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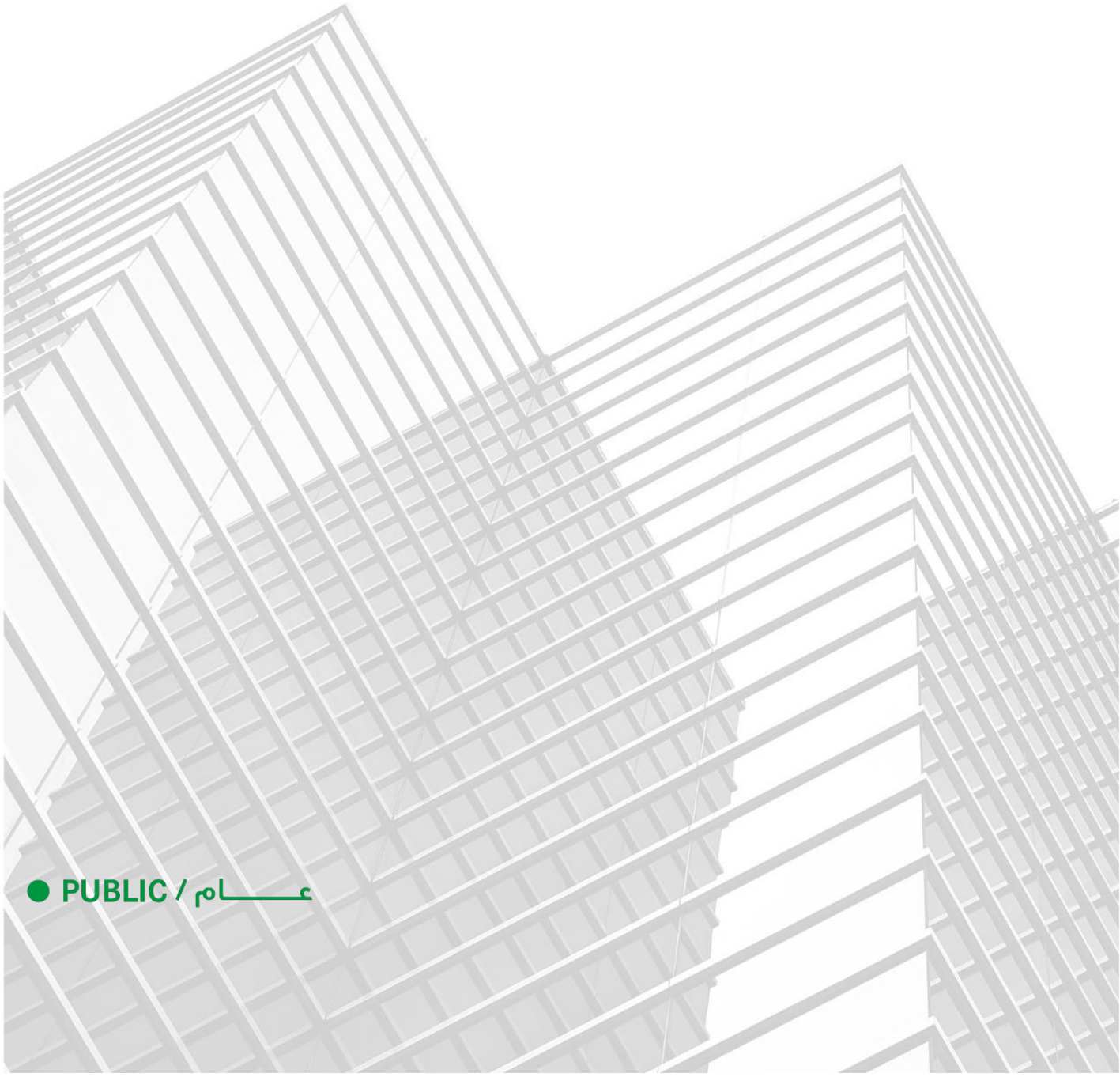
DEPARTMENT OF HEALTH

Medication Safety Policy



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1.Policy Purpose and Brief

1.1 Background

1.1.1 Safe and effective medication use is a fundamental component of quality healthcare and patient safety. Medication-related harm is a significant global patient safety concern and includes medication errors (MEs), adverse drug reactions (ADRs), and other risks associated with the inappropriate or unsafe use of medications.

1.1.2These incidents may result in serious patient harm, prolonged hospital stays, increased healthcare costs, and reduced public trust in healthcare systems. Medication-related harm can be classified as avoidable or unavoidable and requires systematic approaches to prevention, monitoring, and management.

1.2 Purpose

1.2.1 This policy establishes a comprehensive framework to strengthen medication safety across healthcare facilities. It promotes a system-wide approach that emphasizes standardized practices, effective governance, proactive monitoring, transparent reporting, and continuous learning.

1.2.2 The policy aims to ensure that medications are managed safely throughout their lifecycle and that healthcare providers implement evidence-based practices to reduce medication Adverse events (ADEs) and improve patient outcomes.

1.3 Objectives

1.3.1 Promote optimal Medication Use: Ensure that medications across their lifecycle are selected, procured, prescribed, prepared, dispensed, administered, and monitored in a manner that minimizes risks and prevents avoidable harm.
1.3.2 Prevent Medication-Related Harm: Address all types of medication-related harm including MEs , inappropriate medication use, and ADRs through evidence-based prescribing, verification, dispensing, administration, monitoring, and reconciliation practices.
1.3.3 Improve Patient Health Outcomes: Reduce preventable hospital admissions, complications, and long-term harm associated with unsafe medication practices while minimizing medication wastage and resource utilization.
1.3.4 Strengthen Reporting and Learning Systems: Promote engagement in reporting, investigating, and learning from medication errors, adverse drug reactions, and near-miss incidents within a non-punitive environment that supports a just culture.
1.3.5 Enhance Governance and Accountability: Define the roles and responsibilities of healthcare professionals, healthcare facilities, and regulatory authorities in ensuring effective medication safety practices.
1.3.6 Align with National and International Best Practices: Support the implementation of medication safety practices aligned with national priorities and internationally recognized patient safety standards.

2.Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	Avoidable medication harm	is harm resulting from a medication error or system failure at any stage of the medication-use process **(**refer to **Figure.1** for further details**)** and could have been prevented through appropriate clinical practice, safety controls, or adherence to established standards.
2.2	Unavoidable medication harm	It refers to Adverse Drug Events (ADEs) that occur despite appropriate selection of medication, correct use, and compliance with clinical guidelines, and which could not have been reasonably anticipated or prevented.

2.3	Adverse Drug events (ADE)	any untoward medical occurrence that may present during treatment with a pharmaceutical product, but which does not necessarily have a causal relationship with the treatment.
2.4	Adverse Drug Reaction (ADR)	An adverse reaction is a harmful and unintended response to drugs. This includes any undesirable patient effect suspected to be associated with drug use. Unintended effect, drug abuse, overdose, interaction (including drug-drug and drug-food interactions) and unusual lack of therapeutic efficacy are all considered reportable adverse reactions.
2.5	Adverse Event Following immunization (AEFI)	Is any untoward medical occurrence following immunization, and which does not necessarily have a causal relationship with the usage of the vaccine.
2.6	A Just Culture	is an environment that promotes trust and encourages personnel to report errors or near misses without fear of punishment. It distinguishes between honest human error (which is supported and remedied) and reckless or negligent behavior (which is not tolerated). Key principles include encouraging open reporting, focusing on behaviors rather than outcomes, recognizing system failures, and maintaining accountability for conscious disregard of risks.
2.7	Containment Primary Engineering Control	A ventilated device designed to minimize worker and environmental exposure to hazardous drugs when they are handled. Examples include biological safety cabinets or compounding aseptic containment isolators.
2.8	Containment Secondary Engineering Control	The room or area that houses the Containment Primary Engineering Control provides the appropriate environment (e.g., negative pressure, sufficient air changes per hour, externally vented). It serves as a secondary barrier to containing hazardous drug contaminants.
2.9	Department of Health (DoH)	The regulative body of the Healthcare Sector in the Emirate of Abu Dhabi, established based on law No. (10) of 2018.
2.10	High-Alert Medication	Medications that bear a heightened risk of causing significant patient harm when used in error. Errors with these medications are not necessarily more common, but their consequences are more severe
2.11	Hazardous Drugs (HDs)	Drugs that pose a potential health risk to healthcare workers due to their carcinogenicity, teratogenicity, reproductive toxicity, organ toxicity at low doses, genotoxicity, or structure/toxicity profile similar to existing hazardous drugs.
2.12	Look-alike/sound-alike (LASA)	Medications that are easily confused due to similarities in their names (look-alike or sound-alike) or packaging, increasing the risk of medication errors.
2.13	Medication Error (ME)	A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labelling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

2.14	Medication Utilization Review	is a structured, authorized, and ongoing evaluation of prescribing, dispensing, and taking medication to ensure safety, efficacy, and cost-effectiveness. It acts as a quality assurance tool to detect and fix issues like drug interactions, improper dosages, or misuse before, during, or after treatment.
2.15	Medication Incidents	For the purpose of this document, any event that may cause or lead to inappropriate medication use or patient harm these incidents can be related to professional practice, drug products, procedures, and systems, and may occur at any stage during the medication use process (prescribing, order communication, product labeling, packaging, compounding, dispensing, distribution, administration, education, monitoring, use and disposal). Medication incidents could be further classified as medication errors, adverse drug reactions, near misses, serious adverse events and adverse events following immunization.
2.16	Near Miss	A circumstance that has the potential to cause an adverse event (patient harm) but fails to do so because of chance or because it is intercepted.
2.17	Over The Counter (OTC)	Medications that can be purchased without a prescription and are considered safe and effective for use by the general public when used according to the label directions
2.18	Personal Protective Equipment (PPE)	Specialized clothing or equipment worn by healthcare personnel or patients to protect themselves from exposure to hazardous substances, including gloves, gowns, masks, respirators, and eye protection.
2.19	Polypharmacy	The concurrent use of multiple medications by a patient, commonly defined as the use of five or more medications simultaneously
2.20	The Five Rights Principle	The "Five Rights" of medication administration are a fundamental safety principle used by healthcare professionals to prevent errors and ensure quality patient care and they are (Right Patient, Right Medication, Right Dose, Right Time and Right Rout)
2.21	USP <800>	Refers to the United States Pharmacopeia Chapter <800>, titled “Hazardous Drugs—Handling in Healthcare Settings.” It sets forth standards for the safe handling of hazardous drugs to protect healthcare workers, patients, and the environment.

3. Policy Content

3.1 Governance & Accountability

3.1.1 Oversight Authority: The Department of Health (DoH) is the regulatory body that is responsible for setting the overarching standards, policies, and frameworks for medication safety and for monitoring compliance across all healthcare facilities licensed in the Emirate of Abu Dhabi.

3.1.2 Medication Safety committee: The DoH recommends healthcare facilities (including hospitals, chain pharmacies and clinics) to establish a multidisciplinary Medication Safety Committee or equivalent if justified, responsible for overseeing medication safety activities across the facility.

3.1.2.1 Responsibilities of the committee include, but are not limited to:

3.1.2.1.1 Oversee the implementation of medication safety policies and procedures.

3.1.2.1.2 Review and analyze trends of medication incidents, near misses, and ADEs.

3.1.2.1.3 Conduct proactive risk assessments to ensure safe medication use, including the adoption of new technologies to help reduce risk and prevent patient harm.

3.1.2.1.4 Support the development and monitoring of patient therapy plan (addition or discontinuation of therapy).

3.1.2.1.5 implement / Monitor medication utilization review across the facility based on prescribing, consumption data and main outcomes

3.1.2.1.6 Provide staff education and build a competency assessment in medication safety practices.

3.1.3 Medication safety officer: Each facility shall designate a qualified Licensed Healthcare professional as a Medication Safety Officer/ pharmacist responsible for coordinating and overseeing the implementation of medication safety programs.

3.1.3.1 The Medication Safety Officer shall coordinate and support the implementation of medication safety practices across all stages of the medication use process (procurement, storage, prescribing, dispensing, administration, and monitoring, etc.)

3.1.3.2 The Medication Safety Officer shall coordinate medication safety audits, ensure ongoing reporting and learning activities, and report to Medication Safety Committee or any equivalent committee .

3.1.3 This policy encompasses all aspects of safe medication use throughout the medication use process (refer to **Figure.1** for further details), beginning at the point of admission, continuing through assessment, prescribing, dispensing, administration, monitoring, and extending to post-discharge care. It ensures a systematic and coordinated approach to medication safety across all stages of the healthcare process.

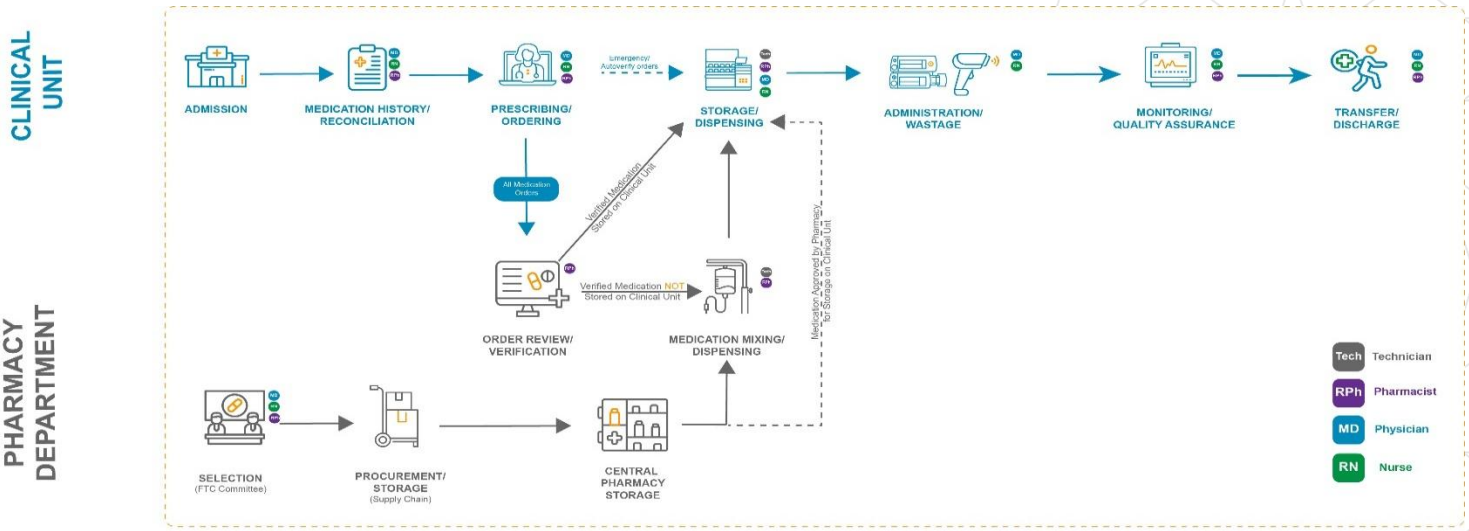

Figure 1. A flow chart for the Medication use process [1].

3.1.4 Accountability and Reporting

3.1.4.1 All medication incidents, including near misses, must be reported to both DoH through the following link (https://bpmweb.doh.gov.ae/usermanagement/login.aspx?Home=1) and internally at the facility level to the medication safety committee or equivalent, in accordance with DoH reporting requirements.

3.1.4.2 The Medication Safety Officer, or equivalent, at facility level is responsible for reviewing and classifying medication incidents according to classification rules mentioned in DoH Standards (Standard on reporting medication errors & suspected quality problems related to medical products and dietary supplements & Standard on reporting suspected adverse drug reactions and adverse events following immunization[2,3]), ensuring timely corrective actions, and facilitate reporting in accordance with the facility governance structures and DoH requirements.

3.1.4.3 Accountability reinforcement mechanisms may include routine performance reviews and monitoring for adherence to safe practices. Identified risks, deviations, or repeated unsafe practices shall be addressed through a structured approach that emphasizes learning, coaching, and fair, proportionate corrective actions, in alignment with Just Culture principles.

3.2 Medication Prescribing & Verification

3.2.1 Medication prescribing and verification are critical steps in the medication-use process. This phase involves the selection of appropriate medications based on patient diagnosis and past medical history / allergy , current

medications , accurate documentation of the prescription, and verification for clinical appropriateness prior to administration.
3.2.2The objective of this section is to ensure that medication orders are complete, accurate, evidence-based, and verified to promote patient safety and reduce preventable medication-related harm, in alignment with international best practices

3.2.3 Unsafe medication prescribing and verification can result in multiple types of errors and harm, including:

3.2.3.1 Wrong drug, dose, route, or frequency due to unclear or incomplete orders.

3.2.3.2 Wrong drug selection, especially Look-alike/sound-alike (LASA) medication errors.

3.2.3.3 Allergic reactions or contraindications due to failure to assess allergic or drug-drug/ drug-disease interactions check.

3.2.3.4 Failure to review patient's current medications or history leading to prescribe contraindicated medication or over dosage and others.

3.2.3.5 Duplication or omission of therapy.

3.2.3.6 Failure in verification leads to dispensing or administration errors.

3.2.3.7 Incomplete patient information (e.g., weight, renal function, pregnancy status).

3.2.3.8 Verbal or telephone orders were misheard or miscommunicated resulting in suboptimal use or unsafe use.

3.2.3.9 Delayed or incorrect transcription into the system or medication chart.

Bypassing alerts or ignoring warnings.

3.2.3.10 Lack of independent double-checks for high-alert medications.

3.2.3.11 Sub-optimal daily medical assessment to verify and maintain essential or critical therapies (e.g., antimicrobial therapy), leading to missed opportunities to discontinue unnecessary medications, optimize treatment, or ensure accuracy of ongoing therapy.

3.2.4 To reduce medications incidents within the facility ensure the following:

3.2.4.1 Clinically appropriate, evidence-based, and individualized prescribing

3.2.4.2 Use of approved electronic systems and accurate documentation review and verification prior to dispensing and administration.

3.2.4.3 Include full patient identifiers and indication on every order.

3.2.4.4 Apply Tall Man lettering and labels for LASA labeling.

3.2.4.5 Perform medication reconciliation at all transitions of care.

3.2.4.6 Independent double-checks for high-alert or medications.

3.2.4.7 Ensure prescribers check allergies, interactions, and dosing appropriateness.

3.2.4.8 Use updated, evidence-based drug information system.

3.2.4.9 Regular training on safe prescribing and verification practices.

3.2.4.10 Encourage reporting of near misses and errors for continuous improvement.

3.2.4.11 Complete Past medical History and allergies and current medication list.

3.2.4.12 Ensure daily medical review and reassessment of ongoing therapies, particularly critical treatments (e.g., antimicrobial therapy), to confirm indication, duration, effectiveness, and timely discontinuation when appropriate.

3.3 Medication Reconciliation

3.3.1 Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of a patient's current medications and comparing it with the physician's orders at every transition of care (admission, transfer, and discharge). The aim is to ensure consistency, accuracy, and continuity in medication management, reducing the risk of MEs and ADRs.

3.3.2 Ineffective implementation of the medication reconciliation process may result in multiple medication errors such as:

3.3.2.1 Polypharmacy-related risks, such as duplication of therapy, cumulative side effects, and increased potential for adverse drug interactions.

3.3.2.2 Incorrect medication dose, frequency, or route.

3.3.2.3 Inclusion of discontinued or outdated medications.

3.3.2.4 Failure to update medication lists during transitions of care.

3.3.2.5 Incomplete or inaccurate documentation of over the counter (OTC) or herbal products.

3.3.3 To minimize the risk of errors during the medication reconciliation process, the following measures shall be ensured:

3.3.3.1 Obtain comprehensive current medication use from reliable sources, combining more than one source (patient, caregiver, previous medical records, pharmacy).

3.3.3.2 Verify and document all medications including prescription, non-prescription, and supplements.

3.3.3.3 Use a standardized reconciliation form or electronic tool integrated into the health information system.

3.3.3.4 Engage pharmacists and appropriately trained healthcare professionals in reviewing and verifying medication lists.

3.3.3.5 Communicate any changes in medication therapy to all members of the healthcare team and to the patient upon discharge.

3.3.3.6 Conduct regular audits and staff training to ensure adherence to reconciliation procedures.

Review processes to monitor and manage polypharmacy, especially for elderly and chronic disease

3.4 Dispensing & Storage Safety

3.4.1 Dispensing and storage safety encompasses all procedures related to the accurate preparation, labeling, and provision of medications, as well as their proper storage under conditions that maintain quality, stability, and security. This process ensures that patients receive the correct medication in the right dose and form, while minimizing risks of contamination, deterioration, or unauthorized access.

3.4.2 Failure to adhere to safe medication dispensing and storage standards may cause:

3.4.2.1 Dispensing the wrong medication, dose, or formulation.

3.4.2.2 Incorrect or incomplete labeling of medication containers.

3.4.2.3 Dispensing to the wrong patient.

3.4.2.4 Failure to detect prescribing or transcription errors before dispensing.

3.4.2.5 Failure to identify potential drug–drug interactions, drug–disease interactions, or contraindications

3.4.2.6 Storage of medications under inappropriate environmental conditions (e.g., incorrect temperature or humidity).

3.4.2.7 Mixing or close placement of look-alike or sound-alike (LASA) medications in storage areas.

3.4.2.8 Lack of proper segregation or control of high-alert and expired medications.

3.4.3 For safe medication dispensing and storage, the following measures shall be ensured:

3.4.3.1 Implement standardized dispensing procedures with pharmacist verification prior to medication release.

3.4.3.2 Use electronic systems and clinical decision support tools to screen for drug–drug interactions and allergy alerts.

3.4.3.3 Verify and document patient allergies and relevant medical history prior to dispensing any medication.

3.4.3.4Ensure clear, complete, and legible labeling including patient name, medication name, strength, directions, and expiry date…etc.

3.4.3.5 Perform independent double-checks for high-alert and LASA medications.

3.4.3.6 Maintain proper storage conditions in line with manufacturer and regulatory requirements, with continuous temperature and humidity monitoring. Refer to Standard for Ensuring Continuous Drug Supply, Storage, Distribution and Therapeutic Governance[4].

3.4.3.7 Segregate and label high-alert, controlled, and expired medications (expired medication to be stored separately away from the dispensing area) please refer to Standard For Prescribing High-Risk Controlled Analgesics & DoH Standard for The Management of Narcotics, Psychotropic and Semi-Controlled Medicinal Products[5,6]

3.4.3.8 Conduct regular inventory audits and compliance checks to ensure adherence to safety and security standards.

3.4.3.9 Provide ongoing staff training and competency assessment of safe dispensing and storage practices.

3.5 Medication Administration

3.5.1 Medication administration safety involves the accurate and timely delivery of prescribed medications to the correct patient in accordance with verified medical orders. This process ensures that medications are administered through the right route, at the right dose, and at the right time, while respecting patients' rights and ensuring their understanding of the treatment regimen. Safe administration is the final checkpoint in the medication management process and plays a critical role in preventing ADEs and ensuring optimal treatment outcomes.

3.5.2 Unsafe medication administration may lead to:

3.5.2.1 Administration of medication to the wrong patient.

3.5.2.2 Incorrect dose, route, or timing of administration.

3.5.2.3 Failure to verify medication orders prior to administration.

3.5.2.4 Omission of doses or administration of unauthorized medications.

3.5.2.5 Failure to review patient allergies, medical history, and contraindications before administration.

3.5.2.6 Drug–drug or drug–food interactions not identified prior to administration.

3.5.2.7 Inadequate patient education regarding the purpose, side effects, and expected outcomes of their medications.

3.5.2.8 Violation of patient rights, including lack of informed consent or failure to respect the patient's right to refuse medication.

3.5.2.9 Incomplete or inaccurate documentation of administered doses.

3.5.3 To ensure medication administration below preventable measures shall be ensured:

3.5.3.1 Apply the principles of the "five rights" of medication administration and associated extended rights.

3.5.3.2 Ensure order verification by a licensed pharmacist or otherwise authorized healthcare professional, in accordance with facility policy and clinical context.

3.5.3.3 Confirm patient identity using at least two identifiers (e.g., full name, medical record number, date of birth), and confirm documented allergy status, and relevant clinical information.

3.5.3.4 Provide appropriate patient information relevant to safe medication administration, in accordance with the facility policy.

3.5.3.5 Respect patient rights, including the right to receive information, the right to refuse medication, and the right to privacy and dignity.

3.5.3.6 Use barcode medication administration or electronic verification systems whenever possible.

3.5.3.7 Maintain accurate and timely documentation of all medications administered, including dose, time, and route.

3.5.3.8 Report and analyze any medication administration errors or near-misses through the organization's medication incident reporting system.

3.5.3.9 Ensure staff involved in medication administration receive appropriate training and competency assessment.

3.6 Medication Disposal

3.6.1 Safe medication disposal must be carried out in accordance with facility procedures and regulatory requirements to prevent environmental contamination, accidental exposure, and diversion of medications. Kindly refer to Medical Waste Management Standard for Healthcare Facilities[7].

3.6.2 Patients should be informed to return unused or expired medications to pharmacies or authorized collection sites and never dispose of them in household trash or drains. These medications must not be reused or dispensed to others, ensuring safety for both individuals and the community.

3.7 Key Contributory Factors to Medication-Related Harm Recognizing and proactively managing the contributory factors to medication incidents is essential to reducing avoidable harm, improving therapeutic effectiveness, and strengthening a just culture of safety across the medication use process. Patient engagement and empowerment are one of the fundamental pillars in preventing medication-related harm and incidents, as informed and involved patients contribute significantly to safe medication practices. This policy section outlines key contributory factors that require heightened attention and structured risk mitigation to support safe, effective, and patient-centered medication practices.

3.7.1 Extremes of Age:

3.7.1.1 Patients at the extremes of age, including pediatric and older adult populations, are at increased risk of medication-related harm due to physiological, developmental, and functional differences. In children, immature organ systems, weight-based dosing requirements, and limited availability of age-appropriate formulations increase the potential for dosing and administration errors. In older adults, age-related changes in renal and hepatic function altered pharmacodynamics, and increased susceptibility to ADEs heightened safety risks.

3.7.1.2 Consistent with international recommendations[5,8,9], the following measures must be taken into consideration:

3.7.1.2.1 Age-specific prescribing.

3.7.1.2.2 Dose adjustment.

3.7.1.2.3 Ensure availability and use of age-appropriate formulations and administration devices.

3.7.1.2.4 Perform medication reconciliation at every transition of care.

3.7.1.2 .5 Enhanced monitoring is essential to minimize preventable harm in these vulnerable groups.

3.7.2 Pregnant patients face higher medication-related risks due to physiological changes and fetal vulnerability. Safe prescribing requires careful risk–benefit assessment, use of the safest effective therapies, evidence-based guidance, multidisciplinary collaboration, thorough patient counseling, and clear documentation of decisions to protect both mother and fetus.

3.7.3 High-Alert medication and Hazardous Drugs

3.7.3.1 High- Alert medications

3.7.3.1.1High-alert medications, which pose a greater risk of harm if misused, must be clearly identified in all healthcare settings. Facilities must keep an updated list and apply enhanced safety measures at every stage of medication use process.

3.7.3.1.2 Storage & Labeling: Store high-alert drugs separately and label them with prominent, red, auxiliary warnings (e.g., "High-Alert Medication"). Labels must be clear and applied to all related containers and doses.

3.7.3.1.3 Double-Checks & Technology: Qualified staff must independently double-check these medications before preparation and administration. Use standardized concentrations, smart infusion pumps, and barcode scanning to minimize errors.

3.7.3.1.4 Patients and caregivers must receive clear information about each high-alert medication, including its name, purpose, dosage, timing, risks, and warning signs, both during reconciliation and at discharge. Patient education shall be documented in the medical record to ensure continuity of care, traceability, and compliance with patient safety and regulatory requirements.

3.7.3.2 Hazardous Drugs <USP 800 >

3.7.3.2.1 To safeguard patients, staff, and the environment from hazardous drug exposure at every stage of the medication-use process, strict adherence to USP <800> and institutional safety protocols for handling, preparing, administering, storing, and disposing of hazardous drugs is essential.

3.7.3.2.2 Compounding and preparation: All HD compounding must occur within a Containment Primary Engineering Control located in a Containment Secondary Engineering Control - that meets USP <800> standards.

3.7.3.2.3 Spill Management and Disposal: The facility shall develop and maintain a standardized, clearly labeled, and readily accessible spill kit in all areas where hazardous drugs (HDs) are stored or handled. Healthcare professionals must be familiar with the location and proper use of these spill kits when managing HDs. Spills must be cleaned immediately by trained personnel using appropriate PPE, Incident reports must be completed and submitted to the Medication Safety Officer, Dispose of HDs waste including PPE and contaminated materials, in accordance with local and institutional regulations.

3.7.4 Multi -morbidity:

3.7.4.1 Significantly complicates medication management by increasing treatment complexity and the likelihood of drug–disease interactions. Patients with multiple chronic conditions often receive care from multiple providers, which may lead to fragmented decision-making and inconsistent therapeutic goals. Clinical guidelines focusing on single conditions may not adequately address cumulative medication risks.

3.7.4.2 The following measures are critical to ensure safe, appropriate, and effective therapy for patients with multimorbidity:

- 3.7.4.2.1 Coordinated multidisciplinary care
- 3.7.4.2.2Patient - Physician shared decision-making
- 3.7.4.2.3 Regular comprehensive medication reviews

3.7.5 Polypharmacy is a major and well-recognized contributor to medication incidents, and reduced adherence. It commonly results from multimorbidity, repeated transitions of care, and insufficient medication review processes. polypharmacy is a priority risk area requiring:

3.7.5.1 Systematic medication reconciliation.

3.7.5.2 Ongoing assessment of clinical necessity, and deprescribing unnecessary, duplicative, or ineffective medications.

3.7.5.3 Adding an indication to a prescription.

3.7.5.4 Proactive management of polypharmacy.

3.7.6 Palliative Care: Medication safety in palliative care settings requires a careful balance between effective symptom management and the minimization of unnecessary medication-related burden. Patients receiving palliative care are often subject to frequent medication changes, altered routes of administration, and increased sensitivity to adverse effects. Continuing medications without clear benefit may expose patients to avoidable harm. Medication use in palliative care should be:

3.7.6.1 Individualized to plan.

3.7.6.2 Regularly reviewed.

3.7.6.3 Aligned with patient goals of care, emphasizing comfort, dignity, and quality of life through clear communication and multidisciplinary collaboration.

3.8 Medication incidents Reporting

3.8.1 Safe medication practice begins with integrating safety principles across every stage of the medication-use process to ensure that risks and errors are minimized and patient outcomes are optimized (refer to **Figure .1** for further details), this process encompasses selection and procurement, storage, ordering and transcribing, verification and preparation, administration, and monitoring and evaluation. Embedding safety measures within each of these interconnected steps is essential to maintaining a consistent, system-wide approach to medication safety and supporting the delivery of high-quality patient care.

3.8.2 All MEs and near misses must be reported promptly to ensure timely corrective action, prevent recurrence, and enhance patient safety, for further information kindly refer to Standard on Reporting Medication Errors & Suspected Quality Problems Related to Pharmaceutical Products and Dietary Supplements[6, 1].

3.8.3 All suspected AEs, ADRs & AEFI whether mild, moderate, severe, or unexpected, must be promptly identified, reported, documented, and investigated, for further information kindly refer to DoH Standard on Reporting Suspected ADRs and AEFI[3].

3.8.4 All suspected quality defects for a Pharmaceutical product , such as changes in appearance, contamination, leakage, labeling errors, or unexpected therapeutic outcomes, must be immediately reported to the pharmacist in charge or the Medication Safety Officer, responsible person must report to regulatory as per reporting requirements , kindly refer to Standard on Reporting Medication Errors & Suspected Quality Problems Related to Pharmaceutical Products and Dietary Supplements[2]**.**

3.9 DoH Recommendation on Adoption of AI and Automation Tools

3.9.1The integration of automation and artificial intelligence (AI) into healthcare facilities services. Automated Systems in hospitals, pharmacies and wards have demonstrated significant benefits over traditional manual methods, including reduced ADEs and improved workflow efficiency thereby supporting safer patient outcomes.

3.9.2 Digital prescriptions represent another critical advancement, offering clear advantages for patients, prescribers, and dispensers. E-prescriptions eliminate handwriting errors, streamline prescription management, and save significant time for healthcare providers. They also support seamless prescription storage, fulfillment, and integration with pharmacy services, contributing to better patient safety and satisfaction.

3.10 Training & Competency

3.10.1 All Healthcare providers shall receive initial and ongoing training in medication safety principles, error prevention, identifying ADEs and safe medication practices. Competency should be verified regularly to ensure compliance with safety standards and to maintain high-quality patient care.

3.11 Continuous Monitoring & Improvement

3.11.1 All Healthcare Facilities are committed to regularly monitoring medication processes, identifying trends and potential areas for improvement, and implementing evidence-based interventions to enhance medication safety.

4. Policy Roles and Responsibilities

Stakeholder Name	Stakeholder Key Role
Department of Health Abu Dhabi (DoH)	Define standards, monitor compliance, and provide oversight through periodic audits and performance reviews.
Healthcare Facilities management	Integrate medication safety practice into the organizational strategy and allocate necessary resources. Appoint a medication safety officer and medication safety committee or equivalent
Pharmacist	Adhere and comply with the medication safety policy Maintain an updated list of all hazardous drugs and High alert medication as per the local and national standards.
Prescribers and Clinicians	Ensure accuracy and appropriateness in prescribing and documentation. Nurses and Allied Health Professionals Follow safe administration practices and promptly report errors or near misses.

5. Policy Scope of Implementation

5.1 This policy applies to all healthcare facilities providing inpatient and outpatient services and to all healthcare professionals licensed by the Department of Health.

5.2 It ensures that medications are managed throughout their medication- use process (selection, procurement, prescribing, preparation, dispensing, administration, monitoring, and disposal) in a manner that supports clinical effectiveness and optimizes patient outcomes.

6. Exempted from Policy Scope

None

7. Enforcement and Compliance

7.1 DoH may impose sanctions and penalties concerning any breach and /or non-compliance under this Policy in accordance with the disciplinary regulation of the healthcare sector.

8. Monitoring and Evaluation (Key success factors)

8.1 Clear Indicators & Regular Review

8.1.1 Key performance indicators for this policy are:

8.1.1.1 Number of reported medication errors.

8.1.1.2 Percentage of near-miss incidents reported compared to total medication incidents.

8.1.1.3 Percentage of medication incidents reported within the required timeframe.

8.2 Monitoring

8.2.1 Comprehensive Reporting Systems: The DoH operates a centralized reporting platform that receives medication incidents from all healthcare facilities. This system enables data collection, trend analysis, and prompt intervention.

8.2.2 DoH Medication Safety Committee Oversight: This Committee actively oversees medication safety initiatives, reviews reported sentinel incidents and recommends policy or practice changes. The committee's multidisciplinary approach ensures that safety concerns are addressed holistically and improvements are continuously implemented.

8.2.3 Continuous Feedback Loop: Insights from reporting systems and committee reviews are disseminated back to healthcare providers, ensuring that lessons learned translate into safer practices.

9.Relevant Reference Documents

No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1	February 2026	AmanViva Consulting. (2026). Medication journey (R. Dabliz & E. Saleh) [Infographic]	https://www.linkedin.com/posts/rabihdabliz_medication-journey-ugcPost-7426529573019877376-MEnX
2	September 2023	Standard on reporting medication errors & suspected quality problems related to medical products and dietary supplements	https://www.doh.gov.ae/en/resources/standards
3	September 2024	Standard on reporting suspected adverse drug reactions and adverse events following immunization	https://www.doh.gov.ae/en/resources/standards
4	December, 2025	Standard for Ensuring Continuous Drug Supply, Storage, Distribution and Therapeutic Governance	https://www.doh.gov.ae/en/resources/standards
5	July 2025	Standard For Prescribing High-Risk Controlled Analgesics	https://www.doh.gov.ae/en/resources/standards
6	June 2021	Standard For the Management of Narcotics, Psychotropic and	https://www.doh.gov.ae/en/resources/standards

		Semicontrolled Medicinal Products	
7	September 2025	Medical Waste Management Standard for Healthcare Facilities	https://www.doh.gov.ae/en/resources/standards
8	February 2024	5 Medication Safety Tips for Older Adults	https://www.fda.gov/consumers/consumer-updates/5-medication-safety-tips-older-adults
9	December 2019	Prescribing medicines to older people—How to consider the impact of ageing on human organ and body functions	https://pmc.ncbi.nlm.nih.gov/articles/PMC7495267/
10	March 2024	WHO Medication without harm Policy	https://iris.who.int/server/api/core/bitstreams/1eacccb6-838e-4787-bfd9-4bdeb4debfcf/content
11	January 2025	Joint Commission International Accreditation Standards for Hospitals 8th Edition	https://www.jointcommission.org/en/products/jcih24p/ebjcih24sl
12	July 2019	Joint Commission International Accreditation Standards for Ambulatory Care 4th Edition	https://www.jointcommission.org/en/products/ebiac19p.
13	June 2020	USP <800> Hazardous Drugs—Handling in Healthcare Settings	https://www.usp.org/sites/default/files/usp/document/our-work/compounding/usp-800-context-for-implementation-fs.pdf
14	May 2013	Medication Safety Officer's Handbook	https://www.ashp.org/-/media/store-files/p2104-sample-chapter-1
15	October 2018	ASHP Guidelines on Preventing Medication Errors in Hospitals	https://publications.ashp.org/previewpdf/display/book/9781585287048/chapter049.xml?pdfJsInlineViewToken=793817727&inlineView=true
16	November 2018	ASHP ACCREDITATION STANDARD FOR INTERNATIONAL HOSPITAL AND HEALTHSYSTEM PHARMACY SERVICES	https://www.ashp.org/-/media/assets/global/Docs/Standards-International-Pharmacy-Services-Accreditation-January-2019.pdf