

Nursing, EDM & SUR Modules

ADA update to Health History



Selected Language fields on the **Health History** Assessment have been updated to enhance identifying patients that need ADA resources as well as ensuring they are offered the correct accessibility services. Verbiage has been updated to align with current ADA recommendations.

Language service type field responses have been updated. 'Other' has been added as an available response.

Note: If Other is selected, then *Additional language services detail* becomes a **required*** Free Text field in order to provide any additional details about language services needs or preferences.

The following verbiage has been updated per ADA recommendations:

1 - *Vision impairment* has been updated to **Blind/low vision**

2 - *Hearing impairment* has been updated to **Deaf/hard-of-hearing**

3 - Under *Vocalization*, the field response 'Mute' has been updated to **'Speechless'**

4 - *Cognitive impairment* has been updated to **Cognitive disability**

Health History Assessment

Language services type:

1 ☐ Interpretation via phone Select mode(s) of services needed.

2 ☐ Interpretation via video

3 ☐ Onsite interpretation Document use of language services in Language Assistant.

4 ☒ Other

Preferred language: ENG ENGLISH

Accessibility needs: Blind/low vision

Language services: Patient/rep accepts

Language services type: Other

Additional language services detail: Free Text *

(Prev Page) (Next Page)

Health History Assessment

Vocalization: [or free text]

1 ☐ Appropriate 7 ☐ None 13 ☐ Slurred

2 ☐ Aphasic expressive 8 ☐ Non-verbal 14 ☒ Speechless

3 ☐ Aphasic receptive 9 ☐ Phonation strong 15 ☐ Word salad

4 ☐ Cri du chat 10 ☐ Phonation weak

5 ☐ Incomprehensible sounds 11 ☐ Repetitive

6 ☐ Intubated 12 ☐ Shrill Cry

1 Blind/low vision:

2 Deaf/hard-of-hearing:

3 Vocalization:

4 Cognitive disability:

Auxiliary aids/services:

(Prev Page) (Next Page)

Health History Assessment

Auxiliary aids/services: [or free text]

1 ☐ Assistive listening dev
 2 ☐ Braille
 3 ☐ Captioning services
 4 ☐ Cochlear implant
 5 ☐ Communication board
 6 ☐ Or<F9> For More Options

Document any auxiliary aids/services the patient is currently using, regardless of whether they were provided by the patient or the hospital.

Blind/low vision:>
 Deaf/hard-of-hearing:>
 Vocalization:>
 Cognitive disability:>
 Auxiliary aids/services

(Prev Page) ☐ (Next Page) ☐

Auxiliary aids/services: Lookup

Select

Options

- 1 Contacts
- 2 Corrective lens
- 3 Cueing
- 4 Hearing aid
- 5 Magnifier
- 6 Notetaker
- 7 Prosthetic eye
- 8 Qualified reader
- 9 Read lips
- 10 Real-time transcription
- 11 SAP Auditory prng
- 12 Telecommunications device
- 13 Texting device
- 14 TTY phone
- 15 White board
- 16 Written material

<End of list>

Auxiliary aids/services is a new multi-select field with the following responses:

- Assistive listening dev
- Braille
- Captioning services
- Cochlear implant
- Communication board
- Contacts
- Corrective lens
- Cueing
- Hearing aid
- Magnifier
- Notetaker
- Prosthetic eye
- Qualified reader
- Read lips
- Real-time transcription
- SAP Auditory programming
- Telecommunications device
- Texting device
- TTY phone
- White board
- Written Material
- Or 'Free-Text comment'

The **Yellow informational** box provides additional guidance:

Document any auxiliary aids/ services the patient is currently using regardless of whether they were provided by the patient or the hospital.

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Admission/Shift Assessment +	Detailed Assessment	SURG: Assessment PAC +
Admission Health History +	Paramedic Intake	SURG: Admission Assessment +
BH: Level of Care Assessment +	Non-Urgent General Focus	SURG: Admission Assessment Int +
BH: Outpatient Initial Nurse Assessment+	Rapid Initial Assessment	SURG: Admission Health History +
BH: Psychosocial Assessment (PSA) +	First Point of Contact - Onc	SURG: Neurological Assessment Pre +
BH: Health History Assessment +	Recept MOA 1st POC	SURG: Neurological Assessment Int +
Neuro Checks +		SURG: Neurological Assessment PAC +
Neonatal Intervention +		

Consult Case Management – SDOH Order Alert



In the 2024.1 MEDITECH 5.6 EHR Release, **Social Determinants of Health (SDOH)** was added to the **Health History Assessment**. A Case Management Consult order will reflex when Food, Living Situation, Safety, Transportation and/or Utility are identified as unmet. A new pop-up alert will now remind nursing what the order is for and provide instructions on how to order the consult.

Health History Assessment

Patient has instability or unmet needs related to:

- ☐ None
- ☒ Food
- ☒ Living situation
- ☒ Safety
- ☒ Transportation
- ☒ For More Options

Select all that apply if the patient is experiencing instability in any of the five social conditions which may impact their health or well-being.

Case Management will be consulted to perform additional screening and potentially identify referrals or other needed services.

Living situation:

Other living situation:

Barriers

Social Determinants of Health (SDOH) Alert

*** Social Determinants of Health (SDOH) Alert ***

Patient meets the following SDOH criteria and requires a Case Management SDOH consult:

- Safety
- Transportation
- Living situation
- Food
- Utility

Please submit the automated Consult Case Management - SDOH order that will appear upon filing this intervention.

*When placing order enter:
Admitting Provider (TEST.DR) & Order Source (Z) 'Department/Process'.

<End of text>

<Return>/<Esc>/<Exit> when done

Upon filing the **Health History Assessment**, the **Social Determinants of Health (SDOH) Alert** will serve as a reminder to the clinician to submit a **Consult Case Management – SDOH** order when one or more of the SDOH needs are identified as unmet:

- Food
- Living Situation
- Safety
- Transportation
- Utility

Note: The alert will include guidance when placing the order to:

- Enter the Admitting Provider as the ordering provider
- Use Order Source (Z) 'Department/Process'

The clinician will be taken directly into **Order Management** where they will then add the:

- **Admitting Provider** as the ordering provider **AND**
- Use **Order Source: 'Z'** (Department/Process) to ensure the consult is properly routed.

Current All Session

Category	Orders	Pri	Date/Time	Status	Stop	My
Admit/Transfer/DC (1)						

Order Management

Ordering Provider

Other Provider

Order Source

OK Cancel

Intake Supplement/Additive Documentation



There is currently no way to document the specific nutritional supplement or additive within intake. The nurse can capture the amount of an oral nutritional supplement or "other" intake but there is no free text box or additional fields to identify what was administered or provided.

The top screenshot shows the 'Meals Consumed Intake' form with the 'Nutritional supplement given:' section. A red box highlights the '1 Yes' selection. Below this, there are fields for 'Meal:', 'Amount taken:', 'AM snack:', 'PM snack:', and 'HS snack:'. A red box also highlights the 'Nutritional supplement given:' checkbox.

The bottom screenshot shows the 'Meals Consumed Intake' form with the 'Nutritional supplement 1 ml:' section. A red box highlights the '100' value entered in the 'Nutritional supplement 1 ml:' field. Below this, there are fields for 'Nutritional supplement 1 type:', 'Nutritional supplement 2 ml:', 'Nutritional supplement 2 type:', 'Nutritional supplement 3 ml:', 'Nutritional supplement 3 type:', 'Nutritional supplement 4 ml:', 'Nutritional supplement 4 type:', 'Nutritional supplement 5 ml:', and 'Nutritional supplement 5 type:'. A red box also highlights the 'Nutritional supplement 1 ml:' field.

The **Intake** documentation fields have been updated to allow for additional supplements given.

This update has been added to the following **Intake** selections:

- Infant Nutrition
- Nutrition
- Meals

If 'Yes' is answered for *Nutritional supplement given*, additional **Intake** documentation becomes available.

Users will have the ability to document up to 5 supplements given at one time.

Note: If an *mL amount* is entered for a supplement, the corresponding supplement number field becomes a **required*** 'free-text' comment field.

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Critical Care Flow Record +	Intake & Output	SURG: Intake and Output Intra-Op +
Intake and Output +	Disposition-DC/TX/ADM/LPT	SURG: Intake and Output PACU +
	Newborn Stabilization	SURG: Intake and Output Pre-Op +

Nursing & Ancillary Module

Clinical Nutrition - Nutrition Related Diagnosis Update



Conflicting definitions of 'Underweight' identified in the **Nutrition Assessment** has been resolved.

Nutrition Assessment

☒ **Nutrition related diagnosis:**

- 1 Mild malnutrition
- 2 Moderate malnutrition
- 3 Severe malnutrition
- 4 Morbid obesity
- 5 Obese
- 6 Overweight
- 7 **Underweight**

Nutrition monitoring:>

Nutrition related diagnosis: Underweigh

Nutrition diagnosis details: BMI less than 18.5

Nutrition prescription:>

In the **Nutrition Assessment**, the *Nutrition diagnosis details* for an 'Underweight' has been updated to **BMI less than 18.5**.

Previously listed as *BMI less than 19.9*, this update resolves the conflict between the *Nutrition diagnosis details* and the *BMI evaluation* fields in the **Nutrition Assessment** intervention.

Nutrition Assessment

☒ **BMI evaluation**

	Adults 20 and older:
1 Normal	Normal (18.5-24.9)
2 Obese class I	Overweight (25.0-29.9)
3 Obese class II	Obesity, class I (30.0-34.9)
4 Obese class III	Obesity, class II (35.0-39.9)
5 Overweight	Obesity, class III (Greater than 40.0)
6 Pediatric obese	
7 Underweight	Underweight (Less than 18.5)

This update affects the following interventions:

Nursing
Nutrition Assessment +

External Ventricular Device Field Update



Within the ICP ventriculostomy screen, two fields have been updated to increase the character limit to 10 for EVD settings. This will allow for more accurate documentation of settings.

ICP/Ventriculostomy

Ventricular device set at mmHg:

7	8	9	Del
4	5	6	
1	2	3	
-	0	.	Calc

Ventricular device: Bolt *

Location: Parietal region left *

Instance list status: Active *

Ventricular device status: Monitor

Ventricular device set at mmHg:

Ventricular device set at cmH2O:

Drain status:

Level:

(Next Page)

In the **ICP/Ventriculostomy** drain documentation, the following fields have been updated to allow up to a ten character response:

- Ventricular device set at mmHg
- Ventricular device set at cmH2O

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Lines/Drains/Airways	ICP/Ventriculostomy	SURG: Lines, Drains, Airways Pre-op
Critical Care Flow Record	Newborn Stabilization	SURG: Lines, Drains, Airways Intra-op
		SURG: Lines, Drains, Airways PACU

OR Site Prep Solution Update



Iodine povacrylex alcohol (Duraprep) is being replaced with povidone-iodine plus isopropyl alcohol (PurPrep). This update will remove the *iodine povacrylex alcohol* response and add **povidone-iodine plus isopropyl alcohol** to possible responses.

The screenshot displays the 'Pre-op Prep Documentation' form. The 'Pre-op prep solution:' section lists various options, with '9 Povid-iodine isopro alcho' highlighted. An arrow points to this option. The 'Also known as:' list includes '9 - PurPrep'. The 'Site 1 prep solution:' section also lists options, with '9 Povid-iodine isopro alcho' highlighted. The 'Also known as:' list for this section also includes '9 - PurPrep'. The 'Prep site 1:' field is set to 'Abdomen'. The 'Site 1 hair removed:' field is set to 'No'. The 'Site 1 hair removal method:' and 'Site 1 hair removed by:' fields are empty. The 'Site 1 prep solution:' field is empty. The 'Site 1 prepped by:' and 'Site 1 prep comment:' fields are empty.

The following response fields have been updated with the 'Povidone-iodine plus isopropyl alcohol' prep solution also known as *PurPrep*:

- 1 - Home prep solution:
- 2 - Pre-op prep solution:
- 3 - Site prep solution fields*

- *Site prep solution* has multiple numbered instances. This update has been applied to all fields.

Note: In addition to this update, "Nonantibacterial soap" has been update to **Nonantimicrobial soap (Option #7 in images)**.

This update affects the following interventions:

Nursing	Emergency	Surgery
Pre-Procedure Checklist	Pre-Op Pre-Proc Checklist	SURG: Prep Screen PACU
OB: OR Record		SURG: Pre-Procedure Checklist, Prep
		SURG: Prep Screen Pre-op
		SURG: Prep Screen Intra-op

Nursing & SUR Modules

Additional OB Response for MRCN



Manage Refer Contact Notify does not have appropriate OB responses needed. Free texting responses does not allow for auditing and safe oxytocin administration.

Manage Refer Contact Notify

Reason notified: [or free text]

1 <input type="checkbox"/> Abnormal vital signs	8 <input type="checkbox"/> Order clarification	15 <input type="checkbox"/> Sepsis notification
2 <input type="checkbox"/> Change in pt condition	9 <input type="checkbox"/> PPH risk	16 <input type="checkbox"/> Stroke alert
3 <input type="checkbox"/> Collateral information	10 <input type="checkbox"/> Pain management	17 <input type="checkbox"/> Suicide risk
4 <input type="checkbox"/> Continuity of care	11 <input type="checkbox"/> Patient concern	18 <input type="checkbox"/> Telemetry interruption
5 <input type="checkbox"/> Critical value	12 <input type="checkbox"/> Patient medication	19 <input type="checkbox"/> Telemetry restart
6 <input type="checkbox"/> Diagnostic test/lab	13 <input type="checkbox"/> PEDS concerning event	
7 <input type="checkbox"/> Family meeting	14 <input type="checkbox"/> Rhythm chg/arrhythmia	

Action: >Notified

Reason notified:

Entity attempted/notified:

Provider attempted/notified:

Sepsis notification:

PEDS concerning event:

Family member notified:

(Next Page)

Updates have been made to the Manage/Refer/Contact/Notify intervention.

After selecting 'Notified' in the Action field, Reason notified becomes available and 'PPH Risk' has been added to the list of field responses.

This update affects the following interventions:

Nursing	Surgery
Manage/Refer/Contact/ Notify +	SURG: Mng/Refer/Contact/Notify Intraop +
	SURG: Mng/Refer/Contact/Notify Preop +
	SURG: Mng/Refer/Contact/Notify PACU +

Subcutaneous Emphysema (Crepitus) Update



There is no designated area to document the presence of subcutaneous emphysema (Crepitus). Updates have been made to the **Integumentary Assessments** as a *Skin alteration type* as it can be located in the face, neck, periorbital area, abdomen and even extremities. Updates have also been made to the Chest Tube documentation.

Skin Alteration

Ok Skin alteration description:

1 Abrasion	7 Contusion	13 Mesh
2 Abscess	8 Crepitus	14 Pressure injury
3 Amputation	9 Graft	15 Procedural site
4 Avulsion	10 Incision	16 Puncture
5 Blister	11 Laceration	17 Rash/hives
6 Burn	12 Maceration	18 or<F9> For More Options

Skin alteration description: Crepitus *

Skin alteration other: *

Location (A/P): *

Location (body): *

Instance list status: Active *

Pressure injury present on admission: ☐

Pressure injury staging: ☐

(Next Page) ☐

Skin Alteration

In the *Skin alteration* documentation instance, the response 'Crepitus' has been added as an option for *Skin alteration description*.

Chest Tube

Ok Chest tube site condition:

1 ☒ Crepitus ☐ Vigorous air leak

☐ Drainage at insertion

☐ Dressing dry/intact

☐ Intermittent air leak

☐ Sutured

☐ Unclamped/no air leak

Chest tube type: Pleural *

Chest tube location: Right *

Chest tube number: Tube 1 *

Instance list status: Active *

Chest tube status: Monitor *

Chest tube occluded: ☐

Chest tube site condition: Crepitus

Site drainage description: *

(Next Page) ☐

Drains: Chest Tube

In the *Chest Tube Drain* documentation instance, the response 'Crepitus' has been added as an option for *Chest tube site condition*.

This update affects the following interventions:

Nursing	Emergency Department	Surgery
Lines/Drains/Airways	Chest Tube Treatment	SURG: Lines, Drains, Airways Pre-op
Critical Care Flow Record	Newborn Stabilization	SURG: Lines, Drains, Airways Intra-op
Skin Alteration Instance	Skin Alteration Instance	SURG: Lines, Drains, Airways PACU
		Skin Alteration Instance

Stroke Mechanical Thrombectomy Documentation



To gain insight into our advanced stroke centers, necessary documentation has been made **required*** to track/trend the performance and outcomes of our advanced stroke center patients.

Mechanical Thrombectomy

Angio-suite arrival date:

Calendar Del
Yesterday
Today
Tomorrow

This is the date of the patient's arrival in the neuro-interventional angio-suite.

Angio-suite arrival date *

Angio-suite arrival time *

Vascular access puncture time *

Retrieval device 1 type:

Retrieval device 1 deployment time:

Retrieval device 1 vessel:

(Next Page)

The **SURG: Mech Thrombectomy Intra Op** has been updated.

The following fields are now **Required***:

- Angio-suite arrival date
- Angio-suite arrival time
- Vascular access Puncture time

Mechanical Thrombectomy

Recanalization time:

7 8 9 Del
4 5 6
1 2 3
0 Now

Time of first pass of retrieval device:→

Recanalization time *

Pre-reperfusion mTICI time:

Pre-reperfusion mTICI score:

Post-reperfusion mTICI time *

Post-reperfusion mTICI score *

(Prev Page)

(End)

On page 2, the following fields are now **required***:

- Recanalization Time
- Post-reperfusion mTICI time
- Post-reperfusion mTICI Score

This update affects the following interventions:

Surgery
SURG: Mech Thrombectomy Int