North of England Commissioning Support Unit

Medicines Optimisation

Prescribing Memo

Safer Use of Controlled Drugs

Date: 10/4/14 **Memo Number: 08/14**

Main Points

The Care Quality Commission (CQC) have received large numbers of patient safety incident reports relating to the use of fentanyl and buprenorphine patches, and oral oxycodone medicines.

Between July 2009 and July 2012 there have been 734 incidents resulting in harm from the use of fentanyl and buprenorphine patches, including eight deaths.

Between January 2010 and December 2012 there have been 801 incidents resulting in harm from the use of oxycodone, including one death.

Harm can result from inappropriate prescribing, dispensing or administration, and all health professionals are urged to use the checklists that have been developed to improve patient care (see attachments).

The summary boxes below are written as reminders only and are not intended as a substitute for the full guidance.

Oxycodone guidance summary

1. Use only as a second line strong opioid
2. Increase doses carefully
3. Check all dose conversions with approved guidance
4. Select the correct formulation (IR or MR)
5. Be aware of polypharmacy by other routes (patches, syringe drivers)
6. Be extra cautious when using concentrate products
7. Prescribe 'as required' oxycodone clearly with specific times and frequencies

Fentanyl and Buprenorphine Patch Summary

1. Do not prescribe for acute pain
2. Do not prescribe in opioid naïve patients
3. Calculate doses using approved guidance
4. Increase doses carefully