quickly identify whether the suicide assessment was completed in the Emergency Department and needs to be readdressed in Inpatient Nursing.



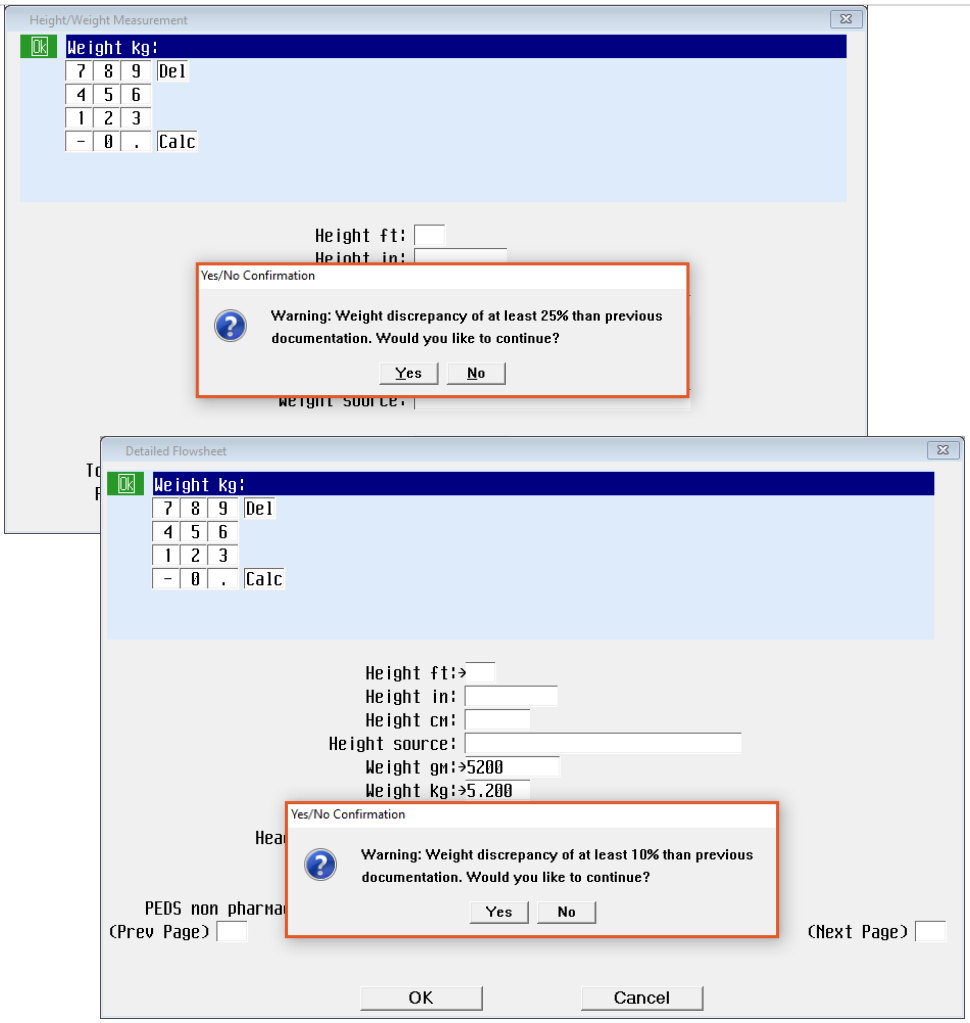
The Yellow Information Box has been updated and allows the clinician to assess if the suicide assessment has been completed previously:

Suicide should be documented at admission and following facility policy.
Last documented:
Calculate suicide risk level:
Admission: 00/00/00 at 0000

Nursing and ED Modules

Height/Weight Measurement

The **Height/Weight Measurement** screens have been updated to alert the clinicians if there is a discrepancy from the last documented weight within the same admission/visit.



The *weight gm* and *weight kg* fields alert the clinician if the weight has increased or decreased by 10% or 25% or greater.

The 10% discrepancy alert affects the Pediatric population, ages 17 and younger. This affects both fields depending upon the age of the patient.

The 25% discrepancy alert affects the Adult population, ages 18 and older.

If “No” is selected, the field is cleared and the clinician may enter a new weight.

If “Yes” is selected, the clinician is forwarded to the next applicable field.

Note: This is only for the same admission. For example, if a patient is discharged and returns, the previous weight would not be compared against. The return visit is counted as a new encounter.

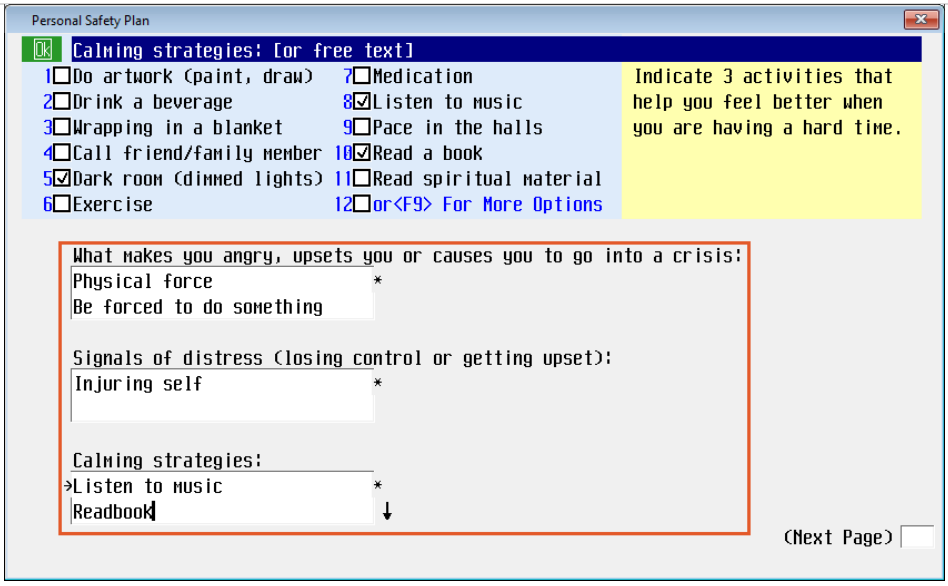
This change affects the following assessments and interventions:

Nursing	Surgery	Emergency Department
MRI Procedure Screening	SURG: MRI Procedure Screening Preop +	MRI Procedure Screening
Pre-Proc Checklist UP RN Assessment	SURG: Pre-Procedure Checklist, Prep +	Pre-Proc Checklist UP RN Assessment
Six Minute Walk	SURG: Height/Weight Intra-op +	Six Minute Walk
Health History Assessment	SURG: Height/Weight Pre +	Rapid Initial Assessment
Height/Weight Measurement	SURG: Admission Health History +	Rapid Flowsheet
Vital Signs		Height/Weight Measurement
Critical Care Flowsheet		Vital Signs
		Triage Reassessment
		Paramedic Intake
		Disposition – DC/TX/ADM/LPT
		Newborn Stabilization

Personal Safety Plan

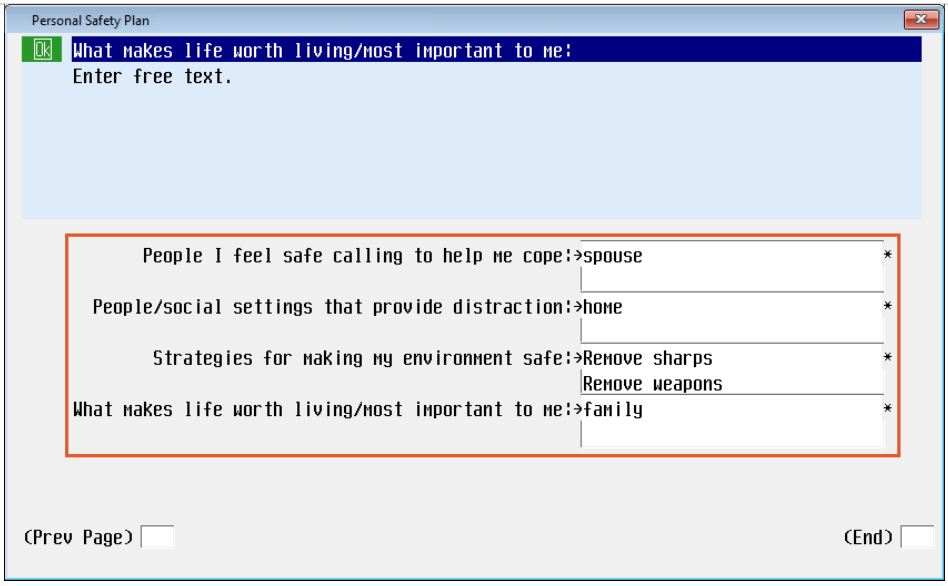
The **Behavioral Health Personal Safety Plan** has been updated to allow entries to pull forward during the current admission. This allows for a bidirectional flow to and from the Provider note and Nursing documentation to produce a comprehensive Personal Safety Plan.

Note: In non-Behavioral Health settings (e.g., ED, Med/Surg), a BH specialist (if available) may complete the EBCD Personal Safety Plan. However, if a BH specialist is not available, the provider is responsible for completing the PSP in provider documentation. For Behavioral Health settings, a BH nurse or specialist completes the EBCD Personal Safety Plan.



The following fields have been updated to allow current visit responses to flow between Provider and Nurse documentation:

- *What makes you angry, upsets you or causes you to go into a crisis*
- *Signals of distress (losing control or getting upset)*
- *Calming strategies*



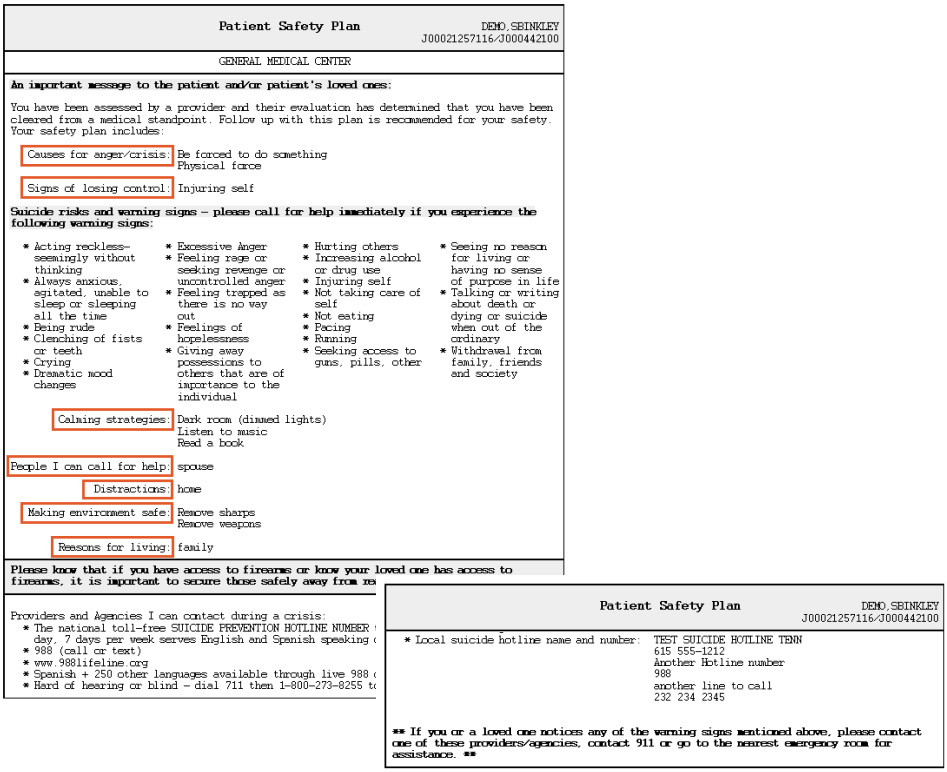
The following fields have been updated to allow current visit responses to flow between Provider and Nurse documentation:

- *People I feel safe calling to help me cope*
- *People/social settings that provide distraction*
- *Strategies for making my environment safe*
- *What makes life worth living/most important to me*

This update affects the following interventions/assessments:

Emergency Department	
BH Personal Safety Plan	
Nursing	
BH Personal Safety Plan	BH Nurse Assessment (INA)
BH Discharge Nursing Summary	BH Discharge Instructions

BH Patient Safety Plan Report



Patient Safety Plan — DEMO,SBINKLEY J00021257116/J000442100

GENERAL MEDICAL CENTER

An important message to the patient and/or patient's loved ones:

You have been assessed by a provider and their evaluation has determined that you have been cleared from a medical standpoint. Follow up with this plan is recommended for your safety. Your safety plan includes:

Causes for anger/crisis: Be forced to do something
Physical force

Signs of losing control: Injuring self

Suicide risks and warning signs – please call for help immediately if you experience the following warning signs:

* Acting reckless– seemingly without thinking
* Always anxious, agitated, unable to sleep or sleeping all the time
* Being rude
* Clenching of fists or teeth
* Crying
* Dramatic mood changes
* Excessive Anger
* Feeling rage or seeking revenge or uncontrolled anger
* Feeling trapped as there is no way out
* Feelings of hopelessness
* Giving away possessions to others that are of importance to the individual
* Hurting others
* Increasing alcohol or drug use
* Injuring self
* Not taking care of self
* Not eating
* Pacing
* Running
* Seeking access to guns, pills, other
* Seeing no reason for living or having no sense of purpose in life
* Talking or writing about death or dying or suicide when out of the ordinary
* Withdrawal from family, friends and society

Calming strategies: Dark room (dimmed lights)
Listen to music
Read a book

People I can call for help: spouse

Distractions: home

Making environment safe: Remove sharps
Remove weapons

Reasons for living: family

Please know that if you have access to firearms or know your loved one has access to firearms, it is important to secure those safely away from re

Providers and Agencies I can contact during a crisis:
* The national toll-free SUICIDE PREVENTION HOTLINE NUMBER
day, 7 days per week serves English and Spanish speaking
* 988 (call or text)
* www.988lifeline.org
* Spanish + 250 other languages available through live 988
* Hard of hearing or blind – dial 711 then 1-800-273-8255 t

Patient Safety Plan — DEMO,SBINKLEY J00021257116/J000442100

* Local suicide hotline name and number: TEST SUICIDE HOTLINE TENN
615 555-1212
Another Hotline number
988
another line to call
232 234 2345

** If you or a loved one notices any of the warning signs mentioned above, please contact one of these providers/agencies, contact 911 or go to the nearest emergency room for assistance. **

The reports below have been updated with the following changes:

- Field labels have been shortened
- Signature lines have been removed to align with other HCA standard reports
- Physician has been changed to Provider

These updates affects the following reports:

Nursing	
Patient Safety Plan Report	Behavioral Health Discharge Instructions Report
Emergency Department	
Patient Safety Plan Report	

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