Clinical Reminders

GO LIVE
SEP 22

Inpatient Influenza Vaccine

Inpatient influenza screening returns to in-season workflow

IT changes go live September 22 for the inpatient influenza vaccine. The nursing influenza screening form will be set to "in season" to allow nursing assessment of vaccine receipt on admission.

Admission screening reminder

1 Open the nursing influenza screening form.	**2** Assess influenza vaccine receipt on admission.	**3** Use the in-season workflow beginning September 22.

Key reminder: At go-live, complete the influenza screening assessment on admission using the in-season nursing workflow.

September 15, 2026

Suicide Risk: Safe Environment Checks & Documentation

Inpatient (Non-Behavioral Health) Units without psychiatric safe rooms

WHO THIS EDUCATION APPLIES TO

Team members caring for patients identified as **low, moderate, or high suicide risk** on inpatient non-BH units. Use the suicide-safe environment interventions appropriate to the patient risk and current plan of care.

WHEN TO REVIEW THE CHECKLIST

- During nursing Bedside Shift Report / each shift
- When there is a change in patient condition
- After a visitor has been in the patient room

TEAM EXPECTATION

- Patient Safety Attendants and Patient Care Techs review the safe environment throughout the shift.
- Risks are reported promptly to the primary nurse.

IVC PATIENT SAFETY ALERT

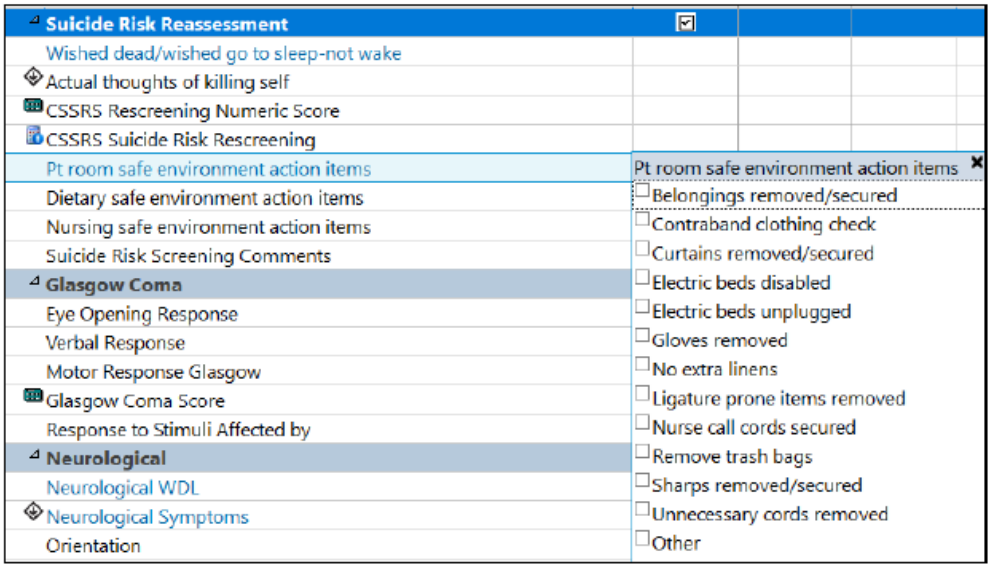
- **IVC order** = one-to-one sitter immediately.
- **Maintain the 1:1 sitter** until the nurse completes the C-SSRS AND the provider completes the Detailed Risk Assessment (DRA) and Overall Risk Level (ORL); then de-escalate per policy.
- **If a sitter is needed,** the nurse must ensure the House Supervisor is notified.
- **The unit must provide continuous coverage** until a Patient Safety Attendant (PSA) is deployed.

DOCUMENTATION

PowerChart > I-View > Assessment band > Suicide Risk Assessment

Document applicable actions in: Pt room safe environment action items • Dietary safe environment action items • Nursing safe environment action items

DOCUMENTATION IN I-VIEW



WHAT TO CHECK

PATIENT ROOM	NURSING	DIETARY
• Belongings removed/secured; contraband clothing check • Ligature-prone items, cords/tubing, extra linen and gloves removed • Call cords, trash bags/containers and sharps secured/removed • Electric bed/equipment safety	• Bed position for safety • Count utensils after meals • Direct line of sight / observation as ordered • Gown with snaps or ligature-free/paper scrubs	• No aluminum cans or knives • Paper plates only • Plastic utensils only • Styrofoam/paper cups only

SAFE ENVIRONMENT CHECKLIST - AT A GLANCE

Use this page as a quick reference for suicide-safe environment actions on inpatient non-behavioral health units.

PATIENT ROOM SAFE ENVIRONMENT

- Belongings removed/secured
- Contraband clothing check
- Electric beds disabled/unplugged
- Gloves removed
- No extra linen
- No ligature-prone items
- Nurse call cords secured/removed or use of breakaway cords
- Remove trash bags/containers
- Sharps removed/secured
- Unnecessary cords/tubing removed

NURSING SAFE ENVIRONMENT

- Bed position for safety
- Count utensils after meal
- Direct line of sight
- Every 15 minute checks, when required
- **IVC patients: one-to-one sitter immediately**
- Safety attendant - physical or virtual, as ordered
- Use a gown with snaps only
- Use paper scrubs or ligature-free/paper scrubs

DIETARY SAFE ENVIRONMENT

- No aluminum cans
- No knives
- Paper plates only
- Plastic utensils only
- Styrofoam/paper cups only

REMEMBER

- Review and document the safe environment during nursing Bedside Shift Report, with a change in patient condition, and after a visitor has been in the room.
- Patient Safety Attendants and Patient Care Techs should review the environment throughout the shift and report risks to the primary nurse promptly.
- Chart applicable actions in I-View > Assessment band > Suicide Risk Assessment.

Clinical Reminders

GO LIVE
SEP 29

CBG Nursing Order: BIDAC Frequency Added

New frequency supports before-breakfast and before-dinner glucose checks

What nurses need to know: Beginning September 29, BIDAC will be available as a Frequency option in the "CBG, Nsg" order. BIDAC directs the RN to check the patient's blood glucose before breakfast and dinner.

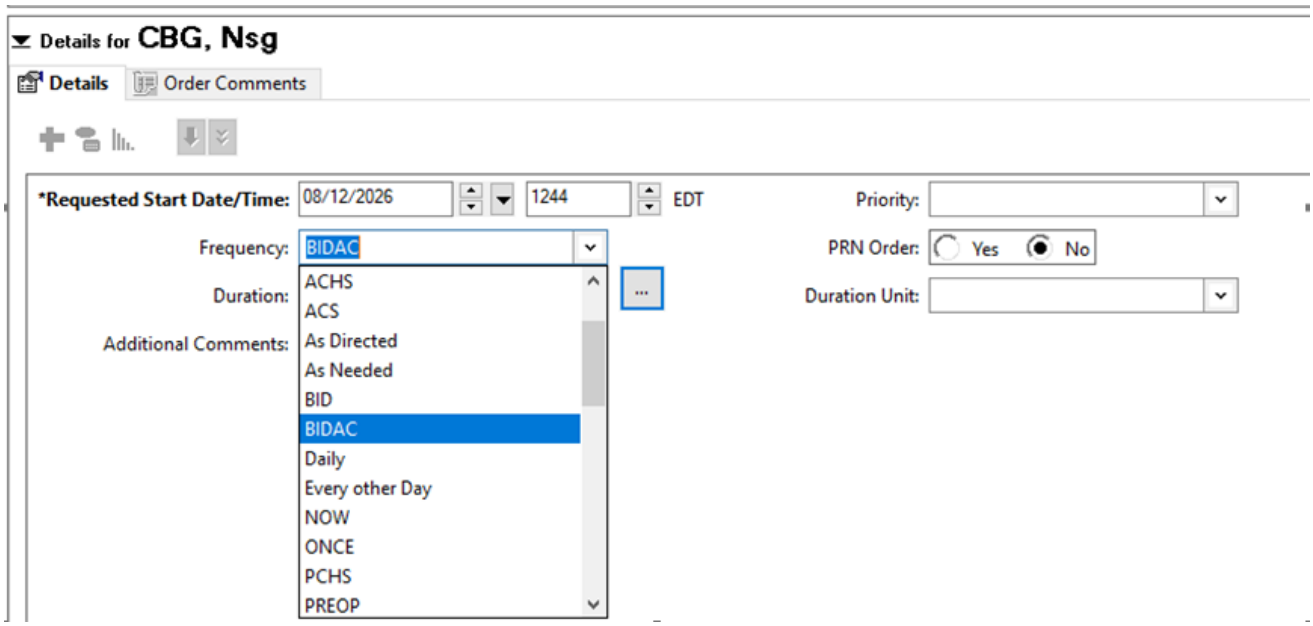
WHAT IS CHANGING
BIDAC is being added to the Nursing Catalog Frequency list for the Procedures/Prep activity type and can be selected in the CBG, Nsg order.

WHAT IS NOT CHANGING
Existing blood-glucose frequency options remain available. This change adds an option; it does not remove or replace current frequencies.

WHO WILL SEE IT
Because CBG, Nsg is a divisionally used order under Procedures/Prep, the BIDAC option will be visible at North Carolina Division facilities.

WHY THIS WAS ADDED
CarePartners uses BIDAC to support glucose monitoring before breakfast and dinner as it transitions from Meditech to Cerner.

Future state in Cerner



Quick check: BIDAC = blood glucose before breakfast and dinner. Follow the frequency selected in the order. CarePartners Cerner go-live is October 14; the BIDAC option becomes available division-wide on September 29.

Clinical Reminders

EDUCATION BOOST
ONGOING

Discharge Education for Patients Discharging to a Facility

Printed discharge instructions and education are required before every discharge

EVERY PATIENT: Provide a printed copy of discharge instructions and education before discharge - whether the patient is going home, to a skilled nursing facility, rehabilitation center, or another post-acute facility.

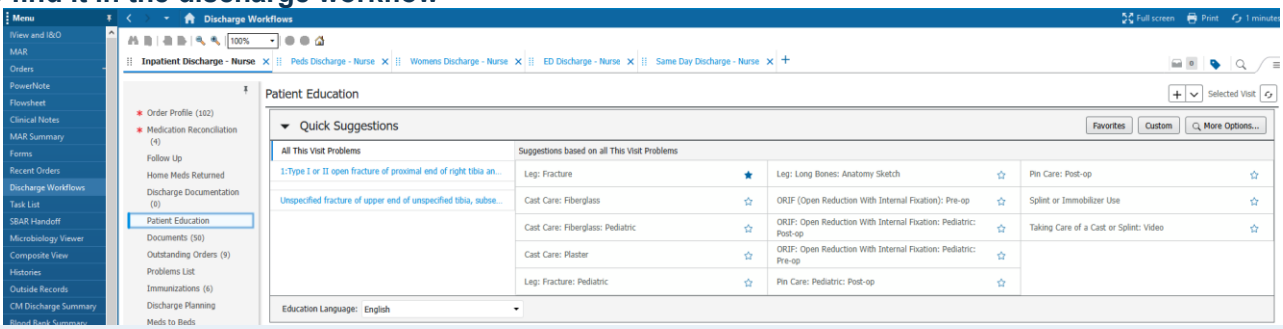
Discharge education workflow

1	**ADD patient education**	Add education for equipment, diagnosis, and medications.
2	**REVIEW Patient Instructions**	Open Patient Instructions and review the discharge education with the patient.
3	**PRINT and SAVE**	Select Print and Save and give the printed instructions/education to the patient before discharge.

Medication education reminder

Print medication education separately for EACH new medication. Each new medication must be selected and printed individually.

Where to find it in the discharge workflow



Bedside takeaway: Going to a facility does not replace patient discharge education. Print and provide the instructions before the patient leaves.

Clinical Reminders

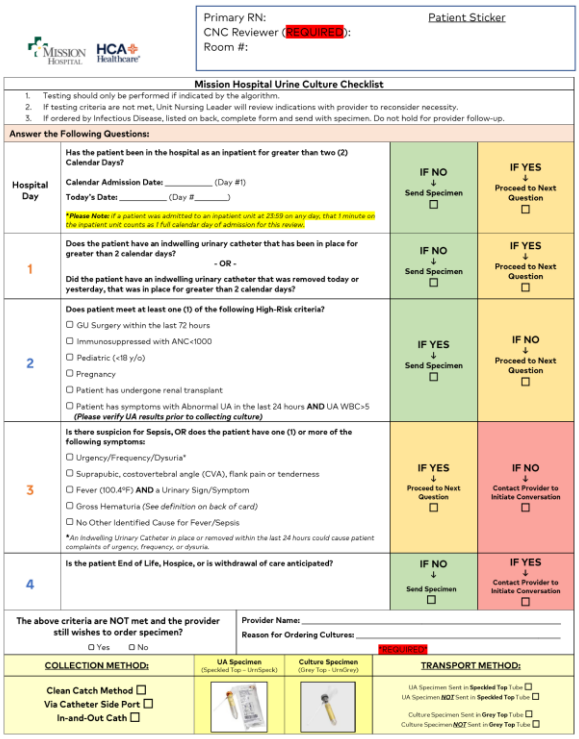
EDUCATION BOOST
UPDATED 9/14

Urine Culture Pause Form Updates

Updated to support accurate urine specimen collection

What changed: The updated form adds documentation at the bottom for how the specimen was collected and which urine tubes/specimens were sent. These fields support accurate collection and transport.

Updated Culture Pause form



Primary RN: Patient Sticker
CNC Reviewer (REQUIRED):
Room #:

Mission Hospital Urine Culture Checklist

1. Testing should only be performed if indicated by the algorithm.
2. If testing criteria are not met, Unit Nursing Leader will review indications with provider to reconsider necessity.
3. If ordered by Infectious Disease, listed on back, complete form and send with specimen. Do not hold for provider follow-up.

Answer the Following Questions:

Hospital Day	Has the patient been in the hospital as an inpatient for greater than two (2) Calendar Days? Calendar Admission Date: _____ (Day #1) Today's Date: _____ (Day #_____) *Please Note: If a patient was admitted to an inpatient unit at 23:59 on any day, that 1 minute on the inpatient unit counts as 1 full calendar day of admission for this review.	IF NO ↓ Send Specimen ☐	IF YES ↓ Proceed to Next Question ☐
1	Does the patient have an indwelling urinary catheter that has been in place for greater than 2 calendar days? - OR - Did the patient have an indwelling urinary catheter that was removed today or yesterday, that was in place for greater than 2 calendar days?	IF NO ↓ Send Specimen ☐	IF YES ↓ Proceed to Next Question ☐
2	Does patient meet at least one (1) of the following High-Risk criteria? ☐ GU Surgery within the last 72 hours ☐ Immunosuppressed with ANC<1000 ☐ Pediatric (<18 y/o) ☐ Pregnancy ☐ Patient has undergone renal transplant ☐ Patient has symptoms with Abnormal UA in the last 24 hours **AND** UA WBC>5 *(Please verify UA results prior to collecting culture)*	IF YES ↓ Send Specimen ☐	IF NO ↓ Proceed to Next Question ☐
3	Is there suspicion for Sepsis, OR does the patient have one (1) or more of the following symptoms: ☐ Urgency/Frequency/Dysuria* ☐ Suprapubic, costovertebral angle (CVA), flank pain or tenderness ☐ Fever (100.4°F) **AND** a Urinary Sign/Symptom ☐ Gross Hematuria *(See definition on back of card)* ☐ No Other Identified Cause for Fever/Sepsis *An Indwelling Urinary Catheter in place or removed within the last 24 hours could cause patient complaints of urgency, frequency, or dysuria.	IF YES ↓ Proceed to Next Question ☐	IF NO ↓ Contact Provider to Initiate Conversation ☐
4	Is the patient End of Life, Hospice, or is withdrawal of care anticipated?	IF NO ↓ Send Specimen ☐	IF YES ↓ Contact Provider to Initiate Conversation ☐

The above criteria are NOT met and the provider still wishes to order specimen? ☐ Yes ☐ No
Provider Name: _____
Reason for Ordering Cultures: _____ REQUIRED

COLLECTION METHOD:	UA Specimen (Speckled Top – UrnSpeck)	Culture Specimen (Grey Top – UrnGrey)	TRANSPORT METHOD:
Clean Catch Method ☐ Via Catheter Side Port ☐ In-and-Out Cath ☐			UA Specimen Sent in **Speckled Top** Tube ☐ UA Specimen ***NOT*** Sent in **Speckled Top** Tube ☐ Culture Specimen Sent in **Grey Top** Tube ☐ Culture Specimen ***NOT*** Sent in **Grey Top** Tube ☐

New collection + transport fields

4		Send Specimen ☐	Contact Provider to Initiate Conversation ☐

The above criteria are NOT met and the provider still wishes to order specimen? ☐ Yes ☐ No
Provider Name: _____
Reason for Ordering Cultures: _____ REQUIRED

COLLECTION METHOD:	UA Specimen (Speckled Top – UrnSpeck)	Culture Specimen (Grey Top – UrnGrey)	TRANSPORT METHOD:
Clean Catch Method ☐ Via Catheter Side Port ☐ In-and-Out Cath ☐			UA Specimen Sent in **Speckled Top** Tube ☐ UA Specimen ***NOT*** Sent in **Speckled Top** Tube ☐ Culture Specimen Sent in **Grey Top** Tube ☐ Culture Specimen ***NOT*** Sent in **Grey Top** Tube ☐

COLLECTION METHOD
- Clean Catch Method
- Via Catheter Side Port
- In-and-Out Cath

TRANSPORT / TUBES
- UA: Speckled Top (UrnSpeck)
- Culture: Grey Top (UrnGrey)

Complete the form accurately and send it with the urine culture specimen. CNC reviewer remains required on the checklist.

Mission Health

HCA Healthcare
Center for Clinical Advancement
NC Division

URINE SPECIMEN COLLECTION

Correct source. Aseptic technique. Accurate results.

Indwelling Urinary Catheter (IUC)

COLLECT ONLY FROM THE SAMPLING PORT

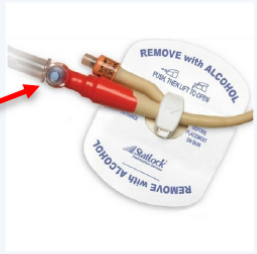
BEFORE A URINE CULTURE

- Check how long the Foley has been in place.
- If in place 72 hours or longer: if placed by urology, contact urology before removal; if not urology-placed, replace if catheter criteria are still met.
- If the catheter is no longer indicated, discontinue it and collect a clean-catch midstream specimen.

Culture indication requirements still apply.

1. Clamp tubing distal to the sampling port as needed to allow urine to collect in the tubing.
2. Scrub the sampling port with alcohol pad or chlorhexidine/alcohol swab and allow it to dry completely.
3. Using aseptic non-touch technique, attach a sterile Luer-lock syringe and aspirate the required urine.
4. Aseptically transfer urine into a sterile specimen cup, then unclamp the catheter tubing.
5. Use the urine transfer straw for ordered tube(s) if needed (see back). Label at the bedside and send to the lab.

DO NOT COLLECT FROM THE INDWELLING CATHETER BAG / DRAINAGE BAG.



Sampling Port

Clean Catch / Midstream

USE CLEANSING WIPES + A STERILE SPECIMEN CUP

Patient self-collection

1. Use the provided cleansing towelettes and sterile specimen cup. If menstruating, use a tampon or gauze at the vaginal opening to help prevent contamination.
2. Clean the periurethral area as shown below.

Vulvar	Penile
• Spread labia with nondominant hand. • Use one wipe on one side, front to back. • Use a new wipe on the other side, front to back. • Use a third wipe over the urethral opening, front to back.	• Retract foreskin if present. • Clean the urinary meatus and glans with a towelette, moving outward in a circular motion. • Repeat using a new towelette.

3. Begin voiding into the toilet while keeping the labia open or foreskin retracted.
4. When a strong flow begins, place the cup into the urine stream and collect 30-60 mL of midstream urine without touching the inside of the cup.
5. Finish voiding, secure the lid, and avoid touching the inside of the container or lid. Label at the bedside and send to the lab.

If staff/caregiver assists:

- Perform hand hygiene and wear nonsterile gloves.
- Explain each step and assist with the same cleansing and positioning instructions above.
- Keep the inside of the cup and lid untouched.

DO NOT COLLECT FROM HAT OR EXTERNAL URINE COLLECTION DEVICE.

Updated 9/14/26

RIGHT CONTAINER + URINE TRANSFER STRAW

Match the test to the container shown on the specimen label.

Grey top
Urngrey

- Urine culture / C&S or Culture if Indicated (CII).
- Preservative helps prevent bacterial overgrowth.

Speckled top
UrnSpeck

- Routine urinalysis (UA).
- Preservative maintains sample integrity.

Sterile urine cup
100 mL Urn Cup

- Drug screen, pregnancy, miscellaneous chemistry, GC/Chlamydia, Trichomonas, microalbumin.
- Very low urine volume (<10 mL).

IF BOTH TUBES ARE ORDERED: GREY FIRST, THEN SPECKLED.

How to Use the Urine Transfer Straw

Vacutainer tubes draw the appropriate amount.

1. Open the sterile straw package. Handle the straw only by the upper end/flange.

2. Do NOT touch the portion of the straw that will enter the urine.

3. Submerge the tip of the straw into the urine specimen.

4. Push the ordered tube into the transfer device and hold until flow stops. If both are ordered: GREY first, then SPECKLED.

5. Mix each filled tube after collection.

6. Discard the transfer straw in the sharps container.

KEEP THE URINE-END OF THE STRAW CLEAN. USE ASEPTIC NON-TOUCH TECHNIQUE.

Label Before It Leaves the Bedside

EVERY SPECIMEN MUST BE LABELED CORRECTLY

- Verify 2 positive patient identifiers - name and date of birth preferred.
- Scan the patient armband at the bedside.
- Place the correct label directly on each tube/cup and scan while in the patient's presence.
- Do not send labels loose in the bag or place labels only on the bag.
- Keep labels flat, readable, and correctly oriented.

LABEL + SCAN BEFORE SENDING TO THE LAB

Mission Hospital Urine Culture: Send the Culture Pause form to the lab with the specimen.

Clinical Reminders

EDUCATION BOOST
ONGOING

2026 Nova StatStrip Glucometers

Patient identification, critical values & result workflow

Use the correct patient identifier and confirm results that do not match the patient's presentation.

Patient ID
Scan the facility-specific armband or manually enter the FIN. Do not include leading zeros. Do not use the MR #.

Where results belong
Lab, CGM and EMS results are not recorded in the CBG field in Cerner.

Critical CBG
Obtain a venous sample STAT if CBG is <20 or >500.

Device landmarks
Barcode scanner at top
Scan button: touch and release
Test strip port: insert strip until a slight click; strip eject button is on the back

If the result does not match the patient history or presentation

1. Repeat the test to confirm.
2. Perform QC if the repeat result is presumed inaccurate.
3. Collect a venous sample.

Connectivity: If multiple glucometers on the same unit are not transferring, submit an IT ticket for department connectivity and state that multiple meters are affected.

Clinical Reminders

EDUCATION BOOST
ONGOING

NovaStat Glucometer Troubleshooting

Quick actions for common meter problems

Start with the simplest check. Escalate a single-meter issue differently from a department-wide connectivity issue.

ISSUE	WHAT TO DO
Meter shuts off unexpectedly	Check the battery expiration date; discard if expired. Replacement batteries are at the Loaner checkout station in the POC area of Lab B205.13.
Soft reset for a random issue	Remove the battery for one full minute. Replace it, dock the meter, wait for Data Transfer to complete, then retry.
Meter not docking / not transferring	Works on one dock but not another: submit an IT ticket for the dock/network port. One meter fails at multiple docks / no green arrow: bring the meter to Lab for troubleshooting. Multiple meters in the same department are not transferring: submit an IT ticket for department connectivity and note that multiple glucometers are affected.
Test strip is not recognized	Using an alcohol pad trimmed slightly wider than a strip, place the folded end over an inserted strip and use it to clean inside the strip port. Repeat as needed.
Other issues that hinder use	Bring the non-working meter to the Loaner checkout station in the POC area of Lab B205.13 (Mission Hospital). Complete the yellow portion of the form, transfer the battery to the loaner meter, and leave the non-working meter and form in the bin labeled “Broken Meters.”

Loaner checkout: POC area of Lab B205.13

Clinical Reminders

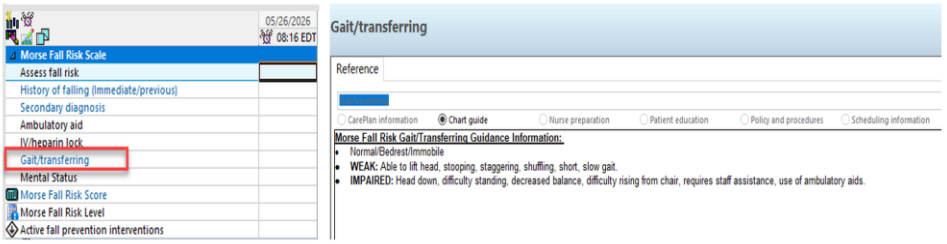
GO LIVE
OCT 6

Cerner 2026 MRP Changes

Quick summary of upcoming Cerner changes - go live October 6, 2026

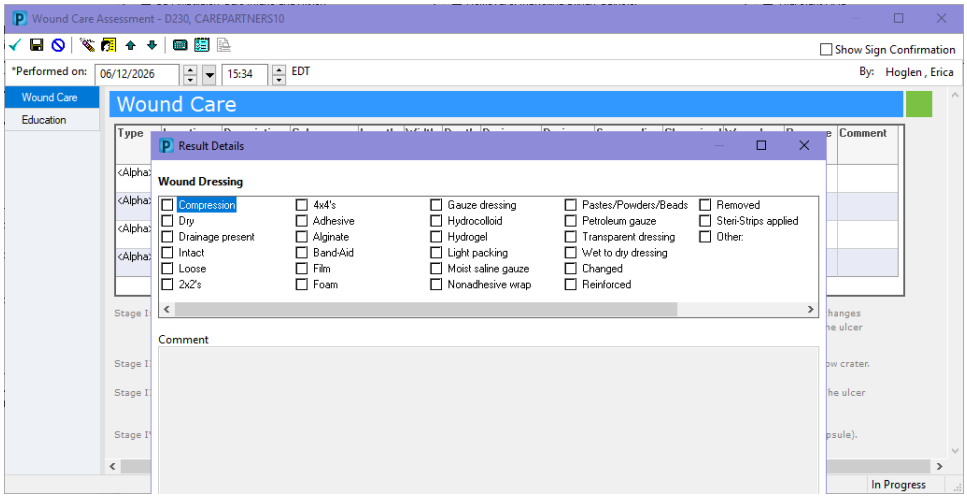
Morse Fall Scale - Gait/Transferring

Reference text is added to the Gait/Transferring field to help nursing distinguish weak from impaired, supporting more accurate Morse Fall Scale scoring.



Wound Dressing Type

Ambulatory wound documentation adds Compression as a discrete dressing type, reducing the need to free-text this treatment modality.



Clinical Reminders

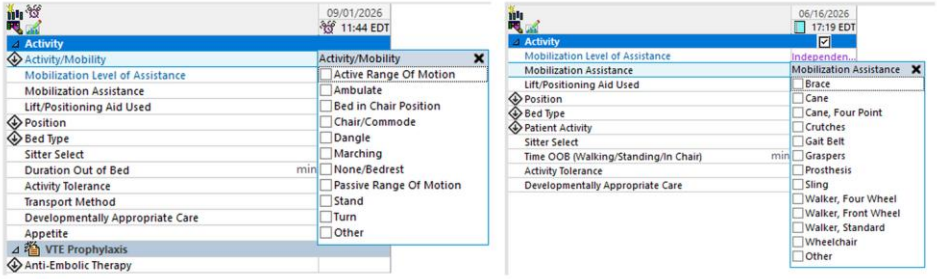
GO LIVE
OCT 6

Cerner 2026.2 MRP Changes

Quick summary of upcoming Cerner changes - go live October 6, 2026

Mobility Documentation

Patient Activity is renamed Activity/Mobility and moved to the first position. Options and assistance selections are refined, reference text is added, Head of Bed Angle becomes a dropdown, and new/renamed fields improve standardized mobility capture.



Rapid Response Documentation

Cerner gains a more dedicated rapid response workflow. New Activated, Arrival and End Date/Time fields are added; trigger and disposition choices are updated; several older fields and the Notify Provider section are removed.