

**UTAH BOARD OF NURSING**  
**MEDICATION AIDE CERTIFIED (MAC)**  
**PILOT ASSESSMENT TOOL**

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

**NOTE: Incomplete reports will be sent back to the facility for completion and corrected information**

Either fax (801) 530-6511 or mail to Utah BON, P.O. Box 146741, Salt Lake City, 84114-6741

Facility Name: \_\_\_\_\_ Reporting for the month of: \_\_\_\_\_

**(Complete for 1 month only, each month requires a separate sheet)**

Date submitted: \_\_\_\_\_ **(MUST BE AT BON BY 10<sup>TH</sup> OF EVERY MONTH)**

Program: Circle one: **Nursing Care Facility** \_\_\_\_\_ **Small Health Care Facility** \_\_\_\_\_ **Intermediate Care Facility for the Mentally Retarded (ICFMR)** \_\_\_\_\_ **Assisted Living Facility Type I or II** \_\_\_\_\_ **Designated Swing Bed Unit in a General Hospital** \_\_\_\_\_

1. Number of **MAC** \_\_\_ FT \_\_\_ PT; **RN** \_\_\_ FT \_\_\_ PT; **LPN** \_\_\_ FT \_\_\_ PT; **CNA** \_\_\_ FT \_\_\_ PT, employees employed by the facility. If no **MAC**'s employed by your facility check here and sign and date below \_\_\_\_\_.

2a. Number of **routine** Medications passed: \_\_\_\_\_ (must be completed using the formula given)

2b. Number of **PRN** medications passed: \_\_\_\_\_ (must be completed using the formula given)

**Formula:**

**Calculate the number of medications passed using the following formula: Average number of medications per client X the number of medications passes per day X 30 days X average monthly census. Census is the number of clients receiving any kind of medications.**

3. Total number of medication errors/occurrences by **MAC**'s during the past month: \_\_\_\_\_ **(IF ZERO ERRORS, COMPLETE NUMBERS 6 AND 7. SIGN, DATE, AND PRINT YOUR NAME ON THE BOTTOM OF FORM)**

4a. Error breakdown: Please indicate number of errors by type:

Wrong medication \_\_\_\_\_

Wrong time \_\_\_\_\_

Wrong route \_\_\_\_\_

Omission \_\_\_\_\_

Wrong patient \_\_\_\_\_

Documentation \_\_\_\_\_

Wrong dose \_\_\_\_\_

5a. Number of events related to medication administration error by the **MAC**:

Prescribing practitioner notified \_\_\_\_\_

Acute care hospitalization \_\_\_\_\_

In house intervention \_\_\_\_\_

Death \_\_\_\_\_

Emergency services \_\_\_\_\_

5b. On a separate attached sheet of paper, provide details of the medication error including drug, dose, route, type of error and remediation provide to the **MAC**.

6. Number of times you met or conducted in-services with **MAC**'s during the month to provide instruction regarding medications, dose, route, method of administration, documentation, and resident observation: \_\_\_\_\_. Document total hours, content covered and number of attendees: \_\_\_\_\_.

7. Number of negative finding (s) (related to medication and **Medication Aide Certified**) from the most recent licensing or certification surveys and/or accreditation visits \_\_\_\_\_.

**COMMENTS:** \_\_\_\_\_

**I certify, under penalty of perjury, to the truth and accuracy of all statements, answers and representations made on this quality assurance progress report.**

Submitted by: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature Printed Name Date

Your Agency Title: \_\_\_\_\_