



This Quick Reference Guide will explain how to:

Complete documentation for the resus patient.

Overview

- Documentation for the critically unwell patient in resus will continue on the paper ED Flow Chart Adult/Paed. This will be in any of the following contexts:
 - a. Clinical deterioration in the cubicles
 - b. Require resus on arrival
 - c. Procedural sedation
- Patient bed movement and decision making will be communicated between the ED in charge team.
- As per current processes, nursing staff will document on the paper ED flow chart throughout management and stabilisation of patient.
- As per current processes, all pathology and imaging is ordered in real time in the EMR.



Any patient moving out of resus

- Nursing and Medical staff will follow current processes for retrospectively documenting medications and lines/devices

Documentation in EMR

- Nursing staff will write a synopsis outlining the resuscitation in an ED nursing progress note: including time of arrival to the resuscitation area, rationale (clinical deterioration) medications administered, procedures and outcome (stabilisation/Died in ED or transfer).
- Medical staff will retrospectively document into FirstNet.
- All paper documentation of management and stabilisation will be scanned into Bossnet via medical records as per current processes.