Incident Reporting in Medicines Information Scheme (IRMIS)

Q1: January – March 2021

Reports	
Total number enquiry incidents since January 2005: 963 (rolling total for 2021: **6**	**Total number publications incidents since April 2013: 14**
Enquiries	**Publications/Pro-active work**
Number for this period: 6	Number for this period: 1
Number of errors: 4	Number of errors: 1
Number of near misses: 2	Number of near misses: 0
Number related to data: 2	Number related to data: 1
Number related to advice: 3	Number related to advice: 0
Number where description 'not known': 1	Number where description 'not known': 0

Report Summary

The main theme from enquiry related errors this quarter were reported as pharmaceutical, administration/dosage and choice of therapy / indication / contraindication enquiries. No incident resulted in patient harm. The most common causes of an incident were reported to be high workload and inadequate analysis. Incident 1185 is missing from the report since it was a test entry. Incident 1189, 1190 and 1191 were considered outside the remit of the IRMIS report and removed (related to local IT issues which had been reported to the IT providers in the first instance).

There was one incident relating to publications this quarter which occurred due the incorrect patient helpline number being advertised on an external website. Click here for QRMG recommendations regarding this incident.

Chart 1 shows a quarterly comparison of potential risk to the patient due to an error or near miss in MI.

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 complete a short survey at https://www.smartsurvey.co.uk/s/D6A8P3/. Alternatively, 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.

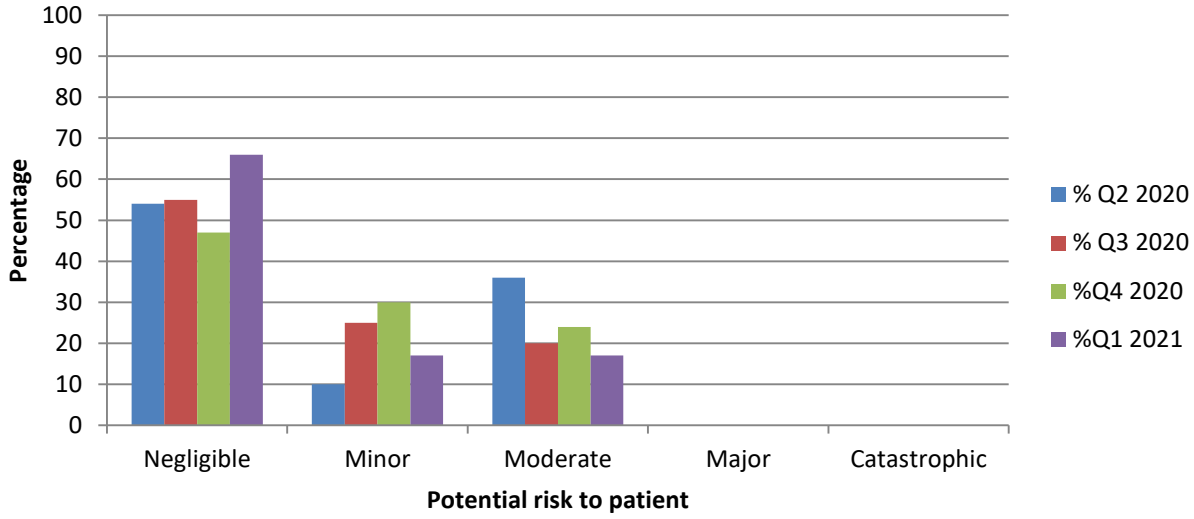


Chart 2: Percentage reported common causes of MI incidents for Q1 2021*

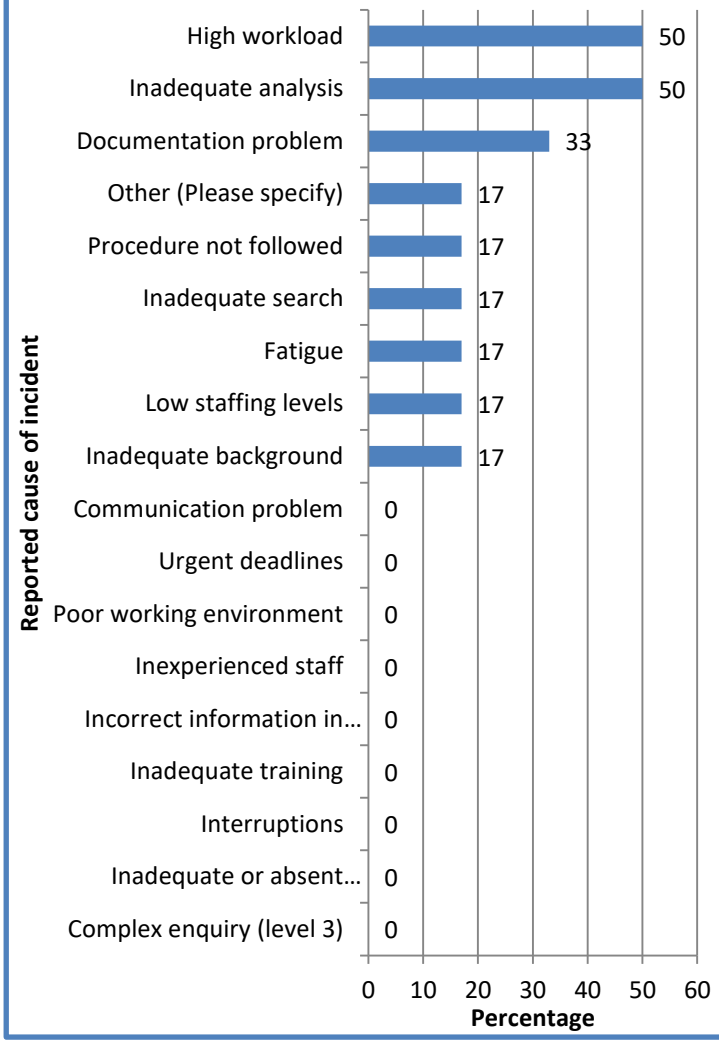
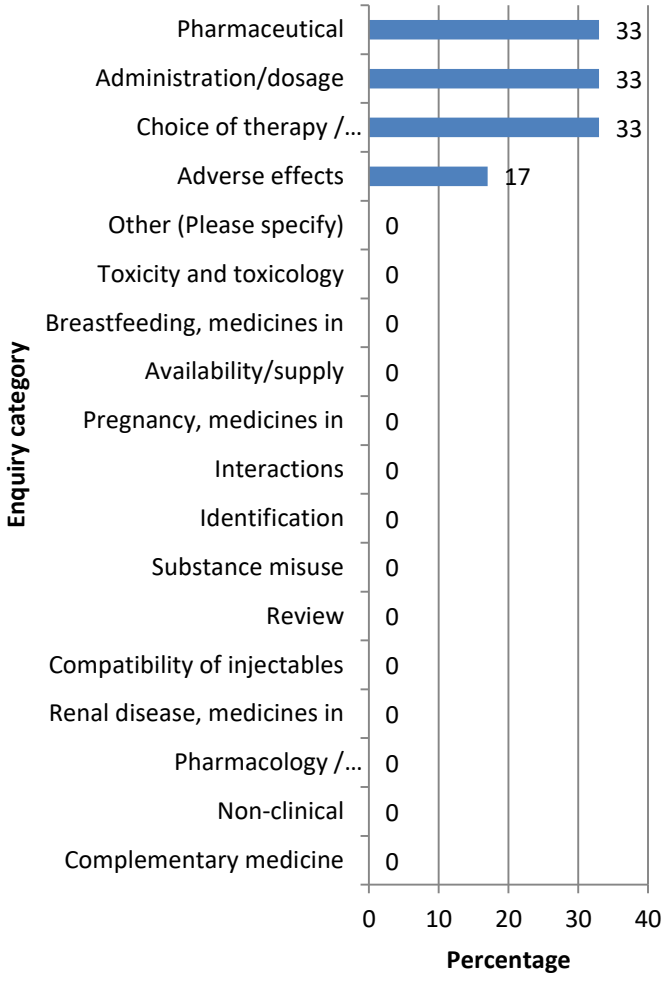


Chart 3: Percentage reported types of enquiry involved in MI incidents for Q1 2021*



*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1188 related to a follow up enquiry where the initial information gathered about the patient had not been transferred into the follow up entry. The information from the question field had been transferred to assist in the follow up question but the additional information noted in the research field had been missed.	➢ It is good practice to use separate entries in MiDatabank for follow up enquiries regarding the same patient. ➢ When using past enquiries, always read the full enquiry where possible. ➢ Concisely summarise patient information in the question field (whilst removing personal identifiers) for every enquiry, even if it relates to the same patient. ➢ Where staff deal with enquiries which are new topics to them, they should be signposted to relevant training options to aid their understanding and development. ➢ It is good practice to revisit the question(s) asked and ensure they are addressed in the answer.
Incident 1192 arose when the most recent FAQ was not consulted and incomplete advice given. This was compounded further by a lack of practical understanding regarding the enquiry topic.	
Incident 1193 referred to misunderstanding the question asked. A patient had asked what to do if they couldn't remember taking their weekly methotrexate dose. The enquiry researched what to do in the event of a missed dose.	

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1187 highlighted the need to know how to use resources, even the simplest ones such as the eMC. The near miss was spotted when an adverse effect was noted in one Brand but not another. Researching the site using the correct filters assisted in viewing the most recently updated first.	➢ All pharmacy staff using the eMC should know how to search the site efficiently and the limitations (which can be found in Tips, hints and limitations for use of common medicines information resources). The eMC site 'about' and 'help' sections are also useful guides. ➢ SPCs on the eMC can be sorted as 'updated – newest first' by using the 'filter search results' feature.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1184 resulted when a single word was omitted from a sentence and changed the information provided. The sentence should have read that the list of issues were not contraindicated for a patient but the 'not' had been omitted. The answer had been second checked, attached as a PDF and emailed to the enquirer and others cc'd. The error was picked up within hours when the writer re-checked the answer for the purpose of sharing enquiries via MiSharer. The email could not be recalled but a corrected response was sent within 2 hours of the original response.	➢ It is good practice to have a checking procedure/guidance in place. Refer to the Guidance on checking MI Enquiries. ➢ Checkers should take time to read the answer without any distractions. ➢ It is good practice to enter and complete enquiries in MiDatabank in a timely manner, ideally on the same day the answer is given. ➢ MI services subscribing to MiSharer should have an SOP in place detailing what to review and which enquiries to share on a daily basis. ➢ It is good practice to review all completed enquiries in a timely manner. ➢ Consider using the SPS Fridge database for fridge excursion enquiries since data is easier to find and read. ➢ Be careful when interpreting data in SPCs. ➢ Be familiar with the UKMi Enquiry Answering Guidelines which contain a section on dealing with enquiries about stability of fridge items at room temperature or frozen. ➢ Consider using a fridge enquiries form such as that in the Fridge Enquiries Guideline.
Incident 1186 involved another second checking issue and related to a fridge excursion. The checking pharmacist rechecked the pre-registration pharmacist's resources and did not realise they had used the SPC fridge data for reconstituted vials rather than unused vials.	

Publication Incidents

The reported publication error (incident 156) occurred when the wrong number for a patient helpline was advertised on an external Trust website. The number was incorrect by one digit. The final text had not been second checked. The error was detected and reported by a member of the public who had been receiving the helpline calls.

QRMG Recommendations:

- All written material published by MI should be second checked regardless of platform.
- Where the material involves a hyperlink, email link, telephone number, etc. these should all be re-checked/tested.
- Consider having an in-house publication checklist that covers all platforms.