National Incident Data Repository for Community Pharmacies

National Snapshot

July 2023

From January 1 to December 31, 2022, a total of 49 650 reports of medication incidents were submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from participating provinces. Most of the reports described near-miss or no-harm incidents; 1.21% (n= 603) of the incidents were associated with mild, moderate, or severe harm, or death. Analysis of incidents has informed the shared learning offered in ISMP Canada Safety Bulletins and provincial NIDR Safety Briefs.

The focus of this NIDR National Snapshot is the 2022 dataset of medication incidents for which "critical patient information missing" was specified as a contributing factor. Reports of 315 incidents with detailed descriptions were included in a multi-incident analysis using the Canadian Incident Analysis Framework.[1] The findings of this analysis (Figure 1) and strategies for improvement (Box 1) are presented here.

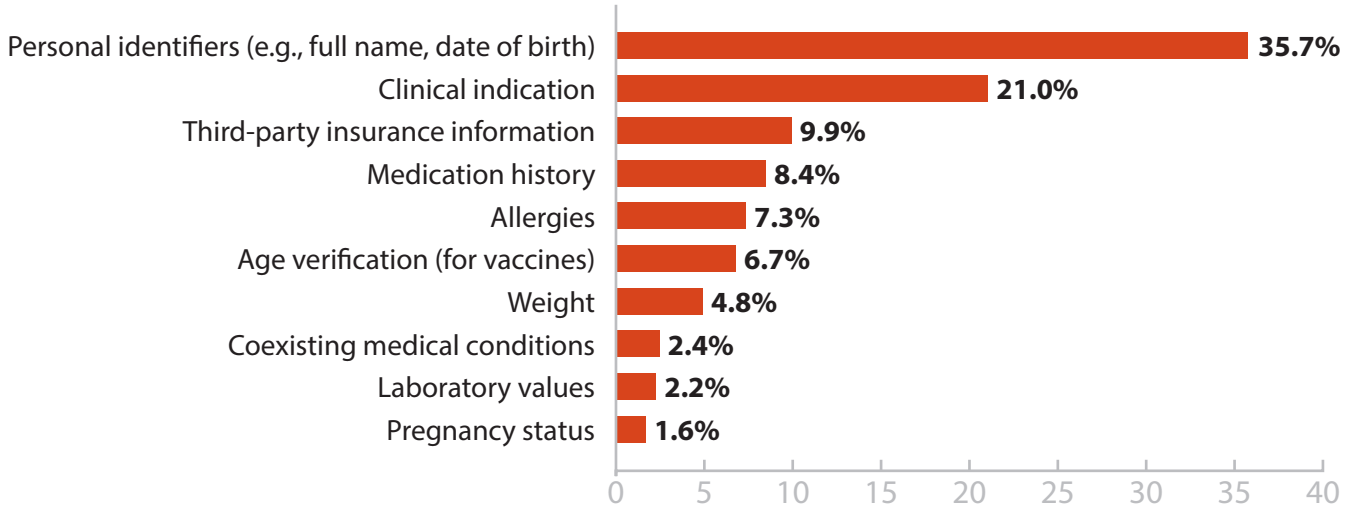

FIGURE 1. Types of critical patient information missed during the processes of prescription order entry, pharmacist clinical check, vaccine administration, and/or prescription delivery.

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

The NIDR contains more than 300 000 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.

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

SAFETY STRATEGIES

Pharmacists have a growing role in supporting safe and effective patient care; strategies provided in Box 1, developed from shared learning, can help ensure that critical information is available to the pharmacy team, to enable accuracy in the identification of patients and the assessment of therapeutic appropriateness.

BOX 1. Strategies to improve the collection and verification of critical patient information

Collection of relevant patient information

- Use a standardized patient intake form (for new patients) or checklist (for returning patients) to capture relevant patient information, including updates (e.g., pregnancy status, medical conditions, weight).[2]
- Incorporate a forcing function in the dispensing software to require completion of the allergy field in the patient profile before a prescription can be filled.[2,3]
- Implement a medical condition alert to trigger review of relevant laboratory values (e.g., filling a prescription for a patient with chronic kidney disease would prompt a check of glomerular filtration rate [GFR]; filling a prescription for a patient with diabetes would prompt a check of glycated hemoglobin [HbA1c]).

Verification of patient information

- Complete a best possible medication history (also known as BPMH) through discussion with the patient and reference to additional sources of information (e.g., discharge prescriptions, medication profile).[4]
- Ask open-ended questions when confirming patient identification (i.e., name and date of birth) at the time of prescription pickup in the pharmacy, before delivering prescriptions to the patient, and before administering vaccines.[5]
- Integrate "same name alerts" within the computer system, to minimize wrong patient errors involving patients with the same or similar names.[2]
- Encourage use of the *5 Questions to Ask* tool to support patient engagement and dialogue.[6]

References
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