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— Michel Gravel
New Brunswick EMS
Moncton, NB, Canada

Presented by:
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NENA has approved this course as credit toward recertification for the Emergency Number Professional designation.

Online registration for the 2015 course is now open.
Go to www.emergencydispatch.org/certccmcourse
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International Academies of Emergency Dispatch™
Cultural Committees exist to address the need to take into account cultural differences between places across the world when updating protocols.

Recognizing the damage stress and trauma can do to their dispatchers, comm. center managers have taken measures to ensure their workforce is equipped to ward off the effects of difficult 9-1-1 calls. One of the answers: get healthy.
Art is a software instructor and IAED™-certified ED-Q™ instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 18 years and works at Union County Regional Communications in Westfield, N.J. Art has been involved in 9-1-1 telecommunicator training and medical quality assurance since 1999.

Victoria began with Thompson Fire & Emergency Services, in Manitoba, Canada, on Sept. 3, 2013. According to her supervisor, Holly McLeod, Victoria is a happy-go-lucky young woman who takes her position as a dispatcher very seriously and with pride and offers callers a calm and compassionate voice on the other end of the line.

MAIL CALL

We’d love to hear from you! Has something outstanding happened in your comm. center recently? Or are you a budding columnist? Should your center be in the running to be our next Your Dispatch story in Your Space? Do you have a suggestion for The Journal? Email editor@emergencydispatch.org with your thoughts.

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Got social media?
Perhaps like many of you, I began dabbling in social media a few years ago, mostly with Facebook, but also daring to explore the puzzling waters of Twitter, LinkedIn, and similar platforms. More recently, I discovered that Pinterest isn’t just for women and that “pinning” can be quite addictive.

It goes without saying that in 2015, for society in general and the comm. center, technology, for better or worse, is king. Technological tools, ideally, assist us in our job, make our tasks more manageable, and create greater economies and efficiencies for response during the emergency dispatch process. Similar to how ProQA® software integrates your use of the emergency dispatch protocols with your comm. center, technology, for better or worse, is king. Technological

platforms. More recently, I discovered that Pinterest isn’t just for women and that “pinning” can be quite addictive.

So, perhaps I should write about social media? Perhaps like many of you, I began dabbling in social media a few years ago, mostly with Facebook, but also daring to explore the puzzling waters of Twitter, LinkedIn, and similar platforms. More recently, I discovered that Pinterest isn’t just for women and that “pinning” can be quite addictive.

As you may have noticed in recent months, the Academy is increasingly using social media to get the word out to you and those in the industry about new Priority Dispatch Corp.’s (PDC™) product launches, Academy research, International Academies of Emergency Dispatch (IAED™) news and events, NAVIGATOR highlights, and to keep members abreast of when new issues of The Journal and related publications are available. We maintain an IAED Facebook page (facebook.com/InternationalAcademiesofEmergencyDispatch) and also IAED (@TheIAED) and IAED NAVIGATOR (@iAEDNavigator) Twitter accounts. Many of you may have “liked” or “followed” us, respectively. We also operate a LinkedIn page and a YouTube channel (NAED911).

Ultimately, the usefulness (and fun factor) of these social media platforms is content-driven, meaning the more “stuff” we have to share, the more helpful and successful they’ll be. Successes and achievements taking place at comm. centers around the world is one type of content visitors to the Academy’s social media platforms love to see. In other words, if you’ve got a great story about how using the protocols made a significant impact on a call or if your center is a new Accredited Center of Excellence (ACE), for example, please send those stories and photos (photos are a big hit on social media) so we that we can share them with visitors around the world via social media. All submissions, photos, and ideas for content can be submitted to editor@emergencydispatch.org.

And if you haven’t checked us out on social media, give it a try. After a little time and tinkering, you’ll likely find that using social media isn’t only beneficial, but that it’s also fun, rewarding, and slightly addictive. •
There is an irony in public expectations when calling emergency services.

People expect to contact emergency services with the technologies they use to communicate every day and without unreasonable delays, while also expecting that their location is available to emergency services independently of the technology used.

The irony exists in both fixed and mobile networks.

For fixed telephone networks, problems include the exclusion of private numbers, the non-localization of calls initiated through public exchanges covering multiple buildings, and the non-standardization of data formats.

For mobile networks, the main problems include accuracy of localization, non-standardization of information transmitted to the PSAPs, and the time needed to provide this information.

Studies from various countries have reached the same conclusion regarding fixed and mobile networks (needs immediate attention) and have developed various approaches to meet challenges in the way the world communicates.

A study commissioned by the European Emergency Number Association (EENA) in 2010 highlighted the importance of improved caller-location technology to overcome obstacles with inaccuracy of then-current technology and caller information. It was also estimated that emergency services were not able to dispatch a rescue team for approximately 2.5 million calls due to the absence of sufficient location information.

As a result, in 2014, the U.K. introduced a new geographical location system called Advanced Mobile Location (AML). When a caller uses a smartphone in an emergency where AML is enabled, the phone automatically activates its location service to establish its position and sends this information via a text message to the emergency number systems, with a radius of 30 meters (approximately 95 feet) or less. The service uses GPS or Wi-Fi (whichever is better for the situation).

In April 2015, EENA also announced the availability of eCall, an in-vehicle system that establishes a connection directly with the relevant PSAP. Even if no one in the vehicle is able to speak—due to injuries, for example—a minimum set of data is sent to the PSAP, including the exact location of the crash, the vehicle’s identification number, a time stamp, and current and previous locations.

Each year, eCall is expected to save 2,500 lives throughout Europe, and, beginning in March 2018, all new car models in the European market must be eCall equipped.

In 1996, the Federal Communications Commission (FCC) required wireless carriers to locate 95 percent of GPS-enabled phones in an emergency. Those rules still apply, but only to outdoor calls. In early 2015, the FCC updated the rules to improve the ability of first responders to locate people indoors.

The E9-1-1 rules, released in January 2015, include requirements focused on indoor location accuracy. The rules establish clear and measurable timelines for wireless providers to meet indoor location accuracy benchmarks, both for horizontal and vertical information. Since this can’t happen overnight, the commission allows wireless providers to choose the most effective solutions with sufficient time for development, testing, and deployment.

Station location for multi-line telephone systems (MLTS) is also a hot topic in the U.S. Currently, 22 states have enacted or have pending legislation that addresses station location in a MLTS. Though the legislation differs to some degree, the representatives from these states are saying that organizations using MLTS must be able to deliver granular location information to the appropriate PSAP when a user anywhere on their network dials 9-1-1. Schools and universities, health care facilities, and multi-location businesses are examples of MLTS users.
Dr. Clawson:

I am having a conversation with a fellow EMD at work and need some help with a legal term. I remember my EMD instructor covering a legal aspect of agencies that provide EMD services that addresses the agency failing to correct or remove an employee who continuously fails to follow protocol, but I can’t remember what it is called. For example, an employee is consistently making mistakes, the agency fails to correct them, and a subsequent mistake ends up causing injury or death to a patient. Can you advise me what that is called? I have been unable to locate it in my EMD textbook or online.

Name withheld upon request

The name of this legal concept is “negligent retention.” It is taught in the EMD course and can be found in the Universal Course Manual on page 38. It is defined as a cause of action against an employer for negligently retaining in its employment an employee it knew, or should have known, was unfit for the job so as to create a danger of harm to third persons. Traveler’s Insurance Risk Control states regarding this issue, “A claim of negligent retention of employees is similar to a claim for negligent hiring both of which, like most tort theories, were developed from common law. If the employer discovers during the course of employment that the employee is unfit to perform the job and takes no action, there may be liability to the employer under [this] theory.”

The Emergency Telecommunicator Course Manual on page 10.10 further states:

“Negligent retention is the omission of remedial or other prudent action on the part of an employer toward an employee whose performance is known. For example, if an agency has documented incidents of poor performance from a dispatcher, that agency is obligated to take appropriate action. Appropriate actions include documentation, remedial training, oversight, monitoring, and, if necessary, termination. If no action is taken, or if such action is inappropriate or ineffective, the agency may be held liable if the employee acts negligently.”

While it isn’t specifically mentioned in the Principles textbook, the Boff case in Dallas (starting on page 1127) had a significant element of this regarding the previous performance issues with Billie Myrick, the nurse triager, who had been put up for discipline and possible termination by her supervisor, which the fire department brass quashed. Then the bomb went off with her “no send” argument and judgmental behavior with Larry Boff, the caller.

Hope this helps.

Jeff Clawson, M.D.
IAED Division of Research,
Standards & Academics
Results are in!

Data collected from a survey investigating repeated stress and its potential impact on a 9-1-1 dispatcher’s quality of life has been compiled and evaluated in an article published in the Annals of Emergency Dispatch & Response (AEDR) (Volume 3, Issue 1, available at aedrjournal.org).

So as not to create a spoiler (survey results), I will first explain the method used to gather the data and describe the personal and professional information dispatchers were asked to provide.

Hypothesis

Based on literature supporting the potential of post-traumatic stress disorder (PTSD) in emergency dispatch, the research team’s intent was to identify the impact of symptoms related to chronic traumatic event exposure; the subsequent effect on job performance; and, based on specific call types and career measures (e.g., number of years as a dispatcher), potential points of intervention.

The research contrasted results for respondents that could be categorized as having acute stress disorder (ASD)—nine or more symptoms of ASD classification—and not having it, according to their survey responses.

A most exciting facet of the survey was the exploratory analysis of a call’s characteristics—what about that call makes it so distressing to handle that it can lead to critical stress, job dissatisfaction, and burnout? This research represents the first time data has been taken to this level of detail—down to the type of call—in the emergency dispatch realm.

Method

The 205 participants were emergency dispatch professionals and primarily female. At the time of the survey, participants were between 18 years and over 60 years, and the majority (57.1 percent) were married. They work predominantly day shift and have been in the profession for 13 to 19 years, dispatching for fire, police, and medical.

The survey asked them to rate a list of 30 calls created for the research; the list included fire, police, and medical calls. To each call on the list, they assigned a value between 0 (None) and 5 (Extremely) for both acute stress experienced and the degree to which the call affected functioning at work and home.

Respondents also completed a questionnaire indicating the current sources of stress among 17 potential sources listed, along with a symptomatic ASD diagnostic test and a self-report to measure professional quality of life—using measures from validated quality of life templates.

Results

The study findings demonstrated that emergency dispatchers are likely to be at risk for ASD and job performance adversely affected by burnout and secondary traumatic stress (STS). The study results revealed a rate of ASD significantly greater than the general population (17 percent endorsed the presence of nine or more ASD symptoms). Dispatchers are also more likely to be at a higher risk, compared to the general population, for mental health problems that contribute to interpersonal, occupational, and social difficulties.

Not surprisingly, study participants reporting nine or more symptoms of ASD related to a call taken within the past 30 days also found specific types of calls to be more stressful, compared to those not meeting the criteria.

Calls involving children, suicide, structure fires, first-party callers, and those requiring the dispatcher to calm an uncooperative caller were rated as significantly more stressful for individuals meeting criteria for ASD. Calls involving traffic accidents, suicides, and children were also more likely to affect the quality of life for participants meeting ASD criteria.

The study also found a higher rate of compassion satisfaction that was unrelated to acute stress disorder symptoms.
There is a fundamental principle of EMD at the core of what we do: “EMDs don’t diagnose.” Most EDs know that but frequently do it without realizing it. Today I admit to a certain feeling of smugness in having proved that this principle is a sound one. Recently, it might have saved a life.

The call was from a woman who dialed 9-1-1 for her 92-year-old father suffering from a panic attack. She volunteered that he had a history of these. Awake and Breathing? Yes to both. Completely alert? Yes. Breathing normally? “Yes, but a little bit rough.” “What do you mean a little bit rough?” “Well, his breathing is a little labored, but that’s just because he’s panicked.” The EMD correctly sent an Advanced Life Support (ALS) unit anyway, in addition to the Basic Life Support (BLS) ambulance. It was a good thing he did, because the BLS crew reported CPR in progress within a minute of their arrival.

In my world, BLS and ALS are separate resources, and an anxiety attack with difficulty breathing requires both. It’s not uncommon to hear dispatchers gripe about sending resources when they “know” they’re not needed, and I’ve yet to meet a paramedic who responds enthusiastically to that kind of call. Most of the time, symptoms like difficulty breathing or a decreased level of consciousness aren’t things an EMS system—or an EMD—can afford to take chances on. We’re supposed to focus and base our dispatch decisions on the presence or absence of critical symptoms. Unfortunately, it doesn’t always happen that way.

Human nature seems to predispose us to drawing conclusions that may be in error. In his espionage novel “Red Cell,” author Mark Henshaw wrote, “Evolution, or God depending on your preference, has left us with brains that latch on to the first explanation that seems to fit the facts and our own mindsets and biases when we face a puzzle. Even smart analysts develop shallow, comfortable ruts.” Being biased by the caller’s diagnosis is a trap we fall into very easily. We think, “I’m not there, and the caller is, and he/she knows the patient, and I don’t.”

Another bias to guard against is being unduly influenced by the patient’s history. Every dispatch center has its “frequent flier.” The term is uniquely American and borrowed from the early days of the commercial airlines’ mileage rewards programs. A frequent flier is a repeat patient who calls in for the same thing all the time. You know him (probably by his first name), the responders know him, and he almost always declines transport to the hospital. The next time he calls, it’s very tempting to withhold the resources he would get if he was a new and unknown patient.

Every dispatch has to be based on clinical criteria and not influenced by fear of being labeled overcautious by our responders or fellow dispatchers. If you withhold a

Source
I had the pleasure of speaking to a group of budding public safety professionals who were in pursuit of their degrees in law enforcement and firefighting at our local technical college. It was my goal to educate them about our profession, reiterating several times how the position has evolved over the years into a specialized support function that is certainly more involved than most people realize.

Near the end of the presentation, one young man raised his hand and asked if it would be a positive step to apply for dispatch positions in order to “prepare” for his “real” career in law enforcement. Instantly, I felt it getting warmer in the room. Nope, it wasn’t a hot flash. It was, however, the irritating burn that is felt every time I hear people minimize the job of the 9-1-1 dispatcher. So, I did what every self-respecting comm. center manager would do: I let him have it in a stern but “kind” way, of course.

“No,” I told him. “It is NOT a good thing to apply for dispatch so you can leave to become an officer or firefighter. Why? For the same reason I would not expect you to leave the police or fire service to become a dispatcher! I need people who have a desire to make this a profession, not someone who uses it as a stepping stone.”

“I couldn’t stop there.

“Why would I spend nearly a year of considerable time, money, and effort to train someone properly as a dispatcher just to have them leave for a ‘real’ job? Dispatching IS a real job. And it’s a really tough job, too. In fact, very few people have the skills to be successful at dispatch. The sooner everyone understands that, the better off we’ll be, my friend!”

He was quiet for the rest of the tour. It made him think.

“People … DO NOT let these donkeys onto your operations floor. There is no place for them. If you do have Eeyores, you’ll need to do some quick donkey-ectomies. Now is the perfect time to turn from Eeyore ‘victim-think’ to develop into the more confident, energized, “can-do” “Tigger” mentality! Here’s how:

**Train and educate:** Nothing says professionalism and pride like investing in the professional development of staff. No money? No problem. Have you seen all of the low-cost/free training opportunities available for the taking? The investment in training will always be worth it.

**Standardization:** There is a big push to standardize training and certify telecommunications professionals. Important work continues to be done in nearly every state in order to make this a reality. Get involved and participate in those discussions and work efforts.

**Make ‘em believe:** Consider affirmation oaths for staff and include them in the development of mission, vision, and values statements. Be consistent in your expectations,

especially when it comes to protocol compliance and customer service deliverables.

**Value and trust:** Dispatchers know what they need, and they have a unique and uncanny ability to anticipate the needs of the officers/firefighters on the street. Making decisions about communication processes with police/fire/EMS agencies should include the dispatchers. Trust them and respect them—they are truly the experts! ●
There is a great deal of literature on how to improve morale in the workplace. All around the country motivational speakers attempt to influence leaders to implement a variety of practices to improve the tone of the work culture. With the numerous resources and “rah-rah” talk, it puzzles me that one of the key contributors to poor morale in 9-1-1 communications is leadership, especially in acknowledging such a stressful environment.

I have formed the opinion that some leaders believe subconsciously that morale is a non-quantifiable, esoteric, and elusive state that cannot be changed at the core.

Is poor morale simply the “nature of the business?” I think not! We must place the state of morale square on the shoulders of leadership: “Who else?” When a coach fails to believe he or she is responsible, the team may not reach its full potential.

In my leadership positions I asked myself the following:

- Am I positive?
- Am I able to motivate my employees?
- Do my subordinates become better employees under my leadership?
- Do they trust me? (More so, am I trustworthy?)
- Do I have a clear vision of the direction of the organization, and do I believe in the mission or vision?
- Am I able to articulate the mission and vision and do I have the resources to be persuasive?
- Do I make solid decisions that are ethical and absent of cynicism, gossip, and rhetoric?
- Does my leadership style create cliques and silos?
- Do I lead by inducing fear?
- Am I emotional, unpredictable, and unapproachable?
- Do I empower employees?
- Do I engage in succession planning? (i.e., have I identified potential replacements for my position, and do I readily train these employees?)

Leaders must openly communicate their willingness to improve. The plan of action to do so must be shared with subordinates and followers. Subordinates should be able to witness their leader actively engaged in enhancing his or her skills.

The shared plan of action does the following:

- It creates a learning environment. Employees will see that their superiors are taking the lead in improving their organizational and leadership skills. This will encourage subordinates to do the same, especially those seeking to be leaders within the profession.
- It allows organizations to keep pace. Many leaders may be stuck in the past. Nothing is more frustrating than listening to a leader speak of how things were different in the past or how employees were better. A manager or director leads individuals “today.” Many tricks are learned through experience, but what worked in the past will not always work in the future. It takes different strokes for different folks and different generations.
- You will remain “in shape” from a leadership perspective. I recently began to work out and exercise. In my mind, I knew I could at least do 25 push-ups. I lay on the floor, got in my push-up stance, and could not believe it. I thought I could do the push-ups on demand, even without exercising. This was a false perception. The same applies to leadership. If leaders or directors do not engage in improving skills on a daily basis, their ability to lead will be lost. This is when we revert to fear tactics and create silos.

I often speak to leaders and potential leaders about 360-degree evaluations. There are several good 360-degree evaluations online. Do not reinvent the wheel. Verbally explain intentions. Make the evaluation anonymous and report the findings to employees. Provide them with a plan of action for improvements. Remember, perception is reality!
Stephan Bunker named president of Maine Municipal Association

Stephan Bunker, former operations manager of Maine’s Emergency Services Bureau (E9-1-1) and strong advocate of the International Academies of Emergency Dispatch (IAED™) protocol systems, was recently named president of the Maine Municipal Association (MMA).

Bunker said while presiding over the MMA “is very challenging,” it complements his interests in civic participation and public safety. Legislation he helped draft more than a decade ago required any person providing emergency medical dispatch to be licensed by the state. During the state’s 2014 session, he supported a bill calling for the voluntary adoption of standardized dispatch protocols for police and fire by the state’s 26 Public Safety Answering Points (PSAPs).

Bunker and the 12-member MMA executive committee have their work cut out for them, beginning with finding the successor to the organization’s Executive Director, Christopher Lockwood, who retires in August.

Bunker’s 40-year career in public safety includes operations manager of the state’s E9-1-1, former military police officer and K-9 handler, emergency medical technician, and emergency dispatcher. He is a member of the Farmington (Maine) Fire and Rescue Department and the Maine Fire Protection Services Commission.

You like us! Journal receives high ratings in reader survey

The Journal of Emergency Dispatch is moving in the right direction when it comes to being liked by its readers, according to the results of a recent 12-question survey answered by more than 1,000 dispatch professionals.

The mix included readers from the U.S., Europe, Australia, and New Zealand.

Results, compiled in early April from responses received during a three-week period, paint an upbeat picture of the publication printed six times a year by the International Academies of Emergency Dispatch (IAED™). The positive reception to the Continuing Dispatch Education (CDE) articles is a big winner—in terms of quality—with more than 96 percent rating for each of the six categories queried. Highest compliance—over 99 percent—went to the article’s capacity to convey complex information in an understandable and informative style.

New graphic design elements merited high approval, particularly in the ease of identifying the magazine’s different sections.

As far as what people are reading, features, Your Space articles, CDEs, and FAQs took the lead, with suggestions for giving more space to describing dispatchers on the job, as well as centers—small or large—in various parts of the world, and a more technical vision of the 9-1-1 future.

Borrowing from Sally Fields’ Academy Award acceptance speech, and allowing for slight modification (1985, best actress, “Places in the Heart”): Right now, you like The Journal! Thank you.

Proclamation declares April 14 Denise Amber Lee Day

Union City, Tenn., Mayor Benny McGuire was so distressed and impressed by the Denise Amber Lee story and the work of the foundation of the same name that he proclaimed April 14 as a day in her honor.

Nathan Lee, President, Denise Amber Lee Foundation, and Geoff Weiss, Supervisor, San Diego County (Calif.) Sheriff’s Office communications, were co-presenting a regional 9-1-1 training session when Mayor McGuire stopped by to corroborate all the positive comments he had heard about the “A Victim’s Plea, Meeting Expectations” workshop.

Weiss serves on the foundation’s advisory council.

The motivational class ties together the tragic event while citing the obvious failures in 9-1-1 communications that resulted in the death of 21-year-old Denise Amber Lee, who was abducted from her Florida home and murdered in January 2008. More than four years after her death, in October 2012, Florida approved the Denise Amber Lee Bill, which, among other measures, requires state certification, recertification every two years, and continuing education for 9-1-1 telecommunicators. The Florida Department of Education established the framework for a 232-hour dispatch curriculum.

The nonprofit Denise Amber Lee Foundation promotes and supports public safety through uniform training, standardized protocols, defined measurable outcomes, and technological advances in the 9-1-1 system.
Coding error causing 9-1-1 outages incurs heavy fines

A simple coding error that was “entirely preventable” and blamed for affecting 9-1-1 services across seven states in April 2014 has resulted in fines into the millions for the three businesses found responsible, following a Federal Communications Commission (FCC) investigation. Two companies—CenturyLink and Intrado Communications—were fined $16 million and $1.4 million, respectively, for their failure to provide timely notification to public safety personnel; cell phone provider Verizon was fined $3.4 million.

The FCC determined that because of a coding bug in Intrado’s software, 9-1-1 calls were not properly routed and, instead, limited to a pre-determined number. As a result, some 6,600 calls were stopped before reaching emergency responders in North Carolina, South Carolina, Pennsylvania, California, Minnesota, Florida, and Washington. As part of the FCC’s orders, CenturyLink and Intrado are required to institute new rules and oversights to prevent outages in the future.

According to the FCC report, the widespread outage was entirely preventable since the system could have been fixed almost as soon as the outage started. The outage lasted for six hours at which point calls coming through Intrado’s redundant hub in Miami, Fla., identified the problem and led to immediate restoration of services.

Dispatch Magazine On-Line publisher “really retiring”

After nearly 30 years of delivering sometimes spicy and always interesting dispatch news, Dispatch Magazine called it quits. According to Publisher Gary Allen’s Wrap-Up column (March 27, 2015) on the Dispatch Magazine On-Line website, he is really retiring from the magazine and a career that included “20 years sitting at a console answering 9-1-1 calls and coordinating police, fire, and EMS field units by radio.” He won’t be adding new material to the online publication or “even tending to it,” but will let it remain for at least some time as a potential reference.

Allen retired as a senior public safety dispatcher in 1999 to take over the print edition of Dispatch Monthly from founder Alan Burton, who saw his friendly newsletter to colleagues develop into a full-fledged publication by 1987. Allen was the assistant editor at the time the publication changed hands.

Allen’s dedication to dispatch is clear in his final article, in which he writes: The future is up to you. Learn, be involved, take control. There is a tremendous number of critical projects in-progress right now within public safety communications. They will affect thousands of lives for decades. It’s an exciting and dynamic time. But it takes participation by those in the industry—those who know it best—to make it successful.

Fake dispatch calls net offender 30 months in prison

A Massachusetts man accused of making fake dispatch calls across Litchfield County, Conn., has been sentenced to 30 months in prison followed by three years’ probation, according to the court clerk.

Adam Perrelli, a resident of Great Barrington, Mass., was found guilty of making at least eight fake emergency radio transmissions over the Litchfield County Dispatch system that interrupted emergency calls between Dec. 25, 2013, and Jan. 6, 2014.

Authorities say he identified himself as a fire officer in most of the calls to send ambulances out to non-emergencies and canceled calls to actual fires using a lost or stolen portable radio or electronic device to place the phony calls.

He was arrested April 2014 in Pittsfield, Mass., and has been behind bars ever since. Sentencing took place in late March.
National 9-1-1 Education Coalition changes its refrain

The effect of text messaging has rewritten the materials available through the National 9-1-1 Education Coalition. In April—the month kicking off the annual awareness campaign—the coalition announced its new theme “9-1-1: Call if you can, text if you can’t,” which is intended to work with local 9-1-1 outreach efforts.

The focus of the message, however, is directed at the means of delivery more than advancing the use of text messaging. According to the coalition, “Even if text to 9-1-1 is available, a voice call continues to be the best way to reach 9-1-1.”

The National Emergency Number Association (NENA) also released texting essential materials in collaboration with the coalition’s campaign through its NG9-1-1 Education and Training group. NENA also advises the use of text messaging only when unable to make a voice call to 9-1-1 and provides the following tips:

- Text location information is not equal to current location technology
- As with all text messages, 9-1-1 messages can take longer to receive
- Text-to-9-1-1 is not available if you are roaming
- A text or data plan is required to place a text-to-9-1-1
- Photos and videos cannot be sent to 9-1-1 at this time
- Text-to-9-1-1 cannot include more than one person
- Do not text and drive!

Flu vaccine saves lives

The seasonal flu vaccine prevented more than 40,000 flu-associated deaths in the U.S. during a nine-year period from fall 2005 through spring 2014, according to estimates in a study published in Vaccines, a new publication from the Centers for Disease Control and Prevention (CDC).

The estimate represents a 22-percent reduction in the deaths that would have occurred in the absence of flu vaccination during that time, according to the CDC. The study showed that people age 65 and older and children 6 months through 4 years of age represented the majority of the flu-associated deaths prevent ed because of the vaccination.

The 2012–13 flu season vaccine contributed to the lowest mortality (9,400 deaths) from the flu, while the 2009–10 flu pandemic dominated by the H1N1 virus holds the highest recorded number of deaths (12,469) during the time period studied; researchers attributed the higher mortality to the monovalent pandemic vaccine’s release well after the illness peaked.

The International Academies of Emergency Dispatch® (IAED™) developed the Pandemic/Epidemic/Outbreak Surveillance and Tracking Tool (Protocol 36) to implement at dispatch to correctly triage and set up potentially decreasing response levels to possible flu patients during an officially declared flu outbreak.

The 2014–15 flu season was dominated by the H3N2 virus.

FCC again considering question of robocalls

The Federal Communications Commission (FCC) has been asked to again consider the issue of whether phone companies can do more to stop unsolicited prerecorded telemarketing calls, aka “robocalls.” Despite do-not-call rules that went into effect in 2003 and subsequent restrictions placed in October 2013, the FCC reportedly receives an average of 150,000 complaints a month on robocalls; however, phone companies contend that it’s problematic stopping calls because of robocaller tactics, including spoofing their identify or altering caller ID.

The FCC took up the defense for emergency communication centers in October 2012 when the commissioners unanimously approved an order creating a do-not-call list for Public Safety Answering Points (PSAPs).

The order gives PSAPs broad discretion in choosing what numbers they wish to submit for protection, provided the numbers are associated with emergency services or are used to communicate with other emergency responders. Robocallers are also required to access the PSAP Do Not Call list and are prohibited from using the registry for any reason other than complying with the rule.

Penalties include fines between $10,000 and $100,000 per call for making robocalls to registered numbers, and penalties between $100,000 and $1 million per incident for robocaller users disclosing or releasing numbers on the PSAP Do Not Call registry.

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The seasonal flu vaccine prevented more than 40,000 flu-associated deaths in the U.S. during a nine-year period from fall 2005 through spring 2014, according to estimates in a study published in Vaccines, a new publication from the Centers for Disease Control and Prevention (CDC).

The estimate represents a 22-percent reduction in the deaths that would have occurred in the absence of flu vaccination during that time, according to the CDC. The study showed that people age 65 and older and children 6 months through 4 years of age represented the majority of the flu-associated deaths prevent ed because of the vaccination.

The 2012–13 flu season vaccine contributed to the lowest mortality (9,400 deaths) from the flu, while the 2009–10 flu pandemic dominated by the H1N1 virus holds the highest recorded number of deaths (12,469) during the time period studied; researchers attributed the higher mortality to the monovalent pandemic vaccine’s release well after the illness peaked.

The International Academies of Emergency Dispatch® (IAED™) developed the Pandemic/Epidemic/Outbreak Surveillance and Tracking Tool (Protocol 36) to implement at
**Bogus calls are international problem**

In 2014, over 21 million calls were made to the 1-1-2 emergency number in Poland, although almost half of them were found to be false alarms, according to a report by the European Union (EU), Ministry of Administration and Digitization.

The 1-1-2 number is a unified emergency number that works in all 28 EU member states.

According to data from the Ministry of Administration and Digitization, approximately 2.15 million calls from the 28 EU member states were made to 1-1-2, of which over 10 million—48 percent—were false alarms. In Poland, 7 million calls (35 percent) were hung up before an operator could answer the call.

The 1-1-2 emergency number is operational throughout all of Poland, and according to the ministry, the number of emergency call centers has risen and the average time to get through to the operator has gone down to 11 seconds.

There are currently 17 Polish emergency call centers, or so-called Public Safety Answering Points (PSAPs)—one for each province, with two for Mazovia (one each in Warsaw and Radom).

In 2014, Polish PSAPs employed 809 operators, with the highest number in Katowice (95) and the smallest number in Opole (25). An average of 1,502 1-1-2 calls were taken by Polish emergency operators each month last year.

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**Switzerland 144 brings responder to SCA patient**

Switzerland’s survival rates from sudden cardiac arrest (SCA) increased from 15 percent in 2005 to 42 percent in 2013 as the result of an innovative program from the Ticino Heart Foundation that relies on emergency communications and the Medical Priority Dispatch System™ (MPDS™).

The program involves a First Responder (FR) network made up of police, firefighters, border guards, and non-public safety employee citizens willing to respond, on a voluntary basis, when Ticino Soccorso 144 sends a geographically sensitive alert of an SCA patient. Volunteers are trained in CPR and defibrillation (BLS-AED) as conditions of joining the FR network.

Assistance begins with a call to the Central Alert and Coordination Ticino Soccorso 144, which uses the MPDS and achieved medical Accredited Center of Excellence in April 2015. EMDs gather essential information to identify the health issue and activate response. In situations of SCA, Ticino Soccorso 144 activates the FR network by pushing a button on the phone; however, the activation won't be relayed to volunteers if questioning indicates potential safety or health hazards or situations that are intensely emotional (such as pediatric patients or violent deaths).

Only FRs in a specific range of the needed intervention receive detailed patient and location information at the time of the alarm.
THE LAND DOWN UNDER
Setting the pace across nearly 400,000 square miles

Audrey Fraizer

South Australia’s arid and semi-arid rangelands and low mountain ranges create a haven for outdoor adventure. Situated in the south-central part of the country, it is the fourth largest of Australia’s six states and two territories.

The Mediterranean climate in the southern part of the state makes for long, hot summers and mild winters that are ideal for year-round fishing, boating, and surfing along South Australia’s 2,361-mile (3,800-kilometer) coastline. The Flinders Ranges, Cleland Wildlife Park where much of the wildlife is free roaming, self-drive Aboriginal Dreaming Trail with stops at sites of ancient cave wall paintings, and the Arkaroola Wilderness Sanctuary are among the sites in the arid interior.

Because of the geographic size and unique terrain of South Australia, it’s clear that South Australian Ambulance Service (SAAS) must and does go the distance and beyond in providing emergency medical services (EMS) using several modes of transport in urban, remote, and regional areas of the country.

“We are South Australia’s sole provider,” said Nichole Bastian, Service Development Manager, Operations & Systems, SAAS. “It’s both a tremendous responsibility and opportunity.”

Volunteer and operational service

More than 1,500 volunteer ambulance officers provide services in the smaller regional parts of the state, while another 1,100 operational staff direct services in the metropolitan and larger regional areas; according to the 2013–14 SAAS annual report, the SAAS Emergency Operations Center (EOC) received about 470,000 calls, sending ambulance response to more than half (265,000). Emergency (lights-and-siren) incidents were reduced by 10.3 percent, (115,786 incidents in 2014 compared to 129,142 in 2013), which was attributed to the increase in the number of Priority 3 cases as a result of the Medical Priority Dispatch System™ (MPDS®) reallocation of some Priority 2 cases to Priority 3 level where the P3 response was deemed appropriate. EOC staff handles and organizes all transport requests received by SAAS, whether received by telephone, fax, or electronic means, including emergency, urgent, and routine journeys at its centralized location in Adelaide—the state’s largest city. Their response area covers 17 million people in a land area of 379,725 square miles (983,482 square kilometers).

In addition, the EOC staff coordinates the response of ambulance resources across the state, manages collaborative rescue operations, and coordinates SAAS MedSTAR, including clinical staff members providing assessment and support to health professionals across South Austra-
Why accreditation?

There was no doubt SAAS would achieve an Accredited Center of Excellence (ACE) despite anything that might present an obstacle, such as potential support issues considering the significant time difference between the operations center in Adelaide and the headquarters of the International Academies of Emergency Dispatch (IAED) in Salt Lake City.

That was counter-balanced by the Web and the SAAS staff’s hands-on drive. “Our staff is extremely passionate about the service we provide,” Bastian said. “We were happy to continue to engage in the ongoing requirements to make sure we achieved accreditation.”

And, of course, the same goes for the IAED.

“They were a joy to work with,” said IAED Associate Director Carlynn Page. “They were very accommodating and very hospitable.”

Bastian said they were motivated.

For starters, ACE reflects their effort and hard work. The EOC measures its achievements against the MPDS, and SAAS continues to achieve a high level of compliance with the MPDS standards. In 2014, SAAS averaged 99.1 percent compliance.3

As Bastian said, ACE recognizes the staff’s proficiency, acknowledges their important and integral role in delivering emergency medical services, and elevates their stature in the EMS community worldwide.

“ACE sets us apart from other organizations,” Bastian said.

The accreditation also represents an achievement that meshes with the SA Health and SA Ambulance Service objective of protecting and improving the health of all South Australians and paves their way into the future.

“It’s the means by which we deliver our services,” she said. “We must invest the effort and resources to make our workforce successful, and ACE is a significant step toward our organizational goals.”

To save lives, reduce suffering, and enhance quality of life through the provision of accessible and responsive quality patient care and transport.

The process

To drive the process, Bastian established clear time frames to reach the objectives and gather the appropriate data.

Foremost to any success, she said, is keeping staff in the loop on a regular basis and providing recognition, which includes everything from acknowledging high compliance to simply saying “hi” to staff in the hallway. The ongoing conversation between management and staff saves surprises (nobody wants to be blindsided at the annual performance review) and increases job satisfaction from involving staff in the center’s initiatives. It also makes the road a lot smoother when staff is sold on the ACE concept as a reflection of their exceptional work.

As mentioned, time zone differences complicated the ACE online submission process, but they got through it “with the excellent support from the [Academy’s] Web support team,” Bastian said.

“It is important not to lose the focus of what we’re trying to achieve,” Bastian said. “This is not just a pretty certificate to hang but recognition that the service you are providing to the community when they are most vulnerable is gold standard and recognized internationally.”

Unique qualities

The MPDS reflects possible encounters with wildlife unique to Australia and New Zealand. On Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites), the ANZ version has additional Key Questions regarding jellyfish—“(Jellyfish) Is s/he out of the water?” and “What part of the body was stung?”—and separate Determinant Codes for Funnel-web spider (FWS) bite, MAJOR jellyfish sting, and Minor jellyfish sting. Protocol 2 also has DLS Links for “Snakebite/FWS Bite,” “Stingray/Stonefish,” and “Box Jellyfish Sting,” and corresponding definitions, Rules, and Axioms for these different dangers.

Also, while most people live in urban settings, the significant number of people in remote regions poses a particular EMS challenge heightened by increasing cellphone use. Tourists lost in the outback or even native Australians may find themselves unable to identify where they are when calling 0-0-0 to report police, fire, or medical emergencies. To remedy the situation, in December 2013, South Australia launched the Emergency+ smartphone app, designed by Australian emergency services, that allows users to read out their latitude and longitude GPS coordinates.

The address locator is one of many improvements coinciding with the SAAS’ five-year strategic plan, “Vision 2020,” anticipated for release this year.

What does Bastian see for the future: A continual improvement through the organization’s commitment to deliver an effective and innovative ambulance service.

Sources


2 See note 1.

3 See note 1.
In the Medical Priority Dispatch System™, perhaps no other protocol appears more straightforward yet causes more confusion than Protocol 26: Sick Person (Specific Diagnosis). There’s more to Protocol 26 than meets the eye, and understanding its intent and structure is key to using it correctly.

It’s worth a moment to review the proper use of this protocol, i.e., when should this protocol be selected? As defined in the Additional Information section, a Sick Person is described as “A patient with a non-categorizable Chief Complaint who does not have an identifiable priority symptom.” The first half of that definition is easy; it makes Protocol 26 a medical “catchall” when nothing else fits. In the second half of the definition, Priority Symptoms refer to the presence of Abnormal breathing, Chest pain (any), Decreased level of consciousness, and SERIOUS hemorrhage.

If the Chief Complaint (as determined in Case Entry) is a breathing patient who’s unconscious, has fainted, nearly fainted, or is not fully responsive, Protocol 31: Unconscious/Fainting (Near) is most appropriate—unless the caller’s information points to a possible cause available as a Chief Complaint Protocol such as a Seizure, Stroke, or Diabetic Problem. That’s why it’s critically important to find out exactly what happened, not merely “What’s going on.” But not every complaint is that specific. A good example is the caller who tells you that her elderly mother hasn’t been eating and she might be dehydrated. When you attempt to clarify what prompted the call to 9-1-1, the caller says, “Because she’s not doing well the last day or so, and I think she needs to be seen at the hospital.” Having made two attempts at this question, you select Protocol 26 and move on. For calls like this, Protocol 26 shows its real value, because the first four Key Questions act like a safety net: They’re intended to catch any Priority Symptoms that weren’t reported up front. They also allow the calltaker to code the call to reflect those symptoms when they’re not the Chief Complaint.

While three of the four Key Questions regarding Priority Symptoms result in shunts to more specific protocols, the “breathing normally” question does not, but rather it results in a CHARLIE-level code on Protocol 26. This is because data has revealed that the acuity of patients tends to be less when this symptom is “discovered” rather than presented as part of the Chief Complaint. The separation of this code on Protocol 26 allows for appropriate local response assignment that may be differentiated from the codes on Protocol 6: Breathing Problems.

Thinking of the first four Key Questions as a safety net also helps explain the list of descriptors within the definition of ALTERED LEVEL OF CON-
SCIOUSNESS (ALOC) on Protocol 26. There are no less than 17, all of which are answer choices to Key Question 1 in ProQA®. While you wouldn’t choose Protocol 26 when a decreased level of consciousness is reported in Case Entry, if you end up on this protocol because of a non-specific complaint, the above list of descriptors allows you to code a patient identified in Key Questions, or elsewhere, as less than fully alert. But why all the descriptors? Why not just consider any of them a “no” answer?

Brett Patterson, Chair of the Medical Council of Standards for the International Academies of Emergency Dispatch, explains: The intent of this protocol addition is to stop patients from falling through the cracks when a caller answers “yes” to Key Question 1 but actually describes the patient using a conflicting term. Through extensive call review, in an attempt to evaluate the accuracy of patients coded in the ALPHA level, we were hearing EMDs essentially talk the caller out of saying ‘no’ when asked about alertness in Key Question 1. This was mainly an issue in centers where EMDs seemed pressured to stop over- triage and, with only ‘yes’ and ‘no’ answer choices available at the time, this question seemed a bit of a culprit. What we noticed was a disturbing trend on the part of EMDs when the caller was ambiguous or hesitant in their response to the initial, first-line question. EMDs would often hurriedly reply to the hesitant caller with something like ‘Well, is s/he responding appropriately?’ in a tone bordering on impatience in a rather obvious attempt to get the caller to say something like ‘Well, I guess so.’ What we decided to do was create a safety net to capture those patients who were technically reported to be ‘alert’ but the caller also used a term that suggested otherwise. Incidentally, the list of ALOC descriptors was obtained through our call review. In other words, these terms were actually being used to describe patients who were reported to be alert at Key Question 1.”

That’s a key point that helps to explain the difference between a yes and no answer to this important question. A straightforward “no” will code out at the DELTA level (Not alert), whereas a “yes” answer that is obtained with the addition of one of the ALOC descriptors will code at the CHARLIE level. However, it’s the “yes” or “no” answer, not the descriptor alone that should “drive” the Determinant Code. Patterson adds, “If the caller says ‘no,’ that’s ‘Not alert’—period. If the caller says ‘yes’ but describes the patient using one of the listed descriptors, use that descriptor to code the call as ‘ALTERED LEVEL OF CONSCIOUSNESS.’”

Unfortunately, callers don’t always give a yes or no answer. It’s not uncommon to ask “Is she completely alert?” only to have the caller say something like “Well, she’s kind of lethargic.” As Patterson explains, “That’s the perfect time to use the clarifier. And if you don’t get a ‘yes’ answer, it’s ‘no’ by default. That way you’re being risk averse.”

As always, proper coding depends on both the accuracy of the information provided by the caller and how the EMD interprets that information. The caller’s “diagnosis” may have been off the mark. The Academy continues to study this very diversified group of patients in an effort to safely improve the triage methods found in Protocol 26. In the meantime, when used compliantly with sound judgment and good intent, this protocol will continue to provide a safety net as we assess the patients we can’t see.
Brett:

I have several questions related to the 33 card (Transfer/Interfacility/Palliative Care).

• What type of facilities would you consider medical?
• Does it require a certain level of staffing or equipment such as a crash cart?
• How do you classify an assisted living center with certified nurse assistants?
• What about an independent living facility with a nurses’ office?

I also have a question about private ambulance companies.
• Is it your interpretation that a private ambulance company should be EMD certified? The company in question does mostly nursing home to direct appointment transfers but does also receive direct admits and some urgent/emergent calls for service requiring the ambulance to respond lights-and-siren.

Thank you,
Brenda Farlow
EMD Program Director
Loyola University Medical Center
Maywood, Illinois, USA

Hi Brenda:

Thank you for your questions about interfacility transports and calls from private ambulance companies. I will do my best to address them, and please don’t hesitate to call me directly if my response is incomplete.

Protocol 33 was designed to make the EMD’s interrogation of medical professionals more appropriate to the needs and knowledge of these callers and eliminate some of the frustration that is sometimes evident when the standard protocol is used for these types of calls. The protocol was not designed for any specific type of facility, but rather a type of caller. In fact, this protocol is often used for home health patients where an on-scene nurse is requesting transport for further evaluation, treatment, or relocation. However, some agencies restrict the use of this protocol to specific types of facilities by internal policy from local medical control, which is perfectly appropriate.

In the first generation of this protocol, which was Protocol 33, no specific definition of “nurse” or “doctor” was included, and this prompted agencies to define these terms by local policy. Another concern involved the fact that this single protocol pathway was being used to process two distinct requests: transport for evaluation and transport for scheduled treatment or simple relocation. These issues, and several others, prompted the creation of a second-generation interfacility protocol, Protocol 37: Interfacility Evaluation/Transfer (Medical Priority Dispatch System™ (MPDS®) v12.1).

Protocol 37 is available in ProQA® only. It includes a Medical Control authorization section to define and authorize the
Encourage your EMDs to err on the side of patient care and get hands-on-chest as fast as possible; don't use the Agonal Breathing Tool when the caller is UNCERTAIN about breathing.

Brett A. Patterson
Academics & Standards Associate
Medical Council of Standards Chair

Brett:
I'm hoping you can help us out with a question. We were going over scenarios, and our Q's have different opinions about the correct path. Here's the scenario: Caller reports that grandma just fell, and she is not breathing. Here are the paths: Do you work this under Protocol 9: Cardiac or Respiratory Arrest/Death or Protocol 17: Falls? On one hand, Rule 2 in Case Entry states, "If the complaint description involves TRAUMA, choose the Chief Complaint Protocol that best addresses the mechanism of injury." According to that Rule, the dispatcher should go to Protocol 17 and ask the three Key Questions, which would lead to a DELTA-2 response. This would be no different than a traffic accident or any other trauma case.

However, the caller volunteered, "not breathing." Per Case Entry instructions for ineffective breathing, this statement, when volunteered, directs the EMD to use an ECHO-level determinant and, in this case, 9-ECHO. Rule 1 in Protocol 17 states, "Always consider that the patient's fall may be the result of a medical problem (fainting, heart arrhythmia, stroke, etc.)."

The discussion centered on this: A fall is a trauma, but the EMD can't rule out a cardiac arrest as the cause of the fall. Which protocol is correct?

Thanks for your help.
Tim Hawkinson
Communications Supervisor
McPherson County Communications
McPherson, Kansas, USA

Tim:
What came first, the chicken or the egg? We know that there is a very high percentage of cardiac arrest cases in the 17-D-2 & 3 codes. This is because the caller sees the fall and doesn't initially realize the cause—cardiac arrest. The problem here really isn't trauma; it's cardiac arrest, and the fastest way to help the patient is to follow the cardiac arrest pathway. The exception to this scenario would be a long fall where it is clear that the cause of the arrest is the fall, and not the other way around.

In Medical Priority Dispatch System™ (MPDS®) Version 13.0, we are introducing a new “Fast Track” from Case Entry Question 3 ("Okay, tell me exactly what happened.") that takes you directly to Pre-Arrival Instructions (PAIs) for the obvious medical arrest. This is in an effort to get hands-on-chest as quickly as possible, which we now know has a critical role in survival from out-of-hospital cardiac arrest.

Please encourage your EMDs to err on the side of patient care and get hands-on-chest as fast as possible, and don't use the Agonal Breathing Tool when the caller is UNCERTAIN (now a defined term) about breathing. Use it only when the caller tells you the patient is breathing but YOU are unsure, i.e., ground level fall and unresponsive, caller says "yes" or "I think so" when asked about breathing. Tell your EMDs it's OK to be wrong [about getting hands-on-chest so quickly]; the patient will object to the compressions and you start over. No problem.

And start measuring how long it is taking to recognize cardiac arrest, and then to get to hands-on-chest. The new v13.0 software will measure this and provide real-time feedback after each case. The ED-Qs™ need to lead the charge on this one. If it looks like a duck, smells like a duck, and tastes like a duck, get hands-on-chest! Don't worry if it turns out to be a chicken!

Brett
Since their creation 36 years ago, the Priority Dispatch System™ (PDS™) protocols have revolutionized the way dispatchers do their jobs. With a standardized set of step-by-step instructions, dispatchers can effectively assess emergencies, guide callers through lifesaving techniques, and send the proper help to respond to dire situations.

From small beginnings, the protocols impact an enormous amount of people every day.

Available in 21 languages/dialects, the PDS has seen great success with its use spreading to 45 countries. With this growth, the International Academies of Emergency Dispatch® (IAED™) recognized the importance of keeping the protocols consistent, regardless of language. The Academy also realized, however, that facets of the protocols needed to be adjusted to match the culture of various countries, regions, and languages. In doing this, the Academy needed assurance that these cultural variations were absolutely accurate and necessary.

Thus, the IAED Cultural Committees were born.

How it all began

The genesis of the Cultural Committees can be traced to 1991 when Dr. Jeff Clawson enlisted the help of Registered Nurse Marie Leroux, of Montreal, Canada, to translate the protocols into French. Leroux was part of what would become the first Cultural Committee, a group that is composed of EMDs, doctors, paramedics, and EMTs.

Today, 12 Cultural Committees exist to address the need to take into account cultural differences between places across the world when updating medical, fire, or police protocols.

For example, did you know that Australia has more venomous snakes than any other continent on Earth—home to seven of the world’s 10 most dangerous snakes? Among these are the Eastern brown snake, the Western brown snake, the mainland tiger snake, and the inland taipan. You won’t find these fearsome reptiles anywhere else.

Australians must also contend with other potentially dangerous animals such as jellyfish, stonefish, the highly venomous blue-ringed octopus, and a host of poisonous spiders.
Other issues are also considered when updating or creating protocols in additional languages and in other parts of the world. For example, on Medical Protocol 22: Inaccessible Incident/Other Entrapments (Non-Vehicle) in the North American English version, and in other language versions, Mudslide/Avalanche is a Determinant Descriptor. However, this is omitted in some language versions, such as the Malaysian Medical Protocol, because this country has no such threat.

On the European continent, it’s noteworthy to point out that due to the nature of its buildings, Germany has additional protocols on how to help people in structural fires get to safety.

“Different instructions and codes are written to deal with the different problems on different continents,” said Irena Weight, Priority Dispatch Corp.™ (PDC™) Director of Translations, Standards & Logic Design.

Weight said the committees play an integral role in the development and refining of the protocols. And the fact that the committees ensure the protocols are appropriate for the culture and the people who use and benefit from them, is greatly appreciated.

“Without the Cultural Committees, it would look like we were pushing an ‘American Thing’ on different cultures,” she said.

Weight further said that each cultural committee is created based on a need for protocol review to fit a specified geographical region and language/dialect. There is not a committee automatically created for every language/dialect in each discipline in which the protocols are translated, though this does happen in most cases. In some instances, a need for a committee arises after the translated protocol has been in use for many years.

Currently, Cultural Committees exist for the following regions/languages or dialects:

- Australia/New Zealand (English)
- United Kingdom/Ireland (English)
- Germany/Austria/Switzerland (German)
- Italy/Switzerland (Italian)
- Canada/Switzerland/France (French)
- Spain/South and Central America/U.S. (Spanish)
- Brazil/Portugal (Portuguese)
- Netherlands/Belgium (Dutch)
- China (Chinese)
- Malaysia/Indonesia (Malay)
- Middle East (Arabic)
- Lithuania (Lithuanian)

Each committee is composed of experts in the field and culture they are representing. The Academy approves all Cultural Committee members.

“Committee members are recommended,” Weight said. “We find them as experts working in dispatch centers using our protocols. They do not serve for a term or any set amount of time. The number of committee members varies and can grow if needed.”

How it works

Adapting the protocols to specific cultures and countries begins with the core protocols—those written in North American English (NAE).

Anytime the Fire Priority Dispatch System™ (FPDS™), the Medical Priority Dispatch System™ (MPDS™), or the Police Priority Dispatch System™ (PPDS™) is implemented into a new language or region, the Cultural Committee convenes to determine how the updates will affect that respective culture. Also, when the Academy releases a new NAE version, the Cultural Committees get together to confirm all changes and updates fit the language and culture. With the ultimate approval of the IAED Council of Standards, the Cultural Committees recommend culturally

Differences in cultural practices and norms lead to variations in medical, fire, and police protocols from country to country. Cultural Committees carefully review and consider these changes.
appropirate changes to their respective medical, fire, and police protocols.

Depending on the nature, size, and scope of the updates, the Cultural Committee will either meet face to face, through Skype, or via email. No matter the form of communication, the Council of Standards is always involved. Ordinarily, it takes three to six months to release a language version after the Cultural Committee conducts its review.

“An expert from the Academy will go and lead the meeting,” Weight said. “Before the meeting, the changes get translated. Translators often attend the meetings as well.”

Culturally adapting the protocols, however, is not always a simple process.

Each Cultural Committee has a vested interest in ensuring the protocols coincide with an area’s customs, norms, and practices, as well as anything distinctive to the area’s physical environment. Naturally, the committee overseeing the protocols in Australia wants those protocols to include more detailed instructions about snake bite response and contact with jellyfish than would be included in the core North American English protocols where these animals are far less common, if not absent altogether. Other countries that use the IAED protocols don’t necessarily face the same challenges and therefore don’t need to address them in the protocols.

At the same time, the Academy must maintain the integrity of the protocols and make sure each instruction is accurate. That is why final authorization rests with the Council of Standards.

“Sometimes other cultures won’t like the way something is written,” Weight said. “So the committee and the Academy have to discuss back and forth until they have the right information. The way something is written might not always sound elegant, but it’s written that way for a reason.”

After the committee members feel comfortable that the core protocol changes fit their country or area, and after the Council of Standards approves the
Because of different types of trucks, the way in which crews fight fires in Germany is different than in the U.S. The protocol addresses these variations.

changes, the protocols are published and made available to dispatchers.

All international dispatchers use ProQA®, so after the changes are approved and made, dispatchers have the updated software at their disposal. But Weight said making country-specific adaptations to the software is not always cut and dried. Sometimes what looks good in the cardsets doesn’t flow logically in the software, so further tweaks are made.

“The protocol software can do logic rules, so sometimes what might seem like a good idea doesn’t fit in ProQA logic,” she said.

The protocols must not only be worded correctly for the dispatcher from a cultural standpoint, but the language must address the needs of the callers.

Leroux said the committees basically have a twofold mission.

“We give verification that the translation will be functional,” she said. “First, we make sure the protocols address the user—the EMD—and second, that they address the general public—everything that will be done with the caller. Both must be covered. We provide the highest quality of interaction with instructions and Key Questions. We make sure we address the caller and that everything will be clear.”

Leroux, who received an Emeritus Award for lifetime service to the Academy, began her career working on a health information telephone line. Today, she and about 10 other members work diligently on the French Cultural Committee to guarantee the protocols provide dispatchers, and by extension the public, with the information they need to respond effectively to emergencies.

“It’s very hard work, very challenging, and fun,” Leroux said. “When you go so much in-depth with a tool that is a standard, you become part of it. You cannot leave it; it cannot leave you.”

To begin with, Leroux said her Cultural Committee is focused on seeing whether the wording after translation is correct.

“One of the committee’s chief focuses is verifying that protocols are localized and include the proper language that is unique to the area. She said the French-speaking people of Quebec, Canada, use various expressions that differ even from the French that is spoken in France. Dispatchers must be aware of these locally used sayings and how to respond to them in their conversations with callers.

The French Cultural Committee carefully observes that the protocol translations use these expressions properly. Often, the North American English core version cannot be translated word for word because the expressions simply won’t make sense in other locations.

Leroux said the French-speaking protocols must also include commonly used and understood expressions by the public that might not necessarily be found in the core North American English protocols. For example, in MPDS Protocol 9: Cardiac or Respiratory Arrest/Death, there are instructions to the dispatcher on how to code certain volunteered statements from the caller regarding ineffective breathing. One such statement French-language dispatchers should look for is “Court après son souffle,” which directly translated into English means “Running after my breath.” Such an expression is nonsensical to English speakers, but it makes perfect sense to a French Canadian. The English equivalent in the protocol is “Barely breathing,” which, directly translated, would be “Respirant à peine,” but the French protocol uses the expression familiar to the local population.

There are even differences in language between the North American English, UK English, and Australia/New Zealand English protocols. For example, the Australian Cultural Committee members helped change the UK English that was in the Australian protocols to include words and phrases that were more common among Australians. These included changing Alert, Seizures, Lorry, and Articulated Lorry
to the more Australian standard Completely Awake, Convulsions/Convulsing, Truck, and Semitrailer. Also, patients in the U.K. say they are “feeling poorly,” while in Australia, they say “feeling crook.” These changes are all reflected in the protocols.

Some protocol variances come because of differences to manmade structures. A prime example is in Germany, where an additional fire protocol has been created to address the uniqueness of the country’s buildings.

Many houses and buildings in Germany have wooden staircases, creating a significant concern that fires could spread even more rapidly. Additionally, a large percentage of the homes and buildings have wooden doors that usually prevent smoke and fire from getting inside the home. With these factors in mind, the German Fire Protocol has Protocol E, whereas the NAE counterpart does not. Protocol E directs dispatchers to keep callers inside the building when a fire is outside.

“We don’t want people going out of their apartment before they are sure the stairway is free of smoke and heat,” said Andre Baumann, Deputy Chief at Berlin Fire Department. “Therefore, people better stay where they are until we get them out. If the fire is in their apartment, we of course want them to leave and close the door behind them to make sure the fire can’t spread.”

Both Germany and neighboring Austria have substantially different equipment to fight fires with and thus employ different tactics to battle them. Recognizing this, the Cultural Committee has made the necessary adjustments to the German Fire Protocol by creating additional suffixes to address the source of the fire, not only the building.

“In the German and Austrian fire departments, there are no trucks like in the U.S.,” Baumann said. “The truck really is a turntable ladder, and that’s it. Firefighting and ventilation are done by the engine companies. So, some fire departments decide to skip the ladder for small buildings or add ladders for roof fires.”

In some cases, the Cultural Committees need to take into account differences in the actual dispatch centers. A prime example is in Italy, where most centers have the presence of a doctor to assist dispatchers and callers. After the EMD handles the call and sends the resources, the doctor will contact the caller if necessary to collect more information. The doctor may even conduct a conference call with poison control if the situation requires.

As the Priority Dispatch System protocols continue to be translated into more languages and are adopted in different countries, Cultural Committees will be formed to address the needs of the local population. Working in tandem with the Academy, the Cultural Committees are devoted to providing the tools dispatch centers need to most effectively communicate with callers and help resolve their life-threatening situations.

“The Cultural Committees are good groups of people,” Leroux said. “They’re very good at looking to see if they’ve covered every aspect of an issue.”

**Source**


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Even the nature of emergency equipment and vehicles can differ from country to country.
**Fit for the Call**

Comm. centers taking steps to increase dispatcher health

Josh McFadden

STRESSFUL SITUATIONS, HIGH-PRESSURE PHONE CALLS, long and grueling shifts: Welcome to the life of a 9-1-1 dispatcher.

Nobody ever said the job of a dispatcher is easy. Truly, to be successful in this critically important role requires cool nerves, crisis management, leadership, and the ability to perform under the most adverse conditions. Certainly, there are good days and bad days—as with any job—but the fact remains that this profession can take a toll on its employees.

**Dispatchers are fighting for their health**

Even the most skillful and experienced dispatchers can struggle with the never-ending volume of emergency calls, some of which involve traumatic events such as homicides, suicides, kidnappings, or far-reaching and widespread disasters. Once one call is over, it’s on to the next. One after another, they come.

In March 2012, Northern Illinois University psychology professor Michelle Lilly co-authored a study in the Journal of Traumatic Stress that explored the potential health hazards dispatchers face in their everyday work. The study, which involved 171 dispatchers from 24 states, showed that all respondents had “one or two symptoms” of post-traumatic stress disorder (PTSD) and that 3.5 percent of those sampled “had symptoms serious enough to qualify for a full PTSD diagnosis.”

In 2012, retired police officer and emergency dispatcher Paul D. Bagley wrote for 9-1-1 Magazine on the subject of dispatcher health. He said in his decades of experience in the industry, the three most common medical complaints he heard from dispatchers were diabetes, depression, and heart disease. Bagley said in his observations, the “vast majority” of emergency dispatchers at one time suffer from one of these conditions or from a combination of them.

Of course, not everyone who deals with stress at work or at home manifests these conditions. Many, dispatchers included, who encounter stressful situations learn how to manage stress and learn to implement healthy habits.
fit for the call | FEATURE •
in their lives to ward off these potentially harmful side effects.

Comm. center managers around the world recognizing the damage stress and trauma can do to their dispatchers have taken measures to ensure their workforce is properly equipped to ward off the effects of difficult 9-1-1 calls. One of the answers may be simpler than one would think: get healthy.

**Walk while you work**

Two comm. centers in California found a unique way to achieve better health on the job for their dispatchers. The Santa Clara Police Department and the Sunnyvale Department of Public Safety installed treadmills in dispatchers’ workstations, allowing these hard-working men and women to burn off calories and stress while they take calls.

“We saw on social media that Johnson County in Kansas had put treadmills in their control center in January 2014,” said Michael Spath, Communications Manager at Sunnyvale DPS. “It moved along slowly, but we got things going in May (2014). It’s a new type of multitasking.”

Sunnyvale DPS has one treadmill at its center. Here, dispatchers are allowed to walk on the machine as they take calls and go through the protocols. There is also an exercise bike that can be moved and taken to any workstation. Dispatchers can generally take all the time they’d like on the machines; they’re not required to use them.

“The rules are be safe and play nice and share,” Spath said.

In October 2014, nearby Santa Clara followed suit and installed a treadmill at one of its workstations.

“I saw Mike’s center and liked it,” said Judi Dziuba, Communication Operations Manager, Santa Clara PD. “Everyone is behind it. Santa Clara is into wellness and health of employees. Dispatchers are multitaskers by nature; it was seamless for them.”

This past December, the two neighboring centers had a friendly mileage competition, with Santa Clara emerging
as the winner in the most miles logged by employees. Together, Santa Clara and Sunnyvale dispatchers walked 900 miles. One dispatcher walked a full marathon—26.2 miles—during a single shift. It took her seven hours.

“I consider us both winners,” Dziuba said. “It has built a relationship between the two centers.”

Both Spath and Dziuba give glowing reviews of the innovative workstations, saying that both employee health and productivity have improved.

“Research shows that people in sedentary jobs run a higher risk of sickness and disease,” Dziuba said. “If I can give them the option to walk 15 to 20 minutes, we’re all happy. We saw attitude changes. Dispatchers are able to de-stress and still be more productive. They are happy to come to work. Using the treadmill builds team camaraderie.”

Spath echoed the positive findings.

“There are a lot more positive, constructive attitudes,” Spath said. “Dispatchers go through monotony, punctuated by ‘hot calls.’ Having something to do breaks the monotony.”

As a Communication Center Manager (CCM) course graduate, Spath has learned that people matter the most in a comm. center. Anytime a manager can introduce a way to improve employee productivity and health, the dividends can be enormous.

“Using the treadmill workstations was a no-brainer,” he said. “It set us up for success.”

Dziuba echoes these sentiments and recognizes the value of her team.

“People are our No. 1 asset,” she said. “We need to invest in our people before ourselves.”

The running man

Not far from Sunnyvale and Santa Clara is the San Jose Fire Department where Senior Dispatcher Rahul Maharaj is taking people from the couch to the finish line. Whether a dispatcher wants to run a 31-mile (5K) race or a 26.2-mile marathon, or even participate in a triathlon or Ironman event, Maharaj is happy to get them there.

With 13 years of experience in the 9-1-1 field, Maharaj understands well the nature of the job: long hours of taking emotion-filled calls, fatigue, and burnout. Only seven years ago, he weighed 300 pounds, was always tired, and could barely walk up a flight of stairs.

“I started getting active,” he said. “I started with a mile here and there. By 2011, I did my first half-marathon and was hooked.”

Last year, Maharaj and his friend and fellow dispatcher Jamey Slaton participated in an Ironman competition in Arizona. The ultimate test of fitness and endurance consisted of a 2.4-mile swim, a 112-mile bike ride, and a 26.2-mile run. Maharaj completed the course in 16 hours.

But his greatest joys are seeing previously inactive dispatchers make exercise an irreplaceable part of their lives.
machines, and workstations can be equipped with exercise balls instead of chairs. The center’s rooftop has a garden where employees can grow fresh fruits and vegetables. All of this has led to a change in attitude, lifestyle, and the overall feeling of wellness for those involved in the staff’s training program.

What’s in it for the team? Not all natural-born athletes, staff members love accomplishing things they never dreamed possible.

“I do this to watch people go from something they hadn’t done before to doing amazing things,” Maharaj said. “The feeling you get crossing the finish line after putting in years of hard work is indescribable.”

Maharaj acknowledged that not everyone is going to catch the running bug. For those looking for alternative ways to exercise, he encourages them to hit the gym and lift weights. Either way, this dedicated leader is helping to change lives and improve his workforce.

Healthy options

It is true that dispatchers have a largely sedentary job. It is not uncommon to work a 12-hour shift where one is mostly confined to a desk while on the phone and computer. Over time, the lack of physical activity builds up, and soon, a person can easily become tired and lethargic.

A lack of regular physical activity can also lead to a tendency to eat poorly. Add to that a dispatcher’s busy, stressful job and many dispatchers find themselves enticed by fast food and unhealthy snacks to munch on throughout the day. For these reasons, one agency in Canada has given dispatchers healthier options when choosing things to eat.

The Winnipeg Fire Paramedic Service (WFPS) in Winnipeg, Manitoba, has an on-site convenience store that sells granola bars, varieties of nuts and fruit bars, and alternatives to the traditional vending machine candy bars and potato chips.

The WFPS also shares a workout area and gym with the Winnipeg Police Service Communications Center. Staff members from both agencies are free to use the facility during work breaks or on days off. Staff members are known to wage friendly competitions such as marathons.

“Affording employees with the opportunity to de-stress and exercise has proven beneficial for everyone,” said Tammy Jewell, WFPS QI/Training Specialist. “Employees are less tired from sitting for 12 hours and use the facilities to exercise with co-workers, which fosters a more cohesive working relationship.”

Jewell said the center uses ergonomic workstations with height adjustable desks to accommodate users’ preferences. Staff members can use an exercise ball and a kneeling chair. They also have access to a city-owned facility complete with a weight room, swimming pool, and walking/running track. Staff is commonly seen walking and biking along the city park’s path during breaks.

At Gallatin County 911 in Bozeman, Mont., dispatchers have similar opportunities to stay active at work. As Trainer/Supervisor John Hinkle said, the center itself does not have a gym, though it is adja-

Staff at Pilipinas911 in Manila, Philippines, participate in a military-style regimen to stay fit.
fit for the call | FEATURE •

SAAS, with the Government of South Australia, has developed a Peer Support program for its staff members. In this program, all EMDs receive personal contact after particularly emotional calls to ensure they are doing all right. EMDs and their families also have access to clinical psychologists for up to four free visits annually.

“The program has been embraced by staff, as it extends to life outside of work, which can have a huge impact on work productivity,” said Liz Charles, Program Development Manager, SAAS. “This initiative is also included during training for EMD staff to help them build emotional resilience and better prepare them for the role.”

SAAS also offers EMDs SAASFit, a program aimed at general physical health and well-being and used to encourage an active lifestyle. SAASFit provides steppers, stationary bikes, and exercise balls for EMDs to use in the center. The program covers fees to enter physical activities such as races and fun runs. Through the program, staff members can work one on one with coaches to provide structured exercise plans and follow-up.

“One of the drivers of this program is to reduce injury and potential absenteeism associated with injury,” Charles said.

In the Philippines, Al Capilit is using his military background to change the bodies and minds of his staff. The U.S. Army Reserve captain and former combat medic, who served two tours in Afghanistan, is the Operations Chief at Pilipinas911 in Manila. Upon starting his job, Capilit noticed many staff members weren’t in the best of health. He quickly began marshaling his troops into top form.

“I noticed how out of shape our medics were,” Capilit said. “This was totally unacceptable to me. You cannot have an out-of-shape medic, especially in the heat of the tropics. What’s the point of being an expert on all things EMS when you can’t get your patient out of physical danger because you’re too winded or in pain from a short hike that you can’t even lift your first aid bag?”

Capilit began running his staff through cardio and CrossFit classes. His regimen includes a test based on modified U.S. Army physical fitness standards. This involves cardio, lifting medium to heavy weights, and answering basic math and logic questions after two minutes of rest.

“Hey, you still have to assess the patient correctly once you get there,” he said. “You can’t tell them to ‘Move over, I need to sit on your couch for a few,’ right?”

Sources
GAME CHANGER
Protocol strengthened the weak link

Jeff Clawson, M.D.

An early but important article in the history of emergency dispatch was hidden in plain sight as a sidebar in the initial concept article “Priority Medical Dispatch—Strengthening the Weak Link” that turned out to be, even today, the most responded to article in the history of JEMS magazine. As far as we know, this was the first public call at addressing the issue of lights-and-siren use and EMVs via the protocolized prioritization within the dispatch center. The use of lights-and-siren was epidemic at this time and often, if not routinely, the end result was ‘sending everything, to everyone, always’! This short but powerful paper addressed some specific clinical and time-based parameters that public safety systems should use to evaluate the myriad calls entrusted to them. The game is not over, as emergency vs. non-emergency response mode issues still plague us to this day.
The Red-Light-and-Siren Response

"Do we need it as much as we use it?"

As never before, EMS response agencies must take a closer look at the number of red-light-and-siren runs that are made to the scene for a number of reasons. First, emergency light-and-siren runs expend a significantly greater amount of fuel. Second, these runs increase wear on emergency vehicles. Third, red-light-and-siren runs are dangerous to the public on the road as well as the EMS personnel responding. And finally, in a sizable number, the use of red-lights-and-siren is unnecessary! Since most EMS personnel prefer an emergency run to the alternative, we find it hard to "slow down" those runs we know really aren’t so urgent. Instead, we abdicate responsibility for assigning response modes to medically untrained dispatchers and fire chiefs. It is certainly time that medical control found its way into the dispatch office.

The private ambulance service that I worked for as an EMT some years ago had a company policy restricting red-light-and-siren runs to cases where the response time actually made a difference in the outcome of the case. When that dictum is applied to most runs, the fact is that in 95 out of 100 runs the time saved by lights-and-siren doesn’t make a bit of difference to the morbidity or mortality of the patient. After discounting all nonemergency transfers, take-homes, etc., the number of red-light-and-siren runs in Salt Lake City’s pre-1974 BLS system was less than 50 percent. Yet today, many systems still respond red-light-and-siren on every run. Think about the needless waste and increased danger that could be prevented if 50 percent of any city’s runs were nonemergency in response mode. Now, think about the last time you responded red-light-and-siren on that “possible appendicitis” (saving one minute and 25 seconds)—only to have the patient, subject to regular Emergency Room routine, undergo surgery more than three hours later. Was that one and a half minute you saved significant? I don’t think so. But this and thousands of similarly needless red-light-and-siren responses occur daily in this country. What can be done about it?

First, if you don’t have a selective, priority-based dispatch system, you need one. The need for emergency response should be a medical decision, made best by emergency physicians and physician advisors to emergency medical systems. The number of vehicles sent as well as the response mode should be carefully evaluated. The following questions should be answered for each type of call to appropriately assign the correct level of response:

1) Will time saved make a difference in the final outcome? (i.e., is the problem a true time-priority case requiring a response of less than five minutes such as):
   a) Cardiac or respiratory arrest
   b) Airway problems
2) How much time leeway do you have?
3) How much time can you save going red-light-and-siren?
4) How much time can be saved sending a closer but larger unit (engine)?
5) When the victim gets to the hospital, will the time you saved be significant compared to the time spent awaiting care (i.e., waiting turn, X-rays, lab tests, etc.)?

These items must be addressed or you are just not functioning at today’s expected level of responsible prehospital care.

Second, all dispatchers, especially ALS system dispatchers, should be trained and certified as emergency medical dispatchers (EMDs). What’s an EMD? The Department of Transportation’s National Highway Traffic Safety Administration will shortly be offering a new program called Emergency Medical Dispatch Priority Training. This 25-hour partially physician-taught course will provide the dispatcher with specific skills and knowledge as it relates to selective medical dispatching, caller-interrogation, and pre-arrival patient intervention.

Certainly, medically trained dispatchers operating from medically approved, selective dispatch protocols will make sure that we use our red-light-and-siren only as much as we, the public, and the patients really need them.—Jeff Clawson, MD

Note: The author realizes that if adequate information is not available, dispatch often has no choice but to maximally respond.
YOU MUST BE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Game Changer,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. The article “Priority Medical Dispatch—Strengthening the Weak Link” was originally published in:
   c. EMS World.
   d. JEMS.

2. The article addressed the:
   a. introduction of CAD systems in the dispatch center.
   b. national training standards for answering 9-1-1 calls.
   c. specific clinical and time-based parameters that public safety systems should use to evaluate the myriad calls entrusted to them.
   d. resurgence of ham operators in emergency dispatch.

3. The article mentions reasons why agencies must take a closer look at red-light-and-siren runs. Which of the following are among those reasons?
   a. Emergency light-and-siren runs expend a significantly greater amount of fuel.
   b. These runs increase wear on emergency vehicles.
   c. These runs are dangerous to the public on the road as well as the EMS personnel responding.
   d. all of the above

4. The time saved by lights-and-siren doesn’t make a bit of difference to the morbidity or mortality of the patient _____ out of 100 runs?
   a. 25
   b. 65
   c. 80
   d. 95

5. The need for emergency response should be a:
   a. medical decision.
   b. gut reaction.
   c. percentage-based calculation (such as every 10 calls).
   d. choice given by the caller.

6. Cardiac arrest, severe trauma, and true obstetrical emergencies are considered time-priority cases requiring a response of less than five minutes.
   a. true
   b. false

7. All dispatchers, especially ALS system dispatchers, should be trained and certified as:
   a. EMTs.
   b. paramedics.
   c. firefighters.
   d. EMDs.

8. Which organization cited in the article was about to offer an EMD Priority Training Course?
   a. American Red Cross
   b. Department of Transportation’s National Highway Traffic Safety Administration
   c. Federal Emergency Management Agency
   d. National Registry of Emergency Medical Technicians

9. The above-mentioned course would provide the dispatcher with skills and knowledge as it relates to:
   a. selective medical dispatching.
   b. caller interrogation.
   c. pre-arrival patient intervention.
   d. all of the above

10. Medically trained dispatchers operating from medically approved, selective dispatch protocols will make sure that red-light-and-siren are used:
    a. in response to every call.
    b. at the direction of EMTs and paramedics.
    c. only as much as the public and the patients really need them.
    d. at the demand of the bystander on scene.

To be considered for CDE credit, this answer sheet must be received no later than 08/31/16. 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 credit. Please retain your CDE letter for future reference.
1 in 5 people are affected by allergies.

Every 3 minutes, a food allergy reaction sends someone to the emergency room—that is more than 200,000 emergency room visits per year.

About 150 Americans, mostly children, die from food-induced anaphylaxis each year.

Anaphylactic reactions to penicillin cause about 400 deaths per year.

Approximately 100 Americans die annually from anaphylaxis induced by stinging insects.

Approximately 220 cases of anaphylaxis and 3 deaths per year are due to latex allergy.

8 foods account for 90 percent of all reactions:
- milk
- eggs
- peanuts
- tree nuts
- shellfish
- fish
- wheat
- soy
BAD REACTION
Anaphylaxis can happen within seconds of exposure

Audrey Fraizer

The IAED™ EMD-Q® Performance Standards state that “the calltaker may not use freelance questions or instructions at any time.” Giving a freelance instruction is considered a moderate deviation. But what happens when a dispatcher gives a freelance instruction that actually enhances the patient’s chance of survival?

“It’s still considered a deviation,” said Adam Johnson, Division Chief, Austin-Travis County EMS, and Regional EMD and EMD-Q Instructor. “You’re talking a very slippery slope here. You can’t have people freelancing instructions.”

A deviation in three calls during 2009 put Johnson to the test. Although the Academy had a different scoring standard at the time, it has never been acceptable for an EMD to provide freelance instructions.

“It was the perfect storm,” Johnson said. “We had three calls in less than a month reporting patients who were having allergic reactions and each had a history of severe allergic reactions. The callers had EpiPens® but were not comfortable in administering the injection.”

An epinephrine auto-injector containing adrenaline can be used by patients or bystanders to counteract a severe allergic reaction. There are several brands available by prescription.

The Key Questions in Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites) do include the question “Does she have any special [see note] injections or other medicines to treat this type of reaction” which, when answered “yes,” continues with the EMD asking if the medication has been used and, if it has not, it is followed by, “Tell her/him to use them now.”

[Editor’s Note: MPDS® v13.0 changes the word “special” to “specific.”]

Two of the Austin-Travis County patients were showing signs of shock and “yes” they did have the medication available. Anaphylactic shock is a severe allergic reaction that presents with life-threatening symptoms such as difficulty breathing or swallowing, caused by a constricted airway, and/or a decrease in the level of consciousness, caused by a drop in blood pressure. The callers, however, did not want to administer the shots; they had never done so before. Epinephrine administration instructions are not part of the Pre-Arrival Instructions (PAIs) in the Medical Priority Dispatch System™ (MPDS) v12.2.

In each instance, the EMDs hesitated but decided on a move contrary to protocol. They provided instructions from their experience as field paramedics for Austin-Travis County EMS.

“These were tough cases,” said Johnson, in relation to performance standards and the proper use of protocol. “Our calltakers did a great job, but what they did was out of the scope of protocol. Our QI unit really struggled over these decisions.
when the calltakers had actually done the right thing for the patient.”

The EMDs understood the performance markdown and, at the same time, they were relieved that the instructions they provided helped the patients. Aside from the real possibility that the caller did not know how to administer a shot, there was also the indecision that can accompany an emergency.

“When someone is in crisis, it’s not unusual to lose your ability to follow instructions,” Johnson said.

Jeff Clawson, M.D., inventor of the MPDS, likes to call this phenomenon “paralysis by analysis.”

There was only one thing to do, Johnson said.

“We went through the Proposal for Change (PFC) process,” he said.

The Austin-Travis County Qs drafted a proposal, distributed it in-house, and incorporated feedback into subsequent drafts. The summer following the “perfect storm,” the PFC was sent to Brett Patterson, Chair, IAED Medical Council of Standards.

A PFC advocates for change, Patterson said.

“It’s not enough to point out what’s wrong or what could be improved in the protocol,” he said. “When it’s possible, we want the people using the protocol to present better alternatives. We’re not only looking for your input regarding problems, but also your ideas about how those problems can be corrected, and the ‘troops on the front line’ are in the best position to provide that feedback.”

The PFC went through the Academy’s formal process for review and was adapted and then adopted for inclusion in MPDS v13.0. Protocol P: Epinephrine (Adrenaline) Auto-Injector Instructions provides instructions for the various brands available and the “what ifs,” such as what to do if the injector kit is expired and what to do if the injector at the scene was not prescribed for this patient.

Johnson was elated about the new PAI for two reasons.

For one, it’s a change that affects people in a very positive way.

“Just think of how many people will be helped by an EMD giving these instructions,” he said. “It’s great to get the whole world on board.”

Secondly, with it came the bragging rights.

“We were part of the change to bring the instructions worldwide,” he said. “That’s a cool feather to put in your hat.”

Allergic reactions

Allergies are not uncommon. According to information from the Food Allergy Research and Education (FARE), shared by Johnson in his NAVIGATOR 2014 presentation Bees! Squeeze & Wheeze: Anaphylaxis, it’s estimated that 15 million Americans have food allergies. Children are more likely to experience food allergies. Approximately 1 in every 13 children in the United States lives with food allergies.

There are lots of triggers. An allergic reaction can be triggered by an allergy to a particular food (e.g., peanuts or shellfish), biting or stinging insects (e.g., bees), medication (e.g., penicillin), latex, or a variety of other allergic triggers.

And not every allergic reaction requires immediate lifesaving intervention.

The allergy begins with exposure and, without immediate medical attention, can result in death within 15–30 minutes.
If there is any doubt about the presence of a severe allergic reaction, the EMD should advise the patient to use the injector based on the symptoms listed: collapse, difficulty breathing, difficulty swallowing, generalized swelling, not alert, pallor, shallow breathing, sweating, and weakness.

The EMD will leave the choice up to the patient/caller; however, the EMD strongly recommends its use.

There’s also the chance that the injector at the scene was not prescribed for this specific patient and, in these instances, the EMD should not “initially advise its use unless there are clear symptoms of a severe allergic reaction or the patient has indicated a severe reaction might be coming on.”

If there is any doubt about the presence of a severe allergic reaction, the EMD should advise the patient to use the injector based on the symptoms listed: collapse, difficulty breathing, difficulty swallowing, generalized swelling, not alert, pallor, shallow breathing, sweating, and weakness.

The EMD will tell the caller to put the used injector back into the package and save it for the paramedics (EMTs).

Symptoms that have been present for over one hour, without increasing severity, are unlikely to suddenly get worse. A worsening condition is a serious sign that may warrant staying on the line to monitor the patient for any changes.

If the patient starts getting worse—difficulty breathing or swallowing or becomes less awake—the EMD would proceed to Panel 1 (Prepare Patient) and go through the steps described.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Bad Reaction,” which starts on page 38. Take this quiz for 1.0 CDE unit.

1. According to the IAED EMD-Q Performance Standards, giving a freelance instruction is considered a:
   a. critical deviation.
   b. major deviation.
   c. moderate deviation.
   d. minor deviation.

2. Anaphylactic shock is a:
   a. severe allergic reaction that presents with life-threatening symptoms.
   b. non-symptomatic reaction to an allergen.
   c. mild reaction that might cause nasal congestion and watery, red eyes.

3. Instructions for epinephrine injection for a severe allergic reaction are part of the PAIs in which version of the Medical Priority Dispatch System?
   a. version 12.0
   b. version 12.2
   c. version 13.0

4. Which PAIs are given for cases of anaphylactic shock?
   a. Protocol P: Epinephrine (Adrenaline) Auto-Injector Instructions
   b. Protocol F: Childbirth–Delivery
   c. Protocol D: Choking (Conscious)-Adult/Child/Infant/Neonate

5. Approximately 1 in every 13 children in the United States lives with:
   a. an allergy related to stinging insects.
   b. an allergy to latex.
   c. food allergies.

6. With each subsequent exposure to an allergen, antibodies trigger the activation of:
   a. neurons.
   b. mast cells.
   c. hives.
   d. red blood cells.

7. What is the only recommended first-line treatment for anaphylaxis:
   a. penicillin.
   b. sertraline.
   c. acetaminophen.
   d. epinephrine.

8. Anaphylactic patients who weigh 33 to 54 pounds (15 to 24 kilograms) should be given the following lower dose of injector:
   a. 0.15 mg.
   b. 0.20 mg.
   c. 0.25 mg.
   d. 0.30 mg.

9. According to Protocol P, studies of expired injectors showed that kits 5 to 7 years past their expiration date still had more than:
   a. 70% of adrenaline (epinephrine).
   b. 80% of adrenaline (epinephrine).
   c. 90% of adrenaline (epinephrine).
   d. 100% of adrenaline (epinephrine).

10. An EMD should always insist that the caller administer the injection; this is not a decision the patient/caller should make.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 08/31/16. 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 credit. Please retain your CDE letter for future reference.
The eight minutes ticking by after 7:40 a.m. on Sunday, April 19, most likely represented the longest chunk of time in the life of 13-year-old Marcus McCoy and his 9-year-old sister Aaliyah. Marcus and Aaliyah were upstairs in their bedrooms when thick smoke in the hallway choked off their escape from the family’s two-story home in Clinton, Md. Marcus dialed 9-1-1. Aaliyah was in the room beside him.

“Tell me exactly what happened,” asks Kristen Ritter, EMD, EFD, EPD, Prince George’s Public Safety Communications, after she verifies their address. “I think my parents are asleep,” Marcus replies, over the background cries of his younger sister. “The house is smoky.”

Ritter keeps Marcus focused and on the line talking, reassuring him, gathering information, and providing Pre-Arrival Instructions (PAIs) from the Fire Priority Dispatch System™ (FPDS®). The firefighters en route are tuned into the constant stream of information from Dispatcher Hunter Dashnaw, EMD, EFD, EPD.

“Stay low to the floor,” Ritter tells Marcus, continuing through the PAIs. Marcus follows Ritter’s instructions, closing the door while telling his sister to remain low to the floor.

Ritter asks where they are in the home. Marcus calmly describes the location of the bedroom—up the stairs, to the right, and the last door on the right. There is a window firefighters can break to rescue them. Outside the room, the phone picks up the sounds of voices.

“Mom, mom,” Marcus calls out. He asks Ritter what to do. If they’re able have them leave, she advises. “Get out, get out,” he tells them. “I’ve called firefighters.”

Ritter repeats the PAIs; the phone picks up his scuffling across the floor to the window but it’s too hot and smoky inside the room.

“You’re doing a great job,” Ritter says to Marcus. “Stay low to the ground.”

Aaliyah is frightened. “We’re going to die,” she cries.

“Aaliyah, please don’t say that,” Marcus responds.

Seconds tick by. “You guys are doing great,” Ritter repeats.


“They’re coming. It’s OK,” Ritter tells Marcus.

At eight minutes, seven seconds sirens are heard. Seconds later, a firefighter announces, “We’re here. We’re here.”

Shattering glass is heard. A second firefighter arriving on scene goes through the front door and up the stairs. The two firefighters reach the brother and sister simultaneously. One of the firefighters removes his air mask and puts it on Aaliyah.

Ten minutes and 12 seconds after the call, Marcus and Aaliyah are safely out of the house and in an ambulance on the way to the hospital where they are treated for smoke inhalation. Their parents had reached safety, also.

Two days later, at Prince George’s County Fire/EMS Station 832, Marcus, Aaliyah, and their family meet the firefighters and 9-1-1 dispatchers who came to their rescue.

Ritter praised Marcus for his wonderful job, particularly in calming his little sister. Marcus, however, was notably uneasy about the media limelight.

“He was very shy and humble,” Ritter said. “He said he was only doing what he thought was the right thing.”

The same goes for Ritter and Dashnaw. Dashnaw, a fire dispatcher for two years and, also, a volunteer firefighter, said the attention has taken him by surprise.

“I couldn’t believe how fast this call was all over the place,” he said. “I don’t do it for the attention. It’s fun to make a difference when helping people and [in this call] everything went perfectly. Everyone’s relieved the kids got out safely.”

Like Dashnaw, Ritter finds the work rewarding.

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Paul Scott said he was lucky to have EMD Rick Hammond on the line when calling to report his friend’s possible cardiac arrest.

Hammond said the credit goes to Scott. “Mr. Scott is the true hero,” Hammond countered. “He remained calm and collected so he could listen to my instructions.”

Scott’s friend—Jack Pearson—doesn’t quibble. After all, he was the lucky one to survive and go home from the hospital.

“He was very appreciative of us both,” said Hammond, who in February was among 12 EMDs at the Dane County Public Safety Communications (PSC) Center, Wis., recognized for their lifesaving efforts. “But I didn’t feel like I had done anything special. From my perspective, any co-worker would have done the same.”

And apparently they would have and did.

In February, the Dane County EMS Banquet celebrated 29 prehospital saves documented in 2014, of which EMDs had direct involvement in 16 incidents of sudden cardiac arrests (12 saves) by providing compressions-only instructions over the phone until EMS arrived on scene.

Dane County PSC Medical Director Paul Stiegler, M.D., said the 12 saves were “much in part” due to EMD-driven compressions-only CPR and the ability to use the Medical Priority Dispatch System™ (MPDS™) to arrive quickly at the ECHO-level calls by sending the closest unit with an AED regardless of jurisdiction.

“This is what drives our satisfaction for what we do, and it provides a template for every call we handle,” he said. “Thank you MPDS.”

In addition to Hammond, the EMDs (and their years at the PSC center) recognized at the banquet were:

- Nathan Waite, 14 years, provided CPR instructions to a caller on March 22 assisting a 57-year-old patient who was unconscious and not breathing
- Mindy Fleming, six years, provided CPR instructions to a caller on April 12 assisting a 57-year-old patient who was unconscious and not breathing
- Joe Wissinger, four years, provided CPR instructions to a caller on April 30 assisting a 77-year-old patient who was unresponsive and not breathing
- Pete Brower, seven years, provided CPR instructions to a caller on May 4 assisting a 52-year-old female patient not breathing, possibly due to choking
- Anita Barman, more than 20 years, provided CPR instructions to a caller on May 6 assisting a 67-year-old unconscious patient whose breathing status was unknown
- Leslie O’Kane provided CPR instructions to a caller for seven minutes on June 6 assisting a 48 year-old patient who was unconscious following a possible seizure
- Kelsey Vike, with the center since April 2014, provided CPR instructions to a caller for nearly seven minutes on July 31 to assist a 33-year-old patient who was without a pulse and not breathing
- Chad Godfroy, six years, provided CPR instructions to a caller for more than four minutes on Dec. 10 to assist a 50-year-old patient who was without a pulse and not breathing.

Dane County’s PSC center provides service to more than 80 agencies, including more than 20 police departments, 22 fire departments, and 19 EMS providers. The PSC center processed more than 500,000 calls in 2014, including nearly 200,000 9-1-1 calls. The center is a tri-ACE.
Thompson, Manitoba, Canada, has every reason to capitalize on its reputation as a cold-weather center north of the 55th parallel.

But that’s not the only asset in a city that during the past 60 years has grown into the educational, health, commerce, and cultural hub of northern Manitoba. A large nickel deposit discovered in 1956 affirmed Thompson’s spot on the map. Since then, the city has flourished as the place for anything outdoors—including businesses dependent on extremely cold conditions—and a secure place to raise children, have a prosperous career, and enjoy amenities associated with cities at least twice its size.

“Thompson is great,” said Holly McLeod, Senior Communication Officer, Thompson Fire and Emergency Services comm. center. “It’s probably one of very few cities in the region where you know most of the people.”

Situated in the beautiful boreal forest of northern Manitoba, lakes, woods, wildlife, and occupations relying on a colder climate have combined to develop into a city boasting low unemployment (3.4 percent in 2014), a well-above-average median family income ($68,416), cultural diversity, and enterprise for its 13,000 residents (a number that triples daily with workers from surrounding areas).

The high employment rate goes with the terrain. The cold season—from late November through February with average daily high temperatures of minus 25 degrees (Fahrenheit)—encourages all sorts of sports, including hockey, snowmobiling, and cross-country skiing. The annual Thompson Winterfest features competitions for trappers, dog sled races, a celebrity bannock (flatbread) bake-off, and sponge hockey.

Cold-weather testing is a booming industry since the area’s extended winter season complements automotive, heavy equipment, and diesel engine performance analysis and studies by the Global Aviation Center for Icing and Environmental Research (GLACIER). Vale Canada Limited employs an average of 1,500 miners at its thriving 250-acre nickel operation.

McLeod was one of four dispatchers at the fire station when Thompson Fire and Emergency Services adopted the Medical Priority Dispatch System™ (MPDS) in 2009. She found the protocol system easier to use than expected, and now, she’d be at a loss without it.

“Before MPDS, there was no selection of a Chief Complaint,” McLeod said. “We didn’t have Key Questions. It was as basic as you can get—what is going on and address.”

Dispatchers have assisted in providing a variety of Pre-Arrival Instructions (PAIs). On Aug. 15, 2010, EMD Charlene Kissock gave instructions to a mother of a four-week-old baby who was choking the story Kissock submitted was published in The Journal. They also receive wilderness-related calls, such as last summer when a group of forestry students conducting surveys in the area came in contact with a bear. They have sent rescue personnel to snowmobile drivers unfamiliar with the territory.

While every dispatcher has responded to the prevalent medical complaints—cardiac arrest, airway obstruction, and sick person—most calls involve medical transport from the airport to regional hospitals; 65 to 70 percent of their average 5,200 ambulance runs carry patients from the airport to regional hospitals and vice versa.

As Thompson is a small community, the comm. center also serves as the city’s after-hour contact. Dispatchers on the night shift handle calls involving road conditions, water breaks, and animal control. They send conservation officers to reported wildlife sightings such as wolves and coyotes.

Although emergency calls relating to cold weather complaints are part of the package, a policy approved in 2013 has helped to decrease cases of hypothermia. When temperatures plunge to minus 35 degrees (Fahrenheit), the city opens added shelters to accommodate those in need.

McLeod, who has lived in Thompson since 1994, admits the cold climate can be intimidating to newcomers.

“If you’re not from here, the weather can be very tough to get used to,” she said. “Other than that, Thompson has given me great opportunities, and it’s where I found the love of my life.”
It’s 3 a.m. and eerie silence fills the fire hall. The six-member crew of responders is sleeping in the back, and the occasional snore or grunt comes from the captain’s office across the hall. You are the only dispatcher on the platoon. You are the only one awake at this unearthly hour and possibly for the next five hours to come. Anticipating the next life-or-death situation, you sit there with your imagination running wild or practicing protocols for insane scenarios that you may encounter tonight.

It is too calm tonight … too calm. That is one thing you never want to say out loud because when you do, all havoc will break loose.

Then it happens.

A fire breaks out and pages are sent out. “We have an emergency; all available personnel please respond to the fire hall.” The phone is ringing off the hook with concerned residents calling about water breaks, dogs roaming the streets, as well as scheduled medevac pickups and emergency medical calls. The trucks are going to and from the hall, everybody is running around full of adrenaline, and dispatch is in control of it all. It can get very stressful during a situation when different members of the department come into the dispatch office to try and assist. On occasion, they watch you work while listening to the hectic radio chatter, which can be even more nerve-wracking while under pressure. Another call comes in, and medics leave for the fire scene by ambulance, sirens blaring.

This is a typical night shift for a dispatcher here at the dual-service fire hall in Thompson, Manitoba, Canada. This is a 24-hour service consisting of four platoons each with a single dispatcher. Our department consists of a fire chief, two deputy fire chiefs, a senior communications officer, four dispatchers, and 24 full-time fire medics. An additional 19 auxiliary-volunteer firefighters come out to assist during a general alarm when a page is sent out. We work directly with the fire medics and when the phone rings, they are literally a shout away.

Servicing a small city of approximately 13,000 residents and being the only fire and ambulance service within 100 km (60 miles), you can say we are comparatively busy. At this writing, we are heading into week nine of 2015 with almost 900 emergency calls, averaging out to 100 incidents every seven days.

During day shifts, our unique fire hall is bustling with action. When not involved with handling emergencies or training, platoons also take care of annual business and apartment inspections. For dispatch, day shift means paperwork, paperwork, and more paperwork, along with the emergency and business calls received. There is data entry for each incident, invoicing for ambulance trips, and taking the occasional business call from animal control or public works. If there is a monstrous situation, the senior communications officer generally acts as an extra set of hands to assist with non-emergent situations. That way, the dispatcher can deal with the emergency and not have to worry about the public calling about dogs at large.

When the sun goes down, the night shift crew of responders gears up for a 14-hour tour of duty. With the chiefs gone home, the six-member crew takes watch over the city. When the emergency is over, the fire is out, everyone has gone home safely, and the platoon on duty has gone back to bed for the last one or two hours of the night shift, dispatch will remain wide awake. We will be selflessly sitting by the phone waiting to serve you, waiting to help you through your darkest hour each and every time.

NORTH OF THE 55TH PARALLEL

Dispatch on watch whatever the time might be

Victoria Wanke
A silent call in Massachusetts has all the characteristics and potential to make it anything but ordinary, but it took the final touch of social media to make it really stand out in a crowd.

“Facebook and Twitter are giving it a lot of attention,” said Monna Wallace, Director of Programs, Massachusetts State 911 Department. “People who have never heard of it or had forgotten about it are now learning about this lifesaving tool.”

In March, the Massachusetts State Police posted the long-standing news about the Silent Call Procedure on its Facebook page, and in 24 hours there were 1.5 million hits on the post; 676 people had signaled thumbs-up (“Like” us) to something new to most of them.

Posts have been mostly positive and in line with the following: “Thank you for this. I am sharing”; “This is the first time I ever heard this. Thank you for letting us know”; and “I have made a copy for my purse. Thank you.”

The positive response on social media prompted the Massachusetts
The Silent Call Procedure allows 9-1-1 callers to communicate without saying a word. The dispatcher can prompt the caller to press 1 for Police, 2 for Fire, or 3 for an Ambulance.

Wallace is well acquainted with 9-1-1 operations. She started her career working for a small police department when she answered a “help wanted” ad in 1984 and was hired to dispatch emergency calls using a three-phone and numbering system. A red phone rang for fire and ambulance; a blue phone rang for police; and a white phone rang for business. She rose to become supervisor and, at the same time, a part-time police officer.

She accepted a position with the state in 1994 while E9-1-1 was going statewide.

“I thought that E9-1-1 was the best tool ever handed to public safety,” she said. “An address with a phone call made all the difference. Now with wireless call volumes exceeding wireline call volumes, we are seeing progress for locating those calls as well.”

And as in the past, the Massachusetts State 911 Department is advancing along another new era in communications as it prepares to deploy Next Generation 9-1-1 and the ability to text to 9-1-1.

Wallace is a 20-year veteran of the Massachusetts State 911 Department and is responsible for overseeing the training department, public education, and the MassRelay and Massachusetts Equipment Distribution (MassEDP) programs.

Despite the role Facebook might play in promoting silent calling, the Massachusetts State 911 Department coordinates a successful and continuous education campaign.

State 911 Department to take the social media plunge and open a Twitter account.

The Silent Call Procedure allows 9-1-1 callers to communicate without saying a word. When a dispatcher is met by silence on the other end of the line at any 9-1-1 Public Safety Answering Point (PSAP) in Massachusetts, the dispatcher can prompt the caller to press 1 for Police, 2 for Fire, or 3 for an Ambulance on their touch-tone phone (landline or wireless).

The button the caller presses displays on the dispatcher's screen and, from there, the dispatcher can gather more information using the extended numbering system prompting the caller to press 4 for Yes and 5 for No. Callers knowing how to use the Silent Call Procedure can begin the process by pressing numbers when the dispatcher answers their call.

The procedure was introduced over 20 years ago after a group representing people with disabilities approached the department to create a feature that would assist a person unable to communicate with requesting emergency services. As Wallace explained, the state was in the late stages of deploying E9-1-1 and agreed to look into the request.

“After some research we found that if the caller pressed numbers on a touch-tone phone, the numbers would appear on the 9-1-1 screen for the dispatcher to see,” Wallace said.

The Silent Call Procedure has exceeded its initial expectations, said Wallace, who has seen the advent of many changes during her 20 years with the department.

Dispatchers are trained to use the procedure for any emergency in which the caller is unable to communicate, including domestic violence and home invasions, and for people with disabilities. The procedure can be invaluable in these situations.

In March, a Waltham, Mass., dispatcher effectively used the procedure to help a boy who was home alone and hiding in a closet after hearing someone break into the house. The dispatcher gathered information leading to the boy’s safety and the suspect’s apprehension.

The feature has become a department staple. Each time the department upgrades its 9-1-1 system, the Silent Call Procedure has remained. It is covered extensively during training as part of the state’s program mandating minimum training requirements for 9-1-1 dispatchers.

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Material relevant to 9-1-1 communications available online includes public education kits for kids and forms individuals can voluntarily complete to designate accommodations necessary in an emergency.

“When there’s an opportunity for 9-1-1 public awareness, we’re there,” Wallace said.

As detailed on the department’s website, MassEDP provides sliding income-based access to telephones for residents with permanent disabilities related to hearing, sight, speech, and cognitive thinking. The telephone device designed for people with cognitive disabilities, for example,

features photo-memory buttons and voice clarity to make every word clear and free of distortion. The wireline phone operates even when power is down.

MassRelay provides help and equipment (text telephone, TTY) for people with hearing or speech disabilities to communicate over regular telephone lines. A Relay Operator (OPR) completes the call and stays on the line to relay messages electronically via a TTY or verbally to people who can hear. The OPRs provide exact transcriptions of the exchange, unless the caller directs otherwise.

Note: The Silent Call Procedure may not work with 9-1-1 systems in other states.
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