Pain Management
Adult Medical

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Austin County EMS Protocol & Guideline	
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Overview: Patients experiencing pain directly benefit with early, appropriate administration of pain management. Comprehensive assessment of the patient is essential not only to identify differential diagnosis, but also to identify which treatment modality is best suited for the patient. The goal is to provide pain management to a comfort level appropriate for the patient and situation.

Definition: Patients with any amount of pain may be considered for application of the Pain Management protocol. Patients presenting with, but not limited to: Musculoskeletal injury, Multi-system Trauma, kidney stones, cardiac related conditions, external pacing / cardioversions, chronic illness / disease (i.t. cancer, sickle cell crisis), and any other acute injury or illness with obvious signs of acute pain

EMT

- Place patient on the **Cardiac Monitor**
- Obtain **12 Lead EKG**
- **CPR** & **AED** as appropriate to patient presentation
- **Oxygen** administration as appropriate to the patient presentation
- **Airway Adjuncts** (Supraglottic Airway, OPA, NPA), EtCO2 monitoring appropriate to patient presentation
- Obtain **BGL**
- Monitor **SPO2**
- **Cold Packs** as needed
- **Ondansetron** 4mg tablet - May repeat once -for Nausea & Vomiting

AEMT

- Establish IV of Normal Saline

Nausea and Vomiting

- **Ondansetron** 4 mg IV – May repeat once
- **Diphenhydramine** 12.5-25 mg IV – 25-50 IM, **Max** dose 50 mg (Use half dose in elderly patients)

Paramedic

Mild to Moderate Pain

- **Ketorolac** 15-30 mg IV or 30-60 mg IM

Moderate to Severe Pain

- **Morphine** 2-10 mg IV/IO; repeat PRN: Max dose of 20 mg
- **Fentanyl** 1-2 mcg/kg IV/IO/IN; repeat PRN: Max total dose 400 mcg

Severe Pain

- **Ketamine** 0.1-0.25 mg/kg IV/IO **OR** 0.5 -1 mg/kg IM/IN: may repeat every 10 minutes as needed

PEARLS

- **Severe ETOH / Drug Intoxication** – **Relative contraindication**. A patient who is intoxicated does not mean the patient is not experiencing pain that is appropriate to treat. Good assessment prior to administration is required and caution with depressing CNS.
- **Pregnancy – Relative contraindication**. Must discuss with patient the risks. If elected, administer minimal dose necessary to achieve an acceptable level of comfort for the patient. Non-recurrent, Severe, Acute situations are acceptable situations for pain management.
- **Abdominal Pain** can be treated with the goal to reduce the patient's pain to a tolerable level. Patients with significant pain associated with known or unknown etiology of abdominal pain can be treated, especially in extreme cases where severity of pain hinders patient assessment. Rule out all possible causes of abdominal pain; documentation MUST support differential diagnosis when treating for a probable cause/source of abdominal pain.
- If known/anticipated common side effects of generalized itching, nausea, vomiting, etc.; a smaller dose of **Benadryl** may be given prior to pain control to minimize effects.
- **Fentanyl** may be administered to patients that are allergic to **Morphine**, however, remain prepared for a possible allergic reaction.
- Do not administer **Ketorolac** to patients with suspected internal bleeding
- Intubation equipment and **Naloxone** must be readily available when administering pain medications
- All treatment options above may be utilized in conjunction with one another. Ensuring maintenance and considerations for anticipated responses must be considered when selecting treatments.
- Sedation Score MUST be assessed and documented a minimum of: 1 time prior to administration and 1 time post each administration. Any patients with a decreased score (i.e. 3 or lower on SAS scale) MUST have continuous ETCO2 monitoring. Routine monitoring with pain management is acceptable.