

**SAGINAW VALLEY  
MEDICAL CONTROL AUTHORITY  
PRACTICE PARAMETER**

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**PEDIATRIC ACUTE ALTERED MENTAL STATUS**

**I. Assessment Information**

- A. Specific Objective Findings:
  - 1. Vital Signs, pupil changes
    - a. Head trauma
    - b. Seizure
  - 2. Pediatric Glasgow Coma Score
  - 3. Mental and neurologic Status: Baseline vs. Current
  - 4. Characteristic odor to breath
    - a. Ketones
  - 5. Medical Alert tags
  - 6. Environmental clues
    - a. Chemical/drug intoxication
    - b. Toxic exposure
  - 7. Determine if signs of hypoglycemia are present

**FIRST RESPONDER**

**I. Management**

- A. Evaluate and maintain airway, provide oxygenation and support ventilations as needed.
- B. If no concern regarding spinal injury, place patient on either side.<sup>1</sup>
- C. Assess circulation and perfusion by measuring heart rate and observing skin color and temperature, capillary refill time, and the quality of central and peripheral pulses. Blood pressure should be measured in children older than three.
- D. Arrange for ALS Intercept, if not already accomplished by MedCom.
- E. Obtain blood glucose level, if available to you.
- F. If blood glucose is <80mg/dl and patient is ALERT/CONSCIOUS,
  - 1. Administer ORAL HIGH CALORIC FLUID available.
- G. If blood glucose is <80mg/dl and patient is NOT alert or vital signs are unstable.

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1. Carefully administer small amounts of ORAL GLUCOSE PASTE, buccal or sublingual, if there is a delay in providing advanced level care.<sup>2</sup>
- H. If glucometer not available, but hypoglycemia is most likely to be expected, **CONSIDER FOLLOWING F & G STEPS ABOVE.**

**BASIC LIFE SUPPORT**

- I. Initiate transport toward ALS intercept, if transporting unit.

**ADVANCED LIFE SUPPORT**

- J. Monitor EKG
- K. IV/IO NORMAL SALINE@ TKO
- L. If history of possible dehydration, Consider FLUID BOLUS of NORMAL SALINE at 20cc/kg set to maximum flow rate.
  1. The bolus may be repeated up to two times.
- M. If blood glucose is <80 and IV/IO has been established administer:
  1. Children >2yrs, use Dextrose 50% at 1ml/kg
  2. Children <2yrs, use Dextrose 25% at 2 ml/kg
  3. Neonates, use Dextrose 10% at 5 ml/kg
- N. If IV/IO access not available
  - a) If blood glucose is <80mg/dl and patient is ALERT/CONSCIOUS Administer ORAL HIGH CALORIC FLUID available.
  - b) If blood glucose is <80mg/dl and patient is NOT alert or vital signs are unstable. Carefully administer small amounts of ORAL GLUCOSE PASTE, buccal or sublingual.<sup>2</sup>
- O. If no response to dextrose or dextrose **NOT** indicated, Administer NARCAN 0.1 mg/kg up to a maximum of 4 mg. The standard initial dose is 2 mg<sup>3</sup>

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- P. Re-check blood glucose level and assess Pediatric Glasgow Coma Score 10 minutes after glucose administration.<sup>4</sup>

NOTIFY RECEIVING FACILITY

- Q. Consider protecting and/or controlling airway with endotracheal intubation.
- R. Consider hyperventilation if any signs of focal neurologic deficit or herniation.

CONTACT MEDICAL CONTROL

- S. Possible orders post radio contact:
1. Dextrose
  2. Naloxone

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<sup>1</sup> Rationale=Patient could vomit and aspirate.

<sup>2</sup> Administer to gums or mucosa in small amounts at the time. Avoid excessive salivation. If risk of aspiration becomes high, stop administration of paste.

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<sup>2</sup> Administer to gums or mucosa in small amounts at the time. Avoid excessive salivation. If risk of aspiration becomes high, stop administration of paste.

<sup>3</sup> Narcan may be given via ET or IM at the same dose if IV/IO is not available. Narcan is contraindicated in the newborn patient.

<sup>4</sup> Pediatric Glasgow Coma Scale= **Eyes**

Opens spontaneously	4
Opens to speech	3
Opens to pain	2
No response	1
Motor	
Spontaneous movements	6
Withdraws to touch	5
Withdraws to pain	4
Flexion (decorticate)	3
Extension (decerebrate)	2
No response	1
Verbal	
Coo's and babbles	5
Irritable cry	4
Cries to pain	3
Moans to pain	2
No response	1
Total	3-15

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