Incident Reporting in Medicines Information Scheme (IRMIS)

Q4: October to December 2022

Reports	
Total number enquiry incidents since January 2005: 1024 (rolling total for 2022: **29**)	**Total number publications incidents since April 2013: 16**
Enquiries	**Publications/Pro-active work**
Number for this period: 5	Number for this period: 0
Number of errors: 4	Number of errors: 0
Number of near misses: 1	Number of near misses: 0
Number related to data: 2	Number related to data: 0
Number related to advice: 3	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:

- Make staff aware of medicines that sound alike
- Restate the questions being asked at the start of the answer
- 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. Where available, ask a colleague to read the question and answer before sending.

Most 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 communication problems, high workload, and documentation problems. The top enquiry type associated with the incidents were administration and dosage, and choice/indication/contraindication of medicine. 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

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.

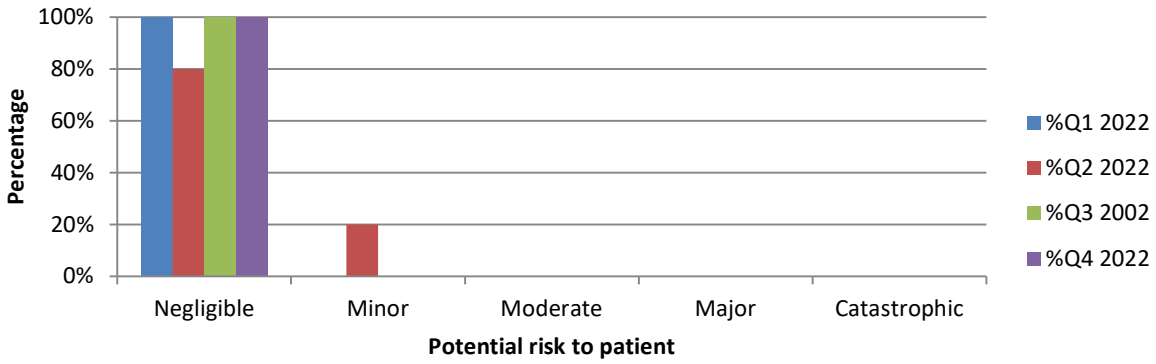


Chart 2: Percentage reported common causes of MI incidents for Q4 2022*

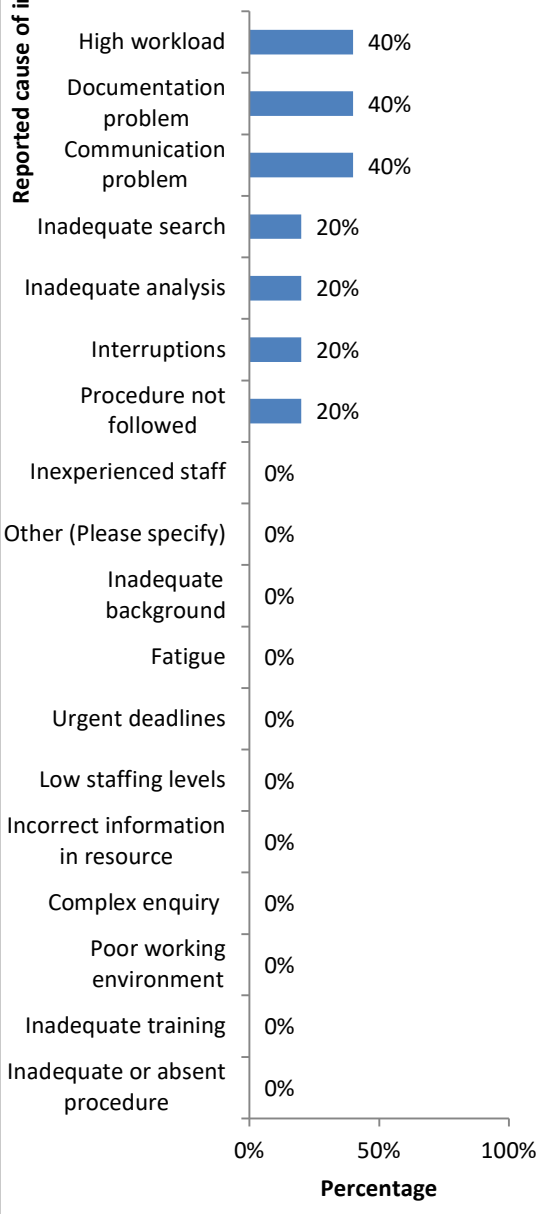
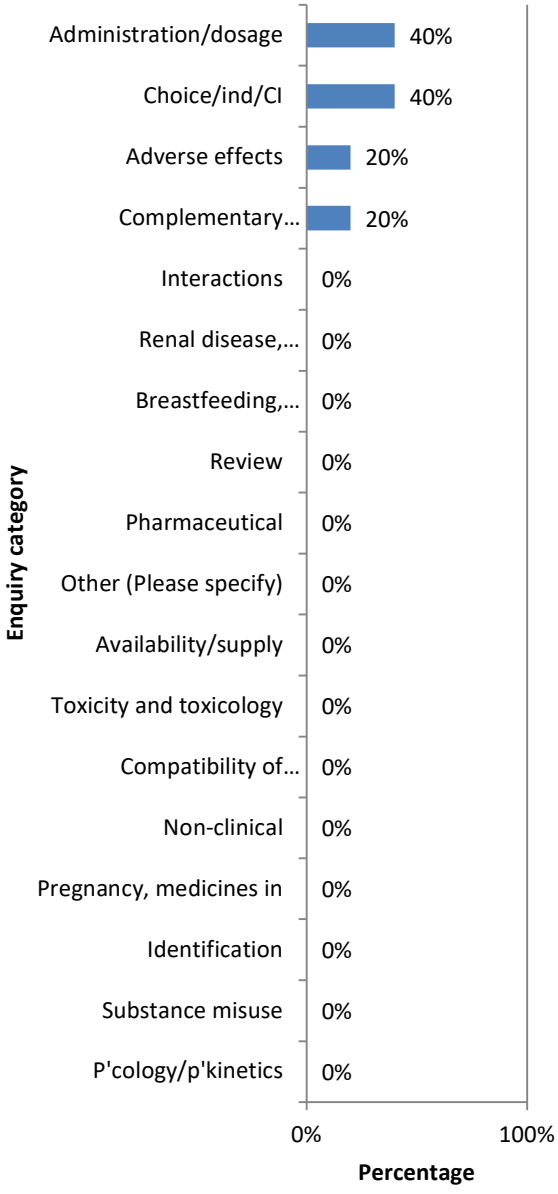


Chart 3: Percentage reported types of enquiry involved in MI incidents for Q4 2022*



*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1265 related to similar sounding drugs: alendronic acid and ibandronic acid. The MI staff repeated the question before ending the call and assumed the question related to alendronic acid whereas it referred to ibandronic acid.	• 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).
Incident 1267 occurred due to a lack of knowledge about glaucoma which resulted in a contraindication to isosorbide mononitrate being incorrectly advised.	• Staff should understand the topic of the question and complete additional training or seek advice if they are unsure.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1263 involved similar sounding drugs: escitalopram and esomeprazole. In this case the drugs were document correctly but during the research, escitalopram was used instead of esomeprazole. The answer then referred to the wrong drug.	• 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). • Restate the question at the top of each resource page in MiDatabank to ensure the correct drugs are researched. • Restate the question asked before providing the answer.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1264 occurred when the answer stated the correct drug (losartan) in the first line but then went on to refer to loratadine throughout. The MI staff sending the written response re-read the answer and spotted the error before sending.	• 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.
Incident 1266 was reported when the written answer referred to an attachment which was not sent with the email. The MiDatabank answer was being sent on behalf of a colleague.	• Always re-read emails before clicking the send button even if you have not been involved in the enquiry. • Have a subheading for attachments in the answer to highlight them. • Use the MiDatabank special fields to indicate the enquiry answer includes an attachment.

Publication Incidents

Recommendations:

There were no publication errors reported this quarter.