



Portage County EMS Patient Care Guidelines



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 MEDICAL 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
 - Consider spinal immobilization, if needed
 - 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: 50 – 200 mcg slow IV/IO push or IM or IN. May repeat 25 – 100 mcg every 10 minutes as needed to a max. of 200 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.
- Reassess patient's pain before each additional dose.
- Monitor capnography.
- Recheck blood pressure before each additional dose; withhold hydromorphone, if SBP < 100 mmHg.
- For severely injured trauma patients who would benefit from pain management and rendering them unresponsive, consider ketamine at the full dissociative dose (5 mg/kg).
- 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, deeper sedation is necessary and should be achieved prior to intubation if possible. Consider ketamine in a full dissociative 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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