SPS Medication Safety Update October 2026

Recent critical patient safety alerts, reports, and publications

Zaid Ali - Medicines Advice Pharmacist

The first stop for professional medicines advice

Wednesday 28th October 2026

Patient Safety Alerts

Title: Levemir® (insulin detemir) FlexPen® 100units/ml solution for injection 3ml pre-filled pens and Levemir® (insulin detemir) Penfill® 100units/ml solution for injection 3ml cartridges

Issue date: 1/10/2026

This alert is to supplement previous MSNs from 16/6/2025, 14/8/2025 and 15/4/2026.

Levemir® (insulin detemir) FlexPen® 100units/ml solution for injection 3ml pre-filled pens and Levemir® (insulin detemir) Penfill® 100units/ml solution for injection 3ml cartridges are being discontinued from end of December 2026 with stocks anticipated to be exhausted by this date

A range of alternative insulins from other suppliers are available. Please refer to the SPS Medicines Supply Tool entry for the discontinuation of Levemir® products for an overview of the supply situation and up to date supply stock overview of recommended insulins. The Medicines Supply Tool should be monitored regularly, as supply capabilities of alternative options remain subject to change.

Immediate effect: Clinicians and prescriber of Levemir must not initiate any patients on any Levemir products

Action completion deadline: 30/11/2026

Useful resource for assessing suitable Levemir alternatives - here

Patient Safety Alerts

Title: Supply disruption for Nova biomedical StatStrip blood ketone test strips

Issue date: 13/10/2026

Nova has identified quality issues affecting specified lots of StatStrip ketone test strips. The affected lots have been associated with quality-control (QC) failures and Nova has initiated a recall, advising that these lots should not be used. Lot numbers can be found on Nova's Field Safety Notice. Nova has paused distribution of affected lots and advised that any further lots found to fail QC testing should also be withdrawn from use. This may result in further disruption to blood ketone point-of-care testing. Nova currently expects new product to be available for shipment to the UK during the week of 26 October 2026.

Actions to be completed by: 20/10/2026

Organisations should identify a clinical lead and form a working group to act on the Field Safety Notice issued by Nova and follow the advice issued by MHRA in their Device Safety Notice.

This will include taking action to:

- Discontinue clinical use and dispose of all lots identified by Nova as subject to recall.
- Assess current and anticipated blood ketone testing capacity.
- Identify and validate alternative ketone testing methods, including alternative point-of-care devices and laboratory testing.
- Prioritise available blood ketone testing for patients at greatest clinical risk where supply is constrained.

Prevention of Future Death Reports (Regulation 28)

Roy Sinclair: 2026-0385

Paracetamol Overdose

Roy Sinclair, aged 45, was a serving prisoner who had a history of mental health difficulties, self-harm, substance misuse, and vulnerability. He reported taking a substantial paracetamol overdose. The jury found that after this first overdose there were failures in his care, including no contact with Toxbase, no effective follow-up when blood tests were refused, and a lack of professional curiosity. Two days later, he seriously self-harmed and was taken to hospital, where he was treated for paracetamol poisoning and later discharged back to prison. Later, Mr Sinclair reported that he had taken a further overdose of paracetamol tablets and said that he wanted to die. He was assessed in prison, and he was taken to hospital, where he received treatment for paracetamol poisoning. His condition deteriorated, he was transferred to intensive care, and he died. The medical cause of death was multi-organ failure, liver necrosis, and paracetamol toxicity.

Concerns:

- Blood samples were not obtained after refusal and no effective further attempt were made overnight. Advice from Toxbase was not sought. The jury found this represented a lack of professional curiosity.
- Failure to raise intelligence reporting and investigate source – No report was issued therefore there was no opportunity to investigate how Mr Sinclair had obtained the paracetamol.

For organisations providing a medicines management service to prisons – review access and storage of medicines.

For all organisations – does your paracetamol overdose pathway inform of next steps if patient refuses a blood test?

Prevention of Future Death Reports (Regulation 28)

Malcolm Campbell: 2026-0400

Fire risk with emollients

Malcolm Campbell, 84, who suffered from dementia, lived alone in his home with regular carers checking in. Carers would apply a prescribed emollient cream to his legs. He regularly smoked in bed and this was seen as risk by his carers and his GP. A fire service assessment in November 2022 considered him at high risk and considered him unable to self rescue with 5 minutes in the event of a fire. The local authority installed monitored smoke/fire alarms as well as a fall alarm. He was also supplied with fire retardant bedding. He was admitted to hospital twice in December 2022, and on both occasions, he was seen to lack capacity and subsequently DOLS authorisations were put in place. Post-discharge, no further capacity assessments were undertaken. He was seen as effectively bed bound and with increasing frailty as well as progression of his dementia. In the new year, a fire started in his home and the emergency services were alerted. On arrival they rescued Mr Campbell, who was resuscitated and taken to hospital due to smoke inhalation. Despite this, he died two days later.

Concerns:

- Mr Campbell's prescribed cream had a paraffin base. A fire investigator believes that the cream may have soaked into the patients' bedding and carpet over time, once the fire started, this would have allowed the fire to spread. Mr Campbell's GP was aware that when prescribers select an item which contains a product that contains paraffin; a warning is displayed. However, there was no ability to install a "Fire" flag on a patient's medical records to show that person has been classed as a fire risk due to smoking in bed.
- NHS patient records do not have the ability to overtly warn HCPs where a person is seen to be a risk of injury/death due to fire to assist them in tasks such a prescribing medication, home visits etc.

Prevention of Future Death Reports (Regulation 28)

Jane Lawrence: 2026-0399

Hypoglycaemia whilst on sulfonylureas

Jane Lawrence had an episode of severe hypoglycaemia with altered consciousness and was treated by a paramedic with 3 boluses of IV Glucose administered over a period of approximately 24 minutes and then complex carbohydrates in accordance with the JRCALC Guidelines. Mrs Lawrence then ate a meal and took her usual medication (including sulphonylureas) and went to sleep. She was found unresponsive the next morning, given emergency treatment and rushed to hospital. Unfortunately, Mrs Lawrence was found to have a profound neurological injury that did not respond to treatment and died in hospital.

Concerns:

- The episode was considered within the flowchart in the JRCALC to be in the “severe” range. She was not conveyed to hospital or considered for further care and was given safety netting advice. The JRCALC flowchart for severe hypoglycaemia following completion of treatment says that when the blood glucose has returned to >4mmol/L , the HCP should be directed back to the “mild” section of the flowchart. This then does not signpost or direct the HCP to consider the pathway for patients who may require further care. This is a risk for patients who are prescribed sulphonylureas and can be a further risk for repeated episodes.

Consider raising awareness amongst HCPs of the risks of not conveying a patient to hospital after a hypoglycaemic episode, particularly if a patient is taking sulphonylureas.

Prevention of Future Death Reports (Regulation 28)

Isla McVeigh: 2026-0402

Neonatal abstinence syndrome

Isla McVeigh was born in June 2024 and died just over a month later. At birth Isla was found to be dependent on opiates and was admitted to hospital to be treated with morphine to mitigate opiate withdrawal. She was discharged against medical advice in early July. It is more likely than not that Isla died of asphyxiation as a result of an unsafe sleeping environment. It is possible that the sedating effects of opiate use were a contributory factor. She was born with Neonatal Abstinence Syndrome; becoming dependent on opiates in utero and required medical care to mitigate the symptoms of opiate withdrawal. Isla had been exposed to opiates because her mother was taking codeine. Whilst in hospital staff raised concerns on several occasions when Isla was found being held by a person who was asleep. Isla was not referred to local authority children services during her life.

Concerns:

- Clinicians did not always understand the extent to which codeine addiction might translate into the misuse of other opiates.

Would your organisation recommend NAS observations and safe sleeping guidance for babies born to mothers who were taking codeine?

Prevention of Future Death Reports (Regulation 28)

Samuel Hand: 2026-0418

Samuel was a 32 year old gentleman with a long history of mental health problems and suicidal ideation. On the morning of 22nd March 2025, he contacted the Integrated Response Hub saying he was going to hang himself. He wanted staff to take him to a place where he could have immediate support. As a result of the above call, a call was made to Ambulance Service from the Integrated Response Hub explaining the situation. The ambulance service explained there could be an 8 hour wait and the call received a category 3 disposition. An hour later Mr Hand made a direct 999 call saying he had taken a significant overdose of an unknown quantity of X medicines. He advised them that he had got it in his head what he wanted to do to end his life. This call was also given a category 3 disposition. It got moved up to a category 2 disposition three hours later, and paramedics arrived just under 6 hours from the first 999 call where paramedics attended and he was confirmed deceased.

Concerns:

- The patient expressed suicidal ideation. Evidence was given at the inquest that the reason for the category 3 disposition was that the “conversation did not disclose any of the high risk drugs that enable a higher disposition. Under the NHS Pathways this is a category 3.”It is clear that no consideration was given to the number of tablets taken when deciding the relevant category for disposition.

Manufacturer RMM

Risk Minimisation Materials for Mygorzo (aficamten)

Materials include a patient card and a checklist to alert healthcare professionals to the important potential risk of heart failure due to systolic dysfunction and embryo-foetal toxicity.

New Mygorzo Patient Card

Risk Minimisation Materials for Remsima

Remsima 100mg and 350mg concentrate for solution for infusion is a new IV formulation of infliximab. Letter advises of the risk of serious metabolic harm in patients with hereditary fructose intolerance, due to the sorbitol content (45mg per mL).

New Remsima liquid patient alert card

MHRA Drug Safety Update

Antidepressants: new safety measures for all patients to improve communication of the risk of suicidal thoughts and behaviours and persistent sexual dysfunction

Published: 15 October 2026

New safety measures are now being implemented for all patients taking antidepressant medications. This follows completion of a detailed review, involving patients and their families, into how the risks of suicidal thoughts and behaviours, and persistent sexual dysfunction are communicated in the patient information leaflets (PILs) that accompany antidepressant medications. These changes involve a new boxed warning in the PIL, a new patient card, and a supporting safety (ancillary) leaflet. The term post SSRI sexual dysfunction ("PSSD") is also being added to the PIL for some antidepressant medications.

HCPs should:

- discuss with patients when starting or changing the dose of an antidepressant or at their next review, the risk of suicidal thoughts and behaviours. Furthermore, HCPS should explain that there is evidence that some antidepressants are associated with a risk of sexual dysfunction and that symptoms may continue after stopping treatment with certain antidepressants.
- follow the relevant NICE guidance and monitor your patients regularly after starting treatment with an antidepressant
- give your patient the safety (ancillary) leaflet when it becomes available in 2027 to support your discussions
- **PJ Article - Pharmacies could stock antidepressant suicidal behaviour warnings - The Pharmaceutical Journal**

MHRA Drug Safety Update

IXCHIQ Chikungunya vaccine: UK marketing authorisation withdrawn following safety review

Published: 20 October 2026

Following advice from the Commission on Human Medicines (CHM), the MHRA has concluded that the benefit-risk balance for the IXCHIQ chikungunya vaccine is no longer considered favourable and the UK marketing authorisation has been withdrawn. Healthcare professionals should no longer prescribe or administer the IXCHIQ vaccine and should instead consider alternative measures to reduce the risk of chikungunya infection in individuals travelling to affected areas.

HCPs should:

- ensure that any materials, systems or communications referring to available UK vaccination options are updated to remove the IXCHIQ vaccine
- advise travellers of alternative measures to prevent chikungunya infection, including other available vaccines for chikungunya, avoidance of mosquito bites and adherence to current health-related travel advice
- patients who have previously received the IXCHIQ vaccine do not need to take any specific action as a result of this regulatory decision. However, they should seek medical advice if they have experienced a suspected adverse reaction following IXCHIQ vaccination

MHRA Drug Safety Update

Continuous renal replacement therapy (CRRT): Consider delayed administration of concurrent echinocandins, such as caspofungin, to reduce the risk of adsorption onto new polyacrylonitrile (PAN)-based filter membranes

Published: 13 October 2026

Continuous renal replacement therapy (CRRT) is used for managing severe acute kidney injury and fluid overload. Published evidence has shown that caspofungin can bind to polyacrylonitrile (PAN)-based membranes used in CRRT which may result in ineffective antifungal treatment with potentially life-threatening consequences in critically ill patients. It is considered that the potential risk is greatest when a new membrane or filter circuit has commenced. This is because adsorption reduces over time as the membrane becomes saturated. The same risk cannot be excluded for other membrane types used in CRRT or other drugs with similar properties. Where possible, it is recommended that echinocandins such as caspofungin, and similar drugs, are administered at least six hours after initiation of PAN-based filter use, and after filter circuit set changes.

Direct HCP communications

The complete MHRA Safety Roundup is available here.

Solivito N: Reports of discolouration of individual vials and advice to inspect the product before use

HCPs should inspect products (within the batches listed in the document) to ensure the solution is yellow. Any vials that have an abnormal discontinuation should be discarded.

Tecovirimat SIGA (tecovirimat monohydrate): restriction of indication due to lack of efficacy shown in randomised clinical trials in patients with mpox

New patients should not be started on Tecovirimat SIGA for the treatment of mpox. This restriction is based on data from recently completed clinical trials, showing that Tecovirimat SIGA lacked efficacy in generally immunocompetent patients with active mpox lesions under the settings studied.

Asthalin 100 microgram Inhaler (Salbutamol Sulphate) – Clarification of paediatric dosing information on the outer carton

HCPs should be aware of an inconsistency between the age-related information currently printed on the outer carton of Asthalin 100mcg micrograms Inhaler and the approved UK SPC and PIL.

Alcensa® (alectinib): Guidance for Management of Severe Hypertriglyceridaemia

Hypertriglyceridaemia-induced pancreatitis was reported in the postmarketing period for Alecensa. Patients should have a baseline blood triglyceride measurement before starting Alecensa, as well as periodically while on treatment. Patients should be monitored for symptoms indicative of acute pancreatitis, particularly in patients at increased risk for pancreatitis.

Direct HCP communications

The complete MHRA Safety Roundup is available here.

Erelzi▼(etanercept) 50 mg solution for injection in pre-filled pen: Interim supply of stock containing the Danish Version of the Patient Information Leaflet

HCPs should discard the Danish PIL. The UK PIL has been supplied alongside the Danish packs

Isturisa 1 mg film-coated tablets (osilodrostat): Interim Supply of Czech Republic, Slovakian and Slovenian Language Stock to Mitigate Supply Disruption - Isturisa 5 mg film-coated tablets (osilodrostat): Interim Supply of Polish, Romanian and Hungarian Language Stock to Mitigate Supply Disruption

HCPs should discard the foreign PIL: The UK PIL should be supplied alongside the foreign packs.

Tyenne 162 mg solution for injection in Pre-filled syringe (tocilizumab): Interim Supply of Estonia/Lithuania/Latvia Stock to Mitigate Supply Disruption

HCPs should discard the foreign PIL: The UK PIL should be supplied alongside the foreign packs.

Avacopan Vifor (previously known as Tavneos) – suspension of use, sale, supply and offer for sale or supply due to unfavourable benefit–risk balance

The single pivotal phase 3 study supporting the marketing authorisation of Avacopan Vifor can no longer be relied upon to demonstrate efficacy. Therefore, the benefit–risk balance of Avacopan Vifor can no longer be considered favourable and its use, sale, supply in the UK has been suspended, except for existing patients during the transitional period. Prescribers should contact patients currently receiving Avacopan Vifor to discontinue treatment and discuss alternative options.

Direct HCP communications

The complete MHRA Safety Roundup is available here.

Guanfacine prolonged-release tablets: Important safety information missing from the Summary of Product Characteristics regarding QT/QTc interval prolongation

The current product information does not fully reflect the available safety information regarding QT/QTc interval prolongation, including relevant post-marketing findings and associated clinical management recommendations.

Important information regarding the use of the alternative name Estraseven Duo 50 micrograms/7 micrograms/24 hours, transdermal patches for FemSeven® Conti 50 micrograms/7 micrograms/24 hours, transdermal patch

This communication is intended to minimise the risk of medication errors by ensuring HCPs are aware that Estraseven Duo 50 micrograms/7 micrograms/24 hours, transdermal patches is the authorised parallel import version of FemSeven® Conti 50 micrograms/7 micrograms/24 hours, transdermal patch.

IKERVIS 1mg/ml ciclosporin eye drops, emulsion: Interim Supply of Australian Stock to Mitigate Supply Disruption

To ensure continuity in supply, Santen has obtained approval from the MHRA to supply Australian product which is expected to be on the UK market from 1st October to 31st December 2026.

Lacosamide Neuraxpharm 10 mg/ml syrup: Important safety information missing from current approved Summary of Product Characteristics regarding myoclonic seizures, ataxia and reproductive health counselling

Myoclonic seizures and ataxia are recognised common adverse reactions to lacosamide and are not currently included in the product information for Lacosamide Neuraxpharm 10 mg/ml syrup.

Direct HCP communications

The complete MHRA Safety Roundup is available here.

BEROMUN® Img, Powder for solution for infusion: Interim Supply of German Stock to Mitigate Supply Disruption

Belpharma s.a. has obtained approval from the MHRA to supply Beromun® product in German pack which is expected to be on the UK market from September 2026 to November 2026.

Caspofungin: use of polyacrylonitrile membranes during continuous renal replacement therapy

There has been some evidence to suggest that polyacrylonitrile (PAN)-based membranes used in CRRT may adsorb caspofungin, potentially reducing systemic exposure and treatment effectiveness. This may result in therapeutic failure with potentially life-threatening consequences in critically ill patients. (See MHRA publication previously for more info)

The association of Patent Blue Violet (Patent Blue V) with serious allergic reactions

A number of serious allergic reactions, including anaphylaxis, have occurred in patients receiving Patent Blue V. Patent Blue V does not carry a license for marketing in the UK. Surgeons are reminded of the risk of serious allergic reactions and are advised to have competent personnel and emergency facilities available for at least 1 hour following administration of Patent Blue V, as delayed reactions may occur.

Medication Supply Notifications

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

Medicine Supply Notification: Lacidipine 2mg and 4mg tablets

Tier 2 – medium impact **Date of issue:** 6 October 2026

Lacidipine 2mg and 4mg tablets are out of stock until **early November 2026**

- Lercanidipine 10mg and 20mg tablets, amlodipine 2.5mg, 5mg, and 10mg tablets and felodipine 2.5mg, 5mg, and 10mg modified release tablets remain available and can support increased demand
- Nifedipine MR tablets remain available but cannot support an uplift in demand

Actions:

Prescribers should not initiate new patients on lacidipine 2mg or 4mg tablets until the shortage has resolved. Where patients have insufficient supply to last until the resupply date, prescribers should review treatment history and consider prescribing.

- lercanidipine tablets, particularly in those who have experienced peripheral oedema on other dihydropyridine calcium-channel blockers (CCBs) or
- another CCB, if appropriate, if above option not suitable

Medication Supply Notifications

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

Medicine Supply Notification: FemSeven Conti (Estradiol 50mcg/levonorgestrel 7mcg/24 hours) transdermal patches

Tier 2 – medium impact **Date of issue:** 12 October 2026

FemSeven Conti patches are expected to be out of stock until late November 2026.

The following 24-hour transdermal patches remain available and can support increased demand:

- Evorel Conti (estradiol 50micrograms/norethisterone 170micrograms)
- Estradot Conti 30/95 or Estradot Conti 40/130 (estradiol /norethisterone)

Alternative hormone replacement therapy (HRT) products remain available.

Actions:

Prescribers should not initiate new patients on FemSeven Conti patches until the supply issue has resolved.

Where patients have insufficient patches to last until the re-supply date, prescribers should:

- consider prescribing Evorel Conti or Estradot Conti patches, taking into account treatment history
- where the above options are not suitable, consider prescribing transdermal estradiol with an alternative progestogen separately, ensuring no intolerance of the excipients, and counselling is provided on dosing and administration

Medication Supply Notifications

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

Medicine Supply Notification: Cilostazol 50mg and 100mg tablets

Tier 2 – medium impact **Date of issue:** 16 October 2026

Cilostazol 50mg and 100mg tablets are out of stock until late November 2026.

- Naftidrofuryl 100mg capsules remain available and can support increased demand.
- Other licensed treatments for intermittent claudication remain available.

Actions:

Prescribers should not initiate new patients on cilostazol 50mg and 100mg tablets until the shortage has resolved.

Where patients have insufficient supplies to last until the resupply date, prescribers should:

- review existing patients to assess treatment response, as the SPC recommends discontinuing where an inadequate effect is observed or symptoms have not improved after 3 months of cilostazol treatment
- for patients who have derived benefit from cilostazol, consider switching the patient on to naftidrofuryl, taking into account treatment history and contraindications if prescribed

National guidance, publications & resources

UKHSA

[The safety of MMRV (measles, mumps, rubella and varicella) vaccine when given in pregnancy]

Guidance highlights women who have had MMRV vaccine in or shortly before pregnancy can be reassured. The weakened varicella and rubella viruses in the vaccine have not been linked to specific problems in babies born to pregnant recipients of varicella or rubella containing vaccines.

Health Innovation Network (NHS)

[National Patient Safety Improvement Programmes: 2025-2026 Impact Report]

This report covers progress made across focus areas in support of the NHS Patient Safety Strategy. This includes Martha's Rule programme; medicines safety – management of antipsychotic medicines in people with a learning disability; and maternitiy and neonatal programmes.

Parkinson's UK

[Self-administration policy template]

A Parkinson's UK report found that one in four NHS trusts does not have policies that allow Parkinson's patients to take their own medication in hospitals. The charity believes that people with Parkinson's who want to manage their medication in hospital should be allowed to, provided they're well enough and have been assessed as safe to do so. This is supported by the NICE quality standard for Parkinson's. On a busy ward, self administration can play a role in freeing up nurses to do other important tasks.

National guidance, publications & resources

NPPG

[Position statement: Use of Steroid Medication Warning Cards for Children and Young People]

Updated guidance from version 1 (November 2021). The main update is a reduction (from 5 years to 6 months) of the age below which a steroid treatment card should be issued with ICS, regardless of dose.

NPPG/PCCS/APA

[Position statement: Safe Use of Continuous Intravenous Propofol Infusions in Paediatric Critical Care]

This work arose from a Prevention of Future Deaths report following the death of Antonio Galisi-Swallow, which highlighted concerns about the risks of Propofol-Related Infusion Syndrome (PRIS) and the need for consistent approaches to the use of propofol in paediatric critical care. The position statement provides a shared national high-level framework describing key principles for safe practice, and factors that should be considered when propofol is used in paediatric critical care. It is intentionally a position statement rather than a prescriptive guideline. Individual units remain responsible for developing and maintaining local protocols that reflect local governance arrangements and clinical practice.

National guidance, publications & resources

HSSIB

Launch of investigation around medication safety in care homes for older people

HSSIB reviewed information about medication safety and spoke with people working across social care, health services and other organisations involved in providing medication. HSSIB identified recurring issues where several organisations are involved, including differences in access to professional support, medication reviews, staff training, digital systems and learning. The investigations will explore how medication is managed in everyday practice, while recognising that care homes are people's homes and should support residents' choices, preferences and independence.

Specialist Pharmacy Service

Medication Safety Across the System (MSATS)

MSATS is a concept that supports medication safety, by addressing complex, system-wide issues and encouraging a collaborative approach to quality improvement. SPS MSATS resources are developed to support a network of engaged Medication Safety Activists (MSAs) in addressing complex, system-wide medication issues and supporting the delivery of safety improvement initiatives.

Save the date - MSATS Webinar – 2/12/2026 - **Safe use of medicines in mental health: a whole-system approach**

Managing the risks of using liquid oral phenobarbital

Safety concerns related to phenobarbital oral liquid formulations are system-wide and errors have the potential to cause harm in all patients who are prescribed phenobarbital, but particularly neonates and children.

Supporting lithium safety across the system

HCPs in all settings who interact with patients prescribed lithium should be aware of safety considerations related to its use.

Primary research - Medication Safety

Co-Designing Medication Safety Interventions for Community Pharmacy: Bringing Together People Living With Visual Impairments and Community Pharmacists Using a Modified Nominal Group Technique Approach.

Health Expectations. 29(5):e70904, 2026 Oct.

This study aimed to identify challenges contributing to medication errors and to co-design potential solutions with people living with Visual Impairment (VI) and community pharmacy professionals. Following discussion and prioritisation, three interventions were selected for further development:

(1) an accessible Patient Safety Guide (PSG) to support communication between pharmacists, patients and carers regarding safe medication use;

(2) a training video for pharmacists to improve awareness and understanding of the needs of people living with VI;

(3) pharmacy system changes, such as alerts or pop-up notifications, to improve identification of people living with VI and facilitate personalised support.

The trial successfully identified practical and acceptable interventions with potential to improve medication safety. The findings highlight the importance of communication, pharmacist awareness and system-level support in reducing medication-related risks for people living with VI.