Medication Errors Involving Concentrated Oral Opioid Solutions in Palliative Care

In the past 2 years, there have been three patient safety incidents involving concentrated oral morphine or oxycodone solutions in our region. This is also a common source of errors throughout the United Kingdom. As a result of this, Thames Hospice and Dr Patrick Clarke have been running a quality improvement project (QIP) to highlight the potential dangers. This has included teaching sessions to the local GPs via their protected learning sessions.

The number of patients on these concentrated formulations are relatively small. The dangers often involve a lack of familiarity with high risks due to strength being ten times that of the standard formulations.

To reduce the risks, requests originating from Thames Hospice will be accompanied by specific patient information sheets and GP letters. This will aim to enhance education for patient, caregivers and prescribers. I have included these resources for your reference.

Specific points which have been highlighted for community pharmacists by the QIP team which included pharmacists are below. Apologies some of these are more obvious.

- Consider setting a Standard operating procedure (SOP) when dispensing concentrated oral opioids.
- Highlight clearly the change in strength of oral opioid solution to patient and / or caregiver (e.g. using coloured sticker to flag reminder for counselling requirement on collection)
- Ensure a process (SOP) in place for communicating to patient/carer if the medication is being delivered and no face-to-face communication with the pharmacist.
- Provide an appropriate oral syringe to help accurate dose administration.
- Consider supplying the medication in the original medication bottle with labelling and warnings present on the bottle highlighting concentration.
- Demonstrate appropriate volume of medication to be given and reinforce advice to always administer dose measured in the syringe.
- Request for the patient/carer to return the original standard-strength oral opioid solution to the pharmacy to prevent confusion between different strengths.
- Consider electronic alerts to your computer systems highlighting the concentrated formulation.
- Ensure the different oral opioid solution strengths are kept separate within pharmacies.

If yourselves, the patient or caregiver has any concerns about the effects of the prescribed dose, the local palliative care team should be contacted for advice.

If any concerns about the above information, please contact Dr Patrick Clarke: Patrick.Clarke@nhs.net.



Morphine Sulphate 20mg : mls



Oxycodone 10mg : mls PILs.docx



Letter to GP re Concentrated



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