

“What Goes Where”: A Guide to Clinical Documentation at Western Health.

Footscray & Sunshine – Intensive Care Unit

iPM:	EMR (Cerner):	Paper:	BOSSnet:	Other Applications:
<ul style="list-style-type: none"> • Patient registration • Updating patient demographic information/compensable • Print patient labels • Admit/Discharge/Transfer patients • iPM Admission/Discharge Form • Presence of an advance care plan – Legal Alert • Presence of a substitute decision maker – Legal Alert 	<p><u>Transfers into ICU</u></p> <ul style="list-style-type: none"> • Patient ID wristband • Allergies • Alerts • Review of inpatient clinical documentation • Review of MAR • ICU MO to discontinue medication and IV/SC infusion orders on EMR • Review of fluid balance chart / lines and devices • ICU Nurse to discontinue patient care orders and activities on EMR • ISBAR Handover • Infectious Diseases screening tool <p><u>Transfers out of ICU</u></p> <ul style="list-style-type: none"> • Allergies • Alerts • ICU MO to order medication and IV/SC infusion orders on EMR (including heparin) • ICU Nurse to document: <ul style="list-style-type: none"> • Latest set of observations • Active lines and devices • Fluid balance from midnight • Administration of current IV/SC infusions running • Nursing discharge note • ISBAR handover 	<ul style="list-style-type: none"> • Consent Form (AD34) • Operation Report (AD253) • Passport To Surgery (AD250) • Post Anaesthetic Care Record (Adult) (AD259.3) • Acute Resuscitation Plan (ARP) ALERT 3 *trial form • Perioperative Count Sheet (AD262) • Multiday Anaesthetic Record (AD263) • Heparin Infusion (AD284.2) • Blood Transfusion Records/Consent (AD283.1) • Group and Hold form • Respond Blue Record AD299 • Electrocardiogram (ECG) • Wound Care Chart (for Post-Acute Care referrals on discharge) 	<ul style="list-style-type: none"> • Outpatient Clinic Referrals • Outpatient Documentation • Emergency Department Summary & Discharge Letter • Theatre/Cath Lab/Day Procedure • Maternity Documentation • Non Synapse and non Dorevitch results • Community Services Referrals (CAU) – with paper drug chart and wound chart as required. <p>*All internal and external paper documentation will continue to be scanned as per pre EMR process.</p>	<ul style="list-style-type: none"> • Synapse • CBORD Diet Management System. <p>ICCA</p> <ul style="list-style-type: none"> • Medication Orders/Administration • Intravenous/subcutaneous infusions (except heparin – on paper) • Clinical documentation • Restraints documentation • Blood Gas performed in ICU