Incident Reporting in Medicines Information Scheme (IRMIS)

Q4: October to December 2023

Reports	
Total number enquiry incidents since January 2005: 1057 (rolling total for 2023: **52**)	**Total number publications incidents since April 2013: 17**
Enquiries	**Publications/Pro-active work**
Number for this period: 11	Number for this period: 1
Number of errors: 10	Number of errors: 1
Number of near misses: 1	Number of near misses: 0
Number related to data: 4	Number related to data: 0
Number related to advice: 5	Number related to advice: 1
Number where description 'not known': 2	Number where description 'not known': 0

Report Summary

Top 3 recommendations from QRMG for this quarter:

- When taking queries in over the phone, repeat back the scenario and questions before ending the call.
- Do not assume indication and/or medicine details. Ask the user to confirm medicine name, strength, formulation, dosing, and indication, where relevant.
- Reading the written answer aloud before feeding it back will help identify mistakes, e.g. medicine names, conflicting information/advice.

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 high workload, documentation, and inadequate analysis. The top enquiry types associated with the incidents were breast feeding, administration, and interactions. No incident was considered to have a major risk to patients.

- 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.

One publication incident was reported this quarter. A specialist user noted that the worked example was factually correct but not correct in practice. The dose conversion of two steroids would potentially result in clinically sub therapeutic effect compared to the original steroid even though the calculation was correct.

The learning included always considering the practical side of using the advice given. The information and conversion were factually correct but did not reflect what occurs in secondary care settings.

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.

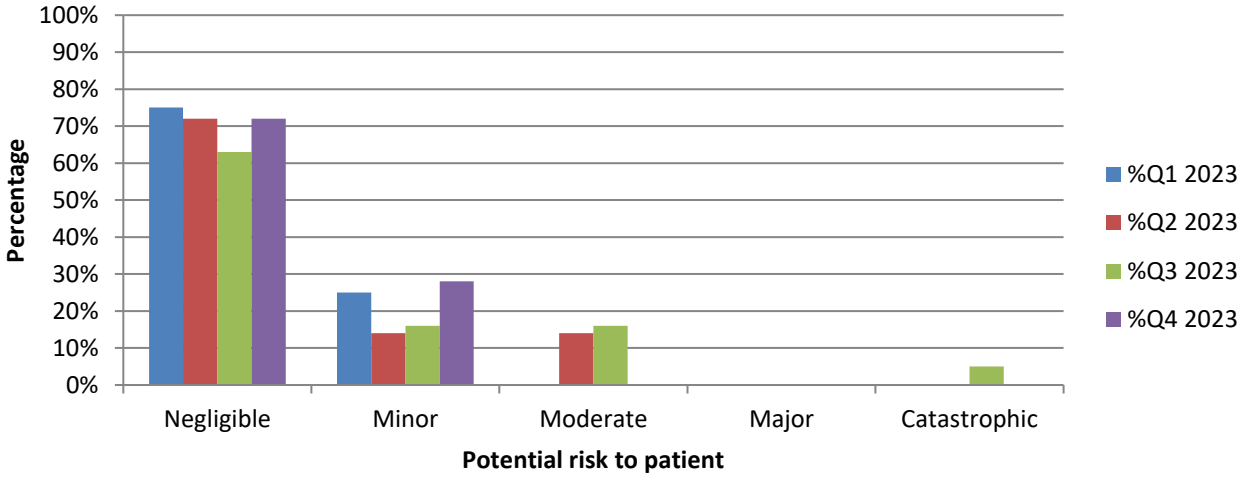

Chart 2: Percentage reported common causes of MI incidents for Q4 2023*

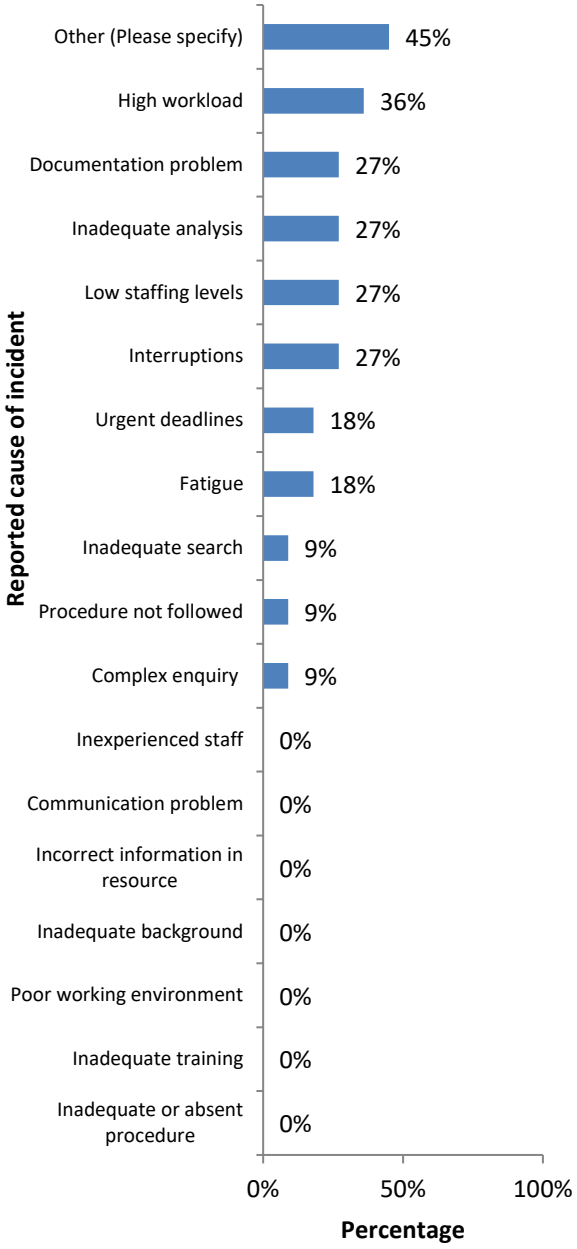

Chart 3: Percentage reported types of enquiry involved in MI incidents for Q4 2023*

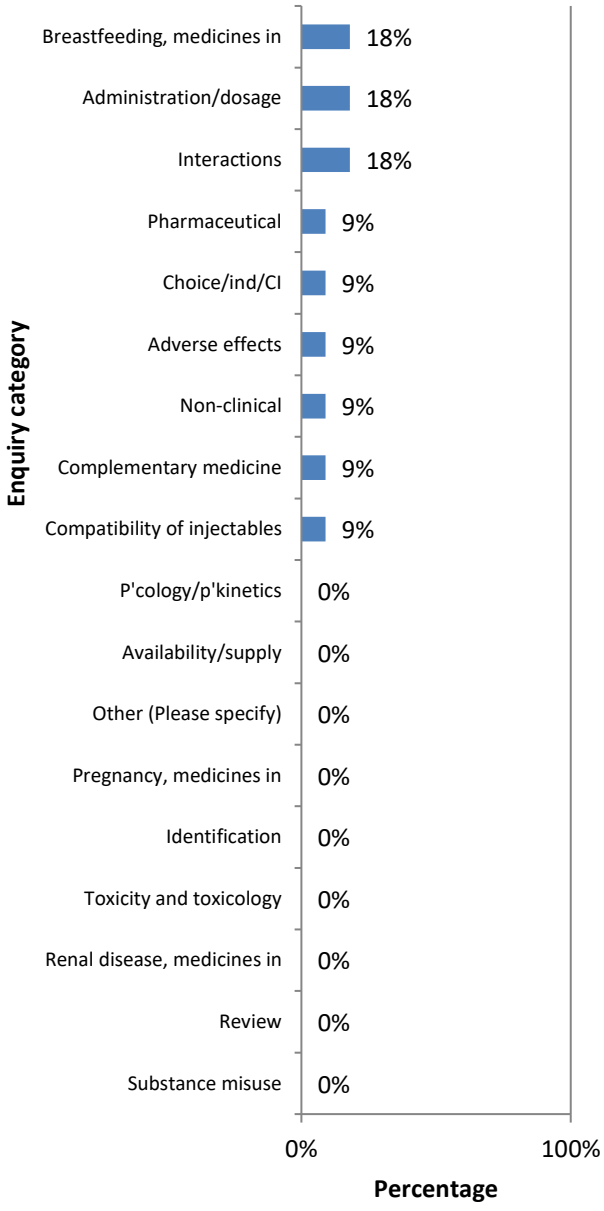

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations

Incident 1310 resulted when an assumption about the route of BCG administration had been made. Staff assumed the BCG vaccine was being administered intradermally when it was being given intravesically. The resulting advice was not incorrect, but the research and answer involved the incorrect route.	• Request the medicine name, strength, and formulation/route for all medicines.
	• Request the indications for medicines where there is more than one indication (including off-licence uses), or where it might help to confirm the identity of the medicine.
	• Repeat the scenario summary and questions to research back to the caller before ending the call.
	• Check if the user has contacted anyone else for advice prior to contacting the MI service. If so, what advice were they given, if any.
	• Quantities of 1 gram or more should be written as 1 g, 1.5 g etc. Quantities less than 1 gram should be written in milligrams, e.g. 500 mg, not 0.5 g. Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg. See https://bnf.nice.org.uk/medicines-guidance/prescription-writing/.
	• If you take in a telephone enquiry on paper (which may occur for valid reasons, e.g. slow computer):
	  ○ Write clearly; use capital letters for extra clarity if required.
	  ○ Ensure you copy it onto MiDatabank (or similar system) as soon as possible, before memory of the detail's fades.
	  ○ Check your handwritten notes to make sure you have transcribed everything into MiDatabank (or similar system).
	  ○ If you are taking in more than one enquiry on paper, keep your notes tidy with each enquiry separated, to avoid mixing up or missing information.
	  ○ Ideally, destroy paper notes after transcribing to MiDatabank (or similar

Incident 1315 occurred when the alternative medicine in question was Evening Primrose Oil but Cod Liver Oil had been documented in MiDatabank. The same staff took the enquiry in, worked on it, and gave the answer out.	
Incident 1316 involved documenting the dose of doxycycline in MiDatabank as 100mg rather than 1000mg. The query was regarding the high dose.	
Incident 1320 happened due to the full information gathered not being inputted into MiDatabank at the point of receipt. The full scenario documented did not include that the caller had been advised by a specialist to select an NSAID. The answer then referred the caller to a specialist for advice on which NSAID to prescribe. Furthermore, the methotrexate was documented as tablets but was actually being given as a weekly injection.	

	system). • Consider the opening times of your service. By taking enquiries in right up to the end of the working day, are you able to respond without time pressures increasing the risk of an error? For example, are pressures reduced by closing the MI service 15 minutes before staff end their working day to allow time to work on urgent end of day enquiries, archive completed enquiries and tidy up enquiry entries?
Incident 1319 was due to an answer being sent to the wrong email address. No person identifiable details were involved. The email address was incorrect when inputted into MiDatabank.	• It is useful to set up enquirers in MiDatabank to avoid inputting the contact details each time for regular users. • When entering contact details for the first time, repeat them back to the user to double check accuracy. • If using pre-recorded contact details, check they are still accurate. • Check you have the right enquirer, especially with common names. • Do not include person identifiable data in answers unless it is necessary.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1312 resulted when a table from Toxbase was copied into MiDatabank for the purpose of a calculation. Information required for interpreting the table did not copy across and impacted the answer. Both researcher and checker missed this when doing a calculation check.	• Avoid copying and pasting tables from resources into MiDatabank. It is possible for the table data to change during copying; if you do, check that it has been copied correctly. Copying from the resource to Word, then to MiDatabank may help. • Always check calculations using the original resources rather than MiDatabank research. • Ensure staff are familiar with the UKMi Guidance on Documenting Enquiries on MiDatabank.
Incident 1314 occurred when the incorrect ustekinumab formulation stability data was used for a temperature excursion enquiry. The question requested advice on vials whereas the research information for pre-	• It is good practice to document the full reference for the resource used. • In the case of SmPCs, document the name of the SmPC, the manufacturer, and the last date of revision as a minimum. Then add any relevant information such as formulation and stability data in the case of temperature stability.

filled pens was used. The incorrect advice was given to amend the expiry date and not return to the fridge.	• Double check you have used the right SmPC for the right product before giving out the answer. • Where there are multiple products, consider using a spreadsheet to collect the Fridge Tool and SmPC data • Refer to https://www.sps.nhs.uk/articles/managing-temperature-excursions/
Incident 1315 noted that the caller had been supplied monographs from Natural Medicines Database. It is not clear if the caller was internal or external to the purchasing organisation.	• Think twice before forwarding monographs from resources purchased by MI services or an organisation. • Check the licensing agreement to make sure conditions of the licence have not been breached.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1311 resulted when the metabolite of fexofenadine was stated as terbinafine instead of terfenadine, for a simple breast-feeding enquiry. Four pharmacy staff were involved in the enquiry including 2 checkers. A similar incident occurred with 1318 where zopiclone was written in the answer rather than zolpidem. The enquiry related to safety in breast-feeding and involved multiple medicines.	• Take a break and re-read answers before giving them. • Consider reading the answer aloud to listen to the words written. • Try to maintain one checker for answer where possible. • Where multiple checkers are involved, ensure all know the extent of the checking needed, e.g., answer only, references, research and answer, etc. • Staff should be familiar with the UKMi Guidance on Checking Medicines Information enquiries. • For enquiries involving the safety of multiple medicines in breast-feeding, consider contacting UK Drugs in Lactation Advice Line (UKDILAS) (ukdilas.enquiries@nhs.net or 0116 258 6491) for any further advice.
Incident 1313 occurred when the final answer stated the wrong volume for a gentamicin and metronidazole compatibility question. 500ml was written in place of 100ml (where mini-bags were being used).	
Incident 1317 involved the answer stating that a medicine was a weak inhibitor of CYP3A4 rather than a moderate inhibitor. The answer involved ceftazidime and did not change because of the typo.	

Incident 1320 resulted when the answer was emailed and ended up in the user's spam folder. Further to this, the answer did not address the user's clinical scenario and questions.	• Consider replying to the original email for emailed enquiries, to ensure the correct user receives the response and it is less likely to go into their spam/junk folder. • When responding to a caller by email, request that they check their spam/junk email by the agreed deadline in the event the response is received there. • When sending emails, consider requesting a delivery receipt by checking the 'request delivery receipt' in the options section of a new email in Microsoft. • Use the 'control + M' function in MiDatabank to timestamp when the answer has been sent or given.

Publication Incidents

One publication incident was reported this quarter. A specialist user noted that the worked example was factually correct but not correct in practice. The dose conversion of two steroids would potentially result in clinically sub therapeutic effect compared to the original steroid even though the calculation was correct.

Recommendations:

- The learning included always considers the practical side of using the advice given. The information and conversion were factually correct but did not reflect what occurs in secondary care settings.
- For topics impacting on care settings not familiar to the author, a specialist from that setting should be asked to comment on content before publishing.