

National Incident Data Repository Safety Brief

Manitoba Data

**5,204 reports received
from community pharmacies**
from April 1, 2017 to September 30, 2022

Reporting period: April 2022 – September 2022

Reports Received	1,306
Types of Incidents (including near misses) (Top 5)	
Incorrect dose/frequency	263
Incorrect drug	214
Incorrect strength/concentration	180
Incorrect patient	141
Incorrect quantity	106
Levels of Harm	
No Error (e.g., Near Miss)	546
No Harm	674
Mild Harm	81
Moderate Harm	4
Severe Harm	0
Death	1



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.

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 appropriate 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.