Instructions for Completion of Form 1201-A
NH Bureau of Developmental Services

This form is required by He-M 1201-Administration of Medications in Developmental Services Programs. It is to be completed two times per year pursuant to He-M 1201.11. The nurse trainer of each provider agency shall complete a separate Form 1201-A for each certified setting, as applicable, in which authorized providers administer medications.

Please read the following instructions carefully and please complete all items.

Do not leave any item or sections blank. Indicate "0", "none" or "N/A" when applicable.

Region: Indicate the region reporting.

1. **Provider Agency Name**: Enter the name of the Agency.

2. **Certification Type:** Check the corresponding box for the type of certified service. If a program is a combined program (e.g. res/day; 1001 with a 525 bed), please indicate by checking both boxes.

   He-M 1001 (Residential services)
   He-M 507 (Day services)
   He-M 518 (Supported employment)
   He-M 521 (Home with personal care services for an adult family member)
   He-M 524 (Home with personal care services for family member under age 21)
   He-M 525 (Participant-directed and managed services)

3. **Service Name:** Enter the name under which the service is certified (e.g.: 246 Main Street, Groveton).

4. **Reporting Period Dates:** Enter the dates for the reporting period pursuant to He-M 1201.

5. **Total number of Providers Authorized:** Indicate the number of providers who are authorized to administer medications.

6. **Total number of doses administered:** Extrapolate the total number of doses administered by taking the total dose count for the very last week of the reporting period and multiplying it with the number of weeks within the period. If other individuals receiving services live at that residence and are not receiving services from your agency, do not include their total in the number of doses administered.
   For example:
   Joe Smith receives Colace bid, Tegretol tid and Paxil qd. He also received prn Motrin two times during the last week of the reporting cycle.

   Calculate the total number of doses in the following way:
   Colace = bid = 14 doses in last week
   Tegretol = tid = 21 doses in the last week
   Paxil = qd = 7 doses in the last week
   Motrin = prn = 2 doses in the last week
   Total doses in last week = 44
   44 doses X 26 weeks (6 months) = 1144= total doses administered

7. **Name of Nurse Trainer:** Clearly indicate the full name of the Nurse Trainer who is delegating responsibilities to individuals/authorized provider(s).

8. **Hours per month:** Enter the average number of hours, per month; the Nurse Trainer spends providing supervision/oversight for this residence.

9.
    a. **Number of He-M 1201 certification deficiencies cited:** Enter the number of He-M 1201-related deficiencies cited by the Bureau of Health Facilities (BHF) during certification review.

    b. **Specify which He-M 1201 certification deficiencies cited:** List the section of the rule cited, e.g. "He-M 1201.08 Storage of Medications." Be sure to include an explanation of what happened and what the corrective action is on the 1201a Form.

10. **Number of individuals receiving medication from authorized providers:** Enter the number of individuals living at the certified residence receiving medications from authorized providers. If other individuals live at the certified residence and receive services from a different agency, state how many individuals live in the residence from the other agency as well.

11. **Number of Psychotropic Medications prescribed per individual: (YOU ARE NOT COUNTING DOSES HERE BUT THE NUMBER OF PSYCHOTROPIC MEDICATIONS AN INDIVICUAL HAS IN HIS/HER REGIMEN)** Indicate how many psychotropic medications were prescribed for individuals receiving medications from authorized providers during the reporting period, including PRNs. List individuals separately by initials only and number of meds psychotropic meds they receive (not doses). Count the number of psychotropic medications an individual has prescribed for them during the very last week of the reporting period, including PRNs. Psychotropic medications, <u>whether they are being used for psychiatric reasons or not,</u> fall into six major classes: antidepressants, stimulants, antipsychotics, mood stabilizers, anxiolytics, depressants

12. **Number of individuals identified to be in frail health**. Enter the number of individuals living at the residence who are considered in frail health.

MEDICATION ERROR REPORTING
Type of errors, number of errors, dates of errors, and medications

Wrong Med: Denotes a situation where an individual is given medication that is not prescribed for him/her.
For example: Joe Smith has an upset stomach. His provider has some Pepcid and thinks it might help Mr. Smith, so he gives it to him before meals for three days. The Nurse Trainer discovers this during a phone conversation with the provider.

(On nine different occasions, Pepcid was given without an order).

Type	Number	Date(s) of error(s)	Medication(s)
Wrong Med	9	1/1/11 – 1/3/11	Pepcid 10 mg

Wrong Time: Denotes a situation where a person is given a medication at a different time than the one approved by the prescribing practitioner or licensed person. A half hour leeway around the prescribed time is usually recognized in general practice.
For example: Jane Doe's morning Fosamax is scheduled for 8 am and is ordered to be given at least one half hour before other morning medications and breakfast. It is 8:40 am; she is eating breakfast and has not yet received the Fosamax.

(**On one occasion, Fosamax was given late).**

Type	Number	Date(s) of error(s)	Medication(s)
Wrong Time	1	2/1/11 – 2/3/11	Fosamax 10 mg once daily

Wrong Dose: Denotes a situation where an individual is given a different dose than the one prescribed.
For Example: Mr. Smith's Depakote is increased from 250 mg qid to 500 mg qid by the prescribing practitioner on 1/1/11. The provider does not implement the medication change until 1/4/11.

(On eight different occasions the increased dosage was not administered).

Type	Number	Date(s) of error(s)	Medication(s)
Wrong Dose	8	3/2/11 – 3/3/11	Depakote 500 mg qid

Wrong Person: Denotes a situation where an individual receives another individual's medication.

For example: Joe Smith receives Jane Doe's 8am medications. Joe Smith received Ms. Doe's Fosamax, Lasix and Digoxin. Ms. Doe received the medications intended for Mr. Smith, including: Depakote and Tegretol.

(Two incidents/individuals involving five different medications).

Type	Number	Date(s) of error(s)	Medication(s)
Wrong Person	2	4/2/11	Fosamax 10 mg, Lasix 40 mg, Digoxin 0.25 mg, Depakote 250 mg, Tegretol 200 mg

Wrong Route: Denotes a situation where an individual is given a medication by a route other than the one prescribed.

For example: Joe Smith has an order for a Tylenol suppository. The authorized provider administered Tylenol two tabs orally instead.

Type	Number	Date(s) of error(s)	Medication(s)
Wrong Route	1	5/2/11	Tylenol 500mg

Omission: Denotes a situation where an individual does not receive his/her medication as prescribed.

For example: Joe Smith and Jane Doe do not receive their morning medications because each of the providers thinks that the other has given the medications.

Type	Number	Date(s) of error(s)	Medication(s)
Omission	2	6/2/11	Digoxin 0.25 mg Lasix 40 mg and Fosamax 10 mg

Omission also denotes a situation when an authorized provider fails to initial a block indicating a medication has been administered, if more than 24 hours have passed and administration cannot be confirmed by other documentation (e.g. controlled count record, prn reverse narrative, medication counts) it should be counted as an error of omission. If less than 24 hours have passed, the Nurse Trainer must be contacted, a late entry made and recorded as a documentation error.

Documentation: Denotes a situation where a mistake or omission in documentation is not identified and appropriately annotated at the time of the mistake.

For example: During QA review, the nurse trainer found two PRN Tylenol administrations, but no effect of administration found in the record.

Type	Number	Date(s) of error(s)	Medication(s)
Documentation	2	7/2/11 & 8/21/11	Tylenol 500 mg

Patterns of non-compliance, if any: For example, in a situation where a Nurse Trainer has had the provider reattend the 1201 training more than once, has provided multiple 1:1 training, has provided multiple on-site visits both announced and unannounced to help the authorized staff become competent and the home provider/staff person continues for whatever reasons to be unable to comply with the regulations, this becomes an issue of non-compliance that needs to be reported to the supervisor/agency.

- **Corrective action:** For example, in this situation the residential coordinator/supervisor at Agency X was notified on (date) of the above situation. The residential manager is providing additional oversight and support.

Significant changes in health status indicators, if any: For example, one of the individuals living in this residence has been noted to have a decrease in weight of over 10 pounds within this reporting period.

- **Actions taken:** The service coordinator, residential manager, and the Nurse Trainer were notified and the individual was evaluated by the PCP and a nutritionist. It was also noted that this individual was having difficulty swallowing. A swallowing evaluation was ordered and the appointment is pending. Individual had a recent dental exam.

Other concerns: (e.g. Individuals in frail health, multiple psychotropics, multiple med errors) For example, there are two individuals living in this residence who have been identified in frail health. Their decrease in functional abilities has been noted in the health status indicators and the service agreement is being amended to reflect the additional supports that are being provided.

Number of medication errors that resulted in medical treatment: An error that may have contributed to or resulted in temporary harm to the individual and required intervention beyond advice.

Identified trends at this residence: For example: Many of the errors identified in this residence appear to be the result of inattention and failure to follow procedure. There were significant deficits in the knowledge level/ability to apply the information learned during the medication administration training process.

- **Corrective action:** For example, The providers are new and both received additional training during the reporting period. Areas of training that were formally reviewed included: coordinating health care appointments, the Six Rights of Medication Administration and how to ensure that documentation is complete. The Nurse Trainer also conducted a repeat clinical evaluation of each provider's ability to administer medications.

Similar trends identified at other residences: For example, several residences have been noted to have new staff who seem to be having difficulties following procedure.

- **Corrective action**: The residential manager of these residences was notified on (date) and the Nurse Trainer plans on conducting unannounced visits at these residences.

Nurse Trainer Signature: **Please have the nurse trainer print and sign the document.** We are unable to accept electronic signatures on the 1201 forms at this time.

Medication errors AT A MINIMUM that reach the individual. All errors, with the exception of documentation errors, reach the person. Please specify if it caused harm or required/s monitoring. **Explain in detail what happened, how it happened, what was done immediately, and any preventative measures. Please be brief regarding documentation errors.**

1. Wrong Med: 9 Pepcid errors discovered during phone conversation with provider that he gave nine doses of Pepcid without appropriate medication order. Primary physician notified; no further doses administered and appointment made to evaluate stomach upset. Provider required to repeat training module regarding medication orders and formal counseling was provided regarding the seriousness of this incident.

2. Wrong Time: 1 Fosamax dose given late due to oversight. (needed to be given ½ hour before other morning meds and Bfast) Consultation with pharmacist recommended give Fosamax now with full glass of water, hold off on finishing breakfast for one half hour and give other morning meds at 9:30AM.

3. Wrong Dose: Mr. S.'s Depakote was increased from 250 mg qid to 500 mg qid by the prescribing practitioner after the last dose on 3-1-11, but the provider did not implement the medication change until 3-4-11 on the first dose. The prescribing practitioner was notified and individual was brought to have blood levels obtained. NT instructed provider to monitor and report any seizure activity, and reinforced the need to implement medication changes immediately. Provider was also reeducated on the "Six Rights" of medication administration and reminded of the requirement to notify the NT whenever there is a change in an individual's medication regime.

4. Wrong Person: J.B. received K.L.'s Fosamax, Lasix and Digoxin. K.L. received J.B.s Depakote and Tegretol. Two individuals each received the wrong medications. The provider had prepared both individual's medications at once and administered to the wrong persons. The Poison Control Center and the prescribing practitioner were notified and the individuals' were evaluated and treated at the local emergency room. The authorized provider was reeducated on the importance of the "triple checks" for one individual at a time, completing the actual administration of medications for one individual before starting medications for another. Authorized provider reobserved administering medications to both individuals.

5. Wrong Route: Authorized provider administered Tylenol tablets instead of Tylenol suppository as ordered. Provider did not perform "triple checks" and did not observe the "Six Rights of Medication Administration." The NT was notified and advised that Tylenol should be given only according to PRN protocol and prescribed route. Provider required to repeat training module regarding the Six Rights of Medication Administration and was reobserved administering medications.

6. Omission: J.B. and K.L. did not receive their morning medications because each of the providers thought the other gave the medications. When administering the 4PM meds, provider discovered the am meds had not been signed off, and further discussion revealed the meds were omitted. The prescribing practitioner was notified immediately and advice given to give meds at 5PM and to give omitted meds at hs.

7. Documentation: PRM Tylenol was administered twice but no record of results noted. Program manager, who is 1201 authorized, notified NT and reinforced the requirement and education module regarding PRN documentation.

Number of medication errors that resulted in medical treatment (DD): One, am dose of Lithium and Cardizem to wrong person

- **Actions taken:** Taken to ER, seen by PCP, etc. (actual treatment, not advice)

Number of medication errors that resulted in medical treatment (ABD): One, am dose of Lithium and Cardizem to wrong person

- **Actions taken:** Taken to ER, seen by PCP, etc. (actual treatment, not advice)