CONTROLLED DRUGS NEWSLETTER

SHARING GOOD PRACTICE IN THE SOUTH WEST

NHS
South Region
South West

August 2016

SPECIAL EDITION – PATIENT SAFETY INCIDENTS (MORPHINE SULFATE SOLUTION 10mg/5ml)

We have had a lot of incidents reported across the South West involving morphine sulfate 10 mg/5 mL oral solution, which includes brands such as Oramorph®. I would like to draw your attention to the risks and learning that we have identified from these incidents.

Where patients are not at risk of opioid overdose (intentional or unintentional), and especially where end of life patients have swallowing difficulties, morphine sulfate 10 mg/5 mL oral solution can be a useful medicine to manage breakthrough pain. However, when used long term for patients with chronic pain, this can cause problems. A prescription for morphine sulfate 10 mg/5 mL oral solution 5-10ml qds could add up to 80mg morphine daily, compared with tramadol 50mg 2 qds being equivalent to 60mg morphine daily, and co-codamol 30/500 2 qds equivalent to 24mg morphine daily.

Despite a 300ml bottle of morphine sulfate 10 mg/5 mL oral solution containing the same amount of morphine as 60 Zomorph 10mg capsules, it is legally classed as a Schedule 5 rather than as a Schedule 2 CD and so is effectively treated as a POM. This may give prescribers the impression that it is a less dangerous medicine than the morphine solid dose forms, in terms of patient safety and risks of misuse and diversion. However, the following incidents show how much of a risk morphine sulfate oral solution presents.

Inquest for man who died after taking an overdose of prescription drugs

A man with a history of depression, anxiety and medication overdoses was prescribed Oramorph® and amitriptyline to treat a head pain, which was possibly caused by his psychological condition. He was already taking a range of CNS depressant medication including benzodiazepines, zopiclone and mirtazapine. An overdose of 75 – 100mls Oramorph® and around 40 amitriptyline 10mg tablets was enough to cause his death by respiratory arrest.

Double suicide attempt

It is believed that a man receiving end of life treatment at home used his stock of Oramorph® to commit suicide, also dosing his wife who had dementia. The man died, but his wife survived after receiving hospital treatment and had no recollection of a suicide pact.

Long term overdose plan

A woman with depression was receiving Oramorph® for use when needed for pain, and she had requested four repeat prescriptions for 300ml over eight months. She was also taking diazepam, zopiclone and SSRIs. She was found dead with several empty Oramorph® and alcohol bottles.

Woman taking 6 litres of Oramorph® a fortnight

A GP is trying to manage a slow reduction dose for a woman who had self-escalated her dose of Oramorph® up to around 400ml a day, equivalent to 800mg morphine. The patient has a history of complex issues regarding mental health, as well as severe orthopaedic problems and a previous history of dependence on opioids.

Care workers collecting Oramorph® prescriptions on behalf of vulnerable patients

A homecare worker was ordering and collecting urgent repeat prescriptions for Oramorph® on behalf of several older patients living at home. This continued for several months before it became clear that none of the patients involved had been taking Oramorph® for a long time, despite it being on their repeat list. The police were unable to press charges as the patients were unfit to give statements.

LESSONS TO BE LEARNED

- Morphine sulfate oral solution is a risky analgesic option for patients with a history of **mental illness**, self-harm, or personality disorder. For an opioid naïve patient, 100ml of morphine sulfate 10 mg/5 mL oral solution (200mg morphine) can be a fatal dose – especially if they are already taking other CNS depressant medicines like diazepam, zopiclone or SSRIs.
- Placing morphine sulfate oral solution **on repeat** or prescribing quantities of 300ml can make it easy for patients to escalate their dose. 100ml as an acute script should be enough for occasional use.
- Consider the risks of prescribing opioids as an oral solution – **patients are prone to swig** out of the bottle, and may unintentionally be taking large doses. If opioids are needed for occasional pain, would a small quantity of immediate release morphine tablets for breakthrough/occasional pain be safer, e.g. Morphine sulfate tablets such as Sevredol?
- Consider the risks of **respiratory depression** when prescribing analgesia for patients with underlying risk factors, e.g. **COPD**, **heart failure**, especially if they are already taking other CNS depressant medicines. For many older patients the risks of NSAIDs for chronic pain will be less than the risks of taking opioids. Oramorph® is often the target of **people seeking prescription medicines for misuse or diversion** – if you are suspicious of any prescription requests, please inform the NHS England CD Accountable Officer (see details below).

CONTACT US:
Secure email address: England.southwestcontrolleddrugs@nhs.net

Accountable Officer:
Sue Mulvenna 0113 824 8129 england.southwestcontrolleddrugs@nhs.net
Deputy Accountable Officers:
Darren Barnett 0113 824 8813 or 07747 443418 darrenbarnett@nhs.net
Graham Brack graham.brack@nhs.net
Project Officer:
Vicky Bawn 0113 824 8129 vickybawn@nhs.net

We can no longer receive or send faxes.