CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES

Manual	Policy
Emergency Medical Services Administrative Policies and Procedures	Number 530.18
Subject Paramedic Treatment Protocols **ALTERED MENTAL STATUS, POSSIBLE STROKE, AND SYNCOPE**	Page 1 of 3
References Title 22, Division 9, Chapter 4 of the California Code of Regulations	Effective Fresno County: 01/15/82 Kings County: 04/10/89 Madera County: 06/15/85 Tulare County: 04/19/05

STANDING ORDERS	
1. Assessment	ABCs
2. Secure Airway	Protect with position, basic airway maneuvers, pharyngeal airway, advanced airway if indicated, assist respirations as needed, suction as needed.
3. Oxygen	High flow for altered mental status. Low flow for stroke or syncope. Refer to EMS Policy #530.02.
4. Monitor	Treat rhythm if appropriate.
5. Naloxone	Intranasal (IN) - Administer 2 mg intranasally (1 mg per nostril) using mucosal atomizer device (MAD) if suspected narcotic intoxication and respiratory depression (rate 8 or less). This dose may be repeated in 5 minutes if respiratory depression persists. Respiration's should be supported with BVM until respiratory rate is greater than 8. Intramuscular (IM) - Administer 1 mg if unable to administer intranasally (see special considerations). May repeat once in 5 minutes. Intravenous (IV) - Administer 1 mg slow IV push if no response to intranasal or IM administration after 10 minutes. Pediatric dose – 0.1 mg/kg intranasally, if less than 10 kg and less than 1 year old. NOTE: Give before Dextrose in suspected narcotic intoxication.
6. IV Access	Saline lock or IV LR TKO – Standard Tubing – Do not delay accucheck for multiple attempts at IV. If IV cannot be established, go to 9. NOTE: IV access should be deferred if Narcan administration results in a patient's return to their normal mental status.
7. Accucheck	Fingerstick for Chemstrip/Accucheck. Record value on PCR and GCS at time of fingerstick.

STANDING ORDERS – CONTINUED ON NEXT PAGE

Approved By	Revision
Signatures on File at EMS Agency EMS Division Manager	**02/01/2011**
Signatures on File at EMS Agency EMS Medical Director	

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STANDING ORDERS (CONTINUED)

8. Dextrose	25 grams IV - if altered mental status more severe than disorientation to time or date, and if blood glucose is less than 80. May repeat in 5 minutes if altered mental status persists and repeat fingerstick is less than 80. Pediatrics - 1 ml/kg D50 IVP (maximum 50 ml). If less than 2 years old Dilute 1:1 with NS NOTE: Diluted solution will double the volume. Example: 10 kg/1 year old = 10 ml/D50 diluted 1:1 with 10 ml NS = 20 ml/D25 IVP. **Refer to Broselow Tape for specific pediatric doses.**
9. Glucagon	1 mg (1 ml) intranasally (0.5 mg per nostril) using mucosal atomizer device (MAD) – if altered mental status more severe than disorientation to time or date, and blood glucose is less than 80 and unable to start IV. May repeat in 5 minutes if altered mental status persists and repeat glucose is less than 80. **Refer to Broselow Tape for specific pediatric doses.** Intramuscular (IM) - Administer 1 mg if unable to administer intranasally (see special considerations).
10. Transport	Minimize on scene time. STAT transport if patient is unstable.
11. Contact Hospital	Per EMS Policy #530.02.

SPECIAL CONSIDERATION AND PRIORITIES

1. Assessment – Airway, vital signs, mental status, pupils, needle tracks, head or spine trauma, pill bottles, ETOH, neuro deficits, focal seizure, postictal paralysis, and medications.

2. Always suspect head and/or spine trauma as a result of falls from syncope or seizures.

3. The Paramedic may also perform an accucheck on a patient complaining of generalized weakness who presents with a diabetic history or is on diabetic medicine when family or acquaintance feels the patient is altered even if the patient is answering all questions appropriately. *This is based on Paramedic Judgement*. If an accucheck is performed and blood glucose is 60 or less, treat per protocol (i.e., orange juice sweetened with sugar, regular soft drinks or candy, oral paste, Dextrose, or Glucagon).

4. Do not insert advanced airway in suspected narcotic intoxication until after Naloxone.

5. Intranasal medication administration should be divided 50% to each nostril. However, the entire dose can be administered in one nostril if the other nostril is obstructed (i.e., NG tube, NPA, trauma). If both nostrils are completely obstructed (i.e., trauma) administer IM or IV as per protocol.

6. Special Considerations for STROKE Patients

   a. Historical Findings:

      - Patient has altered mental status, loss of speech, decreased sensation, or loss of motor function without suspected trauma.

      - Patient may have a past history of stroke or focal seizures.

   b. Physical Findings:

      - Altered mental status. May range from confusion and disorientation to coma.

- Speech disturbances – inappropriate, incomprehensible, slurred, or complete loss of speech.
- Weakness or paralysis on one side of the body.
- Weakness, paralysis, or loss of expression on one side of the face.

c. Follow Protocols – Special Notes and Emphasis

- *Document the **duration of the deficit** by identifying the *last time* the patient showed *normal* neurological function.
- *Encourage any individuals with knowledge of the patient's recent past medical history to proceed directly to the emergency department.
- *Those with transient neurological deficits or TIAs also need to be transported to the hospital for further evaluation, in order to avoid the completed stroke that may otherwise await them.
- *Some patients who have had a stroke may be unable to speak but are able to understand and remember what is said around them.

***NEW THERAPIES FOR STROKE ARE AVAILABLE:** However, successful use is only possible during a very short time window after the start of symptoms. **Notify the receiving hospital promptly, minimize scene time, and expediently transport the patient to the receiving hospital.** This is an important part of the strategy to treat patients quickly.

7. Syncope/Near Syncope

a. If suspected cause is shock/hypovolemia, transport immediately with therapy enroute.

b. If suspected cause is cardiac dysrhythmia, stabilize the patient at the scene.

8. Postural vital signs are rarely used in the field; they should <u>ONLY</u> be considered when transport decisions will be affected (e.g., Refusal of Medical Care or Transportation, EMT turnover).

9. Consider extensive differential diagnosis – AEIOUTIPS.

"A" Alcohol
"E" Epilepsy/Electrolytes
"I" Insulin
"O" Overdose
"U" Uremia
"T" Trauma/Tumor/Time
"I" Infection
"P" Psychiatric
"S" Stroke/Shock/Hypertensive Encephalopathy