Incident Reporting in Medicines Information Scheme (IRMIS)

Q1: January to March 2023

Reports	
Total number enquiry incidents since January 2005: 1032 (rolling total for 2023: **8**)	**Total number publications incidents since April 2013: 16**
Enquiries	**Publications/Pro-active work**
Number for this period: 8	Number for this period: 0
Number of errors: 6	Number of errors: 0
Number of near misses: 2	Number of near misses: 0
Number related to data: 3	Number related to data: 0
Number related to advice: 5	Number related to advice: 0
Number where description 'not known': 0	Number where description 'not known': 0

Report Summary

Top 3 recommendations from QRMG for this quarter:

- Read the documented questions back to the enquirer before ending the call and repeat the question(s) in when you respond.
- Do not feel pressurised into answering high risk questions immediately (e.g., dosing calculations, pregnancy, breast feeding, poisoning).
- If there is doubt about the question asked once research starts, stop, and contact the enquirer to get clarification.

Most incidents reported this quarter were classified as error, i.e., the answer had been given out and the incident picked up later. The most common causes were high workload and interruptions. The top enquiry type associated with the incidents were interactions, and choice/indication/contraindication of medicine. No incident was considered to have a major risk to patients. Several incidents cited time pressures as a cause of error or near miss. Consider whether an enquiry is truly urgent. The enquirer may say it is but that may not be the case.

Chart 1 shows a quarterly comparison of potential risk to the patient due to error or near misses.

Data relating to identified causes and enquiry types for incidents is presented in chart 2 and 3.

Table 1 (a-c) summarises the incidents reported and provides suggested actions and/or reminders from the QRMG to aid mitigation of risks at each stage of the enquiry answering process.

No publication incidents were reported this quarter.

Help us improve

The QRMG are keen to get your views on the IRMIS report. Please email us at QRMG.ukmi@nhs.net.

Contact

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Chart 1: Quarterly comparison of potential risk to patients through reported errors or near misses in medicines information (MI) services.

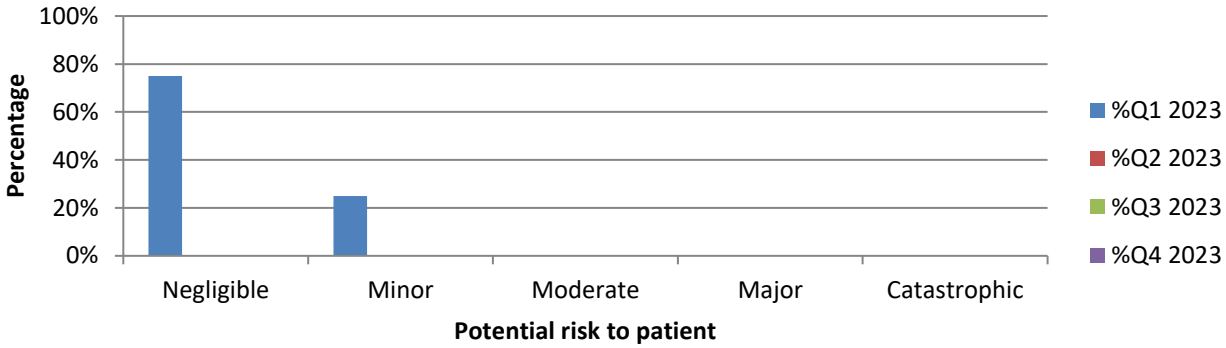


Chart 2: Percentage reported common causes of MI incidents for Q1 2023*

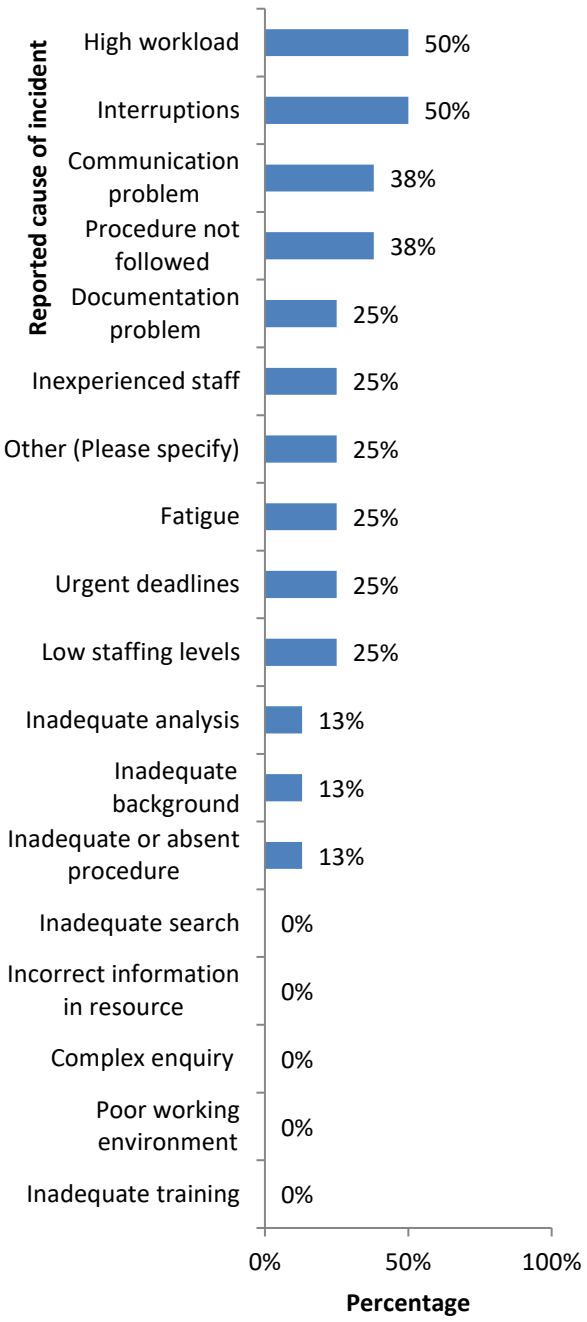
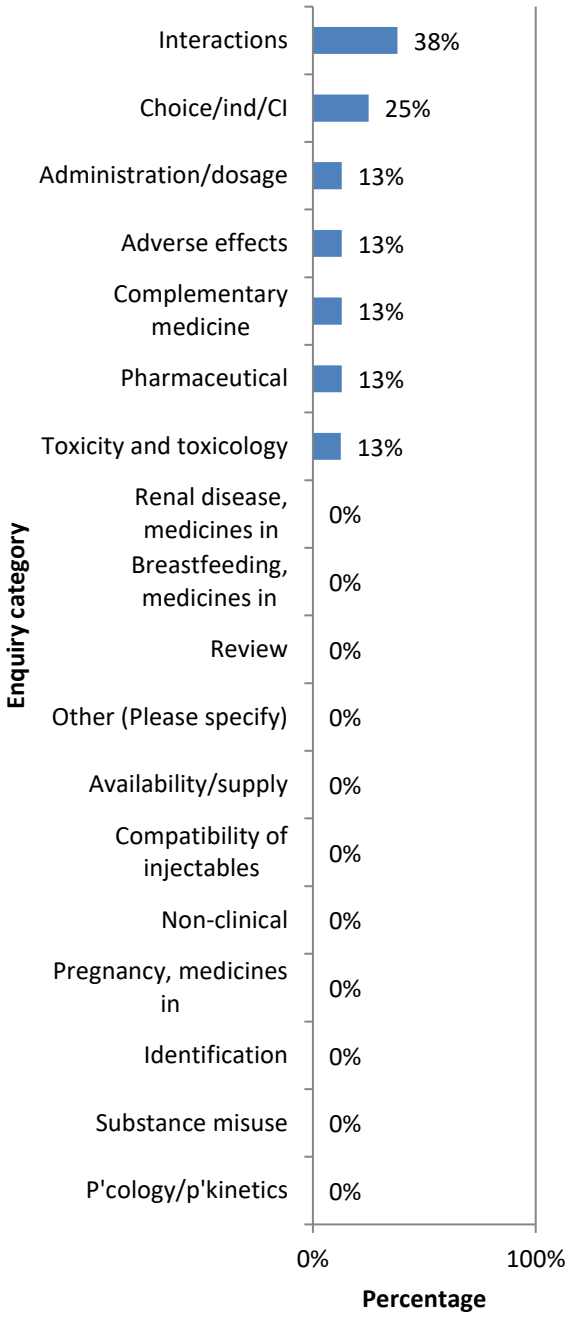


Chart 3: Percentage reported types of enquiry involved in MI incidents for Q1 2023*



*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1269 involved entering the wrong title for an enquiry which requested interaction data for statins and sulfasalazine. It was documented as interactions between simvastatin and sulfasalazine. A similar situation occurred when Twinrix (for hepatitis) was heard as Shingrix (for herpes zoster/shingles) in incident 1270. Incident 1275 resulted when staff thought the enquirer said tadalapril. This is a non-existent drug. The enquirer had said trandolapril. Staff became aware when researching and were able to correct the mistake since they had taken in details of the indication and dosing.	• Read the documented questions back to the enquirer before ending the call. • Repeat the question in the written response. • Ask the indication for use and dosing where appropriate. • For medication that you have not heard of, ask the enquirer to spell the drug letter by letter and then check the BNF whilst the enquirer is on the phone. This may also raise additional questions for the enquirer. • For vaccine questions, it may help to ask who manufactures the product they have.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1271 had a potentially minor risk to patient outcome. It involved responding to a diltiazem overdose enquiry whilst the caller remained on the call. The caller was advised the calculated risk of harm was low, so no action was needed. After ending the call, the staff recalculated the toxic dose and realised medical attention should have been sought.	• Avoid answering medication questions under pressure especially those considered high risk such as poisoning, breast feeding, and pregnancy. • Take time to work through calculations, without distractions and ask a colleague to double check the calculated answer. Where this is not possible, work through the calculation with the caller when responding. • Refer to the 'poisoning or overdose' section of the UKMi Enquiry Answering Guidelines at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=125071525.

Incident 1273 occurred due to a lack of understanding regarding herbal products and their constituents. Research was misinterpreted when black pepper and cayenne pepper were considered the same. The resulting advice given did not change but irrelevant information was presented in the answer.	• Use more than one resource if there is lack of clarity around the constituent in one resource. However, if you have access to Natural Medicines Database, that can be used as a single source for herbal medicine questions. • Do not extrapolate the data from similar herbal monographs. • If you have two similar sounding drug names and you are not familiar with either, check their similarities/differences before answering. • Check enquiries when you are not under pressure. Consider the clinical urgency of the enquiry and whether a deadline extension could be requested.
Incident 1272 related to taking a question about use of choice of antihistamine in a patient allergic to cyclizine. The question focus was changed during research to the choice of antiemetic in a patient allergic to cyclizine. The documentation in the question field was insufficient and caused doubt. The original question was correct, and time was wasted researching the wrong use.	• If there is doubt about the question asked once research starts, stop, and contact the enquirer to get clarification. • Reiterate the question researched in your answer.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1268 occurred when the wrong manufacturer's temperature excursion information was copied into the information regarding a different medicine. The advice resulted in requesting the user to continue using the item whereas it should have been to discard. The potential patient outcome was negligible suggesting that no patients received the product.	• Answers involving multiple medicines should be checked carefully (by a different person where possible) before sending. • It may be helpful to separate out the medicines that are awaiting further information from those with information in the answer. This will also help identify the medicines that require follow up later. • Consider using different font colour in MiDatabank to highlight drugs still awaiting further information. • Try to allocate working on complex enquiries during less busy periods where possible or allocate protected time to staff if you can.

Incident 1274 occurred when staff took in and started working on two enquiries at the same time that involved Peptac interactions. One referred to interactions with levothyroxine and the other interactions with iron salts. The enquiries were confused, and the wrong research and answer added to each.	• Work on one enquiry at a time.

Publication Incidents

Recommendations:

There were no publication errors reported this quarter.