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Assessing And Improving The Quality Of Drug Allergy Documentation

Hannah Watson, Thomas Heaton. [1]NHS Grampian, Elgin, UK, [2]NHS Grampian, Elgin, UK

Introduction: Incomplete documentation of patient's drug 'allergy status' is a recognised cause of medication errors in hospitals and as such, is a very topical debate. In addition, failure to differentiate true allergy from other adverse drug reactions (ADRs) can prevent administration of the most appropriate medication. This audit aimed to assess the quality of allergy status documentation for patients admitted under the general surgical team at a busy district general hospital.

Methods: Data were collected prospectively from the medical notes and drug charts of surgical admissions. Documentation of the patient's 'allergy status' on their drug chart was compared against their medical records and personal knowledge of ADRs. The audit was repeated after educational interventions. The initial audit was conducted without the knowledge of the admitting doctors and before educational interventions. A re-audit was conducted 3 months later to assess the impact of the educational interventions. Both audits were conducted by Foundation Year 1 (FY1) doctors at the hospital. Patients who had been admitted by these doctors were excluded from the audit to avoid positive bias and each audit was time limited to 6 weeks.

Results: A total of 56/84 patients (66.6%) had complete documentation of their ADRs on their drug chart, whilst 11 patients (13.1%) had no ADR documentation on their drug chart. The remainder had incomplete documentation. Of patients who had ADRs documented, 27.6% had the nature of these reactions described. The number of patients with complete documentation of their drug allergy status increased to 46/50 (92%) in the repeat audit. See Table 1 (below).

Conclusion: The causes of medication errors are often complex but by their very definition are avoidable. Medical staff play an important role in the human component of error, given their key role in the management of patients. ADRs are common and an accurate awareness of them is important for safe and effective treatment of patients. Regular audit of aspects of medication error, such as allergy status documentation, is an important part of improving patient safety by reducing these errors. There is suggestion that targeted education of junior medical staff can help reduce these errors, but this remains just one part of the management of medication errors.

	InitialAudit (No. of Patients)	Repeat Audit (No. of Patients)
Complete	56 (66.7%)	46 (92%)
Incomplete	17 (20.2%)	3 (6%)
No documentation	11 (13.1%)	1 (2%)
Total	**84**	**50**

Table 1: Comparison of completeness of ADR documentation in the initial and repeat audit.