



The **Developmental Disabilities Nurses of New Hampshire** (DDNNH) was established with the purpose of sharing knowledge and serving as a resource for advancements in developmental disabilities nursing practice. The DDNNH is committed to broadening the knowledge of all nurses and other professionals involved in supporting individuals with developmental disabilities. The DDNNH mentor new Nurse Trainers and work in partnership with the NH Department of Health and Human Services, Bureau of Developmental Services.

Jan 26th, 2010 Minutes

The **Jan 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, Thomas Fox Memorial Chapel. Fifteen attended.

All Regions were represented by either area agency nurses or vendor nurses except for Region IX.

9:30 – 11:30am

The agenda was addressed as follows:

1. Review and Approval of December Minutes

December minutes were reviewed and accepted.

2. Treasurer's Report

- a. December's report was read and accepted.
- b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members.

3. DDNA Liaison Report:

- i. Our DDNA Liaison, Jen Boisvert, cannot attend the rescheduled-due-to-construction DDNNH meetings. It was brought before the group if Jen should continue as the liaison, including attending the DDNA annual conference as a DDNNH-sponsored person. Two motions were brought to the floor:
 1. Move to allow Jen to continue as the liaison, including as the DDNNH sponsored person to attend the DDNA conference, providing she continues her "work behind the scenes." Motion passed, no objections.
 2. Move to allow a substitute read Jen's "work behind the scenes" reports at the DDNNH meetings, and to allow that substitute to be Linda Catalano. Motion passed, no objections.

4. Business/ Nursing Practice Issues:

Suggestion for each nurse to write up a list of each of their respective responsibilities and bring a copy of each nurse's job description as "we are bogged down with 1201 expectations and paperwork," and nurses are spending a lot of unreportable time – how much time do we spend on healthcare? Brenda Thamm volunteered to compile this list – email her at: growathome@gmail.com

This has really not been done. To date, no one has sent anything in. Discussion ensued that it is important that we write this information down and what we do – we are doing a lot of nursing and not doing a lot of 1201s and because of that, we get behind. Some Area Agencies see the vendor nurses as assets to them, rather than having their own nurse for MED assignments. Please do your homework for February. For the March DDNNH meeting on March 30th, we will engage in a brainstorming session, using charts to documents and prioritize what we want this group to reflect as our duties.

Some quotes from the DD nurses:

"We have 102 clients, 7 group homes with 4-5 people in each, 37 adult foster care homes with 1-2 clients each, a Voke department with 80 people, and 2 full-time nurses. The hardest thing is the day-to-day medication changes and issues that come up with people - always tons of filing that is never caught up. We have nurse descriptions but they are not adequate. We go on hospital visits especially at discharge time, do telephone triage for sickness, illnesses, cuts, accidents, we have walk-in triage when at the office. I have to decide if I need to be at hospital discharge meetings depending on the severity of the illness. With the He-M 1201 regs and the way we've become focused in on them we've gotten away from the art of nursing and what that means because we get bogged down with paperwork. When we do the nursing care there's not a lot of time for the 1201's and because of that we get behind in paperwork. For example, this past Friday at 4pm I was told there was a person discharged from the hospital with a G-tube - no one told me he was getting one, so I spent the whole weekend training staff. It would have been nice to get a heads-up about this and have the staff go into the hospital before hand to get the training."

Goals for 2010:

- a. Continuously look at DD Standards of Practice.
 - i. How do we create a new culture when you're not in a position of authority?
 - ii. We need to update "Communicating for Health."
- b. Suggestion was made to create a List of Topics to explore:
 - i. OTCs
 - ii. Dandruff shampoo
 - iii. Adding to the curriculum – How to prepare for a doctor's appointment?
 - iv. Chapter vs. Network
 - v. Individuals coming into the DD system and receiving services without the nurses' knowledge.
 - vi. Having a DDNA member to represent each Area Agency.



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Feb 23rd 2010 Minutes

The **Feb 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, Thomas Fox Memorial Chapel. Nineteen attended.

All Regions were represented by either area agency nurses or vendor nurses except for Region VIII.

9:30 – 11:30am

The agenda was addressed as follows:

5. Review and Approval of January Minutes

January minutes were reviewed and accepted.

6. Treasurer's Report

- a. January's report was read and accepted.
- b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members. We need more members for DDNNH and this needs to be on our agenda.

7. DDNA Liaison Report:

- a. Linda Catalano is filling in for Jen in her absence. Next quarterly report will be given in March.

8. Business/ Nursing Practice Issues:

- a. Suggestion for each nurse to write up a list of each of their respective responsibilities and bring a copy of each nurse's job description as "we are bogged down with 1201 expectations and paperwork," and nurses are spending a lot of unreportable time – how much time do we spend on healthcare? Brenda Thamm volunteered to compile this list – email her at: growathome@gmail.com

Four responses have been received thus far and forwarded to Brenda. In March, we will use the white board to list our responsibilities. Here are some so far:

- Reauthorizations
- QAs
- Phone triage
- Discharge planning
- Team meetings/Service Coordinator meetings
- Healthcare visit attendance
- Hospital visits
- Transitioning into residential programs
- People dropping in my office with clients I have to assess
- Acute care issues
- Complaints
- Health care histories
- Medically frail list
- Pager calls – on call time
- Unannounced visits
- 1201As
- "Nursing coordination" does not capture the essence of what we do.

b. More quotes from the DD nurses:

- i. Nurse W has 300 people to reauthorize – should we extend the 12-month authorization period? Other states go two years (but other states also have a 5-day 40 hour training curriculum).
- ii. Staff is more and more distracted, stressed out, should we condense the training? Should we have a pretest, and if less than 90% is achieved, then have retraining?
- iii. Remedial work is so much more time consuming than training someone right in the first place.

- iv. Most people use our curriculum over three days at 4-hour days; otherwise, people get saturated and hear nothing that is said.
- v. We should have a mandatory recertification class that is two hours long and make a retraining curriculum. (WHAT SHOULD THIS LOOK LIKE??) What are people using now that are already having a two-hour recert class?

Goals for 2010:

Continuously look at DD Standards of Practice.

- How do we create a new culture when you're not in a position of authority?
- We need to update "Communicating for Health."

Suggestion was made to create a List of Topics to explore:

- OTCs
- Dandruff shampoo
- Adding to the curriculum – How to prepare for a doctor's appointment?
- Chapter vs. Network
- Individuals coming into the DD system and receiving services without the nurses' knowledge.
- Having a DDNA member to represent each Area Agency.
- Program managers/house managers should all be med trained and receive a copy of the QA and have to sign off on it acknowledging the corrective actions that need to take place in a residence.



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Mar 2010 Minutes

The **Mar 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, Thomas Fox Memorial Chapel. Twenty-four attended.

All Regions were represented by either area agency nurses or vendor nurses.

9:30 – 11:30am

The agenda was addressed as follows:

9. Review and Approval of Feb Minutes

Feb minutes were reviewed and accepted.

10. Treasurer's Report

- a. Feb's report was read and accepted.
- b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members. We need more members for DDNNH and this needs to be on our agenda.

11. DDNA Liaison Report:

- a. Jen provided an update as the DDNA Liaison, including the upcoming conference, review of antipsychotropics, individual not getting screenings for cholesterol and blood sugar, and encouraged us to review the JAMA patient pages about falls and older adults <http://jama.ama-assn.org/cgi/reprint/303/3/288.pdf>

12. Business/ Nursing Practice Issues:

13.

- a. The Mass Conference is in October
- b. Judith Guertin nominated for recognition award.
- c. Please email guardians' forms to Joyce for examples
- d. Topical/PO – we will not get cited per Peter Bacon at the October 2009 DDNNH meeting: here are the minutes from that topic during October:
Can we assume that if the “PO” is left off of a doctor’s order, that the assumption is that it is “PO?” Yes. If not a PO med that the route does need to be specified. However, if the route is specified on the dr’s order it should be specified on the label.
- e. We spent time compiling a list of Nurse Trainer duties, including the scope of what is involved with staying in compliance with He-M 1201, and what is involved outside the scope of He-M 1201.
(see attached)

Goals for 2010:

Continuously look at DD Standards of Practice.

How do we create a new culture when you’re not in a position of authority?

We need to update “Communicating for Health.” Suggestion was made to create a List of Topics to explore: OTCs, Dandruff shampoo, Adding to the curriculum – How to prepare for a doctor’s appointment? Chapter vs. Network. Individuals coming into the DD system and receiving services without the nurses’ knowledge, having a DDNA member to represent each Area Agency, Program managers/house managers should all be med trained and receive a copy of the QA and have to sign off on it acknowledging the corrective actions that need to take place in a residence.



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April 20, 2010 Minutes

The **April 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, South Function Room. Twenty-five attended.

All Regions were represented by either area agency nurses or vendor agency nurses.

9:30 – 11:30am

The agenda was addressed as follows:

14. Review and Approval of March Minutes

March minutes were reviewed and accepted.

15. Treasurer's Report

- a. March's report was read and accepted.
- b. Membership applications were left on the table for those interested in joining. The DDNNH 2010 Roster showed 28 paid members. We need more members for DDNNH and this needs to be on our agenda.

16. DDNA Liaison Report:

- a. Jen asked what issues the DDNNH want to bring to the DDNA Conference this year. Jen also talked more about Chapter vs. Network, what the different requirements are, such as that all committee members need to be DDNA certified, etc. Jen mentioned that the focus of the DDNA Pre-conference will be medication administration, and that NH already has a statewide curriculum but that many states do not. Suggestions for Jen to bring to the DDNA Conference included:
 - i. Health disparities, i.e. dental and psych treatment (or the lack thereof);
 - ii. Healthy eating and nutrition – how to manage this in the adult population where unhealthy eating is a culture.
 - iii. How to raise awareness of our local DDNNH network, how to increase our own membership, how to get nurses interested locally as well as nationally.
 - iv. How to promote people to become DDNA certified.

17. Business/ Nursing Practice Issues:

- a. Continuing discussion around how to get nurses more involved in DDNA and DDNNH:
 - i. How each nurse could reach out more to the New Nurse Trainer announcement that goes out when a new Nurse Trainer Orientation takes place;
 - ii. Each region has variation in how nurses meet within each region, with some meeting monthly (mostly the area agencies with no vendors), to quarterly, to semi-annually, and to not at all.
 - iii. How do we get agencies to support and pay for nurses to go to DDNA conference?
 - iv. How do we get agencies to pay for CEUs? (Join DDNA and get free CEUs online!!)
 - v. Leadership skills – how to acquire – get someone to make a CEU presentation.
- b. It was suggested that the DDNNH propose standardized forms across the agencies for the purpose helping nurses save time. Suggestions were made that we use evidence-based research on why we would be doing this. A suggestion was made that we look at the Medication Occurrence forms across agencies and standardize the form. It was tabled until next month.
- c. Another suggestion was to standardize the way the med books are set up – this would prevent errors!!
- d. A suggestion was made to have our Treasurer and Secretary positions for two years as well, to be discussed at the June Meeting.

- e. The DDNNH nurses were queried electronically to change our bylaws and our annual membership meeting to June as the majority of DDNA conferences are scheduled in May, overlapping our important membership and election meeting. Over 30 responded positively to make this change, with the suggestion we have our bylaws flexible enough to have it either May or June, depending on the DDNA conference. We will table this until June.



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May 18th, 2010 Minutes

The **May 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, South Function Room. Nineteen attended.

All Regions were represented by either area agency nurses or vendor agency nurses.

9:30 – 11:30am

The agenda was addressed as follows:

18. Review and Approval of April Minutes

April minutes were reviewed and accepted.

19. Treasurer's Report

- a. April's report was read and accepted.
- b. Membership/election month has moved to June!!

20. DDNA Liaison Report:

To be given in June.

21. Business/ Nursing Practice Issues:

- a. We looked at page 8 of the High Cost Review that was emailed to all DDNNH nurses for discussion today. Several points were brought up:
 - i. There is a natural resistance to change.
 - ii. Unlicensed staff cannot give medications safely without the structure of the 1201's.
 - iii. We have so much documentation requirements, but when someone goes to respite, there are no requirements???
 - iv. An undue amount of nurse's time is spent on paperwork instead of nursing.
 1. We have to go through a year's worth of paperwork to prepare for certification.
 2. Why do we have to fill out a med occurrence form when someone forgets to initial?

3. We should be looking at the medical situation of the whole person instead of having to document every single thing.
 4. Do we really need med logs?
 5. Take documentation error reporting OFF the 1201A reports!
- v. Not all nurses use treatment logs – some nurses use one book for both medication logs and treatment logs, otherwise the treatment logs would never get looked at. Some have a separate “treatment section” within the med log.
- b. The nurse has the knowledge enough if someone moves whether or not they can move and be competent in another situation. We need to have a mechanism to focus our attention on the important issues, such as; Does the individual need new practitioners because of the move? Are there community resources available now in the new location that is sufficient?
 - c. Take dandruff shampoo off the med log.
 - d. What about CPAP, special diets. In general, a diet order is on the PE on an Rx. If lo fat and lo chol then the order in the book is relevant information as to what constitutes a lo fat dies.
 - e. In a hospital discharge situation a diabetic on fluid restriction following an MI – one nurse used a checklist system for staff to subtract as they went rather than write everything down fresh. The dietician would not come out for training but suggested a diet plan that was roughed out. Not counting carbs all day long was much easier. Also used was tracking it in everything that was eaten in a food diary and comparing it with blood sugar readings. Lo cal lo fat guidelines, teaching how to follow up with the doc on cholesterol levels. Use outside sources as much as possible.
 - f. Our program managers have worksheets for them – some managers with larger caseloads – some have 35-40 houses, and we have to have them ready to give meds, and having the nurse supervise them all is difficult.
 - g. **Question: what is our standard of practice around how often a person needs to give meds in a certified setting in order to be considered competent to administer in that location?**
 - h. More and more we have whole life situations – how often should they be QA’d?



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9:30 – 11:30am

The agenda was addressed as follows:

22. Review and Approval of April Minutes

April minutes were reviewed and accepted.

23. Treasurer's Report

- a. April's report was read and accepted.
- b. Membership/election month has moved to June!!

24. DDNA Liaison Report:

To be given in June.

25. Business/ Nursing Practice Issues:

- a. We looked at page 8 of the High Cost Review that was emailed to all DDNNH nurses for discussion today. Several points were brought up:
 - i. There is a natural resistance to change.
 - ii. Unlicensed staff cannot give medications safely without the structure of the 1201's.
 - iii. We have so much documentation requirements, but when someone goes to respite, there are no requirements???
 - iv. An undue amount of nurse's time is spent on paperwork instead of nursing.
 1. We have to go through a year's worth of paperwork to prepare for certification.
 2. Why do we have to fill out a med occurrence form when someone forgets to initial?
 3. We should be looking at the medical situation of the whole person instead of having to document every single thing.
 4. Do we really need med logs?
 5. Take documentation error reporting OFF the 1201A reports!
 - v. Not all nurses use treatment logs – some nurses use one book for both medication logs and treatment logs, otherwise the treatment logs would never get looked at. Some have a separate “treatment section” within the med log.
- b. The nurse has the knowledge enough if someone moves whether or not they can move and be competent in another situation. We need to have a mechanism to focus our attention on the important issues, such as; Does the individual need new practitioners because of the move? Are there community resources available now in the new location that is sufficient?
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- d. What about CPAP, special diets. In general, a diet order is on the PE on an Rx. If lo fat and lo chol then the order in the book is relevant information as to what constitutes a lo fat diet.
- e. In a hospital discharge situation a diabetic on fluid restriction following an MI – one nurse used a checklist system for staff to subtract as they went rather than write everything down fresh. The dietician would not come out for training but suggested a diet plan that was roughed out. Not counting carbs all day long was much easier. Also used was tracking it in everything that was eaten in a food diary and comparing it with blood sugar readings. Lo cal lo fat guidelines, teaching how to follow up with the doc on cholesterol levels. Use outside sources as much as possible.
- f. Our program managers have worksheets for them – some managers with larger caseloads – some have 35-40 houses, and we have to have them ready to give meds, and having the nurse supervise them all is difficult.

- g. **Question: what is our standard of practice around how often a person needs to give meds in a certified setting in order to be considered competent to administer in that location?**
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June 20th, 2010 Minutes

The **May 2010 DDNNH Meeting** was held at the Bureau of Developmental Services, 105 Pleasant Street, Main Building, Concord, South Function Room. Twenty-seven attended.

All Regions were represented by either area agency nurses or vendor agency nurses.

The agenda was addressed as follows:

26. Review and Approval of May Minutes

May minutes were reviewed and accepted.

27. Treasurer's Report

- a. May's report was read and accepted.

28. Review and adoption DDNNH bylaws (attached).

29. DDNA Liaison Report:

- a. Jen is asking people to think about taking over as liaison as she is entering her second year.
- b. Regarding the DDNA Conference – it was exhausting. There were viewpoints from the national perspective around health disparities – some controversial viewpoints were expressed. The nurse was not always a valued member in the room. There was not a lot of discussion but a lot of good information that was thought provoking.
- c. For the Board report – NH was well represented. The Board report was summarized but was very vague and not helpful to the membership. The DDNA was saying they want our viewpoints from the field and some of the Board means it. At the end of the conference, people were writing pages of reviews of room for improvement. The person who presented at the end had a good handout but the stage had no wheelchair access. There were a lot of electronics left and the mike could not be moved to where he was. The Board has strengths and weaknesses.
- d. The Chapter Leadership luncheon – last year learned about leadership and this year learned about being a chapter. At the luncheon, we could not do everything we needed to do. Judy Stykes had prepared a section of what it was like in the field that we did not get to. Someone asked about money – if we became a Chapter, we need to fill out a monetary disclosure. If we change our mind, then if we made any money when we dissolve to a network all of the money goes to the DDNA and we get back what we started with. Not all Chapters had done their disclosures. There are 80 national members and 20 local chapters. We could have fund raising, conferences.
- e. The second part was disheartening. The DDNA is not offering any longer CEUs that are acceptable for State licensure, explained in a handout. The new ANCC – good for every

state. It can take more than \$5000 for initial application to the ANCC. A conference through the ANCC would be an additional cost. For the annual conference we will continue to be eligible for state requirements but for DDNA and state licensure. Online is separate.

- f. Preconference – medication management in the community settings. A task force was put together in January. Sharon Oxx is on it – have met several times via telephone – what do we want to ensure for safe medication administration by unlicensed staff across the nation. 528 nurses (1/3rd) responded to the DDNA. 64% are mandated with less than 20 hours of standard classroom time. 59% felt there was insufficient oversight and training of DSPs, 40% felt they were out of compliance with the NPS, 37% cited lack of funding, 29% said they had no authority to intervene, 29% said there was a lack of standardized competence evaluation. The essential components – 95% said the 5 Rights, 85% said documentation, observing for s&s and identification of medication errors. We broke out into tables with different people – Jen was assigned to the oversight table. There was no deadline as to when the DDNA will assimilate the information they gathered from the tables.
- g. The 2011 Conference will be in Hartford Conn May 13th 14th and 15th (1/2 day shorter than usual).

30. **Bureau of Health Facilities:** Peter Bacon shared a summary of certification reports and where the majority of medication deficiencies fell (documentation at the time of medication administration was the largest). All the surveyors' cell phone numbers were shared with the DDNNH. Peter instructed the nurses that if they do not agree with something that is cited they need to appeal the deficiency. Peter will then speak to both the nurse and the surveyor to get both sides of the story, and make a decision based on the facts presented by both individuals.

31. Kenneth R. Nielsen came for a question and answer opportunity regarding – “If it wasn’t documented, was it done?”

32. Kenda Howell facilitated a discussion regarding “Structured DDNNH Meetings,” the High Cost Report Recommendations, and how we need to approach our practice differently.

- a. We need to structure ourselves to pull together and be more of a cohesive group.
- b. What are our objectives?
 - i. Create a list of unnecessary components in 1201
 - ii. Create a list of necessary components of 1201.
- c. South Function Room needs to be set up differently to facilitate better discussions. We should have nametags. CURTAIL SIDE CONVERSATIONS. Please give respect and attention to whoever is speaking and wait your turn. If you need to have a conversation please step outside. SPEAK UP so we can hear you.
- d. We NEED GROUND RULES. Have the person running the meeting sitting at the center of the room.
- e. One person speaking at a time with a raise of hands.
- f. Our discussion needs to be mindful of the agenda.
- g. Tactical and strategic portions of the agenda.
- h. Be aware of Robert’s Rules of Order (attached)
- i. Follow the agenda and follow the time frames on the agenda.
- j. Have a succinct agenda
- k. Put the educational opportunities on the back.
- l. Be mindful of our limited time.
- m. Be kind.
- n. Ground Rules:

- i. Recognize who is the facilitator (usually the Pres or VP)
- ii. One person speaking at a time
- iii. Follow the agenda
- iv. Be mindful of limited time
- v. Remember – this is idea gathering time
- vi. Be kind to each other
- vii. No anonymity
- viii. No side bar conversations.

33. Business/ Nursing Practice Issues:

- a. **Question: what is our standard of practice around how often a person needs to give meds in a certified setting in order to be considered competent to administer in that location? Keep on September's agenda.**
- b. Omission vs. documentation error?
- c. Liability insurance – Eileen has information and will share with us.
- d. License protection – Wayne has information and will share with us.



Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/DHHS/BDS/DDNNH

September 14, 2010 Minutes

1. Review and approval of June Minutes. There were grammatical changes and clarifications made to the DDNA Liaison Report.
2. Officers Reports:
 - a. Treasurer's Report: The treasurer's report was read and accepted.
 - b. DDNA Liaison Report: Quarterly in September was given. The September newsletter is available for members online. Some copies of the abbreviated version of the newsletter were made available at today's meeting. The DDNA is asking for ideas for speakers and clinical topics for the 2011 Conference. The Conference will be held from May 13th to the 17th. Kenda stated that there is going to be a committee to work on hospitality i.e. food, welcoming room for the next conference. The DDNA is considering having a silent auction. A request was made to put this on October's agenda.

10:00

3. Special Business:

- a. Ground Rules posted on wall.
- b. High Cost Report re-emailed to the DDNNH with a request to please read page 8 of the report.
- c. Table set up. We need to make the table shape bigger to include everyone at the table.
- d. Please note the movie "Lost in Laconia" is playing this weekend through October 1st.

4. **Unfinished Business:**

- a. How often does an authorized person need to administer medications in order to be considered competent?
 - i. S: Our agency has a policy that they have to administer at least one time per month to stay authorized.
 - ii. W: I have 50-70 people authorized in one house alone – they have to administer at least monthly. But the bottom line is the 1201 regulation "or to whom they are regularly assigned."
 - iii. E: How do you arbitrarily come up with 1 month? Can you just give that information over the phone:
 - iv. E: what about some who took the med course 3 months ago and has not yet given a med?
 - v. M: or someone who just has a PRN?
 - vi. R: I have 2 clients with no meds and the providers are authorized with "observation pending" is written on their authorization.
 - vii. M: I have a person who took the med class one month ago, they are coming back for the 2nd ½ of the class to repeat and then take a retest.
 - viii. E: If I have someone that took the class two months ago and has not been observed, I make them go through the whole class again.
 - ix. M: that is very costly. Can't that be looked at individually? What about verbal testing i.e. triple checks, 6 rights, etc. and then if they can't pass then they have to retake the class?
 - x. E: I'd like the group to set a policy.
 - xi. J: I have day program staff who may have a med at some point. All I have to do is observe. I check in with them regularly. The managers are expected to remind staff what it means to give meds.
 - xii. S: I have a concern that once you learn a new skill if you "don't use it you lose it."
 - xiii. J: I have some people I would not do that with.
 - xiv. S: some program managers have been trained for 20 years and have been giving meds and they can make a mistake.
 - xv. L: Our agency has a three-hour reauthorization class and they have three months prior to their expiration to take the class.
 - xvi. J: I can't come up with eight hours right away, it's a logistical issue:
 - xvii. K: if people are getting pressure to authorize people you don't believe are competent, some people are put in bad spots.
 - xviii. P: there are problems with the State Certifiers around people able to self medicate that live in a home with others with forensic issues, have to be under lock and key due to the safety of the home. Recently a certifier took an issue with someone who's self-medicating who had their meds locked up, citing client rights.
 - xix. W: does that client have a key? Lock it up in their own room and give them a key – that would be a solution.
 - xx. J: regarding setting policy on how often a person has to give meds to be considered competent, it really needs to be up the nurses' judgment and the situation at hand. Each situation is so different what works in one scenario might not be practical or safe in another. It has to come down to nursing judgment, and if your practice can

stand up to scrutiny by the BON. If you can stand before the BON and justify your decisions, then that should stand. We have to be careful how much we dictate in terms of nursing judgment.

b. Is it an omission or a documentation error?

- i. L: way back when if the error was discovered more than 24 hours after it was made, it was always listed as an omission.
- ii. W: some nurses report it as a documentation error – we have not been consistent. The numbers don't make sense unless audits are done to prove the med was given.
- iii. M: years ago, it was always looked at as an omission, and then it switched.
- iv. K: in the previous revision of the 1201, we didn't have documentation as a category. Adding it as a category had the unintended by-product where omissions have become listed as documentation errors. I don't understand how it can be a documentation error. The numbers are really skewed. It's clear that people are paying attention. I hope the documentation category goes away.
- v. L: most staff are honest, either they say the did or didn't give the med.
- vi. K: was there corrective action take and was it appropriate are the most important questions.
- vii. E: in a forensic group home they will sign off 4 pages of meds but then forget to sign the last page. The question is, how are you doing your triple checks? So I counted it as a documentation error because it was in my judgment and then we discuss the triple checks.
- viii. K: we're not executing people – how do we account for something that was done 6 months ago? We're not intended to be in a numbers game.
- ix. W: don't assume it's a documentation error – if it's blank then find out!
- x. L: if a person really can remember, then I believe them.
- xi. T: for staffed home we have a protocol to follow to review med logs for blank spots. For a week's worth of omissions it's a different story. We had an individual who had a 12-minute seizure, they get Valium in 5 minutes but they didn't get the 2nd dose. One nurse said it was a documentation error because staff miscalculated the seizure time. Safety of the individual is more important that how an error is documented.
- xii. O: staff are required to count narcotics one time per day, at the shift change it would be odd to pass off without counting – does everyone do one per day?
- xiii. D: minimum 1201 standards are once per day, but we do it on shift change.
- xiv. T: our protocol in our agency is per shift with two people present at the same time.

11:00 – 12:00

5. Continuing Education Series

Continuing Education Series

“Trach Education for Care Providers of People with DD”

The delegation of trach care is not a 24-hour process – it is a couple of weeks of constant practice, and they have to demonstrate repeatedly that they can do it. The person sleeps in overnight before the individual is discharged. Lynn has taught 14 year old to be competent. We utilize a standardized curriculum. There is not a lot of research around trach care delegation but this curriculum was designed by a team of experts and is considered best practice.



Developmental Disabilities Nurses of New Hampshire

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

**Minutes
October 2010**

9:30 – 10:30

6. Call to order

- a. Greetings and Introductions were done.

7. Review and approval of September **Minutes. There were grammatical changes.**

8. A request was made to print out the Ground Rules for the next meeting.

9. Officers Reports:

- a. **Treasurer's Report:** was given by Dianne Crone. A request was made to have membership applications printed out for the next meeting. (They are also available online).
- b. **DDNA Liaison Report:** Quarterly in Mar, Jun; Sep, and Dec. In the September report, Jen brought up an issue about a silent auction, which some nurses had questions about. As Jen was not in attendance, motion to carry this question over to next month made and passed.
- c. **BHF Bureau of Health Facilities** – Jan, Apr, Oct (9:45 – 10:15 full meeting with all inspectors).

10. Unfinished Business:

- a. **How often should a person have to give meds as an authorized person in order to be considered competent?**
 - i. L: One person in day program with meds – retraining is done annually every January, but site training might wait until November. The team leaders are site trained but they do not administer meds.
 - ii. E: How can we make sure the program is up to date – go out every 3 months to do a QA – program manager goes out every two months and doesn't even look at the med book. Program managers need to be med trained!
 - iii. L: Unless we come to an agreement – it is up to the nurse

- iv. E: the person has to have “current knowledge of” how do we know if they have it ? They can call the Nurse Trainer.
- v. S: Should program managers be observed in all ISOs?
- vi. E: W had 50-70 people authorized in one home – makes no sense – how do you supervise?
- vii. G: At Crotched Mountain, how do you justify so many people being authorized?
- viii. P: Everybody has to go to class – how often should they give meds to know what they are doing?
- ix. G: we ask the program managers to give meds one time per month in each home.
- x. S: the managers decide which home to give the meds one time per month, but it should be one that is most representative of the “typical” medication administration. They do not have to go to each home every month but they go into one home – if on call and go somewhere they are not officially authorized and I may do a mod 4 over the phone.
- xi. J: mock authorizations or authorizations over the phone do NOT meet the criteria of “direct observation” as specified in both 1201 and the NURs.
- xii. L: We follow the regulation – if we cannot follow the letter of the law we better have a rationale, such as a snowstorm, etc. I agree with the one month except for day programming – no way I can get everyone site trained one time per month – in general it is a logistic impossibility.
- xiii. E: what S and E were saying is common sense – direct observation is in the reg.
- xiv. The suggestion that med authorized staff have to pass meds one time per month in order to stay authorized is NOT in the regs!!
- xv. J: This again should fall to nursing judgment. How often you supervise one person may vary widely as to how you would supervise another person – it comes back to competency.
- xvi. D: how is it being tracked – if I have four program managers do they call me? I would want it to be their responsibility.
- xvii. D: we have a calendar on the wall and they initial where they gave meds in
- xviii. E: it is that we are giving meds in a regular way, not that we are observing them every time.
- xix. M: when you do a QA you will see how often they administer meds.
- xx. C: When I’ve done it over the phone – somebody that was a manager had expired, they had an appointment to meet with me but it had been rescheduled and they had to give meds so they called me so I did it over the phone and then did an occurrence report because it was a snowstorm.
- xxi. L: I needed to write something so I used the form too
- xxii. M: That is why it is an occurrence form.
- xxiii. B: There were unauthorized staff giving meds so it’s an occurrence:”
- xxiv. M: it is a good way to track things.
- xxv. S: do we put it on a 1201A
- xxvi. C: it is not reportable
- xxvii. M: nurses do report those kinds of occurrence – put it as a paragraph down at the bottom of the 1201A form.
- xxviii. S: Under trends I put it as a notable event – but it does not fall into any categories.
- xxix. D: program managers are responsible to make sure the staff is trained! Why are we not better covered? It is a safety/staff issue.
- xxx. E: how to you supervise people – managers are med trained – not in all 13 homes but I know they are competent so in an emergency I know they can do it.
- xxxi. D: at the 11th hour it is not a nurse issue it’s a staff issue.

- xxxii. C: would be on the nurse if anything happened – managers need to take more responsibility. If a person had a G Tube with lots of meds I had go to the program – it is on us and our license.
- xxxiii. E: I had to go out in an incredible lightening storm once.
- xxxiv. L: to make a blanket statement – I have worked with service coordinators that go through recertification yearly but they do not pass meds every year, but the service coordinators manage our home but they know their individuals. It is up to us to know if they are competent or not.
- xxxv. K: Program managers should be the one who is the most competent!!!
- xxxvi. L: it depends on the people, situation, and knowledge base. We are backing ourselves into a corner when we over regulate ourselves.
- xxxvii. L: I agree with her – it should be up to nurses’ judgment – make sure you document.
- xxxviii. K: if all program managers are not trained that is very odd – it is RIDICULOUS that a program manager is not med trained – It is part of good management.
- xxxix. M: it could be that turnover affects why some are not trained.
 - xl. K: it should be a prerequisite to be med trained to be a program manager!
 - xli. E: a number of managers are not med trained not because they are new – we are getting very large and we have lots of forensic programs.
 - xlii. L: it’s a confusing issue because program managers mean different things in different agencies
 - xliii. E: our are called managers – we have one that is overseeing 13 homes but is not med trained. I had a lady who had her hip replaced who had Down syndrome and then talking to the manager who had never been med trained she had no idea what the individual needed.
 - xliv. K: nurses should NOT be in this situation – someone besides the home provider better be med trained!
 - xlv. L: everyone in our agency IS med trained – you cannot tell me that they have to pass meds every month to stay authorized.
 - xlvi. C: our managers are manipulative – some will call you to be observed – we do not hear from some of they so they do not have to be on call.
 - xlvii. P: our agency used to mandate this – they would never not be observed.
 - xlviii. E: We should not have to explain why managers should be med trained – they should take ownership. I have an individual who self medications and their meds are locked in a safe – I call my program manager to say they can’t lock up the meds – it’s a client rights violation.
 - xlix. K: the regulation has always been silent on that.
 - l. R: we have had a great discussion and I have learned a lot for my practice. The house managers in my programs better be med trained – I am not doing their job for them!
 - li. KD: how will the state surveyors interpret a policy that we set?
 - lii. J: This should fall to nursing judgment. How often you supervise one person may vary widely as to how you would supervise another person – it comes back to competency and being in compliance with the NURs not the 1201s. I make a motion that we leave this frequency of how often a person has to administer meds in a program to be considered competent to nursing judgment and compliance with the NURs delegation requirements and not set a particular time framed policy around this.
 - liii. Motion passed in unison – no dissents.
 - liv. M: I just want to say it is the philosophy of our agency that training in general is very important.

b. Omission vs. Documentation

- i. D: if the 8am box has no initials and no other box is missing initials – can't I call and speak to the person and write on the back – does it always have to be an occurrence?!?
- ii. E: it's a documentation error!! I believed him that he gave it!
- iii. D: we teach in our curriculum to circle the error.
- iv. D: if a person remembers giving it then I believe them.
- v. E: how can you remember 6 months ago?
- vi. D: have you ever been cited for calling it a documentation error?
- vii. C: if someone is shaky I would write it up.
- viii. R: in our training we use the dot system – that would mean they didn't do the triple check – if there's no dot and no 1st initial, I call it an omission.
- ix. S: if it's not documented it's not done!
- x. W: when we look at the documentations error we're not sure because people all report it differently – some have a system and some use trust – there are so many variables – in the end the numbers are meaningless anyway because of the many variables.
- xi. E: take documentation off the 1201 A form and focus on nursing care and off the minutia.
- xii. L: if we take off documentation from the 1201A form – do we leave it to nursing judgment whether or not it's an omission?
- xiii. All of us report differently – some nurses are more stringent than others.
- xiv. S: is there a way to standardize?
- xv. B: we should leave it to nursing judgment.
- xvi. D: we all have our own policies but if the nurse in her judgment feels the person gave the med, I see no reason to fill out an occurrence report but it should be documented
- xvii. L: you would take a person's word?
- xviii. D: that's the nursing judgment – it's up to me as long as I document it.
- xix. L: I'd like to have objective data –I'm not going to do anything I can't justify.
- xx. D: then how do you make that determination?
- xxi. J: we need to get away from this – in the scheme of issues, how important is this? It is more important to find out what happened and how to correct it to prevent it from happening again, rather than spend so much time deciding what category it should be in. How is the individual? What med was “omitted?” What system is in place to help authorized staff safely administer meds?
- xxii. L: I don't appreciate being a bean counter.
- xxiii. E: we serve a lot of people and we need to have standards. If an individual has a hip replacement I want to be there – we have hospitalists now and they don't have a clue who our person is – my goal is a successful hip replacement.
- xxiv. L: we don't have that luxury but I hope that it comes to that. Until something comes off our plates, such as What deficiencies do I have to avoid?
- xxv. L: that's what we should be doing – as a nurse case manager I get to do that. Our agency has that ability to go to the hospital.
- xxvi. D: in some cases that's a delegatable task – I make sure a full time staff person who knows that person to be there.
- xxvii. DB: We need a case study and evidenced-based practice to help us become reporters.

10:30

11. **Bureau of Health Facilities:**

- a. Peter Bacon introduced all the surveyors, stating he brought the same type of report as when he came in June, and that we were pretty consistent with that report, with the problem area still consistent, mostly missing parts of the PRN protocols and med being documented at the time of administration, controlled meds, and homes taking hits the day of the review



Developmental Disabilities Nurses of New Hampshire

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

November 16, 2010 Minutes

9:30

12. **Meeting was called to order**

- a. Greetings and Introductions.
- b. Reminder to sign the attendance sheet.
- c. Reminder for cell phones off or on vibrate please.

13. **Review** and approval of October Minutes with typographical errors corrected.

9:45

14. **Officers Reports:**

- a. **Treasurer's Report:** given by Dianne Crone.
- b. **DDNA Liaison Report:** Questions from last month were unclear, so we will table this until next month. Quarterly report due for December meeting.

10:00

15. **Unfinished Business: omission vs. documentation continues:**

- a. D: Many of us had our own opinion on how we do things. Maybe those who were not here last month should weigh in on this discussion. After all the discussion we all determined that we have our own ways of doing this as we all know our own providers best and their level of competency.
- b. J: It is not about trust but because they were trained to put their first initial they are not doing the process – it is reported as an omission but I note I believe that they gave it. Except if it is controlled – if the count is correct and the count sheet is signed. Occasionally we count for non-controlled and if the count work out I'll put it as a documentation error.

- c. D: Peridex is on the med sheet but not given with the 8pm meds – those are the type of things not signed for because it's given as hs. In my opinion, it should be the Nurse Trainers' decision because ultimately I'm responsible.
- d. L: I tightened up after our last discussion, but I did put out my own policy if someone noticed within 24 hours I believe them but greater than that it's an omission. In nursing if it's not documented it's not done – but because of our conversation it made me put a new policy in place.
- e. M: I mentioned it at our last nurses meeting – I feel the nurses do a great job – so far it's been up to the Nurse Trainer – that's the way it's always been.
- f. K: I agree with that.
- g. D: on the back of the med log I write an explanation of the error.
- h. K: Documentation error reporting around the State of NH has increased in clarity from the Medication Committee perspective. On the reports we get, we can tell what's happening. The issues become where is the policy and procedure? It is a failure to follow these – how do you know what's going on? The reporting generates statistical data – often not to measure one agency against another, but when there are NEVER any errors we raise our eyebrows – when no one EVER makes a mistake. I believe if it's not signed it's an omission and it is more around a procedural issue. Too many times nothing has been written on the med sheet.
- i. D: how much impact does the training have on the documentation issue? For me, it is a big thing in my class. I have to know they're following procedure. Is there a global answer?
- j. K: a non-answer is an answer. If you use blister packs then you know but we can't measure anything against anything. It's the statistical measuring that is the issue for me.
- k. D: Do any have a policy manual in your agency specific to documentation errors?
- l. K: we have policies – it's been there – our policies are from 1201.
- m. L: written by nurses, passed by the med board – nurses review them. The nurses kind of run their own programs. The 1201 is as clear as it needs to be.
- n. K: It is open to interpretation – there are many nuances.
- o. J: If I am strict in my interpretation and someone else is not and documentation categories go away then public reporting will look much better than mine. Then my company looks bad.
- p. L: You're right – our stats will look different, which is OK. It's not like I've been hiding or skewing.
- q. D: if that documentation category disappears, the certifiers said we can put documentation on the back of the med logs.
- r. K: It should be on the QA too.
- s. L: Every single error is an occurrence – we're not reporting these on the QAs.
- t. D: We have to know if it's a simple documentation error – it's not considered an error if they forget to put a signature on the sign-in page, although then can be recorded as a documentation error. That's where we differ in documenting errors from procedures.
- u. L: See, and that's what I report – I report all of those.
- v. K: another example of how we differ.
- w. D: Peter agreed that this was fine; it still will fall back to whichever surveyor is doing it.
- x. De: The definition of a med error – who wrote that?
- y. D: Can we define it?
- z. P: If there's no initials and not the same day, it's an omission.
- aa. G: But that's what we're saying – everyone does it differently. We have differences of opinions.
- bb. K: The question is on the table – can we come to an agreement and take a stand and it's clear everyone does it differently.

- cc. G: Each case is different.
- dd. D: Group homes should be handled differently than residential.
- ee. K: Day program – someone get eye drops at the day program but sometimes they don't sign for it but they gave it – sometimes they omitted it but they tell me. If you can't trust them, then they shouldn't be giving meds!
- ff. D: Exactly – that's what it's about – we all make mistakes and they need to tell me. That happens for the most part.
- gg. K: our job is to guide people to tell us and to feel comfortable to tell us.
- hh. D: Formally tell us in 1201 how to define what a documentation error is.
- ii. L: If we can prove by counting then it's not an omission but when we don't have proof.
- jj. Ka: If you can prove it I agree, otherwise it's an omission.
- kk. Le: If the review is three weeks later and you can't prove it we're making this complicated whether or not the med was omitted. If there is no documentation beyond twenty-four hours in a staffed home, it's an omission. If it's within 24 hours and they tell me they gave it, it's OK but three days later it's an omission.
- ll. K: if you have staff come in at night - it's all about the corrective action so you can't find the staff who made the error then you have to change the corrective action because you don't know. We have a tighter rein – if it's within your shift, it's OK but if the next shift it's an omission.
- mm. L: it's a double check system in our staffed homes as an incentive to help staff.
- nn. O: what is one day an antibiotic wasn't signed for and you can count it?
- oo. K: we have staff that move around – what if they say, “well, that's not how we did it there?”
- pp. D: We'll talk about this later.
- qq. C: How about we take a hand count now for in favor of an unfilled initial it's an occurrence report if over 24 hours?
- rr. L: put four scenarios down and then we can vote on the.
- ss. K: I'll craft it if you give me the four areas:
 - i. One within 24 hours
 - ii. One if you can prove it by counting
 - iii. Nursing judgment
 - iv. Under no circumstances
- tt. L: what we're saying is if not within 24 hours, the rest is nursing judgment.
- uu. K: I'll bring to the next meeting.
- vv. C: If we determine it given – do we fill out an occurrence form?
- ww. D: It has to be documented somewhere – it can be put on the back of the med log.
- xx. K: This is good conversation – let's see if we have a good outcome.

10:30

16. **New Business** including Nursing Practice Issues:

- a. Ca: is an in-home support and CDS – are they the same thing or are they two separate and distinct?
- b. M: 525s are CDS – we have a situation where parents bought a house for their son and hired a roommate.
- c. Ka: in 525s family members direct the program.
- d. L: we had the 524s with the kids and it's worked well – I go out annually on this particular child and the 525s will be a similar situation but it's worked well and I use the delegation forms.

- e. Ca: I'm in the same boat – we're rolling these out weekly – can we as a NT ask the staff that they be required to attend 1201 class?
- f. D: If you tell a Mom I'm not sure this person is competent that Mom won't say OK – it has to be family driven.
- g. Ca: who makes the determination that Mom is OK
- h. D: You can report to the agency
- i. L: The situation is reportable if it's abuse, neglect, or exploitation – it's really none of our business – if you don't see it keep you're nose out of it.
- j. M: If the parent who runs the 525 wants to QA using med logs, is that OK?
- k. Ca: any med occurrences – how do you handle this?
- l. M: make up a checklist of what needs to be done, go over rights, what's a med, the many components we teach. I use these forms and a few other forms, although I do find them cumbersome.
- m. D: it's a lot of nursing judgment.
- n. What if we go through the process and we can't delegate – tell them what your concerns are.
- o. D: I didn't delegate because of storage – the medication was stored with all the other meds and I felt it was not safe.

Gasping for Relief

Article was sent out by email – any comments?

- D: question – how many are required to have CPR? IPP, Easter Seals, Plus. The American Red Cross changes their standards. Anyone with poor dentition is at risk for choking.
- L: I'm in the process to be trained as a basic rescuer trainer. It will take some adjusting for clients because of their disabilities.
- D: It used to be that any fire department would loan out the mannequins. It is a poor utilization of nursing time.
- M: I have been CPR trained to train – it was tough to do both.
- K: Our staff is all CPR trained and all home providers are all CPR trained in our region.
- D: at our company we are all trained. In our health and safety we have that section on choking – you have to know your clients and if they have choking – dentition issues. We have to educate our staff about the potential for choking.
- De: what about liability and supervision during mealtime issues are huge – anyone can choke but teeth teeth teeth!

Relocation Stress Syndrome Article

- D: moving is stressful – what our clients are going through, sending people to respite one time per week.
- D: the new 1001 5-day requirement is great – even though it's not in effect we're starting this already

New Question:

Treatment vs. Medication – I'm confused as to what we consider a treatment.

- Le: I see Prevident on the med sheet and I'm wondering why – if it has medication it goes in the med log.
- D: I have a treatment sheet that I use for other things.

- K: If it's not medicated and anyone can buy it is it appropriate for him to use as a team decision is a perfect example of a treatment. If we change the scenario and the dentist says use Plavix – what happens to that? It still makes in a treatment and we still have to recognize that it needs to be done.
- J: there still needs to be documentation that it will be reviewed.



Developmental Disabilities Nurses of New Hampshire

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

December 21, 2010 Minutes

9:30

17. **Meeting was called to order with:**

- a. Greetings and Introductions.
- b. Signing the attendance sheet?
- c. Cell phones off.

18. **Review** and approval of November **Minutes** with two corrections.

9:45

19. **Officers Reports:**

- a. **Treasurer's Report:** given.
- b. **DDNA Liaison Report:** Full report in Dec:
 - i. **Mary Gage award is presented at the National Conference** – nominees are put forward who demonstrate commitment to DDNA, need nominations by March 15th.
 - ii. There is a call for a President elect and a Treasurer for the DDNA – Board responsibilities are available online – submit you intent between Jan 1 and Mar 31 with voting from July 1-31st.
 - iii. In the Newsletter, the silent auction is asking us to provide items to be sold, something small enough to travel with. Do we have a product –i.e. license plate frames – something to promote us? The Conference is May 13th-17th, with the 13th a certification prep day. Karen has a flexible straw. Eileen suggested a DD related book. Another suggestion was “Lost in Laconia – for us to buy two copies, one for the DDNA – perhaps put together a basket – Debbie suggested maple syrup and Darlene suggested a moose hat.
 - iv. Steps to Clinical Excellence is the topic for the Conference, with the hotel costing \$135 per night. The brochure is available online – have to pay to park at the hotel. Sat. the 14th is the preconference with mental health and DD issues the topic.
 - v. Kenda – we did T-shirts for the conference in Vermont – if we had a large group, this would be a good time to do this, and plug for representation on the DDNA board from NH. The Conference a fun networking opportunity – there will be a dance the first night of the conference and a dinner party. There has been talk about a hospitality suite.

- vi. Posters – the national organization is looking for poster submissions, an illustrative story of your network. Individual posters are welcome.
- vii. We should market Lost in Laconia – NH is a leader in closing the institutions. There is a call for speakers in 2012. Maybe we should get some of the nurses involved like Sharon Oxx, Mary Smith, and Judith Guertin and get some of the families involved.
- viii. On the DDNA website this morning there was a new post for the front page. The U of Minnesota is participating in health care coordination and study supporting people with DD who also have physical disabilities. The survey takes about 30 minutes and then another one is due in 2-4 months.
- ix. The DDNA is interested in literature reviews. For example, there are lots of people with issues with earwax. (I) wanted to do a literature review doing some research and do an article about the literature – they are always looking for articles.
- x. Upcoming classes at St. A's and there are nursing education opportunities all the time. Joann Jordan is speaking on Alzheimer's in Feb and in March there will be a tour of the brain.
- xi. Wayne passed out handouts of the Rx Locker, which costs \$20.00.

10:30

20. **Unfinished Business** Omissions vs. Documentation errors.

- a. Kenda presented four scenarios (handout) It would be beneficial as a group if we could agree on this and staff the BHF would benefit also. We attempt to contact – the most important piece – is the person getting what they need?
 - i. L: we use a dot system
 - ii. E: we put one initial then a 2nd initial. What if all are signed except one med. We don't teach dots in our curriculum – should we have a more uniformed way to teach?
 - iii. K: this is the purpose of the discussion – we implement policy but don't hold people to that policy.
 - iv. E: are we teaching the dot?
 - v. L: I don't use the initial method – whatever thing you teach if you can verify within 24 hours – after that it's an omission.
 - vi. D: this works in group settings but not in AFC's – I don't have 24 hours – I would be looking at something from two months ago.
 - vii. L: but we have to hold the same standard.
 - viii. D: dost not necessarily mean the person didn't get the med
 - ix. E: we use nursing judgment – LOTS – that's how we got into this!!!!
 - x. Everyone was talking about stats!! To everyone who does it differently – we have done something routinely – it puts more teeth into it.
 - xi. I: in Pathways – our direct care providers are part of a union – they have a grievance procedure.
 - xii. K: HR and I arm wrestle around issues all the time – how as you the nurse to you get to treat people differently. The agency needs a polity.

Discussion tabled 'till next year.

21. **New Business** including Nursing Practice Issues:

- a. Lorene Reagan here to help us understand the distinction between a 521 and a 524 and a 525.
 - i. At first, the 521s were disasters regarding the role of the family, but this was about 20 years ago. Now, a 521 means a person is in the family home with the purpose of maximizing supports for the families that integrate staff who work for an agency and family members. Providers have a contract and there are rules around medication administration.
 - ii. 524 – in-home support for ages birth to 21 had the same growing pains – with working language in the NPA for delegation with statutory changes going on at the same time.
 - iii. 525- people living with families and families overseeing – there has to be a strong relationship with the family. The majority of responsibility and authority to direct services – it’s better! We’re going to trust that families provide the best care and know what their training needs are. Also determines when other family members are providing services what the training should be whether they are paid or not. What are the families’ standards? It is a very different dynamic – we are now in negotiation – they are purchasing your services. A 525 has a contract – is the nurse part of that team? Is there a requirement if Mom wants to train? There is one primary person to decide to direct and manage services with the day to day management and supervision.



Developmental Disabilities Nurses of New Hampshire

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

December 21, 2010 Minutes

The December Meeting was called to order with 27 in attendance and all Regions represented either by Area Agency or Subcontract Agency nurses.

9:30

22. Meeting was called to order with:

- a. Greetings and Introductions.
- b. Signing the attendance sheet?
- c. Cell phones off.

23. **Review** and approval of November **Minutes** with two corrections.

9:45

24. Officers Reports:

- a. **Treasurer’s Report:** given.
- b. **DDNA Liaison Report:** Full report in Dec:

- i. **Mary Gage award is presented at the National Conference** – nominees are put forward who demonstrate commitment to DDNA, need nominations by March 15th.
- ii. There is a call for a President elect and a Treasurer for the DDNA – Board responsibilities are available online – submit you intent between Jan 1 and Mar 31 with voting from July 1-31st.
- iii. In the Newsletter, the silent auction is asking us to provide items to be sold, something small enough to travel with. Do we have a product –i.e. license plate frames – something to promote us? The Conference is May 13th-17th, with the 13th a certification prep day. Karen has a flexible straw. Eileen suggested a DD related book. Another suggestion was “Lost in Laconia – for us to buy two copies, one for the DDNA – perhaps put together a basket – Debbie suggested maple syrup and Darlene suggested a moose hat.
- iv. Steps to Clinical Excellence is the topic for the Conference, with the hotel costing \$135 per night. The brochure is available online – have to pay to park at the hotel. Sat. the 14th is the preconference with mental health and DD issues the topic.
- v. Kenda – we did T-shirts for the conference in Vermont – if we had a large group, this would be a good time to do this, and plug for representation on the DDNA board from NH. The Conference a fun networking opportunity – there will be a dance the first night of the conference and a dinner party. There has been talk about a hospitality suite.
- vi. Posters – the national organization is looking for poster submissions, an illustrative story of your network. Individual posters are welcome.
- vii. We should market Lost in Laconia – NH is a leader in closing the institutions. There is a call for speakers in 2012. Maybe we should get some of the nurses involved like Sharon Oxx, Mary Smith, and Judith Guertin and get some of the families involved.
- viii. On the DDNA website this morning there was a new post for the front page. The U of Minnesota is participating in health care coordination and study supporting people with DD who also have physical disabilities. The survey takes about 30 minutes and then another one is due in 2-4 months.
- ix. The DDNA is interested in literature reviews. For example, there are lots of people with issues with earwax. (I) wanted to do a literature review doing some research and do an article about the literature – they are always looking for articles.
- x. Upcoming classes at St. A’s and there are nursing education opportunities all the time. Joann Jordan is speaking on Alzheimer’s in Feb and in March there will be a tour of the brain.
- xi. Wayne passed out handouts of the Rx Locker, which costs \$20.00.

10:30

25. **Unfinished Business** Omissions vs. Documentation errors.

- a. Kenda presented four scenarios (handout) It would be beneficial as a group if we could agree on this and staff the BHF would benefit also. We attempt to contact – the most important piece – is the person getting what they need?
 - i. L: we use a dot system
 - ii. E: we put one initial then a 2nd initial. What if all are signed except one med. We don’t teach dots in our curriculum – should we have a more uniformed way to teach?
 - iii. K: this is the purpose of the discussion – we implement policy but don’t hold people to that policy.

- iv. E: are we teaching the dot?
- v. L: I don't use the initial method – whatever thing you teach if you can verify within 24 hours – after that it's an omission.
- vi. D: this works in group settings but not in AFC's – I don't have 24 hours – I would be looking at something from two months ago.
- vii. L: but we have to hold the same standard.
- viii. D: dost not necessarily mean the person didn't get the med
- ix. E: we use nursing judgment – LOTS – that's how we got into this!!!!
- x. Everyone was talking about stats!! To everyone who does it differently – we have done something routinely – it puts more teeth into it.
- xi. I: in Pathways – our direct care providers are part of a union – they have a grievance procedure.
- xii. K: HR and I arm wrestle around issues all the time – how as you the nurse to you get to treat people differently. The agency needs a polity.

Discussion tabled 'till next year.

26. **New Business** including Nursing Practice Issues:

- a. Lorene Reagan here to help us understand the distinction between a 521 and a 524 and a 525.
 - i. At first, the 521s were disasters regarding the role of the family, but this was about 20 years ago. Now, a 521 means a person is in the family home with the purpose of maximizing supports for the families that integrate staff who work for an agency and family members. Providers have a contract and there are rules around medication administration.
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11:30

**We had our Annual Holiday Luncheon, with many door prizes and GREAT food!!
 Thanks to all who make this such a great affair!
 Happy New Year!**