Applying for Nursing CEs! Who knew?

Objective

- The nurse will gain an understanding of the CE process, submission and maintenance of documents, per OAC 5723-14. The nurses scope of practice will be enhanced by the ability to gain/share his/her knowledge while offering CEs.

Who are we?

- Ohio Department of Developmental Disabilities Approver Unit for Nursing Continuing Education
    - Full committee title as in our policy and procedure
- OBN DODD Approver Unit (or just Approver Unit)
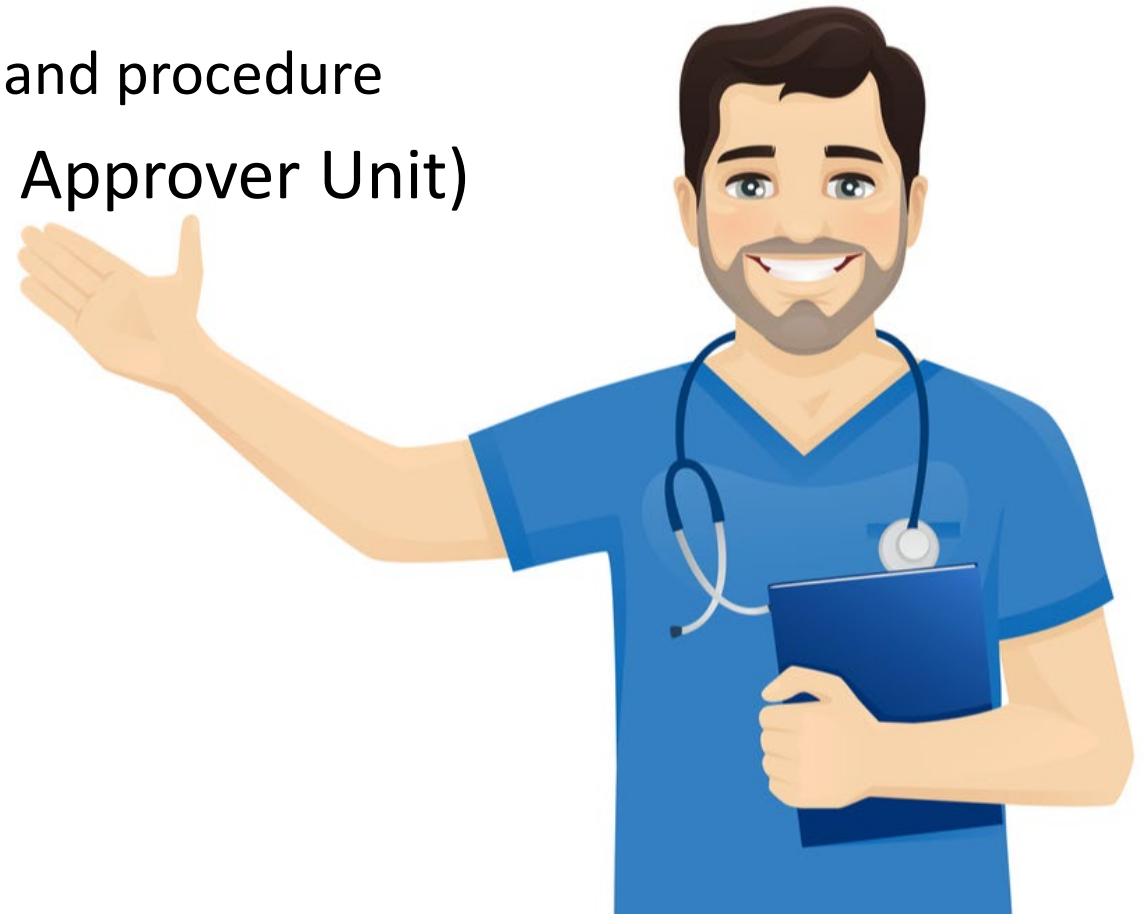
Ohio Administrative Code

- 4723-14
  - 4723-14-03 CE Requirements for RN and LPN
  - 4723-14-08 through 4723-14-18
    - Our rule guiding approver unit policy and procedure

OBN DODD Approver Unit

- **Started in 1980's**

- **Arm of OBN**
  - OBN-010-93-xxxx

- **Leadership**
  - Chair Person
  - Co-Chair Person
  - DODD Representative
  - Intake Coordinator/Peer Review Coordinator

Ohio | **Department of Developmental Disabilities**

OBN DODD Approver Unit

- Nine additional nurses (mix)

How the Committee is Managed

- Quarterly Meetings
  - Review applications as a committee once a year
- Every application gets two independent reviews
- Policy and Procedures developed from OBN rule are reviewed annually
- OBN Audits

So you want to get started?

- When should you turn in an application for CE credit?

DODD.Ohio.gov → Medication Administration → Nursing Continuing Education Approval → Download Forms

Nurse Continuing Ed Approval

Ohio Board of Nursing (OBN) approved continuing education units, or CEUs, for nurse education can be granted by the DODD's Ohio Board of Nursing Approver Unit (OBN-010-93). This OBN Approver Unit is authorized to approve OBN nurse continuing education units related to developmental disabilities nursing.

To submit an application for OBN-approved continuing education units,

- download the instructions for the application process and the required forms,
- complete the application forms and create the required documents,
- and submit application forms and documents no less than six weeks prior to the scheduled education offering.

Applications should be sent to the committee's application intake coordinator:

Anthony Kirkby MBA, BSN, RN
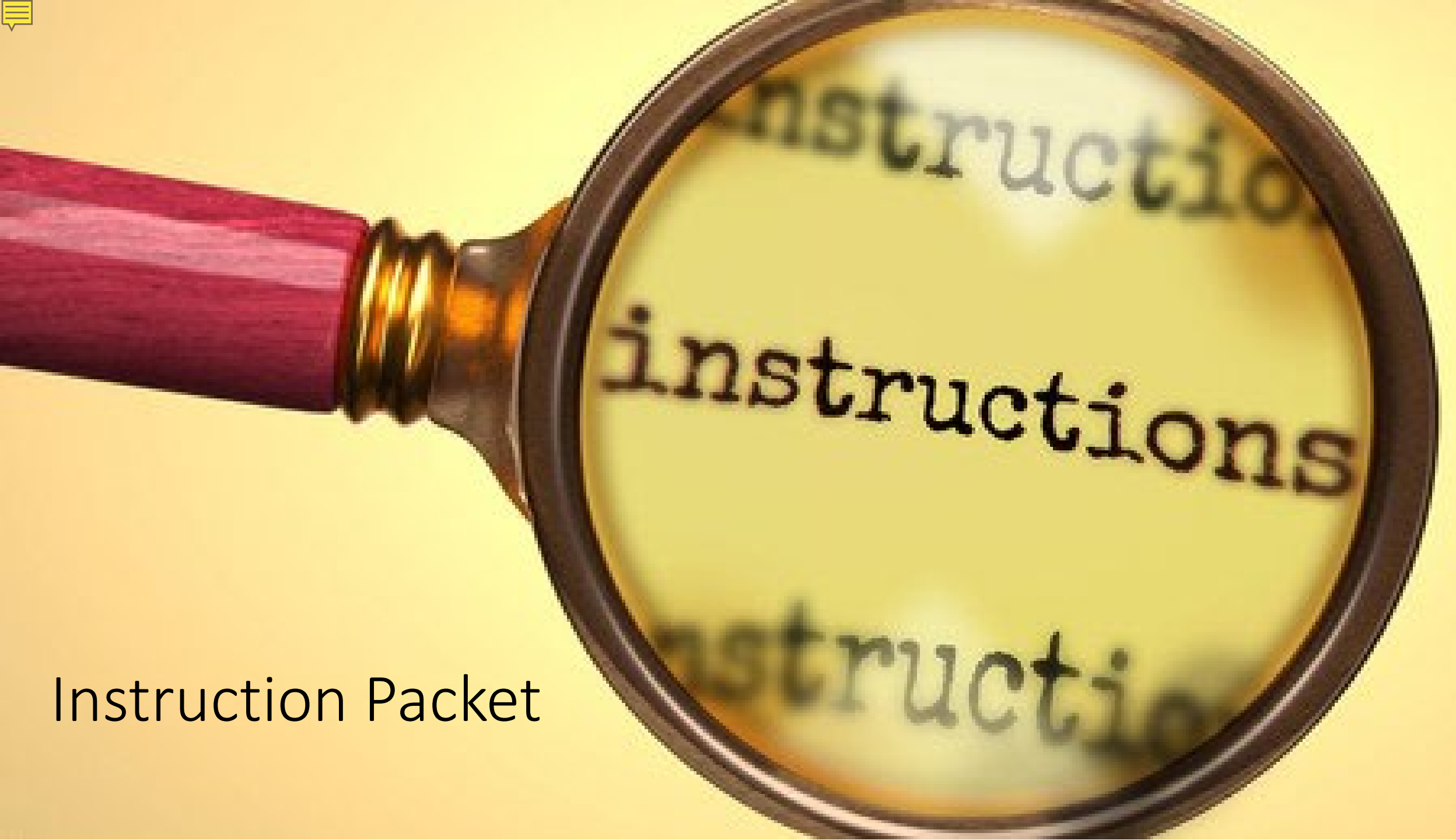
tkirkby@shc-medina.org

phone: 330-722-1900 ext. 325

fax: 330-723-6695

Share this

Medication Administration

WELCOME

SELF ADMINISTRATION

FAMILY DELEGATION

APPROVED MED ADMIN

RN TRAINERS

QUALITY ASSESSMENT RNS

Instruction Packet

Ohio | Department of Developmental Disabilities

NURSES CONTINUING EDUCATION APPLICATION

Applicant Name and Address:	Telephone Number (Including Area Code):
	Email:

Application Submitted for:
- ☐ Presentation (In-person or live webinar)
- ☐ Independent Study (Blended or asynchronous learning)

Request CE for: (Check each that apply)
- ☐ RN
- ☐ LPN
- ☐ Category A

Title should be clear and succinct and should reflect content of program.

Title of Presentation/Independent Study:

First Date to be offered:	Advertising information: (where will the presentation be advertised?) Ads must include a person to contact re: OBN CE approval status)- attach a copy of advertising material/brochure

Documentation of need describing how this education will improve the practice of the RN/LPN and relevance to persons with DD:

Total Classroom Contact Hours is the number of hours of presentation which includes explanation/discussion of outcomes, pre and/or post-tests and evaluation of the presentation. Break times are not included. Total minutes divided by 60 = contact hours.

Total OBN CE Contact Hours requested: **Number of contact hours included in total that are category "A":**

DISCLOSURES:

#1 The primary purpose for this CE activity is to promote the sale of items or services   ☐ No   ☐ Yes **If Yes Explain:**

#2 If any commercial support or sponsorship support is provided for an educational activity, the CE provider will maintain control of the educational content and disclose to attendees all financial relationships, or lack of any financial relationships, between the commercial supporter or sponsor and the CE provider or presenter. In addition, the provider will ensure that arrangements for commercial exhibits will not influence the planning of, or interfere with the presentation of, educational activities. ☐ Agree   ☐ Disagree

#3 Presenter(s) declares vested interested: ☑ No ☐ Yes   **If Yes Explain:**

*The Presenter(s)/Faculty must notify the audience of the status of any vested interest as being none or if so, what that interest is.

YOU MUST SUBMIT A SUMMARY OF THE EVALUATIONS AND THE ATTENDANCE SHEET(S) TO THE INTAKE NURSE WITHIN 6 WEEKS OF THE PRESENTATION

FOR CE INTAKE NURSE USE ONLY			
Date Application Received:		Application Number:	
Approved for: (Check all that apply)	☐ Registered Nurse	Outcome of Review:	☐ Approved
	☐ Licensed Practical Nurse		☐ Denied
			☐ Pending

If Application is denied or pending, give rationale:

_____ _____
Intake Nurse's Signature   Date

Attendance verification sheets, and Summary of evaluations received by Intake Nurse:

Date:_____   Signature_____

Page 1.

Faculty Qualifications and Planning Committee

FACULTY and QUALIFICATIONS: (May Attach Resume or Vitae)

1. Name:	2. Name:
Education and Experience in Area of Content:	Education and Experience in Area of Content:
3. Name:	4. Name:
Education and Experience in Area of Content:	Education and Experience in Area of Content:
5. Name:	6. Name:
Education and Experience in Area of Content:	Education and Experience in Area of Content:

Planning Committee: (At least one RN and, if LPNs in the target audience, at least one LPN)-may attach resume or vitae

1. Name:	2. Name:
Area of Expertise, Work Experience:	Area of Expertise, Work Experience:
3. Name:	4. Name:
Area of Expertise, Work Experience:	Area of Expertise, Work Experience:
5. Name:	6. Name:
Area of Expertise, Work Experience:	Area of Expertise, Work Experience:

Record Keeping System: (Please confirm):
☐ *"The approved application and attendance records will be kept on file in a safe, secure location for 6 years."*

Name of Person Coordinating Offering:	Title and Profession:	Employer:
Street Address:		Telephone Number (Include Area Code):
City:		Fax Number (Include Area Code):
State, Zip Code: OH		E-Mail Address:

Revised 12/2021

Course Outcomes

DODD Nurse Continuing Education Application Course Outcomes for Training

Title :

Participant Centered Measurable Outcomes: (See instructions)	Content: (Must be Evidence Based)	Evaluation of Achievement of the Outcomes: (See instructions)

Revised 12/2021

INDEPENDENT STUDY

*Submit this page only for Asynchronous Learning programs (Independent Study) and Blended Learning programs (a combination of independent study and faculty directed education).

Choose one ☐ Independent Study Program   ☐ Blended Learning Program

| This will be a repeated presentation. Attendance verification and evaluation summaries will be resubmitted according to instructions.   Please check if applicable. ☐ |
|---|

1. Describe the software or other modality (such as reading material) that will be used to present the independent study portion of the program's content:

2. Faculty qualifications must be included on page 2 of the CE application. Identify the role of each faculty member as "Author" or "Media".
   - Author refers to the subject matter developer(s)
   - Media refers to the presenter of the material if different from the Author

   Describe how participants will be able to have questions answered during or after the program:

   Describe how participants will evaluate the:

   - Author
   - Media (presenter or format of material)
   - Feedback (ability to get questions answered)
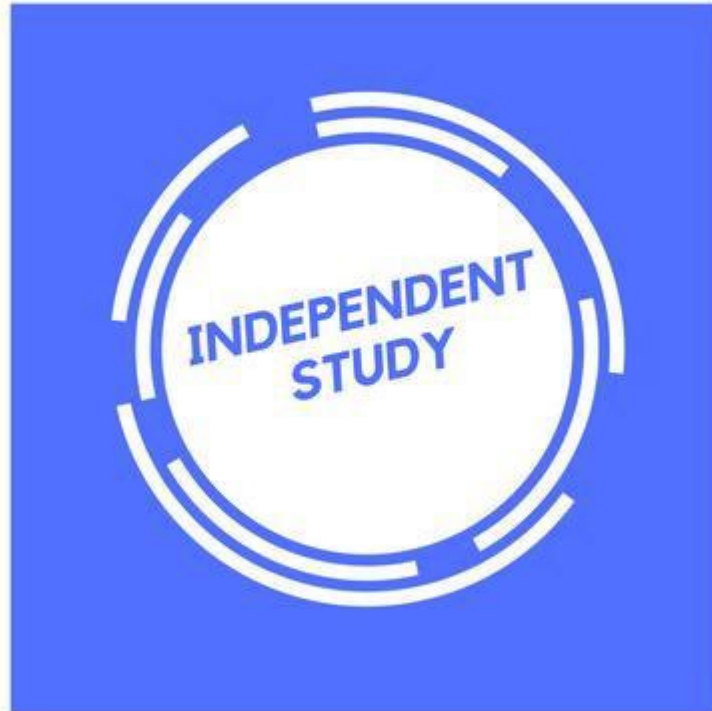
Presentation Title:
Date:
OBN-010-93-
Outcomes:

PRESENTATION EVALUATION FORM Please provide the following information – Thank you!

Name & Contact Information *(optional)* _____

What would improve future presentations? _____

What did you like best about today's presentation? _____

What information would you like to see at future presentations? _____

_____

How did you hear about this presentation? _____

Other Comments: _____

_____

Were the facilities conducive to learning: (Circle one):	YES	NO

1 = No   2 = Slightly   3 = Somewhat   4 = Yes   5 = Yes - significantly

Please evaluate the program according to the above rating scale by circling the number that applies

Overall Program:

	1	2	3	4	5
The outcomes were met as stated.	1	2	3	4	5
The presentation met my expectations.	1	2	3	4	5
The presentation will improve my practice and patient care.	1	2	3	4	5
I will attend future programs offered by the sponsor.	1	2	3	4	5
I would recommend this training program to others.	1	2	3	4	5

Presenter:

	1	2	3	4	5
Teaching effectiveness	1	2	3	4	5
The presenter was knowledgeable about materials covered.	1	2	3	4	5
The presenter answered questions effectively.	1	2	3	4	5
Method of presentation (power points, lecture, activities etc.)	1	2	3	4	5
Did you perceive commercial bias during this presentation (Circle one):	YES		NO		

Nursing Certificate of Attendance

On _____ attended presentation titled:

Provided by

At

OBN approved Total Contact Hours:
Approval Number OBN-010-93-_____

**This presentation has been approved by the Ohio Board of Nursing Approver Unit
of the Ohio Department of Developmental Disabilities
(OBN-010-93)**

Outcome(s)
List Outcome(s) from page 3 of CE Application

Attendance Verification

Provider

Location:
Presentation Title:
Date:
Time Span:
Presenter:
Outcomes:

Attendee Name	Signature	Title	Employer	e-mail	Nurse License # or last 4 SS

Page ____ of _____   Date: OBN #010-93-_____

Submission Checklist

Ohio | Department of
Developmental Disabilities

OBN CE Applicant Submission Checklist

- As you prepare the OBN CE application please complete this checklist to assure all required application packet
- Please include a copy of this checklist with your application packet. Submit all forms for appli

Presentation Title: **Applicant's Name:**

CRITERIA			COMM
1. Target Audience and Need Identified (p.1)			
a. Audience of RN's/LPN's Identified	☐		
b. Need for topics, scheduling identified	☐		
2. Faculty (p.2)			
a. Education and professional qualifications identified	☐		
b. Hours computed correctly	☐		
3. Resources (p.2)			
a. Planning committee identified	☐		
b. Resume provided (Qualifications identified)	☐		
c. 1 RN, 1 LPN	☐		
4. Outcomes (p.3)			
a. Relevance to Nursing	☐		
b. Written in measurable terms	☐		
5. Content (p.3)			
a. Flows from outcomes	☐		
b. Relevance to Nursing and Evidenced Based	☐		
6. Program Schedule or Advertising Material			
a. Included and complete	☐		
7. Co-Providership			
a. Agreement provided (if applicable)	☐	NA ☐	
8. Independent Study (p.4)			
a. Adequately completed/Evidenced Based	☐	NA ☐	
9. Evaluation Form			
a. Evaluation of outcomes	☐		
b. Evaluation of effectiveness of each faculty	☐		
10. Certificate			
a. Title, date, name of attendee	☐		

Now What?!!

- At least six weeks prior to the presentation
- Submit entire packet
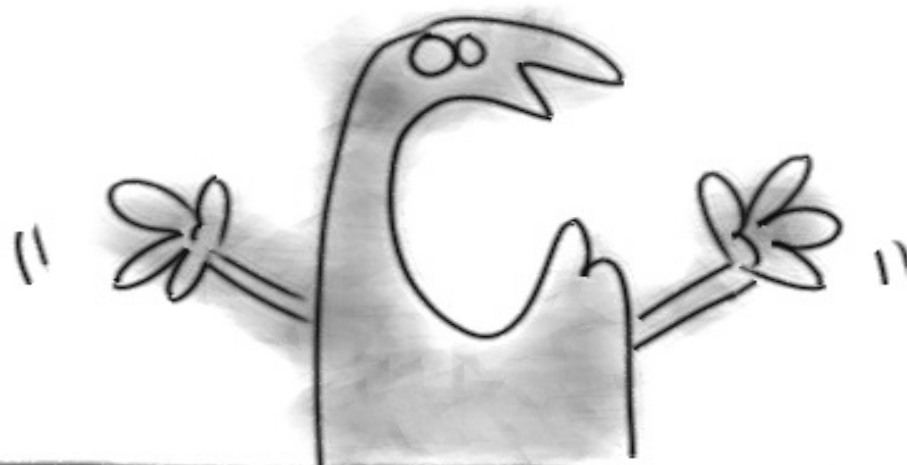
Peer Review

- Application is reviewed by two peers (nurses) and will communicate one of three outcomes:
  - Approved
  - Pending
  - Denied

Once Approved

- Once approved, the CE is active for two years
- Do the presentation
  - Within six weeks following the presentation:
    - Submit copies of sign in sheets
    - Submit a summary of the evaluations completed
    - Maintain all records for at least six years

Advertising

- DODD RN List Serve!
  - DODD.Ohio.gov → Medication administration → RN Trainers → Join List Serve

Administration

Expand All Sections

About Training ⌃

To attend the RN Train the Trainer program, an RN must hold an unrestricted license with the Ohio Board of Nursing, have 18 months full-time experience as an RN, and have previous experience working with people with developmental disabilities.

Classes include pre-program preparation, training offered by a certified RN instructor that complies with OAC 5123:2-6-04, and completion of the post-program assignments to demonstrate knowledge.

This certification is renewed every two years. RN Trainer certification always expires on August 31 of odd-numbered years. Certification renewal requires

- four hours of continuing education that relates to the information addressed in the RN Train the Trainer program or that will enhance the role of the RN Trainer,

- and RN Trainers to enter their own renewal qualification in the Medication Administration Information System, or MAIS App, prior to expiration beginning as early as 180 days prior to expiration.

RN Trainers must subscribe to the RN discussion group email list to receive important communication regarding certification and medication administration. To join, email join-rn-trainer@list.dodd.ohio.gov.

All nurses or people interested in developmental disabilities health may subscribe to this list.

Using the MAIS App ⌄

Related Laws & Forms

OAC 5123:2-6-04

Qualifications, training, and certification of registered nurse instructors and registered nurse trainers

tkirkby@shc-medina.org

- Sign-in Sheet
- Evaluation