Section: ALS Protocols
Subject: PAIN MANAGEMENT
Section #: 345.17
Issue Date: March 21, 2011
Revision Date: December 1, 2017
Approved By: Michael Lozano, Jr., M.D., HCFR Medical Director

1. Intent:
    a. Whereas many patients treated by HCFR personnel will be complaining of varying degrees of pain, it is desirable to diminish the degree of suffering that a patient experiences.
    b. The intent of this protocol is to provide a standing order for the treatment of severe pain when the source of the pain is clear.
        i. Examples of painful conditions that may be addressed by this protocol include, but are not limited to:
            1. Isolated orthopedic injuries
            2. Burns
            3. Kidney stones
            4. Muscle spasms

2. Contraindications:
    a. Altered mental status (due to any internal or external cause)
    b. Hypotension (Adult) – defined as systolic BP < 100 mmHg
    c. Hypotension (Pediatric) – refer to age appropriate BP chart
    d. Hypoxia, defined as SpO_2 of <95%
    e. Head Injury
    f. Undiagnosed abdominal Pain (contact Medic-1 for orders)
    g. New onset back or flank pain in patients > 65 years of age
        i. This is due to a concern for masking a potential acute abdominal aneurysm
        ii. Contact Medic 1 for kidney stone pain management for patients ≥ 65 years of age.

3. Standards of Care:
    a. Standard ALS/BLS supportive care
    b. Reliable oximetry
    c. The narcotic antidote, naloxone (0.1 mg/kg IV, IM, IN or SQ) must be quickly and readily available when using this protocol.
    d. Parental consent is required, if available, before treating pediatric patients with narcotics
    e. For medication associated nausea and vomiting, follow the HCFR NAUSEA/VOMITING protocol.
        i. Prophylactic administration of ondansetron is not authorized under this or any protocol

4. Treatments:
    a. Basic ALS Treatments.
        i. Document the patient's perception of their pain severity on a scale from 0 – 10 before, during and post medication administration
            1. A visual analog scale may be appropriate for pediatric patients and those for whom a 0 – 10 scale is not feasible (i.e. language barrier).
        ii. Document vital signs, mental status, and drug allergies prior to medication administration. Repeat and document vital signs and mental status again post medication administration.
        iii. Document provocation, quality, region, severity, and timing (PQRST) for any patient presenting with a primary complaint of pain, not just those for given pain management measures.
    b. Inhalational analgesia and anxiolytic agent (if available)
        i. Nitrous oxide: (if available) by self-administered patient inhalation
        ii. This can be used in all age groups

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c. Analgesia agents: (use one or the other)
   i. Fentanyl: (for normal to high BP; contraindicated if hypotensive)
      1. Adults: Initial dose of 100 mcg IV/IM/IN, and then 50 mcg IV/IM/IN as needed q5 minutes to a maximum dose 350 mcg.
      2. Pediatrics: Initial dose of 1 mcg/kg IV/IM/IN, and then 0.5 mcg/kg IV/IM/IN as needed q5 minutes to a maximum of 3.5 mcg/kg).
   ii. Morphine: (for normal to high BP; contraindicated if hypotensive)
      1. Adults: 2 mg IV/IM/SQ, and then as needed q5 minutes to a maximum of 20 mg.
      2. Pediatrics: 0.1 mg/kg IV/IM/SQ (maximum 2 mg), and then as needed q5 minutes to a maximum of 20 mg.

d. Adjunctive agents (if needed)
   i. Midazolam: (for anxiety with normal to high BP)
      1. Adults: 2.5 mg IV/IM/IN, and then as needed q5 min to a maximum of 10 mg.
      2. Pediatrics: 0.025 mg/kg (max dose of 2.5 mg) IV/IM/IN, and then as needed q5 min to a maximum of 10 mg.
      3. Geriatrics: 1.25 mg IV/IM/IN, and then as needed q5 min to a maximum of 5 mg.

5. Contact Medic-1:
   a. For additional doses of pain medications above the listed total maximum dosages
   b. If source of pain is unclear or if there are extenuating or unusual circumstances about the call
   c. For advice on situations beyond this protocol