

5.5 Percentage of patients with a new adverse drug reaction (ADR) that are given written ADR information at discharge AND a copy is communicated to the primary care clinician

Purpose

This indicator assesses the effectiveness of processes intended to ensure that patients and their caregivers receive adequate information for safe and effective medication management after discharge.

Background and evidence

An adverse drug reaction (ADR) is defined as “a response to a medicinal product which is noxious and unintended, and which occurs at doses normally used in man for the prophylaxis, diagnosis or therapy of disease, or for the restoration, correction or modification of physiological function”.¹ This includes, but is not limited to, allergy and anaphylaxis to medicines.

Educating patients about their medicines and communication about medication management between hospital and community practitioners are guiding principles in the Australian Pharmaceutical Advisory Council Guiding Principles to Achieve Continuity in Medication Management.² This indicator provides a measure of compliance with these guidelines.

Key definitions

A new adverse drug reaction refers to any ADR that occurs for the first time during the current or most recent admission and is likely to affect future therapeutic decision making. Clinical judgement will be required in making this decision.

Written ADR information should include, as a minimum, the following:

- generic and brand names of the medicine(s) involved
- reaction(s) that occurred, described in lay terms e.g. rash, lip swelling, kidney failure
- advice about how to minimise the possibility of a future ADR to that medicine.

A copy of the information given to the patient should be included in the medical record, or explicit documentation made in the medical record that information was given.

A copy is communicated to the primary care clinician means a copy of the plan is sent to the community-based health practitioner nominated by the patient, or included in the discharge summary or discharge letter. Such communication should be explicitly documented in the medical record.

Data collection for local use

Please refer to the section *Using the National Quality Use of Medicines Indicators for Australian Hospitals* for guidance on sample selection, sample size, measurement frequency and other considerations.

Inclusion criteria: Adult, paediatric and neonatal patients who experience a new ADR during their hospital admission.

Exclusion criteria: Nil.

Recommended data sources: Medication charts, medical records and discharge documentation.

The data collection tool for QUM Indicator 5.5 assists data collection and indicator calculation.

Data collection for inter-hospital comparison

This indicator may be suitable for inter-hospital comparison. In this case, definitions, sampling methods and guidelines for audit and reporting need to be agreed in advance in consultation with the coordinating agency.

Indicator calculation

$$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$$

Numerator = Number of patients with a new ADR that were given written ADR information at discharge AND a copy was communicated to the primary care clinician

Denominator = Number of patients with a new ADR in sample

Limitations and interpretation

This indicator relies on documentation in the medical record that relevant written information was provided. Good documentation supports quality patient care³ and is a critical component of management of adverse drug reactions. Poor communication can result in adverse medicine events.⁴ Thus for the purposes of this indicator, it is assumed that absence of explicit documentation means no written ADR information was provided to the patient or their primary care clinician.

This indicator does not measure the quality of the written information provided to patients regarding ADRs or whether the patient's primary care clinician actually received a copy of the information. It does not measure whether other clinicians involved in the patient's care were notified about the ADR.

Further information

Medication Safety Self Assessment for Australian Hospitals⁵ (MSSA) can help identify potential strategies for improvement with this and other indicators. MSSA encourages development of robust systems for safe prescribing, dispensing, administration and monitoring of medicines. MSSA is available at www.cec.health.nsw.gov.au

This indicator can be used to assist hospitals in meeting the National Safety and Quality Health Service Standard 1 [items 1.2.1, 1.2.2, 1.5.2, 1.6.1, 1.6.2, 1.8.2, 1.18.1], Standard 4 [items 4.1.2, 4.2.2, 4.4.2, 4.5.1, 4.5.2, 4.7.1, 4.7.2, 4.12.4, 4.13.1] and Standard 6 [items 6.1.1, 6.2.1, 6.3.1, 6.4.1].⁶

References

1. Committee of Experts on Management of Safety and Quality in Health Care (SP-SQS) Expert Group on Safe Medication Practices. Glossary of terms related to patients and medication safety. World Health Organisation, 2005.
2. Guiding Principles to Achieve Continuity in Medication Management. Australian Pharmaceutical Advisory Council, 2005.
3. The Good Clinical Documentation Guide. National Centre for Classification in Health, Commonwealth of Australia, 2003.
4. MacKinnon NJ, ed. Safe and Effective: The Eight Essential Elements of an Optimal Medication-use System. Canadian Pharmacists Association, 2007
5. Medication Safety Self Assessment for Australian Hospitals: Institute for Safe Medication Practices USA (Adapted for Australian use by NSW Therapeutic Advisory Group and the Clinical Excellence Commission), 2007.
6. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney, ACSQHC, 2012.