

# Medication Safety on a Busy Shift: Where Nurses Feel the Pressure

What nurses report about medication safety when staffing is tight, interruptions keep coming and technology does not work exactly as planned.

Nurses · 6 countries · Global peer perspectives

238

Complete responses

381

Survey records

6

Countries represented

62.5%

Completion rate

## THE PEER QUESTION

### When the shift gets stretched, which medication safety check becomes hardest to protect?

On a medication round, a scanner, eMAR alert or smart pump can help catch a mistake, but none of them removes the realities of the shift. Nurses still work through short staffing, interruptions, missing medications, changing priorities, equipment problems and the need to find a second checker. This report looks at where medication safety becomes hardest to protect when the unit is busy.

AHRQ describes barcode medication administration as a patient-safety tool, while also noting that training, reliable equipment, workflow fit and attention to workarounds influence how well it performs in practice.

**Coverage:** United States, United Kingdom, Canada, Italy, France, Germany. Findings describe the opinions and reported practice or operating patterns of participating respondents. Question-level response bases vary because not every survey record answered every item.

## EXECUTIVE SUMMARY

### The pattern in one view

The clearest message is not that nurses reject medication technology. They want it to work in the conditions they actually practice in. On a busy shift, safe medication administration still depends on a working scanner, the medication being available, a second nurse who can truly check, alerts that deserve attention, protected concentration, practical training and enough staff to avoid rushing the process. Technology matters, but so do the conditions around the nurse using it.

#### 01 / PEER SIGNAL

##### Short staffing reaches the medication pass

46.9% Ratios exceed stated safe levels on 20% to 50% of shifts.

#### 02 / PEER SIGNAL

##### Checks get rushed under pressure

57.4% Understaffing has a moderate impact on standard medication safety checks.

#### 03 / PEER SIGNAL

##### Workarounds keep care moving

63.5% Occasional workarounds are the most common response when systems block the medication pass.

#### 04 / PEER SIGNAL

##### The second check can become superficial

42.4% Time pressure can reduce the depth of an independent double-check.

## SECTION 01

### Short staffing follows nurses into the medication pass

#### CONTEXT

For many respondents, staffing pressure is part of the shift itself. Medication administration happens inside that pressure, not outside it.

#### DATA

46.9% say patient-to-nurse ratios exceed stated staffing guidelines on 20% to 50% of shifts, while 27.8% say this happens on more than half of shifts. Only 25.3% report that it happens rarely or never.

#### INSIGHT

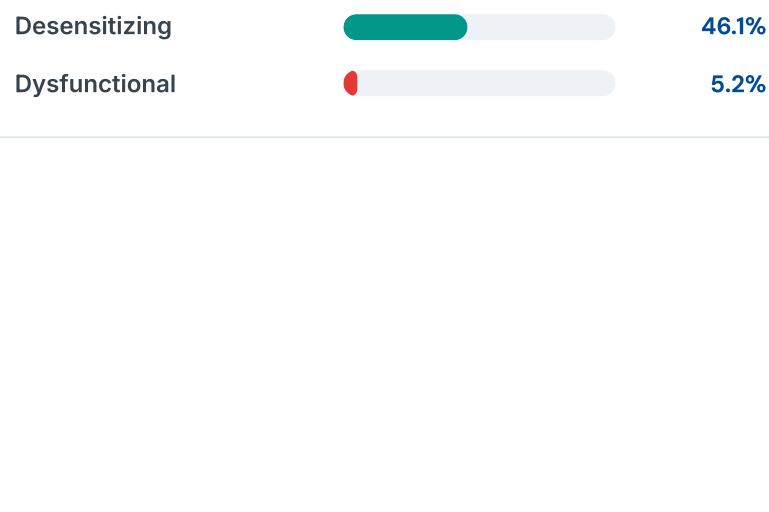
When the assignment stretches, the nurse still has to prepare, verify, administer and document medications while responding to patients. The safety process does not get shorter just because the shift has less time.

#### WHY IT MATTERS

This helps explain why 57.4% also say understaffing has a moderate impact on standard medication safety checks, including rushed double-checks and administration under intense time pressure.

#### Short staffing follows nurses into the medication pass

Percent of responding participants at this question



## SECTION 02

### When alerts become background noise

#### CONTEXT

Medication alerts are meant to stop a nurse at the right moment. On a busy shift, repeated low-value warnings can compete with everything else already demanding attention.

#### DATA

46.7% describe automated medication alerts as desensitizing. The response pattern is nearly split: Highly effective 48.7%, Desensitizing 46.1%, Dysfunctional 5.2%.

#### INSIGHT

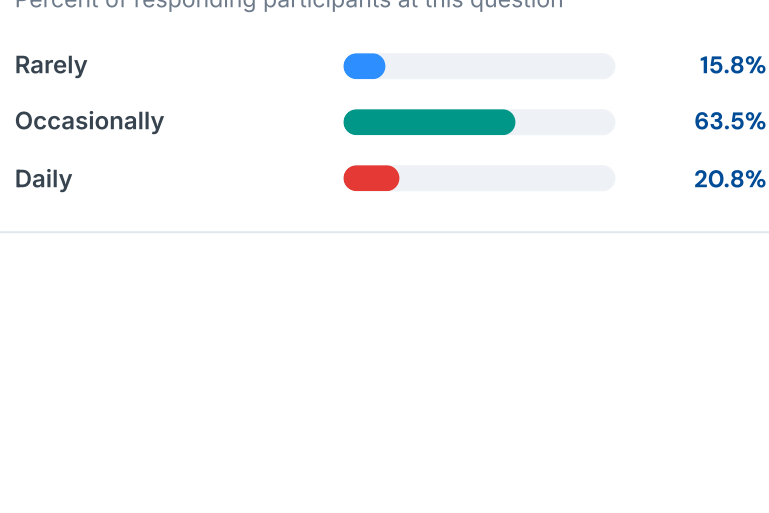
The issue is not whether alerts exist. It is whether the important alert still feels important when a nurse has already seen many other warnings during the medication pass.

#### WHY IT MATTERS

An alert system adds value when it helps nurses focus on the warning that matters, rather than adding another stream of interruptions to an already busy workflow.

#### When alerts become background noise

Percent of responding participants at this question



## SECTION 03

### When the scanner fails, nurses still have to give the medication

#### CONTEXT

Barcodes do not always scan, medications can be missing from automated cabinets and equipment can fail. The patient still needs care, so nurses find a way to keep the medication pass moving.

#### DATA

63.5% say functional medication workarounds are used occasionally, while 20.8% say they are used daily. Only 15.8% say workarounds are rarely needed.

#### INSIGHT

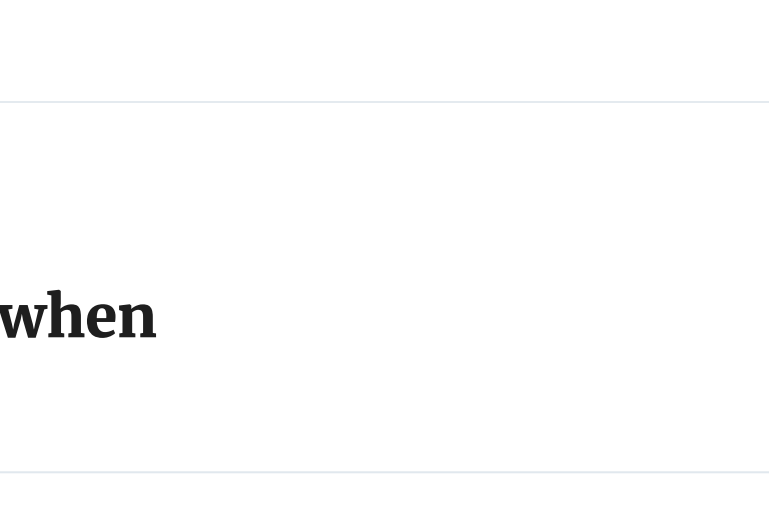
Workarounds are not a side issue in these responses. They are part of how nurses keep care moving when the designed path stops working.

#### WHY IT MATTERS

If nurses repeatedly need an exception path, that is a signal that the workflow itself needs attention before the workaround becomes normal practice.

#### When the scanner fails, nurses still have to give the medication

Percent of responding participants at this question



## SECTION 04

### Near misses only help if nurses feel safe reporting them

#### CONTEXT

Medication safety depends on learning from close calls, not only from errors that reach the patient. That learning becomes harder when reporting feels personally risky.

#### DATA

49.2% say punitive fear has a moderate impact on medication-error or near-miss reporting, and 15.5% report a severe impact. 35.3% say it has no impact.

#### INSIGHT

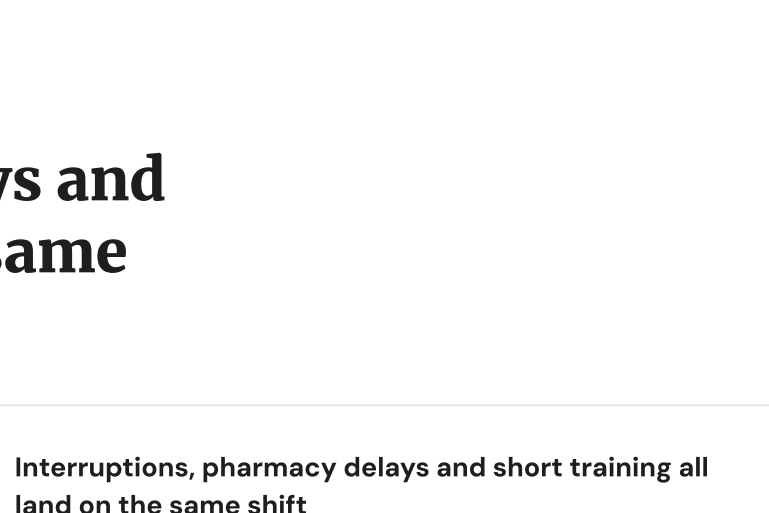
For almost two-thirds of respondents, fear has at least some effect on willingness to report. Useful early warnings about a weak process may therefore never reach the formal safety system.

#### WHY IT MATTERS

Nurses need accountability and a learning environment at the same time. If reporting feels unsafe, teams lose information about where medication processes are breaking down.

#### Near misses only help if nurses feel safe reporting them

Percent of responding participants at this question



## OPEN-ENDED PERSPECTIVE

### What nurses said in their own words



#### Technology helps, but nurses do not see it as foolproof

Open comments repeatedly say scanners, eMAR systems, pumps and alerts can improve safety, but they cannot remove the possibility of medication error.



#### A scanner or software failure changes the whole medication pass

Respondents describe scanner failures, slow or difficult software and hard-to-access information as problems that create delays, extra steps and workarounds.



#### Nursing judgement is still the final check

Several comments return to the same point: technology can support a decision, but it does not replace professional judgement, vigilance and verification at the bedside.



#### Staffing and the second checker matter as much as the device

Open responses link technology problems with workforce shortage, interruptions and the practical difficulty of finding another nurse for a meaningful double-check.



#### Policies can look very different from the floor

Some respondents describe a gap between how medication technology and protocols are designed and what actually happens during live patient care.

## PRACTICE PATTERN

### What nurses are really asking for



#### Nurses need time to do the safety check properly

The data repeatedly connects staffing pressure with rushed checks, interruptions and difficulty protecting the medication pass.



#### Technology has to work with the shift, not against it

Scanner failures, workarounds, smart-pump overrides and abbreviated training all point to the same need: systems that fit real bedside workflows.



#### Near misses need to be safe to talk about

Reporting only strengthens medication safety when nurses can surface problems early without disproportionate fear of personal consequences.

## CLOSING PERSPECTIVE

### Medication Safety on a Busy Shift: Where Nurses Feel the Pressure

The clearest message is not that nurses reject medication technology. They want it to work in the conditions they actually practice in. On a busy shift, safe medication administration still depends on a working scanner, the medication being available, a second nurse who can truly check, alerts that deserve attention, protected concentration, practical training and enough staff to avoid rushing the process. Technology matters, but so do the conditions around the nurse using it.

## PEOPLE ALSO ASK

### Questions nurses ask about medication safety on a busy shift

#### Why do medication workarounds happen on nursing units?

The survey points to practical breakdowns such as scanner problems, missing medications, equipment issues and workflow barriers. A workaround may keep care moving in the moment, but repeated workarounds also show where the intended process is not fitting the realities of the shift.

#### How can alert fatigue affect a medication pass?

When warnings are frequent or repetitive, they compete for the same attention nurses need for patient assessment, preparation, verification and administration. In this survey, almost as many nurses described alerts as desensitizing as described them as highly effective.

#### Why does staffing pressure matter for high-alert medication checks?

High-alert medications often require extra verification and, in some settings, an independent second check. When the unit is stretched, nurses may have less time to slow down, find another available nurse or complete each step with the intended depth.

#### What makes an independent double-check different from a second signature?

The survey distinguishes a full independent re-verification from a fast sign-off made under time pressure. The difference is not the presence of a second name in the record, but whether the second nurse has actually repeated the critical checks independently.

#### Why are interruptions during medication preparation a concern for nurses?

The survey shows that protected medication-preparation zones are often only partly effective. Call lights, conversations, alarms and other demands can still break concentration while a nurse is preparing or checking medications.

#### Why can medication technology still create extra work for nurses?

Technology can add safety, but the survey also captures extra steps when scanners fail, barcodes do not match, pharmacy workflows are delayed, pump profiles are not current or staff receive only brief training before new systems go live.

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## SELECTED EXTERNAL CONTEXT

- [AHRQ Bar-coded Medication Administration](#)
- [AHRQ PSNet: Medication Administration Errors](#)
- [AHRQ: Using Just Culture](#)

**Source note:** External references provide clinical, operational or regulatory context. All MDForLives percentages and response counts come from survey SGID 8917176.

## Visual Graphs and Backend Data

Percentages and counts are reproduced from MDForLives survey SGID 8917176. Question bases vary across partial completes.

### Survey profile

| Metric               | Value                                                         |
|----------------------|---------------------------------------------------------------|
| Completion rate      | 62.5%                                                         |
| Complete             | 238                                                           |
| Partial              | 143                                                           |
| Total survey records | 381                                                           |
| Countries            | United States, United Kingdom, Canada, Italy, France, Germany |

### Section 01: Short staffing follows nurses into the medication pass

| Response option | Percent | Responses |
|-----------------|---------|-----------|
| Never / rarely  | 25.3%   | 70        |
| Sometimes       | 46.9%   | 130       |
| Chronically     | 27.8%   | 77        |

### Section 02: When alerts become background noise

| Response option  | Percent | Responses |
|------------------|---------|-----------|
| Highly effective | 48.7%   | 132       |
| Desensitizing    | 46.1%   | 125       |
| Dysfunctional    | 5.2%    | 14        |

### Section 03: When the scanner fails, nurses still have to give the medication

| Response option | Percent | Responses |
|-----------------|---------|-----------|
| Rarely          | 15.8%   | 41        |
| Occasionally    | 63.5%   | 165       |
| Daily           | 20.8%   | 54        |

### Section 04: Near misses only help if nurses feel safe reporting them

| Response option | Percent | Responses |
|-----------------|---------|-----------|
| No impact       | 35.3%   | 91        |
| Moderate impact | 49.2%   | 127       |
| Severe impact   | 15.5%   | 40        |

### Section 05: High-alert checks are hardest when everyone is already busy

| Response option       | Percent | Responses |
|-----------------------|---------|-----------|
| Never bypassed        | 32.0%   | 82        |
| Occasionally bypassed | 56.3%   | 144       |
| Frequently bypassed   | 11.7%   | 30        |

### Section 06: Interruptions, pharmacy delays and short training all land on the same shift

| Response option          | Percent | Responses |
|--------------------------|---------|-----------|
| Comprehensive onboarding | 26.3%   | 66        |
| Abbreviated              | 61.8%   | 155       |
| Non-existent             | 12.0%   | 30        |