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.
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; 8,103,523; 8,294,570; 8,335,298; 8,488,748; 8,494,868; 8,513,020; 8,771,501; 9,319,859; 9,516,166. The PPDS is protected by U.S. patent 8,312,020. 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.
Sherri is the training and operations manager for Waukesha County Communications, Wisconsin (USA), a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at sstigler@waukeshacounty.gov.

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).

Follow IAED™ on social media for amazing dispatcher stories and news, ACE announcements, prizes, and more!

Facebook and LinkedIn: International Academies of Emergency Dispatch
Twitter: @TheIAED
JUST WHAT YOU NEED

Latest issue packed with variety, relevant content

Josh McFadden

Any good journalist knows that when putting together a publication, the stories must convey information the reader wants. That’s exactly what we strive to do when we write content for the Journal of Emergency Dispatch. We spend significant time and expend great efforts ensuring our articles and columns are timely, relevant, and interesting.

Our feature stories are our longest articles, and this month’s entries are jam-packed with facts, figures, and fascinating information. Make sure you check out our feature on cellphone callers. You know all too well how prevalent these calls are and what challenges can arise when a person calls from a cellphone, not knowing his or her location. This article expounds on these and other hardships these types of calls can pose.

A second feature discusses agencies that use more than one Priority Dispatch System™ (PDS™) and the opportunities this creates for emergency dispatchers.

We also highlight Elk County Office of Emergency Services in Ridgway, Pennsylvania (USA), and its recognition program. You’ll enjoy reading about what this center does when someone at the center helps save a life through his or her mastery of the protocols. There’s also a great piece on ACE Young Clark Regional Communications Agency (CROCA) in Vancouver, Washington (USA). The center is one of the world’s first ACES and has maintained that level of excellence for more than two decades.

We know you look forward to getting your CDE credits, so as usual, we’ve included a pair of CDE articles. Make sure you read our Police CDE on fraud as well as the Medical CDE that focuses on Protocol 17: Falls. The latter discusses, among other things, the injuries commonly associated with extreme falls.

Dr. Jeff Clawson shares with us his Blast From The Past. This version explores the question of whether it’s appropriate to change the response mode while on the way to an incident. Don’t forget about our FAQ by Brett Patterson. In this issue, he writes about using aspirin when going to Protocol 1: Abdominal Pain/Problems.

Don’t crack open the Journal without reading the Your Space stories. This issue gives you a glimpse of some of the amazing things emergency dispatchers are doing and how they handle unique and challenging situations.

Thanks for reading another issue of the Journal!
Have you ever thought about the power of words? If you’re like me, words may seem insignificant at times. It shows when I use phrases like “I don’t care” or “I don’t know” when someone is seeking my opinion or giving me a choice in what to do or eat.

But I didn’t always say things like that. Think about when a child first starts to talk. Her words are small at first and may seem stilted. Gradually these words become easier to say, and more complex words start forming. Young children are eager to share their opinions and don’t hold back.

Think back on learning to write. Those first letters can take some time to form. Next comes stringing together sentences that convey what you want to say and follow the rules of grammar you’ve been taught. It doesn’t happen overnight. There’s a learning process for speaking and writing.

But because we speak so much (and depending on the person, write a lot), words become second nature. Words can flow quickly as we become more experienced with expressing ourselves. Somehow though, the more we do it, the more we don’t always put as much intentionality behind what we’re saying.

Have you ever had that moment when the reaction to what you said shows on the other person’s face, and you can tell that your intended message isn’t what she understood from the words you said out loud? It can be the words you choose to say that make all the difference in your relationships.

There is an art to speaking and conveying your feelings. The words you speak—coupled with your body language—tell the person you’re speaking with how much you care. When it comes person on the other end of the phone only has your words to go by. He can’t see your facial expressions or your actions. People in stressful situations need direction, and you are their source for it.

Instructions like “Stay on the line and I’ll tell you exactly what to do next” can help a caller feel like she can lean on you for help. “Do not attempt to rescue the trapped person(s)” provides clear direction on what not to do rather than leave a caller guessing whether he should try to become a rescuer in a dangerous and precarious situation.

Recall the last time you offered help to a panicked father whose child stopped breathing, or to a wife whose husband was suffering from a heart attack, or to a husband whose wife had gone into labor at home. Words are that lifeline you offer callers.

But the part where words shine even more can be in the customer service you provide. Phrases such as “We’re in this together” and “I’m right here with you” can help callers know that you genuinely care. They can’t see your face, but they can hear your intent through the words you choose to speak. Make their call the best it can possibly be under the circumstances. They may not remember what you said when they hang up, but they will remember how you made them feel.
Interesting question: Is it okay, when using the Police Priority Dispatch System™, to also include the “journalistic” method of questioning, i.e., who, what, when, where, why, and how in the furtherance of their mission?

Answer from Dave Warner: The “why” and “how,” at face value, are obviously freelance and investigatory. Investigatory questions that are not crafted to elicit a special piece of information that, depending on the answer, would or could change a response (based on the agency’s priority level-based response mode), offer little to no value outside of satisfying an emergency dispatcher’s on-the-fly curiosity. In addition, these questions have the potential to create the very kind of issues and challenges for which agencies have implemented structured calltaking processes to avoid in the first place. Variance in the same questions asked between one emergency dispatcher and another, increased call processing times, incorrect coding, and poor customer service, are open game for errors when freelancing is allowed. This is not to say that additional questions should never be asked when using the Police Protocol. Those asked that then elicit a more concise answer, from a given caller to a specific protocol question, can and should be considered by the EPD when using the PPDS™.

For instance, when asking a caller for a suspect’s location (“Where’s the suspect now?”), a follow-up question (“Is he inside or outside of the 7-Eleven?”) may be of high importance to responders, and is certainly considered a protocol enhancement. A common point, when freelance questioning arises in PPDS, is often during Case Exit, particularly when keeping callers on the line. Keeping a caller on the line until officers arrive is practiced in many centers, for a variety of events. This might include a crime in progress, a domestic violence situation, or when a disturbance is likely to turn physical. This leads to the question, how can emergency dispatchers engage a caller in further conversation if they’re not allowed to freelance? Where a primary purpose of keeping callers on the line is to provide updated information to responders, emergency dispatchers should focus on clarifying the very things they’ve already asked. In order to effectively update responding officers of changing events, efforts to determine what’s currently happening should be our primary focus. A suspect’s current location, what he or she is doing or saying now, whether more people are gathering, determining if a caller remains safe, or possibly adding additional, enhanced descriptions might certainly be appropriate. Regardless of this clarifying interrogation, good customer service and appropriate caller management should remain an overarching priority. Reassuring a caller that help is on the way and avoiding questions that could push a caller into a state of greater emotion should be avoided. Our focus should always be on the here and now.

I’ve passed this on to the Academy folks for their feedback. The last thing I want to do is give you bad information.

Doc, what say you? ...

Dave Warner, Police Program Administrator, Priority Dispatch Corp.™

Doc’s answer: This argument sounds like, as Yogi Berra once said, “Déjà vu, all over again,” when you state that EPD calltakers should be allowed to freelance in the “furtherance of their mission.” This is the exact same argument we experienced in the 1980s regarding the Medical Protocol, when it was routinely heard that EMT- or Paramedic-trained EMDs felt they could add “something more” to the protocol process by asking “a few more questions” as they saw fit. To this, I have routinely asked, “Geez, you must have invented some new science? Have you been holding out on us? Tell me please, what those ‘questions’ are, as we would like to put them in the protocol soon.”

In reality, questions aren’t the issue—objectives are. Currently, and for the last 39 years, these objectives in either the police, fire, or medical protocols are basically the same (although their relative importance may vary somewhat per discipline):

1. Determine the proper response configuration
2. Determine the presence of conditions requiring Pre-Arrival Instructions
3. Help the responders address the call (provide all needed information)
4. Provide safety for all those at the scene (patients, callers, bystanders, responders)

A KQ is simply a vehicle to satisfying the specific objective of the things needed to be known at the emergency dispatcher’s point in time. And as questions, these are only a vehicle to fully satisfying an objective, and if the current protocol questions don’t do that, then the protocol needs to be modified, or new questions need to be scripted carefully and put in place, to accomplish these objectives.

A freelance question (like a blind squirrel) might find a neat thing (aka, nut)—once in a while. But if that nut is important, the protocol should then include a question that attempts to identify that nut every time. Freelance questioning has been shown to be detrimental to keeping one’s eye on the ball (the collective objectives) during the very time-limited environment in which our 911 emergency dispatchers are currently forced to live. And the prime
directive here is then not accomplished by doing a bunch of extraneous things. It’s like the surgeon who is heard saying, “Hey, I think I’ll cut that thing, and see what happens.” Maybe it’s okay to experiment on you ... but not on me!

Often freelance questioning is not vertical, but lateral—meaning that it is generated off of an “interest” in the answer to a question, but doesn’t satisfy the next or other listed objectives (covered in the KQ list) per se.

Many years ago, a troubling process of unstructured interrogation was identified in which dispatchers applied their own questioning randomly until a “positive” answer was obtained. Upon making a “hit” (as these “positive” answers were first called 10 years ago) the emergency dispatcher, sensing they were “on the trail,” asked a series of related questions as one such case from a very calm young caller demonstrates (demographic questioning not relevant to understanding this call has been bypassed):

Caller #1: Um, hello, can I have you come over to my house?
Dispatch: What’s the problem?
Caller #1: She started throwing up in the night, and then everybody tried to wake her up and she wouldn’t. She just kept snoring and just kept lying there and wouldn’t wake up.
Dispatch: Okay, who is this? Is this your sister or something?
Caller #1: No, it’s my mom.
Dispatch: It’s your mom? How old is your mother?
Caller #1: Um, she’s 48.
Dispatch: And how old are you?
Caller #1: I’m 10.
Dispatch: Okay, do you know, she wasn’t throwing up blood was she?
Caller #1: I don’t know, let me see. Dad, was she throwing up blood?
Father: (unintelligible)
Caller #1: No, just throw-up.
Dispatch: Okay, and you can’t, you can’t wake her up now, right?
Caller #1: Uh uh (no).
Dispatch: Has she been drinking tonight, do you know?

Caller #1: Yeah.
Dispatch: She has?
Caller #1: Uh huh (yes).
Dispatch: Does she get sick when she drinks very much?
Caller #1: Yeah.
Dispatch: Okay, we’ll have them right there, alright?
Caller #1: Okay.

(First call was terminated at this point. Sick Person ALPHA call assigned. BLS ambulance sent COLD.)

This case represents a consistently observed, risky pattern in unstructured interrogation (the “guidelines” approach). One added but irrelevant question (“Has she been drinking?”) leads to a process known, in medical dispatch terminology, as “side-cycling.” The emergency dispatcher here got off the main track, and, in this case, allowed a bias to creep into ultimate decision-making. In a “protocol” system, emergency dispatchers are prompted—in a verifiable, repeatable manner—to ask for information that they need to know, not what would merely be interesting to know. Such a system protects the emergency dispatcher from being swayed by personal bias, prejudice, and intolerance—as well as by anecdotal experiences and just plain curiosity.

Biases can, as the above case shows, cause a dispatcher practicing without a set structure, to “lead” a caller along inappropriate information-gathering pathways.

For the same reason lawyers are overruled when “leading” a witness, emergency dispatchers should not be allowed to introduce significant personal bias by concocting questions “as-they-go” (i.e., there must be a “reason” why the emergency dispatcher asked them). It has become apparent that such processes defeat the very basic philosophy of introducing consistency, quality assurance, and non-arbitrary appropriateness at dispatch.

Just letting our emergency dispatchers “ask away” isn’t the way to solve each call’s needs or to evolve a protocol forward. If asking something “else” is that important, simply identify the dispatch objective that the current protocol is missing—including when and why—and submit a formal Proposal for Change to the Academy. Once it, and its supporting rationale, passes the required muster by IAED™ experts that are doing this every day (the Police, Fire, and Medical Councils of Standards), it will then be formally added to the protocol—guaranteed. Remember the old saying that “a correct protocol never has a bad hair day” or, more specifically, the protocol never forgets to determine the required information needed to satisfy each of the required objectives—on every call ... but only if that protocol process is actually used and used correctly.

My “question” back then is, do you understand this whole thing a bit better now? Since you are an Academy Instructor, I sincerely hope that you have learned something more about the core philosophy of structured calltaking and the Emergency Priority Dispatch System.

When submitting a PFC, please always do the following:

1. Base it on actual use of the current protocol—not what you surmise it will, or won’t, do.
2. Include the objective (modified or new) needed to be satisfied for your proposed change.
3. Add any real case reports, audios, data, studies, or real examples demonstrating what is missing, or needs fixing, as explained above.

As we say, there are a million ways to practice structured calltaking, and more specifically the various disciplines of priority dispatching—and this is but one of them. But it is the only one that is built, and evolves, on a scientific method of input, data, rationale, studies, and experience from all users—the world’s biggest protocol “user group.” That’s why Unified Protocols, very similar to the AHA’s CPR, BLS, and ACLS protocols, are so clearly maintained this way and move forward on evaluated input, real examples, and studied, if not published, data.

Jeff Clawson, M.D.
Division of Research, Standards, and Academics
PSAP consolidations are exploding in many areas of the country, and along with the merging of personnel, equipment, systems, and procedural changes, many are faced with the challenge that comes with construction and remodeling activities in a 24/7 dispatch operations space.

Our center is wrapping up such a momentous experience. In our case, there were two project phases to live through. First was the construction of a brand new administrative wing as well as a new Emergency Operations Center (EOC). While it was challenging for the administrative and management folks to purge, box, and pack up years of accumulated paperwork, the move to functional new office space was a welcome event.

The new EOC means that folks working exercises as well as real events weren’t packed in like sardines as they were in the old space. It also means that the “old” EOC, which doubled as our training and meeting room, became the communication center training room only. The new training desks, screens, and projectors will benefit our trainees and allow our center to host more regional training opportunities.

The second phase was a doozy, folks. A wall in dispatch came down and the operations space now flows into the former administrative area (now emptied). Knocking down a wall in a 24/7 911 center was a sight and sound to behold. Emergency dispatchers got really good at hearing callers despite the hammering, sawing, and occasional fire alarm activations. Doors disappeared and others appeared. We acted like mice in a maze trying to reach destinations—restroom, lunchroom, or to temporary lockers (boxes) piled in the training room. We improved skills in agility, hopping over doorframes, skirting plastic barriers, and avoiding wet paint (which was everywhere). It was interesting to note how different co-workers adapted to daily disruptions from construction while keeping a sense of humor and making the best of the situation.

But that’s what public safety communications personnel do best. They are able to take the bad stuff and make it better.

If your center has plans to grow, you may want to keep these tips at hand.

**PREPARE.** Nobody likes to be surprised by construction. Management needs to make sure staff is ready by informing them of the scope and timeline of any physical changes to the center. This includes large remodeling projects down to adding a console or other piece of equipment requiring outside vendors working/present in the center. Staff should be told well ahead of time, if possible.

**UPDATE.** Keep staff updated regarding construction phases as they occur, and announce changes to the project or timeline.

**INCLUDE.** Management should include the suggestions of staff as much as possible, especially as it relates to features directly affecting them, such as selection and placement of pods, equipment, mailboxes, and lockers. Remember, this is their “work home,” and they are key stakeholders in any project within those walls.

**ACCOMMODATE.** During the “storming” stage of construction, it might be appropriate to allow dressing more casually due to the construction dust and grubby conditions and provide a place to store personal items while awaiting new lockers. Offer compatible break room options if that area is disrupted. Staff members appreciate your efforts to accommodate them.

Yes, we know growth can be difficult; however, the final product should mediate the short-term discomfort and disruption. At our center, when standing back and assessing the new space, we are grateful. We know these expanded walls will help support the critical work and mission of our roles as “first,” first responders. We are even better prepared and ready to serve our citizens when 911 rings.
Imagine you’re hiking in a large national park. You’re following a trail that’s very familiar to you. Suddenly you stop short: The trail is washed out ahead. You can’t go back because it’s getting dark. Will you be able to navigate safely through unfamiliar terrain to reach your destination?

ProQA® is like a GPS. It will take you to places you’ve never been before. The problem is, calls become routine. We tend to be lulled into complacency by all the difficulty breathing, fall injuries, and chest pain calls that go the same way every time.

I’m old enough to remember driving without a GPS. Even more recently, the days before Google maps seem like the Dark Ages. But back then, in one way I was better prepared before I set out on a trip: I had a printed map, and I studied it ahead of time. I knew the general route, the highway numbers and exit number. Now, I trust my GPS to get me there. Why look at a map when the electronic voice of my choosing will confidently tell me where to go?

Sooner or later, you’ll have a call that takes an unexpected turn. The caller can’t roll the patient onto her back. You’re told the patient is awake but not breathing. Or you direct the caller to begin compressions, and she tells you the patient is on a ventilator. These are the types of scenarios that can cause your call to come to a grinding halt unless you know what to do.

We can’t prepare for every possible scenario. And, of course, trusting and following ProQA will get you through nearly all of them. Two years ago, I handled a breech birth with complications I’d never dealt with and found myself giving a set of instructions I’d never seen before. Such is the strength of the protocols. But we can better handle those situations by being prepared for them mentally and academically.

Mental preparation involves nothing more than being ready for anything at any time. Never anticipate what a caller will tell you or what an answer to your question will be. Academic preparation, on the other hand, involves a little more work because if you want to identify them as such so they can be filtered out of reports and calls for review. (Note: Many CAD systems are capable of launching ProQA without sending a new call to the Waiting incidents Queue so that a Test Case remains unseen by anyone other than the emergency dispatcher running it.)

That gives each individual dispatcher a very powerful learning tool. Calls can be rerun at a slower pace so that Key Question answer choices can be studied. Different Pre-Arrival pathways can be explored. Difficult calls can be rerun step by step to make sure the correct pathway was followed. Or calls can simply be practiced for proficiency—all from our own consoles at our own convenience, often immediately after a call while the details are fresh in our mind. Every one of us, regardless of our experience with ProQA, should be running test calls almost daily.

Ultimately each of us is responsible for our own proficiency. Ultimately each of us is responsible for our own proficiency. Don’t wait for the next call to learn something. Go after the knowledge by running test cases. Develop an insatiable curiosity about the protocols and ProQA, and make it your goal to learn something new about them every day.
Turnover and overtime were down, and I was hiring for a single dispatch position; it was enough to make any leader stick his chest out with pride. Once again, I would soon be humbled. Nothing short of the perfect candidate with the "it" factor would get the job this go-around. I had the luxury of a strong applicant pool and time to drill down into the many resumes sitting on my desk.

Ten applicants were selected for the interview; however, after a quick phone call I realized I had not selected a particular applicant. There was another applicant who was not in the pool of 10 selected for interviews, and he had requested a status update five times. Against conventional wisdom, I added him to the pool of interviewees. This meant 11 candidates. Eleven? I know, I know … rather unorthodox.

After conducting the 10th interview, I was somewhat pleased with two applicants that, on paper, appeared to be suitable. I was looking for something different. At the time, I could not readily put my finger on it. Nevertheless, when the 11th and final applicant walked into the room, it did not take long to realize he was lacking the "it" factor.

During the interview, the 11th applicant struggled with the questions. He was uncomfortable and unprepared. The interview questions seemed foreign, which were dwarfed by his attire. He wore a brown and orange tie—certainly not a combination for a job interview. The tie landed well above his beltline and appeared rather negligent. His coat was much too large with sleeves that carelessly drooped toward the middle of his fingers. He sported a homegrown haircut that was plagued with jagged edges. His attire accentuated his troubled posture, which sagged more and more with each interview question. His answers to the interview questions were rigid, short, and forgettable within seconds of being spoken.

Finally, I advised him to relax since any comfort left in the room was surely at risk. At that very moment, he asked me a question that served to reshape how I analyze talent. He asked, “Can I tell you something, sir?” I smiled because asking my mother the same question would certainly warrant a response of “I don’t know, can you?” I nicely replied, “Sure you can, sir.” His next words continue to crescendo in my mind even today:

“Sir, I know my interview did not go that well, but, if you see past my flaws and hire me, I promise I will be the best employee you ever had. I really need this job, but more importantly, I really want to help people. Just give me a chance. That is all I need.”

I was speechless. I felt several emotions simultaneously: surprised, excited, and shallow. There was something authentic about his tone. The man I’d heard just a few seconds ago who stumbled over his words had turned into a confident patrician avidly seeking a chance. His passion was captivating and suddenly overshadowed his attire and even the unpreparedness of his previous answers.

What do I do? Do I go with one of the two “suitable” applicants for this coveted position with their practiced answers, their business appropriate appearance, their experience and qualification, and their rehearsed promise to do a good job? While the answer sounds like an obvious “yes,” my intuition about this 11th interviewee ricochets in my mind and my gut. This person seems most eager for the opportunity to prove himself by showing himself vulnerable and hungry for this opportunity.

My decision resonated as the “it” factor pooled around him.

I took a chance on him, the “it” factor, and the embodiment of “the diamond” as he outshined the other applicants in that moment. That decision was one of the best I’ve made in my professional career. He motivated staff, rose to challenges with optimism, was promoted, and went on to do great things in his career.
UNTIL PROVEN OTHERWISE?

Should we administer aspirin in suspect cases?

Brett Patterson

Brett:

Hi there, just a quick question regarding one of our protocols.

On Protocol 1: Abdominal Pain/Problems, Rule 1 states that pain above the navel should be considered a heart attack until proven otherwise. We also have a CHARLIE-level coding for patients that answer “Yes” to KQ 4 (“Is her/his pain above the belly button (navel?)”). I noticed that ProQA® does not prompt us to initiate the Aspirin Diagnostic at all regardless of the coding. My question: Is there a reason that we should not be administering aspirin in these circumstances?

Katie McAran
OnStar Emergency Advisor, CSD OnStar

Katie:

You ask an insightful question! Rule 1 of Protocol 1 was written with response assignment in mind to ensure that an ALS evaluation is performed for epigastric pain in patients of cardiac age range. Essentially, it means that these patients are assumed to be at risk of heart attack until a complete, face-to-face evaluation rules that possibility out. However, the Rule was not meant to encourage more definitive therapy PRIOR to that evaluation, such as aspirin administration.

In the Medical Priority Dispatch System® (MPDS®), aspirin administration is advised when patients complain of Heart Attack Symptoms, as listed in the Additional Information sections of Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic) and Protocol 19: Heart Problems/A.I.C.D., when the exclusion criteria of the related CEI and the Aspirin Diagnostic and Instruction Tool are ruled out. If these symptoms are present, Protocol 10, rather than Protocol 1, is indicated.

With that said, I’m now more interested in the frequency of heart attack in the 1-C-5 and 1-C-6 codes. Now that we have better outcome data, we can have a look.

Thanks for the question. If the numbers are higher than I expect, we may want to consider ASA administration aligned with these codes.

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

Hi Brett:

How does the AMPDS™ (or FPDS® for that matter) deal with the specific hazards of electric cars after a crash?

This was a question from the regional fire brigade of one of my centers, as more and more people drive fully electric cars over here (Tesla, for instance). Local firefighters tend not to know how to deal with these incidents...

Kind regards,
Harm van de Pas, Medical Manager RAV Brabant Midden-West-Noord Netherlands

Hi Harm:

There are no specific provisions for electric cars in the MPDS, and I have seen no specific suggestions proposed. I have seen demonstrations at fire conferences to educate firefighters about batteries and extrications, but I am not aware of any specific instructions for bystanders other than what is currently in the MPDS.

I am forwarding your question to Jay Dornseif for comment on the FPDS.

Brett

Harm:

Brett is correct in that we do not have any special or specific instructions for electrical cars whether involved in a fire or in a crash.

The only specifics that we (FPDS) are aware of is when extrication exercises are carried out on an electric vehicle. Since this does not involve call processing, we leave this to the field responders to identify and address on the scene of the event. We (FPDS) keep our eyes and ears open to what changes the Automobile Manufacturers Association make as new makes and models are sold to the public.

If a needed change was to occur with alternative fuel vehicles, we would adopt them into the FPDS and share those changes with our EMD and EPD Council of Standards. Thanks for your question.

Jay Dornseif, Program Administrator – Fire, Priority Dispatch Systems™
AFTER ALL THESE YEARS
CRESA keeps the ACE spirit alive

Audrey Fraizer

The year is 1994, and Dr. Jeff Clawson is visiting Clark Regional Communications Agency (CRCA), Vancouver, Washington (USA), to present the ACE award. CRCA was the world’s fourth ACE, and ACE is a distinction it still holds 23 years later. A photo of the event features Dr. Clawson, EMD Robin Bacon, and Doug Smith-Lee, administrator of the paramedic “fail-safe” ambulance contract of Clark County EMS District #2. Smith-Lee was behind a statewide service ambulance at his previous job in Oregon.

Jack Stout developed the “fail-safe” high-efficiency design system for EMS that typically involved key performance indicators, such as response times, prioritizing medical calls, and clinical standards. Stout’s list of “36 EMS System Design Decisions” for CRCA included upgrading its “current call-processing practices so as to allow bona fide priority dispatch (i.e., Dr. Clawson’s protocols or equivalent).”

Smith-Lee reviewed the few emergency dispatch systems available then and met with the representatives. “Dr. Clawson impressed me,” Smith-Lee said. “He had a real heart and passion for emergency dispatch focused on patient care.”

The Medical Priority Dispatch System™ (MPDS®) was implemented in 1993—only one year after CRCA installed its first CAD system.

Smith-Lee was confident about his choice. “I felt good about the protocols,” he said. “Dr. Clawson’s protocol system was medically based and sound.”

The choice signaled a continued parade of Academy (then called the National Academy of Emergency Dispatch) experts, including Scott Hauert and Fred Hurtado, to train and certify EMDs, teach protocol use, and encourage QA policies and procedures. Dr. Clawson provided the EMD Executive Course to get fire and EMS leaders on board.

Brett Patterson and Ross Rutschman have consistently helped with continuing dispatch education and fielding questions. Jerry Overton, then Director of the Richmond Ambulance Authority, also provided expert guidance in administering the high performance ambulance contract.

Accreditation was a natural step forward and, by this time, Smith-Lee was not alone in welcoming the protocols along with accreditation. “Everyone in the community from our elected officials, fire and EMS officers, and the crews in the field were supportive of the idea [accreditation],” he said. “If we were going to be triaging medical calls and providing patient care, we better be doing it right.”

Push ahead nearly a quarter century and the emergency dispatchers of today are every bit as possessive of the protocol as they were from the beginning. No one better take it away. “Dispatchers would feel lost because there’s nothing worse than being on the phone and not knowing how to help or give instructions in an emergency,” said Bacon, who manages the center’s ACE and QA processes. “It would be like an EMT having a patient but no equipment on the ambulance. Driving fast is all the EMT could do.”

CRCA no more

In 1995, CRCA moved from the basement of Vancouver City Hall to its present site in the same city and in a building that combines emergency management and communications. The next five years brought growth in the number of agencies, residents served, and duties.

In 2001, the name was changed to Clark Regional Emergency Services Agency (CRESA) to reflect its service responsibilities as Clark County’s hub for consolidated 911 police, fire, and medical calls; regional emergency management; and EMS District #2 ambulance contract administration. In 2003, CRESA also became the Region 4 Homeland Security Office for the four southwest Washington counties—Clark, Cowlitz, Skamania, and Wahkiakum.

As part of its emergency management responsibilities, CRESA coordinates search and rescue response, including the Volcano Rescue Team formed in 1986 to handle mountain-related incidents with the opening of Mount St. Helen’s to climbing.

ACE has stood the test of time at CRESA, as well as the Commission on Accreditation for Law Enforcement Agencies (CALEA) Communication
They do what they do for the right reason. As a result, this makes me feel confident in what CRESA does when we pick up the phone to help the caller.

Doug Smith-Lee

Center Accreditation achieved in 2002. But Smith-Lee doesn’t take the credit for their continued success in accreditations. “Talk to Robin [Bacon],” said Smith-Lee, CRESA Program Manager. “She’s key to the success of our agency’s EMD system.”

ACE

Bacon dispatched 10 years for a private ambulance service prior to CRESA, where she has worked since March 1987. After dispatching for 21 years, she has been a dispatch supervisor and training coordinator and, in 2009, she was promoted to QA and Accreditation. She focuses on the EMD side.

ACE made sense, she said. After all, using the Academy’s protocols correctly and running an EMD centric QA program underlies the agency’s success. New and lateral move employees attend an in-house academy divided into three phases (calltaking, police dispatching, and fire/EMS dispatching), and each phase must be satisfactorily completed before progressing to the next. The Communications Training Officer (CTO) assigned to each new dispatcher evaluates daily performance based on standard evaluation guidelines.

Bacon and the EMD-Qs review 108 EMD calls per month.

The hardest part isn’t maintaining the ACE, per se, or reviewing the calls. “It’s all about keeping employees at compliance levels and feedback,” she said.

Experience on the other side of the process taught Bacon the good and bad about evaluating performance. No one likes to be called into the office for a one-on-one with QA any more than receiving a written evaluation pointing out each flaw in the call leading to a non-compliant overall rating. She has built a trust among employees using a positive focus. “It’s all about consistency,” she said. “If the call didn’t go well, we sit down and figure out what went wrong and how to fix it. I’m here to teach them to do it the right way.”

Smith-Lee said ACE is a commitment to high quality backed by protocols and people focused on patient care. “They do what they do for the right reason,” he said. “As a result, this makes me feel confident in what CRESA does when we pick up the phone to help the caller.”

By the numbers

CRESA is governed by a nine-member administrative board representing the cities and agencies in Clark County under an Ordinance and Charter establishing the agency as a municipal corporation. CRESA provides emergency dispatching for nine law enforcement agencies, 12 fire agencies, and three ambulance services. The center receives 314,000 incoming calls per year, which includes non-emergency law enforcement calls from the public.

Total events number 391,000 (calls generated by dispatch, field units, and calls referred to another agency or online reporting system), with the following events according to discipline per year: Police, 345,000; Fire, 7,000; and EMS, 39,000.

Falls are the leading medical event (12 percent), followed by breathing problems (11 percent), sick person (10 percent), and traffic accidents (9 percent).
RECOGNIZING THE ACHIEVEMENTS
Pennsylvania dispatch center likes to focus on individual accomplishments

Josh McFadden

Like staff at all centers, the management and EMDs at Elk County Office of Emergency Services in Ridgway, Pennsylvania, USA, take their responsibilities seriously. Elk County Office of Emergency Services was established in 1980. It serves the residents of Elk County and Cameron County, totaling around 36,000 people. The center has five administrators on its staff as well as 20 telecommunicators. Elk County was an early adopter of the Medical Priority Dispatch System™ (MPDS™), Police Priority Dispatch System™ (PPDS™), and Fire Priority Dispatch System™ (FPDS™).

Ridgway offers a small-town feel and plenty of outdoor activities such as fishing and hunting. Residents are three hours from Pittsburgh, Pennsylvania, and Buffalo, New York, and they’re just four hours away from Cleveland, Ohio.

When an Elk County EMD helps a desperate caller through his or her own life-and-death struggle, or assists the caller with someone else’s perilous moments, recognition is in order. In the spring of 2015, Elk County Emergency Services started giving staff members the Save a Life, Deliver a Life Recognition Award. This initiative highlights the superb work of its emergency dispatchers when help is needed most. When an Elk County EMD successfully handles a call that results in a saved life, or when the EMD assists in a baby delivery, that person’s name, date of the call, and whether the call was a delivery or a save is put on a plaque. The plaque is then posted prominently in the main hallway of the center for everyone to see.

Last year, the center had honored five of its emergency dispatchers for properly using the Priority Dispatch Protocols™ in giving lifesaving instructions to callers. In some larger centers, lifesaving calls may be a common occurrence, but when you’re located in a rural area, they’re less frequent. Center management began the program because it wanted to give EMDs the accolades they rarely receive from what many outside the profession perceive as being a mundane job. “Emergency dispatch is a thankless profession,” said Elk County Office of Emergency Services Qualify Assurance Supervisor Mark Greenthaner. “These men and women sacrifice more than the citizens they serve will ever realize. This recognition lets our staff know they are truly appreciated. Most calls don’t have good outcomes. This is our way of recognizing them for their outstanding effort.”

It’s no secret that the emergency dispatching profession can be mentally and emotionally taxing. The stresses of this demanding job can lead to health
problems and burnout. Greenthaner said the program has helped with morale and the staff has responded positively to it. “It’s been received really well,” he said. “When they take a potentially fatal call, they’re working real hard to save that patient. While the recognition is great, they’re doing it because they truly want to save lives. It makes them truly feel appreciated. Anytime they can be recognized for their hard work, it makes them feel good. As for the center as a whole, they walk by the plaque every day to get to the communication center. Whether they get a save or not, it’s a reminder that what they do is truly important, and they make differences in people’s lives every single shift.”

EMD Melissa Stahli received a call from a local restaurant where an elderly man was choking. Through questioning, she learned that the patient had a complete obstruction. Before she could give instructions on performing the Heimlich maneuver, the patient went unconscious. Stahli immediately instructed a bystander to straddle the patient’s hips and use their weight to push quickly into the patient’s stomach. After several rounds, the food became dislodged, and the patient began breathing and regained consciousness. When the paramedics arrived, the patient was awake and alert.

The second telecommunicator who earned the recognition award was Zuback. On Aug. 12, 2017, Zuback spoke with a caller who witnessed his wife collapse in the middle of a conversation. The caller originally reported that his wife “passed out.” Zuback determined that the patient wasn’t breathing, and he quickly administered “Compressions only” CPR instructions. CPR continued upon EMS arrival, and the patient was revived. It was later determined the patient suffered from a ruptured brain aneurysm.

Telecommunicator Kurt Whiting was recognized for two saves just over an hour apart late on Sept. 24 and early on Sept. 25. In the first call, Whiting walked a caller through CPR instructions on her neighbor, who was found unconscious. Thanks to his instructions, the caller helped the patient until paramedics arrived and took over. The patient was later revived and released from the hospital.

In Whiting’s second call, a 64-year-old man called, complaining of chest pain and pain in the shoulders and arm. When Whiting learned that the man’s son was at home, he instructed the caller to ask his son to bring him aspirin. However, when the son arrived with the aspirin, the father had collapsed. The son took the phone and reported that his father was not awake and not breathing. Whiting gave the son Compressions only CPR instructions, which he performed. Within minutes of arrival at the hospital, the patient regained spontaneous circulation. The patient was sent to the Cath Lab for a stent and was admitted to the ICU.

The fourth team member to receive Elk County’s Save a Life award was Amanda Catalano. On Oct. 7, she processed a call for a patient who had overdosed on a drug known as “Benzos.” The patient was reported as unconscious and not breathing. Catalano quickly began to instruct the caller to give CPR. She made sure the caller didn’t stop and ensured the compressions were being conducted at the proper rate. The patient was revived and transported via medical helicopter. The patient eventually passed away, but Elk County officials still consider this a “save.”

“Some outside of 911 would question how this can be a save if the patient died,” Greenthaner said. “In 911, our mission is to answer a citizen’s call for help. While on the call for help, we will send the citizen the right help the right way, right now. We will also do everything in our power to save or prolong a patient’s life. In this scenario, [Catalano] prolonged her patient’s life. The family of the patient was able tosay a dignified goodbye. So yes, Amanda saved a life that day.”

Greenthaner said the Elk County emergency dispatchers and staff are a close family, all working together to make a difference in the community. Center management has long seen the importance of following a researched-based protocol. Everyone’s efforts at the agency have paid off not just for the calls that have saved lives but for the more routine ones as well.
Why are they called catfish? In the documentary “Catfish,” the husband of the scam’s perpetrator is interviewed and spins an anecdote about how live codfish were shipped from Alaska to China in vats. In order to keep the cod’s flesh from getting mushy, someone came up with the idea of putting catfish in the vats to “keep the cod agile.” He further explained that “there are those people who are catfish in life”: “They keep you guessing, they keep you thinking, they keep you fresh.”

**RULE #1**
If it sounds too good to be true, it is! 1

**CATFISHING**
can range from using old pictures of you to passing off someone else’s picture as you, misrepresenting what you look like currently. 4

59% of people surveyed agreed that “Online dating is a good way to meet people.” 2

Merriam-Webster dictionary added “Catfish” in 2014. 6

54% of Pew Research respondents felt that they were being catfished. 5

66% of people who have online dating profiles have gone on a date with someone they met through a dating site or dating app. 3

---

2. www.pewresearch.org/fact-tank/2016/02/29/5-facts-about-online-dating
3. See note 2.
4. www.lawstreetmedia.com/killers-craigslist
5. www.pewinternet.org/2013/10/21/online-dating-relationships
CELLPHONE TROUBLE

Though convenient, cellphones can give emergency dispatchers headaches

Josh McFadden

With GPS technology, you can use your smartphone and find a destination with ease. So, people might think that when they call an emergency number, the person on the other end of the line will automatically know where they are. Not always.

When people call from a cellphone, it’s not automatic that you will know exactly where they are. With a landline, the caller’s location will pop up on your screen, though you will, of course, still verify the address. It’s a good thing the first question the Medical Priority Dispatch System™ (MPDS®), Fire Priority Dispatch System™ (FPDS®), and Police Priority Dispatch System™ (PPDS®) instruct emergency dispatchers to ask is, “What is the address of your emergency?”

Cellphones use cell towers to determine the caller’s location. The problem is, the caller’s phone may ping a tower miles away, possibly in an area your center doesn’t serve. This wastes precious time, which could be the difference between life and death. In fact, the FCC estimates that a one-minute improvement in response time to cellphone callers could save more than 10,000 lives per year.

In December 2016, Shanell Anderson, of Sandy Springs, Georgia, USA, lost control of her SUV during the early morning hours and landed in a pond in Cherokee County, Georgia. Anderson called 911 from her cellphone, reporting her situation and telling the emergency dispatcher at Alpharetta Department of Public Safety that her vehicle was sinking. Anderson described her location as best she could, but the emergency dispatcher told her that her
location wasn't coming up on the system. Anderson continued giving her location, but eventually, the call was disconnected.

The team at Alpharetta worked feverishly to determine the location, and it sent firefighters to various nearby locations with water. By the time crews arrived on the scene 20 minutes later, Anderson's car was 8 feet underwater. She was alive but was in a coma and died one week later.

Turns out Anderson's cellphone call was routed through the nearest cell tower to another county; Alpharetta didn't cover the area where Anderson was sinking, which is why the emergency dispatcher couldn't find it on her maps. 2

This is hardly an isolated case. A four-part story in USA Today lays out several alarming statistics in the U.S. alone regarding cellphone calls to emergency numbers3:

- In California, more than half of cellphone calls didn’t transmit location to 911 from 2011 to 2013. In 2016, about 12.4 million of California’s cellphone calls to 911 didn’t share location.
- In Texas, from 2010 through 2013, more than 65 percent of cellphone calls in a sample of calls from major cities reached 911 without an instant position on location.
- In 2014, Fairfax County, Virginia, outside Washington, D.C., reported that only 25 percent of cellphone calls included precise location data, while Loudoun County officials said 29 percent of mobile calls included the exact location over the last six months of that year.

In March 2017, AT&T cellphone users in 14 states were unable to call 911 for several hours. AT&T apologized for the interruption but offered no explanation as to what caused the problem. 4

**Cutting out**

Everyone has experienced the annoyance of his or her cellphone call dropping or having to deal with poor reception. While this can frustrate people during routine calls, when emergencies are in progress, emergency dispatchers and callers depend on a clear connection in order to relay vital information and instructions.

Daniel Alexander is a communications officer at Neshoba County 911 in Philadelphia, Mississippi, USA. He said poor quality with cellphone calls is a common problem at his center.

“Signal quality and dropped calls pose a significant obstacle to calltakers attempting to obtain information during interrogation,” he said. “Also, the quality of the voice audio tends to be lower on cellular devices, especially when someone is using a hands-free or Bluetooth-style device in conjunction with a cellular device. In my experience, even people who have a landline option readily available tend to use a cellular device to make an emergency call.”

Emergency calls from cellphones are subject to the same challenges cellphone users have with any call: drops, outages, poor service, and other similar issues. Emergency dispatchers all over the globe deal with these conditions constantly.

**Location solutions**

When cellphone callers aren’t sure where they are, there are some simple things emergency dispatchers can do to pinpoint the location. If the caller can’t provide an exact address or nearby intersections, the emergency dispatcher should ask for landmarks or other distinguishing features of the area: the name of a lake or river or the name of a shopping center, school, park, or well-known business.

Kassandra Lee, emergency medical dispatcher for Action Ambulance in Wilmington, Massachusetts, USA, and a Fire Alarm Operator (FAO) for Seabrook, New Hampshire (USA), Fire Department, said she advises callers to be observant and aware of their surroundings.

“As far as obtaining location from those who are unfamiliar with their surroundings, I often ask them what they can see,” she said. “Can they see an easily identified building like a McDonalds, a post office, etc.? If they are on a residential street, I have them look around them. Do they see a mailbox—what number or name is on it? Do they see a home? What color is it? Are there any unique features to it? Often, I can figure out a pretty accurate location from these things.”

There are also cellphone apps designed to automatically show the emergency dispatcher the caller’s exact address from the moment the call comes in. Google has an app, appropriately named Phone, compatible with all Android devices. The Australian government has developed an app called Emergency+ that uses GPS technology

When your caller has poor cellphone service, good luck understanding what the caller is saying. More than once we’ve had to piece together various words to get a picture of where the incident was.

*EMD Eva Grumbir*
to help callers provide 000 emergency dispatchers important location details. This free app is available for download on Google Play and at the Apple Store.

Also in Australia, St. John Ambulance officials have developed the St. John First Responder App. When someone calls 000 from his or her phone using this app, it sends the caller’s GPS coordinates directly to an emergency dispatcher, making it easier for an ambulance to arrive on the scene quickly.

SirenGPS, One-Touch-911, and SafeTrek are other popular cellphone apps callers can use to aid emergency dispatchers in determining exact location.

**Other problems**

Emergency dispatchers also contend with other obstacles when taking calls from cellphones. These phones often pick up other sounds in the area, making it difficult for the emergency dispatchers to hear what the person is saying, particularly if the caller is outside.

“Another issue is audio quality,” said Tracey Halvorson, Supervising Fire Dispatcher, Kern County (California, USA) Fire Dept. “Many cellphones pick up background noises as loudly as the caller’s voice. More people use speakerphone with cell calls, which distorts audio quality also. Damaged or poor quality phones are common.”

Karina Skegg, a Quality Improvement and consumer Safety Consultant with Ambulance Tasmania in Hobart, Australia, has similar sentiments about sound quality barriers. She also said cellphones account for other troubling obstacles.

“The challenges are with wind noise, background sounds (especially in a pub or nightclub), passing the phone around to others, not knowing how to put it on hands-free,” she said. “No one knows anyone’s phone number anymore.”

In addition to the widely understood problems with location detection, Eileen Selby, an Admin Specialist/EMD-Q® with Dare County Sheriff’s Office in Manteo, North Carolina, USA, said many cellphone callers simply don’t understand what their phones are capable of.

“Another challenge with cellphones is people not realizing that even phones without service can still dial 911,” she said. “I also believe most people think the capabilities within the 911 center are what they see on crime shows on TV. People can stop in the middle of the road and have a pizza delivered to their location, but when they call 911, we can’t locate them, and trying to explain the different technologies can be frustrating.”

Other emergency dispatchers say that many cellphone callers don’t realize that emergency dispatchers can’t call them back, like they can landlines, if they leave the phone. The quality of cellphone batteries is another problem, as some phones run out of power during an emergency phone call, especially if the caller is in a remote area with no power outlets to charge his or her phone.

**The benefits**

Using cellphones to call for emergency help isn’t all negative. There are some advantages for emergency dispatchers when the person on the other end of line isn’t tied down to a landline.

In March 2012, the Journal of Emergency Medicine published a study titled “Mobile Phone Use for Contacting Emergency Services in Life-threatening Circumstances.” The study authors concluded that “the use of mobile phones to alert emergency services in a life-threatening situation is associated with improved mortality rates at the scene in patients with medical problems and a lower likelihood of admission to the emergency department.”

The study further stated that “137 more lives are saved per 100,000 patients when emergency services are called from a mobile phone in the critical moments after the onset of an acute illness or injury compared to a landline phone.”

Researchers noted that because cellphone use is so prevalent today, it’s much easier to quickly notify emergency responders when help is needed.

Lee said cellphone callers can more easily administer lifesaving help to patients as instructed.

“I have had instances of people calling from a landline being unable to go to the patient in need of CPR or other immediate interventions giving me a cellphone number so I could call them to get them close to give instructions,” she said. “An example would be a multi-floor shelter where the office is on the first or ground floor and the patient is on the fifth floor, and they couldn’t see or help the patient from where they ran down to get to a phone, but the patient was unconscious.”

**The history**

In 1973, Martin Cooper and John F. Mitchell, both of Motorola, demonstrated the world’s first handheld cellular phone. The duo even made a phone call on the 4-pound device. It wasn’t much like today’s models, though. One could only talk for 30 minutes before the phone would die, and it took 10 hours to charge.

In 1979, the first cellular network, Nippon Telegraph and Telephone, was launched in Japan. Four years later,
Motorola made history when it launched the DynaTAC 8000X, the world’s first commercial cellphone. Like Cooper and Mitchell’s phone 10 years earlier, the DynaTAC allowed a person to talk for half an hour. It also stored a grand total of 30 phone numbers. The price tag: a cool $3,995 USD.9

No one knows anyone’s phone number anymore. Karina Skegg

Things began to shift in the early to mid-1990s when cellphones became more affordable and were designed with the average consumer in mind. Nokia released several models, much smaller and more sophisticated by standards of the day. By the late 1990s, you could even play games on your phone.

Smartphones began to make their appearance in the 21st century, and their popularity grew immensely at the end of that first decade. Today, you can’t go anywhere without seeing people talking, texting, browsing the internet, or playing games on their phones.

While cellphones—smartphones in particular—can make life easier by providing people with instant information and the ability to communicate virtually anywhere, there are drawbacks in the emergency dispatch environment.

Cellphone calls to emergency numbers

With the accelerating growth of cellphone use and popularity of smartphones, traditional home landlines are disappearing.

In 2004, 92.7 percent of all U.S. households had a landline in their place of residence. In this same year, only 5 percent of homes had only a cellphone.

Fast forward to 2017, and you see some eye-opening numbers. As of 2017, only 43.8 percent of all U.S. homes had a landline, compared with 52.5 percent that had only cellphones.10

With landline use plummeting, so, too, have the number of landline calls to emergency numbers when people are reporting medical needs or fires, or when they’re requesting police assistance.

In September 2017, the Federal Communications Commission reported that 70 percent of all U.S. calls to 911 originated from cellphones.11 This figure may be higher or lower in your center, as factors such as demographics and geographic location vary from place to place. For example, Emergency Dispatcher Eva Grumbir, a Communication Specialist II with Santa Rosa County Emergency Communications in Milton, Florida, USA, estimates up to 80 percent of all the calls she takes come from cellphones.

Cellphones come in handy for callers reporting emergencies when they’re on the go—at restaurants, at the grocery store, driving in their car, or at a public event. But because of the decline in landline use, many callers are using cellphones when they’re at home too.

In summary

It doesn’t appear as though cellphones are going away anytime soon. In fact, at the current rate, one has to wonder if in the coming years emergency dispatchers will even get more than a few random landline emergency calls here and there.

It’s vital for emergency dispatchers to prepare for the challenges that come with taking cellphone calls by being patient, persistent, and precise in their instructions and questioning.

Sources

3. See note 2.
7. See note 5.
NEW FEATURES IN ED-Q VERSION 10.0 AND AQUA 7.0

Brian Dale
Associate Director, Medical Control and Quality Processes, IAED
Quality improvement is the heart and soul of effective emergency dispatching. Case review, feedback, system analysis, and continuous improvement define the high-performing center and provide the structure and support to develop high-performing emergency medical, fire, and police dispatchers. The foundation of this system of continuous improvement is the International Academies of Emergency Dispatch® (IAED™) ED-Q™ Performance Standards. Developed by a volunteer council of quality improvement and emergency dispatch experts, the Performance Standards literally define what high-quality, high-effectiveness emergency dispatching and customer service look like.

As part of its own mission toward continuous improvement, the IAED, through the ED-Q Council of Standards, is always revising, expanding, and improving upon the existing standards—pushing ourselves and all of our member agencies to the highest possible measures of quality and performance.

Performance Standards 10th Edition, released in 2018, marks a significant expansion of the scope of the standards—and also provides unprecedented levels of support and clarity for the ED-Q, the emergency dispatcher, and the agency. The simultaneous release of AQUA version 7.0 also provides a new level of connection between the standards and the software designed to assist the ED-Q in applying them.

Ten features of this double release stand out in particular, demonstrating the innovative new approach ED-Q version 10.0 and AQUA version 7.0 bring to the practice of emergency dispatch quality assurance and quality improvement.

1. **MADE FOR EACH OTHER**
The new ED-Q Performance Standards are made for use with ProQA®. For the first time, the Performance Standards include specific standards for all the workflows and elements of the ProQA software. In particular, the Universal Standards include new clarifications regarding how to handle Operant (or “blue for you”) Questions, ProQA Fast Track features, subquestions, Primary Discipline Selection, and more.

2. **ONE STANDARD TO Q THEM ALL**
Version 10.0 presents a single, unified set of standards for emergency dispatching in all three disciplines. Emergency dispatchers are professionals, and like any professionals, they aspire to meet a high and consistent standard of practice. The new combined standard reflects this—and offers ED-Qs the ability to apply that standard consistently and fairly across all emergency dispatchers, even in multidiscipline or consolidated agencies.

3. **IN THIS TOGETHER**
Gone are the days when ED-Qs had to open ProQA on a separate screen, or hold a QA Guide in one hand, while reviewing a call. In AQUA version 7.0, when ProQA incidents are exported to AQUA, all the elements of ProQA that are needed to review the case are actually visible right there, accessible from the AQUA interface, where and when ED-Qs need them.

4. **IT’S NOT INSIGNIFICANT**
The INSIGNIFICANT error type is a thing of the past. Instead of attempting to decide whether a very minor alteration in word choice is INSIGNIFICANT or not, ED-Qs can now mark questions “Not As Scripted” (NAS) when the verbiage used does not change the meaning, intent, or objective of the question. The change allows ED-Qs to give dispatchers the benefit of the doubt while still tracking trends in NAS question-asking over time.
PERFORMANCE IS THE THING

The purpose of case review isn’t to trap, punish, or “ding” emergency dispatchers; the purpose is to improve outcomes for callers by ensuring appropriate, high-quality dispatcher behaviors. The new ED-Q standards make the distinction even clearer, focusing on providing feedback on performance rather than lists of deviations. Using AQUA version 7.0, ED-Qs can more easily get insights into specific behaviors—such as not asking questions as scripted, difficulties selecting the most appropriate Chief Complaint, or failure to provide PAIs when needed—that can actually be improved. Everybody wins with this approach: emergency dispatchers receive focused, effective feedback on behaviors they can address, and ED-Qs become partners in improvement rather than just “graders.”

DEFINING THE WIGGLE

No matter how much a person wants to achieve perfect performance, some amount of variation is inevitable, especially given the complex and time-pressured nature of emergency dispatching. The question is, how far can a behavior deviate from the expected standard before becoming a problem? At what point does a misspoken word become noncompliance? Where is the line between acceptable clarification and freelancing? The new Performance Standards much more clearly define both the expected behaviors for emergency dispatchers and the allowances, or “tolerances,” for deviation from those behaviors. For example, EPD-Qs will notice increased clarity around requirements for collecting Description Essentials information during Cold Call incidents.

USER FRIENDLY

AQUA version 7.0 includes a large number of user interface upgrades, making the system easier and more intuitive to work with. New menus and menu locations, buttons to access ProQA features and elements during case review, updated report-generating features, and many other improvements make this the best and most user-friendly AQUA version to date.

NOW YOU SEE IT

In addition to ProQA elements, the new AQUA interface also offer ED-Qs the ability to put aside the printed Performance Standards manual while working. All Performance Standards can now be accessed from AQUA, during case review, as needed. No more rummaging through the manual to find the relevant standard; now, ED-Qs can pull up the information they need on the fly.

AIS, DIAGS, AND DES

In addition to the elements of the ProQA call being reviewed, AQUA now also provides ED-Qs the ability to pull up Additional Information, Diagnostic and Instruction Tools, and Description Essentials within the AQUA interface. No need to run test cases just to see whether the emergency dispatcher properly used the Stroke Diagnostic Tool or the Persons Description entry panel. A click of the button pulls up any of these, from any discipline, at any time.

REPORTING FOR THE REST OF US

Finally, no Quality Assurance or Quality Improvement initiative could be complete without feedback—including both the feedback ED-Qs provide to emergency dispatchers and the feedback that provides insight into overall system functioning. That’s where reports come in; they offer visual insight into problem areas, trends, and improvements across time, individuals, and shifts. An entirely new report structure in AQUA version 7.0 reflects the new Performance Standards and provides new ways to gain insight into your personnel and system. Moreover, the new software also offers User Defined reports, giving ED-Qs and agency management the ability to mine their own data for increased insight.

Thanks to the incredible time and effort volunteered to the IAED by the members of the ED-Q Standards Council and the ED-Q Curriculum Board, as well as the tireless work by the software developers who worked on AQUA version 7.0, these new Performance Standards and user interfaces better serve our profession. They represent a major step forward in the drive to build and maintain high-quality, highly-effective emergency dispatching systems and to support, train, and inform the professionals who do this critical work.
For the first time, the Performance Standards include specific standards for all the workflows and elements of the ProQA software.

Version 10.0 presents a single, unified set of standards for emergency dispatching in all three disciplines.

All the elements of ProQA that are needed to review the case are actually visible right there, accessible from the AQUA interface.

ED-Qs can now mark questions "Not As Scripted" (NAS) when the verbiage used does not change the meaning, intent, or objective of the question.

ED-Qs can more easily get insights into specific behaviors that can actually be improved.

ED-Qs can more easily get insights into specific behaviors that can actually be improved.
For the first time, the Performance Standards include specific standards for all the workflows and elements of the ProQA software.

Version 10.0 presents a single, unified set of standards for emergency dispatching in all three disciplines.

All the elements of ProQA that are needed to review the case are actually visible right there, accessible from the AQUA interface.

ED-Qs can now mark questions “Not As Scripted” (NAS) when the verbiage used does not change the meaning, intent, or objective of the question.

ED-Qs can more easily get insights into specific behaviors that can actually be improved.

The new Performance Standards much more clearly define both the expected behaviors for emergency dispatchers and the allowances, or “tolerances,” for deviation from those behaviors.

AQUA version 7.0 includes a large number of user interface upgrades, making the system easier and more intuitive to work with.

All Performance Standards can now be accessed from AQUA, during case review, as needed.

AQUA now also provides ED-Qs the ability to pull up Additional Information, Diagnostic and Instruction Tools, and Description Essentials within the AQUA interface.

An entirely new report structure in AQUA version 7.0 reflects the new Performance Standards and provides new ways to gain insight into your personnel and system.
A NEW ERA IN CASE REVIEW AND QUALITY MANAGEMENT

Let AQUA® 7 ASCENT bring a new focus of simplicity, performance, and positivity to your case review process. The data AQUA provides, along with user-defined reports, can help you improve your system performance.

COMMIT TO CONTINUOUS IMPROVEMENT AT: prioritydispatch.net/AQUA
The perks and pitfalls of being a multidisciplinary center

Becca Barrus

When I was hired by the International Academies of Emergency Dispatch™ (IAED™), I knew next to nothing about emergency dispatch, much less about the Priority Dispatch System™ (PDS™). Although I was a writer, I wasn’t familiar with the protocols, so I decided that it was probably best to become acquainted with them the best way I knew how: running fictional scenarios through them.

multidisciplinary centers

Tanya Polinsky at Manatee County
But when I got to Amy March falling through the ice of the skating pond in “Little Women,” I was stumped. There are a multitude of protocols that could be used: MPDS Protocol 14: Drowning/Near Drowning/Suba Diving Accident; MPDS Protocol 20: Heat/Cold Exposure; and FPDS Protocol 72: Water Rescue/Sinking Vehicle/Vehicle in Floodwater. Would sending the fire department there provide adequate medical care? The water was, after all, freezing, so hypothermia is something to take into consideration. But if I only sent an ambulance, what if they couldn’t get her out of the water? If the nearest center only has either MPDS or FPDS, obviously you would use the one you have. But if you have both? Or all three?

That led me to spiral into a slew of logistical questions such as, “Are emergency dispatchers in those centers tied to one discipline or do they have flexibility?”

Welcome to the decidedly non-fictional world of multidisciplinary communication centers.

**Decisions, decisions**

Who decides which discipline should be used? Does the caller decide or is it up to the emergency dispatcher? Obviously, if the caller phones the non-emergency police or fire line, it will be handled by the respective disciplines, but what if it goes straight to the emergency line?

“We tried it both ways,” said Laurie Wilson-Bell, the Operations Manager of Salt Lake City 911 (Salt Lake City, Utah, USA). The center tried having emergency dispatchers answer the phone with “911, do you need police, fire, or medical?” but they got enough callers misdiagnosing their own problems (like asking for medical when really they needed police) that they knew they needed to do something else.

“Now we start with ‘Tell me exactly what happened,’” said Leslie Crockett, SLC 911’s Quality Assurance Supervisor. That allows the emergency dispatcher to get enough information on the incident to know precisely which discipline to use.

And if it’s a call that requires more than one discipline, like a lightning strike, an assault, a suspicious package, an explosion, a suicide attempt, or a traffic accident? Every one of these incidents could be handled by at least two disciplines, if not all three. At SLC 911, the emergency dispatcher who answers the call has the choice to stay with the call from start to finish and switch between disciplines or take care of one discipline and then send it to whoever is handling the other discipline.

**A high traffic topic**

Because traffic incidents are among the most common calls communication centers receive and because there is a protocol in each discipline that handles traffic incidents, the Academy conducted a study to find out which discipline communication centers use (or use first) and why. In the most recent issue of the Annals of Emergency Dispatch & Response, there’s an article by Chris Knight about just that.

“Although the sample size was relatively small, the findings showed that ‘selections were almost exactly evenly split.’ Neither police nor fire nor medical was significantly favored over its counterparts when it came to reporting traffic accidents. The article goes on to say that ‘a majority of emergency dispatchers use agency policies and/or interrogation at Case Entry to decide which protocol discipline to launch and use to process traffic accident calls.’” In other words, it depends. Sometimes it’s the emergency dispatcher who decides which discipline to use, and sometimes the choice is directed by agency policy.

Heather Hedgcock, Quality Assurance Coordinator for Manatee County Emergency Communications Center (Bradenton, Florida, USA), said that in her center, they have a policy that helps determine which discipline to use based on information gathered before they start Case Entry.

“We ask if anyone needs an ambulance,” she said. “If the answer is yes, we use medical. If the answer is no, we ask if there is a fire or a chemical hazard. If the answer is yes, we use fire. If the caller answers no to both questions, we use police and send highway patrol.”

Stirling Williams, Operations Manager for Boone County Joint Communications (Columbia, Missouri, USA), said that they primarily use police to handle traffic incidents.

Wilson-Bell and Crockett said that their center uses MPDS Protocol 29: Traffic/Transportation Incident for all calls reporting a traffic incident where someone is injured.

Jennifer Osborn, Quality Assurance and Compliance Specialist at Fayetteville Police Department (Fayetteville, North Carolina, USA), said that they also ask about injuries. If someone is injured, they proceed with MPDS Protocol 29. If the only damage
incurred is property damage, the emergency dispatcher will proceed with PPDS 131: Traffic/Transportation Incident (Crash).

These responses line up with what the study found: “Factors influencing the decision are the presence or absence of injuries, the need for special rescue operations or specialized response vehicles, and the presence of on-scene hazards or scene safety concerns.” Every multidisciplinary center tailors its own policy regarding response to traffic incidents according to the needs of the call.

Obviously, this doesn’t just apply to traffic incidents. Communication centers use that kind of filter for all calls that require more than one discipline. It’s all part of a multidisciplinary center’s daily balancing act.

Cross-training: It’s not just for the gym anymore

There is something to be said about the depth of knowledge and experience that emergency dispatchers at single-discipline centers have. It’s a given fact that the more you focus on and use a skill, the stronger it gets—protocol is no exception. However, the idiom, “jack of all trades, master of none” doesn’t quite fit for either centers or emergency dispatchers that handle multiple disciplines.

It varies from center to center, but generally emergency dispatchers in multidisciplinary centers are cross-trained. That is, they can sit down and field fire, medical, or police calls with relative comfort.

At Boone County, all of the emergency dispatchers are cross-trained, and everyone can do calltaker and dispatch functions. Manatee County is the same—all of their emergency dispatchers are cross-trained and certified in all three disciplines. For most calls, whoever answers the call will be the one to dispatch it. The city of Bradenton dispatches their own calls for police and fire, and if someone calling within the city limits gives Manatee County a call, the emergency dispatcher will transfer it to the city.

The emergency dispatchers at SLC 911 either rotate between fire and medical calls or mostly stick to police calls. Like Boone and Manatee, though, everyone is triple-certified and can step up to the plate should the emergency dispatchers in one discipline get overwhelmed.

Fayetteville Police Department divides their emergency dispatchers into two groups: Telecommunicator I and Telecommunicator II. Those with the Telecommunicator II designation are certified on both police and fire dispatch and rotate through the 3 police district channels and 2 fire service channels. Those in the Telecommunicator I group are new hires or those that choose to remain on fire dispatch. All of their telecommunicators rotate through calltaking and assist with calltaking when their dispatch channel is not busy.

One unique thing about Fayetteville’s 911 center is that they process calls for all three disciplines, but they only dispatch fire and police. They field medical calls and send them to the county agency to be dispatched to the medic units.

Loose lips sink PSAPs

As in other sectors of public service, confidentiality is an important issue for communication centers. Add in the fact that privacy standards vary from police to medical to fire, and multidisciplinary centers may be staring down the barrel of a fully-fledged headache. No one wants their center to be in the news because one of their emergency dispatchers took a picture of their computer screen—which listed the client’s name, address, and details of the call—and shared it on social media, along with an unflattering quip about the caller. Neither do they want to be in hot water because one of their emergency dispatchers gave out an assault victim’s name to the press.

Most multidisciplinary centers have a confidentiality policy that covers the complexities of all three disciplines. A solid place to start is by treating every call with high confidentiality, both inside and outside of the center, and to ensure that any stories regarding calls fielded in the center are handled by the communication center manager or public information officer.

One of the things emergency dispatchers have to remember at the SLC 911 center is that it’s OK to say the name of a suspect over the police radio, but they cannot give the name of a patient over medical radio. Another thing they can’t give out over the phone is a license plate number.

“We then use their name to look up the license plate number and send it off to the police.” She explained that this policy exists as part of the effort to keep officers safe. “The officers need to know if they’re dealing with a stolen vehicle if they happen to pull the suspect over,” she said.
The Fayetteville Police Department has also made some adjustments to its privacy policy. Osborn said that her agency and the police department have “decided that it is in the best interest of victims of criminal/sexual assaults to withhold their name from a call. For this reason, when our agency is processing these types of calls, we do not document this information.”

Walking the line between giving out pertinent information to those who need it to do their jobs and withholding it from people who don’t can be a tough act, especially in places where 911 calls are considered public records (like Florida). But it looks like multidisciplinary centers have it figured out.

Let’s talk about stress, baby

It goes without saying that stress is one of the constants in the life of an emergency dispatcher. But do Emergency Medical Dispatchers (EMDs) have higher levels of stress than Emergency Fire Dispatchers (EFDs) or Emergency Police Dispatchers (EPDs)? The Academy hasn’t conducted any studies on the subject (yet), but Hedgcock, Osborn, Wilson-Bell, and Crockett all had something to say on the matter.

“The kinds of stress are just different,” Hedgcock said. “Someone giving CPR instructions over the phone is a different kind of stress than someone taking a domestic disturbance call.” Overall, she said that medical calls are somewhat predictable, whereas violent situations involving police response are very unpredictable. Police calls are “a different monster completely.”

While Osborn hasn’t noticed different stress levels between the calltaking aspects of the disciplines in her own center, she has noticed that on the dispatch side, the EPDs are definitely more stressed than the EFDs. She also noted that the workload is different for each function that exists in the dispatch center, which naturally causes different kinds of stress.

Wilson-Bell and Crockett agreed that the stress levels between disciplines differ, although at their center, the more stressful calls tend to be police and fire.

“Fire stress goes more in waves,” Crockett said. When an incident requiring use of the Fire Protocol—such as a rollover—comes into SLC 911, it becomes a group effort. The EFDs who are handling the call are on the radio with the firefighters as the incident is going down, while the other emergency dispatchers in the center handle the influx of calls reporting the incident as well as those reporting unrelated incidents.

“Police stress is more constant,” said Wilson-Bell, who worked as a police dispatcher for 16 years. “The duties are handled from individual to individual instead of sharing the stress altogether.” In other words, the caller reports to the EPD, and then the EPD sends the information to the police officer, who takes care of it from there. The EPD isn’t necessarily along for the whole process, which generates a distinct kind of stress as opposed to the stress that is generated from handling a call from start to finish.

The ice of March

To end, let’s go back to the fictional scenario of little Amy March falling through the ice into a freezing pond and see how a multidisciplinary center would handle it.

Amy’s older sister Jo calls the local communication center on the telephone (which won’t be invented for another 10 years) and tells the emergency dispatcher—let’s call her Mary—what happened.

Mary is currently taking medical calls, although she has access to the MPDS, FPDS, and PPDS (the oldest of which won’t be invented for another 110 years) and has to decide whether to use the MPDS or FPDS for this particular call. She decides that getting Amy out of the water is the first priority and dispatches the call to the fire department, since they have the equipment best suited to perform such a rescue. After the fire department has been dispatched, Mary also dispatches an ambulance to the scene to handle Amy’s inevitable symptoms of cold exposure when she is pulled out of the water.

Mary, the fictional emergency dispatcher, stays on the phone with Jo until the first responders arrive, then goes back to taking medical calls (mostly complaints involving typhoid and cholera).

After all, it’s all in a day’s work for an emergency dispatcher at a multidisciplinary center.

SOURCE

THE CATFISH, THE SCAM, AND THE FLIMFLAM MAN
Protocol 118 helps you navigate calls regarding fraud

Becca Barrus

When I joked about catfishing in a Journal editorial meeting one day, I got blank stares. I explained further. Catfishing is pretending to be someone else online—with fake pictures and everything—and getting someone else to fall in love with you. My co-workers nodded; they knew the concept, if not the terminology.

Sometimes catfishing isn’t about making someone fall in love with you. Sometimes it’s about getting revenge, like the woman who catfished her cousin to get back at him for a mean-spirited comment he made about her. Sometimes it’s about skirting social rules, like the man who told the women he took on dates that he was single when he was, in fact, married and a father of two. And sometimes it’s about money. One professor in England lost £140,000 ($190,000 USD) to a man she thought she was in a long-distance relationship with.

Catfishing isn’t the only way to dupe people out of their money. There’s also identity theft, investment schemes, hacking, phishing scams, and false billing. Americans lost upward of $16 billion to fraud in 2016; Australians lost some $83 million; Canadians lost $290 million between 2014 and 2016, and it’s estimated that fraud in the U.K. costs £193 billion a year.

Although not everyone who’s been a victim of fraud reports it to the police (one study reported that a mere 27 percent of victims had done so), it’s a common enough occurrence that it’s best to be acquainted with Protocol 118: Fraud/Deception, the main protocol you Emergency Police Dispatchers (EPDs) will use to handle calls reporting acts of a fishy (or catfishy) nature.

Who’s at risk?
Axiom 2 on Protocol 118 states that “Elderly or vulnerable people are frequently the targets for con artists.” The Australian Competition & Consumer Commission reported that those over 65 both made the most number of reports (13 percent) and lost the most money (some $13 million, 16 percent of the total amount lost) in 2016. Heather Hedgcock,
Quality Assurance Coordinator for Manatee County Emergency Communications Center in Bradenton, Florida (USA), stated that her center gets fraud calls almost daily because of the high population of elderly people in the area.

“Unfortunately, a lot of people take advantage of elderly people,” Hedgcock said. “They’ll get a call saying something like, ‘Your grandson has been arrested for some crime. We need X amount of money for his bail.’”

It isn’t just elderly and vulnerable people who are at risk, of course. The Federal Trade Commission (FTC) found that 21 percent of all fraud victims surveyed in the U.S. in 2016 were between 30 and 39 years old, closely followed by those in their forties and fifties. Only 6 percent of those surveyed were over 70.

The Office for National Statistics found that adults aged 45–54 in the U.K. were almost twice as likely to be a victim of fraud than those aged 75 and over.

What’s the diff?

The DELTA-level Determinant Codes are divided into three categories: CRIMINAL DECEPTION, FRAUD/FORGERY, and Prescription. Prescription fraud is when someone writes a fake prescription for a controlled substance like Oxycodone, Adderall, or Xanax and tries to get it passed off as legitimate at a pharmacy. Hedgcock said that prescription fraud isn’t as big as it used to be in her area, which she thinks is due in large part to Florida’s crackdown on pill mills. The data from the International Academies of Emergency Dispatch (IAED)” is similar—an analysis run by Meghan Broadbent, a Research Analyst/Statistician for IAED, found that prescription fraud only made up 0.25 percent of the fraud calls that were recorded between mid-2013 and mid-2017. At 68.21 percent, the most common dispatch code recorded was 118-B-2 “PAST FRAUD/FORGERY.”

When you look at the definitions of CRIMINAL DECEPTION and FRAUD, it doesn’t seem like there’s much difference between the two. FORGERY stands out more. It’s “making, altering, or uttering (passing) of written instruments or documents that represent money, stamps, securities, deeds, wills, checks, prescriptions, or other similar instruments, or that affect a legal right, interest, or obligation.” In other words, it’s faking something that has real value (like money, checks, or legal documents). Who hasn’t heard of art forgeries or, more commonly, counterfeit bills?

Figuring out the difference between CRIMINAL DECEPTION and FRAUD is slightly trickier. As defined by the Police Priority Dispatch System™ (PPDS™), CRIMINAL DECEPTION is “The act of deceiving or intentionally misleading by falsehood [...] with intent to commit a crime.” Dave Warner, Police Program Administrator with Priority Dispatch®, gave the example of an auto mechanic telling a customer that a part needs to be replaced, but the replacement doesn’t actually need to be made. The auto mechanic is deceiving (lying) with the intent to commit a crime (taking the customer’s money on false pretenses).

FRAUD is a more general category: “a false representation of a matter of fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed.” A great example of this is catfishing. It can be used to get money from a victim (which would be deceiving in order to commit a crime), but often it’s committed for its own sake. Although catfishing isn’t honest or healthy, it isn’t illegal either.

Tiers of fraud urgency

Far and away, the most common method scammers will use to contact victims is by phone, as reported by both the FTC and the Australian Competition & Consumer Commission. The next most common method is via the internet, whether by email, social networking, or other means. This kind of fraud allows perpetrators to be at least one step removed from their victims and makes it harder for the authorities to track them down.

The removed nature of an act of fraud committed by someone not immediately present is what divides 118-D-2 FRAUD/FORGERY—and even 118-B-2 PAST FRAUD/FORGERY—from 118-C-1 FRAUD/FORGERY (electronic means, mail, or phone). For those situations where the suspect is still on the scene, like...
in the case of someone trying to pass off a counterfeit bill at a store, 118-D-2 is used. It makes sense to send responders to the scene as soon as possible to apprehend the suspect.

Even in situations where the fraud happened in the past, like if a store employee discovers at the end of the day that they’ve been passed a counterfeit bill (long after the suspect is gone), there is a chance that one of the employees will remember the suspect or there might be security camera footage that the police can utilize to identify the suspect. According to Broadbent’s analysis, 78.2 percent of all reported fraud calls were BRAVO level, as opposed to the 20.7 percent that were DELTA level, indicating that most fraud calls do not require an urgent response.

In cases where 118-C-1 is applicable, the suspect was never on the scene to begin with. The caller has, in all likelihood, limited information about the suspect’s identity or whereabouts. Although the police will still want to ask the victim some questions, there is not as much of a sense of urgency as there would be for a DELTA-level CRIMINAL DECEPTION or FRAUD/FORGERY call.

The DELTA-level Determinant Codes are divided into three categories: CRIMINAL DECEPTION, FRAUD/FORGERY, and Prescription.

Few weapons here

Generally, the point of fraud is for someone to get what they want without using violence, whether with or without a weapon. To the suspect, it might seem less risky to forge a check to get the amount of money he wants than it would be to rob a bank at knife or gunpoint.

Broadbent’s fraud analysis found that weapons were reported for 3 out of 9,736 calls (or 0.03 percent) concerning Protocol 118. Two were reported as a “Gun” and one was reported as “Multiple.” The numbers indicate that using a weapon is not a priority for those who commit this type of crime.

Because the answer to the question “Were weapons involved or mentioned?” is “No” so often, Chris Knight, Chief of Priority Dispatch Program Management and Implementations, said that there’s a Proposal for Change (PFC) for Key Question 1 to be removed. If the PFC is approved, the change will be applied in version 7 of the PPDS.

It can be tempting to privately laugh at stories of people who have been catfished or feel little sympathy for those who have been scammed. How could they not see it coming? However, fraud is a very real issue, one that can happen to anybody. Although today you might be on the receiving end of a call reporting an identity theft, you could very well be making the same kind of call yourself tomorrow. Have compassion and use caution.

SOURCES

7. See note 3.
8. See note 6.
YOU MUST BE POLICE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “The Catfish, the Scam, and the Flimflam Man,” which starts on page 33. Take this quiz for 1.0 CDE unit.

1. How much did Canadians lose to fraud between 2014 and 2016?
   a. $175 million
   b. $290 million
   c. $12 billion
   d. $83 billion

2. According to one study, what percentage of fraud victims report it to the police?
   a. 19
   b. 27
   c. 32
   d. 41

3. Axiom 2 on Protocol 118: Fraud/Deception states that “______ or vulnerable people are frequently the targets for con artists.”
   a. cynical
   b. elderly
   c. sympathetic
   d. young

4. The Office for National Statistics found that adults aged 75 and over in the U.K. were almost twice as likely to be a victim of fraud than those aged 45–54.
   a. true
   b. false

5. Which of the following Determinant Codes was most commonly reported in the fraud data analysis?
   a. 118-B-2 PAST FRAUD/FORGERY
   b. 118-B-3 PAST prescription
   c. 118-D-2 FRAUD/FORGERY
   d. 118-D-3 Prescription

6. _______ is “The act of deceiving or intentionally misleading by falsehood […] with intent to commit a crime.”
   a. CRIMINAL DECEPTION
   b. FRAUD
   c. FORGERY

7. The most common method scammers will use to contact victims is:
   a. in person.
   b. by email.
   c. by internet ads.
   d. by phone.

8. If a caller reported that a suspect was trying to pass off a counterfeit bill at a store, 118-D-2 would be used.
   a. true
   b. false

9. A majority of calls regarding fraud are handled on which determinant level?
   a. DELTA
   b. CHARLIE
   c. BRAVO
   d. OMEGA

10. Out of 9,736 calls regarding Protocol 118, how many reported weapons?
    a. 3
    b. 5
    c. 55
    d. 63

To be considered for CDE credit, this answer sheet must be received no later than 06/30/19. 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.
CLIMBING A LADDER WON’T KILL
But a fall sure could

IAED Staff

Because she had visited my dad in the assisted living facility where he was recovering from a broken hip suffered in a fall from a ladder, you think Mom would have known better. You think she would have hesitated before taking the kitchen step stool outside to clean gutters. You think she would have steadied the step stool on a level surface instead of setting it on a patch of gravel before climbing up the three steps to reach the gutter.

Maybe she should have used the phone to call her daughter or son-in-law to help.

But she didn’t, and no sooner had she reached the top step than the stool swayed on its shaky ground and tipped her off to the hard ground.

Ouch.

She did not hit her head. She did not fall on a hip. She fell on her knee. She was able to sit up and did not feel any broken bones. Fortunately, Mom had carried her cellphone outside and it hadn’t shattered in the fall. She gave us the call she should have made before trying to do something so foolhardy. We drove her to the emergency room where X-rays revealed a hairline fracture to her kneecap. We made her promise never to do that again.

“Cleaning a few leaves from the gutter never hurt anyone,” she said.

Well, she was right in a way. The leaves won’t hurt her, but the fall certainly could.

Take a look at these statistics:

- Worldwide, approximately 28–35 percent of people age 65 and over fall each year, and that number increases to 32–42 percent for those over 70.¹
- Across the Netherlands, 3,884 people 65 or older died as a result of a fall in 2016, a 38 percent increase from two years earlier.²
- In 2014, older Americans (aged 65 and over) experienced 29 million falls causing seven million injuries and costing an estimated $31 billion in annual Medicare costs.³
- Increasing age is associated with a decrease in the mean fall height but worsening injury severity (7.8 feet mean level height for age group 66 years and older).⁴

Protocol and falls

Protocol 17: Falls in the Medical Priority Dispatch System™ (MPDS⁵) is designed to evaluate the nature and severity of a fall in order to send the right
level of care to the patient with the right response mode.

Case Entry Question 3, "Okay, tell me exactly what happened," is generally the most important query in providing the EMD an understanding of the circumstances surrounding the fall. For instance, it may uncover scene safety issues or details that suggest a medical (non-trauma) cause of the fall.

If you are a ProQA® user, the first Key Question in Protocol 17 is "When did this happen?" Interestingly, this Key Question appears in a different order than it does in the manual cardset (the legacy MPDS), where it shows up much further down in the Key Question sequence. The ordering of the questions in ProQA software is particularly important in order for the logic engine to work properly and achieve the proper recommended determinant coding.

If the fall is not clearly from ground level, the next Key Question on Protocol 17, "How far did s/he fall?" is a key factor in determining the priority level and final coding.

EXTREME FALLS—distances of 30 feet/10 meters (three stories) or higher—and LONG FALLS—distances of 10–29 feet (3–9 meters) for adults/children and 6–29 feet (2–9 meters) for infants—require a DELTA-level assignment regardless of apparent injury. Determinant Code 17-D-1 is "EXTREME FALL (≥ 30 ft/10 m)." Nothing changes that until the patient is evaluated in person. EXTREME FALLS and LONG FALLS are each provided their own Determinant Codes (17-D-1 and 17-D-6 respectively) because some agencies will reserve their maximum response only for the EXTREME FALLS. This is because EXTREME FALLS are virtually certain to require emergency transport to a facility such as a trauma center, where rapid treatment by a surgery team is an absolute necessity.

The reason EXTREME FALLS are so deadly is due to a physics principle most of us learned about in high school and probably forgot long ago: the acceleration of gravity. This simple rule states that a free-falling object—in this case a person—will increase its speed by approximately 30 feet (10 meters) per second, for each second of free fall. So if someone were to fall just over 30 feet (10 meters), he would hit the ground at a speed of about 32 miles (51 kilometers) per hour. Landing on a hard surface at that speed can, of course, be fatal.

LONG FALLS also carry a substantial risk for serious injury. It doesn’t matter whether the patient and/or caller says they are OK or not. Occult (hidden) injuries are not uncommon in patients involved in high mechanism of injury (MOI) conditions. The fact that the patient regained consciousness may be completely (and likely) separate from any potential internal injuries or bleeding in the body or brain, which may not manifest early on. Walking around doesn’t rule out a ruptured spleen, damaged liver, or other internal injury.

Ground-level falls are the most common, and they may be caused by a simple slip, trip, or a medical problem that caused fainting, near fainting, or unconsciousness. A ground-level fall includes falling from a standing position or from a height in which the feet can touch the floor (e.g., from a bed or chair). The Rules and Axioms in the Additional Information assist in defining the cause and provide valuable information in determining the appropriate response.

The next Key Question on Protocol 17 determines the cause of the fall: accidental/unknown, dizziness with fall (ground level), electrocution/lightning, fainted or nearly fainted (ground level), or jumped (suicide attempt).

If the caller reports "She fainted," the EMD will go to Protocol 31: Unconscious/Fainting (Near). Similarly, a complaint such as: “He had the power saw on. I think he’s been electrocuted!” will direct the EMD to Protocol 15: Electrocution/Lightning and its explicit safety features.

Rule 1 tells the emergency dispatcher to “Always consider that the patient’s fall may be the result of a medical problem (fainting, heart arrhythmia, stroke, etc.).” In the vast majority of ground-level falls caused by a medical problem, the medical issue will initially take priority over any injuries sustained from the relatively low mechanism of injury associated with a fall from ground level. This is why Protocol 17 shunts to Protocol 31 if it is learned that a ground-level fall was caused by fainting, near fainting, or dizziness (Rule 7). Knowing the true cause of the fall and coding the call appropriately is paramount.

For elderly patients, it’s not uncommon for a ground-level fall to be the result of unconsciousness before the fall and, in some cases, cardiac arrest.
Therefore, Rule 1 (Protocol 31) states: “An unconscious person whose breathing cannot be verified by a 2nd party caller (with the patient) is considered to be in cardiac arrest until proven otherwise.”

Some ground-level falls do not involve medical (non-trauma) causes, and in those cases, the EMD will likely be dealing with an injury and remain on Protocol 17. According to Axiom 1, “Ground-level falls in elderly patients commonly result in hip fractures, which are not prehospital emergencies.” A caller may recognize the possibility of a hip fracture from the appearance of the patient’s leg—which is often shortened slightly and rotated inward—and the inability to bear weight on the leg; pain can be moderate to severe and present anywhere from the pelvis to the knee.

Hip fractures can be very painful and debilitating, but they are not pre-arrival or even prehospital emergencies since a few minutes shaved from the response time would not make a difference in the outcome. Some people disagree, but it has been the Academy’s view that an isolated injury without priority symptoms, from a low mechanism of injury, does not justify the risks associated with a lights-and-siren response. In fact, these patients actually need slow, methodical, and gentle transport, rather than speed, which is often associated with rough handling and a rough ride to the hospital that is painful and can even aggravate the injury.

The patient’s condition after the fall also depends on other factors involved, such as slipping on ice and getting the individual out of the cold. In dry and warm (comfortable) situations, patients can receive adequate support from a pillow or blanket roll, and that’s usually all they need until BLS arrives.

A fall associated with alteration of consciousness, however, is potentially critical even at ground level because of the potential for airway obstruction and even cardiac arrest. Trauma patients described as not alert with ineffective breathing require an airway maneuver, and the EMD should protect life over limb and open the airway (Rule 3). DLS Links direct the EMD to instructions for airway maneuver (NABC-1) if the patient is in arrest or has ineffective breathing and is not alert. Links to specific panels on Case Exit are also available to address scene safety or to direct the caller to handle bleeding or an avulsed tooth, if necessary.

If breathing is effective and PAIs are not necessary, it is prudent to encourage the rescuer to use his/her hands to stabilize the patient’s head and neck in the position found if a spinal injury is suspected (Rule 5) and to monitor the patient for any symptoms. In most cases, however, gentle and careful transport to the hospital for further evaluation and treatment is the priority.

**Reduce the risk**

In my family, the increasing loss of independence is hard on Mom, as it is for the rest of us. The threat of severely limited physical activity or death due to a fall, however, helped convince her to put away the step stool, even when she wants to reach glassware or canned foods stored on a top shelf in the kitchen cabinets. I also suggested some precautions, courtesy of Jane Brody, Personal Health columnist for The New York Times:

- Take smaller steps, bend forward slightly, go slow, and walk as flat-footed as possible when it’s icy or snowy.
- Scan the path six or more feet ahead of you for trip hazards.
- When walking indoors, always wear shoes or slippers with nonskid soles or socks with nonslip grips on the soles.
- Always use a handrail when going up and down stairs.
- Always use a safety stool—not a chair or ledge—when trying to reach an item that’s high up.
- Move all frequently used items to lower shelves.

Finally, do like the Dutch and learn how to fall correctly. See the story and video at nytimes.com/2018/01/02/world/europe/netherlands-falling-elderly.html for more information.

*Note: Much of the information in this article was based on the Medical CDE “Age Factors: Older population more susceptible to falls,” by Brett Patterson, IAED Medical Council of Standards Chair, and published in the Jan/Feb 2014 issue of the Journal.*

**Sources**

YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Climbing A Ladder Won’t Kill,” which starts on page 37. Take this quiz for 1.0 CDE unit.

1. What percent of people over 65 fall each year (worldwide)?
   a. 9 to 15 percent
   b. 20 to 25 percent
   c. 28 to 35 percent

2. A caller reporting, “He had the power saw on. I think he’s been electrocuted!” directs the EMD to:
   a. Protocol 9
   c. Protocol 17.

3. If the fall is not clearly from ground level, which Key Question on Protocol 17 is a key factor in determining the appropriate response?
   a. How far did s/he fall?
   b. What caused the fall?
   c. Is s/he completely alert?
   d. When did this happen?

4. EXTREME FALLS are defined in Protocol 17 as:
   a. distances of 10–29 feet (3–9 meters) for adults.
   b. distances of 30 feet/10 meters (three stories) or higher.
   c. distances of 100 feet or more.

5. LONG FALLS require:
   a. an ECHO-level assignment.
   b. a DELTA-level assignment.
   c. a CHARLIE-level assignment.
   d. a BRAVO-level assignment.

6. What is meant by an occult injury?
   a. The injury is minor and the individual requires no further examination.
   b. The injury is found to be less severe than initially reported on scene.
   c. The injury is obviously life-threatening.
   d. The injury is hidden, which is not uncommon in patients involved in high mechanism of injury (MOI) conditions.

7. Rule 1 on Protocol 17 tells the emergency dispatcher:
   a. “The distance is a key factor in determining response.”
   b. “Always consider that the patient’s fall may be the result of a medical problem (fainting, heart arrhythmia, stroke, etc.).”
   c. “Stay on the line with the caller when the patient is still unconscious to ensure ABCs until responders arrive.”

8. Hip fractures common among the elderly in falls are considered a prehospital emergency when no other injuries or symptoms are discovered.
   a. true
   b. false

9. Because of the potential for airway obstruction or even cardiac arrest, a fall associated with which of the following symptoms could make a ground-level fall critical?
   a. alteration of consciousness
   b. vomiting
   c. occult injury
   d. bleeding

10. To reduce the risk of falling, it’s important to follow which of the following recommendations?
    a. Always use a handrail when going up and down stairs.
    b. Always use a safety stool—not a chair or ledge—when trying to reach high up.
    c. Move all frequently used items to lower shelves.
    d. All of the above.

To be considered for CDE credit, this answer sheet must be received no later than 06/30/19. 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 with your processing fee to receive credit. Please retain your CDE letter for future reference.
At the core of this old Journal article is the argument regarding if an en route responder, whether EMT, paramedic, or captain, should be allowed to determine, or even change, the response mode (HOT vs. COLD) of a call after it is dispatched. Maybe 40 years ago, before any evaluation or determination of the call condition and/or situation was made by dispatch, this might have been okay. However, as we know now, the emergency dispatcher, as a truly professional calltaker, is the one who knows more about the call than anyone else involved, especially before anyone gets to the scene to reassess.

In essence, it is easily argued that the EMD is actually the initial “scene commander,” and clearly remains so, not only until someone else gets to the scene, but until the scene can be accurately assessed. This is simply based on the fact that no one can know more about the scene, per the caller, than the emergency dispatcher—period. The response [by Dr. Jeff Clawson] to the agency involved helped to set the record, and standard of care and practice, straight on this one many years ago.

No one has effectively challenged this rationale, or has even tried, since!...
An official Academy position...  

**Follow the Protocol and Avoid Liability**

*Jeff Clawson, MD*

Earlier this year I was approached by the EMS Coordinator of a Fire Department in the Midwest. Their department was implementing a two-tiered response system, utilizing the MPDS. This coordinator shared with me some concerns that arose about response coding. First, if Dispatch codes a call COLD and the officer in charge of the fire apparatus decides to run HOT anyway, what is the potential liability exposure of the City and of the officer involved? Second, if Dispatch codes a call COLD and the officer runs COLD, but upon arrival finds a medical situation, nor like what they were told, what potential liability exposure might arise? These are good questions that I’ve been asked before in varying ways.

In answer to the first question, in my opinion, there is absolutely no reason for station officers or crews to determine response mode and configuration where the Advanced MPDS is in place and functioning. If department policy states that response mode (HOT vs. COLD) is determined by the EMD, a station officer’s decision to do otherwise would be a direct violation of policy and procedure. In support of the EMD as this decision-maker, no one can know more than the EMD prior to arrival since the EMD is the only person who has talked with and interrogated the caller.

The EMD’s selection of a determinant code-based response is clearly the correct process since these responses are pre-planned by the department’s management in conjunction with sound medical oversight input.

Should an officer change any response for his own reasons, in violation of procedure, it would be very likely that any liability incurred would rest on him. However, if it could be shown, perhaps by the department’s lack of corrective action in a similar or threatened situation, that the department could have foreseen that he would violate this procedure then the department as “captain of the ship” might incur liability. In this case, having an approved MPDS, training the EMDs, and also having a policy and procedure in place clearly stating who has the responsibility for response configuration and mode determination, would establish a rational and non-arbitrary process that would be legally defensible as well as correct.

The second question is an interesting converse to the first. It is apparent that the crew would have no liability for following policies and procedures and responding COLD as directed. What is important is that the EMD comply with the protocol in asking the listed evaluative questions and then codifying the data obtained. It is apparent that the EMD cannot be a prognosticator or clarivoyant in regards to scene findings. The dispatcher is only required to make a reasonable determination of the patient’s problem based on the available information. If the EMD followed the key questioning and picked the closest of the listed determinant codes (without going “under”), then the EMD would have met his/her duty to perform based on their training and procedure (the protocol). While in some instances, scene findings may be different than initially reported by the EMD, that does not mean that the EMD made a “negligent” mistake.

Field crews should be instructed to understand that once the EMD has evaluated the patient and scene, three things can happen in the ensuing time of mobilization, response, and initial patient-in-person evaluation — the patient can get better, get worse, or stay the same. The failure of crews to appreciate this obvious but not well understood fact can make life easier for everyone and prevent inappropriate criticism of dispatch from the field.

It should be pointed out that there has never been a case that has ever claimed negligence for not responding HOT, much less succeed in proving it. Furthermore, no study in the medical or public safety literature proves, or even states, that lights-and-sirens saves significant time. The careful use of lights-and-sirens as warning devices now more than ever requires their measured medically-correct use to prevent the terrible consequences of the predictable occurrence of emergency-vehicle collisions.
AN INCREDIBLE ‘BEAR’
EMD takes care of grandma in crisis

Audrey Fraizer

Marco Gallardo had no previous 911 experience. He had been a worship minister at a Christian academy.

Gallardo had no medical emergency experience to fall back on. He previously taught music and Bible studies.

He had been in emergency dispatch only a short time. Gallardo had recently completed training and was certified in EMD and EFD.

He had a grandmother on the line pleading for help to save her 2 ½-year-old grandson.

“My job is to help the patient,” said Gallardo, EMD/EFD, Lake EMS, Mount Dora, Florida (USA). “I was so glad to have the protocol because it does everything for me. I could take care of the patient.”

The caller, “Grandma MeMe,” was tending the grandson she affectionately calls “Bear” in mid-November when he had a seizure related to a medical condition (Angelman Syndrome, or AS). He was unresponsive.

Grandma MeMe (Carmen Carroll) administered his rescue medication and called his parents, Brian and Kelly David. She called 911 and remembers begging for help and listening to Gallardo’s calming voice as he advised her what to do. She was scared. He stopped breathing “for just a few seconds.”

“We started doing CPR,” Gallardo said. “He started breathing before paramedics arrived. I was very relieved. I thought about my own boys at home.”

Grandma MeMe didn’t waste any time in expressing her gratitude. She wrote a thank you note addressed to Lake EMS. She didn’t know the name of the EMD who had helped, but she did know that his composure made it so she could be there for her grandson.

“I had prayed to God, and he answered my prayers,” she said.

Gallardo said his ability to navigate difficult situations comes from his background and education.

“I see it as being a bridge for people,” he said. “It’s their reality, and it’s our job to meet them where they are.”

Lake EMS Chief Communications Officer Kimberly Stephens acknowledges her “truly amazing” staff for the work they do every day.

“They are serious about the job they do,” she said. “Coming to work and doing your job as a 911 dispatcher certified in EMD and EFD and following the protocols exactly as written while you have a grandma on the phone pleading for help for her grandbaby and getting him to breathe again is downright remarkable.”

Bear was hospitalized for three days, with his mom and dad settling him in with new seizure meds to help control the electrical activity in his brain. Two weeks later, they boarded a plane for a FAST (Foundation for Angelman Syndrome Therapeutics) conference and fundraiser in Chicago, Illinois (USA).

“Life with Angelman Syndrome is a constant wait and watch and worry,” according to Kelly David’s Facebook post. “I am forever thankful to those who dropped everything to answer our calls and offer advice and guidance. For those of you on the outskirts of the community, I share this with you because I want you to understand WHY we want this cure. This handsome, funny, clever, mischievous, brave little boy is why we fundraise for FAST.”

Grandma MeMe ended her letter confirming Bear’s resilience: He’s “back to being his amazing, loving, and mischievous self.”

Gallardo said the benefits of the job speak through the calls they receive.

“I have the ability to serve so many people each day,” he said. “What better way to understand and sympathize with our community than by helping them navigate the scariest, most overwhelming moments of their lives.”

He also gave credit to the people he works alongside.

“Everybody here does all they can to help, every day,” he said. “We’re a lifeline.”

FAST funds research grants and has also entered into contracted research on targeted projects to restore function to the affected gene. Check out cureangelman.org for information about AS and FAST.

EMD Marco Gallardo
ACCIDENTAL SHOOTING
Toddler hit in chest and shoulder

Audrey Fraizer

Temperatures outside were barely into the double-digits, with a wind chill factor below zero. Light snow fell overnight, adding to the considerable amount of lake effect snow that had pummeled parts of western New York during two days at Christmas time.

Roads were bad and although passable, drivers were advised to travel only if necessary. Those venturing out and sliding their vehicles off ice-packed roads dominated calls to the Wyoming County Sheriff’s Department in Warsaw, New York (USA).

“Luckily on that day, not a lot of other calls were coming in,” said Haylee Carle, EMD, Wyoming County Sheriff’s Department communication center.

It was still early morning, close to 8 a.m. on Saturday, Dec. 30, 2017, and two emergency dispatchers were on duty when Carle answered the phone, hearing a female’s voice pleading for help. The woman’s three-year-old son had accidentally shot himself. He was bleeding from the shoulder and chest.

During the next 10 minutes, while awaiting the arrival of response traveling over snow- and ice-packed roads, Carle coached the mother and father in how to apply direct pressure to control the bleeding. She told them to put the gun in a spot away from everyone.

“I was mostly talking to the both of them,” Carle said. “The mom was really scared, but I was able to calm her down by asking questions.”

At one point during the wait, the boy’s mother told Carle that he had stopped crying and was closing his eyes. She encouraged them to keep a close watch on his breathing. Carle continued talking to the parents and giving them status reports of the expected arrival time for the ambulance.

Bennington Ambulance and Monroe Ambulance paramedics provided advanced care and within an hour of the 911 call, the boy was in the ambulance and en route to John R. Oishei Children’s Hospital in Buffalo, New York, which is about a 40-minute drive when roads are good. They arrived at 9:05 a.m. and were greeted by doctors aware of his condition and ready to prepare him for surgery. By the next day, he was able to eat soft foods. A chest tube had been inserted to drain fluid from around his lungs.

“He was recovering very well,” said Carle, who received regular updates from the sheriff’s department.

Carle started in emergency dispatch nearly three years ago and has an associate’s degree in criminal justice. She always had an interest in law enforcement and found a perfect niche in emergency dispatch.

“I couldn’t see myself doing anything else,” she said.

According to the Wyoming County Sheriff report, the boy was shot accidentally after picking up a loaded .45-caliber handgun in the living room. The gun discharged, and the bullet struck his shoulder and chest. The gun was registered in the father’s name, and he was later charged with endangering the welfare of the child, a misdemeanor.1

“Although this was a terrible accident, it was completely preventable,” according to Wyoming County Sheriff Gregory Randolph. “The loaded handgun was left unattended for minutes in the living room, but it was readily accessible to the child, which was the most significant factor in determining the charge. No one wins in a case like this; it is heart-wrenching to everyone involved.”

The eight full-time dispatchers answer calls and send response for the sheriff’s patrols and the four Village Police Departments. All fire and rescue calls for the entire county are also dispatched from this division. Two emergency dispatchers are assigned to every shift.

Source
2. See note 1.
JUMPING IN TO ACTION
Head-on collision leaves few choices

Audrey Fraizer

T he EMD and bystander had a tough decision.

Should the seriously injured passenger be lifted from the car and placed on the road for CPR?

After all, unnecessary movement is one of the most dangerous threats to an injured person and can cause more serious injury, further complicating recovery.

The passenger, however, was unconscious and his breathing shallow and erratic. The bystander sought the aid of a second volunteer (Bud Pierce) on the scene of the head-on collision along Highway 20 in Bend, Oregon (USA), and together they lifted 38-year-old Timothy Walthinsen from the car and laid him flat on his back.

The driver, 71-year-old Terry Walthinsen, was pinned in the driver’s seat and although seriously injured, he was conscious.

The driver of the pickup truck that spun out of control and crashed head on into the Walthinsen SUV was not injured.

A news photo taken at the accident that happened on a rainy May 20, 2016, is startling. The pickup lies on its side and over the center line of the road curving at the crest of a pass. The collision’s force pushed the Walthinsen’s SUV into the unpaved shoulder, and that’s where Pierce provided ventilations under the guidance of EMD Sara Cima until paramedics arrived.

The Deschutes County 911 EMD had already disconnected by the time both father and son were transported (Timothy by life-flight and his father by ground). She was on to the next calls and, in between, she listened to the Oregon State Police highway reports. The news was optimistic.

“I was grateful to hear they both made it,” she said.

Timothy was put into a medically-induced coma. He suffered a serious skull fracture and internal injuries. Terry underwent extensive surgeries to repair multiple broken bones. Three months after the accident, Cima met them and Pierce in person at the Walthinsen home for a news story.

Pierce told reporters that he had never given CPR in public and it was something he had learned 20 years ago in medical school. He credited Cima for her skill in handling the situation.

“You get calm and you listen, and the person on the 911 line was very helpful, that person really guided me,” Pierce said. “I just acted on her directions.”

The Walthinsens and Cima discovered a common faith-based belief system, and Cima gladly accepted their invitation to speak at Highland Baptist Church.

According to a Facebook post (June 3, 2016) from Erik Walthinsen, a family cousin, “My cousin Tim is spending today in his ICU bed tracking people with his eyes, answering yes/no with his toes, and breathing on his own. Every one of the last 18 days he’s been a demonstration of how God is infinitely more powerful than a reckless driver, a massive head trauma, or a doctor’s prediction.”

Cima started in emergency dispatch four years ago. Her dad was a police officer and, although that wasn’t her choice for a profession, she earned a degree in criminal justice.

She was encouraged to try emergency communications, did a “sit along” at Deschutes County 911, and was sold on the experience. Considering her tendency to “jump into action,” she had found a perfect fit. She received a life saving award for her part in the Walthinsen rescue and felt truly privileged in meeting Timothy and Terry.

“It was an awesome experience,” Cima said. “Not many people in dispatch get to meet the people they’ve helped. We always get the beginning but we rarely get the end.”

Source

EVERYTHING PLAYED OUT
EMD provides the instructions to save a life

Audrey Fraizer

You could almost consider them old friends, except they’d only known each other from a telephone call lasting about 10 minutes before meeting in person at the Ozaukee County Sheriff’s Department communication center, Port Washington, Wisconsin, USA.

“We talked about how everything played out,” said EMD Michael Eibs. “She kept thanking us again and again and again.”

Tricia (Patricia) Hallam was well aware of husband David’s potential medical emergency before the call on Sept. 15, 2017. He had a history of cardiac arrest and she had administered CPR. Knowing the likelihood, however, is different from when the event actually occurs, and this time, David had collapsed suddenly on their driveway shortly after 4 p.m. When Eibs asked, “Is he breathing,” Tricia was unsure, prompting Eibs to use the Diagnostic Breathing Tool in ProQA®. Within two minutes of the call, she was following Eibs’ CPR instructions.

“She was there and ready to go,” said Eibs, who had started on shift 17 minutes earlier. As instructed, Tricia counted while pumping her husband’s heart.

“He’s breathing,” she said at count 15. Deputy Sheriff Becky Swanson arrived within seven minutes of initiating CPR, and Eibs, having been told help was on scene, concluded the call.

“Alright, I’m going to disconnect with you,” he said.

“Not yet; not yet,” Tricia pleaded. “OK, that’s fine,” he said. “I can stay with you.”

He stayed until Tricia handed over CPR to the officers. They used an AED to provide a shock to David’s heart and restore normal rhythm. David had a pulse.

Two weeks later, David was home and invited to a celebration in October at the sheriff’s department. David and Tricia arrived early, giving them ample time to meet Eibs. It was the first opportunity ever to meet the people he had helped during his 14 years in emergency dispatch. But before they came face to face, Eibs felt a connection.

“She wanted me to stay on the call,” he said. “That was the point that made it extremely personal. We’re on the same level here.”

They talked for nearly 90 minutes, and following the presentation, Eibs led them on a tour of the communication center, with emphasis on the Medical Priority Dispatch System” (MPDS”) cardset to illustrate the PAIs and Breathing Diagnostic Tool he had accessed in ProQA®.

Ozaukee County Sheriff James Johnson, who presented the Lifesaving award to Eibs, and Deputy Swanson credited Eibs for his reassuring demeanor during the call [Ozaukee County Sheriff’s Office Facebook page]: “Patricia remained focused on following the directions from Dispatcher Eibs, while Dispatcher Eibs remained the calm voice for Patricia, providing support and instructions on performing CPR. Dispatcher Eibs provided the tools for Patricia to succeed in saving her husband’s life.”

The MPDS Protocol is relatively new to Ozaukee County, and before the system was in place, emergency dispatchers kept instructions to a bare minimum.

“We’d tell callers help was on the way and disconnect,” he said. “I knew CPR but wasn’t allowed to give that over the phone. It was rough. You really didn’t feel like you were helping.”

The instructions that saved David made Eibs a firm believer in what the first contact in an emergency can achieve.

“It’s nice to know we have the ability to help someone,” he said. “Our odds of saving people are slim. Hopefully, we can now turn those numbers around.”

But as far as taking any personal credit for the save?

“People call me a hero,” he said. “I tell them I was doing what I was trained to do. Anybody who had picked up that phone would have had the same outcome.”

Eibs started his EMS career about 15 years ago through the local Explorer Program. After three years as a firefighter/EMT, he was deployed to Kuwait and then Iraq as a radio operator for the Wisconsin National Guard.
STANDARDS APPROACH
Best practices depend upon benchmarks

Audrey Fraizer

Hurricane Andrew made a mess of communities in Florida (USA). Months after its Aug. 23, 1992, landfall near Miami, meteorologists upgraded it to a Category 5 hurricane with 167 mph winds at one point and 17-foot storm surge. The storm killed 65 people and stripped thousands of homes to concrete foundations.

The storm was so destructive that meteorologists retired its name forever. Hurricane Andrew’s fury prompted a statewide building code in Florida, passed in 2002. The rules (among other standards) require stronger fasteners on roofs of newly built structures to keep them from blowing off. For example, fasteners for asphalt shingles roofs in Florida must comply with American Society for Testing and Materials (ASTM) F-1667 (Standard Specification for Driven Fasteners: Nails, Spikes, and Staples). The standard covers material requirements and physical properties, such as ductility and tensile strength.

In medicine, most are familiar with the phrase Standard of Care. While the concept has evolved over the years and will continue to do so, it is generally accepted that the standard of care is what a minimally competent physician in the same field would do in the same situation, with the same resources.¹

Standards address a range of issues for the benefit of the whole. Concisely stated, "standards fuel the development and implementation of technologies that influence and transform the way we live, work, and communicate.”²

Standards are applied in operational law, regulations, and municipal and state codes. They guide best practices. Catastrophic events, such as Hurricane Andrew, led to ASTM standards for emergency management. The ASTM EMS Committee, formed in 1984, has four technical subcommittees, including one for communications.

The ASTM has since published standards and position statements addressing EMD system design, safety, and effectiveness. ASTM states in document F-1258 Standard Practice for Emergency Medical Dispatch (Section 4.1.2):

There must be continuity in the delivery of EMD care. To safely and effectively provide correct medical care, the EMD that is medically directing, evaluating and coding, must maintain direct access to the calling party and must use a medically approved emergency medical dispatch priority reference system. The person giving the medical instruction to the caller must be the same person that asks the systematic interrogation questions.

The statement appears in the first version of F-1258 and in the most recent revision released in 2014. The document has changed markedly over the years. It never wavers from the value of EMD or the use of a dispatch priority reference system. Rather, modifications expand and reinforce an EMD’s significance to EMS. Section 5.4/F-1259-95 (2014), which was added in later revisions, encapsulates what IAED™ Founder Dr. Jeff Clawson, who invented the emergency dispatch protocols, has been preaching for years:

This practice [standards for EMDs] may assist in overcoming some of the misconceptions regarding emergency medical dispatching. These include the uncontrollable nature of the caller’s hysteria, lack of time of the dispatcher, potential danger and liability to the EMD, lack of recognition of the benefits of dispatch pre-arrival instructions, and misconceptions that red lights, siren, and maximal response are always necessary.

Wow! How many times have we heard that?

When you consider that the correct use of a protocol is the equivalent of a roof builder’s checklist, any omission can and often will blow the roof right off the house.

Sources
MEDICAL TRANSFER PROTOCOL SUITE

Patient Transfer—Optimized

Are you fielding a large number of patient transfer calls? Let the Medical Transfer Protocol Suite™ (MTPS™) streamline your patient transfer process. MTPS guides emergency dispatchers to identify the best transport vehicle, equipment, personnel, and facility based on the patient’s condition, all right in ProQA!

OPTIMIZE YOUR PATIENT TRANSFER PROCESS AT:
prioritydispatch.net/MTPS