



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS AIR MOBILITY COMMAND

12 MAY 2004

MEMORANDUM FOR TCSG-D

HQ ACC/SG
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HQ AFRC/SG/A3
HQ ANG/SG/XO
HQ AMC/A3
HQ CENTAF/SG
HQ PACAF/SG
HQ USAFE/SG

FROM: HQ AMC/SG
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SUBJECT: AMC/SG Policy Letter for En Route Patient Movement (PM)/Aeromedical
Evacuation (AE) Pain Management (04-19P)

1. This Policy Letter addresses recent OIF/OEF lessons learned regarding en route pain management and is applicable to all AMC and AMC-gained medical personnel. It provides ground medical, AE, and critical care providers with information to meet the intent of JCAHO standards for pain management at the originating medical treatment facility and throughout the PM system.
2. This policy will be incorporated into DRAFT AFI 41-306, *Physicians Roles and Responsibilities in Aeromedical Evacuation* and in the Interim Change (IC) to AFI 41-307, *Aeromedical Evacuation Patient Guidelines and Standards of Care*.
3. If you have any questions, please contact my POC, Colonel Paula Mondloh, HQ AMC/SGO, DSN 779-5314 or paula.mondloh@scott.af.mil.

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Attachment:
AMC/SG Policy Letter for En Route Patient Movement (PM)/Aeromedical Evacuation (AE)
Pain Management

AMC--GLOBAL REACH FOR AMERICA



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EN ROUTE PATIENT MOVEMENT/AEROMEDICAL EVACUATION
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X.1. En Route Patient Movement (PM)/Aeromedical Evacuation (AE) Pain Management.

X.1.1. Pain is a complex experience with multiple dimensions and is always subjective. Pain is defined by the International Association for the Study of Pain (IASP) as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. **NOTE:** The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment.

X.1.1.1. Under treated and poorly managed pain may lead to adverse physical and psychological consequences and complications such as pneumonia, deep vein thrombosis (DVT), delayed recovery and/or progression to chronic pain. Chronic pain diminishes one's quality of life.

X.1.2. The goal of administering any type of medication or treatment in the PM/AE system is to maintain continuity of care from the originating medical treatment facility (MTF) to the destination MTF. **NOTE:** Every patient has a right to consistent and appropriate assessment and adequate pain management to deal with the stresses of the PM/AE environment.

X.2. Stresses of Transport and Flight. Refer to AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*, Chapter 2 for detailed discussion.

X.2.1. Decreased partial pressure of oxygen: Decreases tissue oxygen availability and will exacerbate oxygenation deficiencies due to preexisting hypoxias related to injury, disease, and/or treatment. May exacerbate the CNS effects of pain medication.

X.2.2. Barometric Pressure Changes: Gas expansion in the abdominal cavity at cruise altitude may lead to crowding of the diaphragm increasing pain and splinting. Splinting and diaphragmatic crowding decreases lung volume and expansion, and may exacerbate the risk of hypoxia. Consider placing a nasogastric tube.

X.2.3. Thermal: Cold temperatures may lead to vasoconstriction, shivering and exacerbated pain. Keep patient warm and limit exposure to cold temperatures.

X.2.4. Vibration/Turbulence: Increases muscle activity, metabolic rate, and peripheral vasoconstriction. Avoid excessive speed of ground transportation assets. Secure patients away from the bulkhead and floor of ground vehicles and aircraft, encourage and assist with position changes, and provide adequate padding and skin care, especially for orthopedic patients with internal/external fixators.

X.2.5. Gravitational Forces: Seat belts in side facing and rear facing seats may cause injury during acceleration/deceleration; use extra padding between abdomen and seat belt for patients with abdominal surgery.

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X.2.6. Fatigue: Exacerbates the patient's underlying condition/diagnosis due to the overall effect of previously mentioned stresses of flight, and length of time the patient has been in the PM/AE system.

X.3. Indicators of Pain by Hierarchy:

X3.1. Patient self-report – single most reliable measure of intensity of pain.

X.3.2. Pathological conditions or procedures known to be painful.

X.3.3. Observed pain-related behaviors (grimacing, restlessness, vocalization, groaning).

X.3.4. Reports of pain by family or attendant.

X.3.5. Physiological changes (increased pulse and blood pressure).

X.4. Assessment: *WARNING:* When assessing pain, always rule out and treat life-threatening conditions, such as cardiac pain (Refer to AFI 41-307).

X.4.1. Obtain vital signs, including pulse oximetry and assess pain at least every 4 hours for patients who require en route pain medication administration. ***NOTE:*** Take into consideration the type of medication, time of onset based on route, and duration of known effectiveness.

X.4.1.1. Rule out hypoxia and compartment syndrome.

X.4.2. Ascertain the patient's pain level and their acceptable level of pain. The acceptable level of pain is the level of pain the patient is willing to tolerate.

NOTE 1: Individual practice may lead to differences in delivery of pain medication.

NOTE 2: Healthcare providers' bias, prejudice and stereotyping may lead to differences in delivery of pain medication. Avoid attributing pain to psychological causes, and respect/accept patient's self-report of pain.

X.4.2.1. Have the patient rate pain on a numerical scale of 0 – 10 with 0 being no pain, 1 being the least and 10 being the worst pain possible. Use patient numerical scale verbalization or the Wong-Baker FACES Pain Rating Scale (Figure X.1.)

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Figure X.1. Wong-Baker FACES Pain Rating Scale (From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: [Wong's Essentials of Pediatric Nursing](#), ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc.)

X.4.2.1.1. Wong-Baker Faces Pain Rating Scale (Figure X.1.) is the pain rating scale recommend for persons age 3 years and older.

X.4.2.1.1.2. Explain to the person that each face is for a person who has no pain (hurt) or some, or a lot of pain. **Face 0** doesn't hurt at all. **Face 2** hurts just a little bit. **Face 4** hurts a little more. **Face 6** hurts even more. **Face 8** hurts a whole lot. **Face 10** hurts as much as you can imagine, although you don't have to be crying to have this worst pain. Ask the person to choose the face that best describes how much pain he/she has.

NOTE: Once the best pain grading approach is found for a given patient, document and communicate this scale to en route/in-flight healthcare providers to maintain consistency between evaluations.

X.4.3. Refer to AFI 41-307, 7.4.1, and document on AF Form 3899, *Aeromedical Evacuation Patient Record*. Note the patient's self-reported pain as, 'verbalizes pain scale as "X/10"' or 'chooses Wong-Baker FACES pain scale "X/10."'

X.4.4. Assess patient understanding and educate patient and staff on the patient's acceptable level of pain and the availability of medications.

X.4.5. A pain score of 3 or more usually indicates the need for pain medication.

X.4.6. Ascertain characteristics of pain: quality, region, radiation, what provokes/triggers (movement/dressing changes/deep breathing and coughing), palliates/eases (repositioning/elevation/support/medication), and the adequacy and adverse effects of pain medication.

X.5. When Operationally Feasible:

X.5.1. Assess cultural attitudes, stoicism, guilt, and potential frustration and helplessness, mental functioning, mood, and fear of pain.

X.5.2. Educate patients, family and attendants regarding reporting pain and availability of pain medication, as well as, the low risk of addiction from long-term use and/or high

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doses of medication for pain relief, and document on AF Form 3899. **NOTE:** Include information about prn medications being available around-the-clock.

X.6. Barriers to Communicating Pain: Infants/children, emotional or cognitive disorders, cultural, educational or language barriers; artificial airway; sedated/ventilated, and seriously ill.

X.6.1. Utilize a rating scale (Wong-Backer Faces), interpreter, and medical attendant/family member

X.6.2. Note the patient's body position, facial expressions, posture and any guarding or self-protection movements. Note rate and depth of respirations, and color. Observe for stiffness, rigidity, or flaccid muscles.

X.6.3. For children under the age of 3 and infants, note crying, moaning, arched/rigid torso, grabbing/touching wound, extremities tense or pulled up, kicking/squirming, and the physiological changes of increased pulse and blood pressure.

X.7. Treatment/Management:

X.7.1. Administer pain medication as ordered prior to potential painful events such as transportation movement and en route staging treatments and dressing changes. Take into consideration the type of pain medication, time of onset based on route, and duration of known effectiveness. For example, opioid analgesic onset is immediate when administered intravenously, and rapid when administered via intramuscular and oral routes (approximately 30 – 60 minutes); duration is usually 1– 8 hours.

X7.2. Assess adequacy of pain medication at all patient care handoffs, en route staging locations and in-flight. Consider medication for breakthrough pain (pain that “breaks through” pain relief provided by ongoing analgesia).

NOTE 1: If medication is inadequate or absent at the en route staging facility, the physician/flight surgeon will evaluate and order pain medication prior to continuation of PM. Complete and forward a DD Form 2852, **AE Event/Near Miss Report** IAW AFI 41-307, Atch 14.

NOTE 2: If a physician is not present and pain medication is not available or is insufficient, request and establish immediate radio communication with the Tactical Airlift Control Center/Air Mobility Operations Control Center/Air Operations Center/Patient Movement Requirements Center (TACC/AMOCC/AOC/PMRC) for a physician order. The MCD/nurse will complete DD Form 2852 and document the occurrence on AF Form 3829, **Summary of Patients Evacuated by Air** (if flight related).

X7.3. Non-drug interventions to assist in alleviating pain: Maintain body alignment, elevate extremity, change position; readjust splints and bivalved casts; encourage

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physical activity, if operationally and clinically feasible. Consider heat/cold application if not contraindicated.

X.7.4. Prescribed controlled drugs entrusted to a patient/attendant are considered the property of the individual, who is then responsible for safeguarding and administering the drug(s) during all phases of PM. Ensure patients understand use and have an adequate supply for duration of movement to the receiving MTF. All medical personnel will determine if the patient or attendant is competent to safely manage these drugs. **NOTE:** Patients and non-medical attendants will not carry or administer controlled injectible medications without a written physician's order.

X.7.5. The originating facility will be responsible for providing pain medication. Intratheater requires a 1 day supply and intertheater requires a 3 day supply of medication. If narcotics are sent, refer to AFI 41-307, 7.3. Controlled Drugs.

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