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Table of Contents

EMT-Specific Information and Protocols in Clark County, Nevada

1. Introduction to Clark County EMS Protocols A
2. General Assessment and Operational Protocols
3. Adult Treatment Protocols
4. Pediatric Treatment Protocols
5. Procedures Protocols
6. Formulary and Appendices
7. Special Considerations and Operational Guidelines

EMT-Specific Information and Protocols in Clark County, Nevada

1. Introduction to Clark County EMS Protocols

- The purpose of this manual is to provide guidance for ALL prehospital care providers and emergency department physicians within the Clark County EMS System.
- The goal of the manual is to standardize prehospital patient care in Clark County.
- These protocols are guidelines and should not be construed to expand the scope of practice of any licensed attendant beyond that identified in the Clark County Emergency Medical Services Regulations and these protocols.
- Nothing contained in these protocols is meant to delay rapid patient transport to a receiving facility.
- Patient care should be rendered while en-route to a definitive treatment facility.

2. General Assessment and Operational Protocols

Assessment/Protocol	Key Steps/Considerations	Sources
General Adult Assessment	Scene Safety/Size-Up, Nature of Call/Mechanism of Injury, S.T.A.R.T. Triage, PPE/BSI, Level of Consciousness Check, Airway/Ventilation Management, Breathing, Bleeding, Circulation, Disability, History (HPI & AMPLE), Vital Signs &	

	Physical Exam, Blood glucose testing, Specific treatment protocol, Cervical Stabilization, Comfort measures, Cardiac monitor, Vascular Access, Oxygen therapy, Pain Management, Radio Contact, Transport per Disposition Criteria
General Pediatric Assessment	Scene Safety/Size-Up, Nature of Call/Mechanism of Injury, PPE/BSI, S.T.A.R.T. Triage, Equipment (Broselow Tape), Level of Consciousness Check, Airway/Ventilation Management, Breathing, Bleeding, Circulation, Disability, History (HPI & AMPLE), Vital Signs & Physical Exam, Blood glucose testing, Specific treatment protocol, Cervical Stabilization, Comfort measures, Cardiac monitor, Vascular Access, Oxygen therapy, Pain Management, Radio Contact, Transport per Pediatric Destination Criteria
Communications	Telemetry contact by radio or recorded phone patch, Time sensitive/life threatening transports, EMS provider judgment, Trauma patients to trauma center, Required per protocol, Trauma report details (ETA, age, gender, MOI, etc.), Notification of transport to receiving hospital (age, chief complaint, unit #, ETA)
Documentation	PCR for each incident/patient encounter, Minimum required information (patient name, DOB, time, chief complaint, history, signs/symptoms, care provided, destination, attendant name), Protocol authorization, Monitor file upload (cardiac rhythm, 12-lead ECG, electrical therapy, ETCo2), Trauma documentation (trauma score, TFTC, injury mitigation), Vital signs (full set, reassessment), Verbal report from first response agency

- General Adult Assessment includes steps like Scene Safety and Scene Size-Up. It also involves checking the Level of Consciousness and assessing Airway and Ventilation Management. Vital Signs and Physical Exam are also part of the assessment. Blood glucose testing is indicated. Oxygen therapy is provided to keep SpO2 >94%. Rapid patient transport is not meant to be delayed. Correct life-threatening problems as identified are addressed.
- General Pediatric Assessment follows similar steps, including Scene Safety and Size-Up. It emphasizes bringing all equipment, including the Broselow Tape. Airway and Ventilation Management are assessed. Blood glucose testing is performed as

indicated. Oxygen therapy is given to keep SpO₂ >94%. Radio Contact is required for all pediatric patients.

- Telemetry contact should primarily be established by radio. Telephone contact is permitted only if routed via a recorded phone patch. Telemetry contact is required for all time-sensitive or life-threatening condition transports. It is also needed for any medical emergency where the EMS provider judges consultation is necessary. For trauma patients going to a trauma center, telemetry reports shall include ETA, patient age, gender, mechanism of injury, and suspected injuries.
- Documentation requires a Patient Care Record (PCR) for each incident. PCRs must include patient name, address, age, and sex. Date and location of call are necessary. Time of dispatch, arrival at scene, departure from scene, and arrival at hospital are recorded. Pertinent patient history, including current medications and allergies, should be included. At least one full set of vital signs must be documented. Reassessment after interventions is also required.

3. Adult Treatment Protocols

Protocol	Conditions/Indications	Sources
Abdominal / Flank Pain, Nausea & Vomiting	Abdominal or flank pain with nausea and vomiting, signs of hypovolemia	
Allergic Reaction	Evidence of airway involvement/breathing difficulties, patient in shock	
Altered Mental Status / Syncope	Altered mental status or syncope, BG <60 mg/dl, signs of stroke, hypoperfusion, seizure, trauma, cardiac causes, overdose	
Behavioral Emergency	Patient agitation and risk of violence	
Bradycardia	Persistent HR < 50 causing altered mental status, hypotension, chest pain, signs of shock	
Burns	Thermal, chemical, or electrical exposure, eye involvement, signs of hypoperfusion, >20% BSA burn	
Cardiac Arrest (Non-Traumatic)	Unresponsive with no pulse, witnessed by EMS or CPR in progress, VF/VT, Asystole/PEA	

Chest Pain (Non Traumatic) and Suspected Acute Coronary Syndrome	Chest pain, suspected ACS, non-diagnostic 12-Lead ECG, STEMI
Childbirth / Labor	Pregnant patient with signs of impending delivery, normal presentation, limb presentation, breech presentation, cord presentation, and patient hypoperfusion
Cold-Related Illness	Hypothermia/Frost Bite, Localized Cold Injury, Systemic Hypothermia, Respiratory distress, Pulse present
Epistaxis	Active bleeding from the nose, significant or active bleeding in the posterior oropharynx, or Multi-System Trauma
Heat-Related Illness	Heat Cramps, Heat Exhaustion, Heat Stroke, Symptom Severity, Respiratory distress, Poor perfusion
Hyperkalemia (Suspected)	Suspected hyperkalemia or electrocardiographic findings consistent with hyperkalemia, Bradycardia, Peaked T waves, Widened QRS, Cardiac Arrest
Obstetrical Emergency	Pregnant patient exhibiting seizures, pregnant patient exhibiting pre-eclampsia
Overdose/Poisoning	Potential cause of signs/symptoms (Opiate OD, Dystonic Reaction, TCA/ASA OD, Beta Blocker OD, Organophosphate Toxicity, Cyanide, Calcium Channel Blocker OD), Cardiac arrest, hypotension, profound altered mental status
Pain Management	Mild to Severe Pain, Moderate Pain, Persistent pain, or contraindication to Acetaminophen
Pulmonary Edema/CHF	Respiratory distress, bilateral rales, signs of pulmonary edema, airway & ventilation adequate, Hypotensive, Normotensive, Hypertensive, signs of cardiogenic shock

Respiratory Distress	Respiratory distress, airway & ventilation adequate, Bilateral Rales or Signs of Pulmonary Edema, Wheezing or Bronchospasm, Stridor
Seizure	Patient actively seizing, patient have a history of seizures, Patient \geq 20 weeks pregnant or \leq 6 weeks post partum, BG <60 mg/dl, Persistent or recurrent seizure
Sepsis (Suspected)	Known or suspected source of infection AND two criteria (SBP <90, HR >90, RR >20, AMS, Temp $>/=$ 100.4 or
Shock	Non-trauma, Non-Cardiogenic, Trauma related, Cardiogenic
Smoke Inhalation	Exposed to smoke, Cardiac arrest or hypotension or profound altered mental status
STEMI (Suspected)	Suspected STEMI, 12-Lead ECG within 5 minutes, ASPIRIN, NITROGLYCERIN, Pain Management, antiemetic
Stroke (CVA)	Findings suggestive of RACE \geq 5 (LVO), RACE = 1-4, RACE = 0, BGL 60-400
Tachycardia/Stable	Normal Mental Status, Palpable Radial Pulse, Narrow Complex <0.11 sec, Wide Complex > 0.12 sec, Undifferentiated Regular Rhythm, Torsades De Pointes, Suspected to be SVT With Aberrancy, Monomorphic VT
Tachycardia/Unstable	Mental Status Changes, No Palpable Radial Pulse, Narrow Complex \leq 0.11 Sec, Wide Complex \geq 0.12 Sec, Torsades de Pointes (Polymorphic Ventricular Tachycardia), Monomorphic VT

- The adult treatment protocols cover a wide range of medical emergencies.
- For cardiac arrest (Non-Traumatic), if witnessed by EMS or CPR is in progress, begin chest compressions and apply AED. If the rhythm is shockable (VF/VT), defibrillate. If not shockable (Asystole/PEA), continue CPR and administer Epinephrine. Address H's & T's (reversible causes).

- Chest Pain (Non Traumatic) and Suspected Acute Coronary Syndrome protocol requires a 12-Lead ECG within 5 minutes. Administer ASPIRIN and NITROGLYCERIN if indicated. Pain Management is initiated for continued pain.
- respiratory distress in adults includes assessing airway and ventilation. Depending on the findings (rales, wheezing, stridor), administer ALBUTEROL or IPRATROPIUM. Consider NIPPV and MAGNESIUM SULFATE.
- The Allergic Reaction protocol outlines steps based on evidence of airway involvement or the patient being in shock. EPINEPHRINE is a first-line drug. DIPHENHYDRAMINE and ALBUTEROL or LEVALBUTEROL are also used.
- Altered Mental Status / Syncope involves checking blood glucose. Treat hypoglycemia with ORAL GLUCOSE or D10. Consider various underlying causes such as stroke, hypoperfusion, or seizure.
- Behavioral Emergency protocols emphasize scene safety and assessing the level of agitation. Verbal de-escalation techniques are used. Pharmacological sedation with MIDAZOLAM or droperidol may be necessary. Physical restraints should never restrict chest wall movement.

4. Pediatric Treatment Protocols

Protocol	Conditions/Indications	Sources
Pediatric Abdominal Pain, Nausea & Vomiting	Hypovolemia or witnessed vomiting, Subjective nausea or vomiting	
Pediatric Allergic Reaction	Evidence of airway involvement/breathing difficulties	
Pediatric Altered Mental Status	BG <60 mg/dl, BG <40 mg/dl in newborn, Signs of a seizure of post-ictal state, Signs of hypoperfusion, Signs of trauma or head injury, Overdose/Poisoning	
Pediatric Behavioral Emergency	Threatened or acted in a way that suggests threat to self or others	
Pediatric Bradycardia	Bradycardia causing hypotension, altered mental status, poor perfusion or shock, HR <60 bpm	
Pediatric Burns	Thermal, Chemical/Electrical Exposure, Eye Involvement, Signs of hypoperfusion, >20% BSA burn	

Pediatric Cardiac Arrest Non-Traumatic	Meets Criteria for Prehospital Death Determination or DNR/POLST present, Begin Age Appropriate CPR, VF/VT, Asystole/PEA
Pediatric Cold-Related Illness	Localized cold injury, Systemic hypothermia, Respiratory distress, Pulse present, Poor perfusion
Pediatric Epistaxis	Active bleeding from the nose, Significant or active bleeding in posterior oropharynx, Multi-System Trauma, tolerate nasal spray administration
Pediatric Heat-Related Illness	Heat Cramps, Heat Exhaustion, Heat Stroke, Symptom Severity, Poor perfusion
Neonatal Resuscitation	Term gestation?, Breathing or crying?, Good tone?, Labored breathing or apnea?, HR <100, gasping, or persistent cyanosis?, HR <100?, HR <60?
Pediatric Overdose / Poisoning	Consider potential causes of signs/symptoms (Opiate OD, Dystonic Reaction, TCA/ASA OD, Beta Blocker OD, Organophosphate Toxicity, Cyanide, Calcium Channel Blocker OD), Cardiac arrest or hypotension or profound altered mental status
Pediatric Pain Management	Mild/moderate pain, severe pain, nausea/vomiting after pain medication
Pediatric Respiratory Distress	Airway & ventilation adequate, Wheezing or Bronchospasm, Stridor, history of wheezing, suspected Croup, SpO2 <94%
Pediatric Seizure	Patient febrile?, patient actively seizing?, history of seizures?, BG <60 mg/dl?, Persistent (status) or recurrent seizure?
Pediatric Shock	Trauma-related, Non-trauma related, BG <60 mg/dl, BG <40 mg/dl in newborn, BG >250 mg/dl, BG normal, Hypotension
Pediatric Smoke Inhalation	Exposed to smoke, Cardiac arrest or hypotension or profound altered mental status

Pediatric Tachycardia / Stable	Normal Mental Status, Palpable Radial Pulse, Narrow Complex ≤ 0.11 Sec, Wide Complex ≥ 0.12 Sec, Undifferentiated Regular, Torsades de Pointes, Suspected to be SVT with Aberrancy, Monomorphic VT	
Pediatric Tachycardia / Unstable	Mental Status Changes, No Palpable Radial Pulse, Narrow Complex ≤ 0.11 Sec, Wide Complex ≥ 0.12 Sec, Torsades de Pointes (Polymorphic V-Tach), Monomorphic V-VT	
Pediatric Ventilation Management	Airway & ventilation adequate, Wheezing or Bronchospasm, Stridor, Intervention effective?, Extraglottic/ETT placement successful?, Able to ventilate without extraglottic/ETT in place?	

- Pediatric treatment protocols include age-specific considerations.
- Pediatric cardiac arrest Non-Traumatic involves age-appropriate CPR. Defibrillation energy levels are 2 J/kg initially, increasing to 4 J/kg if unsuccessful. EPINEPHRINE dosage is 0.01 mg/kg IV/IO. Address H's & T's.
- Pediatric respiratory distress involves assessing airway and ventilation. Administer ALBUTEROL or IPRATROPIUM based on symptoms. For suspected Croup, EPINEPHRINE may be used.
- Pediatric Allergic Reaction protocol uses EPINEPHRINE (1:1000, 0.01 mg/kg IM) for airway involvement or breathing difficulties. DIPHENHYDRAMINE and ALBUTEROL or LEVALBUTEROL are also utilized.
- Pediatric Altered Mental Status involves checking blood glucose. Treat hypoglycemia with D10 or GLUCAGON. NARCAN should be administered before advanced airway procedures if narcotic overdose or hypoglycemia is suspected.
- Pediatric Behavioral Emergency protocol recommends implementing the S.A.F.E.R. model. Benzodiazepines may be considered for threatened behavior. Midazolam is NOT recommended for use in children for behavioral emergencies.
- Pediatric Bradycardia protocol focuses on identifying the underlying cause. If bradycardia causes symptoms, administer EPINEPHRINE or ATROPINE. Pediatric pacing requires a telemetry Physician order.

5. Procedures Protocols

Procedure	Indications	Contraindications	Sources
Cervical Stabilization	Potential for spinal injury based on NEXUS	Penetrating trauma to head/neck with no spinal injury,	

	<p>criteria (Midline tenderness, Focal neurologic deficit, Altered mental status, Intoxication, Distracting injury)</p>	<p>Collar compromising assessment/airway/hemorrhage control, Patients in cardiac arrest</p>
Electrical Therapy/Defibrillation	<p>Ventricular fibrillation, Pulseless ventricular tachycardia, Torsades de Pointes</p>	None
Electrical Therapy/Synchronized Cardioversion	<p>Ventricular tachycardia with inadequate perfusion, Supraventricular tachycardia with inadequate perfusion, Ventricular tachycardia with adequate perfusion but refractory to drug therapy</p>	None
Electrical Therapy/Transcutaneous Pacing	<p>Hemodynamically unstable bradycardia, Unstable clinical condition due to bradycardia, Pacing readiness (MI, AV block, BBB), Overdrive pacing tachycardias</p>	None
Endotracheal Intubation	<p>Attempts at basic airway and ventilatory support are unsuccessful AND Hypoxia, Respiratory arrest/failure, Inability to maintain airway patency</p>	<p>Relative: Presence of gag reflex, Suspected narcotic overdose/hypoglycemia before Naloxone/Glucose</p>
Extral lottic Airway Device	<p>Attempts at basic airway and ventilatory support were</p>	<p>Gag reflex, History of esophageal trauma or disease, Recent caustic substance</p>

	unsuccessful, AND Hypoxia, Respiratory arrest/failure, Obtundation, Failed endotracheal intubation	ingestion, Tracheostomy or laryngectomy, Suspected foreign body obstruction
Hemorrhage Control	Bleeding from an extremity, junctional hemorrhage or torso hemorrhage (Extremity Hemorrhage, Junctional Hemorrhage)	Tourniquet: Bleeding has stopped; Hemostatic gauze: Hemorrhaging abdominal wounds
Medication Administration	The patient requires the administration of a medication	None listed for general procedure
Needle Cricothyroidotomy	Total airway obstruction, Inability to be adequately ventilated	Inability to identify landmarks, Underlying anatomical abnormality, Tracheal transection, Acute laryngeal disease, Pediatric (Telemetry Physician order only)
Needle Thoracostomy	Evidence of a tension pneumothorax (Respiratory distress, diminished/absent breath sounds, AND Hypotension, Hypoxia, JVD, Tracheal deviation), Traumatic cardiac arrest with chest/abdominal trauma	None
Non-Invasive Positive Pressure Ventilation (NIPPV)	Patients ≥ 18 years old in CHF, Respiratory Distress with Bronchospasm, Pneumonia, who have TWO criteria (Retractions/accessory	Apnea, Vomiting or active GI bleed, Major trauma/pneumothorax, Altered Mental Status

		muscle use, RR >25, SpO2 ≤ 94%)
Tracheostomy Tube Replacement	Patient has a tracheostomy tube and has Hypoxia, Respiratory arrest/failure, Obtundation, Secretions unable to be cleared by suctioning	None
Traction Splint	Isolated midshaft femur fracture	Pelvic fracture or instability, Knee, lower leg, or ankle instability
Vagal Maneuvers	Supraventricular Tachycardia with adequate perfusion	None
Vascular Access	Potential need for IV drug administration, Need to administer IV fluids for volume expansion, Critically ill/injured patient needing IV/IO access when peripheral line cannot be immediately established, Critically ill/injured patient needing IV/fluids via previously established central line when peripheral line cannot be established	IO: Placement in/distal to fractured bone, Previous significant orthopedic procedure at site, Infection at insertion, Absence of landmarks; Central line: Inability to freely aspirate blood

- The Procedures protocols provide detailed steps for essential interventions.
- Cervical stabilization is indicated for patients with potential spinal injury based on NEXUS criteria. It is not required if all criteria are negative.
- Electrical Therapy includes Defibrillation for VF/pulseless VT/Torsades de Pointes. Synchronized Cardioversion is used for unstable tachycardia. Transcutaneous Pacing is for hemodynamically unstable bradycardia.

- Endotracheal Intubation is indicated when basic airway attempts are unsuccessful and the patient is hypoxic or in respiratory arrest. It is relatively contraindicated with a gag reflex or suspected narcotic overdose/hypoglycemia before administering Naloxone/Glucose. Verification of placement using capnography is mandatory.
- Extraglottic Airway Devices are used when basic airway attempts fail and the patient is hypoxic, in respiratory arrest, obtunded, or after failed ET intubation. Contraindications include a gag reflex or esophageal issues.
- Hemorrhage control involves applying a tourniquet proximal to the extremity bleeding if active. Wound packing with direct pressure is used for junctional hemorrhage.
- Vascular Access can be peripheral IV or intraosseous (IO). IO is indicated for critically ill patients needing immediate access when peripheral attempts fail. Central line access can be used if already established and running fluids.

6. Formulary and Appendices

Item	Description/Content	Sources
Formulary	<p>Lists authorized medications with class, action, dose (protocol, route, repeat, notes), contraindications, and adverse reactions. Includes medications like Acetaminophen, Acetylsalicylic Acid (Aspirin), Adenosine, Albuterol, Amiodarone, Atropine Sulfate, Bronchodilator Metered Dose Inhaler, Calcium Chloride, Diazepam, Diphenhydramine Hydrochloride, Droperidol, Epinephrine (various concentrations), Epinephrine Auto-injector, Etomidate, Fentanyl Citrate, Glucagon, Glucose (Oral, D10), Hydromorphone, Hydroxocobalamin, Ipratropium Bromide, Ipratropium Bromide and Albuterol Sulfate (Duoneb), Ketamine, Levalbuterol, Lidocaine (Injection, Lubricant), Magnesium Sulfate, Metoclopramide, Midazolam, Morphine Sulfate, Naloxone Hydrochloride (Narcan), Nitroglycerin, Ondansetron Hydrochloride (Zofran), Oxymetazoline, Phenylephrine (Nasal, Push Dose), Prochlorperazine, Sodium Bicarbonate, Solu-Cortef</p>	
Appendices	Contains supplementary information and forms.	
First Response Low-Risk Alpha Evaluate and	Example form for evaluating and releasing low-risk patients meeting specific criteria. Includes inclusion/exclusion criteria, patient complaint, vital signs, assessment findings, confirmation checklist, and signatures.	

Release Form (example)	
Release of Medical Assistance	Sample form for patient/guardian to refuse emergency medical care or transport. Includes statements of being informed of risks and consequences, reason for refusal, and release of liability.
Sample Algorithm, Release of Medical Assistance	Algorithm guiding EMS personnel when a patient refuses medical assistance. Includes steps for describing treatment, assessing judgment, enlisting help, and documenting refusal.
Scope of Practice	Outlines authorized medications and skills for EMT, AEMT, and Paramedic levels within the Clark County EMS System. Lists specific medications and skills allowed at each licensure level.
Telemetry Radio Map	Provides radio frequency and talk group information for various EMS agencies and hospitals in the Clark County EMS System. Includes details for CCFD, other fire departments, and EMS agencies.
Mass Casualty Incident	Provides guidelines for EMS providers operating at a receiving facility during a Mass Casualty Incident (MCI) or assisting with patient surge at a hospital. Includes authorization for brief departures from protocol during active hostile incidents.

- The formulary lists authorized medications such as Acetaminophen, Aspirin, Epinephrine, and Naloxone. Each medication entry details its class, action, and dosage for specific protocols. Contraindications and adverse reactions are also listed.
- The Appendices contain important supplementary documents.
- The First Response Low-Risk Alpha Evaluate and Release Form is an example used for evaluating and releasing certain low-risk patients. It includes criteria such as patient age and decision-making capacity.
- The Release of Medical Assistance form is used when a patient refuses care or transport. It documents that the patient has been informed of the risks.
- The Scope of Practice clearly defines the authorized medications and skills for each level of EMS provider: emt, Aemt, and Paramedic. For example, 12-Lead ECG Interpretation is authorized for Paramedics.
- The telemetry Radio Map provides crucial communication information. It lists talk groups for different agencies and hospitals.

- The Mass Casualty Incident appendix describes the role of licensed EMS providers during MCI events. Brief departures from protocol may be authorized during hostile MCI.

7. Special Considerations and Operational Guidelines

- Hostile Mass Casualty Incidents involve situations where persons are under assault. If trained and properly equipped, EMS can respond with law enforcement as a rescue task force. Brief and limited departures from protocol are authorized in these austere environments. Rescue task force providers may perform needle decompression, basic airway maneuvers, or apply a tourniquet.
- Inter-Facility Transport of Patients By Ambulance outlines responsibilities for ambulance attendants transferring patients. Attendants are authorized to administer or monitor medications and crystalloid IV solutions based on their licensure. emts can monitor locked intravenous peripheral lines. The transferring physician is responsible for notifying the receiving physician and providing necessary documentation.
- Pediatric Patient Destination criteria dictate where pediatric patients should be transported. Patients <18 years old are transported to designated facilities like St. Rose Dominican - Siena Campus, Summerlin Hospital, Sunrise Hospital, or University Medical Center based on parent preference or proximity. Critically ill patients may be transported to the closest Emergency Department.
- Prehospital Death Determination provides criteria for not initiating or terminating resuscitation. Obvious signs of death such as decapitation or incineration allow for no resuscitation. For non-traumatic arrests, persistent asystole or agonal rhythm after twenty minutes of appropriate resuscitation may lead to termination via telemetry physician order.
- Public Intoxication protocol allows transport to an approved alcohol and drug abuse facility if the patient meets specific criteria, including normal vital signs and a GCS > 14, and has no other emergent needs or signs of trauma. Physician approval is required for transport to an alternative facility.
- Quality Improvement Review allows for review of incidents involving patient care. A Southern Nevada Health District EMS Incident Report should be completed. OEMSTS staff review cases and may request internal investigations. All documentation is confidential.
- Termination of Resuscitation may occur without telemetry contact in rural/wilderness situations if there's no return of pulse after 20+ minutes of CPR and effective ventilation, transport to ED is >40 minutes, or providers are exhausted.
- Transport Destinations are specified based on patient condition and location. Medically stable patients can go to their hospital of choice if not significantly outside the response area. Trauma patients are transported per the Trauma Field triage Criteria. cardiac arrest patients should go to the closest facility. Remote Outpatient Emergency Department criteria allow transport of stable patients without life-threatening conditions.

- Trauma Field triage Criteria categorize patients for transport to trauma centers based on injury patterns, mental status, vital signs, mechanism of injury, and EMS judgment. Red criteria indicate severe injuries or physiological compromise. Yellow criteria involve high-risk mechanisms or specific patient factors.
- Waiting Room Criteria specify when a patient arriving at the ED may be placed in the waiting room. Criteria include normal vital signs, not receiving parenteral medications (except limited analgesia/antiemetic), not requiring continuous cardiac monitoring (in paramedic's judgment), maintaining a sitting position, and leaving a verbal report to hospital personnel.

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A[Clark County EMS protocols] --> B(Introduction)
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A --> C(General Assessment & Operations)
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A --> D(adult treatment)
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```
A --> E(pediatric treatment)
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```
A --> F(Procedures)
```

```
A --> G(formulary & Appendices)
```

```
A --> H(Special Considerations)
```

```
C --> C1(General Adult Assessment)
```

```
C --> C2(General Pediatric Assessment)
```

```
C --> C3(Communications)
```

```
C --> C4(Documentation)
```

```
D --> D1(cardiac arrest)
```

```
D --> D2(Chest Pain)
```

```
D --> D3(respiratory distress)
```

```
D --> D4(...)
```

```
E --> E1(Pediatric cardiac arrest)
```

```
E --> E2(Pediatric respiratory distress)
```

```
E --> E3(...)
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```
F --> F1(cervical stabilization)
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F --> F2(Electrical Therapy)
```

```
F --> F3(Endotracheal Intubation)
```

```
F --> F4(hemorrhage control)
```

```
F --> F5(Vascular Access)
```

F --> F6(...)

G --> G1(formulary)

G --> G2(Appendices)

G2 --> G2a(Release Forms)

G2 --> G2b(Scope of Practice)

G2 --> G2c(telemetry Map)

G2 --> G2d(MCI Guidelines)

H --> H1(Hostile MCI)

H --> H2(Inter-Facility Transport)

H --> H3(Pediatric Destination)

H --> H4(Death Determination)

H --> H5(Public Intoxication)

H --> H6(Transport Destinations)

H --> H7(Trauma triage)

H --> H8(Waiting Room Criteria)