| **FORM 1201-A Programs with Reportable Errors****Six-Month Nurse Trainer Report to NH Bureau of Developmental Services Medication Committee** |
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| **Provider Agency Name:**  | **Region:**  |
| **Service Name:** |

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| **Reporting Period: (select date) to (select date)** | **Certification Type:** [ ] 1001 [ ] 507 [ ] 518 [ ]  521 [ ]  524 [ ]  525 |
| **Number of Individuals:       in Region       in Total** |  **Average Hours Per Month:** |
| **Number of Current Authorized Providers:** | **Total Number of Doses Administered:** |
| **Total Number of He-M 1201 Certification Deficiencies Cited:****Specify He-M 1201 Certification Deficiencies Type:**  |
| **Number of Medically Frail Individuals:** | **Number of Individuals on ≥ 4 Psychotropic Medications\*:** \*For those on ≥4 psychotropic medications, consider psychiatric provider involvement. |
| **Number of Medication Errors that Resulted in Medical Treatment (for DD individuals only):** | **Number of Medication Errors that Resulted in Medical Treatment (for ABD individuals only):** |
| Type of Error | **# of Occurrences**  | **Date(s) of Error(s)**  | **Medications, Frequencies and Doses**(additional details to be included on page 2) |
| **Wrong Medication** |  |  |  |
| **Wrong Time** |  |  |  |
| **Wrong Dose** |  |  |  |
| **Wrong Person** |  |  |  |
| **Wrong Route** |  |  |  |
| **Omission of Medication** |  |  |  |
| **Documentation Error** |  |  |  |

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| **Patterns of Non-Compliance and/or Identified Trends; Please Include Corrective Action Taken** |
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| **Similar Patterns and/or Trends Identified at Other Related Residences; Please Include Corrective Action Taken** |
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| **Areas of Concern and/or Additional Information** **(e.g. significant health changes, errors requiring medical treatment, multiple psychotropics)** |
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**Please provide a brief description of the medication events. Be sure to include what happened, the immediate response and any preventive measures implemented.**

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| **Wrong Medication** |
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| **Wrong Time** |
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| **Wrong Dose** |
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| **Wrong Person** |
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| **Wrong Route** |
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| **Omission of Medication** |
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| **Documentation Error** |
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| **Nurse Trainer Name:** | **Date:** |
| **Signature or Electronic Signature:** |
| **Nurse Trainer Contact Phone Number:** |