Pasero Opioid-Induced Sedation Scale (POSS) for Soarian and Sedation Precautions

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)

<table>
<thead>
<tr>
<th></th>
<th>Sleeping, easy to arouse</th>
<th>Acceptable; no action necessary; may increase/administer opioid dose if needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Awake &amp; alert</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Slightly drowsy, easily aroused</td>
<td>Acceptable; no action necessary; may increase / administer opioid dose if needed</td>
</tr>
<tr>
<td>3</td>
<td>Frequently drowsy, arousable, drifts off to sleep during conversation</td>
<td>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</td>
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<tr>
<td>4</td>
<td>Somnolent, minimal or no response to verbal and physical stimulation</td>
<td>Unacceptable; stop opioid; notify physician; support respirations as needed; follow order set for decreased respiratory rate (if applicable); <strong>stay with patient</strong>. Consider code rescue or code blue if indicated.</td>
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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 only when a patient is receiving Opioid medications for pain.)
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.
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.
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.
To view previous Pain Assessments, click on the N/A.
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

![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
To search, enter at least 4 letters in the search field then press Enter.
Place a checkmark on the order. Click on Add & Close.
Select ellipses ... next to the **Ordered by** box to search for the Nurse name.
Select dropdown to change **Staff Type** to Nursing.
Type the last name in the search engine and click **Search**.
Select the nurse from the box below and select **Add**.
Add Order details as needed. Select **Order & Finish**.
Click **Sign** to process order. Enter password and click **OK**.
Select **Patient Care Orders** to access all patient care orders. This section will contain orders entered in the last 72 hours.
Select Plan of Care Clinical Summary from dropdown.
Orders displays Plan of Care related orders such as:

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