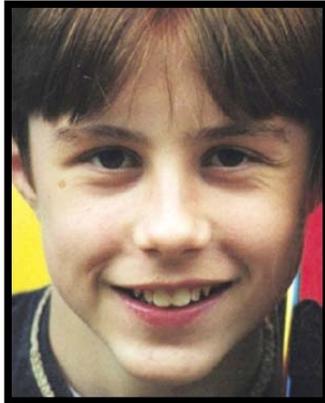


**NATIONAL COALITION TO PROMOTE CONTINUOUS MONITORING OF PATIENTS ON OPIOIDS:
PATIENT STORIES**

**Saving Lives, Saving Families:
Continuous Monitoring for Patients on Opioids
Author: Jill Williams**

Too many patients have died in their hospital beds due to undetected respiratory depression after receiving opioids for pain management over the past decade. These stories have been discussed at medical conferences, published in the medical literature, and even featured in newspapers and on the nightly news. Yet, still today, health care providers—following the standard of practice for their institution—miss the signs of respiratory depression. Their patients die and the patients' families are left distraught, wondering how such a thing could happen. Again. Here are a few of their stories.

Lewis Blackman: Chest Surgery
Risk Factors: None



Helen Haskell's son Lewis Blackman was a bright, active, healthy 15-year-old in November 2000 when his parents brought him to a hospital in Charleston, South Carolina for an elective medical procedure. He was undergoing surgery to correct a congenital defect of the chest called *pectus excavatum*, a sunken breastbone.

The procedure involved a surgeon inserting a bar into his chest to place upward pressure on the sternum. He was placed on a heavy narcotic pain regimen, with high doses of hydrocodone in an epidural plus adjunct injections of Toradol to control his pain. The surgery went well. Lewis was initially monitored with pulse oximetry, but his saturation levels kept dropping below 85% and the machine repeatedly alarmed. Nurses turned off the monitor.

On the third day after surgery, Lewis developed a sudden intense pain in his stomach. Nurses assumed that it was an ileus, an intestinal blockage, and Lewis's epidural narcotics were stopped. Ultimately, he went into cardiac arrest and died. Autopsy revealed a large perforated ulcer of a type usually associated with NSAID overdose. The ulcer had penetrated an underlying artery and Lewis had lost 2.8 litres of blood and stomach contents into his abdominal cavity.

"Losing Lewis was devastating," says Haskell. "We entered the hospital with two children and came out with one. Our son had slowly died from a severe medication reaction while his nurses and residents seemed unable even to respond to our pleas for help. I was stunned at the disorganization we had witnessed, and felt that my son's death would be meaningless if we did not do all we could to change the situation."

Following Lewis's death, Haskell became active in the patient safety movement. She founded the group Mothers Against Medical Error and helped create a coalition of South Carolina health professionals and consumers to pass the Lewis Blackman Act, aimed at addressing the conditions that led to Lewis's death.

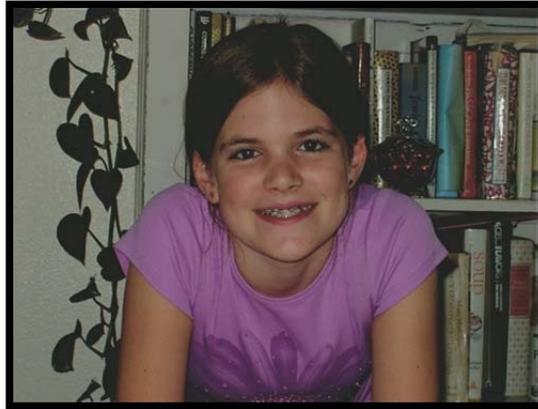
"These stories all involve people not paying attention," says Haskell. "I believe that continuous monitoring must be part of a system for rescuing deteriorating patients. Data must be trended, rolled up into a score, and evaluated by a critical care person who is not part of the original team. Respiratory depression is the key measure, and I believe that technology is the answer to get around toxic relationships in the hospital environment."

"Every patient deserves continuous monitoring," she says. "You never know what's going to happen, particularly with postoperative patients. Lewis is a prime example. He was a perfectly healthy child, which is why no one could believe that anything was wrong with him. You need an objective observer like a monitor."

Website: <http://lewisblackman.net>

Video: <http://www.youtube.com/watch?v=yNsJAf8nONO>

Leah Coufal: Chest Surgery
Risk Factors: None



In December 2002, Lenore Alexander's daughter Leah Coufal, a healthy 11-year-old girl, underwent elective chest surgery at a major medical center in Los Angeles, California to correct *pectus carinatum*, a deformity of the chest. "A lot of things went wrong that day," says Alexander.

Leah came out of surgery successfully. She was on an epidural with fentanyl for pain control. When her pain was not relieved, they increased her fentanyl dosing, ultimately to the highest dose. When Leah's parents insisted that they stop increasing her pain medication dosing, they gave Leah ativan, an anti-anxiety medication, instead. Leah was not on any electronic monitors. Per hospital policy, nurses checked on her every few hours. Alexander stayed at her side that night but, exhausted, finally dozed in a chair next to Leah's bed. When she woke, Leah was dead, a victim of undetected respiratory arrest. An autopsy found that Leah's epidural had been inserted in the wrong place, into the intrapleural space of her left lung rather than to the epidural space in Leah's spine. This explained why she was feeling so much pain.

"That night at the hospital, I didn't know I needed to be ready to save Leah's life," says Alexander. "I didn't know she needed protection. But she did. This was so avoidable. Had she been on a monitor, they would have detected that her breathing was deteriorating and something would have triggered an alert. With no medical training, I could have saved my child's life that night." Ten years later, Alexander began speaking out about Leah's experience, advocating for what she calls Leah's Law: Continuous postoperative monitoring for patients on opioids.

"How many children will die this year because they're not on a monitor after surgery?" asks Alexander. "The way my daughter died 10 years ago, she would die today, just as likely. I think of all the families that have been torn apart and broken by the tragedy of losing a child, and it's because most things have not changed. We're not doing enough things differently. How many families will be told, 'Your child died from respiratory depression,' never understanding that it was a lack of continuous monitoring that ended their child's life?"

"I want a standard of care that uses the existing technology to create a new standard of safety. Because medical errors happen to one person at a time, behind closed doors, it's easy for people not to pay attention. But medical errors are now the third leading cause of death. We no longer have the luxury of believing it could never happen to me. We need to be engaged, educated and smart patients. My part in this is making sure continuous electronic monitoring for all patients on opioids is the standard of care in every hospital in America."

Website: <http://leahslegacy.org>

Video: http://www.youtube.com/watch?v=Kp_Jf65hp3M

Katie Couric interview: <http://www.youtube.com/watch?v=m530yntLZFQ>

John LaChance: Rotator Cuff Surgery Risk Factors: Sleep apnea, previous problems with pain management



In March 2007, Patricia LaChance accompanied her husband of 27 years, John Michael LaChance, to a hospital in Fredericksburg, Virginia for routine rotator cuff repair surgery. He had re-injured his shoulder when he reached out to block a basketball from hitting Patricia during an event at their church. Since he had experienced adverse reactions to pain medication with an earlier surgery for the same rotator cuff problem, his surgeon recommended a 23-hour hospital stay for pain management. In addition, John was previously diagnosed with sleep apnea. He and Patricia shared this information with the medical team prior to surgery, but a continuous positive airway pressure (CPAP) machine was not ordered for him to use after surgery.

To control his pain during surgery, he received a shoulder block, a form of local anesthetic. After surgery, doctors prescribed morphine through a patient-controlled analgesia (PCA) machine, along with monitoring via pulse oximetry. The morphine did not manage his pain but instead caused extreme vomiting. John was removed from the PCA machine as well as the supplemental oxygen he had been receiving and instead given an injection of Dilaudid for pain along with an anti-nausea medication. He was also removed from the pulse oximeter that had been monitoring his oxygenation levels while on the PCA machine.

“Shortly after, John seemed to be sleeping well so I went home for the night with the intent of taking him home the next morning,” says Patricia. When she left at 10 pm, John was snoring. He was in a room by himself at the far end of the hallway. Patricia never got the chance to take him home. After a second dosing of Dilaudid sometime during the night, a nurse making rounds at 4:20 am found John unresponsive in his bed. The crash team worked on John for more than 40 minutes, but he died.

“Why was John removed from monitoring when they began administering stronger opioids?” asks Patricia. “That was the standard of care for post-orthopedic surgery patients. But now we’re finding out how important it is to remain monitored. His sleep apnea diagnosis was really a respiratory issue, and when mixed with opioids, that diagnosis puts patients at a much higher risk for respiratory depression. Each patient, each person, has different needs and issues. Blanket care orders don’t work for everybody.”

“I don’t want any other family to go through this,” she says. “I continue to be shocked as I learn of the deficiencies within our health care systems and in our health care providers when it comes to understanding the dangers of these drugs and the importance of continual monitoring.” “How can patients and their families be expected to understand and monitor these things when even our health care providers don’t?” she asks.

Video: <http://www.youtube.com/watch?v=dH9agqZRdXw>

**Amanda Abbiehl: Severe Throat Pain
Risk Factors: None**



In July 2010, Brian and Cindy Abbiehl brought their 18-year-old daughter Amanda to a hospital in Mishawaka, Indiana with a sinus infection and severely sore and swollen throat due to a virus. She was dehydrated, had lost weight, and was in a great deal of pain. Her physician admitted her to the hospital with the goals of rehydrating her, administering antibiotics, and managing her throat pain.

Amanda was placed on a PCA machine that would allow her to control the amount of pain medication—hydromorphone, also known as Dilaudid—that she received. Her parents hoped that the stay would be short. Instead, in less than 12 ½ hours after being put on the PCA pump, Amanda was found unresponsive in her hospital bed and died.

The most likely cause of her death was respiratory depression caused by the pain medications she was receiving. Opioids can sedate the part of the brain that controls breathing, causing the lungs to slow and ultimately stop. The risk of respiratory depression increases with people who have apnea, are obese or have other problems, but Amanda had none of those risk factors.

“Amanda was on a general care floor and was not on any kind of electronic monitoring that might have alerted staff to her deteriorating condition,” her parents say. They are left to wonder, “Would an alarm signaling Amanda’s dropping levels have alerted caregivers to check on Amanda’s condition in time to save her?”

“Everyone can do everything exactly as the doctor prescribed, and the patient can still perish because of respiratory depression,” says Brian.

Amanda’s parents are working hard to raise awareness about respiratory depression. With the help of a local graphic arts design class and some dedicated healthcare providers, they have started A Promise to Amanda Foundation and launched a website. Their goal is to encourage all healthcare facilities to monitor patients on opioids with both oximetry and capnography to eliminate the possibility of respiratory depression as a cause of death. “Patients and their families must be educated about the need for this monitoring,” they say. “Such monitoring needs to be done on all patients, not haphazardly. There is no way to know how any patient is going to react to these medications. Every patient is high risk.”

“We hope and pray that no one will ever have to feel the emptiness we have in our hearts,” they say. “The lack of will among hospitals to provide this monitoring today is shocking.”

Website: <http://www.promisetoamanda.org/>

Youtube: <http://www.youtube.com/watch?v=gNZbvs3aByc>

Matt Whitman: Neck Surgery
Risk Factors: None



In April 2003, Matt Whitman checked into a hospital in Indianapolis, Indiana to undergo the neck surgery his doctors had been recommending for years. As a state trooper, he was injured in 1990 when a drunk driver struck his squad car. He had returned to his job after undergoing six months of rehabilitation and was eventually named a district Trooper of the Year. But, by 2002, doctors were warning that if he got hit again, he would be a quadriplegic.

The surgery went well. While in recovery, he was placed on a morphine pump to help manage the pain, but not monitored. “I was still in pain, so they upped the dosage later that night,” he says. Per hospital practice, a nurse monitored his vital signs every few hours. Late that night, a nurse had just checked him and proceeded to check other patients on the large hospital floor. But, when another patient needed something, she decided to go to the supply room to restock her cart. “Fortunately for me, her path to the supply room led her past my room,” says Whitman. “So, even though she had just checked on me 15 minutes earlier, she just so happened to be passing my room when she noticed I was not breathing and called a ‘Code Blue.’” Miraculously, Whitman survived. He had been without oxygen for six minutes. “I was a ‘near miss,’” he says. “And if not for the grace of God, I would not be alive today. My doctor told me that only 4% of Code Blue patients live.”

“I was never electronically monitored. There was nothing that would have indicated to a nurse that I was about to experience respiratory depression and almost die. I was 39 years old and in terrific health. I was not a high-risk patient.” Whitman is now speaking out to encourage hospitals to electronically monitor all of their patients, not just the ones at high risk. “A human life is too valuable for you not to do this,” he says. “All hospitals need a technological safety net for their patients. All nurses and caregivers need that safety net too.”

Whitman has since retired as a trooper and is now a teacher. “As soon as I heard about the Amanda Abbiehl story, I contacted a reporter. I want to speak out. I strongly believe that a technology safety net would go a long way in reducing the many ‘near miss’ cases that continue to cause caregivers so much shame.”

“Like Amanda, I was not a high risk patient,” he says. “Continuous monitoring should be used with every single PCA pump, regardless of age, risk, operative status. These tragedies are so avoidable. I don’t understand why that monitoring is not done already.”

Website: <http://ppahs.org/tag/matt-whitman/>