Event: Inappropriate repeat prescription of oral morphine solution

Event description

Patient A, who was partially sighted, fell, and sustained a fracture. With a past medical history of alcohol dependence, it is not known if alcohol was a contributory factor to this fall.

During their three-day inpatient stay at Acute Hospital B, Oramorph™ (oral morphine solution) was prescribed to manage pain. They were discharged home for 'conservative management' with:

- wrist in a plaster of Paris ('POP')
- a plan for follow up in fracture clinic
- a direct acting oral anti-coagulant, and
- a prescription for oral morphine solution, no more than four hourly and/or as needed ('prn').

The decision for conservative management was made due to co-morbidities.

On discharge from Acute Hospital B, the prescription was Oramorph™ 10mg/5ml (**100ml**) and the instruction on the discharge summary was "*GP cont.*" – an abbreviation for "*GP to continue*". The patient prescription was then transferred to a 'repeat prescription' by the prescription clerk at the GP practice. Patient A then received Morphine Sulfate (Oramorph™) 10mg/5ml **300ml**, with the instructions to "*take 2.5-5ml every four hours when required"* on five occasions over a five-month period.

The oral morphine solution continued to be prescribed by the GP practice, without review, until during a consultation regarding an itchy, widespread rash on the body, resulted in both the oral morphine solution and paracetamol should cease and were to be removed from the repeat prescriptions. The working diagnosis was given as allergy to morphine, and to 'stop and treat'.

A few days later, Patient A reported to the GP practice that they had been suffering with diarrhoea and vomiting overnight but had had no vomiting in the last 2-3 hours and was tolerating fluids. It was agreed that the patient would contact the District Nurses with regards to pre-arranged blood tests and to contact the GP practice again if the vomiting did not settle.

Two days later, Patient A was found in a collapsed and unresponsive condition at the home address. Toxicology testing following the death revealed a fatal level of morphine in the blood. A coroner's inquest concluded that the medical cause of death was an accidental fatal intoxication of morphine.

How the event was identified ⚠

The incident was identified following the inquest. A scoping meeting was held within Dorset CCG and a decision was made to hold separate meetings with the acute Trust and the GP surgery to find out more. A multi-agency patient safety review was undertaken.

Conclusion

Whilst this is a multi-factorial incident, morphine should have been for short term use only and not repeatedly prescribed. In addition, the choice of formulation was inappropriate for a patient with a history of alcohol dependence.

It is unknown if Patient A regularly took the prescribed oral morphine solution. Being dispensed monthly, if they took 20mg a day for 30 days, whilst not an optimum treatment choice, it is not an excessive dose of morphine. The fact that this liquid contains alcohol for a previously alcohol dependant individual, may be inappropriate.

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Recommended actions:

There is significant learning from this incident in relation to the safe prescribing and dispensing of opiates, both for those with a history of alcohol dependence, and those without. The recommendations, therefore, have been made as 'system recommendations' rather than for individual Trusts, GP practices and/or pharmacies

General practice

In line with contractual requirements, PCNs/Practices to ensure that:

- Practice protocol reflects the prescribed quantity (particularly in relation to high-risk drugs) and not 'default' quantity is added to their clinical prescribing system (e.g., SystmOne).
- new medications are not added to repeat medication schedule without pharmacy technician, clinical pharmacist or GP review
- there is an established process in place (undertaken by suitably qualified individual(s)) for medicine reconciliation within GP practices, as per NICE guidance.
- practices create a process for processing 'high risk medication' prescription requests. This includes scripts for controlled drugs and high-risk drugs such as methotrexate so that the prescriber is aware to review before issuing. This should become routine practice.
- their repeat prescription processes (and implement 'Electronic Repeat Dispensing) are reviewed alongside structured medication reviews for high-risk drugs.
- practices to continue to participate in local and national audits on opiate use, including:
    - search practice list for patients with an oral morphine solution
    - prescription on repeat prescription and review
    - always look to review and challenge potential excess use opiates and advise patients of side effects
    - Invite patients who are using >120mg morphine a day for medication review and have MDTs to discuss their management.

Provider organisations – All

Acute Provider organisations to ensure that:

- the process is reviewed for when a discharge medication is considered for GP to continue or should be ceased following defined period
- Clinicians across Dorset engage in a review of the acute pain pathway.
- the learning from this case (as it is in the public domain) for Acute Hospital Clinicians (including the Acute Pain Service) across Dorset. This education would also include the:
- importance of, when writing an acute prescription, thinking about the dose/quantity needed and for how long, rather than the size of the packs of analgesia available;
- importance of aiming for exceptional practice' and routinely document the rationale for the choice of analgesia, when prescribed
- need to be alert for inadvisable prescribing practice (oral morphine solution and thiamine on same prescription, indicating history of alcohol dependency) and how to escalate concerns
- alcohol content of oral morphine solution
- sugar content of oral morphine solution when potentially prescribing long term use, particularly for those already overweight/obese
- unsuitability of oral morphine solution for a patient who is diagnosed with postural hypotension
- waste (and cost) associated with prescribing medication without a review of the clinical need.

NHS Dorset

- to review the guidance for the prescription of liquid medication for patients known to be partially sighted (or registered blind) on discharge (when an equivalent tablet is available).

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