DHBNZ Safe and Quality Use of
Medicines Group (SQM group)
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To whom it may concern

Morphine alert

This alert has been issued today and copies have been sent to people within both primary and secondary care for information. The alert has been sent to one identified person in each District Health Board (DHB) for action within DHB hospitals and to PHO clinical leaders for action within their PHO.

Morphine is associated with many adverse events both in the community and in the hospital setting. The adverse events can be caused by errors in prescribing, dispensing or administration and all health professionals need to be aware of the dangers posed by this high risk medicine.

Examples:

Check the conversion factor when switching between opioid analgesics and between dosage forms of the same opioid

A patient admitted with severe pain had been taking codeine 60mg four times daily. Their analgesia prescription was changed to m-Eslon 120mg twice a day. After three doses of m-Eslon the patient was confused, hallucinating and drowsy and required naloxone and an extended hospital stay. What is the correct conversion factor? (See opioid dose equivalence information available on www.safeuseofmedicines.co.nz)

Check your knowledge of morphine preparations

When m-Eslon was initially funded it replaced three other slow release morphine preparations. Many dosage errors involving picking the wrong product were reported in the first months because the packaging convention for m-Eslon varied to the product used previously. It is important to familiarise yourself with the strengths, dosage, release characteristics and packaging of any new morphine product before prescribing, dispensing or administering them.

Check your CD cupboards – what do they look like?

An elderly patient was found one evening unconscious with pin point pupils, she was prescribed m-Eslon 10mg bd and had been on this dose for several days in hospital. Following investigation it became clear that she had received 100mg that evening and was narcosed. The m-Eslon was checked by two nurses (one completed the entry in the CD register, the other got the tablets out of the CD cupboard). The CD cupboard was poorly organised (see **picture**) and over-stacked so that when the nurse went to get the

10mg M-Eslon box out, most of the contents of the CD cupboard fell out. The 10mg box looks very similar to the 100mg box and a simple slip error occurred.

An opioid naïve patient given oral morphine intended for another patient?
A nurse prepared doses of lactulose for one patient and morphine elixir for another patient at the same time (against good practice recommendations) and switched the products so that the morphine was taken by the patient who had been prescribed lactulose. The patient was opioid naïve and went into respiratory arrest and required naloxone infusion over a long period.

Evaluation of compliance with the recommendations in the alert will be carried out six months following publication. This evaluation will allow individual hospitals to audit their own practice with respect to morphine and the risk to patient safety.

Yours sincerely

Beth Loe
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DHBNZ Safe and Quality Use of Medicines Group