Firefighters
FPDS v6.0 brings more tools to dispatch

In Pursuit Of Resiliency
Acknowledging stress is first step in comeback

History Lives On
Haleyville will always be home of first 9-1-1 call

The International Academies of Emergency Dispatch

November | December 2013

THE JOURNAL OF EMERGENCY DISPATCH

Pond Jumping
NAVIGATOR rallies U.K., European dispatchers

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The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 5,989,187; 6,004,266; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234. The PPDS is protected by U.S. patent 7,436,937. FPDS patents are pending. Other U.S. and foreign patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the IAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.
Colleen is deputy director over Operations for SLC911. Colleen is responsible for the day-to-day operations of the bureau, as well as many other duties. She assisted in the consolidation of fire and police dispatch offices and the move to the city’s new Public Safety Building. She was the project manager for the implementation of PPDS®. She has worked for Salt Lake City since 1982.

12 | HEADSET CONFESSIONS

Jim is the Alachua County Sheriff’s Office (Fla.) technical services division manager. He has been involved with public safety communications since 1993. Previously, he worked at DU-COMM and Northwest Central Dispatch System, both in Illinois. John teaches EMD-Q® for Priority Dispatch® and ETC courses at Harper College in Palatine, Ill., and has enjoyed presenting at NAVIGATOR since 2005.

11 | CUSTOMER SERVICE

Jordan is an instructional designer and technical writer for Priority Dispatch Corp.™. Jordan earned a master’s degree in instructional technology and learning from Utah State University. He has worked in the training industry for close to eight years, and has been designing emergency dispatcher training for almost four years. Most recently, Jordan completed the v6.0 update of all the EFD curriculum.

10 | ACADEMY RESEARCH

An emergency communications manager, Kevin is a regular contributor to a number of EMS publications. With a background in quality assurance and instruction, he is passionate about improving the standards and training required for emergency telecommunicators. Kevin is a frequent conference speaker, a certified ENP, and an IAED ED-Q™ instructor.

7 | QUALITY ASSURANCE

Tracey is a registered clinical, forensic, and rehabilitation psychologist. She strives to tackle the issue of trauma from multiple angles through her work with first responders (e.g., paramedics, firefighters, police officers), trauma victims, and criminal offenders. Lori has received several awards for her work. Most recently, she received the Odyssey Award for distinguished early career achievement.

25 | RESILIENCY

Kevin is an Academics & Standards associate and Medical Council of Standards chair for the IAED. His role involves training, curriculum, protocol standards and evolution, quality improvement, and research. He is a member of the IAED College of Fellows and Rules Committee. Brett became a paramedic in 1981 and began his EMS communication career in 1987. Prior to accepting a position with the IAED, he spent 10 years working in Pinellas County, Fla.

19 | FAQ

Jim is director of the 911 Training Institute and co-founder of the 911 Wellness Foundation. Since 2005, he has trained more than 2,500 telecommunicators in management of PSAP stress and call-related trauma. Jim is co-chair of the NENA Working Group on Acute, Traumatic, and Chronic Stress.

27 | RESILIENCY

Dr. Lori is a registered clinical, forensic, and rehabilitation psychologist. She strives to tackle the issue of trauma from multiple angles through her work with first responders (e.g., paramedics, firefighters, police officers), trauma victims, and criminal offenders. Lori has received several awards for her work. Most recently, she received the Odyssey Award for distinguished early career achievement.

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John is the executive director at West Suburban Consolidated Dispatch Center in River Forest, Ill. He has been involved with public safety communications since 1993. Previously, he worked at DU-COMM and Northwest Central Dispatch System, both in Illinois. John teaches EMD-Q® for Priority Dispatch® and ETC courses at Harper College in Palatine, Ill., and has enjoyed presenting at NAVIGATOR since 2005.

11 | CUSTOMER SERVICE

Tracey joined the IAED™ after spending nine years with the ambulance service as a paramedic, EMD, dispatcher, and education manager. While Tracey still teaches EMD, the majority of her time is spent working with European agencies on research projects using the protocols developed by the Academy.

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What Pressures You Out?  
Try a positive spin

Audrey Fraizer, Managing Editor

S
o, what causes you stress?  
For me, the coming of winter is a stressor and although that may sound rather shallow—considering the really horri-
cific stuff to pick from—it’s a time of year that requires a concentrated effort to think positively.

This winter’s outlook—and I took my first peek at the Farmers’ Almanac forecast way back in July—is calling for the “Days of Shivery.” Below-normal temperatures will cut a frigid swath through states east of the Conti-
nental Divide to the Appalachians, north and east through New England. The coldest temperatures will be over the Northern Plains on east into the Great Lakes. Over the roughly identical areas the Midwest and the Great Lakes, Farmers’ Almanac weather see “Caleb” predicts lots of snow.

I’m originally from the Midwest and somehow survived 27 bone-chilling winters before moving west of the Rockies to the high desert country. Chicago’s cold chases to the soul and, once fixed, settles in until the spring thaw. Going outside means bundling and layering, particularly if stand-
ing at the edge of Lake Michigan watching huge waves push to shore. Now that’s something to see. That brings me back to the initial question. What do you do for stress?

It’s taken me long time, but after more than a half century on this planet, with cumulative months of winter adding up to a quarter of that time, I realize attitude and spinning a negative perspecrive can turn a stressor into something tolerable. Take the waves off Lake Michigan, for example. They are captivating to watch, reminding me of sitting at an ocean shore and waiting for Godzilla to appear. Any given wind speed builds higher waves in the winter, and these cliff-like waves average about 4 to 8 feet high, although waves of 18 feet or greater are not unusual.

This is one of the contrasts between the Midwest and West: water cliffs vs. rock cliffs—but they both offer a way to reconnect.

Mountains rimming Salt Lake City provide an ideal winter stress buster, and the dry air does seal our reputation for champagne snow. Our Rocky Mountain light, dry snow makes tough packing for snowballs and snowmen but what it lacks in water content creates a skier’s and snowboarder’s equivalent to a surfer’s perfect wave.

While Chicago obviously falls short of what it takes for great winter downhill skiing—appreciable land elevation and a dry climate—that doesn’t confine the season’s board time to golf courses or nature preserves. Strong winds hitting Lake Michigan in the right direction create ideal surfing waves. Some say winter is the best season for putting the surfboard to water.

Surfing in temperatures below freezing might not be everyone’s idea for reducing stress; however, viewing those who do could just be the few minutes of reprieve you need in your day to relax.
Last Call

Final radio dispatch is hardest part in bidding farewell to fallen officer

Scott Freitag, IAED President

My bearing was fairly well under control until the Last Call, and that’s the part that tears up anyone who has attended a funeral service for a police officer fallen in the line of duty.

Yes, the eulogies, the widows and children left behind, parents paralyzed by grief, fellow officers in procession as a sign of solidarity, the ceremonial flyover, and the loss to the community pull deeply at my emotions.

But it’s the Last Call that gets me every time. The radio dispatch calling out the departed officer’s radio number forces me to acknowledge the tragedy of the officer’s death; the risks we accept every day in protecting our communities.

On Sept. 6, the Last Call was in honor of Draper (Utah) Police Sgt. Derek Johnson, who was ambushed and killed on Sunday, Sept. 1, while on routine patrol in Draper, a city about 15 miles south of Salt Lake City.

Sgt. Johnson had noticed an oddly parked vehicle and pulled over to investigate. He was shot behind the wheel of his police cruiser and was able to drive a few blocks before crashing into a tree.

Sgt. Johnson never got out of his patrol car or drew his weapon during the incident; a man in the car Sgt. Johnson was stopping to investigate gunned him down. Despite heroic efforts to save his life, the young officer died that same morning.

Sgt. Johnson was 32-years-old. He leaves behind a wife, their 6-year-old son, and a community of 44,000 residents, witnesses to the first Draper police officer killed in the line of duty since the agency was established in 2003.

I was told that police work had been his life’s ambition, and it showed in his devotion to law enforcement and the many awards he received, including the Life Saving Award and the Distinguished Service Award. He was the 2012 Community Policing Officer of the Year.

He was known, liked, and respected. An estimated 1200 people attended a candlelight vigil held in his honor less than 24 hours after he was shot and killed.

Crowds gathered outside the arena placed hands over their hearts as the eight pallbearers carried the American flag-draped casket to the awaiting hearse.

The funeral procession along the 1 mile route to the cemetery was led by hundreds of motorcycle police as they traveled slowly past thousands waving flags and flanking both sides of the street. They passed beneath an American flag that firefighters had hoisted above the street earlier that day. The last car arrived one hour after the first car had stopped at the site of interment.

The gravesite was dedicated and officers presented Sgt. Johnson’s wife the flag that had covered his casket. Inside the folds were the spent shells from a three honor volley. Taps played and four helicopters flew overhead in the missing man formation.

The Last Call was made in the silence of mourning from the center that received Sgt. Johnson’s “mayday” call. Valley Emergency Communications Center (VECC) dispatcher Kris Whitney, who took over the police radio at the time of the shooting, gave the 42-second salute in a measured and controlled voice (the full transcript is in a Your Space story profiling Whitney).

She was truly amazing, and I wiped back tears listening to her. Sgt. Johnson will never be forgotten, and I am forever humbled by the steep price this officer paid in protecting the community he served.

According to statistics released in May 2013 by the FBI, 47 law enforcement officers were feloniously killed in the line of duty during 2012.

Circumstances involved investigations, traffic pursuits or stops, tactical situations, ambushes, answering disturbance calls, drug-related matters, robberies in progress, and transporting, handling, or maintaining custody of prisoners.

The officers brought altruism, bravery, and the spirit of public service to their work and paid the ultimate sacrifice to help keep their communities safe.
Lessons From Legos
Each piece has a specific function

Kevin Pagenkop, ENP

I grew up playing with Legos: the small, plastic bricks and shapes that when interlocked and pieced together built anything from spaceships, to dinosaurs, to helicopters, to fire engines. This Danish innovation was one of the staples of my childhood toy chest. Each gift-giving holiday I would eagerly await the familiar-sized box that contained a number of pieces proportional to the abilities of my age. The printed instructions provided a step-by-step, brick-by-brick outline of how to create the object or theme of that particular Lego product. Inevitably, I would either lose the instructions or drop one of the small pieces into the heavy shag carpet of my childhood living room, never to be seen again. Decades later, I'd like to think that whomever purchased that property and remodeled it to his or her own preferences found every lost Lego brick, Star Wars lightsaber, and missing wheel from my Matchbox cars (when they were still made out of metal and detailed in toxic lead paint).

What was great about Legos was that even without the instructions, you were usually able to complete the figure. Each piece had a specific function: a wheel, a wing, a windshield; and when a pattern or theme could be identified, each individual piece could be combined to complete the whole. The more you played with Legos, the more you learned about the specific form and function of each piece and the easier it was to “fill in the blanks” of the lost instructions and complete the item anyway. Provided the essential elements were still in the box, something could be built.

This is similar to emergency calltaking. As there are a variety of different types of calls, there is no template provided that can be applied and followed for every incident. Without an instruction manual to follow step-by-step, dispatchers must apply their experience to interpret the information provided by the caller and try to “fill in the blanks” to get the full picture. The more tenured dispatchers have more experience they’ve locked away in their toy chest to pull out and apply when processing a call. Provided they have the majority of the essential pieces, the incident can still be handled, help sent en route, and assistance provided.

MPDS’ Chief Complaint Protocol 32: Unknown Problem (Man Down) is often utilized in situations where the dispatcher believes he or she does not have all of the information required to select a Chief Complaint Protocol. Case Entry Rule 6 clearly outlines the conditions that must be present for Protocol 32 to be appropriate. Usage is based on a significant lack of essential information rather than just missing one small piece. When dispatchers don’t obtain as much information as they would have liked, it doesn’t mean that the call should be thrown away or that “Unknown Problem” should be chosen by default. Just like Legos, the dispatcher should be able to combine the individual pieces to complete the whole.

Guessing, relying on perceptions or biases, and/or questioning the integrity of the callers is not the same as drawing on past experience to make critical decisions with incomplete information. If a box of Legos contained two wheels instead of the expected four, a bicycle or motorcycle could be considered in place of a car; however, a spaceship or dinosaur would not be supported by the fact that wheels, in any quantity, were present. If a caller advised that someone was unconscious or altered, it would not be appropriate to only infer intoxication, nor would it be appropriate to simply select “Man Down.” Take all of the signs, symptoms, and information into consideration and begin piecing each block together within the context of the situation.

Experience cannot be taught or replicated; therefore, a priority should be on retaining employees so they can be developed into dispatchers who have processed enough calls and put together enough puzzles that they have the experience to select an appropriate Chief Complaint Protocol, and successfully provide assistance even when they don’t have all of the pieces.
Dr. Clawson:
Wellington Free Ambulance in New Zealand is considering adding new material to the guidelines for the field responders. The aim could be to assist responders to call communications for the provision of advanced dispatcher-assisted instructions in cases of high risk childbirth using Pre-Arrival Instruction (PAI) Protocol F.

The directive would be significant in terms of recognition for the Medical Priority Dispatch System™ (MPDS®) system and the advanced childbirth instructions that are now provided by EMDs. In short, this would be a good win for Emergency Medical Dispatchers (EMDs) and patient care here!

Thanks again,
Ruth Lloyd
PDC Implementation Specialist
Australia/New Zealand
Wellington, New Zealand

Ruth:
That is certainly “earth shattering” news—field responders being directed to call EMDs for instructions! It certainly is an amazing win for the respect of EMDs and recognition of the MPDS. You don’t see this sort of thing happening in EMS-land every day. This is not a brand new phenomenon since after the release of MPDS v11.2 in 2004, this has occurred sporadically in several countries, which have had communication centers using the MPDS High Risk Delivery PAI protocols to advise crews at scene.

These very special protocols became a necessity after the International Academies of Emergency Dispatch™ (IAED™) encountered an increasing number of different types of what we call “high risk” delivery cases in which critical care fell completely outside the scope of the then current protocol, not to mention what any other 9-1-1-like centers could or would do.

This High Risk Delivery protocol is actually a group of nine protocols designed to address a host of different critical problems occurring in the early moments of a 9-1-1 call. On a per 9-1-1 center basis, these appear to be rare occurrences, but pose significant clinical as well as ethical problems if not dealt with accurately and immediately by EMDs. Response time can be, and is often, lethal, or brain damaging, in such cases. The Academy has adopted a policy statement regarding the EMD’s involvement in such difficult situations (see Principles of EMD – 4th Ed. page 8.5):

The International Academies of Emergency Dispatch considers situations necessitating the provision of these instructions to be an extremely High Risk-Inherent Situation Case (HiRISC) and believes that the trained EMD, EFD, or EPD (or other agency), making a good faith attempt to provide these instructions, should not be held responsible for any bad outcomes. This should not be considered a legal interpretation, but a strong official opinion of the Council of Standards and Board of Trustees of the IAED.

This list of special delivery PAI sub-protocols includes Footling Breech, Frank Breech, Arm or Hand Presentation, Shoulder Dystocia, Prolapsed Cord, Ruptured Cord, Cord Around Neck/Body, Amniotic Sac Encasement, and Fundal Massage for serious postpartum hemorrhage.
In less than a year [after the release of v11.2], Louise Ganley, now the clinical support representative at the U.K. Office of PDC™, told me that they provided this service for their operational staff at Great Western Ambulance Service in Bristol, U.K. She stated, “It became very apparent that this was a good thing to do after one of our EMDs, who was awarded dispatcher of the year in Dublin, provided PAIs for a breech and successfully delivered the baby who was presenting feet first, cord around the neck, and was successfully resuscitated, all before the crew arrived on scene.”

Tracey Barron, research & studies officer for IAED, formerly of South East Coast Ambulance Service in the U.K, added that their road staff “… were always advised to call in to dispatch during an ‘unusual’ birth so we could provide these PAIs. We did this from v11.2 onwards. While it was never part of their formal clinical training, any member of road staff that set foot in control was shown the instructions and advised to call in.”

In 2008, Dr. Andrew Bacon, medical director for the Melbourne Ambulance Service, Australia, shared this encouraging experience with the Academy. “I reviewed the first breech delivery call brought to my attention today. It was a first-party caller, isolated location, no one else on scene, 20 minutes to the nearest ambulance. I think she was a first pregnancy, undiagnosed breech at 38 weeks, who earlier had rung the hospital and been told not to come in too early in the labour. Two feet had presented in the bathroom, and the patient herself was on a mobile phone. The EMD adapted the script beautifully to a first-party caller. The call started with the patient’s mother ringing in from a suburb an hour away. The EMD goes to conference call, kept both mother and daughter on the line and worked through PAI-F. Twenty minutes later the baby is out, breathing, and all is well. It makes all the reviewing of (the protocol) drafts (as a member of the Council of Standards) so worthwhile. Cheers.”

Several other similar cases have been shared with the Academy since this special protocol set has been available to EMDs.

When the initial High Risk Pregnancy/Delivery Standards Committee met, it became very apparent that even medical practitioners like myself, an emergency physician and previous field responder, as well as emergency or general floor hospital nurses, are not experienced in how to actually deal with these situations, since we rarely, if ever, do. We had the experts present to the Committee that they knew, and they very quickly realized that just how to tell someone else how to actually accomplish these feats non-visually was very much more difficult than simply and physically doing it in person.

It makes perfect sense that an EMD, with the correct PAI tools, should be able to provide help to scene responders as well as lay callers, rather than simply leaving them to reinvent this “rare” type of wheel. It would also seem that this dispatch-to-EMS crew advice should be formally incorporated by many more, if not all, EMS systems utilizing the MPDS to safely dispatch.

If the goal is to help people, then regardless of the origin of that care, even if it’s from an EMD armed with these advanced protocols, these life-improving instructions should not only be provided here and there, but actively embraced by all.

Doc ■
Humans are designed to work during the day and recuperate at night. So it comes as no surprise that a decline in performance has been documented in people working 12-hour shifts.1 An Emergency Medical Dispatcher’s (EMD) performance can be affected as much by tiredness and sleep disturbance as any other shift worker; mistakes, errors, and omissions are made when the mind and body cannot function at their best.

While it has been noted that some workers actually enjoy the variety of rotating shifts and that shiftwork can provide advantages to society at large,2 the single, prominent conclusion from earlier studies is that additional research is needed in order to eliminate the harmful effects of shiftwork.

In her book *Asleep in the Fast Lane: The Impact of Sleep on Work*, Lydia Dotto captured the dilemma faced by all 24-hour dispatch systems: “Industrialized societies are the ones most divorced from the natural, primitive cycle of day and night and they are also the most dependent on and vulnerable to complex technologies whose failure (often brought about by human error) can exact a huge social and economic toll.”

And that’s where the International Academies of Emergency Dispatch” (IAED”) helps pick up the slack these many years later. Let’s first review the factors.

**Effects of shiftwork on EMDs**

Factors affecting performance are common among occupations, and they include:

- Physical factors such as health and age
- Psychological factors such as attitude toward work, motivation, sleep deprivation, and stress
- Nature of work to be performed (the type: physical or mental, complexity: decision-making or rote work, and schedule: day work or shiftwork)

While human performance often depends on the individual’s internal clock—night owls versus morning doves, for example—in some occupations, the shift system and its unconventional clock cannot be avoided. Due to scheduling demands, it’s not always the early bird that gets the day shift or the night owl that works the hours before dawn. This, of course, includes emergency dispatch.

**Shiftwork and its effect on EMDs**

A recent study looking at productivity and performance of the EMD signified an opening into research regarding the impact shiftwork could have on dispatch compliance. Specifically, the London Ambulance Service (LAS) NHS Trust studied whether the shift an EMD works has any bearing on the ability to rapidly categorize calls and subsequently facilitate the dispatching of appropriate emergency ambulance personnel.3

LAS uses the Medical Priority Dispatch System” (MPDS”) to triage emergency 9-9-9 calls, and more than 90,000 calls a month (about one-fifth of the total number of calls received in the U.K.) are handled at LAS headquarters.

Strict compliance to the protocol through a quality management program is an integral component in LAS’ evaluation of EMD performance, and feedback plus patient outcomes are central to the study’s findings.

**Methodology**

For the study, a database consisting of 1,373 9-9-9 calls coming into LAS during a consecutive three-month sampling of emergency calls (June-August 2006) were randomly reviewed for compliance to the MPDS Protocol.

Day shift was defined as the hours between 7 a.m. and 7 p.m., and night shift applied to the hours between 7 p.m. and 7 a.m. LAS staff work through a 24/7 rotating shift pattern. Although those on the day shift handle more cases than night shift EMDs, the data was analyzed for mean compliance, which showed no statistical difference when adjusted for shiftwork.

**Findings**

The results of this study show that the use of a structured set of symptom- and incident-based protocols for triaging emergency 9-9-9 calls leads to equally high levels of compliance irrespective of the shift being worked, whether day or night.

In addition, the findings suggest that a protocol-driven process helps alleviate some of the many factors that contribute to mistakes, errors, and omissions being made, especially across periods of time in which the mind and body may not function at their best.

According to the study’s authors, this is an important conclusion in the world of the ambulance service where time can be crucial to a patient’s outcome, and where the accurate triage of a patient can directly impact the speed and level of response and care.

**Sources**


Delivery Is Everything
Spend time teaching telecommunicators the right way to speak to callers

John Ferraro

When I started my career in 1993, the theory of delivering a high level of customer service to the caller had come a long way. Call screening was no longer acceptable. If the caller wanted police for a neighbor’s grass that was too long, they got them. If they wanted an ambulance for a stubbed toe, that’s what was sent.

As I look back, I realize that the end of call screening probably had as much to do with liability concerns as it did with treating the caller’s request with courtesy and professionalism. After all, what if the neighbor’s grass was too long because the homeowner passed away? What if the patient with the stubbed toe had a bleeding disorder or was on blood thinners, and the call was more serious than first reported? “When in doubt, send them out” was a good step.

In the years that followed, customer service definitely improved several notches with the idea of using a calltaking protocol. I think back to delivering CPR instructions for the first time in my career. In less than a minute, the caller knew I was in control and there to help until responders arrived on the scene. I was doing everything I could to help the patient, and I remember being grateful that my instructions to the caller were more than, “They are on the way!”

Where are we in 2013?
Now is the time for improvement as an industry, and I offer a three-pronged approach for better customer service that I learned through experience and training.

Training
We spend a lot of time training telecommunicators, but how much time do we spend teaching them the right way to speak to callers? Customer service training can take many forms. Here are some suggestions:

• Have the telecommunicator listen to a recording of 10 of his/her own calls, and list customer service aspects of the calls that went well and others that went poorly.

• Send your telecommunicators to retail customer service training, which is useful because of the customer loyalty angle—a concept that is sometimes lost on public safety communications.

• Complete a 30-minute training session that thoroughly covers the IAED™ Universal Standards for Customer Service. Since this is your basis for quality assurance reviews, it will give your telecommunicators clear expectations on how to handle their calls.

• Utilize role-playing by having one employee act as the caller and the other as the calltaker. The results are usually very entertaining, but educational.

Quality assurance
When I began as an ED-Q™, the concept of reviewing customer service was difficult for me. I thought that my reviews were too opinion-based, and I was afraid my approach was less quantitative than it should have been. When I became more familiar with the Academy’s performance standards, I realized the process is quantitative, and that gives me the opportunity to address behaviors in a concrete way. It’s objective. The “yes” or “no” questions take the opinion out of my reviews. Did the telecommunicator explain his or her actions throughout the call? Did the telecommunicator provide reassurance, display compassion, and use the proper volume, tone, and rate?

When a problem is identified, I immediately talk to the telecommunicator to prevent the same mistakes from repeating.

STOP IT!
Here’s a final piece of advice.
How many times have you walked through the center and heard a coworker delivering poor customer service with everyone looking the other way? A customer service seminar I attended a few years ago offered some good simplistic advice: When you hear poor customer service, STOP IT!

The next time you hear a co-worker being rude on the phone, offer advice in a friendly manner. Delivery is everything. Explain that you are not judging, but actually looking out for the person. You do not want to see a co-worker disciplined. Exceptional customer service = Proper care.

Several years ago, I received a call from a woman who had called 9-1-1 when her husband passed away. She complimented the telecommunicator who received her call for being so nice and helpful and said it actually helped her through a tough time. I was proud of the telecommunicator and went looking for a quote to include on her recognition certificate. Here’s what I found: “Kind words can be short and easy to speak, but their echoes are truly endless.” —Mother Teresa

On every call and every call review, let’s remember why we decided to get involved in this field—to help people.
I have a very blessed life. Though I am aging, and I am chubby, I feel there are things that overshadow those issues. I have three amazing blessings in my babies. They are MY babies. I created them, with very little help, and it was through my guidance and love that they became the humans they are today.

The first time my husband called me a “helicopter parent” I was terribly offended and wanted to punch him in the throat. I told him that I relish the label “helicopter parent,” to me, it says I am an involved and loving mother. He had not walked in my shoes, did not know what my life had been, and did not know the extent of the bond formed.

When everything is said and done, we are a functional family with a few dysfunctional moments thrown in.

If, from the outside, I appear to hover over my kids, it’s because they are the children of a dispatcher. They have been overprotected and overcherished. They were not allowed to do a lot of the things that their friends got to do. I knew the consequences of those actions, although that’s not to say they didn’t get one over on mom every once in a while.

Now my babies are grown up and adding to my blessings. I was given two grandbabies in 2013: an adorable granddaughter from my son and a handsome grandson from my stepdaughter. When I met my husband he was a single father of two daughters who are now my stepdaughters.

As I sat holding my granddaughter I was humbled, amazed, and overwhelmed with love. It made me think about my fourth baby, the baby I have nurtured for many years—my dispatch career.

As we’re all well aware, not everyone has what it takes to be a good parent. The same holds true for our profession—not everyone has what it takes to be a good dispatcher. In fact, I would say that, on some occasions, it’s easier to be a good parent than a good dispatcher or calltaker. As with being a good parent, it’s a true calling to be a good dispatcher or calltaker.

During my career, I have met many people who have tried to be dispatchers, and while many succeed, there are also many who have failed. This happens either by the individual’s choice or when a person is let go—the job and person aren’t the right combination. I don’t believe that anyone can truly fathom what the job entails until putting the headset on and hearing what’s coming through. No one can truly understand how many different hats dispatchers wear.

On a call-to-call basis, we switch hats that include: marriage counselor, information operator, psychologist, nurse, caretaker, social worker, translator, Google map location finder and tourist guide, newspaper journalist, clock, Dear Abby adviser, lawyer, veterinarian, social networking expert, punching bag and, of course, the person giving the instructions that could help save a life.

That’s just the tip of the iceberg.

Call one may be the first of many mundane and boring burglaries reported during one day. Call two could be that guy who blames you for every bad thing that has ever happened in his life, calls you every name in the book, and then refuses to listen to any words you might have to say. Call three could be the sweetest little old lady who has never had to call 9-1-1 until that very moment when she awoke to find that her husband had passed away next to her during the night.

Every year, the first Sunday in February doesn’t go by without someone calling 9-1-1 to ask, “What time is the Super Bowl?” I’ve heard of people calling 9-1-1 on the fourth Thursday in November to ask, “How long does it take to thaw a turkey, and how long does it take to cook?”

And no matter the call, no matter the situation, no matter the abuse you’re taking from the other end of the call, we have to maintain a professional and empathetic composure. Sometimes, we have to bite our tongues.

Obviously, not everyone can be a dispatcher or calltaker. Not everyone can take care of your baby, your career, as well as you do.

Protect it, cherish it, and raise it right.
EMS personnel continue at high risk to violence

Violence against emergency responders is certainly not confined to a specific city or country. According to an article in EMS World (It’s Time to Stop the Violence, May 1, 2013), a 2005 National EMS Management Association (NEMSMA) survey conducted in the U.S. and Canada found that slightly more than one in two respondents (52%) reported that they had been assaulted by a patient.

In one study in a large California EMS system, EMS personnel encountered some sort of violence in 8.5% of patient encounters and were subjected to violence directed at them in 4.5% of patient encounters. Of encounters where violence was directed at EMS personnel, 21% involved nonphysical (verbal) violence only, while 79% involved physical violence.

To address the issue, NEMSMA launched the End Violence Against Paramedics project and, in collaboration with the Center for Leadership, Innovation and Research in EMS, developed an anonymous system for EMS practitioners to report near miss, line of duty death, and patient safety incidents by answering a series of questions in an online format. The EMS Voluntary Event Notification Tool (E.V.E.N.T.) will aggregate the data for analysis and use in developing EMS policies and procedures, and for use in training, educating, and preventing similar events from occurring to EMS personnel in the future.

Man charged in swatting spree faces 15-year sentence


According to charges, Nathan Hanshaw, of Athol, Mass., agreed to plead guilty to the charges of making interstate threats, threats to use explosives, and threats to use a firearm. Making interstate threats and making threats to use a firearm each carry a maximum penalty of five years in prison. The count of making threats to use an explosive carries a maximum penalty of 10 years in prison.

According to documents filed in U.S. District Court in Massachusetts, Hanshaw typically claimed during his swatting calls that he was a fugitive who was wanted by the authorities and that he had taken hostages and was armed with weapons, explosives, and nerve agents. He demanded cash and a helicopter ride to Mexico and threatened to detonate his bombs and kill his hostages if his demands were not met. He also threatened to kill any law enforcement personnel who arrived at the location. According to court documents, Hanshaw generally claimed to be calling from an address that, unknown to officers responding to the call, was the address of his intended swatting victim.

The information charges that Hanshaw made swatting calls to police departments across the United States, including departments in Denver, Colo.; Ventura, Calif.; and Waverly, N.Y. In each case, armed police responses ensued. In response to Hanshaw’s swatting call to Ventura, more than 40 local and federal officers arrived at the purported crime scene, a hotel was

Bill would ban policies prohibiting lifesaving medical help

California lawmakers in September sent legislation to Gov. Jerry Brown that would bar employers from having policies that prohibit offering lifesaving medical help in an emergency.

Assemblyman Rudy Salas’ bill was prompted by the February 2013 death of an 87-year-old resident of a Bakersfield independent living facility. The incident sparked national attention when a woman, who identified herself as a nurse, told the 9-1-1 dispatcher that her company’s policy prevented her from performing CPR. The dispatcher implored the nurse to find someone else to perform CPR and said she would provide instructions on how to do it, but the woman refused based on policy.

The bill states that employers shall not adopt or enforce any policy prohibiting workers from voluntarily providing medical services, such as CPR. It does not require or imply that employers should be responsible for training their employees on emergency medical services or CPR.
evacuated, and nearby streets were closed for several hours.

Swatting involves making hoax emergency telephone calls in order to elicit an armed police response (from a SWAT team) for the purpose of harassing someone believed to be at the specific location responders are sent.

**FBI publishes annual crime statistics report**

Agencies participating in the inaugural National Incident-Based Reporting System (NIBRS) statistical record, released by the FBI, reported 4,926,829 incidents that involved 5,643,241 offenses, 5,946,990 victims, and 4,483,142 known offenders in 2011.

Of the reported offenses, 65.4% involved crimes against property (i.e., those crimes in which the object is to obtain money, property, or some other benefit), 23.4% involved crimes against persons (i.e., crimes whose victims are always individuals), and 11.2% included crimes against society (i.e., typically “victimless crimes” that represent society’s prohibition against engaging in certain types of activity, such as prostitution or gambling).

The victim of an offense may be an individual (and can include a law enforcement officer), a business, an institution, or society as a whole. In 2011, NIBRS reported 4,305,708 victims who were individuals. Of these, 29.0% were the victims of larceny/theft offenses and 28.5% were the victims of assault offenses; these two offense categories had the highest number of victims.

Considering age among individual victims, 24.6% were between 21 and 30 years old. Fifty-one percent were female and 48.3% were male.

The majority of reported victims were white (72.5%), followed by African American (21.6%), Asian/Pacific Islander (10%), and American Indian/Alaskan Native (0.4%). Race was unknown for 4.4% of victims.

In 2011, a total of 5,880 law enforcement agencies in the nation, representing coverage for over 87 million inhabitants, submitted NIBRS data. The majority of these reporting agencies (51.7%) were located in cities with fewer than 10,000 inhabitants.

The BLS also reports that California was the highest-paying state for 9-1-1 operators in May 2011, and workers in the state made $55,070 a year on average. Workers in Nevada earned $52,770 on average, and workers in Oregon, Washington, and Illinois earned $46,430 or more on average. Texas employed the highest number of 9-1-1 dispatchers of any state, and workers in Texas earned an average annual income of $32,690.

**Bureau of Labor Statistics releases dispatch income figures**

The United States Bureau of Labor Statistics (BLS) reports the average annual income of police, fire, and ambulance dispatchers was $37,460 in May 2011 (the most recent statistics available), while the median average (exact middle of the pay scale) was $35,930.

During this same year (2011), the personal per capita income in the United States was $41,560.

BLS data show 9-1-1 operators in the top 10% in terms of annual income earned more than $55,640 in May 2011, while workers in the bottom 10% made less than $22,700. Workers in the middle 50% in terms of annual earnings made between $28,240 and $45,120. Discrepancies in annual income can be caused by factors such as years of job experience and overtime.

According to the BLS, local governments employed 80,610 dispatchers in May 2011, and those workers earned an average annual income of $37,790. Dispatchers employed by other ambulatory healthcare service companies earned $32,200 on average; workers employed by state governments earned $41,190 on average, and those employed by universities, colleges, and professional schools made $35,580 on average.

Similar to the International Academies of Emergency Dispatch® (IAED®), the Cardiac Arrest Registry to Enhance Survival (CARES) is interested in tightening the many links connecting the chain of emergency care.

And again, similar to IAED initiatives, the data CARES collects—at least a portion of it—comes from some of the most reliable resources around: 9-1-1 computer-aided dispatch system administrators who have signed participation agreements to enter into the CARES’ database three data elements (time of call, ambulance dispatch, and ambulance arrival) for each event, with events being matched based on date, approximate time, and location.

Grady Emergency Medical Services, Atlanta, Ga., which uses the Medical Priority
Dispatch System™ (MPDS®), was a pioneer in the program, collaborating with the Emory University Department of Emergency Medicine to develop an out-of-hospital cardiac arrest registry in the city of Atlanta. Key elements included tracking EMS response times, including receipt of the 9-1-1 call, dispatch of the ambulance, and on-scene arrival of the ambulance.

During the first eight years of the program (2004–2012), more than $2.6 million in federal funding was invested in the public health surveillance registry allowing it to grow from one community (Atlanta) to eventual national participation and international collaboration. On Oct. 1, 2012, CARES transitioned from its oversight by the Centers for Disease Control and Prevention (CDC) to a private funding mechanism.

The registry has expanded to 40 participating communities in 25 states, as well as nine state-based registries (Arizona, Delaware, Hawaii, Illinois, Minnesota, North Carolina, Pennsylvania, Utah, and Washington).

Out-of-hospital cardiac arrest is the leading cause of death among adults in the United States, killing approximately 325,000 individuals each year, the majority of whom die before reaching the hospital.

According to information from the CARES website, EMS dispatchers who can quickly take control of the call, assess the situation, and engage the caller in lifesaving actions are a crucial link in the chain of survival. According to the American Heart Association (AHA), the recommendation is for dispatchers to initiate bystander CPR within one minute during potential cardiac arrest calls.

Organization wants 9-1-1 to find place in wireless age

Interested in joining hundreds of emergency responders, 9-1-1 dispatchers, and others concerned about helping first responders find people in an emergency?

Then Find Me 911 might be for you.

Find Me 911 is an effort supported by more than 125,000 individuals and national and local organizations recognizing the critically important public safety need to ensure that 9-1-1 works in today’s wireless age. And despite the fact that the majority of 9-1-1 calls originate from mobile phones, the Federal Communications Commission (FCC) has no location requirements for mobile calls—and this is probably a little-known fact—placed indoors. According to facts available from Find Me 911:

- The FCC estimates that of the roughly 240 million 9-1-1 calls placed each year, 70% are now placed from wireless phones.
- At least 50% of all wireless 9-1-1 calls originate indoors, according to industry estimates.
- Nearly one-third of households in the United States are wireless-only, with no landline, making them totally reliant on wireless phones during emergencies.

Find Me 911 plans to take several actions in the coming weeks and months to push the FCC into moving forward quickly to establish a reasonable, measurable level of location accuracy for emergency calls made indoors using wireless phones.

The CDC recommends a yearly flu vaccine for everyone six months of age and older as the first and most important step in protecting against this serious disease. While there are many different flu viruses, the flu vaccine is designed to protect against the three main flu strains that research indicates will cause the most illness during the flu season.

In addition, there are preventative measures to take, including staying away from sick people and washing hands to reduce the spread of germs. People sick with the flu should stay home from work and school to prevent spreading influenza to others.

Flu activity commonly peaks in the U.S. in January or February. However, seasonal flu activity can begin as early as October and continue as late as May. The CDC collects information in five categories from eight different data sources to:

- Find out when and where influenza activity is occurring
- Track influenza-related illness
- Determine what influenza viruses are circulating
- Detect changes in influenza viruses
- Measure the impact influenza is having on hospitalizations and deaths in the United States.

Flu season never skips a year

There’s nothing certain about the flu season, except that the best way to prepare requires the two “Vs”: vigilance and vaccine.

The Centers for Disease Control and Prevention (CDC) states that while flu seasons are unpredictable in timing and strain, everyday steps and the annual vaccine can help people avoid the worst of it.
Shanghai’s changes in emergency medicine include dispatch

A change in the way Shanghai, China, handles medical emergencies can only mean the medical protocols are not far behind in dispatch response.

An increasing number of nonemergency calls is behind the Shanghai medical move that replaces doctors on many of the ambulance runs with less-intensively trained medical staff and—in the Academy’s interest—gives emergency dispatchers more decision-making influence.

Part of the solution comes from Shanghai’s first-ever paramedic program that will replace doctors with less-intensively trained personnel on ambulances transporting patients home from the hospital; nurses will be on board in patient transfers between hospitals. The Shanghai Medical Emergency Center, however, will continue to staff doctors on ambulances responding to emergency calls.

In the past, no ambulance went out without a doctor, which included nonemergency trips. The system led to bottlenecks in dispatching ambulances to actual emergencies, and it was a problem exacerbated by the increasing percentage of nonemergency calls, which in 2012 was at 40%.

In addition, the Shanghai Medical Emergency Center will consolidate nine existing emergency dispatch centers into one; the dispatchers will answer all emergency calls from one location and have the discretion to decide the district responsible for sending an ambulance.

“The new measure aims to ensure that ambulances staffed with doctors are sent only to people with real medical emergen-
The Academy’s protocols are used by several centers in China, with the WuXi Emergency Medical Services communication center becoming the first in the country to achieve Accredited Center of Excellence (ACE) status.

Flagged 9-9-9 calls indicate crucial information

When London Ambulance Service (LAS) medics respond to a 9-9-9 call at a flagged address, they carry out a risk assessment—either for guiding management of patient care or deciding whether it’s safe for responders to enter.

Patient care management—the newest 9-9-9 flag added to the system—provides the control room and ambulance crew with vital information about a palliative care patient, including patient wishes not to be resuscitated (DNR) in case of an emergency. The way it works, a flag is raised—metaphorically speaking—at the point the control room receives a 9-9-9 call placed from an address of a Coordinate My Care (CMC) registered patient. LAS has secured patient/family permission to access more than 7250 patient records.

According to the article “Coordinate My Care from the perspective of the London Ambulance Service” (London Journal of Primary Care 2013;5:111-12), The LAS clinical support desk staff in the control room access CMC records and send a message about the patient to the ambulance crew. Once the crew arrives on scene has assessed the patient, CMC information is used to make decisions regarding treatment, referral, or conveyance. In April 2013, 67 records were shared with crews on scene. Work is under way to develop a Web interface that will enable address “flags” for new patients, alter the records of existing patients, and automatically update records within LAS command and control systems every 12 hours.

Another flag that has been in place in the control room provides cautionary messages to crews arriving at addresses where response scene safety is in question. However, responders only delay treatment if they believe they are in danger at the time of the call.

Risks include people with a history of violence and aggression toward ambulance staff, addresses with dangerous animals or weapons, and patients with psychiatric or alcohol-related conditions and mental health disorders.

According to Ambulance Operations Manager Athar Khan, at least one member of staff is attacked every day in London and at least two are verbally abused. Last year, 451 medics reported a physical assault and 737 were verbally abused as they responded to emergency calls.

“We have a duty to protect our staff and let them know if they’re about to be sent into a potentially violent situation,” Khan said. “We have to balance the need to protect our staff and the need of the patient.”

Protocol helps protect mine workers in Brazil

6,000 fire and EMS calls per year
10,000 employees
Two calltakers/dispatchers on duty 24/7

Now spread that over more than 226,400 square miles (three times the size of Nebraska, the 16th largest state in the U.S.), 10 mine locations, very hazardous conditions, and a round-the-clock operation.

What do you get?
“A challenge,” said Ross Rutschman, PDC™ medical and fire consultant.

Let us introduce you to the Vale Mines communication center, the first EFD user and the second EMD user in Brazil.

Vale is a multi-national diversified metals and mining company—considered the world’s second-largest mining company—controlling over 85% of Brazil’s 300-million ton annual iron ore production.

A call to Brazil’s 1-9-3 emergency number from inside the boundaries of any of the 10 mines is answered by EMDs and EFDs at the Emergency Management and Communication Center (CECOM), in Itabira, Minas Gerais, Brazil. Itabira is in the mountainous geological area known as the “Iron Quadrangle,” and characterized by large quantities of iron ore deposits, mined by Vale since 2000.

Although CECOM is not new to the complex, the center went live with the Medical Priority Dispatch System™ (MPDS®) and the Fire Priority Dispatch System™ (FPDS®) in August 2013.

CECOM’s calltakers (certified EMDs and EFDs) provide Post-Dispatch Instructions and Pre-Arrival Instructions and send the appropriate response to the scene once determining the location. The agent, who analyzes scene safety and gives first aid, forwards patient and scene information to CECOM, which then mobilizes rescue and transport.

Vale also offers an 800 number for employees to call from their residence any time they should need help, day or night, so they can receive instruction employees wouldn’t receive if they called 1-9-3 outside the company lines.

“The emergency team members are true guardian angels of the operation,” said Julio Yamacita, Vale Mine Operations general manager in Itabira, Brazil, at the time the two protocol systems went live. “This is a noble activity, and everyone can count on the emergency system anytime and anywhere. There will always be someone ready to help.”

Vale’s Emergency Medical System also offers emergency trained groups in each mining complex composed of doctors, technical nurses, and nurses with advanced training, and any employee, contractor, or visitor involved in an accident at Vale can access the system.

Implementation of the protocol systems was concurrent with the fourth anniversary of Vale’s Emergency Medical System.
The patent process can take a long time from start to finish, whether it's granted or turned down.

Brent Hawkins, International Academies of Emergency Dispatch® (IAED™)/Priority Dispatch Corp.™ (PDC™) legal counsel, said, “I’ve never seen a patent take so long.”

Most take two to four years. “This was a tough one. Most take two to four years.”

At least it is a PDC victory for the patent application originally filed on May 7, 2002. The patent protects the “method and system” for linking the Academy's nurse triage system—Emergency Communication Nurse System™ (ECNS™)—and the Medical Priority Dispatch System™ (MPDS®) to a computer-aided dispatch (CAD) system.

The patent awarded to PDC on July 23, 2013, expires in 2023, which is an almost two-year extension of the 20-year life of a patent and granted due to the extended length of review.

So, what’s the big deal?

The ECNS provides alternative care for patients calling 9-1-1 with non-emergent health-related complaints falling within the Academy-approved, low-acuity OMEGA Determinant Codes; the patent applies to the link making ECNS a seamless process for the caller, the communication center, and the Academy-certified Emergency Communication Nurse (ECN).

Basically, ECNS is the Academy's answer to providing quality care while, at the same time, preserving resources better spent on higher-level emergencies. For example, a caller might dial 9-1-1 with a complaint symptomatic of a mild case of flu; rather than sending an ambulance, the calltaker—

with caller permission—transfers the caller to the center’s ECN. The ECN asks the caller further questions, with the answers driving a search through 212 medical protocols that are powered through the software application LowCode™.

Based on this structured assessment, the ECN provides a Recommended Level of Care from the 22 built into the system. These include scheduling an office visit with the caller’s primary care provider, seeking a walk-in clinic for care, poison control, community crisis lines, or connection to a medical provider for advice and self-care instruction.

The “seamless interface” is unique among triage systems, and it's a “one-of-a-kind” for emergency communications, said Richard Saalsaa, a principal architect in the PDC nurse triage software.

The ECN can transfer the call back to the 9-1-1 calltaker at any time if, for example, the patient’s condition deteriorates and the ECN determines an elevated level of response is required or the patient has downplayed symptoms that are actually indicative of a more serious condition.

“Think of the classic 50-year-old male who has been having vague pains in his body, but feeling fine enough to call a nurse advice line,” Saalsaa explained. “The health professional could pick up on symptoms of an impending MI and get the individual to a hospital for evaluation using the MPDS process, since the link is in place to safely transfer care.”

At any time during the call, the patient can request and receive ambulance transport despite a low-acuity prognosis.

The interface also represents the continued evolution of the MPDS nurse triage system.

Montreal, Canada, in its first adoption of the MPDS Omega Protocol, was a manual sys-
tem, allowing the physician’s staff to assess patients who were considered low-acuity (OMEGA) candidates based on questioning at Case Entry.

“There was no seamless integration and process in place to effectively gather the information,” Saalsaa said. “They basically had to start from scratch.”

U.K. ambulance services were looking for a comparable approach for treating low-acuity calls, but, similar to the Montreal system, were without a structured process to assist patients meeting the OMEGA criteria. Saalsaa came up with the solution.

Several years ago, the ability to forward and return the caller without interruption was noted as a preeminent feature in the application during patent negotiations.

“This was clearly an interface that was needed; [it is] unique,” said Jerry Overton, IAED Clinical Advice Board chair. “No one had anything like it.”

Overton was chief executive officer of Richmond Ambulance Authority (RAA) in Virginia, which, at that time, was piloting a Community Health Access Program (CHAP) that used computer software triage protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse. CHAP relied on the MPDS protocol for routing apparent low-acuity calls to a nurse.

Data screened during the 15-month pilot program showed outcomes were not adversely affected. The software-suggested disposition guided by the nurse was effective and verifiable. RAA went live with the program in 2006.

Saalsaa never doubted the veracity of effective nurse triage.

“I was clear from the onset that this would revolutionize a gap that existed in 9-1-1-type call centers,” he said. “It was a question of what to do with patients who clearly have no actual emergency. The MPDS Omega Protocol opened the door for this invention.”

Saalsaa, who authored the patent application originally filed on May 7, 2002, attributes the 11-year wait, at least to some degree, on the difficulty patent officials had seeing the forest for the trees.

“Interestingly enough, most of the hurdles were to uniquely distinguish this from our own patented systems for the MPDS,” Saalsaa said. “It took some educating of the patent officials to see the distinctions of the patent as being unique.”

The ECNS is the Academy’s fourth pillar of care. A center must be an Accredited Center of Excellence (ACE) to offer ECNS to its 9-1-1 callers.

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**The Deciding Factor**

**Chief Complaint or specific diagnosis**

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**Brett Patterson**

Brett:

I have a couple of questions for you regarding the protocols.

After debate, review, discussion at the Dispatch Review Committee meeting, and research, I’ll put this simply. Caller states epigastric pain during Case Entry after “Okay, tell me exactly what happened.” The caller states he is a diabetic, was vomiting in hospital the night before, has an ulcer, and has esophagitis. The first complaint was epigastric pain.

The EMD, who usually is 100% compliant in everything, chooses Protocol 26: Sick Person (Specific Diagnosis), and I lowered his performance measurement for Chief Complaint selection. I said he should have gone with abdominal pain, as epigastric is medically defined as upper abdomen (not to mention there is a rule mentioning epigastric pain within the abdominal pain protocol). The EMD originally contended that he didn’t consider epigastric pain abdominal pain; however, he has since conceded after we reviewed multiple sources defining it as such.

His question at this time is: “Does the patient providing a specific diagnosis (esophagitis) affect the Chief Complaint selection?” He argues that the lack of a protocol for esophagitis determined his selection of Protocol 26. I counterargue that the symptom epigastric pain (aka abdominal pain) was reported after “Okay, tell me exactly what happened,” so the symptom we are currently dealing with is abdominal pain. Could you clarify whether the specific diagnosis has a bearing or not?

Jeffrey D.M. Liskin
Training and QA Coordinator
Litchfield County Dispatch, Inc.
Torrington, Conn., USA

Jeffrey:

When a diagnosis other than diabetic problem or stroke is offered in response to Case Entry Question 3, the EMD should attempt to obtain a more specific Chief Complaint description by repeating “Tell me exactly what happened!” Even in diabetic or stroke cases, the Chief Complaint description helps to confirm the reason for calling. While it is true that Protocol 26 is subtitled “Specific Diagnosis,” the protocol should only be used when a specific sign or symptom cannot be obtained at Case Entry.

In your case example, the caller did offer a specific symptom (epigastric pain). From your description of the EMD’s thought process in the selection of Protocol 26, it appears that the patient’s recent history of vomiting and diagnosis of ulcer and esophagitis influenced the Chief Complaint Protocol selection, rather than the presenting symptom. Ultimately, this ‘diagnosis’ of the epigastric pain by the EMD may have been correct; however, the Medical Priority Dispatch System (MPDS) is not designed to be diagnostic, but rather to base response and pre-arrival care on presenting signs, symptoms, and/or events. In this case, the protocol selection should have been made based on the
complaint of epigastric pain and, if that term was not understood by the EMD, the EMD is obligated to ask for another description of the pain.

Overall, this seems like a well-intended error in protocol selection by an otherwise excellent EMD, with a resolution of simple education.

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

Brett:
This is a situational protocol compliance question.

Caller reports diabetic unconscious breathing, 13-D-1. The only Key Question (KQ) asked during KQs is, “Is he breathing normally?” Answer = Yes. The EMD chose the unconscious pathway and entered Pre-Arrival Instruction (PAI) Protocol C: Airway/Air/Arrest/Choking (Unconscious)

IEM – Adult ≥ 8 Yrs. The EMD did not give the first instruction, “Are you right by him now? ...”, and went directly to C-16, which is “Maintain and Monitor.”

I did not see how the EMD could have gotten to C-16 without giving the PAIs, so I lowered his performance measurement for a major PAI deviation and told him we could discuss it. He brought to my attention that the “maintain and monitor” was available within PAIs in ProQA®; however, this was not a DLS Link within the manual cardsets. He selected “maintain and monitor” because he considered the patient to be breathing normally as assessed in KQs. I told him I didn’t think he could do that, but I would find out.

My thinking is that we need to lay the patient flat on the back and reposition the airway to properly assess normal breathing.

Is there a rule that elicits the use of the “maintain and monitor” in this situation? What is the intended purpose of having that link within C-1 in ProQA, and how is it to be used correctly? Your thoughts and insight on this would be greatly appreciated.

Jeffrey

Jeffrey:
C-16 (and the associated ProQA button in PAIs) is a “free-floating” panel to be used AFTER a medical or ineffective breathing trauma patient’s airway has been opened in previous panels; the EMD is somewhere else in the pathway and the patient’s breathing has been deemed effective.

Please note that the instruction begins with “… make sure her/his head is tilted back …”, which implies this instruction has already been given. This could occur either coming from Panels 15a or 17 (most often), or perhaps after the EMD has done an agonal breathing diagnostic test somewhere else in the sequence and breathing has been determined to be effective (airway already opened), i.e., after starting CPR the patient starts breathing effectively. It was added as a “free-floating” panel (use when needed) because this can happen anytime during the sequence and, also, it provides an instruction when a healthcare professional is telling the EMD that the unconscious patient is breathing effectively.

With that said, I would commend the EMD for his thought process and for noticing the availability of this ProQA feature. It is understandable that the availability of this ProQA “button” may be confusing in the sequence but this is simply how ProQA deals with “free-floating” panels; they must be available during the sequence.

Like your first question, this is an educational issue.

First, we need to understand the rationale behind an important Rule in the MPDS: “The airway of an unconscious patient must be constantly maintained.” The positioning of the caller who has one hand under the neck and the other on the forehead enables constant monitoring for patients who cannot maintain their own airway and prevents the caller from leaving the patient.

Second, “free-floating” panels in the MPDS, which are designated by green or red title bars in the cardset, are to be used when events happen out of sequence, i.e., patient vomits (Clear Airway) or patient starts breathing (Breathing Evaluation).

I hope these responses answer your questions and serve to aid your QI process.

Brett

Brett:
These responses were extremely helpful and insightful. I feel that you’ve helped clear up quite a bit of confusion and misunderstanding. Thank you for taking the time to respond so thoroughly.

Jeffrey
training, certification, and compliance officer for Maine’s centralized 9-1-1 system.

And that can be to an agency’s distinct disadvantage.

The ADA defines “disability” and distinguishes between what’s included and what’s not in the definition.

For example, ADA covers a person with a disability that limits major life activities such as hearing, walking, and speaking; the law does not protect a person with a prison record or quick temper (without a documented psychological condition), despite potential consequences for that individual regarding employment.

The ADA outlines the accommodations an employer can make for the individual to accomplish the job’s essential functions.

For example, a person with a documented life-altering disability may request—and receive—modifications to the physical workspace, revised training programs, and a break from full-time work schedules to part-time. An employer is required to accommodate a known disability of a qualified applicant or employee, but is not required to make accommodations for situations the employer might anticipate, although at the time, don’t exist.

There are plans an agency can put in place, however, that protect an employer in the hiring process and help the applicant determine if the job is suited to interests and abilities. Many elements in the process work the same way they do in the overall employment process.

For example, while the ADA does not require job descriptions, written job descriptions do establish what the person must be able to accomplish on the job; an employer should be sure to describe the job’s essential functions completely, objectively, and in enough detail to support why they are important to the overall job duties, Bunker said.

“Job descriptions are the unsung task that gets the little bright blue star,” Bunker said. “You don’t have to have them, but it sure helps potential applicants decide whether they can meet the job’s requirements.”

Maine’s 26 PSAPs use the same application that’s been “tweaked” according to the specific needs of that agency, generated from a statewide job task analysis (JTA) for the position of dispatcher/calltaker.

Bunker also recommends an employer ask qualified applicants for a dispatcher or calltaker job to sit at a console prior to a formal interview. Since an employer cannot ask whether a person has a disability—even if the disability is obvious—or needs accommodations, the chance to observe the job in action gives applicants a window for a decision and invites a “two-way” dialogue.

If the qualified applicant hired requires accommodations, the request and reason for the subsequent modification must be kept confidential and, as Bunker recommended, ADA training for dispatchers, calltakers, and their supervisors should include issues that must not be disclosed or discussed openly.

“You must be very cautious about disclosing any information because of the potential damage it could cause the agency and individual,” he said. “Any harassment must be nipped in the bud. That can only lead to bad feelings and retaliation.”

The accommodation doesn’t have to break the bank, either. An employer can’t use dollars as a defense, although the employer has a final choice among the appropriate accommodations available. An employer, for example, can pick the $350 multitask chair rather than the chair that costs double, as long as the less expensive model meets the individual’s requirements for modification. An employer is not required to make an accommodation if it would impose an “undue hardship” on the operation of the employer’s business.

Bunker said he could easily fill a weeklong workshop with the amount of information he has learned from studying the ADA in preparation for NAVIGATOR and serving as a member of the Maine Commission for the Deaf, Hard of Hearing, and Late Deafened.

“I’m a proponent of ADA,” he said. “But there are many parts of the law an agency should know because there are parts that make it a specialty all its own.”

About the speaker: Stephan M. Bunker recently retired from the Maine 911 bureau where he was the manager for statewide dispatcher training and certification. He now consults for police and fire dispatch training (Maine 911 LLC). The recipient of the 2012 Dr. Jeff Clawson Leadership Award, he is also an IAED™ instructor for ETC, EPD, and EFD in the U.S. and Canada. Contact him at stephan.bunker@gmail.com.
All Aboard
Take a mentor along for the ACE ride

Audrey Fraizer

St. Joseph County Fire Dispatch is the little center that did.

Reminiscent of the popular children’s book, The Little Engine That Could, the center in South Bend, Ind., relied on optimism and hard work to reach what might seem an impossible obstacle for a center of its size.

Repeating the little blue engine’s famous words, “I think I can, I think I can”—at least, perhaps, under their breaths—the 15 dispatchers, Dispatch Director Coni McCloughen, and Operations Manager Nancy Lockhart were able to turn the mantra into “We did it, We did it, We did it” in a relatively short eight-month haul.

And all it took, aside from the “I can” attitude, was a little help from their friends.

“We didn’t want to recreate the wheel, and we were looking for someone to offer to help us through the process,” said Lockhart, who is quite proud of the fact that their center is the “first and only” Medical Accredited Center of Excellence (ACE) awarded in the state of Indiana (on Nov. 11, 2012). “We contacted Susi Marsan, and she gladly accepted.”

Marsan, training coordinator for Grady EMS communications, and Betsy Cobb, Grady EMS quality assurance coordinator, had actually made the “all points” offer after achieving the same goal a year earlier and coming on stage to accept the award at NAVIGATOR 2012. At the same conference, Marsan and Lockhart co-presented sessions relating to training and emotional recovery in a stressful profession. McCloughen co-presented two sessions at NAVIGATOR 2013.

But not everyone interested in pursuing ACE goes to NAVIGATOR, and not everyone knows someone with ACE experience.

“That’s why we decided to put Grady out there,” Marsan said. “Not everyone has the same opportunities, and we believe it’s important to mentor those who want to achieve ACE but [who are] without the benefit of attending the workshops.”

Aside from ACE and everything that goes with the accreditation, St. Joseph County Fire and Grady EMS have little else in common, demographically speaking.

Grady EMS is the hospital-based emergency care component of Grady Health System; it provides basic and advanced life support emergency ambulance services to any resident and visitor within the city of Atlanta—approximately 134 square miles. With a fleet of 46 ambulances and a staff of 300, Grady EMS has provided EMS services for 120 years.

The Grady EMS communication center is a secondary Public Safety Answering Point (PSAP), and it receives more than 120,000 emergency calls per year processed by two dispatchers, four calltakers, and one supervisor per shift on a 12-hour rotating shift. The PSAP moved to an upgraded facility in February 2011. They use the Medical Priority Dispatch System™ (MPDS®) and are one of four ACEs in Georgia.

St. Joseph County Fire Dispatch is a secondary PSAP serving unincorporated South Bend, which comprises about 400 square miles and provides fire and medical dispatch to 108,000 residents. The center receives an estimated 13,000 emergency calls per year processed by three dispatchers on first and second shifts and two dispatchers on the night shift. They use the MPDS and the Fire Priority Dispatch System™ (FPDS®).

The communication center is located in Clay Fire Territory Station 2, built in 1962 and remodeled in 1998. Station 2 (renamed to Station 22 in 2013) is one of five fire stations in Clay Territory, and houses the fire chief.
operations chief, fire marshal, division chief of EMS, training officer, deputy fire marshal, and—since 1982—the 19-foot by 24-foot space allocated to dispatch. Prior to establishing a dedicated dispatch center, calls were answered in a funeral home and forwarded to a volunteer fire department for response.

The dispatch center introduced the MPDS in 1994 at a time when county police dispatchers answered medical calls. It offered a measure of preparedness, especially for the self-reliant population of rural South Bend, Lockhart said.

“We don’t have minor calls,” she said. “Our calls involve very sick people. Around here, they don’t want to rely on public services for help, preferring to fix things on their own.”

Five years later, St. Joseph County Fire assumed control of ambulance/EMD dispatch in unincorporated parts of the county, and the state has since mandated certification for all emergency medical dispatchers. ACE was always on their “to do” list but it wasn’t until NAVIGATOR 2012 that Lockhart and McCloughen dug in their heels.

“We wanted to do it right,” she said.

St. Joseph County Fire had questions ready: where to start, how to get people on board, and how to keep the momentum going throughout the process. Lockhart and McCloughen didn’t need their hands held through the process, but more-or-less wanted a kick-start and someone reliable to go to, if necessary. In other words, their center closely mirrored the resourcefulness of the residents under their jurisdiction.

Cobb knew St. Joseph County was in the same position as Grady EMS had been eight months earlier; that being brand new to the ACE process, beginning the very first point of the 20 needed for accreditation, and with the same aspiration to be “above and beyond” in their commitment to the public.

The best approach was showing St. Joseph County Fire the Grady EMS ACE binder—the point-by-point documentation for the 20 Points of Accreditation, a real page-turner for ACE aspirants. Since much of the information is not meant for eyes outside of Grady EMS, Cobb had legal draw up a confidentiality statement. She also provided suggestions for motivating personnel.

“There are a lot of changes over a short period of time, and you have to make it a great experience for your center,” Cobb said. “At Grady, we had moved into a new center and had the new version 120 (MPDS) to get up to speed. We made sure our people were involved from the start. Everybody had a part.”

Cobb and Marsan held countless training sessions with their staff, and Cobb relied upon inexpensive and creative awards, such as $5 bills in helium balloons (out of pocket), gift cards, casual dress days, and added longer breaks during which Cobb would work for the dispatcher during his or her time away from the console.

They offered their “success tips,” advice, and cheerleading abilities to McCloughen and Lockhart.

“We made ourselves available,” Marsan said. Lockhart was amazed at their level of help and encouragement.

“Their support and their ‘you go guys’ were really helpful,” Lockhart said.

St. Joseph County Fire put together an award system: designing their own T-shirt contests, cooking challenges, rides with the fire department, and posting the names of QA “superstars” on a magnetic board. Dispatchers were involved from day one; after all, Lockhart said, “It is about their work. It’s about what they do daily.”

They studied the Grady EMS 20 Points binder; followed the recommendations of Ivan Whitaker, the IAED™ QA task force member assigned to evaluate the 20 Points submitted by St. Joseph County Fire; and listened closely to Kim Rigden-Briscall’s NAVIGATOR talk “How to Impress Your Board of Accreditation Reviewer.”

“They were a tremendous help,” Lockhart said. “They made sure we stayed moving in the right direction.”

St. Joseph County Fire celebrated its ACE at a combined firefighter/dispatch Christmas party. They produced a video, highlighting what ACE means to the center and individual dispatchers.

McCloughen attributes their success to the ones who made it happen.

“This is a compliment to them, and they wear it like a badge of honor,” she said. “They’re proud to say what they do for the public.”

Lockhart said the process wasn’t easy, although “rightfully meticulous,” considering the significance and what ACE represents for the public. Her advice to others in the running for ACE?

“Find a strong mentor,” she said. “Susi and Betsy were invaluable.”

Marsan said the offer to mentor still stands, although she is not quite sure where the offer will take them, or how many might take them up on it.

“We really didn’t know what we were getting into,” she said. “But it’s the right thing to do. We’re here to help.”

Accredited Centers of Excellence

**EMD Re-ACE**
14 City of Miami Department of Fire & Rescue; Miami, Fl., USA
29 El Paso County Sheriff’s Office; Colorado Springs, Colo., USA
48 M.D. Ambulance Communications; Saskatoon, Saskatchewan, Canada
53 Citrus County Sheriff’s Office; Inverness, Fl., USA
54 REMSA (Regional Emergency Medical Services Authority); Reno, Nev., USA
79 Rehoboth Beach Police Department 9-1-1 Center; Rehoboth Beach, Del., USA
92 American Medical Response – Oregon Communications; Portland, Ore., USA
111 Montgomery County Hospital District EMS; Conroe, Texas, USA
114 Raleigh Wake 911; Raleigh, N.C., USA
134 Guilford Metro 911; Greensboro, N.C., USA
140 Cape County Private Ambulance; Cape Girardeau, Mo., USA
141 Metropolitan Area Communications Center Authority; Centennial, Colo., USA
142 Salt Lake City Department of Airports; Salt Lake City, Utah, USA

**EFD Re-ACE**
4 Mecklenburg EMS Agency; Charlotte, N.C., USA
17 City of Hialeah Public Safety Communications Division; Hialeah, Fla., USA
Stress

Emotions
- Alienation
- Irritability
- Apathy
- Low Confidence

Behavior
- Accident-Prone
- Loss of Appetite
- Restless
- Smoking and Alcohol

Mind
- Anxiety
- Hasty Decisions
- Negativity
- Impaired Judgment

Body
- Headaches
- Skin Problems
- Breathless
In Pursuit Of A Blueprint For 9-1-1 Wellness

Resilience takes more than ignoring the stress

Jim Marshall

The history of our nation’s failure to care for our warriors returning from war is hard to face. Even now we are playing a dangerous game of catch up—even as researchers have finally begun connecting the dots between escalating rates of service-related post-traumatic stress disorder (PTSD) and suicide. But in case you are assuming I am anti-military or a pessimist about to blather on critically, let me offer some assurance: I am not a pessimist or an extremist on a rant. In fact, I’ve been accused more than once of being a “psychotic optimist.”

But my dogged optimism and bent toward hopefulness is well founded—a gift from my courageous trauma clients. Over the years as a mental health clinician, I have witnessed so many survivors fight their way through horrendous memories and rise like a phoenix from the ashes. The point in bringing up our nation’s abysmal shortcoming in recognizing and treating our warriors’ PTSD is that we will repeat this failure in the 9-1-1 community if we don’t systematically evaluate and proactively address the impacts of 9-1-1 stress on our front-line telecommunicators.

The problem is real

In Roberta Troxell’s 2008 study of 497 Illinois telecommunicators, 16.3% acknowledged symptoms consistent with Compassion Fatigue (CF)—a condition in which a person experiences struggles with traumatic stress symptoms and burnout. In 2012, former dispatcher Heather Pierce and Northern Illinois University researcher Michelle Lilly released widely publicized findings from their study of telecommunicators, indicating significant heightened risk for PTSD among 9-1-1 telecommunicators; in fact, as high as 9–10% of their subjects reported symptoms consistent with PTSD.

The good news

We are making progress in safeguarding our 9-1-1 pros’ resilience in the face of traumatic stress, but we’ve only just begun and our long-term success will require stakeholders from all sectors to join in building what I call a Blueprint for 9-1-1 Wellness in the Next Generation PSAP.
Let me offer in a nutshell the gains we’ve made so far, where we need to go from here, and how you can help.

In 2010, the National Emergency Number Association (NENA) launched the NENA Working Group on 911 Stress. NENA leaders joined by mental health professionals and representatives from APCO International, the APCO Institute, the U.S. government, and the commercial sector all chose to acknowledge and take responsibility for facing the 9-1-1 stress risks revealed by Troxell, Pierce, and Lilly. The result was realized on Aug. 6, 2013, when the NENA Executive Board approved the new Standard on 9-1-1 Acute/Traumatic and Chronic Stress Management.

The adoption of this standard is promising; it represents a major first step for the 9-1-1 industry toward fostering 9-1-1 resilience, optimal well-being, and health-driven performance. Now our nation’s PSAP leaders must implement the standard and that will require active and expert support.

Anticipating this need, the 911 Wellness Foundation (911WF) was established in 2011. It is devoted exclusively to ensuring the mental (and physical) health of our 9-1-1 professionals. Subject Matter Experts (SME) from 9-1-1 and the mental health field joined together to advance resilience research, education, policy, and intervention. In support of the 911 Wellness Foundation’s work, the IAED™ Board of Trustees has established a formal alliance between the two agencies.

**Next steps**

The IAED has guided a systematic evolution of dispatch from an unstructured, medically uninformed practice to a research-driven science. 911WF is in the early stages of a similar task-contributing science to advance 9-1-1 resilience and wellness. The Model for Evaluation and Achievement of 9-1-1 Wellness (see Figure 1) is one of many tools providing a rigorous methodology to achieve this task. The model implies that by evaluating needs and ensuring resources to address them, PSAP leaders can empower telecommunicators to assume full personal responsibility for their wellness.

In Figure 1, we can see that there are two pure stressors, two pure buffers, and four work “variables”—aspects of work that can serve either as stressors or stress buffers depending on how they are shaped in relation to six conditions. To ensure optimal well-being or “wellness,” we must systematically manage conditions by counteracting stressors and optimizing buffers and variables.

Planning effectively for optimal 9-1-1 wellness also involves answering specific questions. For example:

- What is the status of Condition 1 pertaining to Stressor (A or B), and how can we optimize this condition to buffer the stress?
- What is the status of Buffer (A or B) and how can we optimize this buffer?

With such a quick first immersion into The Model for Evaluation and Achievement of 9-1-1 Wellness, you might feel as if you were pitched in a dump tank and then dangled over the edge of the Grand Canyon by your belt loop. It’s a lot to take in all at once without more explanation. But the model is introduced as an example of one key tool offered by 911WF to help 9-1-1 stakeholders carefully evaluate 9-1-1 stress. By joining together using such tools, we can build a Blueprint for 911 Wellness that will ensure the health and performance of the very first responder in the Next Generation PSAP.

**Sources**

Plan B
When the other stuff doesn’t work

Dr. Lori K. Gray

Dispatchers commonly ask me how to cope when healthy eating, restful sleep, exercise, and work-life balance aren’t enough to help. In other words, how can we persevere and thrive when our capacity for caring becomes overwhelmed or depleted? What do we do when the other stuff doesn’t work? Let’s break this down based on reasons why this happens.

Human suffering and cruelty

We have the privilege of experiencing humanity at its truest level, at its finest and cruelest moments. We learn that there is no limit on what one human being can do to another, which is reflected in phrases like: “Only the good die young” and my favorite from policing—“No one is truly innocent.” The challenge of weighing the best- and worst-case scenario to arrive at a more “realistic” perspective doesn’t work for us.

It is important to consider not just the traumas but also the moments—the moments that are the reason why you do what you do and that carry you through what you do, regardless of whether it’s your best or worst call. A violent crime in which a little girl and her parents survive but all other kids died and the girl says in a humble voice, “Thanks for helping me keep my mommy and daddy.” Or the elderly gentleman who found his wife deceased due to natural causes and asks, “What do I do? She was my everything!”

It’s not about a pat on the back. It’s about aspiring to have the strength that those people had. We need to think not just about the stressors but also the moments, and the moments are much too easy to miss.

When the toolkit runs out

Through my experiences working in inner-city Detroit with victims of torture and horrendous sexual assaults, I learned that we have to develop a comfort in being there with people. This is how we help when our toolkit runs out. Never underestimate the comfort and security that you provide by being with someone at their worst moment.

We also need to ensure that our expectations of ourselves are reasonable. Getting a “save” (e.g., resuscitating a cardiac arrest patient who then survives) is not reasonable. The odds are too low and these calls are too infrequent to keep you going. A more reasonable goal is to “increase the odds of survival to the best extent possible.” This is something that we can achieve regardless of whether there are positive/negative outcomes and high-/low-acuity calls.

High frequency of low-acuity calls

Frequent low-acuity calls can be frustrating. We get conditioned to call frequency and acuity and may get bored when those thresholds aren’t met. Perspective works for some—the view that you get paid the same regardless of the call that you’re answering. This doesn’t work for many or when you’ve just taken the pediatric arrest and the next one is for a stubbed toe. Although that isn’t an emergency by my standards, that person is quite lucky not knowing the world as we know it: Where bad things happen to good people and life can end in the drop of a hat.

Saturation

We go through loops: stimulus overload (the initial catch-up as you sit down and get into the groove), stimulus max (on the ball and rolling with the information flow), and stimulus saturation (hitting the wall mentally). Regular breaks are important. Schedule a minimum of two consecutive weeks of vacation time to spend your time catching up rather than recuperating.

The burden of caregiving

It’s part of dispatchers’ character to help; they want to contribute to the greater good. As a result, dispatchers tend to care for others before caring for themselves. When a group of people with these attributes works closely together, we end up with people preferring to deal with others’ problems rather than their own and caring for others to the point of depletion and sensitized to feeling devalued. We need to realize and embrace that you can only care for others in so far as you care for yourself. We need to support each other in doing so.

It’s not “just a job” and we need to be mindful of that in how we care for ourselves and how we look out for each other.

Perspective

A father whose child died—an innocent victim of a random crime—said something that I will always remember. He dropped to his knees and then froze in utter disbelief for what felt like forever until he looked up and said: “I made a mistake. I made a mistake. I assumed that my child would live a long life. I realize now that the only thing in life that is guaranteed is death, not when. My mistake was assuming when.”

That father was absolutely correct. Life is too short to devalue your incredibly important role, to lose sight of what truly matters to you personally and professionally, and to lose sight of the reasons why you show up each day to help others.
How did you become so invested in the issue of 9-1-1 stress and resiliency?

Like many others 25-plus years ago, I came from the old school of public safety stress management: Suck it up and move on. As a field responder, 9-1-1 dispatcher, and calltaker, I got my fair share of mental bumps and bruises and often gritted it out because it was all I knew how to do. I did not know the manifestations of the symptoms related to stress, nor did my colleagues, nor our bosses. We did not talk about it because to talk about it was to acknowledge it. To acknowledge it meant to confront it, and it was easier not to confront something that scared us because we felt we had little control over it (which is difficult when your entire career is built around being able to control situations).

I went over the “burnout” cliff twice in my career and both times scratched and clawed my way back to level ground. It’s in our DNA to put others first, so you keep the lid on that nasty box of memories and experiences and move on to the next situation.

I never lost sight of my personal experiences with stress despite my good fortune of promotion (OK, of being shoved) into Public Safety Answering Point (PSAP) management. I noticed that when employees exhibited behaviors that were out of the norm for them, there was a pattern there, and often, the culprit was stress (which may be cumulative or specific-incident related, or even due to external challenges such as family stressors).

What do you see as the stressors unique to the work of the telecommunicator?

The nonvisual environment is a unique stressor because the telecommunicator combines what is heard (or not heard) and what is said (or not said) into a mind’s eye visual of the situation. Mentally visualized traumatic situations don’t always go away; there’s the inherent risk of situations coming back to mind—the classic “I want someone to hear this” as the caller commits suicide. This may change to a degree if live video is placed in the PSAP, but the majority of requests for service will still be nonvisual.

Another unique stressor is situations when the telecommunicator is essentially handcuffed from being able to assist, even though there is a dire need for intervention and the tools (International Academies of Emergency Dispatch® protocols) are available for changing the outcome. For example, most of us have answered a call from a frantic parent about an injured child, and then the parent drops the phone and, consequently, is unable to follow Pre-Arrival Instructions.

Lack of closure is another PSAP stressor. An intense call can result in emotional and mental baggage compounded by its unknown outcome. More than once, I and other 9-1-1 telecommunicators have checked
the newspaper's obituary section to find out whether the cardiac arrest patient survived.

Exclusion, intentionally or not, from the public safety team is a stressor. While this has improved immensely, there are still occasions after a significant event when first responders are brought in for Critical Incident Stress Management and yet the 9-1-1 telecommunicator taking the initial call is left out.

There is also a tendency for task saturation combined with the lack of downtime. Calltakers and dispatchers are often so busy for extended periods of time that they keep pushing through until they are mentally spent.

What have you seen over the years supporting your concerns of stress in the PSAP?

Outside of my own experiences with compassion fatigue (CF) and burnout in the field and in the PSAP, I saw fellow caregivers who were stellar and model employees go through a spiral of decline in their attitudes to the point where they got terminated from or quit a job that previously had been their dream job. I had one co-worker who kept it bottled inside until making the ultimate cry for help with a self-inflicted GSW to the temple. In retrospect, several co-workers had noticed the multiple cries for help along the way, but no one chose to acknowledge them (which goes back to acknowledgement of what is being exhibited in someone else is acknowledging it in us, so keep the lid on it and ignore it).

On the flip side, I have been in situations in which we’ve recognized early or late signs of burnout and CF and, because we knew what to look for, we were able to get the individual appropriate assistance. Some bounced right back to the console while others left the profession, although at least they left it healthier as opposed to those who compounded the problem of being so burned out and fatigued that it caused them to quit without having a psychological “Yellow Brick Road” to lead them back.

What is leadership’s role in fostering resilience among calltakers/dispatchers?

Our personnel are by far our most valuable resource, and to be an effective leader, you have to take a holistic approach to employee support, which includes recognition of the impacts of stress inside and outside the PSAP. A leader has the responsibility to absorb (and prevent) as much stress as possible with an emphasis on colleagues’ wellness and resiliency.

From research, we realized that burnout is a symptom of CF and that there are ways to intervene and assist the person before he or she hits the wall of burnout.

The secret to resiliency is considering past intangibles compared to current tangibles relative to wellness and job satisfaction. We must acknowledge the good and create an environment of continued support and that it’s OK to ask for help before the situation gets out of hand. For example, how much time is unnecessarily spent supervising an employee who can do the job well instead of mentoring and forming more of a personal co-worker and coach relationship? Chain of command is important, but I would offer that a chain of support and communication is critical to a healthy and resilient 9-1-1 workforce.

Do you think that Next Generation 9-1-1 will add to this stress?

Text messaging will bring stressors, not only the nonvisual nature of the message, but because of limited options to interpret unclear messages. For example, a caller on the phone will have different voice inflections and tones contributing to communications, but with a text there are only words. “Please help me” via texting does not tell us much.

Also, the industry must be wary of the temptation to assume that just because a technology (such as streaming video into the PSAP) is available and “cutting edge,” that it should be automatically integrated into the PSAP without due diligence on the impact (operationally and mentally) to front-line staff.

Done right, there are aspects of NG9-1-1 that could reduce stressors for the 9-1-1 telecommunicator. In any event, the industry needs to welcome and integrate suggestions from front-line personnel and take advantage of the unique and exciting opportunity to incorporate stress management and wellness programs in the PSAP.

Where do you think the 9-1-1 industry needs to go to fully address 9-1-1 stress risks and ensure resilience of our front-lines as we go forward?

As the PSAP becomes more complex, so does the need to make sure that we are taking care of our personnel. The National Emergency Number Association (NENA) Stress Standard is an excellent place to start, and if the standard seems intimidating or a daunting task, look for the proverbial low-hanging fruit and see which portions you can implement now and strategize the next steps.

The blueprint to strategically plan our approach is very worthwhile. It is the right thing to do, and in the long run, this will make stress relief and resiliency part of the 9-1-1 culture. This increase in wellness will increase job satisfaction and have other benefits (a happier and healthier workforce which means less stress on 9-1-1 administrators).

You and your wife Sharon began presenting at NAVIGATOR on the issue of compassion fatigue some 10 years ago. What experience compelled you to address it?

Sharon had recognized that when hospital caregivers were exhibiting problematic behaviors, there was often a root cause related to the stress created (or compounded) by caring for others. Often these behaviors were rubber-stamped as “burnout.” She saw this not only at the hospital as a registered nurse and ombudsman, but also in ambulance/EMD dispatch center personnel also employed by the hospital. Ironically, it was a discussion of similar behaviors (extreme outbursts of anger after a frustrating 9-1-1 call) in two different PSAPs that started the discussion of how CF has been recognized in the hospital setting, and many of the same stressors and symptoms are present in the PSAP.

From research, we realized that burnout is a symptom of CF and that there are ways to intervene and assist the person before he or she hits the wall of burnout. Just as importantly, there is support available to bring individuals back from burnout.
Navigating Dispatch
Conferencing across the pond

Audrey Fraizer
Euro NAVIGATOR Waltz
Conference keeps gaining steam

Picture this for your evening out in Lower Austria:

Leave your hotel for a drive to the restored 900-year-old abbey at Melk, a Benedictine monastery beaming over the Danube Valley and considered one of Europe’s greatest sights. Accept a glass of champagne or a non-alcoholic beverage when you board a boat for a leisurely cruise down the Danube River through the Wachau Valley to the town of Krems. The day fading into night pulls a shade over the vineyards although soft electric lighting from castles and villages illuminates the sky and shore, enhancing the history and known beauty of the countryside. Austrian music plays discreetly in the background.

As your trip draws to a close, you are surprised by a bold show of fireworks streaming above the boat, the flash of color reflecting in the Danube River’s evening darkness. You take the napkin from your lap and set it over the plate that held servings from the Austrian-style food buffet. You depart from the boat with the past four hours forever etched in your memory but not without shaking the hands of dignitaries accompanying you on the cruise.

Does it get any better?
Well, that depends.

For the 160 emergency center professionals attending Euro NAVIGATOR, the cruise was a great indicator of things to come.

The opening of the sixth annual Euro NAVIGATOR conference heralded 23 sessions, Medical and Fire Instructor Recertification Workshops, and a police leadership seminar. It was the largest Euro NAVIGATOR to date, quadrupling in size from the 40 people who attended the inaugural conference in 2008.

As the numbers grow, so does the enthusiasm, according to Tudy Benson, IAED™ director of European operations.

“The rooms are always packed at Euro NAVIGATOR,” she said. “It’s amazing. There are no empty seats and during the breaks, there’s a ton of networking.”

The “passion for protocol” doesn’t stop in the classroom.

Euro NAVIGATOR also celebrates the achievement of centers processing calls and sending response using the MPDS® and FPDS®—PPDS® is now being introduced—and honors front-line staff through the Dispatcher of the Year Award.

For example, the boat cruise not only signaled the start of Euro NAVIGATOR but it also celebrated the 10th anniversary of 144 Notruf NÖ. The accredited and reaccredited Center of Excellence played host to the cruise, featuring opening remarks by Jerry Overton, chair, IAED Emergency Clinical Advice System Program, and Lower Austria Governor Erwin Pröll.

“The governor spoke highly about the importance of protocol,” Benson said. “He is proud of what 144 Notruf NÖ is doing for the population of Lower Austria.”

The Dispatcher of the Year Award went to Daniel Wegscheider, of Leitstelle Tirol, Austria. Wegscheider is an EMD, EFD, and EFD-Q™ certified instructor. Wegscheider started as a calltaker with Tyrol Leitstelle in May 2003.

“Daniel practices what he preaches,” Benson said. “Literally. He follows the protocol verbatim and his voice was calm and collected during the call submitted with his nomination as he assisted in the delivery of a baby.”

Leitstelle Tirol was established through an agreement signed in September 2004 between the Tyrol Center and the city of Innsbruck. Leitstelle Tirol dispatches all Tyrolean emergency services (except for police) in northern and eastern Tyrol.

European flair

Euro NAVIGATOR is unique among the IAED’s conferences, of which there are now eight including U.S. NAVIGATOR. Sessions are divided into blocks, and the accepted proposals are clustered around common topics and areas of interest. Four sessions moderated by two chairs are scheduled per block, and each block—lasting about 80 minutes and held in the same room—leaves time for discussion between the speakers.

The final program blocks mirror the interests of protocol research and noted comments from the prior year’s conference. The recent conference, held Sept. 11–13 in St. Pölten, Austria, highlighted management of staff, protocol, and the universally hot topic of stress. A four-session block on the second day delved into the FPDS, which is picking up steam in the European countries.

A free (open floor) presentation scheduled on the final day allows time for topics regarding concerns related to protocol or center operations.

Behind the picture

Austrian EMS Provider Gernot Vergeiner and Benson organized the structure three years ago based on Vergeiner’s experience at the inter- and multi-disciplinary conferences he attends in Europe.

“The face-to-face exchanges and shorter time slots [compared to conferences familiar to most Americans] prove to be an effective way of engaging individuals and broadening the dialogue,” Vergeiner said. “Networking throughout the conference establishes the contacts with other countries and agencies.”

Vergeiner was an early proponent of the MPDS in Austria, building his argument for standardized protocol from the country’s ambulance man law of 2002, which created two tiers of ambulance response (rescue and emergency). Similar to the ambulance plan, he wanted a national standard for calltaking and dispatching.

In 2004, 144 Notruf NÖ adopted the MPDS and since then, the protocol has expanded to a multitude of centers in several European countries, including Austria, Germany, and the Netherlands. New to the conference in 2013 were representatives from the country of Georgia, located at the crossroads of Western Asia and Eastern Europe. Georgia is a member of the Council of Europe.

Benson is pleased with the advance of protocol in Europe.

“The conference was a success,” she said. “We are certainly very happy with the way things are going.”
Call it the ideal dispatch venue to learn, network, or refresh, but never can it be said that this is the place to kick back and put your feet up.

“The experience of UK NAVIGATOR was motivating, rejuvenating, and informative,” said Antoinette Smith, quality assurance manager, London Ambulance Service (LAS) NHS Trust. “I came away with a new zest and energy ready to find new ways of doing things and to test the skills and techniques I learned. The opportunity to communicate with other ED-Qs™ and EMDs from other services was invaluable.”

Smith was among the 90 emergency center professionals—from England, Scotland, Wales, Northern Ireland, Ireland, Gibraltar, and the USA—attending UK NAVIGATOR in the Old Market area of Bristol, England. The three-day conference, Sept. 17-19, highlighted each set of protocol specifically—such as the police and fire leader seminars—and broadly in addressing daily operations of managing staff, setting policy, and getting the most out of the protocols.

And, of course, there were the awards.

**Awards**

Yorkshire Ambulance Service (YAS) NHS Trust brought home three awards recognizing the center’s high standards of care: Accredited Center of Excellence (ACE) for each of their two Emergency Operations Centres (EOCs) in Wakefield and York; Dispatcher of the Year presented to EMD Fiona Dinkel; and the Bill Boehly Clinician of the Year Award presented to Jan Matulewicz.

Dinkel was selected from 29 nominations—11 of those from YAS—and all exemplifying the “very high standards” the judges look for in choosing the Dispatcher of the Year, according to Louise Ganley, PDC™ clinical support representative.

“This was a really hard decision,” Ganley said. “It finally came down to the type of call, and Fiona was brilliant in the way she handled a very difficult situation (see sidebar).”

The Bill Boehly Award is exclusive to UK NAVIGATOR and recognizes an individual making significant contributions to the clinical assessment of the patient over the telephone and/or policy development in the area of secondary triage of emergency callers.

According to the nomination submitted by Annette Strickland, YAS Clinical Hub team leader at the Wakefield EOC, for the...
past two years, Matulewicz has combined his clinical adviser role with a project to improve the care and clinical support to nursing home staff and patients. He has attended meetings on his own time to educate care home staff and develop a direct access clinical advice service that signposts care home staff to the appropriate pathway to meet the needs of their patients. This work has been proven to reduce the volume of 9-9-9 calls received from the care home following the training and education Matulewicz contributed to around the role of the ambulance service. Matulewicz is currently conducting an audit project for the YAS Clinical Hub focusing on breathing diagnostics and abdominal pain. The two centers comprising the YAS were certified as an ACE in January 2013.

Sessions

The 12 one-hour sessions featured customer service, emergency center nurse triage, evidence-based dispatching, the power of listening, leadership, and managing suicidal callers. Longer sessions included the police and fire seminars, medical instructor workshops, and EMD-Q® certification courses.

There were favorites mentioned in the mix, of course, although appeal often hinges on the individual's reason for signing up for the session. "These are busy people taking at least three days away from work, and they want to be absolutely sure they are using the time well," said Beverley Logan, IAED® accreditation officer. "They want information that is relevant and allows the time to provide insight into a different view to the way they might be handling various situations. I think UK NAVIGATOR did that. We had an enthusiastic response."

Melissa Thiele gave a high thumbs-up to the dynamics of IAED Research & Studies Officer Tracey Barron’s “Ignite Your Staff Performance” session.

In addition to the great “how-to” tips of motivation, such as serving cups of tea at random, Thiele welcomed Barron’s refreshing look at the supervisory positions, such as the job Thiele performs at East Midlands Ambulance Service (EMAS) NHS Trust.

“She motivated me to see not only my role as a calling, but to help inspire staff to see their role not as a job, but as a calling,” said Thiele, EMAS control training officer. "Added to that, her talk reminded me to keep an element of fun in all aspects of my life, not only in my role at EMAS."

Another favorite mentioned was Maxine Davis’ “Changing the Emergency Dispatch Centre”, which broke down facility and staffing proposals into “who” and “what” will be affected. Davis took the team approach to her talk, dividing the audience into groups to collectively tackle a practical example of control room layout.

“The groups swapped sheets and added ideas to the existing lists,” Thiele said. “Overall, this gave me a very practical approach to problem solving.”

Networking

Jason Beese, who co-presented “Does One Glove Fit All?”, found the presentations thought provoking and—high on his list—the camaraderie superb.

“UK NAVIGATOR 2013 was a very worthwhile experience,” said Beese, EMD quality assurance auditor, South Western Ambulance Service NHS Foundation Trust. “The opportunity to meet with colleagues and friends from other dispatch agencies was invaluable.”

Susan Ozyer couldn’t be anymore enthusiastic about her three-day stay. “This was a fantastic opportunity to network with colleagues from all over the world,” said Ozyer, quality auditor, Wakefield Emergency Operations Centre, YAS. “It’s the perfect environment to have healthy debate among other professionals and pick up fresh, new ideas for the dispatch center.”

And if it’s a person of few words you’d like to ask, there’s EMAS Control Training Officer Jonathan Pearson.

“I found it enjoyable and we learned something,” he said.

True EOC Ambassador

Fiona Dinkel was the EMD answering the 9-9-9 call placed by a husband whose wife was alerting him to the visible slippage of her baby’s umbilical cord through the birth canal during her early stages of active labor (prolapsed cord).

“The couple was home, and she had just gotten out of the shower," said Louise Ganley, PDC™ clinical support representative. “Fiona started giving instructions (PAIs) but they couldn’t relocate the baby."

According to the nomination submitted by Yorkshire Ambulance Service (YAS) Quality Auditor Linden Horwood, Dinkel’s call signified one of the “truly rare instances whereby AMPDS” directs the EMD to ‘Clarify & Reassure’—only to repeat the same panel.”

Takes a team

While still on the call and unbeknownst to the caller, Dinkel liaisioned with her EMD supervisor and the supervisor contacted the hospital’s midwifery unit. Without any signs of nervousness, she used her “outstanding protocol knowledge” to navigate through the appropriate Protocol F: Childbirth – Delivery panels and the midwife’s instructions, which duplicate the positioning of a pregnant female (lay her on her left side with a pillow wedged behind her lower back) already found in Protocol C: Airway/Arrest/Choking (Unconscious) – Adult ≥ 8Yrs and the Post-Dispatch Instructions (PDIs) of Protocol 12: Convulsions/Seizures.

Dinkel also incorporated instructions from the midwife at the hospital; this enhancement to Protocol F was later submitted to the Academy through the Proposal for Change process.

Dinkel handed over patient care to the crew arriving on scene, providing them with an update. The baby was later delivered in the hospital.

“She was amazing," Ganley said. "Brilliant. She was able to calm the mother and father, which is so important when callers need to do what you are instructing.”

Dinkel had few words to say when accepting the award. “She was really pleased,” Ganley said. “She thanked everybody and said that the award was not only about her. It was about her team.”
On Track

Are You Completely Alert?
MPDS pays close attention to challenge of consciousness

Unconsciousness is classified as one of the nine time-life priority complaints in the Medical Priority Dispatch System™ (MPDS) and has a relatively high probability of being a true emergency that every calltaker/dispatcher will answer sooner rather than later.

And it’s a challenge on both ends of the telephone line.

Callers may describe what they see any number of ways, so figuring out where the patient fits medically along this continuum can challenge your calltaking skills and your knowledge of the protocol. This article will describe how to recognize and handle reports of unconsciousness and will include a few related changes in the upcoming release of MPDS version 13.0.

Brett Patterson

Editor’s Note: This article is updated from a 2009 CDE with the MPDS’ guidelines for determining the patient’s level of consciousness and providing corresponding instructions.
The “conscious” and “breathing” questions

On Case Entry, also called “the primary interrogation,” you aren’t yet concerned about whether the patient has a decreased level of consciousness or difficulty breathing. You want to find out if the patient is awake at all and/or breathing at all so you can select the appropriate Chief Complaint Protocol and begin a more detailed interrogation.

At this point, you need the caller to give you a simple yes or no. That’s why Case Entry Question 5 is worded as “Is s/he awake (conscious)?” because the word “awake” is commonly understood and solicits a clear and decisive answer. If for some reason the caller does not understand “Is s/he awake?” you should then use the designated clarifier and ask “Is s/he conscious?”

Obtaining a clear answer is also necessary with the next Case Entry Question: “Is s/he breathing?” Breathing may be difficult for callers to initially determine in unconscious patients; however, this information is necessary for you to send the correct response and provide appropriate Pre-Arrival Instructions (PAIs) for the patient.

For this reason, several descriptions that qualify as INEFFECTIVE BREATHING are listed on Case Entry for clear recognition. Also, in MPDS v13.0 a new definition for UNCERTAIN BREATHING has been added: “A situation where a 2nd party caller is uncertain, unsure, indefinite, or ambiguous when asked if an unconscious patient is breathing.”

As indicated by Axiom 1 on Case Entry, if a 2nd party caller (who can actually observe the patient) is uncertain if the patient is actually breathing, you should consider the patient to be NOT BREATHING until proven otherwise.

The AGONAL BREATHING Detector is also an important tool that can be used to monitor and evaluate the patient’s breathing if the caller’s report of breathing is questionable.

However, you should understand that you are not required to use the AGONAL BREATHING Detector when the caller expresses UNCERTAIN BREATHING or INEFFECTIVE BREATHING in an unconscious patient (Case Entry Rule 3 in v13.0). In fact, using this tool when it is unnecessary only delays the treatment of a possible cardiac arrest (an ECHO response) and the delivery of critical Pre-Arrival Instructions. To put it quite simply, use the AGONAL BREATHING Detector when you are unsure, not when the caller is unsure. And never hesitate to start compressions. It’s far better to start compressions on a patient who does not need them than to delay compressions for a patient who does.

In most cases, you are required to clearly determine the patient’s status of consciousness and breathing before moving on from Case Entry; however, if you are speaking with a 3rd party caller who cannot go to the patient to personally verify his or her status, you are directed to proceed to Protocol 32: Unknown Problem (Person Down) to continue the interrogation (Case Entry Rule 8).

Choosing the right protocol for unconsciousness

When the caller reports medical unconsciousness as the Chief Complaint during Case Entry, choosing the correct Chief Complaint Protocol is generally straightforward. In the absence of scene safety (especially hazardous materials) and mechanism of injury concerns, your choice is typically between Protocol 31 and Protocol 9: Cardiac or Respiratory Arrest/Death.

The patient’s status of breathing determines which one you choose.

If the patient is breathing effectively, you should go to Protocol 31. If the patient is not breathing effectively, you use Protocol 9, which will most likely result in an ECHO response sent directly from Case Entry. Notice, however, that an ECHO Determinant Code is also available on Protocol 31. This is available for unconscious patients who meet INEFFECTIVE BREATHING criteria, but who are obviously alive from the caller’s description. In these cases, Protocol 9 is not appropriate, and Protocol 31 provides an appropriate response and fast track to PAIs for this critically ill class of patients who have a high likelihood of eventual cardiac arrest.

Dizziness with a fall

Sometimes the caller may report that the patient felt dizzy or fainted and then fell. In this scenario, you might wonder whether you should choose Protocol 31 to handle the fainting or Protocol 17: Falls to handle the fall. A Rule on both Protocol 17 and Protocol 31 provides guidance on choosing the correct Chief Complaint Protocol: “Ground-level falls caused by fainting, near fainting, or dizziness should be handled on Protocol 31.” Additionally, Protocol 17 will shunt you to Protocol 31 if a medical cause of the fall is discovered during Key Questioning.

Why go to Protocol 31 for this kind of incident? The reason is because fainting, near fainting, and dizziness can indicate underlying heart problems that can be the first and perhaps only sign of a heart attack or other serious heart problem requiring ALS care.

Although you might consider going to Protocol 17, there are usually no significant mechanism of injury concerns with a ground-level fall. In this case, the potential for heart problems is more serious than the...
Sometimes the caller does not even notice the patient’s change in consciousness until you ask “Is s/he completely alert (responding appropriately)?” during Key Question interrogation.

Potential heart problems

Patients with fainting/near fainting or who have experienced dizziness prior to a ground-level fall must be carefully evaluated to determine if they are experiencing a potential cardiac emergency. Protocol 31 offers Determinant Descriptors to classify patients in various levels of risk considering cardiac history, age, changing color, and other indications of potential heart problems, which gives agencies flexibility with response options.

For these patients, the most critical factor is to distinguish between the patient who has become fully alert and the patient who remains unconscious or is not alert. The unconscious or not alert patient will receive a DELTA-level response while the fully alert patient may receive a CHARLIE- or ALPHA-level response. Just as important as your response determination is your treatment determination. Notice that unconscious patients or not alert patients with INEFFECITIVE BREATHING are linked directly to ABC-1. This is to ensure that they are breathing effectively. If they are not, CPR is started. If they are, their unprotected airways are maintained and constantly monitored because of the serious risk of aspiration of vomit and airway obstruction caused by uncontrolled positioning of the head and neck.

Determining a conscious patient’s alertness on Protocol 31 depends upon the caller’s response to Key Question 3: “(Conscious) Is s/he completely alert (responding appropriately)?” This Key Question has a different purpose from the consciousness question on Case Entry or even the Key Question preceding it: “(Initially unconscious) Is s/he still unconscious?” The alertness Key Question is intended to determine if a conscious patient has experienced any decrease in level of consciousness to help you correctly triage patients on Protocol 31.

Take special note of the clarifier. If the caller does not understand “Is s/he completely alert?” you should then ask, “Is s/he responding appropriately?” As explained in Axiom 3 on Protocol 31, a responsible EMD can clarify this question in additional ways if there is any trouble getting a useable answer from the caller (e.g., “able to talk normally,” “with it,” “making sense,” etc.).

Dizziness without a fall

Dizziness (a lay term for vertigo) by itself is not likely to be a pre-hospital emergency unless it has caused the patient to fall down, indicating a potential heart problem. In the absence of a ground-level fall or any identifiable priority symptom (abnormal breathing, chest pain, decreased level of consciousness, or SEVERE hemorrhage), dizziness/vertigo is handled on Protocol 26: Sick Person (Specific Diagnosis) as an ALPHA-level NON-PRIORITY complaint (26-A-2).

However, be aware that you must clearly address the patient’s level of consciousness while using Protocol 26 even when the caller seems to be reporting a straightforward “sick person” call. Case review and outcome data have shown that a significant number of patients have been triaged as ALPHE using Protocol 26 when, in fact, it was clear upon call review that an altered level of consciousness was evident. These patients may be experiencing insulin shock, stroke, or a number of other critical problems. The only sign these patients may have of the need for ALS care is an altered level of consciousness, but this may not be initially observed or clearly reported by the caller.

Sometimes the caller does not even notice the patient’s change in consciousness until you ask “Is s/he completely alert (responding appropriately)” during Key Question interrogation. That’s why this Key Question is asked on the majority of the Chief Complaint Protocols in the MPDS.

Changes in the patient’s level of consciousness can also be difficult for the caller to describe. Sometimes the patient seems to be between “fully alert” and “not at all alert.” Because of this frequent caller confusion, obtaining a clear answer to “Is s/he completely alert (responding appropriately)?” is especially important on this protocol.

Determinant Code 26-C-1 “ALTERED LEVEL OF CONSCIOUSNESS” and the associated definition help the EMD identify patients who may be having a serious problem even though the caller answers “yes” to the alert question. This code should be used when any caller description indicates an altered level of consciousness but the caller still reports the patient to be “alert.” While the term “alert” is well understood by medical professionals, it is not always understood in the same context by laypersons.

If you’re dealing with a patient whose normal state is not completely awake, another Rule on Protocol 26 provides guidance: “Patients who are normally not completely awake should be considered alert in the dispatch environment.” These patients are not alert due to chronic problems rather than acute problems that can be life threatening.

In summary, your evaluation of a patient’s level of consciousness ensures an appropriate response for patients who may be experiencing critical, time-sensitive emergencies. A decrease in level of consciousness can be a sign of shock, which involves a lack of perfusion in the brain. Just as important to your identification of these signs and symptoms is the treatment it prompts. Unconscious patients are not able to maintain an adequate airway and are at serious risk of aspiration of gastric contents into the lungs and/or a blocked airway due to uncontrolled positioning. An important Rule on Protocol 31 reinforces the DLS links to PAIs for unconscious patients: “The airway of an unconscious patient must be constantly maintained.” Your vigilance in the evaluation, treatment, and monitoring of these patients, through compliant use of the MPDS, can literally be lifesaving.
CDE Quiz Medical Answers to the CDE quiz are found in the article "Are You Completely Alert?", which starts on page 34. Take this quiz for 1.0 CDE unit.

1. Which of the following best describes the difference between unconsciousness and fainting?
   a. Unconsciousness is a persistent state; fainting is a transient state.
   b. Fainting is a persistent state; unconsciousness is a transient state.

2. The purpose of Case Entry Question 5 "Is s/he awake (conscious)?" is to determine:
   a. if the patient is awake at all so you can select the correct Chief Complaint Protocol.
   b. if the patient is in cardiac arrest.
   c. if the scene is safe for responders.
   d. if you should use the Aspirin Diagnostic and Instructions Tool.

3. Version 13.0 provides a new definition for which one of the following terms related to breathing in the unconscious patient?
   a. INEFFECTIVE BREATHING
   b. AGONAL BREATHING
   c. UNCERTAIN BREATHING
   d. NOT BREATHING

4. As indicated by Axiom 1 on Case Entry, if a 2nd party caller (who can actually observe the patient) is uncertain if the patient is actually breathing, you should consider the patient to be:
   a. NOT BREATHING until proven otherwise.
   b. a good candidate for the AGONAL BREATHING Detector.
   c. alert.
   d. in a transient state.

5. You should use the AGONAL BREATHING Detector when you are unsure, not when the caller is unsure.
   a. true
   b. false

6. If the caller reports that the unconscious patient is breathing effectively, you should go to:
   b. Protocol 26: Sick Person (Specific Diagnosis).

7. Ground-level falls caused by fainting, near fainting, or dizziness should be handled on:

8. Unconscious or not alert patients with fainting/near fainting or who have experienced dizziness prior to a ground-level fall will receive an:
   a. ECHO-level response.
   b. DELTA-level response.
   c. CHARLIE- or ALPHA-level response.

9. The lay term for vertigo is:
   a. conscious.
   b. alert.
   c. dizziness.
   d. syncope.

10. Patients who are normally not completely awake should be considered alert in the dispatch environment.
    a. true
    b. false
The Firetrap
Fire calls can get tricky in a hurry

James Thalman and Jordan Sebresos

The evening’s headliner rock band—Jack Russell’s Great White—had barely cracked the first chord at 11:07 p.m. on Feb. 20, 2003. Less than nine minutes later, The Station nightclub in West Warwick, R.I., was engulfed in flames. An hour later, it had become the world’s fourth-deadliest nightclub fire. The first of a slew of fireworks brought in by the band to add some visual dazzle to the reunion performance ignited flammable sound insulation foam inside the walls and ceiling surrounding the stage. Of the 462 people in the audience, 100 were killed, 230 were injured, and 132 escaped unharmed. Most of the fatalities were caused by smoke inhalation.

Adding mayhem to the incident, investigators were shocked to find out that the nightclub officials were not yet aware that security staff had blocked some emergency exits. On Jan. 27, 2013, history repeated itself with a vengeance when at least 200 people were killed in a nightclub fire at 2:30 a.m. in the southern Brazil city of Santa Maria. Once again, pyrotechnics and a confined space with an inadequate number of exits contributed to the fatalities. The two main causes of death were asphyxiation and being trampled to death as the crowd of more than 500 people rushed away from sudden danger.

Television footage of the incident showed shirtless firefighters using sledge hammers and axes to knock down an exterior wall to create an exit. Emergency dispatchers have since concluded that the combination of intensely dark smoke and the fast pace of the fire overwhelmed emergency responders.

A club fire on Dec. 4, 1971, involving another rock ‘n’ roll show was less deadly but was made legendary in the Deep Purple song Smoke on the Water. The lyrics tell the true story of the entertainment complex of the Montreux Casino in Switzerland going up in flames during a Frank Zappa and The Mothers of Invention concert. An audience member fired an emergency flare gun into the rattan-covered ceiling, i.e., “some stupid with a flare gun,” as the lyrics put it. The blaze burned down the entire complex, built in 1881. There were only a few injuries and no fatalities. Its billowing smoke spreading out over nearby Lake Geneva inspired the song that has kept the fire going in memory for more than 42 years.

Structural fire statistics

Although residential structure fires outnumber nonresidential building fires, the potential number of victims escalates depending on factors that include the event, the building’s capacity (and actual attendance), access to emergency exits, and the origin of the fire (e.g., vehicle storage area or main venue).

According to the Nonresidential Building Fires (2009–2011) report released by the U.S. Fire Administration:

- An estimated 86,500 nonresidential building fires are reported annually to United States fire departments, resulting in an estimated 85 deaths, 1,325 injuries, and $2.6 billion in property losses per year.
- Cooking is the leading cause of nonresidential building fires (29%); however, most nonresidential building cooking fires are small, confined fires (97%).
- Outside/special properties account for the highest percentage of nonresidential building fires (21%), while storage build-
ings account for the highest percentage of nonresidential building fire deaths (29%).

- Nonresidential building fires occur most frequently between 3 p.m. and 6 p.m.
- Nonconfined nonresidential building fires most often start in vehicle storage areas (9%).
- 56% of nonconfined nonresidential building fires extend beyond the room of origin; the leading causes of these larger fires are unintentional or careless actions (19%), intentional actions (13%), and electrical malfunctions (12%).
- Misuse of material or product (32%) is the leading contributing factor in the ignition category of nonconfined nonresidential building fires.
- Smoke alarms are not present in 52% of the larger, nonconfined fires in occupied nonresidential buildings.

Dispatcher’s duty

Each of these nightclub fires illustrates the need for an immediate pre-planned response. People trapped in a fire are dealing with both life-threatening smoke and toxins and, in cases of large gatherings, the added danger of panicked crowds stampeding for the exits. Beyond these elements, fires can grow unbelievably fast and, at times, may even lead to spontaneous combustion.

The dispatcher must be well prepared to handle every type of situation without hesitation. Unfortunately, part of handling these situations is recognizing that people aren’t always able to escape in time. However, the EFD’s role may have a crucial and even lifesaving impact in relaying the right information, sending the right response, and considering the immediate needs of the caller by providing lifesaving instructions.

The new version of the Fire Priority Dispatch System™ (FPDS™)-version 6.0—has streamlined the caller interrogation process to send a more informed response and provide lifesaving instructions earlier in the caller interrogation process. A few of these impactful changes are described in this article in relation to structure fires.

Caller Danger - Not Trapped

In v6.0 of the FPDS a new “Caller Danger - Not Trapped” instruction was added to the Case Entry Protocol. This Pre-Arrival Instruction (PAI) is already on Panel B-2, but it has been modified slightly and added on Case Entry for easier and earlier provision.

Though PAs have not typically been provided on Case Entry, this change resulted from a surprising number of cases where callers had the ability to leave a dangerous situation (eg, a burning building or the site of a carbon monoxide leak) but had not yet done so.

Much of the data on these incidents has been anecdotal but has revealed a need to address these situations early in the protocol. Just like other safety instructions, the new “Caller Danger - Not Trapped” Case Entry PAI is designed to get the caller to safety as soon as possible.

The calltakers will have to be aware of this new instruction and how to use it correctly. For whatever reason, these callers have not yet left the dangerous situation, but they might just need someone to tell them to get out.

Calldicators must be sure to promptly continue with the rest of the callergation once they’ve given the “Caller danger not trapped” instruction. The goal is to get the caller out of danger without delaying the response any further.

If the caller is not able to stay on the line after leaving the area, the calltaker should process the call based on the information obtained before the call terminated.

Trapped in building fire

Though ideally it is best for a first-party caller to leave the premises of a building/structure fire, this may not be possible for all callers. In v6.0, a new ECHO determinant, 69-E-2 “Trapped in building fire,” was added to Case Entry to address building fire incidents involving prevention of escape. These situations are clearly very dire and require early response initiation.

When using this Determinant Code, the EFD must indicate a suffix for the type of building/structure involved as this is crucial for sending the appropriate rescue resources to the incident.

This new ECHO determinant allows the EFD to provide Post-Dispatch Instruction (PDI)-a, initially bypass the Key Question interrogation, and follow the DLS Link to provide PAs on B-1 “Trapped in building fire (1st party)’ earlier than ever before. These instructions have also been slightly modified to ask for information that will help responders locate the trapped person(s) quickly upon arrival:

“Exactly where are you located?” and “What is the best entrance of the building to get to you?”

As a result of these v6.0 changes, individuals trapped in a structure/building fire receive both a more immediate response and instructions earlier to attempt to limit smoke inhalation and make themselves known to responders trying to locate them.

In addition to this new ECHO determinant, the following list describes some of the other key changes to Protocol 69: Structure Fire.

- The new Key Question 5: “Where exactly is the fire?” has been added to Protocol 69 to provide helpful location information for responders.
- Another new determinant, 69-D-11 “Building/Structure over water,” was added to allow agencies to differentiate the type of response or resources for these incidents.
- Four new suffixes were added: I, J, K, and F. The new I and J suffixes allow departments to differentiate their responses and resource allocation according to the presence of injuries. The new K and F suffixes were added to handle common first-party reports of LIGHT smoke and burned food. These new suffixes will help fire departments better customize their responses.

Sources

YOU MUST BE FIRE CERTIFIED TO TAKE THIS QUIZ.

CDE-Quiz  ♦  Fire

Answers to the CDE quiz are found in the article “The Firetrap,” which starts on page 38.

Take this quiz for 1.0 CDE unit.

1. What is the leading cause of nonresidential building fires?
   a. non-extinguished cigarettes
   b. cooking
   c. faulty outdoor lighting
   d. shots from emergency flare guns

2. Which type of facility accounts for the highest percentage of nonresidential building fire deaths?
   a. storage buildings
   b. outside and special properties
   c. malfunctioning elevators
   d. stairwells

3. The new version 6.0 of the Fire Priority Dispatch System (FPDS) has streamlined the caller interrogation process to send a more informed response and:
   a. get the caller off the phone as soon as possible.
   b. handle the text messages (regarding the same incident) coming into the center.
   c. provide lifesaving instructions earlier in the caller interrogation process.
   d. alert EFDs that they might be receiving similar calls.

4. In v6.0 of the FPDS, a new “Caller Danger – Not Trapped” instruction was added to:
   a. Key Questions.
   b. Determinant Descriptors.
   c. Axioms.
   d. Case Entry Protocol.

5. If the caller is not able to stay on the line after leaving the area, the calltaker should:
   a. go on to the next call.
   b. process the call based on the information obtained before the call terminated.
   c. report that the individual is safely out of the building.
   d. terminate the response.

6. In version 6.0, what is the new ECHO determinant added to Case Entry to address building fire incidents involving prevention of escape?
   a. 67-E-1, Person on fire (outside)
   b. 69-E-1, Person on fire (inside)
   c. 69-E-2, Trapped in building fire
   d. 72-E-1, Sinking vehicle

7. The new Key Question 5: “Where exactly is the fire?” has been added to:
   a. Protocol 61: HAZMAT.

8. Which Determinant Code has been added to allow agencies to differentiate the type of response or resources for structure fires over water?
   a. 65-D-1 MUTUAL AID to incident (multiple units – HOT)
   b. 67-D-3 LARGE OUTSIDE fire
   c. 68-C-1 HEAVY smoke
   d. 69-D-11 Building/Structure over water

9. The new I and J suffixes allow departments to:
   a. differentiate their responses and resource allocation according to the presence of injuries.
   b. differentiate the type of structural fire.
   c. recognize the severity of the fire.
   d. collect data on fire sources.

10. The new K and F suffixes were added to handle common first-party reports of:
    a. children playing with matches.
    b. high school bonfires.
    c. LIGHT smoke and burned food.
    d. night club pyrotechnics.
The call was never one Kris Whitney wanted to make until the day she took the radio transmission she had always dreaded.

The voice came over the police radio just shy of 6 a.m., which was about the time Valley Emergency Communications Center (VECC, located near Salt Lake City, Utah) dispatcher Whitney would normally sign off her shift. It was a Sunday morning, and she was at a desk handling a channel different from the channel relaying a garbled message her co-dispatcher could not understand. She was signaled over to help.

“I know their voices but I still couldn’t tell who it was,” she said. “Neither of us could. Then we heard the shots.”

On the other end of the transmission, Draper Police Department Sgt. Derek Johnson lay mortally wounded inside his police SUV. He was the victim of a lone shooter who had aimed a handgun at the officer when he steered his patrol vehicle over to approach a car oddly parked on the side of the road.

Sgt. Johnson was on his way back to the station following his shift. He never left his car, and he never pulled out his service weapon. Although wounded, he was able to drive away from the shooter and attempt what would be his final radio transmission before crashing into a tree two blocks away. Draper police officers and paramedics arriving on the scene, pulled Sgt. Johnson from the car, and provided CPR until he was airlifted to a local hospital. He never regained consciousness and died that same morning.

The alleged shooter, a transient who lived in his car, turned the gun on himself and the person who was with him. They both survived.

Whitney had two requests when she heard the officer had died.

“I asked to go to the debriefing,” she said. “I asked to do the Last Call.”

Whitney started composing the final dispatch before her request was actually granted. She wanted to be ready—or at least be ready to help the person who might be selected—and when she got the OK, she talked to Sgt. Johnson’s fellow officers and her co-workers at VECC. She attended his funeral, leaving early before the other hundreds of attendees formed the long procession leading to the officer’s final resting place.

VECC Police Operations Manager Gigi Smith sat next to Whitney at the dispatch radio when she read the 42-second script. Whitney was composed. She was professional. She found it harder than she had thought it would be. She climbed inside the dispatch bubble.

“There was nobody there but me,” Whitney said. “It was my good-bye. It was what I wanted to tell him.”

Whitney knows the officers. She has worked with them through dispatch for seven years and even if she hasn’t seen a face, she can tell who it is by voice.

“I’m on good terms with all the guys,” she said. “Derek was a work friend.”

She and Sgt. Johnson had met in person. He was congenial. He liked to smile. He came by VECC to meet the people helping to keep him safe on the streets. They worked together on a street-mapping project.

“He was so involved,” Whitney said. “If it was a search and rescue, he’d be there. He did everything. He was awesome and wonderful to work with.”

She tells herself Sgt. Johnson died the way he would have wanted. He died the way he had lived. He died protecting the community he served.

Whitney was back at work for her next shift.

“I like being here,” she said. “I like what I do. I like knowing someone’s bad day might be a little bit better because of the trust placed in us at the worst times.”

Sgt. Johnson was the first officer killed in the line of duty since the Draper Police Department was created in 2003. His death on Sept. 1, 2013, marks the 137th officer in Utah to be killed in the line of duty.

Whitney’s Last Call:

“Draper 8.” Pause.

“Draper 8.” Pause.

“Draper Sierra 8. Sergeant Derek Johnson.”

“We thank you for your dedication, loyalty, and service to the citizens of Draper, Utah, and the United States. You made the people you served your family. You have influenced many for your unending compassion, respect for all people, and service in many facets of law enforcement. All those you served will remember you. Your sacrifice will never be forgotten.”

“Draper 8. Rest in peace.”

“10-42. End of watch.”
**Long Time In Between**

Five years separate 9-1-1 deliveries

Fifteen months ago Megan Carson was a stay-at-home mom raising her identical twin girls and not exactly sure what she wanted to do once returning to the Johnson County (Mo.) workforce.

But her mother knew best.

“I told my mom about the opening with 9-1-1, and she convinced me to apply,” Carson said. “She figured if I could take care of twins, I’d have no trouble handling this job.”

Carson followed her mother’s advice, made it through the hiring process, and is now an emergency medical dispatcher (EMD). With less than one year behind the scenes of response, she was able to do two things very few have done before her at the Johnson County E-911 Central Dispatch (JoCo E-911).

Carson helped in the delivery of a baby boy and, with fellow EMD Samantha Hill, met the mom, dad, and baby on the very next day.

“We decided to take gifts to the hospital, not knowing if we’d be able to meet them or not,” Carson said. “The parents were amazing. They let us hold him.”

Hospital staff had met the mother the night before when, in the early stages of labor, she was told to go home and return when contractions became more intense and frequent. Not long after 1 a.m., mom went into active labor but it was already too late for another dash to the delivery room.

“Her cousin called and said the mom was crowning, and in the next three minutes the baby was out,” said Carson, who provided Pre-Arrival Instructions (PAIs) while Hill dispatched the ambulance and EMD Michael Roomsburg took control of other calls coming into the center.

They weren’t the only ones in rush mode. Despite the makeshift facility, mom had plenty of hands on deck, with each seeming to have an assigned role. The cousin making the call relayed instructions to the new grandma, and they did not send dad out to boil water.

“He held her hand” until PAIs demanded the use of his shoelace, Carson said. “He lost one to the baby.”

Three minutes after baby’s appearance, the ambulance arrived for transport.

Baby deliveries aren’t common for JoCo E-911. Operations Manager Leigh Anne Bowling said the last out-of-hospital delivery was close to five years ago, and during that time the center has had its hands full with improvements, from reviving its use of the Medical Priority Dispatch System™ (MPDS) to becoming its own entity in Johnson County, to building a new facility anticipated for opening in 2014. It also was updated to Next Generation 9-1-1 equipment in step with a population boom brought on by commuters moving to the county’s suburbs, a 45-minute drive from Kansas City.

More residents could even mean more babies for JoCo E-911, and that would be OK by Carson.

“I did not know how much I would love dispatch,” she said. “Everyone does an amazing job, and it’s something different happening all the time.”

**“Storking” Up**

Extra pins honoring baby delivery came in handy

It was a good thing Quality Assurance Coordinator Michel Courtois had the foresight to order a few extra stork pins rather than just the one to acknowledge the “great job” dispatcher Jacynthe Sarazin did helping a caller through a quick delivery.

“I ordered a bunch of them and contacted the local paper,” said Courtois, of the The Laurentian and Lanaudière Center of Health Communication (CCS), in Blainville, Quebec, Canada. “These calls don’t occur that often. Yes, we get calls for labor situations but most of the time the responders get there before the baby is out.”

That was before the call Sarazin answered on May 6; since then, three of the extra pins have flown out of storage and onto lapels during the same month.

“I have never seen anything like this,” Courtois said.
The caller reported the baby’s arrival while mother was in a filled bathtub.

Sarazin had her hands full not only with the expectant mother and the friend making the call, but, also, with the father insisting that they hang up and that he drive his wife to the hospital. Sarazin, a dispatcher for not quite three years, was able to persuade him differently, although that didn’t make the call any easier.

“It was difficult for [Sarazin] to get the information,” Courtois said. “The caller became greatly distressed every time the patient had a contraction.”

Six minutes after the call came in, the baby’s head was crowning and visible to the caller. Six minutes after that, mom was handed her newborn at just about the same time an ambulance pulled up to the home.

On May 18, Jessy Demers-Huot, a dispatcher for five years, merited the second pin on a call that Courtois rates an 11 on a scale of 10, with one being the easiest and 10 the hardest.

“The patient was yelling and swearing at each contraction, and the caller was distracted and disturbed by what was happening around her,” Courtois said. “This made it very difficult for [Demers-Huot] to concentrate.”

Within eight minutes from when Demers-Huot answered the call, the baby was out and ready to meet responders arriving nearly 13 minutes later.

Cathie Savignac, a dispatcher for 11 years, had much less time to make good on earning the third pin. The call she answered at 7:35 a.m. on May 24 was from a panicked mom who had undoubtedly hoped the baby would wait until her husband was home from taking their other children to a friend’s house.

No such luck. Mom was going solo on this one.

“The baby arrived seven minutes from the start of the call, and responders got there a few minutes after,” Courtois said. “It took a couple more minutes before dad was back.”

With little time to spare, Jessyca Latour made it four deliveries before the end of May. A relative newcomer to the center, Latour received the most ominous call with the caller reporting the baby’s arrival while the mother was in a filled bathtub.

“She was not able to get out, and the water was not draining fast enough,” Courtois said. “The baby came out but was not breathing.”

Latour provided Pre-Arrival Instructions and in a matter of seconds, she heard the baby crying and her work was done.

“The caller started showing the baby to the family’s other children, forgetting she was still on the line,” Courtois said. “Everyone was doing OK when the responders arrived on scene soon after.”

Courtois was understandably surprised by the month’s events.

“I was really not expecting what May was going to bring,” he said.

The Laurentian and Lanaudière Center of Health Communication (CCS) is the most recent addition to the 10 centers operated by the Corporation of Partners for Health Communications in Quebec. The 950-square-meter facility was completed in 2011 and fully operational in early 2012.

The CCS is a non-profit organization created to receive, prioritize, manage, and dispatch 9-1-1 calls. Each center in the organization uses the Medical Priority Dispatch System™ (MPDS®) and its dispatchers/call-takers are certified EMDs.
Direction Determinant
SCA influences career choice

A chain of events spinning a normal Saturday into an altogether different direction helped 19-year-old Sadie Hockenberry discover a potential career path.

Of course, her mother, Marie Dodson, and stepdad, Dan Dodson, certainly would have preferred a jumping point far less dramatic than the sudden cardiac arrest Sadie suffered in July.

“This is not the wake-up call I would have wanted for her,” Marie Dodson said.

Sadie was upstairs in her bedroom on July 27 when her mother decided to give her daughter the rundown of Saturday errands before driving away. They chatted for a few minutes, and Sadie mentioned she would be working that evening at her part-time job, prepping a restaurant’s salad bar.

“Sadie wasn’t sure about what to do after high school,” Marie Dodson said. “This was OK for now.”

No sooner had Marie Dodson turned to leave when she heard a “thump” from where Sadie had been sitting up in bed. Her head had hit the bedstead. Her face was ashen and her eyes were rolling to the back of her head. Marie Dodson ran for her husband who was downstairs waiting to get on their way.

Dan Dodson knows CPR. He learned the technique years ago in scouting and the construction company where he’s a crane operator requires CPR certification. Despite the background in CPR, however, he was understandably hesitant when it came to his stepdaughter.

“He didn’t want to accidentally injure her,” Marie Dodson said.

She called 9-1-1.

Cumberland County (Pa.) Department of Public Safety Dispatcher II Jimmy Brandt said Sadie’s condition went downhill fast from the moment he answered the phone call. Her lips had turned blue. She wasn’t conscious, and she had stopped breathing. There was no pulse. He told them to take her out of the bed and lay her on the floor. This time, Dan Dodson didn’t hesitate to provide CPR compressions, according to Brandt’s instructions that he relayed to Marie Dodson.

“He needed someone to get him going,” she said. “I was certainly frantic but he kept giving her compressions.”

The fire department response crew was the first to arrive at the rural home, and Brandt said he would stay on the line until EMS got there. Twelve minutes later, Dan Dodson turned Sadie’s care over to paramedics from Cumberland Goodwill EMS. Brandt cleared the line and went on to his next call.

Marie and Dan Dodson left the room while responders used a defibrillator to shock Sadie’s heart. Six minutes later, her heart was beating without assistance. Her pulse was coming back. She was airlifted in critical condition to Milton S. Hershey Medical Center in Hershey, Pa.

Twenty-four hours later, Sadie was sitting up in a chair in her hospital room. She was no longer hooked to a ventilator, she was breathing on her own, and her heart was beating normally. She was home by the next weekend with explicit instructions to rest for the next six weeks.

“Tell that to a 19-year-old,” her mother said. “She can’t understand why she has to take it easy. She feels fine and wants to get moving again.”

Extensive heart tests haven’t revealed a reason why Sadie went into sudden cardiac arrest. There is no family history to fall back on since Sadie was adopted as a three-day-old baby and arrived without a family medical history; blood was drawn for DNA testing.

For safety’s sake, her physician recommended the pacemaker Sadie will likely carry close to her heart for the rest of her life. She has no obvious physical or cognitive side effects, despite an estimated 18 minutes without a heartbeat. Her short-term memory is returning (as of this writing).

“We’re absolutely amazed that she’s back home recovering,” Marie Dodson said. “If I hadn’t gone upstairs to talk, if Dan hadn’t been home, and if we didn’t have someone giving CPR instructions, she wouldn’t be here. Everything fell into place. Everyone was where they were supposed to be.”

Brandt said this is the first time during his 11 years with Cumberland County 9-1-1 that he knew “for sure” it was a save and the first time he was credited for a save.

“You like to think you’ve helped along the way, but most of the time it doesn’t happen this way,” he said. “You don’t find out the outcome or it’s too late to help by the time the person is found and the call to 9-1-1 is made.”

Marie Dodson said Sadie seems to be taking it all in stride.

“I’m more nervous than she is,” Sadie’s mother said. “I was in her room, sitting at the edge of her bed, and she sneezed. I jumped, thinking something was wrong.”

The emergency has put Sadie in the direction of a career in emergency response. She has met the EMTs and paramedics involved in her emergency care, and they showed her the equipment they used to revive her heart. Sadie plans to go on a ride-along with Cumberland Goodwill paramedics and looks forward to meeting Brandt and his team of co-workers in the comm center.

“I always believe things happen for a reason,” Marie Dodson said. “This could have been God’s way of telling her this is where she needs to be.”
Bystander CPR Scores
Cumberland County 9-1-1 makes two saves

Considering the estimated 344,700 people in the U.S. that each year suffer from a sudden cardiac arrest (SCA) at their homes, and the 8% who actually survive, Cumberland County (Pa.) Department of Public Safety is doing a great job of improving the statistics.

In July, with only three days between incidents, Dispatchers Eric Harne and Jimmy Brandt gave Pre-Arrival Instructions (PAIs) to callers, which resulted in the resuscitation of two patients in cardiac arrest.

On July 23, Harne took a 9-1-1 call reporting a 50-year-old in cardiac arrest. His story follows. Four days later, on July 27, Brandt took a 9-1-1 call reporting a 19-year-old female in cardiac arrest. That story is published on the previous page.

On Aug. 8, both received Life-Saver Awards from the Cumberland County Board of Commissioners.

Staff Development Manager Gary S. Dressler was deservedly proud of Harne and Brandt, although he’s quick to point out that the same goes for everyone at the center. “They all do a great job,” he said. “It all goes to show the power of EMD and the PAIs.”

During the early morning hours of July 23, Harne took the call from a woman who reported her husband might be having a seizure. Because of sounds in the background, Harne thought otherwise. “I could hear agonal breathing in the background,” he said. “He was in cardiac arrest.”

Harne started CPR PAIs, drawing the caller into a focused response that lowered her audible anxiety. Her husband’s pulse had returned by the time EMTs arrived on scene, and he had regained consciousness and was speaking prior to the ambulance reaching the hospital.

The credit, Harne said, goes to the caller. “She was the one doing the heavy lifting,” he said. “We’re advice and counsel.”

Harne said a Zen-like quality often develops from instructions relayed in a calming voice to a bystander providing repetitive CPR compressions. The ability to focus on the moment, he said, tends to ease the stress and worry accompanying the caller’s natural reaction to a medical emergency.

“They’re looking to you for help and you have to remain calm for them,” Harne said. “You don’t want them worrying about what might happen tomorrow. There’s only right now.”

Since MPDS® was in place when Harne started at the center 15 years ago, he knows no other way to answer callers and dispatch response. But he also said it takes more than the one person answering the phone. “We have a team,” he said. “You’re always happy to be the person who answers when everything works out, but it’s never only that one person.”

Harne and Brandt come from non-medical backgrounds. Harne had been in private industry looking for a change. Brandt was a mechanic at a paper company and a volunteer at the local fire department; he had been interested in emergency response since he was a kid.

Both said they find the 9-1-1 profession satisfying, although it’s not the type of job for everyone. “You have to figure out if you’re made of that kind of material, and the only way to find out is by trying,” Harne said. “Some people come in and find it’s not for them. Dispatch is a high-stress job, and you have to accept that. You can’t take the stress home.”

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Bystander CPR

Sudden cardiac arrest is not an isolated event.
According to the American Heart Association (AHA), nearly 383,000 out-of-hospital sudden cardiac arrests occur annually, and 88% of cardiac arrests occur at home.

While effective bystander CPR provided immediately after cardiac arrest can double or triple a victim’s chance of survival, only 32% of cardiac arrest victims get CPR from a bystander. Less than 8% of people who suffer from cardiac arrest outside of the hospital survive.

And there is a difference between a heart attack and sudden cardiac arrest. A sudden cardiac arrest occurs when electrical impulses in the heart become rapid or chaotic, which cause the heart to suddenly stop beating. A heart attack occurs when the blood supply to part of the heart muscle is blocked.

A heart attack may cause cardiac arrest.

AHA bystander recommendations¹

2010 (New): If a bystander is not trained in CPR, the bystander should provide Hands-Only™ (compressions-only) CPR for the adult victim who suddenly collapses, with an emphasis to “push hard and fast” on the center of the chest, or follow the directions of the EMS dispatcher. The rescuer should continue Hands-Only CPR until an AED arrives and is ready for use or EMS providers or other responders take over care of the victim.

All trained lay rescuers should, at a minimum, provide chest compressions for victims of cardiac arrest. In addition, if the trained lay rescuer is able to perform rescue breaths, compressions and breaths should be provided in a ratio of 30 compressions to 2 breaths. The rescuer should continue CPR until an AED arrives and is ready for use or EMS providers take over care of the victim.

Academy position

The following information stating the Academy’s position on CPR was published in the March/April 2013 issue of The Journal.

Mouth-to-mouth resuscitation

Regarding mouth-to-mouth instructions for trauma patients, this is the current standard of care—plain and simple. The AHA recommendation states it is “reasonable” for EMDs to provide a compressions-only pathway for adult arrest victims of probable cardiac origin. Respiratory and traumatic origins are still treated with compressions and ventilations.

Additionally, the incidence of contracting an infectious disease through rescue breathing is extremely low. However, one can respect the rescuer’s concern. We are only obligated to offer the current standard of care instructions; rescuers are free to refuse mouth-to-mouth in such circumstances, and they often do when blood is on the victim’s mouth, especially if the victim is a stranger. This is why we have a “Refused M-T-M” pathway.

Sources

¹ Highlights of the 2010 American Heart Association: Guidelines for CPR and ECC: www.heart.org/idc/groups/heart-public/@wcm/@ecc/documents/downloadable/ucm_317350.pdf
It's tough fighting city hall, especially when the building's falling apart and there isn't the money to fix it.

At stake is the Haleyville, Ala., city hall where the first 9-1-1 call was made in 1968. The building, at that time less than a decade old, was in its prime. Architect Martin J. Lide, who had his firm in Birmingham, Ala., was contracted for the design and, similar to much of his work, its actual construction has received attention among mid-20th century preservationists.

The Haleyville City Hall was listed in the Alabama Historical Commission’s Register of Landmarks and Heritage on Aug. 12, 2013. Eligibility included the age of the property— at least 40 years old—and its association with an event of state significance.

Listing in the state register is an honorary designation and exists to bring attention to and promote the property’s historical significance and, thereby, encourage its long-term preservation. The register does not restrict the rights of private property owners in the use, development, or sale of the property.

The building is scheduled to be demolished by early 2014 should the city close on a lucrative deal to sell the property to a commercial developer.

Haleyville resident Valeria Taylor is inflexible in her view against the sale, and if there's one battle she'll fight to the finish, it's protecting Haleyville’s claim to 9-1-1 history.

“City hall is a grand-looking place,” Taylor said. “It's the one real value to history left in this town, and there's the sign out front ‘Where it all began: What other town can say that?”

Taylor, who is 73, has lived her entire life in the town made famous by the first 9-1-1 call placed in the country. She doesn’t recall what she was doing at the time, and she can’t recall much local reaction to the event. She was married with two sons and a practicing social worker for the state of Alabama.

“I was busy and pretty much a wallflower,” she said. “I didn’t get involved.”

Taylor, however, fondly remembers the “Old Haleyville,” the place where she grew up, went to high school, raised children, and admired the city's Christmas tree decorated for ‘everyone to see’ in the downtown square.

“It was actually more of a triangle,” she said.

Over the years, Taylor said she has watched her memories torn down, one by one, and replaced by businesses she doesn’t necessarily chalk up to progress. Gone are the family-owned hardware stores, barbershops, five-and-dimes, movie theater, and grocery stores.

“The town went wet to attract more business,” she said. “But I don’t think a tattoo parlor or saloon are the types of business we wanted to come here.”

Taylor said city hall is one of few vestiges of Haleyville’s past. One other is the town’s first brick commercial building, a department store that Haleyville residents Dr. Joe Teal and his wife, Judy, bought in 1999 and spent thousands to renovate. The building is registered with the Alabama Historical Commission (since 2004) and the National Historical Commission (since 2009).

“That’s a whole story in itself,” Taylor said. “He had his own struggles with city hall and had to go out of town for help, but he got it.”

Taylor has followed Dr. Teal’s lead. The city hall building has state recognition, but sadly, she said, there is little time remaining to secure the national recognition.

By September’s end, Mayor Ken Sunseri and his five city council members will know whether the site will be sold. A developer offered an amount—in excess of $1 million—that far exceeds anything the city might expect from other commercial developers.

“This is a once-in-a-lifetime opportunity for us,” Sunseri said.

The council agreed. If all goes as anticipated, city offices would have six months to vacate and the building would be torn down in early 2014, and its replacement would be built downtown.
Sunseri appreciates Taylor’s concern. He moved to Haleyville in 1974, and his father-in-law, James Whitt, was Haleyville mayor at the time the first-ever 9-1-1 call was placed on Feb. 16, 1968, by Alabama Legislature Speaker of the House Rankin Fite from Haleyville City Hall to U.S. Rep. Tom Bevill, who answered in a different room at city hall.

Taylor finds irony in the history. “Don’t you think it’s strange that the son-in-law of the mayor who was there when it started wants the building torn down?” she asked. “You’d think he’d be the first person who’d want to save it.”

Sunseri says it comes down to practicality. “I understand why she wants to preserve the building,” Sunseri said. “But sometimes emotion and logic don’t meet in the same place.”

The building turns 60 in two years, and it started showing its age a long time ago, Sunseri said. The air conditioning unit, dating to 1959, hasn’t kept most offices at peak comfort for a good decade. To replace the unit, he said, would take cutting a hole in the roof.

“The roof needs to be replaced anyway,” he said.

The plumbing’s bad—a drainage pipe makes it impossible to reconfigure for disability accessibility—and the original wiring is still in use. Because of a shortage of copper in the 1950s, due to World War II, aluminum filled the urgent requirement to find a replacement. As often happens when there is an urgent need for something, there was a lack of due diligence such as appropriate testing by the labs of the day.

“We’re skeptical about the wiring,” Sunseri said.

Although Haleyville is a small town (pop. 4,172 in 7.4 square miles) with a proportionate number of public service officials, Sunseri said the city hall building is overcrowded and largely obsolete for the water and police departments, dispatch (the county handles 9-1-1 calls), courts, mayor’s office, and council staff.

The room where the call was placed is the office for the magistrate, and the room where the call was received is a storage closet. Sunseri doesn’t recall people asking for tours of the two rooms, and there is public access in the city hall lobby to the relics of the call—phone, plaques, and a written history.

And if the sale doesn’t go through?

“We lose out,” Sunseri said. “We stay here and make the repairs, but we’d have to do it in stages. It would cost us hundreds of thousands of dollars we don’t have. A new roof would be $300,000 alone.”

Building woes don’t impress Taylor, and neither does the money the city stands to make if sold. She heard about the potential sale in May at a city council meeting she attended on an unrelated matter.

“I thought council members were making a joke about selling city hall,” she said. “Come to find out they were serious.”

Taylor immediately got on a campaign to save city hall. Her daughter-in-law took photos that Taylor posted on a website (savethehomeof911.com) targeted to stop the demolition. She designed T-shirts displaying the message and circulated petitions in town and online. Taylor promoted the annual 9-1-1 Festival honoring all police, fire, and emergency personnel.

Dr. Teal, who has joined the fight, is a chiropractor practicing in Georgia, and he and his wife own land in Haleyville. He has plied Sunseri and city council with questions relating to the cost of repairing the city hall building, taxes, and if money is uncertain, “is it wise to invest in a new city hall at this time?”

“Sorry to sound so negative, but in addition to optimists and pessimists, there are also realists,” he said.

Sunseri said there’s no intention of annihilating history. The historic red phone on display in city hall would stay in Haleyville where he said it belongs.

“The phone’s what’s significant and not where the call was made,” he said. “We’d keep the phone and put it on display in the new building. I don’t think the town would miss the current city hall, and we’d still have the history.”

The architect, who is 95 and lives in Texas close to his son, also an architect, said he was delighted to learn the first call was made in the building he designed. Lide hadn’t known that fact until Sept. 10, 2013, when his son, also named Martin, talked to him about the city hall building he designed and its uncertain future.

At the same time, he doesn’t find the building architecturally significant, which is not to dismiss the historical significance.

“It was a design that I did, that I was proud of, and it may rightly have historical significance to some people in Haleyville,” he said. “But, I personally do not regard the architectural design of the building as having historical architectural significance at a broader societal level.”

As far as preserving the building, Lide is non-committal.

“I want the people of Haleyville to decide how they are best served in this case,” he said. “I don’t think that the building’s architect has any relevant standing in this local matter.”

Taylor has no intention of giving up.

“Everyone wants to have one thing that’s always there,” she said. “If it goes away, we lose a last connection to a place that’s been home to a lot of people.”

Sunseri said it’s a tough situation.

“You can’t please everybody,” he said. “And it’s my belief and the council’s belief that we’re doing the best we can for Haleyville.”