Causes of intravenous medication errors: an ethnographic study

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Background: Intravenous (IV) medication errors are frequent events. They are associated with considerable harm, but little is known about their causes. Human error theory is increasingly used to understand adverse events in medicine, but has not yet been applied to study IV errors. Our aim was to investigate causes of errors in IV drug preparation and administration using a framework of human error theory.

Methods: A trained and experienced observer accompanied nurses during IV drug rounds on 10 wards in two hospitals (one university teaching hospital and one non-teaching hospital) in the UK. Information came from observation and talking informally to staff. Human error theory was used to analyse the causes of IV error.

Results: 265 IV drug errors were identified during observation of 483 drug preparations and 447 administrations. The most common type of error was the deliberate violation of guidelines when injecting bolus doses faster than the recommended speed of 3–5 minutes. Causes included a lack of perceived risk, poor role models, and available technology. Mistakes occurred when drug preparation or administration involved uncommon procedures such as the preparation of very small volumes or the use of unusual drug vial presentations. Causes included a lack of knowledge of preparation or administration procedures and complex design of equipment. Underlying problems were the cultural context allowing unsafe drug use, the failure to teach practical aspects of drug handling, and design failures.

Conclusions: Training needs and design issues should be addressed to reduce the rate of IV drug preparation and administration errors. This needs a coordinated approach from practitioners, regulators, and the pharmaceutical industry.

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Box 1 Summary of results of ethnographic study on the incidence, types, and clinical importance of IV drug preparation and administration errors

Incidence of errors
- One or more errors occurred in the preparation and/or administration of 212 of 430 IV doses observed (error rate 49% (95% confidence interval 45 to 54%)).
- Preparation errors occurred in 32 IV doses (7%), administration errors in 155 doses (36%), and both types of errors in 25 doses (6%).

Potential clinical importance
- Errors were potentially severe in three doses (1%), potentially moderate in 126 (29%), and potentially minor in 83 (19%).

Common types of IV drug errors
- An error rate of 73% occurred when giving bolus doses (172 errors in 235 observed administrations). The most common error was giving bolus doses too quickly (163 of 172 (95%)), about half of which were judged to be of potential moderate severity.
- An error rate of 14% occurred when preparing drugs that required multiple steps (50 errors in 345 observed multiple step preparations).

Interviews and document review are commonly used to analyse the causes of adverse events, but these methods rely on adverse events being documented or reported. Previous research and pilot work has shown that nurses are often unaware of the occurrence of medication errors. An ethnographic approach combining several methods, including observation of actual practice and interviews, provides an
errors in two UK hospitals. A detailed analysis of the
identified errors, as outlined by human error theory, can then be
offered the advantage that the context can be explored at the
presentation of causes of IV drug preparation and administration
errors using human error theory as a framework.

METHODS

Setting

Some of the methods used in this study have been reported in
detail previously. Briefly, a purposive sampling strategy was
used to collect data in a range of different hospital settings. Ten
wards (including intensive care, paediatrics, surgery, cardiology
and nephrology) were studied in two hospitals (a university
teaching hospital and a non-teaching hospital) in the UK. Both hospitals operated a typical ward pharmacy service in which
doctors wrote prescriptions on formatted inpatient drug charts and nurses used the charts to determine the doses to be given and to record the administration of drugs. Pharmacists visited wards each weekday to order drugs that
were not stocked on the ward and to review the appropriateness of
prescribing. IV medication in general was prepared and
administered on the wards by nursing staff, with the exception of
cytotoxic medication which was prepared centrally by the pharmacy department. Nurses had to attend a one day IV training course before they were allowed to administer IV medication. An IV drug administration guide
outlining instructions for drug preparation and administration was available on the ward at each site.

Data collection and analysis

The human error framework for data collection and analysis
was adapted from methods used to investigate clinical
incidents. Data were collected on 6–10 consecutive days, including
weekends, on each ward between June and December 1999. One of us (KT), a pharmacist trained and experienced in
observation based medication error research, accompanied nurses during IV drug rounds. An IV medication error was defined as any deviation in the preparation and/or administration of the IV medication from the doctor's
prescription, the hospital's IV policy, or the manufacturer's
instructions. We presented the study to staff at ward level as a
research project investigating common problems of IV drug
preparation and administration. This disguised, observation
based method has been shown to be valid for identification of
medication errors. Permission to observe was obtained from
each individual nurse.

The observer recorded details of each IV drug preparation and
administration. Additional information came from observation and talking informally to staff. Observations were
selected to record information on the chain of events that led to
the error and the actions of those involved. Protocols which
have been used for interviews in previous studies were applied to
the observation technique used in the present study. The
researcher intervened in a discreet and non-judgmental manner
when she became aware that an erroneous medication
likely to cause harm to the patient was going to be
administered. These incidents were still included as
medication errors. The researcher's records were checked and completed for each IV drug within 24 hours of leaving the ward.
Notes of observation and conversation for each error were
transcribed and read by both authors. Reason's four stage model of human error theory and the framework of
categories developed by Vincent et al. formed the basis for coding the data (fig 1); the categories were adapted to the analysis of IV drug preparation and administration errors. Data were coded by KT and coding was checked by NB. Disagreements were
discussed and resolved. Each case of IV medication error was
analysed to identify the main active failure and the factors contributing to this error.

Active failures were categorised as human errors (slips/lapses
and mistakes) or violations, defined as follows:

- Slips or lapses were failures in the process of executing a
task. The observed healthcare professional had an adequate plan, but the action did not proceed as intended because of
recognition, attentional, memory, or selection failures.
- Mistakes were failures at the planning or problem solving
stage of a task.
- Violations were deliberate deviations from safe operating
practices, recommendations or guidelines, but with no indication that any adverse consequences were intended.

Error and violation producing conditions were defined as factors at the ward level which led to active failures. Latent
conditions included any underlying organisational and management
failures which contributed to error and violation producing conditions. The use of human error theory as our
theoretical base allowed us to explore systematically the chain of
events leading to IV drug errors. From these data the main
causes of errors were identified.

Ethics committee approval was obtained from both study
hospitals. The study was also approved by ward managers as
well as nursing and pharmacy directorates.

RESULTS

One hundred and thirteen nurses were observed on 76 study
days. A doctor was observed on one occasion when he took
over drug administration from a nurse. A total of 483 IV drug
preparations and 447 drug administrations were observed and
265 errors were identified. A main active failure was identified in 256 (97%) of the errors. There were 25 (10%) slips and
lapses, 60 (23%) mistakes, and 171 (67%) violations.

Slips, lapses and mistakes

Most drug preparations followed the same procedure—namely, injection of a solvent (about 10 or 20 ml) into the drug vial and
drawing up the dissolved drug. Slips included the failure to
notice that a drug had not dissolved completely or misreading a
drug label. For example, a nurse drew up the whole content of a
heparin vial which would have resulted in a five times overdose.
When the observer pointed out the error the nurse said: “No,
there are 25 000 units in the whole vial”. After checking the label on the vial she said: “I am sure that I had a vial with 25 000 units in 5 ml last time” (A34, general medical ward, university teaching hospital). Mistakes frequently occurred when the preparation or administration of the drug involved uncommon procedures. A typical example was the preparation of a multivitamin drug which required two components supplied in two separate vials to be mixed. The nurse administered only one of the vials. She explained to the observer: “I saw vials 1 and 2 but I thought number 2 was the diluted version of number 1, therefore I administered number 2” (D31, coronary intensive care unit, university teaching hospital).

**Error producing conditions**

Table 1 gives a detailed breakdown of 136 factors which contributed to mistakes, slips and lapses. Handling and design of technology were by far the most common, contributing to 79% (n=67) and 32% (n=27) human errors, respectively. Lack of knowledge of preparation or administration procedures were frequent failures in handling technology. On a neonatal ward incorrect preparation procedures were used to measure very small volumes of <1 ml of drug solution. The drug solution contained in the hub of the syringe was also administered to the patient which resulted in overdosage. The drug solution contained in the hub of the syringe was also administered to the patient which resulted in overdosage. Inadequate use of technology, e.g. drug charts (n=10) contributed to mistakes, slips and lapses. Handling and design of technology—was the second most common error producing condition. As outlined above, the small label on the heparin equipment—was the second most common error producing condition. The design of the syringe driver, which required the infusion rate to be calculated by measuring the length of the syringe, contributed to the wrong administration rate being set.

Medication was omitted because of failures in communication in 14 errors (16%). This occurred when patients were transferred between wards and information on drug administration was not communicated. Communication problems between doctors and nurses included ambiguous handwritten prescriptions. These cases also indicated failures in adequately using and checking patient’s drug charts (box 2). High workload and distractions when carrying out several tasks at the same time were observed in 13 errors (15%). On

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Error producing conditions (n=136) relating to 85 human errors (mistakes, slips and lapses)</th>
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<tbody>
<tr>
<td>Error producing condition</td>
<td>No (%) of human errors</td>
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<tr>
<td>Handling technology</td>
<td>67 (79%)</td>
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<td>Design of technology</td>
<td>27 (32%)</td>
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<tr>
<td>Communication</td>
<td>14 (16%)</td>
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<td>Workload</td>
<td>13 (15%)</td>
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<tr>
<td>Patient related factors</td>
<td>8 (9%)</td>
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<tr>
<td>Supervision</td>
<td>5 (6%)</td>
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<tr>
<td>Other factors</td>
<td>2 (2%)</td>
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**Box 2 Examples of error producing conditions**

**Handling technology: lack of knowledge of preparation procedure and complex design of technology**

A nurse prepared a prescribed dose of 250 mg imipenem from a Monovial containing 500 mg imipenem. She connected the vial directly to an infusion bag, transferred fluid into the vial from the infusion bag, dissolved the drug, and transferred about half of the reconstituted drug solution back into the infusion bag (B24, renal ward, university teaching hospital). Comment: This was likely to result in the patient receiving an incorrect dose.

**Handling technology: lack of communication between nurses and inadequate use of technology**

Two nurses were on the late shift; one carried out the oral drug administrations and selected all the drug charts of patients who were due to receive IV medication, and the other handled the IV drug administrations. Two drug charts belonging to patients who were due to receive IV medication were placed next to a pile of drug charts of patients who had already received their IV medication. Neither nurse realised that these patients still had to have their medication. (G69–71, general surgical ward, non-teaching, general hospital).
an intensive care unit a patient's continuous infusion of adrenaline ran out. There was a delay of about 10 minutes before the new preparation was ready for administration. The patient required a bolus dose of adrenaline and midazolam in the meantime. The nurse responsible for this particular patient explained to the senior nurse that she had not paid attention to the infusions as a ward round had been going on. There was a lack of supervision of the nurse who was an agency nurse and had returned to clinical work during the previous 6 months after working in industry for several years (I21, intensive care unit, non-teaching, general hospital). Similarly, a lack of supervision of student nurses was identified in a few cases.

Patient related factors included a lack of venous access or unwillingness to cooperate with drug administration.

**Violations**

Most violations (n=168, 98%) were fast administration of bolus doses (injections administered faster than the recommended speed of 3–5 minutes); in 116 cases (69%) the bolus dose was given in less than half the recommended time. The majority of bolus dose errors were judged to be clinically significant. Conversations with nurses showed that they knew the correct speed of administration but deliberately deviated from these guidelines. A typical comment was: “I do not take as long as [3 minutes]” (H19, general medical ward, non-teaching hospital). More than two thirds of observed bolus doses (n=168, 72%) were administered too fast, suggesting that these were routine violations, “cutting a corner whenever the situation allows this”, as Reason puts it.

**Violation producing conditions**

Nurses explained that fast administration of low doses was without risk. A typical comment (which also shows confusion over the source of risk) was: “I am quite happy to give 80 mg [furosemide] as a bolus but I would administer 250 mg as an infusion” (A31, general medicine, university teaching hospital). However, the lack of knowledge about medication by nurses sometimes led one to question the validity of their risk assessment.

Examples of poor supervision were seen when nurses not qualified to carry out IV drug administrations were taught. A junior nurse took more than 3 minutes to administer a bolus dose, a senior nurse laughed at her and told her: “You should give the drug over 3 minutes not over 30 minutes” (A29, general medical ward, university teaching hospital). In some cases, especially on the paediatric and neonatal wards, the administration of small volumes over more than 1 minute was technically difficult.

**Latent conditions**

Lack of appropriate training and design issues were identified as the two main latent conditions. Unlike the theoretical background, the practical aspects of IV drug preparation and administration were neither formally taught nor assessed in the two study hospitals. Nurses in general learnt how to prepare and administer IV medication from each other on the wards (box 3). There were no guidelines regarding content and quality of such training; in particular, uncommon preparation procedures did not seem to be covered. Pharmacists were not directly involved in the preparation or administration of IV medication on the wards and knew little about the practical problems encountered (box 3). Nurses seemed to pass on the bad practice, so deviations from guidelines—such as the fast administration of bolus doses—became accepted practice, creating a cultural context of unsafe drug use. Most wards had no separate room or a dedicated area for drug preparation. IV medications were prepared in the middle of a busy ward and nurses were frequently interrupted and distracted during the process. Overall, safe handling of IV drugs had a low priority in the two hospitals studied.

We identified a range of design failures of technology including ambiguous labelling of ampoules and complex design of drug vial presentations and infusion equipment. Two latent conditions contributed to this situation: (1) pharmacists were unaware that they supplied drug products which created problems and (2) the pharmaceutical industry developed and produced drugs and equipment which did not support safe use.

**DISCUSSION**

We have explored the causes of IV drug errors using a framework of human error theory. Observation of actual practice has shown that IV drug errors are not only caused by the immediate individual act, but a range of organisational and managerial issues—including training, cultural context, choice of product, purchasing policy, and design of technology—also contribute to errors.

Our study confirms earlier concerns about nurses’ lack of training in handling IV medications. Clinical pharmacists have been identified as the key health professionals to ensure safe medicine use. The current ward pharmacy system with daily visits to the clinical areas places the pharmacist in a good position to recognise training needs and to address them. Such a multidisciplinary team approach may create a cultural context which supports safe drug use. Pharmacists should also anticipate problems with certain drug vial presentations or complex preparations. In our study these functions did not seem to happen, and pharmacists need to be more engaged with ward practice.

Attempts to reduce the harm caused by IV errors in the past have focused on restricting choice and removing from the nurse the task of making up the drug. Restricted supply of strong potassium chloride to reduce medication errors was recommended a quarter of a century ago, and stocking only one strength of morphine ampoules on paediatric wards has been successful in preventing errors involving the selection of the wrong ampoule. Other changes to reduce medication preparation errors include the central preparation of IV medication, but the evidence base for the success of such a service is currently weak.

Design issues such as ampoules which look similar and the complex design of infusion pumps have previously been recognised as risk factors. We have also shown that the failure to handle complex drug vial presentations correctly resulted in medication errors. Our study again shows that the manufacturer’s role should be to supply products with a high safety standard when in general use.
The application of concepts and techniques of human error theory to problems in medicine was suggested in the 1970s but the pharmaceutical industry does not really seem to have espoused the approach. One way forward for the industry would be to apply a framework of human error theory at the product design stage, including consultations with clinical practitioners and observations in practice. The licensing process should also consider any differences between the product used in trials and the final presentation. In addition, the use of the product needs to be formally assessed during post-marketing surveillance.

The ethnographic approach using a practitioner as observer offered several advantages. We could identify deviations from practice that staff themselves did not notice and would not have brought up at interview, and we did not have to rely on their memory or fear their censoring of the data. We did not have to use records designed for a different purpose. We chose two contrasting hospitals and a careful cross section of wards; it is recognised that the generalisability of these findings has yet to be established, but the authors have worked in several hospitals and think the findings not uncommon. There is often concern that observation changes practice but there is little evidence of this in practice. On the other hand, while conversations with staff were part of the study methodology, we did not interview them in depth and some personal factors, such as those that have been shown to contribute to prescribing errors, may have been missed.

As is often the case with error, it is not those who make the error who should be the focus but the whole system of work and technology around them. While nurse training would have some effect on errors, it needs to be linked to prescribing and medication policies, purchasing of medicines, and pharmacists who have some effect on errors, it needs to be linked to prescribing and technology around them. While nurse training would have some effect on errors, it needs to be linked to prescribing and medication policies, purchasing of medicines, and pharmacists who are involved in distribution, receipt, and dispensing of IV drugs.

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The study was designed by both authors. KT collected the data and analysed it with NB. The final report was written by both authors.

Conflict of interest: none declared.

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