



# National Incident Data Repository Safety Brief

## Prince Edward Island Data

**1314 reports received  
from community pharmacies**  
from October 26, 2012 to March 31, 2023

*50 pharmacies are enrolled in the NIDR*

*Reporting period: October 2022 – March 2023*

<b>Reports Received</b>	<b>129</b>
<b>Types of Incidents</b> (including near misses) <b>(Top 5)</b>	
Incorrect quantity	35
Incorrect dose/frequency	27
Incorrect patient	17
Incorrect drug	15
Incorrect strength/concentration	13
<b>Levels of Harm</b>	
No error (e.g., near miss)	84
No harm	44
Mild harm	1
Moderate harm	0
Severe harm	0
Death	0

## National Learning

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

*In this 6-month period, 50% of the medication incidents, including near misses, reported by community pharmacies involved the order entry stage of the medication-use process. If unrecognized, such errors can reach the patient and persist through multiple refills.*



**SAFETY TIP:** Scan a copy of the original prescription into the pharmacy system during order entry. During the initial fill and subsequent refills, the scanned prescription should be readily accessible and regularly consulted as part of technical and clinical checks.



**SAFETY TIP:** Consider incorporating a pharmacist or pharmacy technician into the order entry stage to facilitate data verification with an earlier double check with the patient (e.g., to confirm the medication, dose, indication, and directions for use), instead of relying on the final check at the time of prescription pickup.

Additional safety recommendations can be found in ISMP Canada Safety Bulletins:

<https://ismpcanada.ca/safety-bulletins/>

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More than 305 000 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) since 2008.