Sierra – Sacramento Valley EMS Agency Treatment Protocol	M-8
Pain Management	
Approval: Troy M. Falck, MD – Medical Director	Effective: 10/01/2025
Approval: John Poland – Executive Director	Next Review: 07/2028

- All pts with a report of pain shall be appropriately assessed and treatment decisions/interventions shall be adequately documented on the PCR.
- A variety of pharmacological and non-pharmacological interventions may be utilized to treat pain. Consider the pt's hemodynamic status, age, and previous medical history/medications when choosing analgesic interventions.
- Treatment goals should be directed at reducing pain to a tolerable level; pts may not experience complete pain relief.

BLS

- Assess V/S including pain scale & SpO_2, every 15 mins or as indicated by pt's clinical condition
- Assess/document pain score using standard 1-10 pain scale before and after each pain management intervention and at a minimum of every 15 mins
- O_2 at appropriate rate if SpO_2 <94% or pt is short of breath
- Utilize non-pharmacological pain management techniques as appropriate, including:
  - Place in position of comfort and provide verbal reassurance to minimize anxiety
  - Apply ice packs &/or splints for pain secondary to trauma

Pain not effectively managed with non-pharmaceutical pain management techniques

Review/consider Medication Contraindications & Administration Notes below & proceed to pg. 2

Medication Contraindications & Administration Notes

ⓘ Clinical judgement shall be utilized to determine appropriate doses within allowable protocol ranges
ⓘ All slow IVP medications contained in this protocol shall be administered over 60 seconds

Acetaminophen
ⓘ Do not administer to pts with any of the following:
- Severe hepatic impairment
- Active liver disease

ⓘ Discontinue infusion if SBP drops to <100

Ketamine
ⓘ Do not administer to pregnant pts

Ketorolac
ⓘ Do not administer to pts with any of the following:
- ≥65 yo
- Pregnancy
- NSAID allergy
- Active bleeding
- Multi-system trauma
- ALOC or suspected moderate/severe TBI
- Current use of anticoagulants or steroids
- Hx of asthma, GI bleeding, ulcers
- Hx of renal disease/insufficiency/transplant

Fentanyl/Midazolam
ⓘ Do not administer to pts with any of the following:
- SBP <100
- SpO2 <94% or RR <12
- ALOC or suspected moderate/severe TBI

ⓘ Consider reduced fentanyl doses for pts ≥65 yo
ⓘ There is an increased risk of deeper level of sedation & airway/respiratory compromise when administering midazolam to pts receiving fentanyl

ALS

- Continuous cardiac monitoring
- IV/IO NS TKO if indicated by pt's clinical condition or necessary for medication administration
  - May bolus up to 1000 mL if indicated by pt's clinical condition
- Administer analgesic intervention, as indicated below, when appropriate

Non-Trauma Related/ Chronic Pain

Acetaminophen: 1 g IV/IO infusion over 15 mins
OR
Ketorolac: 15-30 mg IV/IO or IM

If pain not effectively managed:

- Contact base/modified base hospital for additional pain management consultation

Pain Related to Acute Injury/Burns/Frostbite

Moderate Pain

Acetaminophen: 1 g IV/IO infusion over 15 mins
OR
Ketorolac: 15-30 mg IV/IO or IM

If pain not effectively managed:

- Continuous $EtCO_2$ monitoring

Fentanyl: 25-50 mcg slow IV/IO or IM/IN every 5 mins (max cumulative dose: 200 mcg)

Severe Pain

- Continuous $EtCO_2$ monitoring

Fentanyl: 50-100 mcg slow IV/IO or IM/IN
OR
Ketamine: 15-30 mg slow IV/IO

Acetaminophen: 1 g IV/IO infusion over 15 mins

If pain not effectively managed:

- If fentanyl previously administered, may repeat fentanyl 50-100 mcg slow IV/IO or IM/IN every 5 mins (max cumulative dose: 200 mcg)
- If ketamine previously administered, may repeat (x1) ketamine 15-30 mg slow IV/IO

AND/OR
Midazolam: 1 mg slow IV/IO

- May repeat (x1) 1 mg slow IV/IO
- Wait 5 mins after fentanyl/ketamine administration before administering midazolam