



Developmental Disabilities Nurses of New Hampshire

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

DDNNH@dhhs.state.nh.us

Minutes

January 20, 2015

1. Meeting was called to order with 22 in attendance, one member trialed attending by phone

2. Review and approval of December 2014 minutes as written.

3. Officers Reports:

- a) **Treasurer's Report:** Read and accepted. Rivier University scholarship discussion - \$250 given in the past, group voted to commit to same amount again. DDNA conference for liaison discussion – group committed to providing \$545 towards the conference fee (historically this has been the total amount for the preconference day plus the conference at the early registration rate).
- b) **DDNA liaison report:** .Martha Fenn King told the group that she spoke with Mary Alice Willis, prior DDNA executive director, in December and was informed that the HealthSoft CEU access will be removed from the DDNA membership benefits.

4. Business Discussion:

- a) self med (admin) assessment – one member raised a clarifying question – is the deadline for the reassessment to the end of the 12th month – answer – yes.
- b) **eStudio discussion** – who should have access to the DDNNH folder? One suggestion raised was to limit it to paid members of DDNNH – ultimately this was not chosen. Access to eStudio DDNNH folder will be limited to nurse trainers who are either actively working as NT or seeking a position as a NT. Therefore, Kiki will not have access to the folder in her current position with OOS. Cheryl Bergeron volunteered to be responsible for sharing relevant communications from the DDNNH group to OOS. This will allow flow for our ongoing collaboration to continue.
- c) **FAQ** – group agreed that the work done on the FAQ updates could be posted to the website after format polishing and a few small word changes. A member asked that we be clearer in our use of phrases – some say self medication assessment others say self administration assessment. Self med assessment in some practices specifically means what drugs is the individual choosing to self medicate with – including off label practices, alcohol and street drugs. Therefore the most accurate phrasing for our work would be self administration assessment.

5. HRST discussion excerpts with Denise Sleeper:

Denise shared her appreciation for the information that NTs provided about HRST and the draft protocol (referring to the collation of info sent in December).

Information learned from HRST makes a difference in a person's life and processes to ensure that are being developed.

HRST is a tool designed for a non health care worker to complete and identify any health related gaps.

NT is not required to be the point person.

Service coordinator needs to identify who the most knowledgeable person is – when completing or updating the HRST.

Every Area Agency needs to identify a HRST point person – to ensure raters are trained, processes to implement use of the tool are developed and followed. This point person will be able to determine who needs to have what kind of access. e.g. what access do you have? There is a view only option. This point person will also be responsible for ensuring that there is an accurate log of individuals on HRST – because each area agency pays per individual.

Each Area Agency will be responsible to develop policy to determine who is responsible for what in HRST.

HRST 101 – basic training – looking to be on Relias – which will allow tracking of who has received HRST training.

One member shared – 4 HRSTs due – with deadline of: if not done by Monday this person will be homeless. Service coordinators are leaving off 4-7 diagnoses, incomplete medication section. Denise responded that the deadline imposed upon that NT is NOT the state expectation. It is the area agency's responsibility to have processes in place to emergently serve people who are eligible for services and at risk of becoming homeless.

The HRST protocol (for NH) has bolded **screening** as a reminder that this tool is not an assessment.

Forthcoming changes – there will be a system enhancement on HRST - when a change is made an email will auto happen. One member asked will the auto email notification go both ways – from rater to RN and from RN to rater. Good question – answer unknown, Denise will ask.

Another member commented – oversees individuals receiving services in several regions – for her caseload's biggest region she has no access to HRST for those individuals.

Monthly data tracker – grid for DSP – check off only. Give monthly to service coordinator if there are marks on it and then RN may need to be involved.

Recommendation that DDNNH discuss/compare – HSI and monthly tracker – are there actual overlap items, can the HSI not be used? Are the target populations the same? Where does HSI have content that could be helpful for HRST?

One member commented – the program is not user friendly. Doesn't address: pain, mental health. Feels like it doesn't reflect our individuals and their real lives.

Denise – we haven't given the tool an effective run in implementation to effectively change health outcomes – because as it stands now, our current system is not helping health outcomes as it is (this if based on national health outcomes measures –people with DD compared to people who don't have DD- is there equitable health care access).

Please itemize feedback to the Bureau about specific challenges with using HRST.

Service coordinator group meeting scheduled for Wednesday (1/21) to discuss protocols and systems for HRST implementation.

Area Agency level HRST protocol that Denise has referred to today – Cheryl will share current draft with the group.

Billing – every AA has a monthly contract for \$3/mo/person (\$36 per person per year) for everyone in HRST. The Area Agency has an opportunity for additional billing when HRST completed - \$100/yr

Please consider how HRST could be a better benefit to us – if “x, y, z” were included. RNs could be helpful in reviewing and developing benefits.

CMS has bought into (expectation for use of) HRST implementation in NH.

Next Meeting will be February 17, 2015.

Submitted by: Jennifer Boisvert, RN, Secretary, DDNNH



Minutes

February 17, 2015

1. **Meeting was called to order with 23 in attendance**

2. **Review** and approval of January 2015 minutes as written.

3. **Officers Reports:**

- a) **Treasurer's Report:** Read and accepted. Because Wayne Ward was not present at the meeting, the question was raised for whether he would be able to attend the DDNA conference on DDNNH's behalf in May. Jen asked if anyone was present who had talked to him. Joy Kempton said that she could ask him: if he will be able to go to the conference and whether he has done the network report that was due at the end of January.
- b) **DDNA liaison report:** Jen commented that an email had come out from DDNA with a link to a newsletter – only available to members, but the login didn't work. Other DDNA members present agreed that they couldn't log in. Jen sent an email to DDNA Monday evening. Martha Fenn King noted that she has seen a website under construction notice on DDNA's page.

4. **Business Discussion:**

- a) HRST teleconference – Erin was unavailable to host after our February meeting. Cheryl is in process of attaining a new date. Discussion with those present when preference requested (group experience or from our own computers) – there is a preference for a group experience. Cheryl will try to get a commitment from Erin for after the next meeting (March 17) and if not, then a date will be chosen so that we can participate in this discussion without too much more time passing. The purpose of the teleconference is to openly voice concerns that NH nurse trainers have about HRST in their practice – so that answers can be shared or developed. If the new date is not after a DDNNH meeting, people will be welcome to come to Concord to participate and others will be welcome to participate from their own location. Details will be sent out via email about the date/time. Jen volunteered to send out an email soliciting questions for Erin prior to the meeting – and will post those provided in eStudio.
 - Cheryl said that the plan for roll out of the auto email within HRST when a change is made in a file is scheduled for May/June.
 - One member stated that she feels like she is winging with HRST – she has completed/attended all of the trainings and still feels unprepared.
 - A couple of members questioned why antidepressants are listed in HRST as causing tardive dyskinesia – they have unsuccessfully requested the references to back this up (from HRST). Some members did not know how to find the list of medications in a person's HRST profile that the tool assigns as TD causing.
 - Question was raised – how do we know that the information within HRST is entered correctly (where is it coming from, a reputable source)?
 - One member who works with an agency providing services to individuals in many regions – says that in one region the CM requests updated med lists signed by the physician – no one else present had had that experience.
 - One member asked if it was possible to have the individual's accurate health information linked through a database to HRST. No one present is aware of anyone who has a current electronic system that could do this. It is an intriguing idea – and would require standardization acceptance across regions – which has been a challenge in other areas of service.
 - One member's major ongoing concern, then echoed by others present, is about the liability of the RN reviewer – how is it that we don't have liability – when we are signing off on information entered by someone else without the ability to verify the validity of the entered information.

b) HSI and monthly data tracker tool comparisons – this was suggested at January’s meeting – not something that the group as a whole wants to work on during a meeting. No consensus reached on how to accomplish this comparison. A suggestion was raised to create a “parking lot” section on the monthly agenda.

- One member noted that on the HSI there is no column/question that talks about how the individual communicates – so she adds it on the bottom of the form. This member also said that she had difficulty finding a place on HRST to note if the person is continent or incontinent – Jen suggested Item D – toileting.

c) A member commented that there seem to be new requirements coming forth that require an increase in time spent on checklists and other documents that don’t seem to improve the quality of services that the individual receives. Specifically at her agency, she believes that they have a very comprehensive health related system that has been developed and in place without these new tools – yet the new tools are required and deficiencies are received for missing tools.

- Discussion ensued about the tools themselves not being mandated. The regulation requires certain things be clearly documented. For example the regulation lists 9 areas of consideration for annual health screening – the associated provided document isn’t mandated – an agency can use another means of documenting that these areas were addressed during the annual health assessment.
- One member stated that she understood that the frail worksheet was required – members answered that the tool is available but not mandated. What is mandated is that the NT document that a frail assessment and outcome has been completed.

d) 525 discussion – Martha asked what experiences people present were having with 525 – are you using NUR 404 and how. She had seen an item in the FAQ update about yearly assessment and 525 was one of the regulations listed though there is nothing in He-M 525 that requires this yearly assessment.

- The specific FAQ item was unspecified – when an item lists 525, then the underlying presumption is that He-M 1201 applies. If NUR 404 is being used for these settings (with staff), then the delegation rules are what needs to be followed. When He-M 1201 rules are being used, then 1201 rules need to be adhered to.
- The family situation that made this consideration arise – uses a Phillips medication dispenser – the family sets it up. It’s sophisticated, requires a phone line. The individual could not be successful with self administration without family support. NUR 404 is used in this program – does annual assessment per He-M 1201 apply? No – only applies if the program is using 1201.

e) How long is a PRN order from an ER visit good for? Individual had an order in the community for Motrin 400mg q 4-6 hours for back pain. Pain increased despite use and individual was taken to ER. ER prescriber ordered PT and increased Motrin to 600mg q 6-8 hours – gave 30 tabs, no refill.

- Discussion centered on – this new order supersedes the previous order, the PRN protocol needs to reflect the change, best practice to inform original prescriber of the change.
- This order is good for a year – though, depending on your practice, you may not be able to get supply for that long (in this case only 2 pills were used).

f) Falls prevention series info – included on agenda, uploaded in eStudio. Focus is on geriatrics not individuals with DD or ABD – still may be useful info.

g) A member asked – is there an update on NHH, Lakeview etc? What are we going to have for resources – example – individual living in a group home for about past year. Funded out of one region, physically placed in another and his PCP is in yet another. He has 4 psych meds and no psychiatrist. At Qa RN noticed some EPS symptoms – did assessment and delved deeper into what else was going on with this individual which resulted in the development of a list of issues that need to be addressed: has glasses but they are broken, he’s having problems hearing – ears are full of wax – get a ENT consult, difficult time showering – ortho, environmental mods, needs a psychiatrist. He has a new service coordinator.

- Area agencies are in discussion for a plan, for resource development. No specific news shared about Lakeview, NHH.

Next Meeting will be March 17, 2015.

Submitted by: Jennifer Boisvert, RN, Secretary, DDNNH



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Minutes

March 17, 2015

1. Meeting was called to order with 25 in attendance

2. Review and approval of February 2015 minutes as written.

3. Officers Reports:

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

b) **DDNA liaison report:** New website went live online last week. Annual conference is coming up – May 1-4 in Atlanta, GA. Poster session submission request – no one volunteered to make this happen. Nominations are open for treasurer for Board of Directors. Wayne is not able to attend the conference – DDNNH scholarship open – discussion about how to manage this within the deadline time constraints – decision made for Jen Boisvert to receive the scholarship (and responsibilities) for this year's DDNA conference. Jen says: "thank you all for your vote of confidence and kind words during our discussion".

4. Business Discussion:

a) HRST teleconference – comment responses of attendees varied. Some are still OK in the process of where we are. Others raised concerns about out of date RN knowledge and remaining unconvinced that inaccurate information input by rater doesn't impact liability.

b) Cheryl provided copies to the group of the HRST protocol released from NH DHHS on March 13 to the Area Agencies.

c) Peter Bacon - discussion points raised:

- An individual is new to 1001 services – they have no meds – question from Area Agency – how do we document? Answers from today's attendees: use either the transition form and/or self administration assessment.
- Is self administration assessment annual or PRN? Answer – at least annual
- He-M 507 self administration assessment? No meds while at the program, does get meds at home, never in 507 setting.
- If individual is assessed as not able to self administer, does annual assessment need to be done? No.
- Individual moves from home A to home B – everyone is the same except the actual address – is mod 4 needed (e.g. does NT need to re-observe all authorized providers in new home)? Answer: no, unless there is a question of competency. The NT needs to update the medication certificate(s) – could be a new start date, same end date or could be copy of old cert with notation of new address.
- How do you destroy meds? Meds were flushed – would there be a deficiency cited? No citation because this is not specifically addressed in the regulations. Many present offered the recommendation that we should never be flushing meds – they should be crushed and mixed with something (e.g. used coffee grounds).
- Med committee may ask about how do you (the NT) keep a large number of authorized providers current (e.g. 4 individuals – 29 authorized providers). This raised a side comment about how many sites can an authorized provider safely stay up to date – this is from an old version of the regulation – it used to say 8. Now the regulation is silent – the individual agency can set parameters. The NT needs to have a process in place and be able to articulate it.
- Situation – in a 1001 setting – 300 Ativan in a bottle – haven't used for past year, supply is unexpired. Discussion around destroying a portion, preparing authorized providers to not stockpile or ask

pharmacy for a partial fill (which we know pharmacies do not prefer to do – but will usually do when asked).

d) Penny – HB #2 item #62 proposed to consolidate joint boards of licensures – contact your legislature members. Information is available on NHNA webpage. If this happens, at the very least licensure fees will increase. Links: original bill - <http://cqrcengage.com/nhnurses/app/bill/520213> NHNA call to action update - <http://www.nhnurses.org/Homepage-Announcements/News-and-Announcements/HB2.html>

e) HRST newsletter sign up – If you are a NH RN and not already receiving the newsletter – send a requesting email to: gina@hrstonline.com

Next Meeting will be April 21, 2015.

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



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MINUTES

April 21, 2015

1. Meeting was called to order with 25 in attendance

2. Review and approval of March 2015 minutes as written.

3. Officers Reports:

a) Treasurer's Report: Read and accepted.

4. Business Discussion:

a) HRST discussion continued. Cheryl passed around flyer on HRST 3.0 upgrade. There will be a webinar on Friday 10:30 – 12:30 demo'ing the changes – space is limited. People who indicated interest in participating (outside of the subcommittee looking at redundancy in forms) see Cheryl at the end of the meeting.

Looking at frail list and how to eliminate redundant documentation. Looking to figure out a way for a person who is rated HCL 1 or 2 and has diagnosis like asthma or diabetes that generally are OK – until an episode tips them over into frail period. Only nurses would be inserting this piece.

List of how many people in NH have been HRST rated and/or are still unrated – passed around.

Common med entry errors – we should be sending back to the rater, not fixing it ourselves. Ellen from Region 2 says that the HRST doesn't allow RN to make changes at their agency so they have to send back to the rater for corrections. This seems to be a permissions boundary at this agency rather than something HRS has put in place.

Cheryl – if you as a NT don't have access to your clients' HRST with a particular region – send an email to Cheryl listing who you don't have access to.

b) Nominations – **DDNA liaison** – this is a yearly position. Debbie Ellis-Nailor, Lynn Geoffrion put their names in for consideration. Wayne Ward was not present at today's meeting, Ellen believed that he would be interested to be considered again. **Treasurer** – Dianne is willing to continue in her position – however, she may not be available for the full 2 years. Liz Nelson volunteered to shadow to learn the position since they work together – this will provide us with someone to fill the rest of the position if Dianne does leave early.

c) IM Glucagon – Cheryl looked at waivers going back to 2011 – there were only 2 requests. There is a bill at the legislature now about school access – which would be for non nurses to administer.

Can we waiver this? Do we need to? Depends on whether ordered SC or IM. In 525 example – Mom is trained, wants to have staff – can they be trained?

Does anyone have IM glucagon? – a few people. Wayne K – efficacy of Glucagon SC vs IM is equivalent.

Cheryl – there is a known and accepted protocol for when/how to use Glucagon IM. She has some information from other states about use of Glucagon – all info is about IM.

To all: Please look for Glucagon orders in your program – are they SC or IM? Bring or send info to Cheryl.

Penny found an app for Glucagon – looks pretty clear, has training: lillyglucagon.com

d) Doc-U-Dose/blister pack – handouts provided. What do you do when there's a med change?

Ellen – has an individual who is self administering – most helpful for people who don't have many med changes. Experience with providing pharmacy is when there is a med change, the supply is taken back and re-packaged, this individual has some challenges with different bottles (if you have added med provided in bottle form until current packaging runs out).

Sherrie – Several individuals use in the Nashua area – only one pharmacy (Hollis Pharmacy) – home care providers that use them – swear by them, do their triple check, there is an additional cost. Pharmacy takes back and repackages with med changes.

Penny – pharmacy has sent bottle for med change, RN took the pill out – means that the RN has to be able to identify the med to take out, manage the small slit etc.

Controlled meds – separate container because of need for counting.

Pharmacies have made errors – mostly at first – increase your communication = resolution. In one case it was because the prior authorization ran out, so the med was not supplied).

Ruth – new pharmacy coming to Manchester through Greater Manchester Mental Health Center – The Moore Center will be transitioning staffed residences. Pharmacy will be sending out only 2 weeks supply at a time.

Pharmacies can provide either 2 week or monthly supplies.

e) BDS audit of NT contact hours per He-M 1201.10(d) and (e) – Cheryl will be randomly selecting 10% of NTs and sending out letter to seek compliance information. There was a general discussion about possible places to get credits.

f) New business discussions:

Eileen – passed around handout from NHNA regarding HB2 – strong advocate for keeping separate BON rather than having combined licensing office.

BON has asked to be removed from the med committee – they have not been sending a nurse, usually a nurses' aide.

Penny – surveyor – made a recommendation about how to count Diastat that was not the same as the NT expectation. Staff almost changed to the surveyor's way without discussing with NT.

May 5 – budget discussion hearing – looking for speakers with stories. Have to register to speak, be prepared for a long wait with understanding that you may not be called to speak, then hand in written testimony.

Nurse practice issue: New order for individual with dementia issue requiring self catheterization. Case manager supported the individual at the appt. Staff at the home is very uncomfortable with idea of even helping with this task – this is a very independent style setting. RN is not comfortable delegating.

Another nurse shared a positive story of individual with autism who successfully self cath.

Suggestion to look into self cath products – there are all in one products available on the market.

WellSense – there have been challenges dealing with them approving medications – particularly noted to be slow with approving antibiotics.

Next Meeting will be May 19, 2015.

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



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Minutes

May 19, 2015

1. Meeting was called to order with 25 in attendance

2. Review and approval of April 2015 minutes as written.

a) **Officers Reports:** **Treasurer's Report:** Read and accepted with 2 paid today.

3. Business Discussion:

a) IM Glucagon discussion continued – Wayne K was not at meeting today. Med committee discussed – do you need a waiver or not – answer is not if the order is for SC, yes if for IM. No one emailed Cheryl with glucagon orders. 2 nurses present currently have individuals with IM orders and are in process of changing to SC.

b) Voting – 20 members voted (1 electronically). **Congratulations** to Dianne and Debi - Treasurer – Dianne Crone. DDNA Liaison – Debi Ellis Nailor

c) DDNA conference – next year is in San Diego, CA. April 1-4, 2016

d) 2 handouts from DDNA conference reviewed – DDNA's annual membership meeting and letter from nurse researcher (Kathy Auberry) about participating in an upcoming seizure study.

4. NEPS (Northeast Pharmacy Services) presentation of their medication packaging system. NEPS was created in 2004, they have worked with many group homes and fielded many questions from assisted living facilities. They looked around for the best packaging system to deliver patient safety. Each person present at today's meeting received a NEPS sample folder and example packaging. NEPS is a closed pharmacy – clients cannot walk in off the street. Packaging is done by robotics and they are paperless. NEPS does post consumption billing. Typically med packages are dispensed 1 week at a time – they send 2 weeks supply outside the Concord area – these are mailed. There can be up to 4 doses in each packet.

Q: If there is a change in the order what happens? A: NEPS sends a vial with small quantity to get through to the next package cycle. The home would be responsible to remove the dose that is changed. If this is a non critical order – ask the MD to write the order to start when current supply is exhausted. Worst case scenario – 3 week lag to change package.

Q: antibiotic/critical med – how to manage? A: Example – antibiotic, chronic pain – mail supply out same day the order is received (overnight mailing) – this timing could still be an issue for the patient. Might need to have a local pharmacy if the med needs to start today.

Q: What is the cost of the service? A: \$35 per person charge for NEPS service. CFI waiver can cover fee currently (majority of NTs do not have individuals on the CFI waiver though).

Q: MCO acceptance of this process? A: MCOs don't know yet, meeting scheduled to discuss.

Q: PRN meds. A: Handled separately. PRN meds are not automatically sent. NEPS waits to send until asked. Occasionally NEPS will prompt if there is a pattern of usage.

Q: Camp meds? A: NEPS doesn't package for just camp meds.

Patient/caregiver **MUST** talk with prescribers to clearly say that the **pharmacy of record** is NEPS – so that orders don't go to the local pharmacy.

Concern raised by member re: staffed residences – fear of liability if unlicensed provider is removing dose if order is changed.

Another member asked about how do we ensure triple check process works? Two members discussed their positive experiences – stable meds, not group home. There are a couple of extra steps added. Works great.

NEPS reps – this service is specifically meant for patients whose meds are stable.

NEPS ex. – can split supply if going to dialysis or out with family for the day – all supply is still properly labeled.

NEPS – prior authorizations – can be an issue for billing. If med is dc'd within first 2 weeks of the package cycle – only pay for 2 weeks, not for the rest of the month.

Terri shared her experience with Med World in Nashua – blister pack comes with a sticker – sticker is put on the med log. They have had issues with light sensitive meds and liquids (which can't be packaged). Med World will re-package if you take current supply back. The most useful aspect of this type of packaging – prevents running out of supply.

5. **Peter and Kiki:** Order date that you reference in your med log entry is what you display – age of date doesn't matter. Issue with med log that says 2013, med order itself is dated 2015 – that is a concern.

Q: How long do we need to keep records? A: (from group) 7 years. Although a recommendation from a nurse attorney at DDNA a few years ago was to keep records for 10 years.

Q: Drug info sheets – only need to have ones for current meds in the med log book.

Q: QA when (in 30 days, 1 month) after respite in certified home? A: Old regulation required within 1 month. New reg is at NT discretion.

MFK – He-M 525 has paid staff, lives with family – going for respite in 1001 setting – which rule applies – 525 or 1001? Do we follow the money? A: Peter says can have certified bed for fire code. Doesn't matter for meds – follow the money rule. Peter and his staff don't look at any records for individuals in 525 settings – not in their purview. Peter reminded us that there are currently certified homes that have 1001 certified beds and the same home also provides services for an individual with 525 certification.

Q: How does a NT manage their practice when 1001 and 525 services are provided in the same setting? And there could be 2 agencies responsible for the individuals receiving services. A: Develop a moral best practice.

Q: RN with current license and pharmacist with current RPh – if coming in to administer meds in certified setting – so they need med training? A: No – need copy of license – license needs to be active and in good standing. If they do not want to administer meds using their license, then they do need to be med trained.

Q: compliance form – is it required? A: No – no specific form is required/mandated for any of our work – except 1201 A, B, and C forms plus waiver forms.

Kiki – HSI – not documenting that review is occurring.

Q: Member asked about medically frail – how does NT oversee? What frequency? A: Your agency decides. Related discussion point - Medically frail worksheet – goes to CM/SC – doesn't need to be sent to Cheryl.

Peter's next visit – September meeting.

Next Meeting will be June 16, 2015.

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



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Minutes

June 16, 2015

1. Meeting was called to order with 22 in attendance

2. Review and approval of May 2015 minutes as written with 2 spelling corrections.

a) **Officers Reports:**

Treasurer's Report: Read and accepted.

DDNA Liaison Report: Wayne as outgoing – DDNA website is improving since beginning of the year. Free courseware was due to be available this month – nothing yet. Debi as incoming – encourages our membership to consider over the summer writing an article for DDNA newsletter.

1. Question raised about how to get DDNA membership paid for? Reminder to all present that the back of our monthly agenda has a paragraph about BDS' ongoing incentive program. Many were unfamiliar. One member asked if it would be helpful to develop a templated request – no one signed up to participate in the development.

3. DDNA conference report: Attendees comments: this conference was much more of a nurturing environment for nurses working in the field rather than corporate feel. Photo booth was fun. See attachment for Jen's report as recipient of DDNA Liaison conference scholarship.

4. Business Discussion:

- a. Meeting space for DDNNH – the South Function Conference Room will no longer be available – construction scheduled to start over the summer to turn it into office space. Maureen looked around to find a comparable conference space (that has sufficient room for the attendees and allows food/drinks to be brought in). She was able to schedule our September meeting at Community Bridges in the Wolfenberg Conference Room. CB is located in Concord at 70 Pembroke Road. The group agreed to try this space and see if it meets our needs (and if the host will allow us to come back for further meetings).

Members were asked to think about and suggest other potential meeting spaces in case CB does not work out. In the interim, as a fallback, DDNNH is booked into the Brown Building Auditorium for October and November (only bottled water is allowed to be brought in and the stadium seating makes it difficult to have inclusive conversations).

- b. 1. Diastat – how do you successfully use in public (ex. During day program). Ellen stated that Dr. Thadani, when presented with the practical question of how to, recommended Klonopin wafers. A couple of people also mentioned Midazolam nasal spray – although the wafers are more convenient to administer – you just can't touch them or they dissolve. Wayne King mentioned that in his practice it seems that the Diastat was ordered by pediatric prescribers and just maintained into adulthood rather than discussing practical community needs.

2. Wayne brought a Glucagon kit to show to anyone who has not seen one recently. Discussed IM waivers – BON is not supportive of IM waivers – other than Epi-pen type. Efficacy of delivery system – IV, IM or SQ are all the same – so use SQ. The needle for the glucagon kit is a little longer than an insulin needle. A picture with the difference plus the Glucagon insert info has been uploaded to DDNNH's eStudio acct.

- c. Controlled drug supply – for day program, kept in home care provider’s home while not in day program – does it need to be counted? There was a lot of discussion on this. This specific example is not a shared supply – the home care provider (HCP) has a separate supply for use at home. The day program is community based – but not out of a physical setting other than the home (there is no day program site to go to). One member has a similar situation and instituted a double count system – the HCP and the day program staff count out and in the supply, both signing each time. Wayne King stated that he had seen alternative storage waiver for day program – when the med was only ordered for day program. This could be a possible solution if the HCP does not want to participate in responsibility. However, a waiver would need to clearly indicate that the HCP does not have access to the day program supply at any point.

- d. 5 year plan – NH Council on DD. 21 members sit on this Governor appointed council, divided into 3 categories of 7. 7 members are self advocates or family members. 7 members are mandated seats. Kenda sits on the Council as a member of PPN. The Executive Director, Carol Stamatakis is requesting stakeholder meetings/input. A handout with goals and strategies and the 3 questions for discussion were provided to the group. It is clear that the answers/ideas generated from a group of nurses will likely focus on medical topics – and that is fine. The first question “ What should the future be like for people with developmental disabilities and their families?” was discussed during the rest of the meeting. Ideas for comments for the other 2 questions were welcomed to be submitted via email to Kenda at khowell@resresources.com . The main website for the NH Council on DD is: <http://nhddc.org/> and the current 5 year plan (expiring 9/30/16) can be found in the list on the left hand side of the webpage. Here are the concepts offered during the meeting that Jen captured:
 - a. Employment opportunities – provides sense of self worth. Cautionary tale was offered by Debi – her daughter has worked for dining hall at local college. She wants to work more hours, but her work ethic and output is so great that she gets a raise and that results in a decrease in hours offered. She was originally working 25 hours a week, now works 7 – the rest of the time she is sitting at home.
 - b. Neuropsych unit or psych services availability. NHH just flat out refuses to take anyone with IDD.
 - c. Dental health opportunities missing – need more than just extractions
 - d. Vocational goals are not appropriate for everyone – shouldn’t be a cookie cutter approach. Ex. Offered – 80 year old receiving supports, still has a vocational goal.
 - e. Educational programs for providers/families for health issues/potential (better preventative education and healthcare)
 - f. MCO seen to be looking at goals as more measurable and related to health (more realistic to ISAs)
 - g. Natural supports – sometimes natural supports is someone else who is receiving supports has developed a friendship relationship. Sometimes 507 CPS interpretation is ripping apart friendships that have developed.
 - h. Focus on families – more available respite.
 - i. Sexuality – needs to be addressed.

- e. FAQ update work this summer – Jen asks if anyone is interested and available to meet in July and possibly August. There are several topic areas that were identified in our last overhaul effort that are not addressed at all in FAQ that could be helpful. Eileen Murphy-Hamel stated an interest, Leslie said maybe there is some interest of nurses in Region 5 – she will check into it. Jen will send out an email to the group to see if there are enough interested members (need 5-6, not more than 10). Currently BDS conference room is booked for us from 9 – 12 the 3rd Tuesday in July and August as a possible workspace.

- f. The group was asked if nurses are being asked by other agencies to create care plans. All present (other than the member asking) said no.

Next Meeting will be September 15, 2015 – NOTE LOCATION CHANGE (see 4 a) !!!

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



Developmental Disabilities Nurses of New Hampshire

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

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Minutes

September 15, 2015

1. **Meeting was called to order with 22 in attendance**

2. **Review** and approval of June 2015 minutes as written.

a) **Officers Reports:**

Treasurer's Report: Read and accepted.

DDNA Liaison Report: DDNA certification discussion. Reminder that the 2016 conference is in San Diego – DDNA is looking for speakers. Membership fees for national are \$80. There are 3 courses coming up – free courseware for DDNA members. The Mary Gage award went to Mary Gage this year. Debi reminded us to consider writing articles for the DDNA newsletter.

3. **Business Discussion:**

- a. DDNNH meeting space in October – group decided to try the Crotched Mountain conference room at ATECH – 57 Regional Drive #7 in Concord. It's the last office on the end. Community Bridges space was fine – not many more members would fit comfortably in the space. CB also cannot book out the conference room into the future and we could be bumped if they had a priority need for the space.
- b. Nurse practice question – if a recert med certificate is dated 3/31/15 – 3/31/16 with a notation of med observation 5/20/15 – is this OK, has anyone seen this before? Answer – depends on particular agency policy for recert. Class vs service dates can be different. It's possible that this authorized provider attended a retraining class with the agency and then was unable to be med observed for a variety of reasons until 5/20/15. So long as meds were not administered by the provider and the agency's recert process was followed this is OK. An example was raised of the individual receiving services no longer receiving meds – then how do you med observe the provider? – as a potential rationale for the difference in time. Jen added – consider developing/delineating policy for the agency that you work for/with to address this challenge.
- c. Cheryl – has received requests from companies to present info to the DDNNH group. Compassionate Care Hospice - serves Manchester/Londonderry area. MassTex Imaging (now that they are NH Medicaid authorized – yay!). Members of the group were OK with presentations so long as they are not all at once and don't take up entire meeting. Cheryl will work with both groups – hospice sometime in beginning of 2016, MassTex with van hopefully in November. Jen – if MassTex comes in November, it will be good information to have, there won't be time to get CEUs or contact hours. A new member to the group thought that there was a quicker process than we last experienced and will research it and get back to us.
- d. Penny – shared positive experience that she had using Convenient MD urgent care in Concord. They were very accommodating to request to not have individual have to wait in the waiting room – in fact they pre-registered over the phone and the individual was actually seen in the parking lot. Good paperwork, they sent the info to the PCP office, called to check on the individual.
- e. Ellen M shared with the group that Dr. Thadani at DHMC-Lebanon is not just a neurologist. He also has a dental clinic there – which she has had good experiences with.
- f. Helpful tip from Debi – for individuals who have difficulty with lab draws – consider trying soap and water skin prep rather than alcohol....the smell of the alcohol can be the trigger for issues.

4. **Peter Bacon** joined us for our ongoing collaborative discussion.

Question raised about cert deficiency – NT had reviewed and signed ISA. The individual and provider moved – NT reviewed the HSI and health history, there was no new ISA, so NT didn't re-sign it. Suggested solution – nursing transition form can be used to document that you have seen the ISA.

Question – are surveyors going through the med logs? Program received a new PRN order over the w/e, protocol didn't match (NT wasn't aware of order change). Answer – if orders are in the med logs, then yes. Surveyors also may see med logs when they look for the controlled logs. Some agencies take the orders, PRN protocols and controlled logs out of the med log for the surveyor visit, some leave them in. Surveyor needs access to the orders, PRN protocols and controlled med documentation.

Question – recently did 3 online certification reviews – went really well. (Treeno – software used). This NT is accustomed to primarily working with individuals who are dually diagnoses. Now working also with individuals from Lakeview who have a brain injury and history of noncompliance or street drugs. NT is concerned about self med authorizing or even bringing up the conversation because she wants to always build trust with the individual receiving services. Suggestions – team approach – use steps to demonstrate participation in processes. We cannot violate people's rights. We might not like that they are their own guardian. (Can MD write order to say they can't be self medicating?)

Question – paper certs for biennials – 5 controlled meds – how to archive material to be prepared for surveyor visit? Answer – the same type of review process is expected – so same information is needed by the internal reviewer.

An individual who is assessed to give their own meds and is their own guardian – because of anxiety changed her mind and signed over responsibility for med authorized providers to administer. Concern expressed from surveyor that individual was being taken advantage of.

Question – for a temporary cert – 5 day visit documentation – do you need to do more than one if it becomes a permanent placement? No – only need one 5 day visit review.

5. **HRST** – Cheryl and Peter

HRS will be coming back to provide more training in October – there will be specific training for RNs based on responses to the recent survey sent out (if you haven't filled it out, please do so). Do we want to have the training time take over the regular DDNNH meeting time or come back after lunch? Majority of those who voiced an opinion wanted to retain our meeting time for our own group. Those who are able to spend the day will come back for the afternoon training. Cheryl will check on technology needs of HRS with availability at ATECH. If compatible both meetings will be held there.

Peter shared that the HRST monthly data tracker will take the place of HSI from surveyor perspective. If surveyor sees a concern with HSI at current certs, they will cite as a concern rather than deficiency. Look for the monthly date tracker over the next 6 months. Question was asked to Cheryl if this will be a state mandated form – answer – yes.

Many NT have had little communication from area agencies about HRST. One area agency continues to prevent vendor RNs from accessing HRST (3 NT from different vendors spoke up about this again). Cheryl will send out an email to the group about **who** is the regional HRST coordinator for each area agency – that is the point person to solutions for that agency. Cheryl reiterated that RNs must have access to HRST accounts – send email to the regional coordinator.

Question – what about the medically frail list – will area agency need to send out email to ask NTs to update info every 6 months? - no...there is a toggle on HRST for the RN to turn on if the individual is medically frail. The RN would then write the supporting note under the case management button.

Peter commented that eventually surveyors will want to see HRST record at surveys.

Next Meeting will be October 20, 2015 – NOTE LOCATION CHANGE !!!

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



MINUTES

October 20, 2015

1. **Meeting was called to order with 30 in attendance**
2. **Review** and approval of September 2015 minutes as written (with one item additionally discussed below).
 - a) **Officers Reports:**
Treasurer's Report: Read and accepted.
3. **Business Discussion:**
 - a. Review of the September minutes resulted in a member asking if there was any f/u to/from Peter in regards to the surveyors concern about the individual being exploited for giving her own meds. The NT responsible for program oversight was uncertain if that surveyor concern was written into the cert review – she will look into it and email Cheryl Bergeron if it was.
 - b. FAQ subcommittee work review – each item was individually read and discussed. Question #1 will have “HRST includes medical fragility designation as part of the RN reviewer role.” added at the end. Question #2 was accepted as written. Question #3 will have OTC added to “medicated cough drops”. Question #4 was accepted as written. Question #5 was deleted as recommended. Question #6 was recommended to be put in regulation related section of FAQ rather than Nursing Practice. Question #7 – accepted as written. Cheryl Bergeron will check in with NH BON regarding thoughts and ideas of real time video usage.
 - c. Discussion around meeting space – ATECH conference room is booked and available 3rd Tuesday through June. Chapel at the State office is open on the 2nd Tuesday of the month. If we do not hold meetings in State office space, how will we manage our handouts, nametags etc. Members present at today’s meeting are willing to print own agenda, consensus was that we didn’t need a printed version for all members of the treasurer’s report. Members will also be responsible for printing out their own copy of the draft minutes. A motion was presented that the group stays at ATECH conference room on the 3rd Tuesday through June – the group voted yes. The group also decided that each member will be responsible for their own nametag. Carla Houck from Community Bridges kindly volunteered to be responsible for the unclaimed nametags and make sure that they come back to the next meeting.
 - d. Lakes Region Services (Region 3 in Laconia) – very desperate for nurses to pick up any hours. There are also openings at One Sky, Community Partners, Granite Bay Services and The Moore Center. This led to a discussion about how to develop nurses awareness and interest in our field – perhaps we can proactively go to nursing schools and provide info about our specialty. Can we do a mailing advert – this would be expensive. Many nurses don’t know anything about DD nursing – that it even exists. Advertising idea – write an article for the NHNA paper. Be interviewed on local TV. Write content of our stories – as nurses working in the field of DD – why do we like it etc. Debi Nailor volunteered to spearhead a small group to develop content for presentations. Janet Harmon volunteered to put our written experiences together – so go forth, write and send to her. What about job fairs? Ex: DDNNH members having a spot (table) that talks about the specialty – not talking up any specific job. A member suggested writing letters to nursing schools – maybe asking DDNA do they have a small curriculum to offer for nursing students. Pam TM has contacts with NH 1 when we get to that point. Another member suggested considering creating a YouTube video. Wayne King suggested a committee for outreach – e.g presentations about syndromes.
 - e. Cheryl Bergeron updates on learning: MassTex Imaging isn’t available to come until January – they may or may not have the van with them depending on scheduling but are happy to come and provide info about their services plus an inservice. Compassionate Care offered to do a Lunch N Learn – they will provide lunch. The group then discussed the timeframes, the need to increase the meeting times in order to accommodate both the regular meeting and the learning opportunity. Cheryl will check with both companies to see if 11am will work and the group agreed to extend these meetings until noon.

- f. Future new business topic requested – have the group talk about discussing changing the med curriculum to 4 hrs video portion and 4 hour in person (for example) – will be put on the agenda for November’s meeting.
- g. Leslie requested that the group talk about adding a statement to FAQs about medicated toothpaste, e.g. Prevident (November’s meeting)
- h. Pam White’s BON contact hour “homework” – information is available on the NH BON website. Excerpted section from: <http://www.nh.gov/nursing/licensure/continuing-competence.htm> includes this note:

Please note

The Board does not require that your contact hours be earned at conferences that provide "official" contact hours granted by a professional organization. However, the educational offering must:

- Have specific objectives that guide the learning
- Pertain to and enhance the licensee’s knowledge, skills and judgment
- Pertain to the licensee’s scope of practice
- Have a method for evaluating the learner’s attainment of the objectives
- Maintain a list of attendees
- The licensee should maintain documentation of attendance that includes: the title, length and date of the offering and the name of the entity providing the offering.

Next Meeting will be November 17, 2015

**Submitted by:
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MINUTES

November 17, 2015

1. **Meeting was called to order with 27 in attendance**

2. **Review** and approval of October 2015 minutes as written.

a) **Officers Reports**

Treasurer's Report: Read and accepted. The treasurer reviewed that our average number of members has been 31. If we do not increase our paid membership numbers and continue to support the 2 annual scholarships (\$250 to Rivier and ~\$545 for DDNA Liaison conference registration), we will need to access our savings account to pay for the difference. (31 members at \$25 each = \$775 vs expenditure of \$795)

3. **Business Discussion:**

- a. ATECH tour/overview – the members present indicated interest, a suggestion was put forward that perhaps we could plan to come early (9:15a) in December. Kenda will ask Dennis (ATECH's director) and a notice will be sent out to inform the group.
- b. FAQ item development for Preident toothpaste – group discussion ensued with requests to add other toothpaste and mouth rinses to consideration. Kenda and Jen volunteered to develop the wording based on concepts discussed and forward to the Medication Committee for consideration/comment. (Preident toothpaste, ACT, Biotene and their generic equivalents were the products decided upon as relevant to include.)
- c. A member asked about how to report 1201a information on the 6 month report when an interim 3 month report had been requested. Recommendation was to incorporate information from your 3 month interim report into your 6 month report. There are no hard and fast rules on this. If you are receiving the request for an interim report when your next 6 month report is due, ask the relevant Area Agency decision maker for guidance in developing the appropriate report (ex. Do they want a 3 month interim report and 6 month report submitted together or perhaps they would prefer to have the full 6 month report with documentation about the timing issue.)
- d. A member asked if Preident has to be included/kept in the med box. Appropriate storage management is an area within the NT's role. One suggestion offered was for the NT to document that the Preident supply could be kept in "x" area unlocked.
- e. Discussion around full med curriculum proposal – a member shared that many places use Relias for trainings (which is all online). Ongoing budget issues are going to be a part of companies' training consideration – how to spend resources – what are the best resources, acceptable compromises etc. Some NTs present were open to the training having an online video version option that would be available as an option though not required for everyone. All agreed that it was very important for the NT to have interaction with the students.
 - i. Factors that could be helped by a online training version include: ESL students, students not having access to transportation or time flexibility due to work or family or school commitments, offers time and tools to do work on own – could be helpful with remediation
 - ii. Additional comments – interactive testing for online portions. Background of system and overview of responsibilities – some of the beginning section(s) could be covered in an online version. A member suggested that if the online version was used, the NT could give a competency quiz at the opening of the in person training to determine student's retention on online learning.

- iii. One Area Agency has found that online training outcomes with providers in staffed residences are not as effective – providers are not effectively getting rooted in the application of the trained principles.
- iv. Currently received training evals – NTs who have used these say that students consistently comment that they enjoy NT examples/stories and students usually comment negatively on the current videos.
- v. One member raised a concern about NTs giving away our power – if NTs “only” teach in person for 4 hours, this may be a consideration of budget preparers and may be looked at as a way to decrease nurse funding.
- vi. One member commented that there would need to be a framework for employers – since online learning has suggested timeframes – one person may take 15 minutes to review/learn the material and another may require 2 hours. Employees would need to be paid for training time – at least the amount of time estimated as the expected timeframe.
- vii. How to create film/video updates – suggestion to involve interns. Penny has some sources that could be helpful.
- viii. A member in reviewing the regulation does not see statement that the state curriculum is required to be used.
 - ix. Do we need to create a separate video? Could there be an online video that meets our needs already available in YouTube? HOMEWORK for the group – search for med admin YouTube videos, review and pick ones you like/prefer for the group as a whole to review/consider.
- f. How do we as nurses get to the table of relevant system discussions? The way that we do this is collaboration – being open to discussion, being available to participate in discussion, not being seen as just being a pain to work with but that we will be professional and appropriate in our discussions including when we disagree.
- g. Discussion came up – some NTs have heard that HSI will no longer be required at all as of January 1, 2016, just need a copy from sometime in 2015 in the record, then no more updates needed. The monthly data tracker from HRST will take its place. Many NTs have heard nothing. Question to be sent to Peter and Cheryl for confirmation or clarification of expectation.
- h. Some members of the group are unable to log in to HRST – the root cause seems to be (after discussion) that the web address prior to the September upgrade doesn’t go anywhere. New address provided to those present: nhbds.hrstapp.com

Next Meeting will be December 15, 2015

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



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Minutes

December 15, 2015

1. Meeting was called to order with 25 in attendance

2. Review and approval of November 2015 minutes as written.

a) Officers Reports-

Treasurer's Report: Read and accepted. A discussion ensued about holding raffles to raise money (to supplement our funds other than membership dues). 50/50 raffle idea – Denise Lazott agreed to manage this and bring tickets. We will have a raffle opportunity each meeting. Ruth Beland showed us a lovely quilt piece that she will donate for us to raffle off to raise funds. Thank you Ruth!

DDNA Liaison's Report: Debi contacted DDNA and learned the name of her contact (Katy). 1 DDNA membership = 1 – meaning that a facility cannot pay for one membership that is then used by several people within the facility. Debi spoke of the value of specialty certification and offered encouragement to consider and pursue. Debi also mentioned a docu-series on A & E that started Dec 8 called “Born This Way” – about people who have Down Syndrome – she saw the first one, liked it, it's pretty raw and honest. 6 weekly episodes are planned. Another member commented that Madeline Stuart is a model from Australia who recently walked at NYC fashion week (positive role model for I/DD)

3. Business Discussion:

- a. Cheryl has received emails about preventative screening updates (the form) – she has an example from Cigna – she's not sure if it references DD specific areas and will check. She is not looking to mandate change, just inform.
 - i. Cheryl also reported that in the future ISAs will be standardized and uploaded on HRST.
 - ii. HRST monthly data tracker will be the document used going forward (instead of the current regulatory requirement for HSI). There will be formal communication from the State forthcoming.
 - iii. Cheryl reminded everyone to update HRST with medical fragility status of individuals – right now the State is running reports just looking at Y/N answer. That is an easy toggle on the About Me page for each individual. Default setting is N. Discussion in process with HRST about moving the comment box for medical fragility from the current HSI form to the About Me page. In the meantime document comments on the HSI form in HRST.
- b. A member recommended that something be created for simplified instructions on “how to” in HRST. Because there wasn't a need to log in for the past month, some steps that seemed obvious and clear then, are challenging to remember. The specific question was answered at the meeting. No one was sure how to be more specific in this request to help have a successful product.

Peter Bacon's ongoing collaborative discussion topics:

- c. A member raised a question about a CPS cert deficiency – 1 person has meds administered, a few others are self administering – there has been push back from families about annual review. None of the individuals who self administer take meds during the day program. One concern raised was – what if they are out shopping and buy something? A: If we don't know that the individual has a med that they are taking, then we cannot f/u. If we know, then we need to do the assessment. (For this particular vendor, the previous NT did annual assessments regardless. Question from group was raised whether this was a written policy or not. Not written. Reminder – the surveyors will hold agencies accountable first to the applicable regulations as a baseline standard. If the agency has a company-wide higher standard written in policy – then the surveyors will hold the agency to that standard.)
- d. Peter provided the group with an ongoing example of a current challenge – during a certification survey, Peter asked a question about the NT and discovered through f/u questions that the vendor agency had not had a NT for

weeks. One result was that many providers' med authorization had lapsed. This vendor agency has multiple contracts with different AAs – all of whom were apparently unaware that there was no overseeing NT. Recommendation to the group – if you are leaving a position and know there is no NT covering, call and give Cheryl a heads up.

- e. A member asked about 5 day and 30 day visits. A new home care provider devised own med log on laptop/tablet – which NT saw at 5 day visit. When NT requested a copy be sent to her, the file was not printable. The HCP is electronically “signing” by entering initials on his device. Is this acceptable? A: Not unless the program is clearly permission restricted. As an example – Lifeshare has a program that they own. HCPs have their own access code so that they “sign” and “initial” electronically (a type of electronic medical record).
- f. Peter said that the surveyors have not seen any particular medication trends in the last few months.
- g. Discussion about med safety – especially when going out to/with friends/families. Some NTs have experienced challenges with administration and supply accuracy when the individual is visiting with friends and/or family. This can be particularly concerning when reconciling controlled med supplies. A reminder to all – don't send original med logs – copies are fine. Suggested practice – have authorized provider sign out on the controlled log how many meds were given to friend/family and an authorized provider would sign back in however many were returned.
- h. NOTE: surveyors will be looking for the HRST monthly data tracker as of January 2016 – to be in place in the individual's record instead of the HSI. There will continue to be an expectation that RN/NT has reviewed the data tracker – similar to expectations with HSI.
- i. Further discussion around 5 and 30 day visits. It is possible to fulfill the requirements for both visits within the initial visit if all the pieces are available.

Next Meeting will be January 19, 2016

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