<p style="text-align:center">**Instructions for Completion of Form 1201-A**
<u>**Short Form**</u>
NH Bureau of Developmental Services</p>

This form is required by He-M 1201 – Administration of Medications in NH Bureau of Developmental Services Programs. Reporting is required 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 rendering provider agency shall complete the 1201-A Short form for certified settings without reportable errors in which authorized providers administer medications. When using the 1201-A short form, the NT is asked to include more than one certified setting on the same document as applicable.

Note: Use a 1201- A Long Form for certified settings **with** reportable medication occurrences (*see He-M 1201-A Long form instructions for further details*).

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.

1. **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. This can be done within the **Service Name** cell or can always be added to the section **Areas of Concern and/or Additional Information** at the bottom of the page.

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

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

Service Name	Certification Type	# of Individuals	# of Current Authorized Providers	Average Hours per Month	Total # of Doses Administered	# of 1201 Deficiencies (specify deficiency type)	# of Medically Frail Individuals	# of Individuals on ≥4 Psych meds*

☐ **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.

☐ **Certification Type:** Identify the specific type of certified service being provided. Include if a program is a combined program (e.g., res/day = 1001/507, 1001 with a 525 bed). This requires the nurse to understand how to identify the service setting by "regulation" number.
- He-M 1001 (Residential services)
- 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)

*If the authorized provider/staff is employed by a provider agency, reporting must be completed. If the staff is employed by the family, then nursing delegation is not occurring and no reporting is required.

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☐ **Number of Individuals: ___ in Region ____ in Total** –
  a. The "**in Region**" number reflects the number of individuals reported on by this provider agency <u>in this region/area agency</u>. (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 <u>**certified setting**</u>. (i.e., This number includes <u>all</u> individuals receiving medications from an authorized provider/supports whether from different regions or provider agencies, etc.)

☐ **Number of Current Authorized Providers:** Indicate the number of providers who are authorized to administer medications.
  o This should include the total number of providers who were able to administer medications within <u>**any**</u> period of the reporting cycle.
    ▪ Authorized providers who *remain* authorized throughout that reporting period,
    ▪ Those providers who were authorized *in* that reporting period but no longer authorized, and
    ▪ Newly hired/authorized providers who were added at some point in that reporting cycle

☐ **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 all individuals in this <u>certified setting</u>. (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.

☐ **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.
  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.

  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.

- ☐ **# of He-M 1201 deficiencies (specify deficiency type)**: 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.
    - c. If no certification occurred during this reporting period, then indicate "N/A" in this box
    - d. If there was a certification and zero deficiencies, then indicate "0" in this box
    - e. 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.
    - f. All 1201 deficiencies within a certified setting, regardless of who/how medications are administered, are included within this report.
        - i. If there are *only* self-administering individuals in the certified setting, a 1201 report would *not* need to be generated solely to report this information.

    Note: If additional description is warranted re: deficiency details, they can be added to the section **Areas of Concern and/or Additional Information** at the bottom of the page.

    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.

- ☐ **# 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.

- ☐ **# of Individuals on ≥ 4 Psychotropic Medications*:**
    - g. 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
    - h. 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
    - i. For those on ≥ 4 psychotropic medications, the Nurse Trainer should provide a comment on the level of psychiatric provider involvement

- ☐ **Areas of Concern and/or Additional Information:** 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.

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

- ☐ **Contact Phone Number and Email:**

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

☐ **Date:**