Pasero Opioid-Induced Sedation Scale (POSS) for Soarian

and

Sedation Precautions

Education

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?

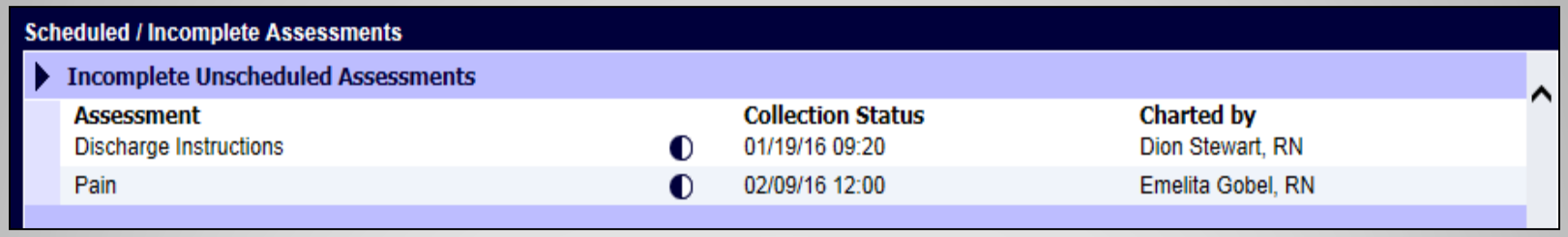
- Patient safety:
  - **Opioid-induced sedation precedes respiratory depression**.
  - **Early identification of unacceptable levels of opioid-induced sedation and appropriate intervention can PREVENT opioid-related respiratory depression**.
- Meets CMS guidelines for sedation assessment for opioid administration 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 analgesia (pain medication) administration
  - For **all** PRN opioids
  - For **all** opioids via IV PCA
  - For routine opioids **if** patient is concurrently taking other opioid medications
    - Example: Patient regularly takes Oxycodone PO BID but is now taking Dilaudid IV for breakthrough pain; therefore, **all** opioid medications administered 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, rectal and subcutaneous opioid administration

Where is POSS located?

- POSS will be included in both the Adult and Pediatric Pain assessment tabs: admission, shift, and incomplete unscheduled pain assessment



- A summary of patient's POSS results can be viewed in Patient Record, under Nursing Documentation → Pain

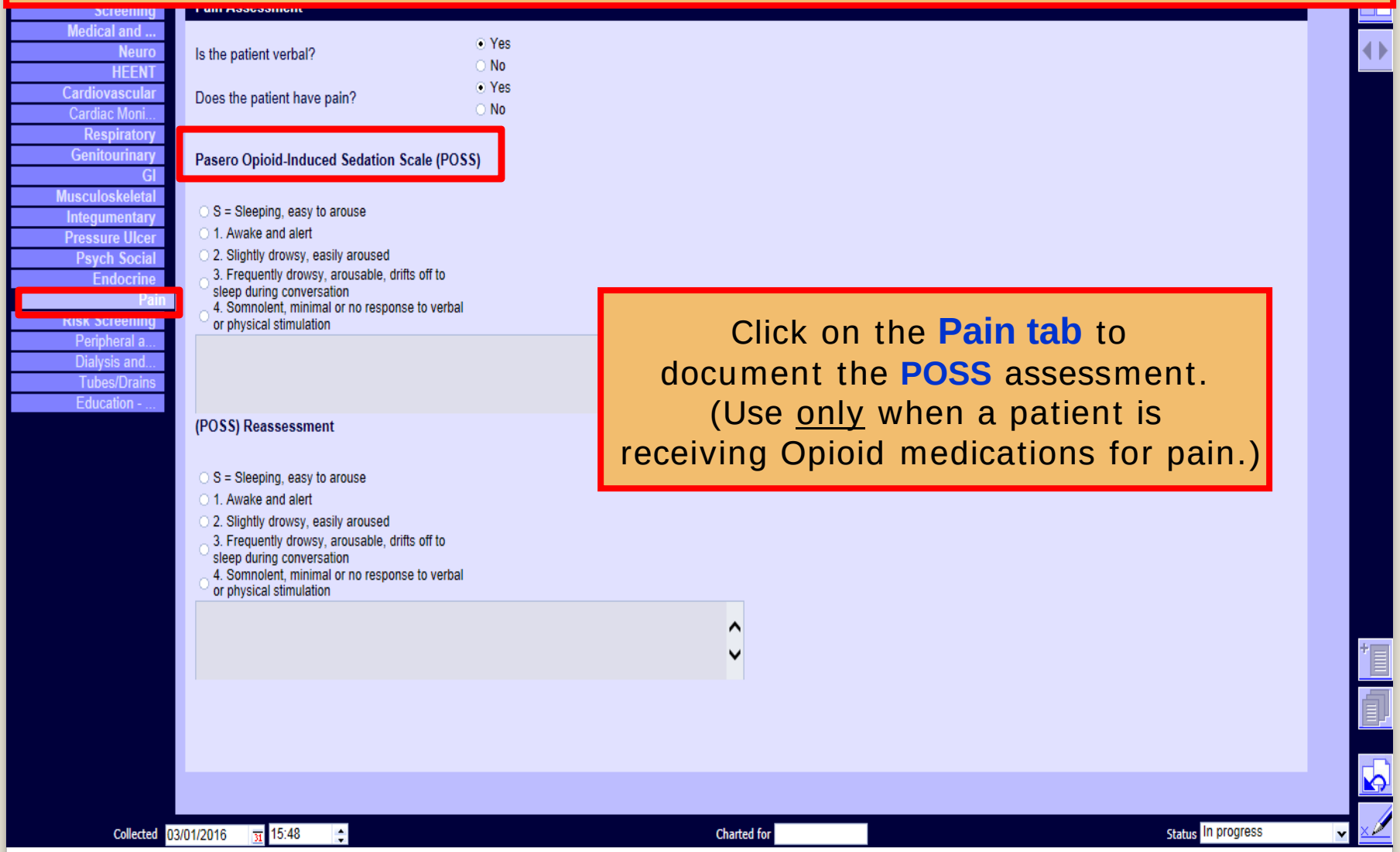
How to Use the POSS

- 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

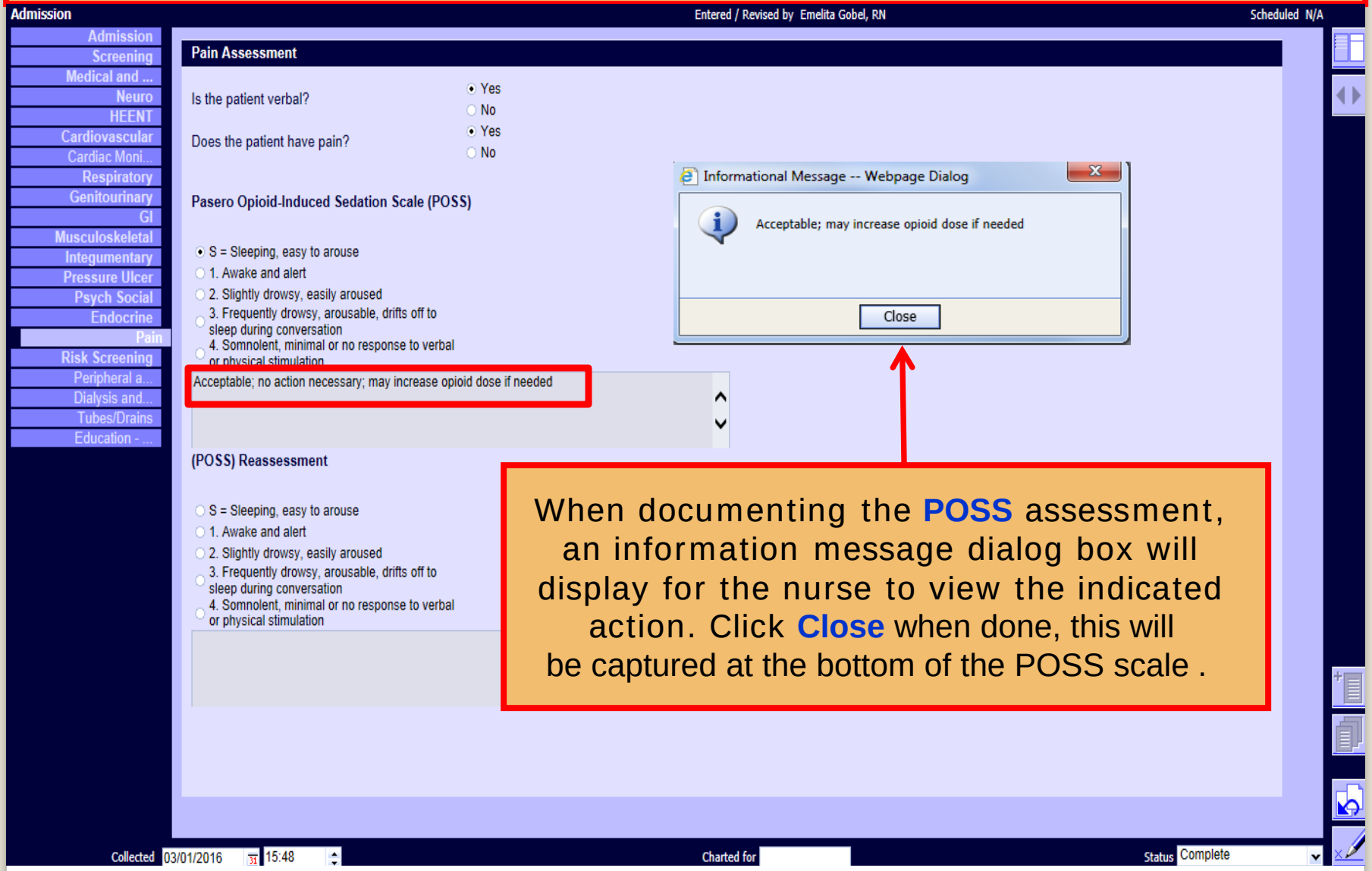
The New Pasero Opioid-induced Sedation Scale (POSS) is available in the Pain Assessment tab



Click on the **Pain tab** to document the **POSS** assessment. (Use <u>only</u> when a patient is receiving Opioid medications for pain.)

Accessing the POSS Scale

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



When documenting the **POSS** assessment, an information message dialog box will display for the nurse to view the indicated action. Click **Close** when done, this will be captured at the bottom of the POSS scale .

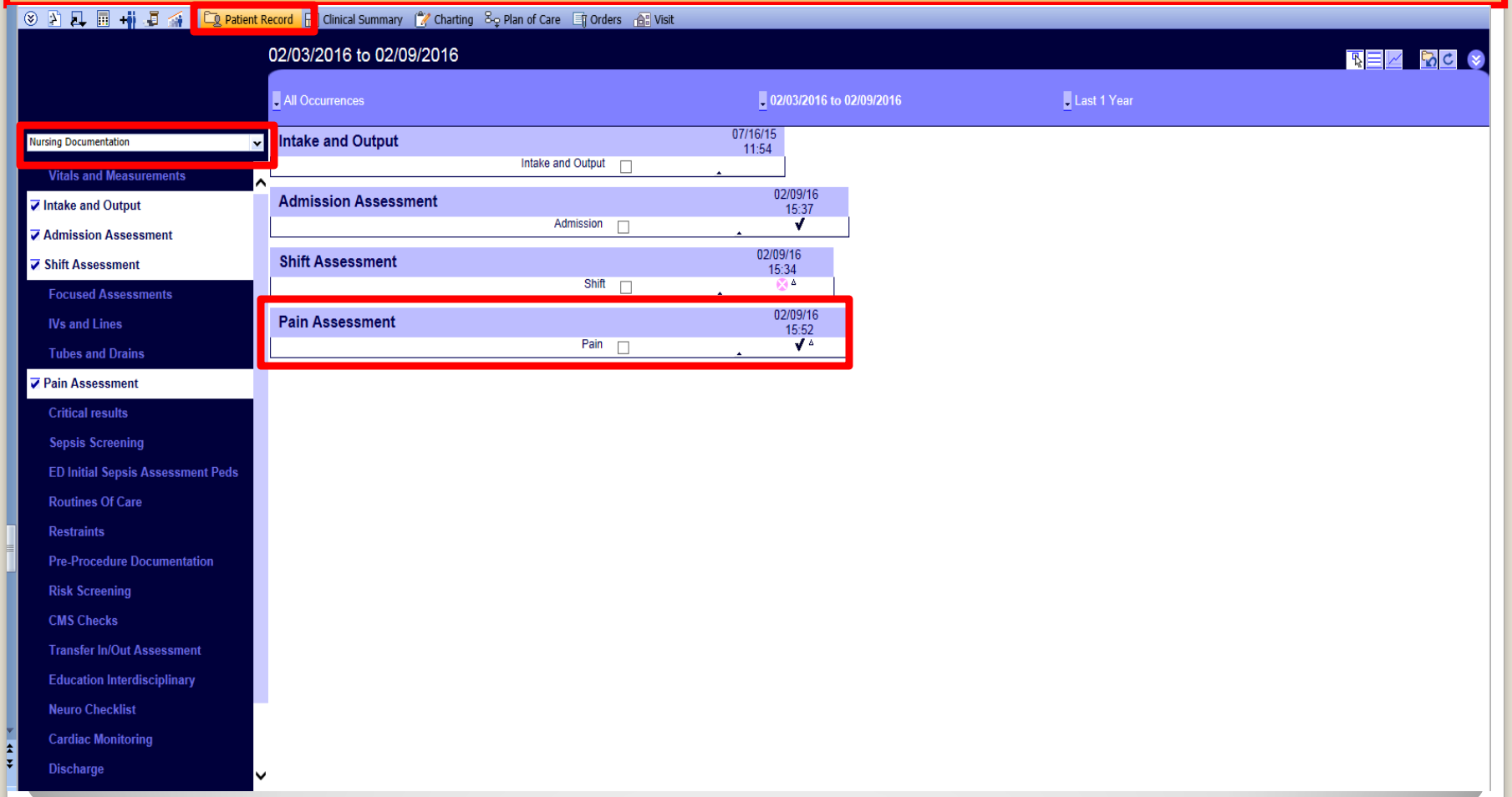
Documentation of the POSS Assessment

The POSS reassessment will be available in the **Incomplete Unscheduled Assessment** section.

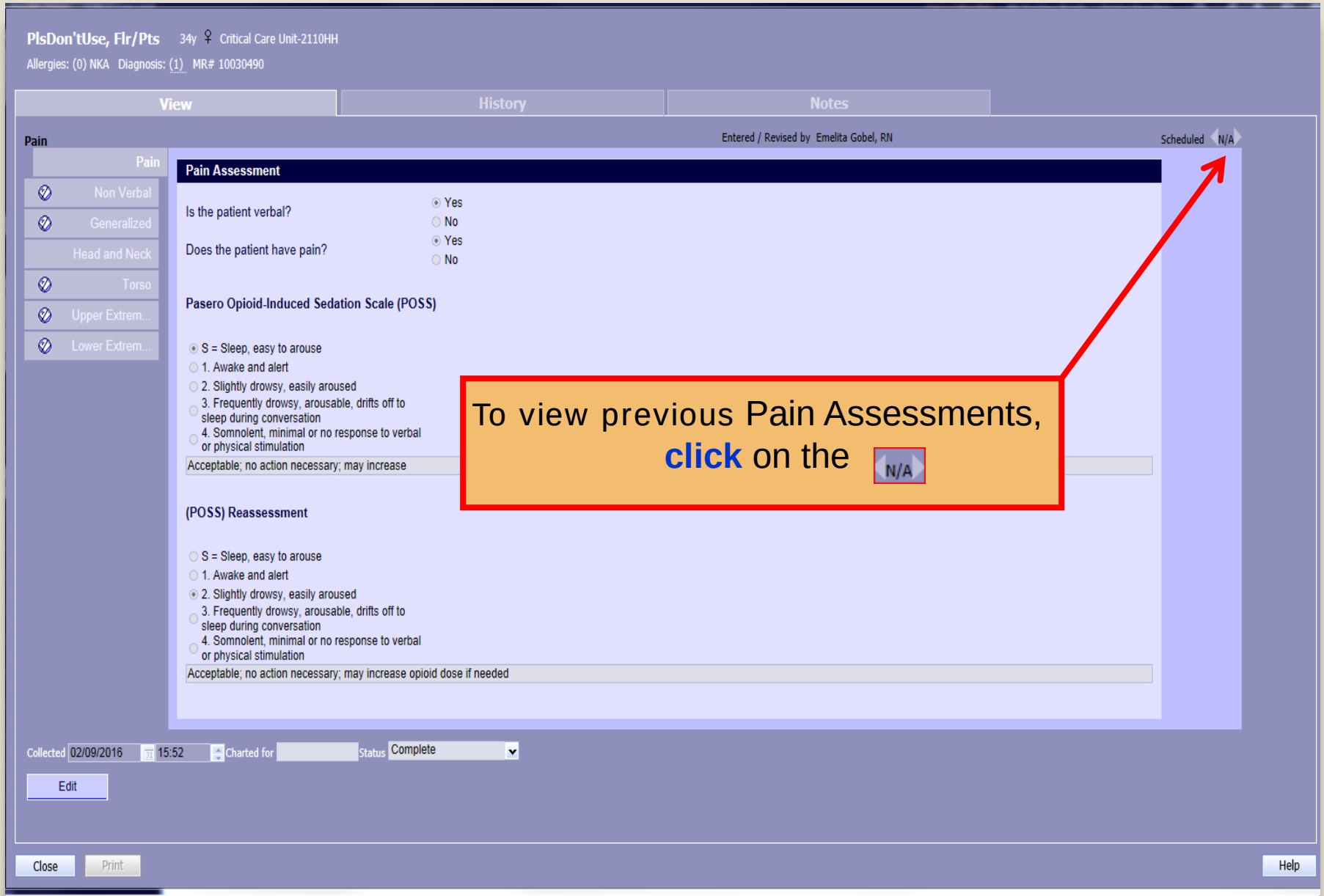
Select the icon for pain. Complete the POSS Reassessment and follow the indicated action (s) and complete pain reassessment

Documentation of the POSS Reassessment

To view the Pasero Opioid-induced Sedation Scale (POSS) results, click on the **Patient Record tab**, select **Nursing Documentation** from the dropdown list. Click on Pain Assessment for the **Date** and **Time** that are to be reviewed.



Accessing POSS Results



Viewing POSS Results

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
- Post operative patients, especially thoracic or abdominal
- Patients with diagnosed sleep apnea
- Morbidly obese patients, BMI > 35 kg/m^2
- Elderly patients, age 65 and older
- Patients also receiving other sedating drugs (ie. benzodiazepines, sleeping aides, or antiemetics)
- Patients with acute or chronic respiratory conditions
- Patients with impaired renal or hepatic function

Initiate: Sedation Precautions

- **Initiate sedation precautions for all patients meeting ANY one of the high risk criteria**

- Add a Nursing order of Sedation Precautions via CPOE

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

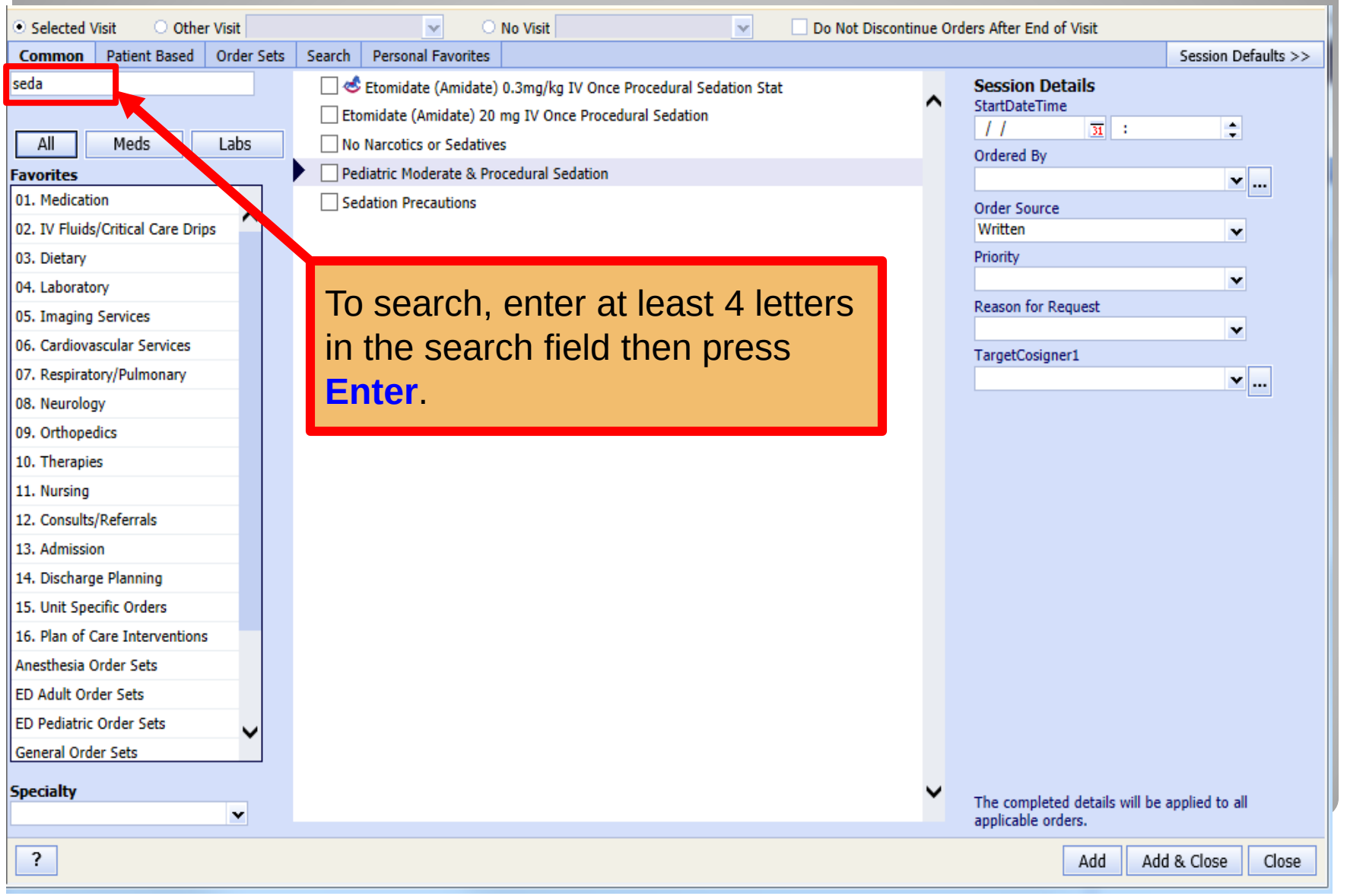
Communicate: Sedation Risk

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

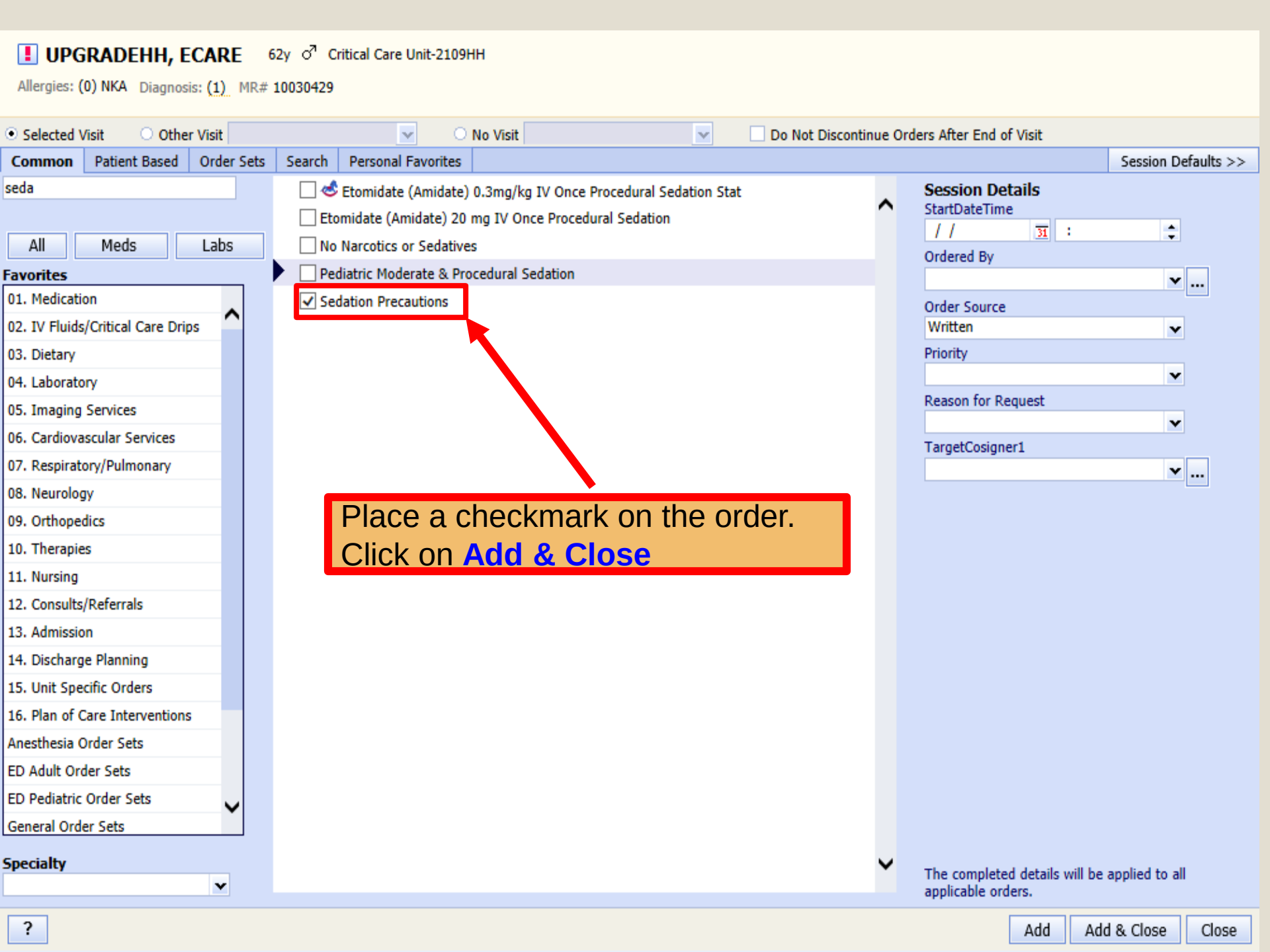
- Explain to patient and family that sedation precautions is a preventative safety measure; educate on signs to look for and when to call nurse

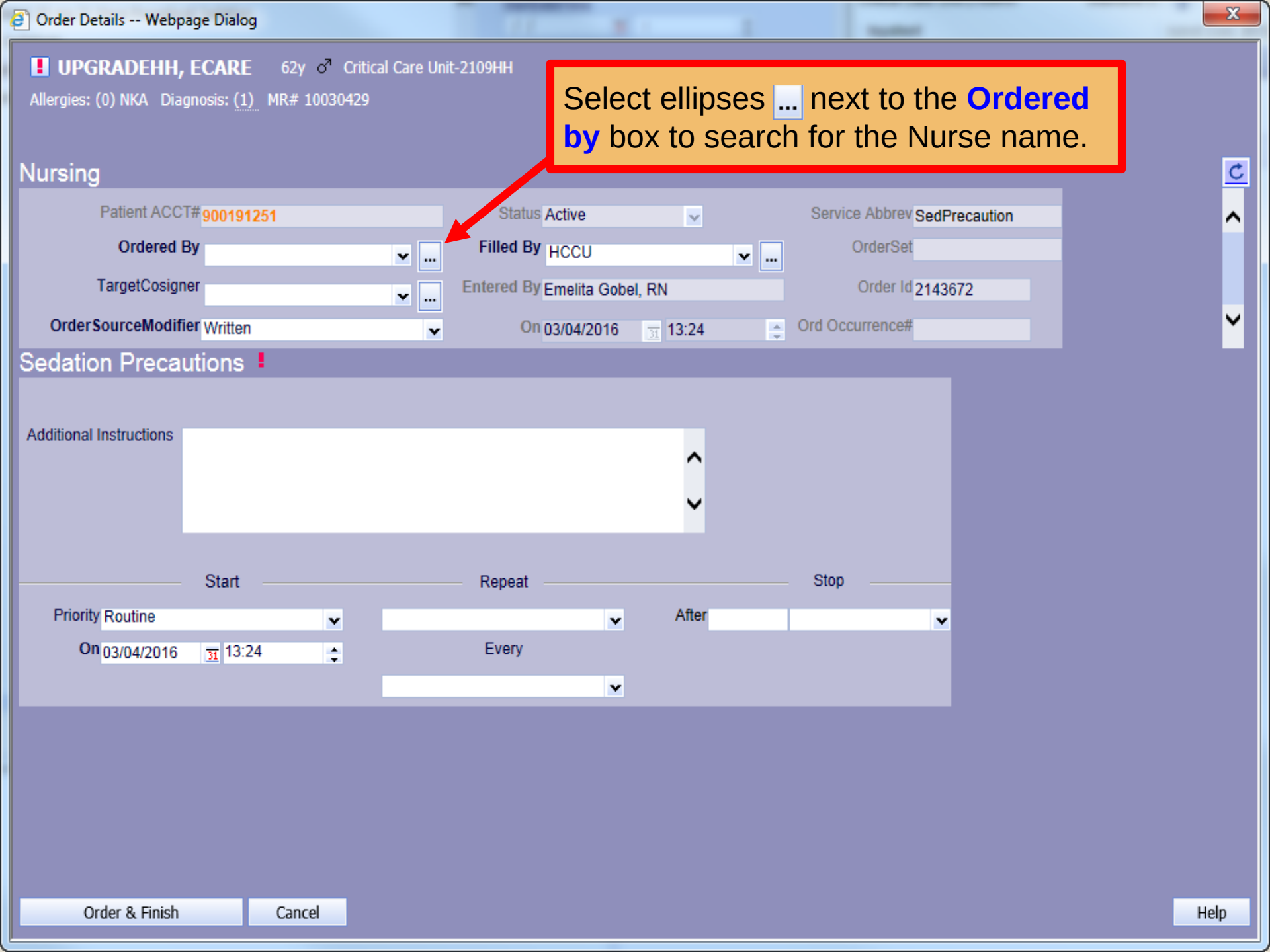
- Communicate sedation risk during hand-off report for careful, appropriate monitoring of excessive sedation

Entering a Nursing order – Sedation Precautions



To search, enter at least 4 letters in the search field then press **Enter**.


UPGRADEHH, ECARE 62y ♂ Critical Care Unit-2109HH
Allergies: (0) NKA Diagnosis: (1) MR# 10030429
Selected Visit
Other Visit
No Visit
Do Not Discontinue Orders After End of Visit
Common
Patient Based
Order Sets
Search
Personal Favorites
Session Defaults >>
seda
All
Meds
Labs
Favorites
01. Medication
02. IV Fluids/Critical Care Drips
03. Dietary
04. Laboratory
05. Imaging Services
06. Cardiovascular Services
07. Respiratory/Pulmonary
08. Neurology
09. Orthopedics
10. Therapies
11. Nursing
12. Consults/Referrals
13. Admission
14. Discharge Planning
15. Unit Specific Orders
16. Plan of Care Interventions
Anesthesia Order Sets
ED Adult Order Sets
ED Pediatric Order Sets
General Order Sets
Specialty
Etomidate (Amidate) 0.3mg/kg IV Once Procedural Sedation Stat
Etomidate (Amidate) 20 mg IV Once Procedural Sedation
No Narcotics or Sedatives
Pediatric Moderate & Procedural Sedation
Sedation Precautions
Session Details
StartDateTime
Ordered By
Order Source
Written
Priority
Reason for Request
TargetCosigner1
Place a checkmark on the order.
Click on Add & Close
The completed details will be applied to all applicable orders.
?
Add
Add & Close
Close


Order Details -- Webpage Dialog
UPGRADEHH, ECARE 62y ♂ Critical Care Unit-2109HH
Allergies: (0) NKA Diagnosis: (1) MR# 10030429
Select ellipses ... next to the Ordered by box to search for the Nurse name.
Nursing
Patient ACCT# 900191251
Status Active
Service Abbrev SedPrecaution
Ordered By
Filled By HCCU
OrderSet
TargetCosigner
Entered By Emelita Gobel, RN
Order Id 2143672
OrderSourceModifier Written
On 03/04/2016 13:24
Ord Occurrence#
Sedation Precautions
Additional Instructions
Start
Repeat
Stop
Priority Routine
After
On 03/04/2016 13:24
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Order & Finish
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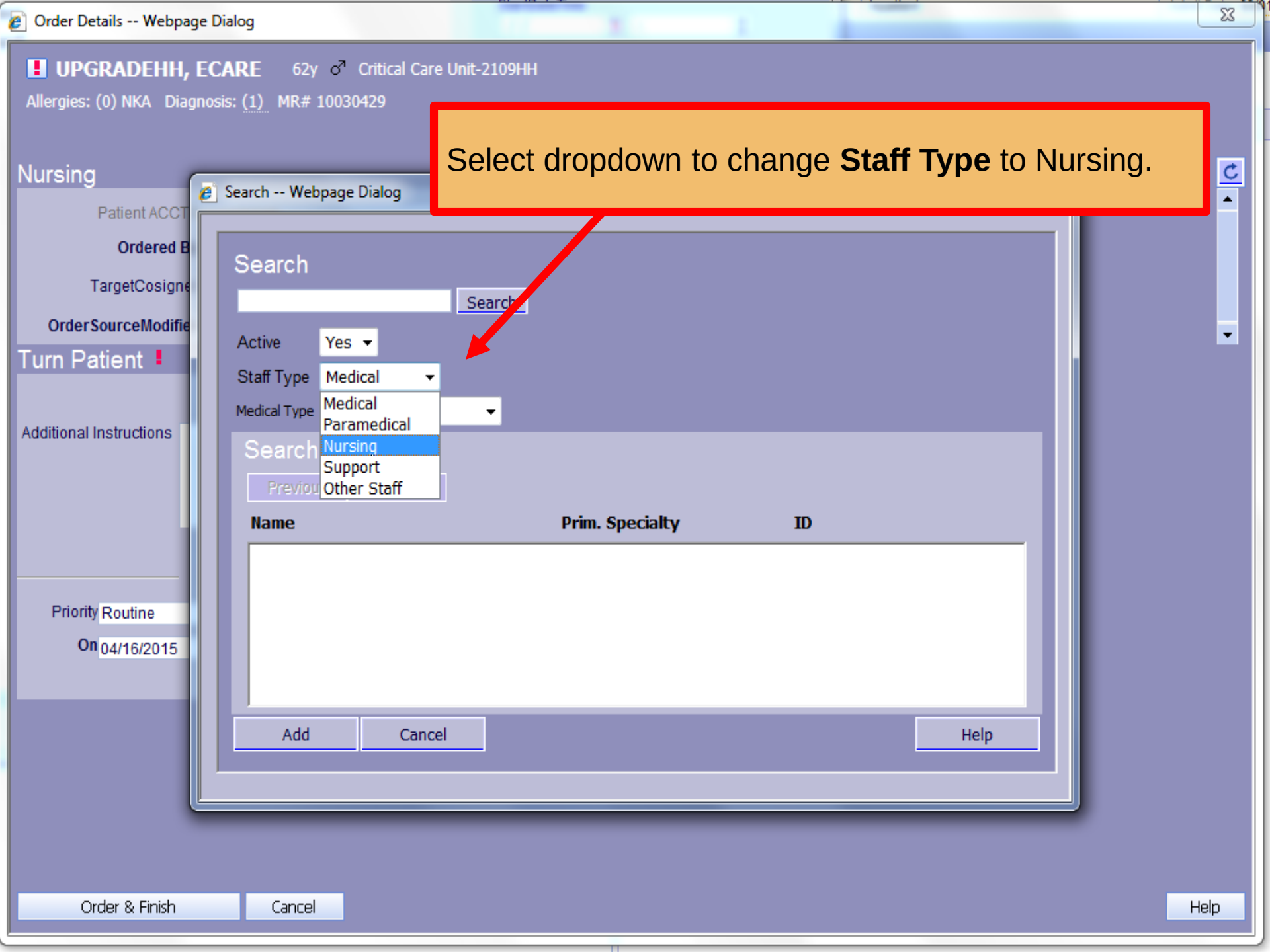
Help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Select dropdown to change Staff Type to Nursing.
Search -- Webpage Dialog
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Other Staff
Search
Name
Prim. Specialty
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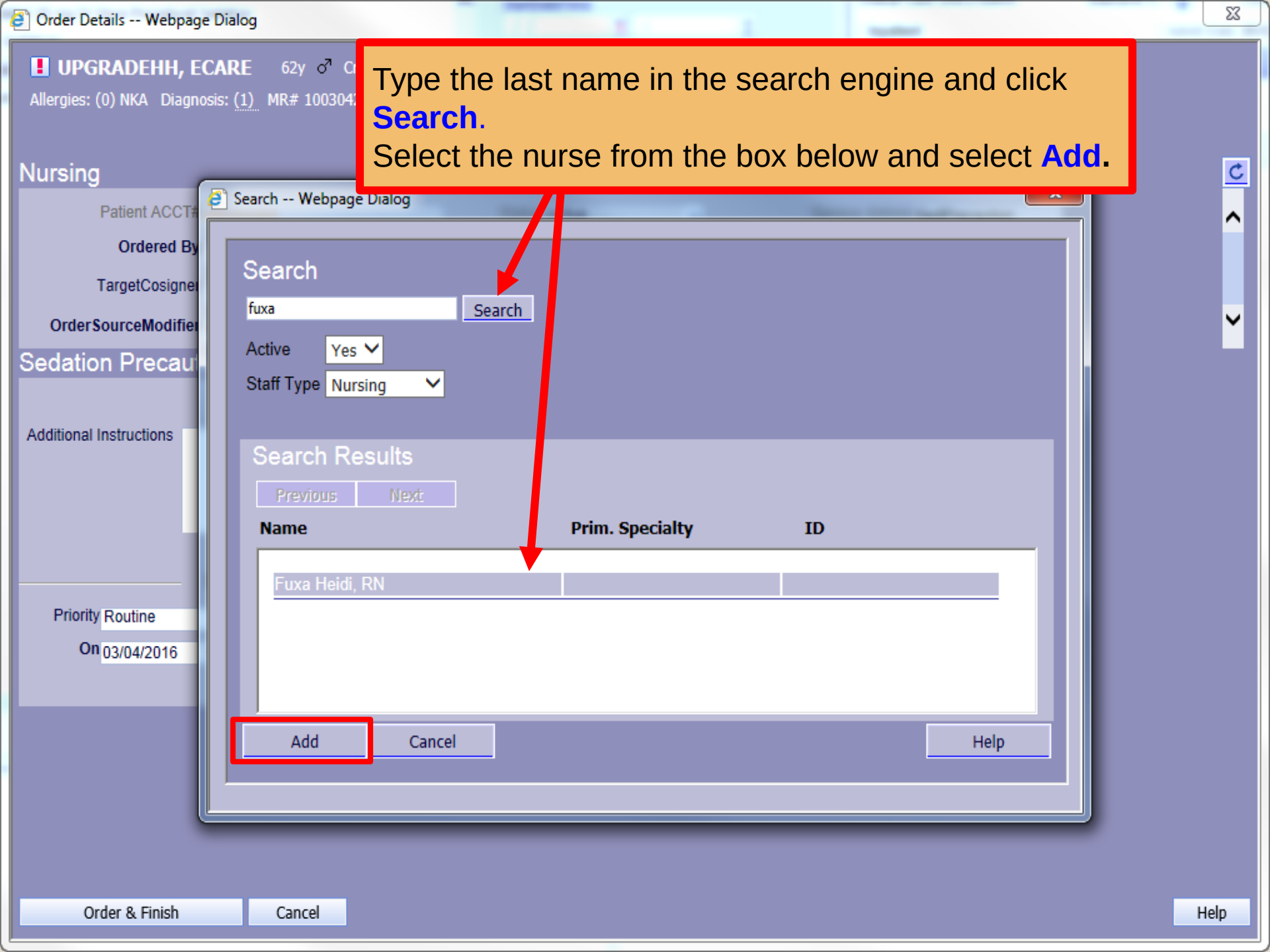
Order Details -- Webpage Dialog
UPGRADEHH, ECARE
Allergies: (0) NKA
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Sedation Precau
Additional Instructions
Priority Routine
On 03/04/2016
Order & Finish
Cancel
Help
Type the last name in the search engine and click Search.
Select the nurse from the box below and select Add.
Search -- Webpage Dialog
Search
fuxa
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Search Results
Previous
Next
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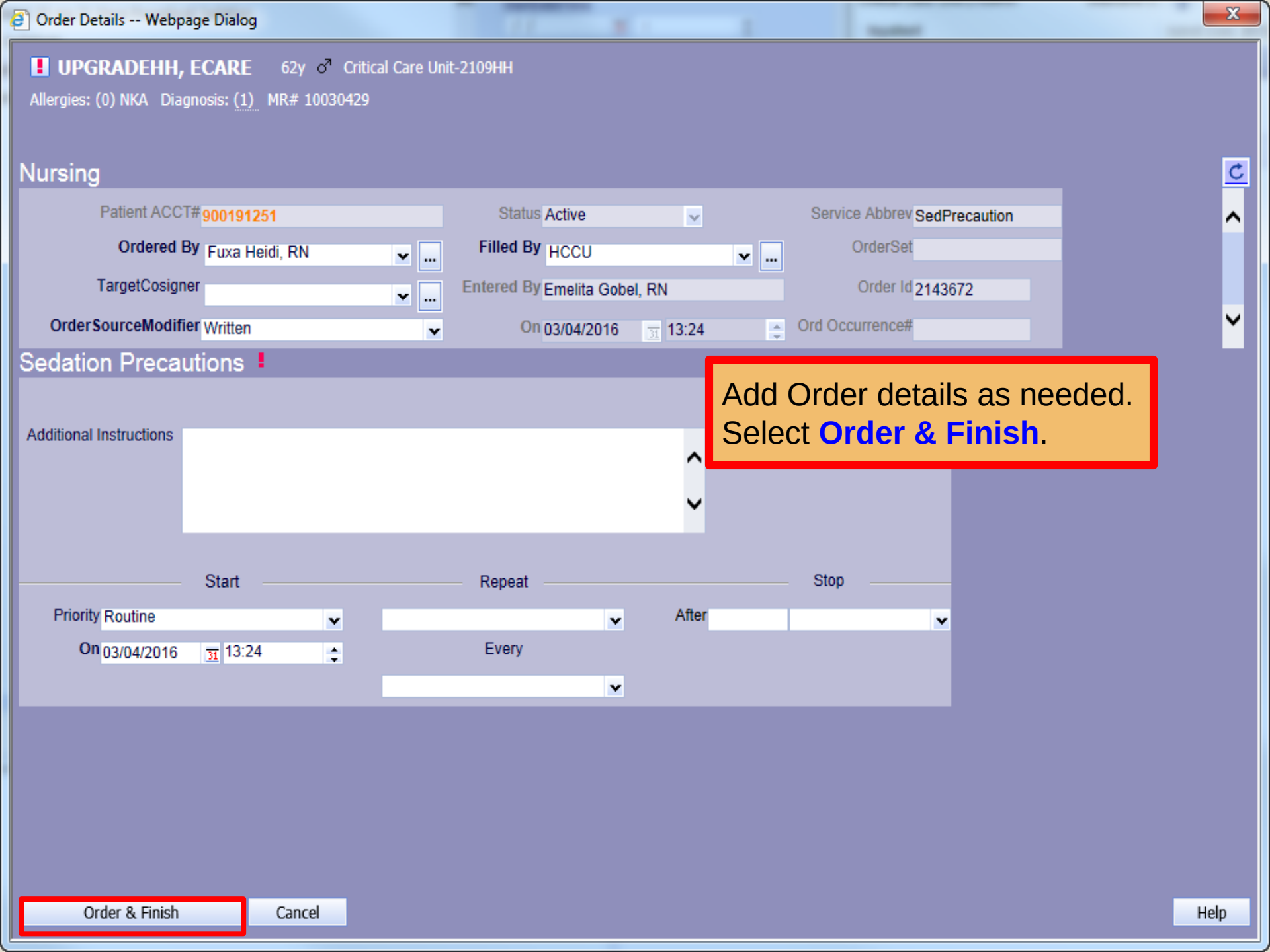
Help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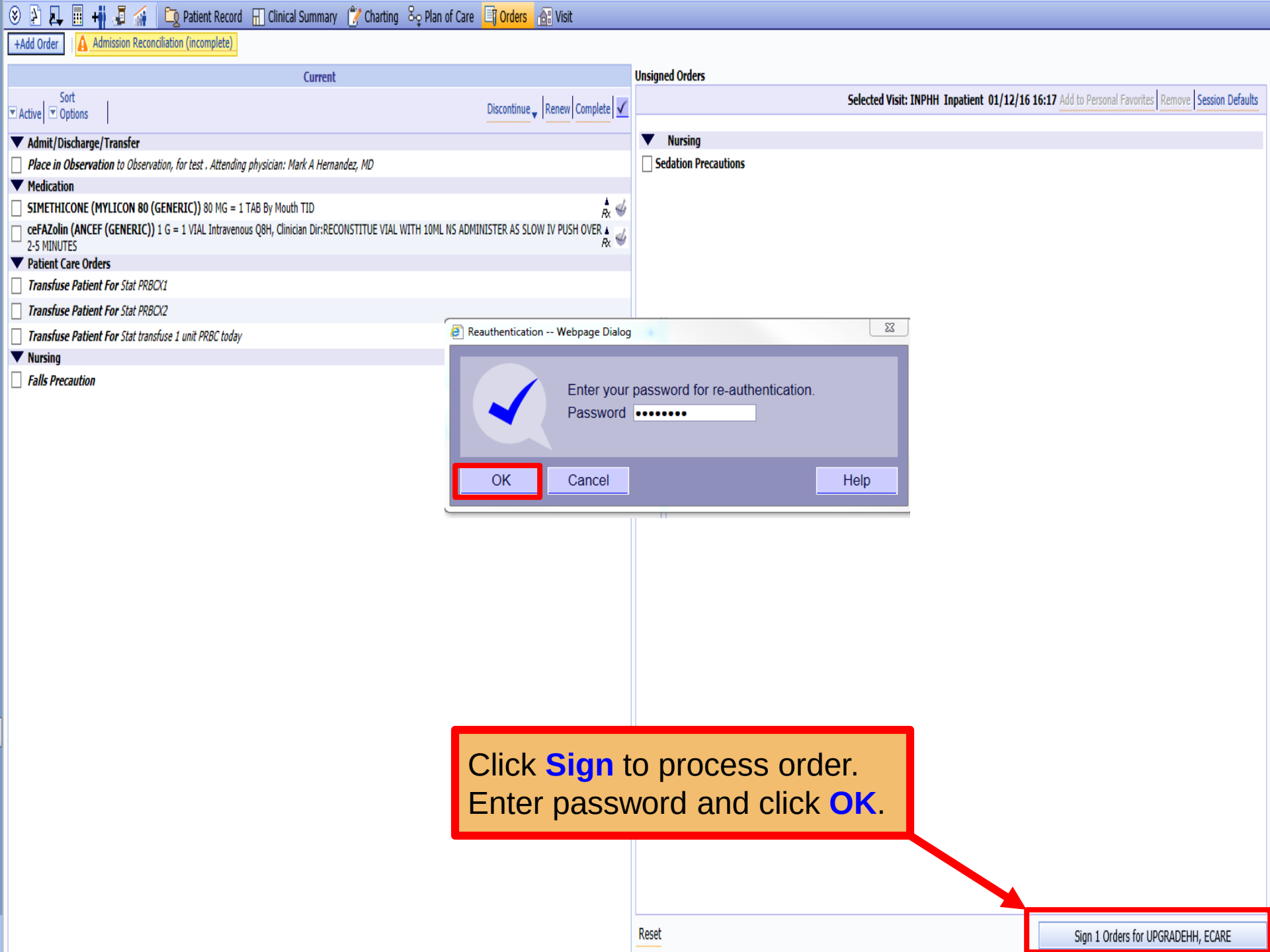
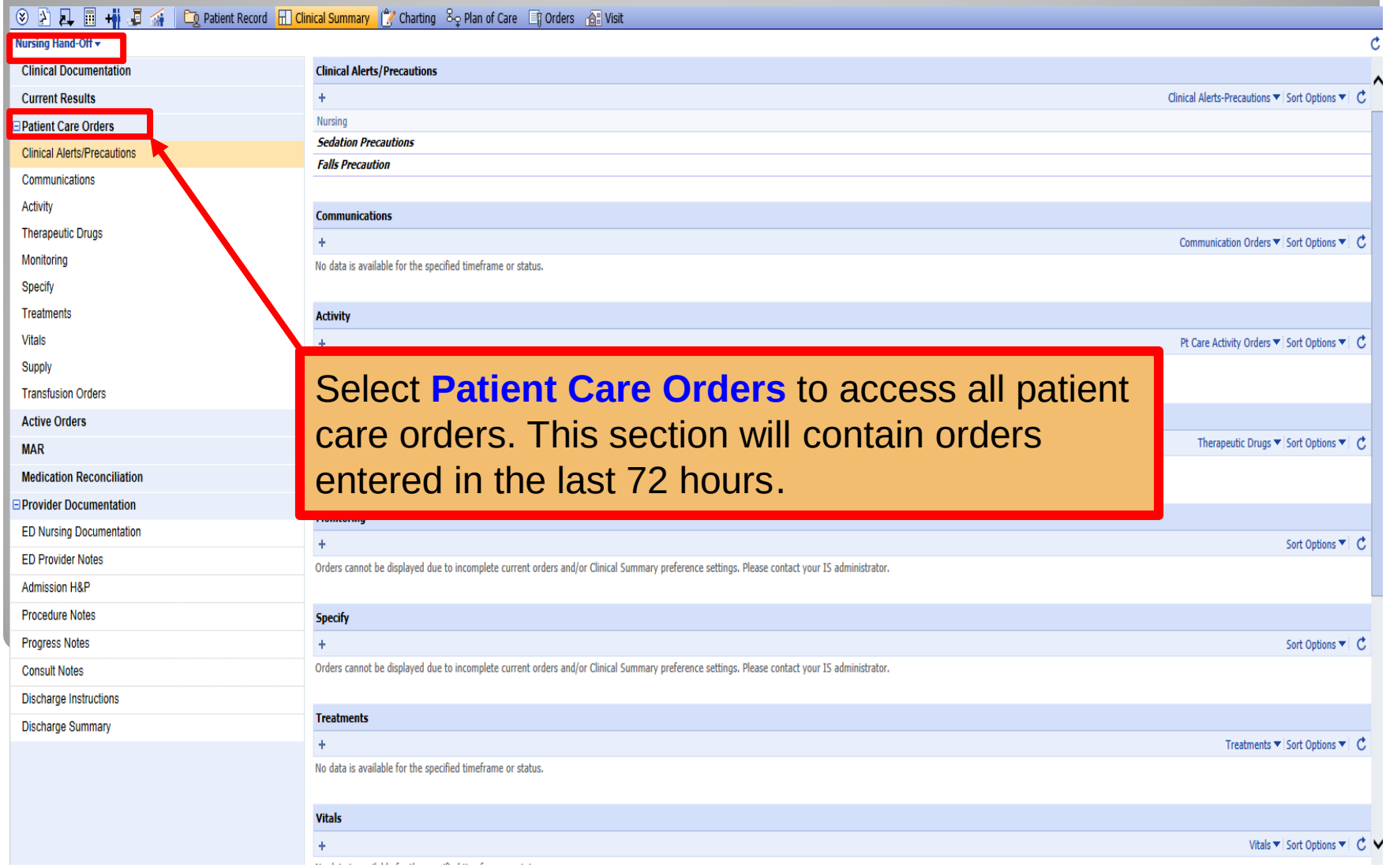
UPGRADEHH, ECARE 62y ♂ Critical Care Unit-2109HH
Allergies: (0) NKA Diagnosis: (1) MR# 10030429
Nursing
Patient ACCT# 900191251
Status Active
Service Abbrev SedPrecaution
Ordered By Fuxa Heidi, RN
Filled By HCCU
OrderSet
TargetCosigner
Entered By Emelita Gobel, RN
Order Id 2143672
OrderSourceModifier Written
On 03/04/2016 13:24
Ord Occurrence#
Sedation Precautions
Additional Instructions
Add Order details as needed.
Select Order & Finish.
Start
Repeat
Stop
Priority Routine
After
On 03/04/2016 13:24
Every
Order & Finish
Cancel
Help


Patient Record
Clinical Summary
Charting
Plan of Care
Orders
Visit
+Add Order
Admission Reconciliation (incomplete)
Current
Sort
Active
Options
Discontinue
Renew
Complete
Admit/Discharge/Transfer
Place in Observation to Observation, for test . Attending physician: Mark A Hernandez, MD
Medication
SIMETHICONE (MYLICON 80 (GENERIC)) 80 MG = 1 TAB By Mouth TID
ceFAZolin (ANCEF (GENERIC)) 1 G = 1 VIAL Intravenous Q8H, Clinician Dir:RECONSTITUE VIAL WITH 10ML NS ADMINISTER AS SLOW IV PUSH OVER 2-5 MINUTES
Patient Care Orders
Transfuse Patient For Stat PRBCX1
Transfuse Patient For Stat PRBCX2
Transfuse Patient For Stat transfuse 1 unit PRBC today
Nursing
Falls Precaution
Unsigned Orders
Selected Visit: INPHH Inpatient 01/12/16 16:17
Add to Personal Favorites
Remove
Session Defaults
Nursing
Sedation Precautions
Reauthentication -- Webpage Dialog
Enter your password for re-authentication.
Password
OK
Cancel
Help
Click Sign to process order.
Enter password and click OK.
Reset
Sign 1 Orders for UPGRADEHH, ECARE

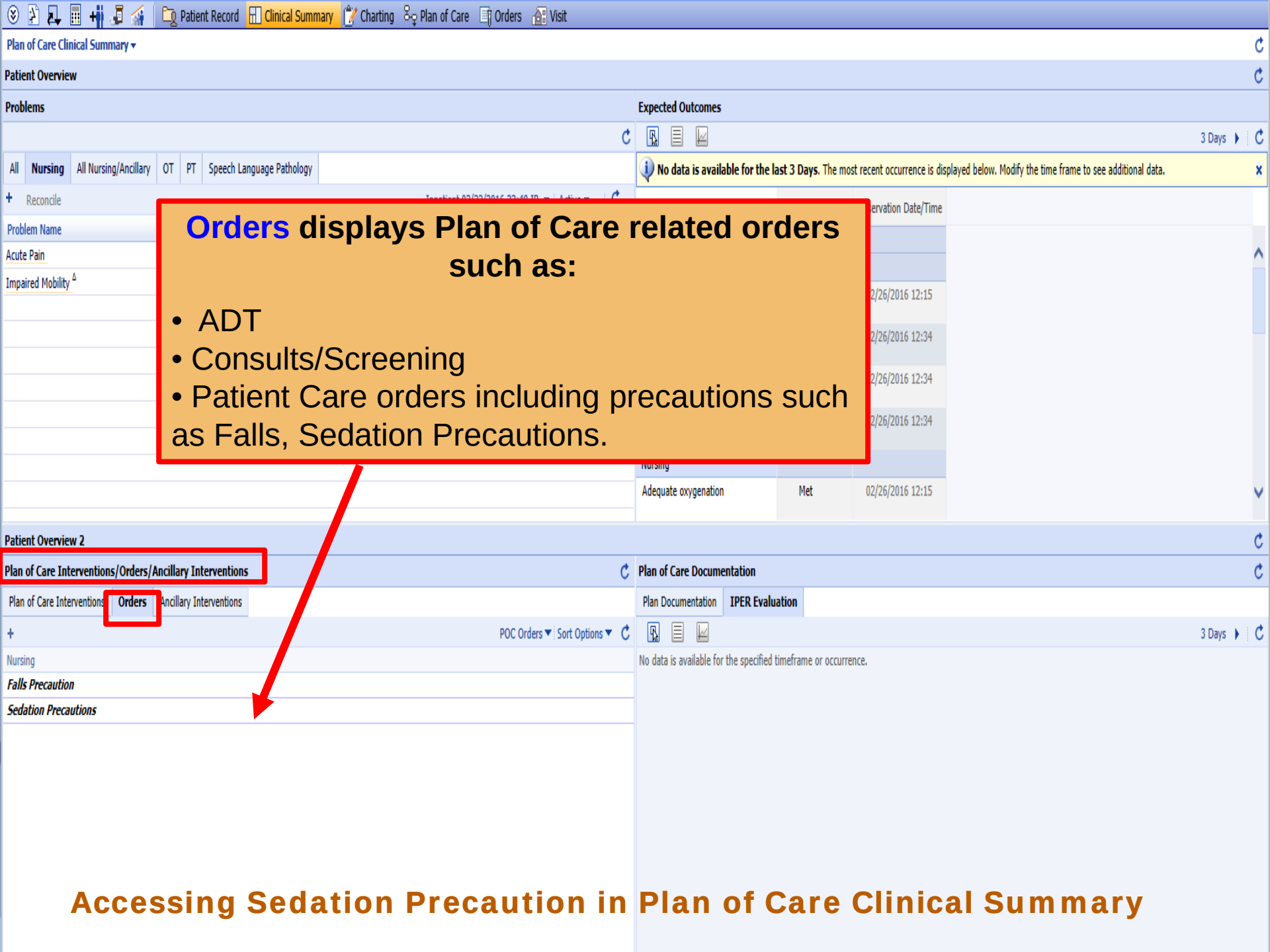
Clinical Summary – select Nursing Hand Off



Accessing Sedation Precaution orders in Clinical Summary

Clinical Summary - select Plan of Care Clinical Summary

Select **Plan of Care Clinical Summary** from dropdown.



Accessing Sedation Precaution in Plan of Care Clinical Summary

Thank you