UKMi
UK Medicines Information

CONFIDENTIAL

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

Q3: July – September 2020

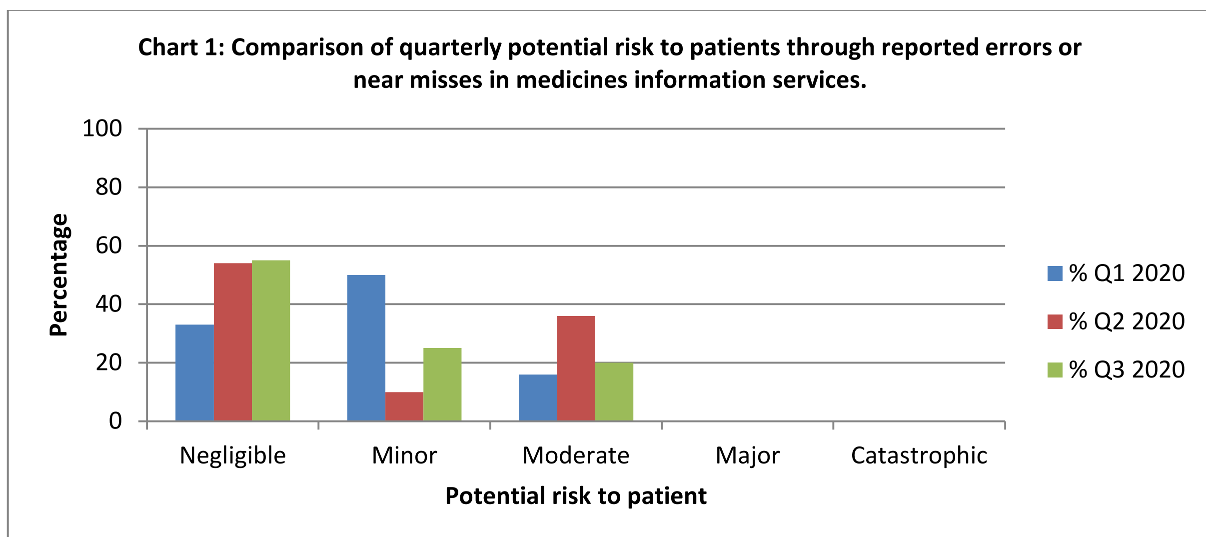
Reports	
Total number enquiry incidents since January 2005: 942 (rolling total for 2020: 37)	**Total number publications incidents since April 2013:** 12
Enquiries	**Publications/Pro-active work**
Number for this period: 20	Number for this period:
Number of errors: 14	Number of errors: 0
Number of near misses: 6	Number of near misses: 0
Number related to data: 6	Number related to data: 0
Number related to advice: 13	Number related to advice: 0
Number where description 'not known': 1	Number where description 'not known': 0

Report summary

The main theme from incidents this quarter relates to errors in calculations. The majority of incidents related to enquiries around administration and dosing of medicines. The most common cause of incident was due to issues in researching such as researching the wrong question and researching whilst the enquirer was on hold. This was closely followed by inadequate research.

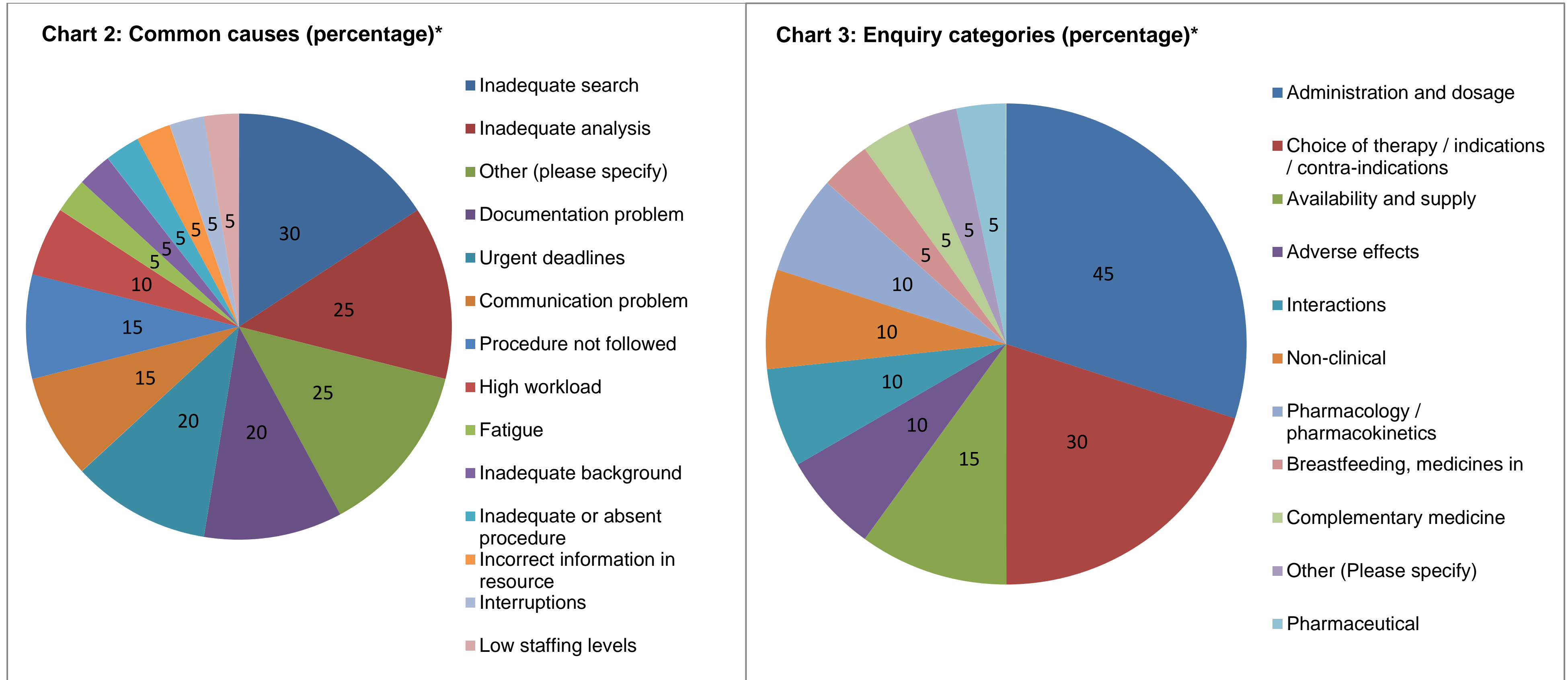
There were no incidents relating to publications in this quarter.

Six reported incidents relate to events that took place prior to 2020. Some of these refer to the use of a past enquiry that contained an error and so an entry was made reflecting the incident on the past enquiry. One incident (1159) was reported as catastrophic risk but on reviewing the entry, the risk from the incident should be considered as minor. A catastrophic event example would be one leading to death, or inquest/ombudsman inquiry, or national media coverage, or total loss of public confidence. IRMIS users are advised to consult the IRMIS guidance notes or with a senior member of MI staff if unsure about how to complete an entry. Chart 1 shows a quarterly comparison of potential risk to the patient due to an error or near miss in MI.



Data previously presented relating to identified causes and enquiry types for incidents is now presented as chart 2 and 3 for ease. Table 1 (a-c) summarises the incidents reported and provides suggested actions and/or reminders from the QRMG to mitigate risks. If you require further information regarding IRMIS or the reports, please contact QRMG.ukmi@nhs.net. Please also use this contact to provide any feedback regarding the IRMIS database or format of these reports. Note that IRMIS database access is only via NHS networks, e.g. via VPN when working from home.

Common causes (chart 2) and types of enquiries (chart 3) involved in incidents:



* Reflects multiple causes/enquiry categories per incident

Table 1: QRMG recommendations

a. Enquiry answering process – receiving the question

<table>
<tr><th>Summary</th><th>QRMG recommendations</th></tr>
<tr><td>Incident 1151 highlighted an error in understanding the issues around a question due to substantial information relating to the question being received and the issues to research not being clarified. The result was the incorrect drug combination being researched.</td><td rowspan="4">
Question fields should contain clear and concise issues that need to be addressed through research. If there is excessive information then consider making it more concise for the question field and moving the full information into a tab in the research field (for record purposes).
It is useful to bullet point the questions to research at the top of the question field.
It is useful for the enquiry title to reflect the question(s) being asked. This may also assist in checking that all issues have been addressed in the answer.
Staff involved in answering questions about medicines may find the Quick Question Guide a useful guidance tool (includes general questions to ask for all enquiries).
Repeat back the questions/issues to be researched to the enquirer before you end the conversation so that expectations are agreed before the enquiry is started.
Have one enquiry screen open at any one time to avoid accidently inputting information into the wrong enquiry.
Re-check the final answer against the question field to ensure all agreed issues/questions are addressed before sending the answer.
All centres should have a local SOP for handling enquiries.
It is good practice to re-read enquiries before archiving to remove person identifiable data, allocate correct local coding, ensure the question has been answered, etc.
In progress enquiries in MiDatabank can be reviewed as full documents by searching for the enquiry number. The incomplete enquiry will appear as a document within MiDatabank and may be easier to review.
Report the impact of remote working on enquiry answering and publication writing through IRMIS. The access to the IRMIS site is currently being investigated given that some regions are unable to login to the site from non-NHS devices. All MI services should have a unique login for the site. If you do not have an active login, please contact pharmacy.support@wales.nhs.uk to request your login details.
</td></tr>
<tr><td>Incident 1152 related to the opposite where too little background information had been taken resulting in the wrong answer being given.</td></tr>
<tr><td>Incident 1153 occurred when the local receiving enquiries procedure was not followed and resulted in multiple enquiries being documented the next day. During retrospective documentation, information was recorded under the wrong enquiry.</td></tr>
<tr><td>Incident 1159 also highlights the need to review the answer against the question before giving out the answer since only part of the question had been responded to. The second half of the question had been missed due to MiDatabank being used on a laptop and having a smaller input screen. The rest of the question was only visible if the user scrolled down the question field.</td></tr>
</table>

b. Enquiry answering process - researching

<table>
<tr><th>Summary</th><th>QRMG recommendations</th></tr>
<tr><td>Incident 1146 occurred due to an error in solution strength calculation. The error was on a past enquiry and could have been transferred to the current enquiry if staff had not been vigilant and rechecked the past calculation. The past enquiry had also been shared more widely via MiSharer and so readers uploading enquiries onto MiSharer are reminded that senior MI staff should know how to remove enquiries from shared access on MiSharer. Incident 1154, 1156 and 1163 also related to dose calculation errors on past enquiries.</td><td rowspan="5">Have all calculations double checked. This may be with a member of the MI staff, pharmacy team, enquirer or regional MI service. If you are lone working, take a break and return to the calculation afresh to re-check it.
Past enquiries in MiDatabank that contain an error should have a note added to them to indicate that the enquiry is not for use.
For off license use of drugs, consider contacting the specialist pharmacist or their MDT to obtain specialist guidance before doing in-depth research especially if the question originated from a specialist. Know how to locate your local specialist guidelines and consider posting a message on the eCompass discussion forum.
Where resources lack clarity or contain errors, highlight this with the author of the document to reduce the risk of a similar error by other users. Maintain a communication trail and note when the resource error has been rectified. If you think it useful, inform the MI network of the error through the QRMG (via QRMG.ukmi@nhs.net) and/or the eCompass discussion forum.
When looking for a patient information leaflet in a foreign language, refer to the guidance on Foreign Language Resources.</td></tr>
<tr><td>Incident 1148 related to a UK licensed product requiring a patient information leaflet (PIL) in another language. An online e-source was misused due to lack of familiarity with the site and language. The enquirer ultimately found the correct PIL on the same site.</td></tr>
<tr><td>Incident 1149 highlighted when a literature search should be conducted or a specialist consulted for unusual off license prescriptions.</td></tr>
<tr><td>Incident 1152 noted a good practice point to use relevant keywords on all enquiries for ease of retrieving at a later date since, had they located the past enquiry, the error may not have happened.</td></tr>
<tr><td>Incident 1158 identified lack of clarity in local guidance and resulted in misleading advice being given.</td></tr>
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c. Enquiry answering process – giving the answer

Summary	QRMG recommendations
Incident 1147 occurred when over writing a past enquiry answer and using it as a 'template'. Not all the drug names were amended and so some text referred to the past enquiry drugs.	• Where a common enquiry answer format has been identified, create a template for use. In MiDatabank, these can be saved as 'special fields' for the answer screen. • Re-read all responses. Ideally ask a colleague to proof read written responses but where this is not possible, take a break and return to the answer for a re-read later. • If a follow up question is received then it should be added as a new enquiry to allow appropriate research and answer formulation. You can add the previous (original) enquiry as a past enquiry in the research section. • Do not be pressured into answering enquiries at the point of receipt. Time is required to read the information even if from one resource. Locally agree which enquiry types are suitable for immediate response. • Review and archive enquiries on the same day that the answer is given out if possible to allow better detection and action on any incorrect answers. • Re-read answers copied into an email from MiDatabank. Consider copying the text from MiDatabank into Notepad or Word to remove or amend formatting before pasting into the body of an email. An alternative is to attach a Word or PDF version of the final answer to the email and make reference to it in the body of the email. Bear in mind that if the recipients email is set to plain text then any formatting such as tables, Trust logo's, etc. in the body of the email will be removed on receipt. • For large amounts of data, such as fridge excursions, consider constructing a table or spreadsheet to populate as you work through the list.
Incident 1155 resulted from rushing to answer a follow up question rather than adding the follow up question as a new enquiry. The original research did not address the follow up question. One resource was reviewed quickly and information read out of context. A similar issue arose with incident 1161 where one resource was used to answer an enquiry whilst the caller was on hold. The information from the online resource was misread and resulted in the patient receiving a dose at the wrong time. Further advice had to then be given on monitoring for drug toxicity. Incident 1165 also highlights the risk of answering enquiries whilst the caller is on hold, even when they seem relatively simple since errors can made when reading the resource information under pressure. In this case, the additional data, which was relevant to the patient, was further down the screen and not seen until after the answer had been given.	
Incident 1157 involved the wrong solution strength being noted and transferred into the answer. The error was picked up the next day when archiving. Incident 1162 had a similar error where the hyperlink to a document was not the same as that referred to in the answer text.	
Incident 1160 highlighted the problems when copying and pasting text from MiDatabank into emails. Formatting of the text may change significantly and require substantial amendments. In this case, the amendments resulted in a paragraph of text being deleted from the answer.	
Incident 1164 related to interpretation of a large amount of fridge data following a temperature excursion. The final answer contained advice to discard one drug which was not supported by the research. The product could have been retained and used within 72 hours. This was not detected when the answer was checked.	