Bubbles Not Included
These bath salts pack disastrous punch

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Police Protocol changes response for the better

Necessary & Nice?
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Quality improvement can be tricky to handle well.

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Improving morale in the comm. center requires making it a priority.

The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 5,989,187; 6,004,266; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234. The PPDS is protected by U.S. patent 7,436,937. FPDS patents are pending. Other U.S. and foreign patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the NAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Pictures of this periodical come from material previously copyrighted beginning in 2004 through this present.
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Kevin Pagenkopf

Brett Patterson

Brett is a research assistant and associate for the IAED. He has trained with the IAED and has experience working with EMD systems. During this time, he oversaw the deployment of ProQA in EMD and time he oversaw the deployment of communications center. During this time, he oversaw the deployment of communications center. During this time, he oversaw the deployment of communications center.

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TIMES AND LOCATIONS

National Academies of Emergency Dispatch

Addressing the importance of the IAED, the IAED provides training for emergency call-center operators, including the deployment of ProQA in EMD and time he oversaw the deployment of communications center. During this time, he oversaw the deployment of communications center.

The Journal of Emergency Dispatch

The Journal of Emergency Dispatch

DEAR READER

SnaKe, RaTTle, And Run

Audrey Fraizer, Managing Editor

likes along the foothills and broader ridges of the Wasatch Mountains are a favorite spring opener for dogs and their two-legged buddies. Snow’s melted from the trees, making it easy to navigate under the welcoming sunshine. About the only negative is the greater likelihood of an encounter with a pair of unforgiving fangs.

The Great Basin Rattlesnake is something to avoid around here, particularly in late May through June when they’re hungry, interactive, and, matting, and according to Utah’s Reptile Rescue Service. Surprising them into action is never a good idea and I doubt snakes look at us as choice mating material.

During the past 25 years, I’ve crossed paths with at least a couple dozen of these snakes. A few gave the warning rattle shake while others were content to continue to slither across the path or remain coiled, head down in the shrubbery. One has yet to give chase and pass me. The largest Great Basin Rattlesnake interrupting my hike was four feet long. I didn’t stop to measure, and the length is likely growing longer in time similar to a fish story, but even to two to three feet provides an impressive lunge and strike force.

The snake’s reflexive spring to action follows a perceived threat; snakes lack ears but pick up on vibrations as a warning signal. The venom from the snake’s bite can immediately kill small creatures. Larger creatures take some time to die and rattlesnakes have killed people.

If a rattlesnake does bite, Ellen has been advised to call 9-1-1 and deliver Albee to a veterinarian emergency clinic pronto. I don’t know if the dispatcher would give the same Protocol 2 Pre-Arrival Instructions but I do doubt paramedics would be sent to retrieve the stricken dog from a mountain. Maybe 9-1-1 would contact the vet, which in that case would mean running like you’re a snake or, at least, running like one is after you for the same doesn’t hold true of dogs. Some 15,000 dogs and cats are bitten by venomous snakes each year in North America. Many die. Dogs are curious and impulsive; when excited, they don’t look where they’re going or exercise caution. My friend Ellen’s dog Albee is a prime example; The Boros/Border Collie mix is an energetic hiking companion with the Border Collie’s intelligence damped by the Boros’s influence (OK, out of fairness, there’s probably not a breed that can sense the danger).

Because of frequent encounters between Albee and startled rattlers, Ellen leads Albee when hiking on rocky trails and through mountain shrubbery. Albee dislikes being led on a hike but that’s not his decision to make. Once bitten, antivenom injections for dogs can cost hundreds to thousands of dollars, and that doesn’t take into account expenses related to intravenous fluids, medicine, and surgery. The annual vaccine costs about $40, but it has received mixed reports.

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P

eople approach me with all sorts of questions about emergency dispatch at the Navigator conference. Most of the questions are answerable in general, but occasionally when a question concerns protocol and the separate programs under the National/International Academy of Emergency Dispatch® (NAED™/IAED™). Questions beyond my expertise, I suggest asking someone at the Academy who should know. A few questions remain in my memory to look up later so I can tack my newfound knowledge into my Navigator conference answer arsenal.

During the past conference, held in Baltimore, Md., I set aside two general interest questions. Both involved numbers. The first—a question involving numbers of public safety answering points (PSAPs) in the United States—followed from my opening keynote. The second—a question involving the points required to become an Accredited Center of Excellence (ACE)—came shortly after NAED Accreditation Chair Brian Dale announced the addition of two Tri-Aces, making the total five.

The PSAP number I had to look up was the total since December 2003 when the FCC started keeping numbers. During the past decade, some centers were orphaned (FCC term for a center no longer considered a primary call-taking answering point) and others were added—or are new, consolidated (leaving the orphan’s behind), or, in a few instances, made it late to the list.

Recent additions include Dickinson County Communications Center in Clintwood, Va.; Lubbock Fire Department in Lubbock, Texas; Marshall County EMS, Lewistown, Tenn.; City of Bethlehem Police Communications Center, Bethlehem, Pa.; City of Thornton 911 Emergency Communications, Thornton, Colo.; City of Aventura Police Department, Aventura, Fla.; and Lee County Communications Authority, Hobbs, N.M.

As you might guess, the centers listed use the Fire, Police, and/or Medical Protocols, with the point being: The reputation of the NAED protocols is preceding the center. The protocols are part of the opening package and, in the United States, close to one-third of the primary PSAPs in the registry use at least one of the protocol systems.

Without getting too heavily into the history, the numbers are remarkable when considering the initial reluctance to adopt the Medical Protocol system outside of Utah when Dr. Clawson introduced the first cardiostimulants a little more than 30 years ago. Now, there are 42 countries, including the United States, using protocol.

The Tri-ACE question can be subjective. The person asking—a dispatch center operations manager—wanted the “real” number of points required to achieve ACE. “There are 30,” I said. “They’re posted on the NAED website.” The manager laughed. “No, there isn’t she said. “Not if you count between the lines.”

I understood what she was talking about. The Salt Lake City Fire Department has labored through the 20 Points twice and will go through once more to become a Tri-ACE. From experience, I know the process involved for each point at least doubles in terms of sub-points and sub-sub-points. For answers, I turned to Don Aker, trainer supervisor for Prince George’s County Public Safety Communications Center in Maryland. Aker and coworker Training Coordinator Angela VanDyke gave their estimates during the “Getting Juiced for ACE” presentation at Navigator.

Aker said the total is closer to 115, when dividing each point down to the sub-sub-sub-point level. “But don’t look at the numbers,” he advised. “It’s a long-term investment and may be indicated in some situations. Decisions on whether or not to use CPR should be left to medical control.”

And once you’re there, no official in the world will want you to lose accreditation. If you do, the points required to achieve ACE can be subjective. The reputation of the primary PSAPs in the registry use at least one of the protocol systems.

Dr. Clawson:
A cardiologist sent me a letter in reference to a patient having a Left Ventricular Assist Device (LVAD). He explained that—in case of an emergency—chest compressions should not be done for this patient. Everything might be OK if a family member happens to call 9-1-1. I am aware of the patient’s condition and know not to do chest compressions. But what if we are talking to someone unfamiliar with the patient’s condition. Do we need some form of questioning or a Pre-Question Qualifier in the Medical Priority Dispatch System® Protocol (MPDS®) to help determine this condition and proceed in the appropriate fashion?

According to an article in JEMS magazine (Wayne A. Riddle, RN, CFRN, PHRN, The High-Tech Heart: LVAD emergencies in pre-hospital care, 2006), CPR & other treatment: Due to the location of the LVAD and its proximity to the heart, there may be risks associated with performing chest compressions. CPR may damage the LVAD itself or dislodge tubing, resulting in massive hemorrhage. The use of hands-only CPR is recommended in place of CPR is possible and may be indicated in some situations. Decisions on whether or not to use CPR should be left to medical control.

The related axiom provides the education:

Protocol 9 Rule

M-2-6 only instructions (e.g., C-13 and C-14) may be provided for patients with INEFFECtIVe BREAtHIng when a healthcare provider insists that the patient has a pulse or if the patient has an implanted Left Ventricular Assist Device (LVAD) or other circulatory support device.

The related axiom provides the education:

Protocol 9 Axiom

When a patient’s condition is unknown, the patient should be treated as any other patient. If known, the cause of the device is unknown, the patient should be considered for emergency care. The device should be treated as any other patient. If known, the cause of the device is unknown, the patient should be considered for emergency care.

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Protocol 9 Axiom

Left Ventricular Assis Devices (LVADs) are a common type of several Circulatory support devices designed to increase cardiac output in heart failure patients. Chest compressions are contraindicated with most but not all of these machines due to the risk of catheter displacement and subsequent hemorrhage. Additionally, the device may be functioning without receiving a pulse. Most of these devices have back-up systems that can be used in case the device fails.

Additionally, Critical EDI Informations:

According to the article, these patients nearly always have support staff that must be notified and, at the same time, able to provide additional assistance.

These devices vary with regard to design, contraindications, back-up systems, etc., and attempting to “protocolize” the machines is problematic. For instance, while compressions are contraindicated with one model due to the potential for tearing catheters and causing hemorrhage, CPR is appropriate for others. Additionally, there is the question of machine failure versus patient failure, which is difficult for the EMD to evaluate and must be determined when considering a definitive course of action. Finally, the machines have different back-up systems, i.e., manual pumps, built-in or external apparatus, etc.

With these factors in mind, the Standards Research Council decided to handle the issue by the Rule (What can I do?) and Axiom (What is it?).

Since ventilating a non-breathing patient is the primary concern and universal instinct, the Rule allows for ventilating a patient with a circulatory support device when compressions may be contraindicated.

Protocol 9 Rule

EMDs should not stray from Protocol or be concerned about potential liability. The standard of care is to provide CPR for unresponsive, ineffective breathing patients and the 9-1-1 call is an implied call for help. If the presence of the device is unknown, the patient should be treated as any other patient. If known, the Protocol provides an option to perform M-2-6 only, which may be considered along with other treatments, including CPR.

Brett A. Patterson
IAED™ Academics & Standards Associate
Research Council Chair

LVAD Status Unknown
Does that influence chest compressions for unresponsive, ineffective breathing patients?

Brett A. Patterson

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Research Council Chair

From Someone Who Knows
Numbers don’t always tell the whole story

Scott Freitag, NAED President

Since the figure was rather dated, the question stuck. I couldn’t let it go. I asked research council Chair Brett A. Patterson to help you with the question. The reputation of the primary PSAPs in the registry use at least one of the protocol systems. The numbers don’t always tell the whole story. g

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Moral is often complained about in the same way a slow CAD applica-
tion or a radio failure is viewed. They are required components of a communications center but the problems are usually forwarded to someone else for resolution. While it is com-
mon for employees to look to management to improve the morale of the center, it is just as common for management to look to their staff. While not routinely a thought that is entertained, management personnel are also employees of the company or agency. There will always be a division between labor and management, us against them, but at the end of the day, everyone is stuck in a room full of CADs, tethered to a radio, breathing stale air, and trading the same colds and flus. Morale is universal and knows no bound-
daries. There are certainly morale problems caused by poor management. Equally, there are morale prob-
lems caused by toxic personalities or cliques within the workforce. Improving morale takes everyone's participation.

Morale matters
Morale drives behavior. Thus, in turn, affects the quality of work as well as self-satis-
faction—which is a key component in the deci-
sion employees make to remain at a job. So it is
bical to value morale as it improves quality as well as employee retention. A core
responsibility of all personnel should be to create an environment where everyone feels
valued for their efforts, recognized for their accomplishments, and encouraged to con-
tinue applying their efforts to improve the overall performance of the center.

Management should solicit input and
Suggestions from their staff members. By
actively engaging key personnel and valuing
their efforts, they will be encouraged to work
toward improving the atmosphere of the cen-
ter. Providing recognition rewards positive
behaviors from callers, and the PDPS will pro-
vide the most up-to-date information while
responders are en route to the call.

For those in the second category, explain
that constant radio interruption slows
down the call process and flow of informa-
tion. Again, we’re talking about trust. Police
have to trust that they will be updated as the
information comes in.

Performance dip
Expect temporary dips in performance.
The Protocol learning curve takes time and the
process can be frustrating, especially for high
performers. Their days of glory are not over, but only back at the beginning. It’s
also helpful to remind responders that their
patience will be appreciated during a period of
possible call processing delays, although they
can expect vast improvements in the
days soon to come.

Policy revisions
Each center has its way of handling cer-
tain tasks not directly covered by Protocol,
and tweaks to policies and procedures prior to,
and most importantly after, the go-live
date should be expected. Instead of back step-
ing to old comfort levels, focus on ideas for
adjusting to new ways to accomplish goals.

Saboteurs may surface
In my experience, most centers have at least
one person determined to subvert the system.
The saboteur might try to use the structure or
wording of Protocol against an outcome to
force process failure. It might mean asking
every single Descriptive Essential element or
taking data out of context to blame Protocol
for their own behaviors. Attitudes are conta-
gious—both positive and negative. Listening
to gossip or accepting hazing is just as dam-
ing to morale as actively participating in
these toxic behaviors. Leadership and ‘Man-
gagement’ are two different things. Anyone
can lead by example and set the standard for
an improved atmosphere and better morale.

Employees
Take accountability for their own behaviors. Attitudes are conta-
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Management
Engage your staff and do so often. The
focus should be on quality interaction, not
quantity interaction. Survey employees, ask-
ning for their suggestions. Value both their
participation as well as their input—even if
you disagree with their opinions.

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ning for their suggestions. Value both their
participation as well as their input—even if
you disagree with their opinions.

Everyone should be held to the same
standards. That includes management per-
sonnel. Gather input and participation from
the bottom up but lead from the top down.

Regardless of title or responsibility,
take the initiative to improve the morale of
your center with the hope that one by one
others will follow, because ultimately,
we’re all responsible for improving morale.
Like everything else this takes practice, but
a small step in the right direction is better
than no movement at all.
35% of injured children had soft tissue injuries—the most common type
26% had puncture wounds or lacerations
76% had head or neck injuries—the most common body regions to be affected
11% had upper extremity injuries—the second most common body region to be affected
911Lifeline keeps on growing
A free Yahoo Group started to fill the void left by the once popular but no longer operational 911Console e-mail site for dispatch has grown into more than a forum for online discussion.

During the past six years since its inception, Michael Wallach has turned 911Lifeline into a recognized industry resource offering a document library, RSS news feed, staffing analysis tools, and customized surveys. "Mike has always been the visionary behind 911Lifeline, adding new features that caught the attention of others in the industry," said 911Lifeline board member Jon Goldman, Communications, Fire Alarm, and Technology director for the Derry (N.H.) Fire Department. "We became a force to be reckoned with."

Four years into the venture, Wallach's dedication made 911Lifeline too elaborate to be applied to a department's specific needs, so the board decided to revamp it into a document library, and obtain IRs 501(c)(3) recognition as a non-profit organization. A board of directors was put in charge of the existing free Yahoo Group e-mail and features available through paid memberships. The free e-mail group fosters unrestricted discussion, although discussions must remain 9-1-1 related; business postings are prohibited although job openings are allowed. The e-mail group is also used as a real-time resource; for instance, one agency posting a real-time question about an out-of-state driver's license had the answer posted by another agency within minutes. The second resource, and parallel to the Yahoo Group, is a paid membership in 911Lifeline Inc. Active members pay $12 in annual dues, and associate members pay $50 in annual dues.

An active member must be employed by, or retired from, a vetted public safety related agency as a dispatcher, firefighter, manager, director, police officer, EMT, etc. Associate memberships include any commercial entity or vendor selling products and services to the 9-1-1 or public safety communities. Associate memberships are also open to any public safety organizations such as APCO or NENA.

Paid membership provides access to all of the 911Lifeline resources. These include:

- Document library organized into 25 categories such as SOPs, PowerPoint presentations, and training materials including 9-1-1 call recordings.
- Customized staffing analysis that can be applied to a department’s specific call characteristics to produce a Staffing Analysis Report suggesting the optimum level of call-takers.
- Compassionate assistance to agencies experiencing a Line of Duty Death (LODD).
- Mentor program pairing a new hire dispatcher with newly promoted Communications Training Officer (CTO) or supervisor with an experienced member of the same rank/grade.

Decorations are the eye of protocol users
The North West Ambulance Service (NWAS) NHS Trust—Manchester area con-
trol center is proud of its use of MPDS and isn’t a bit apprehensive to show it. The center, which last year moved from a rundown facility built in the 1960s for a bus station, features script on walls listing every proto-
col users’ favorite text: “What’s the address of your emergency,” “Stay on the line,” and “I’m organizing help for you now.” The desk pedestal design is specific to housing the Medical Priority Dispatch System (MPDS) card index, and “the definitive measure of flattery—an embossed display on one of the walls resembles a strand of DNA, which intertwines with GIS mapping point and incident numbers. "The reason for the strand should be obvious, at least for those familiar with the MPDS and the writings of Jeff Clasow, M.D., creator of the protocol system. DNA represents life," said NWAS Program Director Ray Lunt, who coordinated the move to the new facility. "For the ambulances service docs," he said, "We respond to geographically spread incidents that influence life outcomes." Ambulance call center staff in Greater Manchester moved in April 2010 to a center they now share with NHS Manchester. The control center staff answers 426,365 9-9-9 calls annually and arranges patient hospital transport. NWAS isn’t alone in its protocol adornation. A seasonal tribute to protocol resolved the age-old question of what to give Christmas for EMD Sue Filleto with Rochester Emergency Communications in New York. Filleto, who was relatively new to the posi-
tion when colleagues rolled around, pulled Richard Rusho’s name for the annual sort of Secret Santa drawing. Rochester Emergency Communications serves 84 public service agencies and last year the 192 employees handled more than 12 mil-
on calls for service. Dedicated message boards designated by rank that give members access to a message board format within a nar-
rowly-focused topic

Firefighter grants fund communication upgrades
800 MHz radio system upgrades aren’t the only perks when awarded Assistance to Fire-
fighters Grants (AFG) through the Federal Emergency Management Agency (FEMA). It also brings peace of mind to resi-
dents living within this corner of the tor-
nado belt, according to Larry Steeby, a fire chief for one of 10 departments in Labette County (Kan.) sharing in the piece of the AFG pie.
SWAT callers could face prison time

A bill introduced in Michigan would make it a felony for anyone found guilty of placing a medical or other emergency report into a dispatch center to confuse or mislead emergency responders. Penalties for those found guilty of placing calls requiring response by Special Weapons and Tactics (SWAT) teams depend on the severity of the death; as a result of the response meeting up to 15 years in prison and fines between $5,000 and $10,000. The guilty party would also be responsible for paying the cost of the response. Parents of a juvenile convicted of the crime could be ordered to pay restitution.

Swatters hack into video game consoles to send 9-1-1 messages using Internet connections in hopes of eliciting a SWAT response. The hoax also highlights a security shortcoming with Voice Over Internet Protocol (VoIP) phone services that let people mask their true location and the advent of Caller ID spoofing services offering to disguise callers’ origins.

The Federal Bureau of Investigation (FBI) headed up the first federal swatting case in 2007 and since then has successfully proscribed seven cases, including a group of swatters responsible for placing 800 calls in 17 states. Three years ago a legally blind Massachussetts phone hacker was sentenced to over 11 years in federal prison following his guilty plea for computer intrusion and witness intimidation charges. Among other charges, the then 19-year-old Matthew Weinman confessed to conspiring with other phone hackers to make hundreds of swatting calls. Each swatting incident resulting in response costs taxpayers an average of $10,000.

Scams keep on coming

An identity theft con to travel the states has callers claiming to be homeowners over extra money to receive 9-1-1 services. Although there are variations on the theme—such as fees related to entering addresses in an emergency database—the caller requests names and medical information in order for the homeowners to “subscribe” and otherwise keep their 9-1-1 services viable. Scammers in Ionia County (Mich.) have even pitched a senior citizen special—a one-time fee of $289.

Police are reminding residents that 9-1-1 services are funded through dedicated 9-1-1 excise taxes included on telephone bills and through other local government funds. The calls to collect fees are just a new twist on identity theft and a way to score free money. A second scam for the record tries convincing grandparents to open their wallets for a “grandchild” unable to call because of injury or arrest. Police say the callers prey on emotions and are very effective in convincing their prey to wire the cash requested.

Shakeouts quaking the country

A practice in protection that started in California four years ago is spreading to other states, albeit in a similar vein, meeting on rocks of unrest. Originally called the Great Southern California Shakeout, the one-day earthquake preparedness event is now being held in a growing number of states. According to the great Utah Shakeout held on Feb. 7, 2012, including Missouri, Illinois, Indiana, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, and Oklahoma.

According to the great Utah Shakeout website, the California Shakeout held on Feb. 7, 2008 was based on a magnitude 7.8 earthquake on the San Andreas fault in southern California and the destruction it would cause. Nearly 5.5 million people spanning eight counties participated. Two years later, the same event drew 79 million participants.

The newest drug on the street is available over the Internet and, in some areas, over the counter in convenience stores, truck stops, head shops, and gas stations. While labeled as bath salts and branded with fanciful names like “Ivy Wave,” “White Dove,” and “Cloud 9,” the more appropriate branding would be more along the lines of a skull and crossbones.

These bath salts have nothing to do with bathing but are more of an imitation cocaine or LSD that when snorted, ingested, or smoked can result in euphoria and hallucinations. In extreme cases, the use of drug has led to self mutilation, unprovoked attacks, and cardiac arrest.

The drug’s relatively recent street debut compounds problems for EMS. There are no nationwide or state rules for response. Emergency behavior and insensible talking prevents dispatchers from gathering the appropriate information and ambulance drivers must make quick decisions about how to handle the drug’s abusers. Police are cautioned against restraining patients because of the risks associated with increased adrenaline release. The severity of the problem put bath salts response on the agenda for the Maine National Emergency Number Association (NENA) conference held in April.

Public access to the drug, however, may soon be designer drug history.

The U.S. Drug Enforcement Administration (DEA) added the emergency response to “grandchild” scam and for the record, at the DEA’s ten-year National Preparedness Day emergency preparedness event in October 2011 to ban chemicals used in the manufacture of the synthetic drug and at least 33 states have measures to control the substance. In February, Sen. Charles Schumers (D-NY) proposed a national ban on the chemicals used in bath salts. The chemicals are already banned in the U.K., Canada, Australia, and Israel.

The DEA’s ban and state regulations make it illegal to possess or sell the drug’s key ingredients—mephedrone, methylethyl-dioxypyrovalerone (MDPV), and methylethyl-dioxypyrovalerone—methylene—lone—or any other products containing the chemicals. The ban is in effect for one year and the DEA works with the U.S. Department of Health and Human Services to further study control of the chemicals.

Newest designer drug isn’t for sprinkling in bathtub as name implies

*See CDE on page 32

Intentional fires kill hundreds each year

During 2005–2009, an estimated 330,000 intentional fires were reported to U.S. fire departments each year, with associated losses of 440 civilian deaths, $1.36 billion in direct property damage, and $1.3 billion in direct property damage. According to the report, a great majority of fires were set by individuals. Three-quarters (75%) of these fires occurred outside, 18% in structures, and 8% occurred in vehicles. Despite being only 18% of all fires reported, structure fires accounted for 88% of civilian deaths, 82% of civilian injuries, and 82% of direct property damage caused by intentional fires. The majority of intentional structure fires occurred in residential properties, 6% occurred in storage facilities, 6% in educational properties, and 4% occurred in mercantile or business properties.

A report NFA recently released on the total cost of fire in the U.S. shows an estimated $30 billion, or 2.3% of U.S. gross domestic product, products for major fire causes includes children playing with fire, electrical failures in homes, home candle fires, home cooking fires, and home heating fires. More than 110,000 fires are reported each year down on about every type of fire and the associated stastics are based on the reports available to both NFPA members and nonmembers. Members have full access to the information.

Albany 9-1-1 might make pranksters think twice

Albany County 9-1-1 in New York might have a surefire route to making prank callers think twice before dialing: make the consequences known and enforce them. According to the “Facebook Story of the Day” presented by the local news station, the communications center considers prank calls a serious matter that is pursued and prosecuted.

“We can trace those phone calls; we have had people that have made prank phone calls even with this law on the books,” said Chief Floyd. “We have proven that we have the capability to do that,” said Charlotte Floyd, Albany 9-1-1 communications manager, in response to the daily question. Conviction of making a phone call to a law enforcement center, punishable up to one year in jail and up to $2,500 in fines.
Ambulance service in Ireland celebrates reaccreditation

While party caps and trumpeting party horns were absent from the celebration, ACE reaccreditation for the National Ambulance Service (NAS) North Leinster Area, Midlands Division caused quite a sensation without the added hoopla.

In addition to the staff gathering for the “Thank-you day” party held by the North Leinster Area Ambulance Control Centre, the event brought in local media and Health Service Executive (HSE) managers from other parts around Ireland, according to Beverley Logan, International Academies of Emergency Dispatch (IAED)™ accreditation officer.

“Those attending already confirmed that these are the footsteps they intend to follow,” Logan said.

This is the control center’s second round at accreditation, having first achieved its initial ACE in 2005. The center takes about 28,500 calls per year and covers a population of about 215,000.

The HSE was established in 2005 to manage and deliver health and personal services in Ireland. Three ambulance command and control centers in NAS North Leinster coordinate pre-hospital emergency care services for 97 ambulance-stations. North Leinster has a population of about 207,000 and covers 16,031 square kilometers; 570 people staff the three centers.

The NAS is the country’s largest pre-hospital care provider operating at a uniform level across the country.

Conference signals things to come in Italy

A quality improvement brainstorming session among three regions in northwest Italy using the Medical Priority Dispatch System™ (MPDS) turned into a full-blown conference attracting representatives from operations centers around the country.

“Emergency medical services are closely knit in Italy” said Amelia Clavson, director of International Relations for the International Academies of Emergency Dispatch (IAED)™. “Word spread and the 30 attendees expected jumped to more than 200”.

The day-long event held May 3 at the San Martino University Hospital of Genoa featured opening remarks from each of the medical directors from Valle d’Aosta, Piemonte, and Liguria and three two-hour sessions covering medical emergency 1-1-8 case reports, key components of the MPDS and ProQA, and culminating with a session covering quality improvement. Dr. Francesco Bermano, the medical director of Genoa Central Operations (C.O.) 118, and Andrea Furgani, M.D., managing director of Genoa C.O. 118 quality improvement, organized the event.

The three regions—Liguria, Valle d’Aosta, and Piemonte—initially planned an afternoon meeting to discuss quality improvement and a more unified emergency dispatch system. Across the regions are no strangers to the MPDS. Northern Italy was the first to adopt uniform levels of emergency assistance nearly 20 years ago, prompting the entry of MPDS. Liguria, with five centers, including the one in Genoa, went live with Medical ProQA between December 2010 and May 2011.

Clavson, project manager for the MPDS implementation, said Dr. Bermano, an advocate of pre-hospital care and 1-1-8 public education, is a standout in emergency medical services. “He doesn’t take anything at face value,” said Clavson, who was invited to give a presentation describing the MPDS in front of a panel of moderators. “But once he was convinced the process works, he’s become a major advocate.”

PDC Consultant Ross Rutschman was among a group of moderators for the quality improvement session.

Changing course

The potential of the MPDS in Italy hasn’t happened overnight. Clavson and others from the Academy have spent more than a dozen years in Italy and taken several trips specific to the three regions in the northwest. Not only have they learned the culture but also, became well acquainted with the country’s evolving emergency healthcare system.

Legislation in 1992 called for the formation of operations centers equipped with a short and universal telephone number (1-1-8) connected to one center. Initial service was limited to provinces in several northern regions (Friuli, Veneto, Trentino Alto Adige, Emilia Romagna, and Piemonte), although by 1995, 1-1-8 operations centers had extended to western (Liguria and Lombardy) and central regions (Tuscany, Abruzzo, and Lazio). Currently, all regions in Italy have at least one center per province.

The 1-1-8 medical centers are the connecting points of all healthcare emergencies. Every medical emergency 1-1-8 calls converge through the national emergency number system. The regional centers operate in close collaboration, although the 1992 directive allows each region to carry out autonomous implementation of local provisions, according to an article in the Journal of Preventive Medicine and Hygiene (2004; 45:27-30).

Several factors delayed the country from taking full advantage of the MPDS, including the importance of economic, political, and negligence.

“Dr. Bermano knew we were sincere about improving the 1-1-8 system,” Clavson said. “This wasn’t about pushing another American product and leaving the country once negotiations were completed. We are here to stay.”

The one-day conference held at the University of Genoa attracted interest from as far away as the Puglia Region at the southern heel of Italy, signaling the continuation of something good.

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International News

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The Q reviewing this call suggested starting the instruction with a situational or conditional statement, such as: “I know you said the cut is on his eyebrow, but if any other injuries are found, do not use a tourniquet.” Would it be more appropriate to skip the instruction or is the instruction required whenever bleeding control instructions are accessed? Heidi Gillespie, EDQ™ Coordinator Weld County Regional Communications Center Greeley, Colo., USA

Heidi: You are correct in that the instruction is mandatory, but PDI’s are to be given when appropriate, possible, and necessary.
As an EMD-Q, I would be OK with either of the options you have described, preferably the one with the situational comment. This is best because it shows concern for the caller/patient and ensures that the instruction was provided. Incidentally, I used to work as a phlebotomist in the hospital nursery and we routinely put a rubber band (tourniquet) around the infant’s scalp to draw blood from scalp veins. Callers do weird things, so it’s best to cover the bases. Again, I would not fault an EMD for not giving the instruction for a non-extremity wound.

Brett A. Patterson
IAED Academics & Standards Associate Research Council Chair

Breth: Are complaints of “seeing things” or “hallucinations,” considered decreased level of consciousness? If we use Protocol 25: Psychotic/Abnormal Behavior/Suicide Attempt, it becomes an ALPHEA-level response, which is nonemergent, according to our medical director. If we use Protocol 26: Sick Person (Specific Diagnoses), it would be considered altered level of consciousness and becomes a CHARLIE-level response, which is an emergent response, according to our medical director. I want to make sure that my EMDs are handling these situations in the same way in order to provide a consistent response to our patients.

Anthony L. Allen
American Medical Response Communications Supervisor Independence, Mo, USA

Anthony:
Hallucinations are generally considered a psychiatric complaint, but drugs or even illness may also cause them. It is important to listen carefully to the complaint and cover the safety and clinical (priority symptom) basics. I would not fault an EMD for using either P25 or P26, but I would lean toward 25 just for patient monitoring purposes. If we use Protocol 26: Sick Person (Specific Diagnoses), it would be considered altered level of consciousness and becomes a CHARLIE-level response, which is an emergent response, according to our medical director. I want to make sure that my EMDs are handling these situations in the same way in order to provide a consistent response to our patients.

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By Audrey Fraizer

Was it inspiration, practicality, or compassion—or a combination of all three—that brought Accredited Center of Excellence (ACE) distinction to Service Mobile Emergency Care of São Paulo (SAMU.SP)?

If you ask Col. Luiz Carlos Wilke, he might say not one of the three elements trumps another. They all came into play and when they merged during the accreditation process is a moot point at best.

After all—and this is the important thing—Wilke, SAMU.SP director, is an ambitious person, determined to offer the best medical Priority Dispatch System™ (MPDS), going live Feb. 24, 2011, and only 10 months later—ready to submit an accreditation packet that would also make SAMU.SP the first in Latin America to become an ACE.

“The ACE title has special value for our SAMU,” he said. “It’s been our mission to meet the requests classified as medical emergencies or urgencies in the shortest time possible.”

At the Navigator conference held in Baltimore, Md., during the third week in April, Wilke spoke of the compassionate point of the care and the inspiration his caring has in turn provided to others.

In 2009, the SAMU went through a gradual hiring of people with disabilities, anyone working in a place that has saving lives as a main goal.

“SAMU emerged as the reason that I no longer work in public service as either firefighting or police officers but they too sustained injuries requiring emergency response and ultimately the loss of jobs due to the severity of the accidents.

Now comes the part about inspiration. Wilke adamantly refuses and actually becomes rather annoyed regarding any hint of “pity” in the hiring process. The option did not arise by chance or even a desire to fulfill the country’s Quota Law. The end to long stretches of unemployment combined with a newfound profession he believed would translate into dedicated employees, empathetic to a caller in crisis, were behind the decision.

“The focus is not inclusion,” Wilke said. “We are not a philanthropic agency. Our goal has always been to seek excellence in service. The people we have hired were indeed the best professionals for the job with the skills required for anyone working in a place that has saving lives as a main goal.”

Vinicius Oliveira is an exemplary fit. Seven years ago, Oliveira took three shots in one arm and two in the back while trying to break up a fight at a relative’s graduation ceremony. He left the party in an ambulance and spent months in rehab. With what has been called an impressive calm, today Oliveira responds to calls from people in similar situations.

“I’ve been in the role of the victim, now I can help others,” he said.

The supervisor of ambulance dispatch, Thiago do Santos, was forced to leave his job after fracturing two vertebrae in a car accident. He spent nine months in a hospital bed and has never regained full movement.

“SAMU emerged as the reason that I should not have died,” he said. “It is gratifying to see that I can make a difference in someone’s life.”

The TARMs also “clicked” with the structure of call processing and dispatching response using the Medical ProQA software. TARMs instructors had the benefit of professional translators in a sound booth at the back of the classroom to provide real-time translation.

“The people we have are indeed the best professionals for the job with the skills required for anyone working in a place that has saving lives as a main goal.”

– Col. Luiz Carlos Wilke

presented by Fitch & Associates on behalf of IAED

two weeks that will change your life...
“The difference in language wasn’t a problem,” said Brett Patterson, International Academies of Emergency Dispatch Academicians & Standards associate and Research Council chair. “I could look directly at the calls and what I saw was heard immediately. They could ask questions and I could give answers without waiting for someone in front of the class translating each sentence.”

As in most implementations, the toughest obstacle proved to be the medical staff assigned to patient triage. Under the former system, phone support transferred calls to a medical regulation team of physicians and assistants; they analyzed calls to decide if patients to alternative fixed resources or appropriate mobile care resource, and directed answering calls. The five supervising doctors were on duty for every shift.

MPDS, 15 medical doctors were routinely assigned to patient triage. Under the former system, phone support transferred calls to a medical regulation team of physicians and assistants; they analyzed calls to decide if patients to alternative fixed resources or offered advice over the phone. Prior to MPDS, 15 medical doctors were routinely on duty for every shift.

Although the communications center was not the medical team’s preferred venue, desired field response to phone response, relinquishing call analysis and dispatch was a tough sell. Once again, MPDS rose to the occasion. “We monitored the call until the patient left the hospital,” said Mordijkian, executive coordinator of central operations for SAMU 192 do Municipio de Sao Paulo (SAMU 192). “We have similar cases every day, but this was the first using Pre-Arrival Instructions. MPDS has tremendous benefits for our people.”

Wilke said the doctors deemed the system safe. They are now back in the ambulances, where they want to be, rather than answering calls. The five supervising doctors routinely on the floor at the center are available for medical decisions involving ALPHA, BRAVO, and CHARLIE calls and to give advice for calls coded as OMEGA.

With doctors, TAMs, and management on board, the ACE became an attainable goal. Adding fire to the fervor was the 9/11 compliance level reached within six months of operations and a positive public response. They were at accreditation levels by October 2001 and ready to submit their accreditation packet in January 2002. Nearly 250 invited guests attended an ACE celebration party held on May 30 at SAMU 192.

Wilke said ACE was a goal from the start. “It is with pride we say that the Service Center SAMU de Sao Paulo is the largest and most modern in Latin America,” he said. “But nothing is more important than our ability to save lives.”

About SAMU-SP

SAMU follows international standards of emergency care and is regulated by national standards of the Ministry of Health and the Federal Council of Medicine (CFM). The organization of emergency care systems began with the GM/MS n. 2048 of Nov. 5, 2002, which created the 1st Technical Regulation: State System of Urgent and Emergency Care that is currently in force.

The mobile service SAMU opened in a new center in October 2009 in Bon Retiro, the central region of Sao Paulo. This date was a historical milestone for SAMU because it was when they started to use Intergraph’s Incident Management solution, fully customized by Sisgraph—the same Brazilian company that one year later supported PDC™ and IAED on the MPDS implementation and the Incident Management solution, fully customized by Sisgraph—the same Brazilian company that one year later supported PDC™ and IAED on the MPDS implementation and the ACE achievement at SAMU. In addition, the three-year-old center is equipped with projectors and LCD televisions, providing the location of vehicles available for response.

Sao Paulo, with a population of about 10.5 million people, has the largest central pre-hospital care system in Latin America. Since 2004, the original fleet of 63 rescue vehicles has grown to 120 ambulances, a number expected to increase to 140 in 2012. The service also manages 55 technical reserve units to replace ambulances sidelined for repairs or in case of exceptionally high demand. Calltakers answer 8,000 calls daily, sending response to about 1,500 patients.

What could be more important than protecting our children?

Announcing 9-1-1 COMMUNICATION CENTER BEST PRACTICES IN CASES OF MISSING CHILDREN

A missing child is a critically important and high profile event that can rip the fabric of your agency and community if not handled correctly. In terms of urgency, use of resources and potential impact on the community, a missing child requires a level of readiness akin to a disaster. This joint initiative of NAED, APCO, NENA, National AMBER Alert and the National Center for Missing & Exploited Children (NCMEC) was created to:

- Promote awareness of the critical role of the 9-1-1 communication center in handling missing and exploited children calls
- Develop and endorse best practices
- Develop tools for handling incidents of missing and abducted children

Helping to PROTECT OUR CHILDREN is as easy as 1-2-3!


2. **Request** a copy of the Public Safety Telecommunicator Checklist for Missing Children.

3. **Apply** to attend NCMEC’s CEO Overview Course in Alexandria, Virginia.

CEO Overview Course

9-1-1 Communication Center Managers and Directors are invited to apply to attend the two-day overview course held at the National Headquarters of NCMEC in Alexandria, VA. Courses are conducted approximately every six weeks at no cost to participants.

For more information, visit www.missingkids.com/911 or email 911@ncmec.org


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What could be more important than protecting our children?
Nobody Doesn’t Like 9-1-1

The free-for-all call, kind of

James Thalman

A sk most Americans what numbers come to mind in case of an emergency and they’ll say 9-1-1. Ask most PSAP managers to say what numbers come to mind in case of an emergency and they’ll string a long series of digits together, all starting with a dollar sign.

They will also be quick to note the significant costs of maintaining the other half of every 9-1-1—two-way radio communications. A 9-1-1 call engages dispatchers who then engage the police, fire, and medical responders over a radio system of relay towers that must work in all weathers at all times all chimes. Whether forest fires rage near the towers in lowland timber or winter encases them in sideways stalagmites of ice 2,000 feet above where trees don’t grow, towers must be up and humming 24/7/365.

Everything has to work, no matter what. Maintaining two-way communication can be tricky, even risky, as the cover photograph of the tower perched on Black Crook Peak near Salt Lake City shows in no uncertain terms. Winter storms regularly sculpt the sky-high tower into one bug-eyed alien monster of a maintenance trip.

And, no matter what time of year, landing a helicopter at 9,274 feet “is a little like balancing a glass of water on a pencil,” said Wade Matthews of Tooele Emergency Management. “The tower has never failed, even though our folks have been certain it would a few times.”

It’s a combination of good luck, good work and money that keeps all the scenes behind the scenes of 9-1-1 going. The system is so good that it is taken for granted and the public it serves thinks it’s a free call. Those who sit night and day at the consoles and those who mind that the radio system so information is reliably transmitted to the field responders know the service isn’t free by a long shot.

In short, the 9-1-1 system might seem self-perpetuating after nearly 44 years, but it is constantly buffeted by some pretty stiff budgetary winds, yet keeps providing unparalleled customer service. No brag, just fact.

While the marketplace will insist in a voice mail to customers how important their call is to a company, then advise them to “listen closely as our options have changed,” a real, live dispatcher answers the phone, usually on the first ring and sends help seconds into the call. If a comm. center uses the NAED® protocols, the “customer” is provided guided help over the phone while emergency responders are on the way.

“Yes, your call is very important to us, but we would never have to say that, callers know,” Danny Gordon, an EMD with Newton County Central Dispatch in Neosho, Mo., told The Journal in April. “The call isn’t just important, it’s vital. It’s the catalyst to how the entire incident is handled. We not only have to provide the ultimate customer service, we’re providing the ultimate public service at the same time. We take it very seriously.”

Money is the main reason companies and telephone service providers have outsourced customer service to India or relegated calls to a menu repeated by a disembodied voice. There is no incoming revenue in staffing customer hotlines. There’s no money in staffing emergency call centers, either, but 9-1-1 still costs plenty. And with the advent of the digital age, providing the new and improved emergency data centers, which one day will save public safety resources flying out the door these days,

Feature | NextGen9-1-1
Free is expensive

Two people in line at a grocery store in March who use prepaid cell phones said they don’t pay a penny for 9-1-1, and that’s how it should be. “The more people use a service, the cheaper it is to run,” you say. “They don’t pay a penny for 9-1-1,” and that’s March who use prepaid cell phones said. “That’s not the case at all. They’re paying for both the legacy 9-1-1 system and the country’s no-service fees collected from the use of a good, old landline home telephone, which have kept some of the digitizing world, the news media is a main information conduit.
months by two reports, one on the federal level and one on the state level.

The first is a report to Congress from the Federal Communications Commission (FCC). Not only do states and agencies within states have their own unique ways of collecting fees, some—10 at least in 2010—used portions of the fees collected for purposes partially or completely unrelated to 9-1-1. In 2009, 12 states were diverting funds for non-9-1-1 related expenditures.

While it’s good that the number of states diverting 9-1-1 funds from their proper purpose has slightly decreased, FCC Chairman Julius Genachowski said in a news release announcing the report, that the agency must be given the power to do more than detail funding practices and discrepancies among the various states.

“As we move toward a next-generation 9-1-1 system, the FCC is today seeking input on how to most effectively use 9-1-1 fees to enable the transition to sending text, video, and photos to 9-1-1. The call to underwrite 9-1-1’s future was apparently heard in Congress. As part of the controversial payroll tax cut extension approved in February, Congress included $115 million in kick-start funding to state and local 9-1-1 authorities.

Chairman Julius Genachowski said in a report to Congress from the Utah Communication Agency Network (UCAN) and a former dispatcher who has been around the two-way radio side of emergency communications for as long as there has been 9-1-1, said succinctly: “NG9-1-1 is a better mousetrap, but it’s being built to Internet-based dispatching as a smartphone is to a teenager.”

Steve Proctor, executive director of the Utah Communication Agency Network (UCAN) and a former dispatcher who has been around the two-way radio side of emergency communications for as long as there has been 9-1-1, said succinctly: “NG9-1-1 is a better mousetrap, but it’s being built for a teenager.”

“In broad terms, the national 9-1-1 upgrade has a lot of lines and multiple-choice blanks to fill in by various state and local emergency communications centers. Overall spending on telecommunications is going up because consumers and businesses are purchasing more sophisticated services in greater amounts. However, voice telephone service, the costs that consumers actually pay, is going down.”
of his hand. He raised his eyebrows, briefly surveyed the group, and then said, “There’s only one person who can answer that one, and that’s me.”

Case reviewing is certainly not for everybody. Dale had said repeatedly during the previous two days. But having people who are willing to do it is a must, “and it must be done with fairness, attention, and near-infallibility if a center is to maintain the quality of call-taking and processing the people who do the work.”

ED-Qs have to be uber-dispatchers in a way. Not only do they have to be an individual of exemplary interpersonal and organizational skills, but having traits listed in the Boys Scout’s Law—trustworthy, loyal, helpful, friendly, courtious, kind, obedient, cheerful, thrifty, brave, and reverent—doesn’t hurt.

In addition, ED-Qs, according to the ED-Q Course Manual, “…will need to be patient, tactful, empathetic, compassionate, and organized. You need to be able to express your thoughts and feelings in a way that shows your concern for the quality of care received by your agency’s customers, as well as your concern for the well-being and advancement of those taking and processing the calls.”

It goes without saying that ED-Qs must know and show extensive working knowledge of the NAED protocols—the standard of care as well as the professional standard for professional emergency dispatchers. Minimum Q requirements vary slightly. EMD-Qs, for example, must have Advanced Life Support certification. EMD-Qs, EMD-Qs®, and EPD-Qs® must have corresponding levels of skill and knowledge in their disciplines. A three-year commitment to be a Q is expected.

Each center can take its own unique approach to quality assurance. The peer-to-peer review is how they do it in Greeley. “Veteran dispatchers have an ED-Q duty for three years or longer and rotate back to the console. Calltaking and processing can be done during the ED-Q commitment, but case reviewing is the primary function. Getting more Q in case review was the goal of dispatchers who attended Dale’s class.”

Aлизо the most effective approach, as long as case reviewers stay professional and don’t get personal, Dale said. A person sitting next to you one day and then in judgment the next day regarding what you think you are” attitude must be openly addressed from the beginning, he said.

**Staying in the game**

The player-coach approach can be much more effective in raising a call center’s quality level and consistency because of the inherent all-for-one, one-for-all ethic, Dale said. It’s a matter of recognizing strengths as well as weaknesses, a big part of which is to be as detail-oriented in the praise as the evaluators tend to be in pointing out deficits, he advised.

“If the objectives are clearly stated and consistently and openly followed in improving performance, the ‘Who do you think you are’ aspect naturally fades away,” he said.

Just like a calltaker should be personable but not personal, case evaluations should be the same way.

“Everyone worthy of the job should be open to improving their handling of every call,” Dale said. “Good enough to get by is neither good enough nor getting by. If the standard is set, and everybody knows exactly what is expected, and that is maintained, a group, individuals can’t help but improve.”

“That, of course, is the ultimate example of ‘easier said than done’,” said Heidi Gillespie, an ED-Q with the Weld County Law Enforcement Center, at the Q course. “When you take work as personally as and seriously as dispatchers tend to take their profession, reviewing it becomes pretty personal, too. It’s pretty tricky.”

It doesn’t have to be. Everyone knows and tries to show that case evaluations are about reviewing the incident, not about criticizing the individual, Dale emphasized at least a dozen times during the course. “People aren’t robots, and every incident has some obvious elements that are black and white and some are just a lot of gray. And sometimes what seems obvious to one might not be to another, and sometimes even obvious isn’t obvious. But, again, case evaluation isn’t about you.”

Those in attendance worked to understand the concept.

“But it is about you in a way,” Paxton, as well as others, said not trying to argue but to understand. “You’re looking for ways the dispatcher screwed up. At least what’s a lot of people think; I know that’s how it feels to me sometimes, even though I try not to take it personally.”

The subjective objective

Maintaining quality in the communications center can be a combination of herding cats and hypnotizing chickens—both difficult tasks, yet easier than you think.

Dale, deputy chief, Administrative Services, with the Salt Lake City Fire Department, took ED-Q down to its essence by showing prompts for quality assurance and public safety every driver knows—speed limit signs.

Showing a slide of the ubiquitous black and white “55” sign, Dale said most driv- ers regard the limit as a “55-ish” suggestion, although they know a highway patrol officer could technically pull them over and give them a ticket for driving 56 mph.

“Most officers won’t stop a driver for going 56; would they be more likely to stop them at 65? Probably, and drivers know it. There’s a tolerance built into the limit, every- body knows it, and traffic seems to keep going smoothly,” Dale showed his next slide, a speed limit sign with the word “School” above “Speed Limit 20,” and then asked, “Does that mean 20 mph? Would a police officer be likely to notice a driver going 25 mph? Would he or she be ticketed? Probably, and both the driver and the officer would know he was deserved.”

“Why?” Dale continued. “Because it’s a shared communal, cultural, and public safety attitude that it is dangerous for kids to be in the close proximity of cars traveling faster than 20. Certain situations have lesser condi- tions and tolerances, in others, the tolerances are very narrow and everybody knows it.”

Times used to be that the tolerance in dispatching was the expectation to say 10-4 at the appropriate time. Dale said, “Then they started expecting dispatchers would get help to show up,” he said. “Now they expect us—and they won’t tolerate less than—to tell people what to do, and they want help showing up.”

That makes dispatching more difficult by a factor of 12, and the job of keeping the best possible performance and sticking to the protocols roughly twice that, Dale said.

Dale stressed that being a Q is not a matter of knowing the protocols inside and out, nor is it figuring out how to get the best review. It makes quality an obvious and abiding goal of the PSAP and defining what is quality in the individual, keeping track of it, and constantly trying to do better,” he said.

Check the local library, or, if your kind of quality includes instant access to infinite bits of information on a subject, google the word. It’s the most popular word in advertis- ing next to the slogan “New and improved.”

The pursuit of quality has been both a great motivator and a difficult task, yet easier than you think. Dale showed his next slide, a speed limit sign with the word “School” above “Speed Limit 20,” and then asked, “Does that mean 25 mph? Would a police officer be likely to notice a driver going 25 mph? Would he or she be ticketed? Probably, and both the driver and the officer would know he was deserved.”

“Why?” Dale continued. “Because it’s a shared communal, cultural, and public safety attitude that it is dangerous for kids to be in the close proximity of cars traveling faster than 20. Certain situations have lesser condi- tions and tolerances, in others, the tolerances are very narrow and everybody knows it.”

Times used to be that the tolerance in dispatching was the expectation to say 10-4 at the appropriate time. Dale said, “Then they started expecting dispatchers would get help to show up,” he said. “Now they expect us—and they won’t tolerate less than—to tell people what to do, and they want help showing up.”

That makes dispatching more difficult by a factor of 12, and the job of keeping the best possible performance and sticking to the protocols roughly twice that, Dale said.

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Handling heat and hyperthermia

By James Thalman

No Sweat

Inhabitants of inner cities may also suffer from the heat by choosing not to open their windows for fear of becoming a victim of crime.

Each protocol provides a specific interrogation to evaluate the patient’s symptoms while considering other possibilities. As stated on Protocol 20, Axiom 3, “Because a patient has a problem in a hot or cold environment does not mean the problem was caused by the environment.

However “nothing serious” could have easily been a heart attack. Priority symptoms, when presented in a patient exposed to extreme heat, may or may not be related to heat stroke or heat exhaustion.

Heat or cold extremes may trigger other medical problems.”

Heat or cold exposure does not mean the environment is the cause of the medical problem. Each protocol provides a specific interrogation to evaluate the patient’s symptoms while considering other possibilities. As stated on Protocol 20, Axiom 3, “Because a patient has a problem in a hot or cold environment does not mean the problem was caused by the environment.

A symptom of severe but dissipating heat and the back seat

Summer also means that a surprising number of children most without any prior health trouble, will be seriously injured or even killed after being left in a parked vehicle in broad daylight. The CDC reports that between 1998 and 2011, at least 500 children in the United States died after being left inside cars, some of which got hot enough to bake cookies in before their caregivers returned. Opening windows has almost no effect because much of the heat radiates off seats and dashboards.

Child vehicle deaths frequently occur on days with afternoon temperatures in the mid-70s. This may be because caregivers falsely assume that the relatively mild temperatures are not a threat to the child or if she or he is left for “just a few minutes.” However, the Police Priority Dispatch System (PPDS) classifies a child intentionally left in a vehicle without appropriate supervision to be neglect, as defined on Protocol 102: Abuse/Abandonment/Neglect.
Though this classification may seem harsh to a well-meaning parent trying to run a quick errand, this scenario can be deadly. A curious child may unintentionally shift the vehicle into gear, an unnoticed child may be abducted in a vehicle theft, or, most frequently, a child left inside a vehicle can suffer hyperthermia, even on mild days, as the glass-enclosed space amplifies the light and heat from the sun. The hotter the temperature is outside, the faster the car's interior temperature rises, which is even worse for a child whose body temperature rises three to five times faster than an adult due to smaller body size.

The Fire Priority Dispatch System (FPDS) cites the following statistics on Protocol 53: Citizen Assist/Service Call to send responders (53-B-1) to quickly get inside the locked vehicle to prevent heat-related illness.

According to forensics meteorologist and researcher Jan Null of the Golden Gate Weather Services, who is arguably the most vigilant tracker of child deaths inside vehicles in the country, 33 children died from hyperthermia in 2011. With warmer weather showing up ahead of schedule this spring, the annual tally is probably headed for a spike this year.

Null said from 1990 to mid-2012, 529 children died from hyperthermia in parked cars; their ages ranged from 5 days old to 14 years old. Most of the deaths (253 or 52%) were the result of a caregiver forgetting the child was in the car (perhaps due to placement in the backseat), according to Null’s latest report. There were 150 children (30%) who were playing in an unattended vehicle when they were overcome by heat, and 86 (17%) of the deaths occurred when an adult unintentionally left a child in the car, most often to run an errand that took more time than she or he planned. Circumstances surrounding five of these deaths couldn’t be verified.

The dispatcher’s role may vary in handling these situations from reporting neglect near a passerby who notices an unattended child left in a vehicle (FPDS Protocol 102), to giving medical instructions to a distraught parent when his child has been playing inside a hot car and is now losing consciousness (FPDS Protocol 20).

A distracted caregiver may also find that she has unintentionally locked her keys in the car with her toddler inside. In this case, a dispatcher may refer to FPDS Protocol 53: Citizen Assist/Service Call to send responders (53-B-1) to quickly get inside the locked vehicle to prevent heat-related illness.

From the dispatching console, the rule of thumb when people call 9-1-1 because they’re too dry, too hot, too burned, or too pooped from the heat to know what to do is this: Seat temperatures can raise up to 20° F (11° C) in 40 minutes.

According to forensics meteorologist and researcher Jan Null of the Golden Gate Weather Services, how many children died from hyperthermia in 2011?

1. a. 700
   b. 300
   c. 500
   d. 135° F (57° C); 150° F (65° C)

2. a. 250
   b. 300
   c. 500
   d. at risk

3. a. true
   b. false

   c. Protocol 7: Burns (Scalds)/Explosion (Blast).

5. a. true
   b. false

6. The Pulsar Priority Dispatch System (PPDS) classifies a child intentionally left in a vehicle without appropriate supervision to be ____________, as defined on Protocol 102: Abduct/Abandonment/Neglect.
   a. abuse
   b. abandonment
   c. neglect
   d. at risk

7. a. true
   b. false

8. When the outside temperature is 93° F (34° C) and the car window is down 1 1/2 inches (4 cm), the temperature inside the car with her toddler inside. In this case, a parent who finds his child has been playing in an unattended vehicle when they are overcome by heat exposure is rarely life-threatening or even serious. A few, particularly heat stroke, can be deadly. The dictates of the protocols provide several correct, go-to options that permit the calltaker to be confident handling the presentation of symptoms. It might take a little more attention to get to the trigger detail. Just get there, code it, and move on.

9. According to forensics meteorologist and researcher Jan Null of the Golden Gate Weather Services, how many children died from hyperthermia in 2011?
   a. 26
   b. 33
   c. 38
   d. 42

10. Also according to Null’s latest report, most child hyperthermia deaths were the result of a caregiver forgetting the child was in the car.
   a. true
   b. false

Sources
3. See note 1
5. See note 4
7. See note 4
8. See note 4
9. See note 4
10. See note 4

Answers to the CDE quiz are found in the article “No Sweat,” which starts on page 28. Take this quiz for 1.0 CDE unit.

A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive your CDE acknowledgement for future reference.
Rub-A-Dub-Dub

These bath salts aren’t meant for the tub

By Audrey Fraizer

“I ask dispatchers what they would think about a caller saying there is someone banging on his roof at five in the morning,” said Reagan, who has given over 70 talks on bath salts during the past 14 months in both Maine and Canada. “It’s the paranoia bath salts can cause. In this case, the guy on the roof was trying to escape what he believed to be people in his yard that were after him. Of course, there was nobody in the yard.”

Doctors talk about ER patients on days-long hallucinogenic highs similar to the effects of LSD. Sometimes, people abusing bath salts become so violent, much like PCP users, that physical restraints are required. On Jan. 11, the Medical Examiner’s Office in Bangor reported the first confirmed case of death associated with bath salts. During January and February of 2012, the Sullivan County (Va.) Sheriff’s Department responded to 13 bath-salt-related cases and reported two deaths also attributed to the drug.

Chemical ingredients

According to the National Institute on Drug Abuse (NIDA), the chemicals used in the manufacture of bath salts present a high risk for overdose, abuse, and addiction. While the exact composition differs among the various brands, bath salts often contain various hallucinogenic and amphetamine-like chemicals described below.

- Mephedrone presents a high risk for overdose according to reports from the United Kingdom
- Pyrovalerone is a psychoactive drug that causes changes to perception, mood, consciousness, cognition, and behavior, which also presents a high abuse and addiction liability
- Cathinone is chemically similar to amphetamines and induces the release of dopamine, which gives the user a euphoric feeling
- Mephedrone is a stimulant drug known as “monkey dust” in the United Kingdom

Sometimes the key ingredients are cut (mixed) with an inactive powder such as baby laxatives, pancake batter, water softener, or laundry detergent. Because of their initially inexpensive street price, the first available bath salts were less likely to be cut unless they were cut with a more potent drug such as lower quality cocaine; however, some decrease in availability (due to legal banning) has led drug dealers to add filler ingredients to decrease the quality while maintaining demand. Beyond the lures of a cheap and still available drug, bath salts offer further appeal in that they’re everything but soothing.

Medical effects

Bath salts are linked to an alarming increase in the number of ER visits across the country; however, the best approach to treatment remains uncertain because of the drug’s limited time on the market and the non standard mix of ingredients used in its production. From January to November 2011, the American Association of Poison Control Centers reported 5,853 calls related to bath salt exposure, a dramatic increase from 303 calls in 2010. Early bath salts users were reported to be an average age of 35 and most were admitted to long-term addicts; recent statistics, however, indicate that the average user’s age is declining into the 20s, although the drug isn’t considered a gateway drug to other addictive drugs.

‘Like most designer drugs, they’re working their way down to younger users,’ Reagan said.

According to Dr. Ronald J. Mathis, Chief Toxicologist at the Virginia Poison Center, bath salts can cause severe, life-threatening symptoms and complications in an overdose.

Toxicology released two ELISA kits for the forensic detection of bath salts, and, late last year, forensic product companies began making portable bath salts drug test kits that police can use on patrol. The tests can detect mephedrone and MDPV in suspected bath salt samples.2

2 Medical effects

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The attraction to bath salts may be due to the desirable psychological effects users describe including increased energy and awareness and extreme euphoria. But the same mixture of ingredients can induce acute side effects such as agitation, anxiety, and delusions. Excessive cathinone usage, for example, can cause loss of appetite, anxiety, irritability, insomnia, hallucinations, and panic attacks. MDPV puts the user at risk for insomnia, nausea, increased body temperature, ringing ears, severe paranoia, breath- ing difficulties, and suicidal actions. Chronic abuse of bath salts can also result in personality disorders and myocardial infarction.3

Physical signs that indicate a person may be using bath salts include: sweating, thirst, jerking body movements, grinding of teeth, and sudden violence with little or no warning. Bath salts can cause severe agitation lasting up to five days. The initial “high” of bath salts may last for hours, but the resulting psychosis can last for hours to days or even longer. The faces of longtime bath salts users often appear drawn—hence the “Monkey dust” street name for the drug in the Bangor area.4
Brewer signed a bill that bans seven primary bath salts, and more than 35 states and the District of Columbia are considering whether to issue a permanent ban.

When the individual is impaired the person is, the officer will decide whether the situation may be classified as "Bath salts are just the latest in the line of drugs, which merits a DELtA-level code (only ashen/gray, blue/cyanotic/purple, or mottled). A CHARLIE-level code should be sent for a patient who is unconscious or not alert, breathing is absent or ineffective, and showing signs of ineffective breathing or who are unconscious.

In the situation of a violent patient, the EMD adds the suffix "V" to the Determinant Code for "violent or combative." The "Notice Police" symbol on Key Question 2: "Is s/he violent?" reinforces that law enforcement should also be notified and a code be sent in conjunction with EMS to a safety measure when responding to violent or combative patients. Since violence can escalate at any time, dispatchers should refer to applicable law enforcement protocol.

The Police Priority Dispatch System (PPDS) handles drug situations on Protocol 116: Drugs; the questions on this protocol address weapons involvement (with variuous suffixes to delineate the specific type of weapon), caller and bystander safety, location of the drugs, suspect description and location, and vehicle description (if applicable). Determinant Codes on this Chief Command Protocol address the use, possession, or sale of drugs, which merits a DELTA-level code while finding drugs or paraphernalia requires a BRAVO level code.

The EMD must begin CPR for patients who are not alert and showing signs of ineffective breathing or who are unconscious.

After initiating dispatch, the EMD must provide Pre-Arrival Instructions (PAI) to begin CPR for patients who are not alert and showing signs of ineffective breathing or who are unconscious.

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A 9-1-1 medical call specific to bath salts poisoning or overdose falls under MPDS Protocol 23: Overdose/Poisoning (Ingestion).

A 9-1-1 medical call specific to bath salts poisoning or overdose falls under MPDS Protocol 23: Overdose/Poisoning (Ingestion). While the ingestion of the drug could be classified as either a poisoning (accidental intake of a potentially harmful substance) or an overdose (intentional intake of a potentially harmful substance), the dispatch response is based on the patient’s condition.

A DELTA-level code should be sent for a patient who is changing colors of clinical significance such as:

- ashen.gray.
- pink.
- blue/cyanotic/purple.
- red.

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- ashen.gray.
- pink.
- blue/cyanotic/purple.
- red.

The EMD must add which of the following suffixes for a violent or combative patient?

- W
- A
- D
- V

The PPDS Protocol specific to drugs is:

- Protocol 107: Assist Other Agencies.
- Protocol 116: Drugs.
A Springer spaniel named Joe was likely enjoying his early evening romp of amazing smells at Jonesville Park in Gainesville, Fla., when quite by accident he triggered a response focusing on the flexibility of Fire Protocol. “They [Joe and his owner] were out walking and Joe disappeared down a hole,” said EMD Shantara Whitehead of the Alachua County (Fla.) Sheriff’s Department. “The owner was frantic.”

When Karen Clark received the Rescue Professional award from the American Red Cross Santa Cruz Chapter, she said she really did it for the profession. “I have to give so much credit to this citizen,” Clark said. “I think she deserves a hero’s share of the credit.”

Dog Day Evening
Protocol applies to more than just people

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Whitehead, who had been at the job for about 15 months, coded the call as an animal call: “I said ‘Moo’ and the calf gave a ‘Moo’ back,” Clemmons said. “The calf actually did very well on its own way out.”

While the calf needed light sedation to attach the harness and steady the roped ascent, the 600-pound Joe was good to go without the syringe. Clemmons said Joe was a “nice dog,” and seemed to understand the submissive attitude necessary to get him out of the deep mess he had accidentally created. Joe was fitted into the harness and clipped into an “O” ring fixed on the harness Clemmons was wearing.

Firefighters and the University of Florida Animal Technical Rescue Team, all trained in technical rescue, pulled Joe and Clemmons to the surface using a technical rope rescue system. “Joe acted like he knew what he was doing,” Clemmons said. “That and having a great team around me made my job a lot easier.”

Joe came through with only a few tender spots resulting from the fall, a temporary loss of appetite—he snubbed the chicken nuggets Clemmons brought along for the ride—and with, perhaps, a better appreciation to watch the ground he’s sniffing. The park district filled the hole the same evening, which in a way is a credit to Joe’s roving instincts. “It’s lucky Joe found the hole for us and not a child,” said Clemmons, a veterinarian for the Veterinary Emergency Treatment Service (VETS), developed by the University of Florida, College of Veterinary Medicine (CVM). Clemmons is an animal lover. He is an associate professor for the Department of Small Animal Clinical Sciences at the University of Florida, specializing in small animal neurosurgery, and would drop just about anything to aid an animal in crisis.

“One of the fire captains called later and the caller was attending a conference, which arrived eight minutes than described by the caller awaited response, which arrived eight minutes after initial dispatch. “There is absolutely nothing new every day. Often we don’t get the happy ending. It was a wonderful outcome.”

A Springer spaniel named Joe rides to the surface of a 50-foot deep sinkhole attached to a hammerhead, Dec. 2011 ride. He was also the vet lowered by waving teriyaki jerky filled the hole the same evening, which in a way is a credit to Joe’s roving instincts. “It’s lucky Joe found the hole for us and not a child,” said Clemmons, a veterinarian for the Veterinary Emergency Treatment Service (VETS), developed by the University of Florida, College of Veterinary Medicine (CVM). Clemmons is an animal lover. He is an associate professor for the Department of Small Animal Clinical Sciences at the University of Florida, specializing in small animal neurosurgery, and would drop just about anything to aid an animal in crisis.

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When Karen Clark received the Rescue Professional award from the American Red Cross Santa Cruz Chapter, she said she really did it for the profession. “I have to give so much credit to this citizen,” Clark said. “I think she deserves a hero’s share of the credit.”

Clemmons’ first call for rescue occurred eight years earlier and from CVM Director of Medical/Health Administration John Haven, who was in charge of deploying a patient (animal) care team in response to Hurricane Charley. “We set up a MASH-type hospital and volunteers treated animals brought in from the storm,” Clemmons said.

After Charley, came Frances and then Jeanne. The results of their animal disaster response during that one hurricane season so impressed the Florida Veterinary Medical Association and the Florida Department of Agriculture and Consumer Services that Haven added a new calling to his card.

“We had done such a good job winging it, we were given the job,” said Haven, a CPA with a professional administrative background.

During the past eight years, VETS has grown into one of the largest non-federal animal disaster response teams in the United States, providing self-contained veterinary care triage for predominantly small animals and advanced technical rescue for large animals. Funded through grants and donations, VETS can deploy up to 17 people in response to local and national disasters and operates a fully-equipped mobile veterinarian’s office, three pick-up trucks, and two equipment trailers.

The team is a core component of the State Agricultural Response Team and can be deployed to other states during a Federal Declaration.

VETS volunteers take technical courses geared for human rescue and adapt the strategies to animal rescue. They’ve trained members of similar organizations and Haven was recently appointed chair of a task group drafting an animal rescue standard for the National Fire Protection Association (NFPA).

“When I got for going to the meeting,” Haven said. “VETS has a lot of extra work, but tremendously rewarding. It’s a good buzz knowing back to owners an animal we’ve rescued!”

And don’t think that Joe’s rescue was the through the call—their before they reached chest compression instructions. “I guess the child must have swallowed the marble,” Clark said. “I was surprised when the woman told me the girl was breathing. I was very happy.”

A completely different scene than described by the caller awaited response, which arrived eight minutes after initial dispatch. “She said she’s fine,” Clark said. “She’s sitting up. She’s talking. It was just a wonderful miracle. It was a great feeling to know that the training I received worked. Often we don’t get the happy ending. It was a wonderful outcome.”

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Administrative Supervisor Marsh MillerAyers nominated Clark for the award after finding out about the successful outcome.

“Of the five captains called later and said the instructions we gave were perfect,” MillerAyers said. “We definitely saved her life. It was one of those high-priority, low-frequency events. The fact that we were successful with it, we were really pleased.”

Even when calls don’t turn out as well as this one did, Clark enjoys the job; it was a change she made 13 years ago after spending 21 years as a newspaper reporter. “I like the fast-paced nature of it,” she said. “There’s something new every day. We do make a difference more often than we realize!”
Rushing into burning building wasn’t part of his new job description

Dispatcher Christian Millette really thought he could dance. Apparently the 20-year-old ballroom dancer and dispatcher for Groupe Alerte Sante in Longueuil, Quebec, Canada, wasn’t the only one. When Season 4 of So You Think You Can Dance Canada (SYTYCDC) aired its finale in September 2011, Millette finished strong in fourth place beating out 18 other dancers also chosen for the show after auditioning.

“It was really, really fun,” Millette said. “We were like one big family. I was not expecting to be in the finals. I was competing against 19 and 20-year-olds. It helped me with my confidence.”

The competition was 75 days in Toronto, Canada, spent at a grueling pace—near the end of the show Millette said they spent 16 hours a day in training from trying on costumes, traveling to practice, going to the gym, checking out music, and dancing for up to eight hours with styles ranging from ballroom, to hip hop, to Bollywood, to Latin, to jazz. “I had a lot of time to concentrate on my dancing,” Millette said. “The last week was sleeping only three to four hours a night. I didn’t have time to sleep. It was a really good experience to see what your body can handle.”

Ballroom dancing is in his blood and his positive attitude and focus on dancing have taken him far—not only on the show, but like many elevated to hero status, the mayor—can still credit himself a fire rescue and medical units.”

On April 21, 2011, Nunez was driving to an inspection when a call came in over his portable service radio. There was a structure fire with potential parties trapped close to his route. Nunez drove to the scene, parked his car against the opposite curb, and ran into the house after radioing West Metro Fire Communications of his plans to help a woman standing in a smoke-filled hallway.

“He told us he was going in, and that was his choice,” said Megan Reyes, who was the supervisor on duty that morning. “We sent fire and medical units.” Nunez did a grab and go, cradling the startled woman like a bride across the threshold. He took her down the porch stairs, carried her to the car, and grabbed an oxygen tank from an engine that had just pulled up. An ambulance transported the 85-year-old woman to the hospital.

“She had just been in the hospital for pneumonia,” Nunez said. “She would have never made it down the stairs alone.”

The incident might have gone unnoticed if a former field paramedic student of Nunez’s hadn’t caught wind of the rescue. Now a West Metro lieutenant, he and another lieutenant nominated Nunez for Colorado’s Red Cross Professional Rescuer Award, which Nunez received at the 2012 Breakfast of Champions and Award Ceremony—held on March 15, 2012, in Denver. Nunez said this rescue was more poignant than others from his firefighting days. But that doesn’t mean he’s feeling any more heroic.

“Once then his long list of accomplishments include placing sixth at the World 10 Dance Championship 2011, having a walk on part in Shall We Dance, being a dancer at Epcot at Walt Disney World in Orlando, Fla., and dancing for Bulgaria (birthplace of his current dance partner Denitsa Ikonomova—she finished in the Top 8 on SYTYCDC) beginning in 2009.

Despite the demanding pace of travel and competition, Millette teaches dance; his dance partner Denitsa Ikonomova have a long list of accomplishments in ballroom dancing for Bulgaria.
A dispatcher is a conglomeration of strong personalities, all under stress at least part of the shift, and expected to work together harmoniously and take turns baking brownies for everyone on staff, including management.

No one is crotchety, preoccupied because of personal issues, or disgruntled because the working conditions are ideal and the pay and benefits are seldom in their favor. Our employ-ees are the priority and to make a difference, we have to go out of our way to thank them.

Students in both workshops offered suggestions they've tried for combatting dipping morale and declining funds. For starters, never dismiss the week set aside each year to honor dispatch-ers and don't ignore any opportunity in general to show appreciation.

Zerelda Nelson, Hillsborough County (Tampa, Fla.) Emergency Operations Center Manager Debbie Jones gave her to dispatchers to fos-ter NTW celebrations.

Crowd Pleaser The inscriptions on a pair of blue jeans don't always equal authenticity.

Between “Taming the Shrew” and “thank-you” bulletin board at West Metro Fire Rescue in Lakewood, Colo., people still talk about the thanksgiving meal they served a few years back to locals in need. "It made us feel good to do that," he said.

We have the ability to change someone’s/ experience in the way we act toward that person,” Deitschman said. "We have to react from their perspec-tive, not our own."

Improving morale can also mean going outside center walls to introduce the voices behind emer-gency communications. Karina Dash, Augusta (Ga.) 9-1-1 Emergency Services, partnered with the Red Cross for clothing and coat drives. For the past four years, center call-takers have trained volunteers answering the hotline at the Safe Home/Domestic Violence Center.

"Going out in the community lets the public see that this is someone they know and someone they can feel comfortable talking to in case of an emergency," Dash said. "The reaction has been very positive on both sides."

No matter what you try, there’s always going to be the bad apple or the “problem child” taking the bulk of corrective attention, a day to sack the uniform in place of a pat on the back of a comforter, but you may never-simply going to turn a Negative into the positive advocate you can bet the farm on. The Journal of Emergency Dispatch
Progression

Salt Lake City made leap to computerized dispatch

Audrey Fraizer

A mistake made during an emergency phone call isn’t the only reason dispatchers might get sent to the office. For a Salt Lake City Fire Department dispatcher was suspended for three days in June 1975 for refusing to cut his hair. The 32-year-old Frank Conte, argued that rules applying to firefighters shouldn’t be enforced across the board, particularly in his case since hair length did not interfere with his ability to answer emergency calls.

The senior dispatcher obviously won his fight. A newspaper article published 10 years later highlighted Conte in a story about hundreds of additional calls in a lightning storm that plunged “foot of Utah into darkness” early on a Sunday morning, according to a story in the July 8, 1985, issue of the Deseret News.

“The computer was down and so everything had to be done off the top of our heads,” Conte said. “We had to keep track of equipment, locations, crews, as well as relief crews. We had to send crews from one place to another and remember where we had them.” Conte was fairly new at the controls when Salt Lake City finally decided to follow the nation’s swelling tide of a standardized 9-1-1 emergency number and computerized dispatch for its police and fire departments.

The concepts weren’t an easy sell.

Salt Lake City Fire Department Chief Leon R. DeKorver had consistently argued against the transition, insisting that dialing three digits would be less efficient than dialing either “O” for the operator or the department’s seven-digit number, which had four lines connected directly to the alarm office. Computerized dispatch was out of the question.

“If a call came into the alarm office on the proposed 9-1-1, it would take a genius to determine the exact location of the fire,” the chief told a reporter in an article published in early 1976. “Some calls made to 9-1-1 merely go into a tape recorder if another call is in progress, and a tape recorder isn’t able to ask questions.” A system incapable of helping the public, he said, wasn’t worth the estimated $800,000 investment.

Chief DeKorver’s resistance lost favor.

The career firefighter left the post on July 1, 1976, after nearly 34 years of rising through the department’s ranks. His successor, Chief Evan Baker, a former assistant chief and with the department for 29 years, had a vision for a technologically and pre-hospital care savvy future. Within two months of his August hire date, Chief Baker unveiled the department’s ultra modern $45,000 computerized dispatching system.

“It’s only part of the total fire alert system,” he told reporters for the Salt Lake Tribune newspaper. “The cathode ray tube computerized program backs up our regular dispatch network. The old system was very old and obsolete.”

Using the new system, Conte could listen to the phone call for help and type the address of the fire or other emergency. The address typed in the computer would pull up additional catalogued data gathered by fire inspectors, and the data would appear on the television-like screen of a cathode ray tube. The same data was printed on teletype-like units in all 14 fire stations and in the battalion chief’s office.

From the computer printout at the dispatch center, Conte could pull up data to advise firefighters about additional hazards such as flammable liquids, the nearest fire hydrants, and water mains.

“In the past we had to rely mainly on oral communication,” Chief Baker said. “Engines were dispatched with loudspeaker instructions and sirens. Printed information is particularly important for the battalion chief driving across town. He doesn’t have time to stop and take down the information. This way he has the information by the time he arrives on scene.”

Chief Baker said the computerized system wouldn’t bring firefighters to the scene any faster—they already responded in about two minutes—but it would provide the information necessary to put out the fire more quickly.

Computerized dispatch and the city’s transition to a 9-1-1 call system were only the beginning. Chief Baker was an early proponent of pre-hospital care. He introduced the public to bystander CPR and brought the first paramedic program to the Salt Lake City Fire Department, believing it would add greater stature to the job of firefighting. Once trained through a five-month classroom and in-service paramedic training course offered through Weber State College (now Weber State University) located 40 miles north, Chief Evans tapped into a progressive emergency medical doctor working at the local St. Mark’s Hospital.

Jeff Clausen, M.D., was already devising his medical dispatch program when Chief Baker approached the Salt Lake City fire surgeon to become the medical advisor for the newly-formed Paramedic Advisory Council. The council’s role in coordinating paramedic services north and south of Salt Lake County proved contentious. Pre-hospital care provided by anyone other than a board certified physician was a relatively new concept.

Chief Baker and Dr. Clausen prevailed.

The chief and his wife Marjorie trained as EMTs and responded to emergencies in vehicles dedicated to medical response. They stabilized the patients, leaving transport to Gold Cross Ambulance. Marjorie was considered the go-to person at South High School, where she worked as an administrative assistant. First and foremost, however, has been her unwavering support of firefighting and emergency medical care.

“I was the fire chief’s wife who helped on calls,” said Marjorie, during a recent phone interview from their home near Salt Lake City. “Evan worked very hard to get it going in the city and loved working alongside him with the paramedics.”

Baker retired 25 years ago, after 25 years with the fire department. He stepped down as fire chief in 1982 and for several years served as an assistant chief. Now 86 years old, he lives in West Jordan, Utah. Firefighting and emergency rescue has been his life.

“Evan left the fire department in very good condition,” Marjorie said. “We have a lot to look back on. Firefighting and the department, that meant everything to him.”