

**Pasero Opioid-induced Sedation Scale
(POSS)
and
Sedation Precautions
for
Net Access**

**Clinical Informatics
March 2016**

What is POSS?

- An evidence based validated assessment tool
- An assessment that is specific for identifying excess (undesired) opioid-induced sedation from pain medications.
- Provides guidance to the nurse in determining whether or not it is safe to administer additional opioids (pain medications)

S	Sleeping, easy to arouse	Acceptable ; no action necessary; may increase/administer opioid dose if needed
1	Awake & alert	Acceptable ; no action necessary; may increase /administer opioid dose if needed
2	Slightly drowsy, easily aroused	Acceptable ; no action necessary; may increase / administer opioid dose if needed
3	Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable ; notify physician; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; ask patients to take deep breaths
4	Somnolent, minimal or no response to verbal and physical stimulation	Unacceptable ; stop opioid; notify physician; support respirations as needed; follow order set for decreased respiratory rate (if applicable); stay with patient . Consider code rescue or code blue if indicated.

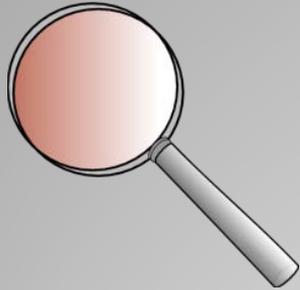
Why POSS?

- Patient safety:
 - **Opioid-induced sedation precedes respiratory depression.**
 - **Early identification of unacceptable levels of opioid-induced sedation and appropriate intervention can PREVENT opioid-related respiratory depression.**
- Meets CMS guidelines for sedation assessment for opioid administration in pain management
- Facilitates the assessment and documentation of patient's level of sedation in conjunction with pain assessment
- Guides appropriate subsequent nursing actions

When to Use POSS?

- On every pain assessment and reassessment for opioid (pain medication) administration
 - For **all** PRN opioids and also for routine opioids **if** patient is concurrently taking other opioid medications
 - Ex. Patient regularly takes Oxycodone PO BID but is now taking Dilaudid IV for breakthrough pain; therefore, all opioid medications must have POSS assessment and reassessment
- One POSS documentation needed per pain assessment form, *not* one per pain site
- **Not** to be used for intentional, directed sedation with opioids for procedures/intubation
- Note: Reassess within 30 minutes for administration of IV opioid or within 1 hour for PO opioid administration

Where is POSS located?



- POSS will be included in both the Adult and Pediatric Pain assessment tabs: admission, shift, and focused
- A summary of patient's POSS results can be viewed in eCharting, under Display → Pain

How to Use the POSS

- Ask the patient a simple question
 - “What did you eat for breakfast today?”
- Observe patient’s ability to stay awake and answer question
 - If excessively sedated, patient will have difficulty keeping eyes open and may fall asleep midsentence
- It is essential to observe patient without stimulation to ensure accurate evaluation
 - Touching patient can arouse patient and give a false impression of acceptable level of sedation

How to Assess the Sleeping Patient?

- May allow a patient to sleep when receiving opioids *only if* patient demonstrates optimal respiratory status
 - determined by comprehensive respiratory assessment - respiratory depth, rate, regularity, and noisiness
- Arouse patient if unsure whether patient is sleeping normally or overly sedated
- Assess respiratory status *prior* to waking patient, as arousing patient will stimulate respirations
- Patients that are sleeping normally and have well-controlled pain will fall back to sleep after being aroused for sedation assessment

The New Pasero Opioid-induced Sedation Scale (POSS) is available in the Pain Assessment tab in Net Access.

The screenshot displays the Net Access Pain Assessment interface. At the top, there are several tabs: Admit History, Body Systems, Miscellaneous, HX/Habit, Nutrition, Education, Home/Dis, Surgical HX, Pain, and ID HX. The 'Pain' tab is selected and highlighted with a red box. Below the tabs, the 'Pain Assessment' section contains three questions with radio button options: 'Is the patient verbal?' (Yes/No), 'Does the patient currently have pain?' (Yes/No), and 'Does the patient have a history of pain lasting more than 3 months?' (Yes/No). A 'POSS Scale' button is highlighted with a red box. On the left side, there is a vertical list of body parts: Non-Verbal, Generalized, Head, Neck, Chest, Arms, Hands, Back, Abdomen, Perineum, Legs, and Feet. At the bottom, there is a status bar with a date dropdown (10/12/2015), a patient ID field (1111), and buttons for 'Update/Pending', 'Update/Complete', 'Clear / Return', and 'Cancel'. A checkbox for 'RN Review' is also present.

Click on the **POSS Scale** button to access the assessment. (Use only when a patient is receiving Opioid medications for pain.)

Accessing the POSS Scale

Complete the POSS Assessment and follow the indicated action(s).

HEENT	Neuro	Card/Masc	Resp	GI	GU / Repro	Mus/Skl	Psyc/Soc	Integ	Pain
Safety	IV/Lines	Tube/Drn	Nutrition						

Pasero Opioid-Induced Sedation Scale (POSS)

Level	State	
<input type="radio"/> 0	Sleeping, easy to arouse	Acceptable; no action necessary, may increase opioid dose if needed
<input checked="" type="radio"/> 1	Awake and alert	Acceptable; no action necessary, may increase opioid dose if needed
<input type="radio"/> 2	Slightly drowsy, easily aroused	Acceptable; no action necessary, may increase opioid dose if needed
<input type="radio"/> 3	Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory, notify prescriber
<input type="radio"/> 4	Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable; stop opioid; consider administering naloxone; notify prescriber or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

POSS Score Total:

Reassessment

Level	State	
<input type="radio"/> 0	Sleeping, easy to arouse	Acceptable; no action necessary, may increase opioid dose if needed
<input type="radio"/> 1	Awake and alert	Acceptable; no action necessary, may increase opioid dose if needed
<input type="radio"/> 2	Slightly drowsy, easily aroused	Acceptable; no action necessary, may increase opioid dose if needed
<input type="radio"/> 3	Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory, notify prescriber

RN Review RNE007 EILEEN E. OXAMENDI RN

1/11/2016 0953

Documentation of the POSS Assessment

When reassessing pain, complete the POSS Reassessment and follow the indicated action(s).

HEENT	Neuro	Card/Vasc	Resp	GI	GU / Repro	Mus/Skl	Psyc/Soc	Integ	Pain
Safety	IV/Lines	Tube/Drm	Nutrition						

4 Somnolent, minimal or no response to verbal or physical stimulation Unacceptable; stop opioid, consider administering naloxone, notify prescriber or anesthesiologist, monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

POSS Score Total:

Reassessment 

[Level](#) [State](#)

0 Sleeping, easy to arouse Acceptable; no action necessary.

1 Awake and alert Acceptable; no action necessary.

2 Slightly drowsy, easily aroused Acceptable; no action necessary.

3 Frequently drowsy, arousable, drifts off to sleep during conversation Unacceptable; monitor respiratory status and sedation level closely, and sedation level is stable at less than 3 and respiratory status is satisfactory, notify prescriber.

4 Somnolent, minimal or no response to verbal or physical stimulation Unacceptable; stop opioid, consider administering naloxone, notify prescriber or anesthesiologist, monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

POSS Reassessment Score Total:

RN Review RNE007 EILEEN E. OXAMENDI RN

1/11/2016 0953

To complete POSS reassessment, First click the **POSS Scale** button, Then click the **reassessment checkbox** to activate the reassessment radio buttons for selection of appropriate score.

Documentation of the POSS Reassessment

To view the Pasero Opioid-induced Sedation Scale (POSS) results, click on **eCharting, Display, Pain** and then look for the results for the **Date** and **Time** that are to be reviewed.

Rm/Bed: 060901

PAIN-HISTORY (Up to 16 latest results)

All Graph

	2016 27 Jan 12:27	2016 27 Jan 12:14	2016 27 Jan 11:30
<input type="checkbox"/> IS THE PATIENT VERBAL	Yes	Yes	Yes
<input type="checkbox"/> HISTORY OF CHRONIC PAIN			
<input type="checkbox"/> PATIENT CURRENTLY HAS PAIN	Yes	Yes	Yes
<input type="checkbox"/> PASERO OPIOID-INDUCED SED SCALE	S	1	S
<input type="checkbox"/> PASERO OPIOID-INDUCED SED REASMT	Yes	Yes	Yes
<input type="checkbox"/> PASERO OPIOID-INDUCED SED RA SCL	2	2	1
<input type="checkbox"/> RN REVIEW	Yes	Yes	Yes

Viewing POSS Results

Screenshot of POSS in Essentris

PAIN EVALUATION				
Pain Intensity				2
Pain Location				LoAb
Behav/Physio Cues				V
Pain Scale Used				N
Acceptable Level of Pain				5
Quality of Pain				C
Pain Pattern				I
Provoked By				C
Interventions				CB RP R
Post-Intervention				U
POSS Score	<input type="text" value="1"/>			1
POSS Reassessment	1 - Sleep, easy to arouse (S) 2 - Awake and Alert (Acceptable; may increase opioid dose if needed) (1) 3 - Slightly drowsy, easily aroused (Acceptable; may increase opioid dose if needed) (2) 4 - Frequently drowsy, arousable, drifts off to sleep during conversation (Monitor closely until POSS less than 3; reduce opioid dose; notify prescriber) (3) 5 - Somnolent, minimal or no response to verbal or physical stimulation (Unacceptable; stop opioid; call Code Rescue; support respiration) (4)			
Side Effects				
Sedation Level 2				
LINES				
Peripheral IV Type			PIV	P



Screenshot of POSS in T-System

Scores and screens: Pasero Opioid-induced Sedation Scale

TRIAGE: Head / Face Injury 1512

triage time: historical: pt family PCP: notified
arrived: prt vehicle EMS with: family friend

vitals: BP / HR
sepsis screen: Alert
GCS
RTS
visual acuity

scores / screens

SCORES / SCREENS

Glasgow Coma Score: _____
pediatric: >5yr 2-5yr <2yr

Revised Trauma Score: _____
Pediatric Trauma Score: _____

breathalyzer: _____

pupillary exam: _____
visual acuity: _____

pulse exam: _____
FHTs: _____

NIHSS swallow screen: _____
Cincinnati Stroke Scale: _____
Simplified Geneva Score: _____
Richmond Agitation Scale: _____
Ramsey Scale: _____ Modified Ramsey: _____
Aldrete: _____

Pasero Opioid-induced Sedation Scale:

Snake Bite Severity: _____

past history problem list ... previous surg: none _____
negative unknown tetanus: UTD >5 unk _____
diabetes heart dz other imm: UTD unk _____
HTN lung dz LNMP preg: yes / no _____

social history family history
smoker never amk self harm assess _____
ETOH drugs fall assess: no risk _____
infect dz expo: no nutritional assess: no deficits _____
reports abuse more: functional assess: no impairment _____
learning needs assess: no barriers _____
skin integrity risk assess: no risk _____

PASERO OPIOID-INDUCED SEDATION SCALE (POSS)

S	sleep easy to arouse
1	awake alert
2	slightly drowsy easily aroused
3	frequently drowsy arousable drifts off to sleep during conversation
4	somnolent minimal or no response to verbal and physical stimulation

C. Pasero. Assessment of Sedation During Opioid Administration for Pain Management. 24 Journal of PeriAnesthesia Nursing 158-160 (June 2009)

Sedation Precautions

- Identifying patients at high risk for excess opioid-induced sedation, initiating precautions, and communicating this risk are essential nurse functions to reduce the chance and/or occurrence of opioid-induced respiratory depression



Identify: Who is at HIGH risk?

- Opioid naïve patients
- All post operative patients
- Patients with diagnosed sleep apnea
- Morbidly obese patients, BMI > 35 kg/m²

- AND/OR -

- Any patient identified by MD to be at higher risk for sedation due to medical conditions (ie. respiratory, renal, hepatic insufficiency)

Initiate: Sedation Precautions

- Initiate sedation precautions for all patients meeting ANY one of the high risk criteria
- Add precaution for "Sedation Precautions" in Patient Factors Screen (PFS)

Precautions Yes No

Prec #1 ASPIRATION RISK

Prec #2 **SEDATION PRECAUTIONS**

Prec #3

Prec #4

Prec #5

Prec #6

Active Orders

Discontinue

Cancel Diet

Cancel Occurrence

Renew

Revise

No Orders Approaching Expiration

CLINICAL ALERTS

45	PRECAUTIONS- ASPIRATION RISK	ORD 03/04
46	PRECAUTIONS- SEDATION PRECAUTIONS	ORD 03/04

ADT

42	ADMIT DIAGNOSIS WRITTEN BY MD SICK	ORD 11/06
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PATIENT CARE ORDERS

44	SEDATION PRECAUTIONS DAILY	ORD 03/01
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RN Interventions for Sedation Precautions

- Start with lowest effective opioid dose ordered
- Assess sedation prior to and following administration of opioid analgesics (POSS)
- Intervene as indicated based on sedation scale (POSS)
- Observe/monitor for desaturation or apneic episodes
- Monitor for hypercarbia (if EtCO₂ monitoring is ordered)
- Place patient in semi-upright position (if not contraindicated)
- Use supplemental oxygen if indicated/ordered
- Make sure “sedation precautions” is on patient’s white board
- Communicate risk with patient, family, and/or staff

Communicate: Sedation Risk

- White Board → place “sedation precautions” magnet or write words “sedation precautions” on board



Sedation precautions

- Explain to patient and family that sedation precautions is a preventative safety measure; educate on signs to look for and when to call nurse
- Communicate sedation risk during hand-off report for careful, appropriate monitoring of excessive sedation

Thank you