MEDICINES INFORMATION & ADVICE ALERT

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IRMIS Alert
Learning from Practice

Instant answers increase the risk of error

Background

- 17% of IRMIS reports during the last 2 years have involved an answer provided whilst a caller waited on the phone.
- Most involved consulting **simple resources**, like the BNF and SmPC.
- MI **staff with all levels of experience** were involved.

Why do we think it happened?

- The pressure to work quickly is a known cause of errors. When the enquirer is right there (in the office or on the phone), there are additional pressures.
- If you are talking the enquirer through resources as you check them, there is less opportunity to pause and reflect, so it is easier to miss or misinterpret information.
- The enquirer may also interrupt, seem unwilling to wait, have additional questions or give more details while you try to process and answer the enquiry.

Actions

- **Document** the enquiry directly onto your enquiry management system.
- **Repeat** the question(s) back.
- **Negotiate** a suitable deadline. Just because the enquirer says it is urgent, doesn't mean it is. Use your clinical judgement and consider enquiry workload.
- **Manage expectations.** Anticipate the rate limiting steps in researching, such as getting information from manufacturers, and explain why you can't give an answer immediately. Remaining on the call will not get them the answer any faster.
- **Reassure** the caller that you will deal with their enquiry as soon as you finish the call (if that's what you agreed).
- **Stop and relax!** Take a few moments and let the question settle in your mind.
- **Have protected time** to focus. Tell others you're busy; get someone else to answer the phone and take messages or use the answerphone for a short while.
- **Don't rush** your research or skim read the information.
- If possible, **write out your answer** before giving it out; bullet points may help. This makes it easier to spot any errors or omissions.
- **Check** your answer against the question(s) asked before you get in contact with the enquirer.

Real Examples:

The following are real incidents which occurred whilst keeping the caller on hold.

- Calculating a drug dose for a preterm baby and confusing the gestational age
- Using an online toxicity tool calculator for a narrow therapeutic window drug and entering the wrong data
- Reading product information in the BNF and selecting the wrong product
- Talking a caller through a Toxbase monograph and forgetting to give monitoring advice
- Reading from the Palliative Care Formulary and not advising on the gap required when switching drugs
- Reviewing a dispensing record and missing an updated label which had the correct directions for drug administration
- Looking for a product without a particular excipient on the eMC and advising the wrong product

When something does go wrong

- Follow your in-house procedure for errors or near misses
- Submit an anonymous report to the UKMi Incident Reporting in Medicines Information Scheme (IRMIS)
- Learn as a team

For further details, resources and supporting materials see https://future.nhs.uk/UKMedsInfoNetwk (registration required).
For any enquiries about this alert, email QRMG.ukmi@nhs.net