

AIMS Medication Incident & Near Miss Procedure

This document is prepared by www.pharmasist.ca

ALL medication incidents and applicable near misses must be documented, analyzed, and incorporated into the Continuous Quality Improvement (CQI) process.

1. Purpose

To ensure medication incidents and near misses are managed consistently, patient harm is minimized, root causes are identified, and quality improvement measures are implemented in accordance with the Assurance and Improvement in Medication Safety (AIMS) Program.

Medication Incident

- A preventable event that reaches the patient.
- May cause or lead to inappropriate medication use.
- May cause patient harm.
- Can involve prescribing, dispensing, compounding, monitoring, administration, labeling, storage, or communication.

Near Miss

- An error intercepted before reaching the patient.
- No patient exposure occurs.
- Provides valuable insight into system weaknesses.
- May identify areas requiring workflow improvement.

2. Immediate Response to a Medication Incident

- Act promptly to support the patient.
- Assess the actual or potential impact on patient safety.
- Notify the pharmacist immediately if identified by another staff member.
- Take appropriate corrective action.
- Document the event as soon as possible.
- Communicate with the patient and prescriber when required.

3. Incident Recording Requirements

- Record medication incidents anonymously in the approved AIMS reporting platform.
- Document details in a timely manner.
- Document contributing factors.
- Document corrective actions taken.
- Document quality improvement plans and outcomes.
- Maintain confidentiality at all times.

Required Analysis

- What happened?
- Why did it happen?
- What factors contributed?
- Could harm have occurred?
- How can recurrence be prevented?
- What process changes are needed?

Quality Improvement Actions

- Modify workflow when necessary.
- Improve checking procedures.
- Provide staff education.
- Implement safeguards.
- Monitor effectiveness of interventions.
- Share lessons learned with staff.

4. Near Miss Recording Guidance

- Record near misses when they identify meaningful patient safety risks.
- Use professional judgment when determining whether a near miss should be entered.
- Recurring near misses should always trigger workflow review.
- Patterns may indicate ineffective processes or inadequate safeguards.
- Near misses are valuable opportunities for prevention and quality improvement.

Examples of Incidents

- Wrong drug dispensed to patient.
- Incorrect strength reaches patient.
- Incorrect directions provided.
- Compounding error reaches patient.
- Incorrect quantity supplied.

Examples of Near Misses

- Wrong DIN entered but caught before dispensing.
- Wrong drug selected but identified during verification.
- Labeling error corrected before pickup.
- Incorrect quantity identified before release.
- Compounding discrepancy caught before dispensing.

5. Pharmacy Responsibilities

- Support open discussion regarding medication safety.
- Encourage staff reporting without fear of blame.
- Monitor incident trends.
- Develop and monitor quality improvement plans.
- Provide resources necessary for reporting and analysis.
- Review recurring events and implement preventive strategies.

6. Designated Manager Responsibilities

- Ensure compliance with AIMS requirements.
- Support timely reporting and investigation.
- Review incidents and near misses regularly.
- Monitor effectiveness of corrective actions.
- Promote a culture of continuous quality improvement.
- Ensure staff are trained on medication safety processes.