



CLINICAL GUIDELINE

Morphine/ Oxycodone sub-cutaneous algorithm, Queen Elizabeth University Hospital

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

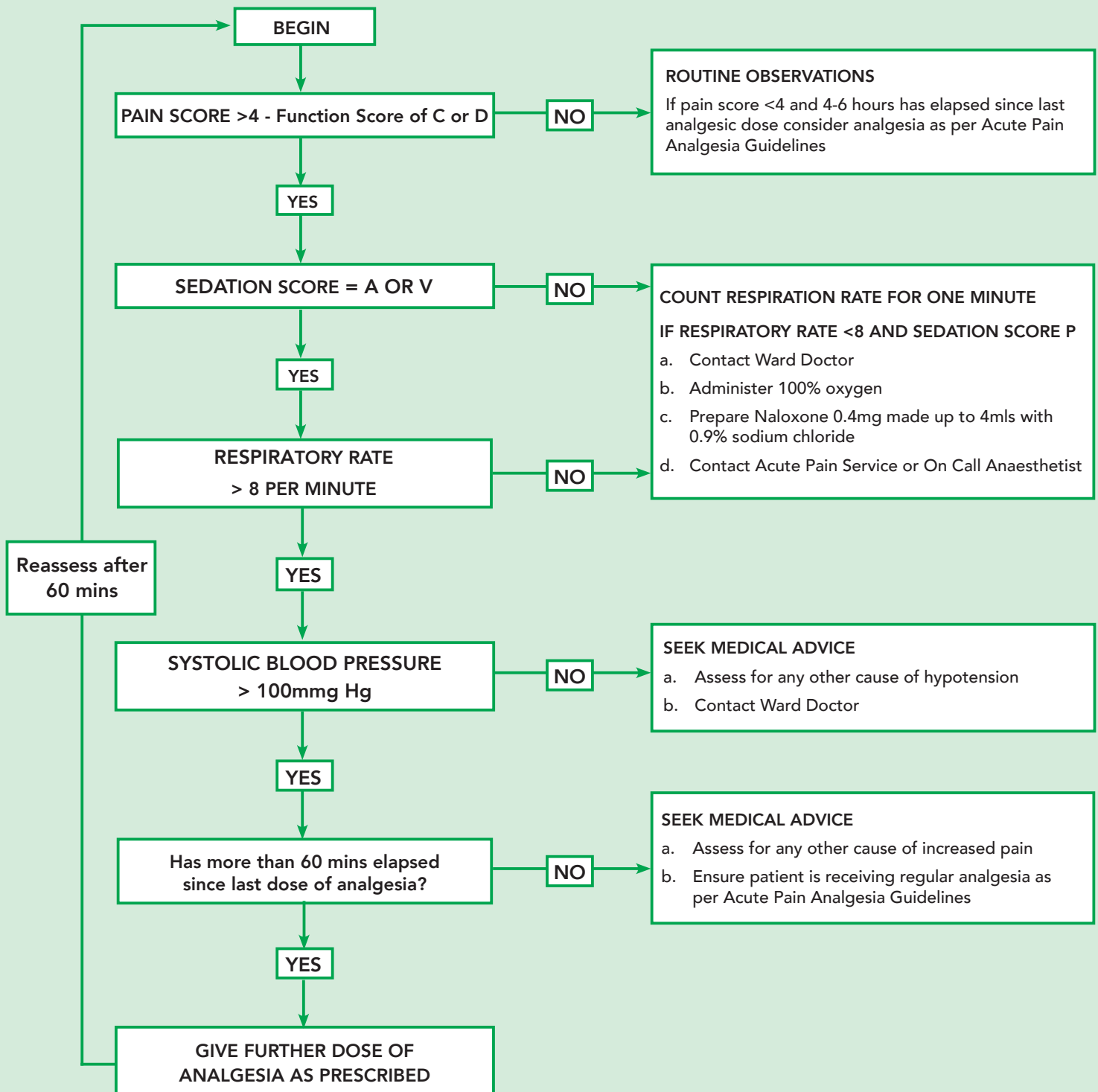
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Sub-cutaneous (S/C) Algorithm

THIS MUST BE FOLLOWED BEFORE FURTHER DOSES OF ANALGESIA ARE GIVEN

Adult suggested starting doses for S/C Morphine (with normal renal function)	
Age	Dose
Under 65	10mg
65 - 80	5mg
Above 80	2.5mg

Adult suggested starting doses for S/C Oxycodone (with normal renal function)	
Age	Dose
Under 65	5mg
65 - 80	2.5mg
Above 80	1-2mg



If patient requires more than 3 SC injections within 6 hours, consider setting up a PCA.

GUIDELINES WHEN USING SUBCUTANEOUS MORPHINE / OXYCODONE ALGORITHM

1. ALL PATIENTS TO HAVE DRUG PRESCRIBED IN AS REQUIRED SECTION OF HEPMA
2. ALL PATIENTS TO HAVE PAIN, FUNCTION AND SEDATION SCORES DOCUMENTED
3. S/C ALGORITHM TO BE FOLLOWED BEFORE DRUG IS ADMINISTERED
4. ONLY Morphine 10mg/1ml or Oxycodone 10mg/1ml preparations to be used
5. ONLY BD Saf-T-Intima™ YELLOW CANNULA (24 GAUGE TO BE USED). DO NOT ADMINISTER ANY OTHER DRUG VIA S/C CANNULA
6. Cannula should be resited every 72 hours ensuring a different site is used
7. Be aware there is potential for reduced absorption in the S/C route in certain patients (e.g hypotension, oedema or hypothermia)

EQUIPMENT

You will need: BD Saf-T-Intima™ YELLOW 24 gauge cannula, 1ml or 2ml syringe, needle, alcohol swab, transparent semi-permeable dressing, non-sterile gloves, sharps container, needle-free access device, prescribed drug.

INSERTION OF CANNULA

- a. Wash hands as per hand hygiene policy.
- b. Explain procedure to patient and gain consent .
- c. Clean skin with an pre-injection swab, allow to dry for a minimum of 15 seconds.
- d. Put on gloves.
- e. Remove needle cover.
- f. Pinch patient's skin between thumb and forefinger to ensure enough s/c tissue is identified.
- g. Insert cannula at a 45 degree angle, pebbled side next to patient's skin. If unsuccessful use another cannula. If blood appears in cannula, remove and insert a new cannula at a different site.
- h. Remove introducer needle by gently pulling on white toggle and dispose in sharps container as per hospital policy.
- i. Secure insertion site with a transparent dressing, document date of insertion on transparent dressing and write for S/C Morphine or S/C Oxycodone use only.
- j. Replace removable bungs with needle-free access devices.
- k. Wash hands as per hand hygiene policy.
- l. Document date, time and place of cannula insertion in nursing notes.

ADMINISTERING THE DRUG

- a. Wash hands as per hand hygiene policy.
- b. Draw up prescribed morphine or oxycodone.
- c. Check S/C site for any signs of swelling, inflammation or infection. Check cannula to ensure there is no blood in it. Do not use if any of these signs are present, remove cannula and insert a new cannula at a different site.
- d. Clean port with an pre-injection swab, allow to dry for a minimum of 15 seconds.
- e. Explain to patient they may experience a stinging sensation when analgesia is administered, but this should only be momentarily.
- f. Attach syringe (do not use a needle), open white clamp and slowly administer analgesia over 1 minute to minimise discomfort.
- g. Ensure that correct prescribed dose is administered.
- h. Observe for any signs of swelling/leakage which may indicate poor absorption or infection.
- i. **Do not** flush cannula.
- j. Close white clamp.
- k. Wash hands as per hand hygiene policy.
- l. Document that drug has been administered on HEPMA.

IF RESPIRATORY RATE IS < THAN 8 PER MINUTE AND SEDATION SCORE IS P, PLEASE CARRY OUT THE FOLLOWING:

- a. Contact ward doctor.
- b. Administer 100% oxygen.
- c. If sedation score = U (irrespective of respiratory rate) OR sedation score = P and respiratory rate < 8/min give 200 micrograms of NALOXONE IV stat. Repeat with 100 micrograms every 2 minutes as required according to response.
- d. Contact the Acute Pain Service or 1st on-call anaesthetist.