

FORM 1201-B

NH Bureau of Developmental Services Six-Month Provider Agency Report to Medication Committee

REGION:

We encourage shared accountability and systems-based solutions to enhance the safety of medication use and to minimize the potential for human error

1. Provider Agency Name:	2. Certification Type: <input type="checkbox"/> 1001 <input type="checkbox"/> 521 <input type="checkbox"/> 507 <input type="checkbox"/> 524 <input type="checkbox"/> 518 <input type="checkbox"/> 525
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3. Report Period:	4. Total number of doses administered:	5. Total number of providers authorized:
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6. Number of Psychotropic Medications prescribed:	7. Number of individual identified to be in Frail Health:
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Summary of Medication Errors for this Provider Agency:	Significant Changes in Individuals' Health Status, if any, and Actions Taken:
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<table border="1" style="width:100%"> <tr><td>WRONG MEDICATION(S)</td><td align="center">0</td></tr> <tr><td>WRONG TIME</td><td align="center">0</td></tr> <tr><td>WRONG DOSAGE</td><td align="center">0</td></tr> <tr><td>WRONG PERSON</td><td align="center">0</td></tr> <tr><td>WRONG ROUTE</td><td align="center">0</td></tr> <tr><td>OMISSION</td><td align="center">0</td></tr> <tr><td>DOCUMENTATION</td><td align="center">0</td></tr> </table>	WRONG MEDICATION(S)	0	WRONG TIME	0	WRONG DOSAGE	0	WRONG PERSON	0	WRONG ROUTE	0	OMISSION	0	DOCUMENTATION	0	
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WRONG DOSAGE	0														
WRONG PERSON	0														
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OMISSION	0														
DOCUMENTATION	0														

Identified Trends and Summary of the Provider Agency's Corrective Action Plan:

Patterns of Non-Compliance, if any, and Corrective Actions

Provider Agency's Plan for Monitoring, Oversight and Quality Improvement:

Other Concerns:

Signature of Provider Director or Designee (must be other than a Nurse Trainer):	Date:
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