



Developmental Disabilities Nurses of New Hampshire

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

DDNNH@dhhs.state.nh.us

Minutes

December 16, 2014

1. **Meeting was called to order with 16 initially in attendance, then 29 by 9:20am**
2. **Review** and approval of November 2014 minutes as written.
3. **Officers Reports:**
 - a) **Treasurer's Report:** Read and accepted.
 - b) **DDNA liaison report:** Diane Moore will be the new executive director for DDNA as of 1/1/15. A reminder that DDNA has CEUs available free on their website for members (and a plug that DDNA membership is supported by BDS – see the paragraph on the back of every month's agenda). Jen reminded/informed Wayne that historically DDNA has required an annual network report due by the end of January – though there may be new processes with a new executive director. Jen volunteered to help as needed for the report completion.
4. **Business Discussion:**
 - a) **FAQ update** – thank you to those who have reviewed and provided comments. We will pend discussion of our homework to January's meeting. If you didn't finish your review – now you have extra time. In particular focus on: 1) flow within category heading, 2) clarity of information provided (one reviewer helpfully questioned a statement that would have changed the practice to something that was not considered nor approved), 3) are any questions missing – send/bring these to Jen to collate for future subcommittee meetings.

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

The draft version is currently available in eStudio.
 - b) Jen is not requesting copies of our various projects in process to be printed out by the state for the group each meeting – this is too much paper usage. She is also not volunteering to print multiple copies at her agency's cost. Individually we should be able to share the cost of printing if a paper copy is needed. People who do not have eStudio access to these documents may request copies via email from Jen at: jboisvert@resresources.com
 - c) **HRST recommendations collation** – thank you Debbie for taking on this task! Debbie collated the information she received into a document that was posted on eStudio. Cheryl provided a copy of this to Denise Sleeper and Lorene Reagan this morning – Denise sends a big thank you to the group for our responses. Denise will be joining our meeting in January to talk more about HRST – Cheryl will invite her (to make sure that she is available that day) and email Jen with her availability and desired time.
 - d) **Kiki's clarification questions** – review by the members present of the discussion from November's subcommittee meeting. Please see attached list of questions and responses for the results of today's meeting discussions. (Group responses for Kiki and Peter's discussion were incorporated with the recommendations from November's meeting and presented verbally to them. Where applicable expanded comments were added in the notes from the discussion with Peter and Kiki. Jen will send Kiki this attachment as soon as possible.)

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

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

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

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

5. Thank you to Peter and Kiki for continuing to engage in collaborative discussions. Peter will be back at our March meeting.
6. **Reminder of new business** – 3 hot button issues – send them to Cheryl today if you have not already responded to this request.
7. Meeting ended on time for our yummy holiday party offerings and fun Yankee swap – thanks to all who participated!

Next Meeting will be January 20, 2015 .

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

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

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

- Omissions
- Wrong Time
- Wrong Dose
- Wrong Person
- Wrong Route
- Only Concerns about documentation issues

DDNNH response:

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

From Kiki:

2. Things I am seeing out there!

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

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

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

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

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

From Kiki:

3. **QA's:**

- 6 months means 6 months? It doesn't extend until the end of the 6th month?

DDNNH response:

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

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

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

From Kiki:

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

DDNNH response:

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

From Kiki:

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

DDNNH response:

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

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

From Kiki:

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

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

From Kiki:

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

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

From Kiki:

8. Medication Logs:

- If an agency uses monthly medication logs for **PRN medications** should there be one for every month?

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

From Kiki:

9. Health Care Coordination:

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

DDNNH response:

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

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

From Kiki:

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

DDNNH response:

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

From Kiki:

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

DDNNH response:

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

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

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

From Kiki:

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

DDNNH response:

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

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

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



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Minutes

November 18, 2014

1. **Meeting was called to order with 27 in attendance**
2. **Review** and approval of October 2014 minutes as written.
3. **Officers Reports:**
 - a) **Treasurer's Report:** Read and accepted.
 - b) December DDNNH meeting – do we want to have small gifts purchased and brought to the meeting as in past years (paid for through our group account) or continue last year's Yankee Swap (brought by those participating)? The majority of those present remembered last year's Yankee Swap as a fun experience worth repeating. Those who are interested in participating can choose to purchase something (limit of \$10 please) OR bring something that is gently used. The emphasis of those speaking was on keeping FUN in mind. ☺
4. **Business Discussion:**
 - a) **FAQ update** – due to time constraints for other tasks, the group agreed to work on reviewing these independently over the next month. Each NT will be responsible to review the FAQ work that the subcommittee is presenting (available in eStudio in projects in process folder). New NTs are asked to review and comment since your new and unbiased eye would be particularly helpful in this process.
 - 1) Review for flow within a category (there are 7 – only the first 5 need review)
 - 2) Review for clarity – is the topic clearly identified and does the following information fit/answer
 - 3) Consider if there are questions that are not asked in this current FAQ work – share them via eStudio or email (Jen will collate topics for future consideration for the group).**Action deadline** – next meeting – December 16, 2014
 - b) Stable client (psychiatrically) – pended to the January agenda as the person posing the question was not present at today's meeting.
 - c) Discussion on med error – should it be counted: Individual moved to a new certified setting with order for Buspar 15mg 2 tabs TID (90mg/day). Supply was running out, individual had gone to START house, PCP called for renewal – order from PCP was for 30mg 2 tabs po TID (double the previous dose). HCP gave according to the PCP order – did not notice the change and so did not contact NT or guardian. The increased dose was given for 42 days. The order and label matched. (The individual happened to have an appt to see the psychiatrist the day after the dosage change was found – asked if any blood work or follow up needed – psychiatrist said no.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion from group present:

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

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

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

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

Decision: service coordinator with input from team members

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

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

- e) Request from last meeting to describe NT approval of PRN protocol when there is no means for NT to go to the home on the day of the order or electronically provide a completed document. The NT can be consulted by phone and instruct the authorized provider in translating the prescriber's order onto the PRN protocol form. The authorized provider will write the information onto a blank PRN protocol throughout the discussion. Once completed, the authorized provider reads back what was written on the protocol. When NT and authorized provider are in agreement, the authorized provider documents under the signature line of the protocol a variation of this phrase: completed via phone conversation with "insert NT name" on "insert full date" at "insert time". This will then be a NT approved PRN protocol. The NT will sign it in person at the next visit.
- f) Kiki's certification clarification list – discussion began, time ran out. A small group agreed to continue the discussion after the meeting and the whole group agreed to change the start time of our December meeting to 9am in order to review the answers generated prior to Peter and Kiki joining the group at 10am.

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

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



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Minutes

October 21, 2014

1. **Meeting was called to order with 34 in attendance**
2. **Review** and approval of September 2014 minutes with one change – add statement about reporting of cert deficiencies (Box 9 on 1201a long report).
3. **Officers Reports:**
 - a) **Treasurer's Report:** Read and accepted.
4. **Business Discussion:**
 - a) E-studio check in – all present are aware, though some have not accessed.
 - b) Can members who live or work far away and can't make it to the meeting access us via technology. Call in, videotape, audio tape, Skype, facetime. This would mainly be for specific presenters, not necessarily for the entire meeting. We have access to technology for phoning in more than one person, they can be muted – so we don't hear what is going on where they are, but they can still hear. The barrier for this technology is limited range of picking up speakers and potential echo or distortion in what they are hearing because of the size of the room. Kenda volunteered to ask Maureen our questions and the answers will be included in these minutes. Questions to ask about the phone in tech:
 - a. are there additional mikes? (after the meeting Kenda and Jen learned that there are 4)
 - b. Is there a line limitation? (after the meeting Jen learned it is unlimited)
 - c. What is the number to call if we want to pilot it? (we don't have it yet, still in process)
 - c) DDNNH email address list – everyone present today received last week's email. Maureen informed Jen that she has been receiving bouncebacks of emails that don't work. Reminder – if you change email addresses (whichever you have listed with us), please send the update to Maureen so that you will still get our info. Jen requested that those present today review the provided Nurse Trainer by Region list for accuracy – both for yourself and for your agency. Thanks!
5. **Certification Questions – Peter and Kiki:** First - a big **Thank You** to Peter and Kiki for their continuing interest in collaboration with our group!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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Minutes

September 16, 2014

1. **Meeting was called to order with 33 in attendance**
2. **Review** and approval of June 2014 minutes as written.
3. **Officers Reports:**
 - a) **Treasurer's Report:** Read and accepted.
 - b) **DDNA Liaison Report:** Ellen spoke for Wayne who had not arrived asking what was to be included. Jen responded (as a past DDNA liaison reporter) – to check the DDNH website for updates of interest to us. – to check the DDNA newsletter (a call for articles was recently sent out). – to provide info about the upcoming conference when available (we know it is in Atlanta, GA next May 2015). – Kenda reported the news that DDNA's executive director contract will not be renewed at the end of this year. What changes this will bring are yet to be seen – however, it does mean that if you call DDNA you will receive limited info about the upcoming conference.
4. **1201A training by Wayne King: Thank you Wayne! Great job!** (These are a few points from the presentation, not a verbatim transcript.)
 - 1201 forms on the DDNNH website are PDF version – however, the med committee prefers typeable submissions. (Jen's note: typeable versions were sent out to the DDNNH group back in May 2014 via email, they are now available on our e-studio folder, some area agencies send them out as an attachment along with the reminder for upcoming reports due date)
 - Med committee composition – primarily volunteer board, review of types of representation sought for membership, Jen McLaren, MD is the chairperson. The med committee is there to help.
 - When 1201 reports are created – 1201a reports are the opportunity for the NT to review error trends for their caseload, 1201b reports are the opportunity for the agency to review error trends for the company's caseload and 1201c reports are the opportunity for the area agency to review error trends for the full client overview. This system provides 3 levels of review – from specific to general.
 - 1201a short form – used for a program that has no errors. Self medicating programs ARE NOT reported.
 - The short form can still be used if there are OOS He-M 1201 deficiencies (that are not med error related in this reporting period) – the deficiency citation can be commented on in the Other Concerns box.
 - Box 3 – Reporting Period Date – should be fixed dates for the entire expected period. If a program opens and closes during the reporting period, those dates can be included on the service name line under the specific service name.
 - When calculating your hrs per month – don't forget to consider time you spent training program staff in class etc – not just the time that you are at the program for QA and med observations.
 - 1201a long form – used for a program that has errors. Self medicating programs ARE NOT reported.
 - Often the first box in the shaded area does not have the REGION filled in.
 - Any information that is not completed by the NT (or added by the person completing the 1201b form at the specific agency, or added by the person at the area agency completing the 1201c form) will be sent back by the med committee to be completed.
 - Box 3. Service Name – this is never the client's name. It is most often the address, could be the provider's last name. Whatever the program's certificate identifies the name as is what should be entered here.

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

5. Business Discussion:

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

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

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

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minutes FINALIZED.doc*

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

Finalized DDNNH September 2014



Developmental Disabilities Nurses of New Hampshire

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

DDNNH@dhhs.state.nh.us

Minutes

June 17, 2014

1. Meeting was called to order with 23 in attendance

- a. To receive an electronic copy of the most current medication certificate please send an email request to the DDNNH email address. (At members' request, the spaces to remind the authorizing NT to include dates of effectiveness were put back onto the certificate.)

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

3. Officers Reports:

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

4. Business Discussion:

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

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

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

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

- c. Item j) **Medication Logs** – sampling by state reviewers of med logs was a conversational suggestion. If a nurse trainer finds a reportable med error, then the nurse trainer is obligated to report the error to the area agency and medication committee.
- f) A question was asked if anyone had heard of med observations being conducted through Skype? – no one at the meeting aware. Peter's group was asked by the questioner and responded. One NT did say that she had heard of in a limited/rare circumstance, but not as a general practice. Because of time constraints this discussion was pended to our next meeting.
- g) Question was raised about how to do med observation in a day program when only prns (specifically Diastat) are ordered since mock observations cannot be done. This remains a challenge with no set solution that works for all scenarios. Suggestion made to use a trainer (ex. auto injector for epinephrine has a trainer). One NT mentioned that a Klonopin wafer could be a possible substitute for prn Diastat.

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

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



Developmental Disabilities Nurses of New Hampshire

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Minutes

MAY 20, 2014

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9:30

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

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

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

9:45

3. **Officers Reports:**

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

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

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

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

1. DDNA Liaison: Wayne Ward

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

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

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

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

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

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

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

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

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

**Linda Catalano RN
Exiting Secretary DDNNH**



Developmental Disabilities Nurses of New Hampshire

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Minutes April 15, 2014

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

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

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

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

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

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

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

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

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

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

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

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

Can have folder of documents. Comment section for document can be useful to share info.
e-team – will list members plus contact info if they added extra info (e.g. address, phone number, other email address)

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

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

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

2. Officers' Reports:

A. Treasurer's Report read and accepted. Dianne will continue to collect membership dues.

Reminder: Only members with paid up dues are eligible to vote.

B. DDNA Liaison Report: N/A

3. New Business:

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

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

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

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

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

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

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

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

3. Unfinished Business:

- a) Peter Bacon:** Will attend the May meeting to discuss certification issues, etc. Group members were asked to respectfully provide Peter with a heads up prior to the meeting for any topics that he might need to gather info/input first. Other than those noted above, people are individually expected to f/u.
- b) FAQ's:** Since we ran out of work time in March, the group was asked to consider how to keep the project moving forward between meetings. Martha and Penny volunteered to work as a sub-committee on a section of the FAQ's. Martha was unable to attend April's meeting. Denise volunteered to review the minutes over the last 18 months for additional information that may need to be added to the present FAQs – however, she was unable to access the minutes and print them off. Jen Boisvert provided her with copies. Next group work meeting will be at our June meeting. Jen proposed that interested members of the group could continue to the work over the summer if needed. Jen spoke with Maureen to book us a room on the 3rd Tuesday of July and August from 9 – 12 with a screen and projector. Necessity and work partners will be determined at the June meeting.

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

Respectfully submitted by Jennifer Boisvert, Acting DDNNH Secretary



**Minutes
March 18, 2014**

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

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

- a) Review of He-M 1201.06
- b) Review of proposed minimal expectations for individual agencies to establish
 - 1} Method of consistently documenting certification period
 - 2} Medication administration re-training processes
- c) Review of proposed versions to be considered:
 - 1} Once the medication certification period ends, the provider is no longer authorized to administer medications. The provider will not be able to administer medications and would need to go back to the full medication training class. No leeway.
 - 2} Once the medication certification period ends, the provider is no longer authorized to administer medications. Any administration occurring after certification has lapsed will be considered a med error. If lapse is discovered/known within a month, then re-training according to usual agency recert process occurs. If longer than 30 days, refer back to #1.
 - 3} Once the medication authorization certification period ends, the provider will no longer be authorized to administer medications. Regardless of the time lapsed, direct clinical observation will be done to reestablish medication privileges (must include minimum regulatory requirements). Please refer to He-M 1201.06 for specific requirements.
- d) Version 2 was agreed upon by the majority of the members present. Kenda will format our statement and send Peter Bacon and his staff for review and comments and then will send on to the Med Committee for review. Some members of the group would like a discussion with Peter and his staff about developing an exception that pertains to a med certification that expired while an authorized provider that was on an approved leave of absence.

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

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

2. Officers Reports:

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

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

Responsibilities of DDNA Liaison at the conference:

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

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

11:30 3. Unfinished Business:

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

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

Respectfully submitted by Linda Catalano, DDNNH Secretary



Minutes

February 18, 2014

9:30

1. Meeting was called to order by Vice President with 13 in attendance. (President was unable to attend this month's meeting)
2. Review and approval of Minutes without corrections

9:45

3. Officers Reports:
 - i. Treasurer's Report: Read and accepted. A decision was agreed upon that membership will continue to purchase coffee for our monthly meetings and members will bring their own refreshments if desired.
 - ii. DDNA Liaison Report: Kiki was not present for the meeting. Jen voiced concern regarding AV equipment that our speaker may need for next month's educational presentation. Jen will contact Kiki to ask.

10:00

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

4. Clarification of test and answer keys were suggested
 5. The site cannot be queried which causes difficulty when looking for specific information.
 6. Information related to camp for individuals could be listed under the "For Your information" Category.
5. **DDNNH E-Mail List:** The general email list will be maintained by the state using the new DDNNH email address. All requests for information to be sent to our group and other pertinent questions should be sent to the DDNNH address: DDNNH@dhhs.state.nh.us
There currently are 3 state employees who have access to the email (Maureen, Deb and Peggy Sue) and one of them will direct questions to the appropriate members of the group.
6. **Question related to certifications requiring immediate attention:** Call Peter Bacon or another Nurse Trainer.
7. **E-Studio:** A decision was agreed upon to invite Ken L, the liaison from the State who manages E-Studio, to the April meeting so our membership can make an informed decision as to whether this would work for our group. (E-studio could be a means for us to form remote work groups electronically which would enable interested parties to focus on development of progress on DDNNH projects without increasing our monthly meeting time.)
8. **New He-M 507 Reg:** There are no changes for Nursing other than knowing the name of the regulation has changed from Day Services to Community Participation Services (CPS). HRSTs are mentioned in the new reg - to be used as a tool to provide health related information to those who are providing services.
9. **Group Decision on How to Handle Expired Med Certifications:** Peter Bacon has asked our group to prepare a uniform statement as to how this should be handled. Once developed we will send to the med committee for review, comments and approval. Due to time limitations the group was asked to come to the next meeting with a statement prepared to discuss.
10. **Communication with Med Committee:** Presently Wayne King is acting liaison between the med committee and questions we may have. Questions can also be directed to the DDNNH email: ddnnh@dhhs.state.nh.us
11. **New Business including Nursing Practice Issues:** Deferred to next meeting.
12. **March Meeting:** It was decided that the meeting hours would be extended from 9am to 12noon for all those who wish to attend. This will allow some extra time to work on above stated issues in addition to the previously scheduled speaker.

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

Respectfully Submitted,

Linda Catalano RN



Developmental Disabilities Nurses of New Hampshire

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

January 21, 2014

Minutes

9:30

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

9:45

3. Officers Reports:

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

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

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

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

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

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

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

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

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

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

- b. Peter shared with the group some of the surveyors' medication related "horror stories" they have encountered.
 - c. A question was asked about signing ISA, health histories, HSI etc. – how to do this if you do not know the individual receiving supports. The He-M 1201 rule does not state that the annual service agreement (ISA) needs to be signed by the nurse, only that it be reviewed by a nurse. Each agency has a responsibility to figure out a process to ensure the intent of the regulation is met.
 - d. Last updated 1201A report was August, 2013 – it is available in PDF form on the DDNNH website. Everyone should be using the latest forms. The 1201B report form was updated in November 2013 – remember - this is to be completed by the director or director's designee (which specifically cannot be the NT).
 - e. A question was raised about clients transferring from one area agency to another with no psychiatric follow through. The new area does not have community psychiatric practitioners available to take on – previous psychiatrist is not willing to keep prescribing since they are no longer following the client. Discussion ensued about the challenges in the NH mental health system – perhaps partnering with MCM to find solution(s). A secondary question was raised to the group asking if anyone knew if there had been an understanding about NH Medicaid requiring individual to see a psychiatrist prior to accessing counseling services – no one present had knowledge that this was true.
 - f. A question was raised – is there a plan for managing transition issues identified with managed care as we look to the future for Stage 2? Answer – unknown.
5. **New business:** Kenda brought up that we had talked about in December sending around a form to document specific concerns/issues regarding HRST – we ran out of time at both meetings – suggested that they can be brought to the next meeting or sent to Judy individually or creating a trouble ticket in the HRST system if the concern/issue is too specific.
6. **Unfinished Business:**
- a. Frequently asked questions work was deferred to Feb meeting due to time constraints.
 - b. E- Studio; we will put on agenda for a discussion as to whether we would like to be part of this communication web site at a future meeting.

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

Respectfully submitted,

Linda Catalano RN
DDNNH Secretary