# 2.15P Pain Management – Pediatric



## 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 2.15P Page 2.

## 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 0.1 mg/kg IV (maximum dose 5 mg) may repeat 0.05 mg/kg (maximum dose 2.5 mg) every 5 minutes. May be repeated to a total of 3 doses.

**Antidote:** For hypoventilation from opiate administration by EMS personnel, assist ventilations and administer as directed in the Poisoning/Substance Abuse/Overdose Protocol 2.16P.

**AND/OR**

- Ketamine for patient > 3 months:
  - 0.5 – 1 mg/kg IN **OR**
  - 0.1 – 0.25 mg/kg IV diluted in 50 – 100 mL 0.9% NaCl or D5W over 10 minutes (no IV pump needed)
    - To minimize chance of dysphoric reaction consider starting at lower doses and increasing if needed for analgesia.

**Antidote**: For dysphoria (emergence reaction) caused by ketamine administer midazolam 0.05 mg/kg IV/IM (max single dose of 2 mg) every 5 minutes as needed.

- For nausea: See Nausea/Vomiting 2.11 Protocol
- Contact **Medical Contro**l for guidance regarding:
  - Altered mental status or
  - Requests to provide additional doses of a medication.

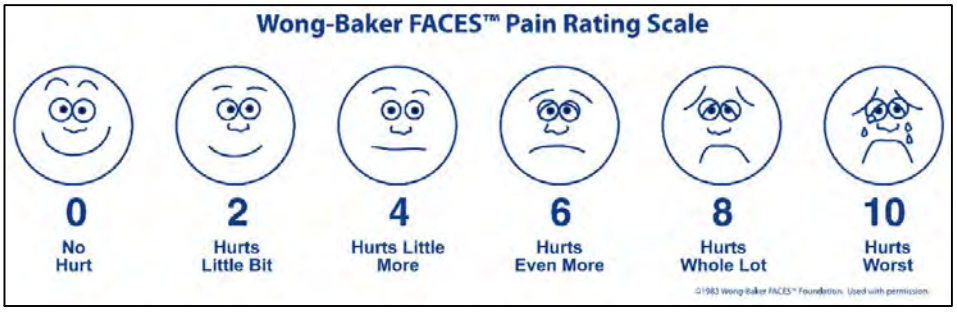
Ketamine contraindicated in patients unable to tolerate hyperdynamic states such as those with known or suspected aortic dissection, myocardial infarction, and aortic aneurysm.

Policy Continues

Policy Continued

PEARLS:

- Ketamine should be considered in patients with severe pain, hemodynamic compromise, pain refractory to opiates, patients on chronic opiate treatment, and patients with history of substance use disorder and receiving medication assisted treatment (e.g. methadone, buprenorphine).
- Ketamine dosing is based on IDEAL body weight or Pediatric Color Coded Appendix
- Ketamine may cause appearance of intoxication at higher doses. Dysphoria may occur as the medication effects wear off.
- 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.




## Faces Legs Activity Cry Consolability Revised Scale (FLACC-R)

| Categories | 0 | 1 | 2 |
|---|---|---|---|
| Face | No particular expression or smile | Occasional grimace or frown, withdrawn, disinterested, **sad, appears worried** | Frequent to constant quivering chin, clenched jaw, **distressed looking face, expression of fright/panic** |
| Legs | Normal position or relaxed, **usual tone & motion to limbs** | Uneasy, restless, tense, **occasional tremors** | Kicking, or legs drawn up, **marked increase in spasticity, constant tremors, jerking** |
| Activity | Lying quietly, normal position, moves easily, **regular, rhythmic respirations** | Squirming, shifting back and forth, tense, **tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs** | Arched, rigid or jerking, **severe agitation, head banging, shivering, breath holding, gasping, severe splinting** |
| Cry | No cry (awake or asleep) | Moans or whimpers; occasional complaint, **occasional verbal outbursts, constant grunting** | Crying steadily, screams or sobs, frequent complaints, **repeated outbursts, constant grunting** |
| Consolability | Content, relaxed | Reassured by occasional touching, hugging or being talked to, distractible | Difficult to console or comfort, **pushing caregiver away, 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.