Incident Reporting in Medicines Information Scheme (IRMIS)

Q4: October to December 2024

Reports	
Total number of enquiry incidents since January 2005: 1101 (rolling total for 2024: **44**)	**Total number of publication incidents since April 2013: 20** (rolling total for 2024: **3**)
Enquiries	**Publications/Pro-active work**
Number for this period: 13	Number for this period: 0
Number of errors: 10	Number of errors: 0
Number of near misses: 3	Number of near misses: 0
Number related to data: 5	Number related to data: 0
Number related to advice: 6	Number related to advice: 0
Number where description 'not known': 2	Number where description 'not known': 0

Report Summary

Top 3 recommendations from QRMG for this quarter:

- Reduce the risk of writing the wrong drug name by using TALLman lettering, repeating the question back to the telephone user, having a colleague proofread your answer and adding information such as dosage, formulation and indication.
- Obtain written manufacturers information before you give out an answer that relies on their data, such as temperature excursion data.
- Avoid researching and answering enquiries whilst the caller is on hold and prioritise work by clinical need.

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 to minor. The most common cause for incidents were communication problems.

One incident was removed by the National Reporter as it was an incorrect entry.

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

- 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.

Announcement: the IRMIS database is being retired on **31st March 2025**. Please use the MS form at https://forms.office.com/e/wPNkxCc31Y to submit errors and near misses associated with enquiries. Save it as your shortcut and amend any in house guidance.

A publication error submission form is in progress and will be launched soon.

Contact

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Enquiry incident submission: https://forms.office.com/e/wPNkxCc31Y.
Publication incident submission: MS form coming soon

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

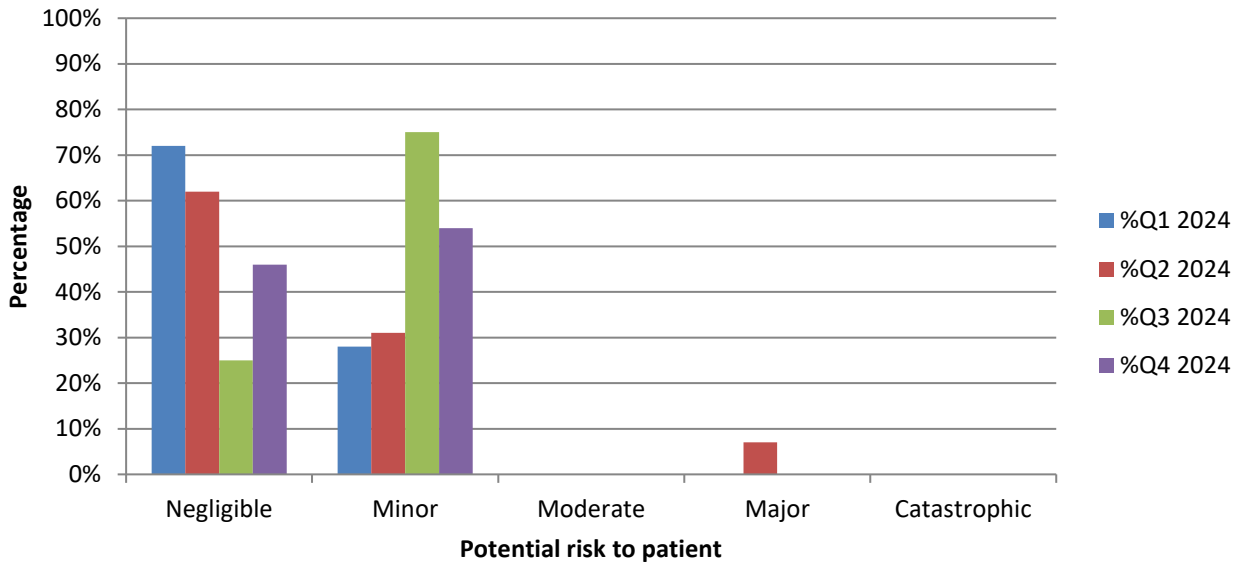

Chart 2: Percentage reported common causes of MI incidents for Q4 2024*

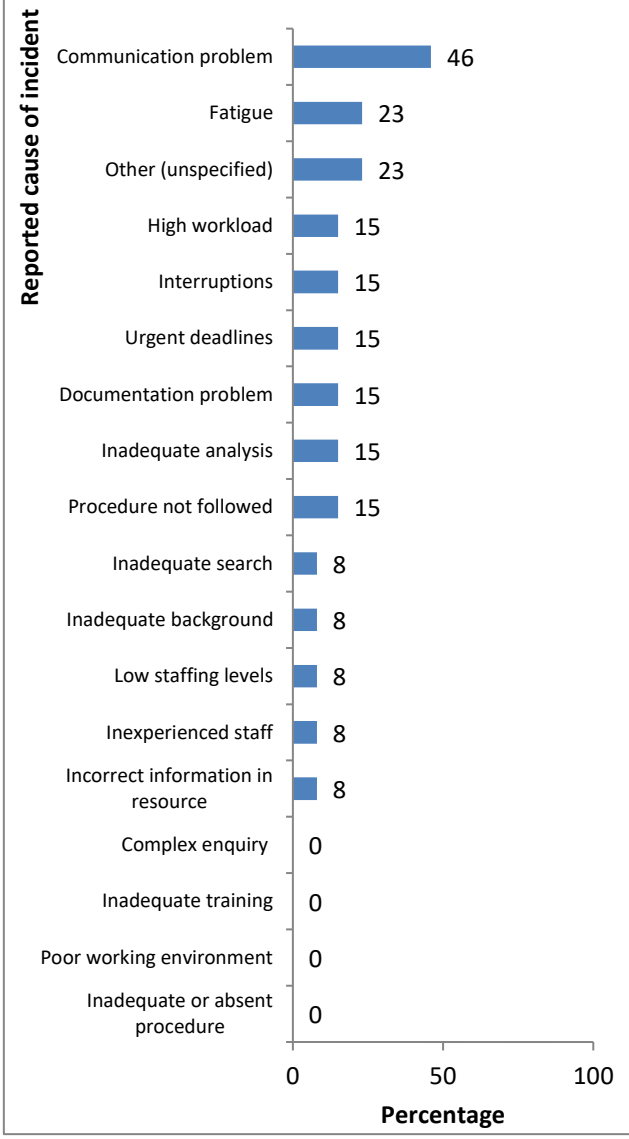

Chart 3: Percentage reported types of enquiry involved in MI incidents for Q4 2024*

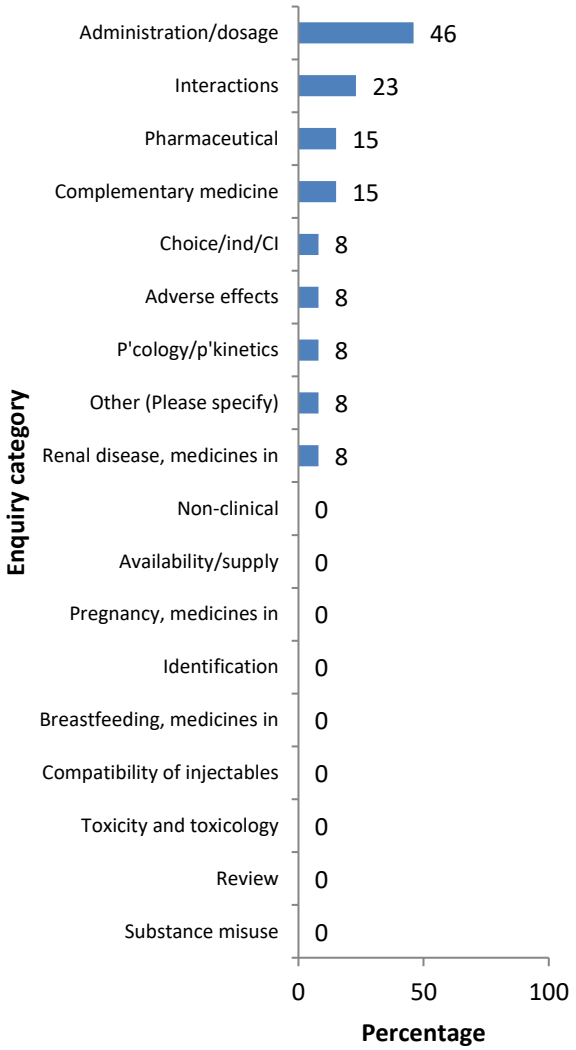

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1355 resulted from mishearing the term HYPOthyroidism as HYPERthyroidism. The enquiry related to gabapentin causing hypothyroidism as a long-term side effect, but this was documented as hyperthyroidism. The error was picked up when checking the local patient records which indicated low thyroid levels. Incident 1367 was about Oseltamivir and dosing in impaired renal function. It was taken in without contact details and researched then answered whilst the caller was on hold. The eMC and BNF were checked whilst the caller was on hold, and the Renal Drug Database consulted later which changed the answer. A lack of contact details impacted contacting the caller with the corrected answer by a few days. Incident 1361 occurred when sulfon blue dye was assumed or misheard as methylene blue dye and the question was answered over the phone without research. When doing the research after hanging up, the call recording was revisited and the mistake identified. On calling the enquirer back to correct the mistake, further information was gathered that later indicated that methylene blue was not a suitable choice for the indication. Incident 1363 was similar when the halal status of a product was advised over the phone whilst researching with the caller on hold. In this case phytomenadione was advised to be halal but the excipients were not taken into consideration at the time.	• Always confirm the contact details for a caller when you start the conversation or before you hang up. • If the caller's details are preset in MiDatabank, recheck their contact details are still correct before you hang up. • When taking in enquiries with medical terms that could be misheard, repeat the term using a different explanation such as 'you have a patient experiencing low thyroid function'. • When documenting terms that could be misread, use tall man lettering. TALLman lettering places letters within the term in uppercase letters, with the aim of highlighting the difference between two similar words. • For patient specific enquiries, use local patient record systems to clarify and confirm information that will impact the answer. • Do not research enquiries whilst the caller is on hold, especially high-risk enquiries such as pregnancy, breast feeding, paediatric, calculation, liver, and renal enquiries. • Simple questions are not always clinically urgent so they can be taken in and researched later while more urgent enquiries are answered. • Refer to the IRMIS alert on 'Instant answers increase the risk of error' at https://www.ukmi.nhs.uk/Resources?ContentID=8c0ef2f7-b950-43cb-8a25-6c1a158d3900. • Refer to the IRMIS alert on 'Managing challenging situations' at https://www.ukmi.nhs.uk/Resources?ContentID=8c0ef2f7-b950-43cb-8a25-6c1a158d3900.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1537 required manufacturers information to advise on a temperature excursion for a vaccine. The manufacturer's verbal response was that the vaccine could be used. The manufacturer called back a few days later to retract this information and advise the vaccine should not be used. The vaccine was discarded following the initial response and potential patient harm avoided.	• When taking enquiries in over the phone, repeat the question you will be researching back to the caller before hanging up. • When taking in temperature excursion question, advise the caller that you may need to contact the manufacturer which could add a few days to your response time. • When requesting manufacturer's temperature excursion data, always request and wait for a written response before advising your user. • You may find useful advice on whether fridge medicines can or can't be used after exposure to out-of-range temperatures at https://www.sps.nhs.uk/home/tools/refrigerated-medicines-stability-tool/ • Make sure your enquiry title is concise and reflective of the question being researched. • Try to allow yourself uninterrupted time to understand the information gathered from resources. • If you are a sole worker in MI, consider diverting your enquiry line to a colleague to take messages in whilst you work on a high priority enquiry or one that requires your full focus. This may help reduce interruptions and errors. Another option is to direct calls to a voicemail.
Incident 1354 related to an interaction search between what was originally edoxaban and omega 3 supplements. The enquiry was researched using another medicine the patient was taking; bisoprolol in place of edoxaban. The error was also carried into the enquiry title. Incident 1358 was similar in that an interaction between lithium, ecstasy and cannabis was researched when the question was about lithium, ecstasy and cocaine.	
Incident 1360 resulted when research was done under pressure without time to interpret. Efudix 5% cream's dental use was researched, and the safety of its excipients also reviewed. The safe amount for ingestion was interpreted incorrectly for propylene glycol. The answer stated a much lower permissible intake (25mg/kg) than that used for the pharmaceutical grade (500mg/kg). The information was lifted from the resources into the answer without time for review.	

Incident 1362 highlighted an error in calculating the zinc content for multiple zinc containing supplements. As a result, the wrong product was nearly recommended.	• Use an enquiry system such as MiDatabank to record each stage of the enquiry answering process clearly. • Formulate your answer as you progress your research. • Ask a colleague to proofread your written response – they don't have to be MI trained. • It is advisable to have all calculations, no matter how simple, checked by a second person. • Refer to the UKMi guidance on 'Checking MI enquiries' at https://www.ukmi.nhs.uk/Resources?ContentID=69688558-86cc-4062-b5fa-a12f48b02830.
Incident 1366 resulted when a patient was advised to withhold ivabradine whilst on fluconazole based on incorrect information on their PMR. The cardiologist had indicated that co-administration was contraindicated. The patient did not take either medicine and reported a high heart rate the next day. The SmPC confirmed that both medicines could be taken.	• Consider using recommended research strategies as advised in the UKMi Enquiry Answering Guidelines at https://www.ukmi.nhs.uk/Resources?ContentID=69688558-86cc-4062-b5fa-a12f48b02830. • UKMi advise that at least two resources should be used for enquiry answering. • Errors in PMR should be escalated locally and appropriate actions taken to correct them, e.g. DATIX.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1359 highlighted the risk of completing enquiries in enquiry recording systems, such as MiDatabank, before the answer is sent. In this case an email was received from a prescriber asking several questions about CBD oil. The enquiry was completed in MiDatabank before sending. When reviewing the answer before sending it was noted that an interaction had been missed. The answer was corrected but the MiDatabank entry could not be amended to reflect the actual answer sent. Incident 1364 could have been avoided by having the answer proofread before sending. The enquiry was about covert administration. Under the Adcal D3 tablet section, the term 'dispersible lansoprazole' had been copied and pasted. A similar situation with incident 1365 occurred when the written response stated information about levobupivacaine instead of bupivacaine. The rest of the email referred to the correct medicine, bupivacaine.	• MiDatabank entries should be completed once the answer has been sent since the response time includes any time spent chasing the user or dealing with email bounce backs. The time taken is the actual time taken to do the enquiry from taking in to ticking the research and answer complete box. • Use the control M feature in MiDatabank to date stamp actions taken such as when a resource is added, final answer written, and when an answer is sent. • For tips on how to use MiDatabank see https://www.ukmi.nhs.uk/Resources?ContentID=9476fb46-7503-49b6-8c0e-1791bd903a13 • Refer to the IRMIS alert on reducing the risk of getting the drug name wrong at https://www.ukmi.nhs.uk/Resources?ContentID=8c0ef2f7-b950-43cb-8a25-6c1a158d3900. • Consider recording inbound and outbound calls where the technology is available to allow you to review information taken in without pressure and to assess answers given out. Discuss what is available with your IT team. • Where possible, have a colleague proofread your written response before sending. • Refer to the UKMi guidance on checking MI enquiries at https://www.ukmi.nhs.uk/Resources?ContentID=69688558-86cc-4062-b5fa-a12f48b02830.