

NEVER EVENTS

Patient Death or Serious Harm Due to a Failure to Inquire Whether a Patient Has a Known Allergy to Medication, or Due to Administration of a Medication Where a Patient's Allergy Had Been Identified

Definition

This event involves a situation where a patient is aware of a medication allergy but is given the medication anyway because either the hospital failed to ask about allergies, or because they knew about the allergy but failed to avoid administering that medication.

This event does not include instances where the allergy was unknown to the patient, or instances where a medication had to be administered in an emergency (e.g., contrast agents for imaging), or to an unconscious patient. However, it is important to acknowledge that harm from these emergency events can still be minimized by effective monitoring and response.

Source: [Never Events for Hospital Care in Canada](#)

Harm Prevention Strategies

This list is intended for quick reference and is not comprehensive; facility-specific factors should be evaluated carefully before implementing any strategy.

- Use a combination of prevention strategies. A one-size-fits-all approach is not applicable; consider strategies that influence as many steps of the medication management system as possible.
- Standardize processes for gathering and documenting information about allergies or history of drug intolerances; for example:
 - Provide standardized forms for obtaining a [Best Possible Medication History](#)
 - Ensure the availability of up-to-date medication lists
 - Conduct a structured medication review whenever a medication is prescribed, prepared, or administered
- Before prescribing new medications, obtain a history of all current medications (including information about known allergies) to maintain a Best Possible Medication History (link above).
- Screen medication orders against validated allergy information available in the patient's records (paper and electronic) and throughout the drug distribution system.
- When a known allergen is administered, document the rationale for administration and monitor the patient closely for allergic reactions; if adverse reactions occur, consider allergy as a possible etiology.

Sources: [Allergy Never Events](#), [ASHP Guidelines on Preventing Medication Errors in Hospitals](#), [Medication Safety in High-Risk Situations](#)

Resources for Patients and Care Partners

- Ontario Health: [Medication Safety](#) patient guide
- Institute for Safe Medication Practices Canada (ISMP Canada):
[Allergies to Ingredients in Medication Products](#)

Resources for Health Care Teams

National and Provincial

- Ontario Health: [Medication Safety](#) quality standard
- Accreditation Canada: Maintaining an accurate list of medications during care transitions is included as a Required Safety Practice in the 2025 accreditation guidelines (national standards can be accessed using your hospital's online portal)
- Healthcare Insurance Reciprocal of Canada: [Care – Medication Adverse Events](#)
- ISMP Canada:
 - [Medication Safety Self-Assessment: Focus on “Never Events” in Hospitals and Ambulatory Care Centres](#)
 - [Allergy Never Events](#) (safety bulletin)
 - [Medication Reconciliation in Acute Care: Getting Started Kit](#)
 - [Best Possible Medication History: Interview Guide](#)

International

- ISMP (United States): [Targeted Medication Safety Best Practices for Hospitals](#) (best practice 21)

Additional tools and resources are available in our [Quality and Patient Safety Program Community of Practice](#) on Quorum, as well as on our [Medication Safety Quality Standard: Tools for Implementation](#) Quorum page.

To learn more about Ontario Health's Never Events Reporting program for hospitals, please visit [Never Events](#).

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ISBN 978-1-4868-9778-0 (PDF)

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