

Opioid-induced Sedation

Sedation precedes opioid induced respiratory depression.

No patient has succumbed to (opioid induced) respiratory depression while awake. APS, 1999

Tips



- ☑ The only safe and effective way to administer an opioid is to WATCH the individual's response, especially to the first dose(s).
- ☑ No set dose of opioid will be safe and effective for everyone.
- ☑ Fear of respiratory depression and hypoxia often leads to inadequate dosing with opioids, **however**
- ☑ respiratory depression can be prevented by careful titration and individualized dosing and close nurse monitoring of sedation.

Arousability is the key to assessing sedation.

When patients are at risk for opioid induced respiratory depression, nurse monitored sedation levels are recommended.

Sedation Scale

Sedation Score	Intervention
1 = awake and alert.	Requires no action.
2 = occasionally drowsy, easy to arouse.	Requires no action.
3 = frequently drowsy, arousable, drifts off to sleep during conversation.	Hold dose. Stimulate the patient and call physician for reassessment of opioid dose.
4 = somnolent, minimal or no response to stimuli.	Hold all opioids and sedating drugs. Call physician immediately. This is an emergency situation!



When is a sedation scale used?

- when initiating opioid therapy in the opioid naïve patient with moderate to severe pain
- when titrating dose or rotating opioids

Patients /situations at greatest risk:

- opioid naïve, i.e. no recent, regular use of opioids.
- some elders because of a slower rate of excretion. For patients over 70, consider ↓ recommended starting doses by 25-50%.
- concurrent use of other respiratory depressants, e.g. benzodiazepines
- renal dysfunction
- compromised pulmonary status e.g. COPD
- history of opioid sensitivity



Opioids in the elderly act “stronger and longer”, so “start low and go slow” and assess.