**Recording of Simple enquiries**

**Background**

A number of MI centres are choosing not to record some/all of what they perceive as simple enquiries on MiDatabank. The options being used are a) not to record simple enquiries at all or b) to record simple enquiries in a different way eg daybook, spreadsheet etc.

UKMi’s CGWG has considered the implications of this practice which seems to be being adopted by increasingly more centres. The UKMi Exec, at its meeting in June 2016, endorsed the recommendations of the CGWG that

* all enquiries received should be recorded contemporaneously on MiDatabank.
* UKMi enquiry answering standards should be updated to include this
* revised paper should include suggestions of how to reduce the time taken to record simple enquiries on MiDatabank.

**Documenting enquiries on MiDatabank**

**What is an enquiry?**

The UKMi CGWG has previously issued guidance on what should be documented as an enquiry (Appendix 1). This states that ‘Any request for information or advice that requires any professional judgment/ knowledge or access to recognised UKMi reference sources about medicines whether it is a general enquiry e.g. for a presentation/review or for a specific patient’. This guidance is not specific about where/how the enquiry should be documented.

**Do we have a standard that says that all enquiries should be documented on MiDatabank?**

Although this is the intention there is currently no standard that explicitly requires that all enquiries are documented. A statement to this effect will be added to the audit toolkit at the next revision.

**Why should enquiries be documented?**

There are a number of reasons:

* **Enquirer Returns**. If the enquirer forgets what you have said or loses your reply, and asks to be reminded of the answer, you have a record which means that you don’t have to do the enquiry a second time. In addition, the enquirer may come back to you with new details concerning a completed enquiry and ask you for new information.
* **Work-saving**. If you are asked a similar enquiry by someone else at a later date, looking back at an enquiry you have already done can give you a head start.
* **Complaints**. If an enquirer complains that you gave an incorrect or misleading answer, or were slow to respond, you have documentation to support how you acted. This is also important if what you did had any impact on a legal case.
* **Education**. Recording enquiries gives MI pharmacists a basis for training staff that are new to MI: completed enquiries can be used to show pharmacists and technicians ‘how to do it’ and illustrates the range of enquiries that are asked. Completed enquiries can also be used as articles in bulletins or at training events.
* **Workload Statistics**. Documenting enquiries enables MI pharmacists to provide workload statistics to support their value to the healthcare community. Some commissioners may make it a requirement of funding the service that such data are made available. Documenting workload may be even more important in the light of the recommendations of Lord Carter of Coles report and their implications for the provision of MI services.1 The RPS benchmarking metrics for acute hospitals2 highlights that patient focussed medicines information enquiries are considered a clinical activity and time taken to complete these should be included in the metric “% pharmacist time spent on clinical activities”. This is very easy to report on if all enquiries are entered in MiDatabank.
* **Specialities**. Provision of information on local custom and practice may not be recorded as it may be viewed as routine for the specific centre.
* **User Satisfaction Survey**. May become unrepresentative of overall workload as questionnaires can only be sent out for recorded enquiries.

**Why are some centres choosing not to document simple enquiries on MiDatabank?**

Anecdotally this would seem to be because they perceive that the time taken to document the enquiry on MiDatabank is disproportionate to the amount of time spent answering the enquiry.

There would also appear to be a concern that only documenting one resource eg own knowledge on MiDatabank is inappropriate and that additional resources would need to be consulted and documented if the enquiry was to be entered onto MiDatabank.

Related to the above is a view that only documenting one resource on MiDatabank eg own knowledge may be viewed unfavourably in an audit. This is not the case; as long as this approach is justifiable. It may be helpful to consider adding a standard statement that the one resource was considered appropriate at the time of answering.

There may also be a view that simple enquiries are unlikely to have a significant impact on patient care. However anecdotal evidence from published studies of the impact of MI on patient care, clinical outcomes and medicines safety3,4 found that some, apparently, simple enquiries were considered by expert panels to have a relatively high positive impact.

**What are the risks associated with simple enquiries not being documented on MiDatabank?**

The risks are mainly (but not wholly) associated with the reasons for recording enquiries given above.

* **Enquirer Returns** – applies to simple enquiries although it could be argued that the length of time taken to redo/add to the enquiry is still less than documenting it originally on MiDatabank.
* **Work-saving** – as for enquirer returns above.
* **Complaints -** this applies equally to simple enquiries as to more complex ones.
* **Education** – this applies to simple enquiries – it is arguably more important for trainees, rather than experienced MI staff, to enter all their enquiries on MiDatabank.
* **Workload Statistics** – having an accurate record of all enquiries handled is important for a number of managerial reasons.

There are additional potential risks associated with not documenting simple enquiries in MiDatabank. These include:

* **Practice extension –** it is possible that MI staff will inadvertently, or deliberately, extend the practice of not recording enquiries in MiDatabank to more complex enquiries.
* **Inappropriate classification of enquiries as simple –** this may be a particular problem for trainee or junior staff.
* **Enquiry becomes more complex during research -** it is sometimes the case that what, at the time of receipt, appears to be a simple enquiry becomes more complex when it is being researched. In this instance the enquiry would need to be entered on MiDatabank during the research stage.
* **Errors -** evidence from IRMIS reports shows that a common cause of errors is not documenting the enquiry as it’s being undertaken ie a number of incidents have come to light when the enquiry was documented in MiDatabank retrospectively. It would be reasonable to assume that similar incidents may occur when enquiries are not documented in MiDatabank at all but as they aren’t documented the incident doesn’t come to light.

**Suggestions to improve recording of all enquiries in MiDatabank**

* Use of headsets allows enquiry to be recorded straight onto MiDatabank at the time of receipt.
* If it is time-consuming to put information into correct boxes on MiDatabank when enquiry is received – put all information in question box at the outset and copy and paste it to correct position later.
* Using generic enquirer titles eg ‘Junior Doctor’. The specific enquirer’s personal and contact details are recorded in the ‘Contact for this enquiry’ box. This saves time looking for an enquirer and checking that they haven’t moved organisation. It also reduces the number of duplicate enquirers entered.
* It is usually necessary to confirm the information/answer provided in more than one resource. However on occasions when an individual, using their professional judgement believes that one resource, including ‘own knowledge’ is sufficient to provide an answer to an enquiry – it is acceptable to do so and to document as such in MiDatabank.
* Consider drafting ‘standard paragraphs’ using the ‘insert special fields’ button on the answer page on MiDatabank – to cover why brief search and/or only one resource was appropriate.
* Awareness amongst audited centres that the purpose of the enquiry assessment as part of the audit process, is to ensure that the analysis, resources used and answer given were appropriate to the enquiry asked and the situation/circumstances at the time. Standard statements/paragraphs could be used at the time to indicate this to anyone (auditor or others) looking at that enquiry at a later date.

**Implications of not recording enquiries on MiDatabank**

* MiDatabank has been adopted as the standard electronic enquiry management system by UKMi for use in MI centres in the UK.
* This decision was made because MiDatabank offered functionality that was deemed to be critical to practice in MI centres.
* Key functions/features of MiDatabank include robust audit trail, secure access (login/password), backup facilities, search facilities, SSPs, statistical analysis, security of logged patient and enquirer details, DM+D coding and a core library of resources.
* Any other system used for recording enquiries should at least have the same functionality to ensure all information governance issues are met.
* If an alternative system is used which does not meet these requirements a risk assessment will need to be undertaken locally.
* Any alternative system used will need to be regularly reviewed to ensure that it is still being used appropriately and that it continues to meet the requirements of the risk assessment.

**References**

1. Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. February 2016

2. RPS benchmarking metrics for acute hospitals March 2018

https://www.rpharms.com/resources/professional-standards/professional-standards-for-hospital-pharmacy/rps-benchmarking-metrics-for-acute-hospitals

3. Innes AJ, Bramley DM and Wills S. The impact of UK Medicines

Information services on patient care, clinical outcomes and medicines safety: an evaluation of healthcare professionals’ opinions. Eur J Hosp Pharm 2014;21:222–228.

4. Bramley D, Innes A and Dass N Impact of Medicines Helplines on patient satisfaction, patient outcomes and medicines safety for hospital patients: the development of a rating scale and an evaluation of patients’ opinions. Eur J Hosp Pharm 2018; Epub ahead of print: doi:10.1136/ejhpharm-2017-001459.

Clinical Governance Working Group  
September 2016 – updated May 2018

**Appendixes**

Appendix 1. Enquiries to document

|  |  |
| --- | --- |
| What medicines information work should be documented as an enquiry? | |
| Document as an enquiry | Do not document as an enquiry |
| **General:**   * Any request for information or advice that requires any professional judgment/ knowledge or access to recognised UKMi reference sources about medicines whether it is a general enquiry e.g. for a presentation/review or for a specific patient. | **General:**   * Services which do not require any professional judgment/ knowledge or access to UKMi reference sources about medicines:   e.g.   * Requests for drug company/rep contact details. * Enquiries referred to another source without any MI input. * Completion of questionnaires or surveys. * Enquiries about stock held in the dispensary. * Requests for verification that a drug is on the hospital formulary. * Lectures. |
| **Photocopying/Printing:**   * Requests for journal references where the complete *citation needs to be identified first.* * Copies of material from websites *where the website is not identified by its URL.* | **Photocopying/ Printing:**   * Requests for journal references *when the complete citation is given.* * Requests for copies of *enquirer-specified in-house or UKMi material.* * Copies of material from websites *where the website is identified.* |
| **Requests by a third party for research to support:**   * Preparation of formulary appraisals, clinical guidelines, bulletins, patient information leaflets etc. | Active Work:   * Consider using project management functions in MiDatabank. * Preparation of work initiated by MI itself. e.g. formulary appraisals, clinical guidelines, bulletins, patient information leaflets. * UKMi work e.g. MI training material, policies, consultations, new products, working parties. |
| **N.B.** Centres should keep a separate record of active work, UKMi work, lectures and requests for copies of copyright material. | |



Appendix2. Enquiry level guidance

## Guidance notes for ranking enquiries

Notes:

* Level is independent of the *time taken* to complete the enquiry.
* Level is independent of the *method* used to communicate the answer.
* There is a degree of subjectivity when assessing levels; no system can completely remove this.
* The way an enquiry is received may partly determine its level. The questioning skills of experienced MI staff may turn an apparently straightforward level 1 enquiry into a level 2 or 3 once the full clinical implications have been teased out.
* Examples are for guidance only; some categories of enquiry may sometimes fit better into another. E.g. enquiries about drugs in pregnancy and lactation (listed as levels 2 and 3) may sometimes fit into level 1 if the drug concerned is widely used in pregnancy and its safety is well known.

|  |  |  |
| --- | --- | --- |
| Level description | Guidance notes | Examples |
| Level 1 | | |
| Simple enquiries or data | * Requests for information which any pharmacist or accredited pharmacy technician would be expected to deal with using readily available sources. * Enquiries answered solely using sources such as local formulary/guidelines, paediatric formularies, or electronic databases such as Drugdex. * Information from such sources passed on to the enquirer without further evaluation or interpretation. | * Requests for standard dosing information and/or administration instructions for licensed, or commonly accepted unlicensed indications. * Basic information about well-documented adverse effects. * Identification of foreign drugs. * Tablet identification using TICTAC where further advice not required. * ‘Librarian services’ such as finding a particular reference on Medline for which some details are known. * Requests to contact the pharmaceutical industry for basic information about the availability, or excipient content. |
| Level 2 | | |
| Complex enquiries – multiple sources | * Enquiries that require the use of more specialist resources and/or the interrogation of multiple sources. * Enquiries where application of medicines information skills and knowledge is needed, but sources provide a reasonably clear answer or course of action to offer the enquirer. | * Dosing information for unlicensed indications. * Intravenous drug compatibilities not found in standard sources e.g. admixtures or Y-site compatibilities. * Dosing adjustments for commonly-used drugs in organ failure. * Information about previous case reports of an adverse drug reaction. * Safety of drugs in pregnancy/lactation where published reviews give clear advice (but see below). |
| Level 3 | | |
| Complex enquiries – professional judgement | * Enquiries where the answer relies on the knowledge, experience and skill of the MI practitioner. * Core concepts of therapeutics, risk management and literature evaluation are applied. * Complex enquiries that cover situations where individual patients have unusual co-morbidities or drug combinations. | * Identifying the most likely causative agent of an adverse drug reaction and advising how to manage the patient. * Offering advice on an appropriate therapeutic regimen when standard options have failed and there is no literature consensus. * Evaluating the safest and most effective treatment where there are multiple contra-indications or cautions. * Calculating drug doses using the first principles of pharmacokinetics or therapeutic drug monitoring. * Assessing the appropriateness of new/ experimental treatments for a patient by appraising published clinical data. * Advising on the safest injectable medicines to mix when mixing is unavoidable but there is no directly relevant published compatibility data. |