FIP STATEMENT OF POLICY AND CALL TO ACTION

The role of pharmacists in promoting patient and medication safety

Executive summary

Patient safety is broadly defined by the World Health Organization (WHO) as the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.[1] Common sources of patient harm include medication errors,[1] surgical errors, healthcare–associated infections, sepsis, diagnostic errors, patient falls, venous thromboembolism, pressure ulcers, unsafe transfusion practices, patient misidentification and unsafe injection practices. Medication safety is a large component of patient safety. It encompasses preventing medication errors and medication-related harm, particularly in relation to high-risk medications and polypharmacy.[2-4] It also involves optimising safe medication use at each stage of a patient's medication-use journey, notably during transitions of care.[5] Moreover, patient safety, and particularly medication safety, is one of the most obvious and legitimate areas of leadership for pharmacists.

In this policy statement, medication safety is covered in line with WHO's Global Patient Safety Challenge: Medication Without Harm and the Global Patient Safety Action Plan 2021-2030.[6,7] It aims to serve as a plan to inform and support policy and practice development of patient safety initiatives internationally, with a focus on medication safety across the continuum of care while providing calls to actions for governments, policy makers, health systems, professional pharmacy organisations, pharmacists and their pharmaceutical support, pharmacy academic institutions and education providers as well as pharmaceutical manufacturers. FIP also recognises that all recommendations require a collaborative approach among the key stakeholders.

In contemporary healthcare systems, medication safety is increasingly influenced by digital and artificial intelligence (AI) infrastructures, including electronic prescribing, shared medication records and clinical decision support systems, which can both reduce and introduce risks if not appropriately designed, implemented and used. AI-enabled medication safety tools should remain subject to human professional oversight, transparency standards, bias mitigation strategies, and ongoing post-implementation evaluation. This is also in line with the first fundamental ethical principle: First do not harm. This policy statement also covers recommendations on technology and AI use for patient and medication safety.

[1] Medication errors: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer.[6]

Introduction

The World Health Organization (WHO) *Global Patient Safety Challenge: Medication Without Harm and the Global Patient Safety Action Plan 2021-2030*, address patient harm associated with use of medications.[6,7] A 2024 WHO systematic review estimates that half of all avoidable harm in medical care is medication-related, and 25% of medication-related harm[2] is severe or life-threatening.[8] This review further shows that 1 in 20 patients experience preventable medication-related side effects, rising to 7% in developing countries, and the estimated global cost of unsafe care is now USD 40 billion/year and causes immense personal, social and economic impact. As it highlights that most of these harmful errors are avoidable, it is important to target and prioritise this area to improve care.[9]

Pharmacists are key healthcare professionals, specialising in the safe and effective use of medication.[10] Their extensive medication knowledge and skills enable them to prevent harm, identify risks, and intervene at critical points in the medication-use process. Pharmacists and their pharmaceutical support workforce contribute/lead directly to patient safety through high-risk medication oversight, participation in multidisciplinary care teams, and system-level safety improvements.[11] Pharmacists are well-positioned to advocate for both safer medication management systems, with safety governance and risk management. This includes management of medication shortages, and a culture of patient safety in healthcare organisations. An effective safety culture facilitates a 'just culture',[3] which encourages pharmacovigilance reporting and learning from errors. In order for pharmacist teams to be involved in the global health agenda, their role in patient safety requires recognition and support, for example, formal inclusion of pharmacists in patient safety governance or clearer roles within safety strategies, by healthcare organisations and regulatory bodies.

However, workforce shortages, excessive workloads, fatigue, and burnout among healthcare professionals are also major contributors to medication-related harm and patient safety incidents thus these can be solved by joined efforts not only by pharmacists, but also for policy makers, governments, pharmacy organisations and educators.

FIP encourages all healthcare professionals and other key stakeholders, including patients and their caregivers, managers, policy makers and educators, to consider designing/optimising services collaboratively to improve patient safety.

Interprofessional collaboration and communication among healthcare professionals in all healthcare settings are key to improving patient safety, along with a multifaceted approach across the entire supply chain at national and international levels.

[2] Medication-related harm: Patient harm related to medication. It includes preventable adverse drug events (e.g. due to a medication error or accidental or intentional misuse) and non-preventable adverse drug events (e.g. an adverse drug reaction).[2]
[3] Just culture: Culture where we shift from blame to learning in order to improve patient safety and consider wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retributions.[7]

Key objectives include:

- To provide timely access to useful information about health and medicines to patients.
- To develop and optimise evidence-based medication safety-related policies and guidelines; timely access to effective and quality medications and evidence-based treatments.
- To develop systems for reporting, monitoring, analysing and disseminating safety events, and
- To develop evidence-based education programmes and campaigns which are regularly evaluated for impact; collaboration among stakeholders; patient empowerment programmes; and research programmes.

The goal is to increase the safe and effective use of medications, prevent errors and decrease the risk of harm associated with health care.

AGAINST THIS BACKGROUND, FIP RECOMMENDS THAT AND CALLS FOR ACTION BY STAKEHOLDERS TO:

A. Governments and policymakers, in consultation with healthcare professionals and/or their associations**:**

Policy, regulation and recognition

1. Implement a safety culture and a regulatory framework that facilitates the sharing of information to support the provision of safe individual patient care. Policymakers should base their decisions and working strategies on evidence stemming from assessment and research activities. Implementation of decision should be regularly assessed using appropriate indicators.
2. Define levels and areas of individual and shared responsibility regarding the adoption of national health and medication-related policies and standards to safeguard patient safety.
3. Implement and monitor national health and medication-related policies that promote safe and effective use of medications.
4. In collaboration with healthcare professionals and/or their associations, support the development, implementation and regular updating of evidence-based standards related to patient safety and, in particular, medication safety.
5. Support the implementation of non-punitive systems to report monitor, analyse and disseminate safety events to encourage shared learning about medication errors and medication-related harms nationally.
6. Promote supply chain resilience and establish comprehensive strategies to prevent and combat the circulation of falsified medicines and mitigate medication supply disruptions that compromise safe and effective patient care.
7. Establish a scope of practice that enables pharmacists to operate at their full scope and ensuring the consistent delivery of standardised services across all settings within the same jurisdiction, thereby safeguarding patient safety.
8. Lead the adoption of supportive technology-enabled safety solutions according to ethical, regulatory and legal considerations (electronic prescribing, clinical decision support tools, barcode/QR-code/RFID scanning, automated dispensing, robotics, etc.) always under the supervision of health professionals to reduce medication-error risks while considering disparities in AI and digital infrastructure, workforce readiness, and financial capacity across healthcare systems.
9. Enable systems' leadership in medicines safety by embedding robust quality management systems (e.g., quality planning, quality assurance/control and quality improvement frameworks, such as root cause analysis and failure mode and effects analysis into pharmacy practice and wider health-system processes.

10. Coordinate efforts across stakeholders, also or in particular even before initiatives begin, ensuring early alignment, effective planning, and shared ownership of patient-safety goals.
11. Address the safety, interoperability, legal and governance of digital medication systems, ensuring they support safe, accurate, and reliable medication practices.
12. Develop and implement national policies and programmes that strengthen responsible medication use, including clear guidance and accessible systems for the safe disposal of pharmaceutical waste and unused or obsolete medical devices, in order to improve patient safety and protect public health and the environment.
13. Ensure workforce planning for pharmacy is embedded so that pharmacy teams are adequately resourced and safe staffing levels are achieved.
14. Ensure investment in AI and digital health technologies including a shared digital patient record which pharmacists in all settings can access to support their safe practice, and
15. Integrate medication safety criteria into procurement and reimbursement decisions, including labelling, packaging, usability, supply continuity, risk minimisation measures and interoperability with digital systems.

Collaboration, research and advocacy

16. Initiate and drive constructive dialogue with all key stakeholders concerned with patient safety.
17. Promote collaborative work and share patient care information between healthcare professionals while fully respecting data protection regulations;
18. Develop, implement and promote programmes related to patient safety and patient empowerment in consultation with individual and/or other caregivers and patient consumer organisations.
19. Implement programmes that allow people to access their health information, including clinical information and prescription records (e.g., via electronic health records) to empower them to take charge of their health and, at the same time, prevent inaccuracies and errors.
20. Implement programmes that allow pharmacists to access relevant patient data, including clinical information (e.g., via electronic health records) to enable them to effectively provide health and pharmaceutical services;
21. Develop strategies to ensure the full use of pharmacy services to improve patient adherence and medicines optimisation.
22. Encourage the development of patient safety programmes/structures to support system-wide learning, facilitate reporting and analysis of patient-safety incidents,[4] and promote a culture of continuous improvement. Such programmes can also coordinate stakeholder engagement, align priorities across the health system, and drive national patient-safety strategies, and
23. Promote adoption of electronic prescribing and other emerging digital technologies (consultations and supply through telehealth/telepharmacy, remote monitoring tools, digital verification systems, validated AI-driven clinical decision support, etc.) along with standards to enhance medication safety and reduce preventable harm.

Workforce, education and capacity building

24. Support the inclusion of patient safety and the role of different healthcare professions in medical, pharmacy, allied health and science undergraduate or

[4] Patient safety incident: "An event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.[2]

postgraduate curricula leading to professional qualification, continuing education and professional development.

25. Initiate and support ongoing programmes to educate the public about the safe use of medications and the roles of pharmacist, and
26. Integrate human factors and systems-engineering principles into health-professional education and training, including team-based competencies and interprofessional collaboration, ensuring that pharmacists, prescribers, and other healthcare workers develop the competencies needed to design, implement and work within safer medication-use systems.

Resources - led by national pharmacovigilance system leaders, through a comprehensive strategy

27. Develop, implement and monitor indicators and tools that proactively measure patient and consumer safety in practice, and use these insights to promote and support the ongoing development of a strong safety culture.
28. Promote the use of shared or integrated information platforms that allow access and sharing of information in a secure, comprehensive and accurate manner.
29. Facilitate reporting of medication errors by all key stakeholders, by removing barriers, and fostering non-punitive and proactive reporting, with the dissemination of evidence-based approaches to error reduction.
30. Emphasise the role of new technologies and digital innovations in healthcare as key drivers of patient safety, always under the supervision of health professionals, regardless of the context in which they are implemented, and
31. Ensure a comprehensive regulatory framework is in place for all medicines, supporting safe medication practices across the entire health system.

B. Payers and health system funders

1. Develop, implement, and regularly update a system-wide patient-safety strategy as the foundation for integrating patient safety into healthcare planning.
2. Coordinate early involvement across all stakeholders, including patients, before initiatives begin to ensure alignment, shared ownership, and effective implementation.
3. Collaborate across patient safety organisations, including global ones like the Patient Safety Movement Foundation and the Institute for Healthcare Improvement to strengthen shared learning, harmonise safety practices, and advance system-wide patient-safety improvements.
4. Provide strong system-level leadership for patient safety by ensuring adequate expertise, staffing, and resources.
5. Encourage healthcare provider leadership, supporting from the top-down for patient safety and providing resources for the pharmacists they employ as well as defining the roles of the interdisciplinary team.
6. Drive leadership for medicines and medication safety by embedding quality-management systems (e.g., quality planning, quality assurance/control and quality improvement) into pharmacy and medication-use processes.
7. Promote a process-oriented approach to medication safety by strengthening system design, standardising workflows, and reducing variability across the medication-use process to minimise risks of errors.
8. Use continuous-quality-improvement methodology such as Plan-Do-Check-Act (PDCA) cycles and Root Cause Analysis (RCA) to analyse medication-use processes that have led to errors, and Failure Mode and Effects Analysis (FMEA) to proactively identify and modify steps that could lead to harm.[12,13]
9. Implement transparent, structured decision-making processes related to patient safety, risk management, and medication-use policies.

10. Extend patient safety frameworks beyond hospital settings and include community pharmacy environments, where pharmacists remain highly accessible points of care.
11. Establish a regulated medication safety reporting system that is based on just culture.
12. Lead or support medication safety initiatives by pharmacists, utilizing standardized processes and tools.
13. Address the safety, interoperability, and governance of digital medication systems, including cybersecurity protections.
14. Strengthen standards for medicine advertising, including online promotion, and collaborate with healthcare regulators to ensure safe, ethical, and accurate communication.
15. Guide technology industries that design and develop digital health tools (electronic prescribing systems, automated dispensing cabinets, clinical-decision support software, and built-in safety 'force-fields' within medication-management programs, etc.) to ensure these technologies incorporate robust safety checks and effectively support safe medication practices.
16. Monitor inappropriate or misleading health information disseminated via social media and address associated risks, and
17. Encouraging accreditation, such as WHO patient safety friendly facility accreditation for hospital-wide patient safety initiatives.[14]

C. Professional pharmacy organisations

Policy, regulation and recognition

1. In collaboration with key stakeholders, develop, regularly update and promote best practice standards on patient safety that apply to all areas of pharmacy practice, targeting transitions of care, high-risk medicines and polypharmacy.[2,8,15]
2. Establish non-punitive and learning-oriented systems for reporting and addressing healthcare-related harm, including empowering individuals and/or their caregivers to report patient safety incidents.
3. Develop, implement, monitor and review system- and process-based indicators and tools to proactively measure improvements in medication safety in practice, and
4. Ensure pharmaceutical teams play an active role in medication-supply governance and risk management, including planning and implementing response strategies during medication shortages and emergencies, to minimise patient harm.

Collaboration, research and advocacy

5. In collaboration with patient/consumer organisations, develop and deliver ongoing campaigns aimed at empowering patients and the public to understand and comprehend their medications so they can use them safely—by understanding their medications, maintaining an up-to-date medication list, knowing their allergy history, and reporting patient safety incidents—while also highlighting the critical role of pharmacists in supporting medication safety.
6. Support vulnerable and special-needs populations in the community by tailoring patient-safety initiatives to their specific needs and barriers.
7. Develop strategies to share lessons learned from patient safety incidents (including medication-related harm) and near misses[5] with other healthcare organisations internationally, and

[5] Near misses: An incident that did not reach the patient.[2]

8. Actively participate in WHO World Patient Safety Day (17 September) through awareness campaigns and educational activities.

Workforce, education and capacity building

9. Develop patient-safety training programmes for pharmacists and their workforce at all levels of practice, in collaboration with key stakeholders.
10. Contribute to medication-safety content in medical, pharmacy, nursing, dental and allied-healthcare education to ensure consistent safety competencies across professions.
11. Deliver continuing-education programmes that equip practising pharmacists and their workforce to lead, implement, and evaluate patient-safety initiatives;
12. Provide practical tools and structured approaches to support effective staff training in patient safety and safe medication-use processes.
13. Advocate for the integration of patient safety into pre-registration pharmacy curricula by promoting the adoption of globally recognised, up-to-date competency frameworks and educational guidelines, and
14. Align training and competency development with international standards to ensure pharmacy professionals maintain current, evidence-based skills in medication safety and systems-based practice.

D. Pharmacists:

Policy, regulation and recognition

1. Develop, implement, promote, monitor and review medication safety policies and procedures in hospital, primary care, community and residential care or other relevant facilities to prevent patient safety incidents.
2. Implement non-punitive systems to record and share patient safety incidents and actions taken, and use these reporting systems to report, monitor, analyse, and disseminate shared learning of medication-related harms and near misses.
3. Actively share anonymised patient safety data in full respect of data protection regulations, with approved local, regional and national bodies or registration databases to support a patient safety culture.
4. Ensure systems are in place for supply of medications in times of shortages and for access to medications by patients most in need.
5. Identify the steps in the medication use process where technology (such as bar codes, computer order entry, patient identification, etc.) can eliminate or reduce medication errors and contribute to the design, implementation and evaluation of these systems to ensure they support safe clinical decision-making.
6. Integrate technology driven solutions such as barcode scanning and automated dispensing systems, always under the supervision of health professionals, to reduce medication errors.
7. Strengthen patient safety through standardised Pharmaceutical Care Services, ensuring all Clinical Professional Pharmacy Services are delivered in accordance with established procedures, thereby guaranteeing safe, effective, and consistent patient care, and
8. Ensure sustainable funding for pharmacist-led medication safety services, including medicines reconciliation, medication review, high-risk medicines management, pharmacovigilance, deprescribing, transitions-of-care support and patient education.

Collaboration, research and advocacy

8. Implement national standards and guidelines on patient safety in their practice.
9. Engage in ongoing continuing education programmes on patient safety;

10. Advocate for the patient with other healthcare professionals on medication-related issues.
11. Deliver education programmes on patient safety to the pharmaceutical workforce team.
12. Advocate for and create a positive patient safety culture at local, regional and national levels to avoid patient harm and to ensure non-punitive reporting and addressing of errors and issues related to patient harm.
13. Promote medication safety processes to decrease the risk of error and harm during all pharmacists' interventions with documentation of adverse drug reactions, documentation and communication of medication changes at transitions of care, monitoring of adherence to medication, empowering individuals and/or their caregivers to ask questions about the harms and benefits of medication.
14. Collaborate with pharmacy organisations, other healthcare professionals and governments to create and implement educational policies to improve patient safety.
15. Actively engage patients and their carers as equal partners, and ensure that they are fully informed and engaged when making healthcare decisions.
16. Implement appropriate technology to improve patient safety.
17. Join the global community of pharmacists in marking the annual WHO World Patient Safety Day (17 September), as well as other global and national public health days (e.g. Antimicrobial Stewardship activities such as World Antimicrobial Awareness Week).
18. Link with national, regional and local patient and medicines safety networks or groups, organisations, and authorities to provide opportunities for shared learning, report emerging medication-safety concerns, and contribute to and support coordinated national medicines or patient safety initiatives.
19. Share medication-safety resources and information, incident-prevention tools, and best practices through national repositories and professional-community platforms to support consistent learning across the pharmacy workforce.
20. Encourage patients to use social media responsibly. Use social media to disseminate accurate, evidence-based medication-safety information for the public and healthcare colleagues, while avoiding the spread of misinformation, and
21. Engage with national and international pharmacy communities through digital channels to exchange knowledge, highlight safety communications (such as patient safety alerts), and strengthen collective capacity for medication-safety improvement.

Workforce, education and capacity building

22. Participate in campaigns to educate the public on patient safety and the roles of pharmacists.
23. Implement patient safety training programmes for all staff in their practice setting, including mechanisms to prevent patient harm, and for reporting, monitoring, analysing and disseminating patient safety incidents;
24. Be actively involved in medication management and quality improvement activities.
25. Promote patient education and responsible medication use, by providing guidance on correct treatment duration, preventing the use of expired or discontinued medicines, and supporting proper disposal of pharmaceutical waste and medical devices waste to enhance patient safety and environmental protection, and
26. Promote pharmacovigilance by detecting, documenting and reporting suspected adverse drug reactions (ADRs) and adverse drug events (ADEs) and supporting patients in recognising and reporting medicine-related harm.

E. Pharmacy academic institutions and education providers

1. Ensure patient safety, and in particular the prevention of medication-related harm, is part of the pharmacy curricula and that interprofessional learning is facilitated.
2. Advocate for medication safety to be part of all healthcare curricula;
3. Collaborate with key stakeholders to develop and implement medication safety training programmes.
4. Be actively involved in delivering medication-related training programmes for medical and other allied healthcare curricula.
5. Promote, participate in and/or initiate medication safety research;
6. Promote pharmacoepidemiology methods and its application to medication safety research, and
7. Actively disseminate findings of research studies in all aspects of patient safety to local, national and international audiences.

F. Pharmaceutical manufacturers

1. Develop, implement and monitor systems related to patient safety according to national and international guidelines and regulations (e.g., systems for pharmacovigilance, emerging health threats, incident management, look-alike/sound-alike medicines, medication supply logistics, track-and-trace system and e-labelling).
2. Develop strategies and actively share patient safety incident data, in full respect of data protection regulations, with approved local, regional and national bodies or registration databases to support a patient safety culture.
3. Standardise and separate high-risk medication workflows. (For instance, make dangerous administration routes physically impossible. Example: vincristine should only be supplied and administered from a minibag, not a syringe to prevent accidental intrathecal injections, which are almost always fatal).
4. Strengthen labelling, training, and verification for high-alert medicines (such as vincristine) and high-risk situations.[6]
5. Ensure open communication and co-ordinated strategies with pharmacy teams in times of medication shortages and increased demands for pharmaceuticals;
6. Ensure transparent communication with healthcare providers during medication recalls and safety alerts, and
7. Observe the International Council for Harmonisation's (ICH) Good Clinical Practice standards and responsible medication safety practices in clinical trials, including in related protocols, registries, publications and reports.[16]

AGAINST THIS BACKGROUND, FIP COMMITS TO:

Policy, regulation and recognition

1. Advocate for the development of a regulatory framework that allows and encourages the sharing of information where it facilitates the provision of safe individual patient care, and
2. Contribute and support FIP Member Organisation in development of current :
   - National health and medication-related policies.
   - Standards on patient safety in the healthcare system.
   - Indicators and benchmarks of patient safety, and

[6] High-risk situations in medication safety: Circumstances in which there is a greater likelihood of significant harm due to unsafe medication practices or medication errors. These situations often involve high risk medications that have a potential to cause serious injury when used incorrectly (insulin, heparin and other anticoagulants, concentrated electrolytes, opioids, chemotherapy agents, and sound alike or look alike medicines) and require enhanced safeguards and monitoring to minimise risk.[3]

- National systems, which are non-punitive, for reporting and sharing patient safety incidents.

Collaboration, research and advocacy

3. Provide leadership for pharmacists globally to ensure that pharmacy remains a key stakeholder in medication and patient safety within healthcare systems and health policy.
4. Ensure that medication safety remains high on the agenda of world health and healthcare professional organisations, as well as national pharmacy organisations.
5. Support campaigns to educate patients and the public on their shared role with pharmacy teams to enable patient safety.
6. Promote best practice and visibility of local pharmacist champions, member organisation champions and related projects.
7. Align its activities with the current WHO global patient safety priorities and provide support to its members, and
8. Support the global community of pharmacists in celebrating the annual WHO World Patient Safety Day (17 September).

Workforce, education and capacity building

9. Support training in patient and medication safety in medical, pharmacy and allied health programmes.
10. Contribute to the development of patient safety training programmes for pharmacists and their pharmaceutical workforce, and
11. Advocate for a globally recognised patient-safety curriculum that embeds patient-safety thinking throughout the entire medication-use process.

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