



National Incident Data Repository Safety Brief

Saskatchewan Data

**39,340 reports received
from community pharmacies**
from September 27, 2013 to September 30, 2022

Reporting period: April 2022 – September 2022

Reports Received	2,581
Types of Incidents (including near misses) (Top 5)	
Incorrect dose/frequency	571
Incorrect drug	496
Incorrect quantity	325
Incorrect patient	324
Incorrect strength/concentration	318
Levels of Harm	
No Error (e.g., Near Miss)	1,054
No Harm	1,338
Mild Harm	174
Moderate Harm	12
Severe Harm	2
Death	1



National Learning

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

One of the most frequently reported types of errors in community pharmacy is incorrect dose/frequency. This is the case for incidents involving direct oral anticoagulants (DOACs).



Thrombosis Canada's *monitoring checklist* considers several factors to help health care providers optimize the safe and effective use of DOACs.



SAFETY TIP: Confirm the indication and patient-specific factors (e.g., renal function, weight) for a DOAC with the patient or prescriber to assess the dose, frequency, and duration.



SAFETY TIP: Pharmacists are uniquely positioned to communicate with patients at every refill. Because DOACs, unlike warfarin, do not undergo regular therapeutic monitoring, it is important to emphasize adherence during patient counselling.

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

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More than 295,000 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) since 2008.

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