UKMi
UK Medicines Information

CONFIDENTIAL

Quality and Risk Management Working Group (QRMG)
Incident Reporting in Medicines Information Scheme (IRMIS) Report

Q2: April – June 2020

Reports	
Total number enquiry incidents since January 2005: 922	**Total number publications incidents since April 2013: 12**
Enquiries	**Publications/Pro-active work**
Number for this period: 11	Number for this period:
Number of errors: 6	Number of errors: 0
Number of near misses: 5	Number of near misses: 0
Number related to data: 4	Number related to data: 0
Number related to advice: 5	Number related to advice: 0
Number not known: 2	Number not known : 0

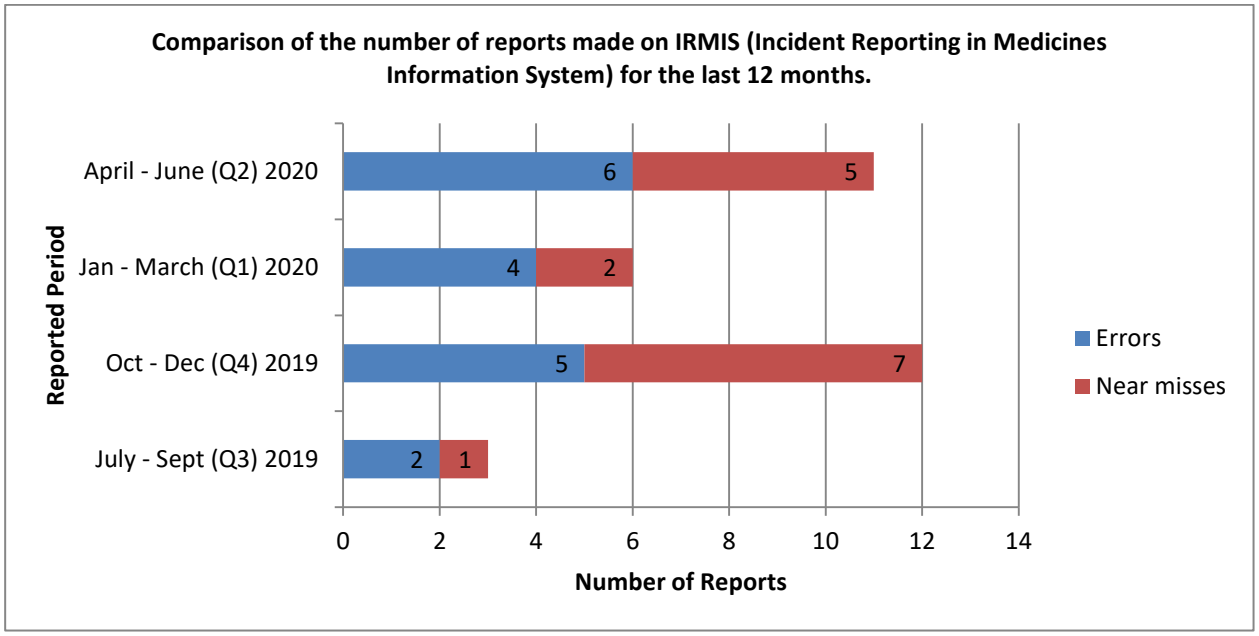
Most common causes	Incident numbers	Proportion (%) **
Other (please specify)	1136 1137 1139 1141 1142 1143 1144	67
Incorrect information in resource	1135 1137 1142 1145	36
Documentation problem	1136 1137 1143	27
Inexperienced staff	1140 1145	18
Procedure not followed	1140 1141	18
Communication problem	1140	9
Fatigue	1144	9
Inadequate analysis	1135	9
Inadequate background	1139	9
Inadequate or absent procedure	1142	9
Inadequate search	1144	9
Interruptions	1138	9
Urgent deadlines	1143	9

Enquiry categories	Incident numbers	Proportion (%) **
Administration and dosage	1137 1143 1144	27
Availability and supply	1135 1142	18
Other (Please specify)	1138 1140	18
Adverse effects	1137	9
Compatibility of injectables	1141	9
Identification	1139	9
Interactions	1136	9
Pharmaceutical	1145	9

**Reflects multiple causes/enquiry categories per incident

Quarterly comparison of IRMIS statistics over the last 12 months:

In March 2020, a pandemic was declared across the country resulting in lockdown from the 23rd March 2020. Staff providing a local MI service may have been deployed to other areas of their Trust during March to support the NHS response to the pandemic. As a result, it is likely that the MI services had a reduced capacity to handle enquiries or produce publications.



Main points to consider/highlight:

- Where MI services have enquiry documentation databases, data should be entered directly into them and not transcribed from paper to avoid transcription errors. In cases where the enquiry documentation database is delaying enquiry recording/answering then escalate the associated risks locally.
- It is good practice to repeat medication lists to ensure the correct information is taken from the caller. Misheard drug names continue to be a source of error.
- All MI services should have an up-to-date business continuity plan in place and MI staff should be made aware of it during their MI induction.
- All pharmacy staff should be trained to use the MI resources available to them and this training refreshed regularly. The UKMi Audit Standards and Toolkit provides some targets for training in MI.
- Pharmacy staff should be encouraged to register with medicines awareness services and portals.
- UKMi will add a drug shortages section to the Enquiry Answering Guidelines.
- MI services sharing enquiries via MiSharer should evaluate all shared enquiries to ensure they meet the standards required for enquiry answering.
- Personal Identifiable Data (PID) should only be recorded if it is needed for the purpose of answering the enquiry and it should not be shared in the process of external enquiry peer review.
- Try not to research and answer questions relating to medicines whilst the caller is on hold. Be aware of the risk of incomplete research and potential errors due to time pressures.
- Always get a colleague (not necessarily MI based) to double check calculations relating to medicines before giving the answer out. If no-one is available then take a break and re-do the calculation yourself as a second check.

Many MI services are currently involved in remote working where there may be an additional risk of enquiry or publication errors/near misses. Readers are encouraged to report the impact of remote working on enquiry answering and publication writing through IRMIS.

Enquiry answering process – receiving the question

Incident 1136 resulted from a transcription error between hand written notes and MiDatabank. This highlights the need to ensure data is inputted directly into MiDatabank. In this particular instance, MiDatabank was

processing at a slow speed and so hand written notes were taken initially. In these situations consider using a Word document (or similar) to take notes to copy into MiDatabank later.
Incident 1137 highlighted an error that had been carried through the patient care process and ultimately detected by MI. The patient's paperwork all stated that they were using Botox when in actual fact they had been supplied Dysport by Pharmacy. On investigation by MI the error lay in the documentation of Botox.

QRMG (Quality and Risk Management Group) Recommendations:

- Repeat medication lists back to the caller for accuracy.
- Ensure the service has a business continuity plan in place in the event of MiDatabank loss, etc. and that all MI staff are aware of it. The UKMi risk management policy should be completed annually as a minimum.
- Working with enquiry information across more than one media introduces risk. Ensure all data is transcribed into a secure database and that original notes are disposed of as per local information governance (IG) processes. Do not start researching the enquiry until all information has been transcribed into the enquiry recording database and re-checked for transcription accuracy.
- Be aware of the Brands your Trust keeps for drugs where the Brand name may be used like a generic name, e.g. Botox or Dysport.
- Make sure that a **clear** question (and associated issues to address) is stated in the question field. Always check the answer against the question(s) asked before responding.
- Errors that originate from outside MI but are detected by MI should be escalated beyond pharmacy through local governance routes.

Enquiry answering process – researching

Incident 1135 resulted when a text search of the Drug Tariff contents did not provide all related results. There are currently no 'how to use' guides for the online Drug Tariff specifically aimed at MI staff.
Incident 1139 related to a lack of awareness of NHS publications. Incorrect advice was given regarding the switching of insulins. A more experienced member of MI staff detected the error based on their own knowledge. Had the Specialist Pharmacy Services (SPS) website been search alongside first line resources, the relevant insulin memo would have been found. All Pharmacy staff should be encouraged to register with the site to obtain full access to useful medicines related material and be referred to the 'how to search for information on medicines' document. Staff should also ensure they keep up-to-date with medicines related news through portals such as the NICE Medicines Awareness Service (daily news compiled by a regional MI service).
Incident 1142 highlighted a lack of awareness regarding suitable resources to answer questions about drug shortages. UKMi currently does not provide guidance on how to handle these questions and so a local crib sheet was created to aid MI staff following this incident.
Incident 1143 resulted from a common issue reported in previous IRMIS reports where text copied from an electronic resource did not copy across into MIDatabank correctly when pasted. In this case, dosing frequency information was lost. MiDatabank users are also reminded that copying and pasting data tables is inadvisable due to loss of formatting and potential risk of data loss.
Incident 1145 was reported following the use of an enquiry viewed on MiSharer. The shared enquiry contained a calculation error. In these circumstances, the MI services detecting the error should contact the MI service sharing the enquiry to inform them of the concern so that they may unshare the enquiry immediately, investigate and complete an IRMIS report if necessary. MI services sharing enquiries on MiSharer are reminded to screen all enquiries for accuracy and appropriateness before sharing (see UKMi MiDatabank® enquiry sharing—identification of suitable enquiries SOP).

QRMG Recommendations:

- Pharmacy staff should know how to effectively use the resources available to them.
- All staff should register to access material held on the SPS website and this resource should be used alongside first line MI resources.
- All staff should register to access current medicines related news such as the NICE Medicines Awareness Service.
- Given the increase in questions about drug shortages, MI staff should follow a consistent process when receiving, researching and answering these enquiries. UKMi will be adding drug shortages to the Enquiry Answering Guidelines.
- Avoid copying and pasting large amounts of research text into MiDatabank. Always re-read the copied and pasted information. Ideally, review the resource information and document the pertinent points to improve the ease of answer formulation and reduce the risk of data loss. When copying and pasting information from an electronic resource, paste into Notepad (removes formatting) or Word and then into MiDatabank.

- Services uploading enquiries to MiSharer must screen all shared enquiries for accuracy and appropriateness before sharing.

Enquiry answering process – giving the answer

Incident 1138 and 1140 involved IG errors. Incident 1138 occurred when an answer was accidently sent to the wrong enquirer due to work pressures and a common mix up between the two enquirer names. PID was not present in the answer. Incident 1140 occurred when enquiries containing PID were sent to another NHS organisation for peer review. The incident was appropriately escalated to the local Trust IG team.
Incident 1141 and 1144 related to the common practice of researching and providing an answer to an enquiry whilst the caller is kept on hold. This practice adds unnecessary pressure and risk to the MI service and the caller. One incident involved a calculation error resulting in the advice that two drugs were not compatible at a Y-site and the other resulted in confusing dose calculation advice for a paediatric patient. Urgent enquiries should not be answered in this manner. The caller should be informed that MI staff will work on their enquiry straight away and that they will be contacted with an answer in the agreed timeframe.

QRMG Recommendations:

- Only include PID in enquiry documentation when essential and, in these cases, ensure that PID is only held in a secure place such as the patient tab in MiDatabank. See UKMi Data Protection and GDPR: Top Tips for MI Centres.
- PID and enquirer data must be removed from enquiries before they are peer reviewed by external MI services.
- Ensure all staff in MI have completed their IG training and know what to do in the event of an IG breach.
- Always cross check the contact details of the enquirer with those being used for the answer. This requires MI staff to ensure the enquirers contact details are accurate when the question is taken.
- Do not add unnecessary risk from time pressures and incomplete research by researching and answering questions whilst the caller is on hold. This risk can be managed by calling the enquirer back with the answer.
- Always get a second check, not necessarily from MI staff, for medicines related calculations. If no-one is available then take a break and re-do the calculation yourself as a second check.

Publication Incidents

There were no publication incidents reported this quarter.

If you require further information regarding IRMIS or the reports, please contact QRMG.ukmi@nhs.net.

Summary of reported incident data

Table 1 and 2 below provide data taken from individual reports of specific incidents and so may reflect local situations. Please note that where text is presented in *italics*, this text has been amended by the IRMIS monitor so as to minimise the likelihood of identifying the reporting centre and individual patients. The information in this report is intended solely for the purposes of raising awareness and training and must never be used as a source of information or advice for specific enquiries.