Is ADE Voluntary Reporting Data Wasting Your Time?

Paul Milligan, Pharm D, MS Pharm

Adjunct Professor of Pharmacology, Washington University, St. Louis, MO.

System Medication Safety Pharmacist, Retired, BJC.

I have no pertinent disclosures to report.

Paul Milligan

Self-Assessment Question:

Actionable information from voluntary reported ADE data should include a ranked list of the:

1. Medication names and/or drug class.
2. Event type and severity Level.
3. The steps in the medication administration process.
4. All above

Now Ponder This……..

- You are assigned to reduce Adverse Drug Events (ADEs) at your hospital by 50% in the next 5 years.
- What are your first steps?
  A. Pull up your self-reported ADEs and start to work.
  B. Ask for a list of Sentinel or “Never” events and implement mitigation strategies.
  C. Determine a surveillance process that is valid, comprehensive, and reproducible
  D. Go back to staffing

Opening Questions

- Who uses voluntary reporting of ADEs in their hospital?
- Who tracks this data to report to quality and safety groups?
- Who reports a graph of the count of reports entered monthly?
- Who uses this data as their Daily Work?
  - Updating harm levels and maybe even some event investigation?
- Who reports the top ten classes of drugs reported each month?
  - The top specific drugs?
  - The top event types? (missed does, wrong dose, etc.)
  - The top steps involved in errors in the med admin process? (Administering, prescribing, etc.)
- Can you do it easily?

ADE Surveillance Methods

- **Triggers:** Manual (Can be automated) Chart Review- IHI Trigger Tool

- **National Electronic Measures:**
  - New and upcoming national eCQM measures from CMS
  - Severe HYPOglycemia
    - Blood glucose <40mG/dL
  - Severe HYPERglycemia
    - Blood glucose >300mG/dL
  - Harm from Opioids
    - Naloxone given
- **Voluntary Reporting**
  - Captures ADEs as observed by health care providers and is relatively easy to implement
  - Suffers from inconsistent reporting rates, user noncompliance, variable definitions, and concerns of punitive action.

Voluntarily Reported ADEs

- Whether you use national quality metrics, a trigger tool, lab values, antidote administrations, or another valid way of identifying your ADEs, we most likely have a collection of voluntarily reported event data-

  It's Easy!

- Limitations of voluntary reporting
  - Inconsistent reporting rates
  - user noncompliance
  - Variable definitions
  - Concerns of punitive action
    - Often reporting others
    - Spiteful
    - Time sensitive- if you have time you enter them!
- Yet it is often the best information we have on what ADEs are occurring.

Risks Of Misuse Of Voluntarily Reported Data

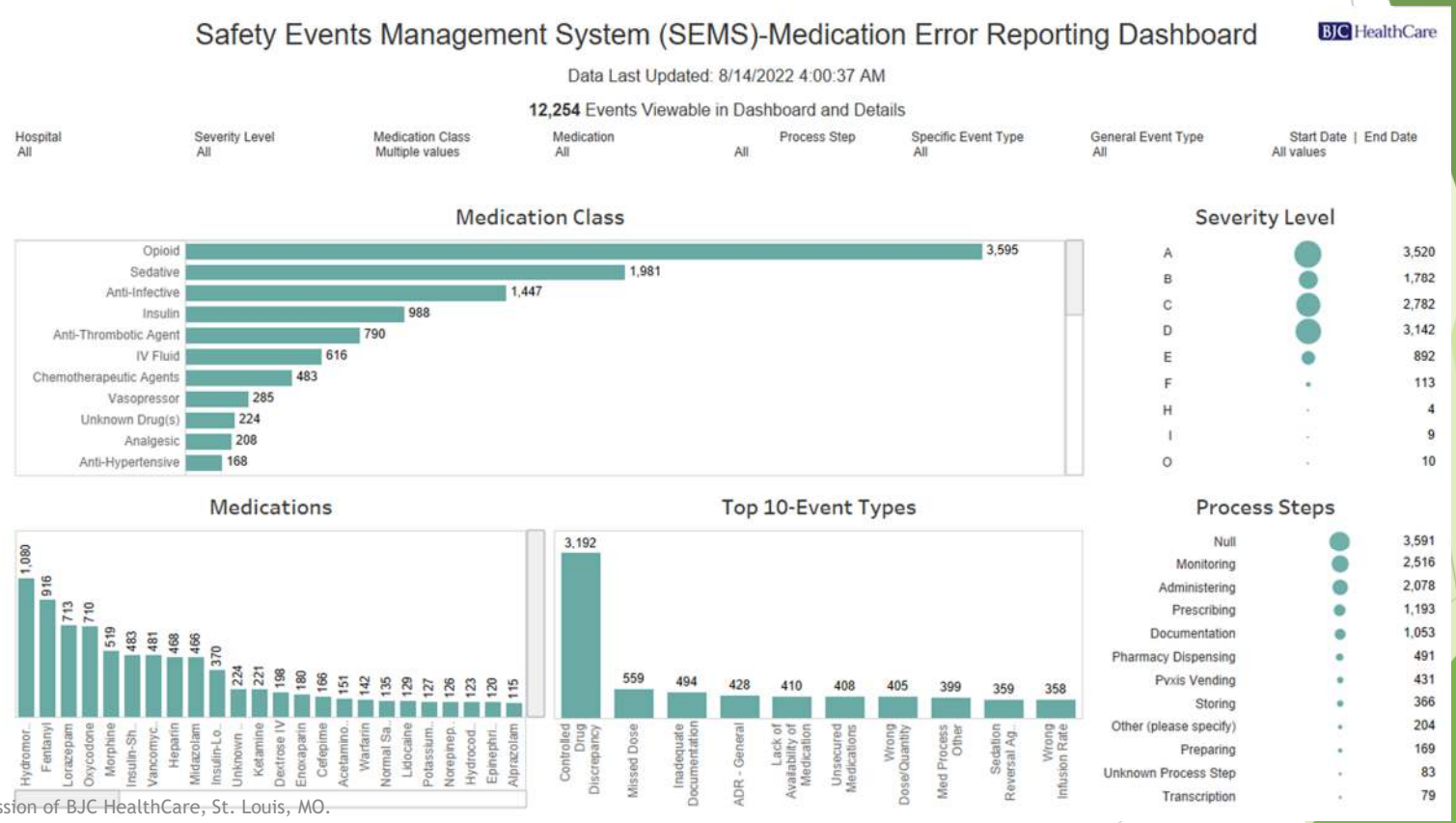
- You may end up working on the events that bubble to the top?
- Mis-prioritizing your time?
- Your ADE event rates do not improve in proportion to your work effort?
- Or WORSE,

  You really don't know if your patients are safer.

Consider These Strategies:

- **Instead of event counts:**
  - Report rates of reporting (e.g., per 1000 admissions) per unit, service or hospital.
    - Answers the question: Are we reporting more or fewer events. **(Culture)**
    - Does not answer: Are we safer?
- **Instead of only reporting Sentinel Events:**
  - Report top drugs or classes
    - Answers the question: What drugs are most involved in self-reports. **(Directional)**
    - Does not answer: Are we safer?
- **Instead of reporting top drugs or classes:**
  - Update the entries to include Process Steps and Event Types
    - Answers the question: What steps of med administration are most involved in reports? **(Directional)**
    - Does not answer: Are we safer?

Example Of A Locally Designed Relational Database Of Self-Reported ADEs



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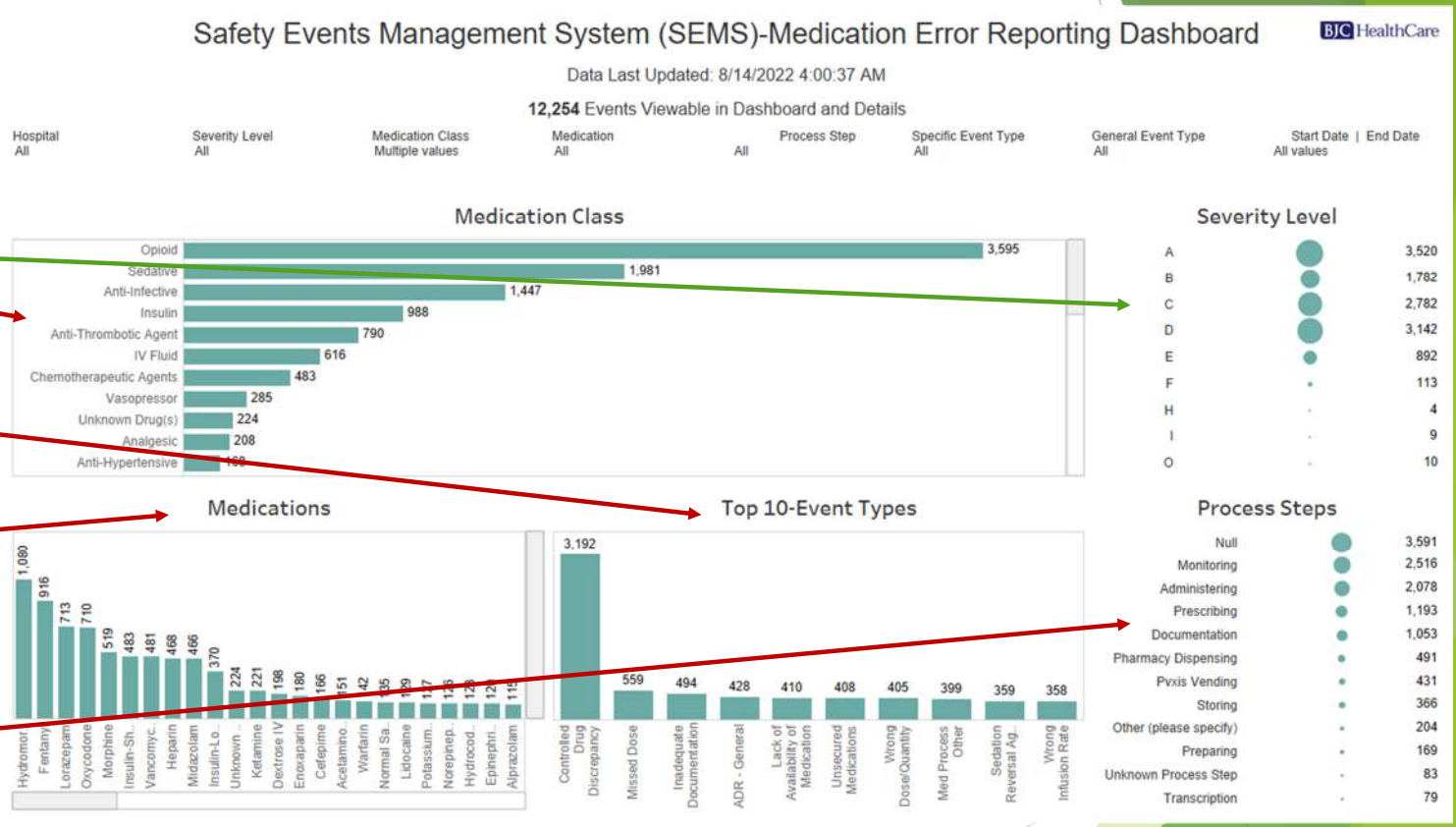
Examples of Sorting

- ✓ Severity Level
- ✓ Medication Class
- ✓ General Event Type (Missed dose, wrong dose, ADE, wrong infusion rate, etc)
- ✓ Medication (specific)
- ✓ Process Step (Administrating, Prescribing, Pharm Dispensing, ADC vending, Preparing, etc)



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Real Life Example

- Reviewing events related to opioid induced respiratory depression necessitating Naloxone reversal.
  - Top 10 drug class overall
  - Top ten when filtering levels E-I harm
  - Top 3 when filtering Level F-I harm.
  - Not related often to administration or prescribing errors
  - Monitoring (delayed recognition) was one of top contributing factors
- Result was implementation of a better method of monitoring- Capnography- at the bedside and resultant significant reduction in severe harm and LOS.

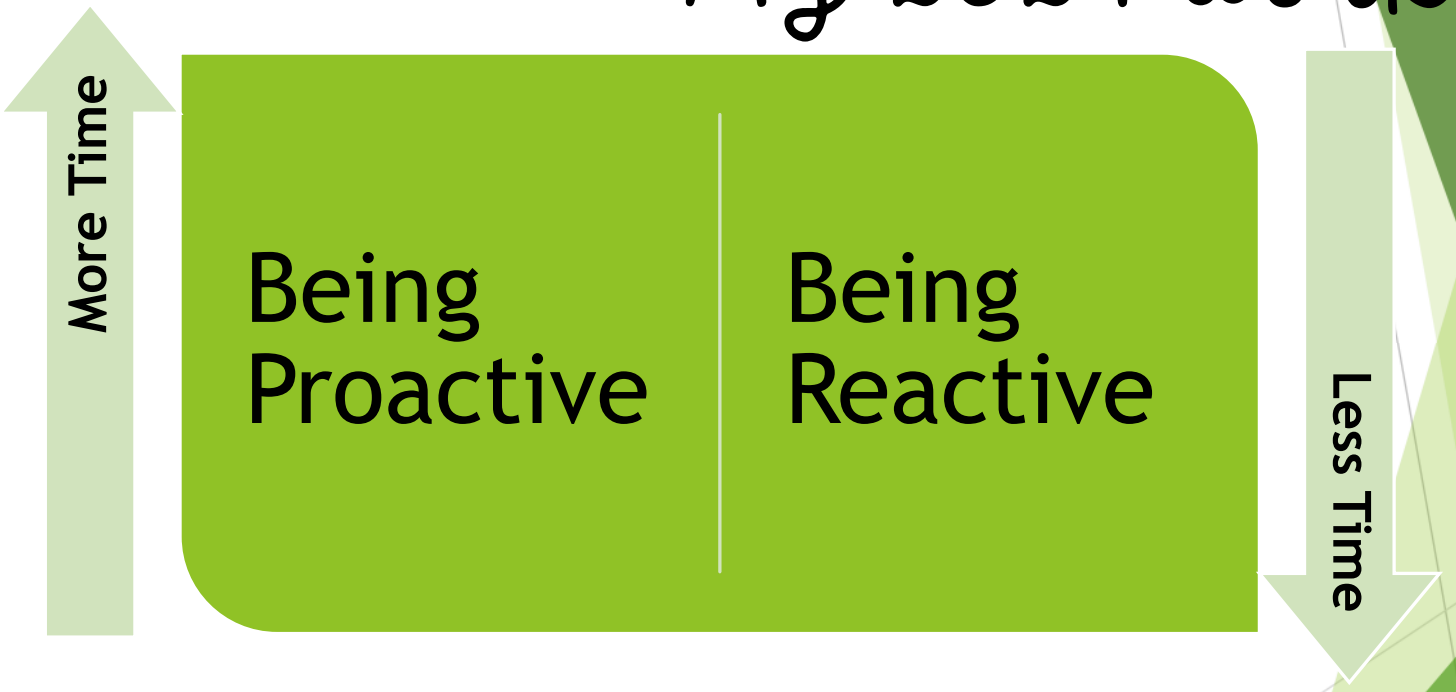
Soap Box

- Remember: The goal of our work is to learn and prevent future harm!
  - It is not to make charts and tables.
  - If you are spending your time doing this, then reassess the purpose of the graphs and tables you are making.
- If we design and implement mitigation strategies based on Actionable and Directional information on the most reported event types, drug classes, process steps, Our work becomes:

<u>Proactive rather than Reactive</u>

(Print this next slide and tape it on your wall…….)

My 2024 Work Goal



Self-Assessment Answer:

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Key Takeaways

Never forget the limitations of self-reported ADEs.

Strive to report rates of reporting vs counts of events to inform culture

If you are going to read them, add content that will give you direction.

Look beyond the Sentinel Events for process steps, event types, and medication classes.

Be more proactive than reactive in your work