UKMi Incident reporting guidance: Publications

This guidance tells you what is classed as a publication-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 the enquiry answering process.

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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”.

## 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.

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

## MI/MA publication

A publication error arises when a MI/MA service authors or reviews an article and fails to detect inaccuracies, omissions, or other errors prior to its release. Such errors—ranging from factual inaccuracies to typographical mistakes—may compromise the publication’s credibility and reliability, thereby introducing potential risks for its users. Publication examples include MI/MA bulletins, newsletters, alerts, social media announcements, and webpages.

## Publication used by MI/MA

In the context of this policy, a publication error refers to any inaccuracy or mistake identified in external publications that the MI/MA service uses as a source of information. When staff rely on such publications, undetected errors may compromise the quality of decision-making or research activities within the department.

To mitigate this risk, staff must remain vigilant when consulting external sources and report any identified errors that could impact the department’s work. This requirement specifically applies to publications listed in the [UKMi Essential Resources list](https://www.ukmi.nhs.uk/Resources?ContentID=3df605e3-ec43-47b7-99ff-aabc3cd91765).

# Why report an incident to UKMi

Recording MI/MA publication incidents helps 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.

Recording errors in resources used by MI/MA allows UKMi to inform registered members (see [Join the UKMi Network](https://www.ukmi.nhs.uk/Default) for details on who can become a member).

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, provides reports on patterns and risks identified, and makes recommendations to the network to reduce the risk of recurrence.

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

UKMi does not provide guidance on checking MI/MA publications, but it is expected that MI/MA services that write or review publications will have their own in-house governance and checking guidance.

# What to report

Please report:

* All errors associated with MI/MA-produced publications
* All errors in resources listed in the UKMi Essential Resource list.
* All near misses associated with MI/MA publication production

# How to report an incident

1. Go to <https://forms.office.com/e/G3TJGJjBn2> to submit details of an incident related to a publication. 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** |
| When was the publication or resource error identified | Select the date the incident was detected using the calendar provided. |
| Are you reporting an error in a publication (produced by your MI/MA service) or in a resource (used by your MI/MA service) | Select one option. See terminology above for definitions.  The form will request information specific to the category you select. |
| An error in a publication produced by my MI/MA services questions |  |
| Please give details about your MI/MA publication such as title, purpose, format, publication frequency, and target audience | Free text box. |
| What type of error occurred | Tick all that apply. There is an option for ‘other’ where you can add an error type if it is not listed. |
| Please describe the MI/MA publication error in detail, including any contributing factors for the error, e.g. tight deadline, lack of resources, etc | Free text box.  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. |
| How significant is the MI/MA publication error in terms of **potential impact** on practice? | * Minimal impact – no impact on patient care or outcome. * Moderate impact – misunderstandings or misinterpretations likely but no serious harm if identified and promptly corrected * Serious impact – affect clinical decisions and patient care leading to incorrect treatment or interventions * Severe impact – could directly lead to harmful clinical decisions and significant patient harm or adverse outcomes * Catastrophic impact – widespread harm and risk of fatalities |
| Please explain how this MI/MA publication error **potentially impacts** patient care or medical practice. | Free text box.  Consider the impact the error would have had if it hadn’t been identified |
| Please describe the **actual outcome** from the MI/MA publication error on patient care, or medical practice. | Free text box. |
| What actions have been taken or are being planned to reduce the risk of the error recurring? | Free text box.  Please indicate planned and/or taken. |
| Please provide your email address. | Free text box.  In case the UKMi Incident Reporter needs to obtain further information on behalf of QRMG |
| An error in a resource used by my MI/MA service questions |  |
| Please provide enough information so that the resource can be found or identified. | Free text box.  Such as title, author, URL, publisher, and ISBN (where applicable). |
| What type of error did you encounter? Tick all that apply. | Tick all that apply. There is an option for ‘other’ where you can add an error type if it is not listed. |
| Please describe the resource error in detail | Free text box.  Provide a description of the facts for a third person to understand. For example:   * Description of the error * Correct information * How the error was identified |
| On a scale of 1 to 5, how significant is the resource error in terms of **potential impact** on practice? | * Minimal impact – no impact on patient care or outcome. * Moderate impact – misunderstandings or misinterpretations likely but no serious harm if identified and promptly corrected * Serious impact – affect clinical decisions and patient care leading to incorrect treatment or interventions * Severe impact – could directly lead to harmful clinical decisions and significant patient harm or adverse outcomes  1. Catastrophic impact – widespread harm and risk of fatalities |
| Please explain how this resource error **potentially impacts** patient care or medical practice. | Free text box.  Consider the impact of the error if it hadn’t been identified. |
| Please describe the **actual outcome** from the resource error on MI/MA practice, patient care, or medical practice. | Free text box. |
| Have you reported the resource error to the publisher? | All errors in resources should be reported to the publisher.  Tick the applicable statement.  For ‘Yes – responses received’ you will be asked ‘What was the response from the publisher’ and a free text box will appear. |
| Please provide your email address in case the UKMi Incident Reporter needs further information for the report. | Free text box.  In case the UKMi Incident Reporter or QRMG need further information for the report. |

# 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 that could identify an individual, they will remove it before presenting the collated report to the QRMG.

# Additional actions to take

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 (ALERT) 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 Spotlights 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 | 28.05.2025 | Iram Husain and IRMIS focus group | QRMG comments addressed. Guidance released to network via UKMi website. |