

To: see attached distribution list

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Dear Colleague

Learning from Adverse Incidents: Prescribing strong opioids for use in syringe drivers

Background

Recently two adverse incidents occurred in primary care following the prescribing of oxycodone for use in a syringe driver via continuous subcutaneous infusion (CSCI). In both cases, the error involved prescribing a ten times higher dose than was intended.

Both errors were detected in secondary care when the electronic care record (ECR) was reviewed. Fortunately one patient did not receive the higher dose. Although the other patient began to show symptoms of toxicity, remedial action was taken and the patient recovered.

Subsequent review of the incidents showed that the doses prescribed for both patients were written as volume ie "mls" only.

Guidance on Prescribing Opioids:

- (i) **NICE guidance** on prescribing strong opioids for patients with cancer¹ suggests the following actions to avoid prescribing errors:
 - Always prescribe the **DOSE** for administration (e.g. 2 mg) rather than the volume of medicine (e.g. 2 mls).
- Doses prescribed in mls should be queried by healthcare practitioners involved in the prescribing, dispensing and administration of injectable medicines.

NICE Palliative Cancer Care- Pain (September 2020). <u>https://cks.nice.org.uk/topics/palliative-cancer-care-pain/prescribing-information/strong-opioids/</u>

- Doses should be prescribed in whole numbers and the use of decimal points should be avoided. Clinical implications of this are negligible and it reduces the risk of dose errors (e.g. 2mg or 3mg rather than 2.5mg).
- (ii) When prescribing opioids for administration via a syringe pump prescribers should:²
 - State the prescribed dose of medicine
 - State the dosage form, i.e. ampoule
 - Write the directions as "dose via CSCI (continuous subcutaneous infusion) in syringe pump over 24 hours"
 - State the NUMBER and STRENGTH of ampoules to be supplied (in WORDS and FIGURES)
 - Ensure that where a dose increase is intended, 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). Refer to guidance at link below:

http://www.medicinesgovernance.hscni.net/download/primary/secondary_care/medicines_safety_documents/opioids/Adult-Opioid-Equivalence-Guide-HSC-2018.pdf

Actions

- Ensure this letter is cascaded to relevant staff involved in prescribing, dispensing and administration
- Exercise additional caution when prescribing, dispensing and administering high dose opioids for syringe drivers in line with the guidance in this letter, to ensure doses are clinically appropriate. Queries should always be checked directly with the prescriber

Please contact your local Pharmacy Adviser if you have any queries about this learning letter.

Yours sincerely

Joe Brogan

Assistant Director of Integrated Care Head of Pharmacy and Medicines Management

 HSCB Prescribing Newsletter Volume 8, Issue 7, July 2017: Prescribing of CDs for administration via a Syringe Pump https://niformulary.hscni.net/download/44/volume-8-2017/1428/issue-7-jul-17

Distribution List

GP Practices, including OOH
Glynis McMurtry for Cascade to GPPs
All Community Pharmacies for cascade to staff involved in dispensing of prescriptions (including Locums)

Trust Medical Directors
Trust Heads of Pharmacy
Trust Directors of Nursing (for cascade to nursing teams including community)

Cathy Glover RQIA (for cascade to nursing homes)
Rodney Morton PHA
Gillian McCorkell PHA

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