

EBCD MEDITECH Content Updates – 2023.1

All Modules

Overview

This 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:

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Summary of Revisions

Date	Revision

Nursing, OR, BH and ED Modules

Health History Assessment – Abuse Fields Update



The **Health History Assessment** has been updated to reduce the likelihood of adverse patient safety events and to meet regulatory requirements. These abuse fields must be captured on every inpatient. “Unable to assess” has been added as an option if the patient or family is not able to provide the information.

Health History Assessment

Do you feel safe at home, work and/or school/daycare: **- Safety / Abuse -**

1 Yes
2 No
3 **Unable to assess**

Click below to default system normal values
DFT Norms
DFT Norms (Go to Next System)

Do you feel safe at home, work and/or school/daycare:→

Evidence/suspicion of physical and/or psychological abuse:
Evidence/suspicion of verbal abuse:

History consistent with presentation/injury:

Possible abuse reported to:

Safety risk to you or your child:

Visitor restriction:

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Do you feel safe at home, work and/or school/daycare has the following new response:

- Unable to assess

Health History Assessment

Evidence/suspicion of physical and/or psychological abuse:

1 Yes
2 No
3 **Unable to assess**

Do you feel safe at home, work and/or school/daycare:→

Evidence/suspicion of physical and/or psychological abuse:→

Evidence/suspicion of verbal abuse:

History consistent with presentation/injury:

Possible abuse reported to:

Safety risk to you or your child:

Visitor restriction:

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Evidence/suspicion of physical and/or psychological abuse has the following new response:

- Unable to assess

If “Unable to assess” is selected for this field, *Possible abuse reported to* is automatically skipped.

Health History Assessment

Evidence/suspicion of verbal abuse:

- 1 Yes
- 2 No
- 3 **Unable to assess**

Do you feel safe at home, work and/or school/daycare: >

Evidence/suspicion of physical and/or psychological abuse: >

Evidence/suspicion of verbal abuse: >

History consistent with presentation/injury:

Possible abuse reported to: >

Safety risk to you or your child: >

Visitor restriction: >

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Evidence/suspicion of verbal abuse has the following new response:

- Unable to assess

If “Unable to assess” is selected for this field, *Possible abuse reported to* is automatically skipped.

Health History Assessment

Possible abuse reported to: [or free text]

- 1 Advocate
- 2 County social services
- 3 Law enforcement
- 4 Social services

Do you feel safe at home, work and/or school/daycare: > **Unable to assess**

Evidence/suspicion of physical and/or psychological abuse: > **Unable to assess**

Evidence/suspicion of verbal abuse: > **Yes**

History consistent with presentation/injury: >

Possible abuse reported to: >

Safety risk to you or your child: >

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However, if “Yes” selected for either field, *Evidence/suspicion of physical and/or psychological abuse* or *Evidence/suspicion of verbal abuse*, *Possible abuse reported to* becomes available for documenting.

If “Unable to assess” is selected on any of the abuse fields, the **Health History Update** will show as “Incomplete”.

Health History Update

Notify family/support:

- 1 Yes
- 2 No

Notify family/support: > Done

Designated caregiver: **Incomplete**

Organ donation preference: **Incomplete**

Advance directive: **Incomplete**

(BH) Legal directive: **Incomplete**

Power of attorney: Done

Surrogate decision maker: **Incomplete**

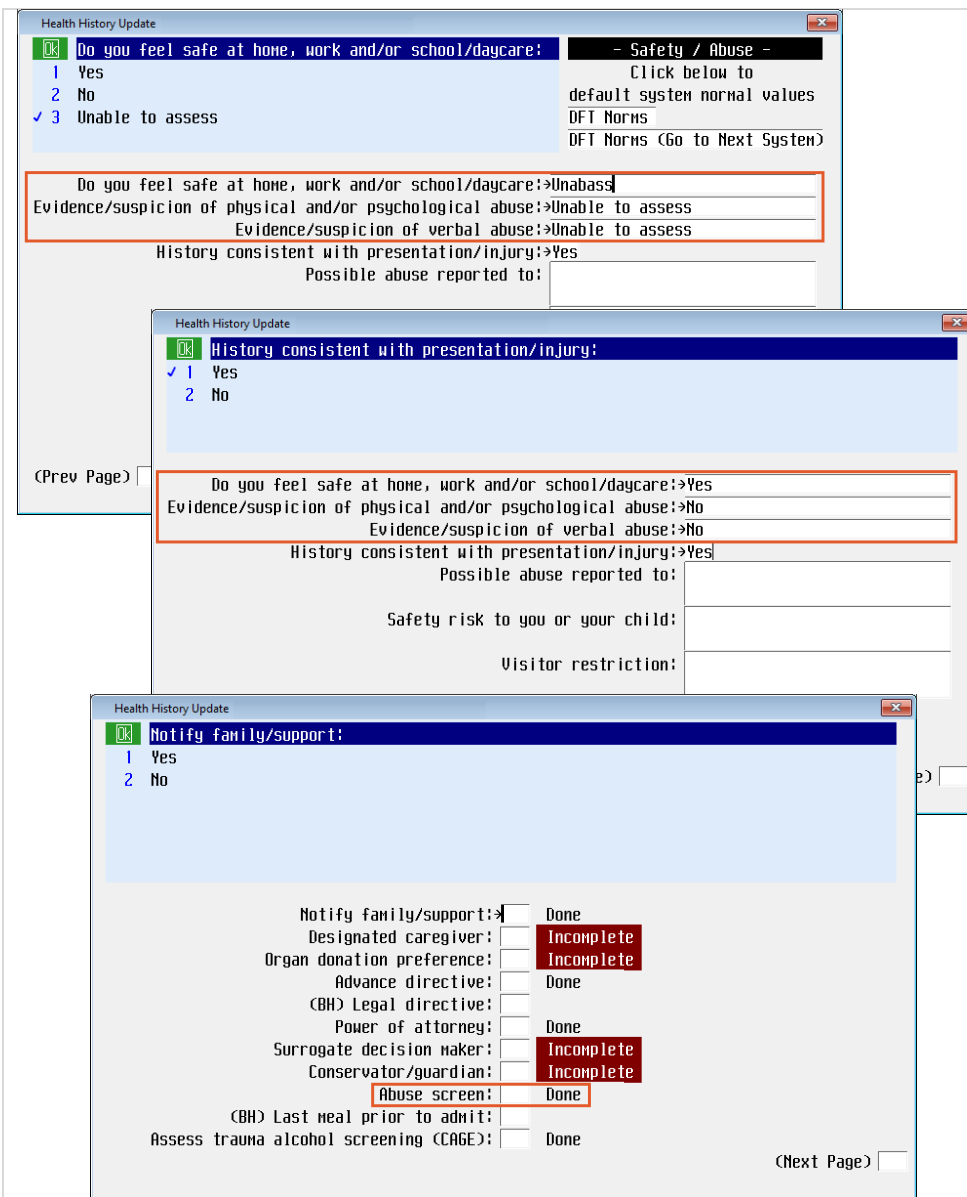
Conservator/guardian: **Incomplete**

Abuse screen: Incomplete

(BH) Last meal prior to admit: Done

Assess trauma alcohol screening (CAGE): Done

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Once the clinician enters into the **Health History Update**, the abuse fields become editable.

If the clinician completes the fields, the *Abuse screen* field will show as "Done".

The following interventions and assessments are affected:

Nursing and Surgery		
Health History Assessment	Health History Update	
SURG: Admission Health History	SURG: Admission Hx Update Pre	
Emergency Department		
Detailed Assessment	Non Urgent General Focus	Paramedic Intake

Nursing, OR and ED Modules

Adult Skin Risk Assessment Update



To reduce the likelihood of adverse patient safety events, pressure injuries are the focus for the CSIP initiative. The **Skin Risk Assessment** has been updated to the Braden II Scale assessment for all admitted patients.

For the Inpatient Nursing and Surgery video click here →

<https://www.healthstream.com/hlc/common/course/quicklinks.aspx?oid=a86b970c-a5b3-da11-8139-000423acef71&quickLink=YT0xJnRzPTlwMjltMTEtMTFUMTU6NDg6MTkmY2lkPTcyOTBhZDk2LTQ2NjAtZWQxMS04MGZkLTAwNTA1NmIxMzUwYiZjdj0w>

For the ED video click here →

<https://www.healthstream.com/hlc/common/course/quicklinks.aspx?oid=a86b970c-a5b3-da11-8139-000423acef71&quickLink=YT0xJnRzPTlwMjltMTEtMTFUMTU6NDk6NTImY2lkPWU0ZDImNzA0LTNIjAtZWQxMS04MGZkLTAwNTA1NmIxMzUwYiZjdj0w>

Sensory perception:

1	1-Completely limited	1- Completely limited: unresponsive to painful stimuli OR cannot feel pain over most of the body
2	2-Very limited	2- Very limited: responds only to painful stimuli; very limited communication
3	3-Slightly limited	3- Slightly limited: limited ability to feel OR communicate pain/discomfort
4	4-No impairment	4- No impairment: responds to commands; no sensory deficit

Moisture: _____ *

Out of bed activity: _____ *

In bed mobility: _____ *

Nutrition: _____ *

Friction and shear: _____ *

Pressure injury risk score: _____

(End)

Sensory perception has the following responses:

- 1 – Completely limited
- 2 – Very limited
- 3 – Slightly limited
- 4 – No impairment

The Yellow Information Box guides the clinicians in selecting the response:

1 – Completely limited: unresponsive to painful stimuli OR cannot feel pain over most of the body

2 – Very limited: responds only to painful stimuli; very limited communication

3 – Slightly limited: limited ability to feel OR communicate pain/discomfort

4 – No impairment: responds to commands; no sensory deficit

Skin Risk Assessment

Moisture:

1	1-Constantly moist	1- Constantly moist: skin constantly moist; dampness detected every encounter
2	2-Often moist	2- Often moist: skin often moist; linen change 3x a day
3	3-Occasionally moist	3- Occasionally moist: skin moist at times; linen change 2x per day
4	4-Rarely moist	4- Rarely moist: skin usually dry; routine linen changes

Sensory perception: 3-Slightly limited *

Moisture: 4 *

Out of bed activity: *

In bed mobility: *

Nutrition: *

Friction and shear: *

Pressure injury risk score: 3 - Risk for pressure injury

(End)

Moisture has the following responses:

- 1 – Constantly moist
- 2 – Often moist
- 3 – Occasionally moist
- 4 – Rarely moist

The Yellow Information Box guides the clinicians in selecting the response:

1 – Constantly moist: skin constantly moist; dampness detected every encounter
 2 – Often moist: skin often moist; linen change 3x a day
 3 – Occasionally moist: skin moist at times; linen change 2x per day
 4 – Rarely moist: skin usually dry; routine linen changes

Note: Pressure injury risk score calculates as the fields are documented.

Skin Risk Assessment

Out of bed activity:

1	1-Bedfast	1- Bedfast: confined to bed
2	2-Chairfast	2- Chairfast: limited ability to walk; needs assistance for walks/transfers
3	3-Walks occasionally	3- Walks occasionally: walks short distances multiple times a day with/without assistance
4	4-Walks frequently	4- Walks frequently: inside/outside room every 2 hours while awake

Sensory perception: 3-Slightly limited *

Moisture: 4-Rarely moist *

Out of bed activity: 4 *

In bed mobility: *

Nutrition: *

Friction and shear: *

Pressure injury risk score: 7 - Risk for pressure injury

(End)

Out of bed activity has the following responses:

- 1 – Bedfast
- 2 – Chairfast
- 3 – Walks occasionally
- 4 – Walks frequently

The Yellow Information Box guides the clinicians in selecting the response:

1 – Bedfast: confined to bed
 2 – Chairfast: limited ability to walk; needs assistance for walks/transfers
 3 – Walks occasionally: walks short distances multiple times a day with/without assistance
 4 – Walks frequently: inside/outside room every 2 hours while awake

Skin Risk Assessment

In bed mobility:

1	1-Constantly immobile	1- Constantly immobile: requires assistance for even slight changes in extremity position
2	2-Very limited	2- Very limited: occasional slight changes in body position but needs assistance for frequent significant changes
3	3-Slightly limited	3- Slightly limited: frequent slight changes in position independantly
4	4-No limitations	4- No limitations: changes position frequently without assistance

Sensory perception: 3-Slightly limited *

Moisture: 4-Rarely moist *

Out of bed activity: 3-Walks occasionally *

In bed mobility: 3 *

Nutrition: *

Friction and shear: *

Pressure injury risk score: 10 - Risk for pressure injury

(End)

In bed mobility has the following responses:

- 1 – Constantly immobile
- 2 – Very limited
- 3 – Slightly limited
- 4 – No limitations

The Yellow Information Box guides the clinicians in selecting the response:

1 – Constantly immobile: requires assistance for even slight changes in extremity position
 2 – Very limited: occasional slight changes in body position but needs assistance for frequent significant changes
 3 – Slightly limited: frequent slight changes in position independantly
 4 – No limitations: changes position frequently without assistance

Skin Risk Assessment

Nutrition:

1	1-Very poor	1- Very poor: poor food/fluid intake; no supplements OR is NPO and/or on clear liquids or IVs more than 5 days
2	2-Probably inadequate	2- Probably inadequate: eats half of food with occasional supplement; sub-optimal liquid diet or tube feeding
3	3-Adequate	3- Adequate: eats most of meals/supplement OR on tube feed/TPN
4	4-Excellent	4- Excellent: eats most of all meals; no need for supplements

Sensory perception: 3-Slightly limited *

Moisture: 4-Rarely moist *

Out of bed activity: 3-Walks occasionally *

In bed mobility: 3-Slightly limited *

Nutrition: 3 *

Friction and shear: *

Pressure injury risk score: 13 - Risk for pressure injury

(End)

Nutrition has the following responses:

- 1 – Very poor
- 2 – Probably inadequate
- 3 – Adequate
- 4 – Excellent

The Yellow Information Box guides the clinicians in selecting the response:

1 – Very poor: poor food/fluid intake; no supplements OR is NPO and/or on clear liquids or IVs more than 5 days
 2 – Probably inadequate: eats half of food with occasional supplement; sub-optimal liquid diet or tube feeding
 3 – Adequate: eats most of meals/supplement OR on tube feed /TPN
 4 – Excellent: eats most of all meals; no need for supplements

Friction and shear has the following responses:

- 1 – Problem
- 2 – Potential problem
- 3 – No apparent problem

The Yellow Information Box guides the clinicians in selecting the response:

1 – Problem: requires moderate to maximum assistance in moving; frequent skin friction against sheets/devices
 2 – Potential problem: moves feebly or requires minimal assist in bed/chair; skin likely to rub against sheets/devices
 3 – No apparent problem: moves in bed/chair independently; has sufficient muscle strength to lift up completely

Pressure injury risk score calculates the total pressure injury risk score by the documented information and is not editable.

The Yellow Information Box guides the clinician for any indication for the Risk of pressure injury to the patient:

A total score of 18 or less indicates the patient is AT RISK for developing a pressure injury.

 A total score of 19 or greater indicates the patient is NOT AT RISK for developing a pressure injury.

Friction and shear:
 1 1-Problem
 2 2-Potential problem
 3 3-No apparent problem

1- Problem: requires moderate to maximum assistance in moving; frequent skin friction against sheets/devices
 2- Potential problem: moves feebly or requires minimal assist in bed/chair; skin likely to rub against sheets/devices
 3- No apparent problem: moves in bed/chair independently; has sufficient muscle strength to lift up completely

Sensory perception: 3-Slightly limited *
 Moisture: 4-Rarely moist *
 Out of bed activity: 3-Walks occasionally *
 In bed mobility: 3-Slightly limited *
 Nutrition: 3-Adequate *
 Friction and shear: 2 *
 Pressure injury risk score: 16 - Risk for pressure injury

Pressure injury risk score:
 A total score of 18 or less indicates the patient is AT RISK for developing a pressure injury.

 A total score of 19 or greater indicates the patient is NOT AT RISK for developing a pressure injury.

Sensory perception: 3-Slightly limited *
 Moisture: 4-Rarely moist *
 Out of bed activity: 3-Walks occasionally *
 In bed mobility: 3-Slightly limited *
 Nutrition: 3-Adequate *
 Friction and shear: 2-Potential problem *
 Pressure injury risk score: 18 - Risk for pressure injury

This update affects the following assessments/interventions:

NUR	OR	ED
Safety/Risk/Regulatory	Safety/Risk/Regulatory	Skin Risk Assessment (New)

Nursing and OR Modules

Health History Assessment – Advanced Directive Update



The **Health History Assessment** has been updated in the Advance Directive field. This field will flow from Registration to Nursing if already answered in Registration.

Health History Assessment

Do you have an advance directive:

1 Yes

2 No

3 **Unable to assess**

Developmental level 18 years+:>

Did patient express/disclose organ donation preference:

Organ donation preference comments:

Do you have an advance directive:>

Copy of advance directive on chart:

In absence of advance directives, patient:

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Health History Update

Notify family/support:

1 Yes

2 No

Notify family/support:> Done

Designated caregiver: **Incomplete**

Organ donation preference: **Incomplete**

Advance directive: **Incomplete**

(BH) Legal directive: Done

Power of attorney: Done

Surrogate decision maker: **Incomplete**

Conservator/guardian: **Incomplete**

Abuse screen: **Incomplete**

(BH) Last meal prior to admit: Done

Assess trauma alcohol screening (CAGE): Done

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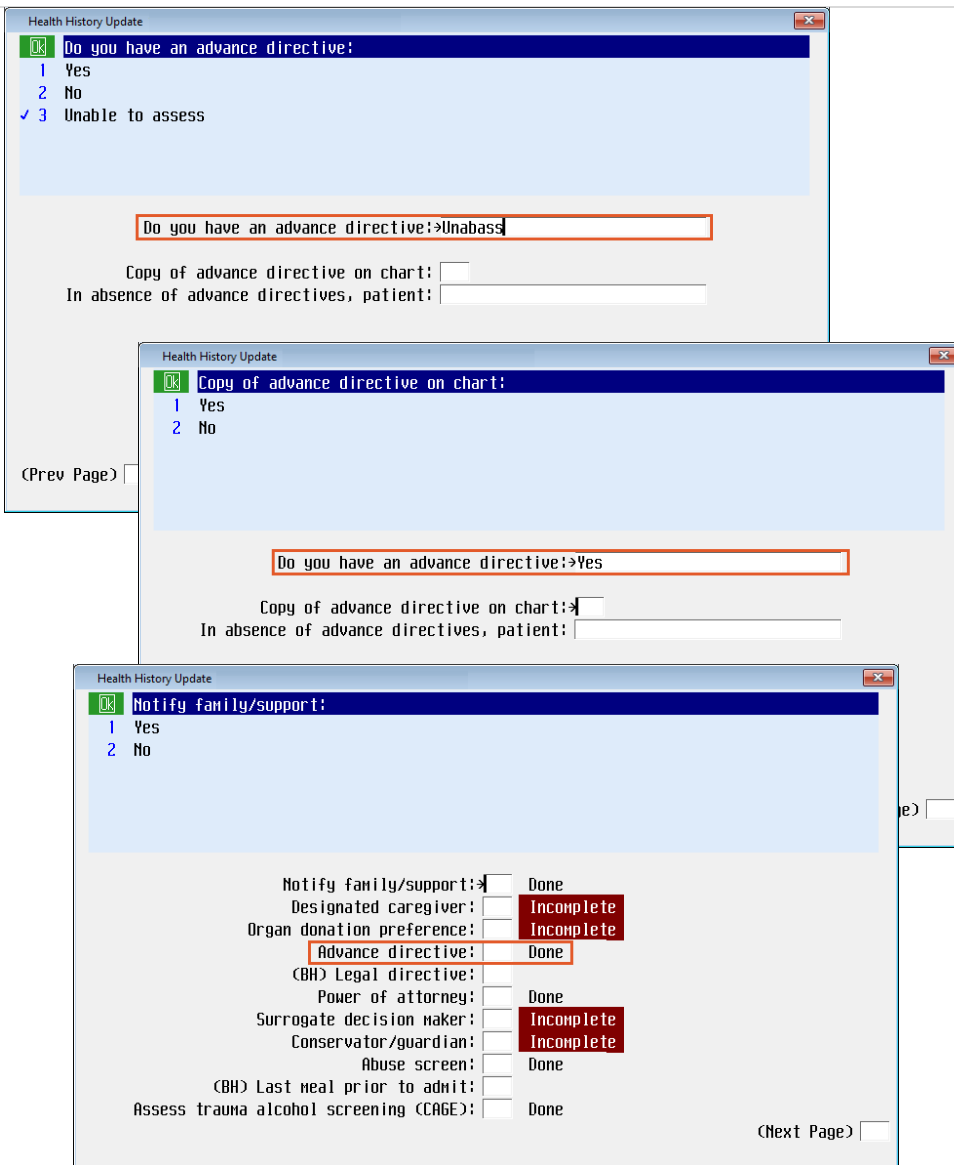
Do you have an advance directive has a new response:

- Unable to assess

If “Unable to assess” is selected, the following advance directive fields will be skipped and the **Health History Update** will show as “Incomplete”.

Once the clinician enters into the **Health History Update**, the *Do you have an advance directive* field is editable.

If the clinician completes the fields, the *Advance directive* field will show as "Done".



The following interventions and assessments are affected:

Nursing and Surgery	
Health History Assessment	Health History Update
SURG: Admission Health History	SURG: Admission Hx Update Pre

Incentive Spirometry



With the Alternative Models of Care, clinicians help to assess the patient with certain Respiratory Therapy interventions. Separate documentation is needed for nursing to capture what is appropriate for their scope of practice. The **Incentive Spirometry** has been updated so nurses may accurately document and capture the Positive Expiratory Pressure (PEP) device therapy in OR and in Inpatient Nursing.

Incentive Spirometry

PEP device number of breaths:

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

Incentive spirometry:→ _____

Target volume (ml):

Achieved volume (ml):

Repetitions:

Effort/motivation:

Incentive spirometry comment: _____

PEP device number of breaths:→

PEP comments: _____

(End)

PEP device number of breaths utilizes the numeric keypad.

Incentive Spirometry

PEP comments:

Enter free text.

Incentive spirometry:→ _____

Target volume (ml):

Achieved volume (ml):

Repetitions:

Effort/motivation:

Incentive spirometry comment: _____

PEP device number of breaths:→ _____

PEP comments:→

(End)

PEP comments is a free text enabled field.

These changes affect the following assessments/interventions:

OR	Nursing
SURG: Incentive Spirometry Pre	Incentive Spirometry
SURG: Incentive Spirometry PAC	

Skin Alteration



The **Skin Alteration** screens have been updated to support the CSIP Hospital Acquired Pressure Injury (HAPI) initiative. **See the Adult Skin Risk Assessment for the Video link*

Skin Alteration

Pressure injury staging:

1	Stage 1	Stage 1: Non-blanchable erythema of intact skin
2	Stage 2	Stage 2: Partial-thickness skin loss with exposed dermis
3	Stage 3	Stage 3: Full-thickness skin loss
4	Stage 4	Stage 4: Full-thickness skin and tissue loss
5	Unstageable	Unstageable: Obscured full-thickness skin and tissue loss
6	Deep tissue injury	DTI: Persist non-blanch deep red/maroon/purple discolor

Skin alteration description: → Press injur immobility related*

Skin alteration other:

Location (A/P): → Posterior

Location (body): → Coccyx *

Instance list status: → Active *

Pressure injury present on admission: → No *

Pressure injury staging: →

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Pressure injury staging is a new field with the following responses:

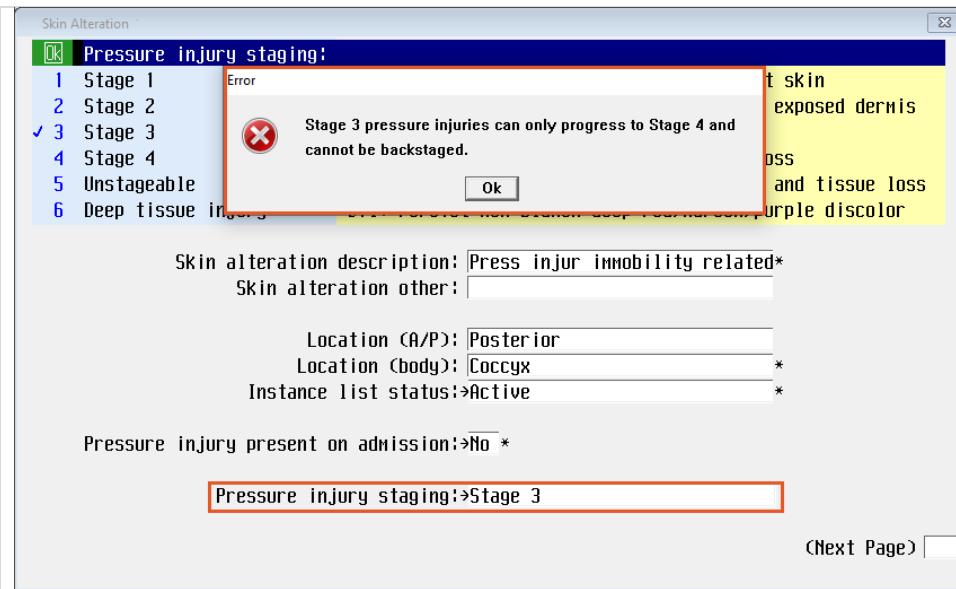
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- Deep tissue injury

The Yellow Information Box guides the clinician in choosing the response:

Stage 1: Non-blanchable erythema of intact skin
 Stage 2: Partial-thickness skin loss with exposed dermis
 Stage 3: Full-thickness skin loss
 Stage 4: Full-thickness skin and tissue loss
 Unstageable: Obscured full-thickness skin and tissue loss
 DTI: Persist non-blanch deep red/maroon/purple discolor

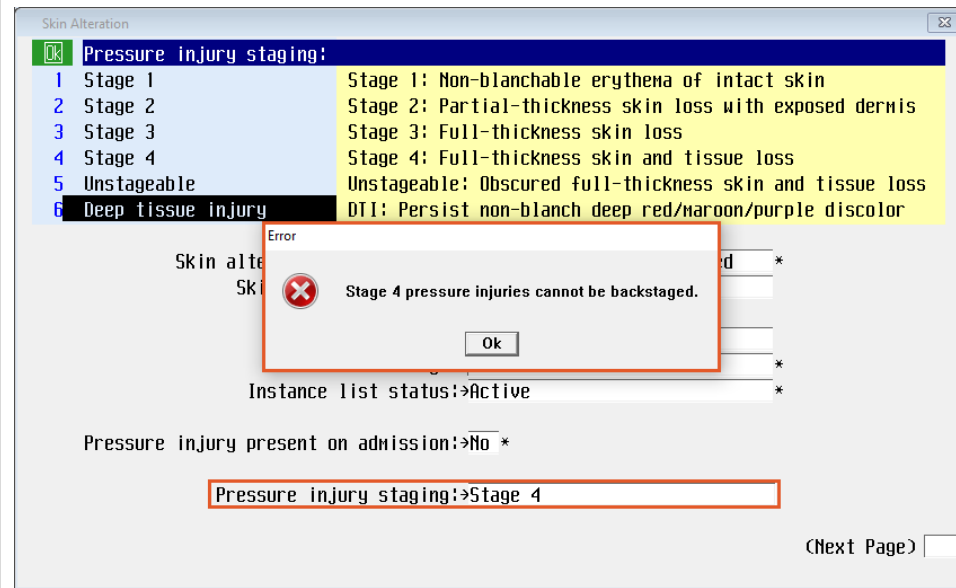
Note: This field is only visited if a “Pressure Injury” is selected in *Skin alteration description*. *Pressure injury present on admission* also becomes required if “Pressure injury” is selected.

Also, if the defaulted response is deleted by the clinician, to repopulate the previously documented response, they must either choose “OK” or move to another field and back to the *Pressure injury staging* field.



When a Stage 3 is selected and Saved, the same Pressure injury will default to a Stage 3 and can only progress to a Stage 4.

That Pressure injury cannot be backstaged past a Stage 3.



When a Pressure injury is entered as a Stage 4 and Saved, the same Pressure injury will default to a Stage 4 and cannot be backstaged.

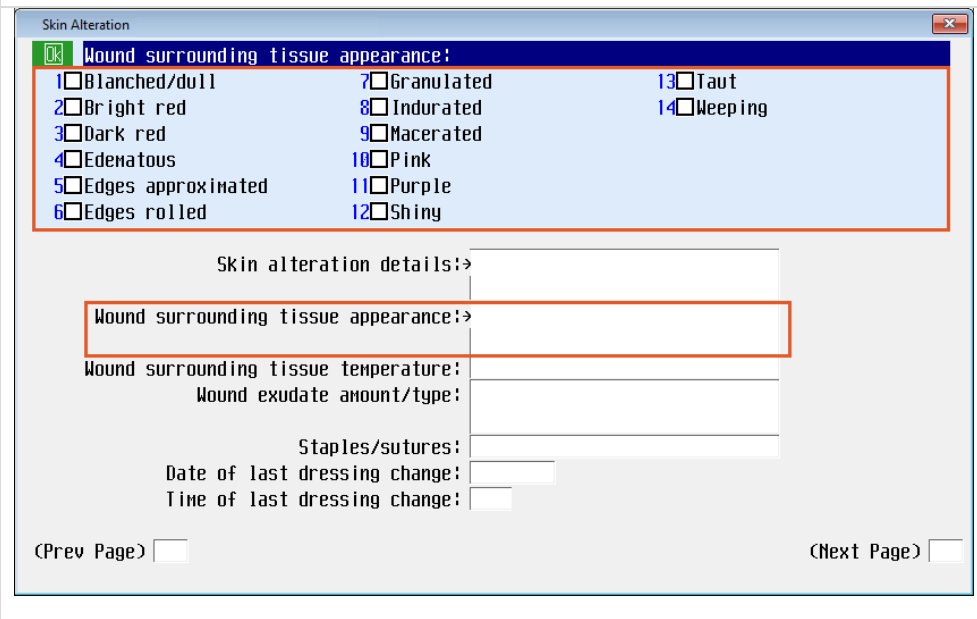
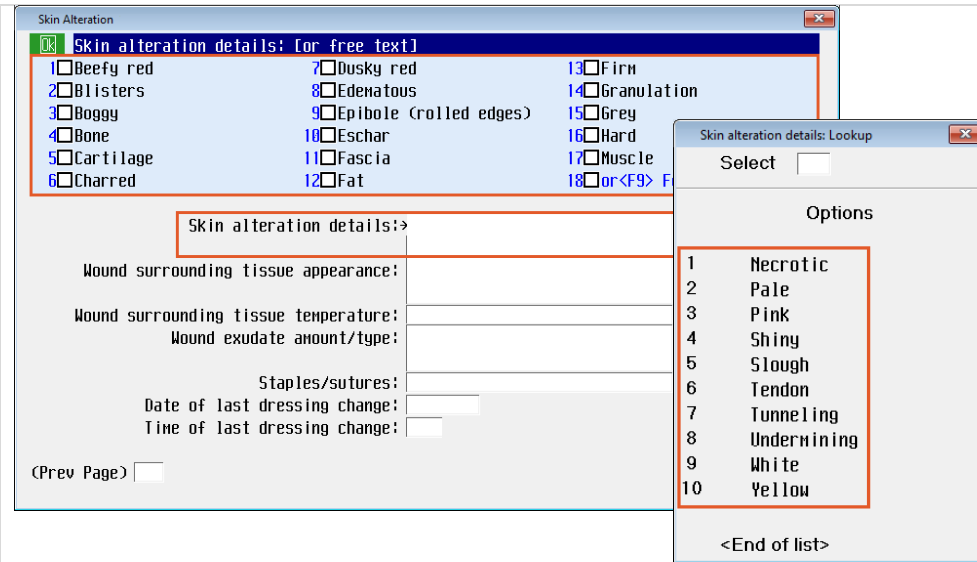
Note: All previously staged pressure injuries will default the previous recorded staging. Only Stage 3 and 4 cannot be backstaged. The only means to correct the Staging of 3 and 4 is to undo the documentation.

Skin alteration details has the following new responses:

- Beefy red
- Blisters
- Charred
- Dusky red
- Edematous
- Eschar
- Granulation
- Grey
- Necrotic
- Pale
- Pink
- Shiny
- Slough
- White
- Yellow

Wound surrounding tissue appearance is a multi-select field with the following responses:

- Blanced/dull
- Bright red
- Dark red
- Edematous
- Edges approximated
- Edges rolled
- Granulated
- Indurated
- Macerated
- Pink
- Purple
- Shiny
- Taut
- Weeping



Skin Alteration

Ok Wound surrounding tissue temperature:

- 1 Hot
- 2 Warm
- 3 Cool
- 4 Cold

Skin alteration details:→

Wound surrounding tissue appearance:→

Wound surrounding tissue temperature:→

Wound exudate amount/type:→

Staples/sutures:→

Date of last dressing change:→

Time of last dressing change:→

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Wound surrounding tissue temperature is a new field with the following responses:

- Hot
- Warm
- Cool
- Cold

This update affects the following assessments/interventions:

Nursing/Surgery	
Admission/Shift Assessment	Skin Alteration Assessment
SURG: Admission Assessment	SURG: Admission Assessment Int
SURG: Assessment PAC	SURG: Packing Intra-op
Admission/Shift Assessment – Neonatal	

Nursing and ED Modules

Six Minute Walk



With the Alternative Models of Care, clinicians help to assess the patient with certain Respiratory Therapy interventions. Separate documentation is needed for nursing to capture what is appropriate for their scope of practice. The **Six Minute Walk** has now been created so nurses may accurately document and capture the assessment in ED and Inpatient Nursing.

<p>RT Six Minute Walk</p> <p>Duration (minutes):></p> <p>Distance (meters):></p> <p>Height ft: _____ Height in: _____ Height cm: _____ Weight kg: _____</p> <p>Duration (minutes):> _____ Distance (meters):> _____</p> <p>Document height/weight measurements: <input type="checkbox"/></p> <p>(Next Page) <input type="checkbox"/></p>	<p><i>Duration (minutes) and Distance (meters) are entered by utilizing the numeric keypad.</i></p> <p>If previous height and weight have been entered, they will auto populate in the Yellow Information Box as shown.</p>
<p>RT Six Minute Walk</p> <p>Room air:</p> <p>1 Yes <input type="radio"/> 2 No <input type="radio"/></p> <p>Duration (minutes):> _____ Distance (meters):> _____</p> <p>Room air:> _____</p> <p>O2 Liters per minute: _____ Blood pressure: _____</p> <p>Document height/weight measurements: <input type="checkbox"/></p> <p>(Next Page) <input type="checkbox"/></p>	<p><i>Room air has the following responses:</i></p> <ul style="list-style-type: none"> • Yes • No <p>If No is selected, <i>O2 Liters per minute</i> becomes available.</p> <p><i>O2 Liters per minute</i> utilizes the numeric keypad.</p> <p>If Yes is selected in the <i>Room air</i> field, <i>O2 Liters per</i></p>

RT Six Minute Walk

02 Liters per minute:

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

Height ft: 5
Height in: 9
Height cm: 175.26
Weight kg: 67.000

Duration (minutes):>
Distance (meters):>

Room air:>No

02 Liters per minute:>
Blood pressure:>

Document height/weight measurements:

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minute is automatically skipped.

RT Six Minute Walk

Blood pressure:

7	8	9	Del
4	5	6	
1	2	3	
/	0		

Height ft: 5
Height in: 9
Height cm: 175.26
Weight kg: 67.000

Duration (minutes):>
Distance (meters):>

Room air:>No

02 Liters per minute:>
Blood pressure:>

Document height/weight measurements:

(Next Page)

Blood pressure utilizes the numeric keypad.

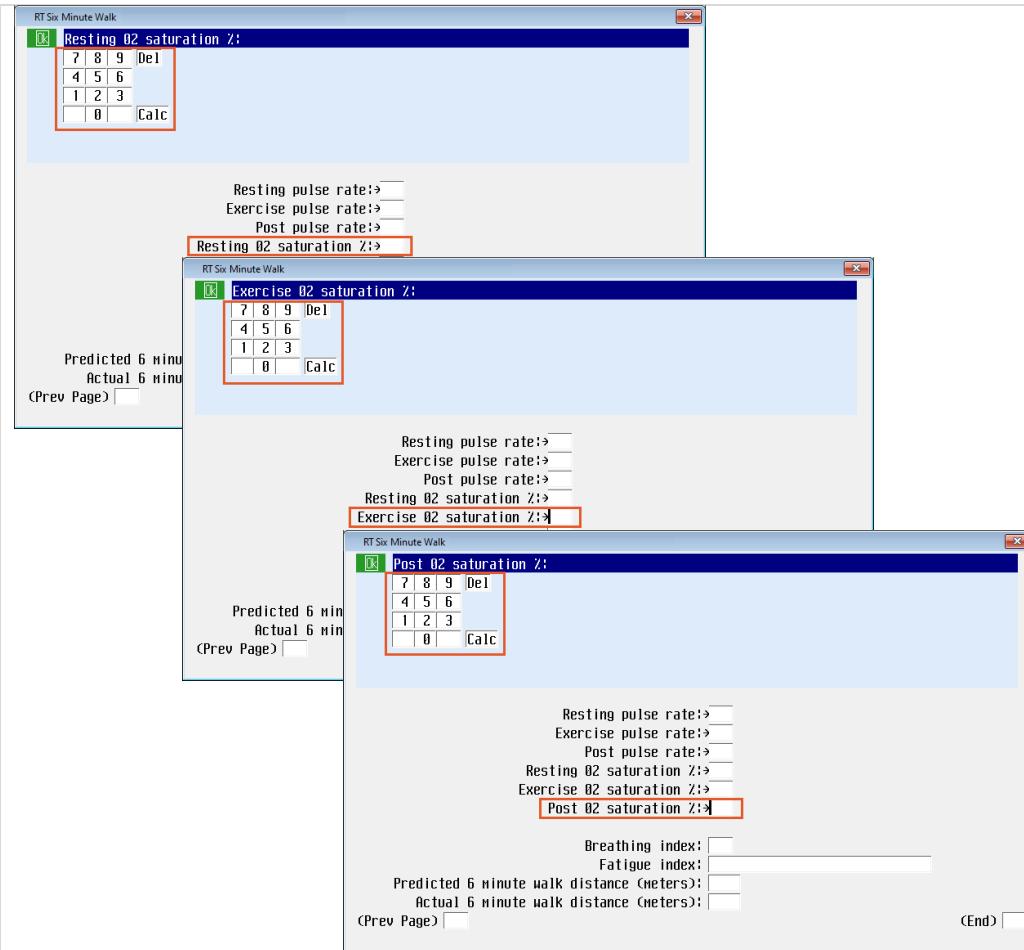
Document height/weight measurements takes the clinician to Height and Weight documentation.

The following fields utilize the numeric keypad:

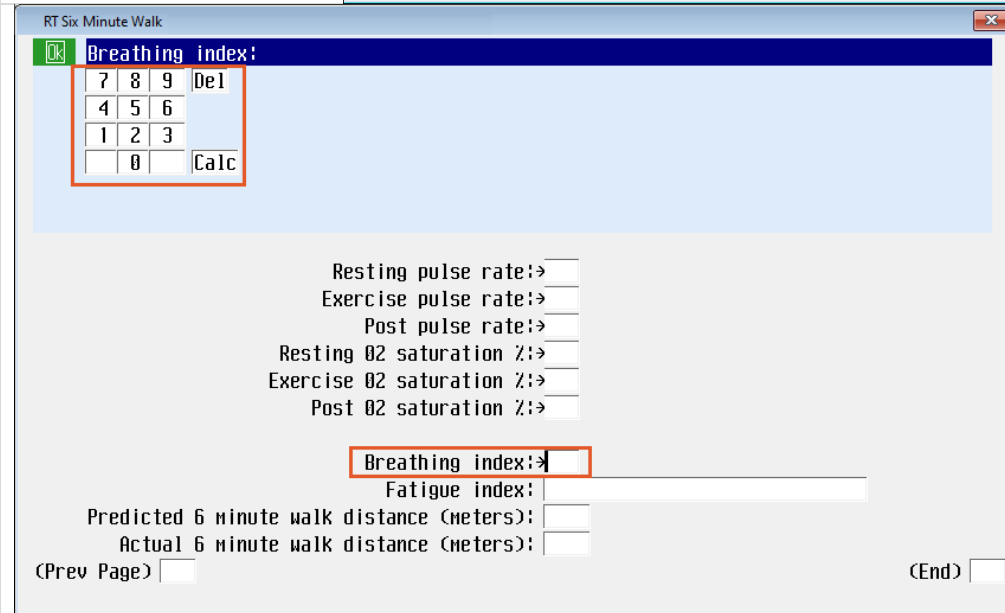
- Resting pulse rate
- Exercise pulse rate
- Post pulse rate

The following fields utilize the numeric keypad to enter the response:

- *Resting O2 saturation*
- *Exercise O2 saturation*
- *Post O2 saturation*



Breathing index utilizes the numeric keypad.



RT Six Minute Walk

Fatigue index:

- 1 No fatigue - 0
- 2 Mild fatigue - 2
- 3 Moderate fatigue - 5
- 4 Severe fatigue - 8
- 5 Severe/worse fatigue - 10

Resting pulse rate:→

Exercise pulse rate:→

Post pulse rate:→

Resting O2 saturation %:→

Exercise O2 saturation %:→

Post O2 saturation %:→

Breathing index:→

Fatigue index:→

Predicted 6 minute walk distance (meters):

Actual 6 minute walk distance (meters):

(Prev Page) (End)

Fatigue index has the following responses:

- No fatigue – 0
- Mild fatigue – 2
- Moderate fatigue – 5
- Severe fatigue – 8
- Severe/worse fatigue – 10

RT Six Minute Walk

Predicted 6 minute walk distance (meters):

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

Resting pulse rate:→

Exercise pulse rate:→

Post pulse rate:→

Resting O2 saturation %:→

Exercise O2 saturation %:→

Post O2 saturation %:→

Breathing index:→

Fatigue index:→

Predicted 6 minute walk distance (meters):→

Actual 6 minute walk distance (meters):

(Prev Page) (End)

The following fields utilize the numeric keypad to enter the responses:

- Predicted 6 minute walk distance (meters)
- Actual 6 minute walk distance (meters)

RT Six Minute Walk

Actual 6 minute walk distance (meters):

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

Resting pulse rate:→

Exercise pulse rate:→

Post pulse rate:→

Resting O2 saturation %:→

Exercise O2 saturation %:→

Post O2 saturation %:→

Breathing index:→

Fatigue index:→

Predicted 6 minute walk distance (meters):

Actual 6 minute walk distance (meters):→

(Prev Page) (End)

ED Module

Skin Alteration



The **Skin Alteration** screens have been updated to support the CSIP Hospital Acquired Pressure Injury (HAPI) initiative. [*See the Adult Skin Risk Assessment for the Video link](#)

Skin Alteration

Pressure injury staging:

1	Stage 1	Stage 1: Non-blanchable erythema of intact skin
2	Stage 2	Stage 2: Partial-thickness skin loss with exposed dermis
3	Stage 3	Stage 3: Full-thickness skin loss
4	Stage 4	Stage 4: Full-thickness skin and tissue loss
5	Unstageable	Unstageable: Obscured full-thickness skin and tissue loss
6	Deep tissue injury	DTI: Persist non-blanch deep red/maroon/purple discolor

Pressure injury staging:

Pressure injury present on admission:

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Pressure injury staging is a new field with the following responses:

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable
- Deep tissue injury

The Yellow Information Box guides the clinician in choosing the response:

Stage 1: Non-blanchable erythema of intact skin
 Stage 2: Partial-thickness skin loss with exposed dermis
 Stage 3: Full-thickness skin loss
 Stage 4: Full-thickness skin and tissue loss
 Unstageable: Obscured full-thickness skin and tissue loss
 DTI: Persist non-blanch deep red/maroon/purple discolor

Note: This field is only visited if a “Pressure Injury” is selected in *Skin alteration description* and ONLY once a patient has an admission order.

Also, if the defaulted response is deleted by the clinician, to repopulate the previously documented response, they must either choose “OK” or move to another field and back to the *Pressure injury staging* field.

Skin Alteration

Pressure injury staging:

1	Stage 1	Stage 1: Non-blanchable erythema of intact skin
2	Stage 2	Stage 2: Partial-thickness skin loss with exposed dermis
✓ 3	Stage 3	Stage 3: Full-thickness skin loss
4	Stage 4	Stage 4: Full-thickness skin and tissue loss
5	Unstageable	Unstageable: Obscured full-thickness skin and tissue loss
6	Deep tissue injury	DTI: Persist non-blanch deep red/maroon/purple discolor

Pressure injury staging:→Stage 3 *

Pressure injury staging:→Stage 3

Error

Stage 3 pressure injuries can only progress to Stage 4 and cannot be backstaged.

Ok

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When a Stage 3 is selected and Saved, the same Pressure injury will default to a Stage 3 and can only progress to a Stage 4.

That Pressure injury cannot be backstaged past a Stage 3.

Skin Alteration

Pressure injury staging:

1	Stage 1	Stage 1: Non-blanchable erythema of intact skin
2	Stage 2	Stage 2: Partial-thickness skin loss with exposed dermis
3	Stage 3	Stage 3: Full-thickness skin loss
✓ 4	Stage 4	Stage 4: Full-thickness skin and tissue loss
5	Unstageable	Unstageable: Obscured full-thickness skin and tissue loss
6	Deep tissue injury	DTI: Persist non-blanch deep red/maroon/purple discolor

Pressure injury staging:→Stage 4 *

Pressure injury staging:→Stage 4

Error

Stage 4 pressure injuries cannot be backstaged.

Ok

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When a Pressure injury is entered as a Stage 4 and Saved, the same Pressure injury will default to a Stage 4 and cannot be backstaged.

Note: All previously staged pressure injuries will default the previous recorded staging. Only Stage 3 and 4 cannot be backstaged. The only means to correct the Staging of 3 and 4 is to undo the documentation.

Pressure injury present on admission will only be visited if "Pressure injury" is selected in Skin alteration description.

Note: This should ONLY be answered once a patient has an admission order.

This update affects the following assessments:

Emergency Department	
Skin Alteration Assessment	Abscess
Abscess Reassessment	Allergic Reaction
Allergic Reaction Reassessment	Assault Human Animal Bite
Assault Human Animal Bite Reassessment	Assault Sexual
Assault Victims of Abuse	Insect Bite
Insect Bite Reassessment	Neck Pain Injury
Neck Pain Injury Reassessment	Neonatal Physical Findings
Non Urgent General Focus	Physical Findings
Snake Bite	Snake Bite Reassessment
Wound Evaluation	Wound Evaluation Reassessment
Wound Care	

OR Module

Intra-operative Laser



The **Intra-operative Laser** assessment has been updated to support accurate capture of laser settings and reduce the likelihood of adverse patient safety events.

Intra-operative Laser

Laser safety measures taken:

1 Yes

Laser safety measures taken: * *

Laser key obtained:

Electrical cord in good condition:

Laser signs posted on all doors:

Fire extinguisher location noted:

Protective eyewear for all team members:

Patient eye protection:

Appropriate laser instruments used:

Laser on standby when not in use:

Laser parameter verified by surgeon:

Doors closed:

All windows covered:

Smoke evacuator:

Laser masks used:

Water/saline on field:

Laser ET tube:

Laser fiber:

Indirect ophthalmoscope:

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Laser safety measures taken has an updated response of only “Yes”.

Intra-operative Laser

Laser ET tube:

1 Yes

2 No

Laser safety measures taken: Yes*

Laser key obtained: Yes

Electrical cord in good condition: Yes

Laser signs posted on all doors: Yes

Fire extinguisher location noted: Yes

Protective eyewear for all team members: Yes

Patient eye protection: Yes

Appropriate laser instruments used: Yes

Laser on standby when not in use: Yes

Laser parameter verified by surgeon: Yes

Doors closed: Yes

All windows covered: Yes

Smoke evacuator: Yes

Laser masks used: Yes

Water/saline on field: Yes

Laser ET tube: *

Laser fiber:

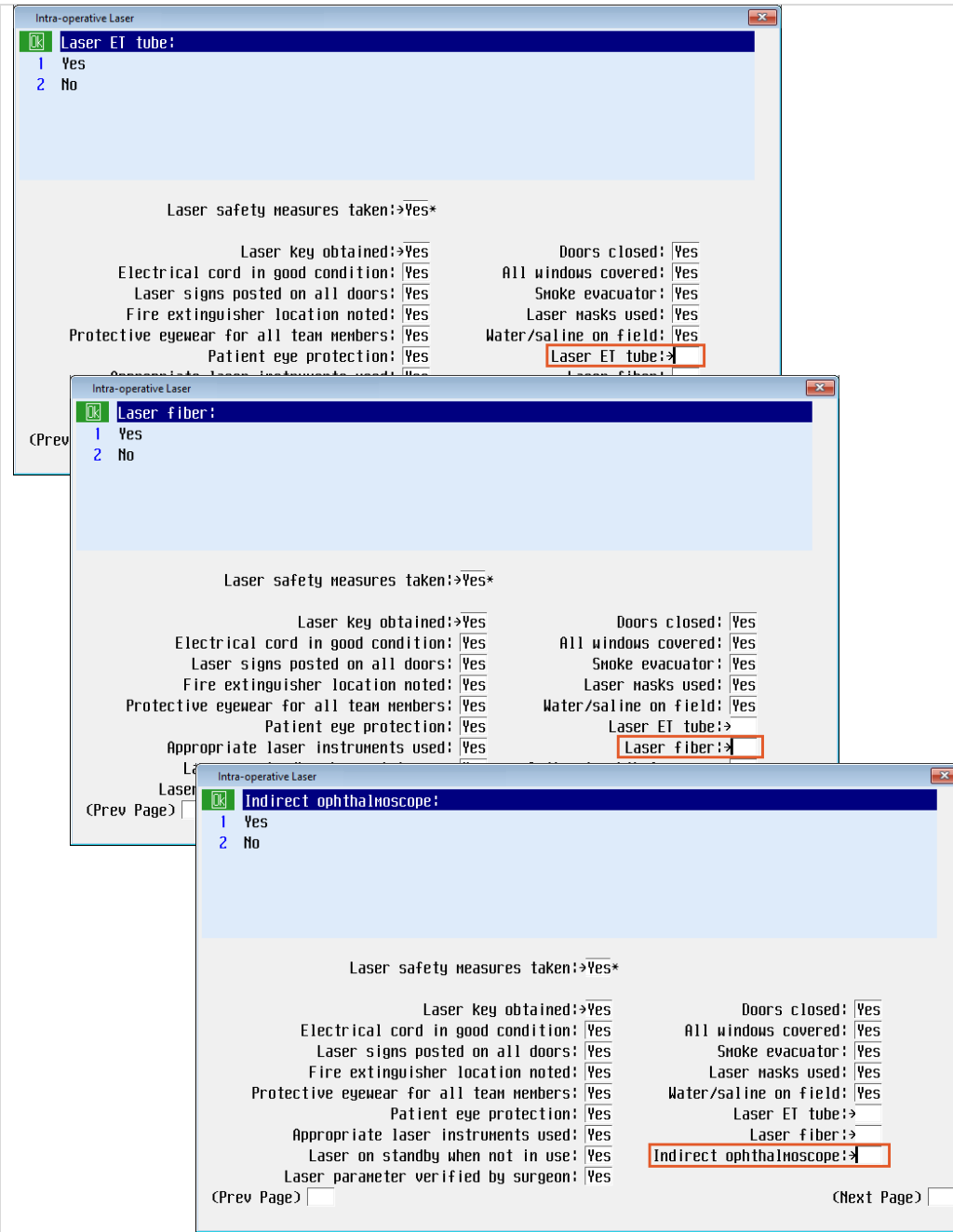
Indirect ophthalmoscope:

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The fields shown default to “Yes” but are editable.

The following fields do not default with a response:

- *Laser ET Tube*
- *Laser fiber*
- *Indirect ophthalmoscope*



Intra-operative Laser

Laser initial setting fiber microns:

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

Microscope:

Laparoscope:

Handpiece:

Endoscope:

Laser initial setting watts:

Laser initial setting mJoules:

Laser initial setting hertz:

Laser initial mode:

Laser initial setting fiber microns:

(Prev Page) (Next Page)

Laser initial setting fiber microns continues to utilize the numeric keypad but has increased to allow for more characters.

Intra-operative Laser

Laser pulse count right eye:

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

Repeat duration:

Repeat interval:

Laser pulse count right eye:

Laser pulse count left eye:

Is this a head, neck or chest procedure:

Laser d

(Prev Page)

Intra-operative Laser

Laser pulse count left eye:

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

Repeat duration:

Repeat interval:

Laser pulse count right eye:

Laser pulse count left eye:

Is this a head, neck or chest procedure:

Laser comments:

(Prev Page) (End)

The following fields continue to utilize the numeric keypad but have increased to allow for more characters:

- *Laser pulse count right eye*
- *Laser pulse count left eye*

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