"What Goes Where": A Guide to Clinical Documentation at Western Health

CCC Community Nursing Service District

Western Health

iPM	EMR (Cerner)	Paper	BOSSnet	Other Applications
• Patient registration • Updating patient demographic information/ compensable (insurance information) • Print patient labels • Admit, Discharge or Transfer (Inpatients) • iPM Admission/Discharge Form • Presence of an advance care plan – Legal Alert • Presence of a substitute decision maker – Legal Alert	• Allergies & alerts • Wound Care Chart • Photographs • Documentation of lines & devices • Pathology Orders, Collection/Results • Radiology Orders/Report • Allied Health/ Care Coordination Referrals • CNC Referrals • Clinical documentation • Clinical Assessment including Point of Care Tests • ISBAR Handover • Patient Discharge information • Discharge Summaries • Emergency Department Summary & Discharge Letter • ICU Patient Record • Theatre/Cath Lab/Day Procedure • Discharge Planning/Case Conference Documentation • Home Risk Assessment	• Medication Orders & Administration • Intravenous & subcutaneous Infusion orders/administration • Discharge Prescriptions	• External pathology and radiology results • Non-Synapse and Non Dorevitch results • External outpatient referrals • Community Services Referrals (CAU) – with paper medication chart and wound chart as required • Scanned documents • Community Services Referrals (CAU) with paper drug chart and wound chart as required *All internal and external paper documentation will continue to be scanned into BOSSnet	• Synapse