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## Child Abuse and Neglect

By: Paula J. Whiteman, MD, FACEP, FAAP, Karen Rodgers, RN MICN, and Deidre Gorospe, RN, MICN

(Portions of this article were reprinted with permission from the California Department of Social Services, Office of Child Abuse Prevention's publication, "The California Child Abuse & Neglect Reporting Law Issues and Answers for Mandated Reporters," which can be found in its entirety at <http://www.cdss.ca.gov/cdssweb/entres/forms/English/PUB132.pdf>)

In 1974, the Child Abuse and Neglect Reporting Act was passed as part of the California Penal Code to protect children from abuse and neglect. Since then, numerous amendments have expanded both the definitions of abuse and requirements for reporting. California Penal Code, Sections 11164 through 11174, requires prompt reporting of all suspected non-accidental injuries, sexual abuse, or neglect of children to local law enforcement and/or Department of Child and Family Services (DCFS). In Los Angeles County, it is recommended that a report is sent to both.

For various reasons, people who abuse children lack necessary internal control. Therefore, they need as many external controls as possible, until they learn methods of self-control. The reporting law is an external control which clearly states that "the abusive behavior is unacceptable and must stop."

The health professional and other mandated reporters often feel reticent to label behavior as abusive. They may feel they have no right to pass judgment on other people. However, if a reasonable suspicion exists, the protective action is beneficial to the parents as well, who may not recognize their behavior as abusive, or may be reluctant to seek help on their own. There may also be nagging doubts about how the person suspected of abusing a child will react, what the outcome will be, and whether or not the report will put the child at greater risk. The best way to minimize the difficulty of reporting is to be fully prepared for the experience.

For the child victim, regular exposure to mandated reporters may not begin until school age, though the abuse is likely to have begun much earlier. In fact, children are most likely to die from abuse and neglect between the ages of birth to 2 years, and are at highest risk for abuse under the age of four, when they can exist in relative isolation from societal eyes. An encounter with EMS in which abuse is suspected – and subsequently reported – can save a life. And because EMS providers get a firsthand glimpse of the child's world, they may be in a unique position to gather information such as scene details, environmental clues, family dynamics, and history inconsistencies that will be invaluable to the identification of abuse, initiation of family intervention and ultimately the protection of the child from further abuse.

Each year in California, as many as 87,000 children are found to be the victims of substantiated child abuse or neglect. Of those, about 60 percent suffer neglect, 20 percent are physically abused,

see **Child Abuse** (continued on pg.2)

## Ethics in EMS... Doing the Right Thing

By Michele Hanley, RN, MSN

Ethics is defined as a set of moral principles, or the examination of how decisions are made regarding what is right and what is wrong. The Department of Transportation defines ethics as personal standards that govern how one should live. In order to decide what is ethical, the human mind must reason or judge actions, and determine one's obligation to self, to others, and to society. Ethical behaviors should govern doing the right thing, but the right thing differs from person to person. Many believe that ethics is a personal set of values and does not cross into professional service. So the challenge is somehow bringing our personal values together with prescribed professional standards in a way that ensures safe and ethical delivery of emergency medical care.

As a service profession, Emergency Medical Services must be governed by a clear set of professional ethics that guide the delivery of healthcare. A key element in the National Association of Emergency Medical Technicians (NAEMT) Code of Ethics is:

Refusing to participate in unethical procedures, and assuming the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

**You are on scene of a motor vehicle collision that has several fatalities. The injuries are significant and gruesome, including severed limbs. In the initial triage of deceased victims, you observe your partner taking pictures of deceased victims with his cell phone camera. Is this ethical? What do you do?**

see **ethics in ems** (continued on pg.5)

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# Child Abuse (from page 1)

10 percent are sexually abused, and 10 percent are emotionally or psychologically maltreated. Children with disabilities are from 3 to 7 times more likely to be victims of maltreatment than non-disabled children.

EMTs, paramedics, nurses and physicians are amongst the professionals identified in the California Penal Code as “mandated reporters.” This means that any such person with a “reasonable suspicion” (NOT proof) of child abuse or neglect must make a report immediately (as soon as practically possible) by phone, and that a written report must follow within 36 hours. If a child appears to be in danger, notify law enforcement immediately, and they will evaluate the need to place the child in protective custody. Where a child is in “immediate and present danger of abuse by a family or household member, based on allegation . . . or threat of abuse” a judge can order an emergency protective order (California Family Code Section 6250). Prehospital providers should document the name of the DCFS social worker and/or name, department, and badge number of the law enforcement officer contacted on the EMS Report Form, along with the time of notification, and disposition of the child if not transported.

Child abuse can occur regardless of socio-economic status, religion, education, ethnic background, or other factors. Health professionals must consider the possibility of abuse whenever questionable signs, symptoms, or situations are encountered. Everyone should be aware of the obvious signs of possible abuse and neglect, such as traumatic injuries in various stages of healing, or emaciation. Other less obvious clues should also be considered and identified in these four key areas:

## ENVIRONMENT

- Infestations (insects, rodents)
- Presence of dirt, filth, or unsanitary conditions
- Lack of running water or heat
- Under- or untreated medical conditions (e.g., infections, dental decay, unfilled inhaler prescription)

## CAREGIVER BEHAVIOR

Some parents who were abused as children may not recognize their behavior as abusive. They may not hide this behavior since to them it is normal and acceptable. Other abusive parents may think of their behavior as abusive, and may seek to hide it, make up stories, or get their children to protect them. Beware of these behaviors:

- Delay in seeking care for child
- No explanation for injuries, a story that changes on repetition, or a story that differs from child’s story
- Reluctance to allow health professionals to speak to child alone
- Seems unable/unwilling to meet child’s basic needs or provide a safe environment
- History of domestic violence in the home
- Employs “out of control” discipline, or use of objects (belts, whips, clothes hangers)
- Expresses unrealistic expectations of child (e.g., toilet training of a 1-year-old)
- Berates humiliates, or belittles child
- Indifferent to child

- Leaves child unattended
- Makes threatening statements, such as “we’ll take care of him”

## PHYSICAL CLUES

Accidental injuries tend to be on bony prominences. Toddlers commonly have accidental bruises on shins, upper leg and forehead. Check child for different stages of bruising – the age of a bruise cannot be exactly determined from its color, however bruises show a progression of color change over time (red/purple/blue initially, followed by green/yellow/brown.) Unexplained, ill-explained, or suspicious injuries warrant heightened awareness and diligent assessment and documentation by health professionals.

- Burns to areas unlikely to be accidentally burned (backs of hands, soles of feet, buttocks, back)
- Scalds with clear demarcation and a symmetrical pattern, (in contrast to accidental scalds where the child will quickly try to withdraw and the burn pattern will be irregular), a glove or sock pattern (as if hands or feet forcibly held underwater), or a ‘doughnut’ pattern (where child’s buttocks are pressed against the hot water container, so the central area is spared)
- Oral injuries
- Any suspected fracture in a baby too young to walk or crawl

## BEHAVIORAL CLUES

Children react differently to being abused. There is no one single reaction that can be clearly associated with child abuse; however, there are a number of possible behaviors which have been found to be consistently correlated with abuse. The presence or report of any of these behaviors does not prove the child is being abused, but should serve as a warning signal to LOOK FURTHER:

- “Frozen watchfulness:” the child looks watchful yet unresponsive, carefully tracking the adults with his eyes (can indicate a severe level of abuse)
- Does not seek comfort from caregivers when distressed
- Inappropriate urination or defecation
- Habitual body-rocking
- Promiscuity, or precocious sexual behavior and/or vocabulary
- Runaway attempts.
- Clingy, indiscriminate attachment
- Passivity, lacks self-esteem; puts self down
- Physically abusive towards siblings, animals
- Out-of-control behavior (angry, panics, easily agitated), self-destructive behavior (self-mutilation, cutting), or extremely fearful/withdrawn/hostile/destructive behavior
- Scavenging for food
- Exhibits signs of eating disorders
- Substance abuse

Mandated reporters must stay alert and responsive to the child behaviors described above. Children will rarely report they are being abused; but, being unable to stop it, they may develop coping mechanisms and behaviors which can bring them to the attention of health professionals. The best source of information from the child is not what they child says, but how the child

behaves. These children tend to be fiercely loyal to their abusers, often demonstrating a pathological dependency on them.

**MANDATED REPORTERS ARE NOT RESPONSIBLE TO INVESTIGATE OR COLLECT EVIDENCE.** Investigations are conducted by Child Protective Agencies. While talking to a child about possible abuse or neglect, don't make promises you can't keep (e.g., promise not to tell anyone.) Take care that your questions do not lead the child to say what they think you want to hear, and avoid using leading or coercive questioning. Use open-ended questions to elicit information specific to the abuse or neglect suspected.

Informing parents that a report is being made is not legally required. In some instances it may be contraindicated by factors such as the likelihood that a parent may flee or exhibit violent or erratic behavior. There are instances in which a child may be at increased risk due to speaking with providers. Advise child welfare staff and/or law enforcement if a child is afraid to stay at home, may be in danger of further abuse or threats, or may be under pressure to change or retract his or her statement.

If the parent or suspected abuser is to be informed, begin by making a statement about what you saw, heard or believe that makes you suspect abuse or neglect. Use only non-judgmental, factual statements, such as, "You seem to be behaving in an out-of-control way, and I'm concerned that you are hurting your child." Follow this with, "As a mandated reporter, I am required by law to report this." Just as important as the words you use is the tone of your voice and your demeanor. The optimal and safest method is to be as non-judgmental as possible, which can be difficult. Parents are frequently frightened and angry in these situations, but remember that most actually do love their children and do not want to hurt them. They are being abusive because they are out of control. They may also – either immediately or eventually – feel relief that steps have been taken to protect their children. When in doubt about what to say, call your local DCFS hotline and ask for assistance.

Once verbal and written reports are made, it is the responsibility of the investigating agency to conduct an active investigation, and forward to the Department of Justice (DOJ) for further action/investigation if the incident is deemed substantiated or inconclusive. The Department of Justice will then decide whether the child needs to be removed from the home, and law enforcement will decide whether to proceed with criminal prosecution.

## FAQs

What if I am wrong about my suspicion?

Dr. C. Henry Kempe, a pioneer in the field of child abuse prevention, once said he would rather apologize to a parent because he made a mistake about reporting the abuse, than apologize to a brain-damaged child because he did not. It is better to err in the direction of over-reporting than under-reporting. It is important to note that mandated reporters are granted immunity if they make a report, but they are liable if they fail to report when they have reasonable suspicion.

## MANDATED REPORTERS FAST FACTS:

- **Reports from mandated reporters may not remain anonymous, so that they can be contacted during investigation**
- **While your name cannot be disclosed to the family or anyone else not directly part of the investigation, it may be revealed in court at the time of trial if you have to testify**
- **Notifying a supervisor, hospital staff, or anyone else of suspected abuse does not satisfy your reporting requirement, but SHOULD be a part of your report to the next level of care**
- **Mandated reporters have civil and criminal immunity, and cannot be sued, harassed, disciplined or fired as a result of, or prevented or impeded from, making a report**
- **Mandated reporters can be fined (up to \$1000), or jailed (up to 6 months) as a result of NOT reporting suspected abuse or neglect, which is a misdemeanor – and can be found liable for damages in a civil lawsuit, especially if further abuse or neglect is sustained as a consequence of not making a report**
- **If two or more people are required to report an instance of suspected abuse, they may select one person to report on behalf of the team. However, if the designated team member fails to make the report, any team member with knowledge shall then be responsible to make the report**
- **After the investigation is completed, the investigating agency shall inform the mandated reporter of the results of the investigation and any action being taken**

## What is the fine line between physical abuse and discipline?

If the discipline is forceful enough to leave marks, physical abuse has occurred. The use of instruments increases the likelihood of injuries, as does the harsh punishment of young children. The intent of the reporting law is not to interfere with appropriate parental discipline, but to respond to inappropriate or high-risk discipline. If you have reasonable suspicion of abuse, even with no visible signs, you are required to report. Under California Welfare and Institutions Code Section 300(a), reasonable and age appropriate spanking to the buttocks where there is no evidence of serious physical injury does not constitute abuse.

## What if abuse occurred in the past?

There is no time limitation regarding the reporting of child abuse. If a victim is under age 18, the abuse must be reported. Not everyone is able to work effectively with these situations. The responsible reporter faces his/her limitations or preferences, and, when appropriate, REFERS OUT to others better able or willing to provide treatment for these families and caregivers. Most people who abuse their children can be successfully treated, and you may play the pivotal role in initiating that treatment and saving a child's life.

**child abuse** (concluded on pg.4)



# CHANGES IN LOS ANGELES COUNTY AMBULANCE COMPANY LICENSING REQUIREMENTS

By Luanne Underwood, RN, BSN

Did you know that in the past, not all private ambulance companies operating in Los Angeles County were required to be licensed by the Department of Health Services' Emergency Medical Services (EMS) Agency? Only those companies that picked up patients in the unincorporated areas of the County or in several cities that had adopted the Los Angeles County Code (County Code) were required to obtain a business license from the EMS Agency. That all changed in July of this year when revisions to the County Code, Chapter 7.16, Ambulances (Ambulance Ordinance), were implemented.

Effective July 28, 2011, all companies that pick-up patients in Los Angeles County (including all incorporated cities) are required to obtain a Los Angeles County Ambulance Operator Business License. Existing ambulance companies will have until January 28, 2012 to submit their applications and will be allowed to continue operating in the areas they are currently licensed for until their applications are processed. At the time the new Ambulance Ordinance went into effect there were a total of 82 ambulance companies operating within Los Angeles County and only 26 of those companies are currently licensed by the EMS Agency. Any new ambulance company that plans to provide services in Los Angeles County will be required to obtain a Los Angeles County Ambulance Operator Business License prior to implementing services.

Additionally, the revised County Code requires all private EMS aircraft operators to obtain a Los Angeles County business license prior to providing services in the County. Previously there were no licensing provisions for private EMS aircraft operators picking up patients in Los Angeles County.

In the past, there has been little to no coordinated medical oversight of ambulance companies that were not licensed by the County. The new requirements are intended to improve public health and safety by creating a more integrated EMS System, one that requires all ambulance operators to follow standard EMS policies. All ambulance operators will also be required to understand hospital capabilities and their role and responsibility as part of the EMS System during a disaster or multiple casualty incident.

The new Ambulance Ordinance provides improved oversight of patient care by ambulance provider and EMS aircraft operators, improving the health, welfare, and safety of

the residents of and visitors to the County. Under the Ordinance, the EMS Agency will have the ability to monitor the operation of all ambulance providers for appropriate staff, staff training, medical equipment, and quality of patient care, to improve services for County residents.

If you would like more information, please visit the Ambulance Licensing page of our website at: <http://ems.dhs.lacounty.gov/AmbulanceLicensing/AmbLic.htm>, or you may contact Luanne Underwood, Ambulance Programs/Special Projects Coordinator at (562) 347-1681 or by e-mail at [luunderwood@dhs.lacounty.gov](mailto:luunderwood@dhs.lacounty.gov).

## Child Abuse (from page 3)

For more information, as well as a free educational module, please visit <http://mandatedreporter.ca.com>. You may also refer to your Prehospital Care Manual, References 822 and 822.2, for prehospital provider information and sample forms. Addition Child Abuse Report Forms (SS8572) can be obtained by calling 800.540.4000.

### REFERENCES

Department of Health Services, County of Los Angeles (2009). Suspected Child Abuse/Neglect Reporting Guidelines (Reference 822). Retrieved from <http://ems.dhs.lacounty.gov/policies/Ref800/822.pdf>

Gil, E., Nissen, D., Kohl, A., Ralph, C.J., Ralph, K. (2003). The California Child Abuse & Neglect Reporting Law Issues and Answers for Mandated Reporters. Retrieved from <http://www.cdss.ca.gov/cdssweb/entres/forms/English/PUB132.pdf>

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### WHEN CHILD ABUSE OR NEGLECT IS SUSPECTED

#### IMMEDIATELY:

Call the LA COUNTY DEPARTMENT OF CHILD AND FAMILY SERVICES  
CHILD PROTECTION HOTLINE (24/7):

**800.540.4000**

#### WITHIN 36 HOURS:

Complete and send a California Suspected Child Abuse Report Form 8572\* to both your local law enforcement agency, AND:

DCFS,  
3075 Wilshire Blvd, Fifth Floor  
Los Angeles, CA 90010

\*this form can be downloaded at [http://ag.ca.gov/childabuse/pdf/ss\\_8572.pdf](http://ag.ca.gov/childabuse/pdf/ss_8572.pdf)

## ethics in ems (from on pg.1)

Do you know what the obligation as an EMS professional is in this situation? Decisions in healthcare must have ethical intent. Speaking up in this situation can be difficult. Are you afraid to speak up because you are concerned with the teams' perception of you? Are you concerned that speaking up will make you "unpopular" with your coworkers? A fundamental responsibility of the Emergency Medical Technician/ Emergency Medical Technician-Paramedic is to protect life, to alleviate suffering, to promote health, to do no harm, and to encourage equal availability of quality emergency medical care. The Hippocratic Oath's "Do no harm" statement has been a primary principle in the delivery of healthcare for centuries. Medical ethics refers to this as nonmaleficence or "first, do no harm". Every member of a healthcare team is ethically responsible for the care rendered to a patient. We are responsible for ensuring that in caring for a patient; we "do no harm".

Photographing the deceased at the scene of an accident you are working may not cause harm to the dead body. Acting unethically or conducting ourselves in a manner in which it appears to be unethical to others, is doing harm...to our profession. Being in uniform, answering the call for service or being at the bedside providing care for the ill or injured places us, and thus our profession, in a highly visible position. Perceptions of our actions are sometimes stronger than the actions themselves. If your team members' actions appear to be unethical to you; they are doing harm. It is our responsibility as healthcare team members to speak up, redirect, and encourage actions that "first, do no harm".

Doing the right thing is not taking the easy way out. It would be easier for us to turn our back on our partner taking pictures. Regardless of the popularity, convenience, or impact, our decision making as EMS professionals, doing the right thing must take precedence. Ethics is a set of moral principles, values, and standards that must apply to both our personal and professional lives.

## NAEMT CODE OF ETHICS

The Emergency Medical Technician provides services based on human need, with respect for human dignity, unrestricted by considerations of nationality, race, creed, color, or status.

The Emergency Medical Technician does not use professional knowledge and skills in any enterprise detrimental to the public well being.

The Emergency Medical Technician respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.

The Emergency Medical Technician, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the Emergency Medical Technician has the never-ending responsibility to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people.

The Emergency Medical Technician shall maintain professional competence and demonstrate concern for the competence of other members of the Emergency Medical Services health care team.

An Emergency Medical Technician assumes responsibility in defining and upholding standards of professional practice and education.

The Emergency Medical Technician assumes responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and knows and upholds the laws which affect the practice of the Emergency Medical Technician.

An Emergency Medical Technician has the responsibility to be aware of and participate in matters of legislation affecting the Emergency Medical Services System.

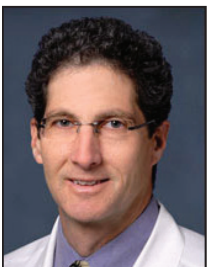
The Emergency Medical Technician, or groups of Emergency Medical Technicians, who advertise professional service, do so in conformity with the dignity of the profession.

The Emergency Medical Technician has an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of an Emergency Medical Technician

The Emergency Medical Technician will work harmoniously with and sustain confidence in Emergency Medical Technician associates, the nurses, the physicians, and other members of the Emergency Medical Services health care team.

The Emergency Medical Technician refuses to participate in unethical procedures, and assumes the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

## DR. MARGULIES APPOINTED TO STATE EMS COMMISSION



The EMS Agency congratulates Dr. Daniel R. Margulies on his appointment to the State EMS Commission. Dr. Margulies is the Director of Trauma Services at Cedars-Sinai Medical Center, Director of the Surgical Critical Care Unit, and Associate Director of the Division of General Surgery. In addition to his clinical work, he teaches in the surgery residency program, conducts research, and is widely published in the fields of trauma and surgical critical care. He was selected from three nominees submitted by the California Chapter of the American College of Surgeons and then appointed to the State Commission by the Speaker of the Assembly.

Dr. Margulies' service as a Los Angeles County EMS Commissioner (he is currently finishing his second four-year term) has supplemented his extensive medical knowledge with an understanding of the systemwide aspects of EMS such as data collection, communications, and issues related to provider agencies and receiving hospitals. We again congratulate Dr. Margulies and feel confident he will be an asset to the State EMS Commission.

# Prehospital Needle Thoracostomy .... More harm than good?

by Susan Mori, RN, BSN

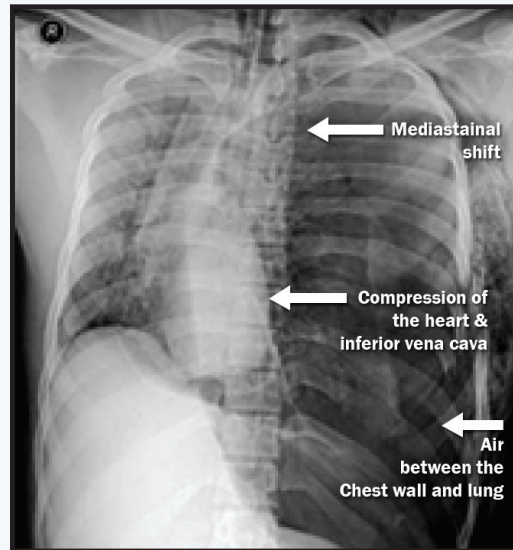
**E**mergent pleural needle decompression is controversial and not without risk. Inappropriate patient selection, treatment failure, and misplacement of the needle are a few of the issues that have experts questioning the benefit of prehospital needle thoracostomy (PNT).

## Patient Selection

Several studies conducted in large urban settings have demonstrated that PNT is infrequently used, representing approximately 1% of the severely injured patients transported to a Level 1 trauma center. The infrequency with which the skill is performed is thought to be associated with the over triage of PNTs placed in patients not experiencing a true tension pneumothorax.

A pneumothorax is a collection of air in the pleural space causing part of or the entire lung to collapse. Characteristic physical findings of a large pneumothorax include decreased chest wall movement and diminished breath sounds on the affected side; subcutaneous emphysema may or may not be present. Thoracic trauma is generally associated with acute pneumothoraces in the prehospital setting, but in some cases this can happen without injury, usually as a complication of an underlying lung disease. Individuals with chronic obstructive pulmonary disease, cystic fibrosis, tuberculosis or other types of pulmonary conditions are at risk for what is called a “spontaneous” pneumothorax. Most often these types of pneumothoraces are not life-threatening but in rare instances can progress into a tension pneumothorax. A tension pneumothorax is more likely to be seen in patients with penetrating chest wall injuries. The chest wound forms a one-way valve allowing air to enter the pleural space during inspiration but does not permit air to escape during expiration. There is a progressive build-up of air in the intrapleural space which can cause obstructive shock from compression of the vena cava leading to impaired right ventricular filling and hypotension.

Research indicates over one-fourth (26%) of injured patients suspected of having a pneumothorax received a PNT even though a pneumothorax was not present. In an effort to evaluate patient selection in Los Angeles County, PNT data were collected for one year during 2010-11. The first six months of data showed that 55% of the patients receiving a PNT had a normal or high systolic blood pressure (SPB) indicating patients were receiving emergent pleural decompression without the presence of hemodynamic changes associated with a pneumothorax under tension. To reduce the number of unwarranted needle thoracostomies performed in the field Reference No. 806.1, Procedures Prior to Base Contact, was revised to include a clinical parameter: patients with a suspected tension pneumothorax must have a SBP < 80 mmHg to receive a PNT prior to base contact. After the policy revision, six months of data showed a modest reduction in the number of PNTs placed in patients with normal-to-high SBPs



## Equipment Requirements

In addition to appropriate patient selection, utilizing the correct needle size is critical to reaching the pleural space and thus, relieving the tension. Studies using ultrasound to measure chest wall thickness at the 2nd intercostal space, midclavicular line indicate that a 1.75-2” catheter length is not sufficient to penetrate the chest wall in up to 35% of the population, depending on patient age and gender. Due to the nationwide rise in obesity, the latest data indicate that a minimum 3”-3.5” needle length and size 14 gauge or larger angiocath is needed to provide adequate decompression of the pleural space. Currently, Reference No. 703, ALS Unit Inventory, requires a 3” needle and a 14 gauge angiocath or a needle thoracostomy kit, which typically includes a 3.25” or 3.5” needle. To remain consistent with evidence-based practice, Reference No. 703, Reference No. 706, ALS EMS Aircraft Inventory, and Reference No. 704, Assessment Unit Inventory, will be revised to require the longer needle.

## Placement

Prehospital Trauma Life Support recommends utilizing the 2nd intercostal space, midclavicular line for needle placement in the prehospital setting, which is the only approved insertion site in Los Angeles County. While utilizing a longer needle increases the likelihood of reaching the pleural space, it also poses a real risk of causing harm in patients without a tension pneumothorax. PNT placement in patients without hemodynamic changes can lead to unnecessary laceration of lung tissue, increasing the chance of creating a pneumothorax when one was not originally present.

## Conclusion

A prehospital needle thoracostomy can be a lifesaver; however, the key to success lies in appropriate patient selection, use of the right equipment, and accurate needle placement. Hypotensive patients with a high suspicion for a tension pneumothorax require prompt recognition and emergent pleural decompression. However, patients suspected of having a tension pneumothorax without hemodynamic compromise do not require emergent pleural needle decompression. Rapid transport to the most appropriate receiving facility for definitive diagnosis and treatment is safest option for these patients.



# HERT



HERT Team members (Left to Right): Pilot Brian Simon, LAFD 88-B; Dr. Scott Bricker, Trauma; Dr. Madonna Fernandez, EM; Dr. David Plurad, Trauma; Antoinette Sala, RN; Dr. Mike Peterson, EM; Susan Simpson, RN, Laura Schneider, RN; Pilot Paul Schori, LAFD 88-B

On June 30, 2011 the Hospital Emergency Response Team (HERT) conducted an exercise to test the HERT response. The HERT exercise involved coordination of Los Angeles County EMS Agency's Medical Alert Center (MAC), Harbor/UCLA Medical Center, Los Angeles Fire Department (LAFD) and Northridge Hospital Medical Center.

The HERT concept was developed in the 1980's, to assist fire departments and emergency services providers when situations arose where it would be necessary to conduct an emergency field amputation in order to save the life of an entrapped victim. The HERT program was put into policy in 1992 and this policy was revised subsequent to the 2008 Chatsworth Train Derailment. The experience gained from the train derailment identified key actions to improve the HERT program including regularly scheduled exercises.

The purpose of the June 2011 exercise was to evaluate the ability of:

1. LAFD to identify that the medical needs of the victim exceeded the paramedic scope of practice and to contact the MAC to activate a HERT response.
2. MAC to coordinate activation of the HERT and transportation of HERT personnel to the field.
3. Harbor/UCLA Medical Center HERT to respond to the incident with appropriate personnel, medical equipment and personal protective equipment.
4. LAFD to provide air transportation of the HERT to the incident site.
5. HERT personnel to integrate with LAFD Incident Command System and the Urban Search and Rescue (USAR) team, which is essential to facilitate patient care and scene safety.
6. HERT and LAFD to coordinate transportation of the patient to the area Trauma Center (Northridge Hospital Medical Center).

**HERT** (con't on page 8)

# AED Stats 2010

The EMS Agency is responsible for the approval of agencies and organizations as Automated External Defibrillation (AED) Service Providers. This allows EMTs and public safety personnel to operate AED's when providing services to the general public.

State regulations require AED Service Providers to submit AED usage data on an annual basis. In Los Angeles County, AED annual reports for the previous calendar year are due by the end of March. AED Annual Report forms are available on the EMS Agency web page at <http://ems.dhs.lacounty.gov>

The AED usage data submitted to the EMS Agency for 2010 is outlined in the table below. Of the 81 approved programs, 18 agencies applied an AED and performed defibrillation at least once on a combined total of 711 patients. While the reported survival numbers are low (5), the actual number of lives saved is unknown because outcome information was not available on all the patients.

## DEFIBRILLATION REPORT FOR LOS ANGELES COUNTY CALENDAR YEAR 2010

1. The number of patients on whom EMT/PS defibrillator shocks were administered: 711
2. Number of these persons who suffered a witnessed (seen or heard) cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation: 404
3. The total number of patients, defibrillated, who were discharged from the hospital alive: 5
4. The number of defibrillated patients witnessed in cardiac arrest, who were discharged from the hospital alive: 5
5. The number of basic life support personnel who are qualified, in your jurisdiction, to perform defibrillation: 11299
6. The number of public safety personnel, (as defined in CCR Chapter 1.5) in your jurisdiction, qualified to perform defibrillation: 3181
7. The number of non-licensed or non-certified (lay public) persons, in your jurisdiction, trained to perform defibrillation: 1973

### AED Service Providers by Category:

Public Safety	
Law enforcement agencies, lifeguards	25
Fire Departments	25
Private Ambulance Companies	7
Other	24
Including colleges/universities, film studios, theme parks, airports, refineries, private EMT companies	
Total	81

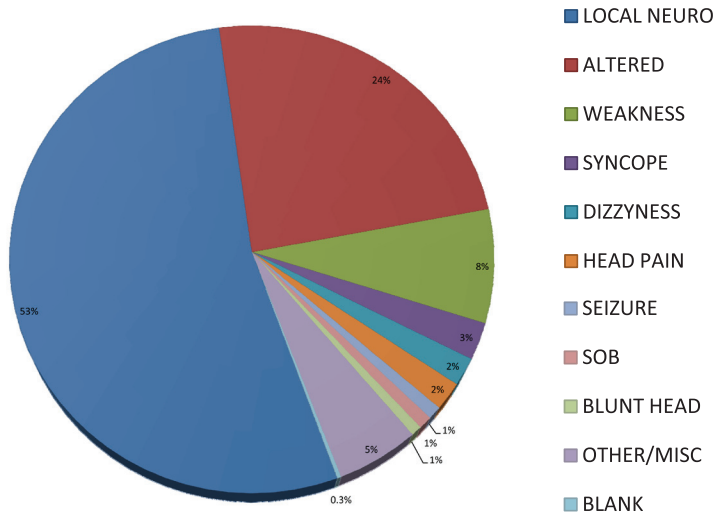
# For Your Information

## Who's Going To Our Approved Stroke Centers (ASC)? By Presenting Chief Complaint

(EMS Agency Data Only)

Jan 2011 - Present

N=1133



### HERT (con't from page 7)

The HERT has only been activated once since 2008 due to the rarity of incidents requiring this service. The exercise provided an excellent opportunity to evaluate important components of a HERT response and demonstrated that LAFD, MAC, Harbor-UCLA Medical Center and Northridge Medical Center were able to successfully coordinate a HERT activation, response, surgical intervention and patient transportation under exercise conditions.

As a coordinated EMS system response, it was evident that ongoing work would be necessary to sustain advancements made and to improve the coordination of the multiple agencies involved in a HERT response, including:

1. Additional HERT and paramedic provider training with respect to scene safety, fire department rescue equipment and operations.
2. Regularly scheduled multi-agency HERT exercises involving other paramedic providers, the HERT from Harbor-UCLA Medical Center, MAC and other Trauma Centers.

This was the second HERT exercise since the program was restructured in 2008 and overall the progress made by the EMS Agency, Harbor/UCLA Medical Center HERT, and LAFD is commendable. The valuable experience gained will be incorporated into the HERT program to prepare for the day when a real life emergency would call the HERT into action and make a difference in a life or death situation.

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The EMERGIPRESS is a newsletter providing the Los Angeles County prehospital care personnel with informative and educational articles, updates, announcements and resources of current interest.

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