A Brief Introduction to Protocols

As we move toward the goal of making sure providers have the information they need to support a person well, it is important to have quick and simple tools for communicating information about necessary supports in a way that is easy for providers to understand and follow.

When a serious risk has been identified, there are several ways it can be addressed. Protocols are one available tool that can provide a helpful structure to address a medical risk.

A protocol is a document that contains personalized instructions that tell support providers how to care for a specific risk or other medical issues.
Protocols are typically written by someone who works directly with the person and who knows the person well. This is done by taking into account what is important to and for a person.

Teams may want to seek the advice of a physician or other qualified professional when developing risk management strategies. In this way, the professional's guidance can inform how the protocol is written.
Most doctors will not want to fill out the entire protocol but will be willing to answer specific questions. Physicians and other qualified professionals can help teams determine if a risk is or is not present and may suggest specific ways to address a risk. This information can then be incorporated into the protocol in a way that providers can understand and follow.

There are a couple things to keep in mind before asking a physician or other licensed medical professional to write a protocol:

- ✓ When a licensed medical professional writes a protocol, it should be treated as an order from that professional. Any changes to the protocol would typically be made or approved by the person writing the order. This can be time consuming for a provider and a burden on the person and medical professionals.
- ✓ Physicians use medical jargon that others might not understand. Providers must be able to understand and follow the protocol. The protocol should be written in language that is commonly used.

Nurses need the opportunity to review and approve any support document (protocol, procedure, etc.) that addresses an issue identified in a person's Nursing Care Plan. Nurses may be but are not required to be the original author of support documents; they may review a document created by someone else, modify it as needed, and then sign the document to indicate that it is consistent with the person's Nursing Care Plan.

When a person lives in a 24-Hour Residential setting, protocols must be used as directed by the ISP process. In other settings, like Foster Care and In-Home, the person writing the protocol can choose to use and develop protocols in a way that is most helpful.
When a person lives in a 24-Hour Residential service setting, providers supporting that person (i.e. Residential, Employment, and Day Support providers) are required to use standardized protocol formats to address the risks of Aspiration, Choking, Constipation, Dehydration, and Seizures. The Financial Plan must also follow a standardized format. A general protocol, as well one for pica, is also available. All of these standardized protocol formats are available for download in Microsoft Word Document format at http://oregonisp.org/forms/.

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When a person lives in a setting other than 24-Hour Residential, providers may use any format that works well for them. They can choose to use the available standardized protocols or create their own format.

If creating your own protocol, keep in mind that there are some basic components that a good protocol includes:
- **What is the issue?** Describe how you know the person is at risk for the issue.
- **What does it look like?** List the signs and symptoms to look for. What are the warning signs for the risk?
- **How do we prevent it?** Describe the preventative measures to be taken. What will be done to minimize the chance of the problem occurring?
- **What do we do if we see it?** Describe the specific steps to take if any warning signs are observed. This typically includes instructions on who to call and where to document that the problem occurred.
- **When do we need to call 911?** List the circumstances for when 911 should be called immediately. Remember, you don't need permission to call 911.

Generally speaking and in all settings, if a provider is being paid to support a person, the expected supports must be written down. A few places these supports can be recorded are: in the ISP, in a Service Agreement, or in a Support Document (e.g. Protocol).
There are times when it is helpful to use a protocol. The Services Coordinator or Personal Agent may direct the use of protocols based on their professional judgement. Because of this, it is important for all Services Coordinators and Personal Agents to understand the fundamental purpose of a protocol and have a basic knowledge for when using one is helpful, regardless of the setting in which they provide case management.

- When there are **multiple providers supporting a person**, protocols help to ensure the person is being supported **consistently**. They make sure that all people who provide support have the same information to do a job well.
- When there are **very specific or complex steps** that must be taken, protocols can provide **clear instruction** that might otherwise be forgotten or missed, especially during a stressful moment.
- When it is important for the provider to know how to prevent a risk, what the warning signs are, **what to do** if they see a problem, and when to call 911, protocols offer all this information in **one, easy-to-access document**.

To learn more about support documents, including protocols, refer to the ISP Instruction manual chapter on Risk Management Strategies at http://oregonisp.org/instructions/.