

SECTION: M-11

PROTOCOL TITLE: Adult Pain Control and Sedation

REVISED: January 11, 2010

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**GENERAL COMMENTS:** Ada County EMS is committed to the relief of suffering in its patient population. Accurate and standardized evaluation of the pain is an essential component of pain management. Assessment should be on the 0 → 10 scale whenever possible, using OPQRST as an assessment tool, to provide a quantitative level of discomfort and allow accurate documentation. Providers at all levels should take a multi-faceted approach to pain control and sedation.

**BLS SPECIFIC CARE:** See adult General Medical Care Protocol M-1

- Treat underlying injury or illness as appropriate
- Consider that proper splinting may either exacerbate or relieve pain, use good clinical judgment in deciding course of action
- Assist patient in maintaining position of comfort
- Use distraction (through conversation, etc) and breathing techniques to help patient alleviate pain
- Ice packs or similar cold therapy for swelling
- Splint fractures as necessary
- Ice packs as necessary for swelling

**ILS SPECIFIC CARE:** See adult General Medical Care Protocol M-1

**ALS SPECIFIC CARE:** See adult General Medical Care Protocol M-1

*Analgesics*

**DO NOT** administer/discontinue administration if:

- Systolic BP < 90 mmHg
- Respiratory rate, SpO<sub>2</sub> and/or mental status diminishes
- Fentanyl IV/IO/IM
  - 25-50 mcg every 5-10 minutes as needed
  - Maximum dose 200 mcg
- Morphine sulfate IV/IM/IO
  - 2-5 mg every 5-10 minutes as needed
  - Maximum dose 20 mg

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*Sedatives*

**DO NOT** administer/discontinue administration if

- Systolic BP < 90 mmHg
- Respiratory rate, SpO<sub>2</sub> and/or mental status diminishes

- Versed (midazolam) IV/IM/IO
  - 0.5-2.5 mg every 5-10 minutes as needed
  - Maximum dose 5 mg

*Anti-emetics:*

Consider with administration of analgesics

- Zofran (ondansetron) IV/IM/IO
  - 4 mg
  - Repeat one time in 15 minutes, if needed
- Benadryl (diphenhydramine) IV/IM/IO
  - 25-50 mg

**PHYSICIAN PEARLS:**

*ALS Providers may decrease the dosage, or prolong the administration intervals of any medication with sedative properties when doing so would decrease adverse effects and still likely obtain the clinical goal.*

*Regarding Abdominal Pain:* Narcotic analgesia was historically considered contraindicated in the pre-hospital setting for abdominal pain of unknown etiology. It was thought that analgesia would hinder the ER physician or surgeon's evaluation of abdominal pain. It is now becoming widely recognized that severe pain actually confounds physical assessment of the abdomen and that narcotic analgesia rarely diminishes all of the pain related to the abdominal pathology. It would seem to be both prudent and humane to "take the edge off of the pain" in this situation with the goal of reducing, not necessarily eliminating the discomfort. Additionally, in the practice of modern medicine the exact diagnosis of the etiology of abdominal pain is rarely made on physical examination. Advancement in technology and availability has made laboratory, x-ray, ultrasound, CT scan, & occasionally MRI essential in the diagnosis of abdominal pain. *Therefore medication of abdominal pain is both humane and appropriate medical care.*

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