



City of Saginaw
Meeting and/or Executive Session Agenda

Tuesday, January 20, 2026, 6:00 PM
Council Chamber
333 West McLeroy Boulevard
Saginaw, Texas 76179

In accordance with Section 551.043 of the Texas Government Code, this agenda has been posted at Saginaw City Hall, and distributed to the appropriate news media within the required time frame. All meetings of the Saginaw City Council are open to the public. Public participation and written comments are invited on all open session business items.

The Mayor and City Council request that all cell phones and pagers be turned off or set to vibrate. Members of the audience are requested to step outside to respond to a page or to conduct a phone conversation. The City Hall is wheelchair accessible and special parking is available on the east side of the building. If special accommodations are required please contact the City Secretary a minimum of 72 hours in advance at 817-232-4640.

1. Call To Order

1.A. Call To Order -- Todd Flippo, Mayor

1.B. Pledges--Pledge of Allegiance to the United States; Pledge of Allegiance to the State of Texas--
"Honor the Texas Flag; I pledge allegiance to thee, Texas, one State under God, one and indivisible"

1.C. Invocation -- Pastor Ramon Smith, Saginaw United Methodist Church

1.D. Audience Participation--Anyone wishing to speak during the discussion of an item listed on the agenda must complete an audience participation form. These forms are located by the Police Chief. After completing the form, give it to the City Secretary. She will give it to the Mayor. The Mayor will call on you when that item is discussed. You will have three (3) minutes to make your comment

2. Consent Agenda

All items listed are part of the Consent Agenda. Public hearing and review are held collectively unless opposition is presented, in which case the contested item will be heard separately.

2.A. Action regarding Minutes from the December 16, 2025, meeting--Vicky Vega, City Secretary

2.B. Action regarding Ordinance No. 2026-01, Appointment of Municipal Court Judge and Associate Judges; and Approval of Municipal Court Judge Agreement

2.C. Action regarding Tarrant County HazMAP Resolution -- Doug Spears, Fire Chief

2.D. Action regarding First Responder Organization agreement with the City of Fort Worth-- Doug Spears, Fire Chief

2.E. Action regarding Business Associate Agreement with the City of Fort Worth-- Doug Spears, Fire Chief

2.F. Action Regarding the Switchyard Cinco de Mayo Festival -- Ericka Gambill, Special Events and Food Truck Tech

2.G. Action Regarding the Independence Day Fireworks Show -- Jason England, Assistant Recreation Services Manager

3. Proclamations-Presentations

3.A. Recognitions/Presentations--Gabe Reaume, City Manager

3.B. Bond Workshop--City Staff & Council

3.C. Work Plan Workshop-- Gabe Reaume, City Manager

4. Public Hearings

4.A. Consideration and Action Regarding Amendment to Zoning Ordinance, Appendix A "Zoning", Section 8-6, Sub-Section D, Relating to Carports-- Doug Spears, Fire Chief

5. Business

5.A. Consideration and Action regarding Resolution No. 2026-01, Calling a General Election to Elect the Offices of City Council Place 4 and City Council Place 6 to be held on May 2, 2026--Vicky Vega, City Secretary

5.B. Consideration and Action regarding award of Bid for the Remodel of the Old Library--Jarred Coursey, Asst. Director of Public Works

6. Executive Session

The City Council may take action on any Executive Session item posted.

6.A. 551.072. Texas Government Code. Deliberations Regarding Real Property. The City Council may convene in executive session to deliberate the purchase, exchange, lease or value of real property if deliberation in an open meeting would have a detrimental effect on the position of the City of negotiations with a third person, including the following matters

6.B. Any Item Posted

7. Adjournment

7.A. Adjournment--Todd Flippo, Mayor

Date Posted: _____ Time: _____ By:

Date Retrieved: _____ Time: _____ By:

Visit www.saginawtx.org/taxpayerimpact for Fiscal Year 2025-2026 Budget and Tax Payer Impact Statement - Pursuant to Section 551.043(c) Texas Government Code.

Date Posted: January 13, 2026 04:03 pm



A. Action regarding Minutes from the December 16, 2025, meeting--Vicky Vega, City Secretary

| Meeting | Agenda Group |
|------------------------------------|--------------------------|
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2A. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

Attached--Draft minutes from the December 16, 2025, meeting.

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

N/A

Attachments

[Draft Minutes--12-16-2025.pdf](#)

**** The following document is a draft of the minutes and the not the official approved minutes ****

City of Saginaw

Minutes for the City Council

333 West McLeroy Boulevard, Saginaw, Texas 76179

December 16, 2025, 6:00 PM

Present at the Meeting:

- Todd Flippo, Mayor
- Paul Felegy, Mayor Pro-Tem, Place 1
- Nick Lawson, Place 2
- Valerie Junkersfeld, Place 3
- Brack St. Clair, Place 4
- Shawn Morrison, Place 5
- Mary Copeland, Place 6
- Bryn Meredith, City Attorney
- Gabe Reaume, City Manager
- Kim Quin, Finance Director
- Doug Spears, Fire Chief
- Brandon Badovinace, Asst. Police Chief
- Randy Newsom, Director of Public Works
- Jarred Coursey, Asst. Director of Public Works
- Pedro Zambrano, Director of Economic Development & Community Engagement
- Melanie McManus, Director of Human Resources
- Ellen Ritchie, Library Director
- Vicky Vega, City Secretary
- Larry Little, Chief Building Official
- Debra Thomas, Permit & Customer Service Supervisor
- Maria Guynes, Permit Technician
- Aleena Davis, Communication Specialist
- Taylor Guadian, Animal Services officer
- Ronnie Horton, Adult Services Librarian
- Cpl. Tinsley

Absent from the Meeting:

- Russell Ragsdale, Police Chief

Visitors at the Meeting:

- Meredith Brown
- James Patterson
- Julie Jacobson
- Marilyn Tolbert
- Rains Berger
- Geo & Karen Merwintz
- Dr. Karen Reed
- Benjamin Guttery
- Tabitha O'Connor
- Clay Cristy
- Debra Brummett
- Stephen Brummett
- Lynn Fife
- Almelia Chavez
- Kim Birkner
- Matt Backe
- Walker White
- Drew Hanlon
- Kaleb Torres
- Siobhan Lilley
- Joe Stout
- Alex Costet

1. Call To Order

1.A. Call To Order -- Todd Flippo, Mayor

Mayor Flippo called the meeting at 6:00 p.m.

1.B. Pledges--Pledge of Allegiance to the United States; Pledge of Allegiance to the State of Texas--"Honor the Texas Flag; I pledge allegiance to thee, Texas, one State under God, one and indivisible"

1.C. Invocation--Pastor Joel Rangel, SOBA Church

In the absence of Pastor Joel Rangel, Councilmember Morrison gave the invocation.

1.D. Audience Participation--Anyone wishing to speak during the discussion of an item listed on the agenda must complete an audience participation form. These forms are located by the Police Chief. After completing the form, give it to the City Secretary. She will give it to the Mayor. The Mayor will call on you when that item is discussed. You will have three (3) minutes to make your comment

2. Consent Agenda

Motion was made by Mayor Pro-tem Felegy and seconded by Councilmember Junkersfeld to approve item 2A, 2B, and 2D of the Consent Agenda as presented. Motion passed unanimously 7-0-0. Item 2C pulled from the Consent Agenda to discuss more in detail.

2.A. Action regarding the minutes from the December 2, 2026, meeting-- Vicky Vega, City Secretary

Council approved the minutes from the December 2, 2025, meeting.

This item was approved through consent.

2.B. Action regarding an Individual Project Order (IPO) for McLeroy Blvd Phase 1 Final Design-- Trenton Tidwell, P.E. City Engineer

Council approved for Kimley-Horn to prepare the project order for the final design of E. McLeroy Blvd between Lavonne Lane and Blue Mound Road. The project order consist of construction documents for roadway, drainage, water line replacements, pavement markings and signage, traffic signal modification, traffic control plans, specifications, as well as project management and coordination tasks.

This item was approved through consent.

2.C. Action Regarding award of Bid of the 2.86 Acres of Vacant Industrial and Located at 616 S. Blue Mound Road Saginaw, Tarrant County, Texas--Pedro Zambrano, Director of Economic & Community Engagement

**** Item was Removed from Consent**

This item was pulled from the Consent Agenda at the recommendation of the City Attorney Meredith. Mr. Meredith advised the Council that any motion to approve the bid award would include authorization for the Mayor to execute the contract of sale, subject to final legal wording contract approval by the City Attorney. He further noted that the deal points had been finalized and that no further negotiations would occur. However, if the City Attorney is unable to approve the final contract language, the City reserves the right to withdraw the bid award.

Motion was made by Councilmember St. Clair and seconded by Councilmember Lawson to approve item 2C with the stipulation, that the City Attorney is able to execute the Contract of Sale.

Motion passed unanimously. 7-0-0-0.

2.D. Action Regarding Economic Development Chapter 380 Agreement with Riverside Builders-- Pedro Zambrano, Director of Economic & Community Engagement

Council approved an Economic Development Chapter 380 agreement with Riverside Builders. Riverside Homebuilders, Ltd. intends to construct new homes on undeveloped property within the City. As part of their operations, Riverside will purchase large quantities of building materials using a Texas Direct Payment Permit, which allows the company to self-assess and remit use taxes directly to the State of Texas. Riverside has indicated that entering into a Chapter 380 Agreement would play an important role in directing more of these purchases in a way that benefits the City. Saginaw would receive new sales tax revenue that we would not otherwise capture.

The City will provide a semi-annual economic development grant equal to 80% of the City's net Use Tax Receipts generated from Riverside's qualifying purchases. CCPD and Streets Maintenance is not included in the calculation. Grants are paid at the end of June and December following receipt of the required documentation and actual use tax revenue from the State. Riverside must submit a Use Tax Certificate within 30 days of each applicable Grant Period, along with supporting documentation (self-assessment reports, amended filings. The City is not obligated to issue reimbursement until all documentation is received and the City has received the corresponding use tax.

The 380 Agreement is structured so that all payments to Riverside are based solely on new use tax revenue received by the City. There is no financial obligation to the City beyond a percentage of new revenue generated by the company's activities within Saginaw.

This item was approved through consent.

3. Proclamations-Presentations

3.A. Recognitions/Presentations--Gabe Reaume, City Manager

Recognition of City Staff who worked the 2025 Holiday Event, and Celebrated the Eagle Mountain High School Volley Ball Team for their recent State Championship Victory by proclaiming December 16th 2025 as "Knights Day".

3.B. Presentation of Updated Design Options for a New Animal Shelter - Kim Dowdy-Hickman, Quorum Architects

Assistant City Manager Howell, provided a background update on the assessment completed by two firms for the Animal Shelter facility, noting discussions have been underway for more than two years. The current shelter consist of several aging structures and is in poor condition with

inadequate drainage, ventilation, and isolation space, making repairs impractical. He also discussed operational improvements made by the Animal Services Department.

Kim Dowdy-Hickman with Quorum Architects, gave an updated presentation regarding design option for a new Animal Shelter. In her presentation she discussed the MoSCoW Method which was used to evaluate the overall facility spaces as Must Haves, Should Haves, Could Haves, and Wont Haves. The Animal Advisory committee reviewed every area of the proposed shelter and their input was incorporated into the updated conceptual plans and reduced overall square footage and project cost.

Council discussion included questions regarding project cost, future staffing levels, and requested that staff provide more detailed information on the potential financial impact to taxpayers prior to making a decision.

Mayor received eight request to speak on topic.

The first request was from Julie Jacobson, Saginaw resident and current member of the Animal Advisory Committee. Ms. Jacobson addressed the Council and expressed that when the committee participated in the MoSCoW assessment, the evaluation was done thoroughly and not taken lightly. She understands the concern regarding the project cost but also understands that the project needs to be done efficiently and cost effective. Ms. Jacobson also discussed the potential size and design of the building, she expressed concerns if the facility is too small, running the risk of potential outbreaks of diseases and strain on staff and animals and would like to see a calm environment for the animals, which would make them more adoptable. Her ask is put the bond on the ballot for a new facility.

The second request was from Tabitha O'Connor, Saginaw resident. Ms. O'Connor addressed the Council and expressed that current facility conditions are a problem and understands that having a new facility will increase her taxes, but is okay with it as long as the animals are in better conditions. Ms. O'Connor discussed that she would not like for this to be prolonged anymore.

The third request was from Dr. Karen Reed, volunteer and the Chair of the 501(c) (3) organization. Ms. Reed addressed the Council regarding potential grants and mentioned they have done some research on grants and found some but not for the entire project. Ms. Reed discussed her experience volunteering at the current shelter, it involved a lot of cleaning and washing the bedding's for animals and mentioned that the facility only has one washer and dryer and is constantly running. She also explained when its kitten season and the influx of kittens and how space is limited and sometimes temporary kennels are setup and it being very challenging. The dog area is also a concern regarding space when its full and sometimes dogs are having to be placed in the quarantine area, it was very concerning for her because they were not able to be seen for adoption.

The fourth request was from Benjamin Guttery, Saginaw resident. Mr. Guttery addressed the Council and noted that he feels that some of the concerns are not being addressed properly as he previously mentioned in the last meeting, he stated that no one is saying that there is no need for

a new shelter but the concern is the amount of kennels, there are too many kennels and he feels that Saginaw is subsidizing the neighboring cities like the City of Blue Mound and City of Fort Worth and feels that animals are being dropped off in Saginaw to receive food and services. He also discussed the MoSCoW assessment doesn't believe it was done properly. Mr. Guttery concluded that there is a need for a new facility but does not believe that it will pass as presented.

The fifth request was from Kim Birkner, Saginaw resident. Ms. Birkner addressed the Council and noted that she takes care of feral cats by feeding and provides medical needs, to prevent the cats to go to the shelter and is proud that the Saginaw Animal Shelter is a no-kill shelter. Ms. Birkner also discussed the limited space for proper meet and greets for potential adoptions. She also understands the financial impact that it will be, but is willing to pay for a new facility that will be done the right way.

The sixth request was from Meredith Brown, Fort Worth resident. Ms. Brown addressed the Council regarding worsening conditions in animal welfare and increasing strain on shelters, noting that City's shelter operate with limited staff and relies on nonprofit support for veterinary care and supplies. Ms. Brown emphasized that stressful shelter environments negatively impact animal behavior and adaptability and the challenges stem from inadequate funding rather than staff performance. She also urged Council to support a properly funded and well designed shelter to improve animal welfare, public perception, and adoption outcomes.

The seventh request was from James Patterson, Saginaw resident. Mr. Patterson addressed the Council regarding his concerns of the proposed animal shelter and the overall cost. He discussed how he was disappointed in the manner of how he was made aware of the potential new animal shelter through social media and emphasized the need for stronger transparency and financial responsibility with taxpayer funds. He also questioned the accuracy of the needs assessment and expressed disagreement with the recommendations from the firm, stating that more information should have been available before consideration of a bond proposal. He also discussed that the existing shelter could be rehabbed and or expanded and recommended increasing partnerships with other rescue groups and improving public outreach and adoption promotion. He mentioned that he did his own research and compared other shelter capacities and population sizes in surrounding cities and urged Council to consider a modest approach and remodel the existing shelter and focus on street improvements and other projects and keep the animal shelter off the ballot.

The eighth request was from Siobhan Lilley, Saginaw resident. Ms. Lilley expressed concerns about the proposed size and cost of the Animal Shelter facility. She questioned the analysis completed, due to the information used to compare for Saginaw were from cities with larger population sizes. She discussed that she had done her own research and based on her research it suggested a smaller facility size that would be adequate for Saginaw's needs and the proposed square footage was way more than needed. She expressed the importance of Council being responsible to voters and to be mindful of other entities like Tarrant County and the school district of what they may be

doing to possibly increase taxes and was disappointed in the MoSCoW assessment. She also discussed concerns regarding transparency and potential conflicts of interest.

Animal Services Supervisor Jose Wheeland, addressed Council and clarified information previously discussed concerning shelter policies, contractual matters, and daily operations at the shelter.

This item was for informational purposes, no action was taken. Further discussions will take place at the January 20, 2026, City Council meeting.

3.C. Animal Shelter Advisory Board Recommendation - Joseph Stout, Chairman

Joe Stout, the Chairman of the Animal Advisory Committee, Mr. Stout addressed the Council regarding the committee's recommendation for the Animal Shelter Project. He outlined the committee's involvement throughout this process and emphasized the need for a modern facility to support animal welfare, public health, and safety. He also noted that while staff performs well with limited resources, the current shelter is outdated and does not meet today's standards. He concluded by stating that Animal Services Advisory Committee recommends placing the Animal Shelter project before the voters as a bond proposition.

Council discussed population and the amount of kennels needed and requested more information to support the need made by the assessment.

This item was for informational purposes, no action was taken.

3.D. Presentation & Discussion on Depot Building -- Larry Little, Chief Building Official

Chief Building Official Mr. Little presented to Council a brief history update/current conditions of the building and future use considerations to include railroad land lease stipulations and potential relocation considerations. The Depot Building is currently being occupied by Building and Code Enforcement Department.

This item was for informational purposes, no action taken.

3.E. Discussion regarding Ordinances related to carports--City Staff & Council

Councilmember Lawson lead the discussion regarding a Textural Amendment to the Zoning Ordinance that is related to the Carport Ordinance. Mr. Lawson is proposing that in zoning districts where carports are currently allowed, carports may exceed the 600 square foot roof area limit

and/or encroach into the required side yard setback. These exceptions would be considered through the established Specific Use Permit (SUP) process. Council discussion reflected both support of the proposal, while others voiced opposition to forwarding the item to the Planning and Zoning Commission, noting that the issue appeared to affect only limited number of isolated cases. Concerns were raised that the proposed changes could create additional safety risk rather than improvements.

Mayor Flippo received one request to speak on topic, Debra Thomas, Saginaw Resident. Ms. Thomas spoke against amending the Carport Ordinance and expressed concerns and would not be in favor for the amendment.

Motion was made by Councilmember Lawson and seconded by Councilmember Morrison to refer the item to the Planning and Zoning Commission for formal consideration. Motion passed. 4-3-0-0. (Yea: Felegy, Lawson, Junkersfeld, Morrison; Nay: Flippo, Copeland, St. Clair)

This item will be heard at the next P&Z meeting on Tuesday, January 13, 2026.

3.F. Discussion regarding Bids received for the remodel of the Old Library Facility at 355 W. McLeroy Blvd--Jarred Coursey, Asst. Director of Public Works

Assistant Director of Public Works Coursey gave a brief update to Council on the Old Library Remodel bid process. Mr. Coursey reported that twelve proposals were received and are currently under review, including reference checks. The project includes remodeling the former Library for city office space and a connecting corridor to City Hall, which requires related facility upgrades. Bidders were asked to provide alternate bids for pricing with and without the corridor and City Hall improvements.

Staff advised that a recommendation will be presented to Council at the January 20, 2026 meeting.

This item was for informational purposes, no action taken.

4. Public Hearings

4.A. PUBLIC HEARING--Consideration and Action Regarding a Proposed Textural Amendment to the Zoning Ordinance Regarding Modifying the City's Permitted Use Table (Automotive Uses) and Section 8-9, "Off-Street Parking and Loading Requirements," of Article 8, "Supplemental District

Regulations," of Appendix A, "Zoning" -- Susy Victor-Trevino, Asst. Director of Economic and Community Engagement

Public Hearing was opened at 8:49 PM and closed at 8:52 PM

Mayor Flippo opened the Public Hearing at 8:48 pm, to consider a proposed Textural Amendment to the Zoning Ordinance regarding modifications to the City's permitted use table, specifically related to off-premise parking. Assistant Director of Economic and Community Engagement Ms. Victor, explained the off-premise parking provision to support upcoming developments. Staff clarified that the current ordinance does not allow off-premise parking and that this amendment would align the ordinance with the permitted use table. The amendment would allow the off-premise parking by Specific Use Permit (SUP) and appropriate legal agreements. The Mayor opened the floor for Public comment. No public comment. At 8:52 pm, Mayor Flippo closed the public hearing.

Motion was made by Mayor Pro-tem Felegy and seconded by Councilmember St. Clair to approve item as presented. Motion passed unanimously. 7-0-0-0.

4.B. PUBLIC HEARING--Consideration and Action Regarding for a Change in Zoning and a Planned Development on 25.62 Acres out of the Property located on 112 Spring Hollow Dr. and 304 E. McLeroy Blvd. from Single Family (SF3), Light Industrial (LI), and Community Commercial (CC) to a Planned Development (PD for Light Industrial (LI) and Community Commercial (CC)). -- Susy Victor-Trevino, Asst. Director of Economic and Community Engagement

Public Hearing was opened at 8:53 PM and closed at 9:07 PM

Mayor Flippo opened the Public Hearing at 8:53 pm, to consider a proposed zoning change for the 25.62 acres planned development located at 112 Spring Hollow Dr and 304 E. McLeroy Blvd. Assistant Director of Economic Development and Community Engagement Ms. Victor, explained that the request involves a two part proposal with the planned development zoning. Ms. Victor stated that at the previous meeting that took place on December 2, 2025, the applicant withdrew the original application in order to address a screening requirement deviation. Which affected the project's financial feasibility and the ability to relocate an access point, which was an issue raised by the Spring Creek HOA. Since then, the Developer, City Staff, and the HOA representatives have met to negotiate a comprise.

The proposed comprise would relocate the primary access point from Spring Hollow to East McLeroy Blvd and require a land swap involving Star Manufacturing, so that the applicant can obtain frontage on East McLeroy Blvd. Reconfigure zoning so that Tract 1 of the planned development is zoned Light Industrial and Tract 2 would be zoned Community Commercial, this would create a more cohesive zoning pattern for Falcon Distribution Center site. Ms. Victor noted that the proposal includes deviation from additional screening requirements, as an existing berm

and fence already provide buffering. The developer has agreed to construct a missing section of fencing to ensure continuous buffer along the boundary.

Walker White, Representative for Falcon Distribution addressed the Council and stated that this process has been over a year in the making and they have worked closely with City Staff, the Spring Creek HOA, and neighboring property owners to resolve access concerns related to the project, particularly the lack of access to East McLeroy Blvd. He noted that several alternates were explored, including a potential rail crossing, which was determined to be infeasible. Mr. White explained that they have negotiated a land swap agreement with a neighboring metal manufacturing company (Star Manufacturing) to facilitate relocating the project's access from Spring Hollow to East. McLeroy Blvd. Under the agreement, Falcon would give one acre of land to the neighboring property owner in exchange for approximately half acre of land closer to Spring Hollow, allowing for the access relocation and a transition in zoning from Heavy Industrial (HI) to Community Commercial (CC) for the exchanged parcel. He further explained that significant grading and site improvements will be required on the land being swap to match the existing property. Mr. White stated that the requested variance related to the fencing requirements would allow Falcon Distribution to redirect funds towards the necessary site improvements and the relocating of the access drive. Mr. White also outline commitments made to the Spring Creek HOA as part of the agreement, including a dedication of land on the north end and install a recreational concrete pad for neighborhood use.

Alex Costet, President of the Spring Creek HOA, addressed Council and stated that the HOA's primary concern throughout the process was safety of the neighborhood children, and he expressed appreciation that Falcons Distribution center access would be relocated to a safe location. He noted that the HOA was pleased with the outcome. He explained that the remaining concern involved screening for the three homes that are not currently buffered by the existing fence. As part of the agreement, Falcon has committed to extending the fence and providing additional screening to be better separate the neighborhood and park area from the adjacent warehouse parking lot.

Mayor Flippo received a couple of statement records. The first one is from Luciano Salinas and Yolanda Cervantez, expressing opposition to the proposal. Their concerns included potential blockage of sunlight, and foundation problems, and wall fixtures coming off the wall.

The second response was from David Hanna. He stated that he was initially viewed the situation negatively, after reviewing the extensive correspondences and hearing from residents in the HOA, has now changed his opinion and now supports the proposal. He also mentioned that McLeroy should be widened.

The third proposal was from Paul Chickowsky, he stated that he is opposed. He referenced concerns related to heavy industrial zoning, noting that such zoning typically involves intense industrial activities that may create noise, odor, dust, fumes, vibrations, and other impacts. These districts are typically situated away from residential and commercial areas with specific regulations to mitigate their impact on adjacent properties.

Mayor called for public input during the Public Hearing. There were none. At 9:07 pm, Mayor Flippo closed the Public Hearing.

Motion was made by Mayor Pro-tem Felegy and seconded by Councilmember St. Clair to approve item 4B with the legal language by the City Attorney for the Ordinance. Motion passed unanimously. 7-0-0-0.

4.C. PUBLIC HEARING--Consideration and Action Regarding a Rezoning Request for some portions of the property located at 112 Spring Hollow Dr. from Light Industrial (LI) to Single Family (SF3) and from Community Commercial (CC) to Heavy Industrial (HI). -- Susy Victor-Trevino, Asst. Director of Economic and Community Engagement

Public Hearing was opened at 9:09 PM and closed at 9:11 PM

Mayor Flippo opened the Public Hearing at 9:09 pm, regarding a rezoning request for a portion of the property located at 112 Spring Hollow, proposing a change from Light Industrial (LI) to Single Family (SF3) and Community Commercial to Heavy Industrial. Assistant Director of Economic Development and Community Engagement Ms. Victor, explained that the rezoning would align with a proposed land swap in which Falcon Distribution plans to donate a triangular portion of property to the HOA for Single Family Use, making the change to (SF3) zoning. She further explained that the portion of property being given to Star Manufacturing as part of the land swap would be rezoned to Heavy Industrial, consistent with the company's existing zoning.

Mayor called for public input during the Public Hearing. There were none. At 9:011 pm, Mayor Flippo closed the Public Hearing.

Motion was made by Mayor Pro-tem Felegy and seconded by Councilmember Lawson to approve item 4C. Motion passed unanimously. 7-0-0-0.

4.D. PUBLIC HEARING--Consideration and Action Regarding a Request to Amend a Change in the Beltmill Planned Development District, Providing Development Standards and a Development Plan for Tract 4, located at the Northeast corner of E. Bailey Boswell Blvd. and Millstone Rd. -- Susy Victor-Trevino, Asst. Director of Economic and Community Engagement

Public Hearing was opened at 9:11 PM and closed at 9:56 PM

Mayor Flippo opened the Public Hearing at 9:11 pm, regarding a request to amend a change in the Beltmill Planned Development District providing development standards and a development plan for Tract 4, located at the northwest corner of East Bailey Boswell Road and Millstone Road. Assistant Director of Economic Development and Community Engagement Ms. Victor presented this item. She explained that the request involves a portion of the Beltmill development and represents one of the final components of the overall master planned area. Ms. Victor stated that the applicant is requesting amendments to the approved development plan. Staff reviewed the

proposal and requested that the design maintain a walkable, multi-building layout rather than a traditional strip center format. She also noted that, as submitted, the proposal does not fully align original intent of the development and is not compatible. The developer updated the concept and is proposing the concept to include, an activated activity space near the pond and a designated restaurant with a patio area.

Ms. Victor emphasized that staff has reviewed multiple plans for the parcel over time and continues to believe the current proposal does not meet the intent originally presented to Council and noted that this tract is one of the last major parcels within the Master Plan making its future use significant to the City.

Clay Cristy representative, on behalf of Sandy Aron, Beltmill, LLC presented to Council regarding the proposed development plan. Mr. Cristy explained the change to the existing Planned Development to update the conceptual development plan. He is proposing new locations and sizes for the buildings to accommodate a 40,000 sq fitness center, a 29,000 sq retail strip, a convenience store with fuel sales, and three restaurants with drive-thru. The previously adopted PD did not include a convenience store with fuel sales or restaurants with drive-thru, instead the buildings were proposed as an open-concept design arranged around a central open space overlooking the detention pond.

Council expressed concerns regarding the proposed planned development, specifically the green space, and sit down restaurants, the new proposals takes away from the vision and character that Council anticipated.

Mayor called for public input during the Public Hearing. There were none. At 9:56 pm, Mayor Flippo closed the Public Hearing.

Motion was made by Mayor Pro-tem Felegy and seconded by Councilmember Lawson to Deny (4D) the change to the Planned Development. Motion passed unanimously. 7-0-0-0.

5. Business

5.A. Consideration and action regarding Appointments: a. Advisory Recreation and Parks Board; b. Animal Shelter Advisory Committee; c. Community Garden Advisory Board; d.-Keep Saginaw Beautiful Committee; e. Planning & Zoning Commission-Councilmember St. Clair, Mayor Pro-Tem Felegy & Councilmember Morrison

The Council Sub Committee reviewed some vacancy on various boards and appointed new board members to the newest board the Community Garden.

Councilmember St. Clair explained the Sub Committee's recommendations. The Council voted on the recommendations for each board separately.

- **Animal Shelter Advisory Committee Appointments:** Place 6; Rick Russell, Alt#1; Machel Hoodie, Alt#2; Debbie Norris,
- **Capital Improvements Advisory Committee and Planning & Zoning Commission Appointments:** Alt#2; Rebeka Arrington
- **Community Garden Board: Place 1;** Minh Placido, Place 2; Dr. Anetta Jackson, Place 3; Makayla Miller, Place 4; Alexandra Braddock, Place 5; Frances Ruiz, Alt#1; Kendel Rogers, Alt#2; Megan Hatlet-Freeman, Councilmember Liaison; Morrison
- **Keep Saginaw Beautiful Committee Appointments:** Alt#1; George Ware, Alt#2; Myranda Beier,
- **Advisory Recreation & Parks Board Appointments:** Place 5; Timothy Hamilton, Alt#1; Scott Gillette, Alt#2; Emily Bell, .

Motion was made by Councilmember Junkersfeld and seconded by Councilmember Lawson to approve the appointments as read by Councilmember St. Clair. Motion passed unanimously. 7-0-0-0.

6. Executive Session

Mayor Flippo called the meeting into executive session at 10:01 pm.

6.A. 551.071. Texas Government Code. Consultation with Attorney. The City Council may convene in executive session to conduct a private consultation with its attorney on any legally posted agenda item, when the City Council seeks the advice of its attorney about pending or contemplated litigation, a settlement offer, or on a matter in which the duty of the attorney to the governmental body under the Texas Disciplinary Rules of Professional Conduct of the State Bar of Texas clearly conflicts with the provisions of Chapter 551, including the following items:

6.B. Any Item Posted

6.C. 551.087. Texas Government Code. Deliberation regarding Economic Development Negotiations. The City Council may convene in executive session to discuss or deliberate regarding commercial or financial information that the City has received from a business prospect that the City seeks to have locate, stay, or expand in or near the City, and with which the City is conducting economic development negotiations; or to deliberate the offer of a financial or other incentive to a business prospect described above, including:

6.D. Redevelopment Grant: 113 Belmont St

7. Adjournment

7.A. Adjournment--Todd Flippo, Mayor

Mayor Flippo called the meeting back into regular session at 10:11 am.

Motion was made by Councilmember St. Clair and seconded by Councilmember Junkersfeld to adjourn the meeting. Motion passed unanimously. 7-0-0-0.

Mayor Flippo adjourned the meeting at 10:11 pm.



B. Action regarding Ordinance No. 2026-01, Appointment of Municipal Court Judge and Associate Judges; and Approval of Municipal Court Judge Agreement

| Meeting | Agenda Group |
|------------------------------------|--------------------------|
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2B. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

In January 2012, a Municipal Court of Record was established by the City Council and Attorney Lorraine Irby was appointed Judge. Judge Irby has been reappointed since the Municipal Court of Record was established. Associate Judges Wendy Cooper, Stewart Bass, and Bonnie Wolf are appointed in conjunction with the Judge's appointment. The current term of office expires on January 31, 2026. Ordinance No. 2026-01 Appoints the Judge and Associate Judges for an additional one year term through January 31, 2027. The proposed Municipal Judge Agreement is the same as the current agreement.

FINANCIAL IMPACT:

The annual cost of the Judge's services is \$45,360 and up to \$350 for training expenses. The cost of the contract is included in the FY2025/2026 Adopted Budget.

RECOMMENDATION:

Staff recommends approval of Ordinance No. 2026-01, appointment of Lorraine Irby as Municipal Court Judge, and Wendy Cooper, Stewart Bass, and Bonnie Wolf as Associate Judges for one year beginning February 2, 2026; and approval of the Municipal Court Judge Agreement.

Attachments

- [Municipal Court Judges ordinance 2026.pdf](#)
- [MUNICIPAL JUDGE AGREEMENT 2026.pdf](#)

ORDINANCE NO. 2026-01

AN ORDINANCE OF THE CITY OF SAGINAW, TEXAS APPOINTING THE JUDGE AND ASSOCIATE JUDGES OF THE MUNICIPAL COURT OF RECORD IN THE CITY OF SAGINAW; PROVIDING THAT THIS ORDINANCE SHALL BE CUMULATIVE OF ALL ORDINANCES; PROVIDING A SEVERABILITY CLAUSE; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City of Saginaw, Texas, is a home rule city acting under its charter adopted by the electorate pursuant to article XI, section 5 of the Texas Constitution and chapter 9 of the Texas Local Government Code; and

WHEREAS, the City Council has created a municipal court of record pursuant to Chapter 30 of the Texas Government Code; and

WHEREAS, Chapter 30 of the Texas Government Code relating to municipal courts of record provides that the judge of the municipal court of record shall be appointed by the City Council by ordinance; and

WHEREAS, the workload of the Saginaw Municipal Court is not large enough to support a full time Municipal Court Judge; and

WHEREAS, it is of great benefit to the City of Saginaw to have an experienced municipal court judge sit on the bench of the municipal court of the City of Saginaw; and

WHEREAS, Section 574.001, Texas Government Code requires that a finding be made to the effect that a person who serves as an officer in more than one appointed position obtain a finding from the governing body that such officer has satisfied Article XVI, Section 40, of the Texas Constitution; and

WHEREAS, there is no conflict between the office of municipal judge of the City of Saginaw and the office of municipal court judge in any other municipality in the State of Texas; and

WHEREAS, the City Council desires to appoint Lorraine Irby as municipal judge and Wendy Cooper, Stewart Bass, and Bonnie Wolf as associate judges for the Municipal Court of Record in the City of Saginaw.

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF SAGINAW, TEXAS:

SECTION 1.

It is hereby found that the office of municipal court judge of the City of Saginaw is of benefit to the State of Texas and to the City of Saginaw and that there is no conflict between the office of municipal judge of Saginaw and the office of municipal judge in any other city.

SECTION 2.

Lorraine Irby is hereby appointed as the Municipal Judge of the municipal court of record in the City of Saginaw, Texas for a one year term beginning February 1, 2026. At the expiration of said term, in accordance with Article 16, Section 17 of the Texas Constitution, Judge Irby shall continue to serve until her successor shall be duly qualified.

SECTION 3.

Wendy Cooper, Stewart Bass, and Bonnie Wolf are hereby appointed as the associate judges to serve when the Municipal Judge is temporarily absent or unable to serve.

SECTION 4.

This ordinance shall be cumulative of all provisions of ordinances and of the Code of Ordinances of the City of Saginaw, Texas, as amended, except where the provisions of this ordinance are in direct conflict with the provisions of such ordinances and such Code, in which event the conflicting provisions of such ordinances and such Code are hereby repealed.

SECTION 5.

It is hereby declared to be the intention of the City Council that the phrases, clauses, sentences, paragraphs, and sections of this ordinance are severable, and if any phrase, clause, sentence, paragraph or section of this ordinance shall be declared unconstitutional by the valid judgment or decree of any court of competent jurisdiction, such unconstitutionality shall not affect any of the remaining phrases, clauses, sentences, paragraphs and sections of this ordinance, since the same would have been enacted by the City Council without the incorporation in this ordinance of any such unconstitutional phrase, clause, sentence, paragraph or section.

SECTION 6.

This ordinance shall be in full force and effect from and after its passage and it is so ordained.

PASSED AND APPROVED on this 20th day of January 2026 at a regular meeting of the City Council of the City of Saginaw, Texas.

Todd Flippo, Mayor

ATTEST:

Vicky Vega, City Secretary

APPROVED AS TO FORM:

Bryn Meredith, City Attorney

MUNICIPAL JUDGE AGREEMENT

This Agreement is made by and between the City of Saginaw, Texas (“City”) and Lorraine Irby (“Irby”), for the purpose of documenting the terms and conditions under which Irby will serve as municipal court judge for the City. It shall be performed in and is enforceable in Tarrant County, Texas.

Recitations:

1. Irby desires to contract with the City to serve as municipal court judge.
2. City desires to contract with Irby as an independent contractor to provide services as a municipal court judge.

Agreements:

1. Irby, while serving as municipal judge, has all the powers and shall discharge all the duties of a municipal judge, and shall serve at the pleasure of the City Council. Irby is expected to work the hours necessary to fulfill the obligations of the municipal judge in order to operate the *Municipal Court of Record of the City of Saginaw* in an efficient manner. The essential functions of the municipal judge include, but are not limited to:

- a. presiding over trials and other court proceedings (including bench and jury trials);
- b. accepting pleas;
- c. processing appeals;
- d. supervising the maintenance of official records of proceedings and the court;
- e. conducting arraignments and performing the duties of magistrate under State law;
- f. signing of warrants and issuance of subpoenas;
- g. administering juvenile warnings; and
- h. other functions established in the City’s job description for the municipal judge.

2. City agrees to pay Irby \$45,360 per year for such services, payable in monthly installments on the first day of each month following a month of service, and annual Judicial Training expenses not to exceed \$350.

3. Irby agrees that she is an independent contractor and is not entitled to any City

benefits, such as health insurance, vacation, or retirements.

4. The term of this agreement shall be effective on the date of mutual execution hereof and shall terminate on the one year anniversary of Irby's appointment by the City Council, which is January 31, 2027, unless sooner terminated by either party.

5. This agreement may be terminated by either party without cause upon fifteen (15) days written notice to the other party, and in the case of termination by the City upon compliance with Section 6.08(1) of the City Charter. Upon termination, neither party shall have any further obligation to the other under such agreement or for the termination thereof. It shall terminate immediately should Irby become permanent disabled or disqualified from performing such services.

6. This agreement is made contingent upon appropriations for the funding hereof.

7. This agreement supersedes all other agreements, whether oral or written, between the parties with respect to the engagement of the municipal judge.

8. If any provision, or any portion thereof, contained in this agreement is held unconstitutional, invalid or unenforceable, the remainder of this agreement, or portion thereof, shall be deemed severable, shall not be affected and shall remain in full force and effect.

CITY OF SAGINAW

Lorraine Irby, Judge

By: _____
Todd Flippo, Mayor

Dated: _____

ATTEST:

Vicky Vega, City Secretary

Dated: _____



C. Action regarding Tarrant County HazMAP Resolution -- Doug Spears, Fire Chief

| Meeting | Agenda Group |
|------------------------------------|--------------------------|
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2C. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

Saginaw is a participant in the Tarrant County Hazard Mitigation Action Plan or HazMAP along with 34 other Tarrant County jurisdictions. The plan is updated approximately every 5 years. The HazMAP is utilized to both identify hazards and outline strategies to potentially mitigate those hazards. HazMAP establishment/updating, submission to and ultimately approval by FEMA is required in order to be eligible for federal grants when they are available. This most recent process of updating and gaining FEMA approval has been a 2 plus year duration. All participating jurisdictions must adopt the FEMA approved Tarrant County joint HazMAP via resolution. Adoption of the plan has no binding actionable or monetary requirements or commitments. It simply outlines identified hazards and potential mitigation strategies for jurisdictions to implement as feasible and appropriate. Federal grant awards, pre- and post disaster are weighted on HazMAPs.

Attached:

Tarrant County - Saginaw HazMAP Resolution 2025

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

Staff recommends adoption via resolution of the 2025 Tarrant County Hazards Mitigation Action Plan

Attachments

[Tarrant County - Saginaw HazMAP Resolution 2025.pdf](#)

RESOLUTION NO. _____

A RESOLUTION OF THE CITY OF SAGINAW, TEXAS, ADOPTING THE 2025 TARRANT COUNTY HAZARD MITIGATION ACTION PLAN

WHEREAS the **CITY COUNCIL OF SAGINAW** recognizes the threat that natural hazards pose to people and property within our community; and

WHEREAS, undertaking hazard mitigation actions before disasters occur reduces the potential for harm to people and property and saves taxpayer dollars; and

WHEREAS an adopted hazard mitigation plan is required as a condition of future funding for mitigation projects under multiple Federal Emergency Management Agency (FEMA) pre- and post-disaster mitigation grant programs; and

WHEREAS the **CITY COUNCIL OF SAGINAW** has fully participated in the update process of the 2025 Tarrant County Hazard Mitigation Action Plan in coordination with Tarrant County and other participating jurisdictions; and

WHEREAS the 2025 Tarrant County Hazard Mitigation Action Plan identifies natural hazards and mitigation strategies specific to the **CITY OF SAGINAW** and being adopted by the Tarrant County Commissioners' Court for submission to the Texas Division of Emergency Management and FEMA.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF SAGINAW, TEXAS.

1. Adoption: The **CITY COUNCIL** of the **CITY OF SAGINAW** hereby adopts the 2025 Tarrant County Hazard Mitigation Action Plan as the official hazard mitigation plan for the **CITY OF SAGINAW, TEXAS**.
2. Implementation: The Emergency Manager and all appropriate departments are encouraged to pursue implementation of the recommended mitigation actions, as feasible and appropriate.
3. Continued Participation: The **CITY OF SAGINAW** will continue to actively participate in future updates and implementation efforts of the countywide hazard mitigation plan.
4. Effective Date: This resolution shall take effect immediately upon adoption.

PASSED and ADOPTED this 20th day of JANUARY 2026.

Adopted by a vote of _____ in favor and _____ against, and _____ abstaining.

BY: _____

TODD FLIPPO, MAYOR

ATTEST: _____

VICKY VEGA, CITY SECRETARY

APPROVED AS TO FORM:

BY: _____

BRYN MEREDITH, CITY ATTORNEY



D. Action regarding First Responder Organization agreement with the City of Fort Worth-- Doug Spears, Fire Chief

| Meeting | Agenda Group |
|------------------------------------|--------------------------|
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2D. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

The Inter-local Agreement for EMS service (EMS ILA) with Fort Worth (FTW) was adopted by Saginaw City Council in February of 2025. The First Responder Organization (FRO) Agreement is a supplement to the existing EMS-ILA. Routinely the FRO Agreement would have been part of the adopted EMS-ILA but with the transition from Medstar to FTW as the service provider it was necessary to establish the FRO Board, officially named the EMS Advisory Board with each municipality having a designated voting member, to collaborate in the drafting of the FRO Agreement and incorporated exhibits. That collaborative effort is now complete.

The FRO Agreement is the framework regarding the Medical Protocols for the EMS service, the required medical equipment and EMS report documentation, medical credentialing levels and some other on scene processes for the First Responder Organizations.

Attached:

Saginaw - City of FTW - FRO Agreement January 2026 with exhibits A, B, C, D Exhibit D requires an additional approval action

Saginaw - FTW EMS ILA Fully Executed February 2025

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

Staff recommends approval of the First Responder Organization Agreement as presented.

Attachments

[Saginaw - City of FTW - FRO Agreement January 2026.pdf](#)

[Exhibit A - OMD Protocols.pdf](#)

[Exhibit B - Medication and Equipment Lists.pdf](#)

[Exhibit C - Patient Care Report.pdf](#)

[Exhibit D Saginaw - City of FTW Business Associate Agreement.pdf](#)

[Saginaw - FTW EMS ILA Fully Executed February 2025.pdf](#)

**CITY OF FORT WORTH AND CITY OF SAGINAW
FIRST RESPONDER AND PROVIDER AGREEMENT**

This First Responder and Provider Agreement (“Agreement”) is made between the City of Fort Worth (“Provider”) and the City of SAGINAW (“FRO”), both units of local government organized under the laws of the State of Texas. Provider and FRO may be referred to individually as a “Party,” and collectively as the “Parties” in this Agreement.

WHEREAS, the relationship between the Provider and FRO is established by the EMS Interlocal Agreement, identified as **City Secretary Contract No. _____**, executed by the Parties;

WHEREAS, FRO, Provider, and each jurisdiction that receives EMS System services from Provider, adopted a Uniform EMS Ordinance that obligates each jurisdiction to comply with the terms of their respective EMS Interlocal Agreements and to operate under the direction of Provider’s Medical Director and the department of the Office of the Medical Director (“OMD”);

WHEREAS, FRO, and other jurisdictions that receive EMS System services from Provider, and as required by its EMS Interlocal Agreement, must establish, operate, and fund a First Responder Program, as contemplated by Texas Administrative Code (TAC) 157.14, within their respective jurisdictions;

WHEREAS, Provider, by and through its Medical Director and OMD, publishes protocols, procedures, and policies in documents entitled the Fort Worth Regional EMS System Out-of-Hospital & Mobile Integrated Healthcare Protocols (“OMD Protocols”);

WHEREAS, Provider and its Medical Director are responsible for, among other things, credentialing and re-credentialing of personnel, establishing minimum equipment and medication requirements for first responder vehicles, and monitoring the quality of patient care provided within Provider’s EMS System; and

WHEREAS, Provider and FRO desire to formalize an agreement to comply with Texas Administrative Code § 157.14, entitled “Requirements for First Responder Organization License.”

NOW THEREFORE, known by all these present, Provider and FRO, acting herein by and through their duly authorized representatives, agree to the following terms:

I. LEVEL OF CERTIFICATION

1.1 Provider recognizes FRO as a Basic Life Support / **Advanced Life Support First Responder Organization**. As such, FRO is to meet all requirements listed in the OMD Protocols associated with the designated level of support.

1.2 When deemed necessary by Provider personnel to aid with patient care at a scene or during patient transport, any of FRO’s members or employees who are credentialed by OMD may provide

care within their credentialed scope. In such cases, equipment, supplies, and medications from a Provider ambulance may be used as needed.

1.3 FRO shall ensure it maintains compliance with Texas Administrative Code § 157.14(e), including, but not limited to its obligations relating to medical oversight, staffing, recordkeeping, infection control, data reporting, vehicle condition, and other responsibilities required for licensure as a First Responder Organization. FRO further agrees to cooperate with Provider and the Medical Director to the extent necessary to ensure such compliance.

1.4 The above notwithstanding, Provider acknowledges that the Texas Department of State Health Services (DSHS) recognizes the Emergency Care Attendant (ECA) as a certified level of EMS provider under Texas law. The ECA level is not a credentialed level under the OMD protocols and, therefore, ECAs are not subject to medical director credentialing requirements applicable to credentialed positions. ECAs may, however, provide services consistent with their DSHS certification level and within the scope of Basic Life Support (BLS) functions as defined by state law and DSHS. FRO ECAs operating under this Agreement may receive appropriate training as determined by Provider but such training shall not constitute or imply credentialing under the Medical Director's protocols. Nothing in this Agreement shall be construed to expand or restrict the statutory or regulatory scope of practice of ECAs under state law, nor to require the Medical Director to credential or supervise ECAs beyond that scope.

II. PROTOCOLS AND MEDICAL EQUIPMENT

2.1 FRO is required to adhere to the OMD Protocols, attached hereto as Exhibit "A."

2.2 FRO must equip first response apparatus with the approved supplies, medications and equipment as referenced in the OMD Protocols consistent with FRO's level of care. A minimum equipment and medication list is provided in the attached Exhibit "B."

III. FRO OPERATION

3.1 FRO must provide EMS first responder EMS System services twenty-four (24) hours per day and seven (7) days per week.

3.2 In the event that such EMS System services are interrupted, FRO must notify Provider and the Medical Director as soon as possible.

IV. PATIENT CARE REPORTING

4.1 Provider and FRO recognize documentation of patient care is essential for effective communication and continuity of care. FRO must adopt or develop a method by which patient care provided prior to Provider's arrival can be documented and shared with Provider before the patient is transported. Such documentation method must be submitted to Provider and the Medical Director for approval.

4.2 Exhibit "C," attached hereto, contains a copy of the FRO Patient Care Report that has been approved by the Medical Director. It is agreed that the original copy (Copy 1) will be retained by FRO and the second copy (Copy 2) will be given to Provider before the patient is transported to the hospital unless Electronic Patient Care Reports (EPCR) are utilized. If approved by the Medical

Director, EPCRs may be used in place of paper copies. EPCRs shall be compliant with Chapter 157.14 of the TAC.

V. CERTIFICATION OF FRO PERSONNEL WHO RENDER PATIENT CARE

5.1 The Medical Director has established a process requiring personnel to be credentialed to provide patient care within the Provider's EMS System. FRO personnel must meet and maintain the OMD requirements of credentialing. The Medical Director and Provider require ongoing testing of personnel within the EMS System.

VI. ASSESSMENT OF CARE PROVIDED BY FRO

6.1 The OMD will assess care provided by the FRO based on factors including but not limited to:

- a. Contribution to the development and alignment of clinical quality goals and strategies within the EMS System;
- b. Access to relevant clinical data supporting quality assurance, performance measurement, and improvement initiatives within the EMS System;
- c. Ensuring documentation supports the accurate measurement of clinical quality goals based on nationally endorsed clinical quality measures and benchmarks;
- d. Engagement in identified quality improvement initiatives, including the development, testing, and implementation of changes aimed at improving clinical performance;
- e. Compliance and participation with the OMD Quality Assurance Policy, including clinical case reviews, implementation of clinical restrictions if necessary, and Clinical Improvement Plans ("CIPs") to address any identified performance gaps or deficiencies; and
- f. Participation in clinical registries and research initiatives as guided by the OMD, supporting studies aimed at improving patient care and clinical outcomes within the EMS System.

VII. FRO RESPONSE CODE POLICIES

7.1 FRO agrees to respond to requests for service when deemed necessary by the Provider's Emergency Medical Dispatch protocols and policies approved by the Medical Director.

7.2 FRO may adopt other response policies that may be necessary to assure the safety and wellbeing of their personnel and community. When such additional policies affect responses to high-acuity medical situations, approval from the Medical Director is required.

VIII. ON-SCENE CHAIN OF COMMAND POLICIES

8.1 In addition to FRO's standard operating procedures related to the chain of command, FRO must recognize the Provider's EMS Supervisor as the highest ranking medically trained EMS person on scene.

8.2 FRO shall comply with the OMD Protocols, including training of supervisory personnel. While FRO may be responsible for incident command, the Provider is responsible for patient care and transport decisions in accordance with the OMD Protocols.

IX. MISCELLANEOUS

9.1 Cancellation of Ambulances. FRO may cancel ambulance responses in accordance with the OMD Protocols.

9.2 First Responder Personnel Accompanying Patients on Ambulances. When deemed necessary by Provider and FRO, FRO and Provider agree to allow at least one OMD credentialed person to assist with patient care on-board an ambulance during transport.

9.3 First Responder Personnel Driving or Operating Provider's Vehicles. When deemed necessary by Provider and FRO, FRO personnel, that are appropriately trained in the operation and usage of Provider's vehicles, are authorized to drive and/or operate Provider's vehicles in situations deemed necessary to care for a patient or to secure the Provider's vehicle(s). (Example: from time-to-time, it may be necessary for the FRO to drive the Provider's vehicle to a fire station, or another appropriate facility, to secure it until Provider can reclaim.) Provider shall maintain adequate insurance coverage for such vehicles whether by separate policy or self-insured status. Provider agrees that in the event FRO operates and/or drives Provider's vehicle for this limited purpose, FRO shall be an authorized operator of the vehicle for insurance purposes. FRO, and its personnel, are not authorized to operate or drive Provider's vehicle for any deviation or detour from the purpose specified herein.

9.4 Confidentiality. FRO agrees to comply with all relevant confidentiality laws of the State of Texas and the Health Insurance Portability and Accountability Act of 1996.

9.5 Business Associate Agreement. FRO must execute a separate Business Associate Agreement ("BAA") in the form, or substantial form, of the BAA attached hereto as Exhibit "D."

9.6 Original Agreement Unaltered. This Agreement is intended to supplement the existing Emergency Medical Services Interlocal Agreement ("ILA") between the Parties. The terms and conditions of the ILA shall remain the same, in full force and effect, and are not altered by the execution of this Agreement.

[Signature Page Follows]

ACCEPTED AND AGREED:

PROVIDER:

| | |
|---|--|
| <p>By: _____ Name: William Johnson Title: Assistant City Manager</p> <p>Date: _____</p> <p>APPROVAL RECOMMENDED:</p> <p>By: _____ Name: Raymond Hill Title: Interim Fire Chief</p> <p>Date: _____</p> <p>ATTEST:</p> <p>By: _____ Name: Jannette Goodall Title: City Secretary</p> <p>Date: _____</p> | <p>CONTRACT COMPLIANCE MANAGER:</p> <p>By signing I acknowledge that I am the person responsible for the monitoring and administration of this Agreement, including ensuring all performance and reporting requirements.</p> <p>By: _____ Name: Dustin Allison Title: Fire Battalion Chief-Operations Administration</p> <p>Date: _____</p> <p>APPROVED AS TO FORM AND LEGALITY:</p> <p>By: _____ Name: Taylor Paris Title: Assistant City Attorney</p> <p>Date: _____</p> |
|---|--|

FRO:

| | |
|---|--|
| <p>By: _____ Name: Todd Flippo Title: Mayor</p> <p>Date: _____</p> <p>ATTEST:</p> <p>By: _____ Name: Vicky Vega Title: City Secretary</p> <p>Date: _____</p> | <p>APPROVED AS TO FORM AND LEGALITY:</p> <p>By: _____ Name: Bryn Meredith Title: City Attorney</p> <p>Date: _____</p> |
|---|--|

EXHIBIT "A"
OMD PROTOCOLS

EXHIBIT "B"

MINIMUM EQUIPMENT AND MEDICATION LIST

EXHIBIT "C"

FRO PATIENT CARE REPORT

EXHIBIT "D"

BUSINESS ASSOCIATE AGREEMENT



FORT WORTH



Fort Worth Regional EMS System
Out-of-Hospital & Mobile Integrated
Healthcare Protocols

These protocol's jurisdictional authority pertains to the following members of the Fort Worth Regional EMS System:

Bell Helicopter Fire Department
Blue Mound Fire Department
Edgecliff Village Fire Department
Forest Hill Fire Department
Fort Worth Fire Department
Fort Worth Police Department
Haltom City Fire Department
Haslet Fire Department

Lake Worth Fire Department
Richland Hills Fire Department
River Oaks Fire Department
Saginaw Fire Department
Sansom Park Fire Department
Westover Hills Police Department
Westworth Village Police Department
White Settlement Fire Department

These protocols apply to clinicians who are credentialed by the Fort Worth Office of the Medical Director (FWOMD). Clinicians are authorized to practice within these protocols while considered to be "On-Duty" by their respective agencies. When outside the service area jurisdiction and not responding with another agency, credentialed clinicians may operate under these protocols within the borders of the State of Texas. Any advanced procedures may be performed, if allowed within the system, only at the request of the on-scene EMS agency.

Clinicians will remain authorized under these protocols for all deployments out-of-state with state programs (EMTF or TIFMAS) under EMAC requests. All deployments must be reviewed by and approved by the medical director.

Questions regarding the applicability of this document within any specific jurisdiction or for a particular event should be directed to the FWOMD by calling 817-923-1500 or in writing to the following address:

Fort Worth Office of the Medical Director
2900 Alta Mere Drive
Fort Worth, Texas 76116

EFFECTIVE:
July 1, 2025



Jeffrey L. Jarvis, MD, MS, EMT-P, FACEP, FAEMS
Chief Medical Officer / System Medical Director

Medical Direction and Oversight of the system includes the following components:

Medical Control Advisory Board

By resolution, the City of Fort Worth established the Medical Control Advisory Board (MCAB) to advise the City about the clinical performance of the EMS System, review medical protocols, clinical policies and procedures for the EMS System, and make recommendations to the Medical Director. MCAB should also represent the interests of the medical community, first responders, medical transportation clinicians, and ambulance standby clinicians by making recommendations for improvements to the EMS System as needed, and recommending and reviewing research conducted within the associated service area of the EMS System. The MCAB is composed of the System area hospital Emergency Department Medical Directors and additional specialty physicians.

Medical Director

The Medical Director is responsible for all aspects of clinical care for the System, including establishing clinical care requirements, credentialing standards, training & education, quality improvement processes, and research. The Medical Director must approve all medical protocols. The Medical Director's power and duties are defined in the Texas Medical Board Rules in the Texas Administrative Code, Title 22, Part 9, Chapter 169, Subchapter C, and in the employment agreement and job description. The Medical Director is also the Chief Medical Officer of the EMS System and has all powers and duties afforded and required of EMS medical directors under state law. The Medical Director provides all independent medical direction and is the exclusive source of medical direction and oversight for the EMS System.

Office of the Medical Director

The Medical Director may appoint members of staff to aid in the provision of medical direction and oversight, which may include physician (Associate/Assistant Medical Directors), and non-physician staff. The Medical Director may delegate certain tasks and responsibilities to this staff. The selection, hiring, separation, and day-to-day direction of members of this staff solely resides with the Medical Director.

Medical Directives

Medical Directives are issued by the Medical Director and describe specific clinical changes that modify these protocols. Each System Agency is responsible for disseminating Medical Directives to their stakeholders and credentialed EMS clinicians.

Medical Advisories

Medical Advisories are issued by the Medical Director and describe general medical topics that do not modify these protocols. Each System Agency is responsible for disseminating Medical Advisories to their stakeholders and credentialed EMS clinicians.

On-line Medical Control (OLMC)

OLMC is provided through direct communication with FWOMD EMS Physicians and is to be used for the purpose of further guidance and advisement of patient treatment, transport, and medical direction outside of, or as required within, these protocols. Contact FWOMD EMS Physicians by calling 682-302-4911.

Organization of the Protocol Document

This document was designed for efficient navigation. Protocol, Procedures, and Pharmacopeia references are underlined and in red. OMD clinical policies referenced are underlined, italicized, and in purple.

The major sections are color coded to allow for rapid identification and are organized as follows:

The master sections are identified by the top-most heading within each protocol, e.g. cardiac, medical, trauma, environmental, and distinguished by their color-coding. The definition of an adult and pediatric patients is outlined in the Patient Assessment protocol.

General
Spans multiple protocols due to their relevance to all facets of patient care, including Drug Assisted Airway, Circulatory Support, Respiratory Support, Acute Pain Management, Release at Scene, Against Medical Advice

Cardiac
Cardiac Arrest, Ischemic Chest Pain, and treatment of dysrhythmias

Medical
General medical emergencies, including Abdominal Pain, Respiratory Distress, Stroke/CVA/TIA

Environmental
Bites/Envenomation, Hypothermia, Hyperthermia, Near Drowning

Trauma
Treatment protocols for the injured patient

OB/GYN
Emergency Childbirth and Newly Born

Protocol Conventions

- All 911 protocols are listed in their entirety on a single page.
- Interventions, including the use of skills or medications, are preceded by individual bullets or lists of bullets.

- Hemorrhage Control
- Cover the stump with saline-soaked sterile dressing and wrap with dry dressing
- Wrap severed part in saline-moistened sterile dressing

- Simple *If* statements provide specific indications for the interventions that follow.

If suspected eclampsia/peripartum seizure, see Preeclampsia / Eclampsia

- While bullets are generally listed in the order of importance, numbers are avoided for the purpose of deemphasizing a rote, *cookbook*, approach to patient management
- The following pages provide a visual guide to the key elements of each protocol page, including:
 - Master and Subsection identification
 - Provider Tabs for individual credentialing levels, i.e. Basic, Paramedic, Critical Care Paramedic (CCP)
 - Pearls & Pitfalls

Procedures

Detailed Procedures are provided in either the Procedure section or, in some cases, are located directly within the individual protocols (Respiratory Support) to standardize the approach to high-risk low-frequency procedures (endotracheal intubation, cricothyrotomy, needle thoracostomy, and vasopressor administration for shock).

Pharmacopeia

Summarization of medications use within protocol with dosing and mixing references along with indication and contraindication of the medication.

Master & Subsection Identification

Master Section (Medical)



Bulleted
Actions

If suspected exposure to toxic agent.

- Remove patient from environment if safe/trained/equipped (PPE) to do so
- Ensure appropriate decontamination

If known or suspected opiate intoxication, see [Opiate Use Disorder](#)

If carbon monoxide (CO) exposure.

- Consider with CO levels above 5% in non-smoker or 10% in a smoker if available
 - High flow O₂ by NRB+ HFNC (as available) 15 LPM each

If caustic ingestion

- Do not induce vomiting or allow the patient to eat or drink

Basic

If
statement

If tachycardia associated with sympathomimetic intoxication (e.g., cocaine, amphetamine, MDMA),

- [Midazolam](#)
Adult - 2.5-5.0 mg slow IV/IO or 5 mg IM/IN, repeat PRN q 5 min (max total dose 10 mg)
Pedi - 0.05 mg/kg (max dose 2.5 mg) IV, repeat PRN q 5 min x 1

If dystonic reaction.

- [Diphenhydramine](#)
Adult - 50 mg IV/IM/IO
Pedi - 1 mg/kg (max dose 50 mg)

In suspected cyanide poisoning (smoke inhalation, dermal or ingestion exposure) AND if altered mental status, hemodynamic instability, or cardiac arrest,

- *If available, [Hydroxocobalamin](#) over 15-minutes through a dedicated IV/IO; contact [OLMC](#) following initial dose*
Adult - 5 g IV/IO, repeat PRN x 1
Pedi - 0-2 years: 0.625 g IV/IO (1/8 bottle)
3-5 years: 1.25 g IV/IO (1/4 bottle)
6-13 years: 2.5 g IV/IO (1/2 bottle)

Hydroxocobalamin
1 bottle = 5 g

Consider the following toxidromes/treatments:

Tricyclic Antidepressant (TCA)

- [Sodium Bicarbonate](#)
Adult - 1 mEq/kg IV/IO, repeat PRN 1 mEq/kg x 1
Pedi - Same as Adult, repeat PRN 0.5 mEq/kg x 1

Beta-blocker

- [Glucagon](#)
Adult - 1 mg IV/IO slow push over 1-minute, repeat PRN q 5 min x 1
Pedi - 0.1 mg/kg IV/IO, slow push over 1-minute (max single dose 1 mg), repeat PRN 0.2 mg/kg IV/IO x1

Calcium Channel Blocker

- [Calcium Chloride](#)
Adult - 1 g IV slow push
Pedi - 20 mg/kg (0.2 ml/kg) IV/IO, slow push (max dose 1 g)

Organophosphate

- [Atropine](#)
Adult - 2 mg IV/IO, repeat PRN q 3 min until secretions dry up
Pedi - 0.02 mg/kg IV/IO/IM, repeat until secretions dry up

Adult and Pediatric
Treatment Plan

Paramedic

→ SpO₂ may be a poor indicator of severity in CO poisoning; therefore, regardless of SpO₂, always treat the patient

→ Toxidromes secondary to toxic substances or to toxic doses of common medications may result from exposure in the form of ingestion, inhalation, injection, skin absorption

→ Dystonias may result from a number of psychiatric and GI medications, including droperidol, haloperidol, fluphenazine, fluoxetine, duloxetine, sertraline, metoclopramide

Provider Tabs

Interventions for each provider credentialing level are listed within their individual tabs on the right of the page:

- Basic
- Paramedic
- Critical Care Paramedic (CCP)

Each successive credentialing level includes interventions for that specific tab, as well as those interventions in the tabs preceding it. Paramedic level providers perform all interventions in both the Basic and Paramedic tabs, while Critical Care level providers are responsible for all interventions in the Basic, Paramedic, and CCP tabs.

| OB/GYN | |
|--|-----------|
| Pre-Eclampsia / Eclampsia | |
| <p>→ Pre-Eclampsia is present in patients between 20 weeks gestation and 6 weeks postpartum with:</p> <ul style="list-style-type: none"> • SBP ≥ 140 <u>and</u> DBP ≥ 90 with severe features, <i>or</i> • Severe Features: new onset headache, visual changes, or RUQ pain • SBP ≥ 160 <u>or</u> DBP ≥ 110 <i>regardless of symptoms</i> <p>→ Eclampsia should be considered present for all tonic-clonic seizures in pregnancy or post-partum patients</p> | Basic |
| <p><i>If SBP ≥ 140 <u>and</u> DBP ≥ 90 with Severe Features confirmed by correctly fitted cuff on 2 readings 5 minutes apart</i></p> <ul style="list-style-type: none"> • Magnesium Sulfate (10g / 250mL NS) bolus 6 g IV/IO over 15 min; followed by 2 g/hr infusion <ul style="list-style-type: none"> • Bolus: rate = 648 mL/hr; total volume = 150 • Infusion: rate = 50 mL/hr <p><i>If SBP ≥ 160 <u>or</u> DBP ≥ 110 confirmed by correctly fitted cuff on 2 readings 5 minutes apart</i></p> <ul style="list-style-type: none"> • Nifedipine 10 mg SL • Magnesium Sulfate (10g / 250mL NS) bolus 6 g IV/IO over 15 min; followed by 2 g/hr infusion <ul style="list-style-type: none"> • Bolus: rate = 648 mL/hr; total volume = 150 • Infusion: rate = 50 mL/hr <p><i>If suspected eclamptic seizure</i></p> <ul style="list-style-type: none"> • Midazolam as per Seizure protocol (only for ongoing seizure) • Magnesium Sulfate (10g / 250mL NS) bolus 6 g IV/IO over 15 min; followed by 2 g/hr infusion <ul style="list-style-type: none"> • Bolus: rate = 648 mL/hr; total volume = 150 • Infusion: rate = 50 mL/hr <i>(administered even if seizure stops)</i> | Paramedic |
| <p><i>If maternal HR is > 60 and SBP ≥ 160 <u>or</u> DBP ≥ 110 confirmed by correctly fitted cuff on 2 readings 5 minutes apart and severe symptoms described above are present</i></p> <ul style="list-style-type: none"> • Labetalol 20mg IV over 2 minutes, repeat 40 mg IV PRN q 10 minutes | CCP |

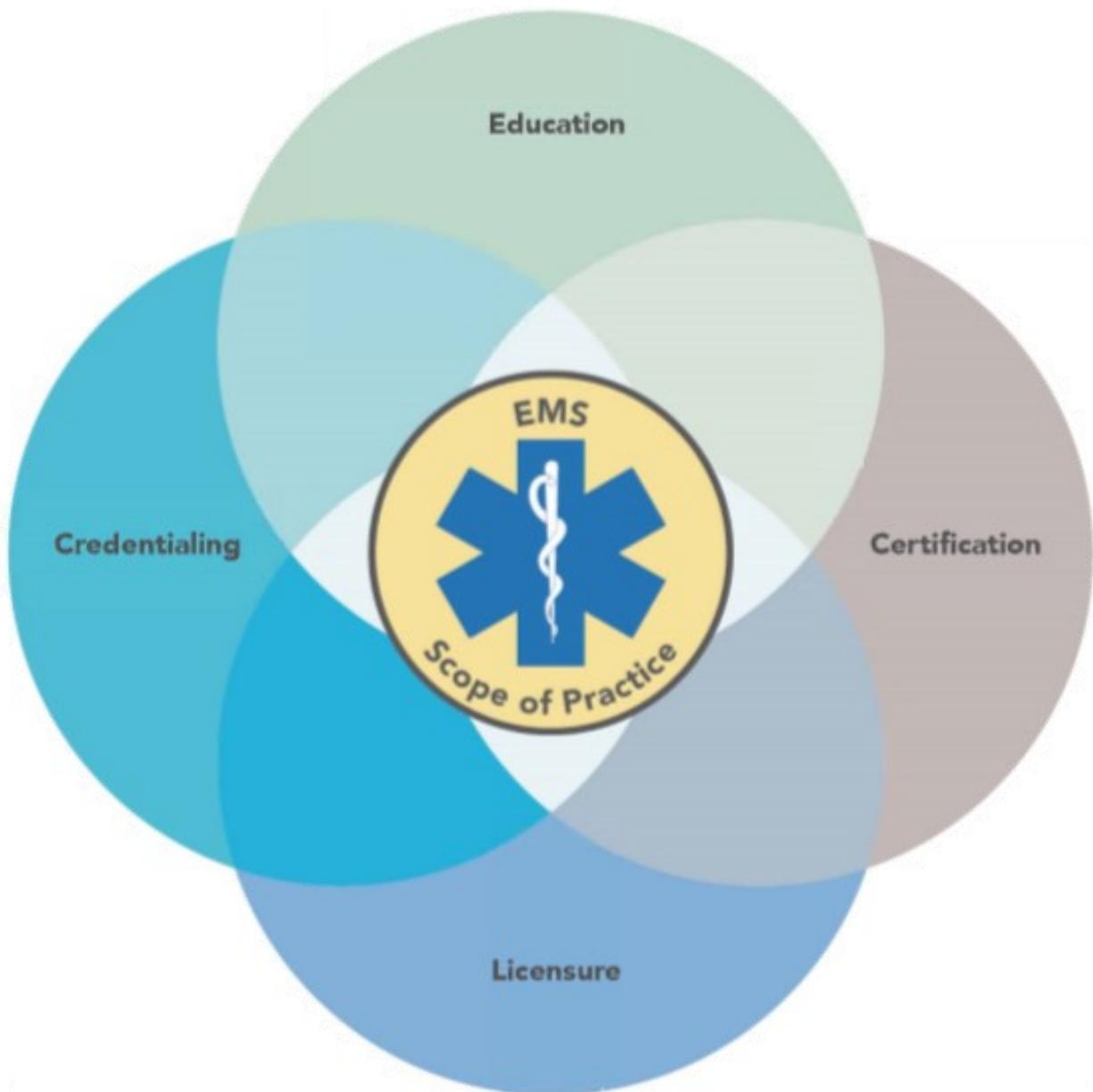
Pearls & Pitfalls

Additional guidance may be listed below the tabs in a white, un-tabbed “Pearls & Pitfalls” box. This may include additional diagnostic and treatment considerations, recommendations, and links to other relevant protocols.

| Medical | |
|--|-----------|
| Seizure/Status Epilepticus | |
| <ul style="list-style-type: none">• Position patient to avoid injury and aspiration, consider recovery position <p><i>If not returned to baseline, evaluate blood glucose and consider Diabetic Emergencies</i></p> | Basic |
| <p><i>If actively seizing, or in status epilepticus (≥ 2-seizures and without intervening lucid period),</i></p> <ul style="list-style-type: none">• Midazolam IM midazolam is the first line route of administration if an IV not already established Adult - 10 mg IM/IN; or 5 mg slow IV/IO, repeat PRN q 5 min x 2 Pedi - 0.15 mg/kg slow IV/IO/IM (max dose 2.5 mg), repeat q 5-min PRN x 1 <p><i>If post-ictal and not actively seizing or not in status epilepticus, pharmacologic therapy with midazolam is not indicated</i></p> <p><i>If refractory despite maximum midazolam,</i></p> <ul style="list-style-type: none">• Ketamine Adult - 1 mg/kg IV/IO Pedi - Same as Adult <p><i>If suspected eclampsia/peripartum seizure, see Preeclampsia / Eclampsia</i></p> | Paramedic |
| <p>→ Consider toxicologic causes of seizure Organophosphate/nerve gas (see chemical warfare policy) Sympathomimetic toxidrome (stuffers/packers, methamphetamine)</p> <p>→ Anticipate that dispatch or initial clinical picture of seizure may be initial presentation cardiac arrest</p> <p>→ Most confused patients following a seizure do not need treatment. Monitor for up to 15-minutes before considering intervention or determining a disposition.</p> <p>→ Always consider eclampsia in 3rd trimester pregnancy or up to 6 weeks post-partum.</p> | |

Scope of Practice

It is the responsibility of each individual clinician to operate within their credentialed scope of practice. Credential level and scope of practice can only be changed by successful completion of the FWOMD credentialing process. Except when specifically detailed, such as in an FWOMD-approved training program, no provider may authorize or delegate clinical care to another provider, which is outside of either's scope of practice. Consideration may be given in cases of declared disasters, and resource limitation in mass casualty incidents.



| Minimum State Certification | ECA | EMT | EMT-P | |
|---|-----|-------|-----------|-----|
| Credential Level | ECA | Basic | Paramedic | CCP |
| Airway | | | | |
| Airway Adjuncts (OPA & NPA) | X | X | X | X |
| Airway Maneuvers (Head tilt-chin lift, Jaw-thrust) | X | X | X | X |
| Airway Obstruction (dislodgement via Magills forceps) | | | X | X |
| Airway Obstruction (manual dislodgement techniques) | X | X | X | X |
| Bag-valve-mask | X | X | X | X |
| BiPAP via transport ventilator | | | | X |
| CPAP/BiPAP | | X | X | X |
| Delayed Sequence Intubation (DSI) | | | | X |
| Emergency Tracheostomy Exchange | | | X | X |
| Endotracheal Intubation | | | X | X |
| Gastric tube insertion via SGA port | | X | X | X |
| High flow nasal cannula via transport ventilator | | | | X |
| Nasogastric tube placement | | | X | X |
| Orogastric tube placement | | | X | X |
| Oxygen therapy (Nasal Cannula or Non-Rebreather Mask) | X | X | X | X |
| Pulse Oximetry | | X | X | X |
| Rapid Sequence Airway (RSA) | | | X | X |
| Suctioning - Tracheobronchial via Endotracheal Tube | | | X | X |
| Suctioning - Tracheobronchial via Tracheostomy | | X | X | X |
| Suctioning - Upper Airway | X | X | X | X |
| Supraglottic Insertion | | X | X | X |
| Surgical Airway | | | X | X |
| Thoracostomy - Needle | | | X | X |
| Thoracostomy - Simple | | | | X |
| Transtracheal Ventilation | | | X | X |
| Waveform Capnography | | X | X | X |
| Cardiovascular | | | | |
| Automated External Defibrillator (AED) Placement & Use | X | X | X | X |
| Blood or Blood Products | | | | |
| <i>Initiation of Transfusion</i> | | | | X |
| <i>Continuation of Transfusion</i> | | | X | X |
| Blood pressure automated | | X | X | X |
| Blood pressure manual | X | X | X | X |
| Cardiac monitoring - 12 lead ECG acquisition & transmission | | X | X | X |
| Cardiac monitoring - 12 lead ECG interpretation | | | X | X |
| Cardiopulmonary resuscitation (CPR) | X | X | X | X |
| Electrical Cardioversion | | | X | X |
| Manual Defibrillation | | | X | X |
| Mechanical Compression Device Placement | | X | X | X |
| Pericardiocentesis | | | | X |
| Transcutaneous pacing | | | X | X |
| Ventricular Assist Device (VAD) NON-VAD therapy complaint | | | X | X |
| Skills - Trauma/Restraint | | | | |
| Extremity stabilization & splinting | X | X | X | X |
| Hemorrhage Control (direct pressure, tourniquet, wound packing) | X | X | X | X |
| Manual Cervical Stabilization & Cervical Collar | X | X | X | X |
| Manual Patient Restraint | X | X | X | X |
| Pelvic Binder | | X | X | X |
| Spinal Motion Restriction (LSB, Scoop Stretcher, KED) | | X | X | X |
| Traction Splinting | | X | X | X |
| Skills - Access/Maintenance | | | | |
| Central Catheter Access (Broviac, Central Line) for Emergency | | | X | X |
| Central Line Catheter Monitoring Only | | | | X |

| | | | | |
|---|---|---|---|---|
| Intraosseous initiation (adult, pediatric, tibial, humeral) | | | X | X |
| Peripheral intravenous access (extremity, truncal, external jugular) | | | X | X |
| Peripherally Inserted Central Catheter Access (PICC) | | | X | X |
| Skill - Miscellaneous | | | | |
| Blood glucose monitoring | X | X | X | X |
| Emergency Childbirth | X | X | X | X |
| Eye irrigation | | X | X | X |
| Telehealth Consultation Facilitation | | X | X | X |
| Venous blood sampling | | | X | X |
| Skill - Critical Care | | | | |
| All Chest Tubes (suction or gravity) | | | | X |
| Extracorporeal Membrane Oxygenation (ECMO) | | | | X |
| Impella | | | | X |
| Intra-Aortic Balloon Pump (IABP) | | | | X |
| Invasive Line Monitoring (Arterial Line, Swan-Ganz) | | | | X |
| Mechanical Ventilation | | | | X |
| Point of Care Ultrasound | | | | X |
| Ventricular Assist Device (VAD) with complaint related to VAD therapy | | | | X |
| Medications | | | | |
| Aspirin | X | X | X | X |
| Acetaminophen | | | | |
| <i>Oral</i> | | X | X | X |
| <i>IV administration</i> | | | X | X |
| Adenosine | | | X | X |
| Albuterol | | X | X | X |
| Amiodarone | | | X | X |
| Atropine | | | | |
| <i>Symptomatic bradycardia</i> | | | X | X |
| <i>All other Indications</i> | | | X | X |
| Buprenorphine | | | | X |
| Calcium Chloride | | | | |
| <i>Entrapment/Crush/Traumatic Rhabdomyolysis</i> | | | X | X |
| <i>All other Indications</i> | | | X | X |
| Dexamethasone | | | X | X |
| Dextrose 10% | | | X | X |
| Diltiazem | | | X | X |
| Droperidol | | | X | X |
| Diphenhydramine | | X | X | X |
| Epinephrine | | | | |
| <i>Auto-injector Epinephrine (patient or EMS supplied)</i> | X | X | X | X |
| <i>Intramuscular (anaphylaxis)</i> | | X | X | X |
| <i>Cardiac Arrest</i> | | | X | X |
| <i>Intravenous Push-Dose Pressor</i> | | | X | X |
| <i>Intramuscular (asthma)</i> | | | X | X |
| <i>Infusion</i> | | | X | X |
| Esmolol | | | | X |
| Fentanyl | | | X | X |
| Glucagon | | | X | X |
| Glucose - Oral | X | X | X | X |
| Hydroxocobalamin | | | X | X |
| Ibuprofen | | X | X | X |
| Ipratropium | | X | X | X |
| Isopropyl Alcohol | X | X | X | X |
| Ketamine | | | | |
| <i>Analgesia</i> | | | X | X |
| <i>For facilitation of pacing/cardioversion</i> | | | X | X |
| <i>Behavioral Emergencies/Agitation</i> | | | X | X |
| <i>Delayed Sequence Intubation (DSI)</i> | | | X | X |

| | | | | |
|---|-------------------------|---|---|------------|
| <i>Rapid Sequence Airway (RSA)</i> | | | X | X |
| Ketorolac | | | X | X |
| Labetalol | | | | X |
| Lidocaine | | | X | X |
| Magnesium | | | X | X |
| Midazolam | | | | |
| <i>Pacing if Ketamine insufficient</i> | | | X | X |
| <i>Sedation after invasive airway placement</i> | | | X | X |
| <i>All Other Indications</i> | | | X | X |
| Naloxone | | | | |
| <i>Auto-injector</i> | X | X | X | X |
| <i>Intranasal</i> | X | X | X | X |
| <i>Intravenous</i> | | | X | X |
| Nicardipine | | | X | X |
| Nitroglycerin | | | | |
| <i>Assist with self-administration of already prescribed NTG & on scene</i> | X | | | |
| <i>EMS Supplied Nitroglycerin</i> | | X | X | X |
| <i>IV administration</i> | | | | X |
| Norepinephrine | | | X | X |
| Normal Saline (0.9%) | | | X | X |
| Ondansetron | | | | |
| <i>ODT</i> | | X | X | X |
| <i>Intravenous</i> | | | X | X |
| Oxytocin | | | | X |
| Phenylephrine | | | | X |
| Racemic Epinephrine | | | X | X |
| Rocuronium | | | | X |
| Sodium Bicarbonate | | | X | X |
| Suboxone | | | | X |
| Tranexamic Acid (TXA) | | | X | X |
| Vasopressin | | | | X |
| Immunizations | | X | X | X |
| Mobile Integrated Healthcare Paramedic | | | | |
| | Credential Level | | | MHP |
| Approved medications prescribed for MIH programs | | | | X |
| Consultation for Medical Director Refusal | | | | X |
| Foley Insertion/Removal | | | | X |
| Furosemide | | | | X |
| In-Home Diuresis | | | | X |
| Peak Flow | | | | X |
| Point of Care Laboratory Analysis | | | | X |
| Potassium Chloride ER Tablets | | | | X |
| Suture/Staple Removal | | | | X |

Glossary (Abbreviations and Terms)

| Abbreviations | |
|-------------------------|--|
| DSI | Delayed Sequence Intubation - a goal-directed and stepwise procedure to facilitate intubation using procedural sedation with ketamine to maximize physiologic preparation prior to administration of a paralytic |
| ELM | External Laryngeal Manipulation, also known as “Bimanual laryngoscopy”, similar to BURP |
| ETSN | Ear-to-sternal notch (airway position, previously known as “sniffing position”), performed by elevating the patient’s head, and confirmed from the patient’s side by visualizing that the auditory canal is level with sternum and parallel to the ground. |
| FWOMD | Fort Worth Office of the Medical Director |
| MAP | Mean Arterial Pressure |
| MIH | Mobile Integrated Healthcare services that are designed to enhance, coordinate, effectively manage, and integrate out-of-hospital care |
| OLMC | On Line Medical Control |
| PCMH | Patient Centered Medical Home refers to the function and/or group of providers through which individuals receive comprehensive, patient-centered, and coordinated care |
| POCUS | Point of Care UltraSound |
| PRN | “as needed” |
| RSA | Rapid Sequence Airway - the placement of a supraglottic airway facilitated by the use of sedation +/- use of a paralytic |
| SBP/DBP | Systolic Blood Pressure/Diastolic Blood pressure - all units of measurement are in mmHg, e.g. SBP \geq 90 means Systolic Blood Pressure \geq 90 mmHg |
| Terms | |
| Atropinization | Drying of mucus membranes and airway secretions resulting from appropriate dosing of atropine in organophosphate poisoning |
| Hemodynamic Instability | Abnormal or unstable low blood pressure. Signs and symptoms include diminished organ function (e.g. AMS, pallor/diaphoresis) due to a low perfusion (blood flow) state; may be manifested as absolute hypotension (e.g. SBP \leq 90 in adults) or relative hypotension in patients with signs of poor perfusion. |

| | |
|---|--|
| Inframammary Line | The anatomic location used to guide needle thoracostomy insertion site selection, especially in patient's with difficult to visualize anatomic landmarks. Defined as the line where the breast meets the torso. |
| Kit Dump | Organized approach to advanced airway management for the purpose of minimizing error and, therefore, adverse patient outcomes (e.g. oxygen desaturation, bradycardia, hypotension, aspiration, cardiac arrest). All equipment necessary for appropriate airway management is placed out of the packing, in 2 sizes, within the airway manager's field of view. |
| Max BVM | BVM with 2 NPA (Nasopharyngeal Airway) + OPA (Oropharyngeal Airway)+ HFNC (High flow Nasal Cannula)+ HFBVMO2 (High flow bag valve mask oxygen) |
| Needle Thoracostomy | Insertion of a large-bore catheter into the chest for the purpose of relieving a tension pneumothorax |
| Patient | A person who requests EMS or, A person whom EMS has been requested and who has any medical or psychological complaint, obvious injury/distress, or has a significant mechanism of injury |
| Shock Index (SI) | A hemodynamic parameter used to assess shock severity. SI is calculated by dividing heart rate (HR) by systolic blood pressure (SBP). An SI >0.9–1.0 is associated with hemodynamic instability and an increased risk of adverse outcomes in traumatic/non-traumatic hemorrhagic shock, sepsis, and peri-intubation patients. |
| Spinal Motion Restriction | Means to mitigate potential or further trauma in patients with suspected spinal injury |
| Serial ECGs | Repeat ECGs, at minimum 2-tracings prior to arrival at the destination |
| Termination of Resuscitation | The process of stopping resuscitation once begun by professionals |
| Violent Agitation with Delirium | A combination of delirium (confusion) with agitation and violence. It is often associated with stimulant use and may be linked to sudden cardiac arrest. |
| Waveform Capnography | The visual representation of the measured exhaled carbon dioxide in graphic form as opposed to a numeric value. Visualized as a 4-phase generally square shaped waveform with each breath. Monitoring is required for all patient's receiving advanced airway intervention, including endotracheal intubation or blind insertion supraglottic airway |
| Withholding of Resuscitative Efforts | The process of not beginning professional resuscitation or not continuing bystander CPR, as differentiated from 'Termination of Resuscitation' |

General

Acute Pain Management

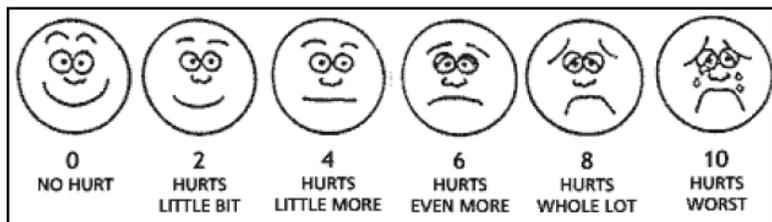
- Place in position of comfort, splint extremity injuries, and ice packs, as appropriate
- Document body weight
- Assess and document initial and final pain scale (see below)
- Monitor and document vital signs and pain scales pre and post every intervention
- **Acetaminophen**
Adult - 1 g PO
Pedi - 15 mg/kg PO (max dose 1 g)
- **Ibuprofen**
Adult - 600 mg PO
Pedi > 6 months - 10 mg/kg PO (max dose 600 mg)

BASIC

- EtCO₂ monitoring required for fentanyl or ketamine
- **Acetaminophen**
Adult - 15 mg/kg IV (max dose 1 g)
Pedi > 2 years of age, same as Adult
- **Ketorolac**
Adult - 15 mg IV or 30 mg IM once
Pedi - 0.5 mg/kg IM or IV once (max dose 15 mg)
- **Fentanyl** - titrate to pain relief and respiratory/hemodynamic status
Adult - 1 mcg/kg IV/IN/IM (max single dose 100 mcg), repeat q 5-min PRN
Pedi - same as Adult
- **Ketamine** - Do not re-dose if **RASS** < 0
Adult - IV/IO - 0.3 mg/kg in 100 mL NS over 10 min (max single dose 30 mg), repeat PRN x 1;
IM - 0.6 mg/kg (max single dose 50 mg), repeat q 10-min PRN x 1
Pedi - > 3 years old, same as Adult

Paramedic

- **Ketorolac** is contraindicated in trauma, bleeding, or kidney injury (acute and chronic)
- Benzodiazepines should not be co-administered with opiates
- In general, ketamine should not be the initial option, however, there may be circumstances where it is an appropriate initial agent. Clinical judgement based on the specifics of the situation should drive management.
- Use 1 mL syringe for accuracy in drawing up Ketamine as concentration carried is 50 mg/mL and thus all dosing will be less than 1 mL.



- Wong-Baker pain scoring for non-communicative patients

Subdissociative Ketamine (SDK) Dosing Chart
500 mg/ 10 mL vials (50 mg/ml concentration)

| POUNDS (lbs) | mL (mg) of Ketamine | KILOS (kg) |
|-----------------|-----------------------|----------------|
| 37- 69 lbs | 0.1 mL (5 mg) | 17-33 kg |
| 70-109 lbs | 0.2 mL (10 mg) | 34-49 kg |
| 110-149 lbs | 0.3 mL (15 mg) | 50-66 kg |
| 150-179 lbs | 0.4 mL (20 mg) | 67-82 kg |
| 180- 219 lbs | 0.5 mL (25 mg) | 83-99 kg |
| 220 lbs or more | 0.6 mL (30 mg) | 100 kg or more |

Blood Administration (911)

Contraindications:

- Known religious objection to receiving blood or blood products

Criteria:

- Hemorrhagic Shock in medical or trauma patients
 - SBP < 70 mm Hg or,
 - SBP < 90 mm Hg and HR \geq 120 bpm or,
 - Age \geq 65 and SBP \leq 100 and HR \geq 110 or,
 - EMS witnessed traumatic arrest secondary to suspected hemorrhagic only if blood can be flowing in under 5 mins
- Age < 15 contact [OLMC](#)

If patient in hemorrhagic shock,

- Obtain baseline patient temperature
- Transfuse 1 unit Low Titer O⁺ Whole Blood (LTO⁺WB)
 - OR
 - If Whole Blood is unavailable, transfuse,*
 - 1 unit Packed Red Blood Cells (PRBC) and/or
 - 2 units Liquid Plasma
- [Calcium Chloride](#) 2 g IV/IO
- [Tranexamic Acid](#), do not give if injury occurred \geq 3 hours before
 - Adult - 2 g IV/IO, slow push over 1-minute
 - Pedi - N/A
- Repeat transfusion above PRN if additional blood and/or blood product is immediately available

If suspected febrile non-hemolytic transfusion reaction (FNHTR), including temperature rise \geq 1° F above baseline and/or rigors, during blood product administration:

- Immediately stop infusion and disconnect IV tubing
- [Acetaminophen](#)
 - Adult - 1 g PO
 - Pedi - 15 mg/kg (max dose 1 g) PO
- [Diphenhydramine](#)
 - Adult - 50 mg IV/IM/IO
 - Pedi - 1 mg/kg IV/IM/IO (max dose 50 mg)

→ Beta Blockers and Calcium Channel Blockers may not allow HR to increase appropriately

BLS Transport Criteria

Clinical judgment should be used when deciding whether to wait on scene for ALS or rapidly transport to the ED. In general, ALS should transport the following types of patients:

- Altered mental status (from baseline)
- Respiratory distress or failure
- Unstable vital signs
- Any interventions performed beyond scope of transporting clinician
 - Exceptions:
 - IV locks not used for medications
 - Ketorolac, dextrose, glucagon, naloxone, or ondansetron
- Note: BLS can transport profoundly unstable hospice patients **IF** ALS interventions are not desired.

Any credentialed ALS clinician may transport a patient meeting above criteria with a BLS ambulance.

If ALS resources are not available in a reasonable time period,

- BLS may transport patients meeting the above criteria.
 - In general, this is appropriate for time critical conditions and short transport times.
- ALS intercept enroute to hospital is an option.

→ If a patient meets BLS transport criteria and an ALS/Advanced credentialed clinician has interpreted an ECG (no ischemia or dysrhythmia), they should sign the appropriate field in the ePCR before transferring care back to the BLS unit.

Circulatory Support

- Position patient in supine position with legs elevated, as appropriate and tolerated (no Trendelenburg)

If suspected traumatic etiology

- **Hemorrhage Control** as appropriate

If gravid uterus

- Manually displace fundus to the patient's left (may be accomplished by left lateral decubitus positioning, if tolerated)

*If suspected tension pneumothorax with hypotension, see **Thoracostomy Procedure***

- Cardiac monitoring; obtain **12-lead ECG** and treat dysrhythmias as appropriate
- **IV/IO access**

Fluid Resuscitation

- Fluid Bolus
 - Adult: 500 mL, repeat PRN to meet target BP goals
 - Pedi: 20 mL / kg, repeat PRN to meet target BP goals
- Titrate to target BP goals:
 - TBI/Stroke: ≥ 110 mm Hg
 - Blunt Trauma: = 100 mm Hg (max 500 mL)
 - Hemorrhagic Shock or Penetrating Trauma: SBP = 90 mm Hg (max 500 mL)
 - Other patients:
 - Adult - MAP ≥ 65 (or SBP ≥ 90 mm Hg if manual measurement)
 - Pedi - SBP ≥ 70 mm Hg + (age in years x 2) or ≥ 90 mm Hg for age 10 or greater

If persistent hypotension despite adequate fluid administration, to temporarily stabilize blood pressure until vasopressor infusion can be initiated

- **Epinephrine push dose** (0.1 mg in 10ml NS)
 - Adult - 10 mcg (1 ml) IV/IO, repeat q 5-minutes PRN, max total dose 50 mcg (5 ml)
 - Pedi - 1 mcg/kg (max single dose 10 mcg), repeat q 5-minutes PRN, max total dose 50 mcg (5 ml)

*If significant traumatic or OB related hemorrhage and SBP ≤ 90 or HR ≥ 110 with poor perfusion, see **Hemorrhage Control***

If suspected anaphylaxis/anaphylactic shock or symptomatic bradycardia

- **Epinephrine infusion** (1 mg 1:10,000 / 250 mL NS or 1 mg 1:1,000 / 250 mL NS; 4 mcg / mL)
 - Adult - start at 5 mcg/min, titrate to goals above
 - Pedi - start at 0.1 mcg/kg/min, titrate to goals above

If any other suspected etiology of shock unresponsive to initial fluid resuscitation

- **Norepinephrine infusion** (4 mg / 250 mL NS; 16 mcg / mL)
 - Adult - 5 mcg/min, titrate to goals above
 - Pedi - 0.1 mcg/kg/min, titrate to goals above

If septic shock with vasopressor infusion or documented history of Addison disease/adrenal insufficiency

- **Dexamethasone**
 - Adult - 10 mg IV/IO/IM
 - Pedi - 0.6 mg/kg PO/IM/IV (max 10 mg)

*If response refractory to norepinephrine infusion, contact **OLMC** for*

- **Vasopressin** (20 units / 100 mL NS; 0.2 units / mL)
 - Adult - 0.04 units /min infusion (12 mL / hr)
 - Pedi - N/A
- **Phenylephrine push dose** (10 mg / 100 mL NS; 100 mcg/mL)
 - Adult - 50 mcg (0.5 mL) q 3 min, titrate to target BP goals
 - Pedi - N/A

- The goal of vasopressor use in trauma is to meet, but not exceed the target goal
- Notify receiving facility of vasopressor use in patient report

Basic

Paramedic

CCP

Consent for Treatment and Transport

Before treating an individual, you must first obtain consent either from the individual or from a legal surrogate.

Consent to treatment may be implied when an individual is:

- **unable to effectively communicate** because of an injury, accident, or illness; or
- **unconscious** and suffering from a life-threatening injury or illness; or
- a minor who is suffering from an immediate life-threatening injury or illness and whose parents, healthcare surrogate, or legal guardian is not present.

Otherwise, you cannot treat a person without their consent.

The right to refuse treatment includes the right to refuse assessment and the right to refuse all or specific treatments or assessments.

A person in law enforcement custody has the right to refuse treatment but not to refuse transport.

If a patient refuses all contact or assessment

- Record disposition of call as “refused all contact”

If a patient effectively communicates a refusal of assessment, treatment, or transport

- Follow [Against Medical Advice](#) (AMA) protocol

If a patient communicates a refusal of assessment, treatment, or transport but appears to lack decision making capacity

- Follow [Refusal Without Demonstration of Capacity](#) protocol

Crashing Patient: Medical

If acutely ill with oxygenation / ventilation or hemodynamic instability:

Address Clinical Instability Prior to Movement*

- Consider requesting additional resources
- Obtain full set of vital signs (BP, HR, SpO₂, ECG, Temp, BGL)
- Initiate waveform capnography
- Obtain 360° access

Assess & Address Oxygenation & Ventilation

- See [Respiratory Support](#), [Delayed Sequence Intubation](#), [Rapid Sequence Airway](#)

GOAL: SpO₂ ≥ 94%; or persistent hypoxia despite appropriate interventions

Assess & Address Hemodynamic Stability

- See [Circulatory Support](#)

GOAL: Resolution of hypotension or initiation of treatment

*Only initiate movement before goals are met/addressed for safety or to obtain 360 access

→ Do not delay transport to meet SBP goals once initial therapy is initiated or attempted

Crashing Patient: Trauma

If acutely injured with oxygenation / ventilation or hemodynamic instability:

Assess & Address Catastrophic Hemorrhage

- See [Hemorrhage Control](#)

GOAL: Bleeding controlled or minimized

Address Clinical Instability Prior to Movement*

- Consider requesting additional resources
- Obtain vital signs (BP, HR, SpO₂)
- Initiate waveform capnography
- Obtain 360° access

Assess & Address Oxygenation & Ventilation

- See [Respiratory Support](#), [Delayed Sequence Intubation](#), [Rapid Sequence Airway](#)

GOAL: SpO₂ ≥ 94%; or persistent hypoxia despite appropriate interventions

Initiate Transport

Assess & Address Hemodynamic Stability Enroute

- See [Circulatory Support](#)

*Only initiate movement before goals are met/addressed for safety or to obtain 360 access

→ Most interventions for critical trauma patients, other than bleeding control and airway management, should be performed enroute if possible

Delayed Sequence Intubation (DSI) - Adult

- Begin [Invasive Airway Preparation](#)
- Ensure appropriate monitoring including: BP q 2 min cycle, ECG, EtCO₂, SpO₂ opposite arm from BP cuff
- Begin preoxygenation via Max BVM, NRB + HFNC, or NIPPV, as appropriate

Basic

Preparation

- Evaluate airway and identify/palpate surgical cricothyrotomy anatomic landmarks
- Confirm Push Dose Epinephrine (PDE) is readily available

If hypotensive, see [Circulatory Support](#)

Sedation & Preoxygenation

- [Ketamine](#) - 2 mg/kg IV/IO (max 200 mg); repeat PRN x 1
- Verify all appropriate monitoring/positioning (ETSN, HOB @ 30° elevation)
- Increase NC to flush rate
- Preoxygenate/Denitrogenate
 - If adequate respirations*
 - Set BVM @ flush rate, form tight mask seal, and allow spontaneous respirations to continue. Ensure PEEP ≥ 5 mmHg.
 - If inadequate respirations*
 - Perform Max BVM with assisted ventilations
- Titrate PEEP to reach maximal SpO₂
- Upon reaching SpO₂ ≥ 94%, begin 3-minute timed countdown
 - *If SpO₂ drops below 94%* - reset 3-min timed countdown once SpO₂ ≥ 94% obtained
- Complete [Intubation Checklist](#) in entirety (MANDATORY)

Paramedic

Abort DSI if SpO₂ remains < 94% and/or SBP < 100 mmHg, maintain BVM or RSA

Paralysis

- [Rocuronium](#) - 1.5 mg/kg IV/IO once (max 150 mg)
- Begin 90-second timed countdown after administration to allow complete paralysis
- Initiate or continue assisted ventilations PRN
- Must have affirmative confirmation of SBP ≥ 100 & at least 3 minutes continuous SpO₂ ≥ 94% at time of intubation attempt

CCP

Intubation (ONLY after all above steps have been successfully achieved)

- Perform [Intubation Procedure](#)
 - Immediately abort attempt if SpO₂ < 94% and begin BVM ventilations
 - Ensure SpO₂ ≥ 94% for at least 3 min before final intubation attempt
 - Max 2 intubation attempts per patient (NOT per clinician)
 - Place [Supraglottic Airway](#) at any time PRN
 - *If Can't Oxygenate, Can't Ventilate (COCV) by any other means* - [Surgical Airway Procedure \(Cricothyrotomy\)](#)
- Confirm ETT placement with:
 - EtCO₂ (4-phase waveform ≥ 5 mmHg with every breath within 5-breaths)
 - Visualization on VL of ETT through cords by two clinicians
- [Post-Invasive Airway Management](#)

Paramedic

- DSI is intended to be a deliberately controlled process with meticulous attention to preoxygenation/denitrogenation and hemodynamic optimization to ensure safe intubating conditions and optimize the chance for first pass success without hypoxia and/or hypotension.
- DSI uses ketamine for procedural sedation, where the procedure is preoxygenation/preparation.

Decision
to DSI

SBP > 100
SpO₂ ≥ 94%

Paralysis

Intubate



Setup/Kit Dump
Hemodynamic Optimization
Ketamine & Preoxygenation

3-min countdown
(Reset if SpO₂ drops < 94%)

90-sec countdown

Fever

If temperature $\geq 100.4^{\circ} F$

- [Acetaminophen](#)

Adult - 1 g PO

Pedi - 15 mg/kg (max dose 1 g) PO

- [Ibuprofen](#)

Adult - 600 mg PO

Pedi > 6 months - 10 mg/kg (max dose 600 mg) PO

Basic

- [Acetaminophen](#)

Adult - 15 mg/kg IV (max dose 1 g)

Pedi > 2 years of age - same as Adult

Param

→ Fever in newborns under 90 days is sepsis until proven otherwise and should be transported or [OLMC](#) contacted prior to release

Consider other protocols as appropriate

→ [Circulatory Support](#)

→ [Seizure](#)

Hemorrhage Control

If ongoing bleeding:

- Apply firm, persistent direct pressure

If ongoing bleeding after persistent direct pressure:

- Apply **Tourniquet**

If ongoing bleeding despite direct pressure and tourniquet to junctional/extremity bleeding:

- Pack wound with hemostatic gauze

If bleeding dialysis fistulas or varicose veins:

- Elevate extremity straight up for gravity assist
- Firm, direct pressure with hemostatic gauze. (consider plastic bottle cap to enhance direct pressure)
- **Tourniquet** above and below for ongoing massive bleeding despite these measures for 10 minutes. (Very rarely needed for varicose veins)

If hemorrhagic shock with suspected pelvic fracture:

- **Pelvic binder**

Basic

If significant traumatic, OB, or tracheostomy related hemorrhage and SBP ≤ 90 or HR ≥ 110 with poor perfusion:

- **Tranexamic Acid** - (do not give if injury occurred ≥ 3 hours before administration OR if isolated TBI)

Adult: 2 g IV/IO slow push over 1 minute

Pedi: N/A

If ongoing epistaxis despite direct pressure:

- Blow nose, then immediately:
 - **Oxymetazoline**
Adult: 2 squirts to affected nare
Pedi: Same as Adult
 - **Tranexamic Acid** - Topical to affected nare(s)
Adult: 2 g saturated on cotton ball or gauze
Pedi: Same as Adult
- Mechanical nose clamp persistently until ED arrival

Paramedic

If significant OB related hemorrhage following complete placental delivery:

- **Oxytocin**
Adult: 10 units IM followed by 20 units / 1 L NS IV run wide open

Pedi: N/A

- **Prehospital Blood Administration**

CCP

- Don't loosen pressure dressing or tourniquet to check for ongoing bleeding.
- Don't wait for hemodynamic instability to apply tourniquet.
- Use commercial windlass-type tourniquet.
- Document time of tourniquet application and be sure to notify ED staff of location.

IFT-Blood & Blood Products

1. Verify consent for administration of blood product. A copy should be included in the patient's chart.
2. Patients receiving blood or blood products are to have a recipient band in place.
3. If product is infusing at time of initial patient contact, verify facility transfusion checklist.
 - a. Patient's name and hospital number matched with transfusion record form (attached to product bag).
 - b. Type and number on transfusion record form matched with product bag.
 - c. Pre-transfusion vital signs are documented on transfusion record form.
 - d. Nurse administering product has signed, dated and timed the transfusion record form.
 - e. All original copies of the transfusion slip should remain with the patient.
4. If the transfusion of blood or blood products is initiated during transport, verify the order and facility transfusion checklist with patient's primary RN prior to transport.
5. Obtain necessary equipment, i.e. tubing, filters, etc. from sending facility to administer transfusion.
6. Prior to administering blood or blood products enroute, complete the facility's pre-transfusion checklist and document accordingly on the product slip and in the run report.
7. Blood or blood products may NOT be piggybacked into an existing IV line.
8. Vital signs including temperature should be obtained and recorded 15 min, 45 min and then 1 hour, at a minimum, after initiating the transfusion until completed. If patient spikes a temperature 2° F greater than baseline, discontinue the blood infusion.
9. If the transfusion is completed enroute, document on the transfusion slip the date and time completed, amount given, whether or not the blood is warmed, if a reaction occurred and post-transfusion vital signs. All completed bags and tubing should be turned over to the receiving facility with the patient.
10. It is the receiving facility's responsibility to return the transfusion slip to the sending facility's blood bank.

Whole Blood, Packed RBCs, Frozen RBCs, FFP, Platelets & Cryoprecipitate

1. Verify transfusion checklist.
2. Prime Y-type blood tubing with Normal Saline and begin infusion slowly.
3. Attach blood bag to Y-type blood tubing. Clamp tubing to saline. Open clamp to blood and adjust flow to run slowly for the first 15 minutes. If no adverse reaction, increase flow based on patient condition and transfusion times.
 - a. Whole Blood: 1-1/2 – 3 hours
 - b. Packed RBC's: 1-1/2 – 3 hours
 - c. Washed Packed Cells: 2 hours maximum
 - d. Fresh Frozen Plasma: 30 min (all units must be infused within 4 hours from thaw time)
 - e. Platelets: 30 min max
 - f. Cryoprecipitate: rapid infusion
4. Monitor vital signs as previously outlined.
5. Monitor for signs/symptoms of adverse reaction. If adverse reaction noted, stop infusion and see [Allergic Reaction](#) protocol.
6. Blood tubing should be changed after each unit. EXCEPTION: If emergent situation and several units of blood are being administered rapidly, tubing should be changed every 4 hours or every other unit.
7. If suspected febrile non-hemolytic transfusion reaction (FNHTR), including temperature rise $\geq 1^\circ$ F above baseline and/or rigors, either during or within 3-hours following blood product administration:
 - [Acetaminophen](#) - per [Fever](#) protocol, and
 - [Diphenhydramine](#) - 50 mg IV

Lift Assist

If request of "lift assist"

- Make scene and evaluate patient
 - Assess for signs of trauma, infection or altered mental status (AMS)
- Assess vital signs
- Evaluate cause of patient fall or need for assistance

If a patient meets any below criteria

- Medical cause of fall
- Signs of new trauma (e.g. pain or injury)
- Altered mental status
- Any loss of consciousness
- Currently on blood thinners (not including ASA)
- HR > 100
- SBP < 100 or > 200
- DBP > 140
- RR > 20
- SpO₂ < 90%
- Blood Glucose < 70 or > 300 (check if diabetic or otherwise indicated)
- New inability to ambulate
- Recommend further evaluation and transport to hospital

For a patient refusing transport

- Follow [AMA Protocol](#)

If an individual meets none of the above criteria

- Assist individual with request
- Disposition call per agency policy regarding lift assistance

→ Agencies may have alternative dispositions for "lift assist", e.g. assist citizen, assist invalid, etc.

Mechanical Ventilation (Hamilton-T1)

Indications for ventilator:

- Cardiac Arrest
- Presence of invasive airway (intubation or SGA)
- Pre-oxygenation prior to DSI
- Need for both non-invasive ventilation (CPAP/BiPAP) and CCP care during transport
 - Otherwise stable patients who are not hypoxic and are comfortable on CPAP may be transported without ventilator or CCP.
- See [Mechanical Ventilator \(Hamilton-T1\)](#) procedure
 - CCP must accompany any patient on our ventilator

Nausea and Vomiting

- Position patient to avoid aspiration
Consider recovery position
- Suction, as appropriate
- Isopropyl Alcohol - Instruct patient to hold pads 1-2 cm from nose and inhale deeply as frequently as required to achieve nausea relief.
- Ondansetron
Adult - 4 mg ODT, may repeat q 10-min PRN x 1
Pedi - 8-15 kg: 2 mg ODT, repeat q 10-min PRN x 1
16-30 kg: Same as Adult

Basic

- Ondansetron
Adult - 4 - 8 mg IM/IV, may repeat q 10-min PRN x1
Pedi - 0.15 mg/kg (max dose 4 mg) IM/IV

If vomiting despite ondansetron, or for patients with suspected gastroparesis, cyclic vomiting, or cannabinoid hyperemesis syndrome

- Droperidol
Adult - 1.25 mg IM/IV, may repeat at 0.625 mg q 10-min PRN x1
Pedi - N/A

Paramedic

- IV opioids do not require co-administration of antiemetics
- Consider other conditions/protocols which may present with nausea/vomiting (e.g. myocardial ischemia)

Patient Assessment

A patient is defined as a person:

- who requests EMS, or for whom EMS has been requested, AND
- who has any medical or psychological complaint, obvious injury/distress, or has a significant mechanism of injury.
- A pediatric patient is defined as:
 - Patients 14-years of age or younger, AND
 - Lack secondary sex characteristics, AND
 - Fit on a length-based-resuscitation tape (e.g. Broselow) OR estimated or known weight <36 kg (~80 lbs)

- Assure scene safety
- Perform initial assessment, including evaluation for life threats to airway, breathing, and circulation.
- Assess mental status (e.g., AVPU) and disability (e.g., GCS).

If provider impression of extremis, including new-onset altered mental status, airway issues, severe respiratory distress/failure, signs and symptoms of shock/poor perfusion, or imminent cardiac or respiratory arrest:

- See **Crashing Patient Medical** or **Crashing Patient Trauma**

- Form a differential diagnosis based on patient complaint
- Perform a focused history and physical exam to narrow differential diagnosis and guide treatment
- Utilize reference guide (Broselow/pre-calculated dosing reference) for medication dosing and equipment sizing
- Document findings and interventions in the chart

If valid DNR, regardless if pulse present or absent see, [DNR Policy](#)

Initial Assessment



General Vital Signs and Guidelines

| Age | Heart Rate (beats/min) | Blood Pressure (mmHg) | Respiratory Rate (breaths/min) |
|-------------|------------------------|-----------------------|--------------------------------|
| Premature | 110-170 | SBP 55-75 DBP 35-45 | 40-70 |
| 0-3 months | 110-160 | SBP 65-85 DBP 45-55 | 35-55 |
| 3-6 months | 110-160 | SBP 70-90 DBP 50-65 | 30-45 |
| 6-12 months | 90-160 | SBP 80-100 DBP 55-65 | 22-38 |
| 1-3 years | 80-150 | SBP 90-105 DBP 55-70 | 22-30 |
| 3-6 years | 70-120 | SBP 95-110 DBP 60-75 | 20-24 |
| 6-12 years | 60-110 | SBP 100-120 DBP 60-75 | 16-22 |
| > 12 years | 60-100 | SBP 110-135 DBP 65-85 | 12-20 |

Pediatric GCS

| Eye Opening (4) | |
|---------------------------------------|---|
| Spontaneous | 4 |
| To Speech | 3 |
| To Pressure | 2 |
| None | 1 |
| Verbal Response (5) | |
| Coos, Babbles (infant)/Talks normally | 5 |
| Irritable cry (infant)/Words | 4 |
| Cries to pressure (infant)/Sounds | 3 |
| Moans to pressure | 2 |
| None | 1 |
| Best Motor Response (6) | |
| Spontaneous Movement | 6 |
| Withdraws to touch | 5 |
| Withdraws from pressure | 4 |
| Abnormal flexion | 3 |
| Abnormal extension | 2 |
| None | 1 |

→ CCP may use point of care ultrasound to aid in assessment as needed, provided it does not otherwise interfere with treatment or unreasonably delay transport.

Post-Invasive Airway Management

Basic

- Maintain SpO₂ ≥ 94% and EtCO₂ 35-45 mmHg
- Avoid providing excessive tidal volume with BVM ventilations
- Re-confirm EtCO₂ with all transfers/movements of the patient
- Maintain HOB at ≥ 30°, if no suspected spinal injury
- Consider wrist restraints for airway device protection
- Monitor and document serial [RASS scores](#)

- Monitor closely for post-airway hypotension and treat per [Circulatory Support](#)
- [Ketamine](#)
Adult – 2 mg/kg IV/IO immediately after invasive airway secured then q 15 min or more frequently PRN
Pedi - same as Adult (max dose 70 mg)
- Maintain RASS goal of -5

If sudden or unexpected clinical deterioration (e.g., profound hypotension, falling SpO₂, difficulty ventilating)

DOPEs

Dislodgement

- Confirm EtCO₂ waveform and evaluate for airway dislodgement/migration
- Remove airway if EtCO₂ unable to be confirmed

Obstruction

- [Suction](#) airway, as indicated; Ensure airway not kinked

Pneumothorax (tension)/Patient

- [Thoracostomy Procedure](#), as indicated
- Check pulses/cardiac rhythm

Equipment

- Verify O₂ source and tubing appropriate
- Check airway cuffs for leaks
- Verify EtCO₂ button pressed on monitor and trace detector line from monitor to airway

Stacking

- Consider breath stacking in bronchospasm; Evaluate BVM compliance and EtCO₂ waveform

If suspected

- Briefly disconnect BVM, allow full exhalation (apply chest wall pressure to assist PRN), and reconnect BVM
- Monitor and ensure EtCO₂ waveform returns to baseline, repeat above PRN

If RASS not at goal or signs of awakening, movement, or discomfort

- [Ketamine](#) bolus as per above

OR

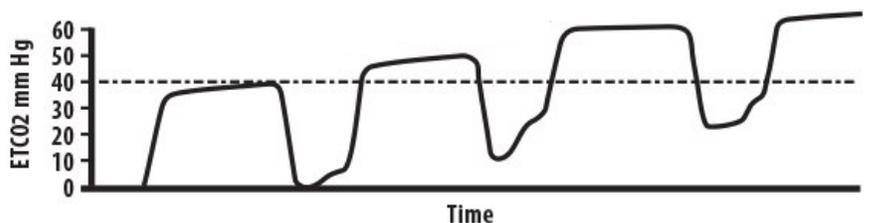
- [Ketamine infusion](#)

Adult – 200 mg in 100 mL NS, start at 1 mg/min, titrate by 1 mg/min to goal RASS

Pedi - 50 mg in 100 mL NS, start at 10 mcg/kg/min, titrate by 5 mcg/kg/min to maintain goal RASS

Paramedic

- Any patient receiving paralytics during DSI/RSA must receive adequate sedation to prevent awareness during paralysis.
- Patients with invasive airways commonly experience pain and anxiety, paralytics may obscure this and make recognition difficult for EMS clinicians.
- Signs of inadequate pain control/sedation may include eye opening, coughing or gagging, sweating, tearing, tachypnea, or new/worsening hypertension and/or tachycardia.
- Breath stacking capnography tracing:



Rapid Sequence Airway (RSA)

- Begin [Invasive Airway Preparation](#)
- Ensure appropriate monitoring including: BP q 2 min cycle, ECG, EtCO₂, SpO₂ on opposite arm from BP cuff
- Begin preoxygenation via Max BVM, NRB + HFNC, or NIPPV, as appropriate

Basic

Preparation

- Confirm appropriate equipment prepared
- Evaluate airway and identify/palpate surgical cricothyrotomy anatomic landmarks

If hypotensive, see [Circulatory Support](#) (optimize hemodynamics as possible)

Preoxygenation & Induction/Paralysis

- Verify all appropriate monitoring/positioning (ETSN, HOB @ 30° elevation)
- Preoxygenate/Denitrogenate
 - If adequate respirations*
 - Set BVM @ flush rate, form tight mask seal, and allow spontaneous respirations to continue. Ensure PEEP ≥ 5 mmHg.
 - If inadequate respirations*
 - Perform Max BVM with assisted ventilations
- Titrate PEEP to reach maximal SpO₂

[Ketamine](#)

Adult - 2 mg/kg IV/IO (max 200 mg); repeat PRN x 1
Pedi - same as Adult

- Increase NC to flush rate

Placement

- Place [Supraglottic Airway](#) (*only after all above steps completed*)
 - If placement unsuccessful - maintain [Assisted Ventilation](#), or consider 2nd SGA attempt with a change of size or insertion technique*
- Confirm airway with EtCO₂ (4-phase waveform ≥ 5 mmHg with every breath within 5-breaths)

If Can't Oxygenate, Can't Ventilate (CO₂V) by any other means

- [Surgical Airway Procedure \(Cricothyrotomy\)](#)

Paramedic

If paralysis required, and only after ketamine given

[Rocuronium](#)

Adult - 1.5 mg/kg IV/IO once (max 150 mg)
Pedi - same as Adult

- Allow sufficient time after administration for complete paralysis
- Initiate or continue assisted ventilations PRN

[Post-Invasive Airway Management](#)

CCP

- RSA is used ONLY to facilitate SGA placement and SHALL NOT be used for intubation.
- Best attempts at preoxygenation/hemodynamic optimization should be made prior to performing RSA in routine situations
- RSA may be used in conditions where adequate pre-oxygenation/hemodynamic optimization isn't possible BUT, best efforts should still be used to increase SpO₂ and BP even with RSA.
- RSA may be a better option than DSI in patients for whom the need for rapid transport outweighs the need for intubation
- Anticipated airway compromise (e.g., burns, angioedema, expanding neck hematoma) MAY benefit from endotracheal intubation if appropriate for DSI.

| | | Premie | | Newborn to 2 mo | | | 3 - 5 mo | 6 - 11 mo | 12 - 24 mo | 2 yr | 3 - 4 yr | 5 - 6 yr | 7 - 8 yr | 10 - 11 yr |
|-------------------------------------|--------|-----------------|--------|-----------------|---------------|--------|----------|------------------|------------|------------|---------------|-----------------|------------|-----------------|
| | | <2 KG | 2 KG | 3 KG | 4 KG | 5 KG | 6 - 7 KG | 8 - 9 KG | 10 - 11 KG | 12 - 14 KG | 15 - 18 KG | 19- 23 KG | 24 - 29 KG | 30 - 36 kg |
| Ketamine (2 mg/kg, 50 mg/mL) | mg | N/A | 5 | 10 | 10 | 15 | 17 | 20 | 25 | 33 | 40 | 55 | 65 | |
| | mL | N/A | 0.1 mL | 0.2 mL | 0.2 mL | 0.3 mL | 0.3 mL | 0.4 mL | 0.5 mL | 0.7 mL | 0.8 mL | 1.1 mL | 1.3 mL | |
| Rocuronium (1.5 mg/kg, 10 mg/mL) | mg | N/A | 5 | 6 | 8 | 10 | 13 | 16 | 20 | 25 | 32 | 40 | 50 | |
| | mL | N/A | 0.5 mL | 0.6 mL | 0.8 mL | 1 mL | 1.3 mL | 1.6 mL | 2 mL | 2.5 mL | 3.2 mL | 4 mL | 5 mL | |
| Air-Q Size & Connector Color | Size 0 | Size 0.5 (pink) | | | Size 1 (Blue) | | | Size 1.5 (Green) | | | Size 1.5 or 2 | Size 2 (Orange) | | Size 3 (Yellow) |

Refusal Against Medical Advice (AMA)

All AMAs must be initiated by patient or guardian. DO NOT SUGGEST THIS

Anytime a patient or their parent/guardian communicates a refusal of treatment, or transport to the extent allowed:

- Perform a thorough history & physical
- Develop a differential diagnosis specific to the patient presentation
- Offer appropriate treatment and transport to the patient, parent, and guardian
- Explain the risks and consequences of refusing treatment and/or transport at the patient or parent/guardian's level of understanding, based on the differential diagnosis
- Explain they should call 911 again for new/worsening symptoms or if they change their mind

If a patient or their parent/guardian that refuses an assessment or continues to refuse treatment or transport after the risks of refusal have been explained

- Attempt to speak with whomever called 911, as well as any family, friends, bystanders, patient surrogates, or guardians and/or medical personnel on scene.
- Assess the patient or parent/guardian's understanding of the risks and consequences of refusing treatment and/or transport, and document this in their own words
- Perform capacity assessment (evaluation of patient's understanding of risk of refusal)
- Document all of the above in the PCR

For the patient suffering from a life-threatening injury or illness

- Enlist the help of an [EMS Supervisor](#)

For the patient that appears to lack decisional capacity, and refuses treatment or transport

- Refer to [Refusal Without Demonstration of Capacity](#)

A patient's decisional capacity may be impaired as a result of, but not limited to, the following:

- ⇒ Use and/or abuse of alcohol, illegal or prescription drugs, or toxic substances
- ⇒ Head trauma, dementia, encephalopathy, and/or mental retardation
- ⇒ Acute or chronic psychiatric illness
- ⇒ Medical illness including, but not limited to, the following: hypoxia, hypotension, hyperglycemia, hypoglycemia, dehydration, and sepsis

Decisional capacity and mental status are distinct:

- ⇒ Mental status is their level of alertness and orientation
- ⇒ Decisional capacity is the patient's ability to understand the risks / benefits of treatment / transport, potential consequences of their decisions, and voice their desires. They should be able to voice a rationale for their choice. We do not have to agree with it or think it's accurate, but it should be consistent for them.

Refusal Without Demonstration of Capacity

If a patient without apparent decision making capacity, effectively communicates their desire to refuse assessment, treatment, or transport

- Ensure provider safety first and foremost
- If concern of acute mental illness or behavioral emergencies, including self-harm or harm to others, request Police
- Contact [EMS Supervisor](#)

Basic

- Reassess patient's medical decision making capacity in person

If patient lacks decisional capacity and is

- Acute (< 1 day), and
- Felt to be caused by acute medical emergency and lack of treatment and transport is felt to be life threatening
- Transport using minimum level of coercion, sedation, and restraint needed to safely facilitate transport

If patient lacks decisional capacity and does not meet above criteria and is refusing care

- No transport without LEO detention app
- Document:
 - Capacity assessment as it was performed
 - All personnel on scene – including any law enforcement name and badge number
 - If any family members present/spoken to, including content of discussions
- Record disposition of call as “refusal without demonstration of capacity”
- Contact [OLMC PRN](#)

CCP

- Making a decision against medical advice does not alone demonstrate a lack of capacity.
- Lack of capacity does not imply consent if the patient is able to communicate.
- The components of medical decision-making capacity include the following four key abilities:
 - Understanding: The ability to comprehend the information relevant to the medical decision, including the nature of the condition, the proposed treatment, and the potential risks and benefits.
 - Appreciation: The ability to recognize how the information applies to one's own situation, including acknowledging the potential consequences of the decision.
 - Reasoning: The ability to compare options logically and to weigh the risks and benefits to make an informed choice.
 - Expressing a Choice: The ability to communicate a clear and consistent decision regarding the treatment.

Release at Scene (RAS)

A Release at Scene (RAS) may **only** be performed if “no” is answered to all of the following questions:

- Did the individual activate 911 for EMS?
- Did law enforcement activate EMS for evaluation?
- Is the individual disoriented, confused, or otherwise impaired (e.g. alcohol or drugs, language barrier, MHMR)?
- Was there any loss of consciousness?
- Is there any complaint of illness, pain, or injury?
- Is there a psychological complaint/concern?
- Was there a significant mechanism of injury (e.g. MCC, ejection, auto vs. pedestrian)?
- Were any patients on-scene dead?
- Does anyone object to the individual being released (e.g. family member, first-responder)?

Respiratory Support - Adult

- Titrate O₂ to SpO₂ ≥ 94% or improved work of breathing
- Respiratory monitoring required (EtCO₂ and SpO₂), if equipped
- [Suction](#) airway as appropriate

If signs of upper airway obstruction or severe respiratory insufficiency / impending respiratory failure

- [Assisted Vent/BVM](#) (Max BVM), confirm EtCO₂ waveform with each breath if equipped
- Consider [Supraglottic Airway](#) if equipped with EtCO₂ waveform monitoring

- Remove foreign body airway obstruction (FBAO), as appropriate (Heimlich maneuver, chest compressions)

If moderate to severe respiratory distress

- [NIPPV](#) as indicated (EtCO₂ required if equipped), caution/consider discontinuation if SBP < 90

If contraindication for NIPPV

- NRB ± HFNC or nasal cannula

If suspected bronchospasm regardless of etiology

- [Albuterol](#) 2.5 mg/[Ipratropium](#) 0.5 mg in 3 ml NS nebulized, repeat PRN x 2

If persistent wheezing/respiratory distress after 3 albuterol/ipratropium doses

- [Albuterol](#) - 7.5 mg in 9 ml NS (continuously nebulized)

If pulmonary edema, see [Sympathetic Crashing Acute Pulmonary Edema \(SCAPE\)](#)

Basic

- Cardiac monitoring, acquire and transmit 12-lead ECG

If progression to severe respiratory insufficiency/respiratory failure, or unable to manage the airway

- [Intubation Procedure](#) (as part of DSI with CCP)
- Consider [Supraglottic Airway](#) if ETT unsuccessful or if unable to meet goals for intubation

If COCV - Can't Oxygenate AND Can't Ventilate (unable to obtain EtCO₂ waveform and persistent hypoxia) via any other means, see [Surgical Airway Procedure \(Cricothyrotomy\)](#)

If suspected tension pneumothorax with hypotension, see [Needle Thoracostomy Procedure](#)

If Asthma/COPD/Wheezing

Consider, especially if subacute presentation (≥ 1-2 days)

- [Dexamethasone](#) - 10 mg IV/IM x 1

If severe (e.g. accessory muscle use)

- [Magnesium Sulfate](#) - 2 g in 250 ml NS over 15 min

For asthma only, and if impending respiratory failure or unable to tolerate nebulizer

- [Epinephrine](#) 1:1,000 - 0.5 mg IM, repeat PRN q 5 min x 1

Paramedic

If invasive airway placement is needed

- [Delayed Sequence Intubation](#)
- [Rapid Sequence Airway](#)

For further management and analgesia/sedation after invasive airway obtained, see [Post-Airway Management](#)

CCP

- If SGA in place and ventilations are adequate, do not replace with endotracheal tube
- Patients with COPD may have chronic low baseline SpO₂ (88-92%), so do not indiscriminately place on high flow O₂
Start 2-3 lpm O₂ via NC, or double baseline flow rate; titrate to patient's baseline SpO₂ and work of breathing

Respiratory Support - Pediatric

- Titrate O₂ to SpO₂ ≥ 94% or improved work of breathing
- Respiratory monitoring required (EtCO₂ and SpO₂), if equipped
- [Suction](#) airway as appropriate

If signs of upper airway obstruction

- Attempt to open the airway by:
 - Jaw thrust/head-tilt-chin-lift
 - Nasopharyngeal and/or oropharyngeal airway placement (NPA/OPA)
 - Position in ETSN; Place padding under infant's shoulders, up to 5 y/o lay flat, and head elevation for ≥ 5 y/o
 - Remove foreign body airway obstruction (FBAO), as appropriate (Heimlich maneuver, chest compressions)

If severe respiratory insufficiency/impending respiratory failure

- Assist ventilation with bag-valve-mask (BVM); confirm EtCO₂ waveform with each breath if equipped (goal 35-45 mmHg)
- Consider [Supraglottic Airway](#) (if EtCO₂ equipped)

If moderate to severe respiratory distress

- Seat patient (semi-) upright if not hypotensive
- Nasal cannula or NRB ± HFNC

If asthma/reactive airway disease

- [Albuterol](#) 2.5 mg/[Ipratropium](#) 0.5 mg in 3 ml NS nebulized, repeat PRN x 2

If persistent wheezing/respiratory distress after 3 albuterol/ipratropium doses

- [Albuterol](#) - 7.5 mg in 9 ml NS (continuously nebulized)
- [NIPPV](#) as indicated, if mask size equipped (EtCO₂ required if equipped); caution/consider discontinuation if hypotensive

If suspected bronchiolitis (< 2 years of age with rhonchi, or undifferentiated illness with rhinorrhea, tachypnea, and/or fever)

- Suction the nose and/or mouth (via bulb or suction catheter), particularly if excessive secretions are present

If suspected croup (stridor & barking cough) or epiglottitis (toxic appearance, drooling, difficulty swallowing, distress)

- Keep patient calm and avoid stimulating

- Cardiac monitoring

If suspected croup AND stridor at rest or exertion

- [Racemic Epinephrine](#)
 - ≤ 10 kg - 0.25 ml (1/2-ampule) mixed with 3 ml NS nebulized, repeat PRN x 1
 - > 10 kg - 0.5 ml (1-ampule) mixed with 3 ml NS nebulized, repeat PRN x 1

If COCV - Can't Oxygenate AND Can't Ventilate (unable to obtain EtCO₂ waveform and persistent hypoxia) via any other means, see

[Transtracheal Ventilation Procedure](#)

If suspected tension pneumothorax with hypotension, see [Needle Thoracostomy Procedure](#)

If suspected croup OR asthma/wheezing (especially if subacute presentation (≥ 1-2 days)

- [Dexamethasone](#) - 0.6 mg/kg PO/IM/IV once (max 10 mg)

If asthma/reactive airway disease

If severe (e.g. accessory muscle use)

- [Magnesium Sulfate](#) - 40 mg/kg IV/IO over 15 min (max dose 2 g)

If impending respiratory failure or unable to tolerate nebulizer

- [Epinephrine](#) 1:1,000 - 0.01 mg/kg IM. repeat PRN q 5 min x 1 (max dose 0.5 mg)

If invasive airway placement is needed, see [Rapid Sequence Airway](#)

For further management and analgesia/sedation after invasive airway obtained, see [Post-Invasive Airway Management](#)

- **Intubation and DSI are prohibited for pediatric patients (per Pediatric Patient Assessment definition)**
- Ensure notification to ED staff of any dexamethasone administration
- Bronchiolitis does not traditionally respond to albuterol/ipratropium or steroids, and asthma is unlikely in the < 2 yo age group

Telemedicine Navigation

If suspected low-acuity medical or trauma complaint and meets inclusion criteria and has no exclusion criteria as listed below,

- Contact Telemedicine Provider

Inclusion:

- Alert, oriented, and have decisional capacity
 - Children should have parent or guardian present and available
 - Adults without decisional capacity because of baseline conditions (ex: dementia), must have POA available
- Adults ≥ 65 refusing transport or don't appear to need transport and have decisional capacity
- Stable vital signs:
 - Systolic blood pressure ≥ 110 mmHg (or age appropriate)
 - Heart rate 50-120 beats per minute
 - Respiratory rate 8-28 breaths per minute
 - Pulse oximetry $\geq 92\%$ on room air

Exclusion:

- Patients with isolated depression or suicidal ideation without immediate plan (these patients are eligible for iCare).
 - Patients in a healthcare facility under the direct care of a physician
 - Age ≤ 3 months with a fever
 - Combative or agitated patients
 - Pregnancy related complaint (pregnancy, by itself, is not an exclusion)
 - Clinician suspicion of moderate or high acuity illness/injury
 - STEMI, Stroke, Trauma alert criteria
 - No demonstrated decisional capacity (refusals without capacity)
- Complete patient assessment, including:
 - Vital signs, including BP, HR, RR, and SpO2
 - Any diagnostics as indicated (blood glucose, 4 lead ECG, or 12 lead ECG)
 - Contact telehealth provider
 - Provide a brief patient report to the telehealth physician
 - The disposition determined by the telehealth provider in consultation with the patient is final
 - Follow telehealth physician orders including use of EMS intervention/medication for indications not included within protocol. Contact [OLMC](#) for conflicts with telehealth physician orders.
 - Complete the documentation on the ePCR
 - All patient contacts, excluding IFTs, will have a validated question: "Was the patient offered a telehealth consult?" with the following options:
 - "Yes, and patient accepted", use one of the following dispositions as appropriate:
 - If treated by telehealth*, "Treated, transferred care to telehealth provider"
 - If transported after consult*, "Transported – by this unit"
 - If patient refuses telehealth recommendations and transport*, "AMA – Assessed and/or Treated and Released"
 - "Yes, but patient refused telehealth consult", use appropriate disposition as though there was no consult.
 - "Yes, but unable to contact telehealth provider", use appropriate disposition as though there was no consult.

- Stable vital signs are ranges used as guidelines. Clinical judgement can and should apply when determining eligibility.

Termination of Resuscitation

If CPR in progress by non-professional rescuer/bystander

- Consider Withholding Resuscitative Efforts

Termination of Resuscitation requires OLMC

Keep family informed of prognosis and begin setting realistic expectations early.

If after in-person CCP assessment and prior to ALS interventions, withholding criteria is present and patient is in asystole

- Resuscitation efforts can stop under Withholding Resuscitative Efforts

Prior to calling OLMC for termination:

- POCUS - Obtain video clip assessing for cardiac wall motion or other significant findings

If traumatic etiology,

- Consider potential for underlying medical causes and manage appropriately
- Contact OLMC for TOR once the following have been assured/performed:
 - Oxygenation & ventilation confirmed by waveform EtCO₂
 - Hemorrhage control
 - All appropriate procedures
- There is no minimum resuscitation time

If medical etiology:

- Contact OLMC for TOR once the following have been assured/performed:
 - Monitored* professional rescuer CPR
 - Oxygenation & ventilation confirmed by waveform EtCO₂
 - IV/IO access
 - Appropriate medications given
 - Defibrillation as needed
 - EtCO₂ values as follows:
 - EtCO₂ < 10 @ 10 minutes
 - EtCO₂ ≥ 10 but < 20 @ 20 minutes
 - EtCO₂ ≥ 20 @ 30 minutes

When calling OLMC for termination, present information in the following format:

- Medic name
- Location type
- Age, Sex
- Pertinent medical history (cancer, dementia, etc.)
- Estimated down time, witnessed or not
- Presence of bystander CPR
- Initial presenting rhythm
- Duration of professional rescuer resuscitation efforts
- Method of ventilation
- Initial EtCO₂ following advanced airway placement
- Current EtCO₂
- Type of vascular access
- Medications given
- Any periods of ROSC or CPR-induced consciousness

- Arrest in a public place, by itself, is not a contraindication for termination. Consider full dynamics of scene.
- With the exception of ECPR, transport without ROSC has less than 1% survival.
- Family/friends should be supported and kept informed of the progression and prognosis of the resuscitation effort.
- Document time of death and physician's name.
- Notification of law enforcement is required. Remain with the deceased until relieved by law enforcement unless unsafe to do so.
- * Monitored professional CPR is the duration of resuscitation on the cardiac monitor.

Withholding Resuscitative Efforts

If patient has Out-of-Hospital Do Not Resuscitate order or there is expression of their desires regarding resuscitation

→ See [DNR](#) policy

Consider withholding resuscitative efforts if any of the following clinical signs of irreversible death/futility and criteria are present:

- Rigor mortis/dependent lividity
- Fetal death after preterm delivery (≤ 20 weeks gestation by best determination)
- Decapitation, decomposition, or incineration
- Exposed brain matter
- Head-under submersion (excluding vehicular submersions) for greater than:
 - 90-minutes if water temperature $\leq 6^{\circ}\text{C}$ (43°F)
 - 30-minutes if water temperature $> 6^{\circ}\text{C}$ (43°F)

AND if all of the following

- Pulseless
- Apneic
- Without pupillary response

- *If patient does not meet above criteria, begin appropriate resuscitation efforts*

Basic

For blunt and/or penetrating trauma, consider withholding if NO clinical signs of irreversible death AND if all of the following:

- Pulseless
- Apneic
- No pupillary response
- Asystole or PEA < 40 bpm on cardiac monitor

- *If patient does not meet above criteria, begin appropriate resuscitation efforts*

Paramedic

- For the purpose withholding of resuscitation, electrical/lightning strikes are not considered trauma
- Remain with the deceased until relieved by law enforcement (Unless unsafe to do so)
- Document objective findings including (each responding agency):
 - Position/location found
 - Any movement of the patient/surroundings
 - Access limitations
 - Assessment findings as appropriate
 - Suspicious/inconsistent scene or physical findings

Cardiac

Acute Coronary Syndrome/STEMI

- **Aspirin** - 324 mg PO chewed
- **Nitroglycerin** - 0.4 mg SL q 5-minutes PRN for pain
Titrate to SBP \geq 100 mmHg and signs/symptoms (recheck BP before each dose)
Do not administer if patient has recently taken medication for erectile dysfunction
- Acquire **12-lead ECG** within 10 minutes of patient contact
 - Transmit 12-lead as soon as possible
 - Assure time of initial ECG is documented in the PCR

Basic

- Cardiac monitoring
Treat dysrhythmias as identified

If ST-Elevation MI (STEMI)

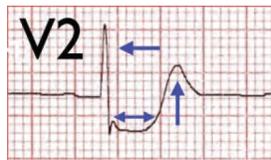
- Place defibrillation pads
- Do not delay transport or other treatment to obtain V₄R lead if inferior STEMI
- Be cautious with nitroglycerin in RV infarcts; however, it is not contraindicated
- Notify facility of STEMI alert within 10 minutes of first diagnostic 12-lead for STEMI

Paramedic

- See **Hospital Capabilities List** for most appropriate transport destination
- Consider Occlusive Myocardial Infarction (OMI) if appropriate clinical presentation and one of the following ECG patterns:

Posterior STEMI

- Horizontal ST-segment depression in leads V1-V3, a dominant R wave (R/S ratio $>$ 1) in lead V2
- Upright T waves in anterior leads
- A prominent and broad R-wave ($>$ 30 ms)

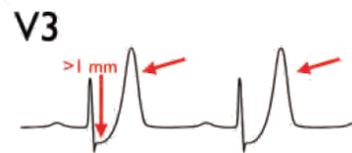


Confirmed by posterior ECG with ST-segment elevation in leads V7-V9

Note: Voltage on posterior ECG may be very small and difficult to see. The posterior ECG has poor sensitivity

De Winter Pattern/T-waves

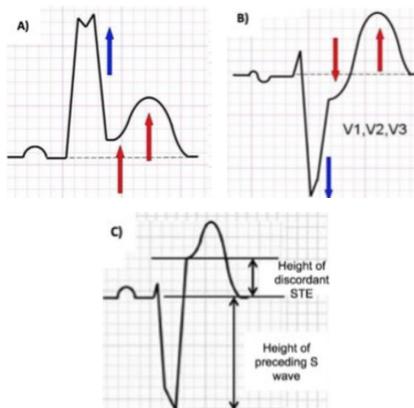
- Tall, prominent, symmetrical T waves arising from upsloping ST-segment depression $>$ 1 mm at the J-point in the precordial (V1-V6) leads
- Slight (0.5-1 mm) ST-segment elevation may be seen in lead aVR



Left Bundle Branch Block or Ventricular Paced Rhythm with Smith-modified Sgarbossa Criteria

Positive if any criteria below are present:

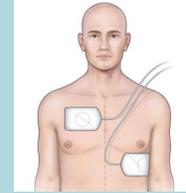
- Concordant ST elevation \geq 1 mm in leads with a positive QRS complex
- Concordant ST depression \geq 1 mm in V1-V3
- ST Elevation at the J-point, relative to QRS onset, is at least 1 mm AND has an amplitude at least 25% of the preceding S-wave



Cardiac Arrest - Adult

High quality BLS interventions are the key to successful resuscitation. Nothing should interfere with them.

- Begin 2-minute cycles of **Pit Crew CPR** with 30:2 compression/ventilation @ 100-120 compressions per minute, limit compression pauses to < 10 seconds
- Rapidly place SGA with waveform EtCO₂ (no PEEP). If delayed or no EtCO₂ begin Max BVM
 - Ventilate during 30:2 pause, 1 second breath “squeeze - release - release”. No breaths with compression.
 - Goal EtCO₂ > 20 mm Hg, if < 20 mm Hg, evaluate quality of rate, depth, and recoil of compressions
- Apply compression feedback device as soon as possible
- Place AED (or monitor in AED mode) with multi-function pads in anterior-lateral (A-L) configuration
 - If arrest witnessed by EMS/FRO* - apply AED and analyze immediately
 - If arrest unwitnessed by EMS/FRO* - apply during initial CPR cycle and analyze at end of cycle
- Mechanical compression device may be considered only when:
 - At least 15 minutes of monitored professional rescuer CPR has occurred or,
 - Transport is necessary or,
 - ROSC has been achieved and the device is being pre-positioned for transport or,
 - Critical shortage of man power prevents adequate Pit Crew CPR



Basic

If patient has gravid uterus

- Manually displace fundus to the patient's left
- Patient to remain on initial cardiac monitor throughout entirety of resuscitation

| Initial Shockable Rhythm | Initial Non-Shockable Rhythm |
|--|--|
| <ul style="list-style-type: none"> • Defibrillate at highest energy setting q 2-minutes • Epi 1:10,000 - 1 mg IV/IO x 1 • Amiodarone - 300 mg IV/IO x 1 after 2nd defib; <ul style="list-style-type: none"> • 2nd dose PRN after 3rd defib, 150 mg IV/IO x 1 <p><i>If persistent or recurrent VF/VT</i></p> <ul style="list-style-type: none"> • DSED (as soon as 2nd monitor available), do not delay single shocks while setting up for DSED • If 2nd monitor unavailable, continue with single shock with pad placement change to Anterior-Posterior (A-P) <ul style="list-style-type: none"> • <i>If conversion to non-shockable</i> - start Epi Cardiac Arrest Infusion | <ul style="list-style-type: none"> • Epi 1:10,000 - 1 mg IV/IO x 1, then • Epi Cardiac Arrest Infusion - 2 mg (20 mL) of 1:10,000 in 250 mL NS, infuse @ 67 mcg/min or 540 ml/hr <ul style="list-style-type: none"> <i>If arrest not witnessed by bystander or EMS,</i> <ul style="list-style-type: none"> • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) • Flush line before and after administration <i>If PEA,</i> <ul style="list-style-type: none"> • Fluid bolus 20 ml / kg IV/IO • Consider reversible causes |

Paramedic

If signs/symptoms of CPR-Induced Consciousness,

- **Ketamine** - 1 mg/kg IV/IO (max single dose 200 mg)

| For any of the following give early in the course of cardiac arrest management. | |
|---|---|
| Metabolic acidosis etiology (e.g. DKA) | • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) |
| Hyperkalemia: | • Calcium Chloride - 1 g IV/IO, slow push • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) |
| Torsades de Pointes: | • Magnesium Sulfate - 2 g IV/IO, slow push |
| Tension Pneumothorax: | • Needle Thoracostomy Procedure |
| Tricyclic Antidepressant Overdose: | • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) |
| Calcium Channel Blockers: | • Calcium Chloride - 1 g IV/IO, slow push |
| Beta Blocker Overdose: | • Glucagon - 1 mg IV/IO slow push over 1-minute, Repeat PRN x 1 |

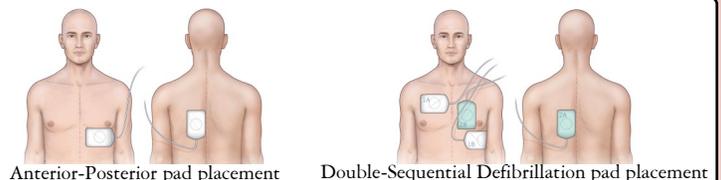
- Contact **OLMC** for ECPR after 2nd dose of Amiodarone or when appropriate for TOR considerations

If after second dose of Amiodarone, as long as the patient remains in a shockable rhythm,

- **Esmolol** - 0.5 mg/kg (max 50 mg) bolus x 1 then infusion at 0.05 mg/kg/min (max 5 mg/min)

CCP

- Resuscitate in the location found unless scene is unmanageable
- Consider tension pneumo in patients with severe asthma/COPD who have poor ventilation compliance not resolved with “burp” technique
- If ROSC, see **Post-ROSC**
- If no pump available, hang epi infusion to gravity using a 10 gtt/mL set at 9 gtt / 6 sec



Anterior-Posterior pad placement

Double-Sequential Defibrillation pad placement

Cardiac

Cardiac Arrest - Pediatric

- Begin 2-minute cycles of [Pit Crew CPR](#); 15:2 compressions-ventilation, 100-120 bpm, no pauses > 10 seconds
- Rapidly place SGA with waveform EtCO₂ (no PEEP). If delayed or no EtCO₂ begin Max BVM
 - Ventilate during 15:2 pause, 1 second breath “squeeze - release - release”. No breaths with compression.
 - Goal EtCO₂ > 20 mm Hg, if < 20 mm Hg, evaluate quality of rate, depth, and recoil of compressions
- Apply AED
 - If arrest witnessed by EMS/FIRE* - apply AED immediately
 - If arrest unwitnessed* - perform 2-minutes of CPR before applying AED
- Utilize Broselow tape

Basic

- Apply cardiac monitor only after completion of last 2-minute cycle of CPR
- IV/IO access

VF/VT

- [Defibrillate](#) at 2 J/kg, Repeat PRN q 2 min, increase by 2 J/kg (max 10 J/kg or max energy setting)
- [Epinephrine 1:10,000](#) - 0.01 mg/kg (max single dose 1 mg) IV/IO q 5-min. 3-dose-max
- [Amiodarone](#) - 5 mg/kg IV/IO (max 300 mg) after second defibrillation, Repeat PRN x 2 every other cycle or 4 min, if persistent or recurrent VF/VT

Asystole/PEA

- [Epinephrine 1:10,000](#) - 0.01 mg/kg (max single dose 1 mg) IV/IO immediately, then q 5 min, 3-dose-max

For any of the following give early in the course of cardiac arrest management.

| | |
|---|---|
| Metabolic acidosis etiology (e.g. DKA) | <ul style="list-style-type: none"> • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) |
| Hyperkalemia: | <ul style="list-style-type: none"> • Calcium Chloride - 20 mg/kg (0.2 ml/kg) IV/IO, slow push (max dose 1 g) • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) |
| Torsades de Pointes: | <ul style="list-style-type: none"> • Magnesium Sulfate - 25-50 mg/kg (max 2 g) IV/IO, slow push |
| Tension Pneumothorax: | <ul style="list-style-type: none"> • Needle Thoracostomy |
| If any of the below causes are suspected, contact OLMC following initial dosing | |
| Tricyclic Antidepressant Overdose: | <ul style="list-style-type: none"> • Sodium Bicarbonate - 1 mEq/kg IV/IO (max dose 100 mEq) |
| Calcium Channel Blockers: | <ul style="list-style-type: none"> • Calcium Chloride - 20 mg/kg (0.2 ml/kg) IV/IO, slow push (max dose 1 g) |
| Beta Blocker Overdose: | <ul style="list-style-type: none"> • Glucagon - 0.1 mg/kg IV/IO slow push over 1-minute (max single dose 1 mg), Repeat PRN 0.2 mg/kg IV/IO × 1 (max single dose 1 mg) |

Paramedic

- *If signs of obvious death, see [Withholding Resuscitative Efforts](#)*
- Resuscitate in the location found unless scene is unmanageable
- Limit chest compression pauses and individual pause length to < 10-seconds
- Do not interrupt CPR for airway management
- Open airway; If choking suspected, remove FBAO as early as possible
- Waveform EtCO₂ required for all advanced airways
 - Confirm waveform EtCO₂ ≥ 5 mmHg for every breath
 - Remove airway if EtCO₂ ≤ 5 mmHg
- Switch AED to monitor/defibrillator only after completion of the current CPR cycle
- Do not interrupt CPR or defibrillation for ACLS drug administration
- If ROSC, optimize patient hemodynamics, oxygenation, and ventilation prior to initiating transport
- Sodium bicarbonate is not indicated for prolonged down time

Cardiac

Post ROSC

If ROSC occurs in-place,

- **Remain in-place for a minimum of 10 minutes**, accomplishing the following:
 - Assess ventilation effectiveness and vital signs
 - BP q 2 minutes
 - Obtain **12-lead ECG** ASAP following ROSC
 - Assess blood glucose
 - Notify receiving PCI center, activate STEMI alert as appropriate
 - Place MCD in ready mode for transport
 - Secure patient

Basic

- Reassess rhythm
- Assure ≥ 2 routes of IV/IO access

If ROSC or rearrest occurs in transport,

- Continue transport and update PCI center of change in patient condition, while accomplishing the above
- MCD should already be in place for transport

If sedation required,

- **Ketamine**
 Adult - 1 mg/kg IV/IO (max single dose 200 mg)
 Pedi - Same as Adult
- Maintain MAP ≥ 65 or age appropriate goals

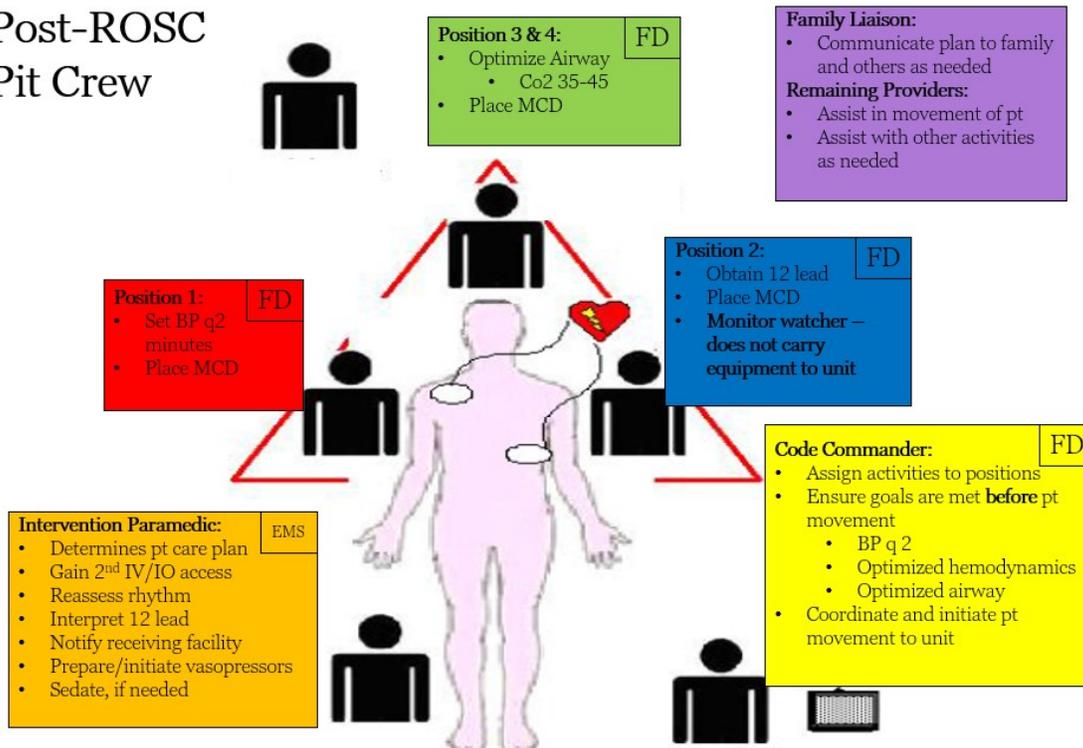
If hypotensive,

- Discontinue Esmolol if infusing
- Utilize Epi infusion if in place, or
- **Norepinephrine**
 Adult - 5 mcg/min, titrate to MAP ≥ 65
 Pedi - 0.1 mcg/kg/min, titrate to age appropriate goals

Paramedic

- Pediatric SBP goals: ≥ 70 mm Hg + (age in years x 2) or ≥ 90 mm Hg for age 10 or greater
- Re-arrest is common immediately after ROSC. Carefully monitor to detect re-arrest.
- 12-lead ECG early after ROSC can be difficult to interpret. If unclear, obtain serial ECGs as able.

Post-ROSC Pit Crew



SCAPE

If respiratory insufficiency / failure, with prior medical history of CHF, and SBP > 180

- Request [EMS Supervisor](#)
- [NIPPV](#) with ETCO₂ monitoring
- [Nitroglycerin](#) - 0.4 mg SL q 5 min until SBP < 180
- [12 Lead ECG](#)

Basic

If SBP > 200 and, (RR > 30 or SpO₂ < 90%)

- BP q 2 mins
- [Nitroglycerin IV](#) - 1 mg Slow IV push
If after IV push, SBP and RR meet above criteria
 - [Nitroglycerin Infusion](#) - 100 mcg/min infusion, titrate rapidly down as SBP drops, goal SBP < 180

CCP

Consider as appropriate:

- [DSI](#)
- [RSA](#)

- Sympathetic Crashing Acute Pulmonary Edema (SCAPE) is acute onset severe respiratory distress / failure as a result of a weakened heart's ability to overcome severely elevated after load. Treatment is aimed primarily at rapidly lowering SBP while supporting ventilation.
- Nitroglycerin push and infusion can rapidly lower blood pressure. While this is the desired effect, be prepared to rapidly titrate infusion down as blood pressure drops to avoid hypotension. It isn't uncommon to be able to turn infusion off all together.

Symptomatic Bradycardia

- Cardiac monitoring and 12-lead ECG

If Infant < 1, see [Newly Born](#)

If Pediatric with heart rate < 60 with signs of hypoperfusion or end-organ dysfunction,

- CPR; 15:2 compressions-ventilation, 100-120 bpm, no pauses > 10 seconds

If chest pain or anginal equivalent symptoms, see [Acute Coronary Syndromes/STEMI](#)

Basic

ADULT

- [External Cardiac Pacing](#) procedure
 - Do not delay pacing for IV placement or medications in the presence of hemodynamic instability
 - Ensure adequate oxygenation/ventilation
 - Begin at 30 mA, increasing energy in 10 mA increments until capture achieved
 - Begin at 70 ppm, increasing rate in 10 ppm increments until hemodynamic response/improved perfusion
- [Atropine](#) - 1 mg IV/IO, repeat PRN to max dose of 3 mg

PEDI

- [Epinephrine 1:10,000](#) - 0.01 mg/kg IV/IO (max dose 0.1 mg)
- [Atropine](#) - 0.02 mg/kg IV/IO (minimum single dose 0.1 mg with max dose 1 mg), repeat PRN x 1
- [External Cardiac Pacing](#) procedure if bradycardia resistant to medications
 - Ensure adequate oxygenation/ventilation
 - Begin at 30 mA, increasing energy in 10 mA increments until capture achieved
 - Begin pacing rate at:
 - Age 0-36 months - 120 ppm
 - Age 36 months to 12 years - 100 ppm
 - Age > 12 years - see Adult
 - Increase rate in 10 ppm increments until hemodynamic response/improved perfusion

If hypotensive, consider [Circulatory Support](#) protocol

If time permits, consider sedation prior to/during pacing

- [Ketamine](#) - 0.3 mg/kg IV/IO Slow Push or 0.6 mg/kg IM (max dose 30 mg)

Paramedic

Refractory Shock/hypotension

- See [Circulatory Support](#)

Hyperkalemia

- Wide complex rhythm, 12-lead ECG findings, or dialysis hx
- [Calcium Chloride](#)
Adult - 1 g IV slow push
Pedi - 20 mg/kg (0.2 ml/kg) IV/IO, slow push (max dose 1 g)
 - [Sodium Bicarbonate](#)
Adult - 1 mEq/kg IV/IO (if suspected acidosis)
Pedi - Same as Adult

Beta Blocker Overdose

- [Glucagon](#)
Adult - 1 mg IV/IO slow push over 1-minute
Repeat PRN q 5 min x 1
Pedi - 0.1 mg/kg IV/IO, slow push over 1-minute (max single dose 1 mg)
Repeat 0.2 mg/kg IV/IO x1 PRN (max single dose 1 mg)
- [Epinephrine Infusion](#)
Adult - Start at 5 mcg/min titrate to MAP \geq 65
Pedi - Start at 0.1 mcg/kg/min, titrate by 0.1 mcg/kg/min q 2 min

Calcium Channel Blocker Overdose

- [Calcium Chloride](#)
Adult - 1 g IV slow push
Pedi - 20 mg/kg (0.2 ml/kg) IV/IO, slow push (max dose 1 g)

- Pacing is only indicated for hypotension caused by bradycardia
- Symptomatic Bradycardia (symptoms/signs do not generally occur unless rate < 50 bpm)
- Monitor pads for burns, pediatrics have more sensitive skin

Tachycardias

| <ul style="list-style-type: none"> • Cardiac monitoring and 12-lead ECG <p><i>If patient < 65 yo, stable with regular pulse rate ≥ 150 bpm and prior history of SVT and no suspicion for sepsis, trauma, or volume depletion</i></p> <ul style="list-style-type: none"> • Modified Valsalva: forcefully blow into a 10 cc syringe up to 3 times | | | Basic | |
|--|--|--|-----------|--|
| <ul style="list-style-type: none"> • Assess rhythm for rate, width and regularity Do not delay cardioversion for IV placement or medications in the presence of severe hemodynamic instability • IV access; consider 500 mL NS IV/IO rapid bolus for hypotension <p><i>If suspected sinus tachycardia or MAT</i></p> <ul style="list-style-type: none"> • Treat the underlying condition | | | | |
| Unstable | Stable (HR ≥ 150 with SBP ≥ 120)* | | Paramedic | |
| | | Narrow (QRS < 0.12) | | Wide (QRS > 0.12) |
| <ul style="list-style-type: none"> • Synchronized Cardioversion Adult - At highest energy setting Pedi - 0.5-1.0 J/kg, then 2 J/kg <p><i>If time permits, consider sedation prior to/ during Cardioversion</i></p> <ul style="list-style-type: none"> • Ketamine Adult - 0.3 mg/kg IV/IO slow push (max dose 30 mg) or 0.6 mg/kg IM (max dose 50 mg) Pedi - same as Adult | Regular | <ul style="list-style-type: none"> • Vagal maneuver • Diltiazem Adult - 0.25 mg/kg slow IV/IO push Repeat PRN x 1 (max single dose 20 mg) Pedi - N/A • Adenosine Adult - 12 mg IV/IO, Repeat PRN 18 mg x 1 Pedi - 0.1 mg/kg IV/IO, Repeat PRN 0.2 mg/kg (max dose 12 mg) <p><i>If sympathomimetic associated, see Toxicology</i></p> | | <ul style="list-style-type: none"> • Treat underlying causes (no adenosine or diltiazem) • Amiodarone (150 mg / 100 mL NS) Adult - 150 mg IV/IO over 10 mins (600 mL / hr) Pedi - 5 mg/kg IV/IO (max dose 150 mg) <p style="text-align: center;">Torsades de Pointes</p> <ul style="list-style-type: none"> • Magnesium Sulfate (slow push) Adult - 2 g IV Pedi - 25-50 mg/kg IV/IO (max dose 2 g) |
| | Irregular | <ul style="list-style-type: none"> • Diltiazem Adult - 0.25 mg/kg slow IV/IO push Repeat PRN x 1 (max single dose 20 mg) Pedi - N/A | | |

Unstable Tachycardia (symptoms/signs do not generally occur unless rate ≥ 150)

- Hypotension (or relative hypotension with signs of poor perfusion or end-organ dysfunction)
- Diltiazem is better tolerated by patients than adenosine and should be first line therapy.
- **If Afib with RVR associated with trauma, fever, hyper/hypothermia, possible sepsis or CHF, do not treat with rate control medications.**
- Do not give diltiazem with nitroglycerin
- Do not give adenosine if wide QRS complex

Common etiology of narrow complex regular tachycardias

- SVT, PAT, A-flutter, or sinus tachycardia

Common etiology of narrow complex irregular tachycardias

- A-fib or A-flutter

Assume a wide complex regular tachycardia is V-tach until proven otherwise

- Other causes could be SVT with aberrant conduction

Assume wide complex irregular tachycardias are A-fib with aberrant conduction pathway

→ Upper limit of sinus tachycardia is approximately 220 - patient age

→ Carotid sinus massages are dangerous and not authorized

* Consult OLMC for non-sinus tachycardias that do not meet these parameters, but are felt to need treatment.

Medical

Abdominal Pain

- NPO
- Position patient for comfort
- Assess for hemodynamic instability and monitor for impending shock

If complaint of upper abdominal pain consider, [Acute Coronary Syndrome, STEMI](#)

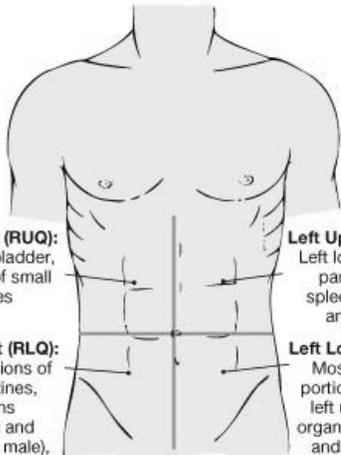
If nausea/vomiting, see [Nausea and Vomiting](#)

If acute pain, see [Acute Pain Management](#)

- Treat other potential causes (e.g., ACS, Overdose/Poisoning, Diabetic Emergencies, Emergency Childbirth, gastroparesis, cyclic vomiting, or Cannabinoid Hyperemesis,)

Basic

Paramed-



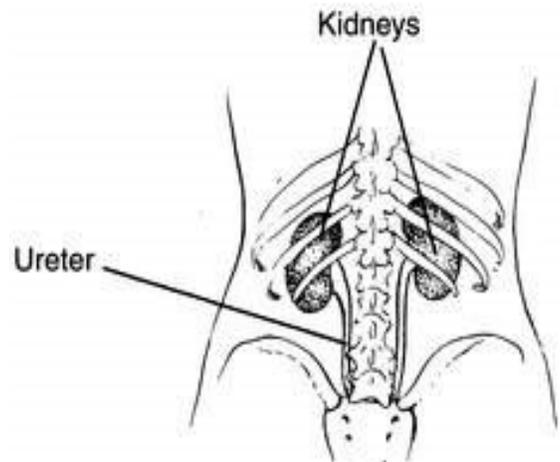
Right Upper Quadrant (RUQ):
Right lobe of liver, gallbladder, right kidney, portions of small and large intestines

Left Upper Quadrant (LUQ):
Left lobe of liver, stomach, pancreas, left kidney, spleen, portions of small and large intestines

Right Lower Quadrant (RLQ):
Cecum, appendix, portions of small and large intestines, reproductive organs (right ovary in female and right spermatic cord in male), right ureter

Left Lower Quadrant (LLQ):
Most of small intestine, portions of large intestine, left ureter, reproductive organs (left ovary in female and left spermatic cord in male)

(a)



Kidneys

Ureter

Allergic Reaction/Anaphylaxis

If suspected respiratory failure, see [Respiratory Support](#)

- Remove inciting agent (e.g. stinger), if possible

If local reaction / rash / hives

- Observe for respiratory distress and hypotension
- [Diphenhydramine](#)
Adult - 25 to 50 mg PO
Pedi - N/A

If wheezing / bronchospasm

- [Albuterol](#)
Adult - 2.5 mg/ipratropium - 0.5 mg in 3 ml NS nebulized, repeat PRN x 2
Pedi - Same as Adult

If anaphylactic reaction or severe signs

- Stridor
- Oropharyngeal swelling/difficulty swallowing/throat tightening
- Severe dyspnea
- Wheezing with accessory muscle use
- Poor air-movement to auscultation
- Difficulty speaking in full sentences
- Hypotension ± signs of shock
- [Epinephrine](#) 1:1,000
Adult - 0.5 mg IM, repeat PRN q 5 min
Pedi - 0.01 mg/kg (max dose 0.5mg) IM, repeat PRN q 5 minutes x 2

- [Diphenhydramine](#)
Adult - 50 mg IV/IM/IO
Pedi - 1 mg/kg IV/IM/IO (max dose 50 mg)

If hypotension, see [Circulatory Support](#)

In presence of signs of anaphylaxis/anaphylactic shock (stridor and or hypotension/end-organ dysfunction)

- [Epinephrine push dose](#) (0.1 mg in 10ml NS)
Adult - 10 mcg (1 ml) IV/IO, repeat PRN q 5-minutes, max total dose 50 mcg (5 ml)
Pedi - 1 mcg/kg (max single dose 10 mcg), repeat PRN q 5-minutes, max total dose 50 mcg (5 ml)
- [Epinephrine infusion](#)
Adult - start at 5 mcg/min titrate to MAP > 65
Pedi - start at 0.1 mcg/kg/min, titrate by 0.1 mcg/kg/min q 2-minutes

Consider

- [Dexamethasone](#)
Adult - 10 mg IV/IM
Pedi - 0.6 mg/kg PO/IM/IV (max 10 mg)

→ Anaphylactic reaction is defined by:

1. Exposure to suspected allergen WITH hypotension
2. Exposure to suspected allergen with symptoms from two or more of the below body systems.
 - A. Respiratory
 - B. Cardiovascular
 - C. Gastrointestinal
 - D. Integumentary

→ If history of ACE inhibitor use, or if personal/family history of non-allergic angioedema, above interventions may provide no benefit

→ Use extreme caution if patient wishes to refuse transport following treatment (several hours of monitoring may be necessary)

Altered Mental Status

- Assess blood glucose concentration
 - If ≤ 60 mg/dl, see [Diabetic Emergencies](#)

If known or suspected opiate intoxication, see [Opiate Use Disorder](#)

Basic

Consider other causes of AMS and treat as per indicated protocol

→ Look for signs of toxicologic or environmental exposure

Atraumatic Headache - Adult

- Obtain focused history and neurologic exam to evaluate for red flags
- Decrease noxious stimuli as able (e.g., move to quiet, dark environment)
- [Acetaminophen](#) - 1 g PO
- Cool compress to forehead

If clinical suspicion of cluster headache

- High-flow oxygen via NRB (regardless of SpO₂)

Basic

- [Acetaminophen](#) - 15 mg/kg IV (max dose 1 g)
- [Ketorolac](#) - 15 mg IV, 30 mg IM
- [Droperidol](#) - 1.25 mg IM/IV, may repeat at 0.625 mg IM/IV, q 10-min PRN x1

If nausea/vomiting, see [Nausea and Vomiting](#)

Paramedic

- **IV opioids are contraindicated for atraumatic headache. They increase rate of rebound headaches.**
- Do not administer ketorolac if suspicion of SAH/intracerebral hemorrhage
- Benign headaches have no historical red flags and no neuro deficits
- Consider cluster headache particularly in males with severe headaches that occur in clusters over weeks, is unilateral in the orbital, supraorbital or temporal region, and is associated nasal congestion, conjunctival injection, and tearing
- Historical and physical exam red flags:
 - *Subarachnoid hemorrhage/ICH* - sudden onset, instantly peaks in intensity (“thunder-clap”), onset during exertion, associated with syncope/LOC, neck stiffness/pain, anticoagulation
 - *Meningitis* - AMS, fever, neck stiffness, +/- rash
 - *Giant Cell/Temporal Arteritis* - Age ≥50, temporal artery tenderness, jaw claudication, monocular vision changes
 - *Acute Angle-Closure Glaucoma* - abrupt onset of severe monocular pain, fixed/non-reactive mid-dilated pupil, conjunctival injection, nausea/vomiting, blurred vision or halos around lights
 - *Pre-eclampsia* - pregnancy ≥20 weeks through 6 weeks post-partum, edema, hypertension
 - *Carbon monoxide* - AMS, dizziness, N/V, dyspnea, multiple individuals with similar complaints, situational factors
- Presence of red flags does not preclude symptomatic treatment, however response to treatment does not exclude emergent conditions.

Behavioral Emergencies/Agitation

| | | | | |
|---|---|--|---|---------------------------|
| <ul style="list-style-type: none"> Use Physical Restraint Procedure, only after verbal de-escalation has failed Passive/active cooling, see Hyperthermia Protocol as appropriate Blood glucose assessment and treatment, see Diabetic Emergencies Protocol Determine and document initial and ongoing reassessments of RASS score | | | | Basic |
| <ul style="list-style-type: none"> Target goal for all interventions is RASS 0 Frequent BP and continuous SpO2, ECG and EtCO2 monitoring required for any restrained or sedated patient | | | | AGITATION SPECTRUM |
| (RASS +1) <i>Anxiety and/or Mild Agitation</i> | (RASS +2 to +3) <i>Moderate Agitation</i> | (RASS +3 to +4) <i>Severe Agitation</i> | (RASS +4) <i>Violent Agitation with Delirium</i> | AGITATION SPECTRUM |
| → These patients are anxious/apprehensive with no aggression. They typically do NOT require medications and should not require restraint. | → These patients are not aggressive but are impeding essential patient care, monitoring, or diagnostics. | → These patients display similar characteristics as those with a RASS 2+ to +3, however are aggressive and a <u>potential</u> danger to self or clinicians. | → These patients are altered, overtly combative or violent, and are actively a danger to self or others. They continue to struggle despite physical restraint. | |
| If non-pharmacological interventions are unsuccessful <ul style="list-style-type: none"> Midazolam Adult - 2.5 mg IV/IO/IM/IN, repeat PRN q 10-min x1 Pedi - 0.05 mg/kg (max dose 2.5 mg) IV/IO/IM/IN, repeat PRN q 10-min x 1 | If non-pharmacological interventions are unsuccessful <ul style="list-style-type: none"> Midazolam Adult - 5 mg IV/IO/IM, repeat PRN q 10-min Pedi - 0.1 mg/kg IV/IO/IM, repeat PRN q 10-min | | | Paramedic |
| | <ul style="list-style-type: none"> Droperidol Adult - 5 mg IV/IO/IM, repeat PRN 2.5 mg q 10-min x1 Pedi - Contact OLMC first 0.05 mg/kg IV/IO IM, repeat PRN q 10-min x 1 | <ul style="list-style-type: none"> Droperidol Adult - 10 mg IM, repeat PRN 5 mg q 10-min x1 Pedi - Contact OLMC first 0.1 mg/kg IV/IO/IM, repeat PRN 0.05 mg/kg (max 5 mg) q 10-min x 1 | <ul style="list-style-type: none"> Request EMS Supervisor Droperidol Adult - 10 mg IM, repeat PRN 5 mg q 10-min x1 Pedi - Contact OLMC first 0.1 mg/kg IM, repeat PRN 0.05 mg/kg (max 5 mg) q 10-min x 1 Ketamine Adult - 4 mg/kg IM x 1 (max single dose 400 mg), repeat PRN 2 mg/kg IM q 10-min x 1 Pedi - Same as Adult | |
| → For patients ≥ 65 years of age, decrease Droperidol to half the original dose. | | | | |
| → Sedation and/or EMS restraints shall NOT be used to assist law enforcement in the detainment of a person without an underlying medical etiology. The decision about sedation that must be made only by the EMS clinician. | | | | |
| → Request EMS Supervisor to the scene for any agitated patient needing physical restraint or in PD custody. | | | | |
| → Evaluate for underlying metabolic/endocrinologic, neurological, infectious, traumatic and toxicological causes. | | | | |
| → For RASS +4: Physical restraint alone is often inadequate to mitigate the potential for continued self-harm and danger to clinicians. | | | | |
| → Frail/elderly patients or young children rarely have violent agitated delirium posing a threat to themselves or others. Thus, they will rarely require ketamine. | | | | |
| → All patients receiving pharmacological intervention shall be transported or OLMC contacted prior to release. | | | | |

Diabetic Emergencies

- Assess blood glucose concentration

If ≤ 60 mg/dl and if conscious/able to tolerate

- High carbohydrate meal
- **Glucose** (Oral)
 - Adult - 15 g buccal
 - Pedi - 7.5 g buccal

Basic

Hypoglycemia: If blood glucose ≤ 60 mg/dl

- **Dextrose 10%** (25 g/250 mL)
 - Adult - 100 mL IV/IO bolus, repeat PRN to 50 g (500 mL)
 - Pedi - 5 mL/kg repeat PRN up to 25 g (250 mL)

Hyperglycemia: If blood glucose ≥ 300 mg/dl

- **Normal Saline**
 - Adult - 250-500 ml IV bolus, repeat PRN to 2 L
 - Pedi - 20 ml/kg IV/IO up to 2 L total

If blood glucose concentration ≤ 60 mg/dl and If IV access cannot be obtained

- **Glucagon**
 - Adult - 1 mg IM
 - Pedi - 0.1 mg/kg IM (max dose 1 mg)

Paramedic

Consider differential diagnosis for hyperglycemia

- Diabetic Ketoacidosis (DKA)
- Hyperosmolar hyperglycemic state (non-ketotic hyperosmolar coma)
- Infection/sepsis
- ACS/MI

Opiate Use Disorder

If approached for Narcan and no clinical complaints

- Provide intranasal leave behind Narcan Rescue kit(s)
- Review instructions for use with patient and/or family
- Document required demographics of those furnished leave behind Narcan

*If known or suspected **opiate intoxication** with respiratory and CNS depression.*

- **Naloxone**
Adult - 2 mg IN (1 mg in each nostril), repeat PRN q 5-min x 1
Pedi - 0.5 mg IN, repeat PRN q 5-min (max total dose 4 mg)

If clinical assessment reveals no life threats and suspected opiate withdrawal

- Perform Clinical Opiate Withdrawal Score (COWS)
*If COWS score is < 8 or **no** patient interest in Buprenorphine treatment*
 - Send referral MIH group
 - Provide Narcan Rescue kit with education
- *If COWS score is ≥ 8 and patient is interested in Buprenorphine treatment, request [EMS Supervisor](#)*
- If patient chooses AMA, provide Narcan Rescue kit

Basic

*If known or suspected **opiate intoxication** with respiratory and CNS depression.*

- **Naloxone**
Adult - 0.5 mg IV/IO, repeat PRN in 0.5 mg increments q 5-min to 4 mg max total dose
Pedi - Same as Adult (max dose 2 mg)

Para-

If COWS score is ≥ 8 and patient is interested in Buprenorphine

- Contact [OLMC](#) for consultation for administration
 - Premedicate as indicated for nausea/vomiting and pain
 - N/V - [Ondansetron](#) 8 mg ODT
 - Pain - [Acetaminophen](#) 1 g PO
 - [Buprenorphine / Suboxone*](#)
Adult - 8-24 mg buccal (SL strips or tabs) per physician order
Repeat 8-16 mg (max 32mg) PRN COWS score >8 or symptoms not resolved q 15 minutes x 1
Second and subsequent day doses covering weekend and holiday periods will be based on previous effectiveness

CCP

If precipitated withdrawal

- Contact [OLMC](#) immediately
- [Normal Saline](#) 500 mL IV fluids bolus
- [Ondansetron](#) 8 mg IV or ODT PRN nausea (max total dose 16 mg)
- [Diphenhydramine](#) 25-50 mg IV PRN anxiety/abdominal cramps (Max total dose 75 mg)
- As directed by [OLMC](#) - [Buprenorphine](#) 8-16 mg (Max total dose 32 mg)

- No limit to the number of boxes of Narcan that can be left behind
- Advise patients/family during reviewing of use that 911 must still be called as the opiate effects can return when Narcan wears off
- If patient meets Criteria for enrollment into the MAT Program, the medication will be provided at No Cost for the first 60 days
- Exclusion for Suboxone administration does not mean patient cannot be referred to Rehab or Treatment

* Suboxone is buprenorphine + naloxone and the naloxone is chemically inactive when taken SL/oral. Either is acceptable and supply may vary based on availability. Dosing is the same between the two agents."

Seizure/Status Epilepticus

- Position patient to avoid injury and aspiration, consider recovery position

If not returned to baseline, evaluate blood glucose and consider [Diabetic Emergencies](#)

Basic

If actively seizing, or in status epilepticus (≥ 2 -seizures and without intervening lucid period),

- [Midazolam](#) IM midazolam is the first line route of administration if an IV not already established
Adult - 10 mg IM/IN; or 5 mg slow IV/IO, repeat PRN q 5 min x 2
Pedi - 0.15 mg/kg slow IV/IO/IM (max dose 2.5 mg), repeat q 5-min PRN x 1

*If post-ictal and not actively seizing or not in status epilepticus, pharmacologic therapy with midazolam is **not indicated***

If refractory despite maximum midazolam,

- [Ketamine](#)
Adult - 1 mg/kg IV/IO
Pedi - Same as Adult

If suspected eclampsia/peripartum seizure, see [Pre-Eclampsia / Eclampsia](#)

Paramedic

- Consider toxicologic causes of seizure
 - Organophosphate/nerve gas (see chemical warfare policy)
 - Sympathomimetic toxidrome (stuffers/packers, methamphetamine)
- Anticipate that dispatch or initial clinical picture of seizure may be initial presentation cardiac arrest
- Most confused patients following a seizure do not need treatment. Monitor for up to 15-minutes before considering intervention or determining a disposition.
- Always consider eclampsia in 3rd trimester pregnancy or up to 6 weeks post-partum.

Stroke/CVA/TIA

- Assess blood glucose
 - If ≤ 60 mg/dl, see [Diabetic Emergencies](#)
- Complete **Initial** Stroke Screen (Modified Cincinnati Prehospital Stroke Scale)
 - Facial Droop
 - Arm-Pronator Drift
 - Speech/language (dysarthria or aphasia)
 - Time patient was last seen prior to onset of symptoms required

If initial stroke screen is positive (any of 3-criteria):

- Complete LAMS evaluation

If symptom onset within 24-hours, and

LAMS 4+

- Transport to closest Comprehensive Stroke Center (CSC)

LAMS 0-3

- Transport to closest Stroke Center (Primary or CSC)

If symptom onset greater than 24-hours

- Transport to closest Stroke Center (Primary or CSC)

- Bedside Stroke Alert to receiving facility, as appropriate

| Los Angeles Motor Score (LAMS) | | |
|--------------------------------|-----------------|---------------|
| Facial Droop | Arm Drift | Grip Strength |
| Absent 0 | Absent 0 | Normal 0 |
| Present 1 | Drifts down 1 | Weak grip 1 |
| | Falls rapidly 2 | No grip 2 |

→ Consider posterior stroke in patients with acute imbalance with inability to walk straight without other cause. This is not a Stroke Alert; however, these findings need to be included in your bedside report at the ER.

Syncope is a brief loss of consciousness and postural tone that resolves spontaneously with return to baseline neurological function quickly.

- [12-lead ECG](#)
- Assess orthostatic pulse and blood pressure, as tolerated

- Cardiac monitoring; treat dysrhythmias

If hypotensive / hypovolemia, see [Circulatory Support](#)

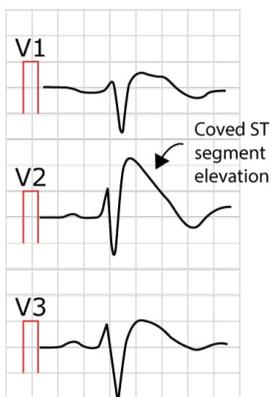
Basic

Para-

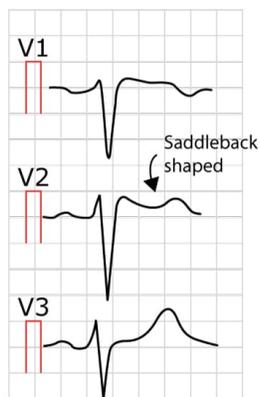
Consider causes of presyncope/syncope:

1. Subarachnoid hemorrhage / ICH
2. Aortic stenosis: *loud murmur with exertional syncope*
3. Ectopic pregnancy
4. Vasovagal
5. Orthostasis
6. Tachydysrhythmias
7. Bradydysrhythmias and Heart Blocks
8. Wolff-Parkinson-White (WPW): *short PR, prolonged QRS, and a delta wave*
9. Brugada Syndrome: *RSR' similar to a right bundle block and ST elevation in the anterior leads*
10. Hypertrophic Cardiomyopathy (HCM): *high voltage and narrow ("needle-like", <20 milliseconds/one small box) q waves in the lateral (V5-aVL) and possibly inferior leads; may also have left atrial enlargement, ischemic-appearing ECG, tall R wave in V1*
11. Long or Short QT interval: *QTc < 300 (autosomal dominant inheritance) or > 500*
12. Arrhythmogenic Right Ventricular Dysplasia (ARVD): *epsilon waves ± T-wave inversions in leads V1-V3*
13. Miscellaneous: *(PE, right-sided heart strain; electrolytes, ICH, etc.)*

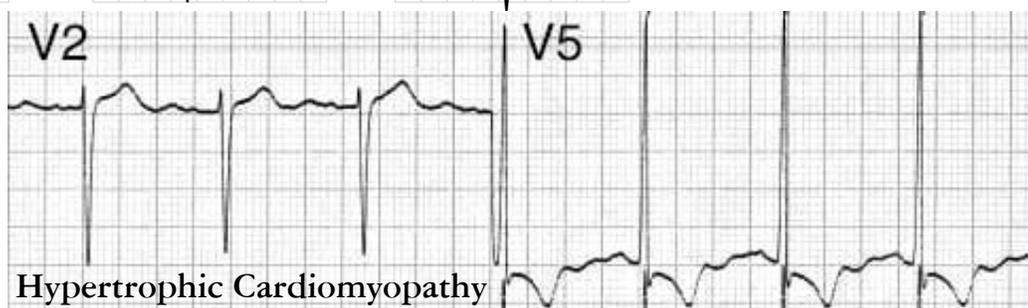
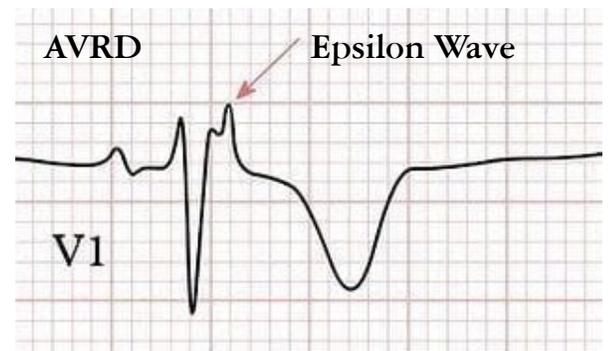
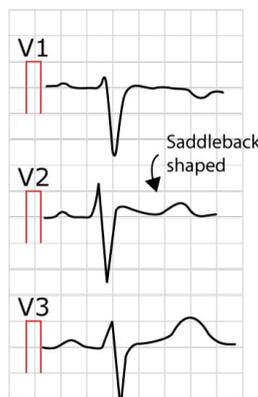
A Type 1 Brugada



B Type 2 Brugada



C Type 3 Brugada



Hypertrophic Cardiomyopathy

Medical Toxicology

Basic

If suspected exposure to toxic agent.

- Remove patient from environment if safe/trained/equipped (PPE) to do so
- Ensure appropriate decontamination

If known or suspected **opiate intoxication**, see [Opiate Use Disorder](#)

If **carbon monoxide (CO) exposure**.

- Consider with CO levels above 5% in non-smoker or 10% in a smoker if available
 - High flow O₂ by NRB+ HFNC (as available) 15 LPM each

If **caustic ingestion**

- Do not induce vomiting or allow the patient to eat or drink

If **tachycardia associated with sympathomimetic intoxication** (e.g., cocaine, amphetamine, MDMA),

- [Midazolam](#)
Adult - 2.5-5.0 mg slow IV/IO or 5 mg IM/IN, repeat PRN q 5 min (max total dose 10 mg)
Pedi - 0.05 mg/kg (max dose 2.5 mg) IV, repeat PRN q 5 min x 1

If **dystonic reaction**.

- [Diphenhydramine](#)
Adult - 50 mg IV/IM/IO
Pedi - 1 mg/kg (max dose 50 mg)

In suspected **cyanide poisoning** (smoke inhalation, dermal or ingestion exposure) **AND** if altered mental status, hemodynamic instability, or cardiac arrest,

- If available, [Hydroxocobalamin](#) (5 g / 200 mL NS) over 15-minutes through a dedicated IV/IO; contact [OLMC](#) following initial dose
Adult - 5 g IV/IO, repeat PRN x 1
Pedi - 70 mg/kg IV/IO, repeat PRN x 1

Consider the following **toxidromes/treatments**:

Tricyclic Antidepressant (TCA)

- [Sodium Bicarbonate](#)
Adult - 1 mEq/kg IV/IO, (max dose 100 mEq)
Pedi - Same as Adult

Beta-blocker

- [Glucagon](#)
Adult - 1 mg IV/IO slow push over 1-minute, repeat PRN q 5 min x 1
Pedi - 0.1 mg/kg IV/IO, slow push over 1-minute (max single dose 1 mg), repeat PRN 0.2 mg/kg IV/IO x1

Calcium Channel Blocker

- [Calcium Chloride](#)
Adult - 1 g IV slow push
Pedi - 20 mg/kg (0.2 ml/kg) IV/IO, slow push (max dose 1 g)

Organophosphate

- [Atropine](#) *
Adult - 2 mg IV/IO, repeat PRN q 3 min until secretions dry up
Pedi - 0.02 mg/kg IV/IO/IM, repeat until secretions dry up

Paramedic

- SpO₂ may be a poor indicator of severity in CO poisoning; therefore, regardless of SpO₂, always treat the patient
- Toxidromes secondary to toxic substances or to toxic doses of common medications may result from exposure in the form of ingestion, inhalation, injection, skin absorption
- Dystonias may result from a number of psychiatric and GI medications, including droperidol, haloperidol, fluphenazine, fluoxetine, duloxetine, sertraline, metoclopramide
- * A true organophosphate poisoning is almost certainly going to require more atropine than can reasonably be stocked on any given response unit. These cases will also have many additional units responding. Use all atropine needed from additional units.

Tracheostomy Emergencies

- Look, listen, and feel at the mouth and tracheostomy for air movement
- Place non-rebreather mask to tracheostomy, and to mouth (unless history of laryngectomy)
 - Titrate O₂ to SpO₂ ≥ 94% or work of breathing
- Reposition airway in slight extension (unconscious), or upright (conscious)
- Respiratory monitoring required (in-line EtCO₂ and SpO₂) if equipped
- Obtain tracheostomy history (e.g., age of tracheostomy, laryngectomy)
 - If unable to determine if laryngectomy, assume upper airway patent

Tracheostomy Respiratory Distress/Failure

- Assume all acute distress or respiratory failure to be dislodgement or obstruction until proven otherwise
- Remove all accessory items (valves/caps) and stoma padding (if present)
- Perform 3 C's, reassess patient condition and SpO₂/EtCO₂ after each step

Cannula

- Remove inner cannula and inspect for obstruction (do not discard)

If obstructed with secretions

- Consider rinsing with saline or tap water, may use 3 ml syringe/suction catheter to “pressure wash”

Catheter

- Attempt to pass suction catheter down tracheostomy

If suction passes and tracheostomy patent

- Perform suctioning and consider partial obstruction

Cuff

If unable to pass suction

- Deflate tracheostomy cuff (if present)

If no improvement after 3 C's

- Remove tracheostomy tube and reassess

If respiratory distress, see [Respiratory Support](#)

If Acute Respiratory Insufficiency/Failure or chronic mechanical ventilation, and patent airway

- Assist ventilation with bag-valve-mask (BVM) to face; cover stoma with gloved hand or gauze

If laryngectomy or unable to ventilate via face

- Assist ventilation with pediatric BVM mask to stoma; if no laryngectomy, may need to close mouth/nose

Tracheostomy Hemorrhage

- Obtain history to determine likely source of bleeding (skin, pulmonary, GI, potential trachea)
- Strongly advocate for transport for even small volume tracheostomy bleeding

If rapid and massive hemorrhage from tracheostomy (suspected tracheo-innominate artery fistula)

- Apply oxygen or BVM to face
 - Apply external digital compression with index finger at sternal notch (do not delay cuff inflation below)
 - Immediately inflate trach cuff to 50 ml

Tracheostomy Respiratory Distress/Failure

If no distress/failure and tracheostomy exchange or replacement required, see [Tracheostomy Replacement/Exchange Procedure](#)

If no improvement

If tracheostomy less than 7-days since initial placement

- Do not attempt tracheostomy replacement or stoma intubation, manage with BVM

If tracheostomy ≥7-days since initial placement, see [Tracheostomy Replacement/Exchange Procedure](#)

- If unable or replacement/backup unavailable, consider intubation of stoma with 6.0 ETT

If unable ventilate or exchange trach or place stoma

- Consider orotracheal intubation (unless laryngectomy)

Tracheostomy Hemorrhage

If uncuffed tracheostomy

- Consider exchange for 6.0 ETT using bougie

If continued severe bleeding

- Consider orotracheal intubation OR remove tracheostomy and intubate stoma
- Once ETT in place (oral or stoma), consider insertion of finger in stoma to apply direct compression of vessel into sternum

If significant hemorrhage and SBP ≤ 90 or HR ≥ 110 with poor perfusion, see [Hemorrhage Control](#)

Environmental



Environmental

Bites/Envenomation

- On patient, document time and mark leading edge of skin changes, pain, and/or tenderness

If bite involves extremity

- Remove all jewelry
- Immobilize affected limb at or above the level of the heart
- Do not tightly wrap the affected limb

If stinger is present

- Attempt to brush away with edge of card
Do not disturb the wound site

Consider other protocols as appropriate:

[Allergic Reaction/Anaphylaxis](#)

[Circulatory Support](#)

Hyperthermia/Heat Stroke

- Remove patient from high temperature environment

If **Mild** symptoms: heat cramps or heat exhaustion; no signs of altered mental status (AMS); temperature $\leq 104^\circ F$

- Passive cooling (loosen clothing, fanning)

If available

- PO fluids (use caution if nausea/vomiting)

If **Severe** symptoms: heat stroke (AMS and temperature $\geq 104^\circ F$)

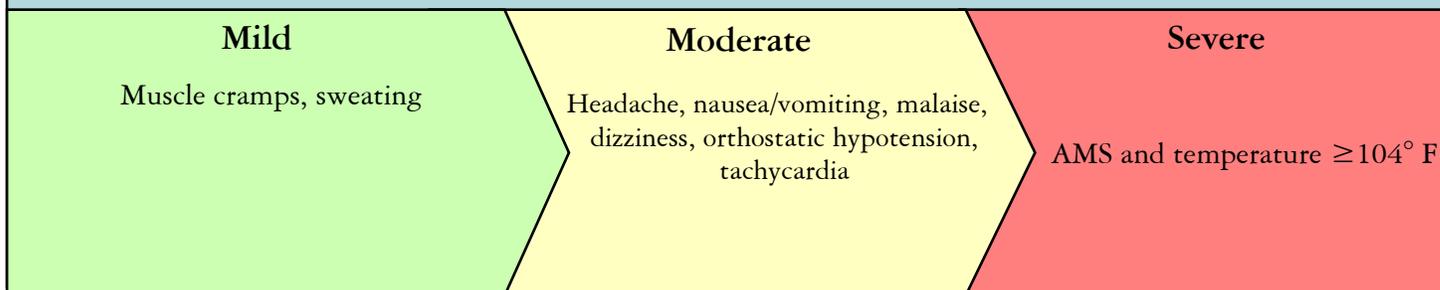
- Begin active cooling
 - Use sheets/towels dipped in ice water directly on skin
 - Ice packs to core (trunk/abdomen)
 - Request [EMS Supervisor](#) for [Cold Water Immersion](#)

If shivering begins, mental status improves, or temperature $\leq 102^\circ F$

- Cease active cooling measures

If ice water immersion is in progress, do not remove patient until temperature $\leq 102^\circ F$

Basic



If hypotensive, see [Circulatory Support](#)

If uncontrolled shivering occurs during cooling

- [Midazolam](#)
 - Adult - 2.5 mg IV/IO/IN
 - Pedi - 0.05 mg/kg IV/IO or 0.1 mg/kg IM/IN
 - Repeat PRN q 5-min (max total dose 2.5 mg) x 1

Paramedic

→ Sweating may or may not be present with heat stroke

Maintain high index of suspicion for heat-related illness if the any of following risk factors are present:

- Elderly
- Psychiatric medication
- Cardiovascular medications (e.g., diuretics, antihypertensives)

Consider other protocols, as appropriate:

- [Seizures/Status Epilepticus](#)
- [Toxicology](#)
- [Circulatory Support](#)
- [Altered Mental Status](#)
- [Diabetic Emergencies](#)

Environmental Hypothermia

- Remove patient from cold environment, dry and insulate
 - Handle the patient gently, consider scoop stretcher (excessive movement may induce ventricular fibrillation)
 - Remove wet clothing
 - Assist passive warming with blankets and/or heat packs for comfort

- 12-lead ECG

If severe symptoms/signs: AMS, unstable, dysrhythmia, and/or temperature $\leq 90^{\circ}$ F

- Actively warm patient with heat packs to neck, groin, and axillae
- Carefully assess vital signs, as they may be diminished but adequate

If patient is in cardiac arrest, and AED advises shockable rhythm

- Administer one defibrillation (no further defibrillation until temperature $\geq 90^{\circ}$ F)

- IV access, as appropriate; warm IV fluids if possible, consider 500 ml NS IV/IO rapid bolus for hypotension, Repeat PRN up to 2 L total

If patient is in pulseless ventricular tachycardia/ventricular fibrillation and not previously defibrillated

- Administer one defibrillation (no further defibrillation until temperature $\geq 90^{\circ}$ F)
- Do not terminate resuscitation

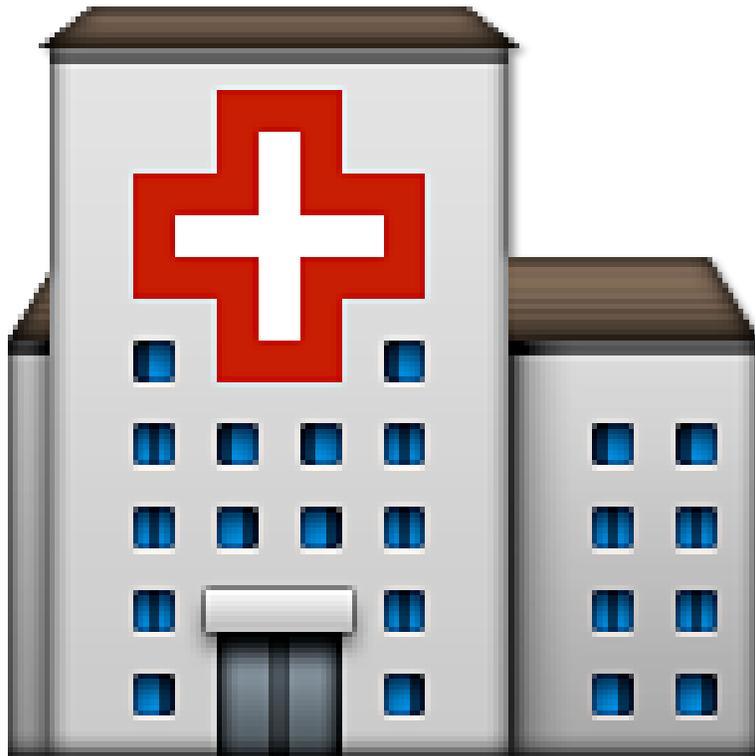
If symptomatic bradycardia (carefully assess vital signs, as they may be diminished but adequate)

- Initiate pacing only for temperature $\geq 90^{\circ}$ F

Basic

Paramedic

Trauma



Amputated Body Part

- [Hemorrhage Control](#)
- Cover the stump with saline-soaked sterile dressing and wrap with dry dressing
- Wrap severed part in saline-moistened sterile dressing
 - Place in watertight plastic bag
 - Place bag in cooler with ice, if possible
 - Do not freeze
 - Do not macerate/soak in water
 - Transport amputated body part with patient or to the same Emergency Department as the patient as soon as feasible

[Acute Pain Management](#), as appropriate

If hypotension, see [Circulatory Support](#)

Basic

Para-

Burns

Assist airway, as appropriate

- Titrate O₂ to SpO₂ ≥ 94% or work of breathing

If suspected carbon monoxide (CO)

- Ensure scene safety, and remove patient from toxic environment
- High flow O₂ by NRB + NC (15 lpm)

If potential for ongoing burning

- Brush dry chemicals then flush with water
Initiate decontamination, as appropriate
- Remove clothing/jewelry (affected area and distal to burn)
- Flush eyes with copious amounts of water, as appropriate
- Apply dressings to burns
 - ⇒ If ≤ 10% BSA, use moist dressings
 - ⇒ If ≥ 10% BSA, use dry burn sheet or dry sterile dressing and insulate to prevent hypothermia

- Advanced airway management, as appropriate

Maintain high index of suspicion for inhalation injury

Stridor, muffled voice, singed facial/nasal hair, carbonaceous sputum

- Cardiac monitoring and 12-lead ECG for electrical burns
- IV access, as appropriate; consider 500 ml NS IV/IO rapid bolus for hypotension, repeat PRN up to 2 L total

If ≥ Partial thickness burn (≥10% BSA), fluid resuscitation as follows:

Adult - 500 ml/hr NS IV/IO

3-14 years - 250 mL/hr NS IV/IO

0-3 years - 125 mL/hr NS IV/IO

- Acute Pain Management, as appropriate

If severe symptoms/signs (≥ 10% BSA partial thickness, full-thickness, circumferential, involvement of face/hands/feet/genitals, significant-chemical or electrical burns, or airway involvement)

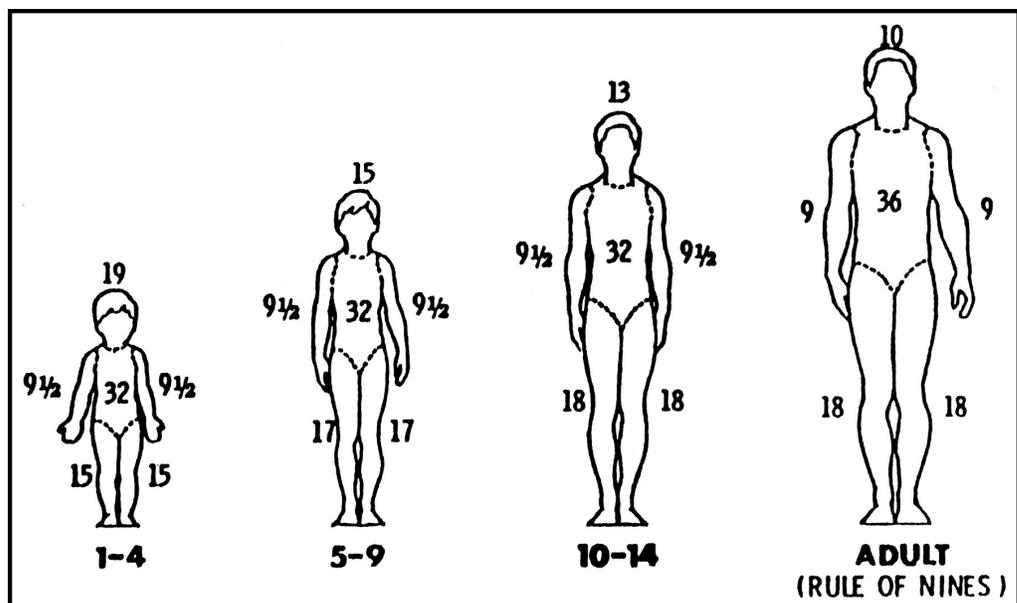
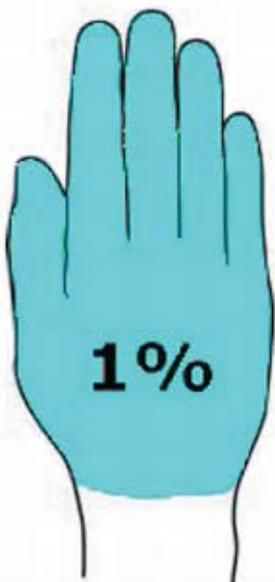
- Provide notification and transport to nearest burn center

If unsecured airway

- Transport to the closest full-service hospital

Basic

Paramedic



Entrapment/Crush/Traumatic Rhabdomyolysis

- Bleeding control (direct pressure, tourniquet)
- Remove constricting clothing, jewelry

Field Amputation

If anticipated prolonged entrapment/extrication, and if potential for worsening of patient condition in the absence of extrication,

- Contact [OLMC](#) to activate field amputation process

Basic

- Cardiac monitoring, [12-lead ECG](#)

- IV access,

Adult - NS 20 ml/kg bolus

Pedi - Same as Adult

- [Acute Pain Management](#), as appropriate

If ECG findings of hyperkalemia (peaked T-waves, wide QRS), contact [OLMC](#) following initial dose

- [Calcium Chloride](#)

Adult - 1 g IV/IO, slow push

Pedi - 20 mg/kg (0.2 mL/kg) IV/IO, slow push (max dose 1 g)

- [Sodium Bicarbonate](#)

Adult - 1 mEq/kg IV/IO (max dose 100 mEq)

Pedi - same as Adult

Paramedic

Trauma

General Trauma

- As appropriate:
 - [Hemorrhage Control](#)
 - [Airway management](#)
 - [Circulatory Support](#)
 - [Prehospital Blood Administration](#)
 - [Acute Pain Management](#)
 - [Amputated Body Part](#)
 - [Spinal Motion Restriction](#)
- Keep patient warm
- See [Trauma Transport Guidelines](#)

If cardiac arrest, see [Traumatic Circulatory Arrest](#)

If suspected tension pneumothorax with hypotension, see [Needle Thoracostomy Procedure](#)

If hypotensive, see [Circulatory Support](#)

Basic

Paramedic

Basic

Basic

Eye Injury

If isolated eye injury

- Irrigate with NS if result of chemical burn (if appropriate to agent)
- Cover unaffected eye/stabilize impaled object

If suspected ocular injury

- Do not delay transport

If outside socket

- Cover with NS soaked gauze

Head/Neck Injuries

- Spinal Motion Restriction
- Maintain $\geq 94\%$ SpO₂ at all times

If respiratory failure

- Ventilate at a rate of 10 bpm, or to maintain EtCO₂ 35-45 mmHg

Chest Injuries

- Hemorrhage Control
- Stabilize impaled objects
- Stabilize flail segments

If suspected open pneumothorax

- Partial occlusive dressing

Abdominal/Pelvic Injuries

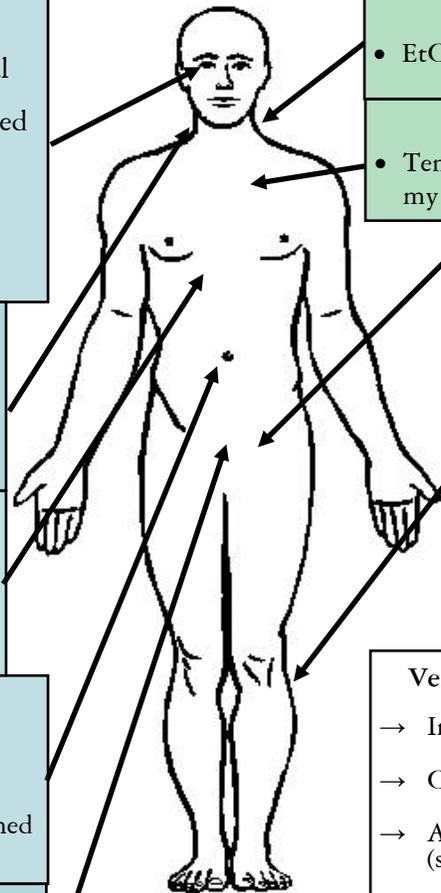
- Control bleeding
- Pelvic binder
- Stabilize impaled objects
- Evisceration— cover with saline moistened gauze

Pregnancy Considerations

- Left lateral recumbent (LLR) position

If signs of poor cardiac output

- Manual fundus displacement (to left)



Head/Neck Injuries

- EtCO₂ between 35-45 mmHg

Chest Injuries

- Tension Pneumothorax— Needle thoracostomy

Junctional/Extremity Injuries

- Hemorrhage Control (direct pressure, tourniquet)

If bleeding uncontrolled by tourniquet

- Pack wound tightly with hemostatic gauze and kerlix gauze
- Splinting, as appropriate
- Sterile dressing— open fractures
- Care for Amputated Body Part

Ventilation Rates for Pediatric Head Injuries

- Infants (0-24 months) 25 breaths per minute
- Children (2-14 years) 20 breaths per minute
- Adolescents (15-17 years) 10 breaths per minute (same as adult)

Blood Pressure Goals for Pediatric Head Injuries

- 0-2 years of age
SBP of 70
- 2-10-years of age
SBP = 70 +(age in years x 2)
- 10 years of age or greater SBP of 90

Spinal Motion Restriction

If penetrating trauma (including to the neck and/or spine with or without neurological deficit)

- Do not initiate **Spinal Motion Restriction** procedure

If any of the following findings are present: History criteria, midline tenderness, pain or paresthesias on external rotation

- Initiate **Spinal Motion Restriction** procedure

Spinal motion restriction may be deferred ONLY IF ALL OF THESE FINDINGS ARE ABSENT

History

- Age ≤ 12 or ≥ 65
- Limited ability to sense or communicate pain
AMS, LOC, intoxicated, head trauma, language barrier, mental retardation
- Distracting injury
Long bone fracture, visceral trauma (abdomen, pelvis), large laceration, crush injury, large burn
- Neurologic deficit
Motor/sensory loss or paresthesia
- Dangerous mechanism of injury
Fall ≥ 3 -feet or 5-stairs
Axial loading injury to the head (diving accident/sports injury)
Vehicular accident
 - High speed motor vehicle accident ≥ 60 mph*
 - Motorized recreational vehicle accident*
 - Ejection*
 - Bicycle collision with immobile object (tree, parked car)*
 - Struck by large vehicle*
 - Roll-over*

Palpation

- Midline cervical tenderness

Active Range of Motion Test

- Patient is able to actively rotate neck 45° both to left and right with no pain, paresthesia or motor deficit

If any pain or paresthesia upon rotation, IMMEDIATELY TERMINATE RANGE OF MOTION TEST

If patient unable to tolerate spinal motion restriction

- Attempt less restrictive means (c-collar only) or use position of comfort and/or allow patient to self-splint

Trauma Transport Guidelines

Major trauma patients may need to be transported to a designated trauma center in a timely manner. It is in the best interest of the patient to be transported to a designated trauma center if the patient meets certain criteria.

If any of the following criteria are present,

- Transport to the closest age appropriate Trauma Center (Level 1 or 2):

| Injury Pattern | Mental Status & Vital Signs |
|---|--|
| <ul style="list-style-type: none"> → Penetrating injury (e.g. GSW, stabbing) to head, neck, torso, upper arm, thigh → Skull deformity, suspected skull fracture → Suspected spinal injury with new motor or sensory loss → Chest wall instability, deformity, or suspected flail chest → Suspected pelvic fracture → Suspected two or more proximal long-bone fractures → Crushed, degloved, mangled, or pulseless extremity → Amputation proximal to wrist or ankle → Active bleeding requiring a tourniquet or wound packing | <ul style="list-style-type: none"> → Unable to follow commands (motor GCS <6) → Age 0-9: SBP < 70 + (2 x age years) → SBP < 90 (or relative hypotension) → Age ≥ 65 AND SBP ≤ 110 → HR > SBP (shock index of ≥ 1) → RR < 10 or > 29 → Respiratory distress or need for assisted ventilation (e.g. BVM, SGA, ETT) → Room air pulse oximetry ≤ 90% |

If any of the following criteria are present,

- Transport to the closest age appropriate Trauma Center (Level 1, 2, 3, or 4):

| Mechanism of Injury | Risk Factors |
|---|--|
| <ul style="list-style-type: none"> → Fall from height > 10 feet → MVC with: <ul style="list-style-type: none"> Partial or complete ejection Significant intrusion (including roof), with any: <ul style="list-style-type: none"> > 12 inches occupant side > 18 inches any site Need for extrication of an entrapped patient → Child (0-9) unrestrained or in an unrestrained child safety seat → Death in same passenger compartment → Vehicle telemetry data consistent with severe injury → Rider separated from transport vehicle with significant impact (e.g. motorcycle, ATV, horse, etc.) → Pedestrian or bicycle rider thrown, run over, or with significant impact | <ul style="list-style-type: none"> → Low-level falls in children (age ≤ 5) or older adults (age ≥ 65) with significant head impact → Anticoagulant use → Special, high-resource healthcare needs (chronic ventilator dependency, ventricular assist device) → Suspicion for child abuse → Pregnancy > 20 weeks → Burns in conjunction with trauma |

Pearls & Pitfalls:

- Amputations distal to wrist/ankle may be evaluated at closest Trauma Center

Traumatic Circulatory Arrest

• DO NOT INITIATE MOVEMENT OF THE PATIENT

If suspicion of non-traumatic cause

- Proceed with [Cardiac Arrest](#) protocol

If traumatic cause

- Consider [Withholding Resuscitative Efforts](#)
- Initiate CPR and place pads
- Rapidly and simultaneously address reversible pathology (H.O.T.T.)

Basic

Hemorrhage

Oxygenation

Tension / Tamponade

- Promptly expose patient

If catastrophic hemorrhage or hemorrhagic shock with suspected pelvic fracture, see [Hemorrhage Control](#)

- BVM or,
- Immediate SGA

If clinical suspicion

- [Needle Thoracostomy](#)
- [Simple Thoracostomy](#)
- [Pericardiocentesis](#)
- [POCUS](#)

Paramedic

GOAL: Catastrophic hemorrhage intervention, oxygenation and confirmed ventilation via EtCO₂, and evaluation +/- treatment for tension pneumothorax

ROSC?

Yes

No

- Prioritize rapid transport while optimizing patient hemodynamics, oxygenation, and ventilation
- Hospital pre-notification ASAP

If significant traumatic or OB related hemorrhage, see [Hemorrhage Control](#)

- After the following resuscitative efforts*:
 - Hemorrhage control interventions
 - Oxygenation
 - Ventilation with confirmed EtCO₂ waveform
 - +/- Thoracostomy / Pericardiocentesis
- Contact [OLMC](#) for termination

CCP

Pearls:

- After in-person assessment by the [EMS Supervisor](#) and prior to ALS interventions, if withholding criteria is present and patient is in asystole, resuscitation efforts can stop.
- Patient may be moved for scene conditions or safety.
- Chest compressions offer very low probability of benefit in traumatic arrest, but public expectation exists for its performance. As a result, perform CPR, however do not allow compressions to interrupt attempts to address treatment goals.
- Interventions must be completed prior to MCD placement if transport is indicated.
- Epinephrine or other medications offer very limited benefit in traumatic arrest: therefore, they are not indicated.
- * There is no minimum resuscitation time required before considering termination, only achievement of treatment goals.
- There is almost no benefit to transport of traumatic cardiac arrest. Transport in absence of ROSC should be rare.
- Despite traumatic event, consider potential for medical cause of arrest, including AMI or commotio cordis.

OB/GYN

Emergency Childbirth

- Administer O₂ and titrate to SpO₂ ≥ 94%
- Check for presentation (crowning, limb, breech, cord) and follow procedures, as below

If crowning

- Emergency Childbirth Procedure

If nuchal cord,

- If cord is loose around the neck: Attempt to gently slip cord over infant's head
- If cord is tight around the neck: Clamp cord × 2 (2-inches apart), cut between clamps

If cord presentation

- Position mother in Trendelenburg or in the knee-to-chest position
- Instruct the mother to pant with each contraction
- Gently push presenting fetal part upward off and into the birth canal
- Maintain hand position so as to maintain cord pulse
- Do not attempt to reposition if the cord retracts
- Apply moist sterile dressing to cord

If breech presentation, see [Emergency Childbirth Procedure: breech presentation](#)

If single limb, rapid transport

If premature birth

- [Emergency Childbirth Procedure](#)
- Dry and cover newborn (start with head, then body)
Cover head and wrap body use dry liner and foil
- Administer blow-by oxygen (humidified, if available) avoid direct O₂ flow into neonate's face
- Minimize family member contact with neonate
- Once delivery complete, see [Newly Born](#)

If uterine inversion

- DO NOT ATTEMPT TO REMOVE PLACENTA
- Apply pressure to fundus upward through cervix, use fingertips and palm of gloved hand
- Cover with sterile moist dressing if unsuccessful

If suspected pre-eclampsia or eclampsia, see [Pre-eclampsia/Eclampsia](#)

If postpartum hemorrhage

- Aggressive fundal massage
- See [Hemorrhage Control](#)

Newly Born

- Assess and document APGAR score at 1-minute and 5-minutes after birth
 - Warm, dry, and stimulate infant.
 - Clear secretions as needed
 - Assess breathing pattern and palpate pulse rate
 - If apneic, gasping, or HR < 100 bpm*
 - Begin assisted ventilation with a BVM without supplemental oxygen at rate 40-60 breaths per minute
 - If HR < 60 despite 30-seconds of confirmed BVM ventilation*
 - Begin CPR, 3:1 compressions-ventilation, 120 bpm
 - If labored breathing or persistent cyanosis*
 - Position and clear airway
 - Supplemental oxygen as needed
 - Begin SpO₂ monitoring (place on right hand)
- Goal timeframe ~1 minute

Basic

- If HR < 100 despite BVM*
- Ensure effective ventilation with BVM (chest rise and fall, waveform capnography)
 - Invasive airway management, if necessary
- If HR < 60 despite 60-seconds of CPR*
- IV/IO access
 - **Epinephrine 1:10,000** - 0.01 mg/kg IV q 5-min
- If failure to respond to epinephrine and suspected hypovolemia*
- **NS** - 10 ml/kg slow IV/IO push (max dose 50 ml), push over 10 minutes
- If blood glucose < 50*
- **Dextrose 10%** (25 g/250 ml) - 2 ml/kg IV/IO bolus
 - Initiate transport

Paramedic

- SpO₂ slowly increases within the first 10 minute post-birth (see chart)
- Routine suctioning for meconium is generally not indicated.
- Intraosseous access is only suitable for term infants > 3kg, and requires a slightly more distal approach than in older children
- Prevent hypothermia

| Targeted Procedural SpO ₂ | |
|--------------------------------------|--------|
| 1 min | 60-65% |
| 2 min | 65-70% |
| 3 min | 70-75% |
| 4 min | 75-80% |
| 5 min | 80-85% |
| 10 min | 85-95% |

| APGAR | 0 | 1 | 2 |
|--------------------|-------------|------------------|--------------------------|
| Appearance | Blue/pale | Blue extremities | Good color |
| Pulse | Absent | ≤100 | ≥100 |
| Grimace | No response | Weak cry | Strong cry |
| Activity | None | Some | Flexed arms/legs |
| Respiratory Effort | Absent | Weak/gasps | Strong (with strong cry) |

Pre-Eclampsia / Eclampsia

- Pre-Eclampsia is present in patients between 20 weeks gestation and 6 weeks postpartum with:
- SBP \geq 140 or DBP \geq 90 with severe features*
 - or
 - SBP \geq 160 or DBP \geq 110 regardless of symptoms
- Eclampsia should be considered present for all tonic-clonic seizures in pregnancy or post-partum patients

Basic

If SBP \geq 140 or DBP \geq 90 with Severe Features confirmed by correctly fitted cuff on 2 readings 5 minutes apart

- Magnesium Sulfate (10g / 250mL NS) bolus 6 g IV/IO over 15 min; followed by 2 g/hr infusion
 - Bolus: rate = 648 mL/hr; total volume = 150
 - Infusion: rate = 50 mL/hr

If SBP \geq 160 or DBP \geq 110 confirmed by correctly fitted cuff on 2 readings 5 minutes apart

- Nifedipine 10 mg SL
- Magnesium Sulfate (10g / 250mL NS) bolus 6 g IV/IO over 15 min; followed by 2 g/hr infusion
 - Bolus: rate = 648 mL/hr; total volume = 150
 - Infusion: rate = 50 mL/hr

If suspected eclamptic seizure

- Midazolam as per Seizure protocol (only for ongoing seizure)
- Magnesium Sulfate (10g / 250mL NS) bolus 6 g IV/IO over 15 min; followed by 2 g/hr infusion
 - Bolus: rate = 648 mL/hr; total volume = 150
 - Infusion: rate = 50 mL/hr
(administered even if seizure stops)

Paramedic

If maternal HR is $>$ 60 and SBP \geq 160 or DBP \geq 110 confirmed by correctly fitted cuff on 2 readings 5 minutes apart and severe symptoms described above are present

- Labetalol 20mg IV over 2 minutes, repeat 40 mg IV PRN q 10 minutes

CCP

*Severe Features: new onset headache, visual changes, or RUQ pain

Procedures

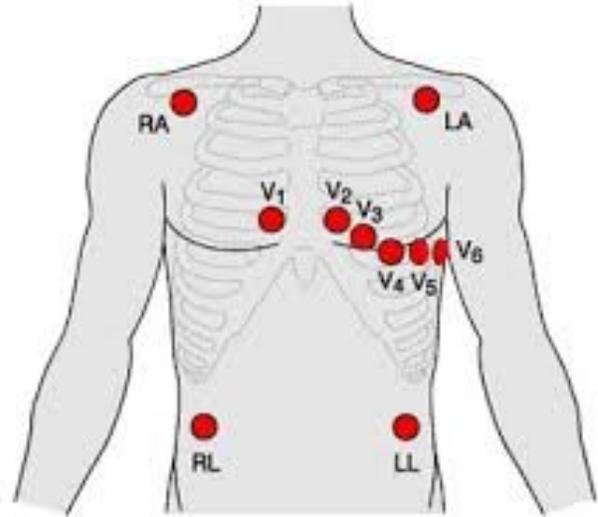
PROCEDURES

12-Lead ECG

Indications:

- Complaints of chest pain or atypical symptoms suggestive of ACS (nausea, palpitations, SOB, dizziness, syncope, weakness)
- Electrical Injuries
- Suspected cardiotoxic overdose
- Suspected severe electrolyte derangement
- Cardiac arrhythmia

- Attach patient to monitor
 - Shave chest (as necessary)
 - Apply electrodes
- Enter demographic information (age, first/last name, DOB)
- Transmit ECG to the receiving ED
- Download/Attach ECG to the PCR



Lead Placement Reference

RA – Right Arm
LA – Left Arm
RL – Right Leg
LL – Left Leg

V1 – 4th intercostal space at right sternal border
V2 – 4th intercostal space at left sternal border
V3 – Directly between V2 and V4
V4 – 5th intercostal space at mid-clavicular line
V4R – Right 5th intercostal space at mid-clavicular line
V5 – Level with V4 at left anterior axillary line
V6 – Level with V5 at left mid-axillary line

- Obtain serial 12-lead ECGs
- Continuously monitor ECG

If meets ST segment elevation MI (STEMI) criteria

- Transmit to STEMI facility
- STEMI Alert (*patient is believed to need emergent PCI*)
 - 2 or more continuous leads with:
 - STE ≥ 1 mm limb leads with reciprocal depression and/or
 - STE ≥ 2 mm precordial leads with reciprocal depression and/or
 - Relative STE ≤ 1 mm with reciprocal changes with QRS voltage ≤ 5 mm

If STEMI criteria met

- Transport to STEMI facility or call for advanced intercept

If any other interpretation

- Transport per Patient Destination Policy

Basic

Paramedic

Assisted Ventilation/Bag Mask Ventilation

Indications:

- Hypoxia uncorrected by passive high FiO_2
- Ineffective minute ventilation
- Respiratory insufficiency/failure
- BVM ventilation

Contraindications:

- Mask– inability to obtain a mask seal
- Oral/Facial/mandibular disfigurement
 - Edentulousness with/without emaciation

Pearls & Pitfalls:

If mask ventilating

- Ensure EtCO_2 waveform for every breath
- Reposition patient head if no waveform
- Do not utilize BURP/Sellick's maneuver to prevent gastric filling
- Position ETSN with 2-hand mask seal to prevent gastric filling

If advanced airway

- Ensure EtCO_2 waveform for every breath
- After initial placement confirmation, avoid excessive ventilation rates/pressures
- Be vigilant for tube migration/dislodgment the duration of placement and for all patient moves
- Disconnect BVM for loading/unloading into the ambulance

Ventilation Rates:

Adult:

Cardiac Arrest:

- 30:2 compression to breath ratio

Perfusing:

- Titrate to $\text{SpO}_2 \geq 94\%$ and eucapnia (as appropriate)

Pediatric:

Cardiac Arrest:

- 15:2 compressions to breath ratio

Perfusing:

- 20 breaths per minute

Neonates:

Cardiac Arrest:

- 3:1 compressions to breath ratio

Perfusing:

- 30-60 breaths per minute

Procedure

- Position for patency
 - Ear-to-sternal notch (ETSN)
 - Up to 2 NPAs \pm OPA (as appropriate)
- Obtain **strong** face-Mask seal (preferred 2 rescuer technique)
 - Thenar grip or
 - E-C "Clamp"
- Squeeze bag
(confirm 4 phase EtCO_2 waveform every breath)

Thenar Grip



EC "Clamp"



If wheezes present

- Continue Albuterol/Ipratropium where applicable in protocol

Capnography

Indications:

- Respiratory distress (*diff. breathing, or requiring ≥ 2 lpm O₂*)
- Decreased LOC/somnolence
- Trending: Perfusion/respiration
- Advanced airway use (ETT and SGA)
- Narcotic/benzodiazepine/sedative administration

Contraindications:

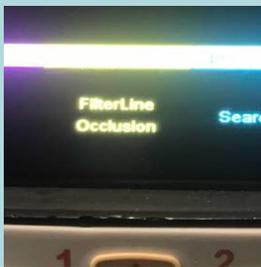
None

Pearls & Pitfalls:

- Clogging of the detector should prompt appropriately aggressive airway clearance by use of suction (strongly consider removing any inserted device)
- An advanced airway or BLS airway adjunct should be removed and reattempted if CO₂ waveform absent
- EtCO₂ alone cannot detect right main stem intubation, confirm lung sounds after 4-phase waveform every ETT placement
- Be vigilant for tube migration/dislodgment the duration of placement and for all patient moves

Airway in place *or* During mask ventilation:

Clogged Detector



- Suction airway immediately
 - Replace detector
- If no noted 4-phase waveform after 1 detector swap*
- Remove airway device
 - Ventilate by different device/method

Malpositioned tube/no ventilation



- If SGA LT, ETT, OPA, BVM*
- Remove device
 - Reposition airway
 - Ventilate by different device/method
- Causes: 0 mmHg EtCO₂
- 1 Loss of airway *e.g. apnea, failed tube, dislodged tube*
 - 2 Loss of circulation *e.g. witnessed cardiac arrest, massive PE, exsanguination, RV rupture*

Side Stream Nasal Cannula

- Connect EtCO₂ detector line to machine
- Apply nasal cannula

Bag Mask Ventilation

- Connect EtCO₂ detector line to machine
- Insert “in-line” detector between the Bag-Valve and Mask
- Ventilate per Bag Mask Ventilation/Assisted Ventilation Procedure
- Appreciate 4-phase EtCO₂ waveform for every breath



“In-Line” EtCO₂ with Advanced Airway

- Connect EtCO₂ detector line to machine
- Insert “in-line” detector between the Bag-Valve and advanced airway
- Ventilate per Bag Mask Ventilation/Assisted Ventilation Procedure
- Appreciate 4-phase EtCO₂ waveform for every breath

Cold Water Immersion (CWI)

Indications:

- Temp $\geq 104^{\circ}\text{F}$ AND AMS

Contraindications:

- Evidence of major trauma
- Suspected infectious cause

Pearls & Pitfalls:

- In cases of very short transport times, evaluate if the benefits of rapid transport outweigh delay of CWI initiation. There may still be a time-lag for setup in the ED. Provide ED early pre-notification of need CWI.
- If ICE bag unavailable, may use patient transport tarp (MegaMover), stretcher cover or non-medical plastic tarp/sheet.

Procedure:

- Remove from environment and initiate/continue active cooling measures if not already completed

If ice immediately available on scene

- Proceed with CWI

If ice available in timely manner

- Determine fastest method for obtaining ice:
 - Request EMS or FRO resource with ice
 - Send clinician to nearby establishment (e.g., gas station, restaurant, grocery) with ice access
 - Detour to nearby establishment with ice access
- Place defibrillation pads and ensure full monitoring
- Place patient in Immersion Cooling Emergency (ICE) bag on the stretcher
- Protect airway and fill ICE bag with ice and cool/cold water or saline (~1-2 L) to cover ≥ 2 inches of the patient's body. Zip bag (or wrap tarp) to mid-chest. Continue to circulate ice bath for maximal cooling.
- Check temperature after 10 minutes
- Criteria to discontinue CWI
 - Core (rectal) temp $\leq 102^{\circ}\text{F}$ or improved mental status

If uncontrolled shivering occurs during cooling, see [Hyperthermia/Heat Stroke](#)

Contact Precautions/Personal Protective Equipment (PPE)

Procedure:

- Explain the reason for use of isolation equipment
- Wear gloves, gown, and eye protection
- Wash hands after leaving the care area
- Splash precautions (goggles/face shield) for suction, intubation, nebulizer updrafts etc.

If standard precautions

- Don the following PPE
 - Disposable exam gloves
 - Goggles/face shield for any airway procedures or patient with active cough
 - Impermeable gown for any situation likely to generate splash/liquid exposures
 - Place surgical mask on patients who are coughing

If contact precautions indicated

- Don the following PPE
 - Disposable exam gloves
 - Goggles/face shield for any airway procedures or patient with active cough
 - Impermeable gown

If droplet precautions indicated

- Don the following PPE
 - 2 Sets of Disposable Exam Gloves
 - Disposable surgical mask
 - Goggles/Face Shield
 - Impermeable gown

If airborne precautions indicated

- Don the following PPE
 - 2 Sets of Disposable Exam Gloves
 - N95 Respirator
 - Goggles/Face Shield
 - Impermeable gown
 - Utilize viral filter, if available, when performing basic or advanced airway management

If special respiratory precautions indicated

- Don the following PPE
 - 2 Sets of Disposable Exam Gloves
 - N95 Respirator
 - Goggles/Face Shield
 - Impermeable gown
 - Boot/Shoe covers

If ebola/viral hemorrhagic fever precautions indicated

- Don the following PPE
 - *Gloves*
 - *PAPR* (Powered Air-Purifying Respirator)
 - *Coverall*

Emergency Childbirth

Indications:

Childbirth/labor

Contraindications:

None

Pearls & Pitfalls:

- Inspect perineum for crowning on all pregnant females reporting symptoms of labor
- Prepare for splashing fluids; sterile gloves, gown, mask/glasses

Childbirth:

- Administer oxygen as appropriate
- Place patient in tilted Left Lateral Position if not crowning
- Visually inspect perineum for crowning
- If delivery imminent or in process, do not initiate or continue transport
- Prepare OB kit and area for delivery and position mother (lithotomy)

Lithotomy Position



As the head delivers:

- Use a gloved hand to control speed of head delivery
- Suction the mouth then nose with suction bulb if:
 - Amniotic fluid is not clear
 - Obvious obstruction to spontaneous breathing or if positive pressure ventilation required
- Address umbilical cord around newborn neck if present:
 - If cord loose around neck:* Attempt to pull cord over infant's neck
 - If cord tight around neck:* Clamp cord × 2 (2-inches apart), cut between clamps, and continue
- Apply gentle downward traction for the top shoulder to deliver with head *sandwiched* between both palms
- Apply gentle upward traction for the bottom shoulder to deliver with head sandwiched between both palms

If delivery fails to progress after head delivers (suspected shoulder dystocia)

- Hyperflex maternal hips via supine knee-chest position (McRobert's maneuver)
- Apply firm suprapubic (not fundal) pressure to attempt to dislodge shoulder
- After complete delivery place the newborn on maternal abdomen or level with the mother's uterus
- Address umbilical cord
 - If infant is vigorous and mother is stable:* delay cord cutting 30-60 seconds
 - Clamp and cut the umbilical cord (minimum 6-inches from the neonate 2-inches apart) *unless already done*
- Dry and cover newborn — start with head, then body
 - If term birth, strong cry, regular respiratory effort, and good tone:* Place infant on mother's chest skin-to-skin
- Assess for maternal bleeding, and, assess for signs of placental separation (*Lengthening cord, pelvic pain, etc.*)
 - If not already done,* encourage the mother to attempt breastfeeding to aid in bleeding control
 - If bleeding present or placenta delivers* perform fundal massage (*vigorous massage of fundus watching for uterine tone/decreased bleeding*)
 - Direct pressure for excessive bleeding from birth canal tears

Breech:

Delivering the legs, abdomen, and umbilical cord:

- Allow fetus to deliver to level of umbilicus
 - After umbilicus is visualized extract 4-6 inch loop of umbilical cord
- Gently extract legs downward after buttocks are delivered

Delivering the shoulders:

- Gently align the fetus' shoulders anterior-posterior to the mother with the infant's face pointing laterally
- Gently guide fetus upward to deliver the posterior shoulder
- Gently guide fetus downward to deliver the anterior shoulder

Delivering the head/neck:

- Rotate the fetal face or abdomen AWAY from the maternal pubis after the shoulders are delivered

Upon delivery of the neck:

- Place gloved finger up into infant's mouth to keep head flexed AND
- Apply gentle pressure to the occiput with the other hand to aid in neck flexion AND

Endotracheal Intubation/Video Laryngoscopy (UEScope)

Indications:

- Respiratory failure
- Need for airway protection
- Adult cardiac arrest after failed SGA

Contraindications:

- Non-cardiac arrest patients if DSI parameters are not met
- Pediatric patients per definition

Definition of an Intubation Attempt:

- Insertion of a laryngoscope blade into the mouth with the intent of performing ETI (regardless of whether a ETT/bougie is placed in the mouth).
- Does not include laryngoscopy for foreign body removal

Pearls & Pitfalls:

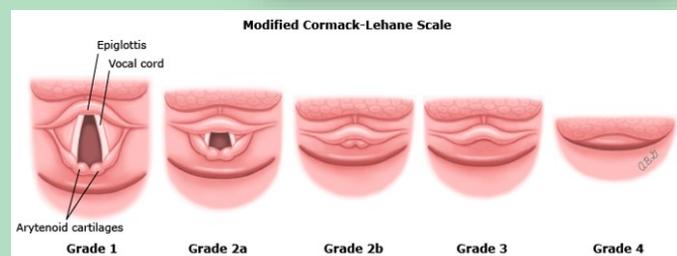
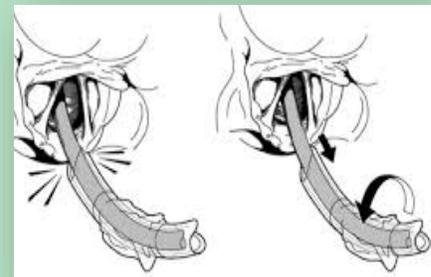
- Intubation is prohibited if DSI parameters ($\geq 94\%$ x 3 min, SBP ≥ 100 mmHg) are not met in non-cardiac arrest patients, and will not be tolerated.
- DSI is required for all intubations not in cardiac arrest
- Upload of the VL (UEScope) file is required
- Do not interrupt CPR to intubate
- Avoid damage to teeth and soft tissue by using gentle, controlled laryngoscope movements
- Maintain manual in-line cervical spine precautions if suspected cervical spine injury, may open c-collar during intubation
- SALAD (Suction Assisted laryngoscopy & Airway Decontamination) technique should be used for all attempts with emesis or other airway contamination to ensure clear VL optics and visual field and reduce aspiration.

- [Invasive Airway Preparation](#)
- Utilize [Intubation Checklist](#)
- External Laryngeal Manipulation (ELM) under guidance from laryngoscopist

- Ensure proper positioning
- Select appropriate UEScope blade for patient size and attach to monitor
- Assure UEScope device is on and recording
- Open patient's mouth using scissor technique (index/thumb)
- Suction airway before blade insertion and PRN during intubation
- **Insert blade midline along the tongue and identify the epiglottis** (do not deliver tube if unable to visualize *epiglottis*)
- **Insert blade into vallecula and lift to view vocal cords**
Perform head-lift or ELM to maximize view PRN

If continuous emesis or other airway contamination build-up

- SALAD Park maneuver - Remove suction from right side, place catheter into left side of mouth behind intubator's left hand, place tip in proximal esophagus.
- Deliver bougie and thread ETT over bougie
If resistance to ETT passage, rotate ETT clockwise or counterclockwise
- Check insertion depth and inflate ETT cuff
- Remove bougie first and then VL device
- **Confirm placement:**
Primary: 4-phase EtCO₂ ≥ 5 mmHg for ≥ 5 breaths
Secondary Confirmation:
Two-provider visual confirmation
Bougie "hold-up"
Bilateral lung sounds
Absent/diminished epigastric sounds
"Misting" in tube
- Secure ETT and continue to monitor placement with EtCO₂ waveform



External Cardiac Pacing

Indications:

Bradycardia associated with:

- Hemodynamic instability
- End organ dysfunction
- Hypotension
 - Adult: SBP \leq 90 or relative \downarrow BP
 - Pedi: SBP \leq 70 + (age in years \times 2), or 90 if \geq 10 years

Contraindications:

- Severe hypothermia (core temp \leq 90° F)

Pearls & Pitfalls:

- Consider underlying profound electrolyte disturbance if unable to achieve capture or if high energy settings required (seek [OLMC](#) for guidance)

As time allows:

- Administer sedative agent
(use caution until hypotension is corrected)

- Sedative agent, as appropriate per protocol
- Attach ECG monitoring electrodes (required for demand pacing)
 - Secure electrodes to wire connector/patient with sturdy tape/kling
- Adjust view to lead with most upright QRS
- Apply pads to patient's chest
 - +++Do not place pads over implanted devices+++**
- Select "PACER" function as per device manufacturer recommendations
- Set pacer rate, as follows:

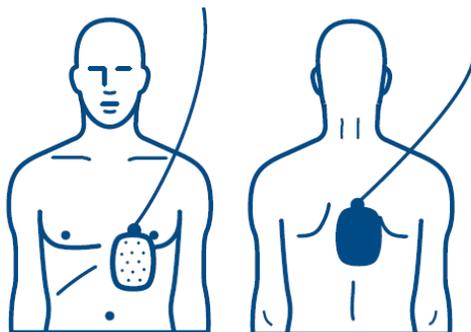
| Age | 0-36 Months | 36 months - 12 years | > 12 years |
|------|-------------|----------------------|------------|
| Rate | 120 ppm | 100 ppm | 70 ppm |

- Press/select "START" or depress the "PACER" button
- Increase output in 10 mA increments till capture is noted or maximum output is reached
- Verify both markers of capture present:
 - Electrical capture – pacer spike immediately followed by wide QRS complex with tall broad T-wave
 - Mechanical capture – palpable carotid and/or femoral pulse; variable presence - pulsatile SpO2 matching pacing rate and increase in EtCO2
- Increase rate in 10 bpm increments if low cardiac output
- Observe for signs of improved hemodynamics
- Treat other causes for poor hemodynamics

If pacing ongoing at emergency department (ED) handoff

- Do not allow removal of pads/leads or discontinuation of EMS pacing until ED pacing established, or ED clinician determines pacing may be discontinued
- ED staff should apply ED pads, set ED pacer rate above the EMS pacer rate, and then gradually increase ED pacer output (mA) until electrical/mechanical capture at higher rate is confirmed, EMS pacing may then be removed.

Anterior/Posterior Pad Placement



Gastric Tube

Indications:

Gastric distention impeding effective ventilation

Contraindications:

History of esophageal tears

Ingestion of caustic substances

Pearls & Pitfalls:

→ Do not let gastric tube insertion interrupt airway confirmation

→ Do not hesitate to remove a SGA if EtCO₂ waveform is lost

Use with SGA designed to allow gastric tube placement

If suspected gastric inflation

- Remove the gastric tube from the packaging, then, using the tube, measure the distance from: nare-to-ear and ear-to– xiphoid process, noting the length at which to insert the tube to
- Prior to insertion, thoroughly lubricate gastric tube and partially insert through the gastric lumen
- Follow Supraglottic Airway procedure, ensuring waveform confirmation of placement
- Advance the gastric tube through the gastric lumen to the depth noted by the earlier measurement
- Using a 60 cc ‘cath-tip’ syringe, inject air through the gastric tube while verifying the presence of “bubble” sounds over the epigastrium
- Following confirmation of sounds over epigastrium, aspirate with the syringe, looking for gastric contents

If insertion was successful

- Secure with tape to the SGA
- Attach gastric tube to suction intermittently at 30-40 mmHg

Use with Endotracheal Tube

If suspected gastric inflation

- Remove the gastric tube from the packaging, then, using the tube, measure the distance from: nare-to-ear and ear-to– xiphoid process, noting the length at which to insert the tube to
- Advance the gastric tube at a downward angle into the oropharynx to the depth noted by the earlier measurement
- Using a 60 cc cath-tip syringe, inject air through the gastric tube while verifying the presence of “bubble” sounds over the epigastrium
- Following confirmation of sounds over epigastrium, aspirate with the syringe, looking for gastric contents

If insertion was successful

- Secure with tape
- Attach gastric tube to suction intermittently at 30-40 mmHg

Highly Contagious Infectious Disease

- Upon notification of a response to or awareness of a patient with HCID
 - Don personal protective equipment before entering scene (do not remove until after patient contact ends)
 - Minimize potential exposure
 - Only **one** EMS provider should approach the patient and perform the initial screening from at least 6 feet away from the patient.
 - Keep other emergency responders further away, while assuring they are still able to support the provider with primary assessment duties.
 - Confirm screening criteria:
 1. Does the patient have any of the following symptoms?
 - a. Fever or chills
 - b. Headache, joint pain, or muscle aches
 - c. Weakness or fatigue
 - d. Stomach pain, diarrhea, or vomiting
 - e. Abnormal bleeding
 - AND
 2. Recent exposure to an individual with a confirmed HCID and/or travel to a region with a known outbreak of an HCID, or if known public health emergency (e.g., COVID, Ebola, Monkeypox).
- If patient remains a person under investigation*
- Follow agency HCID notification process
 - Remove and keep nonessential equipment away from the patient, so as to minimize contamination, on the scene and in the ambulance.
 - Medical equipment used on patients should be disposable whenever possible
Including manual BP cuff and manual suctioning (if necessary).
 - Transfer cardiac monitor and other equipment to supervisor before transporting.
 - Follow disease specific Medical Directives regarding the performance of invasive procedures that may be required for patient stabilization.
 - Minimize aerosolizing procedures to what is necessary while wearing appropriate PPE for airborne precautions
 - If patient is in cardiac arrest contact OLPG immediately for guidance on possible WOR.
 - Notify receiving hospital as soon as possible
 - Outfit ambulance as per HCID procedure.
 - Notify PD to secure scene and keep any exposed persons in same household sequestered until Public Health assesses
 - Documentation of patient care should be done after EMS providers have completed their personal cleaning and decontamination of equipment and vehicle.
 - EMS documentation should include a listing of public safety providers involved in the response and level of contact with the patient (for example, no contact with patient, provided direct patient care). This documentation may need to be shared with local public health authorities.
 - Stay with the patient in the ambulance until the hospital staff is prepared to receive the patient.
 - EMS Personnel will doff PPE at the hospital, using the hospital protocol and monitor.

Influenza Vaccination

Indications:

- Adults: One dose if vaccinated for the seasonal influenza in any previous year
- Children 6 mo - 9 yr: Two doses separated by at least 28 days if they have never received a seasonal influenza vaccination in the past, or if their first seasonal influenza vaccine was last year and they only received one dose

Contraindications:

- Age less than 6 months
- Any acute illness more severe than a common cold
- Oral (or equivalent) temperature elevation $\geq 101.5^{\circ}\text{F}$
- History of Guillian-Barre
- Serious allergic reaction to previous dose of influenza vaccine
- Serious allergic reaction to egg or egg products

Pearls:

- Prepare vaccines in a clean, designated medication area away from where the patient is being vaccinated and away from any potentially contaminated items. This is to prevent inadvertent contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment.
- Different manufacturers have additional allergy contraindications which may include gentamicin, neomycin, polymyxin, thimersol, gelatin, and latex. It is ESSENTIAL that anyone utilizing this protocol understands the packaging insert(s) and contraindications for the specific manufacturers' product(s) being used

Procedure:

1. Provide vaccinee appropriate CDC Vaccination Information Statement (VIS)
2. Vaccinee to complete the top section of the Vaccine Administration Record (VAR)
3. Review completed VAR
 - a. VAR serves as written consent for the vaccination
 - b. If a potential vaccinee answers "yes" to any of the questions, the potential vaccinee should not receive the vaccination until cleared by a physician
4. Prepare and verify appropriate dose
 - a. For persons 3 years of age and older:
 - i. 0.5 mL for all inactivated influenza vaccine products
 - b. For children 6–35 months of age:
 - i. 0.25 mL for Fluzone Quadrivalent
 - ii. 0.5 mL for FluLaval Quadrivalent
5. The injection site (L or R deltoid or L or R anterolateral aspect of thigh) should be identified and cleansed with alcohol pad
6. A 21-25 gauge needle 1 inch long should be used for adults
 - a. In patients less than 60 kg, a 5/8 to 3/4 inch needle is preferred
7. Insert the needle at a 90-degree angle and stretch the skin flat between thumb and forefinger
8. The appropriate dose of vaccine should be delivered in the muscle in a quick, steady manner

Intramuscular (IM) Injection

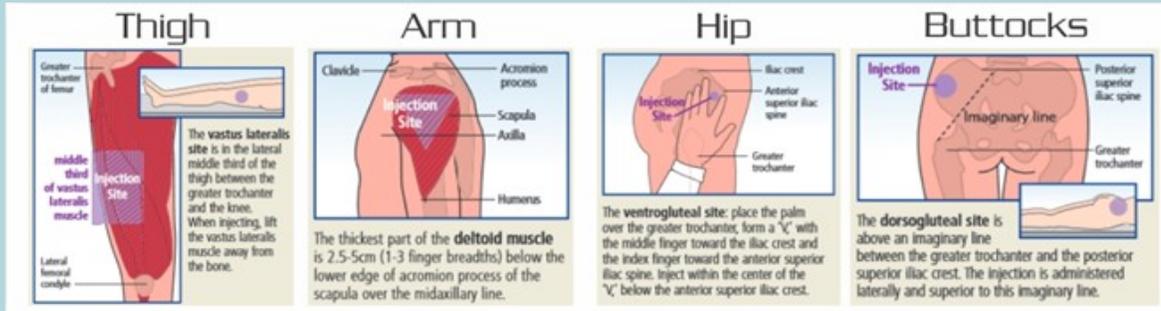
Indications (Basic providers):

Severe allergic reaction

Indications (Assist/Advanced):

Medication administration where applicable in protocol

- Select the appropriate administration site:



- Prepare appropriate equipment:

| Deltoid Muscle | Dorsogluteal Muscle | Ventrogluteal Muscle | Vastus Lateralis Muscle |
|------------------------------|--------------------------------|--------------------------------|----------------------------------|
| Type: IM | Type: IM | Type: IM | Type: IM |
| Size: 23 to 25 G, 5/8" to 1" | Size: 20 to 23 G, 1 1/2" to 3" | Size: 20 to 23 G, 1 1/2" to 3" | Size: 23 to 25 G, 5/8" to 1 1/2" |
| Range: 0.5 to 2 mL | Range: 1 to 5 mL | Range: 1 to 5 mL | Range: 1 to 5 mL |

- Stretch skin and hold tight. Hold the syringe at a 90 degree angle to the skin and insert the needle into the muscle tissue with a steady sharp and controlled motion
- Releases the tension on the skin
- Administer correct dose of medication at the proper push rate

PROCEDURES

Intraosseous (IO) Access

Indications:

- Cardiac Arrest
- Severe illness/injury and at risk for cardiac arrest

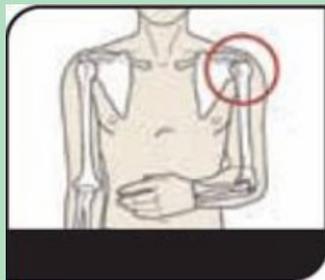
Contraindications:

- Available peripheral access
- Hemodynamic stability
- Fractured extremity (consider alternate site)
- Excess tissue/swelling/edema at insertion site
- Infection at insertion site (consider alternate site)
- Known bleeding disorder

Pearls & Pitfalls:

- Humeral head is the preferred access site for adults
- Syringe bolus as needed (Adult 20 ml/Pedi 10 ml)
- If conscious explain the need for the procedure

- Locate appropriate insertion site
 1. Humeral Head (Adults)
 2. Proximal Tibia
- Prepare insertion site
Aseptic technique
- Prepare needle/driver assembly



Humeral Insertion:

- Aim the needle tip laterally into the deltoid at a 45° angle toward the patient's feet
- Gradually drill the needle into the arm until the hub is flat against the skin (adjust depth as needed for flow)

Tibial Insertion:

- Aim the needle 90° into the medial (flat) surface of the tibia
- Gradually drill the needle into the tibia until the hub is flat against the skin (adjust depth as needed for flow)

- Verify patency:
 - Syringe bolus 10-20 ml (aspiration of marrow is not recommended)
 - Use pressure infuser/IV pump to maintain flow
- Dress the site
Protect from trauma/dislodgment
- Apply wristband
- Administer 2% Lidocaine prior to infusion
 - 40 mg slow IO bolus (Adult)
 - 0.5 mg/kg slow IO bolus (Pedi)

Paramedic

| Needle size Guide | | |
|-------------------|----------|--|
| Pink | Blue | Yellow |
| 15 mm | 25 mm | 45mm |
| 7-90 lbs | ≥ 90 lbs | ≥ 90 lbs with excess tissue; all adult humeral insertions |

Intravenous & Central Line Access

Indications:

Need or potential need for

- Fluids
- Medications

Invasive line Access

- Cardiac arrest
- Hemodynamic instability
- Currently accessed

Pearls & Pitfalls:

- Utilize other methods after 2 peripheral attempts if hemodynamically unstable
 - External Jugular Access
 - EZ-IO device
 - Invasive line access
- Contact [OLMC](#) for access of hemodialysis catheters

Peripheral access (extremity or truncal)

- Apply band tourniquet to extremity
- Identify suitable venipuncture site
 - Straight vein segment
 - Intact, healthy skin
- Select an appropriate size angiocatheter
 - Adult:
 - Hemodynamic instability, continuous infusions
 - 18 g or larger
 - Medication administration only
 - 20 g max preferred
 - Pediatric:
 - Hemodynamic instability, continuous infusions
 - 18 g max
 - Medication administration only
 - 22 g max preferred
- Use aseptic technique to clean site
- Apply traction to skin above intended puncture site
- Insert angiocatheter into the vessel
 - Decrease angle of insertion on noting “flash” of blood
 - Advance needle/angiocatheter slightly
- Retract/lock the needle
- Attach line/lock
 - Flush line/administer fluids

External Jugular Vein Access

- Lay patient with head dependent if possible
(raise legs if unable to make head lower than torso)
- Identify the external jugular vein
 - Examine both sides of the neck
 - Use flat, straight vein segment
- Select venipuncture site highest point above clavicle possible
- Select appropriate size angiocatheter
 - Adult:
 - 18 g or larger
 - Pediatric:
 - 20 max preferred
- Use aseptic technique to clean site
- Apply traction to skin above intended puncture site
- Insert angiocatheter into the vessel
 - Decrease angle of insertion on noting “flash” of blood
 - Advance needle/angiocatheter slightly
- Retract/lock the needle
- Attach line/lock
 - Flush line/administer fluids

Peripherally Inserted Central Catheter (PICC) Access :

- Select the largest lumen available
- Remove cap on the end of the catheter
- Prep the end of the lumen with an alcohol swab
- Aspirate 10 ml of blood with the syringe and discard
- Flush the lumen with 10 ml normal saline using a 10 ml syringe
- Attach IV administration set and observe for free flow of fluid
- If shock is not present, allow fluid to run at rate of 10 ml/hour to prevent the central line from clotting

Equipment:

10 ml syringe (empty), 10 ml syringe (normal saline) and sterile gloves (if available)

Multi-Lumen Catheters

(PICCs and Boviacs can have one, two, or three lumens)

If unable to aspirate blood

- re-clamp the lumen and attempt to use another lumen (if present)

If clots are present

- Do not utilize

If catheter does not flush easily

- If unable to flush, clamp line attempt different port (if available)

PICC line will generally flush more slowly and with greater resistance than a typical intravenous catheter



Invasive Airway Preparation

Indications:

- Insertion of any invasive airway device
- Respiratory failure
- Need for airway protection

Pearls and pitfalls:

- Failure to prepare for intubation puts patients at unnecessary risk for cardiac arrest.
- Ensure all needed equipment is out in the airway manager/assistants field of view to avoid unnecessary delays in retrieving critical equipment.

Position patient:

- HOB @ 30° elevation (non-cardiac arrest)
- Ear-to-Sternal-Notch (ETSN) OR Neutral position (if suspected trauma)
- Consider ramping shoulders for obese patients

Preoxygenate/denitrogenate (non-cardiac arrest):

- NC at flush rate AND

If adequate respirations

- Set BVM @ flush rate, form tight mask seal, and allow spontaneous respirations to continue. Ensure PEEP ≥ 5 mmHg.

If inadequate respirations

- Perform Max BVM with assisted ventilations



Assemble Kit Dump:

Place the following items, within the field of view

- UEScope tested and verified to be recording
- Suction device & catheter
 - Tested, catheter tucked under right side of HOB
- Bougie (curved)
- 2 sizes ET tubes (out of packaging, ready for use)
- 2 sizes of laryngoscope blades (estimated size and next largest)
- 10 mL syringe
- Backup airway device (SGA)
- Tube tamer
- Cricothyrotomy kit or TTV kit (unopened, in view)
- In-line EtCO₂ cannula (if not already in use)

- Evaluate airway and identify/palpate surgical cricothyrotomy anatomic landmarks
- Evaluate risk for hypotension during invasive airway management

If hypotensive see,

- [Circulatory Support](#)

If high-risk (borderline BP, tachycardia, Shock Index > 1.0)

- Prepare Push Dose Epinephrine (PDE)

If hypotension not anticipated

- Ensure PDE components (i.e., epinephrine, syringe, flush, needle) are readily available

If DSI, see [Delayed Sequence Intubation](#)

If RSA, see [Rapid Sequence Airway](#)

All clinicians are responsible for ensuring the [Intubation Checklist](#) is completed prior to DSI

Manual Defibrillation

Indications:

- Ventricular Fibrillation
- Pulseless Ventricular Tachycardia

Contraindications:

- None

Pearls & Pitfalls:

- Withhold defibrillation until removed from standing water/conductive surfaces (metal)
- Hands on defibrillation not recommended
- Do not place defibrillator pads over implanted devices

- Begin chest compressions
- Apply defibrillator pads
- Continue chest compressions during defibrillator charging
- Count down 10 seconds from intended shock delivery (aloud)
- Inform entire resuscitation team prior to shock
- Allow no more than 3 seconds of interruption prior to, and post, defibrillation
- Immediately resume CPR 2 minutes

Basic

During uninterrupted CPR

- Charge defibrillator
- Count down 10 seconds from intended shock delivery (aloud)
- Inform entire resuscitation team prior to shock
- Choreograph team to keep peri-shock pause ≤ 3 sec total
- Attempt additional shock after 2 full minutes of CPR *as indicated*

Electrical Dose Reference

| Adult | Pediatric/Infant |
|---|--|
| Highest energy setting available <i>No change: CPR performance, or energy if shocks from ICD</i> | Begin at 2 J/kg increase by 2 J/kg q 2 min (max 10 J/kg or max energy setting) |

Paramedic

Double Sequential External Defibrillation (DSED) - Adult Patients Only

- Ensure one set of pads is in Anterior-Lateral (A-L) and another in Anterior-Posterior (A-P) position, and that both defibrillators are within reach of a single resuscitation team member.
 - Application of 2nd pads should be performed after a rhythm analysis and shock/no shock, and should not delay compressions >10 sec. Use the CPR puck only from the initial set (typically A-L position) of pads and monitor capturing EtCO₂. Ensure A-P pads do not cover the CPR puck.

If AED (Rapid Shock) Mode Used (Basic credential level may perform)

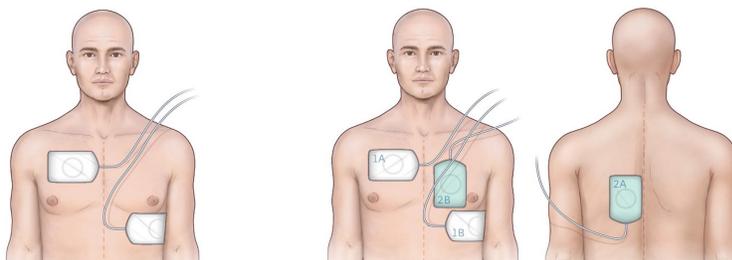
- Maintain the “main” defibrillator in AED mode, use the 2nd defibrillator in manual mode.
- Pre-charge manual mode defibrillator 10 seconds prior to AED rhythm analysis
- Using a single provider deliver defibrillations sequentially (A-L followed by A-P) with a 1 sec pause between shocks
- If “no shock advised”, dump the manual monitor’s charge

If Manual Mode Used

- Maintain both defibrillators in manual mode
- Pre-charge both defibrillators 10 seconds prior to rhythm analysis
- Using a single provider deliver defibrillations sequentially (A-L followed by A-P) with a 1 sec pause between shocks
- If rhythm analysis reveals a non-shockable rhythm a single provider should dump the charge on both defibrillators

Anterior-Lateral

DSED



Mechanical Compression Device (MCD)

Indications:

- Adult medical cardiac arrest and any of the following:
 - At least 15 min of monitored professional rescuer CPR has occurred
 - Transport is necessary
 - ROSC has been achieved and the device is being pre-positioned for transport
 - Critical shortage of manpower prevents adequate Pit Crew CPR

Pearls & Pitfalls:

- Consider withholding MCD placement until transport or ROSC if able to maintain quality uninterrupted manual CPR
- Minimally-interrupted manual CPR is better than perfect CPR after an unacceptable pause (> 10 sec)

Contraindications:

- Traumatic cardiac arrest w/o ROSC or transport
- Application will delay CPR > 10 sec
- Patient size prevents proper application

- Follow Pit Crew Procedure to ensure high quality chest compressions prior to placement
 - Ensure monitor/AED applied and rhythm check \pm defibrillation occurs prior to MCD placement
- Perform Pre-application Timeout
 - S: Size - determine if device will fit on patient per manufacturer recommendations
 - T: Turn on - ensure the device powers on and battery charge is adequate
 - A: Abort - voice abort procedure; ensure all providers are comfortable with procedure
 - R: Roles - ensure all providers understand their role in application procedure
 - S: Strap - abort procedure if neck strap unavailable
- Power on device, prepare, and stage all equipment near patient's head
- Position providers at patient's right and left shoulders, and above patient's head
 - AT THE NEXT 2 MIN RHYTHM CHECK (DO NOT DELAY CPR > 10 SEC)***
- Each provider lift patient by respective shoulder
- Third provider place the back piece below the patient's back, under the armpit
- Resume manual chest compressions immediately
 - AT THE NEXT 2 MIN RHYTHM CHECK (DO NOT DELAY CPR > 10 SEC)***
- Apply device arms to back plate and lock in place
 - LUCAS - Swing arm over and clamp on both sides
 - DefibTech - Clamp on both sides and insert piston
- ADJUST the piston suction cup down to the midsternum, and lock in place (Manufacturer dependent)
- Activate device using correct compression protocol (30:2) and ensure appropriate rhythm/pulse check every 2 minutes
- Apply neck and wrist straps
- Utilize marker to indicate puck and piston placement on chest

If patient's size not appropriate for MCD application

- Perform high-quality manual chest compressions
- Continue Pit Crew Procedure and other treatment as appropriate

Mechanical Ventilator Procedure (Hamilton-T1)

For patients in cardiac arrest after invasive airway placement and confirmation:

- Use CPR mode after adding appropriate sex/height information
- Continue to use 30:2 CPR for adults, 15:2 CPR for pediatric patients with ventilations only occurring during pauses
- During pause in compressions, press and hold “lung” button for 1 second to trigger ventilation.
 - Use ratio of 1 second of ventilation, 2 seconds, then repeated 1 second ventilation before resuming compressions.
 - Confirm full breath is being given by monitoring volume graph:
- If volume graph appears to be a vertical line, like an ECG pacemaker spike, the ventilate button is not being held down.
- If ROSC occurs, switch patient to ASV mode.

For patients needing non-invasive ventilation:

- Use NIV-ST mode after adding appropriate sex/height information
- Use default settings with FiO₂ 100%, PEEP of 5 mmHg and Pressure Support of 15 mmHg.
 - For ongoing hypoxia:
 - Assure FiO₂ is 100%. If not, titrate up FiO₂
 - Increase PEEP in 5 mmHg increments
 - Target SpO₂ >94%
 - For increased work of breathing or patient discomfort with NIV:
 - Increase Pressure Support in 2mmHg increments, titrating to comfort and work of breathing

For patients with an invasive airway in place:

- Use ASV mode after adding appropriate sex/height information
 - For hypoxia:
 - Assure FiO₂ is 100%. If not, titrate up FiO₂
 - Increase PEEP in 5 mmHg increments
 - Target SpO₂ >94%
 - For increased work of breathing or patient discomfort with ventilations:
 - Assure adequate sedation
 - Increase Pressure Support in 2mmHg increments, titrating to comfort and work of breathing
 - For EtCO₂ >60 with history/suspicion of obstructive airway disease:
 - Increase Minute Volume from 100% in increments of 20%
- Wait at least 5 minutes in between adjustments to allow patient to adapt to new settings

For patients undergoing pre-oxygenation during DSI process:

- Use Pre-Oxygenation mode (NIV-ST) after adding appropriate sex/height information
- Give Ketamine per DSI protocol
- Appropriately position patient in head up position and ear to sternal notch position
- Apply NPAs as patient tolerates
- Apply nasal cannula with flush-rate oxygen
 - For ongoing hypoxia:
 - Assure FiO₂ is 100%. If not, titrate up FiO₂
 - Increase PEEP in 5 mmHg increments
 - Target maximum SpO₂
- After achieving physiologic goals and administering paralytic:
 - Monitor EtCO₂ and volume graph to assure ventilator takes over ventilations from spontaneous ventilations as paralytic takes effect and patient stops breathing
- Once ready to begin intubation attempt, place ventilator in standby mode, remove mask while continuing apneic oxygenation at flush rate, and begin intubation attempt.
- If attempt is successful:
 - Attach ventilator circuit (with EtCO₂ attached and connected) and place mode in ASV mode, using ‘last patient’ feature to carry over sex/height settings.
 - Titrate FiO₂ down with goal SpO₂ ≥94%
- If attempt is unsuccessful:
 - Place mask back on patient, return ventilator to “Pre-Oxygenation” mode and assure appropriate ventilations are administered.
 - If ventilations not delivered, default to manual ventilations

Non-invasive Positive Pressure Ventilation (NIPPV)

Indications:

- Respiratory distress with resistant hypoxia
- Awake, able to cooperate for device application
- Ability to wear adult size mask

Contraindications:

- Pending respiratory failure
- Penetrating chest trauma
- Suspected pneumothorax
- Uncontrolled/persistent vomiting
- Facial deformity (traumatic or anatomic) preventing mask seal

Pearls & Pitfalls:

- Utilize EtCO₂ monitoring, monitor for duration of placement
- Caution if patient unable to cooperate for procedure
 - Nausea/vomiting (retching/vomiting episodes)
 - Anatomic deformity (unable to create mask seal)
 - Risk of hemodynamic collapse
- Consider multiple causes for respiratory distress (pneumothorax/mediastinum, effusion, PE, etc.)
- Monitor trends in waveform capnography, CO₂ values, pulse oximetry, mental status, HR/BP
- q ≤ 5 min. reevaluation recommended for all monitoring/Vs, document appropriately
- To increase FiO₂ when using NIPPV, consider additionally placing NC on patient as well

CPAP-only device (e.g. Flow-Safe II EZ)

- Maximize upright sitting position
- Connect oxygen tubing nipple to oxygen source
- Seal the mask to the patient's face using headpiece
- Turn on oxygen source
- Secure the face mask snugly to patient's face using head harness
- Slowly increase oxygen flow to roughly 15 lpm
- Check mask fit to patient and device connections for leaks
- Adjust the flowmeter until desired pressure is obtained

CPAP-Only Device Flow:-Pressure Reference

| Approx. Flow Rate | Pressure |
|-------------------|------------------------|
| 15 lpm | 5 cmH ₂ O |
| 20 lpm | 7.5 cmH ₂ O |
| 25 lpm | 10 cmH ₂ O |

BPAP (Bilevel positive airway pressure - e.g. Flow-Safe II+ BiLevel)

- Maximize upright sitting position
- Connect O₂ tubing nipple to oxygen source
- Turn on oxygen source
- Ensure device is in Bilevel mode by rotating the green switch to the Bilevel setting
- Secure the face mask snugly to patient's face using head harness
- Slowly increase oxygen flow to 15 LPM, to achieve goal IPAP of roughly 8-10 cm H₂O
- Check mask fit to patient and device connections for leaks
- Adjust EPAP knob until manometer reaches 5 cm H₂O during exhalation

→ Effective mask seal is required for device to shift into EPAP mode from IPAP mode

If simultaneous bronchodilators required

- Maximize upright sitting position
- Connect O₂ tubing nipple to oxygen source.
- Seal the mask to the patient's face using headpiece
- Turn on oxygen source
- Ensure device is set in CPAP mode-Green switch is set to CPAP
- Secure the face mask snugly to patient's face using head harness
- Slowly increase oxygen flow to 6 - 8 LPM
- Check mask fit to patient and device connections for leaks
- Adjust the flowmeter until desired pressure is obtained

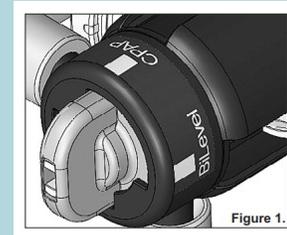
→ Flow of 12 - 14 LPM is required to reach CPAP pressure of 8.5 - 10 cm H₂O

CPAP on CPAP/BPAP Device Flow:-Pressure Reference

| Approx. Flow Rate | Pressure |
|-------------------|--------------------------|
| 10 lpm | 6-7 cmH ₂ O |
| 15 lpm | 11-12 cmH ₂ O |

BPAP on CPAP/BPAP Device Flow:-Pressure Reference

| | |
|--------|-------------------------|
| 15 lpm | 8-10 cmH ₂ O |
|--------|-------------------------|



Pelvic Binder

Indications:

- Mechanism suggestive of pelvic injury and obvious signs of pelvic injury/instability on physical exam
AND
- Signs of hemorrhagic shock (e.g. SBP < 90 and/or Shock Index ≥ 1)

Contraindications:

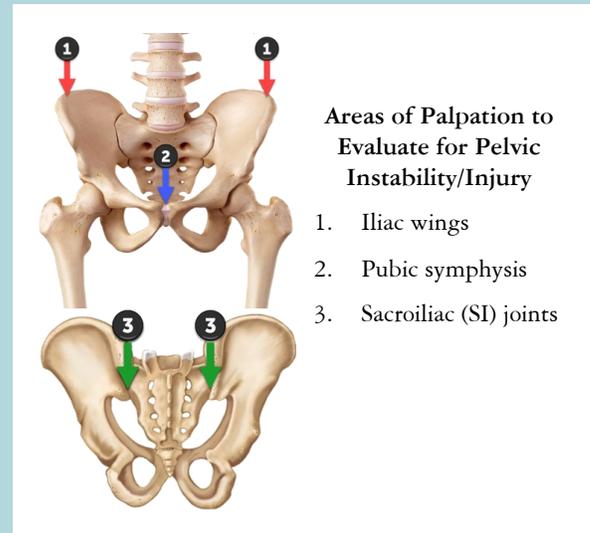
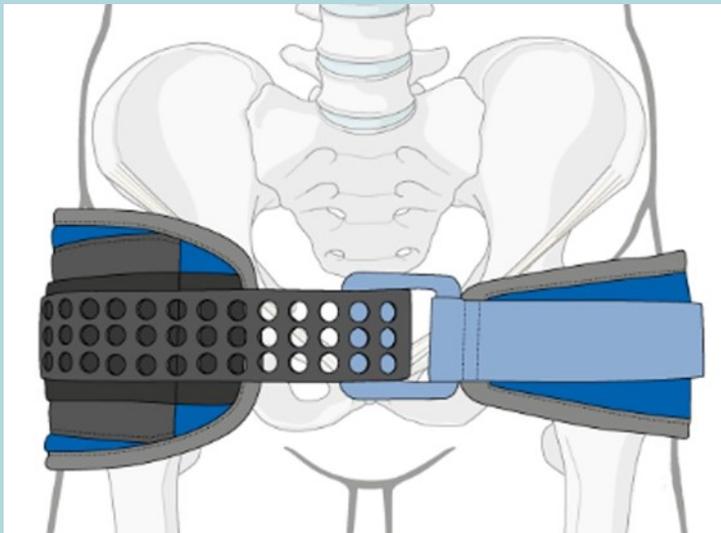
- Isolated proximal femur fracture (isolated “hip fracture”)

Pearls & Pitfalls:

- Low energy mechanisms (e.g. falls from standing) rarely cause unstable pelvic fractures
- Do not “rock” or “spring” the pelvis. Gently compress iliac wings to assess for instability. Palpate for tenderness at pubic symphysis, iliac wings, sacrum/sacro-iliac joints
- In reliable patients with no leg/spinal cord injury and no analgesia, a painless straight leg raise test may exclude a pelvic injury
- Avoid log-rolling, use scoop stretcher or slide techniques
- Consider in blunt traumatic arrest with MOI/findings of pelvic injury

Pelvic binder device

- Remove clothing from patient’s pelvic area
- Place the black side up beneath patient at the level of the greater trochanters
- Place black strap through buckle and pulls completely through
- Hold orange strap and pull black strap in opposite direction until buckle click is felt and heard (approx. 35 pounds of force)
- Maintain tension, immediately press black strap onto surface of the pelvic sling to secure



Improvised Pelvic Binder (no commercial device available)

- Remove clothing from patient’s pelvic area
- Place the material beneath patient with the ends out to either side at the level of the greater trochanters
- Pull each end to the front of the pelvis

If using a sheet and hemostats

- Tuck one end into the opposite side and hold still against force being applied to the other side
- Pull against the sheet on the untucked end with 150 Newtons of force (approximately 35 pounds)
- Maintain tension, secure in place with hemostats at the upper and lower edge of the sheet (ideally at least 2 at each edge for best securement)

If using a sheet only

- Cross ends over the anterior pelvis gripping the side of the sheet that came from the side you are on
- Mirror this action on both sides
- Pull against your assistant until there is a combined force of 150 Newtons (approximately 35 pounds)
- Maintain tension, twist sheet ends an additional rotation and tuck into the portion encircling the pelvis. Add tape for improved securement

Pericardiocentesis

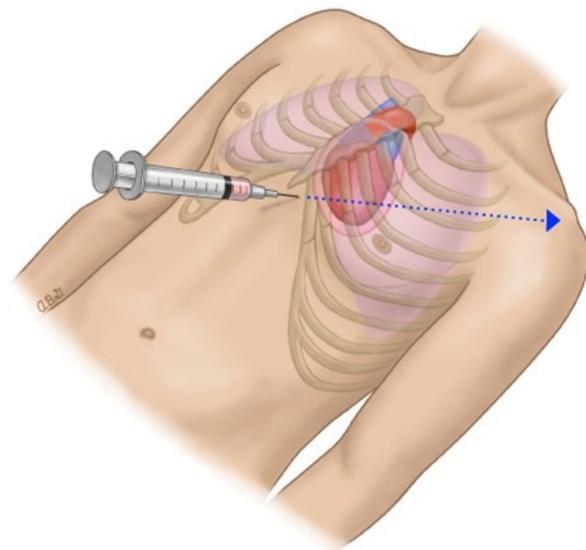
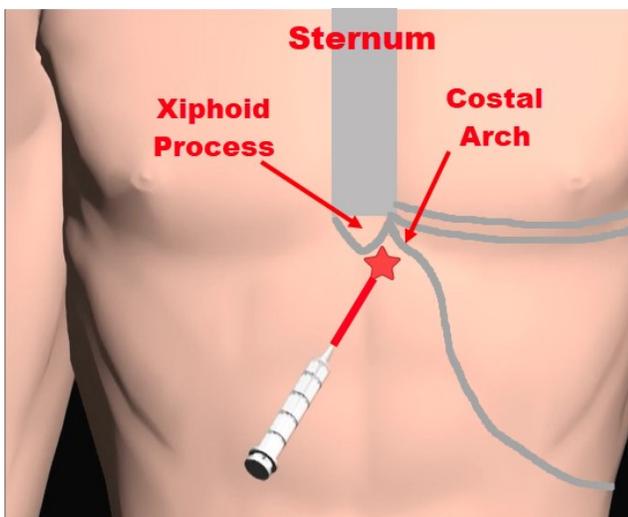
Indications:

- Traumatic circulatory arrest with suspected cardiac tamponade

Precautions:

- Directing too medially (toward sternum) or too steep ($>45^\circ$) carries a risk of right atrial or intra-abdominal puncture/injury.
- If multiple syringes of blood are removed, check position as overpenetration into atrial/ventricle may have occurred.

- Prepare equipment and appropriate PPE
 - Antiseptic swab
 - 20-mL syringe
 - 18-gauge spinal needle (remove and discard stylet, attach needle to syringe)
- Place on continuous ECG prior to procedure, if time allows
- Position the patient supine
- Expose and locate landmarks (xiphoid process and costal arch)
- Prepare site with antiseptic swab
- Insert needle 1 cm inferior to junction between left costal arch and xiphoid process
- Angle the needle between $15-30^\circ$, aimed toward the left shoulder
- Slowly advance needle while continuously aspirating/withdrawing plunger withdrawal stop once fluid aspirated
- Withdraw needle and redirect angle if no fluid aspirated
- Evacuate pericardium until resistance is met or pulses return
- Monitor for signs of tamponade recurrence, repeat procedure x1 PRN
- Contact [OLMC](#) if >2 pericardiocentesis required



Physical Restraint

Indications:

- Behavioral health emergency and/or agitation AND all other calming attempts have failed, which include at a minimum verbal de-escalation techniques.

Contraindications:

- Inadequate personnel to perform restraint process (including law enforcement)
- Use of EMS restraints for law enforcement detainment or arrest purposes only and no medical condition present

Exception:

- The procedure below does not apply to patients who are in custody/under arrest and are not experiencing a behavioral health emergency and/or agitation that would require EMS restraints or sedation. However, precautions regarding patient positioning and law enforcement officer presence apply to all patients in rigid restraints.

Pearls & Pitfalls:

- Rigid restraints (e.g. handcuffs, flex cuffs) should generally be transitioned to commercial restraint devices for combative patients. In the rare situations this cannot be performed, the following requirements will be adhered to:
 - Handcuffs should be double locked (prevents unintended tightening)
 - Patient shall not lie or recline on handcuffs
 - The law enforcement officer must accompany the patient to the hospital in the transporting EMS vehicle or be immediately available.
- Documentation should include:
 - Efforts attempted prior to use of restraints
 - Reason for use of restraints
 - Type and position of restraints used
 - Time restraints were placed
 - Continuous monitoring
 - Neurovascular checks
- **Patients shall never be restrained or be allowed to position themselves in the prone position, or in a position that compromises the airway or constricts the neck or chest.**
- **Do NOT use:**
 - Hobble/hogtie (hands and feet tied behind back) positioning
 - Devices such as backboards, splints, or other devices placed on top of the patient
 - Non-commercial restraint devices (e.g. triangular bandages, bandage rolls)

Procedure:

- Attempt less restrictive means of managing the patient.
- Request [EMS Supervisor](#) and law enforcement assistance.
- Ensure sufficient personnel available to physically restrain the patient safely.
- Restrain the patient using commercial restraint devices
 - Place in a lateral or supine position.
 - Restrain the extremities at the wrists and ankles.
 - Ensure stretcher straps across the chest allow for adequate chest excursion.
- Elevate the head of the stretcher to 30-degrees or more, if possible.
- Administer oxygen, regardless of SpO2
- Maintain constant observation by a Assist or Advanced provider, which includes:
 - Direct visualization of the patient
 - Frequent blood pressure and continuous ECG, pulse oximetry and EtCO2 monitoring
- Perform neurovascular checks (pulse, motor, sensation) of the restrained extremities q15-minutes, with first check immediately after placement.
- Ensure adequate personnel for transport of the patient

PROCEDURES

Pit Crew (2 Responders)

COMPRESSION NOTES

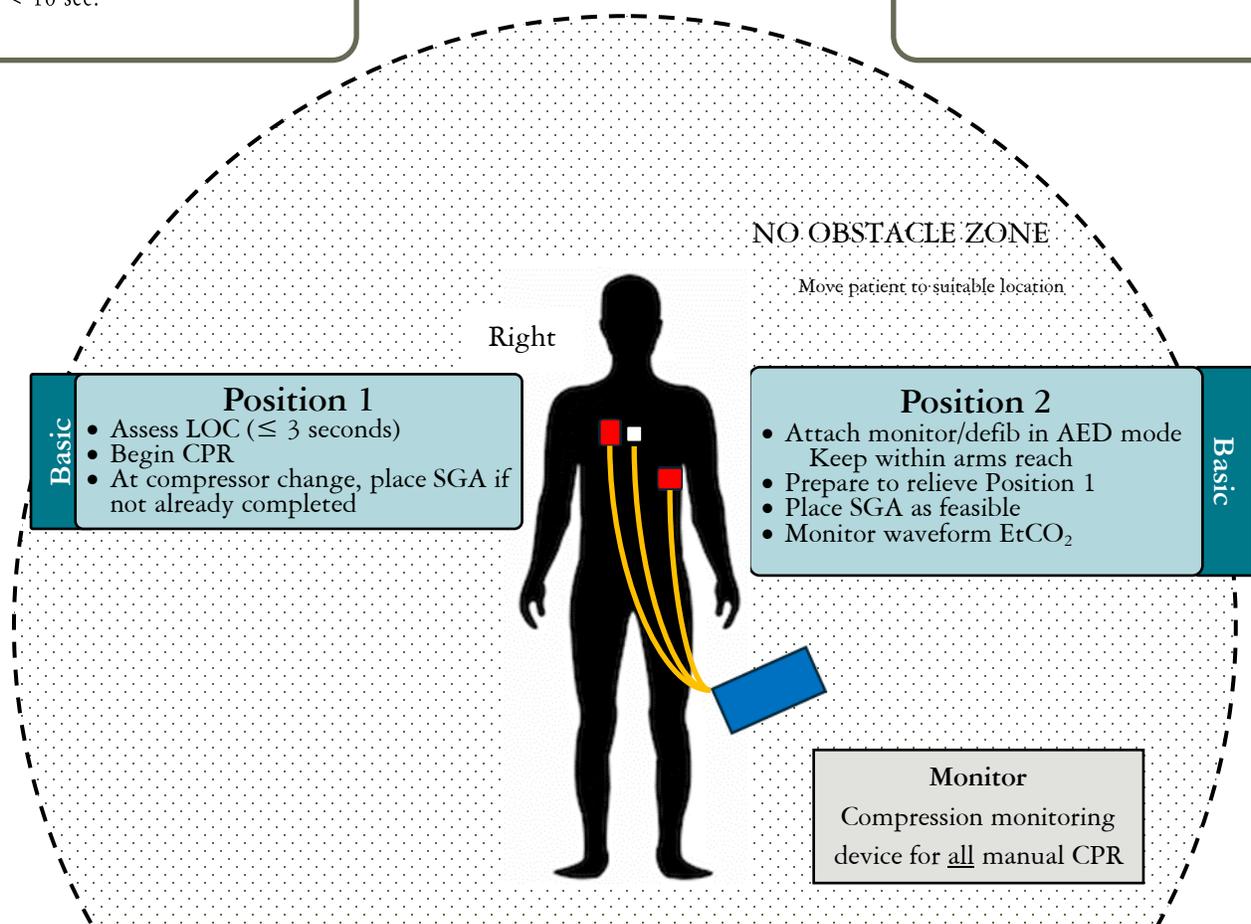
- "Hover Hands" over patient chest (every compressor @ all rhythm checks)
- Continue Compressions during Charge
- Rate: 30:2 @ 100-120 cpm
- Depth: 2-2.5 in
- Pauses: < 10 sec.
- Lean: 0

DEFIBRILLATION:

- Witnessed Arrest*— Immediately apply, analyze, and shock (AED) as advised
- Unwitnessed*— 2 minutes CPR THEN analyze

AIRWAY

- Rapidly place SGA with waveform EtCO₂ (no PEEP) as soon as feasible
- Ventilate only during 30:2 pause
- EtCO₂ verification with first and every breath



Position 1

- Assess LOC (≤ 3 seconds)
- Begin CPR
- At compressor change, place SGA if not already completed

Position 2

- Attach monitor/defib in AED mode
Keep within arms reach
- Prepare to relieve Position 1
- Place SGA as feasible
- Monitor waveform EtCO₂

Monitor

Compression monitoring device for all manual CPR

| | |
|--|--|
| <p>After every 2 minutes of CPR</p> <p><i>Position 1&2</i> alternate compressor and ventilator roles</p> <p>Medication deferred until > 2 providers on-scene</p> | |
| <p>Rhythm Analysis</p> | |
| <p>“No Shock Advised” or Asystole/ PEA</p> <ul style="list-style-type: none"> • Immediately resume CPR | <p>“Shock Advised” or VFIB/VT</p> <ul style="list-style-type: none"> • Resume CPR • Charge defib. <ul style="list-style-type: none"> • Clear patient • Deliver shock • Immediately resume 2 min. CPR |

PROCEDURES

Pit Crew (3 Responders)

COMPRESSION NOTES

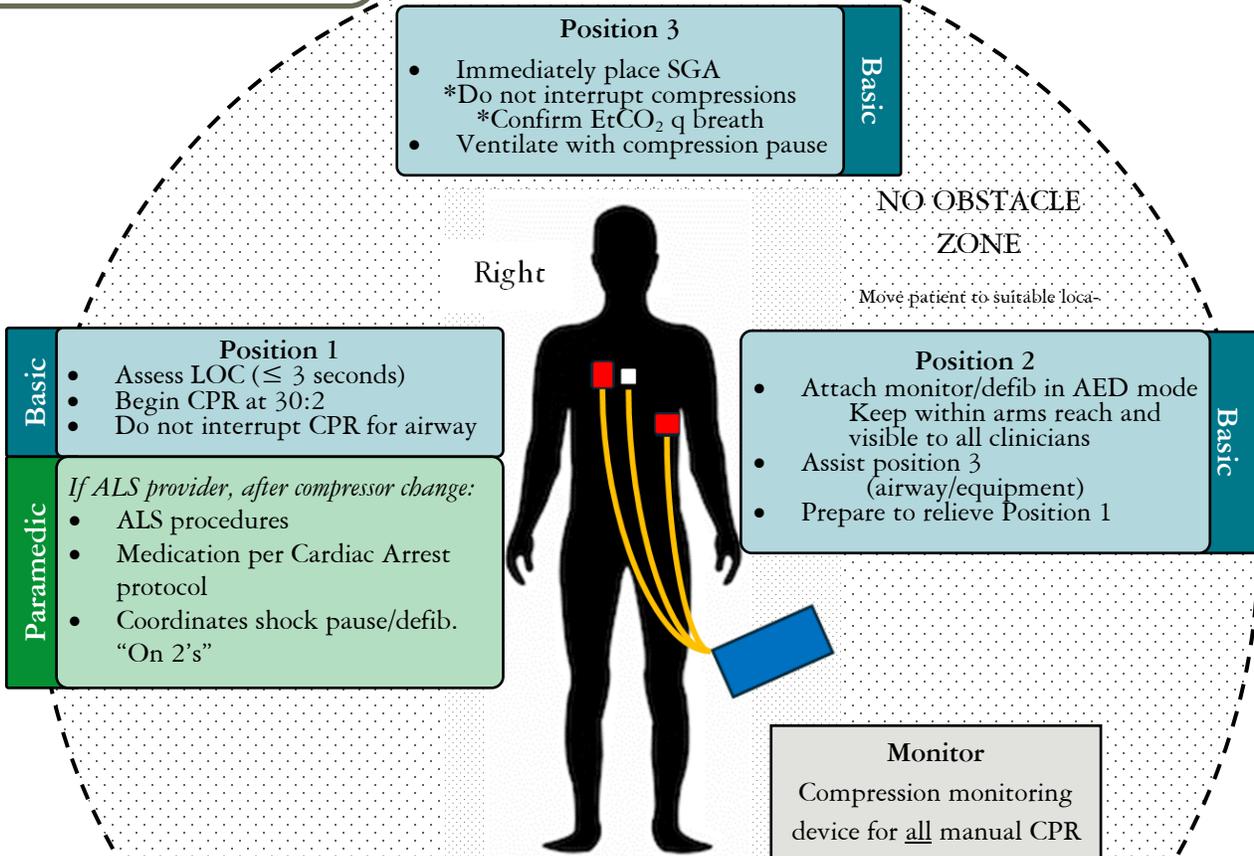
- "Hover Hands" over patient chest (every compressor @ all rhythm checks)
- Continue Compressions during Charge
- Rate: 30:2 @ 100-120 cpm
- Depth: 2-2.5 in
- Pauses: < 10 sec.
- Lean: 0

DEFIBRILLATION:

- Witnessed Arrest**— Immediately apply, analyze, and shock (AED) as advised
- Unwitnessed**— 2 minutes CPR THEN analyze

AIRWAY

- Immediate SGA placement
 - Do not stop CPR to place SGA
- Ventilate only during 30:2 pause
- EtCO₂ verification with first and every breath



After every 2 minutes of CPR

- Position 1&2* alternate compressor role (additional resources on-scene may rotate into *Position 1&2*)
- Medication as indicated per protocol

Rhythm Analysis

"No Shock Advised" or Asystole/PEA

- Immediately resume CPR

"Shock Advised" or VFIB/VT

- Resume CPR
- Charge defib.
 - Clear patient
 - Deliver shock
 - Immediately resume 2 min. CPR

PROCEDURES

Pit Crew (4 Responders)

COMPRESSION NOTES

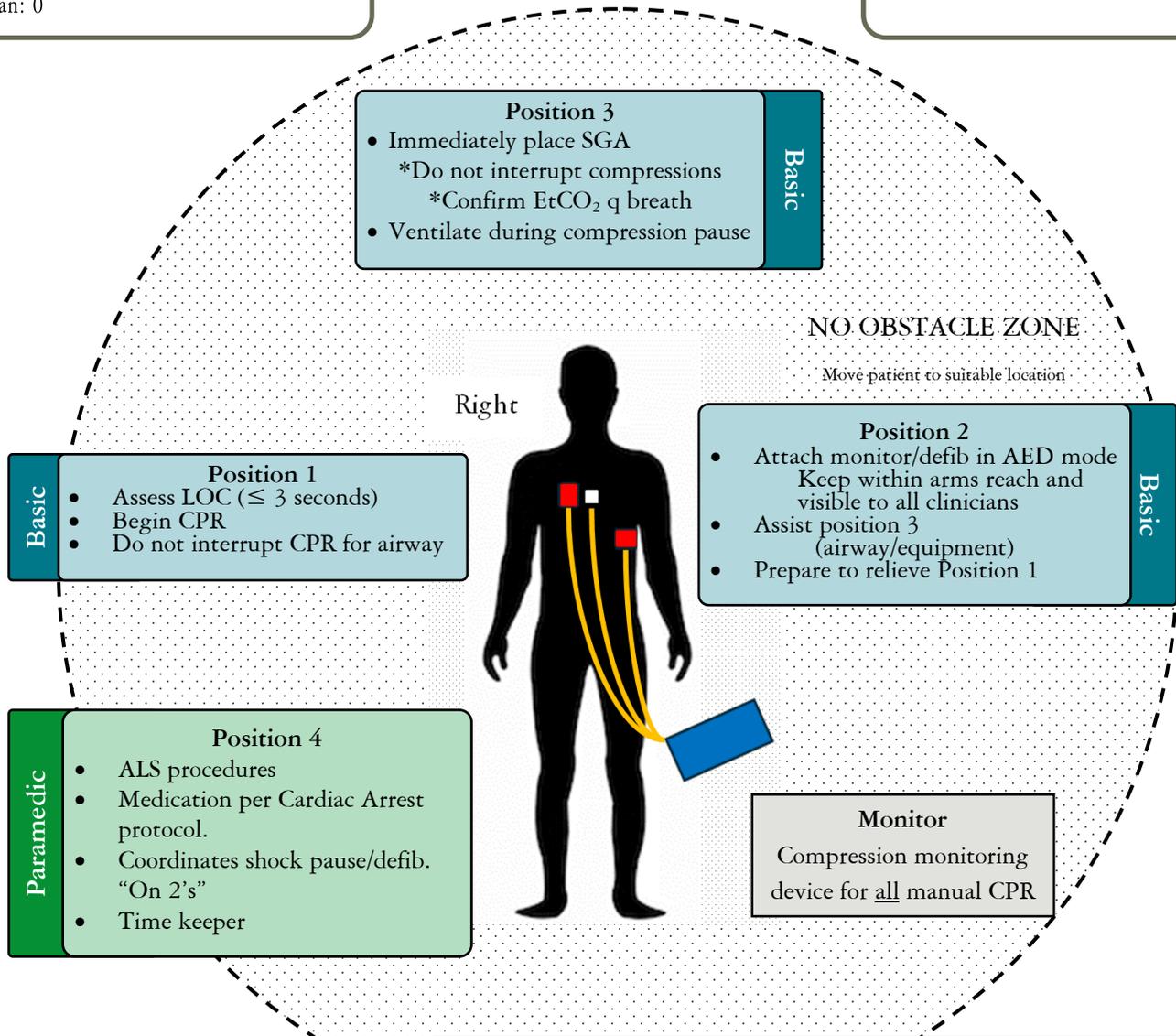
- "Hover Hands" over patient chest (every compressor @ all rhythm checks)
- Continue Compressions during Charge
- Rate: 30:2 @ 100-120 cpm
- Depth: 2-2.5 in
- Pauses: < 10 sec.
- Lean: 0

DEFIBRILLATION:

- Witnessed Arrest*— Immediately apply, analyze, and shock (AED) as advised
- Unwitnessed*— 2 minutes CPR THEN analyze

AIRWAY

- Immediate SGA placement
 - Do not stop CPR to place SGA
- Ventilate only during 30:2 pause
- EtCO₂ verification with first and every breath



Rhythm Analysis

"No Shock Advised" or Asystole/PEA

- Immediately resume CPR

"Shock Advised" or VFIB/VT

- Resume CPR
- Charge defib.
 - Clear patient
 - Deliver shock
 - Immediately resume 2 min. CPR

After every 2 minutes of CPR

Position 1&2 alternate compressor role
(additional resources on-scene may rotate into Position 1&2)

PROCEDURES

Pit Crew (5+ Responders)

COMPRESSION NOTES

- "Hover Hands" over patient chest (every compressor □ @ all rhythm checks)
- Continue Compressions during Charge
- Rate: 30:2 @ 100-120 cpm
- Depth: 2-2.5 in
- Pauses: < 10 sec.
- Lean: 0

DEFIBRILLATION:

- Witnessed Arrest*— Immediately apply, analyze, and shock (AED) as advised
- Unwitnessed*— 2 minutes CPR THEN analyze

AIRWAY

- Immediate SGA placement
- Do not stop CPR to intubate/place SGA
- Ventilate only during 30:2 pause
- EtCO₂ verification with first and every breath

Basic

Position 4 Code Assistant

- Assist Position 3 with airway
- Assist with code activities
 - DSED
 - Swapping compressors
 - MCD placement after 15 mins

Position 3

- Immediately place SGA
 - *Do not interrupt compressions
 - *Confirm EtCO₂ q breath
- Ventilate only during compression pause

Basic

Right

NO OBSTACLE ZONE

Move patient to suitable location

Basic

Position 1

- Assess LOC (≤ 3 seconds)
- Begin CPR
- Place MCD after 15 minutes
- Do not interrupt CPR for airway

Position 2

- Attach monitor/defib in AED mode
 - Keep within arms reach and visible to all clinicians
- Prepare to relieve Position 1
- Monitor manager
- Place MCD after 15 minutes

Basic

Paramedic

Position 6

Intervention Paramedic

- ALS procedures
- Medication per Cardiac Arrest protocol

Monitor

Compression monitoring device for all manual CPR

Basic

Position 5 Code Commander

- Utilize Code Commander TAC Sheet
- Coordinate all positions
- Gather PMH and HPI
 - Down time
 - Cause of the arrest
- Coordinates shock pause/defib. "On 2's"
- Time keeping

After every 2 minutes of CPR

Position 1&2 alternate compressor role
(additional resources on-scene may rotate into *Position 1&2*)
Medication as indicated per protocol

Rhythm Analysis

"No Shock Advised" or Asystole/
PEA

- Immediately resume CPR

"Shock Advised" or VFIB/VT

- Resume CPR
- Charge defib.
 - Clear patient
 - Deliver shock
 - Immediately resume 2 min. CPR

Basic

Position 7 Family Liaison (if available)

- Stay with family
- Keep them informed of resuscitation efforts
- Set expectations
- Handle death notification if necessary

Spinal Motion Restriction

AMBULATORY and Neurologically Intact

- Already self-extricated
- Already standing
- No Thoracic or Lumbar spinal tenderness

1. Place cervical collar
2. Bring stretcher as close as possible
3. Assist patient with pivoting & laying down in position of comfort (may elevate HOB if no thoracic/lumbar spine tenderness)
4. Secure patient to stretcher

OR

ALL OTHERS

1. Place cervical collar
2. Use device (KED/Vacuum Splint/Scoop stretcher/backboard*) to move patient to stretcher
3. Move patient with as little movement as possible, *maintain in-line stabilization*
4. Secure patient SUPINE to stretcher (tape & seat belts)
DO NOT leave EXTRICATION DEVICE in place

*Backboards and Scoop Stretchers are patient movement devices ONLY. DO NOT LEAVE IN PLACE FOR TRANSPORT

Suction

| | |
|---|---|
| <p>Indications:</p> <ul style="list-style-type: none"> → Oral/nasal secretions and/or vomitus unable to be cleared by the patient themselves associated with any condition → Meconium aspiration of non-vigorous neonate (respiratory distress/persistent cyanosis) | <p>Pearls & Pitfalls:</p> <ul style="list-style-type: none"> → Avoid prolonged suction intervals, oxygenate if possible between attempts at clearing the airway → Avoid contaminating deep suction catheters <i>Rinse catheter often</i> → Avoid inducing vomiting with oral suction, especially for patients who are partially alert → Utilize commercial bite block or suction catheter between the molars when inserting hands in patient's mouth |
| <p>Nasal Suction (French catheter)</p> <ul style="list-style-type: none"> • Insert catheter (same technique as for nasal trumpet insertion) Stop insertion at depth of suspected location of blood/secretions/vomitus • Apply suction • Apply suction and spin the catheter while withdrawing (Slow removal when a pool of liquid is encountered until cleared) | |
| <p>Suction Devices</p> | |
| <p style="text-align: center;">Perfusing (no CPR in progress):</p> <ul style="list-style-type: none"> • Drain patient mouth Roll patient to side (maintain in-line cervical stabilization PRN) Remove large or obvious foreign matter with gloved hand • Sweep or scoop bulk material if visible in mouth • Suction mouth and pharynx on removal | <p style="text-align: center;">CPR in progress (or unable to roll patient):</p> <ul style="list-style-type: none"> • Open the patient's mouth <i>Scissor technique (thumb and index finger)</i> • Pinch/remove large or obvious foreign matter with gloved hand • Suction mouth and pharynx on removal |
| <p>Tracheal Suction (ETT and Tracheostomy)</p> <ul style="list-style-type: none"> • Measure catheter from stoma/adapter—to two fingers past sternal notch • Insert catheter to premeasured depth • Apply suction and withdraw in a spiral/spinning motion | |

Supraglottic Airway - Air-Q3

Indications:

- First-line for adult and pediatric cardiac arrest
- Respiratory failure
- Need to protect airway

Contraindications:

- Known laryngectomy

Indications for Removal:

- Inability to confirm ventilation in ≤ 5 -breaths with waveform EtCO₂
- Significant gastric contents, secretions, or vomitus in the ventilation port, with absent EtCO₂ waveform

Definition of an Attempt

- Insertion of a supraglottic airway into the mouth

Pearls & Pitfalls:

- Most patients not in cardiac arrest should have RSA performed with ketamine +/- paralytic. In patients without gag and who are severely obtunded, RSA medications may be deferred.
- Assist/Advanced providers may opt to use the device as a primary airway.
- Endotracheal tube placement through Air-Q3 is prohibited
- Make best attempt at achieving SpO₂ $\geq 94\%$ prior to insertion (non-cardiac arrest)

SIZE GUIDE

| Ideal Body Weight (IBW) | Air-Q3 Size | Max Gastric Tube Size |
|-------------------------|-------------|-----------------------|
| < 2 kg | 0 | 5 Fr |
| 2 - 4 kg | 0.5 | 6 Fr |
| 4 - 7 kg | 1 | 8 Fr |
| 7 - 17 kg | 1.5 | 8 Fr |
| 17 - 30 kg | 2 | 10 Fr |
| 30 - 60 kg | 3 | 14 Fr |
| 60 - 80 kg | 4 | 16 Fr |
| > 80 kg | 5 | 18 Fr |

- Place patient in ear-to-sternal notch or neutral head position
- Suction airway as needed
- Lubricate external surface of device including the mask and ridges
- Consider pre-loading gastric tube into appropriate channel in device
- Open mouth and elevate the tongue (using mandibular lift)
- Place the front portion of the Air-Q3 mask between the base of the tongue and soft palate at slight angle
- Continue to insert the device into position within pharynx by gently applying inward/downward pressure
- Continue to advance until fixed resistance felt
- Confirm ventilation with 4-phase waveform EtCO₂ for every breath (use subjective confirmation techniques as appropriate)
- Secure Air-Q3 using commercial tube tamer (use tape if proper tamer size unavailable)
- Place (or if pre-loaded, advance) gastric tube and connect to suction
- Continue to monitor placement with EtCO₂ waveform

*AirQ3 is shorthand for the Air-Qsp3G

Surgical Airway & Transtracheal Ventilation

Indications:

→ Failure to oxygenate and ventilate

Procedure Selection:

- Surgical airway: patient greater than 35 kg body weight or does not fit Broselow tape
- Transtracheal ventilation: patient less than 35 kg or Broselow tape size green or smaller

Definition of an Attempt

Insertion of a needle or scalpel through the neck

Pearls & Pitfalls:

- Follow Advanced Airway Preparation Procedure
- Utilize aseptic technique for all invasive procedures
- Continue to attempt to maintain oxygenation by BVM during the procedure

Surgical Airway

- Position supine-45° head elevation, head extended upward/backward
- Stabilize the larynx with non-dominant hand (index finger and thumb)
- Stabilize the thyroid cartilage with the provider's non-dominant hand
 - Feel for the depression at the bottom border of the thyroid cartilage
 - Stabilize the wrist/forearm of the incising hand on top of the patient's chest
- Make a vertical incision to the skin on the midline of the trachea large enough to identify the cricothyroid membrane with your finger
- Make a vertical stab incision into the cricothyroid membrane, maintain the scalpel position inside the incision
- Rotate the scalpel horizontally, and incise the cricothyroid laterally to the patients left and right side, leaving the scalpel inside the incision
- Pass a bougie alongside the scalpel pointing the tip toward the patient's feet feeling for hang-up to confirm tracheal placement
- Slide a size 6.0 endotracheal tube over the bougie, rotating at the cricothyroid membrane if unable to pass, until just past the tracheal cuff
- Inflate the cuff via pilot balloon
- Secure with a commercial securing device
- Ventilate and confirm ventilation using EtCO₂; listen for lung sounds to rule out right main stem intubation

Transtracheal Ventilation (Pediatric ONLY)

- Position supine-45° head elevation, head extended upward/backward
- Stabilize the larynx with non-dominant hand (middle finger and thumb)
- Stabilize the thyroid cartilage with non-dominant hand (index finger)
 - Feel for the depression at the bottom border of the thyroid cartilage
 - Stabilize the wrist/forearm of the inserting hand on top of the patient's chest
- Puncture the cricothyroid membrane with a size 16-18G IV catheter, perpendicular to the trachea
- Maintain manual control of the IV catheter
- Orient the needle tip towards the patient's feet and advance the catheter until the hub is reached
- Attach the endotracheal tube connector from a size 3.0 ET tube
- Ventilate using an infant bag-valve-mask device
- Maintain manual control of the catheter until arrival at the hospital
- Attach ETCO₂ and confirm presence of waveform
- Deliver breaths until chest rise is noted, allow time for complete exhalation before next breath

Synchronized Cardioversion

Indications:

Tachycardia resulting in:

- Hemodynamic instability
- End organ dysfunction
- Hypotension; SBP \leq 90 or relative \downarrow BP

Contraindications:

- Unsustained/intermittent tachycardias

Pearls & Pitfalls:

- Withhold defibrillation until removed from standing water/conductive surfaces (metal)
- Hands on defibrillation can result in energy transfer to the provider
- Avoid implanted devices with defibrillator pads

As time allows:

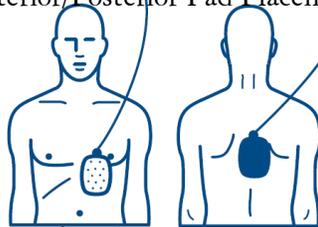
- Remove hair from pad
- Administer sedative agent
(*use caution until hypotension is corrected*)

- Attach ECG monitoring electrodes (required for demand pacing)
- Adjust view to lead with most upright QRS
- Apply pads to patient's chest
 - Use anterior-posterior placement for pediatrics
 - +++Do not place pads over implanted devices+++
- Activate the "SYNC" function
- Adjust the monitored lead until a marker is above each QRS
- Charge to the appropriate energy setting:

| Adult | Pediatric/Infant |
|--|---|
| Highest energy setting available <i>No change (CPR or energy) for shocks from ICD</i> | 0.5-1.0 joules/kg initial shock <i>Then</i> 2 joules/kg Shock |

- Clear entire resuscitation team audibly
- Depress and hold the shock/discharge button till shock is delivered (expect delay)
- Evaluate rhythm/hemodynamic status, repeat as needed
- Treat other causes of hemodynamic instability
- Observe for signs of improved hemodynamics
- Treat other causes for poor hemodynamics

Anterior/Posterior Pad Placement*



Anterior Pad Placement



* variations do exist, use as appropriate for situation

Taser Removal

Indications:

Embedded Taser probes

Contraindications:

Probes located in:

- Face
- Eye
- Neck
- Nipple/areola
- Genitals or perineum

Any probe in the provider's judgment requiring excessive force to remove

Pearls & Pitfalls:

Risk communication with Law enforcement:

Underlying etiologies which prompted Taser use may result in any of the following, and patient may still be at risk for in-custody death:

- Hyperactive Delirium with Severe Agitation Arrhythmia/sudden cardiac arrest
- Rhabdomyolysis/kidney injury-failure

Procedure:

- Ensure crew and patient safety
- Stretch skin surrounding the probe site till tight

If the traditional probe was used

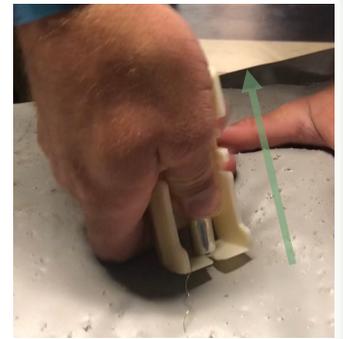
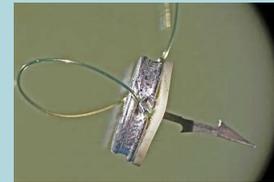
- Pull probe out of the skin in the opposite direction that it penetrated (use firm grip ± gauze)

If the flat probe style was used

- Use the probe removal tool pulling straight out the opposite direction the probe punctured the skin (do not pry the probe out against the skin)

Once removed successfully

- Clean and bandage puncture wound
- Discard probe in sharp safe container



PROCEDURES

Thoracostomy - Needle

Indications:

- Suspected tension pneumothorax with signs of poor ventilation/cardiac output
- Traumatic cardiac arrest with blunt or penetrating injury to the torso

Precautions:

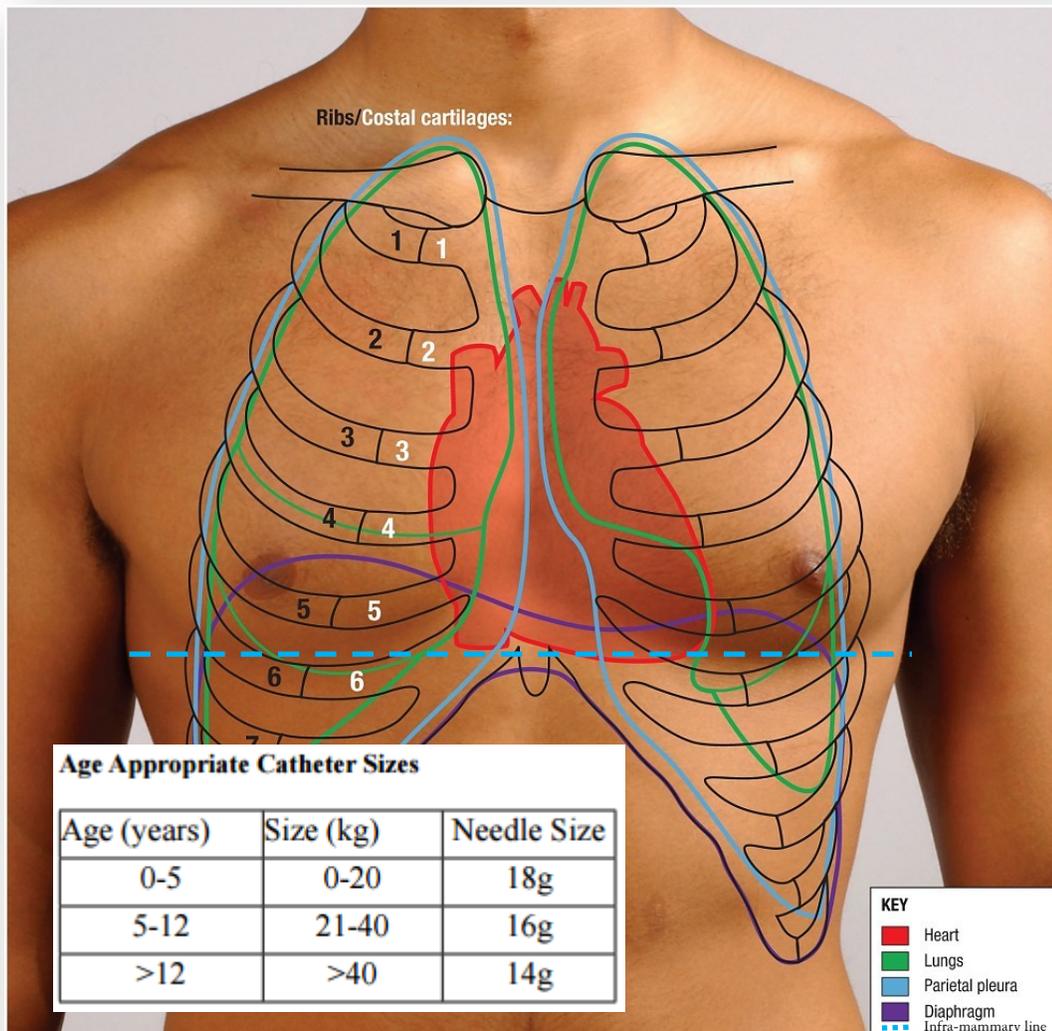
- Insertion too low can cause trauma to the liver, spleen, bowel or diaphragm
- Do not delay the procedure when indicated

- Prepare equipment: 14 G (3-inch long) angiocatheter
- Apply monitor before if time allows; *ECG, Waveform EtCO₂, NIBP every 2-minutes*
- Palpate the 5th-intercostal space, *at the infra-mammary line (just below the nipple line)*
- Insert the needle at a right angle to the chest wall, at the mid-axillary line, over the top of the lower rib
- *Insert until a rush of air is heard or the hub of the needle is reached*
 Decompress the other side as appropriate
- Remove the needle
- Leave catheter in place and open to air

If patient in traumatic cardiac arrest:

- Consider procedure bilaterally

Paramedic



Thoracostomy - Simple (Finger)

Indications:

- Traumatic circulatory arrest (TCA) or multiple failed needle decompressions

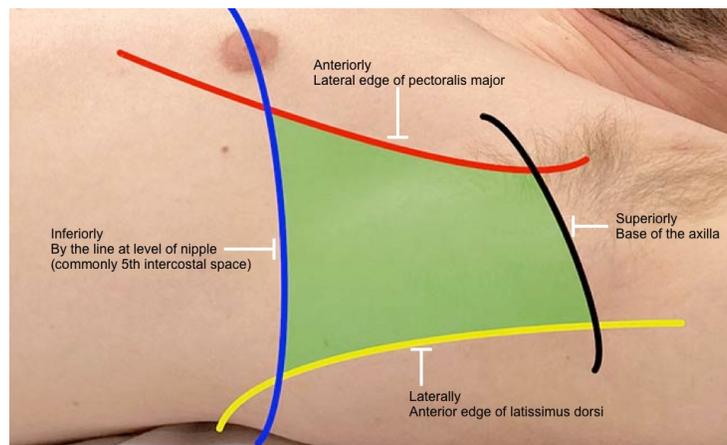
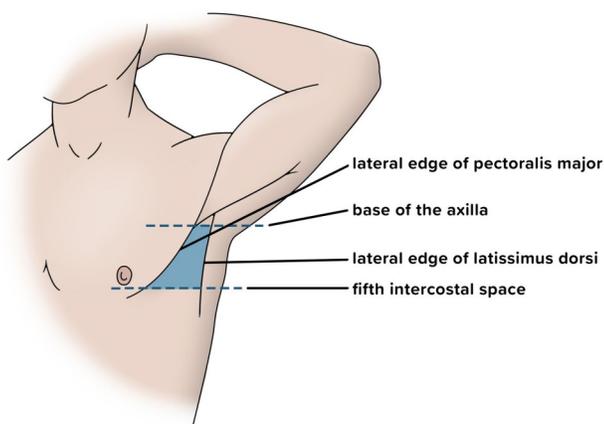
Precautions:

- For TCA - Perform as initial approach if CCP is immediately available, or after an unsuccessful needle thoracostomy prior to CCP care.
- Always err on placement higher (towards head) if landmarks uncertain. Location should be near underarm hair
- Cupping technique for landmark identification: Place your hand into axilla, 4th/5th webspace approximates insertion location

- Prepare equipment and appropriate PPE
 - Antiseptic swab
 - Scalpel
 - Curved "Kelly" hemostat
 - Gauze dressing
- Apply monitor before if time allows; ECG, Waveform EtCO₂, NIBP q2 min
- Position supine (arrest) or if non-arrest 45° upright, place or secure arm on side of procedure above patient's head
- Expose and locate landmarks within triangle of safety (4th or 5th intercostal space anterior-axillary line)
- Prepare the incision site with antiseptic swab
- Make a 1-2 cm horizontal incision over superior rib border at appropriate site
- Bluntly dissect with index finger through subcutaneous tissues until intercostal muscles are reached and identify the rib above and below
- Grip clamps with thumb and index finger 1-2 cm from the tip and while sliding **OVER** the rib puncture into pleural space
- Open/spread hemostats while withdrawing them from the pleural cavity
- Insert finger into the pleural space and sweep 360° (may omit if suspected displaced rib fracture)
- Loosely cover site with non-occlusive gauze
- Reevaluate clinical status

If signs of recurrent pneumothorax

- Remove gauze and resweep pleural space



Tourniquet

Indications:

- Extremity bleeding cannot be controlled with direct pressure

Contraindications:

- Wound over joint
- Junctional wounds

Pearls and Pitfalls:

- If the joint is the 2"-3" above the bleed, place the tourniquet above the joint.
- Placing the tourniquet in direct contact with the skin is preferred.
- Tourniquets can be placed over clothes but avoid placement over pockets containing any items.
- Caution to find the most proximal wound(s) on the extremity and place the tourniquet above, if in doubt place as high on the extremity as possible
- Do not wait for hemodynamic instability to apply a tourniquet
- Damage to the limb is unlikely if removed within several hours

- Place commercial tourniquet 2"-3" inches above the wound or as high as possible
- Tighten until hemorrhage stops and distal pulses are no longer palpable
- If initial tourniquet fails ensure tightness and placement of first tourniquet and consider placing second tourniquet more proximal or if no room below and as close to the first one as possible.
- Document time of tourniquet application
- Do not cover tourniquet
- Dress wounds and consider hemostatic agent or wound packing
- Reassess for bleeding frequently
- Consider pain management
- Do not remove or loosen once hemostasis achieved

Tracheostomy Replacement Procedures

Indications:

BVM

- Respiratory failure (acute or chronic)
- Cardiac arrest
- Suspected airway obstruction

For exchange/replacement

- Failure of 3'Cs of troubleshooting to establish tracheostomy patency
- Complete tracheostomy dislodgement
- Massive tracheostomy hemorrhage and uncuffed tracheostomy

Contraindications for exchange/replacement:

- Fresh Tracheostomy (<7 days)

Pearls & Pitfalls:

- Utilize PPE for all tracheostomy care
- Positioning is critical, tracheostomies are initially placed in hyperextended neck positioning
- If using bougie, trim/cut off coudeé (hooked) tip
- Decision to replace/exchange should weigh risks/benefits (age of tracheostomy, anticipated difficulty)
- Fresh tracheostomies have significant risk of false-tract creation with reinsertion attempts

Basic

BVM Ventilation

• If tracheostomy patent:

- [Assisted Ventilation/BVM Procedure](#)
- Position airway in slight extension
- If bagging via face
 - Perform Max BVM
 - Gently occlude tracheostomy stoma to prevent air leak

• If bagging via stoma (tracheostomy removed and failure of ventilation or laryngectomy)

- Use pediatric mask (ideally circle) and adult sized reservoir/bag
- Apply mask over the trach stoma
 - May need to hold mouth/nose closed to prevent air leak from upper airway
 - Squeeze bag (confirm 4-phase EtCO₂)

Tracheostomy Replacement/Exchange

- Preoxygenate to SpO₂ ≥ 94% if possible
- Position the patient supine with neck hyperextended, consider padding under shoulders

If no device in-situ

- Maintain sterility of equipment as possible

If replacement tracheostomy available

- Remove inner cannula if present and insert tracheostomy obturator
- If cuffed tracheostomy, assess integrity of cuff
- Lubricate tracheostomy
- Consider “preloading” tie or securing device to one side of tracheostomy
- Gently insert tracheostomy initially at a 90-degree angle and then slowly rotate back to a neutral position and curve downward into the trachea in a sweeping motion
- Mild resistance as balloon passes through stoma may occur

If resistance, consider

- Repositioning and inspection of tracheostomy
- Smaller sized tracheostomy (back-up trach)
- Do not advance tracheostomy and discontinue if marked resistance.
- Insert trach gently until seated level with skin
- Inflate cuff with 10 mL (or manufacturer recommended volume)
- Remove obturator and replace inner cannula (if present and required)

If replacement tracheostomy unavailable

- Utilize 6.0 ETT or size appropriate for patient and lubricate tube
- Insert until thick black line just deep to the skin
- Inflate cuff with 10cc of air and gently withdraw the bougie
- Secure device and verify placement with EtCO₂ and bilateral breath sounds

If tracheostomy is in-situ to facilitate exchange

- Prepare equipment tracheostomy or ETT as above
- No obturator required
- Insert bougie through original tracheostomy, do not insert fully
- While maintaining bougie remove original trach
- Insert new device over bougie
- Inflate cuff, as appropriate

Paramedic

Traction Splint (Sager)

Indications:

Mid-shaft femur fracture

Contraindications:

- Injuries close to the knee or involving the knee itself
- Hip or pelvic injuries
- Lower leg or ankle injuries
- Partial amputation or avulsion with bone separation while only marginal tissue connects the distal limb

- After exposing the injured area, check the patient's pulse and motor and sensory function. Adjusts the thigh strap so that it lies anteriorly when secured
- Estimate the proper length of the splint by placing it next to the injured limb
- Fits the ankle pads to the ankle
- Places the splint at the inner thigh, apply the thigh strap at the upper thigh, secure snugly
- Tighten the ankle harness just above the malleoli. Snug the cable ring against the bottom of the foot
- Extend the splint's inner shaft to apply traction at about 10% of body weight
- Secures the splint with elasticized cravats
- Checks pulse, motor, and sensory functions.

Pharmacopeia

| Medication | Class |
|--|---|
| Acetaminophen | Analgesic/Antipyretic |
| Indications: | Contraindications: |
| <ul style="list-style-type: none"> → Acute Pain Management → Fever | <ul style="list-style-type: none"> → Active and severe hepatic disease → Severe hepatic impairment → Hypersensitivity to acetaminophen |

Protocol, Dosage, and Administration

Acute Pain Management,

Adult: 1 g PO

Pedi: 15 mg/kg PO (Max dose 1 g)

Adult: 15mg/kg IV (Max dose 1 g)

Pedi > 2 years of age: Same as Adult

Fever, ≥ 100.4

Adult: 1 g PO

Pedi: 15 mg/kg PO (Max dose 1 g)

Adult: 15mg/kg IV (Max dose 1 g)

Pedi > 2 years of age: Same as Adult

Medication

Class

Adenosine

Endogenous Nucleoside

Indications:

- Conversion of SVT:PAT to sinus rhythm
- Identification of supraventricular rhythms (SVT:PAT vs. A. Flutter)

Contraindications:

- Irregular wide complex tachycardia
- Second or third degree block
- Hypersensitivity to adenosine

Protocol, Dosage, and Administration

Tachycardias: Stable, Regular, Narrow Complex

Adult: 12 mg rapid IV/IO

Repeat PRN, 18 mg x 1

Pedi: 0.1 mg/kg rapid IV/IO

Repeat PRN 0.2 mg/kg (max 12 mg) x 1

| Medication | Class |
|---|---|
| Albuterol | Sympathomimetic, bronchodilator, beta-2 agonist |
| Indications: | Contraindications: |
| <ul style="list-style-type: none"> → Treatment of bronchospasm → Wheezing | <ul style="list-style-type: none"> → Hypersensitivity to albuterol |

Protocol, Dosage, and Administration

Allergic Reaction Anaphylaxis: Wheezing/Bronchospasm

Adult: 2.5 mg with 0.5 mg ipratropium in 3 mL NS nebulized

Repeat PRN x 2

Pedi: Same as Adult

Respiratory Support: Asthma, COPD, Wheezing, Reactive Airway Disease

Adult: 2.5 mg with 0.5 mg ipratropium in 3 mL NS nebulized

Repeat PRN x 2

If persistent wheezing/respiratory distress after 3 albuterol/ipratropium doses

7.5 mg in 9 mL NS (continuously nebulized)

Pedi: Same as Adult

Medication

Class

Amiodarone

Antidysrhythmic

Indications:

- Suppression of VF/pulseless VT refractory to defibrillation
- Suppression of stable VT

Contraindications:

- Medication induced ventricular dysrhythmias
- Second or third-degree block
- Hypotension
- Bradycardia
- Torsades de Points
- Narrow Complex (QRS < 0.12 sec)
- Hypersensitivity to amiodarone

Protocol, Dosage, and Administration

Preparation:

Bolus: 150 mg in 100 mL of NS

Cardiac Arrest: VF/VT

- Adult: 300 mg IV/IO push after second defibrillation
If persistent or recurrent VF/VT 150 mg IV/IO x 1
- Pedi: 5 mg/kg IV/IO (max 300 mg) after second defibrillation
If persistent or recurrent VF/VT Repeat PRN x 2 q 4-minutes

Tachycardias: Stable Wide Ventricular Tachycardia

- Adult: 150 mg IV/IO bolus over 10 min (600 mL/hr)
Repeat PRN x 1
- Pedi: 5 mg/kg IV/IO (max 150 mg) bolus over 10 min

| Tachycardia - Pedi | |
|--------------------|------------------------------------|
| Kg: | Volume (mL) to infuse over 10 min: |
| 2.5 | 8 |
| 5 | 17 |
| 10 | 33 |
| 15 | 50 |
| 20 | 67 |
| 25 | 83 |
| 30 | 100 |
| 35 | 100 |

Medication

Class

Aspirin

Anti-inflammatory, platelet inhibitor

Indications:

→ Chest pain or anginal equivalents suggestive of ACS

Contraindications:

→ Gastrointestinal bleeding

→ Hypersensitivity to NSAIDs

Protocol, Dosage, and Administration

Acute Coronary Syndrome/STEMI

Adult: 324 mg PO chewed

Pedi: N/A

Medication

Class

Atropine

Anticholinergic

Indications:

- Hemodynamically unstable bradycardia
- Organophosphate poisoning
- Nerve agent antidote

Contraindications:

- Tachycardia
- Hypovolemic shock
- Hypersensitivity to atropine

Protocol, Dosage, and Administration

Symptomatic Bradycardia

Adult: 1 mg IV/IO

Repeat PRN to max dose 3 mg

Pedi: 0.02 mg/kg IV/IO (minimum dose 0.1 mg and max single dose 1 mg)

Repeat PRN x 1

Toxicology: Organophosphate poisoning

Adult: 2 mg IV/IM/IO

Repeat PRN 2 mg q 3 minutes until signs of significant atropinization

Pedi: 0.02 mg/kg IV/IM/IO (max single dose 2 mg)

Repeat PRN until signs of atropinization

Medication

Class

Buprenorphine

Opioid partial agonist

Indications:

- Detoxification from opioids
- Maintenance therapy for opiate use disorder

Contraindications:

- Known or suspected GI obstruction
- Respiratory depression
- Acute alcohol or benzodiazepine intoxication
- Adrenal insufficiency
- Hepatic insufficiency
- Pregnancy
- Severe hypersensitivity

Protocol, Dosage, and Administration

Opiate Use Disorder

Adult; 8 - 24 mg buccal (SL strips or tabs) per physician order

repeat 8 - 16 mg (max 32 mg) q 15 minutes PRN x 1 COWS score >8 or symptoms not resolved

Pedi: N/A

Medication

Class

Calcium Chloride

Parenteral Mineral

Indications:

- Calcium channel blocker overdose
- Hyperkalemia

Contraindications:

- Suspected digitalis toxicity

Protocol, Dosage, and Administration

Cardiac Arrest: Hyperkalemia, Calcium Channel Blockers

Adult: 1 g IV/IO slow push

Pedi: 20 mg / kg (0.2 mL/kg) IV/IO, slow push (max dose 1 g)

Symptomatic Bradycardia: Hyperkalemia, Calcium Channel Blocker Overdose

Adult: 1 g IV/IO slow push

Pedi: 20 mg / kg (0.2 mL/kg) IV/IO, slow push (max dose 1 g)

Toxicology: Calcium Channel Blocker Overdose

Adult: 1 g IV/IO slow push

Pedi: 20 mg / kg (0.2 mL/kg) IV/IO, slow push (max dose 1 g)

Entrapment/Crush/Traumatic Rhabdomyolysis: Hyperkalemia

Adult: 1 g IV/IO slow push

Pedi: 20 mg / kg (0.2 mL/kg) IV/IO, slow push (max dose 1 g)

Medication

Class

Dexamethasone

Adrenal Glucocorticoid

Indications:

- Asthma
- Wheezing
- Pediatric anaphylaxis
- Barking cough/stridor

Contraindications:

- Advanced glaucoma
- Systemic fungal infection
- Hypersensitivity to dexamethasone

Protocol, Dosage, and Administration

Allergic Reaction/Anaphylaxis

Adult: 10 mg IV/IM

Pedi: 0.6 mg/kg (max dose 10 mg) IM/IV/PO

Circulatory Support: Addison Disease / Adrenal Insufficiency

Adult: 10 mg IV/IM

Pedi: 0.6 mg/kg (max dose 10 mg) IM/IV/PO

Respiratory Support: Asthma/COPD/Wheezing/Croup

Adult: 10 mg IV/IM

Pedi: 0.6 mg/kg (max dose 10 mg) IM/IV/PO

Medication

Class

Dextrose 10%

Carbohydrate, Altered mental status

Indications:

- Hypoglycemia
- Altered mental status

Contraindications:

Protocol, Dosage, and Administration

Diabetic Emergencies

Adult: 100 mL IV/IO bolus
Repeat PRN up to 50 g (500 mL)

Pedi: 5 mL/kg IV/IO bolus
Repeat PRN up to 25 g (250 mL)

OB/GYN - Newly Born: Blood Glucose < 50 mg/dL

Newborn: 2 mL/kg IV/IO bolus

Medication

Class

Diltiazem

Calcium channel blocker

Indications:

→ Control of rapid ventricular rates caused by atrial fibrillation or atrial flutter during interfacility transports or by order from Hospital at Home (HaH) Physician

Contraindications:

→ Hypotension
→ Second or third-degree block
→ Wide complex tachycardia
→ Cardiogenic shock

Protocol, Dosage, and Administration

Tachycardias: Stable, Narrow Complex, Regular or Irregular

Adult: 0.25 mg/kg IV/IO, slow push

Repeat PRN x 1

Pedi: N/A

Medication

Class

Diphenhydramine

Antihistamine, Anticholinergic

Indications:

- Allergic reaction
- Anaphylaxis
- Acute dystonic reactions

Contraindications:

- Hypersensitivity to diphenhydramine

Protocol, Dosage, and Administration

Allergic Reaction/Anaphylaxis:

Adult: 25-50 mg PO

Pedi: PO N/A

Adult: 50 mg IV/IM/IO

Pedi: 1 mg/kg IV/IM/IO (max dose 50 mg)

Toxicology: Dystonia reaction

Adult: 50 mg IV/IM/IO

Pedi: 1 mg/kg IV/IM/IO (max dose 50 mg)

Medication

Class

Droperidol

Dopamine Antagonist

Indications:

- Behavioral Emergency/Agitation
- Refractory Nausea/Vomiting
- Cannabinoid Hyperemesis Syndrome
- Atraumatic Headache

Contraindications:

- Unconsciousness
- Parkinson's Disease
- Hypersensitivity to Droperidol

Protocol, Dosage, and Administration

Behavioral Emergencies/Agitation: RASS 2+ to 3+ (Moderate Agitation)

Adult: 5 mg IV/IO/IM

Repeat PRN 2.5 mg q 10-minutes x1

Pedi: **Contact OLMC** 0.05 mg/kg IV/IO/IM

Behavioral Emergencies/Agitation: RASS 3+ to 4+ (Severe Agitation) / RASS 4+ (Violent Agitation with Delirium)

Adult: 10 mg IM

Repeat PRN 5 mg q 10-minutes x1

****For patients ≥ 65 years old: Decrease to half the original dose for dosages ≥ 5 mg****

Pedi: **Contact OLMC** 0.1 mg/kg IV/IO/IM

Repeat PRN 0.05 mg/kg q 10-minutes x1

Nausea and Vomiting: Despite ondansetron, or gastroparesis / cyclical vomiting syndrome

Adult: 1.25 mg IM or Slow IV/IO

Repeat PRN 0.625 mg q 10-minutes x1

Pedi: N/A

Atraumatic Headache

Adult: 1.25 mg IM/slow IV/IO

Repeat PRN 0.625 mg q 10-minutes x1

Pedi: N/A

Medication

Class

Epinephrine

Sympathomimetic

Indications:

- Cardiac arrest
- Anaphylaxis
- Shock/hypotension
- Severe allergic reaction
- Asthma
- Symptomatic Bradycardia

Contraindications:

- Hypertension
- Hypothermia
- Trauma (push-dose only)

Protocol, Dosage, and Administration

Preparation:

- Push Dose Epi (PDE): 1 mL 1:10,000 / 9 mL NS Flus
(Solution = 10 mcg/mL)
- Infusion: 1 mg (10 mL) 1:10,000 / 250 mL NS
1 mg (1 mL) 1:1,000 / 250 mL NS
(Solution = 4 mcg/mL)
- CA Push: 1 mg (1 mL) 1:1,000 / 9 mL NS
(When 1 mg 1:10,000 not available)
- CA Infusion: 2 mg (20 mL) 1:10,000 / 250 mL NS

Allergic Reaction/Anaphylaxis: Severe Signs/Symptoms

- Adult: 0.5 mg (1:1,000) IM
Repeat PRN q 5 min x2
- Pedi: 0.01 mg/kg (1:1,000) IM (max dose 0.5 mg)
Repeat PRN q 5-10 min x2

Allergic Reaction/Anaphylaxis: Signs of Anaphylaxis/Shock

- Adult: PDE 10 mcg (1 mL)
Repeat PRN q 5 min,
(max total dose 50 mcg or 5 mL)
- Pedi: PDE 1 mcg/kg (max dose 10 mcg)
Repeat PRN q 5 min,
(max total dose 50 mcg or 5 mL)
- Adult: Epi Infusion 5 mcg/min
Titrate to MAP > 65
- Pedi: Epi Infusion 0.1 mcg/kg/min
Titrate by 0.1 mcg/kg/min q 2 min to age
appropriate goals

Cardiac Arrest: All Initial Rhythms

- Adult: 1 mg (1:10,000) IV/IO x 1
- Pedi: 0.01 mg/kg (1:10,000) IV/IO
Repeat q 5 minutes x 2

Cardiac Arrest: Initial non-Shockable Rhythm

- Adult: Infusion 67 mcg/min or 540 mL/hr
- Pedi: Infusion N/A

Circulatory Support

- Adult: PDE 10 mcg (1 mL)
Repeat PRN q 5 min, (max total dose 50 mcg or 5 mL)
- Pedi: PDE 1 mcg/kg (max dose 10 mcg)
Repeat PRN q 5 min, (max total dose 50 mcg or 5 mL)

Adult: Epi Infusion 5 mcg/min

Titrate to MAP > 65

Pedi: Epi Infusion 0.1 mcg/kg/min

Titrate by 0.1 mcg/kg/min q 2 min to age
appropriate goals

Respiratory Support: Asthma only with impending failure

- Adult: 0.5 mg (1:1,000) IM
Repeat PRN q 5 min x1
- Pedi: 0.01 mg/kg (1:1,000) IM (max dose 0.5 mg)
Repeat PRN q 5 min x1

Symptomatic Bradycardia

- Adult: N/A
- Pedi: 0.01 mg/kg IV/IO (max dose 0.1 mg) x1

Symptomatic Bradycardia: Beta Blocker Overdose

- Adult: Epi Infusion 5 mcg/min
Titrate to MAP > 65
- Pedi: Epi Infusion 0.1 mcg/kg/min
Titrate by 0.1 mcg/kg/min q 2 min to age
appropriate goals

Toxicology: Beta Blocker Overdose

- Adult: Epi Infusion 5 mcg/min
Titrate to MAP > 65
- Pedi: Epi Infusion 0.1 mcg/kg/min
Titrate by 0.1 mcg/kg/min q 2 min to age
appropriate goals

Medication

Class

Esmolol (Adult)

Beta Blocker

Indications:

→ Cardiac arrest

Contraindications:

→ Hypertension

Protocol, Dosage, and Administration

Preparation:

Bolus - push

Infusion - premixed 2,500 mg / 250 mL (10 mg / mL)

Cardiac Arrest: VF/VT

Adult: 0.5 mg / kg IV/IO bolus (50 mg max) then
Infusion 0.05 mg / kg / min (5 mg/min max)

Pedi: N/A

Medication

Class

Fentanyl

Analgesic, Opioid

Indications:

→ Pain

Contraindications:

→ Intolerance / Hypersensitivity

→ Respiratory depression

→ Hemodynamic instability (relative)

→ Active labor (relative)

Protocol, Dosage, and Administration

Acute Pain Management

Adult: 1 mcg/kg IV/IN/IM (max single dose 100 mcg)

Repeat PRN, titrate to pain relief and respiratory/hemodynamic status

Pedi: Same as Adult

Medication

Class

| | |
|---|---|
| Glucagon | Antihypoglycemic, Pancreatic hormone, Insulin antagonist |
| Indications: | Contraindications: |
| → Hypoglycemia → Beta-blocker overdose | → Hyperglycemia → Insulinoma → Hypersensitivity to glucagon |

Protocol, Dosage, and Administration

Cardiac Arrest: Beta-blocker overdose

Adult: 1 mg IV/IO slow push over 1 min

Repeat PRN 1 mg IV/IO x 1

Pedi: 0.1 mg/kg IV/IO slow push over 1 min (max single dose 1 mg)

Repeat PRN 0.2 mg/kg IV/IO x 1 (max single dose 1 mg)

Diabetic Emergencies

Adult: 1 mg IM

Pedi: 0.1 mg/kg IM (max dose 1 mg)

Symptomatic Bradycardia: Beta-blocker overdose

Adult: 1 mg IV/IO slow push over 1 min

Repeat PRN 1 mg IV/IO x 1

Pedi: 0.1 mg/kg IV/IO slow push over 1 min (max single dose 1 mg)

Repeat PRN 0.2 mg/kg IV/IO x 1 (max single dose 1 mg)

Toxicology: Beta-blocker overdose

Adult: 1 mg IV/IO slow push over 1 min

Repeat PRN 1 mg IV/IO x 1

Pedi: 0.1 mg/kg IV/IO slow push over 1 min (max single dose 1 mg)

Repeat PRN 0.2 mg/kg IV/IO x 1 (max single dose 1 mg)

Medication

Class

Glucose - Oral

Antihypoglycemic

Indications:

→ Conscious patient with suspected hypoglycemia

Contraindications:

→ Decreased level of consciousness

→ Unable to swallow/maintain own airway

→ Nausea and vomiting

Protocol, Dosage, and Administration

Diabetic Emergencies

Adult: 15 g buccal

Pedi: 7.5 g buccal

Medication

Class

Haloperidol

Dopamine Antagonist

Indications:

- Behavioral Emergency/Agitation
- Refractory Nausea/Vomiting
- Psychiatric Disease

Contraindications:

- Unconsciousness
- Parkinson's Disease
- Hypersensitivity to Haloperidol

Protocol, Dosage, and Administration

Behavioral Emergencies/Agitation: RASS 2+ to 3+ (Moderate Agitation)

Adult: 5 mg IV/IO/IM

Repeat PRN 2.5 mg q 10-minutes x1

Pedi: **Contact OLMC** 0.05 mg/kg IV/IO/IM

Behavioral Emergencies/Agitation: RASS 3+ to 4+ (Severe Agitation) / RASS 4+ (Violent Agitation with Delirium)

Adult: 10 mg IM

Repeat PRN 5 mg q 10-minutes x1

****For patients ≥ 65 years old: Decrease to half the original dose for dosages ≥ 5 mg****

Pedi: **Contact OLMC** 0.1 mg/kg IV/IO/IM

Repeat PRN 0.05 mg/kg q 10-minutes x1

Nausea and Vomiting: Despite ondansetron, or gastroparesis / cyclical vomiting syndrome

Adult: 1.25 mg IM or Slow IV/IO

Repeat PRN 0.625 mg q 10-minutes x1

Pedi: N/A

Medication

Class

Hydroxocobalamin

Antidote

Indications:

→ Suspected cyanide poisoning

Contraindications:

→ None

Protocol, Dosage, and Administration

Preparation

Bolus infusion: 5 g / 200 mL NS (25 mg/mL)

Toxicology:

Adult: 5 g IV/IO over 15 minutes,
Repeat PRN x 1

Pedi: 70 mg/kg IV/IO over 15 minutes,
Repeat PRN x 1;

Contact [OLMC](#) following initial dose

| Toxicology - Pedi | |
|-------------------|------------------------------------|
| Kg: | Volume (mL) to infuse over 15 min: |
| 2.5 | 7 |
| 5 | 14 |
| 10 | 28 |
| 15 | 42 |
| 20 | 56 |
| 25 | 70 |
| 30 | 84 |
| 35 | 98 |

Medication

Class

Ibuprofen

Nonsteroidal Anti-inflammatory Drug

Indications:

→ Pain

Contraindications:

→ Intolerance / Hypersensitivity

→ Active peptic ulcer disease

→ Active bleeding / bleeding disorder

→ Advanced chronic kidney disease with or without dialysis

→ Renal Transplant

→ Trauma

→ Pregnancy or breastfeeding

Protocol, Dosage, and Administration

Acute Pain Management

Adult: 600 mg PO

Pedi > 6 months: 10 mg/kg PO (max dose 600 mg)

Fever

Adult: 600 mg PO

Pedi > 6 months: 10 mg/kg PO (max dose 600 mg)

Medication

Class

Ipratropium Bromide

Bronchodilator, Anticholinergic

Indications:

- Asthma
- COPD
- Emphysema
- Acute bronchospasm

Contraindications:

- Hypersensitivity to atropine or its derivatives
- Hypersensitivity to ipratropium bromide

Protocol, Dosage, and Administration

Allergic Reaction/Anaphylaxis: Wheezing/Bronchospasm

Adult - Mix 0.5 mg with 2.5 mg Albuterol in 3 mL NS and nebulize
Repeat PRN x 2

Pedi - Same as Adult

Respiratory Support: Asthma/COPD/Wheezing/Reactive airway disease

Adult - Mix 0.5 mg with 2.5 mg Albuterol in 3 mL NS and nebulize
Repeat PRN x 2

Pedi - Same as Adult

Medication

Class

Isopropyl Alcohol (inhaled)

Antiemetic

Indications:

→ Nausea and vomiting

Contraindications:

→ Hypersensitivity to isopropyl alcohol

Protocol, Dosage, and Administration

Nausea and Vomiting

Adult: 3-pads, Repeat PRN x 1

Pedi: Same as Adult

Instruct patient to hold pads 1-2 cm from nose and inhale deeply as frequently as required to achieve nausea relief.

Medication

Class

Ketamine

Anesthetic Adjunct

Indications:

- Analgesia
- Sedation for procedures or post-airway management
- Induction agent in intubation

Contraindications:

- Hypersensitivity to ketamine

Protocol, Dosage, and Administration

Preparation

Push

Infusion: Adult - 200 mg / 100 mL NS

Pedi - 50 mg / 100 mL NS

Delayed Sequence Intubation (DSI)

Adult: 2 mg/kg IV/IO (max 200 mg)

Repeat PRN x 1

Pedi: N/A

Rapid Sequence Airway (RSA)

Adult: 2 mg/kg IV/IO (max 200 mg)

Repeat PRN x 1

Pedi: Same as Adult

Post-Invasive Airway Management: Immediately after invasive airway secured or 15 min after rocuronium given or RASS goal

Adult: 2 mg/kg IV/IO

Repeat PRN q 15 min or more frequently to maintain RASS goal of -5

Pedi: Same as Adult

Post-Invasive Airway Management: Infusion if RASS goal not met or signs of awakening, movement, or discomfort

Adult: 1 mg/min, titrate by 1 mg/min to goal RASS

Pedi: 10 mcg/kg/min, titrate by 5 mcg/kg/min to maintain goal RASS

Acute Pain Management: Moderate to severe acute pain

Adult: IV/IO: 0.3 mg/kg in 100 mL NS over 10 min (max single dose: 30 mg), repeat PRN q 10-min x 1

IM: 0.6 mg/kg (max single dose 50 mg), repeat PRN q 10-min x 1

Pedi: Same as Adult

Behavioral Emergencies/Agitation: Violent agitation with delirium (RASS +4)

Adult: 4 mg/kg IM (max single dose 400 mg)

Pedi: 1 mg/kg IV Or 2 mg/kg IM

Cardiac Arrest: Signs/symptoms of CPR induced consciousness

Adult: 1 mg/kg IV/IO slow push (max single dose 200 mg)

Pedi: Same as Adult

Symptomatic Bradycardia: Sedation prior to/during pacing if time permits and if adequate respiration

Adult: IV/IO: 0.3 mg/kg slow push (max single dose: 30 mg), repeat PRN q 10-min x 1

IM: 0.6 mg/kg (max single dose 50 mg), repeat PRN q 10-min x 1

Pedi: Same as Adult

Tachycardia: Sedation prior to/during Cardioversion if time permits

Adult: IV/IO: 0.3 mg/kg slow push (max single dose: 30 mg), repeat PRN q 10-min x 1

IM: 0.6 mg/kg (max single dose 50 mg), repeat PRN q 10-min x 1

Pedi: Same as Adult

Medication

Class

Ketorolac

Nonsteroidal Anti-inflammatory Drug

Indications:

→ Pain

Contraindications:

→ Intolerance / Hypersensitivity

→ Active peptic ulcer disease

→ Active bleeding / bleeding disorder

→ Advanced chronic kidney disease with or without dialysis

→ Renal Transplant

→ Trauma

→ Pregnancy or breastfeeding

Protocol, Dosage, and Administration

Acute Pain Management

Adult: 15 mg IV or 30 mg IM

Pedi: 0.5 mg/kg IV/IM (max single dose 15 mg)

Medication

Class

Labetalol

Antihypertensive, Beta Blocker

Indications:

→ Maternal Hypertension

Contraindications:

→ Hypotension
→ Severe hypersensitivity
→ Asthma
→ Overt cardiac failure
→ Severe bradycardia

Protocol, Dosage, and Administration

Pre-Eclampsia / Eclampsia: maternal HR > 60 and SBP \geq 160 or DBP \geq 110 with severe symptoms

Adult; 20mg IV over 2 minutes,
repeat 40 mg IV PRN q 10 minutes

Pedi: N/A

MIH - HaH Program

Adult: Dosing per HaH physician order
Standard dosing 200-400 mg every 12 hours

Pedi: 1-3 mg/kg/day divided every 12 hours; not to exceed 1200 mg/day

Medication

Class

Lidocaine 2%

Local anesthetic

Indications:

→ IO access

Contraindications:

→ Hypersensitivity to lidocaine

Protocol, Dosage, and Administration

Procedure: Intraosseous (IO) Access

Adult: 40 mg slow IO bolus prior to infusion

Pedi: 0.5 mg/kg slow IO bolus prior to infusion

MIH-HaH: program dosing per HaH physician order

Adults: 2% Topical Standard dosing

Apply to the affected area 3-4 times daily

Max single application dose 5g for 2% concentration, or 6 inches for 5% concentration

Pedi: Dose is based on body weight and must be determined by physician

Medication

Class

Magnesium Sulfate

Electrolyte

Indications:

- Torsades de Pointes
- Asthma
- Pre-eclampsia
- Eclamptic seizure (peri or postpartum)

Contraindications:

- Heart block
- Renal disease

Protocol, Dosage, and Administration

Preparation:

- Bolus: slow push
- Infusion: 10 g in 250 mL NS

Medical Cardiac Arrest: Torsades de Pointes

- Adult: 2 g IV/IO slow push
- Pedi: 25-50 mg/kg (max 2 g) IV/IO slow push

Respiratory Support: Severe Asthma/COPD/Wheezing

- Adult: 2 g over 15 min (rate 200 mL/hr, total volume 50 mL)
- Pedi: 40 mg/kg over 15 min (max 2 g)

PreEclampsia / Eclampsia: Suspected preeclampsia or eclamptic seizure

- Adult: 6 g IV over 15 min
- Follow with 2 g/hr IV infusion

| Respiratory - Pedi | |
|--------------------|------------------------------------|
| Kg: | Volume (mL) to infuse over 10 min: |
| 2.5 | 2.5 |
| 5 | 5 |
| 10 | 10 |
| 15 | 15 |
| 20 | 20 |
| 25 | 25 |
| 30 | 30 |
| 35 | 35 |

Medication

Class

Midazolam

Short-acting benzodiazepine, CNS depressant

Indications:

- Sedation
- Sympathomimetic overdose
- Behavioral emergencies
- Seizures

Contraindications:

- Depressed vital signs
- Shock
- Hypersensitivity to midazolam
- Musculoskeletal spasms

Protocol, Dosage, and Administration

Toxicology: Sympathomimetic intoxication

Adult: 2.5 - 5.0 mg Slow IV/IO

Repeat PRN q 5 minutes (max total dose 10 mg)

Pedi: 0.05 mg/kg (max dose 2.5 mg) IV,

Repeat PRN q 5 min x 1

Behavioral Emergencies/Agitation: RASS + 1

Adult - 2.5 mg IV/IO/IM/IN

Repeat PRN q 10-min x 1

Pedi - 0.05 mg/kg (max dose 2.5 mg) IV/IO/IM/IN

Repeat PRN q 10-min x 1

Behavioral Emergencies/Agitation: RASS > +1 and non-pharmacological interventions unsuccessful

Adult - 5 mg IV/IO/IM

Repeat PRN q 10-min

Pedi - 0.1 mg/kg (max dose 5 mg) IV/IO/IM

Repeat PRN q 10-min

Seizure/Status Epilepticus: If actively seizing, or in status epilepticus

Adult: 10 mg IM/IN; or 5 mg slow IV/IO, (IM is first-line route if IV not already established)

Repeat PRN q 5 min x 2

Pedi: 0.15 mg/kg Slow IV/IO/IM (max dose 2.5 mg),

Repeat PRN q 5-min x 1

Hyperthermia/Heat Stroke; If shivering during cooling

Adult: 2.5 mg IV/IO/IN

Pedi: 0.05 mg/kg IV/IO or 0.1 mg/kg IM/IN

Repeat PRN q 5-min x 1 (max total dose 2.5 mg)

Medication

Class

Naloxone

Opioid antagonist

Indications:

- Opiate overdose with CNS depression, miosis, and respiratory depression (all 3)
- Coma of unknown origin

Contraindications:

- Cardiac arrest with no evidence of opiate overdose
- Use with caution in narcotic dependent patients
- Use with caution in neonates of narcotic-addicted mothers
- Hypersensitivity to naloxone

Protocol, Dosage, and Administration

Opiate Use Disorder: suspected opiate intoxication with respiratory and CNS depression

Adult: 2 mg IN (1 mg in each nostril)

Repeat PRN q 5-minutes x 1

0.5 mg IV/IO,

Repeat PRN q 5 min (max total dose 4 mg)

Pedi: 0.5 mg IN

Repeat PRN q 5-minutes (max total dose 2 mg)

IV/IO Same as Adult (max total dose 2 mg)

Medication

Class

Nifedipine

Antihypertensive, Calcium channel blocker

Indications:

→ Patients between 20 weeks gestation and 6 weeks post partum meeting blood pressure criteria for preeclampsia

Contraindications:

→ Hypersensitivity to nifedipine

Protocol, Dosage, and Administration

PreEclampsia / Eclampsia : SBP ≥ 160 or DBP ≥ 110 confirmed by correctly fitted cuff on 2 readings 5 minutes apart

Adult: 10 mg SL

Pedi: N/A

Medication

Class

Nitroglycerin

Nitrate, Coronary vasodilator

Indications:

- Acute angina
- Ischemic chest pain
- Congestive heart failure pulmonary edema

Contraindications:

- Recent use of erectile dysfunction medications
- Hypotension
- Hypovolemia
- Intracranial bleeding/head injury
- Hypersensitivity to nitroglycerin

Protocol, Dosage, and Administration

Acute Coronary Syndrome/STEMI

Adult: 0.4 mg SL q 5 min, titrate to SBP \geq 100 and signs/symptoms

Pedi: N/A

SCAPE

Adult: 0.4 mg SL q 5 min, titrate to goal SBP < 180

Pedi: N/A

Adult: Bolus - 1 mg Slow IV push

Pedi: N/A

Adult: Infusion - 100 mcg/min, titrate rapidly down as blood pressure drops, goal SBP < 180

Pedi: N/A

MIH - H@H Program: Angina Pectoris or Congestive Heart Failure

Adult: 2% Topical, Dosing per H@H physician order

Standard - 1.5 inches every 4 hours (increase by 0.5-1 inch up to 4 inches)

Medication

Class

Norepinephrine

Sympathomimetic, Vasopressor

Indications:

Contraindications:

→ Hypotension

→

Protocol, Dosage, and Administration

Preparation:

Infusion: 4 mg / 250 mL NS

Target BP goals:

- TBI/Stroke: > 110 mm Hg
- Blunt Trauma: = 100 mm Hg (max 500 mL)
- Hemorrhagic Shock or Penetrating Trauma: SBP = 90 mm Hg (max 500 mL)
- Other patients:
 - Adult - MAP > 65 (or SBP > 90 mm Hg if manual measurement)
 - Pedi - SBP > 70 mm Hg + (age in years x 2) or > 90 mm Hg for age 10 or greater

Circulatory Support

Adult - 5 mcg/min, titrate to goals

Pedi - 0.1 mcg/kg/min, titrate to goals

Post ROSC

Adult - 5 mcg/min, titrate to MAP \geq 65

Pedi - 0.1 mcg/kg/min, titrate to age appropriate goals

| Dial-a-Flow Dose and Rate <i>*For Pump Failure Only*</i> | |
|--|---------|
| mcg / min | mL / hr |
| 2 | 7.5 |
| 3 | 11 |
| 4 | 15 |
| 5 | 19 |
| 6 | 22.5 |
| 7 | 26 |
| 8 | 30 |
| 9 | 34 |
| 10 | 37.5 |
| 15 | 56 |
| 20 | 75 |
| 25 | 94 |
| 30 | 112.5 |

Medication

Class

Ondansetron

Antiemetic

Indications:

→ Nausea and vomiting

Contraindications:

→ Hypersensitivity to ondansetron

Protocol, Dosage, and Administration

Nausea and Vomiting

Adult: 4 mg ODT

Repeat PRN q 10-min x 1

Pedi: 8-15 kg: 2 mg ODT

Repeat PRN q 10-min x 1

16-30 kg: Same as Adult

Nausea and Vomiting

Adult: 4 - 8 mg IM/IV

Repeat PRN q 10-min x1

Pedi: 0.15 mg/kg (max dose 4 mg) IM/IV

Medication

Class

Oxymetazoline (Afrin)

Decongestant, vasoconstrictor

Indications:

→ Epistaxis

Contraindications:

→ Hypersensitivity to drug or ingredients

Protocol, Dosage, and Administration

Hemorrhage Control: if ongoing epistaxis despite direct pressure, blow nose then:

Adult: 2 squirts to affected nare(s)

Pedi: Same as adult

Medication

Class

Oxytocin

Pituitary hormone, Uterine stimulant

Indications:

→ Postpartum hemorrhage

Contraindications:

→ Hypersensitivity to oxytocin

Protocol, Dosage, and Administration

Hemorrhage Control: if significant OB related hemorrhage following complete placental delivery

Adult: 10 units IM followed by 20 units / 1 L NS IV, run wide open

Pedi: N/A

Medication

Class

Phenylephrine

Vasoconstrictor

Indications:

→ Hypotension refractory to norepinephrine

Contraindications:

→ Ventricular tachycardia

→ Severe hypertension

→ Closed angle glaucoma

→ Severe hypersensitivity

Protocol, Dosage, and Administration

Preparation

Push Dose: 10 mg / 100 mL NS; 100 mcg / mL

Circulatory Support

Adult: 50 mcg (0.5 mL) q 3 minutes; titrate to target BP goals

Pedi: N/A

Medication

Class

Racemic Epinephrine

Bronchodilator

Indications:

→ Moderate to severe croup

Contraindications:

Hypersensitivity to epinephrine

Protocol, Dosage, and Administration

Respiratory Support - Pediatric

Pedi: ≤ 10 kg - 0.25 ml (1/2-ampule) mixed with 3 ml NS, nebulized
Repeat PRN x 1

> 10 kg - 0.5 ml (1-ampule) mixed with 3 ml NS, nebulized
Repeat PRN x 1

Medication

Class

Rocuronium

Non-depolarizing Neuromuscular Blocker

Indications:

→ Paralysis for intubation

Contraindications:

→ Hypersensitivity to rocuronium

Protocol, Dosage, and Administration

Delayed Sequence Intubation (DSI)

Adult: 1.5 mg/kg IV/IO x 1 (max 150 mg)

Pedi: N/A

Rapid Sequence Airway (RSA)

Adult: 1.5 mg/kg IV/IO x 1 (max 150 mg)

Pedi: Same as Adult

Medication

Class

Sodium Bicarbonate

Electrolyte

Indications:

- Known or suspected acidosis
- TCA overdose
- Hyperkalemia

Contraindications:

- Alkalosis
- Hypocalcemia

WARNING This medication cannot be mixed with other drugs. Flush line prior to and after administration this drug to prevent crystallization and loss of IV access.

Protocol, Dosage, and Administration

Cardiac Arrest: Medical CA not witnessed by bystander, Metabolic acidosis etiology (e.g. DKA), Hyperkalemia, Tricyclic Antidepressant Overdose

Adult: 1 mEq/kg IV/IO (max dose 100 mEq)

Pedi: Same as Adult

Symptomatic Bradycardia: Hyperkalemia (if suspected acidosis)

Adult: 1 mEq/kg IV/IO (max dose 100 mEq)

Pedi: Same as Adult

Toxicology: Tricyclic Antidepressant (TCA)

Adult - 1 mEq/kg IV/IO (max dose 100 mEq)

Pedi - Same as Adult

Entrapment/Crush/Traumatic Rhabdomyolysis: ECG findings of hyperkalemia

Adult - 1 mEq/kg IV/IO (max dose 100 mEq)

Pedi - Same as Adult

Medication

Class

Suboxone

Opioid partial agonist

Indications:

- Detoxification from opioids
- Maintenance therapy for opiate use disorder

Contraindications:

- Known or suspected GI obstruction
- Respiratory depression
- Acute alcohol or benzodiazepine intoxication
- Adrenal insufficiency
- Hepatic insufficiency
- Pregnancy
- Severe hypersensitivity

Protocol, Dosage, and Administration

Opiate Use Disorder

Adult; 8 - 24 mg buccal (SL strips or tabs) per physician order

repeat 8 - 16 mg (max 32 mg) q 15 minutes PRN x 1 COWS score >8 or symptoms not resolved

Pedi: N/A

Suboxone is buprenorphine + naloxone and the naloxone is chemically inactive when taken SL/oral. Either is acceptable and supply may vary based on availability. Dosing is the same between the two agents.

Medication

Class

Tranexamic Acid (TXA)

Hemostatic agent

Indications:

- Significant tracheostomy hemorrhage
- Ongoing epistaxis
- Postpartum hemorrhage
- Traumatic hemorrhage (if traumatic cardiac arrest, administer only if ROSC achieved)

Contraindications:

- Hypersensitivity to TXA
- ≥ 3 hours since injury
- Early pregnancy
- Signs of DIC
- Upper or lower gastrointestinal bleeding

Protocol, Dosage, and Administration

Hemorrhage Control: ongoing epistaxis despite direct pressure

Adult - 2 g topical on cotton ball to affected nare(s)

Pedi - Same as Adult

Hemorrhage Control: significant traumatic, OB, tracheostomy hemorrhage and SBP ≤ 90 or HR ≥ 110 with poor perfusion

Adult - 2 g IV/IO, slow push over 1 min

Pedi - N/A

Prehospital Blood Administration

Adult - 2 g IV/IO, slow push over 1 min

Pedi - N/A

Medication

Class

Vasopressin

Vasoconstrictor

Indications:

→ Hypotension refractory to norepinephrine

Contraindications:

→ Coronary artery disease

Protocol, Dosage, and Administration

Preparation

Infusion: 20 units / 100 mL NS (0.2 units / mL)

Circulatory Support: hypotension refractory to norepinephrine

Adult: 0.04 units / minute infusion (12 mL / hr)

Pedi: N/A

Medication

Class

Furosemide

Loop diuretic

Indications:

- Congestive heart failure
- Pulmonary edema

Contraindications:

- Hypersensitivity to Lasix
- Hypersensitivity to sulfa drugs

Protocol, Dosage, and Administration

MIH - Congestive Heart Failure

3-5 lbs over: double PO Lasix x 3 days

> 5 lbs over: administer double the patients PO dose of Lasix as IVP x 1

Medication

Class

Potassium

Electrolyte

Indications:

→ Hypokalemia

Contraindications:

→ Hyperkalemia

Protocol, Dosage, and Administration

MIH - CHF

K+ 2.5-2.9

Increase by 50% for length of time patient has increased Lasix dosing

K+ 3.0-3.4

Increase by 25% for length of time patient has increased Lasix dosing

K+ 3.5-5.0

No change

K+ 5.1-5.4

Discontinue supplement

MIH-HaH program dosing per HAaH physician order

Standard dosing

Adults: 20-100 mEq PO qDay in divided doses

Pedi > 1 month: 2-5 mEq/kg PO in divided doses

CCP

IFT-Chest Tube Management Procedure

1. Inspect the patient's chest wall to ensure that all connections are tight and that the tubing is not kinked. Also check the skin around the insertion site for subcutaneous emphysema. Be sure that all connections are tight and that all connections between the tube and the chest drain system are secured with non-porous tape.
2. Note color, consistency and amount of drainage.
3. Note any air leak in the water chamber. Ask the sending facility staff RN if there has been a prior leak.
4. Mark Pleur-evac (or other drainage system) with a pen at the current level of drainage in the system.
 - Be alert to sudden changes in the amount of drainage.
 - A sudden increase indicates hemorrhage or sudden patency of a previously obstructed tube.
 - A sudden decrease indicates chest tube obstruction or failure of the chest tube or drainage system.
5. Adjust wall suction to create a gentle rolling of bubbles in the water seal chamber or until suction indicator in appropriate range. Vigorous bubbling results in water loss. Note that some systems do not include a water seal chamber and therefore may not bubble.
6. Verify the level of the suction control chamber is at the level prescribed by the physician (usually -20 cm).
7. Do not clamp the patient's drainage tube at any time during travel. The water seal in the unit prevents backflow of air, whether or not suction is applied.
8. Position patient in semi-fowlers (if condition allows) to enhance air and fluid evacuation. NEVER raise the chest tube above the chest or the drainage will backup into the chest. Avoid any dependent loops as drainage problems and tube obstruction may occur. The tubing should be coiled flat on the bed and from there fall in a straight line to the chest drainage system.
9. After placing the patient in the ambulance, place the Pleur-evac next to the cot and secure with 3" tape so that it is kept upright during transport.
10. Dislodgment of the chest tube - If the chest tube falls out or is accidentally pulled out, it is important to quickly seal off the insertion site. Use a gloved hand until petroleum gauze is available. Petroleum gauze is necessary to prevent air from entering the pleural cavity. Apply 4-sided petroleum gauze occlusive dressing. If respiratory distress and/or signs of tension pneumothorax, remove one side of the dressing in an attempt to burp the chest.
11. Dislodgment from the drainage system (Pleur-evac) - If the chest tube becomes disconnected from the Pleur-evac or other collection device, clamp the chest tube (using Kelly clamps) until corrective action can be taken.

IFT-Extracorporeal Membrane Oxygenation (ECMO) Procedure

ECMO accredited staff must be present to manage and maintain changes during transport.

Unlike standard cardiopulmonary bypass which provides cardiopulmonary support following cardiac surgery or cardiac arrest, ECMO provides longer-term support, typically over 3-10 days.

Prevention of complications is fundamental to successful ECMO care. Ensure and document the following prior to initiation of transport.

1. Securing Cannula: All ECMO lines **MUST** be secured at 2 points with properly adherent skin dressings. Initial securing is the responsibility of the cannulator (physician) and cannot be delegated.
2. Prior to transport, ensure that backup components of critical items are available
3. Cannula positions: Cannula position must be confirmed radiographically by medical staff prior to transport.
4. ECMO Cannula dressings: Sterility must be maintained and insertion sites kept unsoiled.
5. Patient Movement: Prevent tension or torsion to the ECMO circuits during patient movement.

During transport:

1. Monitor – vitals every 15 minutes and document all pertinent labs (i.e. INR, PLT) and medications.
2. Contact transferring physician or [OLMC](#) for additional guidance or concerns.

IFT-Hemodynamic Monitoring Procedure

All patients who are transported by a Critical Care Paramedic that have invasive pressure lines will be monitored continuously with the use of a cardiac monitor. All pulmonary artery catheters will be monitored during transport. The following standards will be achieved on all patients meeting the criteria for hemodynamic monitoring.

1. Assess the pressure waveform displayed on the sending facility monitor.
2. Obtain a pre-transport strip of waveform from sending facility's monitoring equipment as well as a post- transport strip from receiving facility's monitoring equipment.
3. Obtain current pressure readings from the monitor and patient care records.
4. The CCP will evaluate the pressure transducer for compatibility with the CCP equipment. If the line is not compatible, the pressure line must be changed to facilitate monitoring by the CCP unit during the transport.
5. Flush the invasive line prior to changing over to CCP equipment to ensure patency.
6. Once line has been changed over, flush any visible air out of line via stopcock before flushing to patient.
7. The pressure bag will be inflated to 300 mmHg.
8. The pressure cable will be connected to the monitor and the patient end will be connected to the transducer port on the pressure tubing.
9. The transducer will be placed at the Phlebostatic axis (4th intercostal space, mid-chest level) line and taped securely.
10. All excess tubing will be coiled and taped in an orderly fashion.
11. The pressure line will be zeroed and calibrated to the monitor.
12. The waveform will be identified by the labels provided in the monitor (PA, ART).
13. The waveform will be assessed on the monitor, a pressure reading will be obtained and a strip will be printed showing the waveform. The strip will be identified as to the type of tracing.
14. Pulmonary artery pressures will be documented in conjunction with the secondary survey, as well as every 10 minutes for the duration of the transport. The pulmonary artery catheter should never be wedged during transport.
15. Arterial pressures will be documented in conjunction with the secondary survey, as well as every 10 minutes for the duration of the transport.
16. All distal pulses, capillary refill times, skin temperature, and sensation will be assessed and documented on extremities used.

IFT-Pulmonary Artery Catheter Procedure

1. Check and document PCWP at sending facility ONLY. Check PA systolic, diastolic and mean pressures at sending facility and every 10 minutes.
The Pulmonary Artery Capillary Pressure (PCWP) will only be obtained at the sending facility
 - a. Normal Mean Values:
 - i. Pulmonary Artery Pressure (PAP) Systolic 15-30 mmHg Diastolic 4-12 mmHg
 - ii. Pulmonary Artery Capillary Pressure (PCWP): 4-10 mmHg
 - iii. Central Venous or Right Atrial Pressure (CVP): 0-12 mmHg
(Therapeutic ranges may be somewhat higher than the above values)
 - b. Exceptions:
 - i. The optimal mean PCWP (wedge) may be 15-20 mmHg in patients with compromised left ventricular function, post-op stress or post MI.
 - ii. For patients with COPD and respiratory failure, expect PCWP pressures in the range of 30-50 mmHg. PCWP should be normal in pure pulmonary hypertension.
2. Trends in PAP and PCWP pressures are the most significant factors in detecting significant physiological changes in the patient's condition. Be sure to obtain history of these values prior to transport.
3. Inspect and document the insertion site. Note and document the PA insertion depth.
4. Calibrate the transducer at the beginning of the transfer before the patient is transferred over to the stretcher and with any major position changes.
5. Maintain pressurized flush system at 300 mmHg.
6. If change in waveform occurs, contact Medical Control for direction.
7. Follow set parameters for specific IV vasoactive drips as ordered by transferring physician or see protocol for IV vasoactive pharmaceutical titrations and/or communicate with the online physician.
8. CCP must document all interventions that take place regarding PA catheter.
9. Label all pressure tracings and document the tracings on the patient care report.

IFT-Transvenous Pacemaker Procedure

1. Place a new battery in the temporary pacemaker and test it prior to use.
2. Connect pacer wires to Temporary Pacemaker Cables with leads/heartwires - the patient cable with lead or heartwire plugs into socket on top of unit. In the absence of patient cables, temporary transvenous leads plug directly into the two smaller sockets.
3. Match the positive (+) and negative (-) leads to the positive (+) and negative (-) sockets or clips (as applicable). There may be instances where the leads are reversed in polarity to obtain capture. CCP will connect in the same manner as the sending facility.
4. Set the pacemaker controls
 - a. Set the sensitivity (the highest number is least sensitive; the lowest is most sensitive)
5. Demand mode - (withholds its pacing stimulus after sensing a spontaneous depolarization) set the sensitivity value to detect intrinsic activity.
 - a. Set pacemaker's rate 10 bpm slower than patient's intrinsic rate (the sense indicator will flash regularly)
 - b. Reduce milliamps (output) to the minimum value (this avoids risk of competitive pacing).
 - c. Sensitivity should be set at its lowest value necessary to ensure mechanical capture, and should be increased only to the point of stopping any oversensing.
 - d. Restore original pulse generator rate and output values.
6. If asynchronous mode is indicated (stimulates at a fixed, preset rate independently of the electrical and/or mechanical activity of the heart) turn sensitivity dial to ASYNC (not the preferred mode for critical care transport).
 - a. Set the rate and milliamps (output)
 - b. Set the milliamps (output) at 5 and the rate at 60 or as directed by the physician orders.
7. Turn the pacemaker ON
8. Check the monitor to ascertain that capture (depolarization of the atria and/or ventricles) is obtained- if not, increase the milliamps slowly until capture is obtained, this is the threshold (minimum electrical stimulus needed to consistently elicit a cardiac depolarization). Then set the milliamps at two (2) x the threshold.

Setting stimulation threshold:

1. Ensure the patient is connected to pacemaker and being monitored on EKG.
2. Set pulse generator rate at least 10 ppm faster than the patient's intrinsic rate (The pace indicator will be flashing regularly at the set rate).
3. Decrease the milliamps (output) until 1:1 capture is lost (the pace and sense indicators will be flashing intermittently).
4. Increase the milliamps (output) to restore 1:1 capture. This value is the stimulation threshold for the chamber being paced. (The pace indicator will be flashing; and the sense indicator will have stopped flashing.)
5. Set output value to 2-3 times the threshold value. This safety margin will allow for threshold variation while maintaining capture.
6. Restore original pacemaker rate value (60 or physician prescribed rate).

Ventricular Assist Device Procedure (all others)

While some VADs produce pulsatile flow, most VADs use continuous flow technology, thereby creating a non-pulsatile continuous flow. This means most patients with a VAD will not have a palpable pulse and, therefore, taking a blood pressure with a manual cuff and stethoscope will rarely allow you to auscultate a pressure. It is imperative that the type and model of VAD be identified (i.e. HeartWare HVAD vs Jarvik 2000 FlowMaker). Important aspects of transport include allowing a family member to ride along with the patient because the family member can be an invaluable resource. They are often trained in the operation of the equipment and know how to handle an emergency, and can also be a comfort to the patient.

Refer to device specific manual for setup and troubleshooting or questions. Verify you are using the most current procedure manual before operation.

If patient not responsive to pain and has capillary refill ≥ 3 seconds (inadequate perfusion)

If CPR and defibrillation can be performed on the patient (see VAD reference or documentation)

- See, [Cardiac Arrest](#)

If CPR and defibrillation are contraindicated

1. Check controller for alarms. (i.e. low battery, driveline malfunction, pump stopped.)
2. Auscultate and feel left upper abdominal quadrant for a continuous whirring sound and vibrations.
3. Determine if there is a “hand pump” or external device to utilize.
4. Remember not to perform chest compressions because they could dislodge the pump, making the patient bleed to death. (Unless the patient is in obvious cardiac arrest and the pump isn’t working. Use the assistance of the VAD coordinator to figure this out before starting any compressions).
5. Perform all other BLS/ACLS protocols as written.
6. Avoid kinking or twisting driveline when strapping the patient onto the stretcher.
7. Keep batteries and controller in reach and secured to the patient during transport. Keep them dry.
8. Take the patient’s emergency travel bag when leaving the scene. (It has an extra controller, batteries and the VAD coordinator’s emergency contact number.) Access back up controller and power sources as needed.
9. Monitor and document all IBP (in hospital), ECG, and Wave form EtCO₂ and ventilator settings every 15 minutes.
10. Contact online medical control for further instructions.
*If feasible, transport the patient to their implant hospital. If not, transport to the nearest most appropriate hospital.

If patient is out-of-hospital and hemodynamically stable

1. If available, utilize doppler device to auscultate blood pressure. The first sound heard is approximately equivalent to the mean arterial pressure (normal Doppler pressure range is 60–90 mmHg). A pressure of 60–90 mmHg is considered acceptable. Note that you may or may not hear normal heart tones with a stethoscope.
2. Assess the patient’s EtCO₂, mental status, skin, and lips to assess perfusion status.
3. Take the patient’s emergency travel bag when leaving the scene. It may have an extra controller, batteries, and the VAD coordinator’s emergency contact number.
4. Ensure the controller and battery packs are close to the patient and aren’t dangling off the side of the cot. Be sure that the driveline (the power cord of the pump) isn’t pulled, kinked, or cut.

IFT-Ventricular Assist Device Procedure (IABP)

Procedure:

1. Review the most recent 12-lead ECG. Select lead with greatest R-Wave amplitude. Place patient in this lead on cardiac monitor for continuous monitoring during transport. Limit chest artifact. ECG leads for the IABP will be secured with tape to the patient's chest and maintained during transport. Lead selection may need to be changed in order to get the best R-wave and capture on the balloon pump (if ECG triggered).
2. Arterial line shall be maintained on the IABP. If a transducer is used, ensure that it is directly connected to the pump and in working order. Maintain adequate arterial tracing. If radial site is used, secure arm with arm board to protect site during transport. Secure tubing.
3. Evaluate balloon insertion site. Note balloon size in the medical record. Check dressing site appearance. Monitor site frequently (every 15 minutes and as needed) during transport. Instruct patient to keep affected leg straight. Ensure that a knee immobilizer is in place prior to transport for additional reinforcement.
4. Establish baseline condition. Evaluate hemodynamics and clinical condition.
5. Hemodynamic assessment will include: temperature; blood pressure; respiration rate and quality; heart rate and rhythm; arterial blood pressure; Augmented pressures, MAP; CVP; PAP; augmented diastolic pressure (ADP). Document findings including patient's weight.
6. Evaluate pulses, both radial sites as well as posterior tibial and dorsalis pedis to facilitate subsequent localization during transport, also capillary filling times and extremity temperature.
7. Review lab values and trends.
8. Maintain H.O.B. at lowest point tolerated by patient, never to exceed 30 degrees.
9. Evaluate and closely monitor urinary output. All patients will have an in-dwelling urinary catheter.
10. Maintain IABP at prescribed timing/ratio (i.e.: 1:1; 1:2; 1:4). Evaluate effects.
11. Document hemodynamics. Document: IABP type, model and trigger (ECG, A-Line)

Precautions:

- Never leave balloon pump inactive in patient for more than 20-30 minutes (i.e., not inflating and deflating). Thrombosis formation could occur after 30 minutes. Utilize 60 ml syringe to manually fill and deflate balloon.
- Balloon leak: Observe tubing for blood. If blood is observed in the pneumatic tubing, shut off the balloon pump and leave intact. Maintain sterile technique and notify the physician and receiving facility immediately.
- IABP Failure: Evaluate patient's condition and hemodynamics. Troubleshoot the device and make every effort to correct the problem and maintain the patient's safety. If IABP is inoperable for greater than 20-30 minutes, inflate IABP manually with 60 cc syringe every 3-5 minutes to avoid clot formation (Inflate with 10cc less than balloon size).
- Ensure IABP battery is charged and Helium tank level is sufficient for transport. The balloon pump should be plugged into the ambulance inverter or generator outlets during transport.
- Ensure there is ample tubing length for transfer and loading the patient into the ambulance. Secure the IABP tubing at patient end and stretcher end, but not mid-line. Put loops in tubing if length permits.
- If bleeding is observed at the insertion site, apply direct pressure to the site until bleeding stops
- If CPR is required, the IABP should be switched to "pressure trigger" mode

IFT-Ventricular Assist Device Procedure (Impella)

The Impella is intended for partial circulatory support using an extracorporeal bypass unit, for periods from 6 hours (Impella 2.5) to 2 weeks (Impella 5.0).

1. Confirm that Impella placement has been verified with echocardiography. Document position of the Impella as reported by sending facility. If possible, bring reports and/or imaging studies that document confirmation of placement.
2. Verify the patient's Activated Clotting Time (ACT) has been checked and is between 160-180 seconds.
 - a. If the ACT is not verified, ensure it is evaluated before transport.
 - b. If the ACT is <160 or >180 seconds, request that it is addressed before transport per the sending facility guidelines.
3. Evaluate and confirm Impella settings. Document and monitor:
 - a. pump performance level (P2-P9)
 - b. flow (1.1 to 5.3 L/min {device dependent})
 - c. placement signal pulsatile [mmHg] (red waveform)
 - d. purge pressure 300-1100 mmHg
 - e. motor current <1000 and pulsatile (green waveform)
 - f. pump position
 - g. purge fluid infusion rate (2-30 mL/hr)
4. Ensure the Tuohy-Borst on the Impella catheter is tight to prevent catheter migration (tighten completely to the right).
5. Evaluate insertion site for signs of bleeding, swelling or hematoma, and catheter on initial assessment, following each patient transfer, and frequently (every 15 minutes and as needed) during transport. Document findings following each evaluation.
6. Evaluate pulses, capillary filling time, and temperature of affected lower extremity on initial assessment, following each patient transfer, and frequently (every 15 minutes and as needed) during transport.
7. Evaluate urine output and color on initial assessment and monitor during transport. Changes in urine color may indicate hemolysis.
8. Establish the patient's baseline condition. Evaluate hemodynamics and clinical progression.
9. Patients should remain flat throughout transport. Under no conditions is head of bed (HOB) elevation to exceed 30°.
10. Instruct the patient to keep the affected leg straight. Apply knee immobilization device if needed to prevent movement.
11. During transport, maintain pump performance level and flow rate at ordered levels. If unable to maintain ordered flow rate at ordered levels, contact OLMC for guidance.
12. If alarms occur during transport, follow on-screen troubleshooting guidance for resolution. If alarms not resolved following troubleshooting, contact OLMC for further guidance.
13. If purge solution requires replacement during transport replace with D10 solution or solution provided by sending facility.
14. Refer to the hemodynamic monitoring protocol for arterial line maintenance.

Impella Precautions: Next Page

Ventricular Assist Device Procedure (Impella)

Precautions:

- Verify the battery charge level before unplugging and moving the Impella controller. A fully charged battery will support the system for approximately 60 minutes. The Impella controller should always be plugged in for transport.
- Place the Impella controller must on a flat surface, where the screen is easily visible during transport. The controller must be secured during transport to avoid accidental dislodgement of the sheath and to prevent the controller from becoming a dangerous projectile. Consider using the bed mount as a loop through which to secure the device with straps.
- Movement of the HOB is the primary cause of migration of the Impella during transport. Do not move the HOB from its initially established position.
- Keep the stopcock on the peel-away introducer or repositioning sheath in the closed position. Significant bleeding can occur if the stopcock is in the open position.
- Do not decrease pump performance (P) level below P2 as long as the pump is in the ventricle. Below P2, retrograde flow will occur across the aortic valve.
- CPR should be initiated immediately per MedStar protocol if indicated. When starting CPR, reduce the Impella flow rate to P2. If return of spontaneous circulation, return the flow rate to the previous P-level, by increasing one P-level every 30-60 seconds and assess placement signals on the controller.
- Infusion through the side port of the introducer can be done only after all air is removed from the introducer. If performed, the infusion should be done for flushing purposes only and NOT for delivering therapy or monitoring blood pressure or MAP.
- Base the management of the patient's hemodynamic status on MAP readings from an arterial line. Target MAP to >65 mmHg or level ordered by sending facility.
- If there are any changes in the patient's condition during transport or there are unresolved Yellow or Red alarms, contact the receiving facility with updated information so they can prepare for the proper interventions before patient arrival.
- Contact the 24-hour clinical support line at 1-800-422-8666 with any questions or concerns during transport. Use only for general information about the device functionality only. For any orders needed for patient management, contact OLMC. the receiving facility with updated information so they can prepare for the proper interventions before patient arrival.

IFT-Ventriculostomy Monitoring Procedure

1. Maintain patient's head position per physician's order (usually 30 degrees).
2. Check and document dressing site and appearance.
3. Confirm level of drain and any other patient specifics in regards to monitoring, as follows.
 - a. Review physician's order to place ventriculostomy to either drain or monitor.
 - i. *If ventriculostomy is placed to drain*
 - Verify that the stopcock at the zero level is opened to the drainage bag side. The drip chamber is placed so that the zero level is at the foramen of Monroe (Point of communication between the 3rd and lateral ventricles of the brain). Anatomical landmark for foramen of Monroe is the external auditory canal. Ensure the Burette is moved so that the pressure line is at the ordered level of drainage.
 - ii. *If ventriculostomy is set to monitor*
 - Do not collect measurements during transport.
4. The system must be secured on a pole at all times. The system is adjusted to obtain the zero level.
5. If tubing becomes occluded during transport, do not flush or manipulate line. Notify receiving staff upon arrival.
6. Document on PCR drainage amount, color, ICP and any other pertinent information.

MIH

Congestive Heart Failure (CHF) Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients. The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#).

- Contact appropriate partner agency staff
- Review relevant patient clinical record and lab values
- Measure and document vital signs (BP, weight, O₂, pulse)
- Perform [12-lead ECG](#)

Considerations for Patient Education

- Educate patient on appropriate dietary and medication compliance.
- Encourage ingestion of food or milk to reduce GI upset if increasing potassium dose.
- Have patient record weight daily.

MIH-Basic

- Interpret 12-lead ECG
- Perform and interpret i-STAT (ensure sample not hemolyzed)

Hypokalemia

If $K^+ < 2.5$ mEq/L or ECG findings consistent with *hypokalemia*

- Administer patient's Potassium - 40 mEq PO
- Request ambulance for transport to ED

Hyperkalemia

If there are any ECG changes consistent with *hyperkalemia*

- Request ambulance for transport to ED, and [treat for hyperkalemia \(see treatment box\)](#)

If $K^+ > 7.0$ mEq/L (regardless of ECG changes)

- Request ambulance for transport to ED, and [treat for hyperkalemia \(see treatment box\)](#)

If there are no ECG changes consistent with *hyperkalemia*

If $K^+ > 5.0 - 6.0$ mEq/L, **AND** if the most recent $K^+ > 5.0$ mEq/L (within the last 72 hrs)

- Contact partner agency staff / OLMC for further guidance to discuss plan of care, to potentially include:
 - Stop oral potassium supplementation for 2 days
 - Recheck potassium at least daily until < 5 mEq/L
- If the patient is not taking oral potassium AND is not scheduled for urgent diuresis
 - Request ambulance for transport to ED

If $K^+ > 5.0 - 6.0$ mEq/L, **AND** if the most recent $K^+ < 5.0$ mEq/L (within the last 72 hrs)

- Request ambulance for transport to ED

If $K^+ 6.0-7.0$ mEq/L (independent of previous K^+ value)

- Request ambulance for transport to ED

If Creatinine > 3 mg/dl

- Contact PCMH

If patient is on warfarin (Coumadin)

- Review patient's PT/INR, when available, with the PCMH, who will provide instructions for changes in dosing and follow-up

- Adjust diuresis and potassium dosing per CHF Protocol Dosing Schedule

Contraindications

- Weight gain of less than 2 lbs. over baseline.
- Potassium of < 2.5 or > 5.5 mEq/L (transport if present)
- Acute clinical changes such as chest pain, dyspnea, or signs of acute decompensation (transport if present)
- If in the MHP's clinical judgment the patient requires transport/ED evaluation

Urgent/Emergent Treatment of Hyperkalemia

- [Calcium Chloride](#) - 1 g IV slow push
- [Sodium Bicarbonate](#) - 1 mEq/kg IV/IO (if suspected acidosis)

MIH-Paramedic

Congestive Heart Failure (CHF) Protocol (Dosing Schedules)

Diuresis Dosing Schedule

| 3-5 lbs. over | >5 lbs. over |
|--|--|
| <ul style="list-style-type: none"> Double PO furosemide or torsemide for 3 days. <p><i>Refer to K⁺ dosing schedule below</i></p> | <ul style="list-style-type: none"> Administer double the patients <u>single</u> PO dose of furosemide as IVP x1. <p>(e.g. Patient on 40 mg PO twice daily = 80 mg IVP)</p> <p><i>Refer to K⁺ dosing schedule below</i></p> |
| <ul style="list-style-type: none"> MIH-P follow-up in 24 hours. | <ul style="list-style-type: none"> MIH-P follow-up in 4 hours (can be phone call). 24 hour follow-up in person |
| <ul style="list-style-type: none"> PCP notification | <ul style="list-style-type: none"> Extensivist / PCP follow up in 48 hours. |
| <ul style="list-style-type: none"> Extensivist / PCP follow up in 48 hours. | |

Potassium Dosing Schedule:

| K ⁺ = 2.5 – 2.9 | K ⁺ = 3.0 – 3.4 | K ⁺ = 3.5 – 4.9 | K ⁺ ≥ 5.0 |
|--|--|----------------------------|----------------------|
| Increase by 50% for the length of time patient has increased Lasix dosing. | Increase by 25% for the length of time patient has increased Lasix dosing. | No Change | Refer to protocol |

PEARLS:

- Furosemide (Lasix), Torsemide (Bumex)
- If diuresis is performed more than 3-visits in a row refer to an Advanced Heart Failure Clinic.

COPD/Asthma Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients. The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#).

- See [Respiratory Support](#)
- Initiate transport if the patient fails to respond to nebulizer therapy

If patient has a positive response to nebulizer therapy

- Contact PCMH to arrange appropriate follow-up

Diabetes Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients. The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#)

If patient is obtunded, unconscious, or altered

- See [Diabetic Emergencies](#) and request ALS transport

If patient is conscious

- Measure Blood Glucose

If blood glucose ≤ 60 mg/dl and symptomatic

- Oral Glucose - 15 g buccal (if intact gag reflex and able to tolerate)
- Recheck blood glucose
- Contact PCMH for any suggested changes in dosing and/or for appropriate follow up

If blood glucose ≥ 300 mg/dl and asymptomatic

- Verify with appropriate partner agency that patient is on insulin sliding scale
 - Teach and assist patient with insulin self-administration

If patient is unable to administer insulin

- Contact PCMH for any suggested changes in dosing and/or for appropriate follow up

If blood glucose ≥ 300 mg/dl and symptomatic (e.g. AMS, signs of hypovolemia, suspected DKA or hyperosmolar state)

- Perform i-STAT

If $CO_2 \leq 16$ or anion gap ≥ 20

- NS - 1 L IV bolus
- Contact PCMH and recommend ambulance transport to ED

High Utilizer Group (HUG) Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients eligible for, or enrolled in, the High Utilizer Group program. Patients with frequent utilization of the 911 EMS or hospital Emergency Department system are eligible for the High Utilizer Group (HUG) program. Patient will either be referred internally or by partner agencies. MedStar will conduct a series of home visits to help enable patients to navigate themselves through the healthcare system. The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#).

Referral Criteria

High Utilizer Group patients may include individuals who meet the following criteria:

- Requested 15 or more 911 ambulance responses during the past 90-days, OR
 - Referred by a partner agency for avoidable visits to the Emergency Department during the past 12-months
- AND
- Live in the MIH service area
 - Possesses mental capacity to support navigational assistance
 - Willing to participate in the program and allow MIH Providers into their home for assessment and follow-up

Initial Home Visit/Patient Assessment

- Conduct initial assessment of barriers to the patient's care, which may include:
 - Living environment
 - Social barriers to appropriate engagement in care
 - Transportation
 - Access to primary care
 - Disease management
- Facilitate the development and implementation of a care plan by the PCMH, which may include:
 - Primary Care Provider (PCP) assignment (if necessary)
 - Series of home visits to educate the patient and family on appropriate care management
 - Assistance with navigation through the patient's primary care network/resources
 - Provision of 24/7 non-emergency number to request mobile healthcare provider support during the duration of the program enrollment

Scheduled Home Visits

Enrolled patients will receive a series of home visits to educate:

- The patient and family on appropriate ways to manage their disease process
- The patient on how to navigate the healthcare system

Unscheduled Home Visits

The patient will be provided a non-emergency phone number in the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

911 Responses

Enrolled patients will be tracked in the computer aided dispatch (CAD) system, and in the event of a 911 call to their residence, a 911 ambulance response will be initiated, along with an MIH provider who will be dispatched to the scene. Once on-scene, the MIH provider may be able to intervene and navigate the patient to an alternate source of care, including PCMH, urgent care, self-care, or by employing the use of the Disease Management MIH protocols.

Care Management Protocols (CMP)

The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#). In consultation with the PCMH, patients with conditions including, Diabetes, COPD, or CHF can either have their medications adjusted in the field, or they may receive in-home therapy through Care Management Protocols, with an in-office follow-up appointment to minimize any unnecessary transport to the Emergency Department. Refer to the appropriate CMP (e.g. Diabetes, CHF, COPD/Asthma)

High Utilizer Group (HUG) Protocol

Program Length

Term of program will be a minimum of 30-days and a maximum of 90-days after acceptance into the program, based on patient compliance and meeting established program goals.

Record Keeping

Patients enrolled in the program have a continual electronic medical record (EMR) that allows all care providers mobile access to the patient's entire course of assessments and treatments during enrollment, including care notes, lab values, vital signs, ECG tracings and treatments initiated. These records can be provided to caregivers in accordance with the Treatment Payment Operations (TPO) definitions of Health Insurance Portability and Accountability Act (HIPAA).

Hospice Patients

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients.

If concern/complaint related to hospice care

- Responding ambulance crew should remain on-scene and only transport if it is unsafe to wait for a MIH provider to arrive.
- Upon arrival on scene, the MIH provider will assist in addressing the family/patients concerns. The MIH provider will help to ensure the patient's comfort and may use the hospice supplied in-home comfort-pack if required once they have consulted with hospice provider or, if unavailable, [OLMC](#).
- The responding MIH provider will remain with the family/patient until the hospice nurse arrives or until the family and patient are comfortable with the patient's status.

If the patient/family insists on being transported to the ED

- Attempt to arrange for a direct admit to an inpatient hospice care facility

If complaint not associated with the patient's hospice diagnosis

- Responding ambulance crew should transport only if acuity/condition is unsafe to wait for MIH provider to arrive
- Upon arrival on-scene, the MIH provider will work with the patient/family to ensure their wishes are carried out and the appropriate care is provided, while awaiting the arrival of a hospice representative.

If the patient/family insists on being transported to the ED and are unwilling to wait or discuss the situation with the responding Hospice representative

- Facilitate transportation by ambulance to the appropriate acute care facility.

Insulin Titration

This protocol is to be used for patients with hyperglycemia or hypoglycemia on the second home visit who have recently been released from the hospital and have not seen their new PCP or their PCP has been contacted twice (on two subsequent visits) without a response.

- Contact appropriate partner agency
- Measure blood glucose

If hyperglycemia present (blood glucose ≥ 300 mg/dl prior to short acting insulin treatment and asymptomatic)

Hyperglycemia

- Perform iStat and calculate anion gap

If anion gap < 12

- Glucose 300-400 mg/dl increase long-acting insulin by 2 units on next dose
- Glucose 400+ increase long-acting insulin by 4 units on next dose

If hypoglycemia present

- For symptomatic with hypoglycemia see, [Diabetic Emergencies](#) and if no transport consider [Insulin Titration](#)

→ Fasting or overnight

| Blood glucose < 54 | Blood glucose 55-70 and | Blood glucose 55-70 and |
|--|---|---|
| Reduce long-acting insulin dose by 40% | Reduce long-acting insulin by 4 units or 10% (whichever is greater) | Reduce evening intermediate insulin dose by 2 units |

→ Daytime and corresponds with sliding scale or set pre-prandial insulin dosage

(use sliding scale insulin dosage given 30 minutes-6 hours prior to hypoglycemic episode)

| Blood glucose ≤ 54 | Blood glucose 55-70 |
|---|---|
| Reduce sliding scale or pre-prandial insulin by 40% | Reduce sliding scale insulin dosage If sliding scale < 10 units reduce by 2 units If sliding scale 11-20 units reduce by 4 units If sliding scale > 20 units reduce by 8 units |

→ Daytime & Does Not Correspond with Sliding Scale

| Blood glucose ≤ 54 | Blood glucose 55-70 and long-acting insulin | Blood glucose 55-70 and intermediate insulin |
|--|---|---|
| Reduce long-acting insulin dose by 40% | Reduce long-acting insulin by 4 units or 10% (whichever is greater) | Reduce morning and evening intermediate insulin dose by 2 units |

→ Fasting or Overnight and Daytime & Corresponds with Sliding Scale

| Blood glucose ≤ 54 | Blood glucose 55-70 and long-acting insulin | Blood glucose 55-70 and intermediate insulin |
|--|---|---|
| Reduce long-acting insulin dose by 40% | Reduce long-acting insulin by 4 units or 10% (whichever is greater) | Reduce morning and evening intermediate insulin dose by 2 units |

→ Fasting or Overnight and Daytime & Does Not Correspond with Sliding Scale

| Blood glucose ≤ 54 | Blood glucose 55-70 and long-acting insulin | Blood glucose 55-70 and intermediate insulin |
|--|---|---|
| Reduce long-acting insulin dose by 40% | Reduce long-acting insulin by 4 units or 10% (whichever is greater) | Reduce morning and evening intermediate insulin dose by 2 units |

Pearls:

- Intermediate-acting insulins (examples): Humulin N, Insulin NPH, Novolin N
- Long acting insulins (examples): Insulin glargine, insulin detemir, insulin degludec
- For this protocol basal insulin is any intermediate or long-acting insulin

i-STAT Procedure

Precautions:

Avoid the Following Circumstances:

- Drawing a specimen from an arm with an I.V.
- Stasis (tourniquet left on longer than two minutes before venipuncture)
- Extra muscle activity (fist pumping)
- Hemolysis (alcohol left over puncture site, or a traumatic draw)
- Time delays before filling cartridge, especially lactate, ACT, and PT/INR

Criteria For Specimen Rejection:

- Evidence of clotting
- Specimens collected in vacuum tubes with anticoagulant other than lithium or sodium heparin
- Specimens for ACT or PT/INR collected in glass syringe or tube or with anticoagulant of any kind
- Incompletely filled vacuum tube for the measurement of ionized calcium or PCO₂
- Other sample types such as urine, CSF, and pleural fluid

Procedure:

Cartridges:

A single-use disposable cartridge contains microfabricated sensors, a calibrant solution, fluidics system, and a waste chamber. A whole blood sample of approximately 1 to 3 drops is dispensed into the cartridge sample well, and the sample well is sealed before inserting it into the analyzer. An individual cartridge may be used after standing 5 minutes, in its pouch, at room temperature. An entire box should stand at room temperature for one hour before cartridges are used. Cartridges may be stored at room temperature (18 to 30° C or 64 to 86° F) for 14 days. Cartridges should not be returned to the refrigerator once they have been at room temperature, and should not be exposed to temperatures above 30° C (86° F). If the pouch has been punctured, the cartridge should not be used. Write the date on the cartridge box or individual cartridge pouches to indicate the two-week room temperature expiration date. Cartridges should remain in pouches until time of use. Do not use after the labeled expiration date.

Testing:

Press the Power button to turn on the Handheld.
DO NOT insert the cartridge to start the test.

Press the “2” button to start a new test. Follow the handheld prompts. For “Operator ID,” enter your MedStar ID number. For “Patient ID,” enter the run number for the call.

Scan or Enter
Operator ID

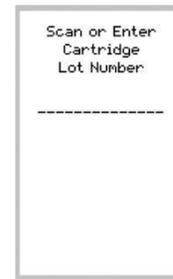
Screen 2

Scan or Enter
Patient ID

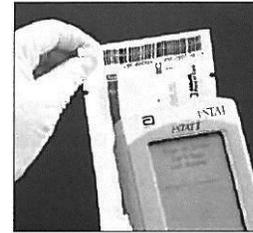
Screen 3

i-STAT Procedure

Scan the Lot Number on the cartridge pouch. Position the barcode 3-9 inches from the scanner window on the handheld. Press and hold "Scan" to activate the scanner. Align the laser light to cover the entire barcode. The handheld will beep when it reads the barcode successfully. If you cannot scan the barcode, enter the lot number using the numbered keys, ignoring any letters. **DO NOT** open cartridge pouch before scanning the barcode.



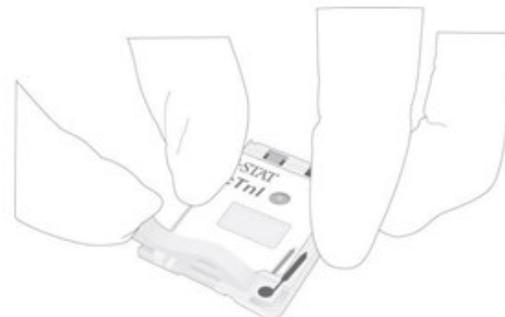
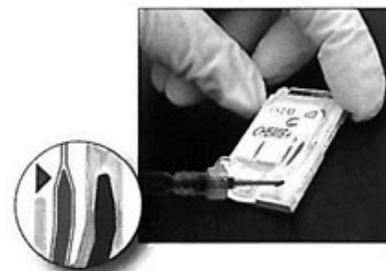
Screen 1



Remove cartridge from pouch. Handle the cartridge by its edges. Avoid touching the contact pads or exerting pressure over the center of the cartridge.



Mix blood and collection tube additives by inverting a tube gently at least ten times. Following thorough mixing of the sample, use a plastic capillary tube, pipette, or syringe to transfer sample from a tube to a cartridge. Direct the dispensing tip containing the blood into the sample well. Dispense the sample until it reaches the fill mark on the cartridge and the well is about half full. Close the cover over the sample well until it snaps into place. (Do not press over the sample well.)



i-STAT Procedure

Insert the cartridge into the cartridge port on the analyzer until it clicks into place. The analyzer must remain horizontal during the testing cycle. Never attempt to remove a cartridge while the LCK or "Cartridge Locked" message is displayed.

Wait until testing cycle is complete. Results are displayed numerically with their units. Electrolyte, chemistry and hematocrit results are also depicted as bar graphs with reference ranges marked under the graphs.

To print the results, turn printer on if green power light is not on. Align IR windows of analyzer and printer. Display results. Press the Print key.

Do not move analyzer or printer until printing is complete.

Note: Results printed on thermal paper will fade with time and are therefore not acceptable as a permanent chartable record.

To print a stored test record(s), select "Print Results" from the Stored Results menu. Select records to be printed by pressing the Key(s) corresponding to the numbers beside the record(s). Press the numbered key again to deselect a record. Then press the PRT Key. Do not move the analyzer while "Printing" is displayed.



Screen 4

Screen 5

Suppressed Results

There are three conditions under which the i-STAT System will not display results:

1. Results outside the System's reportable ranges are flagged with a < or > , indicating that the result is below the lower limit or above the upper limit of the reportable range respectively. (See the table of Reportable Ranges.) The < > flag indicates that the results for this test were dependent on the result of a test flagged as either > or <.
2. Cartridge results which are not reportable based on internal device problem are flagged with ***. Action: Analyze the specimen again using a fresh sample and another cartridge. If the specimen integrity is not in question, the results that are not suppressed should be reported in the usual manner.
3. A Quality Check message will be reported instead of results if the analyzer detects a problem with the sample, calibrant solution, sensors, or mechanical or electrical functions of the analyzer during the test cycle. The device should be serviced as soon as possible.

The following should be used as a guideline to determine appropriate actions when any of the following are identified:

Abnormal Lab Values - When Chem 8 values are abnormal, but not "critical", notification to client's physician's office must be made prior to terminating visit. This may be telephone or email but must also be documented in the client record.

Critical Lab Values - When Chem 8 values report in the "critical range" (as below) patient's physician must be consulted immediately. If consultation with the patient's physician cannot be completed, the Office of the Medical Director on-call physician, or delegate, must be consulted. Consider transport to appropriate facility as needed.

NOTE: For End-stage Renal Disease (ESRD) patients on dialysis who have received regularly scheduled dialysis and have a normal potassium, an abnormal creatinine or BUN value does not require contact.

| Test | Reference Range | Critical Levels |
|---|-----------------|-----------------|
| Sodium (Na) | 138-146 mEq/L | <120 or >160 |
| Potassium (K) | 3.5-4.9 mEq/L | <2.5 or >6 |
| Chloride (Cl) | 98-109 mEq/L | <90 or >120 |
| Ionized Calcium (iCa) | 4.5-5.3 mg/dl | <4 or >6 |
| Total CO ₂ (TCO ₂) | 24-26 mEq/L | <10 or >40 |
| Glucose (Glu) | 10-105 mg/dl | >400 |
| Urea Nitrogen (BUN) | 8-26 mg/dl | <2 or >80 |
| Creatinine (Crea) | 0.6-1.3 mg/dl | >2.8 |
| Hematocrit (Hct) | 38-51% PCV | <20 or >60 |
| Hemoglobin (Hgb) | 12-17 g/dl | <6 or >20 |
| Anion Gap (Agap) | 10-20 mEq/L | >20 |

Non-Compliant HUG Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients who are found to be non-compliant with the High Utilizer Group program.

Non-Compliant Evaluation

When an agency official believes that an individual HUG patient may be chronically and inappropriately utilizing the 911 EMS system, a report shall be provided to the OMD with the following information:

- Identity of the individual
- 911 utilization before and during enrollment in the HUG program
- Chief Complaint when calling 911
- Past Medical History
- Any previous history of enrollment in MIH programs, and the outcomes of those enrollments
- History of Police utilization during prior 911 responses or patient visits
- Frequency of hospital visits
- Contact information for any known PCMH or other outpatient care providers (including mental health providers), and details of prior service requests, interactions, and discussions regarding facilitation of a care plan
- Assigned home hospital
- Copies of patient record forms completed by all EMS providers who have previously interacted with the patient

Non-Compliant Assignment

The Medical Director will review the report. If the individual is deemed non-compliant, the patient will be registered as such, and a Client Specific Care Plan will be issued.

Calls to 911

All 911 requests for Non-Compliant HUG patients shall receive an appropriate 911 response.

If identified as a Non-Compliant HUG patient during 911 call-taking process

- Communications Center will initiate a concurrent MIH response

If not identified as a Non-Compliant HUG patient during 911 call-taking process

- Responding crew shall:
 - Perform and document a careful assessment on all patients
 - Initiate an MIH response via radio or phone request

If the crew identifies an emergent or possible life-threatening condition

- Initiate 911 treatment and transport, as appropriate

If identified as a Super Non-Compliant HUG patient during the 911 call-taking process

- Communications Center will initiate a non-transport response as per the Client Specific Care Plan

MIH Response, Management, and Disposition

- Respond, if available
- Assign themselves to the CAD incident, if not already done so by the Communications Center
- Respond in non-emergency mode
- Access the client's information, if available
- Take a verbal report from the responding 911 crew to obtain the following:
 - Current complaint
 - Vital signs
 - Significant history and examination findings
- Complete a thorough assessment
- Evaluate the patient for possible navigation to an alternative source of care, or initiate 911 transport to the ED

Non-Compliant HUG Protocol

If patient is a candidate for alternate source of care

- Contact **OLMC** for discussion of treatment, transport modality, and disposition
- Facilitate transport and allocation of additional resources, which may include:
 - Bus pass
 - Taxi voucher
 - Follow-up home visit
 - Assisting client to schedule visit with a doctor or urgent care

If patient does not necessitate ED transport, or alternate source of care

- Contact **OLMC**, and if agreement, assign disposition of Medical Director Refusal

Documentation

- Complete ePCR and sign as the primary paramedic, and include summary of **OLMC** disposition
- Attempt to have the client sign the authorization section, acknowledging the assessment provided and assigned disposition
 - If the client refuses to sign, place the client's name in the appropriate field and mark that the client "refused to sign"
- Attempt to obtain a witness signature

Quality Assurance

- A file will be maintained on each OMD registered Non-Compliant HUG patient, including ePCR documentation of all transports and non-transports
- All cases will be reviewed every 6-months for renewal of Non-Compliant HUG status
- Patients whose 911 utilization falls below 1/3 of their original usage may have their non-Compliant status removed

Observation Avoidance Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients eligible for, or enrolled in, the Observation Avoidance program. Patients are referred by the Emergency Department case manager or any member of the care team. The MIH Provider initially consults with care providers and evaluates patients while in the ED. The MIH Provider then performs scheduled home assessment follow-up visits until patient care is transitioned to the PCMH, within 7-days. The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#).

Referral Criteria

To be eligible for enrollment into the Observation Avoidance Program, the patient must:

- Be referred prior to discharge, and be present in the ED when the MIH Provider arrives
- Possess mental capacity to provide informed consent for treatment and management
- Be willing to participate in the program and allow MIH Providers into the home for assessment and follow-up
- Live in the MIH service area
- Be eligible for a follow-up visit within the next 7-days

Program Length

Completion of program is based on the patient's care being successfully transitioned to the PCMH. Term of program will be a minimum of 1-day and a maximum of 7-days.

Enrollment

To enroll patients into the program, the MIH Provider will:

- Perform an initial visit and assessment in the ED
- Meet with the patient and referring physician to discuss patient's management following discharge and prior to PCP or specialist follow-up
- Schedule an appointment with the follow-up care provider within 7-days.
- Explain to the patient the service that will be provided
- Schedule an in-home visit
- Provide the non-emergency contact number to the patient for episodic needs while enrolled in the program.

Any change in the patient's condition, or consultation regarding the patient's condition or treatments, will be communicated to the referring Emergency Department physician or PCMH, for inclusion in the patient record.

Follow-up

The MIH coordinator or Triage Nurse will provide a report to the follow-up provider's office, including the patient's assessment, treatments provided, and any written documentation.

The MIH coordinator or ECNS Nurse will confirm the time of the patient's appointment, remind the patient of the appointment time, and ensure that the patient has transportation to the follow-up provider's appointment

Unscheduled Home Visits:

The patient will be provided a non-emergency phone number for MIH in the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

911 Responses

Enrolled patients will be tracked in the computer aided dispatch (CAD) system, and in the event of a 911 call to their residence, a 911 ambulance response will be initiated, along with a MIH-P who will be dispatched to the scene.

Once on-scene, the MIH-P may be able to intervene and navigate the patient to an alternate source of care, including PCMH, urgent care, self-care, or by employing of the use of the appropriate CMP protocols.

Record Keeping

Patients enrolled in the program have a continual electronic medical record (EMR) that allows all care providers mobile access to the patient's entire course of assessments and treatments during enrollment, including care notes, lab values, vital signs, ECG tracings and treatments initiated. These records can be provided to caregivers in accordance with the Treatment Payment Operations (TPO) definitions of Health Insurance Portability and Accountability Act (HIPAA).

Oropharyngeal / Nasopharyngeal Swab Procedure

Indications:

- Clinical concern for strep pharyngitis
- Clinical concern for COVID-19 +/- influenza

Contraindications:

- Recent facial trauma / fracture / surgery
- History of bleeding disorders
- Nasal septal or palate defect

Pearls & Pitfalls:

- Up to 20% of asymptomatic school-aged children and 25% of asymptomatic household contacts of children with strep throat are colonized with Group-A Strep
- Patients who have recently tested positive for COVID-19 may remain positive for weeks to months

Procedure:

- Wear appropriate PPE for droplet precautions: face mask, gloves, protective eye wear
- Ensure patient is in a comfortable position.

- **Nasopharyngeal Swab**
- Hold swab with a pencil grip and insert horizontally into one nostril parallel to the palate. Insert to the following depth, or until resistance is met:
 - 1 cm if <2 years
 - 1.5 cm if 2-6 years
 - 2 cm if 6-12 years
 - 2-3 cm if >12 years
 Rotate swab 5 times against the nasal wall.
- Remove Swab and insert into transport medium or vial.

- **Oropharyngeal Swab**
- Using a tongue depressor, flatten tongue and insert swab. Swab tonsillar beds and back of throat, avoiding tongue. Rotate tip of swab for 3-5 seconds.
- Remove Swab and insert into transport medium or vial.

Peak Flow Procedure

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients. The primary point of contact for all patient consultations is that individual's PCMH primary provider contact or, if unavailable, contact [OLMC](#).

Indications:

- Patients with limited or severely restricted expiratory flow
- Patients on bronchodilator therapy
- Patient able to understand and physically able to attempt the test

Contraindications:

- Age or cognition does not enable ability to comprehend or cooperate
- Facial condition or neurological condition that alters their ability to do the test.
- Respiratory distress level to point patient could deteriorate with testing

Procedure:

- Ensure indicator is at the bottom of the number scale
- Position patient in an upright sitting or standing
- Instruct the patient to hold the peak flow meter horizontal being careful not to block the opening
- Instruct patient to inhale as deeply as possible and then place mouth firmly around the mouthpiece making a tight seal.
- Instruct patient to blow out as hard and fast as they can through the mouthpiece
- Move the indicator back to the bottom of the scale, and repeat steps 2-5 for two more attempts
- Instruct the patient to repeat this maneuver three times (if able to do so)
- Document the highest reading as the peak flow

*** Please contact the ordering community partner with the results of Peak Flow test***

| Zones | Signs & Symptoms |
|--|---|
| <p style="text-align: center;">Green (80% of predicted)</p> | <p style="text-align: center;">No asthma symptoms No nighttime cough Normal activities No need for rescue medications</p> |
| <p style="text-align: center;">Yellow (50-80% of predicted)</p> | <p style="text-align: center;">Some asthma symptoms Decreased peak flow</p> |
| <p style="text-align: center;">Red (<50% of predicted)</p> | <p style="text-align: center;">Increased asthma symptoms Decreased in peak flow Poor or no response to rescue medications</p> |

Admission/Readmission Avoidance Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients eligible for, or enrolled in, the Admission/Readmission Avoidance program. Patients at risk for admission/readmission are referred by the patient's Case Manager or PCMH. The MIH Provider will conduct a series of home visits to educate the patient and family on appropriate healthcare management, coordinate in-home therapy, schedule a follow-up appointment with the PCMH, or facilitate emergency transport or navigation to an alternate source of care.

Referral Criteria

To be eligible for enrollment into the Admission/Readmission Avoidance Program, the patient must:

- Be referred during an inpatient admission or be at high risk for a preventable readmission
- Possess mental capacity to make informed decisions regarding their disease management
- Be willing to participate in the program and allow the MIH Providers into their home for assessment and follow-up
- Have an established relationship with a PCMH
- Must live in the MIH service area

Patient may be deemed ineligible for the program if, for example, they are:

- Stage-3 or 4 Chronic Kidney Disease (CKD) without an attending nephrologist
- Pregnant
- Age 18-years or younger
- Living outside the MIH service area
- Currently receiving chemotherapy and/or radiation therapy
- Homeless and not living in a shelter
- Previously non-adherent with an MIH program

Any case, at any time, may be deemed ineligible and excluded from the MIH program after review by OMD. All reasonable efforts will be made by the MIH Provider to notify the client, PCMH, and home health partners of the client's status.

Scheduled Home Visits

Enrolled patients will receive a series of home visits by an MIH Provider to:

- Educate the patient and family on appropriate management of their disease process, including:
 - Diet and weight management
 - Medication compliance
 - Healthy lifestyle changes
- Educate the patient on how to navigate their primary/specialty care network for the purpose of managing their disease process, including:
 - When to call for an appointment
 - Important information to share with providers

Unscheduled Home Visits

The patient is provided a non-emergency phone number for MIH in the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

911 Responses

Enrolled patients will be tracked in the computer aided dispatch (CAD) system, and in the event of a 911 call to their residence, a 911 ambulance response will be initiated, along with a MIH-P who will be dispatched to the scene.

Once on-scene, the MIH-P may be able to intervene and navigate the patient to an alternate source of care, including PCMH, urgent care, self-care, or by employing of the use of the appropriate CMP protocols.

In consultation with the patient's PCMH, patients with a Care Management Plan (CMP), e.g. Diabetes, CHF, COPD/ Asthma, can either have their medications adjusted in the field, receive in-home therapy through their CMP, or with the PCMH. Refer to the appropriate CMP.

Admission/Readmission Avoidance Protocol

Program Length

Term of program will be a minimum of 30-days and a maximum of 90-days after acceptance into the program, based on patient compliance and meeting established program goals.

Record Keeping

Patients enrolled in the program have a continual electronic medical record (EMR) that allows all care providers mobile access to the patient's entire course of assessments and treatments during enrollment, including care notes, lab values, vital signs, ECG tracings and treatments initiated. These records can be provided to caregivers in accordance with the Treatment Payment Operations (TPO) definitions of Health Insurance Portability and Accountability Act (HIPAA).

Suture/Staple Removal Procedure

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients.

Indications: Request from a clinician to remove staples or a known type of suture

Contraindications: Signs of wound complications, dehiscence (wound edges do not meet), or infection

Procedure:

- Visually assess the wound for uniform closure of the wound edges, absence of drainage, redness, and swelling
- Utilize non-sterile gloves and cleanse site with alcohol prep prior to beginning

Simple Interrupted Suture Removal

- Gently grasp the knot or the tail of suture with forceps and raise slightly off skin
- Place the curved tip of the suture scissors directly under the knot or on the side, close to the skin
- Gently snip the suture and remove it with forceps. Never snip both sides of the knot.
- Ensure all suture material is removed and placed on sterile gauze
- Remove every second suture until the end of the wound line.
- Assess for signs of dehiscence after each removal (*if present see below*)
- Continue removal until all sutures removed

Staple Removal

- Place the lower jaw of the staple remover under a staple
- Squeeze the handles completely to close the device bending the staple in the middle and pulling the edges of the staple out of the skin
- Gently move the staple away from the wound once both ends are visible
- Relax pressure on the staple remover's handles to release the staple onto clean gauze. Consider staple disposal into a sharps container.
- Remove every second staple until the end of the wound line
- Assess for signs of dehiscence (*if present see below*)
- Continue removal until all staples removed

Post-removal care

- Apply sterile wound strips to reduce likelihood of dehiscence
- Advise patient of ongoing self-care and warning signs for infection

Urinary Catheter (Foley) Malfunction

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients.

- Review clinical record
- Consult with appropriate partner agency.
- Flush the catheter or remove as necessary
- Re-insert new urinary catheter

If two unsuccessful attempts

- Contact appropriate partner agency staff or, if unavailable, contact [OLMC](#)

Wound VAC Malfunction Protocol

This protocol is to be used by an appropriately credentialed Mobile Integrated Health (MIH) Provider as standing orders for patients enrolled in an approved Mobile Integrated Health program. This protocol may be used in visits requested by partner agencies or 911 calls from program clients.

- Review clinical record
- Contact appropriate partner agency staff or, if unavailable, contact [OLMC](#)
- Remove Wound VAC
- Pack wound with wet to dry dressings
- Cover dressing with 4×4 or abdominal pad and secure with tape.
- Notify appropriate partner agency staff

Clinical Policies

Ambulance Capabilities

1. **Purpose.** This policy defines the use and designation of all ambulances in the Fort Worth Regional EMS System (System) to facilitate reliable response to all levels of ambulance calls and outlines the use of non-transport emergency vehicles.
2. **Scope.** This policy applies to EMS ambulance operations, outlining the designation, staffing, and use of BLS and MICU ambulances, Critical Care non-transport units, and use of non-transport emergency vehicles for transport under extenuating circumstances.
3. **Unit Inventory and Staffing Requirements.**
 - 3.1. BLS Ambulances are “Basic Life Support with MICU Capability” units.
 - 3.1.1. Such units shall be equipped and staffed as required by the Texas Department of State Health Services EMS Provider License regulations, contractual requirements, and FWOMD requirements. They must be equipped, at a minimum, to support the Basic level of protocol.
 - 3.1.2. Basic credentialed personnel may be assigned to work on BLS Ambulances with at least a Basic credentialed partner and may function within stated policy, protocol, and credentialed scope of practice.
 - 3.2. MICU Ambulances are “MICU Ambulance” units.
 - 3.2.1. Such units shall be equipped and staffed as required by the Texas Department of State Health Services EMS Provider License regulations, contractual requirements, and FWOMD requirements.
 - 3.2.2. Paramedic credentialed personnel may be assigned to work on MICU Ambulances with at least a Basic credentialed partner and may function within stated policy, protocol, and credentialed scope of practice.
 - 3.3. Critical Care non-transport units.
 - 3.3.1. Such units shall be equipped and staffed as required by agreement and FWOMD requirements.
 - 3.3.2. CCP credentialed personnel may be assigned to work on critical care non-transport units and may function within stated policy, protocol, and credentialed scope of practice.
4. **Appropriate use of Non-Transport Emergency Vehicles**
 - 4.1. Non-transport emergency vehicles may be used under the following circumstances in the transport of patients when concern for emergent transport exists and a transport unit is not immediately available:
 - 4.1.1. MCI with \geq 10 patients
 - 4.1.1.1. Alternate transport considerations have been exhausted
 - 4.1.1.2. Intercept with responding transport unit should be attempted (including Air Medical)
 - 4.1.1.3. An attendant should be present during transport when available
 - 4.1.1.3.1. Attendant should have the highest appropriate level of EMS or other medical licensure or certification available if possible
 - 4.1.1.4. Transport patient to the closest appropriate hospital
 - 4.1.1.5. Patient should be transported in an enclosed environment as available
 - 4.1.1.6. Patient should be appropriately restrained in the vehicle if it will not compromise patient well-being
 - 4.1.2. All other situations
 - 4.1.2.1. Contact On-line Medical Control for further transport guidance

Ambulance Capabilities

5. Appropriate use of BLS Ambulances

5.1. BLS Ambulances may be used for BLS eligible patients described by the protocol and operate under the Basic protocols and procedures.

6. Appropriate use of MICU Ambulances

6.1. MICU Ambulances may be used for any patient and operate under the Paramedic protocol and procedures.

7. Appropriate use of Critical Care non-transport units

7.1. Critical Care non-transport units may be used to supplement BLS and ALS ambulance personnel as described by protocol and operate under the CCP protocols and procedures.

8. Changes in Patient Condition While Engaged in Transport.

8.1. Any treatment beyond the clinician's credentialed scope of practice must be ordered by direct on-line medical direction. In case the condition of a patient deteriorates, personnel should provide the indicated stabilization within their scope, immediately notify Medical Control, and request appropriate orders. If it is an inter-facility transfer that originated at a hospital, the team should return to the facility if still near the sending facility; otherwise, transport should continue to the receiving facility. In extreme cases, proceed to the nearest appropriate facility for additional evaluation of the patient.

Comprehensive Clinical Management Program

1. **Purpose.** This policy addresses the Comprehensive Clinical Management Program (CCMP) for the Fort Worth Regional EMS System (System). Additionally, it addresses credentialed provider eligibility, tracking, and approval of the CCMP renewal option with Texas Department of State Health Services (DSHS).
2. **Scope.** This policy applies to System personnel credentialed within the System for at least six months.
3. **Procedure**
 - 3.1. **Definitions**
 - 3.1.1. CCMP - Comprehensive Clinical Management Program is a recertification / relicensure training program coordinated by the Fort Worth Office of the Medical Director (FWOMD) for System credentialed personnel employed by or affiliated with the System in meeting the recertification or re-licensure requirements outlined in TAC §157.34(b)(5).
 - 3.1.2. CCMP Participation – All credentialed FWFD providers are eligible to participate in the CCMP.
 - 3.1.3. Renewal- The renewal process for a system provider to renew their DSHS EMS certification.
 - 3.2. **CCMP Professional Development Hours**
 - 3.2.1. The System will provide, at a minimum, the following amounts of professional development hours per year: Paramedic -24 hours, AEMT -20 hours, EMT -16 hours, and ECA -10 hours.
 - 3.2 **Eligibility**
 - 3.2.1. Any System personnel who meet the FWOMD Credentialing Requirements policy and have been credentialed for a minimum of six months within the system.
4. **Process**
 - 4.1 **Process**
 - 4.1.1. Upon credentialing, System providers will receive a credentialing letter stating the date of credentialing as well as the date of CCMP participation eligibility. CCMP eligibility date will be six months post-credential date.
 - 4.1.2. The System will provide annually the number of professional development hours listed in 3.2.1 to comply with the CCMP program and this policy.
 - 4.1.3. A 90-day certification expiration report will be generated at the end of each month. CCMP Coordinator will verify biennial maintenance credentialing requirements per OMD Credentialing Requirements policy and DSHS approved EMS Jurisprudence course have been completed.
 - 4.1.4. Upon completion of the biennial maintenance requirements, a letter will be sent on behalf of the System Medical Director to the individual stating their current participation in the CCMP.
 - 4.1.5. Individuals will submit a renewal application, selecting the CCMP Recertification Option, including their CCMP participation letter to DSHS.
 - 4.1.6. All continuing education programs provided or sponsored by the System must be approved by the FWOMD to ensure consistency with the System Medical Director's practice of medicine and alignment with current protocol, procedure, and quality improvement initiatives.

Credentialing Requirements

1. **Purpose:** This policy describes the initial and maintenance requirements of credentialing for Fort Worth Regional EMS System (System) clinicians to provide patient care.
2. **Scope:** This policy applies to all state-licensed personnel that provide clinical care within the EMS System
3. **Definitions**
 - 3.1. DSHS - Texas Department of State Health Services
 - 3.2. IBSC – International Board of Specialty Certification
 - 3.3. PRM - Protocol Review Module
 - 3.4. PIM - Process Improvement Module
 - 3.5. System CE – continuing education provided by FWOMD or System providers in support of licensure maintenance
 - 3.6. FTO – agency assigned field training officer who mentor and evaluate individuals for credentialing
 - 3.7. Skills competency assessment – psychomotor skills evaluation to be conducted by FWOMD or Agency FTO
 - 3.8. Clinical competency verification – the agency’s established field training in verifying FWOMD clinical competencies conducted by an agency FTO
 - 3.9. MegaCode evaluation – scenario-based protocol application assessments of a medical, trauma, adult, pediatric, and infant resuscitation
 - 3.10. Clinical Credentialing Interview (CCI) – table-top case presentation conducted by FWOMD as the final evaluation step to credentialing of EMT provider
 - 3.11. Mock interview – table-top case presentation conducted by FWOMD to assess readiness for Medical Director Interview
 - 3.12. Medical Director Interview (MDI) – table-top case presentation conducted by a Medical Director or designated EMS Fellow as the final evaluation step to credentialing of Paramedic, Mobile Health Paramedic, and Critical Care Paramedic provider
4. **Process**
 - 4.1. On-boarding
 - 4.1.1. Notify FWOMD of new hire and level of credential to be pursued
 - 4.1.2. Individual must hold a current, verified by FWOMD, DSHS or National Registry (EMT/Paramedic)
 - 4.1.2.1. Must hold board certification from IBSC in Critical Care or Community Paramedic for the critical care or mobile health paramedic credential
 - 4.1.3. Individual must complete an on-boarding process that includes, at a minimum, a comprehensive orientation process consisting of the services, policies and procedures, treatment and transport protocols, safety precautions, and the quality management process of the EMS System and their specific agency.
 - 4.1.4. Prior to Field Training, the individual must:
 - 4.1.4.1. Hold a current, verified, DSHS and, if needed, critical care or mobile health paramedic certification for the credential level sought
 - 4.1.4.2. Complete FWOMD Clinical NEOP
 - 4.1.4.3. Complete FWOMD approved cardiac resuscitation course
 - 4.1.4.4. Complete clinical knowledge assessment
 - 4.1.5. Other components of credentialing may be accomplished in field training or lab
 - 4.1.5.1. Skills competency assessment
 - 4.1.5.2. Clinical competency verification
 - 4.1.5.3. MegaCode evaluation as required
 - 4.1.5.4. Patient contacts that include ambulance transport
 - 4.1.6. Final interview and recommendation
 - 4.1.6.1. Upon completion of all components of credentialing, a recommendation for credentialing is to be submitted to FWOMD by the training officer

Credentialing Requirements

- 4.1.6.1.1. For Paramedic, MHP, and CCP credentialing, upon receipt of the recommendation for credentialing, a Medical Director interview will be scheduled
- 4.1.7. The agency is required to maintain a copy of all documentation of the components of credentialing
- 4.1.8. FWOMD will provide and maintain a letter of credentialing to the agency for documentation purposes upon verification of successful completion of all components of credentialing
- 4.2. Maintenance
 - 4.2.1. FWOMD will conduct monthly audits to validate compliance with maintenance requirements of credentialing to include verification of current state certification
 - 4.2.2. Providers must maintain an FWOMD approved card course certification or successfully complete the appropriate MegaCode assessment for their respective discipline
 - 4.2.3. By state regulations, providers must complete an annual PRM on Allergic Reaction/Anaphylaxis
 - 4.2.4. Every two years (biennial), credentialed providers must complete the required maintenance of credentialing components listed within their respective credential level
 - 4.2.4.1. The agency will submit active roster and all credentialing documentation upon FWOMD request
 - 4.2.5. All PIMs must be completed within the designated timeframe during the maintenance period, all other components must be completed by the end of the two-year maintenance cycle
- 4.3. See FWOMD policy, Examination and Testing, for requirements regarding skill assessment, clinical competency verification, and MegaCode evaluation along with retesting and credentialing interviews
- 5. **Emergency Care Attendants (ECA)**
 - 5.1. Initial Requirements:
 - 5.1.1. Current ECA by the DSHS
 - 5.1.2. Completion of FWOMD approved cardiac resuscitation course
 - 5.1.3. Completion of agency specific on-boarding process to include:
 - 5.1.3.1. Completion of all Basic PRMs
 - 5.1.3.2. Completion of National Registry EMR skills assessment
 - 5.2. Maintenance requirements:
 - 5.2.1. Current ECA by the DSHS
 - 5.2.2. Current FWOMD approved cardiac resuscitation course
 - 5.2.3. Completion of all Basic PRMs
 - 5.2.4. Current with all PIMs
 - 5.2.5. Completion of National Registry EMR skills assessment
- 6. **Basic (EMT-B, A-EMT, or EMT-P/LP)**
 - 6.1. Initial Requirements:
 - 6.1.1. Current EMT-B (or above) by the DSHS
 - 6.1.2. Completion of FWOMD approved cardiac resuscitation course
 - 6.1.3. Completion of agency specific on-boarding process to include:
 - 6.1.3.1. Completion of FWOMD clinical NEOP
 - 6.1.3.2. Completion of Basic clinical knowledge assessment
 - 6.1.3.3. Completion of the Basic skills competency assessment
 - 6.1.3.4. Completion of clinical competency verification program (Field Training)
 - 6.1.3.4.1. Includes patient contacts with ambulance transport
 - 6.1.4. Completion of CCI by FWOMD.
 - 6.2. Maintenance requirements:
 - 6.2.1. Current EMT-B (or above) by the DSHS
 - 6.2.2. Current FWOMD approved cardiac resuscitation course

Credentialing Requirements

- 6.2.3. Completion of all Basic PRMs
- 6.2.4. Current with all PIMs
- 6.2.5. Completion of the Basic skills competency assessment

7. Paramedic (EMT-P/LP)

7.1. Initial requirements:

- 7.1.1. Current Paramedic (EMT-P/LP) by the DSHS
- 7.1.2. FWOMD approved cardiac resuscitation course
- 7.1.3. Completion of agency specific on-boarding process to include:
 - 7.1.3.1. Completion of FWOMD clinical NEOP
 - 7.1.3.2. Completion of the Paramedic skills competency assessment
 - 7.1.3.3. Completion of System MegaCodes
 - 7.1.3.4. Completion of clinical competency verification program (Field Training)
 - 7.1.3.4.1. Includes patient contacts with ambulance transport
 - 7.1.3.5. Completion of mock interview by FWOMD
- 7.1.4. Completion of MDI by a Medical Director or designated EMS Fellow

7.2. Maintenance Requirements:

- 7.2.1. Current Paramedic (EMT-P/LP) by DSHS.
- 7.2.2. Current FWOMD approved cardiac resuscitation course
- 7.2.3. Completion of all PRMs
- 7.2.4. Current with all PIMs
- 7.2.5. Completion of System MegaCode verification
- 7.2.6. Completion of the Paramedic skills competency assessment

8. Mobile Healthcare EMT – MH-EMT (EMT, EMT-I, EMT-P/LP)

8.1. Initial requirements:

- 8.1.1. Meet Basic level credentialing requirements.
- 8.1.2. Completion of an approved Mobile Healthcare Paramedic Course
- 8.1.3. Completion of all MIH PRMs
- 8.1.4. Completion of the MIH skills competency assessment
- 8.1.5. Completion of clinical competency verification program (Field Training)
- 8.1.6. Completion of MH-EMT MDI by FWOMD

8.2. Maintenance Requirements:

- 8.2.1. Meet Basic credential maintenance requirements
- 8.2.2. Completion of all MIH PRMs
- 8.2.3. Current with all MIH PIMs
- 8.2.4. Completion of the MIH skills competency assessment

9. Mobile Healthcare Paramedic – MHP (EMT-P or LP)

9.1. Initial requirements:

- 9.1.1. Meet Paramedic level credentialing requirements.
- 9.1.2. Completion of an approved Mobile Healthcare Paramedic Course
- 9.1.3. Hold IBSC Community Paramedic certification (CP-C)
- 9.1.4. Completion of all MIH PRMs
- 9.1.5. Completion of the MIH skills competency assessment
- 9.1.6. Completion of MHP clinical competency verification program (Field Training)
- 9.1.7. Completion of mock interview by FWOMD
- 9.1.8. Completion of MHP MDI by a Medical Director

Credentialing Requirements

9.2. Maintenance Requirements:

- 9.2.1. Meet Paramedic credential maintenance requirements
- 9.2.2. Current Community Paramedic certification (CP-C)
- 9.2.3. Completion of all MIH PRMs
- 9.2.4. Current with all MIH PIMs
- 9.2.5. Completion of the MIH skills competency assessment

10. Critical Care Paramedic - CCP (EMT-P or LP)

10.1. Initial requirements:

- 10.1.1. Meet Paramedic level credentialing requirements.
- 10.1.2. Completion of an approved Critical Care Paramedic Course
- 10.1.3. Hold IBSC Critical Care Paramedic certification (CCP-C or FP-C)
- 10.1.4. Completion of CCP PRMs
- 10.1.5. Completion of CCP clinical knowledge exam
- 10.1.6. Completion of the CCP skills competency assessment
- 10.1.7. Completion of CCP clinical competency verification program (Field Training)
- 10.1.8. Completion of mock interview by FWOMD
- 10.1.9. CCP-MDI and recommendation by a Medical Director.

10.2. Maintenance Requirements:

- 10.2.1. Meet Paramedic credential maintenance requirements
- 10.2.2. Current Critical Care Paramedic certification (CCP-Cor FP-C)
- 10.2.3. Completion of any assigned continuing education
- 10.2.4. Completion of all CCP PRMs
- 10.2.5. Current with all PIMs
- 10.2.6. Completion of the CCP skills competency assessment

11. Extended Absence – Return to Work Re-credentialing

11.1. ≤ 60-days absent

- 11.1.1. Current required certification(s)
- 11.1.2. Complete any new PRMs
- 11.1.3. Complete any new PIMs
- 11.1.4. Complete any new skill assessment

11.2. > 60 to 120 days absent

- 11.2.1. Current required certification(s)
- 11.2.2. Complete all PRMs
- 11.2.3. Complete all current PIMs
- 11.2.4. Complete new skills assessment
- 11.2.5. Complete MegaCode verification
 - 11.2.5.1. Failure of MegaCode will result in FTO time with specific objectives to be accomplished prior to MegaCode reverification
- 11.2.6.

11.3. > 120 to 365 days absent

- 11.3.1. Complete initial requirements of credentialing for desired level with exception of credentialing interview
- 11.3.2. Complete all current PIMs

Credentialing Requirements

11.4. >365 Days

11.4.1. Complete the initial requirements of credentialing for desired level

11.4.2. Complete all current PIMs

Deceased Patient Transport

1. Purpose. To address the procedure for patients who are declared deceased while in an ambulance or where scene factors are unsafe or inappropriate to leave the body on scene. Transport of patients who do not respond to appropriate resuscitative efforts presents risks to crew safety, consumes critical ED/hospital resources, provides false hope for patient's families, and leads to unnecessary expenses.
2. Scope. This policy applies to all FWOMD-credentialed providers.
3. Inclusion criteria
 - 3.1. Patients who have all the following criteria
 - 3.1.1. An online medical control physician has as given an order to terminate resuscitative efforts.
 - 3.1.2. The body is in an ambulance OR a location that is deemed by Incident Command and Law Enforcement to be either unsafe or inappropriate to leave on scene.
 - 3.1.3. Death occurred in Tarrant County Medical Examiner's District jurisdiction
 - 3.1.4. Death felt likely to be determined by ME staff to be ME case:
 - 3.1.4.1. Traumatic arrest
 - 3.1.4.2. Death by, or suspected to be by, suicide.
 - 3.1.4.3. Medical arrest not under direct care of a physician (e.g., hospice, home health care)
4. Exclusion criteria
 - 4.1. Death not in Tarrant County Medical Examiner District
 - 4.2. Death occurred in health care institution (hospital, nursing facility)
 - 4.3. Death in any location where it is safe & appropriate to leave body on scene
5. Procedure
 - 5.1. Ensure all inclusion and no exclusion criteria are met
 - 5.2. Contact the Medical Examiner Forensic Investigator at 817-920-5700, option 5 and discuss the case and confirm it is appropriate to transport to ME office.
 - 5.2.1. If Forensic Investigator approves:
 - 5.2.1.1. Transport body without lights and sirens to ME office at 200 Feliks Gwozdz Pl. Fort Worth, TX 76104
 - 5.2.2. If Forensic Investigator declines:
 - 5.2.2.1. Contact the closest appropriate hospital via phone and speak with the ED charge nurse to inform them that an online medical control physician has declared the patient deceased and the body is being transported without resuscitative efforts to their ED due to on scene circumstances.
 - 5.2.2.1.1. Note: Approval by hospital staff is not required, this is a courtesy report.
 - 5.2.3. Transport the body without further resuscitative efforts and without use of lights & sirens to the hospital report was called to.
 - 5.3. Contact EMS Supervisor for any concerns or disputes.

Do Not Resuscitate

1. **Purpose.** Chapter 166 of the Health and Safety Code establishes Out-of-Hospital Do-Not-Resuscitate (OOH DNR) Orders. The chapter allows the development of a local DNR policy that complies with the State-wide DNR protocol adopted by the Board of Health.
2. **Scope.** This policy applies to all System providers and in all cases of out-of-hospital events including cardiac arrests that occur during inter-facility transports.
3. **DNR Form and Identification of Patients.**
 - 3.1. EMS personnel may only accept the original or a copy of the standardized OOH DNR Order
 - 3.2. EMS personnel may accept an approved OOH DNR bracelet or necklace (identification device) as proof that an OOH DNR order form has been executed by or issued on behalf of the person wearing the identification device.
 - 3.3. When presented with a “DNR Order,” EMS personnel should make every effort to identify the patient as the person for whom the OOH DNR Order has been executed or issued. Relatives, friends, neighbors, documents, ID bracelets, or other identification may be used as sources of identification.
4. **Honoring an OOH DNR Order.**
 - 4.1. When presented with a DNR Order, EMS personnel are to review the form to make sure that it is correctly completed and signed as required by the Health and Safety Code. If the order appears valid, the OOH DNR Order shall be honored.
 - 4.2. EMS personnel are not required to honor an OOH DNR Order that does not comply with the Health and Safety Code.
5. **Revocation of an OOH DNR Order.**
 - 5.1. The patient may revoke an OOH DNR Order, or the patient may direct someone in his or her presence to destroy the order and remove the patient’s identification device.
 - 5.2. A qualified relative, legal guardian or patient’s agent having medical power of attorney (or a person acting on behalf of any of these persons) may revoke the OOH DNR Order.
 - 5.3. The patient’s physician may revoke the OOH DNR Order.
 - 5.4. In case of a revocation of the OOH DNR Order, EMS personnel shall document the name of the person who revoked the order, the date, time, and location of the revocation.
 - 5.5. Upon revocation of the OOH DNR Order, EMS personnel shall provide care for the patient as required by protocol. This does not mean EMS must begin resuscitation if deemed futile per the Withholding Protocol.
6. **Disputes related to OOH DNR Orders.** In case a dispute arises regarding an OOH DNR Order, EMS personnel shall contact On-Line Medical Control (OLMC) for direction and assistance.
7. **Pregnant Persons and OOH DNR Orders.** EMS personnel may not withhold cardiopulmonary resuscitation or certain other life-sustaining treatment from a person known to be pregnant unless futility criteria are met as per the Withholding Protocol.
8. **Other presented paperwork or request for termination.** Contact OLMC if presented with other request to withhold resuscitation efforts such as a verifiable Medical Power of Attorney (mPOA), Medical Orders on Scope of Treatment (MOST), Physician’s Orders for Life-Sustaining Treatment (POLST) or any request by family members on-scene.

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Print Form



This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ Male Female

A. Declaration of the adult person: I am competent and at least 18 years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication: I am the: legal guardian; agent in a Medical Power of Attorney; OR proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

spouse, adult child, parent, OR nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

E. Declaration on behalf of the minor person: I am the minor's: parent; legal guardian; OR managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____.

Signature & seal: _____ Notary's printed name: _____ Notary Seal

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Physician's signature _____ Date _____
Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

Emergency 911 Calls from within a hospital

1. **Purpose.** This policy addresses when a patient calls for an ambulance within a hospital. This policy does not apply when a person or patient is calling from other types of care facilities.
2. **Scope.** This policy applies when a person contacts the Fort Worth Fire Alarm Office (FAO) from within a hospital requesting an ambulance for care. This policy describes the procedure to follow when providing care to this patient.
3. **Appropriate action to follow.** If a person within a hospital contacts the FAO requesting an ambulance, the following procedure will be followed:
 - 3.1. **Properly EMD the call:** The call will be screened utilizing current procedures and then confirm that the patient is calling from within the hospital.
 - 3.2. **Provide instructions:** If the person is calling from within the hospital, they should be instructed to immediately report to the Triage Nurse or Charge Nurse and inform them that they have contacted 911 requesting an ambulance.
 - 3.2.1. Explain to the person that an ambulance may not be dispatched by their request and that it must be requested by the hospital personnel.
 - 3.3. **Contact the Hospital:** The Communications Specialist should immediately contact the charge nurse of that ED or hospital by phone and advise them of the situation.
 - 3.4. **If the person is outside of the hospital:** If the patient requesting the ambulance is outside of the hospital, or there is any confusion, the Communications Specialist should follow regular 911 call procedures. If the patient is on hospital grounds, transport should be to that hospital's emergency department.
4. **If the hospital then requests an ambulance:** If the hospital requests an ambulance for the patient, the Communications Specialist should follow the process for inter-facility transfer.

Emergency Care Attendants

1. **Purpose.** The purpose of this policy is to establish care guidelines for First Responders trained at the Emergency Care Attendant (ECA; Texas Department of State Health Services) / Emergency Medical Responder (EMR; National Registry of EMTs)
2. **Scope.** This policy applies to all Fort Worth Regional EMS System (System) providers credentialed at the ECA / EMR Level.
3. **Protocol variations.** ECA / EMR providers will generally operate under the “Basic” level in the System protocols, with the following modifications. ECA / EMR:
 - 3.1. May provide general first aid as per Basic level protocols.
 - 3.2. May administer oxygen as per protocol at the Basic level.
 - 3.3. Are required to have available epinephrine auto-injectors and be trained in their use; they may not administer IM injections otherwise.
 - 3.4. May administer naloxone (Narcan) as per the Basic level protocol for suspected opioid intoxication; they may not administer intra-nasal medications otherwise.
 - 3.5. Are permitted to assist with patient self-administration of nitroglycerin (already prescribed and available on-scene) if the systolic blood pressure is greater than 100, as per the *Acute Coronary Syndrome/STEMI* protocol.
 - 3.6. May administer aspirin as per the *Acute Coronary Syndrome/STEMI* protocol.
 - 3.7. May administer oral glucose as per the *Altered Mental Status and Diabetic Emergencies* protocols.
 - 3.8. May administer Isopropyl Alcohol as per the Adult and Pediatric *Nausea and Vomiting* protocol.
 - 3.9. May not administer CPAP.
 - 3.10. May not administer nebulized medications.
 - 3.11. May not perform spinal motion restriction; patients who may have suffered spinal trauma should have manual cervical spine stabilization performed until higher-level providers arrive.
4. **Required medications/equipment for ECA / EMR First Responders:**
 - 4.1. Oxygen, with BVM, nasal cannula, and non-rebreather devices in both adult and child sizes
 - 4.2. Emergency childbirth kit
 - 4.3. Epinephrine auto-injector in both pediatric and adult doses
 - 4.4. Aspirin
 - 4.5. Oral glucose
 - 4.6. Naloxone
 - 4.7. Isopropyl Alcohol pads
 - 4.8. Basic bandaging / splinting materials
 - 4.9. Blood pressure cuff with stethoscope
 - 4.10. Glucometer
 - 4.11. Manual suction device

Equipment Failure

1. **Purpose.** This policy describes the process of reporting equipment failures
2. **Scope.** This procedure applies to all Fort Worth Regional EMS System (System) providers who experience an equipment failure while providing patient care.
3. **Overview.** If while rendering patient care, a provider experiences a failure of any piece of equipment, it must be reported to FWOMD and as per the agency's policy. This may also include the manufacturer and the proper State/Federal agencies.
4. **The Process.**
 - 4.1. The provider experiencing the equipment failure should retain the specific item and all associated components if possible.
 - 4.2. Package the item in a biohazard bag if it is contaminated with human fluids.
 - 4.3. Turn the item into their agency's designated individual as stated in their policies & procedures.
 - 4.4. The Agency should then report the failure to the FWOMD and follow agency policy and procedures for reporting requirements to the manufacturer and potentially State and/or Federal agencies.

Examination and Testing

1. **Purpose.** The FWOMD relies on periodic examinations, verifications, and competency evaluations as tools to assess retention of required knowledge, protocol application, and mastery of skill performance among credential EMS clinicians.
2. **Scope.** This policy applies to all Fort Worth Regional EMS System (System) providers seeking initial credentialing or maintenance of current credentials.
3. **Procedure.**
 - 3.1.1.1. All System providers are required to pass the following verification exams/evaluations to be credentialed:
 - 3.1.2. Clinical Knowledge Assessment,
 - 3.1.2.1. A multiple-choice scenario exam evaluating protocol application and understanding for protocols that do not have an associated PRM.
 - 3.1.2.2. Exam pass score is 78% with three (3) attempts
 - 3.1.2.3. Clinicians may utilize the protocol app during testing
 - 3.1.3. Successful completion of a skills verifications packet for credential level
 - 3.1.3.1. Each skill associated with the scope of practice of the credentialed level will be evaluated utilizing a standardized skill verification process
 - 3.1.4. MegaCode evaluation for medical and trauma, along with adult, pediatric, and infant resuscitation.
 - 3.1.4.1. MegaCode evaluation is a standardized scenario-based protocol application assessment required for credentialing at the Paramedic level and above
- 3.2. Clinical Credentialing Interview (CCI)
 - 3.2.1. The CCI is the final step in the credentialing of an individual seeking to be credentialed at any level below Paramedic
 - 3.2.2. The CCI is a table-top case presentation conducted by FWOMD to assess individuals' readiness to function independently in the System
- 3.3. Medical Director Interview (MDI)
 - 3.3.1. Mock-Medical Director Interview
 - 3.3.1.1. The Mock-MDI is a table-top case presentation conducted by FWOMD to assess individuals' readiness for their credentialing MDI
 - 3.3.2. MDI
 - 3.3.2.1. The MDI is the final step in the credentialing of an individual seeking to be credentialed at the Paramedic level or higher.
 - 3.3.2.2. The MDI will be scheduled at the recommendation of FWOMD after a Mock MDI has been conducted in assessment of readiness
 - 3.3.2.3. The MDI is a table-top case presentation conducted by a Medical Director or designated EMS Fellow to assess individuals readiness to function independently in the EMS System
 - 3.3.2.3.1. The MDI at the MHP and CCP credential level will be conducted by a Medical Director

Examination and Testing

3.4. Exam / Evaluation Attempts

3.4.1. Clinical Knowledge Assessment Exam

3.4.1.1. Three (3) attempts are provided with mandatory review sessions between 2nd and 3rd attempt with FWOMD or Agency Training Officer.

3.4.2. Protocol Review Modules

3.4.2.1. Unlimited attempts are given at agency's discretion

3.4.2.2. Upon failing to meet the 80% or agency defined passing score, the individual must rewatch the PRM to attempt the exam again

3.4.3. Skills verification

3.4.3.1. Unlimited attempts for each skill verification at agency's discretion

3.4.3.2. Remediation is to be provided between each failed attempt

3.4.3.3. Should it be determined the individual will not be successful, the individual will be eligible to credential at a lower level at the agency's discretion.

3.4.4. Clinical application scenarios (MegaCodes)

3.4.4.1. Individual is given 3 attempts, at least 72 hours a part

3.4.4.2. If unsuccessful on the third attempt, the individual must successfully complete the corresponding card course of the MegaCode scenario failed

3.4.4.2.1. Corresponding card course with MegaCode

3.4.4.2.1.1. AMLS = Medical

3.4.4.2.1.2. PHTLS = Trauma

3.4.4.2.1.3. ACLS = Adult Resuscitation

3.4.4.2.1.4. PALS = Pediatric / Infant

3.4.4.2.2. Upon presenting a valid course completion card, the individual will then be expected to pass the specific MegaCode. Next steps, should the MegaCode again be failed, will be at the discretion of the System Medical Director and agency.

3.4.4.3. If unsuccessful in passing the corresponding card course, the individual will be eligible to credential at a lower level at the agency's discretion

3.4.5. Clinical Credentialing Interview

3.4.5.1. Individuals are given 3 attempts, at least 24 hours a part

3.4.5.2. If unsuccessful on the third attempt, the individual will be eligible to credential at a lower level at the agency's discretion

3.4.6. Mock Medical Director Interview

3.4.6.1. Individuals are given 3 attempts, at least 24 hours a part

3.4.6.2. If unsuccessful on the third attempt, the individual will be eligible to credential at a lower level at the agency's discretion

3.4.7. Medical Director Interview

3.4.7.1. Individuals are given 3 attempts, at least 24 hours a part

3.4.7.2. If unsuccessful on the third attempt, the individual will be eligible to credential at a lower level at the agency's discretion

Examination and Testing

- 3.5. If an individual fails at any required component of credentialing, they may be offered a lower-level credential if available at agency's discretion and System Medical Director agreement.
 - 3.5.1. The individual's ability and timeframe to reenter the credentialing process is at the agency's discretion

3.6. **Maintaining Credentialing**

- 3.6.1. All existing credentialed personnel within the System are required to follow all requirements listed in the **Continuing Education Policy** and the **Credentialing Requirements Policy** to maintain their FWOMD credential.
- 3.6.2. Individuals are responsible for gathering their own study materials. OMD will provide an electronic copy of the approved protocols and any course material that may be required.

Field Training Officers

- 1. Purpose.** The FWOMD is responsible for credentialing emergency medical services personnel. That process depends on the integrity of the Field Training Officer (FTO) program within the Fort Worth Regional EMS System (System). The objective of the FTO Selection Process is to assure that a standardized method for selection of FTOs will be used in a consistent manner and to assure that the System Medical Director or designee will participate in the selection process.
- 2. Scope.** The FTO assignment procedure applies to System agencies.
While the System Medical Director or designee is a participant in the selection of FTOs, these personnel are employees of that individual agency and must comply with their specific policies.
- 3. The Selection Process.** Each agency is responsible for organizing the FTO selection process. At minimum, the Agency shall implement a non-biased, non-discriminatory selection process that allows candidates to compete based on their qualifications. The System Medical Director or designee shall be a participant in the selection process.
- 4. Final Selection.** The System Medical Director or designee will provide the agency with written confirmation of recommended candidates. The System Medical Director, in cooperation with the agency, shall have final approval of all FTO personnel.
- 5. Allowance for alternate training programs:** If a First Responder agency does not use an FTO-based process, the clinical training process for that agency will be reviewed and approved by the System Medical Director.
- 6.** Due to the diverse nature of FRO training, individual FRO agencies will work with OMD to develop agency-specific FTO selection criteria and training.

Helicopter EMS

1. **Purpose.** The FWOMD is responsible for establishing guidelines for the role of helicopter utilization in emergency care. The FWOMD recognizes the benefit of this specialized service but also realizes it must be used appropriately and safely.
2. **Scope.** This policy applies to Fort Worth Regional EMS System (System) providers responsible for initiating a helicopter response. All HEMS requests must be done through the Fort Worth Fire Alarm Office (FAO).
3. **Appropriate use of helicopter transport.** There are circumstances that will require the expeditious use of HEMS transport. These include, but are not limited to:
 - 3.1. Patient inaccessible due to terrain or environmental conditions (i.e., high water, mud, rough terrain).
 - 3.2. Extended travel time of a critical patient (greater than 30 minutes) to an appropriate receiving facility due to distance or traffic.
 - 3.3. As an additional resource during a Mass Casualty Incident (MCI) with critically injured patients.
4. **Requesting Emergency Helicopter Support.**
 - 4.1. **Initiating a Standby/Launch Request.** “Standby” status places the helicopter crew on alert for possible scene response. A launch order or “alert go” physically request the helicopter and flight crew to lift-off and proceed to the requested location. Provide the height and weight of the patient (if known) at the time of launch request. A standby/launch request through the FAO may be initiated by any of the following:
 - 4.1.1. Any first responding unit or ambulance.
 - 4.1.2. Fire and Civil Defense personnel.
 - 4.1.3. State and Local Law Enforcement personnel.
 - 4.1.4. Industrial safety personnel.
 - 4.2. **Who May Cancel the Helicopter:** Once launched the helicopter will only be cancelled by:
 - 4.2.1. The initiating official/agency or Paramedic provider on-scene after patient contact has been established, and:
 - 4.2.1.1. Performance of a proper patient assessment, and
 - 4.2.1.2. Notifying fire department incident commander of decision
 - 4.2.1.3. If disagreement concerning cancellation exists between the incident commander and credentialed provider, the ultimate decision will be made by the highest credentialed provider on-scene.
5. **Safety.** The decision to launch is totally under the control of the helicopter pilot. Factors influencing flight safety for the patient and HEMS personnel will always take precedence in this decision.
 - 5.1. All personnel within the System shall complete a helicopter safety training program as part of their orientation or continuing education program.
6. **Documentation.** A full patient care form must be completed for each patient transported by a helicopter.
7. **QA/QI.** HEMS utilization will be reviewed on an as needed basis.

Incident Command System

1. **Purpose.** The Fort Worth Office of the Medical Director (FWOMD) is tasked with setting standards for patient care. Large or complex incidents require specialized policies to establish a unified command structure, common terminology, and an incident action plan (IAP). The objective is to assure that rescuers remain safe and that single resources are utilized effectively and efficiently as they treat and transport patients in an organized fashion.
2. **Scope.** This policy applies to Fort Worth Regional EMS System (System) during a large-scale incidents or a Mass Casualty Incident (MCI).
3. **Procedure Overview.** All emergency events will be managed in accordance with the nationally recognized Incident Command System (ICS) as established by the Federal Emergency Management Administration. The Fire Department Incident Commander (IC) will direct the overall operation at the scene. Emergency medical services will operate as a Branch within the ICS structure and will make medical decisions in cooperation with the IC. Patient care must never be delayed due to a jurisdictional dispute.
4. **Training.** Each agency within the System is responsible for assuring designated personnel receive the appropriate ICS training published by the Federal Emergency Management Agency Emergency Management Institute or an equivalent course. All medical personnel should be familiar with ICS and mass casualty response plans.
5. **Emergency Medical Services Operation.** At any scene requiring a unified command structure, EMS personnel will provide care according to medical protocols and within their scope of medical training and qualifications.
 - 5.1. The Fire Department Incident Commander is in command of the incident and the scene. In the event that a FWFD ambulance paramedic is the first to arrive at a scene, that individual will act as the IC until relieved by the Fire Department IC.
 - 5.2. The first FWFD ambulance personnel on-scene will be responsible for patient treatment and transport.
 - 5.3. The FWFD Paramedic, along with a Firefighter, will be in charge of the Triage, Treatment, and Transport areas (T-3).
 - 5.3.1. The FWFD Basic provider, along with a Firefighter, will triage all patients to the designated areas within the T-3 by utilizing the START system.
 - 5.4. The Fire Department personnel on-scene will be responsible for:
 - 5.4.1. Initial triage of victims & Strike Teams to extricate victims to the casualty collection points.
 - 5.5. Requests for additional resources shall be directed to the Incident Commander.
 - 5.5.1. When emergency helicopter service is needed, the Incident Commander is responsible for securing an appropriate landing site and for all safety procedures.
 - 5.5.2. The Appropriate destination-facility decisions will be made with consultation between the FWFD Paramedic and helicopter personnel, taking into consideration patient and/or family wishes when appropriate.
6. **Patient hand-offs**
 - 6.1. See *Transition of Care* policy
 - 6.2. In the event of disagreement in patient care, On-Line Medical Control will be contacted immediately for appropriate orders. All incidents of this nature will be forwarded to the System Medical Director for review.

Incident Disposition and Cancellation

1. **Purpose.** This policy establishes criteria for various dispositions for First Responders and FWFD ambulances, including cancellation.
2. **Scope.** This policy applies to all System agencies.
3. **Disposition reasons for EMS-related calls for service.**
 - 3.1. **First Responder disposition of calls.**
 - 3.1.1. **Assist a Citizen:** Upon completion of a clinical evaluation, the First Responder determines that a person needs assistance unrelated to an acute or deteriorating medical condition and there is no need for an ambulance. Appropriate documentation should be completed by the First Responder.
 - 3.1.2. **No Patient Found:** Upon arrival and after every reasonable effort to find the patient and potential errors have been ruled out, and no patient found. This includes calls to a false/non-existent location.
 - 3.1.3. **Dead on Scene:** Upon arrival, First Responders have identified that a patient is dead as described in the appropriate protocol. Appropriate documentation should be completed by the First Responder.
 - 3.1.4. **Against Medical Advice (AMA):** Anytime a patient or their parent/guardian demonstrates capacity and communicates a refusal of treatment or transport, the First Responder is to complete the appropriate documentation as required by FWOMD.
 - 3.1.5. **Refusal Without Demonstration of Capacity:** Anytime a patient or their parent/guardian communicates a refusal of treatment, or transport, and is unable to demonstrate capacity, the First Responder is to complete the appropriate documentation as required by FWOMD.
 - 3.1.6. **Release at Scene (RAS):** Anytime an individual meets the definition within the RAS protocol, The First Responder will complete the RAS documentation as required by FWOMD.
 - 3.1.7. **Treat-in-place Alternative:** Anytime a patient is treated without transport utilizing any currently implemented treat-in-place alternative. (Telehealth or protocol)
 - 3.1.8. **Care transferred to FWFD personnel** (or agencies responding for mutual aid).
 - 3.2. **FWFD Ambulance disposition of calls.**
 - 3.2.1. **Assist a Citizen:** Upon completion of a clinical evaluation, the FWFD personnel determine that a person needs assistance unrelated to an acute or deteriorating medical condition and there is no need for ambulance treatment and/or transport. Appropriate documentation should be completed by the FWFD personnel.
 - 3.2.2. **No Patient Found:** Upon arrival and after every reasonable effort to find the patient and potential errors have been ruled out, no patient can be found. This includes calls to a false/non-existent location.
 - 3.2.3. **Dead on Scene:** Upon arrival, FWFD personnel have identified that a patient is dead as described in the appropriate protocol. Appropriate documentation should be completed by FWFD personnel.
 - 3.2.4. **Against Medical Advice (AMA):** Anytime a patient or their parent/guardian demonstrates capacity and communicates a refusal of treatment or transport, the First Responder is to complete the appropriate documentation as required by FWOMD.

Incident Disposition and Cancellation

- 3.2.5. **Refusal Without Demonstration of Capacity:** Anytime a patient or their parent/guardian communicates a refusal of treatment, or transport, and is unable to demonstrate capacity, the First Responder is to complete the appropriate documentation as required by FWOMD.
- 3.2.6. **Release at Scene (RAS):** Anytime an individual meets the definition within the RAS protocol, FWFD personnel will complete the RAS documentation as required by FWOMD.
- 3.2.7. **Transfer of care:** When care is transferred from one FWFD provider to another (for example, due to an equipment failure and change to a new ambulance, multiple patients on scene with additional transporting resources, care assumed by Mobile Health Paramedic (MHP) provider or Critical Care Paramedic (CCP). The first on-scene FWFD personnel will document their care, then transfer the chart electronically to the next care provider.
- 3.2.8. **Transport to ED:** Identified patient is transported to the emergency department.
- 3.2.9. **Telehealth – Treatment in Place:** Identified patient has accepted telehealth visit and agreed to treatment on-scene with referral to primary care physician, or a scheduled in-home urgent care visit, or a scheduled in-home visit by crisis outreach team.
- 3.2.10. **Telehealth – Alternate Destination Transport:** Identified patient has accepted telehealth visit and agreed to transport to MHMR clinic or Urgent Care.
- 3.2.11. **MIH Call Complete:** This disposition is to only be used by MHP and CCP providers with patients enrolled in MIH programs. In conjunction with FWOMD, FWFD will create more descriptive codes, as needed, to properly identify specific programs.

Medical Professional On-Scene

1. Purpose. Medical professionals at the scene of an emergency may provide assistance to pre-hospital care personnel and should be treated with professional courtesy.
2. Scope. This policy applies to FWOMD-credentialed providers
3. Physician On-Scene, Not Requested by EMS
 - 3.1. Prior to arrival of FWOMD credentialed providers
 - 3.1.1. An on-scene physician who is caring for a patient may retain responsibility for patient care, provided that physician accepts full legal and medical responsibility.
 - 3.1.2. The on-scene physician will be placed in contact with On-Line Medical Control (OLMC), who may authorize that physician to issue orders to FWOMD credentialed providers. Once authorized by OLMC, the on-scene physician must accompany the patient to the hospital.
 - 3.2. After arrival of FWOMD credentialed providers
 - 3.2.1. A physician arriving after care has been initiated by the prehospital team will be placed in contact with OLMC before becoming involved in patient care.
 - 3.2.2. OLMC, the prehospital care team, and the on-scene physician will work collaboratively if granted permission by OLMC.
4. Physician On-Scene, Requested by EMS
 - 4.1. When a Specialty Care Physician is requested to the scene (e.g., Amputation Team) or is part of an approved specialty transport team (e.g., ECMO)
 - 4.1.1. EMS clinicians are authorized to follow orders given by the on-scene physician within the scope of their credential level.
 - 4.1.1.1. Contact OLMC should the on-scene physician issue orders outside the scope of credential level
 - 4.1.1.1.1. Authorized exceptions that do not need OLMC contact:
 - The administration of blood products, provided and ordered by the on-scene physician
 - Dosing of protocolized medications outside protocol parameters.
5. Responding to Physician's Offices:
 - 5.1. The FWOMD credentialed providers will comply with medical treatment requests the physician makes within his/her office as long as the orders are within the provider's scope of credentialing, and FWOMD protocols. Any orders that are in conflict with above should be discussed with OLMC.
 - 5.2. If the physician gives orders that are to be carried out during transport and are outside protocol, the paramedic will discuss these orders with OLMC once in the ambulance to assure that OLMC agrees with the orders and that the orders comply with the protocols of the System.
6. Poison Control
 - 6.1. Poison Control Center Specialists are authorized to direct medical care related to the medical toxicology and/or hazardous material exposure aspects of patient care if contacted for direction limited by credentialed scope and protocols. Care may be limited by supply and medication available for treatment.
7. Care established by other medical professionals
 - 7.1. Orders by nurses, nurse practitioners, physician assistants, and other State-certified providers are not applicable to System providers.
 - 7.1.1. If on arrival of FWOMD credentialed personnel, the patient is under the direct care of another medical professional, and if the patient and medical professional desire to continue as such, provide care in parallel with the medical professional and within the treatment protocol; if care

Medical Professional On-Scene

beyond

the credentialed scope of practice is requested, contact OLMC (e.g., OB – FHT monitoring)

7.1.2. A medical professional arriving after care has been initiated by the prehospital team will be placed in contact with OLMC before becoming involved in patient care.

8. Critical Care Ground and Air Medical Transport Teams

8.1. The patient will remain in the care of the transport team. FWOMD credentialed providers may assist in patient care at the request of the transport team as long as the care is within the credentialed scope and protocol.

9. Services and Equipment.

9.1. If approved by OLMC, the services, and equipment of the emergency vehicle will be made available to the on-scene physician or medical professional.

Medical Treatment of an Employee

1. **Purpose.** This policy describes the clinical practice of treating ill or injured employees of the Fort Worth Regional EMS System
2. **Scope.** This procedure applies to all credentialed providers who are rendering patient care to an ill or injured employee of the EMS System.
3. **Overview.** If an agency's employee is either ill or injured, that person should be treated as a "patient" and all the FWOMD protocols, procedures, and policies apply to care for that individual. An employee requiring medical care must have a patient care record completed whether or not they are transported to a hospital or if they are released by other means (AMA, RAS, etc.). A credentialed provider may not administer any type of medical treatment to another employee without properly following FWOMD protocols, procedures, and policies.
4. **Process.**
 - 4.1. If an agency's employee is ill or injured, proper medical attention should be activated and initiated. The 911 system should be activated if necessary.
 - 4.2. If the agency's employee refuses transport, then the proper AMA protocol should be followed. An incident must be created, and the proper patient care record documented fully.
 - 4.3. Any deviation from this process is prohibited by the System Medical Director and may lead to disciplinary action by the agency, state, and federal oversight authorities.
 - 4.4. Personnel should refer to agency-specific standard operating procedures for any agency-specific requirements of notification or referral.

Medication Storage

1. Purpose. The Drug Enforcement Administration, and the Texas Department of State Health Services (DSHS) require the System Medical Director to assure that all medications purchased under his/her license are stored and secured according to laws and regulations.
2. Scope. This policy applies to medications required on ambulances, first responder vehicles, special teams, and other response-capable Fort Worth Regional EMS System (System) vehicles.
3. Procedure
 - 3.1. Storage of Medications in the Field.
 - 3.1.1. Schedule II - IV Medications will be secured by field personnel while on duty either:
 - 3.1.1.1. on the person of the Paramedic that accepted receipt of the medications and is assigned to the apparatus, or
 - 3.1.1.2. in a locked container on the apparatus, where the only person with the key or combination is the Paramedic that accepted receipt of the medications and is assigned to the apparatus, or
 - 3.1.1.3. during EMS standby services, in a locked container in a designated first aid room where the only person with the key or combination is the Paramedic assigned to the room.
 - 3.1.2. When the crew is not physically inside the unit, all other medications and equipment will be secured on the apparatus by locking all exterior doors or compartments.
 - 3.1.3. The Paramedic that accepted receipt of the medications on Special Teams, such as the Bike Team, Mounted EMS Team, other Ad Hoc teams, or other response capable System vehicles, will secure all Scheduled medications on their person.
 - 3.2. Securing of ALS medications on a BLS resource
 - 3.2.1. Agencies will have a policy/procedure addressing the securing of ALS medications on a unit when being utilized as a BLS resource.
4. Reconciliation.
 - 4.1. All System agencies that carry controlled substances must have a reconciliation policy and procedure in place. FWOMD may conduct reconciliation record audits to assure compliance with this policy.
5. Drug Adulteration.
 - 5.1. All medicines stored in the field must be stored according to current DSHS rules and regulations. This includes all manufacturer temperature recommendations. Proper temperature monitoring and storage techniques should be maintained by each System agency.

Patient Destination

1. **Purpose.** The purpose of this policy is to establish patient destination guidelines.
2. **Scope.** This policy includes all patient transports within the jurisdiction of the Fort Worth Regional EMS System (System).
3. **Selection of a Destination Facility.** The selection of a destination facility must balance the goal of delivering the highest quality patient care with respecting the individual patient's rights and desires to make an informed choice. To accomplish this, patients will be transported to the closest, most appropriate facility using the following criteria in the order listed.
 - 3.1. Once it has been determined that a patient has decisional capacity, and if medically appropriate, they shall be transported to the hospital of their request.
 - 3.2. If the patient is unable to communicate, the patient is to be taken to the hospital of immediate family request, as medically appropriate
 - 3.3. If the family's facility preference is not known, the patient is to be taken to the closest, most appropriate facility.
 - 3.4. Special patient needs may dictate transport to a hospital that may not be the closest but is the most appropriate facility for that patient's medical care needs (i.e., burns, major trauma, stroke, STEMI). See **Designated Specialty Receiving Facilities** (below).
 - 3.5. If a patient calls for EMS while within 250 yards of a full-service hospital's campus, the patient shall be transported to that hospital's Emergency Department unless dictated as in 3.4.
 - 3.6. If a patient has been seen and discharged from an Emergency Department of a full-service hospital within 24-hours, the patient shall be transported back to that Emergency Department unless an exception exists as outlined in 3.4.
 - 3.7. Cardiopulmonary Arrest patients, if transported, should be transported to the closest full-service hospital.
 - 3.8. Credentialed providers shall not encourage patients to utilize one facility over another.
4. **Resolving Conflicts.** The following guidelines are to be used if the decision to transport the patient to the closest appropriate or other facility results in a conflict with the patient or family of the patient.
 - 4.1. In all cases, the patient or family are to be assisted to make an informed decision. As long as patients have decisional capacity, their informed decision will be honored. The patient's present medical condition and the reasons for transport to the closest appropriate medical facility should be discussed with the patient or family if the patient lacks capacity. If the patient or patient's family, as allowed in 3.1 or 3.2 above, insists on transport to another facility (other than a recommended facility based on patient condition or clinical need), their informed decision will be honored as described in this policy.

Patient Destination

5. **Age-Specific Transport Guidelines.** Any unresponsive patient with secondary sex characteristics shall be treated as an adult patient and transported to an adult-care facility. The following table establishes the age-related guidelines for selecting adult or pediatric destination facilities while recognizing the rules set forth in sections 3 and 4 (above).

| | Adult Care Facility | Cook Children's |
|---|---------------------|-----------------|
| Medical/Trauma Emergencies | ≥ 15 Years | < 15 Years * |
| Psychiatric Emergencies | ≥ 13 Years | < 13 Years |
| <p>* Under certain circumstances, individual patients who are 15-years old or older and who have established relationships with pediatric specialists may be transported to a pediatric care facility. If in doubt, consult with OLMC.</p> <p>* Patients who are exhibiting both an acute medical and psychiatric emergency (e.g., overdose with AMS) should be transported using the Medical/Trauma Emergency criteria</p> | | |

6. **Emancipated Minors.** Current laws dictate who may be declared an emancipated minor.
7. **Police Custody.** A patient who is under the custody of a police officer and who is being transported to a hospital for assessment/treatment, including those under an application for detention, may be transported to any hospital that is selected by the police officer as long as medically appropriate and as meets the age requirements in this policy.
8. **Correctional Facility Patients.** Patients being transported from correctional facilities are to be transported as follows:
- 8.1. Most federal correctional facilities have agreements with local hospitals. Patients should be transported to facilities in accordance with such agreements. FWFD paramedics should ask an appropriate official who is responsible for the patient to select the destination facility.
 - 8.2. Other jails or detention facilities – patients are transported to facilities selected by the police officer responsible for the patient.
9. **Designated Specialty Receiving Facilities.** A list of approved Specialty Receiving Facilities is available on each tablet, on the intranet, and in the protocol app.
- 9.1. **Trauma** - Patients who meet American College of Surgeons trauma activation criteria should be transported to an FWOMD-approved trauma facility.
 - 9.2. **Burn**- Patients with significant 2nd or 3rd-degree burns, as detailed within the Burn protocol, should be transported to an FWOMD-approved Burn center.
 - 9.3. **Cardiac** - Patients experiencing ST-elevation myocardial infarction should be transported to an FWOMD-approved PCI-capable facility.
 - 9.4. **Stroke** - Patients experiencing acute stroke symptoms should be transported to an FWOMD-approved stroke facility. A decision tool for transport to Primary vs. Comprehensive Stroke Center is defined in the Stroke Protocol.
 - 9.5. **Obstetrics** – gravid patients > 20-weeks' gestation should be transported to an FWOMD-approved facility with OB capabilities.
 - 9.6. **Sexual Assault** – patients with suspected or verbalized complaints of sexual assault should be transported to an FWOMD-approved facility with SANE capabilities.
 - 9.7. Designation of Specialty Receiving Facilities will occur based on the below criteria:

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- 9.7.1. **Trauma** – facilities that are approved by the Texas Department of State Health Services as a Level I, II, III, or IV trauma facility; or are in pursuit of such designation
 - 9.7.2. **Burn** – facilities that are verified by the American Burn Association; or are in pursuit of such designation
 - 9.7.3. **Cardiac** – facilities that perform 24/7 percutaneous coronary intervention (PCI) for STEMI-patients and are accredited, or in pursuit of accreditation, by the Joint Commission, American Heart Association, or the American College of Cardiology
 - 9.7.4. **Stroke** – facilities that are designated by the Texas Department of State Health Services as a Primary or Comprehensive Stroke Center
 - 9.7.5. **Obstetrics** – facilities that have a 24/7 Labor & Delivery unit
 - 9.7.6. **Sexual Assault** – facilities that have formalized Sexual Assault Nurse Examiners (SANE), and necessary equipment, available 24/7
10. **Registries and Collaborative Data Sharing.** The Medical Control Advisory Board (MCAB) has further approved that all hospitals that wish to participate as Designated Specialty Receiving Facilities will participate in the appropriate registries (e.g., trauma, stroke) and will share outcome information with the FWOMD so as to determine the appropriateness of care.
11. **Non-traditional Emergency Care Facilities.** A non-traditional emergency care facility is a facility that is structurally separate from a hospital (that may be affiliated or unaffiliated with a Hospital network) and which receives an individual and provides emergency care. These facilities are not considered full-service hospitals. Currently approved Non-traditional Emergency Care Facilities are available on the Specialty Receiving Facilities List
12. **Definitions of Hospital Divert Status**
- 12.1. **Full Divert** – A hospital is CLOSED to ALL patients, including walk-in and EMS traffic.
 - 12.1.1. Ambulance-only divert (where the facility remains open to walk-in traffic) is NOT permitted
 - 12.1.2. When a facility formally declares an *Internal Disaster* and has closed to any new patients (EMS or walk-ins), they will be placed on Full Divert.
 - 12.1.3. Examples of causes of Internal Disasters include, but are not limited to:
 - 12.1.3.1. Structural damage to the facility, e.g., fire, explosion, flood, etc.
 - 12.1.3.2. HazMat incidents
 - 12.1.3.3. Hostage/Bomb Threat/Active Shooter situations
 - 12.2. **Specialty Divert** - When a specific resource (e.g., all radiology, cardiac catheterization lab, etc.) is temporarily unavailable, leading to an inability to care for a specialized patient population
 - 12.2.1. **Trauma Divert**
 - 12.2.1.1. Trauma Divert may occur when a designated trauma facility no longer meets the requirements of a trauma center, e.g., no available OR/ICU bed, surgeon unavailable, etc.
 - 12.2.1.2. Trauma divert may only be initiated with the agreement of the facility's on-duty Emergency Physician and Trauma Surgeon
 - 12.2.1.3. Before a Level 1 or 2 Trauma facility will be placed on Trauma Divert, the Emergency Physician or Trauma Surgeon must first get approval from the other Level 1 or 2 trauma facility who will be responsible for receiving incoming trauma patients. The facility requesting divert must contact the Fort Worth Fire Alarm Office (FAO), who will then independently verify with the open facility before placing the requesting hospital on divert.
 - 12.2.1.4. If all designated Trauma Centers simultaneously require Trauma Divert status, Trauma Divert status shall be removed system-wide. During such times, the FAO will aid with the appropriate distribution of trauma patients.
 - 12.2.2. **Cardiac Divert**
 - 12.2.2.1. Cardiac Divert may occur when a designated Cardiac facility no longer meets the

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requirements of a PCI center, e.g., no available cath lab, Interventional Cardiologist unavailable, etc.

12.2.3. Stroke Divert

12.2.3.1. Stroke Divert may occur when a designated Stroke facility no longer meets the requirements of a Primary or Comprehensive Stroke center, e.g., no available CT scanner, etc.

13. **Outpatient Hemodialysis Facilities** - During a Presidential and/or Texas Governor declared disaster, individuals receiving dialysis for the management of their End Stage Renal Disease (ESRD) may be taken to outpatient hemodialysis treatment facilities, if appropriate. Patients will be evaluated for any significant exacerbation of their ESRD symptoms and for any other acute medical conditions to ensure an appropriate destination for treatment. Patients requesting transport for dialysis, AND who are asymptomatic or have mild complaints consistent with their typical pre-dialysis symptoms (e.g., weight gain, edema, shortness of breath, fatigue, nausea/vomiting), may be transported to an outpatient dialysis facility.

14. **Divert Process** – The following process shall be followed for all changes to Divert status (Full or Specialty):

14.1. The Administrator on Call (AOC) for the facility requesting divert will notify the FAO of the type and expected duration of diverting and the names and direct phone numbers of the facility's on-duty Emergency Physician and AOC.

14.2. **For Specialty Divert**, FAO will notify the System Medical Director, Shift Commander, and Field Crews of facility divert status and timeframe.

14.3. **For Full Divert**, the below steps will be followed:

14.3.1. The Communications Center will dispatch an EMS Supervisor to the facility to meet with and offer assistance to the facility AOC and on-duty Emergency Physician.

14.3.2. After this meeting, the EMS Supervisor shall initiate a conference call with the AOC, Shift Commander, and the System Medical Director

14.3.2.1. The ultimate responsibility of approving a divert status lies with the System Medical Director.

14.3.2.2. Once the conference call has been completed, the Shift Commander will notify the FAO to page on-duty field providers and EMS Supervisors regarding the hospital facility's divert status.

14.3.3. The facility must also update and notify local (e.g., EMResources/NCTTRAC, Emergency Operations Center) and state authorities (e.g., DSHS).

14.3.4. The facility's status shall be verified with the facility's AOC at least every 2-hours by an EMS Supervisor.

14.3.5. The Shift Commander, System Medical Director, and Facility AOC shall confer by conference call and review hospital divert status every six hours.

15. After-Action Review

15.1. Following any Full Divert activation, an after-action review will be held within 72-hours to include the following stakeholders:

15.1.1. Hospital CEO, CMO, or COO

15.1.2. Fire Chief or designee

15.1.3. System Medical Director

16. System-wide Disasters and Patient Overload

16.1. In rare circumstances, such as prolonged public health emergencies, multiple System hospitals may be overwhelmed by large patient volumes in their Emergency Departments.

16.2. In these instances, a distributed patient allocation process may benefit the hospitals and patients of the System,

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16.3. The decision to activate a distributed patient allocation process will be made by discussion amongst the service area full-service hospital administrators

16.3.1. .

16.3.2. Decisions regarding this process will be communicated to the facilities Medical Control Advisory Board representatives

Protocol Maintenance

1. **Purpose.** The protocols, procedures and policies (PP&P) of the Fort Worth Office of the Medical Director (FWOMD) are based on current scientific data, evidence-based best-practices, and standards of care, where these are available. All PP&P are reviewed and approved by the Medical Control Advisory Board (MCAB), which may include board-certified physicians representing a variety of specialties – e.g., emergency medicine, cardiology, pulmonology, public health, trauma surgery, psychiatry and critical care. This policy provides guidance on how these documents will be reviewed and revised to incorporate current best-practice and scientific advances in clinical care
2. **Scope.** This policy applies to FWOMD.
3. **Procedure.**
 - 3.1. **Periodic Review:**
 - 3.1.1. Current protocols related to all aspects of patient care, including specialty programs, will be reviewed by FWOMD at a minimum every 3-years.
 - 3.1.2. Revisions may be made in whole or in part and will be submitted to MCAB for review and approval.
 - 3.2. **Approval of revisions, notification to affected personnel and necessary training:**
 - 3.2.1. Once MCAB approves any revisions to current PP&P, FWOMD will replace the existing electronic file with the revised document.
 - 3.2.2. Members of the Fort Worth Regional EMS System (System) will be notified of any changes and will be provided electronic copies of the revised document.
 - 3.2.3. Any required training for approved changes will be developed by FWOMD in collaboration EMS System agencies.
 - 3.3. **Immediate Revision:**
 - 3.3.1. Revisions to PP&P may be implemented by the System Medical Director prior to the next regularly scheduled MCAB meeting and submitted to MCAB at the next regularly scheduled meeting.
 - 3.4. **Biennial Protocol Competency:**
 - 3.4.1. To ensure maintenance of clinical competency, System credentialed providers may be tested in part or in whole, biennially with any protocol update or revision.
 - 3.5. **Eligibility to Request Review:**
 - 3.5.1. Members of the EMS System, receiving hospital, or other facility may request a review of PP&P by FWOMD.

Safe Haven – Baby Moses

1. **Purpose.** As a Fort Worth Regional EMS System first responder agency that is recognized by the Texas Department of State Health Services under Chapter 773 of the Health and Safety Code as a First Responder Organization, in-service fire apparatus, or any FWFD ambulance, or fire station may be considered a “Safe Haven” for voluntary drop-off of children who appear to be 60-days old or younger in accordance with Texas Family Code, this policy defines the procedure for the care of an infant left at a recognized location.
2. **Scope.** This policy applies to all EMS System providers.
3. **Procedure.**
 - 3.1. **Assessment and Care**
 - 3.1.1. Perform initial assessment:
 - 3.1.1.1. Complete physical exam
 - 3.1.1.2. Gather complete family medical history
 - 3.1.1.3. Gather complete patient medical history
 - 3.1.1.4. Provide care:
 - 3.2. Provide care as indicated in accordance with FWOMD protocol
 - 3.3. **Transport**
 - 3.3.1. The newborn is to be transported to the closest full-service pediatric facility for further evaluation and treatment.
 - 3.4. **Notification**
 - 3.4.1. Notification is to be made to the Texas Department of Family and Protective Services regarding the surrendered newborn and destination of transport.

Supplies and Equipment

1. **Purpose.** TAC Rule 157.11 requires the Medical Director to set standards for patient care. Standards are to include vehicles and onboard equipment. This policy establishes the standards for Medication, Equipment, Devices, and Supplies (M.E.D.S.)
2. **Scope.** This policy applies to Fort Worth Regional EMS System (System) ambulances, first responder vehicles, and special teams.
3. **Procedure.** All vehicles will be equipped per the approved inventory list. Proposed changes in the inventory are to be submitted to the FWOMD for approval.
 - 3.1. **Brand Specific Items:** In certain cases the OMD may specify a particular brand of M.E.D.S. The decision to specify a particular brand will be based on the evaluation of available products and through the participation of representatives from agencies that will use the item.
 - 3.2. **Approved Inventory:** Each ambulance and FRO primary apparatus utilized in first response and transport shall carry at minimum the equipment and drug inventory listed on the applicable minimum inventory equipment and drug list signed by the System Medical Director.
 - 3.3. **Evaluation of New M.E.D.S.** This procedure is to assure that all new M.E.D.S is introduced into the EMS System with the System Medical Director's approval.
 - 3.3.1. The EMS System agency may research and suggest new M.E.D.S.
 - 3.3.2. The EMS System agency and the System Medical Director agree to perform a field trial (if necessary) on the specific M.E.D.S.
 - 3.3.3. The recommendation is brought to the System Medical Director for approval.
 - 3.3.4. The System Medical Director accepts or rejects the proposal.
 - 3.3.5. If the trial proposal is accepted, the System agency's designated personnel will perform a clinical field trial.
 - 3.3.6. If the trial proposal is rejected the item will be dropped from consideration but may be reviewed again later by the System Medical Director if deemed necessary.
 - 3.3.7. Once a clinical field trial is completed a representative of the EMS System agency will present all available data to the System Medical Director for review.
 - 3.3.8. The System Medical Director will approve or reject the implementation of the new item based on the following in collaboration with agency leadership:
 - 3.3.8.1. Logistics, training requirements, implementation constraints,
4. **Implementation of New Equipment**
 - 4.1. If approved by System Medical Director and System agency or FRO's municipality:
 - 4.1.1. The new equipment will be ordered by the agency in a timely fashion.
 - 4.1.2. The agency in collaboration with FWOMD may perform all the necessary training of field personnel.
 - 4.1.3. The FWOMD will compose the applicable protocol and/or procedure for the new M.E.D.S.
 - 4.1.4. After the FWOMD has deemed that the proper training has been completed, the new equipment will be implemented and added to the minimum inventory list.
 - 4.2. If rejected by the System Medical Director the item will be dropped from consideration; however, may be reviewed again at a later time if deemed necessary.
5. **Expiration of medications and supplies**
 - 5.1. Expiration dates should be checked monthly, and items replaced as they expire.
6. For the Fort Worth Regional EMS System, FWOMD will manage all the minimum inventory lists with DSHS

System Quality Improvement

1. **Purpose.** This policy is established to implement a systematic approach for benchmarking and measuring clinical quality using standardized measurement strategies that prioritize patient-centric care and focus on achieving desired outcomes.
2. **Scope.** This policy applies to the Fort Worth Regional EMS System
3. **Clinical Benchmarks**
 - 3.1. The clinical benchmarks for Whole System Quality will be based on the following sources:
 - AHA Mission Lifeline
 - AHA Telecommunicator CPR Performance Measures
 - National EMS Quality Alliance
 - CARES – Cardiac Arrest Registry to Enhance Survival
 - 3.2. Benchmarks for clinical quality will align with national performance measures whenever they are available or follow the goals set forth by the American Heart Association (AHA).
 - 3.3. See Appendix A for measure definitions
4. **Quality Improvement**
 - 4.1. When clinical performance falls below national benchmarks or AHA goals, the "Model for Improvement" will be used as the primary methodology for quality improvement initiatives.
 - 4.2. The quality improvement process will include the following key elements.
 - Identification of performance gaps
 - Formation of multidisciplinary teams
 - Drafting of project charters for each improvement initiative
 - Establishment of outcome, process, and balancing measures to assess the impact of changes
 - Testing and implementation of change theories using the Plan-Do-Study-Act (PDSA) methodology.
5. **Implementation of Quality Improvement Initiatives**
 - 5.1. Identification of Performance Gaps:
 - Regularly monitor and analyze clinical performance data to identify areas where performance falls below national benchmarks or AHA goals.
 - 5.2. Formation of a Multidisciplinary Team:
 - 5.2.1. Establish multidisciplinary teams consisting of healthcare professionals, administrators, and other relevant stakeholders to lead improvement initiatives.
 - 5.3. Drafting of Project Charters:
 - 5.3.1. Develop project charters for each improvement initiative, outlining the objectives, scope, resources, and timeline for the project.
 - 5.4. Establishment of Measures:
 - 5.4.1. Define outcome measures that represent the desired improvements in clinical quality.
 - 5.4.2. Define process measures that track the changes made to achieve these improvements.
 - 5.4.3. Define balancing measures that assess any unintended consequences of improvement efforts.
 - 5.5. Testing and Implementation of Change Theories:
 - 5.5.1. Utilize the PDSA methodology to systematically test and implement changes aimed at achieving the desired outcomes.

System Quality Improvement

5.6. Monitoring and Sustaining Improvements:

5.6.1. Continuously monitor the impact of implemented changes and adjust as necessary to sustain improvements.

6. Compliance and Accountability

6.1. All personnel within the organization are responsible for adhering to this policy and participating in quality improvement initiatives.

6.2. The Fort Worth Office of the Medical Director will oversee and coordinate the implementation of this policy, monitor progress, and report on quality improvement efforts to senior leadership.

7. Review and Revision

7.1. This policy will be periodically reviewed and revised as needed to ensure its effectiveness in promoting clinical quality and achieving desired patient outcomes.

8. Communication

8.1. This policy will be communicated to all relevant staff members and stakeholders within the organization. Training and educational resources will be provided as necessary to facilitate understanding and compliance.

System Quality Improvement – Video Laryngoscopy

1. **Purpose:** The purpose of this policy is to establish guidelines for the review, retention, and deletion of video laryngoscopy data obtained from a video laryngoscopy device in the Fort Worth Regional EMS System, for quality assurance (“QA”) and quality improvement (“QI”) activities.
2. **Scope:** This policy applies to all Video Laryngoscopy video files that have been retained by the Office of the Medical Director (FWOMD) for QA/QI purposes.
3. **Upload Process:** All video laryngoscopy intubations performed in the EMS System will have the accompanying video file uploaded for a quality review prior to the end of shift as outlined below:
 - 3.1. Video laryngoscopy files will be uploaded to the UEScope app on designated devices.
4. **Review:** Video Laryngoscopy videos will be reviewed and may be used for quality assurance purposes outlined below. The video should not be used for any other purpose other than those outlined in this policy. The use of these videos should be limited to:
 - 4.1. **Case Reviews:** Video files may be used to review intubation performance during Quality Assurance case reviews with providers. This confidential review will consist of FWOMD Quality staff and only those providers that were present and involved with the intubation on the respective case. Full, unedited intubation videos will not be shared with any providers that were not involved with direct patient care, more specifically patient intubation.
 - 4.2. **Intubation Training:** Video files may be retained for system training purposes but must be edited to redact all protected health information (PHI) and/or crew member identity.
 - 4.3. **Quality Improvement Activities:** Videos may be reviewed by FWOMD staff to identify system training objectives, research initiatives, performance trends, or any other purposes deemed necessary for quality improvement.
5. **Retention:** Video Laryngoscopy data will be retained for a 90-day period to allow for review and identification of videos that may be retained for training purposes. Videos that are retained for training purposes must be edited to redact all PHI and/or crew member identity.
6. **Deletion:** After 90 days all videos that are not retained for quality assurance purposes shall be destroyed.

Transition of Care

1. Purpose. To minimize the potential for medical error, to ensure continuity of care, and enhance safety during transitions of care.
2. Scope. This policy applies to all FWOMD-credentialed providers.
3. Inclusion criteria
 - 3.1. Patient handoffs in a health care facility from a health care practitioner (Ex. Physician, Physician Assistant, Advanced Practice Registered Nurse - CRNA, NP, Certified Nurse Midwife).
 - 3.2. Handoffs between EMS crews and FROs at same credential level.
4. Exclusion Criteria
 - 4.1. Transitions from non-clinician level staff (RN, LPN, CNA, tech, doula, etc.), non-medical persons (bystanders, family).
 - 4.1.1. Note: EMS System clinicians should, however, politely, and attentively obtain relevant information from these care givers and thank them for their assistance.
 - 4.2. For physicians not in a healthcare setting with an established patient care relationship, follow *Medical Professionals on Scene*.
5. Definitions:
 - 5.1. Sending clinician: the clinician/team responsible for care before hand-off.
 - 5.2. Receiving clinician: the clinician/team responsible for care after hand-off.
6. Transition of Care
 - 6.1. Assume patient care and medical decision making will be directed by the sending clinician until they verbally transfer care to the receiving clinician. Understandably, they may not always verbally communicate transfer of care, assuming it is implied. To minimize the chances for misunderstanding, confirm that the clinician is transferring care and understands that the receiving clinician is now in charge of patient care and will be operating under their protocols.
 - 6.1.1. If there is no on-scene sending clinician physically present in the room with the patient, make every effort to contact them if they are on-location.
 - 6.1.2. Promptly contact OLPG for assistance if there is any conflict between sending and receiving clinicians.
 - 6.2. Prior to handoff: receiving clinicians may assist, within their credentialed scope, with appropriate care prior to formal transfer of care and at the direction/request of the sending clinician.
 - 6.3. After formal transfer of care: sending clinicians may assist, within their credentialed scope, with appropriate care after formal transfer of care and at the direction/request of the receiving clinician.
7. Document estimated time of transfer of care in the ePCR.

Upgrading Ambulance Response

1. **Purpose.** This policy establishes the circumstances under which Fort Worth Regional EMS System first responder personnel may request a FWFD ambulance response upgrade, the process for upgrading a response, and related QA activities.
2. **Scope.** This policy applies to First Responder personnel and affects response priority upgrades. The call would be upgraded based on the EMD criteria.
3. **Procedure.** Certain conditions may become apparent during initial contact with a patient that may not have been identifiable by an EMD, or that had a delayed onset, and that may warrant a response upgrade by FWFD ambulance.
 - 3.1. If a first responder arrives at the patient's side and identifies any of the following findings, conditions, or situations, a response upgrade to Priority 1 is warranted:
 - 3.2. **Airway:**
 - 3.2.1. There is complete airway obstruction; or
 - 3.2.2. The patient's airway cannot be maintained.
 - 3.3. **Breathing:**
 - 3.3.1. The patient has severe difficulty breathing;
 - 3.3.2. The patient cannot be ventilated.
 - 3.4. **Circulation:**
 - 3.4.1. An unanticipated cardiac arrest occurs or has occurred;
 - 3.4.2. Uncontrollable bleeding is present; or
 - 3.4.3. Severe loss of blood has occurred.
 - 3.4.4. **Altered Level of Consciousness:**
 - 3.4.4.1. The patient becomes unresponsive; or
 - 3.4.4.2. Status seizures.
 - 3.4.5. An upgrade to a Priority 2 may be requested if the first responder finds the patient's clinical condition to be urgent.
 - 3.5. **Requesting a Response Upgrade.** The first responder shall request a response upgrade by contacting their respective dispatch center and asking them to contact the Fort Worth Fire Alarm Office (FAO) for the purpose of upgrading a response priority. The reason for the upgrade is required when making such a request. The FAO will upgrade the response based on current EMD criteria.
 - 3.6. **Audit of Upgrade Requests.** FWFD and each First Responder agency that has requested a response upgrade during the month shall conduct a 100% QA review of upgrade requests. The QA review shall meet the following requirements:
 - 3.6.1. A cooperative review shall be conducted each month by FAO quality assurance personnel, the First Responder designee, FWOMD representative, and other personnel who may be needed;
 - 3.6.2. Together, they shall Review the initial dispatch and the request for the upgrade;
 - 3.6.3. Review of the first responder patient care report and the ambulance patient care report;
 - 3.6.4. A QA report shall be provided to the System Medical Director and shall include the total number of upgrade requests, the number of appropriate requests, and a qualitative summary of possible improvements to the process.

Walk-In Patients

1. **Purpose.** The purpose of this policy is to establish a uniform method of managing a person's arrival at fire or EMS stations requesting (explicit or implied) medical assistance.
2. **Scope.** This policy applies to all Fort Worth Regional EMS System agencies and their personnel.
3. Compliance with Safe Haven Law(s), see *Safe Haven – Baby Moses*
4. **Procedure.** When a person arrives at a fire or EMS station requesting medical assistance or who is in obvious medical distress, personnel should:
 - 4.1. Perform initial assessments and administer indicated care in accordance with FWOMD protocol;
 - 4.2. Make indicated notifications as required by agency policy; and
 - 4.3. Request a FWFD ambulance.

Appendix A

System Performance Committee Recommended Measures and Goals

Cardiac Arrest

CA 01: Percentage of OHCA Cases Correctly Identified by PSAP That Were Recognizable

Description: Telecommunicator recognized OHCA / total OHCA (confirmed by EMS impression)

Goal: 95% (AHA)

CA 02: Median time between 9-1-1 call and OHCA recognition

Description: Median amount of time in seconds between 9-1-1 call connected and OHCA recognition.

Goal: < 90 seconds (AHA)

CA 03: Percentage of Telecommunicator-Recognized OHCAs Receiving T-CPR

Description: Number of telecommunicator-recognized OHCA cases receiving T-CPR / number of QI-reviewed EMS-confirmed OHCA with recognition noted.

Goal: 75% (AHA)

CA 04: Median time between 9-1-1 Access to tCPR hands-on-chest time for OHCA cases

Description: Median amount of time in seconds between 9-1-1 call connected and first chest compression directed by telecommunicator.

Goal: <150 seconds (AHA)

CA 05: Utstein Survival %

Description: Patients experiencing non-traumatic, bystander-witnessed out-of-hospital cardiac arrest (OHCA) presenting with a shockable rhythm that are discharged from the hospital alive.

Goal: >30.7% (National Average)

CA 06: Utstein Survival with Good Neurological Function

Description: Patients experiencing non-traumatic, bystander-witnessed out-of-hospital cardiac arrest (OHCA) presenting with a shockable rhythm that are discharged from the hospital alive with good neurological function.

Goal: > 27.5% (National Average)

Airway Management

Airway 01: First Pass Intubation Success without Hypotension or Hypoxia

Description: The percentage of non-cardiac arrest intubations with first pass success without hypotension (SBP \geq 90) or hypoxia (\geq 90) during the peri-intubation period (+/- 5 minutes from procedure time).

Goal: > National Average (when available)

Airway 02: Adequate Oxygen Saturation Achieved Before Intubation Procedure

Description: The percentage of intubation procedures in which adequate patient oxygen levels were achieved and maintained for 3 minutes prior to the intubation procedure.

Goal: > National Average (when available)

Airway 03: Waveform Capnography Airway Device Monitoring

Description: The percentage of advanced airway procedures in which waveform capnography is used for tube placement confirmation and monitoring

Goal: >National Average (when available)

Airway 04: Airway Composite (Defect-Free Care)

Description: The percentage of responses during which adequate oxygen levels (\geq 94%) are achieved and maintained for 3 minutes prior to intubation procedure, endotracheal intubation placement is successful on first attempt without hypotension (SBP \geq 90) or hypoxia (<90%) during the peri-intubation period, and waveform capnography is used for verification and monitoring.

Goal: >National Average (when available)

Airway 05: Unrecognized Failed Airway

Description: The percentage of patients for whom EtCO₂ is NOT present at the end of the event AND for whom adjudication did not reveal a plausible explanation (ex. gradual loss of EtCO₂ in cardiac arrest)

Goal: >National Average (when available)

STEMI

STEMI 02: Aspirin Administration for STEMI

Description: The percentage of EMS patients aged 18 years and older transported from the scene with Aspirin administration for suspected heart attack.

Goal: ≥75% (AHA)

STEMI 03: 12-lead ECG Performed Within 10 minutes for STEMI Patients

Description: The percentage of EMS patients aged 18 years and older transported from the scene with chest pain or a suspected MI for whom a 12-Lead ECG was performed ≤ 10 minutes of first medical contact.

Goal: ≥75% (AHA)

STEMI 04: STEMI Alert Within 10 Minutes in STEMI Patients

Description: The percentage of EMS patients aged 18 years and older transported from the scene with a STEMI positive ECG for whom pre-arrival notification was activated ≤ 10 minutes of positive ECG.

Goal: ≥75% (AHA)

Stroke

Stroke 01: Evaluation of Blood Glucose for Patients with Suspected Stroke

Description: The percentage of EMS patients aged 18 years and older transported from the scene with suspected stroke for whom blood glucose was evaluated during the EMS encounter.

Goal: ≥75% (AHA)

Stroke 02: Stroke Screen Performed and Documented

Description: The percentage of EMS patients aged 18 years and older transported from the scene with a suspected stroke for whom a stroke screen was performed and documented during the EMS encounter.

Goal: ≥75% (AHA)

Stroke 03: Stroke Alert for Suspected Stroke

Description: The percentage of EMS patients aged 18 years and older transported from the scene with a primary or secondary impression of stroke whom a pre-arrival alert for stroke was activated during the EMS encounter.

Goal: ≥75% (AHA)

Stroke 04: Documentation of Last Known Well for Patients with Suspected Stroke

Description: The percentage of EMS patients aged 18 years and older transported from the scene with suspected stroke for whom Last Known Well was documented during the EMS encounter.

Goal: ≥75% (AHA)

NEMSQA

Asthma 01: Administration of a Beta Agonist for Asthma

Description: The percentage of EMS responses originating from a 911 request for patients with a diagnosis of asthma who had an aerosolized beta agonist administered.

Goal: >51% (National Average)

Hypoglycemia 01: Treatment Administered for Hypoglycemia

Description: The percentage of EMS responses originating from a 911 request for patients with symptomatic hypoglycemia who receive treatment to correct their hypoglycemia.

Goal: > 43% (National Average)

Respiratory 01: Respiratory Assessment

Description: The percentage of EMS responses originating from a 911 request for patients with primary or secondary impression of respiratory distress who had a respiratory assessment.

Goal: >92% (National Average)

Seizure 02: Patients with Status Epilepticus Receiving Intervention

Description: The percentage of EMS responses originating from a 911 request for patients with status epilepticus who received benzodiazepine during the EMS response.

Goal: >28% (National Average)

Trauma 01: Pain Assessment of Injured Patients

Description: The percentage of EMS responses originating from a 911 request for patients with injury who were assessed for pain.

Goal: >69% (National Average)

Trauma 03: Effectiveness of Pain Management for Injured Patients

Description: The percentage of EMS transports originating from a 911 request for patients whose pain score was lowered during the EMS encounter.

Goal: >18% (National Average)

Appendix

CPR WORKSHEET

PATIENT INFORMATION

NAME: _____ HISTORY: _____
DOB: _____
ON SCENE TIME: _____ **CPR START TIME:** _____ MEDICATIONS: _____
BYSTANDER WITNESSED: Y / N
BYSTANDER CPR: Y / N BYSTANDER AED: Y / N ALLERGIES: _____

BASIC PROTOCOL

| TIME | PROCEDURE | SUCCESSFUL? | PERFORMED BY / NOTES |
|------|---|-------------|----------------------|
| | CPR—MANUAL | Y / N | |
| | ATTACH PADS IN A/L POSITION | Y / N | |
| | AIRQ-3 | Y / N | |
| | DEFIBRILLATION | Y / N | |
| | MCD AFTER 15 MIN MANUAL CPR | Y / N | |
| | DUAL SEQUENTIAL EXTERNAL DEFIBRILLATION (DSED) | Y / N | |
| | | Y / N | |
| | | Y / N | |

ALS PROTOCOL

| TIME | PROCEDURE | SUCCESSFUL? | PERFORMED BY / NOTES |
|------|----------------|-------------|----------------------|
| | IV / IO ACCESS | Y / N | |
| | EPI | Y / N | |
| | EPI INFUSION | Y / N | |
| | BICARB | Y / N | |
| | | Y / N | |
| | | Y / N | |
| | | Y / N | |
| | | Y / N | |

ADVANCED PROTOCOL

| TIME | PROCEDURE | SUCCESSFUL? | PERFORMED BY / NOTES |
|------|---------------|-------------|----------------------|
| | ESMOLOL | Y / N | |
| | NOREPI (LEVO) | Y / N | |
| | | Y / N | |
| | | Y / N | |
| | | Y / N | |
| | | Y / N | |
| | | Y / N | |
| | | Y / N | |

CODE COMMANDER TAC SHEET

1

2

3

4

CPR

Airway / Meds

Mechanical Compressions

ROSC

POSITION 1 & 2

POSITION 3 & 4

POSITIONS 1, 2, & 3

INTERVENTION PARAMEDIC

2 min. continuous CPR

IMMEDIATE SGA

OPTIONAL AFTER 15 MIN MANUAL CPR

STAY IN PLACE 10 MIN

A/L PAD PLACEMENT

DO NOT BAG DURING COMPRESSIONS

- Hit Analyze on monitor & PAUSE compressions
- Manual CPR at 30:2
 - 30 compressions
 - 2 ventilations
- Pulse/rhythm check every 2 min. (10sMAX)
- Pause compressions when prompted by AED

- EtCo2 goal = ≥ 20 mmHg
 - Turn Co2 on, on monitor
 - Titrate compressions to achieve
- 4 phase waveform for each breath
- ETI only after failed SGA

1. Power ON
2. Role assignments
3. 2 step placement

- Set BP every 2 min.
- Optimize Airway
 - EtCo2 34-45 mmHg
- Obtain a clear 12 lead
 - Transmit
 - PCI alert IF STEMI
- Gain 2nd IV/IO access

RE-CHECK PLACEMENT AFTER PATIENT MOVEMENT EVERY TIME

PHASE 1

- After pulse/rhythm check
- Lift / roll patient
 - Place back plate
 - Continue compressions

POST-ROSC MEDS

PERSISTENT VF/VT

SHOCKABLE

PHASE 2

- Dual Sequential External Defibrillation
- 2nd pads in A/P position
 - Do not use 2nd puck
 - 1 provider operates both monitors
 - Deliver shocks 1 second apart
 - Contact OLMC for ECPR consideration after 3rd shock

- Epi - 1mg 1:10,000
- Amio
 - 300mg after 2nd shock
 - 150 after 3rd shock
- Esmolol - after 4th shock
 - 0.5 mg/kg bolus
 - 0.05 mg/kg/min infusion
 Only while in shockable rhythm

- After pulse/rhythm check
- Attach arms to backplate
 - Engage piston
 - Press play

- Epi infusion
 - Titrate if already in place
- Levo infusion
 - If no Epi in place
- Optimize hemodynamics
 - MAP ≥ 65
- New BP every 2 min

PLAN IN PLACE BEFORE PATIENT MOVEMENT

MONITOR WATCHER

NON SHOCKABLE

POST MCD PLACEMENT

- Eyes on monitor at all times
- Announce START/STOP CPR
- Depth = ≥ 2 inches
- Rate = 100-120 bpm
- Mark pulse points

- Epi - 1mg 1:10,000
- Epi Infusion
 - 2mg of 1:10,000 in 250 NS @ 67 mcg/min
- If unwitnessed give Bicarb
- If PEA give fluid bolus

- Attach neck strap
- Sharpie the chest
- Mark pulse points

MCD Watcher Manages Device

TERM OF RESUS

- Contact OLMC
 - EtCo2 < 10 @ 10 min
 - EtCo2 ≥ 10 but < 20 @ 20 min
 - EtCo2 ≥ 20 @ 30 min

TRANSPORT

- Reassess airway
- Reassess vitals
 - BP every 2 min
- Prepared for re-arrest
- MCD + Fire Riders
- Spare MCD battery

Clinical Opiate Withdrawal Scale (COWS)

| | |
|---|---|
| Resting Pulse Rate: <i>(Measured after patient is sitting or lying for 1 min)</i> | GI upset: <i>(Over last 30 min)</i> |
| <ul style="list-style-type: none"> 0 - HR 80 or below 1 - HR 81 to 100 2 - HR 101 to 120 4 - HR > 120 | <ul style="list-style-type: none"> 0 - No GI symptoms 1 - Stomach cramps 2 - Nausea or loose stool 3 - Vomiting or diarrhea 5 - Multiple episodes of diarrhea or vomiting |
| Sweating: <i>(Over last 30 min and not due to room/environment temp or patient activity)</i> | Tremor: <i>(Observation of outstretched hands)</i> |
| <ul style="list-style-type: none"> 0 - No report of chills or flushing 1 - Subjective report of chills or flushing 2 - Flushed or observable moistness on face 3 - Beads of sweat on brow or face 4 - Sweat streaming off face | <ul style="list-style-type: none"> 0 - No tremor 1 - Tremor can be felt, but not observed 2 - Slight tremor observable 4 - Gross tremor or muscle twitching |
| Restlessness: <i>(Observation during assessment)</i> | Yawning: <i>(Observation during assessment)</i> |
| <ul style="list-style-type: none"> 0 - Able to sit still 1 - Reports difficulty sitting still, but is able to do so 3 - Frequent shifting or extraneous movements of legs/arms 5 - Unable to sit still for more than a few seconds | <ul style="list-style-type: none"> 0 - No yawning 1 - Yawning 1x or 2x during assessment 2 - Yawning 3 or more during assessment 4 - Yawning several times/minute |
| Pupil size: | Anxiety or Irritability: |
| <ul style="list-style-type: none"> 0 - Pupils pinned or normal size for room light 1 - Pupils possibly larger than normal for room light 2 - Pupils moderately dilated 5 - Pupils so dilated that only the rim of the iris is visible | <ul style="list-style-type: none"> 0 - None 1 - Reports increasing irritability or anxiousness 2 - Obviously irritable or anxious 4 - So irritable or anxious that participation in the assessment is difficult |
| Bone or Joint Aches: <i>(If pain previously, only score the additional component attributed to opiate withdrawal)</i> | Gooseflesh Skin: |
| <ul style="list-style-type: none"> 0 - Not present 1 - Mild diffuse discomfort 2 - Patient reports severe diffuse aching of joints/muscles 4 - Patient is rubbing joints or muscles and is unable to sit | <ul style="list-style-type: none"> 0 - Skin is smooth 3 - Piloerection of skin can be felt or hairs standing up on arms 5 - Prominent piloerection |
| Runny Nose or Tearing: <i>(Not accounted for by cold symptoms or allergies)</i> | Total score (sum of all 11 items): 5 to 12 = Mild 13 to 24 = Moderate 25 to 36 = Moderately Severe > 36 = Severe Withdrawal |
| <ul style="list-style-type: none"> 0 - Not present 1 - Nasal stuffiness or unusually moist eyes 2 - Nose running or tearing 4 - Nose constantly running or tears streaming down cheeks | |

Esmolol Dosing Chart

(Pre-mix concentration 2,500 mg / 250 mL = 10 mg/mL)

| LBS | KGS | Bolus | | Infusion Rate (mg/min) |
|---------|---------|-------|-----|-------------------------------|
| | | mg | mL | |
| 88 LBS | 40 KG | 20 | 2 | Calculated by pump |
| 110 LBS | 50 KG | 25 | 2.5 | |
| 132 LBS | 60 KG | 30 | 3 | |
| 154 LBS | 70 KG | 35 | 3.5 | |
| 176 LBS | 80 KG | 40 | 4 | |
| 220 LBS | 100+ KG | 50 | 5 | |

DSI/Intubation Checklist

PATIENT

Plan

Primary: ETT

Backup: BVM, SGA

COCV: Cric

- Designate Roles

Pre-Ox

- HFNC @ max
- ETSN
- HOB 30 deg
- PEEP w/ BVM
- OPA/NPA
- Ventilate PRN

Monitor

- ECG
- BP q 2 min
- SpO2 opposite BP cuff
- EtCO2

PREP

Kit Dump

- Blades
- ETT
- Syringes
- Tamer
- Bougie curved
- Backups
- Suction tested
- VL tested

Medications

- Ketamine given
- Paralytic ready

Goals

- O2 $\geq 94\%$ x **3 min**
- SBP ≥ 100

**IF GOALS NOT MET
DO NOT DSI.
Consider RSA.**

PERFORM

Push

- Push paralytic
- 90 second countdown
- Trauma: Open C-collar

Perform Intubation

**Bail Out Criteria:
SpO2 $\leq 94\%$**

Post Intubation

- EtCO2 ≥ 5
- Auscultate
- Sedation

MECHANICAL COMPRESSION DEVICE CHECKLIST

PRE-APPLICATION TIMEOUT



S-T-A-R-S

- **SIZE** - is the patient too big / small?
- **TURN ON** - ensure the device powers on and battery charge is good
- **ABORT** - when to stop application / resume manual CPR
- **ROLES** - role assignments / providers in place
- **STRAP** - no neck strap = no application

2 PHASE APPLICATION



PHASE 1

1. After full 2 minute CPR cycle, pause CPR for rhythm check, manage rhythm
2. ****BEGIN 10 SECOND COUNTDOWN****
3. Providers lift patient by shoulders / roll patient to the side
4. Place back plate under patient ensuring attachment points are visible
5. ****RESUME MANUAL CPR****

IF UNABLE TO COMPLETE IN 10 SECONDS - ABORT APPLICATION

****At 8 seconds prepare to ABORT and resume manual compressions for a full 2 minute cycle****



PHASE 2

1. After full 2 minute CPR cycle, pause CPR for rhythm check, manage rhythm
2. ****BEGIN 10 SECOND COUNTDOWN****
3. Apply device arms to back plate and lock in place
 - **LUCAS** - swing arm over and clamp on both sides
 - **DEFIBTECH** - clamp on both sides and insert piston arm
4. Engage piston
 - **LUCAS** - pull piston down
 - **DEFIBTECH** - press button to lower piston
5. Press play on device

IF UNABLE TO COMPLETE IN 10 SECONDS - ABORT APPLICATION

****At 8 seconds prepare to ABORT and resume manual compressions for a full 2 minute cycle****

POST APPLICATION



- Apply neck straps and arm straps
- Mark sharpie around piston / puck
- Keep hands and eyes on device watching for movement

PHASE 1



PHASE 2



Richmond Agitation-Sedation Scale (RASS)

| Score | Term | Description |
|-------|-------------------|--|
| +4 | Combative/Violent | Overtly combative or violent and an immediate and significant danger to self and clinician |
| +3 | Very Agitated | Aggressive, non-combative |
| +2 | Agitated | Frequent, non-purposeful movements that impair assessment/monitoring |
| +1 | Restless | Anxious or apprehensive, movements not aggressive or vigorous |
| 0 | Alert & Calm | Spontaneously pays attention to clinician |
| -1 | Drowsy | Not fully alert, sustained (≥ 10 sec) awakening with eye contact to voice |
| -2 | Light Sedation | Awakens briefly (< 10 sec) with eye contact to voice |
| -3 | Moderate Sedation | Movement or eye opening to voice (but no eye contact) |
| -4 | Deep Sedation | No response to voice, but movement or eye opening to physical stimulation |
| -5 | Unarousable | No response to voice or physical stimulation |

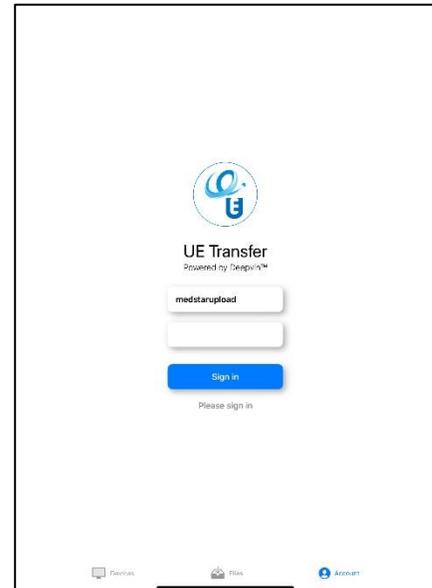
UE Transfer iOS App to DeepVin Cloud Transfer Instructions

Walkthrough Video Link: <https://youtu.be/ilInw7RsKhc>

1. Select the UE Transfer iOS application.



2. Enter the universal uploader account credentials on the UE Transfer app's home screen and tap sign in.
 - a. Username: VLupload
 - b. Password: 911grove



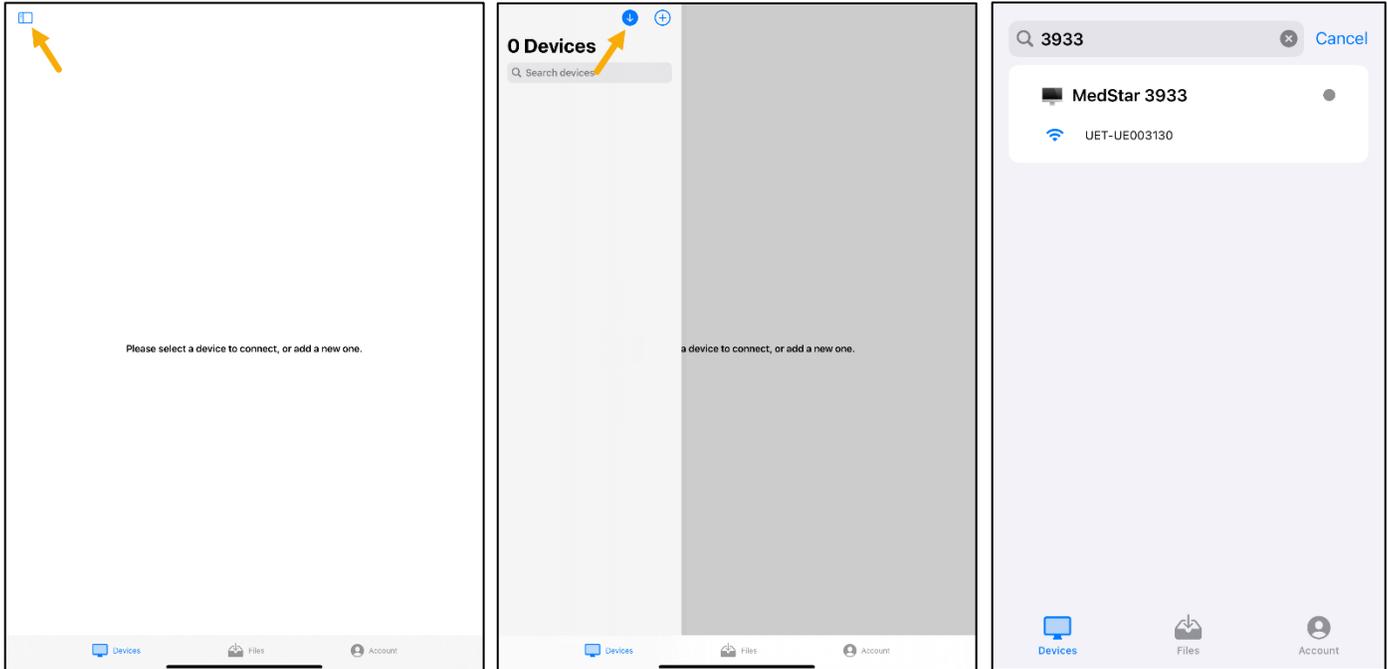
3. Find your device's asset ID # on the back of the UEScope device. If using an FRO device, it will be identified by the unit number, although the serial number may be used as a backup.



4. Device Selection

- a. Tap device list in upper left corner
- b. If the device list is not already populated, click the blue down arrow to download the system's device list.
- c. Type in the search bar your device's asset ID #. Tap on your device.

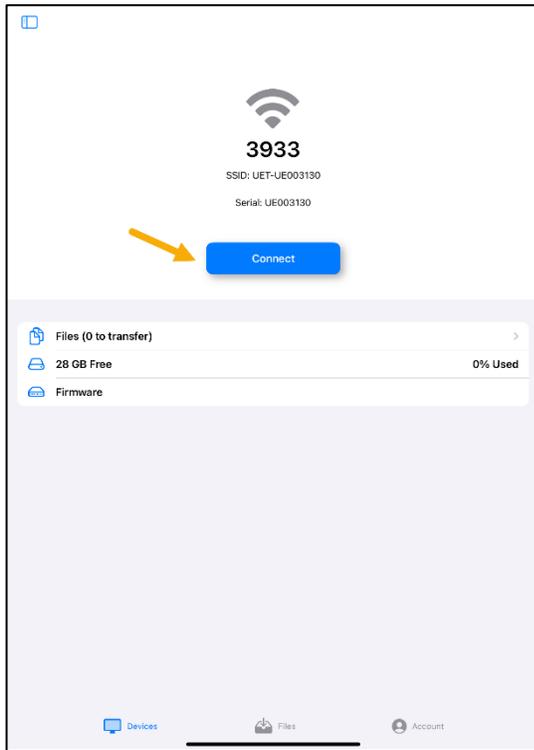
If your device is not listed in the system's device list, see page 7-8 for troubleshooting steps and how to manually add the device.



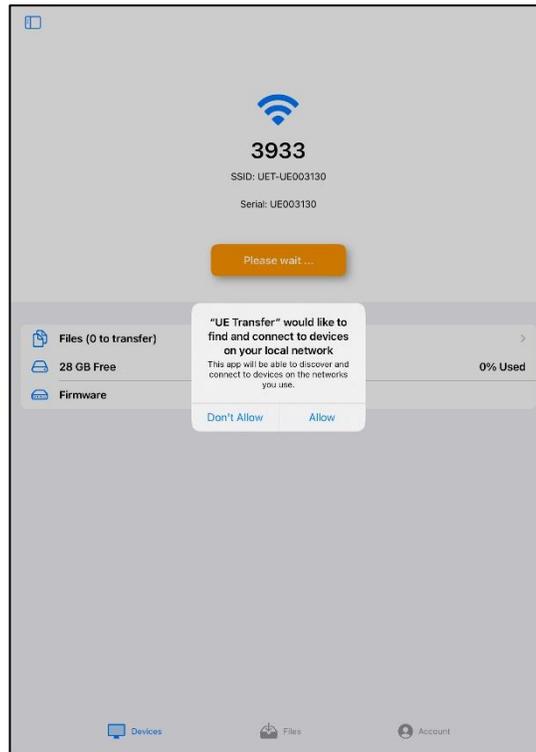
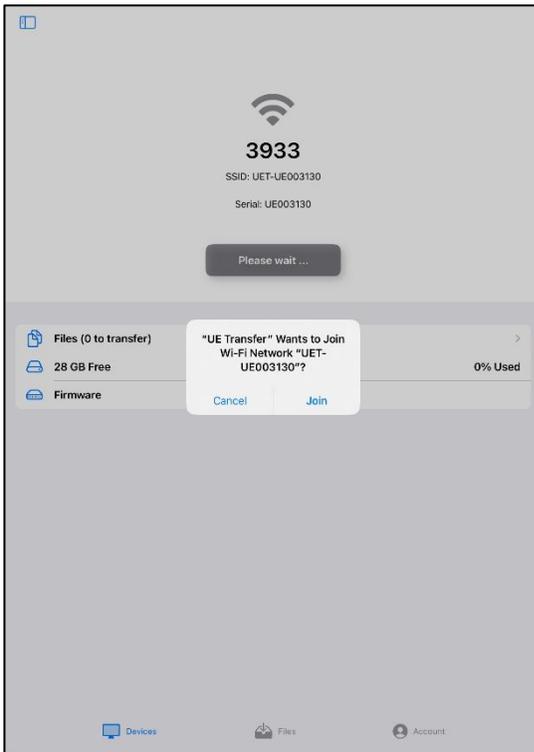
5. Ensure the UEScope device is powered on.



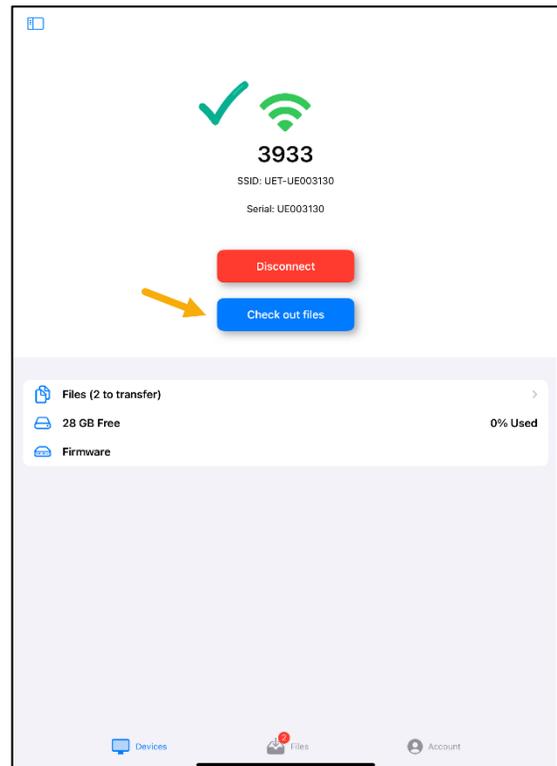
6. Click connect to begin connecting to the UEScope device.



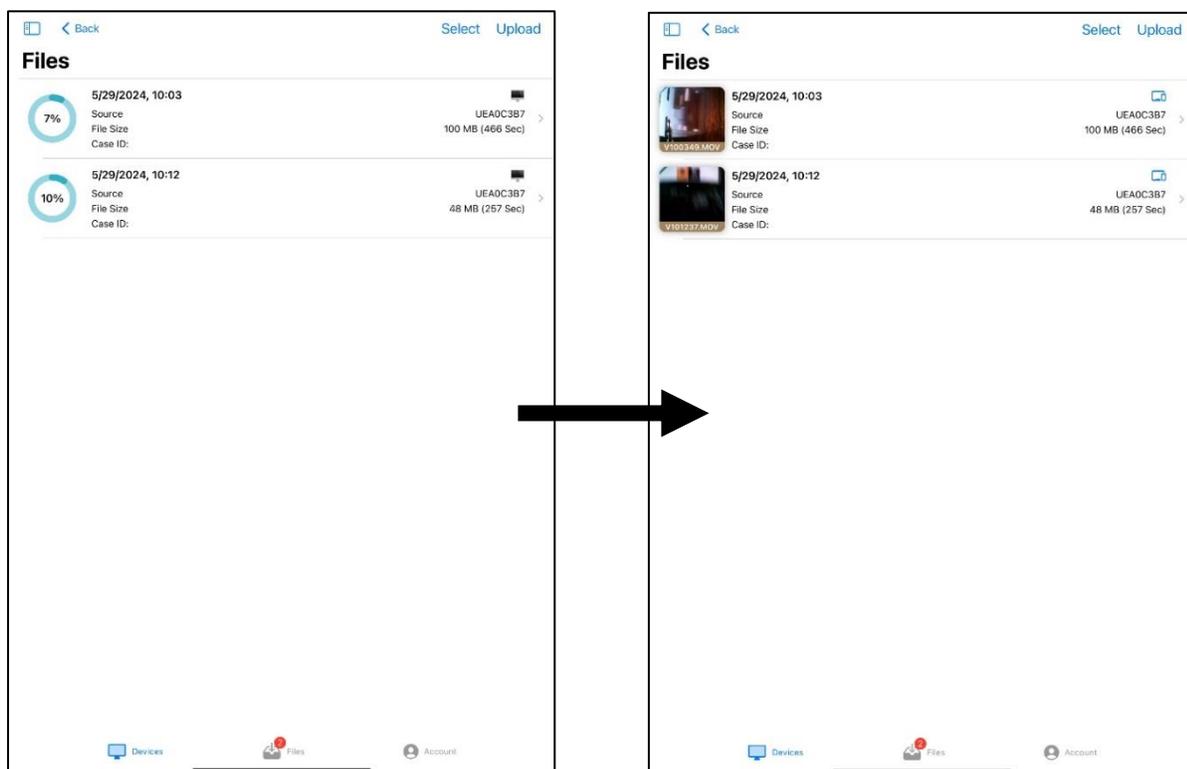
7. Click join/allow for the Apple iOS security pop up prompts.



8. Once the device is connected, the Wi-Fi symbol will turn green. Files will automatically start uploading to the UE Transfer iOS application. Tap “Check Out Files” to track upload progress to the app.

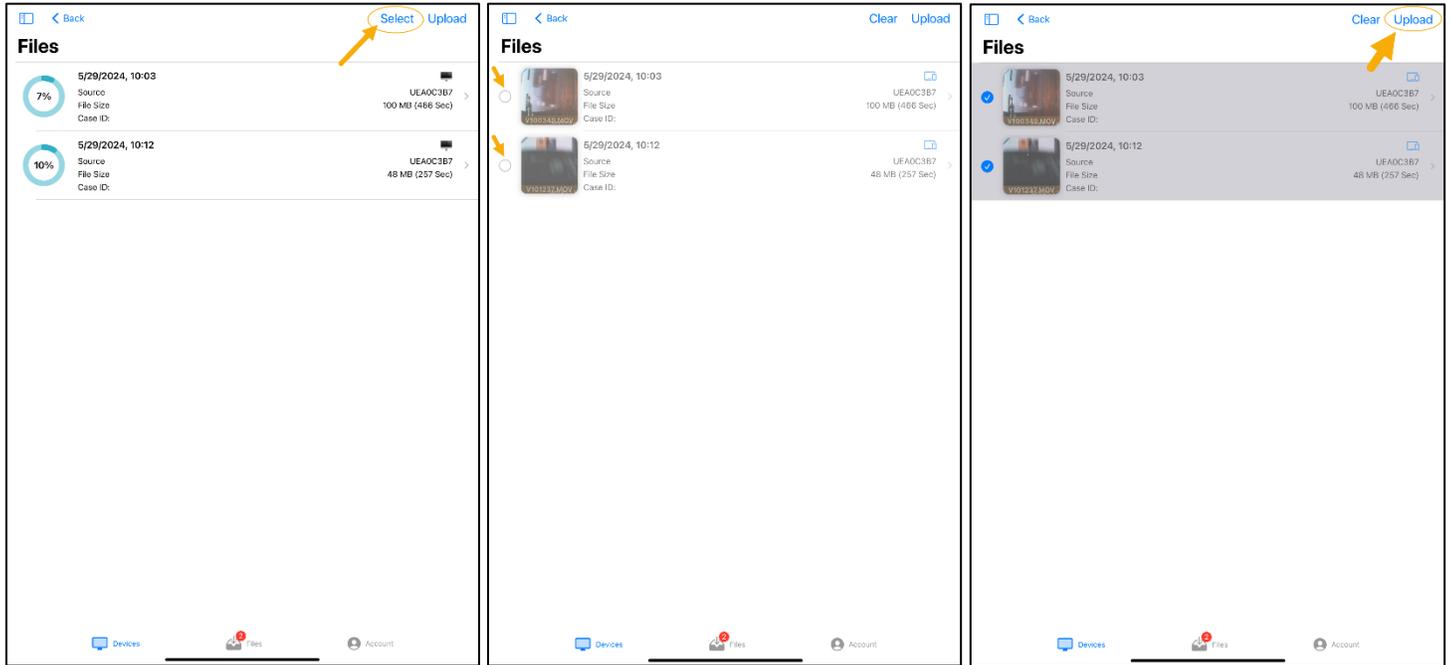


9. Wait for all video files to be completely downloaded to the UE Transfer App. This may take a few minutes for longer or multiple videos. **DO NOT** minimize the app or multi-task on the iPad while files are being uploaded. **IMPORTANT: These videos are only local copies on the iOS app and are deleted at the end of the session, you must continue with the full upload process to the DeepVin Cloud for them to be retained.**

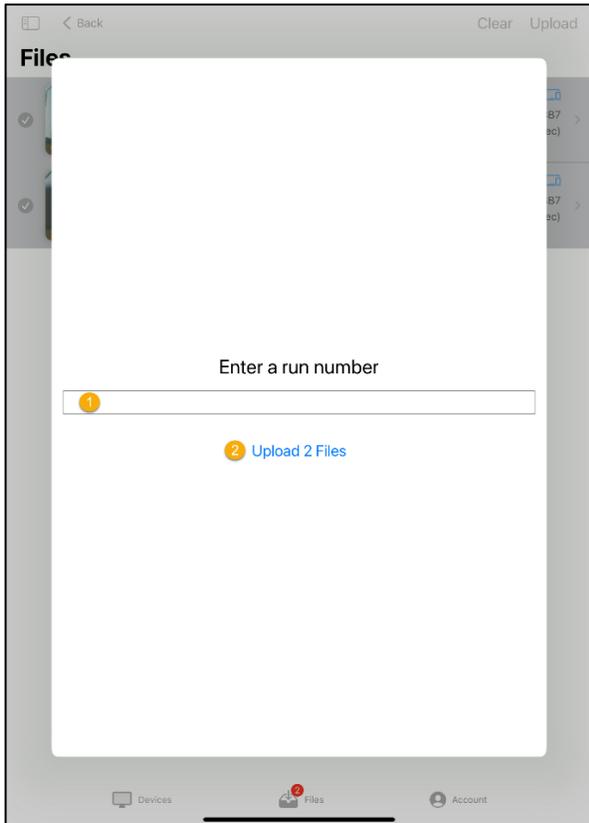


10. Uploading

- a. To upload all the videos listed - Tap “Upload”
- b. To individually select videos for upload – Tap “Select”, then select all files you want to upload, and then tap “Upload”.



- 11. Type the Response Number that the intubation was performed during (DO NOT LEAVE BLANK). Then tap the blue “Upload Files” to begin uploading.



12. The upload process to the DeepVin Video Cloud takes a few moments. As files that are uploading will have a spinning loading icon over them and will disappear once successfully uploaded. **Be patient, this may take some time (~3-5 min for a 10 min file) when using mobile Wi-Fi.** You may navigate away from the app to perform other tasks, but do not “force quit” the app. If you are uploading videos for multiple responses, repeat steps 9-11 for each individual response.



Troubleshooting for Common Problems:

If unable to find your device or upload a video AFTER attempting the troubleshooting steps below:

MedStar Devices

- Turn the UEScope device into logistics
- Email SelfReport with response number, device asset ID #, and serial number (or a photo of the back of the device)

FRO Devices

- Have FRO crew notify their supervisor (e.g., FWFD Medic 1)
- EMS crew should email SelfReport with response number, device asset ID #, and serial number (or a photo of the back of the device)

1) Upload is timing out or never finishes

- a. Most common cause is a loss of the iPad internet connection during the upload.
- b. If possible, ensure you are near the Wi-Fi source and not changing locations. Re-establish Wi-Fi connection and then click Upload again (enter response number if necessary) and wait for the files to upload.
- c. If still unable to successfully upload, wait until you return to deployment center or station and make one final attempt to upload on a different Wi-Fi connection.

2) Device Unable to Connect

- a. Ensure you are selecting the correct device ID
- b. Verify the UEScope device is turned on and fully booted
- c. Click connect again
 - i. Ensure you are selecting join and allow in the iOS prompts
- d. Attempt manual connection with the device (see next page)

3) Device Not Found in the List

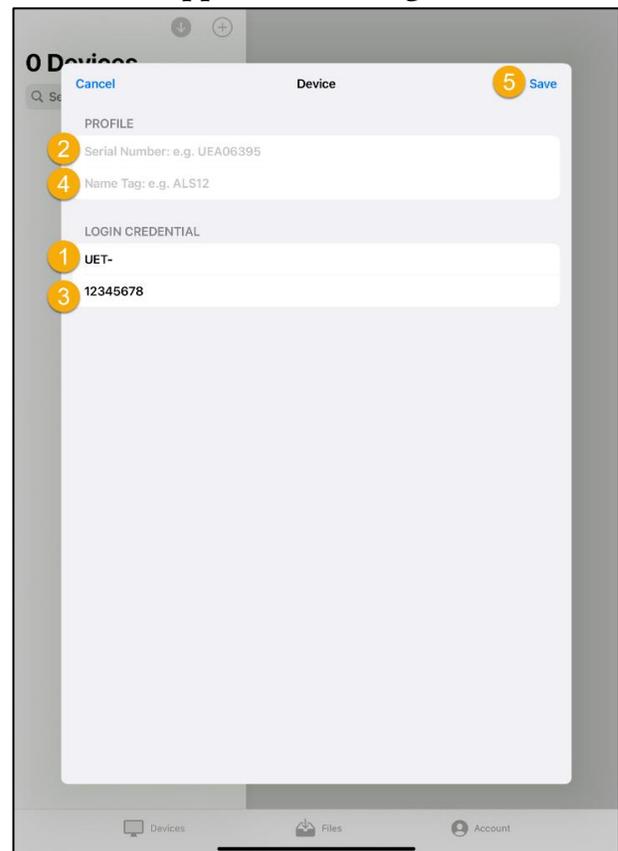
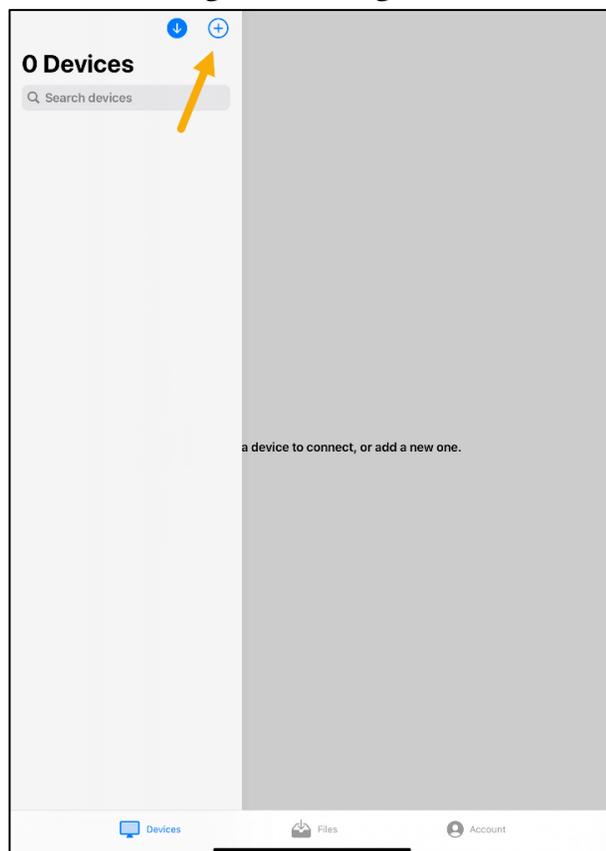
- a. Click the blue down arrow to refresh the system's device list.
- b. If device ID is not found:
 - i. If an EMS device, ensure you are using 4-digit asset ID # and NOT the eight digit white RFID tag.
 - ii. Search via serial number (see next page for photos)
- c. Attempt manual connection with the device (see next page)

Manual Connection Steps

- Find the device's serial number on the back of the device or in the Wi-Fi tab of the settings menu on the UEScope.



- Tap add device and enter the login credentials and profile details, and then click save
 - Login Credentials*
 - UET- is prefilled, enter serial number (NOT the 4-digit MedStar Asset ID) listed on the back of the device.
 - Password should be auto filled, and should always be: 12345678
 - Profile*
 - Enter Serial # again
 - Name Tag is the 4-digit Asset ID or Department & Apparatus Call Sign



- Email SelfReport that device was unlisted (include device ID & serial #).



Basic First Responder Minimum Equipment and Medication List

| Oxygen Accessories | Qty | Medication Delivery Items | Qty |
|--|------|--|----------|
| O2 - Cylinder with Regulator (>700 psi) | 1 | Syringe 1 ml | 2 |
| O2 - Key | 1 | Blunt Needle | 2 |
| Airway & Oxygen Delivery | Qty | Hyperdermic Needle 1 1/2" (21g or 25g or 27g) | 2 |
| Oral Airway - (50 / 60 / 80 / 90 / 100 / 110) | 1 ea | Nasal Atomizer Device | 2 |
| Nasal Airway - (22 / 24 / 26 / 28 / 30) | 1 ea | Nebulizer | 1 |
| Water-Soluable Lubricant | 2 | Manual Vital Sign Tools | Qty |
| Bag Valve Mask - Adult / Pedi / Infant | 1 ea | BP Cuff Adult / Pedi / Infant | 1 ea |
| Neonate Size 0 BVM mask | 1 | BP Cuff Thigh or Adult XL | 1 |
| Nasal Cannula - Adult | 1 | Stethoscope | 1 |
| Non-Rebreather - Adult | 1 | Glucometer | 1 |
| Non-Rebreather - Pedi | 1 | Glucometer Test Strips | 3 |
| BiPap System | 1 | Disposable Lancets | 3 |
| Airway Equipment (Optional) | Qty | Sharps Shuttle | 1 |
| AirQ-SP-3g supraglottic airway - Neonate through Adult Sizes | 1 ea | Alcohol Preps | 10 |
| ETC02 Nasal* | 1 | Thermometer | 1 |
| ETC02 In-line* | 1 | Pedi - Length/Age-based Resuscitation Tape | 1 |
| Suction & Accessories | Qty | Electrical Therapy | Qty |
| Suction - Portable w/Canister & Lid | 1 | AED | 1 |
| Suction - Rigid Tip | 1 | Quick Combo Pads Adult/Pedi | 1 ea |
| Suction - Tubing | 1 | PPE / Cleaning / Biohazard | Qty |
| Suction - Cath 5 / 14 / 18 Fr | 1 ea | Hand Sanitizer | 1 bottle |
| Suction- Gastric Sump Tube 10 & 16 Fr | 1 ea | Medical Exam Gloves | 1 Box |
| Hemorrhage Control / Bandaging / Splinting | Qty | Gown | 3 |
| Band-aids | 5 | Goggles/Face Shield | 3 |
| Burn Sheet | 2 | Masks | 3 |
| Multi Trauma Dressing | 1 | Safety Vest | 2 |
| Roller Gauze | 2 | EMS Scissors | 1 |
| Sterile 5X9 Gauze Pad | 4 | Penlight | 1 |
| Sterile 4X4 Gauze Pad | 4 | Ringcutter | 1 |
| Occlusive Dressing | 2 | Bio Hazard Bags | 2 |
| Triangular Bandages | 4 | MCI | Qty |
| Ridged Splints | 2 | Triage Tape / Tags | 25 |
| Pelvic Fracture Sling | 1 | Monitoring Equipment | Qty |
| 1" Tape | 1 | *Waveform Capnography Device - must be available if carrying optional airway equipment | 1 |
| 2" Tape | 1 | FRO - Basic Medication List | Qty |
| Saline or Sterile Water for Irrigation | 1 | Acetaminophen 500 mg Tablets (may substitute liquid) | 2 |
| Hot Pack | 4 | Acetaminophen Liquid 160mg / 5mL | 35ml |
| Cold Pack | 4 | Aspirin 81 mg Tablets | 4 |
| Commercial Windless Tourniquet | 1 | DuoNeb Albuterol 2.5mg/ipratropium 500mcg** | 3 |
| Hemostatic Dressing / Packing | 2 | Epinephrine 1:1000 1mg / 1ml*** | 3 |
| Traction Splint (optional) | 1 | Ibuprofen 200 mg Tablets (may substitute liquid) | 3 |
| Pedi Immobilizer (optional) | 1 | Ibuprofen Liquid 100mg / 5mL | 30 mL |
| Immobilization / Patient Movement | Qty | Isopropyl Alcohol Pads | 3 |
| Backboard w/ 3 straps (optional) | 1 | Naloxone 2 mg / 2 ml | 2 |
| Extrication Device w/Straps & Pads | 1 | Nitroglycerin 0.4 mg SL Spray or Tablet | 1 btl |
| C-Collars - Adult & Pedi | 1 ea | Odansentron 4 mg ODT | 2 |
| Head Immobilizer (optional) | 1 | Oral glucose 15 g | 1 |
| Obstetrics/Labor & Deliver Items | Qty | ** If not carrying DuoNeb: | |
| OB - Kit | 1 | Albuterol 2.5 mg / 3 ml | 3 |
| OB - Suction Bulb | 1 | Ipratropium 500 mcg / 3 ml | 3 |
| OB - Foil Blanket | 1 | ***If not carrying Epi 1:1000 | |
| Effective: 07/01/2025 | | Epi Pen Adult and Pediatric | 1 ea |

Jeffery L. Jarvis, MD, MS, EMT^P, System Medical Director / Chief Medical Officer



Office of the
Medical Director

ECA First Responder Minimum Equipment and Medication List

| Oxygen Accessories | Qty | Medication Delivery Items | Qty |
|---|------|--|----------|
| O2 - Cylinder with Regulator (>700 psi) | 1 | Syringe 1 ml | 2 |
| O2 - Key | 1 | Blunt Needle | 2 |
| Airway & Oxygen Delivery | Qty | Hyperdermic Needle 1 1/2" (21g or 25g or 27g) | 2 |
| Oral Airway - (50 / 60 / 80 / 90 / 100 / 110) | 1 ea | Manual Vital Sign Tools | Qty |
| Nasal Airway - (22 / 24 / 26 / 28 / 30) | 1 ea | BP Cuff Adult / Pedi / Infant | 1 ea |
| Water-Soluable Lubricant | 2 | BP Cuff Thigh or Adult XL | 1 |
| Bag Valve Mask - Adult / Pedi / Infant | 1 ea | Stethoscope | 1 |
| Neonate Size 0 BVM mask | 1 | Glucometer | 1 |
| Nasal Cannula - Adult | 1 | Glucometer Test Strips | 3 |
| Non-Rebreather - Adult | 1 | Disposable Lancets | 3 |
| Non-Rebreather - Pedi | 1 | Sharps Shuttle | 1 |
| Suction & Accessories | Qty | Alcohol Preps | 6 |
| V-vac manual suction | 1 | Thermometer | 1 |
| Hemorrhage Control / Bandaging / Splinting | Qty | Electrical Therapy | Qty |
| Band-aids | 5 | AED | 1 |
| Burn Sheet | 2 | Quick Combo Pads Adult/Pedi | 1 ea |
| Multi Trauma Dressing | 1 | Personal Protective Equipment / Cleaning / Biohazard | Qty |
| Roller Gauze | 2 | Hand Sanitizer | 1 bottle |
| Sterile 5X9 Gauze Pad | 4 | Medical Exam Gloves | 1 Box |
| Sterile 4X4 Gauze Pad | 4 | Gown | 3 |
| Occlusive Dressing | 2 | Goggles/Face Shield | 3 |
| Triangular Bandages | 4 | Masks | 3 |
| SAM Splints | 2 | Safety Vest | 2 |
| Pelvic Fracture Sling | 1 | EMS Scissors | 1 |
| 1" Tape | 1 | Penlight | 1 |
| 2" Tape | 1 | Ringcutter | 1 |
| Saline or Sterile Water for Irrigation | 1 | Bio Hazard Bags | 2 |
| Cold Pack | 4 | FRO - ECA Medication List | Qty |
| Commercial Windless Tourniquet | 1 | Aspirin 81 mg Tablets | 4 |
| Hemostatic Dressing / Packing | 2 | Epinephrine 1:1000 1mg / 1mL*** | 1 |
| Obstetrics/Labor & Deliver Items | Qty | Isopropyl Alcohol Pads | 3 |
| OB - Kit | 1 | Oral glucose 15 g | 1 |
| OB - Suction Bulb | 1 | Naloxone 2mg / 2ml or 0.4 mg auto injector or 4 mg nasal spray | 1 |
| OB - Foil Blanket | 1 | ***If not carrying Epi 1:1,000 | |
| MCI | Qty | Epi Pen Adult and Pediatric | 1 ea |
| Triage Tape / Tags | 25 | | |

Jeffery L. Jarvis, MD/MS, EMT-P System Medical Director / Chief Medical Officer

Effective: 07/01/2025



Paramedic First Responder Minimum Equipment and Medication List

| Oxygen Accessories | Qty | Hemorrhage Control / Bandaging / Splinting | Qty |
|--|------------|--|--------------------------|
| O2 - Cylinder with Regulator (>700 psi) | 1 | Band-aids | 5 |
| O2 - Key | 1 | Burn Sheet | 1 |
| Airway & Oxygen Delivery | Qty | Multi Trauma Dressing | 1 |
| Oral Airway - (50 / 60 / 80 / 90 / 100 / 110) | 1 ea | Roller Gauze | 4 |
| Nasal Airway - (22 / 24 / 26 / 28 / 30) | 1 ea | Sterile 5X9 Gauze Pad | 4 |
| Water-Soluble Lubricant | 2 | Sterile 4X4 Gauze Pad | 4 |
| Bag Valve Mask - Adult / Pedi / Infant | 1 ea | Occlusive Dressing | 2 |
| Neonate Size 0 BVM mask | 1 | Triangular Bandages | 4 |
| Nasal Cannula - Adult | 1 | Rigid Splints | 2 |
| Non-Rebreather - Adult | 1 | Pelvic Fracture Sling | 1 |
| Non-Rebreather - Pedi | 1 | 1" Tape | 1 |
| Bi-PAP System | 1 | 2" Tape | 1 |
| Airway Equipment | Qty | Saline or Sterile Water for Irrigation | 1 |
| ETT - Size 6.0, 6.5, 7.0, 7.5, 8.0 | 1 ea | Hor Pack | 4 |
| UEScope Video Laryngoscope (VL) Camera/Monitor | 1 | Cold Pack | 4 |
| UEScope VL Disposable Blades - size 0, 1, 2, 3, 4 | 1 ea | Commercial Windless Tourniquet | 1 |
| Invasive Airway Securement Device - Adult and Pedi | 1 ea | Hemostatic Dressing/packing | 2 |
| ETT Introducer - Adult | 1 | Traction Splint (optional) | 1 |
| Magill Forceps - Adult and Pedi | 1 ea | Manual Vital Sign Tools | Qty |
| AirQ-SP-3g supraglottic airway - Neonate through Adult Sizes | 1 ea | BP Cuff Adult / Pedi / Infant | 1 ea |
| ETCO2 Nasal | 2 | BP Cuff Thigh or Adult XL | 1 |
| ETCO2 In-line | 2 | Stethoscope | 1 |
| Cryothyroidotomy Kit / Transtracheal Needle Kit | 1 ea | Glucometer | 1 |
| Suction & Accessories | Qty | Glucometer Test Strips | 3 |
| Suction - Portable w/Canister & Lid | 1 | Disposable Lancets | 3 |
| Suction - Rigid Tip | 1 | Sharps Shuttle | 1 |
| Suction - Tubing | 1 | Alcohol Preps | 10 |
| Suction - Cath 5 / 14 / 18 Fr | 1 ea | Thermometer | 1 |
| Suction- Gastric Sump Tube 10 & 16 Fr | 1 ea | Pedi - Length/Age-based Resuscitation Tape | 1 |
| Vascular Prep, Access, & Medication Delivery | Qty | PPE / Cleaning / Biohazard | Qty |
| Syringe 1cc | 2 | Hand Sanitizer | 1 bottle |
| Syringe 3cc | 2 | Medical Exam Gloves | 1 Box |
| Syringe 10cc | 2 | Gown | 3 |
| Normal Saline Flush 10cc (optional) | 2 | Goggles/Face Shield | 3 |
| Hyperdermic Needle 1 1/2" (21g or 25g or 27g) | 2 | Masks | 3 |
| 18g Needle 1 1/2" | 2 | Safety Vest | 3 |
| IV Tourniquets | 2 | EMS Scissors | 1 |
| IV Cath. 24G 3/4" | 2 | Penlight | 1 |
| IV Cath. 22G 1" | 2 | Ringcutter | 1 |
| IV Cath. 20G 1 1/4" | 2 | Bio Hazard Bags | 2 |
| IV Cath. 18G 1 1/4" | 2 | FRO - ALS Assist Medication List | Qty |
| IV Cath. 16G 1 1/4" | 2 | Acetaminophen 500 mg Tablet (may substitute liquid) | 2 |
| IV Cath. 14G 3 1/4" | 2 | Acetaminophen Liquid 160mg / 5mL | 35 mL |
| Intraosseous Needle - Pedi, Adult, Bari (if EZIO, then 25 & 45 mm) | 1 ea | Adenosine 12 mg / 2 ml (optional) | 2 |
| IV Tubing | 2 | Amiodarone 150mg / 3 mL | 3 |
| Veniguard | 2 | Aspirin 81 mg Tablet | 4 |
| Nasal Atomizer Device | 2 | Atropine 1mg / 10mL | 4 |
| Nebulizer | 1 | Calcium Chloride 10% 1 gm / 10 mL (optional) | 1 |
| Obstetrics/Labor & Deliver Items | Qty | Dextrose 10% (25g / 250mL) | 2 |
| OB - Kit | 1 | Diphenhydramine 50 mg / 2 mL | 1 |
| OB - Suction Bulb | 1 | DuoNeb Albuterol 2.5mg / ipratropium 500mcg* | 3 |
| OB - Foil Blanket | 1 | Epinephrine 1:10,000 1mg / 10mL | 3 |
| Immobilization / Patient Movement | Qty | Epinephrine 1:1000 1mg / mL | 6 or, 2 with Racemic Epi |
| Backboards w/ 3 straps (Optional) | 1 | Fentanyl 100mcg / 2mL (optional) | 3 |
| Extraction Device | 1 | Ibuprofen 200 mg Tablets (may substitute liquid) | 3 |
| C-Collars - Adult & Pedi | 1 ea | Ibuprofen 100mg / 5 mL | 30 mL |
| Head Immobilizer (optional) | 1 | Isopropyl Alcohol Pads | 3 |
| Pedi Immobilizer (optional) | 1 | Ketamine 200 mg / 20 ml (optional) | 1 |
| Monitoring Equipment | Qty | Ketorolac 30 mg / 2 mL | 1 |
| Cardiac Monitor | 1 | Lidocaine 2% 100 mg / 5 mL | 2 |
| Waveform Capnography Device | 1 | Midazolam 5 mg / 1 ml (optional) | 4 |
| Quick Combo Pads Adult / Pedi | 1 ea | Naloxone 2 mg / 2 mL | 2 |
| ECG Electrodes | 1 set | Nitroglycerin 0.4 mg SL Spray or Tablet | 1 btl |
| ECG Paper | 1 roll | Normal Saline 1000 mL | 2 |
| MCI | Qty | Normal Saline 250 mL | 1 |
| Triage Tape / Tags | 25 | Ondansetron 4 mg ODT | 2 |
| | | Ondansetron 4mg / 1mL | 2 |
| | | Oral glucose 15 g | 1 |
| | | Racemic Epinephrine 2.25% 11.25 mg / 0.5 mL (optional) | 2 |
| | | Sodium Bicarb 8.4% 50 ml (1 mEq / mL) | 2 |
| | | *Albuterol 2.5 mg / 3 mL | 6 or, 3 with DuoNeb |
| | | *Ipratropium 500 mcg / 3 mL If not carrying DuoNeb | 3 |

Jeffrey L. Jarvis, MD, MS, EMT-P, System Medical Director / Chief Medical Officer

Effective: 07/01/2025

Front of First (White) and Second (Yellow) Page

**FIRST RESPONDER ORGANIZATION
EMS INCIDENT REPORT**

FRO: _____ Company: _____

FD Inc #: _____ Date: ____ / ____ / ____ FD Alarm Time: ____ : ____

Inc. Location: _____

Pt Name: _____

Address: _____

SSN: ____ / ____ / ____ DOB: ____ / ____ / ____ Age: ____ (M/F)

| | | | | | |
|---|-------|----------------|-----------------------|------|---------|
| SKIN / Capillary Refill <input type="checkbox"/> Absent <input type="checkbox"/> Delayed <input type="checkbox"/> Normal | | | Parent/ Guardian | | |
| TIME | PULSE | BLOOD PRESSURE | RESP | SPO2 | GLUCOSE |
| : | | / | | | |
| : | | / | | | |
| : | | / | | | |
| PULSE QUALITY <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Strong <input type="checkbox"/> Weak <input type="checkbox"/> Absent | | | | | |
| SKIN CONDITION <input type="checkbox"/> Moist <input type="checkbox"/> Dry <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Pale <input type="checkbox"/> Blue <input type="checkbox"/> Red <input type="checkbox"/> Normal | | | | | |
| INITIAL GLASGOW COMA SCALE: | | | INITIAL TRAUMA SCORE: | | |

Chief Complaint: _____

Past History: _____

Medications: _____

Allergies: _____ NKDA

Narrative: _____

AMA

RAS

F.D. Sign Off

FWFD EMS Sign Off

| | |
|--|--|
| | |
|--|--|

Back of First (White) Page

AMA FORM REFUSAL OF TREATMENT / RECHASO DE TRATAMIENTO (PARAMEDIC USE ONLY)

This is to certify that I release (FRO) _____ and its employees from liability for any claim arising from or associated with my injuries or condition; and I refuse further treatment even though I am informed and I am aware that my injuries may be serious and may require further treatment.

Esto es para certificar que renuncio de cargos al (FRO) _____ y sus empleados de toda culpabilidad si algun resultado apareciera asociado con mis lastimaduras o condiciones y rehuso todo tratamiento despues que se me ha informado y me consta que mis lastimaduras pueden ser mas serias y despues requieren mas serios tratamientos.

_____/_____/_____
Legal Representative

_____/_____/_____
Witness

_____/_____/_____
Paramedic

RELEASE AT SCENE FORM

| | |
|--|--|
| Did patient or LEO activate 911 for EMS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Patient disoriented or confused? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any loss of consciousness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any evidence of alcohol and/or drug use? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any complaints of pain, illness, or psychological complaint/concern? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any significant mechanism of injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Same vehicle DOS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Family voicing concerns over patient's refusal? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If YES is answered to any of the above questions, you MUST complete a Patient Record Form AMA and a Release At Scene cannot be used.

I refuse any medical assessment, evaluation or treatment and refuse to be transported to a medical facility. I hereby release MedStar, the AMAA and the EPAB, their officials, officers, agents, and employees from all liability, claims and causes of action arising from or relating to my decision to refuse medical assessment, evaluation or treatment.

Signature

(_____)_____-_____
Phone

Parent/Guardian Signature

Relationship

Home Address

_____/_____/_____
Date

I performed a scene assessment and observed that there appears to be no significant mechanism of injury at the scene and it appears _____ has no obvious injury, illness, medical or physical complaints or symptoms.

EMS Personnel Signature

EMS Personnel Printed Name

_____/_____/_____
Date

Incident Number

Unit Number

Witness Signature

Witness Printed Name

REFUSAL TO SIGN

The person named above refused to sign this form.

EMS Personnel Signature

EMS Personnel Printed Name

_____/_____/_____
Date

Incident Number

Unit Number

Witness Signature

Witness Printed Name

Incident Address

City

Back of Second (Yellow) Page

INITIAL GLASGOW COMA SCALE WORKSHEET

| Eye Opening | Best Verbal Response | Best Motor Response |
|-----------------|-----------------------------|-----------------------|
| Spontaneous = 4 | Oriented = 5 | Obeys Commands = 6 |
| To Voice = 3 | Confused = 4 | Localizes Pain = 5 |
| To Pain = 2 | Inappropriate Words = 3 | Withdraws to Pain = 4 |
| None = 1 | Incomprehensible Sounds = 2 | Flexes to Pain = 3 |
| | None = 1 | Extends to Pain = 2 |
| | | None = 1 |

Eye Opening _____ + Verbal _____ + Motor _____

Glasgow Coma Scale Total = _____

INITIAL TRAUMA SCORE WORKSHEET

| Systolic Blood Pressure | Respiratory Rate | Glasgow Coma Scale |
|-------------------------|------------------|--------------------|
| 89 = 4 | 10—29 = 4 | 13—15 = 4 |
| 76—89 = 3 | > 29 = 3 | 9—12 = 3 |
| 50—75 = 2 | 6—9 = 2 | 6—8 = 2 |
| 1—49 = 1 | 1—5 = 1 | 4—5 = 1 |
| 0 = 0 | 0 = 0 | 3 = 0 |

CGCS _____ + Blood Pressure _____ + Respiratory _____

Trauma Score = _____

APGAR WORKSHEET

| | 0 | 1 | 2 |
|-------------|----------------------------------|-------------------------------------|--|
| SKIN COLOR | Cyanosis of Body and Extremities | Extremities Cyanotic / Body Pink | No Cyanosis |
| HEART RATE | Absent | <100 | >100 |
| REFLEX | No Response to Stimulation | Grimace / Feeble Cry to Stimulation | Sneeze / Cough / Pulls Away to Stimulation |
| MUSCLE TONE | None | Some Flexion | Active Movement |
| BREATHING | Absent | Weak / irregular | Strong |

APGAR at 1 Minute: _____

APGAR at 5 Minutes: _____



CITY OF FORT WORTH BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the “BAA”) is made and entered into by and between the City of Fort Worth Texas, a home-rule municipality organized under the laws of the state of Texas (“Covered Entity”) and **The City of Saginaw**, a [corporation, limited liability company, etc.] (“Business Associate”, in accordance with the meaning given to those terms at 45 CFR § 164.501). In this BAA, Covered Entity and Business Associate are each a “Party” and, collectively, are the “Parties.”

WHEREAS, Covered Entity is a “covered entity” as defined under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended by the HITECH Act (as defined below) and the related regulations promulgated by HHS (as defined below) (collectively, “HIPAA”) and, as such, is required to comply with HIPAA’s provisions regarding the confidentiality and privacy of Protected Health Information (“PHI”);

WHEREAS, the Parties have entered into or will enter into one or more agreements under which Business Associate provides or will provide certain specified services to Covered Entity (collectively, the “Agreement”);

WHEREAS, in providing services pursuant to the Agreement, Business Associate will have access to PHI;

WHEREAS, by providing the services pursuant to the Agreement, Business Associate will become a “business associate” of the Covered Entity as such term is defined under HIPAA;

WHEREAS, both Parties are committed to complying with all federal and state laws governing the confidentiality and privacy of health information, including, but not limited to, the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Part 160 and Part 164, Subparts A and E (collectively, the “Privacy Rule”); and

WHEREAS, both Parties intend to protect the privacy and provide for the security of Protected Health Information disclosed to Business Associate pursuant to the terms of this Agreement, HIPAA and other applicable laws.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein and the continued provision of PHI by Covered Entity to Business Associate under the Agreement in reliance on this BAA, the Parties agree as follows:



1. Definitions

For purposes of this BAA, the Parties give the following meaning to each of the terms in this Section 1 below. Any capitalized term used in this BAA, but not otherwise defined, has the meaning given to that term in the Privacy Rule or pertinent law.

A. “Affiliate” means a subsidiary or affiliate of Covered Entity that is, or has been, considered a covered entity, as defined by HIPAA.

B. “Breach” means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI, as defined in 45 CFR §164.402.

C. “Breach Notification Rule” means the portion of HIPAA set forth in Subpart D of 45 CFR Part 164.

D. “Data Aggregation” means, with respect to PHI created or received by Business Associate in its capacity as the “business associate” under HIPAA of Covered Entity, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a business associate of one or more other “covered entity” under HIPAA, to permit data analyses that relate to the Health Care Operations (defined below) of the respective covered entities. The meaning of “data aggregation” in this BAA shall be consistent with the meaning given to that term in the Privacy Rule.

E. “Designated Record Set” has the meaning given to such term under the Privacy Rule, including 45 CFR §164.501.B.

F. “De-Identify” means to alter the PHI such that the resulting information meets the requirements described in 45 CFR §§164.514(a) and (b).

G. “Electronic PHI” means any PHI maintained in or transmitted by electronic media as defined in 45 CFR §160.103.

H. “Health Care Operations” has the meaning given to that term in 45 CFR §164.501.

I. “HHS” means the U.S. Department of Health and Human Services.

J. “HITECH Act” means the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.



K. “Individual” has the same meaning given to that term in 45 CFR §§164.501 and 160.130 and includes a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

L. “Privacy Rule” means that portion of HIPAA set forth in 45 CFR Part 160 and Part 164, Subparts A and E.

M. “Protected Health Information” or “PHI” has the meaning given to the term “protected health information” in 45 CFR §§164.501 and 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

N. “Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. “Security Rule” means the Security Standards for the Protection of Electronic Health Information provided in 45 CFR Part 160 & Part 164, Subparts A and C.

P. “Unsecured Protected Health Information” or “Unsecured PHI” means any “protected health information” as defined in 45 CFR §§164.501 and 160.103 that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the HHS Secretary in the guidance issued pursuant to the HITECH Act and codified at 42 USC §17932(h).

2. Use and Disclosure of PHI

A. Except as otherwise provided in this BAA, Business Associate may use or disclose PHI as reasonably necessary to provide the services described in the Agreement to Covered Entity, and to undertake other activities of Business Associate permitted or required of Business Associate by this BAA or as required by law.

B. Except as otherwise limited by this BAA or federal or state law, Covered Entity authorizes Business Associate to use the PHI in its possession for the proper management and administration of Business Associate’s business and to carry out its legal responsibilities. Business Associate may disclose PHI for its proper management and administration, provided that (i) the disclosures are required by law; or (ii) Business Associate obtains, in writing, prior to making any disclosure to a third party (a) reasonable assurances from this third party that the PHI will be held confidential as provided under this BAA and used or further disclosed only as required by law or for the purpose for which it was disclosed to this third party and (b) an agreement from this third party to notify Business Associate immediately of any breaches of the confidentiality of the PHI, to the extent it has knowledge of the breach.



C. Business Associate will not use or disclose PHI in a manner other than as provided in this BAA, as permitted under the Privacy Rule, or as required by law. Business Associate will use or disclose PHI, to the extent practicable, as a limited data set or limited to the minimum necessary amount of PHI to carry out the intended purpose of the use or disclosure, in accordance with Section 13405(b) of the HITECH Act (codified at 42 USC §17935(b)) and any of the act's implementing regulations adopted by HHS, for each use or disclosure of PHI.

D. Upon request, Business Associate will make available to Covered Entity any of Covered Entity's PHI that Business Associate or any of its agents or subcontractors have in their possession.

E. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502(j)(1).

3. Safeguards Against Misuse of PHI

Business Associate will use appropriate safeguards to prevent the use or disclosure of PHI other than as provided by the Agreement or this BAA and Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate agrees to take reasonable steps, including providing adequate training to its employees to ensure compliance with this BAA and to ensure that the actions or omissions of its employees or agents do not cause Business Associate to breach the terms of this BAA.

4. Reporting Disclosure of PHI and Security Incidents

Business Associate will report to Covered Entity in writing any use or disclosure of PHI not provided for by this BAA of which it becomes aware and Business Associate agrees to report to Covered Entity any Security Incident affecting Electronic PHI of Covered Entity of which it becomes aware. Business Associate agrees to report any such event within five business days of becoming aware of the event.

5. Reporting Breaches of Unsecured PHI

Business Associate will notify Covered Entity in writing promptly upon the discovery of any Breach of Unsecured PHI in accordance with the requirements set forth in 45 CFR §164.410, but in no case later than 30 calendar days after discovery of a Breach. Business Associate will reimburse Covered Entity for any costs incurred by it in complying with the requirements of Subpart D of 45 CFR §164 that are imposed on Covered Entity as a result of a Breach committed by Business Associate.



6. Mitigation of Disclosures of PHI

Business Associate will take reasonable measures to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of any use or disclosure of PHI by Business Associate or its agents or subcontractors in violation of the requirements of this BAA.

7. Agreements with Agents or Subcontractors

Business Associate will ensure that any of its agents or subcontractors that have access to, or to which Business Associate provides, PHI agree in writing to the restrictions and conditions concerning uses and disclosures of PHI contained in this BAA and agree to implement reasonable and appropriate safeguards to protect any Electronic PHI that it creates, receives, maintains or transmits on behalf of Business Associate or, through the Business Associate, Covered Entity. Business Associate shall notify Covered Entity, or upstream Business Associate, of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 1.M. of this BAA. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract by placement of such notice on the Business Associate's primary website. Business Associate shall ensure that all subcontracts and agreements provide the same level of privacy and security as this BAA.

8. Audit

Upon request, Business Associate will provide Covered Entity, or upstream Business Associate, with a copy of its most recent independent HIPAA compliance report (AT-C 315), HITRUST certification or other mutually agreed upon independent standards based third party audit report. Covered entity agrees not to re-disclose Business Associate's audit report.

9. Access to PHI by Individuals

A. Upon request, Business Associate agrees to furnish Covered Entity with copies of the PHI maintained by Business Associate in a Designated Record Set in the time and manner designated by Covered Entity to enable Covered Entity to respond to an Individual's request for access to PHI under 45 CFR §164.524.

B. In the event any Individual or personal representative requests access to the Individual's PHI directly from Business Associate, Business Associate within ten business days, will forward that request to Covered Entity. Any disclosure of, or decision not to disclose, the PHI requested by an Individual or a personal representative and compliance with the requirements applicable to an Individual's right to obtain access to PHI shall be the sole responsibility of Covered Entity.

10. Amendment of PHI



A. Upon request and instruction from Covered Entity, Business Associate will amend PHI or a record about an Individual in a Designated Record Set that is maintained by, or otherwise within the possession of, Business Associate as directed by Covered Entity in accordance with procedures established by 45 CFR §164.526. Any request by Covered Entity to amend such information will be completed by Business Associate within 15 business days of Covered Entity's request.

B. In the event that any Individual requests that Business Associate amend such Individual's PHI or record in a Designated Record Set, Business Associate within ten business days will forward this request to Covered Entity. Any amendment of, or decision not to amend, the PHI or record as requested by an Individual and compliance with the requirements applicable to an Individual's right to request an amendment of PHI will be the sole responsibility of Covered Entity.

11. Accounting of Disclosures

A. Business Associate will document any disclosures of PHI made by it to account for such disclosures as required by 45 CFR §164.528(a). Business Associate also will make available information related to such disclosures as would be required for Covered Entity to respond to a request for an accounting of disclosures in accordance with 45 CFR §164.528. At a minimum, Business Associate will furnish Covered Entity the following with respect to any covered disclosures by Business Associate: (i) the date of disclosure of PHI; (ii) the name of the entity or person who received PHI, and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure which includes the basis for such disclosure.

B. Business Associate will furnish to Covered Entity information collected in accordance with this Section 10, within ten business days after written request by Covered Entity, to permit Covered Entity to make an accounting of disclosures as required by 45 CFR §164.528, or in the event that Covered Entity elects to provide an Individual with a list of its business associates, Business Associate will provide an accounting of its disclosures of PHI upon request of the Individual, if and to the extent that such accounting is required under the HITECH Act or under HHS regulations adopted in connection with the HITECH Act.

C. In the event an Individual delivers the initial request for an accounting directly to Business Associate, Business Associate will within ten business days forward such request to Covered Entity.

12. Availability of Books and Records



Business Associate will make available its internal practices, books, agreements, records, and policies and procedures relating to the use and disclosure of PHI, upon request, to the Secretary of HHS for purposes of determining Covered Entity's and Business Associate's compliance with HIPAA, and this BAA.

13. Responsibilities of Covered Entity

With regard to the use and/or disclosure of PHI by Business Associate, Covered Entity agrees to:

A. Notify Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. Notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C. Notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. Except for data aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Covered Entity.

14. Data Ownership

Business Associate's data stewardship does not confer data ownership rights on Business Associate with respect to any data shared with it under the Agreement, including any and all forms thereof.

15. Term and Termination

A. This BAA will become effective upon execution by the Covered Entity's City Manager, Deputy City Manager, or Assistant City Manager, and will continue in effect until all obligations of the Parties have been met under the Agreement and under this BAA, unless earlier terminated in accordance with the terms of this BAA.

B. Covered Entity may terminate immediately this BAA, the Agreement, and any other related agreements if Covered Entity determines that Business Associate has breached a material term of this BAA and Business Associate has failed to cure that material breach, to Covered Entity's reasonable satisfaction, within 30 days after written notice from Covered Entity.



Covered Entity may report the problem to the Secretary of HHS if termination is not feasible. Notwithstanding the foregoing, Covered Entity may also terminate the Agreement any other related agreements as provided by the terms of such agreements. Additionally, Covered Entity may terminate this BAA for convenience upon 30 days' prior written notice to Business Associate.

C. If Business Associate determines that Covered Entity has breached a material term of this BAA, then Business Associate will provide Covered Entity with written notice of the existence of the breach and shall provide Covered Entity with 30 days to cure the breach. Covered Entity's failure to cure the breach within the 30-day period will be grounds for immediate termination of the Agreement and this BAA by Business Associate. Business Associate may report the breach to HHS.

D. Upon termination of the Agreement or this BAA for any reason, all PHI maintained by Business Associate will be returned to Covered Entity or destroyed by Business Associate. Business Associate will not retain any copies of such information. This provision will apply to PHI in the possession of Business Associate's agents and subcontractors. If return or destruction of the PHI is not feasible, in Business Associate's reasonable judgment, Business Associate will furnish Covered Entity with notification, in writing, of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of the PHI is infeasible, Business Associate will extend the protections of this BAA to such information for as long as Business Associate retains such information and will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible. The Parties understand that this Section 14.D. will survive any termination of this BAA.

16. Effect of BAA

A. This BAA is a part of and subject to the terms of the Agreement, except that to the extent any terms of this BAA conflict with any term of the Agreement, the terms of this BAA will govern.

B. Except as expressly stated in this BAA or as provided by law, this BAA will not create any rights in favor of any third party.

17. Regulatory References

Regulatory References. A reference in this BAA to a section in HIPAA means the section as in effect or as amended at the time.



18. Notices

Notices required pursuant to the provisions of this BAA will be conclusively determined to have been delivered when (1) hand-delivered to the other party, its agents, employees, servants or representatives, (2) delivered by facsimile with electronic confirmation of the transmission, or (3) received by the other party by United States Mail, registered, return receipt requested, addressed as follows:

| | |
|---|---|
| <p>To Covered Entity:</p> <p>City of Fort Worth Attn: Assistant City Manager 100 Fort Worth Trail Fort Worth, TX 76102-6314 Facsimile: (817) 392-8654</p> <p>With copy to Fort Worth City Attorney's Office at same address</p> | <p>To Business Associate:</p> <p>City of Saginaw Attn: City Manager 333 W McLeroy Blvd Saginaw, TX 76179 Facsimile: 817-232-4644</p> <p>With copy to the Saginaw Fire Chief at same address</p> |
|---|---|

19. Amendments and Waiver

This BAA may not be modified, nor will any provision be waived or amended, except in writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

20. HITECH Act Compliance

The Parties acknowledge that the HITECH Act includes significant changes to the Privacy Rule and the Security Rule. The privacy subtitle of the HITECH Act sets forth provisions that significantly change the requirements for business associates and the agreements between business associates and covered entities under HIPAA and these changes may be further clarified in forthcoming regulations and guidance. Each Party agrees to comply with the applicable provisions of the HITECH Act and any HHS regulations issued with respect to the HITECH Act. The Parties also agree to negotiate in good faith to modify this BAA as reasonably necessary to comply with the HITECH Act and its regulations as they become effective but, in the event that the Parties are unable to reach agreement on such a modification, either Party will have the right to terminate this BAA upon 30- days' prior written notice to the other Party.



[Executed effective as of the date signed by the Assistant City Manager below.] / [ACCEPTED AND AGREED:]

| | |
|---|--|
| Covered Entity: By: _____ Name: [REDACTED] Title: Assistant City Manager Date: _____ | Business Associate By: _____ Name: Todd Flippo Title: Mayor Date: _____ |
|---|--|

CITY OF FORT WORTH INTERNAL ROUTING PROCESS:

| | |
|--|--|
| Approval Recommended: By: _____ Name: [REDACTED] Title: [REDACTED] Approved as to Form and Legality: By: _____ Name: Taylor C. Paris Title: Assistant City Attorney | Contract Compliance Manager: By signing I acknowledge that I am the person responsible for the monitoring and administration of this contract, including ensuring all performance and reporting requirements. By: _____ Name: [REDACTED] Title: [REDACTED] City Secretary: By: _____ Name: Jannette S. Goodall Title: City Secretary |
|--|--|

**CITY OF FORT WORTH – CITY OF SAGINAW
EMERGENCY MEDICAL SERVICES (EMS) INTERLOCAL AGREEMENT**

This EMS Interlocal Agreement (the “Agreement”) is entered into by and between the City of Fort Worth, Texas, hereafter referred to as “Fort Worth”, acting by and through its duly authorized assistant city manager, and the City of Saginaw, a unit of local government, hereafter referred to as the “Client.” Fort Worth and the Client may collectively be referred to herein as the “Parties” or individually as a “Party.”

WHEREAS, Fort Worth and the Client were parties to a Restated and Amended Interlocal Cooperative Agreement, effective July 23, 2020 (the “ILA”), for the provision of out of hospital emergency medical services (“EMS”), non-emergency medical services, unscheduled medical transportation and ambulance service, mobile integrated healthcare (“MIH”)(collectively the “EMS System”), and scheduled interfacility medical transportation (“IFT”);

WHEREAS, through the ILA, Fort Worth, the Client, and other units of local government created the Metropolitan Area EMS Authority d/b/a Medstar (“MedStar”), an administrative governmental agency, to administer and provide these services on behalf of the Parties and other units of local government;

WHEREAS, the Parties agree that it is in the best interests of the public health and welfare of the people of the Parties’ jurisdictions to have available to them a regulated EMS System with an exclusively contracted EMS Provider;

WHEREAS, Fort Worth has elected to establish an EMS division through the City of Fort Worth Fire Department (“FWFD”) to operate a new EMS System and provide services to the people of the Parties’ jurisdictions;

WHEREAS, the Parties, together with all entities participating in MedStar, previously executed a memorandum of understanding and agreement (the “MOUA”) to jointly withdraw from the ILA and dissolve MedStar;

WHEREAS, pursuant to the terms of the MOUA, Fort Worth assumed control of all assets and property of MedStar to facilitate Fort Worth’s ability to operate an EMS System and offer services to the Client and other interested units of local government in accordance with the terms of the MOUA and this Agreement;

WHEREAS, Fort Worth is engaging a physician who is licensed in Texas and board certified in emergency medicine to serve as the Chief Medical Officer and Medical Director for the EMS System (the “Medical Director”);

WHEREAS, pursuant to Chapter 791 of the Texas Government Code, the Texas Interlocal Cooperation Act, and section 774.003 of the Texas Health and Safety Code, the Parties may agree to regulate and provide governmental services for the public health and welfare, and such services include those provided by the EMS System;

WHEREAS, the Parties desire to continue their cooperative efforts so that Fort Worth may provide EMS System services to the Client and the public within their corporate limits through the FWFD and its EMS division (“FW EMS”); and

WHEREAS, the Parties will pay for services to be provided pursuant to this Agreement from current revenues available to the paying Party.

NOW, THEREFORE, the Parties agree to the following:

Section 1: DEFINITIONS

The following index of definitions includes terms that may not appear in this Agreement but are used in the MOUA, the Uniform EMS Ordinance, or in the ordinary course of describing the services of the EMS System. Therefore, the full index is included herein for ease of reference by the Parties.

1. **Advanced Life Support (ALS)**. Out-of-hospital care that uses invasive medical acts (as defined in Tex. Health and Safety Code § 773.003(1)).
2. **Aeromedical Transportation Unit**. Any rotary or fixed wing aircraft providing basic or advanced life support services and Patient transportation that originates within the Service Area.
3. **Ambulance**. A vehicle for transportation of sick or injured person to, from, or between places of treatment for an illness or injury, and provide out of hospital medical care to the Patient.
4. **Ambulance Mutual Aid Agreement**. A written contract between Fort Worth and one or more entities whereby the signing parties agree to provide backup ambulance service to one another under the terms and conditions specified therein.
5. **Ambulance Service**. The transportation of Patients by emergency or non-emergency ambulance; for purposes of this Agreement, Ambulance Service does not include IFT services as defined herein.
6. **Associate Medical Director**. A licensed physician who assists the Medical Director in carrying out his or her duties under the EMS Interlocal Agreements, the Uniform EMS Ordinance, and any Medical Director’s agreement with Fort Worth.
7. **Basic Life Support (BLS)**. Out-of-hospital care that uses noninvasive medical acts (as defined in § 773.003(2), Tex. Health and Safety Code).
8. **Emergency Care Attendant (ECA)**. A person certified as an “emergency care attendant” under § 773.046 of the Tex. Health and Safety Code.
9. **Emergency Medical Services (EMS)**. Services used to respond to an individual’s perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury.
10. **Emergency Medical Technician (EMT)**. A person certified as an “emergency medical technician” under § 773.047 or an “advanced emergency medical

technician” under § 773.048 of the Tex. Health and Safety Code, and any other class of EMT recognized by state law or regulation.

11. **EMS Communications Center.** The facility designated by Fort Worth as the central communications center from which all EMS System services offered by Fort Worth shall be dispatched and coordinated.
12. **EMS Interlocal Agreement.** The service level interlocal agreements executed by Fort Worth and Clients to designate Fort Worth as the exclusively contracted EMS Provider of the EMS System within the Service Area.
13. **EMS Provider.** The entity that has received a Texas EMS Provider License, as required by relevant state law, to provide the EMS System services and is the exclusively contracted provider of the EMS System services within the Service Area. For purposes of this Agreement, the EMS Provider is Fort Worth.
14. **EMS System.** The regulated out-of-hospital EMS, non-emergency medical services, unscheduled medical transportation and ambulance services, and mobile integrated healthcare system provided by Fort Worth within the Service Area, not including those first response services Client chooses to provide itself as a First Responder.
15. **First Responder.** Any agency that, in cooperation with the EMS Provider, provides initial response to requests for EMS and, on its own or in cooperation with the EMS Provider, provides immediate on-scene care to ill or injured persons but does not transport those persons to healthcare facilities.
16. **FW EMS.** The EMS division of the Fort Worth Fire Department responsible for providing the EMS System services.
17. **Interfacility Transportation (IFT).** The provision of scheduled, or by appointment, medical transportation services by a person or entity between hospitals or medical facilities originating within the Service Area.
18. **Medical Director.** The licensed physician employed or contracted by Fort Worth who is responsible for carrying out his or her duties under the terms of their engagement with Fort Worth, the Uniform EMS Ordinance, and the EMS Interlocal Agreements and for directing the Office of the Medical Director.
19. **Medical Transportation.** The transportation of Patients by ambulance, Specialized Mobile Intensive Care Unit, Specialty Care Transport, or Aeromedical Transportation Unit, including both emergency and low-acuity emergency transports, where such transportation originates within the Service Area.
20. **Mobile Integrated Healthcare (MIH).** Services provided by Fort Worth, as requested by Client, that are designed to enhance, coordinate, effectively manage, and integrate out of hospital care, in order to improve outcomes, enhance the participating individual’s experience of care, and improve the efficiency and effectiveness of healthcare services provided to the enrolled individuals.
21. **Office of Medical Director.** The department or division through which the Medical Director carries out his or her functions. The Office of the Medical Director is comprised of the Medical Director, any Associate Medical Director(s), and other individuals assigned to the Office to assist the Medical Director in carrying out the Medical Director’s functions.

22. **Paramedic.** A person qualified as a certified or licensed "paramedic" as defined by Tex. Health and Safety Code Sections 773.049 and 773.0495.
23. **Patient.** A person: who requests EMS, or for whom EMS has been requested; and who has any medical or psychological complaint, obvious injury/distress, or has a significant mechanism of injury.
24. **Service Area.** That geographical area which is contained within the corporate limits of the Parties and other local jurisdictions who have entered into an EMS Interlocal Agreement with Fort Worth and adopted the Uniform EMS Ordinance.
25. **Specialty Care Transport.** The transportation of a critically injured or ill patient requiring a level of service beyond the scope of an EMT or Paramedic due to the patient's condition requiring ongoing specialized care that must be furnished by one or more health professionals, such as emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.
26. **Specialized Mobile Intensive Care Unit.** A vehicle which is specially constructed, equipped, staffed, and employed in the inter-facility transport of patients whose requirements for en route medical support are likely to exceed the clinical capabilities of an Advanced Life Support ambulance.
27. **Uniform EMS Ordinance.** The ordinance adopted by the Parties and other units of local government to establish standards for the provision of the EMS System services and designate Fort Worth as the EMS Provider for the EMS System.
28. **Unscheduled Medical Transportation.** The transportation of Patients by ambulance service, Specialized Mobile Intensive Care Unit, Specialty Care Transport, or Aeromedical Transportation Unit, including both emergency and low-acuity emergency transports, where such transportation originates within the Service Area and is not previously scheduled or made by appointment.

Section 2: ELECTION TO BE CLIENT

2.1 As evidenced by the execution of this Agreement and the concurrent adoption of the Uniform EMS Ordinance (which is attached hereto as Exhibit A and incorporated herein by reference), the Client has elected to designate Fort Worth as the EMS Provider and the exclusively contracted provider of the EMS System services for the Client's jurisdiction, other than those first response services the Client chooses to provide itself as a First Responder, and to receive EMS System services from Fort Worth pursuant to the terms of this Agreement.

Section 3: RESPONSIBILITIES OF CLIENT

3.1 The Client agrees to:

3.1.1 Properly adopt and enforce the Uniform EMS Ordinance and this Agreement;

3.1.2 Establish, operate, and fund a First Responder Program, as provided by Texas Administrative Code 157.14, to represent the interests and needs of Fort Worth and the Client, which may range from an Emergency Care Attendant Program up to an Advanced Life Support

Program adopted by Fort Worth and the Medical Director and as approved in collaboration between Client, Fort Worth, and the Medical Director;

3.1.3 Participate, via the EMS Advisory Board (“EAB”), in the development of and abide by the medical protocols, credentialing requirements, and medical policies for the EMS System and First Responders, as established by the Medical Director;

3.1.4 Provide a mechanism for transferring 911 calls requesting medical assistance from the Client’s 911 center to Fort Worth’s designated EMS Communications Center and transfer 911 callers in accordance with system performance standards adopted by Fort Worth;

3.1.5 Designate a representative of Client to serve as a member of the EAB, who shall then be appointed by the Fort Worth City Council in accordance with the conditions of this Agreement and the MOUA. The designated EAB representative of the Client shall not be removed from the EAB without Client’s consent. The Client retains the exclusive right to remove and name a replacement for its designated EAB representative at any time, and Fort Worth shall appoint the representative as so designated by the Client;

3.1.6 Provide funding for the provision of the EMS System as required by this Agreement and the MOUA; and

3.1.7 Provide additional information, as may reasonably be needed by Fort Worth, to assure the success of Fort Worth’s EMS System such as, but not limited to: updated jurisdictional boundaries or response plans that are unique to the Client.

3.2 Pursuant to Texas Administrative Code 157.11(m), Client authorizes Fort Worth to operate subscription ambulance services within the Client’s corporate limits.

Section 4: RESPONSIBILITIES OF FORT WORTH

4.1 Fort Worth agrees to use the personnel and equipment of Fort Worth for the purpose of providing the EMS System services for Client’s jurisdiction including coordinating with Client to create a mechanism for dispatch services and transferring 911 calls requesting medical assistance from the Client’s 911 center to Fort Worth’s EMS Communication Center. The equipment and personnel of Fort Worth shall be under the control and supervision of Fort Worth employees during an emergency medical response pursuant to this Agreement and the MOUA.

4.2 Fort Worth will serve as the EMS Provider for the Client and provide the EMS System services within the Service Area. It is recognized and understood that Fort Worth does not assume responsibility for the provision of the EMS System services in Client’s extraterritorial jurisdiction or other areas outside of the Service Area.

4.3 Fort Worth’s EMS System services will be provided in accordance with the procedures and protocols of Fort Worth, the Fort Worth Fire Chief, and the Medical Director for the EMS System and under the direction of the Fort Worth Fire Chief.

4.4 Fort Worth agrees to:

4.4.1 Set System Performance standards for the Service Area in compliance with the clinical and medical protocols and standards established by the Medical Director and adopted by Fort Worth and the Client.

4.4.2 Provide the Client with EMS System services including: out-of-hospital emergency medical services, non-emergency medical services, life, or limb, threatening emergency, low acuity emergency, and Advanced Life Support (“ALS”) and Basic Life Support (“BLS”) Unscheduled Medical Transportation and Ambulance Service, and MIH with such service to comply with all applicable laws, rules, and regulations, and with the clinical standards, credentialing requirements and medical policies that may be promulgated from time to time by the Medical Director, including the following commitments:

4.4.2.1: To Provide, on a 24-hour daily basis, a mobile intensive care unit (“MICU”)-capable EMS response and medical transportation service with a minimum staffing as required by relevant state law, which may be amended from time to time, for a BLS Ambulance and an ALS ambulance;

4.4.2.2: Fort Worth’s EMS System resources shall respond to incidents in the Service Area through FW EMS dispatch, using the same algorithms in place for responses within Fort Worth. FW EMS will respond to calls for EMS System services throughout the entire Service Area in less than or equal to 8:00 total travel time 90% of the time for high acuity incidents, as defined by the Medical Director, measured from the time EMS System resources are en route until the time a unit arrives on scene. FW EMS will respond to calls for EMS System services throughout the entire Service Area in less than or equal to 11:00 total travel time 90% of the time for low acuity incidents, as defined by the Medical Director, measured from the time EMS System resources are en route until the time a unit arrives on scene. Fort Worth will calculate the total travel time, and the relevant factors to be considered, in accordance with the information in the attached Exhibit B;

4.4.2.3: FW EMS will transport patients to the closest or most appropriate receiving health care facility as determined by FW EMS. If the patient is incapacitated, otherwise unable to make a choice known, or unable to go to the chosen facility due to diversion status, FW EMS will transport the patient to the facility best able to meet the patient’s needs;

4.4.2.4: FW EMS will keep the EMS System resources stocked at all times in accordance with normal FW EMS operating procedures and local, state, and federal requirements, as applicable;

4.4.2.5: FW EMS will maintain third-party or self-insured vehicle liability insurance on its ambulances and its drivers;

4.4.2.6: FW EMS will provide all maintenance for the ambulances and assume all operational costs of the ambulances, including fuel;

4.4.2.7: FW EMS shall equip the ambulances at all times with current technological advancements in emergency equipment, whether portable or fixed in place on or about the vehicle, as are adopted throughout the FW EMS ambulance fleet.

4.4.3 Obtain the services of a Medical Director that are sufficient to fulfill the Medical Director's powers and duties as identified in the engagement between Fort Worth and the Medical Director, the terms of which will be provided to the Client upon request.

4.4.4 Provide the Client the opportunity to participate in Fort Worth's EMS, or first responder, related continuing education training without charge to the Client to obtain or maintain certifications as agreed upon.

4.4.5 Provide, at least quarterly, written reports of the operational performance of the EMS System to the Fort Worth City Council, EAB, the Medical Control Advisory Board ("MCAB") and by email to the City Manager, or their designee, of the Client, and as reasonably determined to be necessary by Fort Worth.

4.4.6 Prepare and provide to the Client, at least quarterly, a comprehensive review and summary of the financial budget, and clinical and operational performance of the EMS System.

4.4.7 Manage accounts, subscriptions, payments, and billing practices related to the EMS System. Fort Worth may, in its sole discretion and at the EMS System's expense, elect to engage one or more contractors to provide these services.

4.4.8 Create and maintain the EAB and MCAB to ensure coordination and communication between first responder agencies in the Service Area and independent medical oversight related to patient care protocols for Fort Worth's EMS System.

4.4.9 Engage participating organizations on best practices in service delivery, as determined to be necessary or prudent by Fort Worth.

4.4.10 Implement an ambulance subscription program (unless otherwise prohibited by law) and offer memberships in the program to all residents of the Client's corporate limits.

Section 5: TERM AND TERMINATION

5.1 This Agreement will be effective beginning July 1, 2025 and will continue for a term of 10 years, unless earlier terminated in accordance with the terms of this Agreement. Thereafter, the Agreement will renew automatically for successive 10-year terms unless earlier terminated in accordance with the terms of this Agreement.

5.2 In accordance with the terms of the MOUA, Client has received prior notice of the value

of Client's pro rata share of the value of MedStar assets transferred to Fort Worth. The value of those assets as of July 1, 2025, and Client's pro rata share of that value, has been determined by Fort Worth and the amount is \$266,529.00. The method of calculation for determining Client's pro rata share is reflected in the terms and exhibits of the MOUA. The value of Client's pro rata share of such assets will be subject to depreciation over a term of 5 years.

5.3 Termination by Client: The Client may terminate this Agreement and withdraw from the EMS System by providing ninety (90) days' written notice to Fort Worth. If the Client terminates the Agreement within 5 years of July 1, 2025, Fort Worth will determine the value of the Client's pro-rata share of MedStar's assets transferred to Fort Worth pursuant to the MOUA as of the effective date of the Client's notice of termination, less depreciation, and distribute the remaining amount, if any, to the Client within ninety (90) days, however this obligation may be extended by an additional ninety (90) days if determined necessary by Fort Worth in its sole discretion. After five years have lapsed since July 1, 2025, the Client forfeits all rights or claims to any assets of MedStar transferred to Fort Worth pursuant to the MOUA and this Agreement.

5.4 Termination by Fort Worth: Fort Worth may terminate this Agreement for Repeated Uncured Events of Default by the Client, as defined herein.

5.4.1 Event of Default: An Event of Default includes a material breach of this Agreement. A material breach includes any failure by the Client to perform a significant obligation under this Agreement that unreasonably interferes with Fort Worth's ability to provide EMS System services. For example, a material breach includes, but is not limited to: Client's failure to make payments to Fort Worth, as required under Section 6, within 30 days of its due date; Client's failure to enforce any provision of the Uniform EMS Ordinance; Client's failure to abide by the directives, credentialing, and policies of the Medical Director; Client's failure to fund and operate a First Responder Program; and Client's failure to transfer 911 calls to Fort Worth. Fort Worth shall provide the Client with written notice of any Event of Default and allow the Client 60 days to cure it. If the Client fails to cure the Event of Default within the 60-day period, it will be considered an Uncured Event of Default.

5.4.2 If two or more Uncured Events of Default occur in a single fiscal year, or five or more occur over any single term of this Agreement, the Uncured Events of Default will be considered Repeated Uncured Events of Default. In such case, Fort Worth may terminate this Agreement, without penalty, after providing Client with 6 months' written notice of Fort Worth's intent to terminate the Agreement pursuant to this provision.

5.5 Upon the effective date of termination of this Agreement, Fort Worth will cease being the EMS Provider to the Client and the Client will be responsible for all EMS System services within its jurisdiction from the effective date of termination.

Section 6: PAYMENT

6.1 The Parties agree that the long-term sustainability of the EMS System requires public funding. The Parties agree to fund the EMS System using the fully loaded unit hour cost (UHC) allocation strategy as its annual cost allocation method. This method will require Fort Worth to:

(1) determine the total number of consumed unit hours in the EMS System; (2) determine the public funding needed by calculating the total expenditures less total revenues; (3) determine the residual consumed UHC by dividing the total public funding required for the EMS System (step 2) by the total consumed hours in the entire EMS System; (4) determine the consumed units hours by each jurisdiction; and (5) determine the cost allocation for each jurisdiction by multiplying the total consumed unit hours in the jurisdiction (step 4) by the residual consumed UHC (step 3).

For purposes of this Section, the actual unit hours consumed on a 911 call will be based on the number of minutes spent on the call, not including time spent posting or stationed, in a particular jurisdiction. The total time for calls within Client's jurisdiction will be aggregated on a fiscal year basis (October 1 through September 30) and for purposes of calculating the annual UHC for Client, the annual hours consumed by the Client will be rounded up or down to the nearest one (1) hour increment. As detailed below, payment for each fiscal year shall initially be based on a projected budget and projected utilization with a true-up process in the subsequent fiscal year to ensure final payment for each year ultimately reflects actual costs and utilization.

6.2 Beginning in Fiscal Year 2026, on or before March 15th of each year, Fort Worth will communicate to the Client: (1) the projected budget for total public funding for the EMS System for the coming fiscal year (based on Fort Worth's projected costs and projected third-party-payment offset), expressed as a UHC; (2) Client's projected utilization rate for the coming year, which will be the same as the actual utilization rate (number of UHC hours consumed) for the most recently completed fiscal year; and (3) the total budgeted payment for the Client for the coming fiscal year (product of (1) multiplied by (2)). Unless otherwise agreed in writing by the Parties, payment of budgeted costs shall be divided into semi-annual payments with the first payment of fifty percent due on or before October 15th and the remaining payment due on or before June 1st, which payment will reflect any true-up adjustment determined in accordance with Sections 6.3 and 6.4.

For purposes of determining costs for Fiscal Year 2025, Client's projected unit hours consumed are 2,471, and Client's projected annual funding obligation is \$254,290.61. For Fiscal Year 2025, Client's payment obligation has been prorated to \$51,258.00 and is due no later than July 1, 2025.

6.3 Beginning in Fiscal Year 2027, on or before December 15th of each year, Fort Worth will conduct a true up of actual costs and utilization for the preceding fiscal year. As part of this process, Fort Worth will communicate to the Client: (1) the actual total public funding for the EMS System for the preceding fiscal year (based on actual costs and actual third-party-payment offset, expressed as a UHC; (2) the Client's actual utilization rate (number of UHC hours consumed) for the preceding fiscal year; and (3) the total actual cost for the Client for the preceding fiscal year (product of (1) multiplied by (2)).

6.4 The notice provided to Client by Fort Worth on or before March 15th each fiscal year will account for the results of the true up process described by section 6.3 above. Any adjustment that may be required to Client's payment obligations as a result of that true up will be reconciled in the fiscal year immediately following the fiscal year in which the March 15th notice is provided. For the sake of clarity, if the true up reveals the budgeted payment exceeded the actual costs

attributable to the Client, then the overpayment amount will be deducted from the first annual payment of the next fiscal year. If the budgeted payment obligation was less than the actual costs attributable to the Client, then the extra costs will be added to the first annual payment of the next fiscal year. Should the Parties seek to terminate this Agreement before the costs may be reconciled the next fiscal year, the Parties agree to reconcile that obligation, subject to approval and appropriation by their respective governing bodies, before either Party may terminate this Agreement.

6.5 Fort Worth shall be responsible for billing patients and third parties for services and shall have the right to retain all funds received from such billing for services rendered as long as this Agreement is in place. The actual costs for operating the EMS System will be offset by revenues received to ensure the public subsidy accurately reflects unreimbursed costs only.

Section 7: EMS SYSTEM GOVERNANCE

7.1 Fort Worth will have direct oversight and budgetary authority over the EMS System. The Fort Worth City Council, by and through the Fort Worth City Manager or Assistant City Managers, will assume control and responsibility of all operations, oversight, revenues, and expenditures to ensure long-term fiscal sustainability that is publicly accountable.

7.2 The Fort Worth Fire Chief, acting under the direction of the City Manager or their designee, shall be responsible for providing direct management and day-to-day oversight of FW EMS and the EMS System and will have the powers and duties afforded and required of fire chiefs under state law.

7.3 The Parties agree that both an EMS advisory board and a medical control advisory board composed of relevant stakeholders and medical experts are necessary to ensure medical best practices and Client representation and to facilitate community engagement. Therefore, an EMS Advisory Board and a Medical Control Advisory Board will be created by Fort Worth. Such advisory boards are subject to the following conditions at all times:

7.3.1 The EMS Advisory Board (EAB):

7.3.1.1: The EAB shall be created by Fort Worth for the purpose of performing review of and providing advice to Fort Worth on matters related to the EMS System, budget, and service to the Client's jurisdiction.

7.3.1.2: The EAB's membership will consist of the following voting members: one representative designated by the Client and by each of the other units of government that is a party to an EMS Interlocal Agreement; and the Fort Worth Fire Chief, or their designee, who shall serve as the Board Chair. The Medical Director, or their designee, shall serve as a non-voting member.

7.3.1.3: The EAB shall review and advise on matters related to the performance of the EMS System and advise Fort Worth regarding issues related to the EMS System's goals and standards, including medical direction and clinical oversight

and selection of the Medical Director.

7.3.1.4: The EAB will recommend performance standards for the EMS System, including response travel times, call processing time, and data collection and reporting standards.

7.3.1.5: The EAB may, as determined by a majority vote of its members, establish various subcommittees for purposes that the EAB deems necessary and that are consistent with its general role as provided by this Agreement, the resolution creating the EAB, and the EAB's governing documents.

7.3.1.6: To ensure long-term fiscal sustainability of the EMS System, the EAB will review the EMS System budget and conduct an annual budget workshop to advise Fort Worth concerning revenue and expenditures for the EMS System.

7.3.2 The Medical Control Advisory Board (MCAB):

7.3.2.1: The MCAB will serve as an advisory body to Fort Worth. The MCAB's tasks consist of:

- advising Fort Worth about the clinical performance of the EMS System;
- reviewing medical protocols and clinical policies and procedures for the EMS System and making recommendations to the Medical Director;
- representing the interests of the medical community and First Responders, Medical Transportation Providers and ambulance standby providers by making recommendations for improvements to the EMS System as needed;
- recommending and reviewing research conducted within the Service Area; and
- participating in the selection of the Medical Director and review of the Medical Director's clinical performance through processes established by Fort Worth, provided, however, that the then-current Medical Director will not participate in matters related to his current duties and performance.

7.3.2.2: The MCAB's membership shall be composed of the following voting members: (1) the Medical Director (or a designated associate medical director), who shall serve as the Board Chair; (2) the Emergency Department physician medical director, or designee, from each full-service Emergency Department located in the Service Area; and (3) at least four physician members to represent relevant specialties or sub-specialties of benefit in developing standards for emergency out-of-hospital care, with broad representation from different hospital systems, with such members to be recommended by a majority of the then-existing members of MCAB and to be appointed by Fort Worth. The Fort Worth Fire Chief, or their designee, shall serve as a non-voting member. A majority of the voting members of the MCAB must be physicians who are board certified in Emergency Medicine or Pediatric Emergency Medicine, or a related medical field.

7.3.2.3: The MCAB may, by an affirmative vote of two-thirds of its voting members, elect to add other non-voting members as it deems appropriate.

Section 8: MEDICAL DIRECTOR

8.1 The Medical Director for the EMS System will be retained by Fort Worth. The Medical Director must be a licensed physician in the state of Texas who is board-certified in EMS and emergency medicine and meets all state requirements.

8.2 When necessary, Fort Worth shall conduct a hiring and selection process for an EMS System Medical Director and/or Associate Medical Director(s) that will be inclusive, and the EAB and MCAB shall advise Fort Worth and make recommendations concerning selection of a Medical Director for the EMS System.

8.3 The Medical Director is the Chief Medical Officer of the EMS System, will report to the City Manager of Fort Worth or their designee, and will have the powers and duties afforded and required of EMS medical directors under state law. The Medical Director will provide all independent medical direction and clinical oversight for the EMS System. The Medical Director's powers and duties concerning the EMS System will be established by agreement between Fort Worth and the Medical Director, which shall include those afforded and required under state law with the resources necessary to fulfill such requirements.

8.4 Fort Worth, by resolution or ordinance, will establish a new department or division for the Office of the Medical Director ("OMD"). The OMD will serve as the clinical office of Fort Worth through which the Medical Director will carry out their rights and duties.

Section 9: FORCE MAJEURE

9.1 It is expressly understood and agreed by the Parties to this Agreement that if the performance of any obligations hereunder is delayed by reason of war; civil commotion; acts of God; inclement weather; epidemics or pandemics; governmental restrictions, regulations, or interferences; fires; strikes; lockouts, national disasters; riots; material or labor restrictions; transportation problems; or any other circumstances which are reasonably beyond the control of the Party obligated or permitted under the terms of this Agreement to do or perform the same, regardless of whether any such circumstance is similar to any of those enumerated or not (each, a "Force Majeure Event"), the Party so obligated or permitted shall be excused from doing or performing the same during such period of delay, so that the time period applicable to such requirement shall be extended for a period of time equal to the period such Party was delayed. To invoke this section, a Party must provide written notice of the alleged Force Majeure Event to the impacted Parties within a reasonable time after the occurrence of a Force Majeure Event, explaining the Force Majeure Event and the extent to which the Party's performance of obligations are hindered.

Section 10: RIGHT TO AUDIT

10.1 The Parties will have the right to audit each other's financial and business records that relate to the services provided (collectively "Records") at any time during the Term of this

Agreement and for three (3) years thereafter in order to determine compliance with this Agreement. Throughout the Term of this Agreement and for three (3) years thereafter, each Party shall make all relevant records available following reasonable advance notice by the other and shall otherwise cooperate fully with each other during any audit. Notwithstanding anything to the contrary herein, this Section 10 shall survive expiration or earlier termination of this Agreement.

Section 11: STANDBY EMS, INTERFACILITY TRANSPORT (IFT), AND MUTUAL AID AGREEMENTS

11.1 This Agreement is not intended to designate Fort Worth as the exclusive, sole, or single provider of standby EMS for the Client. Nothing herein prohibits the Client from contracting for, regulating, managing, and governing standby EMS and the provider(s) thereof in its own jurisdiction.

11.2 This Agreement is not intended to designate Fort Worth as the exclusive, sole, or single provider of IFT services for any hospital or medical facility. Nothing herein prohibits any hospital or medical facility from privately contracting for interfacility transport services as deemed necessary by that facility. Provided, however, each IFT provider must meet the requirements provided by the Uniform EMS Ordinance.

11.3 This Agreement is not intended to prevent the Client from participating in mutual aid agreements as is typical and ordinary for the Client.

Section 12: GOVERNMENTAL POWERS

12.1 It is understood and agreed that by execution of this Agreement, the Parties do not waive or surrender any of their governmental powers or immunities.

Section 13: ELECTRONIC SIGNATURES

13.1 This Agreement may be executed by electronic signature, which will be considered as an original signature for all purposes and have the same force and effect as an original signature. For these purposes, "electronic signature" means electronically scanned and transmitted versions (e.g. via pdf file or facsimile transmission) of an original signature, or signatures electronically inserted via software such as Adobe Sign.

Section 14: COUNTERPARTS

14.1 This Agreement may be executed in one or more counterparts and each counterpart will, for all purposes, be deemed an original, but all such counterparts will together constitute one and the same instrument.

Section 15: LIABILITY

15.1 Each party agrees to be solely liable for the actions, omissions, and negligent acts of its own employees, agents, and representatives engaged in the provision of services through the EMS

System under this Agreement. Except as expressly provided herein, neither party shall be liable to the other for any indirect, incidental, consequential, special, punitive, or exemplary damages arising out of or in connection with this Agreement, regardless of the form of action, whether in contract, tort, strict liability, or otherwise, even if advised of the possibility of such damages.

15.2 The Client assumes no responsibility or liability for payments, wages, income, and employment tax payments, pensions, benefits, or other payments accrued by or owed to Fort Worth employees who provide services pursuant to this Agreement.

Section 16: INSURANCE

16.1 Each party shall maintain adequate insurance coverage to protect against claims arising from the provision of EMS provided by its own employees and contractors, including but not limited to general liability, professional liability, including malpractice insurance, and worker's compensation insurance.

16.2 Each party may, at its discretion, elect to self-insure against claims arising from the provision of EMS, provided that such self-insurance meets the applicable statutory requirements and guidelines set forth by state law, including but not limited to chapter 2259 of the Texas Government Code.

16.3 Regardless of whether a party chooses to self-insure or obtain commercial insurance coverage, each party shall provide proof of insurance or self-insurance to the other party upon request. Such proof shall include details of coverage limits, deductibles, and any relevant policy exclusions. Each party shall maintain continuous insurance coverage or self-insurance throughout the term of this Agreement and any extensions thereof. Any substantive changes to insurance coverage or self-insurance arrangements shall be promptly communicated to the other Party in writing.

16.4 In the event of any claim, lawsuit, or demand arising under this Agreement, each party shall be responsible for managing and defending its own claims, whether through its insurance provider or self-insurance program. However, parties may collaborate as necessary to resolve claims efficiently and fairly.

Section 17: GOVERNING LAW AND VENUE

17.1 This Agreement shall be construed in accordance with the laws of the State of Texas. If any action, whether real or asserted, at law or in equity, is brought on the basis of this Agreement, venue for such action shall lie in state courts located in Tarrant County, Texas or the United States District Court for the Northern District of Texas, Fort Worth Division.

Section 18: NOTICES

18.1 Notices required pursuant to the provisions of this Agreement shall be conclusively determined to have been delivered when (1) hand-delivered to the other party, its agents, employees, servants or representatives, or (2) received by the other party by United States Mail,

registered, return receipt requested, addressed as follows:

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| TO FORT WORTH: City of Fort Worth Attn: Assistant City Manager 100 Fort Worth Trail Fort Worth TX 76102 With Copy to the City Attorney at same address | TO CLIENT City of Saginaw Attn: City Manager 333 W McLeroy Blvd Saginaw, TX 76179 With copy to Fire Chief at same address |
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Any notices given pursuant to this section shall be confirmed by email sent to the following addresses:

| | |
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| IF TO FORT WORTH: Ashley.Clement@fortworthtexas.gov | IF TO CLIENT greaume@saginawtx.org dougspears@saginawfire.us |
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Section 19: CONFIDENTIALITY

19.1 Fort Worth shall comply with all applicable federal and state laws and regulations regarding the privacy and confidentiality of patient records, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Upon request, Fort Worth will provide the Client with utilization reviews, but all patient information shall be de-identified. Fort Worth, and the FWFD, in providing the EMS System services, and directly related activity such as billing, will be considered a "covered entity" under the HIPAA Privacy Rule and the Texas Medical Privacy Act. 45 C.F.R. §160.103; Tex. Health & Safety Code § 181.001(b)(2). The Parties agree to execute business associate agreements, and any other additional agreements concerning protected health information ("PHI"), as may be necessary, to ensure compliance with the relevant data privacy rules.

Section 20: ACCESS TO RECORDS

20.1 The parties agree that until the expiration of six years after the last date of furnishing of services provided under this Agreement, the parties will make available to the Secretary of the United States Department of Health and Human Services ("the Secretary") and the United States Comptroller General, and their duly authorized representatives, this Agreement and all books, documents, and records necessary to certify the nature and extent of the costs of those services. If a Party carries out the duties of this Agreement through a subcontract worth \$10,000 or more over a twelve-month period, the subcontract will also contain an access clause to permit access by the Secretary, the United States Comptroller General and their representatives to the related

organization's books and records.

Section 21: NO WAIVER

21.1 No course of conduct or verbal waiver or consent shall be deemed a waiver by a Party of its rights under this Agreement. The waiver by a Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision of this Agreement

Section 22: ASSIGNMENT AND DELEGATION

22.1 The Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns. No party may assign or transfer any of its rights or obligations under this Agreement without prior written consent of the other Party.

Section 23: ENTIRE AGREEMENT

23.1 This Agreement, including any exhibits attached hereto and any documents incorporated herein by reference, contains the entire understanding and agreement between the Parties, their assigns and successors in interest, as to the matters contained herein. Any prior or contemporaneous oral or written agreement is hereby declared null and void to the extent in conflict with any provision of this Agreement.

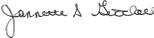
(signature page follows)

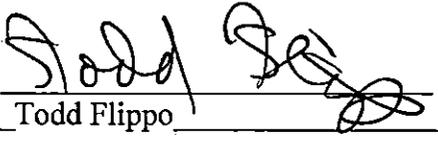
IN WITNESS WHEREOF, the Parties hereto have executed this Agreement in multiples.

[Executed effective as of the date signed by the Deputy City Manager below.] / [ACCEPTED AND AGREED:]

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| <p>City of Fort Worth:</p> <p>By: <u></u> <small>Valerie Washington (Mar 10, 2025 15:25 CDT)</small></p> <p>Name: Valerie Washington</p> <p>Title: Assistant City Manager</p> <p>Date: <u>Mar 10, 2025</u></p> |
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CITY OF FORT WORTH INTERNAL ROUTING PROCESS:

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| <p>Approved as to Form and Legality:</p> <p>By: <u></u></p> <p>Name: Taylor C. Paris</p> <p>Title: Assistant City Attorney</p> <p>Contract Authorization: M&C No. 25-0172</p> | <p>Contract Compliance Manager: By signing I acknowledge that I am the person responsible for the monitoring and administration of this contract, including ensuring all performance and reporting requirements.</p> <p>By: <u></u> <small>Ashley Clement (Mar 13, 2025 14:19 CDT)</small></p> <p>Name: Ashley Clement</p> <p>Title: Deputy Fire Director</p> <p>City Secretary:</p> <p>By: <u></u></p> <p>Name: Jannette S. Goodall</p> <p>Title: City Secretary</p> |
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|---|--|
| City of Saginaw: | Attest |
| By:  | By:  |
| Name: <u>Todd Flippo</u> | Name: <u>Vicky Vega</u> |
| Title: | Title: |
| Date: <u>2-18-2025</u> | Date: <u>2-18-2025</u> |

ORDINANCE NO. _____

AN ORDINANCE AMENDING CHAPTER [INSERT NUMBER] “AMBULANCES/EMERGENCY MEDICAL SERVICES,” OF THE CODE OF THE CITY OF [NAME], TEXAS (YEAR), AS AMENDED, BY REPEALING ARTICLE I “IN GENERAL,” ARTICLE II “BOARDS; THE AUTHORITY,” AND ARTICLE III “VIOLATIONS; PENALTIES; TRAFFIC LAW EXEMPTION;” AND ENACTING A NEW ARTICLE I “IN GENERAL,” ARTICLE II “FORT WORTH EMS SYSTEM AND INTERFACILITY TRANSPORTATION,” AND ARTICLE III “VIOLATIONS, PENALTIES, TRAFFIC LAW EXEMPTION;” PROVIDING THAT THIS ORDINANCE SHALL BE CUMULATIVE OF ALL PRIOR ORDINANCES AND REPEAL CONFLICTING ORDINANCES; PROVIDING FOR A SEVERABILITY CLAUSE; PROVIDING FOR A SAVINGS CLAUSE; PROVIDING A PENALTY CLAUSE; PROVIDING FOR PUBLICATION IN THE OFFICIAL NEWSPAPER OF THE CITY; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City Council of the City of [NAME] ("City Council") seeks to protect the public safety, preserve the quality of life, and promote efficiency within the City of [NAME] (the “City”);

WHEREAS, it is in the best interests of the public health and welfare of the people of the City to have available to them a regulated system for the provision of out of hospital emergency and non-emergency medical services, unscheduled medical transportation and ambulance service mobile integrated healthcare (“MIH”)(collectively the “EMS System”) and scheduled interfacility medical transportation services among and between hospitals and other medical facilities in non-emergency situations (“interfacility transports or IFT”) with the intent of providing quality clinical care with performance measures and standards and a goal of facilitating the best possible outcomes for each patient;

WHEREAS, in 1988 through the adoption of a Uniform EMS Ordinance and Interlocal Cooperative Agreement between local governments, including the City of Fort Worth (“Fort Worth”), the Area Metropolitan Ambulance Authority (the “Authority” a/k/a “MedStar”) was created as a governmental administrative agency to administer and operate an EMS System and exclusively provide interfacility transports in a service area comprised of the member jurisdictions, with Fort Worth constituting more than eighty-five percent of the land mass and call volume of the Authority;

WHEREAS, the Authority has sustained rising operational and capital costs and flat net revenues, leading to a dynamic that requires future public funding to ensure the long-term sustainability of those services;

WHEREAS, the Fort Worth City Council has elected to establish an EMS division through the Fort Worth Fire Department to operate an EMS System and provide services to the people within its jurisdiction and people in other jurisdictions, provided each such jurisdiction adopts this Uniform EMS Ordinance and enters into an EMS Interlocal Agreement with Fort Worth (each a “Client City”);

WHEREAS, Fort Worth is engaging a physician who is licensed in Texas and board certified in emergency medicine to serve as the Chief Medical Officer and Medical Director for the EMS System (the “Medical Director”);

WHEREAS, the member jurisdictions of the Authority have agreed to dissolve the Authority, and with those adopting this ordinance and executing an EMS Interlocal Agreement opting to become Client Cities;

WHEREAS, due to the relatively low population and low population density of some areas at issue and the extremely high, start-up and fixed operating costs of a state-of-the-art EMS System, it is necessary to designate Fort Worth as the exclusively contracted EMS Provider of EMS System services within the City in order to maximize clinical proficiency, enhance operational effectiveness, and maximize economies of scale for providing such services;

WHEREAS, although Fort Worth will not be assuming the Authority’s role as exclusive provider of interfacility transports, there remains a need to ensure such transports within the City are only conducted by properly qualified and authorized providers in order to ensure clinical standards are met and public safety is preserved; and

WHEREAS, the City Council finds this Ordinance to be reasonable and necessary.

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF [NAME] TEXAS, THAT:

SECTION 1.

Chapter [NUMBER] “Ambulances/Emergency Medical Services” of the Code of the City of [NAME] is hereby amended by repealing Article I “In General,” Article II “Boards; The Authority,” and Article III “Violations; Penalties; Traffic Law Exemption,” and enacting a new

Article I “In General,” Article II “ Fort Worth EMS System and Interfacility Transportation” and Article III “Violations; Penalties; Traffic Law Exemption,” the text of which shall read as follows:

“ARTICLE I: GENERAL

§ 5-1 STATUTORY AUTHORITY.

This chapter is enacted by the City pursuant to Tex. Health and Safety Code § 773.051, which provides that local governments may establish standards for ambulances, and pursuant to Tex. Government Code Chapter 791, which authorizes combinations of local governmental units to contract for the provision of governmental services.

§ 5-2 GENERAL PURPOSES AND INTENT OF ORDINANCE.

It is the purpose of this Ordinance:

To establish a regulated out-of-hospital emergency medical services, non-emergency medical services, unscheduled medical transportation and ambulance service, and mobile integrated healthcare system (collectively the “EMS System”) which can provide quality clinical care with performance measures and standards, with the goal of facilitating the best possible outcomes for each Patient.

To designate Fort Worth as the EMS Provider of the EMS System within the corporate limits of City as provided by the terms of the EMS Interlocal Agreement between Fort Worth and the City to maintain consistent, high-quality service while controlling costs through efficiencies and economies of scale;

§ 5-3 DEFINITIONS.

For the purposes of this Ordinance, the following words and phrases shall have the meanings respectively ascribed to them by this section:

- (a) **Advanced Life Support (ALS).** Out-of-hospital care that uses invasive medical acts (as defined in Tex. Health and Safety Code § 773.003(1)).
- (b) **Aeromedical Transportation Unit.** Any rotary or fixed wing aircraft providing basic or advanced life support services and patient transportation that originates within the Service Area.
- (c) **Ambulance.** A vehicle for transportation of sick or injured person to, from, or between places of treatment for an illness or injury, and provide out of hospital medical care to the Patient.
- (d) **Ambulance Mutual Aid Agreement.** A written contract between Fort Worth and one or more entities whereby the signing parties agree to provide backup ambulance service to one another under the terms and conditions specified therein.

- (e) **Ambulance Service.** The transportation of Patients by emergency or non-emergency ambulance; for purposes of this Ordinance, Ambulance Service does not include IFT services as defined herein.
- (f) **Associate Medical Director.** A licensed physician who assists the Medical Director in carrying out his or her duties under this Ordinance, Fort Worth’s EMS Interlocal Agreements, and the Medical Director’s agreement with Fort Worth.
- (g) **Basic Life Support (BLS).** Out-of-hospital care that uses noninvasive medical acts (as defined in § 773.003(2), Tex. Health and Safety Code).
- (h) **Emergency Care Attendant (ECA).** A person certified as an “emergency care attendant” under § 773.046 of the Tex. Health and Safety Code.
- (i) **Emergency Medical Services (EMS).** Services used to respond to an individual’s perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury.
- (j) **Emergency Medical Technician (EMT).** A person certified as an “emergency medical technician” under § 773.047 or an “advanced emergency medical technician” under § 773.048 of the Tex. Health and Safety Code, and any other class of EMT recognized by state law or regulation.
- (k) **EMS Communications Center.** The facility designated by Fort Worth as the central communications center from which all EMS System services offered by Fort Worth shall be dispatched and coordinated.
- (l) **EMS Interlocal Agreements.** The service level interlocal agreements executed by Fort Worth and Client Cities to designate Fort Worth as the exclusively contracted EMS Provider of the EMS System within the Service Area.
- (m) **EMS Provider.** The entity that has received a Texas EMS Provider License, as required by relevant state law, to provide the EMS System services and is the exclusively contracted provider of the EMS System services within the Service Area. For purposes of this ordinance, the EMS Provider is Fort Worth.
- (n) **EMS System.** The regulated out-of-hospital EMS, non-emergency medical services, unscheduled medical transportation and ambulance services, and mobile integrated healthcare system provided by Fort Worth within the Service Area, not including those first response services City chooses to provide itself as a First Responder.
- (o) **First Responder.** Any agency that, in cooperation with the EMS Provider, provides initial response to requests for EMS and, on its own or in cooperation with the EMS Provider, provides immediate on-scene care to ill or injured persons but does not transport those persons to healthcare facilities.
- (p) **FW EMS.** The emergency medical services division of the City of Fort Worth Fire Department responsible for providing the EMS System services.

- (q) **Interfacility Transportation (IFT).** The provision of scheduled, or by appointment, medical transportation services by a person or entity between hospitals or medical facilities originating within the Service Area.
- (r) **Medical Director.** The licensed physician employed or contracted by Fort Worth who is responsible for carrying out his or her duties under their engagement with Fort Worth, this Ordinance, and Fort Worth's EMS Interlocal Agreements with Client Cities and for directing the Office of the Medical Director.
- (s) **Medical Transportation.** The transportation of Patients by ambulance, Specialized Mobile Intensive Care Unit, Specialty Care Transport, or Aeromedical Transportation Unit, including both emergency and low-acuity emergency transports, where such transportation originates within the Service Area.
- (t) **Mobile Integrated Healthcare (MIH).** Services provided by Fort Worth, as requested by City, that are designed to enhance, coordinate, effectively manage, and integrate out of hospital care, in order to improve outcomes, enhance the client's experience of care, and improve the efficiency and effectiveness of healthcare services provided to the enrolled clients.
- (u) **Office of Medical Director.** The department or division through which the Medical Director carries out his or her functions. The Office of the Medical Director is comprised of the Medical Director, any Associate Medical Director(s), and other individuals assigned to the Office to assist the Medical Director in carrying out the Medical Director's functions.
- (v) **Paramedic.** A person qualified as a certified or licensed "paramedic" as defined by Tex. Health and Safety Code Sections 773.049 and 773.0495.
- (w) **Patient.** A person: who requests EMS, or for whom EMS has been requested; and who has any medical or psychological complaint, obvious injury/distress, or has a significant mechanism of injury.
- (x) **Service Area.** That geographical area which is contained within the corporate limits of the City and other local jurisdictions who have elected to become Client Cities by entering into an EMS Interlocal Agreement with Fort Worth and adopting this ordinance.
- (y) **Specialty Care Transport.** The transportation of a critically injured or ill patient at a level of service beyond the scope of the EMT-Paramedic when the Patient's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area; for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.
- (z) **Specialized Mobile Intensive Care Unit.** A vehicle which is specially constructed, equipped, staffed, and employed in the inter-facility transport of patients whose requirements for en route medical support are likely to exceed the clinical capabilities of an Advanced Life Support ambulance.
- (aa) **Uniform EMS Ordinance.** This ordinance.

- (bb) **Unscheduled Medical Transportation.** The transportation of Patients by ambulance service, Specialized Mobile Intensive Care Unit, Specialty Care Transport, or Aeromedical Transportation Unit, including both emergency and low-acuity emergency transports, where such transportation originates within the Service Area and is not previously scheduled or made by appointment.

§ 5-4-5-15 Reserved

ARTICLE II: FORT WORTH EMS SYSTEM AND INTERFACILITY TRANSPORTATION

§ 5-16 POWERS AND DUTIES OF FW EMS

(a) Fort Worth, by and through FW EMS, is hereby designated as the exclusively contracted EMS Provider of the EMS System within the City's corporate limits as provided by the terms, conditions and provisions of the City's EMS Interlocal Agreement with Fort Worth and for so long as Fort Worth is a party to the City's EMS Interlocal Agreement.

(c) Fort Worth shall comply with all terms of the EMS Interlocal Agreement and have all the powers and duties enumerated therein.

§ 5-17 INTERFACILITY TRANSPORTATION

(a) This ordinance is not intended to designate Fort Worth as the sole provider of interfacility transportation services between hospitals and other medical facilities within the Service Area.

(b) Notwithstanding the above, any person or entity who wishes to provide such IFT services within the Service Area must be registered with Fort Worth as an IFT provider and permitted by Fort Worth and the Medical Director to provide such services.

(c) Any IFT provider who obtains a permit to provide IFT services from Fort Worth must comply with the provisions of this ordinance and the directives of the Medical Director.

§ 5-18-5-30 Reserved

ARTICLE III: VIOLATIONS; PENALTIES; TRAFFIC LAW EXEMPTION

§ 5-31 VIOLATIONS.

(a) So long as Fort Worth is a party to the City's EMS Interlocal Agreement, it shall be unlawful:

- (1) To knowingly give false information to induce the dispatch of an ambulance or Aeromedical Transportation Unit.
 - (2) To perform duties as an ECA, EMT, Paramedic or emergency ambulance dispatcher without current credentials issued by the Office of the Medical Director, unless participating in a training program approved by Office of the Medical Director or performing duties as a First Responder of the City;
 - (3) To permit a person to work as an ECA, EMT, Paramedic or emergency ambulance dispatcher without current credentials issued by the Office of the Medical Director, unless participating in a training program approved by Office of the Medical Director or performing duties as a First Responder of the City;
 - (4) To use, or cause to be used, any Ambulance Service other than FW EMS, except as permitted in subsection (b) below;
 - (5) For any person or entity other than Fort Worth and FW EMS to provide EMS System services within the Service Area, not including those first response services which City provides itself as a First Responder and except as permitted by subsection (b) below;
 - (6) For any person to provide Medical Transportation originating in the Service Area without a permit issued by Fort Worth;
 - (7) For any agency to provide First Responder services without a First Responder Agreement with Fort Worth or a written automatic aid or mutual aid agreement with the City;
 - (8) To use an ambulance for the transportation of persons other than in connection with the transportation of a Patient.
- (b) It shall be a defense to any alleged violation of this section that a vehicle is being used or service is provided solely in any of the following manners:
- (1) As a privately-owned vehicle not ordinarily used in the business of transporting persons who are sick, injured, wounded, incapacitated or helpless;
 - (2) Rendering service as an ambulance at the request of the EMS Communications Center upon the declaration of a disaster by Fort Worth, the City, another unit of local government, the State of Texas, or the United States; or a declaration of a major catastrophe or extreme system overload by the City Fire Chief, or the Fort Worth Fire Chief;
 - (3) Any ambulance owned or operated by the federal or state government;
 - (4) Ambulance mutual aid calls when rendered pursuant to an Ambulance Mutual Aid agreement approved by the City or Fort Worth;
 - (5) Wheelchair transport services for persons other than Patients, when the service is not provided by ambulance; and

- (6) Medical Transportation of a Patient where the transport originates outside the Service Area.
- (7) IFT between hospitals or medical facilities within the Service Area if the provider has first obtained a permit from Fort Worth.

§ 5-32 PENALTIES.

- (a) Any person convicted of violating the provisions of Section 5-31 shall be guilty of a Class C misdemeanor and shall be punished by a fine not to exceed \$500 (Tex. Penal Code §12.23).
- (b) This Section does not serve to limit any other remedies available to the City in law or equity.
- (c) Each violation of this Ordinance shall constitute a separate offense.

§ 5-33 TRAFFIC LAWS; EXEMPTION.

When the driver of an emergency medical response vehicle has reasonable grounds to believe that an emergency exists, as determined by the EMS Communication Center, the vehicle shall be treated as an “authorized emergency vehicle” within the meaning of Chapter 546 of the Tex. Transp. Code and shall be exempt from traffic laws as provided therein.

§ 5-34-5-39 Reserved”

SECTION 2.

This ordinance shall be cumulative of all provisions of ordinances of the Code of the City of [NAME], Texas (YEAR), as amended, except where the provisions of this ordinance are in direct conflict with the provisions of such ordinances and such Code, in which event conflicting provisions of such ordinances and such Code are hereby repealed.

SECTION 3.

It is hereby declared to be the intention of the City Council that the phrases, clauses, sentences, paragraphs and sections of this ordinance are severable, and, if any phrase, clause, sentence, paragraph or section of this ordinance shall be declared unconstitutional by the valid judgment or decree of any court of competent jurisdiction, such unconstitutionality shall not affect any of the remaining phrases, clauses, sentences, paragraphs and sections of this ordinance, since the same would have been enacted by the City Council without the incorporation in this ordinance of any such unconstitutional phrase, clause, sentence, paragraph or section.

SECTION 4.

All rights and remedies of the City of [NAME], Texas, are expressly saved as to any and all violations of the provisions of the Code of the City of [NAME], or any other ordinances of the City, that have accrued at the time of the effective date of this ordinance; and, as to such accrued violations and all pending litigation, both civil and criminal, whether pending in court or not, under such ordinances, same shall not be affected by this ordinance, but may be prosecuted until final disposition by the courts.

SECTION 5.

Any person convicted of violating the provisions of the Code of the City of [NAME] Section 5-31 as enacted by this Ordinance shall be guilty of a Class C misdemeanor and shall be punished by a fine not to exceed \$500 (Tex. Penal Code §.12.23). This Section does not serve to limit any other remedies available to the Jurisdiction in law or equity. Each violation of this Ordinance shall constitute a separate offense.

SECTION 6.

The City Secretary of the City of [NAME], Texas is hereby directed to publish the caption, penalty clause and effective date of this ordinance for two (2) days in the official newspaper of the City of [NAME], Texas, as authorized by Texas Local Government Code, Section 52.013.

SECTION 7.

All other provisions of Chapter 5 of the Code of the City of [Name], as amended, shall remain in full force and effect, save and except as amended by this ordinance.

SECTION 8.

This ordinance shall take effect upon adoption and publication as required by law, and it is so ordained.

APPROVED AS TO FORM AND LEGALITY:

ATTEST:

Assistant City Attorney

[NAME], City Secretary

Date: _____

Ordinance No. _____

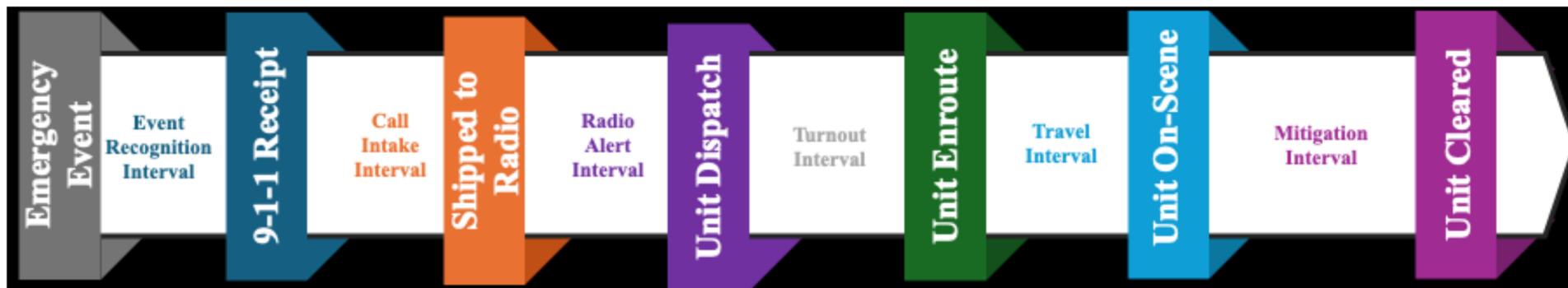
ADOPTED: _____

EFFECTIVE: _____

Ordinance No. _____

Exhibit B – Travel Time Calculation Worksheet

Every 911 request for service involves a cascade of events from the onset of the incident until the ambulance and personnel are available for another request for service. The figure below is a visual representation of the cascade of events in a 911 incident.



The following Elements of Time are key performance indicators that are measured as part of overall EMS System performance.

Call Processing Time – The element of time that is measured from the time that 911 answers the call and receives adequate information to identify the call location and priority level (call back number, location, chief complaint, and MPDS determinant) to dispatch the call and the time the Emergency Dispatch Center dispatches an ambulance.

Turnout Time – The element of time that is measured from the time that the ambulance is notified of a call until the ambulance establishes a continuous state of travel (en-route) to the location of the emergency incident.

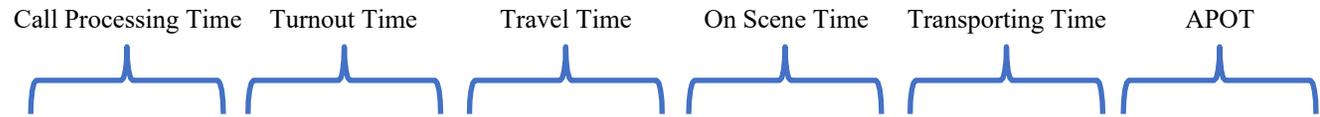
Travel time – The element of time that is measured from the time that the ambulance goes en route to the location of the emergency incident until the ambulance arrives at the location.

On-Scene Time – The element of time that is measured from the time that the ambulance arrives at the location of the emergency incident, designated staging location, or nearest public road access point to the scene to the time the ambulance clears the scene location or begins to transport.

Transport time – The element of time measured from the time that the ambulance begins transporting the patient from the scene to the time the ambulance arrives at the health care receiving facility.

Ambulance Patient Off-load Time (APOT) – The element of time is measured from the time that the ambulance arrives at the health care receiving facility until the time it is available for another assignment.

The figure below visually represents each of the intervals where these elements of time are calculated.



| CAD Incident # | Case Number | Unit | Call Received | Dispatched | Enroute | On Scene | Enroute to Hospital | Arrived at Hospital | Call Cleared |
|----------------|-------------|------|----------------|----------------|----------------|----------------|---------------------|---------------------|----------------|
| 22000005 | 2-000019 | M77 | 1/1/22 0:12:35 | 1/1/22 0:13:17 | 1/1/22 0:13:31 | 1/1/22 0:22:04 | 1/1/22 0:33:36 | 1/1/22 0:58:58 | 1/1/22 1:38:11 |

The figure below visually represents the travel time performance objectives for life-threatening, potentially non-life-threatening, and low-acuity emergencies.

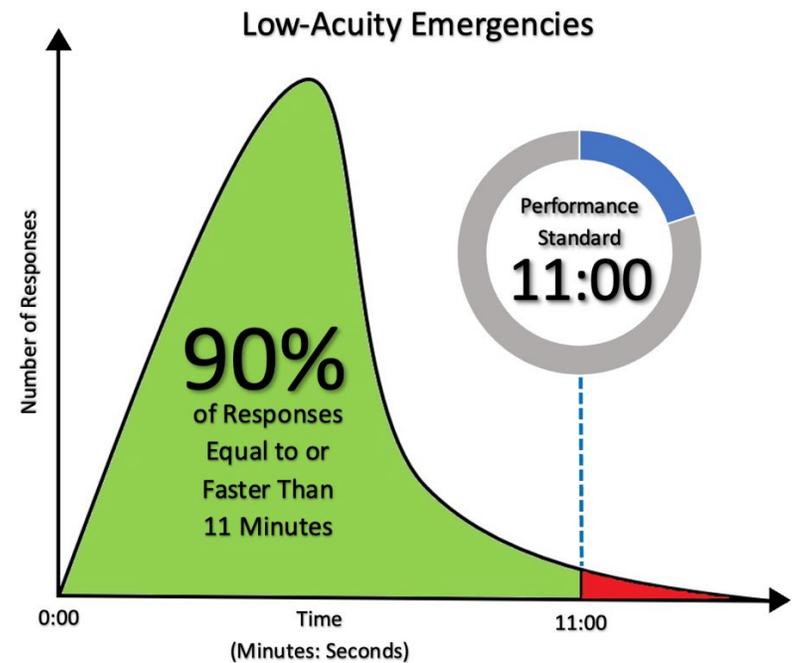
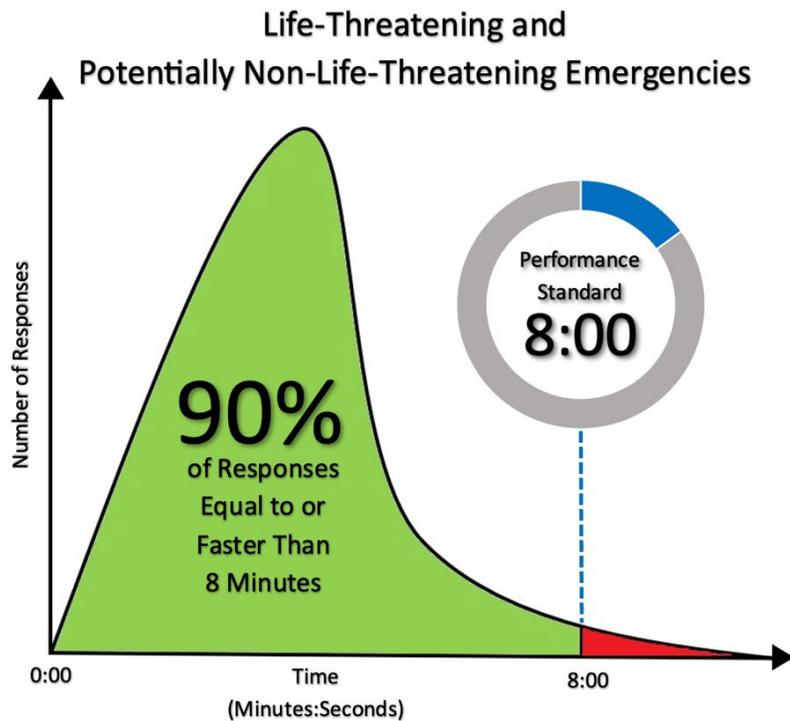




Exhibit C – UHC and Payment Calculation Information

1. Define the total number of consumed unit hours in the entire system.
2. Define the needed public funding for the system calculated as total revenues less total expenses. This residual value is the public funding needed.
3. Determine the residual consumed unit hour cost (UHC) by dividing the total needed public funding (Step 2) by the total consumed hours in the entire system (Step 1)
4. Determine the consumed unit hours by each jurisdiction.
5. Determine the cost allocation for each jurisdiction by multiplying the total consumed unit hours in the jurisdiction (Step 4) by the residual consumed unit hour cost (UHC) (Step 3).

For Client:

1. There have been 168,718 consumed unit hours in the EMS System inclusive of all participating agencies, as determined by the Fiscal Year 2024 MedStar CAD system data;
2. The needed residual public funding for the EMS System is \$17,363,565, determined as follows:
 - a. This number was determined by taking revenues (\$61,332,602) minus expenses (\$70,696,166), including dispatch and medical director's fees (\$8,000,000).
3. Accordingly, the UHC is \$102.91 ($\$17,363,565 / 168,718$ consumed hours)
4. Client utilized 2,471-unit hours in its boundaries according to the Fiscal Year 2024 MedStar CAD system data;
5. The annual cost allocation for Client is \$254,290.61 (2,471-unit hours x \$102.91 UHC) to be paid in two semi-annual payments. For Fiscal Year 2025, Client will owe only one payment which has been prorated to \$51,258.00 and is due July 1, 2025.

Mayor and Council Communication

DATE: 02/25/25

M&C FILE NUMBER: M&C 25-0172

LOG NAME: 36FD EMS ILA

SUBJECT

(ALL) Adopt a Revised Emergency Medical Services Ordinance to be Effective July 1, 2025, and Authorize Execution of Interlocal Agreements with Other Local Jurisdictions to Authorize Fort Worth to Operate as the Licensed Emergency Medical Services Provider and Furnish EMS System Services in Each Jurisdiction

RECOMMENDATION:

It is recommended that City Council:

1. Adopt the attached revised Emergency Medical Services Ordinance, to be effective July 1, 2025, which will replace the City's current ordinance and serve as the uniform Emergency Medical Services Ordinance for all jurisdictions wishing to receive Emergency Medical Services from Fort Worth; and
2. Authorize the execution of Interlocal Agreements with each local jurisdiction that elects to receive Emergency Medical Services System Services from the City of Fort Worth, subject to a requirement that each such jurisdiction adopt the Emergency Medical Services Ordinance and authorize the City of Fort Worth to operate as that jurisdiction's licensed Emergency Medical Services Provider and to furnish EMS System Services, within such jurisdictions.

DISCUSSION:

In 1988, the City of Fort Worth (City) and certain other local municipalities came together to create a regional ambulance and emergency medical services (EMS) agency known as the Area Metropolitan Ambulance Authority, d/b/a Medstar, (Authority) through the adoption of a uniform EMS ordinance and interlocal cooperative agreement under the provisions of Section 773.051 of the Texas Health and Safety Code and chapter 791 of the Texas Government Code.

Beginning in 2020, the Authority (now known as the Metropolitan Area EMS Authority and operating under the trade name MedStar Mobile Healthcare) operated under a Restated and Amended Interlocal Cooperative Agreement (Fort Worth City Secretary Contract No. 54348; hereinafter, the Agreement) and an updated uniform EMS ordinance. The Agreement provided that the Authority would continue in existence until all participating units of government (Member Cities) withdrew from the Agreement.

Pursuant to the Memorandum of Understanding and Agreement (MOUA) executed by all Member Cities and effective December 31, 2024, all Member Cities agreed to: withdraw from and terminate the Agreement; dissolve the Authority; and designate the City as the licensed EMS Provider for the Member Cities. Pursuant to the MOUA, the Authority continues to exist, operate, and serve as the EMS Provider for the Member Cities, under the management and control of the City, in a limited, transitional capacity until at least July 1, 2025 (Transition Period).

It remains in the best interests of the public health and welfare of the people of the Member City jurisdictions to have available to them a regulated EMS System with an exclusively contracted EMS Provider. Therefore, the City has established an EMS division through the City of Fort Worth Fire Department to operate a new EMS System and provide services to the people of the jurisdictions who execute an EMS Interlocal Agreement with the City and adopt a new uniform EMS ordinance, each a "Client City."

The City is engaging a physician who is licensed in Texas and board certified in emergency medicine to serve as the Chief Medical Officer and Medical Director for the City's EMS system (Medical Director). And, by and through Ordinance No. 27372-12-2024, adopted by the City Council on December 10, 2024, the City established a new department, the Department of Office of the Medical Director, which shall be responsible for serving as the clinical office through which the Medical Director carries out his or her rights, duties, and obligations under the City's Uniform EMS Ordinance and the City's EMS Interlocal Agreements.

The purpose of this Mayor & Council Communication (M&C) is to authorize the City to execute the EMS Interlocal Agreements with each Client City, as contemplated by the MOUA. The EMS Interlocal Agreements will govern the relationship between the City and each Client City and authorize the City to serve as the licensed EMS Provider and exclusive provider of certain EMS services within each Client City's jurisdiction beginning July 1, 2025 and upon the City receiving its EMS provider license from the Department of State Health Services, whichever occurs later. With the approval of this M&C, the City will execute an EMS Interlocal Agreements with the following cities:

- Blue Mound;
- Edgecliff Village;
- Forest Hill;
- Haltom City;
- Haslet;
- Lake Worth;
- Lakeside;
- Richland Hills;

- River Oaks;
- Saginaw;
- Sansom Park;
- Westover Hills;
- Westworth Village; and
- White Settlement.

In addition to serving as the licensed EMS Provider for each Client City, the EMS Interlocal Agreements require the City to, among other things: set system performance standards in accordance with protocols established by its Medical Director, provide each Client City with “EMS System services” which include: out-of-hospital EMS, non-emergency medical services, life, or limb, threatening emergency, low acuity emergency, and Advanced Life Support and Basic Life Support unscheduled Medical Transportation and Ambulance Service, and mobile integrated healthcare services; obtain the services of an independent medical director; create two advisory boards known as the EMS Advisory Board and Medical Control Advisory Board; provide quarterly written reports of the operational performance of the EMS System to each Client City and the advisory boards; provide quarterly comprehensive reviews of the budget and clinical performance of the system; and manage the billing, subscriptions, and payment practices. The City will not be the exclusive provider of interfacility transportation services.

The term of each EMS Interlocal Agreement is for 10 years beginning July 1, 2025 and will renew automatically for successive 10-year terms unless earlier terminated in accordance with the terms of the EMS Interlocal Agreement. The above notwithstanding, one Client City, Edgecliff Village, has requested an initial term of 5 years, with successive 5 year renewal terms.

The EMS Interlocal Agreements obligate the City and each Client City to fund the EMS System using the fully loaded unit hour cost (UHC) allocation strategy. This method will require the City to: (1) determine the total number of consumed unit hours in the EMS System; (2) determine the public funding needed by calculating the total expenditures less total revenues; (3) determine the residual consumed UHC by dividing the total public funding required for the EMS System (step 2) by the total consumed hours in the entire EMS System; (4) determine the consumed unit hours by each jurisdiction; and (5) determine the cost allocation for each jurisdiction by multiplying the total consumed unit hours in the jurisdiction (step 4) by the residual consumed UHC (step 3). The actual unit hours consumed on a 911 call will be based on the number of minutes spent on the call, not including time spent posting or stationed, in a particular jurisdiction. The total time for calls within a Client City's jurisdiction will be aggregated on a fiscal year basis (October 1 through September 30) and for purposes of calculating the annual UHC for a Client City, the annual hours consumed by the Client City will be rounded up or down to the nearest one (1) hour increment. Payment for each fiscal year shall initially be based on a projected budget and projected utilization with a true-up process in the subsequent fiscal year to ensure final payment for each year ultimately reflects actual costs and utilization.

In addition to authorizing the execution of the EMS Interlocal Agreements, approval of this M&C will adopt the attached Uniform EMS Ordinance (Ordinance). The purpose of the Ordinance is to replace the existing Uniform EMS Ordinance which designates the Authority as the exclusive EMS Provider within the City. The Ordinance will designate the City as the exclusive EMS Provider of the City's EMS System Services within the City's corporate limits and of those Client City's who also adopt the Ordinance. In addition to the above, the Ordinance will require other EMS providers to register with the City and obtain a permit in order to operate interfacility transportation services within the corporate limits of the City and of those City's who adopt the Ordinance.

Under the Ordinance, it is unlawful, among other things, to knowingly give false information to induce the dispatch of an ambulance or to use or cause to be used any ambulance service other than the City (except in an expressly authorized manner). If found guilty of a Class C Misdemeanor for a violation as set out in the Ordinance, a person shall be punished by a fine not to exceed \$500.00 per violation.

These contracts will be with a governmental entity, state agency or public institution of higher education: Other local governments.

These agreements will serve ALL COUNCIL DISTRICTS.

A Form 1295 is not required because: This M&C does not request approval of a contract with a business entity.

FISCAL INFORMATION / CERTIFICATION:

The Director of Finance certifies that upon approval of the above recommendations and execution of the agreements funds will be deposited into the Emergency Medical Services Fund. The Fire Department (and Financial Management Services) is responsible for the collection and deposit of funds due to the City.

Submitted for City Manager's Office by: Dana Burghdoff 8018

Originating Business Unit Head: Jim Davis 6801

Additional Information Contact:



E. Action regarding Business Associate Agreement with the City of Fort Worth-- Doug Spears, Fire Chief

| Meeting | Agenda Group |
|------------------------------------|--------------------------|
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2E. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

The Business Associate Agreement is the framework for the process of protecting patient health and patient care information for and between partnering entities. In this case for and between our own EMS staff and the EMS staff of the City of Fort Worth. Essentially it ensures compliance with what is commonly known as HIPAA - Health Insurance Portability and Accountability Act which is a federal law protecting sensitive health care information from unauthorized disclosure.

The Business Associate Agreement is an Exhibit of the First Responder Organization Agreement but due to the significance what the Business Associate Agreement entails it requires a separate and individual approval action.

See attached:

Exhibit D Saginaw - City of FTW Business Associate Agreement

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

Staff recommends approval of the Business Associate Agreement with the City of FTW as presented.

Attachments

[Exhibit D Saginaw - City of FTW Business Associate Agreement.pdf](#)



CITY OF FORT WORTH BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the “BAA”) is made and entered into by and between the City of Fort Worth Texas, a home-rule municipality organized under the laws of the state of Texas (“Covered Entity”) and **The City of Saginaw**, a [corporation, limited liability company, etc.](“Business Associate”, in accordance with the meaning given to those terms at 45 CFR § 164.501). In this BAA, Covered Entity and Business Associate are each a “Party” and, collectively, are the “Parties.”

WHEREAS, Covered Entity is a “covered entity” as defined under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended by the HITECH Act (as defined below) and the related regulations promulgated by HHS (as defined below) (collectively, “HIPAA”) and, as such, is required to comply with HIPAA’s provisions regarding the confidentiality and privacy of Protected Health Information (“PHI”);

WHEREAS, the Parties have entered into or will enter into one or more agreements under which Business Associate provides or will provide certain specified services to Covered Entity (collectively, the “Agreement”);

WHEREAS, in providing services pursuant to the Agreement, Business Associate will have access to PHI;

WHEREAS, by providing the services pursuant to the Agreement, Business Associate will become a “business associate” of the Covered Entity as such term is defined under HIPAA;

WHEREAS, both Parties are committed to complying with all federal and state laws governing the confidentiality and privacy of health information, including, but not limited to, the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Part 160 and Part 164, Subparts A and E (collectively, the “Privacy Rule”); and

WHEREAS, both Parties intend to protect the privacy and provide for the security of Protected Health Information disclosed to Business Associate pursuant to the terms of this Agreement, HIPAA and other applicable laws.

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein and the continued provision of PHI by Covered Entity to Business Associate under the Agreement in reliance on this BAA, the Parties agree as follows:



1. Definitions

For purposes of this BAA, the Parties give the following meaning to each of the terms in this Section 1 below. Any capitalized term used in this BAA, but not otherwise defined, has the meaning given to that term in the Privacy Rule or pertinent law.

A. “Affiliate” means a subsidiary or affiliate of Covered Entity that is, or has been, considered a covered entity, as defined by HIPAA.

B. “Breach” means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI, as defined in 45 CFR §164.402.

C. “Breach Notification Rule” means the portion of HIPAA set forth in Subpart D of 45 CFR Part 164.

D. “Data Aggregation” means, with respect to PHI created or received by Business Associate in its capacity as the “business associate” under HIPAA of Covered Entity, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a business associate of one or more other “covered entity” under HIPAA, to permit data analyses that relate to the Health Care Operations (defined below) of the respective covered entities. The meaning of “data aggregation” in this BAA shall be consistent with the meaning given to that term in the Privacy Rule.

E. “Designated Record Set” has the meaning given to such term under the Privacy Rule, including 45 CFR §164.501.B.

F. “De-Identify” means to alter the PHI such that the resulting information meets the requirements described in 45 CFR §§164.514(a) and (b).

G. “Electronic PHI” means any PHI maintained in or transmitted by electronic media as defined in 45 CFR §160.103.

H. “Health Care Operations” has the meaning given to that term in 45 CFR §164.501.

I. “HHS” means the U.S. Department of Health and Human Services.

J. “HITECH Act” means the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.



K. “Individual” has the same meaning given to that term in 45 CFR §§164.501 and 160.130 and includes a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

L. “Privacy Rule” means that portion of HIPAA set forth in 45 CFR Part 160 and Part 164, Subparts A and E.

M. “Protected Health Information” or “PHI” has the meaning given to the term “protected health information” in 45 CFR §§164.501 and 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

N. “Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

O. “Security Rule” means the Security Standards for the Protection of Electronic Health Information provided in 45 CFR Part 160 & Part 164, Subparts A and C.

P. “Unsecured Protected Health Information” or “Unsecured PHI” means any “protected health information” as defined in 45 CFR §§164.501 and 160.103 that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the HHS Secretary in the guidance issued pursuant to the HITECH Act and codified at 42 USC §17932(h).

2. Use and Disclosure of PHI

A. Except as otherwise provided in this BAA, Business Associate may use or disclose PHI as reasonably necessary to provide the services described in the Agreement to Covered Entity, and to undertake other activities of Business Associate permitted or required of Business Associate by this BAA or as required by law.

B. Except as otherwise limited by this BAA or federal or state law, Covered Entity authorizes Business Associate to use the PHI in its possession for the proper management and administration of Business Associate’s business and to carry out its legal responsibilities. Business Associate may disclose PHI for its proper management and administration, provided that (i) the disclosures are required by law; or (ii) Business Associate obtains, in writing, prior to making any disclosure to a third party (a) reasonable assurances from this third party that the PHI will be held confidential as provided under this BAA and used or further disclosed only as required by law or for the purpose for which it was disclosed to this third party and (b) an agreement from this third party to notify Business Associate immediately of any breaches of the confidentiality of the PHI, to the extent it has knowledge of the breach.



C. Business Associate will not use or disclose PHI in a manner other than as provided in this BAA, as permitted under the Privacy Rule, or as required by law. Business Associate will use or disclose PHI, to the extent practicable, as a limited data set or limited to the minimum necessary amount of PHI to carry out the intended purpose of the use or disclosure, in accordance with Section 13405(b) of the HITECH Act (codified at 42 USC §17935(b)) and any of the act's implementing regulations adopted by HHS, for each use or disclosure of PHI.

D. Upon request, Business Associate will make available to Covered Entity any of Covered Entity's PHI that Business Associate or any of its agents or subcontractors have in their possession.

E. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502(j)(1).

3. Safeguards Against Misuse of PHI

Business Associate will use appropriate safeguards to prevent the use or disclosure of PHI other than as provided by the Agreement or this BAA and Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate agrees to take reasonable steps, including providing adequate training to its employees to ensure compliance with this BAA and to ensure that the actions or omissions of its employees or agents do not cause Business Associate to breach the terms of this BAA.

4. Reporting Disclosure of PHI and Security Incidents

Business Associate will report to Covered Entity in writing any use or disclosure of PHI not provided for by this BAA of which it becomes aware and Business Associate agrees to report to Covered Entity any Security Incident affecting Electronic PHI of Covered Entity of which it becomes aware. Business Associate agrees to report any such event within five business days of becoming aware of the event.

5. Reporting Breaches of Unsecured PHI

Business Associate will notify Covered Entity in writing promptly upon the discovery of any Breach of Unsecured PHI in accordance with the requirements set forth in 45 CFR §164.410, but in no case later than 30 calendar days after discovery of a Breach. Business Associate will reimburse Covered Entity for any costs incurred by it in complying with the requirements of Subpart D of 45 CFR §164 that are imposed on Covered Entity as a result of a Breach committed by Business Associate.



6. Mitigation of Disclosures of PHI

Business Associate will take reasonable measures to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of any use or disclosure of PHI by Business Associate or its agents or subcontractors in violation of the requirements of this BAA.

7. Agreements with Agents or Subcontractors

Business Associate will ensure that any of its agents or subcontractors that have access to, or to which Business Associate provides, PHI agree in writing to the restrictions and conditions concerning uses and disclosures of PHI contained in this BAA and agree to implement reasonable and appropriate safeguards to protect any Electronic PHI that it creates, receives, maintains or transmits on behalf of Business Associate or, through the Business Associate, Covered Entity. Business Associate shall notify Covered Entity, or upstream Business Associate, of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 1.M. of this BAA. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract by placement of such notice on the Business Associate's primary website. Business Associate shall ensure that all subcontracts and agreements provide the same level of privacy and security as this BAA.

8. Audit

Upon request, Business Associate will provide Covered Entity, or upstream Business Associate, with a copy of its most recent independent HIPAA compliance report (AT-C 315), HITRUST certification or other mutually agreed upon independent standards based third party audit report. Covered entity agrees not to re-disclose Business Associate's audit report.

9. Access to PHI by Individuals

A. Upon request, Business Associate agrees to furnish Covered Entity with copies of the PHI maintained by Business Associate in a Designated Record Set in the time and manner designated by Covered Entity to enable Covered Entity to respond to an Individual's request for access to PHI under 45 CFR §164.524.

B. In the event any Individual or personal representative requests access to the Individual's PHI directly from Business Associate, Business Associate within ten business days, will forward that request to Covered Entity. Any disclosure of, or decision not to disclose, the PHI requested by an Individual or a personal representative and compliance with the requirements applicable to an Individual's right to obtain access to PHI shall be the sole responsibility of Covered Entity.

10. Amendment of PHI



A. Upon request and instruction from Covered Entity, Business Associate will amend PHI or a record about an Individual in a Designated Record Set that is maintained by, or otherwise within the possession of, Business Associate as directed by Covered Entity in accordance with procedures established by 45 CFR §164.526. Any request by Covered Entity to amend such information will be completed by Business Associate within 15 business days of Covered Entity's request.

B. In the event that any Individual requests that Business Associate amend such Individual's PHI or record in a Designated Record Set, Business Associate within ten business days will forward this request to Covered Entity. Any amendment of, or decision not to amend, the PHI or record as requested by an Individual and compliance with the requirements applicable to an Individual's right to request an amendment of PHI will be the sole responsibility of Covered Entity.

11. Accounting of Disclosures

A. Business Associate will document any disclosures of PHI made by it to account for such disclosures as required by 45 CFR §164.528(a). Business Associate also will make available information related to such disclosures as would be required for Covered Entity to respond to a request for an accounting of disclosures in accordance with 45 CFR §164.528. At a minimum, Business Associate will furnish Covered Entity the following with respect to any covered disclosures by Business Associate: (i) the date of disclosure of PHI; (ii) the name of the entity or person who received PHI, and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure which includes the basis for such disclosure.

B. Business Associate will furnish to Covered Entity information collected in accordance with this Section 10, within ten business days after written request by Covered Entity, to permit Covered Entity to make an accounting of disclosures as required by 45 CFR §164.528, or in the event that Covered Entity elects to provide an Individual with a list of its business associates, Business Associate will provide an accounting of its disclosures of PHI upon request of the Individual, if and to the extent that such accounting is required under the HITECH Act or under HHS regulations adopted in connection with the HITECH Act.

C. In the event an Individual delivers the initial request for an accounting directly to Business Associate, Business Associate will within ten business days forward such request to Covered Entity.

12. Availability of Books and Records



Business Associate will make available its internal practices, books, agreements, records, and policies and procedures relating to the use and disclosure of PHI, upon request, to the Secretary of HHS for purposes of determining Covered Entity's and Business Associate's compliance with HIPAA, and this BAA.

13. Responsibilities of Covered Entity

With regard to the use and/or disclosure of PHI by Business Associate, Covered Entity agrees to:

A. Notify Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. Notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C. Notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. Except for data aggregation or management and administrative activities of Business Associate, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Covered Entity.

14. Data Ownership

Business Associate's data stewardship does not confer data ownership rights on Business Associate with respect to any data shared with it under the Agreement, including any and all forms thereof.

15. Term and Termination

A. This BAA will become effective upon execution by the Covered Entity's City Manager, Deputy City Manager, or Assistant City Manager, and will continue in effect until all obligations of the Parties have been met under the Agreement and under this BAA, unless earlier terminated in accordance with the terms of this BAA.

B. Covered Entity may terminate immediately this BAA, the Agreement, and any other related agreements if Covered Entity determines that Business Associate has breached a material term of this BAA and Business Associate has failed to cure that material breach, to Covered Entity's reasonable satisfaction, within 30 days after written notice from Covered Entity.



Covered Entity may report the problem to the Secretary of HHS if termination is not feasible. Notwithstanding the foregoing, Covered Entity may also terminate the Agreement any other related agreements as provided by the terms of such agreements. Additionally, Covered Entity may terminate this BAA for convenience upon 30 days' prior written notice to Business Associate.

C. If Business Associate determines that Covered Entity has breached a material term of this BAA, then Business Associate will provide Covered Entity with written notice of the existence of the breach and shall provide Covered Entity with 30 days to cure the breach. Covered Entity's failure to cure the breach within the 30-day period will be grounds for immediate termination of the Agreement and this BAA by Business Associate. Business Associate may report the breach to HHS.

D. Upon termination of the Agreement or this BAA for any reason, all PHI maintained by Business Associate will be returned to Covered Entity or destroyed by Business Associate. Business Associate will not retain any copies of such information. This provision will apply to PHI in the possession of Business Associate's agents and subcontractors. If return or destruction of the PHI is not feasible, in Business Associate's reasonable judgment, Business Associate will furnish Covered Entity with notification, in writing, of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of the PHI is infeasible, Business Associate will extend the protections of this BAA to such information for as long as Business Associate retains such information and will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible. The Parties understand that this Section 14.D. will survive any termination of this BAA.

16. Effect of BAA

A. This BAA is a part of and subject to the terms of the Agreement, except that to the extent any terms of this BAA conflict with any term of the Agreement, the terms of this BAA will govern.

B. Except as expressly stated in this BAA or as provided by law, this BAA will not create any rights in favor of any third party.

17. Regulatory References

Regulatory References. A reference in this BAA to a section in HIPAA means the section as in effect or as amended at the time.



18. Notices

Notices required pursuant to the provisions of this BAA will be conclusively determined to have been delivered when (1) hand-delivered to the other party, its agents, employees, servants or representatives, (2) delivered by facsimile with electronic confirmation of the transmission, or (3) received by the other party by United States Mail, registered, return receipt requested, addressed as follows:

| | |
|---|---|
| <p>To Covered Entity:</p> <p>City of Fort Worth Attn: Assistant City Manager 100 Fort Worth Trail Fort Worth, TX 76102-6314 Facsimile: (817) 392-8654</p> <p>With copy to Fort Worth City Attorney's Office at same address</p> | <p>To Business Associate:</p> <p>City of Saginaw Attn: City Manager 333 W McLeroy Blvd Saginaw, TX 76179 Facsimile: 817-232-4644</p> <p>With copy to the Saginaw Fire Chief at same address</p> |
|---|---|

19. Amendments and Waiver

This BAA may not be modified, nor will any provision be waived or amended, except in writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

20. HITECH Act Compliance

The Parties acknowledge that the HITECH Act includes significant changes to the Privacy Rule and the Security Rule. The privacy subtitle of the HITECH Act sets forth provisions that significantly change the requirements for business associates and the agreements between business associates and covered entities under HIPAA and these changes may be further clarified in forthcoming regulations and guidance. Each Party agrees to comply with the applicable provisions of the HITECH Act and any HHS regulations issued with respect to the HITECH Act. The Parties also agree to negotiate in good faith to modify this BAA as reasonably necessary to comply with the HITECH Act and its regulations as they become effective but, in the event that the Parties are unable to reach agreement on such a modification, either Party will have the right to terminate this BAA upon 30- days' prior written notice to the other Party.



[Executed effective as of the date signed by the Assistant City Manager below.] / [ACCEPTED AND AGREED:]

| | |
|---|--|
| Covered Entity: By: _____ Name: [REDACTED] Title: Assistant City Manager Date: _____ | Business Associate By: _____ Name: Todd Flippo Title: Mayor Date: _____ |
|---|--|

CITY OF FORT WORTH INTERNAL ROUTING PROCESS:

| | |
|--|--|
| Approval Recommended: By: _____ Name: [REDACTED] Title: [REDACTED] Approved as to Form and Legality: By: _____ Name: Taylor C. Paris Title: Assistant City Attorney | Contract Compliance Manager: By signing I acknowledge that I am the person responsible for the monitoring and administration of this contract, including ensuring all performance and reporting requirements. By: _____ Name: [REDACTED] Title: [REDACTED] City Secretary: By: _____ Name: Jannette S. Goodall Title: City Secretary |
|--|--|



F. Action Regarding the Switchyard Cinco de Mayo Festival -- Ericka Gambill, Special Events and Food Truck Tech

| Meeting | Agenda Group |
|------------------------------------|--------------------------|
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2F. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

Memo attached.

Parks Board reviewed and approved at the January 12, 2026, meeting.

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

N/A

Attachments

[Memo--Action Regarding Cinco de Mayor Event at Switchyard..pdf](#)



To: Mayor and City Council

From: Ericka Y. Gambill Special Events and Food Truck Tech.

Subject: Switchyard Cinco de Mayo / Taco Tuesday Festival

Purpose

The purpose of this memo is to request City Council consideration and **funding support** for the **Switchyard Cinco de Mayo / Taco Tuesday Festival**. The event and funding support request have been **reviewed and approved by the Parks Board**, and the requested funding would assist with providing additional entertainment and family-friendly activities to enhance the overall quality and reach of the event.

Event Overview

The Switchyard Cinco de Mayo / Taco Tuesday Festival is a family-friendly community event celebrating culture, food, and music.

- **Date:** May 5, 2026
- **Time:** 4:30 PM – 9:30 PM
- **Location:** The Switchyard

The event is designed to bring residents together, utilize public space in a positive way, and encourage community participation through cultural programming.

What Has Already Been Secured

Several event elements have already been confirmed through partnerships and in-kind support:

- A Mariachi band funded through the ArtsNet fund
- A caricature artist from Moss Animation volunteering his services
- Sound system support provided by School of Rock

These commitments reduce the overall cost of the event and demonstrate strong collaboration with local organizations and businesses.



Confirmed Food Vendors

(as of January 12, 2026)

- Salsazón
- Tochaditas Venezuelan Food
- Kona Ice

Additional food vendors may be added as space allows.

Funding Request and Intended Use

We are requesting **\$1,500**. If approved, funds would be used for the following:

- Additional live music and/or a Ballet Folklórico performance
- Balloon artists and/or other family-friendly entertainment
- Arts and crafts and/or interactive stations for children
- Cinco de Mayo-themed décor for park pavilions

These enhancements would further strengthen the festival experience and increase engagement for attendees of all ages.

Community Benefit

- Promotes community engagement and attendance at the Switchyard
- Provides cultural enrichment through live performances and interactive programming
- Supports a safe, inclusive, and family-oriented community event
- Encourages positive and continued use of public facilities

Conclusion

Thank you for your consideration and continued support of community events.



G. Action Regarding the Independence Day Fireworks Show -- Jason England, Assistant Recreation Services Manager

| | |
|------------------------------------|--------------------------|
| Meeting | Agenda Group |
| Tuesday, January 20, 2026, 6:00 PM | Consent Agenda Item: 2G. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

Pyro Shows is the fireworks vendor we have used for the past few years at our Independence Day Celebration. We were able to book them for this year’s event on Saturday, June 27, 2026. The cost for this years show is \$30,250.00 with a 50% (\$15,125.00) deposit due when we sign the contract. Last year’s fireworks cost was \$25,000. The \$5,250.00 increase for this years firework show is due to the nationwide tariffs and a company price increase.

FINANCIAL IMPACT:

\$30,250.00 from the Parks Donation Fund.

RECOMMENDATION:

Staff recommends approval.

The Parks Advisory Board unanimously voted to recommend the use of \$30,250.00 from the Parks Donation Fund at their meeting on January 12, 2026

Attachments

[QUOTE - Saginaw 0627 2026.pdf](#)

[Contract-Saginaw 0627 2026.pdf](#)

[Saginaw_idc_deposit-invoice_26-TX-0627-C-28738-000045.pdf](#)



PYRO SHOWS OF TEXAS, INC.
Contract Agreement

This Agreement made on Jan 13, 2026, by and between PYRO SHOWS OF TEXAS INC., a Texas Corporation, whose address is 6601 Nine Mile Azle Road, Fort Worth, Texas 76135, with a mailing address at P.O. Box 1776, LaFollette, TN 37766 and hereinafter referred to as "PYRO SHOWS" and Saginaw, City of with its principal place of business located at P. O. Box 79070 Saginaw, Texas 76179 hereinafter referred to as "Customer".

In consideration of the mutual promises and undertakings set forth herein, receipt of said consideration being acknowledged, the parties hereby agree as follows:

- I. **FIREWORKS DISPLAY:** PYRO SHOWS agrees to furnish to Customer a fireworks display, hereinafter referred to as "Show", pursuant to the project/sales order # 26 TX 06-27-Custom-28738-000045 dated Jan 13, 2026. The Show(s) will be given on June 27, 2026. Rain date/postponement date: July 5 2026
- II. **TARIFF PROVISION:** Because our pyrotechnics are products which are primarily imported into the U.S., PYRO SHOWS is legally responsible for payment of any applicable tariffs (a border tax imposed on the buyer) for pyrotechnics. From the date of execution of the contract herein, in the event of additional cost due to increased price of product as imposed by manufacturer and/or tariffs levied for imported products. Available options are as follows: Customer may opt to increase their budget to absorb tariff - OR - Customer may maintain the current budget of their show with a corresponding reduction in the amount of product included in their show. Should Customer elect to defer, modify, or cancel Show, Customer shall notify PYRO SHOWS no less than ninety (90) days prior to Show date to cancel or reduce the size of show.
- III. **CANCELLATION:** PYRO SHOWS shall determine what weather conditions prohibit PYRO SHOWS from proceeding with the Show; in which case, PYRO SHOWS agrees to present the Show on the following day or previously agreed upon postponement date. In addition to contracted Show cost, Customer shall remit the actual additional expenses PYRO SHOWS shall incur in presenting the show on subsequent occasion to include labor, lodging, per diem, etc.; in no event shall these additional expenses be less than ten percent (10%) of the contracted price of the Show. In the event the Show must be RESCHEDULED to a mutually agreed upon date other than the previously agreed upon rain date, in addition to contracted Show cost, Customer shall remit the actual additional expenses PYRO SHOWS shall incur in presenting the Show on subsequent occasion to include labor, lodging, per diem etc.; in no event shall these expenses be less than thirty percent (30%) of the contracted price of the Show. Should Customer elect to CANCEL the Show for any reason, Customer must provide PYRO SHOWS with thirty (30) days' written notice by certified mail, return receipt, to PYRO SHOWS' address as set forth above. Customer agrees that PYRO SHOWS shall incur substantial expense in preparation for the Show and, accordingly, agrees to pay PYRO SHOWS fifty (50%) of the total contract price for the show as liquidated damages for cancellation due to the fault of the Customer.
- IV. **SECURITY AREA:** Customer agrees to furnish sufficient space for PYRO SHOWS to properly conduct the Show as determined by NFPA 1123-2014 (hereinafter "Security Area"). Customer agrees to provide adequate security protection to preclude persons unauthorized by PYRO SHOWS from entering the Security Area. For the purposes of the Agreement, "Unauthorized Persons" shall mean anyone other than the employee(s) of PYRO SHOWS or persons specifically designated in writing by the sponsor or the Authority Having Jurisdiction (AHJ), and submitted and approved, to PYRO SHOWS prior to the event. Any expenses for security or stand-by fire protection shall be the responsibility of the Customer.
- V. **SITE CLEANUP:** PYRO SHOWS shall be responsible for basic cleanup of the launch area to include policing of the fallout zone for any unexploded ordnance and removal of all large paper debris, wood, wire, foil, racks, mortars and firing equipment used in the setup for the show. Customer shall be responsible for cleanup of debris located in and around the fallout zone.
- VI. **INDEMNIFICATION AND HOLD HARMLESS:** Customer agrees to hold PYRO SHOWS harmless from any damages caused to Customer which result as a consequence of unauthorized persons entering the Security Area. Furthermore, Customer agrees to defend and indemnify PYRO SHOWS from any and all claims brought against PYRO SHOWS for damages caused wholly or in part by Unauthorized Person who have entered the Security Area.
- VII. **AMENDMENT & ASSIGNMENT:** This agreement is deemed personal and confidential to Customer, his heirs, executors and administrators only, and may not be sold, assigned, amended, or transferred without the prior written consent of PYRO SHOWS.



PYRO SHOWS OF TEXAS, INC.
Contract Agreement

- VIII. COMPLIANCE WITH THE LAWS AND REGULATIONS:** Promptly upon the execution of this Agreement, Customer shall apply for the approval hereof to any agency, officer or authority of any government if such approval is required by any applicable law, ordinance, code or regulation. Customer agrees to indemnify and hold harmless PYRO SHOWS from all claims, suits, causes of action, demands, penalties, losses or damages which may arise or accrue because of the failure or neglect of Customer to obtain the necessary approval(s). This Agreement is made expressly subject to, and Customer expressly agrees to comply with and abide by all applicable laws, ordinances, codes and regulations insofar as the same may be applicable to the terms and conditions of this Agreement, including all rules and regulations now existing or that may be promulgated under and in accordance with any such law or laws.
- IX. PERMITS AND LICENSES:** PYRO SHOWS shall process the necessary permits and licenses to enable PYRO SHOWS to perform fully hereunder unless otherwise forbidden by any other applicable statute, rule or otherwise. It is hereby stipulated that this Agreement is to be construed and governed by the laws of the State of Texas, and any suit involving this contract shall be brought in the Courts of Tarrant County in the State of Texas. The Customer hereby submits itself to the jurisdiction of said Courts and waives any rights to initiate proceedings against PYRO SHOWS in any other courts or jurisdictions. For Shows that include licensed music accompaniment, Customer agrees to verify with their organization, venue, sponsor, and/or municipality, the permission to simulcast music and agrees to pay any and all fees associated with the broadcast of said music in the public environment of the Show.
- X. LATE PAYMENT:** PYRO SHOWS shall charge, and Customer agrees to pay, one- and one-half percent (1 1/2%) per month late payment fee for each month until PYRO SHOWS is paid the amount set forth in Paragraph XIV herein. The stated late payment fee shall begin to run from the applicable date(s) established in Section XIV, unless this provision is prohibited by law.
- XI. ADVERTISEMENT AND PROMOTIONS:** Customer agrees that when promoting fireworks performed by PYRO SHOWS, Customer will name PYRO SHOWS as the fireworks provider in promotional advertising media. Customer agrees to allow PYRO SHOWS to use Customer's name as Customer.
- XII. COMPLAINTS:** In the event that Customer has a complaint concerning the Show, or any material or product used in or pursuant to the Show, or of the conduct of the Show by PYRO SHOWS, or any act or omission of PYRO SHOWS or its agents, either directly or indirectly, without limitation, Customer shall make complaint known to PYRO SHOWS in writing by certified mail to PYRO SHOWS' address as set forth above, within ten (10) days after the date of the Show. In the event that Customer fails to register any complaint in the time and in the manner specified, Customer agrees that it shall not claim such complaint as cause for an offset or withhold any payment due to PYRO SHOWS hereunder on account of or because of such complaint or any matter arising from, relating to or a consequence of the complaint. Furthermore, Customer agrees that should PYRO SHOWS have to collect any amount due PYRO SHOWS hereunder which Customer claims as an offset or which is withheld by Customer on account of, or because of, a complaint not registered with PYRO SHOWS in the time and in the manner specified herein, by law or through an Attorney-at-Law, PYRO SHOWS shall be entitled to collect attorneys' fees in the amount of 15% of the amount owing PYRO SHOWS or the maximum amount allowed by law, whichever is greater, along with all cost of collection.
- XIII. INSURANCE:** PYRO SHOWS will provide General Liability Insurance and Automobile Liability in the amount of \$10,000,000.00, combined single limit, covering its activities and services in connection with the show described in this contract. PYRO SHOWS also agrees to include Customer as an Additional Insured under the terms of this coverage. PYRO SHOWS will provide a Certificate of Insurance. All entities listed on the certificate will be deemed Additional Insured per this contract.
- XIV. TAXES:** Customer shall be responsible for all applicable sales taxes.



PYRO SHOWS OF TEXAS, INC.
Contract Agreement

PAYMENT TERMS: Saginaw, City of shall pay PYRO SHOWS:

| | |
|------------------------------|----------------------------|
| Show Amount | <u>\$ 28,737.50</u> |
| Tariff Surcharge | <u>\$ 1,436.88</u> |
| Sales Tax (if applicable) | <u>\$ 0.00</u> |
| Total Contract Amount | <u>\$ 30,174.38</u> |

Customer shall submit a 50% deposit (**\$ 15,087.19**) upon return of the signed contract by **February 12, 2026**. Balance will be due in the PYRO SHOWS office upon Customer's receipt of invoice.

IMPORTANT: Checks must be made payable to **PYRO SHOWS OF TEXAS, INC.** and mailed to P.O. Box 1776, LaFollette, TN 37766.

All the terms and conditions set forth in any addendum attached to this Agreement are made part of this Agreement and incorporated by reference herein.

IN WITNESS WHEREOF, the parties have hereunto set their hands and seals the day and year first above written.

PYRO SHOWS OF TEXAS, INC.

BY: _____ DATE: _____
Chad Stanley, Vice President

CUSTOMER

BY: _____ DATE: _____
Signature Printed Name Title

WARRANTY EXCLUSIONS

EXCEPT AS SPECIFICALLY PROVIDED HEREIN, THERE ARE NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

No representation of affirmation of fact including but not limited to statement regarding capacity, suitability for use, or performance of equipment or products shall be, or be deemed to be, a warranty by PYRO SHOWS for any purpose, nor give rise to any liability or obligation of PYRO SHOWS whatsoever.

IN NO EVENT SHALL PYRO SHOWS BE LIABLE FOR ANY LOSS OF PROFITS OR OTHER ECONOMIC LOSS, INDIRECT, SPECIAL, CONSEQUENTIAL, OR OTHER SIMILAR DAMAGES ARISING OUT OF ANY CLAIMED BREACH OF OBLIGATIONS HEREUNDER.



Pyro Shows of Texas, Inc

6601 Nine Mile Azle Rd
Fort Worth, TX 76135

Deposit Invoice

| Date | Invoice # |
|-----------|------------|
| 1/13/2026 | 26TX000045 |

| Name / Address |
|--|
| City of Saginaw PO Box 79070 Saginaw, TX 76179 |

| Project | P.O. No. | Show Date | Terms |
|--|----------------------|--------------|-------------|
| | Saginaw Independence | 6/27/2026 | Net 30 |
| Description | Deposit Due | Total | |
| Deposit Due per Contract Agreement: Saginaw; Saginaw Independence 06/27/2026 | 15,087.19 | 15,087.19 | |
| Contract # 26-TX-0627-C-28738-000045 Total: \$30,174.38 | | | |
| <p><i>Please Remit to:</i> Pyro Shows of Texas, Inc. P.O. Box 1776 LaFollette, TN 37766</p> | | | |
| We appreciate your prompt payment. | | Total | \$15,087.19 |



A. Consideration and Action Regarding Amendment to Zoning Ordinance, Appendix A "Zoning", Section 8-6, Sub-Section D, Relating to Carports-- Doug Spears, Fire Chief

| | |
|------------------------------------|---------------------------|
| Meeting | Agenda Group |
| Tuesday, January 20, 2026, 6:00 PM | Public Hearings Item: 4A. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

See attached:

Carport Memo 1-5-2025

Ordinance Amending Zoning Ord Carport Requirements January 2026 - *Current consideration for action*

Ordinance 2022-08 Amending Carport Regulations adding SUP Requirements 8-18-2022 - *This amendment removed the then existing Carport Overlay District and allowed carports city-wide in applicable zoning via a Specific Use Permit*

Ordinance 2025-09 Amending the Req of a SUP for Carports 7-15-2025 - *This amendment removed the SUP requirement and instead allowed carports by right city-wide in applicable zoning*

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

While staff remains neutral, the amendment revisions for consideration do provide reasonable and achievable solution(s) to meet what staff understands to be the desired intent.

Attachments

[Ordinance Amending Zoning Ord Carport Requirements January 2026.pdf](#)

[Carport Memo 1-5-2025.pdf](#)

[Ordinance 2022-08 Amending Carport Regulations adding SUP Requirement 8-18-2022.pdf](#)

[Ordinance 2025-09 Amending the Req of a SUP for Carports 7-15-2025.pdf](#)

[Carports \(Textural Amendment, Notice, Newspaper\).pdf](#)

ORDINANCE NO. 2025-__

AN ORDINANCE OF THE CITY OF SAGINAW, TEXAS, AMENDING SUBPART 1 “INSTALLATION AND DESIGN,” OF SUBSECTION D “CARPORTS,” OF SECTION 8-6, “MISCELLANEOUS REQUIREMENTS,” OF ARTICLE 8, “SUPPLEMENTAL DISTRICT REGULATIONS,” OF APPENDIX A, “ZONING,” OF THE SAGINAW CITY CODE, TO AMEND INSTALLATION AND DESIGN REQUIREMENTS FOR CARPORTS; PROVIDING THAT THIS ORDINANCE SHALL BE CUMULATIVE OF ALL ORDINANCES; PROVIDING A SEVERABILITY CLAUSE; PROVIDING FOR A SAVINGS CLAUSE; PROVIDING A PENALTY CLAUSE; PROVIDING FOR PUBLICATION IN THE OFFICIAL NEWSPAPER; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City of Saginaw, Texas (the “City), is a home rule city acting under its Charter adopted by the electorate pursuant to Article XI, Section 5 of the Texas Constitution and Chapter 9 of the Local Government Code; and

WHEREAS, the City Council has previously adopted an ordinance amending the carport regulations of the municipality; and

WHEREAS, the City Council wishes to further clarify the carport regulations of the municipality; and

WHEREAS, the City has a substantial interest in protecting the health, safety, welfare, convenience, and enjoyment of the general public and has adopted zoning regulations to further this interest; and

WHEREAS, public hearings in accordance with the requirements of the Local Government Code were held after proper notice of these hearings was given in accordance with said Code; and

WHEREAS, the City Council does hereby deem it advisable and in the public interest to amend the City’s zoning ordinance as described herein.

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF SAGINAW, TEXAS, THAT:

SECTION 1.

Subpart 1, “Installation and Design,” of Subsection D, “Carports,” of Section 8-6, “Miscellaneous requirements,” of Article 8, “Supplemental District Regulations,” of Appendix A, “Zoning,” of the Saginaw City Code is hereby amended to read as follows:

- “1. *Installation and design.* The installation and design of carports shall meet the following standards:
- a. No more than one (1) carport shall be permitted per residential lot, unless otherwise approved by the city council.
 - b. Except as provided in subsection j., below, no carport may exceed more than 600 square feet in roofed area.
 - c. No carport may exceed more than ten (10') feet in clear opening height for any open sided area.
 - d. Except as provided in subsection j., below, carports shall maintain the required side yard setback from the property lines according to the applicable zoning district or approved development agreement.
 - e. The front setback for carports shall be a minimum of ten (10') feet from the back of the curb, but in no case shall any portion of the carport project beyond any property line.
 - f. Construction is encouraged to be compatible in both design and materials with the primary structure to mirror or maintain the characteristics of the primary structure, adjacent properties and neighborhood. Construction shall meet the requirements of the city building code and other applicable codes as adopted by the city and require permitting prior to construction.
 - g. Approved materials:
 1. Wood framing and decking meeting the current adopted codes.
 2. Metal C-Purlin & Receiver Minimum 14 gauge.
 3. 0' - 12' in length = 6'' C-Purlin, 0' - 20' in length = 8'' C-Purlin.
 4. Minimum 14-gauge 4x4 steel post.
 5. Minimum 10'' round pier hole.
 6. Minimum buried depth 1/3 height of post.
 7. Minimum 26-gauge R- panel.
 8. Composition shingle allowed > 2:12 roof pitch for wood framed.
 9. Other approved materials.
 - h. Prohibited materials:
 1. Corrugated roofing.
 2. Fiberglass roofing.
 3. Corrugated asphalt roofing.
 4. Rolled roofing.
 - i. Manufactured carport construction shall incorporate associated trim kits or finishing trim. Non-manufactured carports shall incorporate trim components to conceal seams and provide a finished construction appearance.

- j. With the approval of a Specific Use Permit in a zoning district that otherwise allows the installation of a carport, a carport may exceed 600 square feet in roofed area and/or may encroach into the side yard setback. In the permitted erection, repair or remodel of any carport pursuant to this subsection j., if a known drainage problem exists, or if, in the sole opinion of the Chief Building Official, a drainage problem is likely to be created or compounded, an engineered drainage study for mitigation may be required with the cost of said study to be borne by the applicant. In situations where the side yard property boundary location is not known with certainty, an application for a Specific Use Permit seeking permission to encroach into a side yard setback must include a valid survey of the property on which the carport is proposed to be installed. Said survey must: i) clearly identify the property boundaries, ii) include the dimensions of the proposed carport structure's location on the property in reference to property boundaries, and, iii) clearly demonstrate that the proposed carport will not encroach upon the property line. The Chief Building Official shall determine whether a legal survey of the property shall be required. Costs associated with the survey shall be borne by applicant."

SECTION 2.

This Ordinance shall be cumulative of all other ordinances of the City and shall not repeal any of the provisions of such ordinances, except in those instances where provisions of such ordinances are in direct conflict with the provisions of this Ordinance.

SECTION 3.

That it is hereby declared to be the intention of the City Council that the sections, paragraphs, sentences, clauses, and phrases of this Ordinance are severable, and if any phrase, clause, sentence, paragraph, or section of this Ordinance shall be declared void, ineffective, or unconstitutional by the valid judgment or decree of any court of competent jurisdiction, such voidness, ineffectiveness, or unconstitutionality shall not affect any of the remaining phrases, clauses, sentences, paragraphs, or sections of this Ordinance, since the same would have been enacted by the City Council without the incorporation herein of any such void, ineffective, or unconstitutional phrase, clause, sentence, paragraph, or section.

SECTION 4.

That all rights or remedies of the City are expressly saved as to any and all violations of the Saginaw City Code or any amendments thereto regarding carports or permitted uses that have accrued at the time of the effective date of this Ordinance; and as to such accrued violations, and all pending litigation, both civil or criminal, same shall not be affected by this Ordinance but may be prosecuted until final disposition by the courts.

SECTION 5.

Any person, firm, or corporation who violates, disobeys, omits, neglects, or refuses to

comply with or who resists the enforcement of any of the provisions of this Ordinance shall be fined not more than Two Thousand Dollars (\$2,000.00) for each violation of this Ordinance. Each day that a violation is permitted to exist shall constitute a separate offense.

SECTION 6.

The City Secretary of the City is hereby directed to publish at least twice in the official newspaper of the City, the caption and the penalty clause of this Ordinance in accordance with Section 52.013(b) of the Local Government Code.

SECTION 7.

This Ordinance shall be in full force and effect from and after its date of passage and publication as required by law and it is so ordained.

PASSED AND APPROVED ON this the _____ day of _____ 2026.

Todd Flippo, Mayor

ATTEST:

Vicky Vega, City Secretary

APPROVED AS TO FORM AND LEGALITY:

Bryn Meredith, City Attorney



Saginaw Fire Department

700 W McLeroy Blvd. Saginaw, Texas 76179
Tel: 817-230-0412 Fax: 817-232-3731

DOUG SPEARS
FIRE CHIEF

TO: City Council, Staff, Planning and Zoning Commission

FROM: Fire Chief / Building and Code Compliance Director Doug Spears

DATE: February 5, 2025

RE: Amendment to the Carport Ordinance

Attached is an amendment to Saginaw Municipal Code Section 8-6 "*Miscellaneous Requirements - Sub Section D*" pertaining to the regulation of carports. Amendment to the existing ordinance establishes formal discretion for situations of unique or special circumstance. See Section 1-j. In zoning where carports are currently allowed, through the established Specific Use Permit (SUP) process, a carport may be allowed to exceed the current maximum of 600 square feet in roofed area and/or encroach into the applicable zoning side yard setback dimensions.

While unique or special circumstances relating to carports are rare, they can and do exist. The currently adopted ordinance leaves staff and elected governing officials zero flexibility for resolution consideration. The proposed amendment allows reasonable flexibility with the safeguard of formal discretion via the SUP process. In the event a carport SUP is submitted, the amendment incorporates, when necessary, staff tools regarding drainage and property boundaries to address those respective concerns.

With the guidance of City Council, and legal counsel coordination with staff, amendment to the carport ordinance is proposed for your consideration.

ORDINANCE NO. 2022-08

AN ORDINANCE OF THE CITY OF SAGINAW, TEXAS, AMENDING APPENDIX A - ZONING OF THE SAGINAW CITY CODE, TO AMEND REGULATIONS GOVERNING THE PLACEMENT OF CARPORTS WITHIN THE CITY; PROVIDING A DEFINITION OF CARPORT; PROVIDING FOR STANDARDS GOVERNING INSTALLATION AND DESIGN; PROVIDING FOR ADDITIONAL REGULATIONS GOVERNING CARPORTS LOCATED WITHIN LI AND HI ZONING DISTRICTS; REPEALING THE CARPORT OVERLAY DISTRICT; PROVIDING THAT THIS ORDINANCE SHALL BE CUMULATIVE OF ALL ORDINANCES; PROVIDING A SEVERABILITY CLAUSE; PROVIDING FOR A SAVINGS CLAUSE; PROVIDING A PENALTY CLAUSE; PROVIDING FOR PUBLICATION IN THE OFFICIAL NEWSPAPER; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City of Saginaw, Texas is a home rule City acting under its Charter adopted by the electorate pursuant to Article XI, Section 5 of the Texas Constitution and Chapter 9 of the Local Government Code; and

WHEREAS, the City has a substantial interest in protecting the health, safety, welfare, convenience and enjoyment of the general public and has adopted zoning regulations to further this interest; and

WHEREAS, the City Council has previously adopted regulations governing the location, installation and design of carports within the City; and

WHEREAS, the City Council now deems it in the best interest of the public health, safety, morals and general welfare of the City to amend said regulations; and

WHEREAS, public hearings were held in accordance with the requirements of the Local Government Code after proper notice of these hearings was given in accordance with said Code.

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF SAGINAW, TEXAS, THAT:

SECTION 1.

Section 5-1. "Permitted use table" of Article 5 "Permitted Uses" of Appendix A-Zoning of the Saginaw City Code is hereby amended by amending the Accessory Use "Carport, Residential," to read as follows:

| ACCESSORY USES | | | | | | | | | | | Land Use Designation | Nonresidential | | | | | | Supplemental Conditions |
|----------------|---|---|---|---|---|---|---|---|---|---|-------------------------|----------------|---|---|---|---|---|-------------------------|
| A | S | S | S | S | S | D | Z | M | M | M | | O | N | C | C | L | H | |
| G | F | F | F | F | F | X | L | H | F | F | | P | C | C | F | I | I | |
| | 1 | 2 | 3 | 4 | A | | | | 1 | 2 | | | | | | | | |
| S | S | S | S | S | S | S | S | S | P | P | Carport, Residential | | | | P | P | P | 21 |

SECTION 2.

Section 5-2. "Special conditions for listed uses." of Article 5 "Permitted Uses" of Appendix A "Zoning" of the Saginaw City Code is hereby amended, by amending Special Condition "21" to read as follows:

"21. Must comply with regulations provided in Section 8-6.D., Carport."

SECTION 3.

Section 12-2. "Definitions" of Article 12 "Definitions" of Appendix A "Zoning" of the Saginaw City Code is hereby amended by adding a definition for carports, inserted alphabetically to read as follows:

"Carport. A structure which is allowed between the property line and the required front build line, is unenclosed by any coverings on at least three sides, and is an integral portion of the primary structure, constructed for the purpose of providing covering for the off-street parking of private vehicles."

SECTION 4.

Section 8-6. "Miscellaneous requirements." of Article 8 "Supplemental District Regulations" of Appendix A "Zoning" of the Saginaw City Code is hereby amended by adding subsection D. to read as follows:

"D. *Carports.* All carports constructed prior to the repeal of the carport overlay district, and which comply with other applicable provisions of the city code, are considered lawfully existing uses. All carports constructed on or after the effective date of this Ordinance shall comply with the regulations set forth in this subsection, other regulations contained in appendix A of this Code, and other applicable provisions of the city code.

1. Installation and design. The installation and design of carports shall meet the

following standards:

- a. No more than one carport shall be permitted per residential lot, unless otherwise approved by city council.
 - b. No carport may exceed more than 600 square feet in roofed area.
 - c. No carport may exceed more than ten feet in clear opening height for any open sided area.
 - d. Carports shall maintain the required side yard setback from the property lines according to the applicable zoning district or approved development agreement.
 - e. The front setback for carports shall be a minimum of ten feet from the back of the curb, but in no case shall any portion of the carport project beyond the property line.
 - f. Construction must be compatible in both design and materials with the primary structure and shall meet the requirements of the city building code as adopted by the city. However, the city council may modify construction design and material requirements when reviewing a specific use permit application and may impose different conditions for construction design and materials in approving any specific use permit.
2. Carports within property zoned LI or HI. All carports located within property zoned LI or HI shall be subject to the additional following regulations:
- a. No carports may be constructed over the building line on property abutting any one of the following roadways: Saginaw Boulevard (Business 287/81), Blue Mound Road (FM 156), McLeroy Boulevard, and Bailey Boswell Road.
 - b. The maximum depth of a carport shall be 20 feet.
 - c. The maximum width of carport shall not exceed maximum width of the primary building on the property.
 - d. No carport shall extend or overhang into any public right-of-way or easement.
 - e. All carports shall be engineered by a professional engineer who is licensed by the State of Texas.
 - f. No wood construction, corrugated barn tin, corrugated fiberglass or similar construction is permitted.

- g. Shade structures are permitted, provided they are designed in accordance with subsections e and f, above.
 - h. Any application permit for a carport under this section must also be approved by the city's fire department.
3. Fees. All permits and fees relating to development shall be subject to the requirements as established by the city."

SECTION 3.

Section 7-2. "Carport overlay district" of Article 7 "Special Districts" of Appendix A-"Zoning" of the Saginaw City Code, is hereby deleted in its entirety.

SECTION 4.

This ordinance shall be cumulative of all other ordinances of the City of Saginaw and shall not repeal any of the provisions of such ordinances, except in those instances where provisions of such ordinances are in direct conflict with the provisions of this ordinance.

SECTION 5.

It is hereby declared to be the intention of the City Council that the sections, paragraphs, sentences, clauses and phrases of this ordinance are severable, and if any phrase, clause, sentence, paragraph or section of this ordinance shall be declared void, ineffective or unconstitutional by the valid judgment or decree of any court of competent jurisdiction, such voidness, ineffectiveness, or unconstitutionality shall not affect any of the remaining phrases, clauses, sentences, paragraphs or sections of this ordinance, since the same would have been enacted by the City Council without the incorporation herein of any such void, ineffective or unconstitutional phrase, clause, sentence, paragraph or section.

SECTION 6.

All rights or remedies of the City of Saginaw, Texas, are expressly saved as to any and all violations of the Saginaw City Code or any amendments thereto regarding carports or the industrial carport overlay district that have accrued at the time of the effective date of this ordinance; and as to such accrued violations, and all pending litigation, both civil or criminal, same shall not be affected by this ordinance but may be prosecuted until final disposition by the courts.

SECTION 7.

Any person, firm, or corporation who violates, disobeys, omits, neglects or refuses to comply with or who resists the enforcement of any of the provisions of this ordinance shall be fined not more than Two Thousand Dollars (\$2000.00) for each violation of this ordinance. Each day that a violation is permitted to exist shall constitute a separate offense.

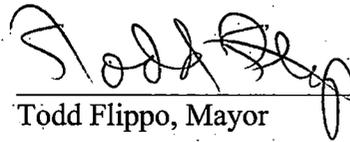
SECTION 8.

The City Secretary of the City of Saginaw is hereby directed to publish at least twice in the official newspaper of the City of Saginaw, the caption and the penalty clause of this ordinance in accordance with Section 52.013(b) of the Local Government Code.

SECTION 9.

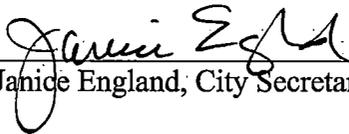
This ordinance shall take effect immediately from and after its passage and publication in accordance with the provisions of the laws of the State of Texas.

PASSED AND APPROVED ON this the 18th day of October, 2022.



Todd Flippo, Mayor

ATTEST:



Janice England, City Secretary



APPROVED AS TO FORM AND LEGALITY:



Bryn Meredith, City Attorney

ORDINANCE NO. 2025-09

AN ORDINANCE OF THE CITY OF SAGINAW, TEXAS, AMENDING APPENDIX A, "ZONING," OF THE SAGINAW CITY CODE TO AMEND SECTION 5-1, "PERMITTED USE TABLE" OF ARTICLE 5, "PERMITTED USES," AND SUBSECTION D OF SECTION 8-6, "MISCELLANEOUS REQUIREMENTS," OF ARTICLE 8, "SUPPLEMENTAL DISTRICT REGULATIONS," TO AMEND MISCELLANEOUS REQUIREMENTS FOR CARPORTS; PROVIDING THAT THIS ORDINANCE SHALL BE CUMULATIVE OF ALL ORDINANCES; PROVIDING A SEVERABILITY CLAUSE; PROVIDING FOR A SAVINGS CLAUSE; PROVIDING A PENALTY CLAUSE; PROVIDING FOR PUBLICATION IN THE OFFICIAL NEWSPAPER; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City of Saginaw, Texas (the "City"), is a home rule city acting under its Charter adopted by the electorate pursuant to Article XI, Section 5 of the Texas Constitution and Chapter 9 of the Local Government Code; and

WHEREAS, the City Council has previously adopted an ordinance amending the carport regulations of the municipality; and

WHEREAS, the City has a substantial interest in protecting the health, safety, welfare, convenience, and enjoyment of the general public and has adopted zoning regulations to further this interest; and

WHEREAS, public hearings in accordance with the requirements of the Local Government Code were held after proper notice of these hearings was given in accordance with said Code; and

WHEREAS, the City Council does hereby deem it advisable and in the public interest to amend the City's zoning ordinance as described herein.

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF SAGINAW, TEXAS, THAT:

SECTION 1.

Section 5-1, "Permitted use table," of Article 5, "Permitted Uses," of Appendix A, "Zoning," of the Saginaw City Code is hereby amended by amending the Accessory Uses section of the City of Saginaw Land Use Table, "Carport, Residential," to read as follows:

“

| ACCESSORY USES | | | | | | | | | | | Land Use Designation | Nonresidential | | | | | | | Supplemental Conditions |
|----------------|---|---|---|---|---|---|---|---|---|---|-------------------------|----------------|---|---|---|---|---|---|-------------------------|
| A | S | S | S | S | S | D | Z | M | M | M | | O | N | N | C | C | L | H | |
| G | F | F | F | F | F | X | L | H | F | F | | P | C | M | C | F | I | I | |
| | 1 | 2 | 3 | 4 | A | | L | | 1 | 2 | | | | U | | | | | |
| S | P | P | P | P | P | P | P | P | P | P | Carport, Residential | | | | | P | P | P | 21 |

”

SECTION 2.

Subsection D, “Carports,” of “Section 8-6, “Miscellaneous requirements,” of Article 8, “Supplemental District Regulations,” of the Saginaw City Code is hereby amended to read as follows:

“Sec. 8-6. D. - *Carports*. All carports constructed prior to the repeal of the carport overlay district, and which comply with other applicable provisions of the city code, are considered lawfully existing uses. All carports constructed on or after the effective date of the ordinance from which this section derives shall comply with the regulations set forth in this subsection, other regulations contained in appendix A of this Code, and other applicable provisions of the Zoning Code.

1. *Installation and design*. The installation and design of carports shall meet the following standards:
 - a. No more than one (1) carport shall be permitted per residential lot, unless otherwise approved by city council.
 - b. No carport may exceed more than six hundred (600) square feet in roofed area.
 - c. No carport may exceed more than ten (10) feet in clear opening height for any open sided area.
 - d. Carports shall maintain the required side yard setback from the property lines according to the applicable zoning district or approved development agreement.
 - e. The front setback for carports shall be a minimum of ten (10) feet from the back of the curb, but in no case shall any portion of the carport project beyond the property line.
 - f. Construction is encouraged to be compatible in both design and materials with the primary structure to mirror or maintain the characteristics of the primary structure, adjacent properties and neighborhood. Construction shall meet the requirements of the city building code and other applicable codes as adopted by the city and require permitting prior to construction.

- h. Approved materials:
 - 1. Wood framing and decking meeting the current adopted codes.
 - 2. Metal C-Purlin & Receiver Minimum 14 gauge.
 - 3. 0' - 12' in length = 6'' C-Purlin, 0' - 20' in length = 8'' C-Purlin.
 - 4. Minimum 14-gauge 4x4 steel post.
 - 5. Minimum 10'' round pier hole.
 - 6. Minimum buried depth 1/3 height of post.
 - 7. Minimum 26-gauge R- panel.
 - 8. Composition shingle allowed > 2:12 roof pitch for wood framed.
 - 9. Other approved materials.

- i. Prohibited materials:
 - 1. Corrugated roofing.
 - 2. Fiberglass roofing.
 - 3. Corrugated asphalt roofing.
 - 4. Rolled roofing.”

- j. Manufactured carport construction shall incorporate associated trim kits or finishing trim. Non-manufactured carports shall incorporate trim components to conceal seams and provide a finished construction appearance.

SECTION 3.

This Ordinance shall be cumulative of all other ordinances of the City and shall not repeal any of the provisions of such ordinances, except in those instances where provisions of such ordinances are in direct conflict with the provisions of this Ordinance.

SECTION 4.

That it is hereby declared to be the intention of the City Council that the sections, paragraphs, sentences, clauses, and phrases of this Ordinance are severable, and if any phrase, clause, sentence, paragraph, or section of this Ordinance shall be declared void, ineffective, or unconstitutional by the valid judgment or decree of any court of competent jurisdiction, such voidness, ineffectiveness, or unconstitutionality shall not affect any of the remaining phrases, clauses, sentences, paragraphs, or sections of this Ordinance, since the same would have been enacted by the City Council without the incorporation herein of any such void, ineffective, or unconstitutional phrase, clause, sentence, paragraph, or section.

SECTION 5.

That all rights or remedies of the City are expressly saved as to any and all violations of the Saginaw City Code or any amendments thereto regarding carports or permitted uses that have accrued at the time of the effective date of this Ordinance; and as to such accrued violations, and all pending litigation, both civil or criminal, same shall not be affected by this Ordinance but may be prosecuted until final disposition by the courts.

SECTION 6.

Any person, firm, or corporation who violates, disobeys, omits, neglects, or refuses to comply with or who resists the enforcement of any of the provisions of this Ordinance shall be fined not more than Two Thousand Dollars (\$2,000.00) for each violation of this Ordinance. Each day that a violation is permitted to exist shall constitute a separate offense.

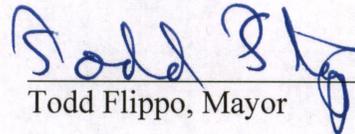
SECTION 7.

The City Secretary of the City is hereby directed to publish at least twice in the official newspaper of the City, the caption and the penalty clause of this Ordinance in accordance with Section 52.013(b) of the Local Government Code.

SECTION 8.

This Ordinance shall be in full force and effect from and after its date of passage and publication as required by law and it is so ordained.

PASSED AND APPROVED ON this the 15th day of July 2025.



Todd Flippo, Mayor

ATTEST:



Victoria Vega, City Secretary

APPROVED AS TO FORM AND LEGALITY:



Bryn Meredith, City Attorney



**NEWSPAPER
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Legals

Legals & Public Notices

PUBLIC NOTICE

RAILROAD COMMISSION OF TEXAS OIL AND GAS DIVISION
 DISTRICT 05 Status/Permit No. 911637DATE OF ISSUANCE: Dec 22, 2025
 NOTICE OF PROTEST DEADLINE: 5:00 PM, Jan 5, 2026
 Address: Railroad Commission of TexasATTN: Drilling Permit UnitP. O. Box 12967
 Austin, Texas 78711-2967
 Fax: (512) 463-6780Email: SWR37@RRC.TEXAS.GOV
NOTICE OF APPLICATION
 NOTICE IS HEREBY GIVEN that the UPP OPERATING, LLC, [RRC Operator No. 875310] has made application for a spacing exception permit under the provisions of Railroad Commission-Statewide Rule 37 (16 Tex. Admin. Code section 3.37). Applicant seeks exception to the lease line distance requirement because the Applicant is less than the required Rule 37/lease line distance to an unleased or non-pooled interest within the subject unit for the NEW DRILL permit in Sec. , Bk. , MAISE, M Survey, A-1001, NEWARK, EAST (BARNETT SHALE)Field, TARRANT County, being 0 miles Within direction from ARLINGTON, Texas. PURSUANT TO THE TERMS of Railroad Commission rules and regulations, this application may be granted WITHOUT A HEARINGif no protest to the application is received within the deadline. An affected person is entitled to protest this application. Affected personsinclude owners of record and the operator or lessees of record of adjacent tracts andtracts nearer to the proposed well than the minimum lease line spacing distance. If you have questions which are specific to the Application or the information set forth in thisNotice, please contact the Commission's Drilling Permit Unit at (512)463-6751. If hearing is called, the applicant has the burden to prove the need for an exception. AProtestant should be prepared to establish standing as an affected person, and to appear at the hearing either in person or by qualified representative and protest theapplication with cross-examination or presentation of a direct case. The rules ofevidence are applicable in the hearing. If you have any questions regarding the hearingprocedure, please contact the Commission's Docket Services Department at(512)463-6848.
 IF YOU WISH TO REQUEST A HEARING ON THIS APPLICATION, AN INTENT TO APPEAR IN PROTEST-MUSTBE RECEIVEDIN THE RAILROAD COMMISSION'S AUSTIN OFFICE AT THE ADDRESS, FAX NUMBER, ORE-MAIL ADDRESS SET OUT ABOVE BYJan 5, 2026 at 5:00 p.m. IF NO PROTEST IS RECEIVED WITHINSUCH TIME, YOU WILL LOSE YOUR RIGHT TO PROTEST AND THE REQUESTED PERMIT MAY BE GRANTEDADMINISTRATIVELY.
 THIS NOTICE OF APPLICATION REQUIRES PUBLICATION
 The location and identity of the well is as shown below:
 FIELD: NEWARK, EAST (BARNETT SHALE)
 ---Lease/Unit Name : YU UNITLease/Unit Well No. : 7HLease/Unit Acres : 604.87
 Nearest Lease Line (ft) : null
 Nearest Well on Lease (ft) : 678.0
 Lease Lines : 498.0 F North L, 4177.0 F EAST L
 Survey Lines : 498.0 F North L, 4177.0 F EAST L
 Wellbore Profile(s) : Horizontal

Lateral: TH1

Penetration Point Location
 Lease Lines : 100.0 F NORTH L
 50.0 F W LTerminus Location
 BH County: TARRANT
 Section: Block: Abstract: 1044
 Survey: MEDLIN, R
 Lease Lines: 2344.0 F S L
 50.0 F E L
 Survey Lines: 2339.0 F S L
 58.0 F E L
 Field Rules for ALL fields on the permit application are as follows:NEWARK, EAST (BARNETT SHALE) :
 GAS Special Rules 330/0, 320.0 acres.GAS Optional Rules 330/0, 20.0 acres.OIL Special Rules 330/0, 20.0 acres.OIL Optional Rules 330/0, 20.0 acres.
 This well is to be drilled to an approximate depth of 17000 feet.
 If you have questions regarding this application, please contact the Applicant's representative, Keith Barton, at (713)4955328.
 IFL0301019
 Dec 24,31 2025

NOTICE OF PUBLIC HEARING

The Benbrook City Council will conduct a public hearing to consider the following item on **Thursday, January 15, 2026**, at 7:00 p.m., in the Council Chambers of City Hall, 911 Winscott Road, Benbrook, Texas 76126. All interested persons are invited to attend.
 PZ-2026-01 - A request to rezone approximately 80 acres of land, situated in the Thomas G. Zachary Survey, Abstract No. 1759, from "C-PD" Multiple-Family Planned Development District to "C-PD" Multiple-Family Planned Development District (18.6 acres) and "B" One-Family District (61.3 acres). The property is generally located on the east side of I.H. 820 between Veterans Pkwy and Chapin Rd (4501 W Loop 820 S).
 For more information, go to http://www.benbrook-tx.gov/AgendaCenter or call 817-249-6061.
 IFL0301913
 Dec 31 2025

NOTICE OF PUBLIC HEARING TO ALL INTERESTED CITIZENS AND ORGANIZATIONS IN THE CITY OF ARLINGTON, TEXAS

On Thursday, January 8, 2026, at 6:00 p.m., the Arlington Landmark Preservation Commission (LPC) will conduct a public hearing at City Hall, 101 W. Abram Street, Council Briefing Room (third floor), Arlington, TX 76010. The purpose of these public hearings is to receive input from the owner(s) and/or representative(s) and/or other interested parties regarding the historic and/or architectural significance to the community of the structure(s) located at 6616 Rickey Lane, 4001 W. Park Row Drive, 3515 W. Sublett Road, and 301 E. Randol Mill Road. During the public hearings, the LPC will entertain discussion(s) from the owner(s) and/or representative(s) and/or other interested parties regarding plans to demolish these structures. At the end of the public hearing, the LPC will decide if this structure is historically and/or architecturally significant and whether or not to approve the demolition permit(s).
 IFL0301846
 Dec 31 2025

LEGAL NOTICE

Johnson County Purchasing Agent, Lance Anderson, is accepting proposals for the following: RFP 2026-300 Request for Proposal - CMAR Renovation of 110 N. Main
 Specifications may be obtained from the Purchasing Department, at 411 Marti Drive, Cleburne, Texas 76033. The closing date for the RFP is February 11, 2026 at 2:00 PM, CST. For additional information contact Lance Anderson, Johnson County Purchasing Agent at (817) 556-6382. Documents can be obtained at: https://www.johnsoncountytx.org/departments/purchasing/bidding-opportunities
 IFL0302176
 Dec 31,Jan 7,14,21 2026

RECEIPT OF BIDS

Electronic bids for Design-Build Services for W. 7th Street Bridge Lighting CPN 105022 will be received for the City of Fort Worth via the Procurement Portal https://fortworthtexas.bonfirehub.com/portal/?tab=openOpportunities under the respective Project until 2:00 P.M. CST, Wednesday, January 22, 2026, as further described below:
 Your submissions must be uploaded, finalized, and submitted prior to the Project's posted due date. The City strongly recommends allowing sufficient time to complete this process (ideally, a week prior to the deadline) to begin the uploading process and to finalize your submission. Uploading large documents may take time, depending on the size of the file(s) and your Internet connection speed. The Bonfire portal can be accessed using Microsoft Edge, Google Chrome, or Mozilla Firefox. JavaScript must be enabled. Browser cookies must be enabled.
 Electronic submission is subject to electronic interface latency, which can result in transmission delays. All bidders or proposers assume the risk of late transmission/ submission. The City shall not be held liable if an interested bidder or proposer is unable to submit a complete bid/response before the published deadline due to transmission delays or any other technical issues or obstructions. The City strongly recommends allowing sufficient time to complete the submission process (ideally, a week before the deadline) to begin the uploading process and to finalize your submission to give adequate time in the event an issue arises.
 All submissions must be submitted electronically prior to the close date and time under the respective Project via the Procurement Portal: https://fortworthtexas.bonfirehub.com/portal/?tab=openOpportunities
 Failure to submit all completed required information listed in the respective Solicitation will be grounds for rejection of a bid as non-responsive. No late bids/proposals shall be accepted. Bids delivered in any other manner than using the Bonfire Platform (Procurement Portal) will not be accepted or considered.
 If, upon being opened, a submission is unreadable to the degree that material conformance to the requirements of the procurement specifications cannot be ascertained, such submission will be rejected without liability to the City, unless such bidder provides clear and convincing evidence (a) of the content of the submission as originally submitted and (b) that the unreadable condition of the Electronic Bid was caused solely by error or malfunction of the Bonfire Platform (Procurement Portal). Failure to scan a clear or readable copy of a bid into the system does not constitute and shall not be considered an error or malfunction of the Bonfire Platform (Procurement Portal). Bidders are encouraged to fully review each page of every document within their submission prior to submitting to ensure all documents are clear, legible, and complete.
 SUPPORT
 For technical questions, visit Bonfire's help forum at https://vendorsupport.gobonfire.com/hc/en-us
 Contact the Bonfire support team at Support@GoBonfire.com or by calling 1-800-354-8010.
 To get started with Bonfire, watch this five-minute training video:
 Vendor Registration and Submission [VIDEO] - Bonfire Vendor Support (gobonfire.com)
 The Design-Build Teams that successfully submitted for this opportunity will be read aloud at 2:00 PM CST at Fort Worth City Hall on January 22, 2026.
 GENERAL DESCRIPTION OF WORK
 The Project consists of the complete replacement of the existing W. 7th Street Bridge Lighting System in Fort Worth, Texas. The existing system includes the following lighting elements:in-grade color-changing LED fixtures along the bridge span arches;in-wall LED fixtures installed along the bridge sidewalks;in-grade LED sidewalk fixtures located at the bridge ends;Decorative LED street lighting along the bridge roadway; andUnderpass lighting.
 The project will replace these existing lighting elements with new fixtures of comparable or improved quality, durability, and performance. The project will also include installation of new wiring, a new lighting control system with communications capability, and the retrofit or replacement of the conduit system, as required.
 The project scope also includes bridge median reconstruction around one street lighting assembly, where the existing lighting assembly was previously damaged and removed.
 PREQUALIFICATION
 Certain improvements included in this project must be performed by a contractor or designated subcontractor who is pre-qualified by the City at the time of bid opening. The procedures for qualification and pre-qualification are outlined in the Section 3 of 00 21 13 - INSTRUCTIONS TO BIDDERS.
 DOCUMENT EXAMINATION AND PROCUREMENTS
 The Bidding and Contract Documents may be examined or obtained via the Procurement Portal https://fortworthtexas.bonfirehub.com/portal/?tab=openOpportunities, under the respective Project. Contract Documents may be downloaded, viewed, and printed by interested contractors and/or suppliers.
 PRE-SUBMITTAL CONFERENCE - In-person and Web Conference
 A pre-submittal conference will be held as discussed in Section 00 21 13 - INSTRUCTIONS TO BIDDERS at the following date and time, as well as simultaneously via a web conferencing application:
 LOCATION: James Avenue Transportation and Public Works Training Conference Room[BD1] [DS2] , 5001 James Avenue, Suite 301; Fort Worth, Texas 76115
 DATE: Wednesday, January 7, 2026
 TIME: 2:00pm
 The Microsoft Teams link is below.
 RFQ Pre-Submittal Conference for W. 7th Street Bridge Lighting (Virtual & In-Person)/5001 James Ave-Suite 301; Fort Worth, TX | Meeting-Join | Microsoft Teams
 After the pre-submittal conference is held, the presentation and any questions and answers provided at the pre-submittal conference will be issued as an Addendum through the City of Fort Worth Procurement Portal in Bonfire.
 Prospective bidders should direct all questions about the meaning and intent of the Bidding Documents electronically through the Vendors discussions section under the respective Project via the Procurement Portal. If necessary, Addenda will be issued pursuant to the Instructions to Bidders. Questions submitted by email or any other means will not be addressed.
 CITY'S RIGHT TO ACCEPT OR REJECT BIDS
 City reserves the right to waive irregularities and to accept or reject any or all bids.
 AWARD
 This Request for Qualifications is the 1st phase of a 2-phase solicitation process. The City will shortlist a maximum of 5 Design-Build teams based on their Statement of Qualification responses who will be invited to submit a proposal in the 2nd phase of the solicitation to be released on or after February 6, 2026.
 FUNDING
 Any Contract awarded under this INVITATION TO BIDDERS is expected to be funded from revenues generated from the City of Fort Worth 2022 Bond Program and reserved by the City for the Project.
 ADVERTISEMENT DATES
 December 24, 2025
 December 31, 2025
 IFL0300836
 Dec 24,31 2025

DEPARTMENT OF HOMELAND SECURITY FEDERAL EMERGENCY MANAGEMENT AGENCY

Proposed Flood Hazard Determinations for the Cities of Grand Prairie and Midlothian and Unincorporated Areas of Ellis County, Texas, Case No. 24-06-2527P. The Department of Homeland Security's Federal Emergency Management Agency (FEMA) solicits technical information or comments on proposed flood hazard determinations for the Flood Insurance Rate Map (FIRM), and where applicable, the Flood Insurance Study (FIS) report for your community. These flood hazard determinations may include the addition or modification of Base Flood Elevations, base flood depths, Special Flood Hazard Area boundaries or zone designations, or the regulatory floodway. The FIRM and, if applicable, the FIS report have been revised to reflect these flood hazard determinations through issuance of a Letter of Map Revision (LOMR), in accordance with Title 44, Part 65 of the Code of Federal Regulations. These determinations are the basis for the floodplain management measures that your community is required to adopt or show evidence of having in effect to qualify or remain qualified for participation in the National Flood Insurance Program. For more information on the proposed flood hazard determinations and information on the statutory 90-day period provided for appeals, please visit FEMA's website at https://www.floodmaps.fema.gov/fhm/BFE_Status/bfe_main.asp, or call the FEMA Mapping and Insurance eXchange (FMIX) toll free at 1-877-FEMA MAP (1-877-336-2627).
 IFL0299217
 Dec 24,31 2025

Legals & Public Notices

Legals & Public Notices

PUBLIC NOTICE

RAILROAD COMMISSION OF TEXAS OIL AND GAS DIVISION
 DISTRICT 05 Status/Permit No. 911580DATE OF ISSUANCE: Dec 22, 2025
 NOTICE OF PROTEST DEADLINE: 5:00 PM, Jan 5, 2026
 Address: Railroad Commission of TexasATTN: Drilling Permit UnitP. O. Box 12967
 Austin, Texas 78711-2967
 Fax: (512) 463-6780Email: SWR37@RRC.TEXAS.GOV
NOTICE OF APPLICATION
 NOTICE IS HEREBY GIVEN that the UPP OPERATING, LLC, [RRC Operator No. 875310] has made application for a spacing exception permit under the provisions of Railroad Commission-Statewide Rule 37 (16 Tex. Admin. Code section 3.37). Applicant seeks exception to the lease line distance requirement because the Applicant is less than the required Rule 37/lease line distance to an unleased or non-pooled interest within the subject unit for the NEW DRILL permit in Sec. , Bk. , MAISE, M Survey, A-1001, NEWARK, EAST (BARNETT SHALE)Field, TARRANT County, being 0 miles Within direction from ARLINGTON, Texas. PURSUANT TO THE TERMS of Railroad Commission rules and regulations, this application may be granted WITHOUT A HEARINGif no protest to the application is received within the deadline. An affected person is entitled to protest this application. Affected personsinclude owners of record and the operator or lessees of record of adjacent tracts andtracts nearer to the proposed well than the minimum lease line spacing distance. If you have questions which are specific to the Application or the information set forth in thisNotice, please contact the Commission's Drilling Permit Unit at (512)463-6751. If hearing is called, the applicant has the burden to prove the need for an exception. AProtestant should be prepared to establish standing as an affected person, and to appear at the hearing either in person or by qualified representative and protest theapplication with cross-examination or presentation of a direct case. The rules ofevidence are applicable in the hearing. If you have any questions regarding the hearingprocedure, please contact the Commission's Docket Services Department at(512)463-6848.
 IF YOU WISH TO REQUEST A HEARING ON THIS APPLICATION, AN INTENT TO APPEAR IN PROTEST-MUSTBE RECEIVEDIN THE RAILROAD COMMISSION'S AUSTIN OFFICE AT THE ADDRESS, FAX NUMBER, ORE-MAIL ADDRESS SET OUT ABOVE BYJan 5, 2026 at 5:00 p.m. IF NO PROTEST IS RECEIVED WITHINSUCH TIME, YOU WILL LOSE YOUR RIGHT TO PROTEST AND THE REQUESTED PERMIT MAY BE GRANTEDADMINISTRATIVELY.
 THIS NOTICE OF APPLICATION REQUIRES PUBLICATION
 The location and identity of the well is as shown below:
 FIELD: NEWARK, EAST (BARNETT SHALE)
 ---Lease/Unit Name : YU UNITLease/Unit Well No. : 5HLease/Unit Acres : 604.87
 Nearest Lease Line (ft) : null
 Nearest Well on Lease (ft) : 580.0
 Lease Lines : 513.0 F North L, 4179.0 F EAST L
 Survey Lines : 513.0 F North L, 4179.0 F EAST L
 Wellbore Profile(s) : Horizontal

Lateral: TH1

Penetration Point Location
 Lease Lines : 50.0 F SW L
 68.0 F NW LTerminus Location
 BH County: TARRANT
 Section: Block: Abstract: 1367
 Survey: RHODES, W A
 Lease Lines: 80.0 F N L
 50.0 F E L
 Survey Lines: 671.0 F S L
 521.0 F E L
 Field Rules for ALL fields on the permit application are as follows:NEWARK, EAST (BARNETT SHALE) :
 GAS Special Rules 330/0, 320.0 acres.GAS Optional Rules 330/0, 20.0 acres.OIL Special Rules 330/0, 20.0 acres.OIL Optional Rules 330/0, 20.0 acres.
 This well is to be drilled to an approximate depth of 17000 feet.
 If you have questions regarding this application, please contact the Applicant's representative, Keith Barton, at (713)4955328.
 IFL0301059
 Dec 24,31 2025

City of Saginaw Public Notice

A Public Hearing will be conducted by the Planning & Zoning Commission at 6:00 p.m. on January 13, 2026 to consider amending the Code of Ordinances, Appendix A (Zoning Ordinance No. 2002-04) Amending Article 8 "Supplemental District Regulations", Section 6 "Miscellaneous Requirements" relating to Sub Item D, "Carports". A Public Hearing will be conducted by the Saginaw City Council at 6:00 p.m. on January 20, 2026 to consider the above-mentioned textural amendment, contingent upon the receipt of a report from the Planning & Zoning Commission. Both meetings will be in the Council Chambers at the Saginaw City Hall located at 333 West McLeroy Boulevard.
FINAL ACTION IS TAKEN BY CITY COUNCIL ON PUBLIC HEARING CASES.
 Please direct any question regarding this matter to the Saginaw P&Z Team at 817-230-0440/0444 or pz@saginawtx.org ; IFL0302076
 Dec 31 2025

LEGAL NOTICE

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 To get started with Bonfire, watch this five-minute training video:
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 LOCATION: James Avenue Transportation and Public Works Training Conference Room[BD1] [DS2] , 5001 James Avenue, Suite 301; Fort Worth, Texas 76115
 DATE: Wednesday, January 7, 2026
 TIME: 2:00pm
 The Microsoft Teams link is below.
 RFQ Pre-Submittal Conference for W. 7th Street Bridge Lighting (Virtual & In-Person)/5001 James Ave-Suite 301; Fort Worth, TX | Meeting-Join | Microsoft Teams
 After the pre-submittal conference is held, the presentation and any questions and answers provided at the pre-submittal conference will be issued as an Addendum through the City of Fort Worth Procurement Portal in Bonfire.
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 ADVERTISEMENT DATES
 December 24, 2025
 December 31, 2025
 IFL0300836
 Dec 24,31 2025

DEPARTMENT OF HOMELAND SECURITY FEDERAL EMERGENCY MANAGEMENT AGENCY

Proposed Flood Hazard Determinations for the Cities of Grand Prairie and Midlothian and Unincorporated Areas of Ellis County, Texas, Case No. 24-06-2527P. The Department of Homeland Security's Federal Emergency Management Agency (FEMA) solicits technical information or comments on proposed flood hazard determinations for the Flood Insurance Rate Map (FIRM), and where applicable, the Flood Insurance Study (FIS) report for your community. These flood hazard determinations may include the addition or modification of Base Flood Elevations, base flood depths, Special Flood Hazard Area boundaries or zone designations, or the regulatory floodway. The FIRM and, if applicable, the FIS report have been revised to reflect these flood hazard determinations through issuance of a Letter of Map Revision (LOMR), in accordance with Title 44, Part 65 of the Code of Federal Regulations. These determinations are the basis for the floodplain management measures that your community is required to adopt or show evidence of having in effect to qualify or remain qualified for participation in the National Flood Insurance Program. For more information on the proposed flood hazard determinations and information on the statutory 90-day period provided for appeals, please visit FEMA's website at https://www.floodmaps.fema.gov/fhm/BFE_Status/bfe_main.asp, or call the FEMA Mapping and Insurance eXchange (FMIX) toll free at 1-877-FEMA MAP (1-877-336-2627).
 IFL0299217
 Dec 24,31 2025

Legals & Public Notices

Legals & Public Notices

PUBLIC NOTICE

RAILROAD COMMISSION OF TEXAS OIL AND GAS DIVISION
 DISTRICT 05 Status/Permit No. 911580DATE OF ISSUANCE: Dec 22, 2025
 NOTICE OF PROTEST DEADLINE: 5:00 PM, Jan 5, 2026
 Address: Railroad Commission of TexasATTN: Drilling Permit UnitP. O. Box 12967
 Austin, Texas 78711-2967
 Fax: (512) 463-6780Email: SWR37@RRC.TEXAS.GOV
NOTICE OF APPLICATION
 NOTICE IS HEREBY GIVEN that the UPP OPERATING, LLC, [RRC Operator No. 875310] has made application for a spacing exception permit under the provisions of Railroad Commission-Statewide Rule 37 (16 Tex. Admin. Code section 3.37). Applicant seeks exception to the lease line distance requirement because the Applicant is less than the required Rule 37/lease line distance to an unleased or non-pooled interest within the subject unit for the NEW DRILL permit in Sec. , Bk. , MAISE, M Survey, A-1001, NEWARK, EAST (BARNETT SHALE)Field, TARRANT County, being 0 miles Within direction from ARLINGTON, Texas. PURSUANT TO THE TERMS of Railroad Commission rules and regulations, this application may be granted WITHOUT A HEARINGif no protest to the application is received within the deadline. An affected person is entitled to protest this application. Affected personsinclude owners of record and the operator or lessees of record of adjacent tracts andtracts nearer to the proposed well than the minimum lease line spacing distance. If you have questions which are specific to the Application or the information set forth in thisNotice, please contact the Commission's Drilling Permit Unit at (512)463-6751. If hearing is called, the applicant has the burden to prove the need for an exception. AProtestant should be prepared to establish standing as an affected person, and to appear at the hearing either in person or by qualified representative and protest theapplication with cross-examination or presentation of a direct case. The rules ofevidence are applicable in the hearing. If you have any questions regarding the hearingprocedure, please contact the Commission's Docket Services Department at(512)463-6848.
 IF YOU WISH TO REQUEST A HEARING ON THIS APPLICATION, AN INTENT TO APPEAR IN PROTEST-MUSTBE RECEIVEDIN THE RAILROAD COMMISSION'S AUSTIN OFFICE AT THE ADDRESS, FAX NUMBER, ORE-MAIL ADDRESS SET OUT ABOVE BYJan 5, 2026 at 5:00 p.m. IF NO PROTEST IS RECEIVED WITHINSUCH TIME, YOU WILL LOSE YOUR RIGHT TO PROTEST AND THE REQUESTED PERMIT MAY BE GRANTEDADMINISTRATIVELY.
 THIS NOTICE OF APPLICATION REQUIRES PUBLICATION
 The location and identity of the well is as shown below:
 FIELD: NEWARK, EAST (BARNETT SHALE)
 ---Lease/Unit Name : YU UNITLease/Unit Well No. : 5HLease/Unit Acres : 604.87
 Nearest Lease Line (ft) : null
 Nearest Well on Lease (ft) : 580.0
 Lease Lines : 513.0 F North L, 4179.0 F EAST L
 Survey Lines : 513.0 F North L, 4179.0 F EAST L
 Wellbore Profile(s) : Horizontal

Lateral: TH1

Penetration Point Location
 Lease Lines : 50.0 F SW L
 68.0 F NW LTerminus Location
 BH County: TARRANT
 Section: Block: Abstract: 1367
 Survey: RHODES, W A
 Lease Lines: 80.0 F N L
 50.0 F E L
 Survey Lines: 671.0 F S L
 521.0 F E L
 Field Rules for ALL fields on the permit application are as follows:NEWARK, EAST (BARNETT SHALE) :
 GAS Special Rules 330/0, 320.0 acres.GAS Optional Rules 330/0, 20.0 acres.OIL Special Rules 330/0, 20.0 acres.OIL Optional Rules 330/0, 20.0 acres.
 This well is to be drilled to an approximate depth of 17000 feet.
 If you have questions regarding this application, please contact the Applicant's representative, Keith Barton, at (713)4955328.
 IFL0301059
 Dec 24,31 2025

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FINAL ACTION IS TAKEN BY CITY COUNCIL ON PUBLIC HEARING CASES.
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 Dec 31 2025

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 IFL0302176
 Dec 31,Jan 7,14,21 2026

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 Electronic submission is subject to electronic interface latency, which can result in transmission delays. All bidders or proposers assume the risk of late transmission/ submission. The City shall not be held liable if an interested bidder



City Council Memorandum

A. Consideration and Action regarding Resolution No. 2026-01, Calling a General Election to Elect the Offices of City Council Place 4 and City Council Place 6 to be held on May 2, 2026--Vicky Vega, City Secretary

| Meeting | Agenda Group |
|------------------------------------|--------------------|
| Tuesday, January 20, 2026, 6:00 PM | Business Item: 5A. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

Resolution No. 2026-01 calls the City's General Election to elect the offices of City Council Place 4, and City Council Place 6, to be held on Saturday, May 2, 2026, and if required, a Run-Off Election to be held on June 13, 2026.

General Election:

First Day to File an Application for a Place on the Ballot: January 14, 2026

Last Day to File an Application for Place on the Ballot: February 13, 2026

Early Voting: April 20, 2026 - April 28, 2026

Election Day: May 2, 2026

Runoff Election: (If required)

Calling a Run-off Election: May 19, 2026, City Council meeting (Tentative Date)

Early Voting for a Runoff Election: June 1, 2026 - June 9, 2026

Election Day for a Runoff: June 13, 2026

RECOMMENDATION:

Staff recommends approving Resolution No. 2026-01

Attachments

[El Resolution Call 2026.pdf](#)

RESOLUTION NO. 2026-01

A RESOLUTION OF THE CITY OF SAGINAW, TEXAS, AUTHORIZING AND CALLING FOR A GENERAL ELECTION TO ELECT THE OFFICES OF CITY COUNCIL PLACE 4 AND CITY COUNCIL PLACE 6 TO BE HELD ON MAY 2, 2026, AND, IF REQUIRED, A RUN-OFF ELECTION ON JUNE 13, 2026; APPROVING A JOINT ELECTION WITH TARRANT COUNTY AND ESTABLISHING PROCEDURES FOR THAT ELECTION; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the City of Saginaw, Texas, (the “City”) is a home rule municipality acting under its charter adopted by the electorate pursuant to Article XI, Section 5 of the Texas Constitution and Chapter 9 of the Local Government Code; and

WHEREAS, Section 41.001 of the Texas Election Code (the “Code”) specifies that the first Saturday in May shall be a “uniform election date” and that a general election of a city may be held on that day; and

WHEREAS, the regular election for City Council members of the City is required to be held on May 2, 2026, at which time the voters will elect persons to fill the offices of City Council Place 4 and City Council Place 6; and

WHEREAS, it is the City Council’s intent that the election will be held as a joint election, conducted under the authority of Chapter 271 of the Code; and

WHEREAS, the City Council finds that it is in the public interest to enter into a Joint Election Agreement with Tarrant County (the “Agreement”) to provide the most efficient and convenient voting opportunities; and

WHEREAS, by this Resolution, it is the intention of the City Council to designate a polling place for the election to appoint the necessary election officers, to establish and set forth procedures for conducting the election, and to authorize the Mayor to execute the Agreement for conducting the election.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF SAGINAW, TEXAS, THAT:

Section 1. Incorporation. The facts and recitations contained in the above preamble of this Resolution are incorporated herein for all purposes.

Section 2. General Election Called. An election is hereby called to elect the offices of City Council Place 4 and City Council Place 6 to serve from May of 2026 until May of 2029, or until their successors are duly elected and qualified. The election shall be held on May 2, 2026, at the location(s) designated in the Joint Election Agreement, and shall be between the hours of 7:00 a.m. and 7:00 p.m.

Section 3. Joint Election Agreement Approved. The Mayor is authorized to execute the Agreement in accordance with Chapter 31, Subchapter D of the Code, and any other applicable statutes and laws. In the event of conflict between this Resolution and the Agreement, the Agreement shall control.

Section 4. Application for Place on Ballot. Qualified persons may file as candidates by filing applications with the office of the City Secretary from 7:30 a.m. to 5:30 p.m., Monday through Thursday, from January 14, 2026, through February 12, 2026; and 7:30 a.m. to 11:30 a.m., on January 16, January 23, January 30, and February 6, 2026; and from 7:30 a.m. to 5:00 p.m. on Friday, February 13, 2026.

Section 5. Early Voting.

a. Early voting clerk. The Tarrant County Elections Administrator, or their successor, is hereby designated as Early Voting Clerk for the special election. Additional Deputy Early Voting Clerks may be appointed, as provided in the Agreement.

b. Early voting by personal appearance. Early voting by personal appearance shall commence April 20, 2026, and shall continue daily, until April 28, 2026, at the locations designated in the Agreement for the joint election. Hours for early voting by personal appearance shall be from 8:00 a.m. to 5:00 p.m., from April 20, 2026, through April 24, 2026; from 7:00 a.m. to 7:00 p.m. on each of April 25, 2026, April 27, 2026, and April 28, 2026; and from 10:00 a.m. to 4:00 p.m. on April 26, 2026.

c. Early voting by mail. Clint Ludwig, the Tarrant County Elections Administrator, or his successor, is hereby designated as Early Voting Clerk for the general election. Applications for early voting by mail may be delivered to the Elections Administrator or his successor at the following address: P.O. Box 961011, Fort Worth, Texas 76161 or Express Courier Delivery at 2700 Premier Street, Fort Worth, Texas 76111, FAX: 817-850-2344, Email: votebymail@tarrantcounty.com, not later than close of business on April 20, 2026. Early voting by mail ballots shall be mailed to the Elections Administrator or his successor at P.O. Box 961011, Fort Worth, Texas 76161-0011.

d. Early voting by Ballot Board. Early voting, both by personal appearance and by mail, shall be canvassed by the Early Voting Ballot Board established by Tarrant County under the terms of the Agreement.

e. Recommended Branch Early Voting Polling Places. The Council finds that the following locations can most adequately and conveniently serve the voters in this election, and that these early voting locations will facilitate the orderly conduct of the election:

1. Saginaw Public Library
304 W. McLeroy Blvd, Saginaw Texas 76179
2. Tarrant County Elections Center

2700 Premier Street, Fort Worth, Texas, 76111

Section 6. Appointment of Election Judge and Alternate Election Judge. The Presiding Election Judge and Alternate Election Judge shall be appointed by Tarrant County as authorized by Chapter 271 of the Code.

Section 7. Method of Voting. Tarrant County's voting system shall be used for absentee voting by mail, early voting by personal appearance, regular voting on election day, and provisional voting. All expenditures necessary for the conduct of the election, the purchase of materials, and the employment of all election officials are hereby authorized and shall be conducted in accordance with the Code.

Section 8. Governing Law and Qualified Voters. The election shall be held in accordance with the Constitution of the State of Texas and the Code, and all resident qualified voters of the City shall be eligible to vote in the election.

Section 9. Publication and Posting of Notice of Election. Notice of the election shall be given as required by Chapter 4 of the Code.

Section 10. Run-Off Election. In the event no candidate receives a majority of votes for an office, there shall be a run-off election held on June 13, 2026.

Section 11. Necessary Actions. The Mayor and the City Secretary of the City, in consultation with the City Attorney, are hereby authorized and directed to take any and all actions necessary to comply with the provisions of the Code in carrying out and conducting the election, whether or not expressly authorized herein.

Section 12. Effective Date. This Resolution shall be effective immediately upon its adoption.

ADOPTED AND APPROVED this 20th day of January 2026.

ATTEST:

APPROVED:

Vicky Vega, City Secretary

Todd Flippo, Mayor

APPROVED AS TO FORM AND LEGALITY:

Bryn Meredith, City Attorney



B. Consideration and Action regarding award of Bid for the Remodel of the Old Library--Jarred Coursey, Asst. Director of Public Works

| | |
|------------------------------------|--------------------|
| Meeting | Agenda Group |
| Tuesday, January 20, 2026, 6:00 PM | Business Item: 5B. |
| Reference File | |
| Community Goals | |

BACKGROUND/DISCUSSION:

Memo attached.

FINANCIAL IMPACT:

N/A

RECOMMENDATION:

N/A

Attachments

[Memo--RFQ Remodel of Old Library.pdf](#)



John Ed Keeter Building Re-Model Contractor Selection

Mayor and Council,

After reviewing all bid proposals for the Keeter Building re-model, staff have selected MSF Hospitality as the best proposal for this project and are requesting your consideration and approval to award MSF Hospitality with a contract to proceed. Staff researched and made calls to all their references provided and visited a location that MSF Hospitality had constructed. Staff are confident from feedback from references and the visual quality of their work to recommend MSF Hospitality. The contract will be for a total of \$2,573,158.09, this will include a full re-model of the Keeter Building, connecting corridor with storage between City Hall and the Keeter Building, and upgrades to City Hall that includes a fire sprinkler system, fire alarm, and new ceiling. 74% of the contract will be paid from the General Fund Balance at \$1,904,136.99, the remaining 26% of the contract will be paid from the Enterprise Fund at \$669,021.10. MSF Hospitality has projected a February 2026 start and finish in October 2026 for a total of 257 days. Thank you for your consideration on this matter.

Jarred Coursey

Assistant Public Works Director