Reviewer's report

Title: Perceived barriers to pharmacist engagement in adverse drug event prevention activities

Version: 2 Date: 14 November 2014

Reviewer: William Doucette

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Major Compulsory Revisions
1. No Objectives were stated in the text or abstract. These are needed so readers know what was intended to be done in the study. The lack of objectives makes it unclear whether the study focused on medication errors or on drug-related problems – which are different issues. Please add Objectives.

2. The Figure of the process model does not connect very well to the text. The figure shows two linked subprocesses, so the overall model doesn't fit with the text. It would be useful to either explain the whole model that is in the figure OR to reduce the model shown in the figure to match what is now in the text. This mismatch is confusing.

3. In the Conclusion it is stated that the attitudes of doctors and nurses were a major barrier to clinical interventions by pharmacists, and led to a lack of acceptance pharmacist recommendations. However, 90% of the pharmacists' recommendations in the studied interventions were accepted. That seems to be a high rate of acceptance, so the effect of the negative attitudes is not clear. Please clarify that.

Minor Essential Revisions
4. There is a difference between medication errors and drug-related problems (E.g. not all DTPs derive from errors). Yet, in the Background and the Discussion both terms are used. It appears that this study was about medication errors present in a hospital. If so, it would be helpful to not mention drug-related problems, and stay with the medication error terminology.

5. The 4th paragraph of the Discussion (lines 242-251) raises a discussion of pharmaceutical care. More elaboration should be made about the process you described and less about how pharmaceutical care is essential for patient care. Can you tell readers anything about which steps were the most difficult? Or, where the barriers are most influential? If your process model is to be a contribution, readers need to know more about it – E.g. add some information about where the various barriers are acting.

Discretionary Revisions
6. Pharmacist clinical knowledge is discussed in lines 260-268. What are some ways that more training can be provided to pharmacists? This could be
addressed here.

7. In lines 276-278 you talk about shared views of team members' roles. Can you elaborate about ways to achieve that? Such information would be useful to readers (E.g. see literature on fostering MD-pharmacist collaboration). Or, maybe establishing a culture of safety in the hospital would help.

8. Do you want to raise the length of time between when the pharmacist filed the clinical intervention report and the interview as a limitation? In some cases that might be over two years. Did you have any concern about accuracy of recall by the pharmacists?

9. Can more description be added about the clinical intervention reports made by the pharmacists? What was their purpose in the hospital? Did the pharmacists resolve medication errors without filing one? Were there punitive results for hospital staff (E.g. MDs) for errors?

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.