AIMS Assurance and Improvement in Medication Safety

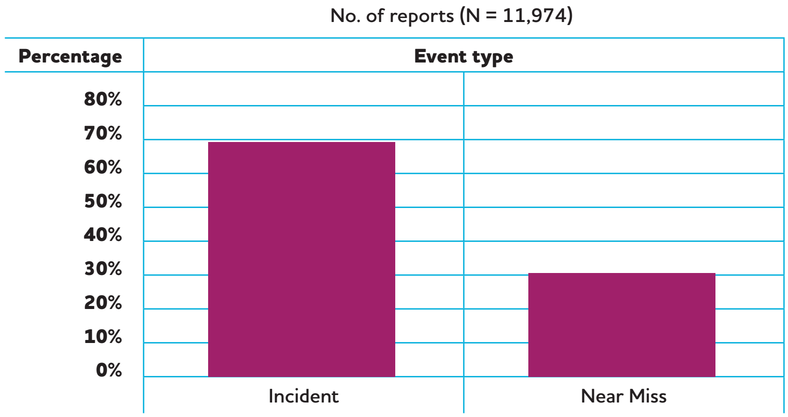
A PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAM OF THE ONTARIO COLLEGE OF PHARMACISTS

2024 AIMS *Annual Data Report*

Date range: January 1, 2024, to December 31, 2024
Number of events: 11,974
Number of reporting pharmacies: 2,460

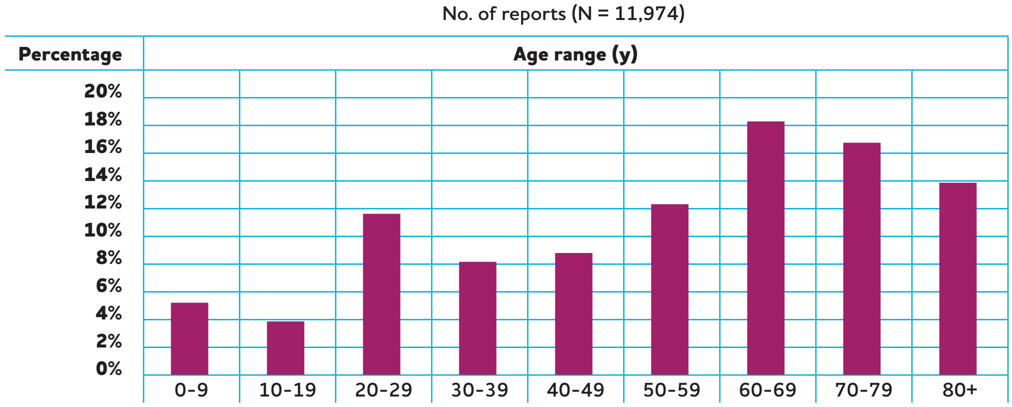
Event type*

*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.



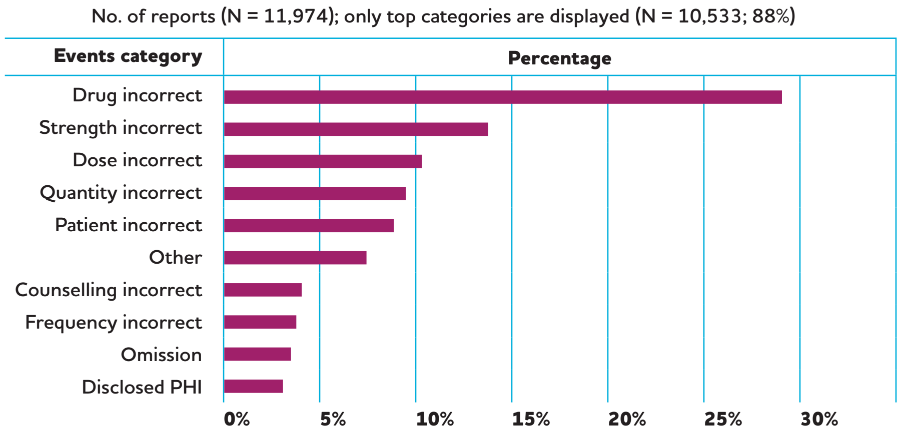
Patient age*

*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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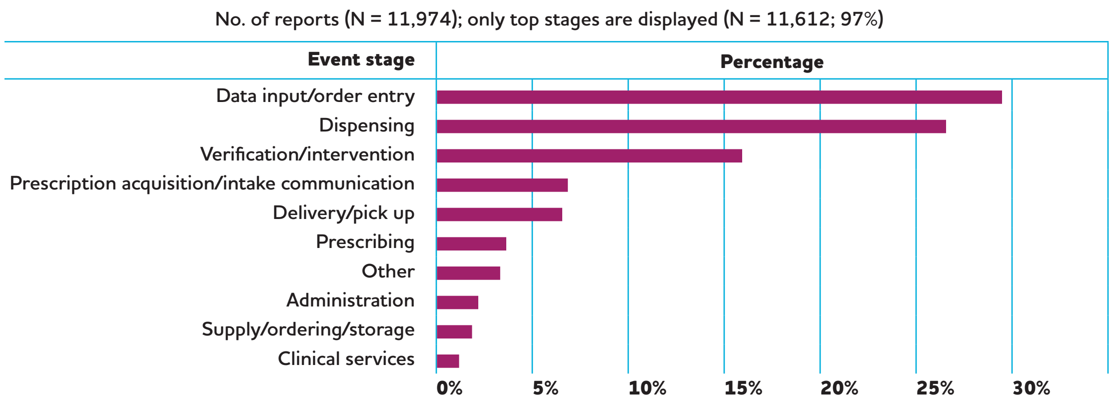
Event stage*

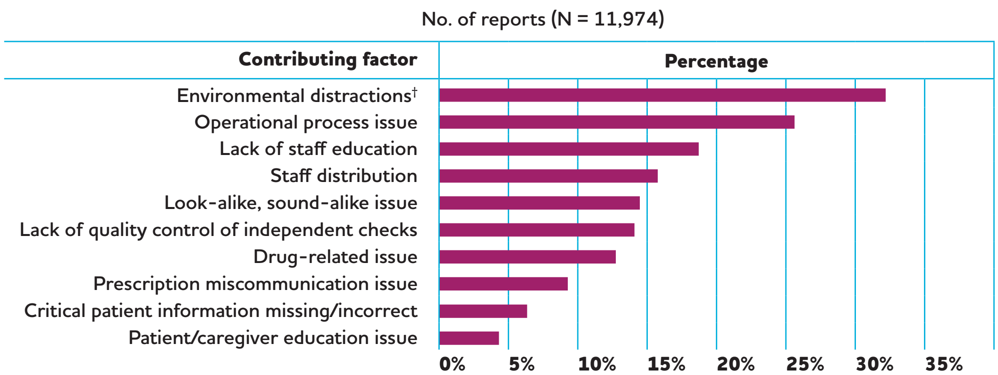
*The primary stage where the event occurred.



Contributing factor*

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

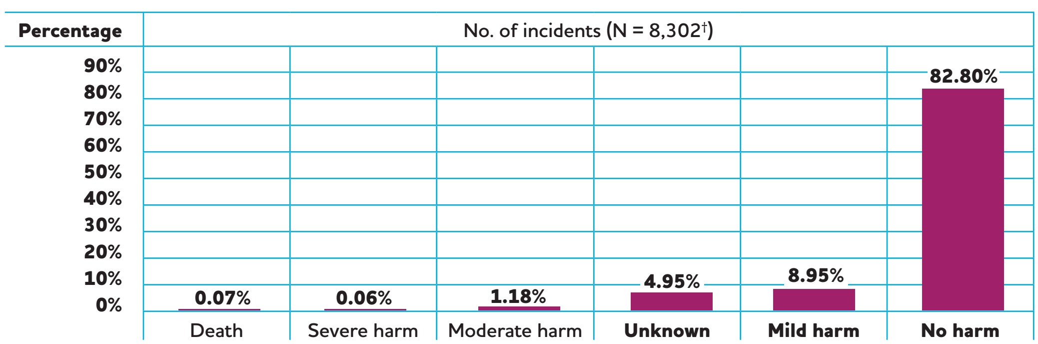
†Environmental distractions, the most common contributing factor to medication events, include clutter, patient interruptions, higher-than-normal dispensing volumes, increased workloads and noise (note that this list is not exhaustive).



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: "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

- Before entering the prescription, review allergies, medical history, indication, and other relevant details to ensure clinical appropriateness of the medication.
- Pay close attention to high-risk medications and implement additional safety measures as required to ensure safe dispensing.
- Separate and clearly label look-alike or sound-alike drug products to reduce the risk of selecting the incorrect medication.
- Ensure all team members receive information on medication events and any improvements implemented as a result (e.g., changes to processes, best practices).
- Implement a double-check system by assigning different pharmacy team members, when possible, to each stage of the workflow: prescription entry, filling, and verification/dispensing.
- Reduce distractions by keeping the workspace tidy, filling prescriptions away from patient areas, and using a checklist to easily resume your task if interrupted.
- Use at least two patient identifiers at pick-up to ensure the correct medication is dispensed to the correct patient. Visually verify the medication during counselling and ask the patient to repeat the directions to ensure understanding.