



Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Fentanyl overdose

Summary:

A patient was discharged home after an eight-day hospitalization for an exacerbation of diverticulitis from an acute care unit with two sets of transdermal opioids (Fentanyl) patches on. The following day the patient was found by a family member with decreased level of consciousness, unable to be woken up, slumped over in a chair. The Emergency Response Services (ERS) was called, and the patient was treated for an opioid overdose and transferred to the Emergency Department (E.D.). The patient recovered and was discharged home.

Keywords: fentanyl, overdose

This review is based on a single event.

Findings of the Review:

Due to side-effects of narcotics being administered in hospital for abdominal pain in conjunction with the patient's home medication regime which included Fentanyl patches increased the likelihood that the patient may have been unaware that the old patches were not removed prior to new ones being applied at time of discharge home.

At the time of hospital discharge, Fentanyl patches were applied without removal of the existing Fentanyl patches contributing to the narcotic overdose.

Transdermal (Fentanyl) patches do not require a nurse double check-signature for application or removal.

System Learning:

Revise Narcotics and Controlled Drugs policy (CLI.6010.PL.015) to indicate that a double-signature is required for application and disposal/removal/waste of transdermal opioid patch(s).

Revise the High Alert Medication List (CLI.6010.PL.001.SD.01) and accompanying High Alert Medication Management policy (CLI.6010.PL.001) to include transdermal opioid patches.

Educate 80% of nursing staff on how to document on the Medication Administration Record (MAR) (CLI.4510.PR. 002.FORM.09) to include double signature on application and removal of transdermal opioid patches, and document site of placement.

Annual High Alert medication audit performed to ensure compliance with High Alert Policy (CLI.6010.PL.001).