Codeine Toxicity

Update 98-01

This Medical Update is based on the work of our Medical Review Subcommittee and should be posted prominently. We will make an effort to take an active role in improving the services provided to people with disabilities by communicating important issues found in the Medical Review Subcommittee's review of deaths and serious injuries. We want to thank you for your prompt reporting of deaths and serious injuries. You are helping us meet our mission.

Medical Update

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This Medical Update is based on the death of two clients whose deaths were attributed to Codeine toxicity (an overdose of Codeine).

Differences in the cases:

- One client was male, the other was female.
- One client was in the mid twenties and the other client was in the mid forties.
- One client died 20 hours after discharge from the hospital. The other client died 20 days after discharge.
- Neglect by four staff persons was substantiated in one case. In the other case, neglect was found to be false.

Similarities in the case:

- Both clients were non-verbal.
- Both clients were developmentally disabled. Their level of mental retardation was profound.
- Both clients had substantially lower body weight than an average adult.
- Both clients had minor surgery that required a PRN (as needed) medication containing codeine for postoperative pain.
- Both clients were discharged to their facilities because it was felt that the client would be more comfortable there.
- Both clients lived in Adult Foster Care Waivered Services facilities. Having a professional nurse on duty is not required.
- Neither client was seen by a health care professional after discharge from the hospital.
- The level of care provided at the residential facilities was inadequate to meet the clients' needs.
- Both cases were reported to Adult Protection.

The Medical Review Subcommittee recommends the following:

- Facility nurses should assess client's condition and orders postoperatively, and take a lead in developing and communicating a care plan to facility staff.
- That a health care professional take the lead in establishing indicators to determine the need to administer PRN medications, the appropriate dose of medication, and to recognize the signs of overdose.
- Hospital discharge planning should include knowledge or awareness of the level of care the discharged client will be receiving.
- Any deficits in the ability of the client to communicate should be included in the discharge planning.

PLEASE POST

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February, 1998

Codeine Toxicity

Case Summaries

CASE #1

Two days before dying this 52 inch tall, 66 pound client was hospitalized for a minor surgical procedure. After the procedure the client was kept overnight at the hospital for observation because of bleeding. The next day the client was discharged to the community facility. It was noted in the hospital discharge documents that the client had tan colored sputum, diminished lung sounds and a fever. Discharge medications included a medication for pain control that contained codeine to be given every 4 to 6 hours as needed. The client received a total of eight doses of the codeine postoperatively, over a period of 27 hours. The client died approximately 20 hours after discharge from the hospital. The death certificate listed the cause of death as codeine toxicity and the manner of death as accident.

The pain medication was ordered in the customary amount for any adult who had the same type of surgery, and was administered as it was prescribed. There was a dosage range and the expectation was that a health care professional would assess the need for the pain medication and any reaction to the medication. This client was not seen by a health care professional after discharge from the hospital. This client was not capable of communicating discomfort. The staff at the group home gave the medication at the highest dose and as frequently as possible because they believed that the patient was in extreme discomfort.

CASE #2

This 62 inch tall, 97 pound client was admitted to the hospital for a minor surgical procedure. The client was discharged from the hospital the day of surgery. Because of concerns that the client would pull out a drainage tube, a sedative was ordered along with a pain reliever containing codeine to be given as needed. No assessment of the client was done by a health care professional after discharge from the hospital.

The client was cared for at the residential facility by staff persons who were assigned to make sure the client did not remove the drainage tube. Both of the medications were given at the most frequent intervals indicated on the prescription, and many times the maximum dosage was given. The client became increasingly sedated over the next two days.

Three days after surgery the client was taken to the hospital unresponsive with aspiration pneumonia and an overdose of codeine and the sedative. The client was initially on life support but the client's condition worsened and life support was withdrawn resulting in the death of the client.