



QUALITY ASSURANCE PROGRESS REPORT

(All events are related to medication administration by Certified Medication Aide)

EITHER FAX (505) 841-8347 OR MAIL TO OUR PHYSICAL ADDRESS

Facility Full Name: _____ Reporting for the month of: _____ **or**

Non-Probationary Reporting months (quarterly) **You must be cleared by BON**

- 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**

Program: DD Waiver _____ ICFMR _____ LTC _____ School _____ Assisted Living _____ Other _____

1. Number of CMA's working in the facility: _____ **(if you are currently not utilizing medication aides indicate "not utilizing certified, medication aide(s) and skip down to signature and sign and date."**
2. Average number of routine Medications passed per month: _____ **(must be completed using the formula given)**
3. Number of CMA's observed passing medication over the past month: _____
4. Total number of medication errors/occurrences by CMA's during the past month: _____ **(if zero errors occurred, please complete #6, 7, 8, 8a, 9, 9a, if applicable, then sign and date)**

Please Note **number** of errors by type:

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

5. During the last month (quarter) your facility was required to address:

5a. Number of Complaints from:

Consumers: _____
 Parents/Guardian: _____
 School Administration: _____
 Residents: _____
 Other (list): _____

5b. Number of events reported to:

CYFD: _____
 District: _____
 Parent/Guardian: _____
 Licensing and Certification: _____
 DHI: _____
 BON: _____
 Board of Pharmacy _____

5c. Number of calls to poison control: _____

5d. Number of events reportable to primary care provider: _____

How many were:
 1. Side effects: _____
 2. Allergic reactions: _____
 3. Adverse effects: _____

5e. Number of events that required emergency services: _____

How many were:
 1. Calls to 911: _____
 2. Urgent care: _____
 3. Emergency room: _____

5f. Number of Hospitalizations resulting from:

1. Medication event: _____
 2. Omission: _____
 3. Death: _____

6. Number of times you met or conducted in-services with CMA's during the month to provide instruction regarding medications, dose, route, method of administration, documentation, and resident observation: _____
7. Number of negative finding (s) (related to medication and certified medication aides) from the most recent licensing or certification surveys and/or accreditation visits. _____
8. **If this information has changed from the previous month, please complete:**
- 8a. Date of last DOH survey/certification. _____ Date of last BON survey/certification. _____
9. Number of significant events as defined by the facility or institution. _____
- 9a. **Please attach significant events in detail for each event.**

Submitted by: _____ / _____
Signature & Printed Name Date