# SURVEY ON THE DOCUMENTATION OF PREVIOUS DRUG ALLERGIES/ SIDE EFFECTS IN MEDICATION CHARTS OF PATIENTS IN A PSYCHIATRIC INTENSIVE CARE UNIT

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## INTRODUCTION

Medication errors are a significant cause of morbidity and mortality in hospitalized patients[1]. Medication error has been estimated to kill 7,000 patients per annum and accounts for nearly 1 in 20 hospital admissions in the US[2]. The incidence is likely to be similar in the UK[2]. Patients in psychiatric intensive care (ICU) settings can be acutely disturbed and often require urgent administration of medication for rapid tranquilization. Information related to any previous adverse reaction/ allergies to any medications should be recorded in drug charts so the ICU staff could avoid administering these medications. This survey was conducted to establish whether this information is being documented in the medication chart by the admitting doctor.

The survey was conducted on patients admitted from the community or transferred from other wards to the Pendered ICU in Northampton between 22 August and 12 November 2007. The data were obtained from the current medication chart, previous medication charts and the patient's clinical records.

## RESULTS

### A. Demographics

33 patients were admitted or transferred to the Pendered ICU during the survey period (18 males and 15 females). Of these patients, 18 were admitted to PICU from the community and 15 were transferred from other wards. 10 patients were admitted for the first time and 23 had previous admissions in the past. 28 patients were white British; 2 each were black Caribbean and white Polish; and one patient was black African.

### B. Medication chart results

Out of the total number of charts available (both current and previous ones), which was 95, only 36 charts had the relevant information documented whereas 59 charts did not.

### C. Current medication chart results

a) **Admissions from the community**: Out of 18 patients admitted to PICU, 8 patients had the relevant information documented in their medication charts, 9 had no documentation and one patient had no medication chart written by the admitting doctor.

b) **Transfers from other wards**: Out of 15 patients transferred to PICU, 5 patients had the relevant information documented in their medication charts and 10 patients had no documentation.

In total, out of 33 patients surveyed, only 13 had the relevant information documented in their current drug charts whereas 19 did not. One patient had no chart written by the admitting doctor on admission. When the information was not available to the admitting doctor at the time of admission, no clear documentation in the patient's clinical records was made advising the team to follow this up later on.

### D. Previous medication chart results:

12 patients had only one medication chart available (the current one); 10 of them were admitted for the first time and had no previous charts, and 2 patients had been admitted many years ago therefore their pervious charts were not available. 21 patients had previous charts available. The number of previous charts for each of these patients ranged from 1 to 7. Out of the total number of available previous charts, which was 63, only 23 charts had the relevant information documented, whereas 40 charts did not.

## DISCUSSION

The survey results indicate that the practice regarding documenting information about previous drug adverse reaction/allergies was inadequate. The relevant information was documented in the current drug chart for only 13/33 patients. This could increase the risk of medication error to the remaining 20 patients. Following the survey, it was recommended to emphasize the importance of this practice to all doctors and nurses and to include this in induction programs. The recommendation was implemented by the management.

## REFERENCES

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