WoundExpert
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Software for Wound Management

PROGRESS NOTES

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Treatment Protocols and Care Plans: What, When & How

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Care planning and documentation of care provided are both essential tasks for all healthcare professionals. Without a plan, it is difficult for a group of care providers to coordinate their efforts to assist the patient in achieving optimum health and, unless everyone documents what they have done, it is impossible to know whether a plan has been enacted and if it is working. There are even regulatory standards that mandate these activities. CMS Standard 482.23 (b) 4 states that the hospital must ensure that the nursing staff develop and keep current, a nursing care plan for each patient and JCAHO's Inpatient Hospital Standards (v2006) P.C.4.10, EP1,2,6,12-14,17 and PC.5.10, EP1 require that individual care plans must be created for each patient. (Niespodziani, 2006) Who hasn't been told, "If it wasn't documented, it wasn't done," in lectures about avoiding legal hassles?

Every healthcare provider has had some education and training regarding both of these topics during their formal education but somehow what worked and made sense in college courses doesn't always translate to real world practice situations. This article is intended to help demystify documenting care plans and treatments in WoundExpert. It is our intent to help you understand how to use both protocols and care plans in WoundExpert as well as how to develop good ones in the first place. With any luck, we'll also help you shave some time off your day-to-day documentation activities and help you better meet regulatory and legal requirements.

Within WoundExpert, there had to be a term used to describe care planning but the actual function of that feature had to be flexible enough to accommodate the needs of different provider types and fit with their definition of the process. Plan of Care seemed fairly generic and could fit with the care planning activities of a variety of providers, as opposed to Nursing Care Plan, for example. The Plan of Care in WoundExpert also allows for capture of many of the key aspects of Practice Guidelines and Clinical Pathways, although it does not currently provide the capability of easily including target dates for outcomes.

The Plan of Care in Wound Expert is customizable and should capture best practice recommendations for care of the typical patient with specific characteristics treated in your facility. It should allow for variability in choice of products or actions to meet the needs of individual patients within that group based on actual assessment data and progress toward desired outcomes. It is this flexibility that differentiates evidence-based practice from "cookbook medicine".

A good bit of the content in a Plan of Care derives directly from the Physicians Orders. One of the responsibilities of nurses and allied healthcare professionals is to enact those orders. But in addition to those orders, each healthcare discipline has specific independent actions they can perform without requiring an order from a physician to do so. For example, a doctor may order vital signs on admission to the clinic only. However, the nurse notes that the patient looks ill and complains of feeling hot and feverish. The nurse checks the patient's vital signs and records the data in the patient record. Because both dependent and independent patient care activities make up the entire plan of care, the care plans you enter in WoundExpert may sound like a different take on the physicians orders and staff may occasionally complain that they are entering the same information twice. This is not the case as you can see here and both documents are required to be included in the patient's legal medical record.

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Definitions

From Taber's Cyclopedic Medical Dictionary 19th Edition. (2001):

- **Protocol** – Formal ideas, plans or expectations concerning the actions of those involved in patient care.
- **Treatment protocol** – an algorithm or recipe for managing a disease or condition. (p.1698)
- **Practice Guidelines** – Consensus statements by professional societies or agents suggesting appropriate diagnostic and therapeutic options for patients with a specified diagnosis (p.1654)
- **Nursing Care Plan** – The statement of goals and objectives of the nursing care provided for a patient and the activities or tasks required to accomplish the plan, including criteria to be used to evaluate the effectiveness of the plan (p.1598)
- **Plan of Care, Care Plan** – A description of the goals and outcomes, prognosis, and proposed interventions for a particular patient, including criteria for discharge and the optimal duration and frequency of therapeutic interventions. (p.1598)
- **Clinical Pathway** – A method used in healthcare as a way of organizing, evaluating, and limiting variations in patient care. This method integrates the components of the care plan into one that addresses the needs and services provided to the whole patient. Development begins with establishment of a multidisciplinary team that examines data to determine which patients will benefit most. These are usually diagnoses with costly or complex care. The following aspects of care are evaluated: consultations and assessments, tests and treatments, nutrition and medications, activity and safety, and teaching and discharge planning. Clinical pathways address timelines, actions, outcomes, and ensure that essential elements of care are provided on time.

Treatment Protocols and Care Plans (cont'd)

The other documentation requirement that must be met covers charting what you actually did to enact the plan of care. In an inpatient record, you probably called this documentation a nurse's note or a therapist's progress note. You may have observed that in wound care, you typically chart very similar notes on most of your patients regarding the actual treatment of the patient's wounds. Sure, the products change, but the note itself is pretty similar in each case. From the Taber's definitions, you'll note that the term protocol fits these notes pretty well. For that reason, the care provider's note in WoundExpert is called a Treatment Protocol. Pretty much all wound programs can use a wound treatment protocol for routine wound cleansing and dressing changes done as part of a patient encounter. Some may also have use for an Apligraf® protocol or a V.A.C.® protocol or something else specific to a wound care treatment they provide.

Any activity that applies to the majority of your patient population or to a very specific segment of that population could probably benefit from using a Treatment Protocol. If you would normally write a note in a paper chart to document the information on a "per wound" basis, you probably can make good use of a Treatment Protocol for it in WoundExpert. Conversely, although your program has procedures to accomplish certain tasks, you do not always chart each step of a procedure. You know you have to set up a sterile field and add instruments and dressings to it to prepare for sharp debridement, but you don't chart doing that process in every patient's record each time you do a debridement. You just record that the procedure was done and, if asked, you could produce the actual policy and procedure to demonstrate what is accepted practice in your program.

When do I use a Protocol and when do I use a Plan of Care?

After reading those Taber's definitions, it's easy to see how you can get confused about what type of activity you are documenting in what part of WoundExpert. An easy way to determine which place to develop or enter information is to think about what you are trying to accomplish.

If you want to describe what should be done for a patient , use a Plan of Care. The statements you enter should be written in present or future tense as these are things that eventually need to be done for or with the patient, whether in the short term or long term, in order to reach the final goal for treatment. That goal may be wound healing and discharge from the program or it may be prevention of amputation and/or complications or worsening of the wound when healing is unrealistic.

If you want to describe what you did for an individual wound, use a Treatment Protocol. The statements you enter should be in past tense as these are the things you did during this visit for this particular wound. Another way of looking at it is, if you might do different things for different wounds, then it should be a treatment protocol. If it applies to the patient as a whole, it should be a Plan of Care.

Hopefully, you feel more comfortable with the use of these two forms of documentation and how to make them fit your program as well as individual patients. It is a big process to get the original material entered as you want it but the time savings and ability to meet regulatory standards once done are well worth the effort.

Please do let us know if you'd like more help with any aspect of these processes by calling Customer Support at 800-411-6281, ext 2. Happy charting!

Mary Ann

Do You Disinfect Your Computer Keyboard?

As the frequency of computers in the healthcare setting grows, so does the risk of bacterial contamination of the computer equipment, particularly on the keyboard. A group from the University of North Carolina Health Care System conducted a study, concluding that computer keyboards in the health care industry should be de-contaminated on a regular basis. In this study, all of the disinfectants used were effective at removing or inacti-vating more than 95% of the test bacteria, with no functional or cosmetic damage to the computer keyboards. Please read more at: http://www.journals.uchicago.edu/ICHE/journal/issues/v27n4/2005161/2005161.html

Help Is a Phone Call Away

Customer support is now available from 8 AM—8 PM (eastern time) Monday through Friday. Send feedback or call 800-411-6281 and select option '2' for immediate response.

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If you have ideas for a future ProgressNotes newsletter, please submit your request to our newsletter staff at feedback@woundExpert.com.

Reference Sources:

- C.A. Niespodziani. The CMS-JCAHO Crosswalk, 2006 ed.HCPro, Inc. 2006. Marblehead, MA
- Taber's Cyclopedic Medical Dictionary 19th Edition. F.A. Davis Company, Philadelphia, PA 2001.

FACT

Those using pathways report reduced length of stay, greater accountability for patient care, greater patient and family satisfaction and improved communication, an improved and integrated process for care delivery, lower patient charges and costs, and 20-40% less time in documentation. (1527)