UKMi Active Learning from Events and Risk Tracking (ALERT) report

Executive summary

Q2: April to June 2025

Reports	
Total number of enquiry incidents since January 2005: 1123 (rolling total for 2025: **22**)	**Total number of publication incidents since April 2013: 22** (rolling total for 2025: **2**)
Enquiries	**Publications/Pro-active work**
Number for this period: 16	Number for this period: 1
Number of errors: 8	Number of errors: 1
Number of near misses: 8	Number of near misses: 0

Top 3 recommendations from QRMG for this quarter

- Take care with patient identifiable information. Only record what you need. Try to record it directly into the correct field of MiDatabank; this avoids the possibility of it being left in the enquiry/answer fields.
- When taking in enquiries by phone, check all information (patient, enquiry, enquirer) by repeating it back to the enquirer.
- Check validity/elderliness of information in past enquiries; referencing answers makes this easier and makes it less likely you will end up using out-of-date information by mistake.

There was an equal number of errors and near misses this quarter. The potential impact on patient safety assigned by reporters was mainly negligible with one major and no catastrophic. The most common cause for incidents were documentation problems. This was followed by 'other' which reporters clarified as:

- Resource unclear
- Manufacturer changed information after response sent
- Level of understanding of enquirer
- Manufacturer not identifying PEG and macrogol are the same thing

The enquiry types most frequently associated with incidents were interactions, followed by pharmaceutical, administration or dosage, complementary medicine, and choice of therapy or indication or contraindications.

Most incidents were identified by 'other' means:

- By person completing enquiry
- By processor during research
- Error discovered when pulling information from SPC to copy into MiDatabank
- Attendance at inquest
- By colleague
- While doing enquiry

Or during a second check (near miss).

When reviewing the stage of enquiry answering, most incidents occurred when processing (researching) the enquiry.

There was one publication error in a resource used by an MI service.

- Chart 1 shows a quarterly comparison of potential risks to the patient due to errors or near misses.
- Data relating to identified causes and enquiry types for incidents is in charts 2 and 3.
- Charts 4 and 5 provide data on how incidents were identified and the trigger point for incidents.
- Table 1 (a-d) 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 and for publications.

Chart 1: Quarterly comparison of potential risk to patient for reported incidents in last 12 months

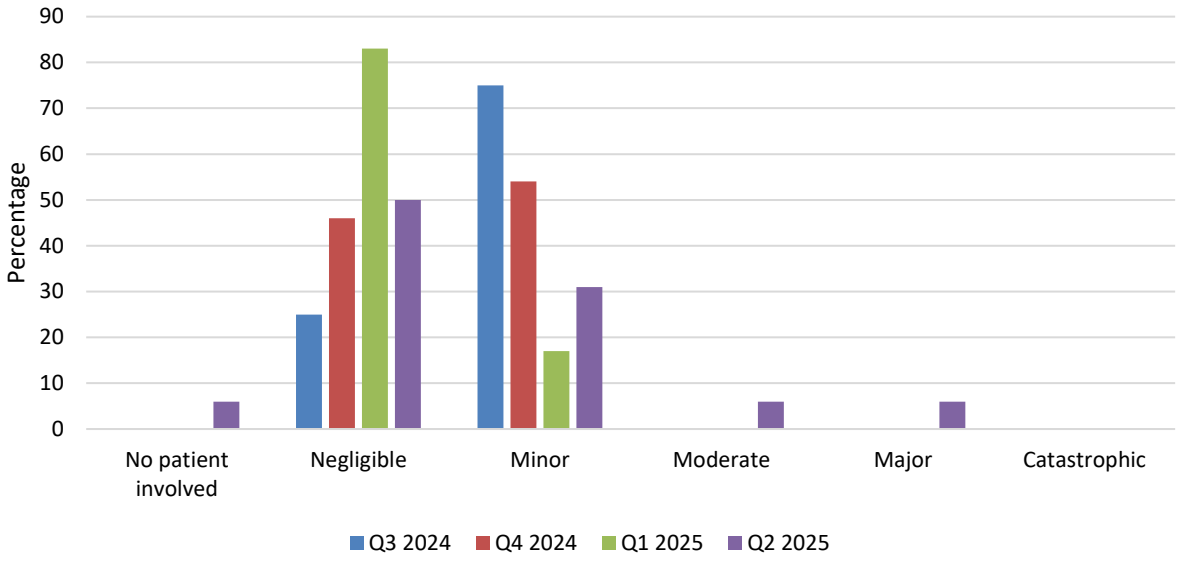


Chart 2: Reported common causes of MI incidents in Q2 2025*

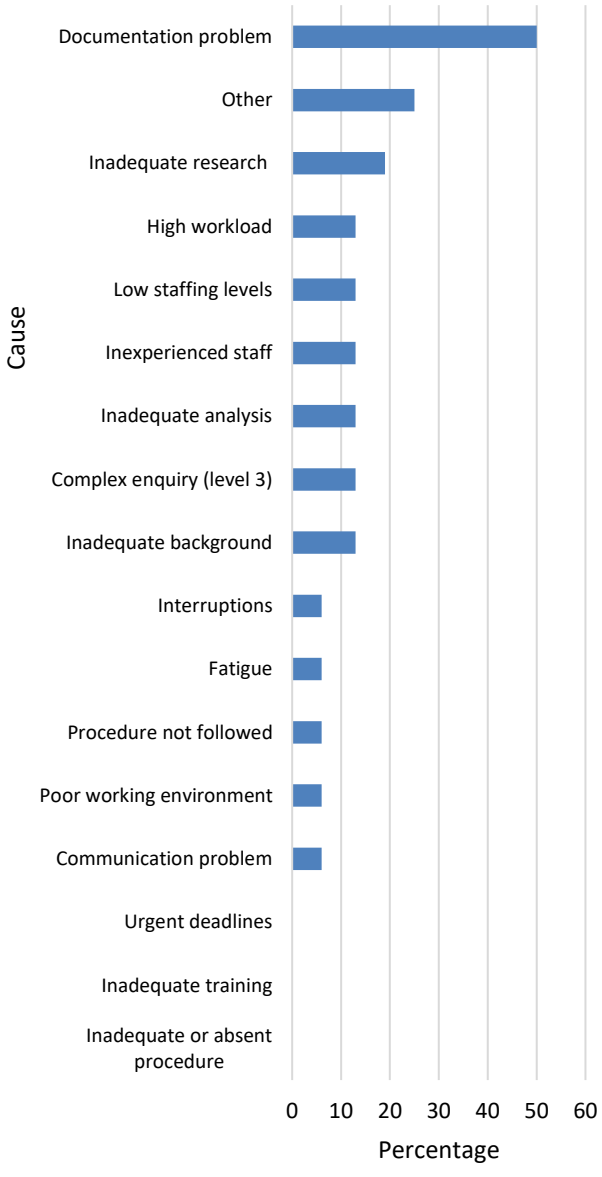
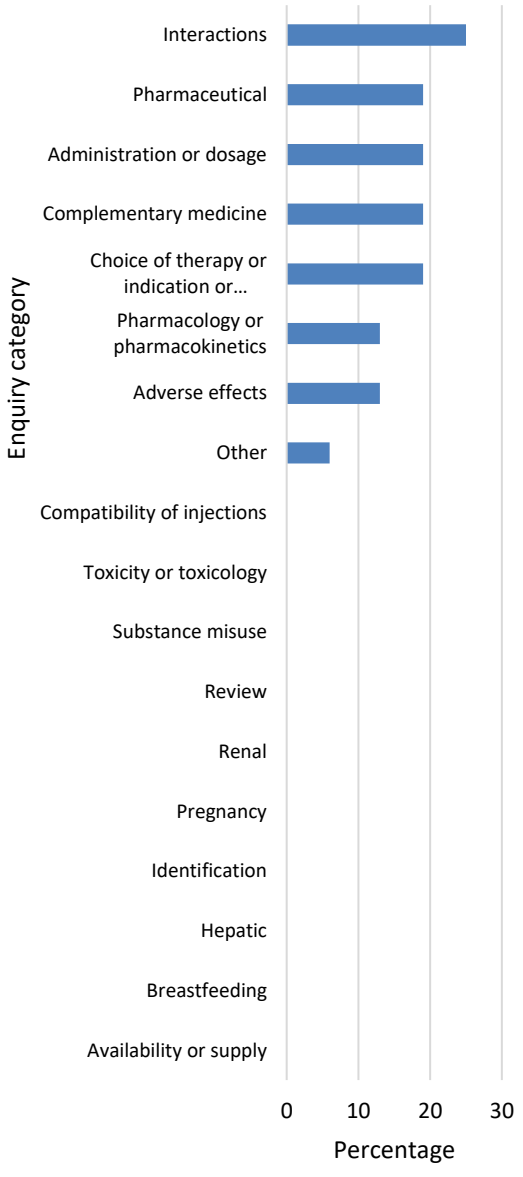


Chart 3: Reported types of enquiry involved in MI incidents in Q2 2025*



*Data do not add up to 100% due to multiple options

Chart 4: How reported incidents were identified in Q2 2025

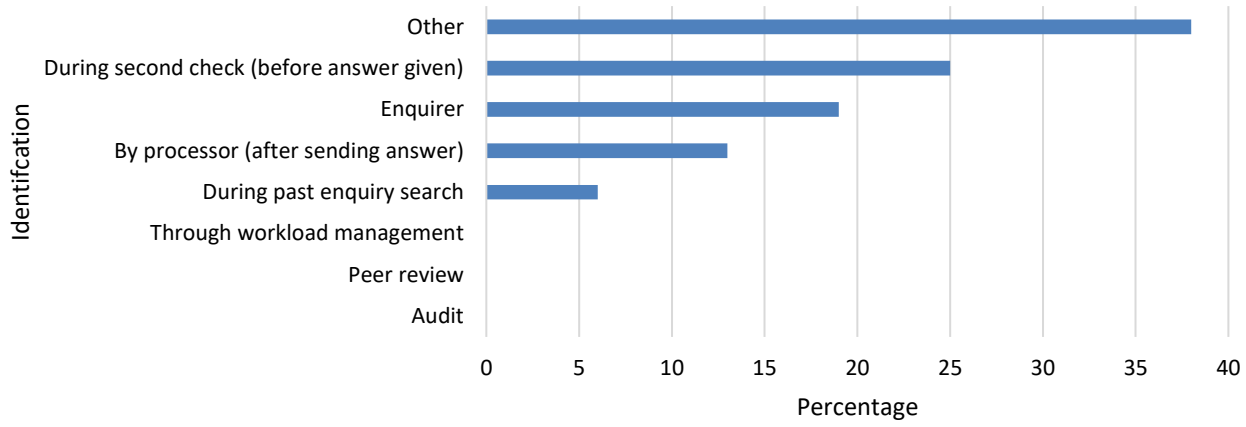


Chart 5: Reported point in enquiry process which triggered incident in Q2 2025

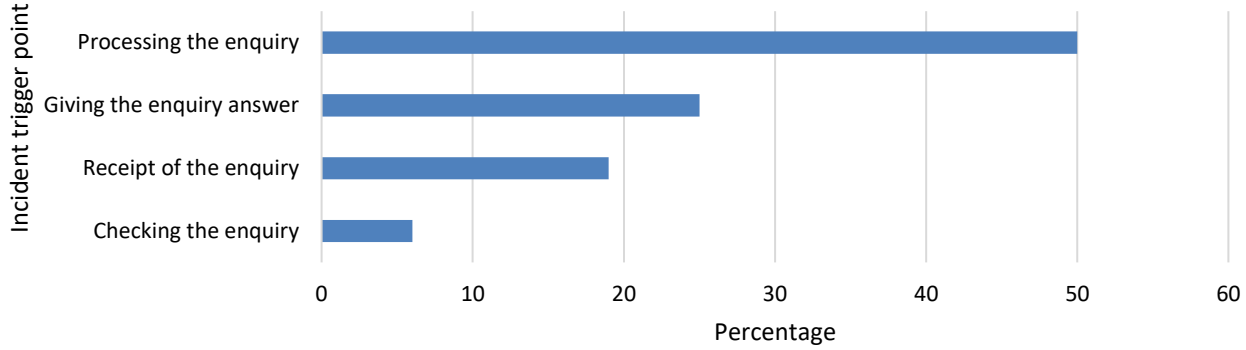


Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 4 related to a discharge enquiry where the enquirer's name had been entered into the patient ID box. The staff used the NHS number to locate the patient records but hadn't noticed that the patient's name in MiDatabank did not match. Incident 7 also related to a documentation error with patient details. The patient identifiers were entered into the question field of an MiDatabank entry. The system then auto populated the first line as the title which were the patient identifiers. The enquiry was completed with the patient identifiers in the title. CoAcS (MiDatabank supplier) were contacted and supported in correcting the title after archiving, as well as amending on MiSharer (Own centre view). Incident 15 was a delayed response to a patient due to the wrong mobile number being entered into MiDatabank. A voicemail message was left with the wrong patient and several further attempts made to contact them. The correct patient hospital number was used to find the contact number once the error had been identified. Incident 17 used MiDatabank's preset enquirer function. Staff selected an enquirer with the same name but different contact details and address.	• It is good practice to cross check the name, date of birth and NHS number before accessing or updating records. NHS England provides general guidance on identity verification. • Always confirm the contact number with the caller by repeating the contact number taken down back to them. • If you contact an enquirer and have to leave a message on voicemail, ask them to call you back for the answer and leave your name, contact number and a reference number rather than leaving the answer. • Be careful when entering enquirer and patient details into MiDatabank especially where generic enquirer entries are used. Enter the enquirer details directly into the free text box of the 'enquirer' section rather than into the 'question' field. • Setting regular enquirers into the MiDatabank database will help reduce the risk of future incorrect entry. Always reconfirm the enquirer details (full name and contact number) even if pre-set in MiDatabank. There have been incidents with mixing up enquirers with similar or identical names, or assuming the contact details have not changed. • Always re-read the final completed enquiry before archiving and double check for patient identifiers.
Incident 9 resulted when staff misheard the medicine name over the phone. Imatinib was misheard as bumetanide. The error was detected when the medication list was cross checked with the patient records and bumetanide was not listed.	• Refer to the UKMi Incident Spotlight on Reducing the risk of getting the drug name wrong for recommendations. It is good practice to summarise and repeat the question back to the enquirer if taking in over the phone. This also allows confirmation that you and the enquirer agree on the question(s) they need answered.

(b) Enquiry answering process – researching the enquiry

Incident summary	QRMG recommendations
Incident 3 used a past enquiry which was incomplete. The past enquiry had indicated requesting further information from the manufacturer, but this was never received and the enquiry completed. The current enquiry used information from a poorly written past enquiry and an answer given which later required a follow response to include the manufacturer's information. Incident 16 also stemmed from a manufacturer being contacted for further information. Manufacturers of atorvastatin were contacted to find out if their product was suitable for vegans. The manufacturer was able to provide a response for the 10mg, 20mg and 40mg strengths but had to recheck the 80mg strength. The response was sent whilst waiting for the manufacturer to confirm the 80mg suitability. The manufacturers responded a week later by which time the response had been sent and included the 80mg strength.	• Assess past enquiries before using them. Consider if the data they provide is still clinically relevant and review them for quality. Review the currency of the resources used to answer past enquiries and update as necessary. Review additional resources as necessary. • MiDatabank users can add a note to completed enquiries which raise concern and avoid future use. The note will appear across the top of the enquiry in bold red print. • When requesting information from manufacturers, it is good practice to obtain their information in writing. Where this information is delayed, inform the enquirer and share what data you can to support their decision making with the limited information. Once the manufacturer's information has been received, follow up with the enquirer.
Incident 5 involved researching interactions between cannabidiol (CBD) oil and apixaban. The Natural Medicines Database was used to identify any interactions. During the search, staff selected the commercial CBD Oil product rather than the ingredient. No interactions were identified. Staff then realised they had selected the incorrect entry for CBD Oil and re-ran the search. The interaction information changed and showed a moderate interaction with apixaban which could increase the risk of bleeding. Incident 14 also involved the Natural Medicines Database where Marine Collagen powder had been selected and searched. Searching Marine Collagen provided a different monograph to that found when using the term powder. The monographs were sent to the enquirer. Incident 18 resulted when the interactions search in the Natural Medicines Database gave the wrong preparation. A search for losartan brought back Hyzaar and Cozaar, both of which displayed	• All staff using MI/MA resources should be trained on how to use them and be aware of any limitations of use. • When databases are updated, staff should be given a refresher in using the resource. • Consider keeping searches broad in the Natural Medicines Database to ensure the correct search terms are selected. Include a review of relevant monographs to decide the correct term to use. • Search engines which provide brand names should be reviewed further to cross check to ingredients of the branded product, especially if the database is not UK based. • UKMi has a tips, hints and limitations for use of common medicines information resources.

losartan next to them. This suggested that either product could be used to search for interactions with losartan. On reading the interaction between Hyzaar and calcium, the monograph discussed a thiazide diuretic component. Hyzaar was searched separately and found to be combination product. The Natural Medicines Database did not indicate this when selecting a losartan product for the interaction search. Incident 10 was similar and involved SmPCs for information on porcine derived excipients. Only the excipients section of the SmPCs were consulted and Creon was advised for a patient wanting to avoid porcine products. On reading the full SmPC, the error was identified. Incident 12 also involved SmPCs. The information in an SmPC was copied into a Word document which was later printed. The ingredients list for Forceval was reformatted and no longer matched the SmPC. The calcium content was read as 12mg instead of 108mg. It is not clear if this enquiry was logged into MiDatabank retrospectively.	• Check the terms and conditions of resources that have been purchased to ensure that sharing documents, such as monographs form the natural Medicines database, does not breach your licence. Refer to open access monographs such as Memorial Sloan Kettering Cancer Center – About Herbs or those listed at Herbal interactions: resources to support answering questions – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice. • Remember that some active drug molecules, such as the pancreatins, are animal derived so searching excipient data alone is not sufficient. • When extracting tabulated data from SmPCs for a response, consider taking a screen shot of the table for use in Word. If copying a table into Word, make sure it has transferred properly. • MiDatabank does not handle tables well and can reformat data resulting in errors. • The MiDatabank record should be concise, therefore only record relevant information from a resource. Include enough context to ensure the resource information makes sense. Consider highlighting the most relevant parts in a different colour. • Refer to the UKMi Guidance on documenting enquiries on MiDatabank for tips on documenting relevant information from a resource.
Incident 6 resulted from a lack of understanding on synonyms of a term. A product containing macrogol was advised by manufacturers to be suitable for a patient with a polyethylene glycol (PEG) allergy. The enquirer identified that macrogols and PEG were similar. Incident 11 occurred when an abbreviation was misinterpreted for a literature search. The enquiry related to multiple sclerosis and had been annotated MS. Staff ran a search using Myasthenia Gravis.	• Staff should research sufficiently to understand the scope of the enquiry and consider alternative terms. • Resources such as Martindale provide alternative drug names. • In the case of allergies, anaphylaxis UK provides useful factsheets that provide a basic understanding of the terms used for excipients of concern. • Other useful resources for allergy questions can be found at Understanding excipients in medicines – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice.

	• When using abbreviations, expand the term in the first instance and then abbreviate for the remaining text. • Cross check research terms with the question being asked.

(c) Enquiry answering process – checking or giving the enquiry answer

Incident summary	QRMG recommendations
Incident 8 resulted when some medicines were missed off a list of medicines involved in a temperature excursion. 23 products were sent by the enquirer and 1 medicine missed from the research. Incident 13 relates to a coroner's case where the answer given was misinterpreted by a pathologist during a coroner's court. The clinical outcome from reducing seizure threshold was mis-interpreted.	• Consider using the UKMi Fridge Enquiries Guidelines when reviewing multiple products in a temperature excursion. • Cross check the products in the question and answer before responding to make sure none have been missed. • When writing to non-pharmacists consider the style of writing required and whether information should be made simpler in reference to practical implications. A plain-language summary is often useful provided the meaning is not lost.

(d) Learning from publication errors (new)

Resource	Description of error	QRMG recommendations
Immunisation against infectious disease (The Green Book) https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book	Inconsistent information on giving live vaccines to children born to mothers on immunosuppressive therapies. The chapter on contraindications and special considerations stated delay until 6 months of age with regards to rotavirus. The chapter on rotavirus did not state this contraindication.	Read the specific vaccine guidance in conjunction with the general guidance chapters.

Useful information

Author: Iram Husain, QRMG.ukmi@nhs.net.
Enquiry incident submission: https://forms.office.com/e/wPNkxCc31Y.
Publication incident submission: https://forms.office.com/e/G3TJGJjBn2
Incident reporting guidance, previous ALERTS and Incident Spotlights: UKMI Resources