AIMS Assurance and Improvement in Medication Safety

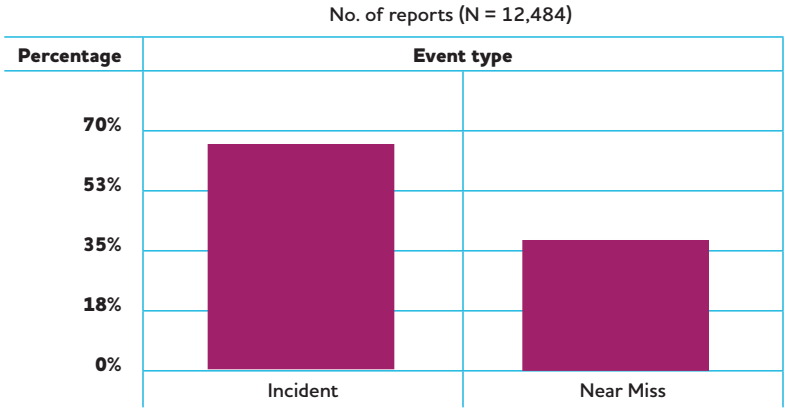
A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

2020 AIMS *Annual Data Report*

Date range: January 1, 2020, to December 31, 2020
Number of events: 12,484
Number of reporting pharmacies: 1,976

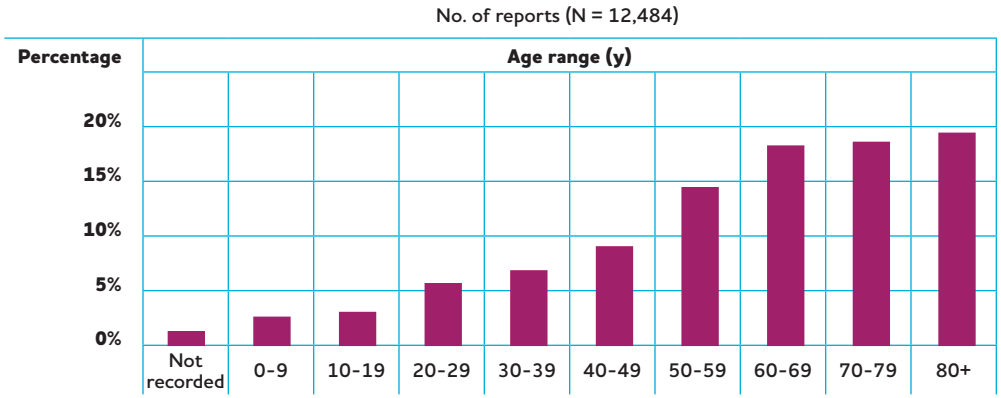
Event type*

*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.



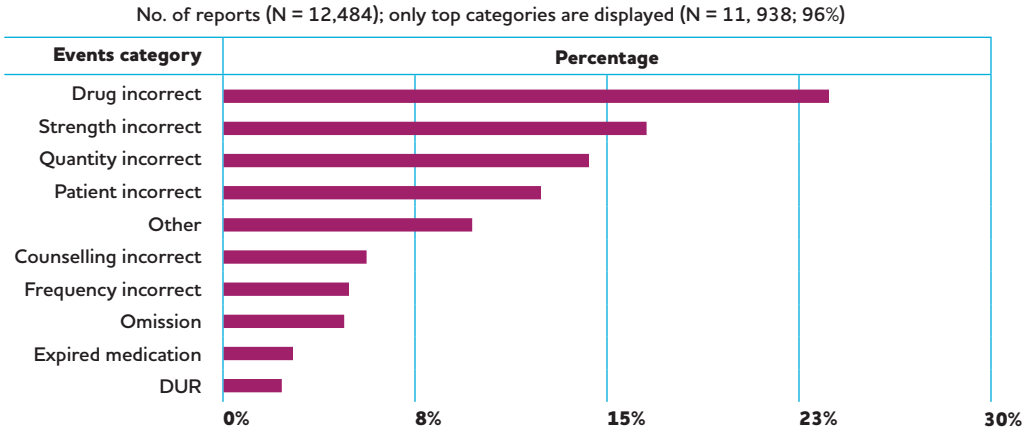
Patient age*

*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

Abbreviations: DUR, drug utilization review.



AIMS Assurance and Improvement in Medication Safety

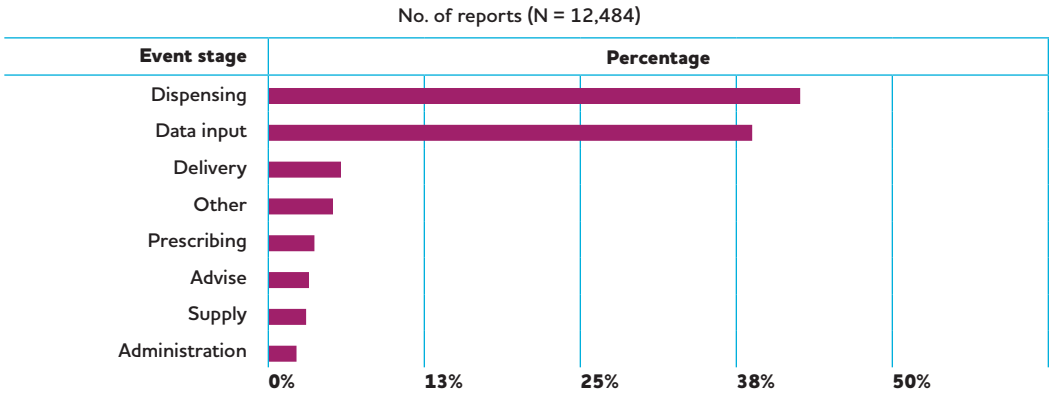
A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

2020 AIMS *Annual Data Report*

Date range: January 1, 2020, to December 31, 2020
Number of events: 12,484
Number of reporting pharmacies: 1,976

Event stage*

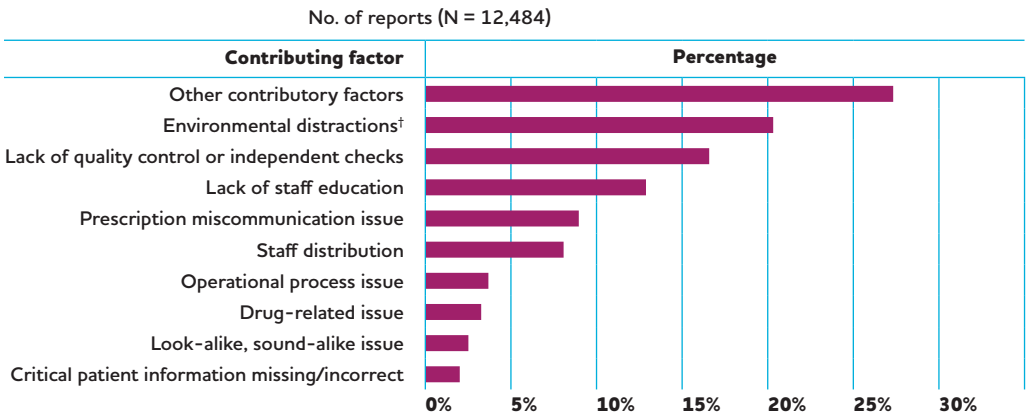
*The primary stage where the event occurred.



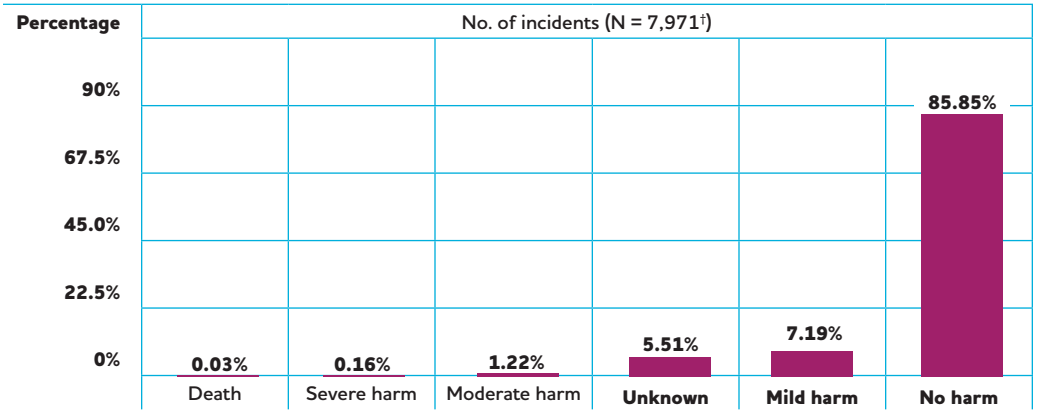
Contributing factor*

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

†Environmental distractions, one of 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: "The incident *may* have caused or contributed to the patient's death."

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