Category: Medication

Preventing: Incorrect fentanyl dose conversion

Key words: Fentanyl Patch, Dose Conversion, Subcutaneous Infusion, Wrong Dose

Shared by: Alison Thomson, Team Leader, Garioch District Nursing Team

Sharing Learning Points

LOCALLY

January 2023

What happened?

Patient on long-term Fentanyl Patch 12 micrograms/hr and progressing towards end of life care in a care home. Subcutaneous (SC) Just in Case medications prescribed including Morphine 5mg, which was an appropriate dose for this patients individual circumstances.

In the following days the patient required & received just in case medication; 5 x doses of 5mg SC Morphine in 24hrs.

Following review a continuous subcutaneous infusion (CSCI) was prescribed of Morphine 50mg/24hrs calculated on the basis of:

- 5 x 5mg SC breakthrough doses of Morphine in 24hrs = 25mg
- Fentanyl Patch conversion: 12 micrograms/hr equivalent to oral Morphine 30mg/24hrs, equivalent to 15mg/24hrs SC.
- Assessment of the patient's pain, opioid tolerance and symptomatic response to previous doses administered.

Fentanyl Patch 12 micrograms/hr remained prescribed and insitu, although it had been the intention of the prescriber to discontinue.

Care home nurse queried when/if Fentanyl Patch to be removed. On further investigation using Scottish Palliative Care Guidelines (SPCG) noted best practice to be:

- Fentanyl patch remains prescribed at current dose
- Morphine CSCI dose to be calculated on the breakthrough doses required over the previous 24hr period (SPCG Fentanyl patches).

Best practice for this patient would have been: Fentanyl Patch 12 micrograms/hr & CSCI Morphine 25mg/24hrs.

What went well?

Patient remained comfortable.

Discrepancy noted quickly & rectified.

Care home staff queried what to do with patch.

SPCG utilised for clarity/best practice.

If you have any comments about this or any similar adverse event please send them to Lindsay Cameron, Medication Safety Advisor, lindsay.cameron2@nhs.scot

NHS Grampian

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What, if anything, could we improve?

Awareness of best practice for these circumstances.

Knowledge of & access to available resources to help aid decision making.

Seek advice from Roxburghe House Specialist Palliative Care 24hr Helpline – 01224 557057

What have we learnt?

Limited knowledge amongst primary care staff & prescribers of the process for calculating/converting breakthrough/just in case medication & what to do with the Fentanyl patch.

Potential for patient to be over medicated if calculated incorrectly & no instruction given regarding the Fentanyl patch. Risk to patient relatively high.

Use available resources to aid prescribing decisions in palliative care:

Scottish Palliative Care Guidelines Home

Scottish Palliative Care Guidelines - Choosing and Changing Opioids

Roxburghe House Specialist Palliative Care Advice Line – 01224 557057

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