World Health Organization

World Patient Safety Day 17 September 2026

World Patient Safety Day goals 2026

Safe care for noncommunicable diseases

Introduction

World Patient Safety Day (WPSD) is observed annually on 17 September. The 2026 day is dedicated to the theme of safe care for noncommunicable diseases (NCDs) with the slogan "Safe care for life!". The aim is to raise awareness of the burden of preventable harm in health care, engage relevant stakeholders and mobilize action to reduce such harm.

People living with NCDs are often at relatively increased risk of preventable harm in health care settings. Harm may occur throughout the continuum of care and may result from, for example, missed opportunities for prevention, delayed or incorrect diagnosis, medication errors, unsafe blood transfusion, surgical errors, unsafe radiotherapy and cancer treatment, inappropriate use of medical devices and health care-associated infections. These risks are amplified by the long-term nature of NCDs, their complex and often extended management, related vulnerabilities and co-existing conditions, as well as by episodes of acute deterioration or complications requiring timely recognition, escalation and coordinated transitions to higher levels of care. They are also influenced by health system challenges, such as barriers to accessing care, or fragmented and poorly coordinated care.

The *Global Patient Safety Action Plan 2021–2030*[1] provides the overarching framework for action to eliminate avoidable harm in health care. Under its strategy 1.5, the World Health Organization (WHO) commits to launching annual World Patient Safety Day goals linked to the annual theme for focused action, with governments, health care facilities and other stakeholders encouraged to adopt, implement and support them. The 2026 World Patient Safety Day goals set out below are proposed to address the most pressing patient safety concerns in NCD care across the life course, from childhood to older age.

- **Goal 1:** Partner with people with lived experience and civil society.
- **Goal 2:** Strengthen prevention and risk assessment.
- **Goal 3:** Provide early detection, accurate diagnosis and integrated management.
- **Goal 4:** Secure access and safe use of medicines and medical devices.
- **Goal 5:** Strengthen care coordination, continuity and transitions of care.

The goals were identified and developed in consultation with the WPSD 2026 Steering Committee and Working Group, with relevant teams in WHO headquarters and WHO regional patient safety and NCDs focal points. This document does not present new WHO clinical or operational guidance. All of the suggested actions are based on existing WHO guidance and resources collated and summarized here for ease of reference.

Each World Patient Safety Day goal is introduced by a short rationale and accompanied by suggested actions organized across five domains: people; tasks; tools and

1 Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021 (see Annex 1. Key WHO resources).

technology; workplace environment; and organization. The goals also include suggested measures that can be adapted to national and local contexts. These are intended to monitor progress rather than constitute a formal monitoring or reporting framework. A consolidated list of the WHO resources informing the goals is provided in Annex 1 for further guidance.

The goals are intended primarily for health workers and health care facility managers involved in the delivery of NCDs prevention and care services and are also relevant to policy-makers and programme managers responsible for creating the conditions for safe care. They aim to translate the World Patient Safety Day 2026 theme into practical action and catalyse sustained improvements beyond the annual campaign. Health workers and health care facility managers can use the goals to identify priorities for improvement and integrate relevant actions into routine practice, while policy- and programme-level stakeholders can use them to strengthen patient safety within relevant plans, programmes and services. Selection and adaptation of the goals and suggested actions to align with national and local priorities and contexts is essential.

Crucially, achieving the World Patient Safety Day goals requires leadership commitment, a culture of safety and continuous learning, and enabling health system conditions, including a supported workforce, reliable supply systems and sustainable financing.

World Patient Safety Day 2026

Safe care for noncommunicable diseases

Goal 1

Partner with people with lived experience and civil society

Goal 2

Strengthen prevention and risk assessment

Goal 3

Provide early detection, accurate diagnosis and integrated management

Goal 4

Secure access and safe use of medicines and medical devices

Goal 5

Strengthen care coordination, continuity and transitions of care

Goal 1

Partner with people with lived experience and civil society

Rationale

People with lived experience of NCDs have unique knowledge of how care is delivered and received across the continuum of care. They provide valuable insights into safety risks and opportunities for improvement. When people with lived experience are not enabled to act as partners in care, opportunities to prevent harm may be missed, warning signs or clinical deterioration may not be recognized, treatment-related problems may go unreported and safe self-management may be compromised. These risks are greatest for underserved and marginalized populations, and for people in situations of vulnerability, who may face additional barriers to participating in their care. Meaningful and inclusive engagement gives people with lived experience and civil society organizations the voice, agency and influence to co-produce safe, responsive and people-centred NCDs services – from individual care to service design, delivery, monitoring, evaluation, improvement and accountability.

People – capacity and capabilities

- **Health worker competencies.** Build health workers' capacity through education and training, supportive supervision and feedback, to deliver respectful and people-centred care, free from stigma and discrimination, and to build trusting partnerships with people living with NCDs enabling their active participation in safe care. Involve people with lived experience in the education and training of health workers, where appropriate.
- **People and caregiver participation.** Support people living with NCDs and their caregivers to recognize and act on safety risks, participate actively in care planning and shared decision-making, and safely manage their health and care.
- **Community empowerment**. Strengthen health literacy and engage communities to promote NCD prevention, support people living with NCDs, reduce stigma and advocate for safe health services.
- **Social participation**. Partner with people with lived experience and civil society organizations in the co-production of safe, quality health services, including underserved and marginalized populations and people in situations of vulnerability.

Tasks – care processes

- **Care planning and shared decision-making**. Engage people living with NCDs in care planning throughout the continuum of care. Discuss care options, including their potential benefits, risks and alternatives, to support shared decision-making that reflects their needs, values and preferences. Facilitate caregiver participation where desired by and with the consent of the person living with an NCD.

- **Self-care support**. Support people living with NCDs and their caregivers to practise safe self-care through counselling, therapeutic patient education and ongoing communication to enable them to follow agreed care plans, monitor symptoms, use medications and medical devices safely, as well as recognize and report warning signs.
- **Speaking up for safety.** Encourage people living with NCDs and their caregivers to ask questions, communicate concerns and report changes in conditions, treatment-related problems and safety risks, without fear of discrimination or negative consequences.
- **Care transitions and continuity of care.** Involve people living with NCDs and their caregivers in care transitions, referrals, counter-referrals, discharge planning and follow-up. Ensure they receive clear information about changes to their care or treatment, where and when follow-up will occur, and who to contact with questions or concerns.
- **Feedback, learning and quality improvement.** Engage people with lived experience and civil society organizations in identifying safety risks, providing feedback on care and co-producing safety improvement efforts.

Tools and technology – equipment, information and job aids

- **Information resources**. Provide access to reliable, accessible, understandable and culturally and linguistically appropriate information and education resources that support health literacy and safe NCD care.
- **Personal health records**. Make available personal health records, individualized care plans and decision aids to facilitate active participation in care and informed decision-making.
- **Self-care and monitoring**. Equip people living with NCDs with tools and technologies that support safe self-care, including self-monitoring – for example, blood glucose or blood pressure self-monitoring devices.
- **Communication and care coordination**. Use appropriate tools to support two-way communication between people living with NCDs, their caregivers and health workers, care coordination, referrals, counter-referrals, follow up and continuity of care – for example, secure messaging platforms, telehealth, mobile health applications or telephone follow up.
- **Privacy and confidentiality**. Protect confidentiality, privacy and personal health data when using communication tools and digital technologies.
- **Digital equity**. Ensure that tools and technologies are accessible and usable for all, including underserved and marginalized populations, people with disabilities, and people with limited digital literacy, while providing appropriate non-digital alternatives.

Workplace environment – physical conditions

- **Physical accessibility and inclusion**. Ensure health care environments are physically accessible and inclusive, with particular attention to people with disabilities and people in situations of vulnerability.
- **Navigation and wayfinding.** Use clear and accessible signage, wayfinding and service-navigation support to facilitate access to care.
- **Consultation areas**. Provide consultation and counselling areas that protect privacy and confidentiality, and support open communication and active participation, particularly for people facing stigma, discrimination, language or literacy barriers.

- **Information displays.** Display clear, accessible, culturally appropriate and disability-inclusive information and safety messages using person-first and non-stigmatizing language.

Organization – governance and systems

- **Governance and social participation**. Establish formal mechanisms for the meaningful participation of people with lived experience and civil society organizations in governance, planning and decision-making, including in relevant quality and patient safety structures. Ensure these mechanisms are inclusive of underserved and marginalized populations and people in situations of vulnerability including those who experience stigma and discrimination.
- **Co-design and co-production**. Engage people with lived experience and civil society organizations in the development, implementation and evaluation of relevant policies, guidelines, standards, tools and technologies and in the co-design, delivery, evaluation and improvement of NCDs care services.
- **Patient-reported information, learning and improvement**. Put in place systems to collect, document, review and act upon patient-reported information and civil society input, including patient-reported experience measures and patient-reported outcome measures. Communicate how this information has informed decisions, service improvements and accountability processes.
- **Culture of safety and transparency**. Foster a culture that promotes partnership, trust, mutual respect and psychological safety between health workers, people with lived experience and civil society.
- **Effective communication**. Implement policies that support effective communication between health workers and people living with NCDs and their caregivers.
- **Disclosure of adverse events and harm**. Establish systems to facilitate the early identification, reporting and management of safety risks, and the open disclosure of adverse events and harm to the people affected and their caregivers.

Measures

- Proportion of respondents who had difficulty accessing the health care services.
- Proportion of respondents who felt their health care provider communicated clearly.
- Proportion of respondents who felt involved in decisions about their care.
- Proportion of respondents who felt their privacy was respected during care.
- Proportion of respondents who agreed on a workable care plan and goals with their health worker.

Link to WHO resources

Goal 2

Strengthen prevention and risk assessment

Rationale

Many NCDs can be prevented or delayed through early identification and management of modifiable risk factors. Risk accumulates across the life course, beginning in childhood, so timely intervention at any stage can reduce lifetime risk and improve long-term health outcomes. Missed opportunities to identify, assess and address modifiable risk factors can expose people to harm by contributing to the preventable onset of NCDs, disease progression, complications and acute events. These missed opportunities may result from inadequate risk assessment and communication, limited health literacy, misinformation and inequitable access to preventive services. Effective prevention requires a life-course approach that systematically assesses NCD risk, addresses behavioural, metabolic, environmental, social and commercial determinants of health, supports people to make and sustain feasible changes, and is underpinned by strong primary health care, community-based interventions and equitable access to evidence-based preventive services.

People – capacity and capabilities

- **Health worker competencies**. Build health workers' capacity, including community-based health workers, through education and training, supportive supervision and feedback, to assess NCD risk factors, communicate risks clearly, deliver evidence-based preventive interventions and support healthy behaviours.
- **People empowerment and self-care**. Support people to understand NCD risk factors, make informed decisions to reduce their risk, access preventive services and adopt healthy behaviours.
- **Public awareness**. Strengthen understanding of modifiable NCD risk factors, benefits of prevention and healthy behaviours, and counter misinformation that discourages risk reduction or delays uptake of prevention, such as misleading claims about tobacco and nicotine products, alcohol or diet.
- **Social participation**. Work with communities, people with lived experience and civil society organizations to participate in the design, promotion and implementation of NCD prevention and health promotion activities.

Tasks – care processes

- **Risk assessment and stratification**. Assess NCD risk factors and determinants of health, identify individuals at increased risk and use risk stratification to guide preventive interventions.
- **Risk communication and prevention**. Communicate risk effectively, provide evidence-based counselling on tobacco

and nicotine cessation, healthier diets, physical activity, harmful use of alcohol and healthy weight, and deliver other evidence-based preventive interventions such as human papillomavirus (HPV) vaccination and tobacco cessation programmes.

- **Address barriers to prevention**. Identify and address structural, environmental and individual barriers that limit access to preventive services and the adoption of healthy behaviours.
- **Support behaviour change**. Support individuals and families to implement agreed preventive care plans and sustain healthy behaviours through ongoing counselling and follow up.
- **Continuity of preventive care**. Ensure timely and appropriate referral and continuity of preventive care for individuals identified at increased risk.

Tools and technology – equipment, information and job aids

- **Risk assessment**. Make available standardized, evidence-based tools for risk assessment and stratification.
- **Decision-support**. Use evidence-based protocols, algorithms and clinical decision-support tools to guide preventive interventions.
- **Health information**. Provide information resources and education tools for NCD prevention that are accessible, reliable, understandable and appropriate, culturally and linguistically.
- **Self-care**. Provide tools and technologies that support healthy behaviours, self-monitoring of NCD risk factors, and adherence to preventive interventions – for example, tools that support physical activity, tobacco cessation or self-monitoring.

Workplace environment – physical conditions

- **Physical accessibility and inclusive prevention services**. Design and maintain care environments that are physically accessible, safe and inclusive, enabling equitable access to NCD prevention services for all, particularly people with disabilities and people in situations of vulnerability.
- **Health-promoting care environments**. Create care environments that promote healthy behaviours, through smoke-free policies, healthy food options and safe, accessible opportunities for physical activity, where appropriate.
- **Information displays**. Display clear, accessible, culturally appropriate and disability-inclusive information and safety messages that raises awareness of NCD risk factors, prevention and healthy behaviours.

Organization – governance and systems

- **Integration of NCD prevention and risk assessment**. Embed NCD prevention and risk assessment into routine primary care and community-based services, in line with the *Operational framework for primary health care* (see Annex 1. Key WHO resources).
- **Community partnerships**. Strengthen partnerships between health services and community settings to improve access to preventive services and community-based interventions addressing tobacco and nicotine use, harmful use of alcohol, unhealthy diet, physical inactivity and other environmental, social and commercial determinants of health.

- **Population outreach and follow up**. Establish population registration systems, such as empanelment, to identify people at risk of NCDs and support proactive recall, follow-up for risk assessment and preventive interventions.
- **Equity and access**. Implement policies to identify and address barriers to equitable access to NCD prevention and risk assessment.
- **Monitoring, learning and improvement**. Establish systems to monitor the delivery, coverage and quality of prevention services, and use the findings to inform service improvement.

Measures

- Proportion of people attending a facility and assessed for overweight and obesity using height, weight and/or body mass index (BMI) measurements.
- Proportion of people aged 18 and over who visited a facility and were screened for hypertension according to national or WHO guidelines.
- Proportion of people attending a facility aged 40 years or more assessed for cardiovascular disease (CVD) risk using WHO CVD risk charts or nationally approved cardiovascular risk assessment tools.
- Proportion of tobacco users receiving cessation advice or support.

Link to WHO resources

Goal 3

Provide early detection, accurate diagnosis and integrated management

Rationale

Many NCDs can be detected early and managed more effectively when symptoms, warning signs and clinical deterioration are recognized and acted upon in a timely way. Delays in diagnosis and treatment can result in disease progression, reduced treatment options and poorer health outcomes. People living with NCDs may experience preventable harm at different stages of diagnosis and management, including: barriers to seeking and accessing care; missed opportunities for early detection; delayed testing and inappropriate use or interpretation of diagnostic tests; missed, delayed or incorrect diagnoses; failure to communicate diagnostic findings; delays in initiating treatment; and inadequate coordination of ongoing care. These risks may be further complicated by multiple co-morbidities and diagnostic uncertainty. Diagnosis and integrated management are collaborative processes involving health care teams, people living with NCDs, their caregivers and supported by health technologies and information systems.

People – capacity and capabilities

- **Health worker competencies**. Build health workers' capacity, through education and training, supportive supervision and feedback in screening and early detection of NCDs, comprehensive assessment, diagnostic reasoning, recognition of cognitive biases, management of diagnostic uncertainty, management of acute disease presentations, and delivery of integrated, people-centred care.
- **People with lived experience and caregiver capabilities**. Support people living with NCDs and their caregivers to recognize symptoms, warning signs and clinical deterioration, seek care when needed, participate in the diagnostic process and engage in care decisions.
- **Diagnostic teamwork and collaboration**. Promote effective teamwork and communication among members of the care team recognizing the contributions of different disciplines, people living with NCDs and their caregivers to the diagnostic process.
- **Biomedical engineering and technical competencies**. Strengthen the capacity of biomedical engineers, technicians and other relevant personnel in the selection, installation, maintenance and management of safe and quality assured medical devices, including in vitro diagnostics.

Tasks – care processes

- **Screening and diagnostic evaluation**. Conduct evidence-based screening where

indicated, followed by comprehensive diagnostic evaluation, including history taking, physical examination, appropriate diagnostic testing and interpretation of findings to support clinical decision-making, following standardized clinical protocols such as those in the *WHO package of essential noncommunicable (PEN) disease interventions for primary health care* (see Annex 1. Key WHO resources). Engage people living with NCDs and their caregivers throughout the diagnostic process and communicate diagnostic findings and any uncertainties clearly and effectively.

- **Acute presentations**. Recognize symptoms, warning signs and disease complications of NCDs. Conduct urgent assessment and diagnosis, and respond appropriately through timely stabilization, referral and escalation of care.
- **Specimen and results handling**. Ensure diagnostic samples are correctly labelled with at least two unique patient identifiers, and that specimen handling, transport and results reporting maintain sample identity throughout.
- **Information and care navigation**. Provide people living with NCDs and their caregivers information, education and clear points of contact for support throughout diagnosis and care.
- **Care planning**. Co-produce evidence-based, individualized care plans with people living with NCDs through shared decision-making, considering their needs, preferences, coexisting conditions and individual circumstances, including factors that may affect access to and continuity of care.
- **Co-morbidities and complex care needs**. Coordinate comprehensive, person-centred care for people living with multiple co-morbidities and complex care needs through multidisciplinary collaboration, individualized care planning and appropriate referral and follow up.
- **Procedural safety.** Ensure surgical and other invasive procedures are planned and performed safely using evidence-based safety practices and appropriate perioperative care.
- **Safe use of medical devices**. Use medical devices, including in vitro diagnostics, safely and appropriately to support diagnosis and treatment, and report device malfunctions or safety concerns promptly.
- **Clinical deterioration and care escalation**. Recognize clinical deterioration during ongoing care promptly and initiate timely escalation, referral and/or transfer to appropriate emergency or specialist care.
- **Infection prevention and control**. Apply standard infection prevention and control precautions, including hand hygiene, appropriate use of personal protective equipment, aseptic technique and safe injection practices, during assessment, diagnostic testing, procedures and treatment.
- **Follow up and monitoring**. Ensure timely review and communication of diagnostic test results, completion of investigations and referrals, initiation of appropriate management, and monitoring of treatment response.

Tools and technology – equipment, information and job aids

- **Screening, assessment and diagnosis**. Make available appropriate tools and technologies for screening, clinical assessment, test interpretation, clinical decision support and integrated management of NCDs – for example, WHO PEN protocols.

- **Health information and communication tools**. Use information systems and communication tools, including electronic health records where available, to support documentation, information sharing and care coordination.
- **Self-care**. Provide tools and technologies that support self-management and active participation in care – for example, blood glucose or blood pressure self-monitoring devices.
- **In vitro diagnostics, laboratory instruments and other medical devices**. Ensure the availability of essential in vitro diagnostics and medical devices needed for NCD diagnosis and management, according to national diagnostics lists informed by the *WHO Model list of essential in vitro diagnostics*.
- **Quality assurance of diagnostic testing.** Ensure diagnostic tests and laboratory instruments are subject to quality assurance, including calibration and routine quality control.
- **Medical device handling**. Ensure medical devices used in diagnosis and management are available, functional, calibrated, maintained and readily accessible and that reusable devices are decontaminated and reprocessed between uses, in line with national standards and manufacturers' instructions.

Workplace environment – physical conditions

- **Emergency assessment and stabilization area.** Ensure a designated area is available and equipped for urgent assessment, stabilization and initial treatment of people with acute NCD presentations or clinical deterioration.
- **Workspace design**. Design work environments to minimize unnecessary interruptions, distractions and cognitive burden, and support diagnostic reasoning and teamwork.
- **Consultation areas**. Provide adequate spaces that support effective communication, discussion of diagnostic findings and care planning with people living with NCDs and their caregivers.
- **Accessible information and decision support**. Make diagnostic information, protocols, algorithms and clinical decision-support resources readily accessible and integrated into clinical workflows.

Organization – governance and systems

- **Screening programmes**. Integrate evidence-based NCDs screening and early detection into routine health services and community outreach activities and ensure timely linkage to diagnostic, treatment and follow-up services.
- **Patient registration and follow up**. Establish systems to register people living with NCDs and support proactive recall, follow up and continuity of care.
- **Clinical guidelines and protocols**. Adapt and implement evidence-based guidelines, protocols and standard operating procedures to support diagnosis and integrated management of NCDs.
- **Diagnostic stewardship**. Put in place policies and procedures for the safe and rational use of diagnostic tests, including medical devices for diagnostic purposes and in vitro diagnostics.
- **Critical diagnostic findings**. Implement standardized policies and procedures for

the timely communication, documentation and follow up of critical diagnostic findings, including laboratory critical values and other urgent test results.

- **Task-sharing and task-shifting**. Define clear roles and responsibilities, competency requirements, training, supportive supervision and referral pathways when implementing task-sharing or task-shifting in NCDs care.
- **Monitoring, learning and improvement**. Establish mechanisms to monitor NCD diagnostic and treatment services, and use the findings to drive quality improvement.

Measures

- Proportion of eligible women aged 30–49 years screened for cervical cancer according to WHO and/or national guidelines.
- Proportion of patients whose blood pressure is controlled six months after treatment initiation.
- Proportion of people with diabetes who achieve the globally recommended target for HbA1c.
- Proportion of people with asthma who visited health facility due to acute asthma symptoms.

Link to WHO resources

Goal 4

Secure access and safe use of medicines and medical devices

Rationale

Many people living with NCDs need long-term treatment, often involving multiple medicines and medical devices in health care settings as well as at home. This increases exposure to medication- and device-related risks. Medication-related harm may result from stockouts and interruptions in treatment, medication errors, polypharmacy, inappropriate prescribing or use, inadequate monitoring and poor communication. Harm associated with medical devices may result from inappropriate selection, unsafe operation, inadequate maintenance, device malfunction or insufficient user training. Reducing medication- and device-related harm calls for coordinated action by health care providers, pharmacists, biomedical engineers, health care facility managers, regulators, supply chain stakeholders, people living with NCDs and their caregivers. This includes ensuring equitable access to appropriate, quality-assured and affordable medicines and medical devices, together with systems that support their safe prescribing, dispensing, administration and use, and the safe selection, operation, maintenance and monitoring of medical devices. The third WHO Global Patient Safety Challenge, entitled "Medication Without Harm", calls for action across the medication-use process, with particular attention to polypharmacy, transitions of care and high-risk situations.

People – capacity and capabilities

- **Health worker competencies**. Strengthen the capacity of health workers to manage medicines safely and use medical devices appropriately, including recognizing and reporting adverse drug events and device-related incidents.
- **Biomedical engineering**. Strengthen the capacity of biomedical engineers, technicians and other relevant personnel to support the selection, installation, maintenance and management of safe and quality assured medical devices.
- **People and caregiver engagement**. Support people living with NCDs and their caregivers to use medicines and medical devices safely, make informed decisions, recognize safety concerns and know when to seek assistance.

Tasks – care processes

- **Safe prescribing**. Prescribe medicines appropriately based on clinical needs, the best available evidence, safety considerations and the person's preferences. Ensure every prescription includes the prescriber's name and contact details, patient name and identifiers, date,

generic medicine name, dose, strength, route of administration, frequency and duration.

- **Medical device selection**. Select devices that are appropriate for the intended clinical use, considering safety, quality, performance, usability and the person's preferences and needs.
- **Medicine preparation, dispensing and administration**. Review prescriptions for completeness, appropriateness and potential errors. Prepare, dispense and administer medicines safely, ensuring the right person receives the right medicine, dose, route and frequency at the right time. For injectables, follow the WHO seven steps for injection safety.
- **Information and education**. Provide people living with NCDs and their caregivers clear information on medicine use, storage, treatment changes, adverse effects and when to seek help.
- **Device preparation and use**. Check and prepare medical devices for use according to manufacturer's instructions including cleaning, disinfection or sterilization, calibration, battery charge, and single-use components.
- **High-risk medicines.** Double-check all high-risk medicines (e.g. insulin, anticoagulants and opioids) using a second, independent, trained and qualified verifier, before dispensing and administration.
- **Medication reconciliation**. Perform medication reconciliation during transitions of care to resolve medication discrepancies and reduce inappropriate polypharmacy.
- **Treatment optimization**. Monitor the safety, effectiveness and appropriateness of medicines and medical devices to optimize treatment throughout the course of care.
- **Monitoring and reporting**. Carry out inspection and maintenance of medical devices and report medication errors, adverse drug reactions, and device-related incidents, malfunctions and/or hazards.

Tools and technology – equipment, information and job aids

- **Electronic prescribing and medication verification**. Implement electronic prescribing and computerized provider order entry, where feasible, linked to patient identification, medication information and pharmacy verification. Consider barcode-assisted dispensing and administration where appropriate infrastructure and implementation capacities are in place.
- **Clinical decision-support**. Integrate evidence-based clinical decision-support tools into prescribing and medication-management workflows to support medicine selection, dose adjustment, allergy and interaction checking, identification of contraindication and monitoring.
- **Safe medication management**. Use standardized tools to support medication reconciliation, medication review, management of polypharmacy, and the reporting of adverse drug reactions and medication errors – such as STOPP/START criteria to identify potentially inappropriate prescribing and support deprescribing.
- **Selection of essential medicines and medical devices**. Ensure the facility's selection of medicines and medical devices is aligned with the national essential medicines list and national medical device list (informed by the *WHO Model list of essential medicines*, as well as WHO priority medical device lists (see Annex 1. Key WHO resources) and the Priority Medical Devices Information System).

- **Medical device inventory.** Maintain an up-to-date inventory and maintenance-management system containing, as appropriate, device identification, manufacturer and model, location, ownership or responsible unit, risk classification, installation and acceptance-testing records, maintenance and calibration schedules, service and repair history, user training requirements, software or cybersecurity updates, safety alerts, recalls, adverse incident information and decommissioning status.
- **Self-management**. Provide tools that support people living with NCDs to use their medicines and medical devices safely – such as the WHO *5 moments for medication safety* tool (see Annex 1. Key WHO resources).
- **Artificial intelligence**. Where AI-enabled tools are used to support medication or medical device safety, ensure their validation, implementation within an established governance framework, continuous performance monitoring, and appropriate human oversight.

Workplace environment – physical conditions

- **Storage and handling**. Maintain appropriate storage conditions for medicines, including temperature control, segregation and correct labelling, with additional safeguards for high-risk and look-alike/sound-alike medications. Ensure proper placement and storage of medical devices in designated and appropriate locations.
- **Access to information**. Ensure medication and device information, protocols, alerts and decision-support resources are readily accessible at the point of care – for example, dosing charts or safety checklists posted at medicine preparation and device-use areas.
- **Medication preparation areas**. Provide dedicated areas for medication preparation, with suitable supplies and equipment, and use of infection prevention and control measures to reduce the risk of errors and contamination – for example, using designated "no-interruption zones" to protect staff from disruptions.

Organization – governance and systems

- **Leadership and governance**. Establish mechanisms within the facility to implement the third WHO Global Patient Safety Challenge: Medication Without Harm in line with national guidance and priorities. Integrate medical device safety into organizational governance, with clear oversight and accountability for device management.
- **Continuity of supply.** Maintain minimum stock levels and conduct regular inventory checks to prevent stockouts and the use of expired medicines. Establish systems for medical device inventory management, maintenance, calibration, replacement and safe disposal.
- **Substandard and falsified medical products**. Verify the authenticity of medicines through batch number checks, tamper-evident packaging and, where available, barcodes or other verification systems. Procure medicines and medical devices from authorized suppliers, ensuring their appropriate registration and labelling in accordance with national regulatory requirements. Detect and report suspected substandard or falsified medicines and medical devices through relevant national mechanisms.

- **Patient identification**. Standardize patient identification throughout the medication and medical device use process by implementing measures such as using standardized identification bands and mandating the use of at least two unique identifiers to verify a person's identity.
- **Reporting and learning**. Establish systems that enable health workers and people living with NCDs to report medication errors, adverse drug reactions, device-related incidents, malfunctions and/or hazards, and use reported information to support learning and improvement.

Measures

- Proportion of patients receiving medication reconciliation.
- Proportion of patients with at least one outstanding unintentional discrepancy.
- Proportion of patients on polypharmacy.
- Medical equipment downtime due to maintenance or repair.
- Medication error reporting rate.

Link to WHO resources

Goal 5

Strengthen care coordination, continuity and transitions of care

Rationale

People living with NCDs often require long-term care over many years, delivered by multiple health workers across different services, organizations and levels of the health system. Each time a person moves between them – on referral, admission, transfer or discharge – important information may be lost and responsibilities for their care may become unclear leading to fragmented care. Such breakdowns can cause preventable harm. Test results and changes to treatment may not reach the next provider, follow-up appointments are missed, tests and procedures are unnecessarily repeated, and medicines are duplicated, omitted or incorrectly changed. People may be left to carry information between providers themselves, which places the burden of continuity on those least able to bear it – particularly people living with multiple conditions and complex care needs. Safer transitions depend on standardized handover and referral processes, complete and timely information transfer, clear accountability for follow up, and the active involvement of people living with NCDs and their caregivers in their own care. The WHO *Framework on integrated, people-centred health services* (see Annex 1. Key WHO resources) provides a foundation for strengthening care coordination and continuity across the health system.

People – capacity and capabilities

- **Health workers' competencies**. Build health workers' capacity in effective communication, multidisciplinary teamwork, care coordination, structured handovers, timely and complete information sharing across providers and care settings, including the ability to recognize when information is incomplete or unclear and to seek clarification before acting, particularly for people living with multiple co-morbidities and other complex care needs.
- **People engagement**. Support people living with NCDs and their caregivers to keep and share records of their own health information, including records of medicines and care plans, and to raise concerns when information about their care appears incomplete and/or incorrect during transitions between providers and care settings.
- **Civil society capabilities**. Strengthen the capacity of civil society organizations to support people living with NCDs in navigating health services and contributing to care coordination and continuity.

Tasks – care processes

- **Care planning**. Co-produce and regularly update individualized care plans that reflect the person's conditions, treatment goals, preferences, responsibilities and

follow-up arrangements across providers and services.

- **Transitions of care**. Use standardized handover, referral, counter-referral, transfer and discharge processes to ensure complete and timely exchange of information, continuity of care and clear accountability for follow-up, ongoing management and timely escalation of care when needed.
- **Patient identification**. Ensure correct patient identification using at least two unique identifiers at care transitions to prevent errors associated with misidentification.
- **Multiple co-morbidities and complex care needs**. Coordinate multidisciplinary care across providers, services and levels of care, align management plans for and with people living with multiple co-morbidities and other complex care needs, and integrate palliative care, where appropriate, to support continuity, symptom management and person-centred care.
- **Information for the person and caregiver.** Provide people living with NCDs and their caregivers with clear verbal and written information at discharge, transfer, referral and counter referral, covering their condition, care received, changes to medicines, follow-up arrangements and who to contact if problems arise.
- **Additional transition support**. Identify people at increased risk of safety incidents during transitions of care and provide enhanced care coordination, transition support and follow up including through care coordinators, case managers, patient navigators or other appropriate mechanisms, where available.
- **Follow up**. Arrange timely follow up after referrals, discharge and other transitions of care to review progress, address outstanding needs and identify emerging risks.

Tools and technology – equipment, information and job aids

- **Shared health records**. Use electronic health records and other interoperable information systems, where feasible, to support continuity of information across providers, services and care settings.
- **Care transition**. Use standardized tools to support referrals, transfers, discharge planning, structured handovers and the timely transfer of clinical information and responsibilities, for example, structured handover techniques such as SBAR (i.e. situation, background, assessment, recommendation), checklists and discharge summary templates.
- **Communication and telehealth**. Use secure communication tools, including telehealth and virtual multidisciplinary team platforms, where feasible, to facilitate consultation, collaboration and care coordination across providers and care settings.
- **Personal health records and care plans**. Provide personal health records, individualized care plans and digital tools that enable people living with NCDs to maintain and share information relevant to their care.
- **Registries**. Use patient registries and care coordination systems to maintain an up-to-date list of people with NCDs receiving care at the facility, identify those due or overdue for follow up, and support continuity of care.

Workplace environment – physical conditions

- **Multidisciplinary collaboration**. Design work environments that facilitate effective communication, collaboration and care coordination across providers, services and

levels of care, including dedicated spaces for multidisciplinary case discussions and joint care planning.

- **Access to information**. Make referral information, care plans, discharge documentation and other information required for care continuity readily accessible to health workers at the point of care.
- **Consultation spaces**. Create private, accessible and culturally appropriate environments that support communication, counselling and the meaningful involvement of people living with NCDs and their caregivers during care coordination and transitions.
- **Uninterrupted handover**. Provide conditions that allow handovers to take place with sufficient time and without unnecessary interruption.

Organization – governance and systems

- **Integrated care pathways**. Develop and implement integrated care pathways for priority NCDs that define roles, responsibilities, accountability and referral pathways across the continuum of care.
- **Transition communication**. Establish standardized handover, referral, counter-referral, transfer and discharge processes that define the information to be communicated, responsible health workers, communication channels and accountability for follow up.
- **Patient identification**. Put in place policies and procedures for correct patient identification, including the use of at least two unique identifiers at care transitions.
- **Follow up and continuity systems**. Establish systems for timely follow up after referrals, counter-referrals, transfer and discharge, including **tracking of diagnostic tests and referrals pending at the time of transition. Use** mechanisms to identify and re-engage people who miss appointments such as follow-up calls, home visits, recall systems or empanelment, as appropriate.
- **Workloads and staffing.** Ensure staffing arrangements and workloads allow health workers sufficient time for handovers, care planning and care coordination.
- **Multidisciplinary care teams**. Establish multidisciplinary care teams and care coordination functions, such as care coordinators, case managers or patient navigators, to support people with multiple co-morbidities and other complex care needs.
- **Monitoring, learning and improvement**. Monitor handovers, discharges, referrals, counter-referrals, follow up and continuity of care as well as related safety incidents, using findings to improve care processes and strengthen coordination.

Measures

- Proportion of people with hypertension who were lost to follow up.
- Proportion of people with diabetes who were lost to follow up.
- Proportion of people with asthma/chronic obstructive airway disease who were lost to follow up.
- Hospital readmission rate for tracer NCD conditions.
- Proportion of children with signs and/or symptoms associated with childhood cancer who had suspicious findings from clinical evaluation conducted at the facility and were referred to a centre with capacity for diagnosis of cancer within one month after clinical evaluation.

Link to WHO resources

Annex 1

List of key WHO resources

Title	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5
Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care	✓	✓	✓	✓	✓
Patient safety rights charter	✓	✓	✓	✓	✓
Global strategy on digital health 2020–2025	✓	✓	✓	✓	✓
Classification of digital interventions, services and applications in health: a shared language to describe the uses of digital technology for health, 2nd ed.	✓	✓	✓	✓	✓
Operational framework for primary health care: transforming vision into action	✓	✓	✓		✓
Framework on integrated, people-centred health services: report by the Secretariat	✓	✓	✓		✓
WHO guideline on self-care interventions for health and well-being, 2022 revision	✓	✓	✓	✓	
Noncommunicable disease facility-based monitoring guidance: framework, indicators and application		✓	✓	✓	✓
Patient safety curriculum guide: multi-professional edition	✓		✓	✓	
Therapeutic patient education: an introductory guide	✓		✓	✓	
Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens	✓	✓			✓
Multimorbidity: technical series on safer primary care			✓	✓	✓
Patient identification			✓	✓	✓
WHO package of essential noncommunicable (PEN) disease interventions for primary health care		✓	✓		
Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, 2nd ed.		✓	✓		
HEARTS technical package for cardiovascular disease management in primary health care		✓	✓		
Technical package for cardiovascular disease management in primary health care: systems for monitoring		✓	✓		
Cancer control: Early detection		✓	✓		

Title	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5
Technical package for cardiovascular disease management in primary health care: implementation guide		✓	✓		
Guidance on global monitoring for diabetes prevention and control: framework, indicators and application		✓	✓		
Population health management in primary health care: a proactive approach to improve health and well-being: primary health care policy paper series		✓			✓
Standard precautions for the prevention and control of infections: aide-memoire			✓	✓	
Safe injection practices			✓	✓	
Standard precautions: Injection safety and needle-stick injury management [website]			✓	✓	
Safe injections for patients and communities			✓	✓	
Decontamination and reprocessing of medical devices for health-care facilities			✓	✓	
Decontamination and reprocessing of medical devices for health-care facilities: aide-memoire			✓	✓	
Decontamination and sterilization of medical devices [website]			✓	✓	
Second WHO model list of essential in vitro diagnostics			✓	✓	
Fifth electronic WHO model list of essential in vitro diagnostics (eEDL) [website]			✓	✓	
WHO Medical Devices Information System (MeDevIS) [website]			✓	✓	
Inventory and maintenance management information system for medical devices			✓	✓	
Patient navigation for early detection, diagnosis and treatment of breast cancer: technical brief			✓		✓
Prehospital Toolkit [website]			✓	✓	✓
Prehospital emergency care: operational guidance for ambulance systems			✓	✓	✓
Emergency care toolkit [website]			✓	✓	✓
WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions	✓				
Social participation for universal health coverage, health and well-being (WHA77.2)	✓				
Voice, agency, empowerment: handbook on social participation for universal health coverage	✓				
Patient engagement: technical series on safer primary care	✓				

Title	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5
Patient-reported experiences in primary care: metrics and assessment tool, reference version	✓				
Hearts technical package for cardiovascular disease management in primary health care: risk-based CVD management		✓			
Technical package for cardiovascular disease management in primary health care: healthy-lifestyle counselling		✓			
WHO guidelines on physical activity and sedentary behaviour		✓			
WHO acceleration plan to stop obesity		✓			
Air pollution and health training toolkit for health workers [website]		✓			
Air pollution and health: An introduction for health workers [WHO Academy]		✓			
WHO clinical treatment guideline for tobacco cessation in adults		✓			
Tobacco and diabetes		✓			
Tobacco and asthma		✓			
Tobacco and chronic obstructive pulmonary disease (COPD)		✓			
Improving diagnosis for patient safety: implementation guidance			✓		
Diagnostic errors: technical series on safer primary care			✓		
Integrated emergency, critical and operative care for universal health coverage and protection from health emergencies (WHA76.2)			✓		
WHO Emergency care system framework			✓		
Basic emergency care [website]			✓		
Laboratory quality management system: handbook, version 1.1.			✓		
Technical package for cardiovascular disease management in primary health care: evidence-based treatment protocols			✓		
Guide to cancer early diagnosis			✓		
CureAll framework: WHO global initiative for childhood cancer: increasing access, advancing quality, saving lives			✓		
HEARTS D: diagnosis and management of type 2 diabetes			✓		
Early diagnosis of cancer in children and adolescents: Interactive quick reference guide			✓		
Implementation manual WHO surgical safety checklist 2009: safe surgery saves lives			✓		
Medication without harm				✓	

Title	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5
Medication without harm: policy brief				✔	
Electronic Model list of essential medicines (eEML) [website]				✔	
5 moments for medication safety				✔	
Medication safety in polypharmacy: technical report				✔	
Medication safety in transitions of care: technical report				✔	
Medication safety in high-risk situations				✔	
Medication errors: technical series on safer primary care				✔	
Medication safety for look-alike, sound-alike medicines				✔	
Control of concentrated electrolyte solutions				✔	
Ethics and governance of artificial intelligence for health: WHO guidance				✔	
WHO list of priority medical devices for management of cardiovascular diseases and diabetes				✔	
Technical package for cardiovascular disease management in primary health care: access to essential medicines and technology				✔	
WHO list of priority medical devices for cancer management				✔	
Availability, price and affordability of health technologies for the management of diabetes				✔	
Thermostability of human insulin				✔	
Guidelines on second- and third-line medicines and type of insulin in non-pregnant adults with diabetes mellitus				✔	
Transitions of care: technical series on safer primary care					✔
Communication during patient hand-overs					✔
Acute transfer checklist					✔
Acute referral form					✔
Interfacility acute transfer checklist					✔
Counter referral form					✔
SBAR handover tool					✔

(All links were accessed on 12 August 2026).

Methodology

The World Patient Safety Day 2026 goals summarize actions drawn from existing WHO guidance and resources, in support of the annual World Patient Safety Day theme and its related campaign.

Each goal is documented using a framework for action that reflects strategy 2.4 of the WHO Global Patient Safety Action Plan. The action framework includes the following categories: 1. People – capacity and capabilities; 2. Tasks – care processes; 3. Tools and technology – equipment, information and job aids; 4. Workplace environment – physical conditions; 5. Organization – governance and systems; 6. Measures.

Following agreement on the World Patient Safety Day 2026 theme in February 2026, the WHO World Patient Safety Day Steering Committee endorsed the development of the goals and the establishment of a working group to support action around the 2026 campaign. Staff from the WHO Quality of Care and Patient Safety Team, the Management of Noncommunicable Diseases Unit and the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases identified five goals as priority areas for action for the 2026 campaign, including a framework for action.

The proposed goals and framework were presented for consultation and feedback to the World Patient Safety Day 2026 Working Group. The working group comprised members of the Steering Committee, people with lived experience and health workers identified through the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases, with consideration given to gender and geographic representation. Patient safety and NCD focal points from all six WHO regions also participated in the consultation. The goals and framework were refined based on the feedback received.

A structured search of existing WHO guidance and technical resources informed by the goals was conducted by a technical officer from the WHO Quality of Care and Patient Safety Team. The identified resources were subsequently reviewed and validated by relevant WHO technical teams and mapped against each goal.

The first draft of the goals and their corresponding actions was finalized in June 2026. The draft was then shared with relevant WHO technical teams to review the technical accuracy of the proposed actions and their consistency with relevant WHO guidance and resources. The draft was also shared with the World Patient Safety Day 2026 Steering Committee and Working Group to review the overall content, coherence and clarity of the proposed actions. The final goals document reflects the feedback received during this review process.

The complete list of WHO identified resources, mapped against the five goals, is provided in Annex 1.

Management of conflicts of interest

All external experts submitted to WHO a declaration of interests disclosing potential conflicts of interest that might affect, or might reasonably be perceived to affect, their objectivity and independence in relation to the World Patient Safety Day goals. WHO reviewed each of the declarations and concluded that none could give rise to a potential or reasonably perceived conflict of interest related to the subjects covered by the goals.

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The principal writing team from WHO was led by Ayda Taha with support of Nikhil Gupta and Blerta Maliqi (Quality of Care and Patient Safety Team), Alarcos Ceiza (Management of Noncommunicable Diseases Unit), Katia De Pinho Campos, Samuel Sieber and Maia Caryn Olsen (Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases).

The search for relevant WHO guidance and resources was conducted by Ayda Taha from the Quality of Care and Patient Safety Team and validated by the following technical officers in WHO headquarters: Prebo Barango, Alarcos Ceiza, Bianca Hemmingsen, Kouamivi Mawuenyegan Agboyibor, Roberta Ortiz Sequeira and Sarah Rylance (Management of Noncommunicable Diseases Unit); and Ana Aceves Capri (Medical Devices Team).

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World Patient Safety Day 2026 Steering Committee and Working Group

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- Steering Committee: Qamra Said Al Sariri (Ministry of Health, Oman); Yoseph Mamo Azmera (Global Health Partnerships); Mark Thomaz Ugliara Barone (ADJ Diabetes Brasil, Brazil); Stéphane Besançon (Santé Diabète); Howard Catton (International Council of Nurses); Elisa Codato (World Heart Federation); Alison Cox (NCD

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