Making Hospitals Safer:

ISMP Canada Priority Recommendations* for Narcotics (Opioids)

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Narcotic accidents are among the most frequent of all serious incidents reported. One reason for errors with these drugs is that parenteral narcotics are usually stored in nursing areas as floor stock. They are often identified, prepared, and administered by a single nurse.

The Project

1. Survey of Ontario hospitals to determine the extent to which system safeguards for narcotic distribution and administration are in place.

Thank you for your 75% response rate!

2. Assist hospitals to make system changes in narcotic systems.

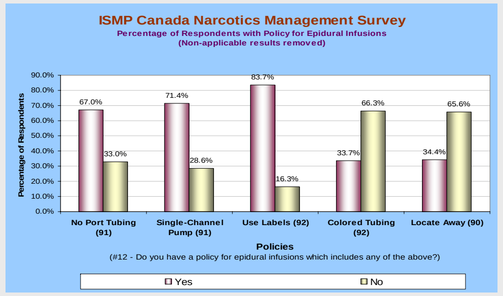
Patient Controlled Analgesia (PCA)

Data suggests that when PCA pumps are involved, the chance for patient harm increases more than 3.5 times.

Respondents with patient selection criteria for PCA:		
Yes: 38.2%	No: 31.5%	NA: 30.3%

Recommendation:
Develop and follow patient selection criteria for PCA.

Epidural



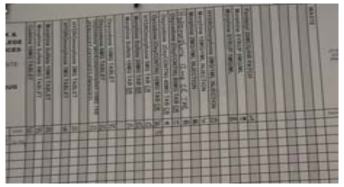
Recommendation:
Identify and implement strategies to differentiate epidural infusions from other infusions.

Storage and Standardization

A standard narcotic sheet used throughout a hospital was identified by a coroner's inquest jury as a factor that led to greater amounts of narcotics being stored: "The jury is suggesting that the possibility of error can be reduced by removing those not given on a frequent basis."

Narcotic Count Sheet

Before Revisions



After Revisions

Narcotic Drawer

Before Revisions

After Revisions

Sunnybrook and Women's Health Sciences Centre, Narcotic Safety Project, Dec. 2004

Recommendations:

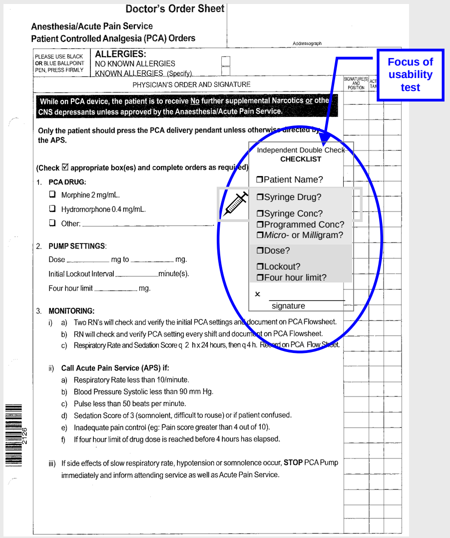
REMOVE:	• Hydromorphone ampoules or vials with a concentration greater than 2 mg/mL • Morphine ampoules or vials with a concentration greater than 15 mg/mL • Morphine ampoules or vials with a concentration greater than 2 mg/mL in paediatric patient care areas • Sufentanil
ASSESS:	• Risk assessment for each narcotic storage area with follow-up being part of pharmacists' on-going responsibilities
STANDARDIZE:	• Opioid infusion solutions • Products approved for pain management
RESTRICT:	• Mixing narcotic solutions outside of pharmacy as much as possible

Independent Double Checks

Working Definition: An independent double check is a process in which a second practitioner conducts an individual verification.

Why perform an independent double check?

- The expectation of 100% accuracy is unreasonable
- Reduces the probability of errors
- Acknowledges that errors happen
- Acknowledges human factors issues with equipment
- Acknowledges complex and high risk systems



Recommendations:

1. Implement a policy of Independent Double Checks for PCA infusions
2. **Consider a policy** of Independent Double Checks for all **opioid and epidural infusions**
3. **The policy should include a clear process** for an independent double check and documentation.

Tips for an Independent Double Check Process
• **Don't communicate what the information should be** (until after the check is completed). This could bias the second person and make the double check less effective.
• **Start from a different perspective.** Instead of looking at the order sheet first, the second person conducting the check can look at the pump or solution bag first.

** This poster is a snapshot of the comprehensive work from the Narcotic (Opioid) Safety Project. For detailed recommendations, strategies and supporting material refer to the Narcotic Project binder. To inquire or obtain a copy of the binder contact ISMP Canada at info@ismp-canada.org.*