

# Minnesota Board of Nursing

## *For Your Information*

Fall

2015

Volume 23, Issue 2

Minnesota  
BOARD OF  
Nursing

### Inside this issue:

Presidents Message	1
Licensure Verification	2
Frequently asked Questions Regarding Post-licensure programs	3
Office of Medical Cannabis	3
Safe Prescribing of Opioids	4-6
Minnesota State Opioid Oversight Project	6
Book review: Nurses Making Policy: From Bedside to Boardroom	7
National Council of State Boards of Nursing News	8

### President's Message: Deb Haagenson, RN



Recently, I and other board members attended the National Council of State Boards of Nursing (NCSBN) annual meeting and Delegate Assembly. The meeting included several keynote speakers with thought-provoking information about nursing practice and regulation. I would like to share a couple of those with you.

Rhonda Flin, professor of industrial psychology at the University of Aberdeen in Scotland, presented *Safe in Their Hands? Non-technical Skills and Competence Assessment*. She promotes the concept that nurses and other clinicians need both technical and non-technical skills. Non-technical skills are defined as “cognitive, social and personal resource skills that complement technical skills, and contribute to safe and efficient task performance.”

Examples of non-technical skills include situation awareness, decision making, team work and leadership. Non-technical skills are already routinely assessed in some high-risk, non-healthcare industries, e.g., aviation, nuclear power, offshore oil and gas. Research indicates that cognitive and social skills care reduce errors and enhance safety. The presenter shared research conducted to identify critical non-technical skills in specific healthcare settings. Implications for nursing practice are significant including how non-technical skills might

be identified, developed, assessed and strengthened in different healthcare settings.

Doris Gunderson, Director of the Colorado Physician Health Program, presented *Marijuana: A Prescription for Trouble*. She addressed the medical, social, and legal issues related to the passage of laws permitting recreational marijuana and medical cannabis. She discussed the impact that legalization of marijuana has had on the regulation of healthcare professionals. Gunderson also shared information known to-date about the uses of medical cannabis, pros and cons, as well as the known risks. She relayed that there is still a need for significant research in the use of medical cannabis. In response to the increasing prevalence of marijuana use, NCSBN will convene a new committee to explore issues related to medical and recreational marijuana use and consider the impact on nursing regulation.

The NCSBN annual meeting provided valuable information. Understanding how non-technical skills impact safe practice provides important research for consideration. Also, the information presented about marijuana use, in addition to the work that will come from the NCSBN committee related to marijuana use, provides valuable information given that the use of medical cannabis is now permitted in Minnesota. This information and work supports the goal of the Minnesota Board of Nursing to be responsive to changes in the healthcare environment and the delivery of care.

- ◆ *For Your Information* is published quarterly by the Minnesota Board of Nursing
- ◆ Phone number:  
612-317-3000
- ◆ Fax number:  
612-617-2190
- ◆ Web site

## Licensure Verification

The Board of Nursing has received recent reports of employers requesting nurses provide a copy of their license. For many years, the Board issued biennial registration cards indicating a license had been renewed. On June 1, 2012, the Board of Nursing stopped issuing biennial registration cards as proof of license renewal and introduced its online verification service as the only safe, accurate, and timely way to verify a nurse's license to practice. Although the biennial registration cards indicated a license had been renewed, they failed to reflect in a timely way any disciplinary actions the Board may have taken since the last renewal period. With the Board's on-line verification service, disciplinary actions and renewal information can be viewed any time. The site is edited daily to provide the most current information available. Employers and the public should consider this the only source of safe, reliable licensure information. Although the Board still issues initial license certificates to nurses, employers should not ask to see these as proof of current licensure and nurses should not allow their license certificates to be copied.

---

## Frequently asked questions regarding post-licensure programs

Although the Board does not regulate post-licensure nursing programs, often nurses who are interested in continuing their nursing education will contact the Board to determine if a post-licensure nursing program is acceptable. Here are some frequently asked questions and answers:

**I'm already a nurse and I plan to get a baccalaureate/master/doctorate degree in nursing. Is my program approved by the Board?** The Board approves programs that prepare individuals for initial licensure as a practical (LPN), professional (RN), or advanced practice registered nurse (APRN). These programs are considered licensure-preparing or pre-licensure programs. Nursing education programs that are post-licensure (e.g. RN-to-BSN) are non-jurisdictional and therefore do not require board approval.

**Where can I find a list of RN-to-BSN programs?** Because post-licensure programs are non-jurisdictional, the Board does not maintain a list of post-licensure programs.

**What should I look for in a post-licensure nursing program?** Your goals for your nursing career are important. Some specialty certifications require completion of a program that holds national nursing accreditation. In addition, check with your employer. Some employers may specify which certifications are preferred or accepted within that organization. They may also have a list of programs they prefer that their employees attend, or identify which programs are acceptable for tuition support.

**What is accreditation and does it matter?** Accreditation is granted to nursing programs when the program has demonstrated it meets nationally established nursing education standards. Graduation from an accredited program may help qualify a graduate to attend other accredited programs when pursuing an advanced nursing degree, and may impact hiring decisions.

**How do I know if my nursing program is accredited?** Nursing programs are accredited through the Commission on Collegiate Nursing Education ([CCNE](#)) and/or the Accreditation Commission for Education in Nursing ([ACEN](#)). You can check the current accreditation status of a nursing program by going to the respective national nursing accrediting body's website.

---

## ( Frequently asked questions continued)

**The program I am considering is online. Is that ok?** The Board does not regulate post-licensure programs nor the format or delivery of the nursing education course. You should check to see whether the school is registered with the [Minnesota Office of Higher Education](#). All post-secondary educational institutions are required by law to register with this office.

**Is there anything else I need to be aware of?** The MN Nurse Practice Act requires faculty to hold current Minnesota RN licensure if they are teaching the theory and practice of nursing. You may wish to check with the program to see if they enroll MN students.

---

## Information from the Office of Medical Cannabis

The Office of Medical Cannabis (OMC), located within the Minnesota Department of Health, was formed to implement the medical cannabis legislation. The OMC has a website (<http://www.health.state.mn.us/topics/cannabis/>), and has recently started a call center. The call center is open Monday- Friday, 8-4:30 PM and can be reached at 651-201-5598. Registered health care practitioners are eligible to certify that their patient has a qualifying medical condition for the medical cannabis program. The nine qualifying conditions are:

- Cancer or its treatment, with severe/chronic pain, nausea or severe vomiting, or cachexia or severe wasting
- Glaucoma
- HIV/AIDS
- Tourette syndrome
- Amyotrophic lateral sclerosis
- Seizures
- Server and persistent muscle spasms
- Crohn's disease
- Terminal illness with life expectancy of less than one year or its treatment, producing severe/chronic pain, nausea or severe vomiting, or cachexia or severe wasting

An eight member Advisory Panel is evaluating the potential to add the condition of intractable pain to the list of qualifying conditions. A report from the Panel is anticipated to be completed by December, 2015. More information on the Advisory Panel may be found at this website <http://www.health.state.mn.us/topics/cannabis/intractable/advisory.html>.

Current statistics from the OMC as of August 2015 are:

- 375 health care practitioners have been registered
    - 307 Physicians
    - 52 Advanced Practice Registered Nurses
    - 16 Physician Assistants
  - 577 patients have become certified by their practitioner
  - 326 patients who are approved to pick up medical cannabis
  - 126 patient designated caregivers (this includes caregivers who may not have been approved yet)
  - 25 of the above listed caregivers have been approved
-

## Safe Prescribing of Opioids

### Scope of the problem

Prescription opioid abuse is a significant and growing problem in the United States. According to the National Association of State Alcohol and Drug Abuse Directors (2015):

- Approximately 1.5 million Americans over the age of 12 years used opioid pain relievers for a non-medical use
- Fifty-three percent of Americans who misuse opioids received it from a friend or relative for free, or from a doctor
- Admission for treatment of opioid dependence increased by 500% from 2000-2012
- Nearly 17, 000 Americans died from opioid overdose.
- The United States population accounts for 80% of the prescriptions for opioid consumption worldwide and 99% of the hydrocodone consumption.

Advanced practice registered nurses (APRNs), as prescribers of opioids, must be aware of safe opioid prescribing practices for acute and chronic pain to prevent, albeit inadvertently, the misuse of opioids. Several guidelines for the treatment of pain and opioid therapy are available. This intent of this article is to provide a broad overview of generally accepted practices and provoke thoughtful contemplation by APRNs who prescribe opioids. Non-opioid and non-pharmacological interventions for the treatment of pain will not be discussed here, although APRNs are accountable to be well versed in alternatives. APRNs are also accountable for recognizing their limits of knowledge and experience, and to recognize when consultation and referral are required.

In an effort to reduce serious adverse outcomes from inappropriate prescribing and abuse of opioids, the Federation of State Medical Boards (FSMB) published a Model Policy on the Use of Opioid Analgesics in the treatment of Chronic Pain in 2013 and has a free continuing education activity on the website (<http://www.fsmb.org/policy/education-meetings/er-la-opioids>). Highlights of this policy and others will be briefly described.

### Patient evaluation and risk stratification

Acute pain is approached and treated differently than chronic pain. The Institute for Clinical Systems Improvement has guidelines for the assessment and management of acute pain (2014) and chronic pain (2013). Treatment differs between acute and chronic pain, and understanding the difference in assessing and managing acute and chronic pain is a basic competency of providers.

Indications for prescribing an opioid should be documented in the medical record and reflect the assessment. A systems review, physical evaluation, pertinent laboratory findings, and social supports/barriers are integral to the assessment and decision to prescribe an opioid. Individuals with mental health issues, such as depression, are at increased risk for misuse, addiction, and overdose of opioids (FSMB, 2013). Therefore, all patients should be screened for mental health issues prior to receiving an opioid prescription. A history of substance use disorder elevates the risk of failed opioid therapy and risk of harm from the treatment itself. Consultation with and referral to an addiction specialist may be required to achieve optimal treatment goals while preventing adverse outcomes, including addiction, relapse, and overdose. In addition to screening for mental health issues, a patient's risk for addiction should be screened prior to prescribing long term opioids. Many tools exist such as the Screener and Opioid Assessment for Patients with Pain (SOAPP)<sup>®</sup>.

## **(Safe Prescribing for Opioids continued from page 4)**

While trust plays a large role in provider: client relationships, information from family, significant others and prescription drug monitoring programs (PMP) is required to fully evaluate the risks of opioid treatment. At a minimum, the Minnesota Prescription Monitoring Program should be consulted every time an APRN prescribes a controlled substance. The PMP will provide specific data on any controlled substances that have been prescribed, dates they were filled, quantity supplied, name and location of dispenser and more. A link to the Minnesota PMP is located on the Minnesota Board of Nursing webpage and here <http://pmp.pharmacy.state.mn.us/index.html>.

### Development of treatment plan and goals

The APRN and patient should establish a treatment plan and goals at the onset of therapy with regular reassessment. The plan should include individual objectives to guide treatment modalities, both pharmacological and non-pharmacological, progress of treatment, further diagnostics, consultations, additional therapies, and timeframe for reassessments.

Informed consent and treatment agreements should be used routinely when prescribing opioids (FSMB, 2013). These should be developed and reviewed with the patient, entered into the medical record and routinely reviewed. Informed consent for opioid therapy includes:

- Potential risks and benefits of opioid therapy.
- Potential short and long term side effects.
- Likelihood of tolerance and physical dependence.
- Risk of impairment of motor skills and impact on daily life.
- Potential drug interactions and over-sedation.
- Risk of misuse, dependence, addiction and overdose.
- Limitations of long term use.
- The APRNs prescribing policies and expectations, including refilling of prescriptions, early refills and replacement of lost or stolen prescriptions.
- Specific reasons for prescription, changes or discontinuation.

Treatment agreements define the shared accountabilities between the APRN and the patient, and are indicated for opioids and other medications with risk of abuse. Treatment agreements should include (Fishman, 2012):

- The goals of treatment in regards to the management of pain, function of activity and safety.
- The patient's specific responsibilities for using opioids safely, such as taking the opioids as prescribed, avoiding use with other mood or mind altering substances, safe storage and disposal of opioids.
- The use of one pharmacy, obtaining opioids and other medications from one provider or practice.
- Patient agreement to periodic urine drug testing for the specific drug prescribed by the APRN.
- The APRN's responsibility to be available to the patient or to have another appropriate provider to care for the patient or prescribe if the APRN is not available.

### Initiation, maintenance and discontinuation of opioids

Initiation of opioid therapy should be discussed with the patient as a trial period with specific outcome measurements to

## (Safe Prescribing for Opioids continued from page 5)

evaluate effectiveness and side effects. Dosage of short acting opioids should start with the lowest dosage possible to the specific needs of the patient, and titrated to the desired effect (Fishman, 2012). Transition to long acting opioids may occur following the trial period. The APRN and patient should have ongoing discussions on the risks and benefits of opioid therapy. Ongoing monitoring includes review of treatment goals, patient response, drug testing, and review of the PMP. Five specific assessments to routinely evaluate at each patient visit are analgesic response, functional activity, adverse effects, observations for aberrant behaviors that are associated with substance use or abuse, and the mood or affect of the patient (FSMB, 2013). The APRN should routinely evaluate if consultation or a referral to mental health, pain, or addictions specialists is warranted. The PMP should routinely be accessed to ensure compliance with the treatment agreement and to assess for multiple prescriptions.

Discontinuation of opioid therapy may occur with resolution of underlying cause of the pain, intolerable side effects of opioids, inadequate control of pain, or non-compliance with the treatment agreement (FSMB, 2013). APRNs who prescribe opioids should reflect on their practice in treating patients who do not adhere to treatment agreements regarding opioid therapy, how this will be communicated to the patient and the ongoing relationship with the patient.

### References

Federation of State Medical Boards. (July, 2013). *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*.

Fishman, S.M. (2012). *Responsible Opioid Prescribing. A Clinicians Guide*. Washington, DC: Waterford Life Sciences.

Hooten, WM., Timming, R., Belgrade, M., Gaul, J., Goertz, M., Haake, B., Myers, C., Noonan, MP, Owens, J., Saeger, L., Schweim, K., shteyman, G., Wlaker, N. (2013). *Assessment and management of chronic pain*. Institute for Clinical Systems Improvement.

National Association of State Alcohol and Drug Abuse Directors. (February, 2015). *NASADAD Fact Sheet: Opioids*. Retrieved from <http://nasadad.wpengine.com/wp-content/uploads/2015/05/Opioids-Final.pdf>

Thorson, D., Biewen, P., Bonte, B., Epstein, H., Haake, B., Hansen, C., Hooten, M., Hora, J., Johnson, C., Keeling, F., Kokayeff, A., Krebs, E., Myers, C., Nelson, B. Noonan, MP, Reznikoff, C., Thiel, M., Trujillo, A., van Pelt, S., Wainio, J. (2014). *Acute Pain Assessment and Opioid Prescribing Protocol*. Institute for Clinical Systems Improvement.

---

## Minnesota State Opioid Oversight Project (SOOP)

On August 25, 2015, the State of Minnesota, the U.S. Attorney, and others hosted a one day conference on opioid abuse entitled Pain. Pill. Problem. Stakeholders from across the state convened to discuss the problem of prescription opioids. Speakers, content, and resources can be found at <http://www.cme.umn.edu/painpillproblem/>. The State Opioid Oversight Project ([https://umn.qualtrics.com/SE/?SID=SV\\_aavZHtiG1eSooQZ](https://umn.qualtrics.com/SE/?SID=SV_aavZHtiG1eSooQZ)) is seeking individuals who are interested in having an active role in this initiative. Seven areas of focus have been identified:

- Neonatal Abstinence Syndrome
  - Medication Assisted Treatment
  - Opioid Prescribing
  - Prescription Monitoring Program
  - Increasing Access to Naloxone
  - Prevention
  - Increasing Prescription Take Back Opportunities
-

## **Book Review: *Nurses Making Policy: From Bedside to Boardroom***

*Reprinted with permission from the Journal of Nursing Regulation, July 2015.*

*Nurses Making Policy: From Bedside to Boardroom* makes the argument that nurses are both well suited and professionally obligated to understand and participate in policy making. The book, co-published by Springer Publishing Company and the American Nurses Association (ANA), was designed with the goal of creating a Washington Fellows Program for Nurses through the American Nurses Foundation endowed fund. The program will be administered through the ANA and supported by royalties from the book. The editors are committed to the role and power of nurses in policy-making positions and are actualizing this commitment by supporting a program that will further equip and enable nurses to take on leadership roles in health policy -- locally, nationally and internationally.

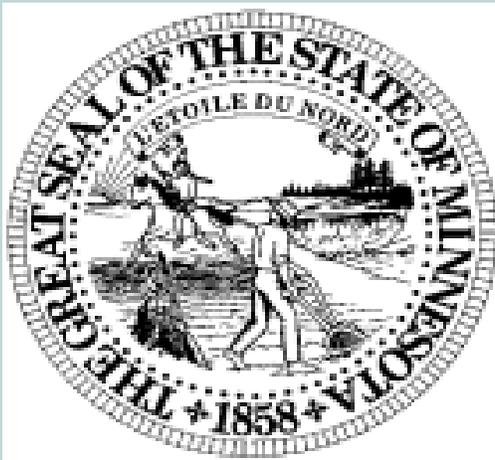
The authors posit that a lack of policy expertise may contribute to the perception that nurses are not leaders within the health care system. Moreover, because nurses are not political, they limit what nurses can do for patients. Nursing education has not consistently provided nurses with tools to change the health care system but rather has provided courses to function within it. Clearly, it is critical for nurses to be effective within the system and yet recognize their ability and responsibility to work towards necessary changes.

The premise of the book is that once nurse understand and practice policy skills, they can successfully engage in policy making. Nurses possess essential skills adaptable to successful policy making. Further, these policy-making skills are essential to nurses in all positions and settings. The authors differentiate policy-making with a large “P”, such as serving in elected office, from that with a small “p”, such as serving on a board of directors or a departmental leadership council. This differentiation further emphasizes the notion that there is a role in policy-making for all nurses, whether at the large “P” level or the small “p”.

The intended audience for the book is registered nurse seeking to improve their working environment; nurses in leadership roles in nursing associations, including educators, administrators, and regulators; as well as graduate nursing students and registered nurses enrolled in baccalaureate-degree completion programs. The format of the book lends itself well to these intended audiences. Each chapter provides actual examples of policy challenges related to the policy process discussed in the chapter. Additional resources for each topic are provided through an extensive reference list and E-Resources, which include websites, documents, and social media links. The authors provide numerous examples throughout the book, often including references to the ANA Code of Ethics and examples of the tenets of the Code applied to realistic practice scenarios. Additionally, there are frequent examples of nurses in policy roles with discussions of the nurse’s motivations, experiences, successes and challenges.

*Nurses Making Policy: From Bedside to Boardroom* is divided into 15 chapters organized into four sections: Making the Case; Analyzing Policy, Strategizing and Creating Change, Judging Worth and Advancing the Cause. The numerous chapter authors are varied in their experiences, and each brings a different but cohesive perspective to the central theme of the book. Note: among the authors are Minnesotans Dr. Joanne Disch, Professor ad Honorem, University of Minnesota School of Nursing, Mathew Keller, JD, RN, Regulatory and Policy Nursing Specialist for the Minnesota Nurses Association and Dr. Eileen Weber, Clinical Assistant Professor, University of Minnesota School of Nursing. They describe applying a “nursing lens” to shape policy while serving in key decision-making roles.

The book is a strong addition to the library of policy literature and would be informative and useful to nurses at any point in the continuum of knowledge of policy-making.



**Minnesota Board of Nursing**

Link to Board member profiles:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

How to become a Board member:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

**Minnesota Board of Nursing Members**

Board Member Name	Board Role
Cindy DeJarlais	LPN Member
Jeanine Gangeness	RN Member
Becky Gladis	LPN Member
Deborah Haagenson	RN Member, Board President
Michelle Harker	Public Member
Bradley Haugen	RN Member
June McLachlan	RN Member
Deborah Meyer	LPN member, Board Secretary
Robert Muster	RN Member
Christine Norton	Public Member
Jan Rainey	Public Member
Christine Renne	Public Member
Sheila Robley	LPN Member
Sue Sendelbach	RN Member, Board Vice President
Steven Strand	RN Member
Natya Stroud	RN Member

**National Council of State Boards of Nursing News**

Deborah Haagenson RN was awarded the Elaine Ellibee award at the annual NCSBN conference held in Chicago on August 19-21, 2015. The Elaine Ellibee award recognizes a board president for exceptional leadership and significant contributions to NCSBN. Board members or staff who serve on or were recently appointed to NCSBN committees are:

- Barbara Damchik-Dykes                      Commitment to Ongoing regulatory Excellence (CORE) Committee
- Deborah Haagenson                              Leadership Succession Committee
- Michelle Harker                                      Bylaws Committee
- Deb Meyer    NCLEX Item Review Subcommittee
- Kimberly Miller                                      NCLEX Examination Committee
- Mariclaire E. England                              NCLEX Item Review Subcommittee

