Pain Management

Priorities	***Assessment Findings***
Chief Complaint	"Pain"
LOPQRST	Location, onset, provocation, palliation, quality, radiation, severity (subjective pain score on a 0-10 scale or mild moderate, severe), time (intermittent or continuous; steady vs. improving or worsening)
AS/PN	Associated symptoms/pertinent negatives
AMPL	Allergies, medications, pertinent past history, last meal
Initial Exam	Check ABCs and correct immediately life-threatening problems.
Detailed Focused Exam	**Vital Signs:** BP, HR, RR, Temp, SpO_2 **General Appearance:** Writhing in pain, facial grimacing, moaning, screaming or crying? Assess objectively how severe the pain appears to you (mild, moderate or severe). **Skin:** Pale, cool, diaphoretic? **Source of pain (chest, abdomen, back, extremities, etc.):** Swelling, ecchymosis or deformity? Tenderness on palpation? CMS?
Data	SpO_2, EKG for chest pain, pain scale
Goals of Therapy	Reduce pain to a tolerable level.
Monitoring	BP, HR, RR, cardiac monitor, SpO_2, pain scale, capnography

EMERGENCY MEDCIAL RESPONDER/ EMERGENCY MEDICAL TECHNICIAN

- Display a calm and compassionate attitude
- Acknowledge and assess the patient's pain by obtaining a thorough history
- Identify and treat the cause
    - Musculoskeletal injuries:
        - Realign angulated fractures, if possible, being cautious not to aggravate the injury or pain
        - Reposition (not reduce) dislocated joints to improve comfort, circulation, sensation, and motion
        - Apply a well-padded splint that immobilizes the long bone above and below the injury or the joint above and below the injury
            - Do not compromise distal circulation
        - Immobilize joints in mid-range position
        - Elevate the injured extremity if no fracture or dislocation is found
        - Apply ice or cold packs to the injured area
        - Apply a compression bandage or ace wrap if a splint is not needed
    - If using a backboard for spinal motion restriction:
        - Pad the backboard with a blanket(s)
        - Pad voids between the patient and backboard—behind knees, and small of back
        - Pad the straps
        - Keep the patient warm and protected from rain/snow, ambulance exhaust etc.
- Reassure and comfort the patient; Use a calm and soothing voice.

- Distract them or encourage them not to focus on their injury, but to think about something more pleasant
- Eliminate stress inducing distractions—i.e. family, police and bystanders
- Coach the patient's breathing—calm, deep full inhalations, and relaxed slow exhalations.
- Explain to the patient what is happening and what will happen next.
- Adjust the ambient temperature of the treatment area to a comfortable level for the patient
- Reassess pain after all interventions

Give a status report to the ambulance crew by radio ASAP.

ADVANCED EMERGENCY MEDICAL TECHNICIAN

- IV normal saline KVO
- Consider a bolus of 500 ml if signs of hypovolemia are present

Contact Medical Control for the following:

- Additional fluid orders

INTERMEDIATE

- **Fentanyl** IV/IO/IM/IN[1]
    - ADULTS: 25 – 100 mcg slow IV/IO push or IM or IN. May repeat 25 – 100 mcg every 10 minutes as needed to a max. of 300 mcg.
    - PEDS (over age 2): 1 – 2 mcg/kg slow IV/IO push or IM or IN. May repeat x1 after 10 minutes.
- Reassess patient's pain after each dose
- Recheck blood pressure before each additional dose; withhold fentanyl if SBP < 90 mmHg

Contact Medical Control for the following:

- Additional orders

PARAMEDIC

- Use the "Pain Management Decision Matrix" (Attachment A) to select which medication to give
- Use the "Pain Management Decision Matrix" to select how much to give, how often, and to what maximum dose.
- All medications may be given by IV, IM or IO routes. Fentanyl, midazolam and lorazepam may also be given IN. The volume of any single intranasal dose should not exceed 1 ml per nostril.
- A minimum of 10 minutes between dosing of two different pain or sedative medications
- Ketamine should be used on only three circumstances
    - Secondary medication for patients whom opioid medication has be ineffective
    - Alternate to opioid pain medication for those with 1) Opioid misuse history or 2) Allergy or similar that prevent use of opioid pain medication
    - Severely injured patients in appropriate clinical settings: Rapid extrication due to deteriorating condition or imminent environmental threat; straightening a badly angulated or mangled long-bone fracture; severe burn injuries, etc.
        - Use of Sedative Dosing for pain management requires Medical Control approval, unless scene safety prohibits Medical Control consultation prior

to use, then Medical Control should be contact as soon as scene safety allows.

- Reassess patient's pain before each additional dose.
- Monitor capnography.
- Recheck blood pressure before each additional dose; withhold hydromophone, if SBP < 100 mmHg.
- For severely injured trauma patients who would benefit from pain management and sedation, consider ketamine at the Sedation dose (1 mg/kg IV or 5mg/kg IM).
- For patients suffering from severe burn pain without indications for RSI/RSA[2], titrate the narcotic and benzodiazepine to the point of minimal pain and light sedation.
- For severe burn patients who meet criteria for RSI/RSA, consider early RSI/RSA. In addition, consider ketamine at a sedation dose.
    - This is strictly a two-paramedic procedure.
    - It should be done in consultation with medical control, except when time is of the essence in securing the airway (threat of imminent airway obstruction).
    - Monitor blood pressure closely and increase fluids if necessary to maintain it.

Contact Medical Control for the following:

- When you've reached the maximum dose, contact medical control for additional orders.
- Additional orders

FOOTNOTES:

[1] Morphine sulfate may be substituted for fentanyl during a medication shortage. Morphine 2 – 5 mg IV/IO. every 5 minutes, maximum 20 mg.

[2] RSI/RSA requires 2 qualified paramedics at the patient's side

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