Safe **Prescribing of Morphine** in Primary Care

Contributed by the Safe and Quality Use of Medicines Group

Common morphine prescribing errors can arise from incorrect strength, measurement or dose. A patient who has had a morphine overdose is likely to become drowsy, confused and lethargic, and require hospital admission.

Below are some recent examples of typical morphine related prescribing errors in primary care.

Inappropriate starting dose of morphine

A patient was prescribed slow-release morphine 60mg twice a day for arthritic pain as an initial dose. Prior to this the patient was using tramadol 50mg three times a day for analgesia. After taking four doses of the morphine the patient was confused, hallucinating and drowsy. The patient was admitted to hospital where he remained for six days after receiving naloxone.

A prescribing error compounded by the lack of a safety check during dispensing

A patient was given 50mg/5mL of oral morphine solution instead of 5mg/5mL. The prescription was copied from the acute discharge note. The GP failed to notice the error and the pharmacy didn't question that the dose was different from that previously dispensed. The patient noticed and did not take the increased dose.

What can you do to reduce the chance of an error for your patients?

- Check the dose of morphine prescribed for opioid naïve patients, they are liable to respiratory depression
- When converting from one opioid to another, or one dose form to another check the conversion factor – it is not always 1:1. (see BPJ 16)
- Check the dose you prescribe when patients are referred back to your care after hospital admission or following treatment by another prescriber
- Review the way your practice stores morphine – clearly differentiate between high and low strength injections
- Always prescribe the oral solution as milligram (mg) of morphine not millilitres (mL) of solution
- When prescribing extended release products add the brand name so that it is clear which product is intended e.g. morphine sustained release tablets (m-Eslon), you may want to put the brand in the "sig" line
- Supplies of naloxone 400 micrograms in 1mL should be in stored in an easily accessible location, including GP bags and bags held by out-of-hours providers
- Adjust the starting dose of morphine for patients with renal impairment