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:

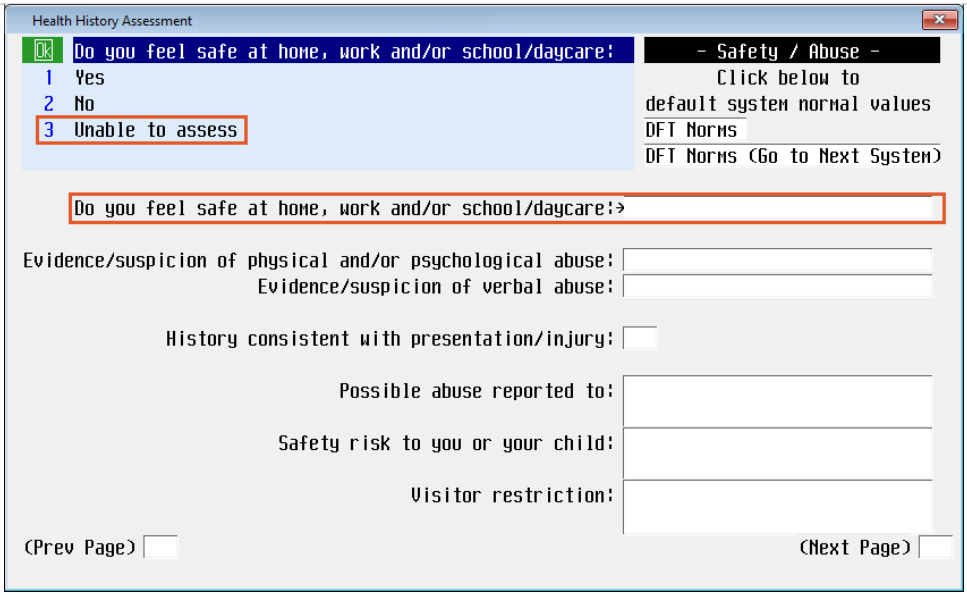
Summary of Revisions

Date	Revision

Nursing, OR, BH and ED Modules

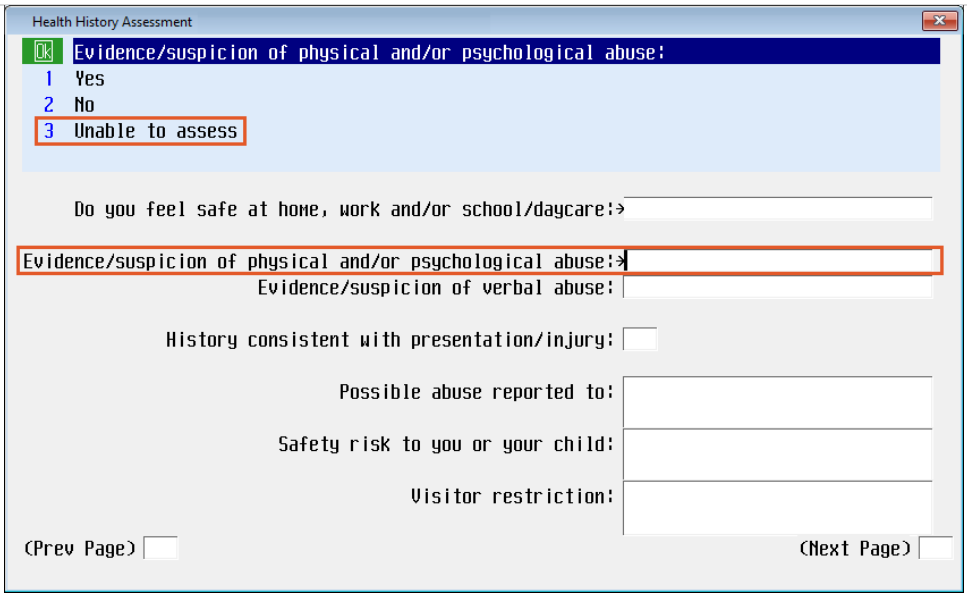
Health History Assessment – Abuse Fields Update

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.



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

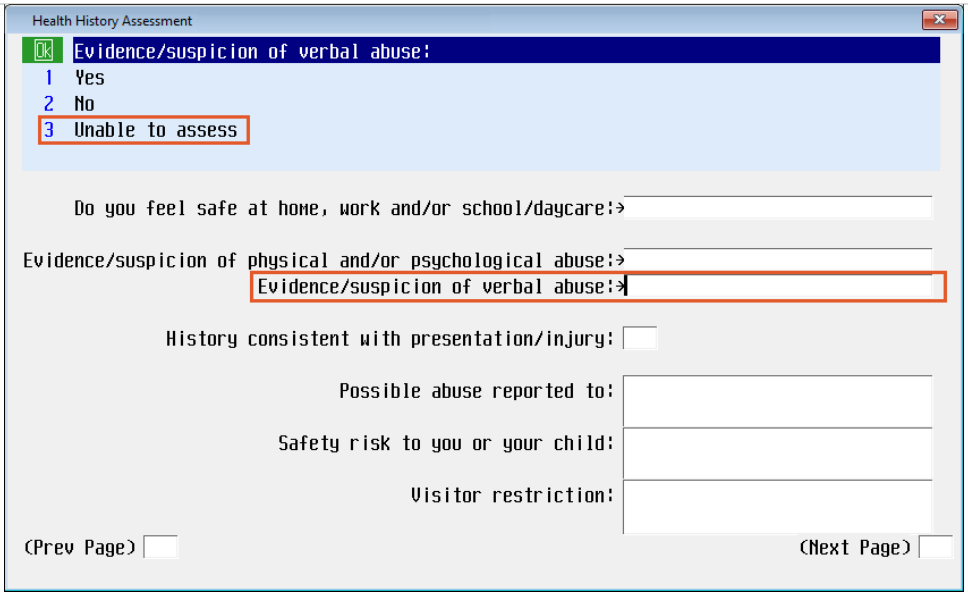
- Unable to assess



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

- Unable to assess

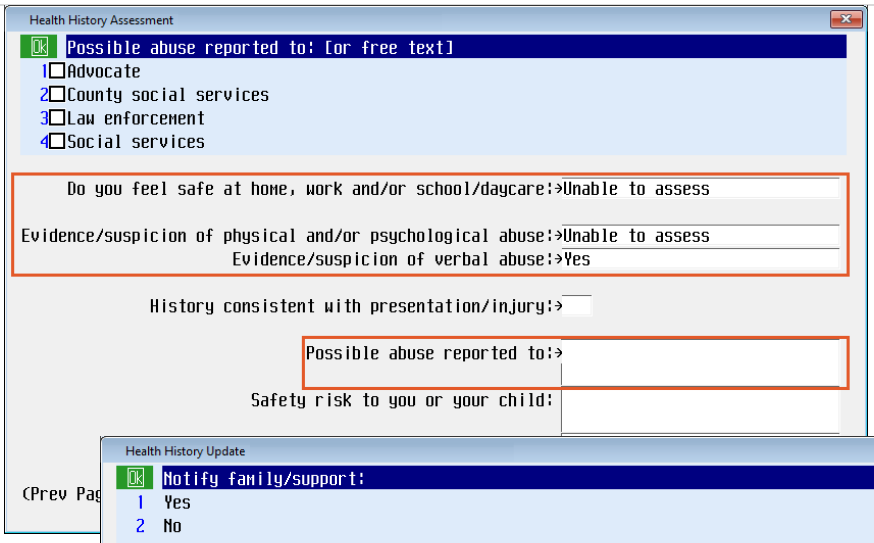
If “Unable to assess” is selected for this field, *Possible abuse reported to* is automatically skipped.



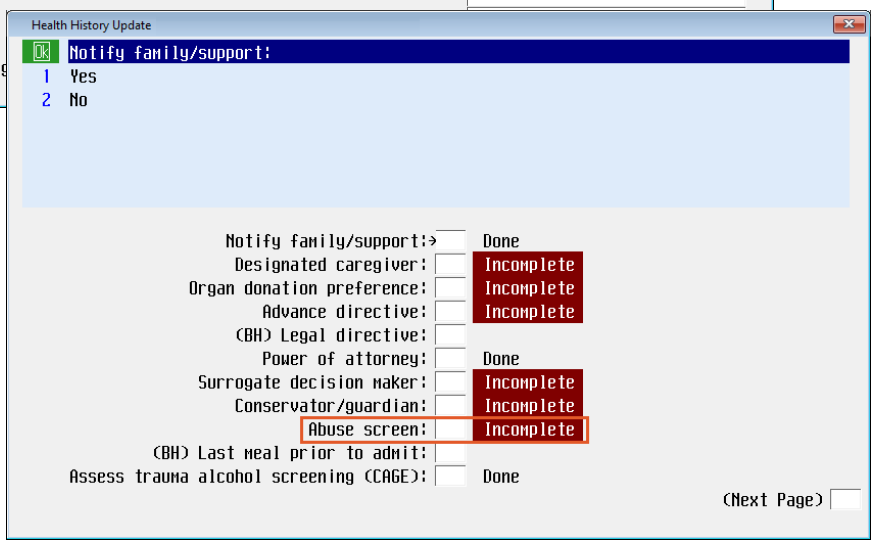
Evidence/suspicion of verbal abuse has the following new response:

- Unable to assess

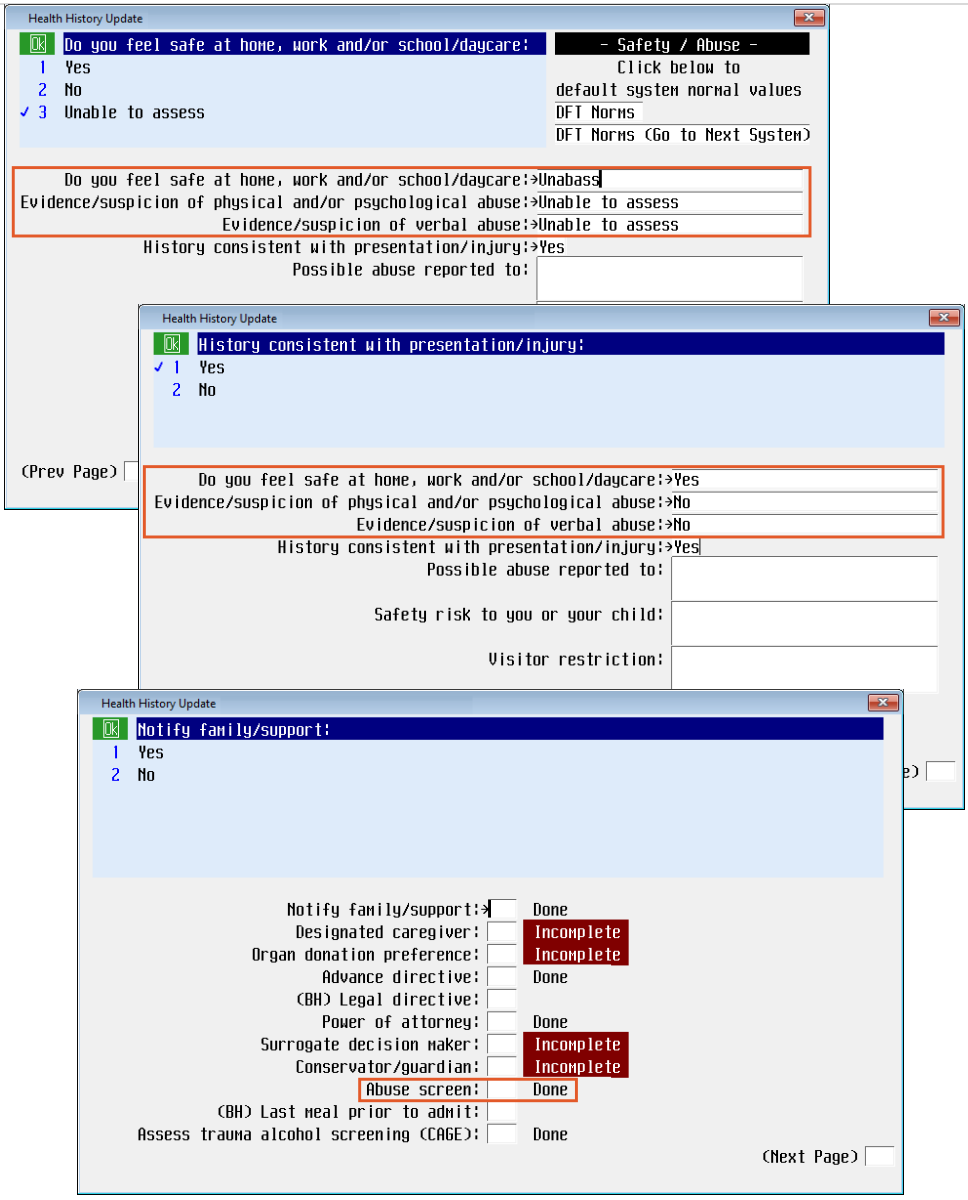
If “Unable to assess” is selected for this field, *Possible abuse reported to* is automatically skipped.



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”.



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	

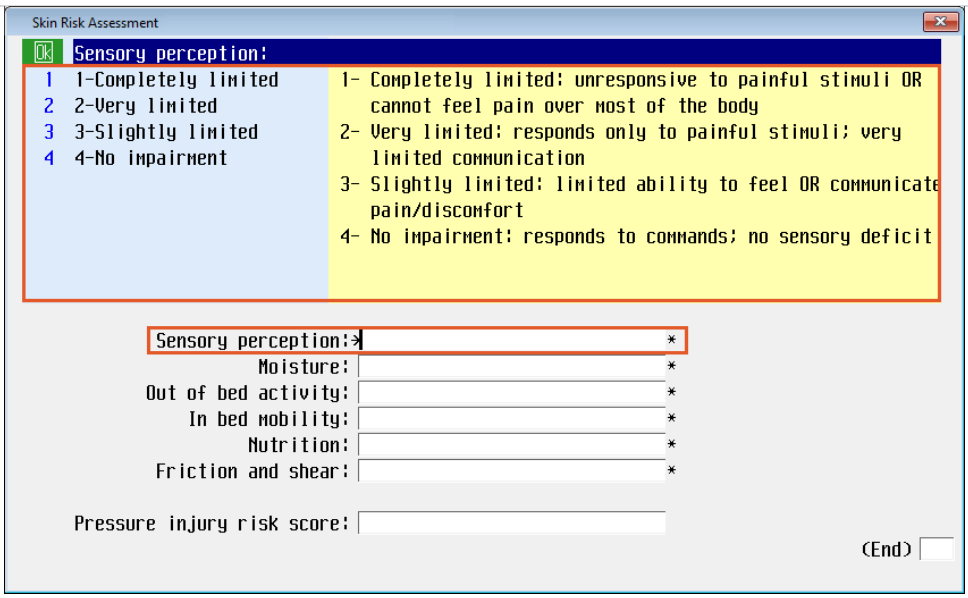
Nursing, OR and ED Modules

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=YT0xJnRzPTIwMjItMTEtMTFUMTU6NDg6MTkmY2lkPTcyOTBhZDk2LTQ2NjAtZWQxMS04MGZkLTAwNTA1NmIxMzUwYiZjdj0w

For the ED video click here →
https://www.healthstream.com/hlc/common/course/quicklinks.aspx?oid=a86b970c-a5b3-da11-8139-000423acef71&quickLink=YT0xJnRzPTIwMjItMTEtMTFUMTU6NDk6NTImY2lkPWU0ZDlmNzA0LTNlNjAtZWQxMS04MGZkLTAwNTA1NmIxMzUwYiZjdj0w

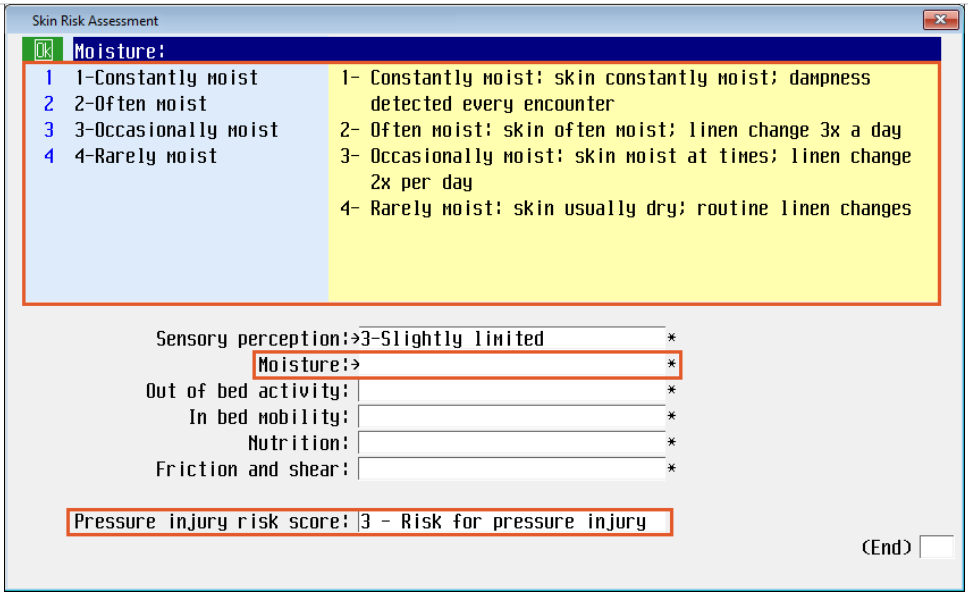


Sensory perception has the following responses:

- 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



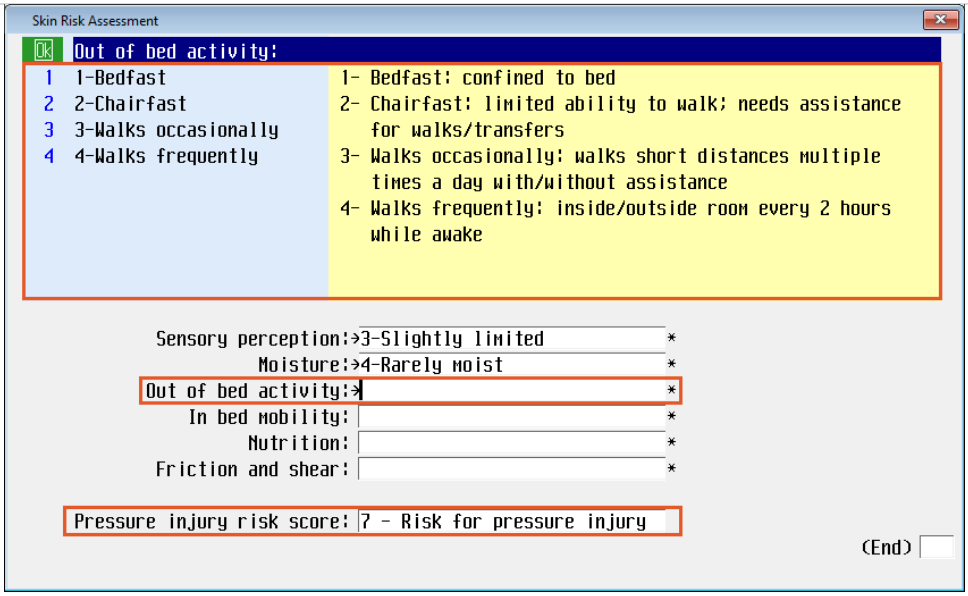
Note: *Pressure injury risk score* calculates as the fields are documented.

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

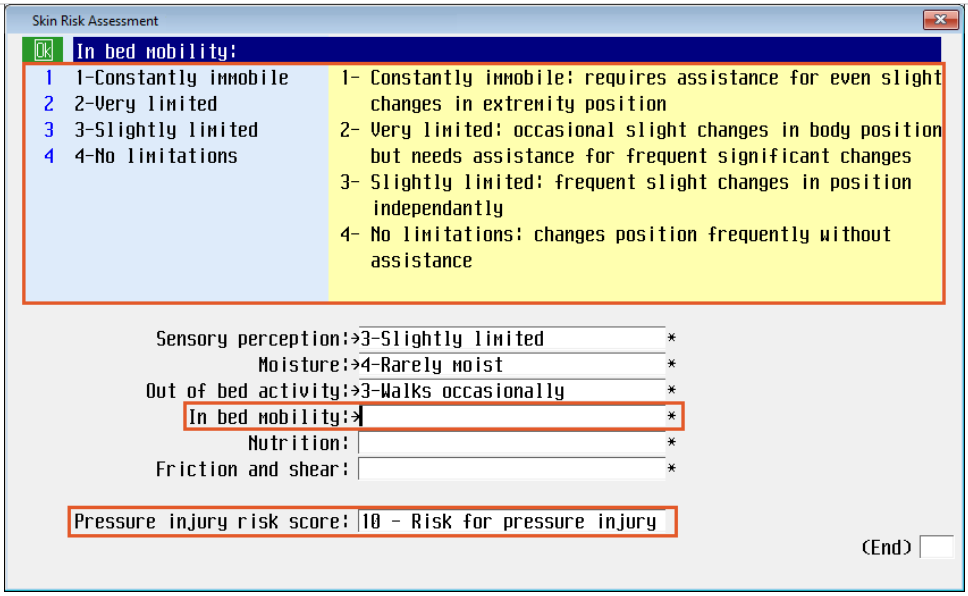


Out of bed activity has the following responses:

- 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

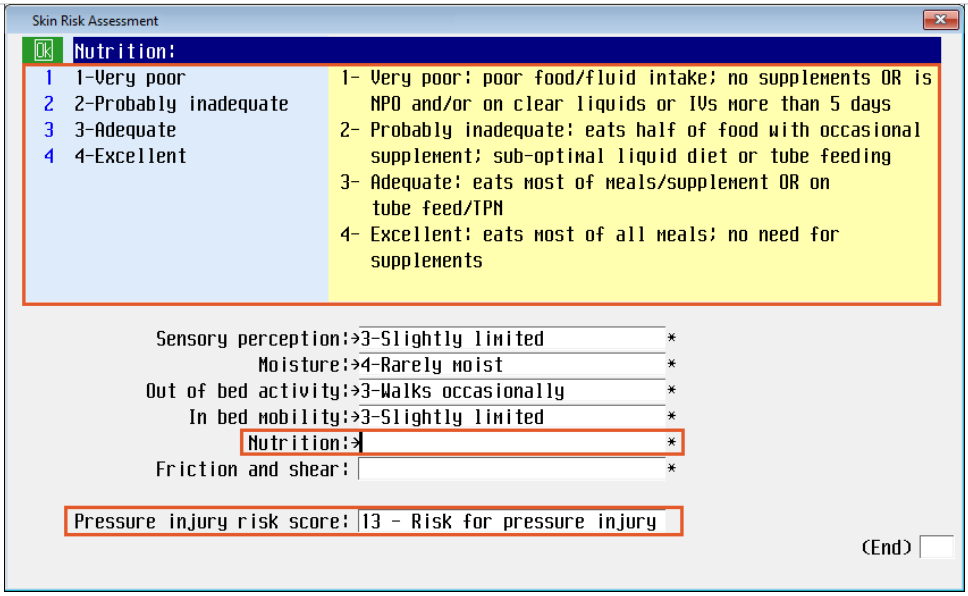


In bed mobility has the following responses:

- 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 independently
4 – No limitations: changes position frequently without assistance

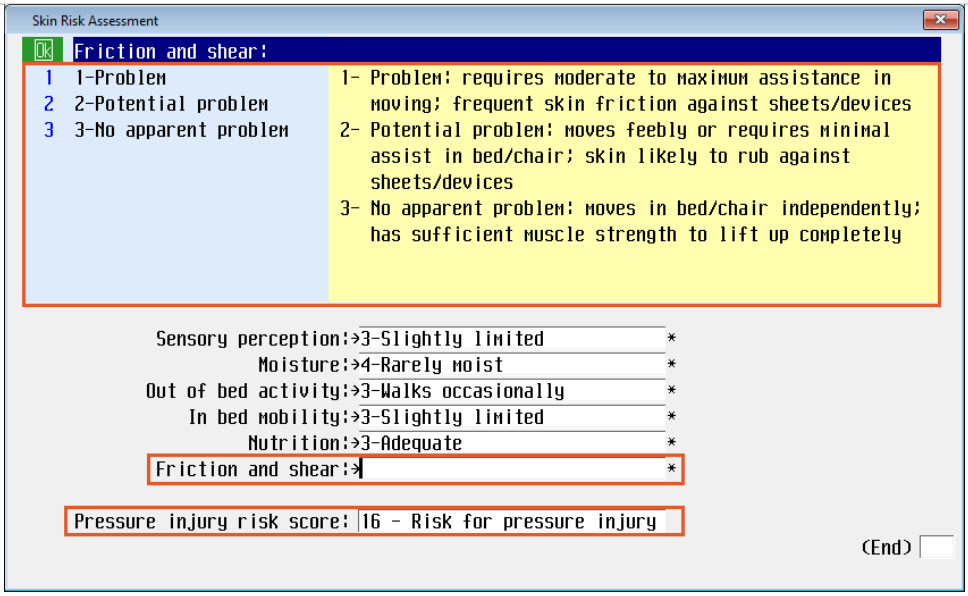


Nutrition has the following responses:

- 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

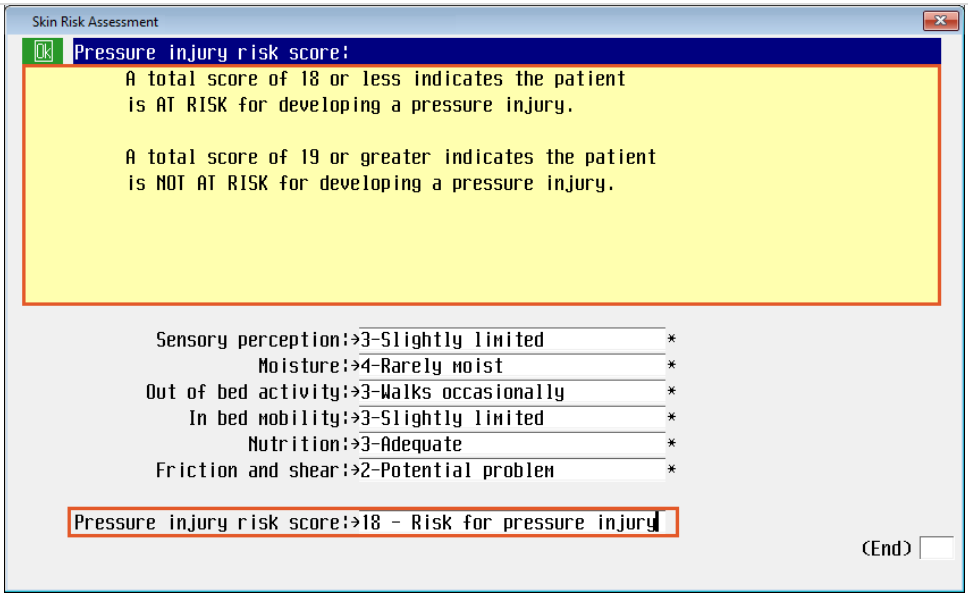


Friction and shear has the following responses:

- 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.

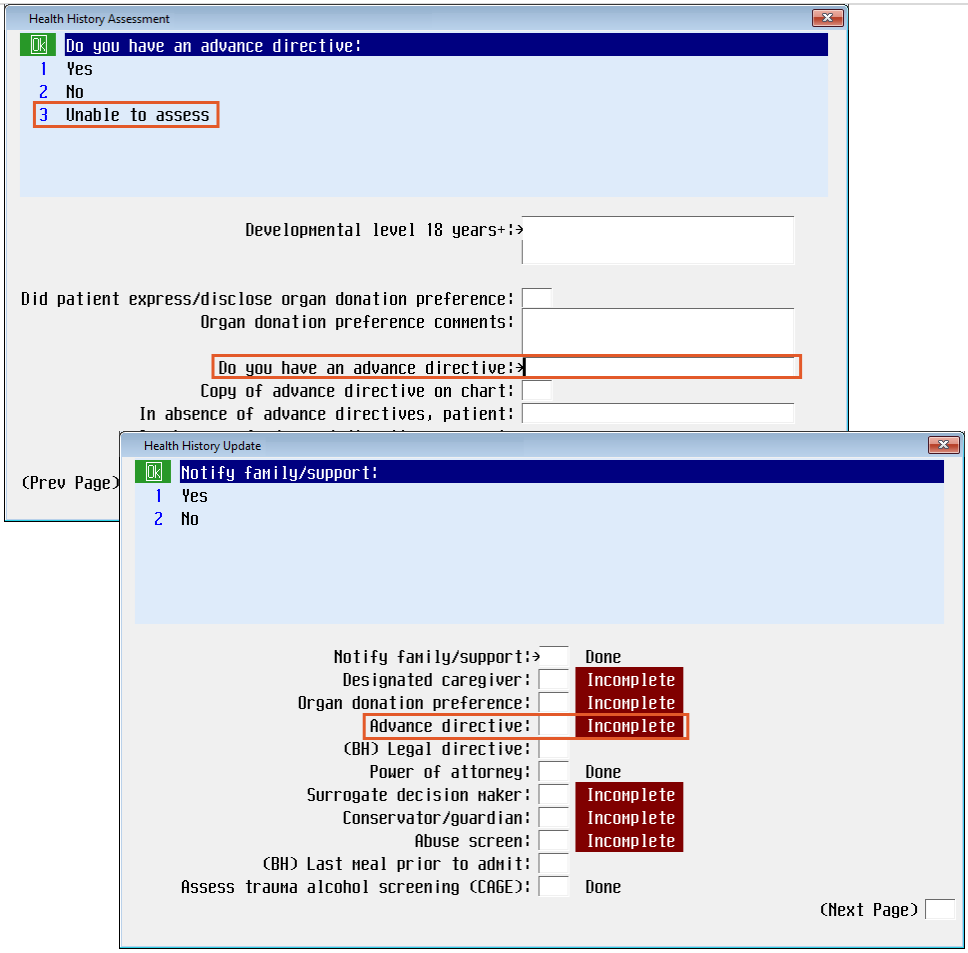
This update affects the following assessments/interventions:

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

Nursing and OR Modules

Health History Assessment – Advanced Directive Update

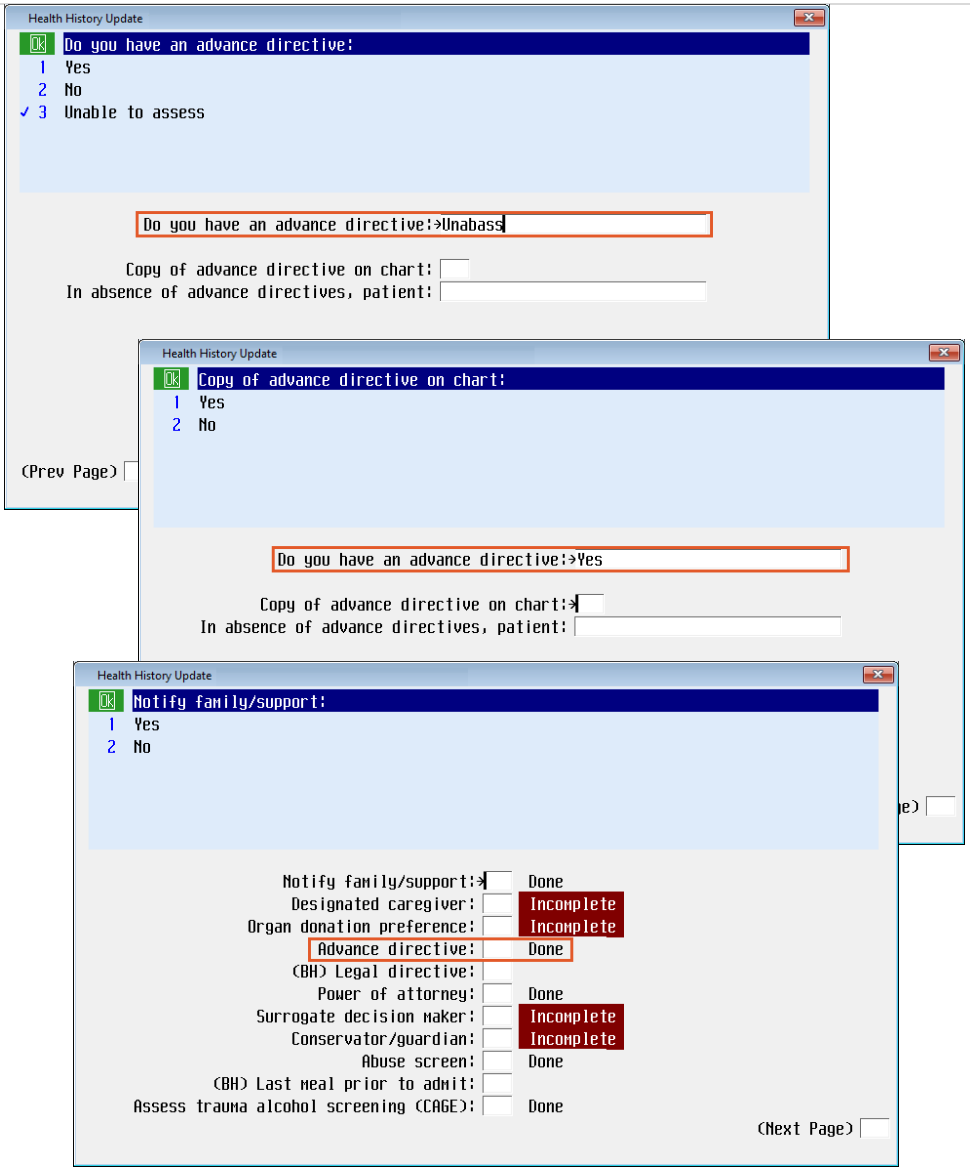
The **Health History Assessment** has been updated in the Advance Directive field. This field will flow from Registration to Nursing if already answered in Registration.



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.

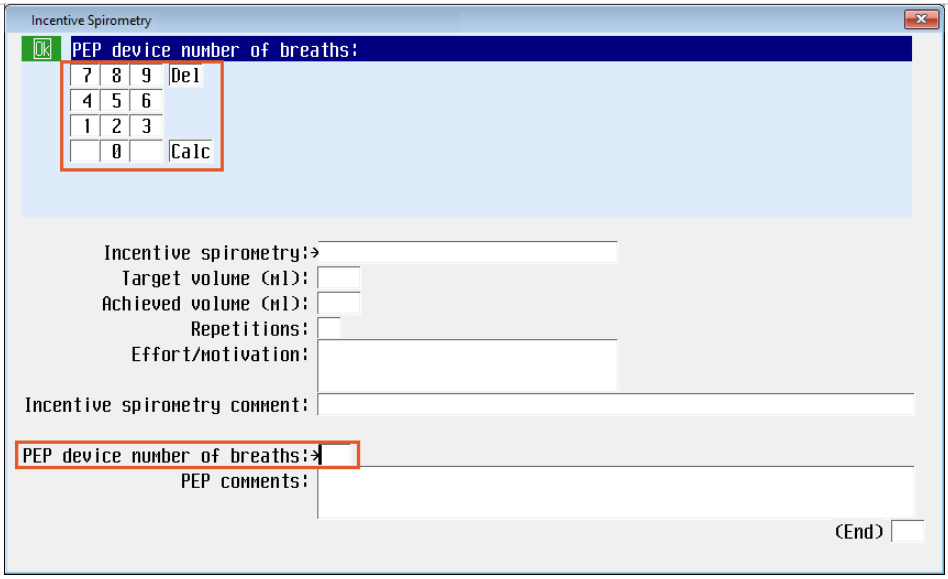
If the clinician completes the fields, the *Advance directive* field will show as “Done”.

The following interventions and assessments are affected:

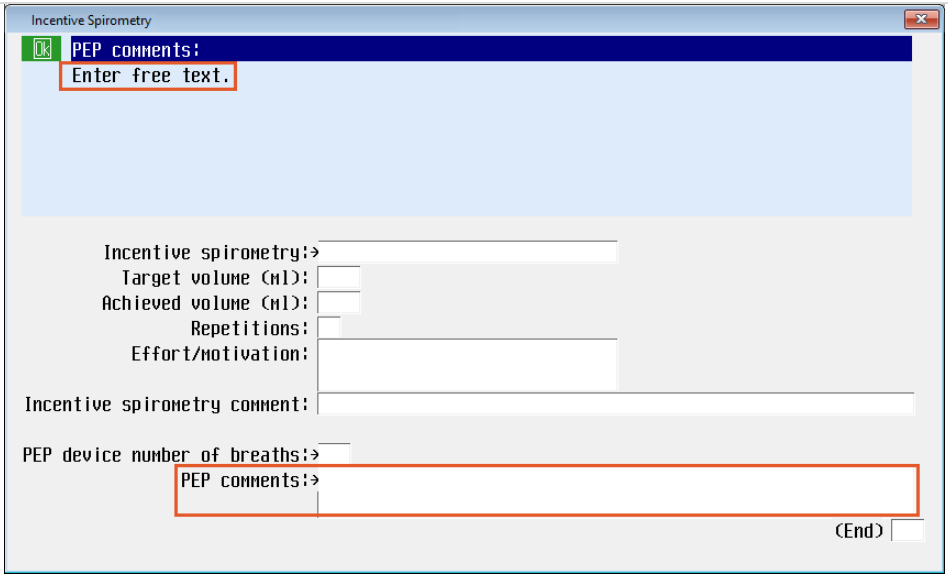
Nursing and Surgery	
Health History Assessment	Health History Update
SURG: Admission Health History	SURG: Admission Hx Update Pre

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.



PEP device number of breaths utilizes the numeric keypad.



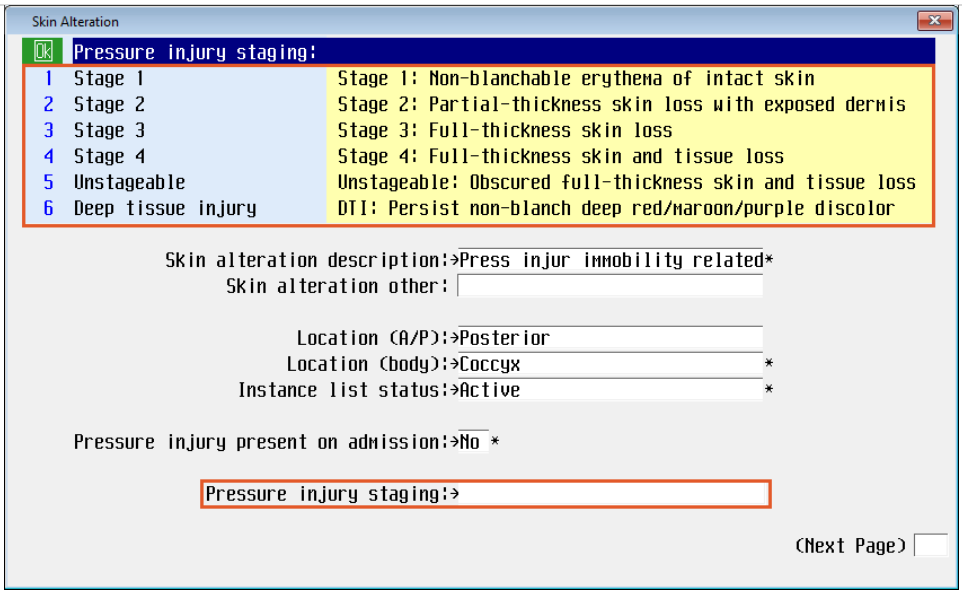
PEP comments is a free text enabled field.

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



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.

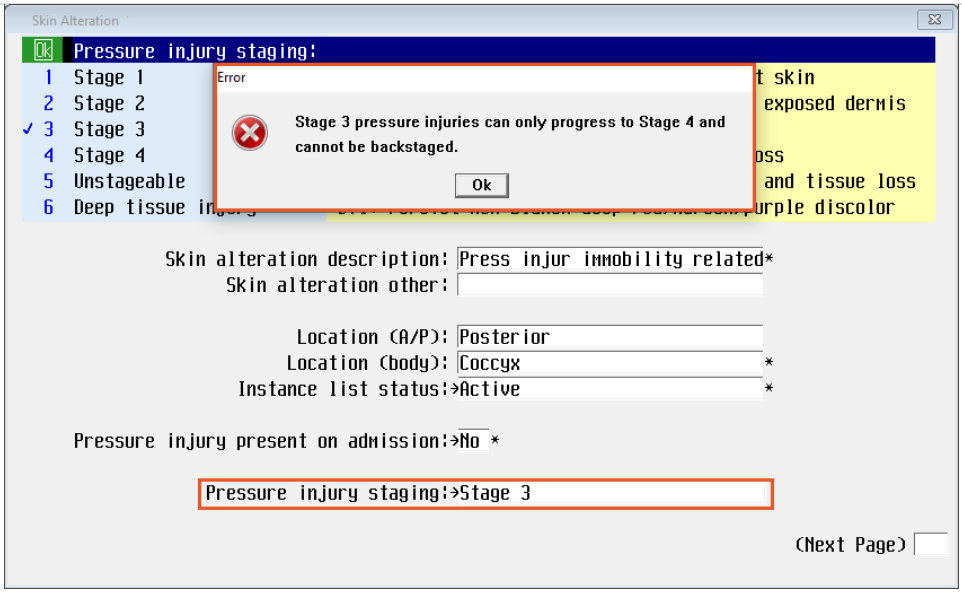
Also, if the defaulted response is deleted by the clinician, to repopulate the previously documented response, they must either choose “OK” or move to another field and back to the *Pressure injury staging* field.

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

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

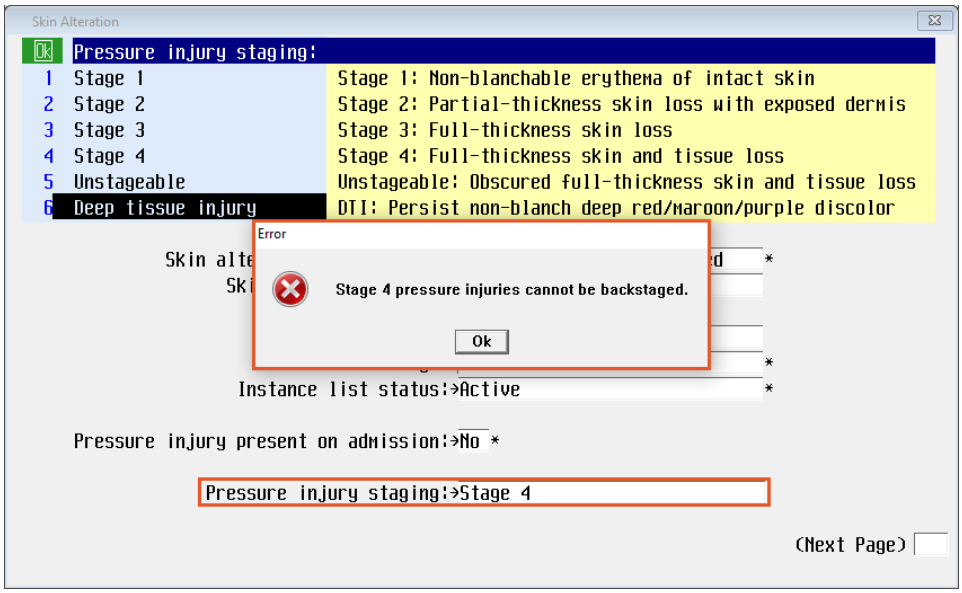
The Yellow Information Box guides the clinician in choosing the response:

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



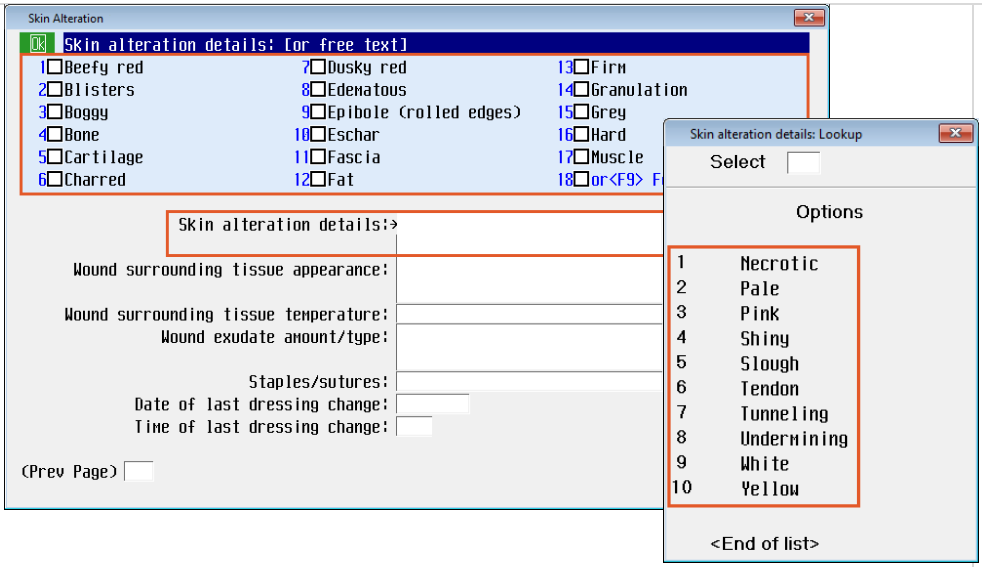
When a Stage 3 is selected and Saved, the same Pressure injury will default to a Stage 3 and can only progress to a Stage 4.

That Pressure injury cannot be backstaged past a Stage 3.



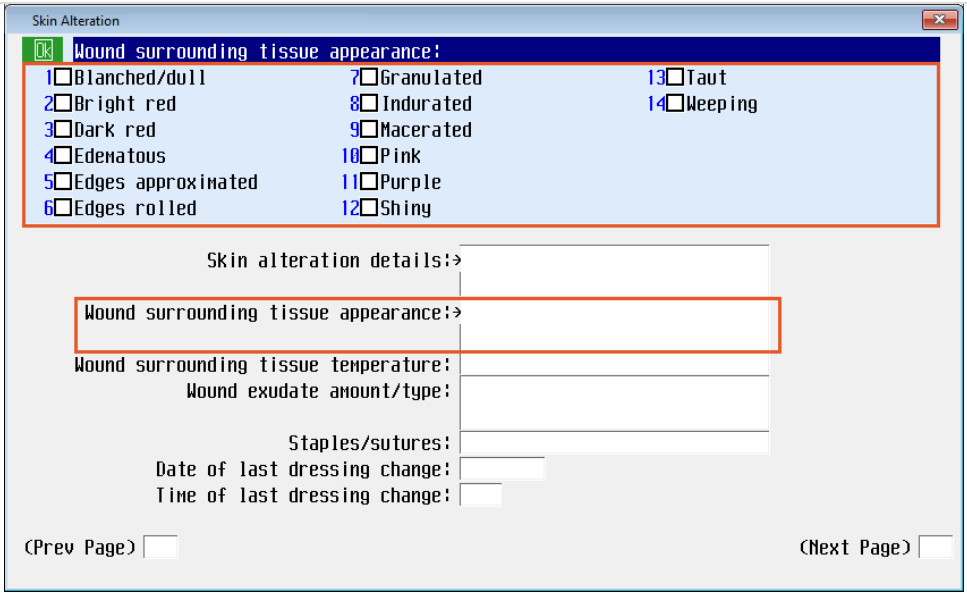
When a Pressure injury is entered as a Stage 4 and Saved, the same Pressure injury will default to a Stage 4 and cannot be backstaged.

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.



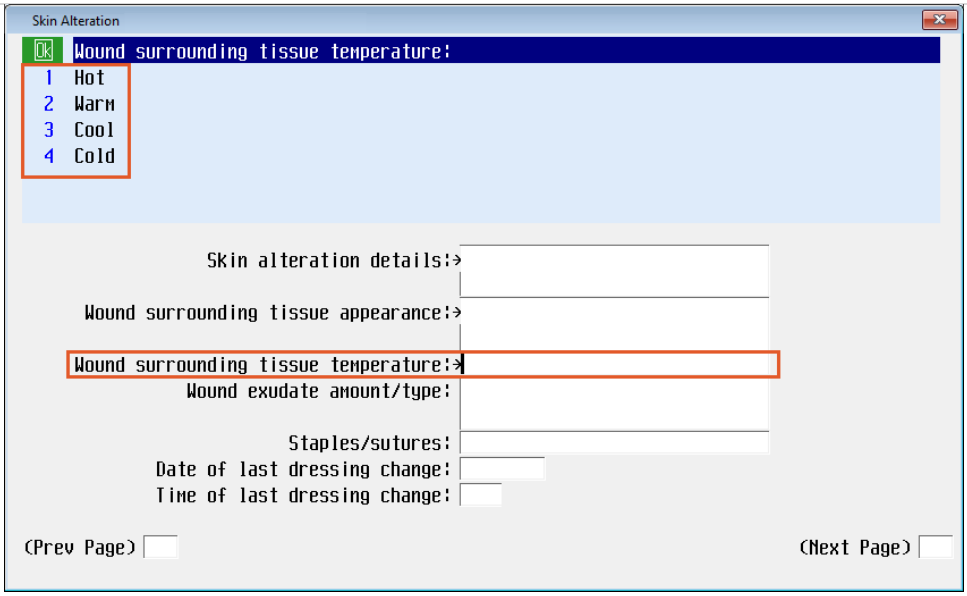
Skin alteration details has the following new responses:

- 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:

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



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

- Hot
- Warm
- Cool
- Cold

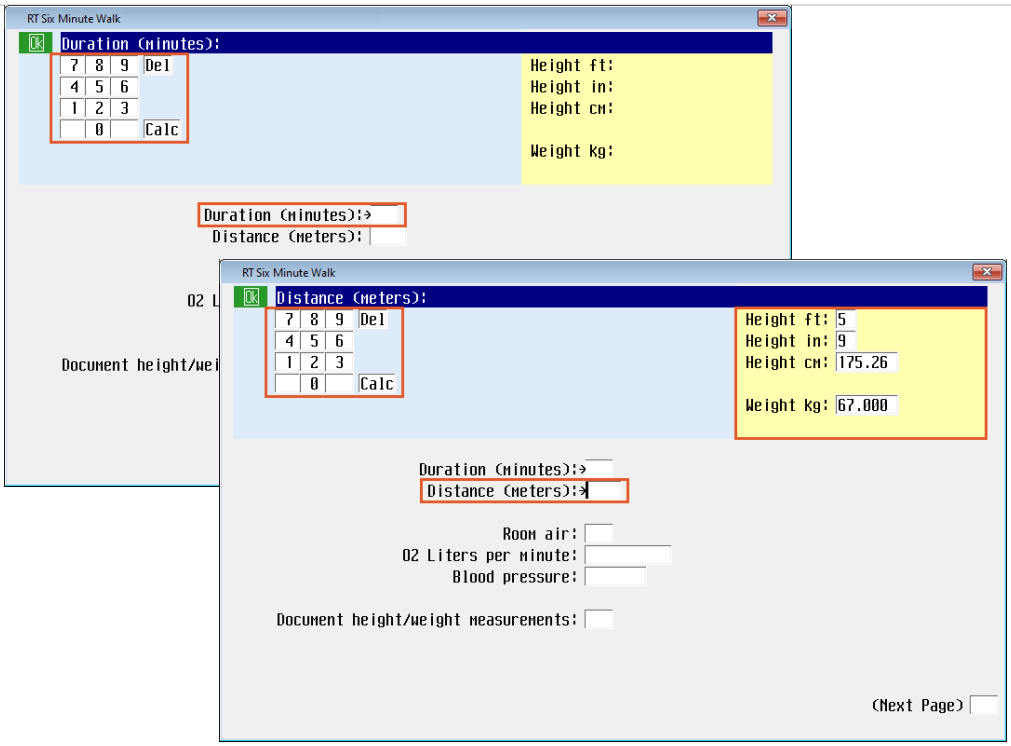
This update affects the following assessments/interventions:

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

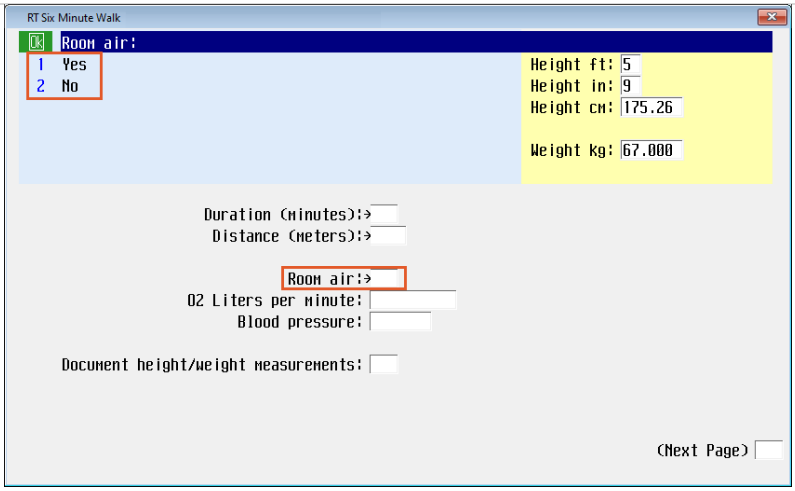
Six Minute Walk

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.



Duration (minutes) and *Distance (meters)* are entered by utilizing the numeric keypad.

If previous height and weight have been entered, they will auto populate in the Yellow Information Box as shown.



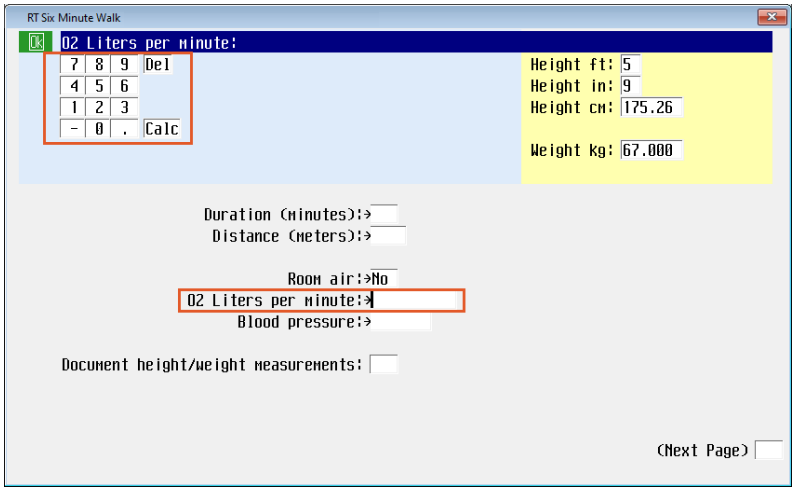
Room air has the following responses:

- Yes
- No

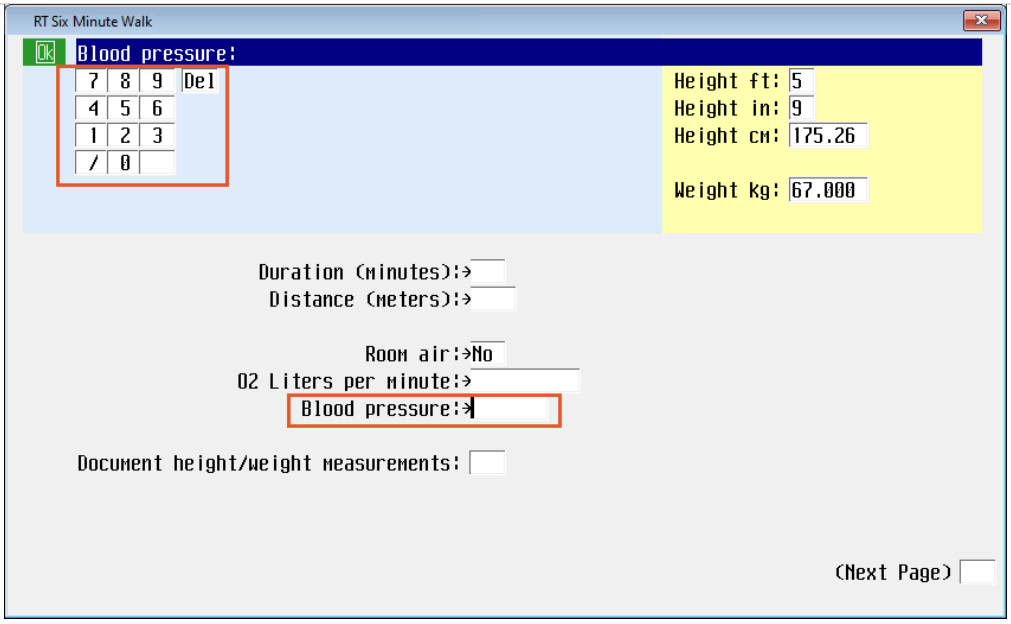
If No is selected, *O2 Liters per minute* becomes available.

O2 Liters per minute utilizes the numeric keypad.

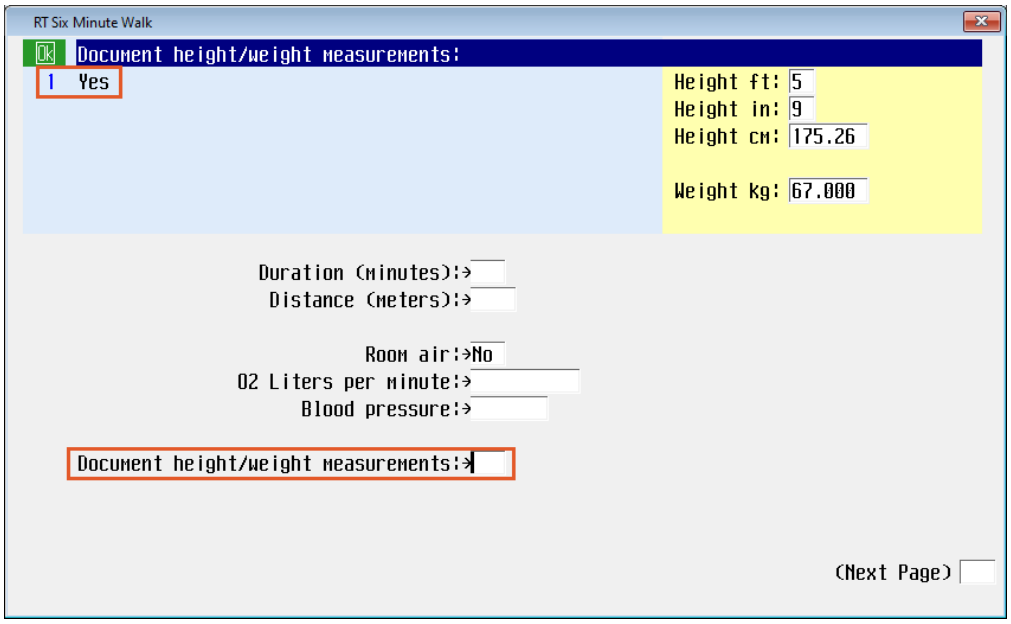
If Yes is selected in the *Room air* field, *O2 Liters per*



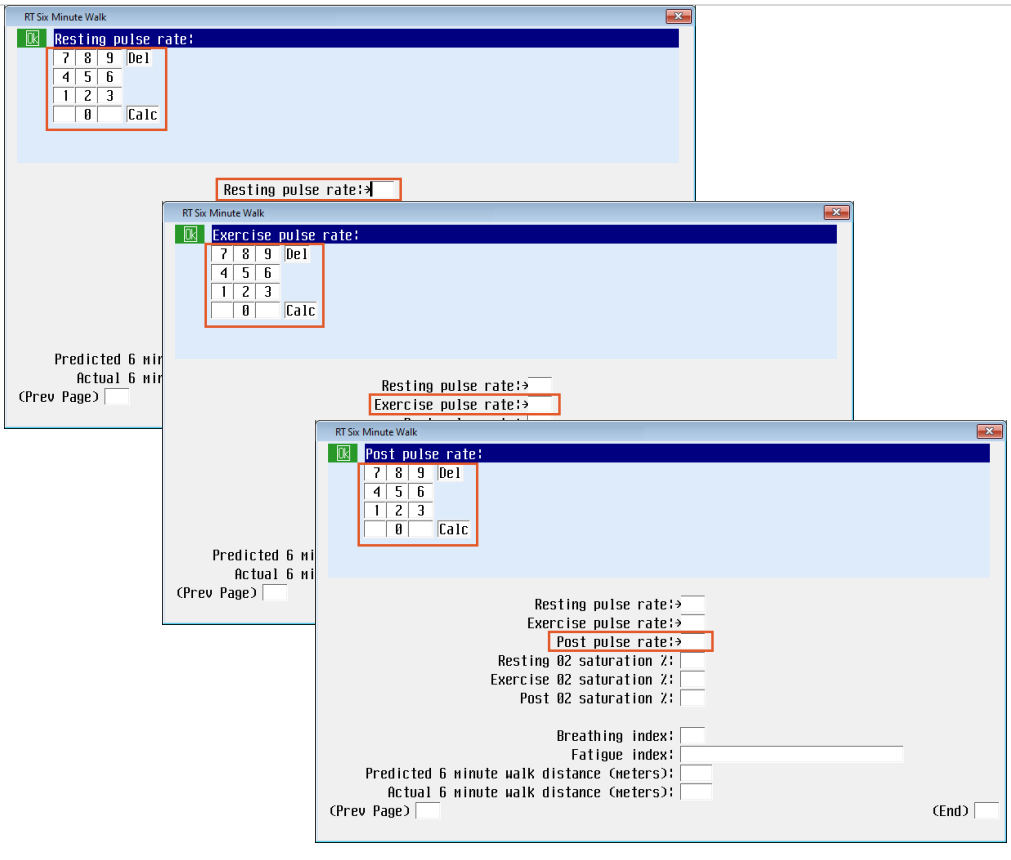
minute is automatically skipped.



Blood pressure utilizes the numeric keypad.

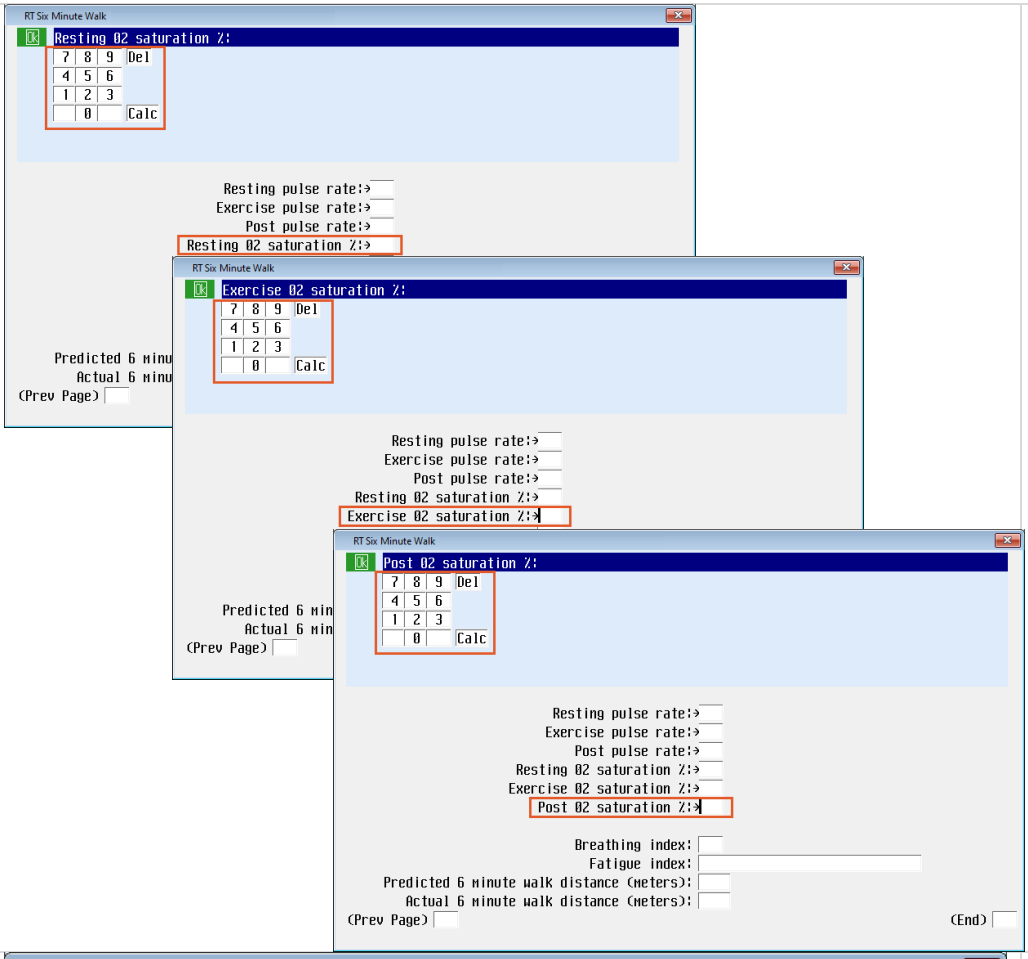


Document height/weight measurements takes the clinician to Height and Weight documentation.



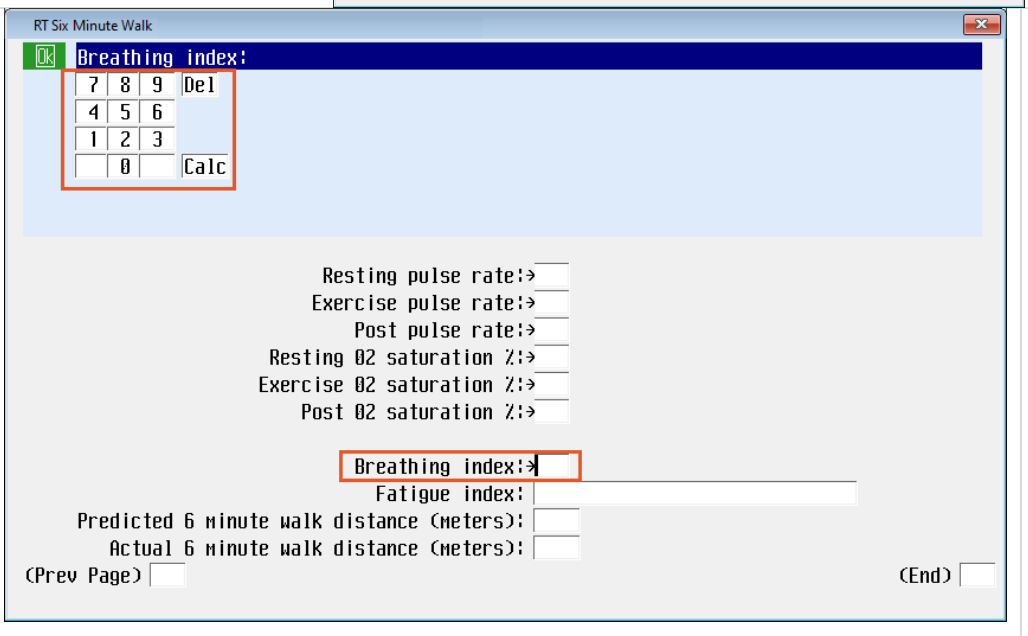
The following fields utilize the numeric keypad:

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

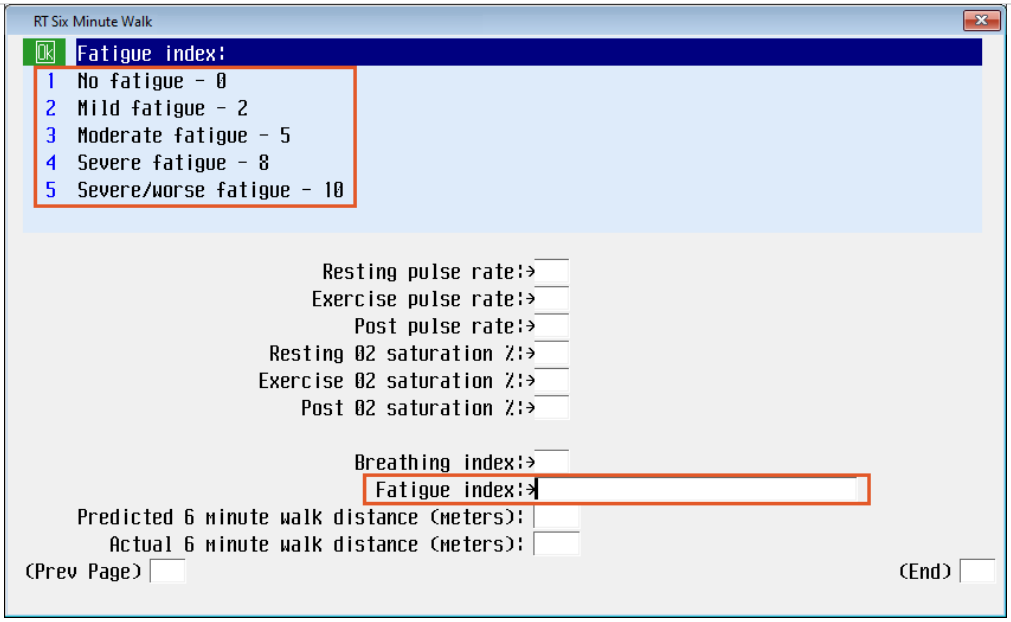


The following fields utilize the numeric keypad to enter the response:

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

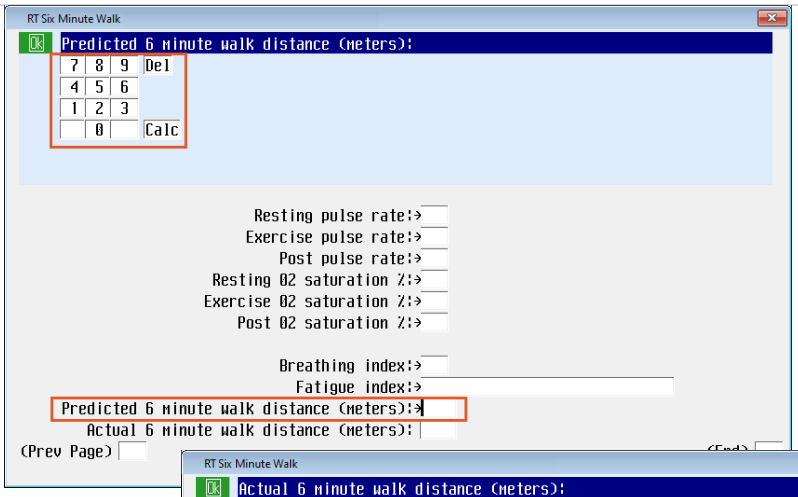


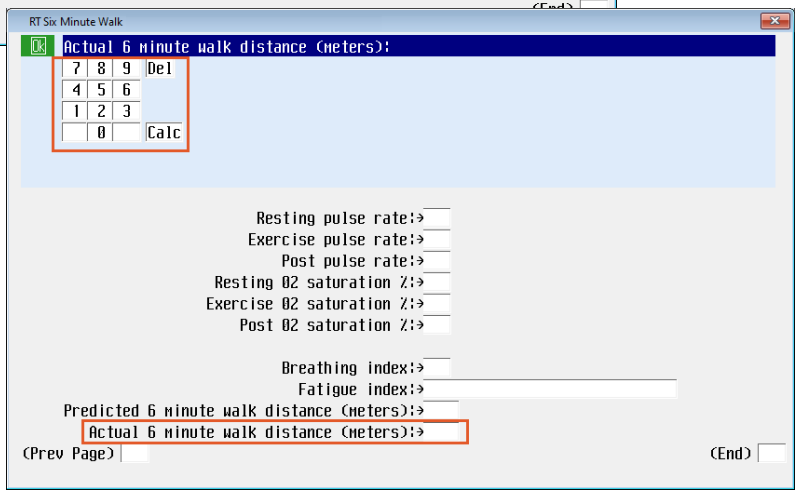
Breathing index utilizes the numeric keypad.



Fatigue index has the following responses:

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





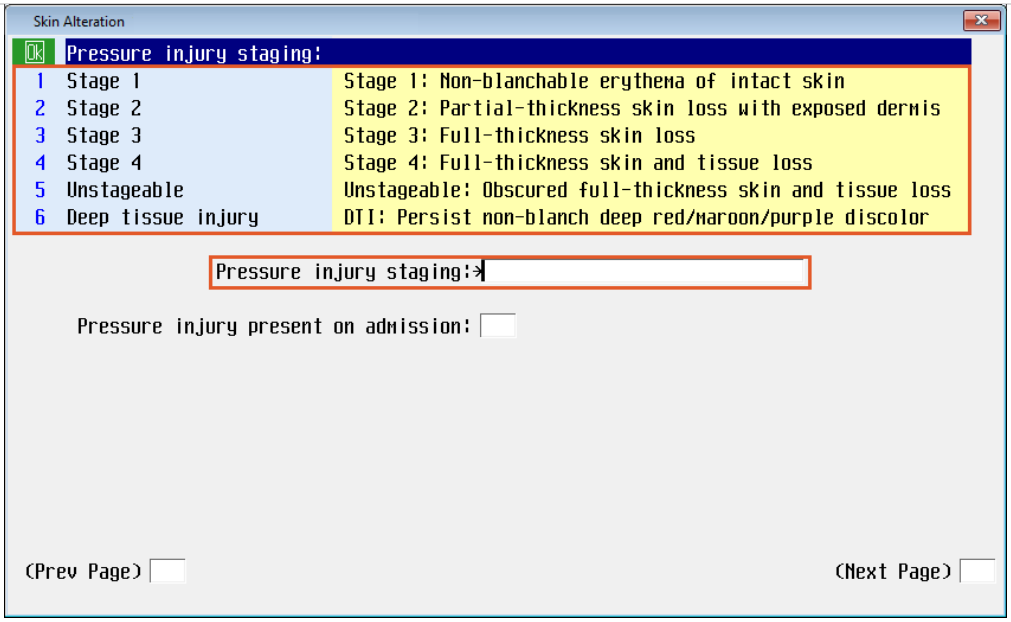
The following fields utilize the numeric keypad to enter the responses:

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

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



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.

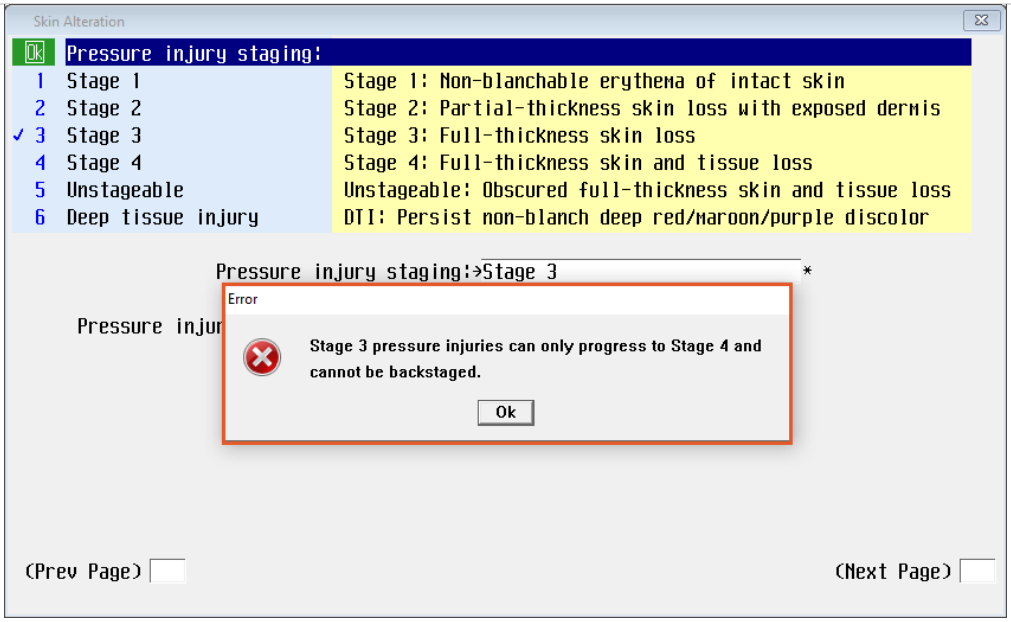
Also, if the defaulted response is deleted by the clinician, to repopulate the previously documented response, they must either choose “OK” or move to another field and back to the *Pressure injury staging* field.

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

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

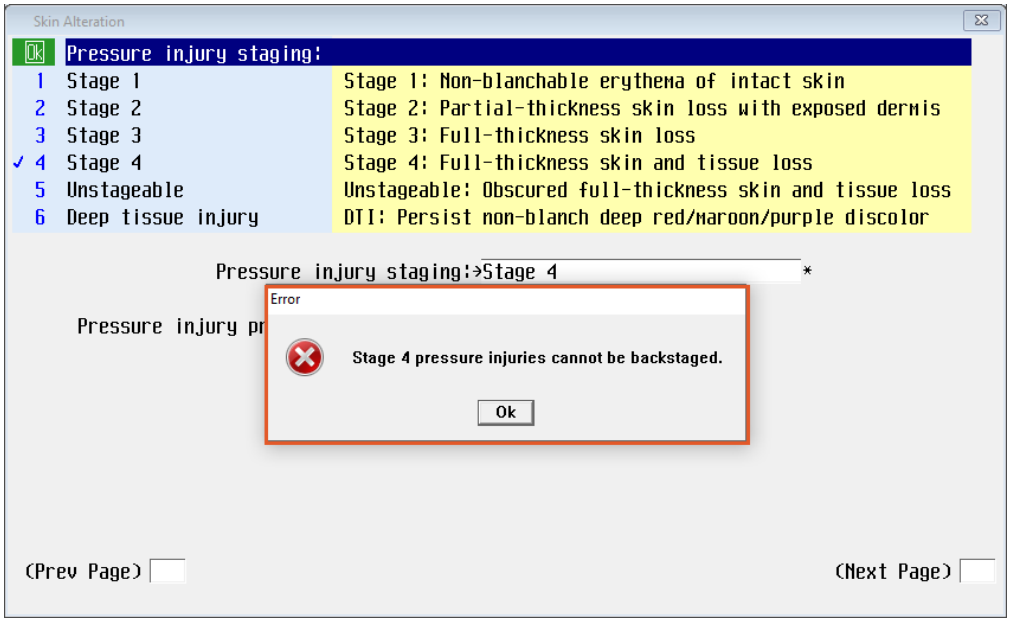
The Yellow Information Box guides the clinician in choosing the response:

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



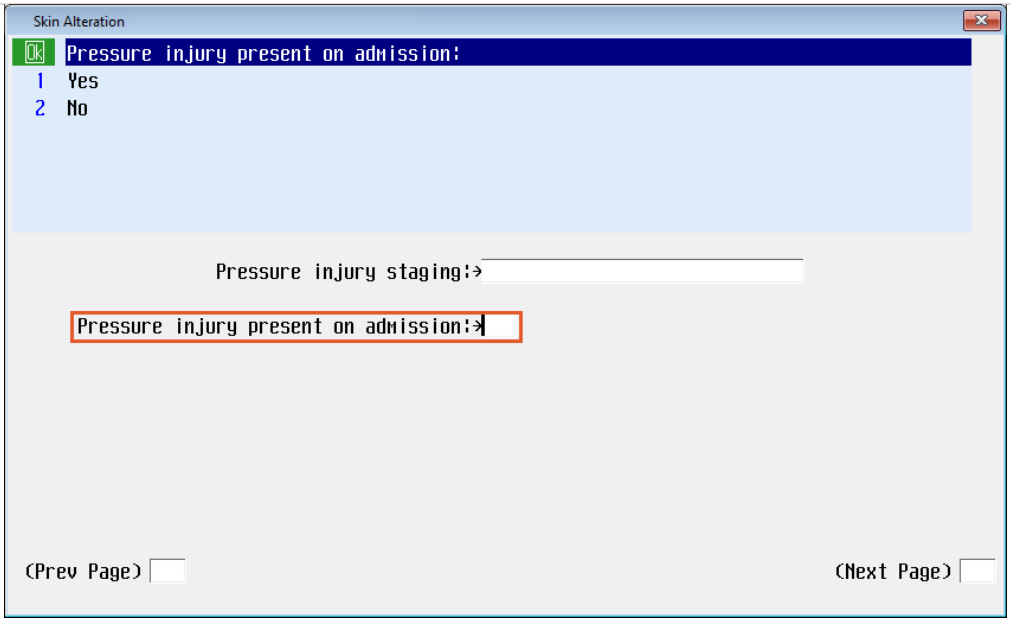
When a Stage 3 is selected and Saved, the same Pressure injury will default to a Stage 3 and can only progress to a Stage 4.

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.



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.

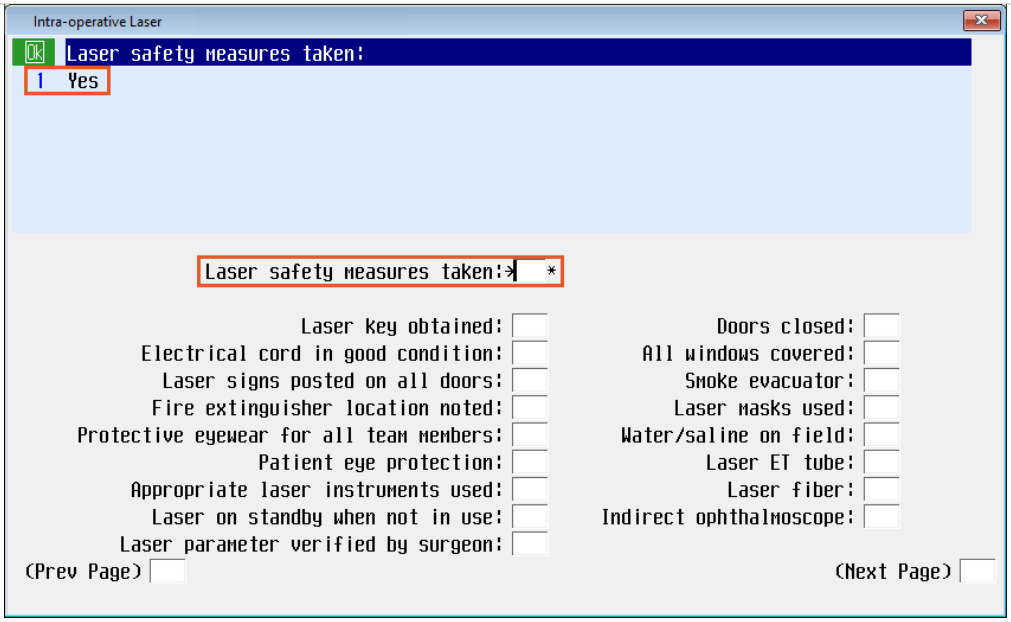
This update affects the following assessments:

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	

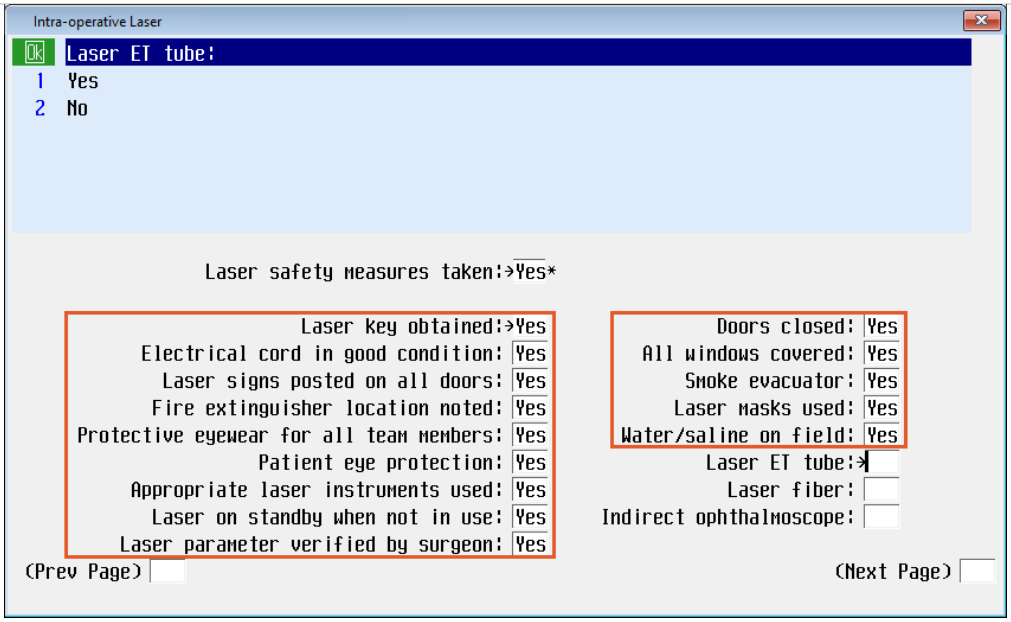
OR Module

Intra-operative Laser

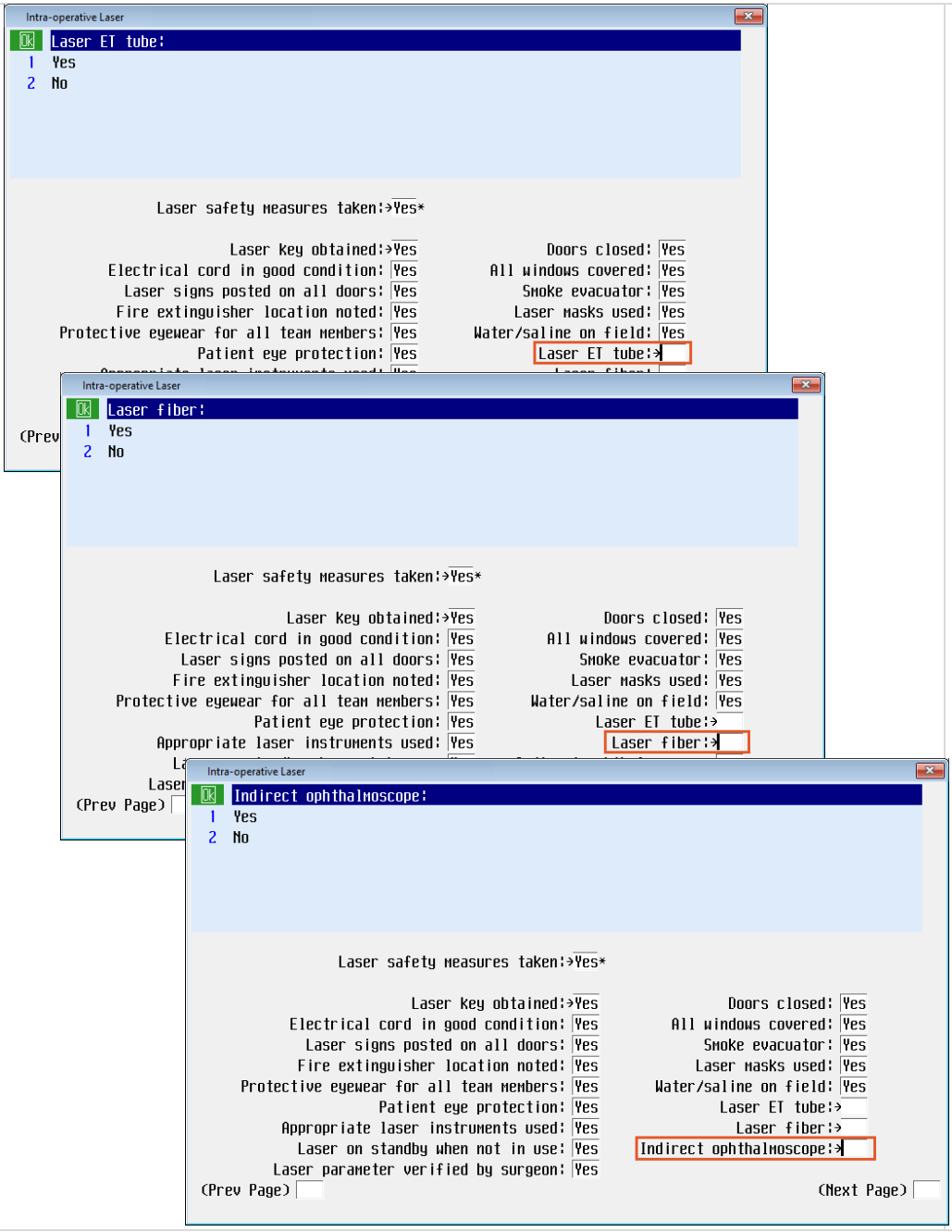
The **Intra-operative Laser** assessment has been updated to support accurate capture of laser settings and reduce the likelihood of adverse patient safety events.



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

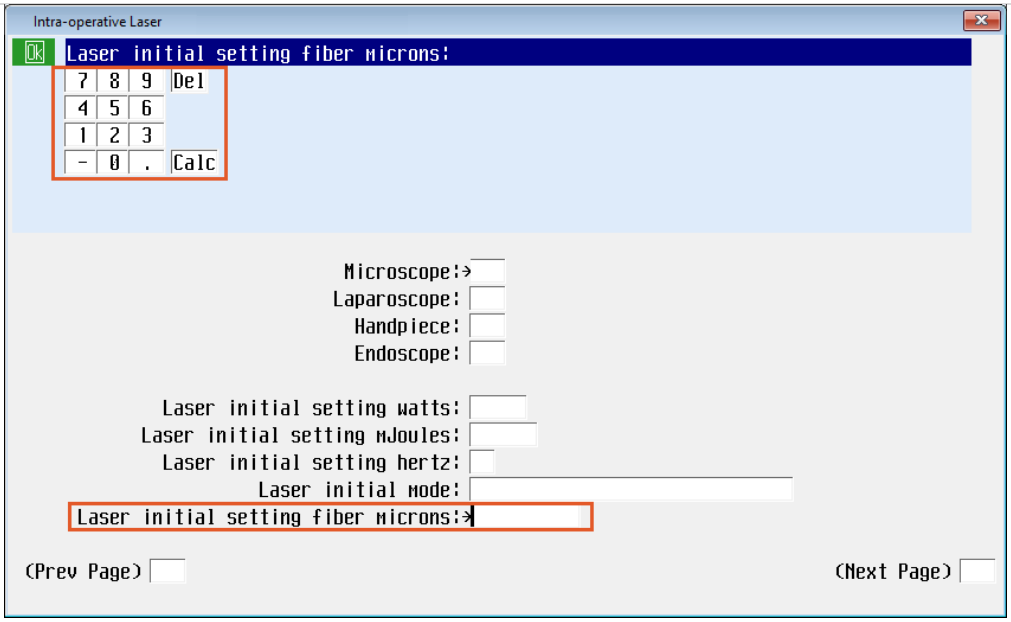


The fields shown default to “Yes” but are editable.

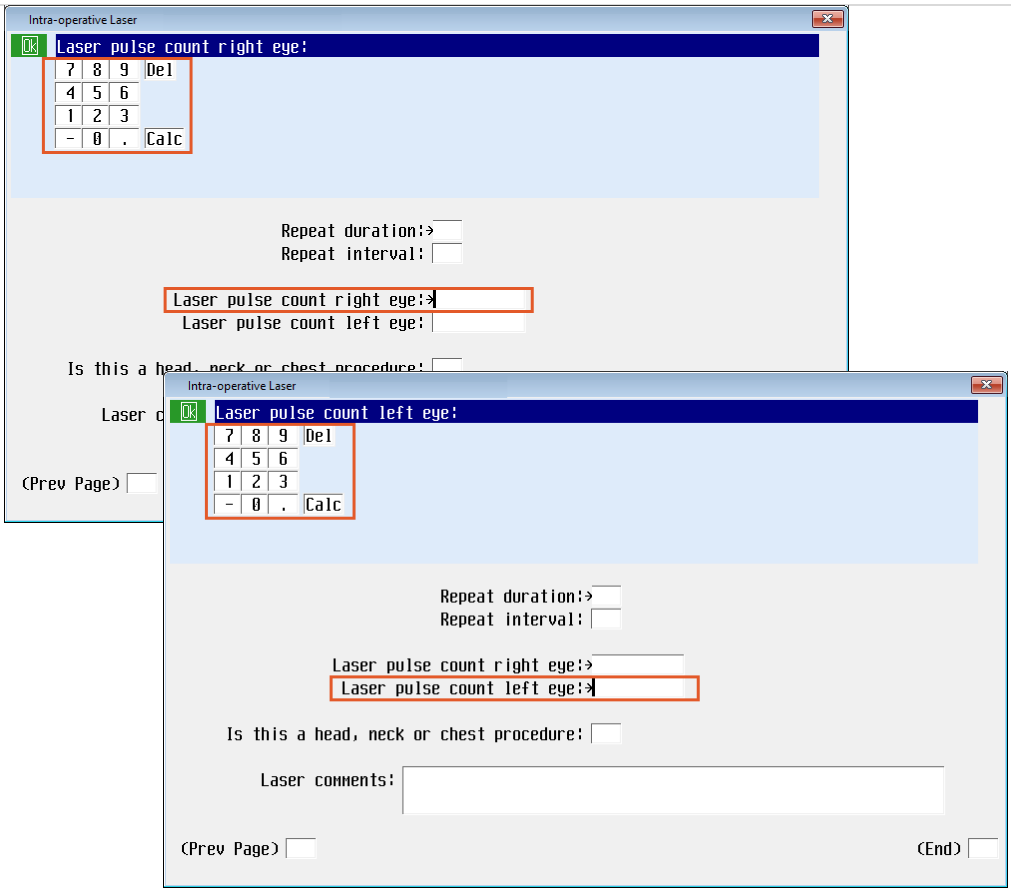


The following fields do not default with a response:

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



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



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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