



National Incident Data Repository for Community Pharmacies

National Snapshot

Between January 1 and December 31, 2025, more than **27,600** reports of medication incidents (including near misses) were submitted to the National Incident Data Repository for Community Pharmacies (NIDR) by over **2,700** community pharmacies in participating provinces, to share learning and inform safety improvements.

Figure 1 shows the 6 provinces currently submitting medication incident data to the NIDR, the 2 provinces (Alberta and British Columbia) implementing continuous quality improvement programs that will include data submission to the NIDR in 2026, and the 1 province (Ontario) with an established program that is preparing to submit data to the NIDR in 2027.

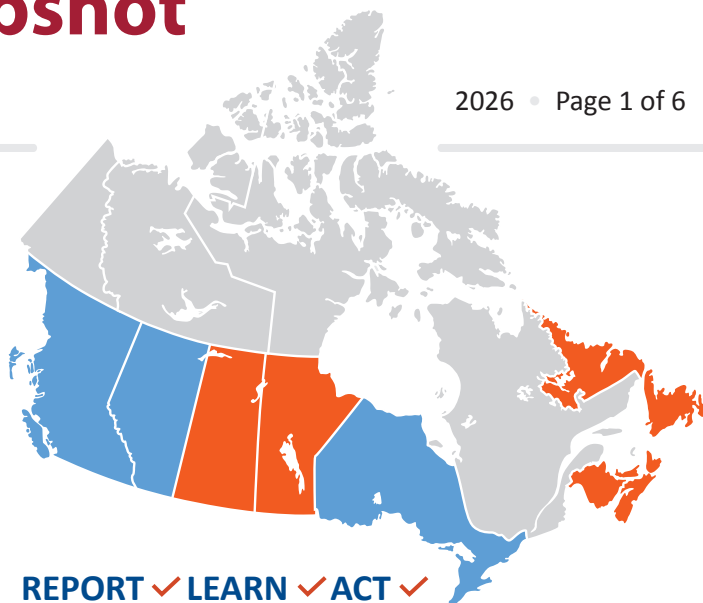


FIGURE 1. Provinces participating (orange) in the NIDR in 2025 and provinces that will soon participate (blue).

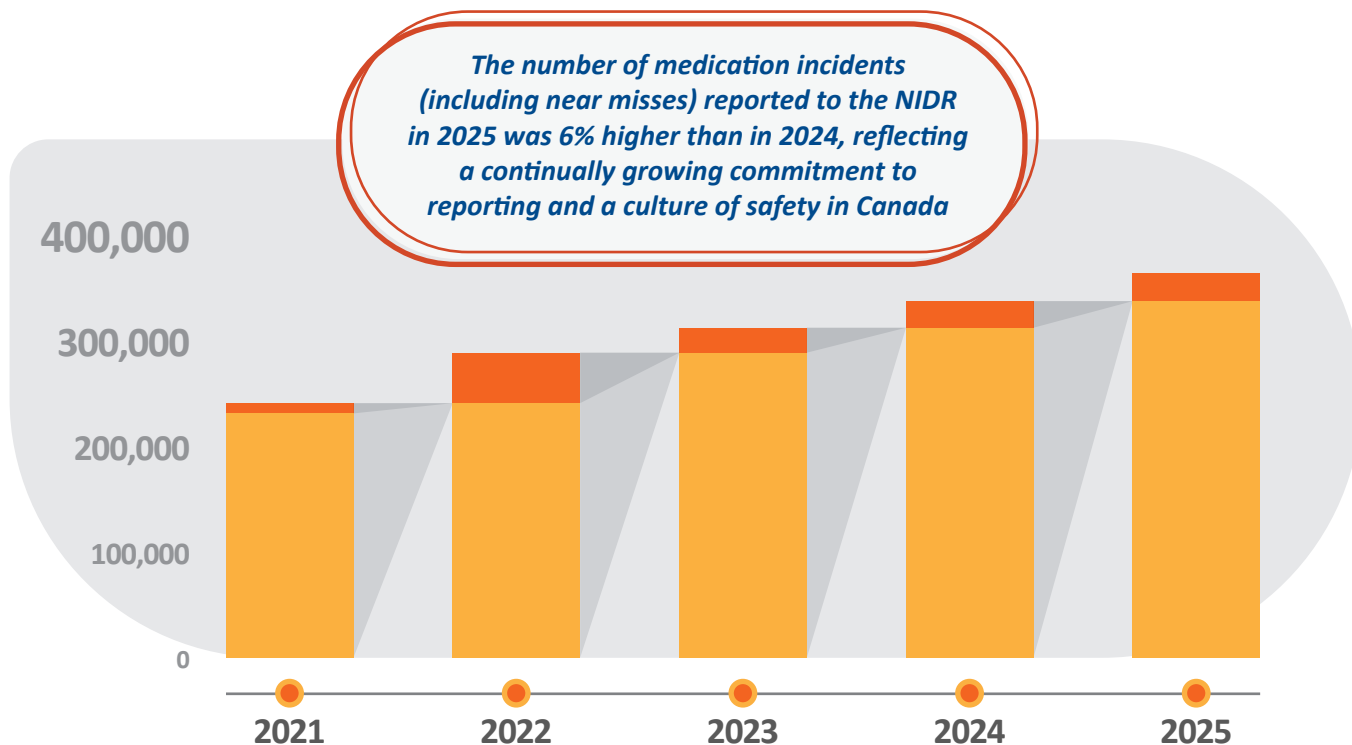


FIGURE 2. Total number of medication incident reports (including near misses) contained in the NIDR for each of the past 5 years, with the orange bars representing the number of reports submitted in that year.

Figure 3 shows the levels of harm described in medication incident reports (including near misses) submitted in 2025. Non-harm-related medication incidents were reported in 97% of submissions to the NIDR; the proportion of incidents reported as near misses (i.e., did not reach the patient) was about 53%, and the proportion of no-harm incidents (i.e., reached the patient and did not cause harm) was about 44%.

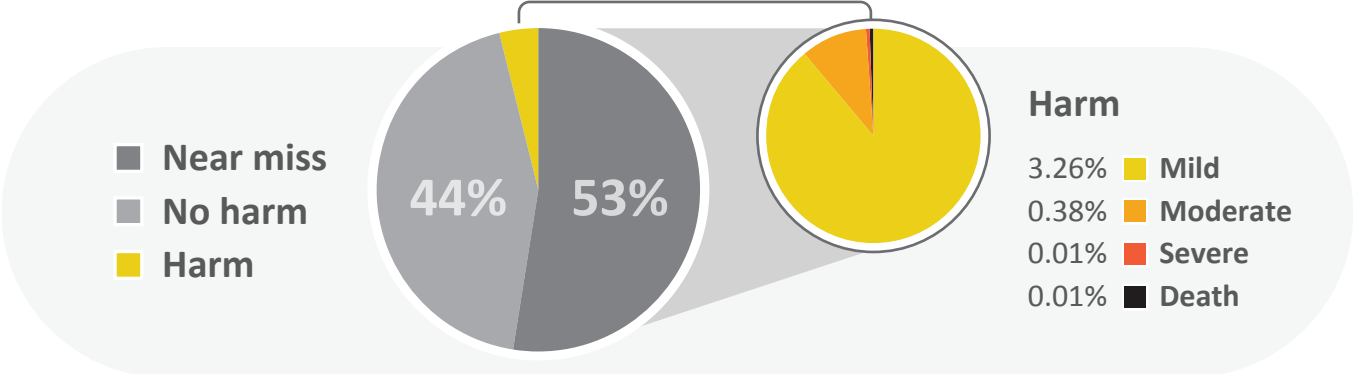


FIGURE 3. Levels of harm described in medication incident reports (including near misses) submitted to the NIDR in 2025.



FIGURE 4. Discoverers of medication incidents (including near misses), as identified in reports submitted to the NIDR in 2025.

Figure 5 compares, for the top 10 incident types, the proportion of all harm-related medication incidents (in blue) with the proportion of all non-harm-related medication incidents (i.e., near misses and no-harm incidents; in yellow). The largest differences are seen for “incorrect quantity” (which are seemingly *less* likely to be harmful) and “omitted medication/dose” (which are seemingly *more* likely to be harmful).

Figure 6 depicts the proportions of all medication incident reports (including near misses) by stage of the medication-use process. Notably, in a subgroup analysis of harm-related incidents, the “administration” stage was 5 times more likely to be reported (i.e., 20% of harm-related reports versus 4% of all medication incidents), and the “monitoring/follow-up” stage was 4.5 times more likely to be reported (i.e., 9% of harm-related reports versus 2% of all medication incidents).

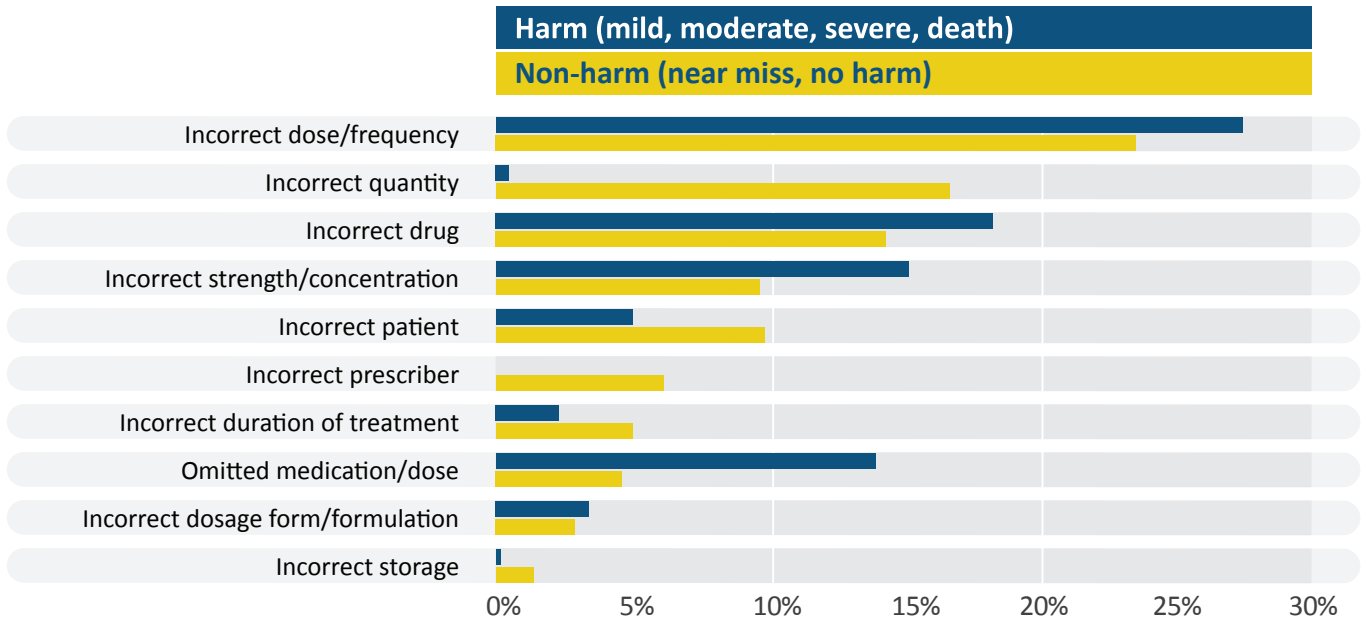


FIGURE 5. For the top 10 incident types, comparison of proportions of harm-related and non-harm-related medication incidents (i.e., near misses and no-harm incidents) reported to the NIDR in 2025. Harm-related incidents are represented in blue, and non-harm-related incidents are represented in yellow.

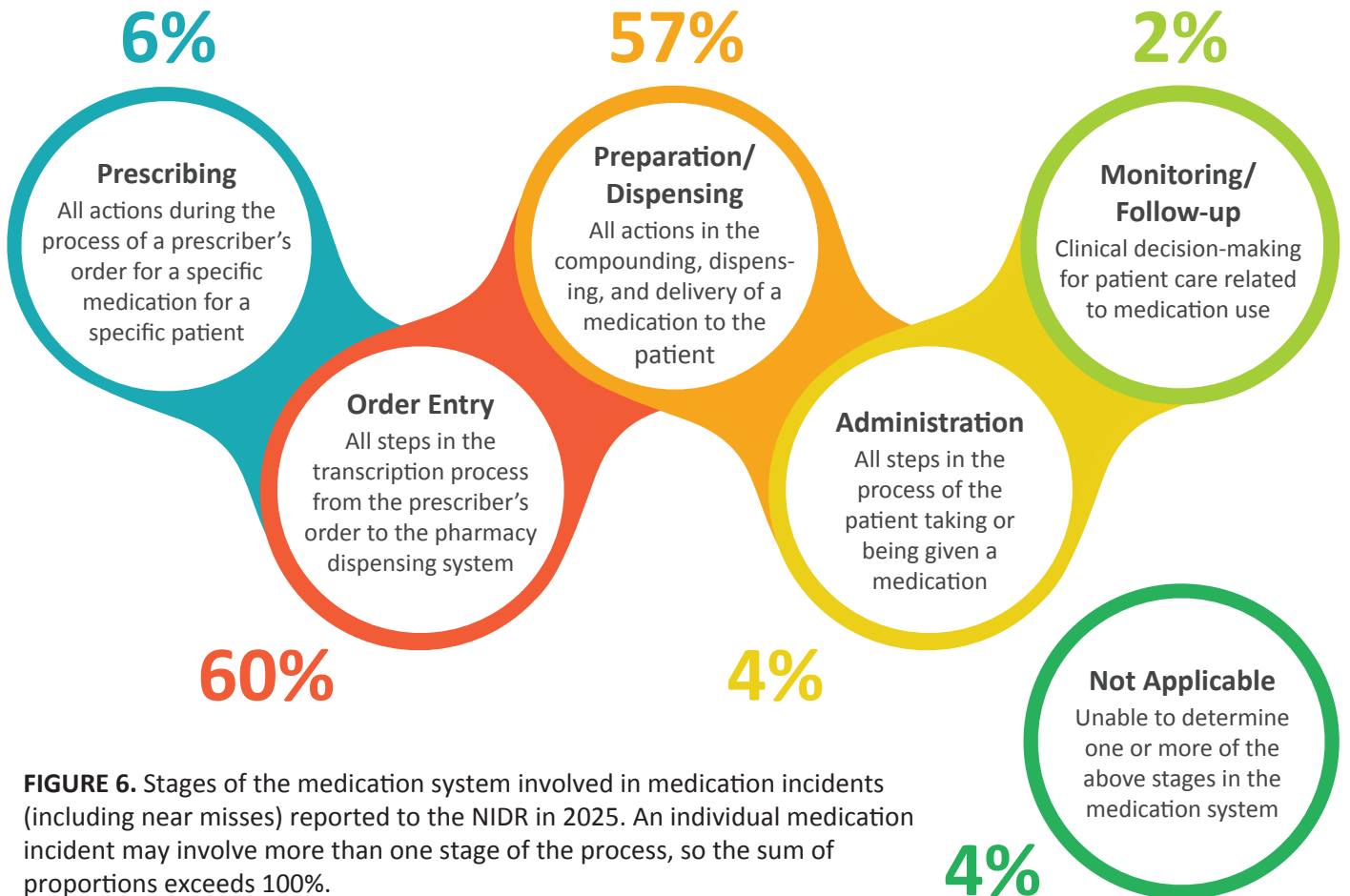
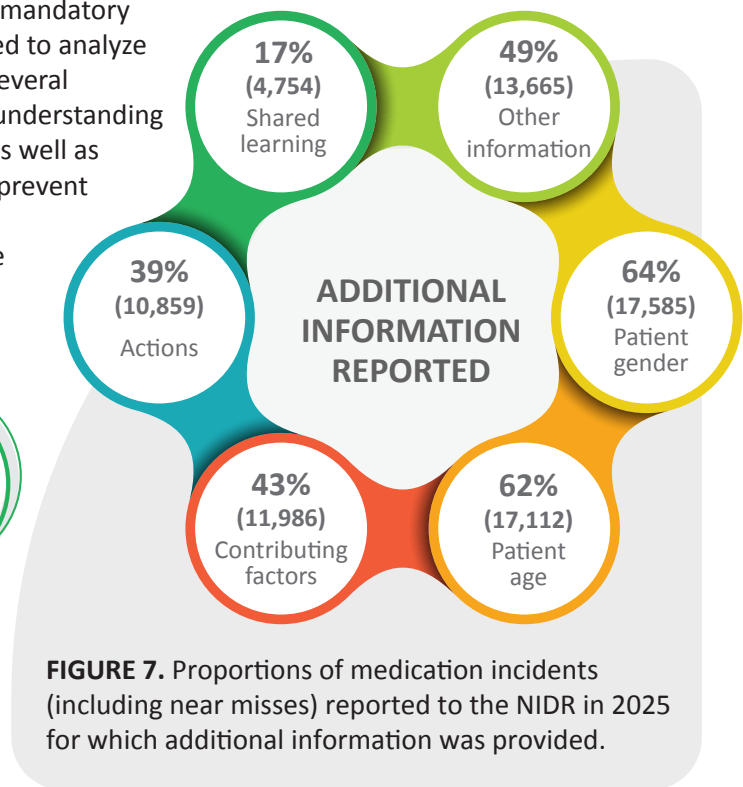


FIGURE 6. Stages of the medication system involved in medication incidents (including near misses) reported to the NIDR in 2025. An individual medication incident may involve more than one stage of the process, so the sum of proportions exceeds 100%.

Medication incident reporting to the NIDR includes mandatory fields representing the minimum information needed to analyze the incident and share learning. Also available are several additional fields (Figure 7), which can enhance the understanding of what happened and how and why it happened, as well as supporting the development of safety strategies to prevent recurrence. In most participating provinces, these additional fields are optional. In 2025, however, one province made “contributing factors” and “actions” (at the pharmacy level) mandatory.



Compared with 2024, reporting of “contributing factors” and “actions” increased by 30% and 6%, respectively, in 2025

28,901 contributing factors were identified in medication incidents (including near misses) reported to the NIDR in 2025

FIGURE 7. Proportions of medication incidents (including near misses) reported to the NIDR in 2025 for which additional information was provided.

Figure 8 shows, for each category of contributing factor, the proportions of incidents that were harm-related (in blue) and non-harm-related (i.e., near misses and no-harm incidents; in yellow). The proportion of harm-related incidents was largest for the “patient education problem” category, which prompted the recent [NIDR Safety Brief](#) (October 2025) recommendation to optimize patient engagement at both intake (for information gathering) and pick-up (for information sharing).

	Non-harm (near miss, no harm)	Harm
Environmental, staffing, or workflow problem	14,144	752
Staff education problem	3,551	217
Drug name, label, packaging problem	3,034	218
Miscommunication of drug order	1,896	136
Critical drug information missing	1,641	123
Drug storage or delivery problem	1,198	52
Patient education problem	594	125
Lack of quality control or independent check systems	622	71
Critical patient information missing	355	40
Drug delivery device problem	112	15

FIGURE 8. Proportions of harm-related incidents (in blue) and non-harm-related incidents (i.e., near misses and no-harm incidents; in yellow) within each category of contributing factors described in medication incident reports submitted to the NIDR in 2025. The numbers of medication incidents reported for each category are shown on the right (harm-related) and on the left (non-harm-related) of the respective bars.

The top medications involved in incidents reported to the NIDR in 2025 are shown in Figure 9 (for all medication incidents, including near misses) and Figure 10 (for harm-related medication incidents only). **The prominence of some medications may reflect the frequency of prescribing.**

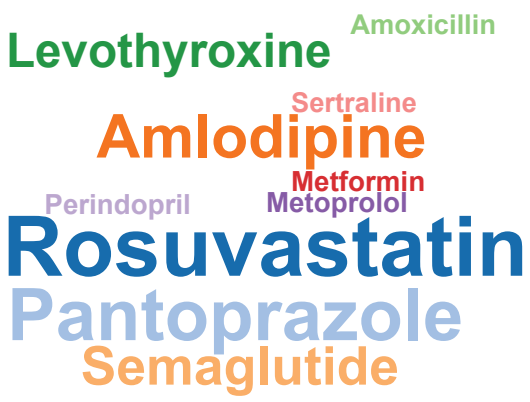


FIGURE 9. Top 10 medications involved in all medication incidents (including near misses) reported to the NIDR in 2025.

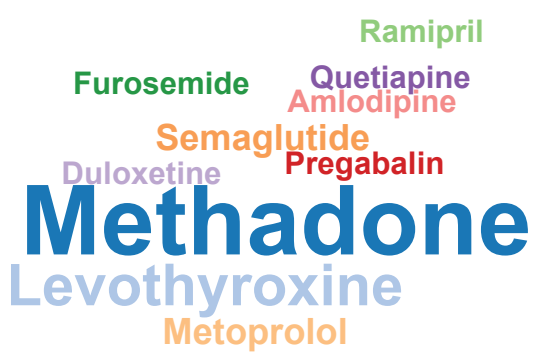


FIGURE 10. Top 10 medications involved in harm-related medication incidents reported to the NIDR in 2025.

Although methadone and levothyroxine remain the medications most commonly reported to be involved in harm-related incidents, 6 medications in the top 10 list for 2025 (semaglutide, metoprolol, furosemide, ramipril, pregabalin, and duloxetine) were not present in the top 10 list for 2024.

More than 27,600 medication incidents (including near misses) reported to the NIDR in 2025

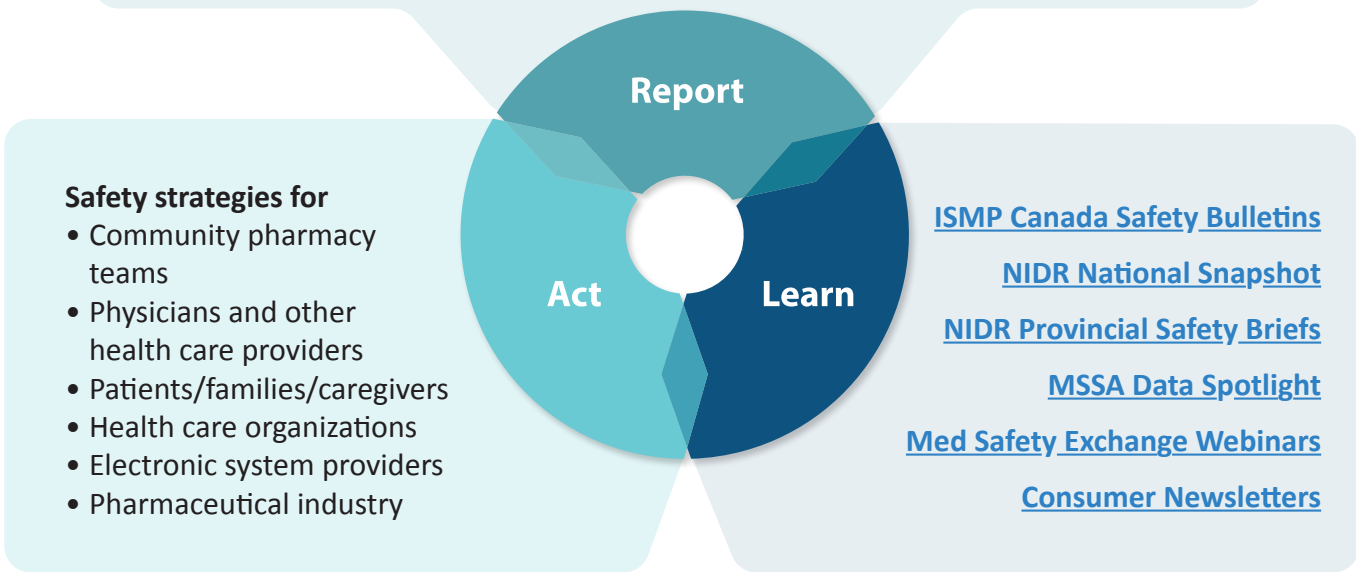


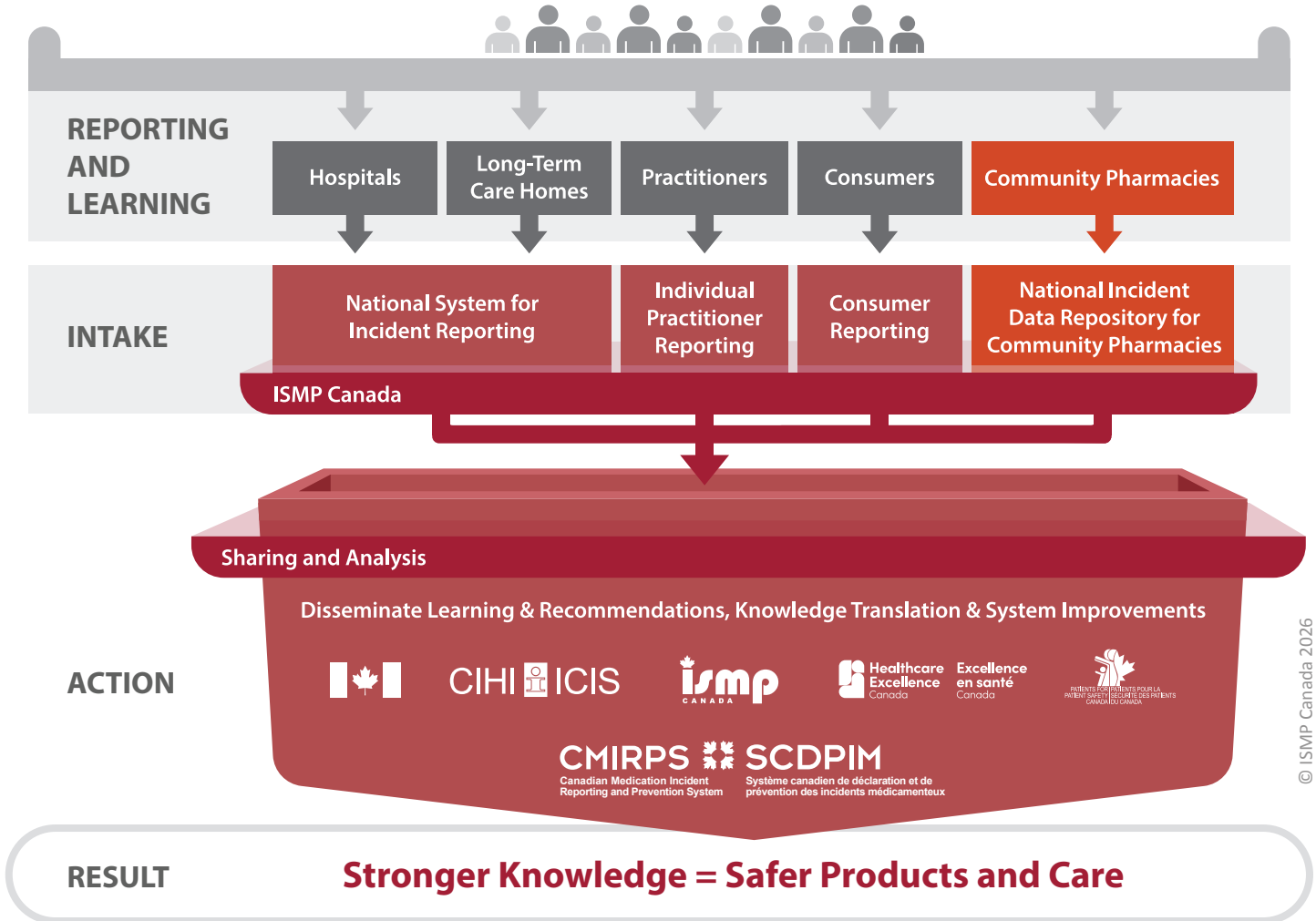
FIGURE 11. Representation of the report–learn–act cycle, illustrating how analysis of reported medication incidents (including near misses) and shared learning inform quality improvement initiatives.



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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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The NIDR contains more than 375,000 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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National Incident Data Repository Référentiel de données nationales sur les incidents

