



Safety Notice

SN: 005/06

23 October 2006

Safe Use of Fentanyl Skin Patches

Fentanyl skin patches are very strong narcotic (opioid) painkillers.

Distributed to:

- Chief Executives
- Directors of Clinical Governance
- Directors of Clinical Operations

Action required by:

- Directors of Clinical Operations

We recommend you also inform:

- Drug and Therapeutic Committees
- Directors of Nursing
- Directors of Pharmacy
- Directors of Cancer Services
- Directors of Geriatric Services

For further information:

NSW Therapeutic Advisory Group
Safer Medicines Group

<http://www.clininfo.health.nsw.gov.au/nswtag/publications/otherdocs/Fentanylalert0706.pdf>

Quality and Safety Branch

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Background

In July 2006 a NSW Therapeutic Advisory Group (TAG), Safer Medicines Group publication alerted health services to a number of safety warnings issued overseas following reports of deaths and serious side effects in patients using fentanyl skin patches. Reports include:

- Death of an elderly patient following application of a heat pack over the patch to relieve pain at the site causing increased fentanyl absorption and the suspected application of a second patch without removing the first.
- Death of a child who applied one of his mother's patches to his body.
- Children escaping near misses following self-application of a patch.

Issue

Since the NSW (TAG) Safer Medicines Group publication was issued an incident involving a **heat pack being placed over a fentanyl patch was reported in a NSW hospital. This matter was picked up by a pharmacist who counselled the patient on the use of fentanyl skin patches and prevented an adverse event. However, the potential outcome could have resulted in a significant opioid overdose.**

Health care professionals, who prescribe, dispense and administer fentanyl skin patches, are to ensure that patients and caregivers are aware of the safe and effective use of these medicines.

Although the published alerts specifically refer to fentanyl patches, safety concerns and principles for use also apply to buprenorphine patches.

What can health services do to prevent incidents?

1. **Health care professionals who prescribe, dispense and administer fentanyl skin patches should do so in accordance with the Product Information.**
2. **Health care professionals should provide patients and their caregivers with a Consumer Medicine Information leaflet for fentanyl patches and counsel them on the potential for an increased effect from fentanyl patches if they take certain other medicines or drink alcohol; or have an increase in body temperature or are exposed to heat.**
3. **Health care professionals should inform patients and their caregivers of the signs of fentanyl overdose and that immediate medical attention must be sought.**
Signs of fentanyl overdose include trouble breathing or shallow breathing, tiredness, extreme sleepiness or sedation, inability to think, talk or walk normally, and feeling faint, dizzy or confused.
4. **Health care professionals should inform patients and their caregivers of safe storage practices for fentanyl skin patches.**
The Consumer Medicine Information leaflet recommends storage in a locked cupboard at least one-and-a half metres above the ground and a method of safe disposal.
5. **Health care professionals should inform patient of the appropriate disposal methods of unneeded or defective fentanyl skin patches as indicated in the Consumer Medicine Information leaflet.**

For further information see the NSW Therapeutic Advisory Group Safer Medicines Group publication *Analgesic Skin Patches* dated July 2006 at

<http://www.ciap.health.nsw.gov.au/nswtag/publications/otherdocs/Fentanylalert0706.pdf>

Suggested actions by Area Health Services

- Ensure staff do not put heat packs on fentanyl skin patches.
- Provide all patients and/or their caregivers who are prescribed fentanyl patches with a copy of the Consumer Medicine Information leaflet and provide counselling on their safe use.