



Developmental Disabilities Nurses of New Hampshire

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

DDNNH@dhhs.state.nh.us

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:
Jennifer Boisvert, RN
Secretary, DDNNH



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

**Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH**



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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

**Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH**



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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

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH



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 waived, however, as an example; PRN Ibuprofen will not likely receive approval as a waived 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:
Jennifer Boisvert, RN
Secretary, DDNNH**



President: Ellen McPhetres

Vice President: Angele Smith

DDNA Liaison: Debi Ellis-Nailor

Treasurer: Dianne Crone

Secretary: Cheryl Bergeron

BDS: Cheryl Bergeron, RN, BS – Nurse Administrator II

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.

Peter Bacon & KiKi Sylvester topics discussed:

- 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



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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**



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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