National Incident Data Repository for Community Pharmacies

National Snapshot

July 2022

Top 10 Medications Causing Harm (2016-2021)

1. Methadone
2. Levothyroxine
3. Warfarin
4. Furosemide
5. Sertraline
6. Hydrochlorothiazide
7. Citalopram
8. Metformin
9. Hydromorphone
10. Candesartan

Shared Learning from Analyses

Methadone

Analysis Finding: A significant number of errors related to methadone involve giving the drug to the wrong patient.

Safety Strategy: Avoid pre-pouring and always confirm patient identification (with two unique identifiers) and the dose.

Levothyroxine

Analysis Finding: Patient harm can occur when the dosage units of levothyroxine are mixed up or misinterpreted.

Safety Strategy: Standardize the expressions of strength in prescribing and dispensing systems with micrograms (mcg), not milligrams (mg), to align with manufacturer labels.

Warfarin

Analysis Finding: Warfarin's complex dosing regimen can increase the risk of error and harm.

Safety Strategy: Clearly communicate the warfarin dose with the patient based on the most recent INR test, especially when the regimen includes a combination of different strengths and/or varying daily doses.

Metformin

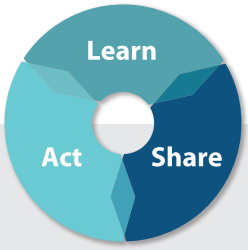
Analysis Finding: The need for frequent metformin dose adjustments and regimen changes can lead to errors and harm.

Safety Strategy: To prevent mix-ups involving metformin, offer patient education as a final check for the correct product and patient understanding.

Hydromorphone

Analysis Finding: Harm can occur when long- and short-acting formulations of hydromorphone are inadvertently interchanged.

Safety Strategy: Include both the generic and brand names throughout the medication-use process to help differentiate between different formulations.



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/

ISMP CANADA

National Incident Data Repository / Référentiel de données nationales sur les incidents

CMIRPS Canadian Medication Incident Reporting and Prevention System / SCDPIM Système canadien de déclaration et de prévention des incidents médicamenteux

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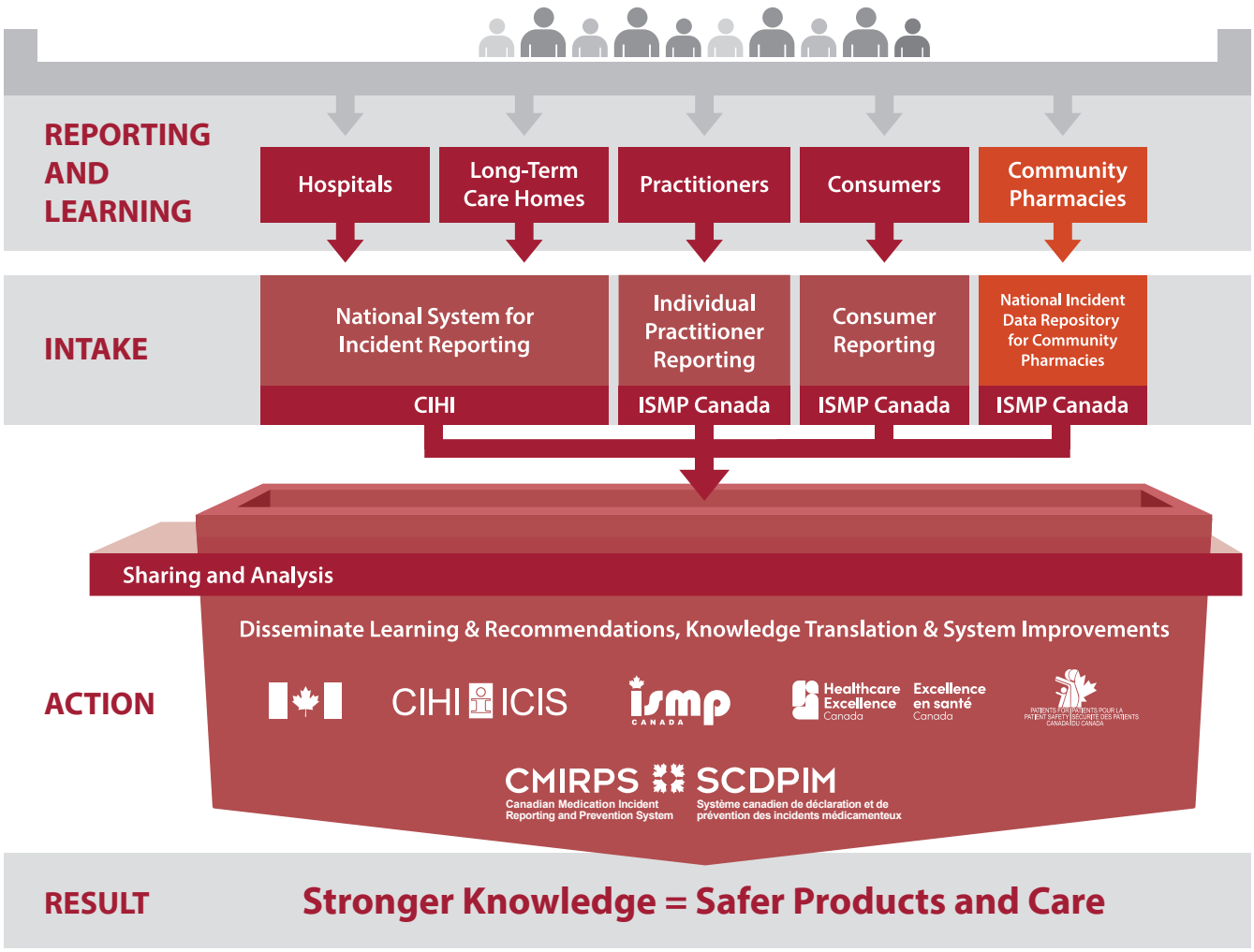
The National Incident Data Repository for Community Pharmacies (NIDR) is a component of the Canadian Medication Incident Reporting and Prevention System (CMIRPS).



The NIDR has more than 275,000 reports of medication incidents shared by community pharmacies since 2008. ISMP Canada is committed to analyzing reports and developing and disseminating learning, with the ultimate goal of improving health care systems and medication safety.

Thank you for reporting medication incidents and informing the learn, share and act cycle!