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Attendees focus on education and awards at Euro and UK NAVIGATORS in Wiesbaden, Germany, and Bristol, England, respectively.
Sherri Stigler is the training and operations manager for Waukesha County (Wis.) Communications, a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at sstigler@waukeshacounty.gov.

Angela Ayala is a registered nurse and an Academy certified Emergency Communications Nurse (ECN) at North Shore-LIJ Center for EMS, Syosset, N.Y., an Academy Accredited Center of Excellence (ACE). She was formerly assistant nurse manager at North Shore-LIJ Health System, which includes 16 hospitals and 400 physician practice locations throughout New York.

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.

Art is a regional software and EMD-Q® instructor for Priority Dispatch Corp™. He has been a fire and EMS dispatcher for 17 years and currently works at one of New Jersey’s largest regional EMS dispatch centers. Prior to that, he was a fire, EMS, and air medical dispatcher at CenCom, one of the state’s largest regional EMS dispatch centers. He has been involved in dispatch training and 9-1-1 medical quality assurance since 1999.

Guy Gleisberg is the research coordinator at Montgomery County Hospital District (MCHD) Emergency Medical Services in Conroe, Texas. He has a master’s degree in business administration and he is an NREMT-B and EMS-1. He is a frequent contributor to several EMS publications and writes about issues relating and patient care and safety.

MAIL CALL

We’d love to hear from you. Drop us a line at editor@emergencydispatch.org to share your thoughts.
Dear Reader,

I'm in awe of you. In fact I'm downright flabbergasted at the amazing job that you as emergency dispatchers perform, often with fewer resources, compensation, and public acclaim than your counterpart first responders.

Though I've never been in your shoes, I've talked with you numerous times in my former life as a newspaper journalist assigned to the “cops and courts” beats to get items to fill the daily police blotter. In that role, I had numerous occasions to get a glimpse of what first responders do—from ride-alongs with a state highway patrol trooper, to scamping 100 feet straight up to the top rung of a ladder truck in full firefighter gear, to wearing a Kevlar helmet and ballistic vest and firing off live rounds from a .40-caliber Glock at paper ‘villains’ in a “house” during a SWAT training exercise.

But similar to 99 percent of Joe Public, I haven’t sat in your seat, nor worn your headset, nor taken your 9-1-1 calls.

That’s why I’m grateful for the opportunities I’ve had since joining The Journal of Emergency Dispatch staff about a year ago to really learn more about what you do, why you do it, and how you do it. The more knowledge I’ve gained, the deeper my respect has grown for the challenges and stress that your job entails. As you know, most people wouldn’t last one week in your vocation. Probably not even one day.

In the time since I’ve come on-board, I’ve taken the EMD certification course; visited a consolidated, metropolitan 9-1-1 PSAP, and been able to talk with some of you. And although I don’t have your training or experience, I regularly connect with emergency communications experts to better provide you with what we hope are insightful articles and columns relevant to your vocation.

This month, I’m in awe of you. In fact I’m downright flabbergasted at the amazing job that you as emergency dispatchers perform, often with fewer resources, compensation, and public acclaim than your counterpart first responders.

The Journal of Emergency Dispatch is the official bimonthly publication of the International Academies of Emergency Dispatch (IAED), a non-profit, standards-setting organization promoting safe and effective emergency dispatch services worldwide. Comprised of three allied academies for medical, fire, and police dispatching, the IAED supports first-responder-related research, unified protocol application, legislation for emergency call center regulation, and strengthening the emergency dispatch community through education, certification, and accreditation. General IAED membership, which includes a Journal subscription, is available for $35 annually, $75 for two years, or $119 for three years. Non-member subscriptions are available for $75 annually. By meeting certain requirements, certified membership is provided for qualified individual applicants. Accredited Center of Excellence status is also available to dispatch agencies that comply with Academy standards. © 2014 IAED. All rights reserved.
NO PARDON FOR THE INTERRUPTION
Legislation would criminalize intentional emergency radio obstruction

Scott Freitag, IAED President

By the time this column goes to print, a resolution from both sides of Congress could be on its way to becoming federal law.

The bill, H.R. 4203: Emergency Responder Radio Communications Protection Act of 2014, amends the federal criminal code to prohibit knowingly interfering with the working or use of any radio frequency used by emergency response providers or obstructing, hindering, or delaying the transmission of any communication over any such frequency.

Reps. Steve Israel, D-New York, and Peter King, R-New York, introduced the resolution in March 2014, and it was referred to the House Subcommittee on Crime, Terrorism, Homeland Security, and Investigations.

Radio jamming is the deliberate transmission of radio signals that disrupt communications. The resolution criminalizes attempts to hijack emergency radio frequencies for malicious purposes.

According to a press release from Israel’s office, under current federal law, those found guilty of intentional radio jamming are subject to a maximum civil penalty of up to $16,000 for each violation or each day of a continuing violation, and as high as $112,500 for any single act. There is no jail time connected to a civil offense. Currently, the only time a criminal penalty can be invoked is if a perpetrator interferes with radio frequencies used for military or civil defense purposes.

The new legislation would make the intentional jamming of radio frequencies used by first responders a felony offense, punishable by up to 10 years in prison and a $10,000 fine, plus the existing civil penalties.

The resolution goes up against incidents that are deliberate attempts to disrupt 9-1-1 communications and, as sometimes happens, EMS response gets sent where none is needed.

Israel and King developed the legislation following the arrest and conviction of a man obstructing Melville Fire Department (N.Y.) radio frequencies over a period of 10 months. When disrupting fire department calls for service on the main frequency, personnel had to switch to another frequency in order to communicate with each other, as well as with dispatchers. According to local news reports, the unauthorized transmissions were coming from a radio programmed with a code assigned to fire department rescue officers in the Suffolk County Fire Service. The man was charged with obstruction of governmental administration and fined $25,000 for hacking the radios and creating interference with chanting and heavy breathing.

The barrage of phony emergency requests received by Litchfield County Dispatch (Conn.) is another example. Unauthorized broadcasts interfered with and interrupted calls for service for both ambulance and fire departments during the period from Dec. 25, 2013, to Jan. 6, 2014. The calls dispatched ambulances to fake calls and canceled firefighters en route to actual emergencies.

The 35-year-old man apprehended in connection with the fake emergency radio calls faces several charges, including first-degree reporting of a false incident (Class D felony), first-degree reckless endangerment (Class A misdemeanor), and third-degree computer crime (Class D felony).

Years earlier, also in Connecticut, the amateur radio group Capitol Region Malicious Interference Tracking helped lead authorities to an individual allegedly using a modified ham radio to transmit on police and fire frequencies used by state public safety agencies. He was charged with criminal mischief, interfering with police, and breach of peace.

These are not isolated incidents, and it’s not all that difficult to do for those so maliciously inclined. Police and fire radios picked up secondhand or online can be programmed on the public safety channels from public listings of police and fire department radio frequencies. Public service radio encryption is expensive.

This is a federal initiative. As King said, “It is imperative that emergency communication remains seamless. Those who seek to intentionally obstruct and put the lives of the community at risk need to be criminally punished. This legislation will do just that.”
WHICH PROTOCOL FITS THIS EMERGENCY?
Seizure causes fall from roof

Jeff Clawson, M.D.

Dr. Clawson:
I am a deployment manager for the Northern Communications Center in Alberta for Alberta Health Services EMS Communications and Deployment. I would like to take a moment of your time to see if you can answer my question or if you can better direct me to another department. We are utilizing the Medical Priority Dispatch System™ (MPDS®) 12.2 with an upgrade to ProQA Paramount this fall. We recently reviewed an event in which a caller had a seizure on the roof of the house and then fell 10 feet to the ground. I am seeking direction on which protocol best handles this situation. This does not happen very often; however, I am certain this question must have a greater frequency with the Academy. Perhaps this question and answer could be answered and posted on the Academy's website for others to review and consider as well.

Thank you for your time and assistance with this perplexing situation.

Sincerely,
Lin Sturgeon
Deployment Manager
EMS Dispatch, Communications and Deployment
North Communications Center
Alberta Health Services
Alberta, Canada

Lin:
You are correct regarding this being a rare event, and also that the Academy is often privy to these rare occurrences simply because of the volume of MPDS users worldwide—2,954 and rising. Coincidentally, I responded to a similar question a few days ago where it was reported that a man was struck by lightning and subsequently fell from a rooftop. I tend to remember these cases when I’m thinking that I’m having a bad day!

Your question relates to the Chief Complaint selection Rules on Case Entry, specifically Rule 2 regarding mechanism of injury, and also the built-in fail-safes of the MPDS that safeguard the EMD when multiple Chief Complaints are initially present. Protocol 17: Falls is most appropriate because of the mechanism of injury (LONG FALL), and the potential for serious, underlying injuries. Note that the first question on Protocol 17 relates to the height of the fall, which helps to qualify the potential medical “shunt” to Protocol 31: Unconscious/Fainting (Near), which is qualified by (ground level) when either “Dizziness” or “Fainted/Nearly Fainted” is determined to be the cause of the fall. The rationale is fairly simple, and it applies to your seizure case as well.

Ground level falls are not likely to cause life-threatening injuries from a prehospital standpoint, especially when the patient is alert. If the cause of the ground level fall is medical in nature, the protocol automatically shunts the EMD to Protocol 31 to evaluate the medical cause, which is often more serious than the fall itself. In fact, many of these cases actually turn out to be cardiac arrests, simply because the caller only witnessed the fall, and not the prior loss of consciousness. If the cause of the fall is unknown, the Unconscious/Arrest or Not alert determinant codes on Protocol 17 provide the appropriate fail-safe. However, LONG or EXTREME falls have the potential to cause very serious, or occult (hidden), injuries that may not be recognized by the caller or even the responder, so knowing the mechanism of injury and coding the call appropriately is paramount.

With that said, the Post-Dispatch Instructions (PDIs) from protocols, other than the one chosen for the case, are always available if needed, and this practice is permissible and encouraged in the ED-Q™ scoring standards. In the case you describe, the EMD should code the call on Protocol 17, provide any applicable PDIs, and then consult the PDIs from Protocol 12: Convulsions/Seizures, if necessary. Note that Protocol 12 has direct links to PAIs should the patient arrest, as does Protocol 17.

I hope this response answers your question. I think your question and this answer would benefit other EMDs. Please do not hesitate to contact me directly if you have any additional protocol questions.

Brett A. Patterson
Academics & Standards Associate
Medical Council of Standards Chair
Preliminary findings from the research survey distributed at NAVIGATOR 2014 adds to the growing body of literature that indicates stress, from secondary exposure to emotional trauma, is an occupational hazard for fire, police, and medical dispatchers.

Significant findings from the survey indicate dispatchers experience a level of secondary traumatic stress that is 30 percent greater than the level experienced by registered nurses participating in a study using the same criteria.

Dispatchers’ levels of burnout are also greater, with nearly one-quarter (24.83 percent) of respondents exhibiting various stages of Compassion Fatigue, a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress, compared to 22 percent of RNs in a similar study.

In addition, 17 percent of the 189 respondents completing the survey at NAVIGATOR met criteria for Acute Stress Disorder (ASD) related to incidents occurring in the 30 days prior to taking the survey. The study defines ASD as acute stress reactions, “that may occur in the initial month after a person is exposed to a traumatic event.” The disorder includes symptoms of intrusion [unwelcome and pervasive memories], dissociation [detachment from immediate surroundings], negative mood [irritable state of mind], avoidance [withdrawing from social action], and arousal [strong reaction to stimuli].

Incidents contributing to the reported ASD involved the secondary traumatic stress dispatchers experienced from helping callers seeking emergency assistance during a typhoon (7 percent), industrial accidents (6 percent), and assaults and burns (13 percent). Although the 189 responses represent only a segment of the number of individuals expected to contribute data for the study, the results nearly mirror findings from Roberta Troxell’s 2008 study of 497 Illinois emergency dispatchers. In that study, 163 percent acknowledged symptoms consistent with Compassion Fatigue (CF), defined as a condition in which a person experiences struggles with work-related secondary traumatic stress symptoms and burnout.

Other findings include an assessment of organizational factors and types of calls that result in the greatest sources of stress:

- Workload, followed by lack of appreciation from management, and lack of training were found to be the primary sources of organizational stress. No participant found poor communication among staff to be a source of stress.
- Traffic accidents were rated as the most stressful type of call to handle, followed by suicide, calls involving injured children, structure fires, and first-party callers (the rankings were based on calls answered in the 30 days prior to the survey and not inclusive of calls taken over a dispatcher’s career).
- The majority of study participants dispatch for all three services (fire, police, and medical), while the majority of respondents handling only one type of service dispatched for EMS. Of the 189 total respondents, 133 were female and 56 were male. Almost one-quarter (50) reported working as a dispatcher for 13 to 19 years.

Results indicating a dispatcher’s quality of life from the responses provided were determined by applying the Professional Quality of Life Scale (ProQOL), a commonly used measure of the negative and positive affects of helping others experiencing a traumatic incident. The ProQOL has subscales for compassion satisfaction, burnout, and CF.

Not surprisingly, the factors causing compassion satisfaction are the same as those causing CF: providing care, the system, work colleagues, and beliefs about self.

The study is a collaborative effort between the International Academies of Emergency Dispatch® (IAED™) and a team led by principal investigator Clint Bowers, Ph.D., from the University of Central Florida (UCF). Bowers co-directs the UCF Recent and Emerging Technology Research Organization (REtRO) and specializes in research involving the nature of effective teamwork and factors influencing cooperation.

Comprehensive results of the study will be published in the IAED’s scientific journal, the Annals of Emergency Dispatch & Response.

**Sources**

A WHEEL IN MOTION
My journey back to the pen

Sherri Stigler

Truth be told, and horrific as it sounds (to me at least), I have been in this crazy business of public safety for more than 30 years. In my opinion, public safety in general tends to operate like a big wheel. The spokes include the different entities, such as law enforcement agencies, fire departments, and, of course, EMS services.

I have been privileged to serve as an undercover county drug officer, a municipal police officer, and a volunteer firefighter and EMT. Great spokes, indeed. But the most important job I’ve ever had was that of public safety dispatcher. I think of that job as the hub; the part of the wheel that makes the spokes turn, the part that connects them and makes them work in unison to move the entire unit down the road.

If you are a hub, I hope you recognize how very valuable you are to your organization. People depend on you for lots of reasons: information, backup, and protocol instructions over the phone until help arrives on-scene. This idea of being the first, first responder is absolutely the truth. Never doubt your worth.

The hubs make the wheels turn and make the difference when it comes to the effect on the outer tire, which is very much like the community we serve. Tires are weird creatures. They wear differently. They fray, and they lose air. Sometimes they blow. They are unpredictable, at best. It is the wheel’s lot in life to serve the tire we bear and keep the spokes in motion.

This is where the “rubber hits the road,” folks!

In every hub’s life, there comes a time where we recognize our rust. When that happens, it’s best to let new hubs take over the central work, which I have done. Ultimately, as manager, I am a hubcap. I protect my hubs from burnout, apathy, and liability. I make sure training is top quality. We are an important part of a wheel on a never-ending journey.

My journey as a writer began a long time ago.

Thanks to my mother, who is a word wizard, I inherited the love of setting words to print, and, more importantly, to the heart. My writing has been concentrated on feature articles in regional print magazines. But honestly, raising a growing family and juggling nonstop career demands bumped the pen aside for the past several years. I owe a debt of gratitude to The Journal staff for welcoming me to the fold, and to Dr. Jeff Clawson for creating, nurturing, and sharing the power of the protocol. The IAED™ is the driving force that has allowed public safety dispatch to transcend from being “just a job” to being a highly respected and valued profession.

I am committed to using the power of this space to share advice about keeping all parts of our wheels in balance. Sometimes, we feel out of alignment. Maybe you didn’t get enough sleep before you came to work. Maybe a co-worker, a supervisor, or your spouse is on his or her last nerve.

How can we help others in the comm. center feel appreciated and valued? What is it that ticks you off or makes you tick?

My hope is that we can, together, fill each other’s toolboxes with items valuable to our profession so that we can fix what needs fixing and continue to drive our forward momentum. If you have thoughts to share, whether you are a hub, hubcap, spoke, or some other part of this crazy wheel of public safety communications, I will welcome them!

The IAED is the driving force that has allowed public safety dispatch to transcend from being “just a job” to being a highly respected and valued profession.

Both hands on the wheel, folks! Let’s roll!
When I started my career in nursing in 2003, I never anticipated a door opening to the exciting experience as an Academy-certified Emergency Communication Nurse (ECN) in our clinical call center at the North Shore-LIJ Health System in Syosset, NY.

Having worked as a registered nurse in pre-hospital and hospital settings, I initially doubted a venture of this magnitude. I never imagined an avenue of quality care delivered indirectly, without the benefit of face-to-face contact.

But since putting my fears aside and digging in with both hands, however, I’m confident our Emergency Communication Nurse System™ (ECNS™) team is going to have a positive impact in the face of certain changes in health care, specifically the care provided outside a hospital setting.

My career choice was based on fulfilling a need that has existed through the ages.

We all require food, water, a stable environment, respect, and care. As a nurse, I am responsible for the care provided to patients who may have very different needs. While that will never change, the environment and ways this can be achieved are moving from direct patient care in a hospital setting to the virtual world offered through electronic communications.

The ECN works directly with the EMD to ensure the patient receives optimal care.

At North Shore-LIJ, the EMD-certified EMTs and paramedics staffing the communication center handle nearly 1,500 calls each day. The type of call varies from an unstable cardiac patient needing emergency cardiac catheterization to time-sensitive pediatric intensive care unit (PICU) transfers and prescheduled basic life support transports.

As required by ECNS, I am a registered nurse and an Academy-certified EMD.

EMD training prepared me for hysterical, fearful, and upset callers, and taught me how to provide over-the-phone CPR, child delivery, and dislodging an obstruction in a choking patient. The training was a vital step in our journey to ECNS because of the protocol-driven system that helps me to understand nurse triage. I learned the importance of applying clinical knowledge in tandem with the LowCode™ software.

The instructors, Dr. Conrad Fivaz, Emergency Response Operations Director, and Jennie McQueen, an RN and Emergency Nursing Communication Specialist, worked diligently to help us understand the connections between all of the important facets of nurse triage. They knowledgeably handled our questions and concerns and provided specific examples of positive interactions with our future patients.

The nine ECNs at North Shore have differing clinical backgrounds and experience, but through ECNS training, we are a team of one, headed toward a necessary movement in health care.

Since the program is new to North Shore and our patient population, we are baby stepping into ECNS through managing a specific patient population that contacts us directly for nurse advice. As we continue to grow the possibilities are quite endless, and I would urge others to look into how ECNS can help your community.

Preliminary results show that ECNS is beneficial. It’s patient-centric, directing patients to the care they need and want.

As an RN who formerly worked on the hospital floor, I know that most patients would rather not be there. So often I would hear: “I would do better if I was home” or “I wish I didn’t have to go through all of this in the ER.” ECNS provides an opportunity to grant a patient’s wish and increases his or her future involvement in medical decision-making.

For quality health care to survive, the ability to remotely assess patients, provide treatment, and follow up remotely is a way of the future. ECNS is an exciting vehicle, and I look forward to the direction it will continue to take us.

As an ECN, I rely on my clinical skill and the protocols to help a patient beyond the walls of an emergency room. It’s the ideal mix that I never thought was possible, until now.
While a dispatcher certainly needs active listening and multitasking skills and exceptional empathy to reassure emotional callers, there is an often-overlooked skill that is every bit as important as the rest.

**Hint:** It relates to a common concern involving protocol compliance.

When callers provide conflicting or vague answers to questions, dispatchers are taught to clarify responses. Without learning the most effective way to clarify, the non-compliant techniques used by dispatchers often confuse or anger the callers.

**Answer:** An emergency telecommunicator must understand the difference between closed-ended questions and open-ended questions.

A closed-ended question solicits limited responses (usually “yes”/“no” options). In many cases, the answers are provided in the body of the question itself.

**Examples:**
- “Is he acting odd because he is drunk?”
- “Is the alarm going off a burglar alarm or a smoke detector?”

Closed-ended questions are detrimental to an emotional caller distracted by the scene (reason for the call) and not 100-percent focused on the person at the other end of the phone or engaged in the interrogation.

Rather than thinking about the questions being asked and providing thoughtful answers and accurate information, the emotional caller might absent-mindedly reply, “yeah, yeah, sounds good.” In addition, the emotional caller is asking for help and reassurance. The caller will often defer (or cling to) anything the dispatcher presents.

“Your husband’s awake?” is perceived to be a statement rather than a question and leads the caller into an affirmative response.

Freelance questions and leading questions are non-compliant behaviors; they do not give the caller an opportunity to freely clarify statements, but rather only serve to confirm the dispatcher’s perceptions of what he or she heard or what is believed to be happening. In these instances, the dispatcher inserts an opinion or a bias into the question.

“So you said ...” is not an effective way to clarify information previously provided by a caller.

An open-ended question allows the other party to freely provide information. The dispatcher is not limiting the caller to specific options or “yes”/“no” responses.

**Examples:**
- “Why is he acting odd?”
- “What type of alarm is it?”

Open-ended questions let the caller provide a narrative that effectively answers the specific question the dispatcher was clarifying and also spontaneously provide additional information to identify previously undisclosed scene hazards, signs/symptoms, or answers to apply elsewhere in the protocol.

**Example:**
Dispatcher: “Okay, tell me exactly what happened?”
Caller: “Please help me. My son has blood all over his face.”
Dispatcher: “I understand. Why does he have blood on his face?”
Caller: “He fell out of our treehouse. It’s almost 15 feet up in the tree. I think he broke his arm, too.”

This open-ended question effectively clarified the Chief Complaint Protocol selection and also answered two Key Questions found on Medical Priority Dispatch System™ (MPDS®) Protocol 17: Falls.

In many situations, simply re-asking the question as written is the most efficient way to clarify information. This is particularly appropriate when given a vague or confusing answer in regard to the Chief Complaint Description Question (MPDS Case Entry Question 3 and PPDS®/FPDS® Case Entry Question 4).

Acknowledging the caller’s response and then re-asking the question exactly as it is written—with an emphasis on the word “exactly”—is the best practice.

Description Question (MPDS Case Entry Question 3 and PPDS®/FPDS® Case Entry Question 4).

Acknowledging the caller’s response and then re-asking the question exactly as it is written—with an emphasis on the word “exactly”—is the best (and most compliant) practice.

“Okay, tell me exactly what happened?”

In addition to the many skills that an emergency dispatcher must learn and employ, defining an open-ended question (and supporting its value as the most effective way to clarify caller information) should be taught during initial training and reinforced through continuing education.

The ability to differentiate between freelancing and clarifying is key to improving compliance as well as providing exceptional service.

And we all want to provide the best service, right?
NOT A ONE-WAY CONVERSATION

The obvious dilemma

Art Braunschweiger

There’s a particular utility company I have to call anytime my fire department needs it to respond to a blown transformer, a wire down, or an emergency shutoff. Once I’ve provided the utility company operator with the address, I am subject to a series of scripted questions:

“Is this in a gated community?”
“Is the fire department on-scene?”
“Is anything preventing emergency personnel from responding to the scene?”
“Are any poles or wires down?”

You get the idea.

So one day, having been through this enough times to have it memorized, I decided to help the operator out. After she pulled up the address, I volunteered (politely, and—I thought—helpfully): “It’s not in a gated community, the fire department is on-scene, nothing is preventing emergency personnel from responding to the scene, and there are no poles or wires down.”

The briefest moment of silence followed. (She was probably thinking “smart-ass.”) And then she replied, with a hint of reproof in her voice, “Sir, I have to ask you these questions.” And—thinking helpfully—“It’s not in a gated community, the fire department is on-scene, nothing is preventing emergency personnel from responding to the scene, and there are no poles or wires down.”

The briefest moment of silence followed. (She was probably thinking “smart-ass.”) And then she replied, with a hint of reproof in her voice, “Sir, I have to ask you these questions.” And she proceeded to ask every one even though I had already given the answers to them.

As emergency dispatchers, we don’t have to ask a question if the caller has explicitly stated the answer to it. But what happens if the answer to a question has been volunteered up front, but we weren’t ready for it? Obviously, we should all have good active listening skills, but there are times where we’re not 100 percent confident in recalling what was said. Asking the protocol question as scripted might give the impression that we weren’t listening. The safe alternative would seem to be to feed the answer back to the caller in the form of a question as in, “You said she fell down five stairs?”

Unfortunately, this is leading the caller.

The Academy’s performance standards don’t allow it, and for good reason: What you think you heard might not be what the caller meant.

Here’s an example. At the opening of a call, when asked for the address of the emergency, the caller—a panicky mother—reports that her son was playing in the backyard when a large dog ran up and bit him. As the ED starts to calm her down in order to get the address, she says, “The dog ran around the front of the house. I don’t see him now.” Once on Protocol 3: Animal Bites/Attacks, the ED reaches Key Question 2— “Where is the animal now?” Recalling what the caller said, the ED says, “And you said the animal left?” This is not the same question. In the example above, the dog had left the yard, but was somewhere in the front of the house—thereby posing a danger to responders.

There’s a way to confirm what we heard without violating the performance standards and without sounding like we weren’t paying attention.

Three short words will do the trick: “Tell me again.” In the case of the dog bite example above, you would ask, “Tell me again—Where is the animal now?” This lead-in phrase preserves the protocol script while sending the message, “I’m pretty sure I remember what you said, but I just want to make sure.” This isn’t altering the protocol script; it’s simply applying good communication skills to enhance the flow of conversation.

Sometimes, we concentrate so much on the protocols that we don’t pay enough attention to our callers when they get ahead of us. When they do, making a conscious effort

Without violating the performance standards and without sounding like we weren’t paying attention, three short words will do the trick: “Tell me again.”
Visit the NAVIGATOR 2015 website today to see the full conference SCHEDULE-AT-A-GLANCE.

Plus, check out The Paris Hotel—home to the NAVIGATOR conference. To book your rooms early before they’re gone, visit www.navigatorconference.org
There’s not a day that’s slow for the dispatch centers in the counties of Indiana. Or, at least, there won’t be a day that’s less than fever-pitched action during the state-mandated consolidation of existing dispatch centers into no more than two centers per county. The deadline to consolidate is Dec. 31, 2014.

Nancy Lockhart is the director of St. Joseph County Fire Dispatch in South Bend, Ind., and the newly appointed operations manager of the single center consolidated from four centers in this county on the northern border of Indiana. The consolidated Public Safety Answering Point (PSAP) will handle police, fire, and emergency medical services (EMS) communications in St. Joseph County.

On Sept. 30, Lockhart watched as the new St. Joseph County Executive Director Todd Geers threw the symbolic shovel of earth during the groundbreaking ceremony held at the site of the primary center and backup center. The multi-million dollar facility will house St. Joseph County Fire Dispatch, St. Joseph County Police Dispatch, South Bend dispatch, and Mishawaka dispatch. The current South Bend Dispatch Facility will serve as the county’s backup center and as a temporary home for the St. Joseph County Police and Fire Dispatch centers while the new building is being completed.

While the initial planning forced extra long hours, the work is far from done and, in some ways, it’s just beginning. Lockhart said the near future includes certification of all dispatchers in the Academy’s medical, fire, and police protocols. St. Joseph County Fire Dispatch—a name it will lose in the consolidation—uses both the medical and fire protocols, and recently recertified as a medical Accredited Center of Excellence (ACE) and became a fire ACE in early 2013.

Mishawaka uses the Academy’s Medical Protocol, while the two other centers follow a mixed approach to calltaking and dispatching.

Lockhart welcomes the change, particularly “the tons” of opportunities it will provide staff in terms of variety and promotion potential.

“I see a lot of great coming from this,” she said. “I’m not so naive to think this will be easy to accomplish, but the result will be worth everything we go through.”

The consolidated PSAP has a staff of 63, and employees of the former four separate centers were given the option to stay. In 2008, Indiana legislators approved sweeping changes to the state’s 9-1-1 laws, including the establishment of a statewide 9-1-1 Board, collection and distribution of surcharges, 9-1-1 abuse penalties, and the requirement to consolidate PSAPs in each of the state’s 92 counties.

The Academy’s Emergency Communication Nurse System™ (ECNS™) is now eligible for Accredited Center of Excellence (ACE) status.

The Twenty Points of [ECNS] Accreditation are similar to the Twenty Points essential to achieve a medical, fire, and police ACE, according to IAED™ Associate Director Carlynn Page, with modification directly related to the way ECNS operates.

“Reaching ACE, no matter the discipline, requires the same high standards,” said Page, who has overseen the ACE process for more than 200 centers during the past 15 years. “The Twenty Points has been the benchmark standard since we’ve recognized these model centers through the ACE program.”

Dr. Conrad Fivaz, IAED Emergency Response Operations Director; Jennie McQueen, registered nurse and ECNS Specialist; and Page will coordinate the ECNS ACE process, while Jerry Overton, the new IAED Accreditation Board Chair, will have oversight of the entire ACE program.

ECNS is the Academy’s Fourth Pillar of Care and Practice. It works in conjunction with utilizing the Medical Priority Dispatch System™ (MPDS™) in ProQA® OMEGA Protocol dispatch software and its companion AQUA® quality improvement software.
National 9-1-1 data can add muscle to local operations

Washington, D.C.—A national report analyzing 9-1-1 data from emergency communication centers around the country will be available from the National 911 Program by the end of the calendar year. The report, based on 2013 data, provides a variety of information, including the number of 9-1-1 calls received, 9-1-1 fees, and progress toward implementing Next Generation 9-1-1 (NG9-1-1).

"Nearly three-quarters of the nation's state administrators are working to collect and share state data through the 911 Profile Database," said Laurie Flaherty, National 911 Program coordinator. "Real data will provide the 9-1-1 community with ammunition to make the case for the needs of 9-1-1 systems locally and nationally."

Flaherty suggested centers use the data to compare activities among states with similar 9-1-1 systems and modify existing 9-1-1 programs. Financial data collected presents a clearer picture of the cost to operate 9-1-1, which can help generate additional funding when presented to local and state leadership.

In addition, data from the National 911 Profile Database will be combined with the National Emergency Number Association's (NENA) state data on Enhanced 9-1-1 deployment and NG9-1-1 planning and transition.

PSAPs safe under HIPAA

The question is settled, generally speaking. The Health Insurance Portability and Accountability Act (HIPAA) does not apply to Public Safety Answering Points, according to a recent National Public Safety Telecommunications Council (NPSTC) conference call.

HIPAA does not apply to communications required to treat patients or to information shared for operations purposes (45 C.F.R. § 164.501). Information to treat patients and to operate effectively as an emergency service are considered incidental disclosures, which HIPAA's provisions specifically permit.

In addition, HIPAA was never intended to be an impediment to patient health, and it applies only to communications made by "covered entities." 9-1-1 dispatchers are not considered a covered entity because, according to HIPAA definition, they do not engage in covered electronic transactions, such as directly billing insurers or transmitting health care enrollment information.

An exception might be a dispatch center that is part of a covered entity, such as a hospital. The question was raised in relation to unencrypted land mobile radio communications that scanners can intercept and whether unencrypted radio properly protects patients' privacy rights under HIPAA.

Source

Police communication dispatched to county center

Police dispatch at Carlisle (Pa.) Police Department was transferred to the Cumberland County 911 center in August, bringing to an end a decades-long tradition of self-dispatch for the officers. The Cumberland County 911 center was poised to pick up the calls immediately in a transition “that officials expect will be a seamless experience for the general public,” according to a story in the Cumberland Sentinel newspaper.

Cumberland County 911 uses the medical and police dispatch protocol systems.

The transition was reportedly more than a year in the making, which included an intra-governmental analysis, a close vote by council members, and the creation of a committee that spent months overseeing the effort.

A new records management system and radios were only a sampling of the work required before the transition was complete. County dispatchers introduced their operations to police and went on ride-alongs to learn the territory.

The transition also meant a public relations campaign to reinforce calling 9-1-1 in an emergency rather than the accustomed seven-digit number for the Carlisle Police Department, and the factors that constitute a police emergency.

But the transition doesn’t mean the meetings are over. Officials anticipate a continuous process of learning, training, and tweaking.
INDUSTRY INSIDER | news

Take the plunge

Law enforcement, fire departments, EMS teams, and their 9-1-1 dispatchers will battle it out in the very cold waters of the Delaware River on Jan. 24, 2015, in the “Battle of the Badges” fundraising challenge to benefit Special Olympics PA.

Battle of the Badges, which includes vying for the coveted traveling trophy, is held during the annual Eastern Polar Plunge, which assists thousands of Special Olympics athletes to continue to participate in Special Olympics activities at no cost to them or their families.

Pennsylvania polar bears aren’t the only ones destined to take the plunge. Polar Bear Plunges are held throughout the country during the coldest time of the year to raise money for Special Olympics.

The 14th annual Maryland State Police Polar Bear Plunge in 2014 raised more than $2 million by plunging into a “balmy” 37-degree Fahrenheit lake water with air temperatures of 17 degrees (not taking into account wind chill).

Special Olympics NY has 16 individual Polar Plunges running—or plunging—through the season from Nov. 8, 2014, to Feb. 8, 2015 (and six dates yet to be posted).

Text to 9-1-1 deadline arrives almost ASAYGT

All carriers and certain IP-based application providers must be ready to implement text-to-9-1-1 by Dec. 31, 2014, according to requirements established by the Federal Communications Commission (FCC).

And it may even be in place As Soon As You Get This (ASAYGT).

After that deadline, 9-1-1 Public Safety Answering Points (PSAPs) may begin requesting the service from wireless carriers, and it must then be provided by June 30, 2015, or six months from the date of request, whichever is later.

Also in August, the FCC issued a third request for comments on future text-to-9-1-1 capabilities, including how a texter’s location might be transmitted and how roaming might be accomplished.

The new rules don’t cover some other smartphone applications.

The National Emergency Number Association (NENA) issued a statement applauding the rules, which in part states:

“[Today’s] action by the Commission underscores the value of alternative means of communicating to 9-1-1 in times of emergencies. SMS texting will be in the marketplace for years to come. Enabling SMS text-to-9-1-1 will undoubtedly benefit many wireless consumers who primarily, or solely, rely on texting as their means of communication. Millions of our citizens are deaf, hard of hearing, and/or speech-impaired. Unfortunately, for those who find themselves in dangerous situations, texting to 9-1-1 is sometimes the safer—or only—option.

Boy Scouts and firefighters partner in time-saving project

A Fredericktown (Mo.) Boy Scout troop has been credited with decreasing residential and commercial property taxes, lowering the Insurance Service Office (ISO) rating, and, at the same time, improving emergency fire service response.

And all with a little help from University of Missouri Extension natural resources engineer Frank Wideman and 20 volunteer firefighters.

The project put Scouts and firefighters side-by-side to locate and map nearly 300 fire hydrants using GPS technology following Wideman’s instruction. The GPS data can be sent digitally to firefighters when dispatched from rural area volunteer fire departments, which saves valuable time when arriving on-scene.

GPS mapping saves firefighters the time and trouble of searching for hydrant information in paper files or stopping their trucks to ask residents for locations. “It’s tough for volunteer firefighters to know where all those fire hydrants are,” according to Wideman, in a story published by Insurance News. “This map helps them to do that.”

A three-point decrease in Fredericktown’s ISO rating attributed to the GPS program reduced premium costs by 15 percent for residential and commercial property owners.

To get your team ready for the plunge, go to www.specialolympics.org(Calendar)/Polar_Plunge.aspx

To get your team ready for the plunge, go to www.specialolympics.org/Calendar/Polar_Plunge.aspx
Queensland Ambulance rolls out green-light technology

Twenty-seven Queensland Fire and Rescue Services and Queensland Ambulance Services vehicles from nine stations are now fitted with the technology to activate green lights in an emergency, allowing the vehicle to move safely through the junction without having to weave through heavy traffic.

The process starts at the station. Crews push directional buttons on a control box to clear the lights in the direction they’re heading. Then, once the unit’s on its way, the interface in the emergency service vehicle’s electrical system, when operating its lights and siren, triggers green lights 700 meters (about 2,296 feet) before the vehicle reaches designated intersections along the route to the incident.

The system does not jeopardize drivers, bikers, or pedestrians moving along the same route. Motorists don’t have to worry about traffic lights behaving strangely as the ambulance approaches since the device is designed to sequence the lights. The lights change as they normally do, although the duration on red could mean a longer wait when an ambulance is approaching.

The device initially installed in one ambulance was set to control 11 sets of traffic lights in a pilot program that lasted several months. The full rollout should be complete in two years.

LAS paramedics celebrate 10 years of cycling to save lives at Heathrow Airport

Nine years ago, on Aug. 6, 2005, London Ambulance Service (LAS) (England) cycle medic Mick Hampson reached cardiac victim Graham Clark within seconds of a 9-9-9 call and was able to restart his heart after three attempts, using the portable defibrillator carried on ambulance bicycles.

“I was definitely in the right place at the right time,” Hampson said (in a story posted on the LAS website). “The fact that we are based here and I was able to get to him so quickly most probably made the difference between life and death.”

Clark and Hampson were reunited this past summer at the same terminal to celebrate the 10-year anniversary of the Heathrow Cycle Response Unit (CRU) and the 15 paramedics responding to 9-9-9 calls at the airport.

Clark, who still works at Heathrow, remembers little of the event. “Everything went blank,” he said. “I’m so grateful to Mick and my colleagues. It’s as if I’ve been given a second chance.”

More than 4,000 of the 42,000 patients that CRU has treated over the past 10 years have been of a serious nature, including cardiac-related. During the program’s first year (2004-2005), cycle paramedics attended 473 incidents, a number that increased to 5,915 in 2013-2014. They treated nearly 75 percent of incidents on-scene without transportation.
SYNCOPE UNDERSTANDING
Caller descriptions vary when reporting fainting episode

Brett Patterson

We have learned through outcome analysis that priority symptoms “discovered” during interrogation on a different protocol are generally associated with less acuity than priority symptoms that are part of the initial Chief Complaint.

Brett:
There is a lot of confusion regarding the various responses volunteered by callers with regard to fainting and the definition of the First Law of Fainting on Protocol 31: Unconscious/Fainting (Near). Many EMDs and EMD-Qs have mixed views on caller responses such as, “She felt like she might pass out or he feels a little faint,” as opposed to a more definitive statement of, “He felt like he was passing out” or “She almost fainted.” When given all of the various descriptions and levels of feeling faint or nearly fainting, is it appropriate to immediately go to Protocol 31 or clarify further?

David A. Clements
Senior Communications Dispatcher
EMD-Q Coordinator
Santa Clara County 9-1-1 Communications
Santa Clara, Calif., USA

Dave:
Establishing a patient’s level of consciousness or, more specifically, quantifying the myriad caller descriptions that lay between completely normal and unconscious, has long been challenging in the non-visual realm of Dispatch Life Support (DLS). For this reason, and because identifying a patient’s level of consciousness is so important with regard to triage and patient care, the Academy tends to err on the side of patient safety when constructing protocol methods to achieve this goal. This cautionary approach is the intent behind the First Law of Fainting, which states: Near fainting is best described as “almost fainted” and should be considered the same as fainting (not just dizzy).

Obviously, there are other ways to describe “almost fainted,” e.g., nearly fainted, feels faint, lightheaded, might pass out, etc. The intent of the Rule is to capture such descriptions and triage them as equal to fainting, rather than to attempt to evaluate further in the non-visual realm of DLS without the benefit...
of face-to-face evaluation and diagnostic equipment such as cardiac monitors, pulse oximeters, glucometers, etc. The Rule was also developed considering the clinical compensatory differences among the patients we care for. For example, a cardiac arrhythmia causing a loss of blood pressure may cause an otherwise healthy, young patient to “feel a little faint,” while the same arrhythmia may cause a complete loss of consciousness in an elderly patient who is less able to “clinically compensate” for the same clinical injury, irritation, or trauma. While the problem is the same, making the clinical evaluation or triage needs similar, the signs and symptoms may vary in both presentation and caller description.

When provided as the Chief Complaint, all of the descriptions you have mentioned should warrant the selection of the same protocol, Protocol 31. When “discovered” on another protocol, such descriptions are generally clarified with the Key Question “Is s/he alert?” Obviously, this question refers to the present, while some of your examples are past tense, and this may need clarification when the question is asked.

We have learned through outcome analysis that priority symptoms “discovered” during interrogation on a different protocol are generally associated with less acuity than priority symptoms that are part of the initial Chief Complaint. In this case, therefore, the MPDS® treats fainting, near fainting, or similar descriptions the same when associated with the Chief Complaint. However, when discovered on another Chief Complaint as a result of the “Is s/he alert?” question, clarification may be necessary to establish the patient’s current condition, which is the intent of the question.

One other point needs to be made when discussing this subject, and that is the protocol’s distinction between near fainting and dizziness. In DLS, the term “dizzy” or “dizziness” refers to vertigo, or a feeling of spinning, causing balance and coordination issues, and often nausea. This is typically due to inner ear issues, and is very different than fainting or near fainting, which may be associated with brain perfusion issues and an underlying cause. Therefore, the complaint of dizziness alone is best handled on Protocol 26: Sick Person (Specific Diagnosis) where_priority Symptoms can be safely ruled out and where a specific response code exists (26-A-3). However, it is important to note that when dizziness is associated with the Chief Complaint of ground-level fall, the protocol cautiously shunts the EMD to Protocol 31 as the likelihood of a more serious etiology is increased.

I hope this answers your question. Please feel free to contact me with any additional MPDS concerns.

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

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The reality is that the incidence of disease being transmitted via M-T-M is very low.

David: This has always been an issue, although of minor concern.

The MPDS® protects callers from HAZMAT and other dangerous scene safety issues, and the move to a Compressions first pathway has dramatically decreased M-T-M exposure. In v13.0, with approval from local medical control, there will be an option to do Compressions Only for patients with cardiac arrest of suspected cardiac origin (respiratory etiology will still be handled with the 30:2 pathway).

The reality is that the incidence of disease being transmitted via M-T-M is very low, and a call to 9-1-1 is, as seen by our courts, a call for help in which we are obligated to provide a standard of care, and CPR is the standard of care. To ask a caller if they want to do CPR, or to provide instructions outside of the standard of care, is simply inappropriate and borders on clinical negligence.

And while hospital and EMS workers are afforded protective equipment and are expected to use it, this is not practical or possible in the DLS environment. Most importantly, CPR saves lives.

Brett:
COUNTY WITH A PAST
Dual ACE follows history of motivation

Guy Gleisberg

The time is 2:37 a.m. and the weather is already hot and humid in Montgomery County, Texas. I turn off the 336 Loop into the driveway of the Montgomery County Hospital District (MCHD) administration building and follow it to the back of the dimly lit parking lot where several vehicles are parked. I pause and notice a faint light coming from the triple-pane, tinted, hurricane-proof windows on the second floor.

The dispatchers are at work.

MCHD emergency dispatchers take their places in this building every day and night, 24/7 x 365. These professionals must remain peaceful and calm no matter the call—a lonely elderly woman who wants to talk; a scared, severely bleeding high school student reporting a multi-vehicle accident; or a hysterical mother whose 8-month-old infant has stopped breathing and is turning blue.

Then seconds later, another 9-1-1 caller comes over the line.

County with a past
Montgomery County was founded in 1875 in a region of prime agricultural land stretching northwest from Houston, Texas, and sweeping farther west to Washington-on-the-Brazos (a major political and commercial center in early Texas). Historians credit the county’s name to the traditional branding route followed by most early counties in Texas, commemorating national and state heroes, battles, and early pioneers.

Maj. Lemuel Montgomery was Sam Houston’s commanding officer at the Battle of Horseshoe Bend and died in Houston’s arms during the charge against the Creek Indian barricade. Houston was the first president of the Republic of Texas.

The new county of Montgomery was huge. In her book, Texas in 1850, Melinda Rankin described the new county as follows:

“Montgomery was at that time the local seat of government of a territory larger than the State of Delaware, extending from the San Antonio road (the old ‘king’s pass’ of the anti-Texan era) on the north, to Spring Creek on the south, and from the Brasos on the west, to the Trinity river on the east, some seventy miles on either course.”

Special legislation
MCHD is a political subdivision of the state of Texas and was established through special legislation in 1977 to provide health care to the indigent residents of Montgomery County. The district has since expanded its charter to provide both emergency and non-emergency ambulance transport for a county covering 1,100 square miles and a population of more than 500,000. The agency’s approximate 280 employees respond to about 50,000 calls for assistance each year.

The communication center—MCHD ALARM—has dispatched MCHD
EMS services since 1994, although it changed locations twice before moving into current quarters at the MCHD administration building in Conroe, Texas.

At the time of submission, it is the only dual-Accredited Center of Excellence (ACE) in Texas, earning both an EFD ACE and an EMD ACE. MCHD ALARM received initial EMD accreditation in 2007.

The drive for dual titles has to do with the MCHD EMS culture, according to MCHD ALARM Manager Mathew Walkup.

“The motivation is our lifeblood, our DNA,” he said. “Accreditation highlights our professionalism, dedication, and commitment.”

Fire ACE implementation was easier to gain because the processes and experience were already in place from achieving the EMD ACE, Walkup said.

MCHD ALARM command staff, along with Conroe Fire Department, gave their support and once dispatchers were EFD certified, it was a matter of organizing committees (Quality Improvement Unit [QIU], Dispatch Review Committee [DRC], and Dispatch Steering Committee [DSC]) and collecting and analyzing the data required for the submission process.

“Then of course we had to learn the EFD methodology, procedures, and, basically, their way of doing things,” he said.

The MCHD ALARM command staff was particularly supportive in understanding the EMD and EFD way of doing things, Walkup said.

In September 2013, command staff approved a full-time quality assurance/improvement supervisor position. The employee—Lois Clancy—is the point person for EMD and EFD: collecting and analyzing reports, organizing committees, and creating weekly continuing dispatch education (CDE) assignments based on the previous month’s scores or items identified during system daily case reviews.

“We constantly observe and measure where we encounter weak areas and then create process improvements to quickly overcome them,” Clancy said. “Sounds like a definition, and it is, but that is what keeps the center out in front and leading.”

The supervisor pulls together information from multiple data sources to present a picture of each calltaker that identifies an individual’s strengths and weaknesses and provides a vehicle for greater interaction and targeted training.

Each calltaker maintains an individual compliance score over 95 percent every month, which Clancy attributes to their passion for excellence.

“For me, the ACE recognition validates what I already knew,” she said. “MCHD is an organization with its focus on saving lives that continuously looks for ways to offer and improve industry-leading patient care.”

ACE benefits

Walkup cites the benefits from accreditation, with the overall goal of providing the public with the correct resources at the right time, when needed. He said their success lies in the Academy’s best practices, methodologies, and the well-defined algorithms that produce repeatable successful results.

“The support of the Academy also helps us mentally and emotionally deal with the calls that are going to have bad outcomes, despite all efforts,” he said.

“That’s important considering the type of calls we receive and the complexity of the situations.”

Walkup manages two shift supervisors and a QA supervisor; there are 29 people on staff. Their backup center is located in The Woodlands Fire Station in The Woodlands, Texas.

MCHD EMS provides 24-hour ambulance coverage to the citizens of Montgomery County by utilizing 21 EMS units, three squads, and four supervisors. MCHD ALARM coordinates the system status management and tactical dispatch for MCHD EMS and Conroe Fire Department. Conroe Fire serves the city of Conroe with five full-time fire stations and five engines, one ladder, one rescue, and one booster.

MCHD ALARM provides EMS first response partners to 15 local fire departments to provide rapid response basic life support and defibrillation to Montgomery County. A community-based program from PHI Air Medical and hospital-based Memorial Herman Life-Flight also services the county.

STAFF DEMOGRAPHICS

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Note: The numbers indicate the number of individuals, while the percentages represent the percentage of the entire staff.

Mathew Walkup, Lois Clancy, Guy R. Gleisberg, Jared Cosper, Brett J. Monroe, Mark E.A. Escott

Source

GET OUT FAST!
Sinking Vehicle Protocol built on expert’s research

Audrey Fraizer

Physiologists Gordon Giesbrecht and Gerren McDonald have sunk literally hundreds of cars and trucks in studies involving cold-water submersion as part of their overall research into the effects of extreme environments on the human body.

Results from submerged vehicle studies conducted since 2005 are central to the IAED’s™ development of the Sinking Vehicle Protocol and, later, the creation of the Vehicle in Floodwater Protocol.

Giesbrecht shared his insights at NAVIGATOR 2014, and led discussion about modifications to the Sinking Vehicle Protocol based on his research.

Escapable or inexplicable

The call is unnerving and uncomfortable to hear. Karla Gutierrez is alone in a car that is sinking into a canal off the Florida Turnpike in West Miami-Dade County on Feb. 16, 2001.

The 32-year-old woman successfully reaches 9-1-1. But the calltaker is unable to provide help beyond trying to reassure the caller that response is on the way if she can only provide her location.

“Relax, honey,” the calltaker says repeatedly in the 3 1/2 minutes before the car is submerged. “We need to know where you are.”

The story does not end well. Gutierrez is dead by the time divers are able to reach the submerged vehicle.

A second example is no less chilling. Lisa Roswell pleads for assistance. Water is up to her knees, then her waist, and the car is “wiggling” in the floodwaters that are sweeping her small car into a creek in northeast Ohio.

“I don’t know what to do,” Roswell says. “What if it gets up to my neck?”

“You should be uh ... They should be able to get to you before that,” the calltaker replies.

Fire crews arrived in three minutes, just long enough for the waters of Cole Creek to swallow Roswell’s car. She drowns inside the submerged car on Feb. 28, 2011.

The two deaths, though tragic, were not extraordinary.

According to statistics compiled by Giesbrecht, 400 people in North America die each year in submerged vehicles, accounting for 5 to 11 percent of all drownings. About half of people that Giesbrecht polled, as part of a study, would let the vehicle fill with water before attempting to exit. It’s the way we’ve been taught despite a lack of evidence supporting the ideas and practices, he said.

“In Florida, we were taught to stay in the car with the windows up and wait for the air bubble and then open the door and leave,” said Giesbrecht, who grew up in the state. “But it’s these types of incorrect and inadequate escape instructions provided by authorities or believed by the public that most probably contribute to the drownings.”
Incident leads to studies

Giesbrecht began his research into vehicle submersion nearly a decade ago after testifying at the inquest of a snowplow driver who died when his vehicle broke through ice on a lake. The event sparked his scientific inquiry.

Although Giesbrecht focused his expert opinion during the investigation on the driver’s potential for survival in the frigid waters, subsequent testing with a five-ton snowplow showed that the victim would have drowned regardless of water temperature. The issue, he theorized, was the lack of an escape route.

Studies point the way

Giesbrecht published a seminal study in 2010 in which he used a crane and two passenger vehicles of the same make, model, and year—one with the passenger compartment intact and one with holes in the floor—to conduct occupied and unoccupied submersions.1 The research redefined the flotation phase of a submersion event, clarified the best options for occupant survival, and identified other countermeasures.

According to the findings, there are three phases to submersion: floating—vehicles floated for 15 to 63 seconds before the water reached the bottom of the side windows; sinking—the subsequent period until the vehicle is completely under water, but before it fills completely; and submerged—the vehicle was full of water and several feet below the surface.

Their research led to the founding of Operation ALIVE (Automobile submersion: Lessons In Vehicle Escape) and the formulation of escape and emergency response strategies.

The authors have pushed public education focus on immediate self-rescue through side windows during the floating phase and, also, 9-1-1 response protocols developed specifically for vehicle submersion cases.

Dispatch protocol follows

Giesbrecht’s research caught the attention of Priority Dispatch Corp.™ Fire Consultant Jay Dornseif and in 2010 collaborations began on refining the original Sinking Vehicle Protocol released in 2008.

According to statistics compiled by Giesbrecht, 400 people in North American die each year in submerged vehicles.

The approach at that time lost precious time for callers.

The bottom line, corroborated by research, is taking action, rather than waiting for rescuers to arrive, Giesbrecht said.

“You have about a minute to get out of a vehicle that’s sinking, or you will drown,” he said. “Any longer and it’s probably too late.”

The existing protocol was modified, directing the calltaker to give Pre-Arrival Instructions (PAIs) with the calltaker focusing attention on instructing the victim to open or break the windows and exit the vehicle as quickly as possible. The primary immediate steps are:

- Seatbelts (unfastened)
- Windows (open)
- Children released from restraints and brought close to an adult
- Out, with children exiting first

Continued discussions over the years have led to enhancements in existing protocol, including guidelines to escape a vehicle carried away in floodwaters.

The rule of thumb in a sinking vehicle is to get out NOW, he said; while a car stranded in water—not moving and not sinking—lends to a more controlled escape from the car and waiting for rescue to arrive from a position on top of the vehicle.

Points to remember

According to Giesbrecht’s primary rules2:

- The dispatcher must weigh the facts of each situation, as conditions may change rapidly (sinking, wet phone problems, car rolling over, car upside down, car moving in the current), and, consequently, must navigate among the most appropriate advice items in the protocol.

- At some point the phone will likely short out; this can happen at any time. Certain instructions must be given early in the instructions sequence prior to losing contact with the caller to prepare the person as much as possible for the escape attempt.

Giesbrecht said not everyone can be saved from a vehicle submerged in water, despite the calltaker’s best attempts at providing instructions.

But that doesn’t mean giving up while the occupant is still on the line.

“There are things you can keep doing to help,” he said. “And continuing to give instructions is infinitely better than telling the occupant to sit calm and wait for someone to come to the rescue.”

Sinking Vehicle Protocol

The Sinking Vehicle Protocol is identical in all three of the Priority Dispatch Systems™: Police Priority Dispatch System™ (PPDS), Fire Priority Dispatch System™ (FPDS), and Medical Priority Dispatch System™ (MPDS). Each system’s code provides agencies with the ability to plan the most appropriate response configuration for a sinking vehicle emergency based upon the resources within their jurisdiction.

The PPDS and FPDS address sinking vehicles with a caller inside through a direct Dispatch Life Support (DLS) Link from Case Entry. The PPDS codes the call a 131-E-1, and the FPDS codes it a 72-E-1. Case Entry Protocols link directly to PAIs for a sinking vehicle. In MPDS Protocol 29, the dispatcher moves from Case Entry, but does not ask any Key Questions. The call is coded a 29-D-2 and links to the Sinking Vehicle PAI Protocol.

Sources


No Walk in the Park

Coordinating response to an MCI at Grand Teton National Park

Michael Rigert
Photos courtesy Grand Teton National Park

In 1902, U.S. President Theodore Roosevelt, an avid naturalist and outdoorsman, penned his thoughts about what he considered one of America’s greatest resources—its diverse continental territory stretching 3,000 miles from the Atlantic Ocean to the Pacific Ocean—and the opportunities its pristine wilderneses afford each citizen to experience.

“All life in the wilderness is so pleasant that the temptation is to consider each particular variety, while one is enjoying it, as better than any other,” he wrote. “A canoe trip through the great forests, a trip with a pack-train among the mountains, a trip on snow-shoes through the silent, mysterious fairy-land of the woods in winter—each has its peculiar charm.”

A staunch advocate of conservation, Roosevelt would be remembered in history for several legacies, among them that he greatly expanded the country’s system of national parks and national forests. Hence, Grand Teton National Park, which showcases the Teton Range in Wyoming near the Idaho border, was first established in 1929, and today is the seventh most visited national park in America. Famous for its monumental scenery and wildlife, the park covers 310,000 acres with an array of lakes, such as Jackson Lake; mountain vistas, such as the Grand Teton (13,770 feet); and the nearby alpine recreation area known collectively as Jackson Hole. In reference to Roosevelt’s idyllic, Norman Rockwell-esque imagery of a summer canoe trip on a trout-filled river versus snow-shoeing to a cozy forest cabin with a stoked fireplace in wintertime, he could well have been describing Grand Teton National Park.

But even tranquil scenes of park visitors taking in amber sunsets on Jenny Lake or gazing up in wonder at star-studded night skies must be tempered with a weighty dose of reality. The park had almost four million visitors in 2013, with the bulk of them coming during the summer. Given that quantity of Homo sapiens traipsing through the great outdoors, there’s bound to be a few mishaps and emergencies.

One such predicament involving a busload of international tourists happened in July at the park. This incident tested the planning, skills, and coordination efforts of more than a half dozen public safety agencies, including Teton Interagency Dispatch Center (TIDC), located in the park. But it also ultimately proved the resourcefulness and mettle of TIDC staff in handling what they often deal with better than anyone—the unexpected.
MCI in a National Park

FEATURE

Jackson Lake Lodge
A road trip

Though the police investigation is yet to be completed, authorities are fairly certain they know what caused a commercial tour bus filled with passengers to flip on its side during the afternoon of July 10. The vehicle slid for several feet before coming to a stop perpendicular to North Highway 89 roughly four miles north of Colter Bay Village. The highway is a main regional transportation artery that connects Grand Teton National Park with Yellowstone National Park (the tourists’ intended destination that day), and serves thousands of traveling visitors each day.

“We think (the driver) dropped a wheel off the road and overcorrected,” said Jackie Skaggs, spokeswoman for Grand Teton National Park. “He was cited with unsafe vehicle operation.”

Aboard were 26 Chinese visitors and the vehicle’s driver, all of whom sustained some type of injury during the crash.

But in the moments just after the mass casualty incident (MCI), the cause of the wreck was the least concern of area public safety agencies. More urgent were the 27 individuals with varying degrees of injuries, ranging from severe to minor, that required immediate emergency medical attention. Compounding the complexities of the EMS response was the fact that virtually none of the victims spoke English. And finally, due to the angle that the bus came to rest on the highway, the 33-foot vehicle blocked all traffic on the north-south thoroughfare during the height of the park’s busiest travel season.

Since cellphone and even radio reception can be spotty in areas of the park due to the rugged topography, it was purely good fortune that park maintenance employees happened upon the wreck and radioed in to the park’s TIDC, Skaggs said.

“Basically, we needed as much help as we could get, as quickly as possible,” said Tiffany Smith, a lead dispatcher with TIDC, who helped manage the situation after the first radio call was received at 4:13 p.m.

Smith and four other dispatchers on duty at the time immediately contacted several area agencies for mutual aid assistance, including the Teton County Sheriff’s Office, Yellowstone National Park, Jackson Hole Fire/EMS, Wyoming Highway Patrol, St. John’s Medical Center in Jackson, Wyo., and Eastern Idaho Regional Medical Center (EIRMC) in Idaho Falls, Idaho.

EMS personnel at the scene triaged the victims as best they could given the language barrier and determined that two of the passengers, a man that couldn’t move and another patient with trauma to the chest and an arm, were seriously injured, Skaggs said. Life Flight helicopters transported the two patients to EIRMC.

The other 25 patients had minor to moderate injuries and were transported by four ambulances to St. John’s Medical Center. Eight “walking wounded” were shuttled to the local hospital in a Grand Teton Lodge Company passenger van.

“It’s one of the largest single vehicle accidents we’ve had in a long time,” Skaggs said.

As a precaution, EIRMC had also dispatched a Life Flight fixed-wing aircraft that landed at Jackson Hole Airport located within the park. This plane remained on stand by in case other injured passengers took a turn for the worse. Grand Teton National Park is the only U.S. national park with a full-service airport capable of accommodating jet-powered aircraft.

Early on, TIDC lead dispatcher Tiffany Smith and the other dispatchers directed resources and sent the park’s ambulances to the site from park headquarters in Moose, Wyo. “We called Teton County and Yellowstone and asked for everything they had,” Smith said.
A hive of activity

TIDC, a public safety answering point (PSAP), has a service area that covers four million acres, including Grand Teton National Park and the Bridger-Teton National Forest in northwestern Wyoming. TIDC also dispatches for wildland fire-related incidents at the National Elk Refuge and dispatches wildland fire incidents and resources for three Wyoming counties.

As an interagency comm. center, TIDC works in close cooperation with nearby county agencies in Wyoming and with Yellowstone National Park on incidents near the common border, Skaggs said.

The center employs temporary, seasonal dispatchers during the area’s hectic summer season in order to support its permanent dispatch staff. TIDC dispatches for law enforcement, wildland fire, aviation, search and rescue, EMS, and structural fire, Smith said.

“Initially, the MCI was reported as a car accident,” Smith said. “My co-worker took the initial radio reports. Then I heard him say there was a tour bus on its side.”

Patrick Hattaway, the park’s Colter Bay District ranger, also acts as an incident commander for exigencies that run the gamut from motor vehicle accidents and natural disasters to wildfires and special events. He has 36 years of experience with the National Park Service in land management and law enforcement, and also serves as an incident command system instructor and risk management program facilitator.

Hattaway’s first reaction to the news of the overturned tour bus was largely practical: “This is what we’ve thought about and trained for over many years.” Afterward, it was more reflective: “Three months from retirement and a bus MCI actually occurred,” Hattaway said.

TIDC was the lead agency since the accident took place within Grand Teton National Park. Teton County Sheriff’s Office Communication Center, which is the 9-1-1 PSAP, sent two county ambulances, a rescue unit, a Jackson Hole Fire/EMS battalion chief, and two sheriff’s deputies, said Terri Sherman, communications supervisor for the county comm. center.

Hattaway said the multi-agency response priority to the MCI was clear—“Bring order to chaos so the injured could be transported as effectively as possible to definitive care facilities.”

Early on, Smith and the other dispatchers directed resources and sent the park’s ambulances to the site from park headquarters in Moose, Wyo. The center’s entire staff worked the incident, with one dispatcher monitoring the radio while the four others operated the phones and answered both incoming related and non-related phone calls.

“We called Teton County and Yellowstone and asked for everything that they had,” Smith said.

After tending to the needs of the injured with the first EMS personnel on-site and air and ground ambulances en route, the center’s next priority was to address the ancillary problem of traffic control.

“There was an immediate need for law enforcement to provide traffic control,” Skaggs said. “North Highway 89 was closed for five hours until about 9 p.m. There were a lot of visitors stranded on the road.”

In a spirit of volunteerism, park maintenance employees who initially discovered the wreck jumped in as “non-traditional” first responders when Hattaway radioed for help with the growing logjam of vehicles on the road, Skaggs said. The six employees, joined by a seasonal park volunteer, worked traffic control until park law enforcement rangers and Wyoming Highway Patrol troopers arrived on-scene.

Communication breakthrough

G.R. Fletcher, a backcountry climbing ranger with the park based out of Jenny Lake, got a phone call from Smith late in the afternoon of July 10 that he wasn’t quite expecting but yet wasn’t a total surprise.

“I knew what was going on,” Fletcher said, who had heard TIDC’s radio chatter over his handset. “I knew there were a lot of Chinese people on a bus that had been in an accident.”

Prior to his seven years with the park, Fletcher, who is also an EMT, had spent nine summers in Taiwan teaching English. He met and married a Taiwanese native, Sarah (her Chinese name is Chia-Hui), and, consequently, he learned to speak some Mandarin.

“Some would be the key word,” he said, jokingly. “I could trick people for a while.”

Smith asked if he could assist ER staff with Mandarin interpretation at St. John’s Medical Center.

As fate would have it, it wasn’t the first time Fletcher’s been able to use his foreign language skills to help an injured park visitor. Earlier in 2014, Fletcher helped an English-speaking Chinese man who had taken a tumble in a river. When a paramedic treating the man got stumped after the patient didn’t understand a question in English about medication, Fletcher asked him...
in Mandarin, eliciting both the answer and a wide-eyed look of disbelief. In previous years, the ranger has also had similar experiences helping Mandarin-speaking visitors.

“At first there was some trepidation,” Fletcher said regarding initial second thoughts about his Mandarin abilities. But after reflecting upon past experiences, he realized there wasn’t anything to make a fuss about.

Fletcher beat the ambulances to St. John’s, and observed that arriving patients had primarily suffered orthopedic and limb fractures, and a few had head injuries. He began talking to the patients, “Where do you hurt? Does it still hurt? Did you lose consciousness?”

“Right off the bat, I could tell it was pretty simple,” he said. “They realized that I could speak with them.”

For more complex questions about a patient’s medical history, ER staff relied on an impromptu innovation of ER Dr. Adam Johnson’s. He used a Google mobile app on his cellphone to query the patients on information that was too complex for Fletcher to interpret back and forth. With the app, users verbalize or type in sentences or phrases in English and the app provides audio and text versions in the language selected. Later on, Li Wang, a Chinese native and Jackson Hole resident, was able to assist ER staff with more nuanced interpretation duties with the injured.

Always prepared

TIDC and law enforcement rangers with the park’s Visitor & Resource Protection Division regularly train for a variety of emergency scenarios, Smith said. All the TIDC dispatchers are EMDs and annually participate in in-house and joint training exercises with local agency partners. A few of the dispatchers, including Smith, are also certified EMTs.

“It’s the reality that something like this could happen in the park,” Smith said.

TIDC’s dispatchers also participate in periodic in-house EMS and law enforcement training that often involves other agencies, including Jackson Hole Fire/EMS and Teton County Emergency Services.

“It’s great to work together in these scenarios, and great practice for us and the field personnel to have an idea so we both know what each other does behind the scenes,” Smith said.

Sherman said the Teton County Sheriff’s Office Communications Center, along with local, county, and federal emergency agencies, including Grand Teton National Park and TIDC, participate in biannual training and planning meetings hosted by Teton County Emergency Management to better coordinate communications and response for search and rescue, aircraft landing zones, and related emergencies.

Rich Ochs, emergency management coordinator for Teton County, said though the department was only minimally involved in the multi-agencies’ response to the July 10 tour bus MCI, the county’s emergency operations center (EOC) can be activated for MCIs in their jurisdiction. During this incident, the county issued emergency alerts to subscribers via the Nixle alert system about the North Highway 89 closure. Nixle then automatically sent it to social media as well as to the county’s Facebook and Twitter pages.

“This is the nightmare scenario that we kind of run through with emergency services as long as I’ve been here—the bus crash,” Ochs said. “But usually the training is for a high-angle rescue on Teton Pass, where a bus might go off the side of the road and down steep embankments. For this one, the complications were that the victims didn’t speak English and that the main thoroughfare between Yellowstone and Jackson was blocked for hours”

That type of complexity had never been considered before. Hattaway reiterated that about the only substantive factor that actually caught public safety leaders off-guard during the July 10 MCI was the foreign language interpretation wrinkle, something that park authorities are reviewing.

“The primary obstacle was the language barrier,” Hattaway said.

Skaggs said the park has seen an exponential increase in the number of Asian visitors in recent years.

On a weekly basis, the Teton County Sheriff’s Office Communications Center is contacted for mutual aid assistance from many of the area’s public safety agencies and regularly takes care of the National Elk Refuge’s communications, Sherman said. In sum, cooperation and coordination between agencies is often critical to public safety response in Teton County and the surrounding area.

“The Teton Interagency Dispatch Center and Teton County Sheriff’s Office Dispatch have a great working relationship and work closely together for search and rescues, driving complaints, road hazards, etc.,” Sherman said.

The park averages about 70 search and rescue missions each year, Skaggs said.

Prior to the July 10 tour bus MCI, the park’s most recent multiple casualty incident was on July 20, 2010, when 17 climbers
suffered injuries from multiple lightning strikes near the summit of the Grand Teton during an active thunderstorm; one of the climbers fell to his death. The 16 other climbers were rescued off the mountain by two interagency contract helicopters and more than 60 interagency personnel and park concessioner staff.

After-action report

Though Smith has dispatched for other MCI, she had never experienced an incident of this magnitude. When events like this take place, dispatchers fall back on the figurative muscle memory of their training, she said.

“It definitely gets your blood pumping,” Smith said. “I thought it went really smoothly considering the complexities of the accident and the number of patients.”

Hattaway said years of multi-agency training paid big dividends and then some on July 10 when the MCI scenario they prepare for the most actually came to fruition.

“Our combined training, agreements, and willingness to work together made a major difference during this accident,” he said.

Across the board, Hattaway said, each agency and its employees involved with the MCI followed the training and planning in a coordinated effort that resulted in a successful outcome for those affected. Most of the patients at St. John’s were treated and released by 9 p.m. that same day, Skaggs said, and the two patients flown to EIRMC were listed in fair condition as of July 11.

“I believe that everyone was outstanding in their performance,” Hattaway said. “Responders accepted assignments, and they saw gaps that they brought forward. TIDC was masterful at handling the incident, staffing up to continue running the park and handling incoming calls. Assisting agencies never hesitated to send support and offer more, if necessary.”

Hattaway and Skaggs said park personnel, from TIDC dispatchers, to first responders, to maintenance employees all came together and essentially put on an impromptu clinic of how to respond and go above and beyond when duty calls. A number of the park’s rangers and other personnel are cross-trained in other disciplines, but even those who aren’t stepped up and came forward to help.

“Within our NPS agency, being able to be a generalist and yet be specialized with EMS, law enforcement, or dispatch skills is typical,” Skaggs said. “We still depend on the ‘renaissance ranger’ that masters a lot of different skills.”

And nobody shined brighter during the tour bus MCI than the park’s emergency dispatchers, she said.

“They’re the unsung heroes and the nerve center of emergencies,” Skaggs said. “They’re that critical cog, and we simply couldn’t do our jobs without them.”

Sources


Attendees at Euro NAVIGATOR 2014 in Wiesbaden, Germany.
Attendees can’t get enough of Euro NAVIGATOR 2014

From the Welcome Reception to the Closing Dinner, it was 99.9 percent about getting down to business at the seventh annual Euro NAVIGATOR, hosted Sept. 10–12 in Wiesbaden, Germany, at the Pentahotel Wiesbaden.

Though plenty of beer glass toasts were made and laughs exchanged during networking opportunities in between sessions, Priority Dispatch Corp.™ (PDC™) President Alan Fletcher said attendees possessed a laser-like focus when it came to absorbing as much of the presentations and protocol education as possible. It didn’t matter if it was Scott Freitag, President of the International Academies of Emergency Dispatch® (IAED®), or Brian Dale, Chair of the IAED’s newly created ED-Q® Council of Standards, speaking in English or native Austrian and German presenters and experts instructing attendees in German, the attention of conference-goers was equally engrossed.

“The attendees love to socialize and network, but when it became time for a session to begin, they were all there,” Fletcher said. “It was serious business for them.”

Officially, 133 public safety professionals attended the conference representing 40 individual agencies in Germany, Austria, the Netherlands, and Switzerland, said Claire Ulibarri, IAED’s Conference Coordinator. Attendees also toured the Wiesbaden Fire Department’s comm. center (a Fire Protocol user) on the first day of Euro NAVIGATOR.

Jerry Overton, newly appointed Chair of the IAED’s Board of Accreditation, was dually impressed with attendees.

“We’re seeing more of a trend in scientific presentation and data, and the Academy views that as being very valuable,” Overton said. “It’s encouraging to see the interest in police and fire also, and to see that the protocols can cross all of the public safety spectrum.”

He was alluding to the news that the first-ever implementation of the Police Priority Dispatch System™ (PPDS®) on continental Europe is currently underway with the Oldenburg Police Department in the northwestern German state of Lower Saxony.

Oldenburg Police Chief Heiko von Deetzen, Police Officer Alexander Militello, and Chris Knight, IAED’s Director of International Police Systems and Standards,
presented the police leadership course at Euro NAVIGATOR, according to Pam Stewart, IAED Executive Manager and Chair of the Academy’s Board of Certification.

“It was great to see the police leadership course so well attended,” she said. “We are very excited for the Oldenburg Police Department to become our first EPD Accredited Center of Excellence in continental Europe.”

Perhaps the most highly anticipated news of the conference was the announcement during the awards ceremony that the Academy had selected Manfred Müllner, an EMD with 144 Notruf Niederösterreich in Austria, for Euro NAVIGATOR 2014’s Dispatcher of the Year accolades. Müllner employed the new Fast Track hands-only CPR compressions tool during a call with a patient who was suffering cardiac arrest.

“Manfred knows how to use these perfectly and efficiently,” said Heinz Novosad, Education and Quality Management Director with 144 Notruf Niederösterreich.

In 2015, Euro NAVIGATOR will take place Sept. 16–18 in Leiden, Netherlands, with tracks offered in Dutch, German, and Italian. It is the first time that the Netherlands has been chosen as the venue for the conference. Leiden, which has a population of about 120,000, is a regional shopping and trade center and home of the famed University of Leiden.

“Euro NAVIGATOR is increasingly becoming about helping comm. centers gain accreditation and continuing to build upon that,” Overton said. “Hopefully, next year in the Netherlands we will be awarding some for their accreditations.”

Suspense was the ticket at UK NAVIGATOR 2014

UK NAVIGATOR scored a 37-percent increase in attendance, with more than 100 dispatchers and their managers gathered for the three-day conference held Sept. 16–18 in Bristol, England.

International Academies of Emergency Dispatch® (IAED™) Conference Coordinator Claire Ulibarri attributed the impressive jump in numbers to a new twist in the Dispatcher of the Year (DOY) Award presentation and the groundwork of Myki Agasee, the conference’s co-coordinator, to rally the dispatch centers.

Agasee is the Customer Service and Processing Administrator for the Priority Dispatch Corp™ (PDC™) offices in the U.K.

“Myki did a terrific job from the U.K. office,” Ulibarri said. “She did the chasing, and to her credit, we had a big increase in the number of award nominees.”

Suspense was the order of the DOY award, said IAED Accreditation Officer Beverley Logan.

It was pins and needles until the time of the presentation.

“No one outside the selection committee knew before we said the name on stage,” Logan said.

When the envelope was opened, EMD Jenny Coventry of East of England Ambulance Service NHS Trust’s Chelmsford location gasped.
Surprise would be an understatement. “Jenny was overwhelmed by the honor, and expressed her admiration for her peers at UK NAVIGATOR,” Logan said. “She also gave her personal thanks to the East of England 9-9-9 QA/QI team for ‘keeping her on track.’”

Coventry’s high protocol compliance—and the full complement of qualifications used in the selection process—was demonstrated through a call in which she gave Pre-Arrival Instructions (PAIs) for childbirth to a couple stopped on the roadside while driving to Southend Hospital.

It was Mothering Day (March 30) 2014. The father delivered the baby, following Coventry’s step-by-step instructions. At birth, however, the baby was not breathing, and Coventry continued to mouth-to-nose CPR instructions. The father again put action to the PAIs. Then the ambulance arrived. The baby—a girl—survived and the family visited Coventry at the communication center not long after the baby’s discharge from the hospital.

“They were so grateful for what everyone had done for their baby,” Logan said. “It was very nice of them. We don’t often hear the results of a call let alone meet the people involved.”

Coventry has been a dispatcher for 10 years.

The award for the best research poster went to Linden Horwood, EMD-Q® with Yorkshire Ambulance Service, NHS Trust. Horwood’s poster, “CDE and Service Improvement,” displayed an abstract of the project to increase compliance to the Medical Priority Dispatch System® (MPDS®) through the use of targeted Continuing Dispatch Education (CDE) lessons.

The Academy’s research staff sponsored the premier poster contest in 2014 to encourage research into the use of the protocol systems and submitting research papers for possible publication in the Academy’s Annals of Emergency Dispatch & Response (AEDR). Judging is based on content, visual display, and the “take-home” message applicable to dispatch.

Horwood’s background is not in research, said Tracey Barron, IAED Research and Studies Officer and Chair of the Council of Research and Clinical Focus Group.

“She came up with the idea and pursued it,” Barron said. “That says a lot about her research interest in relation to the pursuit of quality performance.”

Horwood received a framed AEDR certificate, and she has the opportunity to further develop her research for an article that could be published in the AEDR.

The Bill Boehly Clinician Award for CSD Clinician of the Year was presented to Rebeccaanne Howarth, Clinical Support Desk (CSD) Auditor/Trainer with East of England Ambulance Service. She has been with the ambulance service since 2011.

The CSD provides over-the-phone clinical advice to patients, or someone who has called 9-9-9 on their behalf, regarding less serious conditions to establish the most appropriate response.

Howarth was recognized for her “patient-focused approach” to telephone triage that evolved into accepting her current position. She developed a training program followed by CSD advisers across the region, developed a record keeping system, and publishes a monthly clinical newsletter.

According to the award nomination, Howarth’s “approach to QA allows her to provide constructive, informative feedback,” and she is credited with handling duties in an “effective and diplomatic manner.”

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.


Jerry Overton, Chair of IAED’s Board of Accreditation, acknowledged London Ambulance Service (LAS) NHS Trust and South Western Ambulance Service (SWAS) NHS Trust for achieving their third and fifth consecutive medical Accredited Centers of Excellence (ACE), respectively.

The ACE presentation was Overton’s first as the recently announced chair of the Board of Accreditation.

“It was an excellent experience, and I can only hope for more next year,” he said.

LAS covers the largest population of any 9-9-9 service in the U.K., with more than 5,000 staff members and 70 ambulance stations serving more than seven million people.

SWAS covers 10,000 square miles (20 percent of mainland England) and serves a population of more than 5.3 million from 97 ambulance stations.

In addition to two full days of educational sessions, the U.K. version of NAVIGATOR, which takes place annually in seven major locations across four continents, featured a Welcome Reception and Closing Dinner.
ACADEMY READY AMID EBOLA OUTBREAK
EMS plays vital role in containing hemorrhagic fever

Greg Scott

Introduction
The emergency medical services (EMS) response to Ebola begins at the Public Safety Answering Points (PSAPs), triaging patients and providing notification to responding crews on patients who are potentially affected by the virus. The use of the Academy’s Emerging Infectious Disease Surveillance (EIDS) Tool is described later in this article.

Outbreak
According to the Centers for Disease Control and Prevention (CDC), “the 2014 Ebola outbreak is the largest in history and the first Ebola outbreak in West Africa. This outbreak is actually the first Ebola epidemic the world has ever known”—meaning it has spread rapidly to a large population. As of Oct. 20, 2014, the World Health Organization (WHO) has reported 9,178 probable, confirmed, and suspected cases in seven countries—Guinea, Liberia, Nigeria, Sierra Leone, Senegal, Spain, and the United States—including 4,546 deaths. Senegal has reported at least one case, but no deaths to date.

An outbreak in the Congo during early September with a reported 41 deaths as of Sept. 18 was comforting, although subsequent findings showed the outbreak was unrelated to the outbreak of Ebola in West Africa.3

According to WHO, the two outbreaks represented two different strains of Ebola and bore no relationship to one another. The outbreak reported in Central Africa was found to be a strain indigenous to the Congo where seven outbreaks had occurred since first discovered there in 1976.4

The coincidental timing was encouraging, in some ways. The fact that the same strain wasn’t leapfrogging to other parts of the African continent signaled that the possibility of Ebola striking heavily on every continent remained small, mitigating fears of the disease growing into a global pandemic.

At the time of this printing, those infected with the disease are limited to residents and travelers to or from one of the affected African countries and several health care workers who have treated Ebola patients outside of Africa. As with any infectious disease, however, circumstances and outbreak conditions can change quickly; already, other continents have received patients infected with the disease, including several treated in U.S. hospitals.

In areas where the disease has hit hardest, the situation is dire, both medically and politically.

A New York Times article described the outbreak’s effects: “Doctors Without Borders, which has intervened in many Ebola outbreaks, called the outbreak in West Africa ‘unprecedented’ and warned that the disease had erupted in so many locations that fighting it would be enormously difficult.”5

Ebola virus disease (EVD)
As defined by the CDC, EVD is one of...
numerous viral hemorrhagic fevers that is a severe, often fatal disease in humans. When infection occurs, symptoms usually begin abruptly.

The likelihood of contracting Ebola, however, remains low. Infection develops from direct, unprotected contact with the blood or body fluids (like urine, saliva, feces, vomit, sweat, and semen) of a person who is sick with Ebola. Infection also comes from direct handling of bats, rodents, or nonhuman primates from areas with Ebola outbreaks.

Currently, there is no available vaccine and no reliable treatment for patients with EVD, although experimental vaccines are being tested, and at least one experimental treatment has shown promise.

**Symptoms**

Patients with EVD generally have an abrupt onset of typically 8–10 days after exposure (mean of 4–10 days in previous outbreaks, range of 2–21 days). Initial signs and symptoms may include fever, chills, headache, muscle pain, malaise, vomiting, diarrhea, stomach pain, and unexplained bleeding.

Due to these nonspecific symptoms, particularly early in its course, EVD can be confused with other more common infectious diseases such as malaria, typhoid fever, meningococcemia, and other bacterial infections (e.g., pneumonia).

Patients can progress from the initial nonspecific symptoms after about five days to develop gastrointestinal symptoms such as severe watery diarrhea, nausea, vomiting, and abdominal pain.

Other symptoms such as chest pain, shortness of breath, headache, or confusion may also develop. Patients often have infections in the mucous membrane that covers the front of the eye and lines the inside of the eyelids. Seizures may occur, and cerebral edema has been reported. Bleeding is not universally present but can manifest later in the course of the disease. Pregnant women may experience spontaneous miscarriages.

Patients with fatal cases usually develop more severe clinical signs early during infection and die typically between days 6 and 16 from complications, including multi-organ failure and septic shock. In nonfatal cases, patients may have a fever for several days and typically improve around day 6–11.

Patients who survive can have a prolonged convalescence. The WHO has estimated the mortality of the current outbreak of EVD in West Africa to be about 55 percent, but it appears to be as high as 75 percent in Guinea.

**Coordinating care**

Coordination among 9-1-1 PSAPs, the EMS system, health care facilities, and the public health system is important when responding to patients with suspected Ebola.

The following information is available from the International Academies of Emergency Dispatch (IAED) website.

**Emerging Infectious Disease Surveillance Tool**

The following information is available from the International Academies of Emergency Dispatch (IAED) website. All users have access to the EIDS Tool—developed and approved by the IAED Chemical, Biological, Radiological, & Nuclear (CBRN) Fast Track Committee (last update October 2014).

This tool covers recent travel and all likely symptoms of Ebola. In ProQA®, the EIDS Tool can be accessed at any time, in any active case. The EIDS Tool can be utilized by any agency that has approval from its medical director.

Typically, the Academy recommends that the call be processed through Case Entry and Key Questions and a Final Code be generated as per standard practice. At that point, if the patient has symptoms consistent with EVD (as approved by local medical control), the EMD should select the EIDS Tool to complete the interrogation.

For EVD, the Chief Complaints the Academy strongly recommends use of the EIDS Tool are those that represent typical flu-like symptoms and unexplained bleeding: Protocol 26 Sick Person, Protocol 1 Abdominal Pain, Protocol 18 Headache, and Protocol 21 Hemorrhage (MEDICAL).

Other protocols (e.g., Protocols 6, 10, and 32) and conditions may be warranted based on local conditions, as determined by the system medical director.

This additional interrogation may extend the total calltaking time for those patients presenting initially with related symptoms and risk factors, but will not impact the time it takes to post a call for dispatch, or notify responders, as long as the EIDS Tool is launched after Final Coding is complete.

This additional questioning may identify potential EVD patients and allow for appropriate notification to responders and receiving hospitals, etc., and for the modification of local response assignment and/or referral policies and procedures.

Additionally, for centers that have the need and the resources, sophisticated real-time surveillance software can be set up to provide immediate updates on unusual trends or spikes in specific Chief Complaints, dispatch codes, and symptoms collected using the EIDS Tool.

**Centers for Disease Control and Prevention**

The CDC posted “Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Known or Suspected Ebola Virus Disease in the United States.”

According to the CDC, the guidelines are intended for 9-1-1 PSAPs, EMS agencies and systems, and medical first responders, including firefighters and law enforcement personnel. The guidance is not intended to set forth mandatory requirements or establish national standards but is intended to provide guidance for handling inqui-
ries, responding to patients with suspected Ebola symptoms, and keeping workers safe.

Key points from the report include:

- The likelihood of contracting Ebola in the United States is extremely low unless a person has direct unprotected contact with the blood or body fluids (like urine, saliva, feces, vomit, sweat, and semen) of a person who is sick with Ebola Virus Disease

- When risk of Ebola is elevated in their community, it is important for PSAPs to question callers about:
  - Residence in, or travel to, a country where an Ebola outbreak is occurring (Liberia, Guinea, Sierra Leone);
  - Signs and symptoms of Ebola (such as fever, vomiting, diarrhea);
  - Other risk factors, such as direct contact with someone who is sick with Ebola.

- PSAPs should tell EMS personnel this information before they get to the location so they can put on the correct personal protective equipment (PPE)

- If responding at an airport or other port of entry to the United States, the PSAP should notify the CDC Quarantine Station for the port of entry.

### Outbreak tracking

Epidemiologic investigation linked the laboratory-confirmed cases with the presumed first fatality of the outbreak (a two-year-old boy) in December 2013.

An article in *The New England Journal of Medicine* states, “It is suspected that the virus was transmitted for months before the outbreak became apparent because of clusters of cases in the hospitals of Guéckédou and Macenta [in Guinea]. This length of exposure appears to have allowed many transmission chains and thus increased the number of cases of Ebola virus disease.”

### Sources

6. See Note 1.
9. See Note 1.
10. See Note 7.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

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

1. The two outbreaks—West Africa and the Congo—were caused by the same strain of the Ebola virus.
   a. true
   b. false

2. High-risk exposure to Ebola usually comes from:
   a. direct, unprotected contact with the blood or body fluids (like urine, saliva, feces, vomit, sweat, and semen) of a person who is sick with Ebola.
   b. shaking hands with a person who is sick with Ebola.
   c. being close to someone who has traveled to West Africa.
   d. all of the above

3. Patients with EVD generally have an abrupt onset how long after exposure?
   a. 2–7 days
   b. 8–10 days
   c. 15–20 days
   d. 30 days

4. Due to its flu-like, nonspecific symptoms, particularly early in its course, Ebola Virus Disease (EVD) can be confused with other infectious diseases such as:
   a. malaria.
   b. typhoid fever.
   c. meningococcemia.
   d. all of the above

5. The WHO has estimated the mortality of the current outbreak of EVD in West Africa to be about:
   a. 25 percent.
   b. 55 percent.
   c. 70 percent.
   d. 90 percent.

6. All users have access to the Emerging Infectious Disease Surveillance (EIDS) Tool.
   a. true
   b. false

7. The EIDS Tool can be utilized by any agency that has approval from:
   a. its medical director.
   b. the Academy.
   c. the Centers for Disease Control and Prevention.
   d. the American Medical Association.

8. The IAED recommends that in most centers the EIDS Tool is launched:
   a. during Case Entry.
   b. as the calltaker starts Key Questions.
   c. after Final Coding is complete.

9. Two of the MPDS Chief Complaints that could prompt the EMD to use the EIDS Tool are:
   a. Convulsions/Seizures and Falls.
   b. Sick Person and Hemorrhage (MEDICAL).
   c. Cardiac/Respiratory Arrest and Unconscious.
   d. Traumatic Injuries and Traffic Accidents.

10. If responding at an airport or other port of entry to the United States, the PSAP should notify the:
    a. Centers for Disease Control and Prevention (CDC) Quarantine Station for the port of entry.
    b. World Health Organization’s epidemiology database.
    c. nearest hospital or medical center.
    d. port of entry management.

To be considered for CDE credit, this answer sheet must be received no later than 12/31/15. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
Recertification has abandoned the green to go green.

In other words, the six-page recertification tri-fold printed on green paper is going the way of the Rolodex. From updating personal information to instant notice of recertification, everything can now be accomplished online to renew your EMD, EFD, and EPD certifications and the affiliated Q certifications.

The new Recertification Registry and electronic filing process gives members the ability to access everything online:

- 50-question multiple choice recertification exam
- Application (your personal and demographic information)
- Your preferred payment method
- Academy record of your personal Continuing Dispatch Education

As with paper applications, electronic recertification applications can be accepted as early as six months before expiration and as late as 90 days after the expiration date. The Academy grants a 90-day grace period, so if certification is less than 90 days expired, the member is still OK. Members can also access and submit the lapsed waiver forms necessary when expiration is delayed for a good reason and is more than 90 days late.

The only part of the process that stays with the postal system is your receipt of the actual renewal card and confirmation letter, which will be mailed to you or the agency, depending on the preferred address, as soon as the listed CDE units are verified.

Get ready, get set, go

Starting the process is as easy as turning on your computer, going to the Internet, and accessing the IAED™ website.

The toolbar at the top of the screen displays several options, with the very last icon—Members—providing access to three links: Members Area, ED-Q™ Area, and Medical Director Area.

Your recertification application is accessed from the Members Area link.

Your username and password are required to log in to the Members Area portal. If you are not yet registered to use the site, you can also register to enter the portal from this page and receive instant authorization and email notification, based on the account information submitted.

At login, the screen will display your current certification expiration dates and, if pending approval, the items you are required to submit prior to approval. For example, an EMD might need CPR re-training to fulfill recertification requirements and, if so, that would be listed on your unique identifier profile.

On the recertification screen it lists the steps of recertification for easier navigation to the materials formerly available only on paper. These are: Recertification (acceptance of Academy terms and policies), Order Exams, Exams Ready, Recertification Exams History,
Make sure that you are requesting the correct test.

Your CDE Hours

The electronic system allows you to enter individual records delineating the certificate type (EMD, EPD, EFD, and Q), the category (e.g., Academy CDE or in-house class), the number of hours per record and category, a brief description (e.g., Journal quiz), and your completion date.

CDE hours can be entered at any time. It’s suggested that you enter the hours as they are earned rather than waiting until right before the recertification deadline. Once you have completed all the required CDE hours, you can submit the hours to the Academy for review.

Academy staff will verify your information—to ensure that the number of CDE hours meets recertification requirements—and approve your recertification based on that review, the test score, and the submission of other required forms (such as a waiver).

If, for some reason, the CDE hours are not accepted, an email is sent to the member within 24 hours of the review or the following Monday if reviewed on a Friday.

Forms and Policies

The Academy will continue to send out recertification reminders. However, recertification is the member’s responsibility; as professionals, members are responsible to track their own expiration dates and CDE hours.

The policies for lapsed certifications remain the same: A certified member has up to a 90-day grace period; a member lapse of more than three months but less than six months requires the Expired Certification Waiver Request form, and forms requesting waivers due to special circumstances (e.g., military duty) can be downloaded and easily submitted online.

FAQs

If you have questions during any phase of the process, this is the first place to look for answers.

Benefits

There are multiple benefits to recertification, according to IAED Membership Services Manager Arabella VanBeuge.

“In addition to eliminating paper consumption and waste, the move to an electronic recertification registry and filing system streamlines your process,” she said. “It also improves efficiency through real-time data sharing.”

For the security minded, the IAED computer system has software programs to monitor network traffic to identify unauthorized attempts to upload or change information.

Members update their personal information online, ensuring that all personal information is correct and secure.

“The automatic test scoring is particularly welcome,” VanBeuge said.

The paper process can take several weeks since each test received by the accounting department is date stamped, processed, and forwarded to the Member Services Department for processing. The applications are filed according to the date received, hand graded, scored and, if the score falls below the required minimum passing score, graded again. Once graded, the applications are put into a pending file according to the date received for input into the system (entering the member’s personal profile, test scores, missed questions, and CDE hours).

“We're looking at saving hours just in that specific step of the recertification process,” she said.

But the biggest benefit, she said, is the efficiency of going green.

Members are able to access everything about their recertifications in real time, 24 hours a day, 7 days a week, and waiting time is minimal for any step in the process.

Once you complete the exam, the system automatically generates your test score and a summary that includes the general topics of the questions you answered incorrectly and where to find the reference material to study.

You can submit and track your CDE hours, submit a waiver, and review and print Academy policies. Once your exam and CDE hours are submitted and verified, your recertification exam is put into the queue to print on that immediate Friday.

Despite the push to go completely electronic, agencies may still request paper applications to recertify their staff.
### YOU MUST BE CERTIFIED TO TAKE THIS QUIZ

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
<th>Option D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Recertification Registry and electronic filing process applies to:</td>
<td>EMD, EFD, and EPD certifications and the affiliated Q certifications.</td>
<td>instructor certifications.</td>
<td>executive certifications.</td>
<td>all of the above</td>
</tr>
<tr>
<td>2. Recertification applications can be accepted as early as six months before expiration.</td>
<td>true</td>
<td>false</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The recertification portal is available by accessing this icon on the IAED toolbar.</td>
<td>Resources</td>
<td>Certification</td>
<td>Accreditation</td>
<td>Members</td>
</tr>
<tr>
<td>4. You must provide the following information to enter the Members Area portal:</td>
<td>name and position title</td>
<td>name and birthday</td>
<td>username and password</td>
<td></td>
</tr>
<tr>
<td>5. The version of the test requested can be changed at any time in the process, including after you have paid for the test ordered.</td>
<td>true</td>
<td>false</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. You can complete the test in stages, as your time becomes available, since all data is saved.</td>
<td>true</td>
<td>false</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Test scores in this range require retesting:</td>
<td>80 percent to 100 percent</td>
<td>64 percent to 78 percent</td>
<td>retesting is never an option</td>
<td></td>
</tr>
<tr>
<td>8. If, for some reason, your CDE hours are not accepted, an email is sent to you:</td>
<td>within 24 hours of the review or the following Monday if reviewed on a Friday.</td>
<td>in three to five days.</td>
<td>one week following the submission (send) date.</td>
<td></td>
</tr>
<tr>
<td>9. The Academy will continue to send out recertification reminders.</td>
<td>true</td>
<td>false</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. The policies for lapsed certifications remain the same.</td>
<td>true</td>
<td>false</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To be considered for CDE credit, this answer sheet must be received no later than **12/31/15**. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
LOOKING AHEAD

The first volume of the 2015 *Journal* takes off with a story of emergency dispatch in air ambulances and direct accounts of initiating an ECHO response, packaged in a total redesign by Lee Workman, the graphic designer behind the look of the *Journal*. The new design borrows the best elements from contemporary popular periodicals, such as larger photos, fewer words on each page, and more white space to give the *Journal* a more welcoming and uncluttered appeal. At the same time, we are keeping with the traditions in the types of articles we publish, such as continuing dispatch education, FAQs, Ask Doc, and columns by experts. If you have a chance, and feel so inclined, please drop us a note at editor@emergencydispatch.org.
Brittany Miller had a gut feeling that something was wrong.

The muffled sound she heard over the open line wasn’t someone making a prank call, and she was sure that a cellphone pocket dial wasn’t the cause.

“It sounded like someone gasping, but it was so faint, it was hard to tell,” said Miller, an EMD for the Wasilla Police Department in Wasilla, Alaska. “But something about it told me this needed to be addressed.”

Open lines are common, Miller said. The call had been answered by a calltaker, but the caller wasn’t responding. As is center policy, the telephone connection was established, and the line would remain open. If the call disconnected at some point after the calltaker had answered and no response was received from the caller, only then would the open line be considered a hang-up call.

Miller listened closely through her headset, picking up what she believed was a faint moan for help. She also heard what sounded like agonal breathing, which is a breathing pattern that lingers after the heart has essentially stopped pumping blood to the brain.

She acted on what she was hearing.

“I dispatched response immediately,” she said. “I don’t know if there was someone there who could hear me, but I said, ‘Help is on the way.’”

Miller stayed on the line, straining to distinguish a pattern of breathing and to identify background sounds that would tell her more about the situation and verify when help had arrived.

“I heard a dog barking and a trooper knocking on the door,” she said.

Once inside, the trooper reported a person, female, down. She wasn’t breathing. She was without a pulse.

The scene was a confirmation of what she had sensed from the start.

“The trooper didn’t have much hope and called over to Palmer,” Miller said.

Suddenly, the situation wasn’t so undecided.

“She moved her arm and turned her head,” Miller said. “The trooper gave CPR and was able to get her pulse back. She was transported to the hospital.”

The patient lived through her arrival to the ICU. She later died, crushing the high hopes Miller had for the woman’s survival. Miller takes comfort in recognizing the medical emergency, knowing that her instincts were correct and would again prove valuable in the EMD position she was hired to fill two years ago.

“A lot of what we do in communications is gut feeling,” she said. “With every call, you have to determine the priority and something about this call said, ‘We need to go now.’ I knew this couldn’t wait.”

Miller moved to Alaska from Georgia two years ago. She had plans to go into the military, switched to law enforcement, and applied for an opening in dispatch at the police department.

“It clicked,” she said. “It’s all about being at both ends of the emergency, doing the call research, and being computer savvy. Even though we stay extremely busy, I’m able to get done what’s needed. I can’t imagine doing anything else.”
Thirty-eight years in the profession, and Ronnie Robertson can count on one hand the number of times a caller has come by to say anything.

“It doesn’t happen,” said Robertson, director of Davie County’s (N.C.) E911 Communications Center. “Most times, we’re the unseen service. But that’s OK. There are other reasons that we do this job.”

That might be for most people, but for Terry Lewis, treating EMS to breakfast was the least he could do to acknowledge their contribution in saving his life.

“That was such a small token of our appreciation,” Lewis said. “It was so humbling and gratifying for me to meet them.”

Lewis, 57, experienced a cardiac event during his sleep the night after he returned from a three-day, 36-mile hike on the Appalachian Trail. Despite having a tough time of it on the final three-mile, 1,300-foot ascent, he went home feeling good.

His wife, Lesa, awoke shortly after midnight on April 21 (2014) to discover an unusual sound to her husband’s breathing. She couldn’t wake him, prompting a call to 9-1-1. After following the instructions provided by EMD Stephanie Speer, Lesa did something she had never done before during the scariest moments of her life.

“We started CPR,” Speer said. “Lesa was amazingly calm and did exactly what I told her to do.”

Lewis coded once at home and the Davie County EMS team that arrived spent 19 minutes resuscitating him before determining his condition was stable for transport to the hospital. He doesn’t remember much about the emergency, except for Lesa’s incessant plea “to stay with me, Terry.”

Lewis didn’t understand.

“I did not know what she was talking about and could only respond, ‘I can’t wake up,’” he said. “The next thing I know, I am looking up at this stranger in my bedroom, asking me lots of questions.”

Lewis coded four more times and a cardiac catheterization subsequently performed in the ER revealed a 70 to 90 percent blockage in five coronary arteries.

On the following day, April 22, Lewis was in surgery for a quintuple bypass.

Ten hours after surgery, he was up and walking around the nurses’ station. Three days later, a pacemaker defibrillator was added to help monitor his heart’s rhythm going forward.

“The Almighty God had a plan, and everyone in that chain was part of that plan,” said Lewis, a devoted member of his Calvary Baptist Church. “It was by the grace of God that I did not die while pushing up that mountain, and it’s through the good Lord’s love and mercy that Lesa woke up and let her know something was going on with me.”

By June, Lewis was strong enough to contact Davie County EMS Director Mark Hancock for permission to directly thank everyone in the chain of the response he credits with saving his life.

Hancock arranged the visit to include staff from the ambulance station and communication center.

Speer was off the day Lewis came by. Undeterred, Lewis stopped by a second time to personally extend his gratitude, giving Speer and the three other dispatchers on duty that night special EMS Bibles. He also gifted guardian angel pocket coins to the entire EMS and 9-1-1 teams.

“He was super nice,” said Speer, who has been in dispatch going on six years. “But the guardian angel isn’t me. It’s his wife, Lesa.”

Lewis has every intention of hiking every inch of the 2,180-mile Appalachian Trail. But it has to be with Lesa’s blessing.

“I was thinking of returning in September (2014), but will probably wait until next year because of what Lesa went through and her fear of my going back to the mountains,” he said.

In the meantime, Speer looks forward to meeting Lesa, who has extended heartfelt gratitude to Speer in a letter that also expresses her faith in God’s “grace and mercy in helping all of us so that Terry is still with us.”

Speer anticipates a friendship that’s here to stay.

“It will be a very good lifelong relationship,” she said.
RELIEVING, NOT RELIVING
Poetry writing eases dispatcher’s stress

Audrey Fraizer

Toronto Emergency Medical Services (TEMS) EMD Cindy Armstrong was diagnosed with post-traumatic stress disorder three years ago after a series of stressful calls. She said one call in particular stands out. She took a 9-1-1 call from a Toronto-area construction site after a section of large machinery fell and trapped three people. Armstrong was on the phone to hear the final screams of one of the victims, who died before help was able to reach him.

“He did not die instantly,” she said. “I took the call ... I heard him screaming in the background. I heard his screaming stop. That helpless feeling, as well as hearing that scream stop, has affected me.”

Armstrong is still affected by the call, although therapy—personal and professional—has helped to alleviate the symptoms of stress. Poetry writing is among her strategies.

“Who Am I?”
Cindy Armstrong

I stare at many computer screens,
My hands on a keyboard and mouse.
Colors and sounds are all around.
Who am I?

I answer many calls,
Calls and cries for help.
I tried to stay calm.
Who am I?

I hear screams and shouts.
I hear panicking voices.
I hear angry tones.
Who am I?

I send out crews,
And watch out for their safety.
Listen for their calls for backup.
Who am I?

I see visions of accidents.
I see images of people bleeding.
Sometimes from stabs or gunshots.
Who am I?

I hear people scream.
I hear their last gasps.
And then I hear silence.
Who am I?

I sometimes cry.
I sometimes shake.
My hands get cold and clammy.
Who am I?

A heart that races and pounds.
It is warm but sometimes breaks.
Sometimes I feel helpless to those in need.
Who am I?

I am invisible to those who call.
I am forgotten when calm returns.
Who am I?

I am a Dispatcher, that’s who I am!
Your newest trauma tool isn’t in here.

Seriously injured patients rely on you to give the best medical attention and care. To do that, you need knowledge, experience and the proper tools. That’s why the Centers for Disease Control and Prevention (CDC) has released the widely endorsed Field Triage Decision Scheme: The National Trauma Triage Protocol to help EMTs and paramedics choose the best transport destination for trauma patients. Designed in partnership with other leading organizations and experts in injury care, the Decision Scheme has been published in the prestigious MMWR Report & Recommendations. It’s a valuable tool that can help your EMS system save lives.

Get a free copy of the Field Triage Decision Scheme: The National Trauma Triage Protocol, the MMWR and other free resources at www.cdc.gov/FieldTriage
The virus is named after the Ebola River where the virus was first recognized in 1976.

The virus is named after the Ebola River where the virus was first recognized in 1976.

The origin of the virus is unknown but fruit bats (Pteropodidae) are considered the likely host of the Ebola Virus Disease.

The average Ebola Virus Disease fatality rate is around 50 percent.

As of Oct. 20, 2014, the World Health Organization has reported 9,178 probable, confirmed, and suspected cases in seven countries—Guinea, Liberia, Nigeria, Sierra Leone, Senegal, Spain, and the United States—including 4,546 deaths.

There are currently no licensed Ebola vaccines but potential candidates are undergoing evaluation.

In Guinea, a door-to-door campaign included the delivery of hygiene kits (soap, chlorine) and fliers to 71,000 households composed of 486,000 people.

Unless Ebola control measures in West Africa are enhanced quickly, experts from the WHO and Imperial College, London, England, predict numbers will continue to climb exponentially.
WINNIPEG’S EMS TOOK A PERSONAL TOLL
Private operators benefited more than patients

Audrey Fraizer

A five-company dispatching co-op recommended 45 years ago in Winnipeg, Manitoba, Canada, took a lot of the pressure off Doug James’ personal life.

“I operated from my home for 1 1/2 years and my wife took the calls,” James was quoted as saying in the July 30, 1971, issue of the Winnipeg Free Press. “It was a 24-hour-a-day operation. She didn’t get out.”

Prior to putting his ambulance in the co-op ring, private ambulance (fee for service) operators such as James answered emergency calls from their homes and then drove to the scene. Time off was seldom taken since ambulances had to be on-call 24 hours a day and because pickups and transfers were the bread and butter of private operators.

But that didn’t mean operators had to respond to every beck and call. The operators could be selective—choosing among calls received simultaneously and avoiding calls from the poorer parts of town.

“If they got a call from a destitute area, they would say their unit was busy,” said Robert H. Leiman, owner of Veterans-Prince Ambulance, one of the units joining the co-op.

Leiman estimated a for-profit ambulance service would cost $105 a month to operate. Each ambulance company would have its own two-way radio channel to receive dispatch instructions from Leiman’s office (which was hooked up to Winnipeg’s signal frequency) and also a direct number for people to call in an emergency.

The idea proved a turning point in ambulance system history, although perhaps not of Leiman’s liking. Instead of dispatch co-op, the city created the Winnipeg Ambulance Service (WAS) from the buy out of independents.

Prior to the creation of WAS, fire and police departments and private companies operated ambulance units. It was not a match made in the interest of citizens. Private operators viewed fire and police as the enemies, undermining their ability to make a living. Fire and police viewed private firms as mercenary, with money taking precedence over treatment and transportation. Private operators also had a mutual mistrust of one another.

Leiman’s co-op proposal, on the other hand, could mend fences, so to speak, and consolidate the layers. Control would be on the side of fee-for-service agencies—albeit government subsidized to fund centralized activities—with the caveat that fire and police agree to cease their rescue operations.

The subsequent report, “Amalgamation of the Fire Departments,” submitted to the Legislature on June 29, 1972, took a clear stand against sending rescue vehicles to EMS calls and stipulated that adequate ambulance service with centralized control be made available in the city of Winnipeg.

The city ambulance service commenced operations on June 16, 1975. In 1978, the service was reorganized as a privately operated corporation owned by the city and answerable to a commission appointed by the Winnipeg City Council.

Turf wars, however, continued, resulting in the organization of a task force to resolve the EMS delivery question. A medical director was hired; the first responder program was maintained and expanded. EMS gained independence from the city and evolved into the present-day Winnipeg Fire Paramedic Service.

The two branches—Winnipeg Fire Department and Winnipeg Emergency Medical Services—provide fire and advanced life support, respectively, for the residents of Winnipeg. Dispatchers use the IAED’s™ fire and medical dispatch protocols.

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...and unleash your inner superhero.

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ONLINE SESSION BEGINS: Aug. 24, 2015
ON-SITE: Sept. 20-25 & Nov. 8-13, 2015

"CCM was life-changing. I learned a lot and developed solid relationships with people I might never have known."

— Michel Gravel
New Brunswick EMS
Moncton, NB, Canada

Presented by:
Fitch & Associates
on behalf of IAED™

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

Online registration for the 2015 course is now open.
Go to www.emergencydispatch.org/certccmcourse or call Sharon Conroy at (816) 431-2600 for more course curriculum and registration information.

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