



National Incident Data Repository

Safety Brief

Nova Scotia Data

from community pharmacies

Reporting period: October 1, 2024 – March 31, 2025

6,470 reports received

Stages of Medication-Use Process

| | |
|-------------------------------------|-------|
| Prescription order entry | 4,379 |
| Prescription preparation/dispensing | 3,259 |
| Prescribing | 308 |
| Administration | 197 |
| Monitoring/follow-up | 64 |

"Not applicable" was reported in 119 incidents

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

| | |
|---------------------------------|--------------|
| Incorrect dose/frequency | 1,528 |
| Incorrect quantity | 1,156 |
| Incorrect drug | 791 |
| Incorrect patient | 546 |
| Incorrect prescriber | 541 |

Reported Levels of Harm

| | |
|----------------------------|-------|
| Near miss (e.g., no error) | 4,267 |
| No harm | 2,060 |
| Mild harm | 123 |
| Moderate harm | 16 |
| Severe harm | 2 |
| Death | 2 |

National Learning

Nova Scotia 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 incidents associated with medication management in the community following **hospital discharge**. In Nova Scotia, within this subset of reports (n=45), incorrect dose/frequency and incorrect drug were among the top 3 types of incidents.



The following tips may help optimize safe transition of care following hospital discharge:

- SAFETY TIP:** Conduct a comprehensive medication reconciliation with the patient (or caregiver) after hospital discharge.
- In addition to the patient/caregiver, consult the hospital discharge summary (in the "clinical reports" section of the Secure Health Access Record [SHARE]), the prescription list, and the Nova Scotia Drug Information System.
 - Identify discontinued medications, changes in medication doses, and new medications, and update the patient record accordingly.
 - Clarify any unclear prescriptions with a hospital team member (e.g., pharmacist).
 - Incorporate an independent double check, or a delayed self-check, to minimize confirmation bias.

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 276,300 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from Nova Scotia since 2010.

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