



Oregon State Board of Nursing

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APRN Pharmacological Management Evaluation Form Part B

To be completed by the Preceptor or Academic Advisor when practicum has concluded

Applicant Name: _____

Applicant Social Security Number: _____

Preceptor Name: _____

I have served as a preceptor for the above named Advance Practice Registered Nurse (APRN) during his/her supervised practice component, and in this capacity, I have directly supervised and evaluated his/her competence.

1. I meet the following Oregon State Board of Nursing (OSBN) requirement for preceptors supervising prescriptive authority practicum:

- Oregon APRN with unencumbered Prescriptive Privileges (Clinical Nurse Specialist, Nurse Practitioner, or Certified Registered Nurse Anesthetist)

License Number: _____

- Oregon licensed Medical Doctor (DO / MD) (Practice Specialty : _____)

License Number: _____

2. I do hereby affirm that the applicant has completed _____ hours of supervised practice at:

Facility / Program name: _____

Address: _____ City: _____ State: _____

Contact number: (____) _____

Type of credit for Facility / Program Practicum:

- CME
- CNE
- Academic credit
- Other _____

3. Check the appropriate statement which applies to this applicant and return this form with a completed Prescribing Competencies Evaluation Checklist.

- Demonstrated skills and knowledge during supervised practice that are at a safe and accepted level of prescribing competency for an APRN with a specialty focus in _____ (Specialty)
- Requires additional clinical supervised practice before obtaining prescriptive authority, focusing in these areas. (Explain) _____

4. Please rate observed performance of the following practice behaviors using the three point scale below:

3 — Competent; consistently demonstrates safe, proficient performance of the behavior.

2 — Needs additional supervised practice to develop safe, competent nursing practice.

1 — Unsatisfactory; unsafe to perform.

PRACTICE BEHAVIORS		RATING SCALE		
		1	2	3
Assessment/ Data Collection	Accurately performs a comprehensive, problem-focused, or interval medical history including current and previous diseases or conditions.			
	Assesses client health care risks including environmental, cultural, educational and other risks which may impact therapeutic decision-making.			
	Collects and documents data appropriate to individual client's health needs.			
	Assesses the client's therapeutic self-management including any use of complementary/alternative therapies.			
	Documents and validates data from patient interview and comprehensive evaluation of available clinical information regarding client's physical and overall health status.			
Analysis	Establishes and documents medical diagnosis and appropriate differential diagnosis to serve as basis for pharmacological management.			
	Interprets client information including laboratory and diagnostic testing and identifies client-specific factors which determine pharmacologic management planning.			
	Interprets and applies pharmacokinetic, pharmacodynamic, and pharmacogenomic principles in evaluation and selection of drug therapy.			
	Critically analyzes prescribing standards, references, and decision support tools to provide evidence-based recommendations to clients which optimize clinical efficiency.			
Planning	Plans drug regimens which consider interactions, expected effects and potential side effects, client characteristics, illness and co-morbidity, absorption, distribution, metabolism and excretion and cost or accessibility to patient.			
	Determines appropriate drug therapy including dose, dosage form, route and frequency of administration.			
	Considers no treatment, non-drug and drug treatment options and refers as indicated.			
	Identifies and validates client-specific needs while incorporating informed consent from client or health care representative regarding treatment planning.			
	Prioritizes and develops treatment plan in accordance with mutually agreed upon client/provider goals.			
Implementation	Writes clear, legible, and complete prescriptions and/or orders which comply with state and federal regulations.			
	Demonstrates competency in drug dosage calculation.			
	Uses appropriate references and consultation to implement drug regimens (may include collaboration as appropriate).			
	Prescribes based on knowledge of pharmacological and physiological principles.			
	Provides client specific education regarding use of medication and anticipated effects including cautions.			
Evaluation	Monitors the safety and efficacy of drug therapy treatment plan.			
	Modifies treatment plan as appropriate based upon therapeutic outcome and response.			
	Incorporates and orders periodic lab testing or monitoring as indicated.			

PRACTICE BEHAVIORS CONTINUED		RATING SCALE		
		1	2	3
Professional Behaviors	Demonstrates effective working relationship with other members of healthcare team including collaboration, consultation, and referral resources.			
	Demonstrates ownership of and responsibility for the welfare of the client by providing safe, effective, and appropriate care specific to the Nurse Practitioner or Clinical Nurse Specialist role and scope of practice.			
	Evaluates own practice for continuous improvement opportunities.			
	Provides ethical care for clients including but not limited to incorporating principles of confidentiality, patient self-determination, and issues related to use of information technology.			
	Prescribes in accordance with current professional codes of practice and standards.			
Communication	Adapts communication style to meet the needs of the client regarding pharmacologic treatment and recommendations.			
	Gives clear written and/or verbal instruction to clients regarding obtaining, using, and monitoring their medications.			
	Protects sensitive client communications while enhancing therapeutic information sharing.			
	Accurately and promptly records clinical notes which reflect client assessment and pharmacological management plan.			
Setting-Specific Competencies				

Comments:

Signature of Preceptor: _____ Date: _____

Preceptor Name (Print): _____ Email: _____

Contact number: (____) _____

PLEASE ATTACH / INCLUDE DOCUMENTATION OF PRECEPTORSHIP SHOWING ACADEMIC OR CE CREDIT GRANTED.

Submit completed form to:

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