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West Virginia RN Nursing News

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Official Publication of the West Virginia Board of Examiners for Registered Professional Nurses

Standards of Care for Opioid Prescribing

What Every APRN Prescriber and Investigator Need to Know

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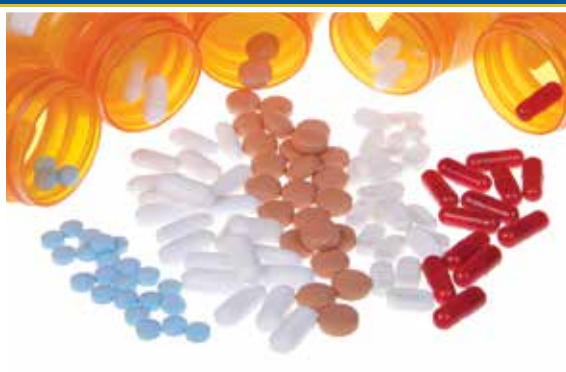

CONGRATULATIONS to the *West Virginia State Board of Examiners for Licensed Practical Nurses.* Our colleagues were awarded the Regulatory Achievement Award that recognizes Boards of Nursing that have made an identifiable, significant contribution to the mission and vision of National Council of State Boards of Nursing in promoting public policy related to the safe and effective practice of nursing in the interest of public welfare. We are proud of your accomplishment.

WEST VIRGINIA BOARD OF EXAMINERS FOR REGISTERED PROFESSIONAL NURSES

MISSION

The West Virginia Board of Examiners for Registered Professional Nurses established to promote and protect public health, safety, and welfare through the regulation of registered professional nurses and dialysis technicians.

GOALS AND OBJECTIVES

In accordance with WV Code §30-7-1 et seq. the Board will:

1. Function according to the Code of Conduct.
2. Be accessible to the public.
3. Assure the quality of the basic education process for registered professional nurses.
4. Assure the quality of the basic education process for the dialysis technician.
5. Assure initial and continuing competence of the registered professional nurse.
6. Assure initial and continuing competence of the dialysis technician.
7. Define the scope of practice for registered professional nursing and advanced practice nurses.
8. Define the scope of practice for the dialysis technician.
9. Provide a disciplinary process.
10. Review issues related to the nursing shortage.
11. Support the mission of the West Virginia Center for Nursing
12. Support the nurse health program, WV Restore.

STATUTORY HISTORY

The Board of Nursing is mandated under Chapter 30 of the West Virginia Code to:

PERFORMANCE MEASURES

1. Review and evaluate National Council of State Boards of Nursing registered nurse licensure examination scores of each program in relation to the standard.
2. Conduct on-site visits to at least two nursing education programs annually.
3. Issue licenses to qualified persons in a timely fashion.
4. Provide educational information to registered nurses, dialysis technicians, nursing education programs, employers and the public related to:
    a. Discipline
    b. Orientation to the Board
    c. Advanced Practice
    d. Licensure
    e. Practice Issues
    f. Conditions that affect an individual's safe practice
5. Process complaints from health care professionals and the public in a timely fashion.
6. Respond expeditiously to public requests related to Board operations.
7. Evaluate regulatory solutions to address borderless health care delivery.
8. Provide and evaluate the effectiveness of the nurse health program "West Virginia Restore."
9. Provide multiple modes of communication opportunities with the Board.
10. Establish a Practice Committee for discussion of practice issues as needed.
11. Seek legislative authority to obtain criminal background checks on all new applicants.

RECOMMENDED IMPROVEMENTS

Continue updating computer equipment and database program. Evaluate and provide personnel, equipment, and database programs.

Reviewed and revised by the Board 6/14/1999; 6/13/2000; 6/13/2001; 6/12/2002; Reaffirmed 6/12/2003; Reviewed and revised by the Board 6/15/2004; 6/15/2005; 6/14/2006; 6/13/2007;Reaffirmed 6/12/2008; Reviewed and revised 6/17/09; Reviewed and revised 6/16/10;Reviewed and revised 6/17/11; Reviewed and revised 6/13/12; reviewed and revised 6/12/13;Reaffirmed 6/10/14; Reaffirmed 06/10/15.

Registered Nurse License Renewal

All RN licenses expire October 31, 2016.

Online Renewal at www.wvrnboard.wv.gov. All Renewals will be completed online again for a second year. There is not an option for a paper renewal.

It is that time of year again to renew your registered nurse license. This year, all applications must be submitted online. To do this you will need a computer and a credit card for payment. No debit cards are accepted. It is important to complete the process as soon as possible in order to assure the application is fully processed before the end of the renewal cycle October 31, 2016.

There are certain questions that if you provide a yes answer, additional information must be provided to the Board. Until all information is received, your application will be in a "pending approval" area. Please read the questions carefully, answer truthfully and provide any additional required documentation as quickly as possible.

Registered Nurse License Renewal Continuing Education Requirements

Pursuant to the West Virginia Legislative Code of Rule WV 19 CSR 11:

Registered nurses are required to complete 12 hours of continuing education during each renewal period inclusive of required continuing education per SB437 and Chapter 30-1-7a annually for best prescribing and drug diversion training if they prescribe, administer or dispense controlled substances, and for mental health conditions common to veterans and their families.

- Exception, if a registered nurse is initially licensed on or after November 1 of the license renewal period, they only have to do the required CE per SB437 and Chapter 30-1-7a for best prescribing and drug diversion training if they prescribe, administer or dispense controlled substances, and for mental health conditions common to veterans and their families. For 2016, the renewal period is 11/1/2015 thru 10/31/2016.

Per SB 437 and Chapter 30-1-7a, each person licensed to practice registered professional nursing must:

- Complete 2 hours of CE for mental health conditions common to veterans and their families annually, and

- Complete 3 hours initially and then 1 hour thereafter annually of CE for best prescribing and drug diversion training if you prescribe, administer or dispense controlled substances.

The guidelines and resources for continuing education for best prescribing practice and drug diversion training and mental health conditions for veterans and their families are located under the resource tab on the West Virginia RN Board website at www.wvrnboard.wv.gov

Print off and keep your CE certificates for each continuing education activity in a safe place so you may provide each individual CE certificate of completion when audited. The Board performs an audit annually on a randomly selected sample of licensees.

APRN CORNER

LICENSURE, RENEWAL AND CERTIFICATION

APRN license renewal will be in 2017. All APRN licenses expire June 30, 2017.

You will need evidence of completing a minimum of 24 contact hours of continuing education obtained within the most recent licensure renewal cycle (i.e.7/1/2015 to 6/30/2017); 12 hours in pharmacotherapeutics, and 12 hours in the clinical management of patients from an approved continuing education provider recognized by the Board. Guidelines for APRN license renewal continuing education are posted on the WV RN Board website homepage at http://www.wvrnboard.wv.gov.

You will need to have an official verification of national certification to be sent directly to the WV RN Board from your certifying body if your current certification expires on or before June 30, 2017. Remember, **to keep your APRN license active you must recertify and have official copies of your certification sent to the WV RN Board prior to your advanced practice certification expiration.**

PRESCRIPTIVE AUTHORITY NOTES

Prescriptive authority renewal will be in 2017.

You will need evidence of completion of 8 contact hours of pharmacology continuing education obtained within the most recent renewal cycle (i.e. 7/1/2015 to 6/30/2017); from an approved continuing education provider recognized by the Board. Completion of 12 hours of pharmacotherapeutics that is required for the APRN license renewal may also be used to meet the requirements for the prescriptive authority renewal.

You will need to print off and send a notarized signed copy of a Collaborative Agreement with a licensed physician holding unencumbered West Virginia license unless you have applied for and been approved by the Board for prescriptive authority with no collaborative agreement required.

SIGNATORY AUTHORITY INFORMATION

During the 2016 session, House Bill 4334 was enacted by the Legislature of WV. In §30-7-15d. Advanced practice registered nurse signatory authority which states the following:

(a) An advanced practice registered nurse may provide an authorized signature, certification, stamp, verification, affidavit or endorsement on documents within the scope of their practice, including, but not limited to, the following documents:

(1) Death certificates: Provided, That the advanced practice registered nurse has received training from the board on the completion of death certificates;

(2) "Physician orders for life sustaining treatment," "physician orders for scope of treatment" and "do not resuscitate" forms;

(3) Handicap hunting certificates; and

(4) Utility company forms requiring maintenance of utilities regardless of ability to pay.

(b) An advanced practice registered nurse may not sign a certificate of merit for a medical malpractice claim against a physician.

For information related to end-of-life care, the West Virginia Center for End-of-Life Care has numerous resources to facilitate conversations with patients. Their website may be found at http://www.wvendoflife.org or call (877) 209-8086 with questions. Additionally, the WV Network of Ethics Committees has courses available for Completion of the POST form and Advance Care Planning: Why, What and How available at www.wvnec.org/courses.

West Virginia Center for Nursing awards $225,000 in scholarships

CHARLESTON, W.Va. – The West Virginia Center for Nursing announced today that 76 students will receive funds totaling $225,000 as part of the Nursing Scholarship Program. The program, which is administered by the West Virginia Center for Nursing in conjunction with the West Virginia Higher Education Policy Commission , helps licensed practical, registered, masters and doctoral nursing students pursue their degrees.

April Shapiro, who received a $10,000 award for the fall and spring semesters, plans to use her scholarship in order to finish her Ph.D. in nursing at West Virginia University. She will continue to teach nursing in West Virginia in order to fulfill the scholarship's service obligation to remain in state after graduation.

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"I was so worried about being able to pay for everything," she said. "What a relief. I can relax now and focus on finishing my dissertation and graduating in May."

Drema Pierson, Administrator for the Center said that a record number of candidates applied for the scholarship this application cycle due to increased awareness and because it is a more streamlined application that can be completed and submitted online. In order to qualify for a scholarship, nursing students must be West Virginia residents and agree to fulfill a service obligation to work in West Virginia for each year they receive an award. To apply for a scholarship, students should visit wvcenterfornursing.org. The online application will reopen on April 15, 2017, and the deadline to apply for an award for the 2017-18 academic year will be June 1.

The West Virginia Legislature created the West Virginia Center for Nursing in 2004. In addition to supporting the Nursing Scholarship Program, the Center focuses on nursing workforce planning and development to help alleviate an ongoing shortage of nurses. The program is funded by a $10 fee paid during the yearly license renewal process completed by every licensed practical and registered nurse in the state.

For more information, visit www.wvcenterfornursing.org.

Standards of Care for Opioid Prescribing: What Every APRN Prescriber and Investigator Need to Know

Randall Steven Hudspeth, PhD, MBA, MS, APRN-CNP/CNS, FRE, FAANP

Opioid misuse is becoming an epidemic. Knowledge of nationally vetted standardized methods of pain assessment, safe treatment options and modalities, and follow-up evaluation for patients on opioids is essential for health care providers. This article outlines the current standards of care for pain management and safe opioid prescribing that are necessary for APRNs and other providers prescribing opioids. These guidelines should serve as the standards of care for prescribers, as well as boards of nursing and their investigators when evaluating violations that involve poor or inappropriate prescribing, abuse, and other issues related to opioid prescribing.

Opioid misuse, diversion, and overdose are major public health problems in the United States (Substance Abuse and Mental Health Services Administration, 2013; Sullivan et al., 2010). An increasing number of people misuse opioids for nonmedical reasons (American Society of Addiction Medicine, 2015), and the media's focus on pain management has increased public awareness of the following: Pain is a common malady, providers can help resolve pain, treatment alternatives are available, and treatments are plentiful and easily obtained. Today, the public focus appears to be shifting away from opioid misuse to an emphasis on untreated pain (Van Pelt, 2012) and the benefits of a controlled treatment plan.

The advanced practice registered nurses (APRNs) who treat patients seeking pain relief are most commonly certified nurse practitioners (CNPs) in family practice settings who, like their family physician counterparts, often lack formal education in pain management (Institute of Medicine, 2011). In fact, more than 50% of opioid prescriptions are written by primary care providers, including CNPs (Breuer, Cruciani, & Portenoy, 2010). These providers may face clinical situations in which they make decisions based on past experience or on-the-job training without any knowledge of nationally vetted standards of care (SOCs) for pain management, and such decisions can have unintended consequences, such as opioid diversion or overdose death, that result in formal complaints to state boards of nursing (BONs).

Complaints to BONs regarding opioid-related problems come from law enforcement, patients, family members of opioid abuse victims, employers, and other providers (U.S. Department of Health and Human Services, 2014). The BON investigator will analyze the circumstances of the complaint and determine if a violation of a nurse practice act (NPA) or its rules occurred. A BON investigator may use a contracted pain management clinical consultant for an in-depth record and

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practice review, but the investigator usually performs the initial assessment to determine if further investigation is warranted by the BON. Some BONs have disciplinary committees or other mechanisms whereby board members must evaluate complaint investigation findings to determine whether an NPA violation has occurred, evaluate risk to the public, and consider the likelihood of repeat violations. The purpose of this article is to provide an overview of accepted SOCs in pain management and opioid prescribing that can help inform decisions about the severity of a complaint and future actions.

Safe Opioid Prescribing Practices

The complexity of treatments, diversity of approaches, and the number of sources that can be used to determine acceptable practice present challenges to clinicians and investigators. Each case must be evaluated on its merit and its distinct circumstances. However, the evidence supports common safety practices and clinical indicators that can guide assessment, interventions, and safe opioid prescribing. No provider can be responsible for all actions that patients take after they leave the office, but a provider maintains a responsibility to make opioid use as safe as possible. For this reason, both patient-focused and provider-focused national associations have developed and endorsed consistent SOCs to protect the patient and the public from opioid misuse.

Determining whether SOCs are met can be easier for BON investigators if they have a broad understanding of the pain management care process and the ways pain management SOCs are developed and implemented. SOCs are established by national organizations that can have a specific focus, such as treating chronic, acute, or neuropathic pain, or by organizations that focus on addiction recovery or broad disease entities associated with the need for pain management (American Society of Interventional Pain Physicians, 2012, Buppert, 2015, Chou et al., 2009, Franklin and American Academy of Nephrology, 2014DOI: http://dx.doi.org/10.1212/WNL.0000000000000839). SOCs are endorsed by members of these organizations who are nationally recognized and credentialed authorities within the pain management specialty and who have coordinated efforts among the associations, thus ensuring similarity among the SOCs. Organizational pain management standards are also established by The Joint Commission (2015).

Four Phases of Assessing Pain Management

SOCs help provide the investigator with an approach to evaluating the pain management care process in four phases.

- Phase one concentrates on the pain-related history and physical examination.
- Phase two focuses on the decision to treat the patient with opioids or to refer the patient to a pain specialist.
- Phase three considers the initial prescription and any subsequent dose changes.
- Phase four concentrates on ongoing treatment and evaluations.

The nationally vetted SOCs have specific recommendations for each phase.

BON investigators should seek evidence that the SOC components of treating pain with opioids are implemented and documented by the APRN in each phase of the treatment process. This evidence will help BON investigators determine whether the treatment by the APRN meets the national SOCs. A checklist can be a useful investigative aid in determining if an APRN had an awareness of and complied with the SOCs, documented fully, and provided safeguards to identify and avoid opioid misuse.

Phase One: History and Physical Assessments

In the clinical record, the BON investigator should find interview documentation reflecting a history of the illness or injury that caused pain, mitigating factors related to treatment, and management of comorbidities that are affected by opioids, such as respiratory and renal diseases. The assessment phase includes reports from referrals to therapies, laboratory and imaging study results, electrophysiology studies, opioid abuse screening tool reports (Arnold & Claxon, 2015), urine drug test (UDT) results, reports from state boards of pharmacy's prescription drug monitoring programs (PDMP),

and use of a level-of-pain patient self-reporting scale (Office of National Drug Control Policy, 2011). Screening tools are widely used, and evidence supports their accuracy (National Institute on Drug Abuse [NIDA], 2014a).

Clinical documentation addressing the use of prescription drugs, illegal substances, alcohol, and tobacco provides insight as does a family history of substance abuse or psychiatric disorders or a history of sexual abuse. The social background should identify the person's current employment, employment history, social networks, marital status, legal history, and behavioral patterns. Three risk factors that have significant association with substance abuse are a personal or family history of alcohol or drug abuse, young age, and a current psychiatric condition (Starrels et al., 2011). All of the data collected during the history and physical examination and evaluation phases is used to formulate a comprehensive plan of care for treating pain that will guide the use of opioids.

If SOC components of treating pain with opioids, such as the use of opioid risk assessment tools, are not documented, the investigator should closely evaluate the documentation throughout treatment. The investigator should also keep in mind that even though recreational marijuana use is legal in some states, the scoring of risk assessment tools based on marijuana use has not changed (NIDA, 2014b). Additionally, BON investigators should question why APRNs who have patients with scores indicating high risk did not refer these patients to pain management or addiction specialists.

Phase Two: Decision to Treat with Opioids

The BON investigator should look for an informed consent document signed by both the APRN and the patient or guardian. This consent serves as documentation that the risks and benefits of treatment have been discussed with the patient and are understood (Cheatle & Savage, 2012). The benefits of opioid treatment include obtaining a level of analgesia so activities of daily living can be maintained. The risks include overdose; life-threatening respiratory depression;

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drug abuse by the patient, household contacts, or friends; physical dependence or tolerance; drug interactions; neonatal withdrawal syndrome; and inadvertent ingestion by children or others.

The BON investigator should also review the patient and provider agreement (PPA), formerly referred to as a pain management contract. The PPA, which should be signed by the patient and the APRN, clearly informs the patient and family about expected behaviors, identifies consequences for noncompliance with the agreement, and gives the provider an exit strategy should the patient be discharged from the practice. Common requirements of PPAs are that a patient will use only one prescriber for pain medicines and only one pharmacy to fill pain medicine prescriptions, will safeguard medications in secure or locked cabinets, will not share medications, will comply with ongoing patient monitoring requirements such as random UDTs and pill counts, and will notify the pain management provider of treatments by other providers or emergency department visits (Starrels et al., 2010).

Phase Three: Prescribing Trial of Opioids

Initial treatment should be considered a therapeutic trial with specific goals, established guidelines, and treatment parameters. During the trial, the opioid dosage may increase, or the prescribed drug may change from one type of opioid to another, such as from oxycodone (OxyContin) to morphine.

Phase Four: Ongoing Treatments and Evaluations

During this phase, most problems tend to surface. The APRN's familiarity with the patient, the treatment, and prescribing routines can result in lax monitoring, reduced documentation, and a disregard for subtle behaviors that can indicate potential problems. When initial treatment progresses to ongoing treatment, the APRN should continue to document evaluations and care thoroughly (Chou et al., 2009). At each visit, the APRN should obtain the patient's self-reported pain rating based on a consistently used standard tool (Williamson & Hoggart, 2005). Dosage reduction should be attempted, and justification for dosage escalation should be documented. Common adverse effects, such as constipation, nausea, drowsiness, sedation, and itching, should be evaluated and treated. At each visit, the APRN should document whether the patient is adhering to the treatment plan and the PPA. Monitoring techniques can include recognition and documentation of aberrant drug-related behaviors. Interviews with the spouse and other family members can provide clues and should be documented. The APRN should be documenting in the visit notes reviews of the PDMP at the time of refills, and sporadic UDTs and opioid-misuse risk assessment tool results as indicated in the PPA or when misuse is suspected (PainEDU, 2015). Deviations from the PPA, positive UDTs, and other aberrant behaviors must be documented in the medical record with a mitigation plan for resolution and future monitoring. The treatment plan should have measurable outcomes to evaluate therapeutic success, including assessing improvement in physical and/or psychological functioning to guide continued care and interventions, and a status evaluation should be documented at each visit.

Throughout the process, investigators should always be aware of the following red flags of inappropriate prescribing of controlled substances, including:

- Lack of documented physical examination/diagnostic testing
- Lack of treatment plan and/or lack of PPA
- High-volume, cash-paying patients
- Prescribes high doses, large quantity
- Care not consistent with national guidelines
- Provider notes unchanged from visit to visit
- Drug Enforcement Administration and law enforcement interest
- Pharmacies refusing to fill prescriptions
- Lack of formal training (education) and precepted experience in pain management

Using the SOC to Evaluate Compliance

The following case studies describe the practices of two APRNs who evaluated patients before prescribing opioids. Case 1 portrays a seemingly compliant patient treated over a prolonged period, and although the APRN meets the SOCs for safe opioid prescribing, misuse is

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discovered. Case 2 depicts an APRN who failed to follow the SOCs, but the resulting problem is not opioid misuse.

Case Study: SOP Compliance and Opioid Misuse

William, a 45-year-old white male, goes to the CNP's office as a new patient to establish care because the provider he has seen for the past 10 years is retiring. The CNP knows of the provider's retirement, accepts the patient, and obtains the patient's medical records. William's history includes a motorcycle accident at age 30 that resulted in a fractured femur and a back injury. The femur healed without problems, but the back pain persists. For 6 years, the pain has been managed with oxycodone 60 mg twice daily. William reports that he is a construction worker with seasonal employment and that he has more pain when he is working, which is about 60% of the time. He has been divorced for 5 years and has two children. His only legal issues were at the time of his divorce when his ex-wife obtained a restraining order. He is a clean, well-dressed, muscular male who appears his stated age. William is friendly and answers all questions and agrees to all requests, including requests for a UDT and an opioid-abuse risk assessment. The UTD is positive for oxycodone metabolite and THC from marijuana use. However, recreational marijuana use is legal in the state, and he admits to smoking because he thinks it helps him reduce his use of oxycodone. William answers the five questions of the Screener and Opioid Assessment for Patients with Pain (SOAPP) tool, which has weighted score responses of 0 to 4. William's score is 5 because he says he has used marijuana frequently, and even though marijuana is legal, it is still scored a 4, indicating illicit drug use. He also scores a 1 (seldom) in responding to this question, "In your lifetime have you ever had a legal problem or been arrested?" The score of 5 places William at high risk for opioid misuse.

In the clinical interview, the CNP discusses and documents the score and obtains clarification on William's answer to the marijuana question and his explanation about his legal issue. An informed consent and a PPA are completed. The CNP gives William a prescription refill based on his existing

treatment plan. William states that he wants to see if he can decrease his dosage and asks not to have a large-dose (40-mg or 60-mg) tablet. Instead, he requests oxycodone 20 mg so he can take one, two, or three at a time as needed, which is his routine. He says that he normally tries to cut down the dose on days off work and at night.

The next visit is straightforward. William receives a 30-day refill prescription for oxycodone 20 mg tablets; the dosage is 60 mg twice daily for a total of 180 tablets per month. This routine continues for 18 months during which William has two UDTs and PDMP reviews every other month without any problems. There is never any evidence that William has successfully decreased his dose, but he has never asked for a dosage increase. Twice he brings in eight unused 20 mg oxycodone tablets, stating that he tried to reduce his usage but that his back pain returned when he went back to work. He resists changing the plan, explaining that oxycodone worked and he is happy with his functional level.

Subsequently, the police investigate the death of a 20-year-old female who was drinking heavily and had taken several oxycodone tablets at a party. Her boyfriend, who gave her the oxycodone, is arrested and reports that he bought the tablets from William. William is arrested for selling drugs, and the prescription is traced to the CNP. William's records are requested, and the CNP's prescribing practices are investigated by the BON investigator.

The BON investigator uses the checklist SOC evaluation tool to determine if the CNP's prescribing practices meet the SOC and if sufficient safety strategies were in place to identify or avoid misuse. The investigator determines that the CNP did meet the SOC because there was a documented and thorough pain assessment and a completed risk assessment tool with the score evaluated and justified. Furthermore, a UDT and PDMP review were documented before the initial prescription, and regular reevaluations were performed. The patient did not demonstrate any aberrant behaviors to alert the CNP to a problem. However, there were three red flags: The SOAPP

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abuse risk assessment tool score indicated a high risk of misuse; the patient resisted a change in medication; and the patient continued to request 20-mg tablets so he could try to reduce his usage, though there was no evidence that he did. William routinely used oxycodone 20 mg twice daily and sold his excess tablets to supplement his income. The UDTs showed presence of oxycodone, but UDTs cannot determine the dose. William's case is an example of unintended consequences despite compliance with the nationally vetted SOC established to aid patient and public protection.

Case Study: Failure to Refer

Martha, a 57-year-old white female, visits a CNP complaining of back, joint, hip, and rib pain. She has an unremarkable medical history except for a mastectomy at age 45. She is employed as a florist and often lifts medium to heavy flower boxes and works in a refrigerated area. She believes she has arthritis that she has treated with acetaminophen as needed, but the medication has become less effective. She has lived in a rural town of 1,500 people all her life, and her husband is a police officer. Her daughter is an elementary school teacher, and her son is in college. Martha and the CNP go to the same church and know each other socially.

The CNP gives Martha a prescription of hydrocodone 10/325 mg every 4 hours as needed. Over the next year, Martha is seen by the CNP every 4 to 6 weeks for medication refills. After 9 months, the pain has increased, and the prescription is changed from hydrocodone to morphine. The morphine controls the pain much better, and the prescription is refilled monthly. Martha reports some nausea and weight and appetite loss, and the CNP prescribes promethazine as adjunctive therapy. As recommended by the CNP, Martha begins using over-the-counter esomeprazole (Nexium). After a year, Martha's daughter encourages her to see an internal medicine physician for her continued weight loss and loss of energy. During visits to the physician, it is discovered that Martha has cancer that has metastasized to her bones. The primary site is her breast, which had been treated surgically. The physician reports the CNP to the BON for missing the correct diagnosis and failing to refer the patient.

Opioid misuse was not the problem, but Martha was treated with opioids, and the BON investigator needed to review the record to determine if the SOCs for safe opioid prescribing were met. There was no evidence that risk screening, UDT, informed consent, PPA, or any safeguards were implemented. There was also no evidence that the CNP conducted a proper physical and diagnostic examination nor did the CNP appropriately evaluate the source of pain via diagnostic testing and imaging scans. Thus, the CNP did not meet the SOCs. Despite the facts that an opioid misuse problem was not suspected and the CNP knew the patient and her family, the SOCs still should have been met. Unfortunately, the CNP did not associate the history of mastectomy for cancer treatment with the current symptoms, and failed to conduct a proper diagnostic assessment and examination. The CNP must corroborate the source of pain beyond what is reported by the patient. The SOC that could have assisted in Martha's treatment was a referral or consultation with a specialist, which was indicated because of dosage increases and a deteriorating physical condition.

Conclusion

Complaints to BONs often involve patients with obvious chronic abuse and manipulative behaviors that are commonly seen in pain management clinics and are becoming more commonly seen in family practice settings. Some patients are more difficult to assess than others. But the drug abuse risk can be just as high for someone who presents as an engaged, employed professional as for someone with a history of depression and unemployment who is in an abusive relationship.

For BON investigators, gathering evidence pertinent to the specific complaint is the primary focus. But APRN practices that fail to meet generally accepted SOCs—whether noted in the patient's complaint or not—should be identified as substandard and reported because such practices pose a safety risk. Evidence must be documented to demonstrate that appropriate assessments were completed, interpreted, and discussed with the patient and that clinical safeguards, such as informed consent, PPAs, UDTs, and regular ongoing monitoring, were used. Appropriate interventions must be implemented and documented whenever opioid abuse is suspected or confirmed.

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Controlled Substances for Pain Management Update

Substance Abuse and Misuse is at the forefront of concerns for the nation. West Virginia ranks as the State with the highest number of drug related deaths. A ranking we all are working on changing and hope will continue to change. Every step related to handling, administering and prescribing controlled substances deserves its due respect. Agency policies and procedures, laws, rules, accreditation standards, Drug Enforcement Agency requirements, pharmacies, continuing education requirements are several resources and guides to direct the management of dangerous drugs.

Every licensed nurse handling and administering controlled substances is required to complete continuing education hours to heighten their awareness of the problem, how to safeguard their patients, their practice and themselves. The very familiar steps of medication administration provide an opportunity at each step to assure everything related to the medication is correct and appropriate. Each step provides an opportunity to stop and question anything that doesn't seem quite right. These steps include cautioning the patient about the effects of the medication, assuring another person is available to drive them when needed, being aware of how much medication is required to manage the pain, evaluating related risks such as previous substance misuse and health conditions that may be affected by the medication, and including alternative methods of pain management when possible, such as meditation, music and massage, for example.

The Advanced Practice Registered Nurse (APRN) who has Limited Prescriptive Authority has a privilege that includes the prescribing of some controlled substances. In the current prescribing laws and rules the APRN is ***not permitted to prescribe*** any medications categorized as Schedule I and Schedule II controlled substances. House Bill 4334, which became law on June 10, 2016, permits APRNs with Prescriptive Authority to prescribe up to a 30 day supply of Schedule III drugs with no refills. Benzodiazepines are limited to a 72 hour supply without refill. Schedule IV through V may be prescribed in a quantity necessary for up to a 90 day supply, with only 1 refill, and the prescription must expire in 6 months, **except**, prescriptions for phenothiazines are limited to up to a 30 day supply and are not refillable; and, prescriptions for non-controlled substances of antipsychotics, and sedatives shall not exceed the quantity necessary for a 90 day supply, will have no more than 1 prescription refill and will expire in 6 months.

The APRN is required to have the knowledge and skill to determine the correct medication and dosage for each individual to whom they prescribe. The Board's Scope of Practice Model provides guidance to nurses regarding scope of practice. Specific to APRNs and prescribing, the model points to considering current national standards, laws, literature, research and agency policies when making decisions. As a result, standards such as those established by the American Pain Society http://americanpainsociety.org/education/guidelines/overview and the Center for Disease Control National Center for Injury Prevention and Control Guidelines http://www.cdc.gov/drugoverdose/pdf/common_elements_in_guidelines_for_prescribing_opioids-20160125-a.pdf / will be helpful to consider when prescribing. The APRN is also required to query the West Virginia Controlled Substances Monitoring Program Database (known as the Controlled Substance Automated Prescription Program or CSAPP) and to know the legal requirements established by the Drug Enforcement Administration.

As a final point, do not forget to discuss the effect a patient's *medical condition and medication use* may have on his or her ability to *safely operate a vehicle in any mode of transportation.*

CDC and FDA Add New Guidelines and Regulations Aimed at Curbing Overprescribing of Opioids

by Alex Scarbrough Fisher,
Administrative Law Attorney,
Thompson Burton, PLLC

The Center for Disease Control and the Federal Drug Administration both recently released new guidelines, from the CDC, and new regulations, from the FDA, aimed at addressing the rising concern about the nationwide opioid epidemic. Not coincidentally, these guidelines and regulations were announced within a week of one another. I think this signals a strong message from the federal government to both state governments and health care providers: if you won't fix this problem, we will.

CDC's New Guidelines for Prescribing Opioids for Chronic Pain

Although many states have released their own guidelines for the management of chronic pain (West Virginia's guidelines, recently published, are accessible at http://bit.ly/2bHACNH), this is the first set of guidelines available nationwide to healthcare providers. The CDC's guidelines include 12 main recommendations, which include establishing treatment goals with patients prior to starting a patient on opioids, and avoiding concurrent opioids and benzodiazepines whenever possible.

The starting dosage recommendation of 50 mg morphine equivalent will likely result in some push back from providers, but I think this low number indicates how strongly the CDC feels about the riskiness of prescribing opioids at all for chronic pain in patients. Health care providers—physicians, nurse practitioners, and physician assistants—who have the ability to prescribe and who provide care for patients with chronic pain need to ensure that they are properly documenting justification for their medical diagnosis of patients with chronic pain, as well as their chosen treatment of each patient's chronic pain.

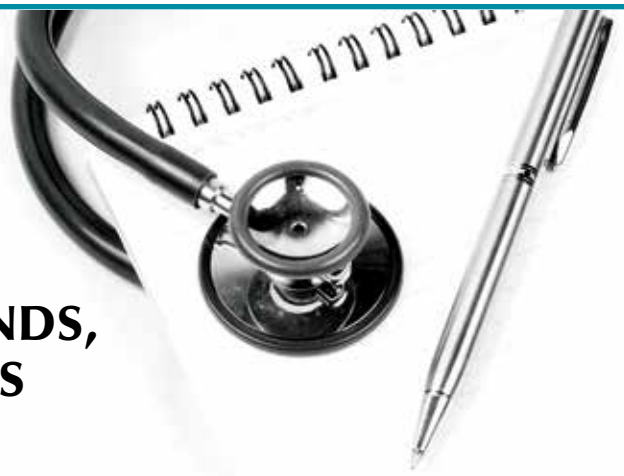
Federal Drug Administration's Safety Label Changes for Immediate-Release Opioid Pain Medications

The FDA released new regulations with required labels on immediate release (IR) opioid pain medication, including a box on IR opioid prescriptions warning about the risks for misuse, abuse, addiction, overdose and even death. These regulations are a follow up to the FDA's 2013 prescription warnings on extended-release/long-acting (ER/LA) opioids resulting from the FDA's concern of the risks associated with long acting opioids. Today, the FDA is acknowledging and clarifying that immediate release opioids are also dangerous, and play a persistent role in addiction, abuse, and overdose mortality related to opioid use.

What Do These Guidelines and Regulations Mean?

The CDC's Guidelines for prescribing opioids and the FDA's new labeling requirements for IR opioid pain medication indicate concern at the federal level regarding the prescribing of opioids. Healthcare providers who prescribe opioids should be cautious about their prescribing of these medications, and always document to demonstrate the provider's decision-making in prescribing an opioid, and the patient's clear medical need for the medication.

The WV Attorney General's initiative "Best Practices for Prescribing Opioids in West Virginia" is aimed at eradicating prescription drug abuse by better equipping the state's prescribers and pharmacists. The plan provides recommendations to prescribers and pharmacists who prescribe or dispense opioid prescriptions across West Virginia. It is designed to reduce misuse, while preserving legitimate patient access to necessary treatment. Read the Attorney General's best practices for prescribing opioid drugs at http://bit.ly/2bHACNH.



CONSENT AGREEMENTS, REPRIMANDS, SUSPENSIONS, REINSTATEMENTS

April '16 - August '16

The information on this web site may change before the update has reached the web page. Prior to taking any actions related to the information on this page, contact this office for more information. You may contact the Board by phone at (304) 558-3596, by mail at 101 Dee Drive, Suite 102, Charleston, WV 25313-1620, or by e-mail at www.wvrnboard.wv.gov. Requests for copies of documents must be made in writing. Clearly state your request and provide a name and address where the information may be mailed. The fee for documents is $5.00 for the first page and 0.50 cents for each additional page. You will be invoiced for this amount.

A **Consent Agreement** is a settlement agreement between the Board and the licensee. The agreement is the result of an informal settlement of a complaint filed against a licensee. Consent Agreements with a Probation requirement generally include certain restrictions in the practice of a registered professional nurse. Time is counted toward the required probationary period only while the individual nurse is working as a registered professional nurse. If an individual does not work for a period of time, this time is not counted toward the probation requirement. Therefore, some individuals may have a probation license longer than the dates may suggest.

A **reprimand** is the least restrictive disciplinary action the Board takes against a license. A licensee can practice if a reprimand has been issued against the license.

A **suspension** is generally the result of a violation of a contract between the licensee and the Board. A suspension can also be the resulting action taken by the Board in relation to discipline. A licensee cannot practice nursing while the license is suspended.

A **Summary Suspension** is an action taken by the Board when a licensee is considered an immediate threat to public safety. A licensee receiving a Summary Suspension cannot work as a nurse or represent themselves as such.

A **Reinstatement** occurs when a licensee has completed the discipline requirements. Reinstatement may return the license to the full unencumbered status or return a suspended license to a Probation status, or any other action the Board deems appropriate.

APRIL 2016				
Carlton, Rachel	91006	Lebanon, TN	Voluntary Surrender	04/08/2016
Cushway, Kathy	44057	Kingwood, WV	Suspension	04/04/2016
Fotos, Rebecca	80212	Huntington, WV	Suspension	04/08/2016
Wilson, Kimberly	60622	Winchester, VA	Full Reinstatement	04/13/2016

MAY 2016				
Altomare, Carol	66535	Weirton, WV	Suspension	05/02/2016
Pecora, David	53904	Bemidji, MN	Probation 5 years	05/19/2016
Sibert, Susan	33029	Martinsburg, WV	Reprimand	05/31/2016
Walker, Bobby Joe	73783	Beckley, WV	Probation 2 years	05/31/2016

JUNE 2016				
Barker, Stephanie	75962	Ashford, WV	Suspension	06/14/2016
Batten, Cody	57493	Weston, WV	Full Reinstatement	06/10/2016
Brown, Jessica	87104	Ocala, FL	Full Reinstatement	06/10/2016

Conrad, Myra	58960	Ashton, WV	Full Reinstatement	06/10/2016
Hackney, Patricia	27896	Belington, WV	Full Reinstatement	06/10/2016
Hedrick, Susanne	36678	Hurricane, WV	Probation 5 years	06/28/2016
Higginbotham, Patricia	39941	Vienna, WV	Full Reinstatement	06/10/2016
Nelson, Barbara	71288	Gallipolis, OH	Full Reinstatement	06/10/2016
Parsons, Carol	68174	Grafton, WV	Full Reinstatement	06/10/2016
Scott, Kenneth	83529	Mt. Lookout, WV	Summary Suspension	06/21/2016
JULY 2016				
Brown, Paula	85690	Woodsfield, OH	Probation 1 year	07/28/2016
Chafins, Lori	51921	Huntington, WV	Full Reinstatement	07/14/2016
Varney, Angela	56987	Chapmanville, WV	Probation 6 months	07/28/2016
AUGUST 2016				
Haws, Emily	83850	Bridgeport, WV	Probation 3 years	08/04/2016
Hosey, Leon	39973	Charleston, WV	Probation 5 months	08/04/2016
Scott, Kenneth	83529	Mt. Lookout, WV	Voluntary Surrender	08/04/2016
Suzza, Cami	62761	Fayetteville, Wv	Reprimand	08/11/2016
Vance, Sara	66066	Swanton, MD	Probation 10 months	08/04/2016

Have You MOVED?

Make sure your address is up to date with the WVRN Board. There is no charge for an address change, but it must be **submitted in writing** to the board within thirty days of the change.

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Soc.Sec#	
Name	
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Old Address	
Phone#	
Email address	

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101 Dee Drive, Suite 102, Charleston, WV 25311-1620

Three additional options are available:
1. Email the information without social security number to rnboard@wv.gov. 2. Fax the form to 304.558.3666. 3. During the renewal process if within the renewal timeframe.

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