

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

### Footscray, Sunshine & Williamstown - Emergency (including EOU)

iPM:	EMR (Cerner):	Paper:	BOSSnet:	EDIS:
<ul style="list-style-type: none"> <li>• Patient registration</li> <li>• Updating patient demographic information/ compensable</li> <li>• Admit/Discharge/Transfer patients</li> <li>• iPM Admission/Discharge Form</li> <li>• Presence of an advance care plan – Legal Alert</li> <li>• Presence of a substitute decision maker – Legal Alert</li> <li>• Lactation Consultant referrals.</li> </ul>	<ul style="list-style-type: none"> <li>• Patient ID wristband</li> <li>• Allergies</li> <li>• Alerts</li> <li>• Place Diet order</li> <li>• Medication Orders/Administration</li> <li>• Intravenous &amp; subcutaneous infusion orders/administration</li> <li>• Fluid balance chart</li> <li>• Pathology Orders, Collections/Results</li> <li>• Radiology Orders/Reports</li> <li>• Documentation of lines and devices</li> <li>• Discharge Prescription</li> <li>• Inpatient clinical documentation (admitting team)</li> <li>• ISBAR Handover (ED to ward)</li> <li>• ED Interim Orders (4 hour plan)</li> <li>• Allied Health/ Care Coordination Referrals.</li> <li>• CNC referrals</li> <li>• Review Infectious Diseases Screening tool – enter into EMR if patient admitted</li> </ul> <p>*If NBS patient admitted via ED, ED staff to continue to document infusions and fluid balance on EMR. NBS team will reconcile upon transfer to ward.</p>	<ul style="list-style-type: none"> <li>• Emergency Department Flow Charts – Adult and Paeds AD 51.2a</li> <li>• ViCTOR Observation charts (Paediatrics)</li> <li>• Enteral nutrition orders</li> <li>• Blood Transfusion Records/Consent (AD283.1)</li> <li>• Group and Hold form</li> <li>• Electrocardiogram (ECG)</li> <li>• Consent Form (AD34)</li> <li>• Passport To Surgery (AD250)</li> <li>• Acute Resuscitation Plan (ARP) ALERT 3 *trial form</li> <li>• Restraints documentation.</li> <li>• Infectious Diseases Screening tool (see note in EMR column – only transcribe into EMR if patient admitted)</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient Clinic Referrals</li> <li>• Emergency Department Summary &amp; Discharge Letter</li> <li>• Non Synapse and non Dorevitch results</li> </ul> <p>*All internal and external paper documentation will continue to be scanned as per pre EMR process.</p>	<ul style="list-style-type: none"> <li>• Triage</li> <li>• Clerk Registrations</li> <li>• Patient Labels</li> <li>• Clinical Notes</li> <li>• Discharge Letter</li> <li>• VEMD Data/ Reporting</li> <li>• CBORD Diet Management System.</li> </ul> <p><b>OTHER SYSTEMS</b></p> <ul style="list-style-type: none"> <li>• Second Screen</li> <li>• Synapse</li> <li>• Patient Journey Board/Miya</li> <li>• Emergency Department Dashboard</li> </ul>