Central Alerting System

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Originator: National Patient Safety Agency

Issue date: 04-Jul-2008 00:00:00

Action by recipients:
- Liaison Officers - Acute Trusts
- Ambulance Trusts
- Care Trusts
- Community Trusts
- Learning Disabilities Trusts
- Liaison Officers MH & Learning Disabilities
- Mental Health & Social Care Trusts
- Mental Health Trusts
- Primary Care Trusts
- Specialists Trusts

Information to recipients:
- Other contacts

Action category: Immediate Action

Title: REDUCING DOSING ERRORS WITH OPIOID MEDICINES

Summary: The NRLS received reports concerning patients receiving unsafe doses of opioid medicines, where a dose/ formulation was incorrect, based on the patient's previous opioid dose. Every team member is responsible for checking the intended dose is safe for the individual patient. Knowledge of previous opioid dose is essential for safe use of these products. There is a wide variety of opioid medicines; supply shortages may result in practitioners using unfamiliar products.

Additional information: All NHS Organisations, the Independent Sector, commissioners, regulators and relevant professional bodies.

Alert reference: NPSA/2008/RRR05

Action underway deadline: 04-Jul-2008

Action complete deadline: 30-Jan-2009

Gateway reference: 10157

Attachments:
- 080704_RRR_Opiates_Supporting_Information_Final.pdf
- 080704_RRR_Opiates_Final.pdf

Response status: Action Completed

Acknowledged on: 08/07/2008 12:06:14

Last changed on: No last updated date is available in the system for this alert. Please refer

to the SABS Report in Help section

Response Notes: Taken to Medication Management Committee for action.

Seek Clarification

Save

Contact the CAS helpdesk

Telephone: 020 7972 1500
Email: safetyalerts@dh.gsi.gov.uk

DHPUBESE712

DH Department of Health