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

Executive summary

Q4: October to December 2025

Reports	
Total number of enquiry incidents since January 2005: 1146 (rolling total for 2025: 45)	**Total number of publication incidents since April 2013:** 28 (rolling total for 2025: **8**)
Enquiries	**Publications/Pro-active work**
Number for this period: 11	Number for this period: 5
Number of errors: 11	Number of errors: 5
Number of near misses: 0	Number of near misses: 0

Top 3 recommendations from QRMG for this quarter

- Report any errors or near misses involving AI information or advice to UKMi via ALERT.
- Reduce the risk of instant answers resulting in errors by actioning our advice at UKMI Resources.
- Before you give an answer out, take a moment to re-read it or ask a colleague to re-read it for you.

All reports related to errors this quarter. One entry was made in error (incident 37) and removed from analysis. The potential impact on patient safety assigned by reporters was mainly negligible. The most common cause for incidents was communication problems.

The enquiry types most frequently associated with incidents were choice of therapy or indication or contraindications.

Most incidents were identified by the enquiry processor after they had given the answer out (over 60%).

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

There 5 publications errors reported relating to external sources. One involved an AI generated response.

- 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

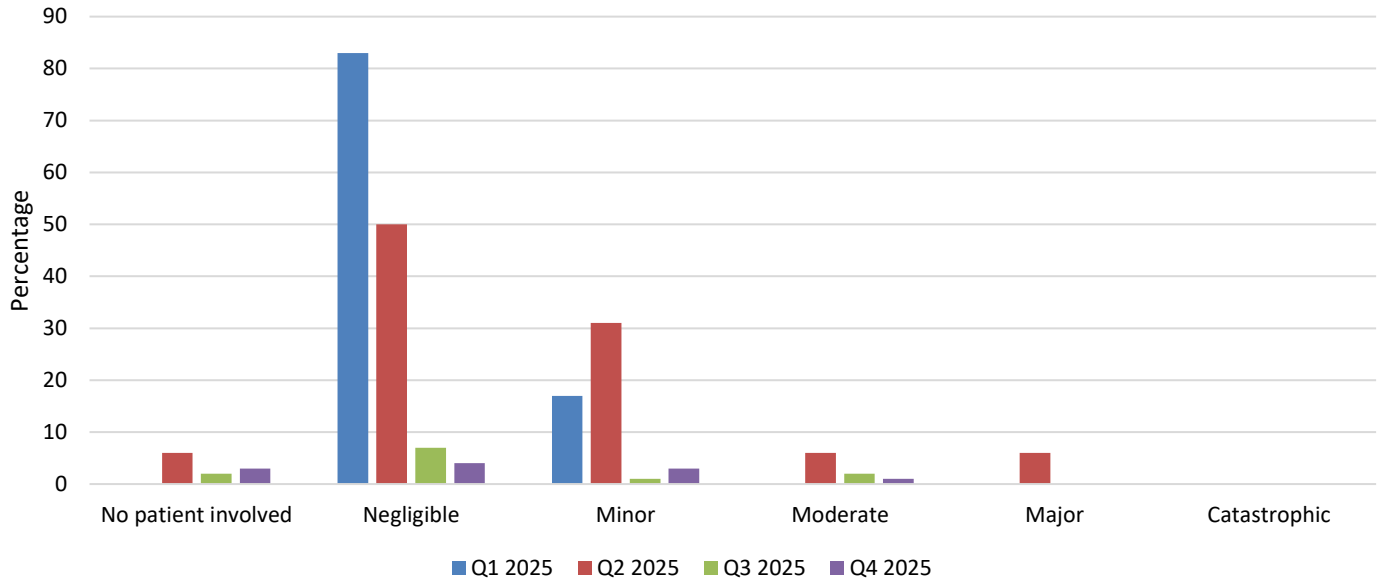


Chart 2: Reported common causes of MI incidents in Q4 2025*

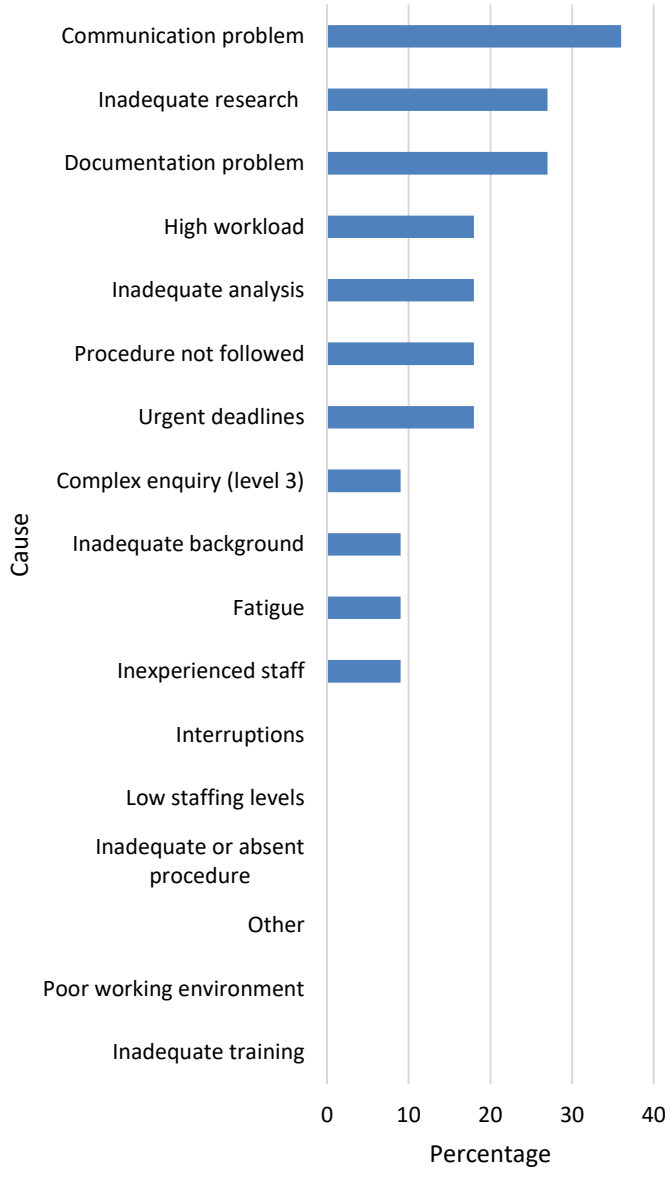
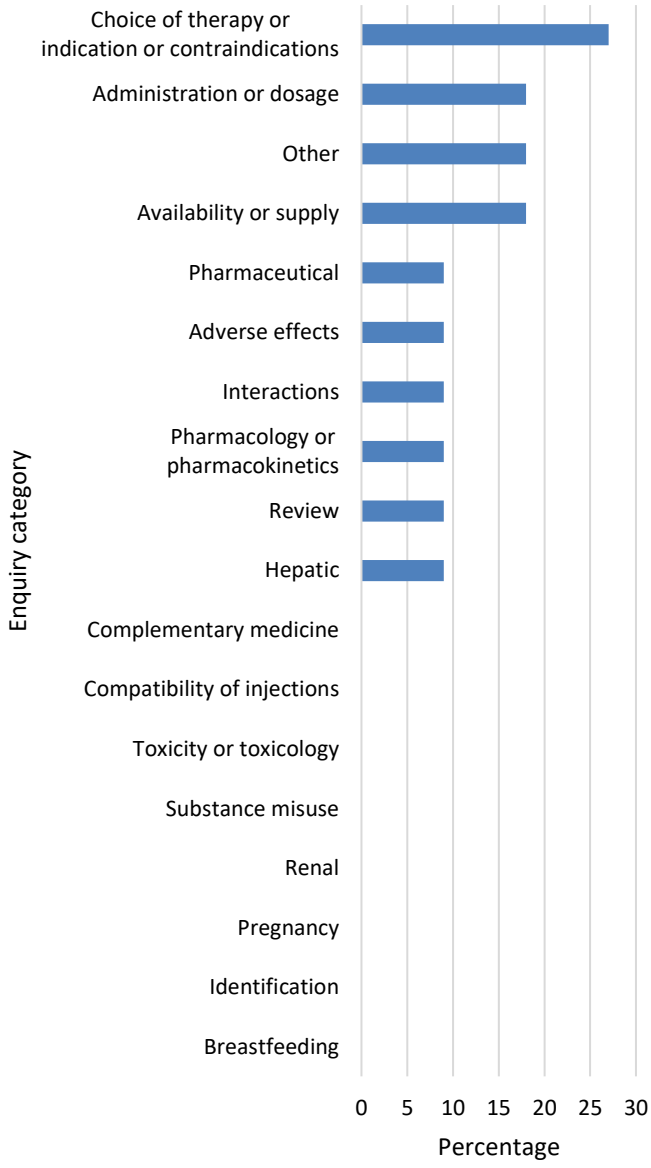


Chart 3: Reported types of enquiry involved in MI incidents in Q4 2025*



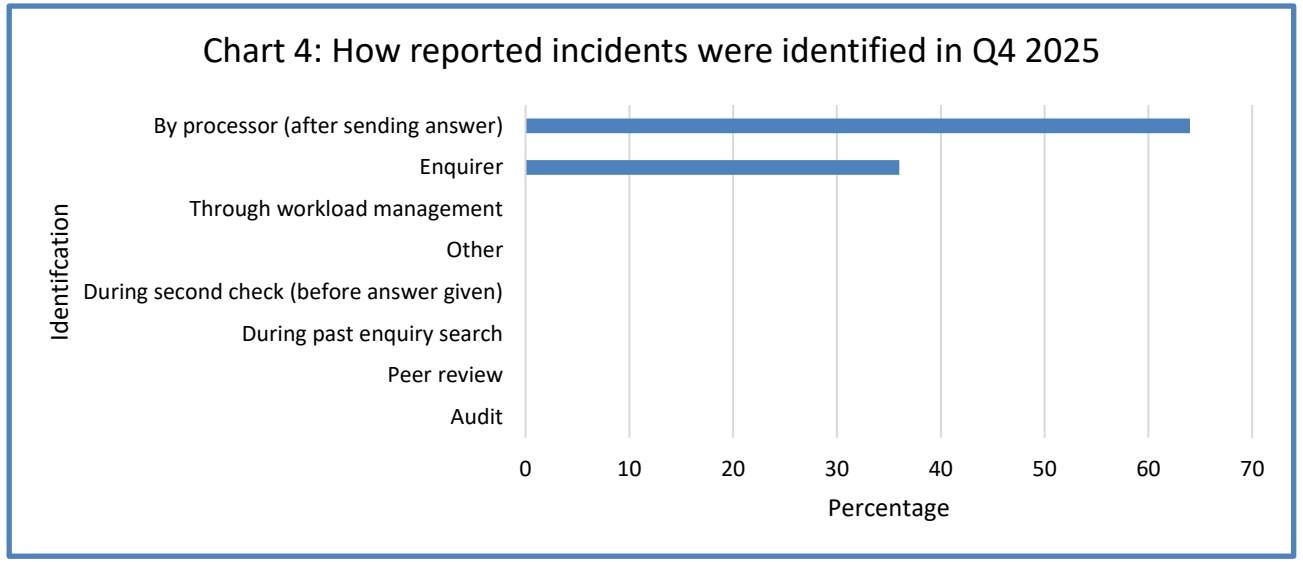


Chart 4: How reported incidents were identified in Q4 2025
Identifcation
By processor (after sending answer)
Enquirer
Through workload management
Other
During second check (before answer given)
During past enquiry search
Peer review
Audit
0
10
20
30
40
50
60
70
Percentage

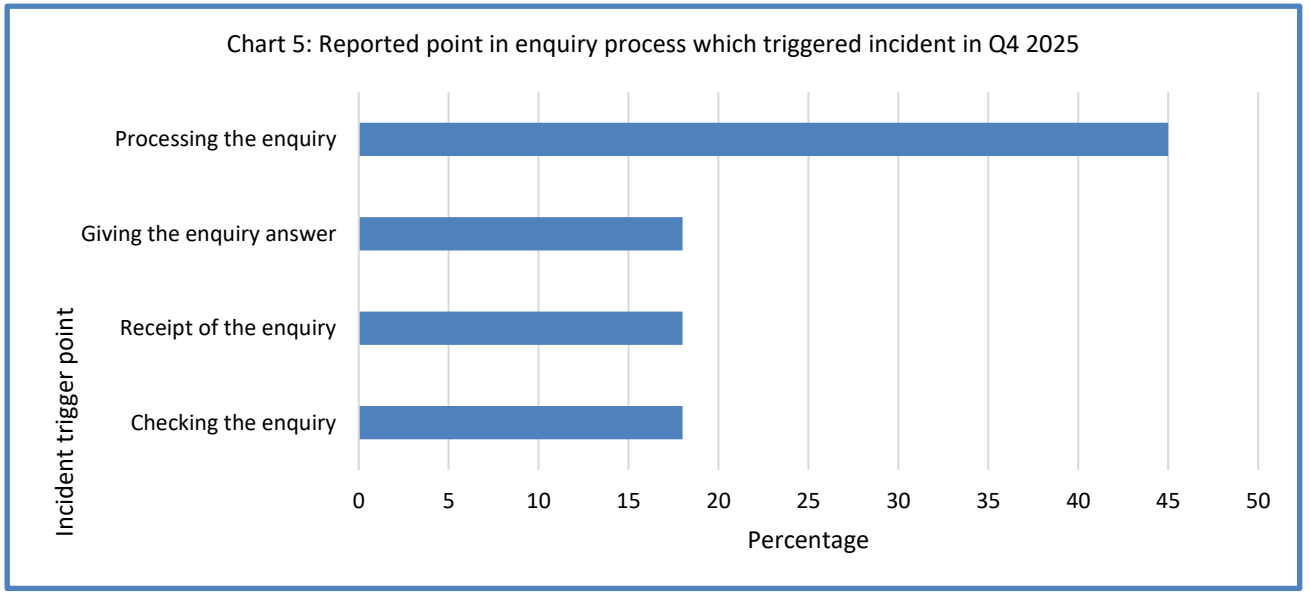


Chart 5: Reported point in enquiry process which triggered incident in Q4 2025
Incident trigger point
Processing the enquiry
Giving the enquiry answer
Receipt of the enquiry
Checking the enquiry
0
5
10
15
20
25
30
35
40
45
50
Percentage

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 39 was about switching valproate from IV to oral. Although the dose conversion advice itself was correct, the documentation did not accurately reflect the true valproate dose due to a mismatch between sources. This was identified but the documentation was not updated.	• Repeat the question back to the caller to clarify the question(s) you will research and answer. • Before finalising the documentation, re-read what has been written. • For complex dosing regimens, reconcile the doses by checking available resources such as Trust patient record, GP record, ward pharmacist, prescriber and drug chart. • Accuracy check enquiries before archiving. • Document enquiries directly into the enquiry answering database on receipt.
Incident 40 occurred when the question was recorded incorrectly as choice of analgesia and anticoagulation in a patient with liver disease. On giving the answer, the actual question was about a patient with an acute rise in LFTs and how to manage their medicines, e.g. could the medicines have caused the change. The initial incorrect question led to unnecessary research in the wrong direction.	
Incident 41 resulted when a question was not documented directly into the enquiry record system. A question about Oramorph solution containing black particles was recorded in a notepad to escalate with the manufacturer. The entry was not transferred into the enquiry recording database for processing and a delay in reporting occurred.	

(b) Enquiry answering process – researching the enquiry

Incident summary	QRMG recommendations
Incident 33 resulted when the advanced search on the eMC used a single term for soya excipients. Two contraceptives were recommended that were later found to contain soybean. The advanced search used ‘soya’ as the term.	• Be aware of synonyms for excipients and consider running each through the eMC advanced search when section searching. • Useful resources for synonym checking include Pharmaceutical Excipients and Martindale: The Complete Drug Reference.

Incident 34 occurred due to inaccurate pharmacy stock information. The enquirer requested capsules as an alternative to IV L-carnitine and was advised none was stocked. The local stock database only listed L-carnitine available as injection. The ward later attempted to re-order L-carnitine capsules from Pharmacy. The late duty pharmacist located and supplied a liquid formulation. This created inconsistent messaging and delayed supplying the patient during pharmacy opening hours.	• Train staff on how to use the advanced search of the eMC using sites such as Searching for presence or absence of an excipient in medicines – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice. • For unusual enquiries, consider briefing the late duty pharmacist or allowing read only access to MI enquiries in case they are asked the same question. • Where stock discrepancies arise, follow up with pharmacy stores to ensure stock entries are reviewed to avoid a repeat. Consider how these enquiries could be tagged in enquiry recording systems, such as MiDatabank, to record MI impact. • Avoid adding additional risk by responding to questions over the phone without taking time to document and reflect on the question. • Document at the time of the enquiry rather than retrospectively, including research. • See our UKMi Incident Spotlight on instant answers increasing the risk of errors.
Incident 35 involved responding to an interactions enquiry whilst the caller was on hold. The research involved multiple medicines including warfarin with dasatanib. The interaction with warfarin was missed and come to light when the enquiry was documented later. A relevant CYP-mediated interaction was omitted from the advice given due to time pressure.	
Incident 38 also involved answering a question over the phone with the enquirer on hold. The enquirer requested switching information for Symbicort DPI to MDI. Advice was given to get clarity from the respiratory team regarding the MDI since MI staff could only see DPIs listed in the BNF and eMC. When documenting the enquiry retrospectively, the Symbicort MDI was located in the resources used originally. The earlier verbal advice had not been fully checked.	

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

Incident summary	QRMG recommendations
Incident 31 occurred when an answer was given to the wrong enquirer. The response was accidentally emailed to the wrong enquirer due to selection of an incorrect address. This meant confidential information was sent to an unintended recipient and the correct enquirer did not receive their answer on time.	• When taking in enquiries, double check the enquirer contact details. • When sending answers, re-check the information in all fields of the email before clicking send. • Avoid including unnecessary patient identification information in written responses. • It is good practice to have written responses double checked. If you are a lone worker, take a break and re-read your answer before sending. • Apply second-check processes for formulary wording, like any written response. • Use standard templates for monographs to reduce risk of errors. • Record publications incidents using Incident Reporting in Medicines Information/Advice: Publications and Resources.
Incident 32 involved incorrectly describing nefopam as an NSAID in the opening sentence of a written response. Although the rest of the answer correctly explained its mechanism of action, the misclassification was only noticed later during further work on the enquiry.	
Incident 36 was recorded as an enquiry error but related to a formulary publication. The formulary text for Eurneffy nasal spray did not accurately reflect its restricted approval for use only within a paediatric oral food challenge service. The published wording suggested broader approval, which could have led to inappropriate prescribing.	
Incident 42 was also a publication error but reported as an enquiry error. A formulary entry for buprenorphine was coded as RED for hospital-only use, but the correct status was RED for a specific mental health Trust. The wording did not match approval emails, creating a risk of misunderstanding its authorised use at the Trust.	

(d) Learning from publication errors

Resource	Description of error	QRMG recommendations
Artificial intelligence (possibly Google Gemini)	A caller asked AI for the safety of formoterol in pregnancy. The AI summary suggested formoterol wasn't safe and the patient refused their inhaler.	Report all AI related errors or near misses from enquiry processing or publication use to UKMi as per UKMI Resources. MI staff should be familiar with the UKMi AI position statement at UKMI.
Green book: Immunisation against infectious disease	Time to wait before giving infants live vaccines when the mother was on vedolizumab in pregnancy. The Green Book advises delaying live vaccines until 6 months of age in infants exposed to immunosuppressive biologics. However, the Green Book's rotavirus chapter suggests that rotavirus vaccine should still be given on the normal schedule because the benefits outweigh the risks, and it does not list maternal biologic exposure as a contraindication. Based on this, the initial interpretation was that rotavirus vaccine should be given at 2 and 3 months as usual. Later, the pharmacist found a newer 2025 BSG guideline recommending waiting 12 months.	Publishers have said they are updating chapter 6.
Abbvie Temperature Excursion Tool	The manufacturer's temperature excursion tool does not match the information in the SmPC. Both times and temperature mismatch.	Manufacturers confirmed the SmPC is correct and the tool will be updated.
Nifedipress MR SmPC	Minor typo where rabbit had been spelt rebbit in the pregnancy section.	Manufacturer to be notified by reporter
Incorrect Yellow Card link embedded in MiDatabank	A local MiDatabank was still directing users to the old iDAPs website, which is no longer updated. The	MI staff should routinely review the UKMi Essential Resources List (ERL) which highlights resource

	MHRA has a new iDAPs platform, and the two versions contain different numbers of ADR reports. The problem came to light during an MI enquiry when the number of ADR reports retrieved from the old iDAPs site did not match the figures shown on the new MHRA iDAPs website. This discrepancy made it clear that MiDatabank was linking to an outdated, obsolete resource, which risks MI staff using incomplete or outdated ADR data when answering enquiries.	changes. This resource is currently undergoing a full review. Any errors in the ERL or MiDatabank resource master list should be reported to qrmg@ukmi.org.uk and CoAcS respectively. Enquiry related errors should be reported using Incident Reporting in Medicines Information/Advice: Enquiry.

Useful information

- Author: qrmg@ukmi.org.uk
- 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