



National Incident Data Repository Safety Brief

Nova Scotia Data

from community pharmacies

Reporting period: April 1, 2023 – September 30, 2023

7,889 reports received

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

Incorrect dose/frequency	1729
Incorrect quantity	1452
Incorrect drug	943
Incorrect prescriber	798
Incorrect duration of treatment	680

Contributing Factors Reported (Top 5)

(Environmental, staffing, or workflow problem) Interruptions
(Environmental, staffing, or workflow problem) Workload
(Environmental, staffing, or workflow problem) Noise
(Environmental, staffing, or workflow problem) Staffing deficiencies
(Environmental, staffing, or workflow problem) Clutter

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.

The following recommendations can help reduce interruptions (a top contributing factor both in Nova Scotia and nationally) and enhance patient safety.

SAFETY TIP: Establish designated work areas that are designed to reduce the likelihood of interruptions and distractions for *high-risk activities* (e.g., compliance packaging, compounding, medication reconciliation with hospital discharge prescriptions).

SAFETY TIP: Encourage patients to use automated systems when ordering medication refills (e.g., telephone/online refill request programs) to reduce distractions and interruptions in *workflow*.

SAFETY TIP: Ensure that staff engage in a structured role-based approach to reduce distractions and interruptions in *workflow*.

SAFETY TIP: Place a checklist in applicable work areas to keep track of steps performed during lengthy safety-critical tasks (e.g., providing opioid agonist therapy). If a task is interrupted, it should be restarted, using the checklist as a guide.

SAFETY TIP: Ensure that workspaces where medications are prepared are clean, orderly, and free of clutter.



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 is gratefully acknowledged.

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

REPORT ✓ **LEARN** ✓ **ACT** ✓

More than 250,000 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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