National Incident Data Repository Safety Brief

Manitoba Data

6345 reports received from community pharmacies
from April 1, 2017 to March 31, 2023

Reporting period: October 2022 – March 2023

Reports Received	**1141**
Types of Incidents (including near misses) **(Top 5)**	
Incorrect dose/frequency	256
Incorrect drug	182
Incorrect strength/concentration	167
Incorrect quantity	110
Incorrect patient	107
Levels of Harm	
No error (e.g., near miss)	472
No harm	647
Mild harm	18
Moderate harm	4
Severe harm	0
Death	0

National Learning

Manitoba community pharmacies contribute to national learning and safety initiatives that incorporate learning from reported medication incidents and suggest system safeguards to prevent patient harm.

In this 6-month period, 50% of the medication incidents, including near misses, reported by community pharmacies involved the order entry stage of the medication-use process. If unrecognized, such errors can reach the patient and persist through multiple refills.

SAFETY TIP: Scan a copy of the original prescription into the pharmacy system during order entry. During the initial fill and subsequent refills, the scanned prescription should be readily accessible and regularly consulted as part of technical and clinical checks.

SAFETY TIP: Consider incorporating a pharmacist into the order entry stage to facilitate data verification with an earlier double check with the patient (e.g., to confirm the medication, dose, indication, and directions for use), instead of relying on the final check at the time of prescription pickup.

Additional safety recommendations can be found in ISMP Canada Safety Bulletins:
https://ismpcanada.ca/safety-bulletins/

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More than 305 000 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) since 2008.