	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8061.18
	PROGRAM DOCUMENT: **Decreased Sensorium**	Draft Date:	10/26/94
		Effective:	11/01/17
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		Review:	11/01/18

EMS Medical Director

EMS Administrator

Purpose:

Emergency Medical Technician (EMT) and Paramedic treatment standards for patients exhibiting signs and symptoms of decreased sensorium.

Authority:

A. California Health and Safety Code, Division 2.5

B. California Code of Regulations, Title 22, Division 9

Protocol:

Determine, if possible, when patient was last observed normal.

A. **Suspected Hypoglycemia**: Suspected hypoglycemia with;
   1. Decreased responsiveness (Glasgow Coma Score < 14),
   2. History of diabetes.

BLS TREATMENT

Supplemental O2 as necessary to maintain SpO2 ≥ 94%. Use the lowest concentration and flow rate of O2 as possible.
Airway adjuncts as needed.
Spinal immobilization when indicated.
If patient is seizing, protect the patient from further injury.
Oral Glucose: Orange juice sweetened with sugar, regular soft drinks, candy, oral glucose paste or 50% dextrose only if the patient has a gag reflex. First have the patient swallow a test dose of water, and if tolerated, EMT may give glucose.
Transport.

ALS TREATMENT

Initiate Intravenous (IV) access with saline lock, or connect Normal Saline (NS) and titrate to a Systolic Blood Pressure (SBP) of 90-100 mmHg.
Perform blood sugar determination*.
If blood sugar >60 mg/dl, consider other causes of decreased sensorium.

If blood glucose ≤ 60 mg/dl, treat as follows:
Dextrose 10-12.5 grams IV. If blood sugar remains ≤ 60 mg/dl, give additional **Dextrose** 12.5-15 grams IV. May repeat for total of 50 grams.
If IV access is unavailable or delay is anticipated, treatment options are:

- **Glucagon:**
  1.0 unit Intramuscular (IM)
  OR
- **Dextrose** 10-12.5 grams IO. If blood sugar remains ≤ 60 mg/dl, give additional Dextrose 12.5-15 grams IO. May repeat for total of 50 grams.

NOTE:

1. Concentrations of 10% Dextrose (D10) or 50% Dextrose (D50) may be used.
2. IO access should be established if IV access is unavailable and if the blood sugar ≤ 60 mg/dl or decreased responsiveness continues for more than five (5) minutes after administration of Glucagon.

* In the event of glucometer failure, administer 10-12.5 grams of Dextrose or Glucagon based on clinical assessment.
Cardiac monitoring.

B. **Suspected Narcotic Overdose:** Inability to respond to simple commands, respiratory insufficiency or respiratory rate < 16.

BLS TREATMENT

Supplemental O2 as necessary to maintain SpO2 ≥ 94%. Use the lowest concentration and flow rate of O2 as possible.
Check patient/victim for responsiveness. Open the away using Basic Life Support techniques. Perform rescue breathing, if indicated. Perform CPR if pulseless.
Naloxone: (Pending approval from EMSA) Administer Intranasal (IN) Naloxone 1mg – 6mg, titrated to adequate respiratory status. IN Naloxone should be given 1mg at a time*. If response to naloxone and patient is possibly a chronic opiate user, prepare for possible narcotic reversal behavior or withdrawal symptoms (vomiting and agitation).
Airway adjuncts as needed.
Spinal immobilization when indicated.
If patient is seizing, protect the patient from further injury.
Transport.

ALS TREATMENT

Initiate IV access with saline lock or connect NS, and titrate to a SBP of 90-100 mm Hg.
Naloxone:
Preferred routes are IV or Intranasal (IN). Can also be given IM when IV or IN is difficult or impossible. 1mg – 6mg IV push, IN or IM; titrated to adequate respiratory status. IN Naloxone should be given 1mg at a time.* Do not administer if advanced airway is in place and patient is being adequately ventilated.
Perform blood sugar determination, if blood sugar ≤ 60 mg/dl, go to hypoglycemia protocol.

ADVANCED AIRWAY ADJUNCTS as needed
Cardiac monitoring.

C. **Seizures:** Active seizures, focal seizures with respiratory compromise or recurrent seizures without lucid interval.

BLS TREATMENT

Supplemental O2 as necessary to maintain SpO2 ≥ 94%. Use the lowest concentration and flow rate of O2 as possible.
Airway adjuncts as needed.
Spinal immobilization when indicated.
If patient is seizing, protect the patient from further injury.
Transport.

ALS TREATMENT

ADVANCED AIRWAY ADJUNCTS as needed.
Initiate IV access with saline lock or connect NS, and titrate to a SBP of 90-100 mmHg.
Perform blood sugar determination, if blood sugar ≤ 60 mg/dl, go to hypoglycemia protocol.
Midazolam:
IV - 0.1mg/Kg (max dose 6 mg) slow IV push, in 2 mg increments - titrate to seizure control. If IV access cannot be established Midazolam may be given IM - 0.1 mg/Kg (max dose 6 mg) in single IM injection (may be split into 2 sites if sufficient muscle mass is not present for a single injection site) – OR – IN.*
****Diazepam:**
May substitute Diazepam when there is a recognized pervasive shortage of Midazolam. 5-10 mg IVP to control seizures. If no IV access, 10 mg IM. May repeat once. Max dose 20 mg.
Cardiac Monitoring.

*Intranasal medications are to be delivered through an atomization device with one-half the indicated dose administered in each nostril.

****Diazepam may be used when Midazolam is not available or when using Diazepam from CHEMPACK supplies.

Consider AEIOUTIPS:

Alcohol
Epilepsy
Insulin
Overdose
Uremia
Trauma
Infection
Psychiatric
Stroke or Cardiovascular