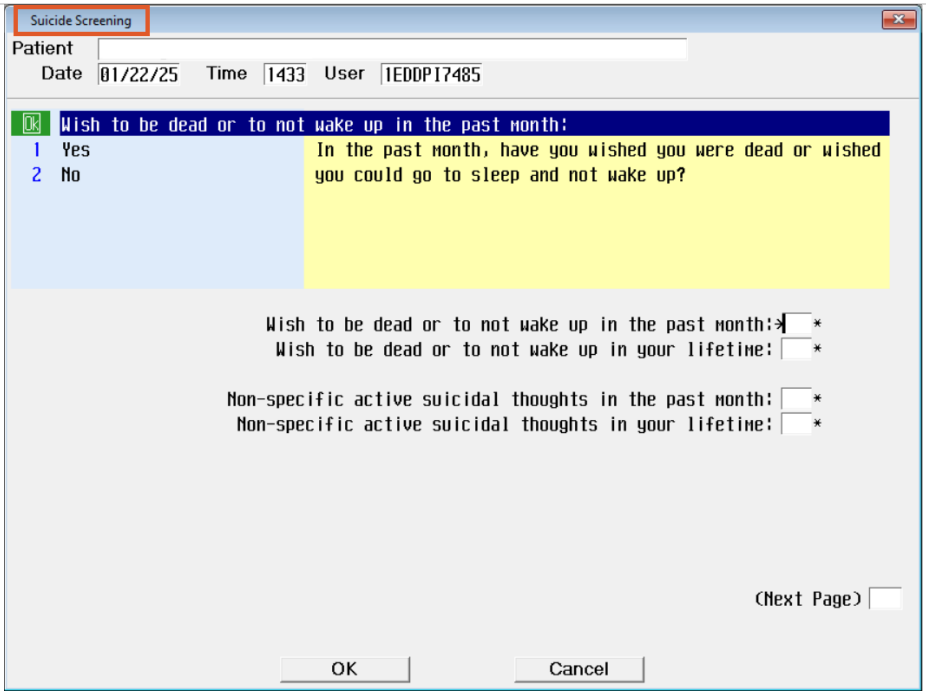
EBCD MEDITECH Content Updates – 2025.2
BH Module

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

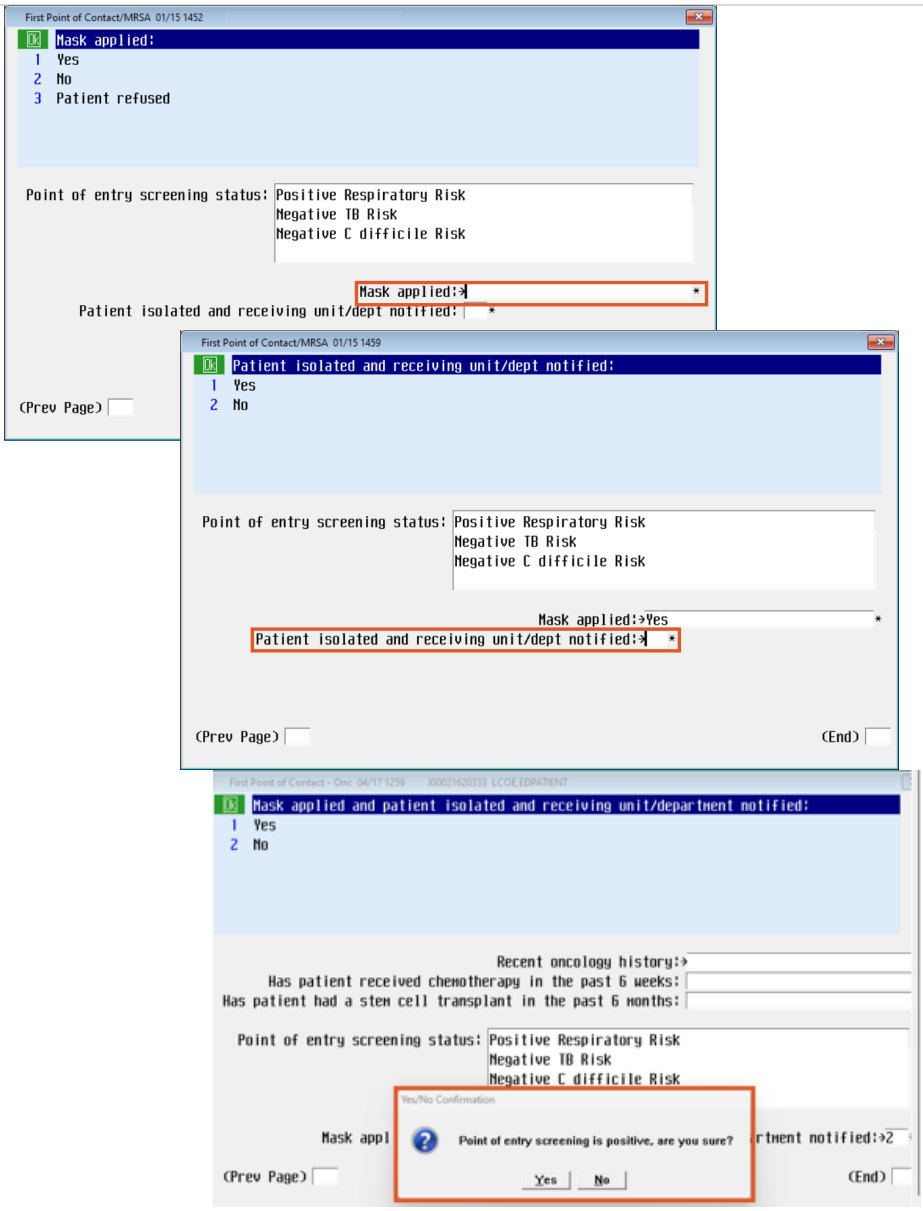
This update affects the following interventions/assessments:

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 +

Updated 03/31/2025

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.

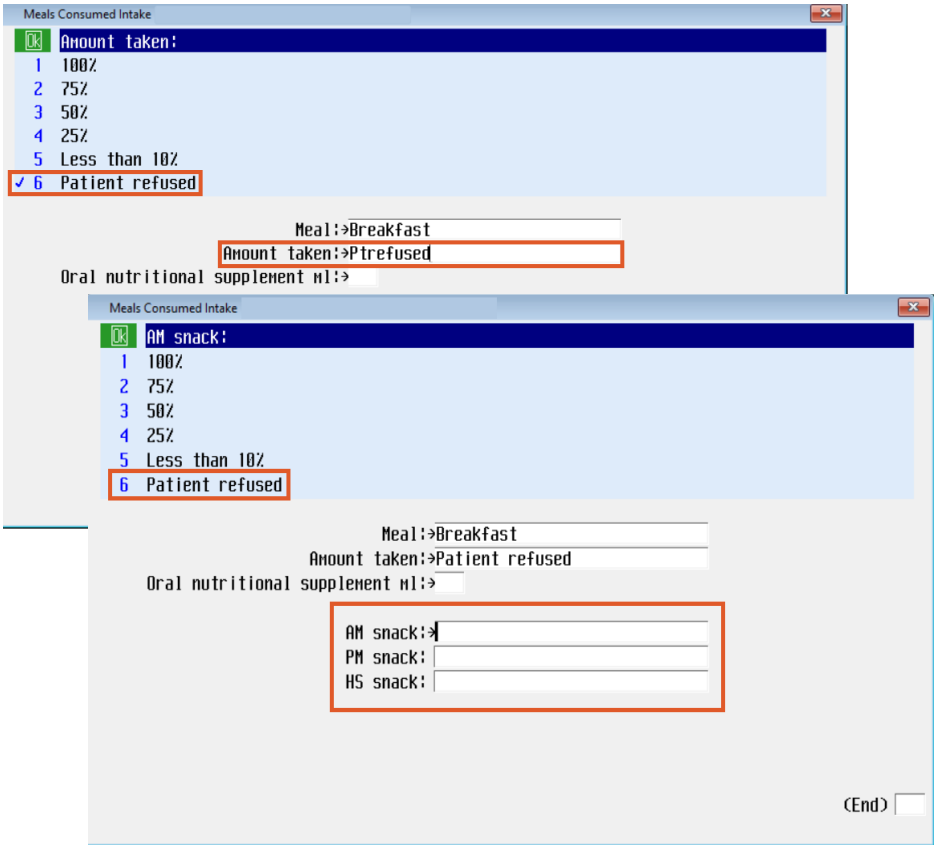
Note: The soft stop alert has been removed, as new documentation allows for the patient to refuse to be masked.

This update affects the following interventions/assessments:

Nursing
First Point of Contact/MRSA

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:

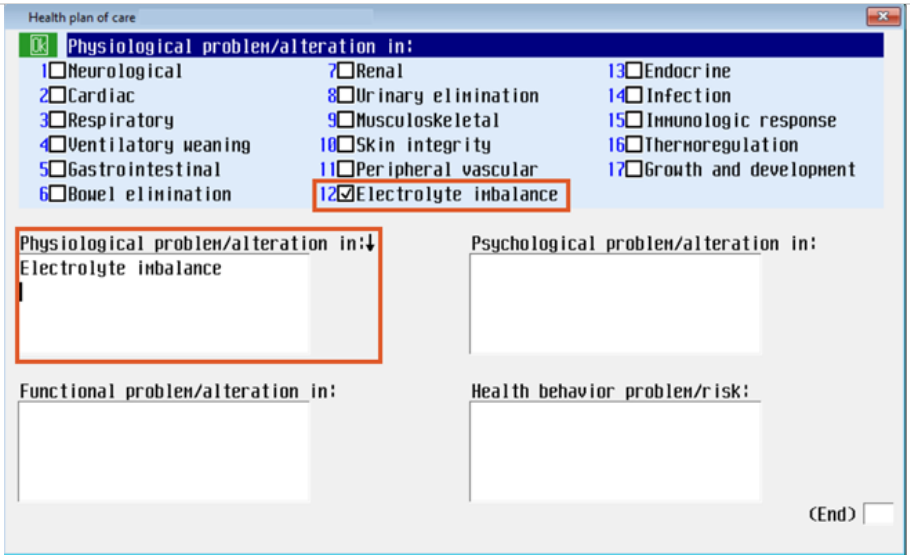
- Amount taken
- AM snack
- PM snack
- HS snack

This update affects the following interventions/assessments:

Nursing
Intake and Output

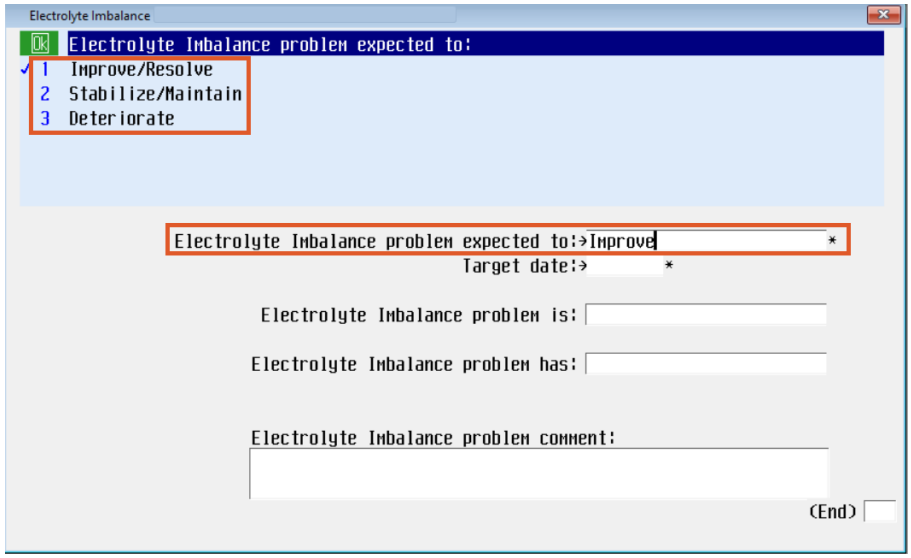
Plan of Care Update: Electrolyte Imbalance

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.



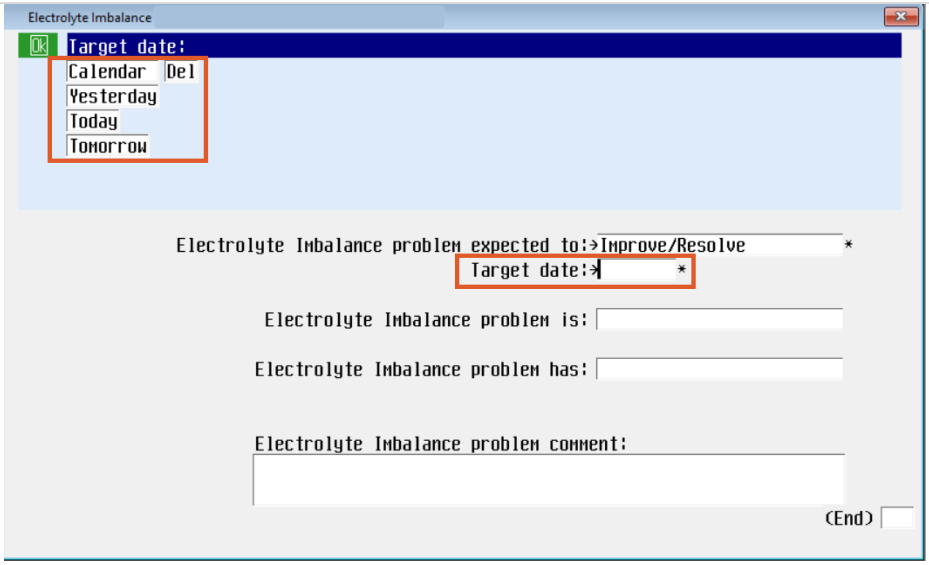
Physiological problem/alteration in has a new response:

- Electrolyte imbalance

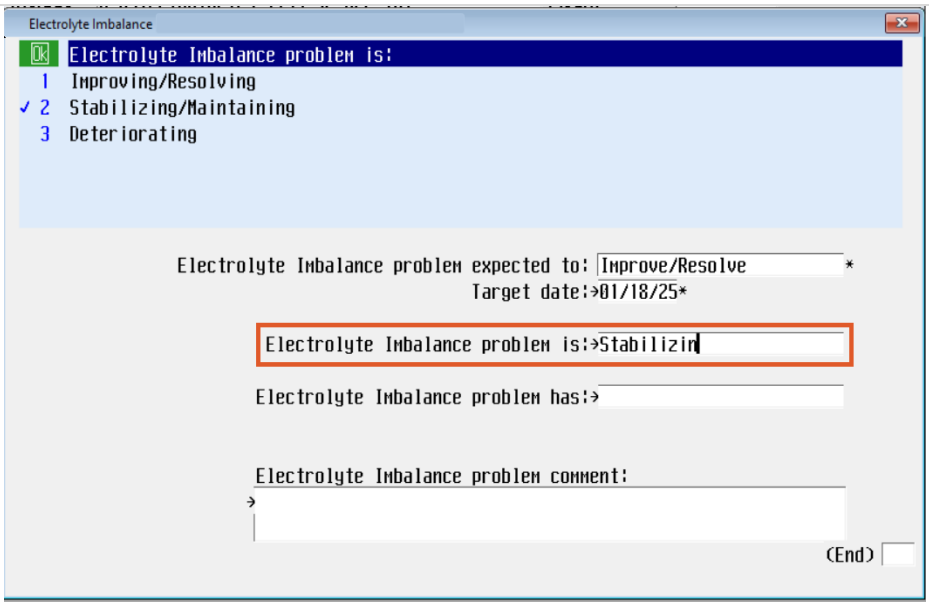


Electrolyte Imbalance problem expected to is a required field and has the following responses:

- Improve/Resolve
- Stabilize/Maintain
- Deteriorate

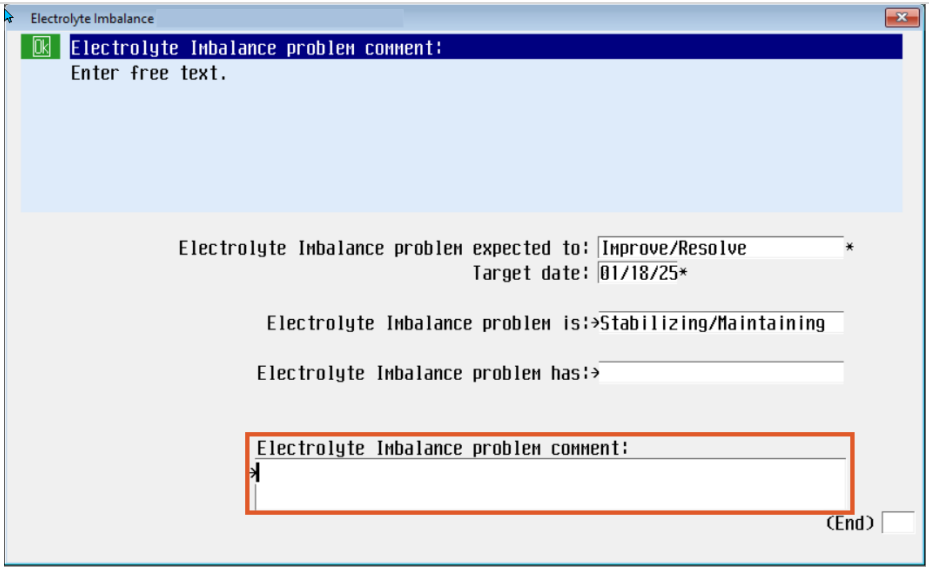


The *Target date* is required, and the calendar or keypad function will be utilized.

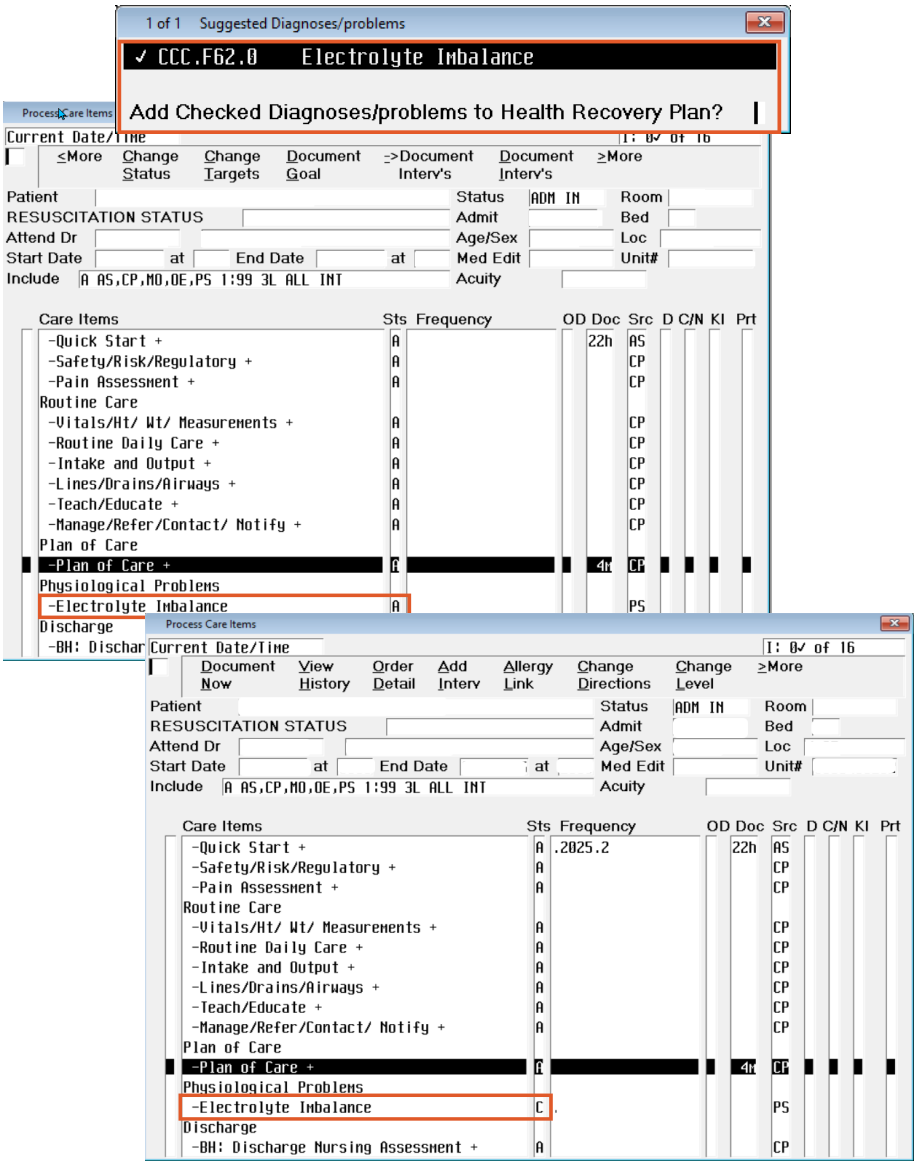


Electrolyte imbalance problem is is a required field with the following responses:

- Improving/Resolving
- Stabilizing/Maintaining
- Deteriorating



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

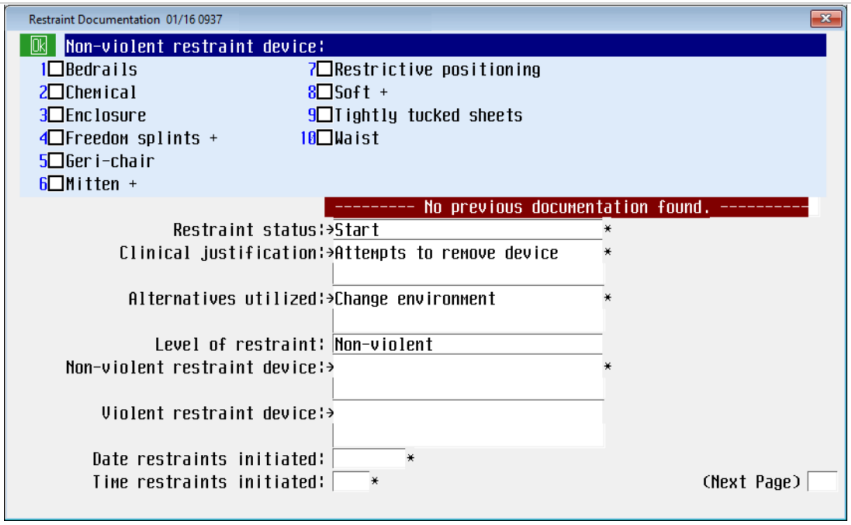


If the *Electrolyte Imbalance problem is* is answered with ‘Stabilizing/Maintain’ or ‘Deteriorating’, the nursing diagnosis *of Electrolyte Imbalance* will be added to the Plan of Care and automatically appear active in the Care Items.

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.



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 +