AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

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The Joint Commission has revised its requirements to provide leeway to clinicians and to clarify administration and documentation of titrated medications, along with minimum elements of a complete medication order.

In this interview transcript, AACN Chief Clinical Officer Connie Barden, MSN, RN, CCRN-K, FAAN, speaks with Dr. Robert Campbell, PharmD, director of clinical standards interpretation hospital/ ambulatory programs at The Joint Commission, about the changes and new requirements.

Connie Barden: I'm Connie Barden, Chief Clinical officer at the American Association of Critical Care Nurses and I'm thrilled to get to chat today with Dr. Robert Campbell, from the joint commission on the topic of titration of medications in critical care. Dr. Campbell is a Director of Clinical Standards Interpretation for Hospitals and Ambulatory as well as Director of Medication Management at the Joint Commission. He's a pharmacist by trade and he's been at the Joint Commission for eight years, six of those years as a surveyor, and the last two years in this director position. Before we get started, I do want to mention that here at AACN we've been working with the Joint Commission and others for a number of months on this topic. Robert, I want to thank you personally for the amount of time and attention that you've given to this issue.

You have really listened to the voices of nurses and the concerns of nurses about this and work tirelessly to help us find solutions. We've focused on, how do we ensure patient safety? At the same time, reducing burden on caregivers, and that is a lofty goal. I'm just so pleased with the progress that we've made, and it is your leadership of this collaboration that has brought us to this point. So thank you for that and welcome.

Robert Campbell: Thank you, Connie. Thank you very much. It's been a pleasure to work with you and the other colleagues at American Association of Critical-Care Nurses, and I appreciate the candor we've had and the great teamwork and collaboration we've had.

Connie: Well, let's get to it and tell people what's going on. We know that changes are coming. Changes have occurred. So, shall we just start with you giving the general outline of what is changing related to titration of meds specifically?

Robert: Sure. After we met with a number of customers and accredited organizations through some work with you and your team, as well as some other customers of accredited organizations that we have, we were really able to put the concerns into three buckets.

The first one had to do with, how should we effectively order titration medications? The second one was the burden that was associated with the

charting, especially in those critical moments where a patient's very unstable and has a high number of alterations that must occur to the medications. Lastly, the selection of those medications during those moments. We wanted to take a look at each one of those. We did that and we made some changes to our standards. We also have altered some of our interpretations of our requirements as well.

So we first looked at the ordering, which is under our Medication Management 040101, DP-1. And we realized right off the bat we needed to enhance look at, what are the complete components of a medication order in general? We put that in there to ensure that everyone was clear on that particular piece, and I think we had some great conversation about that. We then took it a step further and addressed the components that we've had in our frequently asked question now for several years around what needs to be in a titration order. We cross walked that over to those complete medication components and we added that in there as well. It's out in the June *Perspectives*, and then that will be official in the standard starting Jan. 1, 2021.

Those components that need to be there for the medication order are now a part of the standard. We then took a look at the charting requirements. So you have a nurse who has multiple agents that are being titrated, a very critically ill patient, complex care. We heard what was said. We want the nurses to be focused on the care and not focused on charting. So we came up with the concept of block charting, and what needs to be there for that particular piece. That's the abbreviated charting, and we'll talk about a little more of this later on. Some of that abbreviated charting in unique situations where the nurse really needs to be at the patient's bedside and tentative to the care of the patient. We've instituted that particular piece and allowed that.

Lastly, one that I think is a huge win, has to do with when you have multiple agents for the same condition, and you need to denote those minute changes based upon that patient's unique physiological response to the medications – the ability to do that, list some set parameters around it, which really allows the nurse to use their professional judgment in making the right decisions within the confines of the order.

Connie: These are such great strides. And the last one that you mentioned I think really is a nod to, in that moment, in those moments, no one knows the patient better than the nurse who's been watching the response that a patient has to various medications, and as you said, we can get into those details a little bit later. The way that I read the *Perspectives* paper, it seems to me that this applies to three types of medications in general, and those three vasoactives?

Robert: Correct.

Connie: Alright. And titrated pain medications and sedative medications, is that correct?

Robert: Absolutely. We chose those three types of agents based upon conversations that you and I have had, and some other key stakeholders at AACN, and then as well as the bedside nurses that we've interviewed and talked with them across multiple organizations. Those are really the three that you can find yourself in really complicated situations, especially with the complicated care we're seeing today. Our technology allows us to keep patients alive with more complex conditions than years ago, and that requires a more comprehensive and complex approach to care that really has been facing the nurse that we want to make sure that we are relative to now with the care being provided.

Connie: Yes, excellent. You mentioned that the actual elements of the medication order have been clarified further. Do you want to talk about what the key elements are in the new standard?

Robert: Sure. Specifically around titration medications, we continue to enforce, and I think when we all sat down and had a conversation about this, we've determined that these really were the safest things to do. So medication name, clearly you need the medication name, the route it's going to be administered, the starting dose. So when you start the medication, what rate do you start it at? Then how often can you increase the rate and by how much can you change the rate? How high should the rate get before you call the doctor to say, “This isn't working.”

Connie Barden: Yes, right.

Robert Camp: Then lastly, that clinical endpoint. What is your target? Where are you wanting to get the patient to? When we started talking with different organizations, one of the things that we were hearing was that these requirements were so restrictive. But as we further talked, we identified that there's a lot of misunderstandings with some of our requirements. For example, there's nothing that prohibits a range order in any of the things we just talked about. If you want to have a range order in intermittent dose increase, if you want to have a range order and the frequency has changed, that's fine. If you want to have double range orders, Joint Commission does not prohibit that. And really we would encourage you to look at how the medications are being administered today and work backwards to build that order so you accommodate 90% of the time.

Then those unique cases that happen, you likely have a provider very close by that you can make those changes that need to be made. But for the most part, you make the orders broad enough to cover and allow the nurse to have the flexibility to provide the best care she can or he can to the patients.

Connie: Excellent. That was going to be my next question, about the range orders. The range order is actually not new, is that correct? This is just something that's needed to be clarified.

Robert: That is absolutely correct.

Connie: So range orders and double range orders are allowed by Joint Commission.

Robert: Yes, yes. They were allowed in regular orders, titration orders, PRN orders, any type of order you want to have. They're absolutely allowed.

Connie: Great to know. I think that is a myth. If we ever do another one of these sessions on myth busting, that'll be one at them.

Robert: Yes.

Connie: So Robert, let me just pause and clarify, because you and I are talking now in June of 2020, which is still in the midst of the COVID-19 pandemic. Just to be clear, this new release changing the standards and clarification is not related to COVID-19. Is that correct?

Robert: That's right. When I look back at our notes, you and I first made contact August of 2019 and we've been working diligently since then, both by getting voice of the customer, talking with accredited organizations, talking to bedside care providers, working with your leadership team, trying to get a full grasp and understanding of what opportunities there were in addressing this issue. Then we did our entire internal review of looking at the literature. Then we had to work with our CMS stakeholders to make sure that the approval process was there. And so the standard that's changed is set to take effect in January of 2021. We were required to publish that now to allow six months in accordance with our policies. The other things though were set to go out later this year in the September release of the publication, but when I took it to the officers and I said, "A lot of these things really opened the door for reduced burden for bedside nurses."

There's not a better time than right now to reduce that burden with what's being faced on the front line. We made the decision to reach out to AACN and say, "Hey, we're thinking about this again. We need your voice of the customer." If organizations are either experienced in surge or not, they can adopt all of this today and it would be acceptable and allowable. We would encourage to do that, but this has nothing to do with the COVID-19 pandemic. This is here to stay and we'll continue to refine it some if we need to, but this has been a long journey that has taken us to today where we are.

Connie: I think this such great news for nurses taking care of these patients. I would say the things that are important to the nurses – the ability now to work with our hospitals and make it okay, have some policies in place for block charting, decision making between medications and so forth, we'll review those things in a second. Those things that really have been getting in the way of feeling like you were giving the best care to patients – that can be instituted now.

Robert: Right.

Connie: If a hospital has been cited previously related to these topics because this leeway wasn't in place, will this impact them in future surveys? Will it have any impact at all, one connection of one thing to the other?

Robert: Well, I would say it probably has a positive impact, because they can probably go back to part of maybe what they were doing before. So it would not. When we do an onsite survey, our focus is, "what was required at that time?" When we start restarting surveys now, if surveyors go out, they will look at what's occurring now based on the hospital policy and what our requirements are. We're in the process now of educating our surveyors on a number of items, as you can imagine. This is one of those topics that we are talking with them about. If an organization had made changes in the past around some of this and they would like to go back, as long as it's within the compliance of what we've talked about in this *Perspectives* article and in this video interview, they can feel free to do that and there would not be any scoring of noncompliance for that.

Connie: Beautiful. I think there's a lot of curiosity around, when you make changes – and this is certainly significant for nurses – how do these things get communicated out to surveyors? And what should I do if I don't think my surveyor gets it, and what's the best approach in a situation like that?

Robert: So, Connie, that's a great question because it opens up some additional things I think is important for people to understand. First, we'll talk about the surveyor education process. We do that through a number of ways. We have a newsletter that goes out to our surveyors every week, much like organizations do. The computer based learning that we all dread having to do, we have to do those as well. We built modules for some of this. A lot of what we're talking about today though, would be face-to-face Zoom or Skype meetings where we meet with the surveyors. I develop PowerPoints for them, I give them the details in and out, things to look for, the things that I think might be misunderstood or misconstrued to try to prevent the concept of over-surveying, if you will, while surveyors are out.

Then we have an internal database that we utilize. It's called Site, and it's kind of like the Google of a Joint Commission. Surveyors can type in keywords and find stuff. In this *Perspectives* article, there will be a link to the documentation and

the guidance in there. They can always write in to central office during a survey. But let's talk about for a minute, and this isn't just titration, this is anything really, this is something that organizations have the ability to do, but not everyone takes advantage of it, because they're concerned if they say something there'll be some type of retribution to them from a surveyor. Surveyors want to get it right. We don't want people fixing stuff that's not broken. We want you to focus on continuing to improve what you're doing. If there's a risk, we can identify it for you, help you mitigate it and move forward.

If a survey is occurring and the organization just feels, "This is not matching what Robert and Connie talked about, this is not matching what's there," then they can ask for a special issue resolution session where they'll sit down and talk about it. If they can't get that, then they can say, "Can we have a collaborative call with central office and SIG, the Standards Interpretation Group?" the department that I work in. At that point, they would then set up a call with our department, likely it would be need for titrations, and we'll just get on the phone and have a call just like this and talk about it and make sure at the end of that conversation what needs to happen happens. It may be a finding comes out, it may be a finding stays, but the true intent can be further investigated and shared with everyone there to level the playing field and make sure we walk away, that record is as accurate as possible and they only address things that have to be addressed.

So that's something that's taken advantage of that's not well known or understood, that I want to encourage people to take consideration for.

Connie: Well, that just catapulted to the top of my myth busters list, because it's just plain lack of knowledge, I'd say. I would say the majority of people, nurses anyway, don't have any idea that that's a possibility, and it actually sounds to me like it would move the caregivers and the surveyors closer to maybe a little more collaboration.

Robert: Absolutely.

Connie: I don't think we're connecting here. I understand I can do this and I would feel very happy if it got to your office and we would know it would be taken care of. That's great news.

Robert: Absolutely.

Connie: Going back to what we're talking about with the changes, this is a tricky one, but I wanted to ask you, I read something I believe it was in the *Perspectives* about, as we're titrating medications, if we pause a medication, let's say the blood pressure gets stabilized, and we want to pause it but we know good and well in 10 minutes we may have to start it back again, how is pausing a medication as

being titrated different from discontinuing? Are there any things we need to know about that distinction?

Robert: There is, and again, we're going down memory lane here for a minute. If you remember one of our first calls with a larger group of people, I made the statement, "A titration order is nothing more than a PRN order on steroids."

Connie: Yes, you did.

Robert: So, basically, what that doctor is saying is, "I need you to keep that patient's blood pressure above X, and I want you to use this drug to do it." It's no different than if you have an order for morphine and the morphine order is PRN pain, severe pain. And so when the nurse assesses the patient, the patient doesn't have severe pain, so they don't give the morphine. Same concept with a titration order. The patient is on a pressor, the patient's arterial pressure is high enough they don't need to be on the pressors. So the nurse pauses the medication but has it available in case the patient's blood pressure goes down and they need to restart it.

Robert: So, again, if you pause a medication, that is not discontinuing it – it's simply stopping the medication because the conditions are not met to continue to administer the medication. Now, the trick is when you want to restart it. So now if you want to restart it, how do you restart it? The drug you mentioned leaves that to the organization. You can either start them at the dose they were at when they stopped, you can start at half the dose they were at, you could start at the starting dose, you can start at a higher dose, a lower dose. That's all up to the organization to decide in their policies and in the orders, and they can determine the best way to do that. Discontinuing really comes from either A, a physician writes an order discontinue level fed, or B, you could have a policy that says, "If the medication has been paused or stopped for more than 24 hours, it's discontinued from the MAR," those types of things.

Robert: Just stopping it because a patient's criteria was not met to continue the medication at that moment does not mean you need to get a new order to start it later on, unless that is your hospital policy. And I would discourage that. That's a lot of extra work for nurses and physicians to get that done in those acute critical moments.

Connie: It sounds to me like there is a lot more power and capability as long as we have orders to cover things or policies that cover things.

Robert: Yes.

Connie: Clarification from this conversation is – range orders are allowed, range orders are allowed by Joint Commission and even double range orders. So I think that's

huge because most people don't think that is the case. In the case of medications being actively titrated – and we're specifically talking about vasoactive drugs, pain medications, and sedative medications being actively titrated – if a hospital has a policy that states this, we can use block charting in those instances that are delineated in the policy. Then thirdly, once certain criteria have been met, nurses can use clinical judgment in selecting between differing medications and those criteria being met – maybe that the nurse has demonstrated competency in hospital or other types of things. But if there's a policy that allows that and it's consistent with state nursing practice orders and so forth, or nursing practice acts, the nurses can choose between different medications as needed. Correct?

Robert: There are a couple of more nuances and details.

Connie: Okay, good.

Robert: There are just a couple of things to think about. For the block charting, that's reserved for those true critical situations. I'll give you an example. We had a survey going on and I talked to one of the surveyors from that survey event and they had just had a patient come back who had a double organ transplant, was on eight IV titrated medications. Everything that could go wrong seemed to be going wrong. The patient was just not responding well. This was no reflection on the care provided. It was just that things happen. Even when you do everything correct, things can go wrong. So the idea of the block charting, that's when block charting is appropriate, when you have those multiple agents that have significant amounts of change that are rapid and frequent. Frankly, the nurse would have spent all of her time in the medical record charting had she been charting every single change.

What we're saying is, "You know what? You can do block charting, just list the medication that you were given. You want to list the maximum dose they got to. When did you start the charting? When did you end the charting? And you need to keep it within a four hour window, and if it goes beyond four hours, just start a new block." For the most part, the research that we've done was that you should be able to stabilize a patient to get out of those really frequent changes within that four-hour timeframe. If you can't, start a new block and then go from there. So those are some of the pieces, and again, all that's going to be in our glossary of The Accreditation Manual. It's in the *Perspectives* article. Then we have a note at the record of care chapter as well.

The other pieces is, you hit on the head perfect, as long as it's not for the nursing to choose the medication, it used to be either in the policy or the order, it needs to be consistent with the State Practice Act. And when we say consistent, what we mean is it's not prohibited. So it doesn't have to be expressly granted. It just cannot be expressly prohibited, which allows a little

more freedom there. In addition to that, yes, there needs to be some level of competency to ensure that you have adequate skillset and training to go through that path, which there's no question, that you documented it that and you validated it.

Connie: Excellent. I think the other piece of learning that I've had is that, and this is not new, but if we're at loggerheads during a survey, and we're concerned that there are ways that hospitals could reach out to the Joint Commission at the time of their survey to just talk through a situation that doesn't seem to be fitting quite right or doesn't jive with what they heard from you and me or from other places where they learned about Joint Commission surveys.

Robert: Absolutely.

Connie: Great.

Robert: The last thing that I would close with, Connie, is it's been great working with AACN. Thank you for the openness and the candor, the ability for us to really partner together on this. At the Joint Commission, we support healthcare providers. We have to listen to what they're saying, and I really hope that at the end of this we can really see some reduction in the burden for the nurses to really free up time to do what they're there to do, which is care for patients and not have their heads stuck in a chart trying to write stuff down. I really appreciate you bringing this forward to us and getting the chance to work with you and the team.

Connie: Thanks back to you. I think together we've really done something that will make a huge impact to patient care. Thank you.

Robert: Absolutely. Thank you, Connie.