RESPONSE

STAFFING REQUIREMENTS

1. Under normal circumstances, when a request is made for emergency ambulance service, a minimum of one transport capable emergency vehicle will respond to the scene of the emergency. The emergency vehicle must be fully equipped to respond and have all designated equipment in compliance with the unit inventory. The unit inventory must be in compliance with the Public Regulation Commission (PRC) Motor Transportation Rules, Title 18 – Chapter 3 – Part 14.

2. Transport Capable Rescues although exempt from PRC title 18-Chapter 3- Part 14 will be maintain the inventory under the rule.

3. The driver of the emergency vehicle must be a "qualified driver" as defined by the PRC, unless unusual circumstances exist.

4. Certificated Ambulance - A minimum of 2 licensed EMTs must respond and be present at the scene of all emergency calls, although they do not have to respond in the same emergency vehicle. This does not apply to prearranged transfers of a stable patient or in unusual situations that result in an insufficient number of EMTs available for response.

5. For Transport Capable Rescues – A minimum of a licensed First Responder must respond and be present at the scene of all emergency calls, although they do not have to respond in the emergency vehicle.

6. Non Transport Rescues – Starting February 2009, all certified rescues must have a licensed EMS individual on board to respond. This maybe First Responder and above with a License granted by the NM EMS Bureau.

7. When an emergency vehicle responds to stand-by for a planned hazardous event (sporting events, automobile races, etc.), a driver and at least one EMT must respond in the vehicle.

8. When an emergency vehicle responds for mutual aid by another agency, a driver and at least one EMT must respond in the vehicle.

9. When an emergency vehicle responds to stand-by for a planned hazardous event (sporting events, automobile races, etc.), a driver and at least one EMT must respond in the vehicle.

10. When an emergency vehicle responds for mutual aid by another agency, a driver and at least one Licensed EMS person must respond in the vehicle.

EMERGENCY RESPONSE PROCEDURE

1. The responding emergency vehicle operator must follow all state laws and local policies regarding the use of emergency lights, siren, speed, direction of travel, etc.

2. Emergency response must be either with no lights and siren (code 1) or lights and siren (code 3). During a Code 1 response, all traffic laws must be followed. During a code 3 response, emergency lights and siren must be used at all times during response. The siren should be turned off one block away from the scene unless traffic prohibits the unit from arriving at the scene. When approaching an intersection, the "pitch" of the siren should be changed or an air horn should be sounded.

3. New Mexico State law, regarding emergency vehicles, states the driver of the emergency vehicle may:

   a. Park or stand, irrespective of the provisions of the State of New Mexico Motor Vehicle Code.
   b. Proceed past a red or stop signal or stop sign, but only after slowing down as necessary for safe operation.
   c. Exceed the maximum speed limits as long as the driver does not endanger life or property.
   d. Disregard regulations governing direction of movement or turning in specified directions.

4. This section does not relieve the driver of an emergency vehicle from the duty to drive with due regard for the safety of all persons, nor does it protect the driver from the consequences of his reckless disregard for the safety of others. If conditions become too hazardous (i.e. heavy rain, ice, fog, dust or smoke) response should be discontinued until conditions improve enough for safe response.

5. If it becomes necessary for one emergency vehicle to pass another during an emergency response, the emergency vehicle in the rear must notify the emergency vehicle in the front and advise them what side they will be passing on. If contact cannot be made (i.e. multi-agency response) **EXTREAME** caution must be exercised if it becomes necessary to pass.

SEAT BELTS

1. All drivers and passengers, both front and rear, must wear seat belts or restraining devices at all times while the vehicle is being operated.

PASSING SCHOOL BUSES

1. The emergency vehicle **MAY NOT** proceed past a school bus that has warning equipment activated unless the school bus driver signals that it is safe to pass. The emergency vehicle may then proceed past the bus at a safe speed using **EXTREME** caution.

SCHOOL ZONES

1. The emergency vehicle must observe and adhere to all posted school zone restrictions including speed, crosswalks, etc. This includes both emergency and non-emergency responses.

ENCOUNTERING AN INCIDENT DURING RESPONSE

1. If the responding emergency vehicle comes upon another emergency incident during response to an emergency call, the ambulance must stop at the incident, and notify dispatch of needed resources. The first call for emergency service must take priority, so every attempt must be made to administer emergency care to the first caller in a timely manner.

SCENE

EMERGENCY VEHICLE PLACEMENT

1. Upon approaching the scene, a decision must be made regarding the safest and most convenient place to park the emergency vehicle. The emergency vehicle must be parked for maximum visibility. Protection of the EMS personnel, and the patient(s), must also be considered.

2. If it becomes necessary to reposition the emergency vehicle, the driver must ensure that all passengers in the vehicle are seated until the ambulance comes to a complete stop. If backing the vehicle is necessary, a "backer" must be used. The backer must be out of the vehicle and not on the vehicle while it is being positioned.

SCENE SAFETY

1. All emergency scenes have inherent dangers. It is the responsibility of all EMS personnel to constantly be aware of their surroundings, and ensure that the scene is as safe as possible at all times. If at any time safety becomes questionable, personnel must leave the unsafe environment, re-evaluate the situation, and request additional resources if necessary.

2. The emergency vehicle driver will be responsible for scene safety and the safety of other EMS personnel until an incident commander arrives.

3. All personnel must wear approved reflective clothing or vests when working in traffic.

INCIDENT COMMAND

The Incident Command System will be applied to scenes involving multiple patients (i.e. industrial or motor vehicle accidents), and the following guidelines must be followed.

1. The driver of the first arriving emergency vehicle should assume "Incident Command" until command is transferred.

2. The Incident Commander should do the following:

a. Identify and assess scene safety.
b. Give an initial size-up report.
c. Perform a 360-degree walk around of the scene to determine additional resource needs (i.e. police, extrication, or additional EMS response).
d. Assure that patients' conditions are assessed and coordinate the prioritization of patient care.
e. Establish a "Command Name" (i.e. Buck Mountain Command).
f. Establish a "Command Post".
g. Give updates and reports to on scene personnel.
h. Establish a Medical Sector Officer to be in charge of patient triage, treatment and transport.

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INCIDENT COMMAND (cont.)

i. Establish a Level II staging area.
j. Add to the Command Staff or expand the Incident Command System as needed to manage the incident.
k. When transferring command, brief the new Incident Commander on the situation and progress.

MULTIPLE-CASUALTY MANAGEMENT AND START TRIAGE

1. A Major Medical Incident (MMI) is defined as an incident involving more than three patients. (**Any time patient numbers exceed current resources, consider declaring a MMI**). Triage is a process of selecting the priority of patient treatment and transport based on extent of injuries. **START** Triage quickly distinguishes between critically ill victims and the less severely injured. The goal of managing an MMI will be to assign each patient to a category based on the urgency of care and the resources required to save life and limb.

2. Major Medical scenes will be classed in two ways:

   a. Multi-Patient Incident (MPI)
      i. Up to 25 patients
   b. Mass Casualty Incident (MCI)
      i. Over 25 patients

3. When multiple patients are encountered, receiving hospital emergency rooms must be notified as soon as possible to give them adequate time to prepare for patients.

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MULTIPLE-CASUALTY MANAGEMENT AND START TRIAGE (cont.)

4. Multi-Patient Incident (MPI) Guidelines

    a. Triage function and/or sector assignments
    b. Notify receiving hospitals
    c. Consider or establish a treatment area
    d. Consider additional resources
    e. Order additional ambulances early
    f. Complete EMS Tactical Benchmarks

5. Mass Casualty Incident (MCI)

    a. Triage function and sector assignments
    b. Assign a Transport Officer/Ambulance Coordinator
    c. Notify receiving hospitals
    d. Establish multiple treatment areas
    e. Activate Emergency Operations Center (EOC)
    f. Request additional resources
    g. Establish a Medical Supply Sector
    h. Complete EMS Tactical Benchmarks

6. Tactical Benchmarks

    a. Triage Report Completion
    b. Declaration of "All Immediates Transported"

7. Medical treatments rendered when performing START triage:

    a. Open an airway or insert an OPA
    b. Attempt to stop any visible bleeding
    c. Elevate the extremities for shock

8. Patients must be placed in triage categories:

    a. **IMMEDIATE** (Red) Priority #1 is assigned to those patients whose RPM (Respiration, Pulse, Mental Status) is altered.
    b. **DELAYED** (Yellow) Priority #2 is assigned to those patients who are unable to follow instructions to evacuate the scene, but whose RPM is intact. It also includes patients who have a significant mechanism of injury (MOI), but whose RPM is intact.
    c. **MINOR** (Green) Priority #3 is assigned to those patients who were able to evacuate the scene at the instruction of EMS personnel. These are the "walking wounded" and should be tagged later. **(Note: The term "minor" patients should not be confused with "pediatric" patients)**
    d. **DEAD/DYING** (Black) Priority #4 is assigned to those patients who cannot breathe after the airway is opened and are mortally wounded. These patients will probably die despite the best resuscitation efforts.

PATIENT CARE

1. The licensed or certified healthcare professional most medically qualified, specific to the provision of rendering emergency care, will be in charge of patient care. In the case of an incident involving multiple patients, this person may be assigned to triage until adequate resources arrive.

CONFLICTING ORDERS FROM DOCTOR ON SCENE

1. Control of a medical emergency scene will be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

2. The EMS personnel are responsible for the management of the patient under direct or indirect supervision of the service Medical Director and/or the on-line medical control physician.

3. When the patient's physician is present and assumes responsibility for the patient's care, EMS personnel must defer to the orders of the patient's physician if those orders do not conflict with service protocols. All treatment rendered based on orders from the patient's physician, must be in accordance with the EMS personnel's scope of practice and must be documented on the EMS run report.

4. When the medical orders of the patient's physician differ from service protocols, an on-line physician in the ED must be contacted to discuss treatment with patient's physician. If the patient's physician and the on-line physician are unable to agree on treatment, the patient's physician must either continue to provide direct patient care and accompany the patient to the hospital or defer all remaining care to the on-line physician.

5. The pre-hospital provider's responsibility reverts back to the systems Medical Director or on-line medical direction any time the private physician is no longer in attendance.

6. When at the scene of an emergency, a physician who is positively identified by a New Mexico medical license and New Mexico driver’s license or recognition of the physician by the receiving hospital, may:

    a. Assist the EMTs and offer suggestions, but let the EMTs remain under service protocols; **or**
    b. Request to speak to the receiving hospital physician and directly offer medical advise and assistance; **or**
    c. Assume total responsibility for the patient and care given by the EMTs, physically accompany the patient to the receiving hospital and sign for all instructions and treatment given.

7. In the event of a mass casualty incident or disaster, patient care needs may require an intervening physician to remain at the scene rather than accompany the patient to the hospital.

DEPARTING THE SCENE

1. Prior to moving the emergency vehicle after arriving at the scene, the driver of the vehicle must make sure that everyone still on board is aware the vehicle is being moved and if backing the unit, a "backer" should be used. The backer must be out of the vehicle and not on the vehicle while it is being positioned.

2. Upon leaving the scene, the driver must ensure that all passengers are secured by restraining devices.

TRANSPORT

PATIENT CARE ENROUTE

1. **Certificated Ambulance** - At least one EMT, at the appropriate level, must accompany the patient in the patient compartment at all times during transport. If two critical patients are being transported, at least two EMTs must be in the patient compartment. Exceptions to this policy would include transports with a member of a neonatal intensive care team attending a patient in a self-contained newborn intensive care isolette, and catastrophic events.

2. **Transport Capable Rescue**- At least two First Responders must accompany the patient in the patient compartment at all times during transport.
   a. **Transport can only be initiated if no certificated ambulance is available; arrival of the certificated ambulance would exceed 15 minutes *and* the patient has life or limb threatening injuries or illness**.
   b. All attempts for Rendezvous with a certificated ambulance will be exhausted before the transport terminates at a hospital.
   c. All transports using First Responders will be reviewed by the McKinley County QA Board to ensure that the decision to transport was correctly applied and that care was appropriate.

2. All patients must be secured with restraining devices at all times during transport.

3. If infants are being transported, infant seats must be used, unless CPR is being performed, or some other device properly immobilizes the patient and the device is secured to the gurney or bench seat.

4. Family members will be allowed to accompany the patient to the hospital if it will benefit the patient. An example would be a mother who is accompanying her child in an attempt to keep the child calm. If the patient is unconscious or critical, family members will not be allowed to accompany the patient to the hospital.

5. If family members are riding with the patient, they should ride in the front and secured by a seatbelt. If they are riding with the patient in the back (non-critical patients), they must be properly seated and secured by a restraining device.

SELECTION OF MEDICAL FACILITY

1. All unstable patients must be transported to the nearest medical facility that can provide immediate care for the patient. After evaluation in a medical facility, and a determination that a transfer is medically necessary, the patient may be transported to another medical facility.

2. If applicable to local policy, bypass and diversion protocols may be utilized.

NOTIFICATION TO MEDICAL FACILITY

1. The emergency department must be notified as soon as possible with a detailed report of patient condition and treatment rendered. This must be accomplished in a timely manner, to allow for adequate time to prepare a space for the patient and for the emergency department physician to intervene in treatment if necessary.

ENCOUNTERING ANOTHER INCIDENT WHILE TRANSPORTING A PATIENT

1. If EMS personnel encounter another incident while transporting a patient to the hospital, the crew must stop and evaluate the incident.

   a. If a critical patient is being transported, the EMTs first responsibility lies with the transport patient. If EMS personnel are transporting code 3, the crew must notify dispatch of the second incident and continue transport to the medical facility.
   b. If a non-critical patient is being transported, EMS personnel must evaluate the scene and remain at the scene if necessary to conduct triage, evaluate for additional resources, and treat life threats. One EMT must remain with the patient at all times.

HOSPITAL

TRANSFER OF PATIENT CARE

1. Transporting EMS personnel are responsible for the safe and orderly transfer of patient care to

appropriately licensed hospital personnel (ER Technician, EMT, LPN, RN, or physician).

2. Transporting EMS personnel must give a complete report to licensed hospital personnel, including:

    a. A description of the scene, mechanism of injury, and patient assessment.
    b. All treatment rendered.
    c. Any changes in patient condition during transport.

3. If EMS personnel are requested to remain at the hospital for assistance in patient care, personnel should remain at the hospital until their services are no longer needed. A supervisor or dispatcher must be notified of the situation.

4. EMS personnel are responsible for:

    a. Restocking all supplies.
    b. Sterilization of non-disposable supplies.
    c. Checking all equipment for future readiness.
    d. Maintaining the emergency vehicle in operable condition, ensuring cleanliness, decontamination, and orderliness of equipment and supplies.
    e. Complete all necessary paperwork.

INFECTION CONTROL

GENERAL INFECTION CONTROL

1. These general infection control procedures have been developed to minimize the risk of patient acquisition of infection from contact with contaminated devices, objects or surfaces and of

transmission of an infectious agent from health-care workers to patients. These procedures should also protect health-care workers from the risk of becoming infected. These procedures are designed to prevent transmission of a wide-range of microbiological agents and to provide a wide margin of safety in the varied situations encountered in the health-care environment.

2. Because of work environments that provide inherently unpredictable risks of exposures, general infection-control procedures shall be applicable to all work situations. Exposures are unpredictable, therefore protective measures may often be used in situations that do not appear to present risk.

INFECTIOUS DISEASE

1. Definition - An infection or communicable disease is one that can be transmitted from person-to-person or from an infected animal or the environment to a person.

2. Identification - A person should be considered infectious if he/she displays any of the following:

   a. Current history of infection
   b. Fever
   c. A rash, open sore, or skin lesions anywhere on the body
   d. Diarrhea
   e. Vomiting
   f. Coughing or sneezing, especially with chest pain
   g. Draining wounds (pus, blood or other matter oozing, flowing or spurting from open wounds anywhere in the body)
   h. Profuse sweating
   i. Abdominal pain
   j. Headache accompanied by stiffness in the neck
   k. Signs of jaundice (yellowish discoloration of the skin or in the sclera)

EXPOSURE

1. Contact with blood or potentially infectious body fluids through the following methods:

   a. Needle sticks
   b. Contact of blood or blood-contaminated body fluids with chapped or non-intact skin, open wounds or mucous membranes
   c. Saliva in a human bite
   d. Airborne (TB, etc.)

TREATMENT FOR EXPOSURE

1. Immediately wash the affected area with soap or a decontaminating solution.

2. Consult proper medical authorities for assessment, counseling and preventive treatment as appropriate.

3. Some types of exposure, for example human bites, require attention to prevent other types of infection.

REPORTING EXPOSURES

1. Notify immediate supervisor and the EMS Coordinator.

2. Document the time and nature of exposure and submit an exposure report to your immediate supervisor as soon as possible after the incident.

PREVENTING EXPOSURES

1. Hepatitis B vaccination (HBV) and post exposure follow-up.

   a. General Policy

      i. The employer must make available Hepatitis B vaccinations to all employees who have occupational exposure on an average of one or more times per month and post exposure follow-up for all employees with an occupational exposure incident.
      ii. All medical evaluations and procedures must be performed under the supervision of a licensed physician via guideline or actual, and an accredited laboratory will conduct all laboratory tests.
      iii. All evaluations, procedures, vaccinations and post exposure management must be provided at a reasonable time and place, and according to standard recommendations for medical practice.

   b. HBV Vaccination

      i. HBV vaccination will be offered free of charge to all employees occupationally exposed on an average of one or more times per month to blood or other potentially infectious materials, unless the employee has a previous HBV vaccination or unless antibody testing has revealed that the employee is immune. If the employee initially declines HBV vaccination, but at a later date, while still covered under the standard and still employed by this employer decides to accept the HBV vaccine, the employer will provide the vaccine at that time. Should a booster dose(s) be recommended at a future date, under the same conditions listed above, such booster dose(s) will be provided, free of charge, according to standard recommendations for medical practice.

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PREVENTING EXPOSURES (cont.)

   c. Following a report of an exposure incident, the employer must make available a confidential medical evaluation and follow-up, including at least the following elements:

      i. Documentation of the route(s) of exposure, HBV and HIV antibody status of the source patient if known and the circumstances under which the exposure occurred.
      ii. If the source patient can be determined and permission is obtained, collection of and

testing of the source patient's blood to determine the presence of HIV or HBV infection.

iii. Collection of blood from the exposed employee as soon as possible after the exposure incident for the determination of HIV and/or HBV status. Actual antibody or antigen testing of the blood or serum sample may be done at that time or at a later date if the employee so requests.

iv. Follow-up of the exposed employee including antibody or antigen testing, counseling, illness reporting and safe, effective post-exposure prophylaxis according to standard recommendations for medical practice.

d. For each evaluation under this section, the employer must obtain and provide the employee with a copy of the evaluating physician's written opinion, within 15 working days of the completion of the evaluation. The written opinion should be limited to the following information:

i. The physician's recommended limitations upon the employee's ability to receive Hepatitis B vaccination.

ii. A statement that the employee has been informed of the resulting medical evaluation and that the employee has been evaluated for any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

iii. Specific findings or diagnoses that are related to the employee's ability to receive HBV vaccination, and all findings and diagnoses must remain confidential.

2. Gloves

a. All personnel, prior to initiating any emergency patient care involving exposure to blood or other body fluids, must wear disposable gloves.

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PREVENTING EXPOSURES (cont.)

b. In situations where large amounts of blood or other body fluids are likely to be encountered, personnel must make sure that gloves fit tight at the wrist to prevent contamination. "Double gloving" should be considered.

c. When managing multiple patients during an incident, gloves should be changed and discarded between patient contacts, if time allows.

d. In situations involving glass or other sharp objects (e.g. automobile extrication), disposable gloves must be worn under heavy fire fighting or extrication gloves.

e. While wearing gloves, personnel must avoid handling personal items, such as combs and pens, that could become soiled or contaminated.
f. Gloves that have become contaminated with blood or other body fluids must be removed as soon as possible, taking care to avoid skin contact with the exterior surface. Contaminated gloves must be placed and transported in bags that prevent leakage and will be disposed of.

3. Masks eye-wear and gowns

a. Masks, eyewear and gowns must be present on all emergency vehicles that respond or potentially respond to medical emergencies or victim rescues.
b. These items must be used in accordance with the level of exposure encountered. In cases of massive bleeding, arterial bleeding or the possibility of splashes of blood or body fluids or airborne pathogens, masks and eyewear must be worn.
c. Gowns or aprons must be worn to protect clothing from splashes of blood or other body fluids. If large splashes or quantities of blood or other body fluids are present or anticipated, impervious gowns or aprons must be worn.
d. An extra change of work clothing must be available at all times.

RESUSCITATION

1. During artificial ventilation, disposable airway equipment or equipment that can be cleaned and sterilized must be used. In multiple patient incidents, equipment that has become contaminated by use on one patient may not be used on other patients.

2. All disposable equipment must be properly disposed of and reusable equipment must be cleaned and disinfected after each use.

3. Ventilation devices (e.g. pocket masks, bag-valve masks, and positive pressure ventilators) must be available on all emergency vehicles and to all emergency response personnel that respond or potentially respond to medical emergencies or victim rescues.

DISINFECTION, DECONTAMINATION AND DISPOSAL

1. Needles and sharps

a. All workers must take precautions to prevent injuries caused by needles, scalpel blades and other sharp instruments or devices during procedures or when cleaning used instruments.
b. Needles must not be recapped, purposely bent or broken by hand, removed from disposable syringes or other wise manipulated by hand.
c. After they are used, disposable syringes and needles, scalpel blades and other sharp items must be placed in puncture-resistant containers for disposal.
d. The puncture-resistant containers must be located as close as practical to the use area.

e. Reusable needles must be left on the syringe body and must be placed in a puncture-resistant container for transport to the reprocessing area.

2. Hand washing

a. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood, or other body fluids or other contaminated areas.
b. Hands must always be washed after gloves are removed, even if the gloves appear to be intact. Hand washing must be done using appropriate facilities, such as utility or rest room sinks.
c. Water-less antiseptic hand cleanser must be provided if hand washing facilities are not available.

3. Cleansing, disinfecting and sterilizing

a. Sterilization

i. Steam under pressure (autoclave), gas (ethylene oxide, dry heat, or immersion in an EPA - approved chemical "sterilant" for a prolonged period of time, (e.g. 6-10 hours or according to manufacturer's instructions).

b. High-Level Disinfecting

i. Hot water pasteurization (80-100 C) for 30 minutes or exposure to an EPA-registered "sterilant" chemical as above, except for a short exposure time (10-45 minutes or as directed by the manufacturer).

c. Environmental Disinfecting

i. Environmental surfaces, that have become soiled, must be cleaned and disinfected using any cleaner or disinfectant agent that is intended for environmental use. Such surfaces include floors, woodwork, ambulance seats, counter-tops, etc.
ii. Protective gloves, masks, and gowns must be used if appropriate.

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DISINFECTION, DECONTAMINATION AND DISPOSAL (cont.)

iii. To assure the effectiveness of any sterilization or disinfecting process, equipment and instruments must first be thoroughly cleansed of all visible soil.
iv. All bins, pails, cans and similar receptacles intended for reuse which have a potential for becoming contaminated must be inspected cleaned and disinfected on a regularly scheduled basis and cleaned and disinfected immediately after use of or upon visible contamination.
v. Broken glassware, which may be contaminated, must not be picked up directly with the hands. It must be cleaned up using mechanical means such as a brush and dustpan, a vacuum cleaner, tongs, cotton swabs or forceps.

d. Laundry and Uniforms

i. The employer must make laundry facilities and/or services routinely available.
ii. Soiled linen must be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and or persons handling the linen.
iii. All soiled linen must be bagged at the location where it was used and if soiled with blood it must be transported in bags that prevent leakage.
iv. In general, all laundry (linens, pillowcases, blankets, towels, etc.) must be left at a designated location for service.
v. All work clothing contaminated with blood or other body fluids must be placed and transported in bags or containers that prevent leakage. Personnel involved in the bagging, transport and laundering of contaminated clothing must wear gloves. Protective clothing and uniforms must be washed and dried according to the manufacturer's instructions. Boots and leather goods may be brush-scrubbed with soap and hot water to remove contamination.

INFECTIOUS WASTE

1. The relative risk of disease transmission and application of local regulations determine the selection of procedures for disposal of infectious waste. Infectious waste must be either incinerated or must be decontaminated before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions and secretions may be carefully poured down a drain connected to a sanitary sewer, where permitted.

2. Prior to the removal of protective equipment, personnel remaining on the scene after the patient has been cared for must carefully search for and remove contaminated materials. Debris must be disposed of as noted above.

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TRAINING

1. All personnel must attend a training session on prevention and spread of infectious disease each year. As part of the training, employees will receive:

a. Information as to the location of the written Infection Control Plan as well as any applicable OSHA standards.
b. A general explanation of the epidemiology and symptoms of bloodborne diseases
c. An explanation of the modes of transmission of bloodborne pathogens
d. An explanation of the Infection Control Plan
e. An explanation of the appropriate methods for recognizing tasks and activities that may involve exposure to blood and other potentially infectious materials
f. An explanation of the use and limitations of practices that will prevent or reduce exposure

including appropriate engineering controls, work practices and personal protective equipment.

g. An explanation of the basis for selection of personal protective equipment
h. Information on the Hepatitis B vaccine, including information on its efficacy, safety and benefits of being vaccinated
i. Information on the appropriate actions to take, and persons to contact in the event of an emergency
j. An explanation of the procedures to follow if an exposure incident occurs including the method of reporting the incident and the medical follow-up that will be made available

ADHERENCE TO INFECTION CONTROL POLICIES

1. All personnel must comply with all infection control policies set forth by this service, and will be subject to disciplinary action for failure to do so.

RECORD KEEPING

1. Medical Records

   a. The employer must establish and maintain an accurate record for each employee.
   b. This record must include:

      i. The name and social security number of the employee
      ii. A copy of the employee's hepatitis B vaccination records and medical records relative to the employee's ability to receive vaccination or the circumstances of an exposure incident.
      iii. A copy of all results of physical examinations, medical testing and follow-up procedures as they relate to the employee's ability to receive vaccination or to post exposure evaluation following an exposure incident.
      iv. The employer's copy of the physician's opinion
      v. A copy of the information provided to the physician.

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RECORD KEEPING (cont.)

a. The employer must assure that employee medical records are kept confidential and are not disclosed or reported to any person within or outside the workplace.
b. The employer must maintain this record for at least the duration of employment plus 30 years in accordance with "29 CFR 1910.20 Access to Employee Exposure and Medical Records".

PERSONNEL REQUIREMENTS

MINIMAL QUALIFICATIONS

1. All EMS response personnel, with the exception of "Qualified Drivers", must maintain a current New Mexico EMT or First Responder license.

2. It is the individual responsibility of all EMS personnel to meet or satisfy all requirements for maintaining New Mexico State licensure. This includes successful completion of all required continuing education, refresher courses, and annual CPR certification.

FUNCTIONAL POSITION DESCRIPTION

1. Qualifications

    a. All EMS response personnel must complete a recognized training course from a Bureau approved EMS training institution. They must also possess a valid New Mexico EMT license or First Responder certification.
    b. All drivers must possess a valid New Mexico driver's license, equivalent to New Mexico class "E" or higher and be in compliance with all restrictions.
    c. All response personnel must possess a valid Emergency Vehicle Operator's certificate approved by the EMS Bureau.
    d. All response personnel must meet all requirements of New Mexico Public Regulation Commission Motor Transportation Rules, Title 18, Chapter 3, Part 14.

2. Job Requirements

    a. All personnel responding to emergency calls must possess the following:

        i. Ability to communicate verbally, by telephone or radio.
        ii. Ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance).
        iii. Ability to interpret written and oral instructions.
        iv. Ability to use good judgement and to remain calm in high-stress situations
        v. Ability to work effectively in an environment with loud noises and flashing lights.
        vi. Ability to function efficiently throughout an entire work shift.
        vii. Ability to calculate weight and volume ratios and read small English print, under life threatening time constraints.
        viii. Ability to read and understand English language manuals and road maps.
        ix. Ability to accurately apprehend street signs and address numbers.
        x. Ability to interview patients, family members and bystanders.
        xi. Ability to document, in writing, all relevant information in a prescribed format, and to converse orally and in written form in English with coworkers and hospital staff as to the status of patients.

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FUNCTIONAL POSITION DESCRIPTION (cont.)

        xii. Ability to use good manual dexterity to perform all tasks related to the highest quality of patient care.

QUALITY ASSURANCE

1. All EMS responses will have a corresponding NM EMS EMSTARS Electronic Service Report or the equivalent filled out as soon as possible after the incident. A designated member or committee and/or the system Medical Director must review these reports at least once a month. The purpose of the review is to ensure that appropriate medical care is being provided.

2. Standards that will be evaluated during QA activities are:

   a. Appropriate medical assessments.
   b. Compliance with service protocol
   c. Appropriate medical control
   d. Treatment within the New Mexico Scope of Practice

3. A written report of the problem and corrective action will be provided to the service Medical Director.

4. The Medical Director and/or a designee will address problems and discuss any necessary training and counseling.

5. A written report of any disciplinary action and suggested solutions will be provided to personnel involved with the run, if applicable.

PATIENT CONFIDENTIALITY

PROVIDER/PATIENT RELATIONSHIP

1. Information obtained during an incident that pertains to statements or observations made regarding the patient's appearance, chief complaint, physical assessment, symptoms or treatment is considered privileged patient information.

2. Personnel involved in incidents, or who receive information pertaining to patient(s) must avoid making any comments or entering into conversations regarding details of the patient's condition.

3. Personnel must refrain from making comments or statements that may be considered slanderous or a defamation of character.

4. Personnel must avoid comments that may be considered libel or a defamation of character when preparing written documents regarding an incident.

5. The Service Director or his designee must approve all requests for information, written or verbal, regarding an incident.

RECORD KEEPING

EMS SERVICE REPORT

1. A detailed service report must be filled out for each request for emergency medical service. This report must utilize the NMEMSTARS system (NMEMSTARS.ORG)

2. Incidents that require a detailed run report include, but are not limited to:

   a. All EMS incidents
   b. Standbys
   c. Mutual aid
   d. Canceled runs (if the unit clears the station)
   e. Refusal of service
   f. Make a NIFRS Report for those Fire Based Stations for all rescue responses and Fire

Responses

REFUSAL OF SERVICE

1. The Medical Director approved refusal form must be completed for all patients that refuse treatment and/or transport. This does not include patients that are dead at the scene.