Supporting information

Safer use of Controlled Drugs - Preventing Harm From Oral Oxycodone Preparations

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.

Incident report examples

Wrong dose, strength, quantity or frequency

"Sudden death - died in his sleep. The conclusion of the post mortem was that it was caused by an overdose of prescription drugs. Wife says that her husband took 10 oxycodone tablets, he was prescribed 30mg four times a day for chronic back pain. At 3pm he did not wake up and could not be revived. Patient was started on Oxycontin as per clinic on (date) as a trial. Spoke to GP on (date: 3 days later) who advised that increase tablets by 10mg every 2 days up to a maximum of 10 per day. Family questioning whether he was given the wrong information on taking his tablets. They suggested that he was told to increase his oxycodone over a few weeks to a point where he could take 10 tablets of oxycodone together….." ***(Death)***

"Patient noted to have apnoeic episode following morning medications. Patient requires many regular medicines including opioid analgesia. Drug chart and Controlled drugs record cross checked, apparent that the patient had received 500mgs of oxycodone instead of 50mgs oxycodone as prescribed. (Patients own supply of medication used with a concentration of 10mgs per millilitre (10mg / ml) compared with the ward supply which has a concentration of 1mg per millilitre (5mg / 5mls)". ***(Severe harm)***

Wrong drug / formulation

"Routine review of patient during pain ward round. Found that the medical team had changed analgesia from fentanyl 150 microgram transdermal patch with Oromorph 40mg PRN for breakthrough to fentanyl 250microgram transdermal patch with oxycodone 50 – 70 mg PRN, and 30 oxycodone injection 30mg IV or sc PRN. The ward staff gave oxycontin instead of oxynorm from this prescription. Oxycontin 230mg (which is a slow release 12 hour preparation of oxycodone) with given between 2pm and 7pm on the 15th. The patient became drowsy with respiratory rate of 6bpm and Naloxone had to be administered by medical staff. ***(Severe harm)***

"Patient was referred to the palliative care team for advice re psychological distress. On review by palliative care team at 14.30hrs approx it was clear that distress was related to worsening pain. Prescribed prn analgesia (oxynorm) had not been offered, and it was noted from drug chart that usual morning dose of oxycontin 30mg due at 10.00hrs had been omitted, perhaps explaining the pain exacerbation and associated distress. Nursing staff were asked reason for omission of oxycontin and responded that it was because they were busy. Nursing staff were requested to give prn oxynorm as soon as possible but brought oxycontin - they did not seem to perceive the difference between oxynorm and oxycontin". ***(Low harm)***

Omitted or delayed dose(s)

"Patient found to be in uncontrolled, severe pain. Regular analgesia (Oxycontin 5milligrams twice a day) missed from that morning and previous evening. Medication chart stating 'drug not available'. Prescribed Oxynorm for breakthrough pain, also not given since 2:15am, the day before. Oramorph (Morphine sulfate) syrup given instead but at a dose that would likely to be ineffective. Morphine also previously converted to oxynorm due to renal impairment. Ward nurses informed to give dose of Oxynorm immediately and Oxycontin increased to 10mg twice a day as recommended by palliative care consultant in notes. Pharmacy technician informed about lack of medication on ward and asked to ensure stock made available as soon as possible". ***(Moderate harm)***

Other

"86 year old gentleman diagnosed with ….pain . Given initially MST 10mg + PRM Oromorph but later prescribed Oxycontin 5mg bd + Oxycontin 2.5 - 5mg PRN . Received in total 20mg Oxycontin in 24hrs . Had respiratory arrest at [date and time] requiring Naloxone" . ***(Moderate harm)***

"Patient with terminal Liposarcoma admitted with worsening pain. Had been on Oxycontin (Sustained release) 5mg twice a day and Oxynorm 2.5 mg for breakthrough pain. Due to worsening pain, medical staff prescribed a syringe driver containing Oxycodone 10 mg and Levomepromazine 6.25 mg. The regular Oxycodone (Sustained release) 5 mg twice a day and Oxynorm 2.5 mg for breakthrough pain were still prescribed. At [time & date] Morphine Sulphate injection 2.5 mg STAT and 4 hourly for breakthrough pain were also prescribed . Patient continued to receive his Oxycodone syringe driver and the oral Oxycodone sustained relase tablets as prescribed. Patient reviewed by the palliative care team and diagnosed as having opiate toxicity". ***(Moderate harm)***

A summary of research and NHS communications describing these risks and recommended safer practice is included below.

References

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Practice guidance from NHS organisations on the safe use of oxycodone products

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Practice guidance from international organisations

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