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

This form is required by He-M 1201 – Administration of Medications in NH Bureau of Developmental Services Programs. It is to be completed two times per year (for each region) pursuant to He-M 1201.11(c) and (f) (Table 12.1.1). The nurse trainer of each provider agency shall complete a separate 1201-A Long form for each certified setting with reportable errors, as applicable, in which authorized providers administer medications.

Note: Use a 1201- A Short Form for certified settings with NO reportable medication occurrences (*see He-M 1201-A Short form instructions for further details*)

Note: If errors are identified by a rendering service provider agency outside of the reporting cycle (e.g., during a state certification), they will include the error(s) and circumstance(s) within the 1201-A report under **Other Concerns** corresponding to the reporting period in which the error was found.

- Rendering service provider agencies should not report these **older** errors within the current statistical grid on the 1201-A and 1201-B Forms.
- Area Agencies should not report these older errors in the current statistical grid on the 1201-C Form.
- Area Agencies should note the occurrence of the **older** error(s) and circumstance(s) within the 1201-C Form under Corrective Action and /or Plans for Monitoring.
- The Area Agency and Med Committee will review the error(s), and if further actions/instructions are needed, they will be provided at that time.

Note: Each Area Agency may have additional expectations within the report instructions.

The standard expectation is that these forms will be typed. Illegible reports will be returned for revision and resubmission.

The number of errors must be indicated for all error types in the *# of occurrences* column, including instances when there are "0" errors.

- If number of occurrences is "0", no further documentation is required across that row.
  - See instruction #15 for an example of "0" errors.

Throughout the report, language that is concise and succinct is always helpful. Too few words sometimes do not convey enough pertinent details to understand what occurred. Too many words can also cause confusion through extraneous details.

1. **Provider Agency Name**: Enter the name of the rendering service provider agency.

2. **Region**: Indicate the region being reported on.

3. **Service Name:** Enter the service address under which the service is certified (e.g., 241 Main Street or Boynton Ave, B side)
   - This is never the individual's name.

4. **Reporting Period Dates**: Reporting tables are identified within He-M 1201.11(f). The reporting period remains the same for every setting within that region's reporting cycle. The full reporting period dates (use drop down calendar) must be indicated in this section to ensure the information provided reflects data from the entire reporting period. If an individual is not present for the entire

established cycle, feel free to simply make a notation within the report. (e.g., if the report is about one person, an opening or a closing date could be put in parenthesis after the service name. This kind of information can always be added to the section **Areas of Concern and/or Additional Information**.)

a. The only time reporting period dates may differ is if you are doing an ***interim*** report (if requested by Med Committee/area agency).

5. **Certification Type:** Check all applicable boxes for the type of certified service being provided. If a program is a combined program (e.g., res/day = 1001/507, 1001 with a 525 bed), please indicate both boxes. This requires the nurse to understand how to identify the service setting by "regulation" number.
   - He-M 507 (CPS)
   - 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 22)
   - He-M 525* (Participant-directed and managed services)
   - He-M 1001 (Residential services)

   *If the authorized provider/staff is employed by a provider agency, full medication error reporting (occurrence reporting and 1201-A Long form reporting) must be completed. If the staff is employed by the family, then nursing delegation is not occurring and no reporting is required.

6. **Number of Individuals: ___ in Region ____ in Total** –
   a. The "**in Region**" number reflects the number of individuals reported on by this provider agency in this region/area agency. (i.e., This number does not reflect anyone who does not receive medications from an authorized provider.)
   b. The "**in Total**" number reflects the total number of individuals receiving paid support within this **certified setting**. (i.e., This number includes all individuals receiving supports whether from different regions or provider agencies, etc.)

7. **Average Hours Per Month:** Enter the average number of hours per month the Nurse Trainer spends providing supervision/oversight, and other work 'on behalf of' etc. for this certified setting. (e.g., QA, phone calls, email, meetings, Dr's appointment, various training/retraining, case notes, etc.) This number helps reflect the complexity of nursing supports within certified settings.

8. **Number of Current Authorized Providers:** Indicate the number of providers who are authorized to administer medications.
   a. This should include the total number of providers who were able to administer medications within **any** period of the reporting cycle.
      i. Authorized providers who ***remain*** authorized throughout that reporting period,
      ii. Those providers who were authorized ***in*** that reporting period but no longer authorized, and

iii. Newly hired/authorized providers who were added at some point in that reporting cycle

9. **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 the last week
   Tegretol = tid = 21 doses in the last week
   Paxil = qd = 7 doses in the last week
   Total doses in last week = 42

   42 doses X 26 weeks (6 months) = 1092 = total scheduled doses administered

   An estimate of PRN usage for the reporting period should be included in the dosage total as determined by the Nurse Trainer based on frequency of use and nursing judgement.

   For example: Total scheduled doses (1092) plus PRN doses (2) = 1094

No Nurse Trainer is expected to literally count every dose administered. This dose total is a representative number based on extrapolation.

10.
   a. **Number of He-M 1201 certification deficiencies cited**: Enter the number of He-M 1201 related deficiencies cited by the Office of Legal and Regulatory Services (OLRS) during a certification review that occurred only within this reporting period.
      i. If no certification occurred during this reporting period, then indicate "N/A" in this box
      ii. If there was a certification and zero deficiencies, then indicate "0" in this box

   b. **Specify which He-M 1201 certification deficiencies type**: List the section of the rule cited, e.g., "He-M 1201.08 Storage of Medications." You may choose to add a brief notation to include an explanation of what happened and what the corrective action is on the 1201-A Form.

Note: If a deficiency is reported to the Nurse Trainer outside of the regular reporting cycle, then the Nurse Trainer may report this information in the **Areas of Concern and/or Additional Information** within the next reporting period.

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11. **Number of Medically Frail Individuals:** Enter the number of individuals (on your caseload within that specific region) living at the certified setting who are designated by the Nurse Trainer and documented to be in frail health within the HRST.

12. **Number of individuals on ≥ 4 Psychotropic Medications*: ____*For those on ≥ 4 psychotropic medications, consider psychiatric provider involvement.**
    a. Within HRST, psychotropic medications are defined as routine scheduled medications used to treat or control anxiety, mood, mental status, behavior, mental health disorder, sleep, or dementia
    b. The Nurse Trainer has the responsibility to meaningfully review routine and PRN medication usage that comes close to meeting the definition above. The Nurse Trainer may choose to notate the report accordingly
    c. For those on ≥ 4 psychotropic medications, the Nurse Trainer should provide a comment on the level of psychiatric provider involvement

13. **Number of Medication Errors that Resulted in Medical Treatment (for DD individuals only)**: Errors that require more than nursing consultation would be included here. (e.g., The prescriber is contacted, and the authorized provider receives active instruction beyond how to address the next dosage of regularly scheduled medications.) The prescriber may recommend vital sign monitoring, lab work, urgent care, Emergency Room etc. as examples of required medical treatment.
    a. Please provide prescriber recommendations within the description of the error on page 2

14. **Number of Medication Errors that Resulted in Medical Treatment (for ABD individuals only)**: Errors that require more than nursing consultation would be included here. (e.g., The prescriber is contacted, and the authorized provider receives active instruction beyond how to address the next dosage of regularly scheduled medications.) The prescriber may recommend vital sign monitoring, lab work, urgent care, Emergency Room etc. as examples of required medical treatment.
    a. Please provide prescriber recommendations within the description of the error on page 2

15. **Medication Error Reporting Grid**

****Special Pharmacy Error Considerations:** The root cause of an error may be due to a pharmacy error. Pharmacy errors will typically result in an identified category/statistical error.
Examples include:

- Prior authorization issues
- Supply chain issues
- Inaccurate pharmacy counting issue
- Wrong medication even though the label is correct
- Incorrect strength of the correct medication
- Unique issues may occur with multi-dose packaging

Please note that the column "**# of Occurrences**" requires a numerical notation.

- If there have been 0 occurrences, then the subsequent boxes in that row ("Date(s) of Error(s)", "Medications, Frequencies and Doses") do not require a response.

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Medication	9	1/1/24 – 1/3/24	Pepcid 10mg – given before meals
Wrong Time	0		

Wrong Med: Denotes a situation where an individual is given medication that is not prescribed/ordered for them.

Example 1: The individual has an upset stomach. Their authorized provider has a supply of Pepcid and thinks it might help, gives it before meals for three days. The Nurse Trainer discovers this during a phone conversation with the authorized provider.

Example 2: Vit D3 2000 units one tab daily, order expired on 11/30/23. The authorized provider continued to give until January 15th. The original order date was 11/30/2022. Reminder: there is a grace period (agreement with OLRS) of 30 calendar days.

Note: If an expired prescription/order continues to be used and administered, this is typically the reporting category used.

Note: If an individual receives another's medications, this would be documented under 'wrong person'.

(Example 1: On nine different occasions, Pepcid was given without an order.)

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Medication	9	1/1/24 – 1/3/24	Pepcid 10 mg – gave before meals (individual does not have this ordered)

(Example 2: Order expired on 11/30/2023, continued to be given after the 30-day grace period.)

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Medication	16*	12/31/23 – 1/15/24	Vit D3 2000 units daily (*inc. 30-day grace period)

Wrong Time: Denotes a situation where an individual 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.

Note: PRN medications do not have standard time leeway (as above). PRN protocols are required for all PRN medications - PRNs cannot be given sooner than the ordered interval(s) as established in the specific protocol.

Note: The focus of the error is on the authorized provider and whether or not that authorized provider administered the medication at the scheduled time.

For example: If the authorized provider fails to administer the scheduled medication on time, and seeks corrective action, **AND** the Nurse Trainer provides instruction to provide the dose, the occurrence would be documented as a wrong time error.

- It is important to note that if the NT instructs the authorized provider to NOT administer (due to time of next dose), then this would be classified as an omission.

For example: The home care provider didn't administer the morning meds yet, and the day staff came and picked up the individual. The home care provider called the Nurse Trainer for instruction. The Nurse Trainer instructed that the medication be brought to the individual for administration and therefore the medication was given late.

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

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Time	1	2/1/24	Lisinopril 10 mg once daily

Wrong Dose: Denotes a situation where an individual is given a different dose than the one prescribed.

For example: The individual's Depakote is increased from 250 mg qid to 500 mg qid by the prescribing practitioner on 3/2/24 at 1pm. The authorized provider does not implement the medication change until 3/4/24.

Note: other examples to consider would be:

- Antifungal cream ordered once daily but given twice daily
- Depakote 250mg every am and Depakote 500mg every hs – authorized provider inadvertently gave morning dose in the evening
- Ointment order specifies 1 inch dosing, authorized provider estimates amount rather than measuring

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

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Dose	6	3/2/24 – 3/3/24	Depakote 500 mg qid

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

For example: One individual received another's 8am medications (Fosamax, Lasix, and Digoxin).

Note: Be sure to comment if all individuals who receive service ultimately received their correct medication, and if not, why not.

(One incident involving three different medications).

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Person	1	4/2/24	Fosamax 10 mg qd, Lasix 40 mg qd, Digoxin 0.25 mg qd

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

For example: The individual has an order for Tylenol per g-tube. The authorized provider administered Tylenol orally instead.

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Wrong Route	1	5/2/24	Tylenol 500mg per g-tube q 6 hours prn

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

For example: Two individuals did not receive their morning medications because each of the authorized providers thinks that the other has given the medications. (This means that there were 2 reportable errors because it involved two individuals from the same region.)

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Omission	2	6/2/24	Digoxin 0.25 mg qd, Lasix 40 mg qd, multivitamin 1 tab qd Fosamax 10 mg qd

Omission also denotes a situation when an authorized provider fails to initial a med log entry. If more than 24 hours have passed and med administration **cannot** be confirmed by other documentation (e.g., controlled count record, prn reverse narrative, medication counts), then this error should be counted as an error of omission. If less than 24 hours have passed and a late entry can be verified and recorded, the Nurse Trainer can categorize this error as a documentation error.

- When a blank med log entry is found, the Nurse Trainer should be contacted.

Note: One administration time involving 3 medications for one individual counts as one error.

Note: The categorization of an error as omission vs documentation is not viewed as one is more egregious than another. Rather, categorization helps identify appropriate root cause, preventive measures, and related corrective actions. These should be further clarified in the narrative within the description section.

Documentation: There are many examples of documentation irregularities to consider as errors. A documentation error may be an uncorrected mistake or incomplete documentation that is not identified promptly. It may be an incomplete med log entry, a lack of documented result for PRN administration, or inaccurate controlled count documentation (e.g., missed documentation of daily count, incorrect count, etc.).

For example: During the QA review, the nurse found two PRN Tylenol administrations, but no documentation of the effect (result) of administration was found in the record.

Type of Error	# of Occurrences	Date(s) of error(s)	Medications, Frequencies and Doses (additional details to be included on page 2)
Documentation	2	7/2/24 & 7/21/24	Tylenol 500 mg po q 4 hours PRN

Patterns of Non-Compliance and/or Identified Trends; Please Include Corrective Action Taken: if any: Non-compliance and identified trends are not necessarily the same thing. This section allows the Nurse Trainer to provide overarching comments for the setting being reported on rather than specific details regarding each statistical error. The inclusion of "not applicable" is perfectly appropriate when there are no circumstances that fit these descriptions.

- 'Non-compliance' implies repeated disregard for trained and expected processes.

For example: The authorized home care provider has failed to use triple check procedures despite multiple conversations, retraining and formal corrective documentation. Leadership is now involved at a contract compliance level.

- 'Identified Trends' - This section refers to trends that are certified setting specific.
  - Sometimes a trend will only involve one authorized provider and sometimes it will include more than one authorized provider
  - Trends may identify systemic problems within the program that may need to be addressed

For example: There have been multiple controlled count irregularities during this reporting period. This now seems to be a trend in this program. Direct observation and additional training will occur.

Similar and/or Trends Identified at Other Related Residences; Please Include Corrective Action Taken: As the Nurse Trainer reviews the 1201-A reports for this region/reporting period, be mindful of common irregularities that occur in more than one certified setting. The inclusion of "not applicable" is perfectly appropriate when there are no circumstances that fit these descriptions.

Areas of Concern and/or Additional Information (e.g., significant health changes, errors requiring medical treatment, multiple psychotropics): This section is purposefully broad for you to share information that impacts the complexity of the certified setting. An additional example to consider including is when an individual dies during the current reporting period. The inclusion of "not applicable" is perfectly appropriate when there are no circumstances that fit.

This next section begins with the name of the provider agency, region, and service name again (on the template, this is the top of page 2).

16. **Provider Agency Name**: Enter the name of the rendering provider agency.

17. **Region**: Indicate the region being reported on.

18. **Service Name:** Enter the name under which the service is certified (e.g., 241 Main Street or Boynton Ave, B side)
    - This is never the individual's name.

Please provide a brief description of the medication events. Be sure to include what happened, the immediate response, and any preventive measures implemented.

Note: It is important to include:

- Why the error happened and immediate actions,
- If any harm came to the individual,
- If the prescriber was notified and any recommendations given,
- All corrective actions as determined appropriate by the Nurse Trainer.

Also:

- If there were no errors in this category, no further documentation would be needed in the remaining boxes.

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Reminder: Throughout the report, language that is concise and succinct is always helpful. Too few words sometimes do not convey enough pertinent details to understand what occurred. Too many words can also cause confusion through extraneous details.

1. **Wrong Medication**:

Example 1: The individual complained of stomach upset. Authorized provider used their own supply of Pepcid for 9 doses. NT discovered during phone conversation. Authorized provider thought it was ok to just give the med. NT required them to notify the doctor and schedule a f/u visit. No harm to individual. NT is providing ongoing conversations/retraining to ensure compliance and understanding.

Example 2: The medication order was originally written on 11/30/2022, and technically expired 11/30/23. The authorized provider continued to give vitamin D3 until January 15, 2024. No harm to individual. There is an agreed upon 'grace period' of 30 calendar days (*please see 1201.04 Medication Administration section in the DDNNH FAQs*) therefore the total number of errors result in 16 errors for this example.
Nurse Trainer discovered during QA visit and instructed the authorized provider to obtain a new order. The authorized provider was retrained re: when to obtain new medication orders.

2. **Wrong Time:**

For example: Individual left early for day program prior to receiving 8am Lisinopril. NT was called and instructed dose to be given in the community. No harm to individual. Staff were reminded to review the med log prior to individual leaving the setting.

3. **Wrong Dose:**

For example: New Depakote increase was ordered on 3/2 and was not started until 3/4. Staff "forgot" to transcribe new order (not a new issue for this authorized provider). No harm to individual. NT reviewed appointment expectations (and then with entire staff grouping) and involved staff was placed on probation with retraining.

4. **Wrong Person**:

For example: Overnight staff poured an individual's morning medications and then gave them to the wrong individual. When pouring the second individual's medication, the staff realized the previous error. Called the NT who instructed them to call the PCP for instructions. PCP stated to monitor vital signs per provided parameters and encourage fluid intake, monitor elimination – may have regularly scheduled medications as previously ordered. NT provided supervision and retraining. Ultimately both individuals received their ordered medications, no harm to either individual. *(The nurse trainer may include the amount of initial detail to provide as to the impact of the error on the individual.) Please note: this error would be included in the* ***Number of Medication Errors That Resulted in Medical Treatment*** *section.*

5. **Wrong Route**:

For example: Authorized provider administered Tylenol tablets orally instead of as ordered per g-tube. The provider did not perform triple checks and when they reviewed the med log, realized their error. Resulted in aspiration pneumonia (*this error would be included in the* ***Number of Medication***

Errors That Resulted in Medical Treatment *section as well)*. NT was notified and reiterated the importance of trained and expected processes and the need to review the PRN protocol every time. The authorized provider was instructed to call the prescriber to inform. Prescriber recommended monitoring. The authorized provider was placed on probation with retraining.

6. **Omission:**

For example: Both individuals did not receive their morning medications because each of the authorized providers thought the other gave the medications. At 4pm med time, another authorized provider discovered am meds had not been signed off for either individual. Further verification revealed that the meds were omitted. NT instructed them to call relevant ordering prescriber for instructions (ind. with Lasix and Digoxin). Fosamax omitted and given to individual #2 as ordered the following day. No harm to either individual. NT reviewed trained and expected processes during initial conversation; probation, additional training and observation was instituted.

7. **Documentation**:

For example: During the nurse QA visit, two PRN Tylenol administrations were found without documentation of results. Two different authorized providers stated they 'forgot' to write the result of PRN. No harm to individual. Documentation expectations reviewed with relevant staff and the topic was discussed at the next staff meeting. Will continue to monitor.

Nurse Trainer Name: - The name of the NT completing the form.

Date:

Signature or Electronic Signature: - The NT is expected to include their professional credential(s).

Nurse Trainer Contact Phone Number *(Please consider including your email to facilitate communication).*