

Southeast Arizona EMS Region

Standing Order Training Module

Pain Management

January 2005

PURPOSE

This SAEMS Standing Order Training Module has been developed to serve as a template for EMS provider training. The intent is to provide consistent and concise information to all providers practicing within the SAEMS Region. The content of the Training Module has been developed by the Protocol Development and Review Committee, and includes the specific Standing Order, resource and reference material, and instructions for completing the Training Module to obtain continuing education credit. One hour of SAEMS continuing education credit may be issued following successful completion of the module.

OBJECTIVES: Upon completion of this learning module the participant will be able to:

1. Discuss the role of medical direction related to the use of Standing Orders.
2. List three benefits of Standing Orders.
3. Outline inclusion and exclusion criteria for this Standing Order.
4. Describe the communication process between the field and the receiving facility when a Standing Order is implemented.
5. List the elements of the dispatch radio relay.
6. List two reasons for direct facility (on-line) contact following implementation of a Standing Order.

INSTRUCTIONS:

1. Read the accompanying information, Standing Order, and any additional reference material as necessary.
2. Complete the attached Posttest by _____, and return with self addressed envelope to:

3. A SAEMS CE Form will be issued to providers scoring greater than ____% on the Posttest.
4. Please contact _____ for questions, suggestions, concerns.

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Resource Material

OVERVIEW

The EMS system in Tucson has traditionally operated under direct medical control, requiring early radio contact with a base hospital physician on all prehospital encounters. The concept of Standing Orders developed as a natural evolution of a busy EMS system. SAEMS implemented Standing Orders in 1998, with the intent of reducing the amount of time required for radio contact while maintaining or improving the level of patient care provided in the community. The regional Base Hospital Medical Directors approved each Standing Order and granted authority for providers to assess and treat select patients *without* on-line medical direction. The potential benefits of a Standing Order (off-line) system include a shorter on-scene time, more appropriate treatment decisions, more time to interact with the patient, and broader consistency in care.

Providers practicing in the SAEMS region are governed not only by their Scope of Practice, but also by Protocols, Minimum Treatment Standards, and Standing Orders. There are a number of SAEMS *Administrative* Protocols outlining responsibilities for such things as approved documentation abbreviations, infectious disease exposure notification, and select patient triage parameters. The *Advanced Training* Protocols list those skills requiring additional training and medical director approval; for example, automatic transport ventilators and central line insertion.

Minimum Treatment Standards are an algorithmic flow of basic standards of care for various patient care situations. They outline, at a minimum, the assessment and treatment considerations for BLS and ALS providers, and are available should communication attempts for on-line medical direction fail.

Standing Orders differ from Protocols and Minimum Treatment Standards in that there is no required contact with a medical direction authority for orders. The physician orders are outlined on each Standing Order document. They are the legal equivalent of a radio transmitted, on-line order from a medical direction authority. For this reason, they do not allow for any deviation: orders must be followed sequentially and precisely. They are not guidelines or suggested interventions.

DEFINITIONS

- **Protocols** - Guidelines for prehospital care ranging from administrative to procedural.
- **Minimum Treatment Standards** – Algorithm for minimum standard of care guidelines for patient care situations.
- **Standing Orders** – Specific interventions which may be undertaken in lieu of contacting on-line medical direction.
- **On-Line Medical Direction** - Medical direction of prehospital activities by direct radio or telephonic communications with a medical direction authority.
- **Medical Direction Authority** – An administrative medical director or an on-line medical direction physician.
- **MEDS (dispatch) Communication Relay** – Essential information relayed from the field to the receiving facility via dispatch regarding a Standing Order patient.

DOCUMENTATION

Quality prehospital care can be achieved following adequate education and training, accurate patient assessment, skilled procedure intervention, use of good judgment, and continuous quality improvement. Documentation is essential to validate quality care. Reports should allow others to understand and follow the providers' decision-making process, particularly when Standing Orders are implemented, as the prehospital care report will often be the sole document describing the call.

There are key components to the written report when Standing Orders are utilized. Thorough documentation of an adequate assessment is essential. Reference to inclusion and exclusion criteria is recommended, with attention also paid to pertinent negatives. It should be clear why the particular Standing Order was chosen. Implementation and response to interventions is also a critical part of the prehospital report. Independent, off-line practice often requires additional responsibility on the part of the provider when it comes to judgment and documentation.

COMMUNICATION

All standing orders require the following information be provided to dispatch and relayed to the receiving facility: specific standing order used, age, sex, and ETA. Additional information may be required as follows:

- | | |
|---|--|
| 1. Acute Anaphylaxis/Stable Allergic Reaction | Stable/Unstable |
| 2. Acute Pulmonary Edema | |
| 3. Asthma/COPD | |
| 4. Cardiac Arrest | |
| 5. Chest Pain | 12-Lead sent? |
| 6. Dead on Scene | No hospital relay |
| 7. Hypoglycemia | |
| 8. Minor Medical | Chief complaint ("Sick Person" not acceptable) |
| 9. Motor Vehicle Crash | No hospital relay |
| 10. Pain Management | Chief complaint (mechanism of injury) |
| 11. Seizures | BLS or ALS |
| 12. Stroke/TIA | Symptom onset, patient weight |
| 13. Unconscious/Unresponsive | |

There is no need for a dual patch on standing order patients going to a non-medical direction authority facility (VA, HCH, or UPH), as the physician orders are already provided. Receiving facilities must be familiar with each standing order to best anticipate and prepare for the patient's arrival. Standing Orders are not intended for use during interfacility transfers, nor are they appropriate for use on pregnant patients. Check with your medical direction authority for recommendations regarding the use of Standing Orders during scene transfers greater than 30 minutes. Also check with your medical direction authority for a list of those Standing Orders approved for *your* use.

**NEVER HESITATE TO CONTACT MEDICAL
DIRECTION FOR ANY PROBLEM, QUESTION,
OR CHANGE IN STATUS!**

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Post Test

Name: _____ Date: _____

1. Which of the following signs and symptoms would be considered exclusion criteria for the Pain Management Standing Order?
 - a. 5% BSA burn
 - b. Complaint of right side pain
 - c. Hip pain s/p fall
 - d. Shoulder pain s/p fall 2 days ago

2. A pain assessment should be documented:
 - a. With your initial assessment only
 - b. After medication administration
 - c. With your initial assessment and after every medication dose
 - d. Only if the pain is rated above a "5"

3. The adult dose for Morphine use in this Standing Order is:
 - a. 0.2-0.5mg Q 5 minutes up to max of 20mg
 - b. 0.1 mg/kg Q 5 minutes up to max of 20 mg
 - c. 5 – 10mg Q 5 minutes up to max of 20 mg
 - d. 2- 5 mg Q 5 minutes up to max of 20 mg

4. The pediatric dose for Morphine use in this Standing Order is:
 - a. 2 –5 mg Q 5 minutes up to max of 10 mg
 - b. 0.1 mg/kg in increments of 1 –2 mg Q 5 minutes up to max of 10 mg
 - c. 1 – 2 mg/kg Q 5 minutes up to max of 10 mg
 - d. 0.1 – 0.2 mg/kg Q 5 minutes up to max of 10 mg

5. The definition of "Specific interventions which may be undertaken in lieu of contacting on-line medical direction" refers best to:
 - a. Protocols
 - b. Minimum Treatment Standards
 - c. Medical Direction Authority
 - d. Standing Orders

6. In addition to the patients age and sex, and your unit number and ETA, the following is needed in the MEDS relay information for this Standing Order:

7. Which of the following patients meet the inclusion criteria for the Pain Management Standing Order?
 - a. 37 year old male who fell off a 24 ft ladder and is c/o R shoulder pain
 - b. 18 month old female with 9% BSA burn
 - c. 54 year old female c/o back pain after slipping on a wet floor today
 - d. 26 year old male who smells of an alcoholic beverage and c/o L hip pain after falling off his bar stool

8. Your adult patient states “My pain is getting worse not better” after you have given him 10mg of Morphine for his dislocated shoulder. You should:
 - a. Keep giving him more, he can have up to 20mg
 - b. Tell him “Sorry, you have had all the medicine I can give you. Be tough.”
 - c. Contact medical direction immediately and ask to give more medication
 - d. Point out the “No Whining” sign on the wall

9. Which patient demonstrates effective pain management?
 - a. Initially pain described as a “10, after 10mg Morphine pt describes as “still a 10”
 - b. Initially pain described as an “8”, after 10mg Morphine pt moaning
 - c. Initially pain described as an “8”, after 10mg Morphine pt describes as a “4”, Vital signs normal
 - d. Initially pain described as a “5”, after 10mg Morphine pt describes as a “7”

10. You may give up to 20 mg of Morphine as long as the patients SBP remains ≥ 90 , their RR remains ≥ 12 , or until pain is relieved.
 - a. True
 - b. False

Bibliography

1. Rottman SJ, Schriger DL, Charlop G, et al: On-line medical control versus protocol-based prehospital care. *Annals of Emergency Medicine* 1997; 30:1, 62 – 68.
2. Krafur J: What to do when EMS protocols don't fit. *National Association of Emergency Physicians Newsletter*. 2000; 9:3. 2-3.
3. Trauma Team EMS PROTOCOLS
[HTTP://WWW.SSGFX.COM/CP2020/MEDTECH/PROCEDURES/PROTOCOLS.HTM](http://www.ssgfx.com/CP2020/MEDTECH/PROCEDURES/PROTOCOLS.HTM)
Prehospital Medical Protocols & Standing Orders Bryan E. Bledsoe, DO, FACEP.

Tips/Pearls/Pitfalls

Assess pain scale 1 to 10 before morphine administration and document data.

Use same scale as a measure to assess effectiveness after each administration and document data.

“Drug use” is defined as illicit drug use.

Burns > 10% BSA still merit pain medication, however you need to establish medical control with the burn center as they fit into the SAEMS burn patient protocol.

Use narcotics cautiously in the elderly as they will not clear the drug as swiftly. Allow 10 minutes to assess the full effect of the medication prior to additional dosing.

Dramatic drops in SBP and RR can occur once pain is relieved. Administer medication and monitor patient cautiously.

Assess your patients BP, HR, RR, and pain scale during your initial assessment and 5 minutes after every medication administration.

To replace narcotics at UMC, bring your First Care Form to the nurse intermediary (aka: the telemetry nurse) to be “green stamped” then proceed to the Pharmacy to obtain your med.