'Dead in bed' is a common term in hospitals. Here's why patients should know about it

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Sheree Thein's mother was supposed to go home the next day.

Thein's mom, Jadeen Rivard, was hospitalized in 2014 with a partial

intestinal blockage. She had her stomach pumped and after a few days she was feeling better. During Thein's last visit, everything seemed fine, except that her mom kept falling asleep while they were watching television.

"There was nothing going on with her that gave us any reason for concern," Thein said during an interview at her house in Leawood, Kan.

Her mom didn't survive the night.

Thein said her mother was a victim of what's called "Dead in Bed," a phenomenon that's well-known within the medical community, especially among anesthesiologists, but not discussed much with the general public.

The hospital could offer no answers and an autopsy was inconclusive. But the exam didn't include a toxicology report and Thein's family soon became convinced that if it had, it would have shown that her mother died of opioid intoxication from Dilaudid, the common but potent painkiller she was repeatedly given during her hospitalization.

Experts who reviewed her medical records said the doses seemed unusually high for someone being treated for such a minor procedure. Cumulatively, they said, it could have been enough to make a patient stop breathing, especially someone like Rivard who was 80 and hadn't been on opioids before, so she had low tolerance.

It usually happens in hospital wards that aren't intensive care units. Patients on painkillers, often recovering from surgery, quietly suffer respiratory failure while asleep.

Frank Overdyk, an anesthesiologist from South Carolina and national patient safety expert, said an estimated 3,000 to 5,000 Americans die

that way every year.

That's far fewer than die in hospitals of other complications like infections or surgical errors, but Overdyk said it's still too many.

"These tragic deaths continue to happen everywhere—large hospitals and small hospitals, famous hospitals and rural hospitals," Overdyk said. "They are completely preventable."

Overdyk—who disclosed that he receives payments from Medtronic, a medical device company that makes monitoring equipment—is chairman of a coalition of 15 groups pushing for continuous electronic monitoring of all hospitals patients on opioids that are injected or infused intravenously.

Very few hospitals do that now, though it would alert staff immediately if a patient was struggling to breathe. The coalition includes several national nursing groups and the American Association for Respiratory Care.

But other physicians who don't have financial interests also said the public should be aware of the dangers of overuse of painkillers in hospitals.

"It's not just the elderly and it's not just Dilaudid," said Andrew Kolodny, the executive director of Physicians for Responsible Opioid Prescribing. "I believe that opioid overdose deaths in hospital beds are not uncommon."

Kolodny said "aggressive screening for pain" mandated by an accreditation group called the Joint Commission and federal reimbursements that are linked to patient surveys were the main causes of the problem.

Hospitals have known of the problem since at least August 2012, when the Joint Commission released an alert about it. The group identified several risk factors that made patients more susceptible, including sleep apnea, obesity, age, smoking and medication combinations.

It estimated that 47 percent of the adverse events, including deaths, related to inpatient opioids were due to dosing errors. But 29 percent were due to improper monitoring of patients.

Thein has made it her mission to improve patient monitoring and also spread the word about what other families should look for when they have loved ones in the hospital. In retrospect, she said, there were warning signs that both she and the nursing staff missed.

Thein said she didn't want to name the hospital where her mom died, partly because of a legal settlement her family reached with the facility in 2016, but also because she doesn't want people to think other places are risk-free.

"I don't think it's limited to that hospital at all," Thein said.

Continuous electronic monitoring tools include pulse oximeters that are attached to a patient's finger and measure oxygen in the blood and capnography monitors that measure vital signs and beep when they fall to dangerous levels.

They're used in operating rooms and intensive care units, and anyone who has seen a hospital drama on TV is familiar with them. But Overdyk said only about 20 to 25 percent of hospitals have the capacity to use them at every bed and only about 1 percent do.

The main reason, he said, is cost.

Officials from the Missouri Hospital Association and the Kansas Hospital Association said neither kept data on how many of their members use electronic monitoring.

The Kansas City Star asked eight of the Kansas City area's largest health systems for information about what kind of measures they take to prevent inpatient opioid overdoses how they use electronic monitoring.

Truman Medical Center and Olathe Health did not comment.

Shawnee Mission Health chief medical officer Larry Botts said through a spokeswoman that his system follows federal guidelines and electronically monitors all patients "on continuous IV opioid medication." Patients like Rivard who are being given IV opioids intermittently are monitored based on "the unique needs of each individual patient's history and physical status."

The University of Kansas Health System, St. Luke's Health, North Kansas City Hospital and HCA Midwest all also said they use electronic monitoring on a case-by-case basis depending on patient risk.

KU Health spokeswoman Jill Chadwick said KU has formed an Opioid Stewardship Committee to study whether its protocols should be updated.

"The committee and doctors are watching closely the studies around continuous electronic monitoring of all forms with great interest," Chadwick said.

Pat McBratney, a spokesman for Providence Medical Center in Kansas City, Kan., didn't say anything about that hospital's electronic monitoring, but said Providence employs "industry best practices" including the Pasero Opioid-Induced Sedation Scale.

The five-part scale was developed by Chris Pasero, a retired nurse and author of several textbooks on pain management in nursing.

It's intended to help nurses spot patients who may be receiving too many opioids by gauging how drowsy they are while awake and how hard it is to rouse them when they're asleep.

Thein said the scale is no substitute for electronic monitoring. But she wishes she and her family had known about it, because it would have told them something was seriously wrong with her mom.

Thein said her mom was in excellent health for an 80-year-old before she was hospitalized.

"She seemed a lot younger than she was and I think it was misleading for people," Thein said. "Maybe made the doctors and nurses think she was so healthy they didn't need to worry about her."

Thein said her mom was put on Dilaudid initially because the bowel obstruction was causing her significant pain. But that abated after her stomach was pumped and by the second day her only pain was a sore throat caused by the suction tube put down through her nose to do the pumping.

The nurse on duty said she had decided to back off her pain meds at that point, but instead of lowering her mom's dosage, Thein said the nurse instead kept her on the same amount but gave it every six hours instead of every three.

Meanwhile, Thein and her family were seeing what they later learned were signs of opioid intoxication.

Her mom was having trouble staying awake and when she fell asleep it

was hard for them to rouse her. Her speech at times was slurred and mumbling. When she went to the bathroom she seemed dizzy and unsteady on her feet.

But Thein said at the time she knew nothing about the risks of opioid pain medication, and she figured that the hospital staff would know if anything was wrong.

"I didn't know it would be any kind of serious situation," Thein said. "I just thought maybe they had given her something to make her sleep."

Thein said by the end of the day the nurse had decided that her mom shouldn't get more pain medication. But her records showed that later that night, when a different nurse was on duty, Rivard was given another dose.

She was dead before sunrise.

"We were totally shocked by the phone call in the morning, which most of us got from my dad around 5 or 5:30, just telling us that she had died at the hospital," Thein said.

It wasn't until the family members got together and talked about how groggy Rivard was during their hospital visits that last day that they started piecing together the painkiller connection.

Now Thein said she worries every time she hears about someone she loves is going to the hospital, even for routine procedures.

"Until we have all patients monitored," Thein said, "we won't have 100 percent (of) patients coming home from the hospital."