National Incident Data Repository Safety Brief

Manitoba Data

from community pharmacies

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

1,362 reports received

Types of Incidents (including near misses) **(Top 5)**	
Incorrect dose/frequency	291
Incorrect drug	234
Incorrect strength/concentration	192
Incorrect patient	126
Incorrect quantity	97

Contributing Factors Reported (Top 5)
(Environmental, staffing, or workflow problem) **Workload**
(Environmental, staffing, or workflow problem) **Interruptions**
(Drug name, label, packaging problem) **Look-alike/sound-alike names**
(Environmental, staffing, or workflow problem) **Staffing deficiencies**
(Miscommunication of drug order) **Misunderstood orders** (e.g., intentional change of medication or dosage not indicated on prescription)

National Learning

Manitoba 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 Manitoba and nationally) and enhance patient safety. Additional safety tips can be found on the College of Pharmacists of Manitoba website: https://safetyiq.academy/reducing-distractions-and-interruptions/human-factors-engineering/

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 7,500 reports of medication incidents have been submitted to the National Incident Data Repository for Community Pharmacies (NIDR) from Manitoba since 2017.

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