Pasero Opioid – Induced Sedation Scale (POSS)

LOUISIANA HOSPITAL ASSOCIATION
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POSS: What is it?

- An assessment tool – evidence based and validated
- Specifically designed to identify undesired sedation resulting from opioids
- Guides staff in decision making activities regarding safety of administering additional opioids

Pasero Opioid-Induced Sedation Scale

Medscape

Pasero Opioid-induced Sedation Scale (POSS)

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

1 = Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid dose if needed

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; decrease opioid dose 25% to 50%[1] or notify prescriber[2] or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated.

4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable; stop opioid; consider administering naloxone[3,4]; notify prescriber[2] or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

*Appropriate action is given in italics at each level of sedation.
[1]Opioid analgesic orders or a hospital protocol should include the expectation that a nurse will decrease the opioid dose if a patient is excessively sedated.
[2]For example, the physician, nurse practitioner, advanced practice nurse, or physician assistant responsible for the pain management prescription.
[3]Mix 0.4 mg of naloxone and 10 mL of normal saline in syringe and administer this dilute solution very slowly (0.5 mL over 2 minutes) while observing the patient's response (titrate to effect) (Source for naloxone administration: Pasero, Portenoy, McCaffery M. Opioid analgesics, in *Pain: Clinical Manual* [ed 2]. St. Louis, MO, Mosby 1999, p. 267; American Pain Society [APS]. *Principles of Analgesic Use in the Treatment of Acute Pain and Chronic Cancer Pain* [ed 5], Glenview, IL, APS, 2003.)
[4]Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression.

Source: Pain Manag Nurs © 2009 W.B. Saunders

Benefits of POSS

- Sedation precedes respiratory depression – early identification of over sedation and appropriate interventions can prevent opioid related respiratory depression
- Meets CMS guidelines
- Promotes assessment and documentation of the level of sedation combined with pain assessment
- Provides guidance to the nurse in determining whether or not it is safe to administer additional opioids (pain medications)

Frequency of POSS Assessment

- With every pain assessment and reassessment for administration of opioids
- After administration of opioids reassess:
  - Within 30 minutes after IV administration
  - Within 60 minutes for PO

How to Assess

- Ask a simple question
- Assess patient's ability to answer and stay alert
- Do not touch the patient, observation and assessment must be without stimulation to be accurate

What if Patient is Sleeping?

- Perform thorough respiratory assessment (depth, rate, regularity, noise)
- If unclear if patient is sleeping normally or over sedated – wake them up

High Risk Patients

- Post operative patients
- Patients with a diagnosis of sleep apnea
- Morbidly obese patients
- Patients with co-morbidities such as respiratory, renal or hepatic insufficiency, end stage organ failure, altered CNS function
- Age: infants < 6 months, Patients > 65 years
- Concurrent use of sedating meds such as muscle relaxants, antihistamines and anxiolytics

High Risk Patients cont.

- Patient on PCA
- Patients with altered airways: chronic pulmonary conditions, CO2 retention, tracheotomy, home ventilatory support with CPAP or BiPAP

Sedation Precautions Nursing Interventions

- Administer lowest effective opioid dose ordered
- Use POSS to assess sedation prior to and after administering opioids and perform interventions as applicable
- Monitor for desaturation or apnea
- Monitor for hypercarbia
- Position in semi-upright position if not contraindicated
- Administer supplemental O2 as indicated or ordered
- Educate patient and family on risks of over sedation, and when to call the nurse
- Report sedation risk during hand-off communication

Contact Information

Stacie Jenkins, RN, MSN
Sr. Director of Quality & Patient Safety
318-227-7206
staciejenkins@lhatrustfunds.com

Michelle Schouest, BSN, RN
Sr. Patient Safety Consultant
225-368-3836
michelleschouest@lhatrustfunds.com

Allison Rachal, RN
Sr. Patient Safety Consultant
318-227-7207
allisonrachal@lhatrustfunds.com

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