The 62 medication incidents were independently reviewed by two reviewers. Seventy-five incidents were retrieved and 62 of them met inclusion criteria and were included in this analysis. The purpose of this study was to share information about medication incidents involving drug shortages voluntarily reported to the ISMP Canada’s Community Pharmacy Incident Reporting (CPhIR) Program (www.cphir.ca) and the ISMP Canada Safety Bulletin. A multi-incident system-based approach was used to identify the common themes identified through a multi-incident analysis.

Specific examples of reported incidents are provided to develop system-based improvements that can be customized to pharmacy practice setting.

**Methods**

- Reports of medication incidents involving “Drug Shortage” were extracted from the CPhIR Program from November 2010 to June 2012.
- 75 incidents were retrieved and 62 of them met inclusion criteria and were included in this analysis.
- The 62 medication incidents were independently reviewed by two ISMP Canada Analysts.

**Results**

The outcome of the majority of the incidents were reported as “no error” (i.e., near misses), meaning that an error was made, but it was intercepted or corrected before the medication was dispensed to the patient.

The 62 medication incidents were categorized into two main themes (Table 1): 1. Deviation from the intent of the original prescription; and 2. Near misses.

**Conclusions**

- Two major points in the management of drug shortages have been illustrated:
  1. It is important to perform independent double checks during the entire entry and dispensing process when making alternative arrangements for a prescription;
  2. There is the need for patients to understand the identity and use of the medications, communication among staff members of drug shortages, as well as education on policies and procedures for potential problems that may be encountered when dealing with certain drug shortage situations.

**References**

5. Misunderstanding.