Pain Management - Pediatric 2.17P

EMT STANDING ORDERS

E

- Routine Patient Care.
- Use ample padding when splinting musculoskeletal injuries.
- Consider the application of a cold pack for 30 minutes.
- Rate the patient's pain:
  - Children greater than 8 years of age:
    - Ask the patient to rate pain on a scale from 0 – 10, where 0 is no pain and 10 is the worst pain ever experienced by the patient.
  - Children 3 – 8 years of age:
    - Use the Wong-Bakers FACES Scale (see Pain Management - Pediatric Protocol 2.17P Page 2).
  - Children less than 3 years of age or non-verbal:
    - Use the r-FLACC Pain Scale, see Pain Management - Pediatric Protocol 2.17P Page 2.
- Consider sucrose for infants for minor procedural pain or when used with other pharmacologic agents.
  - Full term infants up to 60 days of age:
    - Slowly administer 1.5 to 2 ml of a 24% solution directly onto infant's anterior tongue over a period of 2 minutes, repeat once.
    - Provide a pacifier for non-nutritive sucking and wait two minutes for onset.
    - Pain control effects should persist for up to 8 minutes.
  - Preterm infants:
    - Follow same administration procedure using 0.1 –1.0 ml.
  - Dose may be repeated once for full term and preterm infants.

ADVANCED EMT STANDING ORDERS

A

- Nitronox: Patient must be able to self-administer this medication. Nitronox is contraindicated in patients with abdominal pain, pneumothorax, head injury, or diving-emergency patients.

  Note: Nitronox may only be used if the patient has not received an opiate.

PARAMEDIC STANDING ORDERS

P

Unless the patient has altered mental status consider **one** of the following for pain control:

- Fentanyl 1.0 micrograms/kg IV/IM/IN (maximum dose 100 micrograms) may repeat 0.5 micrograms/kg (Maximum dose 50 micrograms) every 5 minutes. May be repeated to a total of 3 doses, **OR**
- Morphine 0.1mg/kg IV (maximum dose 5mg) may repeat 0.05mg/kg (maximum dose 2.5mg) every 5 minutes May be repeated to a totoal of 3 doses.
  - **Antidote:** For hypoventilation from opiate administration by EMS personnel, assist ventilations and administer naloxone per Pediatric Color Coded Appendix 3.
- Contact **Medical Contro**l for guidance regarding:
  - Altered mental status or
  - Requests to provide additional doses of a medication.

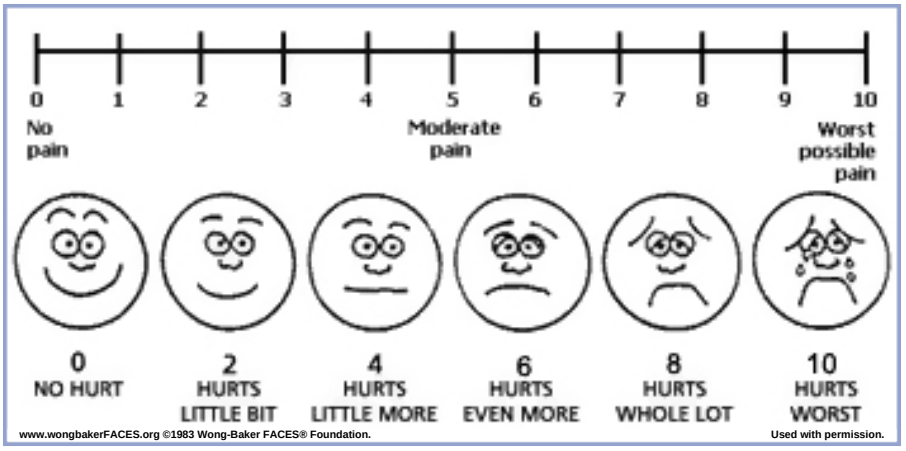
- Medications should be administered cautiously in frail or debilitated patients; lower doses should be considered.
- Narcotics should be administered with caution for patients with altered mental status, hypoventilation, hypotension and / or history of allergies to similar class of medications.
- A scavenger and ventilation fan should be used while administering Nitronox.

PEARLS:

- Avoid coaching the patient; simply ask him/her to rate his/her pain on a scale from 0 – 10, where 0 is no pain at all and 10 is the worst pain the patient has ever experienced.Place the patient in a position of comfort, if possible.
- Give reassurance, psychological support, and distraction.
- Reassess the patient's pain level and vital signs every 5 minutes.

Policy Continues

Policy Continued



Wong-Baker FACES Scale
For patients 3 – 8 years of age
The faces correspond to numeric values from 0 – 10. The scale can be documented with the numeric value or the textual pain description

r-FLACC Pain Scale
For patients less than 3 years of age or non-verbal patients

Categories		Scoring	
	0	1	2
F Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested **appears sad or worried**	Frequent to constant frown, clenched jaw, quivering chin **distress-looking face: expression of fright or panic**
L Legs	Normal position or relaxed	Uneasy, restless, tense **occasional tremors**	Kicking, or legs drawn up **marked increase in spasticity, constant tremors or jerking**
A Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense **mildly agitated (eg. head back and forth, aggression); shallow, splinting respirations intermittent sighs**	Arched, rigid, or jerking **severe agitation, head banging, shivering (not rigors); breath-holding, gasping or sharp intake of breath; severe splinting**
C Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint **occasional verbal outburst or grunt**	Crying steadily, screams or sobs, frequent complaints **repeated outbursts, constant grunting**
C Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractable	Difficult to console or comfort **pushing away caregiver, resisting care or comfort measures**

Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.

Patients who are awake: Observe for at least 1-2 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed

Patients who are asleep: Observe for at least 2 minutes or longer. Observe body and legs uncovered. If possible reposition the patient. Touch the body and assess for tenseness and tone.

The revised-FLACC can be used for all non-verbal children. The additional descriptors (in bold) are descriptors validated in children with cognitive impairment. The nurse can review with parents the descriptors within each category. Ask them if there are additional behaviors that are better indicators of pain in their child. Add these behaviors to the tool in the appropriate category.