UKMi Incident reporting guidance: Enquiry answering

This guidance tells you what is classed as an enquiry related incident in Medicines Information or Advice (MI/MA) services. It also explains what and how to report.

There is a different process for reporting incidents that involve publications produced or used by MI/MA services.

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# Terminology

## Adverse Incident

An adverse incident is any unintended or unexpected event that could have, or did, harm one or more persons.

An adverse incident does not need to be due to a human action. For example, a power cut which prevents access to vital MI/MA systems and resources would be an adverse incident and require escalation.

## Error

An **error** is an action or decision that deviates from what is correct, intended, or expected.

In healthcare, errors often result in adverse effects or harm to a person.

For MI/MA incident reporting purposes, *errors* are often differentiated from *near misses*. For reporting purposes, an error is not corrected before it reaches the “end user”. An MI/MA example is an incorrect answer leaving the department.

## Near Miss

A **near miss** is an adverse incident/error that has the potential to cause an adverse event but fails to do so either by chance or intervention. An MI/MA example is an incorrect answer that is detected and corrected before leaving the department.

Some services have a [checking process for enquiries](https://www.ukmi.nhs.uk/Resources?ContentID=69688558-86cc-4062-b5fa-a12f48b02830). It is not necessary to report every near miss detected through your checking process unless you think there is learning to share with the UKMi network.

Near misses often provide valuable opportunities to identify and address risks before harm occurs.

You should report any error or near miss relating to your MI/MA practice.

# Why report an incident to UKMi

Recording incidents supports the [UKMi](https://www.ukmi.nhs.uk/Default) network to learn from mistakes and to take action to keep people safe. UKMi will be able to see patterns of incidents across the network in a timely manner which cannot be achieved through local incident reporting.

The [Quality and Risk Management Group](https://www.ukmi.nhs.uk/Resources?ContentID=1b1e5047-31c2-40ec-8d3d-a09ff1af151a) (QRMG), a sub group of UKMi, reviews all incidents submitted to UKMi and provides reports on patterns and risks identified, and makes recommendations to the network to reduce the risk of recurrence.

The reports produced by QRMG can also be used to demonstrate the need for additional resources or changes in how MI/MA works in your Trust, for example by demonstrating the risks of excessive workload, inadequate resources, or poor working environment.

Incidents should also be reported locally following your Trust incident reporting procedure. Reporting to UKMi does not replace this.

# What to report

Please report:

* All errors associated with the enquiry answering process
* All near misses associated with the enquiry answering process

## Staff in training

For MI/MA incident reporting purposes, “trainee” is defined as any member of MI/MA staff, whether temporary or permanent, who is not allowed to work independently for the relevant type of enquiry/work. For example:

* A trainee pharmacist or trainee technician
* A qualified pharmacist or MI pharmacy technician doing an enquiry in a category/level other than those they have been “signed off” for

It is not necessary to report all mistakes made by a trainee. Trainee errors or near misses that should be reported include:

* Any error that leaves the department
* Any near miss that would be useful for learning across the network

# How to report an incident

1. Go to <https://forms.office.com/e/wPNkxCc31Y> to submit details of an incident that relates to the enquiry answering process in a MI/MA service. There is no login or password. You do not need an NHS enabled device.
2. Respond to the questions.
3. Submit your MS form. Request a copy for your records if you wish; this is optional as some organisations may block this feature of MS forms.

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| **Question** | **Note** |
| What type of enquiry incident are you reporting | Use the definitions above to decide if the incident is an error (left MI/MA) or near miss (error corrected before it left MI/MA) |
| How has the incident been identified | Indicate how the incident came to light. Select ‘other’ for anything not listed and provide details.  For example, ‘through workload management’ may be from reviewing the previous day’s completed enquiries. |
| When did the incident occur | Give the date that the error or near miss occurred. It may have been detected later. |
| Please state the title of the enquiry as it appears on your enquiry form | Copy and paste the enquiry title. This will help identify any duplicate entries. |
| Please tick the relevant enquiry categories | Select the main enquiry categories as they appear in your enquiry recording system. If the enquiry category does not appear, then select ‘other’ and provide the unlisted category. |
| Please provide a full description of the incident | Provide a description of the facts for a third person to understand. For example:   * What happened: Provide a clear and factual account of the event. * How it happened: Explain the sequence of events leading to the error or near miss. * Why it happened: Identify any contributing factors or root causes you have identified. * Name of the medication: Specify the drug(s) involved, including the brand and generic names. * Dosage and administration: Include details about the prescribed dose, route of administration, and frequency. |
| At what point in the enquiry answering process did the incident occur | Try to identify the main stage of the process that the incident occurred at. For example, the incorrect drug name in the answer may have stemmed from the wrong drug name being taken in during the documentation stage. |
| What was the probable cause of the incident | Select the main contributory factors that lead to the incident occurring. |
| What was the potential risk to the patient | If the enquiry did not relate to a patient, select ‘no patient involved’. Otherwise, decide what the impact on the patient *could have been* if the near miss or error reached them undetected.   * Negligible risk – no harm to patient possible * Minor risk – monitoring required * Moderate risk – temporary harm requiring intervention * Major risk – permanent harm * Catastrophic risk – intervention required to sustain life or contribution to patient death |
| What immediate actions have been taken to correct the incident outcome | These are the actions taken on detecting the error or near miss such as contacting the patient or prescriber to inform them, and any further information or advice given |
| What actions are planned to reduce the risk of incident recurrence | Follow-up actions taken to prevent recurrence such as updating a standard operating procedure (SOP), training MI/MA staff, or discussing the incident at the next team meeting. |
| Please provide your email address in case the UKMi Incident Reporter needs to contact you for further information | Identifiable details of your submitted incident will only be seen by the UKMi Incident Reporter. Once they have reviewed your submitted incident, they may contact you for more facts. Your details will not be shared any further.  The QRMG may occasionally request further information following a review of the collated report; the UKMi Incident Reporter will contact you on their behalf. |

# Data protection and confidentiality

QRMG do not require the identity of patients, healthcare staff or other individuals involved in the incident. Please do not provide any information that could potentially enable the identification of an individual.

If the UKMi Incident Reporter finds any information identifying an individual, they will remove it before presenting the collated report to the QRMG.

# Additional actions to take

Any completed enquiries containing an error should be marked as such to avoid accidental use. For example, add a note to the completed enquiry in MiDatabank to state the enquiry is ‘not for use’ or similar. You may like to state what the incident was, and add any local incident reference numbers, such as DATIX number.

MI/MA services should maintain a log of submitted reports for the purpose of any local or [UKMi key performance indicator](https://www.ukmi.nhs.uk/Resources?ContentID=388fbed3-c5bd-49b1-945e-a27159263c62) metrics.

Local processes should be in place to ensure these take place.

# What happens to the incident submitted

The incident reporting system is managed and operated by QRMG to collect MI/MA service safety incident reports for network learning.

The UKMi Incident Reporter, a member of the QRMG, will collate submitted incidents into a report every quarter. The report will be reviewed at the following QRMG meeting. The QRMG group will provide recommendations, finalise the report, and escalate any issues that impact the network to the UKMi Executive.

QRMG do not investigate individual incidents. They use the information submitted to reduce or highlight MI/MA practice risks and reduce risks to patients. Based on the recommendations, appropriate actions should be taken locally to protect people from harm and improve local MI/MA practice.

The quarterly recommendations are published by the UKMi Incident Reporter, on behalf of QRMG, as follows:

* The full Word report will be distributed via the UKMi members distribution list. [UKMi network membership](https://www.ukmi.org.uk/pages/become-a-member-today) is available to healthcare staff who have MI/MA as a component of their role.
* The summary PDF will be posted on the [UKMi Incident reporting webpage](https://www.ukmi.nhs.uk/Resources?ContentID=8c0ef2f7-b950-43cb-8a25-6c1a158d3900) (unrestricted access).
* The PowerPoint summary will be posted on the [UKMi Incident reporting webpage](https://www.ukmi.nhs.uk/Resources?ContentID=8c0ef2f7-b950-43cb-8a25-6c1a158d3900) (unrestricted access).
* Commonly occurring incidents will form the basis of Incident Alerts posted on the [UKMi Incident reporting webpage](https://www.ukmi.nhs.uk/Resources?ContentID=8c0ef2f7-b950-43cb-8a25-6c1a158d3900) (unrestricted access).

# How to use the reports

The full Word report is useful learning for all staff working in MI/MA services.

The summary PDF report is useful for pharmacy and Trust management to understand the UKMi recommendations to reduce risk to people when handling questions about medicines.

The PowerPoint can be used to present the current report findings to departments or at regional network meetings (where these occur).

The Incident Alerts are collation of recurring themes and provide recommendations to anyone involved in handling questions about medicines.

# User feedback

The incident reporting process was launched in April 2025. The QRMG value your feedback or comments on the process. Please email [QRMG.ukmi@nhs.net](mailto:QRMG.ukmi@nhs.net).

# Document history

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| **Version** | **Date** | **Author** | **Description of change** |
| 1.0 | 21.03.2025 | Iram Husain and IRMIS focus group | QRMG comments addressed. Guidance released to network via UKMi website. |