Incident Reporting in Medicines Information Scheme (IRMIS)

Q3: July to September 2022

Reports	
Total number enquiry incidents since January 2005: 1019 (rolling total for 2022: **24**)	**Total number publications incidents since April 2013: 16**
Enquiries	**Publications/Pro-active work**
Number for this period: 6	Number for this period: 1
Number of errors: 5	Number of errors: 1
Number of near misses: 1	Number of near misses: 0
Number related to data: 0	Number related to data: 1
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:

- Have a phonetic alphabetic and list of lookalike/soundalike available to staff.
- Avoid responding to high risk and clinically urgent questions under pressure. It is good practice to take the question details, end the call and then research the information to provide advice. No matter how simple the question seems.
- Once a response is written, take a break and return to the response to re-read it and cross-check its contents against the questions asked. Repeat or summarise the question before providing the answer. Where available, ask a colleague to read the question and answer before sending.

All incidents reported this quarter were classified as error, i.e., the answer had been given out and the incident picked up later. Incident 1261 was reported as a near miss but has been classed as an error since the incorrect answer left MI. The most common causes were interruptions and high workload, followed by urgent deadlines. The top enquiry type associated with the incidents were drug 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 error was reported this quarter.

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.

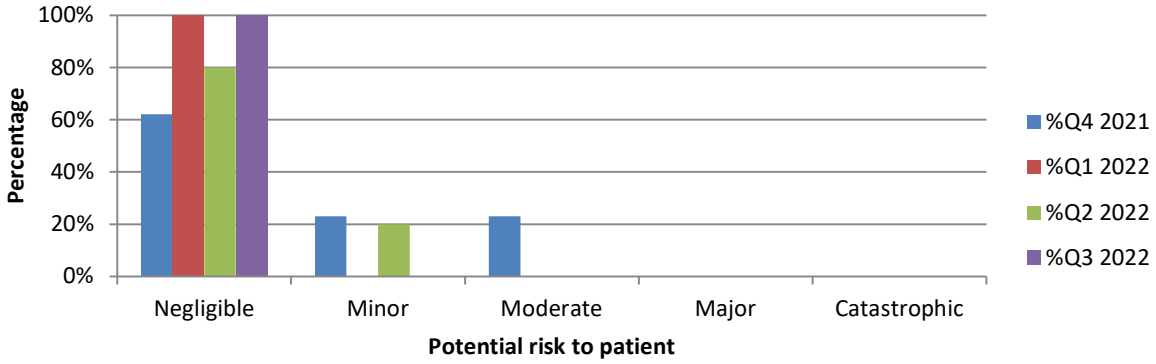


Chart 2: Percentage reported common causes of MI incidents for Q3 2022*

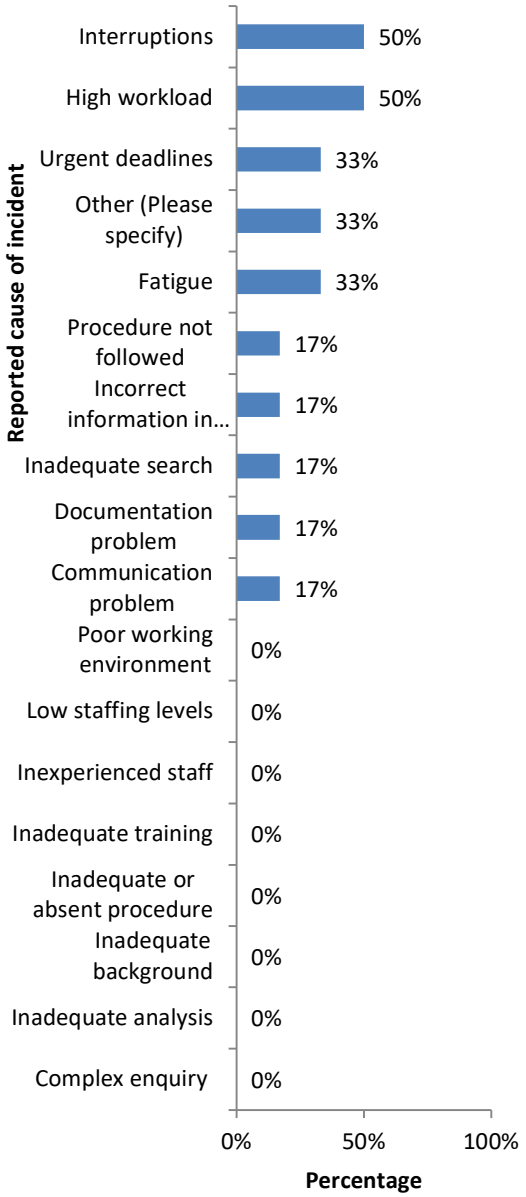
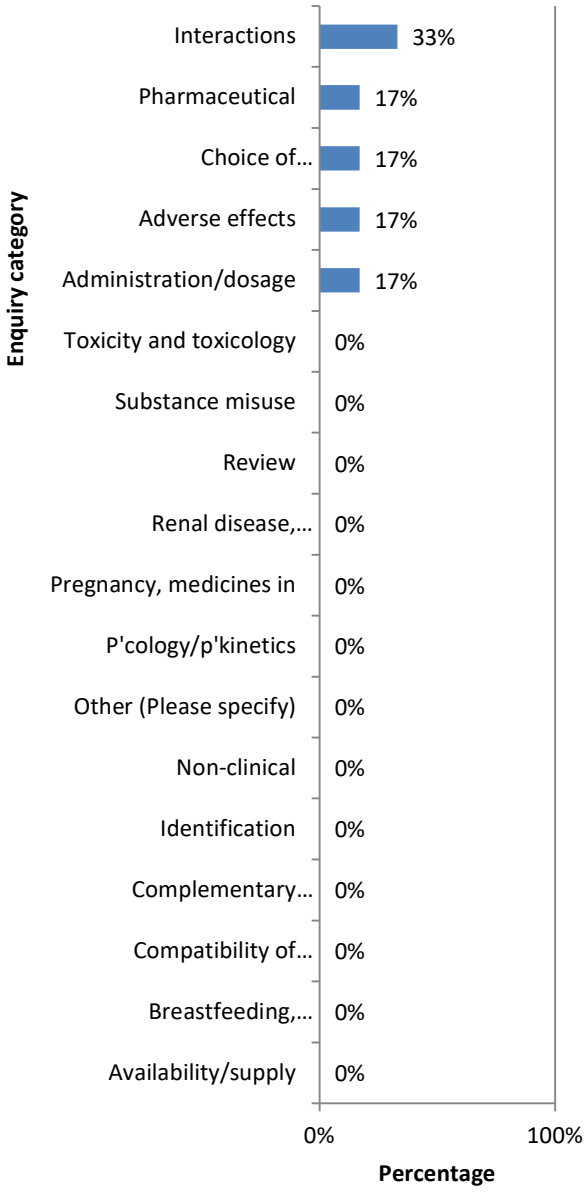


Chart 3: Percentage reported types of enquiry involved in MI incidents for Q3 2022*



*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1257 related to mishearing the type of feeding tube (NG in place of NJ) which resulted in additional information being added to the answer. This was also highlighted by incident 1262 where a verbal response included zolpidem and zopiclone when it should have been about zopiclone.	• Have a phonetic alphabet available to staff taking and giving out verbal MI answers to assist in distinguishing commonly misheard letters. A printable version can be found at https://www.cntw.nhs.uk/content/uploads/2012/10/SM-PGN-09-App2-Phonetic-Alphabet-Iss-2-Sep-17.pdf. • Be aware of the MHRA advice regarding sound-alike drugs at https://www.gov.uk/drug-safety-update/drug-name-confusion-reminder-to-be-vigilant-for-potential-errors. • Have a list of look-alike and sound-alike drug names such as https://www.ismp.org/recommendations/confused-drug-names-list (registration required to access free resource). • Repeat or summarise the question back to the enquirer before giving the answer (for both verbal and written responses). • Staff should understand the topic of the question and complete additional training (e.g., Medicines Learning Portal) or seek advice if they are unsure.
Incident 1260 resulted when the wrong SPC was consulted for an IV injection. Information on the brand being used had not been obtained. This led to the wrong information regarding stability once reconstituted being relayed. It is not clear if the SPC was consulted whilst the caller was on hold. Use of the wrong SPC did not appear to affect interpretation of the information for the scenario in question.	• Pharmaceutical stability of IV products is usually manufacturer specific. It is good practice to obtain the manufacturer and batch number/expiry date prior to researching. • Avoid responding to high risk and clinically urgent questions under pressure. It is good practice to take the question details,

	end the call and then research the information to provide advice. • Ensure staff are familiar with how to use common resources and understand their limitations. See Tips, hints and limitations for use of common MI resources on FutureNHS UK MI Network workspace.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1259 resulted in incorrect information being transferred into the final answer from a past enquiry used during research. Allergy information for the patient in the past enquiry was accidentally added to the current answer.	• Avoid copying and pasting unnecessary information from resources into the research. Try to keep the research information relevant to the questions being asked. • Useful training tools for developing an answer include: HEE Answering Questions on Medicines – MI skills and CPPE Answering Medicines-Related Questions in Practice.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
The written answer in incident 1258 had the incorrect drug name in the information provided. It appears the correct drugs were researched but an error made in the write up and the answer may not have been re-read. Incident 1259 also involved incorrect information being added to a written response. In this case, information from a past enquiry regarding advice for another patient was copied into the answer sent. A similar situation occurred in incident 1261 where two similar questions were being handed simultaneously and the information from the 1st case was included in the second response.	• Clinically urgent questions will not often require an immediate written response. Once a response is written, take a break and return to the response to re-read it and cross-check its contents against the questions asked. Repeat or summarise the question before providing the answer. Where available, ask a colleague to read the question and answer before sending.

Publication Incidents

One publication error was reported this quarter. It involved writing the wrong drug name (agalsidase alfa) in place of idursulfase. The final document was checked by an experienced checker prior to publication. The information was published in November 2020 and the error was detected by a user in August 2022. The information has since been removed and will be reviewed in the next publication. The likelihood of a recurrence is considered common. The checker should also be familiar with the topic of the publication to reduce risk.

Recommendations:

The team involved in the publication production have been reminded to take care when reading the drug names, including a final glance by staff uploading the information.