GUIDELINES FOR CONTINUING NURSING EDUCATION CREDIT

INTRODUCTION

The Oklahoma Nurses Association is an **approved provider** of continuing nursing education through the Texas Nurses Association. The ONA must adhere to the requirements established by the Texas Nurses Association and the ANCC in order to continue as an approved provider. This means that the ONA is not able to approve programs or continuing nursing education activities for entities with which they do not have a co-provider agreement. In order to better serve the education needs of nurses in Oklahoma, ONA will co-provide with organizations and/or agencies that wish to provide educational activities for the registered nurses in Oklahoma. ONA cannot approve educational activities offered independently by other entities.

This informational packet contains the guidelines and standards that ONA must follow and explains what steps to take if you wish to co-provide an educational activity jointly with the ONA.

Since the ONA regions are members of the ONA, they do not have to sign a co-provider agreement but must follow the other guidelines.

A copy of the Co-Provider Agreement is available on the ONA website and can be down loaded for your convince.

STEP 1:

A. Identify a nurse planner to serve as liaison with the Continuing Education Director for ONA.
B. Complete the Application for Continuing Nursing Education Activity and submit it to Continuing Education Director.
C. Complete the Co-Provider Agreement and submit it to Continuing Education Director, if applicable.

STEP 2:

A. Following initial review you will be notified of any changes to be made prior to completing the following documents.

    1. Planning Committee: There must be at least two members of the Planning Committee, one of whom must be a registered nurse with a bachelor's degree in nursing and a member of the ONA. Complete the Biographical Data Form and Conflict of Interest Form for each member of the committee, identifying the role they will serve in on the committee. Committee members may serve in more than one role.

STEP 3:

A. Develop objectives, identify speakers and complete the Education Documentation Form. Submit form to Continuing Education Director.
    1. Develop promotional materials.

B. Have all presenters complete the Biographical Data Form and the Conflict of Interest Form. The Nurse Planner should review these documents and note if there is a conflict of interest, indicating how the conflict was resolved. (Nurse Planners must sign this form before submitting it to ONA.)

C. Develop an evaluation tool using the sample format and submit it to the Continuing Education Director for review.

STEP 4:

A. Before the activity begins, notify all participants of all disclosures (see form ###)
B. Present the activity.

STEP 5:

A. Upon completion of the activity, submit the following documents to the ONA:

    1. Summary of evaluations indicating total number of participants and number of registered nurse participants
    2. Speaker Biographical Data and Conflict of Interest Forms
    3. Certificate of Successful Completion Form (###)
    4. Sign in sheet for all RN participants
    5. Commercial Support Education Grant Agreement (if applicable) (###)
    6. Attestation Statement of Disclosures presented to participants

(###)

Application to Provide Continuing Nursing Education

Title of Activity: _____

Date of First Presentation: ____/____/____

About the Co-Provider

Organization: _____

Organization address: _____

_____

Nurse Planner for this activity: _____

Contact information: Phone (_____) _____-_____ Ext._____ Fax: (____) _____

Email Address(es): _____

Primary contact person (if not Nurse Planner): _____

Contact information: Phone (_____) _____Ext.___ Fax: (_____) _____

Email Address(es): _____

About the Educational Activity

How often will this activity be offered? ☐ One time ☐ Multiple times

Location of activity (if applicable): _____

Proposed registration fee: _____

This activity is *Co-Provider Directed*_____ or *Learner Paced*_____ *(check one)*

ASSESSMENT OF LEARNER NEEDS (Check all that apply)

- ☐ Previous course evaluations
- ☐ Professional organizations
- ☐ Quality improvement data
- ☐ Needs Assessment/Survey
- ☐ Research findings
- ☐ Legislation
- ☐ Nursing experts
- ☐ Societal/Organizational trends
- ☐ Advancement in practice
- ☐ The Registered Nurse
- ☐ Consumers
- ☐ Other _____

TARGET AUDIENCE: ☐ Staff Nurse ☐ Advanced Practice Nurses ☐ Other _____

LEVEL OF RN LEARNER: ☐ Novice ☐ Intermediate ☐ Advanced

LEARNER PRACTICE LOCATION

- ☐ Rural
- ☐ Suburban facility
- ☐ Urban facility
- ☐ Military facility
- ☐ Skilled Nursing Facility/LTC
- ☐ Home Health
- ☐ Education program
- ☐ Other _____

CLINICAL PRACTICE AREA

- ☐ Community/Public Health
- ☐ Critical Care/Emergency/Peri-operative
- ☐ Maternal Child Health
- ☐ Medical-Surgical
- ☐ Pediatrics
- ☐ Psych/Mental Health
- ☐ Other _____

Learning Goal/Purpose Statement: How will the activity enrich the RN's contribution to quality healthcare and/or contribute to his/her professional career goals?

_____

_____

_____

_____

Nurse Planner Signature _____ **Date:**_____

Co-Provider Agreement

Oklahoma Nurses Association
(Name of Co-Provider)

The following co-provider agreement is initiated between the Oklahoma Nurses Association and the **- (Name of Co-Provider)** for the purpose of planning, developing, and implementing the *(Titile of Educational Activity)*.

The Oklahoma Nurses Association is responsible for the following elements. These elements must remain the responsibility of The Oklahoma Nurses Association and are not negotiable:

- Determination of the educational objectives and content
- Awarding of contact hours
- Record keeping procedures
- Evaluation methods and categories

(Name of Co-Provider) will be responsible for the following elements.

- Provide course publicity and registration.
- Provide or arrange for the meeting room and audio-visual equipment.
- Provide refreshments for breaks.
- Assist in course planning and evaluation.
- Ensure the ONA Logo and following statement is on all promotional materials including registration brochure, on-site materials, and website etc:

  Oklahoma Nurses Association is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

The Oklahoma Nurses Association and **(Name of Co-Provider)** will both agree on the selection of topics and speakers for jointly offered CE programs.

The **Oklahoma Nurses Association** and the **(Name of Co-Provider)** agree that ONA will provide this service to the **(Name of Co-Provider)** for the fee _____..

_____	_____
Signature of Approved Provider Representative	Signature
_Oklahoma Nurses Association_____	_____.
Approved Provider Name	ORGNAIZATION NAME
_____	_____
Date	Date

Required Statement for Continued Nurse Educational Activities

The Oklahoma Nurses Association requires a disclosure statement as stipulated by the Texas Nurses Association and ANCC Commission on Accreditation. This statement must appear on all promotional materials, printed or electronic, including brochures, agendas and certificates etc. Entities entering into an agreement to co-provide with the Oklahoma Nurses Association must also utilize this statement.

Required Statement:

Oklahoma Nurses Association is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

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Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, Oklahoma 73116
405.840-3476 FAX 405.840.3013

BIOGRAPHICAL DATA FORM FOR ACTIVITIES

Instructions: *Use this format to provide documentation of an individual's expertise as a planning committee member or as faculty (content specialist) for this activity.* **Submitted information must not be more than 2 pages. Do not attach any additional material.**

Check which role you are fulfilling:

Nurse Planner .....

Target Audience Representative_____

Content Specialist .....

Faculty and/or the Presenter for this Activity_____

Other ..... _____ (explain)

Name and Degrees:	
Preferred Contact Address: **Number and Street:** **City, State and Zip Code:**	
Phone/Cell	
FAX:	
E-mail Address:	

Present Position:_____
(Employer, job title)_____

Education (include basic preparation through highest degree held) Reminder: A degree is awarded from an academic setting; a license is issued by a regulatory agency.

Degree	Institution (Name, City, State)	Major Area of Study	Year Degree Awarded
1.			
2			
3.			

Biographical Data

Use the space below to briefly describe your professional experience as it relates to your role as indicated above, in this continuing nursing education activity:

Email the completed form to ONA@OKLAHOMANURSES.ORG

Form30042010

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OKLAHOMA NURSES ASSOCIATION
6414 N. SANTA FE, SUITE A
OKLAHOMA CITY, OKLAHOMA 73116
405.840-3476 FAX 405.840.3013

CONFLICT OF INTEREST DISCLOSURE

As an approved provider by the Texas Nurses Association, it is the policy of **Oklahoma Nurses Association** to ensure balance, independence, objectivity and scientific rigor in all of its continuing nursing education activities. **All planning committee members and presenters/content specialists/authors participating in a Oklahoma Nurses Association activity must disclose to Oklahoma Nurses Association any financial relationships that they or an immediate family member may have with any commercial interest in any amount occurring within the past 12 months that create a conflict of interest.** A conflict of interest would also occur if you have any potential to benefit personally or professionally from the presentation (work for a proprietary company presenting the learning activity, have written a book about the topic, provided consulting services related to the topic, etc.). An "immediate family member" is defined as someone with whom you have a relationship involving the sharing of income or assets.

*The intent of this disclosure is not to prevent a speaker with commercial affiliations from presenting, but rather to inform **Oklahoma Nurses Association** of any professional, personal or financial relationships so that conflicts can be resolved prior to the activity.*

Name (FirstName LastName, Degree/Designation):_____

For all disclosures, complete each section, sign and date as indicated. Please spell out all acronyms.

I, or an immediate family member, have a professional, personal or financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the following categories:

1. Employment

   ___ Yes, I have an employment relationship with:_____

2. Board of Directors/Other Leadership Position

   _____Yes, I have a leadership relationship with:_____

3. Research Funding

   _____Yes, I receive research funding from: _____

4. Paid Consultant or Member of an Advisory Board or Review Panel

   _____Yes, I have a consultant or advisory board relationship with:_____

5. Speaker's Bureau

   _____Yes, I am on the speaker's bureau(s) for: _____

6. Major Stock or Investment Holder

   _____Yes, I have stock holdings with: _____

7. Other Remuneration

   _____Yes *(please list relationship and company name)* :_____

Signature of Person Disclosing: _____Date:_____

FDA APPROVED DRUG AND DEVICES ASSURANCE STATEMENT

Oklahoma Nurses Association is required by the TNA and ANCC COA guidelines to instruct you that any discussions regarding the utilization of FDA approved drugs or devices must be within approved regulations. If you discuss the utilization of FDA drugs or devices that are outside approved regulations (off-label or investigational uses), you must clearly delineate this for your audience.

Signature of Person Disclosing: _____Date:_____
(Sign this only if discussing drugs or devices in your presentation)

For Oklahoma Nurses Association Nurse Planner use Only:

____No relevant relationship(s) to resolve

_____Session will be monitored to ensure conflict does not arise

____The conflict was discussed with the individual

_____Provided talking points/outline

___ Restricted presentation to clinical data

_____Data, slides added or removed

____Reassigned faculty's lecture/topic

_____Reviewed content – free of sponsorship/commercial bias

Notes: _____

Signature of Nurse Planner: _____ Date: _____

Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, Oklahoma 73116
405.840-3476 FAX 405.840.3013

EDUCATION DOCUMENTATION FORM

***This format is required. Instructions for provider- directed activities*:** Use this five-column format to provide documentation of Educational Criteria, Objectives. Content, Time Frames, Faculty and the Teaching /Learning Strategies that support the purpose/goal(s).
***For learner-paced activities*:** Utilize a three-column format that includes objectives, content and teaching method & strategies.

Title of Activity: _____ **Presenter(s)**_____ **Date of Activity** _____

OBJECTIVES	CONTENT	TIME FRAME	FACULTY	TEACHING / LEARNING STRATEGIES
List the learner objectives in behavioral/measurable outcomes for evaluation. One verb per objective.	Provide an outline/description of the content presented and indicate to which objective the content is related. It must be more than a restatement of the objective.	Provide a time frame in minutes for each objective.	List the faculty for each objective.	List the teaching strategies utilized by each faculty for each objective.

This format is required, email completed form to ona@OklahomaNurses.Org

Oklahoma Nurses Association
Name of Educational Activity
Location

We want to know! Please help us evaluate this workshop. Please complete this evaluation tool and return your survey to the ONA representative to receive your Certificate of Completion.

Purpose of Activity_____

Evaluation

	Yes	No			
Are you a Registered Nurse?					
Objectives: How well did the program meet the following objectives? 1=not at all 5=completely	**1**	**2**	**3**	**4**	**5**
NAME OF TOPIC/SPEAKER					
1. OBJECTIVE AS IT APPEARS ON THE ED DESIGN FORM					
2. OBJECTIVE AS IT APPEARS ON THE ED DESIGN FORM					
3. OBJECTIVE AS IT APPEARS ON THE ED DESIGN FORM					
NAME OF TOPIC/SPEAKER					
4. OBJECTIVE AS IT APPEARS ON THE ED DESIGN FORM					
5. OBJECTIVE AS IT APPEARS ON THE ED DESIGN FORM					
6. OBJECTIVE AS IT APPEARS ON THE ED DESIGN FORM					
Speakers: How effective were the following speakers?					
Speaker:					
Speaker:					

	Yes	No
1. Were the **teaching methods/strategies** effective?		
2. Were the **objectives** relevant to the overall purpose?		
3. Were the **facilities** appropriate?		
4. Did you perceive any inappropriate **bias**?		
5. Were you **informed** at the beginning of the presentation of		
Potential conflict of interest		
Sponsorship or Commercial support		
Non-endorsement of products		
Off-label product use		
6. Something I learned today will change my practice related to …		

Identify 2 strategies you will implement following attendance at this program.

Comments & Suggestions: Please use back of form for comments or suggestions.

REQUIRED DISCLOSURES TO ACTIVITY PARTICIPANTS

1. **Requirements for successful completion of activity**

    A. Attendance at entire program or selected sessions
    B. Completion of evaluation

2. **Conflict of Interest**

    A. Sponsorship
    B. Hosted activities
    C. Funding sources
    D. Identity of those entities that have indicated a potential conflict of interest

3. **Commercial Support**

    A. No commercial support
    B. Sources of commercial support and that there was no influence on planning or content

4. **Non –endorsement of Products**

    A. There are no products endorsed in conjunction of this program.
    B. Any use or demonstration of commercial products does not imply endorsement by the Oklahoma Nurses Association or co-provider.

5. **Off-Label Use**

    A. There is no product use for a purpose other than that for which is approved by the FDA.

SUGGESTED VERBAGE ON AGGENDAS

It is the policy of the Oklahoma Nurses Association to ensure balance, independence, objectivity and scientific rigor in all continuing nursing activities. This educational program was developed free from control from a commercial interest, has no product endorsement or off-label product use.

CERTIFICATE OF SUCCESSFUL COMPLETION

This certifies completion of the educational activity entitled

Name of Activity as Approved

Presented on (Date/Year and Location)

For **XX** Contact Hours of Continued Nursing Education

_____

Name of Participant

Insert Logo Here if co-sponsored.

Delete this text box if not used

Oklahoma Nurses Association is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Oklahoma Nurses Association
6414 N. Santa Fe Ave., Suite. A
Oklahoma City, OK 73116
www.oklahomanurses.org
Provider # 11-285890-B
Activity # _____

OKLAHOMA NURSES ASSOCIATION

Rev Feb 2012

Commercial Supporter Education Grant Agreement

Name of Organization: _____
Address: _____
City, State Zip: _____ _____ _____
Phone Number: ( ) _____ - _____ x _____
Contact Name: _____
Email Address: _____
Sponsor Level/Event: _____ **Amount:** _____

The Organization list above agrees that it shall contribute funds to the Oklahoma Nurses Association or co-provider organization for the continuing nursing education activities offered. This is an unrestricted education grant/sponsorship for the amount listed above.

Statement of Purpose. The **Commercial Supporter** and Oklahoma Nurses Association agree that the program is for scientific and educational purposes and not for the purpose of promoting any product. Any discussion of **Commercial Supporter** products shall be objective, balanced and scientifically rigorous.

Control of Content. The Oklahoma Nurses Association shall be solely responsible for control of program objectives and content, and the selection of presenters.

Payment of Funds. Funding shall be paid by directly to the Oklahoma Nurses Association and no other funds shall be paid to individuals involved in the Program. Checks will be made payable to the Oklahoma Nurses Association. The Signed agreement and payment will be sent to the following address.

Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, OK 73116

Disclosure of Financial Relationships. The Oklahoma Nurses Association shall disclose at the time of the Program/Activity and to the attendees, verbally or in written materials, regarding all funding activities and any significant relationships between the Oklahoma Nurses Association and its sponsors/funders as well as the individual presenters or moderators and sponsors/funders.

Acknowledgment of Support. The Oklahoma Nurses Association shall acknowledge the educational support of its sponsors/funders in Program/activity brochures and other program materials. Sponsorship does not constitute endorsement by the American Nurses Credential Center's Commission on Accreditation (ANCC COA), the Texas Nurses Association (TNA) or Oklahoma Nurses Association.

Standards. The Oklahoma Nurses Association and sponsor/funder agree to abide by the requirements of the ANCC COA and TNA criteria for Commercial Support of Continuing Nursing Education and the current Food and Drug Administration Policy Statement on Industry Supported Scientific and Educational Activities, which is incorporated by reference herein. The sponsor/funder will not be liable for any departure from ANCC COA and TNA criteria, which occurs through no fault of the sponsor/funder..

Name (Print):_____

Signature:_____

Title: _____

Date: _____

Not needed if paying online

Date Agreement Received: _____Date $ Received:_____Total Amount: _____

Deposit: Check #: _____ Date: _____ Amount $ Received: _____

Credit Card #_____ CVV_____ Exp._____

Name as it appears on Credit Card:_____Initials:_____