



# Priority Recommendations\*

## For Ontario Hospital Narcotics (Opioid) Project

### CULTURE AND COMMUNICATION

1. Educate staff regarding the system-based causes of medication error.
2. Educate staff about the hierarchy of effectiveness of error reduction strategies.
3. Include the patient/family in the narcotic medication-use process.

### STORAGE AND STANDARDIZATION



Immediate

1. Remove the following stock items from patient care areas:
  - Hydromorphone ampoules or vials with concentration greater than 2 mg/mL (exceptions may include palliative care).
  - Morphine ampoules or vials with concentration greater than 15 mg/mL.
  - Morphine ampoules or vials greater than 2 mg/mL in paediatric patient care areas.
  - Sufentanil (exceptions may include Operating Room and Labour and Delivery).
2. Assess risk associated with narcotic stock in patient care areas.
3. Restrict as much as possible the admixing of narcotic solutions outside of pharmacy.
4. Standardize infusion concentrations of parenteral narcotic medications and selection of medications for pain management.

### INDEPENDENT DOUBLE CHECK



Immediate

1. Implement a policy of Independent Double Checks for PCA infusions.

The policy should include a clear process for an independent double check and documentation when the following occur:

  - Initial pump programming
  - Changes in pump programming
  - Solution changes
  - Patient transfers
2. Consider a policy of Independent Double Checks for:
  - a. All opioid infusions (continuous or intermittent)
  - b. Epidural infusions

### PCA AND EPIDURAL

1. For PCA, develop and follow patient selection criteria (inclusion and exclusion).
2. For epidural, identify and implement multiple error prevention strategies to enhance differentiation of epidural infusions from other infusions.

\* For detailed recommendations, strategies and supporting material refer to the Narcotic Project binder.