House of Delegates

Board of Directors Reports: Policy Recommendations for the November 2026 House of Delegates

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COUNCIL ON PHARMACY MANAGEMENT POLICY RECOMMENDATIONS

The Council on Pharmacy Management is concerned with ASHP professional policies related to the leadership and management of pharmacy practice. Within the Council's purview are (1) development and deployment of resources, (2) fostering cost- effective use of medicines, (3) payment for services and products, (4) applications of technology in the medication-use process, (5) efficiency and safety of medication-use systems, (6) continuity of care, and (7) related matters.

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1. Documentation of Pharmacy Patient-Care Services in the Permanent Health Record

To promote the use of standardized, integrated documentation of pharmacist patient care services in a patient's permanent health record; further,

To advocate that pharmacy workforce documentation in the medical record be used for billing and attribution of value without requiring additional documentation from other clinicians; further,

To advocate for standardized measurement of pharmacy care provision and the attribution of those activities to patient-centered outcomes.

This policy would supersede ASHP policies 2137 and 2421.

Rationale

Documenting pharmacist care in the patient medical record is essential to ensure accurate and complete records of the care and services provided. However, differences in pharmacy practice within and across health systems make it hard to standardize such documentation in the electronic health record (EHR). The differences are caused by diverse clinical practices, EHR permissions, and documentation elements of the care provided by pharmacists. Documentation

by the pharmacist may change depending on care settings, the level of care provided, or with respect to reimbursement. As a result, it is hard to validate and assess pharmacists' impact on patient outcomes because their contributions are not consistently documented, measured, or attributed in a standardized way.

Other healthcare professions have released similar statements on documentation within their fields. The American College of Physicians states that physicians should define professional standards regarding clinical documentation and use macros and templates appropriately. The American Nurses Association (ANA) Principles for Nursing Documentation states that if patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation (ANA's Principles for Nursing Documentation: Guidance for Registered Nurses. 2010).

Standardized documentation supports efficient access to information by all interdisciplinary team members. Employing accessible, standardized documentation improves communication and information shared between team members. Consistent and standardized pharmacy documentation can provide essential patient care information, such as therapeutic drug monitoring, appropriateness and effectiveness of patient's medications, or pain and antibiotic management. Pharmacy technicians, within their scope of practice, can also document activities in the medical record (e.g., medication history documentation). Standardized notes also enable healthcare team members to review the pharmacy notes for patient medication plans. Standardized and integrated pharmacy documentation should be used for billing and attribution of value without additional requirements from other clinicians. Implementing standardized pharmacy documentation guidance will also inform and enable a metric for evaluating the impact of pharmacist services.

Background

The Council reviewed ASHP policies 2421, Documentation of Patient-Care Services in the Permanent Health Record and 2137, Documentation of Pharmacist Patient Care, as part of an intercouncil policy recommendation referral from the Council on Pharmacy Practice and voted to recommend consolidating them as follows (underscore indicates new text; strikethrough indicates deletions):

> ~~To advocate for public policies that support the use of electronic health records with a common documentation space to accommodate all healthcare team members, including the pharmacy workforce; further,~~ [From 2421]
>
> ~~To advocate for the design and use of electronic health records with a common documentation space to accommodate all healthcare team members.~~ [From 2421]
>
> To promote the use of standardized, integrated documentation of pharmacist patient care ~~provision~~ services in a patient's permanent health record; further, [From 2137]
>
> To advocate that pharmacy workforce documentation ~~by pharmacists~~ in the

medical record be used for billing and attribution of value without requiring additional documentation from other clinicians; further, [From 2137]

To advocate for standardized measurement of pharmacy ~~pharmacist~~ care provision and the attribution of those activities to patient-centered outcomes. [From 2137]

COUNCIL ON PHARMACY PRACTICE POLICY RECOMMENDATIONS

The Council on Pharmacy Practice is concerned with ASHP professional policies related to the responsibilities of pharmacy practitioners. Within the Council's purview are (1) practitioner care for individual patients, (2) practitioner activities in public health, (3) pharmacy practice standards and quality, (4) professional ethics, (5) interprofessional and public relations, and (6) related matters.

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1. Pharmacist's Role in Urgent and Emergency Situations

To affirm that pharmacists should participate in planning and providing emergency team response; further,

To advocate that pharmacists contribute to decision-making regarding patient care, response processes, medications, and resources to support medical emergencies; further,

To advocate that pharmacists serve in all emergency responses, and that those pharmacists receive appropriate training and maintain appropriate certifications.

This policy would supersede ASHP policy 1527.

Rationale

Pharmacists have a leadership role in many hospitals in planning for emergency treatment team services. Data from the 2021 ASHP National Survey indicates that approximately 70% of hospitals have pharmacist participation in cardiopulmonary resuscitation (CPR), or code, teams and 36% have pharmacist participation on rapid response teams. This role includes developing policy on the contents of code carts and other supplies as well as establishing the role of the

pharmacist in supporting these services. The literature demonstrates that pharmacists can make significant contributions to CPR and other emergency response teams as medication-use leaders and as participants, and there is evidence that better patient outcomes result when pharmacists participate. Pharmacists participating in this role should receive appropriate training and certification (e.g., Basic Life Support, Advanced Cardiopulmonary Life support, and Pediatric Acute Life Support). ASHP should continue to look for educational avenues to enhance and expand pharmacist competency in this area. The ASHP Guidelines on Emergency Medicine Pharmacist Services reference many of the patient care services that pharmacists provide during urgent and emergency situations including but not limited to direct patient care activities, medication information, resuscitation, high-alert medication handling procedures, medication selection and preparation, medication order review and medication therapy monitoring, patient and caregiver education, and medication reconciliation.

Background

The Council discussed ASHP policy 1527, Pharmacist's Role in Urgent and Emergency Situations, in response to a 2025 ASHP House of Delegates resolution requesting ASHP advocacy to allow pharmacists to participate in and complete the American College of Surgeons (ACS) Advanced Trauma Life Support certification. In their review, they voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To affirm that pharmacists should participate in planning and providing emergency ~~treatment~~ team response ~~services~~; further,
>
> To advocate that pharmacists ~~participate in~~ contribute to decision-making ~~about~~ regarding patient care, response processes, ~~the~~ medications, and ~~supplies used in~~ resources to support medical emergencies; further,
>
> To advocate that pharmacists serve in all emergency responses, and that those pharmacists receive appropriate training and maintain appropriate certifications.

In addition to revising the policy, ASHP staff contacted ACS, who indicated they are not willing to allow pharmacists to complete the training or to create a pharmacist-specific certification. ACS also noted that they do not offer a certification for nurses; instead, the Society of Trauma Nurses provides a parallel Advanced Trauma Care for Nurses certification, often held in conjunction with ACS ATLS training. Given that information, the Council determined not to incorporate a reference to ATLS in policy clauses or the rationale; however, they felt that the rationale should be revised to urge ASHP to continue to look for avenues for building competency in this area. The rationale has been updated to incorporate that. Council members also suggested updating some of the data in the rationale; however, the 2021 ASHP National Survey continues to be the most recent survey capturing pharmacist participation in emergency situations and code teams. The Council also expressed support for updating the 2020 ASHP Guidelines on Emergency Medicine Pharmacist Services.

2. Role of the Pharmacy Workforce in Interprofessional Care Teams

To recognize pharmacists as essential and accountable medication-use experts who improve interprofessional care team capacity, efficiency, and effectiveness in delivering evidence-based, safe, high-quality, cost-effective, and patient-centered care; further,

To assert that all members of the interprofessional care team have a shared responsibility in coordinating care and are accountable to the patient and each other for the associated outcomes; further,

To urge the pharmacy workforce to lead and collaborate with other disciplines to establish and implement standardized, evidence-based quality and safety outcome measures that reflect pharmacy's contributions in improving patient care.

This policy would supersede ASHP policy 2208

Rationale

Evidence-based, cost-effective, patient-centered care is best achieved through collaboration among interprofessional care teams. As healthcare continues to shift toward team-based and value-driven models, roles and responsibilities of the interprofessional team require ongoing specialization and training. Evidence demonstrates measurable improvements in medication safety, adherence, readmissions, costs, and clinical outcomes when pharmacists are incorporated as full and accountable members of the interprofessional care team. Medication use expertise is unique to pharmacists but is not always formally recognized and fully integrated into team structures and workflows. Formal recognition of pharmacists as essential medication-use experts and accountable team members acknowledges the clinical capacity of their contributions and potential to foster high-performing teams.

Principles of high-performing teams include: shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes. No single discipline can independently ensure coordinated, high-quality care for patients with complex medical and social needs; therefore, effective interprofessional teams depend on a shared understanding that every member holds responsibility for communication, care, and outcomes. Pharmacists, like other healthcare professionals, must be accountable to patients, their profession, and other team members. This mutual accountability is foundational in building trust within interprofessional teams and closing coordination gaps that continue to fragment care and compromise patient safety and quality outcomes.

Many existing safety and quality measures do not adequately reflect the impact of the pharmacy workforce on team-based care interventions or patient outcomes. Such omission discounts the value of the team in performance evaluations, reimbursement structures, and other accountability frameworks. To account for the evidence-based practice of pharmacy, the design of such measures requires pharmacy input to reduce risks and evolve accordingly. Therefore, it is important for the pharmacy workforce to take an active and visible leadership role in collaboration

with other professions to establish and implement measures and outcomes. An example of work that aligns with this need is ASHP's Pharmacy Accountability Measures Work Group, which identified a focused set of evidence-based performance measures that health-system pharmacists can use in collaboration with interdisciplinary care teams to improve patient outcomes and demonstrate pharmacy's measurable contribution to value-based care.

Background

The Council reviewed ASHP policy 2208, Pharmacist's Role in Team-Based Care, as part of sunset review and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

> To recognize ~~that~~ pharmacists~~,~~ as ~~core members and~~ essential and accountable medication-use experts ~~on~~ who improve interprofessional ~~health~~care team~~s, increase the~~ capacity, ~~and~~ efficiency, and effectiveness in ~~of teams for~~ delivering evidence-based, safe, high-quality, ~~and~~ cost-effective, and patient-centered care; further,
>
> ~~To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care and as the provider of comprehensive medication management services; further,~~
>
> To assert that all members of the interprofessional care team have a shared responsibility in coordinating ~~the~~ care ~~they provide~~ and are accountable to the patient and each other for the outcomes of that care; further,
>
> To urge the pharmacy workforce to lead and ~~pharmacists on healthcare teams to~~ collaborate with other disciplines to ~~team members in~~ establish~~ing~~ and implement~~ing~~ standardized, evidence-based quality and safety outcome measures that reflect pharmacy's contributions in improving patient care ~~for care provided by those teams~~.

The Council indicated that this policy was still needed. Despite growth in awareness among healthcare team members around the value of the pharmacy workforce, further awareness is needed among policymakers and the public around accountable care provided by pharmacists. The Council also discussed opportunities to modernize and streamline policy 2208 while also incorporating a reference to the pharmacy workforce where appropriate and removing redundancies with existing ASHP policies. Specifically, the Council noted that clause 2 was repetitive to ASHP policy 2423, Independent Prescribing Authority and suggested removal from this policy. Council also suggested sunsetting ASHP policy 2521, Health Care Quality Standards and Pharmacy Services once this policy moves through the ASHP House of Delegates review process. Based on these revisions, Council requested to change the title of the policy from "Pharmacist's Role in Team-Based Care" to "Role of the Pharmacy in Interprofessional Care Teams" and to update the rationale.

COUNCIL ON PUBLIC POLICY
POLICY RECOMMENDATIONS

The Council on Public Policy is concerned with ASHP professional policies related to laws and regulations that have a bearing on pharmacy practice. Within the Council's purview are (1) federal laws and regulations, (2) state laws and regulations, (3) analysis of public policy proposals that are designed to address important health issues, (4) professional liability as defined by the courts, and (5) related matters.

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Sarah Steinert (South Carolina)
Jordan Wulz (Wisconsin)
Jillanne Schulte, *Secretary*

Christopher Scott, *Board Liaison*

1. Decriminalization of Medical Errors

To advocate for the immunity of the healthcare workforce from criminal liability and responsibility for any harm or damages that arise from an act or omission allegedly related to the provision of health services resulting in medical errors; further,

To assert that such immunity would not limit liability for any gross negligence or wanton, willful, malicious, or intentional misconduct and would not protect healthcare professionals from civil litigation; further,

To advocate that each state enacts legislation to decriminalize medical errors.

Rationale

By explicitly embedding the principles of a just culture (as referenced in ASHP policies 1115 and 1021)—one that distinguishes between human error, at-risk behavior, and reckless conduct—states can ensure that clinicians are not subject to unfair criminal prosecution for unintentional medical errors, while preserving criminal liability for wanton or willful misconduct as well as civil liability. By ensuring that clinicians are not subject to unfair criminal prosecution for unintentional medical errors, while preserving criminal liability for wanton or willful misconduct as well as civil liability, states can contribute to just culture in medicine. Decades of patient

safety research, including findings published in *To Err Is Human* by the Institute of Medicine, suggest that most medical errors result from system failures rather than criminal intent. Criminalizing human error undermines transparency, suppresses reporting, weakens safety culture, and exacerbates workforce shortages. By clarifying that unintentional medical errors are not crimes and preserving consequences for egregious misconduct, states can align legal standards with modern patient safety science, protect patients' rights, and strengthen both public health and healthcare workforce stability.

Background

The Council reviewed the decriminalization new business item that was proposed during the 2025 House of Delegates. The Council agreed with the intent of the policy and offered minimal wordsmithing to align it with ASHP's general standards for policy drafting.

COUNCIL ON THERAPEUTICS
POLICY RECOMMENDATIONS

The Council on Therapeutics is concerned with ASHP professional policies related to medication therapy. Within the Council's purview are (1) the benefits and risks of drug products, (2) evidence-based use of medicines, (3) the application of drug information in practice, and (4) related matters.

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K. Kit Wong (Maryland)
Vicki Basalyga, *Secretary*

Marie Chisholm-Burns, *Board Liaison*

1. Expanding Safe Access to HMG-CoA Reductase Inhibitors

To support pharmacist prescribing models for HMG-CoA Reductase Inhibitors (statins) that ensure their safe and effective use as part of a multimodal approach to advanced atherosclerotic cardiovascular disease prevention; further,

To oppose reclassification of currently available statins to nonprescription status.

Rationale

3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitors ("statins") remain the cornerstone of lipid lowering therapy for both primary and secondary prevention of atherosclerotic cardiovascular disease (ASCVD), with robust reductions in ASCVD events and mortality across multiple populations. They are considered first line therapy according to the American College of Cardiology and in the most recent iteration of the ACC/AHA Clinical Practice Guidelines on the Management of Blood Cholesterol. The effectiveness of statins in reducing LDL-C has prompted calls for more widespread use, including suggestions for a reclassification of statins as non-prescription medication. While the initial application for the change was rejected by the FDA in 2005, there has been potential renewed interest from manufacturers and others to seek out OTC approval.

ASHP believes that existing models for over-the-counter (OTC) dispensing do not provide the safeguards required to ensure the safe and effective use of statins. The FDA requires three conditions for switching a drug to over-the-counter status: it must be safe and effective for its intended use, its benefits must outweigh its risks, and consumers must be able to understand how to use it safely without professional supervision. Statins fail this third requirement, making them unsuitable for OTC availability under current standards. Because adverse drug effects can be subtle, delayed, or difficult for patients to recognize or report, relying on voluntary consumer monitoring would provide inadequate protection—especially given that statins are chronic therapies often used by people with multiple conditions or interacting medications. Although serious adverse events are uncommon at prescription doses, wider OTC use could expose more individuals to risks that require ongoing evaluation, reassessment of risk factors, and professional oversight. Shifting this responsibility entirely to patients would undermine safety, as many are unfamiliar with adverse event reporting systems and may not detect problems that emerge months or years after starting therapy.

Instead, ASHP supports the goal of more widespread use of ASCVD-preventive therapies, including statins, and encourages consideration of pharmacist prescribing models for therapies that would advance ASCVD prevention, including optimizing ASCVD treatment implemented through CDTM/CPAs, statewide protocols, or standard of care regulatory models. This approach protects patient safety, upholds guideline directed therapy, and measurably increases use of effective prevention in populations that need it most.

Background

The Council reviewed the ASHP Statement on Pharmacist Prescribing of Statins as a part of a sunset review. Upon review, the Council believed that the statement would better serve ASHP's needs as a policy rather than a statement and therefore converted the statement into a policy. The Council elected not to include policy language about pharmacogenomic testing as ASHP Policy on Pharmacogenomics addresses this. This policy should be considered for approval in concert with the discontinuation of the ASHP Statement.

2. ASHP Statement on Pharmacist Prescribing of Statins

To discontinue ASHP Statement on Pharmacist Prescribing of Statins.

Background

The Council reviewed the ASHP Statement on Pharmacist Prescribing of Statins as part of a sunset review. The Council believed that a policy would better serve ASHP's needs rather than a statement. This new policy, Expanding Safe Access to HMG-CoA Reductase Inhibitors, captures the intent of the Statement and provides a more up-to-date rationale that reflects ASHP's stance on these medications' over-the-counter status and the pharmacist's role in managing these medications.

3. Sexually Transmitted Infection Prevention

To affirm that drug products for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) and other sexually transmitted infection (STI) prevention should be provided to individuals in a manner that ensures safe and appropriate use; further

To oppose reclassification of currently available drugs used for PrEP and PEP to nonprescription status; further,

To acknowledge that pharmacist scope of practice encompasses initiation of PrEP and PEP for HIV and STI prevention therapy; further,

To advocate that the therapies and associated care for STI prevention are available to patients with zero cost-sharing; further,

To support establishment of specific and structured criteria to guide comprehensive pharmacist interventions related to the prevention of STIs; further,

To support research, education, and training of the pharmacy workforce on the therapeutic, psychosocial, and operational considerations of pharmacist-provided PrEP and PEP therapy; further,

To support research and surveillance on the impact of medications used in PrEP and PEP on resistance and the microbiome; further,

To educate the public about the public health benefits of PrEP and PEP for the prevention of STIs.

This policy would supersede ASHP policy 2330.

Rationale

Increasing access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) prevention, as well as doxycycline post-exposure prophylaxis (doxy PEP) for bacterial sexually transmitted infection (STI) prevention is a public health priority. The *Ending the HIV Epidemic in the U.S.* initiative, for example, includes expanded access to PrEP and PEP in its whole-of-society plan coordinated among agencies across the U.S. Department of Health and Human Services to end the HIV epidemic in the United States by 2030. Concurrently, the incidence of bacterial STIs caused by *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, and *Treponema pallidum* continues to increase in the United States. In June 2024, the Centers for Disease Control and Prevention (CDC) published clinical guidelines recommending doxy PEP as a novel, patient-managed biomedical strategy for STI prevention, particularly in high-risk groups.

Despite the increase in the availability of these prophylaxis therapies, much of the patient population that would benefit from access has been limited by stigma and other barriers, including a requirement for a prescription in many parts of the US. One of those barriers to access is that many states do not provide pharmacists independent authority to order and initiate PrEP and PEP therapies. Given the time-sensitive nature of these therapies, patients and their partners would benefit from being able to access them at community pharmacies. Those forced to seek medications through a physician's office or other sites of care may struggle to find a timely appointment, especially if they do not have an established primary care provider. In contrast to physicians, community pharmacists are often available without an appointment and therefore, expand access to therapy. Through policy, education, and infrastructure changes, pharmacists can be an alternate source for PrEP and PEP, expanding availability and further reducing HIV transmission and bacterial STI incidence.

ASHP advocates for expanding pharmacists' scope of practice to include initiation of PrEP and PEP therapies, including associated screening, testing, monitoring, referrals, product selection, and counseling, as well as the establishment of specific and structured criteria for prescribing, dosing, and dispensing of PrEP and PEP by pharmacists. As one example, California legislation authorizes pharmacists who undergo a board-approved training program every two years to supply HIV PrEP and PEP, with a 60-day supply cap and certain conditions under which the therapies can be prescribed. Similar frameworks could be applied to doxy PEP provision. Other states, including New York, Colorado, Missouri, and New Hampshire, are exploring similar programs. As these practices and programs vary from state to state, ASHP also recommends structured criteria be set that optimizes patient care and access to these drug products.

Expanding collaborative practice, in which pharmacists are permitted under an agreement with a prescriber to prescribe a defined list of medications along with associated monitoring, provides an effective way to advance the scope of pharmacy practice nationwide. Implementation of a standing order for pharmacists to furnish PrEP and PEP for their patients may provide longitudinal benefit, and infrastructure for pharmacists to bill for these services, as

well as the facilities to see patients, must accompany such policy changes. To ensure that patients who present for prophylaxis receive comprehensive care, pharmacists should be allowed to order tests for sexually transmitted infections at the patient's request when possible, as some community pharmacies and other sites of care may not have the ability to provide certain tests onsite.

ASHP opposes reclassification of currently available drugs used for PrEP and PEP (tenofovir and emtricitabine) to nonprescription status, because existing models for nonprescription dispensing do not provide the safeguards required to ensure safe and effective use.

Other barriers to access include a lack of insurance coverage and high out-of-pocket costs, insurers' refusal to cover brand medications when necessary, and insurers failing to cover all formulations, including pediatric formulations. Modifications to national, regional, and local drug coverage decisions are needed to ensure that payer policies do not unintentionally restrict or prevent access. To promote the broadest possible access, ASHP advocates that PrEP and PEP be available to patients with zero cost-sharing, regardless of income or insurance coverage.

Pharmacist initiation of PrEP and PEP therapies will likely result in an increased workload and potential liability associated with provision of this care, which includes patient screening (including point-of-care testing, if applicable), patient education, dosing, counseling, and documentation of the care provided in the pharmacy and medical record. Accordingly, adequate staffing and training, liability protections, and reimbursement mechanisms will be essential to ensure pharmacists can provide this care.

Although doxy PEP has demonstrated substantial reductions in bacterial sexually transmitted infections, it is also important to evaluate its long-term public health impact. ASHP supports ongoing research and surveillance to better understand the potential effects of widespread doxy PEP use on antimicrobial resistance patterns and on the human microbiome. As bacterial resistance and microbiome disruption remain critical considerations in antimicrobial stewardship, continued monitoring will help ensure that expanded access to doxy PEP is implemented in a manner that maintains both individual and population-level safety.

Finally, a survey of community pharmacists revealed that education and training are needed to advance pharmacy practice in PrEP and PEP therapy. Training in necessary laboratory testing, trauma-informed care, destigmatization, and appropriate follow-up should be done to ensure adequate guidance for pharmacists unfamiliar with the procedures. Finally, ASHP supports public education regarding the public health benefits of PrEP and PEP therapy.

Background

The Council reviewed ASHP policy 2330, Pharmacist Prescribing Authority for Antiretroviral Therapy for the Prevention of HIV/AIDS, as part of a continuation of a Policy Week discussion around doxycycline post-exposure prophylaxis. The Council found that many of the barriers, access issues, and roles for pharmacists were similar. By broadening the existing policy to include all STIs, ASHP advocacy efforts remain the same for the prevention of HIV/AIDS but expand their efforts to include other preventable sexually transmitted infections. Updates to the policy and rationale reflect this expansion. The Council voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

To affirm that drug products for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for human immunodeficiency virus (HIV) and other sexually transmitted infection (STI) prevention should be provided to individuals in a manner that ensures safe and appropriate use; further

To oppose reclassification of currently available drugs used for PrEP and PEP to nonprescription status; further,

To advocate for legislation and regulation that expands pharmacist scope of practice to encompass initiation of PrEP and PEP for STI prevention therapy; further,

To advocate that the therapies and associated care for STI prevention ~~PrEP and PEP~~ are available to patients with zero cost-sharing; further,

To support establishment of specific and structured criteria to guide comprehensive pharmacist interventions related to the prevention of STIs ~~PrEP and PEP~~; further,

To support the research, education, and training of the pharmacy workforce on the therapeutic, psychosocial, and operational considerations of pharmacist-provided PrEP and PEP therapy; further,

To support research and surveillance on the impact of medications used in PreP and PEP on resistance and the microbiome; further,

To educate the public about the public health benefits of PrEP and PEP for the prevention of STIs.

This policy was revised in 2025 by the ASHP Board of Directors on April 3, 2025, to ensure compliance with federal law.

4. Post-Intensive Care Syndrome

To advocate that health systems support the development and implementation of intensive care unit (ICU) guidelines for multidisciplinary teams, including pharmacists, to reduce the incidence of post-intensive care syndrome (PICS) and the associated post-intensive care syndrome-family (PICS-F); further

To support research and dissemination of best practices for the prevention, identification, and treatment of PICS and PICS-F in patients of all ages; further,

To advocate for the integration of post-ICU patient and ICU family and caregiver support groups; further,

To provide education on the role of the pharmacist in caring for patients with PICS as well as family members and caregivers with PICS-F.

This policy would supersede ASHP policy 2240.

Rationale

Post-intensive care syndrome (PICS) was defined in 2010 as new or worsening impairments in physical, cognitive, or mental health following the survival of a critical illness. PICS is associated with high morbidity among patients discharged from ICUs, with 30-80% of patients having issues remembering, paying attention, solving problems, or organizing and working on complex tasks. Furthermore, the burden of PICS continues to grow. With only up to 50% of patients with PICS able to return to work within the first year, some are unable to return to the jobs they had before their illness and need help with activities after leaving the hospital. In addition, PICS-F is a derivation of the syndrome that affects family members and caregivers of the patient.

Evidence continues to demonstrate that use of guidelines, such as the A-F Bundle, can help to decrease the incidence of PICS, yet they are not consistently used in ICUs. Pharmacists, as members of the ICU interdisciplinary team, can play a key role in advocating for the use of the bundle elements within their ICUs (adult or pediatric). The A-F bundle provides evidence-based guidelines for pain control, breathing and awakening trials, targeted sedation levels, early mobility, and family engagement. Pharmacists can assist with pain control, coordination of medications with breathing and awakening trials, optimization of sedation levels, collaboration with other team members to facilitate mobility, minimization of muscle weakening medications, and support for family members by sharing information and answering medication related questions. Continued medication review can also result in deescalating medications as the patient improves and upon discharge from ICU. A 2015 study found that pharmacists demonstrated meaningful interventions in both in-person and virtual settings including providing medication reconciliation, identifying ADEs, adjusting medication doses, initiating/discontinuing medications, and improving adherence, thus highlighting their essential role on ICU-RC teams.

Patients with PICS require a multidimensional, interdisciplinary treatment plan that includes cognitive rehabilitation, mental health services, and collaborative care transition to avoid medication misuse after discharge from the ICU. Pharmacist participation in ICU team management and PICS clinics can help improve patient care, research for new treatment options, and assistance with implementing emerging therapies. The COVID-19-driven surge in patients requiring ICU care has intensified the need for high-quality PICS services. At the same time, the rapid expansion of telemedicine and other innovative care models has demonstrated that significant advances in team-based care are achievable when the right incentives and flexibilities are in place.

Background

The Council reviewed ASHP policy 2240, Post-Intensive Care Syndrome, as part of sunset review

and voted to recommend amending it as follows (underscore indicates new text; ~~strikethrough~~ indicates deletions):

~~To recognize that multidimensional rehabilitation is essential for recovery after intensive care; further,~~

To advocate that health systems support the development and implementation of intensive care unit (ICU) guidelines via multidisciplinary teams, including pharmacists, to reduce the development of post-intensive care syndrome (PICS) and the associated post-intensive care syndrome-family (PICS-F); further

To support research ~~on~~ and dissemination of best practices ~~in~~ for the prevention, identification, and treatment of ~~post-intensive care syndrome (PICS)~~ PICS and PICS-F in patients of all ages; further,

~~To advocate that health systems support the development and implementation of interdisciplinary clinics, inclusive of pharmacists, to treat patients with PICS, including provisions for telehealth and innovative practice models to meet the needs of patients with PICS; further,~~

To advocate for the integration of post-ICU patient and ICU family/caregiver support groups; further,

To provide education on the role of the pharmacist in caring for patients with PICS as well as the family/caregivers with PICS-F.

SECTION OF CLINICAL SPECIALISTS AND SCIENTISTS POLICY RECOMMENDATIONS

The Section of Clinical Specialists and Scientists serves as the professional home for pharmacists who function as clinical specialists and pharmacy scientists, focusing on advancing clinical practice, research, and patient care within health systems.

Executive Committee, 2026-2027
Brian Potoski, *Chair* (Pennsylvania)
Angela Colella, *Immediate Past Chair* (Wisconsin)
Megan Corrigan, *Chair-Elect* (Illinois)
Denise Kelley, *Director-at-Large* (Texas)
Zahra Nasrazadani, *Director-at-Large* (Missouri)
Brittany Tschaen, *Director-at-Large Elect* (Massachusetts)
Vicki Basalyga, *Director*

1. Advancing Pharmacy Workforce Contributions to Research

To support the role of the pharmacy workforce in advancing scientific research and development within health-care settings; further

To assert that for research to be meaningful and aligned with the evolving needs of health-care delivery, pharmacists practicing in organized health-care settings must be actively involved in its conception, execution, and dissemination; further

To encourage and support pharmacists to serve as principal investigators in research projects, particularly those that address drug-related issues and patient care outcomes; further

To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for the pharmacy workforce to conduct research.

Rationale

Pharmacists' contribution to research is a core responsibility of the profession and essential to advancing health care and improving patient outcomes. It encompasses pharmaceutical research, which examines the development and testing of novel drug dosage forms, preparation techniques, and administration systems; clinical research, which focuses on the evaluation, comparison, and characterization of drug therapies and treatment regimens with an emphasis on therapeutic outcomes; health services research, which investigates behavioral, economic, and system-level factors influencing patient care including cost-benefit analyses; and operations research, which assesses pharmacy programs and services using methodologies such as time-motion studies and workflow optimization. All facets of the profession must actively support and promote pharmacy workforce involvement in these areas of research to drive innovation, enhance patient outcomes, and advance science.

Pharmacists are well poised to make essential contributions to improving therapeutic innovation and patient-centered outcomes as pharmacy practice is grounded in the principles of pharmaceutical science, clinical knowledge, and patient-centered care. Pharmacists interpret and apply findings from scientific research, clinical trials, and other data analyses alongside clinical expertise and patient preferences to make informed decisions. The continued advancement, impact, and recognition of the pharmacy profession therefore rely on expanding its scientific foundation through dynamic, rigorous research and innovation. Pharmacists in health-care settings can lead and contribute to research that improve drug therapy outcomes, both through collaboration with other healthcare professionals and by serving as principle investigators, particularly in studies addressing drug-related issues and patient outcomes. Health-care organizations and professional bodies must foster a culture that supports pharmacist-led research by ensuring access to resources and mentorship, promoting interprofessional collaboration, and incentivize pharmacists' research contributions through recognition, protected time, and resources.

As pharmacy technicians are taking on a broader range of responsibilities including final product verification, supporting medication therapy management, documenting medication histories, administering vaccines, ensuring regulatory compliance, and overseeing workflow operations it is a logical progression that they are also a part of research. Recognizing this expanding scope, The Pharmacy Technician Society® (TPTS) advocates for technician involvement in research through its strategic plan, which aims to "support ongoing research that evaluates pharmacy technicians' impact on the medication use system, collaboration on healthcare teams, and overall patient outcomes."

Working with healthcare organization leadership to foster opportunities, allocate time, provide recognition to those who conduct research, incorporate research into its organizational values as well as provide resources for the pharmacy workforce to conduct research is vital for advancing pharmacy practice and improving patient care. Leadership support empowers pharmacists to generate evidence that guides safer and more effective medication use, enhances clinical outcomes, and demonstrates the measurable value of pharmacy services. By investing in research infrastructure and protected time, organizations cultivate a culture of innovation, professional growth, and continuous quality improvement. This collaboration not only strengthens the pharmacy workforce but also aligns with broader institutional goals of advancing evidence-based practice, patient safety, and healthcare excellence.

Background

The SCSS Executive Committee and the ASHP Foundation Research Advisory Council met to discuss the need for professional policy surrounding the topic of research as a professional obligation. These members discussed the broad spectrum of what can be considered research and areas included; where applied science fits into research; what pharmacist participation looks like in research activities; ensuring that research is supported by administrators through funding and allocation of time to conduct research; democratizing research and operationalizing how to reduce knowledge translation gaps and how to ensure that what is learned is making it to the patient bedside; the role of pharmacists in clinical drug trials; the role of quality improvement and medication use evaluation projects, particularly when these projects impact patient outcomes; engaging preceptors, residents and students in research.

They identified the need for professional policy to address issues such as administrative support for research, pharmacists as principle investigators, the role of workforce in contributing to improving therapeutic innovation and patient-centered outcomes, and the role of the pharmacist in conception, execution, and dissemination of research. These constitute actionable ways to support research as a priority within pharmacy practice. Such a policy would help hospitals and health systems support research activities by the pharmacy workforce and address an immediate, actionable need within the profession.

SECTION OF INPATIENT CARE PRACTITIONERS (WITH THE COUNCIL ON EDUCATION AND WORKFORCE DEVELOPMENT)
POLICY RECOMMENDATIONS

The Section of Inpatient Care Practitioners serves as the professional community representing the pharmacy workforce across a variety of acute care practice settings.

Executive Committee, 2026-2027
Elizabeth Wade, *Chair* (New Hampshire)
Molly Billstein Leber, *Immediate Past Chair* (Pennsylvania)
Indrani Kar, *Chair-Elect* (Ohio)
C. Whitney White, *Director-at-Large* (Alabama)
Mary Pat Thomas, *Director-at-Large* (Virginia)
Ryan Hannan, *Director-at-Large Elect* (Minnesota)
Rena Sackett, *Director*

1. ASHP Statement on the Role of the Medication Safety Leader

1 To approve the ASHP Statement on the Role of the Medication Safety Leader.

DRAFT ASHP Statement on the Role of the Medication Safety Leader

Position

The American Society of Health-System Pharmacists (ASHP) believes that medication safety is a fundamental and shared responsibility of the pharmacy workforce and all healthcare professionals. Medication safety programs require engagement of the entire healthcare team, as well as innovative leadership to set a vision and direction, identify opportunities to improve the medication-use system, and lead implementation of error-prevention strategies across all practice settings. The medication safety leader plays a key role in driving initiatives focused on patient safety, providing medication safety expertise, and influencing practice change, research, and education. ASHP believes that because of their training, knowledge of the medication-use process, integration within healthcare teams, close patient interaction, and proven leadership in this field, pharmacists are uniquely qualified to serve as the medication safety leader in hospitals and health systems.

Background

Over the past 60 years, hospital and health-system pharmacies have reduced the risk of medication harm through the development and implementation of safety strategies. Medication safety was the basis of several historic innovations in pharmacy services (e.g., unit-dose systems, decentralized clinical pharmacy services, therapeutic drug monitoring, medication reconciliation, and sterile compounding of intravenous medications). The fundamental leadership role of pharmacists in medication safety has been summarized as follows:

> Pharmacy leadership is the core of a successful medication safety program. Pharmacists play a pivotal role in process and performance improvement. Pharmacists lead efforts to reduce patient safety risks, optimize the safe function of medication management systems, and align pharmacy services with national initiatives that measure and reward quality performance. Pharmacists' impact and views go beyond the walls of the pharmacy, making pharmacists integral members of organizational senior leadership teams. While all pharmacists play a role in medication safety, frontline pharmacists are uniquely positioned to identify and address system vulnerabilities.[1]

The growing recognition of pharmacists' critical role in medication-use safety was strengthened by

evolving professional perspectives on patient safety and systems-based thinking, most notably reflected by the landmark Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System,*[2] which generated major patient safety initiatives by government agencies, regulatory and accrediting bodies, professional and organizational associations, and health care organizations. Joint Commission's National Performance Goals (NPGs), previously named National Patient Safety Goals (NPSGs),[3] are an example of a response to the original IOM report. Furthermore, practice guidelines like Practice Advancement Initiative (PAI)[4] and the National Quality Forum (NQF) Safe Practice 18: *Pharmacist Leadership Structures and Systems*,[5] embed core medication safety principles and underscore the critical role of pharmacists in promoting optimal patient safety and outcomes.

The medication safety leader (also referred to as a medication safety officer, medication safety manager, or medication safety coordinator, among other titles) is a clinical practitioner designated by an organization to serve as the authoritative expert in safe medication use. An effective medication safety leader must embody a set of essential characteristics that will enable them to influence change, drive system improvement, and promote safety across the entire medication-use process (Table 1). Traditionally, the medication safety leader has been a clinical pharmacist or manager within the department of pharmacy, although the position is sometimes filled by a nurse or physician. The medication safety leader may report to the organization's pharmacy, risk-management, or quality departments, or to senior administration. The medication safety leader should be positioned on the organizational chart where it will best enhance their "ability to affect change and advocate that the position remains targeted on medication safety" while maintaining sufficient independence from operational reporting structures to minimize bias or undue influence during medication safety initiatives, analyses, and discussions.[6] Medication safety leadership may encompass a single hospital or a group of organizations (e.g., spanning a health system or at a corporate level of a larger organization). Regardless of organization size, it is critical that the fundamentals of medication safety are the central component of the medication safety leader's job function. Although medication safety leaders may have other responsibilities, medication safety should remain a core responsibility, they should have training in medication safety and quality improvement, and they must be strategically positioned and empowered to lead efforts to reduce the risks of medication use.

Table 1. Characteristics of a Medication Safety Leader

Education, Training, and Professional Development	• Completed post-graduate specialized training (e.g., medication-use safety and policy residency or fellowship, related certificate or certification) or three or more years of health-system practice experience.

Table 1. Characteristics of a Medication Safety Leader	
	• Maintains continuous professional development focused on new developments in safety and quality improvement concepts.
Clinical and Medication-Use System Expertise	• Knowledge of and experience with all aspects of the medication-use system, including procurement, prescribing, transcribing, preparation, distribution, administration, documentation, and monitoring. • Strong understanding of the facility's internal systems and processes developed through firsthand experience, observations, medication-use evaluations, interviews, and data analysis for the spectrum of patient populations treated in their organization (e.g., pediatric, geriatric, cardiac, oncology). • Clinical expertise and a broad understanding of health care systems and processes to facilitate accurate interpretation of clinical events. • Proactive drive to learn from external safety events and ability to apply learned insights to strengthen system vulnerabilities to prevent patient harm.
Systems-Focused Quality Improvement and Data Driven Decision-Making Expertise	• Demonstrates mastery in application of safety principles, continuous quality improvement methods, and human factors engineering, and high-reliability principles. • Strong analytical acumen and an understanding of statistics, population data, and risk-prioritization concepts to inform sound safety decisions. • Proficiency in performance-improvement methodology and tools, including root cause analysis (RCA), failure mode and effects analysis (FMEA), cause-and-effect diagramming, process-flow mapping, and methods for monitoring projects and measuring the progress of performance-improvement initiatives. • Ability to trend and leverage data related to the medication use process to proactively identify and mitigate system vulnerabilities.
Safety Mindset, Values, and Professional Philosophy	• Commitment to just-culture[7] principles, fostering transparency, inclusive participation of all health care professionals, and a learning-focused environment within the organization's medication error reporting system. • A passion for medication safety and improving patient outcomes. • Values and actively promotes meaningful patient engagement as an essential as part of the health care team.

Table 1. Characteristics of a Medication Safety Leader	
Leadership, Influence, and Change Management	• Demonstrates transformational leadership skills. • Demonstrates a system-focus approach to adverse drug events, advocates for system-level solutions, and applies just culture principles to all event reviews. • Functions proactively rather than reactively. • Demonstrates appropriate assertiveness- knowing when to ask and how firmly to advocate based on the issue at hand, the organizational landscape, and shifting priorities. • Successfully engages with diverse groups - interdisciplinary clinical teams, health-system leaders, supportive staff, and patient-family advocates. • Assesses growing demands of the medication safety role and proactively advocates for the resources needed to meet these expanding responsibilities.
Communication and Collaboration Skills	• Communicates with exceptional clarity - verbally and in writing, with flexibility to tailor and edit messages to the audience and communication medium. Demonstrates strong presentation skills that are designed to diverse audiences of healthcare professionals and patients.

The scope of a medication safety leader's responsibilities reaches every corner of the health care system and encompasses many roles, such as educator, preceptor, mentor, detective, compliance officer, risk manager, engineer, accountant, statistician, computer analyst, and counselor. A typical day may include activities related to medication safety surveillance, system-level quality improvement, and providing medication safety-related education (Table 2). Most medication safety leaders quickly find themselves involved in many projects and committees as well as serving as the contact person when nursing, pharmacy, or medical staff have questions or problems. The medication safety leader must understand patient safety principles and prioritize work activities to positively impact the safety of patient care. Additionally, the medication safety leader should strive to acquire additional skills crucial to success, such as presentation and communication skills, proficiency with medication-use data and technologies, as well as expertise in process-improvement methodologies such as Six Sigma and Lean. Formalized training in medication safety can be achieved through residency, fellowship, certificate programs, and other methods of continuing education. ASHP supports the expansion of pharmacy education and postgraduate residency training to include an emphasis on medication safety.[9]

Table 2. Proposed Daily Activities of a Medication Safety Leader			
Medication Safety Surveillance	**Systems-Level Quality Improvement**	**Education, Training, and Professional Development**	**Leadership**

• Attend safety rounds and/or clinical staff meetings • Investigate and respond to adverse drug event reports • Conduct tracers to ensure compliance with accreditation standards and best practices • Assess safety during drug shortages and/or drug or drug delivery device recalls	• Lead process improvement teams • Evaluate medication safety data trends by applying analytic frameworks (i.e., dashboards) • Develop and implement error- prevention strategies	• Precept pharmacy students and residents • Provide medication safety and just culture education to new clinical staff, existing staff, and leaders across the system	• Lead medication safety committee, workgroup meetings, and/or technology governance groups • Report medication safety data to health system leaders • Develop policies and procedures related to safe medication use • Provide reporters and stakeholders with feedback, lessons learned, and resulting changes.

Responsibilities of Medication Safety Leaders

Medication safety leaders must collaborate with all types of health care professionals, support staff, management, and patient-family advocates, while considering all components of the medication-use process. To improve medication safety, this must occur in all settings of healthcare (e.g., acute care, ambulatory care, infusion centers, community pharmacies, drug distribution centers). Although responsibilities may vary among organizations, the medication safety leader is responsible for medication safety leadership and expertise that influence practice change, research, and education.

Leadership. To provide leadership, the medication safety leader will:

1. Provide accountable, strategic, health-system-level stewardship of the medication-use process by serving as a chair of the medication safety committee, steering the medication safety team, and operating as the organization's expert leader for medication use-related processes and regulatory/accreditation requirements.
2. Develop and communicate a vision of an ideal, high-reliability medication-use process that informs organizational strategy and medication safety priorities.
3. Ensure medication management and patient safety are embedded in organizational quality and outcomes initiatives, championing high-reliability principles in system and process design.
4. Lead the development, implementation, and continuous refinement of the organization's medication safety program, ensuring alignment with regulations, accreditation standards, best practices and emerging guidelines.
5. Design and implement proactive error-prevention strategies using internal data trends, external

medication safety risk reports, professional practice standards and guidelines, and best practices and evidence-based recommendations from patient safety organizations (e.g., Institute for Safe Medication Management Practices (ISMP), Emergency Care Research Institute (ECRI), ASHP, etc.).

6. Ensure they and the medication safety team, if applicable, has timely access to informatics data and advanced analytics, including emerging technologies such as Artificial Intelligence (AI), by coordinating with organizational data owners.
7. Collaborate in, and when appropriate lead, the planning, implementation, and optimization of the organization's medication error reporting platform and medication-use technologies, including automation, medication preparation and dispensing devices and software, medication delivery devices like smart infusion pumps, and clinical decision support software.
8. Foster a culture of psychological safety and shared responsibility for medication safety across the health system through transformational leadership, by eliminating barriers for voluntary reporting, and by advocating caregiver support through the implementation of a second victim/care-for-the-caregiver program.
9. Advance safety science literacy across the health-systems by guiding leaders and clinicians in process improvement methodology, high reliability principles, and human factor engineering learning.
10. Collaborate with technology vendors through bidirectional feedback, advisory panels, and optimized partnerships to improve clinical usability of informatics and safety systems.

Expertise. In the role of medication safety expert, the medication safety leader will:

1. Serve as the organization's authoritative resource on medication safety, providing expert guidance for clinical teams, medication-use process owners, and in organizational strategic planning.
2. Provide the medication safety perspective in technology initiatives that directly or indirectly affect the medication-use process, ensuring safe design, implementation, and optimization.
3. Contribute medication safety expertise to internal and external emergency-preparedness planning, including contingency workflows to support safe medication use when information systems are inaccessible.
4. Act as an internal consultant by investigating medication safety events or concerns, conducting retrospective and proactive analyses, and developing actionable recommendations to reduce

risk and prevent event reoccurrence.

5. Ensure compliance with state and federal regulatory and accreditation requirements relating to medication safety, including medication management standards and National Performance Goals (NPGs).
6. Apply quality-improvement and human-factors methodologies (e.g., find a problem, organize a team, clarify the problem, understand the problem, select an intervention [FOCUS], Plan-Do-Check-Act [PDCA], Lean, root cause analysis [RCA], and failure mode and effects analysis [FMEA], etc.) to evaluate processes, identify vulnerabilities, and guide system level improvements.
7. Collect, review, and/or analyze the organization's medication-use process data including voluntarily reported adverse drug events, adverse drug event surveillance data (e.g., trigger tools, clinical data trends including those using emerging analytics technology, etc.) and medication-related technology data (e.g., alert override reports, smart pump events or compliance reports, automated dispensing system reports, compounding technology reports, etc.)
8. Use data-driven insights to identify improvement opportunities and proactively develop high-leverage, error-reduction strategies.
9. Anticipate and manage medication safety risks caused by potential or actual drug product shortages and drug-delivery device recalls, including evaluating replacement drug products and coordinating safe practices across the health system (e.g., acute care, ambulatory care, etc.).
10. Maintain and advance professional expertise by staying current with trends in patient and medication safety, engaging in continuous professional development, and participating in local and national safety organizations to share and adopt best practices.

Practice Transformation. To influence practice change, the medication safety leader will:

1. Foster a culture of safety and shared accountability by collaborating with health-system leadership, human resources, clinicians, and patient-family advocates to embed high reliability principles in practice and establish a just, psychologically safe environment committed to continuous learning.
2. Partner with departments across the health-system (e.g., pharmacy, risk management, patient safety, clinical teams, ambulatory care centers, etc.), to identify, prioritize, and address medication safety issues using data-informed, evidence-based risk-reduction strategies.

3. Expand medication safety engagement across all care settings (e.g., ambulatory, primary care, infusion centers, home care, etc.) through collaborative partnerships, data-driven insights, and shared decision making with the associated frontline teams.
4. Manage improvements made to the medication-use system, resolve medication safety issues, and ensure frontline clinicians are supported in delivering safe care for patients (e.g., optimization of clinical decision support tools).
5. Integrate medication safety into the organization's strategic patient safety plan by working closely with senior leaders (e.g., patient safety officer, chief medical officer, etc.) to align medication safety initiatives with broader system priorities.
6. Lead or participate in multidisciplinary committees where adverse drug events, medication-use policy, formulary management, and patient safety are addressed to identify risk points and prioritize system improvements to reduce the potential for medication error and patient harm.
7. Promote robust internal and external medication error reporting including the reporting of identified organizational trends to key committees (i.e., medication safety committee, pharmacy and therapeutics committee, etc.)
8. Optimize safety data analysis through intentional application of data analytics frameworks like dashboards, including those leveraging emerging technologies including cognitive computing, artificial intelligence, and trigger tools.
9. Develop and disseminate best practices for safe medication-use principles across the health-system confirming effective spread and adaptation.
10. Apply continuous quality-improvement principles to plan, address, assess and ensure sustainment of improvement efforts.

Research and Education. To further provide medication safety research and education to staff, the medication safety leader will:

1. Design and assist in the implementation of educational and orientation programs in safe medication by:
    - Leading and periodically refining the provision of effective ongoing programs and presentations related to safe medication use to diverse audiences (e.g., nursing, pharmacy, respiratory care, and medical staff).
    - Developing and providing competency assessments to staff for tasks related to medication safety (e.g., use of smart pumps and automated medication dispensing

systems).

- Disseminating educational resources to health care providers, other pertinent staff, and patients to ensure they are competent in safe medication-use practices.

2. Integrate medication safety into orientation and training for all health care providers who participate in the medication-use process.
3. Provide medication safety education to pharmacy colleagues, students, and residents, as well as other health care professionals across the health-system.
4. Share information about actual or potential medication errors or harm with safety organizations such as ISMP, Food and Drug Administration (FDA), drug or product manufacturers, and state error reporting programs.
5. Conduct medication-use safety research through well-designed, externally validated studies and implement evidence-based practices for medication safety.
6. Publish findings, case studies, and best practices in peer-reviewed journals and professional forums to advance the field of medication safety.

Conclusion

ASHP believes that pharmacists, as medication use experts, are uniquely qualified to serve as medication safety leaders. Medication safety leaders articulate the vision and direction for improving the safety of the medication-use system to prevent patient harm. While responsibilities may vary among organizations, the medication safety leader's role includes subject-matter expertise, leadership through direction and prioritization, fostering staff engagement, influencing practice change, research, and education. ASHP supports an expanded role for medication safety leaders that balances the refinement of traditional safety tools with the integration of emerging technologies to develop proactive, data-informed safety strategies, advance a culture of safety, and strengthen health system-wide impact.

Web Resources

- Agency for Healthcare Research and Quality (AHRQ): www.ahrq.gov
- American Society for Healthcare Risk Management (ASHRM): http://www.ashrm.org American Society of Health-System Pharmacists (ASHP): http://www.ashp.org
- Anesthesia Patient Safety Foundation (APSF): www.apsf.org
- Center for Disease Control and Prevention (CDC): www.cdc.gov
- Consumer Medication Safety: www.consumermedsafety.org

- Emergency Care Research Institute (ECRI): www.ecri.org
- FDA Med Watch: www.access.fda.gov/scripts/medwatch/medwatch/medwatch-online.htm
- Institute for Healthcare Improvement (IHI): www.ihi.org
- Institute for Safe Medication Practices (ISMP): www.ismp.org
- International Center for Health Outcomes and Innovation Research (InCHOIR): www.mers-tm.org
- Joint Commission (TJC) National Performance Goals: https://www.jointcommission.org/en-us/standards/national-performance-goals
- Medication Safety Officers Society (MSOS): www.medsafetyofficer.org
- National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP): www.nccmerp.org
- National Patient Safety Foundation (NPSF): www.psnet.ahrq.gov/issue/national-patient-safety-foundation
- National Quality Forum: www.qualityforum.org
- Patient for Patient Safety (PFPS) US: www.pfps.us
- Patient Safety Authority: www.patientsafety.pa.gov
- Patient Safety Movement Foundation: www.psmf.org
- SafeMedication.com: www.safemedication.com
- The Just Culture Community: www.justculture.org
- The Leapfrog Group: www.leapfroggroup.org
- U.S. Pharmacopeia (USP): www.usp.org
- World Health Organization (WHO): www.who.int/en

Additional Readings

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Disclosures

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Additional Information

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