NSW GOVERNMENT Health

Safety Alert 004/17

HYDROmorphone (high-risk medicine): Changes to Dilaudid® injectable preparations

28 July 2017

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Director Regulations and Compliance Unit

Action required by:

- Directors of Clinical Governance
- Drug and Therapeutics Committees
- Directors of Pharmacy

We recommend you also inform:

- Directors of Anaesthetics
- Directors of Surgery
- Directors of Intensive/Critical Care
- Directors of Oncology / Cancer Care
- Directors of Palliative Care
- Directors of Medical/Clinical Services
- Emergency Departments
- Medical Staff
- LHD/SHN Directors of Nursing and Midwifery
- Nursing Unit Managers
- Oncology / Cancer Care Nurses
- Palliative Care Nurses
- Intensive Care Nurses

Deadline for completion of actions

11 August 2017

Expert Reference Group

Content reviewed by:

- **Medication Safety Expert Advisory Committee**

Clinical Excellence Commission

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Fax. 02 9269 5599
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Internet Website: http://www.health.nsw.gov.au/sabs/Pages/default.aspx
Intranet Website http://internal.health.nsw.gov.au/quality/sabs/

Review date

August 2019

Background

HYDROmorphone is a potent opioid analgesic frequently used to treat moderate to severe, acute or chronic pain. HYDROmorphone is **5 to 7 times more potent** than morphine. Because of its high potency, errors with this medicine may result in serious adverse patient outcomes, including deaths.

This Safety Alert highlights significant changes to HYDROmorphone injectable preparations (Dilaudid® and Dilaudid® HP injections) and advises actions in addition to Safety Alert 001/17 HYDROmorphone: High-risk medicine.

NEW Dilaudid® HP 50 mg in 1mL injection

The **NEW** presentation **Dilaudid® HP 50 mg in 1 mL** ampoule injection is highly potent. It is five times the concentration of the discontinued 50 mg in 5 mL ampoule. The inadvertent injectable bolus administration of 1 mL containing 50 mg of HYDROmorphone (equivalent to 250 to 350 mg of injectable morphine) is likely to result in a fatal outcome.

Hospitals must **NOT** include Dilaudid® HP 50 mg in 1 mL injection on their hospital formulary or hold inventory stock of this product.

Similar appearances of Dilaudid® injections

The similar look-alike clear glass ampoules of all new presentations of HYDROmorphone ampoules increase the risk of product selection errors.

Hospitals should consider stocking only one strength (either the 2 mg in 1 mL or the 10 mg in 1 mL Dilaudid) of HYDROmorphone injection in ward areas where HYDROmorphone is stored. If both strengths are stocked (e.g. in pharmacy), risk mitigation strategies must be put in place to minimise incidents associated with incorrect product selection.

Examples of risk mitigation strategies include storing the products in separate locations; affixing warning labels on the products and storage bins; and where high doses are required, hospitals should consider sourcing manufactured pre-filled products.

Obsolete

Immediate Actions required by Local Health Districts/Networks

In addition to the actions set out in Safety Alert 001/17:

1. Distribute this Safety Alert to all relevant clinical staff.
2. Confirm that Dilaudid® HP 50 mg in 1 mL injection will **NOT** be included on the hospital formulary and inventory stock of this product will **NOT** be held.
3. Consider keeping only one strength of HYDROmorphone injection, in ward areas where HYDROmorphone injections are routinely stored (e.g. palliative care).
4. Implement strategies to minimise product selection errors when more than one strength is stocked (e.g. in pharmacy).
5. Restrict availability of HYDROmorphone 10 mg in 1 mL injection within the hospital.
6. Consider sourcing manufactured pre-filled products for clinical areas where high doses may be required.
7. Provide LHD/SHN responses to the actions in this Safety Alert to: cec-medicationsafety@health.nsw.gov.au by **COB Friday 11 August 2017**.
8. Acknowledge the receipt of the Safety Alert within 48 hours.