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Nurse Delegation of Medication Administration for Elders in Assisted Living

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ABSTRACT

This study examined medication delivery in Assisted Living (AL) settings, using multiple approaches: 1) Interviews with Board of Nursing (BON) executives, creating a summary and analysis of the regulatory environment (nurse practice acts and assisted living regulations) across the 50 states; 2) Gathering the perspectives of key informants in the field; 3) Conducting focus groups with nurses and administrators in this practice setting, and 4) participant observation of two sessions of stakeholders involved in the Assisted Living State Policy Summit. These sources elucidated the following salient findings: 1) Medication administration is an important and common issue in AL settings; 2) There is considerable variation across states regarding medication administration from both the perspective of BONs and AL licensing agencies; 3) Communication and coordination between agencies within states is limited; 4) Lack of clarity in definitions and practice parameters results in confusion and procedures that might "push the envelope"; 5) While professionals were concerned about safety, there was not evidence of harm related to medication administration. This study highlighted the limited articulation of policies between agencies and across states in this important and growing LTC setting. Gerontological nurses have the opportunity to shape this evolving practice arena and to enhance awareness of the professional and clinical issues inherent in working with unlicensed personnel in medication delivery.

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Introduction

Assisted living is the fastest growing long-term care option for older adults. Despite this rapid growth, there is little information about the relationship between this long-term care model and gerontological nursing practice. States regulate both nursing practice and assisted living, and regulation for each varies considerably across the country. It is not surprising that nurses are confused about their roles and responsibilities in this new care arena.

The purpose of this research was to identify current state policies that affect nursing delegation of medication administration for frail elders in assisted living settings. It describes the concerns of nurses who practice in this setting as well as their positive experiences. It also identifies the concerns of assisted living administrators, executive staff of the state boards of nursing, and other key professionals involved in the implementation of rules and regulations governing nursing delegation of medications. The findings of this descriptive research will inform future multi-state studies of medication safety and quality of care in this long-term care setting. They may also help shape health policy, particularly at the state level where regulations governing both nursing practice and assisted living are promulgated.

Background and Significance

Assisted living (AL) offers the elderly a more homelike environment than more traditional forms of care, such as nursing homes. Intended to be a more social model of care, and ideally a less expensive long-term care alternative, few licensed nurses are employed on an on-site, 24-hour basis. Unlicensed assistive personnel (UAPs) help with personal care and health maintenance activities like skin care, nutrition, and exercise. But many elders also need help with medications; assisted living residents take about the same number of medications as nursing home residents (Clark, 2001), and require assistance ranging from "reminding" the elder to take medications to actual "administration of medications." Whether or not non-nurses can administer medications

to assisted living residents is a clinical practice and state policy issue that has significant practical consequences for consumers who seek care outside of nursing homes. Without substantial help with medications outside of institutional settings, elders who may otherwise be able to live in community-based settings will be forced to go to nursing homes, or skilled nursing facilities. Without a way to provide for this help in a safe way, there is little real choice. It is also a major clinical concern for assisted living nurses who want to provide safe, high-quality care.

Assisted living has been growing rapidly, and there is a nationwide trend towards increasing resident acuity in AL (Gelhaus, 2001), yet there is scant information about nursing practice in this setting. Kane and her colleagues (Kane, O'Connor, & Baker, 1995) conducted case studies of nurse delegation in 20 states that were promoting home and community-based care, including assisted living. They found considerable ambiguity, confusion, and inter-state variation regarding delegation of tasks (including medication administration) to non-nurses. In states where nurses can delegate, they are confused about what can be delegated and concerned about their liability. Leaders of the American Assisted Living Nurses Association (AALNA) are trying to address these concerns on a state-by-state basis and seek guidance for this effort (Flores, 2000). Nurses have also raised these concerns at a national conference on delegation and consumer-directed care (Wagner, Nadash, & Sabatino, 1997) and during the first national conference for nurses in assisted living sponsored by the Assisted Living Federation of America (ALFA) in April 2000.

Clearly, this is a clinical gerontological issue that significantly affects the practice of nurses in assisted living settings, the quality of care that elders receive, and state policy development. There is little research available to inform the clinical and public policy dialogue, but two recent studies provide some interesting findings. First, in his national survey of state licensing agencies that oversee assisted living, Mollica (2002) found that 30 states (64%) allow UAPs who have completed training to administer medications; 98% allow UAPs to "assist with self administration of medications" (e.g., remind the person). This is a 200% increase from Mollica's 2000 survey in which only nine states allowed trained aides to administer medications, and another 12 states permitted aides to assist with self-administration (Mollica, 2000). More than half (51%) of the state licensing directors reported that state surveyors found problems with medications frequently or very often, but the frequency of problems was not related to states' policies on who is permitted to administer medications. Some states that permit trained aides to administer

medications report few problems. Other states that allow this practice report many problems. Further research is needed to explore this significant quality issue.

The second study does offer some findings on quality in one state. Young and Sikma (1998; Sikma and Young 2001) led a legislatively mandated descriptive study in Washington. They found no evidence of significant harm or adverse outcomes for consumers receiving delegated care, including the administration of medications by non-nurses in assisted living. Although limited to one state, this study has informed many of the practice issues explored and some of the methodological approaches we use in this current study.

In addition to these research findings, dialogue with stakeholders in assisted living regulation and financing, quality oversight, and nursing practice underscores the need for further investigation of nursing delegation of medications in assisted living. Roundtables conducted by the principal investigator at the 1999 ALFA annual fall conference and the 2000 annual meeting of the National Academy for State Health Policy (NASHP) confirm broad interest in this issue. The Assisted Living Workgroup, formed in 2001 to make recommendations to the U.S. Special Committee on Aging on how to ensure quality of care for assisted living residents, has identified medication management as a critical area for study and policy development.

The research and national/state dialogue establishes that the issue of nursing delegation of medication administration for elders in assisted living is an important clinical and state health policy issue. Within the systems of professions conceptual framework (Abbott, 1988), this is the time for the nursing profession to consider its jurisdictional control over its work—and those who perform it—in a way that balances consumer safety and autonomy. Delegation of nursing tasks does not necessarily weaken jurisdictional control, but legitimate processes are needed to ensure safe yet flexible delegation (Reinhard, 1988). The nursing profession and state regulators must balance consumers' preference to live in an environment that can support their autonomy with the mandate to protect vulnerable consumers. Nurses in assisted living need more clinical guidance, and states are seeking the kind of guidance that objective research can bring (Reinhard, 2000).

Methods

The research design included several methodological approaches, including interviews, focus groups, and participant observation. We also included data from the NASHP survey of state licensing directors (Mollica, 2002).

Interviews

We conducted two types of interviews. We interviewed executive staff from the state boards of nursing. We also conducted semi-structured interviews with key professionals involved in issues of nursing delegation of medications in assisted living.

Interviews with State Board of Nursing Executives

Based on an analysis of the 50 state nurse practice acts and rules/regulations in relation to nursing delegation policies (Reinhard, 2001), we confirmed substantive inter-state variation and developed a protocol to conduct telephone interviews with the executive staff of the state boards of nursing (BON). The interviews were designed to obtain confirmation of Reinhard's 2001 analysis of their laws and regulations related to nursing delegation from state nurse policy leaders, with a particular focus on assisted living and the extent to which the BON permits delegation of medication administration to UAPs. The interviews also sought to determine the respondents' concerns, if any, with the state's current nurse practice or assisted living regulations as they are implemented in the assisted living setting (see appendix A).

We contacted all BON executive directors with an introductory letter, including an analysis of their state nurse practice acts and regulations (Reinhard, 2001), and a sample set of questions. Follow up phone calls were made to schedule a telephone interview appointment. The interviews were conducted with the BON executive director or a designated executive staff member in charge of nurse practice. More than one executive staff member participated in several states.

The interviews took place over a four-month period, from July through October 2002. We conducted interviews with BON executive staff members in 42 of the states, and another two states completed an abbreviated version of the interview protocol. Two states refused to participate, and four states did not respond to our requests. Interviews

ranged from 30 to 90 minutes depending on the amount of detail provided by the interviewees.

Analysis of the interviews included a categorization of data into four areas. First, we examined the state's delegation policy. Can nurses delegate in any setting or only in certain settings (with a particular focus on assisted living)? Does the Nurse Practice Act, rules and regulations, or BON guidance limit the nurse to any list of care tasks? Are there any requirements for UAP training and supervision? To what extent is the nurse held accountable?

The second category summarized the extent to which the nurse can delegate medication administration and other sample care tasks in assisted living. We summarized the extent to which nurses can delegate medications via route of administration (oral, subcutaneous insulin when pre-filled, and other injections) and use of judgment as in delegating pro re nata (PRN) medications that are given "as needed". We also included a range of other care tasks, from relatively simple activities, such as applying unsterile dressings, to more complex activities, such as applying sterile dressings or working with tube feedings, bladder catheters, and bowel treatments. We encouraged discussion of details about these sample activities, such as delegating nasogastric versus tube feedings. The intent was not to obtain an exhaustive account of what nurses can and cannot delegate to UAPs in assisted living, but to explore the range and limits of the nurse's legal authority to delegate care tasks in this setting. We compared responses to the questions about these sample care tasks to the responses to questions about any limits to nurse delegation according to setting or a list of tasks in the law.

The third category summarized BON concerns, if any, about assisted living, particularly the way in which consumers receive help in obtaining their medications. We included any indications of resident harm. The fourth category summarized the BON respondent's assessment of current state policies for how consumers get their medications in assisted living. To some extent, this assessment reflected how informed the BON executive staff were about how consumers get this help according to regulations promulgated by other state agencies (e.g., those that regulate AL). It also reflected an assessment of how well the BON policies were working. Finally, a fifth category summarized additional observations, including discrepancies among the other four categories.

Key Informant Interviews

To include the perspectives of important stakeholders in the issue of medication administration in assisted living, we conducted semi-structured interviews with several key informants (see Appendix B for selected protocols). These interviewees included a researcher focusing on assisted living regulations across states, a national representative for consultant pharmacists who studies medication administration in long-term care settings, a nurse leader in assisted living practice, three state licensing directors (two speak nationally on assisted living regulations), and four middle managers from the AL licensing department in two states.

Focus Groups

We conducted two sets of focus groups—nurses in assisted living and assisted living administrators. Participants were recruited from the attendees at the annual conference of the American Assisted Living Nurses Association in May 2001 and the Assisted Living Federation of America conference in October 2001. Participants provided informed consent to participate in the focus groups, which were conducted in private locations. The questions explored how nurses in assisted living perceived nursing delegation of medication administration. Nurse participants were asked to identify benefits (if any), problems (if any), and any concerns for their own practice, for residents, and for the UAP. Assisted living administrators were asked similar questions, as well as how the administrators and the state agencies that monitor them (if applicable) oversee quality, and any issues related to packaging of medications. Administrators were also asked to reflect whether current rules contribute to safety or have potential unintended consequences in terms of costs and medication errors. The focus group questions are included in Appendix C.

Nineteen nurses and six administrators from 18 states participated in a total of four focus groups. All participants had attended at least one national conference related to assisted living. All were currently practicing in the assisted living field. Some participants practiced in assisted living facilities that are part of multi-facility (and often multi-state) organizations. All focus groups were completed by October 2001. Focus group dialogue was tape-recorded and transcribed verbatim, indicating the state of origin of each speaker throughout the transcript.

The qualitative data derived from focus groups were analyzed using grounded theory methodology. This methodology is appropriate for studying complex, interrelated

research problems and is particularly useful for examining situations where many perspectives exist and for exploring issues about which little is known (Bowers, 1988; Glaser, 1979; Kimichi, Polivka, & Stevenson, 1991; Lincoln & Guba, 1985; Sandelowski, 1986; Strauss, 1987; Strauss & Corbin, 1990).

Data were entered into the QRS NUD-IST Version 4.0 software program that facilitates processing and analyzing data in text form. Analysis followed established procedures for constant comparative analysis. Text was formatted by line and then broken down into fragments representing a single idea. Systematic guidelines for coding the data at consecutively higher levels of abstraction facilitated concept development. Concepts included both structure (e.g., relevant state laws) and process (e.g., how quality is monitored). Ideas were categorized and organized to determine common themes and relationships among ideas. Contributing factors or consequences of a given idea category were identified. The results of the focused interviews are reported in the form of the major themes evident.

Standard strategies were implemented to achieve auditability, credibility and fittingness in order to maximize the trustworthiness of the findings (Lincoln & Guba, 1985). Prior to data collection, face and content validity for the interview schedules was established through consultation with experts in health care. Transcribed interviews were audited for procedural consistency, and spot-checked for accuracy. One investigator (Young) primarily conducted qualitative data analysis. A second researcher (Sikma) then reviewed samples of the analysis, categories and themes to establish reliability. Data were checked for representativeness as a whole as well as the individual coding categories and the examples used to represent each. Procedures and strategies used for collecting, analyzing and reporting data were recorded as procedural field notes so that independent audit could be facilitated.

Participant Observation

To include additional insights from various stakeholders in the assisted living arena, we included participant observations of two sessions of discussions of the work of the Assisted Living Workgroup at ALFA's National State Policy Summit in Washington D.C. on October 11, 2002. The Assisted Living Workgroup (ALW) was formed in August 2001 at the request of the U.S. Senate Special Committee on Aging, which is conducting public hearings on quality of care in assisted living facilities. The ALW is a diverse group of approximately 50 national organizations representing various interests, including assisted living providers, consumer groups, and state health policy makers. Medication

management is one of six topic groups that the ALW set up to develop recommendations for the committee on Aging by April 2003.

Members of the ALW met in October 2002 to debate issues in medication administration in Assisted Living, including the role of "medication assistive personal" (MAPs), the name they have given to UAPs in assisted living who administer medication. Nurse delegation policy is a core issue in relation to MAPs. The principal investigator (Reinhard) conducted a 90-minute semi-structured group session with six ALW members, and co-led (with Kane) a 90-minute open-ended discussion with approximately 30 participants, including assisted living providers, state regulators, consumer advocates, and nurses practicing in assisted living. For both sessions, another research team member (Quinn) recorded major themes. The study findings include these observations to help frame the policy context for the analysis of the focus groups and interviews.

NASHP Survey of State Licensing Directors

Since Mollica was conducting a simultaneous national survey of state licensing directors of assisted living, he included a set of questions about medication administration that paralleled those in the interview schedule used for this study. Mollica's methods and findings are reported elsewhere (2002). For this study, we compared responses from the state BON executives and the state licensing directors and report any discrepancies in our findings.

Findings

The study's multi-method approach provides a rich perspective of the complexities and current practice and policy issues related to medication administration in assisted living. We present these findings in three parts—the interviews, focus groups, and participant observation. The discussion integrates these findings, highlights several of the key clinical gerontological nursing and policy issues, and offers recommendations for additional research.

Interviews with Board of Nursing Executives

The findings summarized in Table 1, Appendix D provide a state-by state analysis of the issues explored in interviews with the BON executives. The findings highlight five areas: delegation policy in general; delegation of medication administration in assisted living; BON concerns; BON assessment of the state's current policies for how to help consumers get their medications in assisted living; and investigators' comments.

Delegation Policy in General

Confirming the findings reported by Reinhard (2001), almost all states (except New York and Pennsylvania) have laws and/or regulations that permit nurses to delegate to UAPs. Among those states that do permit delegation, almost all permit delegation in any setting and most do not specify a list of tasks that can be delegated. Some states, such as California, Connecticut, and Delaware, specifically rule out the delegation of medication administration.

Training of UAPs for delegation purposes is highly variable. Although many BON executives state that the nurse determines the degree of training required, there is more specificity for training UAPs under AL regulations, especially if they are administering medications. Many states require these aides to be certified nursing assistants or obtain training to be medication aides.

The frequency and form of nursing supervision is also quite variable and somewhat setting-specific. In many cases, supervision is detailed in regulations outside of the BON; the state agency that licenses the assisted living residences determines the extent to which the RN must supervise the UAP.

The majority of states have some statutory or regulatory language that addresses nurses' accountability for delegating.[1] Of these states, most BON executives state that nurses are held accountable for both the process and outcomes of this delegation. A few BON executives indicate nurses are held accountable only for the delegation process. Oregon provides a noteworthy example; the nurse who follows the regulations is not subject to an action for civil damages for the performance of a UAP, unless the UAP is acting upon the nurse's specific instructions, or no instructions are given when they should have been provided. Hawaii also has language that clarifies that the nurse is accountable for the delegation process; the nurse is accountable for the decision to delegate and the adequacy of the nursing care to the client, provided that the UAP performed the task as instructed and delegated by the delegating nurse. This is important because nurses often fear that the "UAP is operating under my license" and they are afraid to delegate.

Delegation of Medications in Assisted Living

Responses to questions regarding nurses' ability to delegate medication administration and other sample care tasks in assisted living are most interesting for several reasons. First, in many cases, the same BON that indicates nurses' discretion to

delegate is not limited by setting or lists nonetheless indicates that nurses cannot delegate anything other than application of unsterile dressings in assisted living. It would appear that these BON executives view broad discretion to delegate to UAPs only in terms of traditional activities of daily living (ADLs), such as bathing, dressing, toileting, transferring, and eating. They interpreted anything outside of these ADLs as care tasks that require the skill and judgment of a nurse. Second, some states (Florida and Idaho are examples) appear to permit nurses to delegate complex care tasks, such as managing tube feedings and inserting and changing bladder catheters, but do not allow nurses to delegate medication administration.

Third, the states appear to be almost evenly divided on the issue. Twenty-two states permit nurses to delegate medications (at least oral medications).[2] Twenty-four states do not permit nurses to delegate medication administration.[3] It is unclear what is permitted in the remaining four states[4] either because we were not able to interview them or there was contradictory information.[5]

It is important to note that even in those states that do not permit nurses to delegate medication administration to UAPs, the state may permit trained aides to administer medications—presumably outside of the nurse delegation model. A survey of licensing directors, conducted simultaneously with the BON interviews, revealed that 30 states permit trained aides to administer medications (Mollica, 2002); another 18 permit aides to assist with self- administration of medications. We found some discrepancies between the data provided by BON executive staff and the responses from state AL licensing directors. Indiana and Arizona are two examples of states that do not permit nurses to delegate medication administration, but trained aides can perform this task through regulations promulgated by another state agency.[6] The most logical explanation for these discrepancies is that UAPs in these states are not administering medications within a nurse delegation model. Rather they are exempted from the nurse practice act either explicitly or through rules promulgated by another state agency.

Finally, the BON executives who indicated that nurse delegation of medication administration is not permitted also stated that UAPs are only able to assist with self-administration of medications. That is, the UAP can remind the resident to take their medications and take these medications out of the packaging, but the resident must physically take the medication without assistance.

Concerns

Some BON executives appear to be very familiar with assisted living in their states—the rules and regulations, the other state agency staff most involved, how consumers get help with their medications, concerns that nurses and other express, and other relevant matters. However, in many cases, it was evident that the BON is not very conversant about assisted living. They had difficulty discussing how consumers get help in getting their medications in their states, and referred the investigator to another state agency. Many of these BON executives stated that nurses are permitted to practice nursing in assisted living, but they do not have a sense of how many nurses are practicing in this setting, how they are doing, or an understanding of setting-specific issues.

Assessment of Current State Policies for How Consumers Get Medications in Assisted Living

This lack of knowledge about assisted living was most evident when discussing how consumers get help with their medications, and opinions about how well current state policies are working for these consumers. Some had no idea. Others said it is "convoluted policy" but it seems to work for consumers. Others said UAPs are probably going beyond assistance with self-administration of medications, and it is probably working: "I don't know what I don't know." That is, the aides are probably administering medications to residents who need more than reminding but thus far no problems have come before the BON.

Many of the BON executives who were familiar with state policies on assisted living did have concerns. Several expressed broad concerns about the safety of AL residents. These respondents stated the impression that many residents had needs that could not be met in AL; their acuity levels exceed the capacity of AL staff to provide the extent of help that consumers need. This could be an admission problem (the AL is allowing people to come in when they should be in a skilled nursing facility) and/or an aging-in-place problem (they enter at an appropriate level but need more as they age and become frailer).

In the area of medication administration, respondents who said that the only help consumers get is "assistance with self-administration" (the stated policy in 18 states) often expressed concern with that policy. Several themes in this area emerged. Some expressed the opinion that UAPs are really administering medications without appropriate training and supervision and problems are likely to occur; this is the "dirty

little secret" and AL is really "pushing the edge of the envelop with this assistance-with-self-administration policy." Respondents also expressed the concern that residents often do not get their medications on time and some do not get all of their medications.

In those states that do permit UAPs to administer medications, some were concerned that there is not enough training, that nurses do not understand their responsibilities in delegation, or that UAPs might replace nurses. One respondent noted that the BON needs to pay much more attention to AL and achieve consistency in regulation between the BON and the state licensing agency for AL.

Despite these concerns, few stated that there is any evidence of harm to residents in assisted living in relation to medication administration policies and practice—whether the UAP can administer medications or only assist with self-administration. There are no data systems in place for collecting this kind of information. The BONs might hear from nurses, another state agency, or the media. Few would get complaints from residents. The general sense is "it is difficult to know what is going on" but "there is no deluge of complaints." A few respondents made comments that residents are going to the hospital for being over or under medicated or receiving medications that are discontinued.

The most interesting finding is that despite the variation in state policies in how consumers get help in taking their medication and the BON concerns about the UAPs' role in administering medication, only 7 states[7] said they did not think their current state policies are working well, or "do not always work well."[8] Twenty states say their polices are working well, although many of the respondents qualified their answer with "as far as I know" or "the policies appear to be acceptable for consumers." Those states where the BON has spent much time working with their state AL licensing agencies on this issue (Oregon, Washington, and New Jersey are examples) were the most comfortable with existing policies. It is important to note that 15 BON executives stated that they did not know how their existing state policies on medication administration in assisted living are working for consumers.

Comments and Discussion

In almost all states, nurses are permitted to delegate some things in some settings to some UAPs. The typical situation is that there is language that permits delegation and then that authority is circumscribed by a limitation on the kinds of tasks the nurse can delegate and/or a limitation on the settings in which delegation can occur. After those two major sets of limitations, there are further limits by training and supervision requirements. Finally, there are the limits placed by "norms" of BON concerns and

nurses' own fears. In general, it appears that state law often permits more delegation discretion than that with which the BONs and/or nurses are comfortable.

It was helpful to identify "sentinel" or sample tasks because even those who said nurses can delegate anything, anytime, anywhere, expressed reservations when they were asked about concrete tasks that they considered "intrusive"— such as bladder catheters and removal of fecal impactions. The sample tasks used to probe delegation demonstrate a pattern. Delegation to many BON executives meant help with ADLs, which we did not include a priori in our definition of nursing tasks to be delegated. The most conservative BON policies restricted the delegation of unsterile dressings. The least conservative BON policies permitted nurse discretion in delegating more "invasive procedures" such as insertion of bladder catheters. Delegation of medication administration generally falls between these two examples but some states permit delegation of some complex tasks and not others. Although the rationale for these delegation parameters is not always clear, in some states, the statute is the limiting factor. For example, Connecticut allows broad discretion in delegating care tasks, but the statute specifies that nurses cannot delegate medication administration. Even if the BON's interpretation changes, legislative action is required to codify that changed thinking.

Many—if not most of the BONs—are not familiar with AL. The majority of respondents referred the investigators to other state agencies to ask about medication administration policies. This was true even in those states that permit nurses to practice in AL (few states do not).[9] It was not clear how nurses in those states receive guidance from their regulatory agency on nursing practice issues in AL. If the BON does not know much about the rules from other state agencies that affect nursing practice, how do nurses know them? Presumably these nurses turn to their AL employers and/or state facility licensing agencies to learn what they can and cannot delegate in AL. Some interviewees underscored this policy disconnect, as in the case where the BON executive expressed concern that RNs do not understand delegation governed by another state agency—yet that BON executive did not have much information other than the name in another state agency to contact. As one respondent noted, despite their traditional orientation toward acute care, the BONs need to be more involved in newer settings for consumers and nurses. As state legislatures are taking up the AL issue, more state BONs are becoming involved in assisted living policy development.

The most significant finding is that states are struggling with the best way to balance consumers' desire for a more homelike "social" model of long term care and

support with the reality that many people who want this option also need help with "medical" or "nursing" needs—such as medication administration. "Assistance with self-administration" often becomes medication administration. Medication administration is often provided by "medication aides" who operate outside of a nurse delegation model. Nurses may be involved in supervising these aides, rather than delegating to them (see focus groups below). The difference may be confusing to nurses practicing in AL, and they may not be able to turn to their BON for guidance because "that's under a different agency."

Key Informant Interviews

The key informant interviews provided an important addition to the BON interviews and focus groups (below). They underscored the controversy surrounding medication assistance and administration in assisted living. The pharmacy expert is recommending more regulations governing the training and supervision of "medication assistive personnel" (MAPs), the term that the Assisted Living Workgroup has given to UAPs who are administering medications to residents in AL. He is advocating a stronger role for consultant pharmacists in AL—similar to the role they have in nursing homes to monitor medications for every resident. The assisted living nurse experts fear more federal regulation and paper work that "drowns nurses" but support more training for these MAPs and agree that the nurses' role in relation to these MAPs must be clarified in state policy. Who is the MAP ultimately accountable to? Is the nurse in the middle as a consultant or as an administrator? What does supervision entail? They support a delegation model that closely aligns the delegating nurse with the trained aide who administers medication. They also desire more education for nurses in how to delegate appropriately.

The assisted living researcher validated that three out of five states permit trained aides to administer. These states reported about the same level of concerns about medication administration now as they did two years ago. The three state licensing directors interviewed agreed with this observation. Those who have developed a system for training and delegation that works now believe that they are in "good shape" and would like more flexibility, particularly in the area of PRN medications. They recommend that states should have a great deal of flexibility in how they develop these policies—that one policy does not fit all states. It was their impression that states who have interagency discussions (particularly the BON, facility licensing agency and Medicaid agency) have the most coherent approach. Further, those states who involve active consumer groups

have learned more about changing consumer needs and demands. One state administrator in a "Division of Services for Aging and People with Disabilities" stated that the state's NPA is too restrictive, especially with regard to people with disabilities. Her concern is that the strict interpretation of the NPA prevents independent living for some people, and hopes that federal and state interest will grow in promoting community living for people of all ages and disabilities.

Focus Group Findings

Three focused interviews were conducted, two with nurses active in assisted living settings, and one with assisted living administrators. In total, information from eighteen states was represented. While the same set of questions was not asked about each state, as issues were raised, the location was indicated, allowing analysis by state. Detailed state-by-state results are summarized in Table 2, Appendix E. The following is an overview of common themes, impressions, and issues across states. The major themes include the assisted living setting (philosophy and regulatory environment), medication delivery systems, provider roles and issues (pharmacy, RN, unlicensed staff), quality monitoring, and future directions.

Assisted Living Setting

Assisted Living Philosophy

Implementation of assisted living varied by the philosophical perspectives of the state regulations, the service delivery organizations, and the individual professionals. Across states, and across participants there were differences in understanding and expectations of the service delivery model for Assisted Living, ranging from a social model (if family can do it, so can staff) to a Nursing Home/medical model with clinical assessments and guidelines. Many expressed a desire to balance addressing clinical needs and promoting independence within a residential environment. Participants reported that their own backgrounds heavily influenced their perspective on care in Assisted Living; those with nursing home backgrounds remained more comfortable with a clinical model and a more heavily regulated environment.

Assisted Living companies varied in their commitment to training and their standardization of protocols, with some having policies that were more strict than state regulations required, and others barely meeting minimal state licensing requirements. Some nurses implement programs in training or monitoring due to personal commitment,

without support from their company. Some companies mandate quality oversight and have systems in place to assure compliance, for example, required reviews by RNs, and supervision of staff giving medications.

In states where staff in assisted living was not allowed to perform skilled nursing tasks, facilities developed contractual relationships with Home Health Agencies for skilled care. Some described creative solutions, where the facility held a Home Health license and employed Home Health staff to serve their internal needs. Coordination across providers is more complex when two delivery systems are running parallel and addressing different aspects of care for a resident.

Assisted Living Regulatory Environment

With a few exceptions, administrators had a vague understanding of medication delivery parameters. The assisted living nurses were more complete in their description of the regulatory guidelines for medication delivery, training for UAPs, and state level quality monitoring.

In general, there were lighter training requirements for UAPs to administer medications in Assisted Living than in Nursing Facilities. Some states had specific guidelines for storing and delivery of medications; others did not address medications in regulations at all.

States varied in licensure of assisted living, with several states having multiple levels of care under the general guidelines. Not all states provide Medicaid reimbursement for Assisted Living. Definitions were not consistent, and some states had facilities providing comparable care to comparable residents without licensure, as assisted living licensure was not mandatory. Paradoxically, in some cases (e.g., New York), nurses and administrators report that unlicensed facilities allow medication administration by UAPs without supervision, yet licensed facilities, or those where licensed nurses are involved, come under stricter guidelines. Some providers avoid licensure to allow practices without having the expense of staff and systems that would be required under licensure.

The role of government agencies in oversight was mixed, with some states having strict regulations and mandatory reporting, and others having few regulations and intermittent oversight. Several reported different interpretations by surveyors of the same regulation in the same state, and surveyors leaving the interpretation up to the provider.

A number of participants reported that renewal visits and surveys were not completed in a timely fashion and were behind schedule.

Medication Delivery Systems

Of the 18 states represented in the sample, medications were delivered in three major ways: delegation by a nurse to a UAP (n=4); administration by UAPs (n=8); and supervision of self-administration (n=6). Working definitions of these three medication delivery systems were developed from the perspectives of the participants, based on their understanding of relevant laws and practice acts, as well as their experience in assisted living settings.

- **Delegation** was defined as nurse-directed medication administration, involving direct training of unlicensed personnel to administer medications with ongoing RN oversight and supervision.
- **Administration** was defined as a UAP directly giving medication to a resident without direct supervision by an RN. In all cases medication administration included oral medications (including putting the medication in the mouth), and commonly eye drops or eardrops. In some states, insulin injections were allowed, and a subset of these states allowed other injectables.
- **Supervision** of self-administration was defined as reminding residents to take their medications, and might include removing the medication from the packaging, but the medication was self-administered by the resident. Some states had more strict requirements about the level of knowledge and involvement by the resident.

There was considerable variability by state regarding specific medication guidelines. Five states reported allowing insulin injection by UAPs. There were no setting-specific restrictions reported for Schedule II or psychotropic medications in any state. Dispensing liquid medications and providing PRN medications under self-administration posed difficulty in several states.

Resident characteristics played a role in the dynamics of medication delivery. A high proportion of residents in AL were taking medications, and many take multiple medications daily; hence, medication management is a critical issue for providers in this setting. With increasing acuity in AL, medication management is a growing concern. A significant number of AL residents have cognitive impairment (CI), which is a barrier to self-administration in some states, sometimes necessitating additional services (such

as home health) or higher involvement by family so that the resident can remain in that setting.

Provider Roles and Issues

Pharmacy

Assisted Living settings pose particular challenges to contracted pharmacies, and these are addressed with varying degrees of success. In general, the AL philosophy focusing more on resident-centered service and promoting independence and choice is not compatible with institution-based pharmacy delivery (as in nursing home settings). AL requires a relationship that is more akin to retail pharmacy dealing with the individual customer (resident) rather than the institutional customer (the facility), with multiple prescribing providers and the need for packaging systems appropriate for unlicensed personnel giving meds. Most reported that residents could choose their own pharmacy, making medication delivery more complex for the facility in that different systems might be deployed in the same facility. Some states allow families to bring in medications, and RN staff to dispense these medications into Medi-sets for unlicensed staff to use. With multiple pharmacy providers in a setting, unlicensed personnel might have to understand and work with multiple packaging systems.

Managing medications is a time consuming process, involving coordination with multiple pharmacies, and in some cases, families, to procure the medications. Several participants identified changes in orders as a particular challenge, when medications have been dispensed in packages for weeks or longer, and a change in dose or medication (addition or discontinuation) occurs. Procuring medications or making changes can result in delays in medication delivery to residents. Some states require monthly pharmacy review of medications for residents in Assisted Living. This was commonly implemented in collaboration with an RN in the facility.

Registered Nurse Role

Across states, the role of the RN varies. Some allow provision of skilled nursing care in AL settings by RN staff, others require contracting of Home Health Agencies to provide this care. According to RN participants, roles vary across settings, and in some cases are not clear. A typical role for RNs in AL is care coordination/case management/clinical oversight. Many are involved in training unlicensed staff, particularly in the area of medications. Some states mandate RN clinical oversight and/or

RN training of staff. Some RNs provide direct care (skilled nursing tasks, medication administration), depending on state and facility. In states with delegation, RN training, supervision, and follow up are required.

Administrators report issues with nurses understanding assisted living philosophy and a social model of care, the ability and inclination of RNs to supervise others, and the preparation of RNs for this particular role. RNs differ in comfort level with delegating medications, with some endorsing the practice and others having reservations.

Unlicensed Staff Role

States vary in their requirements for UAP certification and training for medication delivery. Some have formal certifications, others do not. In some states, having a certification as a nursing assistant is a prerequisite to being able to assist with medications. The amount of training, the specificity of the curriculum, and requirements for continuing education varied significantly across states.

Nurses and administrators report that in general they are satisfied with unlicensed staff dealing with medications, that it is empowering, the staff takes these duties seriously, and they have fewer distractions than licensed staff, resulting in greater accuracy of medication delivery.

Quality/Monitoring

Overall, the participants were comfortable with the quality of medication delivery and with the practice of UAPs giving medications. It was their perception that optimal quality was promoted with appropriate training, supervision, medication packaging, communication, and follow up monitoring.

Participants agree that training is necessary, as well as some form of monitoring for errors and side effects. Some participants expressed concern at the lack of regulatory guidelines in assisted living, and the resultant threat to quality when standards are up to the individual facility.

A number of participants reported internal mechanisms for monitoring quality, including routine review of resident/care plan/ medication regimen, incident reports/medication error reports, and supervision by the RN. The annual survey process was a common method for monitoring, as was regular pharmacy review of medications.

Future Directions

Participants identified three major themes for further exploration that could lead to improved outcomes for residents in assisted living settings, in the arenas of the regulatory environment, delivery systems, and recruitment and training of personnel.

There was strong recognition of the variation in regulations across states and the inadequacy of the current standards and guidelines. Those employed by multi-facility organizations with facilities in a number of states were particularly eloquent about the variation and inconsistencies in regulation. Participants generally agreed that there is benefit to development of standards, guidelines, and regulations to assure quality delivery of medications across states, addressing particular needs of AL residents, including those with cognitive impairment. In addition to assuring consistent regulations, participants recommended that surveyors and licensors receive training to improve interpretation of guidelines and consistent application of rules to practice settings.

The second major theme addressed delivery systems. Because medication delivery comprises a major service in assisted living to almost all residents, participants prioritized improving this system in two ways: improved collaboration and improved packaging. They recognized that improvement in system level collaboration and cooperation between pharmacy and assisted living settings would optimize medication delivery within a philosophy of resident-centered, residential care. With the volume and complexity of medication delivery, participants recommended improved packaging specific to the needs of the assisted living industry. In their view, improved packaging would promote accuracy and reduce errors, allow for timely adjustment (e.g., when dose or medication is changed), and promote safer delivery of liquids and PRN medications. Finally, participants recommended streamlining documentation for greater efficiency and accuracy.

The third major theme for future development is recruitment and training of personnel. Participants identified the potential impact of the nursing shortage at a time of increasing resident acuity on medication delivery in Assisted Living settings. In some states, both nursing and unlicensed staff were in short supply, threatening quality and viability of the services. Once staff are obtained, participants indicated that they valued ongoing staff development to promote quality. For UAPs involved in medications, participants recommended development of standardized core training and competency testing. Both administrators and RNs suggested setting-specific education and professional development for RNs to optimize their understanding and enactment of the

assisted living philosophy and their role in that setting, enhance professionalism, and promote quality.

Participant Observation Findings

In summarizing their work and proposed recommendations, members of the ALW discussed their progress and highlighted their challenges in resolving issues. Among the most significant recommendations is clarification of the terms. Instead of relying on 17 different definitions for "assistance with medications" or "assistance with self-administration", the ALW is recommending three levels: resident self-administration (no involvement by any staff); medication reminders (can be done through technology or by staff); and medication administration by appropriate health care professionals or trained UAPs known as medication assistive personnel (MAPs).[10] The ALW Medication Workgroup is advancing a specific curriculum for these MAPs with a written exam—a very detailed process model that exceeds the current policies in many states, including Oregon that has been implementing a nurse delegation model for many years.

Participant reactions to these proposed recommendations to the US Senate Committee on Aging varied. On the one hand, some claimed that they are too "medical model oriented"; consumers do not choose AL for safety reasons, but for quality of life reasons. They were concerned that on a scale of resident protection versus resident autonomy, the recommendations are too regulatory in promoting safety because they will make assisted living more of a facility than a home. This was the predominant view of nurses who currently practice in assisted living settings. Others feel that this focus on safety is essential to reduce the risk management concerns of AL owners and their attorneys.

Discussion

It is clear from these findings that nurses are moving in and around assisted living, with insufficient guidance from BONs and state policymakers in general. In this void, they are experiencing role conflict and confusion. Yet, community-based options, such as AL, are expanding across the US, with growing public funds allocated to these programs. This study established that from multiple perspectives, medication administration is a significant delivery issue in this setting. In addition, this study highlighted the limited articulation of policies between BONs and AL regulations, as well as limited

understanding across regulatory bodies regarding overlapping jurisdiction. The current lack of clarity in definitions and practice parameters results in confusion and procedures that might "push the envelope" of practice. Yet, while professionals were concerned about safety, there was not evidence of harm related to medication administration. There is much potential benefit to improved communication, education, and regulatory coordination

Medications are at the "flashpoint" of the social versus medical model debate over assisted living. Elders take multiple medications, usually for chronic, stable conditions. Many of them need "help" with these medications. Some need more than "help". States are wrestling with policy questions of how to best deliver services safely to consumers in the least restrictive environment possible, including issues of appropriate setting parameters, staff mix, and quality monitoring. This is a controversial and fluid state policy issue that has captured the attention of Congress, driven in part by a desire to assure quality and safety for consumers in AL. Many dedicated experts are struggling to sort through the issues and develop recommendations to the U.S. Senate Committee on Aging by April 2003. Unfortunately, there is little research to provide a rationale for any of these recommendations. It would be most helpful to examine multi-state data on medication errors that result from resident self-administration, medication reminders, and medication administration by UAPs (with different training requirements). It would also be useful to contrast these data with medication errors made by RNs. Anecdotal evidence abounds, and is contradictory —that RNs make more errors than UAPs, and that UAPs make more errors than RNs or the resident. States such as Oregon and New Jersey have experience and there is some research from the state of Washington that provides some guidance. More is needed.

Gerontological nurses have an opportunity to provide their insight into this issue, and to define the appropriate professional response to the demands of this practice setting, including identifying the merits and implications of alternate models for medication delivery (e.g., nurse delegation, assignment) and requisite education and support for implementation of these models.

It is important to note that medication administration is only one aspect of care that is important for older adults and people with disabilities in assisted living. Other care tasks, such as tube feedings, bowel care, and catheters are also important to residents who need help with these care needs. This is true in assisted living as it is in other home and community based settings. It is not feasible to imagine that all these

tasks would be performed by an RN, given the resources available in these settings, hence some form of working through others is required of professionals.

Many states are also wrestling with nurse delegation of complex tasks in home care settings. New Jersey, Texas and Maine all mentioned the emerging issue of RN delegation of medications in home care. Although we did not examine the home care issue, it should be another area of inquiry. Since the home setting is not a congregate setting, BONs might envision the UAP more as a family member or a neighbor and support a delegation model in this one-to-one situation. However, since the UAP may be caring for hundreds of people over the course of his/her employment by an agency, home care UAP may not be much different than an UAP in assisted living.

Nurses practice in many settings. Policies that are designed for acute care, such as restrictions on medication administration by UAPs, may not translate well to home and community-based settings. Nursing practice in AL is evolving as this setting becomes more established as a LTC option, and as resident acuity increases. Gerontological nurses have the opportunity to shape this evolving practice and need research to guide their practice, as in all settings. Consumer preferences are changing; they desire less institution-like settings in appearances and practices and are entering AL settings in growing numbers. Critical questions emerge: To what extent can the nursing profession adapt to new care models, without sacrificing the desire to provide quality care? Can the delegation framework provide that structure, and if so, what implications does this have for professional RN roles? If not, should nursing advocate that medication administration by UAPs in assisted living and other non-traditional settings be implemented outside a delegation model, making it a responsibility of other state agencies and providers?

States are wrestling with these challenging issues now. It is an opportune time for BONs and nurses to learn more about assisted living and other home and community alternatives to acute and long-term care. Gerontological nurses have the opportunity to enhance awareness of the professional and clinical issues inherent in working with unlicensed personnel in medication delivery. People are less likely to receive care in traditional settings in the future. The profession needs research to help guide its practice today and tomorrow.

Endnotes

[1] Maine, Missouri and Wisconsin have no language on accountability; New York and Pennsylvania do not permit delegation so accountability is not applicable.

[2] Colorado, Hawaii, Iowa, Kansas, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin.

[3] Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Mississippi, Nebraska, Nevada, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Virginia, and Wyoming.

[4] Alaska, Arkansas, Michigan, and Missouri.

[5] Arkansas' BON stated the nurse can delegate medication administration but the state's licensing director stated that UAPs cannot administer medication in AL in that state.

[6] Surprisingly, Arkansas permits nurses to delegate medication administration but the state AL licensing director states that trained aides are not permitted to administer medications. Further research is needed to explore this discrepancy.

[7] Delaware, Florida, Idaho, Maryland, Montana, Nevada, and New Hampshire.

[8] We do not have data on this variable for 8 states.

[9] States that espouse a "social model" of AL do not permit even AL-employed nurses to administer medications in AL, except in rare circumstances. The resident must hire a home health nurse to provide this assistance. The nurse hired by the AL acts as a "wellness coordinator" and is not responsible for resident care. Massachusetts is one example of this model.

[10] Note that these new terms are different than the terms we use in the focus group findings.

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Appendix A

BON Interview Protocol

INTRODUCTION: Key Points

Remind BON executives about the purposes of the study:

- Overall, the study is looking at the relationship between each state's Nurse Practice Act and regulations and two recent developments in long-term care—assisted living and consumer directed care.
- We want to explore how your State Board of Nursing is responding to new developments in assisted living in your state—particularly how residents in these setting get help with certain activities, like taking their medications.
- We are also interested in exploring your State Board of Nursing's views about consumer direction.

Review Definitions:

For the purpose of this survey, the following definitions are provided:

Assisted Living is a group residential setting where personal care, household services, and routine nursing services are provided or made available for persons with functional impairments. Specific language defining assisted living in your state can be found in Dr. Robert Mollica's "State Definitions of Assisted Living" guide that we sent you.

Care Task refers to a clinical or health maintenance activity that is often performed by nurses but also may be performed by unlicensed assistive personnel through delegation or exemption. Examples include (but are not limited to) bladder catheters, bowel treatments, tube feedings, dressings, and medication administration.

Consumer Directed Care refers to a philosophy and model of care that recognizes that the person with a disability is knowledgeable about his or her own needs; the consumer has the primary authority to direct others, including those performing care tasks traditionally performed by nurses, to help meet those needs—regardless of the nature or extent of the disability or source of payment for services. Consumer Directed Care programs and settings include (but are not limited to) personal care assistance programs, attendant care service programs, consumers' homes, and independent living centers.

Delegation refers to the transfer to an unlicensed individual the authority to perform a selected care task in a selected situation.

Exemption refers to the statutory or regulatory exclusion of certain types of individuals (like family members or domestic servants), programs (like personal care assistance programs), or settings (like independent living centers) from the regulations governing nursing practice.

Medication Administration is a procedure in which prescribed medication is given to a person. Medication administration goes beyond "reminding" or "assisting with self-administration of medications." A person authorized to administer medications can remove the prescribed medications from its packaging and give the individual dose to the person.
Unlicensed Assistive Personnel (UAP) is an umbrella term for unlicensed individuals who provide assistance to people in assisted living facilities, their homes, or other home and community-based settings. These personnel may have been trained and tested, but they are not licensed. Examples of titles of UAPs include (but are not limited to) personal care assistant, personal care attendant, and aides.

Interview Questions:

1. Overview of the BON in your state:

1a Where is your Board of Nursing administratively located in your state?

1b.How many people are on staff at your state's BON?

1c.How many board members are on your state's BON?

2. Have there been any changes in your Nurse Practice Act or its regulations after May 2001 that would affect nurse practice in assisted living or consumer directed care, including changes related to delegation or to administration of medication?

____Yes, BRIEFLY, WHAT WERE THOSE CHANGES?

___No, no changes

Delegation Policy

First, I'd like to talk about delegation. Just as a reminder, we are defining Delegation as the transfer to an unlicensed individual the authority to perform a nursing care task.

Delegation Policy in General

3. In general, which of these statements are more accurate about the delegation permitted by your state's nurse practice act or its regulations:

_____The nurse can delegate care tasks to UAPs in any setting

_____The nurse can only delegate care tasks to UAPs in certain settings.

SPECIFY

_____The nurse cannot delegate care tasks to UAPs in any setting

4. Does your state's nurse practice act or regulations include any other provisions that permit nurses to "assign" care tasks to UAPs in certain circumstances?

____Yes please explain and provide specific language

____No

____Don't Know

5. Does your state's nurse practice act or regulations include language that holds the nurse accountable for the process of the delegation, the outcomes of that delegation, or both?

____Process of delegation (the nurse follows the delegation policy)

____Outcome of delegation (the nurse is held liable for harm to the consumer even if the UAP did not follow the nurse's directions)

____Both process and outcome

____No language on these issues

Please clarify if needed:

Delegation Policy in Assisted Living

6. Turning now to assisted living, has your state board of nursing addressed nurse delegation policy in assisted living in the nurse practice act or regulations? In your state, assisted living includes (FILL IN FROM MOLLICA's definitions as indicated in the law and regulations of that state)

_____Yes

_____No

_____Don't Know

6a. Can nurses practice as nurses in assisted living in your state?

_____ Yes

_____ No

_____ Please clarify if needed:

7. To your knowledge, has any other state department addressed the issue of nurse delegation policy in assisted living?

_____Yes

If yes, which state department? (Please specify

_____No

_____Don't Know

8. Are registered professional nurses in your state permitted to delegate care tasks to UAPs in assisted living?

_____Yes

_____No (skip to Question 16)

Care Tasks

9. I have some examples of care tasks that registered nurses are sometimes permitted to delegate to unlicensed assistive personnel. For each I would like to know whether your state's Nurse Practice Act or its regulations permit RN's do delegate them to unlicensed personnel. As I go through the list, if there are any special caveats that apply, please feel free to add detail.

Care Task That Can Be Delegated	Yes	No	Comment
a. Administration of oral medication			
b. Administration of pre-drawn insulin			
c. Administration of other injectable medications			
d. Administration of PRN medication			
e. Applying unsterile dressings			
f. Applying sterile dressings			
g. Tube feedings			
h. Bladder catheters			
i. Bowel treatments			

10. Is there any statutory or regulatory language in the nurse practice act/regulations or elsewhere that defines a specific list of care tasks that can be delegated?

_____Yes (please specify what can be delegated)

_____No

_____Don't know

Training requirements

11. Does the UAP require any prior credentials or qualifications before the nurse is permitted to delegate care tasks to that UAP?

_____ Yes

_____ No

12. Does the UAP have to meet any training requirements before the nurse is permitted to delegate care tasks to that UAP in assisted living?

_____Yes

_____No

13. If yes, please describe the training requirements:

Who trains the UAP?

What is covered in the training?

How long does the training take?

Does the UAP take a written test?

Other

Supervision

14. When a nurse delegates care tasks to UAPs in assisted living, what (if any) supervision is required by law? (Check all that apply.)

_____On-site supervision by the nurse

_____Availability by telephone

_____Other (specify)

_____No supervision required

15. What frequency, if any, of supervision is required?

Concerns

16. Based on the experience in your state, what concerns, if any, does your Board of Nursing have regarding nurse delegation of care tasks to UAPs in assisted living? Please be specific

[Probe: how is it working in AL? What happens with residents if they can't get their medications there? Do they leave or stay and get them some other way?]

17. How does your Board of Nursing become aware of any problems that might result from nurse delegation of care tasks to UAPs in assisted living? (Check all that apply.)

_____Consumer complaints

_____Reports from another state agency (specify

_____Other (Please specify

18. If nurses are permitted to delegate the administration of medications to UAPs in assisted living, has there been any indication of patient harm?

_____Yes (Please elaborate or explain)

_____No

_____Not applicable, can't delegate medication administration

_____Don't know

Plans for the Future

19. Is your state considering any changes in the Nurse Practice Act or regulations that will increase or limit the ability of nurses to delegate care tasks to UAPs in assisted living?

_____Yes, increase

_____Yes, limit

_____No

Please describe:

20. If your state is considering any changes in delegation policy in relation to assisted living, will those changes increase or limit the delegation of medication administration to UAPs?

_____Yes, increase

_____Yes, limit

_____No

21. How do consumers who live in an assisted living setting get help taking their medications now in your state? (Check all that apply)

_____Consumer is completely responsible for taking his or her own medications

_____Registered professional nurses on staff at the assisted living facility must administer medications

_____Registered professional nurses from an agency outside of the assisted living facility must administer medications

_____UAPs can remind consumers to take their medications

_____UAPs can assist the consumer in self-administration of his or her medications

_____UAPs administer oral medications

_____UAPs administer injectible medications

_____UAPs can administer medications on an "as needed" (P.R.N.) basis

_____Don't know

Additional explanation (if needed

22. Do you think the current policies for helping consumers get their medications in assisted living are working well for consumers?

_____Yes

_____No

_____Don't know

Please explain

Exemption Policy

Now we are turning to statutory or regulatory exemption from the provisions of the Nurse Practice Act. Most nurse practice acts have general exemptions for tasks provided by family and friends.

The questions below explore whether or not your state has exemptions that relate to care provided in assisted living or consumer directed care settings and programs.

Exemption Policy in Relation to Assisted Living

23. Does your state Nurse Practice Act and/or regulations provide any exemptions that permit UAPs to perform care tasks in assisted living?

_____Yes

_____No

24. An exemption of care tasks in an assisted living setting removes the issue of delegation from the Board of Nursing. Do you have any concerns or comments about the exemptions in your state?

25. To your knowledge, does any other state law or regulation permit UAPs to perform care tasks in assisted living?

_____Yes (Please describe those exemptions or attach specific language)

_____No

_____Don't know

26. To your knowledge, what kinds of care tasks can these UAPs perform?

_____Don't Know

Supervision

27. To your knowledge, are there any requirements for a registered nurse to supervise the UAPs who provide these exempted care tasks?

_____Yes

_____No

_____Don't Know

28. Are you aware of any plans in your state to create exemptions that would permit UAPs to perform care tasks in assisted living facilities?

_____Yes

_____No

29. If there are plans, is the State Board of Nursing involved in the planning process?

_____Yes

_____No

_____Does not apply

Summary

30. Is there anything else you would like to add?

31. Would you like a copy of the survey results?

_____Yes

_____No

Appendix B

Sample Interview Protocols for Key Informant Interviews

B1. Protocol for Pharmacist/Researcher

1 What concerns if any do you have of delegation of medication admin by nurses to unlicensed assistive personnel?

2 You have expressed a concern in the past regarding the status of pre-packaged medications that are administered in assisted living facilities. Does this concern still hold true?

2a. If so, please describe your concerns.

3 What criteria would you consider safe as far as medication packaging and administration is concerned?

4 Is there at least one state that you can think of whose policies of medication administration meets what you consider to be safe criteria?

4a. What states would you say are leading in the area of detecting medication errors?

4b. What states leading in reducing medication errors and what systems do they have to foster this?

5. What would do recommend to be put in place to make it more likely that residents in AL would get right meds at right time?

B2. Protocol for Assisted Living Researcher

1. In your 2000 study of state licensing agencies that oversee assisted living facilities, you found that most states reported they don't allow unlicensed assistive personnel to administer medications. Does your latest survey of the states reflect this, or are there any changes?

1a. If there are any changes, what are they?

2. Also in your 2000 study, you found that Assisted Living regulators reported frequent problems with medication, but that the problems were across states regardless of the skill level of the medication administrator. Has the amount of medication errors changed?

2a. If there have been changes, please describe them. [Probe: Are medication errors still frequently reported? Is there still a lack of correlation b/w errors and UAPs or w/ nurses?]

3. What are some overall impressions you have re: the latest data that you've collected, in relation to medication administration in assisted living?

4. What states do you think are doing best job in assuring people getting their medications correctly?

5. What states do you believe have the best policies that allow residents in Assisted Living Facilities to age in place?

5a. Are any of these policies related to medication administration? [Probe: which states' policies?

Appendix C

Focus Group Protocols

A. Administrators' Focus Group Protocol (Semi-structured)

Does your state allow nurses to delegate any task that might be considered quote unquote nursing tasks? And if so, can you give some examples?

What are the roles of medication technicians?

Are your facilities licensed?

If delegation is not allowed in the rules, can you explain why that is?

Can you explain how self-administration help occurs?

If delegation is allowed, how many residents are getting help with medication administration by a UAP?

Is there a supervising nurse? And does she or he have any requirements?

How do your nurses respond to the social model AL?

Do you feel comfortable with medication technicians or UAPs giving out medication?

How do you monitor medication errors?

How does your state monitor quality in general?

What does your state do with incident reports?

How do your facilities work with consultant pharmacists?

Would you like to have general rules (like assessing quality)?

Is there anything you would like to add?

B. Nurses' Focus Group Protocol (Semi-structured)

What is going on in your state re: the administration of medication?

Can nurses function as nurses in your state?

If UAPs do administer medication, how are they doing?

How comfortable are you with delegating medication administration?

How do you monitor, in general, re: medication problems?

What system do you have for storing medications?

Is PRN medication an issue for you?

If you could change the world (of AL & nursing), what would you do?

Appendix D

Table 1: Selected Findings of Interviews with Executive Staff from State Boards of Nursing

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Alabama	Any setting (Note: see comments) No limit to care tasks through a list except in schools and state sponsored independent living settings Accountability is determined on a "case by case basis" (Note: Regulations state RN accountable for outcome of delegation)	Not permitted UAPs can assist with self administration No delegation of other sample care tasks except unsterile dressings State considered changing medication administration policy but decided to continue requiring licensed persons to administer medications	Concerned about the general safety of residents in AL; feels many have high level of needs and should be in a skilled nursing facility	Believes current policies are working well	Regulations 610-x-6-.02 and 610-x-7-.04 appear to allow broad discretion for delegation but practice appears to be limited in assisted living The issue of delegation was explored but the practice of now allowing nurses to delegate medication administration was continued

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Alaska DID NOT ACCEPT INVITATION TO INTERVIEW Data provided from review of laws and survey of licensing directors (Mollica, 2002)	Specific delegation rules for assisted living settings: Article 9: 12. 44.950.: Nursing tasks in AL Homes: The Board's June 2, 1995 statement 'Regarding Delegation by Nurses of Nursing Tasks to Unlicensed Assistive Staff of Assisted Living Homes' is adopted by reference, as a regulation, for application for assisted living homes, to satisfy AS 47.33.020(e)(2)" (Part of AL statute/regulations) AS 47.33.020 (e) (2): (e) A person who is on the staff of an assisted living home and who is not a nurse licensed under AS 08.68 may perform a nursing task in that home if … that nursing task is specified in regulations adopted by the Board of Nursing as a task that may be delegated Accountable for process and outcome; law also clarifies responsibility of UAP to perform the delegated activities correctly	Appears to be permitted; licensing director says trained aides can administer medications	Not available	Not available	No interview Alaska's regulatory specificity regarding nurse delegated tasks in assisted living is unique Not clear whether or not NPA/regs permit a nurse to delegate medication administration to UAPs in AL but licensing director indicates trained aides can administer medications

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Arizona	Any setting No limit to care tasks through a list Training is included for certified UAPs (C.N.A.), it includes 100 hours of training and it requires both a written and demonstrated test Supervision at the discretion of the nurse Accountable for both the process and outcome of delegation	BON says not permitted (Note: State licensing agency says UAPs can administer medications in AL (Mollica, 2002) UAPs can assist with self-administration Nurses can delegate other sample care tasks (unsterile and sterile dressings, bowel treatments)	Concerned with knowing if the UAP is competent to manage the task and the outcome	Unsure ; does not know AL well enough	Limited knowledge of AL; stated another state department might have regulations Practice Task Force is studying delegation of care tasks in AL (including medication administration)

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Arkansas	Any setting List of tasks that can be delegated is specified for some settings (like schools) (Note: Law states the nurse can delegate what a reasonable and prudent nurse would delegate) Supervision may be by phone at nurse's discretion Accountable for process of delegation (Note: regulations are more vague; nurse "retains accountability for the total nursing care of the individual")	Can delegate administration of oral medications; no injections (including pre-drawn insulin) Can delegate some sample/complex tasks (including gastric tube feedings and bladder catheters) but not others (like bowel treatments)	UAPs have too much responsibility, too little training, too little supervision	Not available	According to licensing director for AL, UAPs cannot administer medications (Mollica, 2002)

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California	Any setting Limit to care tasks specified; Law specifies no delegation of medications, tube feedings, suctioning, inserting nasogastric tubes or catheters Accountable for delegation process	Not permitted UAPs can assist with self-administration Cannot delegate any of the sample care tasks except unsterile dressings (Note: AL Administrator in focus groups stated that outside licensed professional has to be contracted to give any meds)	None—pretty restrictive in this state Unsure which state departments regulates AL	Does not know	Restrictive policies for delegation

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Colorado	Any setting No limit to care tasks through a list Nurse is responsible for determining competency of delegatee and degree of supervision Accountable for delegation process (Note: Law states the nurse is responsible for the quality of care provided by others through delegation; would appear to hold the nurse accountable for the outcome also)	Permitted Department of Health regulations permit trained UAPs to administer oral medications without nurse delegation but nurse must delegate injectibles Can delegate all sample care tasks	None Nurses usually not present in AL No harm	Not sure Another department regulates AL	Nurse has broad discretion for delegation Interviewee notes that another state department has more regulations regarding training and supervision of UAPs in AL because another statute exempts UAPs in AL from the NPA Accountability may need to be clarified in the law

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Connecticut	Any setting No list for care tasks but cannot delegate medication administration Aide in AL must have federally mandated home health training and testing Nurse must be available on site 20 hours a week and phone consultation Accountable for both process and outcome	Not permitted UAPs can assist with self-administration Nurse can delegate other sample care tasks like sterile dressings and tube feedings, but BON does not support bladder catheters and bowel treatments	AL is pushing the edge of the envelope in assistance with self-administration of meds	Works well unless the consumer needs more care than what the state's model of AL allows—then there is a problem; It is an admittance problem and an aging in place problem	Only state that has no nurse practice regulations; does have guidelines that address delegation (but no force of regulation) Social model of AL is a problem for those who need more care, including help with medications

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Delaware	Any setting Limit to care tasks through a list of exclusions (like sterile, invasive procedures); law does not permit delegation of medication administration in any setting Flexible training requirements; nurse needs to know UAP can perform the task and can either do the training or rely on outside training Supervision by phone Accountable for both process and outcome of delegation	Not permitted UAPs can assist with self-administration Can delegate unsterile dressings, tube feedings (if a well established site), care of bladder catheters (but no insertion), and bowel treatments (including impactions and enemas) List of what cannot be delegated: 7.7.4.5: performance of sterile invasive procedures involving a wound or anatomical site; nasogastric, newly established gastrostomy and jejunostomy tube feeding; nasogastric, jejunostomy and gastrostomy tube insertion or removal; suprapubic catheter insertion and removal	Concerned that UAPs who are providing assistance with self-administration of medications are actually administering medications without adequate training Residents often do not get their medications on time and some do not get all of their medications	Does not think current policies are working well	Nurses can delegate complex tasks like tube feedings in AL but not medication administration because the law precludes in any setting BON does not support medication aides but concerned that that UAPs are essentially administering medications without enough training

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Florida	Any setting No limit to care tasks through a list Nurse is responsible for determining the UAP's level of knowledge before delegation; Training for delegation by the nurse or facility Nurse determines competence (no written test) of delegatee and supervision required Accountable for process and outcome (Note: Law does not appear to specifically address)	Not permitted UAPs can assist with self-administration Delegation of all other sample care tasks, including managing tube feedings and inserting and changing bladder catheters	No problems thus far, but lack of monitoring might be a concern; difficult to know what is actually happening	Does not think current policies are working well	Nurses can delegate complex tasks like tube feedings and bladder catheters in AL but not medication administration Nurses in the focus groups indicate that Florida has several types of AL licenses; they can only give medications in the congregate type

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Georgia DID NOT ACCEPT INVITATION TO INTERVIEW Data provided from review of laws, focus groups, and survey of licensing director (Mollica, 2002)	Law appears to allow delegation with some nurse discretion	Not available from BON (Note: Licensing director says UAPs cannot administer medications in AL but can assist with self-administration Also, administrator in focus group states that RNs cannot administer meds in AL as an employee of AL; RN from a licensed agency can administer meds and physicians may delegate a staff person to inject insulin under an established medical protocol)	Not available	Not available	No interview Appears that RN cannot delegate medication administration but MD can

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Hawaii	Law permits the nurse to delegate in any setting, provided that when the nurse is not regularly scheduled (including assisted living) and not available to provide direct supervision, the nurse shall provide indirect supervision (available for consultation) Nurse is accountable for the decision to delegate and is "accountable for the adequacy of the nursing care to the client, provided that the unlicensed assistive person performed the task as instructed and delegated by the delegating nurse"	Permitted by law	None	Seems to be working well	No interview Law has some unusual provisions, with some similarities to Oregon to provide for more discretion in community-based settings, including assisted living

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Idaho	All settings No limit to care tasks through a list Board-approved training for UAPs required for certain tasks, including assistance with medications Board approved training of UAPs Nurse determines the degree of supervision Accountable for both process and outcome (Note: Law states the UAP is personally accountable and responsible for all actions in carrying out activities delegated to them)	Not permitted UAPs can assist with self-administration of meds Nurse can delegate other sample care tasks, including tube feedings, unsterile bladder catheters and bowel treatments	Concerned about the increasing acuity levels of residents in AL; Although UAPs are not permitted to administer meds, they probably do; Has not seen any harm but believes the potential for harm is a concern	Not working well; Feels that consumers' needs exceed the capacity of AL according to current law; This is particularly problematic in making sure AL residents get the help they need in getting their medications; Many need more than assistance with self-administration of medications	Nurses can delegate complex tasks like tube feedings in AL but not medication administration BON has a subcommittee for UAPs now working on issues; future changes in the law or practice rules may make it clearer that UAPs cannot administer medications in AL

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Illinois DID NOT ACCEPT INVITATION TO INTERVIEW Data provided from review of laws and survey of licensing directors (Mollica, 2002)	Law appears to provide broad authority for nurse delegation with no limits to settings or care tasks Regulations state the RN shall be "accountable for the quality of nursing care delegated to others;" Appears to include accountability for outcome	Licensing director indicates trained aides cannot administer medications; they can assist with self-administration	Not available	Not available	No interview

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Indiana	Any setting No limit to care tasks through a list Accountability not defined (Note: Law appears vague)	Not permitted (Note: Licensing director says trained aides can administer meds, Mollica, 2002) UAPs can assist with self-administration Cannot delegate any sample care tasks	Not sure of other departments' regulations on AL	Does not know how residents get assistance with medications	Appears to be very restrictive Although nurses can delegate to UAPs in any setting, it does not appear to be permitted in AL Licensing director says trained aides can administer meds; appears to be outside of a delegation model

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Iowa	Any setting No limit to care tasks through a list No specific training required; nurse must know the UAP is competent to perform the task before delegating Nurse decides supervision Accountable for both process and outcome	Can delegate oral meds, no injections (including insulin) UAPs can assist with self administration of meds Can delegate other sample tasks, but not tube feedings	Not sure how many nurses are practicing in AL but says nurses complain that they are asked to delegate more than they are comfortable delegating No indication of harm; no formal complaints yet	Not familiar enough about AL to express opinion	

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Kansas	Certain settings No limit to care tasks through a list Training varies according to other department regulations Degree of supervision determined by nurse Accountable for process and outcome	Permit oral meds only, but controlled by another state department Cannot delegate other sample care tasks, except unsterile dressings	Concerned that consumers do not have enough protections re: medication administration	Hearing it works well	There is much involvement in AL by other state regulatory agencies; the role of nursing and delegation of care tasks is beyond the control of other agencies—communication and misunderstanding of statutory requirements by other agencies is a frequent problem

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Kentucky	Any setting No limit to care tasks through a list No specific training for UAP but nurse must assure the UAP has skill Supervision at the discretion of the nurse Accountable for both process and outcome (Note: Law appears more vague)	Not permitted UAPs can assist with self-administration for "cognitively able" AL residents Nurse can delegate other care tasks, including gastrostomy tube feedings, bowel treatments, and unsterile/intermittent bladder catheters	Concerned that AL residents have skilled care needs that exceed the capacity of AL to provide Lack of standardized training for UAPs for assistance with self-administration; concern for cognitively impaired AL residents; no evidence of harm yet	Unsure	Continuing to study the issues surrounding the regulation of UAPs including standardization of training and the issuance of credentials; feels understanding and utilization of delegation may increase; possible (but not definite) that strengthened regulations might permit delegation of medications administration

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Louisiana	Any setting No limit to care tasks through a list Training varies Supervison at the discretion of the nurse Accountable for process and outcome	Not permitted UAPs can assist with self-administration Nurse can delegate other sample care tasks, including tube feedings, intermittent bladder catheterization, and some bowel treatments	BON has not really addressed AL Unaware of how many nurses practice in AL or in what capacity	Seems to be acceptable, but rules to address assistance with self-administration are lacking Concerned about cognitively impaired residents in AL	
Maine	Any setting Limit care tasks to those taught in the certified nursing assistant curriculum Training and test required On-site supervision by nurse when delegating Accountability not addressed	Permitted only to certified nursing assistants but no injectibles and PRNs only after nurse assessment Nurse can delegate some other sample care tasks, but not bladder catheters or bowel treatments	Board has not had full discussion of concerns	Does not know	

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Maryland	Any setting No limit to care tasks through a list No requirements to be a nurse assistant in AL, but specific training for med aides Accountable for delegation process State requires nursing assistant certifications if performing nursing functions delegated by a nurse Nursing assistant certification separate from medication assistant regulations	Permitted, including subcutaneous injections Nurse can delegate all other sample care tasks at the discretion of the nurse	Hearing about medication errors, but another state department regulates and they get the information Some indication of harm; residents going to hospitals more for being over or under medicated, or receiving meds that have been discontinued Nurses need more education on delegation	Not always	Complex and continually evolving policies in relation to changing consumer demands; State has given much attention to delegation policy and works with other state departments in issues related to AL; Several levels of ALs in state; Several categories of aides in state—can perform different kinds of care tasks Regulations being reviewed and revised "Delegating nurses" contract with the state to provide case management for community-based care, including AL

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Massachusetts	Any setting Limit to care tasks; primarily delegate only assistance with ADLs and cannot delegate medication administration except in certain circumstances Accountable for both process and outcome	Not permitted UAPs can assist with self-administration Role of the nurse limited in AL by AL regulations and therefore cannot delegate medications		If a person needs more than assistance with self-administration, the family must hire a home health nurse	AL is a "social model" and RNs have limited practice in AL except through home care agencies
Michigan DID NOT PROVIDE AN INTERVIEW Data from laws and survey of licensing directors (Mollica, 2002)	Any setting No limit to care tasks through a list Accountable for both process and outcome	Licensing director says trained med aides can administer medications	Not available	Not available	No interview

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Minnesota	Any setting Core training required Nurse must instruct client how do perform the delegated task for each client (Note: Law states that the AL provider retains documentation by the RN regarding the UAPs demonstrated competency) On-site RN supervision within 2 weeks and every 62 days Accountable for process of delegation	Permitted, including pre-filled insulin but no other injectibles Can delegate all other sample care tasks	Concerned that delegating nurses are unaware of their responsibility to evaluate the outcomes of delegation Anecdotal reports of instances of medication errors by omission or not giving at appropriate time; Don't know if harm	They have concerns re: nursing care in AL because they have received some complaints, some of which are egregious	Regulations outside of NPA refer to assisted living and administration of medications

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Mississippi	Any setting No limit to care tasks through a list Nurse responsible for making sure UAP has the training and competency needed to perform the task Accountable for process and outcome	Not permitted Nurse can delegate some sample tasks, such as bladder catheters (has a BON position statement on catheterization by UAPs)	None provided; BON has not specifically addressed AL	Not provided	
Missouri DID NOT ACCEPT INVITATION TO INTERVIEW Data provided from review of laws and survey of licensing directors (Mollica, 2002)	NPA appears to provide broad discretion for nurse delegation No language in NPA or regs that specifies accountability for process and/or outcome of delegation	Licensing director states that trained aides can administer medications Medication administration (except injectables other than insulin) is permitted in licensed long-term care facilities	Not available	Not available	No interview

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Montana	Certain settings Includes community-based residential settings, but has not addressed AL yet (Note: Law state that delegation is "never appropriate" in acute care or long-term care facilities) Cannot delegate injections, sterile procedures or invasive procedures Nurse determines competency and the degree of supervision, but generally monthly on-site supervision and availability by phone Accountable for delegation process	Permitted for oral medications, including PRNs; no injectibles (including pre-filled insulin) UAPs can also assist with self-administration Can delegate some of the sample care tasks, but limited to unsterile dressings and bowel treatments in AL	Assistance with self-administration really means medication administration UAPs need some training for this—everyone acknowledges this Don't know if any harm	No; Looking forward to more training requirements for UAPs to give medications	BON task force looking at medication administration in AL—will support UAP medication aides in A; BON would regulate these aides Delegation language unusual since it describes settings in which delegation is "never appropriate" Certain aspects of medication administration and gastrostomy tube feedings specified Clearly much discussion about delegation & exemption

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Nebraska	Any setting No limit to care task through a list Degree of supervision left up to the nurse Training required for medication aide Accountable for both process and outcome	Delegation of meds is not permitted, however trained aides can administer all meds including all injectables and prns Nurse cannot delegate any of the sample care tasks However, the AL resident can direct the UAP to administer medications and all other sample tasks as a "health maintenance activity" (so no need for nurse delegation—the consumer is directing the care)	Medication aides can monitor effects of medication under the RN/consumer direction model; resident caretakers can also monitor for side effects of medicaiton	Working, but a learning curve; Need a licensed professional to monitor for side effects	AL care by UAPs falls more under an exemption category than delegation model; Consumer can direct UAP in assistance with health maintenance activities, including medications; In addition medication aides are regulated by another state department and can administer medications in AL

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Nevada	Any setting (but uses "assign" instead of delegation when referring to UAPs) No limit to care tasks through a list Nurse determines competency and degree of supervision States no language on accountability (Note: Law indicates that the nurse is held accountable for both process and outcome)	Not permitted UAPs can assist with self-administration Nurse cannot delegate (or assign) most sample care tasks, except unsterile dressings and bowel treatments	No concerns because BON does not have any jurisdiction	Not working well; UAPs are probably providing more than assistance with self-administration	State refers to "assignment" instead of delegation (unusual, but see New York also)
New Hampshire	Any setting No limit to care tasks through a list, only a list of examples 100 hours of training Supervision is by telephone (after an in-person initial assessment) Accountable for process of delegation	Can delegate oral medications only (Note that licensing director states that UAPs cannot administer medications) UAP can assist with self-administration Can delegate all sample care tasks except injectible medications	Will evaluate delegation processes every six months to ensure for quality	Current policies do not work for the consumer; Reviewing the NPA because it needs to "be more consumer-friendly"	Discrepancy between BON and state licensing director; Licensing director states that a pilot study is underway that is looking at UAPs administering medications in AL

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New Jersey	Any setting No limit to care tasks through a list Board approved training required and a written test and may include a test via observation to assess skills Nurse determines degree of supervision Accountable for process of delegation but when the nurse identifies an error for which the UAP is responsible, she or he must intervene both pathophysiologically and managerially in order to correct the consumer's condition and his or her situation (Note: Law is more vague)	Permitted (except injections other than pre-drawn insulin and PRN medications) Nurse can delegate other sample care tasks, but not inserting bladder catheters	None; Very comfortable with AL No indication of harm	Works well	Regulations under revision; delegation of medication administration in assisted living specified in regulation under the Department of Health and Senior Services

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New Mexico	Any setting No limit to care tasks through a list but delegation of medications only to certified medication aides in programs for people with developmental disabilities (community programs or intermediate care facilities) Training required by Department of Health Nurse determines level of supervision required Accountable for both process and outcome	Not permitted UAPs can assist with self-administration Cannot delegate other sample care tasks, except dressings	BON not involved in AL Concerned with safety of AL residents and whether UAPs are adequately prepared	Does not know	

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New York	No delegation to UAPs in any setting No language on accountability	Not permitted UAPs can assist with self-administration No delegation of other sample care tasks (because no delegation)	BON is not involved in AL	Probably working fine People may need to leave AL because they may not be getting their medications administered	No delegation, but can "assign" to UAPs (like Nevada, uses assignment language instead of delegation to UAPs)
North Carolina	Any setting Care tasks limited through a list Training and test required Nurse determines delegatee's competency and level of supervision or oversight required; Required on-site every 60 days in AL Accountable for both process and outcome (Note: Law appears more vague)	Permitted (except non-insulin injectibles) as an "exception" (when health care within AL as a "social model" is considered "incidental")—nurse providing more oversight than delegation Nurse can provide oversight over all other sample care tasks performed by a UAP	Faculty requirements need to be standardized; Concerned about increasing complex care in AL; Accountability needs to be clearer	Yes; Improved since legislature required UAP competency testing in place for 2 years; legislature provided money to do this to prevent medication errors	BON and Division of Facility Services formed a task force to work on changes that would further clarify delegation and accountability AL regs address nurse delegation or "oversight" of medication administration and other care tasks; health care within AL as a "social model" is considered "incidental"

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North Dakota	Any setting Nurse determines supervision Limit to care tasks specified Training and testing required for medication assistants Nurse determines supervision Accountable for both process and outcome (Note: Law specifies that the nurse is accountable for individual delegation decisions and *evaluation* of outcomes)	Permitted (except injection other than pre-filled insulin) if UAP completes a med course (Note: Law states nurse can delegate medication administration to aides who have met requirements—but also discretion allowed when the "nurse specifically delegates to a specific nurse assistant the administration of a specific medication for a specific client") Nurse can delegate some other sample care tasks but not tube feedings or bladder catheters	Concerned that delegation could be used to replace nurses; wants it used to assist nursing, not replace it; Concerned about improper delegation No indication of patient harm	Working well	Works closely with other state departments involved in AL regulation Nurse can delegate medication administration but not other complex care tasks like tube feedings or bladder catheters

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Ohio	Any setting No limit to care task through a list Training is required: nurse needs to confirm the UAP has appropriate education & training and has demonstrated the competencies to perform the tasks Supervision is determined by the nurse on a case by case basis Accountable for both process and outcome (Note: Law appears more vague)	Not permitted (Note: Licensing director also states that UAPs cannot administer medications) UAP can assist with self-administration Nurse can delegate all other sample care tasks	Concern with some anecdotal reports that help with self-administration occurs with cognitively impaired residents	Does not know; Unaware of any problems that may occur because the UAP is monitored by the Department of Health	Focus group with administrators showed concern with liability for medication delivery systems and the potential for errors Separate legislation for Ohio's Department of MRDD allows the delegation of medication administration to UAPs who completed a prescribed training program

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Oklahoma	Delegation and care tasks are limited to setting type; there are 9 levels of nursing assistants and each level is limited to what tasks they can be delegated-if at all; The setting of care is related to level of care, and therefore delegation is setting specific Three levels of UAPs handle medication and each level has training requirements; Certified nurse assistant does not handle medications, but this is basic level from which the UAPs move into more responsible levels of care; their training includes 75 hours of training and 16 hours of supervised practice; Certified medication aide (CMA) & Medication tech (MT) are trained by the Department of Health, but MT already needs to be a certified nurse assistant; Supervision as agreed upon as necessary Accountable for delegation process	Permitted to CMA and MT for oral meds; CMA can administer pre-drawn insulin and vitamin B-12 (but no other injectables) CMAs and C.N.A.'s can do some sample tasks	No concerns	Works well for the consumer	Multiple regulations govern the delegation process

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Oregon	Certain settings Delegation rules apply only to settings where a RN is not regularly scheduled (like assisted living) Care tasks not limited by any list; Distinguishes between assignment (tasks can be taught to a group of UAPs for a group of consumers) and delegation (tasks delegated to a specific UAP for a specific consumer) Nurse must train UAP for specific delegation; statute provides guidance Supervision at discretion of nurse Accountable for process of delegation (Law states the nurse who follows the regulations is not subject to an action for civil damages for the performance of the UAP, unless the UAP is acting upon the nurse's specific instructions, or no instructions are given when they should have been provided; nurse retains the responsibility for determining the appropriateness of assigning or delegating nursing tasks to UAPs)	Permits assignment of oral meds (including PRNs) and delegation of injectibles Can assign and/or delegate all other sample care tasks	Concerned about lack of knowledge of nurses in AL in how to delegate and assign to UAPs No indication of harm	Working well	Maximum nurse discretion Accountability language noteworthy Assignment and delegation are clearly defined Reviewing policy to simplify rules

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Pennsylvania	Delegation is not permitted in any setting; Laws and regulation are silent re: delegation and the Independent Regulatory Review Committee interprets this as no authority to delegate Training, supervision and accountability do not apply	The BON has no jurisdiction over these settings or over UAPs Licensing director states that trained aides can administer medications (Mollica, 2002)	Unregulated delegation	Disjointed due to lack of explicit authority to delegate	PA nursing law and regulation do not address delegation

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Rhode Island	Certain settings Can delegate only to certified nursing assistants working in settings licensed by the Department of Health Training required and the aide needs to show competency for the delegated tasks The nurse needs to consider availability & proximity of delegatee to assistance (by nurse) Accountable for process and outcome	Not permitted UAPs can administer meds in licensed AL facilities; can also assist with self-administration in all AL facilities Can only delegate unsterile dressing changes	There not been enough attention to the issue of delegation of care tasks to UAPs in AL; Concerned about rising acuity of residents; Need to achieve consistency between BON regulations and Department of Health regulations; Needs much more attention	Says working well (but see concerns)	Licensing director says trained aides can administer meds in one level of care; in the other level of care-UAPs can help with self-administration Nurse practice act and regulations will be reviewed soon

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
South Carolina	Any setting There is a general list of care tasks, including oral & topical medications and anaphylactic medications Nurse conducts training after a competency evaluation; training is determined by the Department of Health and Environmental Control Supervision determined by facility Accountable for process and outcome	Medications (oral and injectables—as long as regularly scheduled insulin, or if it is prescribed anaphylactic treatment) can be delegated to UAP All other sample care tasks can be delegated, but a nurse would need to be present to delegate sterile and unsterile dressings (nurses are not required to be in AL); since tube feedings are nutrition tasks they can be delegated—but nurse needs to be on staff to delegate	No comments	BON does not have information on how their regulations are affecting the provision of meds in AL, concerned about client safety without onsite nursing	

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
South Dakota	Any setting Limit to care tasks set forth in list of prohibited tasks; Specific guidelines for distinguishing what can be delegated under what circumstances Training for med administration Supervision through nurse discretion Accountable for delegation process	Permit oral meds, including PRNs; No injectibles, including pre-filled insulin Can delegate most other sample care tasks, but not sterile dressings or some tube feedings (gastrostomy but not nasogastric)	None No indication of harm	Works well	

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Tennessee	Any setting No limit to care tasks through a list No specific training Unsure of supervision requirements in AL Accountable for process and outcome (Note: Law appears vague)	Not permitted UAP can assist with self-administration Can delegate few sample care tasks—only unsterile dressings	None Little knowledge of AL since regulated by another department Not sure who is administering meds to residents who need more than assistance with self-administration	Works well at present	Law allows delegation with no limits to care tasks through a list, but unable to delegate sample care tasks

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Texas	Two new delegation rules became law on 2/19/03 TX is not in favor of lists in general, but the list is a group of tasks with examples For a consumer who has an acute condition or is in an acute setting and for those in an independent living environment, training is dependent upon practice setting, there are general guidelines in rule for the training of UAPs that includes manner of instruction and demonstrating competency Supervision is up to nurse's discretion Accountable for process of delegation New concept in rule 225: tasks may be exempted from delegation if certain criteria can be met	Can delegate medication and insulin but no other injectables and PRNs only if simple and routine per the RN judgement Can delegate all other sample care tasks There is no delegation of meds in acute care settings or when consumer requires continuous care management	The enforcement division has not had many complaints Concern or mission is to protect the public, there is another driving force in TX for people with disabilities to live in least restrictive setting as possible	Beyond jurisdiction of TX BNE and therefore cannot speak to regulation of other agencies; referred to Department of Human Services	New rules available: www.bne.state.tx.us

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Utah	Any setting No limit to care tasks through a list Nurse has discretion to determine UAPs competency and degree of supervision required Accountable for delegation process (Note: Law appears more vague)	Permitted, including injectibles and PRNs Nurse has authority to delegate all sample care tasks	Concerned about medication administration Aware of one case of harm to a person at the present time because the person was given the wrong medication	Working well under current financial constraints but would rather have an RN or LPN in every AL facility	Nurse appears to have broad discretion to delegate sample care tasks, including medication administration, with flexibility in training and supervision
Vermont	Any setting No limit to care tasks through a list Nurse assesses degree of competence and supervision needed Accountable for both process and outcome (Note: Law appears more vague)	Permitted, including pre-filled insulin but not other injectibles or PRNs Can delegate all other sample care tasks at the discretion of the nurse	Not in AL; more concerned about residential care homes where residents have more acute needs No harm	Working well	Nurse has broad discretion to delegate care tasks; Interviewee notes that other state departments can have rules that restrict the authority of the nurse to delegate, even though the BON allows discretion regardless of setting

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Virginia	Any setting Nurse assesses delegatee's competency and need for supervision Limit to care tasks; administration of medications limited Nurse assesses degree of competency Onsite supervision required in AL Accountable for delegation process (Note: Law appears vague)	Not permitted; however, trained aides can administer medications through an exemption permitted in law UAPs can assist with self-administration	None	Don't know The state department that regulates AL should know	Licensing director confirms that trained aides can administer meds; appears to be outside the delegation model

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Washington	Certain settings: More progressive delegation is in community-based settings including AL; however delegation not fully allowed in home setting—although this may change soon; delegation occurs in boarding homes w/ a care plan in place for more chronic and predictive care No list (there was a list but it was too concrete so changed to no list) Training: basic credential is nursing assistant which includes 9 hours of delegation training; Nursing assistant registered is a more advanced UAP that includes a 22-hour course in the fundamentals of caregiving Supervision: nurse needs to check registration/certification of the UAP, ensure it is current and needs to determine competency of UAP In general nurse is responsible for process and outcome, but if nurse properly delegated then not responsible for outcome	Permitted for oral medications (inlcuding PRNs), but not injectables of any type; However, the UAP needs to be specially trained as does the "Delegating Nurse" Nurse can delegate some other sample care tasks, including unsterile dressings and non-sterile straight catheterizations and bowel treatments (suppositories); no tube feedings	Seems to work very well, because it is more familiar to the participants involved; there were worries in the beginning but now people are comfortable with it	It works well except for the issue of the nursing assistant; nursing assistant needs to be more clearly defined—probably through statute	Training for delegating nurse is noteworthy State has been evolving delegation policy over last several years and has studied outcomes (see Sikma & Young, 2001)

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
West Virginia	Any setting No limit to care tasks through a list Training required for UAP, with a written test Nurse determines degree of supervision Accountable for both process and outcome (Note: Law appears more vague)	Permitted, oral medications only—no injectibles (including pre-filled syringes) or PRNs Cannot delegate other care tasks, except unsterile dressings	None at present No indication of harm	Works well	
Wisconsin	Any setting No limit to care tasks through a list Training is determined by the RN Supervision is availability by telephone (after initially assessing UAP in person) or general supervision for stable clients No language on accountability	Permitted Can delegate all sample care tasks	Nothing specific	Does not know, referred to Department of Health and Family Services	

State	Delegation Policy in General	Delegation of Medication Administration in Assisted Living	Concerns	Assessment of Current Policies for How Consumers get their Medications in AL	Comments
Wyoming	Any setting (as long as facility allows it) List specified in the Rules for the Certified Nursing Assistant/Nurse Aide; includes basic nursing skills like vital signs, ADL assistance, and restorative care (range of motion exercises) Supervision on-site (or by telephone in an AL setting) Accountable for process of delegation (Note: Law states nurse is accountable for the "overall outcome")	Not permitted. C.N.A's can assist with self-administration Licensing director states that trained aides can administer medications (Mollica, 2002) Can only delegate unsterile dressings and bowel treatments (enemas)	AL is taking more complex residents above certified nurses aide care; the Department of Health allows residents to contract with home health agencies to provide higher level of care	Does not know	State appears to permit trained aides to administer medications outside the delegation model

Key

UAP = Unlicensed assistive personnel (includes personal care attendants)

LPN=Licensed practical nurse

RN = Registered nurse

ADLs=Activities of Daily Living (bathing, dressing, eating, toileting, and transferring)

PRNs=medications given as needed; requires some judgement by the consumer and/or person administering the medication. Often used to manage pain.

NPA=Nurse Practice Act.