AIMS Assurance and Improvement in Medication Safety

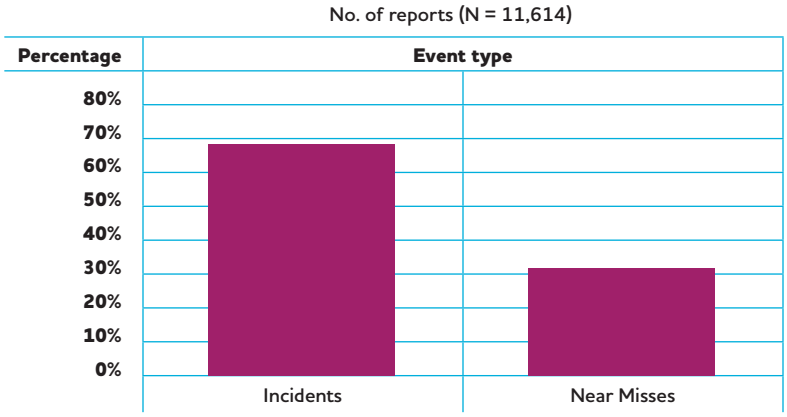
A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

2025 AIMS *Annual Data Report*

Date range: January 1, 2025, to December 31, 2025
Number of events: 11,614
Number of reporting pharmacies: 2,358

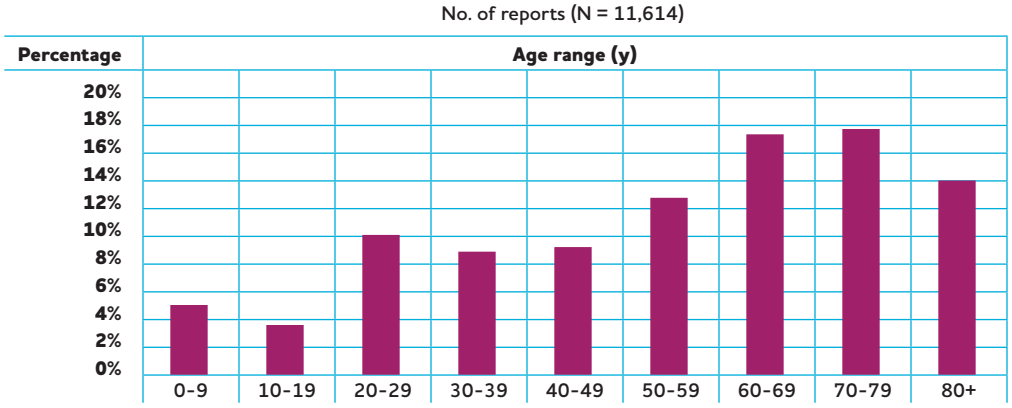
Event type*

*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.



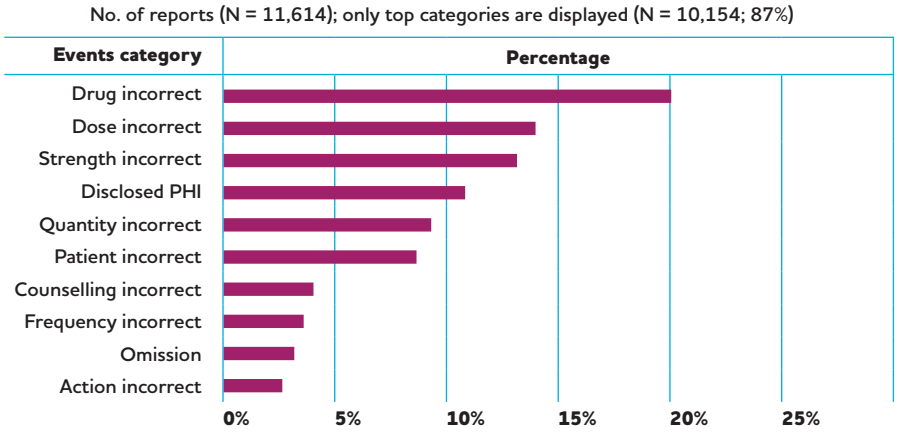
Patient age*

*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.



Event category

Abbrevations: PHI, patient health information.



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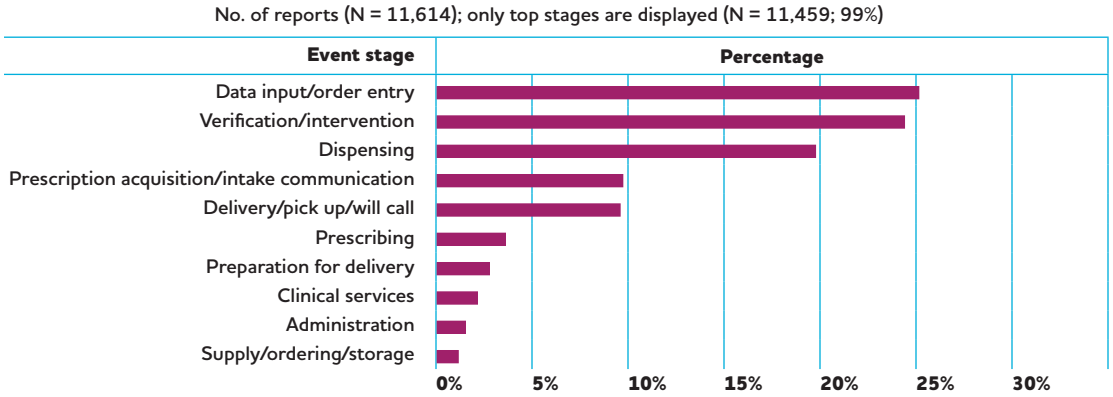
Event stage*

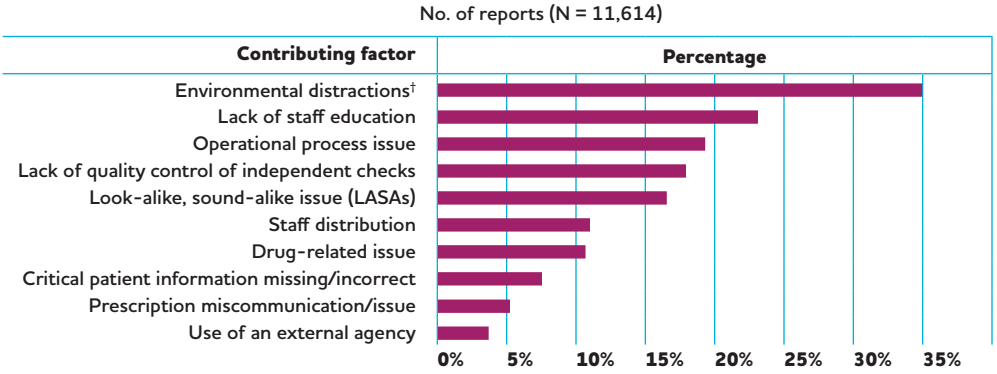
*The primary stage where the event occurred.



Contributing factor*

*More than one contributory factor may be selected per event, leading to more contributory factors than events.

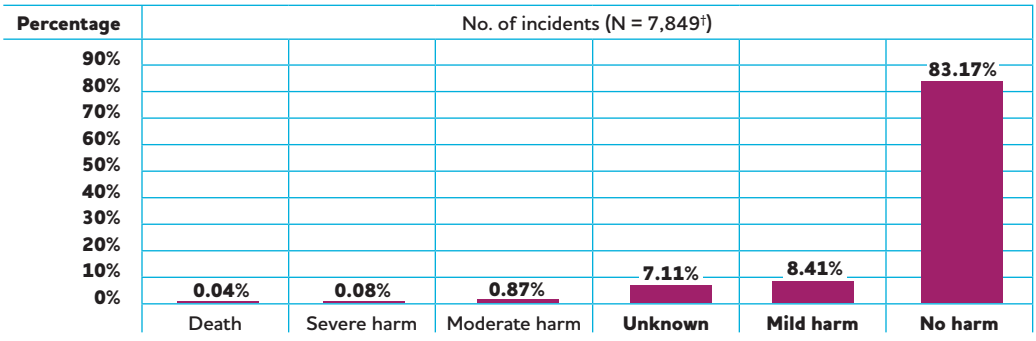
†Environmental distractions, the most common contributing factor to medication events, include clutter, patient interruptions, higher-than-normal dispensing volumes, increased workloads and noise (note that this list is not exhaustive).



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, as per the definition: "The incident may have caused or contributed to the patient's death."

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



Recommendations to Minimize Errors

- Complete a comprehensive therapeutic assessment and document the indication to ensure appropriate medication use.
- Establish safeguards for high-risk medications, such as standardized dose calculations, independent verification, and clear documentation of checks performed.
- Identify and separate, or otherwise distinguish, look-alike or sound-alike medications to reduce the risk of selection errors.
- Implement independent double checks at key stages of the workflow including data entry, preparation, verification, and dispensing, with different pharmacy team members performing checks where appropriate.
- Keep workspaces clear and organized, and where possible, create focused work areas that reduce interruptions and avoidable distractions during the dispensing process, such as by separating checking areas, limiting non-urgent interruptions, and managing clutter.
- Provide ongoing staff education on best practices and ensure staff are informed of medication events, including contributing factors and actions taken to minimize risk.
- Use at least two patient identifiers at pick-up to ensure the correct medication is dispensed to the correct patient. During counselling, visually verify the medication and confirm the patient's understanding of directions for use.