



Raven Alert for High ORLs

Go Live: 11/18/2025

A Raven alert will be sent to the ED CNCs, House Supervisors, Inpatient Charge RN/CNC, Manager, and Director Dynamic Roles in iMobile when an ORL is assigned has High Risk.

- ☐ ORLs are the Overall Risk Level for suicide and will be determined by the Provider.
- ☐ The Provider will assign no risk, low, moderate, or high risk to the patient. This will take precedence over the CSSRS if levels differ.
- ☐ Providers will reassess patients daily and as needed based on condition. When the ORL is assigned as high risk the Raven alert will be sent to unit leadership.
- ☐ Unit Leadership should then take the appropriate steps to ensure high-risk safety interventions are put in place for that patient.
- ☐ House Supervisors, Charge RNs, CNCs, Managers, and Directors ensure you are logged into the appropriate Dynamic Role in iMobile at the start of shift.



Patients at Risk for Suicide in Non-Behavioral Health Settings: Identification and Monitoring 1PC.PSY.0102

Updated: 11/3/25

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Remote Telemetry Monitoring Alarm Standardization

Go-Live Week of 11/17/25

To ensure consistency, clarity, and the highest level of patient safety across all our monitoring systems, key alarm settings on telemetry platforms will be updated and standardized.

Key changes to the settings include:

Alarm	Current State	Future State
A-Fib	Medium	Informational
Heart Rate High Parameter	140 bpm	150 bpm
Heart Rate Low Parameter	47 bpm	45 bpm
SP02 Probe Off	Low	Medium
ECG Leads Off	Escalating	Medium
Ventricular Brady	Informational	Medium

Remote Telemetry Monitoring Alarm Standardization

Go-Live Week of 11/17/25

Units will be notified of their specific go-live date.

❖ Day of Go-Live Process:

- ❑ **Med-Surg Process:** Alarm Settings will be automatically updated.
No additional steps needed.
- ❑ **Step-Down Patients:**
 - All Step-down patients will need to be hardwired only (no tele box monitoring) during the transition
 - Step-down patients will be transitioned patient by patient
 - After transition occurs normal tele monitoring can be resumed (combo monitoring, tele box, etc.)

Traversing Wet and Icy Surfaces

Navigating wet and icy surfaces requires some careful consideration to avoid slips and falls. Here are some tips to help you stay safe:

- ❑ **Wear Appropriate Footwear:** Shoes with good traction and non-slip soles can make a big difference. Avoid smooth-soled shoes.
- ❑ **Take Small Steps:** Short, deliberate steps help you maintain better balance and reduce the risk of slipping.
- ❑ **Keep Your Hands Free:** Use your arms for balance, but avoid carrying heavy items that can affect your stability. Use the elevator when carrying bulky items.
- ❑ **Walk Slowly:** Rushing increases the risk of slipping. Take shorter steps at a slower pace.
- ❑ **Keep an Eye Out for Changing Surfaces:** Be aware of the surface you are walking on and adjust your pace when needed. If possible, walk on cleared paths or areas with gravel or sand.
- ❑ **Keep Your Feet Flat:** Walk flat-footed with your feet pointed slightly outward. This increases your contact area and stability. Penguin waddle!
- ❑ **Maintain a Wide Stance:** Spread your feet apart to increase your balance and lower your center of gravity.
- ❑ **Use Handrails:** If available, use handrails or other supports to help with balance.
- ❑ **Avoid Slippery Areas:** Look ahead to spot and avoid particularly slippery surfaces/icy patches.
- ❑ **Be Mindful of Black Ice:** Black ice is hard to see but can be extremely slippery. Be extra cautious in shaded areas or early in the morning.
- ❑ **Use Caution When Entering or Exiting Vehicles:** The areas around cars can be particularly icy. Take extra care when getting in or out.
- ❑ **Practice Falling Safely:** If you do slip and fall, try to fall with your body relaxed to reduce the risk of injury. Aim to fall on your side rather than your back or front.

**All accidents and injuries should be reported using Vigilanz. Call Mission WorkWell (828-213-9600) to be seen if medical attention is required as a result of your injury.



Broset Violence Checklist: Age Change

Go-Live 11/25/25

The Broset Violence Checklist must now be completed for **ALL patients** (exclusions: newborns admitted to MOMB or NICU). This updates the previous policy, which excluded patients under age 12.

- ❑ This is a tool used to evaluate patient's risk upon admission, and as part of ongoing assessment for signs of violence or behaviors that may indicate a risk for impending violence.

Broset Violence Checklist	
Confusion	Disoriented, unaware of time, people, or location
Irritability	Annoyed, angry, unable to tolerate others
Verbal Threatening	Intent to intimidate or threaten another person
Attacking Objects	Throwing or kicking objects, slamming doors
Boisterousness	Overtly loud, yelling
Physically Threatening	Intent to threaten, aggressive stance, clenched fists

1. **Score of Zero (0) = Minimal risk for violence**
2. **Score of one or two (1-2) = Moderate risk for violence**
 - Preventative measures should be taken
3. **Score of greater than two (>2) = High risk for violence**
 - Preventative measures should be taken, and a plan should be created for how to manage/intervene with a violent episode.

Brøset Violence Checklist 1PC.PSYI.0093

Central Monitoring Unit (CMU)-Bathroom Process

Go-Live 11.17.25

We must ensure that patients continue to receive the appropriate level of monitoring.

- ❑ Patients hardwired to in-room monitors (not utilizing a telemetry box), **must not be removed from the monitor to go to the bathroom.**
- ❑ **CMU will begin escalating any loss of visual.** The previous 15-minute “bathroom grace period” will no longer be observed.
- ❑ **What should caregivers do:**
 - If a patient needs to use the bathroom, **utilize a bedside commode** or **transition to a tele box** with a pulse oximetry cord if needed, consistent with the current monitoring order.



Central Monitoring Unit (CMU)-Shower Process

Adhere to the following steps when removing a patient's telemetry for a shower:

Required Action Steps

- ❖ **Order Required:** Caregivers must have a **physician order** to temporarily remove telemetry for a shower.
- ❖ **Monitor Tech Verification:** Monitor Technicians are **required** to verify the existence of the "removal for shower" order when they are notified of the removal.
- ❖ **Caregiver Supervision:** The **caregiver must stay with the patient** for the entire duration of the shower.
- ❖ **Reapplication Deadline:** Telemetry **must be reapplied** and functional **within 30 minutes** of the initial removal.
- ❖ **Notify CMU:** Caregivers must **call the CMU immediately** upon completion of the shower and reapplication of telemetry to confirm visual monitoring is resumed.



Escalation Procedure

- ❖ **CMU will begin the escalation process if telemetry monitoring has not resumed within 30 minutes of its initial removal.**