

I. General Considerations

- A. Domestic violence is purposeful, coercive behavior to get compliance and/or control. It is not a single incident, but part of a pattern of assaultive behaviors which adults or adolescents use against their intimate partners. It includes physical, sexual, psychological abuse and economic control.
 - B. Domestic abuse crosses all demographics and occurs in all types of intimate partner relationships.
 - C. Domestic disputes are among the most dangerous scenarios emergency personnel encounter.
 - D. EMS responders are routinely dispatched unknowingly to homes where the injuries or illnesses are the result of violence between intimate partners.
 - E. Personal safety is the primary concern when responding to a domestic assault.
 - F. Photographs are best deferred to professionals who can take them and preserve them as evidence.
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II. Procedure

- A. If the call is dispatched as a domestic assault or dispute, are the police on the scene?
 - 1. If no, stage and wait until scene is secured.
 - 2. If yes, stage and notify police of your arrival; enter only as directed by police.
 - 3. Remain vigilant while providing care. The victim may become hostile toward police and/or EMS personnel out of concern for the batterer.
- B. Since few injuries resulting from domestic violence are publicly identified as such, any call should be considered potentially dangerous. Be particularly careful if:
 - 1. Dispatch is having difficulty getting information from the caller, the caller hangs up, or there is a history of calls to this same address.
 - 2. You are met at the door or denied entry by someone who claims there was no call made, or who says the victim is fine and doesn't need medical attention. Contact the police and Medical Control.
- C. On every call, assess the scene carefully upon arrival before entering. Look for:
 - 1. Evidence of a fight (property damage), yelling, evidence of weapons.
 - 2. Evidence of children or pets present.
 - 3. Which lights are on at night.
- D. Upon entry, observe for:
 - 1. Signs of struggle/conflict or attempts at concealment of evidence.
 - 2. Signs of drug/alcohol use
 - 3. Aggressive behavior or heightened emotions
 - 4. Obvious weapons.
- E. Decide whether to withdraw to a staging area and call for police, or proceed with caution. Don't hesitate to return to your vehicle to make decisions, notify police and/or Medical Control. Consider using cell phone instead of radio if possible.
- F. If decision is to proceed:
 - 1. Clearly and simply identify yourself and your role. Use non-threatening body language and approach.
 - 2. Remember, a uniform is a uniform. EMS personnel often wear blue, badge, radio and holsters, all of which can easily confuse an already agitated person.
 - 3. Use a team approach. Designate one provider to observe for safety, one or more to work on the patient, another to calmly distract a potential aggressor or discreetly assess children for injuries.
 - 4. Be aware of surroundings—the number and location of exits, number and location of people in the residence, potential weapons and hiding places. Position rescuers with access to exit.
 - 5. Let occupants lead down hallways or into stairwells or rooms. Keep them in front.

6. Avoid treating patients in a bedroom (only one exit, intimate setting, often weapons hidden) or a kitchen (many possible weapons). Use hard chairs rather than upholstered furniture, as weapons are easily hidden among cushions.
 7. Limit number of people present, whether it be responders, neighbors, etc. Have pets secured before entering, if possible.
 8. Attempt to separate the patient from the suspected batterer for assessment and treatment. If possible, move the patient to the ambulance to assess and treat, even if non-transport appears likely.
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III. Treatment

- A. Injury as a chief complaint:
 1. Look for injuries resulting from a defensive or deflecting move (forearm, shoulder) in the shape of objects (belt buckles, handprint), on areas normally covered by clothing, in different stages of healing or on bystanders such as children or pets who may have gotten caught in the 'crossfire'.
- B. Any injury to a pregnant woman is suspect as 1 in 12 pregnant women are battered:
 1. Look for miscarriage, pre-term labor, multiple injury sites, bruising on the abdomen or breasts, vaginal bleeding. Also look for signs of sexual assault during pregnancy or the postpartum period.
 2. Document discrepancies: stated mechanism of injury vs. actual presentation, conflicting accounts of how injury occurred, delay in seeking medical care.
- C. Illness as the chief complaint.
- D. Screen patients for domestic violence. Ask the questions:
 1. 'Should I be concerned for your safety?' Ask in private, away from all others including suspected abuser.
 2. Present screening of domestic violence as routine. Ask directly and indirectly. Be calm, matter-of-fact and nonjudgmental. Use open-ended questions.
 3. If your patient answers 'yes' to questions about domestic violence in the relationship:
 - a. Document carefully what has been done and said.
 - b. Use the victim's own words, not broad terms like 'abused' or 'battered.'
 4. Assess the possibility for both immediate danger and escalating danger:
 - a. Has violence increased in frequency, severity?
 - b. Are there firearms or other weapons present or easily available?
 - c. If in immediate danger, offer access to crisis services/shelter.
 5. Offer written information about resources. It may be safer to write down just the phone number of local crisis agencies without the names.
 6. If your patient answers 'no' or will not discuss the topic, document any inconsistencies. Make referrals discreetly.
 7. The objective is to make the assessment and offer the resource information.
- E. Transport vs. Non-Transport
 1. Attempt to get patient into ambulance, if only for assessment and the opportunity to talk privately.
 2. If patient accepts transport:
 - a. Advise hospital of security issues prior to arrival.
 - b. Offer to request an advocate from a local domestic violence service agency to meet the patient at the hospital for support.
 - c. Use transport time to provide support, listen.

3. If patient refuses transport:
 - a. Explain symptoms to watch for that might indicate injury/illness is escalating.
 - b. Discuss consequences of not seeking medical care.
 - c. Be nonjudgmental.
 - F. Documentation
 1. In the course of documenting medical care, EMS providers are creating evidence that may be used later to prosecute an abusive partner. Since EMS responds to many domestic violence-related calls to which the police are not dispatched, EMS documentation may be the only evidence to support future charges. Documentation should include:
 - a. Inconsistencies between injury presentation and explanations given.
 - b. Delays in seeking medical care.
 - c. Shapes of bruises.
 - d. Evidence of previous injuries.
 - e. Environmental observations.
 - f. Statements made by parties in their own words.
 - g. Use of a body map to illustrate locations of multiple injuries.
 2. Make it clear to the patient that preserving physical evidence does not obligate the patient to report the abuse, but leaves that option open.
 - G. Take appropriate body substance isolation precautions.
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IV. Resources and Referrals*

- A. State of Vermont Domestic Violence Hotline 800-489-7273
- B. National Domestic Violence Hotline 800-799-SAFE (or 800-799-7233).
- C. Women Helping Battered Women 802-658-1996.
- D. See also: Abuse/Neglect Protocol.

* These phone numbers change frequently and should be updated locally. Local medical direction may be a resource.