The Advanced Practice Registered Nurse as a Prescriber

Marie Annette Brown and Louise Kaplan

WILEY-BLACKWELL
The Advanced Practice Registered Nurse as a Prescriber
Companion website

This book is accompanied by a companion website:

www.wiley.com/go/brownandkaplan

The website includes a webliography containing links to further information on prescribing for advanced practice registered nurses.
The Advanced Practice Registered Nurse as a Prescriber

Marie Annette Brown
PhD, ARNP, FNP-BC, FAAN
Professor
University of Washington
Seattle, WA
Primary Care Nurse Practitioner
Women’s Health Care Clinic
University of Washington Medical Center
Seattle, WA

Louise Kaplan
PhD, ARNP, FNP-BC, FAANP
Director of Nursing
St. Martin’s University
Lacey, WA
To my husband, Eric Leberg, whose deeply loving support has inspired and sustained me. To my patients, students, and colleagues who have fueled my enthusiasm for a lifelong dedication to the advanced practice nursing role. And to my father, Moss Brown, who led me to the understanding that education is transformative.

Marie Annette Brown

To my sons, Kai and Lee, for their understanding of the time I spent working on this project and advocating for advanced practice registered nurses. And to all the advanced practice registered nurses who have worked tirelessly to further autonomous practice nationwide.

Louise Kaplan
**Contents**

<table>
<thead>
<tr>
<th>Contributors</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ix</td>
<td></td>
</tr>
<tr>
<td>Preface</td>
<td>xi</td>
</tr>
<tr>
<td>1 What Do APRN Prescribers Need to Understand?</td>
<td>3</td>
</tr>
<tr>
<td><em>Marie Annette Brown and Louise Kaplan</em></td>
<td></td>
</tr>
<tr>
<td>2 Embracing the Prescriber Role as an APRN</td>
<td>11</td>
</tr>
<tr>
<td><em>Louise Kaplan, Marie Annette Brown, Nancy J. Crigger, and Elizabeth K. Kessler</em></td>
<td></td>
</tr>
<tr>
<td>3 Creating a Practice Environment for Fully Autonomous Prescriptive Authority</td>
<td>39</td>
</tr>
<tr>
<td><em>Marie Annette Brown and Louise Kaplan</em></td>
<td></td>
</tr>
<tr>
<td>4 Strategies for Assessing, Monitoring, and Addressing Special Considerations with Controlled Substances</td>
<td>69</td>
</tr>
<tr>
<td><em>Pamela Stitzlein Davies</em></td>
<td></td>
</tr>
<tr>
<td>5 Managing Difficult Patient Situations</td>
<td>105</td>
</tr>
<tr>
<td><em>Donna Poole, Marie Annette Brown, and Louise Kaplan</em></td>
<td></td>
</tr>
<tr>
<td>6 The Influences of Pharmaceutical Marketing on APRN Prescribing</td>
<td>145</td>
</tr>
<tr>
<td><em>Elissa Ladd</em></td>
<td></td>
</tr>
<tr>
<td>7 Regulation of Prescriptive Authority</td>
<td>175</td>
</tr>
<tr>
<td><em>Tracy Klein</em></td>
<td></td>
</tr>
</tbody>
</table>

**Companion website**

This book is accompanied by a companion website:

www.wiley.com/go/brownandkaplan
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Legal Aspects of Prescribing</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>Carolyn Buppert</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The Role of Cultural Competence in Prescribing Medications</td>
<td>229</td>
</tr>
<tr>
<td></td>
<td>Mary Sobralske, Louise Kaplan, and Marie Annette Brown</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Index</em></td>
<td>257</td>
</tr>
</tbody>
</table>
Contributors

Editors
Marie Annette Brown, PhD, ARNP, FNP-BC, FAAN
Professor
University of Washington
Seattle, WA
Primary Care Nurse Practitioner
Women’s Health Care Clinic
University of Washington Medical Center
Seattle, WA

Louise Kaplan PhD, ARNP, FNP-BC, FAANP
Director of Nursing
St. Martin’s University
Lacey, WA

Contributors
Carolyn Buppert, CRNP, JD
Attorney
Bethesda, MD

Nancy J. Crigger, PhD, MA, ARNP, BC
Associate Professor of Nursing
Graceland University
Independence, MO

Pamela Stitzlein Davies, MS, ARNP
Nurse Practitioner
Palliative & Supportive Care Service
Seattle Cancer Care Alliance
Seattle, WA
Contributors

Elizabeth K. Kessler, MSN, APRN, FNP-C
Assistant Professor of Nursing
William Jewell College
Liberty, MO

Tracy Klein, PhD, FNP, FAANP
Advanced Practice Consultant
Oregon State Board of Nursing
Portland, OR

Elissa Ladd, PhD, RN, FNP-BC
Associate Professor
MGH Institute of Health Professions
Boston, MA

Donna Poole, MSN, ARNP, PMHNP-BC
Medical Services Manager and Psychiatric Nurse Practitioner
Kitsap Mental Health Services
Bremerton, WA

Mary Sobralske, PhD, ARNP
Certified Family Nurse Practitioner
Certified Transcultural Nurse
Transcultural Health Consultants
Spokane, WA
The purpose of this book is to provide advanced practice registered nurses (APRNs) with the information necessary to be a fully informed, rational, and ethical prescriber. The genesis of this book was our teaching, practice, and research. Throughout our professional life as nurse practitioners, we have experienced the demands and difficulties inherent in accomplishing this goal.

In 2001, Washington State APRNs obtained prescriptive authority for Scheduled II–IV drugs. Our research revealed that when this was initially optional, many APRNs did not obtain this hard-won prescriptive authority and some were reluctant to prescribe or provide these drugs. The slower-than-expected transition prompted our desire to create a more in-depth understanding of how APRNs adopt the role of a prescriber. Likewise, our colleagues, the chapter authors, were inspired to share their prescribing wisdom gleaned from experience to mentor students and colleagues. They dedicated countless days to the time-consuming and often difficult challenge of writing in addition to their ongoing professional demands.

We intend for this book to assist students who are adopting the role of APRN prescriber. We also intend to assist practicing APRNs who confront challenges as they transition to the full scope of the prescriber role. Most APRNs need to deepen their knowledge base as they fully implement new or expanded roles, particularly that of fully autonomous prescriber. Ultimately, this information will assist our colleagues across the nation as they work to advance the profession in order to serve patients. Enhancing the prescribing expertise of APRNs will enrich our professional opportunities to contribute to greater access and more patient-centered care. This expertise is also a basis on which we can create changes necessary to improve the quality of health care delivered to Americans.

In 2010, the Institute of Medicine released the report, *The Future of Nursing: Leading Change, Advancing Health*. The first key message
of this report is that nurses should practice to the full extent of their education and expertise. The report recommended that legal and regulatory barriers to APRN practice be eliminated. We thank the APRNs who have worked tirelessly over the decades to do just that.

We acknowledge policymakers as well as local, state, and national nursing organizations that have been instrumental in advancing the profession of nursing. They honored the dream of advanced practice nursing pioneers who championed their creative innovation that is part of our professional heritage. We dedicate this book to the APRNs who continue the work needed to eliminate the barriers to fully autonomous prescribing for all APRNs. We will not rest until we meet that goal!

*Marie Annette Brown and Louise Kaplan*
The Advanced Practice Registered Nurse as a Prescriber
What Do APRN Prescribers Need to Understand?

Marie Annette Brown and Louise Kaplan

Today’s health care transformations herald unprecedented opportunities for advanced practice registered nurses (APRNs) to provide and model patient-centered, evidence-based health care. As APRNs across the country secure fully autonomous practice, they must also seize the opportunity to become pacesetters for ethical and responsible prescribing. The vast majority of APRNs (nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists) work with prescription medications on a daily basis. Many are unable to imagine a practice that does not, in some way, include the ability to prescribe, provide, and/or manage medications for at least some of their patients. A goal of most APRNs, however, is utilization of a wide range of healing therapies in the process of patient-centered care. This may include, but is not focused solely on medications. Health promotion and disease prevention continue to be a hallmark of APRN practice.

At the same time, as the demand for prescriptive medications increases, prescriptive authority becomes an even more vital component of APRN practice. The number of prescriptions increased 39% between 1999 and 2009 from 2.8 billion to 3.9 billion. During this same time period, the U.S. population grew only 9% (Kaiser Family Foundation, 2010). In order to meet the prescribing needs of patients, APRNs must have unencumbered and fully autonomous prescriptive authority and practice.

Practice in today’s complex, fast-paced healthcare delivery system in which there is a constant barrage of information can be
overwhelming. Selection and monitoring of medication appropriate for patients is only one aspect of the complex process of prescribing. This book serves as an easily accessible reference to guide practicing APRNs through these challenges and supplement pharmacotherapeutic knowledge about specific medications. APRN students can also benefit from the content of this book. Standards for APRN programs specify a pharmacotherapeutic course as well as analysis of the APRN role (National Organization of Nurse Practitioner Faculties [NONPF], 2010). Educators barely have time to teach the essential knowledge about pharmacokinetics, pharmacodynamics, and evidence-based drug treatment recommendations. There is little time available in most pharmacology courses for in-depth discussion of the APRN’s role as a prescriber. The information included in this book has been compiled by experts in their areas. Each author has used her particular wisdom and creativity to synthesize and organize key ideas on a wide variety of subjects. These include:

- What it means to be a prescriber
- The many facets of the prescriber role
- The legal, regulatory, and ethical responsibilities of APRNs who prescribe medications
- Patient–APRN collaboration to reach patient-centered medication decisions
- Dealing with difficult clinical situations
- Pharmaceutical industry influences on prescriber decisions
- Cultural competencies to promote patient-centered prescribing.

THE JOURNEY OF APRN PRESCRIPTIVE AUTHORITY
For decades, APRNs have invested innumerable hours in lobbying and regulatory work to advance APRN practice. They have solidified the APRN role, strengthened the foundation for APRN education, and expanded the knowledge base for expert practice. APRNs in Idaho were the first to be authorized to prescribe medication in 1971, though it took 6 years for rules to be written and prescriptive authority to be implemented. Most APRNs have now been granted prescriptive authority in all states. APRNs have repeatedly demonstrated that they provide effective, high-quality care, including prescribing medications (Ingersoll, 2009; Newhouse et al., 2011).
Nonetheless, APRNs in nearly three-quarters of the states confront prescribing barriers on a daily basis. These barriers include requirements for supervision or collaboration, restrictions on prescribing controlled substances, and limitations on the type and quantity of medications that can be prescribed.

As a consequence of prescribing barriers, many APRNs are unable to practice to the full extent of their educational preparation, knowledge, and abilities. This negatively affects patient care and the healthcare system overall. Practice constraints handicap the APRN who is unable to fulfill roles in outpatient and inpatient settings. These restrictions continue despite an increased demand for primary, specialty and acute care providers, and the expansion of “patient-centered healthcare homes.” APRNs are in more demand as work hours for medical residents have been limited and shortages of providers to work with the underserved and those living in rural areas increase. Successful implementation of healthcare reforms in the years to come requires APRNs to be full partners with other health professionals. One of the key recommendations from the Institute of Medicine’s (2010) report, “The Future of Nursing: Leading Change, Advancing Health,” emphasizes the need to remove barriers to allow nurses to practice to the full extent of their education and expertise.

**Washington State as an exemplar**
A legislature must pass a bill to enable any changes in the scope of practice for ARPNs. The law typically cannot be implemented until the Board of Nursing adopts rules that specify the intent of the law. Scope of practice changes can take months to years to finalize. The history of APRN prescribing in Washington State begins with a 1977 law that authorized advanced practice nurses to prescribe legend drugs (medications requiring a prescription). However, dispensing medications and prescribing controlled substances were prohibited. The Board of Nursing then wrote rules that authorized APRNs to prescribe Schedule V drugs in 1982 and dispensing was added in 1983. It was not until 2000, after more than a decade of lobbying, that APRNs in Washington State obtained Schedule II–IV prescriptive authority.

This long-sought authority came with a price. For the first time since APRN practice was authorized by the legislature in 1973,
some type of physician involvement was mandated. APRNs who wanted II–IV prescriptive authority were required to obtain a Joint Practice Agreement (JPA) with a physician. Slowly over the next 4 years many APRNs began obtaining this type of prescriptive authority. However, until the JPA was removed, over one-third of APRNs did not obtain II–IV prescriptive authority. This contradicted the expectation of APRN leaders in the state that nearly all APRNs would want the legal ability to prescribe controlled substances even if it was only utilized occasionally. We conducted research in Washington State to understand this unexpected phenomenon (Kaplan & Brown, 2004, 2007, 2009; Kaplan, Brown, Andrilla, & Hart, 2006; Kaplan, Brown, & Donohue, 2010).

The findings of our research serve as a basis of understanding how APRNs may or may not transition to fully autonomous prescriptive authority and practice when provided the opportunity. It also offers lessons learned about the need to prepare APRNs for a major transition in scope of practice. Change may cause concern for some who have adapted to the status quo, even if prescribing barriers limited their ability to practice. Many of these findings are discussed in Chapter 3 on prescribing barriers. They will enhance your understanding about APRN prescribing practice, the consequences of limiting APRN practice, and the poorly understood experience of scope of practice change. It is not surprising, however, that APRNs respond to change with the natural ambivalence that accompanies most change processes.

OVERVIEW OF CHAPTERS
Chapter 2 guides the reader through an analysis of the role and responsibilities of the APRN as a prescriber. The ability to independently prescribe medications symbolizes the legitimacy of APRNs. The public often perceives the prescribing role as what defines an APRN. This chapter includes an overview of the development of the APRN role and prescriptive authority, the essential nature of autonomy, and the process of transition to the prescribing role. The chapter emphasizes the shift from prescribing medication based on professional preference and tradition to rational prescribing and evidence-based practice as strategies for achieving quality patient-centered care.

With all of the factors that influence the transition of the APRN to becoming a prescriber, there is an understandable degree of uncer-
What Do APRN Prescribers Need to Understand?

What Do APRN Prescribers Need to Understand? 1

Certainty and concern about prescribing. Challenges about the transition from a role that requires administration of medications and prescribed treatments as a registered nurse to manager of care and prescriber as an APRN are delineated. Change can be a professionally invigorating challenge rather than a distressing situation. It is understandable, however, that many role transitions are characterized by uncertainty along with the excitement and promise of change.

Chapter 3 highlights the multitude of challenges and opportunities that APRNs confront when prescribing medication. Laws, regulations, policies, as well as the attitudes of other health professionals often limit prescribing. These are considered external barriers to an APRN’s adoption of the prescribing role. Internal barriers also can diminish an APRN’s interest in fully autonomous practice and can be overlooked when analyzing barriers to APRN prescribing. Internal barriers are invisible or unacknowledged factors within the individual APRN, including personal characteristics such as conflict avoidance or the “need to be liked.” Strategies to overcome internal and external prescribing barriers are offered as a way to generate enthusiasm among APRNs for facilitating change.

Chapter 4 discusses the characteristic clinical challenges inherent in prescribing controlled substances and the strategies to address them. The use of deliberate, concrete approaches to prescribing controlled substances is a key strategy to build prescribing expertise. Topics discussed range from “universal precautions” for use with the prescription of controlled substances and the assessment and management of patients with chronic noncancer pain, to clinical guidelines, consensus statements, and practice standards for the identification of a patient who is a substance abuser. The author offers online resources, examples of useful documentation, and a comprehensive reference list to further hone skill building. Accurate definitions of terms related to drug use or misuse and their application provide a rationale for creating more skillful communication with patients around complex and sensitive issues.

Chapter 5 coaches APRNs to deal with difficult and often complex clinical situations that are inherent in human relationships and professional interactions, even among experienced and dedicated APRNs. These situations often create anxiety and may even generate anger when the APRN feels ill-prepared to deal with them. The basic tenet is that these are not problem patients but...
situations for which the APRN needs more knowledge, skill, and insight from self-reflection. Examples of these situations include dealing with patients who are or appear to be seeking controlled substances, are angry, request inappropriate care such as antibiotics for a viral infection, and who violate boundaries. One goal of the discussion is to enhance understanding of why these difficult situations develop and how they can impact patient-centered care. Specific strategies to identify difficult situations, respond to them appropriately, and build competence as a supportive and courageous APRN prescriber are discussed.

Chapter 6 describes pharmaceutical marketing and its influence on APRN prescribing. There are nationwide efforts to counter drug company influence on providers and healthcare organizations that in many instances have normalized this influence. Pharmaceutical drug promotion is directed at all prescribers through activities such as drug detailing, advertising in journals, and educational offerings. The United States is the only country besides New Zealand where direct-to-consumer advertising of drugs is allowed. Consumers are targeted by advertising on the Internet, television, and in print media.

Increased APRN awareness of drug company activities may assist in understanding the direct and indirect methods used to influence providers and consumers. Continued promotional activities to APRNs and lack of regulatory constraints must be balanced with heightened level of APRN awareness, vigilance, and ethical considerations among APRNs to assure cost-effective, evidence-based prescribing.

Chapter 7 details the laws, regulations, and professional issues that affect prescribing. These include state laws, board of nursing rules, and interprofessional constraints. Fully autonomous prescribing is contrasted with examples of restricted prescribing authority. Restrictions include the requirement for physician supervision, the need to use formularies, and the lack of authority to prescribe controlled substances.

The APRN Consensus Model was developed over several years of dialogue and negotiation by representatives of education, state boards of nursing, and professional practice organizations. Discussion of the consensus model highlights the need for standardized regulation that achieves fully autonomous practice with full prescriptive authority and universal adoption of the term
What Do APRN Prescribers Need to Understand?

APRN. This chapter can assist APRNs across the nation to visualize and positively anticipate their future practice and prescribing.

In Chapter 8 a series of case exemplars convey important legal information for APRNs. This includes prescribing authority based on state law, federal laws on prescribing controlled substances, and the standard of care for prescribing varying classes of drugs. These exemplars highlight the role of Boards of Nursing, malpractice attorneys when a lawsuit is filed, the Drug Enforcement Administration, and government auditors who monitor nursing facilities. The purpose of this chapter is to help APRNs become savvy prescribers and avoid missteps during their career.

Chapter 9 focuses on the role of cultural competence in prescribing medications. Factors such as biological variation, race, ethnicity, primary language, literacy, socioeconomics, disabilities, and religious beliefs need to be considered by the APRN. Discussion of ethnopharmacology highlights the effect of race and ethnicity on the responses to medication, drug absorption, metabolism, distribution, and excretion. Concepts about immigration, acculturation, and assimilation that influence health beliefs and behavior will enable APRNs to understand the multiple strategies necessary for prescribing in a culturally appropriate manner.

CONCLUSION
Ultimately, this book is more than a guide and reference for building and enhancing prescribing expertise. It honors the work of APRNs who use prescriptive authority to provide comprehensive quality care. The book is a tribute to the countless number of APRNs who have worked tirelessly for fully autonomous prescriptive authority. Toward that end, we hope the book is an inspiration to students. You are the next generation of APRNs on whom we depend to join in the efforts to obtain fully autonomous prescriptive authority nationwide. We look forward to the day this is achieved.

REFERENCES


The ability to independently prescribe medications symbolizes the legitimacy of advanced practice registered nurses (APRNs). The public often perceives the prescribing role as what defines an APRN. Therefore, a goal of APRNs is fully autonomous practice and professional integrity to provide comprehensive patient care (Mantzoukas & Watkinson, 2007). APRNs prescribe medications to meet societal needs, the expectations of the profession, and the needs of individual patients and families. Prescribing is a component of each of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and nurse practitioner (NP). Prescribing is within the scope of practice for NPs and CNMs in all 50 states but is more limited for CNSs and CRNAs (National Council of State Boards of Nursing, 2010). This chapter provides information for APRNs to
enhance expertise and confidence for successful adoption of the fully autonomous prescriber role.

DEVELOPMENT OF THE APRN ROLE
The APRN role began with nurse anesthetists in the late 1800s, preceding anesthesiologists by several decades. Nurse midwives became established in the United States in the early 1900s, while the CNS role evolved in the 1940s (Dunphy, Smith, & Youngkin, 2009). The NP role, developed in 1965, has grown the most rapidly, with NPs becoming the largest group of APRNs. Nationally, NP educational programs more than doubled between 1992 and 1997 (Druss, Marcus, Olfson, Tanielian, & Pincus, 2003).

During the 1980s and 1990s, many legislatures enacted laws that provided a scope of practice for APRNs consistent with their educational preparation (Hamric, Spross, & Hanson, 2009). Over time, APRNs have established themselves as members of the healthcare workforce with a distinct role, a unique education, and essential knowledge and skills to provide care.

APRN scope of practice varies across the United States according to state laws that are the basis of regulation (Pearson, 2011). Advanced practice nursing is controlled by licensure, credentialing, and educational preparation, and practice opportunities at higher levels of expertise (Brown-Benedict, 2008; Ford, 2008; Klein, 2008). Variation in APRN roles also result from organizational policies that may support or constrain practice. APRNs are responsible for maintaining a high ethical standard in practice, generating knowledge, and appraising and translating evidence to provide quality, comprehensive, patient-centered care.

Although there has been significant progress in the utilization of APRNs, constraints on consumers’ access to APRNs, legal limitations, and absence of a consistent, fully autonomous scope of practice across states continue to be problematic (Lugo, O’Grady, Hodnicki, & Hanson, 2007). Constraints on APRNs that limit their practice are not supported by data about the quality of care they provide (Fairman, Rowe, Hassmiller, & Shalala, 2011). Over the last several decades, studies have demonstrated that APRN care is as or is more effective than care given by physicians (Brown & Grimes, 1995; Congressional Budget Office, 1979; Dulisse & Cromwell, 2010; Horrocks, Anderson, & Salisbury, 2002; Laurant et al., 2006; Lenz,
Mundinger, Kane, Hopkins, & Lin, 2004; Newhouse et al., 2011; Ohman-Strickland et al., 2008; Prescott & Driscoll, 1980; Safriet, 1992; Simonson, Ahern, & Hendryx, 2007; Spitzer et al., 1974; Wright, Romboli, DiTulio, Wogen, & Belletti, 2011). Many of these studies also validated more widespread acceptance of the APRN role and high satisfaction with APRN care. Increasing demands for APRNs (Fairman et al., 2011) and assessment of their cost-effectiveness (Bauer, 2010) are expected to influence removal of legal barriers remaining in many states. Concurrently, an improved regulatory environment, especially in relationship to prescriptive authority, has helped legitimize and distinguish the APRN role. In states where NPs have fully autonomous practice, prescribing autonomously is a major difference between NPs and physician assistants (PAs) whose practice is always supervised by and is legally linked with a physician. Furthermore, implementation of the Consensus Model for APRN Licensure, Accreditation, Certification and Education (see Chapter 7) can assist APRNs to attain fully autonomous practice, including complete prescriptive authority.

Autonomy is an important professional concept for APRNs; the nursing literature on advanced practice confirms it has been difficult to achieve (Ulrich & Soeken, 2005; Weiland, 2008). The conceptualization of autonomy by Weiland (2008) uses both a legal definition and “…the practical ability to provide primary health care and exercise independent judgment and self-governance within the NP scope of practice” (p. 345). Autonomy is also a professional and personal sense of the ability to make decisions in practice independently when legally granted to a professional through the endorsement of society. Autonomy extends beyond the legal authorization to prescribe. “It is not just in action but in thought that we create our autonomy” (Kaplan & Brown, 2006, p. 37).

DEVELOPMENT OF THE APRN ROLE AND PRESCRIPTIVE AUTHORITY

Obtaining prescriptive authority for APRNs has presented significant challenges nationwide. Even when prescriptive authority is supported in new legislation, significant roadblocks with implementation often occur, particularly those placed by physicians. In 1971, for example, Idaho became the first state to pass legislation
that recognized the NP role and granted prescriptive authority. Although the first Idaho NP entered practice in 1972, opposition from the Board of Medicine resulted in more than one dozen drafts of the prescriptive authority rules. It was not until 1977 that the rules were adopted, and Idaho became the first state to implement prescriptive authority for NPs (personal communication, S. Evans, December 28, 2009). Nearly 30 years later, in 2006, Georgia became the last state to pass a law granting APRNs authority to “order” medications, a variant of prescribing (Phillips, 2007).

As discussed in Chapter 1 and in Chapter 7, the prescribing role remains tightly controlled in many states. In only 15 states and in the District of Columbia (depending on the definition used) is there prescriptive authority for NPs without physician involvement. In the remaining states, NPs have various requirements for physician involvement when prescribing. Prescribing is within the scope of practice for CNMs in all 50 states with varying degrees of physician involvement but is more limited for CNs and CRNAs. Nurse anesthetists can prescribe in 29 states (Kaplan, Brown, & Simonson, 2011) and CNSs in 34 states (National Council of State Boards of Nursing, 2010).

ADAPTING TO THE APRN’S ROLE AS PRESCRIBER

Prescriptive authority

Prescriptive authority is the legal ability to prescribe drugs and devices, a practice regulated by the states. One aspect of prescriptive authority, controlled substances (CSs), is specifically regulated by the federal government through the Drug Enforcement Administration (DEA) (Arcangelo & Peterson, 2006). States may also have additional regulations related to prescribing CSs.

Transition to the prescribing role

One of the greatest responsibilities for an APRN is that of prescription medication management. Prescribing is not a part of the registered nurse (RN) role, and often requires a major paradigm shift to transition from administering drugs to selecting and prescribing medications. Consequently, the individual APRN’s transition to the prescriber role involves a union between knowledge of and socialization to the role. APRNs begin gaining knowledge and competencies throughout their graduate education and continue
this process through practice. Role socialization is also initiated during APRN education and will likewise be part of continuing professional development.

Transition to the prescriber role is part of the larger role transition that the APRN experiences first as a student, as a novice practitioner, and when scope of practice changes. Schumacher and Meleis (1994) identified five factors that influence role transition. These are:

1. Personal meaning of the transition
2. Degree of planning for the transition
3. Environmental barriers and supports
4. Level of knowledge and skill
5. Expectations.

Identification of these factors may allow the APRN to prepare ways for a smooth transition although there are other dimensions of transition that also need to be considered.

Students in APRN programs typically experience a role transition process that involves role confusion and role strain including tension, frustration, and anxiety. Role acquisition as a student may involve four stages of development (Brykcznski, 2009):

1. Complete dependence with a loss of confidence and feelings of incompetence
2. Developing competence, a personal practice philosophy and standards of practice, and increased confidence in the ability to succeed
3. Independence in making practice decisions with the possibility of disagreement in approaches between student and preceptor or faculty
4. Interdependence with the development of a personal vision of the APRN role and relationships with other health professionals.

Role acquisition extends to the practicing APRN. The first year of practice is an especially challenging one. A study by Brown and Olshansky (1998) identified four stages in the transition to primary care NP role. These are laying the foundation, launching, meeting the challenge, and broadening the perspective. Table 2.1 describes these stages. The study findings revealed the importance of skillful mentors who serve as a compass to guide the NP and serve as a