Incident Reporting in Medicines Information Scheme (IRMIS)

Q2: April – June 2021

Reports	
Total number enquiry incidents since January 2005: 963 (rolling total for 2021: 21)	**Total number publications incidents since April 2013: 14**
Enquiries	**Publications/Pro-active work**
Number for this period: 12	Number for this period: 0
Number of errors: 9	Number of errors: 0
Number of near misses: 3	Number of near misses: 0
Number related to data: 2	Number related to data: 0
Number related to advice: 9	Number related to advice: 0
Number where description 'not known': 1	Number where description 'not known': 0

Report Summary

Top 3 recommendations from QRMG for this quarter:

- **Clarify the contact details for all enquirers.**
- **Avoid answering enquiries whilst the caller is on hold.**
- **Ensure your centre has an internal process for when a 2nd check is required.**

The most common incidents this quarter were due to a lack of 2nd checking, not understanding how to use a resource or its limitations, and simple errors in documentation. The main enquiry categories resulting in reports this quarter were choice of therapy and pharmaceutical. No incident resulted in patient harm though one was entered as a major incident. On review, this was not deemed to be the case. IRMIS users are reminded to consult the guidance at: https://www.sps.nhs.uk/wp-content/uploads/2016/10/IRMISGuidanceNotes2012v3.pdf when completing an IRMIS entry. The most common cause of an incident was reported to be documentation problems.

There were no incidents relating to publications this quarter.

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

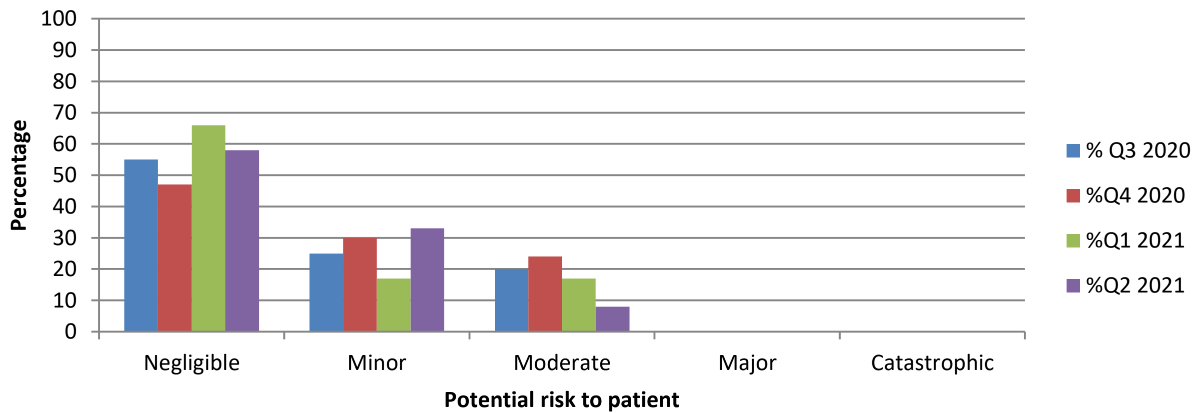
Data relating to identified causes and enquiry types for incidents is presented in chart 2 and 3. Table 1 (a-c) summarises the incidents reported and provides suggested actions and/or reminders from the QRMG to aid mitigation of risks at each stage of the enquiry answering process.

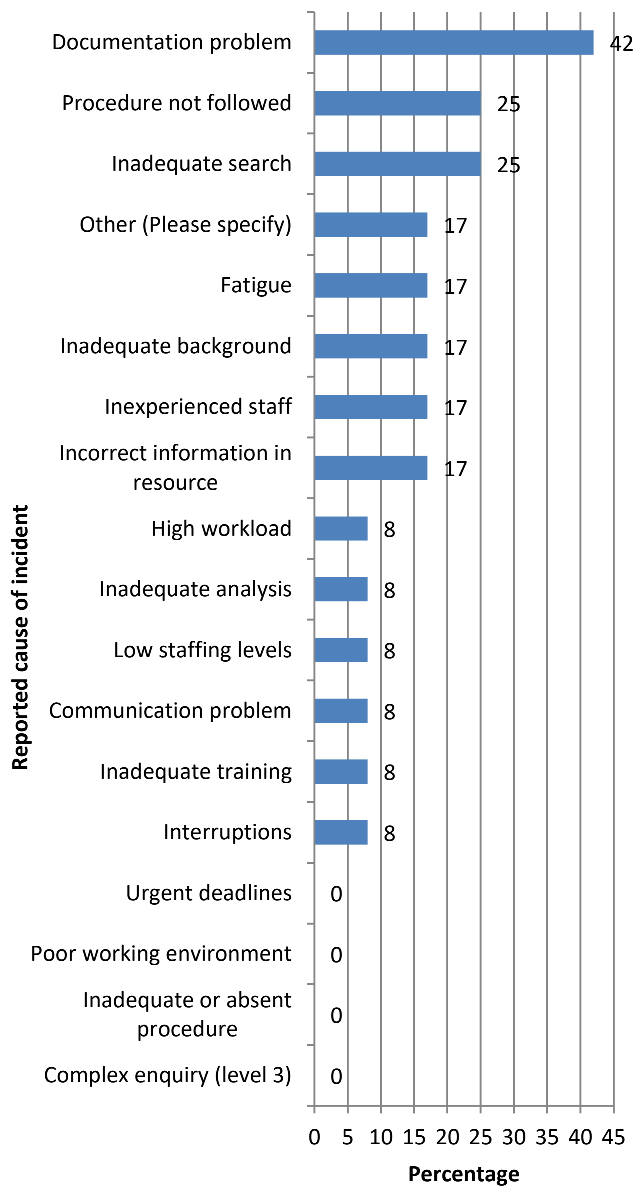
Help us improve

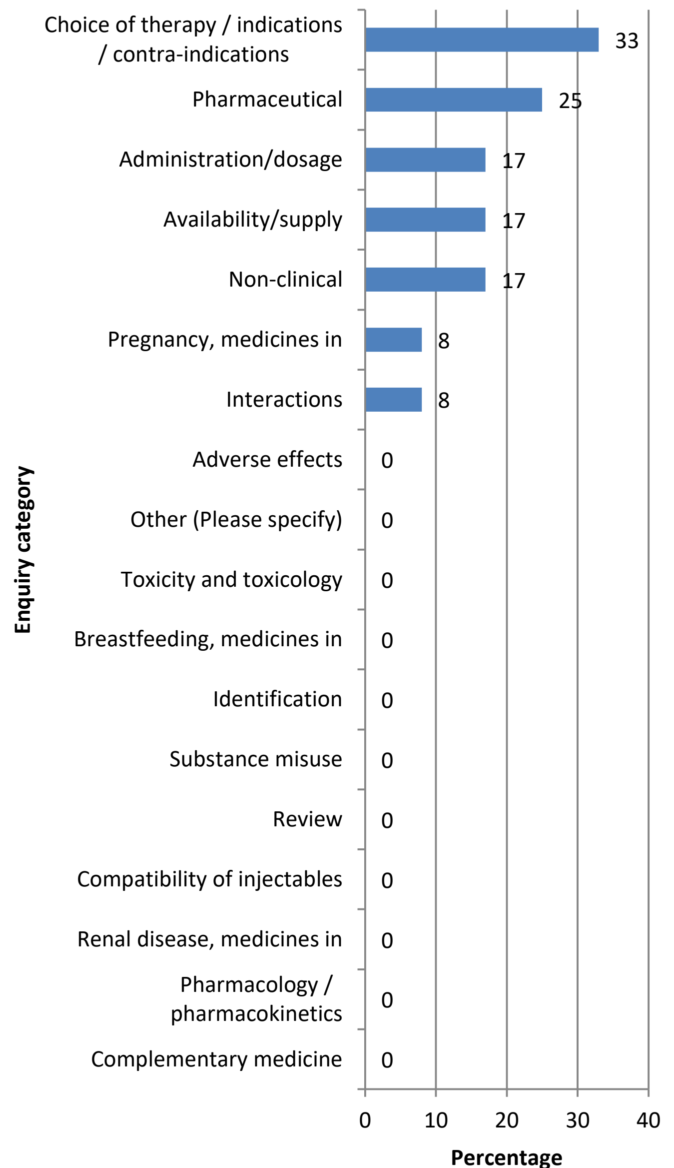
The QRMG are keen to get your views on the IRMIS report. Please complete a short survey at https://www.smartsurvey.co.uk/s/D6A8P3/. Alternatively, email us at QRMG.ukmi@nhs.net.

Contact

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







*Reflects multiple causes/enquiry categories per incident

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 1194 resulted when the incorrect contact number was taken from a new caller even though the number was read back before ending the call. An extra digit had been documented. Incident 1197 was similar in that a contact number had not been taken for a telephone enquiry requiring an email response. The email address had been taken and then used as a means to request further information, to which no response was received.	• Take the contact number for all telephone enquiries, even if the answer will be given in person or via email. • Take care when documenting contact details. Consider the number of digits in the contact number given. • Enter all new enquirers into MiDatabank to reduce contact detail errors and include their organisation/department so that you have another means of contact if necessary. • Transcribe directly into MiDatabank to avoid any errors in transcription from paper. • Read back from what you transcribed rather than from what you heard. Sense-check the information given before you end the call.
Incident 1195 related to a past enquiry consulted for a new enquiry. The past enquiry had confidential person identifiable data (PID) in the question field.	• Re-check the question and answer field for any confidential PID before archiving the enquiry. Consider an in-house checklist of what to do before archiving an enquiry. This could be based on the MiDatabank resource guides available at http://www.midatabank.com/resources.
Incident 1198 was a temperature excursion enquiry and used the fridge forms to gather details of the product. In this case, two emails were sent by the enquirer containing a different list of vaccines in each. Only one email was entered as an enquiry and the original email missed therefore only one list was researched and advised upon.	• It is good practice to have a generic medinfo email account to advertise and to receive and send enquiry related information. This avoids enquiries being held or delayed in personal email accounts. • Consider nominating a member of the MI staff to monitor the generic email account during service hours, and take any relevant action. • A standard email response may be useful indicating a deadline for emailed enquiries.

	• When emailing answers, add a read receipt and/or delivery receipt to the email to confirm it has be delivered and opened by the recipient(s).
Incident 1203 highlighted the risk of error when answering questions whilst the caller is on hold. In this case only one resource was looked at and an answer given suggesting off label practice. On checking a more up to date resource later, the answer changed since the practice was actually licensed.	• It is good practice not to answer question when the caller is on hold, even by experienced MI pharmacists, as this adds pressure and reduces the opportunity to check more than one resource. • There may be situations suited to answering immediately; these should be agreed locally, and should always be by suitably trained MI pharmacists.

(b) Enquiry answering process - researching

Incident summary	QRMG recommendations
Incident 1195 related to a temperature excursion enquiry whereby product details such as batch number and expiry date were not taken. The SPS Refrigerated Storage information was not used correctly to obtain the correct information to inform decision making.	• Consult the UKMi Enquiry Answering Guidelines at https://www.sps.nhs.uk/articles/ukmi-enquiry-answering/ which include how to research temperature excursion enquiries. • Consider using the Fridge Enquiries Guidelines at https://www.sps.nhs.uk/articles/ukmi-enquiry-answering/ to obtain product and excursion details. • Ensure all pharmacy staff know how to obtain and interpret the refrigerated data held on SPS (https://www.sps.nhs.uk/articles/using-our-refrigerated-storage-information-on-medicine-pages/).
Incident 1199 occurred when Stockley's were not used correctly and useful information missed. Incident 1200 involved accessing out of date pertussis vaccination information in the Green Book (Immunisation against Infectious Disease) which had been superseded by the Health Protection pages at GOV.UK – both of which are produced by Public Health England (PHE).	• All pharmacy staff should know how to the use the resources they have access to and the resource limitations. A useful guide on resource limitations can be found at https://www.sps.nhs.uk/wp-content/uploads/2020/07/Tips-hints-limitations-use-of-common-medicines-information-resources-20200929.pdf and includes Stockley's Drug Interactions and Interactions Checker.

Incident 1201 resulted when two resources provided conflicting information regarding choice of 2nd COVID-19 vaccine and a past history of heparin induced thrombocytopenia with thrombosis (HITT). The incorrect vaccine Brand was advised.	• The UKMi Enquiry Answering Guidelines at https://www.sps.nhs.uk/articles/ukmi-enquiry-answering/?preview=true include a section on immunisation and signpost to a number of PHE resources. Escalate any error or discrepancy in a resource with the resource author/publisher. The UKMi Exec have requested that the QRMG monitor, record and highlight errors in non-MI publications. • Where two resources have conflicting information, use additional resources until consensus can be given. Discuss with a colleague for further assurance. • SPS have produced numerous support guides for the COVID-19 vaccines at https://www.sps.nhs.uk/home/covid-19-vaccines/. • For operational and clinical questions on COVID-19 vaccines, consider contacting the designated Regional Vaccination Operation Centre (RVOC).
Incident 1205 highlighted discrepancies that may occur between verbal information and written information received from manufacturer's. In this case information on discontinuation of a product was confused by the manufacturers due to the various strengths of hydromorphone available. The verbal information impacted such that a patient was switched to another product. They later had to be switched back again when the manufacturer acknowledged they had made a mistake in their verbal information.	• UKMi have some guidance on how to use the pharmaceutical industry's (PI) medical information departments at https://www.sps.nhs.uk/articles/ukmi-enquiry-answering/. • In the case of poor responses from Pharmaceutical Industry, consider contacting the company and speak with the Medical Information Manager.

(c) Enquiry answering process – giving the answer

Incident summary	QRMG recommendations
Incident 1196 occurred when the answer was given without consideration of other information provided by the caller. The question concerned antidepressant choice in a glaucoma patient but failed to recognise the use of an interacting drug.	• Before giving out an answer (verbal or written), always go back to the question field and consider all the issues that are raised and require addressing. Ensure that all these issues are addressed in the answer. MiCAL provides tips on answering the question at
Incident 1197 was similar in that the question field was not rechecked before sending the answer and resulted in the wrong drug being researched for a pregnant patient: methylprednisolone instead of	

medroxyprogesterone.	http://www.midatabank.com/MiCal/micalContent.aspx (subscription required) and scenarios to apply enquiry answering skills. • It is good practice to have a second check of high risk enquiries such as drugs in pregnancy. These should include the checker reading the information in the question field before checking the written response for accuracy and sense. • Guidance on checking MI enquiries (including when to consider a 2nd check) can be found at https://www.sps.nhs.uk/articles/ukmi-enquiry-answering/?preview=true. • Even if a second check by another member of staff is not considered necessary, it is always good practice to perform a self-check before an answer is given out.
Incident 1202 highlighted the need for a second check with simple information such an expiry date. It is not clear if the response was given by email or verbally.	
Incident 1203 highlighted the problems of answering an enquiry based on one resource with the caller on hold.	
Incident 1204 involved a 10 fold error in drug dosage.	

Publication Incidents

No publication errors.

QRMG Recommendations: None required