Adverse Event Reporting

The current version of all Hillingdon Hospital R&D Guidance Documents and Standard Operating Procedures are available from the R&D Intranet and Internet sites: www.thh.nhs.uk/Departments/Research/research.htm

Please ensure that you have the latest version.

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1. BACKGROUND

This SOP highlights how Adverse Events and Serious Adverse Events should be reported and conforms to ICH GCP guidance (1996). Researchers must ensure they are aware of the following definitions.

The definition of an adverse event is: “Any untoward medical occurrence in a patient which does not necessarily have a causal relationship with this treatment”. This includes “any unfavourable and unintended sign (including an abnormal laboratory finding), symptom or disease temporally associated with the study drug”. This may include, for example, a cold, or an accident.

The definition of a serious adverse event is one that fulfils at least one of the following criteria:

- Is fatal – results in death (NOTE: death is an outcome, not an event)
- Is life-threatening
- Requires inpatient hospitalisation or prolongation of existing hospitalisation
• Results in persistent or significant disability/incapacity
• Is a congenital anomaly/birth defect

An adverse reaction is ‘unexpected’ if its nature and severity are not consistent with the information about the medicinal product in question set out in the Summary of Product Characteristics, or Investigator’s Brochure.

All serious adverse events should be reported to the trial coordinating centre within 24 hours of the investigator becoming aware of the event.

Adverse event definitions and procedures will be detailed in the study protocol. If any Trust staff are in doubt whether to report an occurrence as a SAE, contact the trial centre for further advice.

2. PURPOSE

To describe the procedure for identifying, recording and reporting adverse events and serious adverse events.

3. PROCEDURE

3.1 Who?

All trials staff and clinicians in contact with patients are responsible for noting adverse events that are reported by the patient and making them known to appropriate medical staff. Patients entered into clinical trials must be encouraged from the outset of any study to contact their research nurse/team at the time of an event occurring.

It is important that if patients are admitted to ward areas that the research team are informed of the hospital admission as soon as possible. The appropriate staff members should conduct study assessments, and ensure that all adverse events are identified for each patient as far as possible.

3.2 When?

At each visit, or study assessment, adverse events that might have occurred since the previous visit or assessment should be elicited from the patient. For source documentation verification these events need to be detailed in the patients medical notes including the start dates (if known) of the onset of the event as well as the date the event stopped or changed, if applicable. Adverse events ongoing on completion of the study should be followed up as required by the protocol and as clinically indicated. The clock starts from the time the study team were made aware of the event.

The ICH GCP Guidelines state that: “All serious adverse events should be reported immediately to the sponsor” (trial organisers), and that “immediate reports should be followed promptly by detailed written reports”.

3.3 How?
Adverse Events

1. Document event in a clear way as far as possible. For example, the patient may say that they ‘felt sick’. This can be interpreted in many ways: either they felt nauseated or they may have felt unwell, or they may even have been vomiting.

2. Ask patient the date and start and stop time of event; If the patient cannot remember, then as near as possible.

3. Document the severity – this may be graded by using the toxicity criteria found in the protocol.

4. Document the action taken regarding study drug – if any e.g. was the treatment dose reduced, or was study drug/treatment delayed etc.

5. Document any treatment/medication given for the event, including the dates the treatment/medication was commenced and the date it was stopped/changed, if applicable.

6. Document the event outcome.

7. Events ongoing at study completion should be followed up as detailed in the protocol and as clinically indicated.

8. Adverse events should be recorded on a CRF and reported to the study centre as required by the protocol.

Serious Adverse Events

9. All adverse events/adverse drug reactions must be documented as above. For definitions of a serious adverse event, see section 1.

10. Inform the research co-ordinating body as soon as possible within 24 hours of the Investigator’s knowledge of the event. This may be by faxing a Serious Adverse Event form to the trial centre. The preferred method will be fully explained in the study protocol, and these procedures must be followed. It is important that the timeline for reporting (i.e. when the investigator became aware of the event, and when the trial centre was notified) are documented.

11. Should the event be initially reported orally (e.g. by telephone), a written report should follow within 24 hours.

12. Note that for specific trials, certain kinds of event may be exempted from immediate reporting – this will be documented in the protocol.
13. Respond promptly to requests for additional information from the Sponsor, and send follow-up reports as required to document the progress of the event.

14. Copies of all correspondence (including emails) relating to the SAE should be retained in the patient's individual patient's research records or master site file including summaries of telephone conversations. All conversations with the study centre must be documented on the communications log. Reasons for late reporting must be documented on the SAE form and in the patient's research records or the master site file.

15. Pregnancy in either a patient or the partner of the patient in a trial taking trial medication should always be reported to the trial centre. Check the protocol for the preferred method of doing this. Sometimes there will be a specific pregnancy reporting form.

4. OTHER RELATED PROCEDURES

Case Record Form (CRF) Completion
Study files and filing

5. REFERENCES AND FURTHER READING

ICH Harmonised Tripartite Guideline for Good Clinical Practice (1996)


Some of the text of this SOP adapted from:

6. APPENDICES

Appendix A – Classification of Adverse Events
**Appendix A**

**ADVERSE EVENT**
- can be related (adverse drug reaction) or unrelated to the study drug.

**SERIOUS (SAE)**
- Report within 24 hrs!
- Death
- Disability
- Overdose
- Birth defect
- Malignancy

**NOT SERIOUS**
- Does not meet the criteria of an SAE.
- Eg. Mild fatigue

**SUSPECTED**
- Suspected to be caused by study drug.
  - Eg. Admission for a fractured ankle.

**NOT SUSPECTED**
- Not suspected to be caused by study drug.
  - Eg. Admission for severe nausea or vomiting following chemotherapy.

**EXPECTED**
- Eg. Admission for severe nausea or vomiting following chemotherapy.

**UNEXPECTED (SUSAR)**
- Eg. Tongue swelling. Not a previously known side effect of the study drug.

Report to trial centre as per protocol guidelines.
Usually no deadline.