Altered Mental Status– 10.020

TREATMENT: Treat per Universal Patient Care protocol.

A. Hypoglycemia
1. Determine capillary blood glucose level. If < 70 mg/dl treat with the following:
   a. If patient can protect their own airway administer **Oral Glucose**.
   b. If patient is unable to protect their own airway, administer **Dextrose 10%, IV/IO** titrate to effect or **Dextrose 50% (Dilute with NS or LR) slow IV. IO** if unable to obtain IV access**.**
2. Repeat blood glucose level after 5-10 minutes and repeat treatment if it remains low.
3. If no IV can be promptly established:
   1. Give **Glucagon 1 mg IM** if available
   2. If inadequate response to **glucagon**, consider prompt IO access for dextrose administration as dictated by patient acuity.

B. Hyperglycemia
1. Determine CBG. If >300 mg/dl, treat with **250-500 ml NS or LR** via IV. May repeat CBG and treatment once after 5-10 minutes.

C. Opiate Overdose
1. If opiate intoxication is suspected, administer **Narcan 0.4 - 2.0 mg IV/IM/IN/IO or prefilled nasal spray 4 mg.**
2. If no improvement and opiate intoxication is still suspected, repeat *Narcan* every 3-5 minutes prn.

D. Combative Patient
1. Crew safety is paramount. Request police assistance.
2. Consider causes for behavior (seizure, stroke, hypoglycemia, poisoning)
3. Determine Behavioral Severity Index (BSI) and treat accordingly.

Level	State	Description
1	Confused	Appears obviously confused and disoriented. May be unaware of time, place, or person.
2	Restless	Anxious. Easily annoyed or angered. Unable to tolerate the presence of others.
3	Agitated	Frequent non-purposeful movement. Behavior is overtly "loud" or noisy. *e.g. Slams doors, shouts out when talking etc.*
4	Verbally Threatening	A verbal outburst with intent to intimidate or threaten another person. *e.g. Verbal attacks, abuse, name-calling, verbally comments uttered in a snarling aggressive manner.*
5	Physically Threatening	Demonstration of intent to physically threaten another person. *e.g. Aggressive stance, grabbing another person's clothing, raising of an arm or leg, making of a fist or modeling of a head-butt directed at another*
6	Attacking Objects	An attack directed at an object and not an individual. *e.g. Indiscriminate throwing of an object, banging or smashing windows, kicking, banging or head- butting an object, or the smashing of furniture.*
7	Attacking People	Any physical assault on another person or persons. *e.g. Kicking, punching, striking, biting, throwing objects at a specific living target, brandishing or use of any object as a weapon.*

Level	Approved Interventions *The interventions listed at each BSI level represent the MAXIMUM intervention allowed. Providers may use*	

	their discretion to apply interventions listed in lower-acuity BSI levels but may not exceed the recommended interventions for the highest-acuity classification the patient meets.	EtCO2 monitoring is mandatory with use of sedating medication. If **droperidol** is administered, perform 12-lead EKG to evaluate QTc once sedation is achieved On reassessment between doses of benzodiazepine, if the patient demonstrates rapidly increasing violence or aggression, consider addition of **droperidol** or **ketamine**. Post-sedation: • IV access • Consider fluid bolus • Continuous cardiac, pulse oximetry, and capnography monitoring. • 12-lead EKG
1	Keep patient informed of plan of care and involved in decision making. Verbally redirect and reorient.	
2-3	Coaching, reassurance, and/or verbal de-escalation *AND, IF NEEDED*: **Midazolam** IM: 2.5 – 5 mg once. Reassess after 10 minutes and consider additional 2.5 – 5 mg IM if necessary. IV/IO: 1 – 2.5 mg once. Reassess after 5 minutes and consider additional 1 - 2.5 mg IV/IO if necessary. OR **Lorazepam** (2nd line if midazolam unavailable) IM: 1 – 2 mg once. Reassess after 10 minutes and consider additional 1 – 2 mg IM if necessary. IV/IO: 0.5 - 1 mg once. Reassess after 5 minutes and consider additional 0.5 – 1 mg IV/IO if necessary. OR **Droperidol/Haldol** IM: 2.5 mg - 5 mg IV: 2.5 mg once PLUS: All gurney seatbelts with buckle guards	
4-5	**Midazolam** IM: 5 - 10 mg once. Reassess after 5 minutes and consider additional 5 mg IM q5 min to maximum of 20 mg. IV/IO: 2.5 – 5 mg once. Reassess after 3 minutes and consider additional 2.5 – 5 mg IV/IO q3 min to maximum of 10 mg. OR **Lorazepam** (2nd line if midazolam unavailable) IM: 2 - 4 mg once. Reassess after 5 minutes and consider additional 2 - 4 mg IM q5 min to maximum of 8 mg. IV/IO: 1 - 2 mg once. Reassess after 3 minutes and consider additional 1 - 2 mg IV/IO q3 min to maximum of 4 mg. OR **Droperidol/Haldol** IM: 5 mg once IV: 5 mg once PLUS: All gurney seatbelts with buckle guards AND limb restraints x4	
6-7	**Midazolam** IM: 5 - 10 mg once. Reassess after 5 minutes and consider additional 5 mg IM q5 min to maximum of 20 mg. IV/IO: 2.5 – 5 mg once. Reassess after 3 minutes and consider an additional 2.5 – 5 mg IV/IO q3 min to maximum of 10 mg. OR **Lorazepam** (2nd line if midazolam unavailable) IM: 2 - 4 mg once. Reassess after 5 minutes and consider additional 2 - 4 mg IM q5 min to maximum of 8 mg. IV/IO: 1 - 2 mg once. Reassess after 3 minutes and consider additional 1 - 2 mg IV/IO q3 min to maximum of 4 mg. OR **Droperidol/Haldol** IM: 5 - 10 mg once IV: 5 – 10 mg once OR If patient presents in a state of psychomotor agitation and/or dissociation from reality that is immediately threatening to the patient, general public, or EMS provider's safety: *Defined by clinical features such as paranoia, hyperaggression, violence, hallucinations, heightened sympathetic tone (e.g. tachycardia, hypertension, hyperthermia, increased strength) and frequently associated with stimulant / sympathomimetic drug use.*	

Consider **Ketamine** 4 mg/kg IM once, to maximum of 500 mg.

Exercise caution in overestimation of weight – providers should agree on best estimate.

If emergence reaction occurs consider:
Midazolam 5 mg IM. May repeat every 5 minutes, as necessary, to maximum 20 mg.
Midazolam 2.5 mg IV/IO. May repeat every 3 minutes, as necessary, to maximum 10 mg.

PLUS: All gurney seatbelts with buckle guards AND limb restraints x4

EMS providers should use good faith judgement in determining appropriate use of physical restraint or chemical sedation to facilitate the safe evaluation and treatment of a suspected emergency medical condition when the patient is unable to demonstrate decisional capacity to make an informed refusal. Inappropriate use of restraint or sedation may be considered an infringement on the patient's civil rights.

EMS providers may not restrain or sedate a patient for law enforcement purposes alone.

EMS providers must use discretion when restraining a patient against their will, and should completely document their assessment and rationale for their actions.

PEDIATRIC PATIENTS:

A. Hypoglycemia
- Infants < 10 kg (birth to 1 year) with CBG < 45 mg%:
  - Give 2.5 - 5 ml/kg of **Dextrose 10%.**
- Children 10 kg – 35kg with CBG < 60 mg%:
  - Give 2 - 4 ml/kg of **Dextrose 25%.**
- Repeat dextrose as needed.
- **Glucagon 0.5 mg IM** (< 5 y/o or < 20 kg) to a maximum of 1 mg.

B. Combative/Patient Restraint

Midazolam:
0.1 mg/kg IV/IO to a max single dose 2.5 mg or
0.2 mg/kg IM to a max single dose of 5 mg
Contact OLMC for re-dosing or ketamine use.

C. If suspected opiate overdose:
- **Naloxone 0.1 mg/kg IV/IO/IM/IN** to a maximum of 2 mg. Repeat prn.

NOTES & PRECAUTIONS:

A. If patient is disoriented, think of medical causes.
B. If patient is suicidal do not leave alone.
C. All patients in restraints must be monitored closely.
D. Observe for decreased LOC, focal neurological findings, and hypothermia.
E. Look for Medical Alert tags.
F. Sedated pts should have cardiac, capnography and SpO2 monitoring if available.