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

Executive summary

Q3: July to September 2025

Reports	
Total number of enquiry incidents since January 2005: 1135 (rolling total for 2025: 34)	**Total number of publication incidents since April 2013:** 23 (rolling total for 2025: **3**)
Enquiries	**Publications/Pro-active work**
Number for this period: 12	Number for this period: 1
Number of errors: 9	Number of errors: 1
Number of near misses: 3	Number of near misses: 0

Top 3 recommendations from QRMG for this quarter

- High workload was a common theme this quarter. QRMG are writing an ALERT spotlight to support reducing the impact of this risk on the enquiry answering process.
- Mis-hearing words and numbers. See our Spotlight on reducing the risk from mis-hearing information.
- 50% of errors were detected by the person processing the enquiry. This suggests that staff need to slow down and process enquiries carefully.

There were more errors (75%) than near misses (25%) reported this quarter. The potential impact on patient safety assigned by reporters was mainly negligible with 2 not involving any patient and 1 being considered minor. The most common cause for incidents was high workload (50%).

The enquiry types most frequently associated with incidents were administration or dosage (50%), choice of therapy or indication or contraindications (33%) followed by pharmaceutical (17%).

Most incidents were identified by the enquiry processor after they had given the answer out (50%) followed by the enquirer (42%).

When reviewing the stage of enquiry answering, most incidents occurred when giving the answer.

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

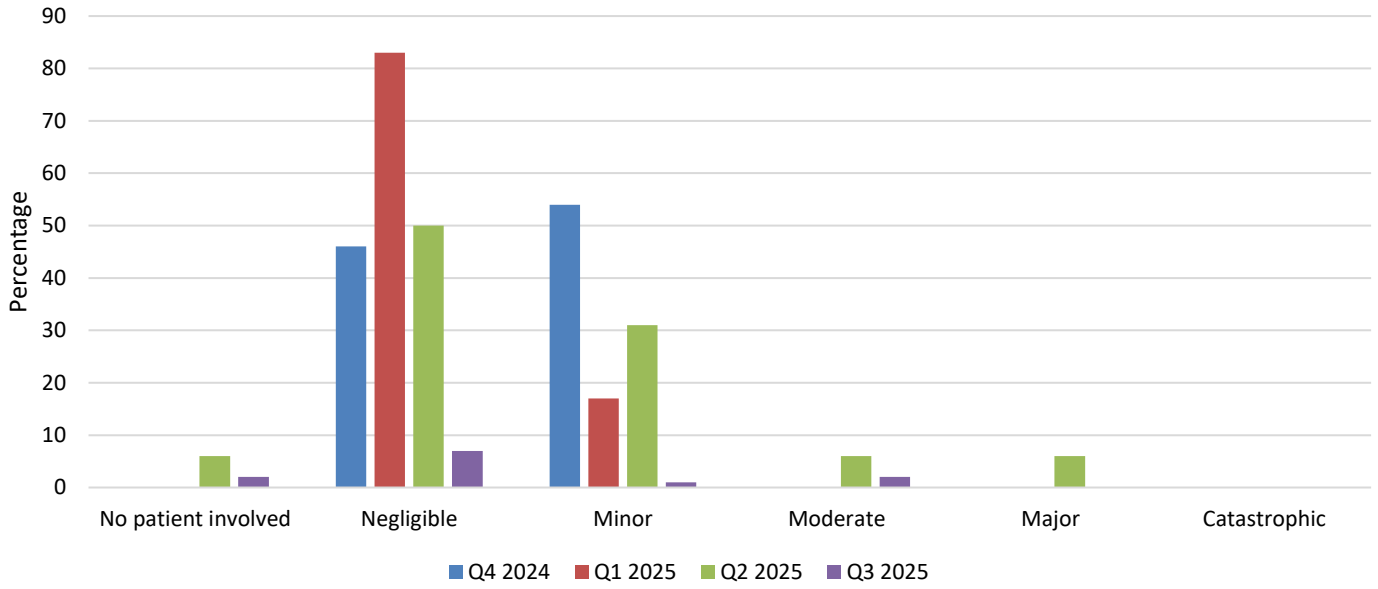


Chart 2: Reported common causes of MI incidents in Q3 2025*

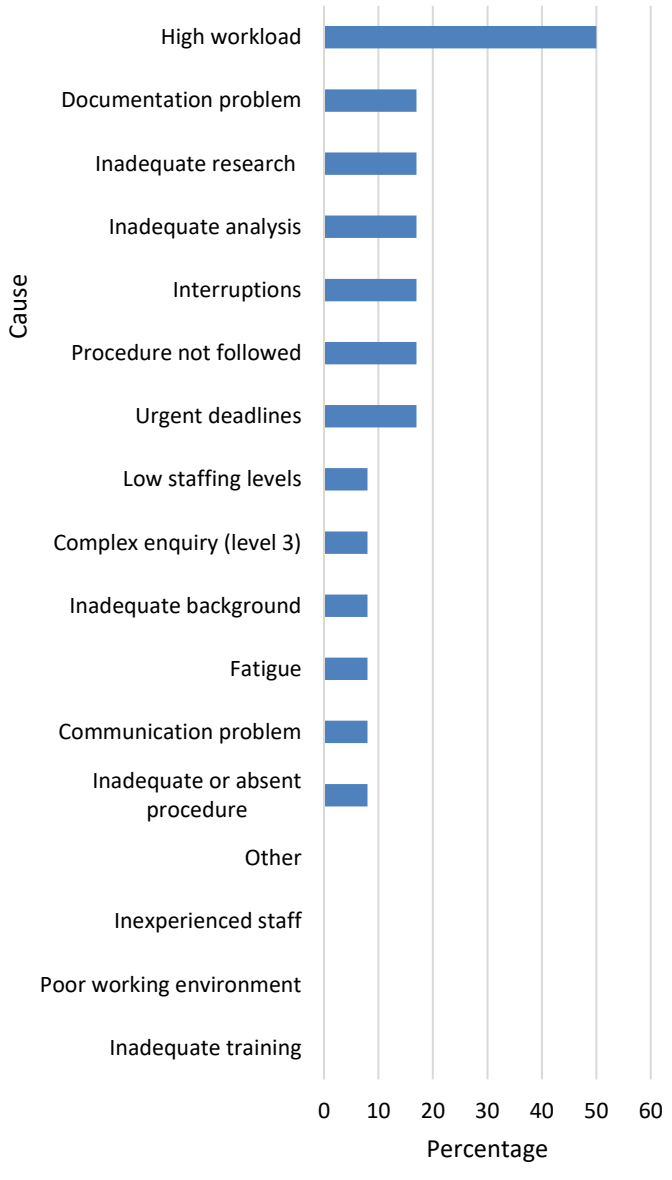
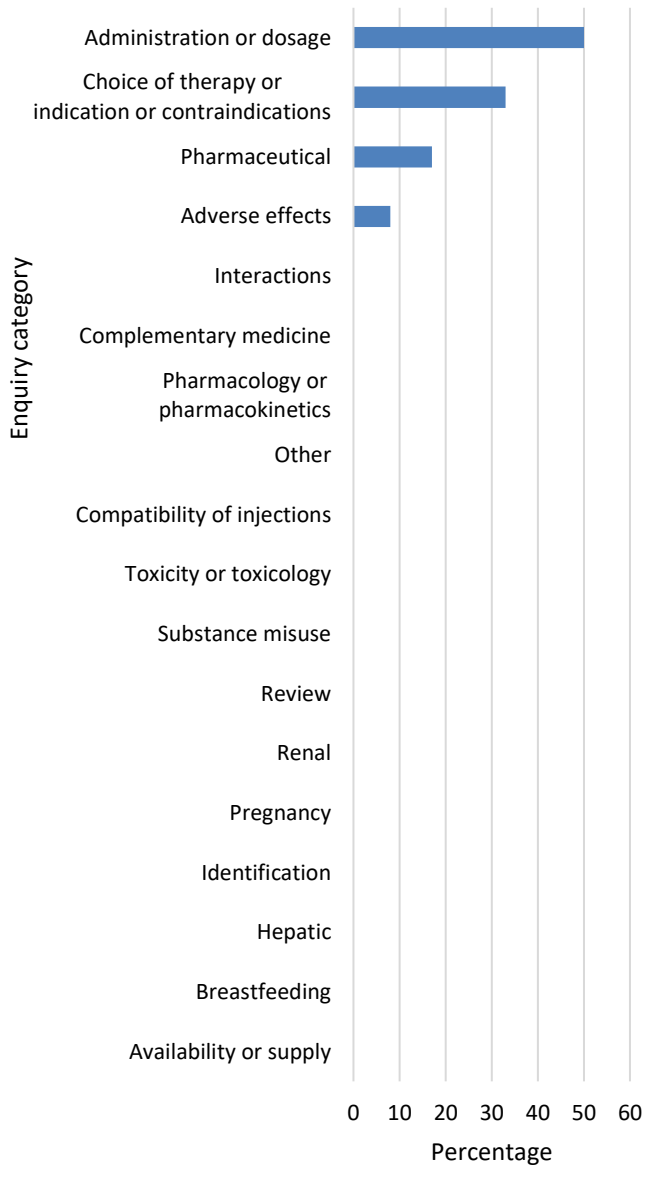


Chart 3: Reported types of enquiry involved in MI incidents in Q3 2025*



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

Chart 4: How reported incidents were identified in Q3 2025

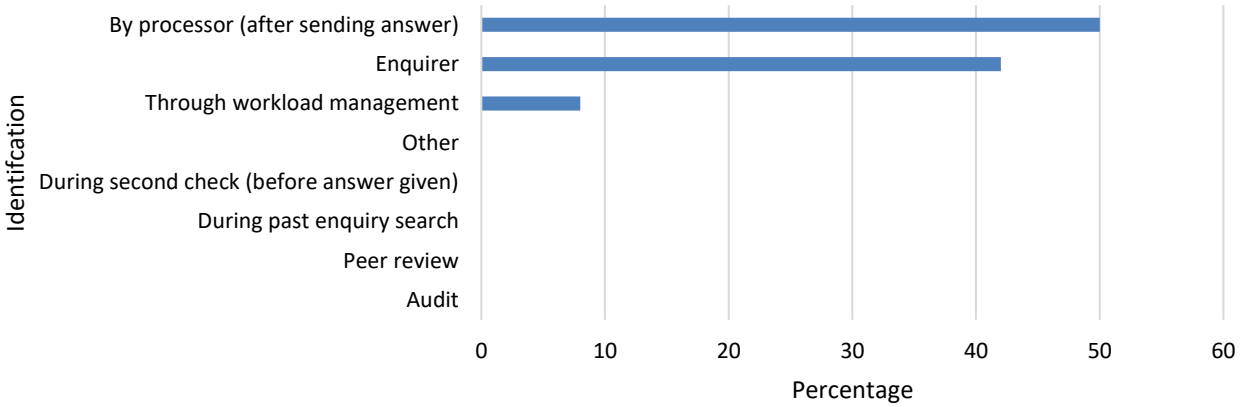


Chart 5: Reported point in enquiry process which triggered incident in Q3 2025

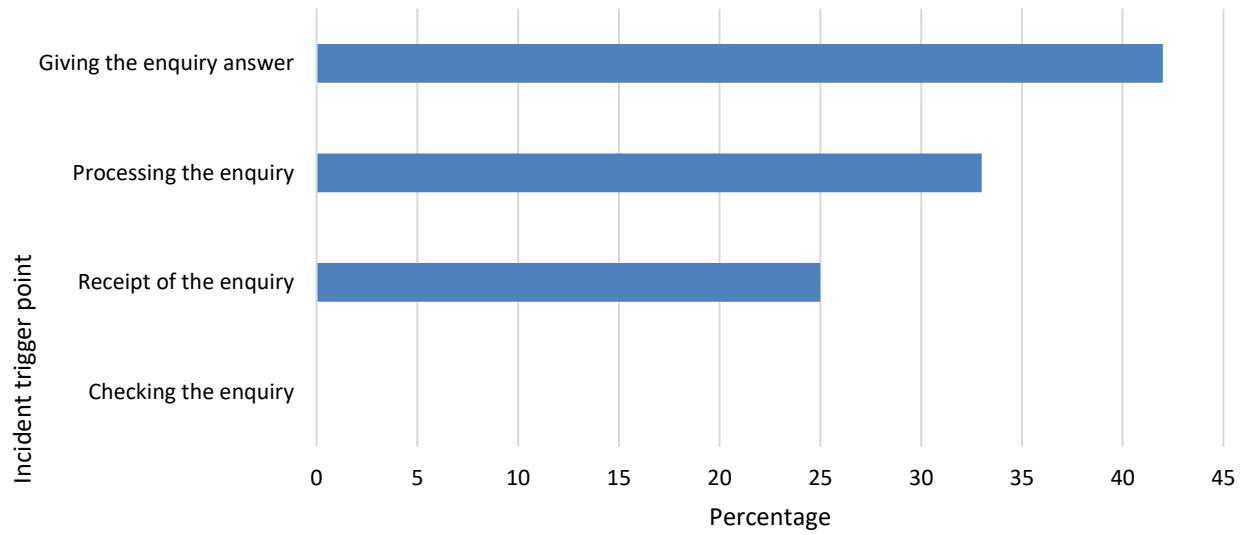


Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 19 resulted when the incorrect temperature excursion was given to the manufacturers. The items had a temperature excursion that lasted about 33 hours at a maximum temperature of 24 degrees. The manufacturers for one product were told 11 degrees. The research had used both SmPC and SPS data before contacting manufacturers.	• UKMi have a suggested template for management of fridge temperature excursion enquiries. See Fridge Enquiries Guidance. • SPS have guidance on managing temperature excursions and where to find fridge stability information. • The Incident Spotlight on Reducing the risk of getting the drug name wrong provides useful tips. • Obtaining the formulation details can catch the error earlier in the enquiry answering processing. • Give yourself time to listen to the caller, note down what you heard and then repeat a summary of the information back to them. If you spot anything unusual, don't make assumptions, confirm it with the enquirer.
Incident 20 occurred when mesalazine 500mg MR tablets were misheard as sulfasalazine. The error was identified when researching as sulfasalazine is not available as MR tablets. Staff were able to listen back to the call and also contacted the enquirer for confirmation of mesalazine. Incident 28 was similar when the dose of omeprazole for child was heard by staff as 14mg rather than 40mg. On this occasion staff had forgotten to spell out the dose and made an assumption that the child would be on a smaller dose. Incident 29 also involved mishearing information given by the enquirer over the phone. The caller had requested information relating to lisdexamfetamine but staff heard dexamfetamine.	

(b) Enquiry answering process – researching the enquiry

Incident summary	QRMG recommendations
Incident 21 related to forgetting an important piece of additional advice when switching from fluphenazine depot injection to either flupentixol or zuclopenthixol. Staff forgot to advise on a test dose which the enquirer later questioned	• Think about the practicalities when switching medicines such as when the next dose should be given and how. • SmPCs for antipsychotics often include first dose advice.

Incident 22 involved a discharge letter enquiry where a GP was questioning if levetiracetam had been stopped on discharge. Staff checked local sources such as the discharge letter, patient notes and the drug chart. The ward pharmacist was on leave. The answer given was to continue. A DATIX investigation identified that the levetiracetam had been stopped. The patient received an extra 10 days of levetiracetam post discharge. Similarly, incident 25 resulted when a patient was advised to stop their mirtazapine due to closed angle glaucoma. The patient did not have this contraindication and stopped their medicine unnecessarily.	• Have a local process in place to investigate discharge questions to ensure if the ward pharmacist is uncontactable then staff know to contact the prescribing team. • All discharge enquiries that highlight an error or near miss should be reported on local DATIX to allow investigation and learning. • Identifying discharge enquiry error trends will help make changes in processes to reduce recurrence. • The Incident Spotlight on Instant answers increase the risk of error provides risk mitigation steps. • SPS provides guidance when advising on delayed or missed doses of high-risk medicines such as Parkinson's medicines. This includes the risk of neuroleptic malignant syndrome when stopping Parkinson's medicines abruptly. • The UKMi Enquiry Answering Guidelines section on ophthalmology are written by Moorfield's Eye Hospital MI pharmacists. This section provides questions to ask and includes identifying the correct type of glaucoma. • Make a local decision as to how far back staff should go when using past enquiries for various scenarios such as clinical questions and temperature excursion questions.
Incident 24 resulted when an answer was giving out over the phone without documentation or full research due to the enquirer putting pressure on staff. A patient was to switch back from rotigotine patches to ropinirole and Madopar and confirmation of when to start oral treatment was required. On retrospective documentation and research in MiDatabank, staff realised that rotigotine should not be stopped abruptly and cross tapering from patch to oral treatments should have been advised in this case.	
Incident 30 occurred when a past enquiry that was over a year old was used for temperature excursion data relating to the ophthalmic medical device Healon GV Pro/ The manufacturers were not contacted for updated excursion data and an error occurred.	

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

Incident summary	QRMG recommendations
Incident 23 was due to two slightly different responses relating to nortriptyline being sent to the same enquirer (one enquiry received). It is not clear why multiple responses were sent.	• Once an answer is finalised and ready for sending in MiDatabank, or other enquiry recording systems, use the control M feature (or similar) to indicate the answer is ready for sending. • Consider adding a resource called 'drafted answer' which can be used in the research section. Keep your drafts and comments in this section instead of the answer field. This will reduce the risk of partial answers or drafted versions being sent accidentally. • Write out your answer before you give it. You are less likely to make mistakes and can use it as a concise summary for verbal responses. • Stop and think before sending patient identifiable data. Do you really need to include it? If so, double check it's the right information going to the right enquirer. • It is good practice to get written responses double checked by a colleague or at least take a break and then come back to your written response with a fresh set of eyes before sending. • UKMi have Guidance on checking medicines information enquiries to aid in deciding when a check is needed and what should be included. • Calculations have a high error rate and should always be double checked by another colleague. Have them workout their answer and compare it to yours.
Incident 26 resulted when the wrong patient identifiers were included in an email sent to an external enquirer. The enquiry related to a discharge summary. Incident 27 was similar when one staff member took in an enquiry, researched it, checked it and sent it. They had made an error in stating how to make up a gentamicin dose for the eye. The answer stated gentamicin 10 to 20mg in up to 50mL rather than in up to 0.5mL. The enquirer later requested clarification of the volume advised.	

(d) Learning from publication errors

Resource	Description of error	QRMG recommendations
Manufacturer medical information department – personal communication	Advised product did not contain any products of animal origin, but it contained lactose. Queried this again with them, and waited for 2 weeks before further reply confirming that it did contain products of animal origin. The manufacturer acknowledged its error on reporting.	It is good practice to get manufacturer responses in writing in case of discrepancy between their initial verbal response and written response. If you think you'll need to contact a manufacturer for their stability or excipient information, inform the enquirer when you take the enquiry in. Explain that there may be a time delay in obtaining information from manufacturers and that you will let them know when responses are expected if delayed.

Useful information

- Author: 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

Summary of Incident Reported Data

Table 2 below provides data taken from individual reports of specific incidents. Please note that where text is presented in *italics*, this text has been amended by the ALERT monitor to minimise the likelihood of identifying the reporting centre and individuals. The information in table 2 is intended solely for the purposes of local discussions to improve service/patient safety through incident sharing and learning and must never be used as a source of information or advice for specific enquiries.

Table 2: Incidents relating to Medicines Information Enquiries

Incident Number	19	**Date of Incident**	2/4/2025	**Incident Category**	A near miss	**Potential risk to patient**	No patient involved
Enquiry Title	Fridge temp excursion						
Summary of Incident	QC usually manage fridge excursion enquiries. I noted on 30/6 that they were very short of staff so offered the MI service to help deal with enquiries. They sent across several, one of which had been sitting there for 10 days and had approx 30 items on it - this needed to be sorted urgently. I cleared the majority using SPCs and SPS but there were a few left to sort out. I checked the costs and decided one product required contact with the manufacturer. I emailed them on 1/7 and stated that the max temp was 11 deg C for approx 33 hrs, this was incorrect, the max temp was 24 deg C. When the company replied I reread the enquiry and realised I'd made a mistake. I've emailed the company to update their response with the correct temp. This info wasn't released to the enquirer. This incident happened because we picked up another team's workload and realised we had an enquiry that needed sorting out urgently, at the same time another enquiry came in that developed into a complex enquiry requiring contact with a variety of HCPs. I was juggling both enquiries in the afternoon as other members of the team worked on other enquiries. On 1/7 I had thought we had band 6 cover in the morning but they had a study day which meant I had less cover than expected						
Solution	I hadn't released the info to enquirer, I've asked the company to update						
Reporter Comment	Discussion in the team about managing workload and ensuring breathing space between writing and sending emails if not being 2nd checked. Potential to ask someone else who wasn't so pressured to send the email to the company to allow me to focus on the complex clinical enquiry.						
QRMG	Click here to see full QRMG recommendations						

Incident Number	20	**Date of Incident**	4/4/2025	**Incident Category**	An error	**Potential risk to patient**	Negligible risk
Enquiry Title	Can mesalazine modified release 500mg tablets be halved or dissolved in water?						
Summary of Incident	Enquiry initially titled whether sulfasalazine 500mg MR tablets can be halved. Done research and found that sulfasalazine only comes as EC tab and not MR tab. Listened back to the call and enquirer wanted information on mesalazine, which does come as a 500mg MR tab. Both mesalazine and sulfasalazine mentioned in the call so emailed enquirer confirming which drug she needed information on. They confirmed it was mesalazine. Research re-done focussing on mesalazine and answer sent.						
Solution	Research was re-done focussing on mesalazine, not sulfasalazine. Answer given focussing on mesalazine only. Informed the line manager of the pharmacist who took in the enquiry. They have arranged a meeting with the pharmacist to discuss the error.						
Reporter Comment	Meeting has not happened yet.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	21	**Date of Incident**	31/3/2025	**Incident Category**	An error	**Potential risk to patient**	Negligible risk
Enquiry Title	Equivalent dose of flupenthixol decanoate or zuclopenthixol decanoate for a patient on depot fluphenazine						
Summary of Incident	I completed an enquiry with advice on how to switch from fluphenazine depot injection to either flupentixol or zuclopenthixol depot for a patient - in my initial email answer I neglected to mention the need for a test dose (this is something I am well aware of and had considered, but for some reason didn't include in my answer). The enquirer emailed back asking if a test dose is needed - I responded with apologies and confirmation that good practice is to give a test dose before starting full treatment dose if the patient hadn't had the drug/injection before.						
Solution	Replied to the enquirer to clarify and apologise for missing that information in my original response.						

Reporter Comment	I plan to try to stop working on multiple enquiries at once, and to not take on too much work - be more realistic with the work load I take on/delegate to others.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	22	**Date of Incident**	5/4/2025	**Incident Category**	An error	**Potential risk to patient**	Negligible risk
Enquiry Title	Discharge medication - levetiracetam						
Summary of Incident	An enquiry relating to a discharge letter. GP noticed that the letter mentioned starting levetiracetam however it did not appear on the medication list therefore asked MI if the patient should be on it. The MI pharmacist checked the discharge letter, notes and drug chart and determined that the levetiracetam had been missed in error. They attempted to contact the ward pharmacist however they were on leave. The MI pharmacist provided an answer stating that the levetiracetam should continue. 10 days later when the DATIX was being investigated the ward pharmacist found that it had in fact been stopped intentionally.						
Solution	The GP was contacted and informed that the patient does not need to be on levetiracetam.						
Reporter Comment	Reiterate process for discharge enquiries to junior staff in MI to speak to the pharmacist involved in the screening of the discharge letter.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	23	**Date of Incident**	6/4/2025	**Incident Category**	An error	**Potential risk to patient**	Negligible risk
Enquiry Title	Nortriptyline - dose to manage IBS symptoms? Is this more effective than amitriptyline?						

Summary of Incident	Two emails were sent in relation to this enquiry—one on 25th July, which was sent in error, and a corrected version on 31st July. Both e-mails contained the same information, however the summaries of both e-mails were worded slightly different to one another.						
Solution	I sent a follow up e-mail to the enquirer, apologising for sending two separate e-mail responses which although had the same answer- had summary information which was written differently.						
Reporter Comment	Ensure to only send response when ready						
QRMG	Click here to see full QRMG recommendations						
Incident Number	24	**Date of Incident**	3/4/2025	**Incident Category**	An error	**Potential risk to patient**	Moderate risk
Enquiry Title	Parkinson's, TD to Oral						
Summary of Incident	Pharmacist on ward who has a Parkinson's patient who's usual medication is Ropinirole 2Mg MR OD and Madopar 125mg QDS (6,10,14,18), had temporarily Switched to Rotigotine Patch 4mg/24° Wants to convert back to oral treatment previously taken, patch due to be removed this evening before discharge, Is it okay to start oral treatment in the morning? Initially advised over the phone as answer wanted urgently as patient about to be discharged home. Advised Abruptly stopping Parkinson's treatment could cause the patients symptoms to worsen. The patient could be converted back to previous oral dosing Discussed that a conversation with the doctors should take place if a stat dose later in this evening would be appropriate until morning dose at 6am. Upon retrospective documentation on MiDB, Past enquiry noted, which discusses BNF and SPC both advise that antiparkinsonian drug therapy including rotigotine should never be stopped abruptly as this carries a small risk of neuroleptic malignant syndrome. The SPC advises that the daily dose of rotigotine should be reduced in steps of 2mg/24 hours with a dose reduction preferably every other day, until complete withdrawal. As the patient had been on TD Treatment for over 48hours there would likely be a need for cross-tapering to reduce the risk of neuroleptic like syndrome. Conversation with colleague for a sense check.						

Solution	Immediately Contacted the Ward Pharmacists to Advise risk of neuroleptic malignant syndrome patient would likely be a need for cross-tapering to reduce the risk. To be discussed with Specialist Parkinson's Disease Consultant or Nurses for Advice on reverting to oral dosing. (Actioned within 30 minutes of incorrect information being provided).						
Reporter Comment	All Enquiries must be documented fully before answers being provided. Contact details for enquirer to be taken for answer to be given once fully confirmed. No Answers should be given immediately over the phone. If enquirer is not happy to be called back to be escalated to the *X* Manager.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	25	**Date of Incident**	7/4/2025	**Incident Category**	An error	**Potential risk to patient**	Negligible risk
Enquiry Title	Patient query: Can mirtazapine + glycopyrronium be given in PMHx glaucoma						
Summary of Incident	Advised patient to stop their medication due to glaucoma however the patient did not have angle closure glaucoma which was the contraindication. The patient did not have to stop their medication.						
Solution	Our specialist ophthalmological pharmacist has sent out an email comparing the different types of glaucoma we should be aware of.						
Reporter Comment	Familiarise myself with the email and different types of glaucoma.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	26	**Date of Incident**	8/4/2025	**Incident Category**	A near miss	**Potential risk to patient**	Negligible risk
Enquiry Title	discharge enquiry- rationale for starting omeprazole						

Summary of Incident	i emailed the enquirer with another patient details. The answer would not have changed- just emailed with another patient details as i received 2 discharge enquiries at the same time and the patient surname was the same as the other enquirers surname and got mixed up and ended up putting wrong patient details in my response back.						
Solution	i apologised for putting wrong patient in the reply and confirmed the answer still remains the same.						
Reporter Comment	to double check the answer and patient details when replying back with an answer.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	27	**Date of Incident**	9/4/2025	**Incident Category**	An error	**Potential risk to patient**	Moderate risk
Enquiry Title	Intracameral vancomycin						
Summary of Incident	We received an enquiry via email regarding the preparation of intracameral vancomycin injections. This was for a patient requiring cataracts surgery who had a history of anaphylaxis with ceftriaxone therefore the first line option, cefuroxime, was unsuitable. I allocated the enquiry to myself, completed the research, wrote and sent a response via email. The answer contained the information as requested as well as contact details of "specials" manufacturers. I also thought that it might be helpful to inform the enquirer of the Moorfields Eye Hospital recommended alternative, subconjunctival gentamicin. Unfortunately, instead of writing "gentamicin 10-20mg in up to 0.5mL" as per the resource, I wrote "gentamicin 10-20mg in up to 50mL". The enquirer responded the following day asking for more information on how to prepare subconjunctival gentamicin. Upon re-reading my initial response, I saw the error. I responded to the enquirer's follow-up email with the required information. I also explained and apologised for the error.						
Solution	I explained and apologised for the error. The email was sent to the enquirer as well as a generic inbox for the team.						

Reporter Comment	Double checking of complex enquiries with a lot of numbers, dilutions and concentrations by myself and another colleague. Sharing and discussing the details with the team,						
QRMG	Click here to see full QRMG recommendations						
Incident Number	28	**Date of Incident**	10/4/2025	**Incident Category**	An error	**Potential risk to patient**	Negligible risk
Enquiry Title	Omeprazole via PEG						
Summary of Incident	Enquirer phoned about choice of formulation for a child requiring a dose of 14mg omeprazole via PEG. Didnt want to prescribe liquids as too expensive. Replied with options then enquirer got back in touch with follow up question and highlighted it was 40mg not 14mg.						
Solution	Emailed back answering follow up question and apologised for mishearing him. Didnt affect first or second answer.						
Reporter Comment	I usually do spell out numbers as well as saying them e.g. 1-4 and 14 but I was rushing and assumed as it was a child it wouldnt be a dose of 40mg.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	29	**Date of Incident**	11/4/2025	**Incident Category**	A near miss	**Potential risk to patient**	Minor risk
Enquiry Title	Choice of antidepressant in a patient on dexamfetamine for ADHD						
Summary of Incident	Took enquiry in over the phone concerning choice of antidepressant with lisdexamfetamine but heard as dexamfetamine.						
Solution	Re-did enquiry looking at correct drug.						

Reporter Comment	-Take more time -Summarise enquirer's question -Change route of taking in calls - work out how to have calls come through headphones to hear better.						
QRMG	Click here to see full QRMG recommendations						
Incident Number	30	**Date of Incident**	21/3/2025	**Incident Category**	An error	**Potential risk to patient**	No patient involved
Enquiry Title	Healon GV Pro Temperature Excursion						
Summary of Incident	the age of the information used to answer this query - it appears to be over a year old and there is no evidence that the manufacturer was contacted again on this occassion to confirm the data previously provided.						
Solution	Discussed with senior - educated team						
Reporter Comment	Agree on a timeline for using past enquiries. Discuss at team meeting.						
QRMG	Click here to see full QRMG recommendations						

Publication errors

Publication incident ID	P8	**Date of incident**	25/06/2025	**Resource involved**	Rx Farma Medical Information department - personal communication	**Type of error**	Unclear or incorrect	**Impact of error**	Serious impact – affect clinical

							information and/or advice		decisions and patient care leading to incorrect treatment or interventions
Error detail	Manufacturer MI department advised product did not contain any products of animal origin, but it contained lactose. Queried this again with them, and waited for 2 weeks before further reply confirming that it did contain products of animal origin. Our query related to a vegan patient, however, if this had been a case of allergy, and manufacturer had given the incorrect advice regarding excipients, it has the potential to be life threatening.								
Outcome	We noted this discrepancy before answering the enquiry, so no harm came to patient in this instance.								
Publisher response to error	*We are documenting this mistake in our system and appropriate preventative actions will be taken.* This was only provided after we replied again stating that we presumed it would be escalated appropriately given initial incorrect reply.								