Infants, Children & Geriatrics
(Class 2)

Infants and Children

Developmental considerations
- Newborns and infants - birth to 1 year of age.
  - Minimal stranger anxiety.
  - Do not like to be separated from parents.
  - Do not want to be suffocated by an oxygen mask.
  - Need to be kept warm - make sure hands and stethoscope are warmed before touching child.
  - Breathing rate best obtained at a distance - watch chest rise, note color and level of activity.
  - Examine heart and lungs first, head last. This is done to build confidence. It is best to obtain heart and lung sounds before the child becomes agitated.

Developmental considerations (Cont.)
- Toddlers - 1 year to 3 years
  - Do not like to be touched.
  - Do not like being separated from parents.
  - Do not like having clothing removed. Remove, exam, replace.
  - Do not want to be suffocated by an oxygen mask.
  - Assure child that he was not bad. Children think their illness/injury is punishment.
  - Afraid of needles.
  - Fear of pain.
  - Should be examined trunk to head approach. This is done to build confidence. It should be done before child becomes agitated.

Developmental considerations (Cont.)
- Preschool - 3 years to 6 years
  - Do not like to be touched.
  - Do not like being separated from parents.
  - Do not like having clothing removed. Remove, exam, replace.
  - Do not want to be suffocated by an oxygen mask.
  - Assure child that he was not bad. Children think that the illness/injury is a punishment.
  - Afraid of blood.
  - Fear of pain.
  - Fear of permanent injury.
  - Modest.

Developmental considerations (Cont.)
- School Age - 6 years to 12 years
  - Afraid of blood.
  - Fear of pain.
  - Fear of permanent injury.
  - Modest.
  - Fear of disfigurement.

- Adolescent - 12 years to 18 years
  - Fear of permanent injury.
  - Modest.
  - Fear of disfigurement.
• Treat them as adults.
• These patients may desire to be assessed privately, away from parents or guardians.

• Airway
  - Small airways throughout the respiratory system are easily blocked by secretions and airway swelling.
  - Tongue is large relative to small mandible and can block airway in an unconscious infant or child.
  - Positioning the airway is different in infants and children, do not hyperextend the neck.
  - Infants are obligate nose breathers, so suctioning a secretion filled nasopharynx can improve breathing problems in an infant.
  - Children can compensate well for short periods of time.
    • Compensate by increasing breathing rate and increased effort of breathing.
    • Compensation is followed rapidly by decompensation due to rapid respiratory muscle fatigue and general fatigue of the infant.

• Airway
  - Specific skills
    • Airway opening
      - Position to open airway is different - head-tilt chin-lift - do not hyperextend.
      - Jaw thrust with spinal immobilization.
    • Suctioning
      - Sizing
      - Depth
      - Technique
    • Clearing complete obstructions
      - Infants <1 year old
        » Back blows/chest thrusts
        » Visual foreign body removal
      - Children >1 year old
        » Abdominal thrusts
        » Visual foreign body removal

• Airway (Cont.)
  - Specific skills (Cont.)
    • Airway adjuncts
      - Oral airways
        » Adjunct, not for initial artificial ventilation
        » Should not have a gag reflex
        » Sizing
        » Techniques of insertion - use tongue depressor.
        » Insert tongue blade to the base of tongue.
        » Push down against the tongue while lifting upward.
        » Insert oropharyngeal airway directly in without rotation.
      - Nasal airways
        » Adjunct not for initial artificial ventilation
        » Sizing
        » Technique of insertion
        » Should not be used in head trauma

• Oxygen Therapy
- Oxygen delivery
  • Nonrebreathers
  • Blow by techniques
    - Hold tubing two inches from face
    - Insert tubing into a paper cup
- Artificial ventilations
  • Mask sizing/bag sizing
  • Mask seal
    - Two hand
    - One hand
  • Mouth-to-mask artificial ventilations
  • Use of bag-valve-mask
    - Squeeze bag slowly and evenly enough to make chest rise adequately.
    - Rates for child and infant are 20 breaths per minute.
    - Provide oxygen at 100% concentration by using an oxygen reservoir.

- Assessment
  - General impression of well versus sick child can be obtained from overall appearance.
    • Assess mental status.
    • Effort of breathing
    • Color
    • Quality of cry/speech

- Assessment (Cont.)
  • Interaction with environment and parents
    - Normal behavior for child of this age.
    - Playing
    - Moving around
    - Attentive versus non-attentive
    - Eye contact
    - Recognizes parents
    - Responds to parents calling
  • Emotional state
  • Response to the EMT-Basic
  • Tone/body position

- Assessment (Cont.)
  - Begin evaluation from across the room
    • Mechanism of injury
    • Assessment of surroundings
    • General impression of well versus sick
    • Respiratory assessment
      - Note chest expansion/symmetry
      - Effort of breathing
        » Nasal flaring
        » Stridor, crowing, or noisy
        » Retractions
        » Grunting
      - Respiratory rate
    • Perfusion assessment - skin color

- Assessment (Cont.)
Hands on approach to infant or child patient assessment

• Assess breath sounds
  - Present
  - Absent
  - Stridor
  - Wheezing

• Assess circulation
  - Assess brachial or femoral pulse
  - Assess peripheral pulses
  - Assess capillary refill in children younger than 3
  - Assess blood pressure in children older than 3; use appropriate size cuff
  - Assess skin color, temperature and moisture

• Detailed physical exam - begin with a trunk to head approach.
  - Situation and age dependent.
  - Should help reduce the infant or child's anxiety.

Common Problems in Infants & Children

• Airway obstructions
  - Partial airway obstruction - infant or child who is alert and sitting.
    • Stridor, crowing, or noisy
    • Retractions on inspiration
    • Pink
    • Good peripheral perfusion
    • Still alert, not unconscious.
    • Emergency medical care
      - Allow position of comfort, assist younger child to sit up, do not lay down. May sit on parents lap.
      - Offer oxygen
      - Transport
      - Do not agitate child
      - Limited exam. Do not assess blood pressure.

• Airway obstructions (Cont.)
  - Complete obstruction and altered mental status or cyanosis and partial obstruction.
    • No crying or speaking and cyanosis.
      - Child's cough becomes ineffective
      - Increased respiratory difficulty accompanied by stridor
      - Victim loses consciousness
      - Altered mental status
    • Clear airway.
      - Infant foreign body procedures.
      - Child foreign body procedures.
    • Attempt artificial ventilations with a bag-valve-mask and good seal.

• Respiratory emergencies
  - Recognize the difference between upper airway obstruction and lower airway disease.
    • Upper airway obstruction
      - Stridor on inspiration
    • Lower airway disease
      - Wheezing and breathing effort on exhalation
- Rapid breathing (tachypnea) without stridor

• Respiratory emergencies
  - Recognize signs of increased effort of breathing.
  - Early respiratory distress is indicated by any of the following:
    - Nasal flaring
    - Intercostal retraction (neck muscles), supraclavicular, subcostal retractions
    - Stridor
    - Neck and abdominal muscles - retractions
    - Audible wheezing
    -
    - Grunting

• Respiratory emergencies (Cont.)
  - Recognize signs of increased effort of breathing.
  - The presence of signs of symptoms of early respiratory distress and any of the following:
    - Rate > 60
    - Cyanosis
    - Decreased muscle tone
    - Severe use of accessory muscles
    - Poor peripheral perfusion
    - Altered mental status
    - Grunting
  - Respiratory arrest
    - Breathing rate less than 10 per minute
    - Limp muscle tone
    - Unconscious
    - Slower, absent heart rate
    - Weak or absent distal pulses.

• Respiratory emergencies
  - Emergency medical care
    - Provide oxygen to all children with respiratory emergencies.
    - Provide oxygen and assist ventilation for severe respiratory distress.
      - Respiratory distress and altered mental status
      - Presence of cyanosis with oxygen
      - Respiratory distress with poor muscle tone
      - Respiratory failure
      - Provide oxygen and ventilate with bag-valve-mask for respiratory arrest.

• Seizures
  - Seizures in children who have chronic seizures are rarely life-threatening. However, seizures, including febrile, should be considered life-threatening by the EMT.
  - May be brief or prolonged.
  - Assess for presence of injuries which may have occurred during seizures.
  - Caused by fever, infections, poisoning, hypoglycemia, trauma, decreased levels of oxygen or could be idiopathic in children.
• Seizures (Cont.)
  - History of seizures. Ask the following questions:
    • Has the child had prior seizure(s)?
    • If yes, is this the child's normal seizure pattern?
    • Has the child taken his anti-seizure medications?
  - Emergency medical care
    • Assure airway position and patency
      - Position patient on side if no possibility of cervical spine trauma.
      - Have suction ready.
      - Provide oxygen and if in respiratory arrest or severe respiratory distress, assure airway position and patency and ventilate with bag-valve-mask.
      - Transport. Although brief seizures are not harmful, there may be a more dangerous underlying condition.
    - Seizures can be caused by head injury.
    - Inadequate breathing and/or altered mental status may occur following a seizure.

• Altered mental status
  - Caused by a variety of conditions
    • Hypoglycemia
    • Poisoning
    • Post seizure
    • Infection
    • Head trauma
    • Decreased oxygen levels
    • Hypoperfusion (shock)
  - Emergency medical care
    • Assure patency of airway.
    • Be prepared to artificially ventilate/suction.
    • Transport.

• Poisonings
  - Common reason for infant and child ambulance calls
    - Identify suspected container through adequate history. Bring container to receiving facility if possible.
  - Emergency medical care
    • Responsive patient
      - Contact medical control.
      - Consider need to administer activated charcoal.
      - Provide oxygen.
      - Transport.
      - Continue to monitor patient - may become unresponsive.
    • Unresponsive patient
      - Assure patency of airway.
      - Be prepared to artificially ventilate.
      - Provide oxygen if indicated.
      - Transport.
      - Rule out trauma, trauma can cause altered mental status.

• Fever
  - Common reason for infant or child ambulance call
  - Many causes - rarely life threatening. A severe cause is meningitis.
  - Fever with a rash is a potentially serious consideration.

• Shock (hypoperfusion)
  - Rarely a primary cardiac event.
  - Common:
    - Diarrhea and dehydration
    - Trauma
    - Vomiting
    - Blood loss
    - Infection
    - Abdominal injuries
  - Less common:
    - Allergic reactions
    - Poisoning
    - Cardiac

• Shock (hypoperfusion) (Cont.)
  - Signs and symptoms
    - Rapid respiratory rate
    - Pale, cool, clammy skin
    - Weak or absent peripheral pulses
    - Delayed capillary refill
    - Decreased urine output. Measured by asking parents about diaper wetting and looking at diaper.
    - Mental status changes
    - Absence of tears, even when crying
  - Emergency medical care
    - Assure airway/oxygen.
    - Be prepared to artificially ventilate.
    - Manage bleeding if present.
    - Elevate legs.
    - Keep warm.
    - Transport. Note need for rapid transport of infant and child patients with secondary exam completed en route, if time permits.

• Near drowning
  - Artificial ventilation is top priority.
  - Consider possibility of trauma.
  - Consider possibility of hypothermia.
  - Consider possible ingestion, especially alcohol.
  - Protect airway, suction if necessary.
  - Secondary drowning syndrome - Deterioration after breathing normally from minutes to hours after event. All near drowning victims should be transported to the hospital.

• Sudden Infant Death Syndrome (SIDS)
  - Signs and symptoms
    - Sudden death of infants in first year of life.
    - Causes are many and not clearly understood.
    - Baby most commonly discovered in the early morning.
  - Emergency medical care
    - Try to resuscitate unless rigor mortis.
    - Parents will be in agony from emotional distress, remorse and imagined guilt.
• Avoid any comments that might suggest blame to the parents.

• Trauma
  - Injuries are the number one cause of death in infants and children.
  - Blunt injury is most common.
  - The pattern of injury will be different from adults.
    - Motor vehicle crashes
      » Motor vehicle passengers
      » Unrestrained passengers have head and neck injuries.
      » Restrained passengers have abdominal and lower spine injuries.
      » Struck while riding bicycle - head injury, spinal injury, abdominal injury
      » Pedestrian struck by vehicle - abdominal injury with internal bleeding, possible painful, swollen, deformed thigh, head injury.
  - Falls from height, diving into shallow water - head and neck injuries
  - Burns
  - Sports injuries - head and neck
  - Child abuse

• Specific body systems
  - Head
    - The single most important maneuver is to assure an open airway by means of the modified jaw thrust.
    - Children are likely to sustain head injury along with internal injuries. Signs and symptoms of shock (hypoperfusion) with a head injury should cause you to be suspicious of other possible injuries.
    - Respiratory arrest is common secondary to head injuries and may occur during transport.
    - Common signs and symptoms are nausea and vomiting.
    - Most common cause of hypoxia in the unconscious head injury patient is the tongue obstructing the airway. Jaw-thrust is critically important.
    - Do not use sandbags to stabilize the head because the weight on child's head may cause injury if the board needs to be turned for emesis.

• Specific body systems (Cont.)
  - Chest
    - Children have very soft pliable ribs.
    - There may be significant injuries without external signs.
  - Abdomen
    - Often a source of hidden injury.
    - Always consider abdominal injury in the multiple trauma patient who is deteriorating without external signs.
    - Air in stomach can distend abdomen and interfere with artificial ventilation efforts.
  - Extremities - extremity injuries are managed in the same manner as adults.

• Other trauma considerations
  - Pneumatic anti-shock garments
    - Use only if child fits, do not place infant in one leg of trouser.
    - Indications - trauma with signs of severe hypoperfusion and pelvic instability.
    - Do not inflate abdominal compartment.
  - Criticality of burns
    - Cover with sterile dressing (non-stick, if possible, sterile sheets may be used).
• Identify candidates for burn centers per local protocol.

• Emergency medical care
  - Assure airway position and patency. Use modified jaw thrust.
  - Suction as necessary with large bore suction catheter.
  - Provide oxygen.
  - Assist ventilations for severe respiratory distress and ventilate with a bag-valve-mask for respiratory arrest.
  - Provide spinal immobilization.
  - Transport immediately.

• Child Abuse and Neglect
  - Definition of abuse – use of improper or excessive action so as to injure or cause harm.
  - Definition of neglect – intentionally or negligently withholding of necessities of life from a child for whom you are responsible.
    • Food
    • Shelter
    • Clothing
    • Medical attention
  - Physical abuse and neglect are the two forms of child abuse that the EMT-Basic is likely to encounter.

• Child Abuse and Neglect (Cont.)
  - Signs and symptoms of abuse
    • Multiple bruises in various stages of healing.
    • Injury inconsistent with mechanism described.
    • Repeated calls to the same address.
    • Fresh burns.
    • Parents seem inappropriately unconcerned.
    • Conflicting stories
    • Fear on the part of the child to discuss how the injury occurred.
  - Signs and symptoms of neglect
    • Lack of adult supervision.
    • Malnourished appearing child.
    • Unsafe living environment
    • Untreated chronic illness; e.g., asthmatic with no meds.

• Child Abuse and Neglect (Cont.)
  - CNS injuries are the most lethal - shaken baby syndrome
  - Do not accuse in the field
    • Accusation and confrontation delays transportation.
    • Bring objective information to the receiving facility
  - Reporting required by state law.
    • Reporting statutes.
    • Report what you see and what you hear - NOT what you think.

Reporting Child Abuse Or Neglect
TCA 37-1-403
(a) (1) Any person who has knowledge of or is called upon to render aid to any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition shall report such harm immediately if the harm is of such a nature as to reasonably indicate that it has been caused by brutality, abuse or neglect or that, on the
basis of available information, reasonably appears to have been caused by brutality, abuse or neglect.

(2) Any such person with knowledge of the type of harm described in this subsection (a) shall report it, by telephone or otherwise, to the:

(A) Judge having juvenile jurisdiction over the child;
(B) Department, in a manner specified by the department, either by contacting a local representative of the department or by utilizing the department's centralized intake procedure, where applicable;
(C) Sheriff of the county where the child resides; or
(D) Chief law enforcement official of the municipality where the child resides.

Immunity From Liability For Reporting Child Abuse Or Neglect
TCA 37-1-410
(a) (1) IF a health care provider makes a report of harm, as required by the provisions of § 37-1-403; AND
IF the report arises from an examination of the child performed by the health care provider in the course of rendering professional care or treatment of the child; THEN
The health care provider shall not be liable in any civil or criminal action that is based solely upon:

(A) The health care provider's decision to report what such provider believed to be harm;
(B) The health care provider's belief that reporting such harm was required by law; or
(C) The fact that a report of harm was made.

(2) As used in this subsection (a), "health care provider" means any physician, osteopathic physician, medical examiner, chiropractor, nurse, hospital personnel, mental health professional or other health care professional.

(3) Nothing in this subsection (a) shall be construed to confer any immunity upon a health care provider for a criminal or civil action arising out of the treatment of the child about whom the report of harm was made.

(b) Any person reporting under the provisions of this part shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes a detrimental change in the employment status of the reporting party by reason of the report.

Infants and Children with Special Needs
• This can include many different types of children.
  - Premature babies with lung disease
  - Babies and children with heart disease
  - Infants and children with neurologic disease
  - Children with chronic disease or altered function from birth
  - Often these children will be at home, technologically dependent.

• Tracheostomy tube
  - Various types
  - Complications
    • Obstruction
    • Bleeding
    • Air leak
    • Dislodged
    • Infection
  - Emergency medical care
    • Maintain an open airway.
• Suction.
• Maintain position of comfort.
• Transport.

• Home artificial ventilators
  - Various types
  - Parents familiar with operation
  - Emergency medical care
    - Assure airway
    - Artificially ventilate with oxygen
    - Transport

• Central Lines
  - Intravenous lines (IVs) that are placed near the heart for long term use
  - Complications
    - Cracked line
    - Infection
    - Clotting off
    - Bleeding
  - Emergency medical care
    - If bleeding, apply pressure.
    - Transport.

• Naso-gastric (NG) tubes
  - A tube placed into the stomach through the nose and esophagus for feeding.
• Gastrostomy tubes and gastric feeding
  - A tube placed directly through the skin into the stomach for feeding.
  - Comes in many shapes.
  - Usually, a few weeks after insertion, the tube is replaced by a “button” that lays flat against the skin.
• Be alert for breathing problems.
  - Assure adequate airway.
  - Have suction available.
  - If a diabetic patient, be alert for altered mental status. Infant will become hypoglycemic quickly if they cannot be fed.
  - Provide oxygen.
  - Transport
    - Sitting
    - Lying on right side, head elevated

• Shunts
  - Description - device running from brain to abdomen to drain excess cerebral spinal fluid.
fluid. Will find reservoir on side of skull.
- Change in mental status
- Prone to respiratory arrest
  - Manage airway.
  - Assure adequate artificial ventilation.
  - Transport.

- Family Response
  - A child cannot be cared for in isolation from the family; therefore, you have multiple
    patients.
  - Striving for calm, supportive interaction with family will result in improved ability to
    deal with the child.
    - Calm parents = calm child; agitated parents = agitated child
    - Anxiety arises from concern over child’s pain; fear for child’s well-being
    - Worsened by sense of helplessness
  - Parent may respond to you with anger or hysteria.
  - Parents should remain part of the care unless child is not aware or medical conditions
    require separation.
  - Parents should be instructed to calm child; can maintain position of comfort and/or
    hold oxygen.
  - Parents may not have medical training, but they are experts on what is normal or
    abnormal for their children and what will have a calming effect.

- Provider Response
  - Anxiety from lack of experience with treating children as well as fear of failure.
  - Skills can be learned and applied to children.
  - Stress from identifying patient with their own children.
  - Provider should realize that much of what they learned about adults applies to
    children; they need to remember the differences.

- Geriatrics

  - The Aging Process
    - Cardiovascular system
      - Degenerative processes decrease the ability of the heart to pump blood.
      - Decline in the maximum heart rate
        - Lessens response to shock.
      - Vessels lose elasticity and tear easily
        - Increases bleeding
      - Vascular reactivity decreases
        - Lessens blood pressure control

  - The Aging Process (Cont.)
    - Respiratory system
      - Respiratory muscles degrade
      - Decreased elasticity and recoil of the thorax
      - Decrease gas diffusion across the alveolar membranes
        - The body’s response to hypoxia is blunted.
      - Decreased cough and gag reflexes
        - Decrease the ability to clear substances from the airway
• The Aging Process (Cont.)
  - Musculoskeletal system
    • Osteoporosis weakens bones, increasing the likelihood of fractures
    • Vertebral discs degenerate causing kyphosis
      - Complicates spinal immobilization
    • Joints lose flexibility
    • Loss of skeletal muscle mass

• Assessment
  - Sensory Degeneration
    • Never assume a patient is hard of hearing or has diminished eyesight; confirm it
    • Diminished eyesight
      - Place yourself where the patient can see you
      - Explain what is happening
      - Make sure the patient is wearing eyeglasses if available
    • Diminished hearing
      - Speak louder, not higher
      - Assist the patient in using a hearing aid if he has one
      - Speak into a stethoscope placed into the patient's ears if not
      - Determine if the patient can lip read
      - Note-writing

• Assessment (Cont.)
  - History
    • Any trouble breathing?
    • Have you had a cough lately? If so, have you been coughing up anything like mucus or blood?
    • Any chest pain?
    • Any dizziness? If so, what were you doing when this occurred?
    • Have you fainted?
    • Any headaches lately?
    • Have you been eating and drinking normally?
    • Have there been any changes in your bowel or bladder habits?
    • Have you fallen lately?

• Assessment (Cont.)
  - Denial of pain with cardiac signs
    • Geriatric patients have depressed pain perception
    • May be suffering a “silent” heart attack
    • Look for other signs of MI
      » Weakness or fatigue
      » Dyspnea
      » Shoulder or jaw pain
      » Indigestion
    • The patient may be experiencing pain but denying it due to fear of hospitalization

• Assessment (Cont.)
  - Detailed physical examination
    • Should always be performed because geriatric patients may be unable or unwilling to reveal all of their problems in describing her chief complaint
    • On-going assessment
• A geriatric patient's condition can deteriorate very rapidly

• Specific Problems
  - Altered mental status
  • Causes
    - Stroke
    - TIA
    - Seizures
    - Syncope
    - Drug toxicity
      » Multiple drugs
      » Multiple health care providers
      » Drug interactions common
    - Dementia or Alzheimer's disease

• Specific Problems (Cont.)
  - Altered mental status
    • Treatment
      » Never assume that a geriatric patient's altered mental status is "normal" or that it is "senility"
        » Inquire of family members or others who know the patient if the mental status is normal or has changed
      » Radios, sirens, and strange voices may add to the patient's confusion
        » Reduce or eliminate the noise if possible
      » Do not take personally any uncooperativeness or hostility that may result from the altered mental status

• Specific Problems (Cont.)
  - Environmental emergencies
    • The aging process diminishes the body's ability to create heat when cold or dissipate heat when hot
      - Smaller insulating layer of fat
      - Reduced muscle mass
      - Slowed metabolic rate
      - Impaired reflexes
      - Decreasing blood flow (especially to the extremities)
      - Reduced shivering response
    • Impaired perception
      - May not realize how cold or hot it is
    • Socio-economic factors
      - Fixed income may be prohibit keeping homes adequately heated or cooled

• Specific Problems (Cont.)
  - Trauma
    • Increased risk for falling
      - Altered mental status
      - Slower reflexes
      - Failing eyesight and hearing
      - Forced to engage in activities that exceed physical limitations
      - Arthritis
      - General loss in muscle tone and strength
• Specific Problems (Cont.)
  - Trauma
    • Spinal immobilization
      - The patient with severe kyphosis should not be forced into the usual immobilization position but immobilized accommodating the patient's kyphosis using blankets or other padding for support.

• Specific Problems (Cont.)
  - Elder abuse
    • Signs and symptoms
      - Bruises
      - Bite marks
      - Bleeding beneath the scalp
        » Hair-pulling
      - Facial lacerations
      - Broken bones
      - Cigarette burns
      - Rope marks
    • Note conflicting stories, if any
    • Do not confront supposed abuser
    • Report suspicions to receiving facility

Reports of abuse or neglect
TCA 71-6-103
(b) (1) Any person, including, but not limited to, a physician, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this part. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.
(5) (A) “Caretaker” means an individual or institution who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement.
• Comment: It is unclear if EMT’s are under a duty to report elder abuse

Immunity from liability
TCA 71-6-105
Any person making any report or investigation pursuant to this part, including representatives of the department in the reasonable performance of their duties and within the scope of their authority, shall be presumed to be acting in good faith and shall thereby be immune from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or investigation. Any person making a report under the provisions of this part shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes a detrimental change in the employment status of the reporting party by reason of the report.
• Comment: It seems that an EMT making a report in good faith is immune if the report turns out to be incorrect.