Safer Use of Controlled Drugs - Preventing Harm From Oral Oxycodone Medicines

Patient safety incident reports with oral oxycodone medicines
Large numbers of patient safety incidents involving oral oxycodone medicines have been reported to the National Reporting and Learning System (NRLS).

There were a total of 7,433 patient safety incidents reported between 1 January 2010 and 31 December 2012.

While the majority of incident reporting were near miss or potential harm, there were 801 (10.8%) incidents reporting actual harm to the patient.

	Level of Harm				
Medication Error Category	**Death**	**Severe**	**Moderate**	**Low**	**Total**
Wrong dose, strength, quantity or frequency	**1**	4	54	180	239
Omitted or delayed dose(s)			46	179	225
Wrong drug / formulation			44	172	216
Other			27	94	121
Total	**1**	**4**	**171**	**625**	**801**

(See the supporting information (PDF) for more details of these incidents)

Clinical practitioners who prescribe, dispense and administer oxycodone medicines should check the following:

Checklist for safer use of oxycodone medicines

1. Oxycodone should **only be used as a second-line strong opioid**, if morphine is not suitable or cannot be tolerated.

   The specialist pain or palliative care team **should be consulted** for advice in cases of complex pain management.

2. Obtain details of the previous daily dose, and frequency of administration of previous analgesics used by the patient.

   i. Ensure where a dose increase is intended, that the calculated dose is safe for the patient (for oxycodone in adult patients, not normally more than 50% higher than the previous dose).

   ii. Where the patient was previously taking another opioid analgesic use a locally or nationally approved dose conversion chart to accurately determine the equivalent daily dose of oxycodone.

Dose conversion charts can be found in the' Prescribing in Palliative Care' section of the British National Formulary (BNF).

3. Confirm the appropriate medicine formulation is being used. There are fast acting short duration (e.g. Oxynorm) and slow acting, long duration (e.g., Oxycontin) oxycodone products.

   There are significant risks of overdose when a fast acting product of short duration is used in error for the slow acting, longer duration products.

   Where possible prescribe by brand name to reduce confusion.

4. Check for therapeutic duplication of strong analgesics by two different routes of administration. There may have been an error and the previous route of administration may not have been cancelled.

5. Confirm any use of oxycodone concentrate products.

   There are significant risks of overdose if a concentrate product is used in error for a normal strength product.

6. Any use of oxycodone medicines 'as required' should have clear guidance on the frequency that the doses can be administered