

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8061.19
	<u>PROGRAM DOCUMENT:</u> Decreased Sensorium	Initial Date:	10/26/94
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Signature on File

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 EMS Medical Director

 EMS Administrator

Purpose:

- A. To serve as a treatment standard 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:

- A. **Suspected Hypoglycemia:**
 1. Decreased responsiveness (Glasgow Coma Score < 14),
 2. History of diabetes.
 3. Determine, if possible, when patient was last observed normal.

BLS	
I.	Supplemental O2 as necessary to maintain SpO2 ≥ 94%. Use the lowest concentration and flow rate of O2 as possible.
II.	Airway adjuncts as needed.
III.	Spinal motion restriction when indicated.
IV.	Perform blood glucose determination <ul style="list-style-type: none"> • Oral Glucose: Orange juice sweetened with sugar, regular soft drinks, candy, oral glucose paste or 50% dextrose only if the patient is alert and oriented. Have the patient swallow a small amount of water, and if tolerated, EMT may give glucose.
V.	Transport.

ALS	
I.	Initiate vascular access and titrate to a Systolic Blood Pressure (SBP) > 90 mmHg.
II.	If blood glucose > 60 mg/dl, consider other causes of decreased sensorium.
III.	If blood glucose ≤ 60 mg/dl, treat as follows: <ul style="list-style-type: none"> • 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.
IV.	If IV access is unavailable or delay is anticipated, treatment options are: <ul style="list-style-type: none"> • Glucagon: 1 mg 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: Concentrations of 10% Dextrose (D10) or 50% Dextrose (D50) may be used.

- 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.

- V. In the event of glucometer failure, administer 10-12.5 grams of Dextrose or 1 mg of Glucagon based on clinical assessment.
- VI. Cardiac monitoring.

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

BLS		
<ol style="list-style-type: none"> I. Supplemental O₂ as necessary to maintain SpO₂ $\geq 94\%$. Use the lowest concentration and flow rate of O₂ as possible. II. Check patient/victim for responsiveness and ABC's. III. Naloxone: Administer *Intranasal (IN) Naloxone per policy 2523-Administration of Naloxone by BLS Personnel. IV. Airway adjuncts as needed. V. Spinal motion restriction when indicated. VI. Perform blood glucose determination. VII. If patient is seizing, protect the patient from further injury. VIII. Transport 		
ALS		
<ol style="list-style-type: none"> I. Initiate vascular access; and titrate to a SBP > 90 mm Hg. II. Naloxone: <ul style="list-style-type: none"> • 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. III. Perform blood glucose determination, if blood glucose ≤ 60 mg/dl, go to hypoglycemia protocol. IV. ADVANCED AIRWAY ADJUNCTS as needed V. Cardiac monitoring. 		
Cross Reference	Administration of Naloxone by BLS Personnel	PD #2523

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

BLS
I. Supplemental O ₂ as necessary to maintain SpO ₂ ≥ 94%. Use the lowest concentration and flow rate of O ₂ as possible. II. Airway adjuncts as needed. III. Spinal motion restriction when indicated. IV. Perform blood sugar determination. V. If patient is seizing, protect the patient from further injury. VI. Transport.
ALS
I. ADVANCED AIRWAY ADJUNCTS as needed. II. Initiate vascular access and titrate to a SBP > 90 mmHg. III. If blood sugar ≤ 60 mg/dl, refer to above suspected hypoglycemia IV. Midazolam: <ul style="list-style-type: none"> • IV - 0.1mg/Kg (max dose 6 mg) slow IV push, or IN in 2 mg increments - titrate to seizure control. • If IV or IN not available 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). V. **Diazepam: <ul style="list-style-type: none"> • 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. VI. 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	Trauma
Epilepsy	Infection
Insulin	Psychiatric
Overdose	Stroke or Cardiovascular
Uremia	