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

Clinical Informatics
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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.

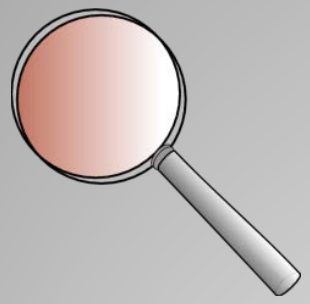
Why POSS?

- 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

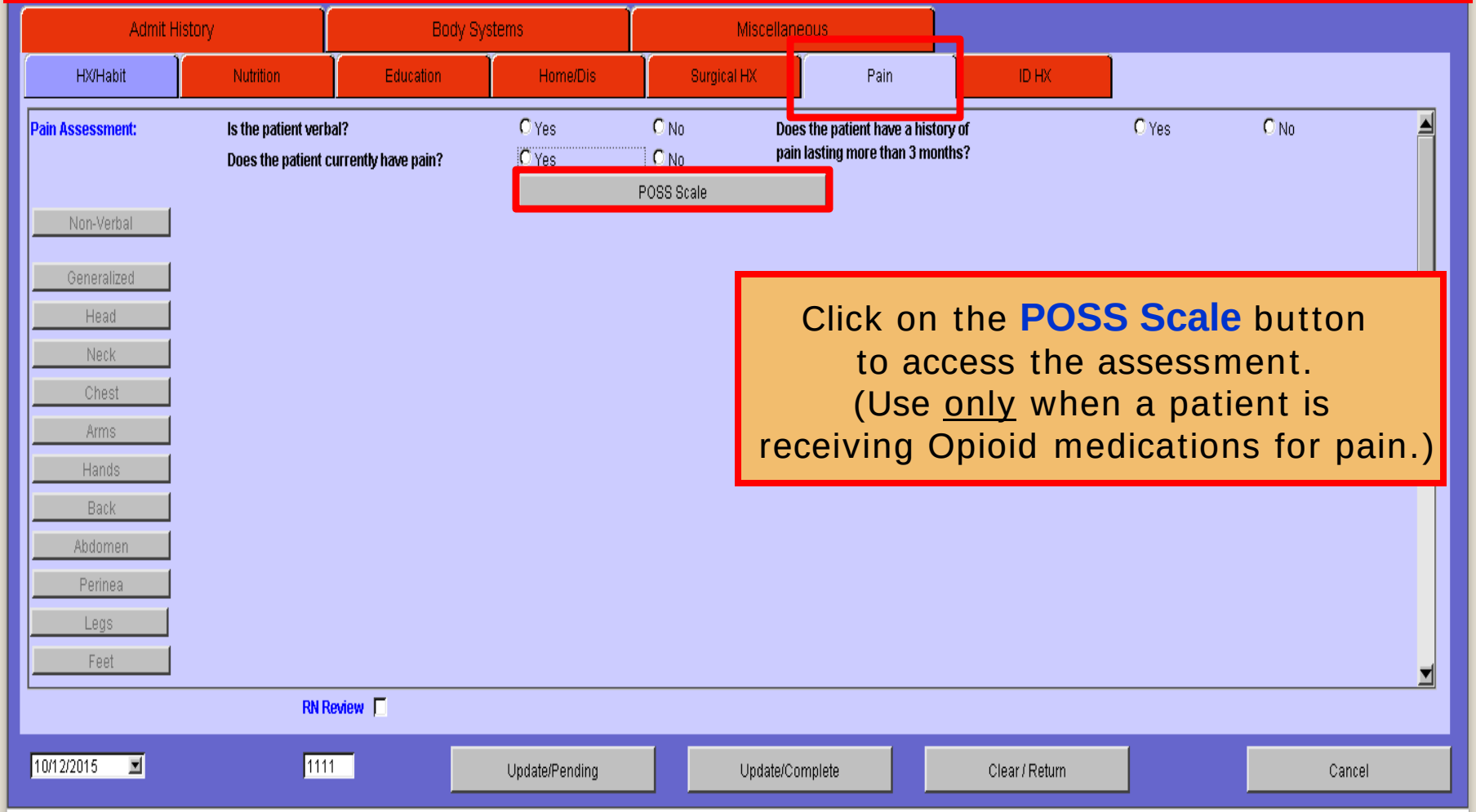
How to Use the POSS

- 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.



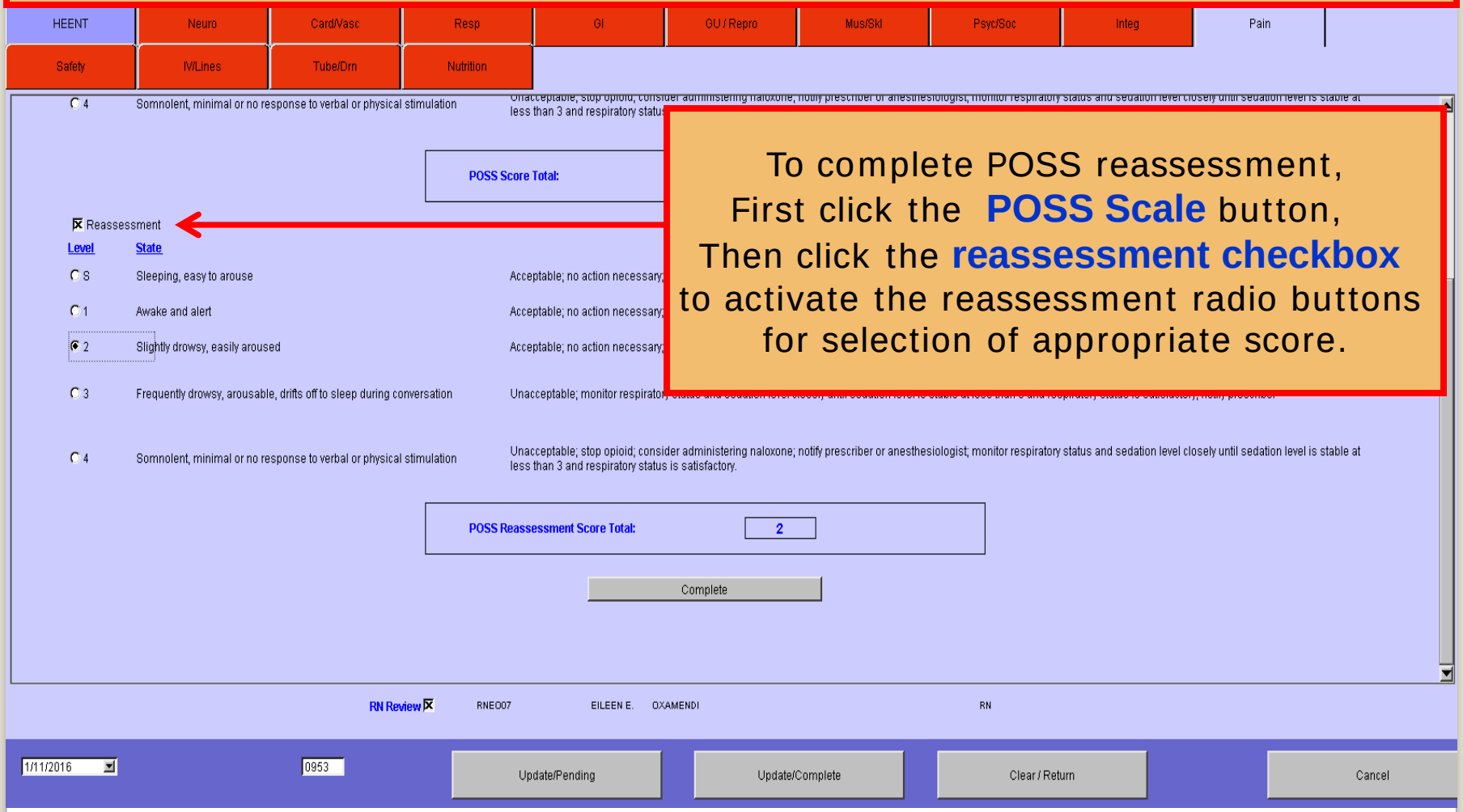
Click on the **POSS Scale** button to access the assessment. (Use only when a patient is receiving Opioid medications for pain.)

Accessing the POSS Scale

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

Documentation of the POSS Assessment

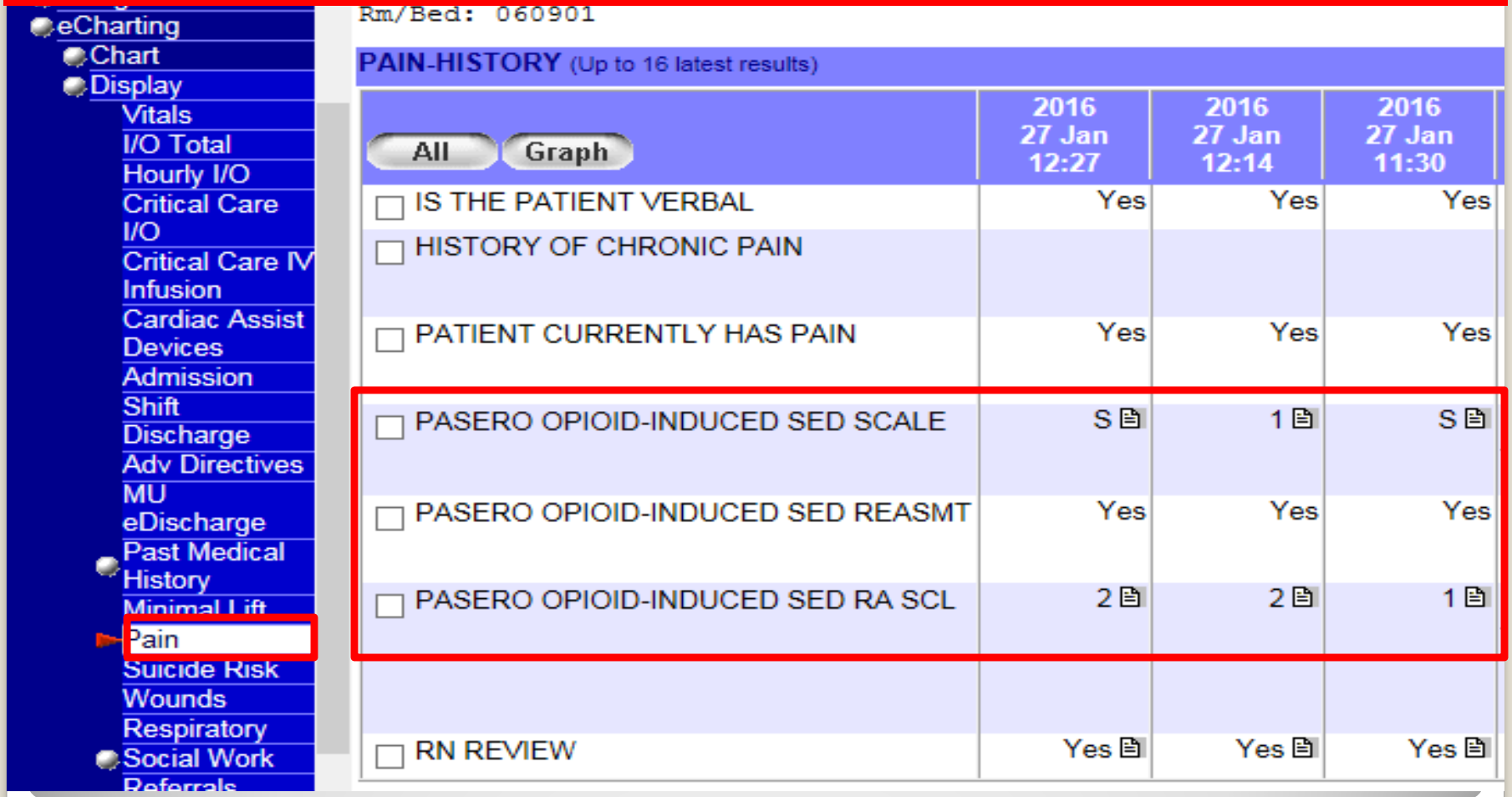
When reassessing pain, complete the POSS Reassessment and follow the indicated action(s).



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.

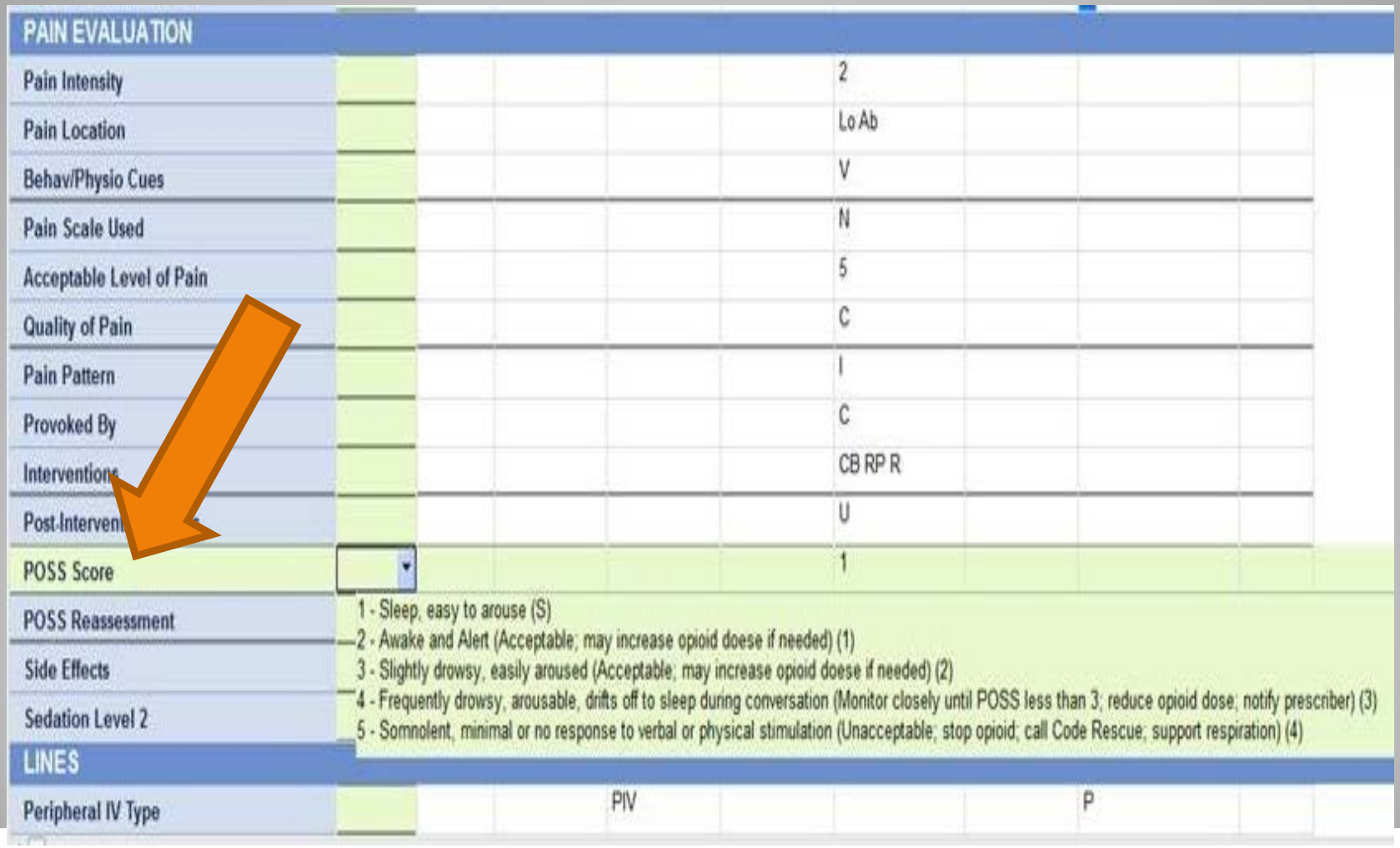
Documentation of the POSS Reassessment

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.



Viewing POSS Results

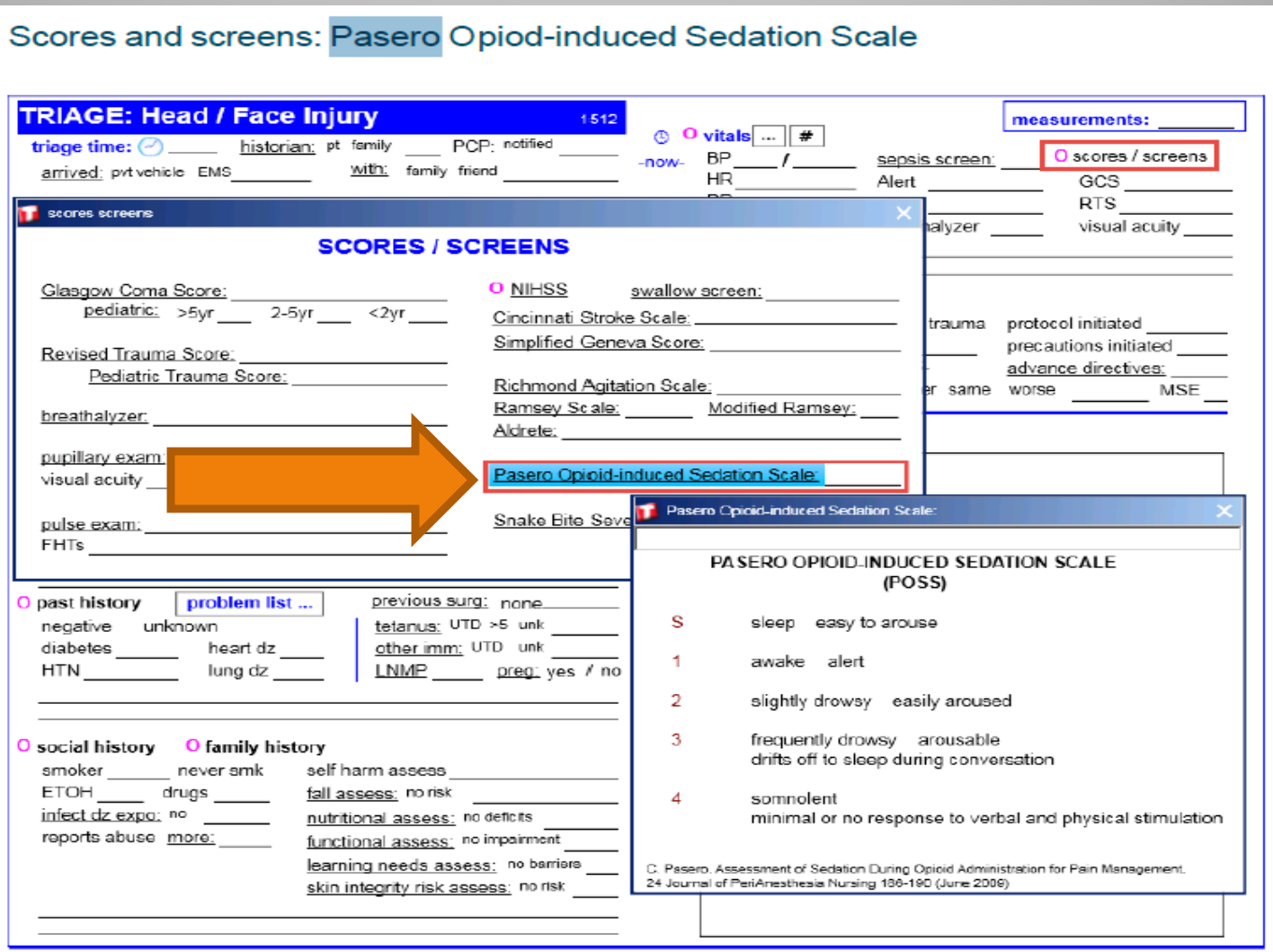
Screenshot of POSS in Essentris



PAIN EVALUATION									
Pain Intensity					2				
Pain Location					Lo Ab				
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-Interven					U				
POSS Score					1				
POSS Reassessment									
Side Effects									
Sedation Level 2									
LINES									
Peripheral IV Type			PIV			P			

1 - Sleep, easy to arouse (S)
2 - Awake and Alert (Acceptable; may increase opioid doese if needed) (1)
3 - Slightly drowsy, easily aroused (Acceptable; may increase opioid doese 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)

Screenshot of POSS in T-System



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/m^2

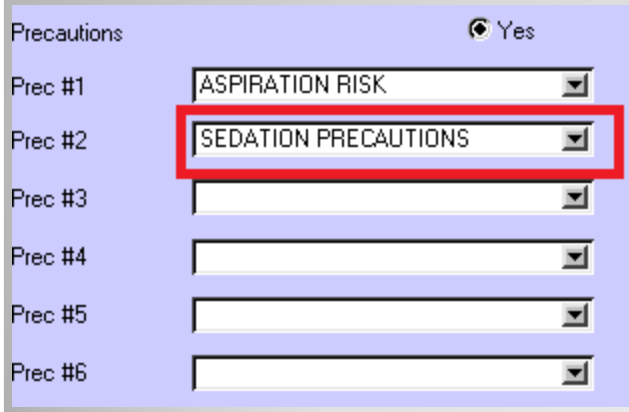
- AND/OR -

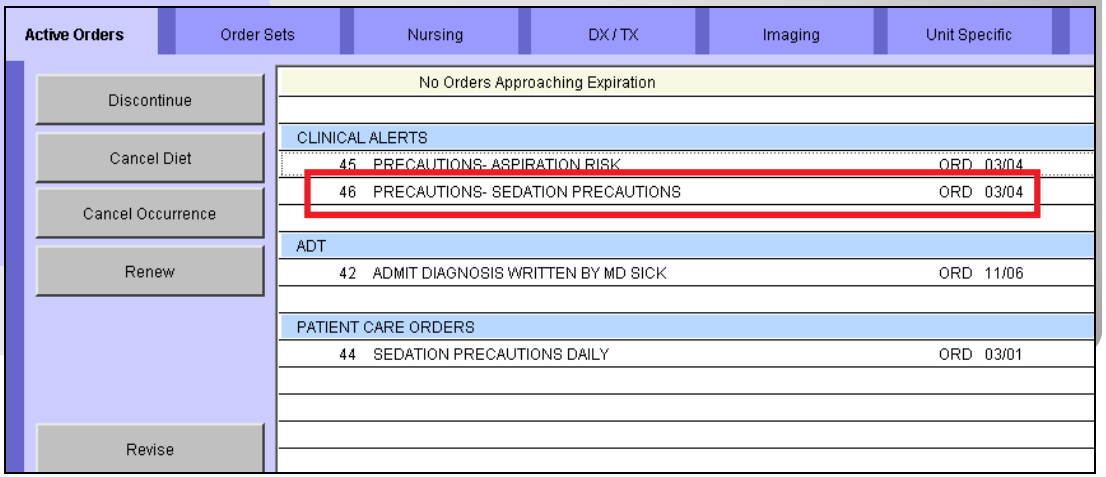
- Any patient identified by MD to be at higher risk for sedation due to medical conditions (ie. respiratory, renal, hepatic insufficiency)

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)





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

- 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