Dear Dr. Jordan,

I have read your Commentary entitled ‘Signposting the causes of medication errors’ (2011) published in the last issue of International Nursing Review. Surely, it will improve international knowledge on the important subject of patient safety. However, I find it necessary to make the following comments on the Commentary.

In the Commentary, you stated ‘with the precise number and types of errors available…’. It is believed that it is impossible to gather data on the exact or precise numbers and types of errors. According to Kingstone et al. (2004), the prevalence of nursing disclosure for errors (and ‘near misses’) tends to be under-reported by nurses who are widely acknowledged as a group that reports incidents more significantly than other health professionals, including medical practitioners. In this regard, some errors are reported because they have had a large impact on patients’ well-being or they have even resulted in patients’ death; therefore, no study can claim that it has presented a precise number of errors.

In addition, you mentioned that ‘…we know little as to their causes, and this study (Joolaee et al. 2011) offers compelling insights’. First of all, from the methodological perspective, the study of Joolaee et al. (2011) has not mentioned how many hospitals have been selected for the data gathering. In this study, in the data gathering zones, Tehran, there are three medical sciences universities, which all hospitals in Tehran are affiliated. Each university supervises a couple of hospitals in the different geographical locations of the city. It should be noted that the context and know-how of the hospitals are very diverse. The hospitals under the supervision of each university provide services to people with different social classes and have different workloads and staffing patterns. If the results would have been expected to be generalized to all hospitals in Tehran, the authors should have been selected one hospital, at least, from each medical sciences university for the data gathering. The authors have not done so, and their data cannot be generalized to other health-care settings in Tehran. Moreover, based on my experiences in the Iranian health-care system, there are differences in the working conditions of nurses working in the hospitals affiliated to the mentioned universities in Tehran. For example, in hospitals affiliated to Beheshti University, there are better working conditions for nurses and a more standard nurse–patient ration. Therefore, the working conditions of nurses in the hospitals may not be considered equal.

Furthermore, you stated that we need to reflect on the causes of medication errors, and the Joolaee et al. study (2011) offers compelling insights. This study has only focused on medication errors, not other kinds of errors. Surely, the presented causes would be applicable to the causes of medication errors rather than other kinds of error. My PhD dissertation subject is about patient safety entitled ‘exploration of the process and the development of a theoretical model of safe nursing care within the Iranian health care system’. Based on my country’s culture and context, the concept of safety encompasses other kinds of errors, and there are many other kinds of errors missed in the international literature. Medication errors form a very small part of the errors (Vaismoradi et al. 2011a,b). In this regard, those papers that consider all causes of nursing errors without prejudgment and direction to the medication ones are preferred. Moreover, such a paper and the relationship between working conditions (management practices, providing a suitable environment with the requisite supply of resources and infrastructure and increasing nurses’ knowledge) and nursing practice errors have been presented before (Anoosheh et al. 2008), and it is not something specifically mentioned in the Joolaee et al.’s study. I am afraid you missed to cite it. It clearly covers the causes of all sorts of nursing practice errors with a strong methodology.

Finally, I am concerned that with such commentaries concentrating and emphasising on medication errors, we miss the main parts of patient safety and just think that ‘medication errors are equal to patient safety’. I apologize for the lengthy letter. Thank you for your consideration and the commentary.

With my warmest regards,

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References


