Incident Reporting in Medicines Information Scheme (IRMIS)

Q2: April to June 2023

Reports	
Total number enquiry incidents since January 2005: 1046 (rolling total for 2023: **22**)	**Total number publications incidents since April 2013: 16**
Enquiries	**Publications/Pro-active work**
Number for this period: 14	Number for this period: 0
Number of errors: 10	Number of errors: 0
Number of near misses: 4	Number of near misses: 0
Number related to data: 6	Number related to data: 0
Number related to advice: 7	Number related to advice: 0
Number where description 'not known': 1	Number where description 'not known': 0

Report Summary

Top 3 recommendations from QRMG for this quarter:

- Reduce the risk of drug name errors by repeating the drug name when taking calls in, include the summarised question at the top of each research entry, and restate the question in your answer.
- Try not to provide instant answers under pressure and re-check all written responses carefully before sending.
- If relying solely on past enquiries, check the references and sense check the currency of the information. Be aware that some areas, e.g., supply issues, are fast moving and can change on a more frequent basis.

IRMIS reports can be submitted via NHS networked devices at https://irmis.wales.nhs.uk/Login.aspx.

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 documentation problems, communication problems and interruptions. The top enquiry type associated with the incidents were administration/dosage and availability/supply. No incident was considered to have a major risk to patients. Two errors were categorised as moderate risk to patient: one occurred when a drug safety in pregnancy answer was given out without authorisation and the other when a fridge excursion answer was checked by new staff but contained incorrect data.

- 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

IRMIS database technical queries: pharmacy.support@wales.nhs.uk Content: QRMG.ukmi@nhs.net.

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

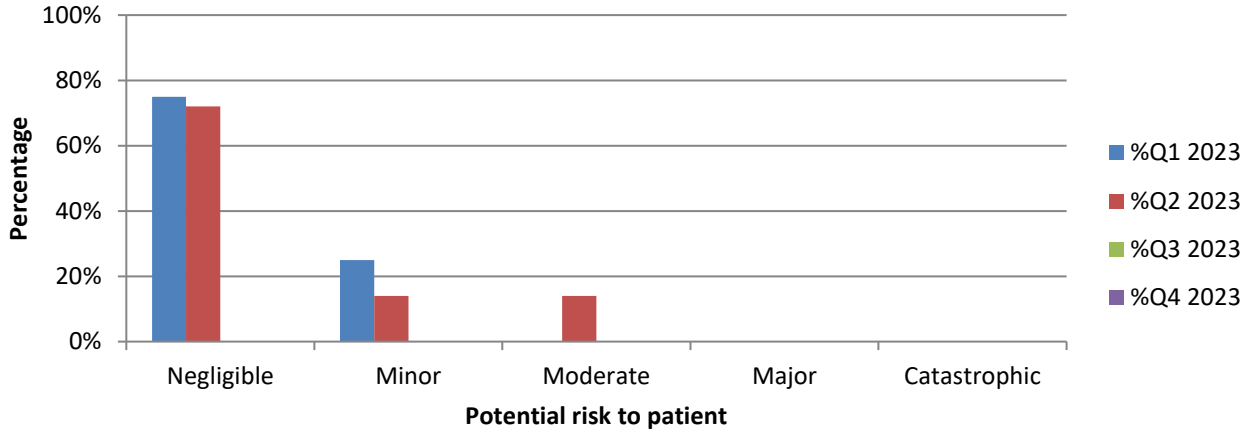

Chart 2: Percentage reported common causes of MI incidents for Q2 2023*

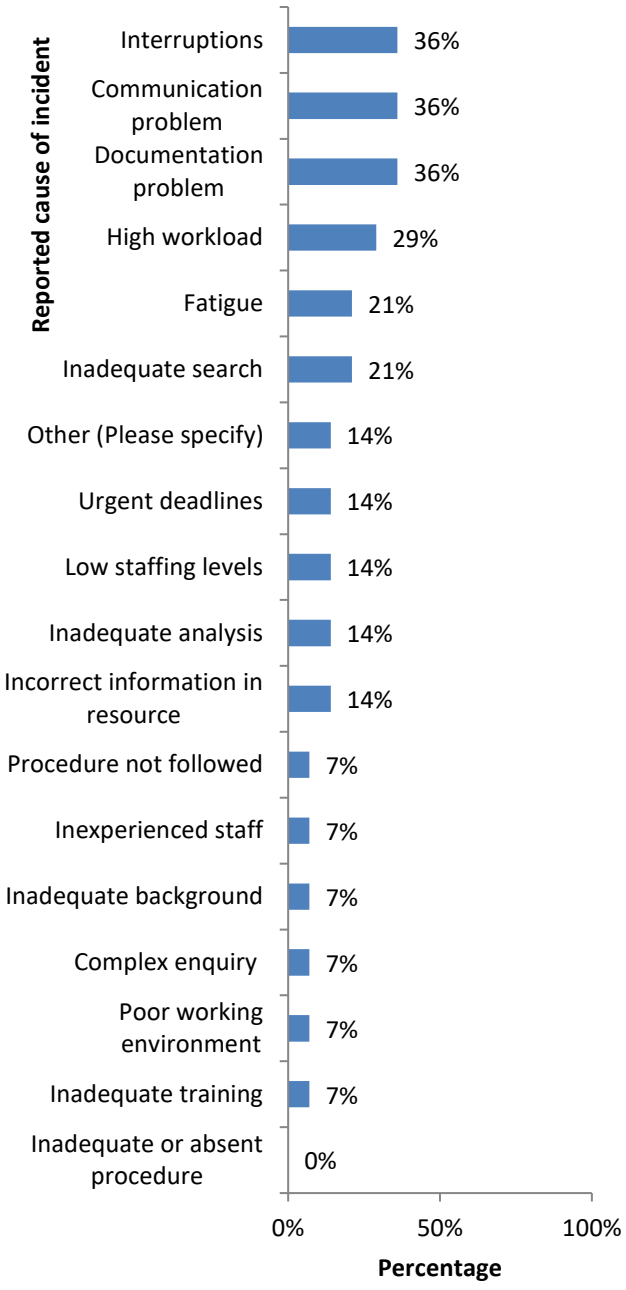

Chart 3: Percentage reported types of enquiry involved in MI incidents for Q2 2023*

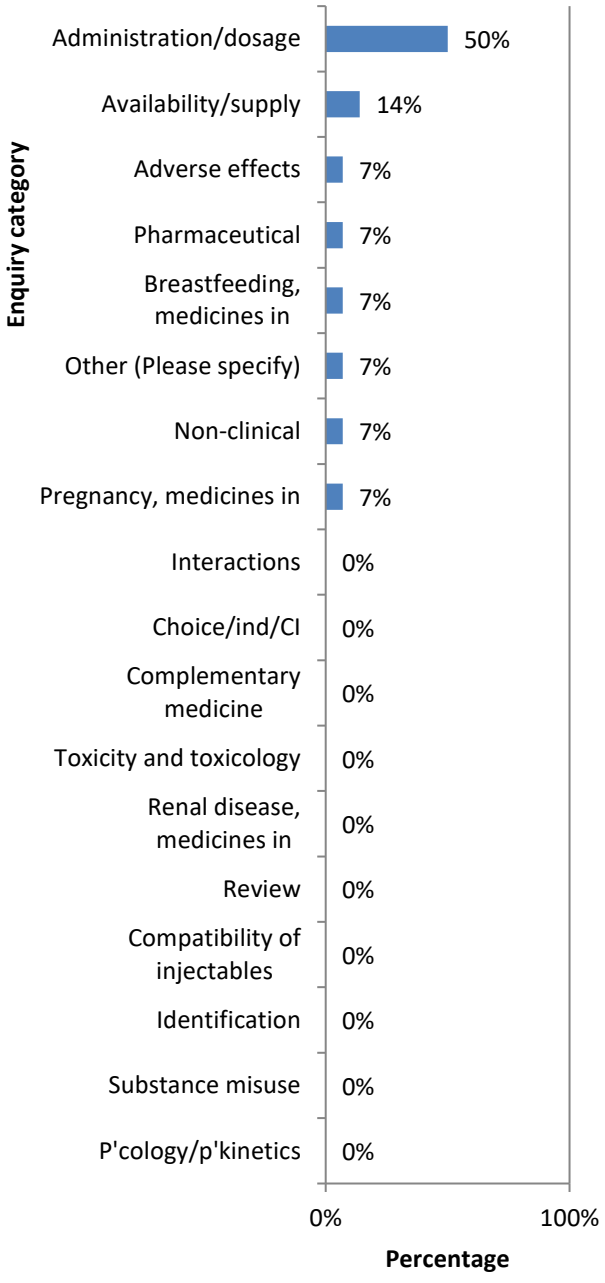

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1279 resulted when the caller requested breast feeding safety advice for sertraline instead of fluoxetine. The dose was given as 10mg or 20mg. This was not picked up prior to research but at the checking point. GP records were accessible and confirmed the drug to be fluoxetine 20mg.	• Repeat the question(s) to the caller before ending the call. • Double check the drug being researched in the BNF in case there are any discrepancies to clarify with the enquirer before starting research. • Be alert for discrepancies in the enquiry at the point of receipt such as unusual drug for the situation, unusual dose for the drug, etc. • Guidance on checking MI enquiries can be found at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=31108944.
Incident 1281 resulted from answering the enquiry whilst the caller was on hold. It involved advice on mixing penicillin with paracetamol oral suspension to improve compliance. The answer given related to mixing penicillin with food.	• Avoid adding unnecessary pressures by trying to answer enquiries whilst the caller is on hold. Always take the enquiry in, document it in your enquiry recording database in real time and repeat the question(s) asked before ending the call. Try not to pre-empt the question. • UKMi tips and guidance for MiDatabank can be found at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=31468176. • The QRMG IRMIS alert (Issue 1) lists actions to take to avoid instant answers. See https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=161686117.
Incident 1288 occurred when linezolid and levofloxacin were interchanged during documentation in the input screen. Incident 1290 was similar when rifaximin was misheard as refluxamine. The drug names were confirmed phonetically, and the written response checked before sending. No indications or dosing information was taken, and the drug list did not assist in identifying diagnosis.	• Consider strategies to minimise the risk from sound alike drugs. See https://www.ismp.org/resources/adopt-strategies-manage-look-alike-andor-sound-alike-medication-name-mix-ups and https://www.ismp.org/recommendations/confused-drug-names-list. • Re-read the MiDatabank input screen and give a sense check straight after taking an enquiry in. Have clear research questions and consider adding keywords at the input stage.

	• For drugs you are not familiar with, always ask the dose and indication as a minimum. • Where calls are recorded, consider listening to the recording where conversations are unclear, or the caller cannot be fully understood.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1278 missed using the most up to date version of a government guideline. The amended document did not change the answer given.	• Reliable websites will usually, but not always, indicate the date the information was last updated. Some will also contain a review date which may or may not have been actioned. This can sometimes assist in highlighting the need to look for updated versions. • Go directly to the PDF rather than the landing HTML page as there is a risk that an out-of-date PDF is still on the website. • Where possible, use a minimum of 2 resources (or 3-4 resources in the case of drug interactions) to avoid relying on one resource that could potentially be outdated. • Consider using a 'site:' search via Google. Steps on how to advance search are at https://support.google.com/websearch/answer/35890?hl=en&co=GENIE.Platform%3DDesktop#zippy=. • For enquiries involving your Trust practice, consider contacting your Trust governance team.
Incident 1282 occurred when the wrong drug was researched in one resource and included in the written response (clonazepam and clonidine). A second check process was not in place. Incident 1283 was similar when the enquiry referred to ropivacaine, but bupivacaine was stated in the answer.	• When researching, consider copying and pasting the simplified research question at the top of each resource entry to avoid losing focus of the question(s) asked. As a minimum, have clear research questions in the question field. • For written responses, where possible have a colleague re-read your answer for accuracy and flow. If this is not possible, write your answer, take a break, and then come back to your answer for a re-read before sending. • Cross check and reiterate the questions asked in the answer field and then state your answer. • Consider strategies to minimise the risk from sound alike drugs. See https://www.ismp.org/resources/adopt-strategies-manage-look-alike-andor-sound-alike-medication-name-mix-ups and https://www.ismp.org/recommendations/confused-drug-names-list.

Incident 1284 resulted from an error in an enquiry found on MiDatabank Viewer being transcribed into the answer. The MiDatabank Viewer enquiry suggested that bisacodyl tablets could be crushed however this was not the case. Incident 1287 was a duplicate entry.	• Enquiries on MiDatabank Viewer are past enquiries and the resources used should be reviewed if necessary. • Any errors detected in shared enquiries should be highlighted with the centre sharing the enquiry so that the enquiry can be investigated, removed if necessary and an IRMIS entry completed if appropriate. • Guidance on sharing enquiries can be found at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=115940581.
Incident 1285 relates to working on two similar enquiries at the same time. The research for one enquiry was put into the other.	• Enter enquiries into your enquiry recording database on receipt and in real time. This will also save time by reducing duplication of work. • Work on one enquiry at a time. Where you have multiple enquiries ongoing at the same time, close the other enquiries and only have one enquiry open in MiDatabank. • Refer to the UKMi tips and guidance when using MiDatabank at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=31468176.
Incident 1289 highlighted the changing advice due to drug shortages such as Ozempic.	• The status of drug shortages are regularly changing and past enquiries alone should not be relied upon. • Refer to the Specialist Pharmacy Services (SPS) Medicines Supply Tool at https://www.sps.nhs.uk/home/tools/medicines-supply-tool/ for the latest advice on national shortages and sign up for weekly updates by registering on the site. The pages will contain links to national guidance where available. If the SPS tool does not match what the enquirer is reporting, then checking other resources.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1276 was reported when a trainee gave out an unchecked answer. The question related to drug safety in pregnancy. The information provided did not suggest any error in the answer.	• Have a list of relevant procedures to read in all staff induction plans. Verbally reinforce the main messages. • UKMi Recommendations for SOPs and good practice guidelines are at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=31109168. • Request that all enquiries need a check unless staff have been signed off (based on local requirements).
Incident 1277 was a temperature excursion enquiry involving two strengths of the same product. The data for each strength was confused and an incorrect answer given. The enquiry involved numerous products and a short deadline. On this occasion the checker was new to the process and written information from the manufacturers was not obtained during the research.	• For temperature excursion enquiries involving fridge items, refer to the UKMi generic fridge enquiries guidance at https://future.nhs.uk/UKMedsInfoNetwk/view?objectId=31108944. • Where there is a long list of fridge items, identify items where the information is needed urgently and prioritise those. The less clinically critical items could be given a longer deadline.
Incident 1286 occurred when the answer was emailed to the wrong enquirer.	• It is useful to set enquirers into MiDatabank with their contact details. • When taking the enquiry in, re-confirm the enquirers contact details and make amendments in their MiDatabank profile or use the ‘contact for this enquiry’ box. • For emailed enquiries, reply to the original email. Reply all if there are multiple contacts. This will also reduce the risk of emails going into the enquirers spam/junk folder. • Write the email first and then add the enquirer’s email address last. This will give you time to check how the email reads and add any attachments before hitting ‘send’. • If you are sending your answer as an attachment, save the document with the enquiry number and drug name to help identify it. This avoids attaching the wrong answer to the wrong email.

	• Check if your Trust adds a disclaimer to outgoing emails regarding emails sent to the wrong recipient and actions to take. • Is it necessary for the email response to contain person identifiable or confidential information? If not, leave it out.

Publication Incidents

Recommendations:

There were no publication errors reported this quarter.