Instructions for Completion of Form 1201-B
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 form is designed to generate summary statements regarding each entity's oversight of healthcare coordination and safe medication administration. The information entered onto the form will be generated through compilation of all the 1201-A forms submitted by the Nurse Trainer(s).

Note: The programmatic/supervisory position of the rendering service provider is responsible to complete this form.

Note: The same person cannot be the author/be responsible to sign more than one piece of the 6-month 1201 reporting process. (e.g., The NT who completed the 1201-A forms cannot be the same person who completes the 1201-B report on behalf of the rendering service provider.)

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

1. **Subcontracted Provider Name**: Enter the name of the rendering service provider.
2. **Region:** Indicate the region being reported on.
3. **Agency Address:** Include the address of the rendering service provider.
4. **Agency Contact Person:** Provide the name of the person completing the form.
5. **Title:** Include the title of the contact person.
6. **Contact Email**: Include the email address of the contact person.
7. **Contact Phone Number**: Include the phone number of the contact person.
8. **Reporting Period**: 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.
   - The only time this would not be true is if you were doing a B form in conjunction with an interim report.

9. **Number of Programs where Unlicensed Persons Administer Medications**:

A: Enter the total number for each type of service setting according to the submitted 1201-A forms. Enter "0" if none.

Number of Programs where Unlicensed Persons Administer Medications:	
507	
518	
521	
524	
525	
1001	
507/1001 Combo	
521/1001 Combo	
525/1001 Combo	

B: Provide the appropriate total for each category. Enter "0" if none.

Number of Current Authorized Providers	
Number of Individuals Receiving Medications From Authorized Providers	
Number of Medically Frail Individuals	
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)	
Number of Individuals on ≥ 4 Psychotropic Medications *(For those on ≥4 psychotropic medications, please consider psychiatric provider involvement.)*	

10. **Medication Errors Occurrences for this Provider Agency**:

A: Enter the total number for each type of error/occurrence according to the submitted 1201-A forms. Enter "0" if none.

Medication Errors Occurrences for this Provider Agency	
Wrong Medication	
Wrong Time	
Wrong Dose	
Wrong Person	
Wrong Route	
Omission of Medication	
Documentation Error	

B: Enter the total number of errors, total number of prescribed doses and provide the error to dosage ratio. (**Note**: Calculate number of errors divided by the number of total doses. This is not a percentage.)

Summary of Medication Errors	
Total Number of Errors	
Total Number of Prescribed Doses	
Error to Dosage Ratio	

11. **Summary of Significant Changes in Individual's Health Status and Associated Actions Taken**: Provide a brief statement of any notable changes during this reporting period. Feel free to indicate "N/A" if appropriate.

<u>This next section begins with the Provider Agency Name and Region again (on the template, this is the top of page 2).</u>

12. **Areas of Increased Compliance and/or Positive Trends**: Feel free to indicate "N/A" if appropriate.

13. **Patterns of Non-Compliance and/or Identified Trends; Please Include Corrective Action Taken by the Provider Agency**: Please summarize the information provided on the 1201-A forms submitted for this region. If as the rendering service provider, additional corrective action was implemented, include that information here. Feel free to indicate "N/A" if appropriate.

14. **Provider Agency's Plan of Monitoring, Oversight and Quality Improvement Initiatives**: The information provided here should indicate that the responsible management team understands what's happening regionally, including any actions taken to enhance the provision of quality services. This section is intended to highlight your agency's response to an increase in errors/occurrences.

15. **Areas of Concern and/or Additional Information**:
    - Please summarize the information provided on the 1201-A forms submitted for this region.
    - If the responsible management team has other knowledge of concerns, this information can be included here.
    - Feel free to indicate "N/A" if appropriate.

16. **Name of Provider Director or Designee*:** The name of the management level person signing the report.

17. **Date**

18. **Signature or Electronic Signature**: Please provide signature and role of person signing report.

19. **Contact Phone Number**

**Must be someone other than a Nurse Trainer* – Remember, the NT who completed the 1201-A forms cannot be the same person who completes the 1201-B report on behalf of the rendering service provider.