Clinical Practice Guidelines:
Medical/Diabetic emergency: Hypoglycaemia

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Date	June, 2026
Purpose	To ensure consistent management of patients with hypoglycaemia.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Diabetic emergency: Hypoglycaemia

June, 2026

Glucose is an essential metabolic fuel for the brain and a constant supply is critical for normal neurological function. **Hypoglycaemia** is defined as a blood glucose level (BGL) of **less than 4.0 mmol/L** in adults and **less than 3.0 mmol/L** in paediatrics.[1]

For patients unable to swallow oral glucose, intravenous glucose is the recommended first-line management strategy.

Ambulance clinicians should aim to achieve a blood glucose level (BGL) of **greater than 4.0 mmol/L** in adults and **3.0 mmol/L** in paediatrics.

Clinical features

Autonomic features *(warning signs)*

- Diaphoresis, hunger, tingling around the mouth, tremor, tachycardia, pallor, palpitations and anxiety.
- These warning signs may be lost in patients with repeated or prolonged hypoglycaemia.[2]

Neurological features

- *Consider hypoglycaemia in all patients who have an ALOC.*
- Lethargy, change in behaviour, headache, visual disturbance, slurred speech, dizziness, ALOC, seizures, coma.
- Patients may present with signs/symptoms mimicking intoxication or stroke.

Clinical features *(cont.)*

Other considerations

- Chronic, poorly controlled diabetics may be relatively hypoglycaemic despite having a BGL greater than 4.0 mmol/L.[2]
- Signs of hypoglycaemia may be masked in patients taking beta blocker medications.[3]

Risk assessment

- Caution is required if the patient is agitated, aggressive or violent.
- Consideration should be given to the possibility of an accidental, or intentional hypoglycaemic agent medication overdose.

Additional information

- Patients < 2 years of age and symptomatically hypoglycaemic may be administered buccal glucose gel. See *CPP: Buccal* for further information.

Diabetes service referral

- Diabetes Service Referral must be considered for all patients (irrespective of whether transported or not) who present with diabetic related complications, e.g. hypo/hyperglycaemia.

Mandatory transport criteria

If the patient has ANY of the following, they must be transported to hospital.

- Newly diagnosed diabetes
- No previous diagnosis of diabetes
- Pregnant
- Patient recovered but unable to be monitored by a responsible adult for 4 hours, or patient unable to self-care
- Not returned to normal mental state within 10 minutes of IV glucose, or incomplete recovery to normal conscious state
- Intentional overdose of glucose lowering agent
- Severe hypoglycaemia episode within previous 48 hours
- Risk of prolonged or recurrent hypoglycaemia
  - Unwitnessed onset or prolonged episode
  - Patient taking long acting oral hypoglycaemic agent that causes hypoglycaemia
  - Unable or unwilling to consume long acting carbohydrate
- Seizure
- Suspected cause of hypoglycaemia due to illness that requires further investigation
- Injury sustained from hypoglycaemic episode requiring further investigation

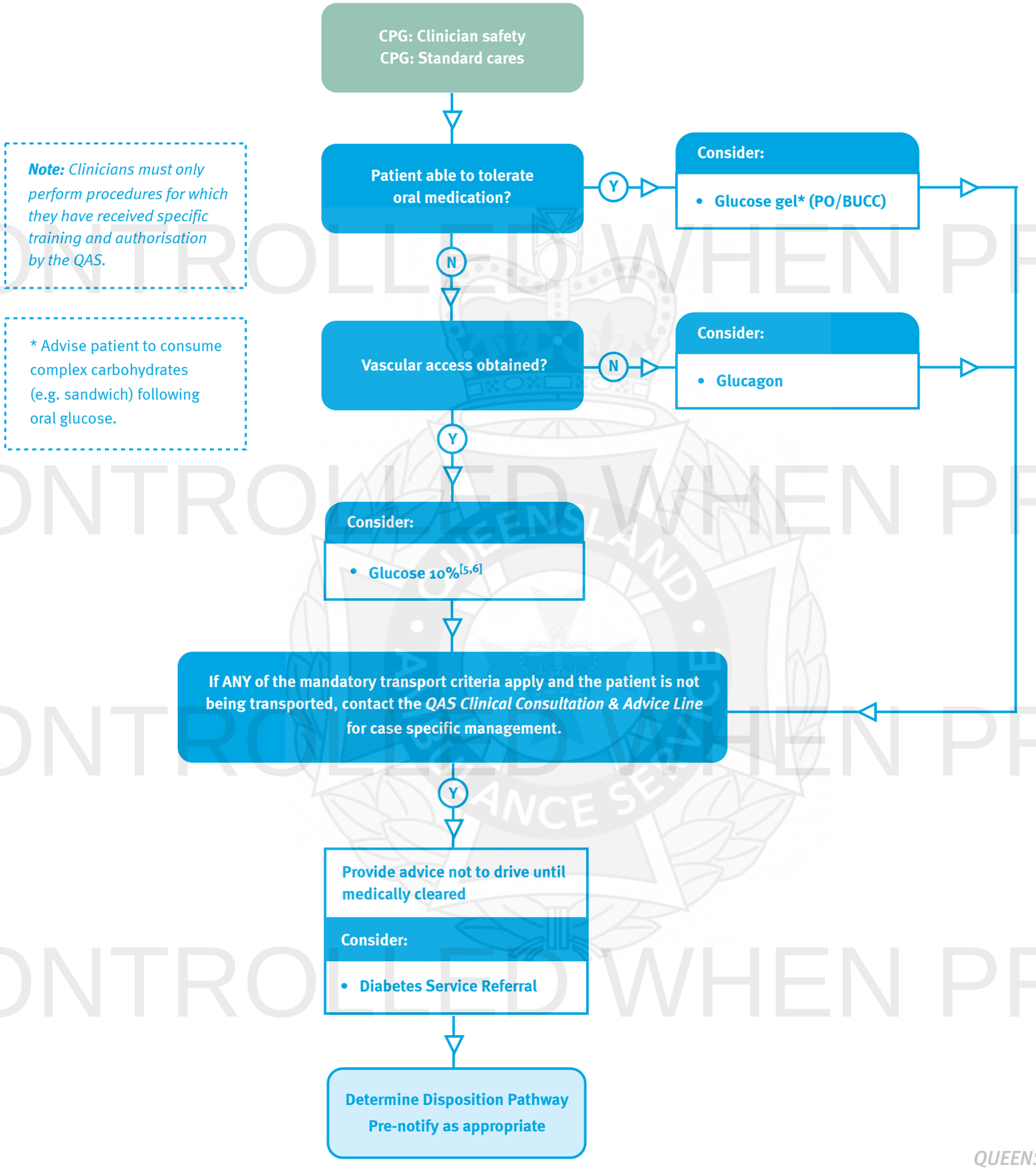
Fitness to drive considerations

In alignment with the *National Driver Medication Standards*[4], patients that experience a severe hypoglycaemic event (defined as an episode requiring intervention from a bystander or paramedic to resolve) should be advised to not operate a motor vehicle until they have been cleared to drive by a general practitioner or endocrinologist. In instances where the patient is provided this advice and attempts to drive, the Queensland Police Service should be notified. All instances where advice not to drive has been provided to patient's must be clearly documented on the eARF.

Hypoglycaemic patients with in-situ insulin pumps

In instances that patients present with a hypoglycaemic episode and have an indwelling insulin pump in-situ, ambulance clinicians are advised not to manually cease or alter the settings in these devices. However, if the patient or their carer are familiar with the workings of the pump and its settings, they may themselves decide to cease or alter the pump settings if part of a personal diabetes management plan.

The receiving facility must be advised of the patient's in-situ insulin pump on hospital arrival, along with any problems with the device that are observed by clinicians or reported by the patient or carer. This patient management recommendation has been made following a careful consideration or a risk-benefit analysis, together with external advice provided by the Queensland Health Diabetes Clinical Network.



Note: *Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.*

* Advise patient to consume complex carbohydrates (e.g. sandwich) following oral glucose.