Medication Safety in Swiss Hospital Settings: Shared Challenges, Different Perspectives

patientensicherheit schweiz
sécurité des patients suisse
sicurezza dei pazienti svizzera

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CONTEXT

The Swiss Patient Safety Foundation is implementing the six-year National Implementation Programme for Medication Safety (NIP-MedS) to strengthen medication safety across Swiss healthcare settings.

NIP-MedS focuses on three areas:

- **High-risk medications**
- **Medication mix-ups**
- **Changes in medicine availability**

As part of the programme's initial assessment, a national survey and complementary assessments explored **challenges, existing practices and improvement needs** across Swiss healthcare settings.

METHOD

Online survey

- National multilingual survey (German, French and Italian)
- July-December 2025
- Healthcare professionals involved in medication processes across Swiss healthcare settings
- Predefined challenges and open-ended questions

Rating scale and analysis

- Predefined challenges rated on a five-point Likert scale
- Percentages: Ratings of 4 or 5 on a five-point Likert scale, excluding “I don’t know” responses
- Additional challenges and comments collected through free-text fields

YOUR WORK MATTERS. MAKE IT VISIBLE.

Share your project in the national overview.

Scan me to share!

Many medication safety initiatives are already underway. Share your project in the national overview to make existing efforts visible, foster collaboration and avoid duplication.

RESULTS – WHAT ARE THE MAIN CHALLENGES IN HOSPITALS?

PARTICIPANTS

1 046	400	189	87	39
Total respondents	Hospital respondents	Nurses	Pharmacy professionals	Physicians

HIGH-RISK MEDICATIONS

Hospital Setting · 400 respondents

65.3% Time pressure

59.2% Frequent interruptions

Shared pression

Time pressure and interruptions were common across professions.

Pharmacy staff more often highlighted insufficient training and awareness, lack of systematic double-checks, and missing or inconsistent SOPs.

MEDICATION MIX-UPS

Hospital Setting · 400 respondents

61.3% Changing products / generics

51.8% Lack of attention

48.5% Technical limitations

Different perspectives

Frequent product changes and switches between generics were a greater concern for pharmacy staff and nurses than for physicians.

Pharmacy staff also more often highlighted lack of attention across medication processes, misunderstandings of verbal prescriptions and difficulties distinguishing similar-looking medicines.

CHANGES IN AVAILABILITY

Hospital Setting · 400 respondents

42.8% Insufficient patient information

41.3% Time pressure during changes

37.8% Lack of training on alternatives

Different priorities

Pharmacy staff highlighted time pressure and unclear internal communication when managing drug shortages and substitutions.

Nurses emphasised training on alternative medicines and informing patients about product changes, while physicians highlighted uncertainty in selecting suitable alternatives.

→ Participant numbers are provided for context; the number of valid responses may vary by item. Differences between professional groups are descriptive and were not statistically tested.

FREE-TEXT RESPONSES · PRACTICES & IMPROVEMENT NEEDS

Challenges and existing practices identified through thematic analysis of hospital free-text responses.

Working conditions & knowledge	Reported practices included staff training, medication safety briefings and interprofessional medication reviews.	Staffing and knowledge gaps remained challenges.
Processes & digital systems	Reported measures included standardised labels, double-checks, electronic prescribing and barcode scanning.	Technical and implementation gaps remained.
Communication & responsibilities	Examples included shortage alerts, updated lists of alternatives and information on substitutions integrated into hospital IT systems.	Communication gaps persisted.

DISCUSSION & OUTLOOK

SHARED CHALLENGES. DIFFERENT PERSPECTIVES. TAILORED ACTION.

FROM FINDINGS TO ACTION

Based on findings from the national survey and complementary assessments, the NIP-MedS is now developing and preparing to pilot prioritised measures with healthcare professionals. Examples include:

High-risk medications
Harmonised definition and self-assessment tool

Medication mix-ups
Safer medication storage and workflows

Changes in medicine availability
Structured communication during medication changes

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REFERENCE

Moscaroli A, Schönenberger N, Fridrich A.
Nationales Implementierungsprogramm zur Medikationssicherheit (NIP-MedS): Konzeptbericht. Bern: EQK; 2026.

NIP-MedS Medication Safety
National Implementation Programme

Commissioned by the Swiss Federal Quality Commission (FQC).