Incident Reporting in Medicines Information Scheme (IRMIS)

Q2: April to June 2022

Reports	
Total number enquiry incidents since January 2005: 1013 (rolling total for 2022: **18**)	**Total number publications incidents since April 2013: 15**
Enquiries	**Publications/Pro-active work**
Number for this period: 5	Number for this period: 0
Number of errors: 5	Number of errors: 0
Number of near misses: 0	Number of near misses: 0
Number related to data: 0	Number related to data: 0
Number related to advice: 5	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:

- All pharmacy staff should refer to the Enquiry Answering Guidelines when receiving, researching, and answering questions relating to medicines.
- When copying and pasting information into MiDatabank, re-read the information to ensure it is correct.
- Try to allocate uninterrupted time to carefully read written responses.

All 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 inadequate research, high workload, and inexperienced staff. There was a broad range of enquiry types associated with the incidents. 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.

Help us improve

The QRMG are keen to get your views on the IRMIS report. Please email us at QRMG.ukmi@nhs.net.

Contact

Author: Iram Husain, QRMG.ukmi@nhs.net
IRMIS database technical queries: pharmacy.support@wales.nhs.uk

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

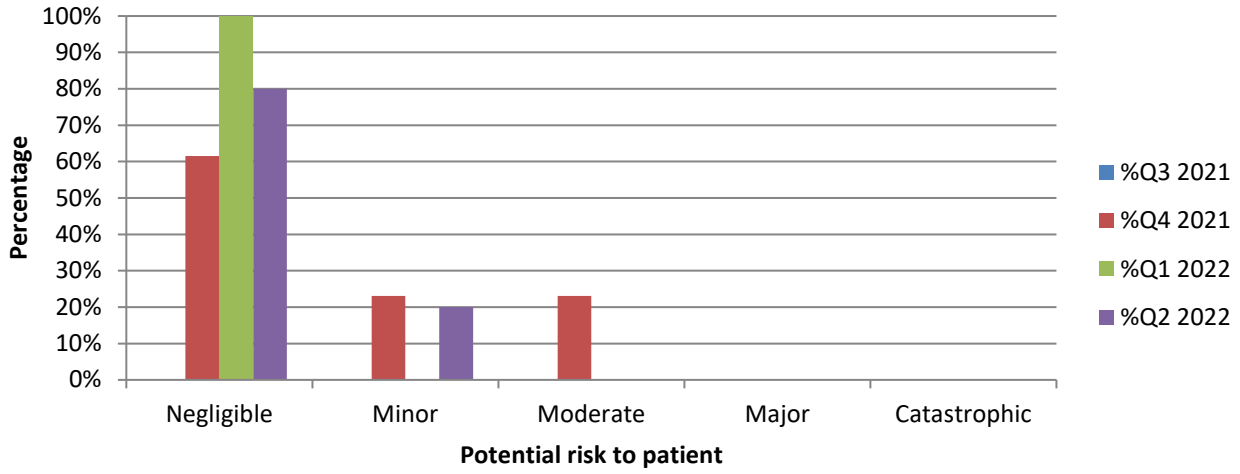
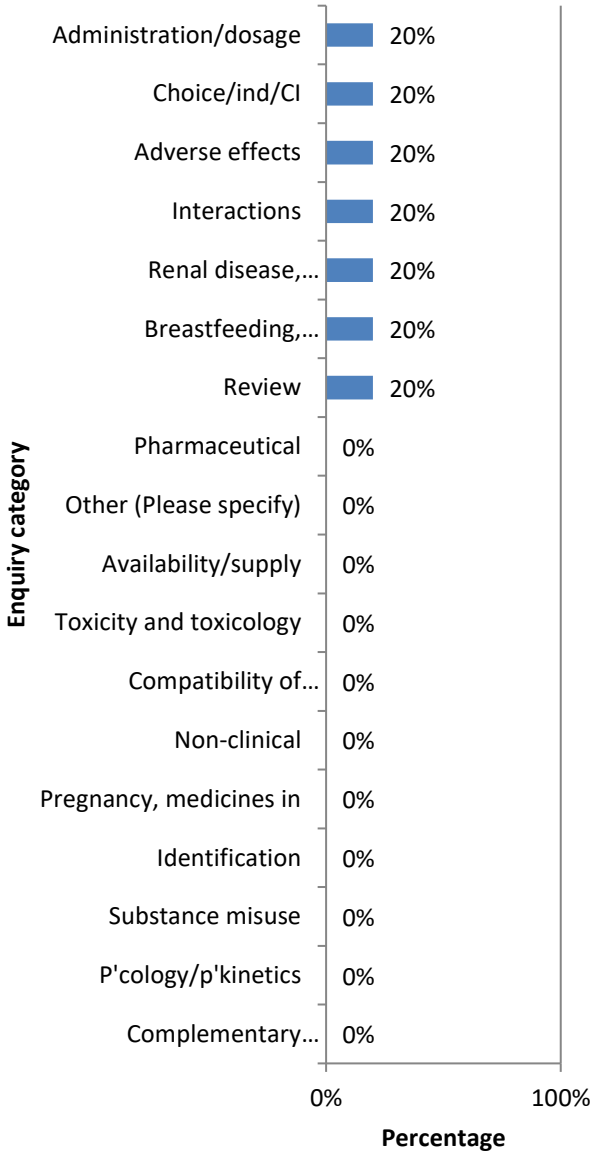


Chart 2: Percentage reported common causes of MI incidents for Q2 2022*

Chart 3: Percentage reported types of enquiry involved in MI incidents for Q2 2022*



*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1256 related to understanding the terminology used to describe an adverse drug reaction. By focusing on the terminology used by the caller, the full spectrum of similar adverse effects was not researched.	• Refer to the Enquiry Answering Guidelines when taking questions involving adverse drug reactions. • In particular, consult the MedDRA database for ADR terminology. • Consider differential diagnosis and synonyms for reactions described.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1252 occurred when information was copied and pasted from an SPC. The process removed subheadings which later impacted on interpreting the data in MiDatabank. A statement was listed under the wrong subheading.	• Always read information at source initially, so such errors may be picked up on transfer • Always re-read any information copied and pasted into MiDatabank from a resource, especially if formatting is removed.
Incident 1255 resulted when the local e-prescribing system for an inpatient was not reviewed in full. Confirmation of an IV dilution and infusion rate were requested but the response did not note the rate information already provided on the local system. The note reflected the patient's renal function.	• Read all resources thoroughly to avoid missing important information. • Know the structure of the resources that you use, so that you look in the correct places/sections for information. • Refer to the Enquiry Answering Guidelines and the SPS website when processing dosing questions relating to renal patients.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1253 occurred when the answer was accidentally changed prior to sending such that the word 'not' was omitted. This impacted on the final advice on action to take. The answer was checked prior to sending but had changed from drafted version to email version. Entry 1254 was a similar incident where the answer field incorrectly stated the age of an infant in months rather than weeks. The input screen stated the correct age.	• Try to allocate uninterrupted time to carefully read written responses. • Where there are multiple drafted versions in MiDatabank, consider using a different resource entry for each so that they are not all on the same entry. • Use a Word document for each draft and attach them in MiDatabank indicating the version in the file name. This will allow clear track changes and comments. • Ensure the answer field only contains the final answer to give and no other versions. • Cross check the response in the answer field with the email sent • Summarise the question in the question field so that it is easy to see what questions need a response. • Restate the question as the first paragraph of the written response. • Even if the answer is to be given verbally, it may be worth copying the question into the answer section.

Publication Incidents

QRMG Recommendations:

There were no publication errors reported this quarter.