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The First National Survey of Medication Aides

The First National Survey of Medication Aides

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National Council of State Boards of Nursing, Inc. (NCSBN®)

Mission Statement

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EXECUTIVE SUMMARY

A survey was developed with the goal of providing insights into medication aide (MA) education, training, supervision and work role from the MA perspective. In general, the data obtained from these surveys provide a snapshot of the MA role. The results will help regulators make decisions about the implementation or development of safe and effective MA programs.

The survey collected information from MAs on the following topics: (1) demographics and work setting; (2) training and education; (3) supervision; (4) communication; (5) authorized duties; and (6) medication administration. Most of the data were analyzed by two types of groups: work setting and regulatory agency.

The work settings were grouped as follows: (1) assisted living; (2) nursing home; (3) other long-term care (i.e., community-based services, board and care homes, home health, continuing care retirement communities, and housing for aging and disabled individuals); and (4) other (i.e., adult day care, group home, hospice, hospital, rehabilitation facility, residential care facility, intermediate care facility, developmentally disabled facility, psychiatric or mental health facility, correctional facility, and schools). The data were broken out by work setting because of the different regulations surrounding these facilities. For instance, nursing homes are more regulated in comparison to other long-term care facilities.

Regulatory agencies were grouped as follows: (1) board of nursing (BON); (2) other state agency (e.g., department of health); and (3) a combination of the BON and another state agency (i.e., the BON and another state agency are jointly responsible for MA regulation). It is important to note that 47% of respondents regulated by the BON primarily worked in assisted living facilities (compared to 17% that worked in nursing homes), while 58% of respondents regulated by another state agency primarily worked in nursing homes (compared to 28% that worked in assisted living facilities).

Key results from each survey section are discussed, followed by a discussion of implications and conclusions. Most results typically varied considerably by work setting and regulatory agency. Because of space constraints, only some of these variations are discussed.

Demographics and Work Setting

The average amount of time respondents worked as an MA was approximately 8.05 years. MAs who were regulated by a combination of the BON and another state agency worked on average the fewest number of years (6.83 years), followed by MAs regulated by BONs (6.90 years), and MAs regulated by another other state agency (9.44 years).

The majority of MAs were required to be a certified nursing assistant (CNA) before becoming an MA (68%). However, percentages varied considerably by type of facility. Specifically, 90% of MAs who worked in nursing homes were required to be a CNA before becoming an MA compared to 64% of MAs working in assisted living, 32% of MAs working in other long-term care facilities and 53% of MAs working in other facilities. There were also large differences by type of regulating agency. Specifically, 51% of MAs regulated by the BON and 46% of respondents regulated by a combination of the BON and another state agency were required to be a CNA before becoming an MA compared to 90% of respondents regulated by another state agency. Of those who were required to be a CNA before becoming an MA, 20% did not need any work experience as a CNA before becoming an MA.

The majority of MAs administer medications to adults (69%) or older adults (89%). However, a higher percentage of MAs who work in assisted living facilities (95%) and nursing homes (97%) administer medications to older adults versus those that work in other long-term care settings (70%) or other settings (70%). This indicates that those MAs working in other long-term care settings and other settings administer medications to a younger population.

In terms of client workload, MAs who worked in assisted living facilities (median=25 clients), nursing homes (median=31 clients) and other facilities (median=15 clients) averaged a much higher number of clients that they administer medications to

during a typical shift versus MAs working at other long-term care facilities (median=4 clients).

Training and Education

Very few MAs reported having no training (1%). MAs who worked in assisted living (49%), other long-term care facilities (70%) and other facilities (47%) where most likely to have obtained MA training from an employer, while MAs who worked in nursing homes (47%) were most likely to have obtained MA training from a community or junior college. Additionally, there were differences in training by the type of regulating agency. Specifically, MAs regulated by the BON (68%) and MAs regulated by a combination of the BON and another state agency (57%) were most likely to have obtained MA training from an employer, while MAs regulated by another state agency (46%) were most likely to have obtained MA training from a community or junior college.

Of the respondents who indicated they had some MA training, those who worked in nursing homes reported the highest amount of classroom training hours (median=60 hours), followed by MAs who worked in other facilities (median=40 hours), assisted living facilities (median=40 hours) and other long-term care facilities (median=20 hours). Additionally, there were differences in classroom training hours by type of regulating agency. Specifically, MAs regulated by the BON (median=40 hours) and MAs regulated by a combination of the BON and another state agency (median=40 hours) had fewer classroom training hours compared to respondents regulated by another state agency (median=64 hours).

Of the respondents who indicated they had some MA training, those who worked in nursing homes reported the highest amount of clinical training hours (median=20 hours), followed by respondents who worked in assisted living facilities (median=16 hours), other facilities (median=8 hours) and other long-term care facilities (median=1 hour). Additionally, there were differences by type of regulating agency. Specifically, respondents regulated by the BON (median=16 hours) and respondents regulated by a combination of the BON and another state agency (median=0 hours) had fewer clinical training hours compared to respondents regulated by another state agency (median=20 hours).

Of the respondents who indicated they had some MA training, those who worked in nursing homes reported the highest amount of total training hours (median=80 hours), followed by respondents who worked in assisted living (median=56 hours), other facilities (median=40 hours) and other long-term care facilities (median=22 hours). Additionally, there were differences by type of regulating agency. Specifically, respondents regulated by the BON (median=52 hours) and respondents regulated by a combination of the BON and another state agency (median=40 hours) had fewer clinical training hours compared to respondents regulated by another state agency (median=90 hours).

Of the respondents who indicated they had some MA training, the majority of training covered nurse delegation (71%) and nurse supervision (83%).

Of the respondents who indicated they had some MA training, the highest percentage of respondents indicated that the MA training needed to be more challenging (46%), specifically those respondents who worked in assisted living and nursing homes compared to respondents who worked in other long-term care facilities and other facilities. Specifically, 59% indicated the classroom component, 83% indicated the clinical component, 55% indicated the in-class testing/quizzes and 51% indicated the certification exam needed to be more challenging. And while many respondents wanted MA training to be more challenging, 28% felt that the training they received adequately prepared them to "some extent" and 71% indicated it "absolutely" prepared them.

Supervision

The highest percentage of respondents who had a registered nurse (RN) supervisor were MAs who worked in nursing homes (84%), followed by MAs who worked in other facilities (74%), assisted living facilities (65%) and other long-term care facilities (64%). A relatively large percentage of respondents indicated they had no supervision (8%). A much higher percentage of respondents who worked in other long-term care facilities (21%) also indicated

that they had no supervision. Additionally, there were differences by type of regulatory agency. Specifically MAs regulated by the BON (70%) and MAs regulated by a combination of the BON and another state agency (67%) had fewer individuals that were supervised by an RN compared to MAs regulated by another state agency (80%). Also, MAs regulated by a combination of the BON and another state agency had the highest percentage who indicated they had no supervision (15%).

Of respondents who had supervision, 41% of MAs who worked in long-term care facilities, 21% of MAs who worked in other facilities, 21% of MAs who worked in assisted living facilities and 8% of MAs who worked in nursing homes indicated their supervisor was never on-site. Results also varied by regulatory agency, where only 29% of respondents regulated by the BON indicated their supervisor was always on-site, while 41% of respondents regulated by another state agency indicated their supervisor was always on-site.

Of the MAs who had supervision, 10% indicated that they interacted with their supervisor during a typical shift "zero/none" times and 27% indicated "1–2 times." However, 42% indicated that they "agreed" and 41% indicated they "strongly agreed" that their supervisor was available whenever they needed assistance or help.

Communication

MAs were asked to report how frequently breakdowns in communication occurred between them and a licensed nurse regarding medication administration (39% reported "never," 26% reported "a few times a year," and 35% reported "about once a month" to "every day"); patient monitoring (43% reported "never," 24% reported "a few times a year," and 33% reported "about once a month" to "every day"); changes in a patient's status/condition (42% reported "never," 24% reported "a few times a year," and 34% reported "about once a month" to "every day"); and a patient refusing to take a medication (49% reported "never," 19% reported "a few times a year," and 33% reported "about once a month" to "every day").

MAs were also asked to report how frequently communication issues related to knowing when to obtain additional information about a patient's status and then conveying that status information to a licensed nurse occurred; 48% reported "never," 22% reported "a few times a year," and 31% reported "about once a month" to "every day." Of respondents who indicated this type of communication issue occurred at least once in the past year, 41% indicated the communication issues were related to obtaining vital signs, 39% indicated communication issues were related to reviewing vital signs, 42% indicated noting critical laboratory values prior to medication administration, 72% indicated documenting other relevant clinical or behavioral changes in a resident's status and 7% indicated "other." The "other" open-ended comments were related to the following: medication changes; changes in status; difficult communications with nurses/supervisors; communication between shifts; documentation issues; assessment issues; resident issues; availability of medications; and physician orders.

Authorized Duties

A relatively large percentage of MAs (21%) indicated that they were not given a written job description that addressed the scope of their medication-related responsibilities, while 33% indicated they needed more information about their authorized duties. There were differences by type of work setting; 36% of MAs who worked in assisted living facilities and nursing homes indicated that there needed to be more information about their authorized duties. In comparison, 27% of MAs who worked in other long-term care facilities and 28% of MAs who worked in other facilities indicated they needed more information about their authorized duties.

A relatively large percentage of MAs (21%) indicated that they thought some of the tasks that they performed were beyond the scope of what they should be doing in their job role. Results varied by type of facility; specifically, 28% of MAs who worked in assisted living facilities, 19% of MAs who worked in nursing homes, 17% of MAs who worked in other long-term care facilities and 17% of MAs who worked in other facilities indicated some of the tasks they performed where beyond their scope.

Those MAs who indicated that some of the tasks they performed were beyond their scope were asked to specify some of these tasks. The open-ended comments of 514 respondents (15%) were categorized into the following categories (example comments are provided):

a. Performing multiple tasks when administering medications/performing multiple roles
   - "Doing CNA tasks during a med pass."
   - "Doing some nursing jobs instead of nurse."

b. Assessments
   - "Assessing residents when falls occur."
   - "Doing pain assessments."

c. Overworked/role issues
   - "Giving medication on 2 separate floors at the same time."
   - "Total care residents in assisted living facility without the needed help or supplies."

d. Medications, treatments, procedures/wounds/insulin/breathing/narcotics/pain
   - "Giving PRN medications for pain and charting results."
   - "Giving insulin shots."
   - "Dressing wounds."
   - "Cath care. Oxygen."
   - "G-tube feedings. J-tube colostomy."

e. Doctor, pharmacy, family communications/change or reorder medications /initial medications/documentation
   - "Calling the doctor. Faxing orders to the pharmacy. Taking phone orders from doctors."
   - "Doing new orders from MD assessment (new residents). Paperwork."
   - "Talking with families. Answering questions about meds and tests."

f. Issues related to patient care
   - "When we have an emergency we are sometimes expected to take full control of the situation because we cannot get a hold of the nurse on call – this happens a lot."

g. Other issues related to patient care (including CNA duties)
   - "Cleaning residents' bathrooms and rooms due to shortage of housekeeping, doing laundry."
   - "Setting tables. Bussing tables. Food server. Patient care. Laundry. Med techs can't focus on medications if they have too many other tasks to do."

h. Multiple issues (combinations of any of the above categories)
   - "Breathing treatments. Tube feedings. Pumps on/off. Some nurses on some type of probation, so sometimes we have to do their jobs. Patches."
   - "Passing ice. Refilling ice chests. Passing snacks. Answering lights when I am in the middle of doing my med pass. Doing smoke breaks."

i. Other
   - "We are classified baby sitters, and should only be working with medications."

Respondents were asked to report how frequently a licensed nurse asked them to perform a task they felt they were not trained or qualified to perform; 73% reported "never," 15% reported "a few times a year" and 11% reported "about once a month" to "every day." These respondents were also asked to specify some of the tasks a licensed nurse asked them to perform that they felt they were not trained or qualified to perform; 554 MAs (17%) provided examples.

MAs were asked to indicate which, if any, of the six rights of medication administration was a priority for them to improve on in their role. Overall, more MAs reported right time (27%) and right documentation (31%) versus right patient (14%), right medication (17%), right route (14%) and right dose (17%). A relatively large percentage of respondents (32%) indicated they were afraid of getting disciplined for administering late medications.

Medication Administration

Inhalants. The following percentages of MAs were allowed to administer the following inhalants: inhalant medications (79%), metered dose inhaler (68%), medications used for intermittent positive pressure breathing (23%), medications or treatments via nebulizer (66%) and oxygen (69%).

Injectables. There were 29% of MAs who indicated they were allowed to administer injectable medications; however, responses varied by work setting and regulatory agency. A higher percentage of MAs who worked in assisted living facilities indicated that they were allowed to administer medications by injection (55%) versus MAs who worked in nursing homes (8%), other long-term care facilities (26%) and other facilities (30%). Also, a higher percentage of MAs regulated by the BON indicated they were allowed to administer medications by injection (52%) versus MAs regulated by a combination of the BON and another state agency (32%), and another state agency (14%).

Of the respondents who indicated they were allowed to administer medications by injection, respondents were allowed to administer medications through the intramuscular route (27%), intravenous route (7%), subcutaneous route (62%), intradermal route (19%) and hypodermoclysis route (7%).

Of the respondents who indicated they were allowed to administer medications by injection, the majority were allowed to administer predrawn insulin (70%), though it varied by facility: 77% of respondents worked in assisted living facilities; 61% worked in other long-term care facilities, 60% of respondents worked in nursing homes; and 57% of respondents worked in other facilities. Additionally, a lower percentage of respondents regulated by the BON (68%) were allowed to administer predrawn insulin, compared to 69% of respondents regulated by a combination of the BON and another state agency, and 78% of respondents regulated by another state agency.

Of the respondents who indicated they were allowed to administer medications by injection, the majority (57%) indicated they were allowed to administer insulin that was not predrawn: 63% of respondents worked in assisted living facilities compared to 51% of respondents who worked in nursing homes, 43% of respondents who worked in other long-term care facilities and 48% of respondents who worked in other facilities. Additionally, a much higher percentage of respondents who were regulated by the BON (72%) were allowed to administer insulin that was not predrawn, compared to respondents who were regulated by a combination of the BON and another state agency (58%), and another state agency (20%).

Of the respondents who indicated they were allowed to administer medications by injection, 34% indicated they were allowed to administer epinephrine by injection and 6% were allowed to administer anticoagulants by injection.

Topicals. The vast majority of MAs (94%) were allowed to administer topical medications. Of the MAs who were allowed to administer topical medications, a much higher percentage who worked in assisted living (54%), other long-term care facilities (58%) and other facilities (52%) indicated that they were allowed to administer topical medications requiring a sterile dressing compared to those that worked in nursing homes (23%). A similar pattern of results was evident for topical medications requiring an assessment of skin condition.

Overall, of the MAs allowed to administer topical medications, respondents were allowed to administer topical patches (93%); nitroglycerin paste (46%); treatments that involve advanced skin conditions, including stage III and IV decubitus ulcers (19%); topical medications requiring a sterile dressing (43%); topical medications requiring an assessment of skin condition (34%); debridement (8%); and duoderm application (40%).

Orals. The majority of respondents indicated they were allowed to administer sublingual medications (82%) and maintenance doses of oral anticoagulants (e.g., Coumadin) (78%).

Tubes. MAs were allowed to administer medication that must be inserted into a nasogastric tube (8%), medication that must be inserted into a gastric tube (17%) and medication that must be inserted into a jejunostomy tube (9%).

Classes of drugs. A strong majority of respondents indicated they were allowed to administer

controlled substances (90%). Of the respondents who indicated they were allowed to administer controlled substances, 82% indicated they were allowed to administer schedule II narcotics.

Additionally, 27% of respondents indicated they were allowed to administer chemotherapeutic agents, 39% were only allowed to administer oral maintenance chemotherapy and 22% were only allowed to administer Tamoxifen.

Others. MAs were allowed to administer the first dose of a new medication (80%); the first dose of a changed medication (87%); Pro re nata (PRN) or "as needed" medications (only after an assessment of the patient by a licensed nurse) (89%); PRN medications (assessment of the patient by a licensed nurse not required) (67%); medications administered when the patient's condition is unstable or the patient has changing nursing needs (49%); medications administered when the supervising nurse is unavailable to monitor the progress and/or the effect of the medication on the patient (46%); medications administered without the task having been delegated by a nurse (67%); medications that require a mathematical conversion between units of measurement to determine the correct dose (35%); and medications being administered as part of clinical research (12%).

The majority of respondents were allowed to administer drops, ointments or sprays into the eyes (95%), ears (93%) and nose (94%). Far fewer indicated they were allowed to administer barium or other diagnostic contrast media (21%).

MAs were allowed to perform the following tasks/activities:

- Regulating of intravenous fluids (4%);
- Programming insulin pumps (4%);
- Complete documentation for medication administration (82%);
- Complete medication error reports (67%);
- Take telephone or verbal orders for medication (18%);
- Receive written orders for medication (37%);
- Transcribe medication and treatment orders (23%);
- Order initial medications from pharmacy (36%);
- Reorder medications from pharmacy (74%);
- Account for controlled substances (perform a narcotic count) if assisted by a licensed nurse (85%);
- Account for controlled substances (perform a narcotic count) if assisted by another MA (76%);
- Receive and count medications (86%);
- Instill irrigation fluids of any type (including, but not limited to colostomy, urinary catheter and enema) (22%);
- Perform any sterile procedure or medication administration that involves sterile technique (28%);
- Conduct patient assessments or evaluations (23%);
- Engage in patient teaching activities related to medications (49%);
- Take vital signs prior to or after administering medications (93%);
- Administer medications that are in a unit dose package or a prefilled medication holder (86%);
- Assume responsibility for medication pumps, including patient-controlled analgesia (8%);
- Perform oral, nasal or tracheal suctioning (12%);
- Perform blood glucose testing (62%);
- Crush medications (authorization by a licensed nurse not required) (59%);
- Crush medications (authorization by a licensed nurse is required) (74%);
- Destroy medications (36%); and
- Calculate drug dosages (26%).

MAs were expected to recognize normal and abnormal conditions for the patient (i.e., identify a change in condition) (94%); recognize changes in patients' conditions or behaviors (98%); recognize side effects (94%); recognize toxic effects (80%); recognize allergic reactions (92%); recognize immediate desired effects (85%); recognize unusual and unexpected effects (90%); recognize changes in client's condition that contraindicates continued administration of the

medication (81%); anticipate effects which may rapidly endanger a client's life or well-being and make judgments and decisions concerning actions to take (51%); review the patient's plan-of-care (61%); and collect and document patient conditions (63%).

A relatively large percentage of respondents (33%) indicated that a licensed nurse never assesses a patient within a 30-minute window prior to or after a patient's medication administration.

Implications and Conclusions

The MA role was designed to administer certain categories of drugs via specific routes authorized by state law and delegated to them by an RN or licensed practical/vocational nurse (LPN/VN), as stipulated by state law. Studies indicate that MAs can perform these responsibilities safely if free from distractions and other responsibilities. The data from the current study implies that a disparity exists between regulation and practice in many nursing homes, long-term care and other institutions. MAs reported being required to take on responsibilities beyond their defined role.

These results have implications for regulators, educators, long-term care administrators, nurses that supervise and delegate to MAs, and the MAs themselves. It is the responsibility of all individuals employing and working with MAs to know state laws and regulations and adhere to them. Regulators are encouraged to educate long-term care administrators about the legal role and responsibilities of MAs. State inspectors from Centers for Medicare and Medicaid Services (CMS), health departments and/or the state's Office of the Inspector General should be aware of the data from this study and observe facilities for violations in state regulations regarding MA role and responsibilities.

Many education programs can be more rigorous and provide an increased number of hours of clinical and classroom education. In addition to knowing what they should do, MAs need to know what they should not do. They need to know when to call a nurse and how to refuse when delegated a responsibility beyond their designated legal role. Nurses delegating responsibilities to MAs must know the law, what they are authorized to delegate and provide the appropriate supervision. Long-term administrators should examine the findings reported in this study and determine whether discrepancies between state laws and expectations of MAs exist in their institutions. Administrators must be held accountable when there is a lack of adherence to state regulations regarding MAs.

Research suggests that MAs can safely administer medications (Scott-Cawiezell, Pepper, Madsen, Petroski, Vogelsmeier, & Zellmer, 2007). However, strict compliance with state regulations, adequate education, adequate supervision and proper authorized duties need to be in place for the MA role to function safely.

The First National Survey of Medication Aides

National Council of State Boards of Nursing, Inc. (NCSBN®)

INTRODUCTION

A survey was developed with the goal of providing insights into medication aide (MA) education, training, supervision and work role from the MA perspective. The data obtained from the survey provides information to help regulators make decisions about the implementation or development of safe and effective MA programs.

Background and Purpose

The general purpose of the survey data was to help boards of nursing (BONs) make decisions about or support decisions regarding: (1) implementing or not implementing an MA program; or (2) developing or changing MA program requirements. In general, BONs should be able to point to specific results from the survey to support their decisions regarding the regulation of MAs in their state.

The main objectives of the study were to obtain information from MAs on the following topics: (1) demographics and work setting; (2) training and education; (3) supervision; (4) communication; (5) authorized duties; and (6) medication administration. In general, the data obtained from the surveys provides a snapshot of the MA role, and results will help regulators make decisions about the implementation or development of safe and effective MA programs.

Survey Development

Survey items were derived by reviewing MA literature and regulations. Literature on MAs was somewhat lacking in that many studies had very low sample sizes and did not cover wide geographic areas. Conducting a nationwide survey provided an opportunity to obtain a more representative sample of responses and provided an alternative method of collecting data on MA safety.

Some of the survey items were developed based on the following results/observations from the literature on MAs:

- Walker (2008) suggested that the implementation of the medication nursing assistant role enhances nursing care and decreases stress among nurses in long-term care facilities.
- The Arizona State Board of Nursing (2008) suggested that there was no reduction in the quality of care when medication technicians were introduced onto a health care team.
- Young et al. (2008) suggested that unlicensed assistive personnel generally do well with the task of medication administration in assisted living, given their level of training and preparation when the bulk of the medications administered are low risk and routine.
- The Arizona State Board of Nursing (2008) suggested that when facilities have medication technicians, resident care improves because nurses' time is freed up to perform higher level tasks.
- Hughes et al. (2006) suggested that facilities that employed medication technicians had more deficiency citations for activities relating to medication errors and pharmaceutical services (including medication administration). The authors posited that this may have been a function of the level of medication technician supervision, which could lead to more errors. The authors stated that in many states, supervision of medication technicians by professional staff is assumed, yet the likelihood that such supervision occurs is questionable.
- Mitty (2009) suggested that 27% of facilities did not provide MAs with written job descriptions that addressed the nature and scope of their medication-related responsibilities. The author also calls for more rigorous training and supervision of MAs.
- Reinhard, Young, Kane and Quinn (2006) stated that there is a lack of clarity in MA practice parameters that result in confusion and procedures that might "push the envelope."
- Vogelsmeier, Scott-Cawiezell and Zellmer (2007) found that scope of practice issues were raised about assessment. This issue was of particular concern in nursing homes in which the medication administrators were predominantly certified medication technicians (CMTs).

- Vogelsmeier et al. (2007) found issues related to administration and monitoring. There appeared to be a lack of communication between a medication administrator's group and a medication management group regarding changes in residents' conditions, as well as the issue of residents refusing to take medications.
- Scott-Cawiezell, Madsen, Pepper, Vogelsmeier, Petroski and Zellmer (2009) found that in one nursing home, CMTs were afraid of being punished for late medications.
- Young et al. (1998) and Young and Sikma (1999) found that, overall, nurses were moderately satisfied with nurse delegation. Registered nurses (RNs) identified the benefits of delegation as positive quality of care; cost savings; improved placement availability; positive changes in RN role; bringing unlicensed and unregulated practice under RN supervision; improved continuity of care; and the benefits of trained staff. RNs identified the concerns over delegation as lack of confidence in the ability of nursing assistants to do the tasks; training; regulatory aspects; introductory training liability; and the potential for negative quality of care. These concerns resolved after one year. Nurses highlighted the following sources of satisfaction: more freedom and time to provide care; the potential for RN role development; better communication among the care team; better staff morale; and bringing unlicensed and unregulated practice under the supervision of RNs. Sources of dissatisfaction were the logistics of training, high staff turnover, redundancy and the volume of paper work.
- Spector and Doherty (2007) and the National Council of State Boards of Nursing (NCSBN) (2007) argued that there should be adequate education for both the MA and the delegating nurse on delegation and supervision. Research has shown that new nurses report that they are not adequately prepared in their nursing programs to delegate tasks to others (Kenward & Zhong, 2006; NCSBN, 2006a).

METHOD

Participants

The MA sampling method was similar to sampling methods used for NCSBN's *Report of Findings from the 2006 Job Analysis of Medication Assistants* (2006). Specifically, state agencies responsible for MA program oversight in states that have MAs were contacted and asked if they could provide a list of MAs in their state. Overall, 18 states provided an MA mailing list containing home addresses. Additionally, there were: (a) states that did not have an MA mailing list, but rather, only had mailing lists of facilities that employed MA; (b) states that did not have either an MA or a facility mailing list; (c) states that did not have any MAs currently working; and (d) states that did not reply (see Table 1 and 2).

Overall, 20,819 surveys were mailed, 2,263 were returned to sender, 1,273 opted out (many of which indicated they no longer or have never worked as an MA), 57 surveys were pulled from analyses for data quality concerns; 3,455 surveys were received resulting in a 20% response rate.

Materials

MA survey. The MA survey contained six sections: (1) demographics and work setting; (2) training and education; (3) supervision; (4) communication; (5) authorized duties; and (6) medication administration (see Appendix B).

Procedure

A letter was sent announcing the arrival of a survey in approximately one week. In the survey mailing, MAs were asked to complete the enclosed survey and were told that all responses would be kept confidential, data would only be reported in the aggregate and the identification number printed on each survey would be used for tracking purposes only. A follow-up postcard was sent to survey non-responders. A few weeks later, a second copy of the survey was sent to non-responders.

Table 1. Study Sampling Methods

	Total MA Population	Study Sample	Number Mailed	Number Received	Title
Arizona	17	5	5	1	Medication Technician
Arkansas	47	15	15	5	Medication Assistive Person
District of Columbia	465	155	155	28	Trained Medication Employees
Indiana	3,161	1,053	1,053	237	Qualified Medication Aide
Kansas	9,036	3,012	2,815	511	Certified Medication Aide
Maryland	68,479	22,826	3,967*	275	Medicine Aide or Medication Technician
Montana	6	2	2	1	Medication Aide
Nebraska (a)	8,933	2,977	2,810	293	Medication Aide
Nebraska (b)	32	10	10	1	Medication Aide – 20 hour
Nebraska (c)	9,590	3,196	2,825	501	Medication Aide – 40 hour
New Hampshire	144	48	48	16	Medication Nursing Assistants (licensed) or Licensed Nursing Assistant-Medication Certified
New Jersey	2,088	696	696	141	Certified Medication Aide
New Mexico	452	150	150	29	Certified Medication Aide
North Carolina (a)	2,628	876	876	137	Medication Aide
North Dakota	1,772	590	590	158	Medication Aide (I, II, or III)
Ohio	93	31	31	7	Medication Aide
Oregon	1,274	424	424	101	Certified Medication Aide
Texas	10,457	3,485	2,840	580	Medication Aide
Virginia	3,989	1,329	1,329	312	Registered Medication Aide
Wisconsin	1,369	456	456	116	Medication Aide
Totals	**124,032**	**41,336**	**21,097**	**3,450**	
Actual Totals			**20,819**[1]	**3,455**[2] **20.06%**	

Note. A stratified sampling technique was used. The entire population was divided into three mailing lists for use with three different studies; hence, study sample are the numbers available for use for the current study. In some cases the number of survey respondents needed (with 4% error and 95% confidence by population size) surpassed the study sample for a particular state. Additionally, in many cases, the number of surveys needed to be mailed (given an estimated 20% response rate) surpassed the study sample for a particular state. In both of these cases the entire study sample for a given state was mailed a survey.

*=Maryland has two types of MAs who function very differently. Because the two types were not identified in the mailing lists and because of the very large MA population, Maryland was slightly oversampled (based on an estimated 15% response rate).

States that only had facility lists: Kentucky, Missouri, South Carolina, West Virginia, North Carolina (b), South Dakota, Minnesota and Massachusetts.

States that did not have MA lists or facility lists: Iowa and Maine.

States that did not have any MAs currently working: Colorado, Utah and Idaho.

States that did not respond: Georgia and Oklahoma.

[1] 278 addresses were not mailed. After the mailing was set-up at the mailing house, 20,819 were mailed.
[2] Number received sums to 3,450; the total reported here is higher because five respondents removed their ID and could not be classified.

Table 2. Agencies that Regulate MAs by Jurisdiction		
Jurisdiction	**Title of Unlicensed Assistive Personnel**	**Regulatory Oversight**
1. Arizona	Certified Medication Technician	BON
2. Arkansas	Medication Assistive Person	BON
3. Colorado	Medication Aide	BON
4. Connecticut	Certified Unlicensed Personnel And Medication Technician (Pilot Program)	DOH*
5. District of Columbia	Trained Medication Employees	BON
6. Georgia	Qualified Medication Aide	BON, LPN; Department of Behavioral Health & Developmental Disabilities (Advisory to BON, LPN); Department of Human Resources, Office of Regulatory Services (rules and regulations over community living arrangements)
7. Idaho	Certified Medication Assistant	BON
8. Indiana	Qualified Medication Aide	DOH
9. Iowa	Certified Medication Aide	Department of Inspections and Appeals
10. Kansas	Certified Medication Aide	Department of Health and Environment
11. Kentucky	Medication Aide Credentialed	Cabinet for Health Services
12. Louisiana	Medication Attendant Certified	Department of Health and Hospitals
13. Maine(a)	Certified Medication Assistants-Medications	BON
14. Maine (b)	Certified Residential Care Medication Aide	Department of Health and Human Services
15. Maryland (a)	Medication Technician	BON
16. Maryland (b)	Certified Medication Aide	BON
17. Massachusetts	Medication Aide	Departments of Public Health, Mental Health and Mental Retardation
18. Minnesota	Trained Medication Aide And Unlicensed Assistive Personnel Administering Medications	BON
19. Missouri (a)	Level I Medication Aide	Department of Health and Senior Services, Division of Regulation and Licensure
20. Missouri (b)	Certified Medication Technician	Department of Health and Senior Services, Division of Regulation and Licensure
21. Montana (a)	Medication Aide (Licensed)	BON
22. Montana (b)	Certified Medication Aide	Department of Public Health and Human Services
24. Nebraska (a)	Medication Aide	BON; Department of Health and Human Services – Licensure Unit
25. Nebraska (b)	Medication Aide – 20 Hour	BON; Department of Health and Human Services – Licensure Unit
26. Nebraska (c)	Medication Aide – 40 Hour	BON; Department of Health and Human Services – Licensure Unit
27. New Hampshire (a)	Licensed Nursing Assistant-Medication Certified	BON
28. New Hampshire (b)	Medication Nursing Assistants (Licensed)	BON
29. New Jersey	Medication Aide	Department of Health and Senior Services
30. New Mexico	Certified Medication Aide	BON
31. North Carolina (long-term care/skilled nursing facility)	Medication Aide	BON; Division of Health Service Regulation/Center for Aide Regulation and Education
32. North Carolina (adult care homes)	Medication Aide	Division of Health Service Regulation/Adult Care Licensure Section
33. North Dakota (a)	Medication Assistant I	BON
34. North Dakota (b)	Medication Assistant II	BON

Table 2. Agencies that Regulate MAs by Jurisdiction		
Jurisdiction	**Title of Unlicensed Assistive Personnel**	**Regulatory Oversight**
35. North Dakota (c)	Medication Assistant III	BON
36. Ohio	Medication Aide Certified	BON
37. Oklahoma	Certified Medication Aide	DOH
38. Oregon	Certified Medication Aide	BON
39. South Carolina	Non-Licensed Staff Person	Department of Health and Environmental Control (responsible for licensing healthcare facilities, are no regulation of non-licensed staff)
40. South Dakota	Unlicensed Assistive Personnel	BON
41. Texas (facilities)	Medication Aide	Department of Aging and Disability Services
42. Texas (correctional institutions)	Medication Aide	Department of Aging and Disability Services
43. Texas: Home Health	Medication Aide	Department of Aging and Disability Services
44. Utah	Medication Aide Certified	Division of Occupational and Professional Licensing in collaboration with the BON
45. Virginia	Registered Medication Aide	BON
46. West Virginia	Unlicensed Personnel, Approved Medication Assistive Personnel and Medication Administrative Personnel	Office of Health Facility Licensure & Certification
47. Wisconsin (nursing home/ facilities for the developmentally disabled)	Medication Aide	Department of Health and Family Services, Division of Quality Assurance
48. Wisconsin (hospice)	Medication Aide	Department of Health and Family Services, Division of Quality Assurance

Note. Results do not include data from jurisdictions that are shaded out. BON=Board of Nursing; DOH=Department of Health; LPN=Licensed Practical Nurse.

*=There are programs regulated by the Department of Developmental Disabilities, the Department of Children and Families, as well as the Department of Mental Health and Addiction Services. All of these programs have their own regulations and different training requirements and were not included in the analyses because of difficulty locating information on these programs.

Table 3. Types of State Agencies that Regulate Respondent MAs		
	n	**Percentage**
BON	933	27%
Other state agency	1,585	46%
Combination	932	27%

RESULTS

For many of the analyses, responses were broken out by the type of agency that regulated the respondent MA including: (1) BON; (2) other state agency (e.g., department of health); and (3) a combination of the BON and another state agency (i.e., the BON and another state agency are both responsible for MA regulation). See Table 2 for a breakdown of each type of jurisdiction who had MAs at the time of this study and the state agency that regulated the role.

Overall, 27% of respondents were regulated by the BON, 46% were regulated by some other state agency (i.e., Department of Health, Department of Aging and Disability Services, etc.), and 27% were regulated by a combination of the BON and another state agency (see Table 3).

Additionally, many of the analyses were broken out by the following types of work settings: (1) assisted living; (2) nursing home; (3) other long-term care (i.e., community-based services, board and care homes, home health, continuing care retirement communities, and housing for aging and disabled individuals); and (4) other (i.e., adult day care, group home, hospice, hospital, rehabilitation facility, residential care facility, intermediate care facility, developmentally

Table 4. Work Setting by Regulatory Agency				
	Overall (n=3,384)	**BON (n=908)**	**Other State Agency (n=1,558)**	**Combination (n=913)**
Assisted living	**1,107 (33%)**	425 (47%)	441 (28%)	239 (26%)
Nursing home	**1,330 (39%)**	154 (17%)	897 (58%)	277 (30%)
A combination of assisted living or nursing home and some other facility	**16 (< 1%)**	6 (1%)	9 (1%)	1 (< 1%)
Other long-term care				
Community-based services	**49 (1%)**	15 (2%)	8 (1%)	26 (3%)
Board and care homes	**18 (1%)**	3 (< 1%)	5 (< 1%)	10 (1%)
Home health	**86 (3%)**	21 (2%)	19 (1%)	45 (5%)
Continuing care retirement communities	**19 (1%)**	12 (1%)	6 (< 1%)	1 (< 1%)
Housing for aging and disabled individuals	**41 (1%)**	13 (1%)	8 (1%)	20 (2%)
Adult day care	**24 (1%)**	10 (1%)	3 (< 1%)	11 (1%)
Group home	**135 (4%)**	62 (7%)	17 (1%)	56 (6%)
Residential care facility	**81 (2%)**	40 (4%)	11 (1%)	30 (3%)
Intermediate care facility (for example, developmentally disabled facility)	**112 (3%)**	30 (3%)	12 (1%)	70 (8%)
Other				
Hospice	**14 (< 1%)**	4 (< 1%)	5 (< 1%)	5 (1%)
Hospital	**33 (1%)**	8 (1%)	7 (< 1%)	18 (2%)
Rehabilitation facility	**62 (2%)**	17 (2%)	20 (1%)	25 (3%)
Psychiatric or mental health facility	**69 (2%)**	18 (2%)	31 (2%)	20 (2%)
Correctional facility	**52 (2%)**	3 (< 1%)	32 (2%)	17 (2%)
Schools	**33 (1%)**	26 (3%)	5 (< 1%)	2 (< 1%)
Other	**103 (3%)**	41 (5%)	22 (1%)	40 (4%)

Table 5. Average Age of Respondents						
	n	**M**	**SD**	**Min**	**Max**	**Median**
Overall	3,300	45.13	12.85	18.15	84.68	46.61

Table 6. Gender of Respondents	
Gender	**Overall (n=3,395)**
Female	3,086 (91%)
Male	309 (9%)

Table 7. Racial/Ethnic Background of Respondents	
	Overall (n=3,382)
Pacific Islander	14 (< 1%)
Asian Indian	11 (< 1%)
Asian Other	74 (2%)
Native American or Alaskan Native	58 (2%)
Black or African American	905 (27%)
Hispanic	238 (7%)
White	2,033 (60%)
Other	49 (1%)

Table 8a. Employment Title by Work Setting					
	Overall (n=3,374)	**Assisted Living (n=1,103)**	**Nursing Home (n=1,324)**	**Other Long-term Care (n=554)**	**Other (n=393)**
Medication aide	**2,425 (72%)**	862 (78%)	1,081 (82%)	278 (50%)	204 (52%)
Medication assistant	**161 (5%)**	40 (4%)	84 (6%)	14 (3%)	23 (6%)
Medication administrative person	**36 (1%)**	11 (1%)	6 (< 1%)	10 (2%)	9 (2%)
Medication technician	**303 (9%)**	125 (11%)	50 (4%)	93 (17%)	35 (9%)
Unlicensed assistive person	**34 (1%)**	9 (1%)	2 (< 1%)	15 (3%)	8 (2%)
Other	**415 (12%)**	56 (5%)	101 (8%)	144 (26%)	114 (29%)

Table 8b. Employment Title by Regulatory Agency				
	Overall (n=3,374)	**BON (n=905)**	**Other State Agency (n=1,556)**	**Combination (n=908)**
Medication aide	**2,425 (72%)**	477 (53%)	1,272 (82%)	672 (74%)
Medication assistant	**161 (5%)**	49 (5%)	94 (6%)	18 (2%)
Medication administrative person	**36 (1%)**	19 (2%)	11 (1%)	6 (1%)
Medication technician	**303 (9%)**	221 (24%)	58 (4%)	23 (3%)
Unlicensed assistive person	**34 (1%)**	23 (3%)	3 (< 1%)	8 (1%)
Other	**415 (12%)**	116 (13%)	118 (8%)	181 (20%)

disabled facility, psychiatric or mental health facility, correctional facility, and schools). The data were broken out by work setting because of the different regulations surrounding these facilities; for instance, nursing homes have more regulations in comparison to another long-term care facilities. The highest percentage of responders (39%) worked in nursing homes. The distribution of work setting is presented in Table 4.

It is important to note that 47% of respondents regulated by the BON primarily worked in assisted living facilities, while 58% of respondents regulated by another state agency primarily worked in nursing homes.

Demographics and Work Setting

The average age of respondents was 45 years old (see Table 5) and the vast majority of respondents were female (91%) (see Table 6). The majority of respondents were White (60%), followed by Black or African American (27%) and Hispanic (7%) (see Table 7).

The majority of respondents had the primary employment title of "medication aide" (72%). This title was more prevalent in nursing homes (82%) and assisted living (78%) versus other long-term care (50%) and other facilities (52%) (see Table 8a). Also, the "medication aide" title was less prevalent for respondents who were regulated by the BON (53%) versus another state agency (82%), and a combination of the BON and another state agency (74%) (see Table 8b).

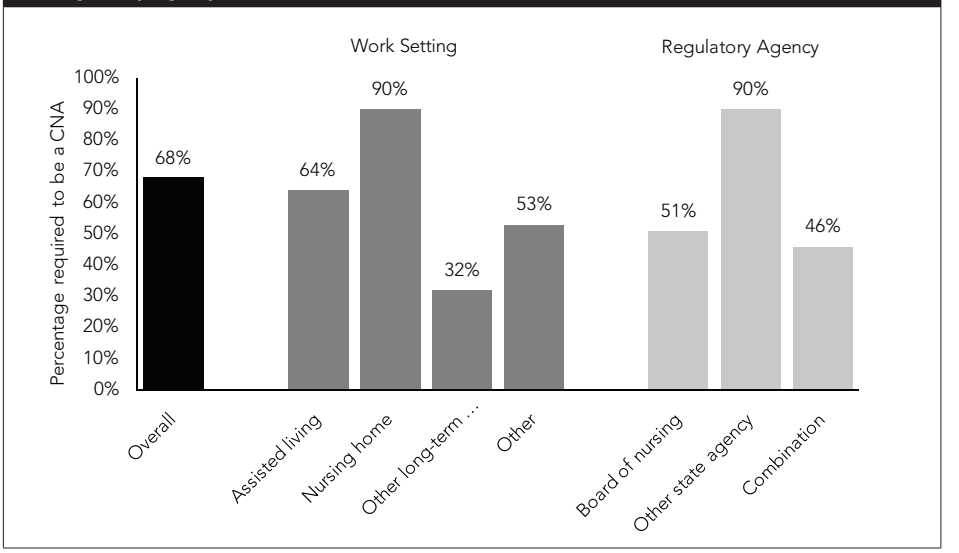
The average amount of time respondents had worked as an MA was 8.05 years. Respondents who were regulated by the BON worked on average fewer years (6.90 years), respondents who were regulated by another state agency worked on average more years (9.44 years), and respondents who were regulated by a combination of the BON and another state agency worked the fewest years (6.83 years) (see Tables 9a and 9b).

The majority of respondents were required to be a certified nursing assistant (CNA) before becoming an MA (68%). However, percentages varied considerably by type of facility. Specifically, 90% of respondents who worked in nursing homes were required to be a CNA before becoming an MA compared to 64% of MAs working in assisted living, 32% of MAs working in other long-term care facilities and 53% of MAs working in other facilities. There were also large differences by type of regulating

Table 9a. Average Number of Years Worked as an MA by Work Setting						
	n	**M**	**SD**	**Min**	**Max**	**Median**
Overall	**3,243**	**8.05 years**	**7.55 years**	**0.00 years**	**54.00 years**	**5.83 years**
Assisted living	1,061	7.08 years	7.16 years	0.00 years	54.00 years	5.00 years
Nursing home	1,286	8.74 years	7.89 years	0.00 years	53.00 years	6.17 years
Other long-term care	526	7.57 years	6.93 years	0.00 years	41.00 years	5.33 years
Other	370	9.13 years	7.93 years	0.00 years	44.00 years	7.00 years

Table 9b. Average Number of Years Worked as an MA by Regulatory Agency						
	n	**M**	**SD**	**Min**	**Max**	**Median**
Overall	**3,243**	**8.05 years**	**7.55 years**	**0.00 years**	**54.00 years**	**5.83 years**
BON	871	6.90 years	6.06 years	0.00 years	42.50 years	5.17 years
Other state agency	1,498	9.44 years	8.35 years	0.00 years	54.00 years	7.00 years
Combination	869	6.83 years	7.05 years	0.00 years	43.00 years	4.33 years

Figure 1. Percentage of Respondents Required to be a CNA Before Becoming an MA by Work Setting and Regulatory Agency



agency. Specifically, 51% of respondents regulated by the BON and 46% of respondents regulated by a combination of the BON and another state agency were required to be a CNA before becoming an MA compared to 90% of respondents regulated by another state agency (see Figure 1).

Of the respondents who were required to be a CNA before becoming an MA, 20% did not need any work experience as a CNA before becoming an MA, while 22% were required to have six months experience and 20% were required to have one year of experience (see Table 10a and 10b).

The majority of respondents administer medications to adults (69%) or older adults (89%); however, more respondents who work in assisted living facilities (95%) and nursing homes (97%) administer medications to older adults versus those who work in other long-term care settings (70%) or other settings (70%) (see Figure 2).

In terms of workload, respondents who worked in assisted living facilities (median=25 clients), nursing homes (median=31 clients) and other facilities (median=15 clients) averaged a higher number of clients who they administer medications to during a typical shift versus those working in other long-term

Table 10a. Amount of Work Experience Needed as a CNA Before Becoming an MA (as Indicated by those Respondents Required to be a CNA Before Becoming an MA) by Work Setting

	Overall (n=2,168)	Assisted Living (n=664)	Nursing Home (n=1,140)	Other Long-term Care (n=164)	Other (n=200)
None	**434 (20%)**	165 (25%)	177 (16%)	50 (30%)	42 (21%)
6 months	**477 (22%)**	131 (20%)	276 (24%)	28 (17%)	42 (21%)
6 months within the last 2 years	**91 (4%)**	27 (4%)	53 (5%)	4 (2%)	7 (4%)
1 year fulltime	**441 (20%)**	109 (16%)	264 (23%)	23 (14%)	45 (23%)
1,000 hours within the last 2 years	**84 (4%)**	31 (5%)	43 (4%)	6 (4%)	4 (2%)
2,000 hours	**29 (1%)**	2 (< 1%)	26 (2%)	0 (0%)	1 (1%)
2,000 hours within 2 years prior to application	**18 (1%)**	3 (< 1%)	11 (1%)	3 (2%)	1 (1%)
2,000 hours of direct patient care within the last 3 years	**29 (1%)**	8 (1%)	14 (1%)	5 (3%)	2 (1%)
2 years fulltime	**101 (5%)**	34 (5%)	55 (5%)	5 (3%)	7 (4%)
Have been employed as a CNA within the past 5 years, for an equivalent of 2 years fulltime	**189 (9%)**	74 (11%)	83 (7%)	14 (9%)	18 (9%)
Other	**275 (13%)**	80 (12%)	138 (12%)	26 (16%)	31 (16%)

Table 10b. Amount of Work Experience Needed as a CNA Before Becoming an MA (as Indicated by those Respondents Required to be a CNA Before Becoming an MA) by Regulatory Agency

	Overall (n=2,168)	BON (n=442)	Other State Agency (n=1,329)	Combination (n=392)
None	**434 (20%)**	62 (14%)	253 (19%)	118 (30%)
6 months	**477 (22%)**	66 (15%)	315 (24%)	95 (24%)
6 months within the last 2 years	**91 (4%)**	15 (3%)	61 (5%)	15 (4%)
1 year fulltime	**441 (20%)**	122 (28%)	256 (19%)	62 (16%)
1,000 hours within the last 2 years	**84 (4%)**	11 (2%)	72 (5%)	1 (< 1%)
2,000 hours	**29 (1%)**	2 (< 1%)	27 (2%)	1 (< 1%)
2,000 hours within 2 years prior to application	**18 (1%)**	6 (1%)	11 (1%)	3 (1%)
2,000 hours of direct patient care within the last 3 years	**29 (1%)**	9 (2%)	17 (1%)	8 (2%)
2 years fulltime	**101 (5%)**	34 (8%)	58 (4%)	40 (10%)
Have been employed as a CNA within the past 5 years, for an equivalent of 2 years fulltime	**189 (9%)**	65 (15%)	84 (6%)	49 (13%)
Other	**275 (13%)**	50 (11%)	175 (13%)	49 (13%)

care facilities (median=4 clients), but this varied by regulating agency. Specifically, the majority of respondents regulated by the BON (median=20 clients), and respondents regulated by a combination of the BON and another state agency (median=15 clients) on average administered medications to a fewer number of clients versus respondents regulated by another state agency (median=30 clients) (see Tables 11a and 11b).

The median number of hours respondents worked in a typical week as an MA was 36 hours (see Tables 12a and 12b) and the median number of hours respondents worked in a typical shift was eight hours (see Tables 13a and 13b).

The most prevalent work shifts were day (7 am – 3 pm) (35%) and evening (3 pm – 11 pm) (26%) (see Tables 14a and 14b).

Training and Education

The highest percentage of respondents who worked in assisted living (49%), other long-term care (70%) and other facilities (47%) obtained their MA training from an employer, while the highest percentage of respondents who worked in nursing

Figure 2. Client Ages by Work Setting and Regulatory Agency

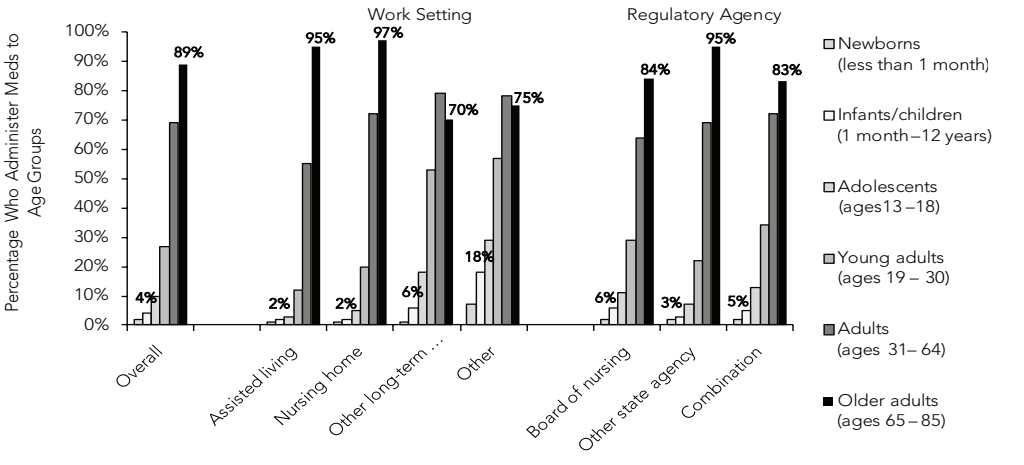


Table 11a. Average Number of Clients MAs Administered Medications to During a Typical Shift by Work Setting

	n	M	SD	Min	Max	Median
Overall	**3,360**	**28.59**	**39.14**	**0**	**844**	**25**
Assisted living	1,098	26.46	27.87	0	800	25
Nursing home	1,327	35.96	26.77	0	600	31
Other long-term care	551	8.77	12.78	0	100	4
Other	384	37.67	87.45	0	844	15

Table 11b. Average Number of Clients MAs Administered Medications to During a Typical Shift by Regulatory Agency

	n	M	SD	Min	Max	Median
Overall	**3,360**	**28.59**	**39.14**	**0**	**844**	**25**
BON	903	21.14	17.21	0	112	20
Other state agency	1,545	39.16	51.15	0	844	30
Combination	907	18.02	23.82	0	500	15

Table 12a. Average Number of Hours Worked During a Typical Week as an MA by Work Setting

	n	M	SD	Min	Max	Median
Overall	**3,312**	**31**	**15.35**	**0**	**128**	**36**
Assisted living	1,082	32.97	13.52	0	120	37.5
Nursing home	1,299	31.21	15.17	0	128	36
Other long-term care	547	28.56	17.85	0	85	36
Other	384	28.24	16.13	0	88	36

Table 12b. Average Number of Hours Worked During a Typical Week as an MA by Regulatory Agency

	n	M	SD	Min	Max	Median
Overall	**3,312**	**31**	**15.35**	**0**	**128**	**36**
BON	891	31.74	15.48	0	120	37.5
Other state agency	1,521	32.55	14.5	0	128	38
Combination	895	27.63	16.13	0	80	32

Table 13a. Average Number of Hours Worked During a Typical Shift as an MA by Work Setting						
	n	M	SD	Min	Max	Median
Overall	**3,256**	**9.85**	**8.58**	**0**	**70**	**8**
Assisted living	1,062	10.12	7.88	0	45	8
Nursing home	1,280	9.66	7.3	0	60	8
Other long-term care	534	10.05	11.79	0	70	8
Other	380	9.51	9.1	0	50	8

Table 13b. Average Number of Hours Worked During a Typical Shift as an MA by Regulatory Agency						
	n	M	SD	Min	Max	Median
Overall	**3,256**	**9.85**	**8.58**	**0**	**70**	**8**
BON	869	9.59	8.23	0	70	8
Other state agency	1,500	10.21	8.3	0	60	8
Combination	882	9.53	9.37	0	66	8

Table 14a. Work Shifts by Work Setting					
	Overall (n=3,398)	Assisted Living (n=1,110)	Nursing Home (n=1,335)	Other Long-term Care (n=556)	Other (n=397)
Day (7am – 3pm)	**1,185 (35%)**	375 (34%)	564 (42%)	128 (23%)	118 (30%)
Day (9am – 5pm)	**176 (5%)**	37 (3%)	31 (2%)	62 (11%)	46 (12%)
Day (12 hour shift)	**264 (8%)**	76 (7%)	101 (8%)	35 (6%)	52 (13%)
Evening (3pm – 11pm)	**867 (26%)**	316 (28%)	358 (27%)	130 (23%)	63 (16%)
Night (11pm – 7am)	**273 (8%)**	131 (12%)	58 (4%)	54 (10%)	30 (8%)
Night (12 hour shift)	**105 (3%)**	42 (4%)	26 (2%)	20 (4%)	17 (4%)
Rotating	**163 (5%)**	56 (5%)	38 (3%)	49 (9%)	20 (5%)
Other	**365 (11%)**	77 (7%)	159 (12%)	78 (14%)	51 (13%)

Table 14b. Work Shifts by Regulatory Agency				
	Overall (n=3,398)	BON (n=919)	Other State Agency (n=1,563)	Combination (n=911)
Day (7am – 3pm)	**1,185 (35%)**	288 (31%)	607 (39%)	288 (32%)
Day (9am – 5pm)	**176 (5%)**	67 (7%)	42 (3%)	66 (7%)
Day (12 hour shift)	**264 (8%)**	67 (7%)	122 (8%)	75 (8%)
Evening (3pm – 11pm)	**867 (26%)**	246 (27%)	397 (25%)	222 (24%)
Night (11pm – 7am)	**273 (8%)**	93 (10%)	112 (7%)	68 (7%)
Night (12 hour shift)	**105 (3%)**	30 (3%)	36 (2%)	39 (4%)
Rotating	**163 (5%)**	49 (5%)	64 (4%)	50 (5%)
Other	**365 (11%)**	79 (9%)	183 (12%)	103 (11%)

Table 15a. MA Training by Work Setting					
	Overall (n=3,293)	**Assisted Living (n=1,062)**	**Nursing Home (n=1,281)**	**Other Long-term Care (n=541)**	**Other (n=409)**
No training was required	**19 (1%)**	4 (< 1%)	3 (< 1%)	5 (1%)	7 (2%)
Training offered by an employer	**1,405 (43%)**	520 (49%)	316 (25%)	377 (70%)	192 (47%)
Training offered by a community or junior college	**1,040 (32%)**	262 (25%)	603 (47%)	69 (13%)	106 (26%)
Training offered by technical or vocational school	**529 (16%)**	156 (15%)	277 (22%)	38 (7%)	58 (14%)
Training received while in the military	**4 (< 1%)**	0 (0%)	2 (< 1%)	1 (< 1%)	1 (< 1%)
Training sponsored by a state agency	**159 (5%)**	66 (6%)	38 (3%)	31 (6%)	24 (6%)
Other	**137 (4%)**	54 (5%)	42 (3%)	20 (4%)	21 (5%)

Table 15b. MA Training by Regulatory Agency				
	Overall (n=3,293)	**BON (n=882)**	**Other State Agency (n=1,522)**	**Combination (n=884)**
No training was required	**19 (1%)**	11 (1%)	4 (< 1%)	4 (< 1%)
Training offered by an employer	**1,405 (43%)**	596 (68%)	308 (20%)	500 (57%)
Training offered by a community or junior college	**1,040 (32%)**	89 (10%)	699 (46%)	251 (28%)
Training offered by technical or vocational school	**529 (16%)**	70 (8%)	415 (27%)	41 (5%)
Training received while in the military	**4 (< 1%)**	1 (< 1%)	2 (< 1%)	1 (< 1%)
Training sponsored by a state agency	**159 (5%)**	57 (6%)	49 (3%)	53 (6%)
Other	**137 (4%)**	58 (7%)	45 (3%)	34 (4%)

homes (47%) obtained their MA training from a community or junior college. There were also differences by type of regulating agency. Specifically, the highest percentage of respondents regulated by the BON (68%), and respondents regulated by a combination of the BON and another state agency (57%) obtained their MA training from an employer, while the highest percentage of respondents regulated by another state agency (46%) obtained their MA training from a community or junior college (see Tables 15a and 15b).

Of respondents who indicated they had some MA training, respondents who worked in nursing homes reported the highest amount of classroom training hours (median=60 hours) followed by respondents who worked in other facilities (median=40 hours), assisted living facilities (median=40 hours) and other long-term care facilities (median=20 hours). There were differences by type of regulating agency. Specifically, respondents regulated by the BON (median=40 hours), and respondents regulated by a combination of the BON and another state agency (median=40 hours) had fewer classroom training hours compared to respondents regulated by another state agency (median=64 hours) (see Figure 3).

Respondents who worked in nursing homes reported the highest amount of clinical training hours (median=20 hours) followed by respondents who worked in assisted living (median=16 hours), other facilities (median=8 hours) and other long-term care facilities (median=1 hour). There were differences by type of regulating agency. Specifically, respondents regulated by the BON (median=16 hours), and respondents regulated by a combination of the BON and another state agency (median=0 hours) had fewer clinical training hours compared to respondents regulated by another state agency (median=20 hours) (see Figure 4).

Respondents who worked in nursing homes reported the highest amount of total training hours (median=80 hours) followed by respondents who worked in assisted living (median=56 hours), other facilities (median=40 hours) and other long-term care facilities (median=21.50 hours). There were differences by type of regulating agency. Specifically, respondents regulated by the BON (median=52

Figure 3. Median Number of Classroom Hours Required for MA Training (as Indicated by Respondents who had some MA Training) by Work Setting and Regulatory Agency

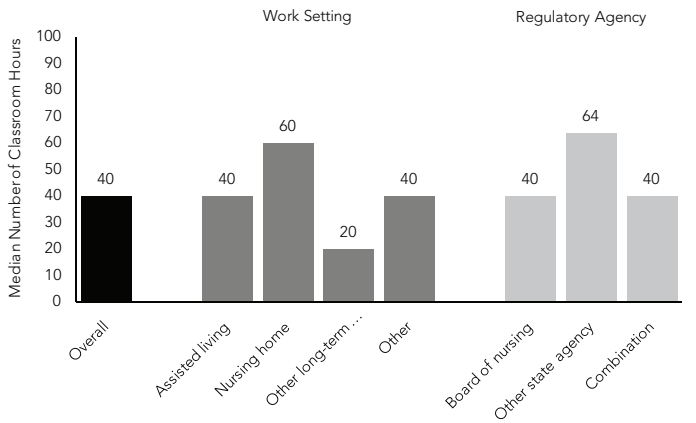


Figure 4. Median Number of Clinical Hours Required for MA Training (as Indicated by Respondents who had some MA Training) by Work Setting and Regulatory Agency

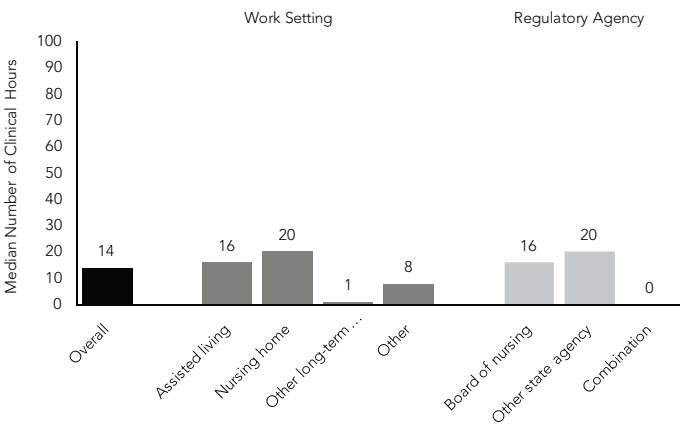


Figure 5. Median Number of Total Training Hours (as Indicated by Respondents who had some MA Training) by by Work Setting and Regulatory Agency

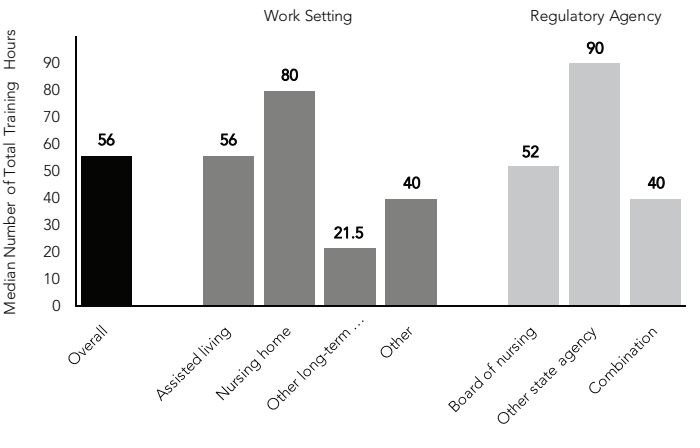


Table 16a. Received Additional MA Training from Employer (as Indicated by Respondents who had some MA Training) by Work Setting

	Overall (n=3,271)	Assisted Living (n=1,062)	Nursing Home (n=1,279)	Other Long-term Care (n=527)	Other (n=403)
No	**1,408 (43%)**	422 (40%)	547 (43%)	253 (48%)	186 (46%)
Yes	**1,863 (57%)**	640 (60%)	732 (57%)	274 (52%)	217 (54%)

Table 16b. Received Additional MA Training from Employer (as Indicated by Respondents who had some MA Training) by Regulatory Agency

	Overall (n=3,271)	BON (n=869)	Other State Agency (n=1,508)	Combination (n=889)
No	**1,408 (43%)**	369 (42%)	626 (42%)	412 (46%)
Yes	**1,863 (57%)**	500 (58%)	882 (58%)	477 (54%)

Table 17a. Average Number of Additional MA Training Received from Employer (as Indicated by Respondents who had some MA Training) by Work Setting

	n	M	SD	Min	Max	Median
Overall	**1,657**	**23.47**	**37.93**	**0.5**	**1,120.00**	**16**
Assisted living	568	23.02	27.01	1	300	16
Nursing home	663	27.87	49.17	1	1,120.00	21
Other long-term care	236	12.77	25.79	0.5	336	8
Other	190	22.77	30.18	1	200	12

Table 17b. Average Number of Additional MA Training Received from Employer (as Indicated by Respondents who had some MA Training) by Regulatory Agency

	n	M	SD	Min	Max	Median
Overall	**1,657**	**23.47**	**37.93**	**0.5**	**1,120.00**	**16**
BON	441	19.71	25.02	1	259	12
Other state agency	789	27.92	47.37	1	1,120.00	21
Combination	424	19.14	26.97	0.5	336	12

hours), and respondents regulated by a combination of the BON and another state agency (median=40 hours) had fewer clinical training hours compared to respondents regulated by another state agency (median=90 hours) (see Figure 5).

Of respondents who indicated they had some MA training, the majority of respondents (57%) received additional MA training from their employer (see Tables 16a and 16b). Respondents who worked in nursing homes reported the highest amount of additional training hours (median=21 hours) followed by respondents who worked in assisted living (median=16 hours), other facilities (median=12 hours) and other long-term care facilities (median=8 hours) (see Table 17a). There were differences by type of regulating agency. Specifically, respondents regulated by the BON (median=12 hours), and respondents regulated by a combination of the BON and another state agency (median=12 hours) had fewer additional training hours compared to respondents regulated by another state agency (median=21 hours) (see Table 17b).

Of the respondents who indicated they had some MA training, the majority of respondents (71%) had nurse delegation training in their MA training; however, fewer respondents regulated by a combination of the BON and another state agency (59%) had nurse delegation training covered compared to respondents regulated by the BON (75%) and respondents regulated by another state agency (76%) (see Tables 18a and 18b). Of the respondents who indicated they had nurse delegation presented in their MA training, most thought the training was "adequate" (44%) or "very adequate" (35%) (Figure 6).

Of the respondents who indicated they had some MA training, the majority (83%) indicated that nurse supervision was covered (see Tables 19a and 19b). Of the respondents who indicated that nurse delegation was covered, most thought the training was

Table 18a. Nurse Delegation Covered in MA Training (as Indicated by Respondents who had some MA Training) by Work Setting

	Overall (n=3,260)	Assisted Living (n=1,051)	Nursing Home (n=1,268)	Other Long-term Care (n=534)	Other (n=407)
No	**941 (29%)**	289 (28%)	328 (26%)	203 (38%)	121 (30%)
Yes	**2,319 (71%)**	762 (73%)	940 (74%)	331 (62%)	286 (70%)

Table 18b. Nurse Delegation Covered in MA Training (as Indicated by Respondents who had some MA Training) by Regulatory Agency

	Overall (n=2,319)	BON (n=877)	Other State Agency (n=1,488)	Combination (n=890)
No	**941 (29%)**	219 (25%)	357 (24%)	363 (41%)
Yes	**2,319 (71%)**	658 (75%)	1,131 (76%)	527 (59%)

Figure 6. Adequacy of Training on Nurse Delegation (as Indicated by Respondents who had some MA Training) by Work Setting and Regulatory Agency

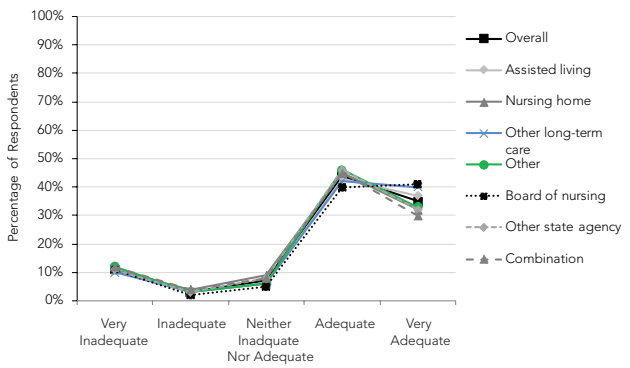


Table 19a. Nurse Supervision Covered in MA Training (as Indicated by Respondents who had some MA Training) by Work Setting

	Overall (n=3,285)	Assisted Living (n=1,061)	Nursing Home (n=1,276)	Other Long-term Care (n=537)	Other (n=411)
No	**550 (17%)**	197 (19%)	156 (12%)	123 (23%)	74 (18%)
Yes	**2,735 (83%)**	864 (81%)	1,120 (88%)	414 (77%)	337 (82%)

Table 19b. Nurse Supervision Covered in MA Training (as Indicated by Respondents who had some MA Training) by Regulatory Agency

	Overall (n=3,285)	BON (n=885)	Other State Agency (n=1,500)	Combination (n=895)
No	**550 (17%)**	145 (16%)	188 (13%)	217 (24%)
Yes	**2,735 (83%)**	740 (84%)	1,312 (87%)	678 (76%)

Figure 7. Adequacy of Training on Nurse Supervision (as Indicated by Respondents who had some MA Training) by Work Setting and Regulatory Agency

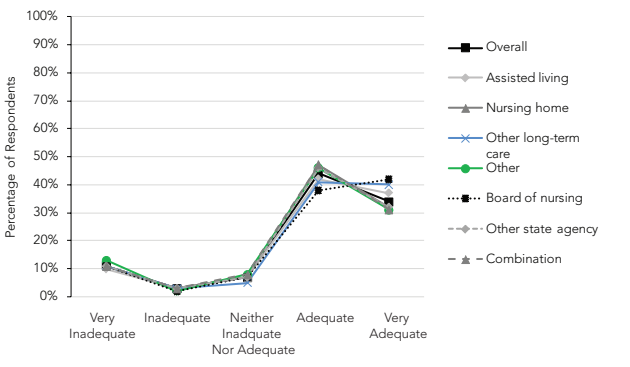


Figure 8a. Perceived Level of Difficultly of MA Training (as Indicated by Respondents who had some MA Training) by Work Setting

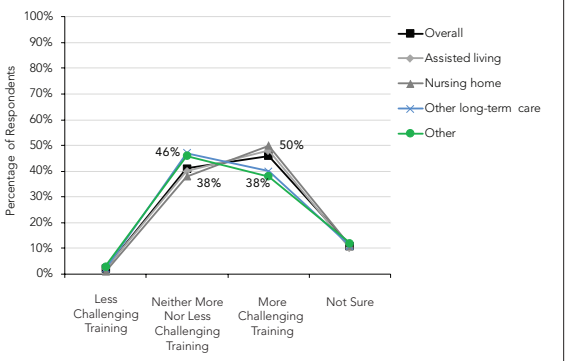
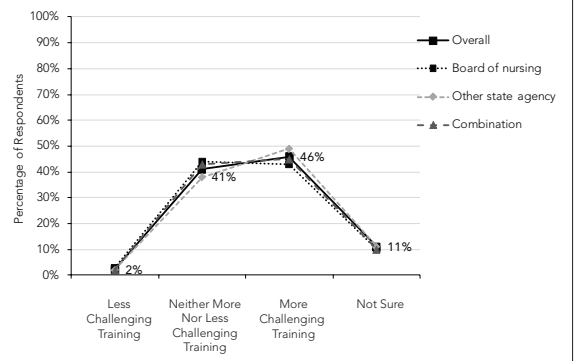


Figure 8b. Perceived Level of Difficultly of MA Training (as Indicated by Respondents who had some MA Training) by Regulatory Agency



"adequate" (44%) or "very adequate" (34%) (see Figure 7).

The highest percentage of respondents indicated that the MA training needed to be more challenging (46%) (see Figures 8a and 8b). Specifically, 59% indicated the classroom component, 83% indicated the clinical component, 55% indicated in-class testing/quizzes and 51% indicated that the certification exam needed to be more challenging (see Tables 20a and 20b).

"Other" open-ended comments about the aspects of training that needed to be more challenging were as follows:

Comments were edited to ensure readability.

Training needs to be more difficult/longer/include more content

- Certification exam was easy.
- Clinical needs to be longer.
- Content may need to be broader, including more real-life situations and provide information on a broader spectrum.
- Definitely need more clinical training.
- More coverage of drug interactions.
- Should require more clinical hours.
- Should learn about some medications and their side effects and how to do conversions.
- The training needs to cover more.
- The new MA course does not prepare people well enough.
- In 1980 we went to class in the morning and did clinical in the afternoon, Monday through Friday, and our test was a lot harder than today's test.
- In our area all training is at the community college – poor.
- It was much more challenging 15 years ago, now it's a joke.
- Less classroom, more clinical.
- Less talking by teacher about personal things, and more talking about medications.
- More adequate teachers – knowledge.
- More computer MAR training.
- More day-to-day learning for students.
- More days for class.
- More focus on drug interactions and importance (i.e., insulin, etc.).
- More hands on with equipment and devices.
- More hands on and more information on medications.
- More pharmacology in class.
- More than a few hours for someone who isn't used to working around medical reports.
- More time. Class is only 5 days.
- More time in clinical setting.
- More training on administering medications.

Table 20a. Aspects of MA Training that Need to be More Challenging (as Indicated by Respondents who had some MA Training) by Work Setting

	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
Classroom component	**(n=1,317)**	**(n=442)**	**(n=553)**	**(n=188)**	**(n=134)**
Does not need to be more challenging	536 (41%)	178 (40%)	224 (41%)	78 (41%)	56 (42%)
Yes, needs to be more challenging	781 (59%)	264 (60%)	329 (59%)	110 (58%)	78 (58%)
Clinical component	**(n=1,379)**	**(n=458)**	**(n=591)**	**(n=192)**	**(n=138)**
Does not need to be more challenging	240 (17%)	74 (16%)	97 (16%)	44 (23%)	25 (18%)
Yes, needs to be more challenging	1,139 (83%)	384 (84%)	494 (84%)	148 (77%)	113 (82%)
In-class tests/quizzes	**(n=1,290)**	**(n=430)**	**(n=541)**	**(n=184)**	**(n=135)**
Does not need to be more challenging	584 (45%)	188 (44%)	250 (46%)	83 (45%)	63 (47%)
Yes, needs to be more challenging	706 (55%)	242 (56%)	291 (54%)	101 (55%)	72 (53%)
Certification exam	**(n=1,282)**	**(n=429)**	**(n=544)**	**(n=176)**	**(n=133)**
Does not need to be more challenging	627 (49%)	205 (48%)	260 (48%)	90 (51%)	72 (54%)
Yes, needs to be more challenging	655 (51%)	224 (52%)	284 (52%)	86 (49%)	61 (46%)
Other	**n=94**	**n=24**	**n=43**	**n=8**	**n=19**

Table 20b. Aspects of MA Training that Need to be More Challenging (as Indicated by Respondents who had some MA Training) by Regulatory Agency

	Overall	BON	Other State Agency	Combination
Classroom component	**(n=1,317)**	**(n=319)**	**(n=630)**	**(n=365)**
Does not need to be more challenging	536 (41%)	136 (43%)	244 (39%)	155 (42%)
Yes, needs to be more challenging	781 (59%)	183 (57%)	386 (61%)	210 (58%)
Clinical component	**(n=1,379)**	**(n=341)**	**(n=672)**	**(n=363)**
Does not need to be more challenging	240 (17%)	64 (19%)	107 (16%)	68 (19%)
Yes, needs to be more challenging	1,139 (83%)	277 (81%)	565 (84%)	295 (81%)
In-class tests/quizzes	**(n=1,290)**	**(n=313)**	**(n=621)**	**(n=353)**
Does not need to be more challenging	584 (45%)	141 (45%)	284 (46%)	157 (44%)
Yes, needs to be more challenging	706 (55%)	172 (55%)	337 (54%)	196 (56%)
Certification exam	**(n=1,282)**	**(n=310)**	**(n=617)**	**(n=352)**
Does not need to be more challenging	627 (49%)	165 (53%)	329 (53%)	133 (38%)
Yes, needs to be more challenging	655 (51%)	145 (47%)	288 (47%)	219 (62%)
Other	**n=93**	**n=20**	**n=43**	**n=30**

- More training on what the medications you are administering do, and what they are used for.
- More training on pharmacology.
- More on learning the medications.
- Need more hands on training.
- Need more initial supervision/training (hands on training).
- Need more on the many ways medicine can be administered (crushed, or what can or cannot be crushed, what goes with what, etc.).
- Need to have more hands-in: ID, medications & narcotics.
- Need more emphasis on adverse reactions, especially with the age group they are caring for.
- New Med Aides don't know the basics.
- Does not necessarily need to be more challenging, but rather, more information.
- On clinical days CNAs were training us on the med cart.
- More education (in-service) certification.

- More nurse supervisors during operation period.
- Need more training and in-services.
- Needs to be more challenging. Need to add nursing classes so that we can take the nursing board examination.
- Training is very compressed. 2-3 weeks is not enough time.
- The only thing that was challenging was the # of drug cards.
- The students coming out of training know nothing and can't speak English well.
- Should have more hands on clinical training.
- Need to cover more on meds and abbreviations.
- The class needs clinical hours.
- Need more hands on.
- Would like to see more clinical hours.
- More hands on training in class room.
- There was no clinical component! We didn't get much training on the actual meds (side effects, purposes, etc).

Testing

- Do not give people the opportunity to re-take the same test twice. If a re-take is allowed, use different tests.
- Teaching manual was not the same as what the test covered. Therefore we were not properly prepared for the tests.
- We have training and tests/quizzes every month, it would be nice if they took it to a higher level.
- We were trained for psych meds and situations. Testing by the state was geared to nursing home meds care and situations. Meds are different!
- Written exam, no clinical exam.

Training content (assumption is respondents want these covered more)

- We could kill someone and it needs to be stressed how easy it is to make mistakes.
- Action and reaction of medication.
- Bandaging, wound care, dressings.
- How to deal with psych issues.
- Identify septic issues.
- In-services on documentation.
- Side effects.
- Mock medication pass, demonstration.
- Physiological aspects of medications on the body.
- Proper setup of meds.
- Should be trained to administer neb treatment.
- Use of insulin & breathing apparatus.
- What to do about things you know you should not do. State rules.
- What is taught in class is different from what is on the ground. Try to be as close as possible.
- When should a medication aide contact a nurse.
- Communication – nurses to med aides!!! MAR notes.

Other

- Realistic expectations by the state as far as staffing goes. One med aide to 60 residents is unrealistic.
- Medication Aide orientation should be a must to avoid medication errors.
- More orientation at the job.
- As time goes on you acquire more responsibility dependent on nurse.
- Change the medication form that we use to administer meds. A new form - new way.
- Some of the CNAs need more training or should not be allowed to do some of the duties they are doing.
- Re-certification education.
- CMA-updates.
- Training in the facility.

While many respondents may have wanted the MA training to be more challenging, 28% indicated the training they received adequately prepared them to

Table 21a. Recieved Adequate MA Training (as Indicated by Respondents who had some MA Training) by Work Setting

	Overall (n=1,317)	Assisted Living (n=442)	Nursing Home (n=553)	Other Long-term Care (n=188)	Other (n=134)
Not at all	**43 (1%)**	8 (1%)	21 (2%)	11 (2%)	3 (1%)
To some extent	**938 (28%)**	305 (28%)	379 (29%)	132 (24%)	122 (30%)
Absolutely	**2,353 (71%)**	763 (71%)	901 (69%)	402 (74%)	287 (70%)

Table 21b. Recieved Adequate MA Training (as Indicated by Respondents who had some MA Training) by Regulatory Agency

	Overall (n=3,334)	BON (n=893)	Other State Agency (n=1,530)	Combination (n=906)
Not at all	**43 (1%)**	5 (1%)	23 (2%)	15 (2%)
To some extent	**938 (28%)**	211 (24%)	443 (29%)	282 (31%)
Absolutely	**2,353 (71%)**	677 (76%)	1,064 (70%)	609 (67%)

Figure 9. Level of Satisifcation with MA Training (as Indicated by Respondents who had some MA Training) by Work Setting and Regulatory Agency

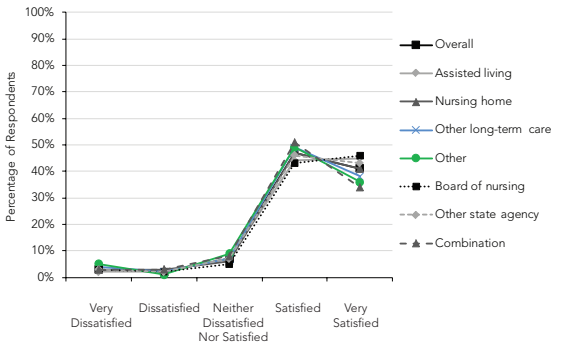


Table 22a. Enrolled in a Formal Nursing Education Program by Work Setting

	Overall (n=3,331)	Assisted Living (n=1,075)	Nursing Home (n=1,291)	Other Long-term Care (n=551)	Other (n=414)
No	**2,703 (81%)**	870 (81%)	1,004 (78%)	476 (86%)	353 (85%)
Have applied but not currently enrolled	**313 (9%)**	92 (9%)	151 (12%)	33 (6%)	37 (9%)
Yes	**315 (9%)**	113 (11%)	136 (11%)	42 (8%)	24 (6%)

Table 22b. Enrolled in a Formal Nursing Education Program by Regulatory Agency

	Overall (n=3,331)	BON (n=906)	Other State Agency (n=1,518)	Combination (n=902)
No	**43 (1%)**	5 (1%)	23 (2%)	15 (2%)
Have applied but not currently enrolled	**938 (28%)**	211 (24%)	443 (29%)	282 (31%)
Yes	**2,353 (71%)**	677 (76%)	1,064 (70%)	609 (67%)

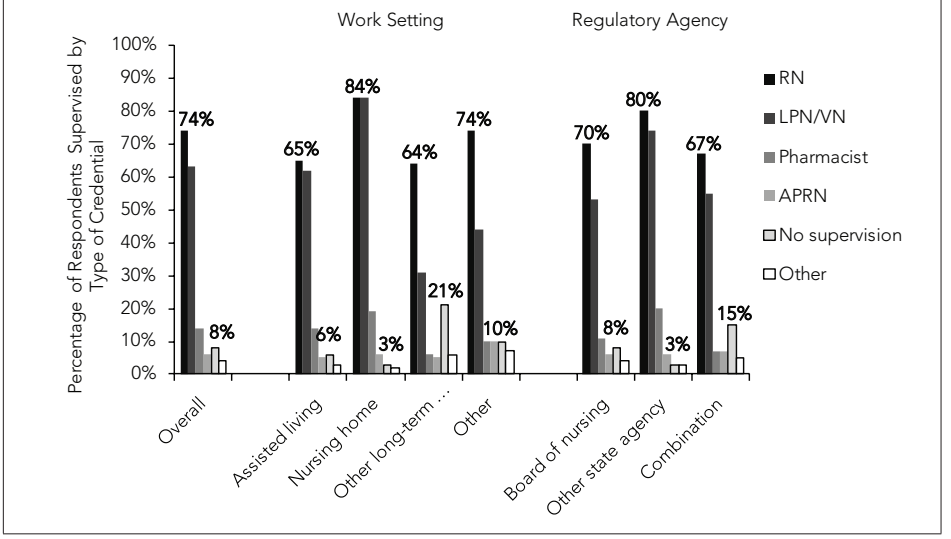
Table 23a. Formal Nursing Education Program (as Indicated by Respondents Enrolled in a Formal Nursing Program) by Work Setting

	Overall (n=325)	Assisted Living (n=116)	Nursing Home (n=140)	Other Long-term Care (n=44)	Other (n=25)
LPN/VN	**144 (44%)**	52 (45%)	71 (51%)	13 (30%)	8 (32%)
RN (associates degree)	**86 (26%)**	28 (24%)	37 (26%)	14 (32%)	7 (28%)
RN (diploma)	**9 (3%)**	4 (3%)	5 (4%)	0 (0%)	0 (0%)
RN (bachelors)	**55 (17%)**	25 (22%)	15 (11%)	9 (20%)	6 (24%)
Other	**31 (10%)**	7 (6%)	12 (9%)	8 (18%)	4 (16%)

Table 23b. Formal Nursing Education Program (as Indicated by Respondents Enrolled in a Formal Nursing Program) by Regulatory Agency

	Overall (n=325)	BON (n=83)	Other State Agency (n=157)	Combination (n=84)
LPN/VN	**144 (44%)**	34 (41%)	85 (54%)	25 (30%)
RN (associates degree)	**86 (26%)**	27 (33%)	33 (21%)	25 (30%)
RN (diploma)	**9 (3%)**	3 (4%)	3 (2%)	3 (4%)
RN (bachelors)	**55 (17%)**	12 (14%)	18 (11%)	25 (30%)
Other	**31 (10%)**	7 (8%)	18 (11%)	6 (7%)

Figure 10. Credentials of MA Supervisor(s) by Work Setting and Regulatory Agency



"some extent" and 71% indicated it "absolutely" prepared them (see Tables 21a and 21b). Additionally, 47% indicated they were "satisfied" with their MA training and 41% indicated they were "very satisfied" (see Figure 9).

The majority of respondents were not enrolled in a formal nursing education program (81%), while 9% had applied, but were not currently enrolled and 9% were in a formal nursing education program (see Tables 22a and 22b). Of those enrolled in a formal nursing education program, 44% were enrolled in a licensed practical/vocational nurse (LPN/VN) program and 26% were enrolled in an RN associate degree program (see Tables 23a and 23b).

Supervision

The highest percentage of respondents who had an RN supervisor were respondents who worked

Figure 11a. Supervisor on Site (as Indicated by Respondents who had Supervision) by Work Setting and Regulatory Agency

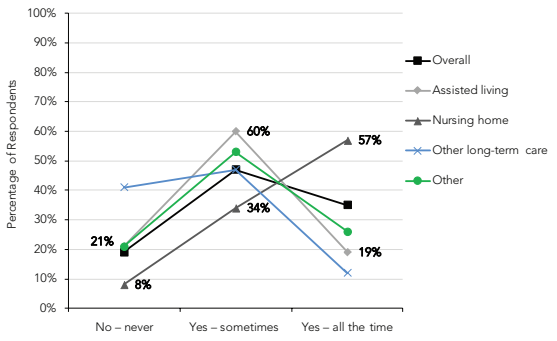
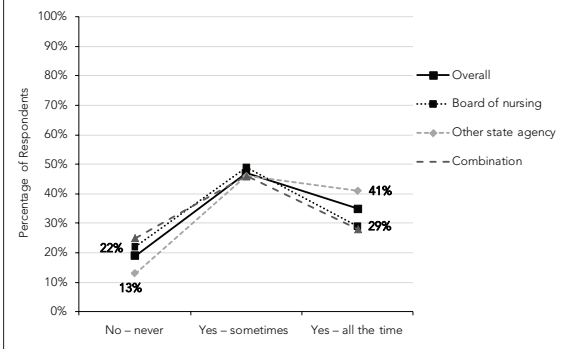


Figure 11b. Supervisor on Site (as Indicated by Respondents who had Supervision) by Work Setting and Regulatory Agency



in nursing homes (84%), followed by other facilities (74%), assisted living facilities (65%) and other long-term care facilities (64%). Also, a large percentage of respondents who worked in other long-term care facilities indicated they had no supervision (21%). Additionally, there were differences by type of regulating agency. Specifically, respondents regulated by the BON (70%), and respondents regulated by a combination of the BON and another state agency (67%) had lower percentages of responders who were supervised by an RN compared to respondents regulated by another state agency (80%). Additionally, a relatively large number reported having no supervision (8%) (see Figure 10).

Of the respondents who indicated they had supervision, MAs who worked in nursing homes had the lowest percentage that indicated their supervisor was never on-site (8%). In comparison, 21% of respondents who worked in assisted living, 21% of respondents who worked in other facilities and 41% of respondents who worked in other long-term care facilities indicated their supervisor was never

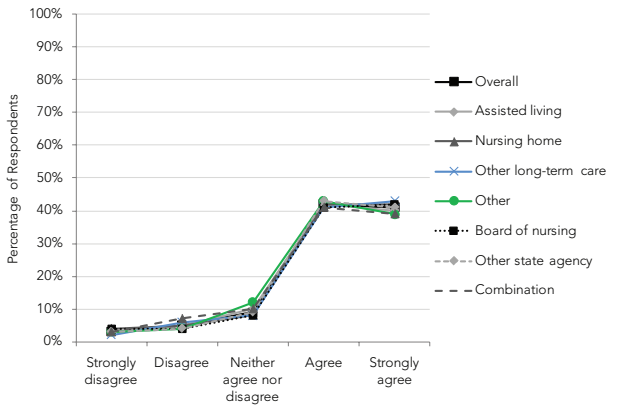
Table 24a. Frequency of Interaction with Supervisor During a Typical Shift (as Indicated by Respondents who had Supervision) by Work Setting

	Overall (n=3,065)	Assisted Living (n=1,004)	Nursing Home (n=1,266)	Other Long-term Care (n=425)	Other (n=307)
Zero/none	**317 (10%)**	127 (13%)	36 (3%)	105 (25%)	49 (13%)
1 – 2 times	**814 (27%)**	331 (33%)	219 (17%)	157 (37%)	107 (29%)
3 – 4 times	**562 (18%)**	202 (20%)	242 (19%)	60 (14%)	58 (16%)
5 – 6 times	**309 (10%)**	103 (10%)	154 (12%)	27 (6%)	25 (7%)
7 – 8 times	**137 (4%)**	33 (3%)	76 (6%)	14 (3%)	14 (4%)
9 – 10 times	**143 (5%)**	23 (2%)	97 (8%)	8 (2%)	15 (4%)
11 – 12 times	**47 (2%)**	11 (1%)	24 (2%)	5 (1%)	7 (2%)
13 – 14 times	**14 (1%)**	5 (1%)	6 (< 1%)	1 (< 1%)	2 (1%)
15 – 16 times	**29 (1%)**	4 (< 1%)	21 (2%)	2 (< 1%)	2 (1%)
17 – 18 times	**6 (< 1%)**	0 (0%)	3 (< 1%)	1 (< 1%)	2 (1%)
19 – 20 times	**16 (1%)**	3 (< 1%)	9 (1%)	0 (0%)	4 (1%)
More than 20 times	**63 (2%)**	16 (2%)	37 (3%)	2 (< 1%)	8 (2%)
Continually	**608 (20%)**	146 (15%)	342 (27%)	43 (10%)	77 (21%)

Table 24b. Frequency of Interaction with Supervisor During a Typical Shift (as Indicated by Respondents who had Supervision) by Regulatory Agency

	Overall (n=3,065)	BON (n=826)	Other State Agency (n=1,471)	Combination (n=763)
Zero/none	**317 (10%)**	98 (12%)	95 (6%)	124 (16%)
1 – 2 times	**814 (27%)**	260 (31%)	334 (23%)	219 (29%)
3 – 4 times	**562 (18%)**	162 (20%)	271 (18%)	126 (17%)
5 – 6 times	**309 (10%)**	67 (8%)	159 (11%)	83 (11%)
7 – 8 times	**137 (4%)**	27 (3%)	74 (5%)	36 (5%)
9 – 10 times	**143 (5%)**	35 (4%)	83 (6%)	25 (3%)
11 – 12 times	**47 (2%)**	9 (1%)	21 (1%)	17 (2%)
13 – 14 times	**14 (1%)**	6 (1%)	4 (< 1%)	4 (1%)
15 – 16 times	**29 (1%)**	6 (1%)	19 (1%)	4 (1%)
17 – 18 times	**6 (< 1%)**	1 (< 1%)	3 (< 1%)	2 (< 1%)
19 – 20 times	**16 (1%)**	4 (< 1%)	8 (1%)	4 (1%)
More than 20 times	**63 (2%)**	11 (1%)	37 (3%)	15 (2%)
Continually	**608 (20%)**	140 (17%)	363 (25%)	104 (14%)

Figure 12. Level of Agreement that Supervisor is Available Whenever Assistance or Help is Needed (as Indicated by Respondents who had Supervision) by Work Setting and Regulatory Agency



on-site. Respondents regulated by another state agency had the highest percentage of respondents who indicated their supervisor was always on-site (41%). In comparison, 29% of respondents regulated by the BON and 41% of respondents regulated by another state agency indicated their supervisor was always on-site (see Figures 11a and 11b).

Of respondents who indicated they had supervision, 10% indicated they interacted with their supervisor during a typical shift "zero/none" times and 27% indicated "1 – 2 times" (see Tables 24a and 24b).

Of respondents who indicated they had supervision, 42% indicated that they "agreed" and 41% indicated they "strongly agreed" that their supervisor was available whenever they needed assistance or help (see Figure 12).

The majority of respondents (74%) reported that it was "fairly easy" or "very easy" to go to an RN if they needed assistance with a patient; 80% of respondents reported that it was "fairly easy" or "very easy" to go to another MA if they needed assistance with a patient (see Tables 25a and 25b).

Table 25a. Level of Ease Asking for Assistance From Someone Other than a Supervisor by Work Setting					
	Overall (n=3,366)	**Assisted Living (n=1,087)**	**Nursing Home (n=1,315)**	**Other Long-term Care (n=548)**	**Other (n=416)**
Fairly easy					
RN	**1,043 (31%)**	291 (27%)	446 (34%)	171 (31%)	135 (32%)
LPN/VN	**934 (28%)**	313 (29%)	404 (31%)	114 (21%)	103 (25%)
Another MA	**829 (25%)**	263 (24%)	349 (27%)	115 (21%)	102 (25%)
Pharmacist	**759 (23%)**	266 (24%)	259 (20%)	135 (25%)	99 (24%)
Physician	**543 (16%)**	217 (20%)	145 (11%)	103 (19%)	78 (19%)
APRN	**402 (12%)**	135 (12%)	137 (10%)	72 (13%)	58 (14%)
Very easy					
RN	**1,447 (43%)**	405 (37%)	618 (47%)	224 (41%)	200 (48%)
LPN/VN	**1,553 (46%)**	476 (44%)	749 (57%)	167 (30%)	161 (39%)
Another MA	**1,863 (55%)**	610 (56%)	715 (54%)	317 (58%)	221 (53%)
Pharmacist	**632 (19%)**	218 (20%)	201 (15%)	124 (23%)	89 (21%)
Physician	**407 (12%)**	131 (12%)	113 (9%)	83 (15%)	80 (19%)
APRN	**345 (10%)**	103 (9%)	113 (9%)	66 (12%)	63 (15%)

Table 25b. Level of Ease Asking for Assistance From Someone Other than a Supervisor by Regulatory Agency				
	Overall (n=3,366)	**BON (n=900)**	**Other State Agency (n=1,555)**	**Combination (n=906)**
Fairly easy				
RN	**1,043 (31%)**	254 (28%)	501 (32%)	286 (32%)
LPN/VN	**934 (28%)**	223 (25%)	457 (29%)	253 (28%)
Another MA	**829 (25%)**	200 (22%)	395 (25%)	233 (26%)
Pharmacist	**759 (23%)**	217 (24%)	326 (21%)	215 (24%)
Physician	**543 (16%)**	164 (18%)	208 (13%)	169 (19%)
APRN	**402 (12%)**	103 (11%)	173 (11%)	124 (14%)
Very easy				
RN	**1,447 (43%)**	388 (43%)	703 (45%)	354 (39%)
LPN/VN	**1,553 (46%)**	384 (43%)	830 (53%)	337 (37%)
Another MA	**1,863 (55%)**	500 (56%)	829 (53%)	532 (59%)
Pharmacist	**632 (19%)**	187 (21%)	286 (18%)	156 (17%)
Physician	**407 (12%)**	118 (13%)	183 (12%)	105 (12%)
APRN	**345 (10%)**	85 (9%)	171 (11%)	89 (10%)

Table 26a. Preference Asking for Assistance by Work Setting					
	Overall (n=3,095)	**Assisted Living (n=1,000)**	**Nursing Home (n=1,205)**	**Other Long-term Care (n=509)**	**Other (n=381)**
RN	**1,493 (48%)**	407 (41%)	567 (47%)	293 (58%)	226 (59%)
LPN/VN	**929 (30%)**	337 (34%)	458 (38%)	81 (16%)	53 (14%)
Another MA	**477 (15%)**	196 (20%)	139 (12%)	79 (16%)	63 (17%)
Pharmacist	**65 (2%)**	21 (2%)	14 (1%)	22 (4%)	8 (2%)
Physician	**44 (1%)**	15 (2%)	3 (< 1%)	10 (2%)	16 (4%)
APRN	**29 (1%)**	6 (1%)	7 (1%)	9 (2%)	7 (2%)
I can't go to any of these for help	**58 (2%)**	18 (2%)	17 (1%)	15 (3%)	8 (2%)

Table 26b. Preference Asking for Assistance by Regulatory Agency				
	Overall (n=3,095)	**BON (n=825)**	**Other State Agency (n=1,415)**	**Combination (n=850)**
RN	**1,493 (48%)**	422 (51%)	652 (46%)	417 (49%)
LPN/VN	**929 (30%)**	219 (27%)	524 (37%)	186 (22%)
Another MA	**477 (15%)**	117 (14%)	181 (13%)	177 (21%)
Pharmacist	**65 (2%)**	16 (2%)	25 (2%)	24 (3%)
Physician	**44 (1%)**	24 (3%)	5 (< 1%)	14 (2%)
APRN	**29 (1%)**	11 (1%)	9 (1%)	9 (1%)
I can't go to any of these for help	**58 (2%)**	16 (2%)	19 (1%)	23 (3%)

Table 27a. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse by Work Setting					
	Overall (n=3,367)	**Assisted Living (n=1,090)**	**Nursing Home (n=1,309)**	**Other Long-term Care (n=548)**	**Other (n=420)**
Never	**1,307 (39%)**	402 (37%)	432 (33%)	228 (53%)	185 (44%)
A few times a year	**887 (26%)**	276 (25%)	357 (27%)	127 (23%)	127 (30%)
About once a month	**314 (9%)**	107 (10%)	127 (10%)	45 (8%)	35 (8%)
A few times a month	**320 (10%)**	114 (10%)	139 (11%)	39 (7%)	28 (7%)
About once a week	**138 (4%)**	58 (5%)	60 (5%)	9 (2%)	11 (3%)
A few times a week	**195 (6%)**	66 (6%)	90 (7%)	23 (4%)	16 (4%)
Every day	**206 (6%)**	67 (6%)	104 (8%)	17 (3%)	18 (4%)

Table 27b. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse by Regulatory Agency				
	Overall (n=3,367)	**BON (n=911)**	**Other State Agency (n=1,553)**	**Combination (n=898)**
Never	**1,307 (39%)**	385 (42%)	529 (34%)	391 (44%)
A few times a year	**887 (26%)**	219 (24%)	430 (28%)	238 (27%)
About once a month	**314 (9%)**	83 (9%)	142 (9%)	88 (10%)
A few times a month	**320 (10%)**	84 (9%)	167 (11%)	69 (8%)
About once a week	**138 (4%)**	37 (4%)	63 (4%)	37 (4%)
A few times a week	**195 (6%)**	51 (6%)	100 (6%)	43 (5%)
Every day	**206 (6%)**	52 (6%)	122 (8%)	32 (4%)

Table 28a. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding Patient Monitoring by Work Setting

	Overall (n=3,362)	Assisted Living (n=1,086)	Nursing Home (n=1,312)	Other Long-term Care (n=546)	Other (n=418)
Never	**1,434 (43%)**	446 (41%)	493 (38%)	295 (54%)	200 (48%)
A few times a year	**816 (24%)**	261 (24%)	320 (24%)	131 (24%)	104 (25%)
About once a month	**259 (8%)**	84 (8%)	117 (9%)	27 (5%)	31 (7%)
A few times a month	**306 (9%)**	101 (9%)	127 (10%)	46 (8%)	32 (8%)
About once a week	**151 (4%)**	57 (5%)	66 (5%)	14 (3%)	14 (3%)
A few times a week	**174 (5%)**	61 (6%)	80 (6%)	16 (3%)	17 (4%)
Every day	**222 (7%)**	76 (7%)	109 (8%)	17 (3%)	20 (5%)

Table 28b. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding Patient Monitoring by Regulatory Agency

	Overall (n=3,362)	BON (n=908)	Other State Agency (n=1,553)	Combination (n=896)
Never	**1,434 (43%)**	415 (46%)	597 (38%)	420 (47%)
A few times a year	**816 (24%)**	212 (23%)	384 (25%)	220 (25%)
About once a month	**259 (8%)**	63 (7%)	123 (8%)	72 (8%)
A few times a month	**306 (9%)**	80 (9%)	145 (9%)	80 (9%)
About once a week	**151 (4%)**	38 (4%)	82 (5%)	30 (3%)
A few times a week	**174 (5%)**	48 (5%)	90 (6%)	36 (4%)
Every day	**222 (7%)**	52 (6%)	132 (9%)	38 (4%)

Table 29a. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding Changes in a Patient's Status/Condition by Work Setting

	Overall (n=3,357)	Assisted Living (n=1,087)	Nursing Home (n=1,308)	Other Long-term Care (n=544)	Other (n=418)
Never	**1,406 (42%)**	433 (40%)	483 (37%)	292 (54%)	198 (47%)
A few times a year	**795 (24%)**	257 (24%)	310 (24%)	125 (23%)	103 (25%)
About once a month	**269 (8%)**	89 (8%)	112 (9%)	35 (6%)	33 (8%)
A few times a month	**281 (8%)**	92 (8%)	124 (9%)	38 (7%)	27 (6%)
About once a week	**162 (5%)**	68 (6%)	67 (5%)	13 (2%)	14 (3%)
A few times a week	**181 (5%)**	57 (5%)	93 (7%)	17 (3%)	14 (3%)
Every day	**263 (8%)**	91 (8%)	119 (9%)	24 (4%)	29 (7%)

Table 29b. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding Changes in a Patient's Status/Condition by Regulatory Agency

	Overall (n=3,357)	BON (n=906)	Other State Agency (n=1,549)	Combination (n=897)
Never	**1,406 (42%)**	422 (47%)	593 (38%)	389 (43%)
A few times a year	**795 (24%)**	200 (22%)	360 (23%)	235 (26%)
About once a month	**269 (8%)**	62 (7%)	127 (8%)	79 (9%)
A few times a month	**281 (8%)**	70 (8%)	145 (9%)	66 (7%)
About once a week	**162 (5%)**	44 (5%)	74 (5%)	43 (5%)
A few times a week	**181 (5%)**	45 (5%)	96 (6%)	39 (4%)
Every day	**263 (8%)**	63 (7%)	154 (10%)	46 (5%)

Table 30a. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding a Patient Refusing to take a Medication by Work Setting					
	Overall (n=3,354)	**Assisted Living (n=1,089)**	**Nursing Home (n=1,303)**	**Other Long-term Care (n=545)**	**Other (n=417)**
Never	**1,631 (49%)**	489 (45%)	557 (43%)	352 (65%)	233 (56%)
A few times a year	**648 (19%)**	241 (22%)	229 (18%)	98 (18%)	80 (19%)
About once a month	**237 (7%)**	84 (8%)	103 (8%)	25 (5%)	25 (6%)
A few times a month	**260 (8%)**	100 (9%)	112 (9%)	20 (4%)	28 (7%)
About once a week	**153 (5%)**	56 (5%)	75 (6%)	9 (2%)	13 (3%)
A few times a week	**189 (6%)**	54 (5%)	100 (8%)	20 (4%)	15 (4%)
Every day	**236 (7%)**	65 (6%)	127 (10%)	21 (4%)	23 (6%)

Table 30b. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding a Patient Refusing to take a Medication by Regulatory Agency				
	Overall (n=3,354)	**BON (n=907)**	**Other State Agency (n=1,547)**	**Combination (n=895)**
Never	**1,631 (49%)**	467 (51%)	672 (43%)	490 (55%)
A few times a year	**648 (19%)**	183 (20%)	281 (18%)	184 (21%)
About once a month	**237 (7%)**	55 (6%)	122 (8%)	60 (7%)
A few times a month	**260 (8%)**	64 (7%)	143 (9%)	52 (6%)
About once a week	**153 (5%)**	42 (5%)	73 (5%)	36 (4%)
A few times a week	**189 (6%)**	41 (5%)	110 (7%)	38 (4%)
Every day	**236 (7%)**	55 (6%)	146 (9%)	35 (4%)

The individual who respondents most preferred to go to for help was an RN (48%) (see Tables 26a and 26b).

Communication

Respondents were asked to report how frequently breakdowns in communication regarding medication administration occurred between them and a licensed nurse; 39% reported "never," 26% reported "a few times a year," and 35% reported "about once a month" to "every day" (see Tables 27a and 27b).

Respondents were asked to report how frequently breakdowns in communication regarding patient monitoring occurred between them and a licensed nurse; 43% reported "never," 24% reported "a few times a year" and 33% reported "about once a month" to "every day" (see Tables 28a and 28b).

Respondents were asked to report how frequently breakdowns in communication regarding changes in a patient's status/conditions occurred between them and a licensed nurse; 42% reported "never," 24% reported "a few times a year" and 34% reported "about once a month" to "every day" (see Tables 29a and 29b).

Respondents were asked to report how frequently breakdowns in communication regarding the issue of a patient refusing to take a medication occurred between respondents and a licensed nurse; 49% reported "never," 19% reported "a few times a year" and 33% reported "about once a month" to "every day" (see Tables 30a and 30b).

Respondents were asked to report how frequently communication issues related to knowing when to obtain additional information about a patient's status and then conveying that status information to a licensed nurse occurred between them and a licensed nurse; 48% reported "never," 22% reported "a few times a year" and 31% reported "about once a month" to "every day" (see Tables 31a and 31b).

Of respondents who indicated communication issues occurred 41% indicated the communication issues were related to obtaining vital signs; 39%

Table 31a. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding Knowing When to Obtain Additional Information about a Patient's Status and then Conveying that Status Information to a Licensed Nurse by Work Setting

	Overall (n=3,278)	Assisted Living (n=1,052)	Nursing Home (n=1,276)	Other Long-term Care (n=538)	Other (n=412)
Never	**1,565 (48%)**	461 (44%)	572 (45%)	311 (58%)	221 (54%)
A few times a year	**709 (22%)**	230 (22%)	260 (20%)	127 (24%)	92 (22%)
About once a month	**230 (7%)**	76 (7%)	103 (8%)	27 (5%)	24 (6%)
A few times a month	**223 (7%)**	84 (8%)	103 (8%)	21 (4%)	15 (4%)
About once a week	**104 (3%)**	34 (3%)	50 (4%)	7 (1%)	13 (3%)
A few times a week	**167 (5%)**	67 (6%)	63 (5%)	17 (3%)	20 (5%)
Every day	**280 (9%)**	100 (10%)	125 (10%)	28 (5%)	27 (7%)

Table 31b. Frequency of Communication Breakdowns Between MAs and a Licensed Nurse Regarding Knowing When to Obtain Additional Information about a Patient's Status and then Conveying that Status Information to a Licensed Nurse by Regulatory Agency

	Overall (n=3,278)	BON (n=886)	Other State Agency (n=1,493)	Combination (n=894)
Never	**1,565 (48%)**	432 (49%)	654 (44%)	476 (53%)
A few times a year	**709 (22%)**	202 (23%)	307 (21%)	200 (22%)
About once a month	**230 (7%)**	55 (6%)	116 (8%)	58 (6%)
A few times a month	**223 (7%)**	59 (7%)	110 (7%)	53 (6%)
About once a week	**104 (3%)**	21 (2%)	61 (4%)	22 (2%)
A few times a week	**167 (5%)**	51 (6%)	83 (6%)	33 (4%)
Every day	**280 (9%)**	66 (7%)	162 (11%)	52 (6%)

Table 32a. Specific Communication Issues (as Indicated by Respondents Who Felt Communication Issues Occured) by Work Setting

	Overall (n=1,731)	Assisted Living (n=603)	Nursing Home (n=705)	Other Long-term Care (n=230)	Other (n=193)
Obtaining vital signs	**712 (41%)**	254 (42%)	313 (44%)	69 (30%)	76 (39%)
Reviewing vital signs	**674 (39%)**	251 (42%)	298 (42%)	54 (23%)	71 (37%)
Noting critical laboratory values prior to medication administration	**720 (42%)**	242 (40%)	350 (50%)	61 (27%)	67 (35%)
Documenting other relevant clinical or behavioral changes in a resident's status	**1,242 (72%)**	442 (73%)	515 (73%)	159 (69%)	126 (65%)
Other	**126 (7%)**	32 (5%)	59 (8%)	21 (9%)	14 (7%)

Table 32b. Specific Communication Issues (as Indicated by Respondents Who Felt Communication Issues Occured) by Regulatory Agency

	Overall (n=1,731)	BON (n=457)	Other State Agency (n=854)	Combination (n=418)
Obtaining vital signs	**712 (41%)**	183 (40%)	396 (46%)	133 (32%)
Reviewing vital signs	**674 (39%)**	160 (35%)	387 (45%)	127 (30%)
Noting critical laboratory values prior to medication administration	**720 (42%)**	167 (37%)	398 (47%)	154 (37%)
Documenting other relevant clinical or behavioral changes in a resident's status	**1,242 (72%)**	321 (70%)	607 (71%)	313 (75%)
Other	**126 (7%)**	30 (7%)	63 (7%)	32 (8%)

indicated communication issues were related to reviewing vital signs; 42% indicated communication issues were related to noting critical laboratory values prior to medication administration; 72% indicated communication issues were related to documenting other relevant clinical or behavioral changes in a resident's status; and 7% indicated the issues was related to "other" (see Tables 32a and 32b).

"Other" open-ended comments about what communication issues were related to include the following:

Comments were edited to ensure readability.

Medication Changes

- Administration of medication changes – new physician orders.
- After doctors' appointments when medication changed occur.
- Change of medication, of discontinued medication, or change of dose.
- Documenting changes in medications clearly.
- Follow ups, medication changes.
- Medication changes.
- Medication changes.
- Medication changes; allergic reactions to medications.
- Medication changes that are not clear.
- Not getting a report about a medication change from a nurse.
- Not reporting change in medication at shift change.
- Number 1 complaint is not being informed of medication that was to be told, or increase and decrease a dose.
- When medications are changed, the effects it has on the resident.
- Medication changes not being put into MAR right away.
- If something should be held or changed sometime.

Changes in Status

- Change of status not relayed to Med Aide.
- Doctor orders changing, meds not notated on MAR.
- I don't feel that all of the residents statuses are communicated. I work a double then I'm off 2 days, a 48 hours report doesn't get to me.
- Inform RN or LPN about behavioral changes.
- Medication Aides are never informed about patients' assessment and changes.
- When patient's status has declined.
- Who is out of the facility, med changes, changes in residents status.
- No verbal report on changes.
- When resident is hospitalized, their status.

Difficult Communications with Nurses/Supervisors

- Charge nurses don't listen to you and don't chart information relayed to them.
- Communication with nurses is difficult, they do not listen.
- General lack of communication on any or all of above information about resident from supervisors.
- Letting a nurse know about residents' status and changes, but the nurse does not care to acknowledge the information.
- Nurse not wanting to listen or check on (not legible).
- Nurse that we had at the time didn't do her job, a nurse is not there now and we haven't got a new one yet.
- Nurses say they are too busy with other paper work.
- Nurses always too busy.
- Nurses don't listen to Med Aides.
- Nurses not doing their jobs. Dr meds, order new dosage.

- When patient (not legible) pain, and you tell the nurse, she'll just ask you to go ahead and give meds.
- When you see a nurse (not legible) you observe and they come and listen. When it is over (not legible)… they could handle a lot of problems if they would listen.
- When the nurse thinks you can read her/his mind.
- Because I am JUST A MED AIDE, I am often not taken seriously or believed when there are changes in a resident, by nurses. Also I don't understand the procedure of when an ambulance needs to be called or how a doctor's appointment is to be scheduled when the (not legible).
- I inform the nurse, we discuss and go from there for patient interest.
- LPN/RN doesn't think any information is a Med Aide's business.
- No nurses at the facility.
- PN is too busy to answer questions about (not legible).
- Nurse in AM 1 hour per week.
- Nurse delegation.
- Small faculty not much interaction with RN.
- Sometimes not listening to what we have to say.
- The problem is that I noticed something and when I see the nurse I forget about it.

Communication Between Shifts

- Communication between shifts.
- Poor communication between shifts and after being off for awhile.
- Often lack of communication during shift change.
- Sometimes there are gaps in communication in regard to the shift change report.
- We don't get report any more. Don't know about FBs, falls, etc.
- Transfer information from one month to the next month.

Documentation Issues

- Documentation issues are a big problem.
- Licensed nurse does not document in a timely manner.
- Nurses not writing on the MARs, wanting Med Aide to do this, when they should do it the correct way and follow rules. Charting, etc.

Assessment Issues

- Accu checks for blood sugars.
- Allergies, etc.
- Allergies to medication is sometimes forgotten, we catch (med aide), we check MARs.
- Knowing correct B/P, pulse, for different medication.
- Getting a medication D/C'd if I feel it would not be needed anymore.
- Critical laboratory values.
- Obtaining blood sugars.
- Insulin, incidents summary – assessment can't do.
- Noting meds are not to be taken together - always being told to do it anyway.
- If the patient is in isolation, or BP, or blood sugar level.
- When taking B/P blood pressure is lower than normal ex. B/P 90/50 I must hold a ten lot report to RN.
- When new residents arrived and how they take their meds.
- The nurses don't discuss with the medication aides the results of any of the tests that clients have, we have poor communication in this area.

Resident Issues

- Refused to take medication.
- Resident getting very confused.
- Residents unable to swallow.
- Care of resident.

Figure 13. Received a Written Job Description by Work Setting and Regulatory Agency

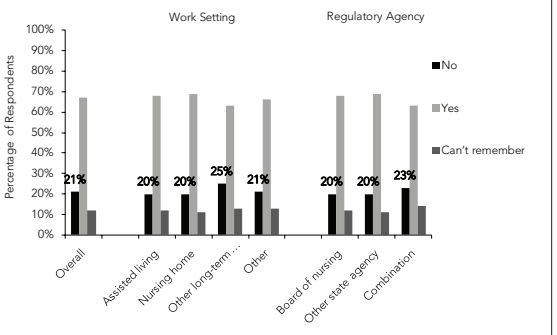


Figure 14. Level of Agreement that the Job Description Matched what MAs Actually Did (as Indicated by Respondents who Received a Written Job Description) by Work Setting and Regulatory Agency

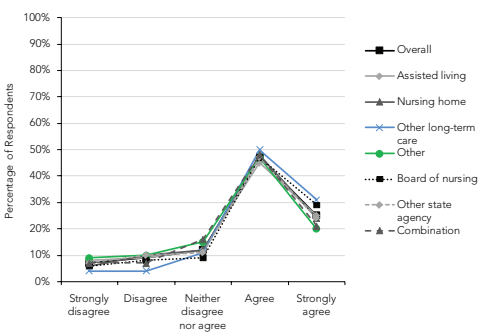


Figure 15. Needed More Information about Authorized Duties by Work Setting and Regulatory Agency

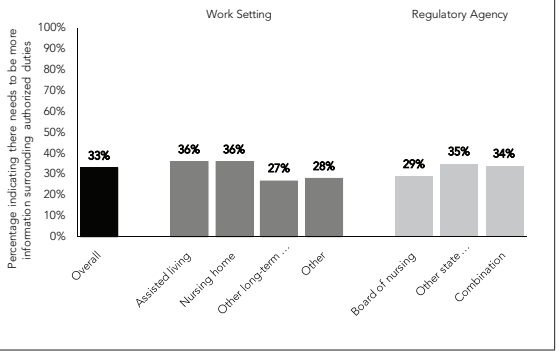
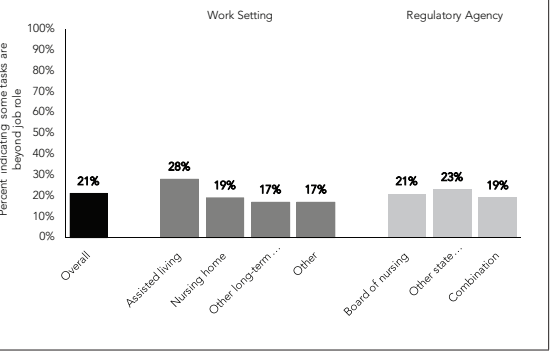


Figure 16. Performed Tasks were Beyond what MAs Should be Doing by Work Setting and Regulatory Agency



- Food take that (not legible) meds per tub.
- Refusals.

Availability of Medications

- Availability of meds.
- Medication orders.
- Medications not available.
- It takes a few days for medications to (not legible) to prison.

Physician Orders

- Physician orders.
- Sometimes doctor orders are unclear.
- Doctor's orders, too much of one medication makes resident toxic-critical.

Other

- Other workplace employees CNA's to CMA or RN.
- Person-to-person conflict.
- Personality, age, and gender difference.
- Lack of communication in general.
- Lack of communication in general.
- Communication very poor.
- Communication was futile. Day CMA/LPN wanted out of facility.
- All information is on a need to know basis.
- Medication administration daily checklist. Keys to reduce medication administration error. Medication storage guidelines avoiding pharmacy deficiencies.

- Medication errors monthly.
- Medications being (not legible) and pharmacy not communicating to us.
- Not acting promptly and have to be (not legible).
- Staffing.
- Because I am working on one-on-one with the client in his/her home, it is sometimes difficult to know exactly what all I should be reporting to the office.
- Forget to tell me that someone needs a pill.

Authorized Duties

A relatively large percentage of respondents (21%) indicated that they were not given a written job description that addressed the scope of their medication-related responsibilities (see Figure 13).

Of the respondents who indicated they obtained a job description, 72% "agreed" or "strongly agreed" that their job description matched what they actually did on the job (see Tables Figure 14).

A relatively large percentage of respondents who worked in assisted living facilities (36%) and nursing homes (36%) indicated that they needed more information about their authorized duties. In comparison, 27% of respondents who worked in other long-term care facilities and 28% in other facilities indicated they needed more information about their authorized duties (see Figure 15).

A relatively large percentage of respondents (21%) indicated they thought some of the tasks they perform were beyond what they should be doing in their job role. Results varied by type of facility; specifically, 28% of respondents who worked in assisted living facilities thought some of the tasks that they performed were beyond what they should be doing in their job role as compared to 19% of respondents who worked in nursing homes, 17% of respondents who worked in other long-term care facilities and 17% who worked in other facilities (see Figure 16).

Respondents who indicated some of the tasks they performed were beyond what they should be doing in their job role were asked to specify some of the tasks. The open-ended comments of 514 respondents (15%) were as follows:

Comments were edited to ensure readability.

Performing Multiple Tasks when Administering Meds/Performing Multiple Roles

- Doing some nursing jobs instead of nurse.
- What a nurse is supposed to do – they want the CMA to do their job.
- Do things nurses should do. Stop and do aide work – showers.
- Sometimes I am required to do some of the duties of the LPN.
- Doing the medications plus doing the CNA job all together.
- All nurse delegations, and some CNA responsibilities, they interfere with time needed to concentrate on correct administration.
- Answer the phone while giving out medication.
- Answer call lights while doing med pass.
- Being pulled to work as a CNA all the time, instead of hiring more staff.
- Team work, but at times you are out of your field work then you are late on your work.
- CNA work (not legible)…will pull, med aide.
- Covering for the nurses when they don't show up.
- Patient care in the middle of a med pass.
- Doing baths in between med passes.
- Doing CNA tasks during a med pass.
- Doing CNA work while trying to pass medication (pottying people, getting snacks, etc.).
- Doing one-on-one with a patient while passing meds and having to do activities all at the same time.
- Doing patient care while on the med carts.
- Due to no nurse in building at night, we usually make calls in emergencies.
- Dispense meds for the nurse on duty when I am not responsible for counting meds, or for the med cart.

- Doing patient care during med pass.
- Facilities get the best of both worlds in CMAs. We are CNAs and are often expect to function as both.
- For example, answer call while you are giving meds. Take out garbage. Care for Residents. Too many things when you are giving meds.
- Helping with CNA tasks that take away concentration and time on passing medications correctly.
- I am a correction officer, I should not be giving meds when I don't know anything.
- I am also a CNA and at times expected to both jobs at once.
- I am now an RN; knowing what I know now, CMAs need much more education than is required.
- I am on the med cart helping the aides. I was always told that when you are on the cart you are on the cart and you should not be bothered.
- I feel like I do a nurse's job.
- I was asked to perform CNA duties after or along with the medication pass (a dual position).
- I often work on the floor as a CNA during the hours I am passing pills.
- Work on floor when needed. Pass meds and also give my residents snacks when on.
- Having more patients – this needs to be regulated by the state and enforced with RN there. Forcing the MA to do things that are to be done by RNs.
- Many times I am removed from the med cart to work as a CNA.
- Med Aides should not be required to stop passing meds to perform personal care if they have (not legible) residents or med passes. Some med techs have as many showers to do as the CNAs.
- No nurse in building. There is a nurse in other buildings. Facility makes us do IPPB treatments and other treatments that a nurse should do, or else we get terminated.
- Not enough CNAs fulltime to cover the floor, so they pull you off the cart to work the floor.
- Not in my present place, but in some places, when short putting you to work as a CNA or after passing pulls help work as a CNA.
- Nursing tasks.
- Pass snacks. Help Aides while passing meds.
- Performing treatments out of our scope of care.
- Pulling me off the medication cart to do (not legible).
- Responsible for ADLs along with medication pass, all while staying in two hour time frame.
- Shouldn't have to perform as much direct patient care when administering medication.
- Some facilities want med aides to do both med aid and CNA duties – med aid is enough to do by itself.
- Some medication treatments should be done by a nurse.
- Sometimes the level of care provided is above what a med aide should do.
- Sometimes they forget we are not nurses and we have to remind them we can't do certain things.
- Sometimes I am assigned ADLs which take much time needed to concentrate with medication administration. Med Aides are forced to hurry and sometimes lose sight, since time was consumed on ADLs. Facilities should plan on enough staffing.
- They want us to be a med aide plus a tech on the floor without any med errors.
- Too much of the floor work as a MA along with passing meds, doing ADLs – too much on plate with short of help.
- Trash collecting. Trays (not legible) while passing meds.
- Taking resident to the restroom, putting them to bed, feeding them, and sometimes this can put me behind on my med pass.

- When I am doing medications I shouldn't have to stop to answer lights when there are 2 CNAs and a LPN on the floor.
- When I first started it was uninterrupted medication passes – now you take care of high fall risk res./alarm on bed and chair. The med pass is constantly being interrupted.
- When short of staff they want us to do CNA's job. This can cause med errors and lack of concentration.
- Sometimes it is very difficult to focus on the meds, call lights, and assisting with showers. Care at the same time.
- Pass the nurses' meds when they don't want to get up off their bottom.
- Passing medication and doing patient care at the same time. Either you do meds or you do CNA work, not both when passing medication.
- When I work as a med aide I am asked to stop the med pass and do CNA tasks, such as, toileting, or feeding a resident.
- Stop med pass to answer lights, stopping to help CNA, having to do 2 halls.
- Some nurses give us all the responsibility. We need to be aware of medication errors.

Assessments

- Assessment of trainee patient.
- Assessing clients pain/PM medications.
- Assessing patients when giving PRN medications. Assessing a patient's pain levels.
- Assessing patient status and determining whether to call a nurse.
- Assessing residents for need of PRN medications.
- Assessing residents when falls occur. No nurse on duty, only available 9 to 5 or via phone, but never answers.
- Assessments. Admissions.
- Assessments before giving PRNs, treatments.
- Assessing a resident.
- Assessing residents, assisting in admissions.
- Body assessments.
- Calling physician and family in regards to a resident's care. Deciding whether or not to send resident to ER (assessments).
- Assessing a client when they are sick.
- Assessing patients – we know that is for an RN to do.
- TX or assessing a patient if critical.
- Delegation of CNA duties. No licensed nurse in building requires "assessment" of residents in some instances.
- Doing pain assessments.
- Monthly summaries, assessments.
- Assessments on skilled residents and fall assessment.
- Diagnosis & identify.

Overworked/Role Issues

- The number of clients I am responsible for.
- Administer medication to all 24 residents and then come back and do (not legible) to residents, endless.
- Doing more work at night and in the morning time.
- Extra duties.
- Giving medication on 2 separate floors at the same time.
- Giving medication tabs to about 60 residents a day. Standing up 3/4th of an 8 hour shift is bad for health.
- Giving meds and care to "total care residents" in an assisted living facility.
- I was under the understanding we would rotate med passes.
- I have to pass meds on two separate units and believe that times are lapsing (i.e., 1 hour before and 1 hour after). Patients cannot get their meds on time.
- In home care for others other than the client.

- In the assisted living facility I work at, residents must be able to control their bowels. This is not the case with some residents.
- Lifting a resident that should be in a nursing home. Being a punching bag for combative residents that should have some meds for mood and agitation but don't.
- A very large variety of things.
- One-on-one with combative residents and no help around.
- Only med tech in the whole facility doing more than one floor of meds.
- Passing 2 med carts and leaving to another. Be responsible for another set of patients.
- We have only 2 med techs and we have 283 people, plus showers and MAR at the end of the month and do med passes. If someone calls we have to go to the homes.
- Sometimes we have people who need too much care.
- The number of patients I administer medications to (55 patients) is too much.
- Sometimes there are too many meds for one person to administer.
- Working a hall and trying to walk a cart with 30 residents on it.
- Working double shifts.
- We are assisted living, sometimes we have residents that are total care.
- We have residents that are (not legible) that need to be in (not legible) instead of assisted living.
- Clients that need a lot of care and need to be in nursing homes.
- We are a facility that aside from light duties and administering medications, have taken on more than they can handle per daily limits.
- They wanted me to do another co-workers job while she watched me. Plus, I did my job.
- Total care of a resident in assisted living facility without the needed help or supplies.

Meds, Treatments, Procedures/Wounds/Insulin/ Breathing/Narcotics/Pain

- Administering PRN doses of morphine when receiving routine morphine.
- Give PRN when charge nurse didn't tell why or assess patients. For me it is very wrong for the state to agree to have PRNs given by CMAs. It is very difficult to see charge nurse going…(not legible).
- Follow up on PRN medication. Follow up on held medications.
- Giving meds I'm not familiar with. Observing effect of med changes. Giving PRN meds with little info as to why.
- Giving antibiotics from the ER box. PRNs and narcotics.
- Giving PRN medications for pain and charting results.
- It is up to us to know when patients may need PRNs and if they need to be sent to the hospital.
- Administer inhalant, oxygen treatments, nebulizer, and intermittent positive pressure. Give initial dose of medication, perform blood glucose test. Assist the nurse instill irrigation fluids. Colostomy, Urinary catheter, enema.
- Drawing up insulin. Taking care of sliding scale insulin.
- Insulin doses. Deep wound care.
- Giving insulin shots.
- Knowing when to withhold insulin or not!
- Blood sugar checks.
- Check Blood sugar levels.
- Blood sugar checks. Insulin. Oxygen.
- Accessing residents blood sugar testing.
- Giving insulin. Wound care.
- Insulin administrator.
- Insulin shots in assisted living.
- Insulin shots. Colostomy bag. Wound wraps.
- Skin tears. Sliding scale insulin. Digoxin.

- Supervise insulin and oxygen over 2 liters.
- Obtaining finger stick blood sugars. Administering breathing treatments without assessing breath/lung sounds.
- Cathing.
- Cath care. Oxygen.
- Catheter bags. Colostomy bags.
- Catheters, debridement, and more.
- Certain treatments that are delegated to a LPN/RN are asked to be done by a Med Aide.
- Changing foley tubing/catheter bag. Changing dressings of open wound.
- Changing out milk on tube feeders.
- Changing colostomy bags.
- Tube feeding, suctioning, insulin shots, wound care.
- Taking care of pressure sores. Catheterization.
- Tracks care, wound care.
- Treating pressure ulcers.
- Treatments.
- Stage treatments.
- Breathing treatments. Dressing changes.
- Nebulizer treatment – not in my scope but charge nurses expect me to do it.
- Treatments to wounds.
- Treatments to wound care.
- Wound care.
- Administering meds, caths, wounds, etc. Not pushing beds.
- Changing dressings on wounds. Giving suppositories.
- Dressing changes, wounds.
- Doing topical treatments. Dressings. Wounds.
- Doing treatments such as apply topical.
- Doing wound care.
- Bed sores. Dressings. Treatments.
- Dressing changes. GI flushing. Oxygen administering. Changing of oxygen tanks.
- Dressing changes, skin tears. We do not have appropriate supplies for skin tears.
- Dressing changes.
- Dressing wound. Giving insulin.
- Dressing wound on patient's buttocks. Serious wounds.
- Dressing wounds. Giving insulin.
- Dressings.
- Dressings. Wound care.
- Some dressing changes.
- Giving breathing treatments. Skin treatments. Wounds, etc. Initial doses.
- Dressings, decubitus ulcers stages III – IV.
- I feel I needed more training. Sterile wound care. Inhaler. Asthma. Diabetes. COPB.
- Changing dressing. Administering (not legible) when patient bottomed out. Certain creams, when I know nothing about the skin conditions we are medicating.
- Monitoring wounds – we are not supposed to assess. Some of the treatments I feel need to be done by a nurse.
- Packing wounds.
- Take care of open wounds. Give inhalants.
- Helping with cath changes.
- Invasive treatments.
- Monitoring patient's conditions. Doing treatments.
- Some of the treatments.
- Some of the TX.
- Some treatments. Also, time is not being properly acknowledged.
- Some treatments (e.g., wounds or cuts). Not trained to perform such tasks.
- Some treatments.
- Neb treatments, med reviews, & verifications.

- Suppositories. Major wound care. Enemas.
- Some treatments, skin assessments.
- Wound care.
- Wound dressing.
- Wound VACs
- Wound care.
- Wound care.
- Wound care.
- Dressing changes. Pain assessments.
- Applying tinactin cream.
- Enemas.
- Morphine injections. Manual tube feedings. Care of open wounds.
- Suppository should be given by nurse. Control 2 narcotics should be the duty of the nurse.
- On 2nd or 1st shift sometimes accuchecks. Years ago give insulin. Bandage some wounds or assess the wound.
- Holding blood pressure medications. Taking blood sugars.
- Administering oxygen while nurse is around. Applying creams to open areas (i.e., skin breakdown). Administer nebulizer meds.
- Medication administration.
- Giving medication (not legible) during treatments.
- G-tube.
- Check for placement of G-Tubes.
- G-tube feedings. J-tube colostomy.
- J-tubes. G-tubes. Or feeding tubes. Doing blood sugars. Some bedsores.
- Medications given via peg tubes.
- Working with individuals that have G-tubes.
- Possible tube feeding.
- Tube feeding.
- Client's gastrointestinal tubes get dislodged from body entry and agency supervisor nurse/ RN request counselor to place back in so the entry opening doesn't close up.
- Distributing psych meds or any other meds. I have no medical background! This should be a job for the medical department only!!
- Administer medications, checking vital signs, fill syringes.
- Administering: vitamins, meds for acid reflux, (not legible).
- After being in an RN program as a Med Aide I know I didn't have enough deep knowledge on the meds being administered, such as B/P with B/P meds.
- Destroying meds. Accuchecks. Tube feedings.
- Destroying all out-dated or left over meds. Breathing treatments.
- Giving non-doctor approved meds.
- Occasionally asked to help with would care.
- Oxygen. Topical meds on opposite sex.
- Oxygen concentrators. Administering meds via G-tube (however this changed recently). Administering meds without a thorough knowledge of any med.
- Observing any reaction after meds are given.
- Pain control.
- Reading feeding pumps.
- Some medications should be premixed – like Vicodin.
- Sign out medications for them. Borrow from other patients' meds.
- Making some decisions on new meds and unable to get a hold of anyone.
- Making decisions on whether to administer or not. Cracking pill packs.
- Giving medications without an order in "medication book" (order is confirmed on nurse desk, they just have not transcribed it to me yet).

Doctor, Pharmacy, Family Communications/ Change or Reorder Medications/Initial Meds/ Documentation

- Calling the doctor. Faxing orders to the pharmacy. Taking phone orders from doctors.
- Calling the pharmacy when meds are not available.
- Asked to call doctors to change or reorder medications.
- Calling pharmacy to re-order meds.
- Calling pharmacy to reorder medications.
- Being responsible for all ordering. Doctor authorization of medications, asking for substitutes if not covered by us.
- Ordering meds. Initial doses.
- Re-ordering meds. Giving initial doses.
- Some nurses will not give initial dose.
- Administer initial desk medications.
- Doctor fax medications, fax accidents.
- Faxing doctors. Taking over the phone orders. Copying med records.
- Faxing the doctor. Taking care of lab results and things that I am not comfortable with.
- Interaction with doctors and other facilities.
- Making decisions on giving meds without doctors orders.
- Talking to MD about patient, but not taking orders.
- Ordering meds. Communication with Doctor.
- Ordering meds from pharmacy.
- Ordering meds. Follow-up doctors if Rx has run out. Writing orders on MAR. Noting and fax Rx.
- Printing consultation forms. Scanning and submitting results of doctor's office (not legible).
- Prescriptions for patients.
- Processing doctor's orders when the nurse (LPN) and med coordinator are not working.
- Having to call pharmacies on discrepancies. Having to give initial dosages. Ordering meds. Taking initial dosages from ER kits.
- Taking individuals to doctor appointments and emergency care at a prompt care clinic.
- Taking students to/from doctor appointment. Escorting to hospital in emergencies.
- Talk to pharmacy, doctors, and family members about all residents care and concerns.
- Talking with families. Answering questions about meds and tests.
- Talking with families. Taking orders. Transferring orders.
- Writing doctor's order on MED-DEX.
- Answer telephone, making order to pharmacy, document (not legible).
- Calling 911 when I'm passing meds. Talking to family members when I'm passing meds. Attend to pharmacy personnel when I'm busy with residents.
- Dealing with pharmacy – most nurses do not have a clue about meds, times, interactions, etc.
- Ordering from pharmacy. Transcribing orders.
- Ordering medications from the pharmacy.
- Ordering meds.
- Ordering meds.
- Ordering meds. Giving ID meds.
- Receive verbal orders from physician.
- Receiving medications from pharmacy.
- Check all monthly MARs. Rewrite orders. Reorder medications.
- Checking medications in from the pharmacists. Now orders on MAR. New prescriptions 1st tried/ admitted.
- Doing new orders from MD assessment (new residents). Paperwork.
- Having to check orders to make sure they are written correctly. Check law, etc.
- Observe new order and report to RN, call pharmacist for clarification, and new orders.

- Stuff that RNs and house manager should be doing (i.e., talking to Drs and med ordering).
- Ordering meds for all carts that are not my assigned carts. Being the only to correct or check MARs at beginning of month.
- Writing medications on the MAR after trying to read the doctor's handwriting.
- Writing orders on MAR.
- MARs once a month.
- Documenting diet sheets.
- Faxing RX's. Deciding what drugs to give.
- Deal with family members because nurse doesn't want to.
- Writing in nurse's notes. Writing on all PRN meds and behaviors.
- Excessive paperwork – most that should be supervisor's responsibility.
- Giving information to families.
- If there is an emergency I have to be the one to send the person out and call family, etc.
- Supervise and decide medical issues week days after 4 pm (e.g., need to go to hospital, accompany to hospital, sit with hospitalized, return to residence, explain D/C care and changes).
- Sometimes when someone falls I do all of the paperwork and decide if they need medical help.
- Making decisions to send someone to the hospital. Talking to the family.

Issues Related to Patient Care:

- Caring for people who should be in a nursing home or hospital or hospice house.
- Caring for residents (not legible) and residents with debilitating dementia.
- After a patient has fallen sometimes it's left to the Med Aide to do vitals.
- Dealing with behavioral issues with consumer when I'm not trained to deal with intense behavioral issues.
- Describing, injuries, I am not a nurse.
- Educating patient.
- Listen and attend to patients who need other help than medication.
- When we have an emergency we are sometimes expected to take full control of the situation because we cannot get a hold of nurse on call – this happens a lot.
- When a patient passes away.
- Answer call lights, shower, and accompany to doctor's appointment.
- Answer call light and help CNAs.
- Monthly evaluations.
- Neuro checks after patient falls.
- Evaluating the resident.
- Left with new admit and office personnel fled. Needed nitro.
- Vital signs. Temps.
- Taking vital signs – this is not taught in medication technician training.
- Removing and cleaning prosthetic eye and replacing.
- Handing out (not legible). Answering lights instead of doing my assigned medications.

Other Issues Relating to Patient Care (including CNA duties):

- Bussing tables. Cleaning.
- Busy. Helping with showers, etc. Sometimes you can lend a hand, but if you do extra you can't get your work done.
- Caring for mental health patients' vehicles.
- Change resident's diaper. (Not legible) bed dress (not legible).
- Turning patients over. Lifting them, dressing them, turn heat on and off, close door, open door.
- Changing diapers. Cleaning up bowl movements off floors, carpets, etc.
- Changing people in beds that are very low and don't come up.
- House cleaning.

- Cleaning patio and porch. Shoveling snow. Gardening. Bathing dog and cat.
- Cleaning rooms and serving meals.
- Cleaning rooms and doing dishes.
- Cleaning rooms. House-keeping.
- Cleaning that could compromise my cleanliness, then having to do hands-on care.
- Cleaning their apartments.
- Cleaning up messy mess. Cleaning dining room.
- Cleaning, laundry.
- Cleaning, laundry and showers up 11-7 shift while expected to pass meds at 6.
- CNA duties. Laundry. House-keeping.
- CNA or other not related.
- Cooking, cleaning, bathrooms.
- Cooking, house-keeping, laundry.
- Cooking, housekeeping, activities.
- Cooking, cleaning, laundry, activities, yard work, answering the door… dishes, serving, pick up after the animals, carry groceries and put away. Never ending chores.
- Counseling resident. Cleaning building. Cooking for residents.
- Cutting nails.
- Cleaning furniture and windows inside facility and in rooms.
- Cleaning residents bathrooms and rooms due to shortage of housekeeping, doing laundry.
- Cleaning the kitchen floors, vacuuming the facility, cleaning public bathrooms.
- Cleaning up behind the evening Med Aide and the night charge nurse.
- Cooking, cleaning, lifting, laundry – we are assisted living.
- Dining room assistance. House-keeping. Laundry.
- Activities with Resident.
- Doing laundry. Give showers. Set tables.
- Doing patient care, baths.
- Doing the laundry.
- Feeding. Showers.
- Laundry, dinning. These are CNA duties.
- Laundry. House-keeping.
- Laundry. House-keeping.
- Laundry. Kitchen duties. Transportation.
- Laundry. House-keeping. Etc.
- Laundry. House-keeping.
- Wash dishes. Serve meals.
- Washing clothes. Cleaning wheelchair.
- Washing dishes, mopping floors, open gate every 10 to 20 minutes.
- Washing kitchen linens. I don't think you should be doing caregiver tasks if you are hired to do medication administration.
- Vacuuming floors.
- Cleaning.
- Cleaning – dusting, mopping, etc.
- Cleaning bathrooms.
- Cleaning bathrooms, mopping floors, bathing.
- Cleaning dishes from dining room. Doing laundry. Cleaning resident rooms.
- Cleaning litter boxes. Washing director's clothes. Cleaning director's house.
- Making mixed alcohol drinks. Doing laundry. Taking out trash.
- Minor household duties. Laundry. Clean, etc.
- Mopping floors. Transporting clients.
- Setting tables. Bussing tables. Food server. Patient care. Laundry. Med Techs can't focus on medication if they have too many other tasks to do.
- Shoveling snow.
- Showering, changing diapers when residents are incontinent, or doing (not legible).
- Laundry. House-keeping.

- ADLs, dressing residents, bathing, etc.
- Care giving – ADLs.
- Feeding. ADLs.
- Feeding. A hydration sheet for every patient.
- Pass snacks and water. Put people to bed. Help feed.
- Passing snacks.
- Plumbing.
- Relieving impactions.
- Serve in the dining room and feedings.
- Serve meals. Wash clothes. Bathing.
- Serve meals. Clean tables. Washing dishes and take trash out. Do activities with residents.
- Serving food.
- Serving meals.
- Snacks should be passed out by the CNAs.
- Some administrative tasks.
- Toilet, feed, transfer.
- Transport, phone, taking messages.
- Too many CNA duties. Too much heavy lifting and direct care.
- Dietary jobs. Housekeeping jobs.
- Dietary work.
- Assisting the later staff in serving patient meals.
- Checking on room temperatures. Escorting to meals. Changing/dressing a person.
- Clipping client's finger/toe nails or shaving (risk of blood exposure).
- CMAs in our facility do restorative programs for our residents in our respective assigned halls.
- Doing CNA duties.
- Facility security. Building maintenance.
- Fixing things that brake. Shoveling snow. Yard work.
- Give baths. Sweep floor. Clear toilets.
- Handing out cigarettes to smokers. A medication aide should only do mediation duty only.
- Having to do floor work and CNA work.
- Help clean up dining. Activity.
- House-keeping. Laundry.
- Housekeeping. Cooking. Laundry. Receptionist. Plumbing. Total care.
- If I have extra time I feed residents. Talk with family and document meals.
- Giving meds to the facility dog.
- Maintaining residents bathing. Washing their clothes.
- Make bed. Give showers. Bring or serve food. Take dirty dishes to the kitchen.
- Making beds. Serving in the dining room. Showers.
- Nail care. Shaves. Toileting. Taking residents to smoke.
- Our secretary's job.
- Record meal ticket help. Feed residents. Give snacks to (not legible).
- Ordering nursing supplies. Cleaning. Organization. Unit secretary work.
- We also have to act as a house keeper and dietary aide when short of help.

Multiple Issues (Combinations of Any of the Above Categories):

- Answering lights when need to assist a patient. Personal care while doing CMA work. Answering phone calls for doctor because RNs and LPNs are usually freaks.
- Assess residents without a nurse. Do wound care without a nurse (even though they have shown you).
- Assessing a patient who has fallen. Document notes in a resident's chart.
- Assessing patients. Insulin shots. Drawing blood. Deciding what level of oxygen for oxygen tanks. Narcotics. Colostomy changes.
- Be a CNA to 13 people. Pass medication to 30 or so people. Vitals. Give showers. Chart. Pass ice. Answer lights.

- Blood check – reorder meds, call doctor in case of death.
- Breathing treatments. Tube feedings. Pumps on/off. Some nurses on some type of probation, so sometimes we have to do their jobs. Patches.
- BP reading before med passes. Making sure the correct meds are in stock.
- Calling pharmacy. Initial doses.
- Calling the Doctor to request new scripts. Doing vitals and weight for admittance.
- Calling the pharmacy. Monitoring bed patient.
- Cath care. Dealing with people who have (not legible) diseases.
- Clean wounds and change dressings. Cut nails. Collect urine & fecal specimens.
- Communications (not legible) Dr for impaction. Open wound cares. Destroying meds. Care plans.
- Doing what a nurse or doctor should be doing. Cleaning wounds. Looking for signs that a doctor or nurse should do.
- Reviewing new MAR sheets. Changing bandages and cleaning deep wounds, such as ulcers and gashes that require stitches.
- Supervising role of caregivers (CNAs) in absence of nurse. Wounds.
- Suppositories. Wound treatments. Correct the MAR. Inhalants.
- Wound care. Some of the paperwork (is writing orders).
- Wound care. Hemorrhoid issues. Restraints. Follow-up from hospital to home.
- Cleaning (not legible). Ordering insulin. Making sure all med aides are doing their job.
- Taking finger-sticks. Administering insulin. Documenting on the resident weekly. Documenting in resident logs. Care. Laundry. Etc.
- Initial dose of meds. Clarifying med orders. Performing duties that a nurse is supposed to do, such as when you obtain an abnormal b/p and you notify the nurse and they do nothing but (not legible).
- Initial dosing. Ordering new med orders. Correcting MARs.
- Implemental behaviors. Driving documentation. Job coach. Cleaning, etc.
- Direct patient care. ADLs. Nutrition. Taking vital signs. Blood glucose. Weights. Changing minor dressings.
- V/S pain med administration enema. Assessing patients.
- We have to do whatever the delegating nurse says, plus documentation or assess the resident.
- Doctors orders. Cleaning dishes.
- Giving meds – helping in dining room. Making beds. Doing baths. Feeding people. Serving trays. Giving towels. Doing charge aide work. Doctor's orders. Anything else asked of us.
- House-keeping. Laundry. Meds exchange (pharmacy needs D/O meds exchange). Over worked.
- DC meds. Re-orders. Feeding patients.
- Enemas – wrapping rectal Tylenol. Ordering meds.
- Narcotics control. Send expired meds to (not legible). Order stock level meds, etc.
- Neb TX. Ordering.
- Ordering medications. Checking blood glucose levels. Auditing charts. Placing orders in MARs.
- Ordering meds. Working floor while passing meds.
- We have to do monthly v/s on residents, not the CNA, and we have to order medications when low.
- Document MAR. Log meds in DCd book. Be in dining room at each med pass passing out trays when should be passing meds.
- Working double shifts. Checking MARs for other's med errors.
- Feeding. Finish or give meds while they are eating. A lot of documentation and paper work.
- Filling out lab reports. Changing oxygen tanks.

- Checking blood sugar. Feeding resident. Peri-care while passing medications. Ignoring the fact that not all medications are delivered on time.
- Checking patient charts to clarify orders. Patient care. Feeding. Answering call lights, etc.
- Cleaning MED RM. Stocking carts.
- CNA tasks are included with CMA time frames. Difficult to adhere to job. Vital signs-parameters with certain heart meds.
- Do dishes, baths, clean, review medications.
- Doing nurse aide work. EKGs. Dressing change.
- Extremely heavy lifting of immobile patients. Bathing/dressing.
- Fixing broken (not legible). Replacing oxygen canisters.
- Giving suppositories while (not legible). Passing hall trays.
- Giving excessive number of residents to take care of. Asking the med aide to pass meds on 2 halls. Asking med aide to count narcotics.
- House-keeping. Residents that have early stages of Alzheimer's
- One person supervising 13 residents. Cooking. Cleaning. Paperwork.
- Pass meds and do patient care at the same time which is cross contaminate. Change dressings.
- Passing ice. Refining ice chests. Passing snacks. Answering lights when I am in the middle of doing my med pass. Doing smoke breaks.
- Passing meds and changing/bathing people.
- Supervision. Security. G-tube.
- Performing suctions. Reviewing patient's plan of action.
- Parameters (not legible) during administration. Cardiac (not legible), etc.
- Pass meds. ADLs.
- Patient care. Administered meds (not legible) to resident. Take vital signs. Send resident to the hospital (not legible).
- TX, evaluating people when they fall.
- Administering medications. Pass ice water, snacks, taking care of all the drinks during meals in my shift (e.g., regular water or thicken liquids.). Giving out pages at the beginning of the shift to all CNAs.
- Resident's status. Change status report to change nurse. Lifting residents when fall on the floor.

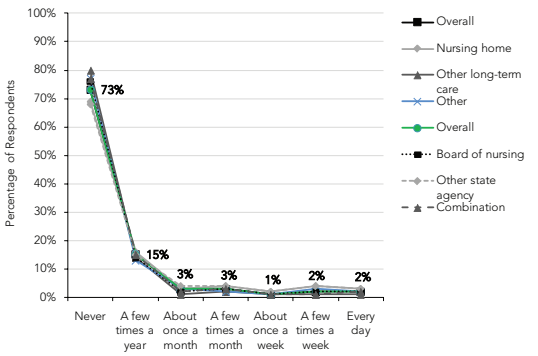
Other

- We are classified baby sitters, and should only be working with the medications.
- Some nurses expect you to sign off on medication they have given to patients.
- Trying to get one of the residents to understand why their complaints are not being taken care of.
- Taking the place of a classroom teacher at job.
- Help staff (volunteer) when not busy – very rare.
- Not being able to check interaction of drug charting.
- Need more training on medications "why they are given to that resident."
- Rather not say.
- No comment.

Respondents were asked to report how frequently a licensed nurse asked them to perform a task they felt they were not trained nor qualified to perform; 73% reported "never," 15% reported "a few times a year" and 11% reported "about once a month" to "every day" (see Figure 17).

Respondents who indicated a licensed nurse had asked them to perform a task they felt they were not trained or qualified to perform were asked to specify some of the tasks. The open-ended comments of 554 respondents (17%) were as follows, categorized by response category:

Figure 17. Frequency of MAs Being Asked to Perform a Task they Feel They Were Not Trained or Qualified to Perform by a Licensed Nurse by Work Setting and Regulatory Agency



A Few Times a Year

- Giving meds I am not familiar with. Observing effect of med changes. Giving PRN meds with little info as to why.
- Communicating with pharmacist. Pace-maker (not legible). Calling 911 when a resident is unresponsive or almost dead.
- Copying orders onto the Mar. Large number of clients.
- Putting on or taking of a colostomy bag.
- A nurse told me to administer Coumadin.
- A resident had fallen and the nurse asked me to assess whether she needed to go to the hospital.
- A treatment.
- Adm nebulizer to a patient. Administer (not legible) to a patient (not allowed in our facility).
- Administer a medication that I haven't administered for a while – need retraining.
- Administer diabetic shot. Administer suppository. Complete an assessment.
- Administering a medication via G-tube. Giving insulin.
- Administer a medication that is not on the MAR yet.
- Administering narcotics. Changing dressings.
- All depends on the situation. Prison riots, clients trying to commit suicide, etc. Life or death situations.
- All I have to do is ask how to do a task and the nurses will show me how.
- Applying creams, etc.
- Tube feeding.
- Ask to give Maalox or Pepto without valid orders.
- Asked to put oxygen on dying resident.
- Asking a CNA to dress wounds.
- Asking a resident about their pain level on the scale from 1 – 10.
- Asking me to deliver a med they set-up. Giving a PRN we have no order for.
- Asking to sign for medications that I did not pull or give.
- Assessing patient, then letting the nurse know.
- Assessing resident – I let them know I can't.
- Assess a patient after a fall.
- Assessing a resident after a fall for injuries or to determine pain.
- Assessing a wound.
- Assessing residents' conditions.
- Administering medications to hospice patients.
- Anal suppositories.
- Bandages. Feeding tube. Insulin. Empty catheter. Stoma care.
- Blood sugar. Vitals on dying person.
- Blood sugars. Insulin. Caths.
- Blood sugars. Initial dose of meds.
- Borrowing meds. Administering the wrong (not legible).
- BP/pulse meds.
- I refuse and let them know I haven't been trained in that task. Either have them teach me now, or allow them to do it.
- Call and verify MD orders. Check for med errors.

- Call in meds and call doctors or hospitals.
- Calling pharmacy, order medications.
- Can't remember now. There have been times where I was asked to do wound care, I wasn't worried about this.
- Can't specifically remember what exactly, but I do know there were a few times I felt uncomfortable doing a task my supervisor told me I had to do.
- Cath's.
- Cath cleaning. Changing a bag.
- CBG's and catheters.
- Call doctor for order.
- Certain dressings on residents.
- Certain eye drops. Blood sugars.
- Change dressings. Sterile drainage tubes.
- Change foley tubing/catheter bag. Wound dressing without prior training.
- Change (not legible) sites. Suction tracks. Complex wound care.
- Changing colostomy.
- Changing dressing.
- Changing foley's.
- Charger decreasing to open wounds.
- Check pupils with flashlight to see how they react to light.
- Check skin. Breathing treatments.
- Check the MAR sheet. File the (not legible) in the Mar. Check Dr's order.
- Check blood sugars – not allowed.
- Clean, change bandage on (not legible) site on resident.
- Complete infection reports.
- Connecting patients to machines.
- Change colostomy bag.
- Changing a sterile wound dressing.
- Wounds.
- Dealing with wound care.
- Death – RN refuses to come in. Resident goes psycho – RN refuses to come in when called.
- Do blood sugars.
- Do ostomy care.
- Documentation.
- Documenting on a skilled resident that needs to be assessed or vital signs after a fall.
- Doing all 2-step treatments on the unit I was working.
- Doing finger sticks.
- Doing treatments on a very rare (not legible).
- Doing wound care. Accessing changes in a resident's condition due to med change without nurse follow-up.
- Don't want to specify. Sorry.
- Dress a wound or sore.
- Dressing advance skin opens and sage III – IV decubitus ulcers.
- Dressing skin wound.
- Dressing wound & treatments.
- Dressing wounds.
- Wound dressings that I haven't been trained on. Some breathing treatments.
- Dressings.
- Draw up insulin.
- Administer no still spray. Giving initial doses.
- Emergency heart problems or (not legible) episodes.
- Enemas.
- Enemas. Last time administering an enema to an unruly, combative client.
- Evaluate stool samples.
- First dose.
- Flush a G-tube or feeding tube. Give meds through a tube. Give insulin.
- Flush a feeding tube. Stop an IV.

- Food service. Activities. Building maintenance after hours.
- Give 1st doses. Med without order.
- Give medications that they have prepared.
- Write orders on med sheet.
- Give PRN meds.
- Give PRN med without nurses assessment or give med that has not been transcribed first.
- Giving breathing treatments. Inhalers.
- Giving injections.
- Giving insulin. Doing treatments only nurses can do. Giving 5 pm and 9 pm meds together – this happens a lot and I refuse.
- Giving medication from someone else's med (i.e., borrowing medications).
- Giving medications before or after scheduled times.
- Giving medications without an order in "medication book" (order is confirmed on nurse desk, they just have not transcribed it to me yet).
- Giving PRN too soon.
- Giving treatments I haven't done before.
- Give enema. Give suppositories.
- Giving certain narcotics that the nurse is suppose to give.
- Giving insulin shots.
- Hand washing… (not legible)…
- Help with insulin and doctor's treatments with broken skin – but I already knew how to do those duties.
- Helping a nurse make a decision about whether client needs to go to the hospital.
- Holding the nurses key for them while they are on break out of facility. If you refuse they fill offended.
- I believe narcotic administration should receive more evaluation by LPN/RN.
- I don't remember because it hardly ever occurs, but when it does, we tell them we are not allowed to do certain things.
- I have been asked to get med consents by phone – I questioned this and it stopped.
- I have been asked to have tube feeding and use the (not legible) machine. Neither are in my scope of practice.
- I'd rather not say.
- I was asked to do G-tubes.
- I was asked to use a stand up lift I had never used before. I was then trained on the lift that day.
- I was told I needed to call the doctor when our resident had a blood sugar reading of 202, when I took her reading at 0600 at her scheduled time, and that was when the nurse came on duty. I am not qualified to call the Dr, that was her responsibility.
- I was asked two times to give an injection that I am not allowed to give by the same nurse (chemotherapy injection).
- In an emergency to dress a wound.
- Inhalers, etc.
- Initial doses.
- Injection and taking orders from doctor, these are not my responsibilities.
- Inserting suppositories or administering (not legible).
- Insulin injection.
- Invasive wound care. Tube feedings. Catheter insertion or any RN duty not in the scope of MA. Insulin for diabetics is a big hassle to get completed.
- It is unclear if I should hook and unhook CBIs – I do it. Some nurses say do it, others say don't.
- It was during a period where the on staff LPN was not working. Our hospice patient was dying and our hospice nurse had not arrived yet. Back flush, blood & meds flowed back from the G-tube.
- Insert enemas. Change or dress wound. Talk to a doctor when they are on duty.
- Judgment calls.

- Just depends if new client.
- Just random tasks that I believe aren't my responsibility (not legible) training.
- Late medications.
- Leaving meds out in a cup without a lid and no name on it.
- Changing a colostomy bag.
- Giving narcotics on the first dose. Antibiotics.
- Turn a pump on/off. You just have to tell the RN that you are not authorized to do this task.
- Liquid meds. Pain management.
- LVN was running behind and asked me to do (not legible).
- LVN will ask me to put the physician order in the MARs for a new med or will ask me to give initial dose.
- Make changes and write out new orders in MAR.
- Making someone take a shower or do something they don't want to do at that time.
- Management of other employees.
- Cath care. My 1st time rectal suppositories.
- Document order in the med MARs.
- (not legible) in pumps.
- Mixing liquid meds. Ordering meds. Changing the type of med to be given.
- Monitoring a patient for signs of strokes.
- Making sure certain residents had meds before the day shift flees.
- Monitor post-fall status on (not legible).
- Monitoring clients with diabetes and signs and symptoms of low or high blood sugar.
- Neb treatment.
- Neuro checks. Tube feeding.
- Nurses are too busy with paper work.
- Office duties. Computer skills.
- Often we are unable to reach our nurse advisor and we are mostly responsible for assessing patients.
- Once in awhile a nurse will ask me to call the doctor or write a nurse's notes. Some of them are not aware that a CMA can't do that.
- Only one nurse does this, but it has to do with Ativan Crème. I refuse to do it.
- Ordering medications.
- Ordering meds. Blood sugars.
- Oxygen...(not legible).
- Pace maker. All the machines are different because there are new ones and old ones.
- Packing pills. Administering meds not on the chart.
- Packing wounds.
- Peg Tube meds.
- Performing a dressing change.
- Performing wound care, especially diabetic wound care.
- Peri cares – I never have been trained.
- Physical therapy.
- Possibly has only happened a couple of times. Not sure of what it was now.
- Prolapses and peg tubes.
- Prolapses and peg tubes.
- Protein values for Coumadin.
- Providing treatments.
- Putting new orders on the MARs for the next month.
- Putting on creams, dressing, around G-tubes.
- Pulse. (not legible). Patch with dressing.
- Read and interpret lab results. Assess residents.
- Reading a feeding pump – nurse did show/tell how it is read.
- Removing needles. Check for impaction.
- Reorder meds.
- Repeating medications before 4 hours. Giving (not legible) or pain meds.
- Reporting patient complaints, change in behavior directly to provider.

- Review of rights and other additional training regarding specific medications such as (not legible).
- Reviewing med list and signing – from what I was taught in my med class, I'm not supposed to do this.
- Client's G-tubes get dislodged from body entry and agency supervisor nurse/RN requested counselor to place back in , to prevent the entry opening from closing up.
- Sending patients out during emergencies.
- Serious wound dressing.
- Cath bags.
- Skin assessments and or applying medication to a diseased leg.
- Some nurses do not want to do blood glucose tests, or check on resident if you report low blood sugar.
- Some of the treatments.
- Some RNs try to make me do injections or draw up injectable meds.
- Some supervisors situations.
- Some treatments with skin issues.
- Some wound care.
- Specially in assisted living. Copy fax sheet and patients to the hospital. Do blood sugar, (not legible) treatments, oxygen.
- Stage treatments.
- Suction.
- Suppositories, accucheck rectal meds – All to be done by licensed nurses in our facility, taking doctors orders.
- Suppository enema. Major wound care.
- Skin breakdown with infection.
- Suctioning a patient – did not do. Wet to dry wound care.
- Take feeding. Changing cath.
- Take order...(not legible)
- Take phone order, not permitted under QMA.
- Talking to doctor about med changes.
- Their paperwork.
- Things that are out of my scope – I have often refused.
- Things that they are too lazy to do – breathing treatments or G-tube feedings.
- This is mainly RN supervisor; Administration and company directions. "Company" nurse will fire you if (not legible) in med passes are reported to her or anyone.
- This pertains more to the nursing home and assisted living situations. Nurses in these setting swill ask med aides to do all sorts of LPN and RN tasks.
- To do patient care and I am not CNA certified.
- To draw up insulin into a syringe.
- To give a shot I was not authorized to give.
- To give an initial dose.
- To plug a nosebleed with gauze.
- Transcribe new orders onto MARs. Administer medication only the LVN may administer.
- Treating bedsores or vaginal infections.
- Treatments.
- Treatments like creams, etc.
- Treatments on open areas.
- Tube feeding. Filling insulin syringes.
- Tube feeding via stomach tube. Changing and monitoring bandages.
- Tube feedings.
- Turn on the tube feeding.
- Treatments.
- The LPN was eventually fired.
- To call the family over some small problems, etc. when I know more questions from family will occur – that I'm not qualified to answer – so they have to talk to the nurse in charge anyway.
- Tube feeders, setting up machine, learned by watching and expected to perform.

- Urine catherization (sterile).
- Using hoxer lift.
- Usually a treatment that licensed nurses should do.
- Update and edit ISPs, create (not legible), service plans for new patients.
- Vacuum. Mop. Dust.
- Visually inspect injury and it is my call whether or not to seek medical attention. Open head wound with bleeding. Open leg wound. Injury which resulted in broken limb.
- Wanting me to assess a resident after he or she has fallen.
- Was asked by an RN if I can do tube feeders and I said "no."
- Was asked to replace ostomy appliance (not by my regular RN supervisor, but a fill in).
- We are an assisted living facility – we have no LVN after 5 pm.
- Writing an order on my MAR.
- When a patient has an accident. (not legible) We have to contact the family and doctor and do all the paper working.
- Wound care – I never had training in this area. Oxygen – I never have been trained yet I'm expect to administer oxygen.
- Wound dressings.
- Wound care.
- Wound care.
- Wound dressing and cleaning.
- Wound dressing and tube feeding. I demand training from a supervisor before I agree to perform such duties.
- Do breathing treatments. Assess a patient who has fallen. Tell family members what is up with patient's condition.
- Taking stool samples properly while respecting the individual's dignity.

About Once a Month

- Assessing a client.
- Add a med to MAR. Do their charting.
- Administering PRN medications including pain/behavior meds.
- Applying dressing or giving med treatments.
- Monitoring wounds – we are not supposed to assess. Some of the treatments need to be done by a nurse. There are treatments I'm asked to do that I don't feel qualified to do and I'm asked to regularly.
- Assess resident's condition.
- Breathing treatments.
- Certain treatments or residents.
- Change colostomy wafer & bag.
- Change med documentation.
- Checking MARs. Administering insulin, writing in MARs.
- Cleaning around a peg tube. Wound care.
- Clipping clients toe nails and finger nails. Helping clients (not legible) poses risks for bleeding exposure.
- Communication and doctor's orders, meds.
- Discussing changes of meds with residents and families.
- Do their neb treatments. Do stage 2 or greater. Do G-tubes.
- Draw insulin from a bottle. Do monthly summary for residents. Teaching resident about meds.
- Dressing wounds that the LPN is supposed to do.
- Doing a shower without having proper tools.
- Dressing changes. Skin assessments. Getting residents who refuse to take their meds.
- Flushing a tube.
- Changing a colostomy bag. Changing a big wound dressing.
- G-tube medications. First dose.
- Getting papers ready for dr. appointments.
- Give 1st dose – med aides in my state are not allowed to do this.

- Give initial dose. Give diabetic meds.
- Give med when (not legible) doc order.
- Give shots. Change diapers. Cleaning them up.
- Giving breathing treatment.
- Giving first dose and they want to sign that they gave it.
- Giving initial doses.
- Giving initial dose medication.
- Giving medication outside the timeframe.
- Helped nurse pass meds that were already set up.
- (not legible)...colostomy care.
- I'd rather not say.
- Insulin pen administration.
- Monitoring a patient while giving medications via a j-tube.
- Doing manual lifts and other things outside our company policy.
- Enemas. Ordering meds.
- Once a month we have to check the old MARs against the new MARs sometimes they are not the same.
- Open stage 3 areas.
- Ordering medications – doing or changing levels on meds – initial dosing.
- Pen meds writing on MAR assessments.
- Performing TB – I thought only RNs or PNs, but they LPN told me how.
- Preparing meds for tube feeding.
- Rather not say.
- Care of open wounds. Giving inhalants.
- Taking BP and (not legible) when they know they need to do these and they want you to give all med before 12. One can learn.
- Taking oxygen (not legible) writing all new order on MARs.
- Taking vital signs/pulse. Not having proper sized cuffs for BP readings.
- Treatments.
- We have a lot of clients that need care that need care that a CNA should do.

A Few Times a Month

- Administer medications without Dr's orders.
- Again, deals with wound care and patient refusing medication.
- Applying Fentanyl patch.
- Applying treatments.
- Asking me to clean and change wounds (not legible) due to deepness of wound, administrator informed the RNs are the ones who should be taking care of such a wound.
- Assessing residents for need of PRN medications.
- Calling physician and family in regards to a resident's care – deciding whether or not to send residents to ER (assessments).
- Change tube.
- Charting for PRNs (understanding what is expected from charting).
- Checking for placement of GI sites before administrating medication nebulizer.
- Cleaning poo off of resident's walls, carpet, cabinets.
- Cleaning patio and porch, shoveling snow, gardening, bathing dog and cat.
- Cleaning, laundry.
- Collect spectrum (home health) collect health sample (home health).
- Changing wounds, looking after patients with specific instructions.
- Counting narcotics. Giving the med aide more than 40 residents to pas meds to all of them.
- Deal with feeding pumps. Oxygen.
- Documentations on new meds MARs – I am not supposed to do it.
- Doing ACER checks.
- Dressing changes.

- Wounds. (not legible) irrigation. Eye flushing.
- Dressing deep wounds. Dressing bed sore.
- Emptying (not legible) tubing. Insulin shots. Making calls to hospital about patient condition. Calling families about need to take patient to hospital.
- Evaluate residents – doing certain treatments.
- Faxing doctors. Taking orders, etc.
- Faxing Dr (not legible) care.
- Faxing reports to the MD.
- Finger sticks. Breathing treatments.
- G-tubes. Abnormals. IV injections. Suppositories. Etc.
- General educating.
- Give an injection or shot for a resident with a wound. Do some wound treatment that are way beyond my skill.
- Give insulin.
- Give the initial doses and order meds from VA and other pharmacy – not me, but other med aides.
- I was asked to give an initial dose of an initial dose of a new medication – when I refused she reported me to the DON.
- I was told to verify physician's orders but was never shown how they are verified.
- I was treated poorly because I did not have a CNA, or want one. As a CMA, I was ignored and expected to work and figure it out on my own.
- ID (IV?) meds
- If someone's light is blinking, ask me to answer it.
- IV (not legible).
- Writing orders in the MAR – I feel that should be the nurse's responsibility. If you do something wrong it is your certificate.
- Making decisions on how and what to medicate patients.
- Neuro checks after a person falls every ½ hour. This is in addition to your regular CNA and CMA duties.
- Ordering meds by phone.
- Oversee changes of certain kinds of wounds. Assessing of patient during falls in the absence of a nurse.
- Performing accu's and administering G-tube feedings.
- Put oxygen on resident, finger sticks.
- Stuff that RNs and house manager should be doing (i.e., talking to doctors and ordering meds).
- Remove cleanse, and apply a new colostomy bag/adhesive. Cleanse resident's stomas.
- Checking medications in from the pharmacists. Orders on MAR. Ne prescriptions 1st tried/admitted.
- Assessing a patient who has fallen, documenting notes in a resident's chart.
- Tracks care. Wound care.
- (Not legible) charts. Looking up doctors orders when they should already be intact.
- Some of the treatments (not legible) catheters.
- Some treatments.
- Suppositories. Open wound care.
- Suppository and medications that I am unfamiliar with.
- Some treatments I felt were too severe for me to treat.
- Suctioning a person with a tracheotomy. Replacing a catheter. Administering narcotics (tablet form). Placing medication patches on a resident. Administering insulin pills for a diabetic when the nurse hasn't check their blood sugar.
- Taking accu on residents.
- Taking individuals to doctor appointments and emergency care and relaying doctor instructions to LPN.

- Talking/discussing with the doctor doing breathing treatment (IPPB shifting the whole responsibility of care to the medication aide since medication pass is the (not legible) heavy and stressful.
- Telling how resident is feeling and amazing for PRNs.
- Care of wounds. Application of insulin.
- Transcribing telephone orders on the MARs.
- Treating decubitis not having proper protection.
- Treatments and dressings are the biggest parts.
- Turn off feed pumps. Give inhalers. Give narcotics.
- Wound care.
- Wound care. Writing physician orders.
- Writing orders on Mar. Giving narcotic meds. Giving meds when I'm on the floor as an aide.
- Sometimes asked to give a new med – I can't do 1st dose. They need to assess a patient before PRN med is given.
- The nurses on call are hard to get hold of – this happens a lot.

About Once a Week

- Admin medications in peg tubes.
- Asked to obtain CBG's. Call pharmacy. Do treatments – it is in the employer's policy that I cannot do these jobs.
- Breathing treatments. Start feeding tubes – feeding.
- Change sterile dressing. Advanced wound care.
- Change a patient dressing after given medication.
- Colostomy bag. Change wound wraps.
- Cutting the patient's nails, I am not qualified, it scared.
- Check patient's blood glucose, give other resident's medication.
- Doing treatment I am not trained to do.
- Feeding tube set ups.
- G-tube.
- I would rather not!
- Insulin shots. Assessing patients. Wound dressings. Drawing blood. Narcotics.
- Ordering meds. Taking doctor's orders.
- Pour out and measure cough syrup with codeine and liquid morphine.
- Refilling oxygen tanks, which I never was in serviced about. Also, nurses should do blood sugar tests so they know right away if they are normal readings.
- Changing dressing on (not legible), administering (not legible) when patient's bottomed out. Certain creams that I know nothing about the skin conditions we are medicating. – they are not in my job description but I'm told a nurse asked me, so I have to do it.
- Skin assessment.
- Skin assessments.
- Skin treatment.
- Snack should be for CNA to do, it interferes with daily medication tasks.
- The MAR review. Dealing with the new orders coming in that need to be verified.
- To set-up inhalations.
- Treatment issues – the nurse signs out, but had med aide do!
- Treatments and changing treatments.
- To change colostomy bag. How to take urine right. How to take blood sugars.
- Wound care.
- Throwing away DC meds (narcs) in the trash, was fired for not doing it. Went to court – ruled in my favor.
- Weekly skin assessments, treatments like ulcers that are bad.

A Few Times a Week

- Oxygen level.
- Accessing situations.

- Accu checks. Initial doses. Start breathing machines. Inhalers. Oxygen.
- Administering nebulizer medications.
- Answer call lights when passing meds. Assist with resident care when passing meds.
- Asking us to do initial doses and suppository.
- Assessing for (not legible).
- Assessments. Admissions.
- Breathing treatments. Administer oxygen.
- Breathing treatment. Admin finger sticks. Blood sugar level. Wound care.
- Calling a doctor about a resident or about scripts.
- Calling in new orders to pharmacy. Giving meds by (not legible). Applying cream to broken skin.
- Changing oxygen tank.
- Checking insulin syringe, we have no training, (not legible) becomes very upset when we have to (not legible) to make sure it is the correct dose.
- Decision on if the patient can take meds.
- Do stage 2 treatments. Give breathing treatments. Write incident reports.
- Doing treatments & G-tubes.
- Doing treatments to open areas. Assessing residents' conditions.
- Dress pressure sores. Approximate skin tears. Do neuro checks and edema checks.
- Dress wounds. Breathing treatments. Shots.
- Dressings. Wound care.
- G-tubes. More current assessment, monitoring of the patient.
- Give initial dose on tube feeder meds.
- Give initial dosage. Give PRN meds. Give nasal sprays. Order meds. Check MARs from month to month. Transcribe orders onto MARs.
- Give pain pills without assessing the patient.
- Giving injection. Insulin. Dress wounds.
- Give inhalants. Give first initial doses – very common.
- Giving initial dose. Checking vital signs.
- Giving initial doses. Giving PRN without being assessed. Ordering meds.
- Giving initial dosing. Giving PRN meds without assessing...(not legible).
- Giving insulin.
- Give initial doses. Order meds.
- Insulin administrator.
- Insulin.
- Opening emergency to pick medication. Administer initial dose.
- Ordering meds. Giving ID (IV?) meds.
- Patient needed colostomy bag. Changed on a daily basis – no training was offered.
- Pick up mail or newspaper over in the next building. Walking resident to the bank.
- Put clean on open sore.
- Retaking vitals numerous times instead of the RN checking! Giving pills to patient even though I'm a med aide in another state and not for them. Applying medicated ointments cause RN is too busy to do it herself and hands it to me because I'm the...(not legible).
- Sign out medications for them. Borrow from other patients' meds.
- Take resident to doctor...(not legible). House cleaning.
- Taking care of a dying patient, no nurse around. Giving insulin which I did not do. Taking care of abusive patient while still passing meds.
- Taking care of stitches and wound care.
- The nurse runs behind on her duties and dumps on aides.
- To give meds in new GT or JT. Check catheter placement.
- Treatments.
- Treatments or things the nurse is supposed to do.

- When I need coverage (not legible). I am asked to do a nurse's notes or do open wound treatments.
- When there is a client on a feeding tube, they want you to either start or stop the pump.
- Wound care.
- We are asked to take orders from doctors and I do not feel I should do this. Also, when the RN is to look and see for herself to check on sores and body, she paid for us to go and do it for her.
- We are asked to take order from doctors and I do not feel I should do this. Also when the RN is to look and see for herself to check on sores and body chest she paid for us to go and do it for her.

Every Day

- Giving out Coumadin or narcotics.
- I can do anything a nurse can do – Foleys, feeding tubes, etc. I watch and have learned.
- I'm asked to do direct care instead of only Med Tech duties as they first told me.
- Administer inhalant. Instill colostomy bags. Breathing treatments perform blood glucose test. Give initial dose of medication.
- Administration of drugs mentioned (not legible).
- Administer initial doses, when they are supposed to do this and assess/observe tolerance.
- Applying a dressing to a small wound.
- Assess patients. Do breathing treatments. Wound care.
- Anytime resident has any type of problem, we are told to keep a close eye on them!
- Blood sugar checks. Oxygen, because they don't (not legible).
- Bowel treatments. Care for stomy bags. Changing catheters.
- Breathing treatments. Wound care. Blood sugar checks.
- Call in pro labs. Accu checks. Sticks. Writing med orders.
- Calling doctor's office for orders. Treatments (not legible).
- Calling family numbers. Taking finger-sticks. Administer insulin. I am trained and/or qualified to do the following duties, but where/what does that leave the nurse to do?
- Calling the doctor about a problem. Looking at a wound or doing a treatment.
- Carrying a cart with food to be served in the unit and take back the dirty dishes to the kitchen.
- Changing seals on a colostomy, etc. But changing the bag is not a problem calling in meds that a nurse needs to do for a prescription.
- Creams/topical treatments. Dressing changes (for severe skin issues/wounds).
- Change dressings on wounds until they are healed, especially on weekend.
- Diabetes.
- Dressing change. EKGs.
- Dressing wound.
- During a med pass, asked to stop and take someone to the bathroom.
- Feel able to perform – Accus, treatments, charting.
- Enemas.
- For a client, I had to hold a blood pressure medication. I had to follow up when the nurse should have to report to the doctor.
- Give breathing treatments. Turn tube pump off/on. Patches. Some nurses are not able to handle the medication because of probation reasons.
- Giving a first dose of new medication. Changing medication dose in the MAR. Correcting medication error.
- Giving initial doses, note that we are not allowed, but nurses expect us to do it!!!
- Giving initial doses of new meds.
- Giving initial doses. Discussing treatment options with family members. Doing treatments.
- Giving insulin. Dressing changes of wounds. Changing colostomy bags. Doing narcotics.

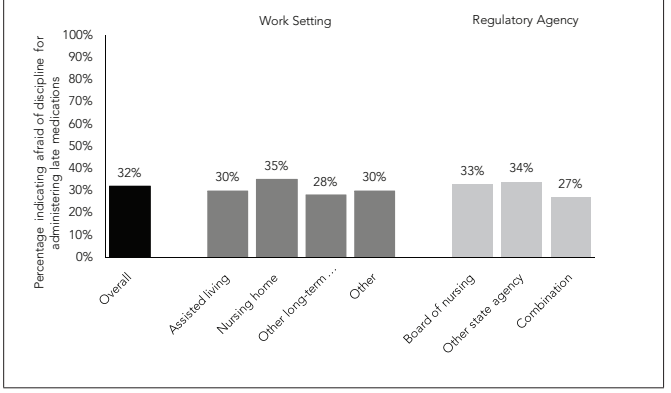
Table 33a. Six Rights of Medication Administration to Improve (as Indicated by Respondents) on by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Right patient	**(n=2,698)**	(n=864)	(n=1,038)	(n=441)	(n=355)
Yes	**387 (14%)**	133 (15%)	145 (14%)	50 (11%)	59 (17%)
Right medication	**(n=2,715)**	(n=869)	(n=1,047)	(n=441)	(n=358)
Yes	**473 (17%)**	155 (18%)	188 (18%)	62 (14%)	68 (19%)
Right route	**(n=2,683)**	(n=862)	(n=1,031)	(n=439)	(n=351)
Yes	**375 (14%)**	134 (16%)	136 (13%)	51 (12%)	54 (15%)
Right dose	**(n=2,710)**	(n=866)	(n=1,048)	(n=440)	(n=356)
Yes	**466 (17%)**	153 (18%)	187 (18%)	60 (14%)	66 (19%)
Right time	**(n=2,825)**	(n=897)	(n=1,113)	(n=453)	(n=362)
Yes	**7755 (27%)**	228 (25%)	358 (32%)	97 (21%)	92 (25%)
Right documentation	**(n=2,854)**	(n=930)	(n=1,095)	(n=467)	(n=362)
Yes	**882 (31%)**	298 (32%)	326 (30%)	139 (30%)	119 (33%)

Table 33b. Six Rights of Medication Administration to Improve on (as Indicated by Respondents) by Regulatory Agency				
	Overall	**BON**	**Other State Agency**	**Combination**
Right patient	**(n=2,698)**	(n=713)	(n=1,209)	(n=771)
Yes	**387 (14%)**	94 (13%)	192 (16%)	101 (13%)
Right medication	**(n=2,715)**	(n=719)	(n=1,221)	(n=770)
Yes	**473 (17%)**	115 (16%)	234 (19%)	124 (16%)
Right route	**(n=2,683)**	(n=709)	(n=1,202)	(n=767)
Yes	**375 (14%)**	91 (13%)	183 (15%)	101 (13%)
Right dose	**(n=2,710)**	(n=717)	(n=1,214)	(n=774)
Yes	**466 (17%)**	104 (15%)	228 (19%)	134 (17%)
Right time	**(n=2,825)**	(n=732)	(n=1,293)	(n=795)
Yes	**7755 (27%)**	169 (23%)	411 (32%)	195 (25%)
Right documentation	**(n=2,854)**	(n=779)	(n=1,269)	(n=801)
Yes	**882 (31%)**	233 (30%)	390 (31%)	258 (32%)

Treatments of all sorts. Assessing before calling 911.

- Give initial doses. Give pain meds.
- Insulin administration use (not legible) and medication aides are not suppose to do that.
- IV's. wound vacs. Insulin.
- IV, IM, Suction.
- Measuring (not legible) wounds (not legible) assessments.
- Nebulizer treatments. Skin treatments are done by med aides even though nurses are supposed to do them.
- Ordering meds. Giving ID (IV?) doses, faxing them. Neb treatments. Calling pharmacies.
- Pass her pills when I am not sure what she has given.
- RN on leave and pretty much took care of every aspect of the nursing role.
- Suppositories. Wound treatments. Correct the Mar. Inhalants.
- Splitting pills. I thought only a pharmacist can change dosage.

Figure 18. Afraid of Being Disciplined for Administering Late Medications by Work Setting and Regulatory Agency



- Start or turn off breathing machine. Turn on oxygen. Help do dressing change or turn, change resident during med pass (lazy LVNs not wanting to do).
- Take blood sugar levels.
- To administer (not legible) to asses pain.
- Patient care work at the dining room. Organized closet of resident.
- Tube feeding. Insulin shots. Wound care.
- Was asked to perform breathing treatments until a year ago, nurse was, "too busy."
- We had a client that needed insulin and we showed once how to do it.
- We had a resident that needed insulin (not legible) day. I thought it was beyond our duties.
- Wound dressing. Changes in resident conditions. Calling families to report.
- Writing down new admit or readmit orders. If we can't sign the orders we shouldn't be writing them!

Respondents were asked to indicate which, if any, of the six rights of medication administration was a priority for them to improve on. Overall, more respondents reported right time (27%) and right documentation (31%) versus right patient (14%), right medication (17%), right route (14%) and right dose (17%) (see Tables 33a and 33b).

A relatively large percentage of respondents (32%) indicated they were afraid of getting disciplined for administering late medications (see Figure 18).

Medication Administration

Inhalants. A higher percentage of respondents who worked in assisted living (91%) indicated they were allowed to administer inhalant medications compared to respondents who worked in nursing homes (69%), other long-term care facilities (79%) and other facilities (74%). The trend of a higher percentage of respondents who worked in assisted living facilities allowed to administer inhalants was evident for the remainder of the following types of inhalants: metered dose inhalers, medication used for intermittent positive pressure breathing, medications or treatments via nebulizer and oxygen (see Table 34a). Also, a higher percentage of respondents regulated by the BON, and a combination of the BON and another state agency indicated they were allowed to administer inhalant medications, metered dose inhaler, medication used for intermittent positive pressure breathing, medications or treatments via nebulizer and oxygen, as compared to respondents regulated by another state agency (see Table 34b).

Injectables. Those that worked in assisted living facilities had a higher percentage of respondents who indicated they were allowed to administer medications by injection (55%) versus respondents who worked in nursing homes (8%), other long-term care facilities (26%) and other facilities (30%).

Table 34a. Administering Inhalants by Work Setting					
	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
Inhalant medications	**(n=3,357)**	**(n=1,087)**	**(n=1,317)**	**(n=541)**	**(n=412)**
No	**634 (19%)**	84 (8%)	382 (29%)	79 (15%)	89 (22%)
Yes	**2,638 (79%)**	991 (91%)	913 (69%)	428 (79%)	306 (74%)
Don't know	**85 (3%)**	12 (1%)	22 (2%)	34 (6%)	17 (4%)
Metered dose inhaler	**(n=3,302)**	**(n=1,052)**	**(n=1,306)**	**(n=533)**	**(n=411)**
No	**760 (23%)**	130 (12%)	416 (32%)	116 (22%)	98 (24%)
Yes	**2,247 (68%)**	817 (78%)	819 (63%)	330 (62%)	281 (68%)
Don't know	**295 (9%)**	105 (10%)	71 (5%)	87 (16%)	32 (8%)
Medication used for intermittent positive pressure breathing (IPPB treatments)	**(n=3,254)**	**(n=1,031)**	**(n=1,290)**	**(n=525)**	**(n=408)**
No	**1,485 (46%)**	358 (35%)	742 (58%)	191 (36%)	194 (48%)
Yes	**739 (23%)**	296 (29%)	228 (18%)	134 (26%)	81 (20%)
Don't know	**1,030 (32%)**	377 (37%)	320 (25%)	200 (38%)	133 (33%)
Medications or treatments via nebulizer	**(n=3,362)**	**(n=1,094)**	**(n=1,316)**	**(n=536)**	**(n=416)**
No	**1,041 (31%)**	148 (14%)	628 (48%)	123 (23%)	142 (34%)
Yes	**2,210 (66%)**	929 (85%)	673 (51%)	354 (66%)	254 (61%)
Don't know	**111 (3%)**	17 (2%)	15 (1%)	59 (11%)	20 (5%)
Oxygen	**(n=3,349)**	**(n=1,089)**	**(n=1,305)**	**(n=538)**	**(n=417)**
No	**866 (26%)**	138 (13%)	398 (31%)	189 (35%)	141 (34%)
Yes	**2,321 (69%)**	925 (85%)	889 (68%)	272 (51%)	235 (56%)
Don't know	**162 (5%)**	26 (2%)	18 (1%)	77 (14%)	41 (10%)

Additionally, a higher percentage of respondents regulated by the BON (52%) indicated they were allowed to administer medications by injection as compared to respondents regulated by a combination of the BON and another state agency (32%), and another state agency (14%) (see Figure 19).

Of the respondents who indicated they were allowed to administer medications by injection, a higher percentage of respondents who worked in other long-term care facilities (41%) and other facilities (36%) were allowed to administer medications through the intramuscular route compared to respondents who worked in assisted living facilities (23%) and nursing homes (20%). Additionally, a higher percentage of respondents who worked in nursing homes (66%) were allowed to administer medications through the subcutaneous route compared to respondents who worked in assisted living facilities (49%), other long-term care facilities (38%) and other facilities (51%). Overall, of the respondents who indicated they were allowed to administer medications by injection, the majority (62%) were allowed to administer medications via the subcutaneous route followed by the intramuscular route (27%), intradermal route (19%), hypodermoclysis route (7%) and intravenous route (7%) (see Table 35a and 35b).

Of the respondents who indicated they were allowed to administer medications by injection, the majority were allowed to administer predrawn insulin (70%); 77% of respondents who worked in assisted living facilities were allowed to administered predrawn insulin, followed by respondents who worked in other long-term care facilities (61%), respondents who worked in nursing homes (60%) and respondents who worked in other facilities (57%) (see Table 36a). Additionally, a lower percentage of respondents regulated by the BON (68%) were allowed to administer predrawn insulin compared to 69% of respondents regulated by a combination of the BON and another state agency, and 78% of respondents regulated by another state agency (see Table 36b).

Table 34b. Administering Inhalants by Regulatory Agency				
	Overall	BON	Other State Agency	Combination
Inhalant medications	**(n=3,357)**	**(n=897)**	**(n=1,540)**	**(n=915)**
No	**634 (19%)**	68 (8%)	481 (31%)	85 (9%)
Yes	**2,638 (79%)**	804 (90%)	1,034 (67%)	795 (87%)
Don't know	**85 (3%)**	25 (3%)	25 (2%)	35 (4%)
Metered dose inhaler	**(n=3,302)**	**(n=880)**	**(n=1,520)**	**(n=897)**
No	**760 (23%)**	114 (13%)	526 (35%)	120 (13%)
Yes	**2,247 (68%)**	686 (78%)	899 (59%)	660 (74%)
Don't know	**295 (9%)**	80 (9%)	95 (6%)	117 (13%)
Medication used for intermittent positive pressure breathing (IPPB treatments)	**(n=3,254)**	**(n=863)**	**(n=1,499)**	**(n=887)**
No	**1,485 (46%)**	330 (38%)	857 (57%)	296 (33%)
Yes	**739 (23%)**	219 (25%)	291 (19%)	228 (26%)
Don't know	**1,030 (32%)**	314 (36%)	351 (23%)	363 (41%)
Medications or treatments via nebulizer	**(n=3,362)**	**(n=898)**	**(n=1,546)**	**(n=913)**
No	**1,041 (31%)**	172 (19%)	715 (46%)	153 (17%)
Yes	**2,210 (66%)**	686 (76%)	816 (53%)	704 (77%)
Don't know	**111 (3%)**	40 (4%)	15 (1%)	56 (6%)
Oxygen	**(n=3,349)**	**(n=899)**	**(n=1,540)**	**(n=905)**
No	**866 (26%)**	225 (25%)	464 (30%)	177 (20%)
Yes	**2,321 (69%)**	617 (69%)	1,052 (68%)	647 (71%)
Don't know	**162 (5%)**	57 (6%)	24 (2%)	81 (9%)

Figure 19. Administering Medications by Injection by Work Setting and Regulatory Agency

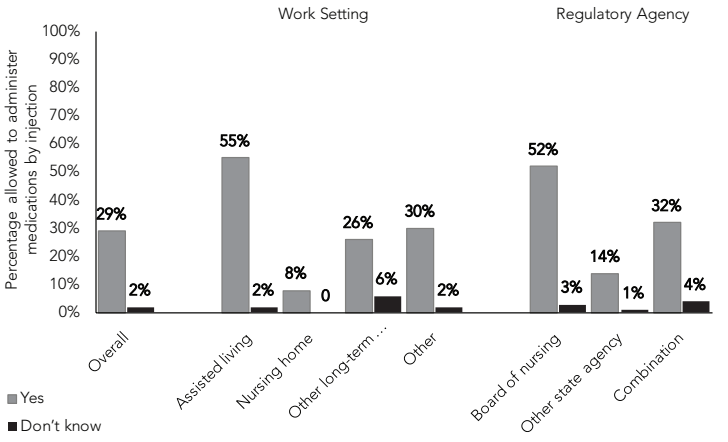


Table 35a. Administering Medications by Injection Through Various Routes (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Intramuscular route	**(n=837)**	**(n=520)**	**(n=97)**	**(n=116)**	**(n=104)**
No	**565 (68%)**	376 (72%)	74 (76%)	56 (48%)	59 (57%)
Yes	**225 (27%)**	121 (23%)	19 (20%)	48 (41%)	37 (36%)
Don't know	**47 (6%)**	23 (4%)	4 (4%)	12 (10%)	8 (8%)
Intravenous route	**(n=821)**	**(n=512)**	**(n=95)**	**(n=110)**	**(n=104)**
No	**713 (87%)**	465 (91%)	81 (85%)	89 (81%)	78 (75%)
Yes	**55 (7%)**	22 (4%)	9 (9%)	6 (5%)	18 (17%)
Don't know	**53 (6%)**	25 (5%)	5 (5%)	15 (14%)	8 (8%)
Subcutaneous route	**(n=857)**	**(n=550)**	**(n=94)**	**(n=110)**	**(n=103)**
No	**225 (26%)**	146 (27%)	27 (29%)	45 (41%)	37 (36%)
Yes	**528 (62%)**	371 (49%)	62 (66%)	42 (38%)	53 (51%)
Don't know	**74 (9%)**	33 (6%)	5 (5%)	23 (21%)	13 (13%)
Intradermal route	**(n=814)**	**(n=507)**	**(n=96)**	**(n=109)**	**(n=102)**
No	**542 (67%)**	363 (72%)	57 (59%)	65 (60%)	57 (56%)
Yes	**153 (19%)**	82 (16%)	28 (29%)	14 (13%)	29 (28%)
Don't know	**119 (15%)**	62 (12%)	11 (11%)	30 (28%)	16 (16%)
Hypodermoclysis route	**(n=811)**	**(n=505)**	**(n=94)**	**(n=109)**	**(n=103)**
No	**602 (74%)**	395 (78%)	63 (67%)	73 (67%)	71 (69%)
Yes	**56 (7%)**	29 (57%)	12 (13%)	5 (5%)	10 (10%)
Don't know	**153 (19%)**	81 (16%)	19 (20%)	31 (28%)	22 (21%)

Of the respondents who indicated they were allowed to administer medications by injection, the majority indicated they were allowed to administer insulin that was not predrawn (57%); a higher percentage of respondents who worked in assisted living facilities (63%) were allowed to administer insulin that was not predrawn compared to respondents who worked in nursing homes (51%), other long-term care facilities (43%) and other facilities (48%) (see Table 37a). Additionally, a much higher percentage of respondents who were regulated by the BON (72%) were allowed to administer insulin that was not predrawn compared to respondents who were regulated by a combination of the BON and another state agency (58%), and another state agency (20%) (see Table 37b).

Of the respondents who indicated they were allowed to administer medications by injection, 34% indicated they were allowed to administer epinephrine by injection. Results also varied by type of facility; 14% of respondents who worked in nursing homes were allowed to administer epinephrine by injection compared to 32% of respondents who worked in assisted living, 42% of respondents who worked in other long-term care facilities and 52% of respondents who worked in other facilities (see Table 38a). Results also varied by type of regulating agency, where 49% of respondents regulated by the BON were allowed to administer epinephrine by injection compared to 28% of respondents regulated by a combination of the BON and another state agency, and 11% of respondents regulated by another state agency (see Table 38b).

Of the respondents who indicated they were allowed to administer medications by injection, 6% were allowed to administer anticoagulants by injection (see Tables 39a and 39b).

Topicals. The vast majority (94%) of respondents were allowed to administer topical medications (see Figure 20).

Of the respondents who were allowed to administer topical medications, a much higher percentage of

Table 35b. Administering Medications by Injection Through Various Routes (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Regulatory Agency

	Overall	BON	Other State Agency	Combination
Intramuscular route	**(n=837)**	**(n=409)**	**(n=172)**	**(n=253)**
No	**565 (68%)**	291 (71%)	126 (73%)	117 (46%)
Yes	**225 (27%)**	100 (24%)	39 (23%)	84 (33%)
Don't know	**47 (6%)**	18 (4%)	7 (4%)	22 (9%)
Intravenous route	**(n=821)**	**(n=405)**	**(n=168)**	**(n=245)**
No	**713 (87%)**	368 (91%)	144 (86%)	199 (81%)
Yes	**55 (7%)**	19 (5%)	15 (9%)	20 (8%)
Don't know	**53 (6%)**	18 (4%)	9 (5%)	26 (11%)
Subcutaneous route	**(n=857)**	**(n=417)**	**(n=185)**	**(n=252)**
No	**225 (26%)**	122 (29%)	59 (82%)	74 (29%)
Yes	**528 (62%)**	265 (64%)	115 (62%)	146 (58%)
Don't know	**74 (9%)**	30 (7%)	11 (6%)	32 (13%)
Intradermal route	**(n=814)**	**(n=401)**	**(n=170)**	**(n=240)**
No	**542 (67%)**	282 (70%)	111 (65%)	148 (62%)
Yes	**153 (19%)**	71 (18%)	41 (24%)	40 (17%)
Don't know	**119 (15%)**	48 (12%)	18 (11%)	52 (22%)
Hypodermoclysis route	**(n=811)**	**(n=399)**	**(n=166)**	**(n=243)**
No	**602 (74%)**	316 (79%)	123 (74%)	162 (67%)
Yes	**56 (7%)**	25 (6%)	16 (10%)	15 (6%)
Don't know	**153 (19%)**	58 (15%)	27 (16%)	66 (27%)

Table 36a. Administering Predrawn Insulin (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Work Setting

	Overall (n=1,037)	Assisted Living (n=620)	Nursing Home (n=105)	Other Long-term Care (n=177)	Other (n=135)
No	**220 (21%)**	99 (16%)	39 (37%)	37 (21%)	45 (33%)
Yes	**728 (70%)**	480 (77%)	63 (60%)	108 (61%)	77 (57%)
Don't know	**89 (9%)**	41 (7%)	3 (3%)	32 (18%)	13 (10%)

Table 36b. Administering Predrawn Insulin (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Regulatory Agency

	Overall (n=1,037)	BON (n=492)	Other State Agency (n=215)	Combination (n=327)
No	**220 (21%)**	111 (23%)	42 (20%)	67 (20%)
Yes	**728 (70%)**	333 (68%)	168 (78%)	224 (69%)
Don't know	**89 (9%)**	48 (10%)	5 (2%)	36 (11%)

Table 37a. Administering Insulin that was not Predrawn (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Work Setting

	Overall (n=991)	Assisted Living (n=609)	Nursing Home (n=96)	Other Long-term Care (n=166)	Other (n=120)
No	**345 (35%)**	199 (33%)	45 (47%)	55 (33%)	46 (38%)
Yes	**563 (57%)**	385 (63%)	49 (51%)	72 (43%)	57 (48%)
Don't know	**83 (8%)**	25 (4%)	2 (2%)	39 (23%)	17 (14%)

Table 37b. Administering Insulin that was not Predrawn (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Regulatory Agency

	Overall (n=991)	BON (n=475)	Other State Agency (n=211)	Combination (n=303)
No	**345 (35%)**	99 (21%)	161 (76%)	84 (28%)
Yes	**563 (57%)**	342 (72%)	43 (20%)	177 (58%)
Don't know	**83 (8%)**	34 (7%)	7 (3%)	42 (14%)

Table 38a. Administering Epinephrine by Injection (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Work Setting

	Overall (n=1,038)	Assisted Living (n=622)	Nursing Home (n=104)	Other Long-term Care (n=177)	Other (n=135)
No	**481 (46%)**	302 (49%)	74 (71%)	61 (34%)	44 (33%)
Yes	**357 (34%)**	197 (32%)	15 (14%)	75 (42%)	70 (52%)
Don't know	**200 (19%)**	123 (20%)	15 (14%)	41 (23%)	21 (16%)

Table 38b. Administering Epinephrine by Injection (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Regulatory Agency

	Overall (n=1,038)	BON (n=493)	Other State Agency (n=215)	Combination (n=327)
No	**481 (46%)**	176 (36%)	162 (75%)	142 (43%)
Yes	**357 (34%)**	241 (49%)	24 (11%)	90 (28%)
Don't know	**200 (19%)**	76 (15%)	29 (13%)	95 (29%)

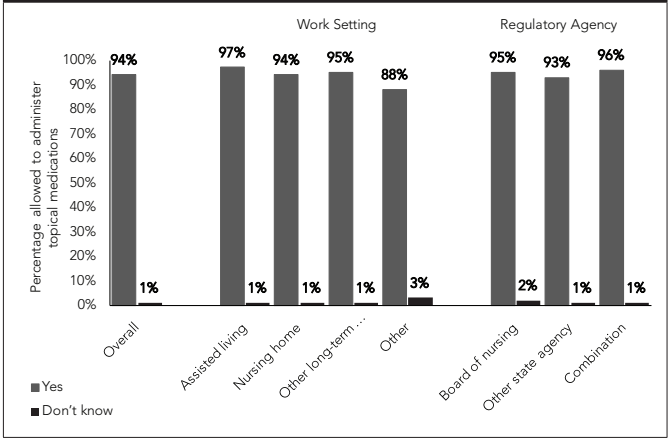
Table 39a. Administering Anticoagulants by Injection (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Work Setting

	Overall (n=1,040)	Assisted Living (n=624)	Nursing Home (n=106)	Other Long-term Care (n=175)	Other (n=135)
No	**783 (75%)**	493 (79%)	88 (63%)	114 (65%)	88 (65%)
Yes	**65 (6%)**	29 (5%)	12 (11%)	9 (5%)	15 (9%)
Don't know	**192 (18%)**	102 (16%)	6 (6%)	52 (30%)	32 (24%)

Table 39b. Administering Anticoagulants by Injection (as Indicated by Respondents who were Allowed to Administer Medications by Injection) by Regulatory Agency

	Overall (n=1,040)	BON (n=495)	Other State Agency (n=217)	Combination (n=325)
No	**783 (75%)**	372 (75%)	185 (85%)	224 (69%)
Yes	**65 (6%)**	30 (6%)	11 (5%)	24 (7%)
Don't know	**192 (18%)**	93 (19%)	21 (10%)	77 (24%)

Figure 20. Administering Topical Medications by Work Setting and Regulatory Agency



respondents who worked in assisted living (54%), other long-term care facilities (58%) and other facilities (52%) indicated they were allowed to administer topical medications requiring a sterile dressing compared to respondents who worked in nursing homes (23%). A similar pattern of results was evident for topical medications requiring an assessment of skin condition, where 42% of respondents who worked in assisted living facilities, 49% of respondents who worked in other long-term care facilities, 39% of respondents who worked in other facilities and 18% of respondents who worked in nursing homes indicated they were allowed to administer topical medications requiring an assessment of skin condition (see Table 40a).

Table 40a. Administering Topicals (as Indicated by Respondents who were Allowed to Administer Topical Medications) by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Topical patches	**(n=3,221)**	**(n=1,071)**	**(n=1,238)**	**(n=534)**	**(n=378)**
No	**113 (4%)**	13 (1%)	24 (2%)	42 (8%)	34 (9%)
Yes	**2,980 (93%)**	1,047 (98%)	1,209 (98%)	409 (77%)	315 (83%)
Don't know	**128 (4%)**	11 (1%)	5 (< 1%)	83 (16%)	29 (8%)
Nitroglycerin paste	**(n=3,171)**	**(n=1,055)**	**(n=1,222)**	**(n=518)**	**(n=376)**
No	**896 (28%)**	273 (26%)	322 (26%)	172 (33%)	129 (34%)
Yes	**1,447 (46%)**	478 (45%)	691 (57%)	129 (25%)	149 (40%)
Don't know	**828 (26%)**	304 (29%)	209 (17%)	217 (42%)	98 (26%)
Treatments that involve advanced skin conditions, including stage III and IV decubitus ulcers	**(n=3,183)**	**(n=1,055)**	**(n=1,231)**	**(n=519)**	**(n=378)**
No	**2,114 (66%)**	656 (62%)	999 (81%)	241 (46%)	218 (58%)
Yes	**592 (19%)**	227 (22%)	167 (14%)	113 (22%)	85 (22%)
Don't know	**477 (15%)**	172 (16%)	65 (5%)	165 (32%)	75 (20%)
Topical medications requiring a sterile dressing	**(n=3,209)**	**(n=1,070)**	**(n=1,235)**	**(n=526)**	**(n=378)**
No	**1,597 (50%)**	406 (38%)	898 (73%)	155 (29%)	138 (37%)
Yes	**1,368 (43%)**	583 (54%)	284 (23%)	303 (58%)	198 (52%)
Don't know	**244 (8%)**	81 (8%)	53 (4%)	68 (13%)	42 (11%)
Topical medications requiring an assessment of skin condition	**(n=3,185)**	**(n=1,058)**	**(n=1,230)**	**(n=521)**	**(n=376)**
No	**1,836 (58%)**	515 (49%)	964 (78%)	174 (33%)	183 (49%)
Yes	**1,079 (34%)**	449 (42%)	225 (18%)	257 (49%)	148 (39%)
Don't know	**270 (8%)**	94 (9%)	41 (3%)	90 (17%)	45 (12%)
Debridement	**(n=3,167)**	**(n=1,037)**	**(n=1,237)**	**(n=518)**	**(n=375)**
No	**2,259 (71%)**	696 (67%)	1,071 (87%)	255 (49%)	237 (63%)
Yes	**251 (8%)**	98 (9%)	58 (5%)	48 (9%)	47 (13%)
Don't know	**657 (21%)**	243 (23%)	108 (9%)	215 (42%)	91 (24%)
Duoderm application	**(n=3,174)**	**(n=1,047)**	**(n=1,234)**	**(n=519)**	**(n=374)**
No	**1,395 (44%)**	344 (33%)	750 (61%)	156 (30%)	145 (39%)
Yes	**1,266 (40%)**	551 (53%)	415 (34%)	166 (32%)	134 (36%)
Don't know	**513 (16%)**	152 (15%)	69 (6%)	197 (38%)	95 (25%)

Additionally, of the respondents who indicated they were allowed to administer topical medications, a higher percentage of respondents regulated by the BON (46%), and a combination of the BON and another state agency (58%) indicated they were allowed to administer topical medications requiring a sterile dressing compared to respondents regulated by another state agency (32%). A similar pattern of results was evident for the administration of topical medications that require an assessment of the skin condition (see Table 40b).

Orals. The majority of respondents indicated they were allowed to administer sublingual medications (82%) and maintenance doses of oral anticoagulants (e.g., Coumadin) (78%). For both of these types of medications a higher percentage of respondents who worked in assisted living and nursing home facilities indicated they were allowed to administer these versus respondents who worked in other long-term care facilities and other facilities (see Tables 41a and 41b).

Table 40b. Administering Topicals (as Indicated by Respondents who were Allowed to Administer Topical Medications) by Regulatory Agency				
	Overall	BON	Other State Agency	Combination
Topical patches	**(n=3,221)**	**(n=879)**	**(n=1,453)**	**(n=884)**
No	**113 (4%)**	36 (4%)	32 (2%)	45 (5%)
Yes	**2,980 (93%)**	799 (91%)	1,410 (97%)	766 (87%)
Don't know	**128 (4%)**	44 (5%)	11 (1%)	73 (8%)
Nitroglycerin paste	**(n=3,171)**	**(n=863)**	**(n=1,434)**	**(n=869)**
No	**896 (28%)**	262 (30%)	405 (28%)	229 (26%)
Yes	**1,447 (46%)**	342 (40%)	784 (55%)	318 (37%)
Don't know	**828 (26%)**	259 (30%)	245 (17%)	322 (37%)
Treatments that involve advanced skin conditions, including stage III and IV decubitus ulcers	**(n=3,183)**	**(n=865)**	**(n=1,447)**	**(n=866)**
No	**2,114 (66%)**	539 (62%)	1,119 (77%)	454 (52%)
Yes	**592 (19%)**	164 (19%)	225 (16%)	201 (23%)
Don't know	**477 (15%)**	162 (19%)	103 (7%)	211 (24%)
Topical medications requiring a sterile dressing	**(n=3,209)**	**(n=876)**	**(n=1,451)**	**(n=877)**
No	**1,597 (50%)**	391 (45%)	921 (63%)	283 (32%)
Yes	**1,368 (43%)**	400 (46%)	461 (32%)	505 (58%)
Don't know	**244 (8%)**	85 (10%)	69 (5%)	89 (10%)
Topical medications requiring an assessment of skin condition	**(n=3,185)**	**(n=865)**	**(n=1,442)**	**(n=873)**
No	**1,836 (58%)**	422 (49%)	1,032 (72%)	381 (44%)
Yes	**1,079 (34%)**	351 (41%)	332 (23%)	393 (45%)
Don't know	**270 (8%)**	92 (11%)	78 (5%)	99 (11%)
Debridement	**(n=3,167)**	**(n=853)**	**(n=1,441)**	**(n=868)**
No	**2,259 (71%)**	555 (65%)	1,189 (83%)	513 (59%)
Yes	**251 (8%)**	66 (8%)	103 (7%)	81 (9%)
Don't know	**657 (21%)**	232 (27%)	149 (10%)	274 (32%)
Duoderm application	**(n=3,174)**	**(n=858)**	**(n=1,439)**	**(n=872)**
No	**1,395 (44%)**	338 (39%)	786 (55%)	269 (31%)
Yes	**1,266 (40%)**	347 (40%)	537 (37%)	379 (44%)
Don't know	**513 (16%)**	173 (20%)	116 (8%)	224 (26%)

Table 41a. Administering Oral Medications by Work Setting					
	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
Sublingual medications	**(n=3,328)**	**(n=1,075)**	**(n=1,306)**	**(n=535)**	**(n=412)**
No	**337 (10%)**	85 (8%)	106 (8%)	84 (16%)	62 (15%)
Yes	**2,716 (82%)**	932 (87%)	1,167 (89%)	319 (60%)	298 (72%)
Don't know	**275 (8%)**	58 (5%)	33 (3%)	132 (25%)	52 (13%)
Maintenance dose of an oral anticoagulant (e.g., Coumadin)	**(n=3,344)**	**(n=1,083)**	**(n=1,314)**	**(n=535)**	**(n=412)**
No	**474 (14%)**	84 (8%)	205 (16%)	94 (18%)	91 (22%)
Yes	**2,611 (78%)**	952 (88%)	1,081 (82%)	319 (60%)	259 (63%)
Don't know	**259 (8%)**	47 (4%)	28 (2%)	122 (23%)	62 (15%)

Table 41b. Administering Oral Medications by Regulatory Agency				
	Overall	BON	Other State Agency	Combination
Sublingual medications	**(n=3,328)**	**(n=1,075)**	**(n=1,306)**	**(n=535)**
No	**337 (10%)**	85 (8%)	106 (8%)	84 (16%)
Yes	**2,716 (82%)**	932 (87%)	1,167 (89%)	319 (60%)
Don't know	**275 (8%)**	58 (5%)	33 (3%)	132 (25%)
Maintenance dose of an oral anticoagulant (e.g., Coumadin)	**(n=3,344)**	**(n=1,083)**	**(n=1,314)**	**(n=535)**
No	**474 (14%)**	84 (8%)	205 (16%)	94 (18%)
Yes	**2,611 (78%)**	952 (88%)	1,081 (82%)	319 (60%)
Don't know	**259 (8%)**	47 (4%)	28 (2%)	122 (23%)

Table 42a. Administering Medications via Tube Routes by Work Setting					
	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
Medication that must be inserted into a nasogastric tube (NG-tube)	**(n=3,384)**	**(n=1,098)**	**(n=1,324)**	**(n=544)**	**(n=418)**
No	**2,741 (81%)**	897 (82%)	1,176 (89%)	343 (63%)	325 (78%)
Yes	**254 (8%)**	61 (6%)	95 (7%)	65 (12%)	33 (8%)
Don't know	**389 (12%)**	140 (13%)	53 (4%)	136 (25%)	60 (14%)
Medication that must be inserted into a gastric tube (G-tube)	**(n=3,388)**	**(n=1,099)**	**(n=1,324)**	**(n=544)**	**(n=421)**
No	**2,519 (74%)**	853 (78%)	1,081 (82%)	293 (54%)	292 (69%)
Yes	**572 (17%)**	130 (12%)	219 (17%)	140 (26%)	83 (20%)
Don't know	**297 (9%)**	116 (11%)	24 (2%)	111 (20%)	46 (11%)
Medication that must be inserted into a jejunostomy tube (J-tube)	**(n=3,377)**	**(n=1,093)**	**(n=1,324)**	**(n=543)**	**(n=417)**
No	**2,658 (79%)**	882 (81%)	1,145 (86%)	325 (60%)	306 (73%)
Yes	**302 (9%)**	66 (6%)	122 (9%)	69 (13%)	45 (11%)
Don't know	**417 (12%)**	145 (13%)	57 (4%)	149 (27%)	66 (16%)

Table 42b. Administering Medications via Tube Routes by Regulatory Agency				
	Overall	BON	Other State Agency	Combination
Medication that must be inserted into a nasogastric tube (NG-tube)	**(n=3,384)**	**(n=913)**	**(n=1,552)**	**(n=914)**
No	**2,741 (81%)**	713 (78%)	1,344 (87%)	680 (74%)
Yes	**254 (8%)**	70 (8%)	107 (7%)	76 (8%)
Don't know	**389 (12%)**	130 (14%)	101 (7%)	158 (17%)
Medication that must be inserted into a gastric tube (G-tube)	**(n=3,388)**	**(n=909)**	**(n=1,556)**	**(n=918)**
No	**2,519 (74%)**	634 (70%)	1,237 (80%)	643 (70%)
Yes	**572 (17%)**	175 (19%)	253 (16%)	144 (16%)
Don't know	**297 (9%)**	100 (11%)	66 (4%)	131 (14%)
Medication that must be inserted into a jejunostomy tube (J-tube)	**(n=3,377)**	**(n=907)**	**(n=1,552)**	**(n=913)**
No	**2,658 (79%)**	675 (75%)	1,307 (84%)	671 (73%)
Yes	**302 (9%)**	92 (10%)	142 (9%)	68 (7%)
Don't know	**417 (12%)**	140 (15%)	103 (7%)	174 (19%)

Table 43a. Administering Controlled Substances by Work Setting

	Overall (n=3,393)	Assisted Living (n=1,103)	Nursing Home (n=1,318)	Other Long-term Care (n=552)	Other (n=420)
Controlled substances					
No	**260 (8%)**	42 (4%)	97 (7%)	56 (10%)	65 (15%)
Yes	**3,064 (90%)**	1,045 (95%)	1,210 (92%)	463 (84%)	346 (82%)
Don't know	**69 (2%)**	16 (1%)	11 (1%)	33 (6%)	9 (2%)

Table 43b. Administering Controlled Substances by Regulatory Agency

	Overall (n=3,393)	BON (n=917)	Other State Agency (n=1,552)	Combination (n=919)
Controlled substances				
No	**260 (8%)**	97 (11%)	88 (6%)	75 (8%)
Yes	**3,064 (90%)**	796 (87%)	1,452 (94%)	811 (88%)
Don't know	**69 (2%)**	24 (3%)	12 (1%)	33 (4%)

Table 44a. Administering Schedule II Narcotics (as Indicated by Respondents who were Allowed to Administer Conrolled Substances) by Work Setting

	Overall (n=3,066)	Assisted Living (n=1,037)	Nursing Home (n=1,204)	Other Long-term Care (n=478)	Other (n=347)
Schedule II narcotics					
No	**184 (6%)**	51 (5%)	65 (5%)	32 (7%)	36 (10%)
Yes	**2,526 (82%)**	884 (85%)	1,042 (87%)	333 (70%)	267 (77%)
Don't know	**356 (12%)**	102 (10%)	97 (8%)	113 (24%)	44 (13%)

Table 44b. Administering Schedule II Narcotics (as Indicated by Respondents who were Allowed to Administer Conrolled Substances) by Regulatory Agency

	Overall (n=3,066)	BON (n=803)	Other State Agency (n=1,437)	Combination (n=821)
Schedule II narcotics				
No	**184 (6%)**	61 (8%)	91 (6%)	32 (4%)
Yes	**2,526 (82%)**	643 (80%)	1,264 (88%)	615 (75%)
Don't know	**356 (12%)**	99 (12%)	82 (6%)	174 (21%)

Table 45a. Administering Chemotherapeutic Agents by Work Setting

	Overall (n=3,361)	Assisted Living (n=1,093)	Nursing Home (n=1,312)	Other Long-term Care (n=543)	Other (n=413)
Chemotherapeutic agents					
No	**1,249 (37%)**	406 (37%)	429 (33%)	237 (44%)	177 (43%)
Yes	**919 (27%)**	275 (25%)	464 (35%)	79 (15%)	101 (24%)
Don't know	**1,193 (36%)**	412 (38%)	419 (32%)	227 (42%)	135 (33%)

Table 45b. Administering Chemotherapeutic Agents by Regulatory Agency

	Overall (n=3,361)	BON (n=910)	Other State Agency (n=1,536)	Combination (n=910)
Chemotherapeutic agents				
No	**1,249 (37%)**	353 (39%)	534 (35%)	361 (40%)
Yes	**919 (27%)**	239 (26%)	511 (33%)	167 (18%)
Don't know	**1,193 (36%)**	318 (35%)	491 (32%)	382 (42%)

Tubes. There were 8% of respondents who indicated they were allowed to administer medication that must be inserted into a nasogastric tube, 17% of respondents indicated they were allowed to administer medication that must be inserted into a gastric tube and 9% indicated they were allowed to administer medication that must be inserted into a jejunostomy tube. In all cases, a higher percentage of respondents who worked in other long-term care facilities and other facilities were allowed to do these tasks versus respondents who worked in assisted living and nursing homes (see Table 42a & 42b).

Classes of drugs. A majority of respondents indicated they were allowed to administer controlled substances (90%) (see Table 43a and 43b). Of the respondents who indicated they were allowed to administer controlled substances, 82% indicated they were allowed to administer schedule II narcotics (see Tables 44a and 44b).

27% of respondents indicated they were allowed to administer chemotherapeutic agents (see Tables 45a and 45b).

Table 46a. Administering Oral Maintenance Chemotherapy (as Indicated by Respondents who were Allowed to Administer Chemotherapeutic Agents) by Work Setting

	Overall (n=1,989)	Assisted Living (n=647)	Nursing Home (n=832)	Other Long-term Care (n=289)	Other (n=221)
No	**107 (5%)**	36 (6%)	49 (6%)	11 (4%)	11 (5%)
Yes	**767 (39%)**	224 (35%)	399 (48%)	63 (22%)	81 (37%)
Don't know	**1,115 (56%)**	387 (60%)	384 (46%)	215 (74%)	129 (58%)

Table 46b. Administering Oral Maintenance Chemotherapy (as Indicated by Respondents who were Allowed to Administer Chemotherapeutic Agents) by Regulatory Agency

	Overall (n=1,989)	BON (n=528)	Other State Agency (n=948)	Combination (n=509)
No	**107 (5%)**	26 (5%)	56 (6%)	24 (5%)
Yes	**767 (39%)**	196 (37%)	436 (46%)	134 (26%)
Don't know	**1,115 (56%)**	306 (58%)	456 (48%)	351 (69%)

Table 47a. Administering Tamoxifen (as Indicated by Respondents who were Allowed to Administer Chemotherapeutic Agents) by Work Setting

	Overall (n=1,951)	Assisted Living (n=632)	Nursing Home (n=826)	Other Long-term Care (n=278)	Other (n=215)
No	**202 (10%)**	50 (8%)	111 (13%)	17 (6%)	24 (11%)
Yes	**423 (22%)**	136 (22%)	216 (26%)	32 (12%)	39 (18%)
Don't know	**1,326 (68%)**	446 (71%)	499 (60%)	229 (82%)	152 (71%)

Table 47b. Administering Tamoxifen (as Indicated by Respondents who were Allowed to Administer Chemotherapeutic Agents) by Regulatory Agency

	Overall (n=1,951)	BON (n=512)	Other State Agency (n=939)	Combination (n=497)
No	**202 (10%)**	47 (9%)	121 (13%)	33 (7%)
Yes	**423 (22%)**	123 (24%)	231 (25%)	68 (14%)
Don't know	**1,326 (68%)**	342 (67%)	587 (63%)	396 (80%)

Of the respondents who indicated they were allowed to administer chemotherapeutic agents, 39% indicated that oral maintenance chemotherapy was the only chemotherapeutic agent they were allowed to administer; however, the majority indicated they did not know if it was the only chemotherapeutic agent they were allowed to administer (see Tables 46a and 46b).

Of the respondents who indicated they were allowed to administer chemotherapeutic agents, 22% indicated that Tamoxifen was the only oral chemotherapeutic agent they were allowed to administer; however, again, the majority (68%) did not know if Tamoxifen was the only oral chemotherapeutic agent they were allowed to administer (see Tables 47a and 47b).

Others. There were 80% of respondents who indicated they were allowed to administer the first dose of a new medication, 67% indicated they were allowed to administer pro re nata (PRN) medication (when an assessment of the patient by a licensed nurse is not required), 49% indicated they were allowed to administer medications when the patient's condition was unstable or the patient had changing nursing needs and 67% indicated they were allowed to administer medications without delegation from a licensed nurse. Responses varied by type of work setting and regulating body (see Table 48a and 48b).

The majority of respondents were allowed to administer drops, ointments or sprays into the eyes (95%), ears (93%) and nose (94%); far fewer indicated they were allowed to administer barium or other diagnostic contrast media (21%) (see Tables 49a and 49b).

The majority of respondents indicated they were allowed to complete documentation for medication administration (82%); complete medication error reports (67%); account for controlled substances if assisted by another MA (76%); receive and count meds (86%); reorder medications from the pharmacy (74%); perform blood glucose testing (62%); crush medications (authorization by a licensed nurse not required) (59%); among other tasks. Tasks varied by type of work setting a regulating agency (see Tables 50a and 50b).

The majority of MAs were expected to recognize normal and abnormal conditions for the patient (i.e., identify a change in condition) (94%); recognize changes in patients' conditions or behaviors (98%); recognize side effects (94%); recognize toxic effects

Table 48a. Administering Specific Types of Medication by Work Setting					
	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
The first dose of a new medication	**(n=3,383)**	**(n=1,090)**	**(n=1,323)**	**(n=554)**	**(n=416)**
No	**639 (19%)**	76 (7%)	432 (33%)	44 (8%)	87 (21%)
Yes	**2,692 (80%)**	998 (92%)	877 (66%)	495 (89%)	322 (77%)
Don't know	**52 (2%)**	16 (1%)	14 (1%)	15 (3%)	7 (2%)
The first dose of a changed medication (for example, a change in dosage)	**(n=3,379)**	**(n=1,092)**	**(n=1,320)**	**(n=551)**	**(n=416)**
No	**401 (12%)**	44 (4%)	266 (20%)	34 (6%)	57 (14%)
Yes	**2,933 (87%)**	1,038 (95%)	1,044 (79%)	500 (91%)	351 (84%)
Don't know	**45 (1%)**	10 (1%)	10 (1%)	17 (3%)	8 (2%)
PRN or "as needed" medications (only after an assessment of the patient by a licensed nurse)	**(n=3,363)**	**(n=1,084)**	**(n=1,315)**	**(n=549)**	**(n=415)**
No	**317 (9%)**	128 (12%)	103 (8%)	45 (8%)	41 (10%)
Yes	**3,003 (89%)**	945 (87%)	1,206 (92%)	489 (89%)	363 (87%)
Don't know	**43 (1%)**	11 (1%)	6 (< 1%)	15 (3%)	11 (3%)
PRN or "as needed" medications (assessment of the patient by a licensed nurse not required)	**(n=3,334)**	**(n=1,075)**	**(n=1,308)**	**(n=543)**	**(n=408)**
No	**1,025 (31%)**	219 (20%)	547 (42%)	138 (25%)	121 (30%)
Yes	**2,220 (67%)**	828 (77%)	734 (56%)	384 (71%)	274 (67%)
Don't know	**89 (3%)**	28 (3%)	27 (2%)	21 (4%)	13 (3%)
Medications administered when the patient's condition is unstable or the patient has changing nursing needs	**(n=3,328)**	**(n=1,068)**	**(n=1,313)**	**(n=536)**	**(n=411)**
No	**1,274 (38%)**	343 (32%)	580 (44%)	199 (37%)	152 (37%)
Yes	**1,623 (49%)**	593 (56%)	618 (47%)	218 (41%)	194 (47%)
Don't know	**431 (13%)**	132 (12%)	115 (9%)	119 (22%)	65 (16%)
Medications administered when the supervising nurse is unavailable to monitor the progress and/or the effect of the medication on the patient	**(n=3,313)**	**(n=1,059)**	**(n=1,311)**	**(n=535)**	**(n=408)**
No	**1,414 (43%)**	337 (32%)	730 (56%)	173 (32%)	174 (43%)
Yes	**1,531 (46%)**	613 (58%)	460 (35%)	273 (51%)	185 (45%)
Don't know	**368 (11%)**	109 (10%)	121 (9%)	89 (17%)	49 (12%)
Medications administered without the task having been delegated by a nurse	**(n=3,335)**	**(n=1,076)**	**(n=1,308)**	**(n=539)**	**(n=412)**
No	**1,794 (54%)**	552 (51%)	743 (57%)	280 (52%)	219 (53%)
Yes	**1,233 (67%)**	420 (39%)	465 (36%)	188 (35%)	160 (39%)
Don't know	**308 (9%)**	104 (10%)	100 (8%)	71 (13%)	33 (8%)
Medications that require a mathematical conversion between units of measurement to determine the correct dose	**(n=3,354)**	**(n=1,084)**	**(n=1,319)**	**(n=540)**	**(n=411)**
No	**1,828 (55%)**	557 (51%)	805 (61%)	250 (46%)	216 (53%)
Yes	**1,182 (35%)**	418 (39%)	430 (33%)	185 (34%)	149 (36%)
Don't know	**344 (10%)**	109 (10%)	84 (6%)	105 (19%)	46 (11%)
Medications being administered as part of clinical research	**(n=3,347)**	**(n=1,085)**	**(n=1,316)**	**(n=538)**	**(n=408)**
No	**1,978 (59%)**	626 (58%)	793 (60%)	316 (59%)	243 (60%)
Yes	**407 (12%)**	128 (12%)	177 (13%)	49 (9%)	53 (13%)
Don't know	**962 (29%)**	331 (31%)	346 (26%)	173 (32%)	112 (27%)

Table 48b. Administering Specific Types of Medication by Regulatory Agency				
	Overall	BON	Other State Agency	Combination
The first dose of a new medication	**(n=3,383)**	**(n=916)**	**(n=1,548)**	**(n=914)**
No	**639 (19%)**	77 (8%)	522 (34%)	40 (4%)
Yes	**2,692 (80%)**	822 (90%)	1,016 (66%)	849 (93%)
Don't know	**52 (2%)**	17 (2%)	10 (1%)	25 (3%)
The first dose of a changed medication (for example, a change in dosage)	**(n=3,379)**	**(n=914)**	**(n=1,546)**	**(n=914)**
No	**401 (12%)**	52 (6%)	317 (21%)	32 (4%)
Yes	**2,933 (87%)**	851 (93%)	1,220 (79%)	857 (94%)
Don't know	**45 (1%)**	11 (1%)	9 (1%)	25 (3%)
PRN or "as needed" medications (only after an assessment of the patient by a licensed nurse)	**(n=3,363)**	**(n=906)**	**(n=1,546)**	**(n=906)**
No	**317 (9%)**	102 (11%)	137 (9%)	77 (9%)
Yes	**3,003 (89%)**	796 (88%)	1,397 (90%)	806 (89%)
Don't know	**43 (1%)**	8 (1%)	12 (1%)	23 (3%)
PRN or "as needed" medications (assessment of the patient by a licensed nurse not required)	**(n=3,334)**	**(n=894)**	**(n=1,525)**	**(n=910)**
No	**1,025 (31%)**	229 (26%)	582 (38%)	212 (23%)
Yes	**2,220 (67%)**	639 (71%)	906 (59%)	672 (74%)
Don't know	**89 (3%)**	26 (3%)	37 (2%)	26 (3%)
Medications administered when the patient's condition is unstable or the patient has changing nursing needs	**(n=3,328)**	**(n=891)**	**(n=1,529)**	**(n=903)**
No	**1,274 (38%)**	325 (36%)	661 (43%)	284 (31%)
Yes	**1,623 (49%)**	457 (51%)	718 (47%)	447 (50%)
Don't know	**431 (13%)**	109 (12%)	150 (10%)	172 (19%)
Medications administered when the supervising nurse is unavailable to monitor the progress and/or the effect of the medication on the patient	**(n=3,313)**	**(n=886)**	**(n=1,519)**	**(n=903)**
No	**1,414 (43%)**	341 (38%)	765 (50%)	305 (34%)
Yes	**1,531 (46%)**	456 (51%)	618 (41%)	456 (51%)
Don't know	**368 (11%)**	89 (10%)	136 (9%)	142 (16%)
Medications administered without the task having been delegated by a nurse	**(n=3,335)**	**(n=896)**	**(n=1,530)**	**(n=904)**
No	**1,794 (54%)**	501 (56%)	893 (58%)	397 (44%)
Yes	**1,233 (67%)**	317 (35%)	531 (35%)	385 (43%)
Don't know	**308 (9%)**	78 (9%)	106 (7%)	122 (14%)
Medications that require a mathematical conversion between units of measurement to determine the correct dose	**(n=3,354)**	**(n=906)**	**(n=1,541)**	**(n=902)**
No	**1,828 (55%)**	444 (49%)	979 (64%)	401 (44%)
Yes	**1,182 (35%)**	380 (42%)	464 (30%)	337 (37%)
Don't know	**344 (10%)**	82 (9%)	98 (6%)	164 (18%)
Medications being administered as part of clinical research	**(n=3,347)**	**(n=905)**	**(n=1,532)**	**(n=905)**
No	**1,978 (59%)**	549 (61%)	952 (62%)	474 (52%)
Yes	**407 (12%)**	115 (13%)	211 (14%)	81 (9%)
Don't know	**962 (29%)**	241 (27%)	369 (24%)	350 (39%)

Table 49a. Administering Drops,Ointment or Sprays by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Drops, ointments or sprays into the *eyes*	**(n=3,399)**	**(n=1,098)**	**(n=1,327)**	**(n=554)**	**(n=420)**
No	**134 (4%)**	25 (2%)	36 (3%)	27 (5%)	46 (11%)
Yes	**3,242 (95%)**	1,071 (98%)	1,287 (97%)	517 (93%)	367 (87%)
Don't know	**23 (1%)**	2 (< 1%)	4 (< 1%)	10 (2%)	7 (2%)
Drops, ointments or sprays into the *ears*	**(n=3,395)**	**(n=1,098)**	**(n=1,324)**	**(n=554)**	**(n=419)**
No	**206 (6%)**	40 (4%)	88 (7%)	22 (4%)	56 (13%)
Yes	**3,148 (93%)**	1,046 (95%)	1,227 (93%)	521 (94%)	354 (84%)
Don't know	**41 (1%)**	12 (1%)	9 (1%)	11 (2%)	9 (2%)
Drops, ointments or sprays into the *nose*	**(n=3,393)**	**(n=1,096)**	**(n=1,324)**	**(n=554)**	**(n=419)**
No	**190 (6%)**	29 (3%)	78 (6%)	28 (5%)	55 (13%)
Yes	**3,174 (94%)**	1,063 (97%)	1,241 (94%)	517 (93%)	353 (84%)
Don't know	**29 (1%)**	4 (< 1%)	5 (< 1%)	9 (2%)	11 (3%)
Barium or other diagnostic contrast media	**(n=3,334)**	**(n=1,070)**	**(n=1,311)**	**(n=538)**	**(n=415)**
No	**1,496 (45%)**	431 (40%)	651 (50%)	201 (37%)	213 (51%)
Yes	**688 (21%)**	243 (23%)	263 (20%)	111 (21%)	71 (17%)
Don't know	**1,150 (34%)**	396 (37%)	397 (30%)	226 (42%)	131 (32%)

Table 49b. Administering Drops,Ointment or Sprays by Regulatory Agency				
	Overall	**BON**	**Other State Agency**	**Combination**
Drops, ointments or sprays into the *eyes*	**(n=3,399)**	**(n=923)**	**(n=1,559)**	**(n=913)**
No	**134 (4%)**	37 (4%)	53 (3%)	44 (5%)
Yes	**3,242 (95%)**	876 (95%)	1,501 (96%)	861 (94%)
Don't know	**23 (1%)**	10 (1%)	5 (< 1%)	8 (1%)
Drops, ointments or sprays into the *ears*	**(n=3,395)**	**(n=922)**	**(n=1,556)**	**(n=913)**
No	**206 (6%)**	57 (6%)	106 (7%)	43 (5%)
Yes	**3,148 (93%)**	847 (92%)	1,438 (92%)	859 (94%)
Don't know	**41 (1%)**	18 (2%)	12 (1%)	11 (1%)
Drops, ointments or sprays into the *nose*	**(n=3,393)**	**(n=918)**	**(n=1,559)**	**(n=912)**
No	**190 (6%)**	37 (4%)	111 (7%)	42 (5%)
Yes	**3,174 (94%)**	867 (94%)	1,443 (93%)	860 (94%)
Don't know	**29 (1%)**	14 (2%)	5 (< 1%)	10 (1%)
Barium or other diagnostic contrast media	**(n=3,334)**	**(n=902)**	**(n=1,527)**	**(n=901)**
No	**1,496 (45%)**	405 (45%)	732 (48%)	358 (40%)
Yes	**688 (21%)**	195 (22%)	316 (21%)	176 (20%)
Don't know	**1,150 (34%)**	302 (33%)	479 (31%)	367 (41%)

Table 50a. Performing Specific Tasks/Activities by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Regulation of intravenous fluids	**(n=3,361)**	**(n=1,079)**	**(n=1,318)**	**(n=549)**	**(n=415)**
No	**2,982 (89%)**	948 (88%)	1,246 (95%)	428 (78%)	360 (87%)
Yes	**137 (4%)**	42 (4%)	34 (3%)	36 (7%)	25 (6%)
Don't know	**242 (7%)**	89 (8%)	38 (3%)	85 (15%)	30 (7%)
Programming insulin pumps	**(n=3,370)**	**(n=1,079)**	**(n=1,325)**	**(n=550)**	**(n=416)**
No	**2,989 (89%)**	924 (86%)	1,276 (96%)	422 (77%)	367 (88%)
Yes	**129 (4%)**	61 (6%)	18 (1%)	33 (6%)	17 (4%)
Don't know	**252 (7%)**	94 (9%)	31 (2%)	95 (17%)	32 (8%)
Complete documentation for medication administration	**(n=3,380)**	**(n=1,087)**	**(n=1,322)**	**(n=555)**	**(n=416)**
No	**513 (15%)**	136 (13%)	263 (20%)	50 (9%)	64 (15%)
Yes	**2,760 (82%)**	917 (84%)	1,021 (77%)	485 (87%)	337 (81%)
Don't know	**107 (3%)**	34 (3%)	38 (3%)	20 (4%)	15 (4%)
Complete medication error reports	**(n=3,371)**	**(n=1,087)**	**(n=1,313)**	**(n=554)**	**(n=417)**
No	**961 (29%)**	271 (25%)	523 (40%)	73 (13%)	94 (23%)
Yes	**2,275 (67%)**	773 (71%)	735 (56%)	458 (83%)	309 (74%)
Don't know	**135 (4%)**	43 (4%)	55 (4%)	23 (4%)	14 (3%)
Take telephone or verbal orders for medication	**(n=3,383)**	**(n=1,089)**	**(n=1,324)**	**(n=553)**	**(n=417)**
No	**2,694 (80%)**	839 (77%)	1,229 (93%)	311 (56%)	315 (76%)
Yes	**607 (18%)**	221 (20%)	78 (6%)	216 (39%)	92 (22%)
Don't know	**82 (2%)**	29 (3%)	17 (1%)	26 (5%)	10 (2%)
Receive written orders for medication	**(n=3,386)**	**(n=1,091)**	**(n=1,324)**	**(n=553)**	**(n=418)**
No	**2,052 (61%)**	512 (47%)	1,126 (85%)	190 (34%)	224 (54%)
Yes	**1,254 (37%)**	555 (51%)	175 (13%)	340 (61%)	184 (44%)
Don't know	**80 (2%)**	24 (2%)	23 (2%)	23 (4%)	10 (2%)
Transcribe medication and treatment orders	**(n=3,376)**	**(n=1,084)**	**(n=1,325)**	**(n=549)**	**(n=418)**
No	**2,446 (72%)**	686 (63%)	1,153 (87%)	314 (57%)	293 (70%)
Yes	**761 (23%)**	342 (32%)	141 (11%)	170 (31%)	108 (26%)
Don't know	**169 (5%)**	56 (5%)	31 (2%)	65 (12%)	17 (4%)
Order initial medications from pharmacy	**(n=3,392)**	**(n=1,096)**	**(n=1,324)**	**(n=555)**	**(n=417)**
No	**2,062 (61%)**	557 (51%)	956 (72%)	294 (53%)	255 (61%)
Yes	**1,223 (36%)**	502 (46%)	341 (26%)	227 (41%)	153 (37%)
Don't know	**107 (3%)**	37 (3%)	27 (2%)	34 (6%)	9 (2%)
Reorder medications from pharmacy	**(n=3,386)**	**(n=1,094)**	**(n=1,324)**	**(n=552)**	**(n=416)**
No	**828 (24%)**	176 (16%)	356 (27%)	153 (28%)	143 (34%)
Yes	**2,497 (74%)**	904 (83%)	950 (72%)	378 (68%)	265 (64%)
Don't know	**61 (2%)**	14 (1%)	18 (1%)	21 (4%)	8 (2%)
Account for controlled substances (perform a narcotic count), if assisted by a licensed nurse	**(n=3,378)**	**(n=1,085)**	**(n=1,325)**	**(n=550)**	**(n=418)**
No	**424 (13%)**	120 (11%)	154 (12%)	75 (14%)	75 (18%)
Yes	**2,886 (85%)**	955 (88%)	1,163 (88%)	433 (79%)	335 (80%)
Don't know	**68 (2%)**	10 (1%)	8 (1%)	42 (8%)	8 (2%)

Table 50a. Performing Specific Tasks/Activities by Work Setting					
	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
Account for controlled substances (perform a narcotic count), if assisted by another Medication Aide	**(n=3,379)**	**(n=1,091)**	**(n=1,319)**	**(n=552)**	**(n=417)**
No	**736 (22%)**	119 (11%)	377 (29%)	111 (20%)	129 (31%)
Yes	**2,565 (76%)**	954 (87%)	932 (71%)	400 (72%)	276 (67%)
Don't know	**78 (2%)**	18 (2%)	10 (1%)	41 (7%)	9 (2%)
Receive and count medications	**(n=3,368)**	**(n=1,084)**	**(n=1,314)**	**(n=554)**	**(n=416)**
No	**411 (12%)**	60 (6%)	233 (18%)	54 (10%)	64 (15%)
Yes	**2,905 (86%)**	1,014 (94%)	1,061 (81%)	486 (88%)	344 (83%)
Don't know	**52 (2%)**	10 (1%)	20 (2%)	14 (3%)	8 (2%)
Instill irrigation fluids of any type (including, but not limited to: colostomy, urinary catheter, and enema)	**(n=3,363)**	**(n=1,081)**	**(n=1,315)**	**(n=551)**	**(n=416)**
No	**2,271 (68%)**	670 (62%)	1,001 (76%)	310 (56%)	290 (70%)
Yes	**747 (22%)**	276 (26%)	252 (19%)	143 (26%)	76 (18%)
Don't know	**345 (10%)**	135 (12%)	62 (5%)	98 (18%)	50 (12%)
Perform any sterile procedure or medication administration that involves sterile technique	**(n=3,357)**	**(n=1,082)**	**(n=1,314)**	**(n=546)**	**(n=415)**
No	**1,999 (60%)**	560 (52%)	971 (74%)	239 (44%)	229 (55%)
Yes	**948 (28%)**	369 (34%)	257 (20%)	194 (36%)	128 (31%)
Don't know	**410 (12%)**	153 (14%)	86 (7%)	113 (21%)	58 (14%)
Conduct patient assessments or evaluations	**(n=3,368)**	**(n=1,083)**	**(n=1,318)**	**(n=549)**	**(n=418)**
No	**2,424 (72%)**	753 (70%)	1,112 (84%)	285 (52%)	274 (66%)
Yes	**769 (23%)**	271 (25%)	173 (13%)	209 (38%)	116 (28%)
Don't know	**175 (5%)**	59 (5%)	33 (3%)	55 (10%)	28 (7%)
Engage in patient teaching activities related to medications	**(n=3,346)**	**(n=1,075)**	**(n=1,312)**	**(n=543)**	**(n=416)**
No	**1,417 (42%)**	427 (40%)	645 (49%)	176 (32%)	169 (41%)
Yes	**1,630 (49%)**	537 (50%)	576 (44%)	301 (55%)	216 (52%)
Don't know	**299 (9%)**	111 (10%)	91 (7%)	66 (12%)	31 (7%)
Take vital signs prior to or after administering medications	**(n=3,372)**	**(n=1,091)**	**(n=1,324)**	**(n=541)**	**(n=416)**
No	**207 (6%)**	30 (3%)	33 (2%)	87 (16%)	57 (14%)
Yes	**3,122 (93%)**	1,056 (97%)	1,287 (97%)	429 (79%)	350 (84%)
Don't know	**43 (1%)**	5 (< 1%)	4 (< 1%)	25 (5%)	9 (2%)
Administer medications that are in a unit dose package or a pre-filled medication holder	**(n=3,350)**	**(n=1,076)**	**(n=1,309)**	**(n=549)**	**(n=416)**
No	**345 (10%)**	99 (9%)	148 (11%)	49 (9%)	49 (12%)
Yes	**2,869 (86%)**	934 (87%)	1,114 (85%)	470 (86%)	351 (84%)
Don't know	**136 (4%)**	43 (4%)	47 (4%)	30 (5%)	16 (4%)
Assume responsibility for medication pumps including patient-controlled analgesia	**(n=3,334)**	**(n=1,067)**	**(n=1,310)**	**(n=544)**	**(n=413)**
No	**2,513 (75%)**	742 (70%)	1,119 (85%)	330 (61%)	322 (78%)
Yes	**281 (8%)**	104 (10%)	86 (7%)	61 (11%)	30 (7%)
Don't know	**540 (16%)**	221 (21%)	105 (8%)	153 (28%)	61 (15%)

Table 50a. Performing Specific Tasks/Activities by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Perform oral, nasal, or tracheal suctioning	**(n=3,374)**	**(n=1,084)**	**(n=1,321)**	**(n=550)**	**(n=419)**
No	**2,614 (77%)**	804 (74%)	1,175 (89%)	324 (59%)	311 (74%)
Yes	**405 (12%)**	146 (13%)	97 (7%)	99 (18%)	63 (15%)
Don't know	**355 (11%)**	134 (12%)	49 (4%)	127 (23%)	45 (11%)
Perform blood glucose testing	**(n=3,379)**	**(n=1,090)**	**(n=1,319)**	**(n=554)**	**(n=416)**
No	**1,186 (35%)**	150 (14%)	720 (55%)	167 (30%)	149 (36%)
Yes	**2,103 (62%)**	925 (85%)	586 (44%)	341 (62%)	251 (60%)
Don't know	**90 (3%)**	15 (1%)	13 (1%)	46 (8%)	16 (4%)
Crush medications (authorization by a licensed nurse not required)	**(n=3,337)**	**(n=1,072)**	**(n=1,309)**	**(n=543)**	**(n=413)**
No	**1,238 (37%)**	422 (39%)	427 (33%)	222 (41%)	167 (40%)
Yes	**1,958 (59%)**	608 (57%)	855 (65%)	271 (50%)	224 (54%)
Don't know	**141 (4%)**	42 (4%)	27 (2%)	50 (9%)	22 (5%)
Crush medications (authorization by a licensed nurse is required)	**(n=3,336)**	**(n=1,071)**	**(n=1,307)**	**(n=545)**	**(n=413)**
No	**725 (22%)**	241 (23%)	238 (18%)	117 (21%)	129 (31%)
Yes	**2,475 (74%)**	794 (74%)	1,046 (80%)	371 (68%)	264 (64%)
Don't know	**136 (4%)**	36 (3%)	23 (2%)	57 (10%)	20 (5%)
Destroy medications	**(n=3,376)**	**(n=1,091)**	**(n=1,317)**	**(n=550)**	**(n=418)**
No	**2,056 (61%)**	655 (60%)	856 (65%)	329 (60%)	216 (52%)
Yes	**1,209 (36%)**	419 (38%)	426 (32%)	177 (32%)	187 (45%)
Don't know	**111 (3%)**	17 (2%)	35 (3%)	44 (8%)	15 (4%)
Calculate drug dosages	**(n=3,358)**	**(n=1,082)**	**(n=1,315)**	**(n=542)**	**(n=419)**
No	**2,202 (66%)**	680 (63%)	919 (70%)	338 (62%)	265 (63%)
Yes	**884 (26%)**	310 (29%)	328 (25%)	123 (23%)	123 (29%)
Don't know	**272 (8%)**	92 (9%)	68 (5%)	81 (15%)	31 (7%)

Table 50b. Performing Specific Tasks/Activities by Regulatory Agency				
	Overall	**BON**	**Other State Agency**	**Combination**
Regulation of intravenous fluids	**(n=3,361)**	**(n=900)**	**(n=1,548)**	**(n=908)**
No	**2,982 (89%)**	786 (87%)	1,437 (93%)	755 (83%)
Yes	**137 (4%)**	42 (5%)	46 (3%)	49 (5%)
Don't know	**242 (7%)**	72 (8%)	65 (4%)	104 (11%)
Programming insulin pumps	**(n=3,370)**	**(n=903)**	**(n=1,551)**	**(n=911)**
No	**2,989 (89%)**	750 (83%)	1,459 (94%)	775 (85%)
Yes	**129 (4%)**	63 (7%)	32 (2%)	34 (4%)
Don't know	**252 (7%)**	90 (10%)	60 (4%)	102 (11%)
Complete documentation for medication administration	**(n=3,380)**	**(n=917)**	**(n=1,548)**	**(n=910)**
No	**513 (15%)**	94 (10%)	291 (19%)	127 (14%)
Yes	**2,760 (82%)**	796 (87%)	1,219 (79%)	741 (81%)
Don't know	**107 (3%)**	27 (3%)	38 (2%)	42 (5%)

Table 50b. Performing Specific Tasks/Activities by Regulatory Agency				
	Overall	**BON**	**Other State Agency**	**Combination**
Complete medication error reports	**(n=3,371)**	**(n=910)**	**(n=1,545)**	**(n=911)**
No	**961 (29%)**	176 (19%)	609 (39%)	175 (19%)
Yes	**2,275 (67%)**	704 (77%)	875 (57%)	693 (76%)
Don't know	**135 (4%)**	30 (3%)	61 (4%)	43 (5%)
Take telephone or verbal orders for medication	**(n=3,383)**	**(n=912)**	**(n=1,554)**	**(n=912)**
No	**2,694 (80%)**	682 (75%)	1,409 (91%)	599 (66%)
Yes	**607 (18%)**	206 (23%)	127 (8%)	273 (30%)
Don't know	**82 (2%)**	24 (3%)	18 (1%)	40 (4%)
Receive written orders for medication	**(n=3,386)**	**(n=915)**	**(n=1,554)**	**(n=912)**
No	**2,052 (61%)**	402 (44%)	1,217 (78%)	430 (47%)
Yes	**1,254 (37%)**	493 (54%)	314 (20%)	445 (49%)
Don't know	**80 (2%)**	20 (2%)	23 (1%)	37 (4%)
Transcribe medication and treatment orders	**(n=3,376)**	**(n=905)**	**(n=1,554)**	**(n=912)**
No	**2,446 (72%)**	581 (64%)	1,298 (84%)	564 (62%)
Yes	**761 (23%)**	286 (32%)	214 (14%)	259 (28%)
Don't know	**169 (5%)**	38 (4%)	42 (3%)	89 (10%)
Order initial medications from pharmacy	**(n=3,392)**	**(n=915)**	**(n=1,559)**	**(n=913)**
No	**2,062 (61%)**	521 (57%)	1,062 (68%)	475 (52%)
Yes	**1,223 (36%)**	363 (40%)	467 (30%)	392 (43%)
Don't know	**107 (3%)**	31 (3%)	30 (2%)	46 (5%)
Reorder medications from pharmacy	**(n=3,386)**	**(n=912)**	**(n=1,555)**	**(n=914)**
No	**828 (24%)**	232 (25%)	400 (26%)	196 (21%)
Yes	**2,497 (74%)**	660 (72%)	1,142 (73%)	690 (75%)
Don't know	**61 (2%)**	20 (2%)	13 (1%)	28 (3%)

(80%); recognize allergic reactions (92%); recognize immediate desired effects (85%); recognize unusual and unexpected effects (90%); recognize changes in client's condition that contraindicates continued administration of the medication (81%); anticipate effects which may rapidly endanger a client's life or well-being and make judgments and decisions concerning actions to take (51%); review the patient's plan-of-care (61%); and collect and document patient conditions (63%). Reponses varied by type of work setting and regulating agency (see Tables 51a and 51b).

A relatively large percentage of respondents (33%) indicated that a licensed nurse never assesses a patient within a 30 minute window prior to or after a patient's medication administration. Results varied by type of work setting and regulating agency (see Tables 52a, 52b, 53a and 53b).

Table 51a. Expected to Perform Specific Tasks/Activities by Work Setting					
	Overall	**Assisted Living**	**Nursing Home**	**Other Long-term Care**	**Other**
Recognize normal and abnormal conditions for the patient (that is, identify a change in condition)	**(n=3,395)**	**(n=1,095)**	**(n=1,324)**	**(n=556)**	**(n=420)**
No	**149 (4%)**	35 (3%)	71 (5%)	14 (3%)	29 (7%)
Yes	**3,204 (94%)**	1,044 (95%)	1,237 (93%)	538 (97%)	385 (92%)
Don't know	**42 (1%)**	16 (1%)	16 (1%)	4 (1%)	6 (1%)
Recognize changes in patients' conditions or behaviors	**(n=3,405)**	**(n=1,098)**	**(n=1,329)**	**(n=557)**	**(n=421)**
No	**62 (2%)**	14 (1%)	27 (2%)	3 (1%)	18 (4%)
Yes	**3,326 (98%)**	1,077 (98%)	1,297 (98%)	554 (99%)	398 (95%)
Don't know	**17 (1%)**	7 (1%)	5 (< 1%)	0 (0%)	5 (1%)
Recognize side effects	**(n=3,396)**	**(n=1,095)**	**(n=1,325)**	**(n=556)**	**(n=420)**
No	**155 (5%)**	43 (4%)	73 (6%)	16 (3%)	23 (5%)
Yes	**3,195 (94%)**	1,037 (95%)	1,239 (94%)	534 (96%)	385 (92%)
Don't know	**46 (1%)**	15 (1%)	13 (1%)	6 (1%)	12 (3%)
Recognize toxic effects	**(n=3,376)**	**(n=1,083)**	**(n=1,321)**	**(n=553)**	**(n=419)**
No	**433 (13%)**	125 (12%)	196 (15%)	53 (10%)	59 (14%)
Yes	**2,708 (80%)**	885 (82%)	1,037 (79%)	454 (82%)	332 (79%)
Don't know	**235 (7%)**	73 (7%)	88 (7%)	46 (8%)	28 (7%)
Recognize allergic reactions	**(n=3,391)**	**(n=1,093)**	**(n=1,323)**	**(n=554)**	**(n=421)**
No	**197 (6%)**	52 (5%)	93 (7%)	23 (4%)	29 (7%)
Yes	**3,119 (92%)**	1,018 (93%)	1,201 (91%)	517 (93%)	383 (91%)
Don't know	**75 (2%)**	23 (2%)	29 (2%)	14 (3%)	9 (2%)
Recognize immediate desired effects	**(n=3,373)**	**(n=1,086)**	**(n=1,320)**	**(n=550)**	**(n=417)**
No	**316 (9%)**	77 (7%)	146 (11%)	36 (7%)	57 (14%)
Yes	**2,862 (85%)**	950 (87%)	1,098 (83%)	478 (87%)	336 (81%)
Don't know	**195 (6%)**	59 (5%)	76 (6%)	36 (7%)	24 (6%)
Recognize unusual and unexpected effects	**(n=3,381)**	**(n=1,089)**	**(n=1,320)**	**(n=553)**	**(n=419)**
No	**233 (7%)**	60 (6%)	110 (8%)	27 (5%)	36 (9%)
Yes	**3,027 (90%)**	993 (91%)	1,156 (88%)	505 (91%)	373 (89%)
Don't know	**121 (4%)**	36 (3%)	54 (4%)	21 (4%)	10 (2%)
Recognize changes in client's condition that contraindicates continued administration of the medication	**(n=3,377)**	**(n=1,087)**	**(n=1,321)**	**(n=553)**	**(n=416)**
No	**367 (11%)**	96 (9%)	171 (13%)	45 (8%)	55 (13%)
Yes	**2,731 (81%)**	894 (82%)	1,049 (79%)	458 (83%)	330 (79%)
Don't know	**279 (8%)**	97 (9%)	101 (8%)	50 (9%)	31 (7%)
Anticipate effects which may rapidly endanger a client's life or well-being and making judgments and decisions concerning actions to take	**(n=3,363)**	**(n=1,082)**	**(n=1,315)**	**(n=551)**	**(n=415)**
No	**1,303 (39%)**	350 (32%)	660 (50%)	145 (26%)	148 (36%)
Yes	**1,711 (51%)**	615 (57%)	533 (41%)	335 (61%)	228 (55%)
Don't know	**349 (10%)**	117 (11%)	122 (9%)	71 (13%)	39 (9%)

Table 51a. Expected to Perform Specific Tasks/Activities by Work Setting					
	Overall	Assisted Living	Nursing Home	Other Long-term Care	Other
Review the patient's plan-of-care	**(n=3,386)**	**(n=1,094)**	**(n=1,321)**	**(n=553)**	**(n=418)**
No	**1,131 (33%)**	288 (26%)	568 (43%)	126 (23%)	149 (36%)
Yes	**2,076 (61%)**	743 (68%)	700 (53%)	391 (71%)	242 (58%)
Don't know	**179 (5%)**	63 (6%)	53 (4%)	36 (7%)	27 (6%)
Collect and document patient conditions	**(n=3,384)**	**(n=1,090)**	**(n=1,320)**	**(n=557)**	**(n=417)**
No	**1,106 (33%)**	211 (19%)	703 (53%)	77 (14%)	115 (28%)
Yes	**2,134 (63%)**	833 (76%)	558 (42%)	458 (82%)	285 (68%)
Don't know	**144 (4%)**	46 (4%)	59 (4%)	22 (4%)	17 (4%)

Table 51b. Expected to Perform Specific Tasks/Activities by Regulatory Agency				
	Overall	BON	Other State Agency	Combination
Recognize normal and abnormal conditions for the patient (that is, identify a change in condition)	**(n=3,395)**	**(n=919)**	**(n=1,556)**	**(n=915)**
No	**149 (4%)**	33 (4%)	75 (5%)	41 (4%)
Yes	**3,204 (94%)**	871 (95%)	1,464 (94%)	864 (94%)
Don't know	**42 (1%)**	15 (2%)	17 (1%)	10 (1%)
Recognize changes in patients' conditions or behaviors	**(n=3,405)**	**(n=922)**	**(n=1,561)**	**(n=917)**
No	**62 (2%)**	14 (2%)	30 (2%)	18 (2%)
Yes	**3,326 (98%)**	901 (98%)	1,526 (98%)	894 (97%)
Don't know	**17 (1%)**	7 (1%)	5 (< 1%)	5 (1%)
Recognize side effects	**(n=3,396)**	**(n=919)**	**(n=1,558)**	**(n=914)**
No	**155 (5%)**	36 (4%)	66 (4%)	53 (6%)
Yes	**3,195 (94%)**	870 (95%)	1,476 (95%)	844 (92%)
Don't know	**46 (1%)**	13 (1%)	16 (1%)	17 (2%)
Recognize toxic effects	**(n=3,376)**	**(n=916)**	**(n=1,543)**	**(n=912)**
No	**433 (13%)**	103 (11%)	200 (13%)	130 (14%)
Yes	**2,708 (80%)**	745 (81%)	1,256 (81%)	702 (77%)
Don't know	**235 (7%)**	68 (7%)	87 (6%)	80 (9%)
Recognize allergic reactions	**(n=3,391)**	**(n=922)**	**(n=1,551)**	**(n=913)**
No	**197 (6%)**	43 (5%)	98 (6%)	56 (6%)
Yes	**3,119 (92%)**	857 (93%)	1,427 (92%)	830 (91%)
Don't know	**75 (2%)**	22 (2%)	26 (2%)	27 (3%)
Recognize immediate desired effects	**(n=3,373)**	**(n=913)**	**(n=1,544)**	**(n=911)**
No	**316 (9%)**	74 (8%)	142 (9%)	100 (11%)
Yes	**2,862 (85%)**	789 (86%)	1,323 (86%)	745 (82%)
Don't know	**195 (6%)**	50 (5%)	79 (5%)	66 (7%)
Recognize unusual and unexpected effects	**(n=3,381)**	**(n=916)**	**(n=1,545)**	**(n=915)**
No	**233 (7%)**	47 (5%)	110 (7%)	76 (8%)
Yes	**3,027 (90%)**	832 (91%)	1,392 (90%)	798 (87%)
Don't know	**121 (4%)**	37 (4%)	43 (3%)	41 (4%)

Table 51b. Expected to Perform Specific Tasks/Activities by Regulatory Agency				
	Overall	**BON**	**Other State Agency**	**Combination**
Recognize changes in client's condition that contraindicates continued administration of the medication	**(n=3,377)**	**(n=914)**	**(n=1,546)**	**(n=912)**
No	**367 (11%)**	78 (9%)	178 (12%)	110 (12%)
Yes	**2,731 (81%)**	762 (83%)	1,263 (82%)	702 (77%)
Don't know	**279 (8%)**	74 (8%)	105 (7%)	100 (11%)
Anticipate effects which may rapidly endanger a client's life or well-being and making judgments and decisions concerning actions to take	**(n=3,363)**	**(n=912)**	**(n=1,540)**	**(n=906)**
No	**1,303 (39%)**	311 (34%)	685 (44%)	305 (34%)
Yes	**1,711 (51%)**	502 (55%)	713 (46%)	493 (54%)
Don't know	**349 (10%)**	99 (11%)	142 (9%)	108 (12%)
Review the patient's plan-of-care	**(n=3,386)**	**(n=919)**	**(n=1,550)**	**(n=912)**
No	**1,131 (33%)**	229 (25%)	627 (40%)	272 (30%)
Yes	**2,076 (61%)**	643 (70%)	856 (55%)	575 (63%)
Don't know	**179 (5%)**	47 (5%)	67 (4%)	65 (7%)
Collect and document patient conditions	**(n=3,384)**	**(n=918)**	**(n=1,546)**	**(n=915)**
No	**1,106 (33%)**	213 (23%)	674 (44%)	217 (24%)
Yes	**2,134 (63%)**	666 (73%)	809 (52%)	656 (72%)
Don't know	**144 (4%)**	39 (4%)	63 (4%)	42 (5%)

Table 52a. Licensed Nurse Assesses a Patient within 30 Minutes Before MA Administers Patient's Medication by Work Setting					
	Overall (n=3,384)	**Assisted Living (n=1,093)**	**Nursing Home (n=1,324)**	**Other long-term care (n=544)**	**Other (n=423)**
Never	**1,130 (33%)**	442 (40%)	271 (20%)	277 (51%)	140 (33%)
Sometimes, but not consistently	**1,011 (30%)**	290 (27%)	456 (34%)	123 (23%)	142 (34%)
All the time	**250 (7%)**	55 (5%)	130 (10%)	21 (4%)	44 (10%)
For certain medications only	**993 (29%)**	306 (28%)	467 (35%)	123 (23%)	97 (23%)

Table 52b. Licensed Nurse Assesses a Patient within 30 Minutes Before MA Administers Patient's Medication by Regulatory Agency				
	Overall (n=3,384)	**BON (n=902)**	**Other State Agency (n=1,568)**	**Combination (n=909)**
Never	**1,130 (33%)**	318 (35%)	388 (25%)	422 (46%)
Sometimes, but not consistently	**1,011 (30%)**	259 (29%)	505 (32%)	246 (27%)
All the time	**250 (7%)**	53 (6%)	155 (10%)	42 (5%)
For certain medications only	**993 (29%)**	272 (30%)	520 (33%)	199 (22%)

Table 53a. Licensed Nurse Assesses Patient within 30 Minutes After MA Administers Patient's Medication by Work Setting

	Overall (n=3,378)	Assisted Living (n=1,089)	Nursing Home (n=1,324)	Other Long-term Care (n=543)	Other (n=422)
Never	**1,125 (33%)**	439 (40%)	261 (20%)	284 (52%)	141 (33%)
Sometimes, but not consistently	**1,016 (30%)**	299 (27%)	458 (35%)	118 (22%)	141 (33%)
All the time	**224 (7%)**	48 (4%)	128 (10%)	15 (3%)	33 (8%)
For certain medications only	**1,013 (30%)**	303 (28%)	477 (36%)	126 (23%)	107 (25%)

Table 53b. Licensed Nurse Assesses Patient within 30 Minutes After MA Administers Patient's Medication by Regulatory Agency

	Overall (n=3,378)	BON (n=900)	Other State Agency (n=1,564)	Combination (n=909)
Never	**1,125 (33%)**	327 (36%)	370 (24%)	425 (47%)
Sometimes, but not consistently	**1,016 (30%)**	266 (30%)	508 (32%)	241 (27%)
All the time	**224 (7%)**	258 (29%)	141 (9%)	34 (4%)
For certain medications only	**1,013 (30%)**	258 (29%)	545 (35%)	209 (23%)

DISCUSSION

Implications and Conclusions

The MA role was designed to administer certain categories of drugs via specific routes authorized by state law and delegated to them by an RN (or LPN/VN in accordance with state law). Studies indicate that MAs can perform these responsibilities safely if free from distractions and other responsibilities. The data from the current study implies that a disparity exists between regulation and practice in many nursing homes, long term care and other institutions. MAs reported being required to take on responsibilities beyond their defined role.

These results have implications for regulators, educators, long-term care administrators, nurses that supervise and delegate to MAs, and the MAs themselves. It is the responsibility of all individuals employing and working with MAs to know the state laws and regulations and adhere to them. Regulators are encouraged to educate long-term care administrators about the legal role and responsibilities of MAs. State inspectors from the Centers for Medicare and Medicaid Services (CMS), health departments and/or the Office of the Inspector General should be aware of the data from this study and observe facilities for violations in state regulations regarding MA role and responsibilities.

Many education programs can be more rigorous and provide an increased number of hours of clinical and classroom education. In addition to knowing what they should do, MAs need to know what they should not do. They need to know when to call a nurse and how to refuse when delegated a responsibility beyond their designated legal role. Nurses, when delegating responsibilities to MAs, must know the law, what they are authorized to delegate and provide the appropriate supervision. Long-term administrators should examine the findings reported in this study and determine whether discrepancies between state laws and expectations of medications exist in their institutions. Administrators must be held accountable when there is a lack of adherence to state regulations regarding MAs

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Research suggests that MAs can safely administer medications (Scott-Cawiezell, Pepper, Madsen, Petroski, Vogelsmeier, & Zellmer, 2007). However, strict compliance with state regulations, adequate education, adequate supervision and proper authorized duties need to be in place for the MA role to function safely.

REFERENCES

Arizona State Board of Nursing. (2008). *Report to the legislature: Arizona medication technician pilot project*. Retrieved from http://www.azbn.gov/Documents/misc/FINAL%20REPORT%20TO%20THE%20LEGISLATURE.pdf

Hughes, C., Wright, R. M., & Lapane, K. L. (2006). Use of medication technicians in US nursing homes: Part of the problem or part of the solution? *Journal of the American Medical Directors Association*, 7, 294-304. doi: 10.1016/j.jamda.2005.11.011

Kenward, K., & Zhong, E. (2006). *Transition to Practice: Newly Licensed Registered Nurse (RN) and Licensed Practical/Vocation Nurse (LPN/VN) Activities*. Chicago: NCSBN.

Mitty, E. (2009). Medication management in assisted living: A national survey of policies and practices. *Journal of the American Medical Directors Association, 10*, 107-114. doi: 10.1016/j.jamda.2008.08.006

NCSBN. (2007a). *Medication assistant-certified model curriculum*. Retrieved from https://www.ncsbn.org/07_Final_MAC.pdf

NCSBN. (2007b). *Report of findings from the 2006 job analysis of medication assistants* (Vol. 27). Chicago: Author.

NCSBN. (2006a). *A national survey on elements of nursing education* (Vol. 24). Chicago: NCSBN.

NCSBN. (2006b). *Report of findings from the practice and professional issues survey; transition to practice: Newly licensed registered nurse (RN) and licensed practical/vocational nurse (LPN/VN) activities*. Chicago: NCSBN.

NCSBN. (1997). *Delegation decision-making grid*. Retrieved from https://www.ncsbn.org/delegationgrid.pdf

Reinhard, S. C., Young, H. M., Kane, R. A., & Quinn, W. V. (2006). Nurse delegation of medication administration for older adults in assisted living. *Nursing Outlook, 54*, 74-80.

Reinhard, S. C., Young, H., Kane, R. A., & Quinn, W. V. (2003). *Nurse delegation of medication administration for elders in assisted living*. New Brunswick, NJ: Rutgers Center for State Health Policy. Retrieved from http://www.cshp.rutgers.edu/PDF/Nurse%20Delegation%20of%20Med%20Admin%20for%20Elders%20in%20AL.pdf

Scott-Cawiezell, J., Pepper, G., Madsen, R., Petroski, G., Vogelsmeier, A., & Zellmer, D. (2007). Nursing home error and level of staff credentials. *Clinical Nursing Research, 16*, 72-78. doi: 10.1177/1054773806295241

Scott-Cawiezell, J., Madsen, R. W., Pepper, G. A., Vogelsmeier, A., Petroski, G., & Zellmer, D. (2009). Medication safety teams' guided implementation of electronic medication administration records in five nursing homes. *The Joint Commission Journal on Quality and Patient Safety, 35*, 29-35. doi: 10.1197/jamia.M2378

Spector, N. & Doherty, M. (2007). Development of a standardized medication assistant curriculum. *JONA's Healthcare Law, Ethics, and Regulation, 9*, 119-124. doi: 10.1097/01.NHL.0000300770.58627.01

Vogelsmeier, A., Scott-Cawiezell, J., & Zellmer, D. (2007). Barriers to safe medication administration in the nursing home: Exploring staff perceptions and concerns about the medication use process. *Journal of Gerontological Nursing, 33*, 5-12.

Walker, M. J. (2008). Effects of the medication nursing assistant role on nurse job satisfaction and stress in long-term care. *Nursing Administration Quarterly, 32*, 296-300.

Young, H. M., Gray , S. L., McCormick, W. C., Sikma, S. K., Reinhard, S., Johnson, T. L., Christlieb, C., & Allen, T. (2008). Types, prevalence, and potential clinical significance of medication administration errors in assisted living. *Journal of the American Geriatrics Society, 56*, 1199-1205. doi: 10.1111/j.1532-5415.2008.01754.x

Young, H. M., Sikma, S. K., Eyres, S. J., Ward, D. H., Strong, B., Bond, G., Shull, Y., & Mathison, D. (1998). *Nurse delegation study: Final research report*. Olympia, Washington: Washington State Department of Health, Heath Services Quality Assurance. Retrieved from http://www.doh.wa.gov/hsqa/uwstudy.doc

APPENDIX A

Additional Comments/Letters from Respondent Medication Aides

Comments were edited to ensure readability.

Participant 1

Medication Aide role is not an easy job. It's a stressful job with a big responsibility that needs understanding, fast and accurate, quick (not legible) to finish on time, sharp mind or alert (not legible) to miss any (not legible) pill, patient or make a med error.

For me training and education is very important because this will help a lot to do the job safe and effective. Some Med Aide are only HS graduates, not enough knowledge to understand what they are doing, just to finish their time, passing meds with a lot of med errors. At least 2 years college level of education to be responsible and matured person to do the job and to know there rights and limitation as a medication aide role.

I cannot imagine myself ended up as a med aide because I retired in the teaching profession for 28 years. Our (not legible) job is different. But my background helped me a lot to do my job well. I find this job more stressful when from the CNA, therapist, and all the nurses giving me an order left and right, like certain patient giving a pain pill while I'm passing meds with a lot of patients I feel exhausted, a public servant and sometimes it touch my ego. But then at the end it challenged my abilities to do the job until I developed my own system to execute my job well. I worked in a Health Care, where most of the patients are sick or just got from the hospital and stay there too for rehabilitation. These patients have a lot of medicines with a lot of changes. Patients here are come and go not like in an assisted living the patients are almost permanent.

What can you say, about (not legible) of the med aides are facility that allow them to work 2 full time job from 6 am to 2 pm and will rush going to other facility from 2:30 to 10 pm and the next morning. Also some, doing 2 straight days like sat and sun and (not legible) of the day. Do you think they don't do a lot of med errors or their brain doesn't get tired and still awake and alert and know what they are doing? This is the situation that you should give time and (not legible) if this is safe or effective if you're not a med aide (not legible) you didn't do the job, you don't know what's going on in the cart, of the right meds or dose are given or the (not legible), meds are dispensed or not or if the meds are available or not. If it's a CNA job, you can do a 24 hour job but for Med Aide, it's your brain that's doing most of the working.

Participant 2

I have a comment to make I believe the medication aide should be paid more than what they are here in the state of Texas we have too much work to do to not get paid for what we do we are not recognized nor are we appreciated for what we do I make $12.50 I should be making $19-$20 at least.

Participant 3

Thank you for contacting me to help with the survey for insights into the Medication Aide role. I am a graduate of the Certified Medical Assistant program (AAMA) and comply with all the requirements of my state and facility I work in. I am a true believer of working within my scope of practice and feel that all medical staff should do the same.

When answering these questions, I answered them according to what duties I am required to do. I may be allowed to perform some of the duties, but it is not a duty that our clinic provides, therefore I checked "no." Possibly another category on the form could have us check if our employment performs such.

I do feel that many of the CNA's that are working in the clinics are allowed to be very liberal in what they are allowed to do. It is difficult when a CMA/RMA witnesses the duties that a CNA does (in some medial areas) with only about a 2 week training period. As a CMA/RMA, we are not allowed here in most of our positions, to supervise a CNA or even the Certified Medication Aides. There are more and more CNA/CMAs taking over the positions in the clinics where Certified Medical Assistants and RMAs

have been working. Makes us feel sad to see this, that a healthy education is no longer needed to do this duty. There are many very good CNA/CMAs, but we find that they do not have the background that we have and take chances and do not always work within their scope of practice.

I am very happy that the duties are being reviewed to better the safety of our patients and our employment. It would be interesting to see the final results of this survey.

Participant 4

I had done the CNA course 12 weeks, 80 hours classroom and 40 hours clinical and worked 6 months – private duty – certified before taking the license exam. This made me understand the course and the path I have chosen better.

I went through the challenges of health care, for example, symptoms and reactions of some medications. My first client was on Hospice care. She had a decubitus ulcer, so I learned how to clean and dress wound. Monitoring her reactions on some of her medication I described to the nurse, it was discontinued. I successfully treated the wound till it healed completely, this inspired me to do the medication aide course.

I took a 40 hour classroom lesson for a certificate before I got a job with an assisted living facility, as a med tech. Before starting with medication, I was again trained, a 32 hour period. 24 hours classroom and 8 hours clinical all with an RN supervision – in fact, that was basically on the job training which was very beneficial, this equipped me very well for the job. So to say I had 72 hours training. This gave me the confidence and experience for minimal supervision on the job I do with passion.

With my experience I will say it is best to do the CNA course and have 6 month to 1 year on the job training before the medication aide program which would expose any candidate for the expectation on the job and the class could be 72 hours – 40 hours and 32 clinical – 2 weeks.

To those who want to do the Medication Aide direct must go through the CNA class work and continue with the medication. A total of 14 weeks – 120 hours classroom and 72 hours clinical.

We did 8 hours refresher courses every year, to review some medications.

Participant 5

May I use this opportunity to ask why a medication aide that had been in the system for more than 6 to 7 years and above can not allowed to have a bridge to LVN we are on more advantage to the course than other people that just go straight to the program? Secondly nobody recognized our experience as a medication aide, they pay experience and non-experienced the same pay which makes us not to boost or be proud of being medication aide. I quite understood that the reason why nobody recognized our experience in the system is that, on our certificate which we renew every year would only bears the awarded date (eg., 9/10/2010), expiration date 09/06/2011, based on the above dates, can you tell how many years I had been in the system? So to my own suggestion, I would have suggested that the awarded dated should be written the first year you was issued/obtain the certificate so that when you present it even a lay man can be able to know how long you have been a medication aide/in the system. We need to be upgrade in this field. I hope this would help you in your survey.

Participant 6

Interesting set of questions but more important questions need to be asked of med aides concerning common decency. Such as 1) if other med aides are illegally drawing insulin to a syringe for a diabetic patient are they turned into the state, the police called and fired with their med aide license revoked or because unethical med aides who draw insulin in syringes for diabetic patients (instead of having a licensed nurse do this which is the only way to have insulin in Kansas drawn) med aides also party with the nurses and director so they are allowed to just leave "without incident and reporting" without the State Nursing Board being aware any illegal activity happened and proceed to nursing school, become a nurse and soon are arrested by federal marshals for medicare fraud & conspiracy to distribute Oxycodone and Oxycotin.

Information removed to ensure anonymity…

The oldest of the 3 was one of those med aides drawing insulin into a syringe to hand to an elderly resident she didn't like. She had her other 4 friend med aides doing it as well. (Summer 2006 this happened). Her scam was to suck up to nurses and the director and she could get out of anything (hopefully now she is headed to a federal prison).

My point in all this is your survey discusses skill with education yet cheats and liars and criminals go to prison who are all skilled and knowledgeable. Ethical compassion and law abiding people make good med aides. Training comes on the job over time. Please focus your attention to ethics.

Participant 7

I wasn't aware when at I first started that I was given 3 to 4 job descriptions, one being a CNA/Medication Aide. I give medicine to 32 residents, patient care, take residents to the beauty shop, doctor appointment and church on Sunday pick them up and bring them back to the floor. Break down dining room, and set up for every meals, serve food, do MAR's for the month, wash clothes, change bed linens, answer the phone at the nurse station and keep resident from wandering off the floor. I feel medication aide should be focus on medicine only and not having so many job tasks at once; without interruption.

Participant 8

Thanks for this survey. I will like the Board (NCSBN) to improve QMA rates we are underpaid we need to be paid more so that we can provide for our family. Also as a QMA we need to work more as a QMA to work more as a QMA not as CNAs. Thanks a lot.

Participant 9

I would like to thank you for the opportunity to participate in this survey. Some of the questions are very difficult to answer in the manner given being that in some instances they may require one answer and at the same time, they may require another. For example:

Question 18: the amount of clinical hours required for my medication aide training was 5 days at 8 hrs per day=40 hrs. The clinical part was only to observe the instructor administer medication, demonstrate the three checks, and pass the written test. I answered "0" for clinical hours because the clinical time was not near an hour.

Question 21-24: I must say that I was very satisfied with MY training because I had been in the long term care environment since 1986 as a nurse assistant and became state certified in 1993. I had had medication education for group homes and in-home care so I was no stranger to the process of administering medication. The reason that I stated that the medication Aide training needs to be more challenging is because many medication aides do not have enough experience and are not rained enough clinically before they are placed on the floor to work. Many cannot handle the fact that in most assisted living facilities, you are still expected to pass medication, do patient care, and all of the other documentation that everyone else has to do. In a nursing home, medication aides should understand that the med passes are constant but at least they are under the leadership of the nurse on their unit.

Questions 26-30: Since my last job administering medication was in an assisted living facility, I answered by questions accordingly. In an assisted living facility on the night shift (11-7); there are no nurses. There is no supervision except for the SIC (supervisor in charge) which is also a medication technician. Our nurse gets angry if she is disturbed at night. It is easier to call the executive director than it is to call our nurse. Judgment-calls are hard to make sometimes. In the cases of emergency, we use a quote that helps us to decide what to do. "When in doubt, send them out." Well, this makes the hospital staff angry that so many people to the emergency department for what they call "nothing". Emergency medical technicians argue with med techs about whether or not the residents need to go to the hospital. One hospital sent one of our dementia residents back to the facility by taxi cab and the cab driver just dropped her off at the front door. Thank God she came inside of the building on her own. About 30 minutes later, a nurse called from the emergency room to make sure that the resident had made it back to the facility safely. This could have been tragic. I am sure that this happened

because the emergency room staff is tired of getting patients who are not in an emergency state. Given the responsibility and liability of the med tech in charge (SIC); it was easier to send the resident to the hospital. We got in trouble sometimes when we sent them and we got in trouble sometimes when we didn't.

Family members are another problem for med techs because they are quick to say that we are not nurses and that we don't know what we are talking about or doing. Many of the residents' powers of attorney have demanded that they be contacted before sending the resident to the hospital. One family member wanted the med tech to wait until she arrived at the facility to send her mother out to the hospital. I refused to wait because the woman was very sick. She was admitted and stayed in the hospital for more than a week.

In a nursing facility I have worked directly under the supervisor of an LPN at all times. When I first began as the first medication aide that the facility ever had, several nurses quit their job because they felt that working with a medication aide was too much of a liability for them in regard to their licenses. Most of the LPNs' treat medication aides very badly. On the other hand, I have grown close to some nurses who at one point in the nursing facility would fight over me for the medication aide on their unit. I love the job.

In assisted living facilities I am constantly made to feel incompetent by executive staff, residents' family members, 911 emergency technicians, and my LPN. Yet, I can work 40-80 hours per week because there is a need. They pay less because they say it does not carry the burden of working in a nursing home. It's worse. The stress is worse, the burden is worse, the management staff is worse. Appreciation is unheard of.

In a nursing facility, I feel more confident and secure because I know that someone can help me if I need it. The pay is better. The atmosphere is better. The work is a little harder, but that's okay.

The reason that I have been a nurse assistant since 1986 - state certified since 1993, and a state certified medication aide since 2007 is because I love what I do.

Participant 10

I opted out of the survey at this time due to I am not presently working at a facility that uses medication techs, aides, etc). I did not see questions regarding to past experiences.

I have worked as a medication technician and I can tell you that I will never take another job as a Med Tech that endangers that life of others and threatens my CNA I – CNA II and med tech/aide certifications. Most med tech are competent to do the duties but the problem I the ratio of residents, patients, clients, that are given as a responsibility. I worked at a facility for 4 plus years and my title Med Tech Supervisor for a building with 70+ residents, "no nurse to call", meds to pass out, patient care, and supervise others. That was the assignment basically the whole building. I work in a hospital setting where nurses complain if they have 6 patients. Under the following circumstances most medication technicians can't go home at shift because other med tech quit, call in especially after they get burnt out form the Alzheimer unit 70+ residents and if takes 3 hours to pass medications. Someone needs to take a look at the WHOLE picture we med tech/CNAs are very capable of the job. We are being put in unfair job situations with too many distractions to even pass medications and in most cases have too much to do. I won't even discuss the $9-13 an hour for such a great job responsibility. Thank you!

Participant 11

I have not answered your survey because I no longer work as a medication aide. If I would describe my experience in one word, it would be "disaster".

I worked in the assisted living area of a nursing home for several years and gave residents their medication from a med cart so I was familiar with what med aides did.

The nursing home promoted the med aide class and hired five of its STNAs who had completed the course. Two aides were discharged for absenteeism and another quit the facility. The fourth aide demanded to be removed the job and return to working as a STNA. I was removed without explanation (because they don't have to explain), and was

reassigned to work as an STNA. Eventually I was able to return to assisted living.

Taking that class was a complete waste of time and money. I feel the DoN set us up to fail. The job was structured so that a med aide would spend the first 5 hours working as a STNA and then start to med pass. The job requirement was to give 194 pills to 22 residents and do 3 blood pressure checks within 1.5 hours. Some residents were not cooperative, not cognizant, or could only take their medication slowly or after pills were crushed.

The med cart had a compartment for each resident. The typical resident had 16 bubble packs of pills jammed into each compartment. Some residents had as many as 24 bubble packs. One compartment contained a large number of tubes of various ointments for residents on the hall, all piled together. They had to be sorted through to find the resident's tube. For liquid medication, the bottles were stocked in the same way that tubes were stocked. When medication was dispensed, all of the bubble packs for that resident were removed from their compartment and spread on top of the med cart. The computer screen did not show all of the meds to be selected for that resident at that hour so from the medications listed on the screen, it was necessary to try to find the bubble packs needed from the bunch that were spread out on the cart. The aide then had to scroll down often several times to find all the medications needed. This took time.

After completing the med pass for the hall the med aide then went to a second hall and had to pass a smaller number medications and do three blood pressure checks within 1 hour to the same number of residents. The pace was just frantic. The last ½ hour was spent restocking the med cart.

After spending 3 days on the job the DoN called me into her office and in the presence of the HR representative demanded that I guarantee I would pass medication on time or I would be removed from the job. I knew that I had worked as fast as I could so I didn't give that guarantee. I was allowed to pass meds for a short time after that.

The nursing home returned to its practice of allowing LPN's an entire shift to pass meds.

When I worked as a med aid I found the nurses to be openly hostile. They saw the med aide as a threat to their job security. The nurses would often complete the med pass before I had a chance to start the job. Nurses would tell me they didn't want to have to come back and give narcotics and injections that I was not allowed to give. I feel that other nurses didn't want to associate with STNAs who had taken a 5 week class and now were performing their routines.

I am glad those days are behind me.

Participant 12

Thank you for your survey on Medication Aides. The only problem with passing medication that should be stop is doing CNA work and passing medication too. If this stops it would cut down on a lot of medication error. If a Med Tech is passing medication that's what she should be doing only one or the other. Another thing we as medication aides do the same work as LPN and get paid a lot less for the work, not FAIR. I worked as a 11-7 supervisor for 8 years on a job had the same responsibility as a LPN. It should be that we as medication aide should be able to work in hospital, nursing home, etc with a licensed and more training. Please write with your input on this. Thanks.

Participant 13

I have been working as a CNA for the past 6 months for which I was told I would be working as a CMA when I was hired. Soon after I was hired, my employer or DON decided not to hire or use CMA any longer. I have been a CMA since 2007 when I took the class again. I let too many years lapse since I took the class in the early 1980's. I feel I worked really hard both times when I took the classes that I should be able to be a CMA. I have been back to school to become a LPN or RN. But the funds are not there. (I did go to school in 2008-2009 year). I had the best intention too. I love working with people. It is a promise to my mom that I would to nursing school. I will keep trying till the day I die. My mom was in nursing for many years. My sister is an RN now and also on the State Board of Nursing. I'm so proud of the little sister. She is the DON now at the facility she works at. She has been the DON since 1994.

Well anyway! I think CMA are a very important part of the medical field I just want to be a part of it. P.S. want to be CMA in Kansas.

Participant 14

I would feel more confident in my medication aide responsibilities if the training was more in-depth and overqualified me for my current job description.

Participant 15

When a nurse does something wrong in administering meds she doesn't get in trouble, but I sure do. Just because a person is elderly, doesn't mean you ignore them or let them get worse/almost die, before the family or doctor is called. Recognize immediate desired effects? Recognize side effects? Yes, but don't' always know what they are.

Participant 16

This is why I feel so strongly that CNAs and sometimes even licensed personal care workers are permitted/allowed to set up and administer medications to residents at assisted living homes, and group homes with a mere 6 – 8 hours of training!! – How can that be safe – or even legal??

I love my job and am very vigilant about being "on top of my game." I stay up to date on all new medications, etc. One of the biggest complaints I have about my job is the lack of proper compensation for the amount of responsibility I and the other 2 current Med Aides at our facility are. We are CNAs 1st (but do not work in that capacity anymore d/t the need for us to be full-time Med Aides). So we get CNA pay with only $1.25/hr additional compensation for the additional responsibility of being a Certified Medication Aide! We are currently in a union and are told the union cannot reclassify us because they do not have enough other CMAs in other countries of our state (WI) to compare/contrast wages with. The employer says it's a union issue and their hand are tied and yet they created theses positions and decided we would get $1.25 over our CNA base pay nearly 7 years ago and it has never changed. (I make $12.89/hour plus 1.25=$14.14 hour) ☹.

That is a very low wage for our duties, expectations, and responsibilities we have and to know that a serious med error could cost me my job and probably end my career for good is a bit unnerving. But I find my job rewarding in the sense that my resident's in our long-term care facility trust in me because they know I take my responsibilities very seriously. Will we be seeing more CMAs in near future to reduce the workload of the nurses? I sure hope so – then maybe our pay will go up as does the need for medication aides! Thank you.

We Need to Be Valued More!

Participant 17

No Assisted Living facility should be without 24 hour LPN. I experienced that unbelievable what Med Aides have on their shoulders. Luckily I am experienced. I truly hope this is important they shouldn't let just anyone be a CNA or Med Aide – or LPN.

Participant 18

I think we should be allowed to administer medication at meal times because it is better for residents to have food with medicine and because of time constraints when trying to pass medications to several people at the same prescribed times.

Participant 19

Note: too many med techs cheat by prepouring or document meds as having been given, that were not. I am extremely disappointed about:

- Low pay for this job with such heavy responsibility.
- Bad med techs continuing to work with impunity because "it's too hard to find a replacement. Jeopardizing resident welfare.
- Med Techs being suddenly given many extra direct-care duties on top of our med tech duties.
- Med Techs slowed down by lazy CNAs
- Staff asking me to give them meds off the med cart for their own use.
- CNAs asking me to drug a non compliance resident who could be calmed with non-pharmacologic measures if the CNA wasn't too lazy and impatient.

- Lazy and impatient CNAs upset my residents who then refuse medication.
- Lazy med techs who don't restock the cart
- Nurses who objectify residents
- CNAs who abuse residents.
- Too heavy of a patient load for our med pass in too short of an amount of time=too many med errors.

I'm sorry to say that I have left the field due to the following stressors:

- My license being jeopardized by the misdeeds of other med techs.
- A crushing patient load that other med techs manage to complete in two hours by cutting corners. EX:
    - Prepouring meds.
    - Documenting meds as administered when they were not.
    - Skipping eye drops, ear drops and nasal sprays but documenting it as done.
    - Skipping the three attempts fifteen mins apart for a refusal. Skipping two attempts after a refusal.
    - Documenting a refusal because it's easier and the patient was likely to give a refusal anyway and this saves time.
    - Way, way, way too much chemical restraint and I was reprimanded for NOT drugging the resident into a more compliant state for staff convenience.
    - 2 witnessed residents being drugged into compliance for staff convenience far too often, several times a week. Chemical restraint was ignored by the nurses since it made the residents more compliant and saved time.
    - The two hour time limit was sometimes impossible to meet and the nurses looked the other way when med techs cut corners to be able to complete a med pass in the required two hours.
    - Hand washing was NEVER done often enough. I even fell into this bad habit when I was a med tech.
    - Too many med techs "saved time" by leaving a CNA to administer topical treatments or a cup of crushed meds, and they rushed to the next resident so as to be able to complete the round in two hours.
    - Resident safety and welfare would be better served if:
- Med techs had a reasonable patient load to complete in 2 hours. If the pay was high enough to prevent rapid turnover that confuses the residents, if Med techs were not forced to do CNA duties on top of their own duties, if nurses were stricter about lazy CNAs and unscrupulous med techs, and med techs had more extensive training since their responsibilities are so great.

Participant 20

You left out the most important data. I have had up to 84 patients in 1 shift. How do you expect us to medicate this many people twice and some times more in a shift, and stay within the parameter of (not legible) AND the law yet take proper care of the residents?

The amount of residents needs to be regulated. Until you do that, all of the above questions don't matter.

Participant 21

The requirements of current med aides in our company has dramatically changed in the last few months due to a state, disorganized, facility, that was blatantly negligent. Now all must pay for a few critical mistakes that we/or many companies were not responsible for. Not Fair! It's gone way over board for administering a simple Tylenol to a client when they are cognizant and intelligent enough to recognize they have a headache. How we have to call a RN. Big Waste of Time. I can go on and on.

Participant 22

I was in one of the first medication assistant programs in our state. It was very intense and now the program is very short and in my opinion too short and the teacher only comes to facility 1 – 2 days for clinical.

Participant 23

Just to note the nurse's I have had working over me in assisted living have been great and wonderful. They check with residents within 5 to 15 minutes if they have changed conditions or I need assistance right away. Example: Resident falls misses come to assist ASAP!!

Participant 24

I love being a CMA but feel 7 hours a day with no report to on coming CMA is dangerous. Errors have been made because of this lack of report between shifts. Also, we are not paid enough to take on so much responsibility.

Participant 25

I think QMAs should be allowed to do more vital procedures. Training should be different every year not the once boring stuff every year. At my facility we have been stripped down to only passing meds and doing treatment.

Participant 26

I wish they could teach Med Aides to do insulin, feeding pumps and finger sticks and get paid more. Med Aides are just as good as nurses, they know more about medication than some nurses.

Participant 27

Questions 55-A+B: The first dose of a new medication can be given when the medication is preapproved by way of doctors script, medications added and approved by the RN onto the MAR. This question as it was written in this hand out is too vague without adequate explanation to correctly answer this question. First dosage may NOT be administered when NOT approved by RN. First dosage may be administered when approved by RN.

Question 57 (v+w): Crush orders must be obtained by way of written script from doctor. However, certain medication regardless of crush order may not be crushed. Regardless if a crush order is or is not approved by RN or doctor.

Participant 28

I think that med aides could and should be able to do more as long as they are trained properly. I know this is hard for RNs/LPNs to understand but we are there to help them. If they will help train (not legible) with our meds the more we will be able to help the patients. Recovery and their jobs. RNs do a lot of paper work so it's hard for them to give meds and assume patients by a certain time. Therefore we could take a lot off of their work duties if they will help teach us and be willing to help us know what to look for. We are there eyes.

Participant 29

The medication aide work is as important as the LVNs and requires a great effort but, the salaries are far below than LVNs. I believe something should be done to upgrade Medication Aide salaries.

Participant 30

Where I work, we don't have med-aides anymore, so I'm back doing CNA work.

I don't think the nurses have time enough to administer medication and everything else they have to do accurately. I have noticed and recorded many med errors recently.

Participant 31

Too much false documentation going on.

Participant 32

Med Aide make nursing assessment and act on it all the time. Med Aide do not get enough training. But nursing homes don't play by the rules. Med errors are covered up all the time.

Participant 33

I think that there should be more control over the nurses, some med aides do things they should not

out of fear of the nurses or the fear of not having a job. Example:

- Pre-punch meds for the nurses pass and placing them in the drawer.
- Checking sugar and measuring shots for nurses.
- Setting up feeding bottles.
- Giving medication that nurses mix together without a doctor's order.
- Giving PRN meds just so patient will go to sleep.

Participant 34

In regards to your survey on Medication Aides: I did receive the survey yet did not complete it and I would like to explain why. I am a certified Medication Aide in the state of North Carolina however I choose to not work as a medication aide. I made this choice because I have severe problems with the role med aides are given in facilities in this state. In my experience med aides are treated as de facto nurses in many, many facilities and given assignments such as supervising other CNAs, receiving new admissions, making patient assessments and deciding if someone should or should not go to a hospital. In my opinion these tasks are way beyond the scope of practice of a CNA and in North Carolina a med aide is nothing more than a CNA who has taken an additional 24 hour class. In my opinion some of the tasks that facilities expect a med aide to do border on being illegal and I am extremely uncomfortable being responsible for tasks that are way beyond my training and ability. I have often seen med aides working with absolutely no input or supervision from any RN, especially at nights and on weekends.

Based on what I have seen for myself in facilities it is my opinion that the role of medication aides should be carefully limited and the amount of training and continuing education requirements increased dramatically.

Thank you for allowing me to express my opinion on this topic.

Participant 35

I just completed your survey and it seems to be lacking the most important item. Until you regulate the maximum amount of residents a med aid can be assigned, everything else is moot. I work agency, and was set to a place in West Lynn. I had over 80 patients. I don't know of any nurse or med aid that can medicate that many people in a 2 hour window.

Until you regulate, there will be many, many med errors that just as easily could have been avoided. These errors aren't done by sloppy inattentive, lackadaisical CMAs. They are done by people who care and have dedicated themselves to taking care of the elderly. I, and all of my peers believe regulation is long over do.

APPENDIX B

Medication Aide Survey

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277

312.525.3600
www.ncsbn.org

January 2011

Dear Sir or Madam:

The National Council of State Boards of Nursing (NCSBN) is conducting a survey that is designed to provide insights into the Medication Aide role (also referred to as Medication Assistants, Medication Technicians, Unlicensed Assistive Personnel, Medication Administrative Person, etc.).

The Medication Aide role is a critical part of today's health care team. As a part of a very select group of Medication Aides throughout the United States, we are asking you to complete the enclosed survey. There is minimal risk of participation, and you will not be compensated for your time. However, by participating you will be providing very valuable information that will help regulators improve your work environment, and develop safe and effective Medication Aide roles.

The main objective and purpose of the study will be to obtain information on the following topics: (1) Medication Aide training & education; (2) supervision of Medication Aides; (3) communication; (4) Medication Aide's authorized duties, by state; and (5) medication administration by Medication Aides. The data obtained from the surveys will provide a snapshot of the Medication Aide role as they vary from state-to-state, and results will help regulators make decisions about the implementation or development of safe and effective Medication Aide programs.

Your decision to participate is voluntary, and should take about 30 minutes to complete. ***All responses will be kept confidential and data will only be reported in the aggregate.*** The identification number printed on the survey will only be used to record that it has been returned. This helps to prevent unnecessary and expensive duplicate mailings to those selected to participate in the study.

If you would not like to participate please check the "opt out" box below and return this letter and blank survey using the enclosed postage-paid envelope.

❑ Opt out

If you would like more information, please contact me at jbudden@ncsbn.org or 312.525.3658.

Please return the survey by mid-February using the enclosed postage-paid envelope.

Sincerely,

Jill Budden, PhD
NCSBN Research Associate

Instructions

This survey contains six sections: (1) demographics & work setting, (2) training & education, (3) supervision, (4) communication, (5) authorized duties, and (6) medication administration. You will notice that many questions ask you to report what you do during a typical week or typical shift. If you have multiple roles (e.g., CNA), please respond for your Medication Aide role only – *(also referred to as Medication Assistants, Medication Technicians, Unlicensed Assistive Personnel, Medication Administrative Person, etc.).*

All of your responses to this survey will be kept completely confidential. No individual data will be reported. Data will only be presented by aggregating all participants' responses. Please respond accurately and honestly. ***Thank you!***

Demographics & Work Setting

1. What is your birth date? M M D D Y Y Y Y

2. What is your gender? ***(check one)***

❑ Female ❑ Male

3. What best describes your racial/ethnic background?
*(check **only one** answer)*

❑ Pacific Islander
❑ Asian Indian
❑ Asian Other
❑ Native American or Alaskan Native
❑ Black or African American
❑ Hispanic
❑ White
❑ Other, *please specify* _____

4. When employed, what state/territory do you primarily work?
*(check **only one** answer)*

❑ AK	❑ HI	❑ MI	❑ NV	❑ UT
❑ AL	❑ IA	❑ MN	❑ NY	❑ VA
❑ AR	❑ ID	❑ MO	❑ OH	❑ VT
❑ AZ	❑ IL	❑ MS	❑ OK	❑ WA
❑ CA	❑ IN	❑ MT	❑ OR	❑ WI
❑ CO	❑ KS	❑ NC	❑ PA	❑ WV
❑ CT	❑ KY	❑ ND	❑ RI	❑ WY
❑ DC	❑ LA	❑ NE	❑ SC	
❑ DE	❑ MA	❑ NH	❑ SD	
❑ FL	❑ MD	❑ NJ	❑ TN	
❑ GA	❑ ME	❑ NM	❑ TX	

5. What is your primary employment title?
*(check **only one** answer)*

❑ Medication Aide
❑ Medication Assistant
❑ Medication Administrative Person
❑ Medication Technician
❑ Unlicensed Assistive Person
❑ Other, *please specify* _____

6. How long have you worked as a Medication Aide? (also referred to as Medication Assistants, Medication Technicians, Unlicensed Assistive Personnel, or Medication Administrative Person – from here on out referred to as "Medication Aides")
*(please **do not** put ranges)*

_____ # Year(s), and _____ # Month(s)

7. Are you certified or licensed as a Medication Aide?
*(check **only one** answer)*

❑ Certification
❑ License
❑ No certification or license
❑ Not sure

8. (a) Were you required to be a Certified Nursing Assistant (CNA) before becoming a Medication Aide?

❑ Yes ❑ No ***Skip to Question 9***

(b) If yes, please select the approximate amount of work experience you needed as a Certified Nursing Assistant (CNA) before you were able to work as a Medication Aide. *(check **only one**)*

❑ None
❑ 6 months
❑ 6 months within the last 2 years
❑ 1 year fulltime
❑ 1,000 hours within the last 2 years
❑ 2,000 hours
❑ 2,000 hours within 2 years prior to application
❑ 2,000 hours of direct patient care within the last 3 years
❑ 2 years fulltime
❑ Have been employed as a CNA within the past 5 years, for an equivalent of 2 years fulltime
❑ Other, *please specify:* _____

_____

9. Please indicate whether or not you administer medications to clients in each of the following age groups:

	No	Yes
a. Newborns *(less than 1 month)*	❑	❑
b. Infants/Children *(1 month – 12 years)*	❑	❑
c. Adolescents *(ages 13 – 18)*	❑	❑
d. Young Adults *(ages 19 – 30)*	❑	❑
e. Adults *(31 – 64)*	❑	❑
f. Older Adults *(ages 65 – 85)*	❑	❑

10. (a) On average, how many clients do you administer medications to during a typical shift? *(please **do not** put ranges)*

_____ # of clients

(b) On average, how many *total* types of medications do you administer to all of your clients during a typical shift? *(note: if you administer 2 Tylenol to a client this would be counted as 1, if you administer 2 Tylenol to two clients it would be counted as 2) (please **do not** put ranges)*

_____ # of medications

11. Which of the following best describes the type of facility at which you are primarily employed? *(check **only one** answer)*

❑ Assisted Living *(long-term care)*
❑ Nursing Home *(long-term care)*
❑ Community-based Services *(long-term care)*
❑ Board and Care Homes *(long-term care)*
❑ Home Health *(long-term care)*
❑ Continuing Care Retirement Communities *(long-term care)*
❑ Housing for Aging and Disabled Individuals *(long-term care)*
❑ Adult Day Care
❑ Group Home
❑ Hospice
❑ Hospital
❑ Rehabilitation Facility
❑ Residential Care Facility
❑ Intermediate care facility *(for example, developmentally disabled facility)*
❑ Psychiatric or Mental Health Facility
❑ Correctional Facility
❑ Schools
❑ Other, *please specify:* _____

_____

12. How long have you been employed at your facility? *(please **do not** put ranges)*

_____ # Year(s), and _____ # Month(s)

13. How long have you been in your current position at your facility? *(please **do not** put ranges)*

_____ # Year(s), and _____ # Month(s)

14. On average, how many hours do you work during a typical week as a Medication Aide? *(please **do not** put ranges)*

_____ # Hour(s)

15. On average, how many hours do you work during a typical shift as a Medication Aide? *(please **do not** put ranges)*

_____ # Hour(s)

16. Which of the following best describes your work shift? *(check **only one** answer)*

❑ Day (7am – 3pm)
❑ Day (9am – 5pm)
❑ Day (12 hour shift)
❑ Evening (3pm – 11pm)
❑ Night (11pm – 7am)
❑ Night (12 hour shift)
❑ Rotating
❑ Other, *please specify:*

_____

Over ▶

Training & Education

17. Where did you obtain your Medication Aide training?

- ❑ No training was required ***Skip to Question 25***
- ❑ Training offered by an employer
- ❑ Training offered by a community or junior college
- ❑ Training offered by technical or vocational school
- ❑ Training received while in the military
- ❑ Training sponsored by a state agency
- ❑ Other, *please specify:* _____

_____

18. Please indicate the number of classroom and clinical hours (clock hours, *not* credit hours) **that were required for your Medication Aide training.** *(please **do not** put ranges)*

_____ # of classroom hours
(write "0" if no classroom hours were required)

_____ # of clinical hours
(write "0" if no clinical hours were required)

19. (a) Did you receive any <u>additional</u> Medication Aide training from your employer?

- ❑ No ***Skip to Question 20***
- ❑ Yes

(b) Please indicate the number of additional **hours of Medication Aide training you received from your employer.** *(please **do not** put ranges)*

_____ # of hours

20. (a) During your Medication Aide training, was nurse delegation covered? *("nurse delegation" is when the licensed nurse transfers selected nursing tasks to nursing assistants in selected situations. The licensed nurse delegating the task retains the responsibility and accountability for the nursing care of the patient.)*

- ❑ No ***Skip to Question 21***
- ❑ Yes

(b) How adequate or inadequate was your training on nurse delegation?

- ❑ Very Inadequate
- ❑ Inadequate
- ❑ Neither Inadequate nor Adequate
- ❑ Adequate
- ❑ Very Adequate

21. (a) During your Medication Aide training, was nurse supervision covered?

- ❑ No ***Skip to Question 22***
- ❑ Yes

(b) How adequate or inadequate was your training on nurse supervision?

- ❑ Very Inadequate
- ❑ Inadequate
- ❑ Neither Inadequate nor Adequate
- ❑ Adequate
- ❑ Very Adequate

22. (a) In your opinion, to what extent does the Medication Aide training/education need to be more or less challenging?

- ❑ Less challenging training ***Skip to Question 23***
- ❑ Neither more nor less challenging training ***Skip to Question 23***
- ❑ More challenging training
- ❑ Not sure ***Skip to Question 23***

(b) Please indicate if the following aspects of training need to be more challenging or not:

	No, does not need to be more challenging	**Yes, needs to be more challenging**
a. Classroom component	❑	❑
b. Clinical component	❑	❑
c. In-class tests/quizzes	❑	❑
d. Certification exam	❑	❑

❑ Other, *please specify:* _____

_____

23. Did the Medication Aide training/education you received adequately prepare you for your job as a Medication Aide?

- ❑ Not at all
- ❑ To some extent
- ❑ Absolutely

24. Overall, how satisfied or dissatisfied were you with your Medication Aide training?

- ❑ Very Dissatisfied
- ❑ Dissatisfied
- ❑ Neither Dissatisfied nor Satisfied
- ❑ Satisfied
- ❑ Very Satisfied

25. (a) Are you currently enrolled in a formal nursing education program?

- ❑ No ***Skip to Question 26***
- ❑ I have applied but am not currently enrolled ***Skip to Question 26***
- ❑ Yes

25. (b) In which program are you enrolled? *(check **only one** answer)*

- ❑ Licensed Practical/Vocational Nursing (LPN/VN)
- ❑ Registered Nurse (Associate Degree Program)
- ❑ Registered Nurse (Diploma)
- ❑ Registered Nurse (Bachelor's Degree Program)
- ❑ Other, *please specify:* _____

Supervision

26. Please indicate whether or not each of the following individuals supervise you:

	No	Yes
a. RN	❑	❑
b. LPN/VN	❑	❑
c. Pharmacist	❑	❑
d. Advanced Practice Registered Nurse (APRN)	❑	❑

- ❑ No supervision ***Skip to Question 30***
- ❑ Other, *please specify:* _____

27. Does your supervisor need to be on site?

- ❑ No – never
- ❑ Yes – sometimes
- ❑ Yes – all the time

28. In general, during a typical work shift, how often do you interact with your supervisor in a work-related manner?

- ❑ Zero/none
- ❑ 1 – 2 times
- ❑ 3 – 4 times
- ❑ 5 – 6 times
- ❑ 7 – 8 times
- ❑ 9 – 10 times
- ❑ 11 – 12 times
- ❑ 13 – 14 times
- ❑ 15 – 16 times
- ❑ 17 – 18 times
- ❑ 19 – 20 times
- ❑ more than 20 times
- ❑ Continually

29. Please rate the extent you agree or disagree with the following question: *"My supervisor is available whenever I need assistance or help."*

- ❑ Strongly Disagree
- ❑ Disagree
- ❑ Neither Agree nor Disagree
- ❑ Agree
- ❑ Strongly Agree

Over ▶

30. (a) How easy or difficult is it for you to go to the following types of workers, other than a supervisor, if you need assistance with a patient?

	Very difficult	Somewhat difficult	Fairly easy	Very easy
a. RN	❑	❑	❑	❑
b. LPN/VN	❑	❑	❑	❑
c. Another Medication Aide	❑	❑	❑	❑
d. Pharmacist	❑	❑	❑	❑
e. Physician	❑	❑	❑	❑
f. Advanced Practice Registered Nurse (APRN)	❑	❑	❑	❑

30. (b) Which individual do you prefer to go to for help? *(check **only one** answer)*

- ❑ RN
- ❑ LPN/VN
- ❑ Another Medication Aide
- ❑ Pharmacist
- ❑ Physician
- ❑ Advanced Practice Registered Nurse (APRN)
- ❑ I can't go to any of these for help

Communication

	Never	A few times a year	About once a month	A few times a month	About once a week	A few times a week	Every day
31. In general, how frequently are there breakdowns in communication regarding medication administration between you and a Licensed Nurse? *(check **one** answer)*	❑	❑	❑	❑	❑	❑	❑
32. In general, how frequently are there breakdowns in communication regarding patient monitoring between you and a Licensed Nurse? *(check **one** answer)*	❑	❑	❑	❑	❑	❑	❑
33. How frequently are there breakdowns in communication regarding changes in a patient's status/conditions between you and a Licensed Nurse? *(check **one** answer)*	❑	❑	❑	❑	❑	❑	❑
34. How frequently are there breakdowns in communication regarding the issue of a patient refusing to take a medication between you and a Licensed Nurse? *(check **one** answer)*	❑	❑	❑	❑	❑	❑	❑

35. (a) How often are there communication issues related to knowing when to obtain additional information about a patient's status and then conveying that status information to a Licensed Nurse? *(check **only one** answer)*

- ❑ Never ***Skip to Question 36***
- ❑ A few times a year
- ❑ About once a month
- ❑ A few times a month
- ❑ About once a week
- ❑ A few times a week
- ❑ Everyday

(b) Please indicate whether or not the communication issue(s) are related to each of the following:

	No, not related	Yes, related
a. Obtaining vital signs	❑	❑
b. Reviewing vital signs	❑	❑
c. Noting critical laboratory values prior to medication administration	❑	❑
d. Documenting other relevant clinical or behavioral changes in a resident's status	❑	❑

❑ Other, *please specify*: _____

_____

Authorized Duties

36. (a) Did your primary employer provide you with a written job description that addressed the scope of your medication-related responsibilities?

- ❑ No ***Skip to Question 38***
- ❑ Yes
- ❑ Can't remember ***Skip to Question 38***

(b) Please write a summary of your written job description below *(or, if possible, include your job description on a separate sheet of paper and return it with this survey).*

_____

_____

_____

_____

37. To what extent do you agree or disagree with the following statement: *"My Medication Aide job description matches what I actually do on the job"*

- ❑ Strongly Disagree
- ❑ Disagree
- ❑ Neither Disagree nor Agree
- ❑ Agree
- ❑ Strongly Agree

38. Does there need to be more information available surrounding your authorized duties (i.e., tasks you should and should not do on the job)?

- ❑ No – my authorized duties are clear
- ❑ Yes – there needs to be more information surrounding my authorized duties

39. (a) Do you think some of the tasks you perform are beyond what you should be doing in your job role?

- ❑ No ***Skip to Question 40***
- ❑ Yes

(b) What are some of the tasks?

_____

_____

_____

40. (a) In general, how frequently have licensed nurses asked you to perform a task you feel you are not trained or qualified to perform? *(check **only one** answer)*

- ❑ Never ***Skip to Question 41***
- ❑ A few times a year
- ❑ About once a month
- ❑ A few times a month
- ❑ About once a week
- ❑ A few times a week
- ❑ Every day

(b) Please specify the task(s) and or situation(s)

_____

_____

_____

41. Which, if any, of the Six Rights of Medication Administration is a priority for you to improve on?

	No	Yes
a. Right patient	❑	❑
b. Right medication	❑	❑
c. Right route	❑	❑
d. Right dose	❑	❑
e. Right time	❑	❑
f. Right documentation	❑	❑

42. Are you afraid of getting disciplined for administering late medications?

❑ No ❑ Yes

Over ▶

Medication Administration

Inhalants

43. Please indicate whether or not you are allowed to administer the following:

	No	Yes	Don't know
a. Inhalant medications	❑	❑	❑
b. Metered dose inhaler	❑	❑	❑
c. Medication used for intermittent positive pressure breathing (IPPB treatments)	❑	❑	❑
d. Medications or treatments via nebulizer	❑	❑	❑
e. Oxygen	❑	❑	❑

Injectables

44. Are you allowed to administer medications by injection?

❑ No *Skip to Question 49*
❑ Yes
❑ Don't know *Skip to Question 46*

45. Please indicate whether or not you are allowed to administer medications by injection through the following routes:

	No	Yes	Don't know
a. Intramuscular route	❑	❑	❑
b. Intravenous route	❑	❑	❑
c. Subcutaneous route	❑	❑	❑
d. Intradermal route	❑	❑	❑
e. Hypodermoclysis route	❑	❑	❑

46. (a) Are you allowed to administer pre-drawn insulin (for example, using an insulin pen device)?

❑ No *Skip to Question 47*
❑ Yes
❑ Don't know

(b) Are you allowed to administer insulin that is not pre-drawn by injection?

❑ No
❑ Yes
❑ Don't know

47. Are you allowed to administer epinephrine by injection?

❑ No
❑ Yes
❑ Don't know

48. Are you allowed to administer anticoagulants by injection?

❑ No
❑ Yes
❑ Don't know

Topicals

49. (a) Are you allowed to administer topical medications?

❑ No *Skip to Question 51*
❑ Yes
❑ Don't know

(b) Are you allowed to administer topical patches?

❑ No
❑ Yes
❑ Don't know

50. Please indicate whether or not you are allowed to administer the following:

	No	Yes	Don't know
a. Nitroglycerin paste	❑	❑	❑
b. Treatment that involves involves advanced skin conditions, including stage III and IV decubitus ulcers	❑	❑	❑
c. Topical medications requiring a sterile dressing	❑	❑	❑
d. Topical medications requiring an assessment of skin condition	❑	❑	❑
e. Debridement	❑	❑	❑
f. Duoderm application	❑	❑	❑

Orals

51. Please indicate whether or not you are allowed to administer the following:

	No	Yes	Don't know
a. Sublingual medications	❑	❑	❑
b. Maintenance dose of an oral anticoagulant (for example, Coumadin)	❑	❑	❑

Tubes

52. Please indicate whether or not you are allowed to administer the following:

	No	Yes	Don't know
a. Medication that must be inserted into a nasogastric tube (NG-tube)	❑	❑	❑
b. Medication that must be inserted into a gastric tube (G-tube)	❑	❑	❑
c. Medication that must be inserted into a jejunostomy tube (J-tube)	❑	❑	❑

Classes of Drugs

53. (a) Are you allowed to administer controlled substances?

❑ No *Skip to Question 54*
❑ Yes
❑ Don't know

(b) Are you allowed to administer schedule II narcotics?

❑ No
❑ Yes
❑ Don't know

54. (a) Are you allowed to administer chemotherapeutic agents?

❑ No *Skip to Question 55*
❑ Yes
❑ Don't know

(b) Is oral maintenance chemotherapy the only chemotherapeutic agent you are allowed to administer?

❑ No *Skip to Question 55*
❑ Yes
❑ Don't know

(c) Is Tamoxifen the only oral chemotherapeutic agent you are allowed to administer?

❑ No
❑ Yes
❑ Don't know

Over ▶

Others

55. Please indicate whether or not you are allowed to administer the following:

	No	Yes	Don't know
a. The first dose of a new medication	❑	❑	❑
b. The first dose of a changed medication (for example, a change in dosage)	❑	❑	❑
c. PRN or "as needed" medications (only after an assessment of the patient by a licensed nurse)	❑	❑	❑
d. PRN or "as needed" medications (assessment of the patient by a licensed nurse not required)	❑	❑	❑
e. Medications administered when the patient's condition is unstable or the patient has changing nursing needs	❑	❑	❑
f. Medications administered when the supervising nurse is unavailable to monitor the progress and/or the effect of the medication on the patient	❑	❑	❑
g. Medications administered without the task having been delegated by a nurse	❑	❑	❑
h. Medications that require a mathematical conversion between units of measurement to determine the correct dose	❑	❑	❑
i. Medications being administered as part of clinical research	❑	❑	❑

56. Please indicate whether or not you are allowed to administer the following:

	No	Yes	Don't know
a. Drops, ointments, or sprays into the ***eyes***	❑	❑	❑
b. Drops, ointments, or sprays into the ***ears***	❑	❑	❑
c. Drops ointments, or sprays into the ***nose***	❑	❑	❑
d. Barium or other diagnostic contrast media	❑	❑	❑

57. Please indicate the tasks/activities you are allowed to perform:

	No	Yes	Don't know
a. Regulation of intravenous fluids	❑	❑	❑
b. Programming insulin pumps	❑	❑	❑
c. Complete documentation for medication administration	❑	❑	❑
d. Complete medication error reports	❑	❑	❑
e. Take telephone or verbal orders for medication	❑	❑	❑
f. Receive written orders for medication	❑	❑	❑
g. Transcribe medication and treatment orders	❑	❑	❑
h. Order initial medications from pharmacy	❑	❑	❑
i. Reorder medications from pharmacy	❑	❑	❑

57. Please indicate the tasks/activities you are allowed to perform: *contiuned*

	No	Yes	Don't know
j. Account for controlled substances (perform a narcotic count), if assisted by a licensed nurse	❑	❑	❑
k. Account for controlled substances (perform a narcotic count), if assisted by another Medication Aide	❑	❑	❑
l. Receive and count medications	❑	❑	❑
m. Instill irrigation fluids of any type (including, but not limited to: colostomy, urinary catheter, and enema)	❑	❑	❑
n. Perform any sterile procedure or medication administration that involves sterile technique	❑	❑	❑
o. Conduct patient assessments or evaluations	❑	❑	❑
p. Engage in patient teaching activities related to medications	❑	❑	❑
q. Take vital signs prior to or after administering medications	❑	❑	❑
r. Administer medications that are in a unit dose package or a pre-filled medication holder	❑	❑	❑
s. Assume responsibility for medication pumps including patient-controlled analgesia	❑	❑	❑
t. Perform oral, nasal, or tracheal suctioning	❑	❑	❑
u. Perform blood glucose testing	❑	❑	❑
v. Crush medications (authorization by a licensed nurse ***not required***)	❑	❑	❑
w. Crush medications (authorization by a licensed nurse ***is required***)	❑	❑	❑
x. Destroy medication	❑	❑	❑
y. Calculate drug dosages	❑	❑	❑

58. Are you expected to...

	No	Yes	Don't know
a. recognize normal and abnormal conditions for the patient (that is, identify a change in condition)?	❑	❑	❑
b. recognize changes in patients' conditions or behaviors?	❑	❑	❑
c. recognize side effects?	❑	❑	❑
d. recognize toxic effects?	❑	❑	❑
e. recognize allergic reactions?	❑	❑	❑
f. recognize immediate desired effects?	❑	❑	❑
g. recognize unusual and unexpected effects?	❑	❑	❑
h. recognize changes in client's condition that contraindicates continued administration of the medication?	❑	❑	❑
i. recognize normal and abnormal conditions for the patient (that is, identify a change in condition)?	❑	❑	❑
j. anticipate effects which may rapidly endanger a client's life or well-being and making judgments and decisions concerning actions to take?	❑	❑	❑
k. review the patient's plan-of-care?	❑	❑	❑
l. collect and document patient conditions?	❑	❑	❑

Over ▶

59. **Does a licensed nurse assess a patient within 30 minutes *before* you administer a patient's medication?**
*(check **only one** answer)*

- ❑ Never
- ❑ Sometimes, but not consistently
- ❑ All the time
- ❑ For certain medications only

60. **Does a licensed nurse assess a patient within 30 minutes *after* you administered a patient's medication?**
*(check **only one** answer)*

- ❑ Never
- ❑ Sometimes, but not consistently
- ❑ All the time
- ❑ For certain medications only

Thank you for your participation in this important work!

If you have any questions, email jbudden@ncsbn.org or 312.525.3658

Please return your completed questionnaire in the postage-paid envelope to:
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