

Bureau of Developmental Services: He-M 1201
Area Agency Instructions for Completion of Form 1201-C

This form is required by He-M 1201-Administration of Medications in Developmental Services Programs. It is to be completed by area agencies and sent to the Medication Committee two times per year pursuant to He-M 1201.11.

The form is designed to generate summary statements regarding the area agency's oversight of healthcare coordination and safe medication administration. The information entered onto the form will be generated through compilation of all the Form 1201-B's submitted by the provider agencies. If the area agency provides services through its own entity, the intent is for the B form to be completed by a programmatic/supervisory position within the agency.

Please read the following instructions carefully before filling out the form and please complete all items. **Indicate "0", "none" or "N/A" when applicable.**

Please do not leave any item or sections blank.

1. **Area Agency Name and Address:** Enter the name and address of the area agency. Please include a contact name, phone number, and email address.
2. **Number of Certified Programs by Type:** Please indicate the number of certified programs by certification type.
3. **Number of psychotropic medications prescribed:** Enter the total number of psychotropic medications prescribed (extrapolated) within each provider agency and/or area agency entity by adding the total prescribed from all 1201-B Forms.
4. **Number of individuals identified to be in frail health:** Enter the number of individuals living who are receiving certified services and considered to be in frail health from all 1201 B Forms.
5. **Number of individuals on four or more psychotropic medications:** Enter the number of individuals who are receiving four or more psychotropic medications from all 1201 B Forms.
6. **Number of individuals receiving medication from authorized providers:** Enter the number of individuals who are receiving certified services and have medications administered to them by licensed or authorized staff from all 1201 B Forms.
7. **Number of medication errors that resulted in medical treatment (DD):** An error that may have contributed to or resulted in temporary harm to the individual with developmental disability and required intervention beyond advice.
8. **Number of medication errors that resulted in medical treatment (ABD):** An error that may have contributed to or resulted in temporary harm to the individual with acquired brain disorder and required intervention beyond advice.

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9. **Summarize medication errors:** Enter the total number of medication errors by class (wrong med, wrong, time, etc.) by utilizing the data provided on the 1201-A and B forms. and then add those numbers for **Total Errors**.

Total number of doses administered: Enter the total number of doses administered within each provider agency by adding the total doses administered for all 1201-B Forms.

Error to dosage ratio: Divide the number of errors by the number of doses.

Total number of He-M 1201 authorized providers: Indicate the number of providers who are presently authorized to administer medications within each provider agency. Providers may be authorized in more than one location and therefore may be counted more than once.

10. **Positive Regional Trends:** Please identify any initiatives or proactive measures taken to improve the individual's life or address any other concerns. Please note trends in improvements of health oversight and medication administration practices for individuals.
11. **Negative Regional Trends:** Please read the 1201A and B Reports to identify any trends in medication administration errors and general trends noted regarding individuals' health status. Please indicate patterns of problems identified along with actions to correct or prevent reoccurrence.
12. **Significant Changes in Individuals' Health Status:** Please describe significant health changes individuals have experienced and actions taken by the area agency to ensure individual's health care needs are met. Please comment on individuals who have been identified to be in frail health, including changes in functional abilities and how supports have been increased to meet those needs.
13. **Quality Improvement Initiatives:** Summarize the area agency's plan for ensuring that the corrective actions taken by the Nurse Trainers and provider agencies are appropriate and designed to address trends/systemic issues or breaches in medication administration systems such that individuals' risk for future errors is minimized or eliminated. Also summarize the area agency's plan for healthcare oversight. Please indicate which quality improvement plans are being enacted.
14. **Patterns of Non-Compliance:** Please comment on any patterns of non-compliance identified by the Nurse Trainers and provider agencies and include the area agency's plan of correction.

Please print, sign, and date the form in either black or blue ink. Electronic signatures cannot be accepted on 1201 Forms at this time.