



National Incident Data Repository Safety Brief

Saskatchewan Data

from community pharmacies

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

2,770 reports received

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

| | |
|----------------------------------|-----|
| Incorrect dose/frequency | 621 |
| Incorrect drug | 515 |
| Incorrect strength/concentration | 380 |
| Incorrect quantity | 337 |
| Incorrect patient | 332 |

Contributing Factors Reported (Top 5)

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| (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 |
| (Drug name, label, packaging problem) Look-alike/sound-alike names |

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.

Related information can be found in the article "Statistics" in the November 2023 issue of *Directions: COMPASS Program Newsletter* (https://saskpharm.ca/document/12227/Directions_Vol8_Issue4_202311.pdf).

The following recommendations can help reduce interruptions (a top contributing factor both in Saskatchewan 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.



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 44,000 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from Saskatchewan since 2013.

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