

Jim Livingstone
Director of Safety, Quality and Standards



Department of
**Health, Social Services
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

For action

Chief Executives of HSC Trusts
Chief Executives HSS Boards
Chief Pharmacists in HSC Trusts/Boards
Medical Director HSC Trusts for cascade to all relevant staff
Directors of Nursing HSS Boards/HSC Trusts
General Practitioners
Community Pharmacists
General Dental Practitioners

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Our Ref: HSC (SQSD) 45/08
Date: 6th November 2008

For information

Medical Director NIAS
Directors of Public Health in HSS Boards
NI Medicines Governance Team
Regulation and Quality Improvement Authority (for cascade to relevant regulated establishments and independent hospitals, clinics and hospices)
Professor Sean Gorman, Head of School of Pharmacy, QUB
Regional Medicines Information Service
Chief Executives NIMDTA, NICPPET, NIPEC
General Manager, HSC Safety Forum

Dear Colleague

Re: National Patient Safety Agency: Rapid Response Report 5: Reducing Dosing Errors with Opioid Medicines

Status: Best Practice Guidance

Incidents have been reported to the National Reporting and Learning System (NRLS) concerning patients receiving unsafe doses of opioid medicines, where a dose or formulation

was incorrect, based on the patient's previous opioid dose. The NPSA received reports of five deaths and over 4,200 dose-related patient safety incidents concerning opioid medicines up to June 2008.

Following NPSA advice, Medical Directors, Nursing Directors and Chief Pharmacists in HSC organisations should remind health care practitioners of their responsibilities to:

- Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient. This may be done for example through discussion with the patient or their representative (although not in the case of treatment for addiction), the prescriber or through medication records;
- Ensure where a dose increase is intended, that the calculated dose is safe for the patient (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose);
- Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, common side effects.

This guidance applies when the following opioid medicines are prescribed dispensed or administered: Buprenorphine, diamorphine, dipipanone, fentanyl, hydromorphone, meptazinol, methadone, morphine, oxycodone, papaveretum, and pethidine.

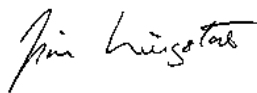
This Rapid Response Report issued on 4 July 2008 is available on:

<http://www.npsa.nhs.uk/patientsafety/alerts-and-directives/rapidrr/reducing-dosing-errors-with-opioid-medicines/>

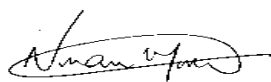
You will wish to bring the contents of this document to the attention of staff, particularly those involved in governance and risk management within your organisation. Organisations need to be aware of this safer practice notice in order to assist in complying with the *Quality Standard for Health & Social Care* –

- Criteria 4.3(i) and 5.3.1(a) (the appropriate management of risk);
- Criterion 5.3.1(f)(viii) and (ix) (ensuring safe practice in medicines management); and
- Criterion 5.3.3(f) (implementation of evidence-based practice through guidance, for example, NPSA guidance).

Yours sincerely



DR JIM LIVINGSTONE
Director Safety, Quality and Standards



DR NORMAN MORROW
Chief Pharmaceutical Officer

Chief Medical Officer Group