

FORM 1201-A

**Six-Month Nurse Trainer Report to NH Bureau of Developmental Services Medication Committee
(For Programs with Reportable Errors)**

REGION: _____

The purpose of this form is to maximize the safe use of medications and to increase awareness of medication errors through open communication, increased reporting and promotion of medication error prevention strategies.

1. Provider Agency Name: _____	2. Certification Type: <input type="checkbox"/> 1001 <input type="checkbox"/> 507 <input type="checkbox"/> 518 <input type="checkbox"/> 521 <input type="checkbox"/> 524 <input type="checkbox"/> 525
3. Service Name: _____	4. Reporting Period Dates: _____ to _____
5. Total Number of Providers Authorized: _____	6. Total Number of Doses Administered: _____
7. Name of Nurse Trainer: _____	8. Avg. Hours Per Month: _____
9. a. Number of He-M 1201 certification deficiencies cited: _____ b. Specify which He-M 1201 certification deficiencies cited: _____	
10. Number of individuals receiving medication from authorized providers: _____	
11. Number of Psychotropic Medications prescribed per individual: a. Initials: _____ # psych meds: _____ b. Initials: _____ # psych meds: _____ c. Initials: _____ # psych meds: _____	
12. a. Number of individuals identified to be in frail health: _____	

TYPE	#	Date(s) of Error(s)	MEDICATIONS, FREQUENCY & DOSE
Wrong Med			
Wrong Time			
Wrong Dose			
Wrong Person			
Wrong Route			
Omission			
Documentation			

Patterns of non-compliance, if any:
Corrective action:

Significant changes in health status indicators, if any:
Actions taken:

Other concerns (e.g., individuals in frail health, multiple psychotropics, multiple med errors):

Number of medication errors that resulted in medical treatment:

Identified trends at this residence:
Corrective action:

Similar trends identified at other residences:
Corrective action:

Nurse Trainer Signature:
(Electronic signatures cannot be accepted at this time)

Date

