New Mexico Board of Nursing  
MEDICATION AIDE 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 period (check one)  
☐ 1st Quarter (Jan, Feb, Mar) Due April 10th  ☐ 3rd Quarter (Jul, Aug, Sept) Due October 10th  
☐ 2nd Quarter (Apr, May, Jun) Due July 10th  ☐ 4th Quarter (Oct, Nov, Dec) Due January 10th  

1. Number of CMAs working in the facility: ________________

2. Average number of routine medications passed by CMAs during the reporting period.

<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>=</th>
<th>Average number of routine medications passed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st month</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>2nd month</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>3rd month</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>=</td>
<td></td>
</tr>
</tbody>
</table>

Reporting period total: = ________________________________

3. Number of CMA medication pass observations during the reporting period: ________________

4. Enter number of CMA medication errors and incident reports during the reporting period. If none, enter “0” here ______ and skip to Question #5.

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

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

5. Enter number of complaints or events in medication administration by CMAs during the reporting period. If none, check here  
☐ and continue to Question #6.

<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>
<tr>
<td>Hospitalizations resulting from:</td>
<td></td>
<td>Board of Pharmacy</td>
<td>Calls to poison control</td>
</tr>
<tr>
<td>Medication event</td>
<td></td>
<td>APS</td>
<td>Events resulting in death:</td>
</tr>
<tr>
<td>Omission</td>
<td></td>
<td>Ombudsman</td>
<td></td>
</tr>
</tbody>
</table>

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

If yes, describe: ____________________________________________________________________________________________________
_____________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________

Nurse Educator Name (please print): ________________________________________________________________

Nurse Educator Signature: ___________________________________________ Date: ____________________________

Email completed and signed form to Patricia.Fernandez2@state.nm.us. Do not fax form to the BON.  
In compliance with the HIPAA Privacy Rule, do NOT submit any protected health information.