

Appendix VII generally reflect the term set as it was published in the first edition.

USING THE PNDS IN OUR DAILY WORK—A SUCCESSFUL JOURNEY

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Learning how to use the PNDS in our daily lives is a journey into uncharted territory. Like explorers, we do not know where all the roads lead, and we may sometimes find a road block or a river that cannot be crossed, causing us to back up and try a different approach. Although this is a new language, it is familiar content—perioperative nursing practice. Translating the familiar content into the new language is the challenge perioperative nurses have accepted. Only in using this language in all areas of perioperative nursing will it become relevant to our daily work lives.

The analogy of foreign language is very helpful in understanding the data set. Much like using a foreign language, nurses need to learn how to “translate” it to our current everyday language. If we were new perioperative nurses learning the PNDS, it would be much easier—it would be our “mother” tongue, like a child learning a language. Because many of us are learning it after we already have ways of talking about our nursing practice, however, it is much harder for us to learn the new language. Patience, trial and error, and practice will be the path to success. As we use it, we will learn what is still needed to make it clearly describe the full dimension of the perioperative nursing process.

A consistent, clear language that all perioperative nurses can “speak” in unison will permit us to describe why we are perioperative nurses. The future of our practice rests with nurses’ ability to systematically document and validate their contributions in surgical settings using a structured perioperative nursing vocabulary.

Is making the PNDS meaningful in everyday practice hard? Yes and no. While I was honored to participate in some of the early committee work, I often found the discussions and work highly theoretical and philosophical. At times, it was difficult for me to see how it would “fit” back in my workplace. Understanding that it is merely a new language, not a new way of doing business, helped me see the path that we have ahead, learning how to

translate what we already do into a new language, which has the same meaning, just uses different terminology.

Education, standards, care plans, competencies, policies/procedures, and documentation are some of the ways the PNDS can be applied in our daily practice. It is not always a direct translation, and some applications are more difficult than others. With all of us working on different clinical applications, however, we will be able to move forward in our use of this perioperative language.

Nurse Competencies and the PNDS

The PNDS has the terminology to clearly describe perioperative nurse competencies. The 2002 AORN *Standards, Recommended Practices, and Guidelines* define competencies as, “. . . the knowledge, skills, and abilities necessary to fulfill the professional role functions of a registered nurse in the operating room.”¹ Competencies are the behavioral, observable evidence of clinical knowledge. Why are they important? They are the way we measure a nurse’s level of competence for practice. Competency evaluation can occur

- ◆ at the end of an orientation program,
- ◆ before independent practice in a specialty, and
- ◆ to address Joint Commission on Accreditation of Healthcare Organizations requirements related to nurse preparedness to manage low volume, high risk issues.

One of the key components of competency is patient assessment. Assessment skills are one of the most important aspects of RNs’ professional perioperative practice. Another component of competency is developing and implementing the plan of care. Obviously, the plan of care is formulated from data obtained from the assessment process and addresses the specific needs or problems of the individual patient. The final aspect of competency is the ability to evaluate the care provided. Any competency statement addresses the three aspects of competency—assessment, plan, and evaluation.

Here is an example of a competency statement from my own place of work: “Provide safe and efficient intraoperative nursing care for the

patient receiving electrocautery." Evaluating this statement one needs to ask, how is this measurable? Is this observable? How does one measure "safe" and "efficient"? The AORN *Standards, Recommended Practices, and Guidelines* includes basic competency statements we can use and adapt. For example, Competency IX states, "Competency to provide equipment and supplies based on patient needs." Components within the plan of care include activities such as "anticipates need," "selects in timely manner," "assures is functioning," and "operates according to manufacturer instructions." Which intervention statements from the PNDS are related to electrocautery, and how do they fit here? "Implements protective measures to prevent injury due to electrical sources (I72)" and "Evaluates for signs and symptoms of electrical injury (I37)" are measurable and observable behaviors that relate to this competency statement on electrocautery.

To relate the electrocautery competency statement back to a plan of care, examine the patient outcome, "The patient is free from signs and symptoms of electrical injury." That outcome statement could serve as a quality indicator. The related nursing interventions and activities include

- ◆ "Implements protective measures to prevent injury due to electrical sources (I27);"
- ◆ "Assesses that patient has removed all jewelry;"
- ◆ "Assesses patient for any history of placement of metal or other implanted devices;"
- ◆ "Evaluates for signs and symptoms of electrical injury (I37);"
- ◆ "Evaluates skin at return electrode site after removal."

All of these interventions and activities should be identified on a nurse competency statement related to electrocautery. In this way, we can begin to organize the information and data related to our nursing activities and patient care quality.

Outcomes as Quality Indicators

Outcome statements can be used as quality indicators for a variety of needs. The patient injury quality indicators parallel the PNDS outcome statements and allow nurses to address peri-

operative patient injuries. Do we need to measure all outcomes for quality indicators? It seems to make sense, in terms of use of resources and JCAHO requirements, to focus on current problems that exist at your institution. Use some of the other data elements, including assessments, interventions, and activities statements, around your institution's particular problems. The advantage of using the PNDS is that the statements are already written. All that is needed is to apply them to the particular facility's needs.

Department Policy and PNDS Outcomes

Policies are meant to link patient outcomes and quality indicators with practice. Here is an example of a policy statement on electrocautery that *does not* include the PNDS:

*The circulating nurse ensures the patient is free from injury regarding the use of electrocautery. He/she is responsible for the placement of the dispersive electrode (grounding pad) and for the use of the electro-surgical unit. The scrub nurse is responsible for all active electrodes.*³

An evaluation of this statement in light of the previous discussion might involve:

- ◆ Does it discuss nurse assessment? No.
- ◆ Is the RN the only individual responsible for the patient being free from injury? Are the comments about the scrub nurse and circulating nurse responsibilities truly exclusive of each other and too specific?

The same data elements related to electrocautery are similar to those described in the PNDS and appear to indicate the actions the nurse is expected to take. If the policy is developed linking patient outcomes and quality indicators with practice, this is a revised statement that incorporates PNDS language:

The nurse is responsible for knowing and applying the principles of electrocautery safety for patient care, based on patient needs

This statement mentions patient needs, risk states, and assessment. The competency statements related to the policy would describe the specific nursing activities. A documentation policy might describe the data elements to be included

on patient and institutional records.

Instead of recreating the wheel every time a new policy or competency is written, we now have a vocabulary that links these together. We should be able to discuss a particular outcome and find a policy describing it, competency statements listing nursing activities that support it, and standards or a plan of care that include it in the overall description of patient care.

Clinical Pathways and PNDS Outcomes

Clinical pathways are sets of activities and goals for a defined population, such as age or procedure or disease, and are aligned with particular time elements for measurement. They specify the anticipated length of stay and particular care activities across a defined timeline. They also provide data that can enhance quality improvement efforts. With the PNDS, we can easily translate the activities and goals used in perioperative pathways into standardized terminology. One could take specific elements to develop a clinical pathway for total hip, diabetics, or pediatric patients in the OR.

Another use for the PNDS and clinical pathways might be to describe the activities related to start time. It seems that every OR discusses strategies to improve the on-time starts of cases or turnover time. One could take the elements particular to start time issues, available in the structural domain of the PNDS, and address the particular outcomes, interventions, and assessments specific to the beginning of cases. This would be an invaluable way to clearly articulate the activities and issues involved in getting cases started in a timely manner.

Documentation Using the PNDS

Much has been discussed about documentation; in fact, this often is the only application of the PNDS discussed. While it would be nice to have electronic records, or simply computer-generated documentation, one does not need computers to incorporate the PNDS into the nursing documentation. A recent effort by the AORN Nursing Practices Committee reviewed more than 100 operative records for common data elements. It was surprising that no single piece of information was found in more than 80% of the records—none. As a perioperative nurse, I

assumed that there were at least some common elements found on all records. This is a reminder that there is little consistency from institution to institution as to how nursing care is documented. No wonder nurses have trouble making our voice heard.

It will not be a surprise to most practicing perioperative nurses, that our records do not provide great evidence of the scope of the nursing care provided, specifically assessment and evaluation. It is no wonder that other providers, who only know what we do by watching us or reading our documentation, think that “anyone could do it, so why should we pay an RN that much?” The PNDS provides a language to describe the critical thinking that constitutes nursing care and the immense planning that is involved in providing every nursing activity.

While the Nursing Practices Committee offers a suggested format for perioperative records, it is most important that we work toward some basic standardized elements, not necessarily a particular format. Not only does each institution demand particular formats, but increasing automation will make the actual format less important in the future. When there is agreement across institutions about which nursing diagnoses, interventions, and outcomes are documented, we will have an immense database to develop and evaluate the contributions of nursing to quality perioperative patient care.

Starting on OR documentation

Take one section of your current document, and either rewrite the statements into PNDS language, or “map” (ie, match) the current statements to the data elements they describe. That is the beginning of “translation” into PNDS. This also is a good time to discuss the documentation of outcomes. While the outcomes are specific, some are particularly problematic for particular time periods in perioperative care. For example, we may be able to measure body fluid balance at the end of the case, but it is much more difficult to measure absence of infection at that point in time.⁴ There are, however, indicators that every OR nurse looks for in his/her patient prior to discharge to the PACU. In the second edition of the PNDS, examples of interim outcome statements are provided and the related outcome indicators are explicated.

The PNDS and Software Documentation

The PNDS has been licensed by a number of software vendors. A license, however, does not mean they know "how" to use it. It is merely a language, a set of terms, and the license gives them permission to use it. How it is used in any software depends on what we, as nurses, tell them. It is our language. It is very important that we speak often and clearly to vendors to tell them what we want, what works, and what will help. This can be anything from how it appears on the hard copy, to what is seen on the screen, to drop down menus, field names, linkages, search words, field flow, and any number of issues.

One idea being considered involves conditional or decisional "bundles" that involve particular data elements related to a procedure, disease, or age. For example, the nurse who is caring for a total hip patient already has a plan of care using the PNDS. That's good, but this patient also has diabetes. It would be beneficial if one could "merge" or drop in that "bundle" of outcomes and related interventions/activities to the existing plan of care. Perhaps this patient also is elderly or blind. Just being able to drop in "bundles" of data elements to an existing plan would allow nurses to easily and quickly develop individualized plans of care, with activities, outcomes, and diagnoses particular to the unique patient. This kind of ability will truly move us forward with standardized language and software applications.

PNDS in Reports

Are you a manager or involved with measurements necessary to run the business of the OR? The structural elements have many standardized definitions for a variety of terms, such as staff per hour or staff per case, or time definitions taken from the Association of Anesthesia Clinical Directors (AACD) lexicon, "Glossary of Times Used for Scheduling and Monitoring of Diagnostic and Therapeutic Procedures."⁵ If you have ever tried to share data with another institution, you know how frustrating it is when they are not comparable because they were based on different definitions. With consistent definitions across institutions, we have a new ability to share information and improve our practice.

What if we could develop a basic "report card" for the OR that involved a "minimum data set"

that could be shared across many institutions of various sizes? Perhaps then we could get closer to the "correct" number of staff for particular sizes of ORs, types of populations, and other administrative issues.

Only in having standardized terms for measuring structural elements (eg, time, staffing) and patient care elements (eg, activities, outcomes) will we finally be able to obtain reliable measurements of cost that include quality. We currently can measure cost of supplies and staff, but quality is sometimes measured only as an absence of problems. Expansion and refinement of the structural elements related to perioperative practice is planned for the future.

Reminders for Bringing PNDS to Your Workplace

Remember that this is a new language, and just as if you were learning German or Italian, be patient. Just jump in, and do not be afraid of making mistakes. As pioneers, we may not do it all correctly the first time, and part of exploring is learning from our mistakes. The work has only begun, so we really don't know all the paths we will cross on our journey, and we must be willing to start down some uncharted roads. Every answer seems to beget more questions, which is alternately exciting and exhausting!

1. Find a buddy, whether in your institution, in your chapter, or by e-mail. It is much like living as an exchange student—the more you can talk the language, the more easily you will be able to think in it.
2. Remember in French class when you would learn words for family one day, and words for animals another day? If you don't like working on documentation, work on something else you enjoy, whether it is policy, standards, or competencies. There are many different applications and all of them need to have our standardized language as linkages.
3. Share questions with others. Do not assume you are the only one asking the question. Some gaps for which we need further elements developed have already been identified. Think of the fun we will have in finding out which interventions/activities best support the outcomes for particular populations. The real development of the PNDS will come from

the staff nurses who use it in daily practice.
Your organization needs to hear from you!

If this is the first time you have looked through the PNDS, then you too can begin the journey. Don't worry about a computer—pencil, paper, and your clinical expertise are all you need. Talk to your chapter and national officers about PNDS clinical applications. It is our tool for articulating our worth as perioperative nurses, and we cannot pause in our efforts to use this tool. So share your thoughts and experience, and help move our specialty into the future.