It should have been 1.2 mL per hour. However, their independent calculations agreed and thus their errors weren’t noticed; moreover the incorrect number they calculated, 28.8 (in units of mL/24h), was written on the bag label, which itself would have misleadingly helped to confirm their calculations.

The patient left the centre, and returned later, surprised that their bag was empty several days earlier than usual. They had had an overdose from a chemotherapy drug delivered 24 times too fast, and unfortunately later died from the drug’s effects. That is the story in brief, though it does not cover related issues such as the problem of managing an overdose from a drug when the hospital has no overdose protocol. Nor does it cover the social consequences on the nurses’ lives, nor whether anybody learns the best lessons, rather than blaming individuals.

What we are interested in here are the specifically IT aspects of the situation, and whether IT helped or hindered. Unsurprisingly, the root cause analysis was not written by IT experts, so it ignores these issues. For example, the nurses made a calculation error. What type of calculator did they use? This isn’t a clinical issue, so we do not know – but it might matter. Please look at figures 1 and 2, which show the actual information given to the nurses. From these figures, work out what dose to give the patient. There are many questions: why are there two separate pieces of paper, and why...