Traumatic Pain Management

- Any patient treated under this protocol must be transported to an appropriate emergency department
- Remember that a pain score > 5 could be distracting other injuries
- Head trauma is not a contraindication to pain management
- Hypotension is not a contraindication to pain management – use smaller doses and titrate to effect

Routine Medical Care / Trauma Care

- Evaluate mechanism of injury (MOI)[1]
- Assess the need for spinal precautions per **Spinal Motion Restriction** protocol

Attempt comfort therapies first:
- Place patient in position of comfort
- Splint/support painful areas
- Consider ice and/or compresion

Record level of pain by either asking patient to rate on scale 1-10 or using FACES scale

Have **Naloxone** readily available to treat narcotic-induced respiratory depression.

Administer **one** of the following for moderate to severe (6-10) pain[1]:

(1) **Fentanyl** 25-50mcg IM or slow IV push q2min prn (max 200mcg)

Consider Acetaminophen IV used in conjunction with opioid
Acetaminophen 1g over 15min IV Infusion (max 4g in 24hr)

or

(2) **Morphine Sulfate** 2-4mg IV/IM q2min prn (max 10mg)

or

(3) **Ketorolac [Toradol]** 15-30mg IV or 30-60mg IM
***Do Not Utilize on RENAL Insufficiency or GI Bleed Patients ***

If additional analgesia is needed for persistently severe pain (8-10) believed to be due to a surgical pathology contact Medical Control

If nausea/vomiting due to analgesia:
Ondansetron 4 mg IV/IO/PO prn (max 8mg) for nausea/ vomiting with active pain

Promethazine 12.5- 25mg IV/IM

Emergency Hallucinations/Agitation

Midazolam 2mg IV/IN/IO/IM PRN

[1]Wong-Baker FACES of pain rating scale.
** Score is based on patient's (not provider's) assessment of their pain**

[1] See **Adult Trauma Center Triage** protocol to determine which MOI(s) is most severe and may be distracting

THESE PATIENTS MUST BE TRANSPORTED TO THE E.D.