University Hospitals of Derby and Burton NHS Foundation Trust

Morphine – Oral – Full Clinical Guideline

Ref No: **CG-PM/2023/010**

These guidelines are intended exclusively for use with Morphine Sulphate oral solution 10mg/5ml (Oramorph)

Purpose

This method of pain relief is applicable to patients requiring strong opioids for the treatment of moderate to severe pain and who are able to tolerate oral fluids, have bowel function and who are not actively vomiting.

Oral morphine is not suitable where rapid onset analgesia, with predictable absorption, is required.

Aim and Scope

Morphine Sulphate Oral Solution (10mg/5ml) is an established opioid commonly used in the treatment of acute, chronic and breakthrough pain and can be effective and safe via the oral route. The oral to S/C potency ratio of Morphine is approximately 1:2 (10mg Oramorph is approximately equivalent to 5mg S/C Morphine). The expected time for effective analgesia is longer than via the parenteral route.

For administration routes other than oral, refer to the Acute Pain Guidelines on the trust intranet.

A prescription and observation algorithm with a one-hour time interval between doses should be used. This ensures that patients are assessed and monitored and can receive effective analgesia safely.

Definitions and Abbreviations

Oramorph 10mg/5ml: Immediate Release Morphine Sulphate Oral Solution – for oral administration only.
S/C: Subcutaneous
RDH: Royal Derby Hospital
QHB: Queen's Hospital Burton

Ward Management of Morphine Sulphate Oral Solution

There is no requirement for this to be treated any differently from other Prescription Only Medications, eg:
Bottles of Oramorph 10mg/5ml must be kept in a locked medicine cabinet, such as the ward drug trolley. It can be checked and dispensed by one Registered Nurse, and must be recorded on the patient's EPMA record.
The patient MUST be witnessed taking the dose by the nurse administering.

Regular Oramorph

Oramorph may be prescribed regularly – this is normally either 5 or 10mg QDS. This prescription forms part of various analgesic order sets including the RDH fractured neck of femur / rib fracture order sets. This should be limited to a maximum course of 5 days, and patients should **not** be discharged on regular oramorph.

This is normally prescribed instead of regular codeine or tramadol – as for certain patient groups the side effects of codeine and tramadol outweigh the benefits, and regular oramorph has more predictable metabolism and analgesic effect.

PRN oramorph or PRN s/c morphine may be prescribed alongside regular oramorph for breakthrough pain. Patients with severe pain do **not** need to wait 1 hour after their regular oramorph dose before they can be given their prescribed subcutaneous morphine for breakthrough pain.

PRN Oramorph for breakthrough pain

- Score pain at rest, deep breathing and coughing, or on dynamic movement, using assessment criteria below as a guide.
- Ensure regular oral analgesics have been given before considering Oramorph - refer to the trust guideline "Pain Management - Clinical Guideline"

If Pain Score is 3 or 2 and maximum co- analgesics have been given:-

- Check Oramorph 10mg/5ml is prescribed ‘as required’.
- Check Sedation, Respirations and Blood Pressure are within guideline limits (as the Oramorph Algorithm) and record on EWS or Patientrack.
- Check 60 minutes has elapsed since last dose of opioid analgesia.
- Give analgesia as prescribed and record on EPMA.
- Reassess pain score in 1 hour and record evaluation in nursing notes. If pain score is 2 or 3 repeat as above.
- If pain is not relieved after two doses of Oramorph, you may need to increase the drug dosage.
- If Oramorph 20mg is prescribed, 10ml may be dispensed.
- If having difficulty with pain control, contact the Acute Pain Team, during office hours, or, the on call F1/anaesthetist out of normal working hours.
- If respiratory rate falls below 8/min and/or sedation score P or U, Naloxone may be required: - Dilute with Normal Saline 0.9% and administer in 100 microgram increments. Seek urgent medical advice from on call F1/ anaesthetist.

Pain and Sedation scoring guidelines

PAIN SCORE	
No pain at rest No pain on movement	None 0
No pain at rest Slight pain on movement	Mild 1
Intermittent pain at rest Moderate pain on movement	Moderate 2
Continuous pain at rest Severe pain on movement	Severe 3

SEDATION SCORE	
A	Awake
V	Voice (The patient responds to voice)
P	Pain (The patient responds to painful stimuli)
U	Unresponsive

Observation Guidelines

- **OBSERVATIONS MUST BE RECORDED on EWS or Patientrack, according to the patient's clinical condition, or *as a minimum,* 4 hourly.**
- Use pain and sedation scoring guidelines

References

McCaffrey M., & Pasero C., (1999) **Pain: Clinical Manual, 2nd. Ed.** Moseby, St. Louis, USA

Australia and New Zealand College of Anaesthetists and Faculty of Pain Medicine **Acute Pain Management Scientific Evidence.** Fourth Edition 2015

Report of the Working Party of Pain after Surgery. (1990) Royal College of Surgeons and College of Anaesthetists.

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Pain Management Guidelines for Adults – Analgesic Stepladder Details for: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) for Acute Pain - Clinical Guidelines › Trust Policies Procedures & Guidelines catalog (koha-ptfs.co.uk)

Documentation Control

Development of Guidelines:	Acute Pain Team
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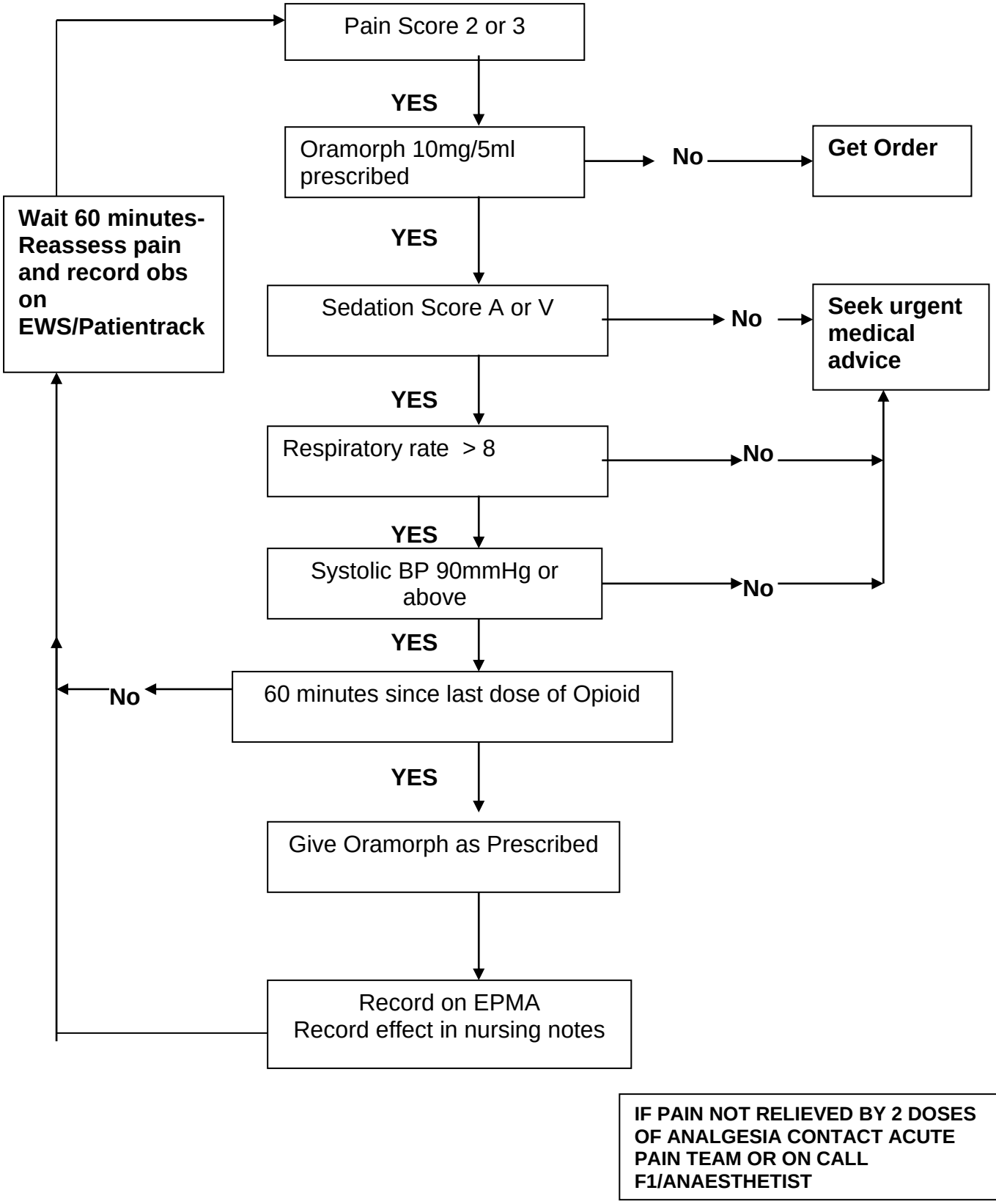
Acute Pain Service

Algorithm Guideline – Adults Only



IF PAIN NOT RELIEVED BY 2 DOSES OF ANALGESIA CONTACT ACUTE PAIN TEAM OR ON CALL F1/ANAESTHETIST