

**Pain Management**

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Approval: John Poland – Executive Director

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- All pts with a report of pain shall be appropriately assessed & 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.

Protocol Definitions:

- Acute Pain: Sudden, short-term pain usually caused by injury, illness, or a specific event.
- Non-Acute Pain: Ongoing or long-term pain that persists over time & is not immediately severe or emergency-related.

BLS

- Assess V/S including pain scale & SpO₂, 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
- O₂ at appropriate rate if SpO₂ <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

If pain is not effectively managed with non-pharmaceutical pain management techniques:

- Review/consider Medication Contraindications & Administration Notes below & proceed to page 2

Medication Contraindications & Administration Notes

- ① Clinical judgement shall be utilized to determine appropriate doses within allowable protocol ranges
- ① All slow IVP medications contained in this protocol shall be administered over 60 seconds

Acetaminophen

- ① Do not administer to pts with any of the following:
 - Severe hepatic impairment
 - Active liver disease
- ① Discontinue infusion if SBP drops to <100

Ketamine

- ① Do not administer to pregnant pts

Ketorolac

- ① 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

- ① Do not administer to pts with any of the following:
 - SBP <100
 - SpO₂ <94% or RR <12
 - ALOC or suspected moderate/severe TBI
- ① Consider reduced fentanyl doses for pts ≥65 yo
- ① There is an increased risk of deeper level of sedation & airway/respiratory compromise when administering midazolam to pts receiving fentanyl



Pain Management

ALS

- Continuous cardiac monitoring
- Continuous EtCO₂ monitoring required for pts receiving fentanyl, ketamine &/or midazolam
- 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 (admin.) analgesic intervention, as indicated below, when appropriate

Non-Acute 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

Acute Pain

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 EtCO₂ monitoring
- Fentanyl:** 25-50 mcg slow IV/IO or IM/IN every 5 mins (max cumulative dose: 200 mcg)

Severe Pain

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

- IV/IO:
 - 15-30 mg admin. slowly
- IM:
 - Pts <50 kg: 25 mg
 - Pts ≥50 kg: 50 mg

Acetaminophen: 1 g IV/IO infusion over 15 mins

If pain not effectively managed:

- If fentanyl previously admin., may repeat fentanyl 50-100 mcg slow IV/IO or IM/IN every 5 mins (max cumulative dose: 200 mcg)
 - If ketamine previously admin., 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 admin. before midazolam admin.