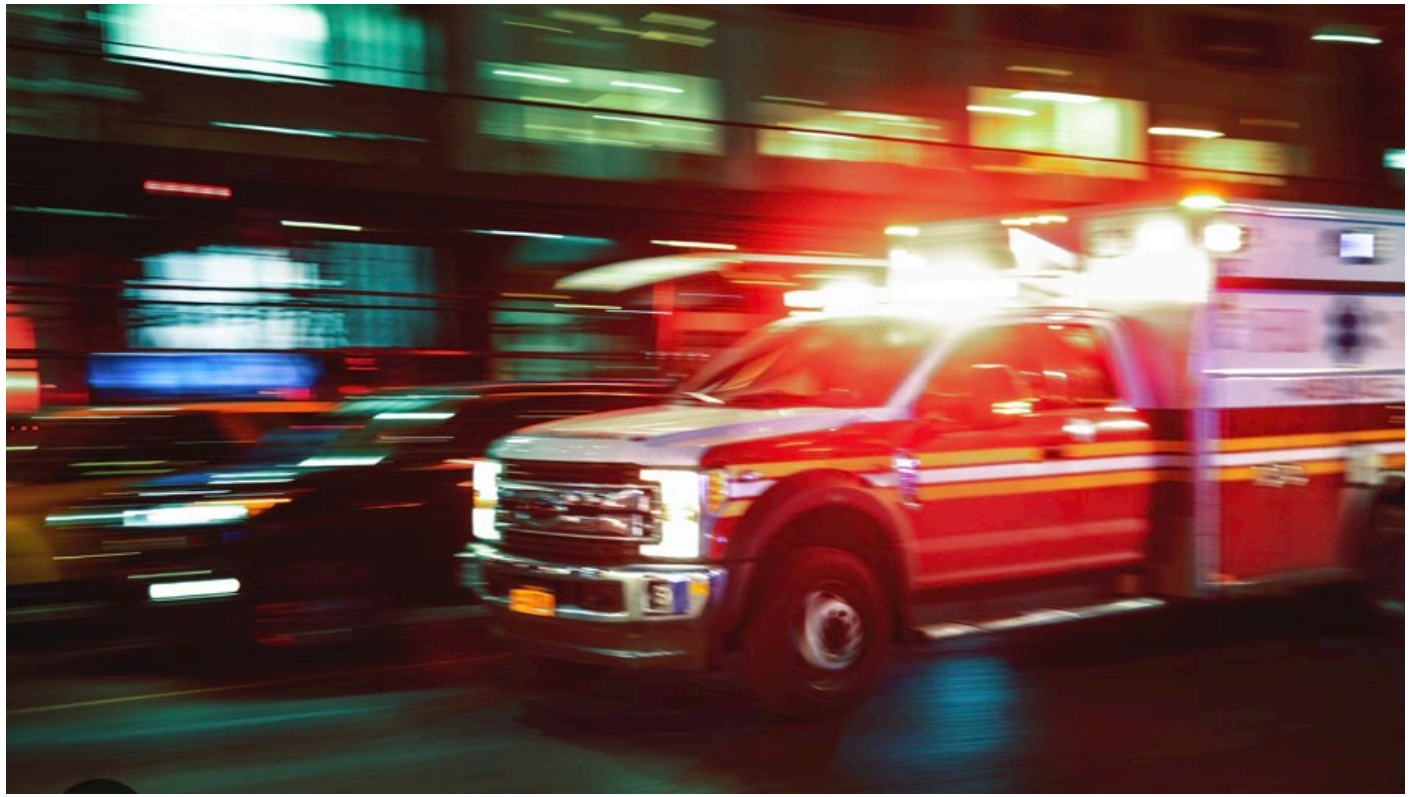

Sustaining Essential Health Care Services Related To Intimate Partner Violence (IPV) During Public Health Emergencies:

Panel 2 IPV Care In Various Care Settings - Prehospital

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Disclosures

- None to report

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Three main themes:

1. Data on Intimate Partner Violence(IPV) is lacking in EMS
2. EMS is often called to care for patients who are injured secondary to IPV yet lack training on management
3. 69% of EMS personnel experiences at least one form of violence in last 12 months

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Data on IPV as a Call Type is Lacking

- EMS Agencies do not routinely collected data on IPV
- Difficult to track exposures and response without research

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Data on IPV as a Call Type is Lacking

Legend

Dataset Level: N National S State D Deprecated

Usage: M = Mandatory , R = Required , E = Recommended, or O = Optional

Attributes: N = Not Values, P = Pertinent Negatives , L = Nillable, C = Correlation ID, and/or U = UUID

eSituation

1 : 1	eSituation.01 - Date/Time of Symptom Onset	N	S	R	N, L, P
1 : 1	eSituation.02 - Possible Injury	N	S	R	N, L
1 : 1	eSituation.07 - Chief Complaint Anatomic Location	N	S	R	N, L
1 : 1	eSituation.08 - Chief Complaint Organ System	N	S	R	N, L
1 : 1	eSituation.09 - Primary Symptom	N	S	R	N, L
1 : M	eSituation.10 - Other Associated Symptoms	N	S	R	N, L, P
1 : 1	eSituation.11 - Provider's Primary Impression	N	S	R	N, L
1 : M	eSituation.12 - Provider's Secondary Impressions	N	S	R	N, L
1 : 1	eSituation.13 - Initial Patient Acuity	N	S	R	N, L
1 : 1	eSituation.18 - Date/Time Last Known Well	N	S	R	N, L, P
1 : 1	eSituation.20 - Reason for Interfacility Transfer/Medical Transport	N	S	R	N, L

eSituation

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Data on IPV as a Call Type is Lacking

NEMSIS Version 3.5.0.211008CP3

eDispatch.01

State | National

eDispatch.01 - Dispatch Reason

Definition

The dispatch reason reported to the responding unit.

National Element	Yes	Pertinent Negatives (PN)	No
State Element	Yes	NOT Values	
Version 2 Element	E03_01	Is Nillable	
Usage	Mandatory	Recurrence	

Associated Performance Measure Initiatives

Airway | Cardiac Arrest | Pediatric | Response | STEMI | Stroke | Trauma

Code List

Code	Description
2301001	Abdominal Pain/Problems
2301003	Allergic Reaction/Stings
2301005	Animal Bite
2301007	Assault
2301009	Automated Crash Notification
2301011	Back Pain (Non-Traumatic)
2301013	Breathing Problem

Legend

Dataset Level: N National | S State | D Deprecated

Usage: M = Mandatory , R = Required , E = Recommended, or O = Optional

Attributes: N = Not Values, P = Pertinent Negatives , L = Nillable, C = Correlation ID, and/or U = UUID

eInjury

1 : M	eInjury.01 - Cause of Injury	N	S	R	N, L
1 : M	eInjury.03 - Trauma Triage Criteria (Steps 1 and 2)	N	S	R	N, L
1 : M	eInjury.04 - Trauma Triage Criteria (Steps 3 and 4)	N	S	R	N, L

eInjury

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PROVIDER IMPRESSION

Definition

Four-letter codes representing the paramedic's primary impression of the patient's presentation

Field Values

ABOP	Abdominal Pain/Problems	**ELCT**	Electrocution	**PREG**	Pregnancy Complications
AGDE	Agitated Delirium	**ENTP**	ENT/Dental Emergencies	**LABR**	Pregnancy/Labor
CHOK	Airway Obstruction/Choking	**NOBL**	Epistaxis	**RARF**	Respiratory Arrest/Failure
ETOH	Alcohol Intoxication	**EXNT**	Extremity Pain/Swelling – Non-Traumatic	**SOBB**	Resp. Distress/Bron
ALRX	Allergic Reaction	**EYEP**	Eye Problem – Unspecified	**RDOT**	Resp. Distres
ALOC	ALOC – Not Hypoglycemia or Seizure	**FEVR**	Fever	**CHFF**	Resp. Distres Edema/CHF
ANPH	Anaphylaxis	**GUDO**	Genitourinary Disorder – Unspecified	**SEAC**	Seizure – Acti
PSYC	Behavioral/Psychiatric Crisis	**DCON**	HazMat Exposure	**SEPI**	Seizure – Pos
BPNT	Body Pain – Non-Traumatic	**HPNT**	Headache – Non-Traumatic	**SEPS**	Sepsis
BRUE	BRUE	**HYPR**	Hyperglycemia	**SHOK**	Shock
BURN	Burns	**HYTN**	Hypertension	**SMOK**	Smoke Inhala
COMO	Carbon Monoxide	**HEAT**	Hyperthermia	**STNG**	Stings/Venom
CANT	Cardiac Arrest– Non-Traumatic	**HYPO**	Hypoglycemia	**STRK**	Stroke/CVA/T
DYSR	Cardiac Dysrhythmia	**HOTN**	Hypotension	**DRWN**	Submersion/D
CPNC	Chest Pain – Not Cardiac	**COLD**	Hypothermia/Cold Injury	**SYNC**	Syncope/Near Syncope
CPMI	Chest Pain – STEMI	**INHL**	Inhalation Injury	**CABT**	Traumatic Arrest – Blunt
CPSC	Chest Pain – Suspected Cardiac	**LOGI**	Lower GI Bleeding	**CAPT**	Traumatic Arrest – Penetrating
BRTH	Childbirth (Mother)	**FAIL**	Medical Device Malfunction – Fail	**TRMA**	Traumatic Injury
COFL	Cold/Flu Symptoms	**NAVM**	Nausea/Vomiting	**UPGI**	Upper GI Bleeding
DRHA	Diarrhea	**BABY**	Newborn	**VABL**	Vaginal Bleeding
DIZZ	Dizziness/Vertigo	**NOMC**	No Medical Complaint	**WEAK**	Weakness – General
DEAD	DOA – Obvious Death	**ODPO**	Overdose/Poisoning/Ingestion		
DYRX	Dystonic Reaction	**PALP**	Palpitations		

EMS DOCUMENTATION MANUAL

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EFFECTIVE: July 2022

TRAUMA			
Crush Injury/Syndrome	1242	1242-P	07/01/2020
Traumatic Arrest	1243	1243-P	07/01/2022
Traumatic Injury *(Multisystem, Isolated head, isolated extremity)*	1244	1244-P	07/01/2022

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EMS Management of IPV

Journal of Forensic and Legal Medicine 38 (2016) 64–69

Contents lists available at ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/locate/jflm

Original communication

What do EMS personnel think about domestic violence? An exploration of attitudes and experiences after participation in training

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EMS Management of IPV

- **EMS is often called to care for patients who are injured secondary to IPV**
  - 403 respondents to survey on domestic violence
  - 71% of respondents indicated that they frequently encounter patients who disclose domestic violence;
  - 45% believe that if a victim does not disclose abuse, there is little they can do to help;
  - 32% to 43% reported assumptions and attitudes that indicate beliefs that victims are responsible for the abuse
  - 50% have received < 1 hour of education on IPV in last 5 years; 19% no training
  - EMS personnel adhere to common misconceptions and erroneous beliefs that minimize abuse or place blame for the abuse on the victim

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EMS Management of IPV

Journal of Interpersonal Violence

Impact Factor: **2.621**
5-Year Impact Factor: **3.363**

JOURNAL HOMEPAGE

Available access | Research article | First published online April 19, 2018

Paramedics as a New Resource for Women Experiencing Intimate Partner Violence

Simon Sawyer, Jan Coles, PhD, MMed, MBBS, [...], and Brett Williams, PhD, FPA +1 View all authors and affiliations

Volume 36, Issue 5-6 | https://doi.org/10.1177/0886260518769363

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EMS Management of IPV

- Paramedics frequently encounter IPV yet rarely receive education on IPV recognition and referral
- There is also evidence that IPV patients are less likely than other patient groups to be transported to emergency department (ED) by paramedics
- EMS mandated reporter (varies by state)

7.14 REPORTING ASSAULT / ABUSE

INDICATION
Suspected assault or Abuse

PROCEDURE

1. Follow appropriate treatment protocol for patient's chief complaint, e.g. head trauma.
2. If concerned about patient safety, transport to an appropriate Receiving Hospital. Notify receiving hospital staff of your concerns.
3. Contact appropriate law enforcement agency (see below).
4. Provide emotional support to the victim and family.
5. When in doubt, transport suspected abuse/neglect victims to a Receiving Hospital.
6. Treat all clothing, medications and personal items with patient at time of transport as potential evidence. If these need to be removed from patient to facilitate assessment/treatment, place them in a container labeled with patient identification and document turnover of these materials to patient treatment team or law enforcement.
7. The patient care report should be descriptive as possible of the conditions of the elder/dependent adult and of his/her living situation.

REPORTING PROCEDURES (SUSPECTED OR ACTUAL INCIDENT)

Contact the appropriate agency by telephone as soon as possible to give a verbal report and receive instructions on how to file a written report (generally must be done within **36-hours**).

DOMESTIC VIOLENCE:

- Notify local law enforcement or Receiving Hospital staff and document.

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American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved April 2019

Domestic Family Violence

Revised April 2019

Reaffirmed June 2013

Originally approved October 2007, replacing rescinded policies: Child Abuse; Domestic Violence; Emergency Medicine and Domestic Violence; Management of Elder Abuse and Neglect; Support for Victims of Family Violence; Mandatory Reporting of Domestic Violence to Law Enforcement and Criminal Justice Agencies

The American College of Emergency Physicians (ACEP) encourages emergency personnel to assess all patients for family violence in all its forms, including that directed toward children, elders, intimate partners, and other family members. Such patients should be appropriately referred for help and detailed evaluation. Identification and assessment can be difficult as violence and maltreatment can encompass abuse in many different forms including neglect, physical abuse, sexual abuse, emotional abuse, financial exploitation and intimidation.

ACEP opposes mandatory reporting of domestic violence to the criminal justice system. Instead, ACEP encourages partnering with and reporting of domestic violence to local social services, victims' services, the criminal justice system, or any other appropriate resource agency to provide confidential counseling and assistance, in accordance with the patient's wishes. Safety planning should be an important component of any screening process. In jurisdictions that have mandatory reporting requirements, persons reporting in good faith should be immune from liability for compliance.

ACEP recommends that:

- Emergency personnel assess patients for intimate partner violence, child and elder maltreatment and neglect.
- Emergency physicians, nurse practitioners, and physician assistants are familiar with signs and symptoms of intimate partner violence, child and elder maltreatment and neglect.
- Emergency medical services, medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment and interventions in intimate partner violence, child and elder maltreatment and neglect.
- Hospitals and emergency departments (EDs) encourage research regarding the epidemiology of intimate partner violence, child and elder maltreatment and neglect as well as best practice approaches to screening, assessment and intervention for victims.
- Hospitals and EDs are encouraged to participate in collaborative interdisciplinary approaches for the screening, assessment, safety planning

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EMS SAFETY TO DOMESTIC VIOLENCE SCENES

En route to call

1. Has police been dispatched? How far away are they?
2. Have there been comparable calls to this residence in the past?
3. Are both you and your partner prepared and equipped for this call? Preparation includes not only equipment, but also mental and emotional preparedness. Have you and your partner practiced what to do in potentially dangerous scenes?

Approach of the scene

1. Approach with your sirens and lights off. Stop your vehicle a half mile from the scene to gather additional clues before stepping from your rig.
2. What clues are evident before stepping out of your rig:
   a. Are there items in the yard or driveway that indicate children might be present?
   b. Are there any indications that firearms may be present at this residence, i.e., gun rack or bumper stickers on a vehicle?
   c. If at night, what lights are on in the house?
3. Is your vehicle parked so that an escape route is available if needed?
4. What is the level or noise at the residence? Any yelling, screaming, or sounds of struggle?

Entry into the residence

1. Don't stand in front of the open door. As you enter a room, turn on the lights. Leave lights on in every room if possible.
2. Are there indications of alcohol or drug use at this residence?
3. Visually frisk everyone for possible weapons when you enter.
4. Identify how many people are in the residence and where they are located; are there neighbors that could be asked to leave: the less people, the better. Never walk down a hallway with someone behind you. Let them lead.
5. If at all possible, do not work on people in kitchens or bedrooms:
   a. Kitchens have numerous and a variety of weapons, including knives, heavy cooking pots, boiling water, glassware.
   b. Bedrooms usually do not have an exit or escape route. Many people keep concealed loaded handguns in the bedroom. And finally, if the perpetrator has jealous nature, the bedroom may be viewed as an intimate and therefore, threatening place.
6. Do not assume that just because the offender has been arrested at the scene, that the situation is under control. The victim or members of the family, even children, have been known to assault police and EMS personnel. Always stay alert!
7. Keep your partner in sight at all times.
8. Maintain link with your dispatch or communication system.
9. Determine location and condition of victim; separate suspect and perpetrator, if still at scene. Interview victim and any witness separately, especially if both are injured.
10. Keep your exit path open at all times.

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Table 1. WHO and NICE Recommendations Adapted Into the Paramedic Guideline.

General recommendations • A guideline should be used to direct the actions of paramedics • Any guideline should follow a woman-centered care approach • Paramedics should document cases with adherence to legal requirements (particularly when children are present) • Paramedics should be appropriately educated and trained and should undertake assessment to ensure competency Recognition of patients • Identification of IPV patients should be based on evidence-based signs and symptoms Response to patients • Training on how to ask about IPV and how to respond to disclosure should be provided • Screening should be performed in a private setting with confidentiality ensured Referral of patients • There should be a system for referrals in place and practitioners should be able to facilitate a referral where requested • Written information should be made available to patients

Note. WHO = World Health Organization; NICE = National Institute for Health and Care Excellence; IPV = intimate partner violence.

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A PARAMEDIC GUIDELINE TO RESPOND TO WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE

RECOGNISE

IPV is defined as physical or sexual violence, psychological or emotional abuse, or other controlling behaviours by a current or former partner. IPV is experienced differently by individuals and therefore can present in many different ways, when assessing a patient look for the following indicators:

FEELINGS
- Patient appears depressed/withdrawn or anxious/distressed without an apparent reason
- Patient or children/dependants/pets appear fearful

BEHAVIOURS
- Suicidality or self-harm
- Alcohol or other drug abuse
- Repeated/suspicious callouts with no clear diagnosis
- Inconsistent or implausible explanations for injuries/symptoms

MEDICAL SIGNS
- Unexplained chronic symptoms (e.g., pain; gastrointestinal, or genitourinary symptoms)
- Pregnancy related complications or trauma, or delays in care

CONTROLLING PEOPLE
- Intrusive or controlling person in consultation (especially a partner or ex-partner)
- Patient (or children/dependants) unwilling to respond without approval from controlling person
- Controlling person stating the patient is 'crazy', 'mad', 'unstable' or other similar terms
- Withholding communication/mobility devices, access to funds/resources/services, over/under medication (especially for disabled patients)

TRAUMA
- Assault or suspicion of assault (e.g., weapons, signs of violence)
- Suspicious bruises or injuries (esp. to neck, face, breasts or genitals)
- Patient indicates someone has threatened to kill or harm them, their children or their pets
- Sexual assault (actual or attempted)

RESPOND

You may suspect IPV based on the above indicators or patients/others on scene may spontaneously disclose, if so you can talk to the patient about IPV using the following method:

1. Ensure patient is alert and clarify confidentiality. If you can't do this and you believe there is an **immediate physical or life threatening risk** request police.
2. Ask an appropriate fear and safety question.
3. If the patient discloses abuse or states they would like you to assist them validate and reassure them before providing a referral by discussing the options in the matrix below.
   If the patient declines a referral consider mentioning they can always access help through safe steps or by calling 1800RESPECT (see below).

REFER

There are several options available to patients, referrals are done in consultation with the patient and based on their needs.
See the matrix below for referral options:

Patient need	Referral agency	How to arrange referral
Advice and advocacy Safety planning Referrals to local/specialist support and care Safe house and refuge accommodation	**safe steps**	Ph. 1800 015 188 (24 hour) (www.safesteps.org.au)
Counselling and support (online and phone)	**1800RESPECT**	Ph. 1800 737 732 (24 hour) (www.1800respect.org.au)
Protection from violence/abuse	**Police**	Request via normal procedures and remain on scene with patient
Sexual Assault	**Sexual assault counselling (Centre Against Sexual Assault)**	Ph. 1800 806 292 (24 hour)
	After hours emergency line for recent sexual assault (Sexual Assault Crisis Line)	Ph. 8345 3494 (note paramedics can call this number any time for advice)
	Police	Request via normal procedures and remain on scene with patient
Medical care	**Emergency Department**	Normal transport procedures with notification
Specialist patient services	**Aboriginal Family Violence Prevention and Legal Service Victoria**	Ph. 1800 105 303 (www.fvpls.org)
	inTouch (Multicultural Centre Against Family Violence)	Ph. 1800 755 988 (www.intouch.asn.au)
Legal Help	**Victorian Legal Aid**	Ph. 1300 792 387 (business hours)
Referral for help for male perpetrators	**Men's Referral Service**	ph. 1300 766 491 (www.mrs.org.au)

RECORD

Documentation of cases where you see indications for IPV should include:
- The observed signs of IPV including a description of any injuries, indicative symptoms or behaviours, and any evidence or statements about who inflicted them
- Note if there were any children or other witnesses present and if they were involved at all
- If you talked with the patient about IPV or provided a referral (include a note of which referral option was used)
- If police attended the scene

L — **Listen closely with empathy and without judging**

I — **Inquire about needs and concerns**

V — **Validate them by showing you believe and understand**

E — **Enhance their safety by discussing options to protect them from further harm**

S — **Refer the patient to support agencies**

Intimate partner violence recognition and referral protocol for paramedics

Status
Female potentially experiencing intimate partner violence

Assess / Consider

Does the patient's current presentation demonstrate known signs of IPV:
- Intrusive partner, ex-partner, or other potential abuser in consultations
- Symptoms of depression or anxiety
- Suicidality or self-harm
- Alcohol or Drug (prescription or non-prescription) use
- Unexplained and chronic symptoms (e.g., gastrointestinal, reproductive, genitourinary symptoms, pain)
- Adverse reproductive outcomes (e.g., unintended pregnancy or termination, delayed pregnancy care, adverse birth outcomes)
- Traumatic injury (particularly to genitals) with vague or implausible explanations
- Repeated call outs with no clear diagnosis

Action

If ***any*** signs of IPV are present **and** patient is GCS 15 consider questioning at appropriate time and place.

Remember NEVER question a patient in front of anyone else or make your suspicions known to anyone other than the patient!

Questioning: Say the following verbatim
"Sometimes when female patients call an ambulance it's related to mistreatment by a partner. If you don't feel safe at home I can arrange confidential advice, help and protection for you (and your children).
Would you like me to help connect you with someone who you can talk to about this?"

- If the patient says 'yes' validate and reassure patient then use Referral Matrix
- If the patient says 'no' or they aren't sure state they can always get confidential advice by calling 1800 RESPECT
- If the patient declines care but you are concerned about the safety of children request police attendance

Referral Matrix

Agency	Reason for referral	How to arrange referral
National sexual assault and domestic violence counselling service (1800 RESPECT)	General advice Counselling (online and phone) Referral to specialist services	Ph. 1800 737 732 https://www.1800respect.org.au/
Victoria Police	Patient or child protection Legal advice Signs of violence Harm to children Risk assessment	Ph. 000 Normal request procedures (eg DM)
Safe Steps	Emergency accommodation	Ph. 1800 015 188 http://www.safesteps.org.au/
Legal Aid	Legal advice	Ph. 1300 792 387 https://www.legalaid.vic.gov.au/
Emergency Department	Medical care	Normal transport procedures
Men's Referral Service	Help and advice for male perpetrators	Ph. 1300 766 491 https://www.mrs.org.au

Documentation

Document the following in addition to your normal PCR with the patient's consent:
- Observed signs of IPV including a description of any injuries
- If you questioned the patient and their response
- Any referrals made
- Any other relevant scene findings, observations or statements made by the patient or potential perpetrators

EMS Personnel Exposed to Violence in Workplace

- **61-93% of EMS personnel in US experiences at least one form of violence in their career**

International Archives of Occupational and Environmental Health (2021) 94:1559–1565
https://doi.org/10.1007/s00420-021-01693-z

ORIGINAL ARTICLE

Association between the experience of violence and burnout among paramedics

Desiree Braun[1,2] · Florian Reifferscheid[3] · Thoralf Kerner[4] · Janina L. Dressler[5] · Markus Stuhr[6] · Stephan Wenderoth[7] · Katja Petrowski[2]

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ORIGINAL CONTRIBUTIONS

A National Description of Violence toward Emergency Medical Services Personnel

Mirinda A. Gormley, MSPH, NRP, Remle P. Crowe, BS, NREMT, Melissa A. Bentley, MS, NRP, Roger Levine, PhD

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EMS Personnel Exposed to Violence in Workplace

- Gormley MA, et al; *Prehospital Emergency Care* 2016
- National Registry of EMTs has conducted longitudinal assessments of EMTs (Longitudinal EMT Attributes and Demographics Study (LEADS))
- 2013 had question on workplace violence
- 4238 nationally certified EMS personnel; 2525 (59.3%) responded
- Most were male (68%); Caucasian (89%); ave age 32 years; half (51.8%) were paramedics

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EMS Personnel Exposed to Violence in Workplace

TABLE 2. Overall prevalence of violence experienced by EMS personnel during twelve months

Variable	*n*	%
Overall Violence*	1,205	69.0
Verbal Violence (VVP, VVFB)	1,168	67.0
Physical Violence** (PVP, PVFB)	760	43.6
Punching, slapping, or scratching	574	32.9
Spitting	515	29.6
Biting	192	11.1
Struck with an object	154	8.9
Stabbing or stabbing attempts	35	2.0
Shooting or shooting attempts	21	1.2

*This category represents the number of individuals who experienced one or more of the specific types of violence listed.
**This category represents the number of individuals who experienced one or more of the specific types of physical violence listed.

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Impact of EMS Workplace Violence

- Risk of non-fatal assault to EMS is 0.6 cases/100 workers compared to national average 1.8/10,000
- Rate of suicide- based on EMS management survey of 4022 EMS providers – 37% contemplated suicide and 7% had attempted suicide

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Conclusions

- EMS personnel frequently are called to manage IPV patients although data collection on IPV is lacking unless as a part of research efforts
- EMS personnel often have misconceptions about IPV and its causation
- Education of EMS personnel in care of IPV patients should be expanded
- EMS personnel play a critical role in care of IPV patients as they often are first medical personnel the IPV patient encounters and reporting can be variable
- EMS personnel are commonly exposed to workplace violence which has impact on performance and health of the EMS workforce

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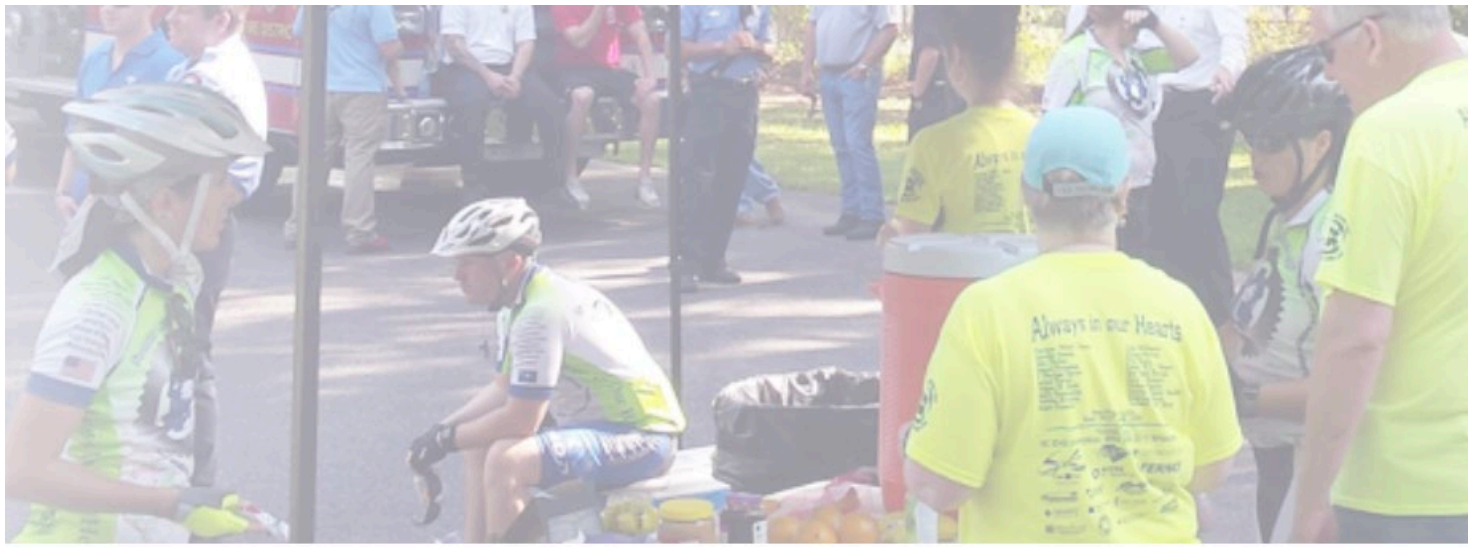

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