RN Protocol: Loss of Consciousness

I. POLICY

A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients with sudden loss of consciousness.

B. Circumstances under which the RN may perform:
   1. Setting: Outpatient Clinic, housing areas, or Triage and Treatment Area.
   2. Supervision: None required.

II. PROTOCOL

A. Definition: This protocol covers the assessment and treatment of patients who suddenly lose consciousness. Loss of consciousness refers to a state of unawareness with inability to respond normally to stimuli.

B. Subjective:
   1. Obtain information from witnesses about events leading up to loss of consciousness (e.g., suspected drug overdose, seizure, physical trauma).
   2. Determine the exact time the patient was found unconscious.
   3. If possible, review the health record.
   4. Check for past medical history of diabetes, seizure disorder, psychiatric illness, previous episodes of loss of consciousness, alcohol or drug abuse.
   5. Check the health record for allergies and current medications.

C. Objective:
   1. Assess ABC (airway, breathing, and circulation)
   2. Vital Signs
   3. Assess level of consciousness using the Glasgow Coma Scale.
   4. Check pupil size, shape, and reactivity to light.
   5. Check for head trauma involving scalp lacerations, hematomas, and bony deformities of the skull.
   6. Check skin for the presence of fresh needle tracks.
   7. Check breath odor for the presence of alcohol or acetone.
   8. Fingerstick blood glucose.

D. Assessment:
   1. Altered mental state related to/evidenced by:
   2. Alteration in tissue perfusion, cerebral, related to/evidenced by:

E. Plan:
   1. Provide BLS (Basic Life Support) if indicated.

2. Maintain a patent airway. (Insert oral/nasopharyngeal airway as appropriate and assist with ventilation).
3. Apply C-spine collar before moving the patient if trauma evident or suspected.
4. Apply pressure dressing to any open bleeding wound.
5. If the patient is unconscious with stable vital signs, place in a left lateral decubitus position, unless C-spine precautions are indicated.
6. Administer O_2 at 2-6 L/minute via nasal cannula to maintain oxygen saturation ≥ 90%. Place on pulse oximeter if available.
7. Notify physician **STAT**.
8. Start IV Sodium Chloride Intravenous Solution (0.9%) at TKO.
9. If fingerstick blood glucose is below 50 mg/dl, administer 50 ml of 50% dextrose IV push over 2 minutes. May administer Glucagon 1 mg IM if unable to gain IV access.
10. If history or physical findings suggest opiate overdose, administer Narcan® (intranasal naloxone) 4 mg [one spray] intranasally in one nostril (may repeat x 1 in other nostril).
    a. Alternatively, administer Naloxone 0.8 mg IV (may repeat x 1). May use Naloxone 0.8 mg IM if unable to obtain IV access.
11. Monitor vital signs, neurologic status, and oxygen saturation at least every 15 minutes.
12. Prepare to transfer the patient to an outside facility or admit to a facility capable of providing a higher level of care.
13. Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to receiving facility.

F. Patient Education:
1. Assess the patient's potential for understanding the health information to be provided.
2. Provide the patient education consistent with the assessment of the condition.
3. Document the education provided and the patient's level of understanding on the emergency care flow sheet.
4. Refer the patient to other resources as needed. Document all referrals on the emergency care flow sheet.
5. Advise the patient to utilize the urgent/emergent process to access medical care if symptoms recur.

G. Documentation:
All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form and filed in the patient's health record.

III. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education/Training: The RN shall attend an in-service on the assessment and management of loss of consciousness and achieve a minimum score of 80% on the written posttest examination.
B. Experience: None.

C. Certification: None
D. Initial Evaluation: Initial competence shall be validated onsite through simulated exercises, mock scenarios, and return demonstration. The RN must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

   A written performance appraisal shall be performed by the Supervising RN or designee six months after initial competence has been validated. Methods to evaluate performance shall include, but not be limited to direct observation, feedback from colleagues and physicians, and chart review.
E. Ongoing Evaluation: Ongoing competence shall be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all RNs authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure shall be reviewed annually.

REVIEW DATE: _____ REVISION DATE: _____
_____ _____
_____ _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

_____ DATE:_____
Chief Nurse Executive/Director of Nursing

_____ DATE:_____
Chief Medical Executive