Avoiding drug errors

Read the label

EDITOR,—The diversity of drug packaging that R E Ferner criticises has existed for many years.¹ What Ferner now identifies is a move towards standardisation through pharmaceutical manufacturers' adoption of the NHS ampoule labelling specification. The work leading to this has been described by Nunn.² The NHS specification seeks to establish a standard for labels, with the information presented in a consistent format and printed in the most legible way. The problem with diversity is that practitioners use features such as colour, shape, etc as a substitute for correct reading and inspection of the label. Use of such substitutes is both fallible and dangerous.

The company whose products are illustrated in Ferner's letter manufactures nearly 100 different ampoules. To differentiate between that number of products by use of colour, shape, etc is obviously impossible. Ferner's hypothetical practitioner with modest presbyopia would obviously find it easier to read the labels illustrated than the text of the letter criticising the labels. The only way to be sure of the contents of an ampoule (or any other product) is to read the label.

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1 Ferner RE. Misleading drug packaging. *BMJ* 1995;311:514. (19 August.)

2 Nunn DS. Ampoule labelling—the way forward. *Pharmaceutical Journal* 1992;248:361-3.

Reporting of errors should be free of recrimination

EDITOR,—We support R E Ferner's sentiments regarding errors of prescribing.¹ There is a profound need for strategies that manage such errors by reviewing systems rather than by apportioning individual blame. Hopefully, the recent papers in *JAMA*, cited by Ferner, will stimulate debate on drug errors and encourage this process.

For several years we have campaigned for multidisciplinary medication quality assurance groups to be established in NHS hospitals.² These groups should aim to create a non-threatening environment in which all staff who prescribe, dispense, and give drugs feel able to report adverse incidents voluntarily, free from fear of recrimination. Reporting may be anonymous if this is thought appropriate, but in our experience staff are commendably forthright in adding their name to completed records, which aids the identification of individual training requirements. Completed reports are reviewed regularly by the quality assurance group and recommendations are made to all staff as to how future risk can be minimised.

Audit criteria set out by the King's Fund include requirements for the monitoring of prescriptions and the management of error and other risk related to dispensing and the administration of drugs. We would like to see the position strengthened such that the existence of a formal system of reporting errors, subject to multidisciplinary review, becomes a condition for the accreditation of NHS hospitals.

These steps will enhance the management of risk

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

associated with giving drugs locally, but what of the national situation? We have provided a facility for colleagues to report incidents that they regard as important and that contain a valuable lesson for future practice²; uptake has been encouraging. In addition, many reports are published anonymously and debated in the pharmaceutical literature.³ Could a similar system be coordinated nationally by the Committee on Safety of Medicines? A process analogous to the system for reporting adverse drug reactions could be adopted to facilitate the reporting of errors of prescribing that result in appreciable morbidity (or, indeed, the reporting of near misses that narrowly avoided causing harm). As with the yellow card scheme, the compilation of reports on a nationwide database would alert the regulatory bodies to particular problems in the safe use of drugs. This in turn would permit national initiatives aimed at minimising the potential harm to our patients from the treatment with which we intend to do good.

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1 Ferner RE. Is there a cure for drug errors? *BMJ* 1995;311:463-4. (19 August.)

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Adopting new NHS specification helps

EDITOR,—In a letter on misleading drug packaging R E Ferner advocates diversity of packaging if the system of distributing medicines in standard ampoules of standard format is not widely adopted.¹ In Britain, Antigen Pharmaceuticals (UK) alone supplies 27 different small volume parenteral products in glass ampoules in 57 different sizes with a range of 41 different strengths of solution—for example, lignocaine hydrochloride injection BP 0.5%, 1%, and 2% in 2, 5, 10, and 20 ml ampoules. In addition, we supply five different small volume parenteral products in plastic ampoules in 16 different sizes with a range of seven different strengths of solution. We are also in the process of developing a considerable number of such products, which will also have a wide variety of ampoule sizes and strengths of solution.

Given the multiplicity of different products,

sizes, and strengths of solution, there are simply not enough colours, symbols, or shapes for use as distinguishing features; even if there were, such an identification system would be too complex to be of value. Ampoules have always looked similar, and they will probably continue to do so. The only reliable distinguishing features are the words.

As the largest supplier of small volume parenteral products to the NHS (over 40 million ampoules a year), we attach particular importance to the clarity and legibility of our product labelling, as evidenced by the fact that we were one of the first companies to adopt what has now become the NHS specification for ampoule labels. Wider acceptance of this specification would resolve many of the problems associated with the identification of products.

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Pharmacists and computerised prescribing can help

EDITOR,—R E Ferner asks a pertinent question regarding what can be done in hospitals to prevent drug errors and provides some potential answers, including that prescriptions should be checked by pharmacists.¹ This is common in hospitals in the NHS. A survey in mid-1992 found that pharmacists in 96% of NHS hospitals monitored prescriptions on the wards, usually daily on weekdays.² Research in Britain shows that hospital pharmacists detect and prevent many errors in prescribing. Hawkey *et al* showed that quality of care improved in most cases when doctors were asked to reconsider prescriptions that ward pharmacists considered to be incorrect.³ A review of British literature shows that many similar studies support these results.⁴ Evidence also exists that hospital doctors, nurses, and managers value the safety net provided by pharmacies.⁵

Such monitoring cannot guarantee the quality of prescribing, not least because pharmacists may also fail to detect errors and may not be able to review every prescription before the first dose is given. Computerised prescribing, as Ferner suggests, may be a useful approach. If sufficient information is placed on a computerised prescribing system and updated regularly many errors, and even interactions, may be detected and prevented. Nevertheless, computers cannot ensure that all prescriptions are appropriate for all patients since there will always be uncertainties regarding what constitutes optimum prescribing.

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