FIGHT STRESS ONE BREATH AT A TIME
NAVIGATOR HAS GONE GLOBAL
GETTING HELP TO REMOTE SPOTS

PAGE  | 22
REACHING OUT TO THE PUBLIC
SPECIAL INSERT
2016 IAED ANNUAL REPORT INSIDE
THE INTERNATIONAL ACADEMIES OF EMERGENCY DISPATCH®

ANNUAL REPORT

annualreport.iaedjournal.org
OUR YEAR IN REVIEW

80 million calls a year using the MPDS®, FPDS®, and PPDS®

80,000,000+

62,000 MEMBERS WORLDWIDE

87,000 certifications in 46 countries
8 NAVIGATORs
21 languages

Number of Communication Centers:
2,650 The United States
129 Canada
39 The United Kingdom
23 China
11 Australia
11 The Netherlands
11 Italy

THE INTERNATIONAL ACADEMIES OF EMERGENCY DISPATCH
In 2016 The Medical Council of Standards introduced MPDS version 13.0 For an in depth break down of the new features v13.0 has to offer visit annualreport.iaedjournal.org.

This update included the following enhancements:
• Ability to provide NARCAN instructions over the phone
• Chemical Suicide identification protocol
• Hands-on-chest “Fast Track” feature
• Instructions for epinephrine auto-injector
• Stroke Diagnostic Tool added to Headache Protocol
• New Miscarriage instruction series

Worldwide Certifications & Recertifications

<table>
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<tr>
<th>Certifications:</th>
<th>Recertifications:</th>
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<td>21,896</td>
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Number of CDE quizzes received and graded: 16,959

The Journal of Emergency Dispatch

396,000 Annual Readership
90 Articles Annually
240 Pages Annually
12 CDE Articles & Quizzes

The Journal website launched this year! For exclusive content, visit http://iaedjournal.org

2016 DISPATCHERS OF THE YEAR

Lisa Siew Phei Fun
Asia

Bethany O’Leary
Australasia

Xia Jing
China

Harald Sulzbach
Europe

Mahmoud Mohamed Osman
Middle East

Louisa Ansell
United Kingdom

Letisha Ghanbari
United States

Tri-ACEs Worldwide: 7
Medical, Fire, and Police Accreditation

Alpharetta Department of Public Safety
Alpharetta, Georgia

Prince George’s County Public Safety Communications
Bowie, Maryland

Boone County Joint Communications
Columbia, Missouri

Salt Lake Valley Emergency Communications (VECC)
West Valley City, Utah

Harford County Department of Emergency Services
Forest Hill, Maryland

Salt Lake City 911 Bureau
Salt Lake City, Utah

Johnson County E-9-1-1 Communications
Smithfield, North Carolina

Medical ACEs: 147
Fire ACEs: 31
Police ACEs: 6
ECNS™ ACEs: 1

To access our full review visit annualreport.iaedjournal.org
THIS IS MY CALL // THIS IS MY STORY // THIS IS OUR JOURNEY
Message from the Board of Trustees

Dear Academy Members, Friends, and Volunteers:

The purpose of the International Academies of Emergency Dispatch—“the Academy”—is to provide Emergency Dispatchers with the support they need to get the right help, to the right place, in the right way, at the right time—and do the right thing until “the troops” arrive. This year, again, you helped us achieve that purpose.

Our members are at the heart of what we do, the front-line heroes who take more than 80 million calls a year using the Academy protocols. This year, not only did we reach 62,000 members in 46 countries, but we certified an amazing 16,585 new members and recertified 19,477 more.

We could not hope to reach so many people without the tireless work of our instructors. As of this year, more than 1,000 Academy instructors spent tens of thousands of hours traveling and teaching so that new dispatchers would know exactly how to use the protocols right the first time, and every time. In addition, this year has seen the Academy’s first move into web-based training, with the EMD Advancement Series™ celebrating its 17th year by moving online.

And of course, when it comes to providing the right help, to the right place, at the right time, quality assurance is critical. We are fortunate to have more than 7,000 ED-Qs™ in four disciplines bringing the Academy’s insistence on quality calltaking and accurate call prioritization to centers the world over.

Finally, in order to do dispatch right, we have to know what “right” is. That means research, and lots of it. This year marked the fourth anniversary of the Annals of Emergency Dispatch & Response, the world’s only peer-reviewed journal of dispatch research. Moreover, the volunteer members of the Council of Research and the Standards Councils ensure that the Academy continues to develop protocol systems tied to the highest standards of care and practice, and the Curriculum Boards ensure that it is taught and understood correctly.

In short, our hats are off to you for being a key part of the world’s largest community of evidence-based practitioners of emergency dispatch. We believe what you do is important enough to do right, and everything we do is dedicated to helping you get there!

Thank you.

Jerry Overton
Chairman, Board of Trustees
COMMUNITY OUTREACH
Communication centers around the world are stepping up their efforts in helping communities understand the critical importance of emergency dispatching.

TRAINING
Want your communication center to run like a well-oiled machine? In order for all the components to work efficiently, you must implement an effective training program.
Jennifer is a Fire/EMS Dispatch Supervisor for Seminole County Fire Department, Sanford, Florida, USA. She has been dispatching since 2004, with six of those years in a supervisory position. Passion for the dispatch world and the people who work in it keeps her motivated.

Mary is with the Washington State Patrol where, for the past 10-plus years, she has worked as a dispatcher, chief training officer, supervisor, and training program supervisor. She is certified by the International Association of Chiefs of Police as a Leadership in Police Organizations instructor. She is also a certified instructor for the Washington Criminal Justice Training Commission.

Daphanie has been a dispatcher with Martin County Fire Rescue in Stuart, Florida, USA, since 2005, where she is currently the Training Coordinator. She is a licensed Emergency Medical Technician and has a bachelor’s degree in public safety. She is passionate about the mental well-being of her dispatch family, including awareness of the various triggers that are inherent in this career.

Art is a software instructor and IAED™-certified ED-Q™ instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 18 years and works at Union County Regional Communications in Westfield, New Jersey, USA. Art has been involved in 911 telecommunicator training and medical quality assurance since 1999.
HAPPY NEW YEAR

Here’s a resolution we’d love you to keep

Audrey Fraizer

T o kick off the year’s first issue of the Journal, we thought it would be rewarding to provide strategies to keep your New Year’s resolutions.

Why? Studies have found that people who make resolutions are 10 times more likely to change their behavior and, perhaps, enjoy longer and healthier lives.

It’s also our way of inviting members to make 2017 the year of contributing your talents to the Journal—printed and online. Since this is a resolution we want you to keep, we’ve included a process that will surely place you among the elite 8 percent who actually achieve their resolution.

Step 1: Make your resolution specific.

The Journal’s readers delight in the good news about emergency dispatch: how your training and people skills contribute to the outcome and chain of response. These stories are most often published in the Your Space section, and in this issue we have two articles in honor of National Public Safety Telecommunicators Week. Regular contributor Art Braunschweiger (The EMD Side) actually achieved his resolution.

It would be rewarding to provide strategies to keep your New Year’s resolutions.

We’ll be glad to do that for you. For example, in this issue we feature a couple from Victor, Colorado, USA, and it all started through a call telling us about the event from the Cripple Creek (Coloro) Rock Center.

Step 3: Acknowledge the sense of accomplishment.

You’ve probably heard it before: Celebrating even small successes will help keep you motivated and energized. A growing body of research associates cultivating positive emotions on a regular basis with psychological well-being, resilience, and living longer. And living longer means you’ll be here next year, and the years after next, to continue writing for the Journal.
Thankfully, I haven’t needed your help very often. Don’t take that the wrong way. I’m sure you understand what I mean. After all, no one wants to be in a situation where they need to call 911, but anyone is sure glad you’re there when emergencies arise.

I’ve called 911 three times in my life. The first time occurred when I was about 6. My older brother and I were messing around on the phone. We had just gotten done dialing a random number (which happened to ring some guy in Norway) when we figured it would be a great idea to dial that three-digit number we’d heard about so much in school. Apparently we had a lot of leisure time on our hands that day. We dialed the number; someone answered. My reaction: I quickly hung up. Naturally, a dispatcher called right back. Problem was, my mom answered the phone. Needless to say, I wasn’t allowed to touch the phone for a year. Plus, I was deprived of my favorite cartoons for a whole week.

The two other times I’ve called 911 were for legitimate reasons. Sixteen years ago, my wife and I were enjoying a quiet Sunday dinner in our apartment. At one point, I glanced out the window toward the parking lot of the complex and saw orange flames shooting out of the dumpster. The fire was close to some parked cars and not too far from the nearest apartment. Who knew what might have been in that dumpster that could’ve increased the fire’s strength.

I called 911 and explained the problem. I remember being instructed not to try to put the fire out. I was OK with that; my garden hose wasn’t long enough anyway. I stayed on the line until firefighters arrived, and the fire was doused in no time. I never found out what started it but suspect it had something to do with the late-night firework show the day before.

Earlier this year I was observing the activities of the neighbors across the street (my wife said I was spying). The mischievous teenage boy, who was known throughout the neighborhood for his antics, and a questionable-looking friend were conducting what I’ll call a business transaction. It wasn’t the type of business I wanted in my neighborhood.

When I made the call on this shady deal, the dispatcher walked me through some instructions that were unmistakably from the Police Priority Dispatch System™ (PPDS™). I wanted to thank the dispatcher for following the protocols.

Needless to say, the police showed up promptly and had a little chat with the boys and the neighbor boy’s mother. I didn’t see the neighbor’s friend ever again, and the disturbing drug activity seemed to have come to an end.

My examples are relatively minor and tame compared with the calls you take every day. Still, it was comforting to know that a skilled, well-trained dispatcher was addressing my small issues. To think you handle situations like these, and many more that are infinitely more urgent, is humbling.
Research workshop leads to discovery, enlightenment

Tracey Barron

I want you to write, type, or calendar the following dates: April 10 and April 11, 2017.

These are the dates of the inaugural Emergency Dispatch Research Workshop.

To take advantage of this landmark event requires only a few steps. Register for the workshop, hosted by the International Academies of Emergency Dispatch (IAED) and the UCLA Center for Prehospital Care, and travel to New Orleans, Louisiana, USA, to participate.

The workshop offers a unique hands-on opportunity to frame research into the further study of emergency dispatch, whether medical, police, or fire. Participants work in small groups to develop a plausible question and methodology. No prior research experience is required. The sponsors provide everything you need to succeed.

The workshop is scheduled over two days. We will discuss the value of research, how research builds upon the work of others, and qualities that demonstrate good, sound research. Statisticians, the IAED, and UCLA researchers, editors, and programmers will be available at your fingertips, ready to provide step-by-step support to identify research topics, design the projects, gather data, and perform statistical analysis. You will leave well on your way to submitting an abstract to the Academy’s peer-reviewed scientific journal, the Annals of Emergency Dispatch & Response (AEDR), or to any other referred journal of your choice. You could also leave ready to organize a poster presentation for NAVIGATOR 2018.

Those leading the workshop will also help you get over a fear of research. Maybe you think research is an area beyond your ability or better left to the experts. Maybe you fear peer rejection.

All of us have felt that way, and still do occasionally, when conducting research. But we’re here for you. We’ll help you break research proposals into manageable studies and reasonable steps. As a group, you will create a list of what you need to do, and you will formulate your plan of attack for each step. You will participate in an environment with people who can provide the confidence to pursue this project and future research endeavors.

I like research. It’s not work to me. Research is an opportunity to broaden my knowledge and put new evidence into the world. Even familiar topics in protocol and prehospital care interest me because research substantiates the information or points to a necessity to update what we presumed timely and relevant.

I know research is also a way to get an idea to the ears of the public and decision-makers (such as the police chief, fire chief, medical response team, and budget-makers). Despite what you might think, people pay attention to independent and effective sources of information collected through a well-conceived scientific process approach. In other words, when research is conducted and applied properly, it can do a lot of good. We use research to make the world better.

Similarly, high-quality research into emergency dispatch is crucial to the profession and the public. It provides important data to enhance police, fire, and EMS case outcomes; improves the caller’s experience; assists in effective decision-making; and ensures the viability of emergency dispatch protocol. This is vital in our profession, where change is constant and innovations are seemingly introduced every day.

Research moves us forward in understanding and perfecting what we do. We need this understanding of protocol and its relation to public safety to create a viable future. Partnerships forged through research lead to a staggering amount of progress, and we are eager for you to become a part of that.
PERSISTENT CASE ENTRY PDIs
When frozen software perception is reality
Jeff Clawson, M.D.

Dr. Clawson:
If Instructions pop up, and before continuing in ProQA®, dispatchers/calltakers need to click the red X to dismiss the red instructions box. This isn’t always obvious, and if they don’t dismiss the message box, they think they’re stuck in unresponsive software.

This software design is sometimes confusing, as the red box looks like an instruction box, not an overlay box that needs to be dismissed before continuing.

Thanks,
Ken Pitts
Public Safety Systems Manager
City of Cambridge, Emergency Communications Department
Cambridge, Massachusetts, USA

Ken:
Thank you for reaching out to us regarding your issue regarding closure/persistence of the Case Entry PDI box. While this box can be closed via the red “X” box in the upper-right corner, we designed it to also be closed in three other ways that are consistent with navigation within some other areas of the program. They are the:
1. Escape button
2. Space bar
3. Enter key

It was done this way to allow folks that are mainly keyboard users to be able to close it without reaching for the mouse. Personally, I prefer to use the space bar, as it is the most movement economical to utilize. We will consider making the box slightly smaller width-wise to make it appear more as a box and not part of the Case Entry screen, which may help that perception; we will also consider adding a “Close window” button within the screen to identify beyond doubt that it needs to be closed via any of the five different methods.

Again, thanks for contacting PDC™ and the Academy with this issue, as this is how we evolve the protocol, software, and our QA processes. To date, there have been over 10,000 modifications, logic changes, and improvements in ProQA alone.

Best regards and Happy Holiday Season to you, your family, and your center...Doc P.S. If the above alterations are made, we will notify you of its availability in a future push of ProQA.

Dr. Clawson:
Thank you for your response. And to be clear (and sorry if I belabor the issue), the fact that there are four or five methods to close the PDI box does little to help the calltaker who is unaware that there is a box that needs to be acknowledged and dismissed. They are in the middle of a cardiac call, and believe the software has frozen on them.

Making the box slightly smaller or adding a “Close window” button should go a long way to avoid confusion.

Thanks,
Ken

Finally, the Doc adds:
A software proof sheet was submitted on 12-27-16 to PDC Development to enact both of these suggested changes, which have since been done via Proof 6556.
THE INTERFACILITY PROTOCOLS
Streamlining calls from medical facilities

Art Braunschweiger

Any EMS agencies process calls received from facilities staffed with medical professionals. These calls are made by individuals ranging in qualifications from unit clerks to physicians, and they’re often challenging for the EMD when the caller and calltaker don’t understand each other’s needs. However, there are two protocols in the Medical Priority Dispatch System™ (MPDS®) that can help streamline patient assessment and call processing time: Protocols 33 and 37. Both are named Transfer/Interfacility/Palliative Care, and the latter is available exclusively in ProQA®.

These Interfacility Protocols differ from the standard protocol, in part, because the decision regarding what resources to send is intended to rely on the joint evaluation of the EMD and the patient’s caregivers. In other words, we’re relying, in part, on the ability of the staff to accurately assess the patient’s clinical condition and transfer needs. For example, if chest pain is reported, Key Question 6a on Protocol 33 asks, “Could this be an MI (heart attack)?” This type of question would not appropriately be asked of a layperson. There are also questions to determine whether any special equipment or personnel are necessary—a key consideration since a given patient may require resources ranging from a basic BLS crew to a critical care transport.

A second key difference is that no clinical Post-Dispatch or Pre-Arrival Instructions (PDIs or PAIs) are required by protocol. The caller is only advised what type of response is being sent, to call back if the patient worsens and, in the case of Protocol 37, to have any advanced directives ready. This avoids offering possibly unneeded or redundant instructions and takes advantage of, and respects, the fact the patient is currently under the care of a medical professional.

This brings us to an important cautionary note: Protocols 33 and 37 are not appropriate based on patient location alone. Use of either depends on not only the ability but the availability of the staff to assess and care for the patient. For instance, staffing varies by time of day. For example, while an assisted living facility may have registered nurses and/or licensed practical nurses available during the day, nursing aides or lay caregivers may be the only staff available at night. These qualifications differ considerably. Additionally, not all medical providers are familiar with the different types of EMS resources available locally. Therefore, there’s a caveat in the Additional Information section of Protocol 33 that reads: “It is not necessary to seek permission from the nurse or doctor to upgrade the response level.” Similarly, if any doubt exists as to the ability of the staff to manage the emergency they’re calling about, PDIs or PAIs from the standard protocol should be offered.

Approval by an agency’s medical director is required before using either protocol, and both protocols require that response levels be locally defined and authorized. In the case of Protocol 37, the terms NURSE and DOCTOR must be specifically defined and authorized to ensure clinical confidence in caller assessment. While specific facility approval isn’t required by the Academy, an agency may prudently choose to do so internally. EMS agencies and responders should consider the capabilities of both staff and facility before authorizing the use of these specialized protocols. When properly implemented and applied, there’s no question that interfacility call processing can be expedited and enhanced by taking advantage of these specialty protocols.

Both protocols require that the patient has been evaluated by a nurse or doctor, although in Protocol 37 an agency’s medical director can authorize other levels of licensure such as a physician assistant to be considered a nurse or doctor for purposes of using this protocol.
DIG DEEPER

I didn’t know ProQA could do that!

John Hancock

Have you ever owned a software program, PC, laptop, or phone and used it so often that you thought you knew everything about it but then found out you didn’t?

I’ll never forget the day someone pointed out the text-to-speech tool on my PC. I was convinced that I was the undisputed expert. I thought I knew everything until someone showed me how to make it say what I typed. “I DIDN’T KNOW IT COULD DO THAT!”

There was little practical use, but I sure had some immature fun making it say ridiculous things. Face it, nearly everyone has the maturity level of a 12-year-old itching to let loose.

The same “I DIDN’T KNOW IT COULD DO THAT!” goes for our ProQA software. It can do things that you might have never known it could do. Unlike my text-to-speech revelation, the software’s capabilities have a great deal of practical use. Although I’m sure some of you might be aware of a few of these functional gems, I’m also sure the opposite is true among others because of the number of times I’ve heard, “I DIDN’T KNOW IT COULD DO THAT!”

This one is my favorite. If you enter the year a patient was born into the age field it will calculate the patient’s age. I never realized how popular this feature is with calltakers who, for years, have received this answer to the age question: “Let me check. Alright, his birth certificate says he was born in 1929.” Ugh. OK. It’s now 2017. Subtract 9 from 17, carry the 1, etc. ProQA will do it all when you enter the year of the patient’s birth in the designated field. Town squares all over the world have erected statues in honor of software instructors revealing the age gem.

Did you know that you can watch a case in progress from the Case Summary tab on an entirely different workstation? The calltaker engaged in the protocol won’t know you’re there. You can neither interfere with the case nor can you open it and take any control. You’ll just watch it unfold from afar. The feature has lots of practical applications. You can use it to dispatch the call if you have no CAD interface. Trainees can watch the flow of the protocol. Supervisors and trainers can monitor protocol compliance.

How about that Sudden Arrest Reset button? Some call it the “Dead Clown Eye.” The button is the big X between the Rule of Nines and the HAZMAT tool at the top of the program, and it brings you to a DELTA response and Arrest/Airway PAIs. It’s a lifesaver, so why, you might wonder, is the feature not available at Case Entry? It’s grayed out; you can’t use it until Key Questions and beyond. Why? Is it because nobody goes into arrest while in Case Entry? Of course they do. However, you have an equally powerful tool available in the ECHO response drop-down from the “Okay, tell me exactly what happened” field. Same result. You’re brought to an immediate send point followed by entry into lifesaving PAIs. The Dead Clown Eye would be repetitive at Case Entry.

These are only three examples of features that you might not have known about until reading this column. There are plenty more, but since I’m limited for space we’ll stop here. Now if we could only get ProQA to give us text-to-speech.
How does the 911 industry forewarn for the inevitability of stress?

If stress is viewed as a disease, we can vaccinate against it by training and preparing new employees appropriately. Most military and law enforcement academies prepare recruits for the real thing by inoculating them against stresses encountered in their job functions (shooting, handcuffing, driving, etc.) The 911 industry can follow suit and use reality-based training (RBT) to counter stress specific to telecommunicators.

What emotions do new employees and trainees experience most often?

Probably fear and worry. Trainers frequently fixate on their perceived ability to perform. The longer they go without a critical incident, the more detrimentally fixated the employee becomes.

Combating the emotion cognitively requires acclimatization, described as “prior success under stressful conditions […] to similar situations and promotes future success.” This is why RBT is recommended. Exposure to scenarios in a real-life setting helps the trainee move past fixation to knowing what to expect.

RBT in professional training is practiced through a series of exercises, drills, and simulators. For example, a dispatcher trained using RBT learns to respond reflexively. The initial “rush” is expected, but the training helps them manage initial reactions, expect, and rely on RBT to help them focus and do the job.

Biologically, the body cannot discriminate if the stress response engages because of a swarming bee attack or arriving late for work. The body will respond by flooding chemicals into the bloodstream and shunting blood toward vital organs.

How does blood get restored to the rational part of our brain?

Breathe. As simple and anticlimactic as it sounds, tactical breathing (combat breathing) is the best way to reverse the stress response on a physiological level. “In through the nose, two, three, four. Hold, two, three, four. Out through the mouth, two, three, four. Hold, two, three, four.

Repeat.” Increased oxygen intake restores blood flow to the brain, helps slow heart rate, and keeps dispatchers from sounding high-pitched when broadcasting.

Tactical breathing is taught in professions where the ability to think rationally during stress response can mean life or death. The technique is not groundbreaking. Lt. Col. Dave Grossman, a retired West Point psychology professor, travels the country teaching the technique to thousands of police officers and military members, among others, and says that it’s been applied in various realms, such as martial arts, sharpshooting, and Lamaze.4

Similar to flu shots required annually for effectiveness, the same goes for tactical breathing techniques. The stress “inoculation” must be practiced frequently to become muscle memory.

We must move as an industry to adequately prepare people for their careers in 911. We need to include stress inoculation in training programs and prepare dispatchers with RBT for this remarkable job.

Sources
2. See note 1.
4. See note 3.
TALES FROM DISPATCH
Former dispatcher tells Exactly What Happened
Caroline Burau

Caroline Burau is the author of two books about emergency dispatch. The first book, “Answering 911: Life in the Hot Seat,” was published in 2007. The second book, “Tell Me Exactly What Happened: Dispatches from 911,” was published in 2016. Both were published through the Minnesota Historical Society Press. During her 12 years in the profession, Caroline dispatched for an ambulance service in Minnesota and White Bear Police Department, Minnesota, USA.

Editor’s Note: Caroline’s answers are paraphrased from an interview and are not direct quotes.

Caroline: I wrote “Answering 911” during my first year at dispatching. At that time, I had no aspirations of writing or publishing a book. Writing about my experiences was a way of helping me cope with a very stressful job. I read my early essays at the Loft [a program for readers and writers founded in a loft above a Minneapolis bookstore], and it happened from there. I was approached by the Minnesota Historical Society Press, and they published “Answering 911,” which was very well received.

2. What was your motivation to write the second book, “Tell Me Exactly What Happened,” particularly since you were no longer working in emergency dispatch?
Caroline: Ten years had passed since the first book, and I was actually waiting for someone with more time in the profession to write a book from that perspective. Nothing happened. So, all those years later, I was that different person. I wanted to give credit to an underrated profession. As I write in the first chapter of the second book:
So, I find myself wanting to write about it, again. Not because the story of my dispatching career is so unique, but because it is not. Because if I tell you what it is like to answer 911 in White Bear Lake, Minn., I’m also telling you a lot about what it’s like to answer 911 just about anywhere.

3. How did your perspective change over the years between publication of the two books?
Caroline: The first book was “You wouldn’t believe what just happened.” As I said, I was new to dispatch and not at all prepared for the phones that never shut off, the angry and upset callers, and the long hours sitting in the same place without a break. The second book is more about “You get used to a certain amount of chaos and stress. It no longer shocks you.”

4. Who is your intended audience?
Caroline: A lot of the readers [of “Answering 911”] were dispatchers, and that’s what I expected. But the book also reached people outside the profession. Dispatch is misunderstood. It’s a lot more important and interesting than people think. It’s definitely a profession. People don’t hear about what dispatchers do unless something bad happens. It’s basically a thankless job. We try to save people, but, think of it this way, the people picking up the phone don’t get saved. We are the first point of contact. We hand it over and rarely hear what happens. If someone [not familiar with dispatch] asks me about reading either book, I tell them to go into the book with the best of intentions. Dispatch is not about what you see on TV. At one moment it can be a nightmare, and, at the next, it can be monotonous.

5. What interested you in applying for a job in dispatch?
Caroline: My lifelong love of writing brought me to newspaper reporting. I covered police, and that introduced me to dispatch. I like people. I liked the idea of being a part of what the police were doing but in the background. I thought it was a great way to help people, and I still believe that.

6. The title of the second book, “Tell Me Exactly What Happened,” is similar to a Case Entry Question in the Academy’s protocol. Did the agencies you worked for use the dispatch systems? If so, you never mention their use in either book. Why?
Caroline: This is a memoir. I wanted to keep names and systems anonymous. I made changes that obscure identities, and I was really cautious about callers and patients I write about. I was concerned with protecting people and places. As I wrote in the second book: I am attempting to expose the way this job has affected me without exposing those I’ve met along the way.

To read the rest of the interview visit us at iaedjournal.org
curious

What could you do with a Statistician, a Writer, and a Data Analyst at your fingertips?

ATTEND OUR RESEARCH WORKSHOP TO FIND OUT!

EMERGENCY DISPATCH RESEARCH WORKSHOP

Hosted in partnership with the UCLA Center for Prehospital Care

Monday, April 10–Tuesday, April 11, 2017

Learn how to make your comm. center data WORK FOR YOU!

Our team of experts will guide you to unlock the possibilities of your CAD and ProQA data to improve and benefit your communications center. You’ll work in small groups to identify a research question, decide on methods, and craft your abstracts in a hands-on approach that makes research easy and fun. Statisticians, programmers, and editors are on-site to immediately give you step-by-step support and assist you in obtaining data, performing a statistical analysis, and constructing an abstract ready for submission or presentation.

No prior research experience required.

Email us at researchhelpdesk@emergencydispatch.org for more information and to register for the workshop.

Powered by:
NAVIGATOR keeps on getting better, and that’s the honest, simple truth. As more and more countries step up to the Academy’s protocol process, NAVIGATOR grows proportionately in scope to accommodate the world. In one word, protocols and NAVIGATOR are continental, a word that in its usage can apply in both the geographical and cultural appreciation of the Academy’s sensibility. The emergency dispatch protocols and emergency nurse triage system can be found in six of seven continents, Antarctica is the exception, although the Antarctic Fire Department, a division of Lockheed Martin’s Antarctic Support Contract, does employ primary and alternate dispatchers. Give the Academy time, and we might be there.

Most of the six continents will be represented at NAVIGATOR, scheduled April 12–14 at the Hilton New Orleans Riverside, New Orleans, Louisiana, USA. Seven spin-offs of the original conference, first held in 1988, have since been added in Europe, Australia, and Asia.

No matter the continents hosting, however, NAVIGATOR offers the impeccable venue for learning, discussion, and networking. Keynote speakers, gala parties, vendor exhibits, great food (and plenty of it), field trips to communication centers, and receptions are a big part of the NAVIGATOR fabric, but the focus remains on developing your protocol know-how.

And this year, the Academy is offering a first-ever scholarship to NAVIGATOR for one lucky emergency dispatcher. Stay tuned for more details.

For NAVIGATOR 2017, the Academy organized an exceptional number and variety of educational tracks: Quality Assurance, Leadership, Management, Research, Motivation, Stress Management, CDE & Training, Special Interest, Operations, Human Resources, Fire Protocol, Medical Protocol, Police Protocol, and an International track that connects the continents.

You can feast on sessions providing solutions to workplace drama, shift strategies, problem employees, morale issues, critical incident planning, training, social media, assisting callers with disabilities, and the hot seat of news reporting. Madeline Marks, of the University of California’s Center for Research and Treatment on Response to Extreme Stressors, will present a Leadership session outlining
the lessons learned from the Pulse Nightclub shooting.

The Academy welcomes back favorite speakers from past conferences and introduces speakers new to NAVIGATOR. Ricardo Martinez, of the popular “Within the Trenches” podcast, will make his NAVIGATOR debut as a speaker. He will record an episode of WTTT during NAVIGATOR, interviewing IAED™ officials and NAVIGATOR attendees. He will also be presenting a session about his dispatch story and how he got into podcasting.

To further show his dedication to emergency communications, Martinez is donating proceeds from his #IAM911 T-shirt sales to sponsor a “Within the Trenches Continuing Education Scholarship” to NAVIGATOR for one lucky emergency dispatcher.

Of course, a show of fun is never far behind at NAVIGATOR. Keynote speakers, gala parties, vendor exhibits, and receptions—as mentioned—are always a big draw.

There is also a cultural appeal that keeps people coming back each year.

Protocols are about simplicity. The Academy develops protocol’s contextual platform for maximum efficiency at communication centers and, essentially, defines emergency dispatch universally. The process saves time and conserves resources. You aren’t flying by the seat of your pants or sending out the “cavalry.”

The cavalry is a description the protocol’s inventor, Dr. Jeff Clawson, is known to use when an agency sends police, fire engines, paramedics, and ambulances with lights and sirens blaring, rather than the response actually required by the incident (e.g., a single ambulance without lights and siren). And, here’s another bit of trivia for the protocol record: New Orleans is the birthplace of protocol. Charity Hospital was where Dr. Clawson, then an emergency room resident, was handed a form of recipe cards the chief resident called a cookbook for handling patient flow.

The rest, as they say, is history.

Ultimately, traveling to NAVIGATOR is much more than visiting a single country over a three- to six-day conference (depending on pre- and post-conference sessions). NAVIGATOR is a hearty continental experience prepared with you in mind.
FEAR OF INFECTION

Blood-borne pathogen fear should not preclude CPR

Brett Patterson

This question comes from a dispatcher who provided a bystander with PAIs to assist a trauma victim:

Dispatcher:
I recently provided PAIs that included mouth-to-mouth ventilations and compressions on a trauma patient. Such patients could be bleeding and potentially expose the bystander-rescuer to blood-borne pathogens. Should we be telling bystanders to do this? Isn’t there a risk to the bystander performing these instructions?

Brett Patterson:
A call to 911 is considered by our courts as an implied call for help. As such, we offer help in the form of the standard of care in dispatch. Our baseline is the standard of care in emergency medicine. The current resuscitation standard for traumatic cardiac arrest is CPR with ventilations. I know of no standard that calls for withholding resuscitative efforts based on a concern about disease transmission. The Ethics section of the 2010 Guidelines for CPR and ECC (unchanged in the 2015 Guidelines) has only this on the subject:

• Withholding and Withdrawing CPR (Termination of Resuscitative Efforts) Related to Out-of-Hospital Cardiac Arrest (OHCA)—Criteria for Not Starting CPR in All OHCA

• Basic life support (BLS) training urges all potential rescuers to immediately begin CPR without seeking consent, because any delay in care dramatically decreases the chances of survival. While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate, as follows:
  • Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril
  • Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition)
  • A valid, signed, and dated advance directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR (Do Not Attempt Resuscitation) order

Aside from standards, we need to consider the risk/benefit ratio. The MPDS® has been advising and instructing
resuscitation for over 35 years, and I am not aware of a single case where a rescuer has contracted a communicable disease related to a resuscitation effort. There is no data that I know of that shows significant risk to laypersons who render CPR, much less placing a rescuer “at risk of serious injury or mortal peril.”

A 1998 study looked at the risk and defining strategies for Infections acquired during cardiopulmonary resuscitation1:

PURPOSE: To estimate the risk for acquiring an infectious disease during cardiopulmonary resuscitation or CPR training and to identify strategies to minimize that risk.

DATA SOURCES: English-language articles published since 1965 were identified through a search of the MEDLINE database and selected bibliographies.

STUDY SELECTION: Studies that contained information about transmission of infectious organisms, particularly HIV and other blood-borne viruses that might be transmitted through mouth-to-mouth ventilation, contact exposures, and needlesticks during CPR.

DATA EXTRACTION: Descriptive and analytic data from each study.

DATA SYNTHESIS: Fear of acquiring infection, especially HIV infection, can delay prompt initiation of mouth-to-mouth ventilation. Although pathogens can be isolated from the saliva of infected persons, salivary transmission of blood-borne viruses is unusual, and transmission of infection has been rare: Only 15 documented cases have been reported. Most of these cases involved a bacterial pathogen, such as Neisseria meningitidis. Transmission of hepatitis B virus, hepatitis C virus, or cytomegalovirus during CPR has not been reported; all three reported cases of HIV infection acquired during resuscitation of an infected patient resulted from high-risk cutaneous exposures. There have been no reports of infection acquired during CPR training. Simple infection-control measures, including use of barrier devices, can reduce the risk for acquisition of an infectious disease during CPR and CPR training. Post-exposure protocols can further protect potential rescuers and trainees.

CONCLUSIONS: The benefit of initiating lifesaving resuscitation in a patient in cardiopulmonary arrest greatly outweighs the risk for secondary infection in the rescuer or the patient. Nevertheless, use of simple infection-control measures during CPR and CPR training can reduce a very low level of risk even further.

In summary, while fear of contracting an infectious disease is a significant factor in layperson reluctance to provide CPR, the chance of contracting an infectious disease while providing CPR is extremely low, and CPR is the current standard of care in the resuscitation literature.

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

Source

WHAT’S AHEAD
Journal takes many directions

The March/April Journal of Emergency Dispatch might make you laugh and cry.

On the lighter side, readers should certainly get a kick from a feature story chronicling the mishaps on a family vacation through fire, police, and medical protocols. Chalk up the family’s safe arrival home to PDIs and PAIs they receive along the way.

A second feature is sobering with its look at the opioid epidemic sweeping the country. The Centers for Disease Control and Prevention attributed 17,536 deaths to prescription painkillers in 2015, an increase of 4 percent from the previous year. Emergency communication centers are pitching in to curb problems through real-time surveillance, PAIs, and overall awareness of callers in danger of overdose.

As always, members can look forward to fulfilling their continuing dispatch education requirements by completing the quizzes accompanying the two CDEs. We also highlight Allina Health EMS communication center in Minneapolis, Minnesota, USA, and the Joint Emergency Services Control Centre (JESCC), Guernsey, U.K.

Happy reading!
Remember, we welcome your story ideas at editor@emergencydispatch.org. You can also visit us on Facebook.
COMMUNICATIONS AT THE HIGHEST LEVEL

Cripple Creek is well worth the drive

Audrey Fraizer

You might think, “I’ll never get there.”

Scenic pullouts along an 18-mile winding road are breathtaking, and the numerous dirt trailheads cutting into the mountainsides are tempting to follow. Abandoned historic mining sites, Colorado blue spruce, and the occasional moose foraging at streams or in the tall grasses of meadows opposite the standing pines are sights not often seen by people living at sea level.

Anticipation builds.

“Where is this place?”

Destination Cripple Creek (pop. 1,200), in central Colorado south of Pikes Peak, is every bit worth the drive, and you can ask just about anyone there to get the same answer.

“We love it here,” said Ellen Moore, who moved to Cripple Creek five years ago with husband, David. “We retired early because we didn’t want to wait any longer.”

Not everyone retires early; a lot of people never leave in the first place. Jobs in the once extremely prosperous gold mining region can still be found in retail (small businesses), the still-active though reduced in scale mining industry (Newmont’s Cripple Creek & Victor Mine), casinos (Cripple Creek approved gaming in 1991), tourism, agriculture and ranching, and city or county government.

Diann Pritchard is director of the Cripple Creek Police Department 911 center, which at an elevation of 9,494 feet might be the highest communication center in the continental USA. She applied for an open position in 1996, which was the same year the El Paso-Teller County 911 Authority instituted the Medical Priority Dispatch System™ (MPDS™). For 23 years before that, Pritchard was a firefighter/EMT navigating emergency vehicles up and down some mighty twisty roads. She was the second woman Green Mountain Falls, Colo., hired as a firefighter/EMT.

“This is home,” she said.

Pritchard shows pictures of the scenic mountain view from her home’s front window as eagerly as someone else might pull up photos of kids or grandkids, do-it-yourself gazebos, or the “free-range” donkeys milling throughout Cripple Creek proper. The pampered donkeys, like most of the buildings and homes in Cripple Creek, are reminiscent of the golden days of mining.

The name “Cripple Creek” is, literally,
quite by accident. One story has a cattleman and his assistant building a shelter close to a creek when a gun discharge hits, frightening a calf, which cripples its leg jumping over the creek. Another story has two brothers building their log house near the same creek; one brother falls from the roof and two days later their hired hand is thrown from his horse. The two suffer “crippling” injuries.

The communication center is on the first floor of police headquarters in a building that was originally a dry goods store and boarding house. The exterior is brick and, by law, the same goes for every commercial structure in the city’s mile-long downtown, rebuilt following a fire in 1896 that, in four days, destroyed two-thirds of the town and left 5,000 people homeless.

The police station is near the end of the business district, west of the casinos, antique shops, ice cream parlors, civic and administrative offices, museums, fire station, and Heritage Center at the city junction. Looking east toward Battle Creek Mountain is a view that gives people another reason to stay.

“You never get lost,” said the barista at a local coffee shop. “Mountains to the east, and the road through town running east to west, buildings north to south.”

Pritchard gets her exercise walking up the sidewalk to municipal buildings, dropping off subpoenas at Teller County courthouse, eating lunch with the police chief at the Pint and Platter restaurant (a local favorite), or bringing reports to city administrative offices. A national run of Hells Angels chapter representatives held in Cripple Creek in July demanded Pritchard’s full attention at the 911 center, managing EMDs and acting as the liaison to the officers and the FBI.

“I think it was a matter of affirmation. It was a matter of putting it all together,” he said. “They needed someone to say, ‘You can do it. You’re there.’” They agreed but hedged on the commitment.

“We thought about this for a long time because our compliance has been in the ACE range for years,” Avery said. “We weren’t sure who would have the time.” As it turns out, Avery did or, at least, had the space to add yet another hat to her job description that already included records management, dispatch, quality assurance, and reviewing the 35 to 40 EMD calls each month. Lofgren, however, would no longer be their QA analyst. He was promoted to supervise the authority’s QA/Training Department, and the job of tending the ACE seed that Lofgren planted was now under the auspices of Ardelle Grima.

“Diann [Pritchard] and her team are the poster child of how to make ACE successful in a small community,” said Lofgren, who received the Academy’s Instructor of the Year Award at NAVIGATOR 2016. “They’ve embraced the protocol. For them, the ACE process was like throwing gasoline on a stack of dry wood and running with it.”

Three years ago, Lofgren was meeting with Pritchard and Avery on a regular basis as the authority’s QA analyst and, at that time, more than casually asked them about ACE.

“They were there, and it was now a matter of putting it all together,” he said. “I think it was a matter of affirmation. They needed someone to say, ‘You can do it. You’re there.’”

There is camaraderie among EMDs and police officers. They know the casino owners, but not because of any gambling habit.

“They’ve explained the process to the casinos,” Lofgren said. “There’s a guy in security who knows the PDIs by heart. He can recite them.”

The EMDs peer-review calls, participate in four-hour training sessions on alternating Wednesdays, collectively test 100 calls in ProQA each month, and compete in their modified version of bingo. The first to blackout (covering all the squares representing Chief Complaints) wins a Thin Gold Line bracelet. The Thin Gold Line is a universal symbol for police dispatchers and signifies commitment to the officers and public they serve.

During National Public Safety Telecommunicators Week, Cripple Creek Police Chief Michael Rulo dropped by to deliver sandwiches, cake, and words of praise.

“They’re absolutely an integral part of emergency services in the community,” said Rulo, who has watched the evolution of MPDS through law enforcement jobs throughout the two-county area. “I am awed by their talent and collaborative effort. They do an amazing job.”

The Cripple Creek Police Department emergency dispatch center handles all police/fire/EMS calls within the 1.3-square-mile town and fire/EMS in neighboring rural jurisdictions. In 2015, they took 14,500 calls, of which many were related to tourists coming from lower elevations and experiencing the effects of higher elevations.
Actress Helen Mirren looks on as dispatchers at London Ambulance Service are hard at work.
NOW HEAR THIS...

Agencies around the world reach out to the public to help improve emergency response

Mike Rigert

Imagine a world in which every child, from age 8 on up, knew that he or she could dial 911 to get help during an emergency. And in this hypothetical world, not only would children (and therefore, adults) know when and how to phone for emergency assistance, but they also could anticipate what types of standardized questions the emergency dispatcher would pose to them and what information callers would need to provide.

What kind of impact would such a scenario have on community medical, fire, and police response? Needless to say, the resulting impact on that society would be equally life changing and lifesaving.

But what if this fictional place was not some far away utopian planet but rather the actual near future of the area in which you live? Thankfully for present-day Earthlings, the future is now, as many public safety agencies are actively engaging young and old alike to develop a more informed citizenry when it comes to emergency calls. More and more, communication centers are investing in the significant returns that a dynamic and sustainable community outreach program can give residents—and dispatchers.

Put simply, helping residents better understand 911 better positions calltakers to give them the most effective response possible.
The public sector

Public safety agencies and communication centers worldwide are grappling with pertinent issues surrounding the use of emergency dispatch service, the national emergency number(s), and opportunities to reach out to the public for help in improving emergency response. For some agencies, educating folks about when and how to contact emergency dispatch centers, and what information callers should be prepared to provide a calltaker with, is a priority. Others are using community outreach programs and presentations to instruct residents how the emergency dispatch system works, explain why dispatchers using the Academy’s Priority Dispatch System™ ask the questions that they do, and even provide interactive opportunities to don a headset to experience taking mock emergency calls.

Regardless of what types of community outreach/public education priorities and objectives agencies are engaged in, one thing remains constant: The more instructional contact communication centers can have with the public in getting their messages out, the greater the overall impact will be. Whether it’s helping the community to correctly use the emergency dispatch service or reducing mishaps that tie up limited agency resources, it ultimately leads to more effective emergency response performance and the ability to save more lives.

The young and the restless

It goes without saying that each agency’s priorities for community outreach are based on a variety of factors, including country; culture; population size; and available resources, such as personnel and funding, unique geography considerations, etc. What may be important for a communication center serving a large urban populace within a small geographic area may be very different from the priorities of a PSAP that serves a small, primarily rural population than covers a sizable swath of land.

In Italy, a major aim of agency 118 Genova’s emergency dispatch community outreach is to connect with youths. Eight times a year, the agency invites local high school-aged students to come learn about their communication center by participating in drills to practice calling the 118 national emergency number along with hands-on training to follow a dispatcher’s Pre-Arrival Instructions over the phone to perform chest compressions on a mannequin. The students rotate through different stations during the events that include listening to an actual recorded emergency call and seeing how the dispatching process works.

Dr. Andrea Furgani, an ER physician and Q instructor with 118 Genova, said students learn when to call 118 and when not to call. They also learn about the Key Questions that calltakers will ask during an emergency, and why it is important to have the answers to those questions.

At the end of a presentation, Furgani said they will often ask the children who the first responder is during an emergency. After getting some answers, such as an ambulance or doctor, the answer he gives them is always the same: “If you’re the caller, you are,” Furgani said. “Follow the dispatcher’s instructions.”

Farther west along Italy’s Mediterranean Sea coast, in the district of Imperia, Laura Alberto, a nurse and EMD instructor with 118 Imperia, said her agency also focuses community outreach on the next generation. Under the moniker “Primo Soccorso a Scuola,” or first aid school, emergency communicators give two-hour lessons about making an emergency call and explain why PAIs are so critical during certain medical scenarios. During the event National First Aid Week, 118 Imperia meets with elementary school children who watch a video simulation of a call that requires BLS response to help them understand what the experience would be like in real life.

“It was really neat to get the kids involved and see them interested in learning more about 118 and what happens in the communication center,” Alberto said.

The agency also fields a booth at the area’s annual Festival della Salute, or
health festival, in April hosted in the city of San Remo where community members can learn about everything from how to properly use emergency communications to healthy foods to yoga 101. Alberto said they got an unexpected reaction this past spring at the festival when the staff screened its 118 calltaking video for a group of lifeguards.

“By the end of the video, they were applauding us,” Alberto said. “They had no idea how much effort and training goes into assisting 118 callers when there is an emergency. It was very touching to see their reaction.”

**Patron Dame**

Chris Hartley-Sharpe, Head of First Responders and also a 30-year veteran of the London Ambulance Service (yes, that London), said one piece to the community outreach puzzle is education. LAS serves the Greater London area of the U.K., with a resident population of 8.6 million and averages 1.8 million calls for service per year. A common practice that drains precious response resources is patients with less serious conditions that call the ambulance service for help largely because they are either unaware of or unable to reach non-emergency resources, he said.

But a major focus of the agency’s community outreach efforts comes from getting the word out about a network of public access AEDs throughout the community connected to the communication center. Promoted by the London Ambulance Service through the public ad campaign “Shockingly Easy,” the idea is to encourage individual organizations to acquire their own AED and recruit volunteers that can then be mobilized to help during cardiac emergencies.

“We have just gone live with an app (that) alerts them to the location of the cardiac arrest and the location of the closest community defibrillator,” Hartley-Sharpe said. “The alerts are generated automatically by our CAD system using MPDS’ determinants as the trigger.”

How does LAS measure the program’s success? Survival rates, Hartley-Sharpe said.

LAS average overall survival from cardiac arrest from all causes is 9 percent. However, if a person happens to be at one of the 3,000-plus locations that have public access to an AED, the rate skyrockets to 59 percent, Hartley-Sharpe said.

“At sites that operate the LAS accreditation standards, the survival rate is 75 percent or greater,” he said.

Perhaps the London Ambulance Service’s biggest community outreach splash has come from an unexpected source. Oscar-winning actress Helen Mirren, known for her portrayal of Queen Elizabeth (she was knighted a “dame” by the same monarch), became a staunch advocate for the agency after a scare that affected her personally. In 2012, during a premier of one of Mirren’s films, a friend had a cardiac arrest and was saved by the quick thinking of a CPR-trained police constable with the agency’s Voluntary Responder Group. The police officer used an agency public access AED from a nearby London subway station to treat Mirren’s friend.

Mirren visited LAS headquarters, received some CPR training, and has become a patron of the VRG’s registered charity that provides financial support to the certified voluntary medics that respond to emergency dispatch calls alongside traditional first responders.

“In these situations speed saves lives, and having immediate CPR and defibrillation saved his life, without doubt,” Mirren said, according to the U.K. press.

**Have ambucycle, will travel**

Thirty-six hundred miles to the southeast, Israel-based United Hatzalah is an organization with international scope that provides free EMS response to all through certified volunteer EMTs, paramedics, and physicians in the community who typically can arrive on scene within three minutes. Authorized by Israel’s Ministry of Health, United Hatzalah has its own EMS communication center (averaging 800 calls per day) that coordinates and shares call information with the government’s medical, fire, and police dispatch centers. They utilize an app that identifies and dispatches the closest medics (often, in the same neighborhood as the caller and driving traffic-skirting, medical gear-equipped scooters called “ambucycles”) to the scene.

As might be imagined, a unique emergency communications and response entity such as United Hatzalah also has more specialized community outreach needs than most agencies. In addition to the necessities of being completely self-funded through donations and recruiting and training volunteers, the group also conducts public education campaigns to get people to understand that their medics can fill the time gap and provide lifesaving care prior to the arrival of ambulance crews. Unlike in other countries, Israel has no single national emergency number, so callers must dial several service numbers depending on what type of emergency they need assistance with.

Dovie Maisel, Vice President of International Operations for United Hatzalah, said their agency utilizes “every means possible” to share their public awareness message with their intended audience, from social media and word-of-mouth endorsements, to working with the news media to share their success stories.

“Volunteers are our biggest advocates,” Maisel said. “We don’t have to encourage them because this is their passion in life beyond their personal lives. It’s about engagement in the community.”

**Back to butt dials**

In our modern smartphone age, technology can save lives. However, its often-inadvertent misuse can also cost lives.

Rhonda Hinch is a Public Safety Dispatcher III with the Harford County (Maryland, USA) Department of Emergency Communications. In addition
to celebrating her 28th anniversary with the agency on Aug. 1, she has a total of 32 years of experience in public safety, getting her feet wet early on as a volunteer firefighter and EMT.

Harford dispatches medical, fire, and police for 12 separate agencies and serves a quarter of a million people. In 2014 alone, Harford Co. DES responded to nearly 240,000 calls for emergency aid covering a jurisdiction of 437 square miles.

Hinch, who was the recipient of her agency’s Above and Beyond the Call Award in March for her notable work with the 911 Education Program, said pocket dials are No. 1 on the most wanted list of emergency dispatch faux pas in Harford County. In fact, butt dials have gotten so bad that the agency began tracking numbers on them last year. Between January and mid-August, they received 14,501 accidental cellphone calls and 2,139 via landline. Following closely behind in the getaway car at No. 2 are calls to emergency dispatch for non-emergencies, she said.

“It’s not abuse,” Hinch said. “It’s more misuse.”

To help reduce the fraternal twin culprits of wanton and reckless freelancing with a cellphone, Hinch has marshaled Harford Co. DES’ resources. Public education campaigns are unleashed regularly at local fairs, communication center tours, school presentations, and the like.

“In addition to 911, we have the police non-emergency phone number printed on all the squad cars in the county,” Hinch said. “You can Google anything and find the number.”

Harford also reaches out to local schools each spring, giving emergency dispatch presentations to second-grade students. They also conduct frequent communication tours for school groups, Scouts, and agency EMTs who are required to take the tour as part of their training. Well-behaved youth groups get to take a special walk through the calltaking floor to listen to dispatchers taking actual calls.

“We want to teach them what happens on both ends of the radio,” Hinch said.

The agency also has what it calls its Gold 911 program for recognizing local children who perform well, follow instructions, and stay calm on the phone during real emergency calls. Hinch and colleagues make a special presentation of the Gold 911 Award during school assemblies with invited government officials and media in attendance. Sometimes, they’ll even play the audio of the call for the student body. Hinch said Harford Co. DES tries to make a big deal about the assemblies in order to underscore the importance of teaching the children about appropriate emergency number use.

They’re currently working on improving the measurement of their community outreach efforts. Second-graders fill out a brief survey at the conclusion of the school presentations, and Hinch said they’re considering expanding the survey program by email to include visitors that have taken the communication center tour.

Hinch said Harford Co. DES gets a lot of help from the agency’s public information officer who pitches relevant stories to the media and administers their social media outreach that includes Facebook, Twitter, and their official website.

“When we present a Gold 911 Award, she’s really good about posting pictures and the stories,” Hinch said. “She’s always posting about something.”

In the end, running an effective community outreach program to promote an agency’s critical emergency dispatch role comes down to personnel, Hinch said. Those individuals need to be well-informed, well-spoken, and genuinely enjoy reaching out to the public and the media to share their message. It’s all about engagement and making connections, she said.

“You want to make it fun, exciting, and interactive,” Hinch said.
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NO CUTTING

There’s no success without training

Josh McFadden
The renowned philosopher, scholar, and scientist Aristotle once remarked, “Excellence is an art won by training and habituation. We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly. We are what we repeatedly do. Excellence, then, is not an act but a habit.”

There are few professions where “acting rightly” is more critical than in dispatch.

After all, with any given call, a person’s life might be on the line. In some cases, your ability to respond correctly and accurately and to quickly relay the right help might determine the fate of multiple people.

Across the world, dispatchers are overwhelmingly performing their work tremendously, especially those who have access to the Medical Priority Dispatch System™ (MPDS®), Police Priority Dispatch System™ (PPDS®), Fire Priority Dispatch System™ (FPDS®), and the Emergency Communication Nurse System™ (ECNS™).

Nevertheless, there are constant changes and tweaks to the protocols as International Academies of Emergency Dispatch® (IAED™) leaders and emergency dispatch professionals seek for improvements to help save lives.

James O. Page, Lifetime Emeritus Member of the International Academy of Emergency Medical Dispatch®, acknowledged that some people might struggle to understand why change has to occur. He said, “Some insist that if the system isn’t broken, we shouldn’t try to fix it. In a discipline where processing information quickly and accurately is paramount, there are many that will resist adding steps and time to the process. Where experienced communicators have learned to distance themselves from the gritty reality of the emergency scene, the suggestion that they get involved with caring for patients—through pre-arrival instructions—may cause discomfort.”

However, Page concluded that, “As we look back over the many EMS improvements that have occurred during the past three decades, it’s obvious that many gaps in the system have been closed.”

With such an important job adhering to an evolving but critical system, it is any wonder that the profession needs well-qualified, well-trained people who are dedicated to “act[ing] rightly”?

**The general meaning and purpose behind training**

Merriam-Webster, one of the foremost authorities on word definitions and meaning, has defined the verb form of the word “train” as “to teach (someone) the skills needed to do something (such as a job): to give instruction to (someone).” Other definitions include “to form by instruction, discipline, or drill” and “to teach so as to make fit, qualified, or proficient.”

Shelley Frost, a researcher with the consulting firm Studio D, succinctly stated that training “presents a prime opportunity to expand the knowledge base of all employees ... training and development provides both the company as a whole and the individual employees with benefits that make the cost and time a worthwhile investment.”

Regardless of the type of job a person performs, no matter what the industry may be, starting an employee off on the right foot with proper training and instruction is vital to the person’s success. Clearly, in the dispatching world, comprehensive training and orientation should be non-negotiable. Dispatchers may resist it, but any good manager knows that lives depend on a well-equipped, confident dispatcher.

Frost further outlines four purposes of training. Each of these is particularly applicable to the communication center.

**Turns weaknesses into strengths**

Sometimes we hate to admit it, but each of us has weaknesses and areas in our work where we need to improve. No one is perfect. Even the most naturally gifted and talented dispatcher needs to iron out some wrinkles and refine rough areas. A major advantage with a training program is that managers can easily identify any flaws and then appropriately address them. By training employees, managers can assess any gaps between an employee’s current skills and the competency needed for certain tasks. Next, the manager and worker can discuss what steps to take to make up this difference.
In Frost’s words, “Providing the necessary training creates an overall knowledgeable staff with employees who can take over for one another as needed, work on teams, or work independently without constant help and supervision from others.”

**Improves performance**

Training isn’t just for the new employee; it’s vitally important for even the most experienced workers in an organization. More so than many other jobs, being a dispatcher brings a tremendous amount of pressure and stress. Each day is a challenge, and these can take their toll. Burnout, emotional overload, lack of motivation, and other factors can lead to the erosion of one’s performance in the communication center. Dispatchers who once exceeded expectations and performed with excellence can easily falter under the heavy loads of difficult calls and exhausting days and weeks. Fortunately, training offers a fresh new start and course correction in these situations.

In addition, a well-trained employee gains valuable confidence. This confidence may urge the person to perform even better and think of new ideas to excel. Continuous training also keeps your employees on the cutting edge of industry developments. Employees who are competent and on top of changing industry standards help your company hold a position as a leader and strong competitor within the industry.

**Fosters consistency**

Dispatchers should have a sound understanding of the importance of being consistent. After all, that’s one distinct advantage of using the Academy’s protocols. When all dispatchers in a comm. center are using the same protocols—and when centers around the world are using it as well—it increases the likelihood that the right care is being administered to patients in need. It also holds all dispatchers to the same standards and keeps everyone on the same page.

“A structured training and development program ensures that employees have a consistent experience and background knowledge,” Frost said. “The consistency is particularly relevant for the company’s basic policies and procedures. All employees need to be aware of the expectations and procedures within the company. This includes safety, discrimination, and administrative tasks. Putting all employees through regular training in these areas ensures that all staff members at least have exposure to the information.”

**Helps employees like their jobs more**

Imagine if new dispatchers were simply “thrown to the wolves” and left to figure things out on their own. Obviously, the notion is ridiculous, but without a good training system in place, this is how a person would feel.

Organizations that invest the time and effort to train employees and arm them with the necessary tools to be successful have a significant advantage over those organizations that lack a structured training program. When employers care enough about their employees’ personal development to spend effort training them, the employees feel appreciated. And when people feel appreciated at work, they are more satisfied with their jobs.

Furthermore, training can boost the morale of the entire organization and inspire loyalty. A recent poll conducted by the firm Louis Harris and Associates found that among employees with poor training, 41 percent desired to leave their company in a year or less. Conversely, of those employees who reported they had access to excellent training opportunities, only 12 percent had any intention of leaving their company.

**How organizations benefit**

Businesses that focus on generating profits and making sales will find that well-trained, proficient employees help the organization’s bottom line. Employees who respond to sound training practices are in a much better position to do their jobs effectively and are thus able to get more done in a much quicker fashion.

While the focus is much different in a comm. center, the principles are the same. Author Jerry Shaw states, “Effective training saves labor by reducing time spent on problem-solving and saves money in the long run by producing a better workforce.”

**Cost and time savings**

Dispatchers know as well as anyone how precious time can be. In your work, every second that ticks away could be the difference between living and dying. Time is a valuable commodity, so the more you can work efficiently, the better off you and your center will be.

Newer dispatchers (and perhaps more seasoned ones as well) may lament that training takes too long and requires far too many steps. But think of how much better it is for your comm. center when employees get excellent training and happily and effectively do their jobs for a long period of time as opposed to a team full of poorly trained, unmotivated, undedicated dispatchers. The latter come and go with frequent turnover. For managers, this means more hiring, more training, and more headaches—over and over.

Turnover and replacement cost includes exit interviews, administrative functions related to termination, severance pay and unemployment compensation, attracting new applicants to fill positions, entrance interviews, testing, travel and moving expenses, pre-employment administrative expenses, medical exams, and employment information.
Better performance as a result of training can minimize this turnover and can even mean supervisors spend less time and energy worrying about team members’ output.

Sets expectations

With a robust training program firmly in place, every member of your comm. center will understand from day one what is expected for on-the-job performance. This ensures greater consistency in everyone’s efforts and can help eliminate confusion and frustration that comes when employees don’t know what is expected of them.

Training programs establish standards that comm. center employees must follow. In turn, employees are motivated to measure up to these requirements and constantly improve in their work.

Another bonus for the comm. center is that good training virtually eliminates valid claims from employees who say they were unaware of expectations. When a person commits an error or overlooks something in their work, he or she can’t plead ignorance and say, “I never knew that” or “No one told me that.”

Consequences of poor training

Resist the urge to skimp on training. The results of inadequate training can be disastrous for your comm. center and for the dispatchers and team members who work there.

Dissatisfaction

Being a dispatcher is challenging enough, even when the person is armed with all the tools and resources needed to excel. But combine an arduous job with little or no training, and you have a recipe for major problems.

If managers and supervisors fail to invest in their employees by offering instruction, guidance, and correction, when needed, employees will feel unappreciated, undervalued, and unimportant to the organization. When these feelings persist, it won’t take long for the person to dread coming to work and develop an apathetic attitude toward his or her daily tasks.

“Employees are interested in performing their jobs well to advance the company, feel a sense of pride for a job well done, and advance to higher positions,” states business writer Tina Amo. “When there is no training, employees do not understand how to do their jobs and none of these goals are possible. This leads to low morale among workers, which results in employee turnover. A company with a reputation for high employee turnover is also unattractive to potential job candidates.”

Don’t take it lightly

By using the protocols, you have the best chance to succeed in your job and to assist callers with a variety of needs. Learning how to use the protocols and how to respond to a multitude of situations comes through dedicated training. No one can step inside a comm. center from the street, sit down at a console, and handle call after call with efficiency without properly learning the tools of this all-important trade.

Managers and supervisors must place the highest priority in making sure their staff members are thoroughly trained and ready to tackle the most difficult calls. Similarly, dispatchers must be willing to accept the training and apply it to every facet of their job.

Every link in the emergency dispatch chain wins when the dispatcher has the skills and training to succeed.

“Untrained employees cannot produce high-quality products. They also lack adequate knowledge and skills to provide satisfactory customer service.”

One of the very last things you want to see in a comm. center is a dispatcher who no longer cares about his or her job.

The callers suffer

In the emergency response profession, dispatchers and responders work with a unique set of customers. Your customer is the person on the other end of the phone—frantic, exasperated, terrified, and possibly clinging to life or relying on you to render aid to a loved one whose life is in the balance.

In other professions, poorly trained employees will have insufficient knowledge or motivation to help customers. Consequently, the customer will become frustrated and upset and will seek service from a competitor, possibly never to return to the business that was unable to satisfy their needs.

But that’s not often the case for communication centers. Your task is so much more important than selling a product.

“Untrained employees cannot produce high-quality products,” Amo writes. “They also lack adequate knowledge and skills to provide satisfactory customer service.”

Like any other business, your service to the customer is paramount. But unlike in retail, food services, or similar industries, when you fail to deliver, lives are at stake.

Sources
2. See note 1.
4. See note 3.
7. See note 6.
Carbon monoxide is a stealthy killer. You can’t see, smell, or hear the silent reaper, and despite the ease of preventing death, this toxic gas is the leading cause of accidental-poisoning deaths and poisoning-related injuries worldwide. Each year in the United States, carbon monoxide (CO) poisoning kills at least 430 people and sends an estimated 15,000 patients to the emergency room, according to statistics from the Centers for Disease Control and Prevention (CDC).\(^1\)

CO poisoning can infiltrate “routine domestic, occupational, and recreational activities, and, also, in the wake of large-scale disasters such as those caused by hurricanes, floods, and winter storms.” Unintentional, non-fire-related (UNFR) CO poisoning is a leading cause of poisoning with toxic levels of the gas resulting from malfunctioning or inappropriately used household items, including malfunctioning gas- and oil-burning furnaces, lawn mowers, portable generators, and charcoal grills.\(^2\)

**Silent killer**

The great danger of carbon monoxide exists in its attraction to hemoglobin in the bloodstream. Since carbon monoxide preferentially binds to hemoglobin, fewer oxygen molecules are able to bind to hemoglobin when carbon monoxide is also inhaled. This reduces the amount of oxygen transported throughout the body, so the heart and brain receive less oxygen than they need to function properly.\(^3\)

In addition to the hazards already mentioned, other high-risk behavior includes adults and children riding in the back of enclosed pickup trucks, as well as individuals working indoors fixing combustion engines or machines operating on combustible gases. Unchecked conditions at pulp mills, steel foundries, and industrial plants producing formaldehyde put workers at high risk for exposure and poisoning.\(^4\)

**Medical effects**

CO poisoning can occur suddenly or over a long period of time. The initial symptoms of low to moderate CO poisoning are similar to flu symptoms but without the fever. Early symptoms a caller might report include headache, dizziness, and nausea. As the carbon monoxide builds up in the blood, symptoms escalate to confusion and drowsiness, fast breathing, fast heartbeat or chest pain, vision problems, and seizures.

Symptoms, however, are not the same for everyone affected. A person with a
low level of exposure could experience lifelong effects, and someone with an extremely high level of exposure may have a full recovery. Outcome is unpredictable.

Despite treatment, CO poisoning victims can die or suffer permanent, severe injury, and as many as 50 percent of all victims who recover consciousness and survive can be left with lifelong impairments affecting the brain, endocrine system, nervous system, and heart. Hypoxic-Anoxic (HA) brain injuries, caused by a diminished supply of oxygen to the brain, can result in serious cognitive, physical, and psychological impairments.

Removing the source (e.g., malfunctioning gas heater) after prolonged exposure (days and months) doesn’t necessarily remedy long-term effects on the brain. A study looking at chronic carbon monoxide exposure reported seven cases of chronic, subacute CO poisoning symptoms after the source of CO was removed. The symptoms included changes in memory, sleep, vision, sense of smell and sense of direction, anxiety, and balance problems. There is also the potential of heart damage due to prolonged exposure, possibly leading to life-threatening cardiac complications years after the poisoning.

Surveillance

National estimates and surveillance activities have long relied on secondary data sources in the absence of an active national surveillance system for CO poisoning. These sources include the National Vital Statistics System, the National Electronic Injury Surveillance System—All Injury Program, and reports from hyperbaric oxygen treatment facilities; however, because none of these sources were developed specific to CO poisoning, there are limitations in timeliness, quality, and availability.

FirstWatch, a dispatch-based syndrome surveillance system, is a possible exception due to the system’s ability to collect real-time data from 911 calls, indicating trends and possible outbreak of disease, illness, or patterns of injury either from natural causes or acts of terrorism.

The system is integrated into the Medical Priority Dispatch System™ (MPDS®) ProQA® software and interfaced with CAD, ePCR, and hospital emergency department and poison control data. FirstWatch was instrumental in isolating the sources and area affected by high levels of CO in Oklahoma City and Tulsa, both in Oklahoma, USA, resulting from residential use of alternate heating sources during a power outage.

The CO trigger added to the existing FirstWatch surveillance system connected to the Regional Emergency Medical Services Authority (REMSA) in Oklahoma City provided a symptom-based application to identify clusters of purported CO poisoning based on calls to the communication center. The real-time data collected, and mapped to call sources, gave responders the geographic boundaries for contacting residents regarding hazards of fuel-burning appliances and devices.

“The CO calls dropped once the residents were warned,” said FirstWatch Founder and President Todd Stout during a phone interview. “This wasn’t about measuring levels of carbon monoxide but the people affected and where the calls were coming from.”

Dispatch response

The MPDS addresses EMS response for CO poisoning in Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/ CBRN; nine Determinant Suffixes distinguish the causative agent for specific response and safety purposes. Suffix M delineates carbon monoxide.

Because the toxic gas is nearly impossible to detect, and symptoms of acute and long-term CO poisoning mimic symptoms of more common illnesses, such as the flu, a person experiencing symptoms who is calling 911 may be confused and disoriented, while someone discovering symptomatic victims on scene would have little indication of cause.

One clue indicating CO poisoning is the number of people taken ill, according to Brett Patterson, IAED™ Academics & Standards Associate and Medical Council of Standards Chair.

“Everyone is exposed to small amounts of carbon monoxide throughout the day, and it’s inhaling too much that can cause poisoning,” Patterson said. “So, in a medical event, as opposed to trauma, the number of people taken ill and with the same symptoms would indicate possible poisoning.”

EMD’s Third Law of Safety, found on the Additional Information card for Protocol 8, states:

One patient down, trouble around?  Two patients down, coincidence found?  Three patients down, danger abound!

Help is on the way

An alarm from an in-home CO detector can help in identifying the problem because they are made to sound at levels well below critical conditions, however, not all homes or heating systems are equipped with automatic sensors.

If the dispatcher can identify suspected CO poisoning from the information provided, the MPDS provides the lifesaving tools.
The EMD will advise residents to leave the home immediately and, if appropriate, ask the caller to leave the door open on the way out to begin ventilation. The EMD will caution the caller against open flames or anything that would cause a spark.

Once the occupants are safely away from the area, the EMD will gather information for fire department and EMS unit response. The Determinant Code selected depends on the severity of the patient’s medical condition.

The caller is told not to enter or re-enter a hazardous or dangerous environment. If the call does not involve patients with illness or symptoms from exposure to fumes or hazardous materials, the fire department will most likely respond without lights or siren (non-emergency). A caller indicating illness requires an appropriate medical response.

There are DLS links to NABC-1 for Unconscious or Arrest, and INEFFECTIVE BREATHING and Not alert patients. The direction not to touch the patient (found on Panel X-7) is only linked from Protocol 8 for Danger or Contamination and Chemical Suicide.

“Whatever is going to kill the patient, happening inside the body, is not changed by urging them not to go to sleep,” said Dr. Jeff Clawson, inventor of the MPDS. “It’s not going to sleep but what’s causing unconsciousness that kills you.”

There is no medical evidence suggesting a bystander should stay with the patient to make sure he or she does not fall asleep.

**Paramedic and fire department response**

It would only be a matter of time for an individual robbed of breath to become unconscious. According to Axiom 2 on Protocol 8, unconsciousness in a patient who has inhaled carbon monoxide is a bad sign. Hyperbaric oxygen treatment, which enables oxygen transport by plasma, may be necessary to prevent death or brain damage. The call quickly turns into an emergency response.

Operations to detect the presence of CO and locate the source are the same for an emergency and a non-emergency response. Crowns responding to the scene of a known CO danger generally check CO levels at least twice: once before entering the home and again when inside. Levels may be checked at several locations inside.

If the source of the CO exposure can be eliminated and the premises ventilated to accepted standards of fresh air, the residents may be allowed to go back inside.

**Treatment**

Treatment for CO poisoning is aimed at replacing the carbon monoxide in the blood with oxygen as quickly as possible. In the hospital, a patient may breathe pure oxygen through a mask placed over the nose and mouth to bring oxygen to organs and tissues. A patient who cannot breathe independently will need ventilator assistance.

In some cases, hyperbaric oxygen therapy is recommended to reduce the carbon monoxide level in the blood and the symptoms of CO poisoning. The way this works is as follows:

- The affected person lies down on a stretcher that slides into an acrylic tube.
- The pressure inside the tube is raised, and 100 percent oxygen is delivered under high pressure.
- After treatment, the chamber is depressurized slowly while the person rests inside.7

**State actions**

CO poisoning is preventable by the correct installation, maintenance, and operation of devices that may emit the toxic gas, combined with the appropriate use of carbon monoxide detectors (also called carbon monoxide alarms).

As of March 2016, 30 states have enacted statutes regarding CO detectors, and another 11 have circulated regulations on CO detectors. Here are some examples:

- Alaska requires detectors approved by the state fire marshal be installed in all dwellings.
- Florida also requires them in new construction and in every room with a boiler.8

CO poisoning is not a disease that requires reporting for record keeping, and there are few programs that monitor and publish statistics.

In New York, annual counts and rates of emergency medical treatment, hospital admission, and death from CO poisoning are monitored and reported publicly on the NYC Environmental Public Health and Tracking Sustainability Portal. The portal also provides data on annual calls to the NYC Poison Control Center for suspected exposure to and/or poisoning by CO, and investigations made by the Fire Department of the City of New York (FDNY) for CO incidents triggered by an alarm or an adverse health event.9

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**Sources**

2. See note 1.
Answers to this quiz are found in the article “Silent Killer,” which starts on page 32. Take this quiz for 1.0 CDE unit.

1. This toxic gas is the leading cause of accidental-poisoning deaths and poisoning-related injuries worldwide.
   a. carbon dioxide
   b. nitric oxide
   c. oxygen difluoride
   d. carbon monoxide

2. What is a leading cause of poisoning with toxic levels of the gas?
   a. structure fires
   b. natural disasters
   c. unintentional, non-fire related CO poisoning
   d. farm waste

3. The great danger of carbon monoxide poisoning exists:
   a. in its attraction to hemoglobin in the bloodstream.
   b. in its inability to turn into carbon dioxide.
   c. in its close association to other blood-borne diseases.
   d. in its binding power to pathogens in the bloodstream.

4. The initial symptoms of low to moderate CO poisoning are similar to:
   a. flu symptoms, but with migraine-strength headaches.
   b. food poisoning, but without the diarrhea.
   c. flu symptoms, but without the fever.
   d. nerve gas poisoning, but without the drooling.

5. As many as 50 percent of all victims who recover consciousness and survive can be left with lifelong impairments affecting the brain, endocrine system, nervous system, and heart.
   a. true
   b. false

6. Secondary data sources in surveillance systems for CO poisoning tend to be limited in application due to:
   a. the lack of longitudinal studies.
   b. development not specific to CO poisoning.
   c. data that is not scrubbed prior to study.
   d. an inconsistent approach in isolating victims of CO poisoning for further study.

7. One clue indicating possible CO poisoning is:
   a. the presence of a barbecue grill indoors.
   b. the smell CO emits in a poisoning situation.
   c. the number of people taken ill and with the same symptoms.
   d. flu symptoms and high fever.

8. The Determinant Code selected for suspected CO poisoning depends on:
   a. the severity of the patient’s medical condition.
   b. the length of time between the onset of symptoms and the 911 call.
   c. other hazards present.
   d. the suspected cause of the poisoning (natural or manmade).

9. Operations to detect the presence of CO and locate the source are radically different for an emergency compared to a non-emergency response.
   a. true
   b. false

10. Treatment for CO poisoning is aimed at replacing the carbon monoxide in the bloodstream with:
    a. carbon dioxide as quickly as possible.
    b. glucagon.
    c. oxygen as quickly as possible.
    d. a combination of atropine and a reactivator.

To be considered for CDE credit, this answer sheet must be received no later than 2/28/18. 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.
BURGLAR, ROBBER, OR THIEF?
Picking the correct PPDS Chief Complaint

Mike Rigert

Stacy is lovin’ life. She’s returning home from a relaxing seven-day Caribbean cruise during which she devoured three “can’t-put-it-down” novels, got a great tan, and chilled with some new friends. However, that vacation euphoria came to a screeching halt when she pulled in the driveway only to discover that the garage back door had been kicked in and that her Apple laptop, her 55-inch smart TV, and some of her most valuable jewelry are nowhere to be found. Suffice it to say, Stacy’s not a happy camper. She dials 911 and blurts out to the EPD, “I’ve been robbed!”

Sound familiar? Joe Public, and sometimes even newer dispatchers, can often get confused about the criminal case terms burglary, robbery, and thievery. And in some ways, it’s no surprise. Whether it’s a line from a Hollywood heist movie or common everyday usage (as in Stacy’s scenario), these types of crimes are frequently used interchangeably or simply misused. If you find yourself in this camp, or if you just want a review, we’re here to chase away any doubts.

In this Police CDE, we’re going to tackle (apprehend, in LEO vernacular?) three Police Priority Dispatch System™ Chief Complaint Protocols—110: Burglary (Break-and-Enter)/Home Invasion, 126: Robbery/Carjacking, and 130: Theft (Larceny).

Our goal, and the emphasis of this CDE, is to help the EPD choose the most applicable Chief Complaint in a variety of call scenarios, review key Additional Information that will assist in Chief Complaint selection, and compare and contrast the three. We want to help you better handle these types of police calls and give callers the best emergency police dispatch service possible.

Just the stats, ma’am

With this trio of PPDS’ Chief Complaints, two fall under the category of Property Crimes (Burglary and Theft), and one goes under the Crimes Against People header (Robbery). This is an important distinction because some critical calls for emergency help require quicker, more aggressive action than others. Crimes Against People typically necessitate a faster response time than Property Crimes because suspects, including suspects with weapons, may still be at the scene and pose a continued threat to the caller, bystanders, and responding officers.

For example, Axiom 2 on Protocol 110: Burglary (Break-and-Enter)/
Home Invasion states, “Burglaries are usually property crimes, not crimes against persons.”

Despite this, the Key Questions for all three of these Chief Complaints begin by asking the caller about weapons, the suspect’s current whereabouts, and if anyone else is in immediate danger. This ensures that whether it’s a Crime Against People or a Property Crime, the Police Protocol priorities of scene safety and caller safety always precede efforts to apprehend suspects or collect evidence.

Statistically, Protocol 130: Theft is the most commonly selected Chief Complaint of the three, according to findings from a 2013 study involving two North American emergency communication centers that was published in IAED’s Annals of Emergency Dispatch & Response. Over roughly 18-month periods, 456,711 police calls with EPDs using the PPDS were taken at two communication centers that were part of the study. Of those calls, the research showed that Protocol 130 was selected as the Chief Complaint 57,222 times; Protocol 110: Burglary came in second with 18,499 Chief Complaint selections; in third place came Protocol 126: Robbery/Carjacking, used 4,420 times.

Interestingly, the study found that Protocol 130 was the fifth-most used PPDS Chief Complaint among all calls for police service.

So, you’re much more likely to select PPDS Protocol 130 followed by Protocol 110 than you are to have calls in which you would choose Protocol 126 as the most appropriate Chief Complaint. More often than not, this is because theft cases tend to be crimes of opportunity—property is left out in the open (sometimes unattended by the owner) and frequently in a public space where suspects have unfettered access to the items. On the flip side, burglary and robbery cases usually require some degree of planning, tools to gain access to buildings, and sometimes, access to weapons.

Protocol CSI

In this section, let’s further break down the three individual protocols for a clearer understanding of what each one is and is not:

Protocol 110: Burglary (Break-and-Enter)/Home Invasion is defined in the fifth edition of the EPD Course Manual as “the report of one or more persons breaking into, unlawfully entering, or remaining unlawfully in a building with the intent to commit a crime. Examples include home invasion (breaking into or unlawfully entering a home with the intent to injure, kill, or terrorize the residents or occupants) and residential or commercial break-in.”

If someone’s backpack is taken from the corridor of a university building, or if a suspect holds up a convenience store using his hand in a hoodie pocket to simulate a pistol, neither scenario is a burglary. However, if suspects storm into an apartment with the intent of “roughing up” the occupants for not repaying a debt, Protocol 110: Burglary would be the most appropriate Chief Complaint selection.

“Most callers will say ‘I’ve been robbed,’ and nine times out of 10, it’s actually a burglary,” said Bob Pastula, Priority Dispatch System™ Program Administrator—Law Enforcement.

The EPD Course Manual also defines Protocol 126: Robbery/Carjacking as “any incident involving the taking of money, personal property, or any other article of value in the possession of another from his/her person or immediate presence, which has been accomplished by means of force or fear and against her/his will.” These include theft with the threat of a weapon, theft with injuries caused, and carjacking. Protocol 126 does not cover burglary, theft without a weapon, or theft without injuries caused.

With Protocol 126, Pastula said one difference between Robbery and Protocols 110 and 130 is that the perpetrator usually has a specific, calculated target in mind, while Burglary and Theft are more likely to be crimes of opportunity.

Some important keys to remember about Protocol 126 are covered under Axioms 1 and 2. First, Axiom 1 states, “weapons are used or mentioned in most robberies.” And second, Axiom 2 explains to the calltaker that “lock(ing) doors and windows may be lifesaving.” The EPD will use PDI-b to instruct the caller to lock doors and windows.

Protocol 130: Theft (Larceny) is "any incident involving the taking of property without the owner’s consent and without the threat of force or intimidation. Common examples include pickpocketing, shoplifting, theft of a
vehicle, and theft from vehicle, but not robbery or burglary,” the EPD Course Manual states. Protocol 130 is further defined in Additional Information as “the act of dishonestly taking property from another with the intent of permanently depriving the owner of it (stealing).”

To reiterate from the AEDR study, EPDs are much more likely, statistically speaking, to answer calls where Protocol 130 is the selected Chief Complaint as opposed to Protocol 110 or Protocol 126.

All signs point to Case Entry
The EPD Course Manual points out some other factors the EPD should remember when choosing a Chief Complaint. Much of it surrounds the use of Case Entry Question 4, “Okay, tell me exactly what happened.”

The manual says, “obtaining a complete description of the problem is essential for accurate classification of the incident.” Perhaps nowhere is this more crucial than during police calls in which callers may be confused, have incomplete information, or fear for their own safety.

“Listen also for background noises that might indicate caller danger or other scene safety issues,” the course manual states. “The caller’s vague statement could refer to a burglary, a robbery, or a theft. Only by getting the caller to tell you exactly what happened will you know which Chief Complaint Protocol to use for the case.”

Pastula said often the best way to get the right information or more information when the caller’s response to Key Question 4 is vague is to ask again. This approach also helps the EPD steer clear of freelancing and asking leading questions.

“Repeat, ‘Tell me exactly what happened,’” he said. “Or, if you don’t get the information you need on Key Question 4, come back with, ‘I really need to know what’s going on right now.’”

And on a final note, the EPD manual states remember “sometimes distraught callers have relatively minor problems and calm callers are reporting an extremely dangerous and volatile situation.”

“Be aware that it is impossible to judge the severity of an incident based solely on the caller’s tone, rate, and volume of speech,” the EPD manual states. “You should always focus on what is being said rather than how it is being said.”

Book and fingerprint ‘em
So, some of the major takeaways from this Police CDE are:
• Callers may initially tell you they’ve been robbed, when in actuality it’s a burglary or theft.
• Statistically speaking, theft calls are more frequent than robbery or burglary calls.
• Review the definitions for each of the three EPD Protocols to aid you in selecting the most appropriate Chief Complaint.
• The answers you get to Case Entry Question 4 are crucial to correct Chief Complaint Selection. If you don’t get the key information you need the first time, repeat or restate, “Okay, tell me exactly what happened” until you have the information you need.

OK, great work EPDs! Now get out there and solve “the case.”
You must be police certified to take this quiz

Answers to this quiz are found in the article “Burglar, Robber, Or Thief?,” which starts on page 36. Take this quiz for 1.0 CDE unit.

1. A caller tells the EPD that his car has just been stolen after the perpetrator walked up, pointed a knife at the victim, grabbed the keys out of his hand, and drove away. Which would be the most appropriate Chief Complaint selection?
   a. Protocol 110
   b. Protocol 126
   c. Protocol 130

2. According to the study in the article, Chief Complaint Protocol 110 was selected for how many calls?
   a. 4,420
   b. 18,499
   c. 57,222

3. A gas station attendant calls and reports to the EPD that a teenage girl just pumped $30 of gas and drove off without paying. Which is the most appropriate Chief Complaint selection?
   a. Protocol 110
   b. Protocol 126
   c. Protocol 130

4. According to the research study, ________ was the fifth-most chosen PPDS Chief Complaint among all calls for police service.
   a. Protocol 110
   b. Protocol 126
   c. Protocol 130

5. A frightened teenager who is home alone calls to report that he heard some glass shatter and can hear someone walking around upstairs. Which is the most appropriate Chief Complaint?
   a. Protocol 110
   b. Protocol 126
   c. Protocol 130

6. In Protocol 126, Axiom 1 states, “threats are used or mentioned in most robberies.”
   a. true
   b. false

7. A convenience store owner calls to say that someone came up to the register as if he was going to purchase some cigarettes, told the owner to give him money from the register, and said he had a gun. Which is the most appropriate Chief Complaint?
   a. Protocol 110
   b. Protocol 126
   c. Protocol 130

8. According to the EPD Course Manual, what is the most important piece of information the EPD needs in order to accurately classify the call and make the correct Chief Complaint selection?
   a. the address of the emergency
   b. whether or not weapons are involved
   c. whether the caller is in imminent danger
   d. a complete description of the problem

9. What does Bob Pastula say is often the best way to get the right information or more information during the Case Entry Question, “Okay, tell me exactly what happened.”
   a. Find out what the suspect is doing right now.
   b. Ask the caller to give a complete description of the suspect.
   c. Repeat the question.
   d. Tell the caller you can’t help them if you don’t get the information.

10. The EPD Course Manual states, “it is impossible to judge the severity of an incident based solely on the caller’s tone, rate, and volume of speech.”
    a. true
    b. false

CDE Quiz Mail-in Answer Sheet

Answer the test questions on this form. (A photocopied answer sheet is acceptable, but your answers must be original.) WE WILL NOT PROCESS ALTERED SIZES.

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ANSWER SHEET  POLICE
Jan/Feb 2017 Journal “Burglar, Robber, or Thief?”
Please mark your answers in the appropriate box below.

To be considered for CDE credit, this answer sheet must be received no later than 2/28/18. 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.
This Blast goes back to the time when the MPDS was first being concocted in draft form. As a very new emergency physician who was now working as the Fire Surgeon/Medical Director for the Salt Lake City Fire Department (Utah, USA), this column in the monthly magazine Emergency Medicine was never to be missed. The December 1977 column specifically caught my attention, so much that I tore it out and saved it. Its Latin title, “Primum non nocere” means simply, “First Do No Harm”—a concept that takes center stage in both emergency dispatch and response. It taught me a lesson that I never forgot. Superficial evaluations and/or jumping to conclusions are always fraught with danger in medicine and public safety. The second case, while a little deeper clinically, also tells a story that should be learned as a general lesson for all. And those hits just keep on comin’...
Edited by James J. Dineen, Jr., M.D.

ERRORS IN EMERGENCY PRACTICE

Primum non nocere
A 65-year-old man was brought to the ER by ambulance. The ambulance crew reported that the patient's mother, with whom he lived, had told them he had lung cancer and had followed a progressively downhill course over the past two weeks, becoming much worse as of that morning. At physical exam the patient was cachectic, cyanotic, and without palpable blood pressure. A faint carotid pulse could be felt at a rate of 120 and jugular venous distention was noted. The patient was not breathing and his pupils were dilated, symmetrical, and reactive. He was extremely barrel chested, with bilateral hyperresonance to percussion. Quick discussion among the ER staff led to the conclusion that no intervention should be made in what was apparently the terminal event of a chronically ill lung cancer patient but one physician pointed out that they really knew only what the ambulance crew had said and that resuscitation should be carried out until they had more definite information.

When the patient was intubated, the respiratory therapist noted extreme resistance to positive pressure breathing. Physical exam showed no breath sounds on the left and a chest film showed a left pneumothorax and findings consistent with bullous emphysema; no tumor mass was seen. Insertion of a chest tube led to an immediate increase in blood pressure and decrease in jugular vein distention. At this point the patient's brother arrived and informed the staff that the patient did not have lung cancer but rather cancer of the prostate and a long history of emphysema. He was sent home after an excellent two-week hospital course.

Comment. The role of the emergency room physician in the "right to die," "no code," or "no extraordinary life-support measures" issue is a difficult one. The decision to withhold life-support measures should not be made in an emergency room setting where the physician does not know the patient and is not the primary provider of his health care. As might have happened in this case, drastic errors can be committed by making hasty decisions.

Investigate the mute
A seven-year-old boy was brought to the ER by his father because he had been found on the kitchen floor in a disoriented state. The father said that the boy had been a slow learner since birth, had difficulty with coordination, and had recently been diagnosed as hyperkinetic because of a poor attention span. Most recently the boy had been kept home in order not to communicate chicken pox. Examination showed an alert, frightened, pale child who did not answer any questions. There was no sign of trauma. The only physical findings were a questionable slight lateral deviation of the left eye and uncomplicated late chicken pox skin lesions. The child was observed for the next hour and was considered to be suffering from the effects of a fall, probably due to incoordination, and was released. Within the next 24 hours he was admitted to another hospital in coma; there the boy was eventually diagnosed as having varicella encephalitis and pneumonia.

Comment. When examining a child with a history of developmental and neurologic difficulties, the physician should not be biased. Often we tend to ascribe inexplicable findings to poorly understood chronic problems, especially when they are found in children who are mute. Disorientation in a seven-year-old boy usually has an organic cause and here it was written off as the result of a fall while in reality it was probably a grand mal seizure related to the varicella encephalitis and pneumonia.
MORE THAN A MILE-HIGH EMERGENCY

CPR offsets long drive down winding road

Audrey Fraizer

Oct. 21, 2015, was gearing up to be just another day for Ralf and Gurtrude Wuellner, until an event made it a day they will never forget. The Wuellners own and operate the Gold Camp Bakery in Victor, Colo., USA, a city at a 9,700-foot elevation near Pikes Peak. Every morning for the past eight years they’ve unlocked the shop’s doors before dawn to bake pastries, rich in natural ingredients and German culture.

“You have to get there early if you want a Bee Sting (cake),” said 80-year-old Theresa “Tarie” Huber, who has spent the majority of her life in the once-bustling gold mining capital of Colorado. “It’s that good.”

Huber stops at the bakery for a slice of the sweetened buttery pastry on her way to a part-time job at the visitors center. It’s not unusual to skip a week between Bee Stings, but on this particular Friday in 2015, Huber heard something that made her come running.

Ralf had suffered sudden cardiac arrest. Gurtrude found him facedown on the floor, unresponsive and his skin turning blue. She called 911.

EMD Cindy Link, at Teller County Sheriff’s Department 911 center in Divide, started CPR immediately, giving instructions to Seanna Forte, a bakery employee, who relayed them to Gurtrude. For the next 18 minutes, until firefighters arrived from Cripple Creek, Link counted, Forte repeated the counting, and Gurtrude pumped her husband’s chest.

“Cindy told me I was going to do CPR, and so that’s what I did,” Gurtrude said. “I didn’t think about whether I could do this because I knew I had to do this. There was no choice.”

Cripple Creek is 49 miles southwest of Colorado Springs, with about half of these miles along Highway 24 at its junction with Highway 67 at the city of Divide. Victor is another seven miles south of Cripple Creek.

Teller County 911 takes calls within the county and transfers EMD dispatch to Cripple Creek 911. A call involving a heart-related condition is generally routed to helicopter dispatch from Memorial Hospital Central in Colorado Springs.

“Chest pain and there’s a good chance the patient will be flown out,” said Diann Pritchard, Cripple Creek Police Department Dispatch Supervisor. “There’s only one main road that takes you down Ute Pass to Colorado Springs, so once you get started by ambulance you’re stuck.”

On a good day, the drive along Highway 24 to Highway 67, between Victor and Colorado Springs, takes 90 minutes; a helicopter reduces travel to an estimated 12 minutes.

Heavy snow and reduced visibility prevented medical helicopter service. Snow and ice glazing the single road like honey on a Bee Sting delayed ambulance response. Once Paramedic Eric Murray arrived, it took seven tries with an AED to get back Ralf’s pulse.

Ralf assumes it wasn’t easy navigating the twisty, slushy, and slippery Highway 24, but he couldn’t say. The last thing he remembers is feeling queasy at the start of his day and taking the aspirin his son retrieved from the nearby convenience store and post office.

Gurtrude, however, does remember her anxiety intensified by bad weather. Nine inches of snow had accumulated in Cripple Creek by 9 a.m.

Halfway down the road to Colorado Springs in a four-wheel drive ambulance, Ralf came to. Five days later, he was back at the bakery, with two stents in place.

“His heart is doing great,” Gurtrude said. “It does what it needs to do.”

“She (Link) doesn’t get rattled,” Pritchard said.

Pritchard nominated Link for a NG9-1-1 Institute Honors Award. Link won in the Public Safety Leader category.

“I am very proud of what we do,” said Link, manager at Teller County 911. “I like being able to help people, and I like the pace. It feels like I’m where I’m supposed to be.”

Gurtrude Wuellner’s call to 911 saved the life of her husband, Ralf.
THANK A DISPATCHER

National Telecommunicators Week provides the opportunity

Art Braunschweiger

This isn’t about how we can do our jobs better. It’s about being appreciated for what we do. Most dispatchers routinely handle calls and call volumes at levels that would be utterly overwhelming to anyone else. Ask any responder who’s done a “ride-along” in dispatch. Perhaps that’s the problem: When excellence becomes the norm, it doesn’t occur to management to acknowledge it.

For comm. centers in the United States, one opportunity for recognition is National Public Safety Telecommunicators Week. It’s the second week of April every year and became law on March 26, 1992, by an act of Congress. In doing so, Congress acknowledged that we “daily serve the public in countless ways without due recognition by the beneficiaries of their services.” Go to www.congress.gov/bill/102nd-congress/house-joint-resolution/284/text to read the resolution’s full text.

Unfortunately, many of us don’t get recognition from our agencies, either. Last year I asked a friend what his agency—a large, regional center—did for them on Telecommunicators Week. “We got a travel mug,” he said. I thought, “Really? That’s it?”

Mugs are nice, but recognition for what we do needs to go beyond token gestures of acknowledgement and involve genuine expressions of appreciation. Many comm. centers have found ways to do this without spending a dime. Last year my comm. center designated one day of Telecommunicators Week as “Jeans and Fire Department T-Shirt Day.” The departments we dispatched were glad to donate shirts of various sizes as their way of saying thanks. The theme for another day was “Wear Your Favorite Sports Jersey.” The best was “Bring Your Dog to Work Day,” with the stipulation of one per shift. We still don’t know who enjoyed the day more, the dogs or the dispatchers.

For comm. centers with a little money to play with, being treated to a free lunch order is a simple gesture that’s always appreciated (you can rarely go wrong with putting food in front of a dispatcher). Some comm. centers organize a food theme for different days of the week (time to bring in that award-winning chili). Providing recognition formally through your city, county, or organization’s website also goes a long way. Some agencies present an award for Telecommunicator of the Year based on past performance or notable calls.

The sad truth is that at some agencies, there’s a huge disparity between what the dispatchers do and what they’re officially recognized for. I have been to agencies where they’re in the same job classification as clerical workers, with an hourly pay rate that’s not much better. Often, that’s because decades-old job classifications and pay rates reflect the era when the job involved only pencil and paper, a single phone line, and no minimum performance expectations. Comm. center administrators may not be able to solve that problem in the short term, but they can make sure their dispatchers feel appreciated. Surprisingly, studies show that employee recognition increases morale, increases teamwork, and keeps employees engaged far more than what can be accomplished with increases in pay. It’s been proven that good pay keeps employees from leaving, but it doesn’t make them happier while they’re there. That’s why establishing a culture of recognition is one of the most important goals an agency can have.

Next time National Public Safety Telecommunicators Week rolls around, make it count. (Kudos to you if you already do.) If you’re an administrator, come up with a plan. If you’re not, submit some ideas or a copy of this column. We rarely seek recognition for ourselves, but we do need to know we’re appreciated.
MAKE NO MISTAKE

I am a first responder

Daphanie Bailes

Editor's Note: Daphanie wrote her column in response to the Office of Management and Budget’s (OMB) refusal to reclassify public safety communicators into the protective service, the same classification as police officers and firefighters. The current classification of 911 professionals under Standard Occupational Classification is under a category of Office and Administrative Support Occupations.

I’m not a first responder—that’s what lots of people say. How can you be a first responder? You just sit in a room. I would like to invite those who think that to step into my world. The world of the faceless, the nameless. The world where I am only known by the sound of my voice. A voice that can portray everything from love to loathing. A voice that can give me away if I dwell on the fight at home, the fourth nastygram email of the day, or the last bad 911 call. A world where I juggle the feelings associated with multiple calls, all at once. A world where I rarely hear “thank you” or “I want to do that when I grow up.” My world encompasses so much more than those four walls or my voice. It is the voice of every caller or administrator on the phone, every firefighter and paramedic or EMT on the radio. It also includes the voices that don’t go away when I hang up the phone, or walk out the door, or try to close my eyes.

I know I wasn’t the first person to put my boots on the ground, but my voice was the first you heard. I broke through language barriers to keep you safe. I instructed your loved one to give you lifesaving breaths until help could arrive. I told you to hide and kept you calm while evil walked past your closet door. I heard your wife’s screams when she realized you were beyond help. I talked to you and distracted you long enough for help to get there and take the gun from your hand. I used every resource available so we could find you when you rolled your car off the highway. I was with you when you took your last breaths. I felt your frustration and fear when the water was just too rough for you to help her. I reassured you when you begged for the minutes to disappear and for the ambulance to arrive. I shouldered your obscenities and continued to be your calming influence when you found your overdosed son. I prayed that you were at peace after you finally stopped the voices in your head. I told you to sing to your sweetheart, to calm him, to drown out the rest of the noise while we waited for EMS and fire to find your mangled truck. I was the first to hear your tiny but strong cries after you made your grand entrance into this world and silently cried tears of joy with your family.

I prayed when I heard your “Mayday” call. I prayed because you are my brother or sister, and when you hurt, I hurt. I train and learn every day, beyond what is required, because I am the one and only person who is not allowed to be caught off guard and not know what to do. So many lives desperately depend on me to know what to do or whom to call and to make it happen in the blink of an eye.

In a way, the OMB is correct. I’m not a first responder by the purest definition. I am a highly trained public safety telecommunicator. I am THE FIRST, FIRST RESPONDER. I am the first to respond to that emergency with lifesaving instructions. I am the first to alert law enforcement, fire, and medical personnel to the cries for help. I am the first to hear and feel heartache and joy from people I will never know. I am the first to comfort those souls in need. And I will be the first to invite you into these four walls to experience my world. Not because I want a pat on the back or to have grandiose feelings of superiority, but because I want you to understand it.

#IAM911
MORE TO DISPATCH

We are family and friends, and we save lives

Jennifer Siracusa

I could tell you that emergency dispatch is hard, that you go home thinking about it, and that it takes multitasking skills to an entirely new level, but then I would be telling you something you already know about emergency dispatch.

So this is what I am going to tell you instead about the profession that has reshaped my life and my perspective on life during the past 12 years I’ve been in the communication center.

Dispatch is about family

This is my second family. I spend more time with the people in the communication center than I spend with my family at home. As family, I am expected to be part of an effective team, even if some members act the same as cousins I don’t get along with or annoying brothers or sisters. I sit within arm’s reach of them for eight to 12 hours a day or more. Compared to my family’s home, however, I don’t have a place to sleep or a quiet space to go for alone time when I don’t like something someone said or if I am having a bad day. Yet, we make it work despite sometimes trying situations. We are a family of dysfunctional, loving, and caring people.

Dispatch is about friends

Emergency dispatch has given me a friend in every person I work with and talk to in the center, on the phone, and on the radio. My friend doesn’t always have the same face and doesn’t always ask me how my day is, but I know that friend is there for me. These friends help in different ways. A friend might help locate an address, help me decide what to order for lunch, or remind me that I am human when mistakes are made. A friend understands that it’s not my fault the CPR instructions I provided for the last nine minutes over the phone to a bystander didn’t save the life of the patient, because in the end we both know we can’t work miracles. We try as hard as we can, but that doesn’t always save a life.

Dispatch is about co-workers

This job gives me lots of co-workers. Sometimes co-workers turn into friends and family, but co-workers may also decide that dispatch isn’t the right choice. A co-worker might stay for a year, a month, or less than a day. As dispatchers, we see tons of co-workers come and go. It reminds us about why we stay and what it takes to stay.

Dispatch is about being a lifesaver

The way we handle a call from the phone ringing to the radio channel can save lives. We bring babies into the world. We comfort a wife who loses her husband of 50 years. We provide instructions to a mother who is holding her unconscious child, while trying to calm her down and make sure she is doing everything we ask. We are accountable for responders on scene and work closely with the commanding chief to ensure that each goes home safely and no one is left behind in a fire. We help people trapped in a bad situation escape from harm.

I grow every day because of my profession. Every day, I learn something to improve the way I handle something the next day. Although my title is supervisor, I would gladly call myself an observer instead. I have the privilege of observing my family and friends save lives every day and develop into the best dispatchers I know! They aren’t perfect, but they are my family, friends, co-workers, and LIFESAVERS!

Thank you to every one of you during the upcoming 2017 National Public Safety Telecommunicators Week, and thank you for coming into work every day and night and being my superheroes!
The Colonie Police Department, Latham, New York, USA, won Olympic distinction through two dispatchers monitoring emergency medical calls at the 1980 games.

Edward Sim and Kevin Moore took six-week leaves of absence to work the phones and radios for the Winter Olympics held at Lake Placid, New York, but it was a thrill-of-a-lifetime opportunity even if they weren’t bringing home a medal.

“How many times can you get to work in the Olympics?” Sim, then 22, asked Schenectady Gazette Reporter Barbara Heins (Dec. 27, 1979).

As certified paramedics, Sim and Moore had the medical background required plus upstanding reputations at dispatch. They knew how to answer calls, take and relay accurate information, and dispatch ambulances. They were Johnny-on-the-spot for dealing with emergencies and their enthusiasm was undeniable.

“We were excited to do the job,” said Sim, who dedicated his career to public service in Colonie. “It was something bringing the world to our little community. It was a big thing for the whole state of New York. We would be a part of history.”

The job also had major benefits.

Sim was in the medal-round men’s ice hockey game when the United States national team, made up of amateur and collegiate players, defeated the heavily favored Soviet Union national team. The “surreal” atmosphere inside the Olympic ice arena is a highlight Sim will always treasure, along with the ski jumping, speed skating, a fiancée who waited until after the games to tie the knot, and enviable scheduling. He was home on weekends during the three-week orientation, and during the games, he worked a predictable eight hours on and 24 hours off rotation.

“It’s ironic that this will be the first time in three years that I’ll actually get a weekend off,” he told Heins.

The two dispatchers were selected from eight civilian dispatchers who applied for the positions, and with two others chosen from a neighboring communication center, they were responsible for monitoring emergency medical calls for Lake Placid Village and the outlying areas of Keene Valley, Saranac Lake, and Elizabethtown.

Orientation familiarized the volunteer dispatchers and volunteer EMTs with the area and equipment. They supplemented the 12 ambulance squads normally servicing the area.

Sim said their Olympic calltaking and dispatching mirrored the jobs they performed for the Colonie Police Department.

“The main thing they’re concerned with is cutting down the response time for the calls,” Sim said. “It is anticipated that the number of ambulance calls will at least triple during the Olympics (two weeks). Usually, Lake Placid averages 50 ambulance calls during the entire month of February.”

Sim and Moore were each paid $1,800, with the state picking up the tab for housing, meals, and transportation. They stayed at Camp Adirondack, a former prison, with state police who were assigned to Olympic detail.

Colonie Police Lt. Lorin Scott, then in charge of the department’s communication center, said it was “really a pat on the back” for his crew, and credited the department’s progressive approach to EMS communications.

Colonie’s signal system also went to the Olympics. At the time, they used 11 different codes or signals varying from non-emergency to emergency, each indicating the nature of the call to the responding ambulance crews.

Although Sim retired as a Colonie Police lieutenant in 2004, he stays active in Colonie public service. He’s been a member of the Colonie Volunteer Fire Co. for 42 years, serving as an ambulance EMT, chief, president, and treasurer. He was named Firefighter of the Year in 1987.

Moore retired to the state of Florida.

The Colonie Police Department communications division is a longtime user of the Medical Priority Dispatch System™ (MPDS®), dating back to MPDS v10.0.
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