

Clinical Reminders

ROLLING GO-LIVE
OCTOBER

Disposable BP Cuff Conversion: GE -> ROI/Regard

NCDV go-live throughout October with rolling facility start dates

HCA is transitioning all GE disposable blood pressure cuffs to ROI/Regard disposable cuffs across the North Carolina Division. Facility conversions will occur on rolling dates throughout October.



Blood Pressure Cuffs

The Regard Blood Pressure Cuff Portfolio is highly accurate and designed with patient comfort in mind. The cuffs are color-coded for quick identification and adaptable to monitors with one or two tubes.

The Regard Blood Pressure Cuffs Portfolio includes:

- » **ComfortCheck** Disposable Blood Pressure Cuffs offer patient comfort and reduce the risk of cross-contamination
- » **DuraCheck** Reusable Blood Pressure Cuffs are built to last with durable nylon material
- » **NeoCheck** Neonatal Disposable Blood Pressure Cuffs conform to the tiniest patients and are designed to last through their entire hospital stay



Connect Regard Blood Pressure Cuffs to NIBP monitors with speed and security. The new quick-connect adapter—available in single or dual-tube configurations—features a durable, streamlined design that delivers a guaranteed leak-free seal and effortless one-handed operation.



CURRENT STATE

BP monitors/hoses have distal GE BP cuff connections.

FUTURE STATE

Current hose connections will be changed/converted to accommodate ROI/Regard cuffs. GE and ROI cuffs are not interchangeable; both use proprietary connectors.



What staff and leaders should know

- Airline/ROI will support each facility conversion and change the BP cuff adaptors on affected monitors on the scheduled go-live day.
- Supply Chain will implement PAR-location changes as monitors are converted.
- Stock ROI cuffs are available through the NCD warehouse for go-live staging.
- Non-stock cuffs should be ordered directly through ROI/Regard as needed.

BEDSIDE TAKEAWAY: GE and ROI/Regard cuffs are not interchangeable. Use the cuff/connector appropriate for your facility after conversion.

Broset Violence Checklist (BVC) and Patient Safety

6 observable
behaviors



Assess and intervene with patients at risk for imminent violent behavior. The BVC is a standardized tool used to guide timely, appropriate safety interventions.

SCOPE Policy applies to patients over age 18. Use the BVC when clinically indicated based on patient behavior, condition, or risk factors.

WHEN TO COMPLETE THE BVC

- Upon admission or initial evaluation
- With any change in behavior or clinical condition
- At ongoing intervals based on clinical judgment and unit-specific practice

SCORING | Each behavior is scored Present (1) or Absent (0).

BVC BEHAVIORAL INDICATORS

● Confusion	Disoriented; unaware of time, person, or place
● Irritability	Annoyed, angry; unable to tolerate others
● Boisterousness	Overtly loud or noisy; may include shouting
● Verbal Threats	Intent to intimidate or threaten another person
● Physical Threats	Intent to physically threaten; aggressive stance/clenched fists
● Attacks on Objects	Throwing, kicking, banging, or smashing objects

RISK STRATIFICATION & ACTIONS

0 | MINIMAL RISK

Continue routine monitoring.

1–2 | MODERATE RISK

Initiate preventative measures.

- Evaluate for underlying clinical causes
- Identify/reduce triggers
- Maintain a safe environment
- Increase observation/reassessment as indicated

≥3 | HIGH RISK

Initiate preventative measures AND develop a plan for an appropriate safety response.

- Initiate immediate safety interventions as indicated
- Engage clinical/security teams as appropriate
- Increase observation/reassessment as indicated

MODERATE–HIGH ESCALATION

Notify appropriate clinical leadership (e.g., Charge Nurse, provider). Activate behavioral/security response (e.g., Code BERT) per hospital policy when indicated. Consider medication intervention per provider order and increased observation (e.g., line-of-sight).

DOCUMENTATION

Record BVC score/assessment findings, interventions implemented, patient response, and communication with provider/care team.



Clinical Reminders

EDUCATION BOOST
ONGOING

Key Steps for Patient Belonging Management

Document disposition of patient belongings in Cerner

Primary goal: Send non-essential personal items home with a responsible adult whenever possible. If sending items home is not possible, secure essential or high-value items with Hospital Security.

SEND ITEMS HOME - PRIMARY GOAL

- Identify a responsible adult (family, friend) and send non-essential personal items such as clothes, phones, and keys home with them.
- Document the specific items sent in the appropriate Cerner documentation fields.

SECURE WITH HOSPITAL SECURITY

- Use this when sending items home is not possible for essential or high-value items such as a wallet, jewelry, hearing aids, dentures, or glasses if not worn.
- Place items in the designated hospital security envelope and follow the unit procedure for contacting Security.
- Document the items secured and the Valuables envelope number.

DOCUMENT ALL ACTIONS IN CERNER - MANDATORY

- Accurately list what items were handled and where they went/who took them for every disposition: sent home, secured, or given to the patient.
- Cerner documentation is the definitive legal record of the belongings' disposition.

HIGH-RISK SUBSTANCE USE PLAN

- If a patient has an active High Risk Substance Use plan order, a corresponding order requires removal of all personal belongings from the patient's immediate environment. These items must be secured immediately.

ALWAYS REMEMBER

- Be specific when listing items.
- If an item is needed for patient safety, such as glasses or hearing aids, attempt to keep it with the patient unless medically contraindicated.

Cerner: I-View > Notifications > Belongings

Item	Comments	Flag	Date	Performed
Medication Storage Bag Number			11/12/2025	
Valuables Envelope Number	123456		10:24 EST	
Locker Number				
Searches				
Dentures				
Dentures Full				
Dentures/Partial Upper				
Dentures/Partial Lower				
Jewelry				
Body Piercing				
Bracelet				
Earrings				
Necklace	With Family			
Ring	With Family			
Watch	With Family			
Clothing				
Clothes				
Coat				
Hat				
Shoes				
Wallet	Hospital Security			
Purse				
Electronic Devices				
Cell Phone				
Other Electronic Devices				
Sensory Aids				
Glasses	With Patient			
Contact Lenses				

Independent Double Check Documentation

- Additional medications will be added to the High Alert Medication Independent Double Check (IDC) documentation requirements beginning November 4th.
- ***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:

*Performed date / time : 10/02/2026 1445 EDT

*Performed by : Administering RN «No Matches»

*Witnessed by : Documenting RN «No Matches»

*Performed date / time : 10/02/2026 1445 EDT

*Performed by : Tran, Nhung RN, I

*Witnessed by : [Signature]

*By : [Signature]

*Volume : [Field]

*Rate (ml) : [Field]

*hePARIN IV in 1/2 : [Field]

*We : [Field]

Cerner Millennium

Username : [Field]

Password : [Field]

Domain : [Field]

OK Cancel

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



Clinical Reminders

MISSION HOSPITAL ONLY
DCS

Mission Hospital- Discharge Courtesy Suite

HCA  Healthcare®



Please join us in the Discharge Courtesy Suite!

NURSING STAFF

Remember to explain to the patient and/or family member, the DCS process and why the DCS is the best option!

Our nurses are experts on discharging patients. We want to ensure you have all the things your doctor recommends for a safe and successful discharge.

A Discharge Nurse will:

- Research your medical information and create a discharge packet.
- Confirm that follow-up appointments and home health services are arranged. (If required)
- Ensure that all your medications and/or equipment are ordered and delivered before discharge.
- Determine when your next dose of medications is due.
- Review educational material related to your medical needs and recovery.
- Arrange transportation if all other options are exhausted.

The RN will then educate you on any details your doctor wants you to know, along with any expectations and/or restrictions for a speedy recovery.

Let your nurse know upon introduction if valet services were used, so we can arrange for the car to be at Entrance 5 at time of discharge.

Please let the staff know...

- If you would like any refreshments while you wait.
- Require any as needed medications.
- Have any IVs that need to be removed.

**Thank you for allowing the DCS to be the last stop of your hospital stay here at
Mission Health!**



Clinical Reminders

GO LIVE
OCT 28

Maternal Early Warning Trigger (MEWT) Alert

New close-chart alert for pregnant patients

A new close-chart alert will fire when certain criteria are met on pregnant patients. It will use the last charted value and populate documented items that meet the criteria. Once documentation meets normal values, the item will no longer show on the alert.

ALERT CRITERIA INCLUDE

- Systolic BP <90 or >160 mmHg
- Diastolic BP >100 mmHg
- Heart rate <50 or >120 bpm
- Respiratory rate >24/min
- WBC <4K or >15K
- Oxygen saturation <95%
- Urine output <35 mL/hr over the previous two hours
- Gestational HTN Neuro Symptoms = Headache, epigastric pain
- Respirations = Dyspneic at rest, dyspneic upon exertion, grunting, labored, nasal flaring, orthopnea
- Orientation = Disoriented x 4

Documents: Close Chart - D230, MEWS2 (1 of 1) "Maternal Early Warning Criteria"

Maternal Early Warning Criteria

Press ALT+F6 to tab out of content or CTRL+Tab to skip content

D230, MEWS2 has met the following criteria for the Maternal Early Warning Score. Please notify a provider of the patient's condition.

Systolic Blood Pressure : 175

Diastolic Blood Pressure : 110

Heart Rate : 49

Temperature Fahrenheit : 100.4

Respiratory Rate : 26

Oxygen Saturation : 93

Urine Output is less than 35 mL/hr in the previous 2 hrs

Gestational HTN Neuro Symptoms : Epigastric Pain, Headache

OK

☐ Provide Feedback

PATIENT CRITERIA

- Current pregnancy documented in Cerner
- Inpatient, Observation, Emergency, Outpatient, or Outpatient Bedded encounter
- Female patient, age 8-70 years

Why this is changing

Improve maternal safety by standardizing surveillance practices, increasing awareness of maternal risk factors, and supporting rapid escalation of care when warning signs of maternal deterioration are identified.

WHAT IS NOT CHANGING: Existing processes for recognition, communication, and escalation of clinical concerns remain unchanged.



Clinical Reminders

GO LIVE
NOV 4

Stepdown IV Infusion Changes

Ketamine + RASS | Cardene | Precedex

Three anchors: KETAMINE + RASS = NO RN TITRATION • ASSESS • SCORE • ACT | CARDENE = TITRATE TO ORDER | PRECEDEX = ≤ 0.4 BEFORE TRANSFER • WEAN ONLY ON STEPDOWN

KETAMINE + RASS

DOSE Start 0.1 mg/kg/hr using IBW; provider may order one increase to max 0.2 mg/kg/hr. No bolus.

SET UP Adult low-dose PowerPlan + Guardrails Progressive/Intermediate profile + portless tubing + lock box.

MONITOR q30 min first hour, then at least q4h: pain, RASS/POSS, HR, BP, RR.

STOP / ESCALATE Mental-status/emergence change, RASS < -2 , POSS 2-3, or significant CV/respiratory change.

SCENARIO Pain 8/10 at 0.1: reassess + call provider; do not increase rate.

CARDENE

ORDER Match indication-specific PowerPlan. Know target/limits + dose range + increment + interval.

TITRATE Use current BP + complete active order first. Never create a target or shorten/invent an interval.

MONITOR Continuous ECG; BP/HR per order; neuro as appropriate; reassess after each rate change.

IV / ESCALATE Avoid hand/wrist IV; rotate q12h; central >24 hr/max concentration. Escalate below limit, intolerance, neuro worsening, range failure, or mismatch.

SCENARIO BP goal ordered but titration interval missing: clarify before changing rate.

PRECEDEX

NEW Severe-agitation PowerPlan uses RASS; do not carry CIWA workflow unless separately ordered.

TRANSFER Must be ≤ 0.4 mcg/kg/hr before Stepdown transfer.

LIMITS No initiate, re-initiate, or upward titration on Stepdown. Decrease/wean only within active order.

MONITOR Telemetry + hypotension/bradycardia monitoring; correct smart-pump medication/care area.

SCENARIO Precedex 0.6 and a Stepdown bed is ready: do not transfer; clarify level of care first.

Resolve order, monitoring, rate, IV/pump, or level-of-care gaps BEFORE transfer, start, or titration.



Clinical Reminders

EDUCATION BOOST

SAFE INFUSION CHECK

Ketamine + RASS | Safe Infusion Check

Use the cues - not a script. Ask one question, correct the gap, and move on.

RASS sequence: Observe > Voice > Physical stimulation. Stop when the response determines the score.

AGITATION / AWAKE

- +4** Combative / violent danger
- +3** Very agitated - pulls lines/tubes; aggressive
- +2** Agitated - frequent nonpurposeful movement
- +1** Restless / anxious; not aggressive
- 0** Alert & calm

SEDATION

- 1** Eye contact >10 sec to voice
- 2** Eye contact <10 sec to voice
- 3** Movement to voice; no eye contact
- 4** Movement only to physical stimulation
- 5** No response to voice or physical stimulation

1 OBSERVE

~30 sec: calm = 0; agitation = +1 to +4.

2 VOICE

>10 sec = -1; <10 sec = -2; movement/no eye contact = -3.

3 PHYSICAL

No voice response: movement = -4; no response = -5.

CONNECT: RASS < -2 while ketamine is running -> STOP INFUSION + NOTIFY PROVIDER.

7-POINT GO / NO-GO SCAN

1 PLAN

Medication + indication + PowerPlan match.

2 RATE

Within Stepdown limits.

3 PARAMETERS

Target + interval + hold/stop + monitoring complete.

4 MONITOR

Telemetry/ECG, BP, pain/sedation/RASS ready.

5 IV + PUMP

Right site, drug and care-area profile.

6 KETAMINE

Lock box + portless tubing + handoff/waste.

7 ESCALATE

Know stop / provider / Rapid Response / higher-level triggers.

IF NO

Resolve gap before transfer, start, or titration.

NEXT: HealthStream - complete the assigned test independently. | K+R: no RN titration + assess • score • document • act | C: titrate to order | P: <=0.4 + wean only