

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)

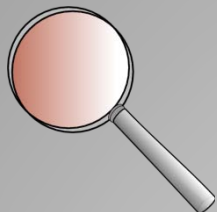
S	Sleeping, easy to arouse	Acceptable ; no action necessary; may increase/administer opioid dose if needed
1	Awake & alert	Acceptable ; no action necessary; may increase /administer opioid dose if needed
2	Slightly drowsy, easily aroused	Acceptable ; no action necessary; may increase / administer opioid 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

Scheduled / Incomplete Assessments		
▶ Incomplete Unscheduled Assessments		
Assessment	Collection Status	Charted by
Discharge Instructions	01/19/16 09:20	Dion Stewart, RN
Pain	02/09/16 12:00	Emelita Gobel, RN

- 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

The screenshot displays a software interface for clinical assessment. On the left is a vertical navigation menu with various tabs: Screening, Medical and Neuro, HEENT, Cardiovascular, Cardiac Moni..., Respiratory, Genitourinary, GI, Musculoskeletal, Integumentary, Pressure Ulcer, Psych Social, Endocrine, Pain, Risk Screening, Peripheral a..., Dialysis and..., Tubes/Drains, and Education. The 'Pain' tab is highlighted with a red box. The main content area is titled 'Full Assessment' and contains two questions: 'Is the patient verbal?' with radio buttons for 'Yes' (selected) and 'No', and 'Does the patient have pain?' with radio buttons for 'Yes' (selected) and 'No'. Below these is the 'Pasero Opioid-Induced Sedation Scale (POSS)', which is also highlighted with a red box. The scale options are: 'S = Sleeping, easy to arouse', '1. Awake and alert', '2. Slightly drowsy, easily aroused', '3. Frequently drowsy, arousable, drifts off to sleep during conversation', and '4. Somnolent, minimal or no response to verbal or physical stimulation'. Below the scale is a section for '(POSS) Reassessment' with the same options. A large text box on the right contains instructions: 'Click on the **Pain tab** to document the **POSS** assessment. (Use only when a patient is receiving Opioid medications for pain.)'. At the bottom of the interface, there is a status bar with 'Collected 03/01/2016 15:48', 'Charted for', and 'Status In progress'.

Accessing the POSS Scale

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

Admission Entered / Revised by Emelita Gobel, RN Scheduled N/A

Admission
Screening
Medical and ...
Neuro
HEENT
Cardiovascular
Cardiac Moni...
Respiratory
Genitourinary
GI
Musculoskeletal
Integumentary
Pressure Ulcer
Psych Social
Endocrine
Pain
Risk Screening
Peripheral a...
Dialysis and...
Tubes/Drains
Education -...

Pain Assessment

Is the patient verbal? Yes No
Does the patient have pain? Yes No

Pasero Opioid-Induced Sedation Scale (POSS)

S = Sleeping, easy to arouse
 1. Awake and alert
 2. Slightly drowsy, easily aroused
 3. Frequently drowsy, arousable, drifts off to sleep during conversation
 4. Somnolent, minimal or no response to verbal or physical stimulation

Acceptable; no action necessary; may increase opioid dose if needed

(POSS) Reassessment

S = Sleeping, easy to arouse
 1. Awake and alert
 2. Slightly drowsy, easily aroused
 3. Frequently drowsy, arousable, drifts off to sleep during conversation
 4. Somnolent, minimal or no response to verbal or physical stimulation

Informational Message -- Webpage Dialog

Acceptable; may increase opioid dose if needed


Close


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 .

Collected 03/01/2016 15:48 Charted for Status Complete

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



Scheduled / Incomplete Assessments

Incomplete Unscheduled Assessments

Assessment
Pain

Collection Status
03/01/16 15:38

Charted by
Emelita Gobel, RN

Entered / Revised by Emelita Gobel, RN

Scheduled N/A

Pain Assessment

Is the patient verbal? Yes
 No

Does the patient have pain? Yes
 No

Pasero Opioid-Induced Sedation Scale (POSS)

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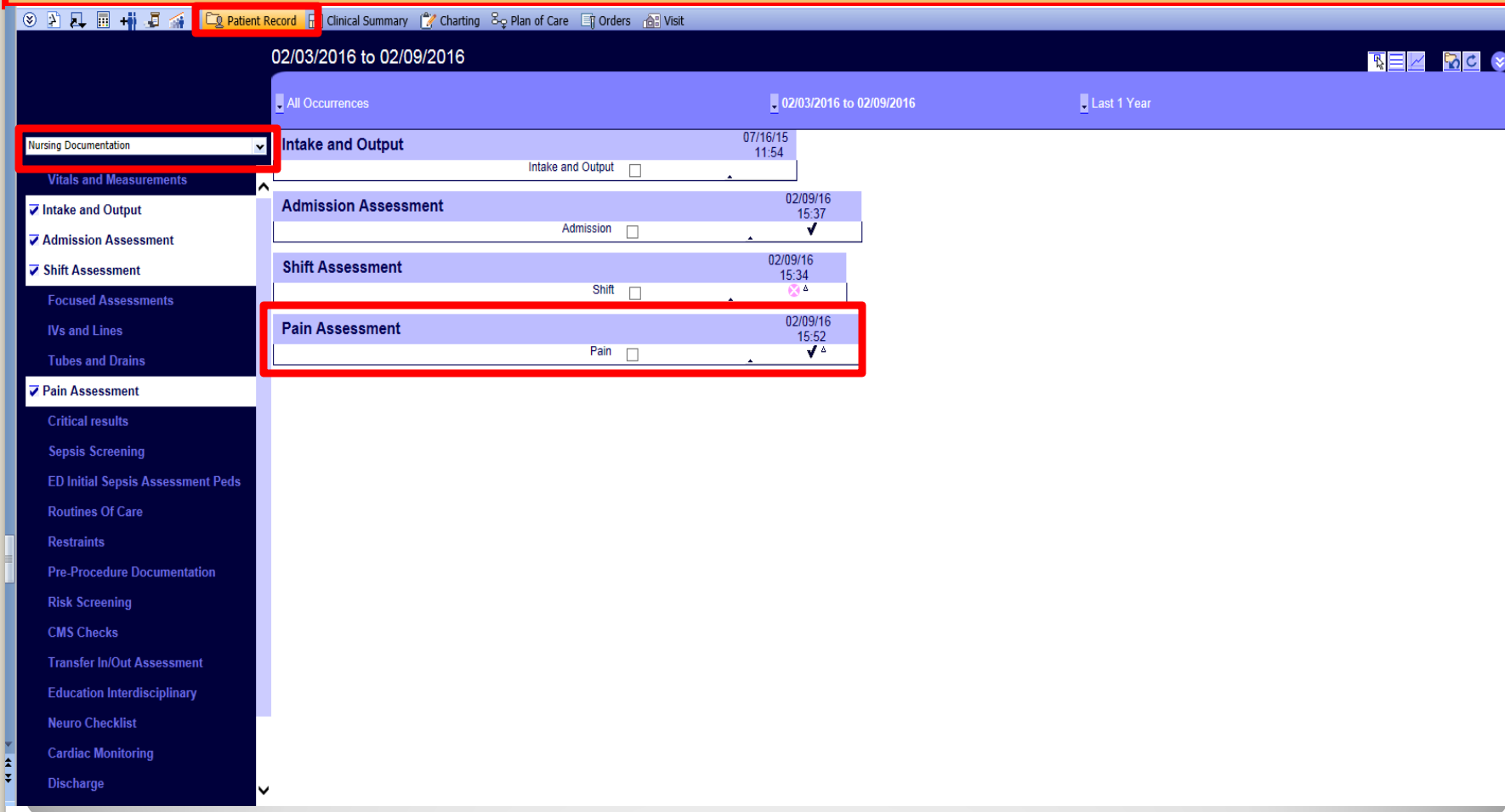
Collected 03/01/2016 15:38

Charted for

Status Complete

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.



The screenshot shows a web-based medical interface. At the top, there are tabs for 'Patient Record', 'Clinical Summary', 'Charting', 'Plan of Care', 'Orders', and 'Visit'. The 'Patient Record' tab is active. Below the tabs, the date range '02/03/2016 to 02/09/2016' is displayed. A dropdown menu is open, showing 'Nursing Documentation' selected. To the left is a navigation sidebar with categories like 'Vitals and Measurements', 'Intake and Output', 'Admission Assessment', 'Shift Assessment', 'Pain Assessment', etc. The main content area displays a list of assessment entries:

Assessment Type	Date	Time
Intake and Output	07/16/15	11:54
Admission Assessment	02/09/16	15:37
Shift Assessment	02/09/16	15:34
Pain Assessment	02/09/16	15:52

Accessing POSS Results

View

History

Notes

Pain

Entered / Revised by Emelita Gobel, RN

Scheduled N/A

Pain

- Non Verbal
- Generalized
- Head and Neck
- Torso
- Upper Extrem...
- Lower Extrem...

Pain Assessment

- Is the patient verbal? Yes No
- Does the patient have pain? Yes No

Pasero Opioid-Induced Sedation Scale (POSS)


- S = Sleep, easy to arouse
1. Awake and alert
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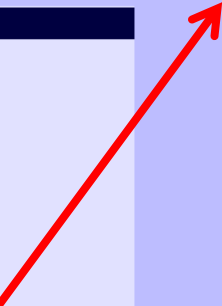
Acceptable; no action necessary; may increase

(POSS) Reassessment

- S = Sleep, easy to arouse
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Acceptable; no action necessary; may increase opioid dose if needed

To view previous Pain Assessments, click on the 



Collected 02/09/2016 15:52 Charted for Status Complete

Edit

Close

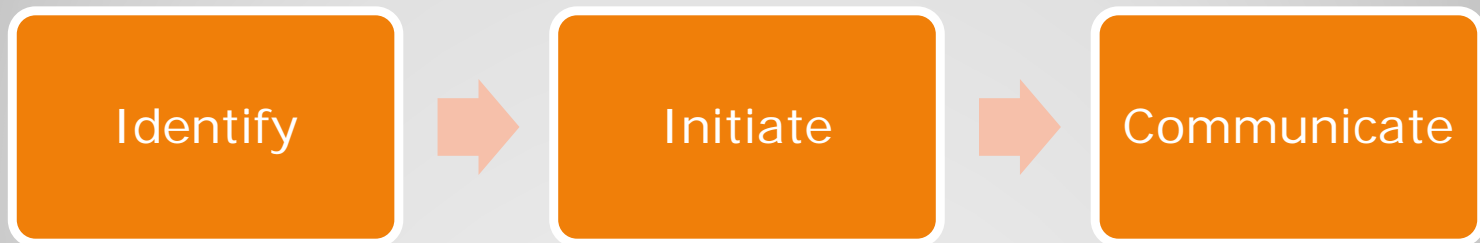
Print

Help

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/m²
- 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

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

Priority

Reason for Request

TargetCosigner1

The completed details will be applied to all applicable orders.

?

Add Add & Close Close

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

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
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 - Anesthesia Order Sets
 - ED Adult Order Sets
 - ED Pediatric Order Sets
 - General Order Sets

- 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.

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

Every

Order & Finish

Cancel

Help

UPGRADEHH, ECARE 62y ♂ Critical Care Unit-2109HH

Allergies: (0) NKA Diagnosis: (1) MR# 10030429

Nursing

Patient ACCT

Ordered B

TargetCosigne

OrderSourceModifie

Turn Patient !

Additional Instructions

Priority Routine

On 04/16/2015

Select dropdown to change **Staff Type** to Nursing.

Search

Active Yes ▾

Staff Type Medical ▾

Medical Type Medical ▾

- Nursing
- Support
- Other Staff

Search

Previous

Name	Prim. Specialty	ID

UPGRADEHH, ECARE 62y ♂
Allergies: (0) NKA Diagnosis: (1) MR# 100304

Nursing

Patient ACCT#
Ordered By
TargetCosigner
OrderSourceModified
Sedation Precau
Additional Instructions
Priority Routine
On 03/04/2016

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

fu

Active Yes ▾
Staff Type Nursing ▾

Search Results

Name	Prim. Specialty	ID
Fuxa Heidi, RN		

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

Start	Repeat	Stop
Priority Routine		After
On 03/04/2016 13:24	Every	

Add Order details as needed.
Select **Order & Finish**.

Order & Finish Cancel

Help

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:RECONSTITUTE 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 [REDACTED]

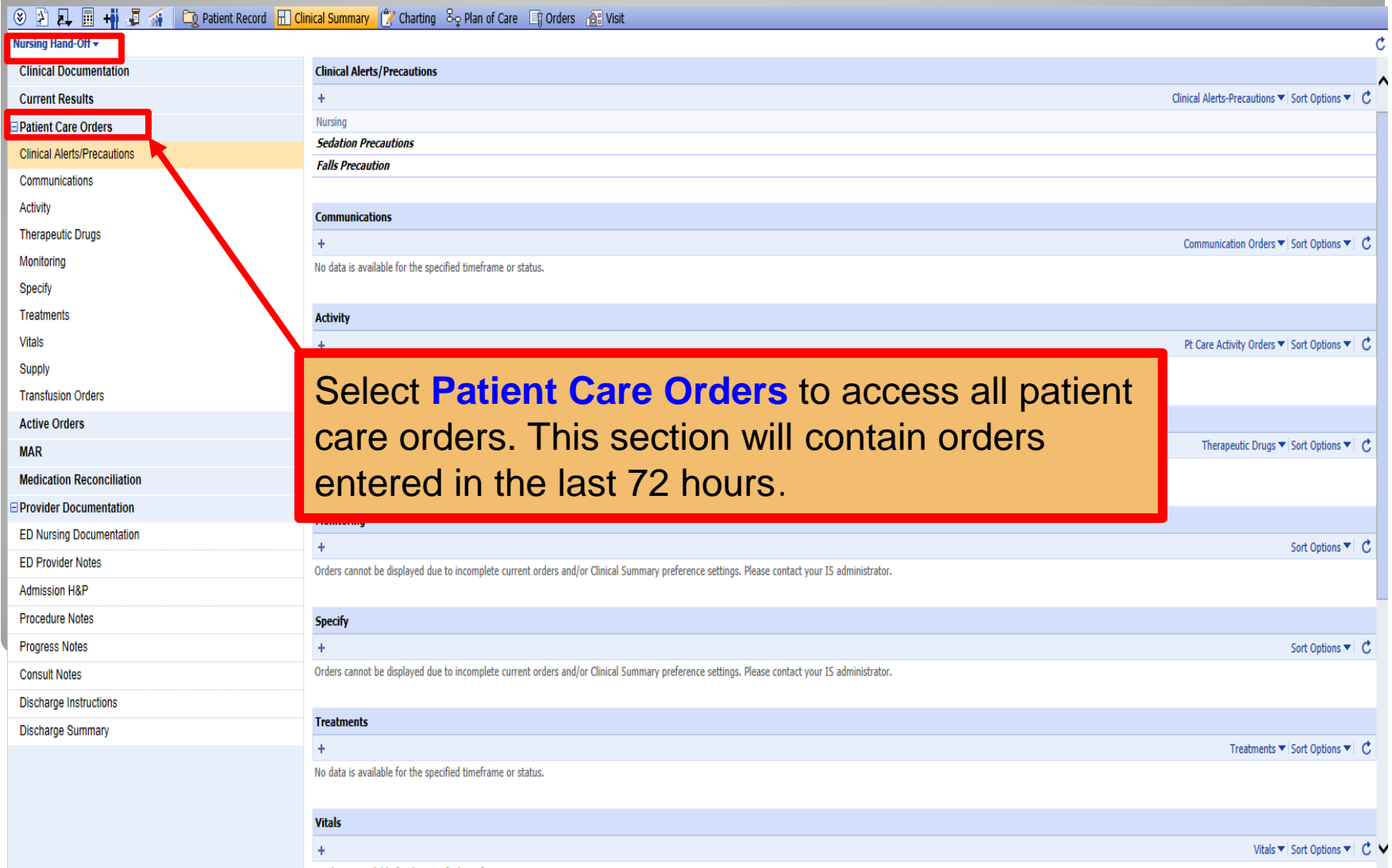
OK Cancel Help

Click **Sign** to process order.
Enter password and click **OK**.

Reset

Sign 1 Orders for UPGRADEHH, ECARE

Clinical Summary – select Nursing Hand Off



Nursing Hand-Off

- Clinical Documentation
- Current Results
- Patient Care Orders**
- Clinical Alerts/Precautions
- Communications
- Activity
- Therapeutic Drugs
- Monitoring
- Specify
- Treatments
- Vitals
- Supply
- Transfusion Orders
- Active Orders
- MAR
- Medication Reconciliation
- Provider Documentation
 - ED Nursing Documentation
 - ED Provider Notes
 - Admission H&P
 - Procedure Notes
 - Progress Notes
 - Consult Notes
 - Discharge Instructions
 - Discharge Summary

Clinical Alerts/Precautions

+ Clinical Alerts-Precautions ▾ Sort Options ▾ ↻

Nursing

Sedation Precautions

Falls Precaution

Communications

+ Communication Orders ▾ Sort Options ▾ ↻

No data is available for the specified timeframe or status.

Activity

+ Pt Care Activity Orders ▾ Sort Options ▾ ↻

Specify

+ Sort Options ▾ ↻

Orders cannot be displayed due to incomplete current orders and/or Clinical Summary preference settings. Please contact your IS administrator.

Treatments

+ Treatments ▾ Sort Options ▾ ↻

No data is available for the specified timeframe or status.

Vitals

+ Vitals ▾ Sort Options ▾ ↻

Select **Patient Care Orders** to access all patient care orders. This section will contain orders entered in the last 72 hours.

Accessing Sedation Precaution orders in Clinical Summary

Clinical Summary - select Plan of Care Clinical Summary

       **Clinical Summary**    

Nursing Hand-Off

- Nursing Hand-Off
- ED Clinical Summary Patient Overview
- ED Clinical Summary Patient Documents
- Patient Clinical Summary
- Ancillary Clinical Summary
- Essentris Data
- BHSF Pharmacy
- Infection Control
- Plan of Care Clinical Summary**
- Gladys Test
- Procedures
- Specify
- Treatments
- Vitals
- Supply
- Trans
- Activ
- MAR
- Medication Reconciliation

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

Clinical Alerts/Precautions

+

Clinical Alerts-Precautions  Sort Options  

Nursing

Sedation Precautions

Falls Precaution

Communications

+

Communication Orders  Sort Options  


No data is available for the specified timeframe or status.

Activity

+

Pt Care Activity Orders  Sort Options  

No data is available for the specified timeframe or status.

Therapeutic Drugs  Sort Options  

Monitoring

+

Sort Options  

Orders cannot be displayed due to incomplete current orders and/or Clinical Summary preference settings. Please contact your IS administrator.

Specify

+

Sort Options  

Orders cannot be displayed due to incomplete current orders and/or Clinical Summary preference settings. Please contact your IS administrator.

Treatments




+

Treatments  Sort Options  

No data is available for the specified timeframe or status.

Vitals

+

Vitals  Sort Options  

No data is available for the specified timeframe or status.

Plan of Care Clinical Summary

Patient Overview

Problems | Expected Outcomes

All | **Nursing** | All Nursing/Ancillary | OT | PT | Speech Language Pathology

No data is available for the last 3 Days. The most recent occurrence is displayed below. Modify the time frame to see additional data.

Orders displays Plan of Care related orders such as:

- ADT
- Consults/Screening
- Patient Care orders including precautions such as Falls, Sedation Precautions.

Patient Overview 2

Plan of Care Interventions/Orders/Ancillary Interventions

Plan of Care Interventions | **Orders** | Ancillary Interventions

POC Orders | Sort Options | 3 Days

No data is available for the specified timeframe or occurrence.

Falls Precaution
Sedation Precautions

Thank you