EMT Clinical Judgment Study Guide

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This study guide focuses on Clinical Judgment for EMTs. It aligns with the NREMT EMT certification exam (updated format effective April 2025), National EMS Education Standards, National EMS Scope of Practice Model 2019 (with Change Notices), and current prehospital care principles. Clinical judgment is not a standalone category but is heavily tested across all exam domains—especially in Primary Assessment, Secondary Assessment, Patient Treatment and Transport, and scenario-based questions. What NREMT Tests in Clinical Judgment: Prioritizing life threats (C-ABCDE), Deciding when to treat vs. load-and-go, Recognizing when to call for ALS intercept, Choosing appropriate interventions within EMT scope, Making safe transport decisions (destination, mode, urgency), Identifying red flags and worst-case differentials, Balancing scene time vs. patient stability. Key Principle: Always think “What is going to kill this patient right now?” Treat in order of lethality: massive hemorrhage → airway → breathing → circulation → disability → exposure. Err on the side of rapid transport for unstable or uncertain patients.

Disclaimer: This is a study aid, not official. For PDF, copy into a word processor and export. Always follow current local protocols, NREMT skill sheets, and your medical director’s standing orders.

Section 1: The EMT Decision-Making Framework

Primary Survey Priority Order (C-ABCDE):

Catastrophic hemorrhage – Control immediately (tourniquet, direct pressure).

Airway – Open/maintain (manual maneuvers, adjuncts, suction).

Breathing – Assess adequacy; ventilate if inadequate.

Circulation – Check for major bleeding, pulses, skin signs, treat shock.

Disability – AVPU/GCS, pupils, glucose check.

Exposure/Environment – Full exposure, prevent hypothermia.

Load-and-Go vs. Stay-and-Play Indicators:

Load-and-Go (Rapid Transport)	Stay-and-Play (On-Scene Treatment)
Unstable ABCs	Stable patient with isolated injury
Altered mental status (GCS <13)	Minor orthopedic injury needing splinting
Signs of shock (tachycardia + poor perfusion)	Hypoglycemia responsive to oral glucose
Penetrating trauma to head/neck/chest/abdomen	Allergic reaction resolved with epi auto-injector
Difficulty breathing not improving with basic measures	Chest pain relieved by 3 nitro doses, stable vitals
Suspected aortic dissection, ectopic, AAA rupture	Patient refusal with intact capacity

When to Call ALS Intercept (High-Yield):

Patient requires advanced airway, IV/IO, cardiac medications, or BSI

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Unstable cardiac arrest (after initial BLS measures).

Complicated delivery or neonatal distress.

Severe respiratory failure needing CPAP/BiPAP.

Multi-system trauma or high suspicion of internal bleeding.

Any patient you are uncomfortable managing alone.

Section 2: Red Flags & Critical Thinking Triggers

Presentation	Must-Consider Worst-Case Diagnoses	EMT Action / Transport Decision
Sudden severe tearing chest/back pain	Aortic dissection	Immediate high-flow O&sub2;, rapid transport to vascular center
Syncope in patient >50 y/o or with cardiac history	Arrhythmia, ACS, PE, AAA rupture	Transport even if feeling better now
Abdominal pain in reproductive-age female	Ectopic pregnancy, ruptured ovarian cyst	Rapid transport; no oral intake
Altered mental status + pinpoint pupils	Opioid overdose	Naloxone + ventilate; transport all
Silent chest in severe asthma patient	Impending respiratory arrest	Immediate ALS intercept; prepare to assist ventilations
Hypotension + JVD + muffled heart sounds	Cardiac tamponade	Rapid transport; high-flow O&sub2;
Elderly fall + hip pain + pale/cool skin	Occult bleed (pelvic fracture, retroperitoneal)	Treat for shock; rapid transport

Section 3: High-Yield Clinical Judgment Scenarios (NREMT-Style)

Scenario 1: 68 y/o male, sudden onset chest pressure 8/10, pale, diaphoretic, BP 88/56, HR 110, SpO&sub2; 92%. **Best Action:** Administer aspirin, high-flow O&sub2;, position of comfort, rapid transport to PCI-capable facility, request ALS intercept.

Scenario 2: 22 y/o female, severe lower abdominal pain, vaginal spotting, BP 92/60, HR 124, pale**Best Action:** High-flow O&sub2;, supine with legs elevated, rapid transport (suspect ectopic), no oral intake, ALS intercept.

Scenario 3: 45 y/o male, MVC, alert but complaining of chest pain, paradoxical chest movement on left side, SpO&sub2; 89%. **Best Action:** High-flow O&sub2;, manual stabilization of flail segment, occlusive dressing if open wound, rapid trauma center transport, ALS intercept.

Scenario 4: 30 y/o female, anaphylaxis after bee sting, stridor, hives, BP 80/40 after epi auto-injector. **Best Action:** Second epi auto-injector if protocol allows, high-flow O&sub2;, rapid transport, ALS intercept.

Scenario 5: 5 y/o child, high fever, lethargic, stiff neck, petechial rash.**Best Action:** High-flow O&sub2; if hypoxic, rapid transport to pediatric-capable facility, suspect meningococcemia, ALS intercept.

Section 4: Common Decision-Making Pitfalls to Avoid

Treating on scene too long when patient is unstable (“stay-and-play” trap).

Assuming syncope is benign in older adults.

Delaying transport to “finish” splinting non-life-threatening injuries.

Giving oral glucose to altered patient who cannot protect airway.

Not calling ALS early enough for deteriorating patients.

Transporting to closest facility instead of appropriate specialty center when time allows.

Example Judgment Question (Math-Integrated):

Question: 70 y/o female, chest pain, BP 86/54 after one nitro dose. Protocol: Hold further nitro if SBP <90. Current time is 14:22. Hospital is 12 minutes away. Should you give another nitro? **Answer:** No – hold nitro, high-flow O&sub2;, rapid transport. **Reasoning:** Hypotension contraindicates further nitro; prioritize transport over additional doses. Review NREMT patient assessment skill sheets (Medical & Trauma), practice scenario-based questions, and mentally run through “What is the most life-threatening thing right now?” for every patient. Strong clinical judgment comes from pattern recognition, prioritization, and knowing your limits. Good luck on your EMT exam—trust your assessment, treat what’s killing them first, and get them moving!

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