QUALITY ASSURANCE PROGRESS REPORT (16.12.5.10.D(2) NMAC)

All events are related to insulin administration by Certified Medication Aide IIs

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

Program Type:     DD Waiver ______  ICF/IDD ______  LTC ______  Assisted Living ______  Other ______

- “Supervision/Direction”: means initial verification of a person’s knowledge and skills in the performance of a specific function or activity followed by periodic observation, direction and evaluation of that person’s knowledge and skills as related to the specific function or activity. ________Initials
- “Delegation” means transferring to a competent individual the authority to perform a delegated nursing task in a selected situation. The licensed nurse retains accountability for the delegation. ________Initials
- The licensed nurse shall be accountable and responsible for the development and initiation of the health teaching plan of the client. ________Initials
- The licensed nurse will make an onsite visit at least every 7-14 days based on the client’s status and provide instruction and direction to the CMA II. ________Initials

The licensed nurse shall be accountable for delegation of the following:
- Monitoring the therapeutic effects of the insulin.
- Observing, recording and reporting untoward effects of the insulin.
- Observing for changes in the individual client’s behavior and clinical status.
- Recording and reporting the observed changes of the clients’ status.
- Withholding administration of the medication based on the clinical status. ________ Initials

1. Number of CMA II’s working in the agency/facility: ________
2. Number of insulin doses administered per quarter: ________
3. Number of CMA II’s observed administering insulin over the past quarter: ________
4. Total number of insulin administration errors /occurrences by CMA II’s during the past quarter: ________

Please note number of errors by type:

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong medication</td>
<td></td>
</tr>
<tr>
<td>Wrong patient</td>
<td></td>
</tr>
<tr>
<td>Wrong time</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td>Wrong route</td>
<td></td>
</tr>
<tr>
<td>Wrong dose</td>
<td></td>
</tr>
<tr>
<td>Omission</td>
<td></td>
</tr>
</tbody>
</table>

5. During the last quarter your agency/facility was required to address:

5a. Number of complaints from:
   - Consumers: ________
   - Parents/Guardian: ________
   - Residents: ________
   - Other (list): ________

5b. Number of events reported to:
   - CYFD: ________
   - District: ________
   - Parents/Guardian: ________
   - Licensing and Certification: ________
   - BON: ________
   - Board of Pharmacy: ________

5c. Number of events reportable to primary care provider: ________

5d. Number of events that required emergency services: ________

5e. Number of hospitalizations resulting from:
   1. Insulin event: ________
   2. Omission: ________
   3. Death: ________

6. Number of times you met or conducted in-services with CMA II’s during the last quarter to provide specialized instruction regarding insulin, dose, and method of administration, documentation, and resident observation: ________

If the following information has changed from the previous quarter, please complete:

7. Date of last DOH survey/certification: ________ Date of last BON survey/certification: ________

8. Number of significant events as defined by the agency/facility or institution: ________

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.