# PAIN MANAGEMENT

- Routine Medical Care
- Monitor the patient closely
- Have Naloxone readily available to reverse any respiratory depression that may occur
- Psychological coaching and BLS measures, including cold packs, repositioning, splinting, elevation, and/or traction splints as appropriate, to reduce the need for pain medication
- The preferred route of administration is intravenous (IV)
- Use the visual analog scale to document level of pain prior to and after administration of MS. Express results as a fraction – (e.g.: 2/10 or 7/10)
- See also: "Sedation" **page 139**

| Pain Management Criteria | Base Contact | Treatment |
|---|---|---|
| Any patient with a complaint of significant pain, including:<br>➔ Significant extremity injuries<br>➔ Burn patients<br>➔ Crush injury patients<br>➔ Prolonged extrication<br>➔ Severe back and spinal pain<br>➔ Immobilized patients<br>➔ Abdominal pain | No<br>unless > 15mg morphine sulfate is needed | O2<br>IV/ IO NS or saline lock<br>Morphine sulfate:<br>►IV/ IO: 2-5 mg every 3-5 minutes, titrated to pain, up to 15 mg maximum<br>No IV/ IO access:<br>►IM: 5-10 mg. May repeat in 20 minutes, up to 15 mg maximum |
| Critical Trauma patients with:<br>➔ Abdominal trauma<br>➔ Thoracic trauma | No<br>unless > 5mg morphine sulfate is needed | O2<br>IV/ IO NS or saline lock<br>Morphine sulfate:<br>►IV/ IO: titrated to pain, up to 5 mg maximum<br>No IV/ IO access:<br>►IM: up to 5 mg maximum |
| Other patients with a complaint of significant pain, including:<br>➔ Head trauma<br>➔ Decreased respirations<br>➔ Altered mental status<br>➔ Women in labor<br>➔ BP < 90 systolic<br>➔ Patients with pain not covered above | Yes | **Contact the Base Physician** prior to administering any pain medication |

## VISUAL ANALOG SCALE