● NGN NCLEX 2026 · VISUAL STUDY LIBRARY / SAFETY · PHARMACOLOGY · PRIORITIZATION

Opioid-Induced *Sedation Scale* (POSS) & Nursing Interventions

Sedation precedes respiratory depression. The Pasero Opioid-Induced Sedation Scale (POSS) is the validated tool that lets nurses catch the silent slide from comfort to crisis — **before** the respiratory rate ever drops.

HIGH-ALERT DRUG | AIRWAY · BREATHING | SAFETY PRIORITY | PASERO & MCCAFFERY | ASPMN GUIDELINE

1 Definition & Why It Matters

OVERVIEW

The **Pasero Opioid-Induced Sedation Scale (POSS)** is a 5-level ordinal scale that grades a patient's level of arousability during opioid therapy so nurses can intervene *before* opioid-induced respiratory depression (OIRD) occurs.

CORE PRINCIPLE

Sedation Comes First

Increasing sedation **always** precedes opioid-induced respiratory depression. Watching only the respiratory rate is dangerously late.

ACTION TRIGGER

Level 3 = Intervene

A POSS of **3** ("frequently drowsy, drifts off mid-conversation") is the line where nurses must act — decrease the dose *now*.

EMERGENCY

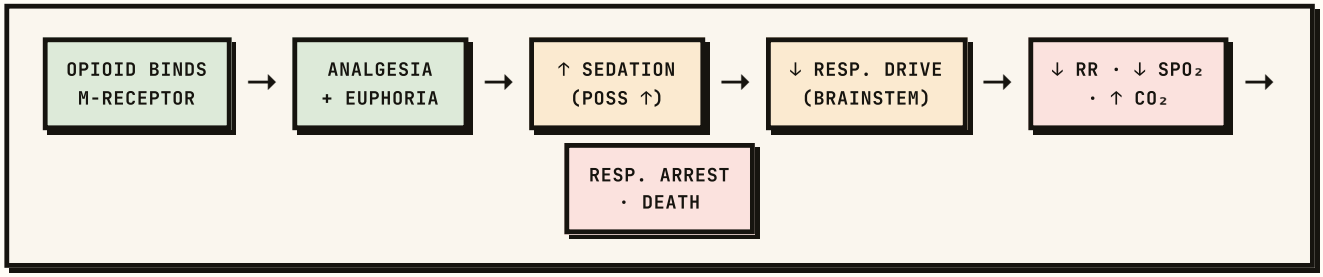
Level 4 = Naloxone

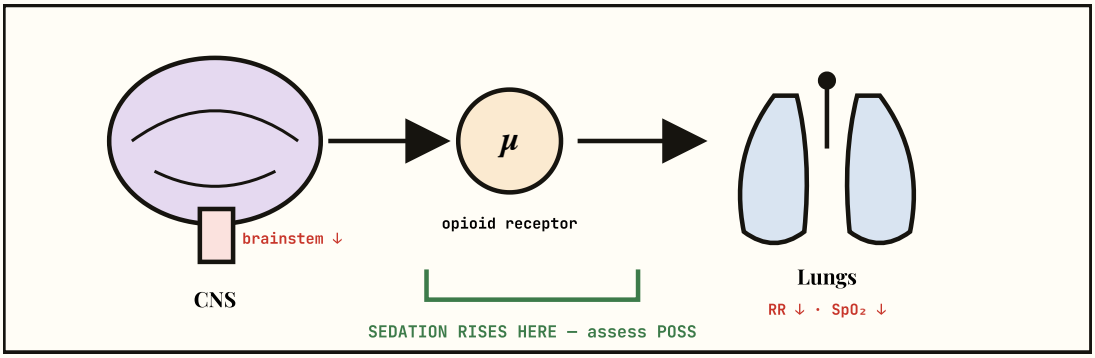
A POSS of **4** (somnolent, minimal/no response to stimulation) is a respiratory emergency. Stop the opioid, give naloxone, call rapid response.

2 Pathophysiology — Simplified

MECHANISM

Opioids bind to **mu (μ) receptors** in the CNS, producing analgesia *and* dose-dependent depression of the brainstem respiratory centers. The clinical cascade is always the same — and predictable:





CLINICAL PEARL · Pulse oximetry can stay falsely normal for several minutes during OIRD — especially with supplemental O_2. **CAPNOGRAPHY ($ETCO_2$)** detects hypoventilation earlier than SpO_2.

3 The POSS Scale — Levels & Action

ASSESSMENT TOOL

Always pair the POSS score with respiratory rate, depth, and SpO_2. Document POSS with every opioid dose, peak effect, and at minimum every 1–2 hours during initiation.

S SLEEP	**Sleep — easily aroused** Patient is asleep but responds promptly to voice or light touch. Normal physiologic sleep.	ACCEPTABLE • No action needed; opioid may be administered if pain present • Continue scheduled monitoring
1 ALERT	**Awake & Alert** Patient is fully alert, conversant, oriented. No drowsiness.	ACCEPTABLE • No action needed; administer opioid as ordered • Continue routine assessment
2 DROWSY	**Slightly drowsy — easily aroused** Patient is drowsy but easily awakened with verbal stimulation and stays awake during conversation.	ACCEPTABLE • No action needed; administer opioid as ordered • Monitor respiratory status
3 FREQUENT	**Frequently drowsy — drifts off mid-conversation** 🚨 Arousable but drifts off to sleep during conversation. **This is the critical alert level.**	UNACCEPTABLE · ACT • **Decrease opioid dose 25–50%** or notify provider • Add non-sedating non-opioid (acetaminophen, NSAID) if not contraindicated • Monitor RR & sedation every 15–30 min until improved • Awaken patient with every assessment • Consider $EtCO_2$ monitoring
4 SOMNOLENT	**Somnolent — minimal/no response to stimulation** 🚨🚨 Patient does not respond, or responds minimally, to physical stimulation. **Respiratory emergency.**	EMERGENCY · STOP • **STOP opioid immediately** • Stay with patient · stimulate · open airway · administer O_2 • Prepare & give **naloxone** per protocol • Call **Rapid Response** · notify provider • Continuous monitoring (RR, SpO_2, $EtCO_2$, LOC)

4 Signs & Symptoms — Early vs Late

CLINICAL CUES

EARLY / SUBTLE

Catch It Here

- Increasing sedation (POSS rising 1 → 2 → 3)
- Drifting off mid-conversation
- Slurred speech
- Snoring (new onset) — partial airway obstruction
- Shallow breathing, irregular respirations
- RR trending downward (still may be ≥ 10)
- Rising $EtCO_2$ before SpO_2 falls
- Pinpoint pupils (miosis)

LATE / CRITICAL

Crisis — Act Now

- **RR < 8–10 breaths/min**
- **SpO_2 < 90%**
- POSS = 4 (unarousable / no response)
- Cyanosis · pale, dusky skin
- Absent or gasping respirations
- Pinpoint, non-reactive pupils
- Bradycardia, hypotension
- Loss of gag/cough reflex

NCLEX TRAP · Don't wait for RR < 10 to act. A **RISING POSS** — even with a "normal" RR — is the earliest reliable warning of OIRD and the answer the NCLEX wants.

5 Priority Nursing Interventions

ABC · SAFETY

Priorities follow the **ABC framework** — and the action depends on the POSS level.

🟢 POSS 1–2 · Routine Monitoring

1. **Assess** POSS, RR, depth, SpO_2 before every opioid dose & at peak effect
2. **Document** sedation level with each vital sign cycle (q1–2h during initiation)
3. **Educate** patient/family that pain control is balanced against safety
4. **Maintain** head of bed elevation 30°, side-lying when feasible (airway)

🟡 POSS 3 · INTERVENE NOW

1. **Decrease** opioid dose by 25–50% (or hold; notify provider per protocol)
2. **Stimulate** the patient — call name, keep awake during assessment
3. **Apply** supplemental O_2 if SpO_2 trending down; consider capnography
4. **Reassess** POSS, RR, SpO_2 every 15–30 minutes until POSS ≤ 2
5. **Add** non-sedating adjunct (acetaminophen, NSAID, ice, repositioning)
6. **Have** naloxone & bag-valve-mask at bedside

🔴 POSS 4 · RESPIRATORY EMERGENCY

1. **STOP** the opioid (turn off PCA / IV / patch removal)
2. **Open airway** · jaw thrust · suction PRN · stay at bedside
3. **Stimulate** vigorously · attempt verbal & tactile arousal
4. **Apply** 100% O_2 via non-rebreather; bag-valve-mask if apneic
5. **Administer naloxone** per protocol (dilute 0.4 mg in 10 mL NS = 0.04 mg/mL; give 1 mL IV push every 2 min until RR ≥ 8 and arousable)
6. **Call Rapid Response** · notify provider · prepare for transfer

7 **Monitor continuously** ≥ 2 hours after naloxone — opioid often outlasts naloxone (re-narcotization risk)

6 High-Risk Patients for OIRD

SCREEN AGGRESSIVELY

Use the **STOP-Bang** screen pre-op and identify high-risk profiles before any opioid order.

PATIENT FACTORS

- Age > 65 years
- Obesity (BMI ≥ 30)
- Obstructive sleep apnea (OSA)
- Snoring history
- Opioid-naïve

COMORBIDITIES

- COPD, asthma, restrictive lung disease
- Heart failure
- Renal or hepatic impairment (slowed clearance)
- Neuromuscular disease

THERAPY FACTORS

- First 24 hours post-op
- Concurrent CNS depressants (benzos, sleep aids, alcohol, antihistamines)
- Continuous IV opioid / PCA basal rate
- Multiple opioid routes simultaneously
- Rapid dose escalation

7 Pharmacology — Key Drugs

OPIOIDS · ANTIDOTE

DRUG / CLASS	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Morphine `opioid agonist`	μ-receptor agonist → analgesia, sedation, respiratory depression	Sedation, ↓RR, hypotension, constipation, miosis, urinary retention, pruritus, N/V	Assess POSS & RR before each dose; hold if RR < 10 or POSS ≥ 3; bowel regimen; avoid in renal failure (metabolite accumulation)
Hydromorphone (Dilaudid)	μ-agonist; ~7× more potent than morphine IV	Same as morphine — but easier to over-dose due to potency	Double-check dose; never substitute mg-for-mg with morphine; high-alert drug
Fentanyl (IV, patch, lozenge)	μ-agonist; ~100× potency of morphine	Rapid sedation, chest wall rigidity (rapid IV push), ↓RR	Patch peaks 12–24 h after first application; remove old patch before new; heat ↑ absorption (fever, heating pad)
Oxycodone	μ-agonist; oral; metabolized hepatically	Sedation, constipation, ↓RR	ER tablets must be swallowed whole; crushing → fatal overdose
Naloxone (Narcan) — ANTIDOTE	Pure μ-receptor *antagonist*; displaces opioid	Acute withdrawal: pain, agitation, ↑HR, ↑BP, sweating, N/V, pulmonary edema	Dilute & titrate slowly (0.04 mg increments) to RR ≥ 8 — not full reversal; half-life shorter than most opioids — **monitor ≥ 2 h for re-sedation**

NALOXONE PEARL · Goal is *reversal of respiratory depression, not pain*. Give the smallest effective dose. Over-reversal causes severe pain, hypertension, tachycardia, and rarely flash pulmonary edema.

8 NCLEX Test Traps ⚠

WRONG VS RIGHT

TRAP	CORRECT
"Wait for the respiratory rate to drop below 10 before acting."	Act on the **rising POSS**. Sedation precedes respiratory depression — by the time RR falls, the patient is already in trouble.
"Give the full 0.4 mg ampule of naloxone IV push for any opioid sedation."	**Dilute** 0.4 mg in 10 mL NS and titrate slowly (1 mL = 0.04 mg every 2 min) until RR ≥ 8. Goal is breathing, not pain reversal.
"Once the patient wakes up after naloxone, you can stop monitoring."	Naloxone half-life (~30–90 min) is **shorter** than most opioids. Monitor for **re-sedation** at least 2 hours after the last naloxone dose.
"A patient asleep but easily aroused (POSS = S) is unsafe — hold the opioid."	**POSS S, 1, and 2 are all acceptable.** Normal sleep that responds to voice is safe. The intervention threshold is POSS 3.
"SpO_2 is 96% on room air — the patient is fine."	SpO_2 is a **late** indicator and may stay normal — especially on supplemental O_2. Assess POSS + RR + depth, and consider **$EtCO_2$**.
"Patient is opioid-tolerant on chronic opioids — sedation rules don't apply."	Tolerance to *sedation* and *respiratory depression* develops, but new escalation, surgery, or added CNS depressants can still cause OIRD. **Assess POSS every time.**

9 Patient & Family Education

TEACH & EMPOWER

DURING HOSPITALIZATION

- Report pain *and* excessive drowsiness — both matter
- Press the call light if you feel unusually sleepy or "out of it"
- Use PCA **only by patient** — never let family push the button ("PCA by proxy" can be fatal)
- Do not take additional sleeping pills, alcohol, or sedatives
- Use ice, position, deep breathing to add to comfort

DISCHARGE EDUCATION

- Take the lowest effective dose for the shortest time
- Do **not** drink alcohol or combine with benzodiazepines, muscle relaxers, or sleep aids
- Bowel regimen: hydration, fiber, stool softener — opioid-induced constipation is universal
- Keep **naloxone (Narcan)** at home; teach family to recognize OIRD & use intranasal naloxone
- Store opioids locked and out of reach of children, visitors, pets
- Dispose of unused doses at a take-back program
- Avoid driving or operating machinery while taking opioids

10 Memory Boosters & Mnemonics

STICK IT IN LONG-TERM MEMORY

"S-1-2-3-4" — Read it like a Stoplight

POSS levels map directly to a traffic-light decision tree.

- **S** — **Sleep · GREEN** — easy to arouse, give opioid as ordered
- **1** — **Alert · GREEN** — give as ordered
- **2** — **Drowsy · GREEN** — give as ordered, watch closely
- **3** — **Drifts · YELLOW** — STOP, drop dose 25–50%, notify provider
- **4** — **Somnolent · RED** — HOLD opioid, naloxone, rapid response

"SLOW" — Signs of Opioid Overdose

- **S** — **S**edation increasing (POSS ↑)
- **L** — **L**ow respiratory rate (< 8–10)
- **O** — **O** — pinpoint pupils (small "o")
- **W** — **W**eak/absent response to stimulation

When the patient is going "SLOW" — think Narcan.

"STOP-Bang" — Pre-op OSA Screen

- **S** — **S**noring loudly
- **T** — **T**iredness during the day
- **O** — **O**bserved apnea
- **P** — **P**ressure (high BP)
- **B** — **B**MI > 35
- **A** — **A**ge > 50
- **N** — **N**eck circumference > 16"
- **G** — **G**ender (male)

The Big Rule

"Sedation comes *before* respiratory depression."

If you only watch RR, you're already late. POSS is your **early-warning radar** — a rising POSS is reason to act, even if the RR still looks fine.

Naloxone half-life is shorter than most opioids — keep watching.

11 NCJMM Clinical Judgment Scenario

NEXT GEN NCLEX · 6-STEP MODEL

SCENARIO · A 68-year-old female, postoperative day 1 from open abdominal hysterectomy, BMI 34, history of obstructive sleep apnea. She is receiving morphine 2 mg IV every 2 hours PRN. She also received lorazepam 1 mg IV 30 minutes ago for anxiety. You enter the room at 1400 to reassess. The patient is in bed, eyes closed. You call her name — she opens her eyes briefly, mumbles, then drifts off again. Vitals: RR 12 (shallow), SpO_2 94% on 2 L NC, BP 108/64, HR 76, T 37.0°C. Last morphine dose was 30 minutes ago.

1 RECOG — Recognize Cues

Relevant cues: Drifts off mid-conversation (POSS = 3), shallow respirations, RR borderline low, recently received both an opioid *and* a benzodiazepine (additive CNS depression), high-risk profile (age > 65, BMI > 30, OSA history), peak effect of morphine ~15–30 min after IV dose.

2 ANALYZE — Analyze Cues

Multiple risk factors + dual CNS depressants + POSS 3 = **impending opioid-induced respiratory depression.** Sedation is the earliest warning. SpO_2 of 94% on O_2 is reassuring but unreliable — supplemental oxygen can mask hypoventilation. RR 12 with shallow depth means minute ventilation is dropping.

3 PRIOR — Prioritize Hypotheses

Highest priority: Opioid (+ benzodiazepine) over-sedation with risk of progression to OIRD.
Lower priority: Postoperative fatigue, electrolyte imbalance, hypovolemia — none explain the cue cluster.

4 SOLN — Generate Solutions

Hold the next morphine dose. Notify provider for new pain plan. Stimulate the patient and keep at bedside. Apply continuous SpO_2 + consider $EtCO_2$. Have naloxone & BVM ready. Reassess POSS, RR, SpO_2 every 15 minutes. Add scheduled acetaminophen as adjunct (if not contraindicated). Position HOB elevated, side-lying.

5 ACT — Take Action

Hold morphine. Verbally and tactically stimulate the patient. Apply continuous pulse oximetry/capnography. Notify provider of POSS 3, the recent lorazepam, and the high-risk profile. Document POSS, RR, SpO_2, LOC. Keep naloxone 0.4 mg + 10 mL NS at the bedside.

6 EVAL — Evaluate Outcomes

Improving (expected): POSS returns to ≤ 2, RR ≥ 12 with normal depth, SpO_2 ≥ 95%, patient stays awake during conversation, reports tolerable pain on adjuncts.
Worsening (act): POSS rises to 4, RR < 8, SpO_2 < 90%, no response to stimulation → administer naloxone per protocol, call Rapid Response, prepare for higher level of care.

Source Disclosure

The topic *Opioid-Induced Sedation Scale (POSS) — Nursing Interventions* was **not present in the uploaded reference notes**. Content above was synthesized from standard NGN NCLEX 2026 references and evidence-based clinical guidelines:

- Pasero C., McCaffery M. — *Pain Assessment and Pharmacologic Management* (Pasero Opioid-Induced Sedation Scale [POSS])
- American Society for Pain Management Nursing (ASPMN) — Monitoring for Opioid-Induced Advancing Sedation and Respiratory Depression: 2024 Guideline
- Saunders Comprehensive Review for the NCLEX-RN — Pharmacology & Pain Management chapters
- ATI RN Adult Medical-Surgical / Pharmacology — Opioid analgesics & antagonists
- Lippincott Illustrated Reviews — Pharmacology, Opioid agonists / antagonists
- The Joint Commission — Sentinel Event Alert #49: Safe use of opioids in hospitals
- Institute for Safe Medication Practices (ISMP) — High-Alert Medications list (opioids)