Strengthening Med Safety in Long-Term Care

ISMP CANADA

Med Safety Signal

Risks in medication safety reported by LTC Homes in Ontario

A Patchy Approach to Transdermal Fentanyl Safety

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Reported Incident (details are modified to ensure confidentiality of the home and reporter)

A resident had a prescription for a fentanyl 12 mcg/h transdermal patch, to be changed every 72 hours, to treat chronic pain. Because of specified provincial drug benefit coverage, fentanyl 25 mcg/h patches are typically dispensed by the pharmacy with instructions to place half of the patch over an occlusive dressing placed on the resident's skin. This practice allows only half of the patch to contact the skin, thus delivering an approximation of the prescribed dose. On 2 separate occasions within a month, nurses noted that upon removal of the previous patch, no occlusive dressing was present. Although no harm was reported, this resulted in the resident receiving a 2-fold overdose of this high-alert opioid. Given the occurrence of similar incidents over the past few years, the long-term care home has decided to pay for the 12 mcg/h patch when that dose is prescribed to reduce the risk of harm to residents.

ISMP Canada staff identified the following key contributing factors and considerations for improvement. It is the responsibility of medication safety leaders in long-term care to determine what, if any, actions for improvement are needed in their particular medication management processes.

Key Contributing Factors:

- Constraint of the provincial drug benefit program, which reimburses the 25 mcg/h fentanyl patch but not the 12 mcg/h patch, often leads pharmacies to dispense the 25 mcg/h patch.
  - The 12 mcg/h patch is available outside the provincial drug benefit program if the resident, family, or a third party agrees to pay out of pocket.
- Preparation and administration of the medication, when provided as a 25 mcg/h patch, required the atypical extra preparation step of occluding half the patch on the skin.
  - The patch cannot be cut or folded to adjust the dose.
- Lack of a systematic process to check for proper occlusion of the patch decreased the chance of detecting the error in the 3 days between patch changes.

Considerations for Improvement:

- Eliminate the need to occlude half of the patch by dispensing the 12 mcg/h fentanyl patch for applicable prescriptions.
  - Consider other payment options for the 12 mcg/h fentanyl patch (e.g., third party, out of pocket).
  - Ask the provincial drug benefit program to provide coverage.*
- If using a 25 mcg/h fentanyl patch for a 12 mcg/h dose:
  - Place a reminder on the package/medication administration record to occlude half the patch.
  - Ensure a systematic, independent double-check process for assessment of occlusion at the time of application and daily checks of patch and occlusion thereafter.
  - Dispense the patch in combination with an appropriate occlusive dressing.
- Always indicate the date and time of application on the patch.

Ontario Drug Benefit fentanyl decision: https://www.health.gov.on.ca/en/pro/programs/drugs/ced/pdf/fentanyl.pdf
ISMP Canada Safety Bulletin: https://ismpcanada.ca/wp-content/uploads/ISMPCSB2006-05Fentanyl.pdf
*ISMP Canada has provided a copy of this Med Safety Signal to the Ministry of Long-Term Care

Report an incident to ISMP Canada https://ismpcanada.ca/report/