FORM 1201-B
Six-Month Provider Agency Report to NH Bureau of Developmental Services Medication Committee

REGION: _____

We encourage shared accountability and systems-based solutions to enhance the safety of medication use and to minimize the potential for human error

1. Subcontracted Agency Name: _____

Subcontracted Agency Address: _____

Subcontracted Agency Contact Person _____
Email Address: _____
Phone Number: _____

2. Number of programs where medications are administered by unlicensed persons:

1001 _____ 1001/507 combo _____
507 _____
518 _____ 1001/521 combo _____
521 _____
524 _____ 1001/525 combo _____
525 _____

3. Report period: _____ to _____

4. Total number of doses administered: _____

5. Total number of providers authorized: _____

6. Number of psychotropic medications prescribed: _____

7. Number of individuals receiving medications from authorized providers: _____

8. Number of individual identified to be in frail health: _____

9. Number of medication errors that resulted in medical treatment (DD): _____

10. Number of medication errors that resulted in medical treatment (ABD): _____

11. Number of individuals receiving psychotropic medications: _____

Summary of Medication Errors for this Provider Agency:

WRONG MEDICATION(S)	
WRONG TIME	
WRONG DOSAGE	
WRONG PERSON	
WRONG ROUTE	
OMISSION	
DOCUMENTATION	
TOTAL	
ERROR TO DOSAGE RATIO	

Significant Changes in Individuals' Health Status, if any, and Actions Taken:

Identified Trends Concerning Med Errors and Summary of the Provider Agency's Corrective Action Plan:

Patterns of Non-Compliance, if any, and Corrective Actions

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Provider Agency's Plan of Monitoring, Oversight and Quality Improvement:
Other Concerns:

Signature of Provider Director or Designee (must be other than a Nurse Trainer): **Date:**