National Incident Data Repository for Community Pharmacies

National Snapshot

Between January 1 and December 31, 2024, more than **26,000 reports** of medication incidents were submitted by more than **1,700 community pharmacies** in participating provinces to share learning and inform safety improvements.

6% more medication incidents were reported to the NIDR in 2024 than in 2023, reflecting a growing culture of safety in Canada

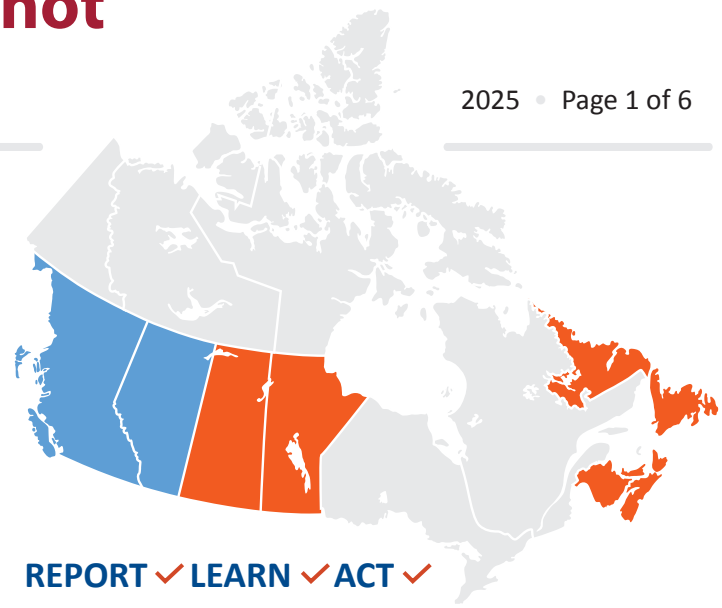


FIGURE 1. Provinces currently participating (**orange**) and provinces that will soon participate (**blue**) in the NIDR.

Figure 1 shows the 6 provinces currently submitting medication incident data to the National Incident Data Repository for Community Pharmacies (NIDR), and the 2 additional provinces that have announced continuous quality improvement programs that will include data submission to the NIDR.

Figure 2 illustrates medication incident data submitted to the NIDR in each month of 2024.

2,167 medication incidents, on average, were reported to the NIDR per month in 2024

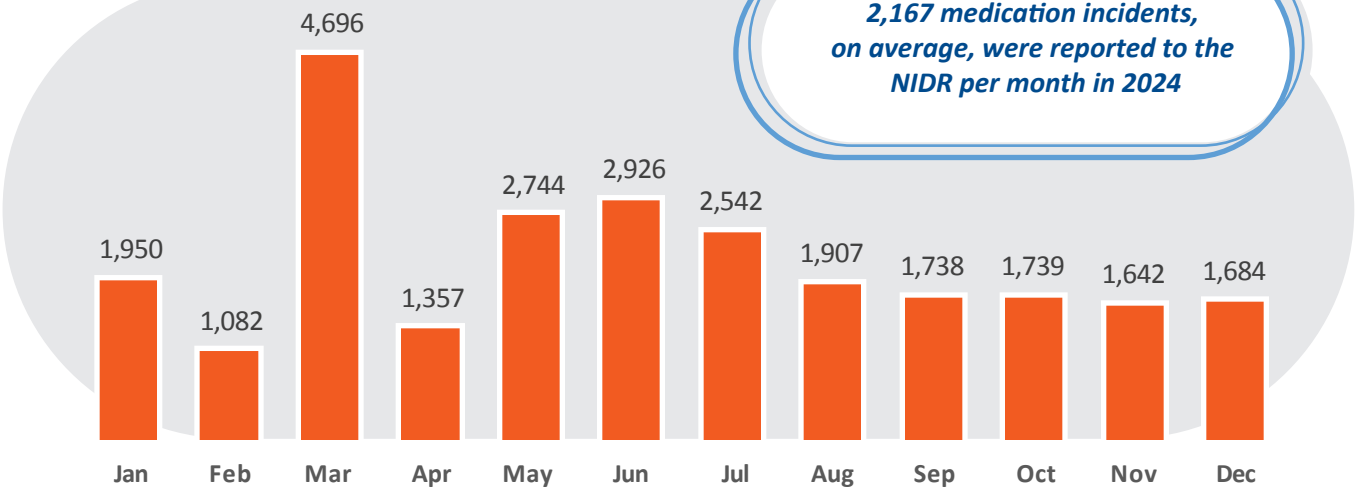


FIGURE 2. Number of reports of medication incidents submitted to the NIDR per month in 2024.
Note: Value for March 2024 reflects batch submissions of medication incident reports from platform providers.

Figure 3 shows the levels of harm reported in medication incidents submitted since the inception of the NIDR and those submitted in 2024. The proportions of incidents reported as near misses (i.e., did not reach the patient) were about 75% and 55%, respectively. The proportions of incidents that reached the patient and did not cause harm (i.e., no harm) were about 24% and 42%, respectively.

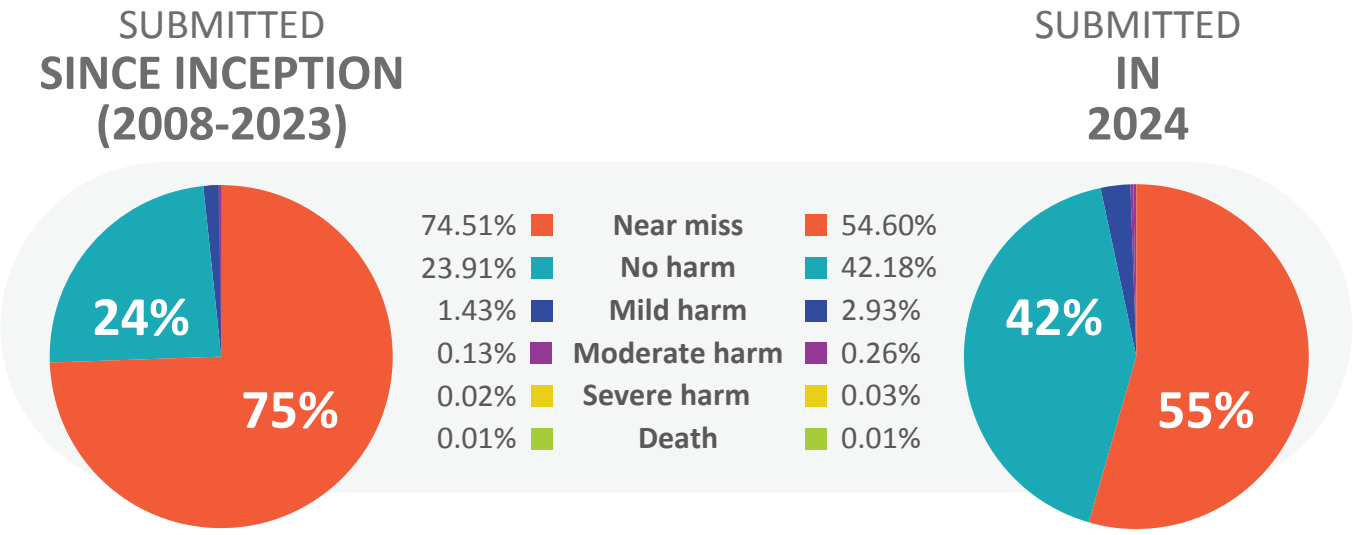


FIGURE 3. Levels of harm reported in medication incidents submitted to the NIDR since inception (left) and those submitted in 2024 (right).

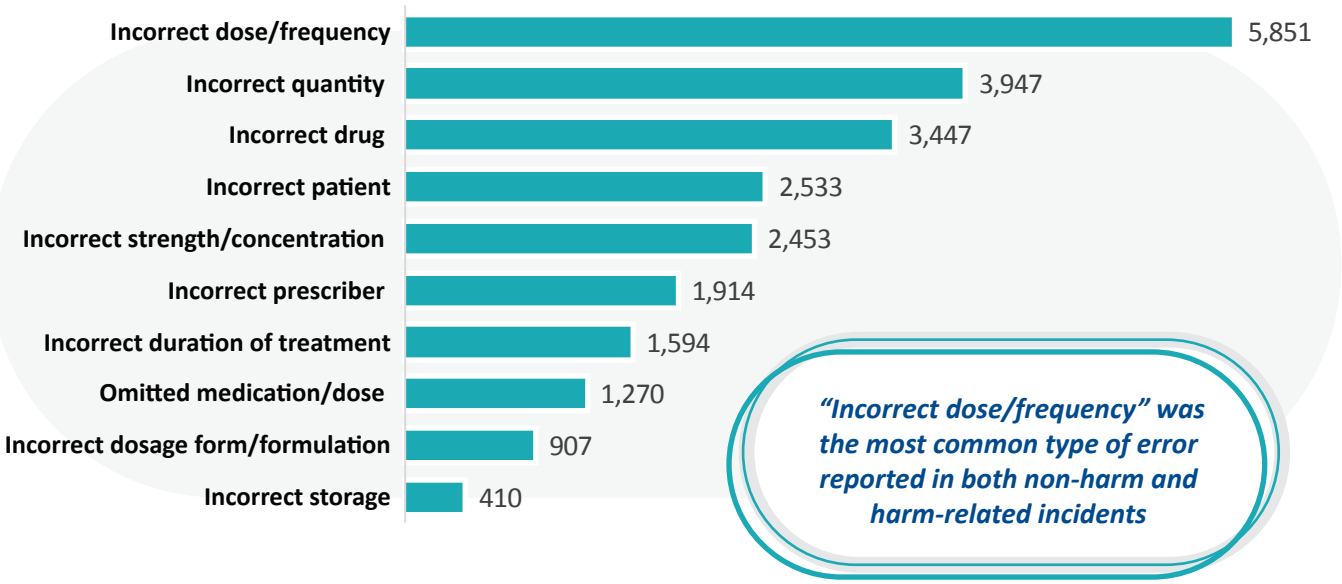


FIGURE 4. Top 10 types of incidents reported to the NIDR in 2024 (including reports of near misses, no harm incidents, and harm-related incidents).

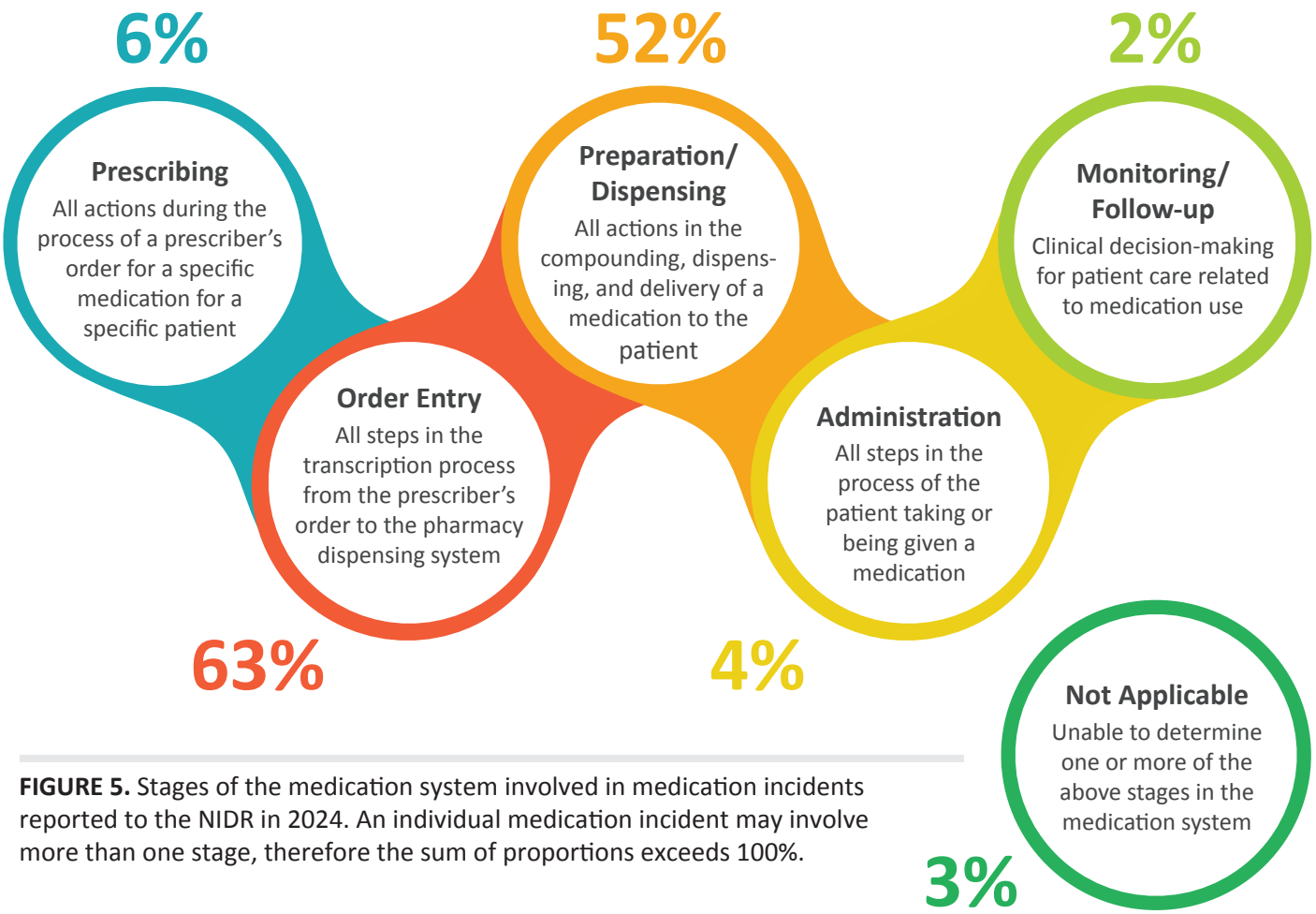


FIGURE 5. Stages of the medication system involved in medication incidents reported to the NIDR in 2024. An individual medication incident may involve more than one stage, therefore the sum of proportions exceeds 100%.

Figure 6 demonstrates the importance of engaging the patient's circle of care to optimize medication safety. Medication incidents were often discovered by pharmacy team members. Patients (or their family, friends, or caregivers) and other health care providers (including nurses and physicians) also identified medication incidents that were reported for shared learning.

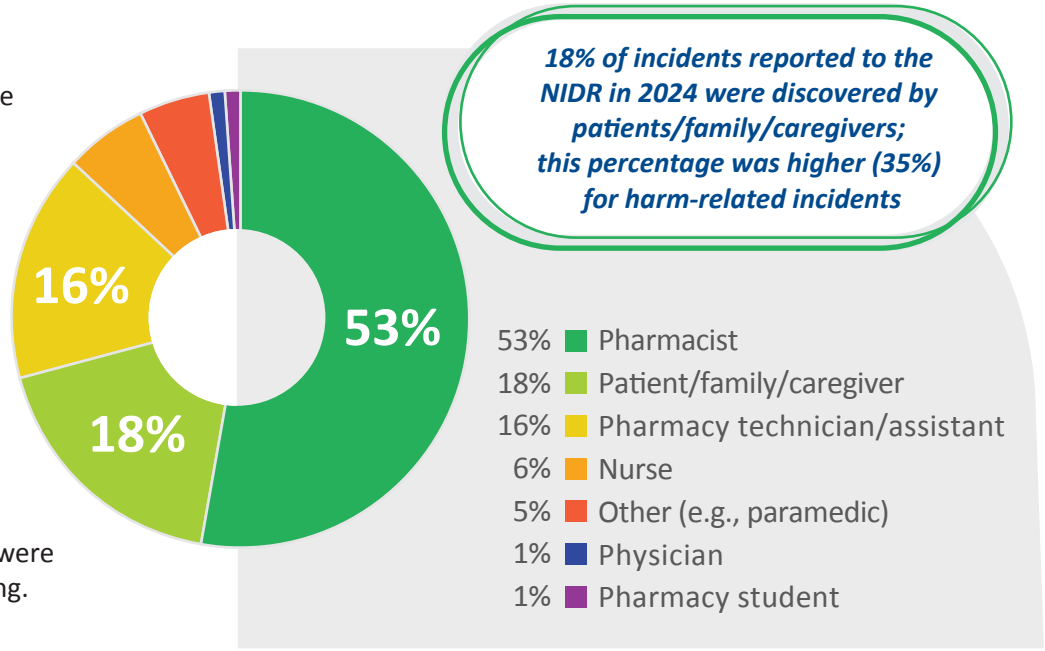


FIGURE 6. Discoverer of medication incidents, as identified in reports submitted to the NIDR in 2024 (including reports of near misses, no harm incidents, and harm-related incidents).

Medication incident reporting to the NIDR includes mandatory fields that represent the minimum information needed to analyze the incident and share learning. Also available are several optional fields (Figure 7), which can enhance the understanding of what happened and how and why it happened, as well as support the development of safety strategies to prevent recurrence.

MANDATORY FIELDS*	OPTIONAL FIELDS
• Date incident occurred • Type of incident • Incident discovered by • Degree of harm to the patient • Medication system stages involved • Medications involved • Incident description	• Time incident occurred • Patient details (gender, age range) • Contributing factors of this incident • Other incident information • Actions at pharmacy level • Shared learning for community pharmacy

*Mandatory fields may differ between provincial quality improvement program requirements.

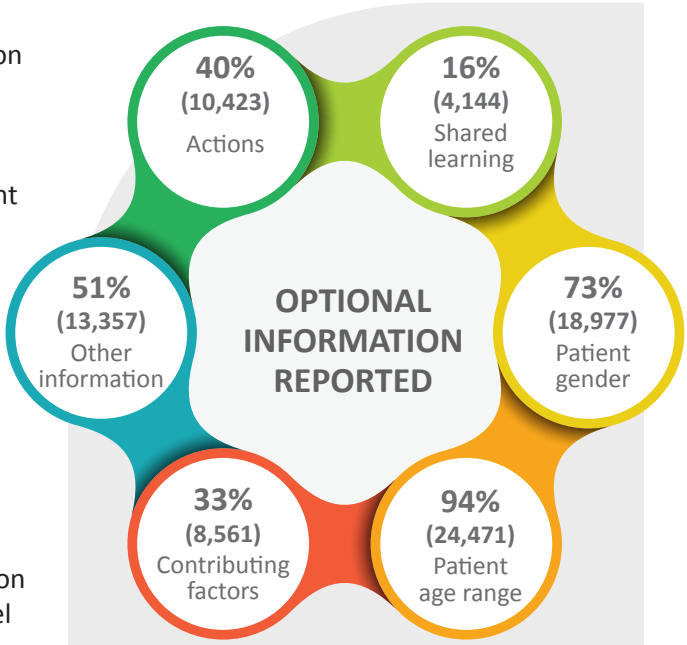


FIGURE 7. Proportions of medication incidents reported to the NIDR in 2024 for which optional fields were completed.

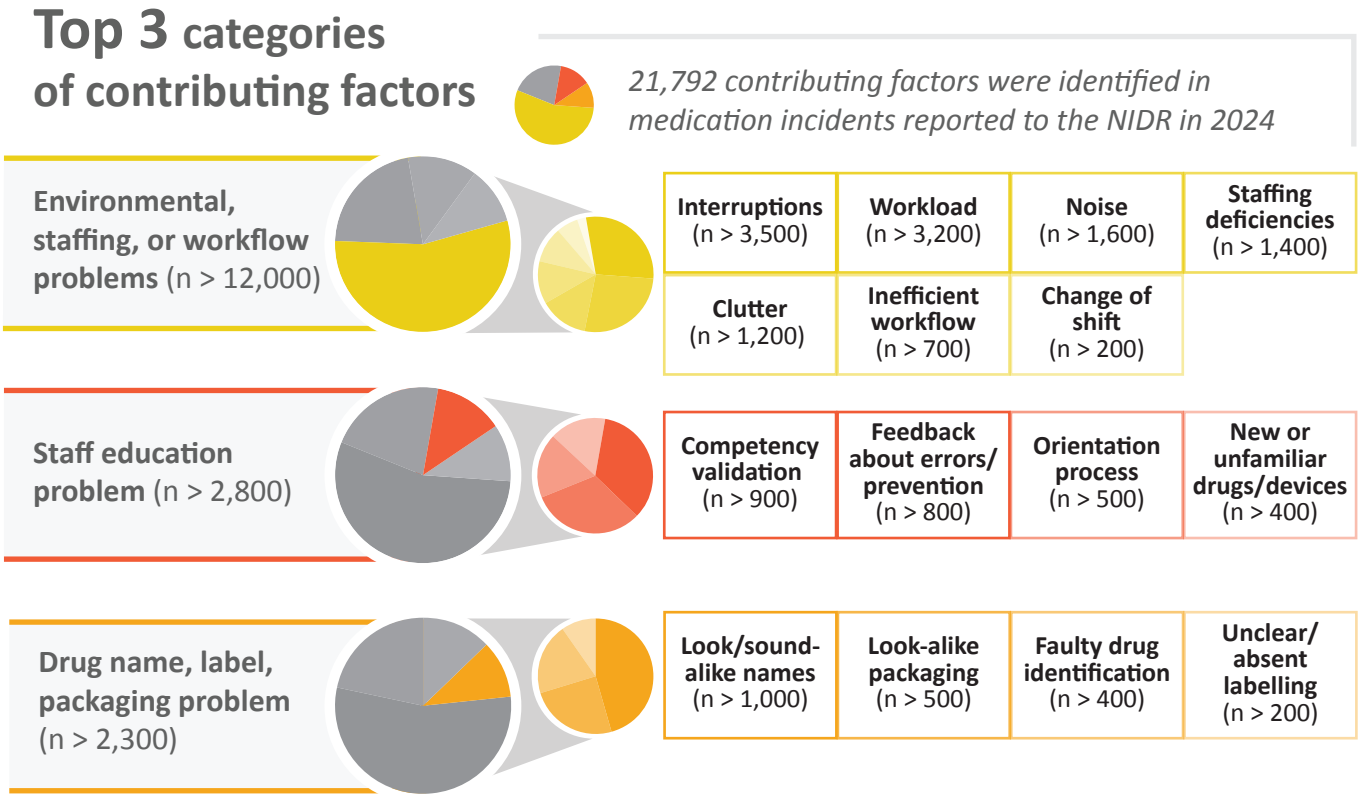


FIGURE 8. Top 3 categories (and corresponding subcategories) of contributing factors identified in medication incidents reported to the NIDR in 2024.

The top medications involved in incidents reported to the NIDR in 2024 (including near misses, no harm incidents, and harm-related incidents) are shown in Figure 9. The top medications involved in harm-related incidents are presented in Figure 10. **The prominence of some medications may reflect frequency of prescribing.**

Methadone has consistently been reported as a top medication causing harm; strategies to optimize its safe use have been shared in multiple publications.

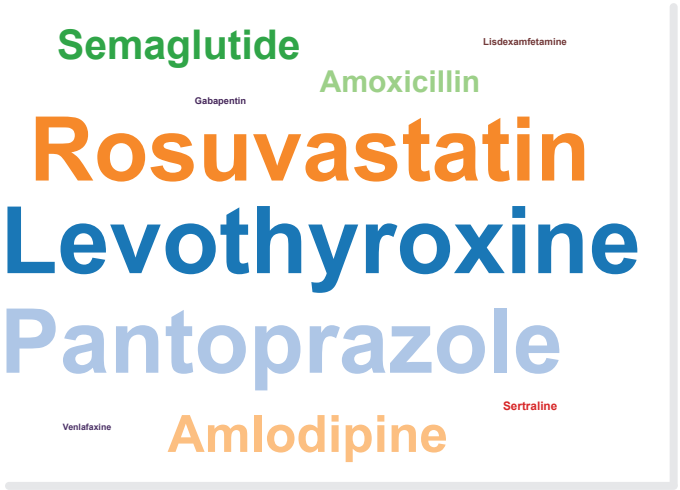


FIGURE 9. Top medications involved in all medication incidents reported to the NIDR in 2024.

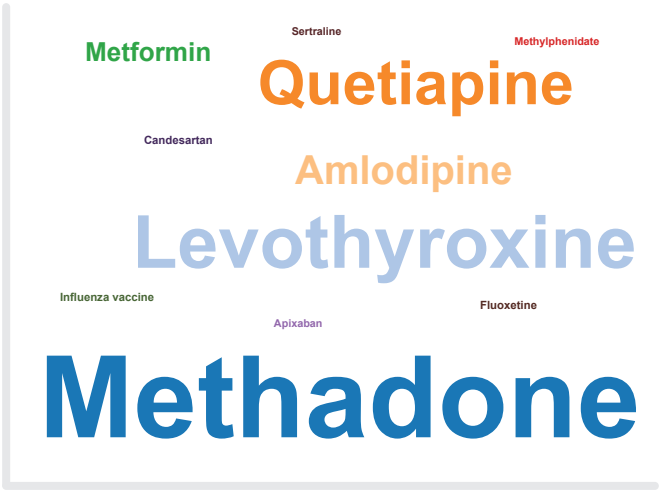


FIGURE 10. Top medications involved in harm-related medication incidents reported to the NIDR in 2024.

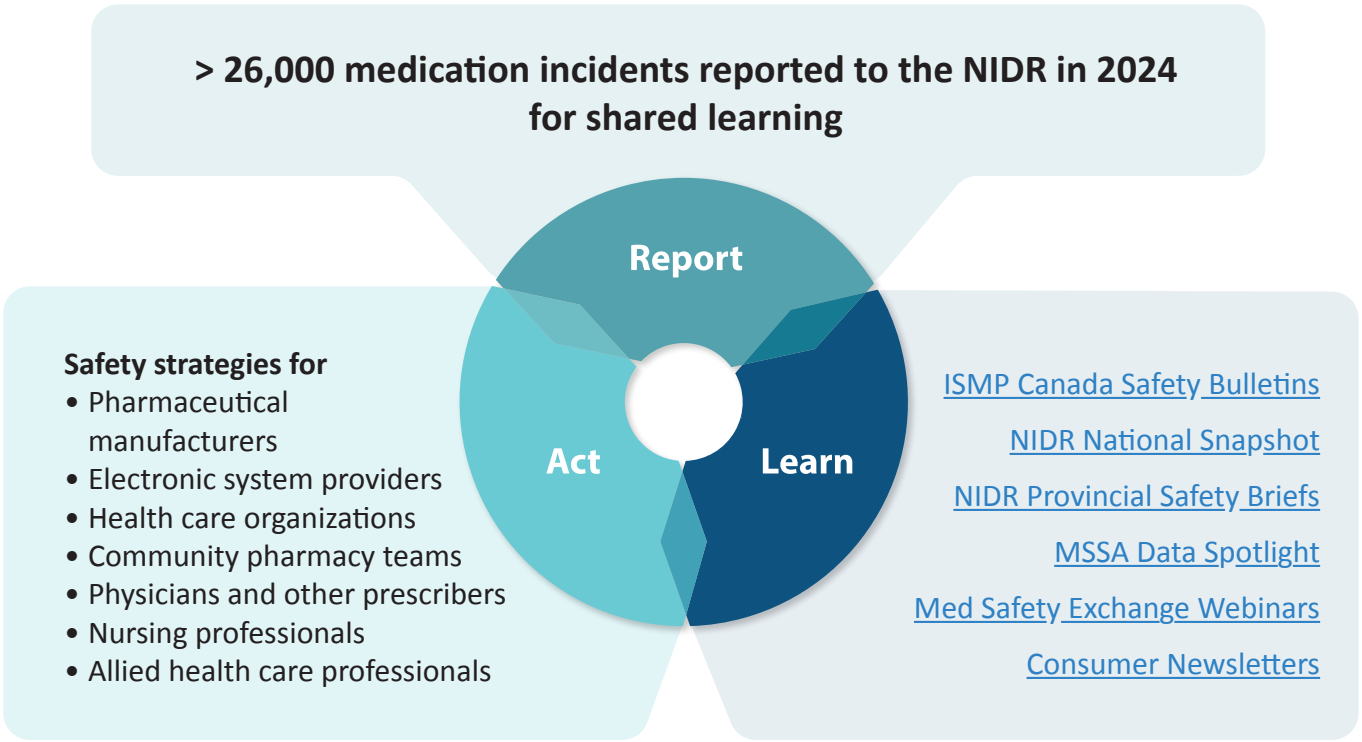
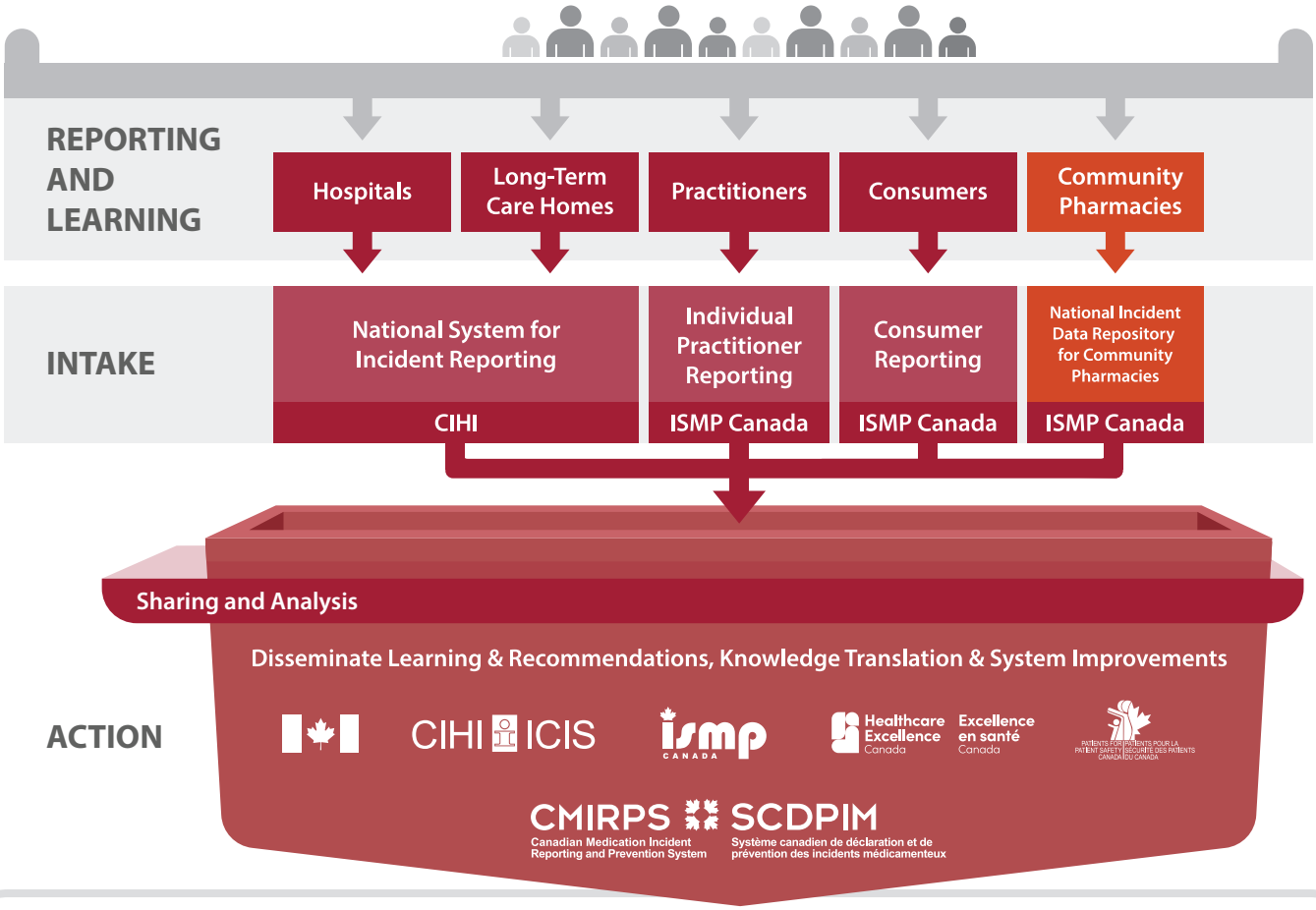


FIGURE 11. Representation of the report–learn–act cycle, illustrating how analysis of reported medication incidents and shared learning inform quality improvement initiatives.

National Snapshot

The National Incident Data Repository for Community Pharmacies (NIDR) is a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).



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RESULT **Stronger Knowledge = Safer Products and Care**

The NIDR contains more than 350,000 reports of medication incidents that have been shared by community pharmacies since 2008. ISMP Canada is committed to analyzing these reports and developing and disseminating learning, with the goal of improving health care systems and medication safety.

The **NIDR National Snapshot** shares information about the types of medication incidents that have been reported by community pharmacies in Canada. Safety bulletins with detailed analyses and recommendations are available here: https://ismpcanada.ca/safety-bulletins/

Thank you for reporting medication incidents. Your efforts help to inform the "learn, share, and act" cycle!

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