

Use of Medication Assistants In Brief

Questions have been raised as to whether the use of assistive personnel, trained to administer medications is the best approach in promoting safe, quality care during a nursing shortage. Currently there are at least 36 states that permit the administration of medications in select settings by assistive personnel, given completion of the required training. A chart of the states and specific parameters is available.

Some health care administrators, legislators and regulators believe this is one way to respond to the nursing shortage. Long term care administrators have argued this approach is a way to avoid regulatory penalties when medications are not administered in a timely fashion; supported by the belief that medication technicians will not be interrupted during the medication pass as nurses are and that the burden is being lifted from nurses.

It has been reported that medication errors are among the most common medical errors, harming at least 1.5 million people annually. The same report cites the extra medical costs associated with treating drug related errors occurring in hospitals alone amount to \$3.5 billion per year. (Institute of Medicine of the National Academies, July 2006). Since errors occur, not just in hospitals, but in multiple settings, this is believed to be a conservative estimate. Medication errors are attributed to a number of system failures, including the process of administration. The Institute of Medicine's (IOM) 1999 report, "To Err is Human" has served as a blueprint for improvements in the health care system, recommending a number of strategies shown to reduce errors in the medication process. In spite of some progress in implementation of some of the suggestions, the number of errors continues to be staggering. This is compounded by the belief there is underreporting of errors in general. Underreporting has, in part, been attributed to a failure of a standardized definition of an error. Is a "near miss" reportable? Another contributing factor is the fear of reprimand that still pervades the psyche of some practitioners. Although there has been no documentation pointing to administration errors resulting from harried nurses and inadequate staffing, this is likely less about identifying the root cause, but more about what is reported.

The 1999 IOM report recognized the complexity associated with medication administration and in particular the multiple tasks performed by nurses. What was lacking at that time is recognition of the cognitive processes in which nurses engage while administering medications. The processes nurses use during medication administration to prevent errors, prevent harm and promote therapeutic responses are not well known. Studies of nurses and nursing students thinking processes have produced inconsistent findings, complicated by the multiplicity of terms. However, the *Journal of Nursing Scholarship (First Quarter 2007)* described a study designed to explain nurses' reported thinking processes during medication administration. The study revealed ten descriptive categories of nurse's thinking: communication, dose time, checking, assessment, evaluation, teaching, side effects, work-arounds, anticipatory problem solving, and drug administration. The researchers concluded that nurse's thinking processes extend beyond rules and procedures as nurses use patient data and interdisciplinary knowledge when administering medications. The study demonstrated the considerable use of the nurse's clinical knowledge, experience and understanding of patient's patterns of response and potential problems when engaged in the medication process. For example, nurses integrated their knowledge of patient's laboratory values and pattern of individual pathophysiological responses to determine the need for a change in drug dose or time and subsequent communication to the prescriber. Checking for the correctness and validity of the order is a step in thinking that has resulted in the reduction of errors, commonly known as near misses. The technical portion of medication administration includes the commonly held steps, known as the five rights, the right: patient, medication, dose, route, and time. Wilson and DiVito-Thomas (2004) proposed a sixth right to the well established five rights of medication administration, that of "the right response of the patient to the medication". This right can be equated to the nurse's thinking associated with evaluation. Another example of nurses' thinking include what the researchers referred to as work a-rounds, representing the thinking about steps nurses need to use to bypass procedures in order to expedite getting drugs to the patients in a more timely fashion for a therapeutic response. This study found the actual act of administering a medication is a small part of the professional role in medication administration. The ten categories of thinking during medication administration indicate the intellectual complexity of the process.

The International Council of Nurses' (ICN) position statement, *Assistive or Support Nursing Personnel*, states that "the delegation of nursing care and the supervision of assistive nursing personnel is the responsibility of nurses", and that "the role, preparation, standards, and practice of assistive nursing personnel must be defined, monitored,

and directed by registered nurses.” Provision 4 of the *Code of Ethics and Interpretive Statements for Nurses* (ANA, 2010) declares a Registered Nurse (RN) is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care.” Nurse managers and administrators are also accountable for the provision of “an environment that supports and facilitates appropriate assignment and delegation. It is expected that the RN assigns and delegates tasks based upon the needs and conditions of the patient, potential for harm, stability of the patient’s condition, complexity of the task and predictability of the outcome. (*Standard 14, Nursing: Scope and Standards of Practice, ANA 2010*). In accordance with professional standards of practice, state nurse practice acts and regulatory language, the Registered Nurses must evaluate the performance of any delegated task and is ultimately responsible for the nursing care related patient outcomes.

The findings of the first national survey of medication aides were reported by the National Council of State Boards of Nursing (NCSBN) in the October 2011 issue of the *Journal of Nursing Regulation*. The data from this study imply that a disparity exists between regulation and practice. Medication aides reported being required to take on responsibilities beyond their defined role and training, some without sufficient supervision, if any. So what does this mean for states in which assistive personnel are or may become authorized to administer medications? Although the “task” has been shifted to assistive personnel, responsibility for the nursing care outcome remains with the nurse. Is the delegation of medication administration to assistive personnel whose training requirements are not standardized the best approach to ensuring the delivery of safe and quality nursing care? Like so much of the practice of registered nurses, it is not about tasks. Nurses must be present when policy and statutory changes are being discussed and be prepared to describe what unique contributions they make and recognize the implications associated with proposed changes. Also, strict compliance with state regulations, appropriate education and adequate supervision are essential.

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