

# OACNS Spotlight

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The Official Newsletter of the Oklahoma Association of Clinical Nurse Specialists

## THE PURPOSE OF OACNS:

- To be a cohesive, supportive group to promote the practice of CNSs
- To unite as Advanced Practice Nurses for the advancement of the practice of nursing

## THE GOALS OF OACNS:

- To address issues impacting the advanced practice of CNSs
- To increase visibility of the CNSs through participation on appropriate state and local committees
- To act as a resource group and provide continuing education programs for CNSs
- To support the coalition of advanced practice groups, such as CNSs, ARNPs, CRNAs, and CNMs

## 2009 OFFICERS:

**President** - April Merrill  
**President Elect** - Susie Jones  
**Secretary** - Rise Kester  
**Treasurer** - Amy Kluge  
**Immediate Past President** -  
Stephanie Moore

## FORMAL BOARD MEMBERS:

**Directors-at-Large for:**  
**Membership** - Stacey Rose  
**Programs** - Linda Baird  
**Public Relations** - Carol Stewart  
**Chair for Nominations Committee** -  
Kimetha Broussard

## INFORMAL BOARD MEMBERS:

**Senior Student Rep** - Katie Lamar  
**Senior Student Rep** - Tamara Meier  
**Junior Student Rep** - Krista Rein  
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**NACNS Liaison** - Susan Dresser  
**Board Advisor** - Susan Goodwin  
**Faculty Advisor** - Sally Tibbals  
**NACNS Affiliate Rep** - Candace Becker  
**Administrative Assistant** - Sandi Hinds

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Need more Pharm Hours?  
OU offering 8 Pharm Hours  
Registration deadline 8-26-09  
See page 5 for details

## Letter From the President

Thank you, Thank you, and Thank you! Our annual OACNS Pharmacology Conference was a huge success. We had 89 attendees and we have already started planning for next year's conference.

I hope everyone is enjoying the summer break. We have several CNS students completing in July - congratulations to all of you. I hope you will continue to be a part of OACNS and NACNS. It is important as you begin your career to stay involved in professional organizations to keep you informed and represent your best interests. The American Medical Association has many legislative actions planned for APNs and I expect the fall legislative session to be a rocky road.

We also have several upcoming events planned for you. There will be a membership meeting in Tulsa planned for September as we also celebrate National CNS Week and a meeting in October here in OKC.

As always, I appreciate everyone's hard work and dedication to this organization. If I can be of assistance to anyone please feel free to contact me any time.

Sincerely,

April Merrill, MS, APRN, CCNS  
President OACNS  
[april@oacns.org](mailto:april@oacns.org)





## 1st National CNS Recognition Week!

September 1 – 7, 2009

### Celebrating 72,000 Clinical Nurse Specialists Across the Nation!

**A CNS is...**

- A nurse leader with a Masters Degree or Doctorate in clinical nursing
- A clinical expert in a specialty area
- A vital link in translating new research into nursing practice at the bedside
- A pioneer in hospital programs that enhance quality and patient safety
- An essential resource to colleagues across disciplines
- An innovator who drives improvements in a complex environment
- A “systems thinker” who looks at the bigger picture

**The 1<sup>st</sup> National CNS Recognition Week**

**Sept. 1-7, 2009**



### Where are your Clinical Nurse Specialists? ... Everywhere!

**A CNS works as a leader in three areas of your health system and community...**

- At the bedside to improve outcomes and evidence-based practices
- With other nurse colleagues to establish best practice models, create and monitor policies, and design nursing practice standards
- With other hospital leaders to enhance quality and patient safety system wide

**The 1<sup>st</sup> National CNS Recognition Week**

**Sept. 1-7, 2009**





## Facts from NACNS

### Celebrate National CNS Recognition Week!



September 1-7, 2009

- Hildegard Peplau, RN, Ed.D. (1/1/1909 – 3/17/1999), is the founding mother of the CNS role. Although Dr. Peplau died at age 89, her 100<sup>th</sup> birthday will be marked and celebrated with the 1<sup>st</sup> annual CNS Recognition Week in September. Rutgers University School of Nursing is the birthplace of the CNS role.
- Dr. Peplau was a nursing theorist who published a landmark work in 1952 titled, “Interpersonal Relations in Nursing.” She emphasized the nurse-client *relationship* as the foundation for nursing practice, and the important partnership model that focused on shared experience through observation, description, formulation, interpretation, validation and intervention. This theory was considered “revolutionary”, since at that time clients or patients typically were passively receiving treatment and nurses were merely acting out doctor’s orders. In 1956, Dr. Peplau established the first nursing Master’s Degree program with a focus exclusively on clinical practice. Graduates of this program were called “clinical specialists.”
- Health systems across the nation are commemorating this recognition week. Plans include community activities and public lectures, receptions honoring Clinical Nurse Specialists, wellness fairs, community outreach, and fundraisers promoting the spirit of nursing, such as organized walks or golf outings which in turn support underserved communities or particular health concerns.
- An estimated 72,521 Clinical Nurse Specialists practice in the U.S. They are licensed registered nurses who hold masters or doctorate degrees in nursing.
- CNSs are expert clinicians in a specialized area of nursing practice. The specialty may be identified in terms of a population (ie. Pediatrics), a setting (ie. Emergency Dept.), a disease or medical subspecialty (ie. Diabetes), type of care (ie. Psychiatric), or type of problem (ie. Pain).
- CNS practice improves the healthcare environment and outcomes by influencing: direct care of patients/clients, nursing standards and personnel, and care delivery systems. In other words, as leaders CNSs drive innovation in their environments from care at the bedside to systemwide improvements.
- Examples of outcomes of CNS practice: reduced medical complications in hospitalized patients, reduced hospital costs and length of stays, improved pain management practices, increased patient satisfaction with nursing care, reduced frequency of emergency room visits.





## Future 2009 Membership Meetings

### September 1, 2009 6:30pm

We will be celebrating  
the 1st Annual National CNS Week  
And the 100th birthday of Hildegard Peplau.

- **Where:** at Ted's Cafe in Broken Arrow, OK
- **Sponsored by:** Abbott
- **Speaker:** James R. Higgins, M.D, Cardiologist,
- **Topic:** Dyslipidemia

For more information: visit [www.oacns.org](http://www.oacns.org)

**Members attend for free!**

Join or renew from now until the meeting and get 10% off  
[RSVP by Aug 31](#)

Come join the FUN!

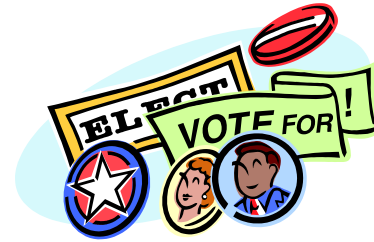
### October 8, 2009 6:30pm

- **Where:** Red Prime Steakhouse-504 N, Broadway OKC
- **Sponsored by:** Bristol Myers Squibb
- **Speaker:** is a CNS from St. Louis: Jeff Boatman -
- **Topic:** Abilify: Helping Your Adult Patients With Unresolved Symptoms of Major Depression Disorder

### Dec. 1, 2009 6:30pm

### Christmas Party

- **Where:** Deep Fork Grill in OKC
- **Sponsored by:** Novo Nordisk Inc.
- **Topic:** Diabetes Updates



## 2010 OACNS Board of Director Election

Now accepting nominations!

Candidates are sought for:

- ✓ **President Elect**
- ✓ **Secretary**
- ✓ **The Director-at-Large for Nominations**
- ✓ **The Director-at-Large for Programs**
- ✓ **Junior Student Member**
- ✓ **Senior Student Member**

(If interested in running for any of these positions, please fill out a [willingness to serve form](#) and contact [Kimetha@oacns.org](mailto:Kimetha@oacns.org))

[Click here to see the functions of the board positions](#)





### AMA joins Hawaii

#### Medical Association in effort to curb confusion about nurse qualifications

The AMA joined the Hawaii Medical Association in opposing H.B. 1378, which would allow advance practice nurses (APRNs) to refer to themselves as "primary care providers."

The bill would also grant APRNs global signature authority and full prescribing privileges. In a letter written to the Senate Commerce and Consumer Protection Committee, the AMA asserted that allowing APRNs to be called "primary care providers" serves to blur the distinction between medical doctors and APRNs, which would only add to the current confusion in the health care marketplace.

Further, the AMA contrasted the 10,000 hours a family practice resident spends in direct patient care to the 500-720 hours an APRN is required to spend in direct clinical practice during their education and training.

"It is an undeniable fact that a nurse with a graduate degree does not have the same education and training as a physician who has completed medical school and residency training," the letter concludes. "While APRNs are a valuable member of the health care team, they nevertheless ought to work in a team that is led by a physician."

### OACNS Member Appointed to NACNS Education Committee

Stephanie Moore has been appointed to a two year term of service, 2009-2011, on the NACNS Education Committee. The committees are a vital part of NACNS, and they rely on committee members to define and achieve much of the work on behalf of clinical nurse specialists nationwide.

The Education Committee will be working on a number of projects to address the concerns of CNS faculty, and will be instrumental in the refining/rewriting of CNS Education Standards that are currently being drafted by a task force that includes AACN and NLN.

Congratulations Stephanie.

### Congratulations

At the end of each day of the April 09 Pharm conference a door prize was given away, "Free admission to the next OACNS Conference" The following lucky people won...who will be next?

**Daphany Parker & Sharon Shirazi**



Saturday, August 29

### Pharmacology for Advanced Practice Nurses Workshop

<http://nursing.ouhsc.edu/CE/conferences.htm>

Nurses completing the entire workshop will be awarded **8 pharmacology hours** level B continuing education category approved by the Oklahoma Board of Nursing and **6.6 nursing continuing education contact hours**. Nurses wishing to take this course for purposes of **renewal of prescriptive authority recognition** are reminded that any pharmacotherapeutic course for continuing education credit must be relevant to their scope of practice. Registration deadline Aug 26<sup>th</sup>.





## NACNS Working Behind the Scenes to Keep CNSs "Front & Center"

Susan Dresser MSN RN CCRN ACNS-BC  
Secretary NACNS Board of Directors

I just wanted to share with our OACNS members that this is an example of how NACNS works constantly behind the scenes for us to keep CNSs "front and center" on any /publications/communications/policies/legislation etc.

The brochure, from the American Association of Colleges of Nursing, ([Nursing Community Title VIII Brochure-6-09](#)) was almost ready for release to the printer when NACNS caught wind of it and found that it did not even mention CNSs at all. In the 9<sup>th</sup> inning we were able to edit and insert content that shows the value of CNSs along with the other APRNs...much to our relief.

The point I'm making is not that this particular publication is critical but that every day NACNS and it's health policy consultants scan the environment for opportunities to keep CNSs visible!

### U-500 insulin

By: April Merrill, MS, APRN, CCNS & Rise' Kester, MS, APRN, ACNS



As the rate of obesity and type 2 diabetes mellitus rise, so does insulin resistance. More and more patients are requiring extreme doses of insulin in order to regulate their blood sugar. In fact, more patients are being started on special, concentrated insulin called Regular U-500. All other insulins that you currently administer are U-100 insulins, meaning that there is 100 units of insulin in every 1mL of solution. U-500 insulin is therefore 5 times more concentrated, meaning that there is 500 units in every 1mL of solution.

Patients use U-500 in insulin pumps as well as multiple daily injections divided between 2 to 4 doses.

U-500 insulin has an action profile similar to isophane (NPH) insulin. Adjustments are usually made based on the morning fasting blood sugar. Target goal is usually < 180 mg/dL. It is unsafe to control BG's between 80-110mg/dL due to risk of prolonged hypoglycemia. Corrective and nutritional insulin should NOT be ordered in addition to the U-500.

### CNS Degree?

Interested in information about a CNS degree or know someone else that is interested

Contact information for OU CNS program:

Sally Tibbals

Phone: (405) 271-1491, ext 49155  
[sally-tibbals@ouhsc.edu](mailto:sally-tibbals@ouhsc.edu)

Stephanie R. Moore

Phone 918.660.3937  
[Stephanie-moore@ouhsc.edu](mailto:Stephanie-moore@ouhsc.edu)





\*\*\*\*\* News Flash \*\*\*\*\*

September is the time to renew your membership in OACNS. Historically it has been a struggle to protect and promote the role of the CNS practitioner but that is changing thanks to the work of OACNS and NACNS. Our strength is in our numbers and our solidarity. The greater our membership numbers the greater our knowledge base and the greater our presence amidst the advanced practice nursing population.

OACNS provides:

1. Conferences with both CE's and pharmacology CE's to meet the requirements of the Oklahoma Board of Nursing with discounted rates for OACNS members.
  2. Representations among the Advanced Practice Coalition and Task Force of Oklahoma Board of Nursing
  3. Protection of practice rights with attention paid to Oklahoma lawmakers.
  4. Representation within the NACNS. Some of our OACNS members are playing an active and vital role on the board of NACNS.
  5. Networking opportunities
- Plus more...

While current members need to renew their membership we are all challenged to recruit new members as well. **Renew now and get 10% off, offer expires Sept 2, 2009**

Membership Levels	OACNS Dues	Dues to join
Regular	OACNS: <del>\$ 60.00</del> \$54.00 (Make check payable to OACNS)	<del>\$75.00</del> \$67.50
Associate	N / A	<del>\$50.00</del> \$45.00
Student	OACNS: <del>\$10.00</del> \$9.00 (Make check payable to OACNS)	<del>\$25.00</del> \$22.50

**CE Changes for Initial Rx Authority**

*April Merrill, MS, APRN, CCNS*

The application for initial RX authority was amended by the OBN on 5-11-09. The changes involving additional CE requirements are as follows:

Category B continuing education is defined in the Rules [485: 10-16-1] as follows: i) Onsite Seminar or lecture or workshop or course approved for contact hours, continuing education units or continuing medical education units through a recognized approver of continuing education ; or ii) Online continuing education for initial applications must be approved through a recognized approver of continuing education, and includes a minimum of thirty hours obtained from a single provider that is faculty-directed, with processes for interaction of the participant with faculty, evaluating the participant's learning through successful completion of case studies or written assignments and a comprehensive examination using a mechanism to ensure security of the evaluation process.

These changes will allow applicants to use the on-line CE's through the OU College of Nursing CE department.





## CORE CNS EXAM

*Susan Goodwin, CNS, CPAN*

Boards of nursing are beginning to require new clinical nurse specialists (CNS) take an advanced practice exam for their initial certification. Many smaller specialties, such as perianesthesia, do not have an advanced practice exam, but have a specialty exam that is open to any RN. A newly graduated CNS whose specialty is perianesthesia, for instance, currently has to take an advanced practice exam in a related field, such as adult health or critical care. Although this meets the letter of the law, it is only a partial substitute, as it does not provide proof of advanced nursing certification in one's chosen specialty.

The American Nurses Credentialing Center (ANCC) and the National Association of Clinical Nurse Specialists (NACNS) have joined forces to create a core CNS exam. This core CNS exam will be available to CNSs who have no advanced practice exam in their specialty. As the name implies, the exam will test core CNS concepts and practices, but will have no specialty content. Individual boards of nursing will determine the demonstration of specialty-specific competencies.

The Core CNS exam committee is comprised of 11 CNSs from around the USA; I am honored to a member of this committee. The exam has been field tested twice; in Oct 2008, and in May 2009. As I write this on June 17, 2009, the eligibility criteria are not yet available on the ANCC website, [www.nursecredentialing.org](http://www.nursecredentialing.org). The eligibility criteria were circulated among the members of the Core CNS exam committee in May 2009. I have not been told when the criteria will be publicly available, but I anticipate that it will be soon. The complete CNS core exam will be offered from Sept 1- Oct 17, 2009, in a paper and pen format. Starting January 2, 2010, this exam will be offered through continuous computer format.

There are two questions for Oklahoma CNSs: will the Oklahoma Board of Nursing (OBN) recognize this Core CNS exam, and if this exam is recognized, how will the OBN require demonstration of specialty specific competency? Susie Jones, the Vice-President, President-Elect of OACNS, and I serve of the Advanced Practice Advisory Committee (APAC) of the Oklahoma Board of Nursing. This committee meets twice a year; the next meeting will be in August. The recognition of core CNS exam will be the agenda. The OBN is aware of this exam, as the progress of the Core CNS exam has been presented at the last several meetings of the APAC. When a decision is made by the OBN, it will be posted on the OACNS website.

## Update for APN Taskforce

*Rise' Kester*

The Oklahoma Board of Nursing has established an Advanced Practice Task Force to review the National Council of State Boards of Nursing Regulatory Model. This task force has been meeting for the past six months and is nearing completion of the assigned task. The task force is composed of representation from each advanced practice role; Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Nurse Practitioner and Clinical Nurse Specialist. The task force is currently working through the proposed regulatory model and comparing recommendations with the current Oklahoma Nurse Practice Act and Rules and Regulations. Some of the key features recently addressed are the issues regarding consistency of education and the requirements for entry into Advanced Practice. Each Advanced Practice Category has been described using consistent language to delineate each role as an independent licensed practitioner within their specific scope of practice. The task force plans to conclude their work by this fall. The recommendations will then be presented to the Board of Nursing and to the legislature for any changes in the Nurse Practice Act.





## When It Comes to Skin Care – Do You Know Your Patients N.A.M.E.?

*By: Stormie Roberson RN, Clinical Nurse Specialist Student  
University of Oklahoma Health Sciences Center*

The clinical nurse specialist (CNS) is the ideal role to make a difference in healthcare settings. The acute care CNS practices within the framework of the American Association of Critical-Care Nurses (AACN, 2005) Synergy Model and the National Association of Clinical Nurse Specialists (NACNS, 2004) three spheres of influence. These frameworks provide a foundation of patient/nursing characteristics that impact the patient, nurse, and organizational spheres of influence. This philosophy of care leads to quality outcomes across all specialty areas, which makes the CNS a great leader of change initiatives. The initiatives require evaluation of current evidence, consideration of regulatory requirements, assessment of current facility practice, plans for improvement with measurable outcomes, and evaluation of the process and outcomes.

A current hot topic in relation to change initiatives and quality outcomes is the prevention of pressure ulcers. The Centers for Medicare and Medicaid (CMS) has contributed to moving this initiative to the top of the list for many organizations. CMS (2007) enacted the “Prospective Payment Rule Change” that went into effect October 1, 2008. The change in policy states institutions will no longer be reimbursed for the care of stage III/IV pressure ulcers acquired during hospitalization. According to CMS (2007), there were 322,946 reported cases of Medicare patients in 2006 with a pressure ulcer as a secondary diagnosis—each case had an average charge of \$40,381 for an annual total cost of \$13 billion.

The CMS rule change has prompted organizations to evaluate current practice in relation to skin care and make a plan for improving patient outcomes. Prevention is the key and often includes bringing attention to the topic. Bringing attention to the topic can be done by creating an eye-catching health message to encourage health care professionals to be proactive in their care related to pressure ulcer prevention. These efforts will bring significant cost savings to organizations, and it is also the right strategy for patients in terms of providing quality care.

The health message, “When it comes to skin care – Do you know your patient’s N.A.M.E.?”, is a proactive way of approaching skin care. The N.A.M.E. acronym represents four of the most common risk factors for pressure ulcers: nutrition, activity, moisture, and environment. Consideration of these four risk factors early in the admission will prompt the healthcare professional to implement preventive interventions. The health message can be used on posters, fliers, buttons, websites, or other forms of media. The information will keep the focus of proactive skin care on the minds of the individuals that provide direct patient care. The CNS can make an impact in the facility by organizing and carrying out the delivery of the health message with subsequent support in implementation of preventive measures.

Nutrition is often an area related to pressure ulcer prevention that gets missed by nursing staff. It is important to evaluate the patient’s weight status, intake/output values, and laboratory data. In a prospective study, patients who were malnourished upon admission to the hospital were twice as likely to develop pressure ulcers as non-malnourished patients (Thomas, Goode, Tarquine, & Allman, 1996).





## Do You Know Your Patients N.A.M.E.? *Continued*

Fleishman (2005) states malnutrition may increase the risk for a pressure ulcer for several reasons. Weight loss and less subcutaneous fat make the bones more prominent, which causes a steeper pressure gradient, thereby putting the patient at increased risk. Malnutrition can also lead to edema and reduced blood flow in the skin, causing ischemic damage, which is a risk factor for developing a pressure ulcer.

Activity is another important component in the effort to prevent alterations in skin integrity. Patients who are immobile are at an increased risk for pressure ulcers. Repositioning patients at least every two hours is often included in prevention protocols. The aim of repositioning is to reduce or eliminate interface pressure and thereby maintain microcirculation to regions of the body at risk for pressure ulcers (Reddy, Gill & Rochon, 2006). It may be necessary to advocate for the use of physical therapy to ensure an interdisciplinary approach for patients with mobility issues.

Moisture can be caused by urine, feces, or excessive perspiration. Incontinence can adversely affect overall skin integrity. Urine and stool on the skin contributes to an abnormal local skin pH, overgrowth of microorganisms, and skin irritation or infection that can further weaken the skins defenses (Driver, 2009). In a study that analyzed 2,189 patients at a single institution, patients with fecal incontinence were 22 times more likely to have pressure ulcers than patients without fecal incontinence (Maklebust & Magnan, 1994).

Environmental factors refer to any external stimulus that can cause excessive pressure or friction on the skin. Proper pressure reducing mattresses must be utilized along with regular assessment of the impact of bed linens, braces, casts, tubing, and other external devices that can cause increased pressure or friction on the skin. All patients should be assessed for possible risk for damage related to inadequate or unsafe handling on bed or chair surfaces. Pressure and friction reducing devices may be recommended such as lifts and slide sheets.

Most facilities gather pressure ulcer prevalence and/or incidence data. When it comes to achievement of measurable outcomes, this is a great place to start to monitor the success of a quality improvement initiative. The CNS will set a goal for the organization based on the evaluation of the prevalence/incidence data and consideration of state and national comparisons. Clear identification of outcomes is imperative for carrying out a change initiative and will allow the CNS the ability to articulate the success to the organization.

The health message, “When it comes to skin care - Do you know your patients N.A.M.E.?” is a way to bring attention to pressure ulcer prevention. Adequately assessing an individual’s nutrition, activity, moisture, and environment will help ensure the health care staff is being proactive with their skin care approach. The CNS is able to monitor the outcomes by evaluating the prevalence/incidence data to ensure success. Positive outcomes yield increased patient/nurse satisfaction as well as decreased expenditures for the organization. The ultimate goal is to keep patient’s skin healthy and prevent pressure ulcers. This goal can be achieved – one patient N.A.M.E. at a time.





## What every Clinical Nurse Specialist Prescribing in Oklahoma *(or thinking about it)* Should Know.

*Susie Jones MS, RN, APN, CCNS-P, CCRN-P, EMT-P*

The role of the clinical nurse specialist is a dynamic one. Over the past several years we have seen a growth in this important healthcare role in our area. One of the issues that has become evident as the number of CNSs in our state continues to grow is that there is a lack of understanding of the role of the clinical nurse specialist by other healthcare providers – including nurses. One of these areas of confusion is the area of prescriptive authority. This lack of understanding is not limited to non-nursing healthcare providers, but includes many CNSs as well. This article will outline the specifics associated with prescriptive authority for clinical nurse specialists in Oklahoma.

The requirements that address advance practice nurses prescribing medications are outlined in the Rules of the Oklahoma Board of Nursing (OBN). An unofficial copy of these rules can be downloaded from the Board of Nursing website at <http://www.ok.gov/nursing/rules08.pdf>. This is where all requirements regarding practice as a nurse and an advance practice nurse in Oklahoma are spelled out. The information as it specifically addresses requirements for prescriptive authority for advanced practice nurses begin on page 36.

Clinical Nurse Specialists who wish to obtain prescriptive privileges must be licensed as an RN and be recognized by the OBN as a CNS. Eligibility is not available to CNSs who only have temporary recognition by the board as a CNS. CNSs wishing to be recognized with prescriptive authority also must have documentation of supervising physician who is licensed in the State of Oklahoma. APNs with prescriptive authority recognition must notify the BON within 30 days of any change in supervising physician association.

Oklahoma utilizes an exclusionary formulary for advance practice nurses. The medications that may be prescribed vary somewhat depending upon the type of APN practice. For nurse practitioners, certified nurse midwives and clinical nurse specialists the exclusionary formulary can be found at <http://www.ok.gov/nursing/prac-exclusfrm.pdf>. This list includes general anesthetic agents – including ketamine, etomidate, midazolam, propofol, and droperidol and all schedule I & II narcotics (morphine, meperidine, fentanyl etc).

It is important for the CNS with prescriptive authority to be aware of all of the information that is required to be included on the prescription. Oklahoma Board of Nursing Rules 485:10-16-8 spells out the following requirements:

1. Prescriptions will comply with federal and state laws.
2. All prescriptions will include:
  - a. **Name, title, address, and phone number** of the APN who is prescribing.
  - b. **Name of physician** prescriptive authority.
  - c. Name of client.
  - d. Date of prescription.
  - e. Full name of drug, dose, route and specific directions
  - f. APN's DEA number if required





## Prescribing in Oklahoma *continued*

3. Written prescriptions need to include APN signature
4. Documentation should be placed in client record of prescription given.

Information that pharmacists are taught to expect when receiving a prescription includes all of the information required by the Oklahoma BON, but goes on to suggest that the following information should also be included (Shargel et al 2006):

1. Strength of the product (if available in more than one strength)
2. Quantity to be dispensed
3. Specific directions for the pharmacist (especially if compounding or specific labeling instructions are needed).
4. Specific directions for the patient. (AVOID the use of “As Directed”)
5. Refill information.

The Oklahoma Board of Narcotics and Dangerous Drugs spells out in the code that address issuing prescriptions (475:30-1-3) the following (OBND 2008).

1. You must be licensed to prescribe.
2. You cannot prescribe to restock an office supply or medical bag used for general distribution to patients.
3. You may not prescribe controlled substances to someone you know is dependent on the drug.
4. You may not  
“distribute, dispense, sell, give, prescribe or administer any controlled substances in Schedules I through V for the practitioner's personal use, or for an immediate family member. Provided that this paragraph shall not apply to family members outside the second degree of consanguinity or affinity. Provided further that this paragraph shall not apply to medical emergencies when no other medical doctor is available to respond to the emergency.”

Several websites may prove helpful to you if you are currently or are considering becoming a CNS with prescriptive authority.

- Oklahoma Board of Nursing Rules <http://www.ok.gov/nursing/rules08.pdf>.
- Oklahoma Board of Nursing Forms and Applications <http://www.ok.gov/nursing/forms3.html> . This has information specific to requirements for APNs interested in prescriptive authority, applications, continuing education and the exclusionary formulary.
- Oklahoma Board of Narcotics and Dangerous Drugs Registration [http://www.ok.gov/obndd/OBN\\_Registration\\_Forms/index.html](http://www.ok.gov/obndd/OBN_Registration_Forms/index.html) . This is where you register in Oklahoma to be able to prescribe controlled substances.
- Drug Enforcement Agency: Office of Diversion Control Forms & Applications [http://www.deadiversion.usdoj.gov/online\\_forms.htm](http://www.deadiversion.usdoj.gov/online_forms.htm) . This is where you register to get your DEA number needed for providing controlled drugs.
- National Plan and Provider Enumeration Registry <https://nppes.cms.hhs.gov/NPPES/Welcome.do> . This is where you register to get your National Provider Identification number.

The responsibility associated with prescribing medications is great. As professionals who have chosen to accept this responsibility it is our obligation to our patients and to each other that we ensure that we do so in the safest manner possible. Hopefully, the information contained in this article will prove helpful to those who prescribe as well as those who are considering completing the additional requirements that would allow them to prescribe in the future.





## Prescribing in Oklahoma *continued*

### References

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## Center to Champion Nursing in America

July 14, 2009

The [Center to Champion Nursing in America](#) is pleased to report a significant advancement for the health care of Americans and for nursing education. Yesterday, Representative Lois Capps (D-Calif.) introduced H.R. 3185 to amend Title XVIII of the Social Security Act. If enacted, this amendment will ensure that Medicare payments for nursing education match the health care needs of current and future Medicare recipients. This development is the result of hard work and unprecedented coordination among AARP and several leading nursing organizations, including:

- American Academy of Nursing
- American Academy of Nurse Practitioners
- American Association of Colleges of Nursing
- American Association of Nurse Anesthetists
- American College of Nurse Practitioners
- American College of Nurse-Midwives
- American Nurses Association
- National Association of Clinical Nurse Specialists
- National Association of Pediatric Nurse Practitioners
- National League for Nursing
- National Organization of Nurse Practitioner Faculties

To meet the current and future demands for health care of the 65 and older population, the Capps amendment focuses on educating more Advanced Practice Registered Nurses (APRNs) and preparing them to provide care in home and community-based settings. An aging population with increasing chronic conditions requires health care services that are focused on primary care, care coordination, transitional care and prevention of disease, areas where evidence shows that APRNs are highly effective.

To learn more about the issue, visit [aarp.org](http://aarp.org).

Again, the Center congratulates all of those who worked tirelessly toward the introduction of this bill.

An initiative of AARP, the AARP Foundation and the Robert Wood Johnson Foundation | [www.championnursing.org](http://www.championnursing.org)

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Student	<del>\$ 2<sup>00</sup></del> \$22.50	<del>\$10<sup>00</sup></del> \$9

