AIMS

Assurance and Improvement in Medication Safety

A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

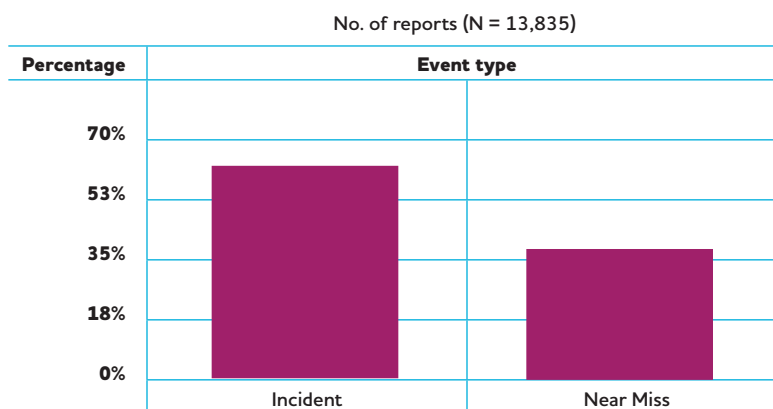# 2021 AIMS
Annual Data Report

Date range: January 1, 2021, to December 31, 2021
Number of events: 13,835
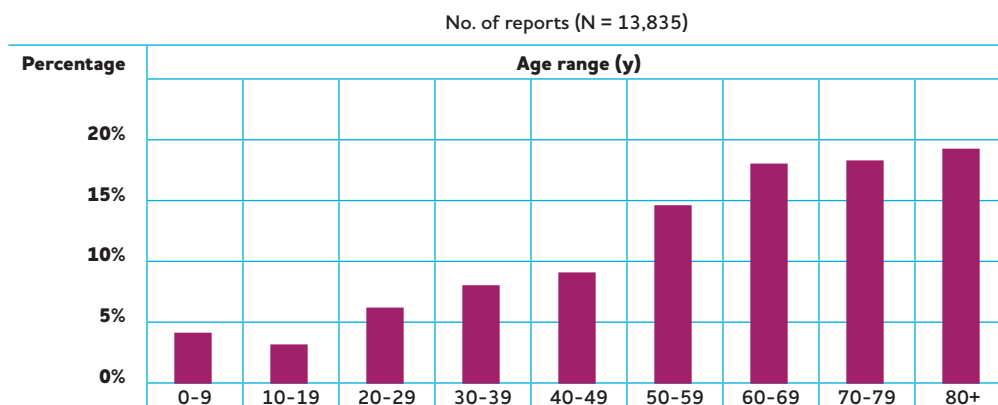**Number of reporting pharmacies:** 2,544

Event type*

*A medication incident is an error that reached the patient, while a near miss is an error that was intercepted before it reached the patient.

No. of reports (N = 13,835)

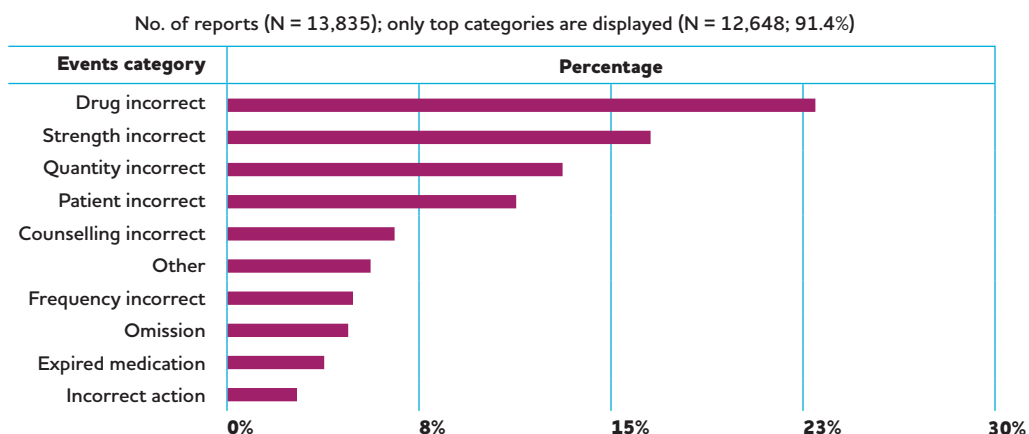| Percentage	Event type	
70%		
53%		
35%		
18%		
0%	Incident	Near Miss

Patient age*

*Age at time of event. Note that individuals 60 y of age and older typically have more conditions and/or take more medications, which may account for the increase in medication events across these age ranges.

No. of reports (N = 13,835)

Age range (y): 0–9, 10–19, 20–29, 30–39, 40–49, 50–59, 60–69, 70–79, 80+

Percentage axis: 0%, 5%, 10%, 15%, 20%

Event category

Abbrevations: DUR, drug utilization review.

No. of reports (N = 13,835); only top categories are displayed (N = 12,648; 91.4%)

Events category (Percentage):
- Drug incorrect
- Strength incorrect
- Quantity incorrect
- Patient incorrect
- Counselling incorrect
- Other
- Frequency incorrect
- Omission
- Expired medication
- Incorrect action

Percentage axis: 0%, 8%, 15%, 23%, 30%

![AIMS logo] **Assurance** and **Improvement** in **Medication Safety**
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ONTARIO COLLEGE OF PHARMACISTS

2021 AIMS
Annual Data Report

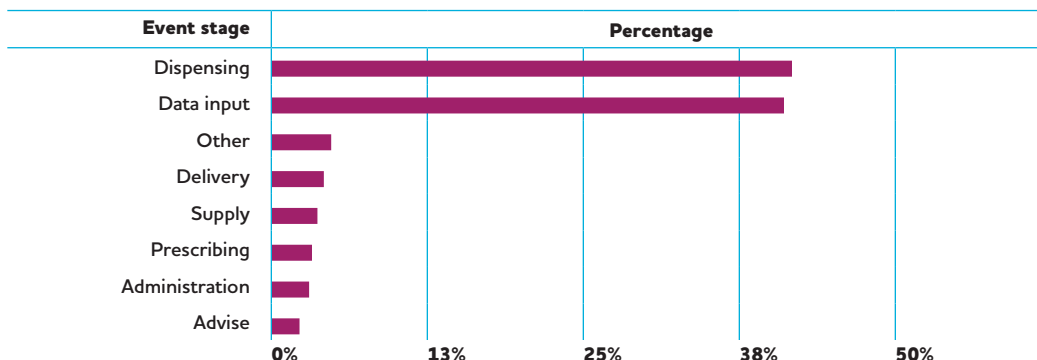**Date range:** January 1, 2021, to December 31, 2021
Number of events: 13,835
Number of reporting pharmacies: 2,544

Event stage*

*The primary stage where the event occurred.

No. of reports (N = 13,835); only top stages are displayed (N = 13,755; 99.4%)

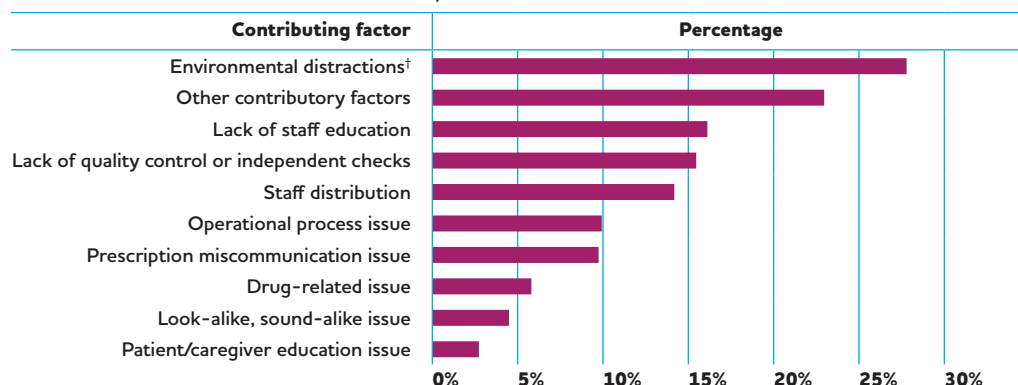| Event stage	Percentage
Dispensing	
Data input	
Other	
Delivery	
Supply	
Prescribing	
Administration	
Advise	

0%   13%   25%   38%   50%

Contributing factor*

*More than one contributing factor may be selected per event.

†Environmental distractions, the most common contributing factor to medication events, include clutter, patient interruptions, higher-than-normal dispensing volumes, increased workloads and noise (note that this list is not exhaustive).

No. of reports (N = 13,835)

Contributing factor	Percentage
Environmental distractions†	
Other contributory factors	
Lack of staff education	
Lack of quality control or independent checks	
Staff distribution	
Operational process issue	
Prescription miscommunication issue	
Drug-related issue	
Look-alike, sound-alike issue	
Patient/caregiver education issue	

0%   5%   10%   15%   20%   25%   30%

Harm level*

*Refers to harm caused to the patient and uses World Health Organization definitions of harm. Note that any correlation between the medication incident and death is not conclusive: "The incident *may* have caused or contributed to the patient's death."

†Harm level is only reported for events that reach the patient.

Percentage — No. of incidents (N = 8,579†)

	Death	Severe harm	Moderate harm	Unknown	Mild harm	No harm
Percentage	0.05%	0.17%	1.55%	6.52%	7.96%	83.67%

90%   67.5%   45.0%   22.5%   0%