OUR YEAR IN REVIEW

80 of 100
Academy protocols are being used in 80 of the largest 100 cities in the United States

63,000+ MEMBERS WORLDWIDE

103,770 Certifications in 46 Countries
8 NAVIGATORs
24 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

WORLDWIDE Certifications & Recertifications

Total Current Memberships: 63,789
Recertifications: 17,821

Total Current Certifications: 103,770
In 2017, the Police Council of Standards introduced PPDS® version 6.0. Key Updates to PPDS v6.0 include:
• More than 200 changes from previous version
• Editable/adding CEIs for agency and geographical specific tasks
• The Police Council of Standards has approved several new Jurisdictionally Approved Questions. On the cardset, these questions are formatted in purple font so EPDs are aware which Key Questions are Jurisdictionally Approved Questions
• Key Questions regarding the suspect/person vehicle description have been streamlined

In 2017, the Medical Council of Standards introduced MPDS® version 13.1. Key Updates to MPDS v13.1 include:
• The Agonal Breathing Detector is now called the Breathing Verification Diagnostic.
• There are additional Key Questions, suffixes, and instructions about opioids in Protocol 23.
• Protocol 24 has a new SIGNS-OF-LIFE Warning to ensure care if a STILLBORN situation or MISCARRIAGE produces an infant with any SIGNS OF LIFE.

BY THE NUMBERS:

v13.1
v6.0

Tri-ACEs Worldwide: 10 Medical, Fire, and Police Accreditations
Alpharetta Department of Public Safety
Alpharetta, Georgia
Boone County Joint Communications
Columbia, Missouri
Fayetteville 911 Communications
Fayetteville, North Carolina
Harford County Department of Emergency Services
Forest Hill, Maryland
Johnston County E-9-1-1 Communications
Smithfield, North Carolina

Manatee County Emergency Communications Center
Bradenton, Florida
Prince George’s County Public Safety Communications
Bowie, Maryland
Salt Lake City 911 Bureau
Salt Lake City, Utah
Salt Lake Valley Emergency Communications (VECC)
West Valley City, Utah
St. Cloud Communications
St. Cloud, Florida

2017 DISPATCHERS OF THE YEAR

Noorzainnora Binti Arshad
Asia NAVIGATOR, Malaysia
Erin Berry
NAVIGATOR, USA
Kelly Anne McKee
Ireland NAVIGATOR, Ireland
Huang Yini
China NAVIGATOR, China
Abdulsalam Mohammed Abunahia
Middle East NAVIGATOR, UAE
Taryne Davey
UK NAVIGATOR, Wales
Fabio DiVita
Euro NAVIGATOR, Italy
Samuel Kellick
Australasia NAVIGATOR, Australia

Online Learning: The College of Emergency Dispatch, learn.emergencydispatch.org

Medical ACEs: 181
Fire ACEs: 33
Police ACEs: 12
ECNS® ACEs: 2
Message from the President

Dear valued Academy members, volunteers, and friends:

It’s been another amazing year for everyone associated with the International Academies of Emergency Dispatch. While those of us who are involved with the day-to-day operations at the Academy have worked diligently, it is you who are to be commended. Your selfless dedication to responding to those in need and to teaching our research-based protocols and techniques truly makes a difference in the lives of many.

The Academy is a standard-setting, accrediting organization. But we’re much more than that. We’re here to support those in the communication centers and those donating their time to this tremendous cause. Our mission is “To advance and support the public-safety emergency telecommunications professional and ensure that citizens in need of emergency, health, and social services are matched safely, quickly, and effectively with the most appropriate resource.”

We give you the tools to succeed, and we appreciate your continued hard work and support of the Academy’s goals and objectives.

Perhaps more than any other year, 2017 was a year of growth at the Academy. Not only did we release Police Priority Dispatch System™ v6.0, Medical Priority Dispatch System™ v13.1, and Emergency Telecommunicator Course Edition 4, but our membership and number of accredited centers accelerated at a rapid pace. This past year, 28 agencies became EMD ACEs, and five more achieved EFD accreditation. We also had a grand total of 17,821 recertifications and more than 11,000 initial certifications.

Membership grew to 63,789. More than 53,000 members come from the United States alone.

The Academy has an international presence, with member agencies in 46 countries speaking 24 languages. This worldwide expansion was on display at our eight NAVIGATOR conferences, held on four different continents and attracting nearly 3,000 dispatchers, Q’s, comm. center managers, and other professionals eager to learn and celebrate.

None of these accomplishments would be possible without you. We thank you for your partnership in this effort and hope to build upon this success in 2018.

Thank you.

Jerry Overton,
President
Everyone benefits from mentoring. Find out how mentors provide the tools to direct emergency dispatchers with little or no experience on a career path.

Fielding emergency calls where lives are on the line is difficult enough. Complicate matters by throwing family or friends into the mix, and who could blame an emergency dispatcher for panicking or not being at his or her best?
Art is a software instructor and IAED™-certified EMD-Q® instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 20 years and is a former air medical dispatcher. He currently works at Union County Regional Communications in Westfield, New Jersey, USA.

Sherri is the training and operations manager for Waukesha County Communications (USA), a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at sstigler@waukeshacounty.gov.

Heidi started in late 1993 in police dispatch and meandered down the career path of calltaking, backup fire dispatch, statistician, SARA TITLE III assistant, supervisor, and finally shift manager for the Harford County Department of Emergency Services in Maryland (USA). What an adventure!

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.
It is bound to happen, over a lengthy career, that a dispatcher will be working when a loved one or friend has to make THAT call.

That’s the opening sentence EMD Daphanie Bailes writes in a column describing a call that turned very personal, very fast (May/June 2016 Journal, Between the Chaos). Bailes had just started her shift when she noted a call in pending. A 27-year-old female was in cardiac arrest from a possible drug overdose. The caller was the boyfriend, and he was performing CPR.

Bailes remembers thinking: same age as my sister—what a shame. It was her sister. Bailes recognized the address, called in a relief, and arrived at the scene in time to see the crew wheeling her sister out—lifeless.

Talk about the unfathomable.

The call and the column got us thinking. Have other emergency dispatchers been in a similar situation, asking questions and giving advice while fully cognizant that the individual—caller or patient—is close to their heart? Does everything emergency dispatchers know and practice get lost in the urgency of sending response to a loved one or friend? Or does the heart go into automatic pilot mode? How does anyone cope during and after such a traumatic experience?

Journal Senior Editor Josh McFadden decided to pursue the inevitability of that call—and an emergency dispatcher’s resolve—through several interviews he conducted over the course of a month. His subsequent story reveals an outlook as unique as the people in the profession.

Also in this issue, Journal Writer Becca Barrus took to the streets (metaphorically) to provide the “how-to” when managing calls and response involving citizen protests.

This issue also highlights the dedicated and spirited team at the Lafourche Parish Fire District 3 communication center in Galliano, Louisiana (USA) (find out why Lafourche is home to the “Longest Main Street in the World,” and it’s got nothing to do with roadwork). Read the true-life saga of Michelle Funk who was “born with a spirit that was going to survive” despite the incredible odds she faced on a hot summer day in northern Utah.

There’s also the usual content our members look forward to: continuing dispatch education, FAQs, and Dr. Jeff Clawson’s Blast From the Past that takes you to a past event and discussion important to the development of emergency dispatch.
AMAZING STORIES
Call of the Week campaign reveals more incredible feats from the field

Josh McFadden

By the time this Journal issue reaches you, the holiday season will have passed, and (if you’re like me) you may be struggling with your New Year’s resolutions. But as we bring you the first issue of this year, we promise a continued collection of informative, educational, engaging articles.

2017 was an interesting one for me here with the Academy. Early in the year, I assumed some new duties. In addition to writing and editing for the Journal, I began managing the Academy’s social media efforts. We maintain pages on Facebook, Twitter, and LinkedIn, and activity has grown on all of these. It has become a place for like-minded professionals to network, collaborate, and share industry news and Academy information. To keep our social media pages fresh, I monitor media outlets for dispatch-related news stories. I come across some amazing tales of heroism, selfless dedication, and inspiring acts from you and your colleagues in the profession. Many of these stories amaze me and my co-workers. I don’t know how you can continually work so calmly and efficiently under this intense pressure. And examples of these types of calls happen every day all over the world. I love reading and hearing about them, and I know you in the profession appreciate what your colleagues are doing as well.

This past year, I also initiated some key public outreach campaigns to increase the organization’s visibility and to build relations with community leaders and with the media. At the Academy, we believe in championing your cause and increasing your visibility in the communities you serve.

I am grateful for these new opportunities. Not only have I expanded my skill set, but I have gained deeper gratitude for what you all do each day.

Earlier this year, I also launched a new social media campaign, “Call of the Week.” Here, communication center managers and Q’s submit examples where dispatchers have exhibited excellence and outstanding professionalism in handling particularly challenging calls. I am grateful for the support and response I’ve gotten from this campaign. It has opened my eyes to some of the heart-wrenching calls you take every day. Some of these calls have even involved emergency dispatchers’ family members, while others have resulted in saved lives and new arrivals. Some calls have dealt with cardiac arrest, strokes, drug overdoses, car accidents, and even officer-involved shootings. Not only is the nature of these calls challenging, but it’s incredible how well the emergency dispatchers handle these situations. In all cases, the person has followed the protocol and helped the caller and patient feel at ease.

Another benefit to Call of the Week is that I’ve worked with communication center managers and public information officers to publicize these achievements. Where appropriate, I have written press releases about this weekly award and the outstanding calls involved. I have sent these releases to local television stations and newspapers and, in several cases, these publications and stations have followed up by running stories, giving further deserved recognition to the emergency dispatchers and to the profession as a whole.

I hope this effort continues to grow, and I hope the public gains an increased awareness of and appreciation for the integral work you do every day.

May you all enjoy success and satisfaction in your daily efforts during this new year. Everyone at the Academy applauds you, and we are here to support you in any way possible.
Hello,

My name is Aaron Buzzard. I am the EMS Medical Director for numerous agencies in the central Texas Brazos Valley region. As part of my prep for the recent EMS Medical Director subspecialty board certification exam I read a lot about code 3 response issues injuries and liability and dispatch times, etc. My fire department currently responds to everything code 3, and it is very difficult to change the mentality. I am making some headway; however, my fire chief would like some examples of fire-based EMS systems that are honoring the EMD ALPHA, CHARLIE, and ECHO COLD dispatch code 1 responses. The fire department leadership would like to see their policies and discuss the resulting response time changes. I was wondering if you have any contact information for any fire-based EMS systems that have protocols for this. If not, do you have any example policies or protocols I can show my chief?

Thank you for your time.

Aaron Buzzard, M.D.
Emergency Physician
Regional EMS Medical Director
Brazos County, Texas, USA

Doctor Buzzard,

Some time ago, Dr. Jeff Clawson asked me to reach out and provide you with relevant information regarding the use (overuse) of lights-and-siren in public safety, and I am sorry to say I let it slip, and I apologize for the delay in answering. I have some experience with the effective reduction in the use of lights-and-siren as I retired last year as the fire chief here in Salt Lake City, Utah (USA). The Salt Lake City Fire Department (SLCFD) was able to reduce our use of lights-and-siren by over 44 percent for both medical and fire requests for service since 1998 by using the coding matrix and outcome data associated with both the Medical Priority Dispatch System™ (MPDS®) and Fire Priority Dispatch System™ (FPDS®) dispatch protocols.

The use of structured calltaking allows any department to obtain consistent, objective information relating to general incident type and very specific information about that incident. This allows a more intelligent decision process as to the number of apparatus that respond, and as important, how they respond.

As an introduction into this subject, I will provide my story and how the SLCFD was able to reduce the use of lights-and-siren without any real citizen concern and no identifiable incidents where this practice compromised the citizens or our firefighters. In 1997, we did a retrospective study on our call types that were designated as BRAVO-level responses. In the MPDS, this means that clinically the patient does not need an ALS assessment, but the closest BLS response unit should respond to evaluate and mitigate the incident. In our department that meant the closest BLS apparatus (engine or truck) would respond HOT, and our BLS transport provider would mimic this response mode.

We found that less than 0.1 percent had an outcome defined as less than Alive/Stable. Based on the outcome of this review, we made the decision to eliminate the use of lights-and-siren on all BRAVO-level responses across the board.

In the next three years, we monitored both the incident of citizen complaints or request for an ALS upgrade or rendezvous. Our upgrade request stayed between 1 percent and 7 percent for all incidents, and we had one (1) citizen complaint on response time on a lower-level incident (ALPHA-level) where the ambulance got lost responding to an incident for an injured ankle. When we first rolled out this new response plan, we expected to see Field Force Resistance from our crews, but we saw very little. In fact, over the next 10 years we saw proposals from our captains, especially in the downtown core, to reduce the use of lights-and-siren on specific incident types, including some in the DELTA-level.

We made the decision to eliminate the use of lights-and-siren on all BRAVO-level responses across the board.

We were able to replicate this same process a few years ago using FPDS. For High Rise, and High Life Occupancies with automatic alarms, our prior response model was to send three (3) engine companies, one (1) truck company, and a battalion chief—all in a HOT mode on the initial alarm. Using the coding matrix provided for the Priority Dispatch System™, we were able to show that in more than 76 percent of these incident types (52-C-1 and 52-C-2), all units were cancelled before arrival, and in only two incidents did we find incidents where our firefighters actually did fire suppression
activities. Both of these incidents were small trash fires in garbage bins—one on a loading dock and the other in a restroom from a discarded cigarette. Based on these findings we reduced the number of units on automatic alarms from five to one or two based on the building type. And without any secondary or confirming phone calls, our responses are COLD to these events. The captain has the ability to upgrade the response to HOT, or request additional units, but they have to articulate the reason for the request over the radio. In a six-month review, using apparatus that are frequently associated with these automatic alarm responses in the downtown core of the city, we showed a fuel savings of more than 2,043 gallons of fuel.

The Priority Dispatch System offers agencies with high compliance to the protocols a variety of performance tools that they have never had access to in the past.

The point to these stories: The Priority Dispatch System offers agencies with high compliance to the protocols a variety of performance tools that they have never had access to in the past. The ability to marry outcomes from their request over the radio with real-time data from the codes derived in the communication center allows command staff to plan and deploy resource allocation resource strategies that are both safer and more effective. The ability to reduce the potential life risk to both the public and firefighters is literally unmatched by any other system on the market.

After Dr. Clawson initiated the MPDS at SLCFD in 1979, a follow-up study to the implementation after bringing in a new fire chief and a reboot of compliance and proper use of the system found that they had reduced the number of all medical responding vehicles, as of 1982–83, by 50 percent, lights-and-siren use by 50 percent, and emergency medical vehicle collisions (EMVCs) by 78 percent! Needless to say, the Fire Chief, Pete Peterson, was praised by the mayor and received many accolades for these amazing (and safe) improvements—concurrently demonstrating in writing to city hall that, because of these time and manpower reductions, they had significantly increased firefighter and paramedic training episodes, increased fire hydrant and building inspections, and had obviously improved street-safety of the responders and driving public.

A few years after, Dr. Clawson wrote another article in JEMS called “The Maximal Response Disease.” As you can start to see, there is a plethora of information on the safe (and now standard of care and practice) ability to respond COLD to a great number of incidents if the dispatch system used is predictively accurate, which the MPDS is as shown by quite a number of peer-reviewed, published studies on its design and use. It is the only evidence-based and standard organization reviewed and updated regularly in the world. Dr. Clawson was reported as saying the management of response manpower, vehicles, and safety was the driving force of the development of the MPDS in the first place. In addition, there was an article that was published in Fire Engineering in the late 1990s or early 2000s where the St. Louis Fire Department (Missouri, USA) showed how reducing their use of lights-and-siren had reduced their vehicle maintenance budget by 70 percent in the areas of the city where they had initiated the reduction in their use.

As you might have seen in the MPDS Response Matrix, the CHARLIE level tier is also a candidate by IAED definition of ALS COLD response per decision of the local medical director and EMS administration. This should be done on a determinant code-by-code basis. Our department slowed some of these responses for incidents like Not Alert Diabetic and a few of the CHARLIE Headache incident types.

Dr. Clawson had previously written a special page in the “Principles of EMD” regarding the process by which one sets up appropriate responses to the various levels and codes in the MPDS.

It seems, even given all the information, articles, and studies available, every place tries to reinvent the wheel of this science. Many comm. centers moving to accreditation performance and compliance levels tend to move much more quickly in this direction of reducing maximal response and lights-and-siren use because the very high compliance to protocol (and its very accurate coding results) gives them newly found confidence in this extremely important area for medical directors to address in achieving equity with today’s modern response science.

As I wrap up my dissertation regarding a topic about which I am most passionate, I would also like to point out that this protocol system is now being used in 46 countries and is translated into 25 languages and dialects. Last year, these centers were responsible for processing over 80,000,000 emergency incidents worldwide. The reason I bring this to your attention is that with a user community that large, our members are constantly studying, reviewing, and enhancing the optimum use of the system through the various peer-reviewed studies, and most importantly through our Proposal for Change (PFC) process. We are about to release v7.0 of our Medical Protocol, and in the spring of 2018, we will release v7.0 of our Fire Protocol.

I hope I have provided enough information that will enable you to further this meaningful conversation with the fire chiefs in your area. I make myself available to you at your convenience to further the dialogue, and the offer stands to have Dr. Clawson and I available for a larger conversation with you and any department representatives you feel are interested in improving the meaningful change the protocols can bring to their communities.

Regards,
Brian Dale
Associate Director of Medical Control and Quality Processes, IAED
If your agency uses ProQA®, you have a very powerful resource allocation tool at your fingertips. At many agencies that dispatch different types of responders, the Determinant Code is used by CAD to recommend who or what to send to the call. But there are intriguing possibilities even for single-tier systems where, for example, Advanced Life Support (ALS) providers go on every EMS call. Let’s look at how CAD systems work with ProQA to present a response recommendation to the emergency dispatcher.

When the emergency dispatcher accepts the Determinant Code presented at the Send screen, a corresponding value called a CAD code passes to CAD. The CAD code may resemble the Determinant Code—for a 10-C-4 it might be 10C04—or it may be different entirely. CAD then looks in its table of response values to see what specific response your agency has associated with that code and recommends those units. In some CADs, the problem/nature displayed will also be based on the CAD code.

On the ProQA side, the user-defined response for each Determinant Code is entered into the ProQA Paramount Admin Utility and appears on the Send screen in the rightmost column titled “Responses (user-defined).” But that text doesn’t actually tell CAD what to do—it’s the alphanumeric CAD code that does that. What the emergency dispatcher sees in the Responses column is just a free-text description corresponding to that CAD code.

For multi-tier EMS systems, a Traffic/Transportation Incident with a Determinant Code of 29-B-1 (Injuries) would get a BLS response. A 29-D-9 (Not alert with normal breathing) would typically get an ALS response.

Having a CAD capable of utilizing the Determinant Codes to recommend these responses is ideal, but not essential. The ability to predetermine the local response for each Determinant Code is what really counts. Even an agency without a CAD system can use a simple computer application or flip cards to indicate to the emergency dispatcher what response corresponds to each Determinant Code, or—for single-tier systems running “HOT” to every call—when additional resources are needed. One such scenario might be a 29-D-1f (MAJOR INCIDENT - Multi-vehicle (≥10) pile-up).

Determinant Codes in ProQA can also identify when a police response is needed for a fire or EMS call and vice versa. A psychiatric emergency coding as a 25-B-3 (THREATENING SUICIDE) could be designated to get a response of BLS PD HOT. Determinant suffixes give additional flexibility to differentiate responses based on specific criteria. A motor vehicle crash involving a pedestrian (29-D-2m) might require just EMS whereas a rollover (29-D-2p) will typically require a rescue unit in addition. Suffixes can also identify when more specialized resources are needed. In Protocol 29, some Determinant Descriptors and suffixes are associated with a high frequency of air medical flights. A 29-D-3k (HIGH VELOCITY impact involving an all-terrain vehicle or snowmobile) could be designated for MedEvac to be automatically placed on standby.

ProQA isn’t just for emergency dispatchers. Consider the possibilities. Your CAD vendor can provide you with more information.
Again this morning, I found myself in receipt of a particularly pointed and “pitchy” email from a supervisor in response to an email question I had posed to the group. As I sat steaming at my desk, I read and re-read every single word, desperately trying to figure out how on earth that supervisor could have possibly misinterpreted my question. Once I cooled down a couple of degrees, it dawned on me that without that supervisor appreciating my “intention,” I could almost (kinda sorta) understand how he may have taken it the wrong way.

In a perfect world, we would communicate face-to-face on every issue. But as you all know, especially in our 24/7 operations, we have no choice but to use email or messaging to deliver and receive information. It is a necessary tool in our environment, but also a fertile ground for misunderstandings, inappropriate “boldness,” and hurt feelings.

We need a better way to deal with difficult conversations prompted by emails and other messaging platforms. My director tells us to “sit on” or “sleep on” these messages, which is excellent advice adopted by many at our center.

Oh the stories our “draft emails” could tell! Sometimes, in my most heated moments at the keyboard, I’ll type out an email detailing exactly how that individual’s message made me feel and explain precisely what they can do with whatever it is they’ve done to get my dander up. I feel better and then delete the email. I send the “real” message, asking if we can meet to discuss the problem.

How do we fix this digital communication breakdown?

We need to start applying what I call a “keyboard to face” approach. When you sit down to type a message or an email, mentally picture that the person is seated in front of you and you both are engaging in a reasonable, rational, and professional conversation, face-to-face.

Hiding behind the comfort of a desk and many shifts away from our recipient, we tend to be bolder with our words as we type, sometimes to a fault. Things we would never say to that person directly slither their way into the text of a message, again, leaving the recipient with a negative feeling about what was sent and read.

A few terse or accusatory words discredit your message because people tend to stop reading the positive and focus on the negative. The negative is not easy to overcome; the message can mimic a virtual “slap” in the face of the intended target.

Hurried and minimal writing skills can also result in messages that are nonsensical. Poor grammar and misspelled words could cause your recipients to completely miss the magic in your message! If this describes your writing style, or you’d like a refresher course, consider taking a course in person or online. Talk to your employer, as there may be low-cost or no-cost options as part of the training and development departments. Advocate for yourself, and take the time to improve your writing. Skill in writing will continue to be an important part of your career—as an emergency dispatcher, a supervisor, or as a manager/director.

Finally, before you hit the “send” button, check your email. Check your tone. Check to see if your message passes the “keyboard to face” test. If it doesn’t, don’t send it. Delete. Type a new one that reads something like this: “I’d love to sit down with you and discuss this so that we have a good understanding about how to move forward. Please let me know what day/time works best for you!”

You won’t regret it, I promise. Good writing, everyone!
WHY TRAIN?
It’s a benefit that never gets old

Heidi DiGennaro

When you started, everything was overwhelming. There was fear or excitement in touching the equipment, the constant dread you might break something, and the encouragement to go ahead from your trainer. Training seemed to take so long, and there was something both terrifying and liberating about operating on your own. Now you have a few months, years, maybe a decade or two (gulp!) of experience and everything has changed and some parts remain the same.

Technology moved forward and in some cases, outpaced our ability to keep up with it. Forward momentum with technology has created challenges and caused us to adapt to keep up. The work—talking to the public and the field providers and ranting at the console when your foot comes off the pedal—has stayed the same. So why train and why train constantly?

Policies and procedures
If you do not have a strong foundation of what to do, policies are meaningless. They are words on a paper or screen if you do not find a way to apply them. It’s not the time to look up an active assailant procedure during an active assailant incident. The same goes for an MCI when heat exposure or a multi-vehicle accident occurs. It’s not good management to quarterback people about how they handled an incident and remind them about the policy they haven’t looked at since it went into effect.

Build confidence
Spend five minutes reading a policy or highlighting a procedure on the off chance you might need it. Mortar the gaps and cracks in your knowledge to create a stable base to lean on when the worst happens. Supervisors need to lead and to lead by example, knowing your procedures and policies. Use any roll call time to go over something, anything, every day.

Public safety
You never know what will happen, and refreshing yourself makes you smart and promotable, if that’s your intent. Training classes teach you what the agency/department does, and it saves you the embarrassment of fumbling for words when someone asks about a certain policy and whether you even have one. Knowing policies and following them during crisis is your best defense when someone outside your organization starts tearing apart your actions.

Liability
When you follow policy, your agency should defend your actions. I’ve seen a few things in my 24-year public safety career, from police dispatcher, to calltaker, to backup fire dispatcher, to supervisor, to shift manager, with several other specialties in between. I have met people who know the policies, know exactly what to do, and how to do it when the equation Chaos + Oscillation Device + the Smelly Spread presents itself. Training saw me through the worst incidents. I use our roll call time to review, to train, and to amuse.

It’s simple—start now
Pick something to go over and search the internet for an image that matches your training topic. Word of caution: Tell your supervisors so they know your internet history will be a little “interesting.” Make learning humorous—there is always a “fail” out there on any topic. One minute, five minutes, 20 minutes—the time is never wasted. Even if one person remembers what you went over during a critical moment, everyone succeeds. An incident does not turn into a cluster. Someone survives because you and your people knew what to do.

That’s why we train.
RESPONDER SAFETY
Explosion emits dangerous chemicals

Brett Patterson

Brett:

Good day. I was teaching continuing education for our EMDs, and I came across a question. Which protocol would best apply to an explosion with reported or suspected (based on grouping of symptoms) CBRN involved?

In my mind, I immediately think secondary device so the 7 card [Burns (Scalds)/Explosion (Blast)]; however, the 8 card (Carbon Monoxide/Inhalation/HAZMAT/CBRN) would apply equally due to the HAZMAT aspect.

In either case, responder safety is important.

Thank you,

Brenda Farlow, Firefighter/Paramedic
Northlake Fire Protection District
Northlake, Illinois, USA

Brenda:

I’m not sure that it matters provided the EMD covers the PDIs from both protocols using the Target Tool and ensures an appropriate HAZMAT response. I would be inclined to use Protocol 8 if I knew CBRN was involved, but I can only justify that decision based on ensuring a HAZMAT team response.

I’ve copied Brian Dale for an opinion from the FD perspective.

Brett A. Patterson
Academics & Standards Associate Chair, Medical Council of Standards International Academies of Emergency Dispatch

Brenda:

I would agree with Brett, but the downside to this conversation is that with explosions it is exceedingly rare to know the device had CBRN components. You may receive a phone call about a bomb that is going to explode at this place or at a specific time, but those scenarios are more commonly seen on television than in real life.

If the EMD feels she is dealing with a “simple” small device or homemade bomb, Protocol 7 is appropriate. If there is mention of other elements, or strange or “funny” smells, or other witnesses collapsing, Protocol 8 is most appropriate. From the perspective of fire command and control, we try to deal with the fire first, then mitigate the HAZMAT component, but that objective is fluid based on the incident dynamics and risk assessment.

While our Fire Protocols deal specifically with this, the two choices listed are best case while using the MPDS*. I hope this helps, but let me know if you have any additional questions or concerns.

Brian Dale
Associate Director of Medical Control and Quality Processes, IAED™

Brett:

Protocol 23: Overdose/Poisoning (Ingestion) Accidental or intentional?
We are seeking clarification as to whether or not it is necessary to ask Key Question 1 on Protocol 23, “Was this accidental or intentional?” for situations involving illicit drug use; the taking of illicit drugs is always an intentional act per the “Principles of Emergency Medical Dispatch” section 6.33.

Indeed, it is difficult to ascertain the true intent of someone who takes an illicit drug: It may predominantly be for getting “high”; however, it may also be an act of self-harm.

How does one measure the required “dose” to just “get high”? The variables in these situations are so great that I definitely think clarification of intent is important.

I really appreciate your reply and look forward to the upcoming changes to assist in this clarification.

Kind regards,
Cassandra Lee Saywell, QA/Educator
Queensland Ambulance Service
Education Centre (QASEC)
Office of the Deputy Commissioner—
Service Planning and Performance
Queensland Ambulance Service
Department of Health
Queensland Government
Woolloongabba, Queensland, Australia

Cassandra:

Thank you for the great question. Interestingly, there has been quite a bit of discussion on this topic lately, independent of your query, but your email has solidified the issue and a protocol change is in the works. Thank you!

OVERDOSE is a DLS-defined term designed to differentiate an intentional act from an accidental one (POISONING). This code separation allows for a safe referral to a poison control center for accidental ingestions without priority symptoms (23-O-1) and ensures a physical response and face-to-face evaluation when there is intent to harm. And the latter is where the confusion lies.

Certainly there is intent when someone partakes of recreational drugs to get high. However, the intent is to get high, not to harm oneself—the overdose is actually accidental. The call is being made because the patient accidentally took too much of the drug. Essentially, it’s akin to a patient accidentally taking too much medication, with the obvious difference being the recreational drug is often illicit, or illegal. However, this is not always the case as prescription drugs cause many overdoses. Please note my use of lowercase for accidental “overdose.” This is common layperson terminology, which is probably the source of at least some of the confusion.

Unfortunately, accidental narcotic overdose is becoming rampant. I suspect this is why this question of intent has become more frequent. After some discussion, the Academy’s Rules Group has proposed some minor protocol modifications to clear up the confusion and make the coding process more intuitive.

While I can’t be very specific because the enhancements are in draft form and have not formally been approved, the changes involve adding the intent to harm oneself to the OVERDOSE definition, the ProQA® answer choice, and perhaps to the Key Question itself in the form of a clarifier. What do you think?

So forgive me for the long answer to your short question, but I wanted to explain why it’s important to ask, “Was this accidental or intentional?” Once we know the purpose of this question, we understand why it most often needs to be asked, and we also know when it needs to be clarified.

In summary, when asking “Was this accidental or intentional?” we want to know if the patient accidentally took something, or accidentally took too much of something (POISONING), versus intentionally taking something with the intent to harm oneself (OVERDOSE). In DLS, an accidental overdose is defined as POISONING in an effort to separate self-harm intent and provide an appropriate response or referral. Once this distinction is understood, the purpose of the Key Question becomes clear.

In answer to your second question: The intent to harm cannot be based on the dose but only on the caller’s answer. If the caller doesn’t know, the ProQA “Unknown” option defaults to intentional to ensure at least the BRAVO response. So, if the caller doesn’t understand what we are asking, clarify. If they simply don’t know, choose “Unknown,” and the default will be “intentional.”

Thanks. And feel free to contact me directly with any other protocol questions.

Brett:

Many thanks for your reply and for the news re: protocol changes in the works. I think it is a great idea to include clarifiers as to the actual intent of the patient and perhaps expand/amend the definition of OVERDOSE.

Cassandra

Brett:
TOP CARE OVER THE PHONE
ACE shows Northwell’s dedicated approach to integrated care

Audrey Fraizer

Janice Warshauer, Registered Nurse, was a longtime hospital and in-home care infusion nurse when circumstances dictated a change, although in retrospect the transition wasn’t so different from what she had been doing for the past 22 years.

It was more about shifting perspective. “It’s a matter of listening closely to what the patient is saying,” said Warshauer, describing her move from a visual to virtual environment in the Northwell Health System complex of integrated services. “Sometimes it takes asking the question differently, but you learn the approaches that work best for helping the patient.”

Warshauer is among 10 certified Emergency Communication Nurses (ECNs) providing care selectively routed to them from callers—patients and caregivers—requesting assistance for symptoms related to acute or chronic medical conditions. Chief Complaints are triaged using algorithms built into the Emergency Communication Nurse System™ (ECNS™), a protocol-based automated system developed by the International Academies of Emergency Dispatch™ (IAED™).

Several primary and secondary Public Safety Answering Points (PSAPs) incorporate ECNS to complement overall EMS goals, but only two have achieved status as an Accredited Center of Excellence (ACE). Northwell Health Clinical Call Center in Syosset, New York (USA), was the second, earning the distinction on Aug. 7, 2017.

Debra Tomassetti, Clinical Call Center Program Director, said it was a team approach. “We’re dedicated to ECNS,” she said. “It works hand in hand with EMS and is part of an integrated approach for ultimate patient care. ACE shows we put the time and effort into what we do.”

Accredited Center of Excellence
ACE was a great fit for Northwell, said Jeffrey Pick, RN, Clinical Call Center Quality Assurance (QA) Manager. Northwell had looked at several measurement-based accrediting options but chose the ACE program because of its focus on call detail. “ACE is the key to the lock of what we are doing,” Pick said. “Accreditation is tailored to listening to calls, and call quality makes for better patient outcomes. If we can make the call better, the whole process improves.”

Pick reviews 100 percent of ECNS calls. He monitors an ECN’s progress, evaluates performance, and recognizes through his review the areas needing further training and the incidence of low to urgent medical complaints. He also assesses the ECN’s customer service—patient/nurse rapport is established through voice only—including
communication skills necessary to clarify or ask for detail and paraphrasing to check accuracy. He also checks their compliance in using the software tool as directed and following instructions.

“We needed the structure and stability the system provides,” Pick said. “LowCode [the program’s software] has literally saved the day on many occasions. You can’t always remember all the questions. It’s important to have the script.”

From clinic to phone

Although Warshauer does not “see” the patient, clinical experience during her career—pattern recognition, skilled know-how, and common sense understanding—and LowCode help her to estimate patient symptom urgency. Software is based on pattern recognition, supporting a nurse’s intuitive ability to compare general descriptions to patient presentation in making triage decisions. After listening to the patient’s description and prompting more information when necessary, she assigns a symptom-based protocol. She verifies there are no priority symptoms (e.g., trouble breathing), performs further assessment, and recommends an appropriate level of care.

“We [ECNs] are able to recognize what’s going on with the patient and provide the best treatment option for the condition,” Warshauer said.

Warshauer has spent her entire career at Northwell, shifting to the clinical call center three years ago because of chronic back pain resulting from two decades of lifting patients. It was a relatively new program at the time and one that 25 years ago she never imagined doing. Advice nurses have been around since the early 1970s—started as a way for HMOs to cut costs by having nurses rather than physicians handle calls, minimize unnecessary office visits, and encourage self-care at home—but that was not what she had trained to do.

“I didn’t want to leave nursing,” she said. “ECNS was a major transition, but I also saw it as a good chance to use my skills in a very challenging way.”

“We needed the structure and stability the system provides. LowCode has literally saved the day on many occasions.”

The transition turned out easier than she had anticipated. She listens to what patients feel and finds each day as atypical as working on a hospital floor or making home visits. She has the opportunity to “know” longer-term care patients, such as those who are homebound, and the ability to get patients to a recommended setting in an appropriate amount of time. She also likes answering patient and caregiver questions.

“I love the program,” she said. “The calls are not always symptom-based. Caregivers want reinforcement and assurance. Are they doing the right thing? Patients want to know they have someplace to go. They know they have care until it’s time to see the doctor.”

Complex operation

Telephone triage is a complex operation that requires accurate and timely referrals to avoid delays in patient care and, if indicated, to make sure the patient is seen before symptoms escalate. While there are no shortcuts, ECNs spend 16 minutes on average per call, depending on several factors, including Chief Complaint and recommended level of care. At the Northwell Health Clinical Call Center, an ECN can recommend self-care, dental care, or direct the PSAP to initiate a three-way conversation to include the ECN, primary care provider, and patient. Community paramedics (CP) trained to evaluate and treat acute illness can be sent to the patient’s home for symptoms requiring urgent in-person evaluation and possibly in-home treatment.

Candidates must have at least five years’ clinical nursing experience, excellent written and verbal communication, and basic knowledge of current pathology and pharmacology. They must be familiar with accessing electronic health records, patient triage, and confidentiality and privacy laws. They must also project a patient-centric personality and demonstrate the ability to multitask (listening while using the computer-based system).

Training involves Emergency Medical Dispatcher (EMD) certification, followed by the ECNS certification course. Upon earning both certifications, the ECN sits with a mentor and listens to calls. The ECN and mentor switch roles, with the mentor acting as a coach. After six weeks of alternating roles—answering calls and mentoring—the ECN acts independently.

Care management system

ECNS complements Northwell’s overall care management system, which includes home-based services to an average of 1,200 people in Queens and Long Island, New York, through its Advanced Illness Management (AIM) program. The program favors options outside of emergency department visits for low-acuity symptoms based on the reported Chief Complaint.

Staying out of the hospital is better for the patient, explained Karen Abrashkin, M.D., Medical Director, Northwell Health Clinical Call Center. Hospital visits can expose the already medically vulnerable patient to infection and further compromise weakened physical agility.

Home is where they want to be.

“That’s where they’re comfortable, and there are many advantages for both the patient and family to treatment at home if the patient’s condition allows,” she said.

Ultimately, the decision rests with the patient. The nurse asks the patient, “Do you want to remain at home?” and offers scenarios describing the various care options.

“The patient trumps everything,” Tomassetti said. “Once you explain and give choices, the patient feels more comfortable. You’re building a level of trust.”

January/February 2018 | The Journal 17
Best practices  

center piece

WATER WATER EVERYWHERE
Lucky Lafourche dispatch is there to help

Audrey Fraizer

Let’s say you’re trolling for redfish in the Louisiana bayou, the motor’s turned off, and suddenly you realize the boat’s drifting past shoreline you don’t recognize. How are you going to find a way back to the family fishing camp before dark?

Well, you’re in luck if you’re calling within the 250 square miles covered by the Galliano-based Lafourche Parish Fire District 3 (LPFD3) communication center. The emergency dispatcher can send the information to your phone using the computer system’s GPS coordinates. If you happen to need help with a quickly emerging medical situation—like if your fishing partner’s in labor with a baby that’s not due for another couple of weeks—the EMD can give Pre-Arrival Instructions, too.

Everybody in Galliano, Louisiana (USA), has a story about living near wetlands—maybe not as intense as giving birth in a shallow drift boat, but otherwise equally dramatic. An alligator close to the shore backing the family fishing camp, for example, put paddle boarding temporarily on hold for EMD/EFD Mary Pellegrin.

“I love the water, but the alligator made me a little nervous,” said Pellegrin, who has been with the LPFD3 communication center for 23 years (and six years before that with the Lafourche Sheriff’s Office). “I gave it a few months [before going back in the water] until I didn’t see him again.”

Water and plenty of it

Louisiana contains 40 to 45 percent of the wetlands found in the lower states, and while Galliano is all land, it’s part of the Lafourche Parish. The parish has 1,085 square miles (73.68 percent) of land and 388 square miles (26.32 percent) of water and borders the “Longest Main Street in the World” (Bayou Lafourche), stretching 106 miles through southeastern Louisiana to the Gulf of Mexico.

Considering the amount of water, it’s safe to say that water lives up to a reputation as hazardous as fire for LPFD3.

“A lot we have to do is because of the bayou,” said Mary Rotolo, LPFD3 Communication Supervisor. “We have all sorts of calls because of water.”

LPFD3 dispatching is co-located with two other primary dispatching agencies operated by the Lafourche Communication District created in 1984. LPFD3 dispatches fire departments in District 3 and Lafourche Ambulance District. Thibodaux Police Department dispatches all calls for their agency and the Thibodaux Volunteer Fire Department. Lafourche Parish Sheriff’s
Office dispatches for Lockport and Golden Meadow Police Departments, Lafourche Parish Port Commission, and all north and central Lafourche Fire Departments.

Rotolo supervises the 10 LPFD3 emergency dispatchers handling the fire, EMS, and non-emergency calls. Their joint facility, completed in 2011, is on the same property as the LPFD fire station and about 100 feet southeast of the Bayou Lafourche; the bayou parallels Louisiana Highway 1 on the west and Louisiana Highway 308 on the east.

People drown in the bayou. No shoulders protect the roads from the water. Cars get hit and the impact can plunge the vehicle into the bayou, or a driver can swerve off the road of his own accord. Six bridges cross Bayou Lafourche in different locations, which are opened for boat traffic and closed for vehicle traffic. Bridge tenders operate lights and barricades to signal right of way, but sometimes the system fails.

Firefighters practice water rescue all the time, Rotolo said. They rappel from bridges to practice pulling victims and cars out of the water, tow disabled boats, maneuver around moving objects (particularly useful during flooding conditions), and certify as water rescue technicians.

The training ethic and water focus also applies to emergency dispatch. Rotolo was hired in 1985 “fresh out of college” when the dispatch center opened in a “cubby hole” accommodating one dispatch position, rotated among four emergency dispatchers. LPFD3 was among the first USA centers outside Utah to use the Medical Priority Dispatch System™ (MPDS®) cardset, and that was five years into Rotolo’s current 33-year emergency dispatch tenure.

“[Dr. Jeff] Clawson was the first to do anything for EMD,” said Rotolo, who has been a certified EMD for 28 years. “[The TV program] Rescue 911 was a big deal and people expected to get that kind of help. Clawson invented the protocol, and we jumped right on board.”

The center never strayed. In September 2017, emergency dispatchers completed training on a new software system incorporating EMD and EFD ProQA®, AQUA®, mapping, and call/response logs.

“It’s been in the works for several years, and the fire department finally said we need it now,” Rotolo said. “They were affected by the time stamp.”

The Property Insurance Association of Louisiana ranks fire departments from 1 to 10 using an ISO rating. The lower the number, the higher the ranking; the higher the ranking, the lower the home and business insurance rates. Factors that go into rating fire departments include response times (the time stamp), equipment, training hours, station locations, availability of water, and professional and quality assurance standards for communication centers.

The department’s next rating will be in 2020.

**Real focus**

It’s not the ISO rating or even threatening water levels holding Rotolo’s attention. She is dedicated to a staff that doesn’t always get the consideration they deserve and the public that can take them for granted.

Rotolo goes big with National Public Dispatch System™ Program Administrator—Technical Integration & Training.

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Rotolo goes big with National Public Safety Telecommunicators Week, and in 2017, they celebrated the Academy Awards of Emergency Dispatch. She gave out plastic Oscars in several job-related categories, with the winners elected by ballot. Acceptance speeches were made under strobe lights and against swimming pool noodles arranged to look like a curtain. Their annual holiday party includes Secret Santa gift-giving.

On an ongoing basis, they play protocol-based bingo, receive stork pins for childbirth and delivery calls, post positive messages on a bulletin board, and take advantage of social media outlets. The public follows the center on Facebook, Rotolo said. The communication center is part of the annual LPFD open house.

“We’re getting the word out about what we do,” Rotolo said.

Sometimes, the calls get personal. The population of Lafourche Parish is relatively small, and Rotolo has lived there her entire life. The same goes for her 10 EMDs/EFDs, some of whom are going on 15 to 25 years with the district. Rotolo’s husband called once. He wasn’t feeling well and went into cardiac arrest during the phone call.

“Talk about scared seeing your address on the phone,” she said. “He was home alone, and the ambulance got there fast.”

He survived.

Rotolo accepted the dispatch job in 1985 not knowing what she would be doing. She didn’t know if she would last because it was a process so new to the area and waiting definition.

“It was something new the parish was putting together,” she said. “I jumped in wholeheartedly knowing I could make a difference and be there for the people.”

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Lafourche Parish Fire District 3 communication center personnel surround John Hancock, Priority Dispatch System™ Program Administrator—Technical Integration & Training.
Research into the causes, effects, and possible solutions that involve structure fires isn’t as easy as you might expect. Just ask IAED™ Data Analyst Meghan Broadbent.

Broadbent is principal investigator in an IAED study comparing the number of smoke alarms activated to the actual number of working fires that require response. The study is also designed to pick up the percentage of nuisance alarms, defined by the National Fire Protection Association (NFPA) as an unwanted activation of a signaling system or an alarm initiating device in response to a stimulus or condition that is not the result of a potentially hazardous condition.

Everything in order

The study depends on several components: smoke detection systems (and there are major differences in the types of systems), Fire Priority Dispatch System™ (FPDS™) Protocol, data captured in ProQA®, and structure fire incidents reported to the National Fire Incident Reporting System (NFIRS).

Smoke detection systems are the common means of detecting a potentially dangerous structure fire and are required by building codes in most residential dwellings and commercial buildings. A smoke detection system sends a signal to the building’s fire alarm to activate a visual warning or alarm.

Protocol 52: Alarms in the FPDS begins with the Key Question: “What type of alarm is this?” Alarm monitoring companies and private callers are addressed separately in both Key Questions and PDIs. CHARLIE and BRAVO Determinant Descriptors provide information about the type of fire reported; an OMEGA Determinant Descriptor designates an alarm other than a structural fire (e.g., vehicle or medical system). The data is collected in ProQA and stored in CAD.

The U.S. Fire Administration (USFA) established NFIRS in 1975 as a national repository of fire data. Participation is voluntary and departments follow a prescribed set of definitions to report a common core of information (incident and casualties).

While Broadbent’s methodology depended on data collected from supposed reliable sources for analysis, the unforeseen occurred early in the project. She found that while NFIRS offers a wealth of data, the data is not always consistent. She was unable to establish the data relationships the project requires.

Obstacles

NFIRS offers the world’s largest database of incident reporting. According to the USFA, about 23,000 state and local fire departments file 22 million NFIRS reports...
annually. Like a lot of things, however, as NFIRS’ sophistication grew, so did the complexity of reporting information. For example, the coding structure for data processing has become increasingly granulated. Each separate incident generally requires completing several lengthy modules and information reporting tends to be inconsistent. Not everyone answers all the questions, and the questions are not answered in the same way.¹

For Broadbent’s research, the information she needs is difficult to sift from the whole.

NFIRS analyzes smoke detector data for presence (was an alarm in place), operation (was it working), and effectiveness (did it accomplish what it was supposed to do). In addition, many incident type queries were designed to capture multiple attributes, such as cause of a nuisance alarm and the type of device or system involved (smoke, heat, sprinkler with water flow detection, and undetermined). When the information is not available, or too difficult to find, the field is marked “U” for unknown or undetermined in the case of detector types.

A tendency for firefighters to put more complete information into modules for major fires than for minor incidents also skewed results. Preliminary findings for Broadbent’s research showed that 13 percent of all alarms turn into full-blown fires.

The 13 percent is misleading, Broadbent said, particularly in contrast to National Fire Protection Association (NFPA) figures.

According to the NFPA, in 2005, U.S. fire departments responded to 2.1 million false alarms, excluding good intent calls and smoke scares. Nine percent of all fire department responses were to false calls and only seven percent were to fires.²

Fire research is an enigma, Broadbent said. The data are far less accessible compared to EMS, with its expanse of research and libraries of available literature.

High rise fires

Former Salt Lake City Fire Department (SLCFD) Chief Brian Dale used NFIRS to analyze city high rise and high life structure fires (NFIRS Code 111) that originally came in as an automatic alarm. The retrospective study, spanning three years (2007–2010), identified the number of alarms that involved putting out a structure fire. In other words, he wanted to know how many of the alarms required the full regalia of resources (three engines, two trucks, one chief, and one ambulance). This research was particularly important in a city experiencing a high rise building boom to accommodate urban sprawl.

Dale used data from the SLCFD Communication Center CAD and NFIRS to analyze the department’s risk and to try and reduce the number of unit responses where safe to do so. The NFIRS data showed that in all alarms during the three-year review, there were two incidents of fire and both times the fire was very small.

“It’s fuzzy logic. It’s another way of finding a solution.”

If it’s burnt toast triggering an alarm, firefighters don’t complain. An alarm was triggered to indicate a potentially hazardous incident. But an alarm tripped because of bad batteries or a system test? That’s not time or money well spent.

Dale, who was SLCFD Deputy Chief at the time of the study, devised a service delivery approach that included sending the closest engine company with four firefighters (HOT) and one truck company with four firefighters (COLD) to assess the urgency of a high rise and high life alarm. One company monitors the building’s fire control panel and controls elevator access, while the other surveys the area triggering the alarm.

“We send the closest vehicle and, if they find an actual fire, we ‘fill the assignment’ with additional resources,” said Dale, who was promoted to SLCFD Chief in May 2015.

The department went from sending four or five heavy apparatus to sending two, with only one going HOT; and in the first year, they realized a reduction of 987 unit responses for FPDS codes 52-C-1 and 52-C-2. The department stands to save thousands of dollars annually (think in terms of the price of fuel and the fact that these heavy apparatuses get an average of two miles per gallon of gas). Dale calculated that more than 2,833 gallons were saved in the first year, in addition to extending the road life of apparatuses that carry a price tag of more than $650,000.

In 2017, Dale retired from the fire service and was subsequently selected as the IAED Associate Director of Medical Control and Quality Processes. Troubleshooting plans to reduce nuisance alarms is no longer part of his job, although their accuracy in relation to real fires is a focal point of the Academy’s fire research.

Broadbent is continuing her research using a much more time intensive approach. She is contacting agencies using ProQA fire and attempting to match the ProQA alarm data (address, date, and time) to working and extinguished fires. The difference between the alarms correctly triggering response—there was a fire—and the alarms triggered for some other reason—there was no fire—should give her a reasonable assessment to satisfy her study question.

“It’s fuzzy logic,” she explained. “It’s another way of finding a solution.”

Note: NFPA 72 allows supervising stations to verify alarm signals from household fire alarm systems before notifying the fire service if such verification will not delay reporting by more than 90 seconds and the authority having jurisdiction agrees. Many agencies charge fees. For example, the SLCFD’s response to more than 2,400 false alarms in 2011 prompted an ordinance of tier-based fines to reduce their frequency.●

Sources


Mentors at communication centers focus on discussion. They talk about the really difficult calls and how they are still unsure if they handled the calls correctly. They talk about their entrance into emergency communications and introduction to protocols, compliance, and performance reviews and down the road—if they so choose—adding credentials beyond their initial EMD.

And central to everything is how their experience and knowledge can benefit those new to the profession in an environment of safety and confidentiality.

“Mentoring is about creating a relationship of trust,” said Louise Todd, Clinical Support Officer, Priority Dispatch Corp.™ (PDC™). “That’s the basis for helping someone build confidence and feel good about what they’re doing.”

Gives professional edge

If anyone thinks emergency dispatch is a job picked up in a snap, the training required to work at the Winnipeg Fire Paramedic Service (WFPS) Communication Centre (Manitoba, Canada) will certainly put that notion to rest forever.

For starters, Manitoba requires every Communications Operator to have a valid technician license and proof of successfully completing the calltaking and dispatch education program. The applicant goes through a rigorous interview process and, if hired, that’s only the beginning as far as being independent on the phones and radio.

“Considerable time goes into getting new hires ready and signing them off,” said Tammy Jewell, Acting Manager, WFPS Communication Centre.

And since WFPS sends responses for both fire and EMS, the “considerable time” can stretch into six to nine months and is focused on classroom training, EMD and EFD certification, and mentoring.

Mentoring is a long-held philosophy at WFPS. When Jewell started 17 years ago, an experienced emergency dispatcher worked alongside the new hires, answering
questions, providing feedback, and offering support. “There was nothing formal,” Jewell said. “They came out of class. They were new. They were learning, and we helped them to make sure they were doing it right.”

Approximately five years ago, emergency dispatchers volunteering to mentor brought attention to their own perceived shortfalls in giving feedback. They wanted more formal training. They wanted to know the best approaches to mentoring. After all, the skills necessary for effective mentoring are different than teaching people how to use the protocol and operate the radio system.

“You must be able to give constructive feedback,” Jewell said. “It takes a person who has patience and an understanding that it often takes more than one time to do something right. Students look to you and must be comfortable going to you for help.”

In recognition of the differences, a new layer of support was added. WFPS assigns a mentor—either a Communications Operator or a Lead Hand—to a new hire, and they both track progress. The Lead Hand provides feedback based on a list of competencies (familiarity with the area’s geography, cailtaking, customer service, and radio operations, just to name a few), and the mentee keeps a daily and weekly log that includes rating the effectiveness of the mentor’s feedback.

“The program worked out quite well for us,” Jewell said.

**Distinct from training**

Nicole Kotak, Training Manager, Medical Transportation Coordination Centre (MTCC), Brandon, Manitoba (Canada), started as a frontline EMD in 2013 and is in her 12th year as a field paramedic. While doing both might take some juggling, she figured the back and forth shouldn’t be too hard. After all, both required the EMS skills she applied in the field. Kotak soon learned the complexities of two different worlds: visual contact and verbal contact.

“Working on my own [in the communication center] was hard,” she said. “Though both follow structure and protocol, I have to be very aware of which hat I am wearing.”

Kotak was drawn to the MTCC System Status Controller training program, which focuses on dispatching EMS resources across Manitoba and coordinating response by the allied EMS agencies. MTCC responds to emergency medical calls forwarded from the Provincial Public Safety Answering Point in Brandon.

She is comfortable in that role and, like changing hats from the field to the floor, she is attuned to the differences between training and mentoring.

“As a mentor, I think about what helped me and how that might help the individual,” Kotak said. “It’s about listening and understanding and acknowledging concerns.”

Training and mentoring do share similarities. Both are considered formalized practices in business and educational settings, and both foster knowledge. Differences in setting determine specifics of delivery. Using paramedics and EMDs as an example, their common goal is ensuring patients in their care are given access to the right treatments, in the right settings, as quickly as possible. They just go about it differently because of their purpose in the chain of response.

The same goes for training and mentoring. They complement one another but occupy contrasting tiers in professional growth.

Training is geared toward developing a general competency in a group of individuals, such as ProQA® training before going live with the software. Training tends to be impersonal and presented in a broader context of group application. The group benefits as a whole through the trainer’s instruction and formal practice to apply the task.

Mentoring is more one-on-one. The mentor is more of a confidante, the person the new EMD can approach to discuss specific challenges, such as clarifying toggling between languages using ProQA although the topic was already covered in training. The individual benefits through the mentor’s insight and knowledge and grows in personal responsibility.

Mentoring allows the training to concentrate on performance and provides an entry for the apprentice into the center’s culture.

“There’s almost immediate buy-in,” Kotak said. “Mentoring motivates. New people feel that the agency cares about them. They matter to the organization.”

**Recognizing potential**

A mentor can also better recognize an individual’s potential, Todd said, and the mentor often discovers personal attributes that contribute to his or her professional growth.

“Mentoring empowers the existing EMDs and helps new EMDs,” Todd said. “It brings both the new and established EMD to a higher level of competency and confidence. It brings a greater depth of understanding.”

Mentors focus on what the IAED™ does best—protocols and process—to make the transition to the Medical Priority Dispatch System™ (MPDS®) smoother for the new EMD.
The mentor knows not to sandwich criticism of a false assurance between praise for the tone of voice used and following Key Questions. The mentor would instead ask the emergency dispatcher to assess performance, tell what was observed (including the false assurance), and ask the emergency dispatcher why that is unacceptable and what a correct alternative would be.

There is an explanation, and the mentor has an opportunity to say, “Hey, this is something I did, and this is how I learned to fix it.”

**Mentoring process**

Details of time, process, and approach depend on the agency.

MTCC shares the responsibility of a new EMD among several mentors to present more than one perspective, and the mentors are generally in supervisory roles.

“This is somebody who really wants to do a good job and help others to do the same,” Todd said. “They are aware of quality assurance standards and confident in what they do.”

Hands-on and two-sided is the approach used by Urgences-santé Health Communication Centre (CCS), Montreal, Quebec, Canada. After an initial internal four-week training program that includes EMD certification, an internship supervisor and new EMD are paired for a total of 10 shifts.

The mentor documents performance, and the EMD keeps a logbook. The documents and logbook entries are compiled daily into reports that rate the EMD’s performance in several areas (e.g., “well done” or “not so well done”) and recommended methods for improvement. An instructor-reviewer is next assigned to the EMD, and they meet every two weeks, regardless of performance.

“The whole probation period supports the new EMD’s development,” said Almendra Galland, Director, Quality Department of Prehospital Care and Teaching, Urgences-santé CCS. “The goal is to instill best practices.”

Todd said the importance of having a mentor—and having the tools to teach others how to be mentors—cannot be overstated. It’s a two-way street.

“Mentoring is not following a script,” Todd said. “This is staff helping staff. Mentors think about what helped them. Everybody gets a better shot out the gate.”

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**RESEARCH WORKSHOP IN LAS VEGAS?**

*No really.*

The IAED®, in collaboration with the UCLA Prehospital Care Research Forum and FirstWatch, will be conducting a two-day Research Workshop at NAVIGATOR 2018.

Learn how to generate a question, gather and analyze data, and publish research. This workshop is open to anyone interested in dispatch research.

“I discovered that I would actually be conducting research on an idea of my own from start to finish ... Meeting everyone and developing the research process was more than I had anticipated and I’m very glad I said ‘Yes.’”

—Dawn Faudere

“You can expect to learn a systematic approach to research in a judgment free arena, the tools and experience needed to complete it, and a support system that is unparalleled.”

—Rich Lindfort

Questions? Email Isabel Gardett at isabel.gardett@emergencydispatch.org or David Page at dpage@emsed.net.
MENTORING 101
What does it take?

Here are answers to some of the questions you might be asking.

What makes a good mentor?

As multiple studies and professional development organizations agree, a good mentor is willing to share skills, knowledge, and expertise for the benefit of the mentee. Good mentoring requires follow through, approachability, diplomacy, and fairness.

What does an EMD Mentor do?

The role depends on the agency, taking into account staffing needs, local policies and procedures, and recommendations from local Dispatch Review and Dispatch Steering Committees. Confidentiality, however, is the one tenant that should be consistent no matter the agency’s staffing, budget, and policies. A mentor should be someone the mentee can approach for advice, instruction, coaching, and counseling without fear of reprisals.

What are the roles and responsibilities of an EMD Mentor?

These are too numerous to list, but include: explaining; the ability to listen and establish a relationship of trust and respect; describing the protocol process and selection and its importance to responders, callers, bystanders, and the emergency dispatch professional; detailing compliance and performance standards; showing how to recognize and alleviate stress; outlining requirements of continuing dispatch education and certification; and emphasizing the importance of customer service.

What are the stages of mentoring to emphasize?

Laying the foundation: Boundaries are set as to what each expects of the relationship, and it develops to a point where the mentor and mentee can discuss issues safely, openly, and honestly.

Clarifying where they are going: The mentor and mentee develop a plan. This is the most time intensive stage, and the mentor focuses on several topics (detailed information about the MPDS, control room benefits and issues, and providing insights into the profession).

Helping the mentee grow: The mentor acts as a counselor and guide and encourages the mentee to find answers on his or her own. Their relationship moderates in line with the mentee’s progress.

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<td>Educates—how to accept feedback, technical abilities, customer service</td>
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PULL UP A PODIUM
IF YOU’VE GOT DATA, WE WANT YOU TO SHARE IT!

Chances are, if you’ve learned something at your agency, others have had the same question, so come present your data or findings and help others improve their centers as well.

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We’ll help you prepare for a poster presentation at NAVIGATOR 2018
THIS TIME IT’S PERSONAL

It’s double pressure when taking calls from family and friends

Josh McFadden
when the call is personal
On Sept. 1, 2017, at 12:30 p.m., Jourdyn Abplanalp, an emergency dispatcher with Utah Valley Dispatch Special Service District in Spanish Fork, Utah, USA, took what some may consider a routine call.

The caller reported that her grandfather hadn’t been out of bed for three days. He was breathing, awake, and alert. He complained of weakness. The caller wasn’t sure what to do but knew the elderly patient needed help. Abplanalp went to Protocol 26: Sick Person and asked the Key Questions.

A simple call, right? Not quite.

The caller was Abplanalp’s sister, making the patient the emergency dispatcher’s grandfather.

While this scenario isn’t a frequent occurrence, it’s not out of the ordinary, especially in rural areas. Whether an emergency dispatcher takes one emergency call from a loved one once during his or her career, or whether it happens multiple times, it’s no doubt a unique situation that tests the mettle, professionalism, and composure for even the most skilled and experienced emergency dispatcher.

**Treat them just the same**

Fielding emergency calls where lives are on the line is difficult enough. Complicate matters by throwing family or friends into the mix, and who could blame an emergency dispatcher for panicking or not being at his or her best?

Of course, sometimes, the emergency dispatcher treats a personal call almost flawlessly.

Abplanalp handled her personal call so well that Quality Improvement Specialist Brenda Argyle, who reviewed the call, didn’t even realize the caller and patient were related to Abplanalp.

“In listening to the call, there was only a slight indication Jourdyn [knew] the caller and the patient,” Argyle said.

Abplanalp’s sister called the admin line at the center and asked directly for her. Abplanalp therefore knew this would be a unique call before hearing her sister say a word. Yet, unfazed, she did her job precisely as she was trained. She followed the protocols and provided excellent customer service.

“Jourdyn asked Key Questions as written and appropriately clarified to get the necessary information when the caller did not give a definitive answer,” Argyle said. “Jourdyn asked if the patient was on oxygen and added that information to the call, which prepared responders for necessary equipment needed for the patient. [She] did not hesitate to check the rate of breathing, and when the caller asked how she was going to do that with the oxygen on, she continued providing the diagnostic as written, which was understood. The rate of breathing was correctly calculated to be effective.”

Though her sister wasn’t sure of the gravity of the situation, Abplanalp realized her grandfather’s condition might be worse than it appeared. She processed the call immediately, which Argyle said saved his life. An ambulance picked up her grandfather, and while it was en route, paramedics informed hospital emergency department doctors that the patient was “in full code.” Abplanalp realized her grandfather was in critical condition.

“He’s alive today because Jourdyn processed the call without delay,” Argyle said.

Abplanalp’s calm demeanor in such a personal moment puzzled even Argyle. In a later meeting between the two, Abplanalp told Argyle how she maintained such a level head while her grandfather was struggling for life.

“I asked Jourdyn how she was able to switch roles from a granddaughter to an EMD,” Argyle said. “She said it was hard to do, but she pretended she didn’t know
who the caller was. This creative thinking allowed Jourdyn to remove herself emotionally from the call to provide the utmost care through use of the protocols.

Argyle praised Abplanalp for not only meeting quality standards for the call but doing so in unusual circumstances where it would be easy to ignore the protocols and go into granddaughter or sister mode.

“Jourdyn faced her own emotional pressures and demonstrated her level of expertise by steadfastly honoring the use of the protocols,” Argyle said. “It can be so frustrating not being able to physically help a loved one. The presence of Jourdyn on the phone, using a tone of voice that was calm and consistent, provided a soothing atmosphere for her sister. When loved ones are involved, making clear decisions can be skewed. It takes a great deal of self-discipline to stick to a script, especially when someone you know is involved.”

Dale (Illinois, USA) Police Department, was on duty alone in the comm. center, waiting for an officer to bring him some dinner from a nearby Taco Bell. Wood Dale dispatched for the city’s police and fire departments but did not provide EMD services.

The phone rang, and Gruenwald had an eerie feeling when he read the screen. He saw his last name.

“My last name isn’t exactly common, so I knew it had to be a relative,” he said. “I heard my aunt’s voice on the other end of the line, somewhat frantic that she needed an ambulance. I asked a couple of times what was going on, and she wasn’t answering my question until I almost yelled her name into the phone. There was a brief pause, followed by, ‘Matthew?’ ‘Yes, Auntie Yura. Now what’s going on?’ Then she was finally able to tell me that my oma (grandmother) was having a stroke.”

Gruenwald told his aunt to gather all his grandmother’s medication and that help would soon arrive. He dispatched the fire department; in accordance with the center’s policy, police officers went to the scene as well.

This was a call he’d never forget.

“There aren’t many dispatches that I clearly can remember verbatim over the last 18-plus years of dispatching,” he said. “This is one. I remember staring at the console as I dispatched. I even remember what part of the console I stared at while I dispatched the fire department.”

Gruenwald listened to fire department and police communication for an update on his 90-year-old grandmother, but it didn’t come for an agonizing several minutes. The police officer on scene didn’t believe Gruenwald’s grandmother was going to survive.

The ambulance took the patient to the hospital, and the officer, who had previously been an emergency dispatcher, came to the comm. center to give Gruenwald a break. The emergency dispatcher originally scheduled to take over for Gruenwald came in four hours early so he could go to the hospital to visit his grandmother.

When he arrived at the hospital, his grandmother was in the emergency room. She was admitted to the hospital and stayed there for a few days. She would never go home again. His grandmother went to a nursing home where she passed away a few years later.

The call was emotionally draining.

“I believe the first thoughts [after taking the call] were something along the lines of ‘This isn’t happening. This...”
isn’t happening. This isn’t happening,” he said. “I remember feeling numb during the call. It helped keep my emotions in check during the call. That feeling stayed with me for a while. Even when I went to the hospital, I was still in full police-style uniform. So that isn’t a time to let your professionalism down. It wasn’t until several hours later, when I finally got home, that I felt feelings again. I sat in my basement and played the call through my head over and over. I did what I could do during the call. I did the best I could.”

Gruenwald has since moved on to a different position. He is currently a public safety telecommunicator with Southeast Emergency Communications (SEECOM) in Crystal Lake, Illinois (USA), an EMD ACE, where he has been since November 2015. Over the years, many people have asked him how he remained calm and professional during such a close-to-home call. His response: “What are my other options?”

“Think about the alternative,” he said. “If I lose my cool, what’s going to happen? If I become too emotional to handle the call properly, then anything bad that happens, I have to live with ‘what-if’ for the rest of my life.”

**Tragedy at home**

In October 2017, in Clark County, Arkansas (USA), emergency dispatcher Denise Chamberlin got a devastating call no one wants to receive. Her husband, Cecil, knowing his wife had answered the phone, reported that the couple’s house was on fire.

From the online publication arkansasmatters.com, one can read an excerpt of the gut-wrenching call:

Denise: “911, where’s your emergency?”

Cecil: “The [expletive] house is on fire, Denise!”

Denise: “OK. I’ve got ’em coming! Our house?”

Cecil: “Yes! It’s our house!”

Denise: “OK, I’ve got them coming!”

Tragically, the fire destroyed almost everything the couple owned. Crews were able to save a henhouse and chickens on the property.¹

Denise Chamberlin sat in shock immediately following the call. She noted how surreal it was to dispatch the fire department to her own home. However, in the days after the incident, she maintained a positive outlook, which she said is critical when handling a personal call of this magnitude. Recognizing that her husband was fortunate to be alive gave her perspective.

Fellow emergency dispatchers and community members have lent their support to the family, which also helped Denise Chamberlin get through this horrible event.

**How to prepare**

Emergency dispatchers receive long and intense training to prepare for the wide range of calls they’ll handle in their career. Anyone who has ever been under the headset understands the importance of this instruction as well as the importance of receiving valuable feedback and guidance from seasoned veterans, managers, and quality assurance professionals.

But how can one possibly be ready to tackle a call when your sister calls about a barely responsive grandfather, when an aunt reports that your grandmother has had a stroke, or when your own exasperated husband calls, frantically telling you that flames have engulfed your house?

“Don’t believe it won’t happen to you,” Gruenwald said. “You owe it to yourself, and you owe it to your family. Prepare. Practice. We are supposed to be a calming voice to our everyday callers. Having you on the other end may be even more so when the caller is a personal connection. So concentrate on the positive. This call may be more stressful for you, but focus on the extra good you’re bringing to them. And in the end, would you want anyone else handling that call?”

**Source**

300,000+ STUDENTS boycotted classes and blacked bridges in protest of a 75% tuition hike in 2012 in Quebec, Canada.

240 MILES were marched by Gandhi and his followers in order to protest the repressive salt tax imposed by the British.

15,000 SENIOR CITIZENS gathered to protest the end of their over-70s medical card in 2008 in Dublin, Ireland.

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600+ RALLIES in protest of President Donald Trump were held worldwide on Jan. 21, 2017.

250,000 PEOPLE participated in the Washington (D.C.) Civil Rights March in protest of racial inequality in August 1963.

92,000 POUNDS of tea were dumped into the harbor during the Boston Tea Party.

40,000+ PEOPLE including Aborigines and non-Indigenous supporters marched in Sydney, Australia, in January 1988 in protest of Australia Day ignoring the existence of Indigenous people.

200,000 PROTESTORS crowded into Trafalgar Square in London, England, in 1990 to protest a poll tax.

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TAKING A STAND

Sources
4. https://socialistworker.co.uk/art/40250/Thatchers-downfall--25-years-since-the-poll-tax-riot
6. https://www.theatlantic.com/photo/2012/06/the-montreal-protests-4-months-in/100315
The right to assemble is acknowledged as a human right by the United Nations and is outlined in most democratic constitutions. People across the world have the right to gather together in public to express dissatisfaction with current events or to convey solidarity with their communities.

But what happens when an assembly of people turns into something else? In November 2014 in San Diego, California (USA), a group of protestors blocked traffic on a highway for hours, causing major traffic delays. In July 2017 in Hamburg (Germany), a group of protestors brought the entire city to a standstill as they faced off with police. In August 2017 in Charlottesville, Virginia (USA), a man drove his car into a crowd of counter-protestors, killing 1 person and injuring 20 others. These are just three of many examples of assemblies of people escalating into a public hazard.

This CDE discusses how you, as an Emergency Police Dispatcher (EPD), should handle calls reporting protests, vigils, riots, or any other public assembly. Protocol 113

A call reporting a gathering of any kind—whether violent or not—should be handled on Protocol 113: Disturbance/Nuisance and classified as a DISTURBANCE. A DISTURBANCE, as defined in the Additional Information section of the Police Priority Dispatch System™ (PPDS™), is “Any act causing disquiet, agitation, or interruption of the peace and quiet.”

Whether or not the DISTURBANCE will be classified as physical or verbal depends on what’s being reported. It’s fairly straightforward. A group of people holding signs and chanting—or something akin to that—is an example of a verbal DISTURBANCE, while a group of people exchanging blows with others is an example of a physical one. People blocking a public sidewalk would be classified as verbal because even though they are physically impeding pedestrians, they are not being violent.

The issue of protestors being on private property is handled on Protocol 133: Trespassing/Unwanted.

According to Kelly Sparks, Deputy Director of Peace Officer Standards and Training for the state of Utah, most protest organizers will get permits to demonstrate in public areas, such as in parks or on sidewalks. If that is the case, you can do a computer check to see if a protest has been scheduled at the time you receive a call reporting one. There will usually be officers on civil standby if a protest has been scheduled, which means that officers will be in the area, allowing people to exercise their rights but making sure that things don’t get out of hand.
of hand. In some situations, there will even be a command center at the scene. However, even if a protest has been scheduled, pay close attention to what the caller is telling you. Are they reporting that the protestors have begun exchanging blows with counter-protestors, the police, or even each other? Are they reporting protestors in a different place than is outlined on the permit? You shouldn’t assume that because a caller is reporting a protest, it is automatically a protest you and the police are already aware of. Even if it becomes clear that they are reporting an already-licensed protest, they could still have valuable information and insights that no one else has reported.

Incident priority

The first Key Question on the DISTURBANCE sub-Chief Complaint is, “Were weapons involved or mentioned?” This is because PPDS incident priority No. 1 is officer/deputy safety, closely followed by caller safety. The presence of weapons greatly increases the opportunities for violence, and officers need to be aware of the situation they’re going into.

In the earlier versions of the PPDS, the caller’s safety was prioritized over that of the police officer. However, Chris Knight, a member of the IAED™ Police Council of Standards, said the Police Council of Standards found that prioritizing caller safety was less effective in containing the situation overall than prioritizing officer safety. The officers cannot help the caller if they themselves have been injured. Keeping officers safe is a large part of doing everything EPDs can to keep the caller—and the public at large—safe.

The second Key Question is “How many people are involved?” This is to give the police a general idea of how many officers they’ll want to send out. A gathering of three or four people will not warrant the same response as a gathering of five hundred. However, the number of people in the gathering will not change the Determinant Code.

One of the many changes made between version 5 and version 6 of the PPDS is the shift from determining whether a disturbance is caused by a large group or an individual/small group, to only determining whether the disturbance is physical or verbal. Version 5 had the emergency dispatcher differentiate between a large group (generally more than five people) causing a physical or verbal disturbance and a small group or an individual causing a physical or verbal disturbance. This separation has been done away with in version 6 because, according to Knight, “user agencies [reported] that they did not respond any differently if the group was large or small.”

You shouldn’t assume that because a caller is reporting a protest, it is automatically a protest you and the police are already aware of.

While getting a description of every person in the crowd might be helpful, it’s not practical. Knight advised EPDs to be sure to get descriptions of people holding weapons and of the weapons themselves. If there are multiple people with a variety of weapons, the EPD should get as much information as possible, especially if more than one person calls it in.

Sparks says another thing to think about is that the size of the gathering is a public safety issue, especially in the area of traffic control.

Blocking traffic

As with the protestors in San Diego and in countless other places and instances around the world, sometimes a group of people will express their views by blocking traffic. It’s an inconvenience at best and a traffic hazard at worst, but no matter the outcome, it is likely that someone will call 911 to report it.

Both Sparks and Knight agree that even if protestors are blocking traffic, the call should be handled on Protocol 113, rather than Protocol 132: Traffic Violation/Complaint/Hazard. It goes back to Chief Complaint Selection Rule 1: “When multiple crimes are reported, choose the protocol that best addresses the primary event.” In this case, the primary event is the protest. The context surrounding the traffic hazard is important. The police will handle protestors blocking traffic differently than they will an overturned semi-truck blocking traffic.

An important thing to remember when handling calls regarding protestors blocking traffic or any other traffic-related call is that the caller might not be able to give you an exact address. They might only be able to give you a crossroads or an approximate area. Don’t get hung up on getting an exact location. Instead, find out as much as you can. Are they northbound or southbound? Can they see any landmarks? Can they actually see the protestors on the road or are they going on what other people are saying?

A step beyond assembly

What about the case of the man who drove his car into a crowd of counter-protestors in Charlottesville? Would that 911 call still be handled on Protocol 113? No. In regard to that incident, Knight said, “It moves beyond [Protocol] 113 and becomes [Protocol] 106 for an assault with a weapon. It’s becoming increasingly common for terrorists to commit violent acts with cars as their weapon. The answer to the question ‘What type of weapon?’ would be a description of the car.” The EPD should shunt from Protocol 113 to Protocol 106: Assault/Sexual Assault while still informing the police that it happened in a protest or riot setting.

This is also true in instances when a public gathering turns into looting, like
a protest in Charlotte, North Carolina (USA), in 2016 in which protestors started by blocking traffic on the interstate and then began breaking into semi-trucks and taking goods out. Some of the looters were taking the goods; others, however, were merely throwing the goods onto the road.

If people who were formerly protestors begin stealing things from nearby stores or homes, the EPD should go to the most appropriate protocol. Theft from a person using a weapon or fear to coerce a victim is handled on Protocol 126: Robbery/Carjacking. Theft from a store that is closed or an empty private residence is handled on Protocol 110: Burglary (Break-and-Enter)/Home Invasion. Theft from a store that is open is handled on Protocol 130: Theft (Larceny).

As mentioned before, you, the EPD, should be sure to give the police as much information as you can about the situation surrounding the primary event. Let them know that the crime being reported has stemmed from a public gathering of some sort. It’s likely that there will already be officers on the scene.

Shooting situation

In the United States in 2016, demonstrations were the fourth leading circumstance of fatal officer shootings (following domestic disturbance, suspicious persons, and attempted arrest). Five officers were killed in the ambush attacks in Dallas, Texas (USA), in July as a sniper opened fire on officers who were overseeing a peaceful march that was taking place. That would not qualify as a physical DISTURBANCE, even though the circumstance surrounding the shooting was a protest.

Should you get a call like that, you should immediately dispatch the Determinant Code 136-E-1 and open Protocol 136: Active Assailant (Shooter) after giving Case Entry PDL-b: “I’m sending help to you now. Stay on the line.”

Even if the caller is in danger, in an active shooter situation you will not go to the CALLER IN IMMINENT DANGER protocol. This is specified in the CALLER IN IMMINENT DANGER definition on Case Entry. CALLER IN IMMINENT DANGER is “a situation that places the caller in immediate danger of death or serious injury that does not involve a[n] [...] ACTIVE ASSAILANT (SHOOTER).”

Time to call a SWAT team?

There’s a common misunderstanding of the primary roles between a Special Weapons and Tactics (SWAT) and Riot or Crowd Control Team, and their deployment during incidents of civil unrest, such as the protests in Ferguson, Missouri (USA), in 2015. According to Shawn Messinger, a former SWAT team Commander, usually a riot or crowd control team will be utilized during these events whenever possible. The differences between the groups come from the varied training and tools a SWAT team receives as opposed to those a Riot Control Team receives, though there are some agencies that have team members who are cross-trained to do both SWAT and riot control work.

SWAT’s training and tools are focused more on tactical intervention—like finding an active assailant or making a tactical entry into a building—rather than on controlling large crowds. The equipment and training utilized by Riot Control Teams generally have less potential to be lethal than the tools used by SWAT teams. Some of the tools are the same, but each of the training programs has a different overall focus.

Although SWAT teams aren’t generally called to handle protests, there are exceptions to the rule. Once a protest or a riot reaches a certain point, a SWAT team will often be called in to handle it. In the Ferguson situation, for instance, SWAT was utilized to help contain the incident and attempt to protect local businesses.

SWAT will not be called in to handle most protests, especially not ones that are classified as a verbal DISTURBANCE. It’s far more likely that an EPD will be involved by taking the call in a communication center. So whether it’s protestors blocking traffic or looting trucks on the freeway, may your next protest-related call go smoothly.

Source

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

1. A call reporting a gathering of any kind—whether violent or not—should be handled on:

2. What is an example of a physical DISTURBANCE?
   a. A group of people blocking a public sidewalk
   b. A group of people exchanging blows
   c. A group of people holding signs
   d. A group of people chanting

3. PPDS incident priority No. 1 is:
   a. additional information.
   b. apprehending suspects.
   c. caller safety.
   d. officer/deputy safety.

4. The change from determining whether a disturbance is caused by a large group or an individual/small group, to only determining whether the disturbance is physical or verbal, happened between versions _____ in the PPDS Protocol.
   a. 3 and 4
   b. 4 and 5
   c. 5 and 6
   d. It has not changed.

5. Even if protestors are blocking traffic, the call should be handled on Protocol 113: Disturbance/Nuisance rather than Protocol 152: Traffic Violation/Complaint/Hazard.
   a. true
   b. false

6. Which Chief Complaint Selection Rule says, “When multiple crimes are reported, choose the protocol that best addresses the primary event”?
   a. Rule 1
   b. Rule 2
   c. Rule 3
   d. Rule 4

7. If a person were to drive a car into a crowd of counter-protestors, the situation would move beyond Protocol 113: Disturbance/Nuisance and become Protocol:
   a. 106: Assault/Sexual Assault.
   b. 111: Damage/Vandalism/Mischief.
   c. 131: Traffic/Transportation Incident (Crash).
   d. 132: Traffic Violation/Complaint/Hazard.

8. Under what circumstances should an EPD shunt from Protocol 113: Disturbance/Nuisance to another Chief Complaint?
   a. Theft from a person using a weapon or fear to coerce the victim.
   b. Theft from a closed store or private residence.
   c. Theft from a store that is open.
   d. All of the above

9. In the United States in 2016, demonstrations were the _____ leading circumstance of fatal officer shootings.
   a. second
   b. third
   c. fourth
   d. fifth

10. A SWAT team will always be called in to handle a riot.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 02/28/19. 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.
RESPONSE NOW
ECHO reverberates across disciplines

IAED Staff

The ECHO-level Determinant was “one of the most exciting” changes to the Medical Priority Dispatch System™ (MPDS®) when introduced in v11.0, according to Brett Patterson, IAED™ Academics & Standards Associate and Medical Council of Standards Chair.

“ECHO-level dispatch is sent directly from Case Entry, and that provides the EMD with the means to dispatch earlier in the interrogation sequence,” Patterson said. “It is used when certain life-threatening conditions are clearly evident.”

Even though a rapid dispatch is associated with the ECHO level, the most valuable aspect of ECHO is the ability to assign non-standard responders that can reasonably make a difference in the outcome of a dying patient. It provides agencies with the means to assign response-capable units that would not normally respond to typical EMS calls (e.g., AED-equipped police and fire vehicles, HAZMAT, and ladder crews). ECHO-initiated crews must be, at a minimum, BLS trained and understand scene safety entry procedures.

For example, a non-standard responder trained in CPR and arriving at the scene within minutes of a call could make a difference for a patient in imminent arrest. In certain cardiac arrest situations, the prompt application of a defibrillator, or AED, can save a dying patient’s life. While in most cases CPR itself doesn’t reverse the patient’s cardiac arrest, it does prolong the window of viability needed for a successful defibrillation. To use an old farmer’s term, it’s like “priming the pump.”

A perfect reason for an ECHO response—that ends happily—started off with a joke that suddenly and unexpectedly turned nearly tragic.

According to the story on DevonLive:¹ A 28-year-old angler was messing around with his friends while fishing at night on Boscombe Pier, Bournemouth, England. He had just caught a 14-centimeter (5.5-inch) long fish and held it over his mouth for a joke.

But the Dover sole wiggled free and dived straight down his throat—causing a complete obstruction. He stopped breathing.

His friends called 999, and an ECHO response sent paramedics from the South Western Ambulance Service National Health Service Foundation Trust directly to the emergency.

According to SWAS Specialist Paramedic Matt Harrison, who arrived on scene, they had to do something fast, knowing the patient would not survive the short trip to hospital.¹ With the first clinician on scene in less than two minutes, friends directed the crew to where another friend was already
Performing CPR, listening to directions from an EMD after calling 999. The patient was in a desperate state, with a blocked airway and in cardiac arrest.

Paramedics continued CPR and once the pulse returned – after three minutes – they readied the patient for transport by ambulance and, further reassessment of the patient once in the ambulance, indicated further deterioration.

Harrison knew he had to get the fish out and in one piece, an extremely difficult task with the fish’s barbs and gills getting stuck on the way up during repeated attempts. On the seventh attempt, Harrison had his fish. Upon arriving at the Royal Bournemouth Hospital Emergency Department the patient had responded well enough to answer a few basic questions. He survived without lasting injury.2

**Prioritize response**

ECHO response is designed to prioritize the response (send the closest available unit immediately to the scene), while the emergency dispatcher provides Dispatch Life Support Instructions to assist patients/victims (sometimes referred to as a “zero-minute response”) until responders arrive. Both measures attempt to provide immediate assistance.

In the cardset, all protocols with at least one ECHO Determinant Code are highlighted with a short purple-colored stripe on the protocol tab; the eight Chief Complaint Protocols with ECHO codes are 2, 6, 7, 9, 11, 14, 15, and 31. ECHO codes exist on Chief Complaint Protocols that also have DELTA codes. DELTA codes may include life-threatening situations similar to those coded as ECHO, but scene safety considerations may require specifically trained crews or specialty resources that require more preparation. Additionally, ECHO codes are limited to those life-threatening emergencies where a single rescuer can make a difference in the patient’s outcome (e.g., the application of an AED in a cardiac arrest situation or the Heimlich maneuver for a choking patient). ECHO-level codes are not typically available for trauma patients due to viability and risk/benefit reasons.

Because they can be applied directly from Case Entry Protocol, ECHO codes give EMDs a means to dispatch response early in the interrogation sequence when certain life-threatening conditions are clearly evident.

While both ECHO and DELTA codes indicate a potentially critical, time-sensitive situation, ECHO is limited to those extreme situations that will most likely benefit from “the absolute closest response of ANY trained crew,” even if that crew is non-standard for most EMS calls, or is not the most economical.

**ECHO is limited to situations most likely to benefit from the absolute closest response of ANY trained crew.**

ECHO codes also allow for the assignment of non-standard responders to specific time-sensitive, life-threatening emergencies when appropriate. Agencies that have vehicles with appropriately trained responders who do not normally respond to typical EMS calls can use ECHO-level codes to assign these non-standard resources to a limited number of critical calls in which such resources may be of great benefit. These units might include fire or police vehicles and specialized rescue teams.

**Case Entry assignment**

ECHOs are the only Determinant Codes assigned during Case Entry. After hearing the caller’s description of what happened, you may conclude that an ECHO response should be initiated right away. This will be the case if the patient is experiencing one of the ECHO-level problems listed after the complaint description question, “Okay, tell me exactly what happened”:

- Obviously NOT BREATHING and Unconscious (non-traumatic)
- Hanging, Strangulation (no assailant involved), Suffocation
- Underwater (DOMESTIC rescue)
- Person on fire

In most ECHO situations, the emergency dispatcher should initiate the ECHO response, provide all appropriate Case Entry PDIs, and return to Case Entry questioning. PDI-a is appropriate for all ECHO cases to reassure and help the caller focus on the instructions that follow: “I’m sending the paramedics to help you now. Stay on the line.” PDIs b through f are incident specific:
- b. Hanging and not OBVIOUS DEATH
- c. Underwater
- d. Strangulation and not OBVIOUS DEATH
- e. Suffocation
- f. Person on fire

The final Case Entry PDI, PDI-g, is not specifically intended for ECHO situations. An EMD can provide PDI-g whenever a caller seems to be in critical danger due to scene safety: (“If it’s too dangerous to stay where you are, and you think you can leave safely,) get away and call us from somewhere safe.”

For most ECHO situations, completing Case Entry Questions and linking to the appropriate Chief Complaint Protocol is essential for assessing scene safety issues and even more critical if sending non-standard responders to the scene.

However, in the case of a patient who is obviously not breathing and unconscious (non-traumatic), the emergency dispatcher will bypass further questioning and PDIs and then utilize a Fast Track directly to Pre-Arrival Instructions for airway/arrest/choking (unconscious) instructions (NABC-1).

Keep in mind that patients in cardiac arrest may require the use of an AED. MPDS v13.0 includes Brock’s Law, which states: “The presence of an AED does not ensure its use – the EMD does.”

In May 2012, 16-year-old Brock Ruether collapsed from sudden cardiac arrest (SCA) during volleyball practice.
People on scene called 911 and started doing CPR, and the EMD asked if there was a defibrillator nearby, and there was. Unfortunately, the AED sat unused by Brock’s side as he died.

**Determinant Levels**

The MPDS Determinant Levels—ECHO, DELTA, CHARLIE, BRAVO, ALPHA, and OMEGA—do not change. Determinant Codes are determined and maintained by the Academy’s College of Fellows, according to current medical practices, user feedback, and ongoing evaluation. The Response Assignment is determined and maintained by each agency according to its available resources, user feedback, and ongoing evaluation. Defining Response Assignments is the responsibility of each agency’s medical director, Medical Dispatch Review Committee, and Steering Committee.

EMS systems implementing the MPDS must understand that the system can designate responses to each determinant as best fits their needs. Each EMS system must decide which resources the six Determinant Levels, and their associated descriptors, best require. In a properly established priority dispatch environment, the code and response areas of the system work together to ensure that EDs choose the most appropriate clinical determinant and assign the most appropriate responses.

**Five rules**

There are five considerations to remember when local Medical Control and EMS administration assign actual response assignments and emergency modes to the MPDS Determinant Codes.

1. When a person’s life clearly depends on quick action and rapid motion, the use of lights-and-siren is an important tool. However, often situations that appear urgent may not be helped by the few seconds saved using lights-and-siren, especially considering other delays before the patient benefits from definitive care.

2. How much time can be saved driving in lights-and-siren mode?

   When a person’s life clearly depends on quick action and rapid motion, the use of lights-and-siren is an important tool. However, often situations that appear urgent may not be helped by the few seconds saved using lights-and-siren, especially considering other delays before the patient benefits from definitive care.

   When the patient gets to the hospital, will the time saved be significant compared with the time spent waiting for care such as X-rays, lab tests, etc.?

   This is the most ignored rule. When the critical needs of the patient warrant the fastest possible response time to the hospital, proper advance notification of the emergency department staff results in immediate, continuing definitive care after arrival. However, except for the most critical cases, the majority of patients do a great deal of waiting. This process can take many hours and requires much endurance. Did the few seconds saved riding HOT (lights-and-siren) help? In essence, was it medically ethical when considering the risk of emergency vehicle collisions or wake-effect collisions for others on the road?

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YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

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

1. The most valuable aspect of ECHO is the ability to:
   a. put all other calls on hold.
   b. send every available resource.
   c. assign non-standard responders that can reasonably make a difference in the outcome of a dying patient.
   d. focus on the crisis of one patient, to the exclusion of others.

2. In the cardset, all protocols with at least one ECHO Determinant Code are highlighted with:
   a. an inverted orange triangle on the protocol tab.
   b. a short purple-colored stripe on the protocol tab.
   c. a red telephone on the protocol tab.
   d. a check mark on the protocol tab.

3. What is the number of Chief Complaint Protocols with ECHO codes that also have DELTA codes?
   a. Two
   b. Four
   c. Six
   d. Eight

4. ECHO codes give EMDs a means to dispatch response:
   a. immediately and prior to beginning interrogation.
   b. during Case Exit.
   c. in any pre-hospital emergency.
   d. early in the interrogation sequence.

5. Which Determinant Code(s) can be assigned at Case Entry?
   a. CHARLIE and DELTA
   b. DELTA
   c. DELTA and ECHO
   d. ECHO

6. An EMD can provide PDI-g whenever a caller:
   a. seems to be in critical danger due to scene safety.
   b. verbally demands immediate attention.
   c. refuses to answer questions.
   d. does not understand the full extent of the situation.

7. MPDS v13.0 includes Brock’s Law, which states:
   a. “Hurts to breathe” is not considered difficulty or abnormal breathing.
   b. Don’t take more victims to the scene.
   c. The science of medial dispatch requires non-discretionary compliance to protocol.
   d. The presence of an AED does not ensure its use—the EMD does.

8. The Response Assignment is determined and maintained by:
   a. the IAED.
   b. the agency.
   c. the state emergency communication board.
   d. separate ambulance services.

9. The response configuration example in Principles of EMD Response designate CHARLIE-level response as:
   a. closest advanced life support unit COLD.
   b. closest basic life support unit HOT.
   c. closest apparatus of any kind HOT, ALS responders HOT.

10. When a person’s life clearly depends on quick action and rapid motion, the use of lights-and-siren is an important tool.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 02/28/19. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please retain your CDE letter for future reference.
SAVING LIVES?
Deflating the EMS myth

Jeff Clawson, M.D.

When Kate Dernocoeur, co-author of the “Principles of Emergency Medical Dispatch,” sat down to write a column for JEMS, she might have wondered if anyone would hear what she wanted to say. This wasn’t her first article after all—she was a frequent JEMS contributor at the time.

Without a doubt her Guest Comment column in 1986 definitely proved that she was being heard loud and clear. But that didn’t mean that everyone agreed with her.

Dernocoeur was greeted with a reader firestorm because her words hit a nerve in EMS-land—as they were intended to. She offered a wake-up call for those working in EMS: that those in it just to save lives would be sorely disappointed.

Dernocoeur stated that to actually save a life was—and is—wonderful but rare, and that the notion of that as a sole purpose for rescuers needed dispelling because of its disabling tendencies.

The point Dernocoeur wanted to hit home was that EMS is actually a service provided to communities by helping people with problems that they are unable to handle alone. It’s not all about saving lives; sometimes it’s about making a scary event more manageable for those you’re helping.

Dernocoeur delves into several reasons why she wanted to deflate the myth. Read this month’s Blast From the Past to learn more and understand why what she penned 31 years ago still applies today.
Guest Comment

The “We Save Lives” Myth

by Kate Dermooceur

There’s a notion that needs dispelling, because it’s disabling for some people, and primarily untrue. That is the idea that ‘we save lives.’ It’s a seductive, thrilling concept, guaranteed to help raise our collective self-esteem (if only superficially).

It’s time to deflate the myth. We have focused too long on the idea that we save lives and have therefore developed inaccurate perceptions of EMS. It is time to recognize that what we actually do, most of the time, is simply help people with problems that they are unable to handle alone.

This is in no way meant to belittle the importance and value of the efforts we each make, whether EMS is a vocation or an avocation. Our work is important. Anyone who has run one emergency medical call knows the gratification that comes with knowing we can help.

The point, though, is that we have unfairly enticed a lot of people into pre-hospital care with the lure that, given the right circumstances, they could become real heroes. They imagine that EMS is constantly rewarding and stimulating, where each action will make the difference between life or death.

Indeed, such circumstances are to be found, occasionally. Once in a while, a person in ventricular fibrillation converts on the first shock, sits up, and talks with you on the way to the hospital. A call like that yields an inexplicable sense of accomplishment. It is also exceedingly rare.

What sorts of calls do we more often see? Many times we see the calls which, while perceived as an emergency by the caller, do not require undue effort on our part — the isolated fracture; the stable chest pain; the psych emergencies; the seizures which aren’t, in fact, pre-cardiac arrest seizures, but non-compliant epileptics; and the non-injury auto accidents.

In fact, we seldom save lives. We provide a service to our communities which, far more often, consists of encountering people in crisis who need a few of our hands-on skills. Even more, they need us to make them feel less frightened and more reassured about a sudden alteration of their plans. A child with a broken collarbone is no big deal in the spectrum where “we save lives” is the bottom line. But if you discard that notion, knowing that your presence made a scary event more manageable should generate a different and lasting sense of accomplishment. It’s less dramatic, to be sure. It won’t make the papers. But it’s just as important, in its own way, as saving a life, and such small, unflashy events are far more common.

So seldom do we encounter a situation that requires lifesaving measures that, for this reason alone, the phrase should be practically eliminated from our vocabulary. It only serves to build unrealistic expectations about how we’ll spend our time out there and unobtrusively stimulates many people to invest a lot of time and energy in EMS because of a misconception.

What we much more commonly do is spend time preparing for or awaiting calls. First, there’s the training — hours of it. Sitting in classes is not what people thinking of getting into EMS envision.

Then, it is natural to be curious whether the information we’ve learned actually works. Thus, the waiting weighs heavily on us — and that’s what we do most in EMS. At first, we wait for any call. Later, when we have a few under our belt we await “good” calls, those which enrich us by their complexity or, even more rarely, drama.

But “ask some, if you aren’t lured by the idea that the next call might be the big one,” how can we find the staying power to stick with EMS? This is a critical point. Some people need big-time calls to justify staying involved.

In the meantime, while they await that big call, they satisfy a need to feel important with their flashing lights and sirens pulsing, radio squawks, and official-looking uniforms. These are the same people who view a little old lady lonely for some company as a worthless call. A minor incursion that caused panic in a person who faints at the sight of blood is a situation worthy of contempt. These are the people who are in it to save lives.

Another reason to eliminate the myth is that it really isn’t uncommon to subtly seduce ourselves (to varying degrees) with the thought, “We save lives!” We begin to believe it, especially when we’ve been fortunate enough to really do it once or twice. Yet what happens when that ultimate cardiac arrest? The percentage of saves is even better for theEMS systems is well below 50 percent.

We “lose” far more often that “win.” We end up consoling ourselves that we did our best.

Yet, if even a whisper of the myth lives in our soul, an incongruent message seizes itself, and nibles, then eventually gnaws at your enthusiasm. Many people have left EMS because over time they have realized that “we save lives” is a lie. They feel cheated, all because of an inappropriate — if honestly intended — message we have sent ourselves and those who yearn to join our ranks.

It’s time to be more realistic. EMS is a community service where we are able to help people with the problems that they have. If we avoid making quality statements about those problems, we can learn to take each call with a more appropriate sense of mission — not just those that test the sophistication of our abilities.

We help other people with problems they don’t know how to handle. It is a valuable, worthy, important task. It in no way diminishes the drama of “putting out” those rare times when we encounter lives in the balance. Rather, this subtle shift in how we view ourselves provides a more honest appraisal of what we actually do.

Minimizing — or eliminating the “we save lives” myth will serve to make each call seem important in its own way. It will serve to draw people into EMS who understand that our assistance seldom is of a lifesaving nature. It’s a much healthier approach to a stressful pursuit. We owe it to ourselves to introduce an attitude other than the one that has prevailed so long.
HISTORY MADE
It’s the first baby delivered “over the phone” in Scarborough

Audrey Fraizer

Michael Mains thought all he was going to do was help move a table. Little did he know, the request for help was a ruse to get him to a party to honor his major part in delivering a baby.

Mains, an EMD with the Scarborough Police Department in Scarborough, Maine (USA), was at the end of his shift when Joe Thornton, Lead Communication Emergency Dispatcher, asked if he had a second to assist with some heavy lifting. Mains said “sure,” and the next thing he saw was a roomful of co-workers, family members, and the press. “I had no idea they had planned this,” he said.

The surprise party, set up by Thornton and Communication Center Director Sgt. Steve Thibodeau, was in recognition of the center’s first-ever over-the-phone delivery of a baby using the PAIs. Mains received a stork pin and an orange embossed stork mug (the latter compliments of the Academy) and his “15 minutes of fame” on TV news. A birthday cake with blue icing gave away what Mains already knew.

“The baby was a boy,” he said. “His grandma was really happy about that.”

The 7 a.m. call on Wednesday, July 5, 2017, came in from a woman who said her daughter-in-law was in labor with her third child. The mom had been in labor since about 2 a.m. and, at this point, labor was progressing rapidly, and it looked like it might be too late for an ambulance to arrive at the home in rural Buxton. “Grandma was understandably a little overexcited,” Mains said, although dad, a U.S. Marine, was able to stay cool and collected.

Grandma relayed the PAIs, dad followed instructions, and, as things turned out, the ambulance crew arrived about four minutes after delivery. Mains said he used the time to chat with grandma while dad and mom made sure the baby stayed warm. Mom was doing well, and the newcomer had already announced his arrival. “The baby cried immediately,” Mains said.

Mains disconnected once the EMTs were inside the house with the family. This was the first time in Scarborough Police Communications memory that an emergency dispatcher was the coach from start to delivery. “It’s really unusual to do the delivery over the phone,” said Mains, who has answered other baby on the way calls but none to the extent of full delivery. “This was great. Really an honor.”

The event held nearly one month later (Aug. 1) was a bit overwhelming for Mains, who is much more comfortable at a CAD talking to more-or-less strangers than behind a podium facing an audience of people he knows. He has 18 years in emergency communications, with the past nine years at the Scarborough Police Department and the nine years before that with the Buxton communication center. Mains has also worked as a firefighter and as an emergency medical technician at Buxton Fire & Rescue.

Emergency calls from Buxton are now covered in Scarborough. This was not the first stork pin for Mains. Fourteen years ago, he and his wife, Kristina, a Buxton paramedic, shared the honors for delivering a baby on scene. Both received a pin for the occasion.

Mains called the profession rewarding because he gets to help people, although that’s not the only reason he has worked the phones and radio for nearly two decades. “You never know what’s going to be on the other end of the call when you pick up,” he said. “I can’t imagine doing anything else.”
BOUND TO HAPPEN
Columnist relates to audience

Daphanie Bailes

Daphanie Bailes has been an emergency 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 her emergency dispatch community and raising the awareness of various triggers that are inherent in this career.

Tell us about the first column you wrote for the Journal. The column received more than a thousand hits and, you could say, it went viral in the world of emergency dispatch.

“Bound to Happen” didn’t actually start as a column; it was more of a mission statement after a very difficult call. I wanted to write about my experience with my sister because lots of people work where they grew up or maybe in an area where they have lived for an extended period, and they know people.

Give us a brief re-telling of the story about your sister.

I’m on the radio that day, and I notice a call pending about a possible drug OD of a 27-year-old female. Her boyfriend is giving CPR. It takes a second, but putting together the age, a familiar phone number, and the boyfriend’s name, I realize it’s my sister who’s needing the ambulance. I get someone to cover for me and call my boyfriend to pick me up. We get to the address in time to see the crew wheeling her out. She does not survive.

The point of the story goes beyond your personal experience—it does happen—to a greater message for others in your profession. Can you summarize the message and why it’s so important?

There was no debriefing. I took the week off for bereavement and handled things with my family, but it was still a long time before I could walk back into the comm. center and not have a flutter in my chest. My co-workers were left on their own, emotionally, and since we tend to spend so much time together on-duty, family-related calls can affect an entire comm. center. My message reminded chiefs and supervisors to take care of your people. Emergency dispatchers will be the last ones to actually ASK for help. We’re not in a field unit, but we’re still affected by what happens. We are plagued by what we think is happening rather than actually being able to touch, feel, and see it ... and the damage is just as real.

Why does the message so resonate with readers?

I write from an emotional standpoint. I write about the way this job can affect us and that it’s OK to get your feelings out in the open. It’s OK to speak up about what you need from your chiefs and supervisors. I want people to find outlets that will help them. We have to take time to care for ourselves, our families, and our co-workers. If we don’t, there’s nothing left that we can give to our callers.

Is it a message that should—or does—resonate with the public?

I think more and more people are beginning to understand what we do. There’s still a long way to go, but our message is getting out there. We care about what happens to you, and we’re here to help. It might take a while for the “I am THE FIRST, FIRST RESPONDER” idea to sink in, but we’re getting there. The more we say [or write], the more others will understand.

Final question: What keeps you in the profession?

It is a privilege knowing that I can be there for someone and can be the calm, caring person that helps them through it until someone can hold their hand for real, and I hope that I would get that same treatment in return if I needed to call for help.
SPIRIT TO SURVIVE
Drowning victim beats the odds

Audrey Fraizer

The voicemail says a lot about Michelle Funk, at least in the way Pam Funk describes her oldest daughter.

Michelle sounds spunky and somewhat hurried, as if she's encouraging you to move on much like she did from an accident that nearly, and in its severity should have, claimed her life.

“She was born with a spirit that was going to survive,” she said.

It was 31 years ago, on June 10, 1986. Michelle and her brother were throwing pebbles into the creek that cuts through their neighborhood south of Salt Lake City, Utah (USA). Pam was sitting in their yard directly across from where they were playing when, for the briefest moment, she shifted her attention to the baby's bottle, a few steps away, inside the house.

The next moment she remembers is four-year-old Derek rushing up the lawn. He was scared. His little sister slipped off the bank and into the fast-moving water. Pam tells the story rapidly from here.

“I ran across the street, thinking there was a chance she was along the bank,” she said. “I couldn't see her. I ran back to the house and called 911. Rescue was there in seven minutes. More people kept on coming. The whole day was the worst day of my life.”

Thad Moore, a volunteer search and rescue member for 10 years and a deputy with the Salt Lake County Sheriff's Office, lifted Michelle's body from beneath a rock and, once on shore, immediately started CPR. At about the same time, her father, Christopher Funk, pulled into the driveway. A life flight helicopter would transport Michelle across the valley to Primary Children's Hospital. Pam and Christopher followed in their car.

“Chris asked what we would do if she didn't survive,” Pam said. “I told him, 'When they pronounce her dead, that's when I'm going to think about it.'”

Michelle had been submerged in icy cold water for 66 minutes. She had no pulse and a body temperature so low—66 degrees Fahrenheit—she could be considered dead.

Pediatric Cardiologist Dr. Robert J. Bolte thought otherwise and was determined to give the child another shot at life. He consulted with Cardiothoracic Surgeon Kent Thorne to use a cardiac bypass machine at Salt Lake City's Primary Children's Hospital in hopes it would stimulate rapid core warming as it did for pediatric surgical patients.

Many staff members thought he was crazy.

He wasn't.

Dr. Bolte recalled in a later interview: “We had to decide how hard to push to save her life. You don’t want to be in the position where you are creating a child that is going to end up in a vegetative state. One crucial factor was her temperature, measured in the hospital as low as 66°..."
degrees Fahrenheit. Most important, the child was so profoundly cold. Also, we had a rough idea she had been under for about 45 minutes, the longest period from which anyone had ever recovered with their brain intact.1

Michelle was removed from the machine after 53 minutes of rewarming. Holly Webster, the Clinical Nurse Supervisor at the hospital, was in the room when Michelle made her first sound, a gasping noise that startled the medical staff present. Past experience with drowning victims had tempered their optimism.

“You do what you can and hope for the best,” said Webster, who remembers the event from 31 years ago. “It’s a scenario of desperation and everyone was focused on their role, what they did for a child during an emergency.”

Yet, it was different, Webster said. “We had never tried this method [using the cardiac bypass machine]” she said. “No one knew what would happen.”

In addition to the gasping sound, doctors detected a faint heartbeat and signs of returning brain function. She was transferred to the intensive care unit.2

Michelle remained in a coma and on life-support equipment for two weeks. She was back at home eight weeks after a diver pulled her from the creek approximately 150 feet from where she had fallen in.

By the time Michelle left the hospital, her motor skills appeared normal. Her parents said their daughter was beginning to walk again and had already mastered the words and tune to “Twinkle, Twinkle Little Star.” Michelle had extended by 21 minutes the previous record for survival after cold-water submersion.3

Doctors at the time of the accident attributed Michelle’s improbable survival to an “ancient hibernation reflex that humans have all but lost.”4 She had been profoundly hypothermic. The primitive diving reflex, as it is called, protects aquatic mammals, such as seals, when deep in the ocean. Their body functions slow down, keeping the brain and other organs in a state of suspension.

Stories published in the years after Michelle’s accident credited a pre-arrival team that fought for her before medical equipment at the hospital could release its power. Then, there was the “tireless deputy”5 Moore who fought for Michelle as he pulled her from the icy waters, continuing CPR until the crew of IHC life flight took over.

The deputy’s efforts might explain Dr. Bolte’s initial observation and decision to attempt medical intervention: The amounts of oxygen and other gases in Michelle’s blood, although abnormal, were “incredibly good under the circumstances.”6

People didn’t just stand there, waiting for response to arrive. The deputy breathed in her mouth and pushed on her chest, a bystander action that Dr. Jeff Clawson, a Salt Lake City emergency room doctor and inventor of emergency dispatch protocol, has been advocating for years. No one had dived in [without proper gear] the fast-moving creek to save her and thus averted the risk of adding victims.

Michelle turned 33 in 2017. She is a full-time dental assistant in her father’s Salt Lake City, Utah, dental office. Occasional hand tremors are minimal physical effects of the accident, considering the potential severity of extended submersion. She wears glasses to compensate for damage to her eyes from anoxia. As a child, therapy helped strengthen physical and cognitive abilities. Her sense of balance is off, although she regularly hikes and golf.

“Basically, she’s leading a normal life, and that’s not because of anything we did,” Pam said. “It’s the way she is. It’s her personality. She doesn’t give up.”

Sources
3. See note 1.