New Brunswick Data

10,039 reports received from community pharmacies

from June 19, 2015 to September 30, 2022

198 pharmacies are enrolled in the NIDR

Types of Incidents (including near misses) **(Top 5)**

Incorrect dose/frequency	2,311
Incorrect quantity	1,634
Incorrect drug	1,325
Incorrect strength/concentration	1,048
Incorrect prescriber	1,007
Levels of Harm	
No Error (e.g., Near Miss)	6,027
No Harm	3,800
Mild Harm	190
Moderate Harm	21
Severe Harm	0
Death	< 3

National Learning

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

One of the most frequently reported types of errors in community pharmacy is incorrect dose/frequency. This is the case for incidents involving direct oral anticoagulants (DOACs).



Thrombosis Canada's monitoring checklist considers several factors to help health care providers optimize the safe and effective use of DOACs.



SAFETY TIP: Confirm the indication and patient-specific factors (e.g., renal function, weight) for a DOAC with the patient or prescriber to assess the appropriate dose, frequency, and duration.



SAFETY TIP: Pharmacists are uniquely positioned to communicate with patients at every refill. Because DOACs, unlike warfarin, do not undergo regular therapeutic monitoring, it is important to emphasize adherence during patient counselling.

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



More than 295,000 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) since 2008.



