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 EHR Maintenance Release Section of the EHR Optimization SharePoint.

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
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.

Summary of Revisions

Date	Revision

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.

Administration Queries [x] Balfaxar Admin Number of vials (Kits): 2 Document Factor IX Units, Lot and Exp from Balfaxar vials Vial #1 Units: [ ] * Lot: [ ] * Exp: [ ] * Vial #2 Units: [ ] * Lot: [ ] * Exp: [ ] * Vial #3 Units: [ ] * Lot: [ ] * Exp: [ ] * Vial #4 Units: [ ] * Lot: [ ] * Exp: [ ] * Cumulative Total: [ ] *units	The number of vials (kits) will automatically populate from Admin Criteria. Required fields include: • Units • Lot • Exp
Error ❌ Verify vial actually contains 500 units. Vials can contain from 400 to 640 units [Ok]	If 500 units is entered by the nurse, a soft-stop alert will appear asking the nurse to verify units is correct. If the vial is not exactly 500 units, the nurse should return to the Units field and enter the correct value.
Error ❌ Each 500 unit vial contains 400 to 640 units of Balfaxar. Verify units in vial. [Ok]	If less than 400 or greater than 640 units are entered by the nurse, a hard-stop alert will appear asking the nurse to verify total units in vial. The nurse must return to the Units to enter the correct value.

Administration Queries ☒ Balfaxar Admin Number of vials (Kits): 2 Document Factor IX Units, Lot and Exp from Balfaxar vials Vial #1 Units: 584 * Lot: LOT NO * Exp: 03/31/25* Vial #2 Units: 584 * Lot: LOT NO * Exp: 03/31/25* Vial #3 Units: * Lot: * Exp: * Vial #4 Units: * Lot: * Exp: * Cumulative Total: 1168 units Record cumulative total units in eMAR as administered dose ***Cumulative total units may not equal ordered dose***	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.
Error ❌ Cumulative dose is 1168 units. Change Dose to match. Ok	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.

Abnormal rhythm findings will be a multi-select field with the option for free text entry.

All abnormal characteristics should be documented in this field.

This update affects the following interventions/assessments:

Nursing
Admission/Shift Assessment - Neonatal
Admission/Shift Assessment

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.

Mask applied will have 3 responses:

- Yes
- No
- Patient refused

Patient isolated and receiving unit/dept notified will be a Yes/No response field only.

Note: These fields become required if the patient screens positive for Respiratory and/or TB risk.

Note: 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.

'Patient refused' has been added to the response options for the following fields:

- Amount taken
- AM snack
- PM snack
- HS snack

This update affects the following interventions/assessments:

Nursing
Intake and Output
Critical Care Flow 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.

	The Newborn Stabilization intervention in **EDM** has new queries related to newborn resuscitation.
	The following fields have been added when documenting *Newborn Resuscitation*: • CPAP Given • Time started CPAP • Time CPAP Complete *Note: If 'CPAP Given' response is "No" or blank, the other CPAP related fields will be skipped.*

OB and Neonatal interventions for **inpatients** have an updated field for CPAP inside the infant delivery screens.

Note: Only facilities without another newborn documentation solution besides Meditech utilize these interventions.

The addition of *CPAP* is available from the group responses when documenting infant stabilization interventions.

Note: Only facilities without another newborn documentation solution besides Meditech utilize these interventions.

This update affects the following interventions/assessments:

Nursing
Neonatal Intervention + *(if applicable)*
OB: Multiple Births + *(if applicable)*
OB: Intervention *(if applicable)*

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.

Physiological problem/alteration in has a new response:

- Electrolyte imbalance

Electrolyte Imbalance problem expected to is a required field and has the following responses:

- Improve/Resolve
- Stabilize/Maintain
- Deteriorate

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.

Restraint Documentation 01/16 0937 **Ok** Non-violent restraint device: 1☐Bedrails 7☐Restrictive positioning 2☐Chemical 8☐Soft + 3☐Enclosure 9☐Tightly tucked sheets 4☐Freedom splints + 10☐Waist 5☐Geri-chair 6☐Mitten + ---------- No previous documentation found. ---------- Restraint status:→Start * Clinical justification:→Attempts to remove device * Alternatives utilized:→Change environment * Level of restraint: Non-violent Non-violent restraint device:→ * Violent restraint device:→ Date restraints initiated: * Time restraints initiated: * (Next Page)	The "Quick Release Synthetic" options are no longer available when documenting Non-violent restraint device.

This update affects the following interventions/assessments:

Nursing
Restraints Documentation +

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.

Within the *Ventilator mode* field, selecting the 'Jet' response now allows for documentation of decimal values in the following fields:

- Delta P (cmH20)
- Servo pressure (cmH20)
- Servo pressure alarms (cmH20)

This update affects the following interventions:

Nursing
RT: Ventilator Flowsheet
RT PED: Ventilator Flowsheet

NUR Module

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.

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SLED/SCUF

Ok SLED/SCUF cartridge lot number:
    Enter free text.

            SLED/SCUF machine number:→
          SLED dialyzer product number:→
         SLED/SCUF cartridge lot number:→

        SLED/SCUF machine temperature C:
    SLED/SCUF alarm/pressure tests passed:
    SLED/SCUF machine tested and verified:

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</td>
<td>

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

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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.

Under *Physiological topics,* a new topic was added to the 'Cardiac' options:

- Durable LVAD

Under *Physiological topics needing follow-up,* a new topic was added to the 'Cardiac' options:

- Durable LVAD

Durable LVAD Teaching

[Ok] Durable LVAD topics: [or free text]
1□Apply/wear sterile gloves 7□Use of backup bag
2□Controller self-test   8□Use of consolidated bag
3□Daily dressing change   9□Wearing LVAD
4□Multi-day dressing change
5□Power connections
6□Securing the controller

Durable LVAD topics:»

(End) ▯

Durable LVAD topics is a new, multi-select field with the following responses:

- Apply/wear sterile gloves
- Controller self-test
- Daily dressing change
- Multi-day dressing change
- Power connection
- Securing the controller
- Use of backup bag
- Use of consolidated bag
- Wearing LVAD
- Or Free text

This update affects the following assessments/interventions:

Nursing
Teach/Educate