



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 O&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/dcbc/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/dcbc/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

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

DDNNH@dhhs.state.nh.us

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

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

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

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

DDNNH@dhhs.state.nh.us

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 waived. 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

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

DDNNH@dhhs.state.nh.us

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 occurrence 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

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

DDNNH@dhhs.state.nh.us

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

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

DDNNH@dhhs.state.nh.us

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



Developmental Disabilities Nurses of New Hampshire

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

DDNNH@dhhs.state.nh.us

MINUTES

JANUARY 17, 2017

- 1) Meeting was called to order with **19** members in attendance.
- 2) Review and approval of **January** 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:
Luanne King, RN
Secretary, DDNNH**