Safely Caring for Patients Experiencing Pain

Memorial HEALTH SYSTEM

Pasero Opioid-Induced Sedation Scale (POSS)

What is the role of the nurse?

Assess POSS prior to administering opioids

S = Sleep, easy to arouse -May safely administer opioid dose if needed
1 = Awake and alert - May safely administer opioid dose if needed
2 = Slightly drowsy, easily aroused - May safely administer opioid dose if needed
3 = Often drowsy, arousable, drifts to sleep in conversation - DO NOT GIVE OPIOID;
4 = Somnolent, min/no response to verbal & physical stimuli - DO NOT GIVE OPIOID;
NA = End of Life; Intubated; Phase I Recovery

POSS S, 1, or 2

- Give the opioid medication
- Sign Documentation
- Reassess pain within 1 hour (POSS Response box will require a pain score, POSS level, and functional ability reassessment)

POSS 3 or 4

- Hold the opioid medication
- Chart POSS level in flowsheet or eMAR.
- Follow Communication Orders for POSS level.

POSS 3

1. Notify Physician of concern for opioid-related sedation
2. Monitor POSS level and respiration rate: q15min x2, then q30 min x3. (*Document in flowsheet*)
3. If POSS does not improve after 2 hours notify physician.

POSS 4

1. Call RRT/Physician of concern for opioid-related sedation and potential need for reversal with naloxone.
2. Remain at bedside until POSS less than 4.
3. Monitor POSS level and respiratory rate: q15 min x2, then q30 min x3. (*Document in flowsheet*)
4. If POSS does not improve after 2 hours notify physician