



Developmental Disabilities Nurses of New Hampshire
State Office Park South
105 Pleasant Street – Main Building
Concord, NH 03301
(603) 271-5034

Frequently Asked Questions (FAQ)

I. NURSE TRAINER RELATED INFORMATION

Process for signing up for Nurse Trainer Orientation:

- Send a letter of request on agency letterhead requesting designation for your nurse as a NH Bureau of Developmental Services Nurse Trainer; and
- A copy of his/her current NH RN license; and
- A chronologically dated resume to:
 - Bureau of Developmental Services
 - Attn: Nurse Trainer Orientation Request
 - 105 Pleasant St - Main Building
 - Concord, NH 03301
- Orientations are then scheduled after requests are approved.

Please indicate if conditional designation is needed. A 45-day conditional designation may be granted, per He-M 1201.10 (b) and (c), if requested. A nurse granted conditional designation cannot authorize or re-authorize providers to administer medications, but can supervise currently authorized providers per He-M 1201.10 (c). http://www.gencourt.state.nh.us/rules/state_agencies/he-m1200.html (He-M 1201 reference updated 3/13)

The He-M 1201 Training Curriculum, revised September 2011 effective January 1, 2012, on the DDNNH website: <http://www.dhhs.nh.gov/dcbcs/bds/nurses/training.htm>

Tests and Answer Keys, Authorization Certificates, 2011 edited, must be obtained by requesting them from the State of NH admin assigned to assist DDNNH: DDNNH@dhhs.state.nh.us

Please request to sign up for the quasi-list serve **email list** where *Questions and Answers* are regularly exchanged. Send your email address to: DDNNH@dhhs.state.nh.us

Membership incentive for DDNA:

The Bureau of Developmental Services is offering an incentive for all nurses working in the developmental service system to join the national Developmental Disabilities Nurses Association. The Bureau is partnering with the Area Agencies by offering fifty percent reimbursement to the Area Agencies towards the \$80 required for DDNA membership for any nurse working for an area agency or for a subcontracted agency. **HOW IT WORKS:** Nurses will need to contact their respective Area Agencies or subcontracted agencies for support to join the DDNA, and will need to go to the DDNA website directly to register themselves. Subcontracted agencies should then contact their respective Area Agencies, who will enter the payment through BTS and contact their respective Bureau Liaison for approval via email, with a copy of the nurses names emailed to: MDiTomaso@dhhs.state.nh.us (added by DDNNH subcommittee workgroup 7-2015, ongoing practice offered from BDS, DDNNH 10-2015)

HRST (Health Risk Screening Tool) is a web-based **screening** tool. HRST was developed by a nurse owned software company (Health Risk Screening, Inc.). It is not an assessment tool. As part of BDS' collective and on-going commitment to improving quality of life and health outcomes for individuals with developmental disabilities and acquired brain disorders, the Bureau supported statewide efforts to effectively implement and utilize the HRST for all individuals receiving waived services (excluding respite only services).

Area agencies have the responsibility to develop and implement strategies for completion of these individual screenings. HRST screenings result in a Health Care Level (HCL) number for each individual. Individuals with a HCL of 3 or above will require an initial and annual RN review. Each area agency has a designated HRST Regional Coordinator who can answer specific questions as to the training and roles required for the HRST process. Initially the role for completing the screening is designated to the service coordinator/case manager. Training for online raters is self-paced and computer based. The initial training takes approximately 10 hours. RN reviewer authorization requires the online rater training plus additional RN specific instruction. HRST includes medical fragility designation as part of the RN reviewer role. *(DDNNH subcommittee workgroup 7-2015, DDNNH 10-2015)*

eStudio is a web-based (licensed) system that DHHS utilizes for multiple levels of work groups. DDNNH has access to a member only folder in eStudio. This is an online workspace where we can see and comment on projects in process (like our FAQ update work). NTs can also access fillable versions of the most up to date 1201 mandated forms. And we have a folder to share posted forms from agencies and vendors – these forms are not mandated outside of a particular agency. Anyone who has an eStudio acct with access to DDNNH can upload forms into this shared folder. If you are a NT or current paid member of DDNNH who does not have an eStudio account, send your first and last name plus your preferred email address to: DDNNH@dhhs.state.nh.us *(DDNNH subcommittee workgroup 7-2015, DDNNH 10-2015)*

II. LICENSING QUESTIONS:

Can a nurse transcribe telephone orders from a pharmacist? NH Board of Nursing response: Several comments and additional information have been received and the board revisited the question. At the 3/16/06 board meeting the board opined it is within the scope of the licensed nurse practice to accept a doctor's order that has been documented or clarified by the licensed pharmacist. <http://www.nh.gov/nursing/>

What is the difference between a person authorized to administer medications under He-M 1201 and a Medication Nursing Assistant?

Nursing Assistants are licensed by the NH Board of Nursing, must be supervised by a LPN or RN and their scope of practice is specifically regulated by the NH Board of Nursing through the NH Nurse Practice Act, the Nursing Administrative Rules (primarily in section NUR 700) and through advisory rulings made by the Board. In order to remain active-in-practice, the LNA must work as a LNA, within the appropriate scope of practice and under the supervision of a RN or LPN, for 200 hours within the 2 years preceding license renewal or reinstatement. Licensed Nursing Assistants may not, according to NUR 404.04(b) (4), be delegated the task of medication administration unless they hold a certificate, issued by the Board of Nursing, pursuant to NUR 900. Licensed Nursing Assistants who work as unlicensed personnel cannot utilize the hours worked in this role toward meeting **LNA active-in-practice requirements** and cannot represent themselves, when working in an unlicensed role, as a LNA. Information about the activities included in the scope of practice of the Licensed Nursing Assistant (LNA) can be found online at: <http://www.nh.gov/nursing/nursing-assistant/scope-of-practice-lna.htm>

Medication Nursing Assistants (MNAs) are Licensed Nursing Assistants who have completed a NH Board of Nursing approved Medication Nursing Assistant educational program consisting of a minimum of 60 hours of theoretical and clinical training. MNA scope of practice is also specifically regulated by the NH Board of Nursing through the NH Nurse Practice Act, the Nursing Administrative Rules (primarily in section NUR 900) and through advisory rulings made by the Board. MNAs, like LNAs must be supervised by a RN or LPN. Medication Nursing Assistants may not administer injectable medications, determine the need for a PRN medication or calculate a dosage. Information about the activities included in the scope of practice of the Medication Nursing Assistant (MNA) can be found online at: <http://www.nh.gov/nursing/nursing-assistant/definition-role-mna.htm>.

Unlicensed personnel, who provide personal care, health-related supports and/or nursing-related tasks such as bathing, continence care, catheter care, blood glucose monitoring, enteral feedings, etc., do so through delegation by a RN or LPN pursuant to NUR 404. Unlicensed personnel who are authorized to administer medications do so pursuant to the Nurse Practice Act, RSA 326-B: 43, VI, NUR 404 and He-M 1201. Nursing supervision is required for LNAs, MNAs and unlicensed personnel to whom nursing-related tasks have been delegated. The type of supervision (either direct or indirect) and the amount of supervision is determined by the delegating nurse based on the health condition and needs of the care recipient, the complexity of the task(s), the overall competence of the person to whom the care has been delegated and factors in the environment that may impact the outcome of the delegated task(s). Decisions about delegation must be based on NUR 404.04. The NH Board of Nursing Administrative Rules can be found online at: http://www.gencourt.state.nh.us/rules/state_agencies/nur.html and the Nurse Practice Act, RSA 326-B, can be found online at: <http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-326-B.htm>. (From Lorene Reagan, NH Board of Nursing, February 2006).

III. REGULATION RELATED QUESTIONS:

Each regulation begins with a section of definitions. Many definitions are common across applicable regulations unless the review cycle has resulted in a change for a common definition. Typically applicable regulations for nurse trainers to review include: He-M 507, He-M 521, He-M 524, He-M 525, He-M 1001, and He-M 1201

Recommended vs. Mandated Forms: The majority of forms available on the DDNNH website for nurse trainer use are recommended rather than mandated. The exceptions are 1201a, b, c forms and 1201 waiver forms. Examples of recommended forms include: QA form 1 & 2, health history information, health status indicators, transition evaluation, annual health screening recommendations, health care practitioner (HCP) visit form, and medically frail supports worksheet. (DDNNH subcommittee workgroup 7-2014, DDNNH 1-2015)

Five Day Visit Rule: *He-M 1001.06 (p) Within 5 business days of an individual's moving into a community residence or a change in residential provider, a service coordinator and licensed nurse shall visit the individual in the home to determine if the transition has resulted in adverse changes in the health or behavioral status of the individual. Be aware that the 5 day rule applies to any provider changes – not just address changes. Even in the case when no one within the home changes – solely the contract changes between adults in the home, the 5 day visit applies. This also means that monthly QAs are required for the first three months. The 5 day visit **must** be done within the first 5 business days from the initial certification date. The licensed nurse visit does not need to occur in conjunction with the service coordinator visit. (June 2013 DDNNH minutes, added DDNNH subcommittee workgroup 7-2014, DDNNH 1-2015)*

Healthcare Coordination He-M 1201.03 (DDNNH interpretative statements 1-2013)

(d) Providers accompanying an individual receiving services pursuant to He-M 1001, He-M 507, He-M 518, He-M 521, He-M 524, or He-M 525, as applicable, to a non-emergent medical appointment shall have, at a minimum, the following information:

- 1. The reason(s) or purpose for seeking non-emergent care;*
- 2. A list of the individual's current medications, allergies, and any recent diagnostic or laboratory testing, as applicable; and*
- 3. The individual's current health status indicators.*

NOTE: in (d)(3) and (f) the use of the term 'indicators' is construed as meaning 'information' and purposefully does not mean the use of a specific tool or form. The definition reference is 1201.02(o).

EXPECTATION: The term "non-emergent medical appointment" will be interpreted as the equivalent to the primary care physician or practitioner as referenced in 1201.03(f) (3).

- This minimum standard interpretation does not prevent the provider from sharing health status information with other prescribing practitioners.

EXPECTATION: For each appointment that is not considered to be an emergency, the provider will be expected to have (available for communicating with the health care practitioner) the necessary and pertinent information about the individual's current health status.

- The provider will be able to demonstrate that current health status information was available for the health care practitioner's consideration.
 - Examples of the range of possible application are:
 - This may be as simple as an acknowledgement statement included on the documentation record for the appointment (which has been signed and dated by the responsible provider), or
 - Specific separate and distinct documentation about the individual's health status that is included along with the documentation record for the specific appointment. When this information is clearly accompanying the appointment documentation, this record itself does not need to be dated the same day as the appointment, rather the understanding is that it will be considered the most current information available for the individual.

(f) For each individual receiving services pursuant to He-M 1001, the provider shall record and communicate an individual's health status indicators prior to:

- (1) The annual health assessment pursuant to He-M 1001.06(a);
- (2) Service coordinator visits pursuant to He-M 503.11(i); and
- (3) Any appointment with the primary care physician or practitioner.

NOTE: in (f) the use of the term 'indicators' is construed as meaning 'information' and purposefully does not mean the use of a specific tool or form. The definition reference is 1201.02(o).

NOTE: The initial intent of the He-M 1201.03 regulation about health care coordination is to communicate changes to the individual's entire team including appropriate health care practitioners.

EXPECTATION: (f) (2) requires the provider to demonstrate that the service coordinator has access to the reviewed health status indicators per the frequency indicated in He-M 503.11(i).

- Examples of the range of possible application are:
 - This may be as simple as the provider dating and signing the agency specific data collection tool.
 - The agency may choose to adopt a more detailed process.

EXPECTATION: (f) (2) service coordinators are expected to have access to the updated health status changes and are not required by minimum standards of the regulation to sign a copy in the individual record.

Definitions (as part of DDNNH interpretative statement section for healthcare coordination)

He-M 1201.02 (o) "Health status indicators" means signs of an individual's health status that suggest illness, such as changes in:

- (1) Functional abilities;
- (2) Weight;
- (3) Vision or hearing abilities; or
- (4) Patterns of:
 - a. Eating and drinking;
 - b. Seizures;
 - c. Breathing;
 - d. Elimination; or
 - i. e. Behavior. (end of interpretative statement from DDNNH, accepted 1-2013)

Define annual health assessment: The intent of He-M 1001.06 is for individuals to receive a professional and complete health assessment one time per year, unless the health care provider specifies otherwise or the exam is declined by the individual/guardian. This should occur once within a 365-day period of time with the grace periods allowed as noted below. *(May 2006 DDNNH meeting)*

60-day grace period: In those situations where an individual's annual health assessment is being delayed *because of a cancellation by the physician or the individual being hospitalized*, and either of these two reasons is clearly documented, a 60-day grace period applies before a deficiency is cited. For all other situations, the 30-day grace period still applies to He-M 1001.06 (a). *(Memorandum of Understanding 10-03-05)*

Annual Health Care Screening Recommendations (usually discussed as a particular form): Regulation reference - He-M 1201.03 (e). The form is not mandated. Its intention was to be a guideline to assure that our individual's health concerns are identified and addressed at their annual physical. The form was never intended to be completed by the physician. It is the obligation of the provider to review appropriate testing with the physician and document. Any way that works for each agency can be used. Some have incorporated the information on their annual health forms. *(September 2012 DDNNH minutes)*

- 1) The form does not need to be signed by practitioner.
- 2) Person reviewing recommendations with practitioner must document that this occurred.
- 3) Nurses should talk to guardian and document if recommended testing cannot be done in certain circumstances, i.e. "Individual will not tolerate". *(January 2013 DDNNH minutes)* *(DDNNH subcommittee workgroup 8-2014 clarifies #3 represents an example – nurses are not the only team members who are authorized to have this discussion with the guardian. DDNNH 1-2015)*

When ordered tests and procedures are noted in the individual's record, it is not necessary to have the actual documented outcomes maintained in the file. What is required is documentation that ordered tests and procedures have been completed. *(DDNNH subcommittee workgroup 7-2015 based on DDNNH 5-2014 minutes, DDNNH 10-2015)*

Medication Orders – do they expire? Though no longer directly addressed in He-M 1201, best practice standards would recommend that prescribing practitioners review ongoing medication orders on a regular basis. Authorized providers should have current copies of medication orders present in their medication log books – these current copies may be more than 365 days old. Medication orders that are greater than one year old may be subject to concern. *(DDNNH subcommittee workgroup 10-2014, DDNNH 1-2015)*

Health History: Regulation requires health history information to be reviewed within 30 days of initiating services and annually thereafter by the nurse trainer. There is a recommended though not mandated form provided by the Bureau on DDNNH's website. Each agency is responsible for developing a system for demonstrating compliance with this requirement. *(DDNNH subcommittee workgroup 7-2015, DDNNH 10-2015)*

Self-Administration Assessments: refer to He-M 1201.04 (b) – (c) and He-M 1201.05. All individuals new to services must have an initial documented nurse trainer review of their ability to manage their own medications. There is no mandated assessment form. Once the initial assessment is documented, if an individual is clearly unable to self-administer, there is no need to do or document a re-assessment. Annual re-assessment of individuals who have been assessed as capable of self-administering needs to be done no later than the last day of the 12th month from the date of the prior assessment. *(updated October 2014 DDNNH)*

Self-administration assessments are only done for individuals who have medications. The question to be answered in the assessment is – can the individual self-manage or do they need support? *(October 2013 DDNNH minutes)* In a day program setting – if the individual has no meds, then there is no need to have or do a documented assessment. When there are meds, then there needs to be an assessment. *(October 2014 DDNNH)*

Documentation of Controlled Medication Errors: Controlled medication discrepancies regardless of when they are found will be documented and reported according to He-M 1201. Examples of reportable errors include:

- Failure to count and document a controlled medication
- Transcription error
- Discrepancy in documented count due to a subtracting problem rather than a counting problem. (“subtracting” vs. “counting”)
- Errors found during a QA visit, *in addition to being reported via the med error reporting process*, will be referenced on the QA documentation. Otherwise, errors will be documented on med error reports and processed accordingly. *(DDNNH subcommittee workgroup 9-2014, DDNNH 1-2015)*

How to Handle Over-The-Counter (OTC) Medications When a Prescription Label Is Not Obtained: When the licensed practitioner writes an order for an OTC medication and the personnel of the certified home do not obtain a prescription label:

- Personnel will place the medication container in a resealable plastic bag along with a copy of the medication order. The medication container will have a clearly and distinctly identified manufacturer’s label that states the name and strength of the medication, and the manufacturer’s expiration date.
- The licensee shall maintain a list in the front of the certified home’s medication record that indicates the following:
 - The name of any individual who has an OTC medication as identified above;
 - The name of the OTC medication;
 - The signature of all personnel who administer medications, indicating that they are aware of the OTC medication as identified above;
 - The signature of the person who purchased the OTC medication signifying that the medication has been confirmed by a *licensed person*, as defined in He-M 1201, as the right medication.

NOTE: The use of “use as directed” on the prescribing practitioner’s order is *not* acceptable for routinely scheduled OTC medications as it is for PRN OTCs. *(Approved by May 2010 Medication Committee, May 2010 BDS Management Team).* To review the regulatory statements about OTCs see He-M 1201.07 (g) & (h). *(reference added February 2014)*

Suggestion from the Medication Committee Regarding How to Handle Prescription Changes When the Label on the Bottle Can’t Be Changed by the Pharmacy: When the licensed practitioner changes the dose or frequency of a medication and the authorized provider of the certified home are unable to obtain a new prescription label:

- Authorized provider will place the medication container in a resealable plastic bag along with a copy of the new medication order. The original container will be clearly and distinctly identified with a red mark on the label in a manner that does not occlude or modify the original pharmacy label. This indicates that there has been a change in the medication order.
- The licensee shall maintain a list in the front of the certified home’s medication record that indicates the following:
 - The name of any individual whose medication dose or frequency has changed as identified above;
 - The name of the medication that has been changed;
 - The signature of all authorized provider who administer medications, indicating that they are aware of the change in the medication dose or frequency.
- Authorized provider shall put a line through the changed entry and the rest of the month’s corresponding spaces on the daily medication record, indicating that the dose has been changed, and transcribe the new order in the next space available on the medication record.
- This shall be allowed until the current supply of medication is exhausted (i.e. 30/60/90 days). *(Approved by Medication Committee and Bureau of Health Facilities, 9-29-05).*

What is the practice with medication samples given from the practitioner's office? See directions for label changes above (June 2006 DDNNH meeting).

OTC Cough Drops: The use of **medicated** OTC cough drops will be determined at the discretion of the Nurse Trainer and the individual's team. Considerations around the safety of using OTC cough drops should include, but not be limited to: choking hazard issues (inadvertent swallowing, cheeking), excessive use, sugar content if diabetic. Medicated OTC cough drops do not require a prescription or pharmacy label or PRN protocol. (DDNNH subcommittee workgroup 7-2015, DDNNH 10-2015)

Nonprescription medicated toothpaste/mouth rinse (limited to Prevident, Sensodyne, Biotene, ACT and their generic equivalents): The Medication Committee recommends that doctor's orders and/or protocols be obtained for these substances only if the individual's health condition indicates the need for a prescriber evaluation. Otherwise, a doctor's order is not necessary. (*Medication Committee approval November 19, 2015*)

Frequency of QAs - please refer to He-M 1201.09 for specifics:

Are QAs required to occur on a specific day of the month, month after month, rather than anytime during the month? No, monthly means at least once every month so that there is some flexibility as to when a monthly QA in accordance with He-M 1201.09 (c) can be done. For example, a monthly QA could be done on January 1, 2006 and then on February 28, 2006 and still be within regulation. (*April 2006 DDNNH meeting*) (He-M 1201 reference updated 3/13)

Abbreviations: When authorizing and reauthorizing staff to administer medications in accordance with the He-M 1201 Curriculum, will **abbreviations (i.e. daily, not qd)** be in use in **per JCAHO standards**? Although the NH Board of Pharmacy has not taken a position on this issue as of February 2007, the NH Board of Nursing voted on February 15, 2007 to adopt the JCAHO position on abbreviations, and stated that the JCAHO ruling is appropriate and applies the element of patient safety important to the BON. http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf

Waivers – The April 2014 He-M 1201 Waiver form must be utilized when applying for a waiver, to include the Area Agency signature. The form can be found on the DDNNH website: <http://www.dhhs.nh.gov/dcbcs/bds/nurses/documents/1201waiver.pdf>

Please send He-M 1201 Waiver Requests to:

DHHS Bureau of Developmental Services
ATTN: Medication Committee
105 Pleasant Street - Main Building
Concord, NH 03301

Epinephrine auto-injector Waiver: –In light of the many He-M 1201 waivers sought for the administration for the Epinephrine auto-injector, the Medication Committee has issued an electronic Epinephrine auto-injector waiver. The Chair of the Medication Committee has authorized the use of this electronic Epinephrine auto-injector waiver form with their typed name as official approval. Please read the form carefully. It can be used for one individual, or for an entire program. However: this Epinephrine auto-injector waiver presumes that the Nurse Trainer is aware of **each** individual's needs. The He-M 1201 Epinephrine auto-injector Waiver Form can be found on the DDNNH website: <http://www.dhhs.nh.gov/dcbcs/bds/nurses/documents/epinephrine-auto-injector.pdf> (*June 2006*). It is not necessary to submit this waiver to Med Committee for signature, as it is already electronically signed. It is the Area Agency signature and the Nurse Trainer signature that ensures the content of the waiver is upheld. (*Epinephrine auto-injector substituted for Epi-Pen 7/2014*)

Med Assessment in Community Participation Services (formerly known as Day Programs):

- Rules governing Community Participation Services (CPS) are He-M 507. A medication review sheet for each individual is required for each medication administered; therefore, if the individual is not receiving any medications, they will not have a medication review sheet.
- However, each individual is required to have a current health assessment. A health assessment is defined as, “an evaluation of a person’s health status done by a physician or other licensed practitioner for the purpose of making recommendations regarding strategies for promoting and maintaining optimum health.” Communication needs to start at the provider agencies so that nurses are aware of new people coming into program. Nurses should be a part of the intake process.

Guidelines for use of Homeopathic Remedies are available on the DDNNH website:
<http://www.dhhs.nh.gov/dcbcs/bds/nurses/documents/homeopathic.pdf>

IV. NURSING PRACTICE ISSUES AND QUESTIONS

Nurses have the statutory right and moral responsibility to make independent nursing assessments and to plan and carry out nursing care according to their own knowledge, skill, and judgment. New Hampshire Board of Nursing: <http://www.nh.gov/nursing/>

Nursing Delegation Standards are clear on training requirements, competency, supervision requirements, and documentation. How a nurse approaches delegation of tasks outside of He-M 1201 is built on **NH Board of Nursing Rules NUR 404** regarding what kind of documentation is in place, including documentation of training, competency, supervision, and rescinding if not competent.

For example, a good standard of nursing care would be to document that Jane Doe was trained on (date), proved competency on this (date), is provided supervision via (state how), is reauthorized annually on this (date), and shall be rescinded after one written warning if no longer competent.

http://www.gencourt.state.nh.us/rules/state_agencies/nur100-800.html

Frail Health: The nurse trainer will use nursing judgment and assessment to determine which individuals on their caseload should be reviewed as appropriate for the frail list.

What is the definition of “frail health?” Means an acute and/or chronic medical condition that results in the inability of the individual to perform activities of daily living or daily routines which the individual previously had the ability to perform, and which has been identified by a Nurse Trainer to require ongoing monitoring to guard against deterioration. (*He-M 1201.02 (m) - reference updated 3/13*).

“Stable client” from NUR 401 means a client whose health status is under control and raises no expectation that the client’s symptoms, vital signs or reactions to medications will suddenly change. NH Board of Nursing Part 400 rules can be found at: http://www.gencourt.state.nh.us/rules/state_agencies/nur100-800.html

How much nursing judgment is the Nurse Trainer expected/allowed to use when developing the PRN protocol for unlicensed staffs’ use?

- The Nurse Trainer can neither alter nor limit the practitioner’s order. It is within the RN scope of practice to interpret medication orders for unlicensed persons as long as the nurse is not changing the essence of the practitioner’s order. (*DDNNH subcommittee workgroup 07-2014 clarification, DDNNH 1-2015*)
- Not only does the Medication Committee believe that Nurse Trainers should use their judgment in deciphering and individualizing medication orders, it is also understood to be an inherent aspect of their job.
- 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)
 - this interpretation includes “PRN” which the Nurse Trainer can expand upon using known manufacturer standards to guide individual specific PRN protocol development (*October 2014 DDNNH meeting*)

- The Nurse Trainer can also request to be notified by med authorized staff at a particular point prior to medication administration. (*Medication Committee response March 2005*)
 - A broad example (not all inclusive): Prescriber orders Tylenol 1000mg po Q 4 hours PRN for pain. Manufacturer standard instructions state to limit maximum 24 hour Tylenol dosage to 3000mg.
 - (The NT cannot alter on the PRN protocol maximum dosage to be less than the prescriber's order; however, NT can reflect the manufacturer standard and request notification by staff.)
 - The PRN protocol should reflect the manufacturer standards and/or clarification by licensed person. (*DDNNH subcommittee workgroup 7- 2014, DDNNH 1-2015*)

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

- He-M 1201.04 (b) – approved by the nurse trainer or prescribing practitioner. Examples of how this can be accomplished:
 - A nurse trainer could create the PRN protocol immediately onsite,
 - When not onsite, a nurse trainer could review the PRN prescription via telephone conversation with an authorized provider. The authorized provider would then document the nurse trainer instructions on the protocol form (this includes authorized provider documenting the specific nurse trainer, date and time as a temporary signature of approval),
 - a nurse trainer could email specific answers to the protocol questions (keeping in practice with the specific agency's HIPAA compliance expectations),
 - a nurse trainer could access other technology options (e.g. faxing, scanning),
 - Authorized providers could have blank PRN protocols available for every prescribing practitioner interaction. (*DDNNH subcommittee workgroup 10-2014, DDNNH 1-2015*)

Diets - are prescriber orders required? He-M 1201.03 healthcare coordination inherently presumes that the nurse trainer is aware of any standing orders. There is no specific reference to diets in the He-M 1201 regulation. The regulatory instruction for expectations is found in He-M 1001.06 (k) 4-6. The current expectation from our state surveyors is that diet orders will be reviewed and renewed by a prescriber annually.

- Examples of diet modifications that Nurse Trainers can provide written recommendations for can be found in the memo from Joyce Butterworth dated January 4, 2012.
 - It is expected that the prescriber would provide written orders for diet orders that include a change in liquid consistency (e.g. thickened liquids), a change in food consistency beyond cutting into small pieces, NAS, 1500 calorie diet, Diabetic diet, low fat diet, low cholesterol diet etc.
 - Lactose intolerance should be listed as an allergy, no order is required. (*04-2013*) (*DDNNH subcommittee workgroup 07-2014, DDNNH 1-2015*)

G-tube feedings: G-tube feedings have historically been reported in an optional way to the Medication Committee; however, the He-M 1201s do not mandate medication authorization for G-tube feedings. How do we know people are receiving their enteral feedings? There also has been discussion around other MD orders (not medications) as to whether or not they should be documented in the same way.

- G-tube feedings are clearly a delegated task under the NUR 404s, which call for the same standard of care, as would any other procedure. It is reaching beyond the 1201 rule http://www.gencourt.state.nh.us/rules/state_agencies/he-m1200.html to require medication authorization for g-tube feedings (NH BON Fall 2005)

- Nurses can make the decision if they want unauthorized people signing on the med log, as long as unauthorized people are not signing off on medications, as 1201 applies to med administration only. **Many use a treatment sheet.** (*December 2005 DDNNH meeting*).

Are saline nasal spray and natural tears treated as medications? The majority of the November 2005 DDNNH meeting voted “yes.” *While these products do not specifically meet the definition of medications (He-M 1201.02 (r)), it was the collective interpretation of best practice to maintain the safe documentation and administration practices in keeping with traditional 1201 medications. (11/2013 DDNNH FAQ updates)*

Bug spray/Sunscreen: The medication committee’s recommendation regarding the use of sunscreen and bug spray has been consistent in that we recommend that doctor’s orders and/or protocols be obtained for these substances only if the individual’s health condition indicates the need for a specialized product and/or physician evaluation (i.e.: in the case of an individual with a skin condition or history of allergic reaction or sensitivity to topical preparations or pesticides). Otherwise, a doctor’s order is not necessary. (*August 2000 Medication Committee*).

What is the standard on the use of hydrogen peroxide to clean ears? It should be considered a treatment, requiring ARNP/MD orders and nursing delegation standards (*DDNNH list serve May 2006*).

First Aid: What is the policy for First Aid? The majority at the February 2006 DDNNH meeting concurred that anything beyond soap and water and a Band-Aid constitutes the need for an ARNP/MD’s order and nursing delegation standards (*April 2006 DDNNH meeting*).

Non-prescription lotions: Regarding the use of non-prescription lotions, the Medication Committee recommends that doctor’s orders and/or protocols be obtained for these substances only if the individual’s health condition indicates the need for a specialized product and/or physician evaluation (i.e.: in the case of an individual with a skin condition or history of allergic reaction or sensitivity to topical preparations). Otherwise, a doctor’s order is not necessary. (*February 2010 Medication Committee*).

Non-prescription medicated shampoos: The Medication Committee recommends that doctor’s orders and/or protocols be obtained for these substances only if the individual’s health condition indicates the need for a specialized product and/or physician evaluation (i.e.: in the case of an individual with a scalp condition or history of allergic reaction or sensitivity to topical preparations). Otherwise, a doctor’s order is not necessary. (*April 2010 Medication Committee*).

Is it appropriate for a staff person authorized to administer medication to document the effects of a PRN medication administered by another med authorized staff person? YES! Not only is it appropriate but also practical as the authorized person who administered the med may not be there to document the effects, as is standard practice in health care settings. (The person documenting the effects must be med authorized).

Can we assume that if the “PO” is left off of a doctor’s order, that the assumption is that it is “PO?” Yes. If not a PO med, then the route does need to be specified. However, if the route is specified on the Dr’s order it should be specified on the label (*BHF during October 2009 meeting with DDNNH*).

Can a person be self-medicating and not be able to open the medication containers? The answer is yes; a person can be self-medicating if there are mechanical problems around opening containers as long as He-M 1201.05 requirements are met. (*April 2006 DDNNH meeting*) (He-M 1201 reference updated 3/13)

Can a person who is self-medicating use a pill planner? Yes, if the individual has been assessed by the responsible nurse trainer as capable of self-administration. The individual is then responsible to manage the pill planner. (*DDNNH subcommittee workgroup 8-2014, DDNNH 1-2015*)

Is it acceptable to maintain a **PRN medication order** without transcribing it to the med log? The December 2005 Medication Committee meeting clearly interpreted the intent of safe medication administration in accordance with He-M 1201 requires that all orders should be on the log.

Do PRN meds need to accompany an individual in the community? It was decided that this could be addressed at a team meeting and the determination could be written in the service agreement. (*May 2013 DDNNH meeting, added by DDNNH subcommittee workgroup 7-2014, DDNNH 1-2015*)

How to document Coumadin orders: Have the order read “give according to blood level indications,” and having the dosages chart directly in the MAR (*June 2006 DDNNH meeting*).

“Respite” and medication administration: When we talk about “respite,” we can mean when an individual goes home with their family, and medication is administered by the family. Some agencies write an “F” with a circle in the med log, signifying that the med was administered by the family. When respite care is provided by employees of an area agency or a subcontracted agency, and services are provided in a residence certified under He-M 1001 or He-M 521, the provider needs to be trained in accordance with He-M 1201. The practice of bringing the individual who is receiving services outside of their certified home and saying they are on “respite” so an unauthorized staff person can administer medications is unacceptable (*Bureau of Developmental Services*).

Can pill planners be used in conjunction with He-M 1201 or Nur 404 med administration by authorized providers?

- There are no circumstances where an authorized provider has the authority to use pill planners.
- It is outside the scope of a licensed nurse’s practice to fill a pill planner for authorized provider use. The definition of authorized provider is found in He-M 1201.02 (d) which includes the multiple types of regulated certified settings. (*NH Board of Pharmacy laws: RSA 318:42*) (*DDNNH subcommittee workgroup, 8-2014, DDNNH 1-2015*)

Who can take a verbal order? Any licensed person – He-M 1201.02 defines this as: (p) “Licensed person” means one of the following persons, who are licensed or registered in the state of New Hampshire:

- (1) A registered nurse;
- (2) A licensed practical nurse;
- (3) An advanced practice registered nurse;
- (4) A physician;
- (5) A pharmacist;
- (6) A physician assistant;
- (7) An optometrist;
- (8) A podiatrist; or
- (9) A dentist.

It is within the scope of a licensed nurse’s practice to accept a verbal order from a prescribing practitioner. This documented verbal order is an accepted medical order. Verbal orders must be co-signed by the prescribing practitioner within a reasonable timeframe.

The organization’s written policies will guide the expectations related to the use of verbal orders received by licensed nurses from prescribing practitioners. (*DDNNH subcommittee workgroup 9-2014, DDNNH 1-2015*)

Who can transport medications from a certified home to another certified setting? Written policy(ies) of the organization providing oversight will guide the expectations for how medication supplies are safeguarded during transport. The He-M regulations are silent in this regard. (*DDNNH subcommittee workgroup 9-2014, DDNNH 1-2015*)

Face to face real time video communication systems: Skype, FaceTime, etc. are examples of new technology that allows remote access to staff and individuals. We are in the early stages of exploring this new technology for the purposes of training and consultation. We feel optimistic that there is good use for this technology and understand that it may have its own limits (for example, both parties need access to the same tool). Membership has agreed to share anecdotes of experiences using this technology. (*DDNNH subcommittee workgroup 7-2015, DDNNH 10-2015*)

V. TRAINING RELATED QUESTIONS

When home providers who are *currently* authorized to administer medications in a “family residence” as defined in He-M 1201 move to a new setting with the same individuals and the same staff, nurses have the knowledge, skills, and judgment to determine if home providers and staff can be competent in another situation. Nurse Trainers can exercise their nursing judgment to determine if an *additional* reauthorization “mod 4” in the new setting is necessary, unless there are *any* changes to the composition of the household and/or staff. (*Bureau of Health Facilities May 2010; May 2010 Medication Committee; May 2010 BDS Management Team.*)

DDNNH Interpretative Statement for medication administration certification renewal processes when certification has lapsed (developed 3- 2014):

He-M 1201.06 Training and Authorization of Providers (regulation reference)

(e) 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.

(f) Re-authorization of an authorized provider shall:

- (1) Include, at a minimum, a demonstration of (a) (3) d. and k., and (b) (3) above;*
- (2) Follow a nurse trainer’s direct observation of the provider in the administration of medication performed in accordance with Nur 404.06 (b)-(f); and*
- (3) Be valid for the period of time described in (e) above.*

This expectation was developed with the following presumptions:

- That each individual agency has established and is accountable to their own:
 - 1) Method of consistently documenting medication authorization certification periods
 - 2) Medication administration re-training processes

Once the medication authorization certification period ends, the provider is no longer authorized to administer medications.

- Any administration occurring after certification has lapsed will be considered a reportable concern and therefore reported on the 1201 A report.
- If the lapse in certification is discovered/known within a month, then the provider may be re-trained according to the relevant company’s recertification process (which must include at minimum the regulatory requirements excerpted above).
- If the lapse in certification is longer than one month, the provider must successfully complete the full medication training process. (*DDNNH 3/2014, reviewed and authorized by Medication Committee 12/2014, end of interpretative statement from DDNNH – accepted 1/2015*)

“Mock” authorizations: The purpose of clinical observation is to determine the authorized provider's competency to safely administer medication. Evaluation of competency requires that providers show they have the "knowledge, skills and judgment" to safely administer meds. Please refer to He-M 1201.06 (b) (4), **which refers to expectation of providing direct observation**, (f) (2) and especially He-M 1201.06 (h) that references the Nurse Practice Act and delegation. http://www.gencourt.state.nh.us/rules/state_agencies/he-m1200.html (He-M 1201 reference updated 3/13)

Management of med authorization for a new residence/contract provider can be done earlier than the official start date of the certification (if the individual stays at the potential new home as a trial, so long as the provider is currently med authorized somewhere, then a med observation can be scheduled with the nurse trainer). In an emergency situation Nur 404 could be used. *He-M 1201.04 (n) in family residences where no more than one individual is receiving services from an area agency, medication administration shall comply with He-M 1201 or Nur 404 as determined by the nurse trainer. (DDNNH subcommittee workgroup 8-2014, DDNNH 1-2015)*

When a practitioner orders med for am, pm, or hs, are nurses writing down specific times on the med logs?

Sometimes because of a particular individual's life it is more useful to have a "freer" interpretation of time than the 1/2hr window. If the prescribing practitioner does not have specific times in mind, then we (nurse/provider) may choose to be more natural in our supports of allowing a time variance. In that case the 1st box of the time space on the med log says AM and under it (for reminding purposes) is written the word Time and then in the 3rd box down is written either PM or HS and in the 4th box the word Time again. Next to AM on each day of administration the provider initials and then below it documents the actual time of administration. A discussion between the provider(s) and nurse trainer occurs at the onset for acceptable time frames but this mechanism allows a much wider "window" - maybe some days the individual has to get up particularly early for work or stay out late for community events or school and on the w/e likes to sleep in. Without changing the prescribing practitioner's order, we allow safe flexibility within the expected guidelines (*June 2006 DDNNH meeting*).

VI. FYI CATEGORY

Camp Nursing Rules are Part Env-Ws 1120 RULES PERTAINING TO THE OPERATION OF YOUTH RECREATION CAMPS. It is advised that the policies of the camp be determined and followed. Camps that are operated for campers who are physically or mentally disabled require that a NH Registered Nurse, LPN, MD, or ARNP/PA be present. Each camper shall have a health history and statement of health status prepared by an MD, ARNP/PA prior to attendance.

VII. HISTORICAL ENTRIES - REFERENCE ONLY, EXPIRED

Self-Med Assessments: A 30-day grace period has been approved for He-M 1201.05 (d) (1) regarding annual assessments of individuals who self-medicate, allowing flexibility for re-assessment scheduling. The expectation remains that assessments shall occur more frequently as necessitated by the need of the individual who is receiving services. (*February 2010 Medication Committee; concurred with the Bureau of Health Facilities Feb. 2010*) (He-M 1201 reference updated 3/13)

How to document special diets: – for example, an order for a NAS diet – have written documentation of diet and place in MAR or in a treatment book, with documentation of nutritional consult (*June 2006 DDNNH meeting*).

What if medication orders expire prior to the annual assessment? Many nurses write up a continuation order for the health care provider to sign, making the medication orders valid until the appointment. (*May 2006 DDNNH meeting*).

The **Bulletin Board** can be found at the DDNNH website. He-M 1201 forms and instructions, DDNNH Meeting Minutes and Agendas, the training curriculum, and waiver forms are posted there: <http://www.dhhs.nh.gov/DHHS/BDS/DDNNH>. It is no longer interactive secondary to spamming issues

OTC drugs - as of December 2, 2008, the NH Medicaid Pharmacy Program (First Health Services) will no longer cover medication not listed on the Non-Legend (OTC) Drug List and all cough and cold preparation, both legend and non-legend. The exception form will no longer be valid. Notices posted by the NH Medicaid Pharmacy Program can be found at: <http://newhampshire.fhsc.com/providers/ptac.asp> The NH Medicaid Clinical Prior Authorization (PA) Program was implemented to improve quality and manage drug classes that have been identified as requiring additional monitoring. This program is also intended as a means of ensuring that drugs are being prescribed for the right patients and for the appropriate reasons, while still monitoring drug expenditures. Clinical Prior Authorization Request Forms can be found at: <http://www.dhhs.nh.gov/DHHS/MEDICAIDPROGRAM/LIBRARY/Form/pdl-prior-authorization-form.htm>

OTC drugs –it is allowable to utilize the manufacturer’s label on an over-the-counter (OTC) medication as the “medication label” as established in He-M 1201, as long as it is clearly identifiable and matches the prescribing practitioner’s order and the medication log (February 2010 DDNNH; March 2010 Medication Committee; Bureau of Health Facilities April 2010).

Frequency of QA's: Per H-M 1201.08 (b), Nurse Trainers perform QA’s on a semi-annual basis at family residences where 3 or fewer individuals are receiving residential/personal care services. Separate day programs under He-M 507 require monthly QA’s. In those cases where individuals receive their day services pursuant to He-M 507 through the family residence (i.e. “whole-life” service arrangements), quarterly (or more frequently as nursing standards of practice dictates) QA’s are permissible if deemed sufficient by the Nurse Trainer. (Medication Committee May 2010; Bureau of Health Facilities May 2010, BDS Management Team May 2010).

New settings: When providers providing services in settings that meet the definition of a family residence in accordance with He-M 1201 move to a new setting with the same individual and same staff with no changes whatsoever in the household composition or with staffing, it is not necessary to “re-mod 4” everyone again. Nurses are expected to have the knowledge, skills, and judgment to determine when those who are authorized to administer medications in accordance with He-M 1201 move whether or not they can be competent in another setting. This does not apply to group homes (*Medication Committee May 2010; Bureau of Health Facilities May 2010, BDS Management Team May 2010*).

Define semiannual QAs: He-M 1201.08 (b) states that Quality Reviews shall be performed semiannually (for residences with 3 or fewer individuals and services provides through He-M 521 or He-M 524). Semiannually means: for example, the time between December 1, 2005 and May 31, 2006 and then June 1, 2006 through November 30, 2006. (*May 2006 DDNNH meeting*).

What is the definition of “medically frail?” Individuals in frail health are those who have an acute and/or chronic medical problem that results in an inability to perform their normal activities of daily living or their daily routines, and which requires ongoing monitoring to prevent deterioration. (*NH DHHS April 2005*).