Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
January 15, 2019

1) Meeting was called to order with **31** members in attendance.

2) Review and approval of minutes as written
3) Officers Reports:

   a) Treasurer's Report – Accepted as written. There are currently 32 paid members. The new dues have been posted on the DDNNH website.
   b) Liaison Report – Deb Ellis-Nailor reported that scholarship applications will be accepted from a caregiver of an individual with I/DD TBI of someone working in the field such as a DSP or another I/DD TBI professional in New Hampshire. The group reviewed the application and it was accepted with two minor grammatical corrections.

4) Business Discussion:

   a) PRN Protocol was discussed with an emphasis on making sure that it is clear how often med can be given and minimum amount of time between doses.
   b) Discussion of review of med sheets by state auditors are being done even though they are supposed to be off limits. Several Nurse Trainers stated that they were routinely being asked for past med sheets. The discussion was tabled for March meeting when we have auditors present.
   c) February meeting will be back at NH Hospital association on Airport road in Concord.
   d) We are asking everyone if they could email the secretary with items for discussion. We have had 2 submissions for next meeting.

Final Note: My recording from our last meeting, which is how I write the minutes, was lost in the cloud. If anyone has notes if you would bring them to the next meeting I would appreciate it as we can then make additions to these minutes. I always erase the recordings after I type the minutes. However, I will be taking written notes from here on. My apologies to the members.

Next Meeting will be February 19, 2019

Respectfully Submitted
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
February 19, 2019

1) Meeting was called to order with **23** members in attendance.

2) Review and approval of minutes as written Accepted as written with addition of the results of discussions about deeming an individual medically frail and pharmacy alternative.

3) Officers Reports:

   a) Treasurer's Report –There are currently 32 paid members. Total balance of all accounts is $3843.85.
   b) Nurse Liaison Report: Deb Ellis-Nailor took the opportunity to nominate our group for the All Pro Nursing Team Award being given by American Nurse Today which is the journal of the American Nurses Association. She wrote an article about what we do and who we care for. She will let us know if anything should come of it. She also reported that the DDNA conference is June 7 though 10 this year and it is in New Orleans. The 7th is the Boot camp for those who want to get our specialty certification and the conference has concurrent sessions for 2 1/2 days ending on the 10th with a half day of workshops and the certification exam. Early bird discounts are available and the cost of the conference is $650. Information can be found on the DDNA website which is up and running. While this can be pricey to attend, this will take care of the CEU's that you need and you may be able to get your employer to pay for or chip in to defray the cost. The airport that you should fly into is the Louis Armstrong International airport. You can also apply for the certification exam online now. We also decided as a group that the Liaison Report will be done in February April and October so we can have time for Deb to present without being rushed as prior to this it was due the same months that Peter Bacon et. al. presents.

4) Business Discussion:

(a) Scholarship applications will be accepted from a caregiver of an individual with I/DD TBI or someone working in the field such as a DSP or another I/DD TBI professional in New Hampshire. The application is completed and it is fitted on to 2 pages including references. Deadline will be April 30th for applications to be submitted they will be reviewed in May and awarded in June. This will be done by the scholarship committee which consists of Kenda Howell, Jen Boisvert, Cheryl Bergeron, Deb Ellis-Nailor and Kathy Metzler. It is important to let people know the scholarship is available. Print out copies and distribute to people who may be interested that are working in the field. Kenda will get it out to CSNI and PPN and Cheryl will send it out area agency directors and the DDNNH nurses. It was decided that the scholarship will go to the student directly.

(b) We also addressed the issue of OTC medications being taken by independent individuals who have not been on prescription meds but have been assessed as being able to take meds independently need to have a prescription, as there have been citations issued for this. The setting is the first consideration. All independent individuals are assessed for the ability yearly by nurse trainer. If those qualifiers have been met then it is up to nursing judgement if an order is needed. It is best practice to have orders for all medications taken as an independent person could suddenly become dependent with medicines. However, it is not in the regulations if assessments have been done yearly and with additional meds being taken. However if a med assessment says that the person is not currently taking meds it becomes necessary to do an assessment. It is advisable that if when you do your assessment do not check "not on meds" simply assess their ability to take a Tylenol or a vitamin.

Pharmacy Alternatives will be presenting their service in April. Details to be emailed to members by Cheryl Bergeron.

Next Meeting will be March19, 2019

Respectfully Submitted
Kathleen Metzler, RN BSN
Secretary, DDNNH

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MINUTES

March 19, 2019

1) Meeting was called to order with 32 in attendance.

2) Review and approval of February 2019 minutes as written with correction from treasurer that the number of members in February's report should be 33 rather than 32.

3) Officers Reports :
   a) Treasurer's Report –There are 34 paid members this month.
   b) DDNA liaison – Debi Ellis-Nailor said that her employer informed her that the DDNNH conference support cap should be $500 for early bird registration and they will cover the rest. They are paying full registration initially to ensure timely registration and DDNNH will need to reimburse them $500.

4) Business Discussion
   a) Cheryl offered reminder of upcoming presentation by Pharmacy Alternatives – rescheduled to April 1 in Fox Chapel, 1p – 3p
   b) Cheryl attended recent He-M 1001 hearing – two takeaways in particular –
      i) There will be an additional clause in regulation addressing guardian refusal of access to documents to the support agency so that this will not need to be cited by the surveyors as a deficiency.
      ii) Wording of annual health assessment is being reviewed – to be more inclusive of actual practices while maintaining the intent of good health care.
   c) Cheryl – re: training video project – what would you like to see different in the curriculum? We will try to incorporate into the video. Please send ideas by end of the month citing piece you would like to change by section, page etc. Plan is for access to completed video to be online – that there will be video excerpts within your PowerPoint training presentation of the medication curriculum. An example of changes in wording for the video include – changing the word "hold" to "not give". They hope to translate the video to Spanish as well as other languages like Nepalese or Bhutanese.
      i) A member suggested that abbreviations did not need to be included – response from another member suggested that while JCAHO does not approve of using abbreviations, we continue to need to teach them while orders that authorized providers are using for triple checks still have them.
      ii) Others requested changes in test questions – this was deferred as it is beyond the scope of the current project.
   d) Peter and Lisa joined the meeting.
      i) Peter concurred with Cheryl's comments about the two takeaways from the He-M 1001 hearing
         (1) Lisa further discussed that the annual health (assessment, physical, or word to be determined for new reg) should have documentation that a review of systems occurred. Medicare wellness visit (MWV) documentation has been accepted by surveyors. Question was raised about MWV being performed by RN rather than a prescriber – is that OK? Response from Peter was that we may have to be moving forward
      ii) A member asked about performing a 5 day and 30 day visit in December with the 1st monthly QA in January and being cited as late with the QA. Discussion ensued with agreement that the nurse trainer's actions were correct and that the citation could have been appealed.
      iii) A member asked about updating PRN protocols – her general practice is to update orders annually and sign off the protocol as reviewed with new signature and date. A surveyor had a stated concern that the protocol has many review dates on the same page – wanted the protocol rewritten annually – that is not required.

iv) Further PRN protocol question – prescriber writes BID or TID PRN – frequency is there and matches the order (e.g. nurse trainer writing the protocol wrote BID or TID) – and received a citation.
   (1) Lisa described an example as a response: Tylenol 500mg 1-2 tabs TID – in our curriculum it says that the PRN protocol will include parameters (e.g. interval between doses). There are a number of providers where English is not their first language and we can help them by being clear.
   (2) A member shared that her understanding as a long time nurse trainer is that PRN orders without specific hour time frames (e.g. 4-6 hours) would have protocol instructions written by the nurse trainer to identify the minimum amount of time before the next dose could be given – example – if the prescriber orders BID and the appropriate interval is 6 hours, then the nurse trainer writes that instruction and reminds the authorized provider that those two doses are the daily 24 hour limit – if given at 12p and 6p, no further doses can be given until the next day.
   (3) A member asked how can we learn in the future – rather than learning through deficiencies, learn through communication heads up – to be proactive rather than reactive. The PRN protocol discussion was believed to have been addressed at a previous DDNNH meeting several months ago – reading the minutes, attending meetings will help. We will include this in the FAQs – though those are currently being updated and the updates are not available to the general members.
      (a) A member suggested that we think about using social media – closed to NTs only – this discussion was beyond the scope of our time with Peter and Lisa and was deferred to a future meeting.

v) Another member asked for clarification around the 5 day/30 day and QA timing. Lisa reminded us that there is nothing specific about the 30 day visit – rather that the regulation requires those elements to be present within 30 days of the transition. Another member reminded us that though we talk about 5 day/30 day visits – each of this is from a different regulation.

vi) A member asked if leaving a straight catheter in place, instilling an antibiotic, waiting for a period of time and then removing the antibiotic and the catheter is a task that can be delegated. For 1201 authorized providers – urethral is not an allowed route of med administration. NUR delegation = stable individual/competent delegate. Cheryl will ask the BON for an opinion. If the overseeing nurse trainer is comfortable delegating and the individual is stable and the DSPs are competent, then the nurse trainer could request a waiver to the med committee for their consideration and decision.

vii) A member brought up a current concern with omissions due to the pharmacy not providing medication due to not having a prior authorization – in this specific case, there are 3 meds impacted, one is controlled…none are newly prescribed, just the need for prior authorization (PA) is new. Question raised if anyone had reached out to the MCO – unknown. The pharmacy did provide a couple of doses initially. The prescriber has not followed up with the PA paperwork though the agency has called and reminded. The med committee has stated previously that someone (area agency, vendor agency) needs to pay for a few days of med supply to bridge the gap – the member stated that they are past that now…and offered that 5 pills of Vivance cost $150.

viii) A member asked about CPS only (residential services provided by another company) – what is the NT responsibility for certification review: self-med assessments for everyone, med review to include who is certified and what is the frequency of QA, annual health visit.

ix) A member asked if there is a rule of thumb for using Skype for med observation. Some NTs have used – so long as you can clearly see the med log, label and process. One NT had the program manager present while the Skyped observation occurred.

x) A member asked – what are the most common deficiencies – Peter replied that the % of 1201 deficiencies compared to the rest is very small, most common 1201 deficiencies are from 1201.03, 1201.04 and 1201.09. Peter gave a presentation to CSNI recently with the top 10 deficiencies – Cheryl will send it out to the group.

xi) Cheryl mentioned that she has received calls from NTs asking about surveyors looking in MARs (beyond the orders, prn protocols and controlled count records that they need to see and can request to see back to the last surveyor visit). Peter replied that when the surveyor opens the med log book to see orders, prn protocols and controlled logs – the surveyor may see something obvious – example – no logs signed for the last week or the logs are signed ahead – the surveyor will write this as a concern.

e) A member shared an experience post hospital discharge with preauthorization for medication issue – the issue was with the specific dosage to make dose of 30 – authorization to give two tabs of 15 to make the 30 were not authorized, instead give a 25 and a 5 and supply was paid by insurance.

f) A member shared that an individual has been self-administering Humalog insulin with a pen, getting new supply with no difficulty. Then ordered on Monday, found out on Friday that it would not be covered ($600), the

individual had enough supply through the weekend. On Monday called PCP – who changed Humalog to Novalog which was covered.

g) Ellen shared that there is a new He-M 1202 nursing group forming and would we allow some of them to attend one of our meetings? Yes.
h) Cheryl shared that Public Health has a new position – we could have a speaker come and talk to us about asthma, treatments, medications etc if we are interested? Yes
i) Cheryl sent Pharmacy Alternatives the 1201 a, b and c forms for them to see.
j) Cheryl stated that the Bureau is looking at the health history form – can redundancy be reduced, is the information captured within HRST or could it be?
k) A member stated that she opened HRST and the pop up message says that there will be a new data tracker coming – do we know when? Because she is scheduled to provide training on the data tracker and would like to let her audience know about changes. Cheryl believes that the changes are related to standardization of the tool from HRS across their company – some changes were made to the tracker at NH's request.
l) A member asked if we could talk about code status as an agenda item for next month's meeting. There can be challenges with obtaining this in advance with public guardians.
m) April meeting will be a time to develop nominations for DDNA liaison, treasurer and to review the bylaws.
n) HRS will be coming back to NH – April 30 there will be 2 trainings offered at the same time – one is advanced review and the other is becoming a clinical reviewer. May 1 and 2 will be customized HRS training – everyone (nurses and SCs) will attend together.
o) A member asked a HRST question – is urgent care documented as an ER visit on the MDT? Yes.

Next Meeting will be April 16, 2019.

Submitted by:
Jennifer Boisvert, RN
Acting Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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Minutes
April 16, 2019

1) Meeting was called to order with **32** in attendance.

2) Review and approval of **March 2019** minutes.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **34** paid members.

4) Business Discussion

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   a) Nominations for offices were made. Cheryl Bergeron will be retiring in 6 weeks and Luanne King, as Vice president has moved to president. Vice president has been vacated and Janet Harmon has accepted the nomination for this position. Kelly Main had recently taken the treasurer position and has also accepted the nomination. Debi Ellis-Nailor will not run for Liaison again. Jen Boisvert and Lisa Clark will run for DDNA liaison. Voting will take place on May 21. Any member who would like to vote and will not be at the meeting in May can use the electronic ballot that was e-mailed out on April 24, 2019. It can be emailed to Peggy.greenwood@dhhs.nh.gov Make sure to put DDNNH Ballot in the subject line
   b) By laws were handed out but discussion was tabled for May meeting. Duties of the Liaison were explained for those choosing to run. Maureen Di Tomaso has also departed the position of BDS secretary. The state is interviewing for both positions.
   c) Discussion arose around advanced directives and DNR orders in particular. Once a person has been put on life support it is almost impossible to remove them from it. Public Guardians have national ethics guidelines and used to go to court for 3 specific issues, sterilization, ECT therapy and DNR orders. These guidelines are there for the protection of vulnerable individuals. The use of advance directives and POLST documents are encouraged and more detailed than just a DNR order. Discussion with guardians should take place before there is a need. Discussion should take place between the PCP and the guardian. Having a state lawyer like Melissa Nemeth or John Kitchen to speak to the group for training purposes was also discussed. The group will try to reach out to all guardians to attend.
   d) Education of DSP/home care providers on advocating for those with advance directives seems to be needed. Some people read DNR orders as do not treat. It is difficult for a non-medical person to navigate those issues. Hospice care was also discussed. A person on hospice receiving comfort care still needs treatment of issues that could make them uncomfortable. Some hospice agencies will not admit a patient without a DNR.
   e) EMS also has their own set of guidelines about transporting patients with a portable DNR. It was advised that if you have an individual in these circumstances it would be wise to be in contact with your local EMS providers to alert them that you have a person who may need to be transported in this situation.

5) Telemedicine—the wave of the future
   a) There have been many questions submitted about the use of online meeting platforms. The board of nursing has approved the use of these tools, for example when winter weather can prohibit travel and in rural areas or when the nurse just can't get out to a home within the allotted time period. The method of communication must be encrypted to be secure.
   b) CMS has approved reimbursement for the use of tele-health. There are issues that need to be addressed regarding an individual's privacy and a photo permission must be signed off. It is permissible to do an observation for re-certification of a DSP who is established but it should not be used for new DSP's.
   c) A 5-day visit could also be done remotely. There is a need to develop a form or add it to a photograph form for permission to use these new technologies. Vendor agencies may also make a decision about this and it may differ from the state guidelines. We are working to develop a permission form for the use of text email and video conferencing.
   d) Peter Bacon also has given approval for the use of technology. We will need to develop guidelines that will enable Nurse Trainers to educate the administration of vendor agencies about the pros and cons of using technology. Check with your company about a secure encrypted method to use.
   e) No one thought it was a good idea to use remote technology for the destruction of controlled substances. It would not be within regulation for the nurse to not be physically present.

6) Pharmacy Alternatives: Technology available through them includes online MARS that can be printed for use. It also updates HRST and is very cost effective. There is a presentation by the Moore Center on May 21st from 12:30pm at the Emanuel Baptist Church in Hooksett.

7) Lisa Main is using technology for MARS called Therap and it time stamps documentation. Pharmacy Alternatives will update MARS. This can be used with online or paper documentation. This led to a discussion about how much of the MARS is to be reviewed at the certification. There is confusion around this, but Cheryl stated that this is the task of the medication committee. There needs to be more clarity in the 1201 rule. There are items that fall under the nurse's discretion. The medication committee meets every 4th Thursday from 1-4 pm at BDS and if you are interested any nurse trainer can go and listen if you ask first.

Respectfully Submitted
Kathleen Metzler, RN BSN
Secretary, DDNNH

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MINUTES
May 21,2019

1) Meeting was called to order with **34** members in attendance.

2) Review and approval of **April 16,2019** minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. Current savings balance is $3565.73 and statements are sent every three months. Checking balance is $125.73 for a grand total of $3691.46. There are currently **36** paid members.
   b) Election results are as follows: Kelly Main Treasurer 2-year term. Lisa Clark DDNA Liaison 1-year term and Janet Harmon Vice President 2-year term.

4) Business Discussion
   a) Cheryl Bergeron is retiring as of May 29 2019 and Luanne King will be stepping into the position of president. Her replacement has not yet been announced. Peter Bacon will be our contact at the bureau until that replacement is installed. Peggy Greenwood will be taking care of the DDNNH website and her contact information is peggy.greenwood@dhhs.nh.gov her direct phone line is (603)271-5010 and the general BDS line is (603)271-5034. Joyce Butterworth will still be teaching Nurse Trainer class and whomever takes Cheryl's position will also be applying to teach the Nurse Trainer course. PASSR is now in the BEAS unit and overseen by that department.

   b) Cheryl had reached out to Melissa Nemeth to see if she was willing to come in and talk about guardianship issues surrounding advance directives and Melissa is willing to do this, perhaps in the fall.
   c) Pharmacy Alternatives has been approved and CSNI is involved.

   d) The Board of Nursing has a written policy on telehealth that the DDNNH will be reviewing before implementing guidelines and parameters for the use of telehealth in regards to He-M1201 rules and Peter Bacon has "given the OK" for the use of telehealth technologies in regards to meeting He-M 1201 regulations and development of guidelines for the use of technology for meeting above regulations.

   e) Speaking of He-M 1201 regulations, the 1201's will be revised this year as it is due Sept 2019 for updating. Melissa Nemeth will also be working on the 1201 committee with Peter Bacon and perhaps Lisa Hoekstra and Peter has requested that we send information questions and ideas to him via email which is peter.bacon@dhhs.nh.gov or Melissa Nemeth at melissa.nemeth@dhhs.nh.gov . ***This is our chance to have input into the rules that we are going to have to live with for the next 8 years. Speak your truth to them, please. Or even better, you can reach out to Peter to sit on the committee that is revising the rules.***

   f) BDS is aware that the DDNNH minutes have not been posted since last June due to staffing changes but all minutes are on the hard drive at the states and they are aware that they still need to be published. A new person, Jessica Kennedy, will be starting in Maureen Di Tomaso's old position as of Friday May 24. This position includes sitting on the med committee as well as other new duties that have been added to the position. So, there will be changes ahead. Peggy Greenwood will be manning the DDNNH email.

g) Easter Seals has been awarded a grant for a dementia program. The program is still in its infancy but will encompass "training the trainer" to train staff to assess for dementia with a new tool that is being developed. Easter Seals is at the helm of the process. It will possibly be in November and it is a two day training. It is much like HRST in that it is done over time. There are trainings also available on the DDNA website but you must be a member, if you are interested.

h) When signing out control medications explanations should be written on the count sheet for any med being poured for use in the community later. The time the med is poured should be written on the count sheet and the time given should be recorded on the medication sheet.

i) CMS has instituted a new regulation that states if your agency provides services it cannot also provide case management services. The bill was passed in NH and the Governor is trying to get CMS to reconsider. This is going to cause problems for rural areas.

j) Also discussed is the need for some process to follow when med certifications are revoked for cause to prevent someone from just going to another agency or for some way to communicate inappropriate care. The thought was that we can also call anyone who has signed a med certification for verification

k) Liz Nelson, our former treasurer, has passed away after a long battle with illness.

l) Changes to bylaws discussed and it was decided by majority vote that we would follow the year from the date of payment. E.g. if you paid in February you would be due the following February. It was decided this would be the best way for tracking purposes and for fairness. There were also minor changes to wording and layout. Also, the term IDD will replace DD within the whole document.

We are looking for a meeting place for our September meeting. We are Ok to use our current location October through December of 2019. There is an option for Fox Chapel or at a location in Laconia.

Our next meeting will include Peter Bacon et. al. so makes sure to bring your questions and concerns to the June meeting. See you there.

Next Meeting will be June 18, 2019.

Submitted by:
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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DDNNH@dhhs.state.nh.us
MINUTES
June 18, 2019

1) Meeting was called to order with **34** members in attendance.

2) Review and approval of **May 2019** minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. Total Checking Account: $125.73
      Total Savings Account: $3981.32 Total: $4107.05
   b) Liaison report was moved to the September Meeting

4) Business Discussion: Goals for the coming year were formulated as follows:

   a) Increase availability of members for mentoring of new nurses
   b) Increase educational opportunities with speakers at some meetings, as well as seminar/webinar information
   c) Welcoming nursing students to shadow our nurses
   d) Would like members to bring in new ideas for discussion to set upcoming agenda
   e) Consider offering teaching to hospitals and clinics to help with understanding our IDD/TBI individuals and their care provider's role
   f) Re-working of Agenda and Minutes making them more concise
   g) FAQ's will be amended to reflect the corresponding 1201 rule change

5) The 1201 re-write was discussed and it was determined that it would be beneficial to have a Nurse Trainer on that committee as of right now there are only administrators and a lawyer. (Peter, Melissa and Sandy) As of right now we can email our suggestions to Peter Bacon at Peter.Bacon@dhhs.nh.gov and Peggy Sue Greenwood at Peggy.Greenwood@dhhs.nh.gov A new subcommittee for the 1201 re-write was formed consisting of Jen, Jill, Ellen and Kathy.

6) Peter Bacon joined us with a power point presentation of the top 10 1201 deficiencies cited. This will be sent out via email. He also discussed the difference between 1201 delegation and 404 delegation. Delegation under 404 and outside of 1201 is direct delegation under your license.

7) Discussion about emergency medication administration for self-administering individuals who do not have authorized personnel with them. It was decided with Peter's input that all staff should be trained to administer an epi pen should the person be incapacitated. Waiver is not be needed, common sense should prevail and this will be brought up before the med committee and then added to FAQ's.

Next Meeting will be September 17, 2019 at Fox Chapel 105 Pleasant St. Concord

Submitted by:
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
September 17, 2019

1) Meeting was called to order with **24** members in attendance.

2) Review and approval of **June 2019** minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – checking account balance $125.73 and savings account balance is $4146.62 total of balances $4272.35. There are currently **35** paid members.

   b) DDNNH Liaison report given by Deb Ellis-Nailor; Conference held in New Orleans LA. Pre-conference Boot Camp available for those who wish to get the CDDN certification which is usually held every year as a pre-conference offering. One of the featured speakers was Barb Bancroft, RN MSN PNP, who addressed Autoimmune Disease and the Immune System. The Power Point print out of Auto Immune Disease and the Immune System presentation is being made available on our DDNNH website, as well as the Stress-Taking it seriously by while lightening up, also presented by Ms. Bancroft. New technology was also covered at the conference, such as an app available on the Apple watch that can alert caregivers to an impending seizure. Deb also told us there were offerings on managing dual diagnosis in our people, such as psychiatric or substance abuse disorder coupled with IDD. Next year the conference will be held April 24, 2020 through the 27 with a pre-conference date of April 23, 2020.

4) Business Discussion
   a) Changes to the DDNNH bylaws were discussed and a few minor changes were added and they were amended and will be approved at our next meeting.
   b) The mission statement wording was addressed and the Officers are trying to engage more of us in mentoring new nurses to the field and well as having everyone write the top two tips for new nurses and those will be compiled for a welcome handout to those new to the field.
   c) Tiffany Crowell introduced herself to the group as she is the new BDS Nurse stepping into Cheryl Bergeron's old position. She welcomed our questions, opinions and comments and is still looking forward to working with us.
   d) The 1201 rule changes are not in effect yet. We are still to go by the old rules until after there is a public hearing on the matter, which we will be able to attend and hopefully give feedback on. Tiffany will make sure that we are notified of the date.

Next Meeting will be October 15 2019 at XXXXXXX

Submitted by:
Kathleen Metzler, RN BSN
Secretary, DDNNH

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MINUTES
October 15, 2019

1) Meeting was called to order with 30 members in attendance. We currently have 36 paid members

2) Review and approval of September minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – Checking Account balance $125.73
      Savings account balance $4146.73
      Total of Balances $4542.46

   Accepted as written by Kelly Main by all in attendance.

Business Discussion

- By laws discussed and, with exception of formatting, were agreed upon by all present. Jenn Boisvert generously offered to fix the formatting to make the document more user friendly.
- Discussion of Zantac recall and everyone was reminded to check their clients' bottles as this recall was voluntary and not mandatory. It is advised that we check with individuals' pharmacy and you can also check the government website for NDR numbers that are affected. The website is www.FDA.gov for more information.
- After the GeneSight presentation the DDNNH nursing student scholarship was discussed. We did not present a scholarship this year due to the lack of opportunities for people to apply. So we may offer two people scholarships this year. The application is being finalized. People who live outside the state but are working and going to nursing school here are eligible to apply.

Presentation by GeneSight Representative Kevin A. Carbaugh.
We were presented with information regarding DNA testing for determination of effectiveness of psychotropic medications. We were then given the opportunity to ask questions about this type of genetic testing for our individuals. While this type of genetic profile is not completely fool proof, the results have been through a rigorous testing process and can help pin point which medications will work for an individual rather that the hit or miss that is currently being used. Even better news, this testing is covered by Medicare and Medicaid 100%! There is training available for practitioners and they have a website for finding practitioners who are already trained. The website is www.Genesight.com then click on find providers. There are other testing companies out there but only this one has been through the vigorous double-blind testing. This was a very informative and useful presentation.

Next Meeting will be November 19,2019 at NH hospital Association 125 Airport Rd. Concord

Submitted by:
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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DDNNH@dhhs.state.nh.us

MINUTES
November 19, 2019

1) Meeting was called to order with **37** members in attendance.

2) Review and approval of **October 2019** minutes as written.

3) Officers Reports:
   a) Treasurer's Report – checking account balance $125.73 and savings account balance is $4478.84 total of balances $4604.57. There are currently **36** paid members.

4) Business Discussion: The need for a way to disseminate information to hospitals and providers regarding how to plan discharge from Emergency Room, inpatient stays and other needs that are unique to our population. Tiffany Crowell is putting together a pamphlet and an educational presentation for hospitals and other providers. Meanwhile it is probably going to fall to the Nurse Trainer and Guardian to make sure at admission that hospitals and providers are aware of our client's unique needs for discharge planning. It may also be wise to remind providers that our staff are non-medical and they are in a home situation. Many providers do not understand the regulations that govern what we can or cannot delegate. Hopefully the presentation will be ready by the end of the winter.
5) HRST information: It was brought up that some Nurses are having difficulty with the frail health toggle in the HRST. There is a mistaken assumption that this is for service coordinators when it was actually developed for the Nurse Trainer's use only.
6) New curriculum: Cheryl Bergeron is now working with UNH to develop a new curriculum and test for He-M 1201 medication delegation. The aim is to make it less medically oriented and more layman friendly with some change is language that is currently used. In addition to video they are also incorporating a power point presentation to aid in teaching a class. Any suggestions or comments can be sent to Cheryl at Cheryl.Bergeron@unh.edu and she will be back to tell us more in May or June.

Next Meeting will be December 17, 2019 at NH Hospital Association
125 Airport Rd Concord NH

Submitted by:
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
June 19, 2018

1) Meeting was called to order with **23** members in attendance.

2) Review and approval of minutes as written with modifications discussed in sections c and f.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently 1**3** paid members. The new dues have been posted on the DDNNH website.
   b) Liaison Report – Deb Ellis-Nailor reported that scholarship applications will be accepted from a caregiver of an individual with I/DD TBI of someone working in the field such as a DSP or another I/DD TBI professional in New Hampshire. It will be decided by a committee of 4 or 5 in May and awarded in June. The application draft was passed out for review. Final decision will be discussed at the next meeting in September.
   c) Deb Ellis-Nailor also reviewed the message of the keynote speaker from the DDNA conference which included a description of a service delivery model based on an interdependent model of care. Also at the conference was Joan Earl Hanh who spoke about person centered assessments. Due to time constraints Deb opted to continue her report at another time as she felt that she was rushed and there had been many important issues discussed at the conference.

4) Business Discussion:

Peter Bacon, Jay Kurinskas & Lisa Hoekstra Q&A session included the following:

   a) Jill Satterfield graciously made handouts of different types of medication orders that were received recently and discussion ensued around what is an acceptable MD order from the standpoint of the state reviewers. We were able to get concerns around pharmacy obtained orders and e-prescriptions answered by Jay, Lisa and Peter. While they felt that the best order is one written and signed by the MD, it was recognized that this was not always possible. It was determined that if a date and an e-signature, NPI or DEA number accompanied it, the E-Rx was legitimate if not ideal.

   b) Cheryl asked if the 5 and 30 day visits can count as 2 of the 3 visits needed after a transition. The surveyors', as well as Peter Bacon said no there is a 5 day a 30 day and then 3 consecutive QA's that must be done. However, the 5 and 30 day can be done together during the 5-day visit.

   c) On annual well visits, the new form needs to include a spot on diet orders for "other" diet type. Surveyors stated that they are looking for diet orders to be renewed yearly. Allergies need to be listed and be consistent throughout a patient's chart and including the HRST and the ISA. HRST and incident reports need to match and needs to be filled out accurately.

   d) If an individual refuses a screening it must be documented with the guardian and if they are their own guardian, they must sign that they refused the procedure(s). they are working on a document for the guardians to sign at the ISA that basically will give the patient permission to refuse.

e) Follow up recommendations from doctors must be documented and/or there needs to be documentation that efforts were made to make appointments or obtain results from family/guardian.

f) Telephone orders need to be co-signed but there is no actual time frame in which they must be signed. The surveyors would like them signed in two weeks but there is no actual regulation that states that. Best practice would be to have telephone orders signed as soon as you can get them to the physician but if they are on an extended vacation there would not be a deficiency since they were not co-signed quickly.

g) PRN protocol needs to have a time interval between doses documented on the protocol. Orders do not expire but should be reviewed yearly. (best practice)

Next Meeting will be September 18, 2018.

Respectfully Submitted
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
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Minutes
May 15 2018

1. Meeting was called to order with **25** in attendance.

2. Review and approval of **April 2018** minutes with modifications discussed. Copy sent to Peter Bacon.

3. Officers Reports:

   a) Treasurer's Report – Accepted as written. There is $3060.42 in savings and $121.51 in checking. There were **31** paid members in April and **8** more have paid for this year.
   b) Liaison's Report deferred to June meeting.
   c) Voting for new Liaison was close but Deb Ellis-Nailor was re-elected.

4. Business Discussion

   a) Group discussion around increasing dues. Initially talked about $15.00 increase but many felt that may be too much for members who are on fixed incomes or work part time. It was decided via a unanimous vote that the increase would be $5.00 bringing the yearly cost of membership to $30.00. People were encouraged to donate what they could through the 50/50 raffle or regular donating if financially able.
   b) We are able to stay in the same place for our meetings, The NH Hospital Association, except for October. We are looking for another place for that month. We may be switching between rooms 1 and 2. The room will be put on the agenda to reduce confusion.
   c) The DDNNH scholarship has been set at $250.00 and the application process is being looked at. It will no longer go to Rivier College.
   d) Cheryl Bergeron requested that names of patients who are unable to find a psychiatrist to follow them be faxed or securely emailed to her. The fax number is **(603) 271-5166.** Only email if you have HIPAA secured email. E-mail is **Cheryl.Bergeron@dhhs.state.nh.us**. She is working with the managed care organization to find practitioners to follow those who need it.
   e) Luanne stated that there are people who are still having issues with E-studio on the state website.
   f) Jen Boisvert went to the screening of "Intelligent Lives" by Dan Habib, Concord resident and former photo journalist for the Concord Monitor. He has a child with disabilities and did a film about him called "Including Samuel" and he also did another film called "Who Cares About Kelsey" both deal with those who have disabilities and advocating for them. He has a Facebook page and his films have websites.

5. Lunch and Learn on PKU presented by Bio Marin representatives Kathy Cody, RD and Dr. Kendra Bjorker, neuropsychiatrist From MN

   - 16,500 known PKU patients in the US.
   - Discovered in 1934. Only known treatment was avoiding phenylalanine in diet. (low protein)
   - MA first state to mandate testing in late 1960's MS the last in 1980's
   - No treatments other than diet in the US until the early 2000's and it was believed you could be discharged from diet after developmental milestones were met. Now it is diet for life.
   - IN 2014 guidelines for treating PKU from American College of Medical Genetics were published.

- Even those with long standing PKU and damage from it can benefit from going on treatment.
- Decrease in anxiety and agoraphobia and increase in initiative ability and motivation. Self-injuring behaviors have completely disappeared in some patients.
- Many are undiagnosed and untreated, especially if born before mandatory testing. They can still benefit from treatment.
- If you have PKU patients or suspect you might it is recommended that you look into the 2014 guidelines and you can contact this presenter. Information available for those who missed this presentation.
- Contact Kathy Cody, RD at Kathy.cody@bmrn.com

Next Meeting will be June 19, 2018 in room 1 at The NH Hospital Association

Submitted by:
Kathleen Metzler, RN BSN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

Minutes
April 17, 2018

1) Meeting was called to order with **38** in attendance.

2) Review and approval of **March 2018** minutes with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **31** paid members.

4) Business Discussion
   a) A list of current nurse trainers and a list of those on e-Studio was circulated to check for accuracy. If any contact information has changed, please make Cheryl aware.
   b) The idea of raising dues was discussed from the current $25 each year. The dues have not gone up for many years. More fund-raising ideas came up (a Pampered Chef party, a fun run to raise awareness for our group as well as cash). The dues go toward a yearly scholarship for a nursing student and pay for the DDNA conference that our liaison attends. We have in the past used some of the money for thank you gifts. The student scholarship is being reworked at this time. These topics will be voted on and finalized at the next meeting.
   c) Nominations for offices were made. Cheryl Bergeron will move from vice president to president. Luanne King accepted a nomination for vice president. Jill Satterfield had recently taken the treasurer position and will continue. Kathleen Metzler accepted the secretary position. Debi Ellis-Nailor, Pam Taber-McCarthy, and Jen Boisvert will run for DDNA liaison. Voting will take place on May 15. Any member who would like to vote and will not be at the meeting in May can use the electronic ballot to email Maureen DiTomaso with your choice. Maureen.DiTomaso@dhhs.nh.gov

5) ***Peter Bacon, Lisa Hoekstra and Jay Kurinskas (licensing evaluation coordinators) Q&A session included the following topics:***
   a) The Medication Technician Board issue is resolved and staff our system will not be on the registry. Initially this board they wanted to include all staff passing medications if they worked in a home with 4 or more people. Peter worked on this for the last two years to prove that our people have safeguards and oversight already and this would not add any additional safety. The registry would cost around 160 dollars every two years for each medication certified person which would be too great an expense for non-profit agencies.
   b) The state certification tool was handed out so we could discuss each area that relates to our medical portion in this process. Peter brought up the biennial certification which can be done if a home had 5 or fewer deficiencies. He is working with BDS on revising the rule (BDS writes the rules the surveyors support). The change may involve going back to the abbreviated review process, which was done before. An agency can submit every year but may or may not get a review every year (if there were no deficiencies). If there were fewer than 3 deficiencies, after submitting request for cert, the agency would fill out the tool for the cert and the surveyor would come out and do a quick walk through. Many vendors earn the biennial, but don't take it because the effort involved. By not skipping a year, this creates a bigger workload for the certifiers.
   c) The 5-day visit, He-M 1001.06(p)(q): "Within 5 business days of an individual's moving into a community residence or a change in residential provider, a service coordinator and licensed nurse shall visit the individual in the home to determine if the transition has resulted in adverse changes in the health or behavioral status of the individual." and "Is there written documentation of this visit available in the home?" Discussion ensued around occasions where an individual is suddenly removed from the home and placed in an uncertified respite (that may or may not become a certified final living situation). Many times, these cases do turn into permanent placements. It was agreed that it's a good idea to check on the individual for any adverse changes during any move, but it is required and needs documentation when the setting is designated a certified placement.

d) Emergency Contact, He-M 1001.08(c)(1) and Doctor/Dentist (c)(6)a: Make sure current emergency contact information is available to anyone that may be with the individual in case of emergency. It is often in a binder that goes out in the community with staff.
e) Annual Health Assessment, RSA 171-A:11, I(a) and He-M 1001.06(a): The terminology of a "wellness check" vs "physical exam" have become an issue. A full assessment by a practitioner has not been completed on every individual due to changes in the system. A physical has to be done annually and the certifier does give 30 days grace period due to difficulty scheduling someone. Most citations are given due to a gap of more than 30 days after the last physical. If an individual only gets a brief wellness check vs a physical, the certifier will note it as a concern instead of a citation as this is a problem with the health care system at this time.
f) Diet, He-M 1001.06(k)5: There must be a new order **annually** for any specific diet change. Any restrictions, change of texture, etc. must have a practitioner order. Although the annual order rule was taken out of the 1201, it is still a good idea to get medication orders renewed.
g) Allergies noted on the record, 1001.08(c)(6)f: The most important thing is that the allergies listed are consistent in all the places they are listed. Between the face sheet, the HRST "about me" page, health history, MAR and encounter sheets certifiers have see different allergies listed.
h) Self-administering individuals, He-M 1201.05(d)(1)(2): Every individual needs to be initially assessed for the ability to self-administer medications. If the individual stays with the same vendor/nurse and it is known that they will never self-administer medication, then that initial assessment is valid from that day on. If the vendor or nurse changes the assessment will be done again by the new nurse. Any individual self-administering medication needs to be assessed annually to continue to self-administer. These assessment forms need to be in the home for the certifier to check.
i) Annual Screenings: There are new guidelines which will be distributed. Citations are given mostly when something was ordered at a visit and then wasn't followed up on by the provider. If an individual is in a range to have a screening which didn't happen it may be a concern. There are situations where the guardian does not want a procedure done, but it must be documented and in the record.
j) PRN protocols: It's a good idea to have the protocol right near the order for ease of use. This is not a citation, but could be a concern if the protocol is not legible, accessible and signed by the NT.
k) Peter was asked about all electronic records and if we are moving toward that. Vendors, while moving forward with more online records are in different places with this. Most MARs are still paper. The certifiers go online to look at as much as they can before a certification.
l) If your vendor or agency has a deficiency, you have 21 days to appeal it. You can always call Peter Bacon and he will go over the deficit and tell you if there are steps to reconcile it.
m) Peter, Lisa and Jay will return in June to finish going through the certification tool and answer questions from the group.

Next Meeting will be May 15, 2018.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MEETING MINUTES

March 20, 2018

1) Meeting was called to order with **21** members in attendance.

2) Review and approval of **February 2018** minutes as written minor corrections in b and c.

3) Officers Reports :
   a) Treasurer's Report – current treasurer has submitted resignation, effective immediately. Jill Satterfield offered her willingness to take on this role, vote taken with members present, passed. Cheryl is the 2nd signer on the bank account and will work with Jill to add her. Cheryl will also update the membership application page info (for where to mail).

4) Business Discussion
   a) Cheryl provided an update on her project with Dr. Plotnik from DH regarding standardized annual physical paperwork – Dr. Plotnik has the suggestions to review and has not had time to complete her review yet. Cheryl mentioned that 70% of individuals served through the waivers are connected to DH. REMINDER: staff take the annual screening recommendation document to appts – they should not be expecting the prescriber to go through each line at the appt. A blank annual screening recommendation document provided at the appt should merely be a helpful reminder of potentially relevant screenings. Specific areas to be addressed should be documented by designated staff prior to the appt.
   b) A couple of nurses mentioned that one of the surveyors has not accepted hospital history and physicals as meeting the annual wellness check regulatory requirement. This will be discussed during April's meeting when Peter and 2 of his staff plan to join us to review certification questions (and cert tool review).
   c) The potential speaker for PKU topic will be contacted by Cheryl to arrange a possible date.
   d) The next HRST in person training will be Tuesday May 22 at NHHA (our regular meeting building, room to be determined).
   e) A question was posed about whether NTs can update meds and diagnoses within HRST. It is within the NT (if the NT has completed rater training at minimum) ability to access these areas in HRST. It is the SCs responsibility to do these updates. However, how do they receive this information from your agency? What is your agency system to provide the information to the SC?
   f) Debi offered a recommendation that NTs who are part time or contracted, speak to their agency about expectations – what tasks are you specifically hired or contracted to provide? Having a direct conversation that allows both parties to know who is responsible for what will lead to success. (This is not just HRST specific.)
   g) DDNNH votes for new officers in May – positions to be voted on: DDNA liaison, VP, secretary.
   h) Cheryl reminded us that this is our group and we should send agenda items from members to the secretary to build the agenda in advance of our meetings.
   i) Cheryl reminded us to review the cert tool that she sent to the group by email – Peter et al will be reviewing this with us next meeting – please send your questions to Cheryl and Peter prior to the meeting if possible. Thanks!
   j) Cheryl passed out a potential OTC med verification form – people present liked it, there was discussion about how to use it.
   k) Debi has a couple of recommendations she would like to add to our medical resources page – she was unable to find it on our website. Jen will look for it and send it to Debi. (recommendations are Dr. Plotnik, New England Audiology and a wonderful neuropsychologist, Dr. Tina Trudel in Peterborough).
   l) A recommendation was made that the DDNA liaison report from Debi about the conference be scheduled in either May or June rather than April when Peter et al will be with us. This will allow Debi plenty of time to share her information rather than being rushed.

m) Lisa H asked a nursing practice question about the right to refuse. Discussion ensued. Debi mentioned a letter that she has used to document how information meeting 1201.04 (l) has been shared with guardian and prescriber. Refusals should also be considered for appropriateness of rating the self abuse item in HRST. Debi requests both parties signatures on the letter before it is filed in the individual's record.
n) Jill S asked – when a new med is prescribed at a prescriber appt – who is called first – the guardian or the NT? Everyone present at the meeting said guardian.

Next Meeting will be April 17, 2018.

Submitted by:
Jennifer Boisvert, RN
Temporary Acting Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
February 20, 2018

1) Meeting was called to order with **29** members in attendance.

2) Review and approval of **January** minutes as written.

3) Officers' Reports:
   a) Treasurer's Report – Accepted as written. There are currently **35** paid members.

4) Business Discussion
   a) There is a speaker that can come to the group and update us on dealing with PKU. There are a few individuals in the state that have services with this issue. There was a majority of interest for some information about this topic. The future date will be posted when a time is determined. "Phenylketonuria (**PKU**) is an inborn error of metabolism involving impaired metabolism of phenylalanine, one of the amino acids. Untreated **PKU** can lead to intellectual disability, seizures, and other serious medical problems." **www.ncbi.nlm.nih.gov**
   b) The topic of fundraising came up and we currently spend our funds on covering the cost of the DDNA conference excluding airfare and hotel for our group liaison. The cost of the conference is going up. It costs $100.00 to apply for the CDDN certification exam and $250.00 to take the exam, as well as $125.00 to attend the pre-conference boot camp day that helps prep members for the exam. Using a portion of our funds to help someone interested in the CDDN certification, was proposed. We also have given a gift of $250.00 to Rivier College each year in memory of a DDNNH nurse. This amount is rolled into a larger scholarship with other funds under a different name. We do get a thank you card and brochure listing the donors each year from Rivier College, but now there is interest in making this donation in a more direct way by our group to an individual. A suggestion was made to look within our own organization for staff that are in nursing school. This would make the gift more personal and meaningful. A memo will go out to CSNI (agencies) and PPN (vendors) so that the information can get out to employees in our system. Our liaison, Debi, will send a card to Rivier College to inform them of the change. After proposing different ideas about additional fundraising and what is involved, the consensus was to simply raise the dues for our group which have not gone up in years. A membership drive would be beneficial to help bring more awareness to our group, build membership and increase funding. A vote will be held in March to finalize the idea and agree on an amount to raise the dues.
   c) Nurse trainers asked specifically what the expectation of the raters is in updating the HRST. Raters will update a few, but not all areas in the HRST. The expectation seems to be that raters have only had to update HRST yearly. When the HRST representatives return in May for a workshop this will be addressed. It will be mandated to update areas more frequently. An idea was proposed to update the HRST as a collaborative team via conference call when necessary to have it done quickly and accurately. Cheryl Bergeron wants to be notified if there are attempts being made to request changes without results. Please send ideas, questions and information to discuss with Cheryl Bergeron so that she can relay this to the HRST trainers for the May session.
   d) There was a question about a 521 setting when staff are giving medications and how often the QA is needed. This has in the past been NT discretion. There are differing opinions on how often to do a QA.
   e) Cheryl Bergeron continues to work with Dr. Plotnik in regard to physical forms and what would be useful for Dartmouth-Hitchcock in terms of our individuals.
   f) The newer Medication Occurrence Form is not mandated by the bureau, but area agencies had requested a more standardized form to use and so far, Area Agencies 5 and 6 have been using this form. This form was released to

use on the CSNI website. Look on the left side of the home page for the **Uniformity of Practice** tab which will link to forms on the site. http://www.csni.org

g) Peter Bacon will be coming to our meeting in April. Forward questions to Peter so he can address them in April. Our group will look over the clinical review piece and how the surveyors can now review the HRST before the certification process.

h) Medication Training Curriculum is due to be renewed. The Relias Medication Administration modules 1 and 2 looked really good to our group, but Cheryl needs more input of what needs to be added or if any changes need to be made. If you can get access through your agency or vendor, please review these modules and give Cheryl Bergeron feedback as to what needs to be added or changed for our use. The module does need the 6th right (documentation) added. The printed copies of the Relias program are posted on eStudio to review.

i) There was a request for a type of guide document within HRST that could be used for medical fragility. Some vendors and agencies wanted another form to use for fragility. Currently the NT will toggle the button on the "About Me" page and then write a supporting narrative in the box below.

Next Meeting will be March 20, 2018.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
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MINUTES
January 16, 2018

1) Meeting was called to order with **20** members in attendance.

2) Review and approval of **December** minutes as written with modifications to sections a and d as discussed.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **35** paid members.
   b) Liaison Report – Debi discussed differences in being a network or a chapter. We are grandfathered in as a network and could not go back if we chose to be a chapter. Cheryl will send out an e-mail with a page from Debi that outlines the differences. One major difference is that every member of our local group would have to join the national group if we became a chapter. Debi will explore this further at the conference and we will vote on this as a group later this year. Debi is collecting items representative of New Hampshire for the basket to bring to the conference.
   Debi was contacted by Kimberly Jordan, RN, BSN who is a BioMarin PKU Clinical Nurse Educator working to ensure people with phenylketonuria receive specialized care. If anyone has an individual or knows of someone in the community, please have them contact her for information on guidelines which have changed. Kim works for Ashfield Patient Solutions and helps families manage care for people with this diagnosis. Kim can be reached by phone at 215-603-7062 or email: Kimberly.jordan@ashfieldhealthcare.com

4) Business Discussion
   a) Cheryl asked if there are any ideas for one hour trainings that HRST can put together for our benefit. The trainings will be free, but won't give CEUs. If you have any suggestions, send them to Cheryl Bergeron: Cheryl.Bergeron@dhhs.nh.gov
   b) HRST clinical reviews should to be done yearly or when there are changes in an individual. The surveyors have access to this report and can view it as a concern if the report has not been reviewed in over a year. Issues still remain with the report being up to date. Contact Cheryl if a clinical review is done with recommendations to update items and several months have passed with no result. The new monthly data tracker is on the website and should be used by our providers.
   c) Our group discussed how much our DDNA liaison should receive for compensation to go to the conference due to the fact that the cost has gone up. The group also votes on an annual scholarship each year. It was agreed to evaluate the price of the upcoming conference yearly and vote on the amount that the group can reimburse.
   d) A training program with staff oversight is a good way to involve individuals who wish to self-administer their medications when the NT feels it is not yet appropriate for that person to self-administer. The NT can set up a program and there is no restriction on how long it continues. The decision is ultimately up to each NT to decide if the individual is safe, and able to self-administer medications.
   e) Cheryl would like everyone to think of agenda topics as well as questions for Peter Bacon's session. Peter (*Community Residence Coordinator*) will be attending the April meeting. Email questions or agenda items to: lking.salus@icloud.com

Next Meeting will be February 20, 2018.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
December 19, 2017

1) Meeting was called to order with **27** members in attendance.

2) Review and approval of minutes as written with modifications discussed in sections b, c and e.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **30** paid members.

4) Business Discussion

Peter Bacon & Lisa Hoekstra Q&A session included the following:

a) Peter was asked about when to document. There has been a difference in when authorized providers document a medication pass. Busy group homes frequently document after a pour to make sure it is done. The rule won't be rewritten for several years but the wording in the curriculum could address this sooner. Peter is most concerned with surveyors seeing no documentation in current logs, sometimes for multiple days.

Section III **Documentation** in the curriculum states,

"**Always** follow the medication log exactly when you are giving medications and sign off on the medication log **immediately."**

Section IV **Right Documentation** in the curriculum states,

"Your documentation of medication administration must be done at the time that you give the medication."

*"*All documentation must be done at the time that the medication is administered."

He-M 1201.07 Documentation states,

(d) The authorized provider or licensed person shall document all medication administration on the individual's medication log as soon as possible following administration including, at a minimum, elements specified in

Nur 404.05 (c)(1)-(3).

This item will be addressed in the FAQ's which are being currently rewritten to assist with clarification.

b) Lisa discussed items that she looks at more from her medical standpoint during the certification process. The HRST full report is now available to all of the surveyors. Lisa looks to see if allergies of the individual are listed (there is a box on the "About Me" page) for allergies. Also, she looks to see if an RN has clinically reviewed clients with a HCL of 3 or higher within the last year. Frail status should be identified in an individual and documented correctly. The toggle for frail status is on the "About Me" page with a box below for comments supporting the frail status. The frail worksheet that is no longer used can be useful to assist with what to write in the box. Any of these items could be noted as a concern because there is no regulation for the HRST yet.

c) There was discussion involving moving an individual and staff into a new house (location change only) when all other things are exactly the same. The regulation indicates a program is "site specific." This item is in the FAQs.

d) Regarding the five-day visit, generally a nurse trainer is there on day one to authorize staff to give medication. There are differing opinions whether a second visit is necessary in five business days. For the health and safety of individuals and making sure all supports are in place it is considered best practice to visit new clients again within five days of placement.

e) Make sure the results of PRN medications are documented within 24 hours or a medication occurrence report needs to be written.

f) A discontinue medication order written via email is not sufficient unless it is delivered through a patient portal or has an electronic signature.

g) Lisa reinforced that when using over the counter medications, make sure to verify with the pharmacist that the medication is the correct item that the health care professional ordered. This verification can also be done with the nurse trainer over the phone prior to using the medication. The OTC medication form needs to be kept in the medication log book as a verification that the medication is the same item ordered because it has no pharmacy label. The FAQs have a section about this.

h) A question came up about some group homes in the past having used stock bottles of medication (acetaminophen, ibuprofen, etc.). Each individual should have their own supply. Peter will investigate this further.

i) Peter was asked about the advantages and disadvantages of an electronic medication administration record. The advantages are that it can be checked remotely and is easy to verify, but the staff need to be trained to record immediately at time of medication administration.

j) There are still issues that remain with the HRST report being complete, correct and current. There are now three text boxes on the "About Me" page accessible to nurses in addition to the height, weight and BMI. There is a "General Notes" text box at the bottom of the page as well as the frail and allergy text boxes.

Next Meeting will be January 16, 2018.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
November 21, 2017

1) Meeting was called to order with **27** members in attendance.

2) Review and approval of **October** minutes as written.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **30** paid members.

4) Business Discussion
   a) There was some discussion around when to document medications (after the pour or after administration). This will be a topic discussed with Peter and Lisa at the December Q&A session.
   b) Direct observations of medication authorized staff are by site authorization (residence or day program). This is done initially and then annually. It is best practice to do additional training if there is medication prescribed that is more complex (such as insulin) or any other drug that may need additional training for administration. In some cases, staff can be cross trained to more than one residence if familiar with the individuals within a vendor or agency. Because the NT knows the provider, the individual and the medications, the level of additional training and observation that is needed in each case falls under nursing judgement.
   c) Remember controlled meds need to be counted a minimum of once in a 24-hour period or more if there is a shift change or a change of who is in possession of the meds. Anyone accepting responsibility for controlled medications should always count the medication. If the house or day program is closed and no one is there the medication remains double locked and is counted again when the next authorized staff comes to unlock and take possession of the medication. Note in the log that the program was closed to account for uncounted days. The count should match what the last authorized person wrote on the count sheet before locking it securely away.
   d) A reminder about renewal deadlines for authorizations. When a DSP is site authorized (mod 4), the date is written on the certificate from that day until the end of that month one year later. Example: December 8, 2017- December 31, 2018. If this person passes that deadline for reauthorization, they do have 30 days to be authorized but cannot pass meds until reauthorized. When a self-administering individual is authorized, annual re-assessment needs to be done no later than the last day of the 12th month from the date of the prior assessment. There is no grace period in this case.
   e) Don't forget to use the OTC form for any meds purchased over the counter without a pharmacy label. These medications still need an order from the PCP, but the care giver for an individual must verify with the pharmacist (at time of purchase) or the nurse trainer that this is the correct medication by comparing the medication with the order.
   f) Self-administering individuals get a yearly assessment from the nurse trainer but additional training may be needed for new medications prescribed. This is again a case where nursing judgement decides the level of involvement between yearly assessments.
   g) Cheryl is working with Dartmouth-Hitchcock on creating a form to bring to appointments that will assist the medical professional in looking at the items relevant to the individual. This will help meet the needs of each person at the annual physical/wellness visit. Dartmouth Hitchcock sees nearly half of our clients in the state, so this will be the starting point for developing a form. There has been confusion among care providers with what needs to be given to the medical professional. An important thing to point out is that the HRST and the tracker in particular is an aid ***to relay*** information (a visual reminder for the home provider or DSP), but the intent is not to give this to the health care professionals in the office.
   h) A quick over view of the Relias online training modules for medication administration was presented to the group with the idea of using these instead of the DVD that is currently used with our curriculum. These training modules could be adapted and used in conjunction with our medication training. The group responded positively to the

idea of incorporating this tool into the new curriculum. Each agency and vendor in our state has access to Relias and you can request a "seat" to view modules 1 and 2 of medication administration. In addition, Cheryl will post a written version in the eStudio workspace to access in order to give input for items that need to be added or changed. Cheryl proposed starting a new committee in January to review the training modules and begin to look at the curriculum. The renewal of the Nurse Trainer Orientation and curriculum is due in May 2018, so the plan is to incorporate the new version of the medication administration training modules in the renewal package.

Next Meeting will be December 19, 2017.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES
October 17, 2016

1) Meeting was called to order with **22** members in attendance.

2) Review and approval of **September** minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **29** paid members.

4) Business Discussion

   a) Sandy Hunt is now the Bureau Chief for the Bureau of Developmental Services.

   b) Kirsten raised a question regarding medication observations of HCP's and DSP's in all settings. Conversation ensued regarding the practice of observation being done by the setting or by the individual. Nurses offered how they practiced. Most nurses observed by the setting and in cases where there were complex medication regimens; these individuals required the Nurse Trainer to also observe the DSP's and HCP's competency as well. Cheryl will further clarify observations with the former Nurse Coordinator Joyce Butterworth. To be re-visited at the November meeting.

   c) The subject of completing a medication observation remotely by teleconference using a tablet, laptop or smartphone was raised with a wide range of opinions based on NT comfort level. This topic is in the FAQs.

   d) The HSI portion of the HRST report contains items not covered in the ratings category. Cheryl has been working with HRST administrators to scale down the HSI section to include only those items not captured when rating an individual. Cheryl asked for input on items that are not included but could be useful. The NT will be able to use this HSI section as needed for additional information on an individual. Communication ability was mentioned as a topic that is not expanded on in the report. The "About Me" page has a "Y" or "N" for verbal ability as well as a communication preference line but it does not give detail and we have no access to this area.

   e) The medication administration curriculum and the 1201 rule differ slightly as to when to document medication administration. There was debate about whether to document after medications are poured or after the individual takes them. This topic will be revisited to decide if there should be a change in the curriculum wording around this subject.

   f) Concerns had been raised last month about delegating insulin administration to care providers. Cheryl clarified the issue after speaking with Denise Nies at the Board of Nursing. For our scope of practice this is covered under the nurse practice act section 326.B:43 VI

   "The administration of medications, by any person employed or under contract, to provide direct care to clients receiving community-based services pursuant to RSA 135-C or RSA 171-A, provided that persons delivering such care who administer medications shall have successfully completed a medication administration educational program conducted by an RN and approved by the board under rules adopted pursuant to RSA 541-A. The commissioner of health and human services, in consultation with the board, shall adopt rules under RSA 541-A establishing criteria for the administration of medications, and for the process of approving an RN to conduct the medication administration educational program."

   g) EpiPen auto-injectors are delegated with the use of a waiver which we were reminded needs to be renewed yearly.

h) Cheryl proposed looking at training modules from Relias for medication administration to see if they would suit our needs for an updated curriculum. These modules could be used to enhance concepts when teaching medication administration. Cheryl is interested in our feedback and will discuss this further at the next meeting. This system could be adapted to our needs. Ask if your agency has access to review this material and look at parts one and two of the medication administration module.

i) The Frequently Asked Questions need some updating and revision. A new FAQ subcommittee will begin meeting following the DDNNH meeting on November 21 from 11:30-1:00 in the same room. Cheryl would like anyone interested to attend. These meetings will continue following the regular DDNNH meeting every month, except in December due to the Christmas party.

November 21, 2017.

Submitted by:
Luanne King
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES
September 19, 2017

1) Meeting was called to order with **29** members in attendance.

2) Review and approval of **June** minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report - Accepted as written. There are currently **24** paid members.
   b) DDNNH Liaison Report – Debi touched on the idea of becoming a chapter but there is no benefit for our group. The conference will be in March of this year in Orlando, FL. This is a great time to become certified in the field of DD nursing. It's best to book a flight early if you plan to attend.

4) Business Discussion
   a) The new HRST data tracker was released but taken down. It will be released in September or October as each agency decides. The toggle button found on the about me page of the HRST combined with the narrative box directly below will be used for indicating medically frail individuals. The medically frail worksheet will be obsolete. The HSI section located under the case management tab will change names and will now have categories that aren't covered in the rest of the HRST.
   b) *Peter Bacon Q&A session included the following:*
      - *Lisa Hoekstra joined Peter as the new RN surveyor for the question and answer session.*
      - *A question was raised about an individual who had the same medication, but in a 10mg tablet and a 2 mg tablet to be given together. The consensus was to write two separate med log entries and make a note under 10 mg (to be given with 2 mg tablet) as well as noting under the 2 mg tablet (to be given with 10 mg tablet).*
      - *Peter continues to work for legislation on the med tech registry issue. The latest is that all licensed homes with 4 or more individuals would require direct support personnel working in these homes to register. Peter will continue to work with the various parties involved to hopefully demonstrate to them why this should not apply to certified and licensed homes.*
      - *Lisa brought up a point regarding annual physicals being eliminated with a wellness check in place for some of our individuals. A wellness check is very abbreviated and the provider looks at the med list and vital signs. No lab work or systems review is done. Apparently, only clients with Medicaid get a full physical. This is a dilemma because the surveyors look for a yearly physical and will cite when there is no physical. This also presents a problem with the Annual Health Screening Recommendations form if no one will screen for the items that are appropriate to that individual. More follow up is required by Cheryl Bergeron.*
      - *Due to a backlog with some reviews still being late, Peter asks that med lists be up to date when the cert occurs.*
      - *There was a question involving a PRN medication for an individual who has hallucinations. The suggestion was to make sure there is a behavior plan and that specific protocols are written. The service coordinator must have the information to be sure everyone is on the same page.*
      - *A question came up about delegating sliding scale insulin. It has been the practice to delegate this to staff deemed competent by the NT if the individual is otherwise stable. Self-administering folks are ok and Cheryl Bergeron will check into this further.*

Next Meeting will be October 17.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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DDNNH@dhhs.state.nh.us

MINUTES
June 20, 2017

1) Meeting was called to order with **29** members in attendance.

2) Review and approval of **May** minutes as written.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently **12** paid members.

4) Business Discussion
   a) A new meeting place was secured for the September meeting and thereafter. Cheryl thanked ATECH on behalf of our group. The new meeting place will be at the NH Hospital Association.
   b) Discussion about conflict-free case management brought up the idea that one entity cannot provide both case management and service coordination to individuals. Some area agencies are splitting this up within the organization. Billing is an issue because vendors are supposed to be able to bill directly to Medicaid, not through a contract with an agency. Some nurse trainers with an area agency feel uncertain about the change. Nurse trainers working strictly for vendors do not notice this change.
   c) The group was questioned about the value of the third page of the incident report form. This would be the page filled in by the nurse in the event of an injury due to an incident. There were mixed opinions as many in the group reported it usually doesn't get filled out, but some did find it useful for documentation.
   d) Peter Bacon Q&A session included the following:
      - *A reminder that CBD oil for individuals is handled as a treatment with controlled count and double locks. Peter reminded everyone that Pathways has a good example of how to write protocols for this.*
      - *A question arose regarding the need for an order to crush pills. Peter said this is not necessary and he considered it the nurse's discretion.*
      - *An assessment of the ability to self-administer medications needs to be done on everyone initially and then left in the book so that the surveyors can see that it was done. If you make it a goal for an individual to work toward self-administering, be very specific and simple with that goal. If an individual is not self-med authorized, then the staff is responsible. A request was made to see some of the training programs out there that nurses are using with individuals working toward this goal.*
      - *If a client is medically frail, the surveyors look to see if they are on the frail list. There is a toggle button and now a narrative box on the "about me" page in the HRST to document frail status.*
      - *If an individual has a transition to a new residence but is self-administering there is no need for 3 visits in 3 months. In addition to the initial five-day visit, the nurse trainer would need to review the documents noted in 1201.03b within the first 30 days of residency in the new home.*
      - *In the event a move is expected for an individual going into a staffed home, a medication observation can be done earlier than the actual move in date by the nurse trainer. Peter said this would be nurse discretion if the NT cannot be available on move in day to observe a medication pour.*
      - *A provider in a certified home has to be current with medication training and needs an observation pour before doing respite for an individual. A non-certified respite provider does not need this.*

- *The medical technician board is still trying to have our providers sign on to their registry, which would provide no value to our group and simply cost agencies money. Peter is waiting to see a ruling on this issue and will keep us informed. Our system will not comply with this action.*
- *In the case of a staffed home that is moving its location and all staff remain the same with the same clients, an onsite observation for each staff member is not necessary. The nurse trainer can add the new address to the medication authorization certificate. Whether to do an individual site observation with each person is up to the discretion of the NT.*
- *A question was raised about needing a behavior plan for every individual who has a PRN medication for agitation or aggression. A surveyor would not look for a behavior plan for a PRN prescribed for anxiety. In the case of a PRN prescribed for agitation or aggression, then the surveyor **would** be looking for a behavior plan.*
- *Nancy Sullivan with NH Healthy Families and Sue Vermette with Well Sense spoke to the group about their quality improvement project working with area agencies for colorectal cancer screening. Their study is focused on Medicaid Prime clients but they want to stress the importance of this screening tool for all individuals in our system. Only about 20% of the general population has received colorectal screening. Colon cancer is the second leading cause of cancer related death in the US. An average of 1 in 20 people will get colon cancer. If you have a first-degree relative that has had colon cancer the risk is even higher. Most colon cancer starts as precancerous polyps, so their removal is important. Cologuard is a non-invasive screening tool available by prescription only for individuals 50-75 years old at average risk. The test is mailed to the home, with instructions and an online video to assist clients. This test can be mailed back to the company. This offers a good screening option for low/average risk individuals who cannot tolerate a colonoscopy.*

Next Meeting will be October 17.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES
May 16, 2017

1) Meeting was called to order with **24** members in attendance.

2) Review and approval of **April** minutes as written with modifications discussed.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently 37 paid members.
   b) DDNNH Liaison Report –The annual DDNA conference is a great way to meet all of the educational requirements for RN as well as for CDDN certification. The DDNA administration is encouraging networks to become chapters. Our group has been a network since the start and would be grandfathered in. DDNA is urging everyone to get the word out for other nurses to enter this field. Debi reached out to various nursing schools in order to go and speak about our work as nurse trainers. In networking at the conference it is clear that other states are having an equally difficult time with clients who need mental health providers to follow them. A handout for The National Task Group for Early Detection for Dementia that Debi shared is a reminder that as our clients age in the system, dementia is a growing reality for many. Statistics show that one in sixteen ID clients will show signs of dementia by age sixty. We were reminded to fill in our specialty when renewing our license or taking surveys to get out from under the "other" category and get recognized as a specialty in nursing. The conference next spring will be March 22-25 at the World Center Marriot in Orlando, Florida.

4) Business Discussion
   a) Cheryl Bergeron spoke with Nancy Sullivan, NH Healthy Families and Sue Vermette, Well Sense about presenting information about the colorectal screening to our group. Only 20% of Medicaid folks are screened. The area agencies have offered training on this screening already. Our group did express interest in a brief training with time for questions after the presentation.
   b) Cheryl also brought up the fact that the 1201 rule is due for renewal in 2018. Cheryl requested that everyone review and note changes that are needed. Health Status Indicators need to be removed and other items need to be added. Start reviewing now and bring any items to her attention that may need to be changed.
   c) The question of where to document self-administration assessments was discussed. Every client entering a program needs a determination of the possibility of being able to self-administer medications. Some nurses have added this item to the Quality Assurance form as a question; "Is this individual capable of self medicating?" There is also a place on the Health History form that could be checked. Sometimes an individual is capable, but the guardian does not want to allow it. Although an individual may have no medications prescribed, this still needs to be documented. There are forms, which are not mandated but widely used for this purpose. Forms are located on the BDS website and e-Studio. Refer to the HE-M 1201.05 Self-Administration of Medication. https://www.dhhs.nh.gov/dcbcs/bds/nurses/documents/selfadminguide.pdf
   d) The subject of IM injections was raised as a part of the Nurse Trainer role. The NT is not supposed to give IM injections nor can we delegate this with the exception of an Epi-pen, which may be waivered. NTs don't practice as RNs because we have no medical director for oversight. IM injections of medication need to be given in a doctor's office or by a home health nurse. Certified programs are not skilled nursing settings. Healthcare coordination and medication administration oversight is the NT role.
   e) The following nominations were made for *DDNA Liaison*: Debi Ellis-Nailor, *Treasurer*: Liz Nelson and *Vice President*: Cheryl Bergeron. Voting procedures will follow.

f) Effective after the June meeting, our meeting location will have to change. The September meeting will be in a new space, which is being investigated now.

Next Meeting will be September 19, 2017.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

April 18, 2017

1) Meeting was called to order with **26** members in attendance.
2) Review and approval of **March** minutes as written with modifications.
3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently 37 paid members.

4) Business Discussion
   a) There is a colorectal screening project by the two managed care companies, Well Sense and NH Healthy Families. This is their own internal quality assurance to create a list of Medicaid managed care patients, 50-75 years of age with no other insurance to develop training for providers associated with this group. This screening involves Cologuard that is ordered by a doctor, sent to the home for a stool sample collection and then mailed off to a lab. This is intended for individuals of average risk for colon cancer.
   b) The Therapeutic Cannabis Program was discussed. Affordability remains an issue for the individuals trying to use this treatment. There is a discount of 30-35% on the first 1/8 of an ounce every two weeks and the cost is dependent on how much raw product is used to make the oil or capsule for medicinal use. The average cost could be between $500-$600 per month which is not feasible for an individual on Medicare. Matt Simon, the legislative analyst for the Marijuana Policy Project in NH, provided Ellen with some information on three house bills currently being looked at in public hearings.
      HB 160 (adding PTSD to qualifying conditions)
      HB 472 (cultivation by patient or caregiver)
      HB 157 (adding chronic pain to qualifying conditions)
      The chronic pain bill was opposed due to fact that it was limited. An individual had to have severe pain that has not responded to previously prescribed medications, surgical measures or for which other treatments have produced serious side effects. This would mean medical providers would have to try everything else first. Matt Simon is interested in rewriting a bill to help with the affordability of this treatment. Ellen McPhetres would appreciate input that could assist with writing this bill. There is a 2016 data report on the DHHS website. http://www.dhhs.nh.gov/oos/tcp/index.htm
   c) The medication occurance report form recently revamped by a subcommittee for the Uniformity of Practice group was shared and discussed. This form is not state mandated but the area agencies have agreed to use the same form. The draft form is being reviewed and will be sent out for use when it is finalized. There was some concern that it was too lengthy and detailed. The topic of individuals refusing medication was discussed. Agencies have different ways of tracking refusals, which are generally a clinical issue and not a medication committee concern.
   d) Incident report forms were passed out to gather input about the situations in which the nurse needs to receive the incident report. The third page of the report is filled out if "yes" box is checked to indicate an injury resulted. This is when the report would go to the nurse. This form will be discussed again next month.

Next Meeting will be May 16, 2017.
Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

March 21, 2017

1) Meeting was called to order with **23** members in attendance.

2) Review and approval of **February** minutes as written after modifications to 4f regarding med pass authorization and adding contact information for PASRR.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are currently 36 paid members.

4) Business Discussion
   a) Janet discussed the NT caseload excel spreadsheet that is posted in e-Studio. There is a questionnaire at the beginning that helps define an individual's caseload that will help when the information is compiled.
   b) Peter Bacon and Kiki Sylvester were in attendance to answer questions. There was a reminder that the auditors cannot accept either gifts or money for any reason from agencies, vendors or the nurses that work for them.
   Other topics included:
      i) Peter updated us on medical cannabis, which is moving forward slowly and will pass. There is an effort by the state to expand conditions and reasons for holding a card to gain access. New information should be available by June. Medical cannabis will still be looked at as a treatment with double locks and a controlled count. Counting is challenging when it is a liquid being measured in drops. Just make sure each dose is logged and subtracted as it is used. The state also looks to see if a consumer has a registry identification card with a condition that is valid for the use of cannabis as a treatment. In a licensed home (He-P 804, 805, 807) staff can administer the treatment. **Currently, in a residential setting, it is one person that obtains and gives the treatment.** John Martin is the state contact person on this issue (271-9256).
      The direct line to the Therapeutic Cannabis Program is 271-9333 or 1-800-852-3345 Ext. 9333.
      For more information: qualifying conditions for medical cannabis
      ii) A question came up about pre-pouring medications. A home provider or staff can never use a pill planner to administer medications. Parents or guardians taking a client home for a weekend have taken medication to use in a pill planner but 1201a certified staff could not fill it for them. A self-administering individual can fill their personal pill planner and use it anytime. A provider or staff can pre-pour one dose of medications using the triple checks to take and administer them at a later time. This is done when meds are held for lab tests for example. Medication should be in a container that is labeled with the name of individual, name of medication, dose, time and route just as it appears on the order.
      iii) There was a recent question about a retired doctor being a nurse trainer. The thought is there would have to be a waiver based on the wording in the He-M 1201.10 rule.
      iv) Another question regarding a doctor who is a shared family living provider being able to waste narcotics with his wife in their home by counting himself as a licensed individual. It may not necessarily be the best practice, as you can't QA yourself. It would be best to have the NT go to the residence to be the second person to destroy narcotics.
      v) There was a question about an agency policy to have another signature on the back of the med logs as well as on the front, which seemed redundant. There was a lot of time spent looking for this extra signature. The NT who oversees the med logs has the final say. The state looks at the orders and the med list primarily because the NT does the QA and finds and corrects discrepancies on a regular basis within the med log.
      vi) Generic name or trade name for meds is sufficient on the pharmacy label and usually both names are written in the med log.

vii) Kiki noted an error in the minutes last month about authorizing a person on site. There are times when a provider can complete medication training and not be authorized immediately when their individual does not have prescribed medications or is self-administering. This provider can have a refresher by the NT each year until there is a need to be observed and give medication. If a long time has passed, a full retraining with the eight-hour class may be necessary. This will be up to the discretion of the NT based on the provider and situation. This topic was discussed in February. It is never appropriate to have a person pour meds for a consumer that they will have little or no interaction with the rest of the year. Our med training in NH is specific to the individuals that someone will work with on a regular basis. The state requires everyone to have a CRC, BEAS, and DMV check as well as all the trainings that need to be documented for certification purposes. There would be a concern if the person were not providing a service at that location. Kiki brought up the fact that the self–medication assessment for an individual is in the service agreement and may or may not be signed by the guardian. In addition, the date of the ISA may not correspond to the date that the assessment was conducted by the NT. This is why the surveyor does not accept the ISA for consent to allow self-administration. There are various forms in use.

viii) Kiki also reminded us that a self-administration assessment must be done for all new people coming in to Community Participation Services (Day Program). The self-administration assessment form can have a notation "no meds prescribed at this time" and then be signed by the NT based on a review of their medication list. This is a safety net to make sure we are aware of everyone in the day program and if they have any meds that may need to be given during the day. This is only an initial assessment and it does not need to be done every year. This policy is to ensure that the nurse is aware of the medication status of new individuals in the program. There have been individuals in day program with a PRN medication that was missed. There is no mandated form for this.

ix) Peter gave an update on the medical technician registry. John Martin and Peter will be meeting with the med tech board to find out more. It appears that only licensed homes with four beds or more will be affected by the mandate.

x) Peter let everyone know that one surveyor has retired and they will not be able to fill the position at this time. Even if they can get another surveyor, it will not be until July when there is a new budget. Everything will now be sent electronically if there are any deficiencies on a certification review.

Next Meeting will be April 18, 2017.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

February 21, 2017

1) Meeting was called to order with **17** members in attendance.

2) Review and approval of **January** minutes as written with the addition of a list of member names on the newly formed subcommittees.

3) Officers Reports :
   a) Treasurer's Report – Accepted as written. There are currently 35 paid members. A motion was made to donate money from this month and next month's 50/50 raffle to assist a colleague in need. The motion passed unanimously.
   b) A report from the DDNA liaison included the schedule of the upcoming conference in April. Information included the pre- conference boot camp session as preparation to take the test for CDDN certification. There are not many local learning opportunities to meet the needs of the certified nurses and the conference provides a chance to satisfy the required hours of education for this field. This additional education is especially important because this specialty topic is not well covered in the basic curriculum of nursing school. The conference gives the latest updated information relevant to the work done in this field. Every agency should view this as important to the ability of RNs in their roles. This could be an enticement to hire and retain nurses by providing funds for ongoing education. Each state liaison brings a basket to raffle off at the conference and Debi is collecting items for our New Hampshire basket. Our next DDNA liaison update will be in June after the conference.

4) Business Discussion
   a) An email went out recently from Well Sense requesting information on colorectal screening of individuals from the area agencies. Several nurse trainers received the email as well and wondered if there was need for action. There is not enough information at this time to know what the information will be used for or if it will involve any changes for our population. A motion was made to table this until more is known.
   b) Another question arose regarding Medicare and annual physicals being only basically a screening process now and not covering additional testing or lab work a provider may order at the physical. Most of our population should have Medicaid or both Medicare and Medicaid so it would not apply.
   c) A point was raised about giving a very potent pain medication such as Fentanyl to our clients for acute pain. A discussion arose regarding negative side effects that occurred in an individual when Fentanyl was given for pain in the ER. Many of our clients are compromised and sensitive to what may be considered a normal adult dose of medication.
   d) In some areas there continues to be a challenge finding a psychiatrist who is taking new clients to manage psychiatric medications. Many clients on these meds are only seeing a primary care provider and they will not continue to renew these meds.
   e) There is sometimes a problem with a guardian or an agency wanting to bring an individual home from the hospital when the delegating nurse feels they're unstable. If a client is being discharged from acute care, it is prudent to make sure that the client is stable enough to be cared for by unlicensed personnel in the home. If not, it should be determined that the individual needs to be in a rehab situation until stable enough to be at home.
   f) A provider can complete medication training and not be authorized immediately when their individual does not have prescribed medications or is self-administering. This provider can have a refresher by the NT each year until there is a need to be observed and give medication. If a long time has passed, a full retraining with the eight-hour class may be necessary. This will be up to the discretion of the NT based on the provider and situation.
   g) When staff or home providers make medication errors there are various steps to take to handle the problem. Agencies may have policies in place and the nurse has latitude in their decision. Every provider needs to

understand that any and all of these steps may be taken if the nurse trainer deems it necessary. Recommendations include:

- verbal warning
- written warning
- probation
- suspension with re-education
- rescinding medication authorization

At any time a nurse trainer, service coordinator or program manager can make unannounced visits if there is a concern.

h) A question was raised about how to contact PASRR-
"Pre-Admission Screening Resident Review (PASRR) unit determines whether or not an individual who has an active diagnosis of Mental Illness (MI) or Intellectual/Developmental Disability (ID/DD) meets the criteria for admission to a nursing facility and may require nursing facilities, regardless of whether their stay at the nursing facility will be paid for by Medicaid, Medicare or with other resources. No individual shall be admitted to a Medicaid certified nursing facility without a completed PASRR screen."
http://www.dhhs.nh.gov/dcbcs/bds/pasarr.htm
Keystone Peer Review Organization, Inc (KEPRO) is the organization that does this review process. This is a service coordinator piece that could be useful for NTs to use. Contact information:

KEPRO
Toll-free # 1-844-526-4480
Fax # 1-844-490-9555
NHReviews@KEPRO.com

The next meeting will be March 21, 2017

Submitted by:
Luanne King, RN
Secretary, DDNNH

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MINUTES

JANUARY 17, 2017

1) Meeting was called to order with **19** members in attendance.

2) Review and approval of **Januar**y minutes with an amendment to section 4 (c) regarding medical cannabis being a treatment, not a medication, as well as keeping a treatment log to document administration.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are **35** paid members. Please note that there were **41** paid members for 2015-2016.
   b) A motion was made for a vote to continue giving $250.00 to the Denise Martinez-Fay scholarship fund at Rivier College of Nursing. The scholarship is now listed in the brochure as being "In memory of a member who was a graduate of Rivier's Division of Nursing and Health Professions". The DDNNH group is recognized every year for this contribution. The motion was approved. There will be two representatives from the group visiting the college this year to detail the NT role in this area of nursing for any future graduates.

4) Business Discussion
   a) NT caseload variables were discussed again to try to assess how much time is involved with the wide range of duties and changes in programs that take place. There is a template in E-studio to use or we can use something personalized that may capture their specific caseload and training experiences in a different way. Mileage charts and day planners could be useful in retrieving information for the amount of time involved. If agencies/regions were working with less than adequate staffing, this factor may also be noted as influencing the amount of work for one NT. A subcommittee was created to identify an online spreadsheet template to record data and organize it in a meaningful way. Janet Harmon, Lisa Hoekstra and Julie Beal volunteered to work on this project.
   b) Caryn-Ann Ferriter was in attendance today on behalf of the Uniformity of Practice Group along with the CSNI Quality Improvement Committee to discuss a standardized medication error form. This group has been working on uniformity statewide with forms and processes. The goal is to help vendor agencies, areas agencies, home providers and staff by creating uniformity as much as possible. This could be especially helpful in cases where two clients are in the same home but have two different agencies for oversight. The Medication Occurrence Form is currently being looked at for standardization. NTs should give their input along with the uniformity of practice group regarding the creation of the form. A subcommittee of several NTs was created to address this task and also look at other forms to standardize as well. This form could be reviewed after completion by the DDNNH group to establish an implementation time. The PRN protocol was suggested as a form to look at next. The volunteers for this subcommittee are Sharon Milan-Snow, Carla Houck, Jill Satterfield, Martha Fenn King, Linda Catalano, Dianne Crone and Jennifer Boisvert.
   c) The FAQ subcommittee was discussed as far as the process for updating and adding items. Medical cannabis was brought up as a topic to potentially add into the FAQs. The HSI information will need to be revisited now that the HRST has replaced this item. These items will be revisited when the subcommittee reconvenes. There was a suggestion to review minutes each meeting with the purpose of selecting items and flagging them for FAQs.
   d) A question came up involving the regulation involving doing a five-day evaluation. The NT gave a client that had a prolonged stay in a nursing home and then returned to the residence a five-day evaluation. This is not necessary but it was felt to be best practice. The answer to the question was similar to the response given in a discussion with Peter Bacon in the September 2016 meeting minutes, which addressed a change of home care provider but the client stayed in the same house.

e) Also asked: When a DSP has their medication administration certification permanently revoked, are they able to retain their job? This is an agency policy decision.

Next Meeting will be February 21, 2017.

Submitted by:
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Minutes

January 19, 2016

1. **Mass Tex Imaging presentation** – dysphagia/swallowing disorder presentation – overview, experiential, video clips. Opportunity to tour an actual mobile unit van at the end of the presentation time. One reason to consider MBSS vs hospital based modified barium swallow study – the hospital study does not look at the esophagus while MBSS does. Mass Tex experience – in a review of 10,000 studies performed – found 36% have silent aspiration; 46% have an esophageal issue which would be unseen/not diagnosed in hospital setting.

2. **Meeting was called to order with 23 in attendance**

3. **Review** and approval of December 2015 minutes as written.

    a) **Officers Reports-**
    Treasurer's Report: Read and accepted. Rivier scholarship $250 – motion passed to send that amount again this year. Discussion about membership numbers, what do we use our dues for ensued. Debi Ellis-Nailor will follow up with future scholarship possibility of funds given being identified (labeled) as DDNNH provided and report back to the group.

3. **Business Discussion:**
    a. November homework – Youtube videos of med administration – a couple of people looked and couldn't find anything that satisfied the need. Request to keep on the agenda. Janet, Penny, Wayne, Debi, Cheryl and Martha volunteered to be part of a subcommittee workgroup – to meet outside of the DDNNH meeting time.
    b. Cheryl will ask about scheduling ATECH tour – possibly for April meeting.
    c. HRST question raised by member – item i – chemical restraint – is this about aggression? Anxiety? Related to behavior plans? Discussion was wide ranging – reminder to group that HRST is a national tool – the item name does not necessarily reflect the NH practice reality. The expanded scoring descriptors may be helpful. If your individual case/question does not seem to be answered, consider sending a help ticket to the clinical director.
    d. HRST monthly data tracker – need to be sent in monthly with progress notes.
    e. HSI discussion – Cheryl – HRST is now in He-M 503 regulation – which is available online. The focus of our discussion was on how do we operationalize. Reminder - the intent of HSI/HRST monthly data tracker – to help advocate for health knowledge and sharing of observations and changes for the individual receiving services.
    f. FAQ HSI discussion – decision postponed.
    g. How do we change focus from the form used to the point/quality of care? Electronic medical record was one suggestion. EMR would be one form/one place. How we work in NH – there are pieces of information everywhere – keeping it up to date with changes is challenging at best.
    h. We had our first 50/50 raffle today. We also raffled off the donated beautiful handmade quilted hanging from Ruth – thank you again Ruth!

Next Meeting will be February 16, 2016

Submitted by:
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MINUTES

February 16, 2016

1. Meeting was called to order with **17** in attendance

2. Review and approval of January 2016 minutes – Accepted as written

3. Officer's Reports:
   a. Treasurer's Report – Read and accepted

4. Business Discussions:

   a. General reminder to the group that Peter is scheduled to join us next month. Jen will send out a reminder to the group to send questions (with specific regulation citations as applicable) to Peter prior to the meeting.

   b. A couple of questions were raised about other members' experience with length of some surveyor visits and the types of concerns being noted. One specific question raised was about verbal orders – a copy of the order in question will be brought to a future meeting as it sounded to the members present as if perhaps the questioned order was actually not a true verbal order, rather a different version of an electronically signed order.

   c. A question was raised about QA frequency – if a QA is not done within exact 6 months (to the day), then a citation could happen? The surveyor reportedly referenced the FAQs, although the specifics were not available at the meeting. A review of the FAQs did not provide specific information to address this. Cheryl requested that a copy of the surveyor communication be sent to her. Discussion ensued around using the same language as has been used for the medication administration certification period. (regulation citation inserted during creation of draft minutes: Providers shall be re-authorized to administer medications at least annually or by the last day of the 12th month from the date of the prior authorization.)

   d. Compassionate Care Lunch n Learn (to review NH Medicaid changes related to hospice care) – needs to be rescheduled – group agreed that April would be next month available. If scheduled, meeting time will be extended to noon to accommodate.

   e. Tour of ATECH – to be scheduled – Cheryl will ask Dennis if either May or June would work with his schedule.

   f. November homework – Janet – transcription of current video is available in eStudio (in projects in process folder). Anyone interested in reviewing and offering suggestions is welcome to participate directly in subcommittee meetings or to send comments to Janet. Most of the identified members were unable to attend today's meeting due to the weather. Cheryl will send out a meeting request with time/date suggestions to the subgroup.

g. HSI/HRST monthly data tracker (MDT) – Cheryl had several areas to start process of seeking input.
    i. An algorithm for determining medical fragility has been proposed as useful – using the current HRST scoring items – please review with your specific knowledge – what item(s) capture information that you currently use in your assessment. What items could be used collectively to trigger an RN consideration of medical fragility. We know that the HCL number alone does not correlate directly to medical fragility as not everyone who has an HCL 6 is medically fragile. It is also true that an individual who is scored HCL 1 could be medically fragile. Cheryl provided handouts of the MDT, a HRST definition of medical fragility (just to have a framework reference – we are not looking to change NH's working definition of medical fragility). Cheryl reminded the group to not only toggle yes on About Me page for medical fragile status, but to include specific notes in the HSI medical fragile comment box – a comment box to go with the medical fragile toggle is being discussed/developed.
    ii. Additionally Cheryl requested that NTs review the HSI form – which topics/questions are not captured at all within the HRST items. Rather than lose that information, there is a proposal to change the HSI form to only include those items. Please send Cheryl your comments from this review.
    iii. Cheryl has queried the HRST system – there are currently 4,050 records in HRST from NH, of those 7% have diabetes (national average is 9%). Cheryl also queried the number of psychotropic meds – she passed around the resulting graph. A small group of individuals have 10 psychotropic meds.
    iv. PLEASE send in tickets to HRST as you are using the system and notice any anomalies or errors. (Don't assume that it is already known about.)
    v. At some point in the future, ISAs will be included in HRST so that everyone with access can see them.

h. Kenda mentioned that she had recently participated in a PPN and CSNI work group – and wondered if the information gathered had been shared with Cheryl (specifically around ideas/comments generated regarding medical info). Cheryl did not know about this. Kenda will contact the group facilitator to request a connection be made.

i. HRST MDT form – weight/BMI monthly box – members of the group commented that we don't necessarily have monthly weights for everyone. For some individuals, their weight is not an issue. For other individuals their weight is an issue and they have a barrier to obtaining accurate weights with any routine frequency. Recommendation – document weights whenever they are available – be aware of that frequency and work with the team to develop awareness and resources if increased frequency is needed.

j. About Me page – Cheryl mentioned that there is a section (with vision etc) that nurses don't have access to make changes. If there is a need to change this, please let Cheryl know. No one present at the meeting needed access.

k. TD risk flagged meds in HRST database – be aware that the list that HRST bought from drugs.com flags some meds that are not usually considered a TD risk. Also, HRST cannot discriminate between a regularly scheduled dose and a rare, occasional use for TD risk – both instances are flagged the same. Ticket has been sent to HRST clinical assist. There are 24 meds on the HRST database that are listed both as having TD risk and not – depending on which is selected. Some members spoke about concern for signing off a clinical review of a HRST record that has item J scored a 4 for TD risk with a med that essentially does not have a TD risk. One member said that her practice has been to input a comment on that item (in the permanent comment box) with which specific drug triggered the rating.

l. The group present was asked if it would be useful to have a projection of HRST screens at a future meeting (to assist with understanding which page/area we are talking about) – there were many who said yes. Cheryl will bring a laptop to the next meeting with a small sample of test individuals. Not all of the screens will be functional.

Next Meeting will be March 15, 2016

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MINUTES

March 15, 2016

1) Meeting was called to order with 34 in attendance

2) Review and approval of February minutes as written

3) Officers Reports :
   a) Treasurer's Report – accepted as written

   b) DDNA Liaison – Debi, Eileen, Pam, Wayne and Luanne are going to DDNA conference. Debi called Rivier College re: scholarship money – what our group donate goes into a pool of money for the Faye-Martinez Foundation and is disbursed to a nontraditional nursing student. Another future option for us to consider would be for DDNNH to pay for one of our DDNNH members to become a CDDN. Debi reminded us that she is looking for members of our group to write about what brought you to DD nursing as she plans to write an article for the spring DDNA newsletter (send directly to Debi's email)

4) Business Discussion
   a) Reminder of upcoming guests for April and May meetings.

   b) Cheryl spoke of mentoring for new nurse trainers – if you are willing to be a mentor, then let Cheryl know.

   c) HRST – HSI (if it remains, it will need a new name) homework – only one person sent suggestions to Cheryl prior to the meeting. Changing the language in He-M 1201 is started – however, because the rule is due in 2018, there won't be an official change until then.

   d) Peter and Kiki joined us for our ongoing collaborative discussions. Questions that had been sent in were discussed first.

      i) Medical marijuana use – thoughts on how this will be managed? Discussion comments included: learn as we go, can look at the State statute (RSA 126x), how to prescribe – practitioners unsure how to prescribe, medical marijuana comes in different forms – not all are equivalent in effectiveness – oral (marinol) doesn't work well with treating spasms. One person has a medical card already – dispensary will determine the form, not the provider; a couple of individuals or their families have expressed interest. It will be treated as a scheduled (controlled) drug. Consideration must be given to a plan for managing the smoked form (re: others in the home)

      ii) HRST vs HSI – specifically – are the surveyors going to be looking for the HRST to be reviewed prior to annual health assessment (physical) and non emergent medical appointments – at this point the surveyors are just looking to see that HRST is there and information is being documented on it. At the end of the discussion – BHF will not expect HRST monthly data tracker to be reviewed prior to annual health assessments and medical appointments. The HRST MDT will still need to be reviewed by the nurse within 30 days of initiating a program and annually thereafter.

      iii) HSI 2015 – should the completed forms be left in for the surveyors or taken out – answer: leave in. HSI is not needed to be processed in 2016.

iv) HRST MDT form – don't double document information. CPS (day) and residential programs (services not provided by the same person) need to have separate HRST MDT forms. However, what happens at CPS should not be documented again on the residential form. How to know when to use 1 form or 2 in your program – different staff providing the service = different form.

v) Error cited by Kiki on verbal/telephone order – the citation was not about the order, rather that the order had not been signed later by the prescriber. There is not a specific date in the regulation for when these needs to be completed – within a reasonable timeframe, depends on the frequency of planned visits. Discussion about maintaining a good relationship with prescribers – we ask them for a lot of paperwork/signatures, some of which their time is not compensated – be thoughtful and manage the process/requests accordingly.

vi) An example of a different med certificate form was presented by both Kiki and Cheryl – discussion ensued – outcome: use the official State med certificate form. There are two versions – both are acceptable – one doesn't have the reminder to put in the date range of the certificate – that info needs to be entered by the authorizing NT.

vii) QAs – semi-annual frequency – discussion ensued. The expectation is that 6 months to the day is the timeframe within which QAs need to occur. There was a question raised about the FAQs offering date ranges – the cited reference is within the historical part of the FAQ and cannot be currently applied to practice.

viii) Is it acceptable to not fill PRN orders until they are needed? After discussion consensus – if you have an order, you need a supply and a med log. The supply on hand for PRNs could be limited to a 3 day supply (ex. a trial/travel size bottle)

ix) BHF is not seeing any particular He-M 1201 trends for deficiencies.

x) A question was sent in asking about using NUR 404 in He-M 525 settings – this is not within BHF's purview.

e) A projection of HRST to demo sign in, Clinical Review, medical fragility toggle on About Me page as well as the comment box on the HSI form and other navigational steps of HRST system ended our meeting. A reminder – in order to be a Clinical Reviewer you have to have completed the online rater training followed by the Clinical Reviewer training AND the system has to recognize you as both. If you have an HRST account you can look at your profile to see what is toggled on or off

Next Meeting will be April 19, 2016: reminder that Compassionate Care will provide a lunch n learn at 11am

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MINUTES

April 19, 2016

1) Meeting was called to order with 25 members in attendance
2) Review and approval of the March minutes as written
3) Officers Reports :
   a) Treasurer's Report – accepted as written
4) Business Discussion
   a) November's homework – DVD – subgroup to meet after today's meeting – script given out previously. Anyone interested in participating is welcome to stay and join in the discussion.
   b) Hospice/1201a –
      i) There was a range of experiences with hospice presented by members – from difficult to wonderful
      ii) Take away messages – be sure to work on relationships that work together during this difficult time (between hospice and NT). The shorter the timeframe of hospice introduction to death of the individual, the more challenging it is to mesh our two systems of care. Consider having increased frequency of team meetings to help people express and be on the same page for goals of care/support.
      iii) Be aware – certain infections/illnesses while receiving hospice services – hospitalizations are discouraged and may lead to disenrollment. Fairly seamless for this process and to be re-enrolled after discharge from hospital.
      iv) When to initiate a hospice evaluation? The sooner the better. Hospice companies are happy to provide an evaluation for whether the individual is eligible for hospice services. Even if the initial evaluation shows that the individual is not yet eligible, you have some baseline information gathered.
      v) a member reported that this was a very challenging process with an experienced home care provider – very emotional, the entire process was short – essentially a month. Another member spoke up saying that she too had just had a pretty difficult time in a residential setting – hospice was instructing staff to give pain med frequently, guardian was aware and in agreement, the amount and frequency of recommended medication administration was concerning to the overseeing NT. Another member spoke of having a couple of experiences years ago with another area agency and a very involved family – overall wonderful experience. This past year had experience for over a year – the hospice nurse came in Monday and Friday. NT provided education to hospice about what NT responsibilities included – overall positive experience. Another member had a couple of experiences with hospice with a few speed bumps. Hospice has come back to work with staff after the individual has passed – this has been beneficial. In another example – the individual receiving hospice was cared for by family caregiver in a 521 setting with some staff. The staff did not have access to the hospice kit (waiver from state) – family caregiver provided all hospice medication support. Very emotional experience for family/caregiver.
   c) Nominations sought for open positions:
      i) Vice President: Angele Smith was nominated and agreed to run.
      ii) Secretary: Jennifer Boisvert was nominated and agreed to run.
      iii) DDNA liaison: Debi Ellis-Nailor was nominated and agreed to run.

      An email will be sent out to the group to seek any additional nominations. If there are no other members nominated, there will not be a need for an election. If there are other members nominated who agree to run, an electronic request to vote will be sent out for any members who know that they will not be present at May's meeting the prior week.

   d) DDNA conference report – Debi: preconference day on forensic – excellent speaker, learned a lot, for example: need to consider supplements that can cause bruising (eg ginger). He talked a lot about insurance company

talking with us, about education, used graphic slides and had audience try to figure out what had happened – audience was usually wrong, recommended using body picture in incident report to document.

i) Luanne attended the boot camp – very helpful info, syndrome sheets (Debi says these are much easier to study for CDDN instead of all the books she used), website recommended

ii) Nanette spoke at the conference – take away message – psychotropic and allergy meds can be a poor mix (some allergy meds form a coat over the psych med – so the prescriber thinks it's not working and increases, when really the underlying issue is the body can't access the medication that is present)

(1) A brief discussion of available genetic testing considerations…Ellen shared that she has found 23 and me to be useful (https://www.23andme.com/)

(2) Pam commented about needing to be aware that clozaril use can result in very increased blood sugars (over 900) – person went into hospital, has permanent kidney damage. This individual also has Diabetes insipidus and uses lithium (which could be contributing factors).

iii) Eileen – Dan Sheridan (forensic nursing speaker at pre-conference day) – says "cuts, scrapes and stuff" are preferential words. Rick Rader was the keynote speaker and compared our type of nursing with burn victims in WW2. Barb Bancroft's presentation was funny as usual and informative.

iv) There were approximately 200 attendees at the conference. The venue was beautiful, everyone felt the environment and staff were welcoming. Overall DDNA membership has declined. There are now less than 400 CDDNs. Next year's conference is in Dallas, TX. Those in attendance were asked to help figure out ways to grow the organization.

e) Compassionate Care presentation on Hospice with Jennifer Mahoney and several staff – thank you for the food and information!

i) After group introductions, Jennifer asked if there were particular areas of interest to cover – responses: alzheimers – (Answer – late stage is covered – individual who speaks 6 words or less now); disenrollment, how to develop relationship (eg what does hospice need from us).

ii) Hospice looks at decline of the past 6 months to a year – has 2 physicians certify need (PCP and hospice MD)

iii) Initial benefit period – 90 days, hospice team meeting, 2nd 90 day benefit, then APRN goes out for face to face visit – presents at hospice team meeting to determine if services can be continued.

iv) Compassionate Care doesn't have a bridge program, they do have weekly liaison monitoring to see if individual is declining and enroll in hospice when eligible.

v) Namenda and Aricept are not covered under Medicare in hospice.

vi) Aggressive treatment meds are generally not covered during hospice care – there may be initial consideration if the person or family needs a little time to adjust from treatment to hospice.

vii) Dialysis is considered aggressive treatment and not appropriate for hospice.

viii) Major differences between Compassionate Care and other hospice companies:

(1) can admit over the w/e

(2) nurses go out at least 2x/week – increases as needed. RN is on call 24/7

(3) aides – 5 days a week (Monday – Friday) for each patient for at least an hour (to provide 1:1 as respite) – can be up to 3 hours if needed.

(4) Only hospice in the state that has a veteran liaison (non medical) – coordinates veteran ceremonies (celebration), looks at veteran benefits eligibility, is someone who understands the veteran mindset

(5) Compassionate Care offers Reiki therapy, aromatherapy, essential oils and dog therapy.

Next Meeting will be

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MINUTES

May 17, 2016

1. DDNNH group received an interesting & informative tour of the ATECH facility and programs.

2. Meeting was called to order with **26** in attendance

3. Review and approval of April 2016 minutes – Accepted as written

4. Officer's Reports:
    a. Treasurer's Report – Read and accepted
        i. We had 41 paid members.
        ii. We have started the new membership year with 7 members.

5. Business Discussions:
    a. Thank you Liz for volunteering to facilitate today's meeting!
    b. Debi stated that the DDNA conference report was completed last month. Debi and Luanne emailed useful handouts that will be shared with the group. A useful website from the slides: http://vkc.mc.vanderbilt.edu/etoolkit/
    c. Eileen stated that she has an article from the conference re: dialectical behavior therapy if anyone is interested.
    d. November 2015 homework update: Janet reported that the subcommittee met after the April meeting. The current script was discussed; the next meeting will be today.
    e. Voting for officers. Debi and Angele were welcomed into their positions (DDNA liaison and VP) without opposition. Ballots were cast for the position of Secretary. Congratulations offered to Cheryl Bergeron who will assume secretarial duties at the June meeting.
    f. CPS QA. A member raised a question about how PRN rescue inhalers are managed. If the PRN meds are not used for an entire year at CPS program, should a d/c be sought (without intending any impact on residential setting)? Discussion. Not all PRN meds need to be at CPS. This should be a team discussion with any necessary specifics documented in the ISA. There may be PRN meds that are not used for a year and would still be beneficial for the individual to have access to.
        i. Can waivers be sought for PRNs? Rescue meds can be waivered, however, as an example; PRN Ibuprofen will not likely receive approval as a waivered med.
        ii. Meds that are in CPS setting? We need the meds that we need to be there. The individual needs to have reasonable community access to PRN meds.
    g. Self-med assessment of an individual in CPS
        i. regulation reference: 1201.04(b)
    h. A question was raised about using smelling salts. Recommendation to check if the individual has a behavior plan and to review with the applicable human rights committee. This could be seen as an aversive treatment.

i. LNAs in 1001 setting; can they be hired as LNAs? Can they give meds? Our community based system does not meet the scope of practice requirement for the LNA. So they generally cannot be hired for an LNA position. It is possible that an agency may be a licensed home care agency in NH, in which case, that agency could have LNA positions. While practicing as an LNA, that employee cannot administer medications using the He-M 1201 regulations. There may be other tasks routinely delegated within the community based waiver service system that are outside of an LNA's scope of practice.

    i. Areas to consider in your particular agency prior to hiring an employee in a LNA position: what is the license of the agency (home care or human service), does the LNA scope of practice include all of the tasks the position requires, and can your agency meet the supervision requirements for the LNA.

j. FAQ suggested amendment - Tabled to future FAQ subcommittee work.

k. A reminder that Peter Bacon will join us at our next DDNNH meeting.

Next Meeting will be June 21, 2016

Submitted by:
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MINUTES
June 21, 2016

Meeting was called to order with **33** members in attendance

Review of the May 2016 minutes. Minutes accepted as written.

Officer's Report:
- Treasurer's Report: Accepted as written

DDNA Liaison Report:
- Debi Ellis-Nailor reports there has been an increase in nurses testing to be a CDDN (Certified DD nurse). There have been problems with getting the CEU certificates, DDNA looking into resolving these issues.

Old Business:
- Medication Administration video/curriculum updates. Members on the sub-committee (and any members present who would like to join) were asked to stay after the meeting in order to discuss possible working date(s) over the summer. Cheryl Bergeron noted there could be training funds available.

New Business (including nursing practice issues)/ Discussions:
- Bylaws update - Cheryl Bergeron will draft changes to be made to the bylaws and present at the September DDNNH meeting.

- Managed Care Organizations have asked what a "normal" caseload number would be. Members discussed that there are many different items which could affect what a "normal" caseload could look like. A questionnaire will be created and disseminated. The information will be submitted to Maureen DiTomaso and compiled into a spreadsheet.

- It was noted that Al Swanson from Health Facilities has health issues and a "Go Fund Me" account has been created for him. Ruth will send out a link to the site for those who would like to donate.

- FAQ subcommittee update – August 16, 2016 was the suggested date to meet to further the work on the FAQs. Please let Cheryl Bergeron know if you are interested in attending this subcommittee workgroup. Suggestions made today were to create a different format; make the document more easily searchable; adding a HRST segment; retool language; looking back through the past minutes to see if there are any areas of discussion captured which should be added into the FAQ document.

- Medication changes when using single packaging – Discussion topics included: bringing the packages back to the pharmacy to have them relabeled & repackaged; having someone who works with bubble package company come to present to the group in the future. Outcome of discussion was the nurse and/or med certified staff should be the only ones removing the pill(s) from the packaging and destroying the pill according to policy and procedures.

<u>Peter Bacon & KiKi Sylvester topics discussed:</u>

- A home provider, who is a nurse and a former nurse trainer should be completing med logs and another nurse should QA them.

- Changing orders – individual went to the dentist and had pain medications prescribed. The home provider thought the pill was too much and the nurse said to break the pill in half. This was cited because nurses cannot change orders. The nurse should have called the physician to get a new order.

- The Annual Health Screening form - Although there is no spot for a physician's signature it needs to be reviewed annually with the practitioner. There needs to be proof that it was reviewed, suggested in the progress notes.

- When oxygen is prescribed, the order should be present (the supply company gets the order from the physician, and the nurse request copy from PCP). Oxygen usage should be placed on the treatment log. Home providers should complete the monthly notes regarding the usage of oxygen. There needs to be signage in the home that oxygen is in use.

- Liquid controlled drugs – there are concerns regarding "how much is in the bottle". There needs to be something in writing for discrepancies. Control drug count error needs to be documented accordingly. There should also be error reports for spillage.

- For individuals with g-tube feedings - A diet order (written by either a dietician or PCP) needs to be on file and reordered on an annual basis. Diabetics also need annual physician order for a diabetic diet.

- Prior Authorizations for medication – If a PA cannot be obtained for a certain medication, physician perhaps could order different medication. Reminder - a denial can be appealed.

- Discussion on medical marijuana – Therapeutic cannabis program. Peter distributed talking points explaining the Department of Health and Human Services role regarding oversight of the program. State Government rules indicated that Medicaid/Medicare funds cannot be used to buy cannabis, although sometimes individuals can get a discount. Questions were raised regarding a staffed settings and the need for further clarification. The New Hampshire Board of Nursing does not consider cannabis as a medication. Anyone who has questions please email them to Peter (Peter.Bacon@dhhs.nh.gov) or Kiki (Kirstin.Sylvester@dhhs.nh.gov) Peter will also get clarification on the staffed setting discussion. You can find the He-C 401 and He-C 402 rules online (http://www.gencourt.state.nh.us/rules/state_agencies/he-c400.html) Statutory Authority RSA 126-X:6, I (http://www.gencourt.state.nh.us/rsa/html/x/126-x/126-x-mrg.htm).

- Group question to Peter and Kiki – "Are you seeing any trends?" Peter and Kiki replied that they are not seeing many 1201 trends.

- HRST & chemical restraints – Look at the doctor's orders to determine if the medication is a PRN or if they have a behavioral plan. The care-giver can always flip the monthly data tracker over and write a reason for the medication. There are still concerns and there needs to be feedback regarding premedication procedure and if you are required to put it on the monthly data tracker as a chemical restraint. Further explanation is found on the expanded descriptor document.

- FAQ's - Hospice clients and yearly physical – If the client is in hospice they are already being seen by medical personnel, they do not have to be brought to PCP's office.

Fundraising:

- Wayne and Luanne King donated a Kindle Fire for the fundraiser. Tickets were sold for $1 a piece or 6 for $5. Total amount raised was $115.00. Eileen Murphy-Hamel won the Kindle Fire and Cheryl Bergeron won the DDNA tote bag.

Next Meeting will be September 20, 2016

Minutes submitted by Cheryl Bergeron, DDNNH Secretary
Typed by Maureen DiTomaso, Administrative Secretary

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcx/bds/nurses
DDNNH@dhhs.state.nh.us

MINUTES

September 20, 2016

1) Meeting was called to order with 27 members in attendance
2) Review and approval of June 2016 minutes as written.
3) Officers Reports :
   a) Treasurer's Report – read and accepted as written. Treasurer noted that last year we had 41 members, this year we only have 21 members – we need to encourage our nurses to become paid members
4) Business Discussion
   a) At our June meeting a suggestion was raised that we would need to update our bylaws – because the meeting location has changed from Pleasant Street at BDS to Regional Drive at ATECH. Discussion at today's meeting determined that we occasionally do get mail sent to our group and though our physical meeting space has changed, the administrative secretarial support remains at BDS. Therefore, updates to the bylaws are determined not to be beneficial at this time.
   b) At our June meeting an initial discussion about a request from MCOs regarding NT caseloads occurred. No action occurred on this during the summer. We determined that this needs to be a larger group discussion (rather than a subcommittee) to ensure that the variety of agency (area agency and vendor agency) expectations of NT role are included. DDNNH needs to have a leading role in defining what a NT caseload is and a full meeting should be devoted to this. Jen suggested **November meeting**.
   c) DDNA liaison report – National conference is April 6, 2017 in Texas. There will be a boot camp for CDDN preparation. Debi raised the idea with DDNA about considering life experience as part of CEU hrs – for example, if you are a family member providing advocacy health care services. DDNA board will discuss – this has never been raised before. MADDNA conference – Oct 6 – full day – Dan Sheridan presenting on forensics – great presenter!
   d) Peter Bacon joined us for our ongoing collaborative discussions
      i) Home care provider recently left, individual stayed at the certified home, new home care provider moves in – Question - Are three monthly QAs required (by reg) or not? Answer – not clear. Discussion – some nurses would consider this a best practice. Regulation is minimum standard – perhaps if QAs not done for first 3 months, should be written as a concern. Outcome: 3 QAs are required in a new setting – minimum standard – this example setting would not receive a citation if monthly QAs were not done with new HCP. A member asked if the response from Peter could be shared with the group, he said yes, that he would send it. (*ACTION – add this to FAQ document)
      ii) Medical technician – new law passed to develop registry. (RSA Chapter 151 Hospitals and Sanitaria). BDS attorney working with AG. This law is about access to controlled substances in certified or licensed settings. Of particular note was a significant increase in cost of criminal record checks ($50) built into the law. DD and ABD waiver settings were not intended to be impacted by this law. Recommendation – no change to current practices.
      iii) Individual needs a self medication assessment – who needs to do the assessment? Question - Can a manager do it? Answer – no. RN cannot delegate assessment. Surveyor cited, agency appealing. The form for the agency's self med review has spaces for 2 signatures – perhaps changing the wording on top from assessment by manager to evaluation with assessment for the nurse could be a solution. (Group discussion resulted in a request to share self med forms from your agency with the DDNNH group – bring to October's meeting)
      iv) Self med at day program – do they need to be done annually? Answer – do they take meds at the day program – if yes, then yes.
      v) Medical marijuana – example – individual with unstable seizure disorder – mother is very involved – asking neurologist to make changes. Mother wants individual to have less meds, more cannabis as solution – neurologist is not on board with this course of proposed treatment. Keep in mind – there is a difference between licensed settings and community residence settings. In community residence – if this is a staffed

residence – no legal mechanism to use medical marijuana. In community residence – if this is a home care provider residence – with one person responsible for administration, could be legally done. A suggestion was offered that Wayne Ward have Pathways policy about medical marijuana sent to Maureen for posting in eStudio – since it is a well crafted policy – no need to reinvent the wheel.

vi) HRST – same home certified for residential/day services – only one form needed, if these are provided under separate certifications, then 2 forms are needed (one for each setting).

vii) What is a reasonable length of time for temporary cert survey? (Surveyor has approximately 3 months of data to review). Peter – usually, shouldn't take more than a couple of hours.

viii) Annual physical being late – certification citation. The physical was scheduled, the individual was not feeling well, appt was cancelled (to protect prescriber relationship as expectation was that the individual would be destructive if appt kept), rescheduled – 13 months between annuals. The agency self reported, were still cited – is this correct? Peter: self reported deficiencies are still counted as citations. Further comment by member of the group – some people in the northern parts of NH do not have access to PCP providers within annual expected time frame due to lack of providers.

ix) Group asked Peter – are you seeing any trends? Peter – has not had time to look as he is on road full time doing certs himself. He has not heard anything that stands out as a trend. Peter commented that there are 2-3 new programs opening every day. Further discussion – these are not new people receiving services – providers aren't staying. Budgets are static despite change in needs, low rate of pay, and often people aren't nice to each other in our field.

x) There is a new BDS director – Christine Santinello – current executive director at Region 3.

xi) Peter's next visit will be December at 10am – he will see if Kiki is also able to come.

e) Authorized providers preparing community doses in advance – this originally came up in med committee meeting last spring – there was an unusual aspect to the question – a waiver was received to prepare a week's worth of doses in advance. Agency policy drives this question – with the underlying understanding that one dose time may be prepared in advance by the person who will be administering the dose in the community.

f) Does the med error report go to the guardian? General practice is notification only, not sending the actual report.

g) A member strongly encouraged the group in attendance to really consider applying for the open Nurse position at BDS.

h) How do you provide NT coverage and take time off if you are the only NT? Suggestions from the group included – having staff contact MD office, if out of the country could potentially use Whatsapp.

i) Due to our vacant Secretary position, we need to nominate and hold a vote to fill this position. Suggestion was made for Jen to resume, however, she is unable to do more than fill in for September and October.

Next Meeting will be October 18, 2016.

Submitted by:
Jennifer Boisvert, RN
Temporary Acting Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

October 18, 2016

1) Meeting was called to order with 16 members in attendance.

2) Review and approval of September 2016 minutes as written.

3) Officers Reports :
   a) Treasurer's Report – read and accepted after a listed name correction (Liz should be Lisa).

4) Business Discussion
   a) A new secretary for DDNNH was sought from among members attending October's meeting - to complete the currently vacant term – Luanne King stepped forward and the members present voted her in. Thank you Luanne!
   b) The group had a lively discussion about how to develop real information about nurse trainer caseloads. Some of us remember a project about this from years ago at a meeting held in the Chapel – Wayne King volunteered to ask Joyce Butterworth about the notes from then. What are the variables that we want/need NTs to bring to our November discussion as we work to develop a statement from DDNNH about NT caseloads? Many ideas of items to include were identified – Jen agreed to create a document that will be posted in eStudio that can be used to capture individual NT information. Everyone will come with their own answers/info (or send it to the meeting with someone else who is coming if they are unable to come themselves) to the November meeting.
   c) HRST – new ISA generation – are nurses aware that there may be medical goals generated based on the HRST? There was a spectrum of confidence from nurses present about whether the HRST items were correctly scored – from confidence of inaccuracies to confidence of accuracy. This spectrum illustrates the challenges of pulling reports across a company, an area agency or the State – if the information entered is inconsistently accurate, then the report generated will have inherent inaccuracies. One nurse is reviewing HRSTs for 525 settings with no staff – resulting in a clinical review of individuals that she doesn't know and doesn't necessarily have access to someone who knows the individual well. A few nurses commented on the amount of service coordinator turnover – and how that impacts the status of HRST updates. One nurse said that she has day program staff tracking items daily – which are then funneled through the program supervisor for compilation on the monthly data tracker. In homes, this same nurse has some tracking items daily and some use the monthly data tracker – it depends on what is happening in the individual situations. There was acknowledgement that the HRST system does not automatically send messages to the new service coordinator when a review is due. HRST expects that the individual agency or area agency will notify them promptly when someone has either left service or their caseload access should be modified. One nurse noted that there is a monthly charge by HRST for each individual whose status is active – if the individual is deceased and the status is not changed within HRST, the monthly charge will still occur.
   d) HRST continued – a question was raised – who is running the HRST show at the State or Area Agency level? There were Regional HRST Coordinators identified for each Area Agency. No one knows who the responsible person at the BDS level is. Many nurses are frustrated about nurse review comments being unanswered (sometimes for years) in the HRST individual update process by the service coordinator. Some nurses note that service coordinators are not updating the HRST for individuals. Since the nurse also has access as a rater and could make changes, should they? No. One area agency specifically has the RNs unable to be a rater within the system (this is possible to do through modifying the roles that are checked for the RN – initial entry into the HRST system requires the nurse to become a rater first and then the nurse is eligible for Clinical Review training. Once the Review training is completed, the nurse automatically is both a rater and a Clinical Reviewer – HRST can turn off the rater access).

e) Self med form sharing – some nurses brought their forms – most brought single copies – Jen volunteered to take them and upload them into our folder in eStudio.
f) Debi asked how to make changes in the preferred medical providers list on our website – Dr. Goodman has changed practices. A member of DDNNH can request an update through Maureen.
g) A reminder to the group from Jen – as nurse trainers who may have 'new to us'/ already authorized providers – please consider contacting the authorizing nurse trainer for medication certificate verification. This process is not an official reference. It is an opportunity to learn that the authorized provider's certificate is currently in good standing – since we have no registry or official means to verify status.

Next Meeting will be November 15, 2016.

Submitted by:
Jennifer Boisvert, RN
Temporary Acting Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

November 15, 2016

1) Meeting was called to order with **21** members in attendance.

2) Review and approval of October minutes as written.

3) Officers Reports :
   a) Treasurer's Report – Accepted as written. There are **33** paid members.

4) Business Discussion
   a) Next month will include a visit with Peter Bacon and our holiday party. There will be box lunches provided by BDS as well as some goodies that five members signed up to bring. There are some main dish items, so something sweet is a good bet if you want to bring food. An ornament swap was suggested, so if you want to participate bring a wrapped ornament.
   b) There is a committee working on an effort to standardize forms routinely used. An example of one in use now is the statewide incident form. The medication error report recently came up for discussion. The committee would like the input of our group and wants to send two representatives to discuss this. There was talk about the confusion of having a med error category on the statewide incident report as well as client refusals not being 1201 reportable and how that is reflected. For these reasons, it will be important to give input pertaining to the form. It will be difficult to fit this discussion into the December meeting making January preferable, but it was agreed to make December work if January is not possible.
   c) The caseload variables form that Jen Boisvert devised to capture general information about NT caseload and workload was discussed. It was encouraged to use this form and add items that are important to reflect individual workload. The goal is to create a broad view of what a NT can expect to do and the approximate time it takes for each task. Individuals who self administer medication arose as a topic due to differences in time spent either on monitoring, training for new medications or a change in the client's ability. Higher health care levels can make a difference in the amount of time needed as well. Time working on HRST should be looked at as a category. It was agreed that this is hard to quantify due to the unpredictability of the work. The form will be on e-Studio and can be downloaded and changed to suit individual needs. A motion was made to try to use the form and revisit this again in January.
   d) Janet Harmon reported on the status of updating the curriculum training video. A script is finalized and she will check on details for funding as well as an animation aspect.
   e) The question was raised regarding the correct way to document medically frail individuals now that there is an HRST toggle to indicate frailty. There is a recommended worksheet to indicate that a client is frail. The requirement is that the nurse makes that judgment based on the frail definition. It is enough to use the HRST toggle combined with a note defining reasons for frail status in the comment section of HSI and some also use the scoring summary section. The frail worksheet can be found in our section of the DHHS website under health and safety. Frailty is also addressed in the FAQ section.
   f) There was discussion involving the state regulation for test results being present during a state certification. There was concern about the surveyor asking to see specific test results. The surveyor only looks for proof that the client actually had the recommended test or procedure done. We were reminded that the surveyors have feedback forms with them and the vendor can ask for one to make comments (positive or negative) about the cert. Peter Bacon will also answer questions about any concerns you may have.
   g) There was a reminder that there is no regulation regarding when a provider completes their initial observation after completing medication certification class. The sooner the better as they cannot pass meds until this is done, but there is not a one-month deadline. There could possibly be a company policy by an agency regarding this, but

no specific regulation. There is a 30-day grace period if someone exceeds 365 days before being reauthorized. The provider cannot pass meds in this 30-day period until re-certified by the NT.

h) Discussion arose around PRN medications and how much to interpret when a prescription does not have all of the information to be considered complete. Be sure to clarify amount and frequency with the ordering clinician. The section in the FAQ's regarding PRN medication was read as follows:

"In the event that an ordering practitioner does not include specific instructions, or, indicates "use as directed," the Nurse Trainer will, in accordance with He-M 1201.04 (h) (2) (a) provide a PRN protocol that identifies the specific conditions(s) for which the medication is given; a maximum daily dosage; and any special considerations. If there is concern about any aspect of the order, the Nurse Trainer should clarify the ordering practitioner's expectations. (He-M 1201 reference updated 3/13)."

The person passing medication has to be able to do triple checks. If the order is clarified and has all the information but the label of an OTC med is not detailed, simply copy the order and put it in a Zip lock with the medication. In an emergency a protocol can be given over the phone that could be written on the med log to allow the first dose to be given.

Next Meeting will be December 20,2016.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

December 20, 2016

1) Meeting was called to order with **21** members in attendance.

2) Review and approval of **November** minutes with an amendment to section (e) regarding documentation of frail status on the HRST.

3) Officers Reports:
   a) Treasurer's Report – Accepted as written. There are **34** paid members.

4) Business Discussion
   a) A quick review of the frail documentation in the HRST. When the frail toggle is activated, make sure to note in the HSI section of the HRST the reasons for frail status. This was the initial direction given during the training. Client frailty can also be noted in the scoring summary of the clinical review but must be noted in the HSI. In addition, you can choose to use the medically frail worksheet for gathering information to determine frailty, but it is not mandated.
   b) There was a reminder from the treasurer that in January we will discuss the scholarship fund for Rivier University. The suggestion was made to have a representative go and speak to the graduate groups outlining the disabilities nursing field. This could be beneficial not only to introduce this area of nursing but also to acquaint new nurses with the skills of interacting with our clients in various clinical settings. This would provide good material for an article to DDNA as well.
   c) Peter Bacon was asked about medical cannabis in relation to our clients in a certified residence. Medical cannabis is a treatment not a medication. Last year certified residences were in the same category as nursing homes. This status was changed and now the request is in to have the certified residences back in the same category as nursing homes so clients are not denied the ability to have this treatment. Being denied the same access as everyone in the state is a client rights violation. For now, it is acceptable for one caregiver in the home to pick up and administer cannabis to the client authorized to receive this treatment. A problem results when there are multiple staff members in a home administering medications because the "facility" situation is not allowed at this time in a certified home setting. One caregiver administering is acceptable even in a home with multiple individuals as long as each individual has an order for cannabis. The dispensary prescribes the treatment for an individual after applying for a card to receive medical cannabis. Pathways agency has a policy that Peter felt was a good example and could be adapted to other programs. A licensed facility has all staff authorized and the procedure is the same as any 1201 situation. All staff are trained and authorized to give this treatment. A control count sheet and treatment log will be used as well as double locking the substance.
   d) A quick reminder by Peter and Kiki that a six-month QA is due six months to the day of the last QA and you do not have to the end of the month.
   e) Peter reminded everyone to keep a minimum inventory of drugs rarely used. An example was given of Diastat where you would expect to see one pack of two doses in the home. This may require stopping an automatic refill so there isn't a stockpile of something that needs to be counted, locked and may never be used.
   f) The question was raised regarding clients and the self-administration of medications. Does the guardian need to sign the assessment form used by the NT? There are some forms used that have a place for a guardian signature and some forms that are not signed because the consent was in the service agreement for self-administering meds. The rule states:

"He-M 1201.05 (e) The nurse trainer shall maintain documentation of the ability to self-

administer medications, including the guardian's approval, if applicable, in the individuals record."

g) Peter and Kiki also reiterated that during certification there needs to be proof of a client having completed an ordered test or lab. Specific results aren't necessary as long as the surveyor can see that the clinician's orders were carried out.
h) Community Support Network, Inc. (CSNI) looks to create some standardized forms used by the nurse trainers. State certifiers are invited to come up with ideas for other forms that should be unified as well. CSNI Executive Director Jonathan Routhier and Caryn-Ann Ferriter, Associate Director at Community Bridges will be here in January to receive input from NTs on standardizing the medication error report.

Next Meeting will be January 17, 2017.

Submitted by:
Luanne King, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/dcbcs/bds/nurses

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Minutes

January 20, 2015

1. **Meeting was called to order with 22 in attendance, one member trialed attending by phone**

2. **Review** and approval of December 2014 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted. Rivier University scholarship discussion - $250 given in the past, group voted to commit to same amount again. DDNA conference for liaison discussion – group committed to providing $545 towards the conference fee (historically this has been the total amount for the preconference day plus the conference at the early registration rate).
   b) **DDNA liaison report:** .Martha Fenn King told the group that she spoke with Mary Alice Willis, prior DDNA executive director, in December and was informed that the HealthSoft CEU access will be removed from the DDNA membership benefits.

4. **Business Discussion:**
   a) self med (admin) assessment – one member raised a clarifying question – is the deadline for the reassessment to the end of the 12th month – answer – yes.

   b) **eStudio discussion** – who should have access to the DDNNH folder? One suggestion raised was to limit it to paid members of DDNNH – ultimately this was not chosen. Access to eStudio DDNNH folder will be limited to nurse trainers who are either actively working as NT or seeking a position as a NT. Therefore, Kiki will not have access to the folder in her current position with OOS. Cheryl Bergeron volunteered to be responsible for sharing relevant communications from the DDNNH group to OOS. This will allow flow for our ongoing collaboration to continue.

   c) **FAQ –** group agreed that the work done on the FAQ updates could be posted to the website after format polishing and a few small word changes. A member asked that we be clearer in our use of phrases – some say self medication assessment others say self administration assessment. Self med assessment in some practices specifically means what drugs is the individual choosing to self medicate with – including off label practices, alcohol and street drugs. Therefore the most accurate phrasing for our work would be self administration assessment.

5. **HRST discussion excerpts with Denise Sleeper:**
   Denise shared her appreciation for the information that NTs provided about HRST and the draft protocol (referring to the collation of info sent in December).

   Information learned from HRST makes a difference in a person's life and processes to ensure that are being developed.

   HRST is a tool designed for a non health care worker to complete and identify any health related gaps.

   NT is not required to be the point person.

   Service coordinator needs to identify who the most knowledgeable person is – when completing or updating the HRST.

Every Area Agency needs to identify a HRST point person – to ensure raters are trained, processes to implement use of the tool are developed and followed. This point person will be able to determine who needs to have what kind of access. e.g. what access do you have? There is a view only option. This point person will also be responsible for ensuring that there is an accurate log of individuals on HRST – because each area agency pays per individual.

Each Area Agency will be responsible to develop policy to determine who is responsible for what in HRST.

HRST 101 – basic training – looking to be on Relias – which will allow tracking of who has received HRST training.

One member shared – 4 HRSTs due – with deadline of: if not done by Monday this person will be homeless. Service coordinators are leaving off 4-7 diagnoses, incomplete medication section. Denise responded that the deadline imposed upon that NT is NOT the state expectation. It is the area agency's responsibility to have processes in place to emergently serve people who are eligible for services and at risk of becoming homeless.

The HRST protocol (for NH) has bolded **screening** as a reminder that this tool is not an assessment.

Forthcoming changes – there will be a system enhancement on HRST - when a change is made an email will auto happen. One member asked will the auto email notification go both ways – from rater to RN and from RN to rater. Good question – answer unknown, Denise will ask.

Another member commented – oversees individuals receiving services in several regions – for her caseload's biggest region she has no access to HRST for those individuals.

Monthly data tracker – grid for DSP – check off only. Give monthly to service coordinator if there are marks on it and then RN may need to be involved.

Recommendation that DDNNH discuss/compare – HSI and monthly tracker – are there actual overlap items, can the HSI not be used? Are the target populations the same? Where does HSI have content that could be helpful for HRST?

One member commented – the program is not user friendly. Doesn't address: pain, mental health. Feels like it doesn't reflect our individuals and their real lives.

Denise – we haven't given the tool an effective run in implementation to effectively change health outcomes – because as it stands now, our current system is not helping health outcomes as it is (this if based on national health outcomes measures –people with DD compared to people who don't have DD- is there equitable health care access).

Please itemize feedback to the Bureau about specific challenges with using HRST.

Service coordinator group meeting scheduled for Wednesday (1/21) to discuss protocols and systems for HRST implementation.

Area Agency level HRST protocol that Denise has referred to today – Cheryl will share current draft with the group.

Billing – every AA has a monthly contract for $3/mo/person ($36 per person per year) for everyone in HRST. The Area Agency has an opportunity for additional billing when HRST completed - $100/yr

Please consider how HRST could be a better benefit to us – if "x, y, z" were included. RNs could be helpful in reviewing and developing benefits.

CMS has bought into (expectation for use of) HRST implementation in NH.

Next Meeting will be February 17, 2015.

Submitted by: Jennifer Boisvert, RN, Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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Minutes

February 17, 2015

1. **Meeting was called to order with 23 in attendance**

2. **Review** and approval of January 2015 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted. Because Wayne Ward was not present at the meeting, the question was raised for whether he would be able to attend the DDNA conference on DDNNH's behalf in May. Jen asked if anyone was present who had talked to him. Joy Kempton said that she could ask him: if he will be able to go to the conference and whether he has done the network report that was due at the end of January.
   b) **DDNA liaison report:** Jen commented that an email had come out from DDNA with a link to a newsletter – only available to members, but the login didn't work. Other DDNA members present agreed that they couldn't log in. Jen sent an email to DDNA Monday evening. Martha Fenn King noted that she has seen a website under construction notice on DDNA's page.

4. **Business Discussion:**
   a) HRST teleconference – Erin was unavailable to host after our February meeting. Cheryl is in process of attaining a new date. Discussion with those present when preference requested (group experience or from our own computers) – there is a preference for a group experience. Cheryl will try to get a commitment from Erin for after the next meeting (March 17) and if not, then a date will be chosen so that we can participate in this discussion without too much more time passing. The purpose of the teleconference is to openly voice concerns that NH nurse trainers have about HRST in their practice – so that answers can be shared or developed. If the new date is not after a DDNNH meeting, people will be welcome to come to Concord to participate and others will be welcome to participate from their own location. Details will be sent out via email about the date/time. Jen volunteered to send out an email soliciting questions for Erin prior to the meeting – and will post those provided in eStudio.
   - Cheryl said that the plan for roll out of the auto email within HRST when a change is made in a file is scheduled for May/June.
   - One member stated that she feels like she is winging with HRST – she has completed/attended all of the trainings and still feels unprepared.
   - A couple of members questioned why antidepressants are listed in HRST as causing tardive dyskinesia – they have unsuccessfully requested the references to back this up (from HRST). Some members did not know how to find the list of medications in a person's HRST profile that the tool assigns as TD causing.
   - Question was raised – how do we know that the information within HRST is entered correctly (where is it coming from, a reputable source?)?
   - One member who works with an agency providing services to individuals in many regions – says that in one region the CM requests updated med lists signed by the physician – no one else present had had that experience.
   - One member asked if it was possible to have the individual's accurate health information linked through a database to HRST. No one present is aware of anyone who has a current electronic system that could do this. It is an intriguing idea – and would require standardization acceptance across regions – which has been a challenge in other areas of service.
   - One member's major ongoing concern, then echoed by others present, is about the liability of the RN reviewer – how is it that we don't have liability – when we are signing off on information entered by someone else without the ability to verify the validity of the entered information.

b) HSI and monthly data tracker tool comparisons – this was suggested at January's meeting – not something that the group as a whole wants to work on during a meeting. No consensus reached on how to accomplish this comparison. A suggestion was raised to create a "parking lot" section on the monthly agenda.

- One member noted that on the HSI there is no column/question that talks about how the individual communicates – so she adds it on the bottom of the form. This member also said that she had difficulty finding a place on HRST to note if the person is continent or incontinent – Jen suggested Item D – toileting.

c) A member commented that there seem to be new requirements coming forth that require an increase in time spent on checklists and other documents that don't seem to improve the quality of services that the individual receives. Specifically at her agency, she believes that they have a very comprehensive health related system that has been developed and in place without these new tools – yet the new tools are required and deficiencies are received for missing tools.

- Discussion ensued about the tools themselves not being mandated. The regulation requires certain things be clearly documented. For example the regulation lists 9 areas of consideration for annual health screening – the associated provided document isn't mandated – an agency can use another means of documenting that these areas were addressed during the annual health assessment.
- One member stated that she understood that the frail worksheet was required – members answered that the tool is available but not mandated. What is mandated is that the NT document that a frail assessment and outcome has been completed.

d) 525 discussion – Martha asked what experiences people present were having with 525 – are you using NUR 404 and how. She had seen an item in the FAQ update about yearly assessment and 525 was one of the regulations listed though there is nothing in He-M 525 that requires this yearly assessment.

- The specific FAQ item was unspecified – when an item lists 525, then the underlying presumption is that He-M 1201 applies. If NUR 404 is being used for these settings (with staff), then the delegation rules are what needs to be followed. When He-M 1201 rules are being used, then 1201 rules need to be adhered to.
- The family situation that made this consideration arise – uses a Phillips medication dispenser – the family sets it up. It's sophisticated, requires a phone line. The individual could not be successful with self administration without family support. NUR 404 is used in this program – does annual assessment per He-M 1201 apply? No – only applies if the program is using 1201.

e) How long is a PRN order from an ER visit good for? Individual had an order in the community for Motrin 400mg q 4-6 hours for back pain. Pain increased despite use and individual was taken to ER. ER prescriber ordered PT and increased Motrin to 600mg q 6-8 hours – gave 30 tabs, no refill.

- Discussion centered on – this new order supersedes the previous order, the PRN protocol needs to reflect the change, best practice to inform original prescriber of the change.
- This order is good for a year – though, depending on your practice, you may not be able to get supply for that long (in this case only 2 pills were used).

f) Falls prevention series info – included on agenda, uploaded in eStudio. Focus is on geriatrics not individuals with DD or ABD – still may be useful info.

g) A member asked – is there an update on NHH, Lakeview etc? What are we going to have for resources – example – individual living in a group home for about past year. Funded out of one region, physically placed in another and his PCP is in yet another. He has 4 psych meds and no psychiatrist. At Qa RN noticed some EPS symptoms – did assessment and delved deeper into what else was going on with this individual which resulted in the development of a list of issues that need to be addressed: has glasses but they are broken, he's having problems hearing – ears are full of wax – get a ENT consult, difficult time showering – ortho, environmental mods, needs a psychiatrist. He has a new service coordinator.

- Area agencies are in discussion for a plan, for resource development. No specific news shared about Lakeview, NHH.

Next Meeting will be March 17, 2015.

Submitted by: Jennifer Boisvert, RN, Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/dcbcs/bds/nurses

DDNNH@dhhs.state.nh.us

Minutes

March 17, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of February 2015 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.
   b) **DDNA liaison report:** New website went live online last week. Annual conference is coming up – May 1-4 in Atlanta, GA. Poster session submission request – no one volunteered to make this happen. Nominations are open for treasurer for Board of Directors. Wayne is not able to attend the conference – DDNNH scholarship open – discussion about how the manage this within the deadline time constraints – decision made for Jen Boisvert to receive the scholarship (and responsibilities) for this year's DDNA conference. Jen says: "thank you all for your vote of confidence and kind words during our discussion".

4. **Business Discussion:**
   a) HRST teleconference – comment responses of attendees varied. Some are still OK in the process of where we are. Others raised concerns about out of date RN knowledge and remaining unconvinced that inaccurate information input by rater doesn't impact liability.

   b) Cheryl provided copies to the group of the HRST protocol released from NH DHHS on March 13 to the Area Agencies.

   c) Peter Bacon - discussion points raised:
   - An individual is new to 1001 services – they have no meds – question from Area Agency – how do we document? Answers from today's attendees: use either the transition form and/or self administration assessment.
   - Is self administration assessment annual or PRN? Answer – at least annual
   - He-M 507 self administration assessment? No meds while at the program, does get meds at home, never in 507 setting.
   - If individual is assessed as not able to self administer, does annual assessment need to be done? No.
   - Individual moves from home A to home B – everyone is the same except the actual address – is mod 4 needed (e.g. does NT need to re-observe all authorized providers in new home)? Answer: no, unless there is a question of competency. The NT needs to update the medication certificate(s) – could be a new start date, same end date or could be copy of old cert with notation of new address.
   - How do you destroy meds? Meds were flushed – would there be a deficiency cited? No citation because this is not specifically addressed in the regulations. Many present offered the recommendation that we should never be flushing meds – they should be crushed and mixed with something (e.g. used coffee grounds).
   - Med committee may ask about how do you (the NT) keep a large number of authorized providers current (e.g. 4 individuals – 29 authorized providers). This raised a side comment about how many sites can an authorized provider safely stay up to date – this is from an old version of the regulation – it used to say 8. Now the regulation is silent – the individual agency can set parameters. The NT needs to have a process in place and be able to articulate it.
   - Situation – in a 1001 setting – 300 Ativan in a bottle – haven't used for past year, supply is unexpired. Discussion around destroying a portion, preparing authorized providers to not stockpile or ask

pharmacy for a partial fill (which we know pharmacies do not prefer to do – but will usually do when asked).

d) Penny – HB #2 item #62 proposed to consolidate joint boards of licensures – contact your legislature members. Information is available on NHNA webpage. If this happens, at the very least licensure fees will increase. Links: original bill - http://cqrcengage.com/nhnurses/app/bill/520213 NHNA call to action update - http://www.nhnurses.org/Homepage-Announcements/News-and-Announcements/HB2.html

e) HRST newsletter sign up – If you are a NH RN and not already receiving the newsletter – send a requesting email to: gina@hrstonline.com

Next Meeting will be April 21, 2015.

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/dcbcs/bds/nurses

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MINUTES

April 21, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of March 2015 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.

4. **Business Discussion:**
   a) HRST discussion continued. Cheryl passed around flyer on HRST 3.0 upgrade. There will be a webinar on Friday 10:30 – 12:30 demo'ing the changes – space is limited. People who indicated interest in participating (outside of the subcommittee looking at redundancy in forms) see Cheryl at the end of the meeting.

   Looking at frail list and how to eliminate redundant documentation. Looking to figure out a way for a person who is rated HCL 1 or 2 and has diagnosis like asthma or diabetes that generally are OK – until an episode tips them over into frail period. Only nurses would be inserting this piece.

   List of how many people in NH have been HRST rated and/or are still unrated – passed around.

   Common med entry errors – we should be sending back to the rater, not fixing it ourselves. Ellen from Region 2 says that the HRST doesn't allow RN to make changes at their agency so they have to send back to the rater for corrections. This seems to be a permissions boundary at this agency rather than something HRS has put in place.

   Cheryl – if you as a NT don't have access to your clients' HRST with a particular region – send an email to Cheryl listing who you don't have access to.

   b) Nominations – **DDNA liaison** – this is a yearly position. Debbie Ellis-Nailor, Lynn Geoffrion put their names in for consideration. Wayne Ward was not present at today's meeting, Ellen believed that he would be interested to be considered again. **Treasurer** – Dianne is willing to continue in her position – however, she may not be available for the full 2 years. Liz Nelson volunteered to shadow to learn the position since they work together – this will provide us with someone to fill the rest of the position if Dianne does leave early.

   c) IM Glucagon – Cheryl looked at waivers going back to 2011 – there were only 2 requests. There is a bill at the legislature now about school access – which would be for non nurses to administer.

   Can we waiver this? Do we need to? Depends on whether ordered SC or IM. In 525 example – Mom is trained, wants to have staff – can they be trained?

   Does anyone have IM glucagon? – a few people. Wayne K – efficacy of Glucagon SC vs IM is equivalent.

   Cheryl – there is a known and accepted protocol for when/how to use Glucagon IM. She has some information from other states about use of Glucagon – all info is about IM.

   To all: Please look for Glucagon orders in your program – are they SC or IM? Bring or send info to Cheryl.

   Penny found an app for Glucagon – looks pretty clear, has training: lillyglucagon.com

d) Doc-U-Dose/blister pack – handouts provided. What do you do when there's a med change?

Ellen – has an individual who is self administering – most helpful for people who don't have many med changes. Experience with providing pharmacy is when there is a med change, the supply is taken back and re-packaged, this individual has some challenges with different bottles (if you have added med provided in bottle form until current packaging runs out).

Sherrie – Several individuals use in the Nashua area – only one pharmacy (Hollis Pharmacy) – home care providers that use them – swear by them, do their triple check, there is an additional cost. Pharmacy takes back and repackages with med changes.

Penny – pharmacy has sent bottle for med change, RN took the pill out – means that the RN has to be able to identify the med to take out, manage the small slit etc.

Controlled meds – separate container because of need for counting.

Pharmacies have made errors – mostly at first – increase your communication = resolution. In one case it was because the prior authorization ran out, so the med was not supplied).

Ruth – new pharmacy coming to Manchester through Greater Manchester Mental Health Center – The Moore Center will be transitioning staffed residences. Pharmacy will be sending out only 2 weeks supply at a time.

Pharmacies can provide either 2 week or monthly supplies.

e) BDS audit of NT contact hours per He-M 1201.10(d) and (e) – Cheryl will be randomly selecting 10% of NTs and sending out letter to seek compliance information. There was a general discussion about possible places to get credits.

f) New business discussions:

Eileen – passed around handout from NHNA regarding HB2 – strong advocate for keeping separate BON rather than having combined licensing office.

BON has asked to be removed from the med committee – they have not been sending a nurse, usually a nurses' aide.

Penny – surveyor – made a recommendation about how to count Diastat that was not the same as the NT expectation. Staff almost changed to the surveyor's way without discussing with NT.

May 5 – budget discussion hearing – looking for speakers with stories. Have to register to speak, be prepared for a long wait with understanding that you may not be called to speak, then hand in written testimony.

Nurse practice issue: New order for individual with dementia issue requiring self catheterization. Case manager supported the individual at the appt. Staff at the home is very uncomfortable with idea of even helping with this task – this is a very independent style setting. RN is not comfortable delegating.

Another nurse shared a positive story of individual with autism who successfully self caths.

Suggestion to look into self cath products – there are all in one products available on the market.

WellSense – there have been challenges dealing with them approving medications – particularly noted to be slow with approving antibiotics.

Next Meeting will be May 19, 2015.

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/dcbcs/bds/nurses

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Minutes

May 19, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of April 2015 minutes as written.

   a) **Officers Reports:** **Treasurer's Report**: Read and accepted with 2 paid today.

3. **Business Discussion:**

   a) IM Glucagon discussion continued – Wayne K was not at meeting today. Med committee discussed – do you need a waiver or not – answer is not if the order is for SC, yes if for IM. No one emailed Cheryl with glucagon orders. 2 nurses present currently have individuals with IM orders and are in process of changing to SC.

   b) Voting – 20 members voted (1 electronically). **Congratulations** to Dianne and Debi - Treasurer – Dianne Crone. DDNA Liaison – Debi Ellis Nailor

   c) DDNA conference – next year is in San Diego, CA. April 1-4, 2016

   d) 2 handouts from DDNA conference reviewed – DDNA's annual membership meeting and letter from nurse researcher (Kathy Auberry) about participating in an upcoming seizure study.

4. **NEPS (Northeast Pharmacy Services)** presentation of their medication packaging system. NEPS was created in 2004, they have worked with many group homes and fielded many questions from assisted living facilities. They looked around for the best packaging system to deliver patient safety. Each person present at today's meeting received a NEPS sample folder and example packaging. NEPS is a closed pharmacy – clients cannot walk in off the street. Packaging is done by robotics and they are paperless. NEPS does post consumption billing. Typically med packages are dispensed 1 week at a time – they send 2 weeks supply outside the Concord area – these are mailed. There can be up to 4 doses in each packet.

   Q: If there is a change in the order what happens? A: NEPS sends a vial with small quantity to get through to the next package cycle. The home would be responsible to remove the dose that is changed. If this is a non critical order – ask the MD to write the order to start when current supply is exhausted. Worst case scenario – 3 week lag to change package.

   Q: antibiotic/critical med – how to manage? A: Example – antibiotic, chronic pain – mail supply out same day the order is received (overnight mailing) – this timing could still be an issue for the patient. Might need to have a local pharmacy if the med needs to start today.

   Q: What is the cost of the service? A: $35 per person charge for NEPS service. CFI waiver can cover fee currently (majority of NTs do not have individuals on the CFI waiver though).

   Q: MCO acceptance of this process? A: MCOs don't know yet, meeting scheduled to discuss.

   Q: PRN meds. A: Handled separately. PRN meds are not automatically sent. NEPS waits to send until asked. Occasionally NEPS will prompt if there is a pattern of usage.

   Q: Camp meds? A: NEPS doesn't package for just camp meds.

Patient/caregiver **MUST** talk with prescribers to clearly say that the **pharmacy of record** is NEPS – so that orders don't go to the local pharmacy.

Concern raised by member re: staffed residences – fear of liability if unlicensed provider is removing dose if order is changed.

Another member asked about how do we ensure triple check process works? Two members discussed their positive experiences – stable meds, not group home. There are a couple of extra steps added. Works great.

NEPS reps – this service is specifically meant for patients whose meds are stable.

NEPS ex. – can split supply if going to dialysis or out with family for the day – all supply is still properly labeled.

NEPS – prior authorizations – can be an issue for billing. If med is dc'd within first 2 weeks of the package cycle – only pay for 2 weeks, not for the rest of the month.

Terri shared her experience with Med World in Nashua – blister pack comes with a sticker – sticker is put on the med log. They have had issues with light sensitive meds and liquids (which can't be packaged). Med World will re-package if you take current supply back. The most useful aspect of this type of packaging – prevents running out of supply.

5. **Peter and Kiki**: Order date that you reference in your med log entry is what you display – age of date doesn't matter. Issue with med log that says 2013, med order itself is dated 2015 – that is a concern.

Q: How long do we need to keep records? A: (from group) 7 years. Although a recommendation from a nurse attorney at DDNA a few years ago was to keep records for 10 years.

Q: Drug info sheets – only need to have ones for current meds in the med log book.

Q: QA when (in 30 days, 1 month) after respite in certified home? A: Old regulation required within 1 month. New reg is at NT discretion.

MFK – He-M 525 has paid staff, lives with family – going for respite in 1001 setting – which rule applies – 525 or 1001? Do we follow the money? A: Peter says can have certified bed for fire code. Doesn't matter for meds – follow the money rule. Peter and his staff don't look at any records for individuals in 525 settings – not in their purview. Peter reminded us that there are currently certified homes that have 1001 certified beds and the same home also provides services for an individual with 525 certification.

Q: How does a NT manage their practice when 1001 and 525 services are provided in the same setting? And there could be 2 agencies responsible for the individuals receiving services. A: Develop a moral best practice.

Q: RN with current license and pharmacist with current RPh – if coming in to administer meds in certified setting – so they need med training? A: No – need copy of license – license needs to be active and in good standing. If they do not want to administer meds using their license, then they do need to be med trained.

Q: compliance form – is it required? A: No – no specific form is required/mandated for any of our work – except 1201 A, B, and C forms plus waiver forms.

Kiki – HSI – not documenting that review is occurring.

Q: Member asked about medically frail – how does NT oversee? What frequency? A: Your agency decides. Related discussion point - Medically frail worksheet – goes to CM/SC – doesn't need to be sent to Cheryl.

Peter's next visit – September meeting.

Next Meeting will be June 16, 2015.

Submitted by:
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Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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Minutes

June 16, 2015

1. **Meeting was called to order with 22 in attendance**

2. **Review** and approval of May 2015 minutes as written with 2 spelling corrections.

   a) **Officers Reports:**
   Treasurer's Report: Read and accepted.
   DDNA Liaison Report: Wayne as outgoing – DDNA website is improving since beginning of the year. Free courseware was due to be available this month – nothing yet. Debi as incoming – encourages our membership to consider over the summer writing an article for DDNA newsletter.

      1. Question raised about how to get DDNA membership paid for? Reminder to all present that the back of our monthly agenda has a paragraph about BDS' ongoing incentive program. Many were unfamiliar. One member asked if it would be helpful to develop a templated request – no one signed up to participate in the development.

3. **DDNA conference report:** Attendees comments: this conference was much more of a nurturing environment for nurses working in the field rather than corporate feel. Photo booth was fun. See attachment for Jen's report as recipient of DDNA Liaison conference scholarship.

4. **Business Discussion:**

   a. Meeting space for DDNNH – the South Function Conference Room will no longer be available – construction scheduled to start over the summer to turn it into office space. Maureen looked around to find a comparable conference space (that has sufficient room for the attendees and allows food/drinks to be brought in). She was able to schedule our September meeting at Community Bridges in the Wolfenberg Conference Room. CB is located in Concord at 70 Pembroke Road. The group agreed to try this space and see if it meets our needs (and if the host will allow us to come back for further meetings).

   Members were asked to think about and suggest other potential meeting spaces in case CB does not work out. In the interim, as a fallback, DDNNH is booked into the Brown Building Auditorium for October and November (only bottled water is allowed to be brought in and the stadium seating makes it difficult to have inclusive conversations).

   b. 1. Diastat – how do you successfully use in public (ex. During day program). Ellen stated that Dr. Thadani, when presented with the practical question of how to, recommended Klonopin wafers. A couple of people also mentioned Midazolam nasal spray – although the wafers are more convenient to administer – you just can't touch them or they dissolve. Wayne King mentioned that in his practice it seems that the Diastat was ordered by pediatric prescribers and just maintained into adulthood rather than discussing practical community needs.

   2. Wayne brought a Glucagon kit to show to anyone who has not seen one recently. Discussed IM waivers – BON is not supportive of IM waivers – other than Epi-pen type. Efficacy of delivery system – IV, IM or SQ are all the same – so use SQ. The needle for the glucagon kit is a little longer than an insulin needle. A picture with the difference plus the Glucagon insert info has been uploaded to DDNNH's eStudio acct.

c. Controlled drug supply – for day program, kept in home care provider's home while not in day program – does it need to be counted? There was a lot of discussion on this. This specific example is not a shared supply – the home care provider (HCP) has a separate supply for use at home. The day program is community based – but not out of a physical setting other than the home (there is no day program site to go to). One member has a similar situation and instituted a double count system – the HCP and the day program staff count out and in the supply, both signing each time. Wayne King stated that he had seen alternative storage waiver for day program – when the med was only ordered for day program. This could be a possible solution if the HCP does not want to participate in responsibility. However, a waiver would need to clearly indicate that the HCP does not have access to the day program supply at any point.

d. 5 year plan – NH Council on DD. 21 members sit on this Governor appointed council, divided into 3 categories of 7. 7 members are self advocates or family members. 7 members are mandated seats. Kenda sits on the Council as a member of PPN. The Executive Director, Carol Stamatakis is requesting stakeholder meetings/input. A handout with goals and strategies and the 3 questions for discussion were provided to the group. It is clear that the answers/ideas generated from a group of nurses will likely focus on medical topics – and that is fine. The first question " What should the future be like for people with developmental disabilities and their families?" was discussed during the rest of the meeting. Ideas for comments for the other 2 questions were welcomed to be submitted via email to Kenda at khowell@resresources.com . The main website for the NH Council on DD is: http://nhddc.org/ and the current 5 year plan (expiring 9/30/16) can be found in the list on the left hand side of the webpage. Here are the concepts offered during the meeting that Jen captured:

    a. Employment opportunities – provides sense of self worth. Cautionary tale was offered by Debi – her daughter has worked for dining hall at local college. She wants to work more hours, but her work ethic and output is so great that she gets a raise and that results in a decrease in hours offered. She was originally working 25 hours a week, now works 7 – the rest of the time she is sitting at home.
    b. Neuropsych unit or psych services availability. NHH just flat out refuses to take anyone with IDD.
    c. Dental health opportunities missing – need more than just extractions
    d. Vocational goals are not appropriate for everyone – shouldn't be a cookie cutter approach. Ex. Offered – 80 year old receiving supports, still has a vocational goal.
    e. Educational programs for providers/families for health issues/potential (better preventative education and healthcare)
    f. MCO seen to be looking at goals as more measurable and related to health (more realistic to ISAs)
    g. Natural supports – sometimes natural supports is someone else who is receiving supports has developed a friendship relationship. Sometimes 507 CPS interpretation is ripping apart friendships that have developed.
    h. Focus on families – more available respite.
    i. Sexuality – needs to be addressed.

e. FAQ update work this summer – Jen asks if anyone is interested and available to meet in July and possibly August. There are several topic areas that were identified in our last overhaul effort that are not addressed at all in FAQ that could be helpful. Eileen Murphy-Hamel stated an interest, Leslie said maybe there is some interest of nurses in Region 5 – she will check into it. Jen will send out an email to the group to see if there are enough interested members (need 5-6, not more than 10). Currently BDS conference room is booked for us from 9 – 12 the 3rd Tuesday in July and August as a possible workspace.
f. The group was asked if nurses are being asked by other agencies to create care plans. All present (other than the member asking) said no.

Next Meeting will be September 15, 2015 – NOTE LOCATION CHANGE (see 4 a) !!!

Submitted by:
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Developmental Disabilities Nurses of New Hampshire

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Minutes

September 15, 2015

1. **Meeting was called to order with 22 in attendance**

2. **Review** and approval of June 2015 minutes as written.

   a) **Officers Reports:**
   Treasurer's Report: Read and accepted.
   DDNA Liaison Report: DDNA certification discussion. Reminder that the 2016 conference is in San Diego – DDNA is looking for speakers. Membership fees for national are $80. There are 3 courses coming up – free courseware for DDNA members. The Mary Gage award went to Mary Gage this year. Debi reminded us to consider writing articles for the DDNA newsletter.

3. **Business Discussion:**

   a. DDNNH meeting space in October – group decided to try the Crotched Mountain conference room at ATECH – 57 Regional Drive #7 in Concord. It's the last office on the end. Community Bridges space was fine – not many more members would fit comfortably in the space. CB also cannot book out the conference room into the future and we could be bumped if they had a priority need for the space.
   b. Nurse practice question – if a recert med certificate is dated 3/31/15 – 3/31/16 with a notation of med observation 5/20/15 – is this OK, has anyone seen this before? Answer – depends on particular agency policy for recert. Class vs service dates can be different. It's possible that this authorized provider attended a retraining class with the agency and then was unable to be med observed for a variety of reasons until 5/20/15. So long as meds were not administered by the provider and the agency's recert process was followed this is OK. An example was raised of the individual receiving services no longer receiving meds – then how do you med observe the provider? – as a potential rationale for the difference in time. Jen added – consider developing/delineating policy for the agency that you work for/with to address this challenge.
   c. Cheryl – has received requests from companies to present info to the DDNNH group. Compassionate Care Hospice - serves Manchester/Londonderry area. MassTex Imaging (now that they are NH Medicaid authorized – yay!). Members of the group were OK with presentations so long as they are not all at once and don't take up entire meeting. Cheryl will work with both groups – hospice sometime in beginning of 2016, MassTex with van hopefully in November. Jen – if MassTex comes in November, it will be good information to have, there won't be time to get CEUs or contact hours. A new member to the group thought that there was a quicker process than we last experienced and will research it and get back to us.
   d. Penny – shared positive experience that she had using Convenient MD urgent care in Concord. They were very accommodating to request to not have individual have to wait in the waiting room – in fact they pre-registered over the phone and the individual was actually seen in the parking lot. Good paperwork, they sent the info to the PCP office, called to check on the individual.
   e. Ellen M shared with the group that Dr. Thadani at DHMC-Lebanon is not just a neurologist. He also has a dental clinic there – which she has had good experiences with.
   f. Helpful tip from Debi – for individuals who have difficulty with lab draws – consider trying soap and water skin prep rather than alcohol….the smell of the alcohol can be the trigger for issues.

4. **Peter Bacon** joined us for our ongoing collaborative discussion.

   Question raised about cert deficiency – NT had reviewed and signed ISA. The individual and provider moved – NT reviewed the HSI and health history, there was no new ISA, so NT didn't re-sign it. Suggested solution – nursing transition form can be used to document that you have seen the ISA.

Question – are surveyors going through the med logs? Program received a new PRN order over the w/e, protocol didn't match (NT wasn't aware of order change). Answer – if orders are in the med logs, then yes. Surveyors also may see med logs when they look for the controlled logs. Some agencies take the orders, PRN protocols and controlled logs out of the med log for the surveyor visit, some leave them in. Surveyor needs access to the orders, PRN protocols and controlled med documentation.

Question – recently did 3 online certification reviews – went really well. (Treeno – software used). This NT is accustomed to primarily working with individuals who are dually diagnoses. Now working also with individuals from Lakeview who have a brain injury and history of noncompliance or street drugs. NT is concerned about self med authorizing or even bringing up the conversation because she wants to always build trust with the individual receiving services. Suggestions – team approach – use steps to demonstrate participation in processes. We cannot violate people's rights. We might not like that they are their own guardian. (Can MD write order to say they can't be self medicating?)

Question – paper certs for biennials – 5 controlled meds – how to archive material to be prepared for surveyor visit? Answer – the same type of review process is expected – so same information is needed by the internal reviewer.

An individual who is assessed to give their own meds and is their own guardian – because of anxiety changed her mind and signed over responsibility for med authorized providers to administer. Concern expressed from surveyor that individual was being taken advantage of.

Question – for a temporary cert – 5 day visit documentation – do you need to do more than one if it becomes a permanent placement? No – only need one 5 day visit review.

5. **HRST** – Cheryl and Peter

HRS will be coming back to provide more training in October – there will be specific training for RNs based on responses to the recent survey sent out (if you haven't filled it out, please do so). Do we want to have the training time take over the regular DDNNH meeting time or come back after lunch? Majority of those who voiced an opinion wanted to retain our meeting time for our own group. Those who are able to spend the day will come back for the afternoon training. Cheryl will check on technology needs of HRS with availability at ATECH. If compatible both meetings will be held there.

Peter shared that the HRST monthly data tracker will take the place of HSI from surveyor perspective. If surveyor sees a concern with HSI at current certs, they will cite as a concern rather than deficiency. Look for the monthly date tracker over the next 6 months. Question was asked to Cheryl if this will be a state mandated form – answer – yes.

Many NT have had little communication from area agencies about HRST. One area agency continues to prevent vendor RNs from accessing HRST (3 NT from different vendors spoke up about this again). Cheryl will send out an email to the group about **who** is the regional HRST coordinator for each area agency – that is the point person to solutions for that agency. Cheryl reiterated that RNs must have access to HRST accounts – send email to the regional coordinator.

Question – what about the medically frail list – will area agency need to send out email to ask NTs to update info every 6 months? - no…there is a toggle on HRST for the RN to turn on if the individual is medically frail. The RN would then write the supporting note under the case management button.

Peter commented that eventually surveyors will want to see HRST record at surveys.

Next Meeting will be October 20, 2015 – NOTE LOCATION CHANGE !!!

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
http://www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

MINUTES

October 20, 2015

1. **Meeting was called to order with 30 in attendance**

2. **Review** and approval of September 2015 minutes as written (with one item additionally discussed below).

   a) **Officers Reports:**
   Treasurer's Report: Read and accepted.

3. **Business Discussion:**

   a. Review of the September minutes resulted in a member asking if there was any f/u to/from Peter in regards to the surveyors concern about the individual being exploited for giving her own meds. The NT responsible for program oversight was uncertain if that surveyor concern was written into the cert review – she will look into it and email Cheryl Bergeron if it was.
   b. FAQ subcommittee work review – each item was individually read and discussed. Question #1 will have "HRST includes medical fragility designation as part of the RN reviewer role." added at the end. Question #2 was accepted as written. Question #3 will have OTC added to "medicated cough drops". Question #4 was accepted as written. Question #5 was deleted as recommended. Question #6 was recommended to be put in regulation related section of FAQ rather than Nursing Practice. Question #7 – accepted as written. Cheryl Bergeron will check in with NH BON regarding thoughts and ideas of real time video usage.
   c. Discussion around meeting space – ATECH conference room is booked and available 3rd Tuesday through June. Chapel at the State office is open on the 2nd Tuesday of the month. If we do not hold meetings in State office space, how will we manage our handouts, nametags etc. Members present at today's meeting are willing to print own agenda, consensus was that we didn't need a printed version for all members of the treasurer's report. Members will also be responsible for printing out their own copy of the draft minutes. A motion was presented that the group stays at ATECH conference room on the 3rd Tuesday through June – the group voted yes. The group also decided that each member will be responsible for their own nametag. Carla Houck from Community Bridges kindly volunteered to be responsible for the unclaimed nametags and make sure that they come back to the next meeting.
   d. Lakes Region Services (Region 3 in Laconia) – very desperate for nurses to pick up any hours. There are also openings at One Sky, Community Partners, Granite Bay Services and The Moore Center. This led to a discussion about how to develop nurses awareness and interest in our field – perhaps we can proactively go to nursing schools and provide info about our specialty. Can we do a mailing advert – this would be expensive. Many nurses don't know anything about DD nursing – that it even exists. Advertising idea – write an article for the NHNA paper. Be interviewed on local TV. Write content of our stories – as nurses working in the field of DD – why do we like it etc. Debi Nailor volunteered to spearhead a small group to develop content for presentations. Janet Harmon volunteered to put our written experiences together – so go forth, write and send to her. What about job fairs? Ex: DDNNH members having a spot (table) that talks about the specialty – not talking up any specific job. A member suggested writing letters to nursing schools – maybe asking DDNA do they have a small curriculum to offer for nursing students. Pam TM has contacts with NH 1 when we get to that point. Another member suggested considering creating a YouTube video. Wayne King suggested a committee for outreach – e.g presentations about syndromes.
   e. Cheryl Bergeron updates on learning: MassTex Imaging isn't available to come until January – they may or may not have the van with them depending on scheduling but are happy to come and provide info about their services plus an inservice. Compassionate Care offered to do a Lunch N Learn – they will provide lunch. The group then discussed the timeframes, the need to increase the meeting times in order to accommodate both the regular meeting and the learning opportunity. Cheryl will check with both companies to see if 11am will work and the group agreed to extend these meetings until noon.

f. Future new business topic requested – have the group talk about discussing changing the med curriculum to 4 hrs video portion and 4 hour in person (for example) – will be put on the agenda for November's meeting.
g. Leslie requested that the group talk about adding a statement to FAQs about medicated toothpaste, e.g. Prevident (November's meeting)
h. Pam White's BON contact hour "homework" – information is available on the NH BON website. Excerpted section from: http://www.nh.gov/nursing/licensure/continuing-competence.htm includes this note:
Please note
The Board does not require that your contact hours be earned at conferences that provide "official" contact hours granted by a professional organization. However, the educational offering must:
    - Have specific objectives that guide the learning
    - Pertain to and enhance the licensee's knowledge, skills and judgment
    - Pertain to the licensee's scope of practice
    - Have a method for evaluating the learner's attainment of the objectives
    - Maintain a list of attendees
    - The licensee should maintain documentation of attendance that includes: the title, length and date of the offering and the name of the entity providing the offering.

Next Meeting will be November 17, 2015

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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MINUTES

November 17, 2015

1. **Meeting was called to order with 27 in attendance**

2. **Review** and approval of October 2015 minutes as written.

   a) **Officers Reports**
   Treasurer's Report: Read and accepted. The treasurer reviewed that our average number of members has been 31. If we do not increase our paid membership numbers and continue to support the 2 annual scholarships ($250 to Rivier and ~$545 for DDNA Liaison conference registration), we will need to access our savings account to pay for the difference. (31 members at $25 each = $775 vs expenditure of $795)

3. **Business Discussion:**

   a. ATECH tour/overview – the members present indicated interest, a suggestion was put forward that perhaps we could plan to come early (9:15a) in December. Kenda will ask Dennis (ATECH's director) and a notice will be sent out to inform the group.

   b. FAQ item development for Prevident toothpaste – group discussion ensued with requests to add other toothpaste and mouth rinses to consideration. Kenda and Jen volunteered to develop the wording based on concepts discussed and forward to the Medication Committee for consideration/comment. (Prevident toothpaste, ACT, Biotene and their generic equivalents were the products decided upon as relevant to include.)

   c. A member asked about how to report 1201a information on the 6 month report when an interim 3 month report had been requested. Recommendation was to incorporate information from your 3 month interim report into your 6 month report. There are no hard and fast rules on this. If you are receiving the request for an interim report when your next 6 month report is due, ask the relevant Area Agency decision maker for guidance in developing the appropriate report (ex. Do they want a 3 month interim report and 6 month report submitted together or perhaps they would prefer to have the full 6 month report with documentation about the timing issue.)

   d. A member asked if Prevident has to be included/kept in the med box. Appropriate storage management is an area within the NT's role. One suggestion offered was for the NT to document that the Prevident supply could be kept in "x" area unlocked.

   e. Discussion around full med curriculum proposal – a member shared that many places use Relias for trainings (which is all online). Ongoing budget issues are going to be a part of companies' training consideration – how to spend resources – what are the best resources, acceptable compromises etc. Some NTs present were open to the training having an online video version option that would be available as an option though not required for everyone. All agreed that it was very important for the NT to have interaction with the students.

      i. Factors that could be helped by a online training version include: ESL students, students not having access to transportation or time flexibility due to work or family or school commitments, offers time and tools to do work on own – could be helpful with remediation

      ii. Additional comments – interactive testing for online portions. Background of system and overview of responsibilities – some of the beginning section(s) could be covered in an online version. A member suggested that if the online version was used, the NT could give a competency quiz at the opening of the in person training to determine student's retention on online learning.

iii. One Area Agency has found that online training outcomes with providers in staffed residences are not as effective – providers are not effectively getting rooted in the application of the trained principles.

iv. Currently received training evals – NTs who have used these say that students consistently comment that they enjoy NT examples/stories and students usually comment negatively on the current videos.

v. One member raised a concern about NTs giving away our power – if NTs "only" teach in person for 4 hours, this may be a consideration of budget preparers and may be looked at as a way to decrease nurse funding.

vi. One member commented that there would need to be a framework for employers – since online learning has suggested timeframes – one person may take 15 minutes to review/learn the material and another may require 2 hours. Employees would need to be paid for training time – at least the amount of time estimated as the expected timeframe.

vii. How to create film/video updates – suggestion to involve interns. Penny has some sources that could be helpful.

viii. A member in reviewing the regulation does not see statement that the state curriculum is required to be used.

ix. Do we need to create a separate video? Could there be an online video that meets our needs already available in YouTube? HOMEWORK for the group – search for med admin YouTube videos, review and pick ones you like/prefer for the group as a whole to review/consider.

f. How do we as nurses get to the table of relevant system discussions? The way that we do this is collaboration – being open to discussion, being available to participate in discussion, not being seen as just being a pain to work with but that we will be professional and appropriate in our discussions including when we disagree.

g. Discussion came up – some NTs have heard that HSI will no longer be required at all as of January 1, 2016, just need a copy from sometime in 2015 in the record, then no more updates needed. The monthly data tracker from HRST will take its place. Many NTs have heard nothing. Question to be sent to Peter and Cheryl for confirmation or clarification of expectation.

h. Some members of the group are unable to log in to HRST – the root cause seems to be (after discussion) that the web address prior to the September upgrade doesn't go anywhere. New address provided to those present: nhbds.hrstapp.com

Next Meeting will be December 15, 2015

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire

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Minutes

December 15, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of November 2015 minutes as written.

   a) **Officers Reports-**
   Treasurer's Report: Read and accepted. A discussion ensued about holding raffles to raise money (to supplement our funds other than membership dues). 50/50 raffle idea – Denise Lazott agreed to manage this and bring tickets. We will have a raffle opportunity each meeting. Ruth Beland showed us a lovely quilt piece that she will donate for us to raffle off to raise funds. Thank you Ruth!
   DDNA Liaison's Report: Debi contacted DDNA and learned the name of her contact (Katy). 1 DDNA membership = 1 – meaning that a facility cannot pay for one membership that is then used by several people within the facility. Debi spoke of the value of specialty certification and offered encouragement to consider and pursue. Debi also mentioned a docu-series on A & E that started Dec 8 called "Born This Way" – about people who have Down Syndrome – she saw the first one, liked it, it's pretty raw and honest. 6 weekly episodes are planned. Another member commented that Madeline Stuart is a model from Australia who recently walked at NYC fashion week (positive role model for I/DD)

3. **Business Discussion:**

   a. Cheryl has received emails about preventative screening updates (the form) – she has an example from Cigna – she's not sure if it references DD specific areas and will check. She is not looking to mandate change, just inform.
      i. Cheryl also reported that in the future ISAs will be standardized and uploaded on HRST.
      ii. HRST monthly data tracker will be the document used going forward (instead of the current regulatory requirement for HSI). There will be formal communication from the State forthcoming.
      iii. Cheryl reminded everyone to update HRST with medical fragility status of individuals – right now the State is running reports just looking at Y/N answer. That is an easy toggle on the About Me page for each individual. Default setting is N. Discussion in process with HRST about moving the comment box for medical fragility from the current HSI form to the About Me page. In the meantime document comments on the HSI form in HRST.
   b. A member recommended that something be created for simplified instructions on "how to" in HRST. Because there wasn't a need to log in for the past month, some steps that seemed obvious and clear then, are challenging to remember. The specific question was answered at the meeting. No one was sure how to be more specific in this request to help have a successful product.

   Peter Bacon's ongoing collaborative discussion topics:

   c. A member raised a question about a CPS cert deficiency – 1 person has meds administered, a few others are self administering – there has been push back from families about annual review. None of the individuals who self administer take meds during the day program. One concern raised was – what if they are out shopping and buy something? A: If we don't know that the individual has a med that they are taking, then we cannot f/u. If we know, then we need to do the assessment. (For this particular vendor, the previous NT did annual assessments regardless. Question from group was raised whether this was a written policy or not. Not written. Reminder – the surveyors will hold agencies accountable first to the applicable regulations as a baseline standard. If the agency has a company-wide higher standard written in policy – then the surveyors will hold the agency to that standard.)
   d. Peter provided the group with an ongoing example of a current challenge – during a certification survey, Peter asked a question about the NT and discovered through f/u questions that the vendor agency had not had a NT for

weeks. One result was that many providers' med authorization had lapsed. This vendor agency has multiple contracts with different AAs – all of whom were apparently unaware that there was no overseeing NT. Recommendation to the group – if you are leaving a position and know there is no NT covering, call and give Cheryl a heads up.

e. A member asked about 5 day and 30 day visits. A new home care provider devised own med log on laptop/tablet – which NT saw at 5 day visit. When NT requested a copy be sent to her, the file was not printable. The HCP is electronically "signing" by entering initials on his device. Is this acceptable? A: Not unless the program is clearly permission restricted. As an example – Lifeshare has a program that they own. HCPs have their own access code so that they "sign" and "initial" electronically (a type of electronic medical record).
f. Peter said that the surveyors have not seen any particular medication trends in the last few months.
g. Discussion about med safety – especially when going out to/with friends/families. Some NTs have experienced challenges with administration and supply accuracy when the individual is visiting with friends and/or family. This can be particularly concerning when reconciling controlled med supplies. A reminder to all – don't send original med logs – copies are fine. Suggested practice – have authorized provider sign out on the controlled log how many meds were given to friend/family and an authorized provider would sign back in however many were returned.
h. NOTE: surveyors will be looking for the HRST monthly data tracker as of January 2016 – to be in place in the individual's record instead of the HSI. There will continue to be an expectation that RN/NT has reviewed the data tracker – similar to expectations with HSI.
i. Further discussion around 5 and 30 day visits. It is possible to fulfill the requirements for both visits within the initial visit if all the pieces are available.

Next Meeting will be January 19, 2016

Submitted by:
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Minutes

December 16, 2014

1. **Meeting was called to order with 16 initially in attendance, then 29 by 9:20am**

2. **Review** and approval of November 2014 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.
   b) **DDNA liaison report:** Diane Moore will be the new executive director for DDNA as of 1/1/15. A reminder that DDNA has CEUs available free on their website for members (and a plug that DDNA membership is supported by BDS – see the paragraph on the back of every month's agenda). Jen reminded/informed Wayne that historically DDNA has required an annual network report due by the end of January – though there may be new processes with a new executive director. Jen volunteered to help as needed for the report completion.

4. **Business Discussion:**
   a) **FAQ update** – thank you to those who have reviewed and provided comments. We will pend discussion of our homework to January's meeting. If you didn't finish your review – now you have extra time. In particular focus on: 1) flow within category heading, 2) clarity of information provided (one reviewer helpfully questioned a statement that would have changed the practice to something that was not considered nor approved), 3) are any questions missing – send/bring these to Jen to collate for future subcommittee meetings.

   Jen is hopeful that we will be able to complete our review of the current draft FAQ updates so that they can be posted on the web for more public access.

   The draft version is currently available in eStudio.

   b) Jen is not requesting copies of our various projects in process to be printed out by the state for the group each meeting – this is too much paper usage. She is also not volunteering to print multiple copies at her agency's cost. Individually we should be able to share the cost of printing if a paper copy is needed. People who do not have eStudio access to these documents may request copies via email from Jen at: Jboisvert@resresources.com

   c) **HRST recommendations collation** – thank you Debbie for taking on this task! Debbie collated the information she received into a document that was posted on eStudio. Cheryl provided a copy of this to Denise Sleeper and Lorene Reagan this morning – Denise sends a big thank you to the group for our responses. Denise will be joining our meeting in January to talk more about HRST – Cheryl will invite her (to make sure that she is available that day) and email Jen with her availability and desired time.

   d) **Kiki's clarification questions** – review by the members present of the discussion from November's subcommittee meeting. Please see attached list of questions and responses for the results of today's meeting discussions. (Group responses for Kiki and Peter's discussion were incorporated with the recommendations from November's meeting and presented verbally to them. Where applicable expanded comments were added in the notes from the discussion with Peter and Kiki. Jen will send Kiki this attachment as soon as possible.)

One member asked if there is data on the scope of the med error problem that surveyors are seeing. The request as presented does not quantify – how many agencies, how often are errors found, etc.

Once Peter and Kiki joined us – this question was posed – the answer was that there is no way to track this. Only citations are entered into the database. Concerns are noted on the actual surveyor report and filed – so reviews would have to be pulled from the files in order to determine this answer.

A suggestion was made that the surveyors bring these concerns to the nurse's awareness – when Peter and Kiki were present, this was shared and members thanked the surveyors for their current work in doing this.

Another member asked if we knew if there are any particular trends in surveyor findings (around med errors) - when Peter and Kiki were asked, Kiki said that during their regular meetings surveyors talk about med errors – the most frequent mentions are of wrong dose and omission. Med errors aren't discussed every week, but they do come up often.

5. Thank you to Peter and Kiki for continuing to engage in collaborative discussions. Peter will be back at our March meeting.

6. **Reminder of new business –** 3 hot button issues – send them to Cheryl today if you have not already responded to this request.

7. Meeting ended on time for our yummy holiday party offerings and fun Yankee swap – thanks to all who participated!

Next Meeting will be January 20, 2015 .

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

From Kiki: (For discussion at November DDNNH Meeting which carried over to the beginning of our December DDNNH meeting):

1. **Citing medication logs**: Specifically medication logs that have not been reviewed by the NT or been quality reviewed. The most important items below that the surveyors want you to consider are omissions and wrong dose, if we could not come to an agreement on the entire list. This is not a response to just one agency or vendor, but to multiple concerns with multiple agencies that have been seen by multiple surveyors. If more specific guidelines are required to come to collaboration, please let us know.
    - Omissions
    - Wrong Time
    - Wrong Dose
    - Wrong Person
    - Wrong Route
    - Only Concerns about documentation issues

DDNNH response:

Surveyor med log review – The re-write of He-M 1201 (effective 9/2011) authorized nurse trainers to have full responsibility for quality reviews of medication logs. Surveyors will continue to have the ability to document concerns as identified.

From Kiki:

2. Things I am seeing out there!
    - **PRN protocols:** is there an understanding that they should you be signed by the NT? The regulation states approval by a NT, but the other certifiers have an understanding from past conversations that the expectation is that they will be signed.- I asked at a staff meeting about a time frame for approval that was acceptable, but the surveyors could not come to consensus. I will have further discussion with them before the December meeting.

DDNNH response: – this is answered in the draft FAQs as follows:

PRN Protocols – How does a program demonstrate approval of a new PRN protocol?

- He-M 1201.04 (b) – approved by the nurse trainer or prescribing practitioner. Examples of how this can be accomplished:
    - A nurse trainer could create the PRN protocol immediately onsite,
    - When not onsite, a nurse trainer could review the PRN prescription via telephone conversation with an authorized provider. The authorized provider would then document the nurse trainer instructions on the protocol form (this includes the authorized provider documenting the specific nurse trainer name, date and time as a temporary signature of approval),
    - a nurse trainer could email specific answers to the protocol questions (keeping in practice with the specific agency's HIPAA compliance expectations),
    - a nurse trainer could access other technology options (e.g. faxing, scanning),
    - authorized providers could have blank PRN protocols available for every prescribing practitioner interaction. *(October 2014 DDNNH subcommittee)*

Although the draft FAQs are not finalized and published on the DDNNH website, we agreed that these examples include the known acceptable methods and may be accepted during certification visits in the interim.

From Kiki:

3. **QA's**:
   - 6 months means 6 months? It doesn't extend until the end of the 6th month?

DDNNH response:

Discussed and agreed at October DDNNH meeting as 6 months, not extending to the end of the 6th month

Regulation reference He-M 1201.09 (c) Reviews pursuant to (b) above shall occur according to the following timeframes:

(1) At least semi-annually, for:
   a. Family residences with 3 or fewer individuals certified pursuant to He-M 1001;

From Kiki:

4. If an individual has only **PRN medications at a CPS program**, but doesn't take any during the month, a QA is still required, correct?

DDNNH response:

The discussion was centered around PRN meds ordered vs administered. If ordered, but not administered, then no QA is required. If ordered and administered, then a monthly QA would be required. A NT may choose to do a monthly QA even if no PRN meds were administered. Kiki shared more detail about why she had this question at the December meeting – a CPS program had Epipen and other anaphylaxis preventative orders – no med logs, no QAs for a year. The nurse trainers present at the meeting agreed that there should have been med logs prepared to have ready for the triple check process if there was a need for administration. While the regulation is apparently silent on the timeframe for QAs for this specific situation, the nurse trainers agreed that best practice would require a QA to be done – to at minimum review that the order is not out of date and the supply is present and within expiration parameters.

From Kiki:

5. For a move some NT's are counting a **QA being done on the transition visit** (as early as the same day an individual moved) **as the first of the 3 monthly QA's** required after a move/transition...is there an expectation that has been set regarding the 3 monthly move QA's?

DDNNH response:

There is no expectation set. Each NT, within their scope of practice, needs to understand the regulatory expectations and develop processes to meet them.

Discussion about how and why a QA might be done the day an individual moved in occurred – while most nurses present did not choose to do/document a QA the first day, examples were raised of NTs essentially doing the work of a QA on the first day because the individual receiving services was new to them and their agency.

From Kiki:

6. Something I learned! Some **CPS programs use one QA sheet for the entire location**, instead of a QA for each individual that has medications. This is nice to know and probably far less time consuming.

December DDNNH members say – Thank you for sharing this information Kiki!

From Kiki:

7. Orders: **Telephone orders** should be signed, correct?-Yes!!

December DDNNH members agree – the expectation is that telephone orders will be signed within a reasonable timeframe.

From Kiki:

8. **Medication Logs**:
   - If an agency uses monthly medication logs for **PRN medications** should there be one for every month?

December DDNNH meeting outcome – a med log needs to exist. The specific practice of a NT could allow the med log to have more than one month on it. There needs to be a med log that clearly documents administration.

From Kiki:

9. **Health Care Coordination**:
   - Annual Health Screening Forms- there are many times that there is no evidence that these are being reviewed. Additionally, when the agency is using the form provided by BDS, and it is essentially blank, should that be acceptable? What are the expectations of the group?

DDNNH response:

Each agency is responsible to establish a practice that documents the review occurred.

During our collaborative discussion, it became clear that some agencies have no documentation process to demonstrate that this review has occurred. If there is no statement on the physical assessment form that the particular agency uses and the annual screening form is present but blank of all but the date, then this is not acceptable as documentation of a review – a verbal statement that the form was taken to the PCP appointment is insufficient. Some surveyors have accepted the Medicare Wellness exam document as demonstration of discussion about screening recommendations – those present agreed that some prescriber offices provide visit documentation in their office notes that demonstrate that applicable annual screening requirements were discussed.

From Kiki:

10. **Health Status Indicators**- there are many times that there is no evidence that these are being reviewed.

DDNNH response:

No prescriber signature is required on the form. Many agencies document the review with a check box on the prescriber visit form – those present agreed that that practice met the regulatory expectation. Each agency is responsible to establish a practice that documents the review occurred.

From Kiki:

11. **Health History**- Is it the expectation of the group that these are updated annually (with a 30 day grace period)? If a nurse signs it as reviewed is that being considered updated- even if there is no evidence of any actual updates?

DDNNH response:

Each agency is responsible to establish a practice that documents the review occurred.

Further discussion at the December meeting makes it clear that there is perhaps a difference in interpretation of the word history from one agency to another – that some nurse trainers may be signing off on the available material as reviewed historically, rather than reviewing that the information gathered is managed and kept in an updated way (could be documented in some other way than the recommended health history form – of which there are several versions in use). The group agreed that we should keep this discussion current at future meetings in order to develop recommended guidelines. Kiki shared that she has seen NT signed health histories this year with information that stopped more than a year ago and in other places in the same record review more current health related information. There is no way for anyone auditing the record to be able to know if a NT actually saw the more up to date information in those situations.

A question was raised about the responsibility of the NT reviewing health histories for individuals receiving CPS from their agency that were created by another agency responsible for the residential service. In cases where the NT oversight for the individual is solely related to 507 services, there is no annual requirement to review health history, HSI or annual screening recommendations. Medical history information needs to be given to the agency providing 507 services.

From Kiki:

12. **Review of HSI's, HH, ISA and medically frail status**- many times there is no evidence that this happened within 30 days of a move or transition.

DDNNH response:

We agree that if this is not documented, then the requirements of the regulation are not being met.

A couple of people throughout the discussion reminded the group that these forms are recommended, not in themselves required – the information/process is required, not the specific form.

A question was raised about whether the compliance check off form that some agencies use is acceptable for this documentation – yes!

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Minutes

November 18, 2014

1. **Meeting was called to order with 27 in attendance**

2. **Review** and approval of October 2014 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.
   b) December DDNNH meeting – do we want to have small gifts purchased and brought to the meeting as in past years (paid for through our group account) or continue last year's Yankee Swap (brought by those participating)? The majority of those present remembered last year's Yankee Swap as a fun experience worth repeating. Those who are interested in participating can choose to purchase something (limit of $10 please) OR bring something that is gently used. The emphasis of those speaking was on keeping FUN in mind. ☺

4. **Business Discussion:**
   a) **FAQ update** – due to time constraints for other tasks, the group agreed to work on reviewing these independently over the next month. Each NT will be responsible to review the FAQ work that the subcommittee is presenting (available in eStudio in projects in process folder). New NTs are asked to review and comment since your new and unbiased eye would be particularly helpful in this process.
      1) Review for flow within a category (there are 7 – only the first 5 need review)
      2) Review for clarity – is the topic clearly identified and does the following information fit/answer
      3) Consider if there are questions that are not asked in this current FAQ work – share them via eStudio or email (Jen will collate topics for future consideration for the group).

      Action deadline – next meeting – December 16, 2014

   b) Stable client (psychiatrically) – pended to the January agenda as the person posing the question was not present at today's meeting.

   c) Discussion on med error – should it be counted: Individual moved to a new certified setting with order for Buspar 15mg 2 tabs TID (90mg/day). Supply was running out, individual had gone to START house, PCP called for renewal – order from PCP was for 30mg 2 tabs po TID (double the previous dose). HCP gave according to the PCP order – did not notice the change and so did not contact NT or guardian. The increased dose was given for 42 days. The order and label matched. (The individual happened to have an appt to see the psychiatrist the day after the dosage change was found – asked if any blood work or follow up needed – psychiatrist said no.)

      The AA involved has a seat on the med committee. They did not feel that it was a technical error given the doctor's order.

      One suggestion – rather than a countable error – note in concerns on 1201a report.

      Is it a statistical error or not? Technically, no (because the order supplied supported what the HCP gave – although this doesn't make the situation less concerning given the lack of awareness on the part of the provider)

Whether this was an intentional change on the prescriber side or not is unknown.

Another member reported that she had a similar type of error (different medication) – reported on 1201a as error, no reporting correction requested. There may have been a difference in how the situation was reported – e.g. if the information provided did not allow the med committee to know that the order, label and log matched.

Clearly this situation is concerning and requires review and corrective action on the part of the NT – whether it is officially reported as an error or as a concern.

d) HRST recommendations discussion. One member requested – can DDNNH have a member on a state committee for HRST if there is such a group? It was posited that there is no group. Cheryl will check.

A member who participated in the 11/17/14 HRST webinar on service and training considerations asked if anyone else in the group had participated. In her view it was a waste of her time. She has a frail individual whose considerations do not reflect his medical issues/needs. No one else present participated.

Comment: we have many forms, is there a way as we look at HRST to make it more robust for us? (A reminder from Jen that Lorene reminded us last month that the format of the HRST is not something that we can change. We can look at how to input info into existing fields to serve our needs.)

Darlene – there is a difference between HRST (a risk assessment tool) and a health history. HRST is used at her agency for risk management and cost awareness.

Penny shared a concern that a vendor should be able to access HRST info.

An email was received by one member (who works for a vendor agency) from an area agency about operationalizing access to HRST – other members in the room who work for other vendors for this area agency had not received any information about process. Some members reported communication from area agencies on HRST processes is inconsistent and incomplete.

Debbie raised a question – who is responsible for data entry? History and risk information go together – though maybe not in one form.

One example from a particular region: there is no communication between data entry (rater) to the RN reviewer. How is that system of bridging going to grow?

The group was asked to respond from a global perspective (not from specific vendor or agency view. Everyone wants to standardize forms – no one wants to change from their own forms.)

As HRST participation expands beyond the 1001 settings, there are settings that have no nursing time purchased. Initial suggestion was that service coordinators input the data. Healthcare coordination would need an RN review.

Concerns: resolve inaccuracies in the current system. There are so many roles of people who are raters – and they are so different in experience and knowledge of the individual.

HRST decision points/activities (attachment sent out by Lorene Reagan 11/6/14) – specifically look at major decisions 1 – 8.

Discussion from group present:

1. service coordinator inputs, RNs have access and can update (RN access is currently inconsistent).

Who should be the initial rater? After some discussion, those present agreed – not the nurse. The service coordinator – with training. The person who knows the individual best needs to have direct input into the initial HRST and updates. The service coordinator can be the official rater.

Program manager (if this role exists for the type of setting) could use the monthly data tracker to collect relevant information on an ongoing basis.

Who completes the rating: collaborative review through service coordinator and NT including the person who knows the individual the best.

Decision: service coordinator with input from team members

Suggestion: create a HRST super user group – service coordinator supervisor from each area agency plus NT rep – to discuss/develop processes of implementation, barriers, solutions, awareness of training needed by users (based on real life NH situations).

Decision: NTs will use eStudio comments to work on answers to the major decision points. NTs can also use email. Debbie Brookes volunteered to accept email comments and collate/condense. Feel free to offer a range of answers if you can think of more than one position for the question. Debbie will collate them from most strict to least. DEADLINE: 2 weeks – December 2 (Tuesday).

e) Request from last meeting to describe NT approval of PRN protocol when there is no means for NT to go to the home on the day of the order or electronically provide a completed document. The NT can be consulted by phone and instruct the authorized provider in translating the prescriber's order onto the PRN protocol form. The authorized provider will write the information onto a blank PRN protocol throughout the discussion. Once completed, the authorized provider reads back what was written on the protocol. When NT and authorized provider are in agreement, the authorized provider documents under the signature line of the protocol a variation of this phrase: completed via phone conversation with "insert NT name" on "insert full date" at "insert time". This will then be a NT approved PRN protocol. The NT will sign it in person at the next visit.

f) Kiki's certification clarification list – discussion began, time ran out. A small group agreed to continue the discussion after the meeting and the whole group agreed to change the start time of our December meeting to 9am in order to review the answers generated prior to Peter and Kiki joining the group at 10am.

Next Meeting will be December 16, 2014 at 9:00am- 11:00am. PLEASE NOTE: Meeting time change!

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
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Minutes

October 21, 2014

1. **Meeting was called to order with 34 in attendance**

2. **Review** and approval of September 2014 minutes with one change – add statement about reporting of cert deficiencies (Box 9 on 1201a long report).

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.

4. **Business Discussion:**
   a) E-studio check in – all present are aware, though some have not accessed.
   b) Can members who live or work far away and can't make it to the meeting access us via technology. Call in, videotape, audio tape, Skype, facetime. This would mainly be for specific presenters, not necessarily for the entire meeting. We have access to technology for phoning in more than one person, they can be muted – so we don't hear what is going on where they are, but they can still hear. The barrier for this technology is limited range of picking up speakers and potential echo or distortion in what they are hearing because of the size of the room. Kenda volunteered to ask Maureen our questions and the answers will be included in these minutes. Questions to ask about the phone in tech:
      a. are there additional mikes? (after the meeting Kenda and Jen learned that there are 4)
      b. Is there a line limitation? (after the meeting Jen learned it is unlimited)
      c. What is the number to call if we want to pilot it? (we don't have it yet, still in process)
   c) DDNNH email address list – everyone present today received last week's email. Maureen informed Jen that she has been receiving bouncebacks of emails that don't work. Reminder – if you change email addresses (whichever you have listed with us), please send the update to Maureen so that you will still get our info. Jen requested that those present today review the provided Nurse Trainer by Region list for accuracy – both for yourself and for your agency. Thanks!

5. **Certification Questions – Peter and Kiki:** First - a big **Thank You** to Peter and Kiki for their continuing interest in collaboration with our group!

Both noted – people do things in the field very differently from each other and interpret things widely.

Kiki – at May's meeting, a conversation was opened to consider the surveyor staff looking at med logs - in a way that errors not accounted for through NT QA can be followed up on. The intention is for the health and safety of the individual receiving services. How can we (DDNNH and BHF) collaboratively work to ensure health and safety? Kiki's initial suggestion was to look at omissions, wrong dose, wrong route – if the nurse has done a QA and missed the error or if has been a long time since the last QA (not just a couple of weeks).

If there is a return to citable med log review – documentation will not be an area re-instated.

Lively discussion ensued. Examples of a couple of concerns raised: seems like a systemic response is being sought to isolated instances; can the surveyors work with the specific agency to create solutions.

Reminder – the surveyors are another set of eyes to help us ensure the health and safety of our individuals – not a punishment.

Peter and his staff will develop a draft statement from BHF based on field experiences for what med log issues could benefit from review – this statement will be provided for DDNNH's review at an upcoming meeting.

A reminder – if a surveyor writes a citation for an area/item that the NT disagrees with – Peter is looking to hear feedback from you. He has freely shared his office number and continues to encourage NTs to call him with questions.

Clarification question from Kiki – PRN protocols – regulation states "approved by nurse trainer" – meaning signed by a prescriber or NT. Is there documentation that a conversation with a NT occurred? Surveyors have seen PRN protocols signed by the authorized provider (staff/contractor) with no indication that a licensed professional has guided the information or reviewed the document.

A question was raised about a recent citation for a PRN protocol (for Claritin & Robitussin)– where the MD wrote PRN without instructions and the NT wrote out QD PRN on the protocol. Is this nursing judgment action within the scope of the regulation? (Does the NT have the ability to write out reasonable instructions for authorized providers based on manufacturer standards?) The group decided this answer is covered in the FAQs as **yes**.

Another question raised – Is there a 30 day grace period for renewing an annual self med assessment every year. When the He-M 1201 regulation was updated **the 30 day grace period was removed**. The annual re-assessment of individuals who have been assessed as capable of self administering needs to be done no later than the last day of the 12th month from the date of the prior assessment.

Due to our meeting time constraints, Kiki agreed to send the rest of her list of clarification questions to the group by email prior to the next meeting.

Peter – all new folks coming into services need to have a self med assessment done. He-M 1201.4 (b). There is no mandated form. There needs to be clear documentation that the assessment is done. Once the initial assessment is done, if the individual is not able to self administer, then there is no need to re-do annually. 1201.05 (b) 1-6 identifies what skills the individual needs to demonstrate to be successful with medication self administration. How and where a NT chooses to document is up to them and their agency. One NT asked if it could be documented on the 5 day transition form – answer: it could be if that is what works best for your agency.

In a day program setting – if the individual has no meds, then there is no need to have or do a documented assessment. When there are meds, then there needs to be an assessment.

Is there reciprocity (individual moves from one agency to another)? **No**, if the individual is new to your agency, then there needs to be documentation from your agency about the individual's ability to self administer.

One NT's strategy is to put a self assessment form in the record that says no meds, will be evaluated if meds are ordered.

It is also possible that the individual may be assessed as capable but the guardian says NO! That needs to be documented by the guardian in the individual's record.

Annual health screenings – example: eye exam annually written up as a concern because the exam wasn't done annually. Insurance only pays every 2 years. Kiki's response – if the MD recommendation states annual, then she has written a concern.

Question – how do agencies document oxygen usage? Answer – treatment sheet.

6. HRST discussion with Lorene Reagan: (example of comments/questions raised follow)

NTs note that there are a lot of inaccuracies of ratings completed by service coordinators.

What is the expectation for the RN? Several nurses said that they had to do the entire tool – mainly due to service coordinator inaccuracies. A lot of time is spent correcting.

The whole tool is not an accurate reflection of the person, frail health is not reflected.

Lorene commented that it was helpful that a number of people responded to the survey from HRST – and one common theme noted was concern about accuracy of service coordinator ratings.

Expectations of HRST updates – when there is a change for the individual – not necessarily annual.

Lorene stated the intention is for HRST results to drive the service agreement. Debbie Nailor shared an example of a gentleman that she provides NT oversight for – was hospitalized in MA, HRST sent and they found it very helpful.

No one was aware of the HRST being using in service agreement processes yet. There are 10 area agencies throughout the state – is the process different – yes seems the most likely answer.

Morna noted that there seems to be redundancies with the HSI, health history, HRST.

Lorene – This is a preliminary discussion. The Bureau is looking to develop structure on use of the tool. What can we stop doing? (What we have now needed to be in place). We need to expand the use of this tool – to all service settings including CPS, CSS – not just certified settings – because this is how the Bureau assures CMS that health and safety is maintained/monitored. We need to look at what is regulation driven in our "redundant" tools, what do we want to have for ourselves (our agency). We are not looking to adapt or change HRST.

Penny asked about the state NT advocate position which remains open. Lorene - there have been a couple of candidates, none have met the qualifications.

Martha – MCM – step 2 date pushed out, no date for DD/ABD waivers yet. Response – Quality Council report not due until January, so stakeholders' forum input has been asked to be put on hold. Stay tuned.

Next Meeting will be November 18, 2014 at 9:30am- 11:30am.

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Minutes

September 16, 2014

1. **Meeting was called to order with 33 in attendance**

2. **Review** and approval of June 2014 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.
   b) **DDNA Liaison Report**: Ellen spoke for Wayne who had not arrived asking what was to be included. Jen responded (as a past DDNA liaison reporter) – to check the DDNH website for updates of interest to us. – to check the DDNA newsletter (a call for articles was recently sent out). – to provide info about the upcoming conference when available (we know it is in Atlanta, GA next May 2015). – Kenda reported the news that DDNA's executive director contract will not be renewed at the end of this year. What changes this will bring are yet to be seen – however, it does mean that if you call DDNA you will receive limited info about the upcoming conference.

4. **1201A training by Wayne King: Thank you Wayne! Great job!** (These are a few points from the presentation, not a verbatim transcript.)
   - 1201 forms on the DDNNH website are PDF version – however, the med committee prefers typeable submissions. (Jen's note: typeable versions were sent out to the DDNNH group back in May 2014 via email, they are now available on our e-studio folder, some area agencies send them out as an attachment along with the reminder for upcoming reports due date)
   - Med committee composition – primarily volunteer board, review of types of representation sought for membership, Jen McLaren, MD is the chairperson. The med committee is there to help.
   - When 1201 reports are created – 1201a reports are the opportunity for the NT to review error trends for their caseload, 1201b reports are the opportunity for the agency to review error trends for the company's caseload and 1201c reports are the opportunity for the area agency to review error trends for the full client overview. This system provides 3 levels of review – from specific to general.
   - 1201a short form – used for a program that has no errors. Self medicating programs ARE NOT reported.
     - The short form can still be used if there are OOS He-M 1201 deficiencies (that are not med error related in this reporting period) – the deficiency citation can be commented on in the Other Concerns box.
     - Box 3 – Reporting Period Date – should be fixed dates for the entire expected period. If a program opens and closes during the reporting period, those dates can be included on the service name line under the specific service name.
     - When calculating your hrs per month – don't forget to consider time you spent training program staff in class etc – not just the time that you are at the program for QA and med observations.
   - 1201a long form – used for a program that has errors. Self medicating programs ARE NOT reported.
     - Often the first box in the shaded area does not have the REGION filled in.
     - Any information that is not completed by the NT (or added by the person completing the 1201b form at the specific agency, or added by the person at the area agency completing the 1201c form) will be sent back by the med committee to be completed.
     - Box 3. Service Name – this is never the client's name. It is most often the address, could be the provider's last name. Whatever the program's certificate identifies the name as is what should be entered here.

- Box 5. Total Number of Providers Authorized – this is not the total number authorized over the period being reported including those who have left. This is your currently certified staff group (normal staff levels). This Box often gets confused with the surveyors needing to know the names and dates of everyone who was authorized to administer medications for the entire certification period.
- Box 6. Total Number of Doses Administered – this is not an actual count of doses administered for the entire period. Rather a reasonable accounting of doses administered based on the formula (found in the 1201 instructions).
- Box 9. Number of He-M 1201 certification deficiencies cited: It is not necessary to include the entire commentary included in a citation – please at least include numerical reference and a short descriptor.
- Box 10. Number of individuals….If the program supports individuals from more than one area agency, it would be really helpful to the med committee in understanding your report to know that. You can indicate this for example as: 2 (Reg 10)/ 1 (Reg 7).
- Box 11. Number of Psychotropic Medications….Remember if 4 or more psych meds are prescribed please provide information on whether or not there is a psychiatrist involved. You can add it here or under the box called Other Concerns.
- When counting the number of errors – please remember that the number reflects the number of dosage times, not the number of pills missed. If an individual was supposed to receive 5 medications at 8am and received none of them, this is ONE omission. On the other hand, if the individual was supposed to receive a 2pm dose of one medication every day for the last 2 months and didn't, the number of errors entered is the number of days the omission occurred (~60).
- Patterns of non-compliance – NTs should use this to communicate corrective actions that they have tried to put in place and they have been ignored or not followed and the NT is looking for advocacy assistance.
- Other Concerns – this is where you should report if meds were administered by a previously authorized provider whose certificate lapsed for a period of time. It is also a tool for NTs to seek advocacy from the med committee.
- Page 2 – provide just the facts – be as succinct as possible. Remember that the med committee will be interested in any outcomes that are known – and the med committee does not have (nor want) individual med error reports that provide all the details.

5. Business Discussion:

a) E-studio -

b) Skype – telecommunication, increased technology is the way of the future. Penny shared that she chose this as a topic for a paper this summer – Skype is more accepted, particularly for distance issues. Biggest concern reported was HIPAA. Some discussion in the literature about the validity of conducting psych interviews via Skype. Kenda says that we should send the question to the med committee for consideration and draft a statement from DDNNH for Peter and his group to have/use. One member raised the concern about the importance of in person assessment by the NT for the vulnerable people that we serve. That Skype shouldn't be routinely used for convenience. Informal poll of the group finds that people are more comfortable with the idea of using Skype for med recert rather than newly authorized provider. A concern was raised – when doing the cert – is the NT actually looking at the same items (label, log, order etc) as the person being observed. Suggestion raised to form a subcommittee of interested NTs to work out the details and possible barriers/boundaries – volunteers: Penny, Martha, Angele, Ruth, Liz)

Next Meeting will be October 21, 2014 at 9:30am- 11:30am.

Submitted by:
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Developmental Disabilities Nurses of New Hampshire

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Minutes

June 17, 2014

1. **Meeting was called to order with 23 in attendance**
   a. To receive an electronic copy of the most current medication certificate please send an email request to the DDNNH email address. (At members' request, the spaces to remind the authorizing NT to include dates of effectiveness were put back onto the certificate.)

2. **Review** and approval of May Minutes as written and discussed with minor edits.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.

4. **Business Discussion:**

   a) FAQ discussion – how will we move forward? A suggestion was made that a subcommittee of interested members be formed to work outside of DDNNH meeting time on updating the FAQ document and then report back to the general membership. Areas that need to be included in this work: review of the minutes from September 2012 forward for items that need to be included, a review for the suggested changes to the PRN FAQ, and developing guidelines for the diet order FAQ. Several members expressed interest and availability to meet over the summer. First meeting will be July 15 from 9 – 12 in Concord in the BDS Conference Room.
   b) E-Studio – can be very useful for importing and exporting forms. A suggestion was made that maybe FAQs could be re-located to e-studio in a different format – this was declined except if the group wanted to work on updates. The finalized version of FAQ must be available for anyone to access – e-studio is a members only option. Since e-studio is a restricted forum, a suggestion was made that the med certificate form could be available there. Some members think it would be useful. A suggestion was made to add in knowledge about e-studio during NT orientation. Ultimately the group agreed to request an e-studio forum for DDNNH be created. Leslie sent around a list for those present to put their name and preferred email address on. Kenda volunteered to give it to Ken Lindberg (done). Members may be added to the forum in the future by request. Jen will send out an email to the general group so that people who were not present may be added.
   c) DDNNH secretary will send minutes out early for review by the group – if there are substantive questions, the person reviewing will ask for clarification prior to the meeting. As necessary, these will be added to the agenda for further group discussion.
   d) Discussion about our current agenda format – does it work? Should we change it? The DDNNH secretary will put out a call to the group for agenda items a week prior to the meeting and will ask the requestor for an approximate timeframe. There will be specific timeframes listed for speaker(s) and we will hold ourselves to these in order to accomplish other items on our agenda without going over the planned meeting time.

Otherwise, we will take off the times from the agenda. A suggestion was made to limit discussion time for some topics and to build in time (ex. 11 – 11:30) reserved for pressing nursing questions. We will hold ourselves true to the stated agenda without full re-hashing of previously discussed topics.

e) Review of May's DDNNH minutes resulted in discussion and/or clarification of items b), d) and j).
   a. Item b) was a suggestion for training on how to correctly complete the 1201 A reports. Discussion ensued on who would be the best presenter (someone from the area agency who reviews or someone from the med committee). Kenda volunteered to contact Wayne King to discuss his availability to talk about 1201A reporting. An area agency rep would be able to look at what happens after 1201A & B goes to them for connecting to the 1201C forms.
   b. Item d) **Medication Orders** – difficult to accomplish at annual physical (health assessment). Regulation does not have an order expiration date for medications that are expected to be given (scheduled or prn) on an ongoing basis. Most members present have a process for approximately annual review of medication orders by the prescriber. One NT's process is to keep the original order in file and a statement is added on the consult to continue med orders (without listing them, though with an accompanying list).

      The **issue of concern** is that med orders in the med logs have been sometimes found to be 3 or 4 years old during survey visits. Prescription meds should have new copies obtained at some point – generally annually. OTC meds will also be reviewed and updated.

   c. Item j) Medication **Logs** – sampling by state reviewers of med logs was a conversational suggestion. If a nurse trainer finds a reportable med error, then the nurse trainer is obligated to report the error to the area agency and medication committee.

f) A question was asked if anyone had heard of med observations being conducted through Skype? – no one at the meeting aware. Peter's group was asked by the questioner and responded. One NT did say that she had heard of in a limited/rare circumstance, but not as a general practice. Because of time constraints this discussion was pended to our next meeting.

g) Question was raised about how to do med observation in a day program when only prns (specifically Diastat) are ordered since mock observations cannot be done. This remains a challenge with no set solution that works for all scenarios. Suggestion made to use a trainer (ex. auto injector for epinephrine has a trainer). One NT mentioned that a Klonopin wafer could be a possible substitute for prn Diastat.

Next Meeting will be September 16, 2014 at 9:30am- 11:30am.

Submitted by:
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Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes

MAY 20, 2014

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9:30

1. **Meeting was called to order with 31 in attendance**

   a) The latest version of the medication certificate was distributed. Maureen will electronically send it out to the group as well.

2. **Review** and approval of Minutes as written

9:45

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted. Dianne presented thank you cards from membership to outgoing officers Linda Catalano and Eileen Corbett.

   b) **Election of Officers for 2014 - 2016 for the following positions:**

      1. President: Leslie Erdoban-Evans moves from Vice President to President
      2. Vice President: Ellen McPhetres
      3. Secretary: Jennifer Boisvert

   c) **Election of DDNA liaison for June 2014 – June 2015:**

      1. DDNA Liaison: Wayne Ward

10:00: BHF Bureau of Health Facilities: Peter Bacon accompanied by Kiki Sylvester, RN updated the group on the following:

a) **Expired Medication Certificates:** The Statement that the group drafted regarding what to do when an authorized provider fails to be re-certified by the expiration date of their certificate was accepted by the BHF. As many of the group present today were not in attendance during the meeting when the statement was drafted and discussed, we will ask Kenda to send the formal statement to Maureen to send out to the group via email. Summary of the statement is as follows:

For Authorized Providers whose med certificate has expired the RN Trainer may give the Provider a chance to recertify according to agency standards without taking the full certification class again as long as the expiration is not longer than 30 days. If the certificate has expired more than 30 days than the full medication certification course must be taken.

FMLA - An attempt should be made to re-authorize a provider whose certificate may expire during the leave period. If unable to do so then the above statement holds true and must be followed.

b) Peter and Kiki asked the group what certification issues they would like more information for. A suggestion for some training in how to correctly complete the 1201 A reports was made.
c) **Diet Orders:** Peter was unable to obtain any clarification regarding the annual renewal of diet orders before Matthew left. Peter will discuss with Lorene Regan.
Surveyors are only looking for the diet order not how it is followed.
d) **Medication Orders:** Although orders do not expire they need to be updated annually with the physical.
e) **Self-Medication Forms:** Kiki will send Maureen a new Self Med assessment form to be sent out via email for those who would like to use it.
f) **Medication Issues:** Peter and Kiki welcome any discussion with both Nurses and Agencies for any certification issues. Email is the easiest way to communicate with them but welcome phone calls as well.
g) **ISAs:** A signature by an RN indicates that the nurse has reviewed the entire service agreement and not just the medical part. Some feel that all the paperwork required seems institutional. The group was reminded that the Nurse Trainers were an integral part in writing the new regulation.
h) **HRST:** A copy of the completed HRST does not need to be printed out and placed in the individual's book. They just need to be completed on line. No assigned individuals for 2015 have been sent to the agencies at this time. **New 507:** indicates that the staff need to be trained on the individuals HRST. Peter suggested that Lorene Regan be invited to a meeting to discuss the HRST
i) **Lab Tests:** Surveyors should not be looking or asking to see results of lab tests. They should only be checking that the tests that were ordered by the physician were done.
j) **Medication Logs:**. There has been a suggestion that the medication logs be added into the surveyors' review. The Bureau feels that the agency may not be reporting all errors to the state. The Bureau relates this to the possibility of agency system reviewers not nurse trainers. A proposal was made that a sampling of med logs be reviewed rather than all of the logs.
k) **Annual Health Screening Forms:** The surveyors are noting that many of these forms are incomplete. A mechanism to indicate that the form was reviewed must be in place.

Peter and Kiki will attend the October 2014 Meeting. Please forward any issues to be discussed to them to review prior to meeting.

11:00 – 12:00: The group enjoyed lunch for Nurses' Week provided by the Bureau. A cake in honor of the exiting officers was provided by DDNNH.

Next Meeting and last meeting for the summer will be June 17, 2014 at 9:30am- 11:30am.

It has been my pleasure serving you for the last two years. Thank you for your support.

Linda Catalano RN
Exiting Secretary DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
April 15, 2014

9:00: Change of Meeting Format: Due to several time sensitive issues that require attention the meeting began at 9:00am. The following was discussed:

1. HRST discussion: Late in January the group was asked to discuss what we thought and hoped to get out of HRST. Not everyone present has experience with HRST since every area agency has a slightly different method of developing the RN reviewer position.

Discussion included does the higher HCL score correlate in any way with the frail list – this is unclear. Those present who had access were asked to bring to the next meeting how many people had HCL scores of 5 and 6 and of them who was on the frail list. One area that clearly increases the HCL score and does not correlate with the frail list is behavioral components. One RN commented that she has individuals with asthma who ordinarily are a lower HCL score, but they can fail quickly which could rapidly change their HCL score for a period of time before they are back at baseline. One nurse has 2 individuals on the frail list and their HCL score is 1. Some members of the group asked what the state is looking for. What do we want from HRST? Consensus that the tool can provide a good global overview IF the ratings are correct – many commented that there are incorrect ratings that have not been corrected.

Continued discussion on what can be replaced by HRST – are there redundancies in information collected. Discussion around using HRST instead of HSI – practically this seems to add an unsupportable level of complexity for most nurses – because the number of people who have access to the HRST system is limited. We reminded ourselves that the recommended HSI form is just that – recommended not mandated. Agencies can collect the required information in a way that works well for their agency.

A couple of tangents were discussed – on 1201a report box 9 deficiency – surveyor asked for plan of correction –why? ISA – where to sign? – just the medical section? Cited at survey. The intention with the ISA is for the NT to be aware of the individual's overall plan and to ensure that the information in the medical section is accurate and inclusive of anything that could impact program planning. Some people sign the ISA, some people use the checklist, some people document on their QA form – the method chosen must clearly indicate that the NT has reviewed the ISA at least annually (unless the individual requires a 5 day visit due to a move or change in provider).

10:00: Guest Speaker: Ken Lindberg from DHHS presented an overview of e-studio (how it could be used by DDNNH).

E-studio is a secure, web-based product which allows a group to work together on the same page no matter where you are. There are over 400 people enrolled in DHHS.

Two main uses – a group can exchange documents and it can be used as a project management tool (can upload documents).

Can restrict folder to e-team members. If you can organize your files on your computer, you can use (navigate) e-studio.

Upon sign in you will only see the groups that you are part of.

Any number of folders can be set up (so we would not be limited to one folder).

Can use to access/share reading materials without making multiple copies.

Can have folder of documents. Comment section for document can be useful to share info.

e-team – will list members plus contact info if they added extra info (e.g. address, phone number, other email address)

Can be a great tool – but only if you use it. In order to set up an e-studio acct Ken would need each person's name and preferred email address.

DDNNH needs to discuss how/what we would use e-studio for and if we decide to move forward, then let Ken know.

10:30: Review and Approval of the Minutes without correction.

2. Officers' Reports:

A. Treasurer's Report read and accepted. Dianne will continue to collect membership dues. **Reminder:** Only members with paid up dues are eligible to vote.

B. DDNA Liaison Report: N/A

3. New Business:

A. May DDNNH Elections: Nominations for our open positions (Secretary and DDNA Liaison) were sought from the group present. Eileen Corbett announced that she is retiring as of June 1st and will be stepping down from her position as President. This resulted in the President Elect position re-opening. Ellen McPhetres stepped forward to accept nomination for the President Elect position. 3 people who were not present at the meeting were put forward as possible candidates – Jen Boisvert contacted all three to determine their interest in the position and all respectfully declined at this time. Jen Boisvert stepped forward to accept nomination for Secretary. Wayne Ward stepped forward to accept nomination for DDNA Liaison. He is not currently a member of DDNA, however, he understands that that is a position requirement and will become one. If no other members indicate interest by the May meeting, then those accepting the nominations as noted above will be elected.

B. Question was raised about updating medication certificate because there are not dates. New nurse trainers or those who are unable to attend meetings may not know to add the dates in. Jen Boisvert volunteered to contact Joyce Butterworth to learn the history. (After the meeting Jen did contact Joyce and learned that the dates were inadvertently left off. New certificate update with date reminders in process.)

C. A member heard in 3 different forums that surveyors are looking to reopen the 1201 regulation to enable surveyors to be able to review med logs in the future. Some members stated that surveyors are looking through med logs. Discussion that the regulations can be reopened at any time which may or may not result in actual changes. Jen Boisvert volunteered to contact Peter Bacon so that he can discuss this at our May meeting.

D. 2 individuals who are assessed as self administering – no indication of NT reviewing health history annually. This is an agency system issue – 1201.03 – if individual resides in a 1001 certified setting, health history must be reviewed within 30 days of move and annually thereafter.

E. NT comment – MD writes orders for labwork, mammogram, dexa scan etc – agency has documentation for what was ordered and documentation that it was done. Surveyor cited program for not having results. Lively discussion ensued. This issue was brought to Peter Bacon's attention in the fall, and he said then that surveyors should not be asking for results in this

scenario. Jen Boisvert volunteered to contact Peter Bacon so that he can be aware and discuss at our May meeting.

F. Lively discussion on what does a nurse trainer do – this can be very different from agency to agency. How much time is spent to do many of the new tasks – dependent on systems in place as well as the nurse and the expectation of the agency. Nursing judgment and scope of practice issues are ongoing discussions with agency management. What is our role, caseload. Some members were interested in pursuing how to quantify this information.

G. Question raised – MCM case manager – who will they be talking to – how will NT be connected. Excellent question, no answers.

3. Unfinished Business:

a) **Peter Bacon:** Will attend the May meeting to discuss certification issues, etc. Group members were asked to respectfully provide Peter with a heads up prior to the meeting for any topics that he might need to gather info/input first. Other than those noted above, people are individually expected to f/u.

b) **FAQ's:** Since we ran out of work time in March, the group was asked to consider how to keep the project moving forward between meetings. Martha and Penny volunteered to work as a sub-committee on a section of the FAQ's. Martha was unable to attend April's meeting. Denise volunteered to review the minutes over the last 18 months for additional information that may need to be added to the present FAQs – however, she was unable to access the minutes and print them off. Jen Boisvert provided her with copies. Next group work meeting will be at our June meeting. Jen proposed that interested members of the group could continue to the work over the summer if needed. Jen spoke with Maureen to book us a room on the 3rd Tuesday of July and August from 9 – 12 with a screen and projector. Necessity and work partners will be determined at the June meeting.

Meeting ended at 12:00 noon. Next Meeting is Tuesday, May 20, 2014, from 9:30am to 11:30.

Respectfully submitted by Jennifer Boisvert, Acting DDNNH Secretary

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
March 18, 2014

9:00: Change of Meeting Format: Due to several time sensitive issues that require attention the meeting began at 9:00am. The following was discussed:

1. Creating an interpretative Statement for Expiration of a Medication Certification:

a) Review of He-M 1201.06

b) Review of proposed minimal expectations for individual agencies to establish
1} Method of consistently documenting certification period
2} Medication administration re-training processes

c) Review of proposed versions to be considered:

1} Once the medication certification period ends, the provider is no longer authorized to administer medications. The provider will not be able to administer medications and would need to go back to the full medication training class. No leeway.

2} Once the medication certification period ends, the provider is no longer authorized to administer medications. Any administration occurring after certification has lapsed will be considered a med error. If lapse is discovered/known within a month, then re-training according to usual agency recert process occurs. If longer than 30 days, refer back to #1.

3} Once the medication authorization certification period ends, the provider will no longer be authorized to administer medications. Regardless of the time lapsed, direct clinical observation will be done to reestablish medication privileges (must include minimum regulatory requirements). Please refer to He-M 1201.06 for specific requirements.

d) Version 2 was agreed upon by the majority of the members present. Kenda will format our statement and send Peter Bacon and his staff for review and comments and then will send on to the Med Committee for review. Some members of the group would like a discussion with Peter and his staff about developing an exception that pertains to a med certification that expired while an authorized provider that was on an approved leave of absence.

10:00: Guest Speaker: Jeremie Coull, Associate VNS Therapeutic Consultant, presented "Beyond Medication", the latest on the Vagul Nerve Stimulator. Jeremie will send out the electronic version of his presentation to the group email address, and he offered availability by e-mailing him at jeremie.couu@cyberonics.com. If you are interested he has information on the Ketogenic Diet available by email.

10:45: Review and Approval of the Minutes without correction.

2. Officers Reports:

A. Treasurer's Report read and accepted. Dianne will continue to collect Membership dues. **Reminder:** Only members with paid up dues are eligible to vote.

B. DDNA Liaison Report: Kiki Sylvester notified group that she will be leaving her present position @ Community Partners and has accepted a position as a surveyor with Peter Bacon's office. She will begin her new position on 4/18/2014. Kiki will still be attending DDNNH meetings and act as a liaison between this group and the certification office. She will not be able to attend the conference in May on behalf of the membership. Names of those interested in taking over responsibilities for DDNA liaison at the conference were submitted and randomly drawn - Jen Boisvert was the first name pulled and if she is unable to attend, Dianne Crone will be the alternate. DDNNH membership will pay for conference and pre-conference for Jen. Congratulations to all three of you!

Responsibilities of DDNA Liaison at the conference:

1} Attendance at any Network Meetings
2} Attend all sessions of DDNA Conference
3}Present summary of conference to DDNNH group

C. Upcoming Elections: At our May meeting this year we have two positions that will be open: the DDNA liaison position (open annually) and the Secretary position that Linda presently holds (2 year term). Be thinking of people you would like to nominate (perhaps yourself!)

11:30 3. Unfinished Business:

a) **E-Studio:** Ken L will attend the April meeting to give a brief overview of what E-studio is and answer questions the group may have regarding the group using this communication mechanism to work on projects.
b) **Peter Bacon:** Will attend the May meeting to discuss certification issues
c) **FAQ's:** Since we ran out of work time, the group was asked to consider how to keep the project moving forward between meetings. Martha and Penny volunteered to work as a sub-committee on a section of the FAQ's. Denise volunteered to review the minutes over the last 18 months for additional information that may need to be added to the present FAQs.

Meeting ended at 12:00 noon. Next Meeting isTuesday, April 15, 2014, from 9:00am to 12:00 noon.

Respectfully submitted by Linda Catalano, DDNNH Secretary

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes

February 18, 2014

9:30

1. **Meeting was called to order by Vice President with 13 in attendance.** **(President was unable to attend this month's meeting)**

2. **Review** and approval of Minutes without corrections

9:45

3. **Officers Reports:**
   i. **Treasurer's Report**: Read and accepted. A decision was agreed upon that membership will continue to purchase coffee for our monthly meetings and members will bring their own refreshments if desired.

   ii. **DDNA Liaison Report**: Kiki was not present for the meeting. Jen voiced concern regarding AV equipment that our speaker may need for next month's educational presentation. Jen will contact Kiki to ask.

10:00

4. **Unfinished Business:**
   i. **FAQs: History:** Both Jen and Kenda spent a great deal of time reviewing the FAQs that are presently on line. They divided the listed frequently asked questions into 6 categories. The membership divided into 6 work groups to review each category and make recommendations. Due to time limit no decisions were finalized. (November 2013 mtg). We continued the work this meeting focusing in on the following points:
      1. Kenda reminded group that NO alteration of the information in the present FAQ's was done. Some additional information was added.
      2. Do we want to have the same information referenced in multiple sites? **It was decided not to duplicate the information.**
      3. Do the heading categories make the most sense? **It was decided that the 6 categories identified plus a "For Your Information" category will be used.**

         1. Nurse Trainer Related Questions
         2. Licensing Questions
         3. Regulation Related Questions
         4. Nursing Practice Issues and Questions
         5. Training Related Questions
         6. Historical Entries
         7. For Your Information – new addition today

4. Clarification of test and answer keys were suggested
5. The site cannot be queried which causes difficulty when looking for specific information.
6. Information related to camp for individuals could be listed under the "For Your information" Category.

5. **DDNNH E-Mail List:** The general email list will be maintained by the state using the new DDNNH email address. All requests for information to be sent to our group and other pertinent questions should be sent to the DDNNH address: DDNNH@dhhs.state.nh.us
There currently are 3 state employees who have access to the email (Maureen, Deb and Peggy Sue) and one of them will direct questions to the appropriate members of the group.

6. **Question related to certifications requiring immediate attention:** Call Peter Bacon or another Nurse Trainer.

7. **E-Studio:** A decision was agreed upon to invite Ken L, the liaison from the State who manages E-Studio, to the April meeting so our membership can make an informed decision as to whether this would work for our group. (E-studio could be a means for us to form remote work groups electronically which would enable interested parties to focus on development of progress on DDNNH projects without increasing our monthly meeting time.)

8. **New He-M 507 Reg:** There are no changes for Nursing other than knowing the name of the regulation has changed from Day Services to Community Participation Services (CPS). HRSTs are mentioned in the new reg - to be used as a tool to provide health related information to those who are providing services.

9. **Group Decision on How to Handle Expired Med Certifications:** Peter Bacon has asked our group to prepare a uniform statement as to how this should be handled. Once developed we will send to the med committee for review, comments and approval. Due to time limitations the group was asked to come to the next meeting with a statement prepared to discuss.

10. **Communication with Med Committee:** Presently Wayne King is acting liaison between the med committee and questions we may have. Questions can also be directed to the DDNNH email: **ddnnh@dhhs.state.nh.us**

11. **New Business including Nursing Practice Issues:** Deferred to next meeting.

12. **March Meeting:** It was decided that the meeting hours would be extended from 9am to 12noon for all those who wish to attend. This will allow some extra time to work on above stated issues in addition to the previously scheduled speaker.

The Meeting was adjourned at 11:30am. The next scheduled meeting will be Tuesday, March 18, 2014.

Respectfully Submitted,

Linda Catalano RN

Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

January 21, 2014

Minutes

9:30

1. Meeting was called to order with 22 in attendance:
2. **Review** and approval of Minutes without changes

9:45

3. **Officers Reports:**

    a. **Treasurer's Report**: Reviewed and accepted. Dianne passed around the "Donors Report from Riviera College for all to review. A decision was made to continue the donation of $250.00 for the Martinez – Fey scholarship for 2014.

        1. **Refreshments**: Dianne informed the group that it costs approximately $30.00 per month for refreshments for our meetings. She asked the group if all wanted to continue this option as it does lower our checking account significantly. Several options were presented. (Everyone contribute $1.00 per meeting for refreshments; Increase the annual membership cost to cover the year's refreshments; Members would volunteer to bring in refreshments; Discontinue refreshments)

            Those present decided that we could bring snacks to share ourselves and that DDNNH will continue to pay for coffee supplies and paper products.

    b. **DDNA Liaison Report**: KiKi informed the group that DDNA has announced an opportunity to win registration to the upcoming conference. Details are in DDNA's December newsletter.

        1. **J**eremy Coull from Cyberonics is willing to make a 25-30 minute presentation on the vagal nerve stimulator (VNS) at no cost to the membership. He will be added to the 3/18/2014 agenda. KiKi will check on AV equipment needs. It is unlikely that CEUs can be offered for this presentation, but KiKi is checking with Massachusetts DDNA as Jeremy mentioned that he presented for their group recently.

    c. Linda C informed group that she would no longer be forwarding emails to the group from other members as she is making a career change. She updated the emails of the members present. There is a new person hired to take what was Stacy's position for our group and will be in training as of 2/3/14. As part of our FAQ work, the State was able to create a DDNNH email address that will be monitored by Deb G, Peggy Sue G and the new hire. All information that members would like to have sent out to group should be emailed to ddnnh@dhhs.state.nh.us. (including questions on practice issues to the group, notification of NT opening etc)

4. **BHF Bureau of Health Facilities** –Peter Bacon, Supervisor of State Surveyors reviewed some of the universal problems that the surveyors are encountering. A summary of the discussion is as follows:

    a. **Providers who have let medication certifications expire**: There was much discussion as well as opinions on how this should be handled. (examples brought up: is there a difference if the expiration was a month ago or many months ago; who pays for re-training, is there a difference

between a contractor and employee in how this is handled; who gives meds until training is completed)

As a result of the discussion, Peter made a suggestion that a statement be developed about medication administration certification lapses which can ultimately be uniformly applied in practice. The statement should address the breadth of the problems discussed e.g., should lapsed administrators attend a full certification class or can the Nurse decide how it should be handled depending on the situation. A further discussion will be held at our February meeting. When a statement is crafted it will be sent to the med committee for review and approval and then on to Peter. He will pass the information on to his staff.

b. Peter shared with the group some of the surveyors' medication related "horror stories" they have encountered.

c. A question was asked about signing ISA, health histories, HSI etc. – how to do this if you do not know the individual receiving supports. The He-M 1201 rule does not state that the annual service agreement (ISA) needs to be signed by the nurse, only that it be reviewed by a nurse. Each agency has a responsibility to figure out a process to ensure the intent of the regulation is met.

d. Last updated 1201A report was August, 2013 – it is available in PDF form on the DDNNH website. Everyone should be using the latest forms. The 1201B report form was updated in November 2013 – remember - this is to be completed by the director or director's designee (which specifically cannot be the NT).

e. A question was raised about clients transferring from one area agency to another with no psychiatric follow through. The new area does not have community psychiatric practitioners available to take on – previous psychiatrist is not willing to keep prescribing since they are no longer following the client. Discussion ensued about the challenges in the NH mental health system – perhaps partnering with MCM to find solution(s). A secondary question was raised to the group asking if anyone knew if there had been an understanding about NH Medicaid requiring individual to see a psychiatrist prior to accessing counseling services – no one present had knowledge that this was true.

f. A question was raised – is there a plan for managing transition issues identified with managed care as we look to the future for Stage 2? Answer – unknown.

5. **New business**: Kenda brought up that we had talked about in December sending around a form to document specific concerns/issues regarding HRST – we ran out of time at both meetings – suggested that they can be brought to the next meeting or sent to Judy individually or creating a trouble ticket in the HRST system if the concern/issue is tool specific.

6. **Unfinished Business:**

   a. Frequently asked questions work was deferred to Feb meeting due to time constraints.

   b. E- Studio; we will put on agenda for a discussion as to whether we would like to be part of this communication web site at a future meeting.

Meeting adjourned at 11:30am. Next scheduled meeting Tuesday, February 18, 2014

Respectfully submitted,

Linda Catalano RN
DDNNH Secretary

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes

JANUARY 15, 2013

9:30

1. **Meeting was called to order with 26 in attendance**

2. **Review** and approval of Minutes without correction

9:45

3. **Officers Reports**:

   a. Treasurer's Report: Read and accepted. Diane will be sending a check for $250.00, our contribution for the Scholarship program at Riviera College this month. A reminder was made that $545.00 will be needed for our Liaison to attend the annual DDNA Conference.

   b. DDNA Liaison Report: KiKi Sylvester was absent but Jen Boisvert reviewed some of the conference details with the group. The DDNA conference will be in Philadelphia Pennsylvania on April 27-29th. The pre conferences will be on April 25 & 26th. Further information can be obtained at DDNA.org.

   c. Unfinished Business: Copies of the curriculum "Everyday Health and Safety" were distributed for those who did not receive them in the past. This is also available online through the DDNNH website. A list of those members desiring to have a copy of the DVD that accompanies this training was obtained and given to Stacy Colby. Stacy sent out an email to the group in December requesting those interested to send her a reply – one copy available per agency.

10:00

4. **Peter Bacon from BHF:** Several issues were discussed as follows:

   a. Interpretive Statement for He-M 1201.03 (d&f) (regarding health status indicators) – Statement was accepted by bureau as written. . Statement was then voted on and accepted by the group In summary:

      1) **At the minimum, HSI's need to be reviewed for Primary Care Visits.**
      2) **Agencies may choose to review for other specialties as well**
      3) **No particular form is required. The form from the bureau is a guideline. The purpose is to assure that functional changes are communicated to the primary care practitioner. Some form of documentation that this was done must be available for review by the surveyors.**
      4) **The word practitioner is defined as whoever does the physical exam**
      5) **The meaning of the word "equivalent" in the statement was discussed. It was decided that the word reflected other choices that Individuals have for other specialties that may manage their health care. The word will remain in the statement.**

6) **If any questions related to the Surveyors arise please notify Peter right away so resolution can be determined sooner.**
7) **If missed documentation of the HSI"s is noted and documented on the QA no deficiency will be given.**

b. **Documentation of Controlled Medications:** Documentation of a medication error can either be noted on a Med Occurrence Form or on the QA according to regulation. Adding and subtracting errors on the count sheet **Are errors and must be reported on the 1201 A reports.**

c. **Pill Counters:** Please make sure all homes that have controlled medications have pill counters or some mechanism to count medications properly. Peter asked nurses to consider if paper plates are a safe enough mechanism as he has seen spills during cert visits. A suggestion from Leslie was using bead trays as a count mechanism.

d. **Health Care Recommendations:** The form is a tool meant to advocate for the individual.

1) **The form does not need to be signed by practitioner**
2) **Person reviewing recommendations with practitioner must document that this occurred. Signing the form is one way to do this.**
3) **Nurses should talk to guardian and document if recommended testing cannot be done in certain circumstances, i.e. "Individual will not tolerate".**

e. **Dental Work for Individuals:** Cost for Dental Care for the individuals need to be taken to the area agency for funding. Agency is responsible for determining funding allocations.

f. **Medicare not reimbursing for P/E's** Some of the members reported that Medicare will not pay for physical exams. Terminology under regulation states that an "annual Health Assessment" is required. Peter suggested for anyone experiencing this should send an email to Matthew Ertas.

Peter will be attending our March meeting.

11:00 – 12:00

5. **Continuing Education Series:** Joan Kelly Arsenault CEO and Director of Clinical Services of Mass Tex Imaging gave a very interesting presentation on "Dysphagia Management for Individuals with Developmental Disabilities". DDNNH Nurses attending received 1.0 contact hour of continuing education after passing in their evaluation.

12:00 Noon – Meeting was adjourned. The next scheduled meeting will be Tuesday, February 19, 2013.

9:30

1. **Meeting was called to order with: 29 in attendance**

2. **Review** and approval of January 2013 minutes with one minor correction

Minutes
February 19, 2013

9:45

3. **Officer's Reports:**

4. **Treasurer's Report**: Read and accepted

   a. **DDNA Liaison Report**: Ki Ki Sylvester reviewed conference details to include the following:

      a. Conference is April 27-29th
      b. Pre conference dates are the 25th re: (Telephone Triage) and the 26th
      c. Cost is $395.00 for 3 day conference; extra fees for pre conference
      d. Does anyone have any ideas as to what we as a group could donate for the possible auction? Last year we spent $15.00 on the auction. Ki Ki will find out by next meeting whether there will even be an auction
      e. Barbara Bancroft and Anne Pooler will be repeat presenters. Ki Ki states that they are very good speakers.
      f. One of the pre- conference subjects on the Affordable Care Act.

   b. **Jen Boisvert reported** that the DDNA is requesting articles from their membership. Deadline for these articles is March 13th. Further information on these subjects can be found on the DDNA website.

5. **Special Business:** Deb Nailor reported on her findings on the differences of the updated MA Health Screening Recommendations from the ones we are using presently. Deb felt that the updated version was more concise. Deb will ask Stacy to send out the updated Health Screening tool to membership again. She asked that everyone review the form and be prepared to discuss at the March meeting.

6. **Unfinished Business:**

   a. **HRST**: Diane Kordas (from One Sky) developed a questionnaire screening tool to help with data collection for the Health Risk Screening Tool. Diane will ask Stacy to send the questionnaire out to everyone. Darlene Foley stated that Plus Company was part of the pilot study. Both Darlene and Diane are willing to lend a helping hand if anyone should need assistance. Please contact them directly.

   b. **Frequently Asked Questions:** Group was asked to review the questions on the web site and come to the next meeting prepared to form a subcommittee to review and update them.

10:30

7. **New Business**

1. Deb Nailor asked the group if they were aware of the annual Woman's Expo held in Manchester. She recommends it. She has found that Hannaford's has provided a great deal of free dietary information that could be used for teaching. It was held in February and is inexpensive to attend - $7.00 to get in.
2. Diet Orders do need to be renewed annually. Regulation 1001.06 states that Dietary Restrictions need to be ordered by MD. The regulation does not specifically state the time required for renewal. Group will discuss with Peter at March meeting.
3. Everyone was reminded to contact Peter Bacon directly if you are cited for issues you do not agree with. Peter requested this so he can make a determination more expeditiously. A question was raised for 521 settings – does self med admin assessment need to be done yearly? Answer was yes. 1201.03 deficiencies have been reported by some nurses as given for 30 day and annual nursing review even though they are noted on QA forms.
4. Some members of the group have experienced that Medicare is no longer paying for physical exams. Some physicians will not complete our annual physical forms and the documentation they provide may not cover all that is required by our regulations. Medicare will only pay for "Wellness Checks". Please notify Matthew Ertas if you are having any problems getting a physical/wellness check for your individuals.
5. The procedure for an incorrect label was reviewed. When there has been a medication label change and the pharmacy will not re-label the medication, a red line or dot is placed on the label and the pills are placed in a baggy with a copy of the new order. This procedure is in our FAQs and is permitted until a refill is obtained. No one but a pharmacist can re-label a medication bottle.
6. A question was asked whether anyone was using med sheets for 525 homes where med administration is under delegation (e.g. are you using NUR 404 or He-M 1201). Some do and others do not. Leslie Evans has a home using NUR 404 delegation that had long experience with med logs and wanted to continue. So she created and uses a one page 6 month med sheet for that home and will forward a copy to the group.
7. Diane Kordas asked group if anyone experienced a physician refusing to see an individual who has behavioral issues when brought to the office. Some suggestions from group were as follows:
    a. See if there is a medical provider who will do house calls.
    b. Switch the gender of the physician. Possible different response
    c. Ask physician to see individual in a more open space rather than the office. i.e. lunch room

11:30 Meeting adjourned

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes

April 16, 2013

9:40

1. **Meeting was called to order with 27 in attendance**

2. **Review** and approval of February 2013 minutes with no corrections. The March meeting was cancelled due to snow storm.

9:45 Officers Reports:

a Treasurer's Report:: Read and accepted. Dianne is accepting checks for membership for 2013-2014 .

b DDNA Liaison Report:: Kiki Sylvester reminded everyone that the DDNA conference was in two weeks. 5 members are going. There are no rooms left at this point.

9:50 HRST:

- **a.** Many Nurses have not completed the initial training
- **b.** You will not get a login until after completing the initial training
- **c.** KiKi will speak to Erin from HRST co. and request training dates be sent to membership
- **d.** Each agency has their own design as to how this program will be rolled out
- **e.** Darlene suggested that someone be appointed liaison to the HRST program to help answer questions we are having. She will email Matthew to regarding this.

10:05 Peter Bacon from BHF: The following issues were discussed:

a. **Diet Orders**- Reg 1001.06K5 requires a medical order for a specific diet. The regulation does **not** indicate that this order needs to be renewed annually. Peter's understanding was that it did. Peter will discuss with Matthew and report back the outcome. A question was asked why diet was under 1001 and not 1201.
b. **Allergy Issues**- i.e. lactose intolerance just need to be listed under allergies and does not follow diet guidelines
c. **Deficiencies**- Any deficiencies that a Nurse feels are unwarranted please email Peter Bacon @ **Peter.E.Bacon@dhhs.state.nh.us** or call him at **271-9044**
d. **Med Error**s- If an error is documented on a Med Occurrence report and the Nurse is obviously aware of the error a deficiency should not be given, even if it is not on the QA.

e. **Physicals-** an annual physical exam is required for all individuals under RSA 171. The timing for this can be up to 60 days with a Drs note stating the appointment was canceled. Any comprehensive exam can be used as a physical.
f. **Health Status Indicators –** Several members have received deficiencies for test results not in the chart. Peter stated that all that is required is a consult indicating that the test was done. Please contact Peter if this should occur.

Either the staff or the hcp taking an individual to a Primary Care Visit need to review the HSI's and document. Dr does NOT need to sign them. Form does NOT need to be taken to the office.

g. **Frequency of QA's-** In enhanced family care the RN under He-M 1201 can make the decision how frequently the QA needs to be done. This should be documented on a note in the Med Book or on the QA. If documented, every 6 months is sufficient.
h. **Compliance Form-** Peter passed out a compliance form that some of the agencies are using. This form in not mandatory just a suggestion.
i. **PRN Protocols –** The reviewers may site concerns but no deficiencies for any recommendations based on medical reasons by the RN
j. **Reg 507-** Regulation is up for revision. Peter will forward the proposed changes to Stacy and ask her to send them to membership

Peter will attend the September meeting.

11:00

Special Business:

a. Nominations: Elections for Vice President and DDNA Liaison will occur at the May 2013 meeting.

1. Several nominations were made for the Vice President Position. Nominees will confirm at the May meeting whether they are interested in the position. The position of Vice President is a 2 year commitment. The Vice President will then move up to President for the following 2 years.
2. Ki Ki Sylvester was nominated by Leslie for her position of DDNA Liaison that she presently holds. She has accepted the nomination.
3. Eileen Corbett will move from Vice President to President for 2013-2015.

11:15

Unfinished Business: DDNA auction items need to be given to one of the members who are attending. $15.00 was authorized by members to purchase some stationary that is made by the individuals to be auctioned. Darlene will check on some art that may be able to be donated.

Meeting was adjourned at 11:30pm. Next meeting scheduled for May 21 at 9:30am

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
May 21, 2013

9:30

1. **Meeting was called to order by the Vice President as President was absent:** approximately 20 members were present

   Leslie made an apology to the group for a statement that was made to Peter Bacon at the April Meeting.

9:40

BHF Bureau of Health Facilities – Jill Desrocher, Attorney with the bureau, who leads the investigators for human rights infractions, posed this question to the group;: **Are Med Errors a Human Right Infraction?** A lively discussion ensued to which no definitive answer was determined, however, the majority of the Nurses felt that we are doing a good job in making the necessary corrections and follow up from med errors. Some of the issues that **may** result in a human rights infraction are the following:

1. **Administering meds in a disguised manner**
2. **Medications used as a chemical restraint without team agreement**
3. **Errors that are not reported**
4. **Refusal or omissions that may lead to the harm of an individual**
5. **Withholding of medications**

The bureau is not able to address neglect in a hospital setting. For violations in this arena. Adult Protective Services need to be contacted. Jill agreed that whenever possible an investigator would try speak to the Nurse for clarification. It was agreed that the Med Committee oversees med errors and will ask for follow up and more information when needed.

Jill may be contacted at jill.desrochers@dhhs.state.nh.us

Human rights hot line # is 1-800-949-0470. Caller may remain anonymous

10:30

1. **Review** and approval of April minutes without correction
2. **Treasurer's Report :** Read and accepted. Dianne will continue accepting checks for membership for 2013-2014. It was agreed that a gift between $25-$30 would be purchased for the outgoing president to be presented at the June meeting.
   a. **DDNA Liaison Report:** KiKi was absent. She will present a report at the June meeting on the annual DDNA conference.

Special Business: The position of DDNA Liaison and Vice President were up for reelection this year. Ki Ki Sylvester will remain our DDNA Liaison and Leslie Evans will be our new Vice President . Congratulations to Ki Ki and Leslie! The officers for the 2013-2014 year are as follows:

President: **Eileen Corbett**
Vice President: **Leslie Evans**

Secretary: **Linda Catalano**
Tresurer: **Dianne Crone**
DDNA Liaison: **KiKi Sylvester**

2. **Unfinished Business:**

1. **HRST's:** Still much confusion. There is a question as to whether vendor nurses will be required to do these. It appears that in some area they will and in others they will not. A question was asked as to how can a nurse evaluate the information on a HRST if they do not know the individual.. Kenda volunteered to communicate with CSNI and see how they are utilizing HRST.

2. **Replacement for Joyce:** At this time there is no information on her replacement. Linda will invite Matthew to attend the June meeting so we can discuss these issues.

3. **PRN Meds:** Do prn meds need to accompany an individual in the community? It was decided that this could be addressed at a team meeting and the determination could be written in the service agreement.

4. **Annual Health Screening Tool:** A motion was made to accept the updated Mass Annual Health Screening tool as the screening tool that we will now use. Kenda will present the new form at the June meeting to Matthew for endorsement by the Bureau.

5. **QA's:** HeM -1201.09 states that the minimum requirement for a QA that is **NOT** a staffed residence, a day program, or a residence with over 3 individuals that a QA needs to be done every 6 months.

6. **Diet Renewal :** Jen will email Peter to see if a decision was made on whether diets will need to be renewed annually and report back at the June meeting.

11:00a

3. **New Business including Nursing Practice Issues:**

1 Staff terminated due to an investigation: A question was raised as to how we can notify each other when a staff has been terminated for unfavorable behavior? It was decided that there is really no legal way to do this. It was suggested that when a nurse needs to verify a certification, she/he should communicate with the terminating agency nurse to verify if the employee's med certification is valid and current.
2. Start Program: Deb inquired if other Nurses were being asked for recommendations for an individual in the start program? More information on this program needs to be given.

11:45 Meeting adjourned.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
June 18, 2013

9:30

1. **Meeting was called to order with 20 members in attendance**

2. **Review** and approval of Minutes without correction

9:45

3. **Officers Reports:**
   i. **Treasurer's Report**: Read and accepted.

   b. **DDNA Liaison Report**: Ki Ki reported that 4 members attended the May DDNA conference. She felt the conference was good. The next conference (2014) will be in Orlando, FL at the same hotel as last time (Rosen Plaza) . Ki Ki will send to group her report on the sessions she attended in a future email.
      1. KiKi attended the DDNA board meeting and DDNA's goal is to increase membership.
      2. KiKi was not invited to the chapter luncheon as we are a network and not a chapter.
      3. She contacted the member Rep to request that we receive same information that the chapters receive. No response from Rep at this time.
      4. Jen (past Liaison) stated that DDNA is trying to maintain a difference between the Chapters and the Networks, the luncheon being one of them.
      5. A discussion has occurred in the past relating to our being a Chapter rather than a Network. The group felt that there wasn't enough benefit to do so.
      6. Ki Ki - DDNA is in the process of trying to develop an alliance with ANA, however, ANA does not agree with our position of Med Administration (delegation).

4. **Unfinished Business:**

   A. Diet Orders: Jen B followed up with Peter Bacon regarding the need to renew diet orders annually. Peter has had discussion at the bureau and a question was raised that if special diets were not required to be renewed annually they may "fall through the cracks" (because they are not tracked routinely on a document – as medications are logged on a med log if the order continues on after the previous annual deadline). Peter stated that he would get back to Jen after further consideration/exploration of issues. No response thus far. This means that diet orders will continue to need to be renewed annually.

   B. Meeting Room: A decision was made to continue to hold our meetings in Brown Bldg auditorium for Sept, Oct and November. The South Function Room would be available then, however, the parking lot will be under construction. We are scheduled to return to the South Function room in December (Jen double checked and we are on the schedule to have the room).

C. Scheduled Meeting Time: Our monthly meetings are scheduled to end at 11:30am. It was agreed that the meeting could run until 12:00 noon in the event of a special speaker.

D. HRST Issues:

1. Diane stated there is no mechanism on the tool that addresses chronic pain and the need to take pain medication for this. Some felt that a note under pain clinic or safety would suffice. Diane will bring an answer to this question to the September meeting..
    a. Group felt that there is so much duplication of medical data and hope that the HRST will take the place of some of our present forms required by the Bureau. (Jen reminds us that the information is required not the forms.)

10:00

5. **Speaker from CSNI:** Dottie Treisner, Executive Director of CSNI was invited to speak to our group relating CSNI's involvement with the HRST. CSNI is the association for area agencies comprised of the executive directors of each. Dottie was not very familiar with the tool but invited the group to ask questions that she would take back to CSNI. She informed us the "Big Picture" was that area agencies and vendor groups would eventually be moving to "Health Homes" (medically fragile, which is approx 10% of our population) to better meet the medical needs. Region 6 is presently involved with a pilot program (through a grant) to address acute and long term care needs specific to I/DD – working specifically on a health home embedded in Dartmouth (Nashua office only) and improving communication between the doctors and the Agency. Some of the strategies identified are as follows:
    1. Acute medical needs may need an acute care manager to navigate the system
    2. "Marrying" the acute care system with the agency and vendor systems to develop a better relationship between Dartmouth (Nashua) and agency staff resulting in better communication.
    3. Data collection: "supportive asset" for Nurses. Nothing at this point has been assigned
    4. Data Sharing: HRST is one of the data tools to gather information to decide who has a need for a health home.

Preparing for Managed Care is driving the agency to become more aware of the acute care needs of our individuals.

10:30

6. **New Business** including Nursing Practice Issues:

A. Mass Tex Imaging: Now has NH Medicaid approval. Jen B shared her experiences with the group. Members of the group who have worked with them are very pleased with both their time line as well as their treatment of our individuals. The referral from the physician needs to be written in a specific way. **For more information contact Mass Tex Imaging @ 800-508-6277**

B. Five Day Visit Rule: Be aware that the 5 day rule applies to any provider changes – not just address changes – Jen has had two instances where the individual did not move, instead the companion or the contracted provider changed. In one case no one within the home changed – the contract changed from one adult to another. This also means that monthly QAs are required for the first three months. Discussion occurred around how members have managed Med Authorization for a new residence/contract provider – for example: these can be done earlier than the official start date of the certification (if the individual stays at the potential new home as a trial, so long as the provider is currently med authorized somewhere, then a med observation can be scheduled). The 5 day visit **must** be done within the first 5 business days from the initial certification date. In an emergency situation Nur404 could be used as long as the residence does not have more than 3 individuals.

C. Potential lethal combination of medications: Leslie shared a sad story about an individual in one of her forensic homes that died at the age of 37 from a deadly combination of clozaril and fluvoxamine. She wanted the group to be aware of the danger of this combination as we are all seeing more mental health issues.

7. **BHF Bureau of Health Facilities –Matthew Ertas:** Spoke to group about the following:

A, .HRST: Mathew distributed a handout about the evolution of the Health Risk Screening Tool (HRST) and why the Bureau feels that it will be an important tool for the agencies. Additional points that were emphasized were:

1. HRST is a screening tool not an assessment tool, raises yellow flag to raise awareness about information to consider for possible action.
2. The Bureau will not dictate to the agencies how to utilize the tool
3. The tool will aid in long term care issues of our individuals
4. Nurses will be a resource in all areas
5. The contract is for one year (for 2,000 individuals in NH which is ~ ½ of the adults we serve) and a decision to extend will be based on the feedback given in December.
6. We serve approx. 4800 adults
7. Feedback on the HRST will be collected for 3 years
8. It is possible that information currently collected on other forms may be able to be captured solely with the HRST.
9. Data needs to be updated at least annually
10. Minimal funding is available for administrative support

B. Replacement for Joyce:

1. The Bureau is getting ready to hire a nurse
2. Matthew explained that the reason it has taken so long is that a problem was noted by human resources with the labor grade and the job description (after 30 years of the position).
3. All Frail List work sheets that would previously have been sent to Joyce should be kept until the new nurse is hired
4. The expectation of the Bureau is that the new nurse will go out and meet the frail clients as Joyce had done.

D. Mass Health Screening Tool: The Bureau accepted DDNNH's recommendations to adopt the updated version of the annual screening tool. Linda will send an email to Joyce to see if she will post the new form on the web.

11:30 Meeting was adjourned. The next scheduled meeting will be September 16, 2013

Respectfully submitted,

Linda Catalano RN
Secretary DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
June 18, 2013

9:30

1. **Meeting was called to order with 20 members in attendance**

2. **Review** and approval of Minutes without correction

9:45

3. **Officers Reports:**
   i. **Treasurer's Report**: Read and accepted.

   b.

   DDNA Liaison Report: Ki Ki reported that 4 members attended the May DDNA conference. She felt the conference was good. The next conference (2014) will be in Orlando, FL at the same hotel as last time (Rosen Plaza) . Ki Ki will send to group her report on the sessions she attended in a future email.

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Respectfully submitted,
Linda Catalano RN
Secretary DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes

SEPTEMBER 17, 2013

9:30

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of June minutes with one minor correction

9:45

3. **Officers Reports:**

1.Treasurer's Report: Dianne Crone was absent. Treasurer's report read. Any questions will be directed to October meeting when Dianne is present. Linda Catalano will collect any membership dues to give to Dianne.

a. **DDNA Liaison Report**: Kiki passed out a summary of the DDNA conference that she attended in April..
b. Kiki informed group that the "epi pen waiver" on the DHHS website is listing the wrong regulation. The correct regulation is section He-M 1201.06(a) (l)(11). Kenda will bring to the attention of the Med Committee as they are in the process of updating forms.
c. Linda C informed group that she has an updated email list that she and Deb Gibbs now have. It was decided that Linda Catalano would maintain the database at this time. She will be responsible for updating the list and sending it to Deb Gibbs. If you have anything that you would like sent to the group send it to Linda and she will send it out to the group.

10:00

4. **Special Business:**

a. Jen B distributed a handout that Peter B used in a presentation identifying the top ten deficiencies noted within the State for the past 18 months.
b. Jen also distributed an information packet on the NH Medicaid Management Program (MCM). She advised group to search the provider directory under provider's name as that is how they are set up at this time. Directories are not complete (continue to have names added).
    i. Individuals who receive Medicaid in any form have the option to open a NH Easy Acct – which will allow them to manage many things including health plan enrollment online. A letter has gone out (to one of the following – the individual, their guardian or their representative payee) indicating which next step they need to take for MCM: mandatory enrollment in a health plan, voluntary enrollment (or opt out), or they may be exempt.
    ii. They have 60 days to choose from the date of the letter.
    iii. If a choice is not made a plan will be auto assigned which may not benefit the individual

iv. It will be relatively easy to switch.
v. As soon as someone signs up the health plans are required to send a health plan card within 7 days. They also will call (up to a max of 3 tries) to welcome the individual.
vi. If you have any questions, there is a contact number on the MCM website.
vii. For those enrolled in a health plan, 2 cards will need to be taken to physician appointments (NH Medicaid card, health plan card). It is the provider's responsibility to check to see if services are covered.

5. **Unfinished Business:** Several members voiced concerns/frustrations with some of the reviewers and what they are citing. Kenda reminded the group again what Peter has told us many times: **If you are cited for something you do not agree with or feel is unjust, please notify Peter and appeal.** (Please be sure to have the specific citation to reference during your conversation.)

Health Screening Recommendations: A member stated that the form was updated on the bureau's web site but the date was not changed on the bottom of the form. A reminder to everyone that tool is a guideline only. You are responsible for the parts that are stated in the regulation only. The Health Screening guideline is what is suggested.

Lists of Current Medications from the physicians offices: are not always accurate and should not be used as orders. It was stated that Peter has informed the surveyors not to use them. Linda C stated be aware that the electronic medical records may not coordinate with the physician consult report. A discrepancy in these could delay medical services that are needed.

Replacement for Joyce: Linda C read an email from Matthew Ertas stating the position is posted externally and there is one person who has applied but Human Resources has not notified them whether the person qualifies for the position so they can be interviewed.

11:00am

6. **New Business** including Nursing Practice Issues:

Deb Nailor : Would like the group to develop a mechanism to share physicians names who demonstrate excellent communication with our individuals. This could also be beneficial in notifying group what physicians take Medicaid. Jen will ask Deb Gibbs if she would post information online for us.

Site Training of Staff when there are no meds to admin: A lively discussion followed. The regulation states that annual site training **MUST** be done in each certified residence. Staff who are working at multiple sites **MUST** be site trained in each site that they will be administering medications from.

11:30am

Meeting was adjourned. Next Scheduled Meeting is Tuesday, October 15, 2013.

Respectfully Submitted by

Linda Catalano RN
Secretary DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes

OCTOBER 15, 2013

9:30

1. **Meeting was called to order with:** 25 in attendance. Deb Gibbs announced to the group that Matthew has approved the purchase of handbooks on "Intellectual Disabilities at your fingertips" for those who are interested. A list of those interested was generated and given to Deb. Thank you Deb.
2. **Clarification:** The online epi- pen waiver is correct. There was an issue with the font. The letter "l" and the number "1" look the same.
3. **Review** and approval of Minutes without correction

9:45

4. **Officers Reports:**
   a. **Treasurer's Report**: Read and accepted. Dianne presented out going president, Darlene Foley with a gift from the membership. Darlene expressed her appreciation.
   b. **DDNA Liaison Report**: Nothing to report this month

10:00 **BHF Bureau of Health Facilities:** Peter Bacon welcomed questions from the group related to certifications. The following were discussed:

a. **Health History record**: This can be filed either in the house book or in the med book. The medication book is probably the most effective place to file it. The only requirement is that a copy be in the home.
b. **1201 A- Short Form:** Everyone needs be using the new form that was sent out. There is an additional column that asks whether the individual is followed by psychiatry.
c. **Bubble packs for medications:** Peter warned the group to be aware that there have been errors in the packaging of these medications.
d. **Controlled Medications:** Documentation of controlled count needs to occur when administration occurs or at least daily.
e. **Master Schedule for the Reviewers:** Peter maintains this schedule and will tell you who your surveyor will be if you are interested.
f. **Please notify Peter if you are being cited for anything that you question!** Be sure to include the specific citation information.
g. **Annual Health Screening Recommendation Form:** is a tool only. The recommendations can be documented on any form you choose, i.e, physician progress notes, physical form etc. The form is to remind the person attending the physician annual visit of the recommended testing that should be done for **everyone.**
h. **Wellness Visit:** Peter is aware that for some PCPs Wellness visits are being performed rather than an annual physical. Medicare pays for an annual wellness visit rather than a physical. Peter will check into this.
i. **Self- Med Assessment:** Make sure there is a current self med assessment in the House book or Med Book. There have been different dated copies – an old one available at the home that is out of date which the surveyor sees and an up to date one at the office. Re-assessment is an annual requirement. Self Med Assessments only need to be done for individuals receiving medications.

j. **Behavioral Health:** The He-M 1202 expired 3 years ago. The extension has also expired. Much of the leadership is leaving. With no rule it may revert to Nursing 404.

k. **Respite Care:** Care Givers do not need to be med certified if administering medications in a non- certified home. We do have a responsibility to assure that the care givers have the information to deliver the meds safely. "Follow the Money" when determining whether the providers need to be trained. The state does not have any authority to make demands on non-certified residences.

l. **Nurse signature on Service Agreements (SA):** A nurse can sign the service agreement itself indicating they have reviewed the plan, they can indicate that they have reviewed the plan on their QA, or they could institute another system like signing a separate form that the review occurred. Clear documentation from the nurse needs to exist that the nurse reviewed the SA.

m. **Diets:** No definitive answer has been reached as to whether a diet needs to be reviewed annually. There is a difference in opinion as to when a diet is a "diet" vs a "recommendation". Clarification is needed. A suggestion that diet be added to the physical form was made. Another suggestion is to place it on the Health Status Indicator or Annual Screening tool. He-M 1201.06 (k) does not state any requirements that diets be renewed annually. The concern is how the reviewers are assured that oversight has been maintained.

The group felt there has been great improvement with the review process since Peter has been attending our meetings. Thank you, Peter. Peter will attend the January 2014 meeting.

11:00

5. **New Business** including Nursing Practice Issues:

a. Area Agency 3 uses a signature page for their 1201 A reports that Kenda stated the med committee really liked. She asked that the form be sent to Linda Catalano to send out to membership.

6. **Old Business:**

1.Frequently Asked Questions: Jen and Kenda have met to discuss updating our website FAQs. They have requested that the current FAQs be reviewed by the membership – they found it helpful to keep the following 5 categories in mind:

1. **Nurse Trainer Related Questions**
2. **Licensing Questions**
3. **Regulation Related Questions**
4. **Nursing Practice Issues and Questions**
5. **Training Related Questions**
6. **Historical Entries (no longer current information)**

Please come to the next meeting prepared to discuss these in length. It will be the major part of our agenda for November.

11:30: Meeting Adjourned. PLEASE NOTE upcoming meeting location change - November will be our last meeting in the Brown Building. We will be back at the Main Building for December.

Respectfully Submitted

Linda Catalano RN. Secretary DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
November 19, 2013

9:30

1. **Meeting was called to order**, with 18 in attendance

2. **Review** and approval of Minutes with 2 minor corrections

9:45

3. **Officers Reports:** Dianne Crone was acting president as both president and vice president were absent.
    i. **Treasurer's Report**: Read and accepted
        a. Dianne informed the group the amount of money that the membership pays annually for the following:
            1} $250 in the spring for nursing scholarship at Rivier College
            2} $545 for the DDNNA Liaison to attend the annual conference
            3) $100-$200 for miscellaneous gifts, coffee, paper goods

For the last 2 years Dianne has purchased gifts out of the checking account for everyone to receive a small gift at the Christmas Party. This year we voted to bring a "gently used item" from home for a Yankee Swap! Please bring your gifts wrapped.

10:00

4. **Special Business:**
    a. The annual Christmas Party will be on December 17th at our next meeting. It was agreed upon to only use one hour of the next meeting to discuss Nursing Issues. The other hour will be used for eating and socializing. Deb Gibbs provided a sign up sheet for members to indicate what they would bring for the "pot luck" celebration.
5. **Unfinished Business:**
    a. Kenda asked that Davina send a copy of the 1201 signature sheet that Reg 3 Area Agency uses to Linda C to send out to membership.
    b. Deb Gibbs asked to inform the group of the following:
        1} The handbook " Intellectual Disabilities at your fingertips" is on backorder.
        2} When submitting your 1201 A report please send single sided only !

6 **Updating FAQs:** The remainder of the meeting was utilized to review and suggest updates of the" Frequently Asked Questions'. The group was split into sub groups, with each group reviewing one of the following categories that had previously been agreed upon
    1. Nurse Trainer Related Information
    2. Licensing Questions
    3. Regulation Related Questions
    4. Nursing Practice Issues and Questions

5. Training Related Questions
6. Historical Entries.

Kenda and Jen gathered each groups' comments and suggestions and will provide a draft to review in January.

The Meeting was adjourned at 11:30am. BEGINNING NEXT MEETING WE WILL GO BACK TO 105 PLEASANT STREET IN THE SOUTH FUNCTION ROOM. As the door is locked Darlene Foley has volunteered to arrive a little early to open the door when people arrive!

HAPPY HOLIDAYS!

Respectfully submitted,

Linda Catalano RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
December 17, 2013

9:30

1. **Meeting was called to order** with 18 in attendance (by 10am).

2. **Review** and approval of minutes

3. Debbie Gibbs (from BDS) brought in the previously requested copies of the handbook – copies were handed out to members present who had signed up to receive them. If a member of your agency was there and you had signed up, the copy was given to them to bring back to the office.

9:45

4. **Officers Reports:**

i. **Treasurer's Report**: Read and accepted. Dianne shared the Christmas card that Riviera University sent to our group (most years we vote to support an ongoing scholarship fund established in the name of a distant past member).

ii. **DDNA Liaison Report:** Kiki shared that she had been contacted by a representative from Cyberonics of MA/NH/ME to offer a 30-45 minute training on epilepsy treatment and VNS at a future meeting. He did not mention if there would be a cost – Kiki will ask him. Some members of the group were interested in knowing if this could be a CEU type offering. This process takes several weeks to set up – therefore, it was suggested that Kiki ask him about availability for April as well as if he has other material that would increase the time to a full hour.

Kiki also informed us that the conference schedule for DDNA is now posted on the website (ddna.org). The pre-conference will be held May 2nd and the theme for the day is Down Syndrome throughout the Lifespan. The full conference will be May 3 – 5, 2014. The conference will be at the Rosen Plaza in Orlando, FL. May 5 is a partial day – and the one session scheduled is "Neuro for the not so neuro minded" by Barbara Bancroft.

10:00

5. **Special Business:** Jen shared with the group that Debbie Gibbs had updated the section on DDNNH's website that includes recommendations for physicians/specialists who members have had very positive experiences with. You can find this by clicking on publications in the box on the right hand side of the main page and then clicking the link for Medical Resources.

Word of caution: Dr. Goodman and MassTex Imaging are the new resources added so the info for them is up to date. The other resources have not been updated for at least a few years, so the info may not be up to date.

6. **Unfinished Business:**
    a. In October Kenda asked Jill to send a copy of the 1201 signature sheet that Reg 3 Area Agency uses to Linda C to send out to membership. In November Davina was the rep present from Reg 3 and we asked again about this sheet. At our meeting today Jill said that she had requested it, but had not received it. Kenda will see Steve at the next med committee meeting and ask him then.
    b. HRSTs – there was discussion about this experience. A couple of nurses are done with their reviews. Others have had challenges. Each area agency is managing the process differently. Kenda suggested that we send around a piece of paper and write down the facts (not anecdotes) of individual concerns. Judy C offered to bring the list to somewhere – at least the quality group. We did not actually start the list at this meeting – put on your thinking caps for January!
    c. Med committee – Kenda, as a member of the med committee, recently received an email that new 1201 forms were added to the website – and it appears that at some point some needed information was deleted – particularly on the 1201b and c forms. All nurses present today reported using the new 1201a forms that we received by email. Kenda's email also stated that the instructions on the website were updated. Kenda said that the med committee was due to meet and this would be on the agenda. The committee is particularly concerned about the right forms and directions being available for general use.
    d. During the FAQ work last month, Cheryl asked it if would be possible for DDNNH to have access to e-studio. Kenda asked Ken Lindbergh – he said yes, if we want to. The individual access accounts would be email based (so you MUST give the correct address) with a password. E-studio would be a way to share documents posted there – you can review material, upload new files, make comments to send to the group etc.

7. **Updating FAQs:** We will continue our work at the January meeting. Jen has requested that a laptop, projector and screen be available for our use. The updated drafts will be sent out before the meeting – please print out a copy and bring it with you.

8. **New business**: I. Brad asked about a situation he recently had – individual had a sore throat, was seen by MD, prescribed Cepacol lozenges prn – individual chose not to purchase and instead got lifesavers. What next? Kenda reminded us that the med committee discussed cough drops – first thing to consider is are there swallowing/choking concerns for the particular individual. There should be a team process – if there is no risk of choking, med committee is NOT looking to manage cough drops. Kenda referred us back to the FAQs.

    ii. Eileen MH asked if we can review the new He-M 507 regs at a future meeting – to see if there are items that nurses will be responsible to do/manage.

The Meeting was adjourned at 10:30am and fun presents were unveiled while delicious food was enjoyed. REMEMBER WE ARE BACK AT 105 PLEASANT STREET IN THE SOUTH FUNCTION ROOM!

Respectfully submitted,

Jennifer Boisvert RN
Acting Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
November 19, 2013

9:30

1. **Meeting was called to order**, with 18 in attendance

2. **Review** and approval of Minutes with 2 minor corrections

9:45

3. **Officers Reports:** Dianne Crone was acting president as both president and vice president were absent.
   i. **Treasurer's Report**: Read and accepted
      a. Dianne informed the group the amount of money that the membership pays annually for the following:
         1} $250 in the spring for nursing scholarship at Rivier College
         2} $545 for the DDNNA Liaison to attend the annual conference
         3) $100-$200 for miscellaneous gifts, coffee, paper goods

For the last 2 years Dianne has purchased gifts out of the checking account for everyone to receive a small gift at the Christmas Party. This year we voted to bring a "gently used item" from home for a Yankee Swap! Please bring your gifts wrapped.

10:00

4. **Special Business:**
   a. The annual Christmas Party will be on December 17th at our next meeting. It was agreed upon to only use one hour of the next meeting to discuss Nursing Issues. The other hour will be used for eating and socializing. Deb Gibbs provided a sign up sheet for members to indicate what they would bring for the "pot luck" celebration.
5. **Unfinished Business:**
   a. Kenda asked that Davina send a copy of the 1201 signature sheet that Reg 3 Area Agency uses to Linda C to send out to membership.
   b. Deb Gibbs asked to inform the group of the following:
      1} The handbook " Intellectual Disabilities at your fingertips" is on backorder.
      2} When submitting your 1201 A report please send single sided only !

6 **Updating FAQs:** The remainder of the meeting was utilized to review and suggest updates of the" Frequently Asked Questions'. The group was split into sub groups, with each group reviewing one of the following categories that had previously been agreed upon
   1. Nurse Trainer Related Information
   2. Licensing Questions
   3. Regulation Related Questions
   4. Nursing Practice Issues and Questions

5. Training Related Questions
6. Historical Entries.

Kenda and Jen gathered each groups' comments and suggestions and will provide a draft to review in January.

The Meeting was adjourned at 11:30am. BEGINNING NEXT MEETING WE WILL GO BACK TO 105 PLEASANT STREET IN THE SOUTH FUNCTION ROOM. As the door is locked Darlene Foley has volunteered to arrive a little early to open the door when people arrive!

HAPPY HOLIDAYS!

Respectfully submitted,

Linda Catalano RN
Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
December 17, 2013

9:30

1. **Meeting was called to order** with 18 in attendance (by 10am).

2. **Review** and approval of minutes

3. Debbie Gibbs (from BDS) brought in the previously requested copies of the handbook – copies were handed out to members present who had signed up to receive them. If a member of your agency was there and you had signed up, the copy was given to them to bring back to the office.

9:45

4. **Officers Reports:**

i. **Treasurer's Report**: Read and accepted. Dianne shared the Christmas card that Riviera University sent to our group (most years we vote to support an ongoing scholarship fund established in the name of a distant past member).

ii. **DDNA Liaison Report:** Kiki shared that she had been contacted by a representative from Cyberonics of MA/NH/ME to offer a 30-45 minute training on epilepsy treatment and VNS at a future meeting. He did not mention if there would be a cost – Kiki will ask him. Some members of the group were interested in knowing if this could be a CEU type offering. This process takes several weeks to set up – therefore, it was suggested that Kiki ask him about availability for April as well as if he has other material that would increase the time to a full hour.

Kiki also informed us that the conference schedule for DDNA is now posted on the website (ddna.org). The pre-conference will be held May 2nd and the theme for the day is Down Syndrome throughout the Lifespan. The full conference will be May 3 – 5, 2014. The conference will be at the Rosen Plaza in Orlando, FL. May 5 is a partial day – and the one session scheduled is "Neuro for the not so neuro minded" by Barbara Bancroft.

10:00

5. **Special Business:** Jen shared with the group that Debbie Gibbs had updated the section on DDNNH's website that includes recommendations for physicians/specialists who members have had very positive experiences with. You can find this by clicking on publications in the box on the right hand side of the main page and then clicking the link for Medical Resources.

Word of caution: Dr. Goodman and MassTex Imaging are the new resources added so the info for them is up to date. The other resources have not been updated for at least a few years, so the info may not be up to date.

6. **Unfinished Business:**
   a. In October Kenda asked Jill to send a copy of the 1201 signature sheet that Reg 3 Area Agency uses to Linda C to send out to membership. In November Davina was the rep present from Reg 3 and we asked again about this sheet. At our meeting today Jill said that she had requested it, but had not received it. Kenda will see Steve at the next med committee meeting and ask him then.
   b. HRSTs – there was discussion about this experience. A couple of nurses are done with their reviews. Others have had challenges. Each area agency is managing the process differently. Kenda suggested that we send around a piece of paper and write down the facts (not anecdotes) of individual concerns. Judy C offered to bring the list to somewhere – at least the quality group. We did not actually start the list at this meeting – put on your thinking caps for January!
   c. Med committee – Kenda, as a member of the med committee, recently received an email that new 1201 forms were added to the website – and it appears that at some point some needed information was deleted – particularly on the 1201b and c forms. All nurses present today reported using the new 1201a forms that we received by email. Kenda's email also stated that the instructions on the website were updated. Kenda said that the med committee was due to meet and this would be on the agenda. The committee is particularly concerned about the right forms and directions being available for general use.
   d. During the FAQ work last month, Cheryl asked it if would be possible for DDNNH to have access to e-studio. Kenda asked Ken Lindbergh – he said yes, if we want to. The individual access accounts would be email based (so you MUST give the correct address) with a password. E-studio would be a way to share documents posted there – you can review material, upload new files, make comments to send to the group etc.

7. **Updating FAQs:** We will continue our work at the January meeting. Jen has requested that a laptop, projector and screen be available for our use. The updated drafts will be sent out before the meeting – please print out a copy and bring it with you.

8. **New business**: I. Brad asked about a situation he recently had – individual had a sore throat, was seen by MD, prescribed Cepacol lozenges prn – individual chose not to purchase and instead got lifesavers. What next? Kenda reminded us that the med committee discussed cough drops – first thing to consider is are there swallowing/choking concerns for the particular individual. There should be a team process – if there is no risk of choking, med committee is NOT looking to manage cough drops. Kenda referred us back to the FAQs.

   ii. Eileen MH asked if we can review the new He-M 507 regs at a future meeting – to see if there are items that nurses will be responsible to do/manage.

The Meeting was adjourned at 10:30am and fun presents were unveiled while delicious food was enjoyed. REMEMBER WE ARE BACK AT 105 PLEASANT STREET IN THE SOUTH FUNCTION ROOM!

Respectfully submitted,

Jennifer Boisvert RN
Acting Secretary, DDNNH

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Jan 17, 2012 Minutes

9:30

1. **Meeting** was called to order with 23 in attendance.

2. **Review** and approval of December Minutes.

3. **Officers Reports:**
   a. **Treasurer's Report**: read and accepted.

4. **New Business**

   a. Review of article published in Concord Monitor from the Disabilities Rights Commission regarding six deaths in the DD system over the past 10 years. Numerous suggestions culminated in "the best response is no response."
   b. How many people are DDNA members? Suggestion was made to add a column to the SignIn Sheet for a count.
   c. What does the Quality Council do and should we be involved? Comments included that we as a DDNNH group have a hard time getting people to step up to the plate and participate in our own group's needs let alone participate in another group.
   d. Should we create and adopt our own mission and vision and post on our DDNNH website? Please put on next month's agenda.

10:30

5. **Nursing Practice Issues:**
   a. Situation: individual with diabetes has BS above 400 because he eats a box of Twinkies and a bag of candy and threatens to destroy the house if he doesn't get access to the food – he is in a group home – can't lock up the food.
   b. Review of DDNA Medication Standards – please obtain and put on next month's' agenda.

February 21, 2012 Minutes

9:30

6. **Meeting** was called to order with 25 in attendance

7. Review and approval of January **Minutes**.

8. **Officers Reports:**

   a. **Treasurer's Report**: read and accepted

   b. **DDNA Liaison Report**:
      i. The Annual DDNA Conference is coming up from May 4th to May 7th (the 4th is the preconference) – flyers went out. There is a special hotel rate - $119 per night. Topics will include preventing sexual abuse and end of life issues. There are two preconference days – one for risk management and the other is cert prep and telephone triage. Randy Bryson, who specializes in forensic nursing will be there. The will also be a dinner/dance recognition of the 20th anniversary
      ii. Poster presentation – the board with our information was available for review. Does the group want to put together something? We can bring the pieces and boards will be supplied once there.
      iii. The annual report was submitted. If you haven't already, please go to the DDNA website, there is lots of information there for members, with over 70 CEUs offered online.

9. **Special Business:**
   a. Annual DDNNH Bylaws to be review in April and approval in May. A motion was made to send out the bylaws ahead of the March meeting to discuss changes in March, then review them in April.
   b. Annual DDNNH elections – the Secretary and the DDNA Liaison positions will be open. We will have nominations in April and election in May.
   c. The incentive for nurses to join the DDNA is still active and available for anyone wanting to join the national organization. The Bureau continues to partner with the Area Agencies by offering fifty percent reimbursement to the Area Agencies towards the $80 required for DDNA membership for any nurse working for an area agency or for a subcontracted agency. **HOW IT WORKS:** Nurses will need to contact their respective Area Agencies or subcontracted agencies for support to join the DDNA, and will need to go to the DDNA website directly to register themselves. Subcontracted agencies should then contact their respective Area Agencies, who will enter the payment through BTS and contact their respective Bureau Liaison for approval via email, with a copy of the nurses names emailed

to JButterworth@dhhs.state.nh.us A motion was made to put another column on the sign-in sheet so we can keep better track of number of members.

10. **Unfinished Business:**
    a. The Developmental Services Quality Council's purpose and membership was reviewed. A motion was made to make available more information about the Quality Council, such as links to a website where more information about the Quality Council could be obtained. A suggestion was made to invite Dick Cohen to come speak at our September DDNNH meeting.

11. **New Business:**
    a. How long are orders good for? Please refer to the new 1201s.
    b. Notifying a guardian when an antibiotic is prescribed and you can't get a hold of them – different agencies have different policies – one has a release they give to guardians to sign that unlicensed staff can administer meds and allows guardians to have a choice, either they have to contact before each med or they can start the med and be notified. OPG will never allow meds without notification. It is the expectation that antibiotics have to be started within 24 hours.
    c. Discussion about people from other agencies attending another NTs med class. Some agencies have a policy that people don't attend med class until they've been employed for 60 days.
    d. Please put the DDNA's Position on Med Management on next month's agenda for comment and review.

10:30 – 11:30

12. **Peter Bacon:** from the Bureau of Health Facilities with discussion on the Health Status indicators.
    a. Certifiers are seeing the HSI everywhere - people are doing a good job.
    b. If someone has a physical when do they complete the HSI? Some people complete it 5-6 days prior to the appointment. Are people asking for a specific time frame? If it's the annual physical, how far in advance? The group came to a consensus that the expectation was for this to be done at least quarterly in compliance with the rule.

March 20, 2012 Minutes

9:30

13. **Meeting was called to order with 29 in attendance:**

14. **Review** and approval of February Minutes. Revision to be added to questions with Peter Bacon.

15. **Officers Reports:**
    a. **Treasurer's Report**: read and accepted.
        i. The scholarship check was cashed by Rivier College and we received a lovely thank you letter from them, which was passed around for all to see. Next month we will be sending in the check for the Liaison's attendance at the DDNA conference and we can send this directly to DDNA to take advantage of the early registration discount. Motion made, seconded and passed.
        ii. The DDNNH is now accepting membership applications and payments for our own membership drive.
    b. **DDNA Liaison Report**:
        i. DDNA conference in May, with 2 full preconference days focusing on telephone triage and risk management. The hotel has a special rate for $119.00 per night.
        ii. Poster presentation discussed.
        iii. March is DD awareness month.
        iv. Silent auction: Kiki will need items by next month. We can donate a gift certificate or maple syrup of if anyone thinks of anything send an email to Kiki.
        v. March 25th we will send in out update for the DDNA website. Kiki will speak with others about the progress we've made and add to the report. Anyone can also send Kiki an email with suggestions.

16. **Special Business:**
    a. Annual DDNNH Bylaw review: The bylaws were distributed via email prior to this meeting for review. Comments included:
        i. They are good but "vanilla" – we are thinking about the President and Vice President assuming a larger role in the leadership of the group and it would be good if the President and Vice President received some training on how to facilitate a good meeting. We have a lot of experience and knowledge in this group and it is difficult to herd it all together in a cohesive way. Consider adding to the bylaws that this group would support the President and Vice President to attend some kind of facilitator training. Cay will look into facilitator training – it can be expensive. The HigherBar.com – how to have an effective meeting. If anyone has info it would be good to share on how to run meetings – if everyone could look around and bring back information it would be helpful. Cay will bring concrete ideas – please contact her.

b. Election of officers: we elect the secretary and Liaison in 2012; the secretary is for a two-year period and the Liaison for one. Question was raised as to why the Liaison is only a one-year term- because of the expense involved for that individual if their agency does not help with flight costs to the conference, and to give this position/person more flexibility. A person can run consecutively for any office. Kiki wants to say on as Liaison.

17. **Unfinished Business:**
    a. **DDNA Position Paper on Medical Management**
        i. Comments included:
            1. NH is far ahead of other states. This statement from the DDNA was made as to how they can support the 50 states who all have a wide margin of differences in how medication management is performed. We are fortunate to have strong under pinning. This paper was to help guide states as they change their structure and the paper addressed the basics. NH participated in influencing the document. It is easy for us to support it, as "this is how we roll." We should include this on the poster board. We have competency-based trainings and are on a really good track – we do more than what DDNA recommends.
            2. We can use this paper to support and validate our practice by endorsement of the national organization. We have a lot to be proud of.

    b. **DDNNH statement** – who we are and what we do. We decided to have a formal statement because it would become the mission of this group. Our bylaws outline but no one really knows what we do. The idea originated because of the White Paper from the DRC, and although we decided not to respond we began talking about this from a marketing perspective, on how to become an entity that other stakeholders would want us to participate more fully. Originally, we were going to have a letter drafted by Eileen H. but it morphed into make in a statement. A suggestion was raised to also share this with nursing schools around the state, letting them know about this specialty. Suggestion was made and accepted to form a sub-committee led by Lisa Hoekstra to begin thinking about our goals in a mission and vision statement. Volunteers for this subcommittee are Darlene, Christine, Joyce, Kenda, and Eileen C.
    c. Part of our bylaws/mission should include a drive for us to welcome new DD nurses and to encourage DDNNH membership. Linda volunteered to lead this charge by forming a "welcome wagon" to help new nurses feel more supported.
    d. Our monthly meetings consist of nurses with lots of questions. A suggestion was made for Kiki to bring to the DDNA to hold more leadership conferences.
    e. Suggestion for agenda – have the most important issues first. Start the meeting with the hot topics so we can have a better focus. Motion was made to try a new agenda structure for next month. We will also end the meeting with a brief "success story." Kiki volunteered to share how her agency was involved with a local nursing school and had nursing students shadowing DD nurses and how they made that happen.
    f. Personal Mission Statement: Assist with the coordination of healthcare for the DD/ABD population between the individual/guardians/staff and healthcare providers. We train; monitor and support lay people who care for the individuals so they may live a full life.

11:25 Success Story: shared by Ruth Beland.

11:30 Meeting End.

9:30 SHARP

18. **Meeting was called to order** with 27 in attendance.

19. **Review** and approval of March Minutes.

9:40

20. **Peter Bacon** here to discuss **1201 cert inspections.** His question to us concerned where home providers were documenting that the **Health Status Indicators** had been reviewed prior to a Dr.'s appt. Some document right on the HSIs and some have converted there Office Visit Contact Note to contain elements of the functional status and use that form. Again, the HSI form is not required – it is available as a tool. As long as individual's HSIs are documented (see He-M 1201 for the definition of health status indicator = functional abilities). As long as why/what appoint. Is verified it's OK. Most people make one form that is modified. BHF would like us to be clear so that they can see it meets the intention of the rule.
    a. **Must all OTCs be purchased OTC?** No. The new 1201 allows us to purchase OTCs (as long as there is a doctor's order!) without having a pharmacy label (we can use the manufacturer's label), but it does not require you to.
    b. **Expectations of renewal of Epi-pen waivers?** They must be done yearly.

9:45

21. **Officers Reports:**
    a. **Treasurer's Report**: letter from Center for Staff Development at Antioch.
    b. **Liaison**: Kiki was finding out if the DDNA was still having the silent auction.

10:00

22. **Special Business:**
    a. **Caryn-Ann Ferriter** from Region 4 Community Bridges came to talk about common 1201 reporting issues from the Area Agency perspective. Community Bridges contracts with several vendors and reviews their 1201A and B reports. Caryn offered the following regarding the most common errors:
        i. Lots of blank/empty fields – people are not filling out the form completely.
        ii. Inaccuracies found between the A reports and the total figures on the B report.
        iii. Missing specific individual A reports form some residences.
        iv. There are errors reported on the B form but not on any A form.
        v. Using old 1201A forms
        vi. Categorizing errors incorrectly.

vii. Non-reportable errors – these should be noted but not included in the counts.
viii. Number of individuals living in the home not correct.
ix. Number of frail individuals inaccurate
x. Missing page 2 of A reports.

b.
c.
d. Annual DDNNH Bylaw review in April and approval in May.
e. Annual DDNNH elections
    i. April nominations - Linda Catalano volunteered to be nominated for the Secretary position, and Kiki was nominated for the Liaison position in absentia.
    ii. Elections held at May meeting

23. **Unfinished Business:**
    a. DDNNH Mission/Vision – started talking about statement to be used in various situation/settings. Subcommittee looking for input about this statement or please send an email to Lisa. Why do we exist – training professionals, education in healthcare to families, staff, qualified vs. situated language. Should we define the AA system? Put a link to their website?
    b. Welcoming new members into DDNNH – Linda Catalano is still willing to be the Welcoming Committee.

10:30

24. **New Business** including Nursing Practice Issues:
    a. For an individual receiving day services with a new order for diastat for seizures >30 seconds – how to accomplish that. Suggested to get a different order as 30 seconds is not a standard protocol, requested that the home provider have a cell phone paid for by the agency, and clarify to the MD the nature of the seizures and home provider did not accurately describe them. Nurse will be going to next appointment.
    b. For a frail diabetic – adolescent – carb count vs. sliding scale – how to wrap the protocol. Type I, blood sugars run from 38 to 420 – looking for behavior plans.
    c. Add FAQs need for update with the new rule at next meeting.
    d. Eileen Murphy Hamel suggested that BON highlights be added to the agenda and volunteered to look into doing this.
    e. Should we have a timekeeper to help facilitate our meeting and keep the agenda on-track?
    f. Success story still on the agenda for Kiki next month.

11:30 END

9:30

25. **Meeting was called to order with 25 in attendance.**

26. **Review** and approval of April Minutes with correction to #7b..

27. **Officers Reports:**
    a. **Treasurer's Report**: read and accepted
    b. **DDNA Liaison Report**: full report deferred until June meeting. Highlights included:
        i. Risk management
        ii. Barbara Bancroft – nutrition, supplements, "basal rate"
        iii. Taking care of yourself
        iv. Pet therapy
        v. Music therapy
        vi. Breakouts – antipsychotics and link to diabetes; Fall prevention presented by Sharon Oxx; CP in 2012, Autism, and aging successfully
        vii. TBI – neurosurgeon and Professor in Florida – controversy with concussions
        viii. Med error rates – national overall is 29%; of those 79% were wrong time.
        ix. Filming some of the conference – it might be available in the future
        x. Items were brought for the auction – we had enough to have 3 baskets! There was pottery, pictures, jewelry.
        xi. Next year the conference is Phili.
        xii. There was no hospitality room this year; we will talk about doing that again next year.
        xiii. Doctors and Dentists are no longer a part of DDNA.
        xiv. Chapter vs. Network issues remain.
        xv. There is a letter available on the DDNA website for you to give to your employer listing rationale for your employer to help you get to the DDNA conferences.

9:40

28. **Peter Bacon from BHF**: continued discussions:
    a. How are people identified in frail health? Some agencies have this added as a check box yes/no on the Health History Information; others only document when people are identified. BHF needs to know that the question of frail health has been considered for each individual.
    b. Review of Certification Expectations – Peter will revise for next meeting.

29. **Special Business:**
    a. DDNNH new mission and vision was discussed and revised and will be ready for the June 19th meeting.

b. Annual DDNNH Bylaw review in April and approval in May – delayed until June meeting.
c. Annual DDNNH elections
    i. April nominations/May elections:
        1. Linda Catalano nominated and elected secretary – congratulations Linda! Linda will type up the minutes and submit them to the BDS for publication on the DDNNH website. Deb Nailor will bet he back-up secretary if Linda can't be here.
        2. Kiki Sylvester will remain our DDNA Liaison – congratulations Kiki! We look forward to continued up-to-date news blasts from the national DDNA.

10:30

30. **New Business** including Nursing Practice Issues:
    a. Discussion around the new curriculum –
        i. Problem: has anyone taught using it and are there any issues? – the way it is structured it seems a bit choppy and the flow needs to be improved. Additionally, the video is backwards.
        ii. Solution: Please keep notes as you are teaching as to how you are teaching the curriculum – put a chronological list together and we will discuss it at our September DDNNH meeting.
        iii. Should we update our references from DD vs. I/DD – should we change these? Motion to stay current to update our language on all references.

11:45

31. Kiki – Success Story about involving nursing students in a rotation in our system from Great Bay College. Community Partners hosted 3 nursing students two days per week for 7 weeks, and the students spent time in the day program, went to observe QAs, and ended their program feeling comfortable talking and interacting with people with IDD. The students were also involved with a teaching plan as part of their curriculum, and did one of hygiene. The student invited Kiki to their pinning ceremony!
32. Eileen Hamel suggested that we regularly address the newsletter from the NH BON and read a few highlights from a few articles, such as the nursing shortage is over and the effects of working a 12 hour shift, and legislative bills that affect our practice. This will be on the June agenda as well, and more information can be found at www.nhnurses.org

9:30

33. **Meeting was called to order with 23 in attendance.**

34. **Review** and approval of May Minutes.

9:45

35. **Officers Reports:**
    a. **Treasurer's Report**: read and accepted
    b. **DDNA Liaison Report**: there will be a forum on the DDNA website to ask questions (for DDNA members only.) There is discussion about a telephone triage certification.

10:00

36. **Unfinished Business:** coffee mug motto?

10:30

37. **New Business** including Nursing Practice Issues:
    a. Question how to handle a situation at a staffed home with three missing controlled medications and one pill in the lorazepam bottle looked different at it was a loratadine.
    b. Individual went to family and a whole bottle of pills was missing (controlled meds).
    c. The count was off by one pill and there was powder at the bottom, never reported.
    d. Does long-term Depakote cause pancreatitis?
    e. Curriculum issues, the films on the DVD are backwards, need to be reversed. Can we have them put on the website?

June 2012 Minutes

9:30am

1. **Meeting was called to order with 18 in attendance.**

2. **Review** and approval of the May minutes with no corrections

3. **Officers Reports:**

   a. **Treasurer's Report:** read and accepted

9:40am

4. **Peter Bacon from BHF:** A handout titled , **Certification Expectations for He-M 1201.03,** was distributed to attendees. Highlights of the discussions are as follows:

   a. Peter stated there have been very few deficiencies since the beginning of the year

   b. Many areas are adding required information on to their existing forms, i.e, Have HIS's been review?; is individual on frail list?.

   c. Any certified home is required to have HIS's completed within 30 days

   d. The latest Frail List Form is 2011. It needs to be reviewed annually. A new form does not need to be completed unless there has been a status change

   e. If using the QA form that was suggested by the Bureau a separate form may need to be completed for each individual in the residence. Some areas are using the form as a guideline or have incorporated the information on their own QA form so only one form could be used for each site. The forms issued from the Bureau are not mandated.

   f. Nurses will not be sited if a Service Coordinator fails to sign the HSI's. It is the responsibility of the provider to assure that the SC does review the HSI's quarterly.

Clarification of above per Peter Bacon is as follows: Regarding your question related to the Health Status Indicators and the required review by the service coordinators, this would certainly not be the responsibility of the nurses to ensure that it took place. He-M
1201.03(f)(2) clearly states that this is the responsibility of the home care provider and the service coordinator.

   g. The Bureau is providing Trainings around the State on Certification Review.

   h. Health Screening Tool does not need to be signed by a Nurse or a Provider.

   i. Peter welcomes any phone calls or emails with questions. He can be reached at:

      Office -271-9044

      Email- pebacon@dhhs.state.nh.us

10:00am Deb Nailor was unable to attend. Will postpone her presentation until the September meeting.

5. Darlene reminded membership to drop their name tags in the basket by the door before leaving each meeting.

6. **DDNA Liaison Report:** Ki Ki Sylvester reported on conference that was held in Orlando, Fla. in May. She distributed to the group a summary of programs she attended while at the conference. She briefly pointed out the highlights of each program. She shared some of the following statistics and points of interest.

a. DDNA has 1,393 members

b. Total money in bank before 2012 conference expense is $477,254.14

c. Membership includes 34 CDDNs and 35 DDCs.

d. There are 23 chapters and 14 networks in 2012, which is an increase from 2010

e. There are Forums available on the website which questions/concerns may be posted

f. Anyone can read the posts but only DDNA members can actually post.

g. DDNA has a Facebook page- questions and comments can be posted there

h. The DDNA website contains a news feed which contains current research information.

i. As a group we should begin considering new ideas for the raffle for the 2013 conference in Philadelphia.

10:45

7. **New Business** including Nursing Practice Issues: The president reviewed the ground rules with the group

a. **First Issue**: Pam presented a practice issue she has been having. In summary the issue is as follows:

1) Staffed residence with 3 separate incidents of missing controlled medications for the same individual. Last episode was an entire bottle of prn

lorazapam.

2) No clear proof of what has happened to this medication

3) Pam asked group for suggestions on how to handle this situation.

4) Joyce stated that the following should have been done after the first episode:

A. Police should have been notified by management

B .Procedure was not followed as Nurse was not notified of missing narcotic when it was first observed

C. Med Certifications should be pulled but the decision was the Nurses

D. Everything must be documented and sent to Manager and Bureau

5) In this situation proof is not required. This can be addressed from nursing responsibility as well as judgment.
6) Kenda reminded group that there is an area on the 1201 A report to address nursing concerns that should be used.
7) Joyce stated that the Trend section of the 1201 A reports are being left blank. This is were this issue of non compliance should be listed as a trend . The trend is that staff is not following policy.
8) Many of group shared their experiences, both of successes and failures.
Pam thanked the group for their input and suggestions. Joyce will work with Pam on this situation.

b) **Second Issue:** Joy asked if a psychotropic med is being used for something else, i.e. migraines, do we list it or not. Joyce responded stating all psychotropic drugs must be recorded on the 1201 A reports. The Bureau is going to request that if an individual is on 4 or more psychotropic drugs an indication of when the individual's last psyche eval was..
Joyce also stated that a 1201 A short report be completed for each separate certification; 507, 1001, 525, 524, 521s.
c) Karen shared that 2 individuals have been dx with acute pancreatitis from long term use of Depakote. Others shared similar awareness of extended use of Depakote.

.11:00 am

8. Unfinished Business:

a. The completed mission statement was distributed. The committee asked everyone to think of a tag line that can be used. More discussion will take place at September's meeting.

b. A unanimous vote to update the language in the Bylaws and the web page

a) Dianne stated that Article 6-"Dues" as not been adhered to. Group agreed to have membership year be from 6/1-5/31. Annual membership fees will be due in May. No membership cards will be issued.

c. New Curriculum: Group was asked for input on new HeM-1201 Curriculum. Summary is as follows:

a) The video/cd would not be updated at this time due to cost. A possible partnership with UNH may be possible in the coming year.

b) A correction of the present video is underway.

d. Joan Hahn Rn, was introduced to the group. As a former DDNA president and presently a UNH educator she brings with her a vast amount experience that will be an asset to our group. Her specialty is in research and welcomes any projects that our group may want to undertake.

11.25am

9. Success Story: Karen told of a 38yr old woman with intellectual l disabilities who is also deaf. One year ago she had a massive stroke that left her with hemiplegia and severe muscle spasms in legs. After a great deal of suffering she received Botox injections in her legs and is now doing terrific and pain free.

Respectfully Submitted,
Linda Catalano RN
Secretary

9:30am

38. **Meeting was called to order with 18 in Attendance.** Lorene Reagan, MS, RN, in attendance as bureau representative.

39. **Review** and approval of June Minutes with two minor corrections. A clarification of section 4 f will be obtained from Peter Bacon. Some members felt the statement was incorrect. The June minutes that will be posted on line will reflect the clarification, from Peter.

9:45am

40. **Officers Reports:**

a. **Treasurer's Report:** Read and Accepted

9:50am

41. **New Business:**

a. A question was asked whether the HSI's are to be completed for Residential only or should they be filled out for individuals in day program. Group was referred to He-M 1201.03 (c) for clarification. Lorene stated that some agencies may require a higher standard requesting that Health Status Indicators be completed for day program individuals, but it is not a requirement from the bureau.

b. Health Screening Recommendations: The form is not mandated. Its intention was to be a guideline to assure that our individuals' health concerns are identified and addressed at their annual physical. The form was never intended to be completed by the physician. It is the obligation of the provider to review appropriate testing with the physician and document. Any way that works for each agency can be used. Some have incorporated the information on their annual health forms.

Some areas are being cited for not having the form signed by a physician. A question was raised when the form should be reviewed. Lorene stated that the rule is "silent" on this. The information needs to be reviewed annually. She emphasized that any clarifications that Joyce Butterworth had given the group are to be honored.

Kenda suggested that we all work with our agency. If anyone has any questions, Peter Bacon is available to discuss them through email or telephone.

A suggestion was made that the surveyors should cite for noncompliance of standards of practice not "areas of concern".

The surveyors should be giving out satisfaction surveys after a review to be filled out. If you do not receive it, ask for one. After completion send a copy to Peter Bacon.

c. It was pointed out that the "Frequently Asked Questions" on the website are not current and we as a group need to update them. It was decided that everyone should print out a copy. The group will review these in an upcoming meeting.

d. An issue was raised regarding the pharmacy at Dartmouth. Some confusion as to what should be considered a legitimate order. An electronic order can be accepted as long as the physician's name and DEA number is present. A pharmacy order is also acceptable but must be signed within a "reasonable time" by the physician.

e. Lorene reviewed the steps involved for hiring a replacement for Joyce due to the hiring freeze on government positions. The process is in the first stage which is departmental approval. The next stage could take between four to six weeks.

f. A suggestion was made that members bring in copies of their forms that have been successful with integrating the new regulation requirements to share with the group.

10:30 – 11:45am

42. **Continuing Education Series:** Attorney Richard Cohen, Executive Director, Disabilities Right Center in Concord presented **" General Legal Standards and Obligations of the Service Delivery System".** After a very interesting presentation, Mr. Cohen welcomed questions as well as impressions from the group.

    Certificates were distributed for 1 contact hour to those who turned in evaluations of the presentation.

11:45 – 12:00 Noon

43. Epi Pen Waiver: It was noted that the Epi Pen waiver online was signed by a physician that was no longer with the bureau. Jen McLaren, MD should be the appropriate signature. If an individual is not a self med individual a special waiver must be submitted for review and approval from the med committee for the individual to carry and administer their own Epi Pen.

The meeting was adjourned at 12:00 N. Next meeting is scheduled for October 16, 2012.

Respectfully Submitted,

Linda Catalano RN
Secretary DDNNH

9:30 am

44. Meeting was called to order with 17 in Attendance.

45. **Review** and approval of minutes with 3 minor corrections.

9:45 am

46. **Officers Reports:**
    a. **Treasurer's Report**: Read and accepted.
    b. **DDNA Liaison Report**: KiKi Sylvester will present at November meeting

9:50 am

47. **Old Business:** Epi- Pen Waiver
    a) The updated Epi-Pen waiver is located on the DDNNH website
    b) Guardian consent must be given
    c) The date of waiver should be the date the waiver was initiated
    d) Waiver needs to be updated annually
    e) Guardian date maybe updated annually if one chooses to but is not required

10:00

48. **New Business** :

a) Jen shared with the group that she attended the MADDNA Conference which was excellent. The speaker, Sam Rhine, is "great". She visited an exhibitor from Mass Text Imaging that does mobile onsite swallowing evaluations and brought/shared handouts. (They do not accept NH Medicaid). They do provide services in southern NH up to the Concord area. They could provide services further north if there were sufficient cases scheduled. They are based in MA. The cost of mobile eval vs. hospital eval is same.

Jen will also work on setting up an educational session for a future meeting with a Speech Pathologist from this group. The group suggested asking about January or February.

b) A question was asked whether anyone in the group had the Health and Safety DVDs that contain Hygiene and Nutrition. It was stated that curriculum is on the DDNNH website. Lori Jones will bring in the DVD for the group to review.

c) A question was asked regarding verifying narcotic counts if 2 certified staff were being used. The regulation does not require two staff to sign. Non certified staff CANNOT sign for narcotic count.

d) Resources and Educational Opportunities: Peter Bacon from BHF answered questions related to the new He-M 1201 regulation. The major points are as follows:

- **a) Health Screening Recommendations can be reviewed anytime annually**
- **b) Rule doesn't specify who should sign it**
- **c) Nurse should review screenings prior to annual physical**
- **d) An acknowledgement from whoever takes the individual to the annual physical appt should be noted on the form**
- **e) HSI's are not required for day programs (He-M 507) unless day program staff are taking individuals to MD appointments**
- **f) He-M 1201.03 refers to the health status indicators that require ongoing review (the HSI tool that was provided for optional use) does not have to be initialed by the Nurse monthly**
- **g) Many have added a line on their Report of Consult to be signed by the physician that Health Status Indicators were reviewed**
- **h) HSI was designed as a tool and never meant to be taken to the Dr's office.**
- **i) Standard of Care is to note any change in functional ability and to report these to the individuals' primary physician.**
- **j) At this time HSIs will be reviewed for Primary Care Visits only (see below)**

Much discussion occurred as to what visits the HSI's should be reviewed for. Some felt primary physician only. Others felt that HSI's should be reviewed for all doctors' appts. The group agreed to devise an interpretation statement that will be posted on the DDNNH FAQs and utilized uniformly throughout the group pertaining to this discussion.

- **k) Diets:** If a diet is noted and signed by a physician, it is an order and needs to be updated annually. If a therapist writes a diet recommendation, it is considered a recommendation only and should be discussed with the primary physician. There could be a lapse of time between the therapist visit and the MD visit. Adhere to the recommendations until then to assure safety. "Thick It" does need an order.
- **l) Med Certificates:** There is a new med certificate to use that does not list a rule number. You can continue to use the old certificates as long as the rule number is crossed out.

11:00 – 11:30:am :

Group will collectively discuss the 5 d) j) statements above at the November meeting. Peter has been invited to the December meeting to discuss the created interpretative statement and potential application/interpretations from the surveyor group. The group was asked to bring in ideas to share at the November meeting. Kenda began gathering data from the group regarding the HeM-1201.03 regulation and the usage of Health Status Indicators. Thoughts were written on a flip chart to further discuss at the November meeting.

At this time there is no Nurse at the Bureau to direct medical issues to.

The Meeting was adjourned at 11:35am. Next Mtg is scheduled for Tuesday, November 20, 2012.

Respectfully submitted,

Linda Catalano RN
Secretary DDNNH

9:30

49. Meeting was called to order with 18 in Attendance:

50. **Review and approval of minutes without correction**

9:40

51. **Officers Reports:**

a. **Treasurer's Report:** Read and accepted

b. **DDNA Liaison Report:** Jen Bosviert read the DDNA liaisons' report for KiKi as she was unable to attend this months meeting.

Then next DDNA national conference will be held on April 27-29, 2013, in Philadelphia PA. The pre-conference will begin on the 26th of April. The conference brochure should be available within the next 2 months.

Ki Ki is in the process of attempting to set up an educational in-service for our January Meeting with Joan Arsenault. The cost to for obtaining Ceu's for the membership will be $25.00.

10:00

52. **Unfinished Business:**

Several members brought in forms that they are presently using to share with the group. Stacy will scan in the forms and send them out to the members to use if desired.

Group continued to work on statement for the Bureau for the Health Status Indicators. It was decided that we would ask Peter Bacon to attend the January meeting rather than December's meeting to allow everyone to have more time to think about how the statement should read. The statement will be finalized at the December meeting.

Lori distributed a copy of "**Everyday Health & Safety"** that goes with a video that she has . Further research needs to be done as to where this came from and why everyone does not have a copy of this video.

10:30

53. **Continuing Education Series**:

Jo Ann Jordan, RN, M. Ed presented " Dementia Care Consultation Opportunity" that she is able to provide. Jo Ann can be reached at (603) 228-2445; 738-5304; or by email at jacjordan@comcast.net. If you have an individual who you feel is a difficult challenge please contact Jo Ann and she can further discuss her services and funding.

11:15

54. **New Business:**

Wayne King will act as facilitator for any medication issues between Nursing and the Medication Committee that should arise until a replacement for Joyce has been hired.

We will have our annual Christmas party/lunch next meeting. A list of what people were bringing was passed around. We will break at 11:15 for our party.

Kenda notified the group that the Nurse Practice Rule is up for revision. She also informed the group that the HRST project is still "alive" and will be discussed at Decembers meeting.

The Meeting was adjourned at 12:00 noon. Next Mtg is scheduled for Tuesday, December 18, 2012.

Respectfully submitted,

Linda Catalano RN

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Feb 15, 2011 Minutes

9:30

1. **Meeting was called to order by the Vice President in the President's absence with:**
   - **a.** Greetings and Introductions and 20 in attendance.

2. **Review** and approval of December Minutes (snowstorm in Jan.)

3. **Treasurer's Report**:

   a. The name Joan Hahn was brought to everyone's attention as someone who as a past president of the DDNA who was with UNH and was involved in the original curriculum development – do we have Joan's address – Kenda will contact and invite her to come to our meetings.
   b. The DDNNH membership is $25 and the DDNA membership is $80. A request was made to send out the email that announced the partnership between the area agencies and BDS to fund memberships to the DDNA for interested nurses. Our $25 DDNNH dues go for food and two scholarships, one to the Rivier College and one for the DDNNH liaison to attend the DDNA annual conference.
   c. We did talk about purchasing two copies of "Lost in Laconia," one to donate to the annual DDNA conference this year. We also talked about a hospitality suite as not something the current executive membership is focused on so Sharon Oxx, Lorene, Kenda and some from the NE network are promoting a welcoming committee to support a hospitality room. Sharon Oxx contacted the hotel to find that there could be refreshments and that each network needs to offer staff and money as the cost for the room is $100 per day, and $250 is needed from each network to make it work. Sharon may n need to get a donor and the request was made for the DDNNH to discuss this. The Treasurer stated we have enough in our accounts to donate $250 – a motion was made and passed to donate this money, and a motion was made and passed to purchase two copies of "Lost in Laconia." Ideas were discussed as to how to let people know the hospitality room would be there, and suggestions were made such as having a flower clip so people would ask what it was four. The conference is coming up fast and Lorene will ask Massachusetts to manage the funds. Suggestions were made to not have the hospitality room all four days to cut expenses, perhaps specifically listed days or maybe the first two days.
   d. Our DDNNH Liaison, Jen, stated that you could go to just one day of the conference if you want, but don't pick the last day, as it is only a ½ day.

4. **Unfinished Business:**

Omissions vs. Documentation errors

Kenda put together four scenarios for the group to discuss so we can come to an understanding and set policy as to how to interpret error categorization for the purposes of consistency across the State.

After discussion, a vote took place that decided on Scenario #3, where complete nursing judgment was to be utilized in categorizing, with one opposing vote. Due to the opposing vote, further discussion ensued, and it was determined that the real issue was that triple checks were not being performed and the best way to get at for corrective action; thereafter the group proposed to take a re-vote. Standards of Nursing Practice were also discussed and put at the forefront. The new proposal on the table was for authorized providers to have 24 hours in which to go back and correct, with notation and documentation error reporting, that a medication was indeed given but not signed off. After 24 hours, missing initials would be then counted as errors of omission. The DDNNH voted unanimously to pass and set this as policy.

5. **New Business** including Nursing Practice Issues:
    a. Martha joined the AAIDD taskforce on IDD and dementia – the Center for Excellence in NY – three different sections.
    b. Discussion regarding difference between hiring an RN or an LPN or an LNA – it is essential that they are hired as such or else the hours they work will not count towards their license. It is incumbent upon licensees to know the requirements of their licenses and their respective Standards of Practice. For example, if an LNA is hired as a DSP, their hours of employment do not count towards their LNA license
    c. More discussion regarding how we are teaching the curriculum in terms of documentation – people are doing different things, such as one initial after three checks and then the second initial after the actual administration; others put both initials after the three checks. It goes back to what works in one house may not work for another house.
    d. 521s, 524s, 525s have been a rocky road, sometimes families don't understand how much work they are really taking on with a 525 and find out that it's too much and end up vendering out services. It can get really complicated. In some 525 contracts, nursing is not even in the budget.
    e. In one 525 the family gives all the meds and we're only the employer of record – it's a family driven model – but what are people doing about blood borne pathogen trainings? - Some HRs are handling this by handing out brochures. Let's talk about 525s more at the next meeting.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

March 15th, 2011 Minutes

9:30

6. **Meeting was called to order with:**
    a. Greetings and Introductions.
    b. Signing the attendance sheet
    c. Cell phones off.
    d. 19 were in attendance.

7. **Review** and approval of February Minutes with one grammatical correction.

9:45

8. **Officers Reports:**
    a. **Treasurer's Report**: Two DVDs of "Lost in Laconia" were purchased, one to donate to the DDNA conference in May. A motion was made to continue the nursing scholarship to Rivier College for $250, and passed unanimously.

    b. **DDNA Liaison Report**: For the conference in Hartford, Jen, our Network Representative, needs a special badge – Darlene will select something special for Jen to wear as our rep. Jen mentioned that we need a poster presentation of the DDNNH – Joyce volunteered for this. It was suggested to put on the poster:
        i. **DDNNH Nurses Make a Difference!**
        ii. Blurb about the State offering pay for ½ DDNA membership
        iii. That we adopted the DDNA bylaws.

    Jen talked about the network connection planning on Monday May 16th from 5:30 – 6:30, that we will donate Lost in Laconia for the silent auction, Karen's straw – maybe one to demonstrate and one to win for someone – Eileen has seen lots of giveaways to promote products. DDNA elections are coming up - applications are due 3-31-11. The DDNA National Achievement awarded is also given, and nominations are also due. Our annual report has been submitted.

    There was a conference call last Monday with NY, CT, NJ. Sharon was unable to participate. Concerns were reviewed and no decisions were made regarding the hospital suite. An accounting of how the money is being used will be provided. Another conference call is set up for next week. The nurses in CT will be scoping out local r4estaurants to recommend and will have this available for the hospitality suite. We have about 12 going form DDNNH. Eileen expressed interest in running for DDNA Treasurer.

10:00

9. **Special Business:**
    a. Annual DDNNH Bylaw review in April and approval in June.
    b. Annual DDNNH elections
        i. April nominations - we need a Treasurer and a Vice President and the Liaison is open! Jen said the hardest part of the Liaison's position was the email list. You need to update to DDNA 4x per year with information taken from the minutes; do an annual report, and occasional emails from DDNA, with quarterly reporting to DDNNH, and attend the conference. Lisa Hoekstra in interested in the Liaison next year but not this year. Kiki is considering. For VP, Eileen Corbett will think about it. The Treasurer is willing to keep going. Darlene mentioned we also need to focus on growing this organization.

        ii. Elections held at June meeting

10:30

10. **New Business** including Nursing Practice Issues:

a. Portable DNRs can be purchased from the NH Hospital Association.
b. Put on agenda for next month's discussion: Frequency of QAs!

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

April 19, 2011 Minutes

9:30

11. Meeting was called to order with 23 in attendance:

12. Review and approval of March Minutes.

9:45

13. **Officers Reports:**
    a. **Treasurer's Report**: copies provided to membership. The DDNNH donated for the DDNA conference towards a hospitality room

10:00

14. **Special Business:**
    a. Annual DDNNH Bylaw review – two changes were recommended:
        i. On page 4 of 4, to add, "as the need arises."
        ii. On pg 2 of 4 under article of purpose add "To welcome and encourage new nurses in the field of developmental disabilities and be available for mentoring"

    b. Annual DDNNH elections
        i. April nominations
            1. Eileen Corbett was nominated for Vice President
            2. Dianne Crone nominated for Treasurer
            3. Kiki Sylvester nominated for DDNA Liaison

        ii. Elections to be held at June meeting

15. **Unfinished Business:**
    a. The Family Support Conference is selling raffle tickets, 5000 only, giving away case prizes, gas gift cards, and an Apple IPod.
        i. Comments were made about what great presence and exposure the DDNNH had when we went – it would be great if we could do it again. Families saw us as a face and a presence and we good press.

b. The DDNA Conference: the hospitality suite is happening, looking into alternative parking because it's expensive ($40 per day). There is some arm wrestling going on with the hotel – we've gone to gift bags and special flowers for people representing – we'll be making gift bags when we get there and may need help getting stuff there. The preconference is the 14th.

c. QA Frequency: - what is posted on the FAQs was provided on the agenda for people to read. Regarding occasional staff who go in to family homes, is it safe to advocate to broaden and redefine what we're going? Otherwise, it makes nurses go to every single program every single month. The issue is safety – can we create a way to make them a part of the "family" definition as opposed to staff. What are the pitfalls? We include med authorized persons who are competent and approved the NT to administer meds.

11:00 – 12:00

16. Draft He-M 1201 presentation - proposed changes reviewed.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

June 21, 2011 Minutes

9:30

17. Meeting was called to order with 33 in attendance:

18. Review and approval of April Minutes.

9:45

19. **Officers Reports:**
    a. **Treasurer's Report**: membership drive month was announced; applications forms were available on the back table. Treasurer's report read and accepted.
    b. **DDNA Liaison Report**: Jen reported on and provided a handout regarding the DDNA Conference "Steps to Clinical Excellence," which was held from May 4th though May 7th. Highlights included presentations from Dr. Robert Fletcher, the founder and CEO of National Association for the Dually Diagnosed (NADD); Dr. Kenneth Rickler on the challenge of neuropsychiatric diagnosis in adults with developmental disabilities; Nanette Wrobel BS, Rph on psychoactive medications and their use in persons with developmental disabilities; Carl Tyler, MD, MS on high impact health information,' Leonard Fisher MD on GERD and treatment of adults with I/DD.Kathleen Keating, RN, MSN on telephone triage; and Susan Stolwyck, RN, MSN on the health pyramid.

    Membership meeting at the DDNA: there are 330 CDDN's and 10 DDC's nationwide at this time. Financially, the goal is to have 2 years of operating costs in the coffers;

presently there is $324,000 with $75000 let to go to meet that goal. Right now there are 17 Chapters and 13 Networks.

Questions for DDNNH: what do we want to donate for the silent auction for next year? A suggestion was made to donate something from Art Works.

Medication Management Paper Position: is supportive of what we already to – some states have no connection with the Nurse Practice Act/Board of Nursing as we do.

Northeast Hospitality Suite was widely accepted and we got kudos for doing it.

Fetal ETOH Syndrome – DVDs and booklets were brought back by Darlene and available.

10:00

20. **Special Business:**
    a. Annual DDNNH Bylaw were reviewed and approved:

    b. Annual DDNNH elections were held:
        i. Eileen Corbett was elected for Vice President
        ii. Dianne Crone elected for Treasurer
        iii. Kiki Sylvester elected for DDNA Liaison

21. Unfinished Business:
- **a.** Ruth Beland requested 15 minutes during a DDNNH meeting to share her experience of being a nurse at Camp Allen.
- **b.** PRN sheets miralax – how do you handle "no effect?"
- **c.** Parents are hiring RN home providers for kids with trachs – what is our responsibility? It depends on what is in the Service Agreement.
- **d.** 525s.

11:00 – 12:00

22. Draft He-M 1201 presentation - proposed changes reviewed. 1201 Cert tool utilized by BHF during cert inspections reviewed: one suggestion for "special diets" to come off the tool and be placed on the QA instead.

9:30

23. Meeting was called to order with 42 in attendance:
24. Review and approval of June Minutes.

9:45

25. **Officers Reports:**
    a. **Treasurer's Report**: Treasurer's report read and accepted.
    b. **DDNA Liaison Report**: Kiki reported on:
        i. The next upcoming DDNA Conference in 2012 in Orlando. Room rate is $119 per night..
        ii. The IOM has stated that vaccines don't cause autism.
        iii. What is the DDNA? Trying hard to get more nurses to participate with an incentive for the first 50 people who past a new post.
        iv. There is a tool for Alzheimer's assessment for people with DD
        v. DDNA medication administration position was finalized.
        vi. There is a new Chapter handbook. We need to keep the conversation alive regarding Network vs. Chapter.

10:00

26. Unfinished Business:

a. Ruth Beland spoke about her experiences with being a nurse at Camp Allen. Camp Allen provides individuals with DD an overnight camp experience, with wonderful staffing at a true camp setting. As a nurse, you would go in on check-in days and make sure the meds are there, review any special instructions and treatments. Mary Constance, the director, is always looking for nurses. There are about 50-60 kids there, and they have finally found a pharmacy that will prepackage. A lot of the issues they've had with medication administration have been resolved.

10:30

27. New Business:

a. Judith Guertin had requested time on the agenda for Suzanne Barr from OurHealthConnector, who presented an electronic health record that Region 7 is using.
b. The motion was made and passed to have the DDNNH's DVD "Lost in Laconia" available for signing out.

1100-12:00

Brief introduction to He-M 1201 Healthcare Coordination and Administration of Medication

9:30

28. **Meeting was called to order with:**
    a. Greetings and Introductions with 29 in attendance.
    b. Signing of the attendance sheet
    c. Cell phones off.

29. **Review** and approval of September Minutes with changes within the DDNA Liaison report.

9:45

30. **Officers Reports:**
    a. **Treasurer's Report**: read and accepted.

10:00

31. **Unfinished Business:**

32. **New Business** including Nursing Practice Issues:
    a. Pam brought up a question about how to deal with an individual who is in the last stages of hospice care, how to keep track of meds that family members are giving in a 1001 setting, how to track narcotics. Several nurses spoke about the importance of working together as a team with the family/guardian, with the program manager, the option of bringing in another staff person for support, the option of applying for a waiver, the suggestion of keeping a communication book. Delegation under Nur was discussed, which launched the discussion of the new 1201 and delegation of medication administration under both 1201 and Nur 404.

11:00 – 12:00

33. **Peter Bacon** from the Bureau of Health Facilities joined us as we looked at a PPT of changes to 1201, questions about delegating in a 525, the difference between 1201 and Nur.

November 15 2001
Minutes

9:30

34. **Meeting was called to order with:** 26 in attendance.
35. **Review** and approval of October Minutes.

9:45

36. **Officers Reports:**
    a. **Treasurer's Report**: Dianne Crone PO Box 349, Freedom, NH 03836 email: dcrone@northernhs.com Membership forms available. Please note that membership **forms for membership should be sent and checks made out to Dianne Crone.**

10:00

37. **Special Business:**
    a. Ground rules reviewed due to our large group and less-than-optimal acoustics:
        - Recognize who is the facilitator (President or Vice President)
        - One person speaking at a time
        - Follow the agenda
        - Be mindful of limited time – STAY ON TOPIC
        - Remember – this is idea gathering time
        - Be kind to each other
        - No anonymity
        - No side bar conversations
38. **Unfinished Business:**
    a. Continued discussions on the differences between He-M 1001, 521, 524, and 525 and why it is ESSENTIAL that the nurse know how the house is certified in order to know which rules apply and how.
    b. Continued discussion about nursing delegation.
    c. Continued discussion med admin delegation checklist developed with NHBON.

10:30

39. **New Business** including Nursing Practice Issues:
    a. Special diets – when do you need an order?
    b. Swallowing issues need to be addressed
    c. Relying on NT to make sure recommendations are followed.
    d. Allergies: need to be listed on face sheet. Individual told the dr. he head all these allergies so the doc wrote an order for an epipen without any allergy testing even though the nurse requested testing as the individual is not really allergic to the things he said he was do how to document?
    e. 1201.03 stuff – health hx – checking timelines within 30 days and annually – need documentation that the NT reviewed.

40. **11:00 – 12:00 Continued discussions regarding the new He-M 1201 with Peter Bacon joining us.**

- The new cert tool that will be going out – any questions please call Peter.
- Regarding annual recommendations – the inspectors will be looking for evidence that the recommendations were either advocated for or deferred by guardian.
- Regarding medication orders: looking at the precert packet that the orders are there for the precert.
- Looking for a PRN order to be present and that the PRN protocol is present.
- Self-administration paperwork – no changes. The NHBON has opined that it is within the scope of nursing practice to delegate the tasks listed on the self-admin sheet, the nurse must make the final assessment.
- Looking for medication administration authorizations to be present in the homes.
- In 1001 setting, when there is only ONE individual receiving services, NUR 404 may be used rather than 1001. Continued discussions about the continuum chart regarding how to decide.
- Controlled medications counts will still be looked at.
- Storage – no changes.
- QA reviews – looking to see that the timelines are followed.
- Issue – day meds stored in the residence on the weekends – do the controlled meds need to be counted? NO. Day program is responsible for these, just as they would not count if at a day program and the business was closed for the weekend.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

December 20, 2011 Minutes

9:30

41. **Meeting was called to order** with 21 in attendance:

42. **Review** and approval of November Minutes.

9:45

43. **Officers Reports:**
    a. **Treasurer's Report**: given by Dianne Crone and accepted.

    b. **DDNA Liaison Report**: given by Kiki Sylvester. The Newsletter is available for DDNA members – please go on to the website to print it out. The Annual Conference will beheld in Orlando on May 4th – info is also available on the website. Discussion about having a Poster Presentation of our DDNNH Network – to be discussed at January meeting. There are great resources on the DDNA website – Forums about Alzheimer's and DD, there are links to DDNA Twitter, also linked in Myspace. We could post our webpage to share. There are 1364 links to resources for members of the DDNA. Information discussed about the BDS incentive for nurses to become members. It was brought up that the DDNNH

nurses that we might as a group draft a letter to give to their respective employers regarding the importance of supporting membership in the DDNA, suggested to be put on the January agenda.

10:00

44. **Unfinished Business:**
    - **a.** Continued 1201 discussions to be held at 11:00 with Peter Bacon.

45. **New Business** including Nursing Practice Issues:
    a. Negative article about the DD system in Concord Monitor from the DRC by Dick Cohen regarding deaths in our system. To be reviewed at the January meeting. Should we respond by encouraging our employers to help us join the DDNA? Also, MD wrote a positive response to this article, also to be reviewed at the Jan meeting.
    b. Dosing in the community – how to people handle this?
        i. We teach in documentation class after the staff passes the test, so they are familiar with our forms. It has to be administered the same person who prepares the med, and the med has to be on their person at all times, with the name of the drug, time to be administered, client's name, dr's name date and sign. They put the 1st initial on the log, and when they return finish with their 2nd initial signing that it has been given. The controlled drug count reflects that drug was taken out (if controlled drug).
        ii. We make the person and staff come back to the house to administer.
        iii. For diastat, we have to carry it at all times, the home provider, the van driver, the day program, anytime in the community, with everyone signing off, but that got too complicated so now the individual carries it (with a waiver for storage.)
        iv. We take the med log sheet in a page protector with a copy of the doctor's order.
        v. For PRNs, we go back to the home if Ativan is needed (is this a rights violation??)
        vi. The day program is based from the home so we take a locked banker's bag, may not carry every single PRN. If they are not feeling well (i.e. headache) we go home, or if having behaviors, our protocol is to remove from the situation and go home to calm.
        vii. Day program has their copies of orders but one dose envelope rule – necessary prns in envelope in individual envelop if not they come back and get locked up. There is a PRN communication slip, meds given, reason why with one copy to home and one to day program med log, sign off PRN at that time on that slip.
        viii. For people in day-res program, many have issues, i.e. frequent h/a, or frequent falls, Ativan, Klonopin, but people in day offices are pretty close if they are going shopping, gym, don't take with them but not if they are going too far.
        ix. We should come up with a general statement so that client rights are not violated.
        x. For day program with 80 consumers if they have any prns at home - how to be responsible for that? If a person needs a med we call the home provider, we don't have a stock of meds.
        xi. Our day program every person has a stock of PRNs – lots of them go to work sites.
        xii. This should be on a case-by-case basis, this could get completely out of control.
        xiii. In day program do we have to have PRNs for every individual, anytime, anywhere?
        xiv. This should be a team decision deciding what med should be available for the person.

c. New issue: how do I QA 6 different regions, considering mileage, expensive to do every month for prns if not given? A waiver needs to be done for frequency of qas in day program for people who don't use prns.

10:30 – 11:30

46. **Continuing 1201 Discussions:** Peter Bacon shared the revised Cert Tool.

11:30 – 12:00

Annual Holiday Party!! Thanks everyone for such a good time!!! Happy New Year!!

The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

Jan 26th, 2010 Minutes

The **Jan 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, Thomas Fox Memorial Chapel. Fifteen attended.

All Regions were represented by either area agency nurses or vendor nurses except for Region IX.

9:30 – 11:30am

The agenda was addressed as follows:

1. **Review and Approval of December Minutes**
   December minutes were reviewed and accepted.
2. **Treasurer's Report**
   a. December's report was read and accepted.
   b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members.

3. **DDNA Liaison Report:**
   i. Our DDNA Liaison, Jen Boisvert, cannot attend the rescheduled-due-to-contstruction DDNNH meetings. It was brought before the group if Jen should continue as the liaison, including attending the DDNA annual conference as a DDNNH-sponsored person. Two motions were brought to the floor:
      1. Move to allow Jen to continue as the liaison, including as the DDNNH sponsored person to attend the DDNA conference, providing she continues her "work behind the scenes." Motion passed, no objections.
      2. Move to allow a substitute read Jen's "work behind the scenes" reports at the DDNNH meetings, and to allow that substitute to be Linda Catalano. Motion passed, no objections.

4. **Business/ Nursing Practice Issues:**

Suggestion for each nurse to write up a list of each of their respectively responsibilities and bring a copy of each nurse's job description as "we are bogged down with 1201 expectations and paperwork," and nurses are spending a lot of unreportable time – how much time do we spend on healthcare? Brenda Thamm volunteered to compile this list – email her at: growathome@gmail.com

This has really not been done. To date, no one has sent anything in. Discussion ensued that it is important that we write this information down and what we do – we are doing a lot of nursing and not doing a lot of 1201s and because of that, we get behind. Some Area Agencies see the vendor nurses as assets to them, rather than having their own nurse for MED assignments. Please do your homework for February. For the March DDNNH meeting on March 30th, we will engage in a brainstorming session, using charts to documents and prioritize what we want this group to reflect as our duties.

Some quotes from the DD nurses:

"We have 102 clients, 7 group homes with 4-5 people in each, 37 adult foster care homes with 1-2 clients each, a Voke department with 80 people, and 2 full-time nurses. The hardest thing is the day-to-day medication changes and issues that come up with people - always tons of filing that is never caught up. We have nurse descriptions but they are not adequate. We go on hospital visits especially at discharge time, do telephone triage for sickness, illnesses, cuts, accidents, we have walk-in triage when at the office. I have to decide if I need to be at hospital discharge meetings depending on the severity of the illness. With the He-M 1201 regs and the way we've become focused in on them we've gotten away from the art of nursing and what that means because we get bogged down with paperwork. When we do the nursing care there's not a lot of time for the 1201's and because of that we get behind in paperwork. For example, this past Friday at 4pm I was told there was a person discharged form the hospital with a G-tube - no one told be he was getting one, so I spent the whole weekend training staff. It would have been nice to get a heads-up about this and have the staff go into the hospital before hand to get the training."

Goals for 2010:

a. Continuously look at DD Standards of Practice.
   i. How do we create a new culture when you're not in a position of authority?
   ii. We need to update "Communicating for Health."
b. Suggestion was made to create a List of Topics to explore:
   i. OTCs
   ii. Dandruff shampoo
   iii. Adding to the curriculum – How to prepare for a doctor's appointment?
   iv. Chapter vs. Network
   v. Individuals coming into the DD system and receiving services without the nurses' knowledge.
   vi. Having a DDNA member to represent each Area Agency.

The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

Feb 23rd 2010 Minutes

The **Feb 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, Thomas Fox Memorial Chapel. Nineteen attended.

All Regions were represented by either area agency nurses or vendor nurses except for Region VIII.

9:30 – 11:30am

The agenda was addressed as follows:

5. **Review and Approval of January Minutes**

January minutes were reviewed and accepted.

6. **Treasurer's Report**

a. January's report was read and accepted.

b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members. We need more members for DDNNH and this needs to be on our agenda.

7. **DDNA Liaison Report:**

a. Linda Catalano is filling in for Jen in her absence. Next quarterly report will be given in March.

8. **Business/ Nursing Practice Issues:**

a. Suggestion for each nurse to write up a list of each of their respectively responsibilities and bring a copy of each nurse's job description as "we are bogged down with 1201 expectations and paperwork," and nurses are spending a lot of unreportable time – how much time do we spend on healthcare? Brenda Thamm volunteered to compile this list – email her at: growathome@gmail.com

Four responses have been received thus far and forwarded to Brenda. In March, we will use the white board to list our responsibilities. Here are some so far:

- Reauthorizations
- QAs
- Phone triage
- Discharge planning
- Team meetings/Service Coordinator meetings
- Healthcare visit attendance
- Hospital visits
- Transitioning into residential programs
- People dropping in my office with clients I have to assess
- Acute care issues
- Complaints
- Health care histories
- Medically frail list
- Pager calls – on call time
- Unannounced visits
- 1201As
- "Nursing coordination" does not capture the essence of what we do.

b. More quotes from the DD nurses:

i. Nurse W has 300 people to reauthorize – should we extend the 12-month authorization period? Other states go two years (but other states also have a 5-day 40 hour training curriculum).

ii. Staff is more and more distracted, stressed out, should we condense the training? Should we have a pretest, and if less than 90% is achieved, then have retraining?

iii. Remedial work is so much more time consuming than training someone right in the first place.

iv. Most people use our curriculum over three days at 4-hour days; otherwise, people get saturated and hear nothing that is said.
v. We should have a mandatory recertification class that is two hours long and make a retraining curriculum. (WHAT SHOULD THIS LOOK LIKE??) What are people using now that are already having a two-hour recert class?

Goals for 2010:

Continuously look at DD Standards of Practice.

- How do we create a new culture when you're not in a position of authority?
- We need to update "Communicating for Health."

Suggestion was made to create a List of Topics to explore:

- OTCs
- Dandruff shampoo
- Adding to the curriculum – How to prepare for a doctor's appointment?
- Chapter vs. Network
- Individuals coming into the DD system and receiving services without the nurses' knowledge.
- Having a DDNA member to represent each Area Agency.
- Program managers/house managers should all be med trained and receive a copy of the QA and have to sign off on it acknowledging the corrective actions that need to take place in a residence.

The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

Mar 2010 Minutes

The **Mar 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, Thomas Fox Memorial Chapel. Twenty-four attended.

All Regions were represented by either area agency nurses or vendor nurses.

9:30 – 11:30am

The agenda was addressed as follows:

9. Review and Approval of Feb Minutes
Feb minutes were reviewed and accepted.

10. **Treasurer's Report**
a. Feb's report was read and accepted.
b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members. We need more members for DDNNH and this needs to be on our agenda.

11. **DDNA Liaison Report:**

a. Jen provided an update as the DDNA Liaison, including the upcoming conference, review of antipsychotropics, individual not getting screenings for cholesterol and blood sugar, and encouraged us to review the JAMA patient pages about falls and older adults http://jama.ama-assn.org/cgi/reprint/303/3/288.pdf

12. **Business/ Nursing Practice Issues:**
13.

a. The Mass Conference is in October

b. Judith Guertin nominated for recognition award.

c. Please email guardians' forms to Joyce for examples

d. Topical/PO – we will not get cited per Peter Bacon at the October 2009 DDNNH meeting: here are the minutes from that topic during October:

Can we assume that if the "PO" if left off of a doctor's order, that the assumption is that it is "PO?" Yes. If not a PO med that the route does need to be specified. However, if the route is specified on the dr's order it should be specified on the label.

e. We spent time compiling a list of Nurse Trainer duties, including the scope of what is involved with staying in compliance with He-M 1201, and what is involved outside the scope of He-M 1201.

(see attached)

Goals for 2010:
Continuously look at DD Standards of Practice.
How do we create a new culture when you're not in a position of authority?
We need to update "Communicating for Health." Suggestion was made to create a List of Topics to explore: OTCs, Dandruff shampoo, Adding to the curriculum – How to prepare for a doctor's appointment? Chapter vs. Network. Individuals coming into the DD system and receiving services without the nurses' knowledge, having a DDNA member to represent each Area Agency, Program managers/house managers should all be med trained and receive a copy of the QA and have to sign off on it acknowledging the corrective actions that need to take place in a residence.

The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

April 20, 2010 Minutes

The **April 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, South Function Room. Twenty-five attended.

All Regions were represented by either area agency nurses or vendor agency nurses.

9:30 – 11:30am

The agenda was addressed as follows:

14. Review and Approval of March Minutes

March minutes were reviewed and accepted.

15. **Treasurer's Report**

a. March's report was read and accepted.
b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members. We need more members for DDNNH and this needs to be on our agenda.

16. **DDNA Liaison Report:**

a. Jen asked what issues the DDNNH want to bring to the DDNA Conference this year. Jen also talked more about Chapter vs. Network, what the different requirements are, such as that all committee members need to be DDNA certified, etc. Jen mentioned that the focus of the DDNA Pre-conference will be medication administration, and that NH already has a statewide curriculum but that many states do not. Suggestions for Jen to bring to the DDNA Conference included:
    i. Health disparities, i.e. dental and psych treatment (or the lack thereof);
    ii. Healthy eating and nutrition – how to manage this in the adult population where unhealthy eating is a culture.
    iii. How to raise awareness of our local DDNNH network, how to increase our own membership, how to get nurses interested locally as well as nationally.
    iv. How to promote people to become DDNA certified.

17. **Business/ Nursing Practice Issues:**

a. Continuing discussion around how to get nurses more involved in DDNA and DDNNH:

    i. How each nurse could reach out more to the New Nurse Trainer announcement that goes out when a new Nurse Trainer Orientation takes place;
    ii. Each region has variation in how nurses meet within each region, with some meeting monthly (mostly the area agencies with no vendors), to quarterly, to semi-annually, and to not at all.
    iii. How do we get agencies to support and pay for nurses to go to DDNA conference?
    iv. How do we get agencies to pay for CEUs? (Join DDNA and get free CEUs online!!)
    v. Leadership skills – how to acquire – get someone to make a CEU presentation.

b. It was suggested that the DDNNH propose standardized forms across the agencies for the purpose helping nurses save time. Suggestions were made that we use evidence-based research on why we would be doing this. A suggestion was made that we look at the Medication Occurrence forms across agencies and standardize the form. It was tabled until next month.

c. Another suggestion was to standardize the way the med books are set up – this would prevent errors!!

d. A suggestion was made to have our Treasurer and Secretary positions for two years as well, to be discussed at the June Meeting.

e. The DDNNH nurses were queried electronically to change our bylaws and our annual membership meeting to June as the majority of DDNA conferences are scheduled in May, overlapping our important membership and election meeting. Over 30 responded positively to make this change, with the suggestion we have our bylaws flexible enough to have it either May or June, depending on the DDNA conference. We will table this until June.

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May 18th, 2010 Minutes

The **May 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, South Function Room. Nineteen attended.

All Regions were represented by either area agency nurses or vendor agency nurses.

9:30 – 11:30am

The agenda was addressed as follows:

18. Review and Approval of April Minutes

April minutes were reviewed and accepted.

19. **Treasurer's Report**
    a. April's report was read and accepted.
    b. Membership/election month has moved to June!!

20. **DDNA Liaison Report:**

To be given in June.

21. **Business/ Nursing Practice Issues:**

a. We looked at page 8 of the High Cost Review that was emailed to all DDNNH nurses for discussion today. Several points were brought up:
    i. There is a natural resistance to change.
    ii. Unlicensed staff cannot give medications safely without the structure of the 1201's.
    iii. We have so much documentation requirements, but when someone goes to respite, there are no requirements???
    iv. An undue amount of nurse's time is spent on paperwork instead of nursing.
        1. We have to go through a year's worth of paperwork to prepare for certification.
        2. Why do we have to fill out a med occurrence form when someone forgets to initial?

3. We should be looking at the medical situation of the whole person instead of having to document every single thing.
4. Do we really need med logs?
5. Take documentation error reporting OFF the 1201A reports!

v. Not all nurses use treatment logs – some nurses use one book for both medication logs and treatment logs, otherwise the treatment logs would never get looked at. Some have a separate "treatment section" within the med log.

b. The nurse has the knowledge enough if someone moves whether or not they can move and be competent in another situation. We need to have a mechanism to focus our attention on the important issues, such as; Does the individual need new practitioners because of the move? Are there community resources available now in the new location that is sufficient?
c. Take dandruff shampoo off the med log.
d. What about CPAP, special diets. In general, a diet order is on the PE on an Rx. If lo fat and lo chol then the order in the book is relevant information as to what constitutes a lo fat dies.
e. In a hospital discharge situation a diabetic on fluid restriction following an MI – one nurse used a checklist system for staff to subtract as they went rather than write everything down fresh. The dietician would not come out for training but suggested a diet plan that was roughed out. Not counting carbs all day long was much easier. Also used was tracking it in everything that was eaten in a food diary and comparing it with blood sugar readings. Lo cal lo fat guidelines, teaching how to follow up with the doc on cholesterol levels. Use outside sources as much as possible.
f. Our program managers have worksheets for them – some managers with larger caseloads – some have 35-40 houses, and we have to have them ready to give meds, and having the nurse supervise them all is difficult.
g. **Question: what is our standard of practice around how often a person needs to give meds in a certified setting in order to be considered competent to administer in that location?**
h. More and more we have whole life situations – how often should they be QA'd?

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All Regions were represented by either area agency nurses or vendor agency nurses.

9:30 – 11:30am

The agenda was addressed as follows:

22. Review and Approval of April Minutes

April minutes were reviewed and accepted.

23. **Treasurer's Report**

a. April's report was read and accepted.
b. Membership/election month has moved to June!!

24. **DDNA Liaison Report:**

To be given in June.

25. **Business/ Nursing Practice Issues:**

a. We looked at page 8 of the High Cost Review that was emailed to all DDNNH nurses for discussion today. Several points were brought up:
    i. There is a natural resistance to change.
    ii. Unlicensed staff cannot give medications safely without the structure of the 1201's.
    iii. We have so much documentation requirements, but when someone goes to respite, there are no requirements???
    iv. An undue amount of nurse's time is spent on paperwork instead of nursing.
        1. We have to go through a year's worth of paperwork to prepare for certification.
        2. Why do we have to fill out a med occurrence form when someone forgets to initial?
        3. We should be looking at the medical situation of the whole person instead of having to document every single thing.
        4. Do we really need med logs?
        5. Take documentation error reporting OFF the 1201A reports!
    v. Not all nurses use treatment logs – some nurses use one book for both medication logs and treatment logs, otherwise the treatment logs would never get looked at. Some have a separate "treatment section" within the med log.

b. The nurse has the knowledge enough if someone moves whether or not they can move and be competent in another situation. We need to have a mechanism to focus our attention on the important issues, such as; Does the individual need new practitioners because of the move? Are there community resources available now in the new location that is sufficient?
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e. In a hospital discharge situation a diabetic on fluid restriction following an MI – one nurse used a checklist system for staff to subtract as they went rather than write everything down fresh. The dietician would not come out for training but suggested a diet plan that was roughed out. Not counting carbs all day long was much easier. Also used was tracking it in everything that was eaten in a food diary and comparing it with blood sugar readings. Lo cal lo fat guidelines, teaching how to follow up with the doc on cholesterol levels. Use outside sources as much as possible.
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g. **Question: what is our standard of practice around how often a person needs to give meds in a certified setting in order to be considered competent to administer in that location?**
h. More and more we have whole life situations – how often should they be QA'd?

The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

June 20th, 2010 Minutes

The **May 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, South Function Room. Twenty-seven attended.

All Regions were represented by either area agency nurses or vendor agency nurses.

The agenda was addressed as follows:

26. Review and Approval of May Minutes

May minutes were reviewed and accepted.

27. **Treasurer's Report**
    a. May's report was read and accepted.
28. **Review and adoption DDNNH bylaws** (attached).
29. **DDNA Liaison Report:**
    a. Jen is asking people to think about taking over as liaison as she is entering her second year.
    b. Regarding the DDNA Conference – it was exhausting. There were viewpoints from the national perspective around health disparities – some controversial viewpoints were expressed. The nurse was not always a valued member in the room. There was not a lot of discussion but a lot of good information that was thought provoking.
    c. For the Board report – NH was well represented. The Board report was summarized but was very vague and not helpful to the membership. The DDNA was saying they want our viewpoints from the field and some of the Board means it. At the end of the conference, people were writing pages of reviews of room for improvement. The person who presented ant the end had a good handout but the stage had no wheelchair access. There were a lot of electronics left and the mike could not be moved to where he was. The Board has strengths and weaknesses.
    d. The Chapter Leadership luncheon – last year learned about leadership and this year learned about being a chapter. At the luncheon, we could not do everything we needed to do. Judy Stykes had prepared a section of what it was like in the field that we did not get to. Someone asked about money – if we became a Chapter, we need to fill out a monetary disclosure. If we change our mind, then if we made any money when we dissolve to a network all of the money goes to the DDNA and we get back what we started with. Not all Chapters had done their disclosures. There are 80 national members and 20 local chapters. We could have fund raising, conferences.
    e. The second part was disheartening. The DDNA is not offering any longer CEUs that are acceptable for State licensure, explained in a handout. The new ANCC – good for every

state. It can take more than $5000 for initial application to the ANCC. A conference through the ANCC would be an additional cost. For the annual conference we will continue to be eligible for state requirements but for DDNA and state licensure. Online is separate.

f. Preconference – medication management in the community settings. A task force was put together in January. Sharon Oxx is on it – have met several times via telephone – what do we want to ensure for safe medication administration by unlicensed staff across the nation. 528 nurses (1/3rd) responded to the DDNA. 64% are mandated with less than 20 hours of standard classroom time. 59% felt there was insufficient oversight and training of DSPs, 40% felt they were our of compliance with the NPS, 37% cited lack of funding, 29% said they had no authority to intervene, 29% said there was a lack of standardized competence evaluation. The essential components – 95% said the 5 Rights, 85% said documentation, observing for s&s and identification of medication errors. We broke out into tables with different people – Jen was assigned to the oversight table. There was no deadline as to when the DDNA will assimilate the information they gathered from the tables.
g. The 2011 Conference will be in Hartford Conn May 13th 14th and 15th (1/2 day shorter than usual).

30. **Bureau of Health Facilities:** Peter Bacon shared a summary of certification reports and where the majority of medication deficiencies fell (documentation at the time of medication administration was the largest). All the surveyors' cell phone numbers were shared with the DDNNH. Peter instructed the nurses that if they do not agree with something that is cited they need to appeal the deficiency. Peter will then speak to both the nurse and the surveyor to get both sides of the story, and make a decision based on the facts presented by both individuals.

31. Kenneth R. Nielsen came for a question and answer opportunity regarding – "If it wasn't documented, was it done?"

32. Kenda Howell facilitated a discussion regarding "Structured DDNNH Meetings," the High Cost Report Recommendations, and how we need to approach our practice differently.

    a. We need to structure ourselves to pull together and be more of a cohesive group.
    b. What are our objectives?
        i. Create a list of unnecessary components in 1201
        ii. Create a list of necessary components of 1201.
    c. South Function Room needs to be set up differently to facilitate better discussions. We should have nametags. CURTAIL SIDE CONVERSATIONS. Please give respect and attention to whoever is speaking and wait your turn. If you need to have a conversation please step outside. SPEAK UP so we can hear you.
    d. We NEED GROUND RULES. Have the person running the meeting sitting at the center of the room.
    e. One person speaking at a time with a raise of hands.
    f. Our discussion needs to be mindful of the agenda.
    g. Tactical and strategic portions of the agenda.
    h. Be aware of Robert's Rules of Order (attached)
    i. Follow the agenda and follow the time frames on the agenda.
    j. Have a succinct agenda
    k. Put the educational opportunities on the back.
    l. Be mindful of our limited time.
    m. Be kind.
    n. Ground Rules:

i. Recognize who is the facilitator (usually the Pres or VP)
ii. One person speaking at a time
iii. Follow the agenda
iv. Be mindful of limited time
v. Remember – this is idea gathering time
vi. Be kind to each other
vii. No anonymity
viii. No side bar conversations.

33. **Business/ Nursing Practice Issues:**

a. **Question: what is our standard of practice around how often a person needs to give meds in a certified setting in order to be considered competent to administer in that location? Keep on September's agenda.**
b. Omission vs. documentation error?
c. Liability insurance – Eileen has information and will share with us.
d. License protection – Wayne has information and will share with us.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/DHHS/BDS/DDNNH

September 14, 2010 Minutes

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1. Review and approval of June Minutes. There were grammatical changes and clarifications made to the DDNA Liaison Report.

2. Officers Reports:
   a. Treasurer's Report: The treasurer's report was read and accepted.
   b. DDNA Liaison Report: Quarterly in September was given. The September newsletter is available for members online. Some copies of the abbreviated version of the newsletter were made available at today's meeting. The DDNA is asking for ideas for speakers and clinical topics for the 2011 Conference. The Conference will be held from May 13th to the 17th. Kenda stated that there is going to be a committee to work on hospitality i.e. food, welcoming room for the next conference. The DDNA is considering having a silent auction. A request was made to put this on October's agenda.

10:00

3. **Special Business:**

a. Ground Rules posted on wall.
b. High Cost Report re-emailed to the DDNNH with a request to please read page 8 of the report.
c. Table set up. We need to make the table shape bigger to include everyone at the table.
d. Please note the movie "Lost in Laconia" is playing this weekend through October 1st.

4. **Unfinished Business:**
   a. How often does an authorized person need to administer medications in order to be considered competent?
      i. S: Our agency has a policy that they have to administer at least one time per month to stay authorized.
      ii. W: I have 50-70 people authorized in one house alone – they have to administer at least monthly. But the bottom line is the 1201 regulation "or to whom they are regularly assigned."
      iii. E: How do you arbitrarily come up with 1 month? Can you just give that information over the phone:
      iv. E: what about some who took the med course 3 months ago and has not yet given a med?
      v. M: or someone who just has a PRN?
      vi. R: I have 2 clients with no meds and the providers are authorized with "observation pending" is written on their authorization.
      vii. M: I have a person who took the med class one month ago, the are coming back for the 2nd ½ of the class to repeat and then take a retest.
      viii. E: If I have someone that took the class two months ago and has not been observed, I make them go through the whole class again.
      ix. M: that is very costly. Can't that be looked at individually? What about verbal testing i.e. triple checks, 6 rights, etc. and then if they can't pass then they have to retake the class?
      x. E: I'd like the group to set a policy.
      xi. J: I have day program staff who may have a med at some point. All I have to do is observe. I check in with them regularly. The managers are expected to remind staff what it means to give meds.
      xii. S: I have a concern that once you learn a new skill if you "don't use it you lose it."
      xiii. J: I have some people I would not do that with.
      xiv. S: some program managers have been trained for 20 years and have been giving meds and they can make a mistake.
      xv. L: Our agency has a three-hour reauthorization class and they have three months prior to their expiration to take the class.
      xvi. J: I can't come up with eight hours right away, it's a logistical issue:
      xvii. K: if people are getting pressure to authorize people you don't believe are competent, some people are put in bad spots.
      xviii. P: there are problems with the State Certifiers around people able to self medicate that live in a home with others with forensic issues, have to be under lock and key due to the safety of the home. Recently a certifier took an issue with someone who's self-medicating who had their meds locked up, citing client rights.
      xix. W: does that client have a key? Lock it up in their own room and give them a key – that would be a solution.
      xx. J: regarding setting policy on how often a person has to give meds to be considered competent, it really needs to be up the nurses' judgment and the situation at hand. Each situation is so different what works in one scenario might not be practical or safe in another. It has to come down to nursing judgment, and if your practice can

stand up to scrutiny by the BON. If you can stand before the BON and justify your decisions, then that should stand. We have to be careful how much we dictate in terms of nursing judgment.

b. Is it an omission or a documentation error?
   i. L: way back when if the error was discovered more than 24 hours after it was made, it was always listed as an omission.
   ii. W: some nurses report it as a documentation error – we have not been consistent. The numbers don't make sense unless audits are done to prove the med was given.
   iii. M: years ago, it was always looked at as an omission, and then it switched.
   iv. K: in the previous revision of the 1201, we didn't have documentation as a category. Adding it as a category had the unintended by-product where omissions have become listed as documentation errors. I don't understand how it can be a documentation error. The numbers are really skewed. It's clear that people are paying attention. I hope the documentation category goes away.
   v. L: most staff are honest, either they say the did or didn't give the med.
   vi. K: was there corrective action take and was it appropriate are the most important questions.
   vii. E: in a forensic group home they will sign off 4 pages of meds but then forget to sign the last page. The question is, how are you doing your triple checks? So I counted it as a documentation error because it was in my judgment and then we discuss the triple checks.
   viii. K: we're not executing people – how do we account for something that was done 6 months ago? We're not intended to be in a numbers game.
   ix. W: don't assume it's a documentation error – if it's blank then find out!
   x. L: if a person really can remember, then I believe them.
   xi. T: for staffed home we have a protocol to follow to review med logs for blank spots. For a week's worth of omissions it's a different story. We had an individual who had a 12-minute seizure, they get Valium in 5 minutes but they didn't get the 2nd dose. One nurse said it was a documentation error because staff miscalculated the seizure time. Safety of the individual is more important that how an error is documented.
   xii. O: staff are required to count narcotics one time per day, at the shift change it would be odd to pass off without counting – does everyone do one per day?
   xiii. D: minimum 1201 standards are once per day, but we do it on shift change.
   xiv. T: our protocol in our agency is per shift with two people present at the same time.

11:00 – 12:00

5. **Continuing Education Series**

Continuing Education Series

"Trach Education for Care Providers of People with DD"

The delegation of trach care is not a 24-hour process – it is a couple of weeks of constant practice, and they have to demonstrate repeatedly that they can do it. The person sleeps in overnight before the individual is discharged. Lynn has taught 14 year old to be competent. We utilize a standardized curriculum. There is not a lot or research around trach care delegation but this curriculum was designed by a team of experts and is considered best practice.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

Minutes
October 2010

9:30 – 10:30

6. **Call to order**
   a. Greetings and Introductions were done.

7. **Review** and approval of September **Minutes**. There were grammatical changes.

8. **A request was made to print out the Ground Rules for the next meeting.**

9. **Officers Reports:**
   a. **Treasurer's Report**: was given by Dianne Crone. A request was made to have membership applications printed out for the next meeting. (They are also available online).
   b. **DDNA Liaison Report**: Quarterly in Mar, Jun; Sep, and Dec. In the September report, Jen brought up an issue about a silent auction, which some nurses had questions about. As Jen was not in attendance, motion to carry this question over to next month made and passed.

   c. **BHF Bureau of Health Facilities –** Jan, Apr, Oct (9:45 – 10:15 full meeting with all inspectors).

10. **Unfinished Business:**
    a. How often should a person have to give meds as an authorized person in order to be considered competent?
       i. L: One person in day program with meds – retraining is done annually every January, but site training might wait until November. The team leaders are site trained but they do not administer meds.
       ii. E: How can we make sure the program is up to date – go out every 3 months to do a QA – program manager goes out every two months and doesn't even look at the med book. Program managers need to be med trained!
       iii. L: Unless we come to an agreement – it is up to the nurse

iv. E: the person has to have "current knowledge of" how do we know if they have it ? They can call the Nurse Trainer.
v. S: Should program managers be observed in all ISOs?
vi. E: W had 50-70 people authorized in one home – makes no sense – how do you supervise?
vii. G: At Crotched Mountain, how do you justify so many people being authorized?
viii. P: Everybody has to go to class – how often should they give meds to know what they are doing?
ix. G: we ask the program managers to give meds one time per month in each home.
x. S: the managers decide which home to give the meds one time per month, but it should be one that is most representative of the "typical" medication administration. They do not have to go to each home every month but they go into one home – if on call and go somewhere they are not officially authorized and I may do a mod 4 over the phone.
xi. J: mock authorizations or authorizations over the phone do NOT meet the criteria of "direct observation" as specified in both 1201 and the NURs.
xii. L: We follow the regulation – if we cannot follow the letter of the law we better have a rationale, such as a snowstorm, etc. I agree with the one month except for day programming – no way I can get everyone site trained one time per month – in general it is a logistic impossibility.
xiii. E: what S and E were saying is common sense – direct observation is in the reg.
xiv. The suggestion that med authorized staff have to pass meds one time per month in order to stay authorized is NOT in the regs!!
xv. J: This again should fall to nursing judgment. How often you supervise one person may vary widely as to how you would supervise another person – it comes back to competency.
xvi. D: how is it being tracked – if I have four program managers do they call me? I would want it to be their responsibility.
xvii. D: we have a calendar on the wall and they initial where they gave meds in
xviii. E: it is that we are giving meds in a regular way, not that we are observing them every time.
xix. M: when you do a QA you will see how often they administer meds.
xx. C: When I've done it over the phone – somebody that was a manager had expired, they had an appointment to meet with me but it had been rescheduled and they had to give meds so they called me so I did it over the phone and then did an occurrence report because it was a snowstorm.
xxi. L: I needed to write something so I used the form too
xxii. M: That is why it is an occurrence form.
xxiii. B: There were unauthorized staff giving meds so it's an occurrence:"
xxiv. M: it is a good way to track things.
xxv. S: do we put it on a 1201A
xxvi. C: it is not reportable
xxvii. M: nurses do report those kinds of occurrence – put it as a paragraph down at the bottom of the 1201A form.
xxviii. S: Under trends I put it as a notable event – but it does not fall into any categories.
xxix. D: program managers are responsible to make sure the staff is trained! Why are we not better covered? It is a safety/staff issue.
xxx. E: how to you supervise people – managers are med trained – not in all 13 homes but I know they are competent so in an emergency I know they can do it.
xxxi. D: at the 11th hour it is not a nurse issue it's a staff issue.

xxxii. C: would be on the nurse if anything happened – managers need to take more responsibility. If a person had a G Tube with lots of meds I had go to the program – it is on us and our license.
xxxiii. E: I had to go out in an incredible lightening storm once.
xxxiv. L: to make a blanket statement – I have worked with service coordinators that go through recertification yearly but they do not pass meds every year, but the service coordinators manage our home but they know their individuals. It is up to us to know if they are competent or not.
xxxv. K: Program managers should be the one who is the most competent!!!
xxxvi. L: it depends on the people, situation, and knowledge base. We are backing ourselves into a corner when we over regulate ourselves.
xxxvii. L: I agree with her – it should be up to nurses' judgment – make sure you document.
xxxviii. K: if all program managers are not trained that is very odd – it is RIDICULOUS that a program manager is not med trained – It is part of good management.
xxxix. M: it could be that turnover affects why some are not trained.
xl. K: it should be a prerequisite to be med trained to be a program manager!
xli. E: a number of managers are not med trained not because they are new – we are getting very large and we have lots of forensic programs.
xlii. L: it's a confusing issue because program managers mean different things in different agencies
xliii. E: our are called managers – we have one that is overseeing 13 homes but is not med trained. I had a lady who had her hip replaced who had Down syndrome and then talking to the manager who had never been med trained she had no idea what the individual needed.
xliv. K: nurses should NOT be in this situation – someone besides the home provider better be med trained!
xlv. L: everyone in our agency IS med trained – you cannot tell me that they have to pass meds every month to stay authorized.
xlvi. C: our managers are manipulative – some will call you to be observed – we do not hear from some of they so they do not have to be on call.
xlvii. P: our agency used to mandate this – they would never not be observed.
xlviii. E: We should not have to explain why managers should be med trained – they should take ownership. I have an individual who self medications and their meds are locked in a safe – I call my program manager to say they can't lock up the meds – it's a client rights violation.
xlix. K: the regulation has always been silent on that.
l. R: we have had a great discussion and I have learned a lot for my practice. The house managers in my programs better be med trained – I am not doing their job for them!
li. KD: how will the state surveyors interpret a policy that we set?
lii. J: This should fall to nursing judgment. How often you supervise one person may vary widely as to how you would supervise another person – it comes back to competency and being in compliance with the NURs not the 1201s. I make a motion that we leave this frequency of how often a person has to administer meds in a program to be considered competent to nursing judgment and compliance with the NURs delegation requirements and not set a particular time framed policy around this.
liii. Motion passed in unison – no dissents.
liv. M: I just want to say it is the philosophy of our agency that training in general is very important.

b. Omission vs. Documentation

i. D: if the 8am box has no initials and no other box is missing initials – can't I call and speak to the person and write on the back – does it always have to be an occurrence?!?
ii. E: it's a documentation error!! I believed him that he gave it!
iii. D: we teach in our curriculum to circle the error.
iv. D: if a person remembers giving it then I believe them.
v. E: how can you remember 6 months ago?
vi. D: have you ever been cited for calling it a documentation error?
vii. C: if someone is shaky I would write it up.
viii. R: in our training we use the dot system – that would mean they didn't do the triple check – if there's no dot and no 1st initial, I call it an omission.
ix. S: if it's not documented it's not done!
x. W: when we look at the documentations error we're not sure because people all report it differently – some have a system and some use trust – there are so many variables – in the end the numbers are meaningless anyway because of the many variables.
xi. E: take documentation off the 1201 A form and focus on nursing care and off the minutia.
xii. L: if we take off documentation from the 1201A form – do we leave it to nursing judgment whether or not it's an omission?
xiii. All of us report differently – some nurses are more stringent than others.
xiv. S: is there a way to standardize?
xv. B: we should leave it to nursing judgment.
xvi. D: we all have our own policies but if the nurse in her judgment feels the person gave the med, I see no reason to fill out an occurrence report but it should be documented
xvii. L: you would take a person's word?
xviii. D: that's the nursing judgment – it's up to me as long as I document it.
xix. L: I'd like to have objective data –I'm not going to do anything I can't justify.
xx. D: then how do you make that determination?
xxi. J: we need to get away from this – in the scheme of issues, how important is this? It is more important to find out what happened and how to correct it to prevent it from happening again, rather then spend so much time deciding what category it should be in. How is the individual? What med was "omitted?" What system is in place to help authorized staff safely administer meds?
xxii. L: I don't appreciate being a bean counter.
xxiii. E: we serve a lot of people and we need to have standards. If an individual has a hip replacement I want to be there – we have hospitalists now and they don't have a clue who our person is – my goal is a successful hip replacement.
xxiv. L: we don't have that luxury but I hope that it comes to that. Until something comes off our plates, such as What deficiencies do I have to avoid?
xxv. L: that's what we should be doing – as a nurse case manager I get to do that. Our agency has that ability to go to the hospital.
xxvi. D: in some cases that's a delagatable task – I make sure a full time staff person who knows that person to be there.
xxvii. DB: We need a case study and evidenced-based practice to help us become reporters.

10:30

11. **Bureau of Health Facilities:**
    a. Peter Bacon introduced all the surveyors, stating he brought the same type of report as when he came in June, and that we were pretty consistent with that report, with the problem area still consistent, mostly missing parts of the PRN protocols and med being documented at the time of administration, controlled meds, and homes taking hits the day of the review

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Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

November 16, 2010 Minutes

9:30

12. **Meeting was called to order**
    a. Greetings and Introductions.
    b. Reminder to sign the attendance sheet.
    c. Reminder for cell phones off or on vibrate please.

13. **Review** and approval of October Minutes with typographical errors corrected.

9:45

14. **Officers Reports:**
    a. **Treasurer's Report**: given by Dianne Crone.
    b. **DDNA Liaison Report**: Questions from last month were unclear, so we will table this until next month. Quarterly report due for December meeting.

10:00

15. **Unfinished Business:** omission vs. documentation continues:
    a. D: Many of us had our own opinion on how we do things. Maybe those who were not here last month should weigh in on this discussion. After all the discussion we all determined that we have our own ways of doing this as we all know our own providers best and there level of competency.
    b. J: It is not about trust but because they were trained to put their first initial they are not doing the process – it is reported as an omission but I note I believe that they gave it. Except if it is controlled – if the count is correct and the count sheet is signed. Occasionally we count for non-controlled and if the count work out I'll put it as a documentation error.

c. D: Peridex is on the med sheet but not given with the 8pm meds – those are the type of things not signed for because it's given as hs. In my opinion, it should be the Nurse Trainers' decision because ultimately I'm responsible.
d. L: I tightened up after our last discussion, but I did put out my own policy if someone noticed within24 hours I believe them but greater than that it's an omission. In nursing if it's not documented it's not done – but because of our conversation it made me put a new policy in place.
e. M: I mentioned it at our last nurses meeting – I feel the nurses do a great job – so far it's been up to the Nurse Trainer – that's they way it's always been.
f. K: I agree with that.
g. D: on the back of the med log I write an explanation of the error.
h. K: Documentation error reporting around the State of NH has increased in clarity from the Medication Committee perspective. On the reports we get, we can tell what's happening. The issues becomes where is the policy and procedure? It is a failure to follow these – how do you know what's going on? The reporting generates statistical data – often not to measure one agency against another, but when there are NEVER any errors we raise our eyebrows – when no one EVER makes a mistake. I believe if it's not signed it's an omission and it is more around a procedural issue. Too many times nothing has been written on the med sheet.
i. D: how much impact does the training have on the documentation issue? For me, it is a big thing in my class. I have to know they're following procedure. Is there a global answer?
j. K: a non-answer is an answer. If you use blister packs then you know but we can't measure anything against anything. It's the statistical measuring that is the issue for me.
k. D: Do any have a policy manual in your agency specific to documentation errors?
l. K: we have policies – it's been there – our policies are from 1201.
m. L: written by nurses, passed by the med board – nurses review them. The nurses kind of run their own programs. The 1201 is as clear as it needs to be.
n. K: It is open to interpretation – there are many nuances.
o. J: If I am strict in my interpretation and someone else is not and documentation categories go away then public reporting will look much better than mine. Then my company looks bad.
p. L: You're right – our stats will look different, which is OK. It's not like I've been hiding or skewing.
q. D: if that documentation category disappears, the certifiers said we can put documentation on the back of the med logs.
r. K: It should be on the QA too.
s. L: Every single error is an occurrence – we're not reporting these on the QAs.
t. D: We have to know if it's a simple documentation error – it's not considered an error if they forget to put a signature on the sign-in page, although then can be recorded as a documentation error. That's where we differ in documenting errors from procedures.
u. L: See, and that's what I report – I report all of those.
v. K: another example of how we differ.
w. D: Peter agreed that this was fine; it still will fall back to whichever surveyor is doing it.
x. De: The definition of a med error – who wrote that?
y. D: Can we define it?
z. P: If there's no initials and not the same day, it's an omission.
aa. G: But that's what we're saying – everyone does it differently. We have differences of opinions.
bb. K: The question is on the table – can we come to an agreement and take a stand and it's clear everyone does it differently.

cc. G: Each case is different.
dd. D: Group homes should be handled differently than residential.
ee. K: Day program – someone get eye drops at the day program but sometimes they don't sign for it but they gave it – sometimes they omitted it but they tell me. If you can't trust them, then they shouldn't be giving meds!
ff. D: Exactly – that's what it's about – we all make mistakes and they need to tell me. That happens for the most part.
gg. K: our job is to guide people to tell us and to feel comfortable to tell us.
hh. D: Formally tell us in 1201 how to define what a documentation error is.
ii. L: If we can prove by counting then it's not an omission but when we don't have proof.
jj. Ka: If you can prove it I agree, otherwise it's an omission.
kk. Le: If the review is three weeks later and you can't prove it we're making this complicated whether or not the med was omitted. If there is no documentation beyond twenty-four hours in a staffed home, it's an omission. If it's within 24 hours and they tell me they gave it, it's OK but thee days later it's an omission.
ll. K: if you have staff come in at night - it's all about the corrective action so you can't find the staff who made the error then you have to change the corrective action because you don't know. We have a tighter rein – if it's within your shift, it's OK but if the next shift it's an omission.
mm. .L: it's a double check system in our staffed homes as an incentive to help staff.
nn. O: what is one day an antibiotic wasn't signed for and you can count it?
oo. K: we have staff that move around – what if they say, "well, that's not how we did it there?"
pp. D: We'll talk about this later.
qq. C: How about we take a hand count now for in favor of an unfilled initial it's an occurrence report if over 24 hours?
rr. L: put four scenarios down and then we can vote on the.
ss. K: I'll craft it if you give me the four areas:
    i. One within 24 hours
    ii. One if you can prove it by counting
    iii. Nursing judgment
    iv. Under no circumstances
tt. L: what we're saying is if not within 24 hours, the rest is nursing judgment.
uu. K: I'll bring to the next meeting.
vv. C: If we determine it given – do we fill out an occurrence form?
ww. D: It has to be documented somewhere – it can be put on the back of the med log.
xx. K: This is good conversation – let's see if we have a good outcome.

10:30

16. **New Business** including Nursing Practice Issues:
    a. Ca: is an in-home support and CDS – are they the same thing or are they two separate and distinct?
    b. M: 525s are CDS – we have a situation where parents bought a house for their son and hired a roommate.
    c. Ka: in 525s family members direct the program.
    d. L: we had the 524s with the kids and it's worked well – I go out annually on this particular child and the 525s will be a similar situation but it's worked well and I use the delegation forms.

e. Ca: I'm in the same boat – we're rolling these out weekly – can we as a NT ask the staff that they be required to attend 1201 class?
f. D: If you tell a Mom I'm not sure this person is competent that Mom won't say OK – it has to be family driven.
g. Ca: who makes the determination that Mom is OK
h. D: You can report to the agency
i. L: The situation is reportable if it's abuse, neglect, or exploitation – it's really none of our business – if you don't see it keep you're nose out of it.
j. M: If the parent who runs the 525 wants to QA using med logs, is that OK?
k. Ca: any med occurrences – how do you handle this?
l. M: make up a checklist of what needs to be done, go over rights, what's a med, the many components we teach. I use these forms and a few other forms, although I do find them cumbersome.
m. D: it's a lot of nursing judgment.
n. What if we go through the process and we can't delegate – tell them what your concerns are.
o. D: I didn't delegate because of storage – the medication was stored with all the other meds and I felt it was not safe.

Gasping for Relief

Article was sent out by email – any comments?

D: question – how many are required to have CPR? IPP, Easter Seals, Plus. The American Red Cross changes their standards. Anyone with poor dentition is at risk for choking.
L: I'm in the process to be trained as a basic rescuer trainer. It will take some adjusting for clients because of their disabilities.
D: It used to be that any fire department would loan out the mannequins. It is a poor utilization of nursing time.
M: I have been CPR trained to train – it was tough to do both.
K: Our staff is all CPR trained and all home providers are all CPR trained in our region.
D: at our company we are all trained. In our health and safety we have that section on choking – you have to know your clients and if they have choking – dentition issues. We have to educate our staff about the potential for choking.
De: what about liability and supervision during mealtime issues are huge – anyone can choke but teeth teeth teeth!

Relocation Stress Syndrome Article

D: moving is stressful – what our clients are going through, sending people to respite one time per week.
D: the new 1001 5-day requirement is great – even though it's not in effect we're starting this already

New Question:

Treatment vs. Medication – I'm confused as to what we consider a treatment.
Le: I see Prevident on the med sheet and I'm wondering why – if it has medication it goes in the med log.
D: I have a treatment sheet that I use for other things.

K: If it's not medicated and anyone can buy it is it appropriate for him to use as a team decision is a perfect example of a treatment. If we change the scenario and the dentist says use Plavix – what happens to that? It still makes in a treatment and we still have to recognize that it needs to be done.

J: there still needs to be documentation that it will be reviewed.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

December 21, 2010 Minutes

9:30

17. **Meeting was called to order with:**
    a. Greetings and Introductions.
    b. Signing the attendance sheet?
    c. Cell phones off.

18. **Review** and approval of November **Minutes** with two corrections.

9:45

19. **Officers Reports:**
    a. **Treasurer's Report**: given.
    b. **DDNA Liaison Report**: Full report in Dec:
        i. **Mary Gage award is presented at the National Conference** – nominees are put forward who demonstrate commitment to DDNA, need nominations by March 15th.
        ii. There is a call for a President elect and a Treasurer for the DDNA – Board responsibilities are available online – submit you intent between Jan 1 and Mar 31 with voting from July 1-31st.
        iii. In the Newsletter, the silent auction is asking us to provide items to be sold, something small enough to travel with. Do we have a product –i.e. license plate frames – something to promote us? The Conference is May 13th-17th, with the 13th a certification prep day. Karen has a flexible straw. Eileen suggested a DD related book. Another suggestion was "Lost in Laconia – for us to buy two copies, one for the DDNA – perhaps put together a basket – Debbie suggested maple syrup and Darlene suggested a moose hat.
        iv. Steps to Clinical Excellence is the topic for the Conference, with the hotel costing $135 per night. The brochure is available online – have to pay to park at the hotel. Sat. the 14th is the preconference with mental health and DD issues the topic.
        v. Kenda – we did T-shirts for the conference in Vermont – if we had a large group, this would be a good time to do this, and plug for representation on the DDNA board from NH. The Conference a fun networking opportunity – there will be a dance the first night of the conference and a dinner party. There has been talk about a hospitality suite.

vi. Posters – the national organization is looking for poster submissions, an illustrative story of your network. Individual posters are welcome.
vii. We should market Lost in Laconia – NH is a leader in closing the institutions. There is a call for speakers in 2012. Maybe we should get some of the nurses involved like Sharon Oxx, Mary Smith, and Judith Guertin and get some of the families involved.
viii. On the DDNA website this morning there was a new post for the front page. The U of Minnesota is participating in health care coordination and study supporting people with DD who also have physical disabilities. The survey takes about 30 minutes and then another one is due in 2-4 months.
ix. The DDNA is interested in literature reviews. For example, there are lots of people with issues with earwax. (I) wanted to do a literature review doing some research and do an article about the literature – they are always looking for articles.
x. Upcoming classes at St. A's and there are nursing education opportunities all the time. Joann Jordan is speaking on Alzheimer's in Feb and in March there will be a tour of the brain.
xi. Wayne passed out handouts of the Rx Locker, which costs $20.00.

10:30

20. **Unfinished Business** Omissions vs. Documentation errors.
    a. Kenda presented four scenarios (handout) It would be beneficial as a group if we could agree on this and staff the BHF would benefit also. We attempt to contact – the most important piece – is the person getting what they need?
        i. L: we use a dot system
        ii. E: we put one initial then a 2nd initial. What if all are signed except one med. We don't teach dots in our curriculum – should we have a more uniformed way to teach?
        iii. K: this is the purpose of the discussion – we implement policy but don't hold people to that policy.
        iv. E: are we teaching the dot?
        v. L: I don't use the initial method – whatever thing you teach if you can verify within 24 hours – after that it's an omission.
        vi. D: this works in group settings but not in AFC's – I don't have 24 hours – I would be looking at something from two months ago.
        vii. L: but we have to hold the same standard.
        viii. D: dost not necessarily mean the person didn't get the med
        ix. E: we use nursing judgment – LOTS – that's how we got into this!!!!
        x. Everyone was talking about stats!! To everyone who does it differently – we have done something routinely – it puts more teeth into it.
        xi. I: in Pathways – our direct care providers are part of a union – they have a grievance procedure.
        xii. K: HR and I arm wrestle around issues all the time – how as you the nurse to you get to treat people differently. The agency needs a polity.

Discussion tabled 'till next year.

21. **New Business** including Nursing Practice Issues:

a. Lorene Reagan here to help us understand the distinction between a 521 and a 524 and a 525.
    i. At first, the 521s were disasters regarding the role of the family, but this was about 20 years ago. Now, a 521 means a person is in the family home with the purpose of maximizing supports for the families that integrate staff who work for an agency and family members. Providers have a contract and there are rules around medication administration.
    ii. 524 – in-home support for ages birth to 21 had the same growing pains – with working language in the NPA for delegation with statutory changes going on at the same time.
    iii. 525- people living with families and families overseeing – there has to be a strong relationship with the family. The majority of responsibility and authority to direct services – it's better! We're going to trust that families provide the best care and know what their training needs are. Also determines when other family members are providing services what the training should be whether they are paid or not. What are the families' standards? It is a very different dynamic – we are now in negotiation – they are purchasing your services. A 525 has a contract – is the nurse part of that team? Is there a requirement if Mom wants to train? There is one primary person to decide to direct and manage services with the day to day management and supervision.

Developmental Disabilities Nurses of New Hampshire
www.dhhs.nh.gov/dcbcs/bds/nurses/index.htm

December 21, 2010 Minutes

The December Meeting was called to order with 27 in attendance and all Regions represented either by Area Agency or Subcontract Agency nurses.

9:30

22. <u>Meeting was called to order with:</u>
- a. Greetings and Introductions.
- b. Signing the attendance sheet?
- c. Cell phones off.

23. **<u>Review</u>** and approval of November **Minutes** with two corrections.

9:45

24. **<u>Officers Reports:</u>**
- a. **<u>Treasurer's Report</u>**: given.
- b. **<u>DDNA Liaison Report</u>**: Full report in Dec:

i. **Mary Gage award is presented at the National Conference** – nominees are put forward who demonstrate commitment to DDNA, need nominations by March 15th.
ii. There is a call for a President elect and a Treasurer for the DDNA – Board responsibilities are available online – submit you intent between Jan 1 and Mar 31 with voting from July 1-31st.
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11:30

We had our Annual Holiday Luncheon, with many door prizes and GREAT food!!
Thanks to all who make this such a great affair!
Happy New Year!

The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

January 20, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Fifteen signed the attendance sheet.

All Regions except Region 3 and Region 9 were represented by either area agency nurses or vendor nurses.

The agenda was addressed as follows:

1. **Review and Approval of December Minutes**
   December minutes accepted.

2. **Treasurer's Report**
   December's Treasurer's Report was read, clarified and accepted. We will need a treasurer to replace Valerie with she retires on June 5th!

3. **Business:**
   a. DDNNH elections will be held in May – now is the time to start thinking about our organization.

4. **Nursing Practice Issues:**

   a. OTC's – the NH Medicaid Pharmacy Program (First Health Services) released a memo on December 2nd stating that they will no longer cover medications not listed on the Non-Legend (OTC) Drug List, nor will they cover any cough or cold preparation. The exception form is no longer valid. Notices are posted at:
   http://newhampshire.fhsc.com/providers/ptac.asp
   We are getting calls from service coordinators and providers for folks who are rep payees, who are asking who will pay for needed drugs if they do not have enough money. Wayne and Martha offered to check pharmacies about reimbursement related to the size of bottles, as some questions buying larger bottles of OTCs in an effort to save money.
   Peter's Pharmacy in Nashua sold out to Target, and now people are having trouble getting labels as they had in the past.

   Discussion ensued: "Do we need to take OTC requirements out of 1201?" When 1201 was developed, the Board of Pharmacy was not involved – they do not have to label OTC's because 1201 says so as they are not governed by that rule at all.

   Another question: "Should we allow the same protocol as what is found on the DDNNH Frequent Questions – what to do when you can't get a label changed?"

b. Speaking of 1201, they will expire in 2011 – it is not too early to start thinking about what changes may be beneficial. What about issues that have come up over the past several years, such as:
   i. The need for more oversight for people that are in frail health, or for
   ii. The need for advocating for an individual when they are at a medical appointment or when hospitalized?

c. "Zero Tolerance Policies" – we need to be clear that punitive policies around medication errors are not conducive to self-reporting of medication errors. We rely on self-reporting from the program providers, for without them community-based care services could be lost. In we create an environment that is not conducive to integrity, it defeats the intent of safe medication administration in accordance with the He-M 1201's. We should not be as concerned about the number of errors as we should as to the nature of the errors and the appropriateness of their corrective actions. Any policy that offers global punishment without identifying what the particular problem is, rather than re-education specific to the situation and a corresponding corrective action, raises concern.

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February 17, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Fifteen signed the attendance sheet.
All Regions were represented by either area agency nurses or vendor nurses.
The agenda was addressed as follows:

5. **Review and Approval of January Minutes**
   January minutes accepted.
6. **Treasurer's Report**
   January's Treasurer's Report was read, clarified and accepted. We will need a treasurer to replace Valerie with she retires on June 5th!
7. **Business:**
   a. **OTC drugs** – the group discussed the fact that as of December 2, 2008, the NH Medicaid Pharmacy Program (First Health Services) no longer covers certain OTCs not listed on the Non-Legend (OTC) Drug List and all cough and cold preparations, and that the exception form is no longer valid.
      i. A lively discussion ensued, stemming from a citation from the BHF about a prn protocol involving Tylenol. The policy set forth on the DDNNH FAQ website was read. It will be brought forward to medication committee for discussion and placed again on the March agenda.
      ii. We discussed the request for examples of specific medications that individuals need that are no longer covered, in order to present a compelling case to the Office of Medicaid and Business Policy (OMBP) about the impact the decision to

discontinue coverage for some over-the-counter (OTC) medications is having. The Bureau needs to have:

1. what was paid in January, and in February for those medications, and to please be as specific as possible, for example, Jane Doe, who is living in a certified residence, paid $30 during the month of January for Miralax, and $15 for Delsym. Your information is necessary in order to show the impact on individuals living in community residences.

8. **Nursing Practice Issues:**

d. Certain OTC's that are no longer covered: after meeting with the Medication Committee, it was recommended that "baggie method" as described in the DDNNH FAQ item #2 be utilized. We discussed the DDNNH FAQ policy and will also bring this forward to Med Committee and will discuss this also again in March.

e. He-M 1201 will expire in 2011 – a request has been made for all nurses to provide written feedback as follows:
   i. What about issues that have come up over the past several years, such as:
      1. The need for more oversight for people that are in frail health, or for
      2. The need for advocating for an individual when they are at a medical appointment or when hospitalized?

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March 17th, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Thirty-six were in attendance.

All Regions were represented by either area agency nurses or vendor nurses except Regions 5 and 9..

The agenda was addressed as follows:

9. **Review and Approval of February Minutes**
   February minutes revised and accepted.
10. **Treasurer's Report**
    February's Treasurer's Report was read and accepted.
    Valerie will find out more info about the Rivier College Denise Martinez scholarship for March discussion.
11. **Business:**
    a. **Elections –** a brief discussion ensued describing each DDNNH Officer's position. All positions will be due for election during the May DDNNH meeting, which are President, Vice-President, Treasurer, Secretary, and the DDNA Liaison.
    b. **OTC Update:** Here is a copy of a draft letter given to Matthew Ertas, who will be speaking with Nancy Rollins this week:

RE: Change in Coverage for Over-The-Counter (OTC) Preparations and Prescription Cough and Cold Products

Dear New Hampshire Pharmacy and Therapeutics Advisory Committee (PTAC):

The changes in coverage for over-the-counter preparations and cough and cold preparations effective January 5, 2009, have had a deleterious effect on the population receiving services from the Bureau of Developmental Services (BDS).

Since January 5, 2009, the BDS received numerous phone calls and emails that voiced concerns about individuals' with developmental disability and acquired brain disorders inability to cope adequately with the cost increased incurred because of the New Hampshire Medicaid Pharmacy program's changes. A request was made to case manager supervisors to collect information over the period of January and February regarding costs and hardships. We received examples from ten individuals receiving services who combined had approximately a $400 increase in out-of pocket expenses, averaging an increase of $40 per month per individual.

One example included an individual with cerebral palsy, scoliosis, and a bowel resection who could no longer afford the $12 per month for Benefiber. She is also on numerous medications that have constipation as a side effect. As a result, Benefiber was initially discontinued by the guardian, relying on the judgment of unlicensed homecare providers to observe for increased bowel symptoms. Another example is of a person now with an additional $23.03 per month to pay for guaifenesen syrup, multivitamins, and Unifiber from her personal needs funds, which leaves her with about $97 per month to cover all other expenses. This means she is experiencing a 22% increase in what is required of her to spend from this account.

12. **Nursing Practice Issues:**

f. He-M 1201 will expire in 2011 – a request has been made for all nurses to provide written feedback as follows:
    i. What about issues that have come up over the past several years, such as:
        1. The need for more oversight for people that are in frail health, or for
        2. The need for advocating for an individual when they are at a medical appointment or when hospitalized?

g. Steve Colombo and Terry Clark visited from Region 3 and shared best practices around the Nurse Case Management Pilot Project regarding Preparing for a Doctors Appointment.

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April 21st, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Sixteen attended.

All Regions were represented by either area agency nurses or vendor nurses except Region 9.

The agenda was addressed as follows:

13. **Review and Approval of March Minutes**
    March minutes revised and accepted.
14. **Treasurer's Report**
    February's Treasurer's Report was read and accepted.
    Valerie will find out more info about the Rivier College Denise Martinez scholarship for March discussion.
15. **Business:**
    a. **Elections –** discussion included a suggestion that we stagger the election process so that we are not looking for a whole new slate of people all at once. Suggestions included having the DDNA Liaison elected every year – motion made, seconded, and approved. The Bylaws will need to be amended to reflect these changes. Another suggestion was to have the Vice-President automatically move into the President position – motion made, seconded, and approved. Eileen Murphy Hamel will assume the President of the DDNNH in May 2009, the Vice Presidential Nominations during the meeting resulted in Kenda Howell. Emails received after the meeting included the nomination of Darlene Foley for Vice President. Martha Fenn King was nominated in absentia for the DDNA Liaison, which she declined. Jennifer Boisvert was nominated to assume the Treasurer's position.
    b. DDNA Liaison Report: there is a different shift in how the DDNA newsletter presents information. The conference is next month. Attendees need to print their own manuals. Only 216 people registered for the conference with is a third of what registered last year. Will be bringing back exciting information. Jen will go to the Chapter induction and leadership information session in the afternoon. Health promotion articles in the current newsletter speak about death by indifference and other health care system issues.
    c. Membership drive discussed – how to people function without coming to the DDNNH? Also discussed, motion made, seconded, and passed that only members can nominate, vote, and be elected.

16. **Nursing Practice Issues:**
    h. He-M 1201 will expire in 2011 – a request has been made for all nurses to provide written feedback – a group will form next Wednesday to convene and make suggestions.
    i. It was suggested that the Board of Pharmacy's input be solicited regarding the 1201 rewrite.

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April 21st, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Sixteen attended.

All Regions were represented by either area agency nurses or vendor nurses except Region 9.

The agenda was addressed as follows:

17. **Review and Approval of March Minutes**
    March minutes revised and accepted.
18. **Treasurer's Report**
    February's Treasurer's Report was read and accepted.
    Valerie will find out more info about the Rivier College Denise Martinez scholarship for May discussion.
19. **Business:**
    a. **Elections –** discussion included a suggestion that we stagger the election process so that we are not looking for a whole new slate of people all at once. Suggestions included having the DDNA Liaison elected every year – motion made, seconded, and approved. The Bylaws will need to be amended to reflect these changes. Another suggestion was to have the Vice-President automatically move into the President position – motion made, seconded, and approved. Eileen Murphy Hamel will assume the President of the DDNNH in May 2009, the Vice Presidential Nominations during the meeting resulted in Kenda Howell. Emails received after the meeting included the nomination of Darlene Foley for Vice President. Martha Fenn King was nominated in absentia for the DDNA Liaison, which she declined. Jennifer Boisvert was nominated to assume the Treasurer's position.
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    c. Membership drive discussed – how to people function without coming to the DDNNH? Also discussed, motion made, seconded, and passed that only members can nominate, vote, and be elected.

20. **Nursing Practice Issues:**
    j. He-M 1201 will expire in 2011 – a request has been made for all nurses to provide written feedback – a group will form next Wednesday to convene and make suggestions.
    k. It was suggested that the Board of Pharmacy's input be solicited regarding the 1201 rewrite.

May 19th, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Thirteen attended.

All Regions were represented by either area agency nurses or vendor nurses except Region 9.

The agenda was addressed as follows:

21. **Review and Approval of April Minutes**
April minutes revised and accepted.

22. **Treasurer's Report**
April's Treasurer's Report was read for the very last time by Valerie: (and accepted.
Valerie found out more info about the Rivier College Denise Martinez scholarship for our discussion. This scholarship is specific to a nursing scholarship, for which the DDNNH gave $250 in 2008. A motion was made to give $250 again in 2009 to Rivier College in memory of Denise Martinez, seconded, and passed unanimously.

23. **Business:**
    a. DDNNH Bylaws were amended, read, and approved for readoption.
    b. **Elections: the following are the 2009-2010 elected officers of the DDNNH:**
        i. **President: Eileen Murphy Hamel**
        ii. **Vice President: Darlene Foley**
        iii. **Treasurer: Diane Crone**
        iv. **Secretary: Joyce Butterworth**
        v. **DDNA Liaison: Jen Boisvert**
    c. DDNA Liaison Report: the DDNA Conference was held over Mother's Day weekend on May 8-12th. The 2010 DDNA Conference is already planned to be held in Reno, Nevada from May 15th to the 18th. This year's conference included a keynote speech from Sharon Oxx, entitled, "DD Nursing – It Ain't For Wimps." During the presentation , Sharon shared the Eleven Commandments of DD nursing survival:
        i. Be alert to changes
        ii. Get involved in solutions
        iii. Never point fingers
        iv. Speak don't should with a united voice
        v. Educate others
        vi. Learn others' perspectives and share yours
        vii. Be flexible
        viii. Be persistent
        ix. Be supportive of each other
        x. Know the value of compromise
        xi. Learn to negotiate

24. **Nursing Practice Issues:**
    l. One issue brought up by nurses is the self-administration form – if everything is checked "Independent" except for one, can the certification inspectors cite us and say the person is not independent with medication adminstration?
    m. Sue also cited a nurse for not doing a QA on a person who was independent with medication administration, but that person choose to keep a med log for his own as part of his self administering.

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June 16th, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty-three attended.

All Regions were represented by either area agency nurses or vendor nurses except Region 3.

9:30 – 11:00am

The agenda was addressed as follows:

25. **Review and Approval of May Minutes**
    May minutes revised and accepted.
26. **Treasurer's Report**
    May's Treasurer's Report was read and accepted. Diane will call Rivier College regarding the Denise Martinez Scholarship. All accounts have been transferred successfully from Valerie to Diane.

27. **Business/ Nursing Practice Issues::**
    a. DSP presentation in October, discussion about a poster presentation. Joyce will contact Chery Soper to see if the DDNNH can have a table at the conference.
    b. We need to have a connection between certification deficiencies and certification changes.
    c. Should program manager be required to be med trained? Should this be put into the He-M 1201s?
    d. Only authorized staff should be handling the med logs.
    e. Respite packet – Plus Co has a policy that planned respite has to notify the coordinator at least 2 weeks prior to the time off – a plan is put into place that requires the Nurse Trainer's signature. The NT has a check off list and it has to include a list of medications. The person that they're going to has received information so they have to let you know and there is documentation that training around the person's medical needs and medication administration needs have been communicated.
    f. When the med authorization expires, should staff/providers be required to go through the training again? Should there be recertification class requirements every year?
        i. What about a take-home test requirement?
        ii. Should we require monthly QA's for new home providers?

11:00 – 12:00

Continuing Education Series

"Trach Education for Care Providers of People with DD"

Instructor: Lynn M. Feenan, R.N., M.S.N., AE-C

offering **1.0 contact hours** of continuing education for developmental disabilities nursing certification.

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September 15th, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty-three attended.

All Regions were represented by either area agency nurses or vendor nurses.

9:30 – 11:00am

The agenda was addressed as follows:

28. **Review and Approval of May Minutes**

June minutes revised and accepted. A question was raised as to "What was the outcome of requirements for reauthorization of unlicensed providers to administer med?" to which the answer was, it is up to each agency.

29. **Treasurer's Report**

June's Treasurer's Report was read but numbers are needed. **DDNA Liaison's Report:**
The next DDNA Conference is May 15 – 18th in Reno, with the Preconference topic: "Medication Administration in the Community." Cathy Engal from the State of NY will be speaking.

30. **Business/ Nursing Practice Issues::**

a. Jen has purchased copies of presentations form the May 2009 DDNA conference that she suggested we use for the November meeting, as Sharon Oxx will not be able to present.

b. Pam asked if electronic signatures are acceptable on prescriptions and yes, they are.

c. The DDNNH membership brought to the floor for a vote that all agency-funded memberships will be transferable for the remaining of the DDNNH year (May to May) to another same-agency nurse taking the place of a previously hired nurse.

d. Details of the memo from the Bureau of Health Facilities to the DDNNH dated August 5, 2009 were discussed. BHF is asking DDNNH nurses to have available a list of all the individuals in a residence who have been authorized to administer medication at the particular site for the past year, not just the currently authorized staff.

e. Discussion of the letter to the NH Board of Pharmacy regarding allowing DDNNH nurses to utilize "pill planners" in the community for individual's who are being trained to become self-medicating. Currently, the NH Board of Pharmacy rules does NOT allow a nurse, other than a nurse employed by a home health agency or hospice agency, to fill pill planners as this is considered dispensing.

f. H1N1 flu article dated September 3rd reviewed, where a large proportion of kids who died had developmental delay from neurological conditions such as cerebral palsy, muscular dystrophy, and seizures.

g. Request made to the DDNNH to respond via email regarding two issues:
   i. Who is interested in obtaining their CDDN, and
   ii. Whether the agency that the NT works for would be interested in cost sharing?

h. The NYS MR/DD Nurses Association is having a conference Oct 4-6 at the Marriott Hotel in Albany, offing sessions on Care & Compassion for Life; The Future of MRDD Nursing; Diabetes Management; among others.

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October 20th, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty-eight attended.

All Regions were represented by either area agency nurses or vendor nurses.

9:30 – 11:00am

The agenda was addressed as follows:

31. **Review and Approval of September Minutes**
    September minutes were reviewed, revised and accepted.
32. **Treasurer's Report**
    October's report was read, September's report was revised and listed all checks. The DDNNH membership cards did not get to everybody but we will get them out next month. A suggestion was made to buy a book of receipts. The Membership form online still had Valerie's name and address, which needed to be changed to: Diane Crone PO Box 349, Freedom, NH 03836 email: dcrone@northernhs.com

33. **Business/ Nursing Practice Issues::**
    a. The DSP presentation on Friday October 23rd and Saturday October 24th was again discussed. Darlene, Cheryl, and Susan are going up to "woman" the DDNNH table, and to support Steve during his presentation "Preparing for a Doctor's Appointment" to the DSPs. Two poster presentations were prepared and brought up to the conference, one highlighting the DDNNH, and the other emphasizing information to prepare for accompanying an individual receiving services to a doctor's appointment. Thanks so much to Darlene, Cheryl, Susan, and Steve! Discussions with Steve after the conference revealed that the conference itself was not well-attended, perhaps because of the conference being held on a Saturday this year.

i. Nurses contributed to the conversation by stating that:
    1. a "going to dr's appt" video is used
    2. teach saying "no" if asked to take a person whom they do not know to a dr's appointment
    3. Some believe they should take the med book to the dr's office, some believe that is absolutely beneficial, and there was talk about a "grab and go" book.

ii. The DDNNH voted to generously donate ½ of their Frisbee inventory regarding making healthy eating choices, and many healthy eating food brochures were given to Cheryl to bring up.

iii. Other statements included:
    1. "I'm told I'm not a triage nurse, that I'm just here for 1201 trainings and paperwork,"
    2. Health is such an integral part of providing community services – it is a juggling act that we are asked to do.

iv. This led to comments such as:
    1. "Why can't we have a nurse's job description from the State, so that the agencies will know what is expected of us?"
    2. "Why can't we take the nurse out of the role of QAing the med logs, since the certifiers come in and redo it all anyways?"
    3. "What is the maximum amount of individuals/homes a nurse should have?" "Is it realistic with the way we are staffed for us to be expected to extend ourselves into roles beyond 1201?"

v. This led to suggesting for each nurse to write up a list of each of their respectively responsibilities and bring a copy of each nurse's job description as "we are bogged down with 1201 expectations and paperwork," and nurses are spending a lot of unreportable time – how much time do we spend on healthcare? Brenda Thamm volunteered to compile this list – email her at: growathome@gmail.com

vi. Another commenter stated three items that she sees is her role:
    1. 1201's;
    2. teaching about health issues per diem;
    3. keeping a database of appointments and med changes; however
    4. The consultative part of the job is gray and murky.

vii. Suggestion to put a description of a nursing license to CSNI to help people understand how the nurse is responsible.
    1. The Nurse Practice Act is clear on what our roles are. What is possible to oversee, delegate, and supervise will be different for each agency due to individual's varying needs and complexities.

viii. Suggestion/request was made to have this on our agenda regularly in the coming months for discussion.

ix. Getting back to doctor's appointments, there are problems with the individual receiving services, who is their own guardian, is in the doctor's office and the individual doesn't understand, the DSP is outside the room and doesn't get to express what the individual needs

b. A lively discussion ensured regarding cough drops, bag balm, and suntan lotion/bugspray issues.
    i. Bag balm is not approved by the FDA for human use.
    ii. Should we even have doctor's orders for OTCs?
    iii. Cough drops:
        1. If a person is compromised by cough drops such as someone with a swallowing issue or medical conditions, doctor's orders should be obtained

for cough drops. If it does not go through the nurse, how will we know this has happened?
2. Cough drops are a frequently asked question.
3. Suggestion to make the rule that if anyone needs a cough drop the nurse should be called to discuss it with.
4. What about guardianship? A med of any kind, including cough drops – the guardian must be notified and guardian approval must be obtained.
5. Cough drops are a medication and need to be labeled like all others.

c. H1N1 flu article dated September 3rd included in agenda packet, where a large proportion of kids who died had developmental delay from neurological conditions such as cerebral palsy, muscular dystrophy, and seizures.

11:00 – 12:00 Joint Meeting with the Bureau of Health Facilities:

Questions:

1. Since Testosterone comes in a pump bottle that cannot be counted does this fall under treatment? The pump testosterone: two pumps = 5mL, If it's a 30 oz. bottle, then 30-5=25 mLs left. **This is a controlled substance schedule III medication that needs to be counted and kept on a med log.**
2. Can we assume that if the "PO" if left off of a doctor's order, that the assumption is that it is "PO?" Yes. If not a PO med that the route does need to be specified. However, if the route is specified on the dr's order it should be specified on the label.
3. Is it possible to email PRN protocols? Yes, but many residences do not have the ability and not every agency has an encryption ability. HIPPA – we want to email PRN protocols but our IT people say it is not considered safe. But we're emailing the PRN protocol to the individual that it concerns, isn't that OK? Maybe we shouldn't put in identifiers (then what if there is more than one individual living in the house?)
4. Terri states that regarding the medical log, some people have six pages of meds, and if someone didn't sign one of the pages out of six months worth of six pages, it's frustrating to get a deficiency – in some ways our hands are bound. Can we do a monthly page rather than have everyone sign every page each month. But we are bound by our own forms. If the forms call for all signatures each month, then they have to be there. But is acceptable to have one page of all signatures and initials each month rather than have each med log page signed each month. The nurse still has to sign the signature page that it has been QA'd.
5. Trends that the surveyors are seeing:
    a. DSPs are writing out the PRN protocols and having them signed EVENTUALLY – the home providers themselves are telling this to surveyors. Not every nurse gets to respond to the deficiency, and sometimes the nurse isn't even in the loop on 1201A deficiencies. The med committee is looking for the nurse to be in the loop.
    b. Nurses responded that before a MD appointment, sometimes the DSP will bring a PRN protocol to the MDs appointment, especially if the appointment is late on a Friday. We train the DSPs to discuss medications and interactions with the docs. Sometimes the max dosage is written at a later date and cosigned i.e. max Tylenol doses are less than the manufacturer's recommendations.

c. Sometimes with med changes, or meds not given on time, there is no documentation on the back, sometimes nothing at all is written on the back, especially in the southern tier of the State.
d. There are more documentation errors than any other type of error. The #1 is on the PRN med sheet – the time is not always written or as to why it was given.
e. Can we have standardized med logs? Some agencies have a program where the medication list populated the med logs and the PRN protocols. Should nurses from all agencies bring in a copy of their med logs? The question was asked, "What is the best med log form you've seen?" The answer given was, "Whatever works best for the provider." We have at least 50 different versions of med logs out there.
f. Is the "baggie" method still viable? Yes.
g. Emergency certifications: not all providers are med authorized, because many times the nurse is out of the loop. The nurses are just as frustrated as the surveyors.
h. Question: If you have the same provider and same individual receiving services who both move together to a new address, can they use the same med logs they were using? NO. They have to start over. Nurses stated sometimes they unable to get to the site physically due to time and distance, especially in an emergency situation – sometimes the program managers have to do it.
i. Respite: certified residence – some people don't' understand that 1201 has to be complied with. For example, a home with 3 certified beds and 1 uncertified bed doesn't understand that didn't understand – felt they shouldn't have been held for accountability for 2 beds because one person was "on respite." Respite doesn't happen in a certified home.

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November 17th, 2009 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty attended.

All Regions were represented by either area agency nurses or vendor nurses.

9:30 – 11:00am

The agenda was addressed as follows:

34. Review and Approval of October Minutes

October minutes were reviewed, revised and accepted.

35. **Treasurer's Report**
    a. The DDNNH Membership form is online – to become a DDNNH member please complete and mail to Diane Crone PO Box 349, Freedom, NH 03836 email: dcrone@northernhs.com
    b. **N**ovember's report was read and accepted.,

36. **DDNA Liaison Report:**
    a. Discussion about the deadline for DDNA newsletter.
    b. Quarterly report/information sharing in March, June, September, and December.

37. **Business/ Nursing Practice Issues:**
    a. 3 X 5 cards for Brenda Thamm – so many different things that each of us does - Brenda Thamm – will compile what she gets, what the job descriptions are compared to what we actually do.
    b. What about the NH Nurse's Association?
    c. Discussion regarding the RN Case Manager Role in Reg 3 – is there conflict at all with the 1201 nurse's role? Mary Lou offered that sometimes the roles overlap and you and the nurse case manager have to work it out. Paperwork & QA vs. healthcare oversight. The case manager goes to dr's appointments instead of the QA nurse, but both go to team meetings. The CM does not do 1201A's, except she gets one home with medically frail individuals but on their caseload. Teaming up with VNA, homecare & hospice – get a team going with nurses.
    d. Not having Laconia State School is great, but sometimes serving people with intense medical needs in the community is unrealistic.
    e. Look at DD Standards of Practice.
    f. Discussion around "Should we continue to have orders for OTCs?
        i. In order for authorized staff to perform triple checks there has to be doctor's orders.
        ii. Too much OTC's can cause adverse effects.
        iii. We need orders for OTCs or authorized staff will make decision about OTC's that could be dangerous.
        iv. People with limited English, unless specifically spelled out problems can happen.
        v. How else can we monitor what medications a person is getting?
    g. Orders for cough drops?
        i. If it's medicated or a prescription cough drop.
        ii. Can we not have orders for cough drops please?
        iii. The Board of Pharmacy states cough drops are medicine (where does it say that??)

11:00 – 12:00

Continuing Education Series

"I/DD Nursing: It Ain't for Wimps"

Instructor: Sharon Oxx, RN, CDDN

THANK YOU SHARON!!!!

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December 15th, 2009 Minutes

The **DDNNH Holiday Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, Break Room. Twenty five attended.

All Regions were represented by either area agency nurses or vendor nurses.

9:30 – 11:00am

The agenda was addressed as follows:

38. Review and Approval of November Minutes

November minutes were reviewed and accepted.

39. **Treasurer's Report**

a. The DDNNH Membership form is online – to become a DDNNH member please complete and mail to Diane Crone PO Box 349, Freedom, NH 03836 email: dcrone@northernhs.com
b. **N**ovember's report was read and accepted.
c. Membership cards were passed out.

40. **DDNA Liaison Report:**

a. Discussion about the deadline for DDNA newsletter.
b. Quarterly report/information sharing in March, June, September, and December.
   i. December's update included information about the DDNA newsletter published in December, pointing to the Network Section on pages 34-35.

41. **Business/ Nursing Practice Issues:**

a. At our November DDNNH meeting, a suggestion was put on the floor for us to look at DD Standards of Practice, which were distributed.
   i. How do we create a new culture when you're not in a position of authority?
   ii. We need to update "Communicating for Health."
b. Suggestion was made to create a List of Topics to explore:
   i. OTCs
   ii. Dandruff shampoo
   iii. Adding to the curriculum – How to prepare for a doctor's appointment?
   iv. Chapter vs. Network
   v. Individuals coming into the DD system and receiving services without the nurses' knowledge.
   vi. Having a DDNA member to represent each Area Agency.

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January 15, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room: Thirteen were in attendance.
Regions represented: I, III, IV, VI, VII, VIII, IX, X
The agenda was addressed as follows:

1. **Review and Approval of December Minutes**

December minutes accepted.

2. **Treasurer's Report**

December Treasurer's report submitted by Valerie F. and approved.

3. **Business**
   a. Membership card were distributed.
   b. Membership present voted to extend the meetings to 12:00 on the days we have either CEU presentations or guest speakers.
   c. An invitation has been extended to Mary Constance from Camp Allen and to service coordinators to facilitate medical oversight. Also discussed was to invite Silver Towers, Camp Fatima, Waban, and Outpoint to discuss what is needed for smooth transitioning for individuals attending summer camps.
   d. DDNNH Mini-conference. The consensus thus far is that a conference would be a risky adventure for the DDNNH, one that could possibly outspend the treasury, given the difficulties of finding affordable keynote speakers. A new focus/discussion is perhaps to hold a "health fair," or feature a "consumer walk," where vendors could gather at no cost. A suggestion was to investigate grant writing. Jen Boisvert has been selected to fill the position as official representative to the D.D.N.A. The DDNNH Bylaws will be amended in May to reflect this office.
   e. Another suggestion was to have a representative attend regular CSNI meetings for PR and informational purposes.
   f. A 2007 Annual Report to the D.D.N.A. was reviewed and accepted.
   g. It was discussed and voted on by those present to extend the meetings by ½ hour when there is a CEU presentation or a guest speaker.

4. **Nursing Practice Issues:**
   a. It is up to the individual and/or guardian if HIV information is to be shared. All emergency rooms and dentists treat everyone as if they are infected, utilizing universal precautions.

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The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room: Twenty-two were in attendance.

Regions represented: I, II, IV, V, VI, VII, VIII, IX, X

The agenda was addressed as follows:

5. **Review and Approval of January Minutes**
January minutes accepted.

6. **Treasurer's Report**
January Treasurer's report submitted by Valerie F. and approved.

7. **Business**
   a. Membership card were distributed.
   b. If nurses want to have their input into the Introductory Training Instructional Guide and Resource Manual, Health and Safety curriculum changes, planning meetings regarding this will take place after the DDNNH meetings in March, April, and May from 12-1. .
   c. The DDNNH is planning to participate in the Family Support Conference on Saturday, May 3rd by having a table there with health promotion information. We would also like to have "hand-outs," perhaps consisting of pedometers and such, which would require some fund-raising. The Family Support Conference Planning Committee met just prior to this meeting (and we will meet prior to the DDNNH meetings through April) for the purposes of brainstorming. A letter was drafted and finalized by the committee and sent out courtesy of BDS to area agencies and vendor agencies, explaining what we're trying to do. A copy of this letter was emailed to all of the DDNNH. So far, Rita, Kenda, Cheryl G., possibly Jen, and Joyce will be going.

8. Nursing Practice Issues:
   a. Citations from the Bureau of Health Facilities are sometimes inconsistent, for example, the latest regards the remote storage of medications. If a person's day program is run out of Manchester and the person happens to live in Derry, sometimes the medications are stored in uncertified remote locations where it is more convenient for the individual to obtain them. Discussion ensued around how we need to keep the individual's needs first while meeting the intent of the regulations and having medications available for the certifiers for inspection. Comments included that the certifiers had not required this before. Joyce will be meeting with BHF on a regular basis to discuss these situations, and we will invite the certifiers to our October meeting.
   b. Can peritoneal dialysis be performed in certified sites? This is outside the scope of He-M 1201 and the NUR 404s apply.
   c. Continued discussions around the 524's and the 2003 MOU and delegation.

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room: Twenty-one were in attendance.

Regions represented: I, III, IV, VI, VII, VIII, IX, X

The agenda was addressed as follows:

9. **Review and Approval of January Minutes**
February minutes accepted.

10. **Treasurer's Report**
February Treasurer's report submitted by Valerie F. and approved.

11. **Business**

a. The DDNNH is planning to participate in the Family Support Conference on Saturday, May 3rd by having a table with health promotion information. The Family Support Conference Planning Committee met before the regular DDNNH meeting in March. A letter asking for contributions went out immediately following the March meeting, and $750 has been generously donated from supporting agencies. DDNNH Letterhead was sent to the Treasurer for thank you's to be sent to all agencies that donate. Frisbees were discussed as handouts to encourage activity and nutrition. Posters are available for $11.95 each. Bookmarks with the TASTE acronym are available for 100 at $6.00. Eat More brochures are $7.50 for 50. Darlene will be sending in Hydra-aid samples. The Raffle Basket was discusses – Rita will make one up at a cost of approximately $45, to be given Saturday at lunch. Raffle tickets can be purchased from BigLots in Derry. We will have tabletop displays about exercise and healthy food choices, and about the DDNNH – who we are and what we do.

b. The first Introductory Training Instructional Guide and Resource Manual curriculum changes planning meeting was held after the DDNNH meeting. We will meet again in April and May to update and finalize the Health and Safety section.

c. Region VIII Area Agency has moved and has a new name! They are now known as "One Sky Community Services." Their new address is 755 Banfield Rd., Suite 3, Portsmouth, NH 03801. The phone number is still 436-6111 and the new website is under development.

d. DDNA website update – there is a new newsletter out. Old issues are available for everyone on the website, but new issues can be accessed by members only. See the DDNA website for more details: http://www.ddna.org/

e. The Self Med Assessment Guide, originated by Darlene Foley, is now available on the DDNNH website: http://www.dhhs.nh.gov/DHHS/BDS/DDNNH. There are sections on it that give sections to check off, such as if a person is cognitively capable but needs mechanical assistance. It gives freedom if someone is on a training program. The nurse can obtain information from Mom /Dad and/or the caregiver. The Self-Med assessment can be tricky when Mom wants the individual to be self-medicating but they're not really capable, as well as the reverse, sometimes parents don't want them to be self-medicating and they really are capable. The RN should always do the initial baseline assessment in order to have a good baseline to judge by.

f. Disposal of medications via flushing and toxicity to the environment issues: The Department of Environmental Services has some guidance on the website that may be useful: http://www.des.nh.gov/factsheets/sw/sw-33.htm

g. Providers who have difficulty with English are sometimes found to be not competent according to He-M 1201 to administer medications. There are at least 20 different languages spoken in the Nashua area, and Region 6 provides a list of translators to try to help people. Check with your agencies to see if translators are available.
h. Storage of Medications in uncertified remote locations was discussed. If a program has a certification for one location and the meds are stored in another, a waiver should be obtained for where the medications are stored. This is different from an individual who may bring their medications home with them.

12. Nursing Practice Issues:

HYDRATION – CONSTIPATION – ASPIRATION
The three most common problems for people with DD!

Continuing Education Series ***"Bowel Management – A Team Approach;"*** Instructor: Marie P. Gagnon, RN, BSN for **1.0 contact hours** of continuing education for developmental disabilities nursing certification.

a. How to communicate with unlicensed staff and give the best instruction to caregivers to prevent consequences.
b. For caregivers without a license, it is best to provide very concrete instructions.
c. Individuals are found to be impacted even through staff is writing down that there are small-medium bm every day when they're having oozing.
d. Need more basic, concrete and descriptive language and instruction around this sometimes-uncomfortable subject.
e. Why is it important to talk about? Individuals cannot verbalize and cannot tell you when they are in pain.
f. It can be uncomfortable and affect appetite – they just don't feel good and don't want to participate. More than three days without a bm is unacceptable – it can lead to impaction and obstipation.
g. Our population tends to have decreased activity.
h. Who is taking the time to help a person eat who takes a long time to eat? Prevent aspiration!! Hospice gets frequent requests for assistance with food and fluid issues because people don't have time to help people eat and drink.
i. Disease process – cancer and opiates – if these two conditions are present there should be an immediate request for something for bowels. Constipation side effects of medications never goes away! For every increase in narcotic medication, there must be an increase in dosage of bowel medications. There is never a development of tolerance to constipation.
j. Question – if someone is prescribed a short-term narcotic, is it OK to increase fiber instead of another pill. One should still watch for bowel function – if there is no bm in 3 days, something needs to be done. Heated prune juice is very effective. Stewed prunes with senna was another suggestion. Another suggestion was stewed raisins, prunes, or apricots put into oatmeal.
k. How to convey this to staff??? This can become a medical emergency and be **excruciating.**
l. Again, if a person is on narcotics, there must be something for bowels. Colace is a stool softener but does not promote/produce a bm. Senna S promotes motility and can take as many per day as needed. It is not like Mild of Mag and will not produce diarrhea. It is meant to be given daily. Many elderly take two per day – it is not a laxative like ducolax and can be given long-term.

m. If that is not effective, a next step must be taken. Doculax can be taken at night. Mil of Mag (yuk – cramps). Lactulose – 30 cc for problems that don't go away.
n. Quad/paraplegic individuals will probably need a suppository routinely – schedule it! Not PRN.
o. Beware of Metamucil – if someone is sick and is not taking enough fluids, it can actually make someone worse.
p. Keep track of PO intake!!
q. People with Down and Alzheimer's syndrome tend to have decreased fluid intake. When someone calls to say an individual has decreased bm's, the first question should be: what is the PO intake?!?
r. Sometimes families are a challenge. One situation was related where Mom insisted on no more than 3 cups of water daily was to be given secondary to bladder spasm and was being given Ducolax, Metamucil, and Colace. Sometimes it helps to call the MD and ask them to explain it to the family.
s. Bowel charts: are they accurate?? In your education, be as specific and concrete as possible. Use a smile/frown chart – are they holding their belly and refusing to eat? Teach what non-verbal cues are.
t. People should be drinking 6 8ox glasses of fluid per day – can they do that?
u. Get an order for a range of medications to be given so you don't have to call the MD all the time.
v. Unannounced visits to group homes often show there are no juices in the fridge, no fruits, and no vegetables in the cabinets.
w. Barriers: There is no real dietary training for anyone!!
x. Barriers: limited resources.

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April 15th, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room.

The agenda was addressed as follows:

13. **Review and Approval of March Minutes**
March minutes accepted.

14. **Treasurer's Report**
March Treasurer's report submitted by Valerie F. and approved.

15. **Business**
a. The DDNNH is going to participate in the Family Support Conference on Saturday, May 3rd by having a table with health promotion information. The Family Support Conference Planning Committee met before the regular DDNNH meeting in March. A letter asking for contributions went out immediately following the March meeting, and $750 has been generously donated from RRI, Area Agency of Greater Nashua, and Monadnock Worksource. DDNNH Letterhead was sent to the Treasurer, who sent thank yous to those

agencies. Jen (thank you Jen!) is buying Frisbees, bookmarks, and Eat More Fruits and Vegetables. Darlene will be bringing Hydra-aid samples. Rita (thank you Rita!) will make up at raffle basket a cost of approximately $45, to be given Saturday at lunch. We will have tabletop displays about exercise and healthy food choices, and about the DDNNH – who we are and what we do.

b. The second Introductory Training Instructional Guide and Resource Manual curriculum changes planning meeting was held after the DDNNH meeting. Certain sections were assigned and we will meet again in May to update and finalize the Health and Safety section. Suggestions were made to go to national websites such as the Epilepsy Foundation for free videos and teaching aids.
c. We asked Ken Lindberg if he could transfer the 1201 videos to DVD.
d. Valerie will not be here next month for the Annual Membership meeting. She wants everyone to know to **please** make sure they submit the Application Form (available on the DDNNH website) to her.
e. We are able to provide a full scholarship to the D.D.N.A. conference this year, including the preconference costs. Jen Boisvert is our D.D.N.A. Liaison and recipient of the scholarship and will be bringing back the latest and greatest information.
f. Guidelines from www.WhiteHouseDrugPolicy.gov and the Office of National Drug Control Policy regarding unused, unneeded, or expired prescriptions drugs. The NH Board of Pharmacy has information regarding a "Take Back" program – contact Brenda McBride, RPh from the Pharmacy Center at Laconia Clinic – 524-5064.

16. Nursing Practice Issues:

a. We talked about the recommendation for visually impaired individuals, especially those in a new placement, should have a professional OT evaluation conducted by a licensed professional to ensure maximum safety. Recommendations may need to be followed up prior to a move, or they may involve suggestions for how best to support people after they move.
b. The International Journal of Nursing in Intellectual & Developmental Disabilities is available on line at http://journal.hsmc.org/ijnidd/index.asp
c. **"Infectious Diseases and Their Impact on DD Populations"** conference is scheduled at the Holiday Inn in Marlboro, MA on Friday, September 26th by the Bay State DD Nurse Network.
d. Disposal of sharps: check with your local hospital for collection of sharps.

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May 20th, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty-five were in attendance.

Regions represented: II, III, IV, V, VI, VII, VIII, IX, and X.

The agenda was addressed as follows:

17. **Review and Approval of April Minutes**
April minutes accepted.

18. **Treasurer's Report**
April Treasurer's report submitted by Vice-President Eileen M. Hamel in Valerie F's absence. The Treasurer's report needs to be corrected with the following:

a. The check #135 want to pay for the DDNA conference (not the DDNNH).
b. Monies reimbursed the Family Support Conference (not the Direct Support Conference).
c. The group would like a breakout and permanent separation of donations received/spent for the Family Support Conference, and not grouped in with our general funds. These funds were intended for educational purposes and should be used and tracked as such.

19. **Business**

a. The DDNNH participated in the Family Support Conference on Saturday, May 3rd by having a table with health promotion information. **Thank you** to all who helped and participated during the planning sessions, a special thank you to Jen Boisvert for all the material ordering, and an extra-special thank you to Kenda Howell, Rita Piesak-Houghton, and Darlene Foley as we manned (or womanned) the table at the Mt. Washington Hotel. (and Rita, you DO snore, by the way!!) The Health Record was very well received – some of the parents clutched them to their chests and asked for more copies. Many of the family members said they wanted to meet with nurses in their area to help facilitate transition from the school into the DD system. The basket raffle was also well received – we had over 350 entries.
b. The By-Laws were amended to reflect the addition of the DDNNH Liaison to the D.D.N.A. then and passed.
c. D.D.N.A. Update:
    i. Jen indicated the March D.D.N.A. newsletter in available online (for members). The DDNNH will have a poster for the conference. Diane Moore is the president-elect and had a lot of questions. Leadership is an issue and Darlene and Eileen are going and staying for the leadership seminar at the end of the conference, with Eileen going as a DDNNH officer.
    ii. The D.D.N.A. Board has formalized a Chapter/Network meeting to discuss and review the differences.
    iii. The new 2008 D.D.N.A. Standards of Care is available by members on their website: http://www.ddna.org/
    iv. The next deadline for DDNNH to contribute to the D.D.N.A. quarterly newsletter in May 25th.
    v. Their Treasurer's position is open.

d. Lorene Reagan, Matthew Ertas, and Jeanne Cusson joined our meeting to speak about a new rule He-M 525 Consollidated Services. Medication administration will comply with He-M 1201 when administered by area agency or subcontract agency staff or home providers. Med administration will comply with NUR 404 when administered by providers who are neither family members nor under contract with an area agency or subcontract agency, and only if med are given during services.

e. Chip Maltais from the Bureau of Behavioral Health came to speak with us about Accessing Mental Health Services. A summary of the discussion follows:

i. It is somewhat easier for children to get services than it is for adults.
ii. For adults, there are three categories of eligibility for services:
    1. Severe and persistent MI – the person has a severe functional impairment as a result of the MI, ADLs and interpersonal function with the length of impairment over one year. Services include psychiatry, functional support services (MIMS), and group therapy.
    2. Severe MI – everything as #1 but less than one year, with no documentation of previous services.
    3. Low Utilizer – most are low utilzers and could be just receiving meds, group therapy, or functional support services. There is a $4,000/year cap.

20. Nursing Practice Issues:

a. The International Journal of Nursing in Intellectual & Developmental Disabilities is available on line at http://journal.hsmc.org/ijnidd/index.asp
b. **"Infectious Diseases and Their Impact on DD Populations"** conference is scheduled at the Holiday Inn in Marlboro, MA on Friday, September 26th by the Bay State DD Nurse Network.

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June 17th, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Nineteen attended.

Regions represented: I, II, V, VI, VII, VIII, and IX.

The agenda was addressed as follows:

21. **Review and Approval of May Minutes**
May minutes accepted.

22. **Treasurer's Report**
April Treasurer's was revised to reflect the following:
a. The check #135 want to pay for the DDNA conference (not the DDNNH).
b. Monies reimbursed the Family Support Conference (not the Direct Support Conference).
c. The group would like a breakout and permanent separation of donations received/spent for the Family Support Conference, and not grouped in with our general funds. These funds were intended for educational purposes and should be used and tracked as such.

May's Treasurer's Report was read and accepted.

23. **Business**

a. The Bay State Developmental Disabilities Nurse Network (BSDDNN) is hosting their conference called **"Infectious Diseases and Their Impact on DD Populations"** (working title), scheduled at the Holiday Inn in Marlboro, MA on Friday, September 26th. See their website for more information: http://www.ddnursing.org/events.htm
b. Wayne is bringing membership cards for the September meeting.
c. The new 2008 D.D.N.A. Standards of Care is available by members on their website: http://www.ddna.org/
d. Jen Boisvert, the DDNNH Liaison to the DDNA, brought us back information from the DDNA 2008 Annual Education Conference held at Foxwoods.
    i. Several speakers had handouts to update the "book" of handouts of previous conferences.
    ii. Often speakers that shared the time did two different topics within the same time slot. DDNA has a new Board and this is really their first conference as opposed to the 16th for the DDNA.
    iii. Networks vs. Chapters: Networks are loosely affiliated – DDNA has no responsibility for and cannot count the number of members, where Chapters are closely affiliated. An email was sent to Diane Moore to request information about Chapters, which said that we can count numbers within their numbers, and all monies would go to the DDNA. The would send back the amount of dues for us and everybody would be the same - $80 + $20 = $100 fee. There is a minimum number to be a Chapter, which is ten. We would charge for other non-members who come in? We decide. There are 39 Networks across DDNA and they have no idea who is a DDNA member within the Networks.
    iv. This conference was the first time nurses and docs were mixed together, with physicians, psychologists, neurologists listening to nurses. There were 18 from NH.
    v. The preconference was on Autism and the genetic fluke in 75% of studied kids.
e. The Bureau of Developmental Services' Special Medical Services (SMS) Unit came to present for us about what they do:
    i. Care coordination – attend MD appointments. They come up with a care plan. SMS finds funding for people, many are not on Medicaid.
    ii. An example was given for a child approved for Katie Beckett – she had been hospitalized for 8 months and was discharged with a trach and vent/ on O2, suctioning, and apnea monitor. She gets block nursing, 40 hours per week, but family can only find nurses to fill 15 hours. Problems arise when Mom is more knowledgeable that the nurses that come in.
    iii. Nutrition/Feeding/Swallowing issues. This is a statewide program to help under 21 with these issues. There is a statewide network of nutritionists and f/s specialists.
    iv. Psych Consults – helps staff determine what kind of services are available.
    v. Family Support – NH Family Voices – to help maneuver through the maze.
    vi. Parent to Parent.
    vii. ESS also involved.
    viii. Child Development Clinics: diagnostic evaluation services and there are satellites around the state in Lebanon, Lancaster, and Manchester.
    ix. Neuromotor Clinic – sites around the state with 3 pediatric neurologists in Berlin, Concord, Keene, Lebanon, Exeter, and Manchester to help with ortho and neuromotor disabilities.
    x. What does Katie Beckett cover?
    xi. What happens after they turn 21?
    xii. SMS is mainly an information and referral resource – there is a nurse on call.

xiii. Transition services – HC-CSD – (Katie Beckett) is Title XIX but not based on parent's income for complex medical and behavioral needs, often need multiple benefits for chronic illnesses or disability. Helps 185% of FPL.

24. Nursing Practice Issues:

a. The International Journal of Nursing in Intellectual & Developmental Disabilities is available on line at http://journal.hsmc.org/ijnidd/index.asp

b. **"Infectious Diseases and Their Impact on DD Populations"** conference is scheduled at the Holiday Inn in Marlboro, MA on Friday, September 26th by the Bay State DD Nurse Network.

c. Ongoing discussions around delegation of medication and other tasks outside of He-M 1201. Delegation skills checklists have been developed and reviewed by the NH Board of Nursing.

d. Martha did an assessment of a 21-year-old individual with Down syndrome who has had 27 strokes, is on ASA and has a trach, in a w/c and can wt. bear. He receives five hours of community support services – 2.5 hours two times per week. He is going to Synergy – doing some weight lifting. Lives with Mom and two siblings. The nurse is asked to evaluate if we can safely serve him in the community. Martha shared her draft assessment and response. She was able to video removing and replacing the trach, and will try to video the instillation of the saline and present a case study to DDNNH.

e. We've been meeting over the past several months regarding a group effort to update the Health & Safety Curriculum.

Nutrition/hydration - Joyce
Regular exercise - Joyce
Handwashing - Rita
Caregiver stress - Eileen
Existence of rules for med administration - Eileen
Awareness of individual health and med history - Joyce
Seizure disorders - Wayne/Martha
Good dental practices - Cindy

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September 16th, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty-four attended.

All Regions were represented by either area agency nurses or vendor nurses.

The agenda was addressed as follows:

25. **Review and Approval of June Minutes**
June minutes accepted with typo corrections.

26. **Treasurer's Report**
June's Treasurer's Report was read and accepted.

27. **Business:**
    a. Completed sections of the Health & Safety Curriculum were distributed. We are still waiting for sections (see below). Linda offered to add another section pertaining to sexuality. The Curriculum will be added to as the group decides what other sections should be included.

Nutrition/hydration – Joyce (done)
Regular exercise – Joyce (done)
Awareness of individual health and med history – Joyce (done)
Communication for Health Care Appointments – Joyce (done)
Speak up Campaign – Lorene (done)
Good dental practices – Cindy (done but needs to be formatted)
Handwashing – Rita (pending)
Caregiver stress – Eileen (pending)
Existence of rules for med administration – Eileen (pending)
Seizure disorders – Jen (pending)
Sexuality - Linda (pending)

28. **Nursing Practice Issues:**

a. The Bay State Developmental Disabilities Nurse Network (BSDDNN) is hosting their conference called **"Infectious Diseases and Their Impact on DD Populations"** (working title), scheduled at the Holiday Inn in Marlboro, MA on Friday, September 26th. See their website for more information: Wayne King and Eileen Murphy Hamel are attending. Wayne will come prepared to the October meeting to share information from the conference.
b. Discussion around the NH Nurse Practice Act and delegation ongoing. Darlene shared her experience with the initiation of the implementation of the requirements around the IHS Waiver and nursing supervision of medication administration of non-family providers.
    i. While the BON does not have a "laundry list" of what can and cannot be delegated, a scope of practice decision tree was adopted by the NH BON in Jan 2007 to assist licensed nurses to interpret the applicability of laws and rules in a given practice situation. The following was emailed to the DDNNH: Go to www.state.nh.us/nursing and click on "Nursing Practice" for examples of decision-making tools. Also to go "Nurse Practice Act" and Administrative Rules, NUR Chapter 400. All nurses are advised to study this section of the rules as it pertains to individual practice settings.

11:00 - 12:00 Continuing Education Series "Nursing Care of the Patient with Diabetes" Instructor: Melinda Leighton, BSN, RN, CDE, approved for 1.0 contact hours of continuing education by the Developmental Disabilities Nurses Association for developmental disabilities nursing certification.

Goals of survival skills level of diabetes education were reviewed:

1. Caregivers can
    a. Verbalize a basic understanding of diabetes and symptoms to report.
    b. Demonstrate ability to test blood sugar
    c. Demonstrate how to draw up correct dose of insulin, select site for injection, and verbalize how, when, and where to inject insulin in relation to meals (Sharps disposal too)
    d. State name, purpose, dose, route and 1-2 possible side effects and food/drug interactions. Can state when to take in relation to a meal.
    e. Verbalize signs and symptoms of hypoglycemia and actions to be taken (drink 4 oz. Juice or regular soda, test BG, wait 15 min and retest).
    f. Verbalizes understanding of when to test ketones (BG >250 or illness).
    g. Verbalized when to test BS and urine when sick.
    h. Discuss potential side effects of exercise.
    i. Verbalizes modified diet and rational.
    j. Verbalizes the signs and symptoms of hyperglycemia.

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October 21, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Nineteen attended.

All Regions were represented by either area agency nurses or vendor nurses.

The agenda was addressed as follows:

29. **Review and Approval of September Minutes**
September minutes accepted.

30. **Treasurer's Report**
September's Treasurer's Report was read and accepted. Membership is continually open for any nurse to join.

31. **Business:**

a. The Health & Safety Curriculum was discussed and a deadline was set for November 18th to have sections completed. We are awaiting sections (see below). Linda added another section pertaining to sexuality, and Martha offered to add a section on End-of-Life issues. The Curriculum will continue to be a work in progress, and sections can be added to or modified as the group decides.

Nutrition/hydration – Joyce (done)
Regular exercise – Joyce (done)
Awareness of individual health and med history – Joyce (done)
Communication for Health Care Appointments – Joyce (done)
Speak up Campaign – Lorene (done)
Good dental practices – Cindy (done but needs to be formatted)
Handwashing – Rita (pending)
Caregiver stress – Eileen (done –needs to be formatted)
Existence of rules for med administration – Eileen (pending)
Seizure disorders – Jen (pending)
Sexuality - Linda (done – needs to be formatted ?reference?
End of Life - Martha)
MRSA, VRE, and C.Diff Management Protocol - Joyce (pending – thank you Eileen and Mass DMR.)

32. **Nursing Practice Issues:**

a. Discussion around the NH Nurse Practice Act and delegation ongoing.
   i. The following situation was brought up: "We have a gentleman with CF and CP, a central line, who received enzymes in applesauce daily. He has a percussive vest and lifts. He is non-verbal and asked by the family support to go out and assess because staff was hired for the weekend." The question is: how often should this person be monitored? Various checklists sheets were used; one from Region 9 and one from the State. The parents were not there during the assessment! It took a few visits to get to know the individual and the situation – the VNA took care of the central line. Potential for pneumonia.
   ii. Another situation: a lady who lives in a 1001 is on dialysis, whose fistula was blocked x2, now has a temp central line till the doc gets back from vacation. The dialysis nurses will be changing the central line dressing.
   iii. More and more kids are coming into the adult system that are more and more involved. We need to continue discussions around delegation.
   iv. Tracheotomy Mini- Presentation from Martha:

   Martha was asked "Can we safely serve this person in the community?" He has a trach with a filter that gets blown off when he coughs. Previously, Ryan had the VNA coming in. He graduated high school and was now just sitting around watching movies, his ambulation skills had decreased. It was suggested that he to go Synergy, associated with Exeter Hospital's cardiac rehab program, and there are nurses right there. The nurse in charge of the cardiovascular services was happy to assist. Martha had visited Ryan's home several times to get to know him and his circumstances, and determined that the instillation of saline was not a delegatable task, and had a meeting with the nurse at the rehab, Ryan, and Ryan's Mom and two other nurses. A staff person was observed replacing the vent piece that was "Ryan's nose" and was deemed competent to do this. The trach itself is changed every 6-7 weeks so it does not get clogged.

b. The Bay State Developmental Disabilities Nurse Network (BSDDNN) hosted their conference called "Infectious Diseases and Their Impact on DD Populations" on September 26th. Wayne King and Eileen Murphy Hamel attended and shared the following information:
   i. The Mass MRSA, VRE, and C.Diff Management Protocol was distributed, as acute and long term care facilities have seen a dramatic increase of MRSA, VRI and C.Diff infections, along with increasing numbers infections in the community.
   ii. MRSA is transmitted by direct person-to-person contact, usually on the hands of caregivers. If a person has no signs of infection, there is no need to test individuals for the presence of bacteria.
   iii. Management included that the individual's physician should determine whether the MRSA represents colonization or an active infection and treat as necessary, with antibiotics. Hospitalization for severe infection is usually required.
   iv. The service provider in consultation with the person's HCP should review the health issues specific to the individual and make recommendations regarding home, work, and other activities as appropriate. Consideration is given that transmission of MRSA from roommate to roommate in other than acute settings rarely occurs.

v. MRSA positive individuals may share a bedroom with a low-risk individual (i.e. one who does not have tubes, catheters, wounds, decubiti, IV lines, and/or is not immunocompromised.)
vi. Standard Precautions are guidelines created by the Centers for Disease Control (CDC) and should be used when caring for any person, regardless of the person's diagnosis and whether the person is known to have an infectious disease.
    1.
vii. The head of Massachusetts's Public Health spoke about MRSA, VRE, and C.Diff. We all have these bacteria on our bodies. People have to have a condition that allows the bacteria to colonize. Acute and LTF dramatic increase in infections and in the community. A protocol has been developed for people in Mass and will be included in our Training Manual.

11:00 - 12:00

Bureau of Health Facilities: Peter Bacon, Sue Ouellette, Sue Nickerson, Al Swanson, and Jay Kurinskas attended and discussed issues that have come up during the year.:

2. Storage of medications in remote locations - Sometimes an individual has a day program, for instance, that is certified out of Manchester, but the individual actually is provided services out in the community and requires medication administration. It is better for the individual to have that medication stored at a remote site. The solution is that a waiver needs to be completed that satisfies the intent of safe medication storage in accordance with the He-M 1201.

3. Documentation of med errors on med occurrence reports - The variety of med QA forms that are used and the questions that are asked on the QA, such as whether or not there were any errors during this reporting period, can be confusing. Depending on how that nurse requires the error to be documented, the answer could be yes or no, and there is no way for the surveyors to know. Some nurse note all errors on the QA, while others only note errors if they found them on the day of the review. The outcome is that the surveyors have a right to ask for documentation about med errors, and the med occurrence reports should be available for them if the nurse does not re-document the info on the qa.

4. Is ok for the MD to sign one page of Dr's orders and the Dr can initial the rest that come in a set for the same person, does this suffice for surveys? Yes, this is common practice.

5. Definition of family residence - The Dept. of Labor defines "staffed" differently than the He-M 1201s. "Family residence" means as residence that is: 1. operated by a person or family residing therein; and 2. under contract with a provider agency. That means one provider, who is under contract and lives in the home, is administering medications. However; if any other staff are coming in, then it is a staffed home and reviews should be monthly. Additionally, there should not be a need for a waiver to have semiannual reviews if the home meets the definition of family. In terms of frequency of QA's, this falls under the 1201 regulations and not under the Dept. of Labor definition of "staffed."

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November 18, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Seventeen signed the attendance sheet.

All Regions except Regions 3 and 9 were represented by either area agency nurses or vendor nurses.

The agenda was addressed as follows:

33. **Review and Approval of September Minutes**
October minutes accepted.
34. **Treasurer's Report**
October's Treasurer's Report was read and accepted. Membership is continually open for any nurse with an active license to join.
35. **Business:**
    a. Thanks to Peter Bacon – he is very responsive, hats off and kudos to him.
    b. Update – sections of the Introductory Training Instructional Guide and Resource Manual, Health and Safety curriculum due were reviewed.
    c. DDNA update: Jen Boisvert, DDNA Liaison. Copies of the Summer/Fall 2008 DDNA News Network publication are available. Jen stated the newsletter is challenging to print. The upcoming conference "Enhancing Mind, Body, Spirit" is May 9, 10, 11 in Orlando. Maximizing Health and Wellness for Persons with ID will be a focus. The hotel is $159.00 per night. There will be a formal induction of chapters, with workshops about leadership and networks becoming chapters with national bylaws in compliance with 513Cs. We should put Chapter vs. Network on our agenda. Should we have our liaison talk to chapters that have joined? All members in the chapter have to be DDNA members. It is $100 per year, with $80 to the DDNA and $20 to DDNNH per year. No one form NH went to the Leadership seminar. It will be the same speaker for the 2009 Conference, Dr. Jo Manyer, who will be speaking. Reminder about a poster presentation – need to be thinking about it and what activities we do and challenges we face. The newsletter contributions are four times per year. The deadline was 11-25.

36. **Nursing Practice Issues:**
    a. Update – sections of the Introductory Training Instructional Guide and Resource Manual, Health and Safety curriculum were due

Nutrition/hydration – Joyce (done)
Regular exercise – Joyce (done)
Awareness of individual health and med history – Joyce (done)
Communication for Health Care Appointments – Joyce (done)
Speak up Campaign – Lorene (done)
Good dental practices – Cindy (done but needs to be formatted)
Caregiver stress – Eileen (done –needs to be formatted)
Existence of rules for med administration – Eileen (done needs formatting)
Seizure disorders – Jen (done)
Sexuality - Linda (done – needs to be formatted ?reference?
End of Life – Martha - drafted)
MRSA, VRE, and C.Diff Management Protocol - Joyce (pending

)

b. We talked about how to professionalize our staff in preparation for BHS certification inspection, that is, with someone who is extremely detailed oriented. We talked about the need to train staff that it is not OK to be bullied or to be pushed around. The nurses in general are not present during the certification inspections.
c. We also talked about the need for role playing and having Lakes Region Community Services Council, Steve Colombo and Terri Clark, come to the DDNNH and present the case management pilot project, with a report on how they have developed "Preparing for a Medical Appointment" training.
d. Anxiety vs. agitation:
    i. For agitation, or for aggressions, there has to be a behavior plan in place.
    ii. People have been cited if the prn for anxiety is given for agitation. Lorazepam is given for anxiety but also given for aggression. How is the anxiety demonstrated? How it is demonstrated has to be in the PRN protocol. Clonazapam for agitation has a behavioral support plan.
    iii. Nursing role is overseeing the amount of prn's that are being given – we cannot make generalized decisions about each individual situation. Has the team decided on the use of the medication? Is the med being used properly.
    iv. How do you monitor anxiety agitation medication? Independent judgment and assessment of the situation needs to take place. There should be input form the team, from the home care provider to the service coordinator, and then documented in the service agreement, with MD or psych with prescribing privileges.
    v. It is the expectation as part of the team that the nurse is notified of any change of behavior that receives or requires more frequent use of PRN's.
e. Are there any Neighborhood Health Clinics? Not really in NH – a lot of doctor's offices will do sliding scale if they are asked. The economy was discussed with increasing difficulties of some people receiving health care.
    i. Home Of Your Own program is being phased out. People currently in their own homes will continue to stay there.
f. Continued discussions around delegation, please keep in mind that NH Nurse Practice Act RSA 326-B specifically allows a nurse to delegate tasks in accordance with the NUR 404s. We are in the position of trying to balance two goals: one is to promote independence, dignity, and choice for individuals, and the other is to protect individual's health and safety.

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December 16, 2008 Minutes

The **DDNNH Monthly Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Concord, South Function Room. Twenty signed the attendance sheet.

All Regions except Region 3 were represented by either area agency nurses or vendor nurses.

The agenda was addressed as follows:

37. **Review and Approval of November Minutes**
November minutes accepted.

38. **Treasurer's Report**
November's Treasurer's Report was read, clarified and accepted.

39. **Business:**
    a. DDNA Chapter vs. Network discussion: all chapters must be a DDNA member - $100 per year, of which $80 goes to DDNA and $20 would go to DDNNH, which would be $5 less per person for us to have in our treasury, but we would gain a lot of resources via their website. Would we need to become a 513C?

40. **Nursing Practice Issues:**
    g. Sections of the Introductory Training Instructional Guide and Resource Manual, Health and Safety curriculum were reviewed:

Nutrition/hydration – Joyce (done)
Regular exercise – Joyce (done)
Awareness of individual health and med history – Joyce (done)
Communication for Health Care Appointments – Joyce (done)
Speak up Campaign – Lorene (done)
Good dental practices – Cindy (done but needs to be formatted)
Personal hygiene – Rita (pending)
Caregiver stress – Eileen (done –needs to be formatted)
Existence of rules for med administration – Eileen (done –needs to be formatted)
Seizure disorders – Jen (done)
Sexuality - Linda (done – needs to be formatted ?reference?
End of Life – Martha – draft with instructions)
MRSA, VRE, and C.Diff Management Protocol - Joyce (pending)

h. Emergency preparations review in light of the ice storm.

i. BDS Medication Administration Curriculum Section III, page 2. Confusion regarding page 2 of Curriculum Section III, where examples of some different types of medication orders. Listed are a copy of a pharmacy call in order, and a telephone order taken by a nurse. Both still need to be cosigned by the prescribing practitioner for it to be valid. Margaret Walker, the Executive Director from the NH BON has stated that if a nurse chooses to not obtain a cosignature they are putting their licenses in serious jeopardy. In a facility, state law requires the signature be obtained within 48 hours.

j. **10:30 – 11:00** The In-Home Support (He-M 524) Coordinators joined the group for continued discussions around delegation in He-M 524 certified homes.