Royal Brisbane and Women's Hospital

Audit of Adverse Drug Reaction Reporting and Communication at a Quaternary Hospital

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Background

Adverse Drug Reactions (ADRs) are unintended, and sometimes harmful occurrences associated with the use of medicines. Reporting is an important part of surveillance, contributes to identifying trends, influences education and medication safety initiatives, and reduces patient harm. Due to several factors there appears to be a reduction in reporting and documentation in the hospital.

Aims

This audit aims to investigate the ADR reporting process of the hospital and to determine the percentage of ADRs recorded according to Medication Safety Standards.

It also aims to review the communication of ADRs to primary health providers, the profession of those reporting ADRs and if any ADRs reported were re-exposure events.

Methods

A retrospective audit was conducted of 41 adverse drug reaction reports made between January and December of 2022.

Drug reaction and patient information was collected from the hospital ADR database, electronic hospital records and pharmacy dispensing software.

Data was analysed using an audit tool formulated by the ADR pharmacists.

Results

The audit reviewed 41 reports entered between January 2022 and December 2022.

- 29% of ADRs were appropriately entered into the electronic patient record
- 39% of ADRs were entered into pharmacy dispensing software
- 71% of ADRs had been communicated in discharge summaries to primary health providers
- 15% of ADRs were not recorded in electronic patient records or pharmacy dispensing software

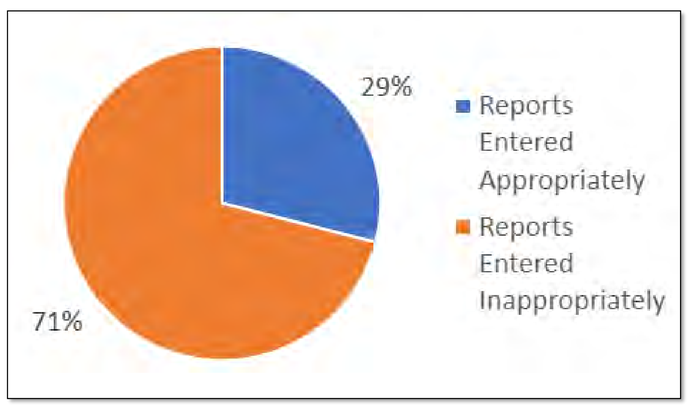


Figure 1: Percentage of reports appropriately entered into electronic patient record

- 100% of ADRs reported to TGA were reported by pharmacists

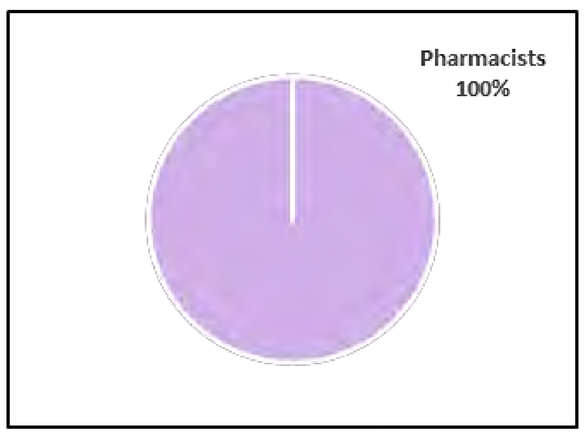
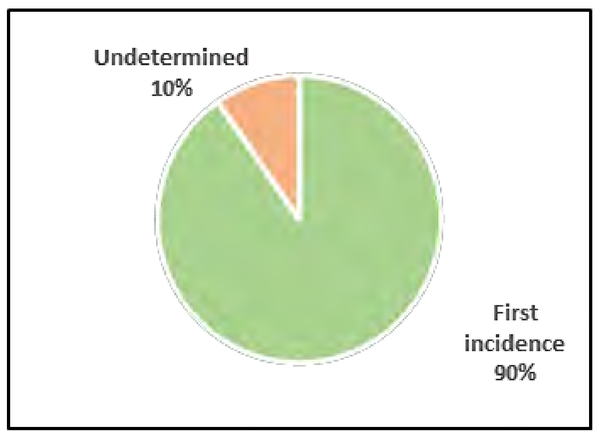


Figure 2: Proportion of health professionals who report ADRs

- No ADRs reported were found to be re-exposure events, however one ADR was unable to be determined

Figure 3: Proportion of ADR reports that were re-exposure events



Conclusion

The proportion of ADRs reported in electronic patient records was found to be low, at only 29%, and therefore not complying with the Medication Safety Standard Criterion 4.08. Reporting and appropriately documenting and communicating ADRs is crucial from a patient safety perspective to minimise risk of re-exposure events. Results indicating low levels of reporting of ADRs within the hospital support a change in reporting process.

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