

NURSING CARE PLANS, DOCUMENTATION, AND THE PNDS

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Until recently, the contributions of most perioperative nurses have not consistently been made explicit in a formal nursing care plan or as part of the patient's record. In fact, the professional aspects of the perioperative nurse's role are often embedded in the care provided and never fully articulated, described, or documented. Regardless of this clinical reality, professional nursing practice and the nursing process provide the framework for assessing patients' needs, identifying clinical problems (ie, nursing diagnoses), planning and delivering appropriate nursing care, and evaluating patient outcomes.

The development of the PNDS emerged from efforts to describe the dimensions of nursing practice within surgical settings. Nursing diagnoses from the North American Nursing Diagnosis Association (NANDA) taxonomy provide a framework for understanding the human responses identified and managed by professional nurses in perioperative settings. Specific perioperative outcome and intervention statements establish a meaningful relationship between nursing care and clinical outcomes in surgical settings. Identification of clear, precise terms related to perioperative practice is critical to describing and documenting the care provided by nurses to patients undergoing surgical or other invasive procedures.

Perioperative Nursing Care Plans

The formal written nursing care plan in the OR or perioperative service generally takes one of three forms. Many facilities establish standards of care or "standard" nursing care plans in an effort to describe nursing care. A second strategy is to incorporate this standard of care within the perioperative record. The third approach supports the development of an individualized plan of care for each patient undergoing surgery.

Standards of care or standard care plans often are placed in a department manual as a reference for clinical staff. Typical standards describe commonly occurring clinical problems and the facility-approved interventions and expected outcomes. These types of standards reflect policies and procedures for specific care routines in an effort to address the majority of patients' needs with one nonspecific nursing care plan. Perioperative documentation forms may require that the nurse document the specific standard of care provided for a specific patient. For example, the clinical record may state "Care provided consistent with standard care plan for general surgery patient." These generic types of care plans address the common experiences and needs of surgical patients, but do not reflect how care is individualized to meet the unique needs of a patient. Care plans such as these also might migrate to the patient's record via a printed copy of the standard that the nurse then initials and places in the chart. Few such care plans provide an opportunity or space for individualized care needs to be addressed or documented.

Building on the standards concept, many institutions have embedded a generic care plan within the perioperative record. Using this framework, the nurse is essentially obliged to document using a nursing process framework and records care by selecting one or more pre-identified nursing diagnoses, related nursing interventions, and expected patient outcomes. In this model, some type of check-off framework in an electronic or manual documentation form is commonly used. It allows the nurse to readily document patients' responses to the surgical experience within this predetermined nursing process framework.

This documentation model often depends on the patient's problems and needs fitting the clinical record. Thus, patient specific needs and problems may never be fully represented or documented on the clinical record. Given the demands of most clinical environments, few nurses or facilities can afford the time to implement the third option of a fully individualized care plan for each surgical patient. While many facilities describe a philosophy of individualized care, it may never be fully evidenced in a standard nursing care plan or within a generic documentation form. Despite these practice realities, regulators require clinicians to document an individualized care plan and meet related standards despite today's fast-paced clinical settings.

Nursing Care Plan Standards

State health departments or regulatory or accrediting agencies (eg, JCAHO) are most frequently cited as authorities that establish and evaluate standards for nursing care planning. For example, according to JCAHO's *Comprehensive Accreditation Manual for Hospitals* (CAMH), "Care of Patients" chapter, standard TX.5.3 states that: "plans of care are developed and documented in the patient's medical record before the operative or other procedure is performed." Furthermore, in describing the intent of TX.5.3, JCAHO states that

adequate preoperative assessment and planning helps meet patients' needs with an appropriate level of safe and effective care. To ensure optimal patient care and safety, the following are developed or performed before the procedure is performed:

- a. A nursing plan of care;
- b. A plan for the operative or other procedure;
- c. A post-procedure plan of care;
- d. Assessment of the need for additional diagnostic data;
- e. Initial assessment of patient acuity to determine the appropriate level of post-procedure care; and
- f. Initial assessment of the patient's physical, mental, and neurological status and needs

*Plans of care are developed and documented in the patient's medical record before the operative or other procedure is performed. During the procedure, the patient's physiological status is monitored at a level consistent with the procedure's potential effect and a registered nurse supervises perioperative nursing care.*¹⁰

The CAMH provides a helpful example of effective implementation of the standard by describing how, during the preoperative assessment, the nurse notes any information that could affect the postanesthesia care phase. Examples of such information include the finding that a patient scheduled for inguinal hernia repair complains of low back pain when lying on his back. Effective implementation of the standard is demonstrated when this specific information is

communicated to both the intraoperative and PACU nursing staff members.¹¹

This individualization and coordination of nursing care can only occur when clinical records support effective communication of patients' special needs and requests as patients move from a clinical unit or admission department to the OR, PACU, and eventual discharge. In this example, the preoperative assessment contributes to subsequent clinical decisions about positioning devices—thus addressing an identified clinical problem and implementing appropriate nursing interventions. Nursing care plans can provide one helpful approach to identifying, providing, and documenting individualized patient care in the perioperative setting.

Nursing Care Plans and the PNDS

When nurses use a standardized vocabulary or set of terms, such as the PNDS, they identify and address clinical problems using a common language. In the example given, the clinical problem (ie, nursing diagnosis) is "risk for perioperative positioning injury related to back pain." When the nurse completing the assessment identifies this patient's need and includes it as part of the written care plan, subsequent caregivers recognize the need to implement specific interventions to address the patient's needs.

The use of a standard vocabulary in written care plans further facilitates continuity of care across the continuum by classifying patients' experiences, nursing interventions, and patient outcomes using the same terms. This supports a shared understanding and common meaning by clinicians. For example, nurses could label skin breakdown in a variety of ways using terms such as *stage II ulcer*, *ulcerated area*, *skin breakdown*, *bedsore*, *pressure area*, or *decubitus ulcer*. Using a clear, precise term such as *stage II decubitus ulcer* should help all professional nurses understand the degree of skin loss and the appearance of the ulcer. Clear, precise, and consistent language complete with definitions should provide the basis of identifying and recording nursing care.

The PNDS provides a framework and terminology for identifying clinical problems, nursing interventions, and clinical outcomes and can be used in standards of care; standard care plans or clinical pathways, generic documentation forms,

and individualized care plans. The nursing process provides the foundation for determining patients' needs and establishing the nursing care plan. Subjective and objective assessment data support the identification of clinical problems or nursing diagnoses and the related etiology or cause. Assessment data are used to identify the signs and symptoms of a nursing diagnosis or clinical problem. The etiology of a clinical problem and the desired outcome should help determine appropriate nursing interventions. Assessment data collected regarding the patient's status and response to interventions across the continuum of care contribute to the evaluation process.

A number of surgical departments have used the PNDS to develop their manual or electronic care plans. By providing a structured documentation form, these institutions have provided nurses with a framework to record routine aspects of care and individualize documentation based on the patient's condition, needs, and clinical situation (Appendix VII). In addition, a number of software vendors have used a similar documentation framework for developing documentation software and designing screens.

AORN has developed two care plans that represent the most common needs of adult general surgical patients in the immediate preoperative and intraoperative phases of care (Appendix VI). These care plans provide examples of strategies to incorporate the PNDS in both nursing care plans and related documents. Identifying common patient responses to the surgical experience and appropriate interventions helps clinicians provide safe, competent care to all patients. Documenting care in a uniform manner allows data to be captured, compared, retrieved, and used to a meaningful way. This is when the true value of structured vocabulary is realized.

Clinical Documentation Using the Perioperative Nursing Data Set

In 2000, The AORN Nursing Practices Committee was charged by the AORN Board of Directors to "investigate and develop a sample intraoperative record based on the Perioperative Nursing Data Set (PNDS)." To meet this charge, the Committee, with the assistance of AORN's director of research, requested AORN members to submit samples of intraoperative records currently in use.

Based on an analysis of more than 100 clinical records, Committee members concluded that in surgical settings, the professional aspects of intraoperative nursing practice are embedded in the care delivered and not accurately or fully represented in the reviewed clinical documentation tools. The group decided that to understand the contributions of perioperative nurses to surgical outcomes, the framework for documentation must be structured in such a way to accurately represent nursing assessment, nursing diagnoses, interventions, and outcomes. Thus, the benefits of a structured vocabulary can only be fully realized when documentation tools are developed that reflect the professional role of the RN.

Next, the Nursing Practices Committee developed a proposed list of data fields for an intraoperative record using a nursing process framework. The data fields represent examples of how the PNDS can be incorporated into a perioperative nursing record. Though the PNDS is intended for use throughout the entire perioperative experience, this initial documentation effort only addressed the intraoperative phase of care. The following year, the Committee developed a list of data fields for a preoperative assessment. Further efforts will address refinement of the existing data fields, documentation of the postoperative phase of care, and identification of specialty-related data fields.

Both lists of data fields identify common data elements found on many preoperative assessments and intraoperative records. This reflects efforts by the Nursing Practices Committee to describe and document professional nursing practice activities and structural data elements commonly collected during both phases of care. These lists are considered a working document. They should help perioperative nurses work toward documentation forms that better reflect perioperative professional nursing practice and incorporate structured vocabulary. Utilization of these data fields will establish a more consistent pattern of documentation across settings. These data fields represent perioperative professional nursing practice during the preoperative assessment and intraoperative period and can be used in either paper or electronic records. Each PNDS nursing diagnosis, intervention, and outcome is identified with its unique identifier. See Appendix VI for intraoperative and preoperative assessment data fields.

This strategy provides a consistent approach to documenting nursing assessments, clinical problems, nursing interventions, activities, and outcomes. The list of data fields might need to be adapted based on case types, clinical situations, and patient experiences within a particular setting or system. Obviously, any clinical record should provide an opportunity for clinicians to document the unique needs and experiences of the patient as well as address age-specific and cultural needs and interventions. These draft data fields are proposed as an example and not as a requirement or guideline. See Appendix VI for sample records using some of these data fields.

These current efforts focus on documentation for an adult general surgical population in an acute care setting. It is anticipated that clinical settings will add/delete data fields based on the unique needs of the setting and population(s) served. The AORN Nursing Practices Committee hopes that clinical agencies will work toward validating this framework and provide feedback to Committee members regarding its utility and fit to clinical practice.

Within this proposed list, structural data fields are defined as information generally collected by the nurse, but not integral to professional nursing practice. Nursing data fields are defined as specific data fields that reflect professional nursing practice—assessment; identification of clinical judgments (ie, nursing diagnoses); and nursing interventions, activities, and outcomes. Additional problems, interventions, activities, and outcome indicators should be identified based on the individual needs of the patient. Within this framework for documentation, example interim outcome statements are identified and mapped back to the broader PNDS outcome statements. Intervention statements also have been mapped to the PNDS. Intervention statements without unique identifiers have been recommended as potential additions to the PNDS after clinical testing and validation.

This effort to identify “best practice” in perioperative documentation is consistent with the need to accurately represent professional nursing practice in perioperative settings using the PNDS. The scope of professional nursing practice is distinguished from other nursing roles by assessment activities and the identification of clinical problems. Documenting these aspects of practice con-

tributes to our understanding of the contributions of RNs to patient outcomes.

A structured documentation format that uses the PNDS supports categorizing information and collecting data about the contributions of nurses in perioperative settings. The members of the AORN Nursing Practices Committee welcome your comments and suggestions. Testing and validation of these data fields in paper and electronic records will assist in efforts to refine this proposed list.

Regardless of the format, nursing care plans and related documentation forms must reflect the dynamics of patient-related assessment and the identification of clinical problems. Experienced perioperative nurses may routinely perform assessments, identify problems, and implement appropriate interventions without documenting those aspects of care. If they do record them in a narrative fashion, it may be difficult if not impossible to retrieve the information in a meaningful way. Use of a structured vocabulary such as the PNDS in nursing care plans and related documents supports the ability to categorized information and collect and analyze data related to the contributions of nurses to patient outcomes in perioperative settings.