Letter to the Editors

Confidence, clarity and simplicity are the key to better medication incident reporting?

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The 6 year review of voluntary medication incident reporting by Cousins *et al.* [1] is very interesting, and I agree wholeheartedly with its conclusions that the new National Health Service (NHS) must continue to interrogate the National Reporting and Learning System (NRLS) to mandate NHS organizations to make changes to reduce harms from, in particular, high-risk medication/practices.

It is, however, impractical to expect health professionals voluntarily to report all medication incidents, because prescribing errors alone have been shown to occur in 8.9% of all medication orders written in UK hospitals [2]. This equates to approximately 40 000/year, of which 700 are potentially fatal, for an average 900-bedded hospital. The sheer 'size' of the medication error problem thus adds to the already accepted barriers to the reporting of any adverse events by health professionals [3], namely knowledge (what and when to report), outcomes (perceived lack of feedback and positive change), effort (simplicity of reporting form) and fears (personal).

Recently, I have explored the attitudes of hospital pharmacists to reporting medication errors, involving both focus groups [4] and a Theory of Planned Behaviour [5] questionnaire, and this has led me to conclude that the key to improved reporting of medication errors by pharmacists, and possibly by all health professionals, is potentially threefold, and in this order: (i) confidence, i.e. increasing personal confidence of health professionals to report their clinical colleagues' errors and increasing overall confidence by positively 'selling' system changes after reporting; (ii) clarity, i.e. greater clarity about which medication errors should be reported, including locally targeted reporting or a nationally implemented reporting hierarchy; and (iii) simplicity, i.e. simpler drug-specific reporting forms.

Whilst increasing confidence is not a short-term fix, the introduction of a national simpler reporting form and introduction of targeted reporting could be done more easily and swiftly.

With regard to greater clarity about reporting, I think it could be extremely helpful if NHS organizations uniformly

adopted a 'yellow card'-like approach to which medication incident reports we really want health professionals to report, such as the following: all serious medication errors for any drugs which are fatal, life-threatening, disabling or incapacitating, which result in or prolong hospitalization or are medically significant; all medication errors (including near misses) for high-risk medicines or medicines under intensive surveillance by the NRLS (identified by a new symbol in the British National Formulary, like the black triangle for adverse drug reactions); any medication errors due to a witnessed repetitive failure by an individual practitioner or because of a system; and all malicious or reckless violation-type medication errors.

Exactly as for our national voluntary adverse drug reaction reporting scheme, we need to be able to 'see the wood for the trees' and reliably detect the important signals in all the noise that is generated about medication incidents. I believe this measure, in particular, could allow local organizations, and the NHS as a whole, better to focus their efforts in protecting our patients from preventable and repetitive harms due to medication.

Competing Interests

All authors have completed the Unified Competing Interest form at http://www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: no support from any organization for the submitted work; no financial relationships with any organizations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work.

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