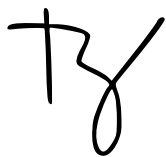


Pecos Valley Public Services  
Emergency Medical Services  
Operations Guidelines

First Responder  
EMT Basic

Reviewed and Adopted from the New Mexico Emergency Medical  
Guidelines  
September 25, 2024

Reviewed and Approved September 25, 2024

A handwritten signature in black ink, consisting of a vertical line for the letter 'T', a horizontal line for the top bar, and a loop for the letter 'B'.

Timothy Bajema, MD  
Medical Director Pecos Valley Public Services EMS

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**DUTY TO PROVIDE SERVICE**

1. It is unlawful for an ambulance or medical rescue service, or any of its personnel or agents, to refuse to provide service to a person in need of emergency medical treatment or transportation, or to require advance payment prior to rendering such service.
2. An ambulance service and its personnel or agents may accept a refusal for treatment or transport from a patient who has been informed of the potential consequences of such a refusal.
3. When ambulance transport is requested or determined to be necessary, an ambulance service shall transport a patient requiring medical treatment to the closest appropriate facility capable of providing definitive care and treatment, as determined by the service's medical director through local EMS system protocol.
4. The ambulance or medical rescue service should make every attempt to give priority to emergency response calls.
5. The ambulance or certified medical rescue service must be available 24 hours a day, 365 days a year or have in place **MUTUAL AID** plans with all appropriate entities that may be implemented anytime the service cannot respond to a call or if a disaster or emergency occurs.
6. The ambulance service or certified medical rescue must develop mutual aid plans with all appropriate entities that may be implemented anytime an ambulance service cannot respond to a call or if a disaster or emergency occurs. Mutual aid that may be provided includes:
  - a. in an emergency or disaster situation when requested by state or local authorities;
  - b. when requested by another EMS service, an EMT, or healthcare facility during an emergency in accordance with established mutual aid agreements;
  - c. when requested by a law enforcement agency or officer; or
  - d. when requested by an official of a political subdivision of the state.

**EMERGENCY MEDICAL DISPATCH (EMD)****EMERGENCY MEDICAL DISPATCHING**

1. Emergency Medical dispatching includes the reception, evaluation, processing, provision of pre arrival instructions, management of requests for emergency medical assistance, and participation in ongoing evaluation and improvement of the emergency medical dispatch process. This process includes identifying the nature of the request, prioritizing the severity of the request, dispatching the necessary resources, providing medical aid and safety instructions to the callers and coordinating the responding resources as needed by does not include call routing.
2. The agency providing Emergency Medical Dispatch is required to be certified by the State of New Mexico and have a Bureau approved Emergency Medical Dispatch Priority Reference System (EMDPRS) used by State licensed Emergency Medical Dispatchers.
3. The agency must have an “EMD Medical Director” who is responsible for the management and accountability for the medical care aspects of an emergency medical dispatch agency including:
  - a. responsibility for the medical decision and care advice rendered by the emergency medical dispatcher and emergency medical dispatch agency;
  - b. approval and medical control of the operational emergency medical dispatch priority reference system (EMD-PRS);
  - c. evaluation of the medical care and pre-arrival instructions rendered by the EMD personnel;
  - d. direct participation in the EMD system evaluation and continuous quality improvement process; and, the medical oversight of the training of the EMD personnel.
4. All dispatchers providing Emergency Medical Dispatch (EMD) must be currently licensed by the State of New Mexico as an Emergency Medical Dispatcher.
5. All EMDPRS protocols used by emergency medical dispatch agencies must be approved by the Bureau and should be used on every request for medical assistance.

**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 [18.3.14.14 NMAC - Rp, 18.3.14.14 NMAC, 2-13-15] and [18.3.14.15 NMAC - Rp, 18.3.14.15 NMAC, 2-13-15].
2. The driver of the emergency vehicle must be a "qualified driver" as defined by the PRC, unless unusual circumstances exist.
3. If the responding Agency is regulated by the PRC, 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 emergency vehicle. If the Agency is certified as a Medical Rescue, a minimum of one New Mexico licensed EMS provider must be present at the scene of an emergency. For transport of a patient, a minimum of one licensed New Mexico-licensed EMS provider must be present in the patient compartment of the medical rescue vehicle at all times while the compartment is occupied by a patient.
4. Healthcare personnel not licensed as an EMS provider may accompany and monitor a patient in the patient compartment of emergency vehicle, provided that at least one appropriate New Mexico licensed EMS provider is also present in the patient compartment, subject to the policies of the EMS agency. 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. If the incident involves multiple patients, a supervisor or his/her designee will determine how many emergency vehicles will respond initially. No more than two severely injured patients may be transported in one emergency vehicle, except in catastrophic events.
6. When an emergency vehicle responds for assistance to the public, and transportation to a medical facility is not required, a qualified driver and at least one EMT, or in the case of a Medical Rescue response, a licensed EMS provider, must respond in the vehicle.
7. When an emergency vehicle responds to stand-by for a planned hazardous event (sporting events, automobile races, etc.), a qualified driver and at least one EMT or in the case of a Medical Rescue response, a licensed EMS provider, must respond in the vehicle.
8. When an emergency vehicle responds for mutual aid by another agency, a qualified driver and at least one EMT, or in the case of a Medical Rescue response, a licensed EMS provider, 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.

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### EMERGENCY RESPONSE PROCEDURE (Cont.)

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. [66-1-1 NMSA 1978];
  - 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. The exemptions granted to an authorized emergency vehicle apply only when the driver of the vehicle, while in motion, sounds an audible signal by bell, siren or exhaust whistle as reasonably necessary and when the vehicle is equipped with at least one lighted lamp displaying a red light visible under normal atmospheric conditions from a distance of five hundred feet to the front of the vehicle, except that an authorized emergency vehicle operated as a police vehicle need not be equipped with or display a red light visible from in front of the vehicle.
5. This section does not relieve the driver of an authorized 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.
6. 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) **EXTREME** caution must be exercised if it becomes necessary to pass.

#### **SEAT BELTS**

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**

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**

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 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). Contact additional resources as needed.
  - 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.
  - 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 (Simple Triage And Rapid Treatment) is a system that quickly distinguishes between critically ill victims and the less severely injured. The goal of 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.
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.

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**MULTIPLE-CASUALTY MANAGEMENT AND START TRIAGE (Cont.)**

- 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****PRIMARY CARE PROVIDER**

1. The licensed 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 credentialed 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 system's 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 document 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" must be used. The backer must be out of the vehicle and not on the vehicle while it is being positioned.
2. Before leaving the scene, the driver must ensure that all passengers are secured by restraining devices.

**TRANSPORT****PATIENT CARE ENROUTE**

1. If the responding Agency is regulated by the PRC, at least one EMT, at the appropriate level, must accompany the patient in the patient compartment at all times during transport. If the Agency is certified as a Medical Rescue, a minimum of one licensed New Mexico EMS provider must be present in the patient compartment of the medical rescue vehicle at all times while the compartment is occupied by a patient. If two critical patients are being transported, at least two appropriate EMS providers 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. 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 may 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 appropriate medical facility that can provide immediate care for the patient. After evaluation in a medical facility, if it is determined 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 trauma activation if necessary, 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 consider if it would be appropriate to 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 stop, evaluate the scene and remain at the scene if necessary to conduct triage, evaluate for additional resources, and treat life threats. One appropriate EMS provider 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 written report to licensed hospital personnel at the time of patient transfer or deliver, if available, containing, at a minimum:
  - a. ambulance unit number, EMT name and level of licensure;
  - b. patient age and sex;
  - c. patient's chief complaint;
  - d. a brief history of the present illness, including scene assessment and mechanism of injury;
  - e. major past illnesses;
  - f. patient's mental status;
  - g. patient's baseline vital signs;
  - h. pertinent findings of the physical examination;
  - i. description of emergency medical care that has been provided for the patient, including that provided by any first response units; and
  - j. the patient's response to the emergency medical care received.
3. Transporting EMS personnel must deliver a copy of the completed pre-hospital patient care record to the receiving facility emergency department for inclusion in the patient's permanent medical record upon delivery of the patient to the hospital; in the event the unit is dispatched on another call, the patient care record shall be delivered as soon as possible after that call, but not later than the end of a shift or 24 hours after the transportation and treatment of the patient;
4. 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.
5. 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.

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**TREATMENT FOR EXPOSURE (Cont.)**

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

**REPORTING EXPOSURES**

1. Notify immediate supervisor.
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, 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.
  - 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.

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## PREVENTING EXPOSURES (Cont.)

- 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.
  - 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 or, in the case of reusable gloves, cleaned and disinfected properly.
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.

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**RESUSCITATION (Cont)**

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 otherwise 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.
    - 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.

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**DISINFECTION, DECONTAMINATION AND DISPOSAL (cont.)**

- 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.

**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

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**TRAINING (Cont.)**

- 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.
  - 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. Successfully complete a recognized training course from an approved EMS training institution;
2. Possess a valid course completion certificate, and accomplish all state licensure examination application requirements;
3. Applicants shall meet all established requirements for initial licensing as identified by the current EMS licensure regulations. A copy of these regulations is available through the EMS bureau;
4. Generally, the knowledge and skills required demonstrate the need for a high school education or equivalent;
5. Ability to communicate verbally; via telephone and radio equipment;
6. Ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance);
7. Ability to interpret written, oral, and diagnostic form instructions;
8. Ability to use good judgment and to remain calm in high-stress situations;
9. Ability to work effectively in an environment with loud noises and flashing lights;
10. Ability to function efficiently throughout an entire work shift;
11. Ability to calculate weight and volume ratios and read small English print, both under life threatening time constraints;
12. Ability to read and understand English language manuals and road maps;
13. Accurately discern street signs and address numbers;
14. Ability to interview patient, family members, and bystanders;
15. Ability to document, in writing, all relevant information in a prescribed format;
16. Ability to converse orally and in written form in English with coworkers and hospital staff as to status of patient;
17. Good manual dexterity, with ability to perform all tasks related to the highest quality of patient care;
18. Ability to assume a variety of postural positions to carry out emergency and non-emergency patient care, including light extrication; from crawling, kneeling, squatting, twisting, turning, bending, to climbing stairs and ladders, and the ability to withstand varied environmental conditions such as extreme heat, cold, and moisture; and
19. Ability to work in low light, confined spaces and other dangerous environments.

**COMPETENCY AREAS**

1. **Licensed EMS First Responder (EMFR):** Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of first responder, to include the ability to demonstrate competency for all skills and procedures currently approved for the first responder, as identified by the current scope of practice document.
2. **Emergency Medical Technician-Basic (EMT-B):** Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-basic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-basic, as identified by the current scope of practice document.

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**COMPETENCY AREAS (Cont)**

3. **Emergency Medical Technician-Intermediate (EMT-I):** Must demonstrate competency handling emergencies utilizing all basic life support and intermediate life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-intermediate, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-intermediate, as identified by the current scope of practice document.
4. **Emergency Medical Technician-Paramedic (EMT-P):** Must demonstrate competency handling emergencies utilizing all basic life support and advanced life support equipment and skills in accordance with all behavioral objectives of an approved New Mexico curriculum of EMT-paramedic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-paramedic, as identified by the current scope of practice document.

**DESCRIPTION OF TASKS FOR ALL EMS LEVELS**

1. Receives call from dispatcher, responds verbally to emergency calls, reads maps, may drive emergency vehicle to emergency site, uses most expeditious route, and observes traffic ordinances and regulations.
2. May use equipment and other devices and procedures as authorized by level of licensure and scope of practice.
3. Assists in lifting, carrying, and transporting patient to an ambulance and to a medical facility.
4. Reassures patients and bystanders and searches for medical identification emblem to aid in care.
5. Extricates patient from entrapment, assesses extent of injury, uses prescribed techniques and appliances, radio dispatcher for additional assistance or services, provides light rescue service if required and trained, provides additional emergency care following service established protocols.
6. Complies with regulations in handling deceased, notifies authorities, arranges for protection of property and evidence at scene.
7. Determines appropriate facility to which patient will be transported, report nature and extent of injuries or illness to the facility, asks for direction from hospital physician or emergency department staff.
8. Observes patient in route and administers care as directed by physician or service-established protocols.
9. Identifies diagnostic signs that require communication with facility.
10. Assists in removing patient/s from ambulance and into emergency facility.
11. Reports verbally, and in writing, observations about and care of patient at the scene, en-route to facility, and to the receiving facility.
12. Provides assistance to emergency department staff as required.
13. Replaces supplies, sends used supplies for sterilization, checks all equipment for future readiness, maintains ambulance in operable condition, ensures ambulance cleanliness and orderliness of equipment and supplies, decontaminates vehicle interior, determines vehicle readiness by checking oil, gas, water in battery and radiator, and tire pressure, maintains familiarity with all specialized equipment.

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**COMPETENCY AREAS (Cont)****CRIMINAL HISTORY BACKGROUND SCREENING**

1. The EMS Bureau is authorized to obtain the criminal history records of applicants and licensees and to exchange fingerprint data directly with the federal bureau of investigation, the department of public safety and any other law enforcement agency or organization. The Bureau requires fingerprinting of applicants and licensees for the purposes of this section. The purpose of the process includes:
  - a. criminal history background checks for applicants and licensees;
  - b. identify the information from a criminal history background check that may form the basis of a denial, suspension or revocation of licensure or any other disciplinary action
  - c. otherwise carry out the provisions of this section.
2. The Bureau must comply with applicable confidentiality requirements of the department of public safety and the federal bureau of investigation regarding the dissemination of criminal history background check information.
3. An applicant or licensee whose license is denied, suspended or revoked, or who is otherwise disciplined based on information obtained in a criminal history background check, is entitled to review the information obtained pursuant to this section and to appeal the decision pursuant to the Uniform Licensing Act [61-1-1 through 61-1-31 NMSA 1978].
4. The applicant or licensee will bear any costs associated with ordering or conducting criminal history background checks.
5. The provisions of the Criminal Offender Employment Act [28-2-1 through 28-2-6 NMSA 1978] will govern any consideration of criminal history records required or permitted by the Emergency Medical Services Act.



**QUALITY ASSURANCE**

1. The ambulance service must have a written Quality Assurance (QA) program.

All EMS responses will have a corresponding NM EMS Service Report or the equivalent completed and delivered to the receiving medical facility upon delivery of the patient to the hospital. In the event the unit is dispatched on another call, the patient care record must be delivered as soon as possible after that call, but not later than the end of a shift or twenty-four (24) hours after the transportation and treatment of the patient. The minimum patient information required upon patient delivery to the destination facility includes:

  - a. ambulance unit number, EMT name and level of licensure
  - b. patient age and sex
  - c. patient's chief complaint or EMT's primary impression
  - d. a brief history of the present illness, including scene assessment and mechanism of injury
  - e. major past illnesses
  - f. patient's mental status
  - g. patient's baseline vital signs
  - h. pertinent findings of the physical examination
  - i. description of emergency medical care that has been provided for the patient, including that provided by any first response units
  - j. the patient's response to the emergency medical care received.
2. A designated member or committee and/or the system Medical Director must review these reports at least quarterly to determine whether appropriate medical care is being provided.
3. The Medical Director, or designee, must document the steps taken during the review. Subsequent reviews must include an evaluation of whether appropriate follow-up has been accomplished. Receiving hospitals and other EMS agencies within the patient catchment area should be invited to participate in these reviews when appropriate;
4. Standards that will be evaluated during QA activities are:
  - a. Appropriate medical assessments.
  - b. Compliance with service protocol
  - c. Appropriate medical control
  - d. Treatment in compliance with the New Mexico Scope of Practice
5. The Medical Director and/or a designee will address problems and discuss any necessary training and counseling.
6. 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.

**HIPAA ( Health Insurance Portability and Accountability Act)**

1. This Privacy Rule was enacted to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. A complete description of the rule can be found at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>
2. Protected Information includes all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information" (PHI).
3. Individually identifiable health information is information, including demographic data, that relates to:
  - a. the individual's past, present or future physical or mental health or condition,
  - b. the provision of health care to the individual, or
  - c. the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).
4. The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
5. There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either: (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

**RECORD KEEPING****EMS SERVICE REPORT**

1. It is required by the PRC that ambulance services complete a patient run report for each patient contacted during an emergency response or inter-facility transport; the minimum data elements from these reports, as identified by the EMS bureau, shall be compiled to the extent possible and submitted to the pre-hospital data collection system at the EMS bureau as prescribed in 7.27.4 NMAC, Emergency Medical Services Fund Act;
2. Minimum patient information required upon patient delivery to the destination facility, pursuant to ambulance service protocol, an ambulance service shall communicate, electronically or in writing, clinical patient information to the intercepting ambulance or receiving facility at the time of patient transfer or delivery, if available:
  - a. Ambulance unit number, EMT name and level of licensure;
  - b. Patient age and sex;
  - c. Patient's chief complaint or EMT's primary impression;
  - d. A brief history of the present illness, including scene assessment and mechanism of injury;
  - e. Major past illnesses;
  - f. Patient's mental status;
  - g. Patient's baseline vital signs;
  - h. Pertinent findings of the physical examination;
  - i. Description of emergency medical care that has been provided for the patient, including that provided by any first response units; and
  - j. The patient's response to the emergency medical care received.
3. An ambulance service shall deliver an electronic or written copy of the completed pre-hospital patient care record to the receiving facility emergency department for inclusion in the patient's permanent medical record upon delivery of the patient to the hospital; in the event the unit is dispatched on another call, the patient care record shall be delivered as soon as possible after that call, but not later than the end of a shift or twenty four (24) hours after the transportation and treatment of the patient;
4. Incidents that require a detailed run report include, but are not limited to:
  - a. EMS incidents
  - b. Standbys
  - c. Mutual aid
  - d. Canceled runs (if the unit clears the station)
  - e. Refusal of service

**SERVICE RECORDS**

1. All ambulance and medical rescue services are required to maintain accurate and separate records of its services in New Mexico, including but not limited to:
  - a. driver records including current licenses, history of DOT physical examinations or physician certifications, and emergency vehicle operator training history;
  - b. EMS personnel licensure;
  - c. statement of employment or volunteer status, including employment start and stop dates;
  - d. records of equipment, such as reports, repair and maintenance records, equipment lists,

- vehicle titles, and registration certificates;
- e. complete accounts;
  - f. organized records of all ambulance runs, including a copy of the patient care record.
  - g. patient care records retention: an ambulance service shall retain pre-hospital patient care records for seven (7) years, as approved by local medical protocol;
  - h. An ambulance service may only release patient care records as provided by state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA).

**REFUSAL OF SERVICE FORM**

1. A refusal form must be completed for all patients that are potentially in need of emergency care, but refuse treatment and/or transport. This does not include patients that are dead at the scene.