

From the Chief Medical Officer:



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

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

HSS(MD)15-2006

Chief Executive's of HSS Boards and Trusts - for cascade to clinical & social care governance leads/risk managers
Medical Directors of Trusts
Directors of Public Health in HSS Boards – for cascade to local hospices
Directors of Pharmaceutical Services in HSS Boards and Trusts
Dental Directors HSS Boards
Directors of Nursing in HSS Boards and Trusts - for cascade to relevant nursing staff in Trusts and community
Directors of Primary Care Services - for cascade to Out-of-Hours Services, and Prescribing and GP advisers
All General Practitioners for cascade to practice and treatment room nurses
Community Pharmacists
General Dental Practitioners
Director, NI Clinical and Social Care Governance Support Team
Regional Governance and Risk Management Adviser
Regulation and Quality Improvement Authority – for cascade to Independent Healthcare Establishments and nursing and residential care homes
Chief Executive, NIMDTA, NIPEC and NICPPET
Professor James McElroy, Queens University Belfast
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Your Ref:
Our Ref:
Date: 10 July 2006

Dear Colleague

**RE: ENSURING SAFER PRACTICE WITH HIGH DOSE AMPOULES OF
DIAMORPHINE AND MORPHINE**

Introduction

The purpose of this letter is to alert you to learning which has emerged from the National Patient Safety Agency (NPSA) regarding the safe prescribing, labelling, supply, storage, preparation and administration of diamorphine and morphine injections.

The NPSA has identified that the major risks are:

- Packaging of different strengths of diamorphine and morphine ampoules look the same; the outer carton and ampoule labelling is poorly differentiated, and 5mg, 10mg, 15mg, 20mg, and 30mg products have similar appearances;



- Higher strength ampoules of the diamorphine and morphine (e.g. 30mgs) being stored alongside lower strength products (e.g. 10mgs), in clinical areas in both primary and secondary care; and
- Insufficient therapeutic training and understanding on the part of healthcare staff of the risks and precautions when prescribing, dispensing, administering higher doses of diamorphine and morphine injections.

Background

In England, between 2000-2005, 7 case reports were published on deaths due to administration of high dose (30mgs or greater) diamorphine or morphine to patients who had not previously received doses of opiates. In addition, the NPSA's National Reporting and Learning System, between January and October 2005, received 16 reports of similar patient safety incidents, 2 of which resulted in deaths.

Local Adverse Incident

A recent serious adverse incident, which occurred within a local HPSS Trust, has also highlighted the need for enhanced safety systems. In this particular incident, which involved the use of a morphine-based infusion, the need for increased vigilance in the monitoring of patients receiving a controlled drug by syringe driver or parenteral infusion was highlighted.

ACTION

A full text of the NPSA Safer Practice Notice on high dose diamorphine and morphine is available on www.npsa.nhs.uk. Whilst this Notice is written for cascade to the NHS in England, nevertheless HPSS Trusts, Family Practitioner Services and Out-of-hours Services are strongly advised to discuss the contents of both this letter and the NPSA Notice at local level and to ensure that appropriate risk assessment and procedures are in place in order to enhance patient safety.

Educational establishments are asked to bring this Safer Practice Notice to the attention of healthcare staff and trainees to ensure that staff are aware of the risks and precautions that need to take place when prescribing, dispensing and administering higher doses of diamorphine and morphine injections.

Yours sincerely

			
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cc Northern Ireland Prison Service
Members of Safety in Health and Social Care Steering Group
In Service Consortia

••••• This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at <http://extranet.dhsspsni.gov.uk> or by going through the HPSS Web at <http://www.n-i.nhs.uk> and clicking on DHSSPS. •••••