Title 15 - Mississippi Department of Health

Part III – Office of Health Protection

Subpart 31 – Bureau of Emergency Medical Services

Chapter 01 AMBULANCE SERVICE LICENSURE

100 Ambulance Service Licensure

100.01 §41-59-9. License and permit required.

From and after October 1, 1974, no person, firm, corporation, association, county, municipality, or metropolitan government or agency, either as owner, agent or otherwise, shall hereafter furnish, operate, conduct, maintain, advertise or otherwise engage in the business of service of transporting patients upon the streets, highways or airways of Mississippi unless he holds a currently valid license and permit, for each ambulance, issued by the board.

SOURCES: Laws, 1974, ch. 507, § 5(1), eff from and after passage (approved April 3, 1974).

100.02 §41-59-11. Application for license.

1. Application for license shall be made to the board by private firms or nonfederal governmental agencies. The application shall be made upon forms in accordance with procedures established by the board and shall contain the following:

    a. The name and address of the owner of the ambulance service or proposed ambulance service;

    b. The name in which the applicant is doing business or proposes to do business;

    c. A description of each ambulance including the make, model, year of manufacturer, motor and chassis numbers, color scheme, insignia, name, monogram, or other distinguishing characteristics to be used to designate applicant's ambulance;

    d. The location and description of the place or places from which the ambulance service is intended to operate; and

    e. Such other information as the board shall deem necessary.

2. Each application for a license shall be accompanied by a license fee to be fixed by the board, which shall be paid to the board

SOURCES: Laws, 1974, ch. 507, § 5(2); 1979, ch. 445, § 1; 1982, ch. 345, § 1; 1991, ch. 606, § 3, eff from and after July 1, 1991.

100.03 §41-59-13. Issuance of license.

The board shall issue a license which shall be valid for a period of one (1) year when it determines that all the requirements of this chapter have been met.

SOURCES: Laws, 1974, ch. 507, § 5(3), eff from and after passage (approved April 3, 1974).

Rules and Regulations

The Bureau of Emergency Medical Services (BEMS) licenses ambulance services by location and issues permits for each vehicle operated at the location licensed. Individual problems regarding licensure that arise are dealt with by the BEMS. If locations are used to intermittently station ambulance employees and vehicles, and do not serve as points of contact for public business or for deployment control/dispatch centers, licenses for those locations are not required. Ambulance service areas that extend through multiple and/or adjacent counties require an ambulance service license for each county within that area. In these instances, licensure is required though there may not be a fixed identifiable location in each county. BEMS may, at its discretion, allow for exceptions, i.e. when an ambulance service from a single control point provides coverage for only portions of counties that are adjacent, only one license is required.

1. A provider of ambulance service can be licensed by the Bureau of Emergency Medical Services as an ambulance service by request and by signing a completed application for service license (EMS Form 1). An inspection of premises must be made. A member of the BEMS staff will complete the EMS Form 1 due to the coding requirements of the form.

2. If it is determined that the provider meets all requirements, the BEMS staff member has the authority to grant a license at the time of inspection. The owner copy of EMS Form 1 shall serve as proof of service license until permanent document is received by owner. The license is valid for one (1) year from date of issuance. Any change of service ownership constitutes issuance of a new license and permit(s).

3. Applicants for ambulance service license must provide a roster of all employees including Medical First Responders, EMTs, EMS-Ds, dispatchers, RNs, and others if appropriate. This list must include state-issued certification and/or license numbers where applicable.

4. Applicant must submit one copy of the plan of medical control at least 30 days prior to service start date for approval by the BEMS staff and the

State EMS Medical Director. The plan must include the patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan. All Medical Control Plans shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services.

5. Plan must include the names of all off-line and on-line medical directors accompanied by credentials, proof of Mississippi physician licensure and controlled substances registration number. The Ambulance Service Medical Director must be approved by the State EMS Medical Director. In addition, controlled substances registration number and DEA required controlled substances registration certificate for non-hospital based paramedic services for the off-line medical director. Only the lead on-line medical director or each medical control hospital need be listed. Additionally the primary resource hospital and associate receiving hospital(s); description of methods of medical control; quality assurance and skill maintenance process must be included (See Appendix 1).

NOTE: Revisions in the medical control plan must be submitted prior to implementation. At a minimum, medical control plans shall be resubmitted to BEMS every three (3) years for approval by the BEMS staff and the State EMS Medical Director.

a. Applicant must provide a letter signed by the off-line medical director stating he/she approves the ambulance provider's protocols and understands his/her responsibilities as stated in Appendix 1 of this document. This statement may be on forms provided by BEMS.

b. Applicant must provide evidence of 24-hour continuous service capabilities including back-up. Should also include staffing pattern and affiliations with non-transporting ALS services where applicable.

c. Applicant must provide a description of its communications capabilities, however - minimally - the system must be capable of communicating with the primary resource hospital throughout its immediate area of response.*

d. 911 is the universal emergency phone number for public access of Emergency Medical Services in the State. Ambulance service providers shall only advertise 911 as their emergency number. Exception: If a municipality or county has not implemented 911, then for that area, a seven-digit phone number may be used. This exception must have prior approval in writing by the BEMS. It is the intent of this regulation that 911, the universal access number for EMS, be the only emergency number advertised to the public. Any advertisement of a non-emergency phone number must include a

prominent display of 911 or other BEMS approved emergency phone number.

**(Bio-medical telemetry is not required if so documented in the communications plan by the medical director).*

NOTE: Ambulance services shall submit Mississippi Uniform Accident Reports involving EMS permitted vehicles with license renewals

100.04 <u>§41-59-15. Periodic inspections.</u>

Subsequent to issuance of any license, the board shall cause to be inspected each ambulance service, including ambulances, equipment, personnel, records, premises and operational procedures whenever such inspection is deemed necessary, but in any event not less than two (2) times each year. The periodic inspection herein required shall be in addition to any other state or local safety or motor vehicle inspections required for ambulances or other motor vehicles provided by law or ordinance.

SOURCES: Laws, 1974, ch. 507, § 5(4), eff from and after passage (approved April 3, 1974)

"It shall be a regulation of the State Board of Health that during the inspection of emergency and/or invalid vehicles the owner, or an employee of the particular ambulance company, be present during the inspection and where necessary be subject to demonstrating certain equipment items."

<u>Policy for Administration</u>

Inspections to insure compliance with the law will be made not less than two (2) times each year licensed and in most cases four (4) times.

100.05 <u>§41-59-17. Suspension or revocation of license; renewal</u>

1. The board is hereby authorized to suspend or revoke a license whenever it determines that the holder no longer meets the requirements prescribed for operating an ambulance service.

2. A license issued under this chapter may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board. Renewal of any license issued under the provisions of this chapter shall require conformance with all the requirements of this chapter as upon original licensing.

SOURCES: Laws, 1974, ch. 507, § 5(5, 6); 1979, ch. 445, § 2; 1982, ch. 345, § 2; 1991, ch. 606, § 4, eff from and after July 1, 1991.

3. No employer shall employ or permit any employee to perform any services for which a license/certificate or other authorization (as required by this act or by the rules and regulations promulgated pursuant to this act) unless and until the person possesses all the licenses, certificates or authorization that are so required.

4. No owner of a publicly or privately owned ambulance service shall permit the operation of the ambulance in emergency service unless the attendant on duty therein possesses evidence of that specialized training as is necessary to insure that the attendant or operator is competent to care for the sick or injured persons, according to their degree of illness or injury, who may be transported by the ambulance, as set forth in the emergency medical training and education standards for emergency medical service personnel established by the State Department of Health, Bureau of EMS.

5. The owner/manager or medical director of each publicly or privately owned ambulance service shall immediately inform the State Department of Health, Bureau of EMS of the termination or other disciplinary action taken against an employee because of the misuse of alcohol, narcotics, other controlled substances, or any failure to comply with an employer's request for testing.

6. A Mississippi licensed ambulance service shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services. Licensed service must follow the respective region's patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan.

7. Other common grounds for suspension or revocation are for example, but not limited to:

    a. Lack of State certified EMT attending patient.

    b. Lack of driver with valid driver's license and state EMS driver certification.

    c. Lack of proper equipment required by law.

    d. Not adhering to sanitation of vehicle and equipment requirements.

    e. Failure to adhere to record keeping or reporting requirements required by BEMS.

    f. Failure to maintain proper insurance required by law.

8. A license can be temporarily suspended or revoked by any staff member of the BEMS at time of violation, and will be followed up by a letter of temporary suspension or revocation. This letter will be certified, return receipt requested. This action may be taken with just cause in an effort to protect the public. Within five days from the time of temporary suspension or revocation, BEMS may extend the suspension, reinstate or revoke the license.

9. The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

Other Information

The right to appeal process is discussed in section 41-59-49.

101 OWNERSHIP CHANGES

101.01 §41-59-19. Changes of ownership.

1. The board is authorized to provide for procedures to be utilized in acting on changes of ownership in accordance with regulations established by the board.

2. The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

   SOURCES: Laws, 1974, ch. 507, § 5(7), eff from and after passage (approved April 3, 1974).

Policy and Administration

Any change of ownership or location voids original license and permit(s). Such changes constitute issuance of new service license and permit(s). (Application process must be initiated and completed by the new owner).

102 CONFORMANCE WITH LOCAL LAWS

102.01 §41-59-21. Licensee to conform with local laws or regulations.

1. The issuance of a license shall not be construed to authorize any person, firm, corporation or association to provide ambulance services or to operate any ambulance not in conformity with any ordinance or regulation enacted by any county, municipality or special purpose district or authority.

   SOURCES: Laws, 1974, ch. 507, § 5(8), eff from and after passage (approved April 3, 1974).

103 PERMITS, ALL VEHICLES

103.01 §41-59-23. Ambulance permit.

1. Before a vehicle can be operated as an ambulance, its licensed owner must apply for and receive an ambulance permit issued by the board for such vehicle. Application shall be made upon forms and according to procedures established by the board. Each application for an ambulance permit shall be accompanied by a permit fee to be fixed by the board, which shall be paid to the board. Prior to issuing an original or renewal permit for an ambulance, the vehicle for which the permit is issued shall be inspected and a determination made that the vehicle meets all requirements as to vehicle design, sanitation, construction, medical equipment and supplies set forth in this chapter and regulations promulgated by the board. Permits issued for ambulance shall be valid for a period not to exceed one (1) year.

2. The board is hereby authorized to suspend or revoke an ambulance permit any time it determines that the vehicle and/or its equipment no longer meets the requirements specified by this chapter and regulations promulgated by the board.

3. The board may issue temporary permits valid for a period not to exceed ninety (90) days for ambulances not meeting required standards when it determines the public interest will thereby be served.

4. When a permit has been issued for an ambulance as specified herein, the ambulance records relating to maintenance and operation of such ambulance shall be open to inspection by a duly authorized representative of the board during normal working hours.

5. An ambulance permit issued under this chapter may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board. Renewal of any ambulance permit issued under the provisions of this chapter shall require conformance with all requirements of this chapter.

   SOURCES: Laws, 1974, ch. 507, § 6; 1979, Ch. 445, § 3; 1982, ch. 345, Section 3; 1991, ch. 606, Section 5, eff from and after July 1, 1991.

Policy for Administration

1. Permits are issued by the BEMS to a licensed ambulance service after an inspection of the vehicles and equipment has been completed and a determination made by BEMS that all requirements have been met.

2. Permits issued shall expire concurrently with the service license.

3. An EMS Form 2 must be filled out by BEMS and signed by the owner or his designated representative.

4. BEMS may give permission for vehicle operation at the time of inspection if judgment is made that the vehicle meets all requirements. The owner copy of EMS Form 2 shall serve as proof of permit until permanent document is received by owner.

5. All permits for vehicles are issued by licensed location. If, at any time, a vehicle is permanently moved to a new location a new inspection must be made and a new permit issued in accordance with the service license for the new location.

6. Common grounds for suspension or revocation of vehicle permit are, for example:

   a. Improper or lack of essential required equipment, design and construction standards

   b. Sanitary requirements not maintained

   c. Lack of properly certified personnel in rear of vehicle when patient is present or lack of properly qualified driver

   d. Failure to maintain insurance as required

e. Change in location of vehicle

f. Failure to carry BEMS issued permit card on vehicle

7. Common grounds for issuance of temporary permit (limited to 90 days) are for example:

a. Minor equipment items missing, but to be replaced within a reasonable time period.

b. Permitted vehicle is under repair and a replacement vehicle, meeting standards, is needed on a temporary basis.

104 VEHICLE STANDARDS

104.01 <u>§41-59-25. Standards for ambulance vehicles.</u>

1. Standards for the design, construction, equipment, sanitation and maintenance of ambulance vehicles shall be developed by the board with the advice of the advisory council. Each standard may be revised as deemed necessary by the board when it determines, with the advice of the advisory council that such will be in the public interest. However, standards for design and construction shall not take effect until July 1, 1979; and such standards when promulgated shall substantially conform to any pertinent recommendations and criteria established by the American College of Surgeons and the National Academy of Sciences, and shall be based on a norm that the ambulance shall be sufficient in size to transport one (1) litter patient and an emergency medical technician with space around the patient to permit a technician to administer life supporting treatment to at least one (1) patient during transit.

2. On or after July 1, 1975, each ambulance shall have basic equipment determined essential by the board with the advice of the advisory council.

3. Standards governing the sanitation and maintenance of ambulance vehicles shall require that the interior of the vehicle and the equipment therein be maintained in a manner that is safe, sanitary, and in good working order at all times.

4. Standards for the design, construction, equipment and maintenance of special use EMS vehicles shall be developed by the board with advice of the advisory council.

SOURCES: Laws, 1974, ch. 507, § 7(1-3); 1991, ch. 482, § 2, eff from and after July 1, 1991.

Cross references -Definition of authorized emergency vehicles, see § 63-3-103. Lights required on emergency vehicles, see § 63-7-19.

Rules and Regulations

1. Standards for the design, construction and equipment of ambulance vehicles.

2. All new ambulance vehicles, before being issued an original ambulance permit as authorized by Mississippi Code 41-59-23, shall conform to current Federal Specification `Star-of-Life Ambulance' as published by the General Services Administration, Specification Section. Ambulances that were constructed prior to the implementation of the current Federal Specifications shall conform to the applicable Federal Specifications that were in effect at the time of original construction. The following are exceptions and additions:

3. Height

    a. Overall height of the ambulance at curb weight shall not exceed 110 inches, excluding roof-mounted light bars and communications accessories.

4. Color Paint and Finish

    a. The exterior color of the ambulance shall be basically white in combination with a solid uninterrupted orange stripe and blue lettering and emblems. The band (stripe) of orange not less than 6 inches wide, nor more than 14 inches wide shall encircle the entire ambulance body configuration at the belt line below the lowest edge of cab windows but may exclude the front of the hood panel. (The orange stripe may be edged/pin striped in black or blue.) This solid (single) band, when viewed horizontally, shall appear as a stripe near parallel to the road. When vinyl orange stripes are used rather than paint, it is acceptable to interrupt the strip at the corners of the vehicle to allow the vinyl to mold appropriately.

5. Additional lettering and markings are allowed in, above and below the stripe, however, these markings shall not completely traverse or interrupt the stripe at any point.

6. The name of the ambulance company shall be printed in minimum 4 inch high letters of highly visible contrasting color on each side of the ambulance or on the doors.

7. Letters, words, phrases, or designs suggesting special services, i.e., advanced life support, etc., shall be allowed provided such specialty services are in fact available in the vehicle at all times when in operation.

8. If the construction and design of an ambulance prohibits the placement of the ambulance (reverse) decal on the front hood, it shall be an acceptable exemption. BEMS shall have the authority to grant exceptions to requirements for color, paint, finish and essential equipment for certain transport capable vehicles that are used exclusively for special situations, i.e. neonatal transport.

9. The BEMS shall have the authority to grant exceptions to requirements for color, paint, finish, and essential equipment for certain transport capable vehicles that are used exclusively for special situations, i.e. neonatal transport, etc. If the special needs of the patient-types for these special use vehicles are not met by the standards required in these regulations, the vehicles shall be exempt from said regulations and instead should be equipped with essential equipment needed to manage the individual patient types.

10. Suction aspirator system

    a. Shall be electrically powered. Shall provide a free airflow of at least 30 lpm at the distal end of the connected patient hose. It shall achieve a vacuum of at least 300 mmHG (11.8 inches) within 4 seconds after the suction tube is clamped closed.

11. Portable suction aspirator

    a. The unit will be self-contained, portable, battery operated, suction apparatus with wide-bore tubing. Gas powered or manual, portable suction aspirators may be substituted for battery operated suction units provided that they meet same operational standards.

12. Two-way (mobile) radio equipment

    a. One two-way radio (155.340 MHZ) or acceptable alternative that is compatible or interoperable for communication on radio frequency 155.340.

13. Standard mandatory miscellaneous equipment

    a. Unless otherwise precluded elsewhere in this specification, each ambulance shall be equipped with, but not limited to, the following:

14. Fire extinguisher: one, ABC dries chemical, multi-purpose (Halon, C02) minimum 5 pound unit in a quick-release bracket mounted in the patient compartment.

15. Medical, surgical, and bio-medical equipment

a. When specified, the ambulance shall be equipped with, but not limited to, the following:

b. One stretcher for primary patient as specified in current Federal Specifications for ambulances, dimensions as per KKK-A-1822.

c. 3 strap type restraining devices (chest, hip, knee) attached to stretcher. Straps shall not be less than two inches wide, nylon, and consist of two-piece assembly with quick release buckles.

d. Portable and fixed oxygen equipment with variable flow regulator capable of delivering 15 lpm in calibrated increments. Cylinder must contain 300 psi of medical grade 02 at a minimum.

e. Three oxygen masks, adult. (Non-rebreathing face mask)

f. One oxygen mask, child.

g. One oxygen mask, infant.

h. Three oxygen bi-pronged nasal cannulas.

i. One mouth-to-mask artificial ventilation device with supplemental oxygen inlet port with one-way valve, i.e., "pocket mask", etc.

j. One bag-valve-mask device, adult, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

k. One bag-valve-mask device, pediatric, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

l. One bag-valve-mask device, infant, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

m. Two adult oropharyngeal airways.

n. Two child oropharyngeal airways.

o. Two infant oropharyngeal airways.

p. One adult nasopharyngeal airway 28-36 fr. or 7.0-9.0 mm.

q. One child nasopharyngeal airway 20-26 fr. or 5.0-6.0 mm.

r. One bite stick.

s. Six large, sterile, individually wrapped, trauma dressings (minimal six 8" x 10").

t. Twelve sterile, individually wrapped (or in two's), dressings 4" x 4".

u. Three soft roller bandages, 4" or larger.

v. Three triangular bandages or commercial arm slings.

w. Two rolls adhesive tape, 2" or larger.

x. One pair of shears for bandages.

y. One sterile, Vaseline gauze, 3" x 8" or larger.

z. One rigid cervical collar, large.

aa. One rigid cervical collar, medium.

bb. One rigid cervical collar, small.

NOTE: Two adjustable, rigid collars may be substituted for items 1.7.1.7.25., 1.7.1.7.26., and 1.7.1.7.27.

cc. One lower extremity traction splint, limb-support slings, padded ankle hitch, padded pelvic support, traction strap.

dd. Assorted sized extremity immobilization devices which will provide for immobilization of joint above and joint below fracture and rigid support and be appropriate material (cardboard, metal, pneumatic, wood, plastic, etc.).

ee. One short spine board with accessories or commercial equivalent (KED, Kansas Board, etc.).

ff. Two long spine boards with accessories.

gg. One folding stretcher as specified in current Federal Specifications for Ambulances, style 3 (folding legs optional) or a combination stretcher chair designed to permit a patient to be carried on stairways and/or through narrow areas.

hh. Two blanket rolls or commercial equivalent.

ii. Two sterile or clean burn sheets (packaged and stored separately from other linens).

jj. Six clean sheets (2 on cot and 4 spare).

kk. Three pillow cases (1 on pillow and 2 spare).

ll. Two blankets.

mm. One sterile OB kit.

nn. One adult blood pressure cuff with aneroid gauge.

oo. One pediatric blood pressure cuff with aneroid gauge.

pp. One stethoscope.

qq. One roll aluminum foil or silver swaddler (enough to cover newborn).

rr. Infant blood pressure cuff with aneroid gauge.

ss. One penlight/flashlight.

tt. Two liters sterile water for irrigation.

NOTE: Sterile saline may be substituted. Unbroken seal required.

uu. One container of water for purging fixed suction device.

vv. One container of water for purging portable suction devices.

ww. One 15g. glucose or other commercial derivative for oral administration.

xx. 50g. activated charcoal.

yy. Infectious disease precaution materials

zz. Disposable latex gloves (6 pair)

aaa. Disposable goggles and masks (2 pair) or face shields (4)

bbb. Impervious gown or apron (2)

ccc. Disinfectant for hands and equipment

ddd. Sharps container (see OSHA regulations in Appendix 8)

eee. Two leakproof plastic bags for contaminated waste.

fff. Two disposable rigid non-metallic suction tips with wide-bore inside diameter of at least 18 fr.

ggg. Two of each size sterile disposable suction catheters

i. (2 each - 5-6 fr.)

ii. (2 each - 8-10 fr.)

iii. (2 each - 14-18 fr.)

hhh. One bedpan, one urinal, and one emesis basin or commercial equipment.

iii. Automated external defibrillator (AED) (Basic Level Ambulance Only)

NOTE: In addition to the previously listed BLS regulations, the following additional ALS requirements must be met:

a. Only vehicles meeting current state regulations for emergency ambulance classifications may be approved and permitted as ALS vehicles.

b. All ALS vehicles shall conform to the advanced equipment guidelines established by the American College of Surgeons, Committee on Trauma, and as may be modified by the State Board of Health.

c. If not stored on the ambulance, the equipment and supplies required for advanced life support at the EMT-Intermediate or EMT-Paramedic level, must be stored and packaged in such a manner that they can be delivered to the scene on or before the response of the ALS personnel. This may be accomplished by rapid response units or other non-ambulance emergency vehicle.

NOTE: ALS services are required to have ALS equipment commensurate with the ALS staffing plan submitted as part of the application for service licensure.

104.02 <u>EMT- Intermediate</u>

For the EMT-I all the equipment for the EMT-B as previously listed plus the following equipment and supplies:

1. Intravenous administration equipment (fluid should be in bags, not bottles), ringers lactate and/or normal saline (4000 ML minimum), dextrose (5% in water 250 cc bags, 2 each minimum), intravenous administration set (3 each), intravenous catheter with needle (1"-3" in length; 22, 20, 18, 16, 14 gauge, 6 each minimum), venous tourniquet, antiseptic solution, IV pole or roof hook.

2. Airway

a. Esophageal obturator airway or esophageal gastric tube airway with mask, 35cc syringe, stethoscope. (NOTE: May utilize either EOA, EGTA, PTL, or combitube.)

b. End-tidal CO2 Detectors (may be made onto bag valve mask assemblies or separate)

3. Cardiac

4. Manual monitor defibrillator (with tape write-out), Defibrillation pads or jell, quick-look paddles, EKG leads, Chest attachment pads (telemetry radio capability optional). Automated or semi-automated defibrillator (AED) which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a rhythm and display a message advising the operator to press a "shock" control to deliver the shock; c) must be capable or retaining and reproducing a post event summary (at a minimum the post event summary should include time, joules delivered and ECG). (Intermediate Level Ambulance Only)

104.03 EMT-Paramedic

All the equipment and supplies listed above plus the following additional equipment and supplies:

1. Airway

   Endotracheal tube (adult, child, and infant sizes), 10cc syringes, stylets, laryngoscope handle, blades (adult, child, and infant sizes, curved and/or straight), end-tidal CO2 detector (adult and pediatric).

2. Manual cardiac monitor defibrillator with tape write-out and synchronization capabilities.

3. Drugs:

   a. The Bureau of EMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA) will approve pharmaceuticals available for use by EMS providers. A list of 'Required', 'Optional', and 'Transport only' drugs for EMS providers in the State is compiled and maintained by the BEMS and the MDTQA. All pharmaceuticals carried and administered by EMS providers in the state must be in the 41 classifications of drugs as defined by the 1998 EMT-Paramedic National Standard Curriculum. A current list of fluids and medications approved for initiation and transport by Mississippi EMS providers is available from the BEMS office or the BEMS website (www.msems.org).

NOTE: A System Medical Director may make requests for changes to the list. These requests should be submitted in writing to the BEMS. All requests must detail the rationale for the additions, modifications, or deletions.

104.04 Sanitation regulations

The following shall apply regarding sanitation standards for all types of ambulance vehicles:

1. The interior of the ambulance and the equipment within the ambulance shall be sanitary and maintained in good working order at all times.

2. Equipment shall be made of smooth and easily cleanable construction.

3. Freshly laundered linen or disposable linen shall be used on cots and pillows and linens shall be changed after each patient is transported.

4. Clean linen storage shall be provided on each ambulance.

5. Closed compartments shall be provided within the ambulance for medical supplies.

6. Pillows and mattresses shall be kept clean and in good repair.

7. Closed containers shall be provided for soiled supplies.

8. Exterior and interior surfaces of ambulance shall be cleaned routinely.

9. Blankets and hand towels used in any ambulance shall be clean.

10. Implements inserted into the patient's nose or mouth shall be single service, wrapped and properly stored and handled. When multi-use items are used, the local health care facilities should be consulted for instructions in sanitation and handling of such items.

11. When an ambulance has been utilized to transport a patient known to the operator to have a communicable disease, the vehicle shall be placed "out of service" until a thorough cleansing is conducted.

12. All storage spaces used for storage of linens, equipment, medical supplies and other supplies at base stations shall be kept clean and free from unnecessary articles. The contents shall be arranged so as to permit thorough cleaning.

13. In addition, current CDC and OSHA requirements apply.

Other Information

1. Narcotics

   a. Certified ALS personnel (paramedics and RNs) functioning under approved medical control jurisdiction may be issued approved controlled substances for pre-hospital use upon the discretion of the off-line medical director. For ALS services that are not hospital-based, the Drug Enforcement Administration (DEA) requires the off-line medical director to secure a separate CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE to store, issue and prescribe controlled substances to ALS personnel. This CERTIFICATE should list the medical director as a "practitioner" at the physical address of the ambulance service where the drugs are stored. The off-line medical director will determine who may issue and administer the controlled substances and who will have access to storage of these narcotics.

   b. Controlled substances must be secured in accordance with applicable state and federal regulations. The paramedic's narcotics should be secured in a designated location when he is not on duty and actively functioning under the service's medical control. When on duty, each paramedic should keep his controlled drugs in his immediate possession or securely locked in the vehicle at all times.

   c. Whenever an order is received from medical control for administration of a narcotic, the paramedic must keep track of the vial/ampule being utilized. If the full amount of the narcotic was not administered, the remainder must be wasted in the presence of a witness and the witness must sign the patient report documenting same. The witness should preferably be a licensed health care provider who is authorized to administer narcotics themselves.

   d. Narcotics should be replaced and logged within 24 hours of administration. Narcotics logs should be maintained by the ALS service. Paramedics should individually document the following minimum information in the narcotics log:

      i. Date of administration

      ii. Time of administration

      iii. Amount administered

      iv. Amount wasted

      v. Witness to wasted amount

      vi. Patient's name

vii. Call number

viii. Ordering physician

e. Any paramedic/RN that is separated from the ALS service's medical control authority shall surrender his narcotics upon demand or be subject to prosecution under applicable statutes.

104.05 Prescription Items

All ambulance services licensed by the BEMS are required to have approved medical directors. BLS ambulance services are required to have designated an off-line medical director only. These physician directors are necessary to allow the services to store and administer certain prescription items as required in the Rules and Regulations of the BEMS.

104.06 Storage of Prescription Items

Ambulance services and personnel should not store or carry prescription drugs or items which they are prohibited from using. Personnel who are allowed to administer prescription drugs or use prescription items should carry these drugs and/or items only when they are on duty and actively functioning under their ambulance service's medical control authority.

1. Prescription items and drugs should always be stored and carried in secure locations accessible only to authorized personnel. These items and drugs should be stored within temperature ranges as recommended by the manufacturer.

104.07 High Visibility Safety Apparel for Staff

Each ambulance must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

105 SPECIAL USE EMS VEHICLES

105.01 §41-59-3 Definitions [Repealed effective July 1, 2011].

As used in this chapter, unless the context otherwise requires, the term:

(a) "Ambulance" means any privately or publicly owned land or air vehicle that is especially designed, constructed, modified or equipped to be used, maintained and operated upon the streets, highways or airways of this state to assist persons who are sick, injured, wounded, or otherwise incapacitated or helpless;

(b) "Permit" means an authorization issued for an ambulance vehicle and/or a special use EMS vehicle as meeting the standards adopted under this chapter;

(c) "License" means an authorization to any person, firm, corporation, or governmental division or agency to provide ambulance services in the State of Mississippi;

(d) "Emergency medical technician" means an individual who possesses a valid emergency medical technician's certificate issued under the provisions of this chapter;

(e) "Certificate" means official acknowledgment that an individual has successfully completed (i) the recommended basic emergency medical technician training course referred to in this chapter which entitles that individual to perform the functions and duties of an emergency medical technician, or (ii) the recommended medical first responder training course referred to in this chapter which entitles that individual to perform the functions and duties of a medical first responder;

(f) "Board" means the State Board of Health;

(g) "Department" means the State Department of Health, Division of Emergency Medical Services;

(h) "Executive officer" means the Executive Officer of the State Board of Health, or his designated representative;

(i) "First responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons;

(j) "Medical first responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons who (i) is trained to assist other EMS personnel by successfully completing, and remaining current in refresher training in accordance with, an approved "First Responder: National Standard Curriculum" training program, as developed and promulgated by the United States Department of Transportation, (ii) is nationally registered as a first responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a medical first responder by the State Department of Health, Division of Emergency Medical Services;

(k) "Invalid vehicle" means any privately or publicly owned land or air vehicle that is maintained, operated and used only to transport persons routinely who are convalescent or otherwise nonambulatory and do not require the service of an emergency medical technician while in transit;

(l) "Special use EMS vehicle" means any privately or publicly owned land, water or air emergency vehicle used to support the provision of emergency medical services. These vehicles shall not be used routinely to transport patients;

(m) "Trauma care system" or "trauma system" means a formally organized arrangement of health care resources that has been designated by the department by which major trauma victims are triaged, transported to and treated at trauma care facilities;

(n) "Trauma care facility" or "trauma center" means a hospital located in the State of Mississippi or a Level I trauma care facility or center located in a state contiguous to the State of Mississippi that has been designated by the department to perform specified trauma care services within a trauma care system pursuant to standards adopted by the department;

(o) "Trauma registry" means a collection of data on patients who receive hospital care for certain types of injuries. Such data are primarily designed to ensure quality trauma care and outcomes in individual institutions and trauma systems, but have the secondary purpose of providing useful data for the surveillance of injury morbidity and mortality;

(p) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(q) "Emergency medical call" means a situation that is presumptively classified at time of dispatch to have a high index of probability that an emergency medical condition or other situation exists that requires medical intervention as soon as possible to reduce the seriousness of the situation, or when the exact circumstances are unknown, but the nature of the request is suggestive of a true emergency where a patient may be at risk;

(r) "Emergency response" means responding immediately at the basic life support or advanced life support level of service to an emergency medical call. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call;

(s) "Emergency mode" means an ambulance or special use EMS vehicle operating with emergency lights and warning siren (or warning siren and air horn) while engaged in an emergency medical call.

Sources: Laws, 1974, ch. 507, § 2; Laws, 1991, ch. 482, § 1; Laws, 1998, ch. 429, § 1; Laws, 2000, ch. 594, § 1; Laws, 2002, ch. 623, § 1; brought forward without change, Laws, 2002, 1st Ex Sess, ch. 3, § 1; Laws, 2004, ch. 425, § 1; Laws, 2004, ch. 581, § 1; Laws, 2008, ch. 549, § 1, eff from and after July 1, 2008.

105.02 <u>§63-7-19. Lights on police and emergency vehicles; lights on rural mail carrier vehicles.</u>

Except as otherwise provided for unmarked vehicles under Section 19-25-15 and Section 25-1-87, every police vehicle shall be marked with blue lights. Every ambulance and special use EMS vehicle as defined in Section 41-59-3 shall be marked with red lights front and back and also may be marked with white and amber lights in addition to red lights. Every emergency management/civil defense vehicle, including emergency response vehicles of the Department of Environmental Quality, shall be marked with blinking, rotating or oscillating red lights. Official vehicles of a 911 Emergency Communications District may be marked with red and white lights. Every wrecker or other vehicle used for emergency work, except vehicles authorized to use blue or red lights, shall be marked with blinking, oscillating or rotating amber colored lights to warn other vehicles to yield the right-of-way, as provided in Section 63-3-809. Only police vehicles used for emergency work may be marked with blinking, oscillating or rotating blue lights to warn other vehicles to yield the right-of-way. Only law enforcement vehicles, fire vehicles, private or department-owned vehicles used by firemen of volunteer fire departments which receive funds pursuant to Section 83-1-39 when responding to calls, emergency management/civil defense vehicles, emergency response vehicles of the Department of Environmental Quality, ambulances used for emergency work, and 911 Emergency Communications District vehicles may be marked with blinking, oscillating or rotating red lights to warn other vehicles to yield the right-of-way. This section shall not apply to school buses carrying lighting devices in accordance with Section 63-7-23.

Any vehicle referred to in subsection (1) of this section also shall be authorized to use alternating flashing headlights when responding to any emergency.

Any vehicle operated by a United States rural mail carrier for the purpose of delivering United States mail may be marked with two (2) amber colored lights on front top of the vehicle and two (2) red colored lights on rear top of the vehicle so as to warn approaching travelers to decrease their speed

because of danger of colliding with the mail carrier as he stops and starts along the edge of the road, street or highway.

Rules and Regulations

1. Special Use Emergency Medical Services Vehicles (SUEMSV) used on roadways shall be equipped with the following minimum emergency warning devices:

2. A combination electronic siren with integral public address system.

3. Strobe, light emitting diode (LED) or quartz halogen incandescent red or combination red/clear emergency lights providing the vehicle with a conspicuous appearance for safety during emergency response. The emergency lights must display highly perceptible and attention-getting signals designed to convey the message "clear the right-of-way."

4. Use of emergency warning devices by SUEMSV is restricted to actual EMS responses as authorized and requested by the licensed ambulance service or BEMS.

Policy for Administration

1. Permits for special use EMS vehicles are issued by BEMS to a licensed ambulance service after an inspection of the vehicles has been completed and a determination made by BEMS that all requirements have been met.

2. Permits issued shall expire concurrently with the service license.

3. All permits for vehicles are issued by licensed location. If, at any time, a vehicle is moved to a new location, a new inspection must be made and a new permit issued in accordance with the service license for the new location.

4. Payment of a renewal fee to be fixed by the Board, which shall be paid to the Board.

5. Personnel operating ground SUEMSV must be certified as EMS-D.

6. Each SUEMSV must be insured as per Section 41-59-27, Mississippi Code of 1972, Annotated.

7. All Special Use EMS Vehicles must be marked with flashing red lights front and back and may be marked with white and amber lights in addition to red lights.

105.03 High Visibility Safety Apparel for Staff

Each Special Use EMS Vehicle must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

106 REQUIRED PERSONNEL.

106.01 §41-59-29. Personnel required for transporting patients.

From and after January 1, 1976, every ambulance, except those specifically excluded from the provisions of this chapter, when transporting patients in this state, shall be occupied by at least one (1) person who possesses a valid emergency medical technician state certificate or medical/nursing license and a driver with a valid resident driver's license.

SOURCES: Laws, 1974, ch. 507, § 8(1), eff from and after passage (approved April 3, 1974).

Rules and Regulations

1. Every ALS ambulance, when responding to and transporting patients requiring care beyond the basic life support level, must be occupied by a driver with a valid driver's license and one (1) person who possesses a valid EMT-I or EMT-P state certificate (if service is licensed as Intermediate level), or one (1) person who possesses a valid EMT-P state certificate (if service is licensed as a Paramedic level), or one (1) person who possesses a valid medical/nursing license.

2. In addition, any ambulance service that wishes to provide ALS and employ ALS personnel to function in an ALS role, intermittently or consistently, must be licensed at the ALS level by the State Department of Health, Bureau of Emergency Medical Services.

3. Anyone driving an ambulance or (invalid) vehicle must possess a valid emergency medical service driver (EMS-D) state certificate in addition to a valid driver's license.

Other Information

Verification of training for personnel functioning in an out-of-hospital Advanced Life Support (ALS) role may be as follows:

a. Current registration as an EMT-I/EMT-P by the National Registry of EMTs.

b. Letter/statement signed by the ambulance service owner/manager which attests to equivalency of training (National Standard Training Curriculum for EMT I/P) for each employee possessing a medical/nursing license.

107 INSURANCE REQUIREMENTS

107.01 §41-59-27. Insurance.

1. There shall be at all times in force and effect on any ambulance vehicle operating in this state insurance issued by an insurance company licensed to do business in this state, which shall provide coverage:

2. For injury to or death of individuals resulting from any cause for which the owner of said ambulance would be liable regardless of whether the ambulance was being driven by the owner or his agent; and

3. Against damage to the property of another, including personal property.

4. The minimum amounts of such insurance coverage shall be determined by the board with the advice of the advisory council, except that the minimum coverage shall not be less than twenty-five thousand dollars ($25,000.00) for bodily injury to or death of one (1) person in any one (1) accident, fifty thousand dollars ($50,000.00) for bodily injury to or death of two (2) or more persons in any one (1) accident, and ten thousand dollars ($10,000.00) for damage to or destruction of property of others in any one (1) accident.

SOURCES: Laws, 1974, ch. 507, § 7(4), eff from and after passage (approved April 3, 1974).

Annotations -

Liability of operator of ambulance service for personal injuries to person being transported. 21 ALR2d 910.

108 RECORD KEEPING

108.01 §41-59-41. Records

Each licensee of an ambulance service shall maintain accurate records upon such forms as may be provided, and contain such information as may be required by the board concerning the transportation of each patient within this state and beyond its limits. Such records shall be available for inspection by the board at any reasonable time, and copies thereof shall be furnished to the board upon request.

SOURCES: Laws, 1974, ch. 507, § 10, eff from and after passage (approved April 3, 1974).

Rules and Regulations

1. All licensed ambulance services operating in the State of Mississippi must submit electronically, the State of Mississippi Patient Encounter Form and/or information contained on the form via network, or direct computer link, for each ambulance run made and/or for each patient transported.

2. A completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form shall be left with hospital staff for all patients delivered to licensed Hospitals. If in the best interest of the public good, an immediate response to a patient is required of an ambulance delivering a patient to a licensed Hospital, a complete oral report on the patient being delivered will be given to the receiving facility and a completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form for that patient shall be delivered in person or by fax to the hospital staff of the licensed Hospital within 24 hours.

3. All Mississippi Patient Encounter Forms are due in the BEMS office by the seventh day after the close of the preceding month.

4. All Mississippi Patient Encounter Forms or computer disk information returned to an ambulance service for correction must be corrected and returned to the BEMS office within two weeks calculated from the date of their return.

5. Returns to a licensed ambulance service provider greater than 3 times may result in a penalty as outlined under Section 41-59-45, paragraph 3.

109 INVALID VEHICLES

109.01 §41-59-39. Standards for invalid vehicles.

The board after consultation with the emergency medical services advisory council, shall establish minimum standards which permit the operation of invalid vehicles as a separate class of ambulance service.

SOURCES: Laws, 1974, ch. 507 § 9, eff from and after passage (approved April 13, 1974).

Rules and Regulations

1. Standards.

    a. No vehicle used exclusively for invalid transfer is to have any markings, flashing lights, sirens, or other equipment that might indicate it is an Emergency Vehicle. The word "Ambulance" is not to appear on the vehicle.

    b. The vehicle will have at least two doors leading into the patient compartment; one at the rear for patient loading and one on the curbside so that the patient may be easily removed should the rear door become jammed. All doors should be constructed so that they may be opened from inside or outside.

    c. Stretcher holders and litter straps will be required for patient safety. Seat belts will be required for occupants of the driver compartment.

2. Required equipment.

    a. First aid kit: Commercially available kit containing gauze pads, roller bandages, and adhesive tape acceptable

    b. 5 pound dry chemical fire extinguisher

    c. 1 box disposable tissues

    d. 1 bed pan (fracture type acceptable)

    e. 1 emesis basin

    f. 2 towels

    g. 1 blanket

    h. 4 sheets

    i. 2 pillow cases

j. wheeled cot meeting or exceeding requirements in Federal Specifications for Ambulances

k. wheeled cot retention system as determined by BEMS

l. detachable safety retaining strap for wheeled cot

m. Vehicle Standards

n. Patient Compartment:

o. 42" high, floor to ceiling

p. 48" wide, measured 15" above floor from side to side

q. 92" long, measured 15" above floor from divider to rear door

3. Emblems and markings

a. The name of the company shall be printed on each side of the vehicle or the cab doors of the vehicle.

109.02 High Visibility Safety Apparel for Staff

Each invalid vehicle must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

110 LICENSE NOT REQUIRED

110.01 §41-59-43. Exemptions.

1. The following are exempted from the provisions of this chapter:

a. The occasional use of a privately and/or publicly owned vehicle not ordinarily used in the business of transporting persons who are sick, injured, wounded, or otherwise incapacitated or helpless, or operating in the performance of a lifesaving act.

b. A vehicle rendering services as an ambulance in case of a major catastrophe or emergency.

c. Vehicles owned and operated by rescue squads chartered by the state as corporations not for profit or otherwise existing as nonprofit associations which are not regularly used to transport sick, injured or otherwise incapacitated or helpless persons except as a part of rescue operations.

d. Ambulances owned and operated by an agency of the United States Government.

SOURCES: Laws, 1974, ch. 507, § 11, eff from and after passage (approved April 3, 1974).

111 PENALTIES

111.01 §41-59-45. Penalties; injunctive relief

1. It shall be the duty of the licensed owner of any ambulance service or employer of emergency medical technicians for the purpose of providing basic or advanced life support services to insure compliance with the provisions of this Chapter 59 and Chapter 60 and all regulations promulgated by the board.

2. Any person, corporation or association that violates any rule or regulation promulgated by the board pursuant to these statues regarding the provision of ambulance services or the provision of basic or advanced life support services by emergency medical technicians shall, after due notice and hearing, be subject to an administrative fine not to exceed One Thousand Dollars ($1,000.00) per occurrence.

3. Any person violating or failing to comply with any other provisions of this Chapter 59 and Chapter 60 shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined an amount not to exceed fifty dollars ($50.00) or be imprisoned for a period not to exceed thirty (30) days, or both, for each offense.

4. The board may cause to be instituted a civil action in the chancery court of the county in which any alleged offender of this chapter may reside or have his principal place of business for injunctive relief to prevent any violation of any provision of this Chapter 59 and Chap, or any rules or regulation adopted by the board pursuant to the provisions of this chapter.

5. Each day that any violation or failure to comply with any provision of this chapter or any rule or regulation promulgated by the board thereto is committed or permitted to continue shall constitute a separate and distinct offense under this section, except that the court may, in its discretion, stay the cumulation of penalties.

6. It shall not be considered a violation of this Chapter 59 and Chapter 60 for a vehicle domiciled in a nonparticipating jurisdiction to travel in a participating jurisdiction.

SOURCES: Laws, 1974, ch. 507, § 12; 2001, ch. 542, § 2, eff from and after July 1, 2001.

Cross reference -

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

112 PARTICIPATION, OPTIONS

112.01 §41-59-47. Options of counties and municipalities as to participation.

1. The provisions of this chapter shall apply to all counties and incorporated municipalities except those counties and incorporated municipalities electing not to comply as expressed to the board in a written resolution by the governing body of such county or incorporated municipality. The election of any county to be included or excluded shall in no way affect the election of any incorporated municipality to be included or excluded. If any county or municipality elects to be excluded from this chapter, they may later elect to be included by resolution.

2. All financial grants administered by the state for emergency medical services pertaining to this chapter shall be made available to those counties and incorporated municipalities which are governed by the provisions of this chapter.

SOURCES: Laws, 1974, ch. 507, § 13, eff from and after passage (approved April 3, 1974).

113 APPEAL PROCESS

113.01 § 41-59-49. Appeal from decision of board.

Any person, firm, corporation, association, county, municipality or metropolitan government or agency whose application for a permit or license has been rejected or whose permit or license is suspended or revoked by the board shall have the right to appeal such decision, within thirty (30) days after receipt of the board's written decision, to the chancery court of the county where the applicant or licensee is domiciled. The appeal before the chancery court shall be de novo

and the decision of the chancery court may be appealed to the supreme court in the manner provided by law.

SOURCES: Laws, 1974, ch. 507, § 14, eff from and after passage (approved April 3, 1974).

Other Information

1. The State Board of Health and the Bureau of EMS shall provide an opportunity for a fair hearing for every licensee of ambulance service who is dissatisfied with administrative decisions made in the denial and/or suspension/revocation of a license.

2. BEMS shall notify the licensee by registered mail, the particular reason for denial or revocation/suspension of the license. Upon written request of the licensee within ten days of the notification, BEMS shall fix a date not less than thirty days from the date of such service at which time the licensee shall be given an opportunity for a prompt and fair hearing before officials of the Mississippi State Department of Health.

3. On the basis of such hearing or upon the fault of the applicant or licensee, the Mississippi State Department of Health shall make a determination specifying the findings of fact in conclusion of the law. A copy of such determination shall be sent by registered mail to the last known address of the licensee or served personally upon the licensee.

4. The decision to suspend, revoke or deny a license shall become final thirty days after it is mailed or served unless the applicant or licensee within such thirty days, appeals the decision to the Chancery Court of the county where the applicant or licensee is domiciled.

114 SUBSCRIPTION SERVICES

114.01 §41-59-63. Membership subscription programs for prepaid ambulance service not to constitute insurance.

The solicitation of membership subscriptions, the acceptance of membership applications, the charging of membership fees, and the furnishing of prepaid or discounted ambulance service to subscription members and designated members of their households by either a public or private ambulance service licensed and regulated by the State Board of Health pursuant to Section 41-59-1 et seq. shall not constitute the writing of insurance and the agreement under and pursuant to which such prepaid or discounted ambulance service is provided to the subscription members and to designated members of their households shall not constitute a contract of insurance.

SOURCES: Laws, 1988, ch; 541, § 1; reenacted, 1991, ch. 348, § 1; reenacted, 1992, ch. 327, § 1, eff from and after July 1, 1992.

114.02 §41-59-65. Application for permit to conduct membership subscription program; fees; renewals.

1. Either a public or private ambulance service licensed and regulated by the State Board of Health desiring to offer such a membership subscription program shall make application for permit to conduct and implement such program to the State Board of Health. The application shall be made upon forms in accordance with procedures established by the board and shall contain the following:

    a. The name and address of the owner of the ambulance service;

    b. The name in which the applicant is doing business;

    c. The location and description of the place or places from which the ambulance service operates;

    d. The places or areas in which the ambulance service intends to conduct and operate a membership subscription program; and

    e. Such other information as the board shall deem necessary.

    f. Each application for a permit shall be accompanied by a permit fee of Five Hundred Dollars ($500.00), which shall be paid to the board. The permit shall be issued to expire the next ensuing December 31. The permit issued under this section may be renewed upon payment of a renewal fee of Five Hundred Dollars ($500.00), which shall be paid to the board. Renewal of any permit issued under this section shall require conformance with all requirements of this chapter.

SOURCES: Laws, 1988, ch. 541, § 2; reenacted, 1991, ch. 348, § 2; reenacted, 1992, ch. 327, § 2, eff from and after July 1, 1992.

Policy for Administration

1. All subscription permits issued are valid for a maximum period of one (1) year. This period is from January 1 through December 31. Regardless of date of issuance, all subscription permits expire on December 31 of each calendar year.

2. The Five Hundred Dollars ($500.00) permit fee is in addition to the fee for BLS or ALS licensure.

114.03 §41-59-67 Program Requirements

Requirements for issuance of permit; reserve fund; ambulance service to pay cost of collection of judgment against fund.

1. The issuance of a permit to conduct and implement a membership subscription program shall require the following:

    a. The posting of a surety bond with one or more surety companies to be approved by the State Board of Health, in the amount of Five Thousand Dollars ($5,000.00) for every one thousand (1,000) subscribers or portion thereof; and

    b. The establishment of a reserve fund to consist of a deposit to the reserve fund with any depository approved by the state for the benefit of the subscription members in the amount of Three Dollars ($3.00) for each subscription member currently subscribing to the subscription program, but not for the designated members of the subscribing member's household, to guarantee perpetuation of the subscription membership program until all memberships are terminated; and

    c. No further deposits shall be required to be made by the ambulance service to the reserve fund after the aggregate sum of the principal amount of said surety bond plus the deposits in the reserve fund is equal to Two Hundred Thousand Dollars ($200,000.00).

2. In any action brought by a subscriber against the surety bond or the reserve fund, the cost of collection upon a judgment rendered in favor of the subscriber, including attorney's fees, shall be paid by the ambulance service.

SOURCES: Laws, 1988, ch. 541, § 3; re-enacted, 1991, ch. 348, § 3; re-enacted, 1992, ch. 327, § 3, eff from and after July 1, 1992.

<u>Policy for Administration</u>

1. Each membership subscription ambulance service provided must forward a copy (copies) of all surety bonds purchased along with an official statement of total subscribers covered. Such information is made part of the application for subscription permit. During the permit period, should bonds be cancelled, voided, or changed in any way, BEMS must be notified by the service provider.

2. Proof of the establishment of a reserve fund must be provided to BEMS as a prerequisite to BEMS issuance of a subscription permit. Monthly reserve statements of cash balances must be forwarded to BEMS by either the EMS provider and/or the bank in which the reserve account is established.

115 ANNUAL REPORTS

115.01 §41-59-69. Annual report of ambulance service conducting subscription program.

1. Annual reports shall be filed with the State Board of Health by the ambulance service permitted to conduct and implement a membership subscription program in the manner and form prescribed by the State Board of Health, which report shall contain the following:

   a. The name and address of the ambulance service conducting the program;

   b. The number of members subscribing to the subscription program;

   c. The revenues generated by subscriptions to the program; and

   d. The name and address of the depository bank in which the reserve fund is deposited and the amount of deposit in said reserve fund.

SOURCES: Laws, 1988, ch. 541, § 4; re-enacted, 1991, ch. 348, § 4; re-enacted, 1992, ch. 327, § 4, eff from and after July 1, 1992.

Policy for Administration

1. Each subscription ambulance service must submit its annual report with all information as required in Section 41-59-69 within 45 days after the expiration of the subscription permit period (February 14).

2. The annual report may be submitted in letter form to BEMS with supporting documentation as is necessary.

3. BEMS will suspend all subscription permits of ambulance services failing to file annual reports within the prescribed period.

116 SOLICITATION OF MEMBERSHIP

116.01 §41-59-71. Methods of soliciting members; license not required.

Solicitation of membership in the subscription program may be made through direct advertising, group solicitation, by officers and employees of the ambulance service or by individuals without the necessity of licensing of such solicitors.

SOURCES: Laws, 1988, ch. 541, § 5; reenacted, 1991, ch. 348, § 5, re-enacted, 1992, ch. 327, § 5, eff from and after July 1, 1992

Chapter 02 INTER-HOSPITAL TRANSFERS

100 TRANSFERS

100.01 <u>§41-60-13. Promulgation of rules and regulations by state board of health.</u>

The Mississippi State Board of Health is authorized to promulgate and enforce rules and regulations to provide for the best and most effective emergency medical care, and to comply with national standards for advanced life support. Notwithstanding any other provision of law, advanced life support personnel may be authorized to provide advanced life support services as defined by rules and regulations promulgated by the state board of health.

Rules and regulations promulgated pursuant to this authority shall, as a minimum:

a. Define and authorize appropriate functions and training programs for advanced life support trainees and personnel; provided, that all such training programs shall meet or exceed the performance requirements of the current training program for the emergency medical technician-paramedic, developed for the United States Department of Transportation.

b. Specify minimum operational requirements which will assure medical control over all advanced life support services.

c. Specify minimum testing and certification requirements and provide for continuing education and periodic recertification for all advanced life support personnel.

SOURCES: Laws, 1979, ch. 488, § 2, eff from and after July 1, 2001.

<u>Rules and Regulations</u>

1. EMS personnel are restricted to performance of those skills as authorized by the State Department of Health, Bureau of Emergency Medical Services. EMS personnel cannot transport patients with needs or reasonably perceived needs for care which exceed the scope of practice for the ambulance attendant.

Note: The only exception to the above is as follows:

a. EMT's may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

b. There is no need, or reasonably perceived need, for the device or procedure during transport; and

c. An individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

2. Ambulance personnel aiding in the transfer should confirm that the facility to which the patient is to be transferred has been notified and has agreed to accept the patient. They should also inquire whether the patient's condition is stable (no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from the facility) and whether a nurse, physician or other medical personnel should accompany the patient during transfer.

3. If a patient at a hospital has an emergency medical condition which has not been stabilized (as defined herein), the hospital should not request the transfer and the ambulance service should not transfer the patient unless:

   a. the patient (or legally responsible person acting on the patient's behalf) request that the transfer be effected;

   b. a physician or other qualified medical personnel when a physician is not readily available, has verified that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer; or,

   c. the transfer is an appropriate transfer to that facility.

Chapter 03 AERO MEDICAL EMERGENCY MEDICAL SERVICES

100 AERO MEDICAL SERVICES

§41-59-9. License and permit required.

From and after October 1, 1974, no person, firm, corporation, association, county, municipality, or metropolitan government or agency, either as owner, agent or otherwise, shall hereafter furnish, operate, conduct, maintain, advertise or otherwise engage in the business of service of transporting patients upon the streets, highways or airways of Mississippi unless he holds a currently valid license and permit, for each ambulance, issued by the board.

SOURCES: Laws, 1974, ch. 507, § 5(1), eff from and after passage (approved April 3, 1974).

100.01 Definitions Relative to Aero Medical EMS:

1. Advanced Life Support Care (ALSC) - Means a sophisticated level of pre-hospital and inter-hospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of anti-arrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures. This level of care (quantity and type of staff member(s), equipment and procedures) is consistent with a patient in a pre-hospital emergency or non-emergency incident. In addition, this level of care (quantity and type of staff member(s), equipment and procedures) is consistent with a patient in a inter-hospital incident who is in a non-acute situation and is being cared for in an environment where monitoring of cardiac rhythm, neurological status, and/or continuous infusions of anti-arrhythmic and/or vasopressors, are part of the patient's care needs.

2. Aeromedical Physiology - (Ualtitude physiology, flight physiology)U Means the physiological changes imposed on humans when exposed to changes in altitude and atmospheric pressure and the physical forces of aircraft in flight. Persons whose physiologic state is already compromised may be more susceptible to these changes and the potential physiologic responses they may experience while in flight in an aircraft. It is directly related to physical gas laws and the physics of flight. See also Stressor of Flight.

3. Air Ambulance Aircraft - (aircraft, airplane) Means a fixed-wing or rotor-wing aircraft specially constructed or modified that is equipped and designated for transportation of sick or injured persons. It does not include transport of organ transplant teams or organs.

4. Air Ambulance Service - (service, provider) Means an entity or a division of an entity (sole proprietorship, partnership or corporation) that is authorized by the Federal Aviation Administration (FAA) and BEMS to provide patient transport and/or transfer by air ambulance aircraft. The patient(s) may be ambulatory or non-ambulatory and may or may not require medical intervention of basic or advanced nature. It uses aircraft, equipped and staffed to provide a medical care environment on board appropriate to patient's needs. The term air ambulance service is not synonymous with and does not refer to the FAA air carrier certificate holder unless they also maintain and control the medical aspects that make up a complete service.

5. Air Medical Personnel - Means a licensed physician, registered nurse, respiratory therapist, State of Mississippi current certified EMT-Paramedic, EMT-Intermediate or EMT-Basic who has successfully completed a course in aeromedical physiology and flight safety training and orientation.

6. Air Ambulance Transport System Activation - Formerly referred to as Dispatch, the term was changed to avoid conflict with the meaning in the FAR's - Means the process of receiving a request for transport or information and the act of allocating, sending and controlling an air ambulance and air medical personnel in response to such request as well as monitoring the progress of the transport.

7. Authorized Representative - Means any person delegated by a licensee to represent the provider to county, municipal or federal regulatory officials.

8. Basic Life Support Care (BLSC) - (UBLS, basic care) Means the level of care (quantity and type of staff members(s), equipment and procedures) which is consistent with a stable patient in a non-acute situation who prior to transport may be in a skilled care setting or non-health care facility. The patient's condition will be such that he requires only minimal care such as monitoring of vital signs or administration of oxygen. It does not include patients with continuous IV infusions with or without additives or artificial airways. This level of care will be rendered by at least a basic level emergency medical technician. This level of care requires minimal equipment such as basic monitoring and diagnostic equipment - stethoscope, blood pressure cuff, flashlight, etc.

9. Cockpit Crew Member - (pilot, co-pilot, and flight crew) Means a pilot, co-pilot, flight engineer, or flight navigator assigned to duty in an aircraft cockpit.

10. Critical Care Life Support (CCLS) - Means the level of care (quantity and type of staff member(s), equipment and procedures) that is consistent with a patient who may or may not be stable and who is in an acute situation or

at high risk of decompensating prior to transport. The following patient categories are included: cardiovascular, pulmonary, neurologic, traumatic injury including spinal or head injury, burns, poisonings and toxicology. These patients are being cared for in an acute care facility such as the emergency department, intensive, critical, coronary or cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilatory functions by artificial means is being performed. This level of care must be rendered by at least two air medical personnel, one of which is a registered nurse or physician. This level of care requires specific monitoring and diagnostic equipment above the advanced level.

11. FAA - Means the Federal Aviation Administration.

12. FAR - Means the Federal Aviation Regulation.

13. FCC - Means the Federal Communications Commission.

14. Fixed-wing Air Ambulance - (fixed-wing) Means a fixed-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher. It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.

15. Inter-facility Transfer - (transfer) Means the transportation of a patient, by an air ambulance service provider, initiating at a health care facility whose destination is another health care facility.

16. Medical Director - Means a licensed physician (MD or DO) who is specifically designated by an air ambulance provider and has accepted the responsibility for providing medical direction to the air ambulance service. He or she must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director whose primary practice is in Mississippi or at a Mississippi trauma center. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.) The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients. The Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

17. Patient - Means an individual who is sick, injured, or otherwise incapacitated or whose condition requires or may require skilled medical care for intervention.

18. Permit - Means a document issued by BEMS indicating that the aircraft has been approved for use as an air ambulance vehicle by BEMS in the state of Mississippi.

19. Physician - (doctor) Means a person licensed to practice medicine as a physician (MD or DO) by the state where the air ambulance service is located.

20. Pilot - Means a person who holds a valid certificate issued by the FAA to operate an aircraft.

21. Public Aircraft - Means an aircraft used only in the service of a government agency. It does not include government-owned aircraft engaged in carrying persons or property for commercial purposes.

22. Reciprocal Licensing - (reciprocity) means mutual acceptance of an air ambulance service provider's valid license to operate an air ambulance service in a state other than the one in which it is licensed.

23. Registered Nurse - (RN) Means an individual who holds a valid license issued by the state licensing agency to practice professional nursing as a registered nurse.

24. Rotor-wing Air Ambulance - (rotor-wing) Means a rotor-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher/litter (as per FAR Section 23.785 and 23.561). It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.

25. Specialty Care Transport (SCS) - Means the level of care (quantity and type of staff member(s), equipment and procedures) that is consistent with a patient whose condition requires special care specific to their age and/or diagnosis. The patient may or may not be stable or in an acute situation prior to transport. The following patient categories are included: pediatric intensive care, maternal care, neonatal intensive care and burn care.

    Note: These patients are being cared for in an acute care facility environment such as the emergency department, coronary care unit, intensive care unit, pediatric or neonatal unit, burn care or other similar unit where continuous monitoring of vial signs, cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilatory functions by artificial means are being performed. This level of care must be

rendered by medical personnel of appropriate training. This level of care requires monitoring and diagnostic equipment specific to the patients special care needs. Patients requiring this level of care should be identified during medical screening so that special staffing and equipment requirements can meet the patients potential needs. These patients are considered at risk for de-compensation during transport which may require close attention or intervention.

26. Stressors of Flight - Means the factors which humans may be exposed to during flight which can have an effect on the individual's physiologic state and ability to perform. The stressors include - hypoxia, barometric changes (expanding and contracting gas), fatigue (sometimes self induced), thermal variations (extremes of temperature), dehydration, noise, vibration, motion and G-forces.

101 LICENSING

101.01 Air Ambulance Licensure

1. Licensure as an air ambulance service shall only be granted to a person or entity that directs and controls the integrated activities of both the medical and aviation components.

   Note: Air ambulance requires the teaming of medical and aviation functions. In many instances, the entity that is providing the medical staffing, equipment and control is not the certificate aircraft operator but has an arrangement with another entity to provide the aircraft. Although the aircraft operator is directly responsible to the FAA for the operation of the aircraft, one organization, typically the one in charge of the medical functions directs the combined efforts of the aviation and medical components during patient transport operations.

2. No person or organization may operate an air ambulance service unless such person or organization has a valid license issued by BEMS. Any person desiring to provide air ambulance services shall, prior to operation, obtain a license from BEMS. To obtain such license, each applicant for an air ambulance license shall pay the required fee and submit an application on the prescribed air ambulance licensure application forms. Applicant must submit one copy of the plan of medical control at least 30 days prior to service start date for approval by BEMS and State EMS Medical Director. The license shall automatically expire at the end of the licensing period.

3. Prior to operation as an air ambulance, the applicant shall obtain a permit for each aircraft it uses to provide its service.

4. Each licensee shall be able to provide air ambulance service within 90 days after receipt of its license to operate as an air ambulance from the licensing authority.

5. Each aircraft configured for patient transport shall meet the structural, equipment and supply requirements set forth in these regulations.

6. An air ambulance license is dependent on, and concurrent with, proper FAA certification of the aircraft operator(s) to concurrent with proper FAA certification of the aircraft operator(s) to conduct operations under the applicable parts of the Federal Aviation Regulations (included are Parts 1, 43, 61, 67, 91, 135).

7. Current, full accreditation by the Commission on Accreditation of Air Medical Services (CAAMS) or equivalent program will be accepted by BEMS as compliance with the requirements set forth.

8. A provider's license will be suspended or revoked for failure to comply with the requirements of these regulations.

9. No licensee shall operate a service if their license has been suspended or revoked.

10. Any provider that maintains bases of operation in more than one state jurisdiction shall be licensed at each base by BEMS having jurisdiction.

11. The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

102 RECIPROCITY

Any provider who is licensed in another jurisdiction whose regulations are at least as stringent as these, and provides proof of such license, and who meets all other regulatory requirements shall be regarded as meeting the specifications of these regulations.

102.01 Access - Inspection of records; equipment/supply categories, and air ambulance aircraft.

1. BEMS, after presenting proper identification, shall be allowed to inspect any aircraft, equipment, supplies or records of any licensee to determine compliance with these regulations. BEMS shall inspect the licensee at least twice every licensing period.

2. The finding of any inspection shall be recorded on a form provided for this purpose. BEMS shall furnish a copy of the inspection report form to the licensee or the licensee's authorized representative. Upon completion of an inspection, any violations shall be noted on the form.

102.02 Issuance of Notices.

1. Whenever BEMS makes an inspection of an air ambulance aircraft and discovers that any of the requirements of these regulations have been violated or have not been complied with in any manner, BEMS shall notify the licensee of the infraction(s) by means of an inspection report or other written notice.

   The report shall:

   a. Set forth the specific violations found;

   b. Establish a specific period of time for the correction of the violation(s) found, in accordance with the provisions in Violations.

102.03 Reports

1. Notification

   a. Each holder of a license shall notify BEMS of the disposition of any criminal or civil litigation or arbitration based on their actions as a licensee within 5 days after a verdict has been rendered.

   b. The licensee will notify BEMS when it removes a permitted aircraft from service or replaces it with a substitute aircraft meeting the same transport capabilities and equipment specifications as the out-of-service aircraft for a period of time greater than 7 days but not to exceed 90 calendar days. Upon receipt of notification, BEMS shall issue a temporary permit for the operation of said aircraft.

2. Patient Reports

a. Each licensee shall maintain accurate records upon such forms as may be provided, and contain such information as may be required by BEMS concerning the transportation of each patient within this state and beyond its limits. Such records shall be available for inspection by BEMS at any reasonable time, and copies thereof shall be furnished to BEMS upon request.

b. All licensed ambulance services operating in the State of Mississippi must electronically submit the State of Mississippi Patient Encounter Form and/or information contained on the form for each ambulance run made and/or for each patient transported.

c. A completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form shall be left with hospital staff for all patients delivered to license Hospitals. If in the best interest of the public good, an immediate response to a patient is required of an ambulance delivering a patient to a licensed Hospital, a complete oral report on the patient being delivered will be given to the receiving facility and a completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form for that patient shall be delivered in person or by fax to the hospital staff of the licensed Hospital within 24 hours.

d. Mississippi Patient Encounter Forms are due in the BEMS office by the seventh day after the close of the preceding month.

e. All encounter forms or computer disk information returned to a licensee for correction must be corrected and returned to the BEMS office within two weeks calculated from the date of their return.

f. Returns to a licensee greater than 3 times may result in a penalty as outlined under Section 41-59-45, paragraph 3.

g. The licensee shall maintain a copy of all the run records according to statutory requirements, accessible for inspection upon request by BEMS.

h. A copy of the patient encounter form shall be given to the person accepting care of the patient.

102.04 <u>Location indentification</u>

1. The Licensee shall identify on the prescribed form any and all physical locations where a function of their operations are conducted. These

locations include: permanent business office, aircraft storage, repair, communications/activation facilities, training and sleeping areas.

103 ADVERTISING

103.01 Aero Medical Advertisement

1. No person, entity or organization shall advertise via printed or electronic media as an air ambulance service provider in the state of Mississippi unless they hold a valid license in the state of Mississippi or has licensure in another state which is reciprocally honored by BEMS.

2. The licensee's advertising shall be done only under the name stated on their license.

3. The licensee's advertising and marketing shall demonstrate consistency with the licensee's actual licensed level of medical care capabilities and aircraft resources. The name of the Air Carrier Operating Certificate holder shall be listed if the licensee leases or otherwise does not operate the aircraft under their own Air Carrier certificate.

104 REQUIRED INSURANCE COVERAGE

104.01 Property & Casualty Liability

1. Every licensee or applicant shall ensure that the Part 135 Air Carrier Operating certificate holder operating the aircraft carries bodily injury and property damage insurance with solvent insurers licensed to do business in the state of Mississippi, to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any of the certificate holders aircraft. Each aircraft shall be insured for the minimum amount of $1,000,000 for injuries to, or death of, any one person arising out of any one incident or accident; the minimum amount of $3,000,000 for injuries to, or death of, more than one person in any one accident; and, for the minimum amount of $500,000 for damage to property from any one accident.

2. Government-operated service aircraft shall be insured for the sum of at least $500,000 for any claim or judgment and the sum of $1,000,000 total for all claims or judgments arising out of the same occurrence. Every insurance policy or contract for such insurance shall provide for the payment and satisfaction of any financial judgment entered against the licensee or any aircraft owner or pilot(s) operating the insured aircraft. All

such insurance policies shall provide for a certificate of insurance to be issued to BEMS.

104.02 Professional Medical Liability (Malpractice)

1. Every air ambulance licensee or applicant shall carry professional liability coverage with solvent insurers licensed to do business in the state of Mississippi, to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the care or lack of care of a patient. The licensee or applicant shall maintain professional liability coverage in the minimum amount of $500,000 per occurrence.

2. In lieu of such insurance, the licensee or applicant may furnish a certificate of self-insurance establishing that the licensee or applicant has a self-insurance plan to cover such risks and that the plan has been approved by the State of Mississippi Insurance Commissioner.

105 AIRCRAFT PERMITS

105.01 Aircraft Permits Required

1. BEMS shall issue a permit to the licensee when the licensee initially places the aircraft into service or when the licensee changes the level of service relative to that aircraft. The permit shall remain valid as long as the aircraft is operated or leased by the licensee subject to the following conditions:

   a. The licensee submits an aircraft permit application for the aircraft and pays the required fees.

   b. Permits issued by BEMS for an aircraft pursuant to this rule shall be carried inboard the aircraft and readily available for inspection.

   c. If ownership of any permitted aircraft is transferred to any other person or entity, the permit is void and the licensee shall remove the permit from the aircraft at the time the aircraft is transferred and return the permit to the licensing authority within 10 days of the transfer.

   d. If a substitute aircraft is in service for longer than 90 days, this aircraft shall be required to be permitted. An un-permitted aircraft cannot be placed into service, nor can an aircraft be used unless it is replacing aircraft that has been temporarily taken out of service.

2. When such a substitution is made, the following information shall be maintained by the licensee and shall be accessible to BEMS:

a. Registration number of permitted aircraft taken out of service.

b. Registration number of substitute aircraft.

c. The date on which the substitute aircraft was placed into service and the date on which it was removed from service and the date on which the permitted aircraft was returned to service.

3. Aircraft permits are not transferable.

4. Duplicate aircraft permits can be obtained by submitting a written request to BEMS. The request shall include a letter signed by the licensee certifying that the original permit has been lost, destroyed or rendered unusable.

5. Each licensee shall obtain a new aircraft permit from BEMS prior to returning an aircraft to service following a modification, change or any renovation that results in a change to the stretcher placement or seating in the aircraft's interior configuration.

6. The holder of a permit to operate an air ambulance service, shall file an amended list of its permitted aircraft with BEMS within 10 days after an air ambulance is removed permanently from service.

106 MEDICAL DIRECTION

106.01 Off-Line Medical Direction

1. Qualifications

a. Each air ambulance service shall designate or employ an off-line medical director. The off-line medical director shall meet the following qualifications:

b. The off-line medical director shall be a physician (MD or DO) currently licensed and in practice.

c. The physician shall be licensed to practice medicine in the state(s) where the service is domiciled.

d. Services having multiple bases of operation shall have an off-line medical director for each base. If the off-line medical director for the service's primary location is licensed in the state where the base(s) is/are located, they may function as the off-line medical director for that base in place of a separate individual.

e. Must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director whose primary practice is in Mississippi or at a Mississippi trauma center. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.) The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients. The Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

f. The off-line medical director shall have knowledge and experience consistent with the transport of patient's by air.

2. Responsibilities

a. The physician shall be knowledgeable in aeromedical physiology, stresses of flight, aircraft safety, patient care, and resource limitations of the aircraft, medical staff and equipment.

b. The off-line medical director shall have access to consult with medical specialists for patient(s) whose illness and care needs are outside his/her area of practice.

c. The off-line medical director shall ensure that there is a comprehensive plan/policy to address selection of appropriate aircraft, staffing and equipment.

d. The off-line medical director shall be involved in the selection, hiring, training and continuing education of all medical personnel.

e. The off-line medical director shall be responsible for overseeing the development and maintenance of a quality assurance or a continuous quality improvement program.

f. The off-line medical director shall ensure that there is a plan to provide direction of patient care to the air medical personnel during transport. The system shall include on-line (radio/telephone) medical control, and/or an appropriate system for off-line medical control such as written guidelines, protocols, procedures patient specific written orders or standing orders.

g. The off-line medical director shall participate in any administrative decision making processes that affects patient care.

h. The off-line medical director will ensure that there is an adequate method for on-line medical control, and that there is a well defined plan or procedure and resources in place to allow off-line medical control.

i. In the case where written policies are instituted for medical control, the off-line medical director will oversee the review, revision and validation of them annually.

j. The plan for medical control must be submitted to BEMS at least 30 days prior to the service start date for approval by BEMS and the State EMS Medical Director.

k. Revisions in the medical control plan must be submitted prior to implementation. At a minimum, medical control plans shall be resubmitted to BEMS every three (3) years.

106.02 On-line Medical Control

The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

107 CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM

116.02 CQI process

1. The licensee shall have an ongoing collaborative process within the organization that identifies issues affecting patient care.

2. These issues should address the effectiveness and efficiency of the organization, its support systems, as well as that of individuals within the organization.

3. When an issue is identified, a method of information gathering shall be developed. This shall include outcome studies, chart review, case discussion, or other methodology.

4. Findings, conclusions, recommendations and actions shall be made and recorded. Follow-up, if necessary, shall be determined, recorded, and performed.

5. Training and education needs, individual performance evaluations, equipment or resource acquisition, safety and risk management issues all shall be integrated with the CQI process.

108 AIR MEDICAL PERSONNEL

108.01 Licensing of Air Medical Personnel

6. There shall be at least one licensed air medical person on board an air ambulance to perform patient care duties on that air ambulance. The requirements for air medical personnel shall consist of not less than the following:

7. A valid license or certificate to practice their level of care (MD, DO, RN, EMT-B, EMT-I, EMT-P, RT) in the state; and possess as applicable to their scope of practice current Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS) and Pre-hospital Trauma Life Support (PHTLS) or Basic Trauma Life Support (BTLS) certifications.

   Note: The requirements of this section are established in regard to scope of practice for air medical personnel and the mission of the air ambulance service. The medical director of the service will outline requirements in the medical control plan of the service and upon approval of BEMS, verification of these requirements will be the documentation required.

8. Documentation of successful completion of training as outlined in Training-Medical Attendants.

9. The licensee shall maintain documentation of each attendant's training and qualifications and shall insure that the attendant meets the continuing education requirements for their licensed specialty.

10. Required Staffing

When an aircraft is in service as an air ambulance, it will be staffed according to the level of care being provided:

1. Basic level care (BLS) requires at least one state of Mississippi current certified basic level EMT.

2. Advanced level care (ALS) - Intermediate

a. Fixed-wing aircraft requires at least two personnel, one of which must be at least a state of Mississippi current certified Intermediate.

b. Rotor-wing aircraft requires at least a state of Mississippi current certified Intermediate.

3. Advanced level care (ALS) - Paramedic

a. Fixed-wing aircraft requires at least two personnel, one of which must be at least a state of Mississippi current certified Paramedic.

b. Rotor-wing aircraft requires at least a state of Mississippi current certified Paramedic.

4. Critical care (CCLS) requires at least two personnel, one of which must be at least a registered nurse, or physician.

5. Additional medical staff not licensed as air medical personnel can be added to or in place of licensed air medical personnel as long as at least one licensed air medical personnel with the highest level of certification (EMT-B, EMT-I, EMT-P, RN) required to care for the patient is also on board.

6. Air medical personnel will not assume cockpit duties when it may interfere with patient care responsibilities.

7. The aircraft shall be operated by a pilot or pilots certified in accordance with applicable FAR's. The captain or pilot in command will meet the following requirements:

a. Fixed-wing air ambulance

i. Has accumulated at least 2000 hours total time as a pilot.

ii. Has accumulated at least 1000 hours as pilot in command of an airplane.

iii. Must have accumulated at least 500 hours as pilot of a multi-engine aircraft.

iv. Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance.

v. Possess an Airline Transport certificate.

b. Rotor-wing air ambulance

i. Has accumulated at least 2000 rotor craft flight hours total time as a pilot.

ii. At least 1000 of those hours must be as pilot in command.

iii. At least 100 of those hours must be night-flight time.

iv. Factory school or equivalent in aircraft type (ground and flight).

v. Has accumulated 5 hours in aircraft type as pilot in command or at the controls prior to EMS missions if transitioning from a single engine to a single engine; from a twin engine to a single engine; or from a twin engine to a twin engine.

vi. Has accumulated 10 hours as pilot in command or at the controls prior to EMS missions if transitioning from a single engine to a twin engine aircraft.

vii. Must possess at least a commercial rotor craft-helicopter rating.

8. ATP certificate is encouraged.

9. A First Officer or co-pilot, if used, will meet the following requirements:

a. Fixed-wing air ambulance

i. Has accumulated at least 500 hours total time as a pilot.

ii. Must have accumulated at least 100 hours as pilot of a multi-engine aircraft.

iii. Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance.

iv. Possess a Commercial Pilot certificate.

b. Rotor-wing air ambulance

i. Has accumulated at least 500 rotor craft flight hours total time as a pilot.

ii. Factory school or equivalent in aircraft type (ground and flight).

iii. Must possess at least a commercial rotor craft-helicopter rating.

109 TRAINING

109.01 Air Medical Personnel

The licensee shall ensure that all medical personnel receive orientation and training specific to their respective aircraft (fixed-wing or rotor-wing) transport environment in general and the licensee's operation specifically. The curriculum shall be consistent with the Department of Transportation (DOT) Air Medical Crew - National Standard Curriculum, or equivalent program.

1. Initial - The licensee shall ensure that all air medical personnel successfully complete initial training and orientation to their position including adequate instruction, practice and drills. This training will include the following topics:

   a. Aeromedical physiology, gas laws and stressors of flight.

   b. Aircraft familiarization and flight safety.

      i. aircraft and cabin systems familiarization.

      ii. operation of emergency exits, evacuation procedures and use of emergency equipment.

   c. location of medical equipment and supplies.

   d. enplaning, deplaning and securing of patients for flight.

   e. In flight procedures for normal conditions and emergencies such as cabin depressurization, smoke or fire in the cabin, fire suppression, electrical failures.

   f. Medical equipment familiarization.

   g. Patient care policies, procedures and protocols, standards of care, and patient assessment.

   h. Documentation.

   i. Local EMS system communication and medical conventions.

   j. Survival.

   k. Infection control including OSHA blood borne pathogens.

   l. Pharmacology.

   m. Hazardous materials.

n. Legal and ethical issues

2. Recurrent - The licensee shall ensure that all air medical personnel shall successfully complete training consistent with the requirements set forth in the previous section annually.

3. Drills - The licensee shall make provisions for actual practice of those procedures that require complicated physical work or those that are technically complex such as enplaning and deplaning of patients, emergency evacuation, medical equipment identification, mock situational problem annually.

4. Documentation - The licensee will document the completed training for each air medical staff member.

109.02 Flight Crew Member

The licensee shall have a structured program of initial and recurrent training for the aviation personnel specific to their function in the medical transport environment. The aviation specific requirements of FAR (section 135.345) are controlling, however, BEMS recommended guidelines are listed below:

1. Initial - The licensee shall ensure that all cockpit crew members successfully complete initial training and orientation to the skills and knowledge necessary to perform their functions in air medical transport operations. Training shall include the following topics:

   a. Pre-flight planning to accommodate special patient needs including weather considerations, altitude selection, fuel requirements, weight and balance, effective range and performance and selection of alternate airports appropriate for a medial or aviation diversion.

   b. Flight release - effective communication between communications specialist, air medical personnel and pilot(s). Aviation considerations for release (approval to proceed) based on the latest weather and aircraft status.

   c. Ground ambulance handling in direct vicinity of aircraft.

   d. Baggage and equipment handling (pressurized and non-pressurized compartments)(fixed-wing pilots)

   e. Patient enplaning - passenger briefing. (fixed-wing pilots)

   f. Coordination of aircraft movement with air medical personnel activities prior to taxi to ensure their safety.

g. Smooth and coordinated control of the aircraft when maneuvering, transition of control surface configurations and ground operations for patient, air medical personnel and passenger comfort.

h. Intermediate stop procedures - (fueling, fire equipment standby, customs).

i. Medical emergencies during flight.

j. Aircraft emergency procedures - evacuations including patient.

k. Cabin temperature control to maintain comfortable cabin temperature for the occupants.

2. Recurrent - The licensee shall ensure that all aviation personnel receive recurrent training - at least annually - on the topics included in their initial indoctrination as well as any changes or updates made to policies or procedures.

3. Drills - The licensee shall make provisions for actual practice of those procedures that require complicated physical work or that is technically complex such as enplaning and deplaning of patients, emergency evacuation, medical equipment identification, and mock situational problem solving.

4. Documentation - The licensee will document the completed training for each air medical staff member.

110 COMMUNICATIONS

110.01 Activation Capability

The licensee shall have facilities and plans in place to provide the telephonic and radio systems necessary to carry verbal communication. The system should be consistent with the services scope of care and includes three elements: receipt of incoming inquiries and transport requests; activation and communications with aircraft flight crews and air medical personnel during transport operations; and medical control communications.

1. Initial contact/coordination point - The licensee shall have a plan to receive requests for service and assign resources to handle the transport requests.

2. Contact data resources - The licensee shall maintain an information file available to the person handling communications that contains the

necessary contact person's phone numbers and other pertinent data to manage routine and emergency communication needs.

3. Documentation - The licensee shall record the chronological events of each transport. The following data elements shall be included:

   a. Time of initial request

   b. Time of aircraft liftoff

   c. Time of aircraft arrival at pickup point

   d. Time of aircraft liftoff

   e. Time of any intermediate aircraft stops

   f. Time of aircraft arrival at destination

   g. Time aircraft and crew are returned to service and available.

110.02 Communications Continuity and Flight Following Capability

There shall be a well defined process to track transport activities and provide the necessary support to efficiently follow aircraft, flight crews and air medical personnel movement. The licensee shall have a written emergency plan which addresses the actions to be taken in the event of an aircraft incident or accident, breakdown or patient deterioration during transport operations.

110.03 Medical Control Communications

The licensee shall have a means of providing communications between the aircraft, the coordination point, medical control personnel and other agencies by telephonic or radio as appropriate. This shall be accomplished by local or regional EMS radio systems; and/or radio or flight phone as available inboard the aircraft. All aircraft shall have 155.340 statewide hospital net available for air crew member(s) in the patient area.

110.04 Requirements For Aircraft

When being used as an air ambulance, in addition to meeting other requirements set forth in these rules, and aircraft shall:

1. Be multi-engine. (Fixed-wing)

2. Be pressurized. (Fixed-wing)

3. Be equipped for IFR flight.

Note: Fixed-wing aircraft should be equipped and rated for IFR operations in accordance with FAR's. Rotor-wing aircraft should be equipped for inadvertent IFR if operating as a VFR operator.

4. Have a door large enough to allow a patient on a stretcher to be enplaned without excessive maneuvering or tipping of the patient which compromises the function of monitoring devices, IV lines or ventilation equipment.

5. Be designed or modified to accommodate at least 1 stretcher patient.

6. Have a lighting system which can provide adequate intensity to illuminate the patient care area and an adequate method (curtain, distance) to limit the cabin light from entering the cockpit and impeding cockpit crew vision during night operations.

7. Have an environmental system (heating and cooling) capable of maintaining a comfortable temperature at all times. (Fixed-wing)

8. Have an interior cabin configuration large enough to accommodate the number of air medical personnel needed to provide care to the patient in accordance with Required Staffing, as well as an adult stretcher in the cabin area with access to the patient. The configuration shall not impede the normal or emergency evacuation routes.

9. Have an electrical system capable of servicing the power needs of electrically powered on-board patient care equipment.

10. Have all installed and carry on equipment secured using FAA approved devices and methods.

11. Have sufficient space in the cabin area where the patient stretcher is installed so that equipment can be stored and secured with FAA approved devices in such a manner that it is accessible to the air medical personnel.

12. Have two fire extinguishers approved for aircraft use. Each shall be fully charged with valid inspection certification and capable of extinguishing type A, B or C fires. One extinguisher shall be accessible to the cockpit crew and one shall be in the cabin area accessible to the medical crew members. (fixed-wing)

13. One fire extinguisher type A, B or C, fully charged with valid inspection, shall be accessible to the cockpit crew and cabin area medical crew members. If not accessible, two fire extinguishers are required. (rotor-wing)

111 MEDICAL EQUIPMENT & SUPPLIES

Each air ambulance aircraft shall carry the following minimum equipment set forth in the following section unless a substitution is approved by BEMS and an off-line medical director.

111.01 Required Equipment for All Levels of Care

Medical Equipment for All Levels of Care Shall Include:

1. STRETCHER - There shall be 1 or more stretcher(s) installed in the aircraft cabin which meets the following criteria:

    a. Can accommodate a patient who is in the 95 percentile for an adult male - 6 feet tall, 212 lbs. or 96.2 kg. There shall be restraining devices or additional appliances available to provide adequate restraint of patients under 60 lbs or 36" in height.

    b. Shall have at least two cross-body patient restraining straps, one of which secures the chest area and the other about the area of the knee and thigh area. If the patient(s) is/are secured in the aircraft with his/their head toward the nose of the aircraft, there shall be a harness which goes over the shoulders to secure him/them from forward movement.

    c. The stretcher shall be installed in the aircraft cabin so that it is sufficiently isolated by distance or physical barrier from the cockpit so that the patient cannot reach the cockpit crew from a supine or prone position on the stretcher.

    d. Attachment points of the stretcher to the aircraft, the stretcher itself, and the straps securing the patient to the stretcher, shall meet FAR Part 23 restraint requirements.

    e. The head of each stretcher shall be capable of being elevated up to 45 degrees. The elevating section must hinge at or near the patent's hips and shall not interfere with or require that the patient or stretcher securing straps and hardware be removed or loosened. (fixed-wing)

    f. The stretcher shall be positioned in the cabin to allow the air medical personnel clear view of the patient's body.

    g. Air medical personnel shall always have access to the patient's head and upper body for airway control procedures as well as sufficient space over the area where the patient's chest is to adequately perform closed chest compression or abdominal thrusts on the patient.

Note: The licensee may be required to demonstrate to the licensing authority that airway control procedures and cardiac compressions/abdominal thrusts can be adequately performed on a training manikin in any of its aircraft.

h. The stretcher pad or mattress shall be impervious to moisture and easily cleaned and disinfected according to OSHA blood borne pathogens requirements.

i. If the surface of the stretcher under the patient's torso is not firm enough to support adequate chest compressions, a device to make the surface rigid enough will be provided.

j. A supply of linen for each patient.

111.02 Respiratory Care

1. OXYGEN - An adequate and manually controlled supply of gaseous or liquid medical oxygen, attachments for humidification, and a variable flow regulator for each patient. A humidifier, if used, shall be a sterile, disposable, one-time usage item. The licensee shall have and demonstrate the method used to calculate the volume of oxygen required to provide sufficient oxygen for the patients needs for the duration of the transport. The licensee will have a plan to provide the calculated volume of oxygen plus a reserve equal 1000 liters or the volume required to reach an appropriate airport whichever is longer. All necessary regulators, gauges and accessories shall be present and in good working order. The system shall be securely fastened to the airframe using FAA approved restraining devices.

   a. A separate emergency backup supply of oxygen of not less than one E cylinder with regulator and flow meter.

      Note: "D" cylinder with regulator and flow meter is permissible for rotor-wing aircraft in place of the "E" cylinder requirement.

   b. 1 adult and 1 pediatric size non-rebreathing oxygen mask; 1 adult size nasal cannula and necessary connective tubing and appliances.

2. SUCTION - As the primary source, an electrically powered suction apparatus with wide bore tubing, a large reservoir and various sizes suction catheters. The suction system can be built into the aircraft or provided with a portable unit. Backup suction is required and can be a manually operated device.

3. BAG-VALVE-MASK - Hand operated bag-valve-mask ventilators of adult, pediatric and infant size with clear masks in adult, pediatric and infant sizes. It shall be capable of use with a supplemental oxygen supply and have an oxygen reservoir.

4. AIRWAY ADJUNCTS

   a. Oropharyngeal airways in at least 5 assorted sizes, including adult, child, and infant.

   b. Nasopharyngeal airways in at least 3 sizes with water soluble lubricant.

111.03 Patient Assessment Equipment

Equipment suitable to determine blood pressure of the adult, pediatric and infant patient(s) during flight.

a. Stethoscope.

b. Penlight/Flashlight.

c. Bandage scissors, heavy duty.

d. Pulse Oximeter

e. Bandages & Dressings

f. Sterile Dressings such as 4x4's, ABD pads.

g. Bandages such as Kerlix, Kling.

h. Tape - various sizes.

111.04 Miscellaneous Equipment and Supplies

1. Potable or sterile water.

2. Container(s) and methods to collect, contain and dispose of body fluids such as emesis, oral secretions and blood consistent with OSHA blood borne pathogens requirements.

111.05 Infection control equipment.

The licensee shall have a sufficient quantity of the following supplies for all air medical personnel, each flight crew member and all ground personnel with incidental exposure risks according to OSHA requirements:

a. Latex gloves.

b. Protective gowns.

c. Protective goggles.

d. Protective face masks.

e. There shall be an approved bio-hazardous waste plastic bag or impervious container to receive and dispose of used supplies.

f. Hand washing capabilities or antiviral towellets.

g. An adequate trash disposal system exclusive of bio-hazardous waste control provisions.

h. Survival Kit

The licensee shall maintain supplies to be used in a survival situation. It shall include, but not be limited to, the following items which are appropriate to the terrain and environments the licensee operates over:

i. Instruction manual.

j. Water.

k. Shelter - space blanket.

l. Knife.

m. Signaling device - mirror, whistle, flares, dye marker.

n. Compass.

o. Fire starting items - matches, candle, flint, battery.

111.06 ALS level equipment

To function at the ALS level, the following additional equipment is required:

1. Endotracheal Intubation Equipment:

a. Laryngoscope handle.

b. One each adult, pediatric and infant blades.

c. Two of each size of assorted disposable endotracheal tubes according to the scope of the licensee's service and patient mixture with assorted stylets, syringes.

d. End-tidal CO2 detectors (may be made onto bag valve mask assemblies or separate)

e. Alternate airway management equipment.

2. IV Equipment and Supplies

a. Sterile crystalloid solutions in plastic containers, IV catheters, and administration tubing sets.

b. Hanger for IV solutions.

c. A device for applying external pressure to flexible IV fluid containers.

d. Tourniquets, tape, dressings.

e. Suitable equipment and supplies to allow for collection and temporary storage of two blood samples.

f. A container appropriate to contain used sharp devices - needles, scalpels which meets OSHA requirements.

3. Medications

Security of medications, fluids and controlled substances shall be maintained by each air ambulance licensee. Security procedures shall be approved by the service's medical director and be in compliance with the licensee's policies and procedures. Medication inventory techniques and schedules shall be maintained in compliance with all applicable local, state and federal drug laws.

Medication Inventory:

Quantity	Medication	Concentration
2	Atropine	1mg/10ml
2	Benadryl	5mg/ml
2	Bretylium	500mg/10ml
2	Calcium Chloride	1mg/10ml
2	Dextrose	50%5gm/50ml
2	Dramamine(fixed-wing only)	50mg/ml
25	Dramamine (fixed-wing only)	50mg/tab
1	Dopamine	400mg/5ml or 400mg/50ml D5W
4	Epinephrine	1:10,0001mg/10ml
2	Epinephrine	1:1,0001mg/1ml
8 or 4	Lasix	20mg/2ml or10mg/4ml
2	Lidocaine	100mg/5ml or 10 ml
2 or1	Lidocaine	1gm/5ml or 10ml or2gm/500ml D5W
2	Narcan	1mg/2ml
1	Nitroglycerin	1/150gr tabs or 0.4mg/metered dose spray

4	Sodium Bicarbonate	50mg/50ml

a. The medical director can modify the medication inventory as required to meet the care needs of their patient mix and in compliance with section (111.06-3C) below.

b. The licensee shall have a sufficient quantity of needles, syringes and accessories necessary to administer the medications in the inventory supply.

c. The medical director of the licensee may authorize the licensee with justification to substitute medication(s) listed provided that he first obtains approval from BEMS, and provided further that he signs such authorization.

4. Cardiac Monitor-Defibrillator - D.C. battery powered portable monitor/defibrillator with paper printout and spare batteries, accessories and supplies.

5. External Cardiac Pacing Device

6. Non-Invasive Automatic Blood Pressure Monitor

7. IV Infustion Pump capable of strict mechanical control of an IV infusion drip rate. Passive devices such as dial-a-flows are not acceptable.

8. Electronic Monitoring Devices - Any electronic or electrically powered medical equipment to be used on board an aircraft should be tested prior to actual patient use to insure that it does not produce Radio Frequency Interference (RFI) or Electro Magnetic Interference (EMI) which would interfere with aircraft radio communications or radio navigation systems. This may be accomplished by reference to test data from organizations such as the military or by actual tests performed by the licensee while airborne.

111.07 <u>To function at the CCLS or SPECIALTY level of care</u>

The following additional equipment shall be available as required:

1. Mechanical Ventilator - A mechanical ventilator that can deliver up to 100% oxygen concentration at pressures, rates and volumes appropriate for the size of patient being cared for.

2. Isolette - for services performing transport of neonatal patients.

3. Intraaortic Balloon Pump (IABP)

4. Invasive Line (ARTERIAL AND SWAN-GANZ CATHETERS) monitoring capability.

111.08 Equipment Maintenance and Inspection Program

The licensee shall have a program to inspect and maintain the effective operation of its medical equipment. The program should include daily or periodic function checks and routine preventive inspection and maintenance. There should be a plan for securing replacement or backup equipment when individual items are in for repair. There should be manufacturer's manuals as well as brief checklist available for reference. The equipment maintenance and inspection program shall include:

1. Daily or periodic checks - shall include a checklist based on the manufacturer's recommendations which verifies proper equipment function and sterile package integrity.

2. Routine preventive maintenance - shall include a program of cleaning and validating proper performance, supply packaging integrity.

3. A documentation system which tracks the history of each equipment item.

4. A procedure for reporting defective or malfunctioning equipment when patient care has been affected.

111.09 High Visibility Safety Apparel for Staff

Each air ambulance must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

112 VIOLATIONS

Violations should be corrected at the time of the inspection, if possible.

Violations of the requirements set forth in this section will require appropriate corrective action by the licensee.

112.01 Category "A" Violations

1. Category “A” violations require the air ambulance aircraft be immediately removed from service until it has been reinspected and found to be in compliance with these regulations. Category "A" violations include:

    a. Missing equipment or disposable supply items.

    b. Insufficient number of trained air medical personnel to fill the services staffing requirements.

    c. The provider has no medical director.

    d. Violation or non-compliance of FAR or OSHA mandates.

112.02 Category "B" Violations

1. Category “B” violations must be corrected within 72 hours of receiving notice and a written report shall be sent to BEMS verifying the correction. Category "B" violations include:

    a. Unclean or unsanitary equipment or aircraft environment.

    b. Non-functional or improperly functioning equipment.

    c. Expired shelf life of supplies such as medications, IV fluids and items having limited shelf life.

    d. Package integrity of sealed or sterile items is compromised.

    e. Failure to produce requested documentation of patient records, attendant training or other reports required by BEMS.

113 SUSPENSION; REVOCATION OF LICENSE

113.01 Suspension, Revocation of License

May occur as outlined in 41-59-17 and 41-59-45. Appeals from decision of the board can also be referred to in 41-59-49.

A Mississippi licensed ambulance service shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services. Licensed service must follow the respective region’s patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan.

Chapter 04 MEDICAL CONTROL

100 MEDICAL CONTROL

See Appendix 1.

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Chapter 05 MEDICAL FIRST RESPONDER

100 MEDICAL FIRST RESPONDER

100.01 Definitions [Repealed effective July 1, 2011].41-59-3, MAC;

As used in this chapter, unless the context otherwise requires, the term:

As used in this chapter, unless the context otherwise requires, the term:

(a) "Ambulance" means any privately or publicly owned land or air vehicle that is especially designed, constructed, modified or equipped to be used, maintained and operated upon the streets, highways or airways of this state to assist persons who are sick, injured, wounded, or otherwise incapacitated or helpless;

(b) "Permit" means an authorization issued for an ambulance vehicle and/or a special use EMS vehicle as meeting the standards adopted under this chapter;

(c) "License" means an authorization to any person, firm, corporation, or governmental division or agency to provide ambulance services in the State of Mississippi;

(d) "Emergency medical technician" means an individual who possesses a valid emergency medical technician's certificate issued under the provisions of this chapter;

(e) "Certificate" means official acknowledgment that an individual has successfully completed (i) the recommended basic emergency medical technician training course referred to in this chapter which entitles that individual to perform the functions and duties of an emergency medical technician, or (ii) the recommended medical first responder training course referred to in this chapter which entitles that individual to perform the functions and duties of a medical first responder;

(f) "Board" means the State Board of Health;

(g) "Department" means the State Department of Health, Division of Emergency Medical Services;

(h) "Executive officer" means the Executive Officer of the State Board of Health, or his designated representative;

(i) "First responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons;

(j) "Medical first responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons who (i) is trained to assist other EMS personnel by successfully completing, and remaining current in refresher training in accordance with, an approved "First Responder: National Standard Curriculum" training program, as developed and promulgated by the United States Department of Transportation, (ii) is nationally registered as a first responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a medical first responder by the State Department of Health, Division of Emergency Medical Services;

(k) "Invalid vehicle" means any privately or publicly owned land or air vehicle that is maintained, operated and used only to transport persons routinely who are convalescent or otherwise non-ambulatory and do not require the service of an emergency medical technician while in transit;

(l) "Special use EMS vehicle" means any privately or publicly owned land, water or air emergency vehicle used to support the provision of emergency medical services. These vehicles shall not be used routinely to transport patients;

(m) "Trauma care system" or "trauma system" means a formally organized arrangement of health care resources that has been designated by the department by which major trauma victims are triaged, transported to and treated at trauma care facilities;

(n) "Trauma care facility" or "trauma center" means a hospital located in the State of Mississippi or a Level I trauma care facility or center located in a state contiguous to the State of Mississippi that has been designated by the department to perform specified trauma care services within a trauma care system pursuant to standards adopted by the department;

(o) "Trauma registry" means a collection of data on patients who receive hospital care for certain types of injuries. Such data are primarily designed to ensure quality trauma care and outcomes in individual institutions and trauma systems, but have the secondary purpose of providing useful data for the surveillance of injury morbidity and mortality;

(p) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(q) "Emergency medical call" means a situation that is presumptively classified at time of dispatch to have a high index of probability that an emergency medical condition or other situation exists that requires medical intervention as soon as possible to reduce the seriousness of the situation, or when the exact circumstances are unknown, but the nature of the request is suggestive of a true emergency where a patient may be at risk;

(r) "Emergency response" means responding immediately at the basic life support or advanced life support level of service to an emergency medical call. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call;

(s) "Emergency mode" means an ambulance or special use EMS vehicle operating with emergency lights and warning siren (or warning siren and air horn) while engaged in an emergency medical call.

Sources: Laws, 1974, ch. 507, § 2; Laws, 1991, ch. 482, § 1; Laws, 1998, ch. 429, § 1; Laws, 2000, ch. 594, § 1; Laws, 2002, ch. 623, § 1; brought forward without change, Laws, 2002, 1st Ex Sess, ch. 3, § 1; Laws, 2004, ch. 425, § 1; Laws, 2004, ch. 581, § 1; Laws, 2008, ch. 549, § 1, eff from and after July 1, 2008.

101 TRAINING AUTHORITY MEDICAL FIRST RESPONDER

The guidelines and minimum standards are set forth in order to establish a minimum level of training for the Medical First Responder in the State of Mississippi. These guidelines and minimum standards shall be met by all Medical First Responder courses in the state. BEMS may approve Medical First Responder programs if it is determined after review by the BEMS staff, State EMS Medical Director, and the Medical Direction, Training and Quality Assurance Committee that the objectives of the training program equal or exceed those of the State of Mississippi. Additionally, organized EMS districts as recognized by BEMS, Mississippi State Department of Health, are authorized to provide this training. All Medical First Responder training programs must have BEMS approval prior to the start of class.

101.01 Medical First Responder Curriculum

1. Medical First Responder training curriculums must conform, at minimum, to the National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions as approved for use by BEMS. Minimum hours required for Medical First Responder are: 40 didactic/lab. In addition, a Healthcare Provider CPR course that meets current AHA Standards and Guidelines for CPR and AED must be completed. BEMS and the State EMS Medical Director must approve all training curriculums. Written permission from BEMS must be obtained prior to the start of a Medical First Responder course.

101.02 Request for approval of Medical First Responder training programs

1. A list of BEMS approved Medical First Responder training programs will be available at the BEMS office and on the BEMS website. Request for approval of Medical First Responder training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

   a. The Medical First Responder training program meets, at minimum, the requirements of the Medical First Responder curriculum as given in this Section.

   b. There are Medical First Responder instructor certification and re-certification requirements, including an evaluation of instructor terminal competencies, provided in the requested training program.

      Note: Credentialed EMS instructors of BEMS as trained through the Mississippi EMS Instructor training program and in good standing, are considered as meeting the above requirement.

   c. Approval must be given by the Medical Direction, Training and Quality Assurance Committee (MDTQA), State EMS Medical Director, and BEMS, prior to the start of any classes utilizing the proposed Medical First Responder training program.

101.03 Medical First Responder Training Programs

Mississippi Medical First Responder training should include at least forty hours of instruction on the objectives of the First Responder National Standard Curriculum. The participants must receive training at the Healthcare Provider level in CPR and AED prior to completion of the program. This portion of the training should be a minimum of eight additional hours if incorporated into the Medical First Responder training program. S

1. The length of the Healthcare Provider CPR and AED course shall not be less than 8 hours (didactic and practical). This training should meet the current AHA Standards and Guidelines for CPR and AED.

2. The complete Mississippi Medical First Responder educational program should be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the Medical First Responder.

3. The program should consist of at minimum two components: didactic instruction and clinical instruction, with optional supervised field experience in a system which functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their

mastery of the educational objectives by written, verbal, and practical examination.

4. The program should maintain on file for each component of the curriculum a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives should delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

5. The student should be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

6. Evidence of student competence in achieving the educational objectives of the program should be kept on file. Documentation should be in the form of both written and practical examinations.

7. Classroom, clinical, and optional field faculty should also prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

8. Faculty should be presented with the program's educational objectives for uses in preparation of lectures and clinical and field practice. The course coordinator should ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

    a. Didactic instruction: Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

    b. Clinical and other settings: Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation should be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

    c. Field Experience (optional): The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care

responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The initial position of the student on the EMS care team should be that of observer and should progress to participation in actual patient care. The student should not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present.

9. General courses and topics of study must be achievement oriented and shall provide students with:

   a. The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Job Description" and "Functional Job Analysis" found in the DOT, NSTC Course Guide.

   b. Comprehensive instruction which encompasses:

      i. Development of knowledge and clinical skills appropriate for this level of care in the areas of:

         i. Introduction to EMS Systems

         ii. The well-being of the First Responder

         iii. Legal and Ethical Issues

         iv. The Human Body

         v. Lifting and Moving Patients

         vi. Airway management procedures

         vii. Patient assessment including both initial and ongoing assessment.

         viii. Managing patient circulation

         ix. Identify and manage illness and injury

         x. Childbirth

         xi. Assessment and management of common medical and trauma situations of infants/children

         xii. EMS operations

Operational Policies

Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number accepted, as well as a placement history of those who complete the program.

** Announcements and advertising about the program shall reflect accurately the training being offered.*

** The program shall be educational and students shall use their scheduled time for educational experiences.*

** Health and safety of students, faculty, and patients shall be adequately safeguarded.*

** Costs to the student shall be reasonable and accurately stated and published.*

** Policies and process for student withdrawal and refunds on tuition and fees shall be fair, and made known to all applicants.*

Curriculum Description

Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the skills that are taught in this program. It is important not to lose sight of the original purpose of the Medical First Responder level. Students should have an opportunity to acquire clinical experience and practice skills related to the emergency medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students and are being prepared to assume as graduates.

101.04 Medical First Responder classes, class approval

1. The BEMS may approve Medical First Responder training classes if it is determined, after review of Medical First Responder class request forms that the objectives of the class equal or exceed those of the State of Mississippi.

2. Medical First Responder class approval forms can be requested from BEMS or be completed on the BEMS website. Credentialed Medical First

Responder instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class. BEMS will assign a class number to all approved requests and return to the credentialed Medical First Responder instructor. Incomplete paperwork will be returned without action.

101.05 Medical First Responder classes, initial roster

Initial rosters shall be completed by the credentialed Medical First Responder instructor immediately following the second meeting of the class. Initial roster forms can be obtained from BEMS or be completed on the BEMS website. A final roster for a full or refresher Medical First Responder class will not be accepted without an initial roster on file with BEMS.

101.06 Medical First Responder classes, final roster

Final rosters shall be completed by the credentialed Medical First Responder instructor immediately following the end of a full Medical First Responder or Medical First Responder refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the Medical First Responder class. The final roster form can be obtained from BEMS or be completed on the BEMS website. Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with BEMS. Credentialed Medical First Responder instructors must complete the final roster affidavit regarding Medical First Responder DOT practical skills completion S

101.07 Medical First Responder Training Programs, Minimum Admittance Criteria

Must be eighteen (18) years of age prior to class completion.

Students currently enrolled in a Mississippi Community or Junior College dual enrollment program may also be considered eligible to enter First Responder training program in exception to other stated admission requirements.

101.08 Medical First Responder Refresher Training

The Mississippi Medical First Responder Refresher curriculum must conform, at minimum, to the National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions as approved for use by BEMS. Minimum hours required for Medical First Responder refresher training are: 12 hours didactic/lab. Written permission from BEMS must be obtained prior to the start of a Medical First Responder refresher course. Instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class. Medical First Responder refresher training must be accomplished by all

certified Mississippi Medical First Responders during their National Registry certification period.

NOTE: Medical First Responder Refresher Course Instructors should refer to:

101.2 for request for approval of Medical First Responder training programs

101.4 for Medical First Responder classes, class approval

101.5 for Medical First Responder classes, initial roster

101.6 for Medical First Responder classes, final roster

101.09 Prerequisites to certification as a Medical First Responder (training obtained in Mississippi)

1. Age of at least 18 years.
2. Completion of the Board's approved Medical First Responder Training Program (Note: This includes passage of the National Registry examination).
3. National Registry certification at minimum level of First Responder

101.10 Prerequisites to certification as a Medical First Responder (training obtained in another state)

1. Age of at least 18 years.
2. Completion of a Medical First Responder program which meets the minimum guidelines of the First Responder National Standard Curriculum. Provide written verification from the State of training and of current status.
3. Completion of a State-approved Medical First Responder skills course.
4. Applicant must be registered at a minimum level of First Responder by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card.

NOTE: The Mississippi BEMS maintains the right to refuse reciprocity to any Nationally Registered Medical First Responder applicant if the submitted curriculum does not meet the guidelines of the national standard curriculum and those required by the State of Mississippi.

102 MEDICAL FIRST RESPONDER CERTIFICATION

102.01 Medical First Responder Certification

1. Any person desiring certification as a Medical First Responder shall apply to the BEMS using forms provided (Application for State Certification).

2. All certification applications must be accompanied by a ten dollar ($10.00) money order or business check payable to the Mississippi State Department of Health - BEMS, a copy of the applicant's current National Registry card. BEMS may withhold or deny the application for certification for a like period of time equal to the like period of time under which a person failed to comply. Mississippi requires that all Medical First Responder's maintain current registration with the National Registry of Emergency Medical Technicians.

102.02 Grounds for Suspension or Revocation

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty.

6. Recklessly disregarding the speed regulations prescribed by law while on duty.

7. Failure to carry the Mississippi State Department of Health issued certification card while on duty or failure to wear appropriate identification as approved by State Department of Health, Bureau of EMS.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current training standards as required by the State Department of Health.

10. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the State Department of Health, BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

15. Functioning outside the Medical First Responder scope of practice.

16. Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

18. Failure to comply with an employer's request for drug and alcohol testing.

19. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

102.03 Recertification of Medical First Responders

1. Any person desiring re-certification as a Medical First Responder shall apply to BEMS using forms provided (Application for state certification)

2. All re-certification applications must be accompanied by ten dollar ($10.00) money order or business check payable to the Mississippi State Department of Health – BEMS. Also, include a copy of the applicant's current National Registry card.

3. All Medical First Responders failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

4. BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

5. A Medical First Responder certificate issued shall be valid for a period not exceeding two and one-half (2 ½) years from date of issuance and may be renewed upon payment of a renewal fee of ten dollars ($10.00), which shall be paid to the Board, provided that the holder meets the qualifications set forth in regulations promulgated by the Board.

6. The Board may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

103 OCCUPATION AND COMPETENCY OF THE MEDICAL FIRST RESPONDER

103.01 Job Summary

A Mississippi Medical First Responder activates the EMS system, surveys the scene for hazards, contains those hazards, gains access to the injured or sick, gathers relevant patient data, provides immediate emergency medical care using a limited amount of equipment, controls the scene, and prepares for the arrival of the ambulance. Ongoing evaluation of the functioning Medical First Responder is essential to the maintenance of medical care quality. As with all professionals in the medical community, it must be realized that continuing education is an integral part of the Medical First Responder's ability to maintain a high degree of competency.

103.02 Functional Job Analysis

1. Mississippi Medical First Responder Characteristics

   a. The Mississippi Medical First Responder must be a person who can remain calm while working in difficult and stressful circumstances, as well as one who is capable of combining technical skills, theoretical knowledge, and good judgment to insure optimal level of fundamental emergency care to sick or injured patients while adhering to specific guidelines within the given scope of practice.

   b. The Mississippi Medical First Responder is expected to be able to work alone, but must also be a team player. Personal qualities such as the ability to "take charge" and control the situation are essential, as are the maintaining of a caring and professional attitude, controlling one's own fears, presenting a professional appearance, staying physically fit, and keeping one's skills and abilities up to date. The Mississippi Medical First Responder must be receptive to the evaluation required for the maintenance of quality medical care.

   c. Self-confidence, a desire to work with people, emotional stability, tolerance for high stress, honesty, a pleasant demeanor, and the ability to meet the physical and intellectual requirements demanded by this

position are characteristics of the competent First Responders. The Mississippi Medical First Responder also must be able to deal with adverse social situations which include responding to calls in districts known to have high crime rates. The Mississippi Medical First Responder ideally possesses an interest in working for the good of society and has a commitment to doing so.

2. Physical Demands
   Aptitudes required for work of this nature are good physical stamina, endurance, and body condition that would not be adversely affected by having to walk, stand, lift, carry, and balance at times, in excess of 125 pounds. Motor coordination is necessary because over uneven terrain, the patient's and the First Responder's well being, as well as other workers' well-being must not be jeopardized.

3. Other
   Use of telephone or radio dispatch for coordination of prompt emergency services is essential. Accurately discerning street names through map reading, and correctly distinguishing house numbers or business addresses are essential to task completion in the most expedient manner. Concisely and accurately describing orally, to dispatchers and other concerned staff, one's impression of a patient's condition, is critical as the First Responder works in emergency conditions where there may not be time for deliberation. The Mississippi Medical First Responder must also be able to accurately report all relevant patient data, which is generally, but not always, outlined on a prescribed form. Verbal and reasoning skills are used extensively. The ability to perform mathematical tasks is minimal, however, it does play a part in activities such as taking vital signs, making estimates of time, calculating the number of persons at a scene, and counting the number of persons requiring specific care.

   Note: A more detailed Functional Job Analysis can be found in Appendix A of the First Responder National Standard Curriculum

103.03 Performance Standards for Medical First Responder

The Mississippi Medical First Responder who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the certifying agency. Training programs must be approved by the Mississippi State Department of Health, BEMS, and/or the Department of Education.

The Medical First Responder's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help, and consideration of cervical stabilization.

The skills listed herein will enable the Medical First Responder to carry out all First Responder level patient assessment and emergency care procedures.

1. Given a possible infectious exposure, the First Responder will use appropriate personal protective equipment. At the completion of care, the First Responder will properly remove and discard the protective garments.

2. Given a possible infectious exposure, the First Responder will complete disinfection/cleaning and all reporting documentation.

3. Demonstrate an emergency move.

4. Demonstrate a non-emergency move.

5. Demonstrate the use of equipment utilized to move patient's in the pre-hospital arena.

6. Demonstrate competence in psychomotor objectives for:

    a. a. EMS Systems

    b. b. Well-Being of the First Responder

    c. c. Legal and Ethical Issues

    d. d. The Human Body

    e. e. Lifting and Moving Patients

7. Demonstrate the steps in the head-tilt chin lift.

8. Demonstrate the steps in the jaw thrust.

9. Demonstrate the techniques of suctioning.

10. Demonstrate the steps in mouth-to-mouth ventilation with body substance isolation.

11. Demonstrate how to use a resuscitation mask to ventilate a patient.

12. Demonstrate how to ventilate a patient with a stoma.

13. Demonstrate how to measure and insert an oropharyngeal and nasopharyngeal airway.

14. Demonstrate how to ventilate infant and child patients.

15. Demonstrate how to clear a foreign body airway obstruction in a responsive child and adult.

16. Demonstrate how to clear a foreign body airway obstruction in a responsive and unresponsive

    a. Infant

    b. Child

    c. Adult

17. Demonstrate the ability to differentiate various scenarios and identify potential hazards.

18. Demonstrate the techniques for assessing

    a. Mental status

    b. The airway

    c. If the patient is breathing

    d. If the patient has a pulse

    e. External bleeding

    f. Patient skin color, temperature, condition, and capillary refill (infants and children only)

19. Demonstrate questioning a patient to obtain SAMPLE history.

20. Demonstrate the skills involved in performing the physical exam.

21. Demonstrate the on-going assessment.

22. Demonstrate the proper technique of chest compression on

    a. Adult

    b. Child

    c. Infant

23. Demonstrate the steps of CPR

    a. One rescuer adult CPR

    b. Two rescuer adult CPR

    c. Child CPR

d. Infant CPR

24. Demonstrate the steps in providing emergency medical care to patient with

a. A general medical complaint

b. Altered mental status

c. Seizures

d. Exposure to cold

e. Exposure to heat

f. A behavioral change

g. A psychological crisis

25. Demonstrate the following methods of emergency medical care for external bleeding.

a. Direct pressure

b. Diffuse pressure

c. Pressure points

26. Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding.

27. Demonstrate the steps in the emergency medical care of

a. Open soft tissue injuries

b. A patient with an open chest wound

c. A patient with open abdominal wounds

d. A patient with an impaled object

e. A patient with an amputation

f. An amputated part

28. Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity.

29. Demonstrate opening the airway in a patient with suspected spinal cord injury.

30. Demonstrate evaluating a responsive patient with a suspected spinal cord injury.

31. Demonstrate stabilizing of the cervical spine.

32. Demonstrate the steps to assist in the normal cephalic delivery.

33. Demonstrate necessary care procedures of the fetus as the head appears.

34. Attend to the steps in the delivery of the placenta.

35. Demonstrate the post-delivery care of the mother.

36. Demonstrate the care of the newborn.

37. Demonstrate assessment of the infant and child.

38. Perform triage of a mass casualty incident.

39. Other knowledge and competencies may be added as revisions occur within the National Standard EMT Basic Curriculum.

Note: Skills not listed in these regulations may not be performed by a Mississippi Medical First Responder.

104 AREA AND SCOPE OF PRACTICE OF THE MEDICAL FIRST RESPONDER

The Mississippi Medical First Responder represents the first component of the emergency medical care system. Through proper training, the Medical First Responder will be able to provide basic life support to victims during emergencies, minimize discomfort and possible further injuries. The Medical First Responder may provide non-invasive emergency procedures and services to the level described in the First Responder National Standard Training Curriculum. Those procedures include recognition, assessment, management, transportation, and liaison.

A Mississippi Medical First Responder is a person who has successfully completed an approved training program and is certified. The Medical First Responder training program must equal or exceed the educational goals and objectives of the National Standard Training curriculum for the First Responder.

104.01 Description of Tasks

1. The Mississippi Medical First Responder answers verbally to telephone or radio emergency calls from dispatcher to provide efficient and immediate care to critically ill and injured persons using a limited amount of equipment. Responds safely to the address or location as directed by radio dispatcher. Visually inspects and assesses or “sizes up” the scene upon

arrival to determine if scene is safe, to determine the mechanism of illness or injury, and the total number of patients involved. Directly reports verbally to the responding EMS unit or communications center as to the nature and extent of injuries, the number of patients, and the condition of each patient, and identifies assessment findings which may require communication with medical direction for advice.

2. Assesses patient constantly while awaiting additional EMS resources, administers care as indicated. Requests additional help if necessary. Creates a safe traffic environment in the absence of law enforcement. Renders emergency care to adults, children, and infants based on assessment findings, using a limited amount of equipment. Opens and maintains patient airway, ventilates patient, performs CPR, utilizes automated and semi-automated external defibrillators. Provides pre-hospital emergency care of simple and multiple system trauma such as controlling hemorrhage, bandaging wounds, manually stabilizing painful, swollen, and deformed extremities. Provides emergency medical care to include assisting in childbirth, management of respiratory problems, altered mental status, and environmental emergencies.

3. Searches for medical identification as clues in providing emergency care. Reassures patients and bystanders while working in a confident and efficient manner, avoids misunderstandings and undue haste while working expeditiously to accomplish the task. Extricates patients from entrapment, assesses extent of injury, assists other EMS providers in rendering emergency care and protection to the entrapped patient. Performs emergency moves, assists other EMS providers in the use of prescribed techniques and appliances for safe removal of the patient.

4. Assists other EMS providers in lifting patient onto stretcher, placing patient in ambulance, and insuring that patient and stretcher are secured. Radios dispatcher for additional help or special rescue and/or utility services. Reports verbally all observations and medical care of the patient to the transporting EMS unit, provides assistance to transporting staff. Performs basic triage where multiple patients needs exist. Restocks and replaces used supplies, uses appropriate disinfecting procedures to clean equipment, checks all equipment to insure adequate working condition for next response. Attends continuing education and refresher courses as required.

Chapter 06 EMERGENCY MEDICAL SERVICES (EMS) DRIVER

100 GENERAL PROVISIONS

100.01 §41-59-5. Establishment and administration of program [Repealed effective July 1, 2011].

(1) The State Board of Health shall establish and maintain a program for the improvement and regulation of emergency medical services (hereinafter EMS) in the State of Mississippi. The responsibility for implementation and conduct of this program shall be vested in the State Health Officer of the State Board of Health along with such other officers and boards as may be specified by law or regulation.

(2) The board shall provide for the regulation and licensing of public and private ambulance service, inspection and issuance of permits for ambulance vehicles, training and certification of EMS personnel, including drivers and attendants, the development and maintenance of a statewide EMS records program, development and adoption of EMS regulations, the coordination of an EMS communications system, and other related EMS activities.

(3) The board is authorized to promulgate and enforce such rules, regulations and minimum standards as needed to carry out the provisions of this chapter.

(4) The board is authorized to receive any funds appropriated to the board from the Emergency Medical Services Operating Fund created in Section 41-59-61 and is further authorized, with the Emergency Medical Services Advisory Council acting in an advisory capacity, to administer the disbursement of such funds to the counties, municipalities and organized emergency medical service districts and the utilization of such funds by the same, as provided in Section 41-59-61.

(5) The department acting as the lead agency, in consultation with and having solicited advice from the EMS Advisory Council, shall develop a uniform non-fragmented inclusive statewide trauma care system that provides excellent patient care. It is the intent of the Legislature that the purpose of this system is to reduce death and disability resulting from traumatic injury, and in order to accomplish this goal it is necessary to assign additional responsibilities to the department. The department is assigned the responsibility for creating, implementing and managing the statewide trauma care system. The department shall be designated as the lead agency for trauma care systems development. The department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma Care System Plan, trauma system standards, trauma center designations, field triage, interfacility trauma transfer, EMS aero medical transportation, trauma data collection, trauma care system evaluation and management of state trauma systems funding. The department shall promulgate regulations specifying the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those

regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma care system, or which participate at a level lower than the level at which they are capable of participating. The department shall promulgate rules and regulations necessary to effectuate this provision by September 1, 2008, with an implementation date of September 1, 2008. The department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma Care System Plan and all associated trauma care system regulations necessary to implement the Mississippi trauma care system. The department shall cause the implementation of both professional and lay trauma education programs. These trauma educational programs shall include both clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the department shall coordinate the development of the inclusive trauma system with the Mississippi Department of Rehabilitation Services and all other appropriate rehabilitation systems.

(6) The State Board of Health is authorized to receive any funds appropriated to the board from the Mississippi Trauma Care System Fund created in Section 41-59-75. It is further authorized, with the Emergency Medical Services Advisory Council and the Mississippi Trauma Advisory Committee acting in advisory capacities, to administer the disbursements of those funds according to adopted trauma care system regulations. Any Level I trauma care facility or center located in a state contiguous to the State of Mississippi that participates in the Mississippi trauma care system and has been designated by the department to perform specified trauma care services within the trauma care system under standards adopted by the department shall receive a reasonable amount of reimbursement from the department for the cost of providing trauma care services to Mississippi residents whose treatment is uncompensated.

(7) In addition to the trauma-related duties provided for in this section, the Board of Health shall develop a plan for the delivery of services to Mississippi burn victims through the existing trauma care system of hospitals. Such plan shall be operational by July 1, 2005, and shall include:

(a) Systems by which burn patients will be assigned or transferred to hospitals capable of meeting their needs;

(b) Until the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 1 of this act is operational, procedures for allocating funds appropriated from the Mississippi Burn Care Fund to hospitals that provide services to Mississippi burn victims; and

(c) Such other provisions necessary to provide burn care for Mississippi residents, including reimbursement for travel, lodging, if no free lodging is available, meals and other reasonable travel-related expenses incurred by burn victims, family

members and/or caregivers, as established by the State Board of Health through rules and regulations.

After the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 37-115-45 is operational, the Board of Health shall revise the plan to include the Mississippi Burn Center.

Sources: Laws, 1974, ch. 507, § 3; Laws, 1982, ch. 344, § 2; Laws, 1989, ch. 545, § 1; Laws, 1991, ch. 597, § 1; Laws, 1992, ch. 491 § 27; Laws, 1998, ch. 429, § 2; Laws, 2005, 2nd Ex Sess, ch. 47, § 8; Laws, 2007, ch. 569, § 8; Laws, 2008, ch. 549, § 2, eff from and after July 1, 2008.

Cross references –

General powers and duties of state board of health, see § 41-3-15.

Powers and duties of the state board of health and the EMS director to administer disbursements from the emergency medical services operating fund, see § 41-59-61.

101 TRAINING AUTHORITY

These guidelines and minimum standards are set forth in order to establish a minimum level of training for the EMS Driver in the state of Mississippi. These guidelines and minimum standards shall be met by all EMS Driver courses in the state. Additionally, organized EMS districts as recognized by the BEMS, are authorized to provide this training. The BEMS may approve EMS Driver programs if it is determined after review by the BEMS staff, State EMS Medical Director, and the Medical Direction, Training and Quality Assurance Committee that the objectives of the training program equal or exceed those of the state of Mississippi. All EMS Driver training programs must have the BEMS approval prior to the start of class.

101.01 EMS Driver Curriculum

EMS Driver Curriculum must conform, at minimum, to the National Standard Emergency Vehicle Operator Curriculum developed by the United States Department of Transportation and all current revisions as approved for use by the BEMS. Minimum hours required for EMS Driver are: 4 didactic, and lab instruction sufficient to ensure operator competency, minimum 4 hours. BEMS and the State EMS Medical Director must approve all training curriculums. Written permission from the BEMS must be obtained prior to the start of an EMS Driver course.

101.02 Request for Approval of EMS Driver training programs

Note: A list of BEMS approved EMS Driver training programs will be available at the BEMS office and BEMS web site. (www.msems.org)

1. Request for approval of EMS Driver training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

   a. the EMS Driver training program meets, at minimum, the requirements of the EMS Driver curriculum as given in this section.

   b. there are EMS Driver Instructor certification and re-certification requirements, including an evaluation of instructor terminal competencies, provided in the requested training program.

Note: Credentialed EMS Instructors of BEMS as trained through the MS EMS Instructor Training Program, and in good standing, are considered as meeting the above requirement.

2. Approval of any EMS Driver training program curriculum must be given by the Medical Direction, Training and Quality Assurance Committee (MDTQA), State EMS Medical Director, and the BEMS staff, prior to the start of any classes.

101.03 <u>EMS Driving Training Programs</u>

1. The length of the EMS Driver course shall not be less than eight (8) hours (didactic and practical).

2. The complete EMS Driver educational program shall be designed to provide the knowledge that will allow the student to safely operate emergency vehicles.

3. The program shall consist of, at minimum, two components: didactic instruction and practical evaluation. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

4. The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives shall delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

5. The student shall be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions

governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

6. Evidence of student competence in achieving the educational objectives of the program shall be kept on file. Documentation must be in the form of both written and practical examinations.

7. Classroom and field practical faculty must prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations given to students must be maintained. Instruction must be supported by performance assessments.

8. Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer. The field practical is a period of supervised experience.

Policy for Administration

1. Operational Policies

Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

101.04 EMS Driver classes, class approved

1. BEMS may approve EMS Driver training classes if it is determined, after review of EMS Driver class request forms that the objectives of the class equal or exceed those of the State of Mississippi.

Note: EMS Driver class approval forms can be requested from the BEMS or be completed on the BEMS website. (www.msems.org)

2. Credentialed EMS Driver instructors must complete the class approval form and submit to the BEMS, at minimum, fourteen (14), preferably thirty (30) calendar days prior to the first day of class. The BEMS will assign a class number to all approved requests and return to the credentialed EMS Driver instructor. Incomplete paperwork will be returned without action.

101.05 EMS Driver classes, final roster

1. Final rosters shall be completed by the credentialed EMS Driver instructor immediately following the end of training. The final roster shall be inclusive of all students successfully completing the course. The final roster will note students who withdrew, failed, and completed the EMS Driver class.

   Note: The final roster form can be obtained from the BEMS or be completed on the BEMS web site. (www.msems.org)

2. Students successfully completing an EMS Driver course will not be eligible for state certification until a final roster is on file with the BEMS.

101.06 EMS Driver Training Programs, minimum admittance criteria

1. Possession of a valid driver's license

2. Age of at least 18 years.

101.07 EMS Driver Refresher Training

EMS Drivers are required to complete an initial EMS Driver course. There is currently no BEMS approved refresher training course for EMS Driver re-certification with the exception of BEMS approved vehicle operation monitoring system(see note below).

Note: Licensed ambulance services operating approved vehicle operation monitoring systems are required to repeat the didactic section of their training program and submit a copy of the latest employer approved performance driver monitor strip/record.

101.08 Prerequisites to certification as an EMS Driver (training obtained in Mississippi).

1. Age of at least 18 years.

2. Completion of the Board's approved EMS Driver Training Program.

3. Possession of valid driver's license.

101.09 Prerequisites to certification as an EMS Driver (training obtained in another state

1. Age of at least 18 years.

2. Completion of the Board's approved EMS Driver Training Program.

3. Possession of valid driver's license.

4. Written verification that training obtained out of state meets the guidelines of the Mississippi EMS Driver Training Program(s).

5. Verification of training within the past two years, or written verification of training from sending state and of current status.

6. Submission of official driver's license history concurrent with date of application.

Note: The BEMS maintains the right to refuse reciprocity to any EMS Driver if the submitted curriculum does not meet the requirements of this section.

102 EMS DRIVER CERTIFICATION

102.01 Temporary EMS Driver Certification.

1. The BEMS may issue temporary EMS driver certification not to exceed 90 days. Temporary certification will be issued only upon receipt of a written request from an owner/manager of a licensed ambulance provider. Licensed ambulance providers may utilize personnel awaiting temporary EMS driver certification provided that such providers notify the BEMS prior to employment.

2. A temporary EMS Driver certification will not be granted to an individual who has previously been issued a Mississippi BEMS EMS Driver certification.

102.02 EMS Driver Certification

1. Any person desiring certification as an EMS Driver shall apply to the BEMS using forms provided (application for state certification). All certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include a copy of EMS Driver course certificate of completion, a copy of a current state driver’s license and complete a successful review by the BEMS of the driver's license history from the Mississippi Highway Patrol.

2. An EMS Driver certificate shall be valid for a period not exceeding four years from the date of issuance and may be renewed provided that the holder meets qualifications as required by the Board. The expiration date of each EMS Driver certificates shall be the same as the holder's driver's license.

102.03 EMS Driver Re-certification

Any person desiring re-certification as an EMS Driver shall apply to the BEMS using forms provided (Application for state certification). All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include a copy of EMS Driver course certificate of completion and a copy of current state driver's license. The BEMS will conduct a review of the applicant's driver license history from the Mississippi Highway Patrol.

102.04 EMS Driver, Grounds for Suspension or Revocation.

1. Fraud or any mis-statement of fact in the procurement of any certification or in any other statement of representation to the BEMS or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disregarding the speed regulations prescribed by law while on duty.

6. Revocation or any other loss of Mississippi driver's license.

7. Failure to carry the BEMS issued certification card while on duty or failure to wear appropriate identification as approved by BEMS.

8. Failure to maintain all current EMS Driver training standards as required by the BEMS.

9. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

10. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel, or the conviction of any felony. The record of conviction or a certified copy thereof will be conclusive evidence of such conviction.

11. Violating or attempting to violate directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

12. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

13. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

14. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

15. Failure to comply with an employer's request for drug and alcohol testing.

16. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

Chapter 07 EMERGENCY MEDIAL TECHNICIAN BASIC (EMT-B)

100 GENERAL PROVISIONS

100.01 §41-59-5. Establishment and administration of program[Repealed effective July 1, 2011]..

(1) The State Board of Health shall establish and maintain a program for the improvement and regulation of emergency medical services (hereinafter EMS) in the State of Mississippi. The responsibility for implementation and conduct of this program shall be vested in the State Health Officer of the State Board of Health along with such other officers and boards as may be specified by law or regulation.

(2) The board shall provide for the regulation and licensing of public and private ambulance service, inspection and issuance of permits for ambulance vehicles, training and certification of EMS personnel, including drivers and attendants, the development and maintenance of a statewide EMS records program, development and adoption of EMS regulations, the coordination of an EMS communications system, and other related EMS activities.

(3) The board is authorized to promulgate and enforce such rules, regulations and minimum standards as needed to carry out the provisions of this chapter.

(4) The board is authorized to receive any funds appropriated to the board from the Emergency Medical Services Operating Fund created in Section 41-59-61 and is further authorized, with the Emergency Medical Services Advisory Council acting in an advisory capacity, to administer the disbursement of such funds to the counties, municipalities and organized emergency medical service districts and the utilization of such funds by the same, as provided in Section 41-59-61.

(5) The department acting as the lead agency, in consultation with and having solicited advice from the EMS Advisory Council, shall develop a uniform non-fragmented inclusive statewide trauma care system that provides excellent patient care. It is the intent of the Legislature that the purpose of this system is to reduce death and disability resulting from traumatic injury, and in order to accomplish this goal it is necessary to assign additional responsibilities to the department. The department is assigned the responsibility for creating, implementing and managing the statewide trauma care system. The department shall be designated as the lead agency for trauma care systems development. The department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma Care System Plan, trauma system standards, trauma center designations, field triage, interfacility trauma transfer, EMS aero medical transportation, trauma data collection, trauma care system evaluation and management of state trauma systems funding. The department shall promulgate regulations specifying the methods and procedures by which

Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma care system, or which participate at a level lower than the level at which they are capable of participating. The department shall promulgate rules and regulations necessary to effectuate this provision by September 1, 2008, with an implementation date of September 1, 2008. The department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma Care System Plan and all associated trauma care system regulations necessary to implement the Mississippi trauma care system. The department shall cause the implementation of both professional and lay trauma education programs. These trauma educational programs shall include both clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the department shall coordinate the development of the inclusive trauma system with the Mississippi Department of Rehabilitation Services and all other appropriate rehabilitation systems.

(6) The State Board of Health is authorized to receive any funds appropriated to the board from the Mississippi Trauma Care System Fund created in Section 41-59-75. It is further authorized, with the Emergency Medical Services Advisory Council and the Mississippi Trauma Advisory Committee acting in advisory capacities, to administer the disbursements of those funds according to adopted trauma care system regulations. Any Level I trauma care facility or center located in a state contiguous to the State of Mississippi that participates in the Mississippi trauma care system and has been designated by the department to perform specified trauma care services within the trauma care system under standards adopted by the department shall receive a reasonable amount of reimbursement from the department for the cost of providing trauma care services to Mississippi residents whose treatment is uncompensated.

(7) In addition to the trauma-related duties provided for in this section, the Board of Health shall develop a plan for the delivery of services to Mississippi burn victims through the existing trauma care system of hospitals. Such plan shall be operational by July 1, 2005, and shall include:

(a) Systems by which burn patients will be assigned or transferred to hospitals capable of meeting their needs;

(b) Until the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 1 of this act is operational, procedures for allocating funds appropriated from the Mississippi Burn Care Fund to hospitals that provide services to Mississippi burn victims; and

(c) Such other provisions necessary to provide burn care for Mississippi residents, including reimbursement for travel, lodging, if no free lodging is available, meals and other reasonable travel-related expenses incurred by burn victims, family members and/or caregivers, as established by the State Board of Health through rules and regulations.

After the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 37-115-45 is operational, the Board of Health shall revise the plan to include the Mississippi Burn Center.

Sources: Laws, 1974, ch. 507, § 3; Laws, 1982, ch. 344, § 2; Laws, 1989, ch. 545, § 1; Laws, 1991, ch. 597, § 1; Laws, 1992, ch. 491 § 27; Laws, 1998, ch. 429, § 2; Laws, 2005, 2nd Ex Sess, ch. 47, § 8; Laws, 2007, ch. 569, § 8; Laws, 2008, ch. 549, § 2, eff from and after July 1, 2008.

101 EMT-B CERTIFICATION

101.01 §41-59-33. Emergency medical technicians; certification.

Any person desiring certification as an emergency medical technician shall apply to the board using forms prescribed by the board. Each application for an emergency medical technician certificate shall be accompanied by a certificate fee to be fixed by the board, which shall be paid to the board. Upon the successful completion of the board's approved emergency medical technical training program, the board shall make a determination of the applicant's qualifications as an emergency medical technician as set forth in the regulations promulgated by the board, and shall issue an emergency medical technician certificate to the applicant.

SOURCES: Laws, 1974, ch. 507, § 8(3); 1979, ch. 445, § 4; 1982, ch. 345, Section 4, 1991, ch. 606, § 6, eff from and after July 1, 1991.

101.02 §41-59-35. Emergency medical technicians; period of certification; renewal, suspension or revocation of certificate; use of certain EMT titles without certification prohibited.

1. An emergency medical technician certificate so issued shall be valid for a period not exceeding two (2) years from the date of issuance and may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board, provided that the holder meets the qualifications set forth in this Chapter 59 and Chapter 60 and rules and regulations promulgated by the board.

2. The board is authorized to suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

3. It shall be unlawful for any person, corporation or association to, In any manner, represent himself or itself as an Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver, or use in connection with his or its name the words or letters of EMT, EMT, paramedic, or any other letters, words, abbreviations or insignia which would indicate or imply that he or it is a Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver, unless certified in accordance with Chapters 59 and 60 of this title and is in accordance with the rules and regulations promulgated by the board. It is unlawful to employ any uncertified Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, or Emergency Medical Technician-Paramedic to provide basic or advance life support services.

4. Any Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver who violates or fails to comply with these statues or rules and regulations promulgated by the board hereunder shall be subject, after due notice and hearing, to an administrative fine not to exceed One Thousand Dollars ($1,000.00).

SOURCES: Laws, 1974, ch. 507, § 8 (4,5); 1979, ch. 445, § 5; 1982, ch. 345, § 5, 1991, ch. 606, § 7, 2001, ch. 542, § 1, eff from and after July 1, 2001.

101.03 <u>§41-59-37. Temporary ambulance attendant's permit.</u>

The board may, in its discretion, issue a temporary ambulance attendant's permit which shall not be valid for more than one (1) year from the date of issuance, and which shall be renewable to an individual who may or may not meet qualifications established pursuant to this chapter upon determination that such will be in the public interest.

SOURCES: Laws, 1974, ch. 507, § 8(6), eff from and after passage (approved April 13, 1974).

101.04 <u>§41-60-13. Promulgation of rules and regulations by state board of health.</u>

The Mississippi State Board of Health is authorized to promulgate and enforce rules and regulations to provide for the best and most effective emergency medical care, and to comply with national standards for advanced life support. Notwithstanding any other provision of law, advanced life support personnel may be authorized to provide advanced life support services as defined by rules and regulations promulgated by the state board of health.

Rules and regulations promulgated pursuant to this authority shall, as a minimum:

a. Define and authorize appropriate functions and training programs for advanced life support trainees and personnel; provided, that all such training programs shall meet or exceed the performance requirements of the current training program for the emergency medical technician-paramedic, developed for the United States Department of Transportation.

b. Specify minimum operational requirements which will assure medical control over all advanced life support services.

c. Specify minimum testing and certification requirements and provide for continuing education and periodic recertification for all advanced life support personnel.

SOURCES: Laws, 1979, ch. 488, § 2, eff from and after July 1, 2001.

102 TRAINING AUTHORITY EMT-BASIC LIFE SUPPORT

102.01 Training Authority EMT-Basic Life Support

The Mississippi Vocational-Technical Education Division of the Department of Education, with the cooperation of the Governor's Highway Safety Program, the Mississippi State Department of Health, and the American College of Surgeons-Mississippi Committee on Trauma, and the Mississippi Chapter of the American College of Emergency Physicians, offered the EMT-B training course through the Mississippi Community College System. Additionally, organized EMS districts as recognized by the BEMS, are authorized to provide this training. The Guidelines and minimum standards are set forth in order to establish a minimum level of training for the Emergency Medical Technician at the Basic level. These guidelines and minimum standards shall be met by all Basic Emergency Medical Technician Courses in the state.

102.02 EMT Basic Curriculum

EMT Basic Curriculum must conform, at minimum, to the National Standard EMT Basic: National Standard Curriculum developed by the United States Department of Transportation and current revisions as approved for use by the BEMS. Minimum hours required for EMT Basic are: 110 didactic, 12 hours of hospital emergency clinical lab and 5 documented emergency runs aboard an ambulance. BEMS and the State EMS Medical Director must approve all training curriculums. Written permission from the BEMS must be obtained prior to the start of an EMT Basic Training course.

102.03 Request for Approval of EMT Basic training programs

Note: A list of BEMS approved EMT Basic training programs will be available at the BEMS office and BEMS web site. (www.msems.org)

1. Request for approval of EMT Basic training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

   a. The Community College has been approved by the Mississippi State Department of Education, Mississippi Vocational-Technical Education Division.

   b. EMT Basic training program meets, at minimum, the requirements of the National Standard EMT Basic curriculum as given in this section.

   c. EMT Basic Instructors meet the requirements of the Mississippi State Department of Education and the BEMS. There must be certification and re-certification requirements that must be met, including an evaluation of instructor terminal competencies, provided in the requested training program.

   Note: Credentialed EMS Instructors of BEMS as trained through the MS EMS Instructor Training Program, and in good standing, are considered as meeting the above requirement.

102.04 <u>EMT Basic Training Programs</u>

1. The length of the EMT Basic course shall not be less than 110 hours didactic, 12 hours of hospital clinical lab and 5 documented emergency runs aboard an ambulance.

2. The complete EMT Basic educational program shall be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT Basic.

3. The program shall consist of, at minimum, three components: didactic and lab instruction, hospital clinical and practical evaluation on emergency runs under a medical command authority. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

4. The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives must delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

5. The student must be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program must be clearly defined in writing and distributed to the student at the beginning of the training program.

6. Evidence of student competence in achieving the educational objectives of the program must be kept on file. Documentation must be in the form of both written and practical examinations.

7. Classroom, clinical and optional field faculty must prepare written evaluations on each student. Documentation must be maintained identifying the counseling given to individual students regarding their performance and the recommendations maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

8. Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

    a. Didactic Instruction:

        i. Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

    b. Clinical and Other Settings:

        i. Instruction and supervised practice of emergency medical skills.

        ii. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation must be maintained for each student’s performance in all of the various areas. A frequent performance evaluation is recommended.

    c. A Field Experience

        i. The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student

progress in acquiring the desired skills to be developed through this experience. The EMT Basic must have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer only utilizing limited learned skills. After progression through record keeping and participation in actual patient care, the student should eventually function as the patient care leader. However, the student should not be placed in the position of being a necessary part of the patient care team. The team must be able to function without the necessary use of a student who may be present.

9. General courses and topics of study must be achievement oriented and shall provide students with:

   a. The ability to recognize the nature and seriousness of the patient's condition or extent of injuries to access requirements for emergency medical care;

   b. The ability to administer appropriate emergency medical care based on assessment findings of the patients condition;

   c. Lift, move, position and otherwise handle the patient to minimize discomfort and prevent further injury; and,

   d. Perform safely and effectively the expectations of the job description.

Policy for Administration

Operational Policies

Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

a. Announcements and advertising about the program shall reflect accurately the training being offered.

b. The program shall be educational and students shall use their schedule time for educational experiences.

c. Health and safety for students, faculty, and patients shall be adequately safeguarded.

d. Cost to the student shall be reasonable and accurately stated and published.

e. Policies and process for student withdrawal and refunds on tuition on fees shall be fair, and made known to all applicants.

Curriculum Description

Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the skills that are taught in this program. It is important not to loose sight of the original purpose of the EMT Basic level. The curriculum is the NSTC for the EMT Basic. Students should have an opportunity to acquire clinical experience and practical skills related to the emergency medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students are being prepared to assume as graduates.

10. All requirements given in the Guidelines and Minimum Standards related to Basic Emergency Medical Technician Training must be met.

102.05 EMT Basic classes, class approved

EMT Basic class approval forms can be requested from the BEMS or be completed on the BEMS website. (www.msems.org) Credentialed EMT Basic instructors should complete the class approval form and submit to the BEMS, at minimum, thirty (30) calendar days prior to the first day of class. The BEMS will assign a class number to all approved requests and return to the credentialed EMT Basic instructor. Incomplete paperwork will be returned without action.

102.06 EMT Basic classes, initial roster

Initial rosters shall be completed by the credentialed EMT Basic instructor immediately following the second meeting of the class. Initial roster forms can be obtained from the BEMS or be completed on the BEMS website (www.msems.org). A final roster for full or refresher EMT Basic class will not be accepted without an initial roster on file with the BEMS.

102.07 EMT Basic classes, final roster

Final rosters shall be completed by the credentialed EMT Basic instructor immediately following the end of a full EMT Basic or EMT Refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the EMT Basic class. The final roster form can be obtained from the BEMS or be completed on the BEMS web site. (www.msems.org) Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with the BEMS.

102.08 EMT Basic Training Programs, minimum admittance criteria

1. Age of at least 18 years.

2. For other admittance criteria, refer to the Guidelines and Minimum Standards related to Basic Emergency Medical Technician Training.

3. Students currently enrolled in a Mississippi Community or Junior College dual enrollment program may also be considered eligible to enter an EMT-Basic training program in exception to other stated admission requirements.

102.09 EMT Basic Refresher Training

EMT Basic refresher training shall consist of: the current National Standard Basic EMT Refresher Curriculum (24 hour minimum), and shall include successful completion of a local written and practical examination. Written permission from BEMS must be obtained prior to the start of an EMT Basic refresher course. Instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class.

102.10 Prerequisites to certification as an EMT Basic (training obtained in Mississippi).

1. Age of at least 18 years.

2. Completion of the Board's approved Emergency Technician Training Program (Note: This includes passage of the National Registry examination).

3. Verification of medical control (Jurisdictional Medical Control Agreement)

102.11 Prerequisites to certification as an EMT-Basic (training obtained in another state)

1. Age of at least 18 years.

2. An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement from a licensed ambulance service or a facility providing basic life support service indicating the applicant is presently employed or will be employed upon moving to the state.

3. Completion of an EMT program (basic level) which meets the guidelines of the national standard curriculum. A copy of the program curriculum

and educational objectives must be submitted to an approved by the BEMS.

4. Applicant must be registered as an EMT-Basic by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card.

103 EMT-BASIC CERTIFICATION

103.01 EMT-Basic Certification

1. Any person desiring certification as an EMT-Basic shall apply to BEMS using forms provided (Application for state certification)

2. All certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

3. The BEMS may withhold or deny an application for certification for a like period of time equal to the period of time under which a person failed to comply. Mississippi requires that all EMT-Basics maintain current registration with the National Registry of Emergency Medical Technicians.

103.02 EMT-Basic Re-certification

1. Any person desiring re-certification as an EMT-Basic shall apply to BEMS using forms provided (Application for state certification)

2. All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

3. All EMTs failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

4. BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

103.03 EMT Basic, Grounds for Suspension or Revocation.

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty

6. Disregarding the speed regulations prescribed by law while on duty.

7. Failure to carry the Mississippi State Department of Health issued certification card while on duty or failure to wear appropriate identification as approved by the BEMS.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current EMT-Basic training standards as required by the BEMS.

10. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the BLS provider.

16. Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

18. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

19. Failure to comply with an employer's request for drug and alcohol testing.

20. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

104 OCCUPATION AND COMPENTENCY OF THE EMT-BASIC

104.01 Description of the Occupation and Competency of the EMT-Basic

The EMT's Primary responsibility is to bring expert emergency medical care to the victims of emergencies and to transport them safely and expeditiously to the proper facility." The EMT-B must accomplish these duties unsupervised, in a great variety of circumstances and often under considerable physical and emotional stress. The concept of an emergency medical technician, therefore, is of a person capable of exercising technical skills with authority and good judgment under difficult and stressful conditions. Personal qualities of stability, leadership, and judgment are primary. It must also be stressed that ongoing medical control and evaluation of the functioning EMT is essential to the maintenance of medical care quality. As with all professionals in the medical community, it must be realized that continuing education is an integral part of the EMT's ability to maintain a high degree of competence.

104.02 Job Summary

1. A Mississippi EMT-Basic responds to emergency calls to provide efficient and immediate care to the critically ill and injured, and transports the patient to a medical facility.

2. After receiving the call from the dispatcher, drives the ambulance to address or location given, using the most expeditious route, depending on the traffic and weather conditions. Observes traffic ordinances and regulations concerning emergency vehicle operations.

3. Upon arrival at the scene of the crash or illness, parks the ambulance in a safe location to avoid additional injury. Prior to initiating patient care, the EMT-Basic will also "size-up" the scene to determine that the scene is safe, the mechanism of injury or nature of illness, total number of patients,

and to request additional help if necessary. In the absence of law enforcement, creates a safe traffic environment, such as the placement of road warning devices, removal of debris and re-direction of traffic for the protection of the injured and those assisting in the care of injured patients.

4. Determines the nature and extent of illness or injury and establishes priority for required emergency care. Based on assessment findings, renders emergency medical care to adult, infant and child, medical and trauma patients. Duties include, but are not limited to, opening and maintaining an airway, ventilating patients and cardiopulmonary resuscitation, including use of Automated External Defibrillators. Provide pre-hospital emergency medical care of simple and multiple system trauma such as controlling hemorrhage, treatment of shock (hypoperfusion), bandaging wounds, and immobilization of painful, swollen, deformed extremities. Medical patients include: Assisting in childbirth, management of respiratory, cardiac, diabetic, allergic, behavioral, and environmental emergencies, and suspected poisonings. Searches for medical identification emblem as a clue in providing emergency care. Additional care is provided based upon assessment of the patient and obtaining historical information. These interventions, include assisting patients with prescribed medications, including sublingual nitroglycerine, epinephrine auto-injectors and hand-held aerosol inhalers. The EMT-Basic will also be responsible for administration of Oxygen, oral glucose, and activated charcoal.

5. Reassures patients and bystanders by working in a confident, efficient manner. Avoids mishandling and undue haste while working expeditiously to accomplish the task.

6. Where a patient is extricated from entrapment, assesses the extent of injury and gives all possible emergency care and protection to the entrapped patient and uses the prescribed techniques and appliances for safely removing the patient. If needed, radios the dispatcher for additional help or special rescue and/or utility services. Provides simple rescue service if the ambulance has not been accompanied by a specialized unit. After extrication, provides additional care in triaging the injured in accordance with standard emergency procedures.

7. Complies with regulations on the handling of the deceased, notifies authorities, and arranges for protection of property and evidence at scene.

8. Lifts stretcher, placing in ambulance and seeing that the patient and the stretcher are secure, continues emergency medical care.

9. From the knowledge of the condition of the patient and the extent of injuries and the relative locations and staffing of emergency hospital facilities, determines the most appropriate facility to which the patient will

be transported, unless otherwise directed by medical control plan or director. Reports directly to the emergency department or communications center the nature and extent of injuries, the number being transported, and the destination to assure prompt medical care on arrival. Identifies assessment findings which may require communications with medical direction for advice and for notification that special professional services and assistance be immediately available upon arrival at the medical facility.

10. Constantly assesses patient en route to emergency facility, administers additional care as indicated or directed by medical direction.

11. Assists in lifting and carrying the patient out of the ambulance and into the receiving facility.

12. Reports verbally and in writing their observation and emergency medical care of the patient at the emergency scene and in transit to the receiving facility staff for purposes of records and diagnostics. Upon request, provides assistance to the receiving facility's staff.

13. After each call, restocks and replaces used linens, blankets and other supplies, cleans all equipment following appropriate disinfecting procedures, makes careful check of all equipment so that the ambulance is ready for the next run. Maintains ambulance in efficient operating condition. Ensures that the ambulance is cleaned and washed and kept in a neat orderly condition. In accordance with local, state, or federal regulations, decontaminates the interior of the vehicle after transport of patient with contagious infection or hazardous materials exposure.

14. Determines that vehicle is in proper mechanical condition by checking items required by service management. Maintains familiarity with specialized equipment used by the service.

15. Attends continuing education and refresher training programs as required by employers, medical direction, licensing, or certifying agencies.

16. Meets qualifications within the functional job analysis.

104.03 Functional Job Analysis

EMT Basics work as part of a team. Thorough knowledge of theoretical procedures and ability to integrate knowledge and performance into practical situations are critical. Self-confidence, emotional stability, good judgment, tolerance for high stress, and a pleasant personality are also essential characteristics of a successful EMT-Basic at any level. EMT-Basics also must be able to deal with adverse social situations, which include responding to calls in areas having high crime rates.

104.04 Physical demands

Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by lifting, carrying, and balancing at times, patients in excess of 125 lbs. (250, with assistance). EMT-Basic must be able to work twenty-four-hour shifts. Motor coordination is necessary for the well-being of the patients, the EMT-Basic, and co-worker over uneven terrain.

105 PERFORMANCE STANDARDS FOR THE EMT-BASIC

105.01 Performance Standards for EMT-Basic.

The EMT-Basic who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the BEMS Training programs must be approved by the BEMS. The skills listed herein will enable the basic level EMT-Basic to carry out all EMT-Basic level patient assessment and emergency care procedures.

Policy for Administration

The skills listed herein will enable the basic level EMT to carry out all EMT level patient assessment and emergency care procedures.

1. Assess areas of personal attitude and conduct of the EMT-Basic.

2. Characterize the various methods used to access the EMS system in your community.

3. List possible emotional reactions that the EMT-Basic may experience when faced with trauma, illness, death and dying.

4. Discuss the possible reactions that a family member may exhibit when confronted with death and dying.

5. State the steps in the EMT-Basic's approach to the family confronted with death and dying.

6. State the possible reactions that the family of the EMT-Basic may exhibit due to their outside involvement in EMS.

7. Recognize the signs and symptoms of critical incident stress.

8. State possible steps that the EMT-Basic may take to help reduce/alleviate and explain the need to determine scene safety.

9. Discuss the importance of body substance isolation (BSI).

10. Describe the steps the EMT-Basic should take for personal protection from airborne and blood borne pathogens.

11. List the personal protective equipment necessary for each of the following situations:

    a. Hazardous materials

    b. Rescue operations

    c. Violent scenes

    d. Crime scenes

    e. Exposure to blood borne pathogens

    f. Exposure to airborne pathogens

12. Explain the rationale for serving as an advocate for the use of appropriate protective equipment.

13. Given a scenario with potential infectious exposure, the EMT-Basic will use appropriate personal protective equipment. At the completion of the scenario, the EMT-Basic will properly remove and discard the protective garments.

14. Given the above scenario, the EMT-Basic will complete disinfection/cleaning and all reporting documentation.

15. Define the EMT-Basic scope of practice.

16. Discuss the importance of Do Not Resuscitate [DNR] (advance directives) and local or state provisions regarding EMS application.

17. Define consent and discuss the methods of obtaining consent.

18. Differentiate between expressed and implied consent.

19. Explain the role of consent of minors in providing care.

20. Discuss the implications for the EMT-Basic in patient refusal of transport.

21. Discuss the issues of abandonment, negligence, and battery and their implications to the EMT-Basic.

22. State the conditions necessary for the EMT-Basic to have a duty to act.

23. Explain the importance, necessity, and legality of patient confidentiality.

24. Discuss the considerations of the EMT-Basic in issues of organ retrieval.

25. Differentiate the actions that an EMT-Basic should take to assist in the preservation of a crime scene.

26. State the conditions that require an EMT-Basic to notify local law enforcement officials.

27. Explain the role of EMS and the EMT-Basic regarding patients with DNR orders.

28. Explain the rationale for the needs, benefits, and usage of advance directives.

29. Explain the rationale for the concept of varying degrees of DNR.

30. Identify the following topographic terms: medial, lateral, proximal, distal, superior, inferior, anterior, posterior, midline, right and left, mid-clavicular, bilateral, mid-axillary.

31. Describe the anatomy and function of the following major body systems: Respiratory, circulatory, musculoskeletal, nervous and endocrine.

32. Identify the components of the extended vital signs.

33. Describe the methods to obtain a breathing rate.

34. Identify the attributes that should be obtained when assessing breathing.

35. Differentiate between shallow, labored and noisy breathing.

36. Describe the methods to obtain a pulse rate.

37. Identify the information obtained when assessing a patient's pulse.

38. Differentiate between a strong, weak, regular and irregular pulse.

39. Describe the methods to assess the skin color, temperature, condition (capillary refill in infants and children).

40. Identify the normal and abnormal skin colors.

41. Differentiate between pale, blue, red and yellow skin color.

42. Identify the normal and abnormal skin temperature.

43. Differentiate between hot, cool and cold skin temperature.

44. Identify normal and abnormal skin conditions.

45. Identify normal and abnormal capillary refill in infants and children.

46. Describe the methods to assess the pupils.

47. Identify normal and abnormal pupil size.

48. Differentiate between dilated (big) and constricted (small) pupil size.

49. Differentiate between reactive and non-reactive pupils and equal and unequal pupils.

50. Describe the methods to assess blood pressure.

51. Define systolic pressure.

52. Define diastolic pressure.

53. Explain the difference between auscultation and palpation for obtaining a blood pressure.

54. Identify the components of the SAMPLE history.

55. Differentiate between a sign and a symptom.

56. State the importance of accurately reporting and recording the baseline vital signs.

57. Discuss the need to search for additional medical identification.

58. Explain the value of performing the baseline vital signs.

59. Recognize and respond to the feelings patients experience during assessment.

60. Defend the need for obtaining and recording an accurate set of vital signs.

61. Explain the rationale of recording additional sets of vital signs.

62. Explain the importance of obtaining a SAMPLE history.

63. Demonstrate the skills involved in assessment of breathing.

64. Demonstrate the skills associated with obtaining a pulse.

65. Demonstrate the skills associated with assessing the skin color, temperature, condition, and capillary refill in infants and children.

66. Demonstrate the skills associated with assessing the pupils.

67. Demonstrate the skills associated with obtaining blood pressure.

68. Demonstrate the skills that should be used to obtain information from the patient, family, or bystanders at the scene.

69. Define body mechanics.

70. Discuss the guidelines and safety precautions that need to be followed when lifting a patient.

71. Describe the safe lifting of cots and stretchers.

72. Describe the guidelines and safety precautions for carrying patients and/or equipment.

73. Discuss one-handed carrying techniques.

74. Describe correct and safe carrying procedures on stairs.

75. State the guidelines for reaching and their application.

76. Describe correct reaching for log rolls.

77. State the guidelines for pushing and pulling.

78. Discuss the general considerations of moving patients.

79. State three situations that may require the use of an emergency move.

80. Identify the following patient carrying devices:

    a. Wheeled ambulance stretcher

    b. Portable ambulance stretcher

    c. Stair chair

    d. Scoop stretcher

    e. Long spine board

    f. Basket stretcher

    g. Flexible stretcher

81. Explain the rationale for properly lifting and moving patients.

82. Working with a partner, prepare each of the following devices for use, transfer a patient to the device, properly position the patient on the device, move the device to the ambulance and load the patient into the ambulance:

    a. Wheeled ambulance stretcher

    b. Portable ambulance stretcher

    c. Stair chair

    d. Scoop stretcher

    e. Long spine board

    f. Basket stretcher

    g. Flexible stretcher

83. Working with a partner, the EMT-Basic will demonstrate techniques for the transfer of a patient from an ambulance stretcher to a hospital stretcher.

84. Name and label the major structures of the respiratory system on a diagram.

85. List the signs of adequate breathing.

86. List the signs of inadequate breathing.

87. Describe the steps in performing the head-tilt chin-lift.

88. Relate mechanism of injury to opening the airway.

89. Describe the steps in performing the jaw thrust.

90. State the importance of having a suction unit ready for immediate use when providing emergency care.

91. Describe the techniques of suctioning.

92. Describe how to artificially ventilate a patient with a pocket mask.

93. Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust.

94. List the parts of a bag-valve-mask system.

95. Describe the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers.

96. Describe the signs of adequate artificial ventilation using the bag-valve-mask.

97. Describe the signs of inadequate artificial ventilation using the bag-valve-mask.

98. Describe the steps in artificially ventilating a patient with a flow restricted, oxygen-powered ventilation device.

99. List the steps in performing the actions taken when providing mouth-to-mouth and mouth-to-stoma artificial ventilation.

100. Describe how to measure and insert an oropharyngeal (oral) airway.

101. Describe how to measure and insert a nasopharyngeal (nasal) airway.

102. Define the components of an oxygen delivery system.

103. Identify a nonrebreather face mask and state the oxygen flow requirements needed for its use.

104. Describe the indications for using a nasal cannula versus a nonrebreather face mask.

105. Identify a nasal cannula and state the flow requirements needed for its use.

106. Explain the rationale for basic life support artificial ventilation and airway protective skills taking priority over most other basic life support skills.

107. Explain the rationale for providing adequate oxygenation through high inspired oxygen concentrations to patients who, in the past, may have received low concentrations.

108. Demonstrate the steps in performing the head-tilt chin-lift.

109. Demonstrate the steps in performing the jaw thrust.

110. Demonstrate the techniques of suctioning.

111. Demonstrate the steps in providing mouth-to-mouth artificial ventilation with body substance isolation (barrier shields).

112. Demonstrate how to use a pocket mask to artificially ventilate a patient.

113. Demonstrate the assembly of a bag-valve-mask unit.

114. Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask for one and two rescuers.

115. Demonstrate the steps in performing the skill of artificially ventilating a patient with a bag-valve-mask while using the jaw thrust.

116. Demonstrate artificial ventilation of a patient with a flow restricted, oxygen-powered ventilation device.

117. Demonstrate how to artificially ventilate a patient with a stoma.

118. Demonstrate how to insert an oropharyngeal (oral) airway.

119. Demonstrate how to insert a nasopharyngeal (nasal) airway.

120. Demonstrate the correct operation of oxygen tanks and regulators.

121. Demonstrate the use of a nonrebreather face mask and state the oxygen flow requirements needed for its use.

122. Demonstrate the use of a nasal cannula and state the flow requirements needed for its use.

123. Demonstrate how to artificially ventilate the infant and child patient.

124. Demonstrate oxygen administration for the infant and child patient.

125. Recognize hazards/potential hazards.

126. Describe common hazards found at the scene of a trauma and a medical patient.

127. Determine if the scene is safe to enter.

128. Discuss common mechanisms of injury/nature of illness.

129. Discuss the reason for identifying the total number of patients at the scene.

130. Explain the reason for identifying the need for additional help or assistance.

131. Explain the rationale for crew members to evaluate scene safety prior to entering.

132. Serve as a model for others explaining how patient situations affect your evaluation of mechanism of injury or illness.

133. Observe various scenarios and identify potential hazards.

134. Summarize the reasons for forming a general impression of the patient.

135. Discuss methods of assessing altered mental status.

136. Differentiate between assessing the altered mental status in the adult, child and infant patient.

137. Discuss methods of assessing the airway in the adult, child and infant patient.

138. State reasons for management of the cervical spine once the patient has been determined to be a trauma patient.

139. Describe methods used for assessing if a patient is breathing.

140. State what care should be provided to the adult, child and infant patient with adequate breathing.

141. State what care should be provided to the adult, child and infant patient without adequate breathing.

142. Differentiate between a patient with adequate and inadequate breathing.

143. Distinguish between methods of assessing breathing in the adult, child and infant patient.

144. Compare the methods of providing airway care to the adult, child and infant patient.

145. Describe the methods used to obtain a pulse.

146. Differentiate between obtaining a pulse in an adult, child and infant patient.

147. Discuss the need for assessing the patient for external bleeding.

148. Describe normal and abnormal findings when assessing skin color.

149. Describe normal and abnormal findings when assessing skin temperature.

150. Describe normal and abnormal findings when assessing skin condition.

151. Describe normal and abnormal findings when assessing skin capillary refill in the infant and child patient.

152. Explain the reason for prioritizing a patient for care and transport.

153. Explain the importance of forming a general impression of the patient.

154. Explain the value of performing an initial assessment.

155. Demonstrate the techniques for assessing mental status.

156. Demonstrate the techniques for assessing the airway.

157. Demonstrate the techniques for assessing if the patient is breathing.

158. Demonstrate the techniques for assessing if the patient has a pulse.

159. Demonstrate the techniques for assessing the patient for external bleeding.

160. Demonstrate the techniques for assessing the patient's skin color, temperature, condition and capillary refill (infants and children only).

161. Demonstrate the ability to prioritize patients.

162. Discuss the reasons for reconsideration concerning the mechanism of injury.

163. State the reasons for performing a rapid trauma assessment.

164. Recite examples and explain why patients should receive a rapid trauma assessment.

165. Describe the areas included in the rapid trauma assessment and discuss what should be evaluated.

166. Differentiate when the rapid assessment may be altered in order to provide patient care.

167. Discuss the reason for performing a focused history and physical exam.

168. Recognize and respect the feelings that patients might experience during assessment.

169. Demonstrate the rapid trauma assessment that should be used to assess a patient based on mechanism of injury.

170. Describe the unique needs for assessing an individual with a specific chief complaint with no known prior history.

171. Differentiate between the history and physical exam that is performed for responsive patients with no known prior history and patients responsive with a known prior history.

172. Describe the unique needs for assessing an individual who is unresponsive or has an altered mental status.

173. Differentiate between the assessment that is performed for a patient who is unresponsive or has an altered mental status and other medical patients requiring assessment.

174. Attend to the feelings that these patients might be experiencing.

175. Demonstrate the patient care skills that should be used to assist with a patient who is responsive with no known history.

176. Demonstrate the patient care skills that should be used to assist with a patient who is unresponsive or has an altered metal status.

177. Discuss the components of the detailed physical exam.

178. State the areas of the body that are evaluated during the detailed physical exam.

179. Explain what additional care should be provided while performing the detailed physical exam.

180. Distinguish between the detailed physical exam that is performed on a trauma patient and that of the medical patient.

181. Explain the rationale for the feelings that these patients might be experiencing.

182. Demonstrate the skills involved in performing the detailed physical exam.

183. Discuss the reasons for repeating the initial assessment as part of the on-going assessment.

184. Describe the components of the on-going assessment.

185. Describe trending of assessment components.

186. Explain the value of performing an on-going assessment.

187. Recognize and respect the feelings that patients might experience during assessment.

188. Explain the value of trending assessment components to other health professionals who assume care of the patient.

189. Demonstrate the skills involved in performing the on-going assessment.

190. List the proper methods of initiating and terminating a radio call.

191. State the proper sequence for delivery of patient information.

192. Explain the importance of effective communication of patient information in the verbal report.

193. Identify the essential components of the verbal report.

194. Describe the attributes for increasing effectiveness and efficiency of verbal communications.

195. State legal aspects to consider in verbal communication.

196. Discuss the communication skills that should be used to interact with the patient.

197. Discuss the communication skills that should be used to interact with the family, bystanders, individuals from other agencies while providing patient care and the difference between skills used to interact with the patient and those used to interact with others.

198. List the correct radio procedures in the following phases of a typical call:

    a. To the scene.

    b. At the scene.

    c. To the facility.

    d. At the facility.

    e. To the station.

    f. At the station.

199. Explain the rationale for providing efficient and effective radio communications and patient reports.

200. Perform a simulated, organized, concise radio transmission.

201. Perform an organized, concise patient report that would be given to the staff at a receiving facility.

202. Perform a brief, organized report that would be given to an ALS provider arriving at an incident scene at which the EMT-Basic was already providing care.

203. Explain the components of the written report and list the information that should be included on the written report.

204. Identify the various sections of the written report.

205. Describe what information is required in each section of the prehospital care report and how it should be entered.

206. Define the special considerations concerning patient refusal.

207. Describe the legal implications associated with the written report.

208. Discuss all state and/or local record and reporting requirements.

209. Explain the rationale for patient care documentation.

210. Explain the rationale for the EMS system gathering data.

211. Explain the rationale for using medical terminology correctly.

212. Explain the rationale for using an accurate and synchronous clock so that information can be used in trending.

213. Complete a prehospital care report.

214. Identify which medications will be carried on the unit.

215. State the medications carried on the unit by the generic name.

216. Identify the medications with which the EMT-B may assist the patient with administering.

217. State the medications the EMT-B can assist the patient with by the generic name.

218. Discuss the forms in which the medications may be found.

219. Explain the rationale for the administration of medications.

220. Demonstrate general steps for assisting patient with self administration of medications.

221. Read the labels and inspect each type of medication.

222. List the structure and function of the respiratory system.

223. State the signs and symptoms of a patient with breathing difficulty.

224. Describe the emergency medical care of the patient with breathing difficulty.

225. Recognize the need for medical direction to assist in the emergency medical care of the patient with breathing difficulty.

226. Describe the emergency medical care of the patient with breathing distress.

227. Establish the relationship between airway management and the patient with breathing difficulty.

228. List signs of adequate air exchange.

229. State the generic name, medication forms, dose, administration, action, indications and contraindications for the prescribed inhaler.

230. Distinguish between the emergency medical care of the infant, child and adult patient with breathing difficulty.

231. Differentiate between upper airway obstruction and lower airway disease in the infant and child patient.

232. Defend EMT-Basic treatment regimens for various respiratory emergencies.

233. Explain the rationale for administering an inhaler.

234. Demonstrate the emergency medical care for breathing difficulty.

235. Perform the steps in facilitating the use of an inhaler.

236. Describe the structure and function of the cardiovascular system.

237. Describe the emergency medical care of the patient experiencing chest pain/discomfort.

238. List the indications for automated external defibrillation (AED).

239. List the contraindications for automated external defibrillation.

240. Define the role of EMT-B in the emergency cardiac care system.

241. Explain the impact of age and weight on defibrillation.

242. Discuss the position of comfort for patients with various cardiac emergencies.

243. Establish the relationship between airway management and the patient with cardiovascular compromise.

244. Predict the relationship between the patient experiencing cardiovascular compromise and basic life support.

245. Discuss the fundamentals of early defibrillation.

246. Explain the rationale for early defibrillation.

247. Explain that not all chest pain patients result in cardiac arrest and do not need to be attached to an automated external defibrillator.

248. Explain the importance of prehospital ACLS intervention if it is available.

249. Explain the importance of urgent transport to a facility with Advanced Cardiac Life Support if it is not available in the prehospital setting.

250. Discuss the various types of automated external defibrillators.

251. Differentiate between the fully automated and the semiautomated defibrillator.

252. Discuss the procedures that must be taken into consideration for standard operations of the various types of automated external defibrillators.

253. State the reasons for assuring that the patient is pulseless and apneic when using the automated external defibrillator.

254. Discuss the circumstances which may result in inappropriate shocks.

255. Explain the considerations for interruption of CPR, when using the automated external defibrillator.

256. Discuss the advantages and disadvantages of automated external defibrillators.

257. Summarize the speed of operation of automated external defibrillation.

258. Discuss the use of remote defibrillation through adhesive pads.

259. Discuss the special considerations for rhythm monitoring.

260. List the steps in the operation of the automated external defibrillator.

261. Discuss the standard of care that should be used to provide care to a patient with persistent ventricular fibrillation and no available ACLS.

262. Discuss the standard of care that should be used to provide care to a patient with recurrent ventricular fibrillation and no available ACLS.

263. Differentiate between the single rescuer and multi-rescuer care with an automated external defibrillator.

264. Explain the reason for pulses not being checked between shocks with an automated external defibrillator.

265. Discuss the importance of coordinating ACLS trained providers with personnel using automated external defibrillators.

266. Discuss the importance of post-resuscitation care.

267. List the components of post-resuscitation care.

268. Explain the importance of frequent practice with the automated external defibrillator.

269. Discuss the need to complete the Automated Defibrillator: Operator's Shift Checklist.

270. Discuss the role of the American Heart Association (AHA) in the use of automated external defibrillation.

271. Explain the role medical direction plays in the use of automated external defibrillation.

272. State the reasons why a case review should be completed following the use of the automated external defibrillator.

273. Discuss the components that should be included in a case review.

274. Discuss the goal of quality improvement in automated external defibrillation.

275. Recognize the need for medical direction of protocols to assist in the emergency medical care of the patient with chest pain.

276. List the indications for the use of nitroglycerin.

277. State the contraindications and side effects for the use of nitroglycerin.

278. Define the function of all controls on an automated external defibrillator, and describe event documentation and battery defibrillator maintenance.

279. Defend the reasons for obtaining initial training in automated external defibrillation and the importance of continuing education.

280. Explain the rationale for administering nitroglycerin to a patient with chest pain or discomfort.

281. Demonstrate the assessment and emergency medical care of a patient experiencing chest pain/discomfort.

282. Demonstrate the application and operation of the automated external defibrillator.

283. Demonstrate the maintenance of an automated external defibrillator.

284. Demonstrate the assessment and documentation of patient response to the automated external defibrillator.

285. Demonstrate the skills necessary to complete the Automated Defibrillator: Operator's Shift Checklist.

286. Perform the steps in facilitating the use of nitroglycerin for chest pain or discomfort.

287. Demonstrate the assessment and documentation of patient response to nitroglycerin.

288. Practice completing a prehospital care report for patients with cardiac emergencies.

289. Identify the patient taking diabetic medications with altered mental status and the implications of a diabetes history.

290. State the steps in the emergency medical care of the patient taking diabetic medicine with an altered mental status and a history of diabetes.

291. Establish the relationship between airway management and the patient with altered mental status.

292. State the generic and trade names, medication forms, dose, administration, action, and contraindications for oral glucose.

293. Evaluate the need for medical direction in the emergency medical care of the diabetic patient.

294. Explain the rationale for administering oral glucose.

295. Demonstrate the steps in the emergency medical care for the patient taking diabetic medicine with an altered mental status and a history of diabetes.

296. Demonstrate the steps in the administration of oral glucose.

297. Demonstrate the assessment and documentation of patient response to oral glucose.

298. Demonstrate how to complete a prehospital care report for patients with diabetic emergencies.

299. Recognize the patient experiencing an allergic reaction.

300. Describe the emergency medical care of the patient with an allergic reaction.

301. Establish the relationship between the patient with an allergic reaction and airway management.

302. Describe the mechanisms of allergic response and the implications for airway management.

303. State the generic and trade names, medication forms, dose, administration, action, and contraindications for the epinephrine auto-injector.

304. Evaluate the need for medical direction in the emergency medical care of the patient with an allergic reaction.

305. Differentiate between the general category of those patients having an allergic reaction and those patients having an allergic reaction and requiring immediate medical care, including immediate use of epinephrine auto-injector.

306. Explain the rationale for administering epinephrine using an auto-injector.

307. Demonstrate the emergency medical care of the patient experiencing an allergic reaction.

308. Demonstrate the use of epinephrine auto-injector.

309. Demonstrate the assessment and documentation of patient response to an epinephrine injection.

310. Demonstrate proper disposal of equipment.

311. Demonstrate completing a prehospital care report for patients with allergic emergencies.

312. List various ways that poisons enter the body.

313. List signs/symptoms associated with poisoning.

314. Discuss the emergency medical care for the patient with possible overdose.

315. Describe the steps in the emergency medical care for the patient with suspected poisoning.

316. Establish the relationship between the patient suffering from poisoning or overdose and airway management.

317. State the generic and trade names, indications, contraindications, medication form, dose, administration, actions, side effects and re-assessment strategies for activated charcoal.

318. Recognize the need for medical direction in caring for the patient with poisoning or overdose.

319. Explain the rationale for administering activated charcoal.

320. Explain the rationale for contacting medical direction early in the prehospital management of the poisoning or overdose patient.

321. Demonstrate the steps in the emergency medical care for the patient with possible overdose.

322. Demonstrate the steps in the emergency medical care for the patient with suspected poisoning.

323. Perform the necessary steps required to provide a patient with activated charcoal.

324. Demonstrate the assessment and documentation of patient response.

325. Demonstrate proper disposal of administration of activated charcoal equipment.

326. Demonstrate completing a prehospital care report for patients with a poisoning/overdose emergency.

327. Describe the various ways that the body loses heat.

328. List the signs and symptoms of exposure to cold.

329. Explain the steps in providing emergency medical care to a patient exposed to cold.

330. List the signs and symptoms of exposure to heat.

331. Explain the steps in providing emergency care to a patient exposed to heat.

332. Recognize the signs and symptoms of water-related emergencies.

333. Describe the complications of near drowning.

334. Discuss the emergency medical care of bites and stings.

335. Demonstrate the assessment and emergency medical care of a patient with exposure to cold.

336. Demonstrate the assessment and emergency medical care of a patient with exposure to heat.

337. Demonstrate the assessment and emergency medical care of a near drowning patient.

338. Demonstrate completing a prehospital care report for patients with environmental emergencies.

339. Define behavioral emergencies.

340. Discuss the general factors that may cause an alteration in a patient's behavior.

341. State the various reasons for psychological crises.

342. Discuss the characteristics of an individual's behavior which suggests that the patient is at risk for suicide.

343. Discuss special medical/legal considerations for managing behavioral emergencies.

344. Discuss the special considerations for assessing a patient with behavioral problems.

345. Discuss the general principles of an individual's behavior which suggests that he is at risk for violence.

346. Discuss methods to calm behavioral emergency patients.

347. Explain the rationale for learning how to modify your behavior toward the patient with a behavioral emergency.

348. Demonstrate the assessment and emergency medical care of the patient experiencing a behavioral emergency.

349. Demonstrate various techniques to safely restrain a patient with a behavioral problem.

350. Identify the following structures: Uterus, vagina, fetus, placenta, umbilical cord, amniotic sac, perineum.

351. Identify and explain the use of the contents of an obstetrics kit.

352. Identify predelivery emergencies.

353. State indications of an imminent delivery.

354. Differentiate the emergency medical care provided to a patient with predelivery emergencies from a normal delivery.

355. State the steps in the predelivery preparation of the mother.

356. Establish the relationship between body substance isolation and childbirth.

357. State the steps to assist in the delivery.

358. Describe care of the baby as the head appears.

359. Describe how and when to cut the umbilical cord.

360. Discuss the steps in the delivery of the placenta.

361. List the steps in the emergency medical care of the mother post-delivery.

362. Summarize neonatal resuscitation procedures.

363. Describe the procedures for the following abnormal deliveries: Breech birth, prolapsed cord, limb presentation.

364. Differentiate the special considerations for multiple births.

365. Describe special considerations of meconium.

366. Describe special considerations of a premature baby.

367. Discuss the emergency medical care of a patient with a gynecological emergency.

368. Explain the rationale for understanding the implications of treating two patients (mother and baby).

369. Demonstrate the steps to assist in the normal cephalic delivery.

370. Demonstrate necessary care procedures of the fetus as the head appears.

371. Demonstrate infant neonatal procedures.

372. Demonstrate post delivery care of infant.

373. Demonstrate how and when to cut the umbilical cord.

374. Attend to the steps in the delivery of the placenta.

375. Demonstrate the post-delivery care of the mother.

376. Demonstrate the procedures for the following abnormal deliveries: vaginal bleeding, breech birth, prolapsed cord, limb presentation.

377. Demonstrate the steps in the emergency medical care of the mother with excessive bleeding.

378. Demonstrate completing a prehospital care report for patients with obstetrical/gynecological emergencies.

379. List the structure and function of the circulatory system.

380. Differentiate between arterial, venous and capillary bleeding.

381. State methods of emergency medical care of external bleeding.

382. Establish the relationship between body substance isolation and bleeding.

383. Establish the relationship between airway management and the trauma patient.

384. Establish the relationship between mechanism of injury and internal bleeding.

385. List the signs of internal bleeding.

386. List the steps in the emergency medical care of the patient with signs and symptoms of internal bleeding.

387. List signs and symptoms of shock (hypoperfusion).

388. State the steps in the emergency medical care of the patient with signs and symptoms of shock (hypoperfusion).

389. Explain the sense of urgency to transport patients that are bleeding and show signs of shock (hypoperfusion).

390. Demonstrate direct pressure as a method of emergency medical care of external bleeding.

391. Demonstrate the use of diffuse pressure as a method of emergency medical care of external bleeding.

392. Demonstrate the use of pressure points and tourniquets as a method of emergency medical care of external bleeding.

393. Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding.

394. Demonstrate the care of the patient exhibiting signs and symptoms of shock (hypoperfusion).

395. Demonstrate completing a prehospital care report for patient with bleeding and/or shock (hypoperfusion).

396. State the major functions of the skin.

397. List the layers of the skin.

398. Establish the relationship between body substance isolation (BSI) and soft tissue injuries.

399. List the types of closed soft tissue injuries.

400. Describe the emergency medical care of the patient with a closed soft tissue injury.

401. State the types of open soft tissue injuries.

402. Describe the emergency medical care of the patient with an open soft tissue injury.

403. Discuss the emergency medical care considerations for a patient with a penetrating chest injury.

404. State the emergency medical care considerations for a patient with an open wound to the abdomen.

405. Differentiate the care of an open wound to the chest from an open wound to the abdomen.

406. List the classifications of burns.

407. Define superficial burn.

408. List the characteristics of a superficial burn.

409. Define partial thickness burn.

410. List the characteristics of a partial thickness burn.

411. Define full thickness burn.

412. List the characteristics of a full thickness burn.

413. Describe the emergency medical care of the patient with a superficial burn.

414. Describe the emergency medical care of the patient with a partial thickness burn.

415. Describe the emergency medical care of the patient with a full thickness burn.

416. List the functions of dressing and bandaging.

417. Describe the purpose of a bandage.

418. Describe the steps in applying a pressure dressing.

419. Establish the relationship between airway management and the patient with chest injury, burns, blunt and penetrating injuries.

420. Describe the effects of improperly applied dressings, splints and tourniquets.

421. Describe the emergency medical care of a patient with an impaled object.

422. Describe the emergency medical care of a patient with an amputation.

423. Describe the emergency care for a chemical burn.

424. Describe the emergency care for an electrical burn.

425. Demonstrate the steps in the emergency medical care of closed soft tissue injuries.

426. Demonstrate the steps in the emergency medical care of open soft tissue injuries.

427. Demonstrate the steps in the emergency medical care of a patient with an open chest wound.

428. Demonstrate the steps in the emergency medical care of a patient with open abdominal wounds.

429. Demonstrate the steps in the emergency medical care of a patient with an impaled object.

430. Demonstrate the steps in the emergency medical care of a patient with an amputation.

431. Demonstrate the steps in the emergency medical care of an amputated part.

432. Demonstrate the steps in the emergency medical care of a patient with superficial burns.

433. Demonstrate the steps in the emergency medical care of a patient with partial thickness burns.

434. Demonstrate the steps in the emergency medical care of a patient with full thickness burns.

435. Demonstrate the steps in the emergency medical care of a patient with a chemical burn.

436. Demonstrate completing a prehospital care report for patients with soft tissue injuries.

437. Describe the function of the muscular system.

438. Describe the function of the skeletal system.

439. List the major bones or bone groupings of the spinal column; the thorax; the upper extremities; the lower extremities.

440. Differentiate between an open and a closed painful, swollen, deformed extremity.

441. State the reasons for splinting.

442. List the general rules of splinting.

443. List the complications of splinting.

444. List the emergency medical care for a patient with a painful, swollen, deformed extremity.

445. Explain the rationale for splinting at the scene versus load and go.

446. Explain the rationale for immobilization of the painful, swollen, deformed extremity.

447. Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity.

448. Demonstrate completing a prehospital care report for patients with musculoskeletal injuries.

449. State the components of the nervous system.

450. List the functions of the central nervous system.

451. Define the structure of the skeletal system as it relates to the nervous system.

452. Relate mechanism of injury to potential injuries of the head and spine.

453. Describe the implications of not properly caring for potential spine injuries.

454. State the signs and symptoms of a potential spine injury.

455. Describe the method of determining if a responsive patient may have a spine injury.

456. Relate the airway emergency medical care techniques to the patient with a suspected spine injury.

457. Describe how to stabilize the cervical spine.

458. Discuss indications for sizing and using a cervical spine immobilization device.

459. Establish the relationship between airway management and the patient with head and spine injuries.

460. Describe a method for sizing a cervical spine immobilization device.

461. Describe how to log roll a patient with a suspected spine injury.

462. Describe how to secure a patient to a long spine board.

463. List instances when a short spine board should be used.

464. Describe how to immobilize a patient using a short spine board.

465. Describe the indications for the use of rapid extrication.

466. List steps in performing rapid extrication.

467. State the circumstances when a helmet should be left on the patient.

468. Discuss the circumstances when a helmet should be removed.

469. Identify different types of helmets.

470. Describe the unique characteristics of sports helmets.

471. Explain the preferred methods to remove a helmet.

472. Discuss alternative methods for removal of a helmet.

473. Describe how the patient's head is stabilized to remove the helmet.

474. Differentiate how the head is stabilized with a helmet compared to without a helmet.

475. Explain the rationale for immobilization of the entire spine when a cervical spine injury is suspected.

476. Explain the rationale for utilizing immobilization methods apart from the straps on the cots.

477. Explain the rationale for utilizing a short spine immobilization device when moving a patient from the sitting to the supine position.

478. Explain the rationale for utilizing rapid extrication approaches only when they indeed will make the difference between life and death.

479. Defend the reasons for leaving a helmet in place for transport of a patient.

480. Defend the reasons for removal of a helmet prior to transport of a patient.

481. Demonstrate opening the airway in a patient with suspected spinal cord injury.

482. Demonstrate evaluating a responsive patient with a suspected spinal cord injury.

483. Demonstrate stabilization of the cervical spine.

484. Demonstrate the four person log roll for a patient with a suspected spinal cord injury.

485. Demonstrate how to log roll a patient with a suspected spinal cord injury using two people.

486. Demonstrate securing a patient to a long spine board.

487. Demonstrate using the short board immobilization technique.

488. Demonstrate procedure for rapid extrication.

489. Demonstrate preferred methods for stabilization of a helmet.

490. Demonstrate helmet removal techniques.

491. Demonstrate alternative methods for stabilization of a helmet.

492. Demonstrate completing a prehospital care report for patients with head and spinal injuries.

493. Identify the developmental considerations for the following age groups:

   a. infants

   b. toddlers

   c. pre-school

d. school age

e. adolescent

494. Describe differences in anatomy and physiology of the infant, child and adult patient.

495. Differentiate the response of the ill or injured infant or child (age specific) from that of an adult.

496. Indicate various causes of respiratory emergencies.

497. Differentiate between respiratory distress and respiratory failure.

498. List the steps in the management of foreign body airway obstruction.

499. Summarize emergency medical care strategies for respiratory distress and respiratory failure.

500. Identify the signs and symptoms of shock (hypoperfusion) in the infant and child patient.

501. Describe the methods of determining end organ perfusion in the infant and child patient.

502. State the usual cause of cardiac arrest in infants and children versus adults.

503. List the common causes of seizures in the infant and child patient.

504. Describe the management of seizures in the infant and child patient.

505. Differentiate between the injury patterns in adults, infants, and children.

506. Discuss the field management of the infant and child trauma patient.

507. Summarize the indicators of possible child abuse and neglect.

508. Describe the medical legal responsibilities in suspected child abuse.

509. Recognize need for EMT-Basic debriefing following a difficult infant or child transport.

510. Explain the rationale for having knowledge and skills appropriate for dealing with the infant and child patient.

511. Attend to the feelings of the family when dealing with an ill or injured infant or child.

512. Understand the provider's own response (emotional) to caring for infants or children.

513. Demonstrate the techniques of foreign body airway obstruction removal in the infant.

514. Demonstrate the techniques of foreign body airway obstruction removal in the child.

515. Demonstrate the assessment of the infant and child.

516. Demonstrate bag-valve-mask artificial ventilations for the infant.

517. Demonstrate bag-valve-mask artificial ventilations for the child.

518. Demonstrate oxygen delivery for the infant and child.

519. Discuss the medical and non-medical equipment needed to respond to a call.

520. List the phases of an ambulance call.

521. Describe the general provisions of state laws relating to the operation of the ambulance and privileges in any or all of the following categories:

    a. Speed

    b. Warning lights

    c. Sirens

    d. Right-of-way

    e. Parking

    f. Turning

522. List contributing factors to unsafe driving conditions.

523. Describe the considerations that should by given to:

    a. Request for escorts

    b. Following an escort vehicle

    c. Intersections.

524. Discuss "Due Regard For Safety of All Others" while operating an emergency vehicle.

525. State what information is essential in order to respond to a call.

526. Discuss various situations that may affect response to a call.

527. Differentiate between the various methods of moving a patient to the unit based upon injury or illness.

528. Apply the components of the essential patient information in a written report.

529. Summarize the importance of preparing the unit for the next response.

530. Identify what is essential for completion of a call.

531. Distinguish among the terms cleaning, disinfection, high-level disinfection, and sterilization.

532. Describe how to clean or disinfect items following patient care.

533. Explain the rationale for appropriate report of patient information.

534. Explain the rationale for having the unit prepared to respond.

535. Describe the purpose of extrication.

536. Discuss the role of the EMT-Basic in extrication.

537. Identify what equipment for personal safety is required for the EMT-Basic.

538. Define the fundamental components of extrication.

539. State the steps that should be taken to protect the patient during extrication.

540. Evaluate various methods of gaining access to the patient.

541. Distinguish between simple and complex access.

542. Explain the EMT-Basic's role during a call involving hazardous materials.

543. Describe what the EMT-Basic should do if there is reason to believe that there is a hazard at the scene.

544. Describe the actions that an EMT-Basic should take to ensure bystander safety.

545. State the role the EMT-Basic should perform until appropriately trained personnel arrive at the scene of a hazardous materials situation.

546. Break down the steps to approaching a hazardous situation.

547. Discuss the various environmental hazards that affect EMS.

548. Describe the criteria for a multiple-casualty situation.

549. Evaluate the role of the EMT-Basic in the multiple-casualty situation.

550. Summarize the components of basic triage.

551. Define the role of the EMT-Basic in a disaster operation.

552. Describe basic concepts of incident management.

553. Explain the methods for preventing contamination of self, equipment and facilities.

554. Review the local mass casualty incident plan.

555. Given a scenario of a mass casualty incident, perform triage.

556. Identify and describe the airway anatomy in the infant, child and the adult.

557. Differentiate between the airway anatomy in the infant, child, and the adult.

558. Explain the pathophysiology of airway compromise.

559. Describe the proper use of airway adjuncts.

560. Review the use of oxygen therapy in airway management.

Other knowledge and competencies may be added as revisions occur with the National Standard EMT Basic Curriculum.

Note: Skills and medications not listed in these regulations may not be performed by any BLS provider until each skill and/or medication has been individually and specifically approved by BEMS in writing.

106 AREA AND SCOPE OF PRACTICE

106.01 Area and Scope of Practice of the EMT-Basic

1. The EMT-Basic represents the first component of the emergency medical care system. Through proper training the EMT-Basic will be able to provide basic life support to victims during emergencies, minimize discomfort and possible further injuries. The EMT-Basic may provide non-invasive emergency procedures and services to the level described in the EMT-Basic National Standard Training Curriculum. Those

procedures include recognition, assessment, management, transportation and liaison.

2. An EMT-Basic is a person who has successfully completed an approved training program and is certified. The EMT-Basic training program must equal or exceed the educational goals and objectives of the National Standard Training curriculum for the EMT-Basic.

Policy for Administration

1. It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the ambulance attendant, if the following conditions are present:

   a. The patient has existing advanced therapeutics or treatment modalities for a preexisting condition, and

   b. The patient is located in a non-hospital setting, and

   c. The patient's condition is considered to be so urgent that the benefits of prompt transport by available personnel to an appropriate hospital outweigh the increased risk to the patient from affecting a delay waiting for qualified medical personnel to arrive.

2. The person possessing the highest level of certification/license must attend the patient unless otherwise authorized by medical control or as otherwise specified by approved protocols.

3. EMTs of all levels (Basic, Intermediate, Paramedic), may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

   a. there is no need, or reasonably perceived need, for the device or procedure during transport; and

   b. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

Chapter 08 EMERGENCY MEDICAL TECHNICIAN ADVANCED LEVEL SUPPORT

100 EMT-ADVANCED LEVEL SUPPORT

100.01 §41-59-5. Establishment and administration of program {Repealed effective July 1, 2011].

(1) The State Board of Health shall establish and maintain a program for the improvement and regulation of emergency medical services (hereinafter EMS) in the State of Mississippi. The responsibility for implementation and conduct of this program shall be vested in the State Health Officer of the State Board of Health along with such other officers and boards as may be specified by law or regulation.

(2) The board shall provide for the regulation and licensing of public and private ambulance service, inspection and issuance of permits for ambulance vehicles, training and certification of EMS personnel, including drivers and attendants, the development and maintenance of a statewide EMS records program, development and adoption of EMS regulations, the coordination of an EMS communications system, and other related EMS activities.

(3) The board is authorized to promulgate and enforce such rules, regulations and minimum standards as needed to carry out the provisions of this chapter.

(4) The board is authorized to receive any funds appropriated to the board from the Emergency Medical Services Operating Fund created in Section 41-59-61 and is further authorized, with the Emergency Medical Services Advisory Council acting in an advisory capacity, to administer the disbursement of such funds to the counties, municipalities and organized emergency medical service districts and the utilization of such funds by the same, as provided in Section 41-59-61.

(5) The department acting as the lead agency, in consultation with and having solicited advice from the EMS Advisory Council, shall develop a uniform non-fragmented inclusive statewide trauma care system that provides excellent patient care. It is the intent of the Legislature that the purpose of this system is to reduce death and disability resulting from traumatic injury, and in order to accomplish this goal it is necessary to assign additional responsibilities to the department. The department is assigned the responsibility for creating, implementing and managing the statewide trauma care system. The department shall be designated as the lead agency for trauma care systems development. The department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma Care System Plan, trauma system standards, trauma center designations, field triage, interfacility trauma transfer, EMS aero medical transportation, trauma data collection, trauma care system evaluation and management of state trauma systems funding. The department shall promulgate regulations specifying the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those

regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma care system, or which participate at a level lower than the level at which they are capable of participating. The department shall promulgate rules and regulations necessary to effectuate this provision by September 1, 2008, with an implementation date of September 1, 2008. The department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma Care System Plan and all associated trauma care system regulations necessary to implement the Mississippi trauma care system. The department shall cause the implementation of both professional and lay trauma education programs. These trauma educational programs shall include both clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the department shall coordinate the development of the inclusive trauma system with the Mississippi Department of Rehabilitation Services and all other appropriate rehabilitation systems.

(6) The State Board of Health is authorized to receive any funds appropriated to the board from the Mississippi Trauma Care System Fund created in Section 41-59-75. It is further authorized, with the Emergency Medical Services Advisory Council and the Mississippi Trauma Advisory Committee acting in advisory capacities, to administer the disbursements of those funds according to adopted trauma care system regulations. Any Level I trauma care facility or center located in a state contiguous to the State of Mississippi that participates in the Mississippi trauma care system and has been designated by the department to perform specified trauma care services within the trauma care system under standards adopted by the department shall receive a reasonable amount of reimbursement from the department for the cost of providing trauma care services to Mississippi residents whose treatment is uncompensated.

(7) In addition to the trauma-related duties provided for in this section, the Board of Health shall develop a plan for the delivery of services to Mississippi burn victims through the existing trauma care system of hospitals. Such plan shall be operational by July 1, 2005, and shall include:

(a) Systems by which burn patients will be assigned or transferred to hospitals capable of meeting their needs;

(b) Until the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 1 of this act is operational, procedures for allocating funds appropriated from the Mississippi Burn Care Fund to hospitals that provide services to Mississippi burn victims; and

(c) Such other provisions necessary to provide burn care for Mississippi residents, including reimbursement for travel, lodging, if no free lodging is available, meals and other reasonable travel-related expenses incurred by burn victims, family

members and/or caregivers, as established by the State Board of Health through rules and regulations.

After the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 37-115-45 is operational, the Board of Health shall revise the plan to include the Mississippi Burn Center.

Sources: Laws, 1974, ch. 507, § 3; Laws, 1982, ch. 344, § 2; Laws, 1989, ch. 545, § 1; Laws, 1991, ch. 597, § 1; Laws, 1992, ch. 491 § 27; Laws, 1998, ch. 429, § 2; Laws, 2005, 2nd Ex Sess, ch. 47, § 8; Laws, 2007, ch. 569, § 8; Laws, 2008, ch. 549, § 2, eff from and after July 1, 2008.

100.02 <u>§41-59-33. Emergency medical technicians; certification.</u>

Any person desiring certification as an emergency medical technician shall apply to the board using forms prescribed by the board. Each application for an emergency medical technician certificate shall be accompanied by a certificate fee to be fixed by the board, which shall be paid to the board. Upon the successful completion of the board's approved emergency medical technical training program, the board shall make a determination of the applicant's qualifications as an emergency medical technician as set forth in the regulations promulgated by the board, and shall issue an emergency medical technician certificate to the applicant.

SOURCES: Laws, 1974, ch. 507, § 8(3); 1979, ch. 445, § 4; 1982, ch. 345, Section 4, 1991, ch. 606, § 6, eff from and after July 1, 1991.

100.03 <u>§41-59-35. Emergency medical technicians; period of certification; renewal, suspension or revocation of certificate; use of certain EMT titles without certification prohibited.</u>

1. An emergency medical technician certificate so issued shall be valid for a period not exceeding two (2) years from the date of issuance and may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board, provided that the holder meets the qualifications set forth in this Chapter 59 and Chapter 60 and rules and regulations promulgated by the board.

2. The board is authorized to suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

3. It shall be unlawful for any person, corporation or association to, In any manner, represent himself or itself as an Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver, or use in connection with his or its name the words or letters of EMT, EMT, paramedic, or any other letters, words, abbreviations or insignia which

would indicate or imply that he or it is a Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver, unless certified in accordance with Chapters 59 and 60 of this title and is in accordance with the rules and regulations promulgated by the board. It is unlawful to employ any uncertified Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, or Emergency Medical Technician-Paramedic to provide basic or advance life support services.

4. Any Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver who violates or fails to comply with these statues or rules and regulations promulgated by the board hereunder shall be subject, after due notice and hearing, to an administrative fine not to exceed One Thousand Dollars ($1,000.00).

SOURCES: Laws, 1974, ch. 507, § 8 (4,5); 1979, ch. 445, § 5; 1982, ch. 345, § 5, 1991, ch. 606, § 7, 2001, ch. 542, § 1, eff from and after July 1, 2001.

100.04 <u>§41-59-37. Temporary ambulance attendant's permit.</u>

The board may, in its discretion, issue a temporary ambulance attendant's permit which shall not be valid for more than one (1) year from the date of issuance, and which shall be renewable to an individual who may or may not meet qualifications established pursuant to this chapter upon determination that such will be in the public interest.

SOURCES: Laws, 1974, ch. 507, § 8(6), eff from and after passage (approved April 13, 1974).

100.05 <u>§41-60-13. Promulgation of rules and regulations by state board of health.</u>

1. The Mississippi State Board of Health is authorized to promulgate and enforce rules and regulations to provide for the best and most effective emergency medical care, and to comply with national standards for advanced life support. Notwithstanding any other provision of law, advanced life support personnel may be authorized to provide advanced life support services as defined by rules and regulations promulgated by the state board of health.

2. Rules and regulations promulgated pursuant to this authority shall, as a minimum:

   a. Define and authorize appropriate functions and training programs for advanced life support trainees and personnel; provided, that all such training programs shall meet or exceed the performance requirements of the current training program for the emergency medical technician-

paramedic, developed for the United States Department of Transportation.

b. Specify minimum operational requirements which will assure medical control over all advanced life support services.

c. Specify minimum testing and certification requirements and provide for continuing education and periodic recertification for all advanced life support personnel.

SOURCES: Laws, 1979, ch. 488, § 2, eff from and after July 1, 2001.

101 TRAINING AUTHORITY

101.01 Training Authority for EMT-Advanced Life Support

The Mississippi Vocational-Technical Education Division of the Department of Education, with the cooperation of the Governor's Highway Safety Program, the Mississippi State Department of Health, and the American College of Surgeons-Mississippi Committee on Trauma, and the Mississippi Chapter of the American College of Emergency Physicians, offered the advanced life support training course through the Mississippi Community College System. The guidelines and minimum standards are set forth in order to establish a minimum level of training for the Emergency Medical Technician at the Advanced level. These guidelines and minimum standards shall be met by all Advanced Emergency Medical Technician Courses in the state. The University of Mississippi Medical Center, Department of Emergency Medical Technology, is authorized by the BEMS to conduct ALS training programs statewide. All advanced life support programs must have the BEMS approval.

101.02 EMT Advanced Life Support Curriculum

EMT-Paramedic curriculum must conform, at minimum, to the National Standard Training Curriculum developed by the United States Department of Transportation and all current revisions as approved for use by the BEMS. Minimum hours required for EMT-Paramedic are: 800 didactic/lab, 200 clinical, 200 field. EMT-Intermediate curriculum shall consist of modules numbers I, II, and III as developed for the United States Department of Transportation under Contract No. DOT-HS-900-089, as well as, the BEMS, EMT-Intermediate defibrillation curriculum. BEMS, the State EMS Medical Director, and the Medical Direction, Training, and Quality Assurance Committee must approve all training curriculums. Minimum hours required for EMT-Intermediate are: 150 didactic, 40 clinical, 40 field. Written permission from the Director of the BEMS must be obtained prior to the start of an EMT-Intermediate course.

101.03 Request for Approval of EMT Advanced Level Training Programs

Note: A list of BEMS approved EMT Advanced Level training programs will be available at the BEMS office and BEMS web site. (www.msems.org)

1. All BEMS approved advanced life support training programs must be accredited by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP). BEMS shall be present for any site visit conducted by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP).

2. Pre-requisites for beginning a new advanced life support program without the existence of an accredited paramedic program.

3. The following requirements are to be met and approved by the BEMS before the approval will be issued to begin the programs instructional component:

    a. Full time program director that's position is delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.a.1. This must be verified by a copy of a contractual agreement to the BEMS.

    b. A Medical Director who's position is delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.a.2. This must be verified by a copy of a contractual agreement to the BEMS.

    c. Instructional Faculty who's qualifications will be delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.b. This must be verified by a copy of a contractual agreement to the BEMS.

    d. Financial Resources will be adequate as described by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.2. This must be verified by a letter from administration.

    e. Physical Resources as delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.3.a. and b. This will be verified by a site visit by a staff member of BEMS.

    f. Clinical Resources as delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.4.and B.5. This must be verified by a copy of a contractual agreement from each site to the BEMS.

4. Before a consecutive class will be authorized to commence, the Self Study, as specified by Committee on Accreditation of Education Programs

for the EMS Professions (CoAEMSP) formerly known as the Joint Review Committee on Educational Programs for the EMT Paramedic (JRCEMT-P), is to be completed and submitted to the CoAEMSP's administrative office with the appropriate fees. To maintain training authority, the programs must submit:

a. reports of training activities as specified by BEMS; copies of any and all written communications to and from the school and the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP) and/or CAAHEP, will be submitted within (10) ten working days from submitting or receiving to BEMS.

b. program updates and revisions as specified by BEMS. All reports and updates must be submitted to the BEMS no later than June 30 of each year.

NOTE: The University of Mississippi Medical Center, Department of Emergency Medical Technology, is authorized by the BEMS to conduct ALS training programs statewide.

101.04 EMT Advanced Training Programs

1. The length of the EMT-Intermediate course shall not be less than 150 hours didactic, 40 hours of hospital clinical and 40 hours of pre-hospital field clinical. The length of the EMT-Paramedic course shall not be less that 800 hours didactic/lab, 200 hours of hospital clinical and 200 hours of pre-hospital field clinical.

2. The complete EMT Advanced Level educational programs must be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit professional growth.

3. The program shall consist of, at minimum, three components: didactic instruction, hospital clinical lab and practical evaluation in pre-hospital field clinicals under a medical command authority. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

4. The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives must delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

5. The student must be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

6. Evidence of student competence in achieving the educational objectives of the program must be kept on file. Documentation must be in the form of both written and practical examinations.

7. Classroom, clinical and field faculty must also prepare written evaluations on each student. Documentation must be maintained identifying the counseling given to individual students regarding their performance and the recommendations maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

8. Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

    a. Didactic instruction:

        i. Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

    b. Clinical and Other Settings:

        i. Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation must be maintained for each student’s performance in all of the various areas. A frequent performance evaluation is recommended.

    c. A Field Experience:

        i. The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There must be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through

this experience. The EMT Advanced Level student must have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer only utilizing limited learned skills. After progression through record keeping and participation in actual patient care, the student must eventually function as the patient care leader. However, the student must not be placed in the position of being a necessary part of the patient care team. The team must be able to function without the necessary use of a student who may be present.

9. General courses and topics of study must be achievement oriented and shall provide students with:

    a. The ability to recognize the nature and seriousness of the patients condition or extent of injuries to access requirements for emergency medical care;

    b. The ability to administer appropriate emergency medical care based on assessment findings of the patients condition;

    c. Lift, move, position and otherwise handle the patient to minimize discomfort and prevent further injury; and,

    d. Perform safely and effectively the expectations of the job description.

<u>Operational Policies</u>

1. Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

    a. Announcements and advertising about the program shall reflect accurately the training being offered.

    b. The program shall be educational and students shall use their schedule time for educational experiences.

    c. Health and safety for students, faculty, and patients shall be adequately safeguarded.

    d. Cost to the student shall be reasonable and accurately stated and published.

e. Policies and process for student withdrawal and refunds on tuition on fees shall be fair, and made known to all applicants.

101.05 Curriculum Description - EMT-Intermediate

1. Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the advanced skills that are taught in this program. It is important not to loose sight of the original purpose of the EMT Intermediate level. The curriculum includes only the portions of the NSTC for the EMT Paramedic which is relevant for this level of care. Students should have an opportunity to acquire clinical experience and practical skills related to the emergency medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students are being prepared to assume as graduates.

   a. MS EMT-I training shall also include the instructor lesson plan for EMT-I National Standard Training Curriculum (NSTC), Defibrillation Section. Additionally, it should be noted that current AHA Standards and Guidelines for CPR and ECC will supersede NSTC.

   b. The length of the EMT-I defibrillation course shall not be less than 16 hours (12 hours didactic and 4 hours practical).

   c. The educational program should be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT-Intermediate.

   d. The program should consist of three components: didactic instruction, clinical instruction, and supervised field experience in an advanced life support unit which functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

   e. The program should maintain on file for each component of the curriculum a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives should delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

f. The student should be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

g. Evidence of student competence in achieving the educational objectives of the program should be kept on file. Documentation should be in the form of both written and practical examinations.

h. Classroom, clinical, and field faculty should also prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

i. Faculty should be presented with the program's educational objectives for uses in preparation of lectures and clinical and field practice. The course coordinator should ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

j. Didactic instruction:

    i. Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

k. Clinical (in-hospital) and other settings:

    i. Instruction and supervised practice of emergency medical skills in critical care units, emergency departments, operating rooms and other settings as appropriate. Supervision in the hospital can be provided either by hospital personnel, such as supervisory nurses, department supervisors, and physicians, or by the program instructor. The hospital practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, pathophysiology of medical and surgical conditions, development of patient rapport, and care for and understanding of the patient's illness. Documentation should be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

l. Field Experience:

i. The field internship is a period of supervised experience on an intensive care vehicle. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The intensive care vehicle should have telecommunication with medical command authority. The student must be under the direct supervision and observation of a physician, or nurse with experience in the pre-hospital ALS setting, or an EMT-Paramedic approved by the medical command authority. The experience should occur within an emergency medical care system that involves EMT-Paramedics in the provision of advanced emergency medical services and that maintains a defined program of continuing education for its personnel. The initial position of the student on the pre-hospital care team should be that of observer. After progressing through record keeping and participation in actual patient care, the student should eventually function as the patient care leader. However, the student should not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present. The ALS Provider being utilized should have established a continuing education program for its field personnel that adequately maintain an acceptable level of required skills and knowledge. The ALS Provider should function under communications with a medical control authority that provides pre-hospital direction of the patient care. The ALS Provider should also have a program to provide prompt review of pre-hospital care provided by the EMT-Intermediate.

m. General courses and topics of study must be achievement oriented and shall provide students with:

n. The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Description of the Occupation" found in the DOT, NSTC Course Guide.

o. Comprehensive instruction which encompasses:

i. Orientation to the occupation

i. Responsibilities of the role

ii. Inter-professional responsibilities

iii. Career pathways in emergency medical services

iv. Development of interpersonal skills

ii. Awareness of one's abilities and limitations

i. Ability to accept direction

ii. Awareness of impact to others

iii. Willingness and ability to communicate with others

iv. Ability to build a working relationship with patients and peers

v. Ability to function as a team member and/or team leader

vi. Ability to accept patients as they present themselves, without passing judgments

vii. Ability to involve others significant to the patient

viii. Ability to respond to a patient's sense of crisis

iii. Development of knowledge and clinical skills appropriate for this level of care

i. Roles and responsibilities of the EMT-Intermediate

ii. Emergency medical services systems and medical control

iii. Medical/legal consideration

iv. Communication procedures

v. Medical terminology

vi. Patient assessment including both a primary and secondary survey

vii. Airway management procedures

viii. Assessment and management of shock

NOTE: The following curriculum must be taught in addition to that listed above.

101.06 <u>EMT-I - Curriculum For Defibrillation</u>

Introduction: The student must have successfully completed the following sections prior to participating in this section:

Section 1. Roles and Responsibilities

Section 2. EMS Systems

Section 3. Medical/Legal Considerations

Section 4. Medical Terminology

Section 5. EMS Communications

Section 6. General Patient Assessment and Initial Management

Because of the high number of pre-hospital deaths attributed to coronary artery disease, this is a subject that continues to receive great emphasis in the training of the EMT-I. This is particularly true in light of recent data which suggests that early defibrillation makes a significant difference in the outcome of patients suffering from ventricular fibrillation.

Overview

1. Anatomy and Physiology of the Cardiovascular System
    a. Anatomy of the Heart
    b. Physiology of the Heart
    c. Electrophysiology (Basics)
2. Assessment of the Cardiac Patient
    a. Common Chief Complaints and History
    b. Significant Past Medical History
    c. Physical Examination Pertinent to the Cardiac Patient
3. Pathophysiology and Management
    a. Pathophysiology of Atherosclerosis
    b. Specific Conditions Resulting from Atherosclerosis Heart Disease
        i. Angina Pectoris
        ii. Acute Myocardial Infarction

iii. Cardiac Arrest/Sudden Death

4. Dysrhythmia Recognition

   a. Introduction to ECG Monitoring

   b. Rhythm Strip Analysis

   c. Introduction to Dysrhythmias

   d. Dysrhythmias Originating in the Ventricles

5. Techniques of Management

   a. CPR

   b. ECG Monitoring

   c. Defibrillation

Objectives

At the completion of this section the student will be able to:

1. Describe the size, shape, and location/orientation (in regard to other body structures) of the heart muscle.

2. Identify the location of the following structures on a diagram of the normal heart:

   a. Pericardium

   b. Myocardium

   c. Epicardium

   d. Right and left atria

   e. Interatrial Septum

   f. Right and left ventricles

   g. Interventricular septum

   h. Superior and inferior vena cava

   i. Aorta

   j. Pulmonary vessels

k. Coronary arteries

l. Tricuspid valve

m. Mitral valve

n. Aortic valve

o. Pulmonic valve

p. Papillary muscles

q. Chordae Tendineae

3. Describe the function of each structure listed in Objective #2.

4. Describe the distribution of the coronary arteries and the parts of the heart supplied by each artery.

5. Differentiate the structural and functional aspects of arterial and venous blood vessels.

6. Define the following terms that refer to cardiac physiology:

   a. Stroke volume

   b. Starling's Law

   c. Preload

   d. Afterload

   e. Cardiac output

   f. Blood pressure

7. Describe the electrical properties of the heart.

8. Describe the normal sequence of electrical conduction through the heart and state the purpose of this conduction system.

9. Describe the location and function of the following structures of the electrical conduction system:

   a. SA node

   b. Internodal and Interatrial tracts

   c. AV node

d. Bundle of His

e. Bundle branches

f. Purkinje fibers

10. Define cardiac depolarization and repolarization and describe the major electrolyte changes that occur in each process.

11. Describe an ECG

12. Define the following terms as they relate to the electrical activity of the heart:

    a. Isoelectric line

    b. QRS complex

    c. P wave

13. Name the common chief complaints of cardiac patients.

14. Describe why the following occur in patients with cardiac problems:

    a. Chest pain or discomfort

    b. Shoulder, arm, neck, or jaw pain/discomfort

    c. Dyspnea

    d. Syncope

    e. Palpitations/abnormal heart beat

15. Describe those questions to be asked during history taking for each of the common cardiac chief complaints.

16. Describe the four most pertinent aspects of the past medical history in a patient with a suspected cardiac problem.

17. Describe those aspects of the physical examination that should be given special attention in the patient with suspected cardiac problems.

18. Describe the significance of the following physical exam findings in a cardiac patient:

    a. Altered level of consciousness

    b. Peripheal edema

c. Cyanosis

d. Poor capillary refill

e. Cool, clammy skin

19. State the numerical values assigned to each small and large box on the ECG graph paper for each axis.

20. Define ECG artifact and name the causes.

21. State the steps in the analysis format of ECG rhythm strips.

22. Describe two common methods for calculating heart rate on an ECG rhythm strip and the indications for using each method.

23. Name 8 causes of dysrhythmias.

24. Describe proper use of the following devices used for defibrillation:

    a. manual monitor/defibrillator

    b. semi-automatic monitor/defibrillator

    c. automatic monitor/defibrillator or Automatic defibrillator

25. Demonstrate on an adult mannequin, the technique for single and two-person CPR according to American Heart Association standards.

26. Demonstrate on an infant mannequin, the technique for infant CPR according to American Heart Association standards.

27. Demonstrate proper application of ECG chest electrodes and obtain a sample Lead II.

28. Demonstrate the proper use of the defibrillator paddles electrodes to obtain a sample Lead II rhythm strip.

29. Demonstrate how to properly assess the cause of poor ECG tracing.

30. Demonstrate correct operation of a monitor-defibrillator to perform manual defibrillation on an adult and infant.

31. Correctly identifies and treats within the scope of their practice the following dysrhythmias:

    a. asystole

    b. v-fib

c. pulseless v-tach

d. normal sinus rhythm

e. EMD

f. artifact

g. PVC recognition

101.07 Curriculum Description - EMT-Paramedic

1. Instructional content of the educational program shall include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum shall be organized to provide the student with knowledge of the acute, critical changes in physiology, and in psychological, and clinical symptoms as they pertain to the pre-hospital emergency medical care of the infant, child, adolescent, adult, and geriatric patient. Students shall have an opportunity to acquire clinical experience and practice skills related to the emergency medical care of these patients. Students shall also understand the ethical and legal responsibilities which they assume as students and which they are being prepared to assume as graduates.

2. The educational program shall be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT-Paramedic.

3. The program shall consist of three components: didactic instruction, clinical instruction, and supervised field internship in an advanced life support unit that functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

4. The program shall maintain on file for each component of the curriculum a reasonably comprehensive list of the terminal performance objectives to be achieved by the student. These objectives shall delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

5. The student shall be informed about the methods and data used in determining grades, about pass/fail criteria, and about the mechanism for appeal. Conditions governing dismissal from the program shall be clearly defined in writing and distributed to the student at the beginning of the training program.

6. Evidence of student competence in achieving the educational objectives of the program shall be kept on file. Documentation shall be in the form of both written and practical examinations.

7. Classroom, clinical, and field faculty shall also prepare written evaluations on each student. Documentation shall be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation identifying whether or not the student followed through on faculty recommendations shall also be maintained.

8. Instruction shall be supported by performance assessments. Faculty shall be presented with the program's educational objectives for use in preparation of lectures and clinical and field practice. The course coordinator shall insure that stated educational objectives are covered and shall answer any questions from students or clarify information presented by a lecturer.

    a. Didactic instruction -

        i. Lectures, discussion, and demonstrations presented by physicians and others who are competent in the field.

    b. Clinical (in-hospital) and other settings -

        i. Instruction and supervised practice of emergency medical skills in critical care units, emergency departments, OB units, operating rooms, psychological crisis intervention centers, and other settings as appropriate.

        ii. Supervision in the hospital can be provided either by qualified hospital personnel, such as supervisory nurses, department supervisors and physicians, or by paramedic or nurse program instructors. The hospital practice shall not be limited to the development of practical skills alone, but shall include knowledge and techniques regarding patient evaluations, pathophysiology of medical and surgical conditions, development of patient rapport, and care for and understanding of the patient's illness.

        iii. Documentation shall be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

9. Field Internship -

    a. "The field internship is a period of supervised experience on an intensive care vehicle which provides the student with a progression of increasing patient care responsibilities which proceeds from

observation to working as a team member. There shall be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience."

b. The intensive care vehicle shall have communication with medical command authority and equipment and drugs necessary for advanced life support. The student must be under the direct supervision and observation of a physician or nurse with experience in the pre-hospital ALS setting, or an EMT-Paramedic approved by the medical command authority.

c. The experience shall occur within an emergency medical care system that involves EMT-Paramedics in the provision of advanced emergency medical services and that maintains a defined program of continuing education for its personnel.

d. "The initial position of the student on the pre-hospital care team shall be that of observer. After progressing through record keeping and participation in actual patient care, the student shall ultimately function as the patient care leader. However, the student shall not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present."

e. The ALS Provider being used shall have established a continuing education program for its field personnel that adequately maintain an acceptable level of required skills and knowledge.

f. The ALS Provider shall function under direct communications with a medical control authority that provides pre-hospital direction of the patient care.

g. The ALS Provider shall also have a program to provide prompt review of pre-hospital care provided by the EMT-Paramedic.

10. General courses and topics of study must be achievement oriented and shall provide students with:

a. The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Description of the Occupation" found in the DOT, NSTC Course Guide.

11. Comprehensive instruction which encompasses:

a. Orientation to the occupation

i. Responsibilities of the occupation

ii. Professional responsibilities

iii. Career pathways in emergency medical services

iv. Legal responsibilities

b. Development of interpersonal skills

i. Awareness of one's abilities and limitations

ii. Ability to accept direction

iii. Awareness of impact on others

iv. Willingness and ability to communicate with others

v. Ability to build a working relationship with patients and peers

vi. Ability to function as a team member and/or team leader

vii. Ability to accept patients as they present themselves, without passing judgment

viii. Ability to involve others significant to the patient

ix. Ability to respond to a patient's sense of crisis

12. Development of clinical assessment skills

a. Ability to obtain information rapidly by talking with the patient and by physical examination; by interviewing others; and from observation of the environment

b. Ability to organize and interpret data rapidly

c. Ability to communicate concisely and accurately

d. Ability to understand pertinent anatomy, physiology, pharmacology, microbiology, and psychology

13. Development of clinical management and technical skills (from American Medical Association Joint Review Committee Essential Guidelines for EMT-Paramedic Training Programs) relating to the assessment and emergency treatment of:

a. Medical Emergencies including:

i. Respiratory System (as addressed in didactic objectives), Cardiovascular system (as addressed in didactic objectives),

Endocrine system (as addressed in didactic objectives), Nervous system (as addressed in didactic objectives), Gastrointestinal system (as addressed in didactic objectives), Toxicology (as addressed in didactic objectives), Infectious diseases (as addressed in didactic objectives), Environmental problems (as addressed in didactic objectives), Problems by age extremes i.e., pediatrics, neonatal, geriatrics (as addressed in didactic objectives), Shock (as addressed in didactic objectives), Central nervous system (as addressed in didactic objectives).

b. Traumatic Emergencies including:

i. Central nervous system (as addressed in didactic objectives), Neck (as addressed in didactic objectives), Thorax (as addressed in didactic objectives), Abdomen (as addressed in didactic objectives), Extremities (as addressed in didactic objectives), Skin (as addressed in didactic objectives), Environmental (as addressed in didactic objectives), Shock (as addressed in didactic objectives)

c. Obstetrical/Gynecological Emergencies (as addressed in didactic objectives),

d. Behavioral Emergencies (as addressed in didactic objectives)

e. Stress (as addressed in didactic objectives)

f. Psychiatric disease (as addressed in didactic objectives)

g. Emotional dysfunction (as addressed in didactic objectives)

h. Medical personnel communications (as addressed in didactic objectives)

i. Clinical/Medical equipment (as addressed in didactic objectives and by institution or service policy).

14. Development of technical skills:

a. associated with biomedical communications, including telemetry, record keeping, use of equipment, emergency and defensive driving, and principles and techniques of extrication.

15. Optional skills shall be included in all EMT-Paramedic training programs.

101.08 <u>EMT Advanced Level classes, class approved</u>

EMT Advanced Level class approval forms can be requested from the BEMS or be completed on the BEMS website. (www.msems.org) Credentialed EMT

Advanced Level instructors should complete the class approval form and submit to the BEMS, at minimum, thirty (30) calendar days prior to the first day of class. The BEMS will assign a class number to all approved requests and return to the credentialed EMT Advanced Level instructor. Incomplete paperwork will be returned without action.

101.09 EMT Advanced Level classes, initial roster

Initial rosters shall be completed by the credentialed EMT Advanced Level instructor immediately following the second meeting of the class. Initial roster forms can be obtained from the BEMS or be completed on the BEMS website. (www.msems.org) A final roster for full or refresher EMT Advanced Level class will not be accepted without an initial roster on file with the BEMS.

101.10 EMT Advanced Level classes, final roster

Final rosters shall be completed by the credentialed EMT Advanced Level instructor immediately following the end of a full EMT Advanced Level or EMT Intermediate or Paramedic Refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the EMT Advanced Level class. The final roster form can be obtained from the BEMS or be completed on the BEMS web site. (www.msems.org) Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with the BEMS.

101.11 EMT Advanced Level Training Programs, minimum admittance criteria

1. Must be a Mississippi certified EMT-Basic

2. Must successfully pass a re-test of EMT-Basic skills and knowledge.

3. Must provide past academic records for review by an admissions committee (may or may not be faculty members).

4. Completion of 8 semester hours of human anatomy and physiology (A&P 1 and II with labs) from an accredited post-secondary school. Minimum average of C or higher must be obtained. Human anatomy and physiology may be taken as prerequisite or co-requisite courses.

101.12 EMT Advanced Level Refresher Training

1. EMT Intermediate Refresher training shall consist of: Successful competition of the EMT-Basic refresher course as outlined previously and successful competition of a formal 14 hour DOT EMT Intermediate refresher training program (must include 2 hours of defibrillation refresher training). Successful competition of Division 1 and 2 of the EMT Paramedic Curriculum will satisfy this requirement.

2. EMT Paramedic Refresher Block training shall consist of: Successful competition of a formal MSDH, BEMS DOT EMT Paramedic Refresher Training Program. An ACLS course is applicable toward this section within the appropriate blocks and competition of the appropriate terminal competencies.

3. Written permission from BEMS must be obtained prior to the start of an EMT Advanced refresher course. Instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class.

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, BEMS approved 72 hour transitional course.

101.13 Prerequisites to certification as an EMT Advanced Level (training obtained in Mississippi).

1. Age of at least 18 years.

2. Completion of the Board's approved Emergency Medical Technician Intermediate or Paramedic Training Program (Note: This includes passage of the National Registry EMT-I or EMT-P examination).

3. Competition of a BEMS approved EMT-I defibrillation course and passage of the state defibrillation exam (applicable to EMT-Intermediate only), or equivalent with MSDH, BEMS approved terminal competencies (ACLS may be substituted for the EMT-I defibrillation course, but applicant must still pass the state defibrillation exam.)

4. Must meet all Mississippi criteria for EMT Basic certification.

5. Verification of medical control (Jurisdictional Medical Control Agreement)

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, BEMS approved 72 hour transitional course.

101.14 Prerequisites to certification (training obtained in another state)

1. Age of at least 18 years.

2. An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement from a licensed ambulance service or a facility providing Advanced life support service indicating the applicant is presently employed or will be employed upon moving to the state.

3. Completion of an EMT-Intermediate or EMT-Paramedic program (Advanced level), which meets the guidelines of the national standard curriculum for EMT-I or EMT-P. A copy of the program curriculum and educational objectives must be submitted to and approved by the BEMS.

4. Applicant must be registered as an EMT-Intermediate or EMT-Paramedic by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card to the BEMS. Must meet all Mississippi criteria for EMT-B certification.

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, BEMS approved 72 hour transitional course.

Note: The Mississippi BEMS maintains the right to refuse reciprocity to any EMT-Intermediate and EMT-Paramedic if the submitted curriculum does not meet the guidelines of the national standard curriculum and those required by the state of Mississippi.

102 EMT ADVANCED CERTIFICATION

102.01 EMT-Advanced Certification

1. Any person desiring certification as an EMT-Advanced shall apply to BEMS using forms provided (Application for state certification)

2. All certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

3. The BEMS may withhold or deny an application for certification for a like period of time equal to the period of time under which a person failed to comply. Mississippi requires that all EMT-I/P maintain current registration with the National Registry of Emergency Medical Technicians.

102.02 EMT-Advanced Level Re-certification

1. Any person desiring re-certification as an EMT- I/P shall apply to BEMS using forms provided (Application for state certification)

2. All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card equivalent to the level of re-certification requested and a Jurisdictional Medical Control Agreement (JMCA). (Jurisdictional Medical Control Agreements are valid only for the certification period in which they are submitted. Therefore, all EMT-Intermediates and EMT-

Paramedics recertifying must complete and resubmit a JMCA for each licensed provider for which they function.)

3. All EMT's failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

4. BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

Note: All EMT-Paramedics trained under the EMT-Paramedic curriculum prior to 1999 must complete a MSDH, BEMS approved 72 hour transitional course.

Note: All EMT-Paramedics trained prior to 1991 or trained in another state must provide evidence of training in all optional skills identified by the BEMS. This training must be obtained through a state approved training program.

102.03 EMT Advanced Level, Grounds for Suspension or Revocation.

The BEMS may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty

6. Disregarding the speed regulations prescribed by law while on duty.

7. Failure to carry the BEMS issued certification card while on duty or failure to wear appropriate identification as approved by the BEMS.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current EMT-Advanced training standards as required by the BEMS.

10. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

16. Permitting, aiding or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

18. Failure to comply with the requirements of a Mississippi EMS scholarship program.

19. Failure to comply with an employer's request for drug and alcohol testing.

20. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

103 OCCUPATION AND COM PENTENCY OF THE EMT ADVANCED

103.01 Description of the Occupation and Competency of the EMT-Advanced

1. "The Emergency Medical Technician-Intermediate or Emergency Medical Technician-Paramedic (EMT-I/P) is qualified in advanced emergency care and services by a competency-based training program of clinical, didactic,

and practice instruction and by a field internship. Competencies include but are not limited to the recognition, assessment, and management of medical emergencies under the direction of a physician."

2. "An EMT-I am a person who has successfully completed both an EMT-B and an EMT-I training program curriculum that shall consist of modules numbers I, II, III as developed for the United State Department of Transportation under Contract No. DOT-HS-900-089 as well as the MSDH, BEMS EMT-Intermediate defibrillation curriculum and is certified or licensed.

3. An EMT-P is a person who has successfully completed both an EMT-B and an EMT-P training program and is certified. The EMT-I or EMT-P training programs are programs of instruction which equal or exceed the educational goals and objectives of the National Standard Emergency Medical Technician - Intermediate or Paramedic Course."

4. "Competency, knowledge, awareness of one's abilities and limitations, the ability to relate with people, and a capacity for calm and reasoned judgment while under stress are essential attributes of the EMT-I and EMT-P. The EMT-I and EMT-P respects the individuality and privacy of patients and their family members."

103.02 Competency of the EMT-Intermediate

1. Given the knowledge, skills, and field experience, the EMT-I is competent in:

   a. Recognizing a medical emergency; assessing the situation managing emergency care and, if needed, extrication; coordinating his efforts with those of other agencies involved in the care and transportation of the patient; and establishing rapport with the patient and significant others to decrease their state of crisis.

   b. Assigning priorities of the emergency treatment and recording and communicating data to the designated medical command authority.

   c. Initiating and continuing emergency medical care under medical control including the recognition of presenting conditions and initiation of appropriate invasive and non-invasive therapy.

   d. Exercising personal judgment in case of interruption in medical direction caused by communication failure or in case of immediate life-threatening conditions. (Under these circumstances, provides such emergency care as has been specifically authorized in advance.)

103.03 Competency of the EMT-Paramedic

1. Given the knowledge, skills, and field experience, the EMT-P is competent in:

    a. Recognizing a medical emergency; assessing the situation; managing emergency care and, if needed, extrication; coordinating his efforts with those of other agencies involved in the care and transportation of the patient; and establishing rapport with the patient and significant others to decrease their state of crisis.

    b. Assigning priorities of emergency treatment and recording and communicating data to the designated medical command authority.

    c. Initiating and continuing emergency medical care under medical control, including the recognition of presenting conditions and initiation of appropriate invasive and noninvasive therapies (e.g., surgical and medical emergencies, airway and respiratory problems, cardiac dysrhythmias, cardiac pulmonary arrest, and psychological crises), and assessing the response of the patient to that therapy.

    d. Exercising personal judgment in case of interruption in medical direction caused by communications failure or in cases of immediate life-threatening conditions. (Under these circumstances, the EMT-P provides such emergency care as has been specifically authorized in advance.)

104 PERFORMANCE STANDARDS FOR EMT-ADVANCED LEVELS

104.01 Performance Standards for Emergency Medical Technician-Advanced Levels.

The EMT-Intermediate and EMT-Paramedic who functions within the State of Mississippi, must be able to demonstrate the following skills to the satisfaction of the EMS medical director and the BEMS, State Department of Health, to meet criterion established for advanced life support personnel.

The skills listed herein are in addition to those performed by the EMT-Basic. Some of the skills are restricted to performance by EMT-Paramedics. Others may be performed by EMT-Intermediates as well.

Skills proceeded by an asterisk (*) indicate those restricted to EMT-P's. No markings indicate that the skill may be performed by both levels of ALS personnel.

It should be noted that utilization of some of the more specialized advanced skills requires special approval by the medical director each time they are attempted.

1. Perform an appropriate patient assessment, including: history taking a chief complaint, pertinent history of the present illness and past medical

history). Physical examination, including: assessment of vital signs, including pulse, blood pressure, and respirations. Trauma-oriented and medically oriented head-to-toe surveys, including, but not limited to:

2. Inspection and palpation of the head and neck;

   a. inspection of the chest and auscultation of heart and lung sounds

   b. inspection of the abdomen and auscultation of abdominal sounds;

   c. inspection and palpation of extremities;

   d. evaluation of neurological status and neuromuscular function.

3. Demonstrate aseptic technique of extremity peripheral venipuncture and drawing blood samples for hospital use only and Blood Glucose Determination by capillary sample (Limited to Unconscious Patients only for EMT-Intermediate).

4. *Demonstrates aseptic technique of external jugular intravenous insertion in life threatening situations when alternate sites are impractical. Demonstrate techniques of maintenance of central intravenous therapy (internal jugular, subclavian, femoral) EMT-P's are limited to only monitoring central line IV's; they shall not initiate central lines. The central line IV's may be used for approved fluid and drug administration only. Hemodynamic monitoring shall not be performed by EMT-P's.

   NOTE: EMT-Intermediates and EMT-Paramedics are permitted to monitor and administer only those IV fluids and/or medications which are approved by the BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA). A current "Required and Approved EMS Fluids and Drugs List" is available from the BEMS office and on the BEMS website (www.ems.doh.ms.gov). Requests for additions or deletions from the list should be made in writing by the System Medical Director to the BEMS. Requests should detail the rational for the additions, modifications, or deletions.

   In addition, EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

5. Demonstrates the techniques for aseptic assembly of intravenous equipment and for calculation of flow rates.

6. Demonstrate the techniques of establishing an IV infusion using a catheter-over-the-needle device.

7. Recall and demonstrate use of the type of IV fluid appropriate in:

   a. a "keep open" lifeline in cardiac patients

   b. hypovolemic shock

   c. specific medical emergencies

   Note: (EMT-Intermediates do not routinely start IV's on patients in categories 1 and 3. Their training concentrates on trauma and hypovolemic patients. They may, however, be requested to establish IV's in other situations such as when they are awaiting the arrival of higher qualified ALS personnel).

   The BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA) will compile a list of intravenous fluids and medications that may be initiated and transported by EMS providers in the State. The current list of fluids and medications approved for initiation and transport by Mississippi EMS providers is available from the BEMS office or the BEMS website(www.ems.doh.ms.gov).

   Requests for additions or deletions from the list should be made in writing by the System Medical Director to the BEMS. Requests should detail the rationale for the additions, modifications, or deletions.

8. Demonstrate the application, inflation, and correct sequence of deflation of the pneumatic anti-shock garment (PASG).

9. *Demonstrate the technique for calculating dosage and drawing up a designated volume of medication in a syringe from an ampule or vial.

10. *Demonstrate the technique for administering drugs using a prepackaged disposable syringe.

11. *Demonstrate technique of subcutaneous, intradermal, intramuscular, intravenous, and intra tracheal administration of drugs.

    Note: In addition, EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route-that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

12. *EMT-Paramedics should be familiar with all of the 41 classifications of medications as defined by the 1998 EMT-Paramedic National Standard Curriculum. Paramedics must be able to list indications, contraindications, actions, dosage, and route of administration of each of the fluids and medications on the “Approved and Required EMS Fluids

and Drugs List" as compiled by the BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA).

13. Demonstrate the technique of aseptic and atraumatic endotracheal and tracheotomy suctioning.

14. Recall the indications for and demonstrate the insertion of an esophageal obturator and esophageal gastric tube airway.

15. Demonstrate the technique for direct laryngoscopy and insertion of an endotracheal tube and end-tidal CO2 detection in an adult and infant.

16. Demonstrate the technique for insertion of a nasotracheal tube using the blind technique and by direct laryngoscopy with use of Magill forceps.

17. Demonstrate the application of electrodes and monitoring of a patient's electrocardiographic activity.

18. Identify on Lead II or modified chest lead - 1 (MCLl) and provide appropriate therapy (according to American Heart Association) for the following cardiac rhythms:

    a. normal sinus rhythm

        i. *sinus arrhythmia

        ii. *sinus arrest

        iii. *sinus bradycardia

        iv. *premature atrial contractions

        v. *premature junctional contractions

        vi. *supraventricular tachycardia

        vii. *atrial fibrillation

        viii. *atrial flutter

        ix. *first degree heart block

        x. *second degree heart block

        xi. *third degree heart block

        xii. *premature ventricular contractions

        xiii. *ventricular tachycardia

xiv. *ventricular fibrillation

xv. electromechanical dissociation

xvi. asystole

xvii. *pacemaker rhythms

xviii. PVC recognition

xix. artifact

19. Demonstrate the proper use of the defibrillator paddle electrodes to obtain a sample Lead II rhythm strip

20. Demonstrate how to properly assess the cause of poor ECG tracing.

21. Demonstrate correct operation of a monitor-defibrillator to perform defibrillation on an adult and infant.

22. *Demonstrate correct operation and indications for an external non-invasive pacemaker (optional).

23. *Apply rotating tourniquets in cases of acute heart failure.

24. Demonstrate proficiency in:

    a. biomedical communications, VHF and UHF (RTSS)

    b. ECG telemetry

    c. medicolegal responsibilities

    d. record keeping

    e. emergency and defensive driving

    f. principles and techniques of light extrication

    g. management of mass casualties and triage

25. In addition to the above skills, the EMT-Paramedic and the EMT-Intermediate should be well versed in pertinent anatomy, pathophysiology, history taking, physical examination, assessment and emergency treatment relating to:

    a. the cardiovascular system including recognition of selected dysrhythmias associated with potential acute cardiac compromises;

b. the respiratory system, including pneumothorax, chronic obstructive pulmonary disease, acute asthma, trauma to the chest and airways, respiratory distress syndrome, and acute airway obstruction;

c. chest and abdominal trauma;

d. soft tissue injuries including: burns, avulsions, impaled objects, eviscerations, amputations, and bleeding control;

e. the central nervous system (medical) in regard to cerebrovascular accidents, seizures, drug overdose, drug incompatibilities, and alterations in levels of consciousness;

f. musculoskeletal trauma including management of fractures, strains, sprains and dislocations;

g. medical emergencies, including: endocrine disorders, anaphylactic reactions, environmental emergencies, poisonings, overdose and acute abdomen;

h. obstetrical and gynecological emergencies including: breech birth, premature birth, abortion, multiple-infant birth, arm or leg presentation, prolonged delivery, prolapsed umbilical cord, pre- and postpartum hemorrhage, ruptured uterus, birth of an apenic infant, preeclampsia or eclampsia, rape, and supine hypotensive syndrome;

i. pediatric emergencies, including: asthma, bronchiolitis, croup, epiglottis, sudden infant death syndrome, seizures, child abuse;

j. behavioral emergencies, including: negotiations, recognition and intervention techniques with suicidal assaultive, destructive, resistant, anxious, bizarre, confused, alcoholic, drug-addicted, toxic, amnesic, paranoid, drugged, raped and assaulted patients.

26. *Optional skills

Performances of these skills are optional however, they must be taught in all training programs.

a. Administration of transfusions of blood and its components.

b. Automatic Transport Ventilators (as specified in UJAMA, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac CareU).

c. CPap and BiPap Initiation and Management

d. Chest decompression

e. External cardiac pacing

f. INT Placement

g. Pediatric and Adult Intraosseous infusions

Note: *EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.*

h. MSDH approved Nitroglycerin and Thrombolytic Transport Course

i. Nasogastric Tube Insertion

j. Orogastric Tube Insertion

k. Percutaneous transtracheal catheter ventilation

l. Twelve Lead Electrocardiography

m. Umbilical Vein Cannulation

n. Vascular Access Devices

o. Drug Assisted Intubation, using benzodiazepine class drugs, in strict adherence with the following measures:

i. A specific verbal order from online medical direction must be obtained to institute DAI;

ii. Initiate and continue, before, during and after each DAI, continuous monitoring and recording of heart rate and rhythm, oxygen saturation, and end-tidal carbon dioxide using a capnography or capnometric device (to exclude colormetric only devices);

iii. Appropriate resources for drug storage and delivery must be present and used;

iv. DAI protocols must contain continuing quality assurance, quality control and performance review measures, and when indicated, supplemental training;

v. DAI protocols must include requirements for initial training and continuing education in:

1. Proper patient selection for DAI;

2. Demonstrating initial and continuing competency in the DAI procedure;

3. Confirming initial and verifying ongoing tube placement, including training in the utilization of appropriate instrumentation;

4. Airway management of patients who cannot be intubated;

5. The use of backup rescue airway methods in the event of failed DAI.

vi. Every instance of the initiation or attempted initiation of an airway by DAI shall be reported to BEMS by the local EMS on forms or in a format approved by BEMS. Every instance of the institution or attempted institution of an airway by DAI shall be reviewed by the State Medical Director, who shall submit a quarterly report to MDTQA and the EMS Advisory Council.

27. Optional skills for EMT-Intermediates

a. These optional skills and optional medications must be included in the BEMS approved medical control plan of each ALS provider utilizing them.

i. Currently there are no optional skills or optional medications approved by the BEMS.

28. Other skills

a. Other skills and medications not listed in these regulations may not be performed by any ALS provider through ALS trained employees until each skill and/or medication has been approved by BEMS in writing.

b. EMTs of all levels (Basic, Intermediate, Paramedic), may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

i. there is no need, or reasonably perceived need, for the device or procedure during transport; or

ii. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

The EMT-Advanced who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the BEMS. Training programs must be approved by the BEMS and the Department of Education. The skills listed herein will enable the EMT-Advanced to carry out all EMT-Advanced level patient assessment and emergency care procedures.

The EMT's -Advanced's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help and consideration of cervical stabilization.

105 AREA AND SCOPE OF PRACTICE

105.01 Area and Scope of Practice of the EMT-Advanced Level

1. ALS personnel are restricted to functioning within the geographic boundaries of their licensed ALS service employer. They primarily provide out-of-hospital emergency care to acutely ill or injured patients while on duty for a licensed ALS provider under medical command authority approved by the BEMS. This does not apply to extended transports which may require EMS personnel to function outside of said boundaries.

2. EMT-I/Ps may routinely or periodically participate in patient care in the emergency department of a licensed hospital. Their presence may be in the form of:

   a. student clinical rotations

   b. graduates participating in a clinical rotation for skill retention.

   c. field units stationed out of the emergency department under direct physician supervision (i.e., hospital based ALS services)

      i. BEMS Certified EMT-I/Ps will be able to function in the emergency service area of the hospital. They would also be permitted to function in life-threatening emergency situations in other areas of the hospital if directed to do so by the medical command authority.

   d. providing assistance to the emergency department staff after delivering a patient.

**NOTE: In accordance with letter B, EMT-I/Ps must, when functioning in the hospital, only do so under the direct supervision of a physician. This is necessary because the scope of practice of an EMT-I/P does not coincide with that of any other licensed personnel. Paramedics of a hospital owned and based ambulance service may function in the Emergency Department under the direct supervision of a Mississippi licensed physician, physically located in Mississippi, via telemedicine. Paramedics may not function in other areas of hospitals which do not have on-site 24 hour physician availability.*

3. EMT-I/P students may function in all areas of a hospital, under direct supervision of licensed or certified personnel, in a continuing education program or in a training program approved by the licensed ALS service.

4. An EMT-I/P may perform only those skills authorized by the BEMS regulations relating to their certification.

5. Because the EMT-I/P's primary responsibility is to respond to emergency situations outside the hospital, they cannot be utilized to replace any members of the hospital emergency service area staff, but may be utilized to support and assist the staff in the care of patients in accordance with their performance standards. Since their scope of practice is limited to a number of specific procedures, which can only be performed under the direction of a physician, all emergency patients clearly require nursing intervention in order to insure that all the patients' needs are met.

6. It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the ambulance attendant, if the following conditions are present:

    a. The patient has existing advanced therapeutics or treatment modalities for a preexisting condition and

    b. The patient is located in a non-hospital setting, and

    c. The patient's condition is considered to be so urgent that the benefits of prompt transport by available personnel to an appropriate hospital outweigh the increased risk to the patient from affecting a delay waiting for qualified medical personnel to arrive.

7. The person possessing the highest level of certification/license must attend the patient unless otherwise authorized by medical control.

8. EMTs of all levels (Basic, Intermediate, Paramedic), may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

a. there is no need, or reasonably perceived need, for the device or procedure during transport; or

b. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

Chapter 09 EMERGENCY MEDICAL SERVICES OPERATING FUND (EMSOF)

100 EMERGENCY MEDICAL SERVICES OPERATING FUND

100.01 <u>§41-59-61. Emergency medical services operating fund; assessment on traffic violations.</u>

1. Such assessments as are collected under subsections (1) and (2) of Section 99-19-73 shall be deposited in a special fund hereby created in the State Treasury to be designated the "Emergency Medical Services Operating Fund." The Legislature may make appropriations from the Emergency Medical Services Operating Fund to the State Board of Health for the purpose of defraying costs of administration of the Emergency Medical Services program and for redistribution of such funds to the counties, municipalities and organized medical service districts (hereinafter referred to as "governmental units") for the support of the emergency medical services programs. The State Board of Health, with the Emergency Medical Services Advisory Council acting in an advisory capacity, shall administer the disbursement to such governmental units.

2. Funds appropriated from the Emergency Medical Services Operating Fund to the State Board of Health shall be made available to all such governmental units to support the emergency medical services programs therein, and such funds shall be distributed to each governmental unit based upon its general population relative to the total population of the state. Disbursement of such funds shall be made on an annual basis at the end of the fiscal year upon the request of each governmental unit. Funds distributed to such governmental units shall be used in addition to existing annual emergency medical services budgets of the governmental units, and no such funds shall be used for the payment of any attorney's fees. The Director of the Emergency Medical Services program or his appointed designee is hereby authorized to require financial reports from the governmental units utilizing these funds in order to provide satisfactory proof of the maintenance of the funding effort by the governmental units.

SOURCES: Laws, 1982, ch. 344, § 1; 1983, ch. 522, § 38; 1985, ch. 352; 1985, ch. 440, § 6; 1990, ch. 329, § 7, eff from and after passage (approved October 1, 1990).

Cross references -

Deposit of portion of standard state assessment into Emergency Medical Services Operating Fund, see § 99-19-73.

Editor's Note -

Section 1 of ch. 352, Laws, 1985, effective from and after July 1, 1985 (approved March 19, 1985), amended this section. Subsequently, Section 6 of ch. 440, Laws, 1985, effective from and after passage (approved March 27, 1985), also amended this section without reference to ch. 352. As set out above, this section contains the language of Section 6 of ch. 440, which represents the latest legislative expression on the subject.

100.02 Eligibility

1. Applicants are restricted to counties, municipalities and emergency medical service districts formed and recognized pursuant to §41-59-53 through §41-59-59. Political subdivisions are not eligible to receive Emergency Medical Services Operating Funds (EMSOF).

2. To be eligible for EMSOF, in part, governmental units must have expended from local funds directly to the ambulance service, at minimum, an amount equal to or greater that $0.15 per capita, with population computed from the most current federal census, in the year the EMSOF was collected. For governmental units that own and operate governmental ambulance service, to be eligible, in part, the governmental unit must show equal to or greater that $0.15 per capita, with population computed from the most current federal census, in the year the EMSOF fund was collected.

100.03 Process

1. Applications for EMSOF will be forwarded to applicants receiving EMSOF funds for the prior year. Other counties, municipalities and legal EMS districts wishing to receive applications shall submit in writing a request for application on or before October 1 of the year in which they plan to request EMSOF. Original applications, as provided by BEMS, for EMSOF must be received at the Bureau of Emergency Medical Services office by 5:00 PM on the second Friday of November each year. Applications received after this date will not be processed.

2. Applications for EMSOF must have satisfactory proof of the maintenance of the funding effort by the governmental unit in the form of a line item local fund expense for ambulance in the fiscal year in which EMSOF funds were collected. Satisfactory proof must also be provided in the form of a line item budget of local funds for ambulance in the fiscal year that EMSOF is being requested.

3. Applications must be signed by:

   a. Counties: Chancery Clerk, County Administrator or President Board of Supervisors

   b. Municipalities: Mayor

c. EMS Districts: District Administer or President of the Board.

4. Applicants are required to attend an "EMSOF grantee meeting" to be held in their public health region before grant approval.

5. All EMSOF funds must be deposited into the governmental units' treasury. Items purchased with EMSOF funds must be purchased in the name of the governmental unit. The Governmental unit must follow its existing rules for the purchasing, inventory and disposal of these items. A sticker which states "This equipment purchased by the citizens of the State of Mississippi" shall identify equipment purchased with EMSOF funds.

100.04 Eligible Uses of EMSOF Funds

1. EMSOF must be used for improvements in the Bureau of Emergency Medical Services regulated Emergency Medical Services and may not be used for operating expenses. All EMSOF funds must be expended or escrowed by the end of the local fiscal year in which the EMSOF funds were disbursed to the governmental unit. "Escrow" is defined as depositing the funds in an interest-bearing account in accordance with Miss. Code Ann. §27-105-1, et seq. and applicable state fiscal and financial control regulations, said funds to be used only in accordance with the provisions of the EMSOF grant. No funds granted hereunder may be escrowed for more than three (3) years. All expenditures of funds from an EMSOF grant must be done in accordance with Mississippi purchasing and property accounting laws, rules and regulations. A detailed justification for all EMSOF expenditures or funds escrowed, indicating their compliance with purchasing laws and regulations, as well as how they will improve local emergency medical services, must be provided.

2. **Personnel Expenses.** EMSOF may be used to pay payroll and benefit differential pay for governmental units for the first year that a governmental unit improves its' level of ambulance service licensure.

3. **Regionalization.** EMSOF may be used to pay dues to an EMS district formed and recognized pursuant to §41-59-53 through §41-59-59, for regional medical control, training, or improvements in Bureau of Emergency Medical Services. EMSOF may also be used for governmental support of trauma care systems.

4. **Training.** EMSOF may be used for initial training or continuing education of EMS Drivers, EMT-Basic, EMT-Intermediate, or EMT-Paramedic.

5. **Commodities.** EMSOF may be used for the purchase of commodities that improve local Emergency Medical Services. EMSOF may not be used to purchase any commodities that will be billed to a patient.

6. **Equipment.** EMSOF may be used to purchase equipment or capital outlay items that improve local Emergency Medical Services. Equipment purchased with EMSOF by a governmental unit must appear on the governmental units equipment inventory and be accounted for in accordance with State of Mississippi property inventory laws, rules and regulations. This is not intended to limit the temporary use of equipment in adjacent counties or jurisdictions within Mississippi or during patient transport either inside or outside the state.

7. EMSOF may be escrowed (up to a maximum of three years) for local improvements in Emergency Medical Services regulated by the Bureau of Emergency Medical Services. (Example: Purchasing a new ambulance or radio system that cost more than grant amount.) Grant awards may be escrowed up to three years from the disbursement. All escrow amounts and interest must be fully expended by the end of the fourth grant year. (Example: ABC County received $10,000 in EMSOF for FY2008, $10,000 for FY2009 and $10,000 for FY2010 and wishes to replace a high mileage ambulance that will cost $40,400. ABC County received $10,000 in EMSOF for FY 2011 and must fully expend the $40,000 plus interest accrued on escrowed amounts prior to the end of the governmental fiscal year for FY2011.) Escrow funds not fully expended by the end of the fourth grant year must be returned to the State. All interest posted must be reported and expended consistent with these regulations.

100.05 Reports

1. Prior to EMSOF proceeds being distributed to any governmental unit, proof or proper expenditure of EMSOF in the previous year, if applicable, must be submitted to include the signature of the signing authority of the governmental unit indicating all expenditures were made properly.

2. The director of the Bureau of Emergency Medical Services or his designee will perform random program reviews of governmental units to assure that EMSOF law, rules, regulations and policies are followed.

100.06 Appeal Process

Any county, municipality or organized medical service districts whose application for EMSOF has been rejected shall have the right to appeal such decision, within thirty (30) days after receipt of the Bureau of Emergency Medical Services' written decision, to a hearing officer who will make a final recommendation to the State Health Officer.

APPENDIX I – MEDICAL DIRECTION

101 STANDARD PRACTICE FOR QUALIFICATIONS, RESPONSIBILITIES, AND AUTHORITY

101.01 Medical Direction (pre-hospital Emergency Medical Services)

All aspects of the organization and provision of emergency medical services (EMS), including both basic and advanced life support, require the active involvement and participation of physicians. These aspects should incorporate design of the EMS system prior to its implementation; continual revisions of the system; and operation of the system from initial access, to pre-hospital contact with the patient, through stabilization in the emergency department. All pre-hospital medical care may be considered to have been provided by one or more agents of the physician who controls the pre-hospital system, for this physician has assumed responsibility for such care.

Implementation of this standard practice will insure that the EMS system has the authority, commensurate with the responsibility, to insure adequate medical direction of all pre-hospital providers, as well as personnel and facilities that meet minimum criteria to implement medical direction of pre-hospital services.

102 OFF-LINE MEDICAL DIRECTION

102.01 Medical Direction (Off-Line A.K.A. System Medical Director)

Each EMS agency providing pre-hospital care shall be licensed by the Mississippi State Department of Health, BEMS, and shall have an identifiable Medical Director who after consultation with others involved and interested in the agency is responsible for the development, implementation and evaluation of standards for provision for medical care within the agency.

All pre-hospital providers (including EMT-Bs) shall be medically accountable for their actions and are responsible to the Medical Director of the licensed EMS agency that approves their continued participation. All pre-hospital providers, with levels of certification EMT-B or above, shall be responsible to an identifiable physician who directs their medical care activity. The Medical Director shall be appointed by, and accountable to, the appropriate licensed EMS agency.

The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to EMS personnel on board any permitted unit at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

102.02 Requirements of a Medical Director

The medical aspects of an emergency medical service system shall be managed by physicians who meet the following requirements:

1. Mississippi licensed physician, M.D. or D.O.

2. Experience in, and current knowledge of, emergency care of patients who are acutely ill or traumatized.

3. Knowledge of, and access to, local mass casualty plans.

4. Familiarity with base station operations where applicable, including communication with, and direction of, pre-hospital emergency units.

5. Active involvement in the training of pre-hospital personnel.

6. Active involvement in the medical audit, review and critique of medical care provided by pre-hospital personnel.

7. Knowledgeable of the administrative and legislative process affecting the local, regional and/or state pre-hospital EMS system.

8. Knowledgeable of laws and regulations affecting local, regional and state EMS.

9. Approved by the State EMS Medical Director

102.03 Authority of a Medical Director includes, but is not limited to:

1. Establishing system-wide medical protocols in consultation with appropriate specialists.

2. Establishment of system-wide trauma protocols as delineated by the State Trauma Care Plan.

3. Recommending certification or decertification of non-physician pre-hospital personnel to the appropriate certifying agencies. Every licensed agency shall have an appropriate review and appeals mechanism, when decertification is recommended, to assure due process in accordance with law and established local policies. The Director shall promptly refer the case to the appeals mechanism for review, if requested.

4. Requiring education to the level of approved proficiency for personnel within the EMS system. This includes all pre-hospital personnel, EMTs at all levels, pre-hospital emergency care nurses, dispatchers, educational coordinators, and physician providers of on-line direction.

5. Suspending a provider from medical care duties for due cause pending review and evaluation. Because the pre-hospital provider operates under the license (delegated practice) or direction of the Medical Director, the Director shall have ultimate authority to allow the pre-hospital provider to provide medical care within the pre-hospital phase of the EMS system.

6. Establishing medical standards for dispatch procedures to assure that the appropriate EMS response unit(s) is dispatched to the medical emergency scene when requested, and the duty to evaluate the patient is fulfilled.

7. Establishing under which circumstances a patient may be transported against his will; in accordance with, state law including, procedures, appropriate forms and review process.

8. Establishing criteria for level of care and type of transportation to be used in pre-hospital emergency care (i.e., advanced life support vs. basic life support, ground air, or specialty unit transportation).

9. Establishing criteria for selection of patient destination.

10. Establishing educational and performance standards for communication resource personnel.

11. Establishing operational standards for communication resource.

12. Conducting effective system audit and quality assurance. The Medical Director shall have access to all relevant EMS records needed to accomplish this task. These documents shall be considered quality assurance documents and shall be privileged and confidential information.

13. Insuring the availability of educational programs within the system and that they are consistent with accepted local medical practice.

14. May delegate portions of his/her duties to other qualified individuals.

15. The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

16. Medical direction with concurrent and retrospective oversight supervision;

17. Standardized protocols;

18. Actively engaged in a continuous quality assurance, quality control, performance review, and when necessary, supplemental training.

103 ON-LINE MEDICAL DIRECTION (DIRECT MEDICAL CONTROL)

103.01 Medical Direction (Online, Direct Medical Control)

The practice of on-line medical direction shall exist and be available within the EMS system, unless impossible due to distance or geographic considerations. All pre-hospital providers, above the certification level of EMT-B, shall be assigned to a specific on-line communication resource by a predetermined policy and this shall be included in the application for ALS licensure.

When EMS personnel are transporting patients to locations outside of their geographic medical control area, they may utilize recognized communication resources outside of their own area.

Specific local protocols shall exist which define those circumstances under which on-line medical direction is required.

On-line medical direction is the practice of medicine and all orders to which the pre-hospital provider shall originate from/or be under the direct supervision and responsibility of a physician.

The receiving hospital shall be notified prior to the arrival of each patient transported by the EMS system unless directed otherwise by local protocol.

1. Requirements of a Medical Director

    a. This physician shall be approved to serve in this capacity by system (Off-Line) Medical Director.

    b. This physician shall have received education to the level of proficiency approved by the off-line Medical Director for proper provision of on-line medical direction, including communications equipment, operation and techniques.

    c. This physician shall be appropriately trained in pre-hospital protocols, familiar with the capabilities of the pre-hospital providers, as well as local EMS operational policies and regional critical care referral protocols.

    d. This physician shall have demonstrated knowledge and expertise in the pre-hospital care of critically ill and injured patients.

    e. This physician assumes responsibility for appropriate actions of the pre-hospital provider to the extent that the on-line physician is involved in patient care direction.

f. The on-line physician is responsible to the system Medical Director (off-line) regarding proper implementation of medical and system protocols.

g. The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

h. There must be – at all times - Medical direction with concurrent and retrospective oversight supervision; Standard Protocols; Continuing quality assurance, quality control, performance review, and when necessary, supplemental training.

104 AUTHORITY / CONTROL OF MEDICAL SERVICES

104.01 Authority for Control of Medical Services at the Scene of Medical Emergency.

1. Authority for patient management in a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

   a. When an advanced life support (ALS) squad, under medical direction, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction.

   b. The pre-hospital provider is responsible for the management of the patient and acts as the agent of medical direction.

104.02 Authority for Scene Management.

Authority for the management of the scene of a medical emergency shall be vested in appropriate public safety agencies. The scene of a medical emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious risks to life and health. Public safety personnel shall ordinarily consult emergency medical services personnel or other authoritative medical professionals at the scene in the determination of relevant risks.

104.03 Patient's Private Physician Present

The EMT should defer to the orders of the private physician. The base station should be contacted for record keeping purposes if on-line medical direction exists. The ALS squad's responsibility reverts back to medical direction or on-line medical direction at any time when the physician is no longer in attendance.

104.04 Intervener Physician Present and Non-Existent On-Line Medical Direction

1. When the intervener physician has satisfactorily identified himself as a licensed physician and has expressed his willingness to assume responsibility and document his intervention in a manner acceptable to the local emergency medical services system (EMSS); the pre-hospital provider should defer to the orders of the physician on the scene if they do not conflict with system protocol.

2. If treatment by the intervener physicians at the emergency scene differs from that outlined in a local protocol, the physician shall agree in advance to assume responsibility for care, including accompanying the patient to the hospital. In the event of a mass casualty incident or disaster, patient needs may require the intervener physician to remain at the scene.

104.05 Intervener Physician Present and Existent On-Line Medical Direction

1. If an intervener physician is present and on-line medical direction does exist the on-line physician should be contacted and the on-line physician is ultimately responsible.

2. The on-line physician has the option of managing the case entirely, working with the intervener physician, or allowing him to assume responsibility.

3. If there is any disagreement between the intervener physician and the on-line physician, the pre-hospital provider should take orders from the on-line physician and place the intervener physician in contact with on-line physician.

4. In the event the intervener physician assumes responsibility, all orders to the pre-hospital provider shall be repeated to the communication resource for purposes of record-keeping.

5. The intervener physician should document his intervention in a manner acceptable to the local EMS system.

6. The decision of the intervener physician to accompany the patient to the hospital should be make in consultation with the on-line physician. Nothing in this section implies that the pre-hospital provider CAN be required to deviate from system protocols.

105 COMMUNICATIONS

105.01 Communication Resource

1. A communication resource is an entity responsible for implementation of direct (on-line) medical control. This entity/facility shall be designated to participate in the EMS system according to a plan developed by the licensed ALS provider and approved by the system (off-line) medical director and the State Department of Health, BEMS.

    a. The communication resource shall assure adequate staffing for the communication equipment at all times by health care personnel who have achieved a minimal level of competence and skill and are approved by the system medical director.

    b. The communication resource shall assure that all requests for medical guidance assistance or advice by pre-hospital personnel will be promptly accommodated with an attitude of utmost participation, responsibility and cooperation.

    c. The communication resource shall provide assurance that they will cooperate with the EMS system in collecting and analyzing data necessary to evaluate the pre-hospital care program as long as patient confidentiality is not violated.

    d. The communication resource will consider the pre-hospital provider to be the agent of the on-line physician when they are in communication, regardless of any other employee/employer relationship.

    e. The communication resource shall assure that the on-line physicians will issue transportation instructions and hospital assignments based on system protocols and objective analysis of patient's needs and facility capability and proximity.

    f. No effort will be made to obtain institutional or commercial advantages through use of such transportation instructions and hospital assignments.

    g. When the communication resource is acting as an agent for another hospital, the information regarding patient treatment and expected time of arrival will be relayed to the receiving hospital in an accurate and timely fashion.

    h. Communication resource shall participate in regular case conferences involving the on-line physicians and pre-hospital personnel for purposes of problem identification and provide continuing education to correct any identified problems.

i. If the communication resource is located within a hospital facility, the hospital shall meet the requirements listed herein and the equipment used for on-line medical direction shall be located within the emergency department.

106 EDUCATION AND TRAINING

106.01 Educational Responsibilities

1. Because the on-line and off-line medical directors allow the use of their medical licenses, specific educational requirements should be established. This is not only to insure the best available care, but also to minimize liability. All personnel brought into the system must meet minimum criteria established by state law for each level; however, the law should in no way preclude a medical director from enforcing standards beyond this minimum.

2. Personnel may come to the system untrained (in which case the medical director will design and implement the educational program directly or through the use of ancillary instructors), or they may have previous training and/or experience. Although the Department of Transportation has defined curricula for training, the curricula are not standardized nationally, and often are not standardized within a state or county. Certification or licensure in one locale does not automatically empower an individual to function as an EMT within another system. The medical director must evaluate applicants trained outside the system in order to determine their level of competence. Such evaluation may be made in the form of written examinations, but should also include practical skills and a field internship with competent peers and time spent with the medical director.

3. The educational responsibilities of the medical director do not end with initial training; skills maintenance must be considered. To insure the knowledge does not stagnate, programs should cover all aspects of the initial training curriculum on a cyclical basis. Continuing education should comprise multiple formats, including lectures, discussions and case presentations, as well as practical situations that allow the EMT to be evaluated in action. The continuing education curriculum should also include topics suggested by audits, and should be utilized to introduce new equipment or skills.

   EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

107 REVIEW AND AUDIT

107.01 Review and Audit

Personnel may be trained to the highest standards and many protocols may be written, but if critical review is not performed, the level of patient care will deteriorate. Review is intended to determine inadequacies of the training program and inconsistencies in the protocols. The data base required includes pre-hospital care data, emergency department and inpatient (summary) data, and autopsy findings as appropriate. The cooperation of system administrators, hospital administrators, and local or state medical societies must be elicited. On occasion, the state legislature may be required to provide access to vital information.

The medical director or a designated person should audit pre-hospital run records, either randomly or inclusively. The data must be specifically evaluated for accuracy of charting and assessment; appropriateness of treatment; patterns of error, morbidity, and mortality; and need for protocol revision.

It cannot be assumed that all pre-hospital care will be supervised by on-line physicians. When proper or improper care is revealed by the audit process, prompt and appropriate praise or censorship should be provided by the medical director after consultation with the system administrator.

1. Individual Case Review.

    a. Compliance with system rules and regulations is most commonly addressed by state and regional EMS offices. Audit by individual case review requires a more detailed plan. Each of the components defined in detail by the individual EMS system must be agreed on prior to the institution of any case review procedures. Case review may involve medical audit, including reviews of morbidity and mortality data (outcome-oriented review), and system audit, including compliance with rules and regulations as well as adherence to protocols and standing orders (process-oriented review). The personnel to be involved in a given case review process should include the off-line medical director; emergency department and critical care nurses; and EMS, technical and other support personnel who were involved in the specific cases.

    b. The following must be written and agreed to in advance:

        i. Procedural guidelines of how the individuals will interact during meetings.

        ii. Because considerations of medical malpractice may be present when issues concerning appropriateness of care and compliance with guidelines are raised, legal advice for procedural guidelines

must be obtained prior to the institution of any medical audit program in order that medical malpractice litigation will neither result from nor become the subject of the meeting.

iii. Confidentiality of case review in terms of local open meeting laws and public access to medical records and their distribution.

iv. Format for recording the meeting and its outcome.

v. Access to overall system performance records, both current and historical, to allow comparison.

2. Overall outcome data (morbidity and mortality) and individual, unit-specific, and system-wide performance can be measured by the following means:

a. The severity of presentation of patients must be known, and a scale for that measurement must be agreed on, included in all EMT education, and periodically checked for reliability.

b. Appropriate treatment on scene and in transit should be recorded and subsequently evaluated for its effect on overall patient outcome.

c. At the emergency department, the severity of cases presenting (according to a severity scoring technique) and treatment needed should be recorded in detail.

d. An emergency department diagnosis and outcome in terms of admission to a general medical bed, critical care unit, or morgue must be known. The length of stay in the hospital, cost of stay, discharge status, and pathologic diagnosis should be made available.

APPENDIX 2 - PROTOCOLS

100 PROTOCOLS

100.01 General Provisions

Protocols are designed by the off-line (system) medical control system to provide a standardized approach to each commonly encountered patient problem. This provides a consistently defined level of pre-hospital care. When treatment is based on such protocols, the on-line physician assists the pre-hospital personnel in their interpretation of the patient's complaint, the findings of their evaluation, and the application of the appropriate treatment protocol. The process should be reviewed periodically in order to consider changing medical standards, new therapies, and data generated from audits of patient care.

In the realm of pre-hospital emergency medicine, there are a limited number of interventions to cover the myriad of problems that may be present. Although advanced life support may be skilled in many maneuvers, there are limitations on what they can accomplish in the pre-hospital setting. Basic life support personnel can do even less. The goal of pre-hospital care is to respond correctly and consistently.

Because the types of illnesses and inquiries commonly encountered in a given EMS system may be grouped into broad categories, protocols and standing orders may be established to help accomplish this goal. There are three major advantages to using protocols:

1. Pre-hospital personnel may be trained to respond to a given medical problem in a defined manner. Regardless of the weather, the hostility of the crowd, the immediate danger of any other outside stress, the pre-hospital personnel can consistently treat the problem in a defined manner with minimal chance of omission.

2. The EMS system will have a set standard by which care may be audited. The system and its successes or failures may be measured against consistent standards allowing for necessary change and improvement based on documented evidence, and not on the notion of this year's medical director or any other outside influence not based in fact and logic.

3. Protocols provide a standard of medical treatment for each patient problem so that individual variations necessary for nonroutine patient problems may have a context to aid the on-line physician in a complex treatment regimen.

100.02 Protocol Development

1. The development of protocols may include the following steps:

a. List the common illnesses and injuries that are currently encountered by the local EMS system. A chart review on a random basis for all months of the preceding year should suffice. All months are important, for there may be significant seasonal variations with particular illnesses or injuries.

b. This list must also include any life-threatening problems that can be affected positively in the pre-hospital setting, but that are not seen routinely (e.g., anaphylaxis, snake bite).

c. This list may be divided into two general categories-pediatric problems and adult problems-even though there will be duplication within these two lists. Asthma, seizures, trauma, and other illnesses and injuries are common to both groups, but the physical interventions and medications are sufficiently different to justify this separation.

d. Similar problems (e.g., cardiopulmonary, trauma, poisons/overdose, etc.) may be combined into groups.

e. Some problems that will not fit easily into groupings (e.g., hypothermia) may be listed separately or included in a miscellaneous group called "other."

f. In each of these groups, there will be common parameters, such as the ABCs, vital signs, history of the current illness/injury, medical history, and medications, allergy history.

g. For each of the problems within the group, additional parameters or interventions may be added to further reduce the patient's morbidity or mortality.

h. Additional treatments for special cases may be added to create a more specifically detailed protocol.

i. For a given region, the level of training of the pre-hospital personnel involved, the capabilities of the EMS response system as a whole, the capabilities of the receiving hospital and the medical opinion in the region must be considered before applying protocols synthesized outside the EMS system.

100.03 Protocol Implementation

Protocols are the responsibility of the medical director, who often delegates their development to a committee consisting of emergency physicians and other appropriate physicians. This committee implements the protocols, which reflect the currently optimal method for pre-hospital treatment of the defined problems. All levels of controllers, the medical director and off-line and on-line

physicians, must be cognizant of the adopted protocols, and must agree to function "by the book."

Discrepancies of disagreements that evolve should be brought back to the committee for consideration.

Pre-hospital personnel are then trained in the use of the protocols and held accountable through the audit and review process. Variance from protocol must be clearly documented and justified.

Consistently occurring variances, whether or not justified and documented, should induce review of that protocol. Even when no problems emerge, the committee should review all protocols at least annually in light of past experience and new medical insight.

APPENDIX 3 – EMS DRIVER TRANING PROGRAMS

100 EMS DRIVER TRAINING PROGRAMS

100.01 State Approval Process

Each EMS Driver Training Program must be formally approved by the Mississippi State Board of Health. The Mississippi EMS Advisory Council and the BEMS jointly reviews all proposals for BEMS training. Affirmative reviews are submitted as recommendations to the Board for adoption (state approval). All inquiries relative to EMS Driver Training and/or requests for state approval for the establishment of EMS Driver Training programs should be submitted in triplicate as follows:

1. Address

   Mississippi State Department of Health

   Bureau of Emergency Medical Services

   P.O. Box 1700

   Jackson, Mississippi 39215-1700

2. Format (application content)

   a. As governed by state regulations, all applications for the establishment of Emergency Medical Services Driver Training Programs must demonstrate adherence to the Department of Transportation's Training Program for Operation of Emergency Vehicles as a minimum. The skid pad requirement is not required. The proposal for training must include as a minimum the following requirements:

      i. Faculty profile - Provide names and resumes of all faculty (include instructor training obtained); indicate whether faculty are full-time, part-time, or consultants; and indicate those that are classroom vs. field preceptors.

      ii. Entry requirements - Taking all applicable state requirements into consideration, list all additional student selection criteria.

      iii. Class size - Indicate minimum and maximum numbers of students per class.

iv. Facilities - Name and describe all facilities used for classroom and field training.

v. Course Implementation - Provide copies of all instructor lesson plans; provide testing and evaluation of student competencies and skills.

vi. Budget - List sources of funds supporting the training program.

vii. Equipment - Identify equipment and training materials available.

APPENDIX 4 – EMS LAWS

100 SECTION 41 PUBLIC HEALTH – CHAPTER 23 – CONTAGIOUS DISEASES

100.01 §41-23-39. Definitions applicable to Section 41-23-41.

The following terms when used in Sections 41-23-39 and 41-23-41 shall have the following meanings herein ascribed:

a. "Emergency medical technician" means a person licensed pursuant to Section 41-59-1 et seq., Mississippi Code of 1972, to provide emergency medical services as an emergency medical technician-ambulance, emergency medical technical-intermediate, emergency medical technician-paramedic, or emergency medical technical-nurse-paramedic.

b. "Fire department" means service groups (paid or volunteer) that are organized and trained for the prevention and control of loss of life and property from fire and/or other emergencies.

c. "Fire fighter" means an individual who is assigned to fire fighting activity and is required to respond to alarms and perform emergency actions at the location of a fire, hazardous materials or other emergency incident.

d. "Infectious disease" means any condition as listed or determined by the State Department of Health that may be transmitted by an infected person.

e. "Licensed facility" means hospital, nursing home, medical clinic or dialysis center, as licensed by the state to provide medical care, but shall not include a physician's office.

f. "Bystander Caregiver" means any person who is unlicensed or noncertified in providing medical services or emergency medical services, who provides care or services to an injured person at the scene of an emergency before the arrival and rendering of emergency medical services by a licensed or certified emergency medical services provider.

SOURCES: Laws, 1988, ch. 557, § 6, eff from and after July 1, 1988.; Laws, 1998, ch. 316, § 1, eff from and after July 1, 1998.

100.02 §41-23-41. Emergency service provider notice of exposure to blood or body fluids; licensed facility duties regarding infectious disease.

If, in the course of providing emergency services to any person subsequently transported to a licensed facility, an emergency medical technician, fire fighter,

bystander care giver or other provider of emergency rescue services is exposed by direct contact to the patient's blood or other internal body fluids, the emergency medical technician, fire fighter, bystander care giver or the emergency service provider, or his/her employer, shall notify the licensed facility to which the patient is transported of the blood and/or body fluid exposure. If the patient is subsequently diagnosed as having an infectious disease specified by the State Department of Health as being transmissible by blood or other internal body fluids, the licensed facility shall notify the emergency medical technician, fire fighter, bystander care giver, emergency service provider, or his/her employer, in such detail and according to the manner prescribed by the State Board of Health in its regulations. The State Board of Health shall adopt appropriate regulations to address the diseases involved.

SOURCES: Laws, 1988, ch. 557, § 7; Laws, 1998, ch. 316 § 2, eff from and after July 1, 1998.

Cross references -

Definitions applicable to this section, see § 41-23-39.

Annotations -

Tort liability for infliction of venereal disease. 40 ALR4th 1089.

Products liability: what is an "unavoidably unsafe" product. 70 ALR4th 16.

100.03 §41-23-43. Vaccination Program for first responders who may be exposed to infectious diseases when sent to bioterrorism or disaster locations; definitions; participation in program; exemptions; vaccine shortages; notification of program; administration of vaccination program; program dependant upon receipt of federal funding.

As used in this section:

a. "Department" means the Mississippi State Department of Health, Bioterrorism Division;

b. "Director" means the Executive Director of the State Board of Health;

c. "Bioterrorism" means the intentional use of any microorganism, virus, infectious substance or biological product that may be engineered as a result of biotechnology or any naturally occurring or bioengineered component of any microorganism, virus, infectious substance or biological product, to cause or attempt to cause death, disease or other biological malfunction in any living organism;

d. "Disaster location" means any geographical location where a bioterrorism attack, terrorist attack, catastrophic or natural disaster or emergency occurs;

e. "First responders" means state and local law enforcement personnel, fire department personnel, emergency medical personnel, emergency management personnel, and public works personnel who may be deployed to bioterrorism attacks, terrorist attacks, catastrophic or natural disasters and emergencies.

The department shall offer a vaccination program for first responder who may be exposed to infectious diseases when deployed to disaster locations. The vaccinations shall include, but are not limited to, hepatitis A vaccination, hepatitis B vaccination, diptheria-tetanus vaccination, influenza vaccination, pneumococcal vaccination and other vaccinations when recommended by the United States Public Health Service and in accordance with Federal emergency Management Director's Policy. Immune globulin will be made available when necessary.

Participation in the vaccination program shall be voluntary by the first responders, except for first responders who are classified as having "occupational exposure" to blood borne pathogens as defined by the Occupational Safety and Health Administration Standard contained at 29 CFR 1910.10300 who shall be required to take the designated vaccinations or otherwise required by law.

A first responder shall be exempt from vaccinations when a written statement from a licensed physician is presented indicting that a vaccine is medically contraindicated for that person or the first responder signs a written statement that the administration of a vaccination conflicts with their religious tenets.

If there is a vaccine shortage, the director, in consultation with the Governor and the centers for Disease Control and Prevention, shall give priority for vaccination to first responders.

The department shall notify first responders to the availability of the vaccination program and shall provide educational materials on ways to prevent exposure to infectious diseases.

The department may contract with county and local health departments, not-for-profit home health care agencies, hospitals and physicians to administer a vaccination program for first responders.

This section shall be effective upon receipt of federal funding and/or federal grants for administering a first responder’s vaccination program. Upon receipt of that funding, the department shall make available the vaccines to first responders as provided in this section.

SOURCES: Laws, 2003, ch. 549, § 1, eff from and after July 1, 2003.

101 CHAPTER 55 PUBLIC AMBULANCE SERVICE

§41-55-1. Maintenance and operation of public ambulance service by political entities.

§41-55-2. Defrayal of cost of public ambulance service.

§41-55-3. Joint service by counties and municipalities; contracts; apportionment of ownership of property and costs of operation.

§41-55-5. Casualty and liability insurance in connection with ambulance service; partial waiver of immunity.

§41-55-7. Effect of existence of adequate private ambulance service; public subsidies.

§41-55-9. Maintenance and operation of ambulance service by certain hospitals.

§41-55-11. Minimum insurance coverage requirements of ambulance service operators; salver of immunity to extent of insurance.

Air Ambulance Service Districts

§41-55-31. Legislative declaration.

§41-55-33. Establishment of air ambulance service districts authorized; boundaries.

§41-55-35. Publication of notice of intention; election.

§41-55-37. Board of directors established; qualifications and term.

§41-55-39. Oath of office.

§41-55-41. Compensation.

§41-55-43. Officers; bond.

§41-55-45. Powers of district.

§41-55-47. Funds for support and maintenance of district.

§41-55-49. Payment to district of tax avails or appropriations; advances for preliminary expenses.

§41-55-51. Acceptance of funds from public or private sources; repayment.

§41-55-53. Deposit of funds.

§41-55-55. Additional counties may join.

§41-55-57. Rates for services.

102 PUBLIC AMBULANCE SERVICES BY GOVERNEMENTAL ENTITIES

102.01 §41-55-1. Maintenance and operation of public ambulance service by political entities.

The board of supervisors of any county and the governing authorities of any city, town, or any political subdivision thereof, either separately or acting in conjunction, in their discretion and upon finding that adequate public ambulance service would not otherwise be available, may own, maintain, and operate a public ambulance service as a governmental function, fix and collect charges therefore, and adopt, promulgate and enforce reasonable rules and regulations for the operation of said service. Any political subdivision, or parts thereof, acting hereunder may contract and otherwise cooperate with any department or agency of the United States government or the state of Mississippi, or any county, city, town, or supervisors district of the same, or other counties of the state of Mississippi in carrying out any of the power herein conferred or otherwise effectuating the purposes of sections 41-55-1 to 41-55-11 and in so doing accept gifts, money, and other property of whatever kind.

SOURCES: Codes, 1942, § 2997-21; Laws, 1968, ch. 290, § 1, eff from and after passage (approved July 19, 1968).

Cross references -

Effect of existence of adequate private ambulance service on contracts for public ambulance service, see § 41-55-7.

Operation and maintenance of ambulance service by public hospitals, see § 41-55-9.

Air ambulance service districts, see § 41-55-31 et seq.

Emergency medical services law, see § 41-59-1 et seq.

Advanced life support personnel and services, see § 41-60-11 et seq.

102.02 §41-55-2. Defrayal of cost of public ambulance service.

The board of supervisors of counties having a population of not more than twenty-two thousand (22,000) nor less than fifteen thousand (15,000) as shown by the 1970 federal census and having an assessed valuation in excess of Twenty Million Dollars ($20,000,000.00) in 1970 and being traversed by

Interstate Highway No. 55, may, in the discretion of the board, set aside, appropriate and expend moneys from the general fund to be used solely for defraying the cost of providing public ambulance service as authorized by Sections 41-55-1 through 41-55-11.

SOURCES: Codes, 1942, § 2997-21; Laws, 1972, ch. 462, §§ 1, 2; 1986, ch. 400, § 25, eff from and after October 1, 1986.

102.03 §41-55-3. Joint service by counties and municipalities; contracts, apportionment of ownership of property and costs of operation.

In acting jointly the board of supervisors of any such county acting for the county or supervisors district of the county, and the governing authorities of any city or town, acting for the city or town, are hereby authorized and empowered to contract with each other, for and on behalf of the political subdivisions or parts thereof which each represents, with respect to any and all things related to the matters and things authorized in sections 41-55-1 to 41-55-11, and particularly to apportion and prorate the ownership of the property acquired or to be acquired in such a joint undertaking, and to determine the proportionate part of the cost of maintenance, support and operation to be assumed by each.

SOURCES: Codes, 1942, § 2997-22; Laws, 1968, ch. 290, § 2, eff from and after passage (approved July 19, 1968).

Cross references -

As to emergency medical services law, see §§ 41-59-1 et seq.

102.04 §41-55-5. Casualty and liability insurance in connection with ambulance service; partial waiver of immunity.

The governing authority of or for any such political subdivision or part thereof shall have further power and authority to obtain insurance against casualty to the property used or useful in such public ambulance service.

SOURCES: Codes, 1942, § 2997-23; Laws, 1968, ch. 290, § 3; 1984, ch. 495, § 18, reenacted and amended, 1985, ch. 474, § 27; 1987, ch. 483, § 28; 1988, ch. 442, § 25; 1989, ch. 537, § 24; 1990, ch. 518, § 25; 1991, ch. 618, § 24, 1992, ch. 491, § 25, eff from and after passage (approved May 12, 1992).

Cross references -

Participation in a comprehensive plan of one or more policies of liability insurance procured and administered by the Department of Finance and Administration, see § 11-46-17.

Emergency medical services law, see §§ 41-59-1 et seq.

Annotations -

Liability of operator of ambulance service for personal injuries to person being transported. 68 ALR4th 14.

102.05 §41-55-7. Effect of existence of adequate private ambulance service; public subsidies.

If there is in operation an adequate privately run ambulance service, then the governing authorities are hereby prohibited from contracting for ambulance services to be run by the public body. The governing authorities may, however, subsidize such existing privately run ambulance service, in their discretion, if they deem necessary to keep such service in operation.

SOURCES: Codes, 1942, § 2997-25; Laws, 1968, ch. 290, § 5, eff from and after passage (approved July 19, 1968).

Cross references -

Emergency medical services law, see § 41-59-1 et seq.

102.06 §41-55-9. Maintenance and operation of ambulance service by certain hospitals.

In addition to other authority specifically conferred on it or arising by necessary implication, the board of commissioners or board of trustees of any hospital owned separately or jointly by one or more of such counties, cities, towns, or supervisors districts of the same or other such counties as defined in section 41-55-1 may, in its discretion and upon a finding that adequate ambulance service would not otherwise be available, own, operate, and maintain a public ambulance service as an integral part of its governmental function of operating and maintaining a hospital and, in so doing, shall possess and may exercise and enjoy the same authority, powers, rights, privileges and immunities with respect to the operation and maintenance of said service as it possesses and may exercise and enjoy with respect to the operation and maintenance to other departments of the hospital, including the right to fix and collect charges for such ambulance service, and to adopt, promulgate and enforce reasonable rules and regulations for the operation of said service.

In addition to the foregoing, the board of commissioners or board of trustees of any such public hospital may, in its discretion and upon a finding that adequate public ambulance service would not otherwise be available, either contract with the governing authority or authorities of one or more other such public hospitals, with the governing authority or authorities of one or more private nonprofit hospitals, or with the governing authorities of a combination of both types of hospitals as aforesaid, for the joint ownership, operation and maintenance of a public ambulance service. Moreover, the board of commissioners or board of trustees of any such public hospital, upon a further finding that it is necessary or expedient to do so, may, individually or jointly with the governing authority or

authorities of either or both types of hospitals as aforesaid, organize and participate in the ownership of a nonprofit corporation organized under the laws of the state of Mississippi for the specific purpose of providing public ambulance service. Any such contract and any such charter of incorporation shall include specific provisions for retaining majority control in the public hospital or hospitals involved, to preserve and protect the funds and property of the public hospital or hospitals involved and to provide for termination of the arrangement upon reasonable notice by the public hospital or hospitals.

SOURCES: Codes, 1942, § 2997-24; Laws, 1968, ch. 290, § 4, eff from and after passage (approved July 19, 1968).

Cross references -

Effect of existence of adequate private ambulance service on contracts for public ambulance service, see § 41-55-7.

102.07 §41-55-11. Repealed.

Repealed by its own terms by Laws, 1992, ch. 491 § 26, eff from and after October 1, 1993.

[Codes, 1942, § 2997-26; Laws, 1968, ch. 290, § 6, repealed, 1984, ch. 495, § 36, and repealed by 1984, 1st Ex Sess, ch. 8, § 3, reenacted and amended, 1985, ch. 474, § 43; 1986, ch. 438, § 28; 1987, ch. 483, § 29; 1988, ch. 442, § 26; 1989, ch. 537, § 25; 1990, ch. 518, § 26; 1991, ch. 618, § 25; 1992, ch. 491, § 26, eff from and after passage (approved May 12, 1992), and shall stand repealed from and after October 1, 1993.]

103 AIR AMBULANCE SERVICE DISTRICTS

103.01 §41-55-31. Legislative declaration.

It is hereby declared as a matter of legislative determination that deaths from highway traffic accidents have reached an alarming rate, that ambulance service is not readily available to many rural outposts in the state, that many deaths could be prevented if prompt medical attention were provided, and that the provision of air ambulance service would be for the general welfare of the entire population of the state.

SOURCES: Codes, 1942, § 2997-41; Laws, 1971, ch. 457, § 1, eff from and after passage (approved March 29, 1971).

Cross references -

Operation and maintenance of public ambulance service see § 41-55-1 et seq.

Aircraft for use of governor, state departments and agencies, see § 61-13-1 et seq.

103.02 §41-55-33. Establishment of air ambulance service districts authorized; boundaries.

The boards of supervisors of two or more counties are hereby authorized to act jointly in the establishment of an air ambulance service district by spreading upon their minutes by resolution their intention to create the district. The boundaries of the districts as they are established shall coincide with the nine districts of the Mississippi Highway Safety Patrol as constituted on March 29, 1971.

SOURCES: Codes, 1942, § 2997-42; Laws, 1971, ch. 457, § 2, eff from and after passage (approved March 29, 1971).

Cross references -

Emergency medical services law, see § 41-59-1 et seq.

State highway safety patrol, see § 45-3-1 et seq.

103.03 §41-55-35. Publication of notice of intention; election.

Notice of the intention to create an air ambulance service district shall be published at least three times during a period of twenty-one days in one newspaper circulated in the county in which shall be stated the counties cooperating to create the district, the date the district shall be created, and the purpose of the district. If twenty percent of one thousand five hundred of the qualified electors of said county shall file a written protest against the creation of said district on or before the date specified in such resolution then an election on the question of said county joining said district shall be called and held as provided by law. The determination of said issue shall be determined by a majority of the qualified electors voting in said election.

SOURCES: Codes, 1942, § 2997-43; Laws, 1971, ch. 457, § 3, eff from and after passage (approved March 29, 1971).

103.04 §41-55-37. Board of directors established; qualifications and term.

When the governor shall have received at least two such resolutions from any one air ambulance service district, he shall within five days appoint from the district-at-large his one member of the board of directors of the district. Thereafter the board of supervisors of each county in the district which has certified to its joinder in the district shall appoint one resident of its county as its member of the board of directors of the district. The appointee may by vocation be related to the hospital or medical fields or engaged in an ambulance service but all appointments shall not be limited to persons with such backgrounds. The

term of each member shall coincide with that of the appointing official, so that after the initial appointment the terms shall be for a period of four years.

SOURCES: Codes, 1942, § 2997-44; Laws, 1971, ch. 457, § 4, eff from and after passage (approved March 29, 1971).

103.05 §41-55-39. Oath of office.

Each director of an air ambulance service district shall take and subscribe to the general oath of office, required by Section 268 of the Constitution of the State of Mississippi, before a chancery clerk that he will faithfully discharge the duties of the office, which oath shall be filed with the said clerk and by him preserved.

SOURCES: Codes, 1942, § 2997-45; Laws, 1971, ch. 457, § 5, eff from and after passage (approved March 29, 1971).

103.06 §41-55-41. Compensation.

If compensation is to be paid to any member of the board of directors of an air ambulance service district, it shall be paid by the district from any funds available. In no event shall such compensation exceed the sum of twenty-two dollars and fifty cents ($22.50) per day.

SOURCES: Codes, 1942, § 2997-46; Laws, 1971, ch. 457, § 6, eff from and after passage (approved March 29, 1971).

103.07 §41-55-43. Officers; bond.

The board of directors of an air ambulance service district shall annually elect from its number a president and a vice president of the district, and such other officers as in the judgment of the board are necessary. The president shall be the chief executive officer of the district and the presiding officer of the board, and shall have the same right to vote as any other director. The vice president shall perform all duties and exercise all powers conferred by sections 41-55-31 to 41-55-57 upon the president when the president is absent or fails or declines to act, except the president's right to vote. The board shall also appoint a secretary and a treasurer who may or may not be members of the board, and it may combine these officers.

The treasurer shall give bond in the sum of not less than fifty thousand dollars ($50,000.00) as set by the board of directors, and each director may be required to give bond in the sum of not less than ten thousand dollars ($10,000.00), with sureties qualified to do business in the state. The premiums on said bonds shall be an expense of the district. The condition of each such bond shall be that the treasurer or directors will faithfully perform all duties of their offices and account for all money or other assets which shall come into his custody as treasurer or director of the district.

SOURCES: Codes, 1942, § 2997-47; Laws, 1971, ch. 457, § 7, eff from and after passage (approved March 29, 1971).

103.08 §41-55-45. Powers of district.

Any air ambulance service district, through its board of directors, is hereby empowered:

a. To develop, in conjunction with the head of any federal and/or state agency as may be involved, a plan for air ambulance services to persons within or without the district, including communications and other systems incident to the efficient performance of such services.

b. To acquire and maintain any equipment necessary for the provision of such services.

c. To set reasonable rates for services and charge for each ambulance call made.

d. To establish rules and regulations for the use of air ambulance services both within and without the boundaries of the district, including cooperation with other air ambulance district organizations within the state and other emergency service agencies, including ground ambulances.

e. To employ professional managerial, technical, and clerical help as may be needed in providing air ambulance services.

f. To enter into agreements with ground ambulance facilities.

g. To borrow, acting by and through the boards of supervisors of the individual counties comprising the district, a sum of money in anticipation of the revenue to be received from taxes levied by such counties for the support of the district; the boards of supervisors in so doing shall follow the requirements of section 19-9-27.

h. To make contracts and to execute instruments necessary or convenient to the exercise of the powers, rights, privileges, and functions conferred upon it by sections 41-55-31 to 41-55-57.

i. To make, or cause to be made, surveys and engineering investigations relating to the project, or related projects, for the information of the district, to facilitate the accomplishment of the purposes for which it is created.

j. To apply for and accept grants from the United States of America, or from any corporation or agency created or designated by the United States of America, and to ratify and accept applications heretofore or

hereafter made by voluntary associations to such agencies for grants to construct, maintain or operate any project or projects.

k. To do any and all other acts or things necessary, requisite or convenient to the exercising of the powers, rights, privileges or functions conferred upon it by sections 41-55-31 to 41-55-57 or any act of law. 47

In addition to the powers set forth in subsection (1), the board of directors of any air ambulance service district is further authorized and empowered to exercise all powers conferred upon the governing boards of emergency medical service districts under the provisions of the Emergency Medical Services Act of 1974 and amendments thereto.

SOURCES: Codes, 1942, § 2997-48; Laws, 1971, ch. 457, § 8; 1972, ch. 416, § 1; 1975, ch. 427, eff from and after passage (approved March 27, 1975).

Cross references -

Public ambulance services, generally, see § 41-55-1 et seq.

Tax levy for air ambulance service, see § 41-55-47.

Determination of reasonable rates for services, see § 41-55-57.

Emergency medical services law, see § 41-59-1 et seq.

103.09 <u>§41-55-47. Funds for support and maintenance of districts.</u>

The board of supervisors of any county of the state which becomes a part of an air ambulance service district may levy a county-wide tax for the support and maintenance of the district in an amount not to exceed one (1) mill. Any county which desires to become a part of an air ambulance service district shall levy each year a tax of not less than one-half (½) mill on all taxable property of the county for the support and maintenance of the district or such county will not be qualified to become or remain a part of the district, with the exception that should any county desire to appropriate an equivalent sum from the general fund or other available funds of the county, as provided in Section 41-55-49, the levying of the tax shall not be mandatory.

Should the board of directors of any air ambulance service district determine that a tax levy of less than one-half (½) mill on the properties comprising the district would be sufficient to maintain and operate the district for the forthcoming fiscal year, such determination shall, by resolution, be spread, upon the minutes of the board of directors, which resolution shall recite the amount of the tax levy which would suffice. A certified copy of such resolution shall be delivered to the clerk of the board of supervisors of the counties affected thereby. When so done, the board of supervisors of the counties comprising the

district may for the forthcoming year levy a tax of no less than the amount of levy declared to be sufficient in such resolution without losing their qualification as members of the district.

Any tax levy made under the provisions of this section shall be used exclusively for the support and maintenance of the district and shall be made by the boards of supervisors at the time and in the manner that other county tax levies are made. The revenue provided by this section shall not, under any circumstances, be commingled with other county funds.

SOURCES: Codes, 1942, §§ 2997-49, 2997-56, Laws, 1971, ch. 457, §§ 9, 16; 1986, ch. 400, § 26; Laws, 1998, ch. 527, § 1, eff from and after passage (approved April 6, 1998).

Cross reference -

Homestead exemptions, see §§ 27-33-1 et seq.

Local ad valorem tax levies, see §§ 27-39-301 et seq.

Financial contribution requirement for county to join existing air ambulance service district may not exceed amount authorized by this section, see § 41-55-55.

103.10 §41-55-49. Payment to district of tax avails or appropriations; advances for preliminary expenses.

The board of supervisors of each county becoming a member of an air ambulance service district shall annually, on or before March 15 of each year beginning with the calendar year in which the district is created, pay or cause to be paid to the depository of the district the total avails from the tax levied on all of the taxable property within the county for the purpose of supporting the district. Such payments shall be made and continued as long as the district remains in existence, there is need therefore and the county remains a part thereof. The board of supervisors of each county shall annually provide the district the total avails from tax levied on all taxable property within the county for such purpose; in lieu of a tax levy the board of supervisors may appropriate an equivalent sum from the general fund or other available funds of the county.

Any municipality or county which is within the territorial limits of the district may advance funds to the district to pay the preliminary expenses of the district, including reports, organization or administration expenses, on such terms or repayment as the governing body of such municipality or county shall determine.

SOURCES: Codes, 1942, § 2997-50; Laws, 1971, ch. 457, § 10, eff from and after passage (approved March 29, 1971).

Cross references -

Depository of district funds, see § 41-55-53.

103.11 §41-55-51. Acceptance of funds from public or private sources; repayment.

The board of directors of an air ambulance service district is hereby authorized and empowered to accept grants, loans, gifts, bequests or funding from any source, public or private, that the granting agency has authority to provide, but in no circumstances shall the acceptance of any such funding obligate any district to repay a sum in excess of the avails of the tax levies set forth in section 41-55-47.

SOURCES: Codes, 1942, § 2997-52; Laws, 1971, ch. 457, § 11, eff from and after passage (approved March 29, 1971).

103.12 §41-55-53. Deposit of funds.

All funds of an air ambulance service district shall be deposited in the bank or banks located within the district qualified as county or state depositories which the board of directors of the district desire to utilize.

SOURCES: Codes, 1942, § 2997-42; Laws, 1971, ch. 457, § 12, eff from and after passage (approved March 29, 1971).

Cross references -

State depositories, see § 27-105-1 et seq.

Depositories for funds of local governments, see § 27-105-301 et seq.

103.13 §41-55-55. Additional counties may join.

After an air ambulance service district has been formed, any other county within the same highway patrol district or any county lying immediately adjacent to said district may join the district by the same procedure as if it were initiating the district, including the appointment of an additional member of the existing board of directors.

After a district has been in existence for at least fifteen (15) years, a county may join the district only with the approval of the board of directors of the district after the board of directors first finds that the services to the new member county will not result in an undue financial burden upon the district. The board of directors of the district may establish guidelines for the admission of new member counties but may not require a financial contribution in excess of that authorized by Section 41-55-47, Mississippi Code of 1972.

SOURCES: Codes, 1942, § 2997-53; Laws, 1971, ch. 457, § 13; 1972, ch. 416, § 2; 1993, ch. 372, § 1, eff from and after July 1, 1993.

103.14 §41-55-57. Rates for services.

The rates for services hereunder shall be determined by the board of directors with regard to what is reasonable in the individual air ambulance service district.

SOURCES: Codes, 1942, § 2997-54; Laws, 1971, ch. 457, § 14, eff from and after passage (approved March 29, 1971).

Cross references -

Power of district board of directors to set reasonable rates for services, see § 41-55-45.

104 CHAPTER 59 EMERGENCY MEDICAL SERVICES

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41-59-73. [Repealed].

104.01 §41-59-1. Title.

This chapter shall be cited as the "Emergency Medical Services Act of 1974."

SOURCES: Laws, 1974, ch. 507, § 1, eff from and after passage (approved April 3, 1974).

Cross references -

Public ambulance service law, see § 41-55-1 et seq.

Advanced life support personnel and services, see § 41-60-11, 41-60-13.

104.02 41-59-3..Definitions [Repealed effective July 1, 2011].

As used in this chapter, unless the context otherwise requires, the term:

(a) "Ambulance" means any privately or publicly owned land or air vehicle that is especially designed, constructed, modified or equipped to be used, maintained and operated upon the streets, highways or airways of this state to assist persons who are sick, injured, wounded, or otherwise incapacitated or helpless;

(b) "Permit" means an authorization issued for an ambulance vehicle and/or a special use EMS vehicle as meeting the standards adopted under this chapter;

(c) "License" means an authorization to any person, firm, corporation, or governmental division or agency to provide ambulance services in the State of Mississippi;

(d) "Emergency medical technician" means an individual who possesses a valid emergency medical technician's certificate issued under the provisions of this chapter;

(e) "Certificate" means official acknowledgment that an individual has successfully completed (i) the recommended basic emergency medical technician training course referred to in this chapter which entitles that individual to perform the functions and duties of an emergency medical technician, or (ii) the recommended medical first responder training course referred to in this chapter which entitles that individual to perform the functions and duties of a medical first responder;

(f) "Board" means the State Board of Health;

(g) "Department" means the State Department of Health, Division of Emergency Medical Services;

(h) "Executive officer" means the Executive Officer of the State Board of Health, or his designated representative;

(i) "First responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons;

(j) "Medical first responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons who (i) is trained to assist other EMS personnel by successfully completing, and remaining current in refresher training in accordance with, an approved "First Responder: National Standard Curriculum" training program, as developed and promulgated by the United States Department of Transportation, (ii) is nationally registered as a first responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a medical first responder by the State Department of Health, Division of Emergency Medical Services;

(k) "Invalid vehicle" means any privately or publicly owned land or air vehicle that is maintained, operated and used only to transport persons routinely who are convalescent or otherwise non-ambulatory and do not require the service of an emergency medical technician while in transit;

(l) "Special use EMS vehicle" means any privately or publicly owned land, water or air emergency vehicle used to support the provision of emergency medical services. These vehicles shall not be used routinely to transport patients;

(m) "Trauma care system" or "trauma system" means a formally organized arrangement of health care resources that has been designated by the department by which major trauma victims are triaged, transported to and treated at trauma care facilities;

(n) "Trauma care facility" or "trauma center" means a hospital located in the State of Mississippi or a Level I trauma care facility or center located in a state contiguous to the State of Mississippi that has been designated by the department to perform specified trauma care services within a trauma care system pursuant to standards adopted by the department;

(o) "Trauma registry" means a collection of data on patients who receive hospital care for certain types of injuries. Such data are primarily designed to ensure quality trauma care and outcomes in individual institutions and trauma systems, but have the secondary purpose of providing useful data for the surveillance of injury morbidity and mortality;

(p) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably

expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(q) "Emergency medical call" means a situation that is presumptively classified at time of dispatch to have a high index of probability that an emergency medical condition or other situation exists that requires medical intervention as soon as possible to reduce the seriousness of the situation, or when the exact circumstances are unknown, but the nature of the request is suggestive of a true emergency where a patient may be at risk;

(r) "Emergency response" means responding immediately at the basic life support or advanced life support level of service to an emergency medical call. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call;

(s) "Emergency mode" means an ambulance or special use EMS vehicle operating with emergency lights and warning siren (or warning siren and air horn) while engaged in an emergency medical call.

Sources: Laws, 1974, ch. 507, § 2; Laws, 1991, ch. 482, § 1; Laws, 1998, ch. 429, § 1; Laws, 2000, ch. 594, § 1; Laws, 2002, ch. 623, § 1; brought forward without change, Laws, 2002, 1st Ex Sess, ch. 3, § 1; Laws, 2004, ch. 425, § 1; Laws, 2004, ch. 581, § 1; Laws, 2008, ch. 549, § 1, eff from and after July 1, 2008.

104.03 <u>§41-59-5. Establishment and administration of program[Repealed effective July1, 2011].</u>

(1) The State Board of Health shall establish and maintain a program for the improvement and regulation of emergency medical services (hereinafter EMS) in the State of Mississippi. The responsibility for implementation and conduct of this program shall be vested in the State Health Officer of the State Board of Health along with such other officers and boards as may be specified by law or regulation.

(2) The board shall provide for the regulation and licensing of public and private ambulance service, inspection and issuance of permits for ambulance vehicles, training and certification of EMS personnel, including drivers and attendants, the development and maintenance of a statewide EMS records program, development and adoption of EMS regulations, the coordination of an EMS communications system, and other related EMS activities.

(3) The board is authorized to promulgate and enforce such rules, regulations and minimum standards as needed to carry out the provisions of this chapter.

(4) The board is authorized to receive any funds appropriated to the board from the Emergency Medical Services Operating Fund created in Section 41-59-61 and is further authorized, with the Emergency Medical Services Advisory Council acting in an advisory capacity, to administer the disbursement of such funds to the counties, municipalities and organized emergency medical service districts and the utilization of such funds by the same, as provided in Section 41-59-61.

(5) The department acting as the lead agency, in consultation with and having solicited advice from the EMS Advisory Council, shall develop a uniform non-fragmented inclusive statewide trauma care system that provides excellent patient care. It is the intent of the Legislature that the purpose of this system is to reduce death and disability resulting from traumatic injury, and in order to accomplish this goal it is necessary to assign additional responsibilities to the department. The department is assigned the responsibility for creating, implementing and managing the statewide trauma care system. The department shall be designated as the lead agency for trauma care systems development. The department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma Care System Plan, trauma system standards, trauma center designations, field triage, interfacility trauma transfer, EMS aero medical transportation, trauma data collection, trauma care system evaluation and management of state trauma systems funding. The department shall promulgate regulations specifying the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma care system, or which participate at a level lower than the level at which they are capable of participating. The department shall promulgate rules and regulations necessary to effectuate this provision by September 1, 2008, with an implementation date of September 1, 2008. The department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma Care System Plan and all associated trauma care system regulations necessary to implement the Mississippi trauma care system. The department shall cause the implementation of both professional and lay trauma education programs. These trauma educational programs shall include both clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the department shall coordinate the development of the inclusive trauma system with the Mississippi Department of Rehabilitation Services and all other appropriate rehabilitation systems.

(6) The State Board of Health is authorized to receive any funds appropriated to the board from the Mississippi Trauma Care System Fund created in Section 41-59-75. It is further authorized, with the Emergency Medical Services Advisory Council and the Mississippi Trauma Advisory Committee acting in advisory

capacities, to administer the disbursements of those funds according to adopted trauma care system regulations. Any Level I trauma care facility or center located in a state contiguous to the State of Mississippi that participates in the Mississippi trauma care system and has been designated by the department to perform specified trauma care services within the trauma care system under standards adopted by the department shall receive a reasonable amount of reimbursement from the department for the cost of providing trauma care services to Mississippi residents whose treatment is uncompensated.

(7) In addition to the trauma-related duties provided for in this section, the Board of Health shall develop a plan for the delivery of services to Mississippi burn victims through the existing trauma care system of hospitals. Such plan shall be operational by July 1, 2005, and shall include:

(a) Systems by which burn patients will be assigned or transferred to hospitals capable of meeting their needs;

(b) Until the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 1 of this act is operational, procedures for allocating funds appropriated from the Mississippi Burn Care Fund to hospitals that provide services to Mississippi burn victims; and

(c) Such other provisions necessary to provide burn care for Mississippi residents, including reimbursement for travel, lodging, if no free lodging is available, meals and other reasonable travel-related expenses incurred by burn victims, family members and/or caregivers, as established by the State Board of Health through rules and regulations.

After the Mississippi Burn Center established at the University of Mississippi Medical Center under Section 37-115-45 is operational, the Board of Health shall revise the plan to include the Mississippi Burn Center.

Sources: Laws, 1974, ch. 507, § 3; Laws, 1982, ch. 344, § 2; Laws, 1989, ch. 545, § 1; Laws, 1991, ch. 597, § 1; Laws, 1992, ch. 491 § 27; Laws, 1998, ch. 429, § 2; Laws, 2005, 2nd Ex Sess, ch. 47, § 8; Laws, 2007, ch. 569, § 8; Laws, 2008, ch. 549, § 2, eff from and after July 1, 2008.

104.04 <u>§41-59-7. Advisory council [Repealed effective July 1, 2011].</u>

(1) There is created an emergency medical services advisory council to consist of the following members who shall be appointed by the Governor:

(a) One (1) licensed physician to be appointed from a list of nominees presented by the Mississippi Trauma Committee, American College of Surgeons;

(b) One (1) licensed physician to be appointed from a list of nominees who are actively engaged in rendering emergency medical services presented by the Mississippi State Medical Association;

(c) One (1) registered nurse whose employer renders emergency medical services, to be appointed from a list of nominees presented by the Mississippi Nurses Association;

(d) Two (2) hospital administrators who are employees of hospitals which provide emergency medical services, to be appointed from a list of nominees presented by the Mississippi Hospital Association;

(e) Two (2) operators of ambulance services;

(f) Three (3) officials of county or municipal government;

(g) One (1) licensed physician to be appointed from a list of nominees presented by the Mississippi Chapter of the American College of Emergency Physicians;

(h) One (1) representative from each designated trauma care region, to be appointed from a list of nominees submitted by each region;

(i) One (1) registered nurse to be appointed from a list of nominees submitted by the Mississippi Emergency Nurses Association;

(j) One (1) EMT-Paramedic whose employer renders emergency medical services in a designated trauma care region;

(k) One (1) representative from the Mississippi Department of Rehabilitation Services;

(l) One (1) member who shall be a person who has been a recipient of trauma care in Mississippi or who has an immediate family member who has been a recipient of trauma care in Mississippi;

(m) One (1) licensed neurosurgeon to be appointed from a list of nominees presented by the Mississippi State Medical Association;

(n) One (1) licensed physician with certification or experience in trauma care to be appointed from a list of nominees presented by the Mississippi Medical and Surgical Association; and

(o) One (1) representative from the Mississippi Firefighters Memorial Burn Association, to be appointed by the association's governing body.

The terms of the advisory council members shall begin on July 1, 1974. Four (4) members shall be appointed for a term of two (2) years, three (3) members shall be appointed for a term of three (3) years, and three (3) members shall be appointed for a term of four (4) years. Thereafter, members shall be appointed for a term of four (4) years. The executive officer or his designated representative shall serve as ex officio chairman of the advisory council.

Advisory council members may hold over and shall continue to serve until a replacement is named by the Governor.

The advisory council shall meet at the call of the chairman at least annually. For attendance at such meetings, the members of the advisory council shall be reimbursed for their actual and necessary expenses including food, lodging and mileage as authorized by law, and they shall be paid per diem compensation authorized under Section 25-3-69.

The advisory council shall advise and make recommendations to the board regarding rules and regulations promulgated pursuant to this chapter.

(2) There is created a committee of the Emergency Medical Services Advisory Council to be named the Mississippi Trauma Advisory Committee (hereinafter "MTAC"). This committee shall act as the advisory body for trauma care system development and provide technical support to the department in all areas of trauma care system design, trauma standards, data collection and evaluation, continuous quality improvement, trauma care system funding, and evaluation of the trauma care system and trauma care programs. The membership of the Mississippi Trauma Advisory Committee shall be comprised of Emergency Medical Services Advisory Council members appointed by the chairman.

Sources: Laws, 1974, ch. 507, § 4; Laws, 1983, ch. 522, § 37; Laws, 1986, ch. 363; Laws, 1998, ch. 429, § 3; Laws, 2008, ch. 325, § 1; Laws, 2008, ch. 549, § 3, eff from and after July 1, 2008.

104.05 <u>§41-59-9. License and permit required.</u>

From and after October 1, 1974, no person, firm, corporation, association, county, municipality, or metropolitan government or agency, either as owner, agent or otherwise, shall hereafter furnish, operate, conduct, maintain, advertise or otherwise engage in the business of service of transporting patients upon the streets, highways or airways of Mississippi unless he holds a currently valid license and permit, for each ambulance, issued by the board.

SOURCES: Laws, 1974, ch. 507, § 5(1), eff from and after passage (approved April 3, 1974).

104.06 <u>§41-59-11. Application for license.</u>

Application for license shall be made to the board by private firms or nonfederal governmental agencies. The application shall be made upon forms in accordance with procedures established by the board and shall contain the following:

a. The name and address of the owner of the ambulance service or proposed ambulance service;

b. The name in which the applicant is doing business or proposes to do business;

c. A description of each ambulance including the make, model, year of manufacturer, motor and chassis numbers, color scheme, insignia, name, monogram, or other distinguishing characteristics to be used to designate applicant's ambulance;

d. The location and description of the place or places from which the ambulance service is intended to operate; and

e. Such other information as the board shall deem necessary.

Each application for a license shall be accompanied by a license fee to be fixed by the board, which shall be paid to the board

SOURCES: Laws, 1974, ch. 507, § 5(2); 1979, ch. 445, § 1; 1982, ch. 345, § 1; 1991, ch. 606, § 3, eff from and after July 1, 1991.

104.07 <u>§41-59-13. Issuance of license.</u>

The board shall issue a license which shall be valid for a period of one (1) year when it determines that all the requirements of this chapter have been met.

SOURCES: Laws, 1974, ch. 507, § 5(3), eff from and after passage (approved April 3, 1974).

104.08 <u>§41-59-15. Periodic inspections.</u>

Subsequent to issuance of any license, the board shall cause to be inspected each ambulance service, including ambulances, equipment, personnel, records, premises and operational procedures whenever such inspection is deemed necessary, but in any event not less than two (2) times each year. The periodic inspection herein required shall be in addition to any other state or local safety or motor vehicle inspections required for ambulances or other motor vehicles provided by law or ordinance.

SOURCES: Laws, 1974, ch. 507, § 5(4), eff from and after passage (approved April 3, 1974)

104.09 <u>§41-59-17. Suspension or revocation of license; renewal.</u>

The board is hereby authorized to suspend or revoke a license whenever it determines that the holder no longer meets the requirements prescribed for operating an ambulance service.

A license issued under this chapter may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board. Renewal of any

license issued under the provisions of this chapter shall require conformance with all the requirements of this chapter as upon original licensing.

SOURCES: Laws, 1974, ch. 507, § 5(5, 6); 1979, ch. 445, § 2; 1982, ch. 345, § 2; 1991, ch. 606, § 4, eff from and after July 1, 1991.

104.10 §41-59-19. Changes of ownership.

The board is authorized to provide for procedures to be utilized in acting on changes of ownership in accordance with regulations established by the board.

SOURCES: Laws, 1974, ch. 507, § 5(7), eff from and after passage (approved April 3, 1974).

104.11 §41-59-21. Licensee to conform with local laws or regulations.

The issuance of a license shall not be construed to authorize any person, firm, corporation or association to provide ambulance services or to operate any ambulance not in conformity with any ordinance or regulation enacted by any county, municipality or special purpose district or authority.

SOURCES: Laws, 1974, ch. 507, § 5(8), eff from and after passage (approved April 3, 1974).

104.12 §41-59-23. Ambulance permit.

Before a vehicle can be operated as an ambulance, its licensed owner must apply for and receive an ambulance permit issued by the board for such vehicle. Application shall be made upon forms and according to procedures established by the board. Each application for an ambulance permit shall be accompanied by a permit fee to be fixed by the board, which shall be paid to the board. Prior to issuing an original or renewal permit for an ambulance, the vehicle for which the permit is issued shall be inspected and a determination made that the vehicle meets all requirements as to vehicle design, sanitation, construction, medical equipment and supplies set forth in this chapter and regulations promulgated by the board. Permits issued for ambulance shall be valid for a period not to exceed one (1) year.

The board is hereby authorized to suspend or revoke an ambulance permit any time it determines that the vehicle and/or its equipment no longer meets the requirements specified by this chapter and regulations promulgated by the board.

The board may issue temporary permits valid for a period not to exceed ninety (90) days for ambulances not meeting required standards when it determines the public interest will thereby be served.

When a permit has been issued for an ambulance as specified herein, the ambulance records relating to maintenance and operation of such ambulance shall be open to inspection by a duly authorized representative of the board during normal working hours.

An ambulance permit issued under this chapter may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board. Renewal of any ambulance permit issued under the provisions of this chapter shall require conformance with all requirements of this chapter.

SOURCES: Laws, 1974, ch. 507, § 6; 1979, Ch. 445, § 3; 1982, ch. 345, Section 3; 1991, ch. 606, Section 5, eff from and after July 1, 1991.

104.13 <u>§41-59-25. Standards for ambulance vehicles.</u>

Standards for the design, construction, equipment, sanitation and maintenance of ambulance vehicles shall be developed by the board with the advice of the advisory council. Each standard may be revised as deemed necessary by the board when it determines, with the advice of the advisory council, which such will be in the public interest. However, standards for design and construction shall not take effect until July 1, 1979; and such standards when promulgated shall substantially conform to any pertinent recommendations and criteria established by the American College of Surgeons and the National Academy of Sciences, and shall be based on a norm that the ambulance shall be sufficient in size to transport one (1) litter patient and an emergency medical technician with space around the patient to permit a technician to administer life supporting treatment to at least one (1) patient during transit.

On or after July 1, 1975, each ambulance shall have basic equipment determined essential by the board with the advice of the advisory council.

Standards governing the sanitation and maintenance of ambulance vehicles shall require that the interior of the vehicle and the equipment therein be maintained in a manner that is safe, sanitary, and in good working order at all times.

Standards for the design, construction, equipment and maintenance of special use EMS vehicles shall be developed by the board with advice of the advisory council.

SOURCES: Laws, 1974, ch. 507, § 7(1-3); 1991, ch. 482, § 2, eff from and after July 1, 1991.

Cross references -

Definition of authorized emergency vehicles, see § 63-3-103.

Lights required on emergency vehicles, see § 63-7-19.

104.14 §41-59-27. Insurance.

There shall be at all times in force and effect on any ambulance vehicle operating in this state insurance issued by an insurance company licensed to do business in this state, which shall provide coverage:

(a) For injury to or death of individuals resulting from any cause for which the owner of said ambulance would be liable regardless of whether the ambulance was being driven by the owner or his agent; and

(b) Against damage to the property of another, including personal property.

The minimum amounts of such insurance coverage shall be determined by the board with the advice of the advisory council, except that the minimum coverage shall not be less than twenty-five thousand dollars ($25,000.00) for bodily injury to or death of one (1) person in any one (1) accident, fifty thousand dollars ($50,000.00) for bodily injury to or death of two (2) or more persons in any one (1) accident, and ten thousand dollars ($10,000.00) for damage to or destruction of property of others in any one (1) accident.

SOURCES: Laws, 1974, ch. 507, § 7(4), eff from and after passage (approved April 3, 1974).

Annotations -

Liability of operator of ambulance service for personal injuries to person being transported. 21 ALR2d 910.

104.15 §41-59-29. Personnel required for transporting patients.

From and after January 1, 1976, every ambulance, except those specifically excluded from the provisions of this chapter, when transporting patients in this state, shall be occupied by at least one (1) person who possesses a valid emergency medical technician state certificate or medical/nursing license and a driver with a valid resident driver's license.

SOURCES: Laws, 1974, ch. 507, § 8(1), eff from and after passage (approved April 3, 1974).

104.16 §41-59-31. Emergency medical technicians; training program.

The board shall develop an emergency medical technicians training program based upon the nationally approved United States Department of Transportation "Basic Training Program for Emergency Medical Technicians - Ambulance" prepared in compliance with recommendations of the National Academy of Sciences. The program shall be periodically revised by the board to meet new and changing needs.

SOURCES: Laws, 1974, ch. 507 § 8(2), eff from and after passage (approved April 3, 1974).

104.17 §41-59-33. Emergency medical technicians; certification.

Any person desiring certification as an emergency medical technician shall apply to the board using forms prescribed by the board. Each application for an emergency medical technician certificate shall be accompanied by a certificate fee to be fixed by the board, which shall be paid to the board. Upon the successful completion of the board's approved emergency medical technical training program, the board shall make a determination of the applicant's qualifications as an emergency medical technician as set forth in the regulations promulgated by the board, and shall issue an emergency medical technician certificate to the applicant.

SOURCES: Laws, 1974, ch. 507, § 8(3); 1979, ch. 445, § 4; 1982, ch. 345, Section 4, 1991, ch. 606, § 6, eff from and after July 1, 1991.

104.18 §41-59-35. Emergency medical technicians; period of certification; renewal, suspension or revocation of certificate; use of certain EMT titles without certification prohibited.

1. An emergency medical technician certificate so issued shall be valid for a period not exceeding two (2) years from the date of issuance and may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board, provided that the holder meets the qualifications set forth in this Chapter 59 and Chapter 60 and rules and regulations promulgated by the board.

2. The board is authorized to suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

3. It shall be unlawful for any person, corporation or association to, In any manner, represent himself or itself as an Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver, or use in connection with his or its name the words or letters of EMT, EMT, paramedic, or any other letters, words, abbreviations or insignia which would indicate or imply that he or it is a Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver, unless certified in accordance with Chapters 59 and 60 of this title and is in accordance with the rules and regulations promulgated by the board. It is unlawful to employ any uncertified Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, or Emergency Medical Technician-Paramedic to provide basic or advance life support services.

4. Any Emergency Medical Technician-Basic, Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, or Emergency Medical Technician-Driver who violates or fails to comply with these statues or rules and regulations promulgated by the board hereunder shall be subject, after due notice and hearing, to an administrative fine not to exceed One Thousand Dollars ($1,000.00).

SOURCES: Laws, 1974, ch. 507, § 8 (4,5); 1979, ch. 445, § 5; 1982, ch. 345, § 5, 1991, ch. 606, § 7, 2001, ch. 542, § 1, eff from and after July 1, 2001.

104.19 <u>§41-59-37. Temporary ambulance attendant's permit.</u>

The board may, in its discretion, issue a temporary ambulance attendant's permit which shall not be valid for more than one (1) year from the date of issuance, and which shall be renewable to an individual who may or may not meet qualifications established pursuant to this chapter upon determination that such will be in the public interest.

SOURCES: Laws, 1974, ch. 507, § 8(6), eff from and after passage (approved April 13, 1974).

104.20 <u>§41-59-39. Standards for invalid vehicles.</u>

The board after consultation with the emergency medical services advisory council, shall establish minimum standards which permit the operation of invalid vehicles as a separate class of ambulance service.

SOURCES: Laws, 1974, ch . 507 § 9, eff from and after passage (approved April 13, 1974).

104.21 <u>§41-59-41. Records</u>

Each licensee of an ambulance service shall maintain accurate records upon such forms as may be provided, and contain such information as may be required by the board concerning the transportation of each patient within this state and beyond its limits. Such records shall be available for inspection by the board at any reasonable time, and copies thereof shall be furnished to the board upon request.

SOURCES: Laws, 1974, ch. 507, § 10, eff from and after passage (approved April 3, 1974).

104.22 <u>§41-59-43. Exemptions.</u>

1. The following are exempted from the provisions of this chapter:

    a. The occasional use of a privately and/or publicly owned vehicle not ordinarily used in the business of transporting persons who are sick,

injured, wounded, or otherwise incapacitated or helpless, or operating in the performance of a lifesaving act.

b. A vehicle rendering services as an ambulance in case of a major catastrophe or emergency.

c. Vehicles owned and operated by rescue squads chartered by the state as corporations not for profit or otherwise existing as nonprofit associations which are not regularly used to transport sick, injured or otherwise incapacitated or helpless persons except as a part of rescue operations.

d. Ambulances owned and operated by an agency of the United States Government.

SOURCES: Laws, 1974, ch. 507, § 11, eff from and after passage (approved April 3, 1974).

104.23 <u>§41-59-45. Penalties; injunctive relief</u>

1. It shall be the duty of the licensed owner of any ambulance service or employer of emergency medical technicians for the purpose of providing basic or advanced life support services to insure compliance with the provisions of this Chapter 59 and Chapter 60 and all regulations promulgated by the board.

2. Any person, corporation or association that violates any rule or regulation promulgated by the board pursuant to these statues regarding the provision of ambulance services or the provision of basic or advanced life support services by emergency medical technicians shall, after due notice and hearing, be subject to an administrative fine not to exceed One Thousand Dollars ($1,000.00) per occurrence.

3. Any person violating or failing to comply with any other provisions of this Chapter 59 and Chapter 60 shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined an amount not to exceed fifty dollars ($50.00) or be imprisoned for a period not to exceed thirty (30) days, or both, for each offense.

4. The board may cause to be instituted a civil action in the chancery court of the county in which any alleged offender of this chapter may reside or have his principal place of business for injunctive relief to prevent any violation of any provision of this Chapter 59 and Chap, or any rules or regulation adopted by the board pursuant to the provisions of this chapter.

5. Each day that any violation or failure to comply with any provision of this chapter or any rule or regulation promulgated by the board thereto is committed or permitted to continue shall constitute a separate and distinct

offense under this section, except that the court may, in its discretion, stay the cumulation of penalties.

It shall not be considered a violation of this Chapter 59 and Chapter 60 for a vehicle domiciled in a nonparticipating jurisdiction to travel in a participating jurisdiction.

SOURCES: Laws, 1974, ch. 507, § 12; 2001, ch. 542, § 2, eff from and after July 1, 2001.

Cross reference -

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

104.24 §41-59-47. Options of counties and municipalities as to participation.

The provisions of this chapter shall apply to all counties and incorporated municipalities except those counties and incorporated municipalities electing not to comply as expressed to the board in a written resolution by the governing body of such county or incorporated municipality. The election of any county to be included or excluded shall in no way affect the election of any incorporated municipality to be included or excluded. If any county or municipality elects to be excluded from this chapter, they may later elect to be included by resolution.

All financial grants administered by the state for emergency medical services pertaining to this chapter shall be made available to those counties and incorporated municipalities which are governed by the provisions of this chapter.

SOURCES: Laws, 1974, ch. 507, § 13, eff from and after passage (approved April 3, 1974).

104.25 § 41-59-49. Appeal from decision of board.

any person, firm, corporation, association, county, municipality or metropolitan government or agency whose application for a permit or license has been rejected or whose permit or license is suspended or revoked by the board shall have the right to appeal such decision, within thirty (30) days after receipt of the board's written decision, to the chancery court of the county where the applicant or licensee is domiciled. The appeal before the chancery court shall be de novo and the decision of the chancery court may be appealed to the Supreme Court in the manner provided by law.

SOURCES: Laws, 1974, ch. 507, § 14, eff from and after passage (approved April 3, 1974).

104.26 § 41-59-51. Districts; authority to establish.

A special subdivision to be known as an emergency medical service district may be established by the board of supervisors or boards of supervisors of any county or group of counties, and/or governing authority or authorities of a municipality or municipalities located in such counties, acting separately or jointly in any combination, to provide emergency hospital care and ambulance services for an area composed of all or part of the geographic areas under the jurisdiction of such boards of supervisors or municipal governing authorities, as may be agreed upon .

SOURCES: Laws, 1974, ch. 507, § 15(1), eff from and after passage (approved April 3, 1974).

104.27 §41-59-53. Districts; procedure for establishing.

The boards of supervisors and the municipal governing authorities which intend to establish an emergency medical service district shall set forth such intention, along with a description of the area to be served, the nature of services to be provided, the allocation of expenses among the participating subdivisions, and the form of administration for such district in substantially similar resolutions which shall be adopted by each governing board participating in the emergency medical service district.

SOURCES: Laws, 1974, ch. 507, § 15(2), eff from and after passage (approved April 3, 1974).

104.28 §41-59-55. Districts; administration.

Any emergency medical service district created pursuant to this chapter shall be administered in one of the following manners:

a. The governing authorities of the participating political subdivisions shall appoint a person or persons, who may be an elected official of such political subdivision, or a person authorized to promulgate policy for and guide the administration of the activities of the district; or

b. The governing authorities, by mutual and unanimous agreement, shall appoint an executive manager who shall have full authority over the operation of the district.

SOURCES: Laws, 1974, ch. 507, § 15(3), eff from and after passage approved April 3, 1974).

104.29 §41-59-57. Districts; power to receive and expend funds.

The emergency medical service districts authorized under this chapter are empowered to receive funds from all sources and are authorized to expend such funds as may be available for any necessary and proper purpose in the manner

provided by law for municipalities. The participating political subdivisions may expend funds from any source for the necessary and proper support of such a district, and they may expend such funds by making a lump sum payment to the board or manager designated to administer the district.

SOURCES: Laws, 1974, ch. 507, § 15(4), eff from and after passage (approved April 3, 1974).

104.30 §41-59-59. Funds for support and maintenance of districts.

1. The board of supervisors of any county of the state participating in the establishment of an emergency medical service district under the provisions of Section 41-59-51 and related statutes of the Mississippi Code of 1972 may set aside, appropriate and expend moneys from the general fund for the support and maintenance of the district. In the event the district is comprised of more than one (1) county, the contributions for support and maintenance may be made on a per capita basis.

2. Emergency medical service districts may borrow funds in anticipation of the receipt of tax monies as otherwise provided by law for counties or municipalities.

SOURCES: Laws, 1975, ch. 445; 1986, ch. 400, § 27, eff from and after October 1, 1986.

104.31 §41-59-61. Emergency medical services operating fund; assessment on traffic violations.

1. Such assessments as are collected under subsections (1) and (2) of Section 99-19-73 shall be deposited in a special fund hereby created in the State Treasury to be designated the "Emergency Medical Services Operating Fund." The Legislature may make appropriations from the Emergency Medical Services Operating Fund to the State Board of Health for the purpose of defraying costs of administration of the Emergency Medical Services program and for redistribution of such funds to the counties, municipalities and organized medical service districts (hereinafter referred to as "governmental units") for the support of the emergency medical services programs. The State Board of Health, with the Emergency Medical Services Advisory Council acting in an advisory capacity, shall administer the disbursement to such governmental units.

2. Funds appropriated from the Emergency Medical Services Operating Fund to the State Board of Health shall be made available to all such governmental units to support the emergency medical services programs therein, and such funds shall be distributed to each governmental unit based upon its general population relative to the total population of the state. Disbursement of such funds shall be made on an annual basis at the end of the fiscal year upon the request of each governmental unit. Funds

distributed to such governmental units shall be used in addition to existing annual emergency medical services budgets of the governmental units, and no such funds shall be used for the payment of any attorney's fees. The Director of the Emergency Medical Services program or his appointed designee is hereby authorized to require financial reports from the governmental units utilizing these funds in order to provide satisfactory proof of the maintenance of the funding effort by the governmental units.

SOURCES: Laws, 1982, ch. 344, § 1; 1983, ch. 522, § 38; 1985, ch. 352; 1985, ch. 440, § 6; 1990, ch. 329, § 7, eff from and after passage (approved October 1, 1990).

Cross references -

Deposit of portion of standard state assessment into Emergency Medical Services Operating Fund, see § 99-19-73.

Editor's Note -

Section 1 of ch. 352, Laws, 1985, effective from and after July 1, 1985 (approved March 19, 1985), amended this section. Subsequently, Section 6 of ch. 440, Laws, 1985, effective from and after passage (approved March 27, 1985), also amended this section without reference to ch. 352. As set out above, this section contains the language of Section 6 of ch. 440, which represents the latest legislative expression on the subject.

104.32 <u>§41-59-63. Membership subscription programs for prepaid ambulance service not to constitute insurance.</u>

The solicitation of membership subscriptions, the acceptance of membership applications, the charging of membership fees, and the furnishing of prepaid or discounted ambulance service to subscription members and designated members of their households by either a public or private ambulance service licensed and regulated by the State Board of Health pursuant to Section 41-59-1 et seq. shall not constitute the writing of insurance and the agreement under and pursuant to which such prepaid or discounted ambulance service is provided to the subscription members and to designated members of their households shall not constitute a contract of insurance.

SOURCES: Laws, 1988, ch; 541, § 1; reenacted, 1991, ch. 348, § 1; reenacted, 1992, ch. 327, § 1, eff from and after July 1, 1992 .

104.33 <u>§41-59-65. Application for permit to conduct membership subscription program; fees; renewals.</u>

Either a public or private ambulance service licensed and regulated by the State Board of Health desiring to offer such a membership subscription program shall make application for permit to conduct and implement such program to the State

Board of Health. The application shall be made upon forms in accordance with procedures established by the board and shall contain the following:

a. The name and address of the owner of the ambulance service;

b. The name in which the applicant is doing business;

c. The location and description of the place or places from which the ambulance service operates;

d. The places or areas in which the ambulance service intends to conduct and operate a membership subscription program; and

e. Such other information as the board shall deem necessary.

Each application for a permit shall be accompanied by a permit fee of Five Hundred Dollars ($500.00), which shall be paid to the board. The permit shall be issued to expire the next ensuing December 31. The permit issued under this section may be renewed upon payment of a renewal fee of Five Hundred Dollars ($500.00), which shall be paid to the board. Renewal of any permit issued under this section shall require conformance with all requirements of this chapter.

SOURCES: Laws, 1988, ch. 541, § 2; reenacted, 1991, ch. 348, § 2; reenacted, 1992, ch. 327, § 2, eff from and after July 1, 1992.

104.34 <u>§41-59-67. Requirements for issuance of permit; reserve fund; ambulance service to pay cost of collection of judgment against fund.</u>

The issuance of a permit to conduct and implement a membership subscription program shall require the following:

a. The posting of a surety bond with one or more surety companies to be approved by the State Board of Health, in the amount of Five Thousand Dollars ($5,000.00) for every one thousand (1,000) subscribers or portion thereof; and

b. The establishment of a reserve fund to consist of a deposit to the reserve fund with any depository approved by the state for the benefit of the subscription members in the amount of Three Dollars ($3.00) for each subscription member currently subscribing to the subscription program, but not for the designated members of the subscribing member's household, to guarantee perpetuation of the subscription membership program until all memberships are terminated; and

c. No further deposits shall be required to be made by the ambulance service to the reserve fund after the aggregate sum of the principal

amount of said surety bond plus the deposits in the reserve fund is equal to Two Hundred Thousand Dollars ($200,000.00).

In any action brought by a subscriber against the surety bond or the reserve fund, the cost of collection upon a judgment rendered in favor of the subscriber, including attorney's fees, shall be paid by the ambulance service.

SOURCES: Laws, 1988, ch. 541, § 3; re-enacted, 1991, ch. 348, § 3; re-enacted, 1992, ch. 327, § 3, eff from and after July 1, 1992.

104.35 §41-59-69. Annual report of ambulance service conducting subscription program.

1. Annual reports shall be filed with the State Board of Health by the ambulance service permitted to conduct and implement a membership subscription program in the manner and form prescribed by the State Board of Health, which report shall contain the following:

   a. The name and address of the ambulance service conducting the program;

   b. The number of members subscribing to the subscription program;

   c. The revenues generated by subscriptions to the program; and

   d. The name and address of the depository bank in which the reserve fund is deposited and the amount of deposit in said reserve fund.

SOURCES: Laws, 1988, ch. 541, § 4; re-enacted, 1991, ch. 348, § 4; re-enacted, 1992, ch. 327, § 4, eff from and after July 1, 1992.

104.36 §41-59-71. Methods of soliciting members; license not required.

Solicitation of membership in the subscription program may be made through direct advertising, group solicitation, by officers and employees of the ambulance service or by individuals without the necessity of licensing of such solicitors.

SOURCES: Laws, 1988, ch. 541, § 5; reenacted, 1991, ch. 348, § 5, re-enacted, 1992, ch. 327, § 5, eff from and after July 1, 1992.

§ 41-59-73. [Laws, 1991, ch. 348, § 7] Repealed by Laws, 1992, ch. 327, § 6, eff from and after July 1, 1992.

Editor's Note -

Former § 41-59-73 provided for the repeal of sections 41-59-63 through 41-59-71.

Laws, 1988, Ch. 541, § 6, provided that sections 41-59-71 would stand repealed from and after July 1, 1991. Subsequently, Laws, 1991, ch. 348, § 6, amended Laws, 1988, ch. 541, § 6, deleting the provision for the repeal of sections 41-59-63 through 41-59-71. However, Laws, 1991, ch. 348, § 7, added a new section, 41-59-73, providing for the prospective repeal of sections 41-59-63 through 41-59-71. Subsequently, Laws, 1992, ch. 327, § 6, repealed § 41-59-73, effective from and after July 1, 1992.

104.37 § 41-59-75. Mississippi Trauma Care Systems Fund established.

The Mississippi Trauma Care Systems Fund is established. Five Dollars ($5.00) collected from each assessment of Fifteen Dollars ($15.00) collected from each assessment of Twenty Dollars ($20.00) as provided in Section 41-59-61, and any other funds made available for funding the trauma care system, shall be deposited into the fund. Funds appropriated from the Mississippi Trauma Care Systems Fund to the State Board of Health shall be made available for department administration and implementation of the comprehensive state trauma care plan for distribution by the department to designated trauma care regions for regional administration, for the department's trauma specific public information and education plan, and to provide hospital and physician indigent trauma care block grant funding to trauma centers designated by the department. All designated trauma care hospitals are eligible to contract with the department for these funds.

SOURCES: Laws, 1988, ch. 429, § 4, eff from and after July 1, 1998.

Cross References - State Board of Health authorization to receive and disburse funds appropriated from the Mississippi Trauma Care System Fund, see § 41-59-5.

104.38 § 41-59-77. Trauma registry data confidential and not subject to discovery or introduction into evidence in civil actions.

Data obtained under this act [Laws, 1998, ch. 429] for use in the trauma registry is for the confidential use of the Mississippi State Department of Health and the persons, public entities or private entities that participate in the collection of the trauma registry data.

Any data which identifies and individual or a family unit that is collected for use in the trauma registry shall be confidential and shall not be subject to discovery or introduction into evidence in any civil action.

SOURCES: Laws, 1998, ch. 429, § 5, eff from and after July 1, 1998.

104.39 § 41-59-79.

Any person desiring certification as a medical first responder shall apply to the board using forms prescribed by the board. Each application for a medical first

responder certificate shall be accompanied by a certificate fee to be fixed by the board, which shall be paid to the board. Upon the successful completion of the board's approved medical first responder training program, the board shall make a determination of the applicant's qualifications as a medical first responder as set forth in the regulations promulgated by the board, and shall issue a medical first responder certificate to the applicant.

104.40 41-59-81.

1. The State Board of Health is authorized to promulgate and enforce rules and regulations to provide for the best and most effective emergency medical care by medical first responders, and to comply with national standards for medical first responders. Notwithstanding any other provision of law, medical first responder personnel may be authorized to provide medical first responder services as defined by rules and regulations promulgated by the State Board of Health.

Rules and regulations promulgated under this authority shall, as a minimum:

a. Define and authorize functions and training programs for medical first responder personnel; however, all those training programs shall meet or exceed the performance requirements of the most current training program "First Responder: National Standard Curriculum" as developed by the United States Department of Transportation, National Highway Traffic Safety Administration.

b. Specify minimum testing and certification requirements and provide for continuing education and periodic recertification for all medical first responder personnel.

2. Counties, municipalities and designated EMS districts may regulate the activities of medical first responders in addition to the regulation imposed by rules and regulations promulgated by the State Board of Health.

3. The State Board of Health and the State Department of Health shall not be authorized to regulate the activities of, or require the state certification of, those first responders who are not medical first responders.

104.41 § 41-59-83. Repealed 2004

105 CHAPTER 60 EMERGENCY MEDICAL TECHNICIANS - PARAMEDICS

41-60-1 through 41-60-9. [Repealed]

41-60-11. Definitions.

41-60-13. Promulgation of rules and regulations by state board of health

§41-60-1 through 41-60-9. [Laws 1976, ch. 358, §§ 1-5] Repealed by Laws, 1979, ch. 488, § 3, eff from and after July 1, 1979.

Editor's Note -

Former Section 41-60-1 contained a legislative finding and declaration concerning emergency medical care.

Former Section 41-60-3 defined the term "mobile intensive care paramedics."

Former Section 41-60-5 authorized hospital ancillary medical services and ambulance services to establish emergency medical programs, utilizing mobile intensive care paramedics.

Former Section 41-60-7 authorized mobile intensive care paramedics to perform certain specified emergency medical services.

Former Section 41-60-9 authorized mobile intensive care paramedics to perform certain specified additional emergency medical services, upon authorization by a physician and upon order of such physician or a registered nurse, when direct communication was maintained between the paramedics and the physician or registered nurse.

105.01 <u>§41-60-11. Definitions.</u>

As used in sections 41-60-11 and 41-60-13, unless the context otherwise requires, the term:

a. "Advanced Life Support" shall mean a sophisticated level of pre-hospital and interhospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of antiarnhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures.

b. "Advanced Life Support personnel" shall mean persons other than physicians engaged in the provision of advanced life support, as defined and regulated by rules and regulations promulgated by the board.

c. "Emergency Medical Technician-Intermediate" shall mean a person specially trained in advanced life support modules numbers I, II, III as developed by the United States Department of Transportation under

Contract No. DOT-HS-900-089 as authorized by the Mississippi State Board of Health.

d. "Emergency Medical Technician-Paramedic" shall mean a person specially trained in an advanced life support training program authorized by the Mississippi State Board of Health.

e. "Medical control" shall mean directions and advice provided from a centrally designated medical facility staffed by appropriate personnel, operating under medical supervision, supplying professional support through radio or telephonic communication for onsite and in-transit basic and advanced life support services given by field and satellite facility personnel.

SOURCES: Laws, 1979, ch. 488, § 1; Laws, 2001, ch. 542, § 3, eff from and after July 1, 2001.

Annotations -

Liability for injury or death allegedly caused by activities of hospital "rescue team". 64 ALR4th 1200.

105.02 <u>§41-60-13. Promulgation of rules and regulations by state board of health.</u>

The Mississippi State Board of Health is authorized to promulgate and enforce rules and regulations to provide for the best and most effective emergency medical care, and to comply with national standards for advanced life support. Notwithstanding any other provision of law, advanced life support personnel may be authorized to provide advanced life support services as defined by rules and regulations promulgated by the state board of health.

Rules and regulations promulgated pursuant to this authority shall, as a minimum:

a. Define and authorize appropriate functions and training programs for advanced life support trainees and personnel; provided, that all such training programs shall meet or exceed the performance requirements of the current training program for the emergency medical technician-paramedic, developed for the United States Department of Transportation.

b. Specify minimum operational requirements which will assure medical control over all advanced life support services.

c. Specify minimum testing and certification requirements and provide for continuing education and periodic recertification for all advanced life support personnel.

SOURCES: Laws, 1979, ch. 488, § 2, eff from and after July 1, 2001.

106 USE OF AUTOMATED EXTERNAL DEFIBRILLATOR IN CASES OF SUDDEN CARDIAC DEATH

41-60-31. Definitions.

41-60-33. Requirements and training for use of automated external defibrillator.

41-60-35. Individual authorized to use automated external defibrillator not limited from practicing other authorized health occupations.

106.01 § 41-60-31. Definitions

As used in this act [Laws, 1999, ch. 489]:

a. "AED" means an automated external defibrillator, which is a device, heart monitor and defibrillator that:

i. Has received approval of its premarket notification filed under 21 USCS, Section 360(k) from the United States Food and Drug Administration;

ii. Is capable of recognizing the presence or absence of ventricular fibrillation, which is an abnormal heart rhythm that causes the ventricles of the heart to quiver and renders the heart unable to pump blood, or rapid ventricular tachycardia, which is a rapid heartbeat in the ventricles and is capable of determining, without intervention by an operator, whether defibrillation should be performed; and

iii. Upon determining that defibrillation should be preformed, automatically charges and advises the operator to deliver hands-free external electrical shock to patients to terminate ventricular fibrillation or ventricular tachycardia when the heart rate exceeds a preset value.

b. "Emergency Medical Services (EMS) notification" means activation of the 911 emergency response system or the equivalent.

SOURCES: Laws, 1999, ch. 489, § 1, eff from and after July 1, 1999.

106.02 § 41-60-33. Requirements and training for use of automated external defibrillator.

Any person may use an automated external defibrillator for the purpose of saving the life of another person in sudden cardiac death, subject to the following requirements:

a. A Mississippi licensed physician must exercise medical control authority over the person using the AED to ensure compliance with requirements for training, emergency medical services (EMS) notification and maintenance;

b. The person using the AED must have received appropriate training in cardiopulmonary resuscitation (CPR) and in the use of an AED by the American Heart Association, American Red Cross, National Safety Council or other nationally recognized course in CPR and AED use;

c. The AED must not operate in a manual mode except when access control devices are in place or when appropriately licensed individuals such as registered nurses, physicians or emergency medical technicians - paramedics utilize the AED; and

d. Any person who renders emergency care or treatment on a person in sudden cardiac death by using an AED must activate the EMS system as soon as possible, and report any clinical use of the AED to the licensed physician.

SOURCES: Laws, 1999, ch. 489 § 2, eff from and after July 1, 1999.

106.03 <u>§ 41-60-35. Individual authorized to use automated external defibrillator not limited from practicing other authorized health occupations.</u>

An individual may use an AED if all of the requirements of Section 41-60-33 are met. However, nothing in this act [Laws, 1999, ch. 489] shall limit the right of an individual to practice a health occupation that the individual is otherwise authorize to practice under the laws of Mississippi.

SOURCES: Laws, 1999, ch. 489 § 3, eff from and after July 1, 1999.

107 SECTION 63 MOTOR VEHICLES AND TRAFFIC – TRAFFIC REGULATIONS

107.01 <u>§63-3-313. Disobedience of official traffic-control devices.</u>

No driver of a vehicle shall disobey the instructions of any official traffic-control device placed in accordance with the provisions of this chapter, unless at the time otherwise directed by a police officer.

SOURCES: Codes, 1942, § 8516, Laws, 1938, ch. 200.

Annotations -

Liability of governmental unit for collision with safety and traffic-control devices in traveled way. 7 ALR2d 226.

Motorist's liability for collision at intersection of ordinary and arterial highways as affected by absence, displacement, or malfunctioning of stop sign or other traffic signal. 74 ALR2d 242.

107.02 <u>§63-3-315. Obedience to official traffic-control devices; emergency vehicles.</u>

The driver of any authorized emergency vehicle when responding to an emergency call upon approaching a red or stop signal or any stop sign shall slow down as necessary for safety but may proceed cautiously past such red or stop sign or signal. At other times drivers of authorized emergency vehicles shall stop in obedience to a stop sign or signal.

SOURCES: Codes, 1942, § 8148; Laws, 1938, ch. 200.

107.03 <u>§63-3-517. Applicability of speed restrictions to emergency vehicles; duties to drivers of emergency vehicles.</u>

The speed limitations set forth in this article shall not apply to authorized emergency vehicles when responding to emergency calls and the drivers thereof sound audible signal by bell, siren, or exhaust whistle. This section shall not relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all person using the street, nor shall it protect the driver of any such vehicle from the consequence of a reckless disregard of the safety of others.

SOURCES: Codes, 1942, § 8180; Laws, 1938, ch. 200; 1948, ch. 328, § 4.

Annotations -

Liability of governmental unit or its officers for injury to innocent occupant of moving vehicle, or for damages to such vehicle, as result of police chase. 4 ALR4th 865.

107.04 <u>§63-3-809. Procedure upon approach of authorized emergency vehicles; duty of driver of emergency vehicle.</u>

1. Upon the immediate approach of an authorized emergency vehicle, when the driver is giving audible signal by siren, exhaust whistle, or bell, the driver of every other vehicle shall yield the right-of-way and shall immediately drive to a position parallel to and as close as possible to, the right-hand edge or curb of the highway clear of any intersection and shall stop and remain in such position until the authorized emergency vehicle has passed, except when otherwise directed by a police officer.

2. This section shall not operate to relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons using the highway.

SOURCES: Codes, 1942, § 8199; Laws, 1938, ch. 200.

Cross references -

Warning lights used on authorized emergency vehicles, see § 63-7-19.

108 CHAPTER 7

108.01 <u>§63-7-19. Lights on police and emergency vehicles; lights on rural mail carrier vehicles.</u>

4) Except as otherwise provided for unmarked vehicles under Section 19-25-15 and Section 25-1-87, every police vehicle shall be marked with blue lights. Every ambulance and special use EMS vehicle as defined in Section 41-59-3 shall be marked with red lights front and back and also may be marked with white and amber lights in addition to red lights. Every emergency management/civil defense vehicle, including emergency response vehicles of the Department of Environmental Quality, shall be marked with blinking, rotating or oscillating red lights. Official vehicles of a 911 Emergency Communications District may be marked with red and white lights. Every wrecker or other vehicle used for emergency work, except vehicles authorized to use blue or red lights, shall be marked with blinking, oscillating or rotating amber colored lights to warn other vehicles to yield the right-of-way, as provided in Section 63-3-809. Only police vehicles used for emergency work may be marked with blinking, oscillating or rotating blue lights to warn other vehicles to yield the right-of-way. Only law enforcement vehicles, fire vehicles, private or department-owned vehicles used by firemen of volunteer fire departments which receive funds pursuant to Section 83-1-39 when responding to calls, emergency management/civil defense vehicles, emergency response vehicles of the Department of Environmental Quality, ambulances used for emergency work, and 911 Emergency Communications District vehicles may be marked with blinking, oscillating or rotating red lights to warn other vehicles to yield the right-of-way. This section shall not apply to school buses carrying lighting devices in accordance with Section 63-7-23.

5) Any vehicle referred to in subsection (1) of this section also shall be authorized to use alternating flashing headlights when responding to any emergency.

6) Any vehicle operated by a United States rural mail carrier for the purpose of delivering United States mail may be marked with two (2) amber colored lights on front top of the vehicle and two (2) red colored lights on rear top of the vehicle so as to warn approaching travelers to decrease their speed because of

danger of colliding with the mail carrier as he stops and starts along the edge of the road, street or highway.

108.02 §63-7-65. Horns and warning devices.

1. Every motor vehicle when operated upon a highway shall be equipped with a horn in good working order and capable of emitting sound audible under normal conditions from a distance of not less than two hundred (200) feet. The driver of a motor vehicle shall, when reasonably necessary to insure safe operation, give audible warning with his horn but shall not otherwise use such horn upon a highway. No horn or other warning device shall emit an unreasonably loud or harsh sound or a whistle.

2. Any authorized emergency vehicle may be equipped with a siren, whistle, or bell, capable of emitting sound audible under normal conditions from a distance of not less than five hundred (500) feet and of a type approved by the department. No such siren shall be used except when such vehicle is operated in response to an emergency call or in the immediate pursuit of an actual or suspected violator of the law, in which said latter events the driver of such vehicle shall sound such siren when necessary to warn pedestrians and other drivers of the approach thereof.

3. No vehicle shall be equipped with nor shall any person use upon a vehicle any siren, whistle, or bell, except as otherwise permitted in this section. No bicycle shall be equipped with nor shall any person use upon a bicycle any siren or whistle

4. Any vehicle may be equipped with a theft alarm signal device which is so arranged that it cannot be used by the driver as an ordinary warning signal.

SOURCES: Codes, 1942, § 8250; Laws, 1938, ch. 200; Laws, 1994, ch. 324, § 1, eff from and after July 1, 1994.

109 SECTION 73 PROFESSIONS AND VOCATIONS CHAPTER 25 PHYSICIANS

109.01 §73-25-37. Liability of physician, dentist, nurse, or emergency medical technician, etc., for rendering emergency care.

1. No duly licensed, practicing physician, dentist, registered nurse, licensed practical nurse, certified registered emergency medical technician, or any other person who, in good faith and in the exercise of reasonable care, renders emergency care to any injured person at the scene of an emergency, or in transporting the injured person to a point where medical assistance can be reasonably expected, shall be liable for any civil damages to said injured person as a result of any acts committed in good faith and in the exercise of reasonable care or omissions in good faith and in the exercise of reasonable care by such persons in rendering the emergency care to said injured person.

a. Any person who in good faith, with or without compensation, renders emergency care or treatment by the use of an automated external defibrillator (AED) in accordance with the provisions of Sections 41-60-31 through 41-60-35, shall be immune from civil liability for any personal injury as a result of that care or treatment, or as a result of any act, or failure to act, in providing or arranging further medical treatment, where the person acts as an ordinary, reasonably prudent person would have acted under the same or similar circumstances and the person's actions or failure to act does not amount to willful or wanton misconduct or gross negligence.

b. The immunity from civil liability for any personal injury under subsection (2)(a) of this section includes the licensed physician who is involved with AED site placement, and the person who provides the CPR and AED training.

The immunity from civil liability under subsection (2)(a) of this section does not apply if the personal injury results from the gross negligence or willful or wanton misconduct of the person rendering the emergency care.

SOURCES: Codes, 1942, § 8893.5; Laws, 1962, ch. 413; 1964, ch. 431; 1975, ch. 329; 1976, ch. 405; 1979, ch. 376, § 1, Laws, 1999, ch. 489, § 4 eff from and after July 1, 1999.

Cross references -

Implied waiver of medical privilege of patient to extent of any information other than that which would identify patient, see § 13-1-21.

Exception from the requirement that sealed hospital records be opened only at time of trial, deposition, or other hearing, and in the presence of all parties, with respect to physician or podiatrist disciplinary proceedings, see § 41-9-107.

Non-liability in civil damages of persons rendering assistance at scene of boating accident, see § 59-21-55.

Certain patient records, charts and other documents being subject to subpoena by the board of medical licensure for use in disciplinary proceedings initiated pursuant to the provisions of this section, see § 73-25-28.

Annotations -

Construction and application of "Good Samaritan" statutes. 68 ALR4th 294.

Construction and application of Emergency Medical Treatment and Active Labor Act (42 USCS § 1395dd). 104 ALR Fed 166.

APPENDIX 5 – EMERGENCY TRANSPORT TO MEDICAL FACILITIES

Emergency Ambulance Transport To Medical Facilities

Patients who are transported under the direction of an emergency medical service system should be taken whenever possible to an in hospital facility that meets the Emergency Care Guidelines of the American College of Emergency Physicians.

The EMS Medical Control Authority should have the discretion to authorize transport to non-in hospital medical facilities that meet the Emergency Care Guidelines under that extraordinary circumstance when lack of timely availability of such an in hospital facility necessitates earlier patient stabilization.

If an area does not have a facility that meets the Emergency Care Guidelines, it may be necessary for the responsible EMS Medical Control Authority to designate some medical facility to receive patients by ambulance. The American College of Emergency Physicians strongly encourages the modification of such facilities to meet the Emergency Care Guidelines of the College, so that every area has a facility capable of providing emergency care.

APPENDIX 6 - TRANSFERS

100 INTERHOSPITAL AND OTHER MEDICAL FACILITIES

100.01 Definitions - Inter-Hospital And Other Medical Facilities

1. Appropriate Transfer - An appropriate transfer to a medical facility is a transfer

   a. in which the receiving facility: a) has available space and qualified personnel for the treatment of the patient, and b) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

   b. in which the transferring hospital provides the receiving facility with appropriate medical records of the examination and treatment effected at the transferring hospital;

   c. In which the transfer is affected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.

2. Medical Control During Interhospital Transfers

   Once an emergency patient arrives for initial evaluation at a medical facility the patient becomes the responsibility of that facility, and its medical staff. This responsibility continues until the patient is appropriately discharged, or until the patient is transferred and the responsibility is assumed by personnel and a facility of equal or greater capability for the patient's existing condition.

3. Routine Interhospital Transfers

   If a transfer is being made for the convenience of the patient or patient's physicians, and the patient is not receiving treatment, and is expecting to remain stable during transport, the transfer may be conducted by and appropriately trained medical provider (EMT-Basic or higher).

4. Emergency Interhospital Transfers Conducted by the Transferring Facility

   a. If the patient is being transferred to another facility for other convenience, is receiving treatment, is medically unstable, or is potentially unstable, it is the responsibility of the transferring physician and hospital to provide medical records and assure that appropriately qualified personnel and transportation equipment are utilized.

b. The transferring personnel will act as the agents of the transferring hospital and the physician approving the transfer, regardless of any other employer/employee relationship.

c. The transferring physician must provide written orders to non-physician personnel for use during the interhospital transfer.

d. If the patient experiences complications beyond situations addressed in these written orders, the provider should, if possible.

Contact the transferring hospital or the receiving facility for additional orders or, if necessary, contact a recognized communications resource for medical direction.

5. Emergency Interhospital Transfers Conducted by Receiving Facility

(Transferring personnel are agents of the receiving hospital)

a. If the transferring personnel include a physician, the patient becomes the responsibility of the receiving facility as soon as the patient leaves the transferring facility.

b. If the transferring team does not include a physician, the responsibility for the patient's well being may be shared between the receiving and transferring facility. The transferring facility retains the responsibility to assure that the transport agency has qualified personnel and transportation equipment.

6. Critical Care Transfers

If the patient is receiving treatment beyond the scope of practice of available transferring non-physician providers or if the patient’s needs or reasonably perceived needs cannot be managed within the scope of practice of non-physician personnel, the transfer shall be managed by an appropriately trained physician.

APPENDIX 7 – JURISDICTIONAL MEDICAL CONTROL AGREEMENT

APPENDIX 8 – RELATED OSHA REGULATIONS

XI. THE STANDARD

General Industry

Part 1910 of title 29 of the Code of Federal Regulations is amended as follows:

PART 1910-[AMENDED]

Subpart Z-[Amended]

The general authority citation for subpart Z of 29 CFR part 1910 continues to read as follows and a new citation for 1910.1030 is added:

Authority: Sec. 6 and 8, Occupational Safety and Health Act, 29 U.S.C. 655.657. Secretary of Labor's Orders Nos. 12-71 (36 FR 8754). 8-76 (41 FR 25059), or 9-83 (48 FR 35736), as applicable; and 29 CFR part 1911.

Section 1910.1030 also issued under 29 U.S.C. 653.

Section 1910.1030 is added to read as follows:

1910.1030 Blood borne Pathogens.

Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

Definitions. For purposes of this section, the following shall apply:

a. Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

b. Blood means human blood, human blood components, and products made from human blood.

c. Blood borne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

d. Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

e. Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

f. Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials on an item or surface.

g. Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

h. Decontamination means the use of physical or chemical means to removed, inactivate, or destroy blood borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

i. Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

j. Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles) that isolate or remove the blood borne pathogens hazard for the workplace.

k. Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

l. Handwashing Facilities means a facility providing an adequate supply of running potable water soap and single use towels or hot air drying machines.

m. Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

n. HBV means hepatitis B virus.

o. HIV means human immunodeficiency virus.

p. Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

q. Other Potentially Infectious Materials means

i. The following human blood fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

ii. Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

iii. HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

r. Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites cuts, and abrasions.

s. Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard is not considered to be personal protective equipment.

t. Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

u. Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or potentially infectious materials are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

v. Research Laboratory means a laboratory producing or using research laboratory-scale amounts of HIV or HBV. Research laboratories may product high concentrations of HIV or HBV but not in the volume found in production facilities.

w. Source Individual means any individual living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include but are not limited to hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human

remains; and individuals who donate or sell blood or blood components.

x. Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

y. Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if know to be infectious for HIV, HBV, and other blood borne pathogens.

z. Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

C. EXPOSURE CONTROL

1. Exposure Control Plan.

(i) Each employer having an employee(s), with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

(ii) The Exposure Control Plan shall contain at least the following elements;

(A) The exposure determination required by paragraph(c)(2).

(B) The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard and

(C) The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph(f)(3)(i) of this standard.

(iii) Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29 CFR 1910.20(e).

(iv) The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which effect occupational exposure and to reflect new or revised employee positions with occupational exposure.

(v) The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

2. Exposure determination.

(i) Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

(A) A list of all job classifications in which all employees in those job classifications have occupational exposure;

(B) A list of job classifications in which some employees have occupational exposure, and

(C) A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of paragraph(c)(2)(i)(B) of this standard.

(ii) This exposure determination shall be made without regard to the use of personal protective equipment.

D. METHODS OF COMPLIANCE

1. General-Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

2. Engineering and work practice controls.

(i) Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls personal protective equipment shall also be used.

(ii) Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

(iii) Employees shall provide handwashing facilities which are readily accessible to employees.

(iv) When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

(v) Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

(vi) Employers shall ensure that employees wash their hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

(vii) Contaminated needles and other contaminated sharps shall not be net, recapped, or removed except as noted in paragraphs(d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.

(A) Contaminated needles and other contaminated sharps shall not be recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.

(B) Such recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

(viii) Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly processed. These containers shall be:

(A) Puncture resistant;

(B) Labeled or color-coded in accordance with this standard;

(C) Leakproof on the sides and bottom; and

(D) In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

(ix) Eating, drinking, smoking applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

(x) Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or other potentially infectious materials are present.

(xi) All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

(xii) Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

(xiii) Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping.

(A) The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph(g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with paragraph(g)(1)(i) is required when such specimens/containers leave the facility.

(B) If outside contaminations of the primary container occurs, the primary container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard.

(C) If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

(xiv) Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment is not feasible.

(A) A readily observable label in accordance with paragraph(g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

(B) The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate prior to handling, servicing, or shipping so that appropriate precautions will be taken.

3. Personal protective equipment-

(i) Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

(ii) Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When

the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

(iii) Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(iv) Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs(d) and (e) of this standard, at not cost to the employee.

(v) Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

(vi) If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.

(vii) All personal protective equipment shall be removed prior to leaving the work area.

(viii) When personal protective equipment is removed prior to leaving the work site.

(ix) When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage or disposal.

(x) Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and on-intact skin; when performing vascular access procedures except as specified in paragraph(d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

(A) Disposal (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

(B) Disposable (single use) gloves shall not be washed or decontaminated for re-use.

(C) Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

(D) If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

(1) Periodically reevaluate this policy;

(2) Make gloves available to all employees who wish to use them for phlebotomy; and

(3) Require that gloves be used for phlebotomy in the following circumstances:

(1) When the employee has cuts, scratches, or other breaks in his or her skin;

(2) When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and

(3) When the employee is receiving training in phlebotomy.

(xi) Make, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chinlength face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

(xii) Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

(xiii) Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopedic surgery).

4. Housekeeping.

(i) General. Employers shall ensure that the worksite is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

(ii) All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

(A) Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

(B) Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have become contaminated during the shift.

(C) All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(D) Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

(E) Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

(iii) Regulated Waste.

A. Contaminated Sharps Discarding and Containment.

(1) Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

(i) Closable;

(ii) Puncture resistant;

(iii) Leakproof on sides and bottom; and

(iv) Labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard.

(2) During use, containers for contaminated sharps shall be:

(i) Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

(ii) Maintained upright throughout use; and

(iii) Replaced routinely and not be allowed to overfill.

(3) When moving containers of contaminated sharps from the area of use, the containers shall be:

(i) Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping;

(ii) Placed in a secondary container if leakage is possible. The second container shall be:

(A) Closable;

(B) Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; and

(C) Labeled or color-coded according to paragraph(g)(1)(i) of this standard.

(4) Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

B. Other Regulated Waste Containment.

(1) Regulated waste shall be placed in containers which are:

(i) Closable;

(ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

(iii) Labeled or color-coded in accordance with paragraph(g)(1)(i) this standard; and

(iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(2) If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be:

(i) Closable;

(ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

(iii) Labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard; and

(iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

C. Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

(iv) Laundry.

(A) Contaminated laundry shall be handled as little as possible with a minimum of agitation.

(1) Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

(2) Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the container as requiring compliance with Universal Precautions.

(3) Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

(B) The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

(C) When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph(g)(1)(i).

(e) HIV and HBV Research Laboratories and Production Facilities.

(1) This paragraph applies to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV and HBV. It does not apply to clinical or diagnostic laboratories engaged solely in the analysis of blood, tissues, or organs. These requirements apply in addition to the other requirements of the standard.

(2) Research laboratories and production facilities shall meet the following criteria:

(i) Standard microbiological practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy blood borne pathogens.

(ii) Special practices.

(A) Laboratory doors shall be kept closed when work involving HIV or HBV is in progress.

(B) Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leakproof, labeled or color-coded container that is closed before being removed from the work area.

(C) Assess to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

(D) When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph(g)(1)(ii) of this standard.

(E) All activities involving other potentially infectious materials shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these other potentially infectious materials shall be conducted on the open bench.

(F) Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

(G) Special care shall be taken to avoid skin contact with other potentially infectious materials. Gloves shall be worn when handling infected animals and when making band contact with other potentially infectious materials is unavoidable.

(H) Before disposal all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy blood borne pathogens.

(I) Vacuum lines shall be protected with liquid disinfectant traps and high-efficiency particulate air (HEPA) filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced as necessary.

(J) Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of other potentially infectious materials. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

(K) All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

(L) A spill or accident that results in an exposure incident shall be immediately reported to the laboratory director or other responsible person.

(M) A biosafety manual shall be prepared or adopted and periodically reviewed and updated at least annually or more often if necessary. Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

(iii) Containment equipment.

(A) Certified biological safety cabinets (Class I, II, or III) or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrigue safety cups, sealed centrifuge rotors, and containment caging for animals, shall be used for all activities with other potentially infectious materials that pose a threat of exposure to droplets, splashes, spills, or aerosols.

(B) Biological safety cabinets shall be certified when installed, whenever they are moved and at least annually.

(3) HIV and HBV research laboratories shall meet the following criteria:

(i) Each laboratory shall contain a facility for hand washing and an eye wash facility which is readily available within the work area.

(ii) An autoclave for decontamination of regulated waste shall be available.

(4) HIV and HBV production facilities shall meet the following criteria:

(i) The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-doored clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

(ii) The surfaces of doors, walls, floors and ceilings in the work area shall be water resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

(iii) Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

(iv) Access doors to the work area or containment module shall be self-closing.

(v) An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

(vi) A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be recirculated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area).

(5) Training Requirements. Additional training requirements for employees in HIV and HBV research laboratories and HIV and HBV production facilities are specified in paragraph(g)(2)(ix).

F. Hepatitis B vaccination and post-exposure evaluation and follow-up-

(1) General.

(i) The employer shall made available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and pot-exposure evaluation and follow-up to all employees who have had an exposure incident.

(ii) The employer shall ensure that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis are:

(A) Made available at not cost to the employee;

(B) Made available to the employee at a reasonable time and place;

(C) Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

(D) Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph(f).

(iii) The employers hall ensure that all laboratory at no cost to the employee.

(2) Hepatitis B Vaccination

(i) Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph(g)(2)(vii)(I) and within 10 workings days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

(ii) The employee shall not make participation in a pre-screening program a prerequisite for receiving hepatitis B vaccination.

(iii) If the employee initially declines Hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

(iv) The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in appendix A.

(v) If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section(f)(1)(ii).

(3) Post-exposure Evaluation and Follow-up. Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

(i) Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred;

(ii) Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

(A) The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's

consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

(B) When the source individual is already known to be infected with HBV or HIV, testing for source individual's known HBV or HIV status need not be repeated.

(C) Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(iii) Collection and testing of blood for HBV and HIV serological status;

(A) The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

(B) If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

(vi) Post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

(v) Counseling; and

(vi) Evaluation of reported illnesses.

(4) Information Provided to the Healthcare Professional.

(i) The employer shall ensure that the healthcare professional responsible for the employee’s Hepatitis B vaccination is provided a copy of this regulation.

(ii) The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

(A) A copy of this regulation;

(B) A description of the exposed employee's duties as they relate to the exposure incident:

(C) Documentation of the route(s) of exposure and circumstances under which exposure occurred;

(D) Results of the source individual's blood testing, if available; and

(E) All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

(5) Healthcare Professional's Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

(i) The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

(ii) The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

(A) That the employee has been informed of the results of the evaluation; and

(B) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

(iii) All other findings or diagnoses shall remain confidential and shall not be included in the written report.

(6) Medical recordkeeping. Medical records required by this standard shall be maintain in accordance with paragraph(h)(1) of this section.

G. Communication of hazards to employees-

(1) Labels and signs.

(i) Labels.

(A) Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious material; except as provided in paragraph(g)(1)(i)(E), (F) and (G).

(B) Labels required by this section shall include the following legend:

Biohazard

(C) These labels shall be fluorescent orange or orange-red or predominantly so, with lettering or symbols in contrasting color.

(D) Labels required by affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

(E) Red bags or red containers may be substituted for labels.

(F) Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of paragraph (g).

(G) Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

(H) Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

(I) Regulated waste that has been decontaminated need not be labeled or color-coded.

(ii) Signs.

(A) The employer shall post signs at the entrance to work areas specified in paragraph(e), HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:

Biohazard

(Name of the Infectious Agent)

(Special requirements for entering the area)

(Name, telephone number of the laboratory director or other responsible person).

(B) These signs shall be fluorescent orange-red or predominantly so, with lettering or symbols in a contrasting color.

(2) Information and Training.

(i) Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

(ii) Training shall be provided as follows:

(A) At the time of initial assignment to tasks where occupational exposure may take place;

(B) Within 90 days after the effective date of the standard; and

(C) At least annually thereafter.

(iii) For employees who have received training on blood borne pathogens in the year preceding the effective date of the standard, only training with respect to the provisions of the standard which were not included need be provided.

(iv) Annual training for all employees shall be provided within one year of their previous training.

(v) Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

(vi) Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

(vii) The training program shall contain at a minimum the following elements;

(A) Inaccessible copy of the regulatory text of this standard and an explanation of its contents;

(B) A general explanation of the epidemiology and symptoms of blood borne diseases;

(C) An explanation of the modes of transmission of blood borne pathogens;

(D) An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

(E) An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

(F) An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment;

(G) Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

(H) An explanation of the basis for selection of personal protective equipment;

(I) Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

(J) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

(K) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

(L) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following and exposure incident;

(M) An explanation of the signs and label and/or color coding required by paragraph(g)(1); and

(N) An opportunity for interactive questions and answers with the person conducting the training session.

(vii) The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

(ix) Additional Initial Training for Employees in HIV and HBV Laboratories and Production Facilities. Employees in HIV or HBV research laboratories and HIV or HBV production facilities shall receive the following initial training in addition to the above training requirements.

(A) The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV or HBV.

(B) The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV or HBV.

(C) The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as technique are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

H. Recordkeeping-

(1) Medical Records.

(i) The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.20.

(ii) This record shall include:

(A) The name and social security number of the employee;

(B) A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph(f)(2);

(C) A copy of all results of examinations, medical testing, and follow-up procedures as required by paragraph (f)(3);

(D) The employer's copy of the healthcare professional's written opinion as required by paragraph (f)(5); and

(E) A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B)(C) and (D).

(iii) Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(1) are:

(A) Kept confidential; and

(B) Are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

(iv) The employer shall maintain the records required by paragraph(h) for at least the duration of employment plus 30 years in accordance with 29 CFR 1910.20.

(2) Training Records.

(i) Training records shall include the following information:

(A) The dates of the training sessions;

(B) The contents or a summary of the training sessions;

(C) The names and qualifications of persons conducting the training; and

(D) The names and job titles of all persons attending the training sessions.

(ii) Training records shall be maintained for 3 years from the date on which the training occurred.

(3) Availability.

(i) The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

(ii) Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

(iii) Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

(4) Transfer of Records.

(i) The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.20(h).

(ii) If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

(i) Dates-

(1) Effective Date. The standard shall become effective on March 6, 1992.

(2) The Exposure Control Plan required by paragraph(c)(2) of this section shall be completed on or before May 5, 1992.

(3) Paragraph (g)(2) Information and Training and (h) Recordkeeping shall take effect on or before June 4, 1992.

(4) Paragraphs (d)(2) Engineering and Work Practice Controls, (d)(3) Housekeeping, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, and (g) (1) Labels and Signs, shall take effect July 6, 1992.

Appendix A to Section 1910.1030-Hepatitis B Vaccine Declination (Mandatory)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV)a

infection, I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

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APPENDIX 9 – RELATED COBRA REGULATIONS

H.R. 3128-83

Subpart B-Miscellaneous Provisions

Sec. 9121. Responsibilities of Medicare Hospitals in Emergency Cases.

(a) Requirement of Medicare Hospital Provider Agreements.-Section 1866(a)(1) of the Social Security Act (42 USC 1395cc (a)(1) is amended-

(1) by striking out "and" at the end of subparagraph (G),

(2) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof", and ", and

(3) by inserting after subparagraph (H) the following new subparagraph: "(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable."

(b) Requirements-Title XVIII of such Act is amended by inserting after section 1866 the following new section:

Examination and Treatment for Emergency Medical Conditions and Women in Active Labor

"Spec. 1867 (a) Medical Screening Requirement.-In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (3)(1) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

(b) Necessary Stabilizing Treatment for Emergency Medical Conditions and Active Labor.-

(1) In general.-If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either-

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to Consent to Treatment - A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

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(3) Refusal to Consent to Transfer - A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

(c) Restricting Transfers Until Patient Stabilized -

(1) Rule. - If a patient at a hospital has an emergency medical condition which has not been stabilized (with the meaning of subsection (e)(4)(B) or is in active labor, the hospital may transfer the patient unless-

(J) (i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

(ii) a physician (within the meaning of section 1861(r)(1), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(d) Enforcement-

(1) As Requirement of Medicare Provider Agreement. - If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to-

(A) termination of its provider agreement under this title in accordance with section 1866(b), or

(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

(2) Civil Monetary Penalties. - In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previous sentence, the term "responsible physician" means, with respect to a hospital's, a physician who-

(A) is employed by, or under contract with, the participating hospital, and

(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

(3) Civil Enforcement-

(A) Personal Harm.- Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as appropriate.

(B) Financial Loss To Other Medical Facility.- Any medical facility that suffers a financial loss as a direct result of participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations On Actions.- No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) Definitions.- In this section:

(1) The term `emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(3) The term `participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

(4) (A) The term `to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term `stabilized' means with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

(5) The term `transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) Preemption.- The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(c) Effective Date.- The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

(d) Report.- The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

Sec. 9122. Requirement For Medicare Hospitals for Participate In Champus and Champva Programs.

(a) In General.- Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1) is amended-

(1) by striking out "and" at the end of subparagraph (H),

(2) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof", and", and

(3) by inserting after subparagraph (I) the following new subparagraph:

(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code."

(b) Effective Date.- The amendments made by subsection (a) shall apply to agreements entered into our renewed on or after the date of the enactment of this Act, but shall apply only to

inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

(c) Reference to Study Required.- For a study of the use by Champus of the Medicare prospective payment system, see section 634 of the Department of Defense Authorization Act, 1985 (Public Law 98-525), the deadline for which is extended under section 2002 of this Act.

(d) Report.- The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection(a).

APPENDIX 10 - DEATHS

100 PRONOUNCEMENTS/REPORTING/MOVING BODIES/PENALTIES FOR VIOLATIONS

1. When to resuscitate

2. Laws as they relate to Emergency Medical Services

3. The Law

Section

41-61-53 Definitions

41-61-59 Reporting of deaths to Medical Examiner or Medical Examiner Investigator

41-61-61 Notification of death, Moving bodies, Penalty for violations

100.01 When to Resuscitate

1. The statute in no way attempts to define when resuscitation should be initiated or withheld. This always has been and still is a medical and not a legal decision. The American Heart Association has established guidelines on decision-making and CPR, and the National Registry of Emergency Medical Technicians recognizes these as acceptable standards. They are as follows:

2. Few reliable criteria exist by which death can be defined immediately.

   Decapitation, rigor mortis, and evidence of tissue decomposition and dependent lividity are reliable criteria. In the absence of such findings, CPR generally should be initiated immediately unless there is an acceptable reason to withhold it. If the decision not to initiate CPR is made by medical professional functioning in his professional capacity, the basis of the decision should not be arbitrary. The reason to withhold CPR should be sufficiently firm so that, should it later be subject to question, a decision can be effectively supported. Contact Medical Control in any questionable decision.

100.02 Laws As They Relate To Emergency Medical Services

1. The source of the laws which pertain to death is the Medical Examiners Act of 1986 and its revisions. For the purpose of this appendix only the portions of the laws that directly effect EMS will be quoted.

2. It should be pointed out that in any case and under any circumstances, if it is felt by EMS personnel that the patient is resuscitable, neither the Medical Examiner nor Law Enforcement personnel can force the withholding of treatment.

100.03 The Law

41-61-53 Definitions

For the purposes of Sections 41-61-51 through 41-61-79, the following definitions shall apply:

a. "Certification of death" means signing the death certificate.

b. "Coroner" means the elected county official provided for in Sections 19-21-101 through 19-21-107.

c. "County medical examiner investigator" means a nonphysician trained and appointed to investigate and certify deaths affecting the public interest.

d. "County medical examiner" means a licensed physician appointed to investigate and certify deaths affecting the public interest.

e. "Death affecting the public interest" means any death of a human being where the circumstances are sudden, unexpected, violent, suspicious or unattended.

f. “Medical examiner” means the Stat Medical Examiner, county medical examiners and county medical examiner investigators collectively, unless otherwise specified.

g. "Pronouncement of death" means the statement of opinion that life has ceased for an individual.

h. "State medical examiner" means the board certified forensic pathologist/physician appointed by the Commissioner of Public Safety to investigate and certify deaths which affect the public interest.

Sources: Laws, 1986, ch. 459, 7, eff from and after July 1, 1986.

100.04 41-61-59 Report Of Death To Medical Examiner; Investigation Of Death; Compensation Of Chief Medical Examiner Or Investigator.

1. A person's death which affects the public interest as specified in subsection (2) of this section shall be promptly reported to the medical examiner by the physician in attendance, any hospital employee, any law

enforcement officer having knowledge of the death, the embalmer or other funeral home employee, any emergency medical technician, any relative or any other person present. The appropriate medical examiner shall notify the municipal or state law enforcement agency or sheriff and take charge of the body.

2. A death affecting the public interest includes, but is not limited to, any of the following:

   a. Violent death, including homicidal, suicidal, or accidental death.

   b. Death caused by thermal, chemical, electrical or radiation injury.

   c. Death caused by criminal abortion, including self-induced abortion, or abortion related to or by sexual abuse.

   d. Death related to disease thought to be virulent or contagious which may constitute a public hazard.

   e. Death that has occurred unexpectedly or from an unexplained cause.

   f. Death of a person confined in a prison, jail or correctional institution.

   g. Death of a person where a physician was not in attendance within thirty-six (36) hours preceding death, or in prediagnosed terminal or bedfast cases, within thirty (30) days preceding death.

   h. Death of a person where the body is not claimed by a relative or a friend.

   i. Death of a person where the identify of the deceased is unknown.

   j. Death of a child under the age of two (2) years where death results from an unknown cause or where the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

   k. Where a body is brought into this state for disposal and there is reason to believe either that the death was not investigated properly or that there is not an adequate certificate of death.

   l. Where a person is presented to a hospital emergency room unconscious and/or unresponsive, with cardiopulmonary resuscitative measure being performed, and dies within twenty-four (24) hours of admission without regaining consciousness or responsiveness, unless a physician was in attendance within thirty-six (36) hours preceding presentation to the hospital, or in cases in which the decedent had a prediagnosed terminal or bedfast condition, unless a physician was in

attendance within thirty (3) days preceding presentation to the hospital.

Sources: Laws, 1986, ch. 459, 10; 1987, ch. 504; 1989, ch. 455, 2; 1990, ch. 453, 2, eff from and after October 1, 1990; 1991, ch, 591, 1, eff from and after October 1, 1991.

100.05 41-61-61 County medical Examiner To Be Notified Of Death; Disturbing Body At Scene Of Death; Reports; Penalty For Violations; Transporting Body to Autopsy Facility.

1. Upon the death of any person where that death affects the public interest, the medical examiner of the county in which the body of the deceased is found or, if death occurs in a moving conveyance, where the conveyance stops and death is pronounced, shall be notified promptly by any person having knowledge or suspicion of such a death, as provided in subsection (1) of Section 41-61-59. No person shall disturb the body at the scene of such a death until authorized by the medical examiner, unless the medical examiner is unavailable and it is determined by an appropriate law enforcement officer that the presence of the body at the scene would risk the integrity of the body or provide a hazard to the safety of others. For the limited purposes of this section, expression of an opinion that death has occurred may be made by a nurse, an emergency medical technician, or any other competent person, in the absence of a physician.

2. The discovery of anatomical material suspected of being part of the human body shall be promptly reported to the medical examiner of the county in which the material is found, or to the State Medical Examiner.

3. A person who willfully moves, distributes or conceals a body or body part in violation of this section is guilty of a misdemeanor, and may be punished by a fine of not more than Five Hundred Dollars ($500.00), or by imprisonment for not more than six (6) months in the county jail, or by both such fine and imprisonment.

4. Upon oral or written authorization of the medical examiner, if any autopsy is to be performed, the body shall be transported directly to an autopsy facility in a suitable secure conveyance, and the expenses of transportation shall be paid by the county for which the service is provided. The county may contract with individuals to make available a vehicle to the medical examiner or law enforcement personnel for transportation of bodies.

Sources: Laws, 1986, ch. 459, 11, eff from and after July 1, 1986.

101 APPENDIX 11 - GLOSSARY

1. "Advanced life Support" - shall mean a sophisticated level of pre-hospital and interhospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of antiarrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures.

2. "Advanced life support personnel" - shall mean persons other than physicians engaged in the provision of advanced life support, as defined and regulated by rules and regulations promulgated pursuant to Section 41-60-13.

3. "Advanced Life Support Services" - shall mean implementation of the 15 components of an EMS system to a level capability which provides noninvasive and invasive emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Services shall include use of sophisticated transportation vehicles, a communications capability (two-way voice and/or biomedical telemetry) and staffing by Emergency Medical Technician-Intermediates or Emergency Medical Technician-Paramedics providing on-site, pre-hospital mobile and hospital intensive care under medical control.

4. "Ambulance" - shall mean any privately or publicly owned land or air vehicle that is especially designed, constructed, modified or equipped to be used, maintained and operated upon the streets, highway or airways of this state to assist persons who are sick, injured, wounded or otherwise incapacitated or helpless.

5. "Ambulance Placement Strategy (System Status Plan)" - a planned outline or protocol governing the deployment and event-driven redeployment of the ambulance service's resources, both geographically and by time-of-day/day-of-week. Every system has a plan; the plan may be written or not, elaborate or simple, efficient or wasteful, effective or deadly.

6. "Ambulance Post" - a designated location for ambulance placement within the system status plan. Depending upon its frequency and type of use, a "post" may be a facility with sleeping quarters or day rooms for crews, or simply a street-corner or parking lot location to which units are sometimes deployed.

7. "Ambulance Service Area" - the geographic response area of the licensed ambulance service. The service area must correspond to each individual service license. The service's employee staffing plan, ambulance placement strategy and available resources must be commensurate with the service area.

8. "Area wide EMS System" - is an emergency medical service area (trade, catchment, market, patient flow) that provides essentially all of the definitive emergency medical care (95%) for all emergencies, including the most critically ill and injured patients. Only highly specialized and limited-use services may need to be obtained outside of the area. The area must contain adequate population and

available medical resources to implement and sustain an EMS operation. At least three major modes exist: (a) multiple urbanized communities and their related suburbs; (b) a metropolitan center and its surrounding rural areas; and (c) a metropolitan center and extreme rural-wilderness settings. The areas may be inter- or intra-state.

9. "Associate/Receiving Hospital" - is a designated participating hospital working in conjunction with and under the supervision of the Resource Hospital to carry out the system implementation. They shall have an emergency department/service which offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation must be available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided. They must be capable of providing 24-hour-a-day acute care to critically ill patients. They do not, however, have to be equipped with biomedical telemetry within its confines.

10. "Automated External Defibrillator (AED)" - means a defibrillator which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a shock-advisory device in which the defibrillator will analyze the rhythm and display a message advising the operator to press a "shock" control to deliver the shock; c) must be capable of printing a post event summary (at a minimum the post event summary should include times, joules delivered, ECG) and d) an on screen display of the ECG. (optional)

11. "Base Station Hospital" - is designated participating hospital working in conjunction with and under the supervision of the Resource Hospital to carry out the systems implementation. These hospitals may function as a pre-hospital Communications Resource as defined in the section on Medical Direction. The hospitals may participate in training and evaluation of ALS personnel. They must have emergency department’s staffed 24-hours-a-day by critical care nurses and at least one emergency physician or physicians under the direction and supervision of a physician totally versed and committed to emergency medicine. It must have specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Pre-hospital ALS personnel transmit patient information to the Base Station Hospitals and receive appropriate medical directions from them. The hospitals should be equipped with voice and biomedical telemetry equipment. Each Base Station Hospital must have an On-Line Medical Director.

12. "Basic Life Support Services (BLS)" - Implementation of the 15 components of and EMS system to a level of capability which provides pre-hospital noninvasive emergency patient care designed to optimize the patient's chance of surviving the emergency situation. There would be universal access to and dispatch of national standard ambulances, with appropriate medical and communication equipment

operated by Emergency Medical Technicians-Ambulance. Regional triage protocols should be used to direct patients to appropriately categorized hospitals.

13. "Board" means the State Board of Health;

14. “Bypass” (diversion) - A medical protocol or medical order for the transport of an EMS patient past a normally used EMS receiving facility to a designated medical facility for the purpose for accessing more readily available or appropriate medical care.

15. "Certificate” means official acknowledgment that an individual has successfully completed (i) the recommended basic emergency medical technician training course referred to in this chapter which entitles that individual to perform the functions and duties of an emergency medical technician, or (ii) the recommended medical first responder training course referred to in this chapter which entitles that individual to perform the functions and duties of a medical first responder;

16. "Critical Care Units (Centers)" - are sophisticated treatment facilities in large medical centers and hospitals that provide advanced definitive care for the most critically ill patients. The units are available for the diagnosis and care of specific patient problems including major trauma, burn, spinal cord injury, poisoning, acute cardiac, high risk infant and behavioral emergencies.

17. "Communication Resource" - an entity responsible for implementation of direct medical control (See detailed description in section on Medical Direction).

18. "Delegated Practice" - Only physicians are licensed to practice medicine. Pre-hospital providers must act only under the medical direction of a physician.

19. “Department” - the Mississippi State Department of Health, Bureau of Emergency Medical Services.

20. "Direct Medical Control" - When a physician provides immediate medical direction to pre-hospital providers in remote locations.

21. “Diversion” - see "Bypass."

22. "DOT" - shall mean United States Department of Transportation.

23. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

24. "Emergency Medical Services (EMS)" - Services utilized in responding to a perceived individual's need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.

25. "EMS Personnel" - Key individual EMS providers. This includes physician, emergency and critical care nurse, EMT-Basic, EMT-Intermediate, EMT-Paramedic, dispatchers, telephone screeners, first aid responders, project administrators and medical consultants and system coordinators.

26. "EMS System" - A system which provides for the arrangement of personnel, facilities, and equipment of the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occurring as a result of the patient's condition or because of natural disasters or similar conditions). The system is managed by a public or nonprofit private entity. The components of an EMS System include:

    a. manpower

    b. training

    c. communications

    d. transportation

    e. facilities

    f. critical care units

    g. public safety agencies

    h. consumer participation

    i. access to care

    j. patient transfer

    k. coordinated patient recordkeeping

    l. public information and education

    m. review and evaluation

    n. disaster plan

    o. mutual aid

27. "Emergency medical technician" - shall mean an individual who possesses a valid emergency medical technician's certificate issued pursuant to the provisions of this chapter.

28. "Emergency medical technician-intermediate" - shall mean a person specially trained in advanced life support modules as authorized by the Mississippi State Department of Health.

29. "Emergency medical technician-paramedic" - shall mean a person specially trained in an advanced life support training program authorized by the Mississippi State Department of Health.

30. "Emergency mode" means an ambulance or special use EMS vehicle operating with emergency lights and warning siren (or warning siren and air horn) while engaged in an emergency medical call.

31. "Emergency response" means responding immediately at the basic life support or advanced life support level of service to an emergency medical call. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call;

32. "Emergency medical call" means a situation that is presumptively classified at time of dispatch to have a high index of probability that an emergency medical condition or other situation exists that requires medical intervention as soon as possible to reduce the seriousness of the situation, or when the exact circumstances are unknown, but the nature of the request is suggestive of a true emergency where a patient may be at risk;

33. "Executive officer" - shall mean the executive officer of the State Department of Health or his designated representative.

34. “Field Categorization” (classification) - a medical emergency classification procedure for patients that is applicable under conditions encountered at the site of a medical emergency.

35. “Field Triage” - Classification of patients according to medical need at the scene of an injury or onset of an illness.

36. "First responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons

37. "Medical first responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons who (i) is trained to assist other EMS personnel by successfully completing, and remaining current in refresher training in accordance with, an approved "First Responder: National Standard Curriculum" training program, as developed and promulgated by the United States Department of Transportation, (ii) is nationally registered as a first responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a medical first responder by the State Department of Health, Division of Emergency Medical Services.

38. “Implementation” (or "implemented") - the development and activation of a Regional Trauma Plan by a designated Trauma Care Region including the triage, transport and treatment of trauma patients in accordance with the plan.

39. “Inclusive Trauma Care System” - a trauma care system that incorporates every health care facility in a community in a system in order to provide a continuum of services for all injured persons who require care in an acute care facility; in such a system, the injured patient's needs are matched to the appropriate hospital resources.

40. "Implied Consent" - shall mean legal position that assumes an unconscious patient, or one so badly injured or ill that he cannot respond, would consent to receiving emergency care. Implied consent applies to children when parent or guardian is not at the scene.

41. "Intervener Physicians" - A licensed M.D. or D.O., having not previously established a doctor/patient relationship with the emergency patient and willing to accept responsibility for a medical emergency scene, and can provide proof of a current Medical Licensure.

42. "Lead Agency" - is an organization which has been delegated the responsibility for coordinating all component and care aspects for an EMS system.

43. “Level I” - Hospitals that have met the requirements for Level I as stated in the Mississippi Trauma Rules and Regulations.

44. “Level II” - Hospitals that have met the requirements for Level II as stated in Mississippi Trauma Rules and Regulations.

45. “Level III” - Hospitals that have met the requirements for Level III as stated in Mississippi Trauma Rules and Regulations.

46. “Level IV” - Hospitals that have met the requirements for Level IV as stated in Mississippi Trauma Rules and Regulations.

47. "Licensure" - shall mean an authorization to any person, firm, cooperation, or governmental division or agency to provide ambulance services in the State of Mississippi.

48. "License Location" - shall be defined as a fixed location where the ambulance service conducts business or controls the deployment of ambulances to the service area.

49. “Major Trauma” - that subset of injuries that encompasses the patient with or at risk for the most severe or critical types of injury and therefore requires a system approach in order to save life and limb.

50. “Major Trauma Patient” (or "major trauma" or " critically injured patient") - a person who has sustained acute injury and by means of a standardized field triage criteria (anatomic, physiology, and mechanism of injury) is judged to be at significant risk of mortality or major morbidity.

51. “Mechanism of Injury” - the source of forces that produce mechanical deformations and physiological responses that cause an anatomic lesion of functional change in humans.

52. "Medical Control" - shall mean directions and advice provided from a centrally designated medical facility staffed by appropriate personnel, operating under medical supervision, supplying professional support through radio or telephonic communication for on-site and in-transit basic and advanced life support services given by field and satellite facility personnel.

53. "Medical Direction" - (medical accountability) - When a physician is identified to develop, implement and evaluate all medical aspects of an EMS system.

54. "Medical Director" - (off line, administrative) should be a physician both credible and knowledgeable in EMS systems planning, implementation, and operations. This off-line physician assumes total responsibility for the system's activities. He is appointed by the local EMS lead agency. The administrative medical director works in close liaison with government agencies, public safety and disaster operations, legislative and executive offices, professional societies, and the public. Off-line program activities include liaison with other state and regional EMS medical directors to conceptualize clinical and component system designs, establish standards, monitor and evaluate the integration of component and system activities.

    a. This off-line physician assures medical soundness and appropriateness of all aspects of the program and is responsible for the conceptual and systems design and overall supervision of the EMS program.

    b. The administrative (off-line) medical director in conjunction with the supervisory ALS (on-line) medical directors of each Base Station Hospital, medical directors for paramedic services, medical director for EMS training, and critical care consultants develop all area protocols. These protocols serve as the basis for EMS system role definition of ALS personnel, curriculum development, competency determination, and maintenance, monitoring, and evaluation.

    c. The off-line medical director meets on a regular basis with on-line medical directors and the EMS training director to evaluate on-line system performance, to review problems, and suggest changes in treatment, triage, or operational protocols. All on-line medical directors must be approved by the off-line medical director.

55. “Mississippi Trauma Advisory Committee” (MTAC) - (See Appendix A) advisory body created by legislature for the purpose of providing assistance in all areas of trauma care system development and technical support to the Department of Health; members are comprised of EMS Advisory Council members appointed by the chairman.

56. “Mississippi Trauma Care System Plan” (State Trauma Plan) - a formally organized plan developed by the Department of Health, pursuant to legislative directive, which sets out a comprehensive system of prevention and management of major traumatic injuries.

57. "On-Line (Supervising ALS) Medical Director" - On-Line medical control is provided through designated Primary Resource and Base Station Hospitals under the area direction of a supervisory ALS medical director who is on-line to the pre-hospital system stationed at the designated Base Station Hospital. Each provider of ALS must also have an on-line medical director. The system must also have an on-line medical director for EMS training. These supervisory medical directors are organizationally responsible to the administrative (off-line medical director of the local EMS lead agency for program implementation and operations within his area of jurisdiction).

    a. The ALS (on-line) medical director supervises the advanced life support, pre- and inter-hospital system and is responsible for the actual day-to-day operation of the EMS system. He carries out the "EMS systems design" in terms of pre-and inter-hospital transportation care and provides ALS direction to EMS providers depending on the transportation care and provides ALS direction to EMS providers depending on the system's configuration. He monitors all pre-hospital ALS activities within that system's region or area of responsibility. The ALS physician must review and monitor compliance to protocols for both the pre-and inter-hospital settings.

    b. The ALS (on-line) medical director in conjunction with the EMS training medical director reviews paramedics, intermediates, mobile intensive care nurses, and physician competencies and recommends certification, re-certification, and decertification of these personnel to the EMS health officer of the lead agency responsible for the certification decertification, and recertification of EMS personnel. Monitoring the competency of all pre-hospital EMS personnel activities is within his responsibility.

    c. He attends medical control meetings where area system performance and problems are discussed and recommendations to the administrative off-line director are made. He also conducts regular case reviews and other competency evaluation and maintenance procedures and reports back to the administrative (off-line) medical director.

d. This ALS (on-line) physician assumes the supervision and responsibility for all advanced care rendered in an emergency at the scene of an accident and en route to the hospital under his area jurisdiction. Each on-line medical director representing the hospitals providing medical control has the authority to delegate his duties to other emergency department physicians who may be on duty and placed in a position of giving medical direction to pre-hospital ALS personnel.

58. “Pediatric Trauma Center” - Either (a) a licensed acute care hospital which typically treats persons fourteen (14) years of age or less, which meets all relevant criteria contained in these Regulations and which has been designated as a pediatric Trauma Center; or (b) the pediatric component of a Trauma Center with pediatric specialist and a pediatric intensive care unit.

59. “Performance Improvement” (or "quality improvement") - a method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome.

60. "Permit" - shall mean an authorization issued for an ambulance vehicle as meeting the standards adopted pursuant to this chapter.

61. "Pre-hospital Provider" - all personnel providing emergency medical care in a location remote from facilities capable of providing definitive medical care.

62. "Primary Resource Hospital" - The Primary Resource Hospital (PRH) is responsible for implementing the medical control design of the ALS system. It has the major functional responsibility for implementing protocols (treatment, triage, and operations) and the monitoring of program compliance to these by on-line medical supervision. This hospital must be an acute general care facility equipped with voice and biomedical telemetry equipment. It should be staffed with critical care nurses and emergency physicians, or physicians under the direction and supervision of physicians totally versed and committed to emergency medicine. It must be capable of functioning as a Communications Resource as described in the section on Medical Direction and pre-hospital ALS personnel should be able to receive medical control and direction from this facility anywhere within the district. It is also understood that this facility is responsible for overall supervision of medical directions that may be issued by other participating hospitals within the district.

a. This hospital provides and coordinates interdisciplinary training for ALS providers within the district. The lead agency may choose to delegate or contract this responsibility to other institutions."

63. “Protocols” - standards for EMS practice in a variety of situations within the EMS system.

64. “Regional Trauma Plan” - a document developed by the various Trauma Care Regions, and approved by the Department of Health, which describes the policies, procedures and protocols for a comprehensive system of prevention and management of major traumatic injuries in that Trauma Care Region.

65. “Regionalization” - the identification of available resources within a given geographic area, and coordination of services to meet the need of a specific group of patients.

66. “Service Area” (or "catchment area") - that geographic area defined by the local EMS agency in its Regional Trauma Plan as the area served by a designated Trauma Center.

67. “Specialty Care Facility” - an acute care facility that provides specialized services and specially trained personnel to care for a specific portion of the injured population, such as pediatric, burn injury, or spinal cord injury patients.

68. “Surveillance” - the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event.

69. “Trauma” - a term derived from the Greek for "wound"; it refers to any bodily injury (see "Injury").

70. “Trauma Care Facility” (or "trauma center") - a hospital that has been designated by the department to perform specified trauma care services within a Trauma Care Region pursuant to standards adopted by the department.

71. “Trauma Care Region” - Trauma Care Region is a geographic area of the state formally organized, in accordance with standards promulgated by the department and has received designation from the department, for purposes of developing and inclusive care system.

72. “Trauma Care System Planning and Development Act of 1990” - The federal law that amended the Public Health Service Act to add Title XII - Trauma Programs. The purpose of the legislation being to assist State governments in developing, implementing and improving regional systems of trauma care, and to fund research and demonstration projects to improve rural EMS and trauma.

73. “Trauma Care System” - an organized approach to treating patients with acute injuries; it provides dedicated (available 24 hours a day) personnel, facilities, and equipment for effective and coordinated trauma care in an appropriate geographical region, known as a Trauma Care Region.

74. “Trauma Center Designation” - the process by which the Department identifies facilities within a Trauma Care Region.

75. "Trauma Program Manager" - a designated individual with responsibility for coordination of all activities on the trauma service and works in collaboration with the trauma service director.

76. "Standing Orders" - are those specific portions of the treatment protocols that may be carried out by ALS personnel without having to establish contact with medical control facility. These standing orders represent nationally recognized treatment modalities and allow the ALS personnel to treat life-threatening problems without delay.

77. "State EMS Medical Director" – A Mississippi licensed physician, employed by the Mississippi Department of Health, who is responsible for the development, implementation, and evaluation of standards and guidelines for the provision of emergency medical services and EMS medical direction in the state. This physician must have experience in EMS medical direction and be board certified in emergency medicine. This physician must be experienced with EMS systems, EMS medical direction, evaluation processes, teaching, and curriculum development. It is the goal of the State EMS Medical Director to ensure the care delivered by EMS systems in the state is consistent with recognized standards and that quality is maintained in a manner that assures professional and public accountability. The State EMS Medical Director must serve as an advocate for efficient and effective emergency medical services throughout the state.

a. The Responsibilities of the State EMS Medical Director include but are not limited to:

i. * Oversight of all aspects of EMS Medical direction in the state

ii. * Oversight of the of standards and minimum qualifications for EMS Medical Directors

iii. * Approval of System Medical Directors for ambulance services

iv. * Approval of protocols for ambulance services

v. * Approve training programs, training standards, and curricula for EMS providers and medical directors.

vi. * Oversight of all aspects of EMS quality assurance and performance improvement in the state

vii. * Approval of the Quality Assurance and Performance Improvement plans for ambulance services

viii. * Serve as Chairman of the Committee on Medical Direction, Training, and Quality Assurance

ix. * Serve as Chairman of the EMS Performance Improvement Committee

x. * Serve as Chairman of the EMS Protocol Committee

xi. * Act as a liaison with public safety and disaster planning agencies

xii. * Act as a liaison with national EMS agencies

xiii. * Oversight of issues related to complaints, investigations, disciplinary procedures involving patient care, performance standards, and medical direction

78. “State Trauma Plan” – See Mississippi Trauma Care Plan

79. "Transfer" - The movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such a movement of a patient who (a) has been declared dead, or (b) leaves the facility without the permission of any such person.

80. "Treatment Protocols" - are written uniform treatment and care plans for emergency and critical patients. These treatment plans must be approved and signed by the off-line medical director and/or medical groups. (Appendix 2)

81. “Triage” - the process of sorting injured patients on the basis of the actual or perceived degree of injury and assigning them to the most effective and efficient regional care resources, in order to insure optimal care and the best chance of survival.

82. “Triage Criteria” - a measure or method of assessing the severity of a person's injuries that is used for patient evaluation, especially in the prehospital setting, and that utilizes anatomic or physiologic considerations or mechanism of injury.

83. "Triage Protocols" - are region wide plans for identifying, selecting and transporting specific critical patients to appropriate, designated treatment facilities.