



Safety signal

The risk of serious adverse drug reactions

For the attention of:

Chief Executives, Chief Pharmacists, Quality and Risk Managers, Directors of Nursing, Chief Medical Officers, Medicines Advisory Committees, College of General Practitioners, Schools of Nursing and Medicine, Private Surgical Hospitals Association members

Background

Recent Health and Disability Commissioner reports about cases in which patients have died or been seriously harmed have highlighted the need for all health professionals to take note of a patient's previous adverse drug reactions (including allergies) before prescribing, dispensing or administering medicines.

These cases are not isolated and illustrate failings in the current system relating to documenting, reviewing and responding to a patient's adverse reaction history.

Ways to reduce risk

- Always check and review a patient's known adverse drug reactions (including allergies) before prescribing, dispensing or administering a medicine – this is a critical first step.
- Seek adverse drug reaction information from:
 - the patient, family/whānau and carers (ask for details)
 - clinical records
 - national medical warning system
 - MedicAlert®.
- Always report incidents where patients are inadvertently prescribed or administered a medicine to which they have had a previous adverse reaction, even if no harm occurs. These incidents can inform system change to reduce the risk of future incidents.
- Accurately diagnose, and document new adverse drug reactions in the clinical record, medication chart and discharge summary. Report these to CARM so the medical warning system can be updated (<https://nzphvc.otago.ac.nz>). Consider with the patient the value of MedicAlert® and educate them about the medicine(s) they are allergic to. (Follow the World Allergy Organization's drug allergy prevention recommendations: www.worldallergy.org/professional/allergic_diseases_center/drugallergy.)
- Review and look for ways to improve your organisation's systems and processes for identifying and documenting a patient's adverse drug reaction history.

Further action

The Medication Safety Expert Advisory Group will be scoping possible interventions to reduce adverse drug reaction incidents.

This signal is online at: www.hqsc.govt.nz.

For more information or to provide feedback, email beth.loe@hqsc.govt.nz.

These recommendations are based on a review of currently available information in order to assist practitioners. Recommendations are general guidelines only and are not intended to be a substitute for individual clinical decision-making in specific cases.