New Mexico Board of Nursing

MEDICATION AIDE TRAINING PROGRAM

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 10t

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:

_____ Wrong medication _____ Wrong patient _____ Wrong time _____ Documentation

_____ Wrong route _____ Wrong dose _____ Omission

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

5.a. 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:_____
How many were:
1. Side effects:_____
2. Adverse effects:_____

5d. Number of events that required emergency services:_____
How many were:
1. Calls to 911:_____
2. Urgent care:_____
3. Emergency room:_____

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.