Patient Safety Agency (NPSA) collects data pertaining to this and has made relevant recommendations.

Aims To identify and systematically review errors in high risk opiate prescribing and/or administration in Northumbria Healthcare Trust, 2012, in order to inform patient safety recommendations locally.

Methods The audit identified all errors reported via the trust's electronic incident management system, the associated case notes were reviewed and data analysed using descriptive statistics/thematic analysis.

Results 34 (of 45) sets of notes were available for review (75%). 5 drugs were involved, of these 3 accounted for 91% of all errors (Morphine, 50%; Oxycodone 23%; Fentanyl, 18%).

Administration errors accounted for 56% (n=19) of errors identified, prescribing 23% (n=8) and the remainder (21%; n=7) demonstrated errors in both domains.

Themes associated with administration errors were variable but included:

- 6 incidents related to Fentanyl (failure to remove patch, patch re-applied at inappropriate interval, incorrect patch applied).
- 6 incidents of an incorrect drug being given;4 of which involved Oxycodone liquid and Oxycontin M/R.

Other errors included administration without a signed prescription, incorrect doses, delays/omissions and inadvertent repetitions of doses.

Themes associated with prescribing errors included incomplete or illegible prescriptions, incorrect drug/dosing and failure to prescribe regular medications.

Conclusions The audit is limited by sample size, reporting practice and an incomplete data set. However, the data obtained demonstrated similar themes to data collected by the NPSA. A proportionally high degree of errors occurred within the context of Fentanyl and Oxycodone prescribing/administration.

Specific interventions include:

- A trans-dermal patch administration and removal chart.
- An educational opiate 'wall chart' for healthcare staff.
- An alert sticker for high concentration opiate solutions.
- Recommendations may be applicable in other settings given the correlation the findings have with national data.

P 249 ABSTRACT WITHDRAWN.

P 250 AN AUDIT OF REPORTED OPIATE ERRORS IN NORTHUMBRIA HEALTHCARE TRUST, 2012

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Background Opiates are frequently identified in medication incidents resulting in severe harm or death. The National