



National Incident Data Repository Safety Brief

Newfoundland and Labrador Data

from community pharmacies

Reporting period: April 1, 2024 – September 30, 2024

422 reports received

Stages of Medication-Use Process

| | |
|-------------------------------------|------------|
| Prescription preparation/dispensing | 353 |
| Prescription order entry | 253 |
| Prescribing | 33 |
| Administration | 13 |
| Monitoring/follow-up | 10 |

"Not applicable" was reported in 15 incidents

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

| | |
|---------------------------|-----------|
| Incorrect dose/frequency | 96 |
| Incorrect patient | 56 |
| Incorrect drug | 51 |
| Omitted medication/dose | 46 |
| Incorrect quantity | 45 |

Reported Levels of Harm

| | |
|----------------------------|-----|
| No error (e.g., near miss) | 131 |
| No harm | 281 |
| Mild harm | 10 |
| Moderate harm | 0 |
| Severe harm | 0 |
| Death | 0 |

National Learning

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

A selected focus for this safety brief is errors associated with prescription transfers. In Newfoundland and Labrador, within this subset of errors (n=5), the order entry stage was most often involved (80%), and incorrect quantity was among the top 5 types of error.



The following tips can optimize safe transcription of transferred prescriptions:

SAFETY TIP: Send a copy of the original prescription along with the transfer record, to facilitate technical and clinical verification by the receiving pharmacy.

SAFETY TIP: Include in the order entry process a double check of the transfer record, particularly of fields that lack units of measure and can differ between pharmacy dispensing systems (e.g., "quantity" could be "1" [bottle] in some, and "50" [mL] in others).

SAFETY TIP: When providing a transferred prescription at pick-up, ask the patient to confirm that it is the expected medication and dose.

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 400 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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