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

Executive summary

Q2: April to June 2026

Reports	
Total number of enquiry incidents since January 2005: 1169 (rolling total for 2026: 23)	**Total number of publication incidents since April 2013:** 39 (rolling total for 2026: **11**)
Enquiries	**Publications/Pro-active work**
Number for this period: 11	Number for this period: 8
Number of errors: 7	Number relating to own MI publication: 2
Number of near misses: 4	Number relating to an MI resource: 6

Top 3 recommendations from QRMG for this quarter

- Implement a "clarify and confirm" approach for all enquiries by obtaining complete clinical details, repeating key information back to the enquirer, and documenting the exact clinical question before commencing research.
- Avoid immediate responses where adequate research cannot be completed safely.
- Introduce a verification step before emailing answers, including confirmation of recipient details and key facts within the response.

Most enquiry related incidents related to errors this quarter. 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, and administration or dosage.

Most incidents were identified by the enquirer (over 30%).

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

Of the 8 publications errors reported, 7 related 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

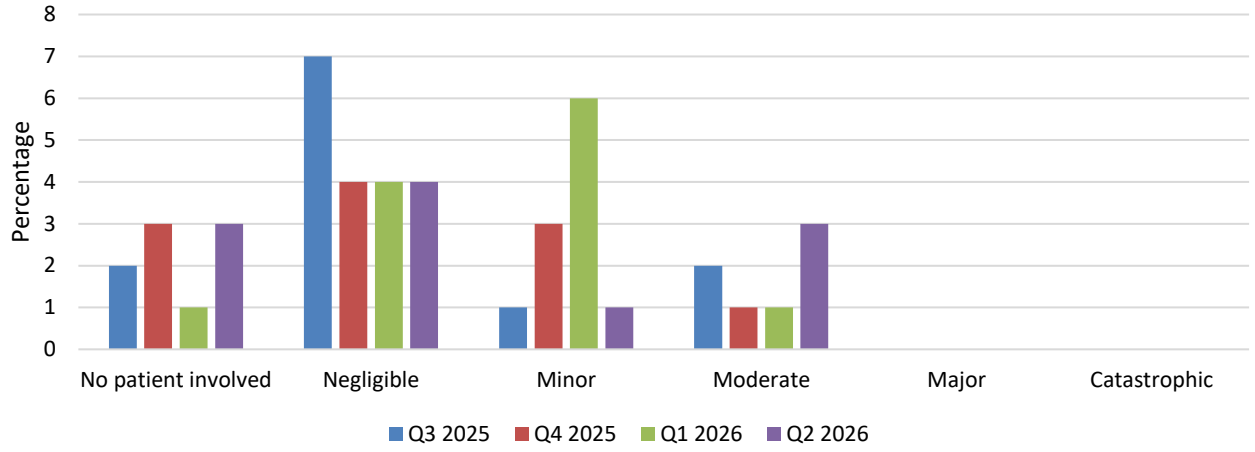


Chart 2: Reported common causes of MI incidents in Q2 2026*

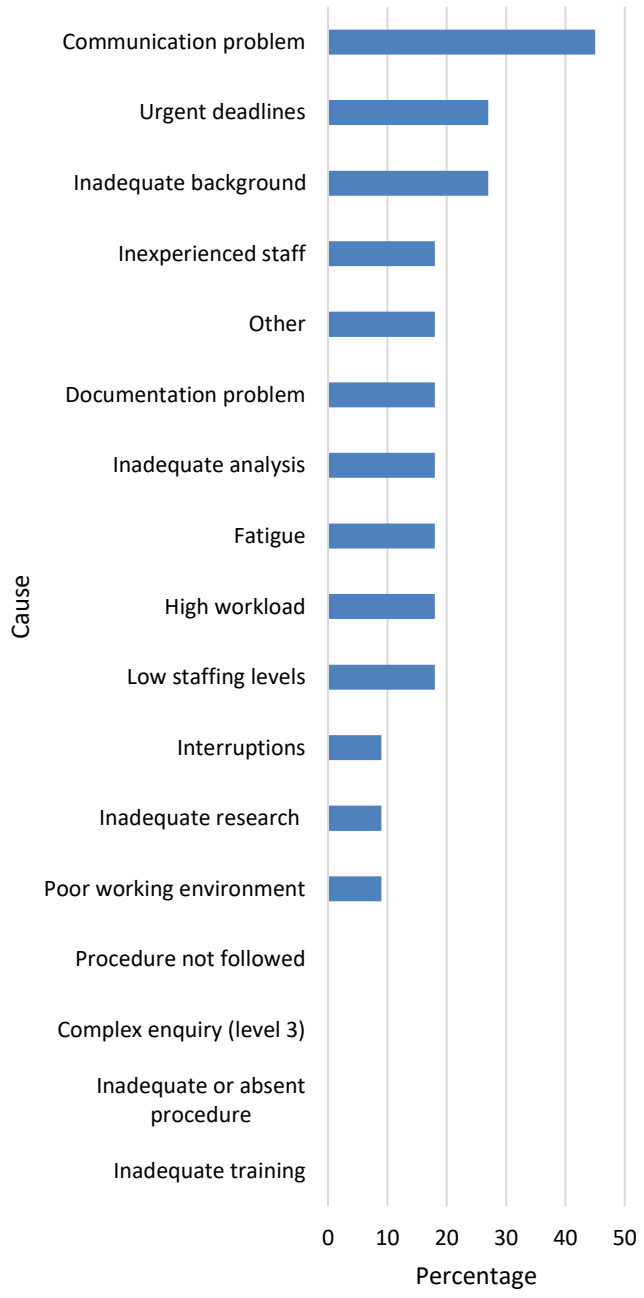
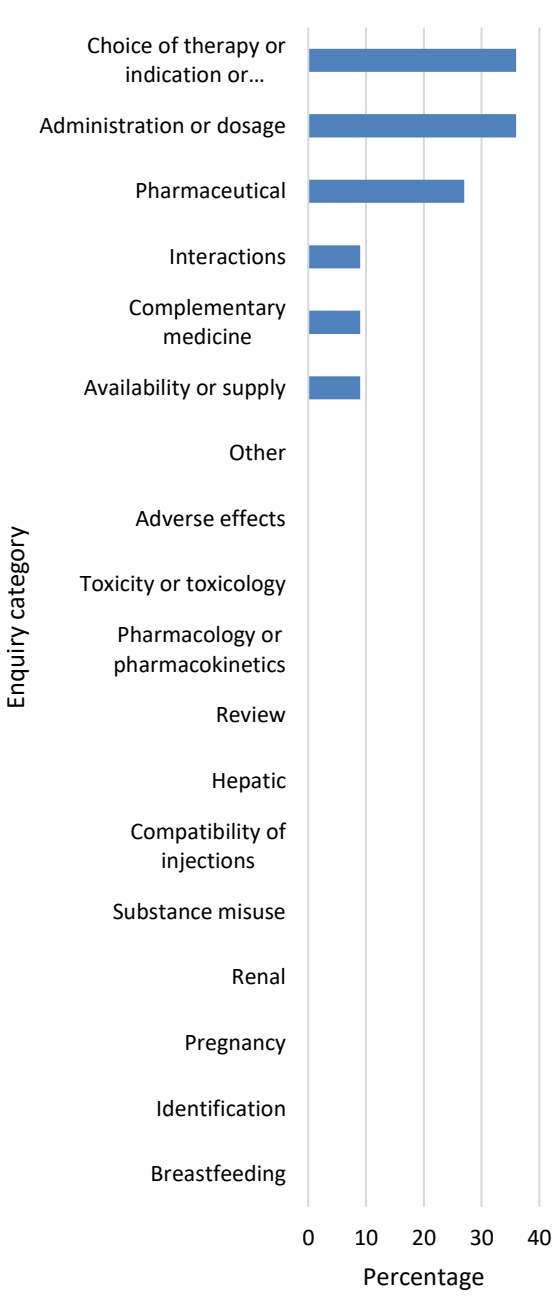


Chart 3: Reported types of enquiry involved in MI incidents in Q2 2026*



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

Chart 4: How reported incidents were identified in Q2 2026

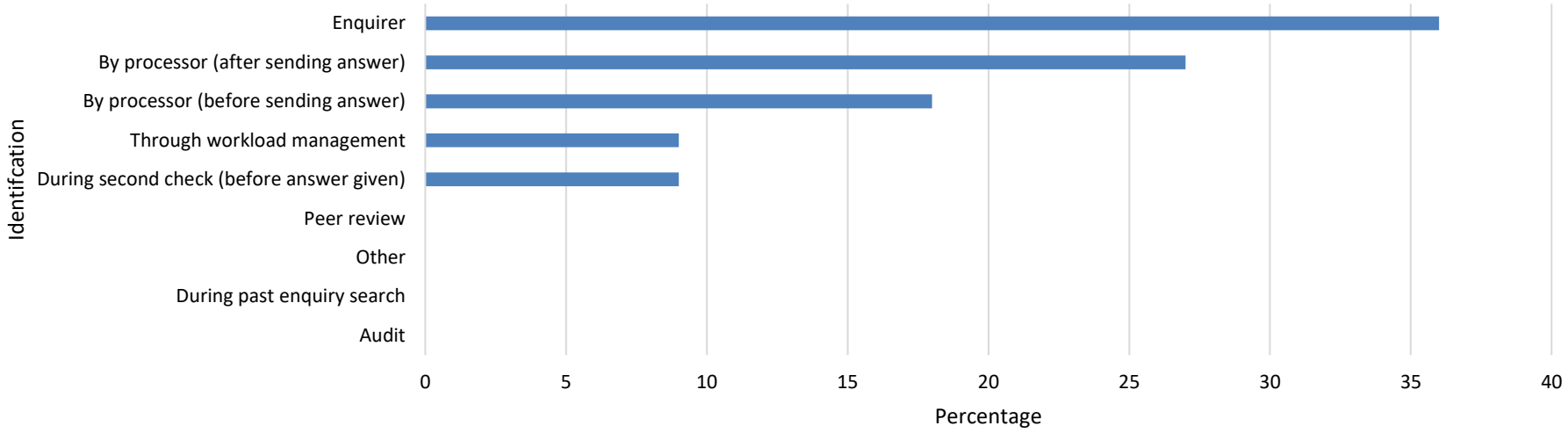


Chart 5: Reported point in enquiry process which triggered incident in Q2 2026

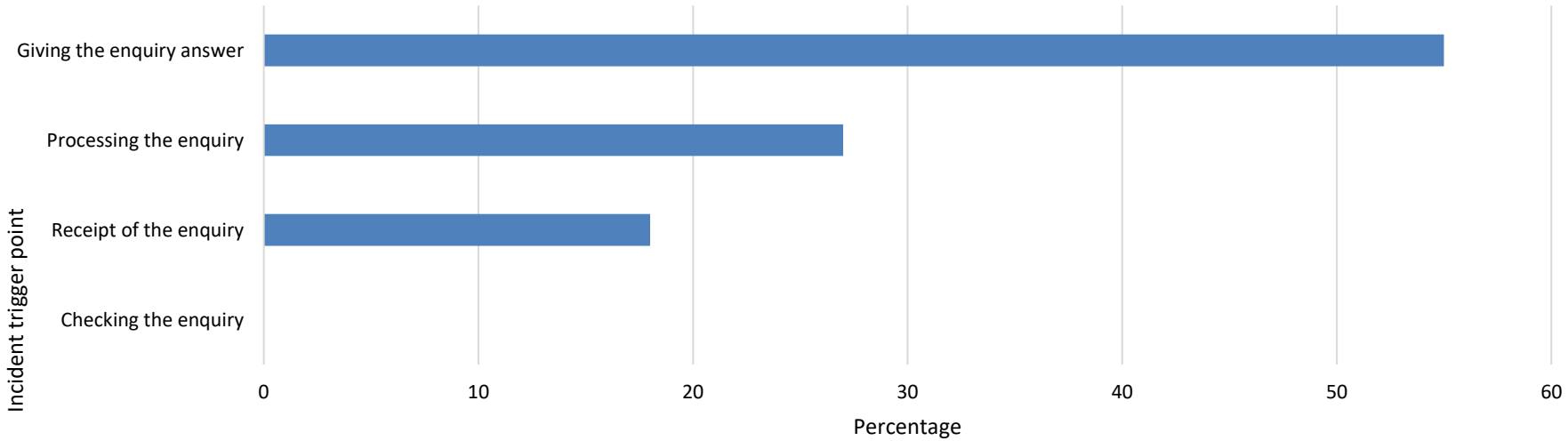


Table 1: QRMG Recommendations

(a) Enquiry answering process – receiving the enquiry

Incident summary	QRMG recommendations
Incident 55: An urgent enquiry was initially researched based on documented and verbally communicated information that the patient was allergic to lidocaine. Further questioning identified that the reported allergy was actually to tetracaine, meaning the clinical scenario had not been fully clarified before research commenced.	• Obtain a detailed allergy history before commencing research, including drug, formulation, reaction type and previous tolerated exposures. • Repeat key facts back to the enquirer to confirm understanding. • A short delay to clarify information is often safer than researching an incorrect scenario. • Ensure adequate information gathering and evidence review before providing advice, even when enquiries are perceived as urgent. Avoid allowing time pressures to compromise the quality of the answer • Maintain all required 2nd checks; these should not be omitted or abbreviated due to workload or urgency. • Establish a clear process for managing enquiries that are both urgent and complex, including identifying colleagues or senior staff who can provide support, peer review, or independent checking when required. • Where an urgent response is needed, consider providing an interim evidence-based recommendation that addresses the immediate clinical need, while clearly communicating that a more comprehensive review and follow-up advice will be provided as soon as possible. • The Summary of Product Characteristics (SmPC) is a legal document and not a clinical document. It will only include information for licensed uses. • Consider whether to review temperature records for a longer time period before answering. • Use SPS temperature excursion resources such as Managing temperature excursions – NHS SPS and Refrigerated medicines stability tool – NHS SPS.
Incident 58: Multiple pieces of information changed during the enquiry. A lengthy temperature log contained earlier, more significant excursions which were missed. Advice was initially provided based on an incomplete interpretation of the data and later corrected.	
Incident 61: Although clarification was sought, the enquiry was misunderstood. The answer addressed long-term use of Evra rather than continuous use without a hormone-free interval. A new enquiry was entered and corrected answer provided.	
Incident 64: An urgent telephone enquiry from Ophthalmology asked whether fluorescein 20% injection could be used in a 16-year-old patient. Due to workload pressures and the caller remaining on hold, advice was based largely on SPC information stating use in those under 18 years was not recommended, without sufficient exploration of local practice, specialist guidance or paediatric evidence.	

	• Use a standard fridge-excursion proforma to capture dates, temperatures, products, batches and duration. UKMi is currently reviewing a fridge enquiry template. • Clearly document the clinical question before beginning research. • Use the UKMi enquiry-answering guidelines (EAG) for suggestions on questions to ask for various enquiry categories. The EAG is currently under review. • Do not feel pressured to answer complex enquiries whilst the caller is on hold. • Avoid providing immediate answers whilst callers remain on hold if adequate research cannot be completed. • Agree a callback timeframe, undertake a structured literature search, seek specialist input where appropriate and use a second check for high risk enquiries.

(b) Enquiry answering process – researching the enquiry

Incident summary	QRMG recommendations
Incident 54: The pharmacist identified that stability information for aflibercept was unavailable in standard resources and contacted a manufacturer for further information. However, the wrong manufacturer was contacted. The error was identified before any advice was provided, making this a near miss.	• Verify the exact product, brand and manufacturer before contacting companies for questions requiring access to manufacturer held information, such as temperature excursions. • Consider a second check for complex fridge-excursion queries.

Incident 55: An urgent enquiry regarding potential cross-reactivity between lidocaine, prilocaine and tetracaine was researched using incomplete allergy information. Further investigation later identified an additional contraindication (parabens cross sensitivity) in the specific prilocaine brand stocked locally. The patient had already received treatment. Incident 62: An interim answer relied on SPC wording indicating no special storage conditions. Subsequent manufacturer clarification revealed that stability above 25°C could not be guaranteed, requiring correction of the advice. Incident 63: During answer preparation, the pharmacist identified that searches had been conducted using estradiol instead of estriol. The error was detected before advice was supplied.	• UKMi guidance on enquiry checking and use of pharmaceutical medical information departments may assist. • For allergy enquiries, check the full SPC including contraindications and excipients, verify the specific brand stocked locally. • Consider senior review, where available, for urgent or high-risk enquiries. • Use SPS temperature management resources and avoid relying solely on SPC wording for excursion assessments. • It may be useful to become familiar with the storage conditions that need to be labelled on medicinal products - Declaration of storage conditions for medicinal products particulars and active substances (Annex) - Scientific guideline | European Medicines Agency (EMA). • Never use AI-generated text as the sole basis for giving out medical/clinical/MI advice. • Verify search terms against the original enquiry before and during research. • Use a documented search strategy, such as the UKMi EAG. • Do a final review of key drug names before drafting answers.
Incident 64: Due to workload pressures and limited staffing, advice was based primarily on SPC information stating use of fluorescein below 18 years was not recommended. Additional paediatric experience and local guidance were not identified initially. The advice was challenged and corrected before patient care was affected.	• UKMi advise using more than one resource to answer MI enquiries as good practice. • Ensure staff know the limitations of the resources they are using. See UKMi Tips, Hints and Limitations for use of common medicines information resources. • Use relevant paediatric resources and seek second checks for complex or high-risk enquiries. • Ensure workload pressures are recognised and support sought early. • UKMi checking guidance supports additional review of higher-risk enquiries.

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

Incident summary	QRMG recommendations
Incident 56: Research and advice were correct, but the response was emailed to the wrong GP surgery. Patient initials were included, potentially creating an information governance risk. Incident 57: An email address was transcribed incorrectly during the enquiry intake process. The error was detected when the email bounced back and the answer was subsequently sent to the correct recipient. Incident 59: The answer was sent to a staff member with a very similar name and role to the intended recipient. The error was identified quickly and no confidentiality breach occurred. Incident 60: The response was sent as a reply within the wrong email thread and reached the wrong recipient. No confidential patient information was involved.	• Read back and verify email addresses during calls. • Record contact details directly into enquiry systems during the call. • Where available, use auto-populated contact details in the enquiry management system and double check with the enquirer each time. • Introduce a final recipient verification step before sending emails. • Verify email threads before sending replies. • Use the 'fax' field in MiDatabank organisation record to record organisational (e.g. GP surgery) emails. • Check emails with the Directory if you have access – consider using the copy function instead of manually typing the email; this allows you to check job title to check you have the right person. • For emails that arrive as a thread, consider sending the answer as a new email.

(d) Learning from publication errors

Publication incident ID	17	**Date of incident**	16 April 2026	**Type of error**	Human error	**Impact of error**	Minimal impact – no impact on patient care or outcome
Resource involved	MCA Stability Tool (SPS page) update process for multi-compartment compliance aid (MCA) monographs.						
Error detail	During review of Azithromycin monographs for the MCA Stability Tool update project, the Azithromycin tablet monograph was inadvertently uploaded into the Azithromycin capsule monograph record and subsequently checked as complete. The capsule-specific research had not yet been undertaken. The error was identified during the review process before publication.						
Outcome	No impact on patient care. The error was identified before the updated monographs became live. Had it not been detected, there was potential for incorrect formulation-specific advice to be included, possibly leading to inappropriate placement of a medicine in an MCA.						

Publisher response to error	The error was fed back to the MCA project team and discussed at an MCA team meeting. The checker was informed and learning shared with the team to reinforce the importance of verifying that the correct formulation-specific monograph has been uploaded before sign-off.						
Publication incident ID	18	**Date of incident**	31 March 2026	**Type of error**	Unclear or incorrect information and/or advice	**Impact of error**	Minimal impact – no impact on patient care or outcome
Resource involved	HPRA (Health Products Regulatory Authority) SmPC for Plaquenil® (hydroxychloroquine) 200mg film-coated tablets.						
Error detail	During research into a potential interaction between hydroxychloroquine and sertraline, a wording error was identified within the pharmacokinetic interactions section of the SmPC. The phrase “CYP2D6 strong or inhibitors” appeared incomplete, creating ambiguity regarding whether the warning applied to strong inhibitors only or both strong and moderate inhibitors.						
Outcome	The ambiguity could have led to an overestimation of the clinical significance of interactions involving moderate CYP2D6 inhibitors such as sertraline and potentially influenced treatment decisions. Other references were available to clarify the issue and no patient harm occurred.						
Publisher response to error	The regulatory authority was contacted. Following review, the wording was amended by removing the erroneous term, clarifying that the warning relates to strong CYP2D6 inhibitors.						
Publication incident ID	19	**Date of incident**	6 April 2026	**Type of error**	Unclear or incorrect information and/or advice	**Impact of error**	Minimal impact – no impact on patient care or outcome
Resource involved	NHS Medicines webpages relating to buprenorphine patches and SPS guidance on transdermal patch disposal.						
Error detail	Inconsistent advice was identified regarding disposal of used buprenorphine patches. One NHS webpage advised returning used patches to a pharmacist for destruction, while another advised seeking pharmacist advice regarding disposal without specifically recommending return to pharmacy.						
Outcome	The inconsistency could cause confusion among patients and healthcare professionals regarding the preferred method of disposal of used patches. No patient harm was identified.						
Publisher response to error	The discrepancy was identified during review of source material for SPS content. SPS guidance was updated to accommodate both approaches and the inconsistency was highlighted for further review. Publisher to be notified.						

Publication incident ID	20	**Date of incident**	7 May 2026	**Type of error**	Unclear or incorrect information and/or advice	**Impact of error**	Moderate impact – misunderstandings or misinterpretations likely but no serious harm if identified and promptly corrected
Resource involved	Loqvia tablets SmPC.						
Error detail	The SmPC stated that the product “does not require any special storage conditions”. Following a patient enquiry about accidental refrigeration, the manufacturer advised that intended storage is at room temperature and that no data are available to support refrigerator storage. The wording in the SmPC was considered potentially misleading.						
Outcome	Users may incorrectly assume that storage in a refrigerator is acceptable when no supporting stability data exist. In this case, the refrigerated tablets were not used and a replacement supply was provided.						
Publisher response to error	The manufacturer was informed of the concern and asked to review the SPC wording to provide greater clarity regarding appropriate storage conditions. A response was awaited at the time of reporting.						
Publication incident ID	21	**Date of incident**	2 April 2026	**Type of error**	Incorrect dosing	**Impact of error**	Severe impact – could directly lead to harmful clinical decisions and significant patient harm or adverse outcomes
Resource involved	MD+Calc Local Anaesthetic Dosing Calculator.						
Error detail	The online dosing calculator calculated lidocaine doses based solely on patient weight and failed to apply the maximum recommended dose cap. In the reported case, the calculator suggested a maximum dose that exceeded both UK and US recommended limits.						
Outcome	The incorrect calculation contributed to administration of a lidocaine dose above recommended limits. The patient subsequently presented with jerky movements, a potential symptom of lidocaine toxicity.						
Publisher response to error	The error was reported internally and to the calculator provider. No response had been received at the time of reporting. Learning was shared through Trust medicines safety groups to reinforce use of approved clinical resources and applications.						
Publication incident ID	22	**Date of incident**	27 May 2026	**Type of error**	AI involved; Unclear or incorrect information and/or advice	**Impact of error**	Moderate impact – misunderstandings or misinterpretations likely but no serious harm if identified and promptly corrected

Resource involved	Google AI Overview/Gemini response relating to administration of Thorens® (colecalciferol oral solution) via PEG tube.						
Error detail	The AI-generated response stated that Thorens oral solution could be administered via a PEG tube and provided administration advice. However, the cited references did not support this conclusion and did not specifically address PEG administration of the product. The information failed to mention that the product is oil based and risked tube blockage if special administration techniques were not used.						
Outcome	Reliance on the AI response alone could have resulted in non-evidence-based advice being provided. The information was verified with the manufacturer before any response was issued and no harm occurred.						
Publisher response to error	The AI output was not formally reported. The incident was discussed within the team to reinforce the need to critically evaluate AI-generated information and verify all cited references.						
Publication incident ID	23	**Date of incident**	1 June 2026	**Type of error**	Unclear or incorrect information and/or advice; wrong link to monograph	**Impact of error**	Moderate impact – misunderstandings or misinterpretations likely but no serious harm if identified and promptly corrected
Resource involved	Stockley's Drug Interactions Checker (MedicinesComplete).						
Error detail	When searching for an interaction between colchicine and ranolazine, the interaction checker displayed summary advice correctly. However, selecting the link for full information directed users to the monograph for ciclosporin and colchicine instead of colchicine and ranolazine.						
Outcome	Users relying on the incorrect linked monograph could potentially provide advice relating to the wrong interaction pair, leading to confusion or misinterpretation. Alternative references were used and no patient impact occurred.						
Publisher response to error	The issue was reported to the publisher and a response was awaited at the time of reporting.						
Publication incident ID	24	**Date of incident**	23 June 2026	**Type of error**	Unclear or incorrect information and/or advice	**Impact of error**	Moderate impact – misunderstandings or misinterpretations likely but no serious harm if identified and promptly corrected
Resource involved	Guideline for the Administration of Medicines to Adults via Enteral Tubes (local guideline).						

Error detail	The guideline stated that absorption of co-beneldopa may be enhanced by enteral feed proteins. Following an enquiry, review of the SPC, NEWT Guidelines and the Enteral Medicines Handbook confirmed that feed proteins may reduce levodopa absorption rather than enhance it. The erroneous statement had been present in previous versions of the guideline and may have arisen from an interpretation error.
Outcome	The practical administration advice remained unchanged, but the rationale and clinical interpretation were incorrect. Users may have monitored for increased adverse effects rather than reduced efficacy following feed interactions. No known patient harm was identified and there had been no previous reports relating to this error.
Publisher response to error	Local incident reporting procedures were initiated. The guideline committee was notified, a correction notice was planned, and the error will be corrected as part of the scheduled guideline review. The incident has also been reported through local governance processes.

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