

**Institute for Safe Medication Practices**  
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[www.ismp.org](http://www.ismp.org)

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**More than 17,500 Nurses Tell ISMP 30-Minute  
Medication Administration Rule Can Lead to Patient Harm**

**Horsham, Pa---**For the first time, the Institute for Safe Medication Practices (ISMP) has surveyed nurses about the often-questioned “30-minute rule” that requires scheduled medications in healthcare settings be administered within 30 minutes before or after the scheduled time. A landslide of more than **17,500** frontline nurses responded, providing more than **8,000** optional additional comments. The magnitude of the response shows that this issue is of great significance to nurses and a hot button issue in medication safety.

The Centers for Medicare & Medicaid Services (CMS) 30-minute rule is a requirement that hospitals and other healthcare facilities must comply with to receive payments from Medicaid and Medicare. Nurses overwhelmingly stated that it exposes patients to unsafe situations, particularly when nurses do not have time to assess patients before drug administration and prioritize their work based on patient needs rather than the rule.

ISMP invited readers of *Nurse Advise-ERR*<sup>®</sup>, its newsletter for nurses, to participate in the online survey regarding the 30-minute rule and provided a link. Almost half (44%) of the nurses who responded work on medical/surgical units, and the other half (56%) in critical care, telemetry, or specialty inpatient units in acute care hospitals.

Most respondents felt that the 30-minute rule is unsafe, unrealistic, impractical, and virtually impossible to follow. Approximately three out of four (70%) told ISMP their organization enforces such a policy. Of those nurses, only five of every 100 (5%) were *always* able to comply with the policy, and more than half (59%) were *infrequently* or only *sometimes* compliant.

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### **Barriers to Rule**

Nurses who responded found it difficult to comply with the rule for multiple reasons, including:

- High patient load and number of medications being given
- Unsafe healthcare staffing levels
- Medications not available on time for administration
- Interruptions and delays during medication administration
- Having to meet other patient needs while in the room
- Needing to review medications and assess patients before medication administration
- Time-consuming gathering, preparation, and documentation of medications
- Drug administration schedules that do not match patient care needs or nursing workflow

Despite these barriers, many nurses who responded to the survey cited increasing pressure to give medications within a required timeframe, as electronic medication administration record (eMAR) technology can now detect and quantify all late drug administration and link each occurrence to a specific nurse. According to numerous respondents, “late” administration often requires an incident report to be filed and can involve disciplinary action.

### **Dangerous Consequences**

Many nurses commented that they felt the 30-minute rule set them up to fail by compelling them to take shortcuts to administer medication within the required time, resulting in at-risk behaviors and actual medication errors.

Removing medications from automated dispensing cabinets or other storage locations well before administration time and gathering more than one patient’s medications at a time were the most common shortcuts taken to comply with the rule. Approximately 1 in 10 respondents *always* takes those shortcuts, and 1 in 4 *often* takes them. About one-third reported documenting medication administration at the scheduled time to avoid possible disciplinary action, but actually administered the medications earlier or later. Many other at-risk behaviors were noted in the survey.

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One in four nurses (25%) reported making and/or observing one or more medication errors in which attempts to comply with the 30-minute rule played a large role. Considering that just a small percentage of errors are actually recognized or detected in most organizations, the actual error rate associated with the 30-minute rule may be much higher.

**Securing Change**

The vast majority of nurses (9 out of 10) who participated in ISMP's survey believe the 30-minute rule should be changed, with most (75%) opting for 60 minutes before or after the scheduled time for medications administered every 4 hours or less. Many also suggested that nurses should be able to exercise their clinical judgment and make exceptions to the rule when necessary.

ISMP has provided CMS staff with preliminary findings from the survey, and will be working with an expert advisory group to document best practices associated with timely administration of medications. ISMP plans to publish its recommendations in a future issue of its newsletter for acute care facilities, the *ISMP Medication Safety Alert!*<sup>®</sup> as well as its *Nurse Advise-ERR*<sup>®</sup> newsletter.

An article that discusses the results of ISMP's survey of nursing concerns about the 30-minute rule and the risks for patients is included this week's edition of the *ISMP Medication Safety Alert!*<sup>®</sup> Included are tables summarizing excerpts from participant comments and additional at-risk behaviors caused by the rule. For a copy of the article, go to:

[www.ismp.org/newsletters/acutecare/articles/20100909.pdf](http://www.ismp.org/newsletters/acutecare/articles/20100909.pdf)

**About ISMP:** The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit [www.ismp.org](http://www.ismp.org).