

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

Executive summary

Q1: January to March 2026

Reports	
Total number of enquiry incidents since January 2005: 1158 (rolling total for 2026: 12)	Total number of publication incidents since April 2013: 31 (rolling total for 2026: 3)
Enquiries	Publications/Pro-active work
Number for this period: 12	Number for this period: 3
Number of errors: 3	Number of errors: 3
Number of near misses: 9	Number of near misses: 0

Top 3 learning from QRMG for this quarter

- Focus on not rushing enquiries.
- Understand and use resources properly.
- Understanding how Large Language Models (LLM) AI systems work and the risks they contribute.

No incident in Q1 2026 resulted in a major or catastrophic risk to patient care.

The most common cause of incidents were inexperienced staff and other. Other causes were described as:

- Poor handover and multiple revisions of written answer
- Similar organisation names close together in drop down list

The main enquiry type involved was pharmaceutical with 5 incidents involving temperature excursion enquiries.

Most incidents were detected after sending the answer, through workload management or during a 2nd check (before sending the answer).

Half of the incidents reported occurred during enquiry processing (researching). One incident was a duplicate.

There were 3 publication errors reported relating to external sources. One involved an AI generated response citing a hallucinated reference.

Report data

- 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

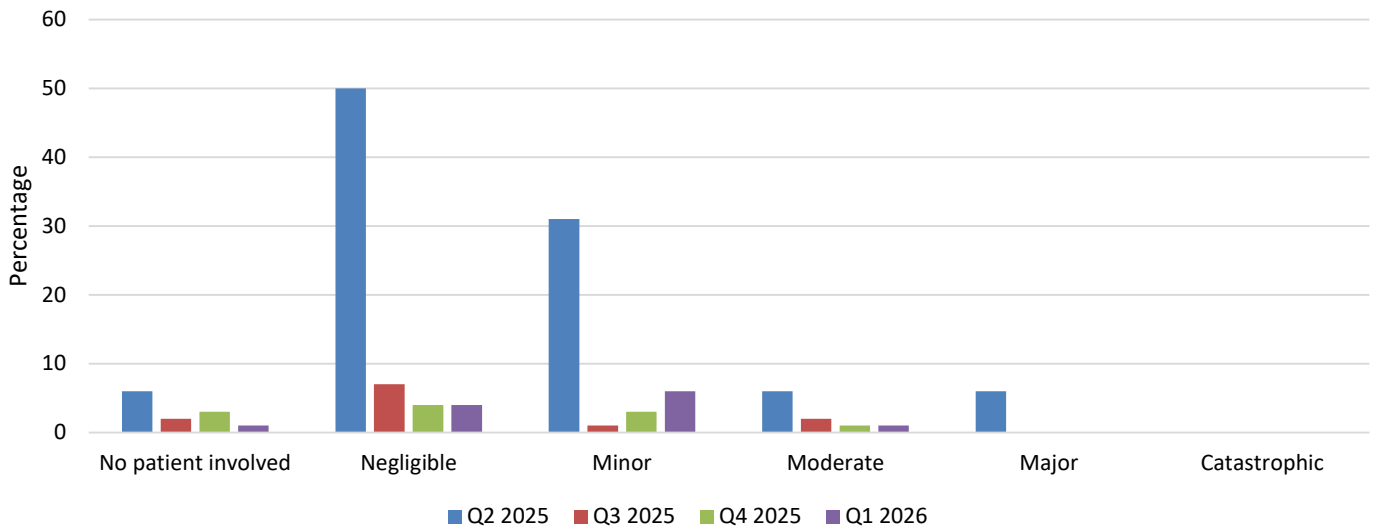


Chart 2: Reported common causes of MI incidents in Q1 2026*

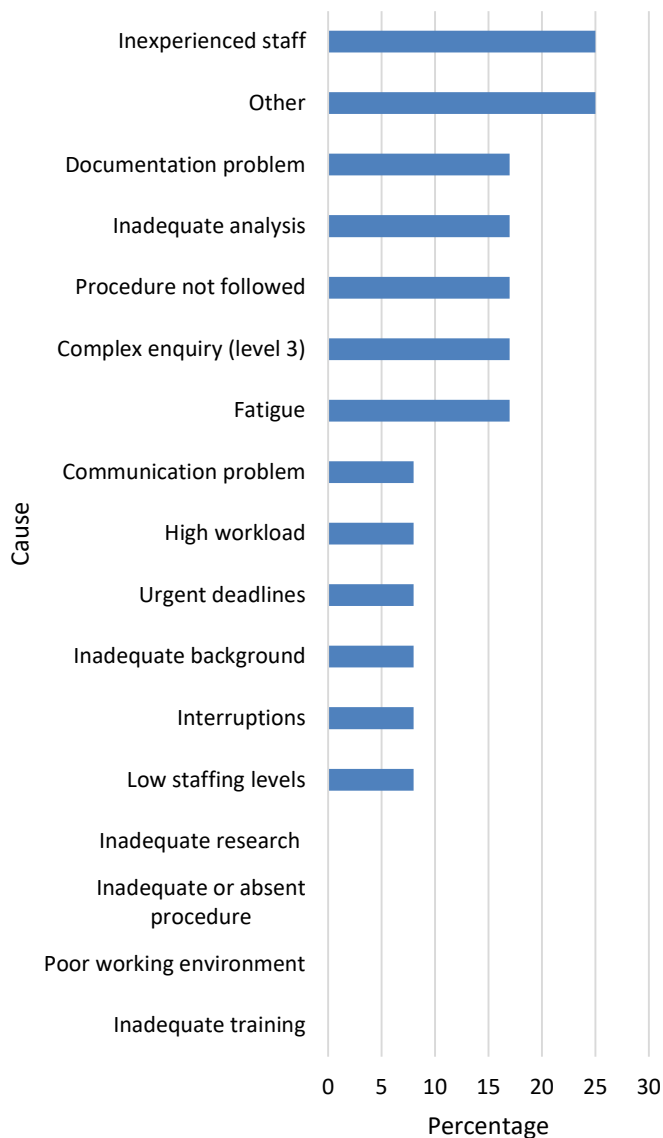
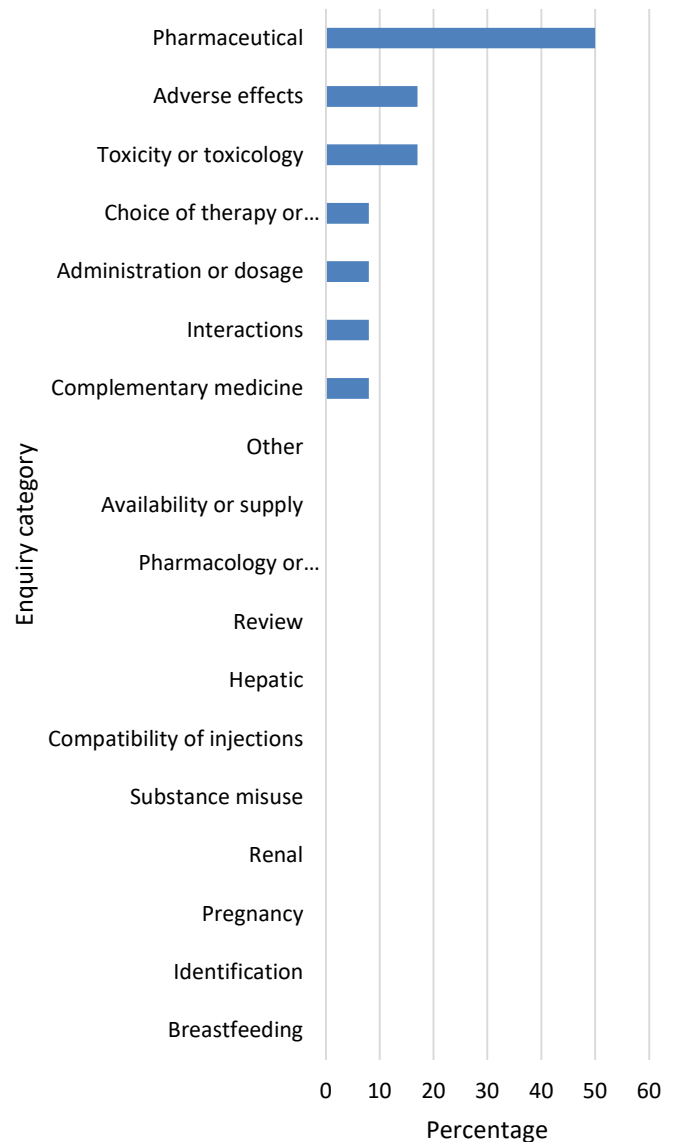


Chart 3: Reported types of enquiry involved in MI incidents in Q1 2026*



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Incident Reporting in Medicines Information Scheme (IRMIS)

Chart 4: How reported incidents were identified in Q1 2026

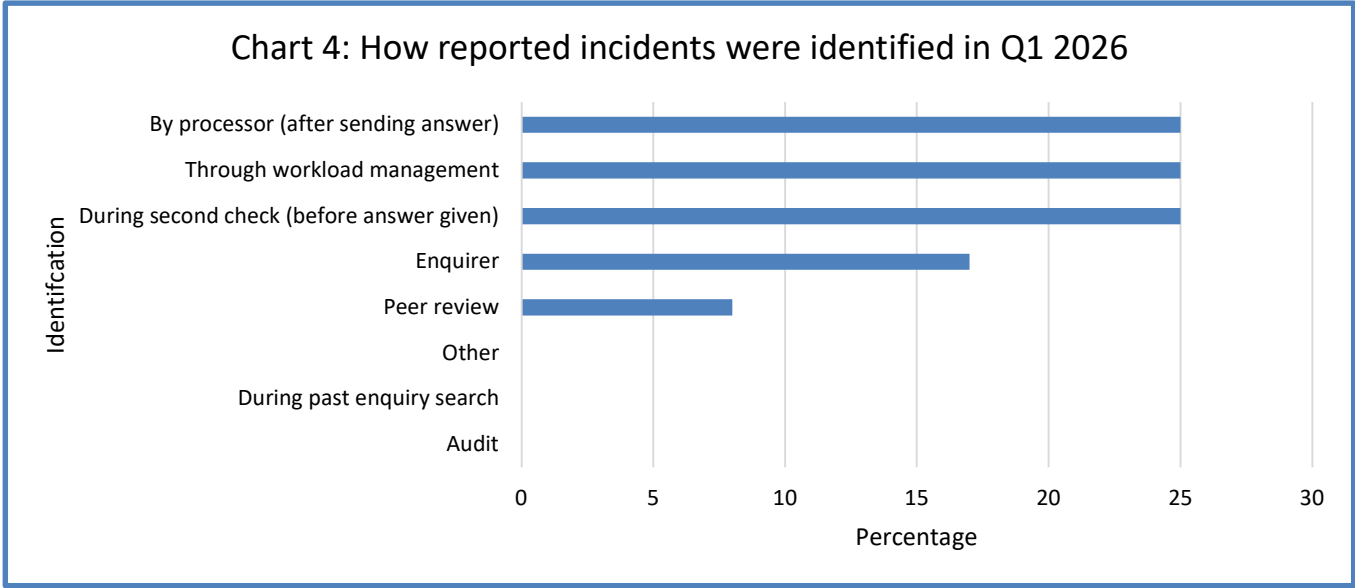
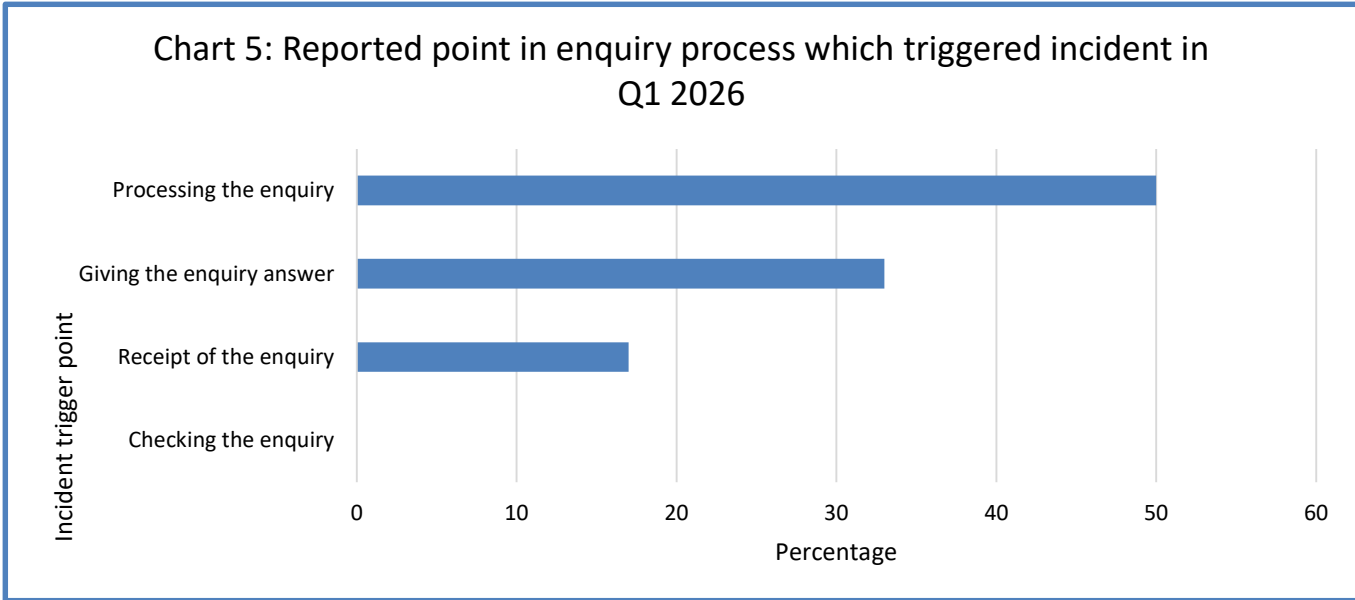


Chart 5: Reported point in enquiry process which triggered incident in Q1 2026



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

Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
<p>Incident 44 resulted when the answer was sent to the wrong email address. The enquiry came from a patient regarding interactions between complementary products and their conventional medicines. The email address taken was incorrect and the incident identified when the patient contacted the MI service to chase their answer. The answer contained no patient identifiable data.</p>	<ul style="list-style-type: none"> • Repeat the caller’s contact information before ending a call. • Log the user’s contact information in an enquiry management database such as MiDatabank and recheck it each time they contact the service. • Where calls are recorded, listen to the recording when the caller has given their contact details, but staff did not repeat it. • For email enquiries, reply to the original email and maintain the contact’s string. • Trust email disclaimers do not replace duty to act. Even if a disclaimer exists, contact the recipient if sensitive information is sent in error. • Avoid including personal data (information that could identify a person) in communications unless it is needed. • See the UKMi Incident Spotlight on reducing the risk of getting the drug name wrong. • See the UKMi guidance on documenting enquiries on MiDatabank (Jan 2022) and CoAcS MiDatabank Quick Start Guide (Version 3.0).
<p>Incident 49 occurred when apixaban was misheard as edoxaban for an interaction enquiry involving prednisolone. The answer did not change.</p>	
<p>Incident 52 was due to a new enquirer on MiDatabank being entered with the wrong organisation details (contact and address). The enquiry was completed and the error spotted later. A note was added to the archived enquiry to highlight the error.</p>	

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(b) Enquiry answering process – researching the enquiry

Incident summary	QRMG recommendations
<p>Incident 43 occurred when a specialist enquiry regarding deprescribing of venlafaxine lacked use of information from the Maudsley Deprescribing Guidelines. The omitted information reduced the options available to the prescriber for deprescribing.</p>	<ul style="list-style-type: none"> • Consult specialist resources where required as suggested in the UKMi Essential Resource List (ERL) and UKMi Enquiry Answering Guidelines (EAG). • Ensure you are aware of the specialist resources available within your own centre and consult them as appropriate. Consider using the ‘recommended resources’ tab in enquiry management databases such as MiDatabank to list your local resources. • Consider the wider clinical context and implications of the enquiry, not just the specific question asked. • When handing an enquiry over for completion, review the enquiry questions and research with the staff handing over before proceeding. Ideally avoid handing over where possible to reduce duplication of effort and risk of information being omitted. • The Specialist Pharmacy Services (SPS) has some information on deprescribing and will be producing a series of resources to support further. • Document research as it is done, not retrospectively. • Do not feel pressurised into giving an answer out without taking time to stop, review and formulate an answer. Do not equate perceived urgency with clinical urgency. • Staff should feel empowered to agree realistic deadlines and clearly manage enquirer expectations in the interests of accuracy and patient safety. • See the UKMi Incident Spotlight on reducing the risk of errors from giving instant answers and the guide on managing high workload and pressures.
<p>Incident 45 was the result of researching whilst the caller was on the phone and retrospective documentation. The BNF was checked to advise on how to manage a double application of buprenorphine 40mcg/hr patches. The information in the BNF varied by Brand and the incorrect information was read out. The answer did not change.</p>	
<p>Incident 46 resulted when staff were asked to find lactose free preparations of mirtazapine, olanzapine and venlafaxine. The Brand of mirtazapine advised as lactose free contained lactose according to the SmPC excipient list. This was realised on the next working day.</p>	
<p>Incident 53 was the result of staff not considering other medical terms for side effects when researching if aspirin, atorvastatin or lansoprazole could cause stomach pain and mouth ulcers. Stomatitis was missed when reviewing the side effects of lansoprazole and malaise was not considered for tiredness (another side effect described by the patient).</p>	

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	<ul style="list-style-type: none">• Consider referring to Searching for presence or absence of an excipient in medicines – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice when running an eMC advanced search.• See Assessing the clinical impact of lactose in medicines – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice to understand the impact of lactose as an excipient.• When reviewing medical terms, check understanding using a medical dictionary or the NHS Digital SNOMED CT Browser. The latter is a structured clinical vocabulary to code for diseases, symptoms, procedures, tests, substances and medicines.• Checking terminology can help ensure symptoms and side effects are appropriately identified and not overlooked.
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(c) Enquiry answering process – checking or giving the enquiry answer

Incident summary	QRMG recommendations
<p>Incident 47 occurred when a fridge excursion was investigated and the incorrect information given to keep the product when the SmPC advised a maximum of 30 days for reuse. The medicine involved was not stated.</p> <p>Incident 48 was similar when the information in the Refrigerated medicines stability tool – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice was misinterpreted and incorrect advice given. The medicine involved was not stated.</p> <p>Incident 51 related to misinterpreting the lorazepam information in Refrigerated medicines stability tool – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice.</p> <p>Incident 54 also involved a fridge excursion but occurred when the incorrect manufacturer was contacted for aflibercept information.</p>	<ul style="list-style-type: none"> • Refer to the UKMi advice when checking MI enquiries. • Consider using the SPS Refrigerated Medicines Stability tool with the SPS advice on Managing temperature excursions. The UKMi Fridge enquiries guidance is currently under review by QRMG and SPS.

(d) Learning from publication errors

Resource	Description of error	QRMG recommendations
The syringe Driver by Dickman. 4 th edition (book)	The concentration or dose of haloperidol in the combination of morphine, haloperidol and metoclopramide does not equate to that stated in the syringe.	<p>Publisher to be notified by local reporter.</p> <p>It is good practice to use a minimum of 2 resources when researching enquiries.</p>

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Google Gemini	AI asked 'pilocarpine tablets crush and dispersed'. The citation referenced in the AI answer did not support the conclusion that Salagen tablets could be crushed and dispersed as they were not modified release. The answer is likely to be correct, but the references used did not support the answer given.	Refer to the UKMi position statements on the use of AI in MI services and by NHS professionals when answering medicines-related questions . AI is not an evidenced based resource.
Briggs Drug in Pregnancy and Lactation 12 th edition 2021 (book)	The mexiletine monograph refers to a case study where a mother took 200mg 3 times a day. The original 1987 reference states that the mother took 250mg 3 times a day. The dose quoted in Briggs is lower than that in the case study.	Publisher to be notified by local reporter.

Useful information

- Author: grmg@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](#)