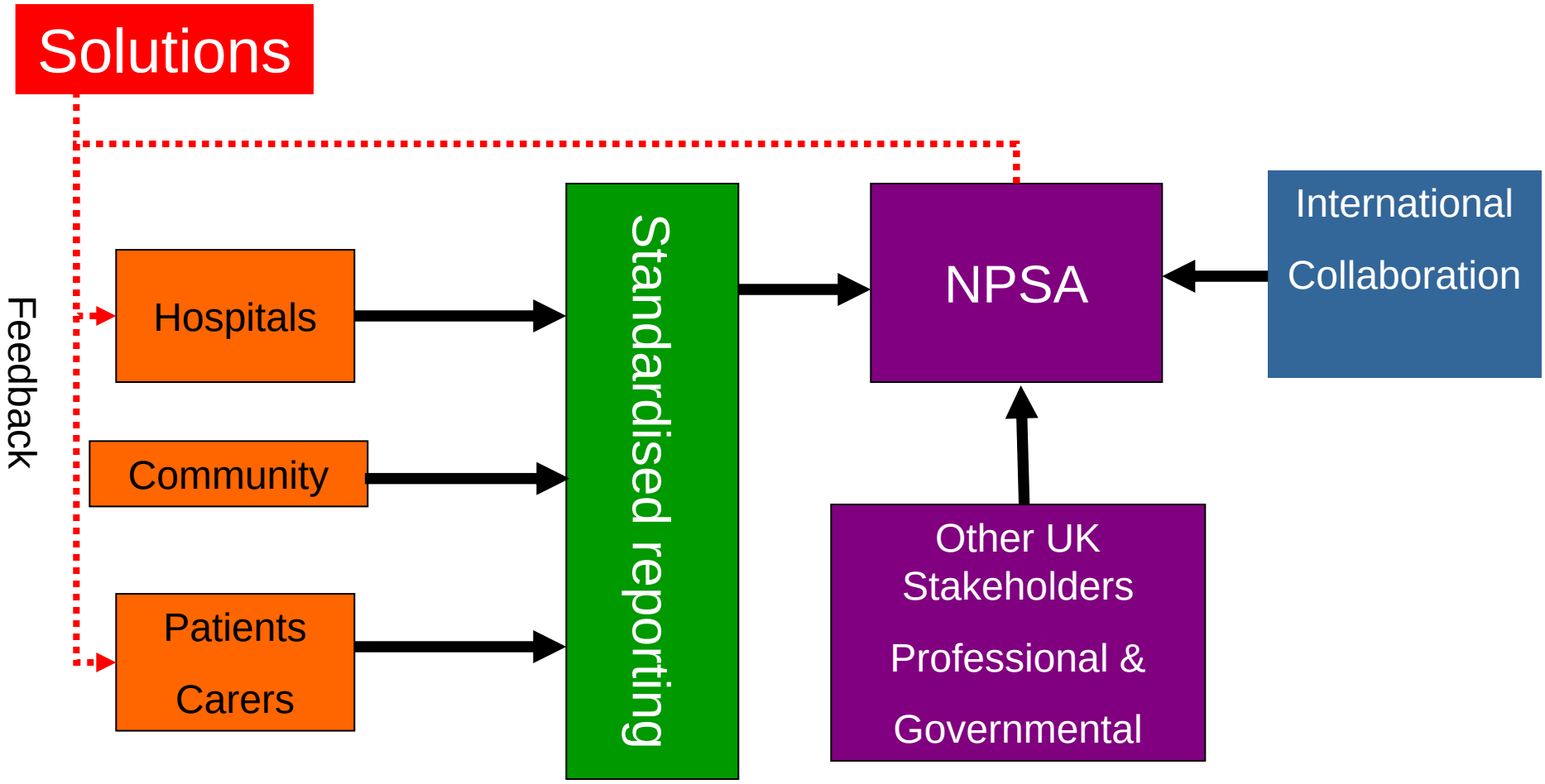

NHS
National Patient Safety Agency
Safe Medication Practice
NPSA - UK
David Cousins
Patient Safety 2006

The role of the NPSA

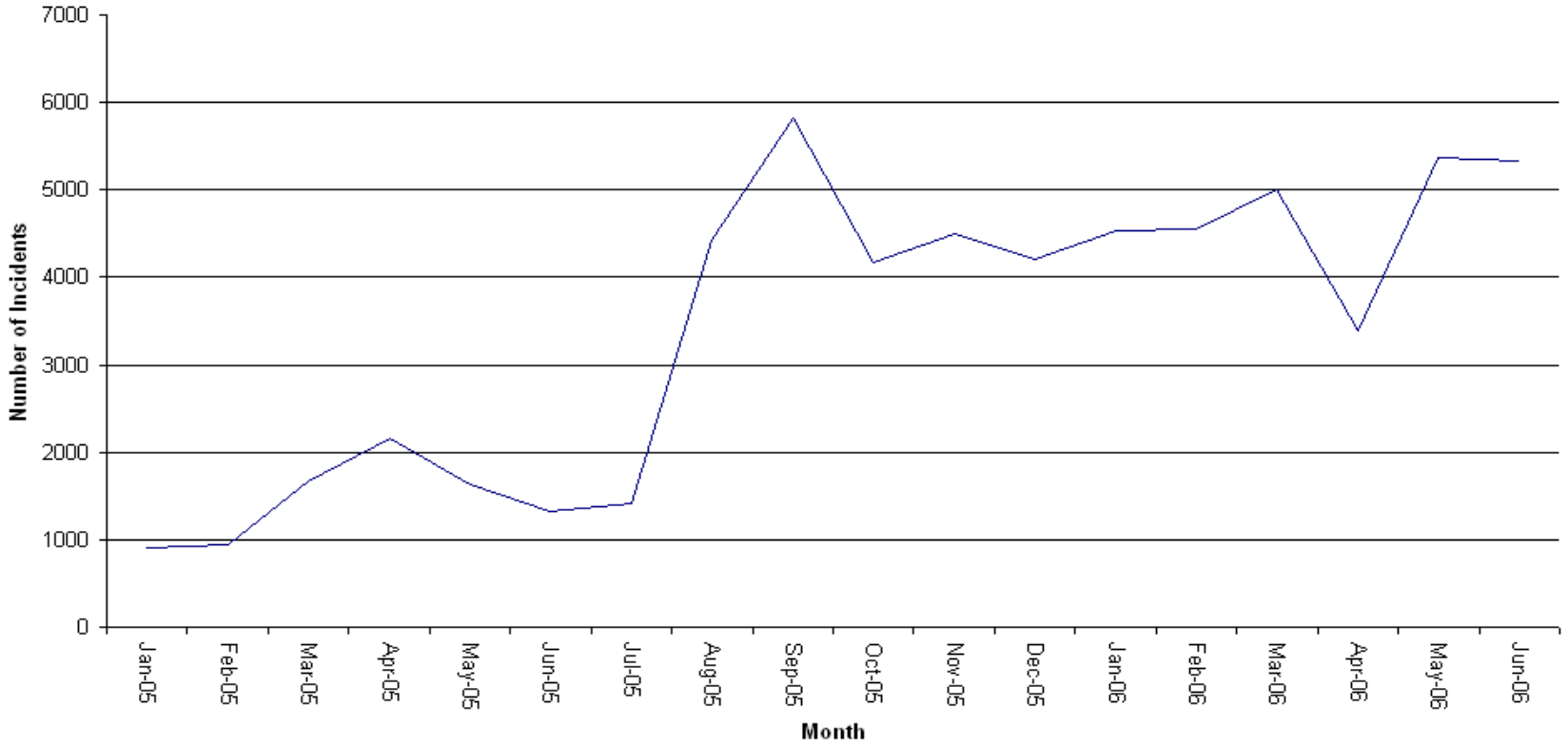
- The NPSA is a special health authority within the National Health Service in the UK with a role to:

- collect and analyse information on patient safety incidents (adverse events) in the NHS
- assimilate other safety related information from within the UK and worldwide
- learn lessons and ensure that they are fed back into practice
- where risks are identified - produce solutions to prevent harm, specify national goals, establish mechanisms to track progress

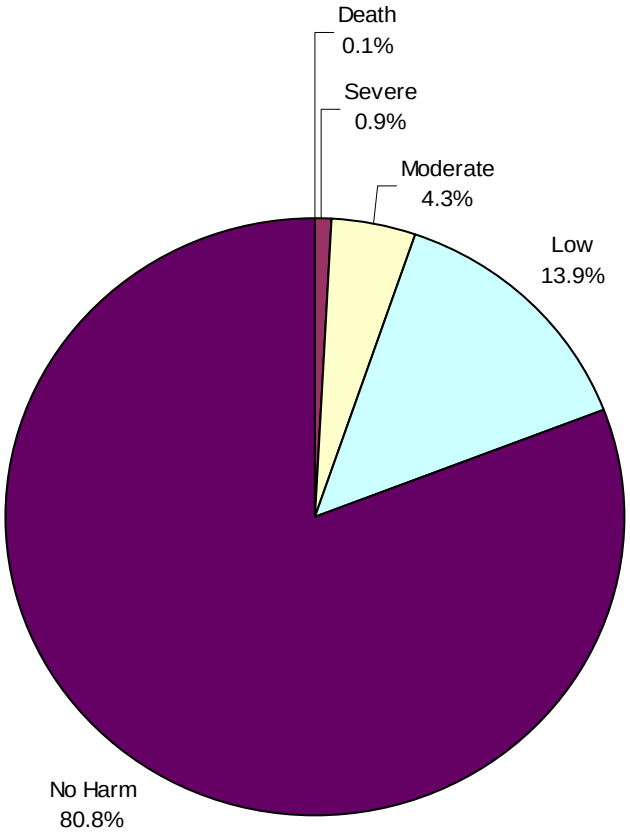
National Reporting & Learning System (NRLS)



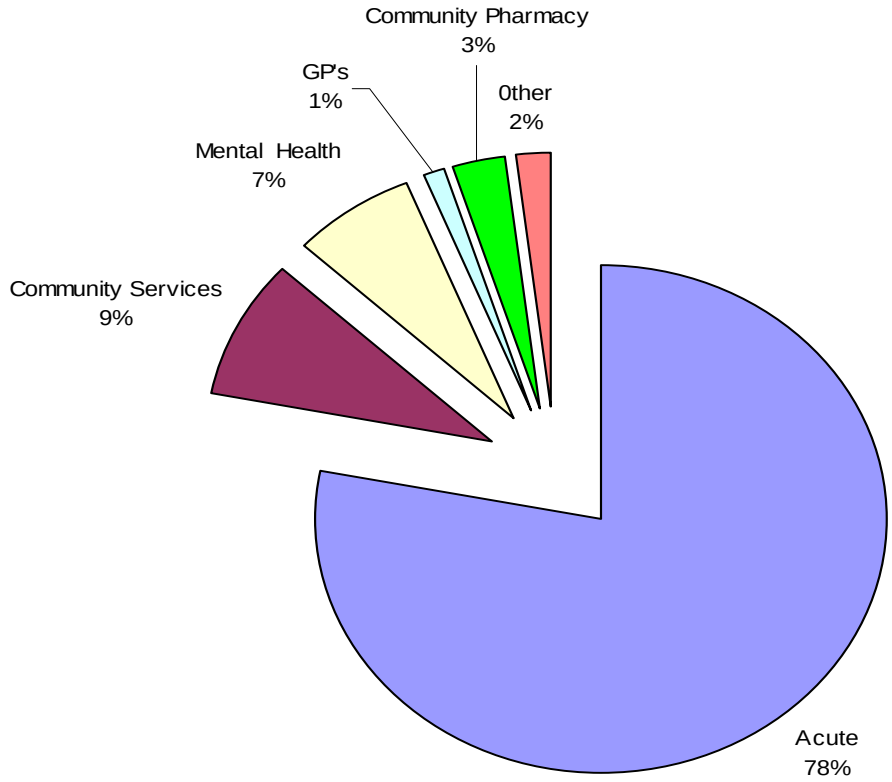
NRLS Medication Incidents
January 2005 - June 2006
n = 61348



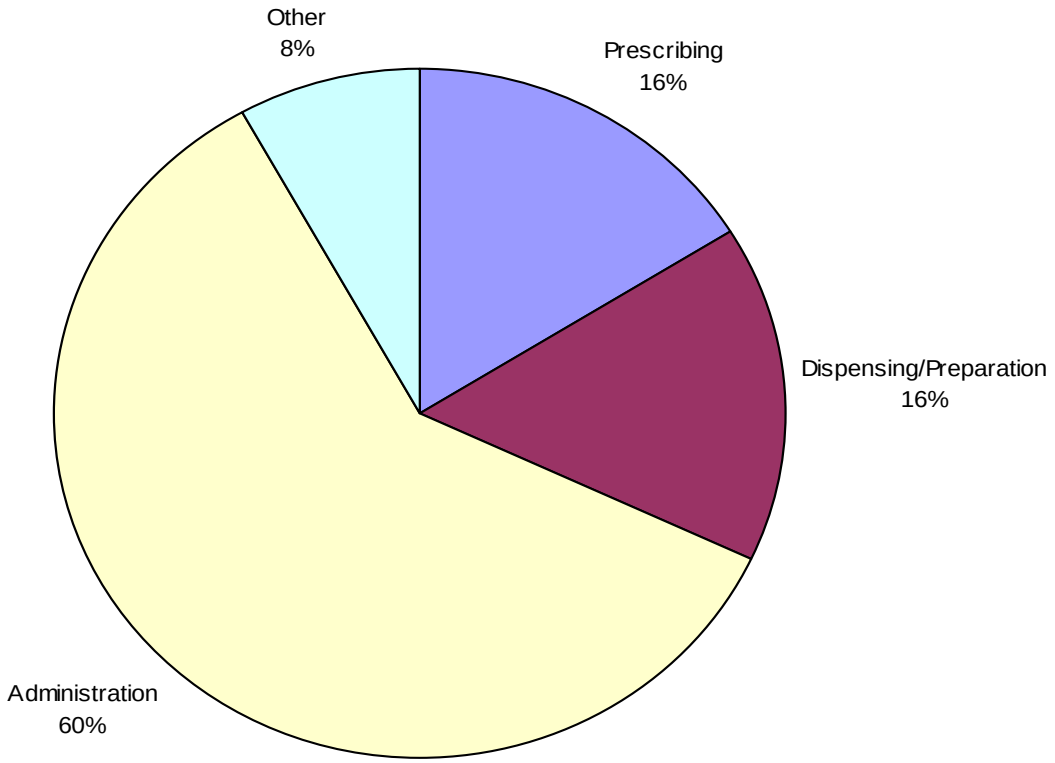
NRLS Medication Incidents – Reported Degree of Harm



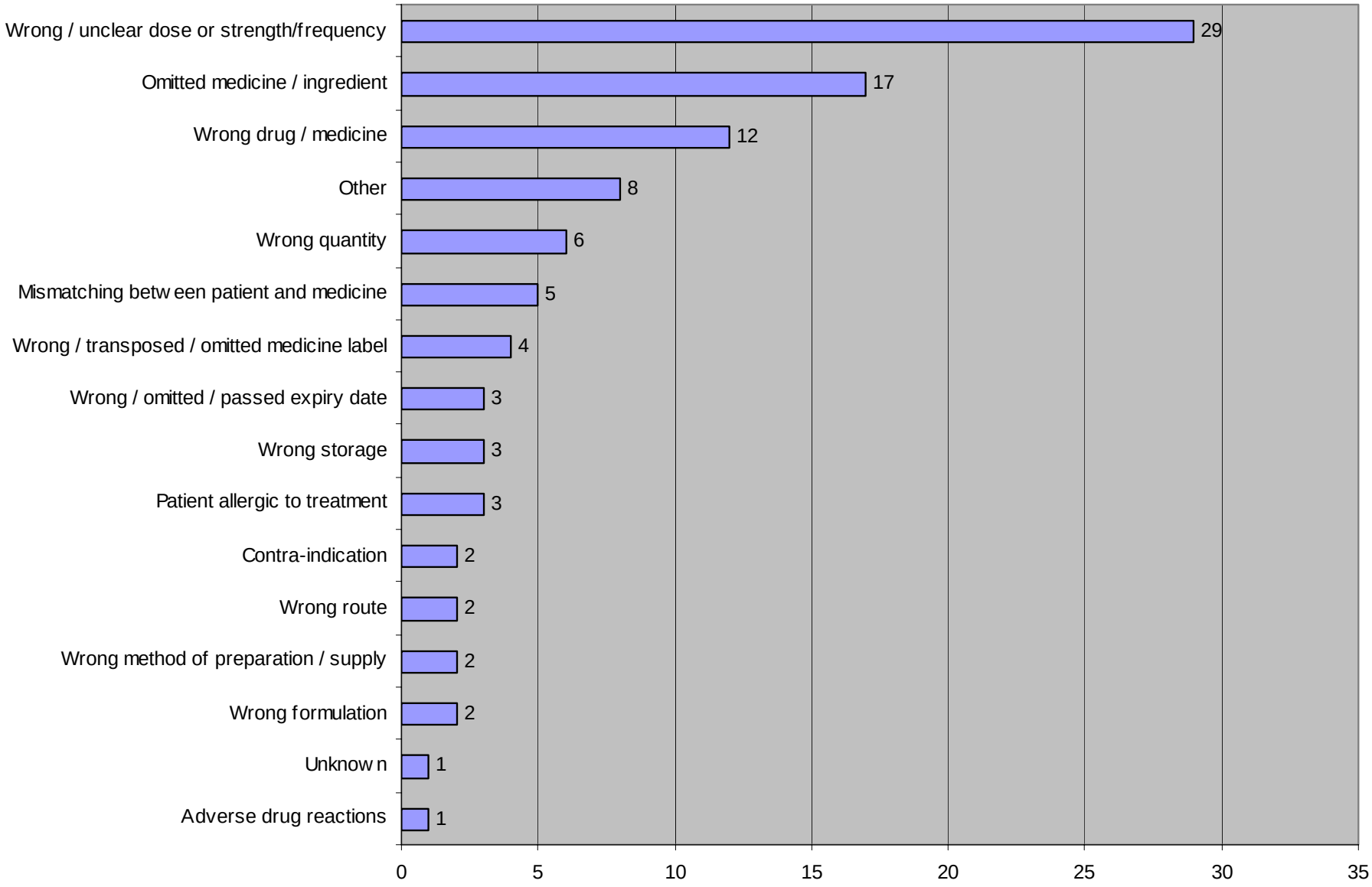
NRLS Medication Incidents – Care Setting



NRLS Medication Incidents – Stage



NRLS Medication Incidents – Type %



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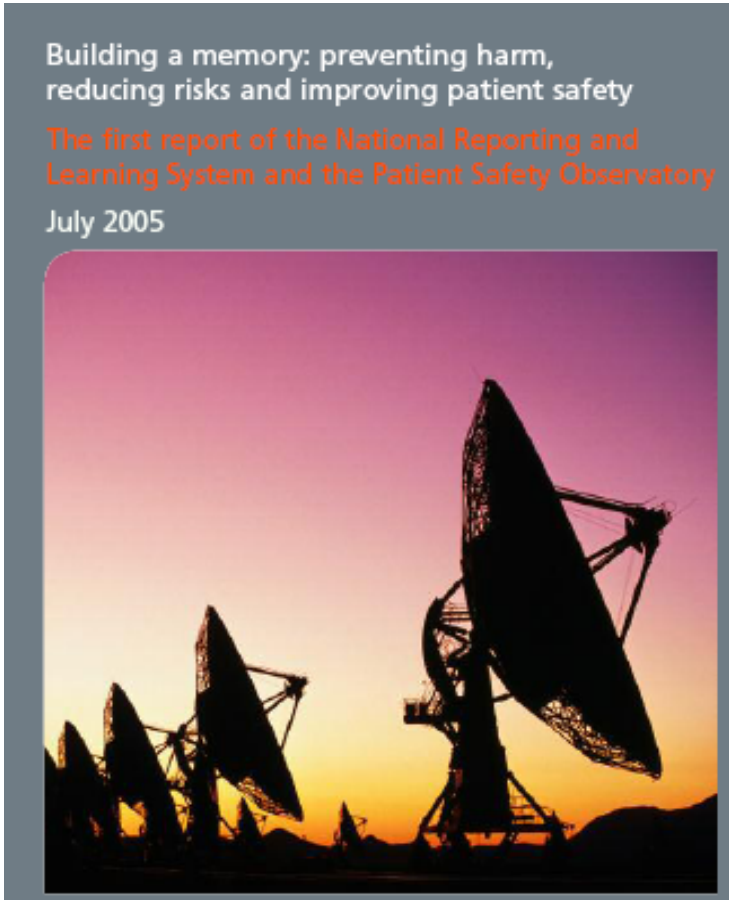
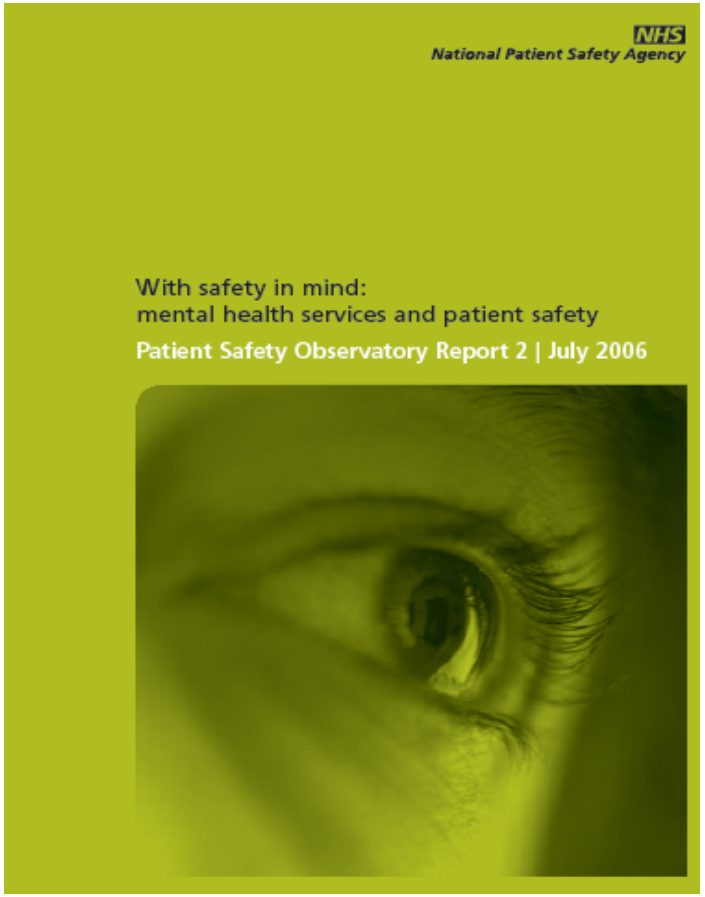
Patient Safety Feedback





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PATIENT SAFETY ALERT

PROBLEM:

Research in UK and elsewhere has identified a risk to patients from errors occurring during intravenous administration of potassium solutions.

Potassium chloride concentrate solution can be fatal if given inappropriately.

ACTION FOR NHS BY 31 OCTOBER 2002:

This alert sets out action, including initial action in the following areas:

1. Storage and handling of potassium chloride concentrate and other strong potassium solutions
2. Preparation of dilute solutions containing potassium
3. Prescription of solutions containing potassium
4. Checking use of strong potassium solutions in clinical areas

For the attention of:

Chief Executives of NHS Trusts and Primary Care Trusts

For action by:

Chief Pharmacists and pharmaceutical advisers in NHS Trusts and Primary Care Trusts

For information to:

Regional Directors of Health and Social Care
Chief Executives of Strategic Health Authorities
Directors of Public Health: Regional, StHA, PCT
Medical Directors
Directors of Nursing
Risk Managers
Lead Consultants/Clinical Directors – critical care areas
Communications Leads
Patient Advice and Liaison Service (PALS)

Date: 23 July 2002

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Safer practice notice 12

Notice

XX February 2006

Immediate action	☐
Action	☑
Update	☐
Information request	☐

Ref: NPSA/2006/12

Ensuring safer practice with 30mg doses of diamorphine and morphine

The National Patient Safety Agency (NPSA) has received reports of patient safety incidents involving the administration of 30mg doses of the opiates diamorphine and morphine in primary care locations.

Between January and October 2005, the NPSA received 16 reports that described diamorphine/morphine usage in primary care where 30mg doses were administered to 'opiate naïve' patients (patients who had not previously received lower doses of these opiates) with adverse consequences. A 30mg bolus can be excessive for opiate naïve patients and result in overdose, respiratory depression, loss of consciousness or death if support procedures are not implemented.

Some of the incidents reported to the NPSA were the result of staff mistakenly selecting and administering the wrong strength of injection due to similar product names, labelling and packaging. In recent months there have been shortages in the supply of all strengths of diamorphine injections in the NHS and this may have resulted in changes to the medicine products being supplied and used.

This safer practice notice aims to raise awareness of the risks from inadvertent use of diamorphine and morphine and makes safer practice recommendations. The risks and recommendations are applicable to all NHS care locations.

Action for the NHS

1 Undertake risk assessments and ensure safe procedures are in place for labelling, supplying, storing, preparing and administering diamorphine and morphine injections.

2 Review therapeutic guidelines for the use of diamorphine and morphine in acute care, including post-administration observation of opiate naïve patients.

3 Update induction and training for all staff involved in the use of diamorphine and morphine injections to include the risks, safe procedures and therapeutic guidelines.

4 Ensure that naloxone injection, an antidote to opioid-induced respiratory depression, is available in all clinical locations where diamorphine and morphine injections are stored or administered

Safe Medication Practice Work Streams

Completed/ongoing

- Potassium Chloride Injection
- Methotrexate tablets
- Labelling and packaging
- Diamorphine/morphine Injections

Current

- Anticoagulants
- Wrong route errors
- - oral liquid medicines
- - epidural medicines
- Injectable medicines

More information

www.npsa.nhs.uk

http://www.saferhealthcare.org.uk/hi

A new web portal, trying to provide healthcare professionals with the best available evidence and tools to improve patient safety.