HIGH-PRIORITY CALLS NEED PREP

CONFINED SPACES CAN BE FATAL

HELP FOR TWO DURING ONE CALL
For the most up to date conference and attendee event information always
visit navigatorconference.org
Make sure to download the app before heading to Vegas!
The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234; 8,066,638; 8,103523; 8,294,570; 8,335,298; 8,488,748; 8,494,868; 8,712,020; 8,971,501; 9,319,859; 9,516,166. The PPDS is protected by U.S. patent 8,396,191; 8,670,526; 8,873,719. The FPDS is protected by U.S. patent 8,417,533. Other U.S. and foreign patents pending. Protocol-related terminology in this text is additionally copyrighted within each of the IAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.

Follow IAED on social media.
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.

Kristin has been married to her husband for 12 years, and they have 4 children together. She has been dispatching police, fire, and EMS for the city of Southaven in Mississippi (USA) for 11 years. Along with dispatching, Kristin is also a Training Officer. She has a bachelor’s degree in Liberal Arts with a minor in Criminal Justice from the University of Mississippi.


Lindsey is a Dispatch Shift Supervisor at a consolidated emergency communications center in the Midwest. She recently completed her Master of Public Policy graduate studies. Her thesis, Exploring Current Data Tracking Systems Throughout Public Safety Agencies to Improve the Effectiveness of Dispatcher-Assisted Telephone Cardiopulmonary Resuscitation, included original research on data accumulated from agencies in her area.
This issue will hit your communication center not long before NAVIGATOR rolls out in Las Vegas, Nevada (USA). The March/April issue offers you a chance to score some high credit before arriving at NAVIGATOR to amass the high stakes amount of CDE offered there.

Speaking of CDE, check out our Fire CDE about confined spaces. Become more familiar with Protocol 54 and learn how to handle a trapped caller and what to do when hazardous materials are involved on scene. Don’t miss taking a stab at our Medical CDE, which covers Protocols 21, 25, and 27.

And here’s more exciting news about CDE: Our Journal quizzes are now part of your College of Emergency Dispatch subscription, which means you no longer have to pay for quizzes when you take them on the College, plus the results are instantaneous. It’s magical. But back to NAVIGATOR. There will be presentations at NAVIGATOR covering generational differences with help to training and finding ways to foster better working relationships with those of other generations. Get a preview of the four generations currently in the workforce by reading our feature in this issue.

Feeling like you might get that call—the high-priority, low-frequency one? Our managing editor has the lowdown on handling those types of calls in the feature High-Priority Calls. Plus, read about an amazing call involving two bystanders, two victims suffering from overdoses, and one EMD in Wisconsin (USA) in Your Space. Another article shines light on a program working for Deschutes County, Oregon (USA), training and finding ways to foster better working relationships with those of other generations. Get a preview of the four generations currently in the workforce by reading our feature in this issue.

Need a dose of Best Practices? Take a trip to the Mountain West to learn more about the Nampa, Idaho (USA), Police Department in our Center Piece article. Then travel to the East Coast to find out about our featured ACE—Charleston County Consolidated Dispatch Center in South Carolina (USA).

Be on the cutting edge of best practices by reading what one generation is doing to lower the amount of calls coming in from supersusers by sending a different kind of help to their door.

We hope you find something in this issue of the Journal that makes your job easier.
Millennials get a lot of flak. I can’t count the number of articles and think pieces I’ve seen calling millennials lazy and selfish and, in general, blaming all the woes of the world on them. I try not to take it personally, but it’s hard.

In conjunction with the article I wrote about cooperation between the generations in the dispatch center, I’ve also decided to tackle some myths about millennials to show that we aren’t as hopeless as some would have you think.

Myth: Millennials are teenagers.

Fact: The youngest millennials are turning 21 this year and the oldest are turning 37. There’s some debate as to exactly when each generation begins and ends, but the Pew Research Center defines millennials as those who were born between 1981 and 1997.2 (If the idea of being a millennial horrifies you after decades of thinking you’re Generation X, you should know that the birth years of each generation aren’t legally binding or even widely agreed upon.) So if you want to do some grumbling about those darn teenagers and their cellphones, you’ll have to call them by their correct generational title: Generation Z.

Myth: Millennials love their phones more than they love actual people.

Fact: Millennials are using their phones to interact with other people. OK, so Facebook and Twitter aren’t the pinnacle of meaningful interaction, but they are interaction nonetheless. (I’m not going to give millennials a free pass on this one: It’s super rude to be on your phone interacting with someone else while ignoring the person standing in front of you. Shape up.)

Myth: Millennials are lazy.

Fact: A large percentage of millennials don’t take vacation time for fear of being seen as slackers. That’s right, 43 percent of millennials don’t use their allotted vacation time and, when they do, they feel guilty about taking the time off (compared to the 29-percent average of millennials, Gen Xers, and baby boomers all together).3 It’s still relatively difficult for millennials to find jobs in the workforce at all, so it’s understandable that they want to do everything they can to show how dedicated they are (especially when the other generations have labeled them as “lazy”).

Myth: Millennials are the participation trophy generation.

Fact: Although millennials were given participation trophies by older generations, they know the difference between participation awards and achievement awards. I played rec soccer and softball as a kid and let me tell you, even though we all got trophies at the end of the season, everyone on that team knew which players put in actual effort and which ones phoned their performance in. It’s the same story in the workplace. We know how to distinguish between people who are being rewarded for their achievements and people who are being rewarded for showing up.

Myth: Millennials are selfish.

Fact: Millennials are big into volunteering and donating. In 2014, 84 percent of millennial employees made a charitable contribution and, according to that same study, 70 percent of millennials volunteer their time each year.4 Millennials averaged 40 volunteer hours in 2016, compared to 34 for Gen Xers and 41 for baby boomers.4 So we haven’t beat out the baby boomers quite yet, but to be fair, most millennials are volunteering on top of holding down full-time jobs (and not taking vacations).

Millennials aren’t as hopeless as some would have you think.

Myth: Millennials are a single entity, communicating and making decisions with other millennials using an intricate hive mind.

Fact: The millennial generation is made up of individuals. Some millennials are hardworking, some are lazy. Some are unmotivated, some are ambitious. While there are certain trends among the millennial generation, you shouldn’t assume that every single millennial you come across, whether on the street or in the workplace, is the same.

Sources
A SUDDENLY DISCOVERED OBVIOUS OR EXPECTED DEATH

How can EMDs downgrade from ECHO if OBVIOUS Death is later discovered?

Jeff Clawson, M.D.

Western Jeff,

In the case of a cardiac arrest—initially thought to be a 9-E-1 resulting in a quick push to the dispatcher and multiple unit response: If the calltaker later during the call processing realizes that the call really fits into the obvious or expected death category, does ProQA® allow for the “downgrade” of the call?

Thanks,

... a more southern Jeff

Jeffrey M. Elder, M.D., FAAEM, FAEMS
Director | Medical Director
Emergency Medical Services
City of New Orleans, Louisiana, USA

Southern Jeff,

ProQA (the automated MPDS®) has several processes and features that your EMDs should know about, but might not. These apply in the following situations (all caps for OBVIOUS DEATH and EXPECTED DEATH means that they are both defined situations per the protocol). I will, for simplicity’s sake, refer only to OBVIOUS DEATH, although both function in nearly the same way:

1. EMD finds an OBVIOUS DEATH condition before or right at the Case Entry coding point
2. EMD finds an OBVIOUS DEATH condition after an ECHO code is recommended but not actually sent yet
3. EMD finds an OBVIOUS DEATH condition after an ECHO code is initiated: in KQs or PAIs

By referring to the attached ProQA screenshots, you can follow along with the explanations below:

Regarding Item 1, by using the new Sub-Chief Complaint Selection Tree feature (in the new v13.1 release), the EMD can easily, directly pick the Sub-Chief Complaint of OBVIOUS or EXPECTED DEATH option, not just initially “Cardiac Arrest” in Protocol 9. This bypasses the need for any delay and send process activation to follow the desired OBVIOUS DEATH pathway.

Regarding Item 2, when the EMD finds out information clearly indicating that a situation now involves an apparent “defined” OBVIOUS DEATH, use the “Delay Send and Continue” button. This delays the send action and allows the further interrogation, if needed, and the entry of Key Questions now suggesting a presenting OBVIOUS DEATH. This then resets the send code of 9-E-1 to a 9-B-1.

Regarding Item 3, depending on which KQ in Protocol 9 the EMD is on, they should use the back “red” arrow to return to KQ1 and then re-answer it as OBVIOUS DEATH, which will reconfigure the response code to 9-B-1.

If the EMD has already reached PAIs (CPR beginnings) and then determines, usually upon advising CPR, that the patient is beyond help, PAI C-2 has an OBVIOUS DEATH answer choice button that can take you back to KQs, where the EMD simply clicks on KQ1 and re-answers as OBVIOUS DEATH.

At any other time, the EMD can return to the KQs to do the same thing by selecting the KQ Answers section tab and clicking on the desired KQ answer.

Best regards, always ... Western Jeff

Item 1

Item 2

Item 3
RESEARCH WORKSHOP IN LAS VEGAS?

No really.

The IAED™, in collaboration with the UCLA Pre-hospital 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 Lindfors
Two weeks that will change your life ...

... without having to learn a new language.

Register by December 18, 2017 and save $200 on the Spring Course!

The Communication Center Manager SPRING Course
Online Begins: February 5
Onsite Week 1: March 4–9 | Onsite week 2: May 6–11

SPRING Course Costs:
CCM Course
EARLY $2,310
REGULAR $2,510
ACE Accredited Organization*
EARLY $2,195
REGULAR $2,385

*ACE registrants receive a 5% discount off the cost of the course—subject to verification. Enter discount code ACE2018 on the payment page. Must be paid in full by December 18, 2017 to receive early pricing.

Location: Embassy Suites KCI Airport
7640 NW Tiffany Springs Parkway | Kansas City, MO 64153
816-891-7788

Presented by:
Fitch & Associates on behalf of IAED

Online registration for the 2018 course is now open.
Go to emergencydispatch.org/certccmcourse or call Sharon Conroy at (816) 431-2600 for more course curriculum and registration information.
Determining dispatch link changes research intent

Lindsey Tazzioli

During my seven years as an emergency dispatcher, I have grown increasingly curious regarding the impact I have on the outcome of the incidents called in, specifically calls involving out-of-hospital cardiac arrests (OHCAs). The chain of survival requires fast action and quality service from each responder—from dispatch PAIs to ambulance response times and through hospital care. I wanted to know more about dispatch’s link in a successful outcome of the chain’s application.

My curiosity intensified after I began working for Westcom Emergency Communications, a consolidated PSAP in West Des Moines, Iowa (USA). Westcom recognizes emergency dispatchers with Life Saver Awards when a patient survives after the EMD uses MPDS® CPR PAIs to provide telephone cardiopulmonary resuscitation (TCPR) instructions to a caller reporting an OHCA. Westcom considers a patient to have survived an OHCA if he or she is discharged from the hospital following the event.

I found the perfect opportunity to research this when choosing a topic for my graduate thesis. My original research question intended to investigate whether dispatch-provided TCPR instructions had a positive impact on patient survival. The plan was to contact eight fire and EMS departments from the Des Moines metropolitan area to request run numbers and patient survival information for OHCA calls they responded to between Jan. 1, 2016, and Dec. 31, 2016. The next step was to contact the three PSAPs handling calls for those departments to request a copy of the phone call recording and CAD report from each run number provided. I wanted to analyze each call to determine if TCPR was provided and whether the patient survived. I anticipated a sample size of approximately 300, an estimate calculated based on the call volumes of the included departments. From those 300 calls, I planned a statistical analysis to find out how often patients receiving TCPR survived.

PSAPs could benefit from an overhaul of data collection and management practices.

With a solid plan in place, the blessing from the university’s Institutional Review Board, and a professor to help keep the project on track, I set out to collect data. It didn’t take long to encounter serious problems. The study’s retrospective design made it impossible to include all that I had originally intended. Some of the fire and EMS departments either did not collect data on patient survival or had yet to receive data on numerous calls from 2016. Some recorded patient status upon hospital arrival. Others were unable to provide information because their overburdened staff did not have time to honor the requests. A combination of these factors eliminated one PSAP. The phone recorder retention policies at all three PSAPs made it impossible to retrieve any recordings. Another PSAP, and consequently its fire department, had to be excluded because of the irretrievable phone calls. Without the phone calls to verify application of TCPR, their CAD records were not reliable enough to determine dispatcher involvement. I encountered similar problems when contacting hospitals to request the remainder of the 2016 patient outcome data.

The data collected revealed a weakness in current retention policies and interoperability in data collection. From this research, I concluded that the Des Moines metro and possibly many other PSAPs could benefit from an overhaul on data collection and management practices. I plan to recommend the creation of a local database tracking OHCA patients from the 911 call through hospital discharge. With cooperation between PSAPs, fire departments, EMS departments, and hospitals, this database could alleviate constraints to assess strength of the chain of survival, retrospectively. It would also allow for comparability of data across agencies and jurisdictions.

The database, prospectively titled the Metro Area CPR Initiative (MACI), will be designed for a generalized region to include data from public safety agencies and hospitals from surrounding communities in hopes to create larger data sets to draw conclusions from quicker than if it were kept strictly local. A framework for uniform reporting from each participant must also be established for MACI to ensure comparability across agencies.

Note: Disa Cornish, Ph.D., Assistant Professor of Health Promotion and Education, University of Northern Iowa, Cedar Falls, Iowa, USA, contributed to this project.
I’m a staunch believer in delivering good customer service. Sadly, being able to really talk to someone when you have a problem is rarely possible today. More and more phone companies, cable companies, and other service delivery firms have replaced real conversational interaction with robotic dialogue. Scripted phrases of politeness like “I’m very sorry to hear that” and “I’d be more than happy to help you” are read by rote and carry no feeling whatsoever.

Recently while en route to the airport, I had occasion to call Alaska Airlines because neither its website nor its mobile app would recognize my confirmation number. Irritated, I called the 800 number. After receiving a friendly greeting, I explained the problem and was asked what day I was traveling. “Today,” I replied. That day happened to be June 21st. “First day of summer!” the airline representative exclaimed. “We’ve been waiting a long time for that here in Seattle. Let me get your last name, and I’ll see what’s going on.” Her human approach immediately took away my irritation with the situation. I walked away from that call impressed, and not just because my problem had been taken care of.

Kudos to Alaska Airlines for allowing their employees to talk to people like people. That’s what real customer service centers around: the human element in the interaction. It’s why I constantly remind my trainees to talk to people like real people. It’s not always easy, especially when a caller is impatient or has unrealistic expectations. All too often the emergency dispatcher becomes impatient or irritated with the caller, and the call goes downhill from there. I’ve seen dispatchers who feel self-righteous after a call like that, but here’s the problem: Projecting a negative attitude won’t do anything for your agency’s reputation and will probably hurt it. No caller will ever think to herself, “I deserved the way he talked to me.” Instead she’ll probably tell five friends how unhelpful you were.

Real customer service centers around the human element.

As emergency dispatchers, all of us have to deal with unrealistic expectations on a daily basis. Take the case of a resident living next door to a fire scene who called to complain that the firefighters were all just “standing around” in front of her house doing nothing. Those particular firefighters had just gone through rehab (rehabilitation, or cooling down, rehydrating, and having EMS check their vital signs.) She didn’t know that. Or the caller who insists that the patient—a family member—needs to be transported to a faraway hospital because that’s where her surgery was done. Taking a moment to explain why it isn’t possible goes a long way.

Obviously there are times to keep the dialogue at an official level and times where it’s OK to step back from that. Even in crisis, though, it’s appropriate to be human at times. Years ago my partner took a call from a frantic mother whose baby was having a first-time seizure. At one point she said, “Listen—I know this is scary. Trust me, I know this is scary. But you have to calm down so we can help your baby, OK?” Said with empathy, it was the key that opened the door through that wall of hysteria.

Make it a game. I do. It’s simple: If I get someone on the phone who starts out impatient or dissatisfied and I get that call to end on a pleasant note, I win. I live for that turnaround and a genuine “thank you” from the caller. It’s what gives me satisfaction in this job. I believe that a 100 percent turnaround rate should be every emergency dispatcher’s goal. It shows you’re a true dispatch professional and one who’s never willing to deliver anything less than your best.
GET INVOLVED
Stop by booth #1110

The Academy is doing cool things to support our members and promote emergency dispatching! Come check out the schedule for our short presentations on Tuesday and Wednesday. Learn more about the College of Emergency Dispatch, getting involved with the Journal, data analytics, and a research study you can play a part in.

We look forward to seeing you at NAVIGATOR!

A BETTER WAY TO TAKE JOURNAL QUIZZES
learn.emergencydispatch.org

All Journal quizzes are now included with your College of Emergency Dispatch subscription, and your results are instantaneous.

Visit learn.emergencydispatch.org to start saving time and money.
THE ART OF EMS
Revisiting a seminal emergency care book

Kate Dernocoeur

There are by now several generations of emergency care providers who have perhaps missed one important EMS book: “Streetsense: Communication, Safety, and Control.” The book’s first edition was published way back in 1986, and the third edition was released in 1996. But many industry leaders today will tell you it had a huge impact on their street careers.

I wrote the first edition in the early 1980s out of desperation. Although my paramedic school instructors back in the 1970s were magnificent at teaching about bodies, what could go wrong, and what I could do about it in the prehospital setting, they were nurses and doctors. They had no direct experience with the streets.

As I started my years of service (at the Denver Paramedic Division from 1979–1986 in Colorado, USA, and for a private service for a year before that), I realized there was much—oh, so very much—still to learn about the craft of EMS. It was quickly evident that capable and efficient field providers incorporated abundant non-medical skills on every call. How not to knock on a door. When to dig in at a scene, and when to cut and run. Why I should learn how to hold a patient’s hand sometimes.

I learned these and many other tips and tricks of effective delivery of emergency care from watching both gifted mentors and others showing me what not to do. Over time, I wondered why no one had written a book about these things. Finally, I decided to write that book myself.

I mulled over the possibilities for a couple of years, keeping idea lists while awaiting calls at the corner of 17th and Federal or somewhere up on Denver’s Capitol Hill. I noticed, when running our average of 10 calls in a 10-hour shift, many various elements that would need to be included in such a book as the one I was proposing. Over time, I decided there were three main pillars of street sense: effective interpersonal communication, a variety of aspects of safety, and control of everything from crowds and weaponized situations to ways of handling stress and death and dying.

When I pitched the idea to the Brady Communications Co. at a conference, I was told they’d mail a contract to me within a week. The book’s time had come.

So much has changed since the 1970s! Believe it or not, when I started, my instructors pounded into us that our very first priority on a call was the patient’s ABCs (Airway, Breathing, and Circulation). It took years (and I do credit “Streetsense” for having a hand in this) to alter that message; these days, everyone knows that the first priority is personal safety. It’s been fun to revise and build a better book with each new edition (second edition in 1990, third in 1996). Infection control came into the collective conversation for the second edition. Gangs and a new chapter on customer service and the nature of routine debuted in the third edition.

This book is being updated yet again. The fourth edition retains its usual triad of communication, safety, and control while reflecting the evolution of the EMS industry since the arrival of the millennium: computers and cellphones, social media, active shooters, and so much more. Scheduled for release in February 2019 by PennWell, the fourth edition of “Streetsense” will offer the same lodestone of tips and tricks to help EMS providers—both new and street-savvy—do the job even better. Watch for it!
Speed bumps. I don’t know about you, but when I hear that word, I automatically get annoyed. Speed bumps are those annoying little things that always appear to slow me down. I know that speed bumps are placed where they are for good reasons—to slow the speed of cars in a residential area, for example—but it doesn’t mean that I have to like them.

In the communication center, I sometimes feel like I am driving down a highway of speed bumps. I feel like I am on top of my game when a speed bump appears and slows me down.

There are even different kinds of speed bumps. I remember as a little girl riding my bicycle over speed bumps that made me bounce. These were the tall and skinny ones. I was impatient with my dad driving over these inconvenient spots in the roadway. Couldn’t he go around them? In my grandmother’s neighborhood, speed bumps are the vehicle’s full length. They are called speed tables. The speed bump is so wide that you laugh—how is this supposed to slow me down? I never slow down and end up looking like an episode of “The Dukes of Hazzard” with my vehicle flying through the air and landing nose first on the other side.

Then there are speed bumps that sneak up on me. I saw the warning sign but got distracted and didn’t hit the brakes fast enough, and I end up bracing for impact. In the aftermath, I tell myself not to let that happen again. There are also speed bumps in the communication center. They are inconvenient incidents that happen in intervals that slow us down. No one really likes a speed bump, but once you hit one, you stop and consider why the speed bump is there.

The speed table incidents are the ones that no one wants to go through. The media are a prime example. Sometimes they camp out near the department as a constant reminder of a mishap. They play up the event, and the not always accurate facts run throughout the day on the communication center TV. These situations unhinge or unravel the comfort zone. These incidents can force some emergency dispatchers to question their passion. Is it worth holding on tight and going through the storm?

The speed bumps that come with warning signs that are ignored or forgotten are incidents that you truly never saw coming, although the signs were all there. The death of a co-worker brings sadness. If the person was ill, the warning signs were probably there, but everyone ignored them because it’s easier than accepting reality. The department regroups from the incident and tries to move forward.

Speed bumps in the communication center are inevitable. These inconvenient incidents remind us why we chose this profession. It is easy to get complacent, and we shouldn’t. We need to develop ways to approach these speed bumps. We should look at them as learning experiences so that in the future we remember to double-check an address, remember that we know what happened during an event, and remember not to take co-workers for granted. Together, we can learn to go over these speed bumps with grace.
CELEBRATE YOUR CENTER
Share your story with us

We’ll share winning stories with the world. Winning writers will receive a plaque honoring them and gift cards.
We do **PODCASTS** now!

Visit [aedrjournal.org](http://aedrjournal.org) to listen or use your favorite podcast media player to see the full lineup of podcasts that the IAED offers!
SEIZURE DUE TO OVERDOSE
What protocol do we use?

Brett Patterson

Hello Brett,

I was wondering if you could please answer a few questions for me. I was talking with one of our QA coordinators about a situation in which we received a call about a patient seizing as a result of an overdose. What protocol would you go to? Secondly, please explain the rationalization for 12-C-6: OVERDOSE/POISONING (ingestion). There aren’t any PDIs to give Narcan on Protocol 12: Convulsions/Seizures, so how would you get 12-C-6? I hope my question makes sense.

Thanks for your time,
Susi Marsan
Communications Training Coordinator
Grady Emergency Medical Services
Atlanta, Georgia, USA

Susi,

Your question makes sense. We added the seizure code to Protocol 12 for cases where the caller does not offer the cause of the seizure until being questioned. In other words, the Chief Complaint is seizure, and the fact that OVERDOSE/POISONING was involved was “discovered” later, much like abnormal breathing might be discovered on Protocol 26: Sick Person (Specific Diagnosis). If this happens, the EMD has the code available and can provide seizure instructions, then use the Target Tool if narcotics are involved and Narcan is available.

If both OVERDOSE/POISONING and seizure are known at Case Entry, Protocol 23: Overdose/Poisoning (Ingestion) is appropriate for scene safety, and Narcan and the Target Tool can be used to provide some seizure instructions. This is even more relevant in MPDS’ v13.1 where significant changes have been made to Protocol 23 due to the prevalence of very strong and dangerous synthetic narcotics.

Hope that answers your question.
Thanks,
Brett Patterson
Academics & Standards Associate
Chair, Medical Council of Standards
International Academies of Emergency Dispatch

Brett,

Awesome, thanks so much for your help. It makes perfect sense what you said, and I will certainly pass it on.
Susi

Brett:

We have a question regarding Protocol 26. When the caller statement includes “confused,” “lethargic,” or similar, is it still necessary to ask “Is s/he completely alert?” or is this considered obvious and the calltaker can immediately select “confused” or “lethargic” from the drop-down list? Any additional direction/feedback is appreciated.

Jeannie Shadaram
Lead Communications Training Officer
Lee Control/Lee County Public Safety
Fort Myers, Florida, USA

Hi Jeanne:

While answering the completely alert Key Question as “no” based on a caller’s previous description is completely appropriate, the ALTERED LEVEL OF CONSCIOUSNESS list was never meant to universally imply a not alert status. For example, if a caller previously told me that a patient was semi-conscious, I would not even ask the Key Question; I would consider the answer obvious. However, lethargic is obviously not an equivalent to semi-conscious, and I would ask the question for a reported lethargic patient.

So, the short answer to your question is that the completely alert Key Question should be asked unless it is obvious that the patient is not alert.

It is also important that EMDs understand the history and function of the ALTERED LEVEL OF CONSCIOUSNESS list on this Protocol. Here’s a link to a related article to help you with this: iaedjournal.org/safety-net-protocol-26. Please let me know if you have any additional questions.
Brett
**MEASURE OF SUCCESS**

10 centers rolled into one medical and fire ACE

Audrey Fraizer

Sharon Martin was well into her emergency dispatch career when the Medical Priority Dispatch System™ (MPDS®) entered her world. “After 17 years, asking all those questions was something to get used to,” said Martin, Support Services Manager, Charleston County Consolidated Dispatch Center, Charleston, South Carolina (USA).

But get used to it, she did, plus some. Martin no longer answers calls or dispatches response. Her focus hasn’t shifted—she is still dedicated to 911 and the calling public—but her emphasis is on helping new hires surpass what she has done in a career going on 24 years. She gives “kudos” and “high fives” to everybody working the floor and credits receiving dual medical (2012) and fire (2012) Accredited Center of Excellence (ACE) recognition as clear indication of their skill behind the controls.

“ACE is the confirmation that they are doing a wonderful job,” she said. “It’s a measure of our success.”

Charleston County Consolidated Dispatch Center began operations in 2009, and in 2013 it added the last of 10 911 communication centers destined to go under one roof (sending response to 15 police, fire, and EMS agencies in the consolidation). There are approximately 120 EFDs/EMDs in two shifts covering the largest county in the state, totaling 1,388 square miles, of which roughly one-third is water. A Consolidated Dispatch Board provides oversight. Jim Lake is the Center Director.

**Doing their best matters**

Consolidation, however, was more than just a matter of convenience. With Charleston County being among the nation’s fastest growing populations, the move to one facility made economic sense and put everyone in the area under the same best practices standard of care.

“With ACE, there is a level of care each person is going to receive, and that makes a big difference,” said Jason Scott, QA Supervisor. “People saw the benefit of protocol. They knew we were asking all the right questions.”

Admittedly, it was not an easy task getting everybody from 10 agencies on board for ACE, although it did help to put the onus on team participation. They have also enjoyed full support by Charleston County EMS Director Dr. David French.

“This was for us, this helps make us better,” Scott said. “No matter what your part is, mission matters.”

Achieving dual ACE was also part of the center’s strategic plan’ (December 2014) to accommodate the recognition that Charleston County is a great place...
to live and visit. According to facts and figures cited in the plan, the 2010 county census had a population of 350,209 residents, which by 2020 is expected to grow by 75,000 (for an estimated population of 425,000). About 13 percent of residents are age 65 or older, which is expected to increase by 50 percent in the next 10 years. An estimated 4.9 million tourists visit the area each year.

A no end in sight escalating population and tourist trade have a corresponding effect on 911 calls. In 2013, the center’s total call volume was 847,775, which was an increase of 26,217 calls from 2012. The increase in the 65 years and older group is expected to increase medical calls for service. The center’s call volume is expected to increase to 1.2 million annually.2

During the five years since the strategic plan was released, the emphasis has been technology to meet demand and NG911 benchmarks, and public education. New equipment, such as CADs, and furnishings were budgeted in a move to a completely new, dedicated building in 2013.

The public education program focuses on extensive outreach, and to meet its objectives, its manager, Sasha Vargas-Fimiani, organizes tours, visits schools among other public and civic organizations, and gives up her evenings and weekends to attend community events. #911 Team members are familiar voices and faces in the county, and they’re definitely not afraid to kick up their heels in support of Charleston County 911 (take a look at their Facebook page facebook.com/charlestoncounty911/).

Times change

The atmosphere in emergency communications and in Charleston County has changed since Martin started in the profession, and that’s an understatement.

Newspaper stories in 1992 cited the same predicament other areas nationally were facing due to the recession—rising unemployment and a less than booming economy—and, specific to Charleston, bad weather. Tourism declined dramatically, at least temporarily, after Hurricane Hugo swept through the Caribbean and into the Carolinas in September 1989.

ACE is the confirmation that they are doing a wonderful job. It’s a measure of our success.

Emergency communication was not centralized, with centers dedicated to separate police, fire, and EMS entities. Martin answered a help wanted ad, got the job, was shown a chair, and given a brief lesson on what to do.

Then came the expansion of Charleston Port to attract international trade, a marketing campaign drawing industry and business and rejuvenating an area savaged by Hugo. The state spent millions to restore beaches along the 60-mile coastline studded with hotels and retail shops.

The “sit down and learn” training style has morphed into up to nine weeks of classroom training, depending on the trainee’s experience and background, plus another four months of rotating through the fire, police, and medical calltaking and dispatch responsibilities on the floor with an experienced emergency dispatcher. Everyone is dual-certified and will be tri-certified when the time comes. Continuing Dispatch Education is offered both in-house and off-site, such as through the annual NAVIGATOR conference.

Growth is good, Martin said, and, at the same time, challenging to counties struggling to widen roads, build schools, and provide community and public services.

“It makes our jobs much tougher,” she said. “The calls are nonstop, all day and night. It can get very stressful around here.”

The professional demands of emergency dispatch—stress, long hours, and holiday scheduling—added to lucrative employment opportunities due to commercial and industrial growth fuels constant turnover at the communication center. Strategies to attract and retain new hires and seasoned emergency dispatchers include a wellness program, creation of a quiet room for staff to use after a difficult call or otherwise take a break, exercise balls and small foot pedals at consoles, and a recruitment program that highlights the benefits of working for 911, including a fun-loving and dedicated staff.

Scott said realizing the potential of a career in emergency communications has kept him from looking elsewhere. He started at the center in 2011, and in the past six years has risen to a supervisory position.

“The people who do this job have a strong emotional draw that 911 fulfills,” Scott said. “There’s also the sense of accomplishment drawing people to 911. The strong leadership lets us get invested in the way we want. It’s a sign of good management that recognizes both.”

Some things never change

Charleston County has the charm of antebellum homes, history as one of America’s earliest and wealthiest trading ports, Revolutionary War and Civil War museums and sites (a single shot fired from Fort Sumter began the Civil War on April 12, 1861), and beautiful islands and coastlines.

The county borders the Atlantic Ocean and with so much water and so many tourists, it’s little wonder that water-related 911 calls from the beach, cruise ships, or from drifting kayak or paddle-board enthusiasts are year-round, although primarily concentrated during the warmer summer months.

“Movies are made here; our wedding season is big,” said Vargas-Fimiani, who has overseen the public education program since 2014. “It’s a wonderful city close to the ocean. People just want to be here.”

Sources


2. See note 1.
Nampa Police Department (Idaho, USA) EMDs are proud of their profession. They receive wholehearted support from their police officers and get lots of thumbs-up on the department’s Facebook posts.

It’s no wonder that they believe that what they do—and what others in the same profession do—belongs in the same occupational category as police officers and firefighters.

And that’s as a ‘Protective Service Occupation,’ rather than the “Office and Administrative Support Occupations” category where they are now grouped. It isn’t about immediate pay raises or enhanced benefits or to impress anyone in case they’re asked. The EMDs at the Nampa Police Department have absolutely nothing against administrative professionals. They do not belittle the clerical profession or consider clerical work insignificant.

The change is more about clarifying what emergency dispatchers do.

“It wouldn’t change a dispatcher’s job,” said Nampa Police Department 911 Manager Carmen Boeger. “But it would help in getting other things done. The way it is now [the classification], people aren’t sure about what we do.”

More than filing and stamping

People checking the Nampa Police Department 911 center webpage would learn that the EMDs dispatch for Nampa Police Department and the Nampa Fire Department. There are 16 full-time EMDs, under the direction of Boeger and Dispatch Supervisor Beth Mills. Medical calls are dispatched to both the fire department and the Canyon County Sheriff’s Office, which handles response for Canyon County Paramedics.

But that’s just a broad description that doesn’t define the specifics of what they do, such as handling thousands of 911 calls annually (81,833 in 2016), which includes giving lifesaving instructions using the Medical Priority Dispatch System™ (MPDS®) and keeping officers safe when responding to shootings, drug-related arrests, criminal pursuits, domestic disputes, and the usual incidents in a state’s major metropolitan area. They are unique in being one of five 911 centers in Idaho operating within a police department and in a profession in which they protect lives and property, similar to those police officers and firefighters they support. They might organize files and prepare documents in relation to their work, but not as a routine part of their job as described under the administrative category.

“This is a chosen profession,” Boeger said. “We take great pride in what we do.
You will never find people more dedicated to their profession than dispatchers.”

Boeger is closing in on her 30th year in emergency communications. She started in August 1987 at the Gem County (Idaho) Sheriff’s Office, and after 18 months there, transferred to the Canyon County (Idaho) Dispatch center. In 1992, the Nampa Police Department hired her in dispatch. Over the years, Boeger’s job description has changed. As manager, she no longer answers calls except in an overflow emergency situation. Her surroundings have also changed. In 2012, 911 operations moved from the basement in the former police station to the newly constructed 65,000-square-foot Hugh Nichols Public Safety Building.

Nichols is the only Nampa police officer killed in the line of duty. He was 46 years old when on Oct. 5, 1931, he was shot at a commercial garage during a burglary. The killer was never found. The officer’s police badge, service revolver, and holster are on display inside the public safety building dedicated in a ceremony attended by law enforcement, emergency dispatchers, city administrators, and several of Nichols’ descendants.

The tribute says a lot about the way Nampa works. It’s about getting everyone involved, and that encourages people to put down roots, including those in public safety.

“We’re lucky to attract dispatchers with a lot of experience, and this is where they end up staying,” Boeger said. “They want to come here. They want to work here.”

A welcoming place

Nampa is in southwestern Idaho, and it’s the largest city in Canyon County, Idaho. With a population of about 90,000 (as of 2014), it’s second only to Boise for people calling the place home.

Nampa started as a railroad town, a stop for emigrants planning to move farther west. Many stayed because of an irrigation system creating thousands of acres of prime farmland. A fire started by a firecracker let off in a cigar store destroyed most of downtown Nampa in 1909, but that only served to expand upon what the city had already offered.

The railroad laid more tracks, and agriculture remained central to the economy. Canyon County produces more than 90 percent of the world’s sweet corn seed. Nampa Amalgamated Sugar factory, built in 1942, processes 12,000 tons of sugar beets and 1,000 tons of sugar from the beets per day. Nampa also has a strong manufacturing base, with furniture, boxes, wood products, and computer chips as some of the goods produced.

They want to come here. They want to work here.

Industry and railroads bring continued prosperity. In 2017 Nampa was named the “Best Run City in America” based on operating efficiency (fiscal management) out of the 150 U.S. cities evaluated. There are 24 parks close to downtown, with lots of outdoor venues close by (e.g., Soldier Mountain Sun Valley and the Deer Flat National Wildlife Refuge). The city is rated as a safe place to live and raise children, according to a blog post on Sperling’s Best Places to live online guide.

The decision to stay in the area comes down to a tight, supportive community and for emergency dispatchers, the positive support they receive from administration, particularly law enforcement.

“They understand the importance of us,” Boeger said.

Training equalizer

Boeger represents Nampa 911 on the PSAP Standards and Training Committee. During the 2017 legislative session, the committee’s efforts resulted in a mandatory 40 hours of basic emergency dispatch training plus a minimum 40 hours of continuing dispatch education every two years. Legislation went into effect July 1, 2017, for Idaho’s 46 primary and several secondary PSAPs.

The legislation is an equalizer, Boeger explained. While some centers are way above the new minimum standards, such as Nampa Police Department, the entire width of the spectrum will, at least, provide a complementary and sustainable level of training.

Now that training standards are legislated, it’s back to the SOC (Standard Occupational Classification), and Nampa Police Department 911 staff will continue their efforts to further their classification. Knowing President Donald Trump’s partiality for Twitter, the EMDs took to Twitter using the #911ProtectsUsAll hashtag to garner his support well ahead of the next SOC deadline.

Boeger said it’s all part of their journey. “Everyone benefits from these types of changes, and it’s not only us,” she said. “It tells the world more about what we do.”

The SOC

The SOC system is used by federal agencies to classify workers for purpose of collecting, calculating, and disseminating data, and revising the SOC is a multi-year process, taking about five years to collect data, solicit comments, and publish. The SOC Policy Committee began planning an update to the 2013 release in early 2012 and published the 2018 SOC in spring 2017. Revisions are coordinated with the years following North American Industry Classification System (NAICS) revisions, which occur for years ending in 2 and 7. Using the NAICS calendar, the next SOC revision would be released in 2023.

Sources
COMMUNITY MEDICINE
Prevention starts in 911

Audrey Fraizer

Master Firefighter/Paramedic Ian St John wanted to be the guy giving voice to people unable to connect to help on their own. He was an advocate for his father-in-law who was able to receive care at home after experiencing a devastating illness, and he wanted to extend that sort of compassion to people in similar predicaments but lacking social networks.

“A lot of people don’t have someone to advocate for them, and I wanted to help give them the support they need,” said St John, Montgomery County Fire & Rescue Service, Gaithersburg, Maryland (USA).

And that’s exactly what St John’s doing through a pilot program launched by a research project into a problem vexing emergency medical services: superusers, the relatively small group accounting for a disproportionate use of EMS resources. It begins in the communication center.

Capt. Jamie Baltrotsky, Program Manager, Montgomery County Non-Emergency Intervention and Community Care Coordination, initiated the eventual two-phase research project from observations during her 17 years as a paramedic. People needed help and didn’t know where to find it, so they called 911. Working with the communication center, Baltrotsky identified the top EMS superusers during the first phase that also included referral to community services. The second phase evaluated the potential effect of referral on EMS services, including the impact on 911 calls.

The positive results—a decrease in calls for EMS response—led to Montgomery County Fire & Rescue Service’s Mobile Health pilot program.

This is where St John enters the story. As a caretaker, he understood people’s desperation to stay home despite medical issues and, as a paramedic, he had been on multiple runs for patients who did not require emergency medical care.

“They just needed a little extra help to stay at home,” he said. “It might be a language barrier or not knowing how to connect to resources. They turn to EMS because they don’t know where to go.”

The six paramedics taking on Mobile Health duties (in addition to their normal scheduled hours) command an ALS stocked and specially marked “EMS buggy” (Chevy Impala) to make house calls. They meet frequent callers, find out the underlying issue, conduct a home safety check, and connect them to the appropriate resources. Depending on their circumstances, Mobile Health clients are provided with referrals to doctors, home health agencies, and local and state social services.

The relationship doesn’t stop there. They continue to monitor calls as an indication of the solution’s effectiveness. They also maintain a direct connection.

St John contacts a senior homebound patient every week to make sure she’s OK, having once been a frequent caller, averaging one call to 911 every five to seven days. She complained of stomach pain or catheter management and no matter the ache or pain, she wanted hospital transport. Mobile Health scheduled a visit.

“She couldn’t get to the doctor,” St John said. “She had below knee amputations and couldn’t get out of her bed. There was no one to help, and her way of managing was calling 911.”

The home visit identified safety issues. They installed smoke detectors and fixed light switches. They also discovered that all she needed was a doctor who made house calls. They found one.

“She’s on home health, and there’s been no calls since June [as of four months later],” he said. “She went from multiple calls to zero. She’s getting the help she needs.”

Mobile Health, he said, has made a huge dent in the number of 911 calls and EMS responses.

St John talks candidly about the program and his interest in seeing similar programs enacted nationally, calling it an eye-opener for paramedics used to walking into a home and taking care of the patient’s immediate medical problem.

“Everyone wants to do for themselves,” he said. “They don’t want to be a burden. We help them. We create networks that are deep and interlaced. We build relationships based on respect and compassion. That’s why I’m here today.”

Jamie Baltrotsky
OnStar technology tells a crash’s story.

As you respond to the scene, EMD-certified OnStar® Emergency Advisors can relay crash data that includes an Injury Severity Prediction (ISP). By using Automatic Crash Response® data — such as change in velocity, direction of impact, whether there were multiple impacts and more — the ISP algorithm calculates and reports if there is a high probability of severe injury. This helps you prepare for the scene and make decisions about the best treatment center for patients. It’s our way of helping you deliver the right care, right away.

Visit public-safety.onstar.com for more information.

*OnStar acts as a link to existing emergency service providers. Not all vehicles may transmit all crash data. ©2018 OnStar. All rights reserved.
Eric Parry was on the verge of becoming a teenager when the Beatles first performed on the “Ed Sullivan Show” in 1964. He was watching it on the TV at his grandparents’ house, and his grandfather wasn’t at all impressed by the band’s appearance, especially their mop top hair. Parry’s grandfather called them reprobates and lamented that the world was about to end.

It taught Parry, an ENP in Point Roberts, Washington (USA), a valuable lesson.

“There have always been generational differences,” he said, “and it hasn’t resulted in the destruction of the planet yet.”

It’s a nice mantra to mutter when you’re struggling to get along with a millennial who won’t get off the phone, a Gen Xer whose cynical attitude is bumming you out, or a baby boomer who won’t stop asking for technological help. But how well does it hold up in practice in the dispatch center?

Drawing a generational line in the sand

When exactly does each generation start and end? The only generation with an exact definition...
provided by the U.S. Census Bureau are the baby boomers—those born from 1946 to 1964. After that it gets fuzzy. Some studies put the generations into neat 20-year packages, while others put 15 years between generations. Pew Research Center, largely regarded as one of the foremost experts in generational research, names Generation X as those born between 1965 and 1980, the Millennial Generation (or Generation Y) as those born between 1981 and 1997, and the Post-Millennial Generation (or Generation Z or iGen) as those born after 1997.¹ These dates are flexible, and generations after the boomers tend to self-identify with a certain cohort over another. Ask almost anyone born in the ’80s, for instance, and they will vehemently deny being a millennial.

As of 2015, millennials became the largest generation in the United States labor force, and the numbers have only grown since then. The next largest generation in the workforce is Generation X, followed by the baby boomers (which is declining), and ending with Generation Z (which is growing).² So you could have anywhere from two to four generations in your dispatch center.

**Training**

One of the biggest questions when it comes to generational differences in the workforce is that of training. Can you train a millennial the same way you train a baby boomer and vice versa? IAED’s emergency dispatch certification courses often take place in a classroom setting, with a lecturer and slides, as well as plenty of practice and discussion. Other training methods include on-the-job coaching, computer-based training (e-learning), practice scenarios, and group discussion.³

Most people would assume that the younger a person is, the more they would prefer to have their training presented to them in a digital manner. A survey of over 18,000 professionals in Generations X, Y, and Z across 19 countries showed that 78 percent of Gen Xers, 77 percent of millennials, and 70 percent of Gen Zers would take an online course if offered by their employer. However, just because recent generations are tech savvy doesn’t mean that they’d rather do job-related learning online than interact with another human being to learn the same content. At 25 percent, Gen Xers had the highest number of respondents who would prefer training online rather than in person. Twenty-one percent of millennials also said they would choose online training over in-person training, and—surprisingly, given that some people call them “screenagers”—only 13 percent of Generation Z respondents would pick online over in-person training.⁴

Not every individual adheres to the stereotypes of their generation.

While it’s surprising that most Gen Zers would choose to interact with a person rather than a screen to train, you should keep in mind that they also have a far shorter attention span than their baby boomer, Gen X, and even millennial co-workers. Some sources claim that Gen Z only has an eight-second attention span,⁵ although the original source of that statistic is spurious at best because it doesn’t cite a single study. Let’s say for argument’s sake that Gen Z does indeed have a significantly shorter attention span than those of older generations. Fast Company (an American business magazine that focuses on technology, business, and design) likes to call it an “eight-second filter.” That is, Gen Z has unlimited resources but only so much time, so they need to make quick decisions as to what they’re going to care about and what they’re going to blow by.⁶ Chances are that if you’ve got Gen Z emergency dispatchers in training, you’ve made it past their filter.

Still, it’s important to let millennials and Gen Zers know up front why you’re asking them to do what you’re asking them to do. Parry said like most baby boomers, he was brought up to do as he was told. The “why” of a policy doesn’t seem to matter much to his generation. Not so with the younger generations. Parry thinks that’s great.

“PSAPs created policies and procedures in reaction to things that happened but don’t have explanations built into them,” he explained.

“Millennials want to know why a rule exists. It causes us to rethink why the rule exists and if it’s still necessary.”

Such an attitude is especially important in the emergency dispatch community, where rules and protocols are constantly shifting and adapting to provide the best possible care to the people they serve.

**Mentoring**

If you’ve got baby boomers in your dispatch center, there’s a pretty good chance that they’ve been there for a while, so you probably don’t need help in knowing how to train them. And even though baby boomers are on their way to retirement (some sources say that around 10,000 baby boomers retire a day⁷), the youngest of them are barely hitting their fifties.

Robin Chamberlain, a Q for Northwest Central Dispatch in Arlington Heights, Illinois (USA), is one of the younger baby boomers. She started noticing that people are staying in dispatch centers longer before retiring—until 65 or so rather than 50—but no one wants to talk about the elephant in the room (the fact that they’re getting older). Chamberlain is conducting research in her own center as to what can be done to make the transition from working full time to retirement easier.

Not only do centers have to look at making the transition easier for baby boomers, they should also look at making the transition easier for the Gen Xers and millennials who are being left to fill the baby boomers’ shoes. Chamberlain suggests creating a mentoring program that pairs up a baby boomer and a millennial so the millennial has guidance.
and the baby boomer has someone to hand their hard-earned wisdom to. Studies have shown that similar mentoring programs increase the retention of new employees by 25 percent.8

Lexi Pinkerton and Tony Hilley of the Alpharetta Department of Public Safety (Alpharetta, Georgia, USA) have noticed that intergenerational relationships aren’t just beneficial between baby boomers and millennials—bridging the gap between Gen Xers and millennials brings rewards too. Pinkerton and Hilley believe that each of the generations has a lot to offer to one another.

“Millennials have a lot of ideas, but they bounce around so much that they lose credibility,” said Hilley, who is a millennial with Gen Xer tendencies. “Gen Xers come in and mentor millennials to make their ideas really succeed.”

And what do millennials bring to the table?

“Millennials run on risk—they’re not afraid of failing,” added Pinkerton, a Gen Xer with millennial tendencies. “Gen Xers are more hesitant to take risks. They learn back and forth from each other in a continuous cycle of growth.”

Hilley and Pinkerton have seen the effects of such interactions in their own center. Millennials are taking on skills they’re seeing from Gen Xers and adapting them, and Gen Xers are seeing the millennials step up and accept responsibilities. It’s resulted in a revamping of passion in Gen X for sure.

“Millennials say, ‘We’re here to succeed. We’re here to win,’ which inspires the Gen Xers, who are kind of burned out and jaded,” Pinkerton said.

Rewarding

If there’s one unifying idea that brings the generations together, it’s that everyone likes to be rewarded for a job well done. How they like to be rewarded is another matter.

According to the Incentive Research Foundation, baby boomers “are said to look for peer recognition, promotions, more responsibility, and greater formal respect (titles, deference, etc.).” Gen Xers also appreciate being recognized, but on the whole they prefer being recognized privately, like in an email sent just to them and not the entire center. Some research states that millennials and Gen Zers want awards and certificates (rewards that are tangible and immediate); however, other research suggests that the youngest generations prefer experiential rewards.9

For example, at the Alpharetta Department of Public Safety, emergency dispatchers who have high compliance get to wear casual clothes for a day, and their picture goes up on the wall. Pinkerton said it’s generally millennials who get excited about that kind of recognition, but the Gen Xers are working hard to keep up.

The center is also working on getting greater public recognition for their emergency dispatchers. One of the Gen Xers got to meet the parents of a baby she helped deliver over the phone, and it made her whole month.

“She wanted to hold that baby more than she wanted to hold that award,” Pinkerton said.

Not every individual adheres to the stereotypes of their generation. There are some baby boomers who would prefer to be recognized for their achievements privately, just as there are Gen Xers who would love someone making a speech about them. There are some millennials who love constant feedback, and there are Gen Zers who would prefer training online instead of face-to-face.

The trick is finding out which rewards work best for your center and your emergency dispatchers.

If you’re interested in learning more about generational differences in the dispatch center, be sure to check out the following presentations at

NAVIGATOR 2018:
• “Talkin’ Bout My Generation” by Lexi Pinkerton and Tony Hilley
• “Generational Differences—You’ve Got to be Kidding!” by Eric Parry
• “Baby Boomers in the Communication Center: The Silver Lining” by Robin Chamberlain

Sources
2. See note 1.
4. See note 3.
Millennial Breakdown

77 MILLION of the U.S. population are millennials!

Industries millennials have allegedly killed:
- diamonds
- marriage
- dinner dates
- homeownership
- 9 to 5 workweek

Millennials’ annual median income is $33,833 (working year-round, full time).

5.3 MILLION U.S. households living in poverty were headed by millennials in 2016.

More millennial households are in poverty than households headed by other generations.

1. www.agencyascend.com/blog/41-revealing-statistics-about-millennials-every-marketer-should-know
2. www.agencyascend.com/blog/41-revealing-statistics-about-millennials-every-marketer-should-know
3. www.businessinsider.com/millennials-are-killing-list-2017-8/#motorcycles-7
Fast and Flexible POLICE Dispatching

Give your emergency dispatch center the tools it needs to handle 911 calls efficiently and accurately. ProQA® with the Police Priority Dispatch System™—just updated with major enhancements—is faster and more flexible than ever, giving you the information you need, when you need it. ProQA helps you dispatch smarter, always prioritizing officer safety.

SEE IT IN ACTION. REQUEST A DEMO AT prioritydispatch.net.
How do you prioritize calls?

For police and fire communication centers, anything in progress is a top priority. An active shooter situation is dispatched immediately, and the same goes for an explosion at a fertilizer plant. Anything life threatening in EMS takes top priority, whether a sudden cardiac arrest or a baby on the way.

These same types of incidents—high priority—can be low or high frequency.

Sudden cardiac arrest (SCA) is the largest cause of natural death in the U.S.—about 383,000 adult deaths each year—and is responsible for half of all heart disease deaths.\(^1\) SCA, however, is a low-frequency 911 call. Statistics put it as low as one percent.

Active shooter mass incidents (commonly defined as four or more people killed, excluding the shooter) increased dramatically from one incident to 20 incidents during the period between 2000 and 2015.\(^2\) Although a relatively low-frequency occurrence, an active shooter incident demands the highest priority.

So, what does sudden cardiac arrest have to do with active shooter incidents, especially in relation to emergency dispatch?

They make the heart pound faster, particularly if unprepared.

“It’s a real issue in EMS,” said Brett Patterson, Academics and Standards Associate and Chair, Medical Council of Standards, International Academies of Emergency Dispatch® (IAED®). “You certainly get comfortable with the more frequent types of calls. Unfamiliarity can cause apprehension. It’s something you’re not used to working with all the time.”

Understand the “why”

Familiarization requires training, and training requires more than simply memorizing the script, Patterson said.

The unified protocol concept (script) and systems approach distinguishes the IAED protocols...
to, among other reasons, standardize care no matter where it is used. However, an actual incident involving a seldom used protocol is not the time to practice. In addition, patient-driven events—such as childbirth—might require starting the PAIs at a section of the scripted sequence you’ve never needed (e.g., breech, cord wrapped around baby).

“You don’t want to go searching to find out where you are in the process,” Patterson said. “You need training and practice. You have to understand the goal of that protocol.”

As an example, Patterson cites a call he took in 1991 while working in dispatch in Pinellas County, Florida (USA). The 18-year-old caller was pregnant, in hard labor, and home alone with her two-year-old daughter. The delivery went quickly—twins, one weighing 1.5 pounds and the other weighing 1.7 pounds. An ambulance was on the way, but what could be done until paramedics arrived on scene?

“I remembered the goal of the protocol,” Patterson said. “Keep them breathing and warm. I focused on that. Focusing on understanding the basic need of the patient is what’s needed in these types of situations.”

Focus, he said, also keeps an emotional response at bay. As a result, the EMD conveys confidence. Patients understand their role and what you expect of them.

Supply the right tools

Megan Craig was introduced to the Medical Priority Dispatch System™ (MPDS®) when she started at Deschutes County 9-1-1 (Bend, Oregon, USA) in 1998. Similar to other new hires, she attended an initial training that included instructions on how to use the cardset.

“There was very little continuing education or explanation behind the protocol,” said Craig, now the center’s Training Coordinator. “This could make it unnerving to be on certain types of calls and not understand the best way to process them.”

Providing the tools for a deeper understanding of the protocol and ProQA® has since become a major goal, so regardless of the outcome, she said, “We know we’ve done everything we could for that situation, and the callers received excellent care.”

An initial challenge was where to go for the tools. Craig recalls talking to other EMDs, finding instructions online for choosing the correct Chief Complaint, and developing scenarios based on these with her teammates. She now uses the Academy’s Advancement Series and rotates through all the protocols for training lessons, all in the interest of practicing the protocols in preparation for the “what-ifs.”

Calls are the luck of the draw. Without practice, it’s like having a plan to fail.

Craig also sends out weekly emails summarizing call compliancy, congratulating emergency dispatchers for their efforts (even if the outcome is not always what they had hoped), and providing a pop quiz.

“I am thankful to work at a center where people want to do a good job,” she said. “We offer a high level of care, and we’re proud of that.”

Realize potential

Despite a gregarious, outgoing personality, the voice of EMS is where Chad Hicks plans to stay. It’s his niche. He identifies with the attention the profession demands.

“I’m a stickler for detail,” said Hicks, who is an emergency dispatcher and trainer at Deschutes County 9-1-1. “It’s something I got from my dad. He always said, ‘Anything worth doing, is worth doing right.’”

The life and death consequences of what emergency dispatchers say, hear, and relay to response is why he tries to tap into the motivation of the newcomers he trains. It’s not only for accuracy’s sake.

“You have to want to do this,” said Hicks, who left private industry for public service. “If it’s just a job, something to get through each day, it’s probably not right for you.”

Realizing the potential to help is central, he said, to mastering protocols.
and proficiently handling high-priority/low-frequency situations. Hicks’ most memorable call, in fact, was not one he answered directly. He was training when a call requiring the use of childbirth PAIs came through to his trainee. He acted in an oversight position, guiding the trainee’s actions.

“Pregnancy doesn’t happen here at the center that often, and it’s really hard to navigate the CAD and at the same time walk through the protocol while trying to keep the caller calm,” he said. “I let her do it, and we heard the baby’s first cries. This is something I don’t think either of us will ever forget, and we did it as a team.”

Retaining the specifics of a low-frequency call takes repetition for new and seasoned emergency dispatchers alike, Hicks said. The emergency dispatcher must understand the sequence of events (why the steps occur in that order) and practice protocols and PAIs in a no-stress training environment.

“Calls are the luck of the draw,” he said. “When the call comes in is past the time to learn. Without practice, it’s like having a plan to fail. My goal is to be the best, and I want the same for my trainees.”

Prepare for randomness

The unpredictability factor is the impetus behind Heidi DiGennaro’s roll call training at the Harford County Department of Emergency Services, Forest Hill, Maryland (USA). DiGennaro is a shift manager at the tri-accredited center (fire, police, and medical ACE) and entering her 25th year in emergency communications.

Roll call training is the 30-minute period overlapping shift change, and during that time, supervisors summarize events of the previous shift, give position assignments, and provide a training exercise. DiGennaro favors the latter and over the years has created scenarios of the unpredictable. She scours the news, takes suggestions, dramatizes little used protocols, and plain relies on her imagination to develop the situations involving active shooters at shopping malls, explosions, teenage parties gone wild, bar fights, and airline crashes.

“Set up a scenario, and work through it like a tabletop exercise,” she said. “Be outlandish, go crazy because you never know. What if a boat hits a bridge when a train carrying hazmat is on it, and the boat breaks the bridge? Sounds unusual, especially if you have no waterways, but what about overpasses? What if a tanker hits a highway bridge abutment and breaks the overpass with cars on it? Can that happen? Create the discussion.”

Engaging the emergency dispatchers motivates them, which is critical for unpredictable events, DiGennaro said.

“That first five minutes of the incident is crucial,” she said. “That’s when the call is make-or-break. We are the front line. We are the ones who will set the initial tone for the call. The field doesn’t know the call exists when we are making decisions on what to do from the first telephone or first radio call. We must be prepared.”

Give your best

While agency policy may be helpful in these situations, Patterson said, “You can see how difficult it would be to create a policy that covers every possible situation.”

More often, policies are created to change response plans or suspend PDIs/PAIs during unpredictable, high call volumes. In addition to the consideration of policy, however, Patterson said agencies might be comforted to know that doing your best, given certification, training, and experience, is always considered in a court of law. In addition, he said predictable spikes in call volumes—which can happen during high-priority and low-frequency events—are generally not considered under the Emergency Doctrine.

“An agency is obligated to prepare for what is predictable,” he said. 

Sources

What is the best indication of preparedness in a communication center for an active shooter incident at a shopping mall? Disaster preparedness and management policies? Resource allocation procedures? What about the caller having chest pains at the same time but in a different place than an active shooter? What can you do for him? Providing appropriate assistance to secondary high-priority callers—for situations not related to the major incident—is every bit as significant as response to a major event.

“A center can’t put everything else on hold for one event,” said Kevin Anderson, Director of Communications, American Medical Response (AMR) Northwest. “You have to attend to the non-emergent callers and what they need.”

Anderson speaks from experience: 30 years in EMS, including EMT and supervisory and management positions with AMR Portland, Oregon (USA), communication center. He has been in the field responding to mass casualty incidents, including directing response to a mass shooting at a shopping mall, and, most recently, voluntarily providing aid at the mass casualty shooting in Las Vegas, Nevada (USA).

“People in EMS want to fix things,” Anderson said. Even at times when the event is more than they’ve ever been through. Five years ago, on Dec. 11, 2012, communication centers in the Portland, Oregon, metropolitan area handled 22 minutes of chaos when a 22-year-old shooter opened fire on shoppers at the Clackamas Town Center. The number of 911 calls soon overwhelmed the Clackamas County emergency system, subsequently routing the overload to outlying dispatch centers, including AMR Portland.

Anderson was “very proud” of everyone at the center who responded to the shooting. He also acknowledges the 40 secondary calls they ran at the same time, reinforcing a perspective he finds integral for management during crisis. “Pump the brakes,” he said. “We all want to help. Everyone wants to go to the shooting, but there has to be dispatchers waiting for that minor chest pain call from the nursing home.”

The second mass casualty incident in his experience was directly related to his job in Portland. Anderson and his wife, Elaine, were among the thousands clapping and dancing to country music when hell broke loose on the Las Vegas Strip (Oct. 1, 2017). They heard the shots. They were 30 yards from stage right, opposite the side where bullets first hit.

“I was convinced shots were on the street,” Anderson said. “No crack by the side of my head. Nobody moved. Nobody knew what was going on.”

Four minutes into the shooting, Anderson realized the terror was coming from within the venue. He and Elaine fled toward an exit. The first victim in their path was a man concertgoers were dragging across the grass, his head wrapped in a shirt to staunch the blood from a head wound. Anderson helped lift him into a car in a line of vehicles coming from the adjacent parking lot. Elaine stayed to comfort the man’s wife.

So it went for the next two hours after the gunfire stopped. Anderson looked for silhouettes on the ground, placing the wounded on wheeled containers and rolling them to waiting vehicles and carrying the deceased to an alley alongside the venue. He lost sight of Elaine who, he later learned, was sequestered at Hooter’s Restaurant. He mustered the strength people expect from EMS.

“I remember being very scared and angry,” he said. “People are hurt, dying, and screaming, and there is absolute chaos. No one in this type of situation stays the coolest cucumber, but people in EMS are looked upon as the voice of reason, and that’s what I knew I could do to help. I was trying to be calm for them, at least on the surface.”

Anderson went home and returned to work two days later. He told the emergency dispatchers what had happened, from his perspective, and it wasn’t an easy story for them. “This was beyond what anyone had heard,” he said. “I could tell that in their eyes. What would happen to me? This is not only about preparation. It’s also about recovery.”
Intelligent Dispatch Solution

- Easy integration
- System status management
- Workflow automation
- Mobility
- Voice communication

Find out more: www.logisolutions.net
The first man in the crew of utility workers removed a manhole and went underground to inspect a clogged sewer line. A second man, worried at the silence that followed the first man’s descent, climbed down in search of his co-worker. A third man, unable to hear or see what was going on underground, took his turn hoping, perhaps, that the depth of the hole in the Key Largo, Florida, USA, subdivision was muffling the sound of their voices. Or maybe he was desperate, knowing they might need help in an unknown emergency. He, too, shimmied down the hole just wide enough to squeeze through, and, similar to his two co-workers, entered the 15-foot deep confined space without safety equipment such as a mask or air packs.

The three men did not make it to the surface of the drainage trench alive. Subsequent atmospheric testing within the hole revealed lethal levels of hydrogen sulfide gas and carbon monoxide from rotting vegetation.

Two other employees of the underground utility and municipal infrastructure company and a volunteer firefighter also exposed to the toxic gases during rescue attempts survived, although they required extended hospital stays.

The Occupational Safety and Health Administration (OSHA) investigated the deadly incident that occurred in January 2017 and six months afterward released a report citing 10 serious safety violations netting the company nearly $120,000 in fines. The company’s failure to provide a confined space entry program and the lack of confined space entry permits by a qualified person were among the violations cited.1

The same company was cited by OSHA in 2002 for safety violations involving a manhole project in Marco Island, Florida, USA.

Dangerous places

Many workers and employers are unaware of the dangers confined spaces pose, which include lack of oxygen; poisonous gases, fumes, or vapors; liquids and solids suddenly filling the confined space or releasing gases into it when disturbed; and gases entering through piping. Injuries and deaths can occur as a result of work being carried out in a confined space, such as welding, painting, flame cutting, or using chemicals.

About 90 deaths involving confined spaces occur every year across a wide range of industries. Two-thirds of those deaths are workers killed while trying to rescue someone from a confined space. According to one source, “For every victim who dies in a confined space, three would-be rescuers die trying to save that victim.”2

TIGHT PLACES
Confined spaces can be fatal

Audrey Fraizer

T

h e first man in the crew of utility workers removed a manhole and went underground to inspect a clogged sewer line. A second man, worried at the silence that followed the first man’s descent, climbed down in search of his co-worker. A third man, unable to hear or see what was going on underground, took his turn hoping, perhaps, that the depth of the hole in the Key Largo, Florida, USA, subdivision was muffling the sound of their voices. Or maybe he was desperate, knowing they might need help in an unknown emergency. He, too, shimmied down the hole just wide enough to squeeze through, and, similar to his two co-workers, entered the 15-foot deep confined space without safety equipment such as a mask or air packs.

The three men did not make it to the surface of the drainage trench alive. Subsequent atmospheric testing within the hole revealed lethal levels of hydrogen sulfide gas and carbon monoxide from rotting vegetation.

Two other employees of the underground utility and municipal infrastructure company and a volunteer firefighter also exposed to the toxic gases during rescue attempts survived, although they required extended hospital stays.

The Occupational Safety and Health Administration (OSHA) investigated the deadly incident that occurred in January 2017 and six months afterward released a report citing 10 serious safety violations netting the company nearly $120,000 in fines. The company’s failure to provide a confined space entry program and the lack of confined space entry permits by a qualified person were among the violations cited.1

The same company was cited by OSHA in 2002 for safety violations involving a manhole project in Marco Island, Florida, USA.
Many factors lend to the danger of working in a confined space. There is smaller margin for error. An error in identifying or evaluating potential hazards can have more serious consequences. Variability and unpredictability of circumstances make it nearly impossible to judge the degree of risk. Fatalities can be due to the critical nature of these rescues, which sometimes lead to poorly planned retrieval attempts and the existing potential of asphyxiation.

Asphyxiation occurs when an individual does not have enough oxygen to sustain life, either because the oxygen amount in the atmosphere is too low and/or a hazardous chemical concentration is too high (e.g., a carbon dioxide concentration of four percent or more is considered immediately dangerous to life or health). Changes in the atmospheric conditions can change over time, as in the case of the Key Largo tragedy. Decaying organic matter, such as plants and animals, uses up oxygen and produces hazardous gases, and a space acceptable during initial entry a year ago could be host to atmospheric changes that result in injury and death.

**Technical definitions**

So, what is a confined space? OSHA considers everything from a tank to a tunnel to a manhole to be a confined space, according to its definition:

- large enough for a person to enter
- limited or restricted exits, and
- not designed for continuous human occupancy

In addition, a confined space is a place that is substantially—although not always entirely—enclosed and where there is a risk of death or serious injury from hazardous substances or dangerous conditions, such as a lack of oxygen.

Places can also become confined spaces during construction work, fabrication, or modification. Confined spaces do not always have to be an area with only one opening. Likewise, a space with multiple openings can be considered a confined space if a worker has to crawl under and over various obstructions to get to the opening. Permit-required confined spaces pose serious hazards.

OSHA uses the term “permit-required confined space” (permit space) to describe a confined space that has one or more of the following characteristics: contains or has the potential to contain a hazardous atmosphere; contains material that has the potential to engulf an entrant; has walls that converge inward or floors that slope downward and taper into a smaller area that could trap or asphyxiate an entrant; or contains any other recognized safety or health hazard, such as unguarded machinery, exposed live wires, or heat stress.

It is these conditions that result in fatalities, according to OSHA, making efficient and immediate exit or rescue from the space imperative.

If a space is identified as a permit-required confined space and an employee will need access to the space, then the employer must develop a written program that includes a plan for rescuing the entrants.

An OSHA rule, effective Oct. 2, 2015, expands confined space safety requirements and applies to all construction workers who may be exposed to confined space hazards, such as those who work in sewers, manholes, crawl spaces, boilers, tanks, storage bins, silos, stacks, vaults, pits, chambers, vats, trenches, drains, flues, ductwork, unventilated or poorly ventilated rooms, and many more locations that have cramped spaces and narrow openings. The rule requires employers to determine what kinds of spaces their workers are in, what hazards could be there, how those hazards should be made safe, what training workers should receive, and how to rescue those workers if anything goes wrong.

In addition, according to the same rule, controlling contractors and employers must discuss spaces on the site and their hazards with entry employers and each other before and after entry.

---

**Protocol 54: Confined Space/Structure Collapse**

**Sequencing**

The EFD can make sure the proper resources are identified in confined space situations by adherence to the interrogation sequence in Protocol 54: Confined Space/Structure Collapse in the Fire Priority Dispatch System™ (FPDS™).

The opening Key Question provides the EFD with information regarding the type of space or structure involved. This question can help determine the appropriate suffix. Key Questions 2 and 3 ask whether anyone is trapped and whether any hazardous materials are involved. Depending on the answers to these questions, the EFD will send the correct Determinant Code and then immediately provide Post-Dispatch Instructions (PDIs) and Pre-Arrival Instructions (PAIs) as appropriate.
If the answer to Key Question 2 indicated that the caller is trapped, the EFD will go to Panel B-5 on Protocol B: Fire and Hazards Rescue. While on Panel B-5, the EFD will attempt to gather more information, including where the individual is located, what the individual can see and hear, and if other dangers are present. The EFD will advise the caller to make as much noise as possible to aid in rescue efforts.

A caller identifying a possible HAZMAT danger will direct the EFD to provide the instructions from Panel B-4. Instructions include leaving the contaminated area if it’s safe to do so, not touching anything contaminated with chemicals, not touching anyone who may be contaminated with chemicals, and not entering or re-entering any hazardous or dangerous areas.

While providing Pre-Arrival Instructions to the caller is very important, it is also critical that the EFD keep the caller on the line while notifying appropriate agencies (e.g., OSHA, the utility service, or relevant city department) and the Technical Rescue Team, if one is included in the agency’s response plan. Depending on the setup of the agency, the EFD may also have the responsibility of providing fire and EMS responders with any known information regarding the location and number of people trapped or in danger to enable earlier location and assistance of victims. Once Panel B instructions are given, the EFD returns to Key Questioning.

If the caller isn’t trapped and no hazardous materials are involved, the EFD should return to Key Questioning after providing PDIs.

**Hazards**

A confined space situation is extremely serious. Rules 1 and 2 on Protocol 54 make it clear that this is an emergency dangerous to callers, bystanders, and responders.

**Rule 1:** All “unknown” ENTRAPMENTS are considered “unconfirmed” until proven otherwise.

**Rule 2:** All collapsed buildings/structures are considered occupied until proven otherwise.

The EFD can make a significant difference for the victim and the bystanders by following the appropriate instructions. With that in mind, the EFD adheres to the emergency dispatcher’s first Rule: “Don’t take more victims to the scene!” It is up to the EFD to take control as the initial incident commander and direct the appropriate actions for everyone until other responders take over.

Accordingly, the EFD’s hardest, but most important task, is to maintain order on the scene prior to field unit arrival and to make the site as safe as possible. This requires the EFD’s effective communication skills and call management techniques to take control of the call and provide PDIs to callers who, by default, take on the role of “surrogate incident commander.” Bystanders must be prevented from doing something that turns an already bad situation into a fatal one for the bystander or an already-trapped victim who may still be alive. They must not allow other well-meaning bystanders to attempt rescue prior to the fire department’s arrival. Even fire department personnel place themselves at risk jumping into a confined space before testing.

Crews must also contend with the potential for atmospheric contamination. Since the victim and the rescuers are below grade, they must constantly monitor the air and other gases in the trench to ensure they are not in a toxic atmosphere. According to PDI-d on Protocol 54, when appropriate, the EFD should tell the caller to turn off all equipment, if it’s safe to do so, except the ventilation.

Remember, one of the most critical duties of the EFD is the ability to communicate effectively and take appropriate actions in the emergency. The EFD is the vital link.

**Sources**


5. See note 4.
YOU MUST BE FIRE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Tight Places,” which starts on page 36. Take this quiz for 1.0 CDE unit.

1. What is the cause of two-thirds of deaths from confined space accidents?
   a. trench collapse
   b. sensory deprivation
   c. going into the confined space to rescue someone
   d. serious injury from a fall

2. What percent of carbon dioxide concentration is considered immediately dangerous to health?
   a. 4 percent
   b. 8 percent
   c. 12 percent
   d. 20 percent

3. According to OSHA, a confined space:
   a. is large enough for a person to enter
   b. has limited or restricted exits
   c. is not designed for continuous human occupancy
   d. all of the above

4. A confined space is always entirely closed.
   a. true
   b. false

5. An employer must develop a written program that includes a plan for rescuing the entrants when:
   a. a space is just wide enough to shimmy through although not strictly a confined space by OSHA definition.
   b. a space is identified as a permit-required confined space and an employee will need access to the space.
   c. the earth around the space is liable to collapse.
   d. the depth of the confined space is greater than waist-high to the employee.

6. Which protocol do you use when sending a response to a person trapped below ground in a sewer?
   a. Protocol 53: Citizen Assist/Service Call
   b. Protocol 54: Confined Space/Structure Collapse
   d. Protocol 65: Mutual Aid/Assist Outside Agency

7. Depending on the answers to Key Question 2 and 3, the EFD will:
   a. send the correct Determinant Code and then immediately provide Post-Dispatch Instructions and Pre-Arrival Instructions as appropriate.
   b. delay sending the correct Determinant Code until after providing Post-Dispatch Instructions and Pre-Arrival Instructions as appropriate.
   c. continue interrogation until the caller can no longer respond.
   d. continue interrogation while reassuring the caller that help is on the way.

8. Which panel should the EFD go to if the caller is trapped?
   a. Protocol B: Fire and Hazards Rescue, Panel B-2
   b. Protocol B: Fire and Hazards Rescue, Panel B-5
   c. Protocol B: Fire and Hazards Rescue, Panel B-6

9. In situations involving confined spaces, the EFD must adhere to the first rule of emergency dispatch, which is:
   a. “Ask all questions unless the answer is completely obvious.”
   b. “Never assume that an entrapment notification has been received until it has been specifically acknowledged by responders.”
   c. “A thing not looked for is seldom found.”
   d. “Don’t take more victims to the scene!”

10. The EFD’s hardest, but most important task, is to maintain order on the scene prior to field unit arrival and to make the site as safe as possible.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 04/30/19. 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.
TAKE A STAB
Is it a stab wound or a laceration?

Becca Barrus

In England in May 2017, enough people were going to the emergency room after slicing their hand while cutting avocados that doctors nicknamed the phenomenon “avocado hand.” It even has its own hashtag on Instagram and Twitter, where people who have injured themselves while cutting up an avocado display their wounds (usually with some self-deprecating remark).

Knife-related injuries are common and, with the exception of avocado hand, rarely trendy. A retrospective analysis conducted in 2013 showed that roughly eight million knife-related injuries, both intentional and accidental, were treated in U.S. emergency departments from 1990 to 2008. That’s about 400,000 injuries per year or 1,190 per day. In 2016, a little over 21,000 knife crimes were reported in London, England. Unlike guns—which are strictly controlled in countries like England, Canada, Germany, China, India, France, Italy, Spain, and Australia—knives are easily accessible to almost everyone and can be used to slice fruit or stab a partner in a domestic disturbance.

The two Medical Priority Dispatch System™ (MPDS®) Protocols that best address knife-related injuries are Protocol 21: Hemorrhage/Lacerations and Protocol 27: Stab/Gunshot/Penetrating Trauma. Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt is also used in certain cases of self-inflicted knife wounds.

When choosing which Chief Complaint is best for a call involving a knife injury, remember Case Entry Rule 1: “If the complaint description includes scene safety issues, choose the Chief Complaint Protocol that best addresses those issues.” The safety of the caller, the patient, and the responders is paramount. If someone reports that she accidentally cut her arm, there will generally not be any scene safety concerns. However, if someone reports that someone else ran by with a knife and slashed his arm, there will be scene safety issues, as the patient could be attacked again or the knife-wielding person could attack someone else.

Another rule to take into consideration when dispatching a knife-related injury call is Case Entry Rule 2, which says, “If the complaint description involves TRAUMA, choose the Chief Complaint Protocol that best addresses the mechanism of injury.” Knife wounds, whether they are accidental or intentional, fall under the definition of TRAUMA on Protocol 21 (“a physical injury or wound caused by an external force through accident or violence”).

Please note that Protocol 4: Assault/Sexual Assault/Stun Gun should not be
used in instances where the patient has been stabbed by an attacker. Protocol 27 adequately addresses both the mechanism of injury and scene safety concerns.

Many penetrating wounds cause little or no external bleeding. That does not mean that they don’t bleed.

**An issue of blood**

Protocol 21 is more concerned with the blood coming out of the wound than the wound itself. None of the Key Questions on this Protocol ask the caller to describe the size or shape of the wound; rather, you will ask for the location of the wound and whether or not the bleeding is SERIOUS. SERIOUS Hemorrhage is defined as “uncontrolled bleeding (spurting or pouring) from any area, or anytime a caller reports ‘serious’ bleeding.”

Areas of the body that are considered DANGEROUS, due to hemorrhage, are the armpit, the groin, and the neck. These areas are considered the most dangerous because major arteries run through them, and a reported laceration in a DANGEROUS area will warrant a DELTA response. POSSIBLY DANGEROUS areas are the abdomen; arm, upper; back; buttck; chest; elbow; groin; head; hip; knee; leg, upper; neck; and shoulder. PERIPHERAL wounds are those in the finger; foot; forearm; hand; leg, lower; toe, and wrist.

If a caller reports a wound in any of these PERIPHERAL locations, the Determinant Code will be 27-B-2S. However, if there are multiple stab wounds, even if they are in PERIPHERAL areas, the response should be bumped up to a DELTA response (27-D-5).

In the case of a penetrating object that is still embedded in the patient, PDI-b tells you to instruct the caller not to pull it out. The knife is effectively closing the wound and preventing it from hemorrhaging too heavily. Additionally, according to Greg Scott, Operations Research Analyst for the IAED™, the knife could cause further damage on its way out of the wound, whether to internal organs, tissue, nerves, or all three. The responders will take care of it when they get there.

**Control the bleeding**

Whether you use Protocol 21, Protocol 27, or Protocol 25, you will be sent to Case Exit Panel 5 to help the caller control the bleeding. Remember that, as per Axiom 2 of Protocol 21, in most cases external bleeding is not as serious as it appears. Do not let the caller neglect airway maintenance or other less obvious injuries as they attempt to stop the bleeding.

In cases where there are penetrating wounds present, the EMD may or may not receive reports of serious bleeding. Many penetrating wounds cause little or no external bleeding. That does not mean that they don’t bleed.

Controlling the bleeding with a patient who still has a knife penetrating them can be a delicate situation. The Direct Pressure Warning for Case Exit Panel 5 states “Direct pressure on the wound should be avoided in the presence of visible fractured bone or foreign objects,” such as a knife. “Principles of EMD” (sixth edition), though, clarifies: “However, unlike bone shards or fragments of foreign objects that are
found on other protocols, penetrating trauma often involves a clean wound with a well-defined penetrating object. In these cases, it might be possible to control bleeding by applying pressure around the object (without pressing on it).” In other words, if the patient still has a knife stuck in him, you can instruct the caller to apply a dry, clean cloth around the wound and apply pressure there, rather than right on top of the wound itself.

Application

How would you handle someone calling with a bad case of avocado hand? Avocado hand could be handled on either Protocol 21 or Protocol 27. With either protocol, it wouldn’t warrant a DELTA response because the hand is classified as a NOT DANGEROUS hemorrhage area on Protocol 21 and a PERIPHERAL wound on Protocol 27. Your choice of Chief Complaint might depend on the wording of the caller. If the caller’s main concern is the wound itself—“I stabbed myself while trying to get the pit out of an avocado”—you would probably choose Protocol 27. If her main concern is the amount of blood coming out of her hand—“I sliced my hand while cutting up an avocado, and now it’s bleeding everywhere”—you would probably choose Protocol 21 to best handle the bleeding. However, if the caller classified the bleeding as SERIOUS on Protocol 21, it would be bumped up from an ALPHA to a BRAVO response.

What about cases that aren’t routine? In 2012, a New Zealander named Mark Wells had his throat cut in his own home. Wells’ attacker came up behind him in the bathroom, slit his throat with a bread knife, and left him for dead. Wells pressed a towel to his wound and staggered out to the street, trying to find help until eventually an ambulance was called. Against all odds, he survived. The danger of an injury like this is the copious bleeding as well as the location of the wound, which might make you inclined to use Protocol 21; however, Brian Dale, IAED Associate Director of Medical Control and Quality Processes, says that Protocol 27 would be the best choice as it better addresses both scene safety issues and mechanism of injury.

Whether it’s a vicious street attack or a clumsy kitchen accident, the key to correctly coding a call involving a knife-related injury is remembering to prioritize scene safety. Once scene safety issues have been addressed, make sure you also address the mechanism of injury.

Sources
CDE Quiz Mail-in Answer Sheet

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

A CDE acknowledgement will be sent to you. (You must answer 8 of the 10 questions correctly to receive credit.)

Clip and mail your completed answer sheet along with the $5 USD (U.S. currency) NON-REFUNDABLE processing fee to:

The International Academies of Emergency Dispatch
110 South Regent Street, 8th Floor
Salt Lake City, UT 84111 USA
Attr: CDE Processing
(800) 960-6256 US; (801) 359-6916 Intl.

Please retain your CDE acknowledgement for future reference.

Name ________________________________________
Organization __________________________________
Address ________________________________________
City ____________________ St./Prov. ____________
Country ________________ ZIP ____________
Academy Cert. # ____________________
Daytime Phone ( ) _______________
Email ________________________________________

PRIMARY FUNCTION
☐ Public Safety Dispatcher (check all that apply)
☐ Medical
☐ Fire
☐ Police
☐ Paramedic/EMT/Firefighter
☐ Comm. Center Supervisor/Manager
☐ Training/QI Coordinator
☐ Instructor
☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other

ANSWER SHEET  MEDICAL
March/April 2018 Journal “Take A Stab”
Please mark your answers in the appropriate box below.

1.  ☐ A ☐ B ☐ C ☐ D
2.  ☐ A ☐ B ☐ C ☐ D ☐ E
3.  ☐ A ☐ B
4.  ☐ A ☐ B ☐ C ☐ D
5.  ☐ A ☐ B ☐ C
6.  ☐ A ☐ B ☐ C ☐ D ☐ E
7.  ☐ A ☐ B ☐ C ☐ D
8.  ☐ A ☐ B
9.  ☐ A ☐ B ☐ C ☐ D
10. ☐ A ☐ B ☐ C

To be considered for CDE credit, this answer sheet must be received no later than 04/30/19. 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.
MAKING THE CUT
The ALS process defines the profession

Jeff Clawson, M.D.

Seems odd that some inside the medical profession initially debated the merits of emergency medical dispatchers (EMDs) when it came to providing prehospital care. EMDs were overlooked in the chain-of-survival and seldom recognized in the context of being emergency medical colleagues.

While the introduction of Medical Priority Dispatch System™ (MPDS®) Protocols helped shift EMD recognition, some still criticized a layperson’s (non-medical) ability to give potentially lifesaving pre-arrival instructions and, at the same time, send the most appropriate response.

The point they failed to see was the process involved.

From the very beginning of this now nearly 40-year journey, the Academy has stressed compliance to a protocol model: certification, training, continuing education, and quality improvement. Think of it in the way of a medical analogy. A doctor’s physical exam of a patient is part of a process intended for proper diagnostic and therapeutic interventions. The emergency dispatcher’s interrogation of a caller is actually part of an ALS process intended for proper chief complaint and response interventions.

This initial primary and secondary exam—whether hands-on or over-the-phone—must be based on a reliable, evidence-driven standard. Neither a medical doctor, nor an EMD, can afford to skip an evaluative step, no matter how evident the findings at first impression might seem. This takes an irrevocable process, shown over and over again, to separate those who perform well from those who should never make the cut, no matter what the task at hand.
THE EMD AS A MEDICAL PROFESSIONAL

By Jeff Clawson, MD, Robert Martin, Bill Lloyd, MBA, Mike Smith and Geoff Cady

There is probably no medical profession other than emergency medical dispatching in which the core time for patient evaluation and decision making is routinely around one minute, and more is potentially at stake on a case-by-case basis. Unfortunately, the emergency medical dispatcher (EMD) is not generally accepted as a professional by EMTs, paramedics and other members of the medical team. Thus, EMDs occupy somewhat ambiguous roles within the medical profession and public safety agencies. Early in the history of emergency dispatching, dispatchers were seen as little more than public safety clerks. Early functions essentially consisted of identifying the emergency’s location, determining which unit should respond, then notifying the units of the call and tracking their progress. In 1978, the first comprehensive emergency medical protocol tool was developed, and EMDs were born, ushering in a new era of EMS delivery. Since then, the EMD protocol and process has evolved as the EMD’s performance has been shown to be an effective adjunct to emergency medical care. This formal dispatch method—radical at the time—has redefined the EMD’s role and professional standing.

One of the difficulties EMDs have in gaining acceptance as medical professionals is that the rest of the medical profession isn’t clear on the EMD’s role and whether the EMD’s tasks are truly medical. Most prehospital care providers are directed and regulated by medical control physicians and some form of governmental authority. In contrast, EMDs are typically hired, trained, managed and paid by law enforcement, fire or ambulance agencies. They have limited or no medical direction and little or no government regulation. In many areas, the EMD’s practice lacks adequate medical control and management. No quality improvement is undertaken, and the dispatchers lack professional certification. However, properly trained EMDs performance is based on medical protocols similar to other medical professionals except in two ways: a lack of direct...
EMDS

Practice Dissimilarities

EMDs essentially practice their profession via remote control, dealing nonvisually with someone who is generally not the patient. The lack of direct patient access requires EMDS to rely heavily on interrogative skills. However, with tested protocol-driven questioning, EMDs can successfully elicit the necessary information to dispatch appropriate personnel with adequate information.\(^8\)

Unfortunately, in addition to the physical constraints, there exist system-imposed time limits on emergency medical dispatching. "The 60-second dilemma" was a phrase coined several years ago to emphasize that in today's high performance EMS systems, the EMD has only 60 seconds to interrogate (i.e., evaluate the situation) and render a decision (i.e., provisional diagnosis). Very few, if any, medical professionals are required to consistently perform the evaluation and decision-making part of their patient care process in 60-seconds. Even more astounding is that there is no scientific rationale for the 60-second time frame.

The 60-second time interval should be used as a goal or objective to strive for in most situations—not a rule or absolute upper limit. In most medical situations, the time to dispatch should not be treated as a ticking time bomb, since the majority of incidents are not escalating in any appreciable way.

Table 1. Patient Care Routines for EMDS and EMS

<table>
<thead>
<tr>
<th>EMD</th>
<th>Emergency Physician/Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call receipt</td>
<td>Patient introduction</td>
</tr>
<tr>
<td>Case entry interrogation</td>
<td>Primary survey</td>
</tr>
<tr>
<td>Four commandments/questions</td>
<td>Vital signs</td>
</tr>
<tr>
<td>Immediate dispatch (when necessary)</td>
<td>Call for MD specialist</td>
</tr>
<tr>
<td>Pre-arrival instruction</td>
<td>Support ABCs</td>
</tr>
<tr>
<td>Key question interrogation</td>
<td>Secondary survey</td>
</tr>
<tr>
<td>Dispatch code selection</td>
<td>Working diagnosis/action plan</td>
</tr>
<tr>
<td>Routine dispatch</td>
<td>Further evaluation of patient</td>
</tr>
<tr>
<td>(send mobile evaluators)</td>
<td>(order lab tests, ECG, X-ray, etc.)</td>
</tr>
<tr>
<td>Post-dispatch instructions</td>
<td>Routine treatments</td>
</tr>
<tr>
<td>Case review</td>
<td>Morbidity/mortality conferences</td>
</tr>
<tr>
<td>QA/QI processes</td>
<td>QA/QI processes</td>
</tr>
<tr>
<td>Total quality management</td>
<td>Professional review organization</td>
</tr>
</tbody>
</table>

whether life-threatening or otherwise. With this in mind, 75 to 90 seconds is a more reasonable goal for most calls of a non-time-life priority basis, and some places are instituting just that. As Thera Bradshaw, past-president of the National Emergency Number Association recently said, "It's time we start doing it right, not just fast."

Practice Similarities

Fortunately, the similarities between EMDs and other medical professionals are more prominent. In fact, the individual practice of a physician-managed EMD closely resembles the emergency medical model. (See Table 1.)

The elements of medical care cross over easily and are equally relevant to both groups. For example, the primary survey must be as consistent and complete for the EMD as for the hands-on medical provider. No one can afford to abort or supersede this evaluation, no matter if other findings seem obvious. The importance of this is reflected in the EMD's term for the dispatch primary survey: the "Four Commandments."

Like an EMT who checks the airway but not breathing and circulation, an EMD who does not always ask these four questions risks missing essential information. As with an EMT's secondary survey, the answers provide relevant information regarding patient care, scene safety and response choices. Omissions in this information-gathering process can result in sending the wrong response and providing the wrong treatments. Table 2 outlines the essential areas the interrogation covers.

Perhaps this point can best be made by asking yourself, "When you or a family member are taken to the emergency department, do you want the emergency physician to perform a complete or incomplete evaluation?"

Table 2. Reasons for asking all interrogation questions.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine the appropriate response</td>
<td>Decide on proper field-unit response configuration and mode of travel to scene</td>
</tr>
<tr>
<td>To provide dispatch life support</td>
<td>Determine the presence of conditions requiring pre-arrival and post-dispatch instructions</td>
</tr>
<tr>
<td>To prepare and inform responders</td>
<td>Help EMS field responders prepare for and address the call</td>
</tr>
<tr>
<td>To ensure scene safety</td>
<td>Provide for the safety of all those at the scene (patients, bystanders, responders and caller)</td>
</tr>
</tbody>
</table>

constructed on page 75
tion?" Keeping in mind that each of the interrogation questions may lead to a different evaluative conclusion, different treatment, different information relay or different advice, EMDS cannot assume answers to questions they never asked. It is true that "a thing not looked for is seldom found.

Compliance to the EMD protocol ensures all essential elements will be "found," and clarification or expansion of the protocol will be accomplished only when necessary. In fact, EMD training directs that "dispatch personnel will follow all protocols per se, avoiding free-lance questioning or information unless it enhances, not replaces, the written protocol questions and scripts.

The EMD as an ALS Professional

It is widely believed a trained EMD is essentially a basic life support-level provider. Reacting to this notion, an EMD once asked me what "that's right, we're sub-basic life support. This belief, however, is incorrect. The basis of the core curriculum for EMD training specifically the "dispatch priorities" is, in fact, ALS-level.

What has confused most casual observers is that the EMD appears to perform BLS-type tasks, such as CPR, the Heimlich maneuver and airway control. However, the EMD is not required to perform the BLS skill but instruct it on the fly. In fact, the majority of the information in the EMD curriculum is derived from the knowledge base of emergency physicians and nurses. For example, the commonly taught dispatch rule, "A previously healthy child found in cardiac arrest is considered to have a foreign body airway obstruction until proven otherwise," cannot be found in Karen and Hagen's EMT text. Neither Caroline's paramedic text, or the basic text by American Academy of Orthopedic Surgeons. Most paramedics eventually learn this "rule" from emergency department physicians.

This level of knowledge is why it is necessary for ALS-level personnel (paramedics, RNs and MDs) to train EMDS. No EMD training program should use non-ALS personnel as instructors. The use of specific EMD protocols to aid in the provision of a complete and comprehensive "remote" assessment of the patient in combination with on-the-fly bystander training requires that the EMD process information or "think like ALS personnel.

Medical and Protocol Models of Practice

With all this knowledge, then why shouldn't EMDS routinely practice their medical routines as doctors do—without a formal protocol in hand? After all, the practice of medicine by physicians appears to be safe without the use of well-defined protocols. The answer lies in a very important distinction between physician and "paramedical" practice methods, which can be illustrated by comparing the "medical model" of medical practice with the "protocol model" of evaluation and care. Physicians are allowed by law to deliver medicine in the way they deem best because of years of rigorous education and training and even more years of supervised post-doctoral practice. The sole practitioner in his or her office working from years of experience, perhaps best illustrates the medical model of practice. In contrast, the new physician or intern with approximately 10,000 hours of medical training and experience on his or her first day is hardly an amateur, but a professional who relies on routine access to pertinent additional information. Pockets are stuffed with all kinds of help: Harriet Lane's Pediatric Handbook, the Washington Manual of Therapeutics, the Surgical Manual, and a plethora of drug company-sponsored neonatal and gestational cardboard calculators. Such "peripheral brains" are commonly used by medical professionals to ensure complete and accurate medical treatment under demanding time constraints. They are called protocols.

Compared to that, the typical paramedic has 1,000 to 1,500 hours of training and the EMD has 120 to 200 hours of training. The current minimum amount of training for an EMD is 24 hours. Thus, it's easy to see that an EMD may need a "peripheral brain" that outweighs him or her. It need not be a big peripheral brain but simply be well-designed, medically sound and kept up-to-date.

The EMD and other out-of-hospital providers, therefore, use the protocol model of medical practice. The protocol model is the backbone of the EMD's permission from responsible medical authority to "practice" dispatch life support medicine. As such, compliance to the protocol model significantly enhances the EMD's method of practice by:

- Executing the basic rules of dispatch medicine
- Standardizing patient and situational evaluations
- Permitting the EMD to concentrate on processing obtained information
- Reducing dispatcher bias by formalizing interrogation question structure
- Structuring medical pathways to further evaluations, verifications and necessary treatments
- Reducing the time required for evaluation through optimization of interrogation and decision processes

Enabling rapid, consistent evaluation and treatment within a time-restricted environment.

For example, physicians and nurses use a protocol model for resuscitations and trauma codes. The white board found in every major trauma room lists an orderly series of actions, tests and treatments that must be accomplished in rapid but standardized resuscitative efforts—in essence, a protocol.

The EMD/EMS Partnership

The time has come when we should start thinking of EMDS as medical professionals and, in every sense of the word, medical colleagues, who care for the patient when other medical professionals can't. They must receive the tools, training and time to perform their jobs well. Doing it right is even more important than doing it fast. This fact should be impressed on medical dispatchers by public safety management and medical control.

Rather than decree the formal use of protocol as somehow demeaning, punitive, robotic or even non-medical, it is important to understand they are the tools of all fields practitioners and EMDS. They speed up and improve the evaluation and decision making in both EMD and traditional medical practice.

Non-EMDS can help the professionalization process in a number of ways. Ask them in pre-hospital care surveys. Recognize them as part of the EMD team in papers and articles. Routinely list them as part of the medical control span of responsibility. Include them in consideration of EMS funding issues as well as for reasonable parity in pay.

EMDS can demonstrate their professionalism to their medical colleagues by seeking on-going medical dispatch education to keep current as their relatively new profession and protocol evolve: certifying and recertifying; being customer service-oriented, rather than complaint-driven and reactive in attitude, and maintaining and demonstrating a high respect for those conditions entrusted to them, whether minor indecision on the part of the caller, or outright terror at the scene. Such actions by those in responsible positions within public safety, EMS, and the medical community as well as by EMDS themselves, will ultimately place the imprimatur of "medical professional" on the EMD, where it should have been all along.

Jeff J. Clauzon, MD, is chief executive officer of Medical Priority Consultants Inc., in Salt Lake City, Robert Martin is executive director of National Academy of Emergency Dispatchers in Salt Lake City, Bill Lloyd, MBA, is vice president of Medical Priority Consultants Inc., Mike Smith is the design manager for Medical Priority Consultants Inc., and Geoff Reddy is a consultant for Medical Priority Consultants Inc.

References
PUSH FOR CPR
Deschutes EMS links chain of survival

Audrey Fraizer

Few patients seek medical help for sudden cardiac arrest (SCA) symptoms prior to one actually occurring. In fact, according to a prospective, population-based study,1 more than half of patients had warning symptoms in the four weeks before suffering a sudden cardiac arrest. However, only 19 percent of patients called EMS to report their symptoms. Remarkably:

Of the patients who called EMS, 78 percent developed sudden cardiac arrest before emergency medical responders arrived at the scene, while 18 percent had sudden cardiac arrest in the ambulance on their way to the hospital. The survival rates were 32.2 percent for patients who called 911 compared with 6 percent for those who did not report their symptoms [at all].

EMS-related SCA studies similar to these struck a chord with Capt. Petar Hossick, EMS Training Officer/Paramedic, Bend Fire Department, Oregon (USA). Although providing CPR to a drowning victim motivated his career in EMS during college, it was later as a paramedic that he realized the significance of connecting all the pieces for SCA survival, beginning with 911. “Emergency dispatch is the first piece in the chain of survival,” said Hossick, who has been with Bend Fire Department for 17 years. “And I can’t say enough about the importance of the piece they control in [patient] survival.”

Hossick runs the department’s resuscitation quality assurance program, a position that evolved from his fellowship in 2012 with the Seattle (Washington, USA) Resuscitation Academy. The program was a “light bulb moment,” sparking his conviction to “engender” a SCA survival culture among Bend County police, fire, and dispatch. Deschutes County 9-1-1, Bend, Oregon, was among his first stops. Deschutes County 9-1-1 dispatches for 15 police and fire/emergency medical services (EMS) agencies. In 2016, emergency dispatchers answered 256,541 incoming calls, of which 66,989 came in on the 911 line (18,840 dispatched for EMS).

Hossick did not know a lot about the Deschutes 9-1-1 system. He knew their work was critical and highly important, but he knew little about the process they used, which includes the Medical Priority Dispatch System™ (MPDS®) and Fire Priority Dispatch System™ (FPDS®).

His scheduled visit was welcomed by Training Coordinator Megan Craig and the intra-agency collaboration Hossick wanted was an offer she readily accepted. “He got a conversation going,” she said. “He wanted to make sure that we were all on the same page when something happened.”

Fire, police, and EMS agencies interested in the collaborative project wrote policies and participated in ongoing CPR training. For emergency dispatch training, Hossick brings mannequins to the communication center and uses metronome apps to help them visualize what they’re instructing the caller to do: high-performance CPR (minimal breaks in compressions, full chest recoil, adequate compression depth, and adequate compression rate). He offers advice. It’s OK if you get it wrong and provide bystander CPR for a patient not in cardiac arrest. The risk of harming the patient is extremely low. “We give permission to miss things, because every time you get it right, you can make a difference in a person’s life,” he said.

Craig said they no longer ask callers “if” they will give CPR. “We assume they will do CPR before they say they won’t,” she said. “Everything we do depends on getting hands-on-chest fast and following protocol to increase survivability in SCA.”

The intra-team approach has proven successful. Since 2012, according to Hossick’s data, Bend County’s rate of survival from SCA has increased from approximately 20 percent to 71 percent in 2016. “We could not have done it without Megan and 911,” Hossick said. “If your dispatch center is not firing on all cylinders that number is not possible. We absolutely need dispatch to be super good at what they do.”

Source
TWO Bystanders, Two Victims
It’s help for two during one call

Audrey Fraizer

Two bystanders, two victims, and one EMD.
That was the situation confronting EMD Sarah Liebenthal during the final hours of her 12-hour shift on Tuesday, Oct. 31, 2017, at Waukesha County Communications (WCC) center, Waukesha, Wisconsin, USA.

But managing the situation wasn’t the only difficulty. Two problems added to the complexity: the call was coming from a jurisdiction Waukesha does not cover and, as was revealed during the call, only one injectable dose of Narcan was available for the two victims suspected of experiencing drug overdoses.

“Sarah reacted unbelievably,” said Sherri Stigler, Training and Operations Manager, WCC. “What do you do when you have two patients needing immediate help at the same time?” Apparently, Liebenthal did the right thing.

Liebenthal said the caller was upset, and understandably so. He had just arrived home and found his brother and his brother’s girlfriend sprawled on the garage floor. Neither was conscious. Breathing was agonal for both. Fortunately, the caller was soon joined by a second bystander. “Their mother arrived home at about the same time,” Liebenthal said.

As per policy, Liebenthal transferred the call to the proper jurisdiction and offered to stay on the line to provide the PAIs that would be unavailable if she disconnected at the transfer. She was asked to stay on the line. Liebenthal calmed the caller. He asked who he should inject with the Narcan. “I said that was for him to decide,” Liebenthal said.

Liebenthal reassured him that he and his mother could provide CPR according to the instructions she was about to provide over the phone. How could they do that? With two bystanders—one for each victim—she quickly devised a way to help both. “I asked them to put the call on speakerphone,” she said.

“I gave instructions, checking with both, separately, to check how they [the bystanders] were doing and to reassure them.”

She counted, pacing their compressions equally through three rounds of mouth-to-mouth CPR (30 compressions/two breaths) by the time paramedics arrived. Although the caller’s brother and his brother’s girlfriend were still unconscious, Liebenthal later learned that both survived.

Liebenthal has a bachelor’s degree in criminology and psychology. She works full time at WCC and part time as a police officer for the Villages of Summit and Lannon, also in Waukesha County. Several days after the phone call, she was alerted to an unconscious and potential drug overdose victim while on her patrol in Lannon. She gave hands-on CPR. The person survived.

That’s when Liebenthal realized the consequences of her actions.
“It hit me hard,” she said. “I started crying. I’m not a hero. This is all part of my job and what I’m supposed to be doing, but I wasn’t able to shake it off as easily as I thought I could.”

Stigler commends Liebenthal for her quick thinking over the phone and ability to manage bystander PAIs that led to the survival of two patients. “It’s absolutely incredible what Sarah did,” Stigler said. “She thought outside the box and really did a great job.”

Liebenthal wears two Life Saver pins awarded by Waukesha County Communications, one pin for the brother and the other for the girlfriend.

WCC recently completed a 7,500 square-foot garage and administrative office addition to its existing 12,000 square-foot building. The center answers 911 and most non-emergency calls for 23 municipalities (police, fire/EMS) and is staffed by 46 EMDs. The center is also the primary dispatch center for Division 106 of the Mutual Aid Alarm System and coordinates the dispatch of mutual aid units from multiple fire departments. Gary Bell is WCC Director.
ADOPION OF 911
Death a driving force for dialing single number for help

Heather Darata

Kitty Genovese was a 28-year-old New York City bar manager with a dream of opening her own Italian restaurant.\(^1\)

On March 13, 1964, she left work around 3 a.m. to drive home to her apartment in Kew Gardens, Queens, New York (USA). She was attacked twice by a man who followed her home; Genovese died before making it to her apartment.

An initial report from The New York Times said 38 people heard her cries for help and did not call to report the attack.\(^2\) That account was later largely dispelled. A neighborhood man remembers his father phoning the police that night, according to Kevin Cook, author of “Kitty Genovese: The Murder, The Bystanders, The Crime That Changed America.”

We may not know how many witnesses there were and how many tried to help. What we do know is that while accounts of what happened after the initial attack differ, Genovese’s death sparked how we get help today. Her case is attributed as one of the driving forces for the adoption of the 911 system throughout the United States.

At the time of Genovese’s death in 1964, no 911 system existed. The way to summon help was what the man mentioned earlier remembers his father doing—calling the police or fire department nearest to you, depending on the type of emergency. People could also dial 0 and ask the operator to connect them.

The 911 system’s beginnings are linked back to communication company Ericsson, according to the Industry Council on Emergency Response Technologies (iCERT). Ericsson developed a portable phone in the early 1900s.\(^3\) “Utilizing an extension wand, two metal hooks were placed over the wires to form a connection and the handbox was cranked to create a signal that would hopefully be answered by someone on the line,” according to a report from iCERT about the history of 911.

In 1907, a train robbery was reported using this portable phone. Decades passed and in 1957—seven years before Genovese’s murder—calls for a nationwide emergency number started. It was believed that a single number would make calling to report a fire easier.\(^4\)

But no central emergency number was in place by 1964. It wasn’t until three years after Genovese’s death that President Lyndon Johnson’s Commission on Law Enforcement and Administration of Justice released a report that recommended people have the ability to call one number to reach police departments.

A few years later in 1968, AT&T, which operated nearly all telephone connections in the U.S. at the time, put a 911 line in place nationwide. The number was chosen because it was short (rotary phones were being used then), had never been used as an area code or service code previously, and was easy to remember.

The first call was made in Haleyville, Alabama (USA), in 1968, and the rest is history.

But something else thing came from Genovese’s case interest in the reported apathetic responses from witnesses. Following her death, social psychologists John Darley and Bibb Latané popularized the concept known as the bystander effect.\(^5\) The term describes when the presence of others discourages an individual from helping in an emergency situation.

Darley and Latané attributed the bystander effect to two things—perceived diffusion of responsibility and social influence. Diffusion of responsibility means that witnesses are more likely to intervene if there are few or no other witnesses around.

While accounts differ regarding exactly how many people summoned help for Genovese on the night of March 13, 1964, the bystander effect helps explain why more calls were not received that night. Each onlooker presumably concluded that his or her help was not needed based on the inaction of other neighbors.

Sources
3. See note 2.
4. See note 2.
PUBLIC
ONE FOCUS
SAFETY

Booth #101 & 200
Host a Class

Earn free seats for hosting. Bring PSTC classes to your area.

Here are just a few classes that you can host:
- Avoiding Drama & Bullying at Work
- Active Assailant/Shooter for 9-1-1
- Customer Service for 9-1-1
- Crisis & Suicidal Callers
- HIGH RISK (Responder Safety)
- Avoiding Liability
- Communications Training Officer (CTO)
- Supervisory & Leadership Courses
- Surviving 9-1-1 Stress

See our full class list at www.pstc911.com

VISIT www.911cares.com for merchandise supporting everyday heroes

800-348-8911
ask@pstc911.com
THANK YOU TO OUR 2018 SPONSORS AND EXHIBITORS
PRIORITY DISPATCH CORP.  
BOOTH #409

Priority Dispatch Corp.™ (PDC™) is the leader in multi-service 911 dispatch calltaking solutions and is endorsed by the internationally recognized International Academies of Emergency Dispatch®. While many have attempted to provide products and training for communication center calltaking, PDC is the only company to take a comprehensive systems approach. The Priority Dispatch System™ has been in use for more than 35 years with substantial, frequent updates. Historical data shows the system reduces the risks to field responders, lowers the cost of emergency services and liability for local governments, and increases the quality of service and citizen satisfaction. The Priority Dispatch System is available in ProQA® software format, which interfaces with most CAD and phone systems, as well as in a cardset format. We also offer AQUA® quality assurance and improvement software, training, consulting, and Academy accreditation support.

For more information, email info@prioritydispatch.net, call 800-363-9127, or visit us at prioritydispatch.net

FIRSTWATCH  
BOOTH #209

Ask us about the FirstWatch-ProQA® / Paramount Dashboard & Report (FREE for FirstWatch customers with ProQA interface). Provides Comm. Center managers, supervisors & QA/QI teams with an automated, real-time tool to monitor and improve call center operations, as well as the effectiveness of your teams ProQA usage. More than 350 Public Safety teams across the USA & Canada count on FirstWatch every day, to monitor CAD, ProQA, ePCR, RMS, Phone and Hospital data in real-time, automatically! Performance, Operational, Clinical and Quality measures, in real-time via your iPad or iPhone, there’s an App for that - it’s FirstWatch!

See real world examples at FirstWatch.net

LOGIS SOLUTIONS INC.  
BOOTH #1009

Logis Solutions delivers state of the art computer aided dispatch (CAD) solutions to the EMS market (Emergency Medical Services), including Non-Emergency Transfers, Homecare Services, and Mobile Integrated Health. Our solutions provide deep support for an innovative and coherent workflow, adding significant value to a diverse set of operational environments. Our clients are major public and private EMS providers in Europe, North America and Oceania, served from Logis’ headquarter in Copenhagen and from our subsidiaries in Seattle, Vancouver, Prague and Sydney.

For more information, visit logisids.com

OnStar, the leading provider of in-vehicle safety, security and communication services, is exhibiting to educate the First Responder community about the vital and life-saving information OnStar can provide to 9-1-1 centers. OnStar provides services to over 7 million subscribers in the U.S., Canada, China, Mexico and Europe. OnStar offers a comprehensive portfolio of safety and security services, including Automatic Crash Response, Injury Severity Prediction, Emergency Medical Dispatch, Stolen Vehicle Slowdown and Remote Ignition Block. Working together, we can help to save lives and keep our roadways safe.

For more information, visit onstar.com/publicsafety

TRITECH SOFTWARE SYSTEMS  
BOOTH #200

TriTech revolutionized the public safety industry by becoming one of the first vendors to embed mapping technology into computer-aided dispatch software and to develop one the most sophisticated recommendation algorithms. Today, TriTech leads the way as the undisputed leader with software that covers every facet within the incident-response workflow, including 9-1-1, computer-aided dispatch, field-based reporting, records management, jail management, analytics and intelligence, patient care reporting, and ambulance billing software. Providing customers with unmatched satisfaction levels and delivering innovative solutions has made TriTech the most trusted partner in public safety software.

For more information, visit tritech.com

Infor builds beautiful business applications with last mile functionality and scientific insights for select industries delivered as a cloud service, on premises, or both. With 15,000 employees and over 90,000 customers in more than 170 countries, Infor is a leading provider of software applications. Infor delivers a comprehensive suite of integrated, industry-specific solutions, including dispatch software purpose-built for the fire, police and EMS.

To learn more about Infor, please visit infor.com
CIRCADIAN®
CIRCADIAN® is the global leader in providing 24/7 workforce performance and safety solutions for businesses that operate around the clock. Through a combination of consulting expertise, research and technology, CIRCADIAN helps organizations economy optimize employee performance and reduce the inherent risks and costs of their extended hours operations. Our science-based solutions boost productivity, reduce errors and injuries, decrease absenteeism and employee turnover, and reduce health care costs.

Learn more at circadian.com

CIRCADIAN Light
CIRCADIAN Light is a member of the worldwide CIRCADIAN® group of companies, bringing health, productivity and safety solutions to the 24/7 business workplaces around the globe. Born out of breakthrough research on human circadian clocks at Harvard Medical School, CIRCADIAN Light produces intelligent circadian white light fixtures which regulate the dosage and timing of bio-active blue light to increase human health and productivity throughout the 24/7 day-night cycle.

Visit us at circadianlight.com

NENA: THE 9-1-1 ASSOCIATION
BOOTH #210

The National Emergency Number Association (NENA) improves 9-1-1 by providing training and certifications for public safety professionals; developing standards and best practices; informing policymakers about issues facing 9-1-1; and educating the public about 9-1-1 and its proper use. NENA's nearly 12,000 members are part of a grassroots network of public-safety professionals dedicated to improving 9-1-1 across North America and beyond. NENA is where hands-on work to improve emergency communications yields truly meaningful results; our members are directly involved in shaping the future of 9-1-1 and keeping our communities strong, safe, and vibrant.

Learn more and get involved at nena.org

PSTC 911 CARES
BOOTH #507

PSTC is America’s #1 In-Service training provider for 9-1-1 and emergency communications centers. Our Instructors are the best at building skill sets and knowledge that will last a lifetime. We travel to your agency to hold our classes and you get free seats for hosting! 911 CARES is part of the PSTC family and we are dedicated to providing appreciation and support for 9-1-1 professionals. We have helped thousands of dispatchers in our 16 year history.

For more information stop by our booth, visit pstc911.com, or email Kevin@pstc911.com

911 TRAINING INSTITUTE
BOOTH #313

911 Training Institute (911TI) is the industry’s only training organization led by a licensed clinician specializing in 911 Mental Health. The institute delivers a full curriculum of innovative courses including stress management, Certified 911 Peer Support, and Emergency Mental health Dispatching. This curriculum empowers 911Pros to deliver Resilience-Driven Peak Performance in their responses to high-risk psychiatric emergencies. That means optimal employee well-being, PSAP morale, and Best Practice response to callers in mental health crises. Institute Director Jim Marshall served as CEO of the 911 Wellness Foundation from 2011 to 2017 and is editor of The Resilient 911 Professional.

Visit us at 911Training.net

BRADSHAW CONSULTING SERVICES, INC.
BOOTH #106

BCCS is more than just innovative solutions; we understand the commitment and dedication to a passion that is required to be successful in public safety. We create solutions by partnering with organizations that are seeking to leverage technology and strategies to improve their operations performance in the field. From high performance solutions designed to help you improve the delivery of time-critical services to managing non emergency transportation in the most efficient way possible, BCCS is focused on helping you achieve your desired results. Talk with us if you are serious about becoming more efficient and effective in your logistical operations.

Visit us at bcs-gis.com

CCM - FITCH & ASSOCIATES, LLC
BOOTH #111

The Communication Center Manager (CCM) Course, now celebrating its 15th year, is a one-of-a-kind program that presents the fastest management and leadership practices used by emergency service providers around the world. It has proven to be successful for business leaders and students in implementing effective changes in today’s communication center. CCM is structured as an accelerated program designed to deliver minimum time investment with maximum results. A small group of up to 40 students progresses through two dynamic, separate weeks of education and training building a lifelong network of peers and colleagues.

For more information, visit fitchassoc.com, email ccm@fitchassoc.com, or call (816) 431.2600
Columbia Southern University provides an alternative to the traditional university experience for busy, working adults. CSU offers online associate, bachelor’s and master’s degrees and certificate programs in fields such as emergency medical services administration, occupational safety and health, fire science, public administration and business administration. With affordable tuition rates, textbooks provided by the CSU Book Grant and flexible online classes, CSU understands the concerns of adult learners. Our dedicated staff and expert faculty follow the university’s principles of providing excellent service and an adaptable learning experience to ensure student success.

Visit ColumbiaSouthern.edu or call 800-977-8449 to learn more!

Concept Seating provides sophisticated, ergonomic, and durable seating for 24/7 environments. Public Safety and Dispatch personnel must always remain alert, focused, and productive. Concept Seating chairs and stools help to minimize fatigue and discomfort for all body types, encouraging maximum performance. Backed by a comprehensive 6-Year Warranty, Concept Seating is simply the best choice for 24/7 workplaces.

For more information, visit conceptseating.com

CritiCall pre-employment testing software is designed to measure dispatcher/calltaker applicants’ job-related behaviors and skills such as data entry, multi-tasking, decision-making, memory recall, map reading, and more. The computerized test, which is virtually self-administering and self-scoring, is used by over 1,200 public safety agencies. Many users have reported a dramatic reduction in turnover and an increase in the productivity of those they hire after adopting CritiCall for their pre-employment testing. Custom Test Writer and Validation Wizard included. NEW! TactiCall customizable dispatcher training software is now available. TactiCall helps assess and train dispatchers on speech and protocols necessary to succeed. Demos available.

For more information, visit critical911.com

The Denise Amber Lee Foundation is a non-profit foundation borne out of a tragic breakdown of the 9-1-1 system. The foundation now offers many highly acclaimed, full day, onsite training presentations. The Denise Amber Lee Foundation also now offers consulting opportunities to help agencies with their in-house training programs and assistance with establishing or improving QA/QI processes. We also offer 3rd Party QA Call Review services.

For more information, visit deniseamberlee.org

At Domore, our seating products are engineered from the floor up to stand up to rigorous environments with style and comfort. Our legendary intensive use seating lines stand up to harsh, multi-shift applications. We’ve been building the best for almost 100 years. We prove that intensive use seating can be comfortable, attractive, and durable. Put our experience to work for you.

For more information, visit domoreseating.com

With over 10,000 locations installed in the past 37 years, Evans designs and manufactures furniture and turnkey solutions for public safety, government, command and control, and homeland security environments. Evans’ worldwide headquarters and 170,000 SF manufacturing plant is located in Calgary, Alberta, Canada with US operations centers in Washington DC, Grapevine, Texas and a dedicated Public Safety office in Falmouth, ME. Get with it, get Evans……

For more information, visit evansonline.com

Serving the public safety industry since 2001, GeoConex is a leading provider of public safety software products, hardware and network services. We have designed and developed many products and solutions to save time, money and lives; while keeping in mind that each product must remain user friendly. Our products consist of NG911 CAD, NG911 Mobile CAD, NG911 GIS Map Viewer, Mobile Mapmaker, GIS based addressing, AVL, RMS, JKS; also, hardware, network, training, support and Zetron Call-Taking solutions.

For more information, visit geoconex.com
Performance management software that provides a centralized and standard method of documentation to gain an accurate reflection of employees' overall performance. Employees are an organization's most valuable asset — improve organizational culture, create more engaged employees, and save careers with Guardian Tracking.

For more information, visit guardiantracking.com

Critical communications technology pioneer HigherGround has partnered with Priority Dispatch to simplify the quality assurance process. HigherGround's full-featured solutions transform data into actionable intelligence, enabling decisions with certainty to enhance agent performance, optimize operations, improve customer satisfaction and reduce costs, which ultimately increases revenue. The cost-effective and dependable HigherGround Capture911 multi-channel recording and incident reconstruction solution integrates with Priority Dispatch’s AQUA Evolution product using an Application Program Interface (API) to exchange data. Interactions recorded with Capture911 can now be accessed and searched directly from the AQUA user interface, with just the click of a button.

For more information, visit higherground.com

The IAED™ is a non-profit, standard-setting organization promoting safe and effective emergency dispatch services worldwide for more than 35 years. Comprised of four allied academies for medical, fire, and police dispatching and Emergency Communication Nurse triage. IAED supports first responder-related research, unified protocol application, legislation for emergency call center regulation, and strengthening the emergency dispatch community through education, certification, and accreditation.

For more information, visit emergencydispatch.org

Born out of the heavy equipment and automotive industries, United Group, Inc. manufactures its own brand of ergonomic office chairs and custom heavy duty seats under the IRON HORSE Seating brand. Through extensive market knowledge and known customer requirements, IRON HORSE Seating is designed for 24/7 intensive use for a variety of user statures across multiple environments. As a part of United Group, Inc. the team at IRON HORSE Seating prides itself on offering custom seating solutions, delivering quality products and providing unparalleled customer support.

For more information, visit ironhorseseating.com

Motorola’s Integrated Command and Control solutions enhance incident management and resolution by automating workflows and data retrieval, so you stay focused on the information at hand to act with speed and decisiveness. With evolving communications technologies, your ability to manage a new kind of call for help brings added complexity and challenges in responsiveness. Rely on the global leader in public safety solutions to transform the way your agency receives, analyzes, responds to and resolves an incident with a true end-to-end application — designed for you.

For more information, visit motorolasolutions.com

NICE is the world’s leading provider of mission-critical communications recording, quality assurance and incident information management solutions. NICE Inform captures manages and synchronizes multimedia call, radio and text communications to provide a complete, true record of emergency incidents. The time-saving Priority Dispatch AQUA call playback integration enables users to conveniently playback audio recordings related to cases of interest directly from the AQUA case review interface. NICE Inform is Next Generation 9-1-1 ready, supports digital, IP and P25 recording, and is open standards for hardware platform flexibility and ease of integrations. More than 3,000 NICE Inform systems are deployed worldwide.

For more information, visit nice.com
PLANTRONICS, INC.
BOOTH #203

Powered by a 50-plus year obsession with perfecting headsets and backed by a worldwide network of services and support, Plantronics audio devices have earned a sound reputation in mission-critical applications. Plantronics is proud to be a primary supplier for E911, Emergency Dispatch and First Responders, NASA, DoD, the Armed Forces, to hold the exclusive contract with the FAA for ATC headsets, and to have carried the historic words “That’s one small step for man, one giant leap for mankind” from the moon. We design headsets for day-to-day wear in demanding environments and our expertise ensures every product we build meets the highest standards of quality and reliability.

For more information, visit plantronics.com/us/en/solutions/public-sector

RAPIDDEPLOY
BOOTH #1102

RapidDeploy is the world’s most advanced call taking and computer-aided dispatch platform. We combine advanced telematics with real, on-the-ground experience to provide relevant, simple-to-use systems that allow you to maximize the efficiency of your service and enable your teams to share and report critical information in real-time. RapidDeploy is designed to make every second count, because saving time means saving lives.

For more information, visit rapiddeploy.com

REGOLA SRL
BOOTH # 410

REGOLA is a pure software Company, specialized in Public Safety, Emergency and Non-Emergency Management since 1995. Based in Torino, North-West of Italy, it is recognized in the market to be a dynamic and responsive organization which fully develops software in-house. REGOLA delivers both comprehensively integrated software solutions based on a modern modular architecture, and independent ready-to-use applications. REGOLA’s key people is recognized as domain experts and technological pioneers about Public Safety. REGOLA operates in synergy and respectful relationship with local partners, in order to enhance local skills transfer and to preserve the highest dynamism. REGOLA is proudly the 1st Italian company to integrate ProQA® and LowCode™ Protocols by Priority Dispatch Corp.™ and International Academies of Emergency Dispatch® (IAED™), being awarded with Paramount Integration Certification.

For more information, visit regola.it

Russ Bassett Corporation is a leading designer and manufacturer of dispatch console furniture for PSAPs and other 24/7 mission critical operations centers. Proud to be ‘Made in the USA’ and committed to delivering an excellent customer experience, Russ Bassett offers turnkey console furniture solutions including all associated accessories, design, project management, installation, detailing and maintenance services.

For more information, visit russbassett.com

SCHEDULE EXPRESS
BY INFORMER SYSTEMS
BOOTH #412

Born in the cloud in to address complex 24/7/365 scheduling problems facing public safety agencies, Schedule Express builds and maintain shift-based schedules while it uniquely automates absences, trades, overtime, training and special assignment processes — from request through approval — effectively eliminating paperwork, man-power costs and substantially reducing errors, omissions and abuse. Our customers across America, from Boston to San Diego, Orlando to Salt Lake City, and Houston to Syracuse, have reduced time management of their workforce by 40-60%. Come see why so many agencies are choosing Schedule Express for all their scheduling needs!

For more information, visit informersystems.com

SAVE CORPORATION
BOOTH #1100

Save Corporation’s E911 Real-Time Simulation Systems function in a state-of-the-art reality simulation training arena. We create opportunities for new and seasoned dispatchers to practice “REAL” Procedures & Protocols in a safe and recorded environment. Multitasking Skills can be evaluated immediately, increasing proficiency, ability and accuracy. Partnerships with several International Certification Agencies make SAVE the best choice. SAVE Time Money and Lives with 911simulators.com.

For more information, visit 911simulators.com
Select Advantage partners with its clients to ensure their human capital practices are compliant, relevant and strategic. We foster cross-functional team collaboration between executives, operations, legal, and human resources personnel to maximize human capital programs and initiatives.

Our job specific assessments use cutting-edge testing technology to assist with employee selection, placement, promotion and hiring. The behaviors most vital to the organization’s success form the standard for selection and placement of workers. This causes dramatic and positive effects on employee turnover, absenteeism, trainability, retention, morale and overall effectiveness. The strength behind our pre-employment assessments is the fact that they are so very job specific. This allows organizations a unique advantage when it comes to matching applicants to likely success in the job as well as providing valuable legal protection.

For more information, visit SelectAdv.net

SPILLMAN TECHNOLOGIES, INC.
A MOTOROLA SOLUTIONS COMPANY
BOOTH # 300

For more than 30 years, Spillman Technologies has provided public safety professionals with reliable customer service, trusted stability, and integrated software solutions, including Computer-Aided Dispatch, Records Management Systems, Mobile Data & Field Reporting, Mapping & GIS, Jail Management Systems, Fire, Data Sharing, Personnel & Resources, and Analytics & Intelligence-Led Policing. More than 1,800 agencies nationwide use Spillman’s solutions. Spillman’s flagship on-premises software, Spillman Flex, offers industry-leading integration and multi-jurisdictional capabilities. Spillman’s software-as-a-Service (SaaS) product, Spillman Nova, provides smaller agencies with a world-class public safety software experience directly in the cloud.

For more information about Spillman, visit spillman.com

SUPERION
BOOTH #205

At Superion, our suite of products was designed by public servants, for public servants. Providing reliable, integrated, instant information, our technology helps keep our communities safe, from first responders and corrections staff to the people they serve each day. We are powering the public experience.

Visit us online at superion.com

TROOPS TO TELECOMMUNICATORS
BOOTH #104

Troops To Firefighters is a non profit organization encouraging Transitioning Troops, Veterans and their family members to enter a career in the Public Safety sector. We offer two certification programs one is a 911 Operator Certification Program and the other is a Firefighter I/II EMT Certification Program.

Visit us online at troostofirefighters.org

NEW WORLD™ public safety software from Tyler Technologies is a fully-integrated, multi-jurisdictional product for police, fire and EMS. It offers computer aided dispatch, records, mobile, field reporting, decision support, corrections and fire solutions for public safety agencies throughout the United States. New World public safety software is equipped to meet the needs of today and future requirements. With Text-to-911 functionality in CAD, Esri-powered mapping, and mission-critical information available at users’ fingertips, this leading public safety software helps those who are committed to serving and protecting communities continue to do what they do best.

Visit us online at tylertech.com

WITHIN THE TRENCHES
BOOTH #110

The podcast series called Within The Trenches, invites dispatchers on to tell there stories, and other guests in the industry who advocate for the profession and try to elevate it. Stop by the booth to be a part of the show.

Visit us online at thejabberlog.com/within-the-trenches

XYBIX SYSTEMS, INC.
BOOTH #309

XYbix designs, builds, and implements uniquely suited height-adjustable ergonomic workstations and consoles for public safety professionals. We work closely with 911 Dispatch Centers, PSAPs, and Emergency Operations Centers to create a solution that will accommodate your needs well into the future. We believe everyone can improve their health and we care about making innovative furniture solutions to help you achieve better health.

Visit our website at xybix.com or call 800.788.288 for more information
SEE YOU NEXT YEAR FOR NAVIGATOR2019 IN WASHINGTON, D.C.!