Incident Reporting in Medicines Information Scheme (IRMIS)

Q3: July to September 2024

Reports	
Total number of enquiry incidents since January 2005: 1088 (rolling total for 2024: **31**)	**Total number of publication incidents since April 2013: 20** (rolling total for 2024: **3**)
Enquiries	**Publications/Pro-active work**
Number for this period: 10	Number for this period: 0
Number of errors: 9	Number of errors: 0
Number of near misses: 1	Number of near misses: 0
Number related to data: 4	Number related to data: 0
Number related to advice: 6	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:

- Take care to get the right recipient when sending emails: check the correct email address is recorded on MiDatabank; consider replying to the original email for email-receipt enquiries.
- Do not put unnecessary confidential information into emails.
- Create templates for frequently-used enquiry elements instead of copying-and-pasting from previous enquiries.

Most incidents reported this quarter were errors, i.e., the incorrect answer had been given out and the incident picked up later. The potential impact on patient safety assigned by reporters ranged from negligible (4) to moderate (3). The most common cause for incidents was high workload.

The enquiry types most frequently associated with incidents were administration/dosage.

- Chart 1 shows a quarterly comparison of potential risks to the patient due to errors or near misses.
- Data relating to identified causes and enquiry types for incidents is in charts 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.

There were no publication errors reported this quarter.

Contact

Author: Iram Husain, QRMG.ukmi@nhs.net.
IRMIS database technical queries: pharmacy.support@wales.nhs.uk
You can submit IRMIS reports via NHS networked devices at https://irmis.wales.nhs.uk/Login.aspx.

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

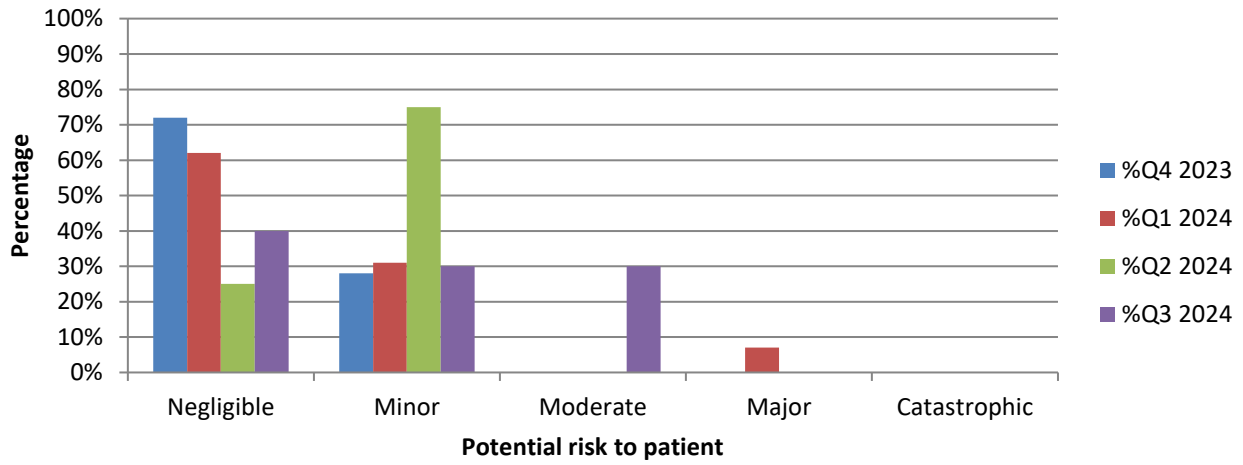

Chart 2: Percentage reported common causes of MI incidents for Q3 2024*

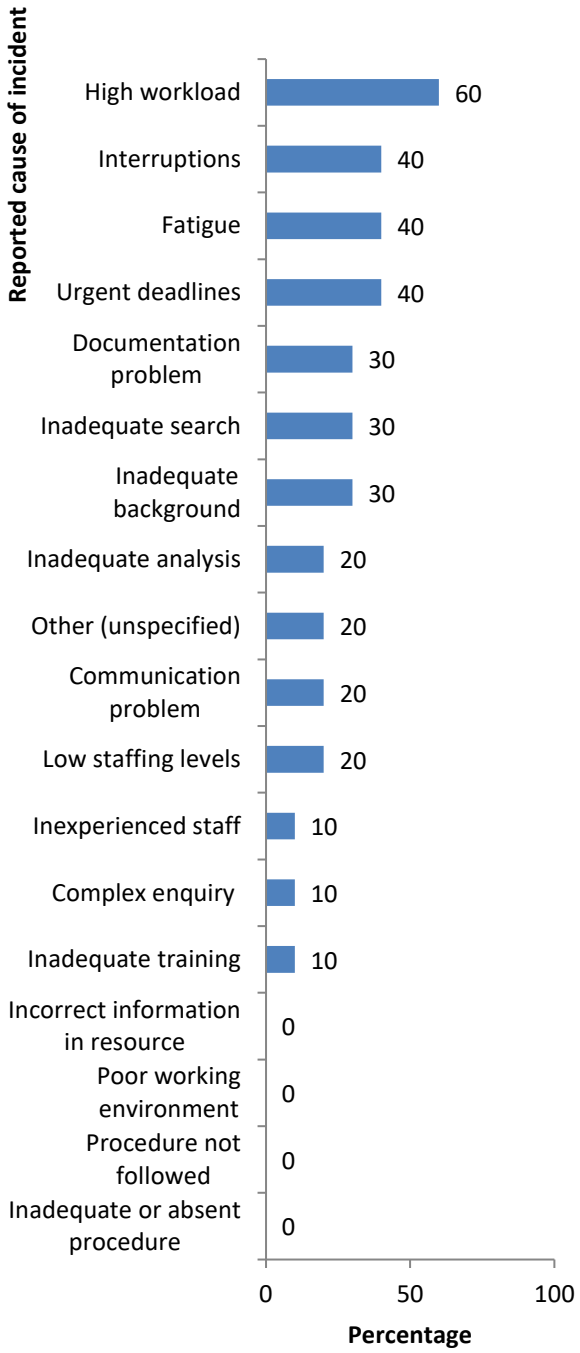

Chart 3: Percentage reported types of enquiry involved in MI incidents for Q3 2024*

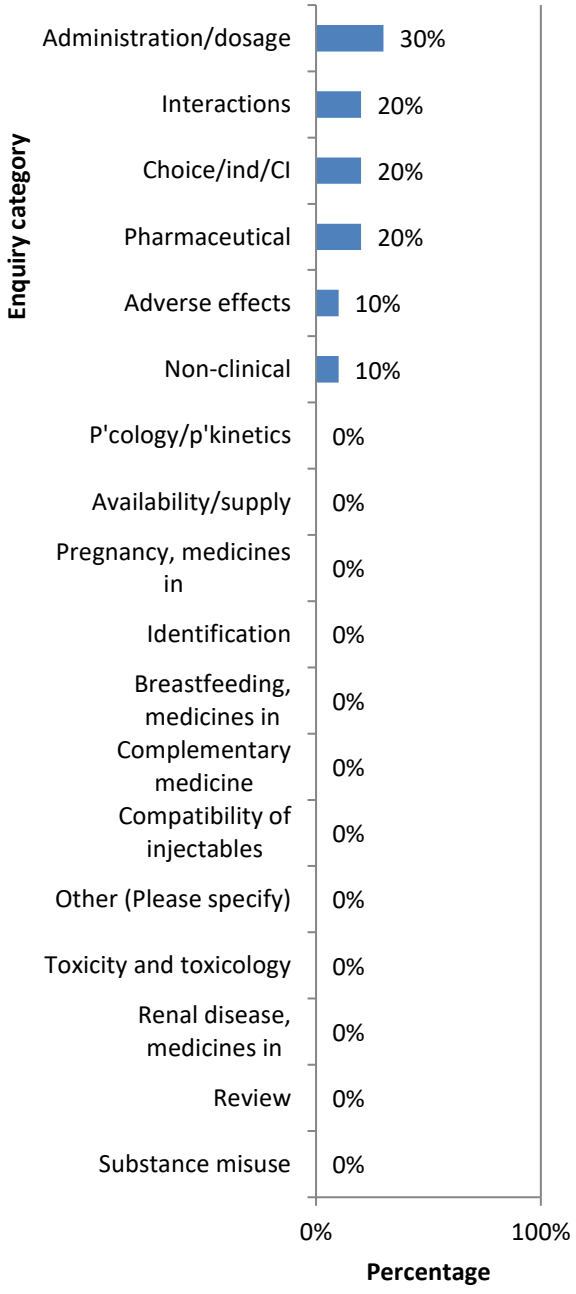

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1345 occurred when it was advised that Tresiba (long-acting insulin degludec) vials could be substituted for the cartridges. The answer was given out over the phone whilst the caller was on hold. It later transpired that Tresiba did not come in vials and the patient had been given short-acting insulin from a vial instead.	• When taking in enquiries over the phone, avoid answering immediately if possible. Take time to research and then call the enquirer back. See our IRMIS alert on instant answers.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1344 related to an interaction between oxcarbazepine and rifampicin that was not listed in Stockley's Drug Interactions. The interaction was listed in the SmPC for oxcarbazepine and in other interaction resources. The lack of information in Stockley's was escalated to the publisher. Incident 1350 occurred when the incorrect product number was transcribed when trying to identify if stores held glass or plastic ampules of lidocaine. The caller required plastic ampules following an incident but could only get hold of glass ones. Incident 1348 resulted when the research missed some essential resources that would have impacted the answer regarding converting diazepam liquid to tablets. The question was not initially clear, and attempts had been made to contact the enquirer to get clarity. This may have impacted the research done.	• For interaction enquiries, QRMG has previously recommended using 3 or 4 interaction resources when researching. Refer to the Essential Resources List for interaction resources. • Always escalate publication errors (including web pages) to the publisher. • Consider contacting the manufacturer for information relating to their product coding. • When answering questions where background information is missing, consider the need to state the limitations of your answer if missing information would have an impact. Consider whether you need to inform the enquirer that you cannot answer their question without further information from them. • The UKMi Enquiry Answering Guidelines includes a list of resources to consider based on enquiry type.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1346 contained a typographical error where the Yellow Card date range quoted in the answer stated 1197 instead of 1997. Incident 1347 also contained an error in the answer. Instead of stating potassium chloride MR tablets (Slow K), the answer stated sodium chloride MR tablets (Slow K). Incident 1349 occurred when the answer was emailed to the wrong person within the same organisation. This resulted in an enquirer receiving a delayed response. Incident 1351 also involved the wrong enquirer receiving the answer.	• Refer to the advice provided in our IRMIS Alert on reducing the risk of getting the drug name wrong. • For email enquiries, adding the MiDatabank (or equivalent) enquiry number into the subject heading and answer heading or body is good practice. • When taking in a phone enquiry that you are likely to answer by email, check that the email address you have on file is (still) correct. • Consider whether you can reply to the original email rather than starting a new email. • To reduce the risks of wrong-recipient emails, avoid putting in any patient-specific information unless it is essential.
Incident 1352 used a template answer from another enquiry, resulting in the answer being sent with the wrong drug stated, Botox instead of eliglustat.	• Consider creating blank templates for commonly asked questions, rather than using a past enquiry. • If you *have* used a past enquiry and are changing important details (e.g. drug name) run a ctrl+F search for the old details to ensure you have not left any in. • Before responding to an enquiry, take a break from it and come back to re-read your answer. Or ask a colleague to read your answer before you send it.
Incident 1353 involved a gap in the Trainee Pharmacist checking process where an enquiry answer was not fully checked before being given out. The enquiry research did not pick up on the patient having a history of brain haemorrhages in relation to the use of ibuprofen for pain. The trainee's work had been partially checked and verbally authorised. The answer had not been date stamped in MiDatabank to authorise the answer to be given.	• Have clear processes in place for trainees and follow them. Do not take shortcuts. • Make sure staff are clear on what type of checks can be done. Refer to the UKMi Guidance on checking enquiries. • Be clear in communicating with colleagues about what you have checked (or not), and what you are authorising them to do next.