# EBCD MEDITECH Content Updates – 2025.2 NUR Module

#### **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 <a href="EHR Maintenance Release Section">EHR Maintenance Release Section</a> of the <a href="EHR Optimization SharePoint">EHR Optimization SharePoint</a>.

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 | Women's and Children's |
|-----------------------|---------------------|------------------------|
|                       | - Ti-               |                        |
| 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.

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# **Summary of Revisions**

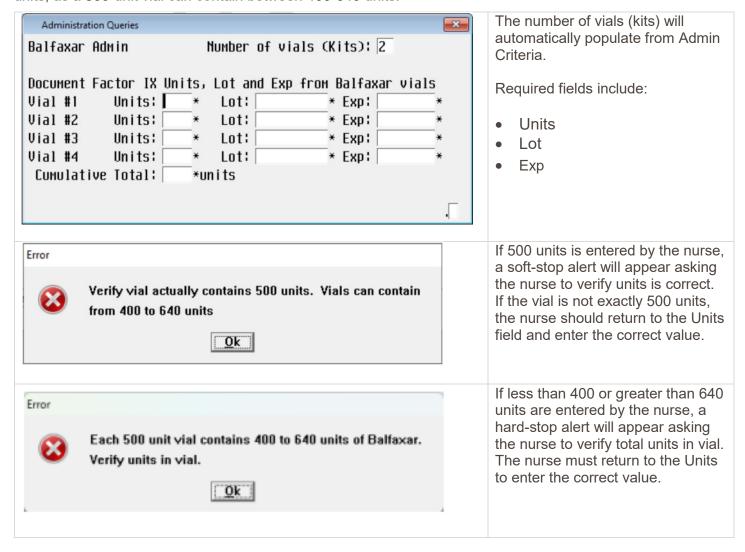
| Date | Revision |
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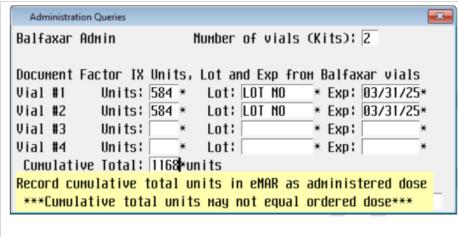
# **eMAR Updates**

## eMAR Admin of Nurse Compounded Balfaxar



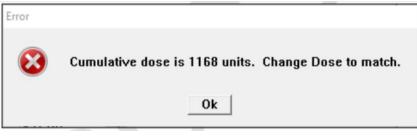
Current documentation does not prompt nurses to review incorrect number of units entered for Balfaxar, which can lead to incorrect dosage documentation within the medical record. Future documentation for Balfaxar orders will include a pop-up to the nurse if the field units entered for a vial are less than 400 or more than 640 units, as a 500-unit vial can contain between 400-640 units.





The message to record total units in eMAR will display at the end of the screen. The nurse will document the Cumulative Total units from the MAR Admin CDS as the dose.

If the documentation does not match the cumulative total, then the MAR Dose rule displays a hard-stop alert which contains the Cumulative Total dose on the screen.



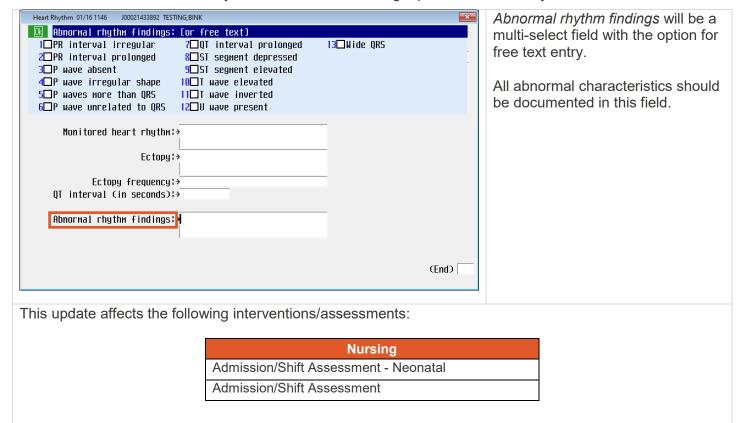
The nurse should acknowledge the pop-up and update the dose to match the Cumulative Total. There will not be a hard-stop alert if documenting as "Not-Given."

# **Nursing Modules**

### **Cardiac Assessment**



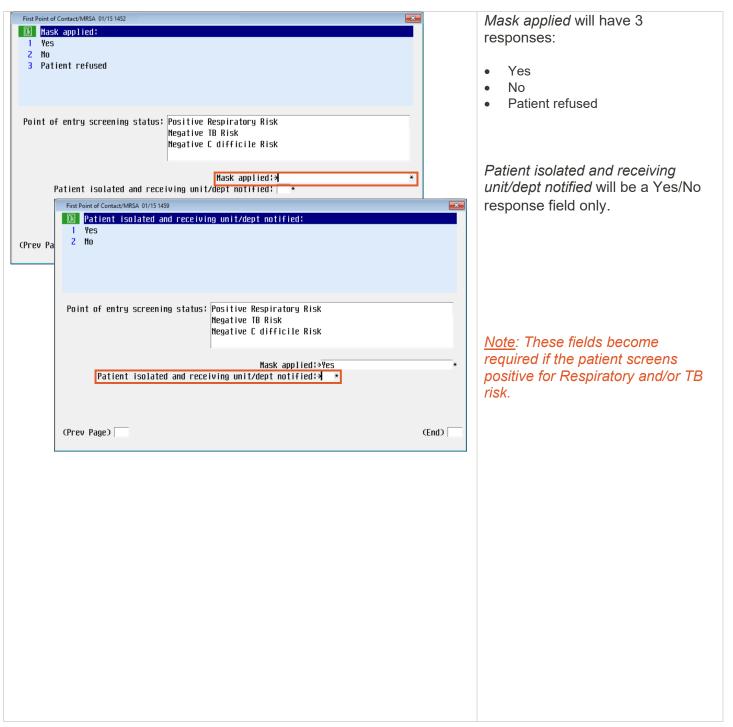
An abnormal rhythm findings field has been added to the Cardiac Assessment to allow for documentation of abnormal characteristics that may be found when assessing a patient's cardiac rhythm.

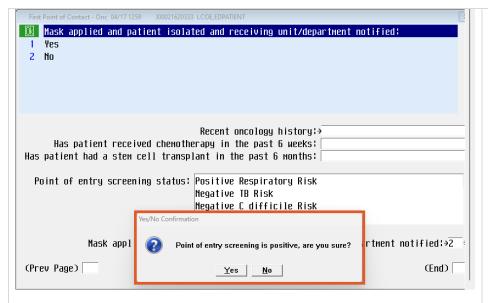


#### **First Point of Contact**



The existing documentation within the First Point of Contact does not address scenarios where patients refuse to wear masks or whether patients are isolated and the receiving unit/department is notified. This gap in documentation can lead to inconsistencies in patient management and communication between departments. The new updates will introduce additional fields at the end of the screening process to account for these circumstances.





<u>Note</u>: The soft stop alert has been removed, as new documentation allows for the patient to refuse to be masked.

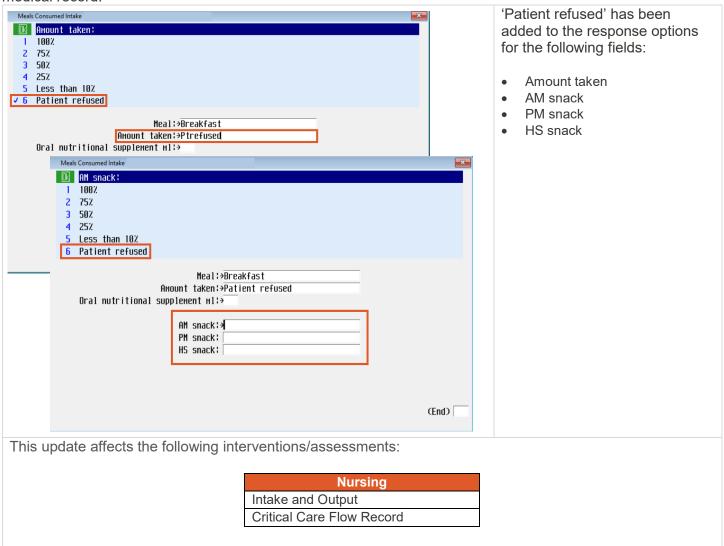
This update affects the following interventions/assessments:

Nursing
First Point of Contact/MRSA/TB/R

#### **Meals Consumed Intake**



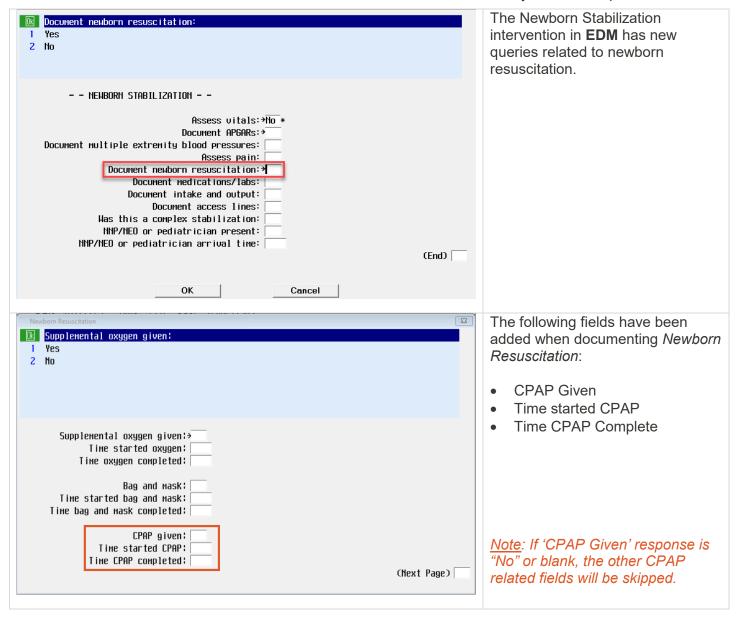
Currently, clinicians cannot document when a patient refuses a meal or snack as part of **Intake and Output**. To address this issue, "Patient refused" has been added as a new option, facilitating instances when a patient refuses a meal or snack offered. Information regarding patients who are NPO can be found elsewhere in the medical record.

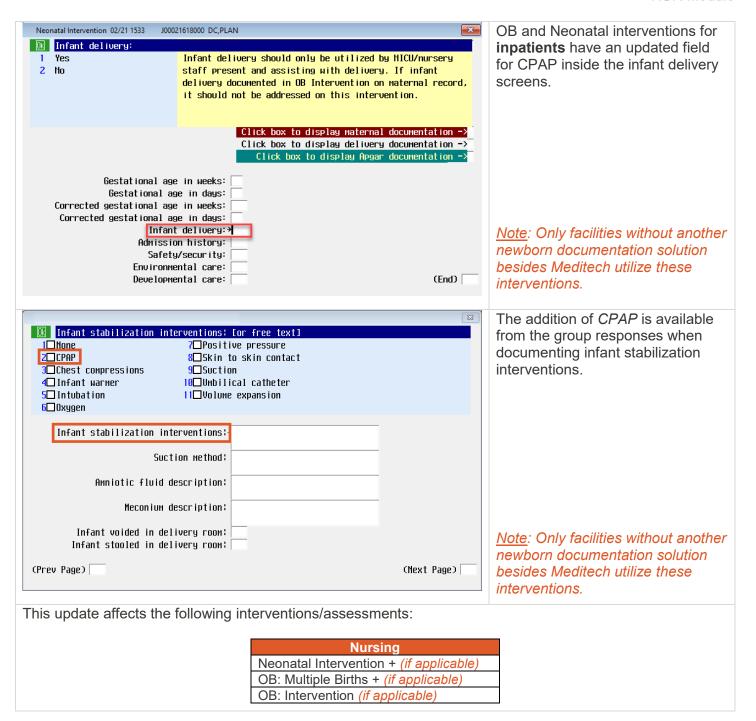


#### **Newborn Resuscitation Efforts**



Current documentation for newborns does not allow for nurses to enter CPAP within resuscitation or stabilization efforts. Fields have now been added to include CPAP to accurately reflect care provided.

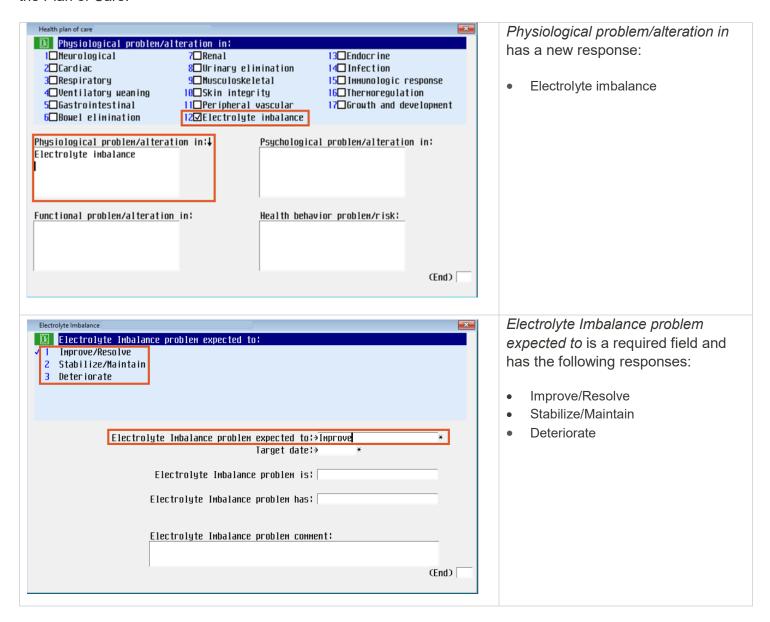


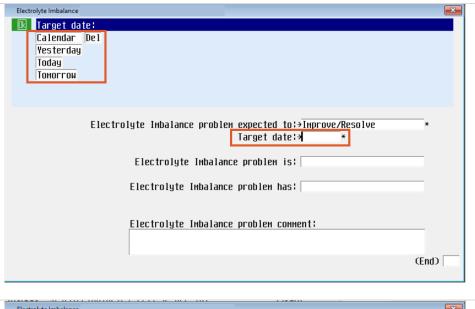


## Plan of Care Update: Electrolyte Imbalance

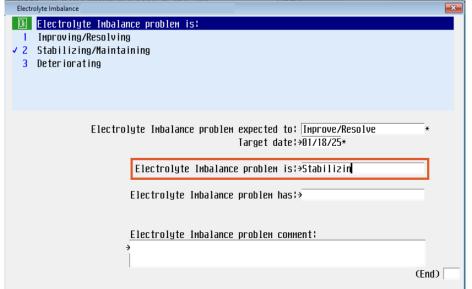


The nursing Plan of Care previously did not have a Clinical Care Classification (CCC) nursing diagnosis for patients with an electrolyte imbalance. Electrolyte Imbalance has now been included as a nursing diagnosis in the Plan of Care.



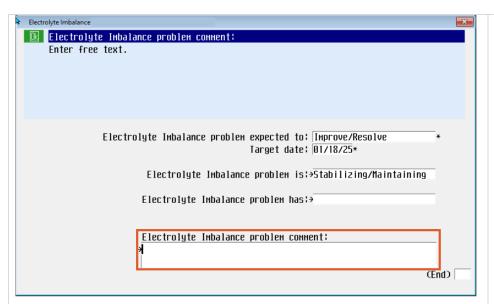


The *Target date* is required, and the calendar or keypad function will be utilized.

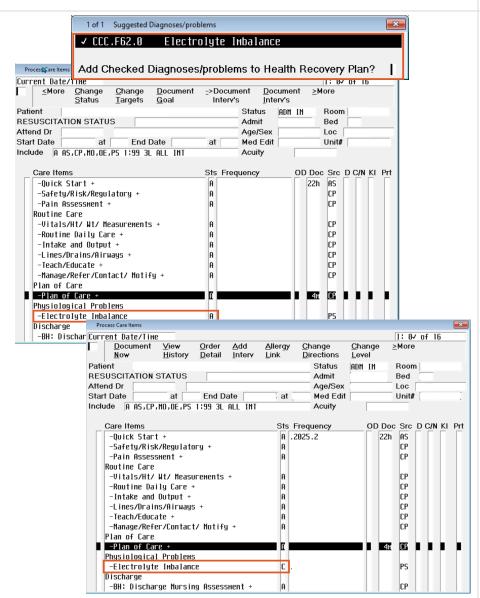


Electrolyte imbalance problem is is a required field with the following responses:

- Improving/Resolving
- Stabilizing/Maintaining
- Deteriorating



The *Electrolyte Imbalance problem comment* field is free text enabled.



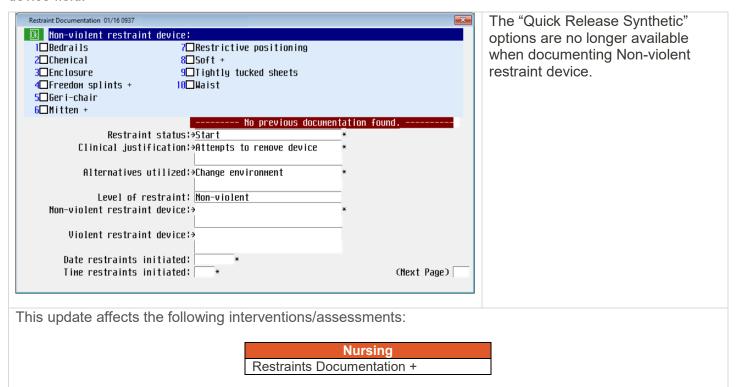
If the Electrolyte Imbalance problem is is answered with 'Stabilizing/Maintain' or 'Deteriorating', the nursing diagnosis of Electrolyte Imbalance will be added to the Plan of Care and automatically appear active in the Care Items.

If the *Electrolyte Imbalance problem is* is answered with 'Improving/Resolving', the status in the care items will automatically change from Active to Complete.

#### **Restraint Documentation**



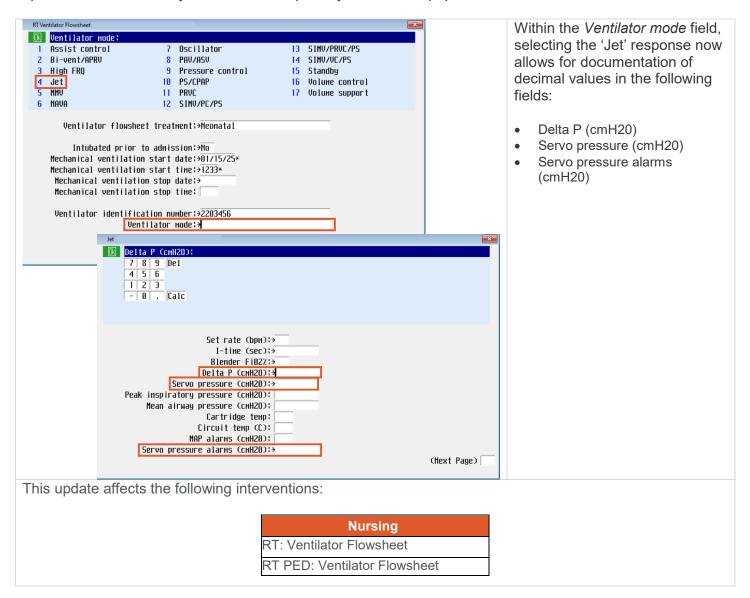
Current documentation allows for the selection of "Quick Release Synthetic" options when non-violent restraints have been ordered. Quick release synthetic restraints should be reserved for violent restraint use only. Future documentation will remove all "Quick Release Synthetic" options from the Non-violent restraint device field.



#### **RT Ventilator Flowsheet**



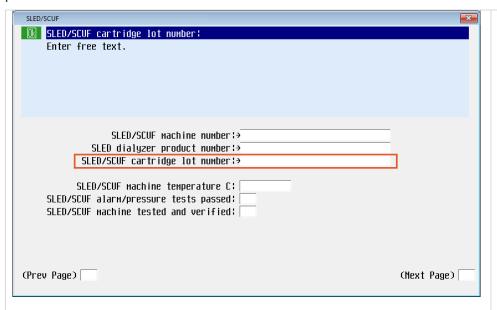
The Servo Pressure, Servo Pressure Alarms and Delta P fields have been updated to allow for accurate capture of these values by the end user; especially in the NICU population.



# **SLED/SCUF Update**



To improve consistency of documentation of the lot number, 'lot' has been added to the SLED/SCUF cartridge number field. The lot number is unique to the cartridge and should be documented for reference in case of problems or errors.

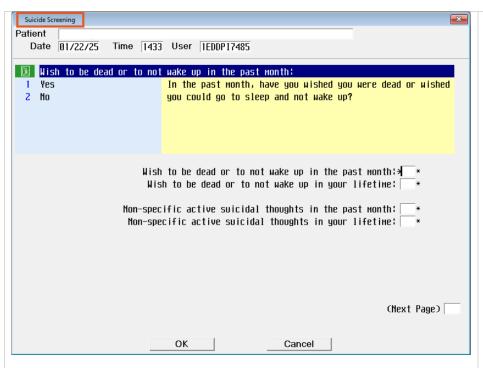


SLED/SCUF cartridge number has been updated to SLED/SCUF cartridge lot number.

## **Suicide Screening**



The naming convention of the Suicide Assessment intervention is inaccurate as the C-SSRS is not an assessment but a screening tool to evaluate the patient's suicide risk level. In the future state, all interventions that have Suicide Assessment within the name will be changed to Suicide Screening.



Suicide Screening will be the new verbiage used for required documentation and BH related screenings.

This update affects the following interventions/assessments:

| Nursing                          |
|----------------------------------|
| Suicide Screening +              |
| Suicide Rescreening +            |
| BH: Initial Nurse Assessment +   |
| BH: Level of Care Assessment +   |
| BH: Psychosocial Assessment      |
| (PSA)+                           |
| BH: RN Reassessment +            |
| BH: Suicide/Homicide Screening + |
| BH: Outpatient Initial Nurse     |
| Assessment +                     |
| Safety/Risk/Regulatory +         |

## Teach/Educate - Durable LVAD Teaching



To meet The Joint Commission requirements, durable LVAD specific topics have been added to the Teach/Educate screens to allow nurses to address specific teaching needs for LVAD patients.

