Wound Addendum-Creating Wound Orders

SUMMARY

The following describes the process for entering and working with physician wound orders in Wound Advisor/ Wound Addendum of Horizon.

ROLES

Clinician

1. The clinician will enter the order in Horizon when taken.

2. Each wound order will be separate.

3. The clinician will document receipt of the verbal order in the Notes section of Horizon in a **Case Communication Note** or in the visit documentation if received during a visit.

4. The clinician who took the order should review and sign the printed verbal order. In the event that the clinician is not available to review/sign the order in a timely manner, then the supervisor/RN staff can review and sign the order if the receipt of the verbal order is clearly documented in the record.

5. If a clinician does not have a computer available when the order is taken, the clinician will document the verbal order on the modified order form, HBS 209 or the Therapy Care Plan, HBS-114c, HBS-117c, HBS-119d. As soon as a computer is available, the clinician will enter the order into Horizon. The Order entered in Horizon will be tracked and mailed to the Physician. A note will need to be made on the original HBS 209 to explain. The original HBS 209 will not be mailed to the physician but will be placed in the permanent record.
    - The clinician will date and sign the original HBS 209 prior to placing in the permanent record.

Process

There are two different methods for entering Wound Orders. The orders can be entered from the **Order Screen** or the orders can be entered from the **Wound Addendum** of Wound Advisor.

Entering Orders from the Order Screen

1. From the Horizon main menu, go to **Clinical/Clinical Explorer**.
    - Go to **Tools** and **Add Case.**
    - Select the correct patient and admission. Click **Ok.**
    - Highlight the patient name in the tree then click **Orders.**
    - Click **Add Treatment** or go to **Tools/Add Treatment Order**.

2. The **New Order** screen appears. Use the drop down box to select the correct **Service Type** (discipline) for the new order.

3. Do not complete the **Amount/Frequency/Duration (AFD)** for wound orders. (The **Amount/Duration/Frequency (AFD)** will be captured in the separate SN or PT orders.)
    - If you accidentally tab too far and get an extra line, put the curser in the extra line to highlight the line then press the delete key.

4. Do not select **Generate Service Order**. (The separate SN or PT orders mentioned above in #3 will be generated.)

5. Select **Add Wound Order** (located approximately in the middle of the Order Screen).

6. Select **Existing Wound** or **Create New Wound**.

    When **Select Existing Wound** is chosen a grid will be visible that shows all existing wounds. (If desired to show/choose **Inactive Wounds** click in the **Show Inactive Wound Box** on the right side of grid. An Inactive Wound should be re-activated if a wound re-opens.)

    - Select the existing wound by placing a check mark in the box located beside the desired wound, then click **Ok.**
    - The **New Order Screen** will appear.

- **Select a Standard Protocol** or **Create a Non-Standard Protocol**.

  Standard Protocol

  - If a **Standard Protocol** is chosen, the **Protocol Screen** will appear with the **Available Protocols** section. The **Wound Type** will be displayed.
  - Click the **Search** button for the displayed **Wound Type** to view all **Standard Protocols** available for the patient's **Wound Type**.
  - The **Available Protocols** can be expanded by clicking the **+** sign beside the desired Wound Protocol.
  - Highlight the desired Wound Protocol and then click **Ok.**
  - Complete the Wound Protocol **Amount** and **Frequency**. Complete this section to show how often the Wound Protocol will be performed. (This is not how often the nurse will visit, but is intended to show how often the Wound Protocol selected will be done.) Click **Ok** and the **Order Screen** will re-appear. (**Do not click Ok/Save New** button because the system will group all the wound orders on one order which **is not the correct process**.)
  - Verify that the correct **Wound Label** is on the order. The **Wound Label** is located on the Order Screen above the Wound Protocol. Each wound must be entered separately.
  - Type in the **Order Text Section** (located above the Wound Protocol section of the Order) the procedure and the generic products/supplies to be used. Document who will perform the wound care when the clinician doesn't visit. (The reason the nurse must enter the specific wound care procedure and the wound care products, is that the Standard Protocols are general. Once the specifics of the wound care and products are entered in the order, a check mark can be placed beside **Performed** in the Wound Addendum, to indicate that the exact wound care was provided.)

  Non-Standard Protocol

  - When the **Non-Standard Protocol** is selected the Protocol **Amount** and **Frequency** must be completed. Complete this section to show how often the Wound Protocol will be performed. (This is not how often the nurse will visit, but is intended to show how often the Wound Protocol selected will be done.)

- Document the **Non Standard Protocol** specifying the specific wound care procedure and the generic wound care products used. Document who will perform the wound care on the days that the clinician doesn't visit. A check can be placed beside **Performed in the Wound Addendum** to indicate that the exact wound care was provided.

When **Create New Wound** is selected the **Wound Addendum** will display the **Create New Wound Screen** with the body diagram. Complete the location of the wound on the body diagram.

- The clinician can toggle between front, side, feet and back views. Rotate the body to choose left, right, front, or back.
- The **Zoom** button is used to zoom in or out on the diagram. Click the **New** button, and then click on the body to designate the location of the wound. There will be a bandaid to appear at the desired location of the wound. The bandaid will be green until the wound is saved, then the bandaid will turn blue.
- On the top Right section of the body diagram screen the **Wound ID** number will be displayed along with the description of the **Wound Location**. Prior to clicking **Done,** if a wound has been documented in the wrong location, the location of the wound can be moved by clicking and moving the green bandaid. (If the **Done** button is clicked the wound cannot be moved while in the **Order** Screen.) The location of the wound can be moved from the Wound Addendum Screen if necessary at this point. If unable to move a wound contact the Division of Home Care-Horizon Support staff for assistance.

- Use the drop down to select the **Onset Date** or **First Observed**. The **Onset Date** would be the date, for example, of a patient's surgery or trauma date, etc, if known. The **First Observed** date can be selected to indicate the date the clinician first observed the wound or it can be used if the **Onset Date** is not known. Choose the most appropriate for each patient.

- Select **Type** of wound from the drop down box. Click **Done**. (**Do not Click Save/Add New** because the wounds need to be documented separately. Grouping the wounds together creates an error in Horizon.)
- Choose **Select Standard Protocol** or **Create Non-Standard Protocol**. Follow the procedure above for **Selecting a Standard Protocol** or **Creating Non-Standard Protocol.**

7. Complete the **Order Text Section** by listing the specific wound care procedure and the generic wound care products used. Document who will perform wound care on the days that clinician doesn't visit.

8. When more than one wound is in the **same location** (as labeled on the **Wound Addendum Wound Location Section**) enter the last 4 digits of the **Wound ID#** into the **Order Text Section** to differentiate the wounds. (The Wound ID # is then displayed in the orders and 485 if applicable, so that the clinician and office staff will be able to differentiate the wounds.)

9. Enter **Taken, Begin** and **End Dates**.
    - Use the last day of the 60 day certification period or the date that the orders end.
    - A 1 day visit can have the **Begin** and **End** date the same date.

10. Verify **Author**. Click **Search** to select and alternate personnel as the author.

11. Verify **Physician's Name**. Click **Search** to select an alternate physician.

Entering Orders from the Wound Addendum

1. From the Wound Addendum go to the **Protocol Section** located near the bottom of the document. Click **Add.**

2. Click **Standard** or **Non- Standard Protocol.**

3. Verify **Wound Type** and click **Search** to display available **Wound Protocols** for the **Standard Protocols**. Click the **+** sign to expand the **Protocols**.

4. Highlight the desired **Wound Care Protocol.**

5. Enter **Amount** and **Frequency** of the **Wound Protocol**. (This is not how often the nurse will visit, but it indicates how often the **Wound Protocol** will be done.)

6. If a **Non-Standard Protocol** is desired, type the specific wound care procedure and the generic wound care products to be used in the blank **Wound Protocol Section** located below the **Amount** and **Frequency** of the Wound Protocol.

7. Click **Create Order.**

8. The Clinician will then see the **New Order Screen**.

9. Verify the **Service Type** (discipline) for the new order. Utilize the drop down box if necessary to select the correct discipline.

10. **Do not** fill in the **Amount, Frequency, and Duration (AFD)** on wound care orders. (The Amount/Frequency/Duration (AFD) will be captured in the separate SN or PT orders.)

11. Verify that the Order has the correct **Wound Label** on the order. The Wound Label is located on the Order Screen above the Wound Protocol. Each wound must be entered separately.

12. Enter the specific wound care procedure and generic wound care products used in the **Order Text Section.** If more than one wound is in the same location, enter the last 4 digits of the **Wound ID #** in the **Order Text Section** to differentiate the wounds. Document who will perform wound care on the days that the clinician doesn't visit.

13. Enter **Taken, Begin** and **End Dates**.
    - Use the last day of the 60 day certification period or the date that the orders end.
    - A 1 day visit can have the **Begin** and **End** date the same date.

14. Verify **Author.** Click Search to select an alternate personnel as the author.

15. Verify **Physician's Name**. Click **Search** to select an alternate physician.

16. Click **Ok.**

17. The screen will then return to the **Wound Addendum**. Verify that the correct Wound Protocol has pulled to the Wound Addendum. If desired, change or correct the Wound Protocol by clicking **Change** just above the Wound Protocol to change.

Create the desired Wound Protocol and return to the Wound Addendum. (It may be necessary to click out of Wound Addendum and then back in, to populate the correct Wound Protocol. Once the clinician verifies that the Wound Addendum has the correct Wound Protocol, place a check in the box indicating that the Wound Protocol was **Performed.**

Create Interim Order for Physician Signature

18. If the orders have been obtained for a SOC certification or a recertification check **NO** to create **Interim Orders for Physician Signature.**
    - Orders will be placed in Locator 21 of the CMS 485 when the cert/recert is created**.**

19. If the orders have been obtained as a change in the plan of care during the 60 day period, the orders are considered modified or interim orders. Check **Yes** in **Create Interim Orders** for signature.

20. Orders that have the **Create Interim Order** for **Physician Signature** box checked will go to job scheduler and will be printed out to go to the physician for signing separately from the Cert/Recert.
    - It is **very important** to check this box for interim/modified orders so that the order is sent to the physician.

Completing Orders

21. Do not complete orders that are obtained for a SOC certification or recertification. These orders will be completed at the time the Cert/Recert is completed.

22. Complete all interim/modified orders (any orders that will not go on the 485) at the time that the order is written by checking the **Complete Order** box.

23. Click **Ok** to save the order.

24. A new order is needed for each discipline. Repeat process for each discipline order.

Completing Orders-If Orders Are Not Completed When Written

1. To complete orders from the main Horizon menu, go to the **Clinical/Clinical Explorer**.

2. Click **Tools** and **Add Case**, select the correct patient. Click **Ok.**

3. Highlight the patient then click **Orders**.

4. Locate the order that needs completing on the orders summary screen.

5. Highlight the order, then click **Edit**.

6. Review all content and modify if necessary.

7. Once reviewed, put a check in **Complete Order.**

8. Click **Ok.**

9. Note: The hyperlink for **Incomplete Documents** from **Clinical Explorer** can also be used to go to the incomplete order.