Canterbury District Health Board
Te Poari Hauora ō Waitaha

Clinical Pharmacology Bulletin

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Adverse Reaction Documenting at Christchurch Hospital

A guideline for documenting and reporting adverse drug reactions (ADRs) has been in place at Christchurch Hospital since 1991. Audits were conducted in April 2003, April 2005 and July 2009 with the aim of evaluating compliance with the guideline. A summary of these audits is presented below.

The 2003 ADR audit compared the documentation of ADRs in practice with the existing guideline by comparing patient-reported ADRs with documented ADRs. Of the 133 patients assessed for inclusion in the audit* 59% were suitable to participate in the audit. Of the eligible patients, 53% reported a total of 61 ADRs (including allergies). Of the 61 ADRs, only 7% were completely documented as per the ADR reporting guideline (all were for one patient). In 18%, patient-reported ADRs that were not documented at all.

These results showed that there was poor compliance with the guideline. Only about one-third of ADRs were documented in a useful way (ie the name of the drug and type of reaction included either on the drug chart or in the patient's medical admission). A multidisciplinary team reviewed these results and recommended the ADR guideline should be changed to encourage better ADR reporting and therefore drug safety. In an effort to simplify the policy and therefore improve compliance, a new guideline utilising a single sticker (rather than two stickers) was developed.

The 2005 and 2009 ADR audits compared the documentation of ADRs in practice with the revised 'single sticker guideline' using the same audit tool. The proportions of ADRs documented on the drug charts and in the medical admission for all three audits are summarised in the table below for comparison.

In 2005 and 2009, only one ADR (3% and 2%, respectively) was documented as per the existing ADR reporting guideline.

Year and number of ADRs		Drug & reaction documented	Drug only documented	No documentation
2003	Medical admission	33%	31%	36%
n = 61	Drug Chart	39%	28%	33%
2005	Medical admission	28%	39%	33%
n = 36	Drug Chart	17%	11%	72%
2009	Medical admission	38%	24%	38%
n = 47	Drug Chart	53%	19%	28%

* patients were not include if they were <18 years of age, admitted for <48 hours, not able to communicate readily or not present on the ward at the time of the audit.

What does this mean?

These 'snap-shot' audits have limitations as they represent "moments in time" and are conducted in small numbers of patients. However, it is concerning they suggest that at Christchurch Hospital approximately two-thirds of ADRs are not documented in a useful way.

The aim of ADR documentation is to minimise patient harm. Once ADRs are suspected, further patient harm can be minimised when health professionals document the ADR in sufficient detail for other clinicians to make rationale prescribing decisions. This requires at least the name of the drug and the nature of the reaction it caused.

New CDHB-wide Adverse Reaction Identification and Documentation Policy

The results of these audits and other quality assurance activities conducted in the CDHB prompted a review of ADR documentation. A new policy was adopted in March 2010. A major change is that the policy now covers the reporting of adverse reactions thought to be due to foods and wound dressings (including latex) as well as to drugs (including complementary medicines). Other changes are to the Adverse Reaction Sticker and the additional use of orange ADR Bracelets (which will be phased in when available). This policy does not cover adverse reactions to blood transfusions.

The new policy was adopted after considerable consultation. The changes to the documentation process, including having a policy that is consistent across the CDHB, are hoped to simplify the process and contribute to an increase in clinically useful reporting of adverse reactions. However, an improvement in adverse reaction documentation will also require a change in our 'organisational culture'. The reporting of adverse reactions involves a number of health professionals and clerical staff. Each of these groups needs to be aware of their role in this process to improve patient safety.

If you would like more information, or assistance with education and implementation of adverse reaction monitoring in your area, contact the Medicine Safety Pharmacist Mary Young (MaryY1@cdhb.govt.nz).

For the full Adverse Reactions Identification and Documentation Policy, see the intranet link:
http://intraweb.cdhb.local/manuals/policies-procedures/adverse-reactions-idenification-documentation.pdf