**ANA Issue *Brief* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Use of Medication Assistants / Aides / Technicians

More than half the states have recognized the role of medication assistant / aide / technician (hereafter referred to as MA) in statute and /or regulation in at least one setting, often excluding some categories of medications and routes. Some health care administrators, legislators and regulators believe this is one way to respond to a 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 MAs will not be interrupted during the medication pass as nurses are and that the burden is being lifted from nurses. However, there is a great deal of variation between states as to the agency with oversight as well as the required training and who may train. Adding to quandary are settings either unregulated or loosely regulated in which employers have created MA positions, without authority by the state.

What do we know about medication administration?

Traditionally, medication administration has been a function of licensed individuals, primarily nurses. Nurses recognize that safe administration of medications is much more than a technical process. The administration of medications involves complex thinking and application of scientific knowledge. What began with five rights has now been extended to the eight rights, of medication administration, the: Right Patient, Right Medication, Right Dose, Right Route, Right Time, Right Documentation, Right Reason, and Right Response. Nurses have been educated to observe for signals and cues as to whether the medication is working as intended, while calculating the risk associated with the medication and a readiness to act appropriately and effectively when it is not.

Seventy percent of individuals in the U.S. take at least one medication per day, and more than half of all Americans take two.1 Every day at least one death in the U.S. happens as a result of a medication error, and approximately 1.3 million people annually are injured due to medication errors. 2  We know that unless there has been an injury or death, many errors go unreported. Underreporting has, in part, been attributed to a failure of a standardized definition of an error. Is a “near miss” or omission reportable? The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as: “… any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Another contributing factor to underreporting is the fear of reprimand that still pervades the psyche of some practitioners/ healthcare workers. Medication errors may be human related such as from a distraction or lack of knowledge or information, but often results from a flawed system with inadequate backup to detect mistakes.

 There are several steps in the process prior to administration in which an error can occur: ordering, transcribing, and / or dispensing. Nurse’s clinical knowledge, experience and understanding of the patient’s condition and indications for a medication serves as a safety valve. For example, a nurse’s integrated knowledge of a patient’s laboratory values and pattern of individual pathophysiological responses will determine appropriateness for a medication, usual dosage or time and subsequent communication to the prescriber. This sort of clinical judgement is outside the boundaries of the training and practice of an MA.

What has been the impact of the use of MAs?

Due to a lack of reporting / data collection, it is impossible to determine the safety and efficacy of utilizing MAs. However, in a national survey, MAs reported their concerns of insufficient training, inadequate supervision, and employer expectations that exceed regulations and training. (National Council of State Boards of Nursing (NCSBN) *Journal of Nursing Regulation* (October 2011): Vol 2/Issue 3). This study presented some limitations, given the variation in regulations between states.

What is the role for Registered Nurses (RNs)?

 It is recommended that RNs:

be knowledgeable of the relevant statute (s) / regulation(s) pertaining to MAs and the particular setting as well as employer policies, procedures and position descriptions. Note whether the employer’s practices are in concert with the regulations.

recognize and utilize the legal authority conferred by the state nurse practice act, specific to the delegation of tasks to an appropriately trained assistive personnel / MA. Some states have explicit / unique language pertaining to the administration of medications and delegation of “nursing” functions. Some Boards of Nursing reference the ANA-NCSBN National Guidelines for Delegation (updated 2019) outlining the responsibilities of the delegator, delegatee and the employer. [ana-ncsbn-joint-statement-on-delegation.pdf (nursingworld.org)](https://www.nursingworld.org/~4962ca/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/nursing-practice/ana-ncsbn-joint-statement-on-delegation.pdf) When a “task” has been shifted to assistive personnel, responsibility for the outcome remains with a licensed provider; 3 potentially the nurse, depending upon the setting.

advocate for the patient’s right to receive nursing care / medications from an appropriately trained individual who can be held accountable, is safe, and of the highest quality possible. Ensure the training matches the expectations. Utilize the right and obligation to validate the MAs competence and safety, and be permitted to exercise authority to provide additional training or withdraw their ability to perform medication administration, either for a single patient / resident or more broadly. This decision may be related to the MA’s performance or may be the result of a more complex medication regimen.

support collection of data pertaining to medication administration, beginning with the employer. Encourage a just culture environment in which practices that deviate from the norm, subsequent errors and / or unintended consequences result, the reaction is not punitive; rather the information is collected and used for learning purposes and continuous improvement.

be engaged when policy and statutory changes are being discussed. Help administrators and policymakers understand the implications associated with proposed changes and provide alternate solutions as necessary.

1. [Nearly 7 in 10 Americans Take Prescription Drugs, Mayo Clinic, Olmsted Medical Center Find – Mayo Clinic News Network](https://newsnetwork.mayoclinic.org/discussion/nearly-7-in-10-americans-take-prescription-drugs-mayo-clinic-olmsted-medical-center-find/) (2013)
2. <http://www.fda.gov/Drugs/DrugSafety/MedicationErrors/ucm080629.htm>
3. Nurses Utilization of Nursing Assistive Personnel in All Settings [Microsoft Word - FINAL ASSISTIVE PERSONNEL Position Statement from 071307.doc (nursingworld.org)](https://www.nursingworld.org/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements-secure/final-assistive-personnel-position-statement-from-071307.pdf)

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