

METHODS FOR PAINFUL STIMULUS

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I. INTRODUCTION

Altered level of consciousness is defined as an altered state of awareness and/or disorientation to time, place, purpose, or person. This can present as confusion, lethargy, disorientation, impaired cognition, or coma. Inappropriate aggressiveness or hostility should alert prehospital care personnel to the possibility that the patient's thinking process may be impaired. Evaluation of a patient's level of consciousness includes tests for memory, attention, and alertness. The purpose of painful stimulus is to provide the Paramedic and EMT with information regarding the level of consciousness (LOC) and/or the depth of coma of the patient who is altered. As first responders, our goal is to establish LOC based on a standard of care and not cause the patient bodily harm.

The easiest and perhaps safest way to elicit a painful response in an altered patient is to exert pressure on nerves. The degree of pressure applied does not have to be great for it to be effective. This will also reduce the chance of damage occurring as a result of using a painful stimulus. The acceptable methods of painful stimulus are outlined in this Training Bulletin and are appropriate for evaluating an altered patient with minimal risk of causing damage.

II. CONSIDERATIONS

As prehospital care workers, our actions are dictated by State, County and local laws. Specifically, the Health and Safety Code states that unprofessional conduct is:

“The mistreatment or physical abuse of any patient from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance.”

Some considerations are based upon medical ethics. Ethics goes beyond examining what is wrong. It also looks at what is right, or good behavior.

The painful stimulus should never leave a temporary or permanent injury. Some assessments and treatments do cause secondary complications, but the benefits must be outweighed by the risks.

The information that is needed in the prehospital setting would **NEVER** indicate a need for the use of a painful stimulus that causes permanent injury. The first rule in medicine is to do no harm.

The painful stimulation should not be done punitively. First responders should not pre-judge the type of call prior to arrival. Personal attitudes and biases can lead to a poor decision. It may cause a rescuer to want to “punish” a patient, or “teach them a lesson.”

The level of painful stimulation shall not be in excess of what is needed to elicit an assessable response. Treatments are limited to pre-hospital care providers. In the field setting, it is not appropriate to determine responses to light pain versus deep pain. Complete diagnosis can only be determined in a hospital by an M.D. after reviewing specific neurological tests that have been done.

III. PREVIOUS PRACTICES

- A. Supraorbital Pressure (pressure on the bone above the eye) - this practice does not produce enough reaction to warrant a true test
- B. Sternal Rub - this can be very painful, damage skin and underlying tissue, and may be inaccurate if spinal trauma is present
- C. Trapezius Pinch - this can be extremely painful and can cause further injury if spinal trauma is present
- D. Calf Pinch - this can be very painful

IV. CURRENT POLICY

Currently, in the County of Los Angeles, there are **ONLY** two approved and acceptable forms of painful stimuli that can be used in the prehospital setting. These methods are:

- A. Inter-digital pressure
- B. Slight pressure on the nail bed

- Inter-digital pressure is performed by placing a hard object such as a penlight or pen between two fingers and squeezing the fingers together against the object.



- Nail bed pressure is performed by placing the tip of the patient's finger between your thumb and index finger, and pressing on the patient's nail bed with your thumb. It is better to press down at the lateral nail bed, rather than centrally (as you would to check capillary refill).



V. DOCUMENTATION

It is imperative that members documenting EMS incidents have a thorough understanding and good working knowledge of the F-902M. Members shall refer to the F-902M Instruction Manual (LAFD Book 5) Section 1.4 – Level of Consciousness.

A brief descriptive assessment should be documented on the EMS form, in addition to the numerical Glasgow Coma Scale. Reference No. 809 – Assessment of Level of Consciousness.

Maintain a complete, accurate, and legible EMS report. EMS reports shall reflect:

- All patient assessment findings and observations
- The care provided to the patient
- The patient's response to the painful stimuli, stimulus used, and other treatment interventions

Record only your observations, not your opinions, **i.e:** Pt. withdraws to inter-digital pressure. Do not record "patient is faking."

VI. CONCLUSION

Paramedics and EMT's shall perform a patient assessment to determine orientation and level of consciousness on each patient they encounter. This assessment should determine the patient's state of awareness and orientation. Painful stimulus is an effective tool to aid in the assessment of the altered patient. It allows the prehospital care worker to evaluate the level of consciousness without causing harm.