
HOSPITAL AND MEDICATION SAFETY LITIGATION

Found Unresponsive

Opioid Sedation, Monitoring, and the Hours Before

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A healthy-ish adult comes in for a knee replacement. Pain is controlled with a PCA pump. Sometime before dawn, a nurse finds her barely breathing. She's resuscitated with a severe brain injury, or she isn't resuscitated at all. These cases are devastating, and they're rarely mysterious. The answer is almost always in the hours before, if you can reconstruct them.

The risk has been well known for a long time. The Joint Commission's 2012 Sentinel Event Alert on safe opioid use in hospitals pointed to inadequate monitoring, missed sedation, and failure to account for high-risk patients. The Anesthesia Patient Safety Foundation has pushed for continuous electronic monitoring of oxygenation and ventilation for post-op patients on opioids. The FDA put a boxed warning on combining opioids and benzodiazepines in 2016. And the CDC's 2022 opioid prescribing guideline recommends offering naloxone to patients at increased overdose risk; naloxone nasal spray has been sold over the counter since 2023. So the standards aren't in doubt. What matters is whether they were followed for this patient.

WHO'S AT HIGHER RISK

Obstructive sleep apnea is one of the biggest risk factors, and it's frequently undiagnosed. That's why many hospitals screen with STOP-BANG (snoring, tiredness, observed apneas, blood pressure, BMI, age, neck size, gender). Other factors: older age, obesity, lung disease, kidney impairment, being new to opioids, and getting other sedating drugs at the same time, like benzodiazepines, sleep aids, or some anti-nausea medications.

Did anyone screen her? Was the result documented and acted on? If she used CPAP at home, was it ordered and at the bedside? What else sedating was she getting?

SEDATION COMES FIRST

Patients usually get more and more drowsy before their breathing drops to a dangerous level. That's why many hospitals use a sedation scale, such as the Pasero Opioid-Induced Sedation Scale, and require a sedation check before more opioid is given. And oxygen saturation can fool you. A patient on supplemental oxygen can show a normal pulse ox while carbon dioxide climbs because she isn't breathing enough. That's why capnography is recommended for higher-risk patients.

A FICTIONAL CASE

She's 57, about 240 pounds, and her husband says she snores heavily, though she's never had a sleep study. After her knee replacement she's on a hydromorphone PCA, gets a sleep aid at bedtime and an anti-nausea drug, is on 2 liters of oxygen, and has intermittent pulse ox checks. At midnight the note says "sleeping comfortably." At 2 a.m., vitals are charted as normal. At 4:30 she's found unresponsive with a very slow respiratory rate. She's resuscitated with a significant brain injury.

REBUILDING THE NIGHT

Start with the orders. What were the PCA settings: dose, lockout, any continuous background infusion, hourly limit? A basal infusion in an opioid-naïve patient raises the risk, and many guidelines discourage it.

Then get the pump history. The PCA pump logs every button press, every delivered dose, and every denied attempt. It's often the most important evidence in the case, it usually isn't in the chart, and it can be overwritten when the pump goes back into service. It has to come from pharmacy or biomedical engineering, and it has to be requested fast.

Check the MAR for every other sedating dose and its time. Figure out what monitoring was actually in place: spot checks, continuous pulse oximetry, capnography. If there was continuous monitoring, did alarms fire? Many hospitals send alarms to nurses' phones or a central station, and alarm logs can show whether anyone responded.

Look hard at the sedation assessments. "Sleeping comfortably" isn't one. If policy required a sedation score at set intervals, were those done? Did anyone actually wake her to check? And look at the respiratory rates. A rate charted as 16 at every single check sometimes means nobody counted.

Talk to the husband. He may have been in the room. Did he tell anyone she was snoring unusually loudly or was hard to wake? Families often notice first.

THE NIGHT SHIFT AND THE SYSTEM

Nights are when these events cluster: thinner staffing, sleeping patients, and a natural reluctance to wake someone who looks comfortable. That's exactly why many policies require sedation checks during sleep for high-risk patients. How many patients did her nurse have? Were other sick patients pulling attention away? Was she flagged as high risk under a continuous monitoring policy?

Ask what the hospital knew. Had there been similar events on that unit? Did quality reviews identify opioid respiratory events as a problem? Did the hospital consider continuous monitoring and decide against it because of cost or alarm fatigue? Peer review and quality privileges vary by state, but policies and their revision history usually aren't protected.

THE RESCUE

When she was found, how long until the rapid response or code team arrived? Was naloxone given, and when? Was her airway supported? Delays in the resuscitation can add to the injury, and the code record's timestamps show them.

AFTER DISCHARGE

The same issues come up at home. Someone goes home after surgery with oxycodone, already takes a benzodiazepine, has sleep apnea, and is found dead three days later. Now the questions are about prescribing. What dose, how many days? Did the prescriber check the state PDMP, which many states require? Did they know about the benzodiazepine? Was naloxone prescribed or offered, as the CDC guideline recommends and some states require for patients with certain risk factors? What were the patient and family told about warning signs and mixing medications?

CAUSATION

If the pump history shows heavy use in the hours before and proper sedation checks or monitoring would probably have caught the trend, the link can be strong. If the event was truly sudden, from an arrhythmia or a pulmonary embolism, it looks different. Autopsy, toxicology, and labs drawn at the time of the event matter. For survivors, the neurological exams, imaging, and recovery course define the damages.

RECORDS WORTH REQUESTING

- The complete MAR and order history
- PCA pump event history and programming records (request preservation immediately)
- Nursing flowsheets, including sedation scores and vital signs
- Continuous monitor data and alarm logs

- Rapid response and code records
- The pre-op assessment, including sleep apnea screening
- Hospital opioid, PCA, and monitoring policies, with revision history
- For discharge cases: prescriptions, PDMP query logs, discharge instructions, and pharmacy records

SOURCES

- The Joint Commission, *Sentinel Event Alert 49: Safe Use of Opioids in Hospitals* (2012)
- Dowell D, et al., *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022*, MMWR Recomm Rep 2022;71(3)
- FDA Drug Safety Communication on opioid and benzodiazepine co-use boxed warning (Aug. 2016); FDA approval of over-the-counter naloxone nasal spray (Mar. 2023)
- Anesthesia Patient Safety Foundation recommendations on postoperative monitoring for opioid-induced ventilatory impairment

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have an opioid-related respiratory arrest case and want the hours before rebuilt from the pump, the monitors, and the chart, we'd welcome the conversation.

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