Manitoba
Health, Seniors and Active Living

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

Methadone Dosing Error

Summary:

An inpatient received their morning medications including Methadone and was then provided a pass to go outside the facility. The patient was found outside the facility with altered level of consciousness, no verbal response, floppy uncoordinated movements, pinpoint pupils, and slow shallow breathing. The bystander notified the emergency department staff and the patient was brought in to the emergency department at which time it was learned the patient received 10 times the prescribed dose of methadone.

Naloxone was administered and the patient was kept in the emergency department for monitoring. Once the patient's condition stabilized they were returned to the inpatient unit.

Patient recovered and was discharged home.

Keywords:

Medication, Methadone

This review is based on a single event

Findings of the Review:

The ward narcotic & controlled inventory sheet that was used was an old form. This form has no blank spaces for nursing staff to write down non-formulary medications.

The Methadone was not poured into a graduated container, making it difficult to do a proper narcotic count.

The Narcotic and Controlled Drugs Policy was not followed correctly.

Provider/ Patient rounds are being completed at the same time the majority of patient medication needs to be given, causing delays in treatment or a work alone setting for one nurse.

There was no label on the bottle of methadone to state who was to receive this medication or dosage information.

System Learning:

Discard all old Ward Narcotic & Controlled Inventory Sheets, and implement new Ward Narcotic & Controlled Inventory Sheets on the unit.

Ensure liquid narcotic medication not in a graduated container is placed into a graduated container before being distributed to the units.

Implement a pharmacy safety huddle to review pharmacy team roles in the existing Narcotic Controlled Drugs Policy to ensure a clear transition from the pharmacy to the units.

Explore opportunities to distribute staff workload to meet patient care needs; including review of provider/ patient round times or medication times to accommodate medication schedules to enable two nurse checks.

Ensure patient labels with patient name, dose, time, strength, duration and route; are brought by a pharmacy team member for all nonstock medications

Date of Posting: February 2019