



National Incident Data Repository

Safety Brief

Newfoundland and Labrador Data

from community pharmacies

Reporting period: October 1, 2025 – March 31, 2026

586 reports received

Medication System Stage(s) Involved

Prescription preparation/dispensing	480
Prescription order entry	269
Administration	28
Prescribing	26
Monitoring/follow-up	9

"Not applicable" was reported in 29 incidents

Top 5 Types of Incidents (including near misses)

Incorrect dose/frequency	144
Incorrect drug	138
Incorrect patient	61
Incorrect quantity	49
Incorrect strength/concentration	49

Reported Degree of Harm to Patient

Near miss (e.g., no error)	177
No harm	381
Mild harm	25
Moderate harm	3
Severe harm	0
Death	0

Note: Values reflect data submitted by platform providers within this reporting period.

National Learning

Newfoundland and Labrador community pharmacies contribute to improvement initiatives to advance patient safety. Reporting of incidents, including near misses, reflects a growing commitment to a culture of safety in Canada.

A selected focus for this safety brief is recurring reports involving multiple prescription entries in the dispensing software to complete a treatment regimen (e.g., multiple strengths of a single medication or multiple medications for complementary effect).



The following tips can help to minimize these types of incidents:

SAFETY TIP: If using the "copy" function during order entry for medications that may require multiple strengths, conduct a full profile review to ensure no new prescriptions have been missed and no previous prescriptions remain active.

- **Example:** Multiple prescriptions of different strengths are used for prednisone tapering regimens

SAFETY TIP: Require that a pharmacy professional consult the original prescription during a final check to confirm that all prescribed medications have been entered and dispensed, particularly those intended to be used together.

- **Example:** Multiple prescriptions for complementary effect are used for fertility (and other hormone) treatment

A key component of ISMP Canada data analysis is a review of the incident descriptions. The efforts by reporters to provide information that helps identify emerging issues and shared learning opportunities are gratefully acknowledged.

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

REPORT ✓ **LEARN** ✓ **ACT** ✓

More than 2,100 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from Newfoundland and Labrador since 2024.

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