MEDICATION AIDE TRAINING PROGRAM
QUALITY ASSURANCE PROGRESS REPORT (16.12.5.10.D(2) NMAC)

All events are related to medication administration by Certified Medication Aides

Agency/Facility Name: ____________________________________________________________

Reporting time period. Select one: quarterly report or board mandated monthly report.

Quarterly report (check one)
☐ 1st Quarter (Jan, Feb, Mar) Due April 10th
☐ 2nd Quarter (Apr, May, Jun) Due July 10th
☐ 3rd Quarter (Jul, Aug, Sept) Due October 10th
☐ 4th Quarter (Oct, Nov, Dec) Due January 10th

Board mandated monthly report - due the 10th of the following month
Reporting for ____________________________/___________
(month/year)

1. Number of CMAs working in the facility: __________

2. Average number of routine medications passed by CMAs during the last quarter/month:

<table>
<thead>
<tr>
<th>Month</th>
<th>Average number of medications per consumer</th>
<th>Number of medication passes per day</th>
<th>X</th>
<th>30 days</th>
<th>X</th>
<th>Average monthly census</th>
<th>X</th>
<th>Average number of routine medications passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st month</td>
<td>X</td>
<td>X</td>
<td>30</td>
<td>X</td>
<td>=</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd month</td>
<td>X</td>
<td>X</td>
<td>30</td>
<td>X</td>
<td>=</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd month</td>
<td>X</td>
<td>X</td>
<td>30</td>
<td>X</td>
<td>=</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Quarter total =

3. Number of CMA medication pass observations during the last quarter/month: __________

4. Total number of CMA medication errors and incident reports during the last quarter/month: __________ (if none, enter “0” and skip to #6.)

4.a. Enter number of CMA errors by type:

Wrong medication   Wrong patient   Wrong time   Documentation
Wrong route        Wrong dose       Omission

5. Did the nurse educator provide appropriate instruction/education to the CMA(s) regarding error(s)? ☐ Yes ☐ No

6. Enter number of complaints or events in medication administration by CMAs during the last quarter/month:

<table>
<thead>
<tr>
<th>Complaints from:</th>
<th>Events reported to primary care provider for:</th>
<th>Events reported to:</th>
<th>Events requiring emergency services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident/consumer</td>
<td>Adverse/side effects</td>
<td>Family/Guardian</td>
<td>Calls to 911</td>
</tr>
<tr>
<td>Family/guardian</td>
<td>Allergic reactions</td>
<td>DHI</td>
<td>Urgent care visit</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Board of Nursing</td>
<td>Emergency room visit</td>
</tr>
</tbody>
</table>

Hospitalizations resulting from:

Medication event  APS  Events resulting in death: Events requiring emergency services:
Omission          Ombudsman

7. Have there been any significant events that have impacted or may impact the CMA program? ☐ Yes ☐ No

If yes, describe: _____________________________________________________________________________
__________________________________________________________________________________________

Submitted by Nurse Educator: ____________________________________________________________
Signature                                    Print Name                                    Date

Email completed and signed form to Patricia.Fernandez2@state.nm.us. Do not fax form to the BON.