

EBCD MEDITECH Content Updates – 2025.2

BH Module

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

Patient

Date 01/22/25 Time 1433 User TEDDPI7485

1 Wish to be dead or to not wake up in the past month:

1 Yes

2 No

In the past month, have you wished you were dead or wished you could go to sleep and not wake up?

Wish to be dead or to not wake up in the past month: ☐ *

Wish to be dead or to not wake up in your lifetime: ☐ *

Non-specific active suicidal thoughts in the past month: ☐ *

Non-specific active suicidal thoughts in your lifetime: ☐ *

(Next Page) ☐

OK

Cancel

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

This update affects the following interventions/assessments:

Nursing
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 +

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.

The first screenshot shows the 'Mask applied:' dropdown menu with options: 1 Yes, 2 No, 3 Patient refused. Below it, the 'Point of entry screening status' is listed as Positive Respiratory Risk, Negative TB Risk, and Negative C difficile Risk. The 'Mask applied:' field is highlighted with a red box, showing a selection of '2'.

The second screenshot shows the 'Patient isolated and receiving unit/dept notified:' dropdown menu with options: 1 Yes, 2 No. Below it, the 'Point of entry screening status' is listed as Positive Respiratory Risk, Negative TB Risk, and Negative C difficile Risk. The 'Patient isolated and receiving unit/dept notified:' field is highlighted with a red box, showing a selection of '1'.

The third screenshot shows the 'Mask applied and patient isolated and receiving unit/department notified:' dropdown menu with options: 1 Yes, 2 No. Below it, the 'Point of entry screening status' is listed as Positive Respiratory Risk, Negative TB Risk, and Negative C difficile Risk. The 'Mask applied and patient isolated and receiving unit/department notified:' field is highlighted with a red box, showing a selection of '1'.

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

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.

Meals Consumed Intake

Amount taken:

- 1 100%
- 2 75%
- 3 50%
- 4 25%
- 5 Less than 10%
- 6 Patient refused

Meal: Breakfast

Amount taken: Patient refused

Oral nutritional supplement ml:

Meals Consumed Intake

AM snack:

- 1 100%
- 2 75%
- 3 50%
- 4 25%
- 5 Less than 10%
- 6 Patient refused

Meal: Breakfast

Amount taken: Patient refused

Oral nutritional supplement ml:

AM snack:

PM snack:

HS snack:

(End)

‘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

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.

Health plan of care

Physiological problem/alteration in:

1 <input type="checkbox"/> Neurological	7 <input type="checkbox"/> Renal	13 <input type="checkbox"/> Endocrine
2 <input type="checkbox"/> Cardiac	8 <input type="checkbox"/> Urinary elimination	14 <input type="checkbox"/> Infection
3 <input type="checkbox"/> Respiratory	9 <input type="checkbox"/> Musculoskeletal	15 <input type="checkbox"/> Immunologic response
4 <input type="checkbox"/> Ventilatory weaning	10 <input type="checkbox"/> Skin integrity	16 <input type="checkbox"/> Thermoregulation
5 <input type="checkbox"/> Gastrointestinal	11 <input type="checkbox"/> Peripheral vascular	17 <input type="checkbox"/> Growth and development
6 <input type="checkbox"/> Bowel elimination	12 <input checked="" type="checkbox"/> Electrolyte imbalance	

Physiological problem/alteration in:
Electrolyte imbalance

Psychological problem/alteration in:

Functional problem/alteration in:

Health behavior problem/risk:

(End) ☐

Physiological problem/alteration in has a new response:

- Electrolyte imbalance

Electrolyte Imbalance

Electrolyte Imbalance problem expected to:

1 <input checked="" type="checkbox"/> Improve/Resolve
2 <input type="checkbox"/> Stabilize/Maintain
3 <input type="checkbox"/> Deteriorate

Electrolyte Imbalance problem expected to: Improve *

Target date: *

Electrolyte Imbalance problem is:

Electrolyte Imbalance problem has:

Electrolyte Imbalance problem comment:

(End) ☐

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

- Improve/Resolve
- Stabilize/Maintain
- Deteriorate

The screenshot shows the 'Electrolyte Imbalance' form. At the top, there is a dropdown menu for 'Target date:' with options: Calendar, Del, Yesterday, Today, and Tomorrow. The 'Target date:' field is highlighted with a red box. Below this, the form contains several input fields: 'Electrolyte Imbalance problem expected to: Improve/Resolve *', 'Target date: *' (highlighted with a red box), 'Electrolyte Imbalance problem is:', 'Electrolyte Imbalance problem has:', and 'Electrolyte Imbalance problem comment:'. There is also an '(End)' button at the bottom right.

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

The screenshot shows the 'Electrolyte Imbalance' form. At the top, there is a dropdown menu for 'Electrolyte Imbalance problem is:' with options: 1 Improving/Resolving, 2 Stabilizing/Maintaining (checked), and 3 Deteriorating. The dropdown menu is highlighted with a red box. Below this, the form contains several input fields: 'Electrolyte Imbalance problem expected to: Improve/Resolve *', 'Target date: 01/18/25*', 'Electrolyte Imbalance problem is: Stabilizin' (highlighted with a red box), 'Electrolyte Imbalance problem has:', and 'Electrolyte Imbalance problem comment:'. There is also an '(End)' button at the bottom right.

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

- Improving/Resolving
- Stabilizing/Maintaining
- Deteriorating

Electrolyte Imbalance

Electrolyte Imbalance problem comment:
Enter free text.

Electrolyte Imbalance problem expected to: *

Target date:

Electrolyte Imbalance problem is:

Electrolyte Imbalance problem has:

Electrolyte Imbalance problem comment:

(End)

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

1 of 1 Suggested Diagnoses/problems

✓ CCC.F62.0 Electrolyte Imbalance

Add Checked Diagnoses/problems to Health Recovery Plan?

Current Date/Time: 1/18/25 10:16 AM

Process Care Items

Patient: RESUSCITATION STATUS: Status: ADM IN Room:

Attend Dr: Age/Sex: Loc:

Start Date: at End Date: at Med Edit: Unit#:

Include: A AS,CP,MO,OE,PS 1:99 3L ALL INT Acuity:

Care Items	Sts	Frequency	OD	Doc	Src	D	C/N	KI	Prt
-Quick Start +	A		22h	AS					
-Safety/Risk/Regulatory +	A			CP					
-Pain Assessment +	A			CP					
Routine Care									
-Vitals/HT/ Wt/ Measurements +	A			CP					
-Routine Daily Care +	A			CP					
-Intake and Output +	A			CP					
-Lines/Drains/Airways +	A			CP					
-Teach/Educate +	A			CP					
-Manage/Refer/Contact/ Notify +	A			CP					
Plan of Care									
-Plan of Care +	A		4h	CP					
Physiological Problems									
-Electrolyte Imbalance	A			PS					
Discharge									
-BH: Discharge Nursing Assessment +	A			CP					

Current Date/Time: 1/18/25 10:16 AM

Process Care Items

Patient: RESUSCITATION STATUS: Status: ADM IN Room:

Attend Dr: Age/Sex: Loc:

Start Date: at End Date: at Med Edit: Unit#:

Include: A AS,CP,MO,OE,PS 1:99 3L ALL INT Acuity:

Care Items	Sts	Frequency	OD	Doc	Src	D	C/N	KI	Prt
-Quick Start +	A	.2025.2	22h	AS					
-Safety/Risk/Regulatory +	A			CP					
-Pain Assessment +	A			CP					
Routine Care									
-Vitals/HT/ Wt/ Measurements +	A			CP					
-Routine Daily Care +	A			CP					
-Intake and Output +	A			CP					
-Lines/Drains/Airways +	A			CP					
-Teach/Educate +	A			CP					
-Manage/Refer/Contact/ Notify +	A			CP					
Plan of Care									
-Plan of Care +	A		4h	CP					
Physiological Problems									
-Electrolyte Imbalance	C			PS					
Discharge									
-BH: Discharge Nursing Assessment +	A			CP					

If the *Electrolyte Imbalance* problem 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 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

Non-violent restraint device:

- 1 ☐ Bedrails
- 2 ☐ Chemical
- 3 ☐ Enclosure
- 4 ☐ Freedom splints +
- 5 ☐ Geri-chair
- 6 ☐ Mitten +
- 7 ☐ Restrictive positioning
- 8 ☐ Soft +
- 9 ☐ Tightly tucked sheets
- 10 ☐ Waist

----- 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/assessment:

Nursing
Restraints Documentation +