

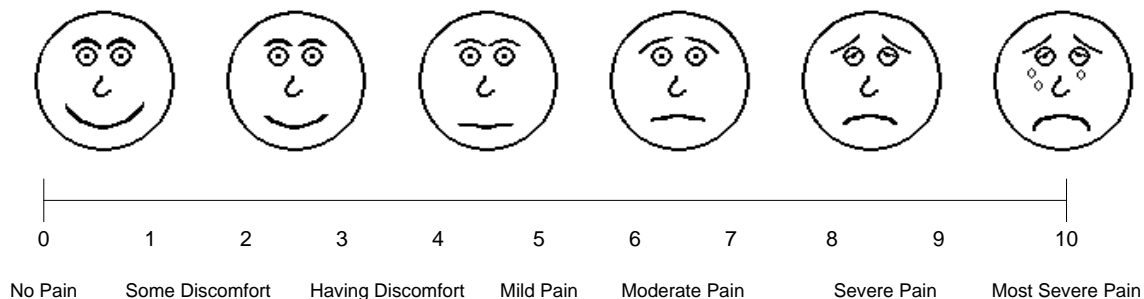
**MEDICAL CONTROL GUIDELINE: PAIN ASSESSMENT**

**PRINCIPLES:**

1. All patients with any complaint of pain shall have an appropriate pain assessment and management.
2. An accurate and thorough pain assessment requires initial and ongoing assessments be performed and documented.
3. Measurement of a patient's pain is subjective; therefore, the patient best determines the presence and severity of their pain.
4. Recording a pain level using a pain scale provides health care providers with a baseline against which to compare subsequent evaluations of the patient's pain.
5. Los Angeles County utilizes the "Numeric Pain Intensity", the "Facial Expression", and FLACC (Face, Legs, Activity, Cry and Consolability) Behavioral Tool pain scales.

**GUIDELINES:**

1. Perform an initial pain assessment including:
  - a. Onset
  - b. Provoked
  - c. Quality
  - d. Region, Radiation and Reoccurrence
  - e. Severity – Scale/Intensity
  - f. Time/Duration
2. Use the Numeric Pain Intensity scale by asking the patient to rate their pain on a 0-10 scale; zero (0) equals no pain and ten (10) equals the most severe pain. Document the number selected on the EMS Report Form.
3. Use the Facial Expression pain scale if unable to use the Numeric Pain Intensity scale.



4. Utilize the FLACC Behavioral Tool for children less than 3 years of age or those with cognitive impairments or any child who is unable to use the other scales. The patient is assessed in each of the categories with a score applied to behaviors being evaluated. The five scores are totaled and the severity of pain determined based on the 0-10 pain scale.

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| Behavior      | 0  | 1   | 2   |
|---------------|--|---|---|
| Face          | No particular expression or smile            | Occasional grimace or frown, withdrawn, disinterested                 | Frequent to constant frown, clenched jaw, quivering chin          |
| Legs          | Normal position or relaxed                   | Uneasy, restless, tense   | Kicking or legs drawn up  |
| Activity      | Lying quietly, normal position, moves easily | Squirming, tense, shifting back and forth, hesitant to move, guarding | Arched, rigid or jerking, fixed position, rubbing of body part    |
| Cry           | No cry/moan (awake or asleep)                | Moans or whispers, occasional cries, sighs or complaint               | Cries steadily, screams, sobs, moans, groans, frequent complaints |
| Consolability | Calm, content, relaxed, needs no consoling   | Reassured by hugging, talking to, distractible                        | Difficult to console or comfort                                   |

5. Reassess the patient's pain frequently and after any intervention. Document the reassessment of pain on the EMS Report Form.