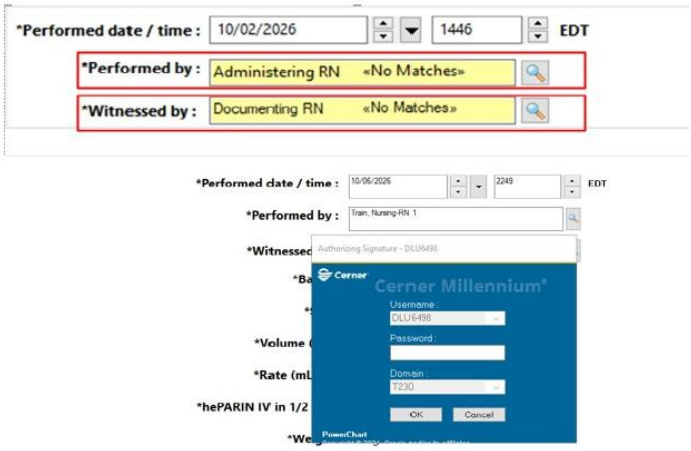
Clinical Reminders

GO LIVE
NOV 5

Independent Double Check Documentation

- Additional medications will be added to the High Alert Medication Independent Double Check (IDC) documentation requirements.
- ***In addition to* the current IDC requirements, medications that will prompt a co-sign in the MAR will now include:**
  - IV insulin
  - IV opioid infusions
  - Neuromuscular blocking agents
  - Hypertonic solutions (>0.9% NaCl)
  - IV push sedative agents (Ketamine, Phenobarbital)
  - Argatroban
  - TPN
  - Population Specific Requirements Remain
    - Mannitol (Pediatrics only)
    - Concentrated electrolytes (Potassium Chloride) – Pediatrics and NICU only
    - All controlled substances (NICU only)
    - Antiarrhythmics (NICU only)

Follow required IDC process and obtain a second RN co-sign in the EMR:



Refer to 1MM.MED.0001 "High Alert Medications and Independent Double Check (IDC) – Adults and Pediatrics" policy

Clinical Reminders

GO LIVE
NOV 5

Additional Adult and Pediatric Code Cart Changes

ADULT
- Dopamine Premix - Remove
- D50W Syringe - Add 1 additional syringe

PEDIATRIC
- 4.2% Infant Bicarb - remove from Peds Code Cart Tray
- 8.4% bicarb - Add 1, 50 mEq syringe
- Calcium gluconate - remove from Peds Code Cart Tray
- Calcium chloride - Add 2, 1 gm syringes
- Pediatric Code Sheet - Add
- Dopamine Premix - remove from Peds Code Cart Tray
- D50W Syringe - Add 1 additional syringe

Clinical Reminders

EDUCATION BOOST

Insulin Answers! Rapid Facts

Meal & Correction Insulin

Goal: Insulin given within 30 minutes of CBG and meal tray arrival.





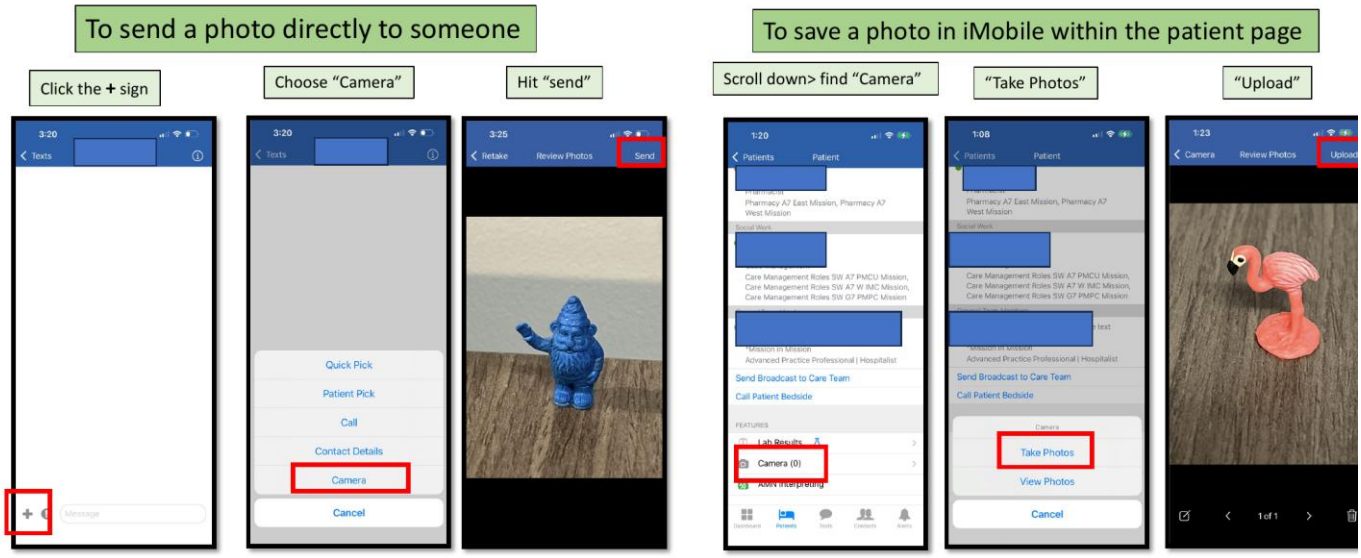
Safety pearls: Do not give MEAL insulin if the tray is delayed or the patient is not eating. Give CORRECTION insulin regardless of NPO. Reassess CBG if the meal is delayed >30 minutes. “HOVER” over MAR orders for rapid-acting insulin dose accuracy.

Clinical Reminders

EDUCATION BOOST
WOUND & SKIN

PIP Tip: Wound Photos

iMobile photo workflow



- **Photos taken within the app DO NOT upload to the EMR**
- **Complex wounds, new pressure injuries, PI stage 3 and above: notify wound team about photos**

Photos taken within the app DO NOT upload to the EMR. For complex wounds, new pressure injuries, and pressure injuries stage 3 and above, notify the wound team about photos.

Clinical Reminders

EDUCATION BOOST
PATIENT SAFETY

Physical Holds | Violent Restraint

Nursing and Security education

What is a physical hold?

A physical hold is hands-on control of a patient's body or movement. When staff manually immobilize or reduce the patient's ability to move freely, it is a manual restraint under CMS rules, regardless of whether nursing or security performs it. Brief contact for support, guidance or a routine procedure is not automatically a restraint; evaluate the actual restriction and circumstances.

When may a restraint hold be used?

- Only when needed for immediate physical safety and less restrictive measures are ineffective or inappropriate; never for convenience, discipline, coercion or retaliation.
- Use the least restrictive safe response, trained personnel, continuous attention to breathing/circulation, and stop as soon as the safety threat resolves.

Operational workflow: from event to order

1 Recognize / call	Identify imminent danger. Activate emergency response; attempt verbal de-escalation and safer alternatives when feasible.
2 Apply / communicate	Trained staff initiate only the minimum necessary hold. Security assists under the clinical team's direction and communicates start/stop times, techniques and safety concerns.
3 Notify / obtain order	RN promptly notifies the authorized physician or licensed independent practitioner (LIP). Obtain a patient-specific restraint order before application when possible; for an emergency application, obtain the order immediately afterward in accordance with hospital policy and applicable rules. No standing or PRN restraint orders.
4 Evaluate / monitor	RN assesses patient and documents behavior, alternatives, clinical justification, monitoring, patient response and release. For violent/self-destructive restraint, ensure the required in-person evaluation within 1 hour by a qualified practitioner per regulation/policy.
5 Release / close out	Discontinue at the earliest safe moment, regardless of order expiration. Record end time, patient reassessment, provider notifications, required incident reporting and team debrief.

Role clarity

- NURSING: clinical assessment; initiate clinical escalation; obtain/verify order; monitoring, reassessment, release decision and clinical documentation. If part of BERT response, enter Vigilanz report > Patient Event > BERT.
- SECURITY: assist only within training and policy; use least restrictive safe contact; immediately report observed distress and exact start/stop times; complete security report as required. Security does not independently prescribe or authorize clinical restraints.
- Document the order's clinical reason, type of restraint and permitted duration according to policy. An order does not justify continued restraint after the danger ends.
- Avoid prone positioning, pressure to the chest/neck/back, or any technique that impairs airway, breathing or circulation; follow approved training and policy.

Clinical Reminders

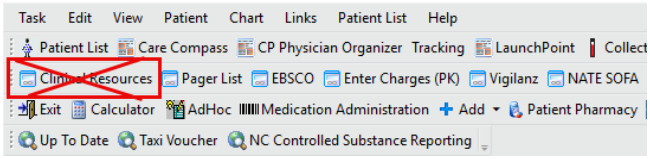
GO LIVE NOV 9

MOD Retirement - Accessing the New Medication Calculator Links

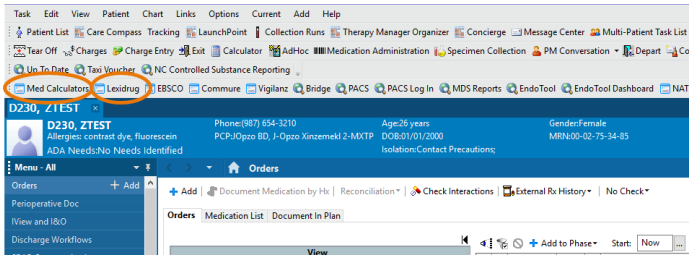
Cerner build update

- MOD is being retired.
- The "Clinical Resources" button in the toolbar is being removed and replaced with links to (1) LexiDrug and (2) the new SharePoint Med Calculator page.
- Users can continue to access Med Dosing Calculators via PowerPlan links and Reference Text links; those links are being updated to point to the new SharePoint med calculator link.

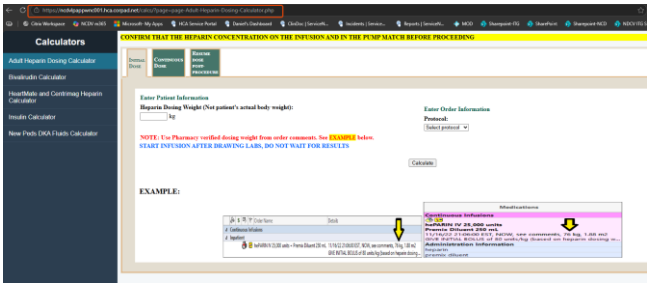
CURRENT STATE - Toolbar



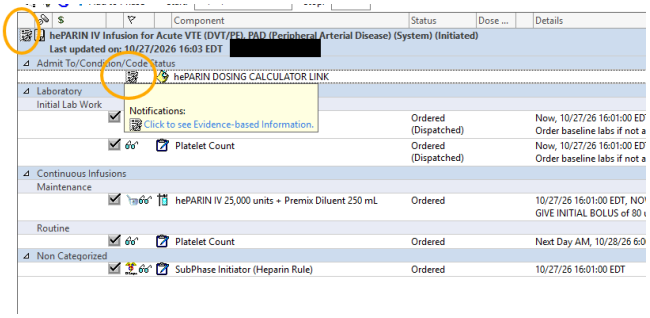
FUTURE STATE - Toolbar



FUTURE STATE - SharePoint Med Calculators



NOT CHANGING - PowerPlan Access



Not changing: PowerPlans and Reference Text continue to be accessed the same way; only the link endpoint is changing.