SPS Medication Safety Update July 2026

Recent critical patient safety alerts, reports, and publications

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The first stop for professional medicines advice

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Patient Safety Alerts

None in July

Recent regulator and statutory body activity

MHRA Drug Safety Updates

Domperidone: new contraindication in patients with phaeochromocytoma due to the risk of severe hypertension

The product information has been updated for all domperidone products, to include a contraindication for patients with confirmed or suspected phaeochromocytoma (a rare tumour of the adrenal gland), due to the risk of episodes of severe hypertension.

Botulinum toxin type A products: updated warnings regarding risk of iatrogenic botulism

Cases of iatrogenic botulism have been reported following the therapeutic or cosmetic use of botulinum toxin containing products where the toxin's effect extends beyond the area of treatment. Patients should seek immediate medical advice if they experience signs and symptoms.

MHRA Safety Roundup: June 2026

Summary of the latest safety advice for medicines and medical device users. Includes drug safety update on angioedema risk with ACE inhibitors and new liver monitoring requirements with cenobamate treatment.

Recent regulator and statutory body activity

BNF Updates

July BNF + BNFC knowledge updates

Latest monthly update of the BNF and BNFC. Includes updated safety warnings for psychiatric and sexual dysfunction side effects with dutasteride and finasteride (BNF only), and increased risk of rebound congestion, rhinitis medicamentosa, and tachyphylaxis with overuse of xylometazoline/oxymetazoline nasal sprays and drops (BNF and BNFC)

GPhC Updates

GPhC supports HSSIB recommendations to improve safety of independent online prescribing

Press release comments on the report, noting the gap in regulation relating to online services in England that are not pharmacies, previously highlighted by the GPhC, and agreeing that independent prescribing organisations should have access to appropriate NHS records.

Recent regulator and statutory body activity

MHRA Medicines Recall and Defect Notifications

Class 2 Medicines Recall: Beckton Dickson UK Ltd, ChloraPrep 1mL applicator, EL(26)A/34

Becton Dickinson UK Ltd are recalling batches of ChloraPrep 2% w/v / 70% v/v cutaneous solution 1mL applicators due to a potential breach of sterility in the packaging process.

Class 2 Medicines Recall: Bristol Laboratories Limited, Phenoxymethylpenicillin 250 mg/5ml Sugar free Oral Solution BP, EL(26)A/33

Bristol Laboratories Limited is recalling one batch (7124002) of Phenoxymethylpenicillin 250 mg/5 ml Oral Solution Sugar Free due to product labelling issues.

Class 3 Medicines Recall: Orbit Pharma Limited, Cyclizine Lactate 50 mg/ml Solution for injection, EL(26)A/29

Orbit Pharma Limited is recalling a specific batch of Cyclizine Lactate 50 mg/ml Solution for injection as a precautionary measure due to Good Manufacturing Practice (GMP) deficiencies identified at the manufacturing site.

Recent regulator and statutory body activity

Class 3 Medicines Recall: Flamingo Pharma UK Ltd, Flucloxacillin Capsules BP 500mg, EL(26)A/32

Flamingo Pharma UK Ltd have informed the MHRA that certain packs of Flucloxacillin Capsules BP 500mg contain the incorrect PIL. The affected packs contain the PIL for Amoxicillin 500mg Capsules instead of the PIL for Flucloxacillin BP 500mg capsules.

Class 4 Medicines Defect Notification: Neuraxpharm UK Ltd, Tuzulby prolonged-release chewable tablets, EL(26)A/36

Neuraxpharm UK Ltd has informed the MHRA of missing safety information in the Patient Information Leaflet (PIL) and Summary of Product Characteristics (SmPC) for certain batches of Tuzulby prolonged release 20mg, 30mg and 40mg chewable tablets.

Class 4 Medicines Defect Notification: Macarthys Laboratories Ltd T/A Martindale Pharma, Xaggitin XL Prolonged-release Tablets, EL(26)A/35

Macarthys Laboratories Ltd T/A Martindale Pharma has notified the MHRA of a manufacturing issue impacting several batches of Xaggitin XL Prolonged-release Tablets, due to the occurrence of incorrect tablet counts in the bottles.

Recent regulator and statutory body activity

Class 4 Medicines Defect Notification: Brancaster Pharma Limited, Benzylpenicillin benzathine 1.2 Million I.U. and 2.4 Million I.U. powder for suspension for injection, EL(26)A/30

Brancaster Pharma Limited has informed the MHRA that the Patient Information Leaflet (PIL) in the cartons for the batches listed in this notification were released with an outdated PIL.

UPDATE: Class 4 Medicines Defect Notification: Relonchem Limited, Gabapentin Relonchem 50mg/ml Oral Solution, EL(26)A/31

Relonchem Limited have informed the MHRA that particles have been observed inside some bottles of Gabapentin Relonchem Oral Solution, identified through a customer complaint.

Direct HCP communication

Ontozry ▼ (cenobamate): new requirements for liver monitoring due to reports of severe liver injury

Severe liver injury, including hepatic failure, has occurred with Ontozry, often in patients on polytherapy with other antiseizure medicines. Check liver function before starting, and monitor during treatment as needed. Any symptoms of liver injury require urgent clinical review and liver tests. Advise patients to seek immediate medical attention if symptoms arise. If liver injury is suspected, consider reducing the dose or stopping Ontozry.

Tyenne 20 mg/mL concentrate for solution for infusion (tocilizumab): Interim Supply of Swedish/Finnish Stock to Mitigate Supply Disruption

To ensure continuity in supply, Fresenius Kabi Limited has obtained approval from the MHRA to supply Swedish/Finnish product (batch number 16UL19; 1920 units which is expected to be on the UK market from July 2026 up to end October 2028. Healthcare professionals should note that the storage conditions are not clear on the packs which need to be stored in a refrigerator (2 °C – 8 °C).

Manufacturer RMM

Risk Minimisation Materials for Paracetamol (B.Braun Medical)

Materials include a dosing card and poster, regarding the risk of medication errors leading to accidental overdose. The poster includes a table outlining the dose and volume per administration, maximum daily dose, and appropriate IV container for different age group

SPS Resource: Prescribing and administering intravenous paracetamol safely

Risk Minimisation Materials for Penthrox inhalation vapour, liquid (methoxyflurane)

Risk materials include an administration checklist and administration guide, to ensure the appropriate management of important selected risks, and a patient alert card.

Manufacturer RMM

Risk Minimisation Materials for Leqselvi (deuruxolitinib phosphate)

Materials include a Prescriber Guide containing important safety information that should be considered when prescribing and maintaining patients on deuruxolitinib and a patient card covering the main risks of treatment and when to seek medical help.

Patient Card for Tevimbra (tislelizumab)

The card contains important safety information for patients and healthcare providers on immune-mediate adverse reactions, which may occur any time during or even after treatment.

Drug shortages

Recent medicine shortages and discontinuations are available via: the SPS Medicines Supply Tool (registration required to access)

Serious Shortage Protocols (SSPs) for Creon® 10,000 and 25,000 gastro-resistant capsules further extended

The SSP for Creon® 10,000 gastro-resistant capsules (SSP060) has been further extended to Friday 7 August 2026. The SSP for Creon® 25,000 gastro-resistant capsules (SSP061) has also been further extended to Friday 7 October 2026.

Serious Shortage Protocols (SSPs) for Estradot® patches (SSP079, SSP080, SSP081, SSP082) further extended

The SSPs for Estradot® 50mcg/24hours patches (SSP079), Estradot® 75mcg/24hours patches (SSP080), Estradot® 100mcg/24hours patches (SSP081) and Estradot® 25mcg/24hours patches (SSP082) have been further extended to Friday 2 October 2026.

Drug shortages

Medicine Supply Notification: Sodium valproate (Epilim Chronosphere®) 50mg, 250mg, and 500mg modified-release granules sachets sugar free

The 50mg out of stock until late Aug 2026, 250mg until early Jan 2027, and 500mg until end of Sept 2026. The 100mg modified-release granules and Epilim 200mg/5ml syrup remain available but cannot support uplift in demand. Alternative sodium valproate products remain available.

Medicine Supply Notification: Nabilone 1mg capsules

This product is out of stock until end of August 2026. Nabilone 0.25mg capsules remain available and can support increased demand. Unlicensed imports of nabilone 1mg capsules are also available and can be sourced; lead times vary

Medicine Supply Notification: Nifedipine 10mg, 20mg, 30mg and 60mg modified-release tablets

Various brands and strengths of nifedipine modified-release tablets are experiencing supply issues (Tensipine® MR; Dexipress® MR; Adalat® LA; Neozipine® XL); Adanif® XL has been discontinued. Alternative brands remain available and can support increased demand.

Drug shortages

Medicine supply notification: Latanoprost 50micrograms/ml/ Timolol 5mg/ml (Fixapost®) eye drops 0.2ml unit dose preservative free

This product is out of stock until January 2027. Vizilatan Duo® preservative-free eye drops remain available but cannot support increased demand. Latanoprost/Timolol eye drops containing preservatives remain available. Notification discusses other single-component alternatives.

Medicine supply notification: Disopyramide (Rythmodan®) 100mg capsules and disopyramide (Rythmodan Retard®) 250mg modified-release tablets

Disopyramide (Rythmodan®) 100mg capsules will be out of stock from late June 2026 until early April 2027. Disopyramide MR (Rythmodan Retard®) 250mg tablets will be out of stock from late June until late July 2026 after which it can support a partial uplift in demand.

Medicine supply notification: Aztreonam 1g and 2g powder for solution for injection vials

Aztreonam 2g vials are currently out of stock with a resupply date to be confirmed. Aztreonam 1g vials will be out of stock from end of June 2026 with a resupply date to be confirmed. Alternative anti-microbials remain available. Unlicensed products have been sourced.

Drug Discontinuation

Discontinuation of Calcitriol (Silkis) ointment

This product will be discontinued in August 2026. Clinicians should not initiate any new patients on Silkis ointment and consider prescribing an alternative topical Vitamin D preparation, ensuring that the patient is not intolerant to any of the excipients and is counselled on the correct frequency and method of application.

Discontinuation of Quinagolide

Quinagolide 25microgram, 50 microgram tablets will be discontinued in February 2027 and 75 microgram tablets will be discontinued in December 2026. Specialists should not initiate new patients on quinagolide tablets. Primary care clinicians should identify patients on this treatment and seek advice from specialists who can review treatment history and consider alternative management options, including whether a (re)trial of an ergot-derived dopamine agonist (bromocriptine/cabergoline) is appropriate, ensuring no intolerance to excipients.

Specialist Pharmacy Service

Heatwaves and medicines: assessing and managing patient risk
Hot weather can affect the body's responses to some medicines and medical devices. This page provides a step wise approach on how to identify people at risk and how to manage the potential impact. Specific medicines and devices are also considered.

Managing fire risk with emollients and other skin products
Emollient residue can increase the risk of fatal burns. This article outlines how fire risk occurs, which patients may be at increased risk, and harm reduction.

Prescribing and administering intravenous paracetamol safely
Guidance on safe prescribing and administration of IV paracetamol, including dosing, infusion, risk mitigation, and monitoring to prevent errors.

Managing the risks of using liquid oral phenobarbital
Webpage highlights ways to reduce confusion between phenobarbital oral liquids and to raise awareness of ethanol content, especially in neonates and children. Updated to reflect the availability of a new licensed ethanol-free phenobarbital liquid.

Developing direct oral anticoagulant safety across a system
This resource supports healthcare professionals in taking action to promote the safer use of DOACs. It provides insights, guidance and shared learning to help identify and address aspects of DOAC practice that may lead to harm.

National guidance, publications and resources

MHRA Updated guidance: Warning statements for labels and leaflets of certain medicines
This guidance sets out the warning statements which should appear on the label and/or in the leaflet of certain medicines, updated to include additional warning statements for inclusion on the label and/or in the leaflet of certain medicines.

Health Services Safety Investigation Body: Patient safety across regional care pathways: learning from an investigation pilot
The learning in this report is shared to support organisations and ICBs to adopt effective change management processes that are informed by patient safety considerations when designing, implementing and overseeing care pathways across organisational boundaries.

Health Services Safety Investigation Body: response to the Ockenden report
Statement on the Ockenden report, noting that it demonstrates wider system pressures in clinical care, organisational culture and effective oversight, and a provides a stark reminder that patient safety must be understood at a system level.

Health Services Safety Investigation Body: Online prescribing report: opportunities to improve patient safety
Report exploring the patient safety risks associated with accessing prescription medications online through independent prescribing organisations, which are not part of the NHS, although they may be part funded by NHS contracts. Safety observations and recommendations are made.

The safer management of controlled drugs: CQC Annual update 2025
Controlled drug prescribing in NHS primary care fell by 0.3% in 2025; however, prescribing of ADHD drugs such as dexamfetamine, lisdexamfetamine and methylphenidate increased. Non-medical prescribing (NMP) continued to rise, but nurse NMP has reduced slightly for the first time.

Patient Safety Commissioner annual report 2025 to 2026
Patient Safety Commissioner's annual report highlights unresolved redress for valproate/pelvic mesh harm, Martha's Rule impact data, and new work on AI regulation in healthcare via the National AI Commission.

National guidance, publications and resources

Use of chlorhexidine for skin cleansing in neonates – NPPG update
Updated guidance providing pragmatic, expert consensus opinion, aiming to balance risks of neonatal infection due to inadequate skin antisepsis against those of skin injury due to inappropriate chlorhexidine use. It links to list of unlicensed aqueous 0.5% chlorhexidine solutions

Selection of Administration Devices for Oral Liquid Medicines Dispensed to Children position statement – NPPG
Oral liquid medicines are widely used in children, but inconsistent use of administration devices leads to dosing errors and safety risks. A new NPPG position statement provides evidence-based recommendations to standardise device selection and use across healthcare settings, while still considering family preferences. The aim is to reduce medication errors and improve the safe administration of oral liquid medicines.

Warning on promoting newly licensed prescription-only medicines and unlicensed medicines for weight management
The MHRA, Advertising Standards Authority, and the General Pharmaceutical Council have issued a warning to businesses seeking to promote newly authorised medicines, as well as those that do not yet have a marketing authorisation

NPA: Medicine shortages 'most severe' on record, health leaders warn
Primary care leaders have said medicine shortages 'have never been so chronic and severe', with new data showing 96% of pharmacies felt the current situation posed a serious risk to the safety of their patients. The NPA is calling for an urgent taskforce to be convened.

UKHSA: Inadvertent vaccination in pregnancy (VIP) - updated
Advice for health professionals on pregnant women who are inadvertently vaccinated against chicken pox (varicella), shingles or measles, mumps, rubella. There is no known risk associated with giving these during pregnancy.

National guidance, publications and resources

BMJ Journals: Managing home-stored refrigerated medicines following a prolonged power outage: lessons for hospital pharmacy practice
Article highlights the essential role of hospital pharmacists in managing such incidents and suggests information provided at the time of dispensing should include specific recommendations on how to manage events that compromise the cold chain.

UKHSA: Travellers reminded to take precautions to avoid infections abroad this summer
UKHSA data shows rising imported dengue, Zika, chikungunya, malaria and enteric fever cases, plus ongoing measles circulation. Travellers urged to take precautions such as mosquito bite avoidance, up-to-date vaccinations (incl. MMR), food/water hygiene, and malaria prophylaxis.

MHRA: Heat, travel and late nights: How summer can affect your medicines and how to stay safe
The MHRA is launching “Summer-proof your health”, a five-week campaign to help people stay safe with their medicines and medical devices over summer, noting that simple changes to routine, like staying out later, travelling, or coping with the heat, can all have an impact.

Prevention of Future Death Reports (Regulation 28)

Theresa Lydon: 2026-0244

Diagnosed with ulcerative colitis in 2021. A key prescribed medicine (balsalazide) was not issued for over a year due to unclear consultant-to-GP communication. Repeated admissions followed, with missed recognition of severe disease and lack of repeated blood tests, delaying appropriate escalation to biological therapy. Final surgery was high-risk; she died from intra-abdominal haemorrhage with contributing anticoagulation.

Matters of Concern

- Consultant-to-GP letters unclear, leading to failure to action a prescribed medicine.
- Specialists unable to prescribe at diagnosis, causing delays in starting indicated therapy.
- Cross-trust medical records inaccessible, preventing clinicians from seeing recent investigations and treatments.
- Absence of repeated blood tests during key admission, delaying appropriate treatment.
- No effective shared-care process between specialist teams and primary care for initiating and continuing UC medicines.

Key Questions for Organisations

- Are consultant letters standardised so treatment plans and actions are clear?
- Are shared care agreements in place for UC medicines, with clear responsibilities?
- Can specialists initiate essential medicines when clinically required?
- Do clinicians have real-time access to cross-trust records?
- Are monitoring requirements (e.g., repeat blood tests) reliably triggered?

Prevention of Future Death Reports (Regulation 28)

Caroline Harris 2026-0266

Patient with severe mental illness stopped attending for her monthly depot antipsychotic in August 2022. This non-attendance and refusal were not communicated to the Adult Mental Health Team (AMHT) or her GP. Police later raised concerns about relapse, but information was routed through MASH and Adult Social Care, who could not refer directly to AMHT. AMHT stated they would have followed up urgently had they been informed. Caroline was found deceased at home in July 2023.

Matters of Concern

- No process for reporting missed or declined depot antipsychotic doses.
- GP not informed of non-attendance, so did not escalate police concerns.
- Adult Social Care unable to refer directly to AMHT.
- Critical information about relapse risk not shared with the team overseeing medication adherence.

Questions for Organisations

- Is there a clear pathway for reporting non-attendance/refusal of depot medication?
- Can non-clinical agencies notify AMHT directly when medication non-compliance is identified?
- Are communication routes for high-risk mental-health medicines robust and consistent?

Prevention of Future Death Reports (Regulation 28)

Tung Thanh Tran: 2026-0259

Renal-transplant recipient with chronic hepatitis B on long-term reactivation prophylaxis (Entecavir). After disengagement from hepatology, prescribing continued via renal services. In early 2025, medication supply moved to home delivery and Entecavir was inadvertently discontinued due to assumptions about responsibility for prescribing. Mr Tran believed this was an intentional change. He presented in August 2025 with acute liver failure from hepatitis B reactivation and died in September 2025.

Matters of Concern

- No national guidance defining which service is responsible for monitoring and prescribing hepatitis B reactivation prophylaxis.
- Ambiguity in shared-care responsibilities between hepatology, renal transplant teams, and home-delivery services.
- Inadvertent discontinuation of a critical antiviral due to unclear ownership of prescribing.
- Large cohort of hepatitis B–positive patients identified via ED opt-out screening, but no commissioned pathway to ensure ongoing engagement with specialist services.

Questions for Organisations

- Are responsibilities for HBV reactivation prophylaxis clearly defined across specialties?
- Are shared-care arrangements robust enough to prevent unintentional discontinuation of critical medicines?
- Do home-delivery and prescribing systems have safeguards for high-risk long-term antivirals?
- Is there a pathway to ensure ongoing specialist follow-up for HBV-positive patients identified via ED screening?

Primary research - Medication Safety

[Drug therapy safety: methotrexate-associated medication errors]

Journal of Public Health, July 2026

MTX errors still occur despite existing safeguards; proactive interdisciplinary review, especially pharmacist and physician collaboration is essential for patients on complex or high-risk dosing regimens, as passive information-based approaches alone are insufficient.

[Causes and types of voluntarily reported unintentional medication discrepancies in care transitions: a cross-sectional study]

International Journal of Clinical Pharmacy, July 2026

Most medication incidents during care transitions involved unintentional medication discrepancies, with almost all attributed to human factors, particularly verification and intervention errors. Omissions were the most common discrepancy type, often involving cardiovascular medicines, and most incidents occurred at hospital admission or discharge, with the majority reaching the patient. The findings highlight the need for stronger preventive measures such as patient-centred medication reconciliation to reduce errors at transitions of care.

[Standardising medicines in digital paediatric discharge summaries to improve safety]

Archives of Disease in Childhood, June 2026

Inconsistent discharge communication for children leads to avoidable medication errors in the NHS, especially with liquid medicines where dosing is high-risk. Recent incidents show how unclear instructions, multiple concentrations and fragmented systems put patients at risk. Standardised digital discharge summaries and routine pharmacist involvement are needed to ensure families receive clear, accurate and safe medicines information at discharge.

Primary research - Medication Safety

Incorporation of pharmacy technicians into the medication administration process in an inpatient paediatric oncology service – An implementation study

Research in Social and Administrative Pharmacy, July 2026

Integrating pharmacy technicians into IV medication administration was shown to be safe, acceptable, and beneficial. Technicians handled one-fifth of IV doses, saving nursing time while increasing detection of near-misses and strengthening medication-safety culture. Staff reported improved workflow, clearer roles, and better IV rounds. Overall, the service enhanced patient safety and freed nurses for direct care.

Economic impact of switching to licensed ready-to-administer injectable anaesthetic and critical care medicines in the National Health Service: a model-based evaluation of prefilled syringes

British Journal of Anaesthesia, July 2026

Switching from conventional ampoules and vials to licensed ready-to-administer (RTA) prefilled syringes was associated with potential patient safety benefits by reducing medicine preparation steps, medication errors and preventable adverse drug events. RTA products simplified administration, reduced cognitive workload and supported standardisation of injectable medicines in high-risk settings such as anaesthesia and critical care. The study also found reduced drug wastage and preparation time, although cost-effectiveness varied between medicines because of differences in acquisition costs.