Royal United Hospitals Bath NHS Foundation Trust

Reduce harm! 9th October 2020

Opioid Conversion Chart

Situation: Wessex Palliative Care Handbook was found to contain a mistake in one square of the Opioid Conversion Chart
Background: Error in table was identified by a member of staff and corrected in one department; later the same error was identified by a member of staff in a different department and escalated to Pharmacy
Assessment: Version on intranet has been updated, palliative care team have looked for laminated copies on the wards

Opioid Conversion Chart — Wessex Palliative Physicians Handbook of Palliative Care 9th Edition 2019

'Strong' opioids													Patches		'Weak opioids'	
Morphine					Oxycodone					Diamorphine		Alfentanil	Fentanyl	Buprenorphine	Tramadol	Codeine Phosphate
Oral (mg)			Subcutaneous (mg)		Oral (mg)			Subcutaneous[1] (mg)		Subcutaneous (mg)		Subcutaneous[2] (mg)	Transdermal Patch (mcg/hr) *Stable pain only*	Transdermal patch (mcg/hr) *Stable pain only*	Oral (mg)	Oral (mg)
4 hr dose (IR)	12 hr dose (MR)	24 hr total dose	4 hr dose	24 hr total dose	4 hr Dose (IR)	12 hr Dose (MR)	24 hr total dose	4 hr dose	24 hr total dose	4 hr dose	24 hr total dose	4 hr dose	24 hr total dose	Change every 72 hours	Change at intervals indicated	24 hr total dose	24 hr total dose
1.25		10													5 *7 days*	100	120
2.5	10	20	1.25	10	1.25	5	10	1.25	5	1.25	5	0.125	0.5		10 *7 days*	200	240
5	15	30	2.5	15	2.5	10	20	1.25	10	1.25	10	0.125	1	6-12	15 *7 days*	300	
7.5	20	40	5	20	5	10	20	2.5	10	2.5	15	0.25	1.5	12	20 *7 days*	400	
10	30	60	5	30	5	15	30	2.5	15	2.5	20	0.25	2	12-25	35 *72 hrs*		
15	45	90	7.5	45	7.5	25	45	3.75	25	5	30	0.5	3	25-37	52.5 *72 hrs*		
20	60	120	10	60	10	30	60	5	30	7.5	40	0.75	4	37-50	52.5 *72 hrs*		
30	90	180	15	90	15	45	90	7.5	45	10	60	1	6	50-75			

[1]Some units recommend a 1:1 conversion from CSCI morphine to CSCI oxycodone* rather than the 2:1 conversion in the table above.
[2]Some units recommend an 18:1 conversion from PO morphine to CSCI alfentanil* rather than the 30:1 conversion in the table above.
*Seek specialist advice when doses are greater than the equivalent of 180mg PO morphine in 24 hours
Consider reducing the equianalgesic dose by 25-33% if converting from a less sedating opioid, e.g. fentanyl to morphine, oxycodone or diamorphine, as sedative actions may be greater for an equianalgesic dose.

This is the correct conversion

Key actions required:

- **Please check your departments and remove any old printed copies of the opioid conversion chart**
- **Check any versions saved on desktops, smartphones etc**
- ***Learning point* – if you identify an error in a clinical document please make sure it is escalated to the author or an appropriate senior colleague so it can be corrected promptly**

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