National Incident Data Repository Safety Brief

Prince Edward Island Data

from community pharmacies
Reporting period: October 1, 2025 – March 31, 2026
431 reports received

Medication System Stage(s) Involved	
Prescription order entry	**370**
Prescription preparation/dispensing	101
Prescribing	11
Administration	6
Monitoring/follow-up	0

"Not applicable" was reported in 14 incidents

Top 5 Types of Incidents (including near misses)	
Incorrect quantity	119
Incorrect dose/frequency	107
Incorrect prescriber	49
Incorrect drug	33
Incorrect strength/concentration	32

Reported Degree of Harm to Patient	
Near miss (e.g., no error)	314
No harm	96
Mild harm	18
Moderate harm	2
Severe harm	0
Death	1

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

National Learning

Prince Edward Island 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 3,200 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from Prince Edward Island since 2012.

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National Incident Data Repository / Référentiel de données nationales sur les incidents
CMIRPS SCDPIM
Canadian Medication Incident Reporting and Prevention System / Système canadien de déclaration et de prévention des incidents médicamenteux