Altered Mental Status
(including, but not limited to hypoglycemia and opioid overdose)

Note:
Request Advanced Life Support if available.
Do NOT delay transport to the appropriate hospital.

Note:
This protocol is for patients who are NOT alert (A), but who are responsive to verbal stimuli (V), responding to painful stimuli (P), or unresponsive (U).

I. Assess the situation for potential or actual danger. If the scene/situation is not safe, retreat to a safe location, create a safe zone and obtain additional assistance from a police agency.

Note:
Emotionally disturbed patients must be presumed to have an underlying medical or traumatic condition causing the altered mental status.

Note:
All suicidal or violent threats or gestures must be taken seriously. These patients should be in police custody if they pose a danger to themselves or others.
If the patient poses a danger to themselves and/or others, summon police for assistance.

II. Perform primary assessment. Assure that the patient's airway is open and that breathing and circulation are adequate. Suction as necessary.

III. Administer high concentration oxygen. In children, humidified oxygen is preferred.

IV. Obtain and record patient's vital signs, including determining the patient's level of consciousness. Assess and monitor the Glasgow Coma Scale.

A. **If the patient is unresponsive (U) or responds only to painful stimuli (P), prepare for transport** while continuing care.

B. **If the patient has a known history of diabetes controlled by medication, is conscious and is able drink without assistance,** provide an oral glucose solution, fruit juice or non-diet soda by mouth, then transport, keeping the patient warm. If regionally approved to obtain blood glucose levels utilizing a glucometer, follow your regionally approved protocol.

C. **If patient has a suspected opioid overdose:**

i. If patient does not respond to verbal stimuli, but either responds to painful stimuli or is unresponsive; and

ii. Respirations less than 10/minute and signs of respiratory failure or respiratory arrest, refer to appropriate respiratory protocol.

iii. If regionally approved and available, obtain patient's blood glucose (BG) level.

1. If BG is less than 60, in adult and pediatric patients, follow IV (B) above.

2. If BG is more than 60 in adult and pediatric patients, proceed to next step.

iv. Administer naloxone (Narcan®) via a mucosal atomizer device (MAD).

1. **Relative contraindications:**
   - **a.** Cardiopulmonary Arrest,
   - **b.** Seizure activity during this incident,
   - **c.** Evidence of nasal trauma, nasal obstruction and/or epistaxis.

2. Insert MAD into patient's left nostril and for;
   - **a.** ADULT: inject 1mg/1ml.
   - **b.** PEDIATRIC: inject 0.5mg/0.5ml.

3. Insert MAD into patient's right nostril and
   - **a.** ADULT: inject 1mg/1ml.
   - **b.** PEDIATRIC: inject 0.5mg/0.5ml

4. Initiate transport. After 5 minutes, if patient's respiratory rate is not greater than 10 breaths/minute, administer a second dose of naloxone following the same procedure as above and contact medical control

V. If underlying medical or traumatic condition causing an altered mental status is not apparent; the patient is fully conscious, alert (A) and able to communicate; and an emotional disturbance is suspected, proceed to the Behavioral Emergencies protocol.

VI. Transport to the closest appropriate facility while re-evaluating vital signs every 5 minutes and reassess as necessary.

VII. Record all patient care information, including the patient's medical history and all treatment provided, on a Prehospital Care Report (PCR).