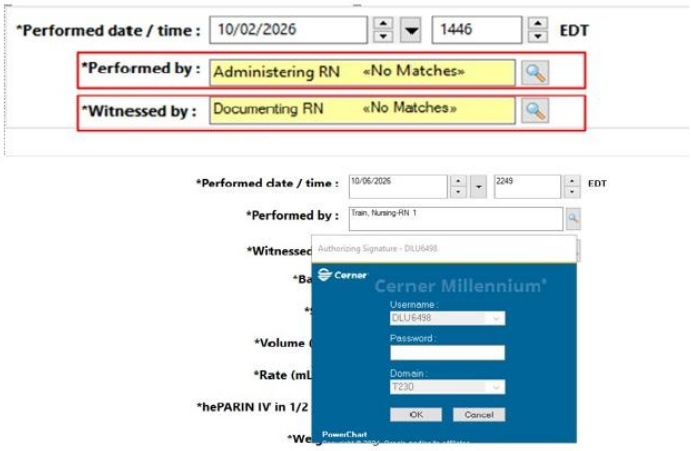
Clinical Reminders

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

DELAYED
TENTATIVE NOV 30

Stepdown IV Infusion Changes

Ketamine + RASS | Cardene | Precedex

DELAY NOTICE: Original 11/4/26 go-live is postponed. Tentative new go-live: 11/30/26.

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.

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Clinical Reminders

DELAYED
TENTATIVE NOV 30

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

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Clinical Reminders

GO LIVE
NOV 5

Vasopressor Concentration Standardization (Adults and Pediatrics)

EPINEPHrine • norepinephrine • phenylephrine

All HCA facilities are moving to standard drug concentrations for certain vasopressor infusions.

The Why

- Currently, HCA facilities use a variety of concentrations for these medications. However, guidelines and national societies for medication safety recommend limiting the number of available drug concentrations.
- Standardization of concentrations is being implemented to help decrease medication errors, such as under or over-dosing, especially when moving between facilities.



Infusion Initiation

When programming the IV pump, if the new standard concentrations are NOT listed in the pump library, STOP and do the following:

- Take the pump out of service and tag it for inspection, according to your facility policy.
- Obtain a new pump and verify that it has the updated medication library and the correct concentration option. Program pump according to orders/protocol.
- Always scan the barcode on the medication bag to ensure the correct concentration is infused.
- Always scan the medication and patient to ensure right drug and right patient.
- Always use the IV pump medication library with safety guardrails.
- Double check the concentration in the pump against the medication label and the patient's order before starting the infusion.
- Do NOT use a memorized dose.
- Always refer to patient's order for initial dose and titration information.

Clinical Reminders

GO LIVE
NOV 5

Vasopressor Concentration Changes - Adult

IV pump and preparation changes

EPINEPHrine

Current Preparation	New Formulation	IV Pump Library Changes	Code Cart Changes
16 mcg/mL (4mg/250mL compound/cmp premix)	20 mcg/mL (5 mg/250mL) PREMIX	New Concentration build	Adult Code Cart
40 mcg/mL (10mg/250mL compound)	40 mcg/mL (10 mg/250mL) Vial 2 Bag (V2B)	Formulation change (260mL total volume in pump)	

norepinephrine

Current Preparation	New Formulation	IV Pump Library Changes	Code Cart Changes
16 mcg/mL (4mg/250mL compound/cmp premix)	16mcg/mL (4 mg/250mL) V2B	Formulation change (254mL total volume in pump)	Adult Code Cart (kit to include 250mL bag, V2B adapter and label)
64 mcg/mL (16mg/250mL compound/cmp premix)	64 mcg/mL (16 mg/250mL) from pharmacy	Formulation change (266mL total volume in pump)	

phenylephrine

Current Preparation	New Formulation	IV Pump Library Changes	Code Cart Changes
100 mcg/mL (50mg/500mL compound/cmp premix)	200 mcg/mL (50 mg/250mL) V2B	New Concentration build (255mL total volume in pump)	Adult Code Cart (kit to include 250mL bag, V2B adapter and label)
200 mcg/mL (100mg/500mL) compound	400 mcg/mL (100 mg/250mL) V2B	New Concentration build (260 mL total volume in pump)	
	100 mcg/mL (10 mg/100mL) Vial 2 Bag **Anesthesia only**	101mL total volume in pump	

ADULT Concentration and formulation changes will increase availability of drips on the floor. Concentration changes affect EPINEPHrine and phenylephrine. Formulation changes affect EPINEPHrine, norepinephrine and phenylephrine. cmp = compounded

Concentration change education support

- Pyxis Clinical Decision Category (CDC) concentration alerts will display for pyxis stocked products (for 90 days post go-live).
- Pharmacy prepared formulations will be labeled with concentration change sticker (for 90 days post go-live).
- Pyxis fliers with notification of concentration change and distribution method.



Clinical Reminders

GO LIVE
NOV 5

Vasopressor Titration Instruction Updates

• Adult titration verbiage will be updated to more clearly define titration instructions. An example using EPINEPHrine is provided below, but adult norepinephrine and adult phenylephrine titration verbiage will be updated as well.

EPINEPHrine Infusion

Starting dose: 2 mcg/min, Maximum dose: 12 mcg/min, Goal: Keep MAP ≥ 65 mmHg

If BELOW goal: Increase the infusion rate by 2 mcg/min every 3 minutes until goal is reached. Contact provider if maximum dose is reached and goal parameter is not met.

If at goal: maintain current infusion rate

If ABOVE goal: Decrease the infusion rate by 2 mcg/min every 3 minutes until goal is reached.

Weaning Instructions: When directed to wean by provider order, decrease the infusion rate by 2 mcg/min every 3 minutes until the infusion is off. If the patient is receiving more than one vasopressor, clarify with the provider which medication should be weaned first.

Additional Information: Standard concentration: 20 mcg/mL. For suspected extravasation (medication leaking outside the vein), follow the Extravasation Non-Cytotoxic Plan, Adult (System) and notify the provider for treatment orders.

Clinical Reminders

GO LIVE
NOV 5

Vasopressor Concentration Changes - Pediatrics

IV pump and preparation changes

EPINEPHrine

Current Preparation	New Formulation	IV Pump Library Changes	Code Cart Changes
50 mcg/mL [NICU/PEDS] 20mL syringe (1,000mcg/20mL)	20 mcg/mL (5 mg/250mL) PREMIX	New Concentration build	Pediatric Code Carts
50 mcg/mL [NICU] 3mL syringe (150 mcg/3mL)	20 mcg/mL (0.06 mg/3mL) syringe from pharmacy	New Concentration build	
50 mcg/mL [PEDS] bag (25mg/500mL)	20 mcg/mL (1 mg/50mL) syringe from pharmacy	New Concentration build	
	40 mcg/mL (10mg/250mL) Vial 2 Bag	New formulation (260mL total volume in pump)	

norepinephrine

Current Preparation	New Formulation	IV Pump Library Changes	Code Cart Changes
64 mcg/mL [NICU] 3mL syringe	16 mcg/mL (4 mg/250mL) Vial 2 Bag	New formulation (254mL total volume in pump)	Pediatric Code Carts (kit to include 250mL bag, V2B adapter and label)
64 mcg/mL [PEDS] 50mL syringe	16 mcg/mL (0.048 mg/3mL) syringe from pharmacy	New formulation	
64 mcg/mL [PEDS] bag (16mg/250mL)	16 mcg/mL (0.8 mg/50mL) syringe from pharmacy	New formulation	
	64 mcg/mL (16mg/250mL) from pharmacy	No change (266mL total volume in pump)	

phenylephrine

Current Preparation	New Formulation	IV Pump Library Changes	Code Cart Changes
100 mcg/mL [PEDS] Standard 50mL syringe	80 mcg/mL (40mg/500mL NS) from pharmacy	New Concentration build	
	80 mcg/mL (0.24mg/3mL) syringe from pharmacy	New formulation	
	80 mcg/mL (4mg/50mL) syringe from pharmacy	New formulation	
	400 mcg/mL (100mg/250mL NS) Vial 2 Bag	New Concentration build (260mL total volume in pump)	

PEDIATRIC Concentration and formulation changes. Concentration changes affect EPINEPHrine, norepinephrine and phenylephrine. Formulation changes affect EPINEPHrine, norepinephrine and phenylephrine.

Concentration change education support

- Pyxis Clinical Decision Category (CDC) concentration alerts will display for pyxis stocked products (for 90 days post go-live).
- Pharmacy prepared formulations will be labeled with concentration change sticker (for 90 days post go-live).
- Pyxis fliers with notification of concentration change and distribution method.



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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

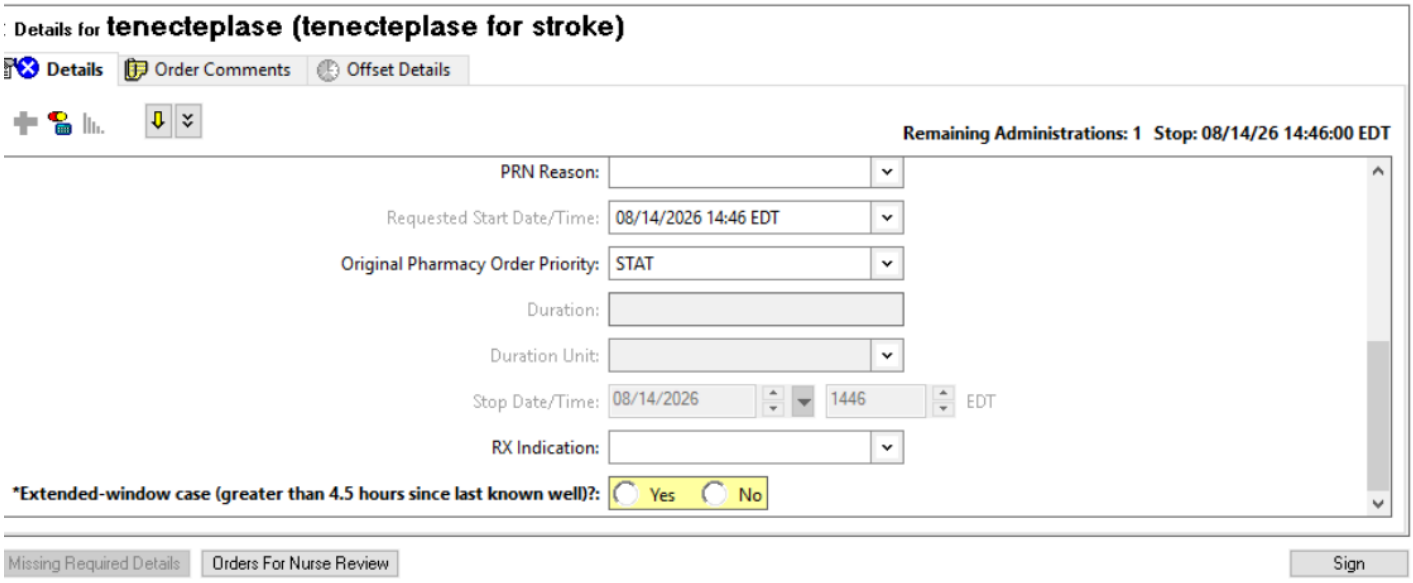
GO LIVE
NOV 3

Cerner 2026: Tenecteplase Extended-Window Query

Reuse of prior Change Week content with updated go-live date

For tenecteplase orders placed from stroke PowerPlans, providers receive a required Yes/No query identifying an extended-window case (>4.5 hours since last known well). The response is retained in the order audit trail.

Future State Screenshot



GO LIVE • NOV 3

Clinical Reminders

ROLLING DIVISION
GO-LIVE

BD Alaris™ Infusion System Updates

PEDIATRICS • Full system: Point of Care Unit (PCU) / Pump / Syringe / Patient Controlled Analgesia (PCA) / $EtCO_2$

RED DOTS MUST MATCH — Point of Care Unit (PCU) + EVERY ATTACHED MODULE
Use updated red-dot components together only. Never attach an unmarked older module to an updated PCU.

CORRECT • All components marked



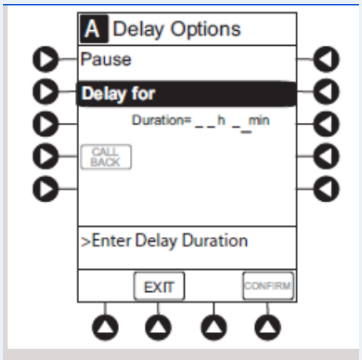
INCORRECT • Mixed marked/unmarked



New Programming Screens

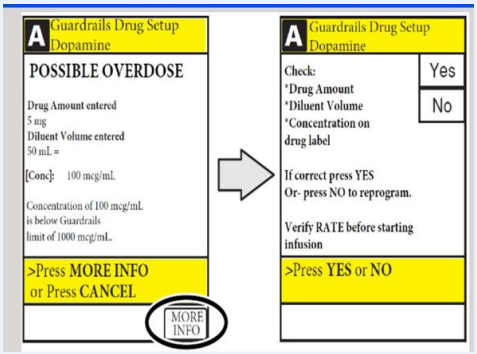
DELAY FOR

"Delay Until" is removed. Use "Delay For" (1 min to 11 hr 59 min); verify the programmed duration.



CUSTOM CONCENTRATION: MORE INFO

A two-step Guardrails alert shows the entered drug amount, diluent volume and concentration. Verify before proceeding.



- HIGH-PRIORITY ALARMS: "Infusion Complete" and "Infusion Complete–KVO" now require immediate response.
- $EtCO_2$: "NO CO_2" replaces "No Breath." Assess patient and sampling setup; message meaning is not an apnea diagnosis.
- SYRINGE / PCA SUPPLIES: Check manufacturer, model, size, flow rate and current approved disposables before loading.
- CLEAN + DISINFECT: Clean first, then disinfect with a BD-approved product and required contact/drying time. Never clean while attached to a patient. Include PCA handset/cord.

30-SECOND SAFETY CHECK: Red dots match • Correct patient/profile • Guardrails/settings verified • Syringe/sets approved

Clinical Reminders

ROLLING DIVISION
GO-LIVE

BD Alaris™ Infusion System Updates

ADULT ACUTE CARE • PCA USERS ONLY

RED DOTS MUST MATCH — Point of Care Unit (PCU) + EVERY ATTACHED MODULE
Use updated red-dot components together only. Never attach an unmarked older module to an updated PCU.

CORRECT • All components marked



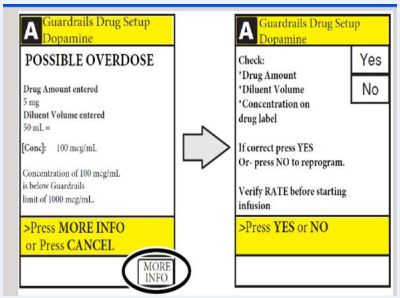
INCORRECT • Mixed marked/unmarked



PCA / $EtCO_2$ Screen Examples

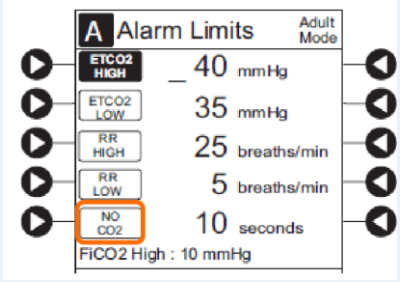
PCA CUSTOM CONCENTRATION

Two-step Guardrails warning: select MORE INFO and verify drug amount, diluent volume and concentration.



$EtCO_2$: "NO CO_2" (IF USED)

"No Breath" becomes "No CO_2." Assess the patient and sampling setup; this text does not diagnose apnea.



PCA Syringes • Examples from BD v12.6.X compatible list

SIZE	BD-COMPATIBLE PCA SYRINGE / MODEL
20 mL	BD 302830
30 mL	BD 302832; IMS Pump-Jet® NDC 76329-1912-1
35 mL	Cardinal Health Monoject™ detachable-plunger barrel 8881135609
50 mL	BD 309653

Clinical Reminders

EDUCATION BOOST

Insulin Answers! Rapid Facts

Meal & Correction Insulin

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





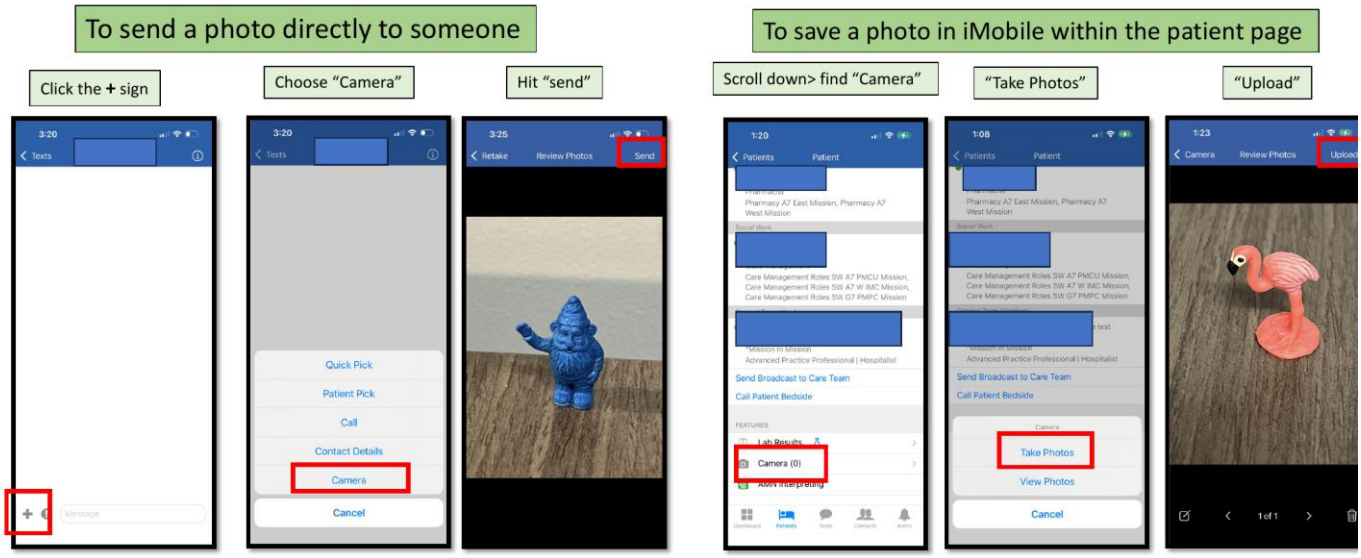
Safety pearls: Do not give MEAL insulin if the tray is delayed or the patient is not eating. Give CORRECTION insulin regardless of NPO. Reassess CBG if the meal is delayed >30 minutes. “HOVER” over MAR orders for rapid-acting insulin dose accuracy.

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

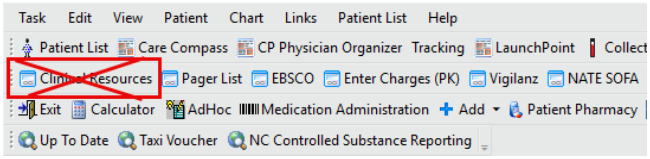
GO LIVE NOV 9

MOD Retirement - Accessing the New Medication Calculator Links

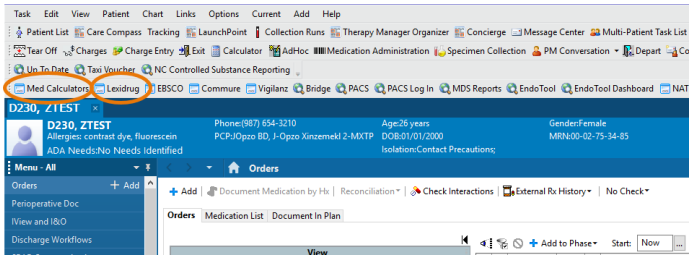
Cerner build update

- 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.

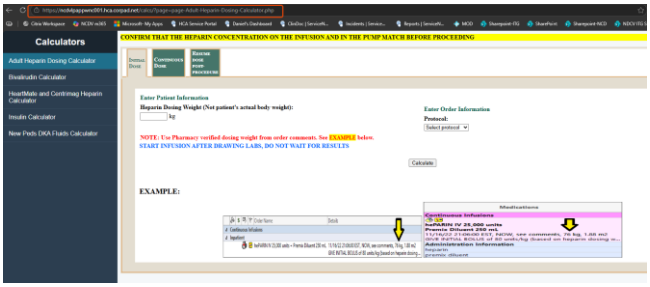
CURRENT STATE - Toolbar



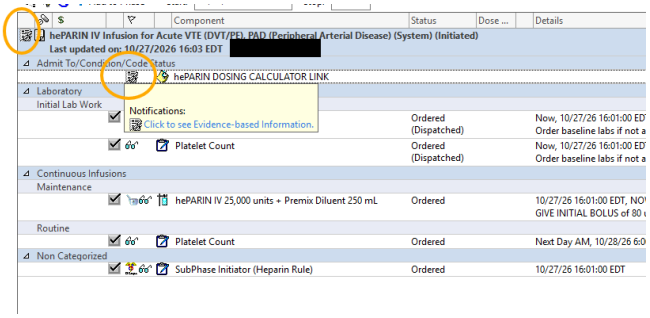
FUTURE STATE - Toolbar



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.

Clinical Reminders

EDUCATION BOOST
NURSING PRACTICE

Uresil Accordion Drain

Interventional Radiology drainage system

- This is a closed system drain for abscess and other fluid drainage.
- Drainage will fill the accordion first, then flow into the gravity drainage bag as long as the bag is below the level of the drainage site.

- Key Points:

  Suction must be maintained, indicated by compression of the accordion.

  To activate suction:

  1. **Loosen** blue valve port at the bottom of the drainage bag



  2. Compress accordion to the **closed position**



  3. *While holding the accordion closed,* **close/tighten** the blue valve port



- Stopcock must be maintained on the end of the drainage tube. Add a needless connector to the open female port. The male port will be attached to the drain tube coming out of the patient.
- While the drain is in use, the stopcock must remain in the “off position” to the open port.
- MD orders must be followed for flushing, indicating volume and frequency. To flush:

Close stopcock to the drainage bag and attach prefilled syringe



Flush per MD order into the patient



Close the stopcock to the flush port, keeping the drain open from the patient to the drainage tube.



For more information on the forward flushing process, refer to the EBSCO procedure “Flushing a Biliary T-Tube”