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WHAT MORE CAN I DO?
Find out about the emotional tools emergency dispatchers use to serve callers who can’t be saved.

FAST FACTS
Learn about the connection between the founder of Gold Cross Ambulance and our own Dr. Jeff Clawson.

NAVIGATOR BY THE NUMBERS
Read highlights from this year’s conference.

FEATURES

COLUMNS
4 | contributors
5 | the skinny
6 | dear reader
7 | ask doc
8 | from the emd side
9 | lean in

SECTIONS
BEST PRACTICES
10 | faq
12 | ace achievers
16 | stuck accelerator

ON TRACK
34 | medical cde
38 | fire cde
42 | blast from the past

YOUR SPACE
45 | dispatch in action
46 | stork story

CASE EXIT
47 | extra-special delivery

COVER PHOTO BY LUDMILLA PARSYAK
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Becca Barrus

Batten down the hatches! No matter which hemisphere you’re on, if you live on or near a coastline, it’s tropical storm season. Did you know that the difference between cyclones, typhoons, and hurricanes—which are all tropical storms—is not what they do, but where they form? Cyclones form over the South Pacific and Indian Ocean, typhoons form over the Northwest Pacific Ocean, and hurricanes form over the North Atlantic Ocean and Northeast Pacific. Even though the names are different, the essential function is the same.

The same holds true for the Journal—even though there are different categories, the overall goal is to help you become a more fulfilled emergency dispatcher.

This issue of the Journal covers many aspects of emergency dispatching. Art Braunschweiger, Sherri Stigler, and our own Audrey Fraizer have all written columns about issues that will interest emergency dispatchers no matter how much or how little experience they have. FAQ and Ask Doc both answer specific protocol-related questions that were submitted by inquiring minds.

In the Best Practices section, you’ll find two stories about Accredited Centers of Excellence on America’s East Coast. One highlights the New Hampshire communication center that covers the whole state, and the other showcases the communication center in St. Cloud, Florida, a center that is no stranger to hurricanes.

The middle of the Journal is where you can find a Medical CDE about Obvious Death and sudden cardiac arrests, as well as a Fire CDE about incident command. Blast From the Past brings a historically significant EMD article to light for those of us who haven’t been in the field for 40 years. One feature story helps answer the question “What can I do when there’s nothing I can do?” and the other tells the history of Gold Cross ambulance and its relation to emergency dispatch protocol (both hail from the same city).

Finishing up the issue are stories about emergency dispatchers who have had exceptional experiences. One of the Your Space pieces covers the story of an EMD who gave CPR instructions over the phone to a woman who ended up giving chest compressions to her mother on a snowbank; the other article tells about an EMD who followed in her dad’s footsteps and helped with a baby delivery after only being on the job for six months! Don’t forget to read the Case Exit story about a pregnant EMD who gave childbirth instructions over the phone to a mother in labor.
Would you want to be a patient riding in a driverless ambulance? Would you want to be an emergency dispatcher for a service that uses a driverless ambulance?

EMS has come a long way in the past 50+ years, but are we ready to hitch our transport system to an automated ambulance even if it meant double the paramedic care in the back of the ambulance (since paramedics wouldn’t be needed for driving)?

It’s something to think about, particularly since the driverless concept is getting lots of attention in all types of road transportation, including EMS.

Researchers at Embry-Riddle Aeronautical University and Florida Institute of Technology found consumers had mixed feelings about the prospect of riding in an automated ambulance. The norm of traditional ambulance configuration—driver in the front and paramedic in the back—was considered the better prospect during an emergency.¹

Predictability tends to be important to people, said Scott Winter, an assistant professor of aviation science at Florida Tech who served as primary author of the team’s paper.² A driverless ambulance could cause more strain on an already physically and emotionally compromised patient.

Two paramedics available to treat the patient en route might hold to the belief that more is always better, particularly with more hands on deck to perform critical interventions. Not everyone agrees. A study involving dual vs. single paramedic ambulances in Santa Cruz County by EMS Medical Director David Ghilarducci, M.D., cites a possibility of reduced survival rates with more hands on deck.³

In many respects, however, a driverless ambulance is inevitable. EMS ambulance providers look for innovative ways to streamline practices to reduce costs, particularly in light of decreased public and private reimbursement.⁴ Driverless ambulances could help cut expenses and keep ambulance services in business.

Secondly, autonomous systems are a solid part of EMS development. Autonomous system processes support, replicate, and, in some cases, replace human decision-making, and when ambulances are viewed in this context, EMS is already heading in a driverless direction (e.g., navigational aids and destination voice and data transmission systems). EMS has the technology (or, at least, EMS is certainly capable of getting the connectivity necessary), but it’s a change that must happen gradually. It’s a matter of changing the way we think about it and securely adapting to new paradigms.

A driverless ambulance isn’t the only solution for cost savings in EMS.

For example, drones already deliver AEDs to remote locations. Their use could be expanded to the delivery of medical equipment to remote locations, with patient care instructions available through the emergency dispatch center.

The Emergency Communication Nurse System™ (ECNS™) could be central to such an operation, with the Emergency Communication Nurse (ECN) at the communication center coordinating both the care and necessary medical supplies. If an ambulance is necessary for patient care and transport, drones could drop medical equipment at a specified zone prior to an ambulance’s arrival for immediate treatment.

I like the ECN and drone scenario, and it’s not because I work here. A professional driver at the communication center is the perfect hitch for my health care.

Sources
NEW TWIST ON ‘TIME WILL TELL’ IN DISPATCH

Does ProQA walk on by?

Jeff Clawson, M.D.

Doc,

I have recently been informed that in certain circumstances (I am not sure what circumstances as I have not been able to replicate this) Paramount will skip a Key Question.

I have just listened to a call where the EMD, using Protocol 19: Heart Problems/ A.I.C.D., asked if the patient was clammy (she was), sent a 19-D-4, and went on to ask if she had any chest pain/discomfort.

The question “Do you have a history” was not asked, yet it was answered in ProQA®!

I have had reports of this happening before but have never been able to replicate it on my laptop or on the live system!

Has anyone else reported this before?

Kindest regards,

James D. Gummett
Quality Assurance Manager
London Ambulance Service
London, U.K.

James,

Great to hear from you and looking forward to buying you a “few” gin-and-tonics (wink, wink) in Vegas. In reviewing this call, while I can’t prove it, I am almost sure that this is a case of “happy fingers” wherein the EMD accidentally hit the <enter> or <space bar> keys that quietly (nothing heard on the tape) “answered” this question. This also answers why you didn’t hear this question asked on the audio review.

Since the history KQ appears, right after the send point, with the green cursor starting on the “Yes” answer choice, this would clearly be the result—if my premise is correct. If another answer (any below it) was achieved, I wouldn’t make this assertion.

Another finding in support of my theory, is that the time shown in the Case Sequences shows only one second between the send time and when this question was answered—not nearly time enough to have asked, then answered, and moved on regarding this question. This is almost “proof” that what I think happened, actually happened.

I am sharing this assessment with others involved with the software and the logic system. If some other angle on this is shared, we will then vigorously evaluate this situation.

Prepare for Vegas, because what happens in Vegas must stay in Vegas! ...

See you there! ... Doc

Doc's final comments:

This particular situation can be considered in a number of ways, but the first is to at least entertain that the software or its logic is not always at fault when something untoward is experienced by the emergency dispatcher using it. I must admit, I didn’t do this myself on the initial read through of this case until I did my required “due diligence” to look at the full case record, or in many other cases, actually listen to the case—not just accept someone else’s description or interpretation of it.

Quality assurance is also an essential part of the protocol and software development process, and not just about the emergency dispatchers using it. We at PDC™ and the Academy attempt to require a reasonably robust process within PDC’s Core Software Development Division to find issues with the various programs we deal with, prior to release, whether ProQA, AQUA®, ACE and Supervisor Portals, or College of Emergency Dispatch CDE and lesson software, and even other internal software and logic diagnostics such as Zarkov that you have likely never heard of (more about this one in the future).

Like with any evaluation, it’s important to always look beyond the obvious to be sure we have the “Big Picture” on each situation we are asked to evaluate before we make a conclusion. Like with anyone, I almost missed checking the right things on this one.

James, one less gin-and-tonic for me ... Doc
GREAT EXPECTATIONS
The challenges of handling third-party callers

Art Braunschweiger

Most of my co-workers would be very surprised to learn that I have several tattoos, including a fairly large one. (No, it’s not the Priority Dispatch® logo.) Tattoos are common nowadays, but most people who know me wouldn't expect me to have one. One of my co-workers even said once, “That would be a bit extreme for you.”

Our expectations channel our actions. If we don’t expect to find something, we rarely go looking for it or put much energy into the search. That’s a problem in 911, where we have to rely entirely on information from remote sources. It’s especially problematic with third-party callers, who make up a significant percentage of our call base. Many of these callers are quick to tell us that there’s no point asking questions because “I’m not there, I don’t know anything.” Some calltakers accept this all too readily, assuming that if a caller isn’t at the scene with the patient, he can’t provide any information.

Our use of the Medical Priority Dispatch System™ (MPDS®) Protocol is governed by Performance Standards established by the International Academies of Emergency Dispatch®. One of those standards says, in part, “Anytime a caller is not in direct contact with those needing assistance, the calltaker will continue interrogating the caller according to protocol.” This standard is in place for a good reason: Callers usually know more than they think! The person who drove by the motor vehicle accident and isn’t there anymore might have slowed down as he passed and took a good look at the scene. I’ve had callers like that insist they don’t know anything and then proceed to give me definitive answers to four of the five Key Questions when asked. Or consider the person calling about a relative in another town. That caller might have talked to the patient and can tell you whether he’s alert, breathing normally, and what medical history is involved. You won’t know unless you ask!

There’s no question that third-party callers require special handling because of the resistance they frequently project to questioning. That’s reflected in the performance standard previously mentioned, which allows us to preface our questions with a statement such as “It’s very important that I get as much information as I can for the responders. I’m going to ask you some questions; I know you’re not there, but do the best you can.” On my calls, if the caller says “I don’t know,” I go one step further by saying, “That’s okay, you’re doing fine, I appreciate the help.” These enhancements go a very long way toward minimizing callers’ frustrations and gaining their cooperation. On occasion I’ll get pushback from the call anyway. I respond by saying “I understand, but you might know one piece of information that will help us out. This will only take a minute.” As with all difficult callers, I view them as a challenge, not an aggravation.

We need to remember that third-party callers have their own expectations. Often they expect to tell us nothing more than an ambulance is needed and what address it needs to go to. They’re ready to hang up and move on since they have nothing further to tell us.

When we keep them on the phone and start asking questions, our needs conflict with their expectations. It’s easy to label them as uncooperative and, over time, expect all such callers to be that way—but that’s doesn’t help us do our job. Don’t just ask questions because you have to. Broaden your expectations instead and develop some good third-party management skills. We’re all about information processing, and the more we get, the better we—and our responders—can do our job.

Source
Age is creeping up on me, but there’s still a little gas in the tank, folks. Contrary to what you might think, older people know stuff. LOTS of stuff. Sometimes we forget what that “stuff” is, but it does resurface from time to time. I wholeheartedly believe that every point in life is a gift, including my current vantage point—looking back at over three decades in this business. Age and experience can typically shine a little light—a glimpse of wisdom as it were—a skill you just can’t get any other way except by simply putting in your time. By surviving the school of hard knocks. By experiencing failure and finding growth in its wake.

We all have some nugget of truth to share—some lessons learned along the way—no matter how old we are, how young we are, or how long we’ve been basking beneath the headset. Having said that, I am going to do my very best to share some of the most important lessons I have learned, as well as those gems I’ve come across along the path of my own professional journey.

I’ve put a lot of thought into how to best warn emergency dispatchers about the ravages of personal and professional pitfalls. What are those things that get emergency dispatchers in hot water, resulting in discipline, lawsuits, or putting the person on a guilt trip that can extend a lifetime? Nobody wants any of that, so what are those dangerous pitfalls that I can warn all of you—our line first first responders—to avoid at all costs?

I’ll apologize now for the all too appropriate four-letter word associated acronym, but I’d like to share a few snippets from a workshop put together for our new folks. Appropriately enough, it’s titled “D.A.M.N.! The four critical points of failure in the 911 environment.”

Lack of training is the most significant failure for those managing communication centers. The good news is that we’re moving in a positive direction.

What about emergency dispatchers personally? What are those nagging pitfalls that can be avoided at the first line level? Here’s what I think they are:

Documentation
• There are a few problem areas that need attention. They include:
  - Leaving out critical information in call notes
  - Not entering calls for service
  - Failure to pay attention to detail (readouts on plates)
  - Failure to ensure updates, especially those of a critical nature

Assumption
• Never assume ANYTHING. Many of the assumptions seem to revolve around locations, caller intention, or a choice of inaction based upon how responders performed on past calls.

Minimization
• Relying on history that this current issue is “nothing.” Treat every call like it was the “real thing.”
• Understand the theory of “The Princess and the Pea.” Think of yourself as the one (princess/prince) who can recognize (or feel) the potential significance of even the smallest piece of information (the pea) instead of ignoring it through dozens of “mattresses” (distractions, bias, opinion, etc.).

Not being nice
• Rude emergency dispatchers give all of us a black eye. Treat every caller as though it was your mom, your brother, or your aged grandmother calling for help. When you lose your humanness and your ability to show empathy and care, it’s time to hang up the headset.
• Mother always said you catch more flies with honey than with vinegar. It’s still true.
• My pet peeve is hearing emergency dispatchers try to gain control by shouting, “MA’AM! MA’AM! MA’AM!” Get a first name and use that. Repetitive persistence is your best weapon against hysteria.

So, please, my friends, take note and avoid these “D.A.M.N.” pitfalls at all costs. Don’t forget to help your peers by pointing out the potholes in the road before them as well because sometimes we become so focused on the destination that we forget to watch for the dangers that lurk in the path just ahead. These pitfalls are preventable, so steer clear!
NEW AGE QUESTION
Why the alternative approach on Fast Track?

Brett Patterson

Brett:
I was reading through all of the changes again on MPDS® v13.1 and have a question on the obviously ≥1 year old AED question on the Obviously NOT Breathing Fast Track. Can you give me some guidance on how to handle these scenarios? Here is my scenario: Caller calls in and says her son is not breathing, and she can’t get him to wake up. I select the Obviously NOT Breathing Fast Track. The Protocol takes me to this new added question: (≥ 1 year old) If there is a defibrillator (AED) available, send someone to get it now, and tell me when you have it. The age isn’t obvious at this point. So because the answer isn’t obvious, do I provide the instruction? What answer do I select? If I select N/A once getting to the “about how old are they” question, it only has infant age answer options.

I feel that these questions should be reversed. I should find out about how old they are first and then get to the AED question. Or the question should be a part of PAIs instead.

Also, there is a concern about what obvious would be. I remember a call I took several years ago in which the caller referred to the patient as a child. When getting to the age question, he gave an age of an adult, but because he was an elderly male, the patient, in his eyes, was a child. This makes me think of those calls in which a parent calls in and refers to their child as a “baby” because the child is their baby. However, the patient is actually a grown adult.

I worry about the N/A answer being selected in these situations because of the “baby” reference.

Thanks for your help.
Michelle Haynes
EMD Quality/Performance Improvement Coordinator
Weld County Regional Communications
Greeley, Colorado, USA

Michelle:
The logic order is purposeful to save seconds in the majority of cases where the basic age range is known. If the EMD doesn’t know if the baby is under 1 at the point described, simply ask so that an appropriate answer choice can be selected. It’s a small trade-off but, as mentioned, it is most common to 1) be over the age of 1 and 2) have a decent caller description, so most of the time we will get into PAIs without the question, saving time.

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

Brett:
We had discussions regarding the shark determinant on MPDS Protocol 3: Animal Bites/Attacks. Although the shark
Hi Kellie:

Coincidentally, we had a similar concern, albeit related to pit bulls and Rottweilers about the same time you submitted your question, and I have since been discussing the issue with colleagues and slowly gathering consensus.

First of all, it’s important to note that DLS Axioms are general truths that explain the “whys” of DLS. They are not action statements that tell us what to do in a given situation, as DLS Rules do. The Axiom you are referring to does not tie the animals in the answer choice list to a specific code, definition, or response, but rather states that these animals “… are capable of inflicting serious injuries.” And, “… in rare cases, a maximal response is indicated.” Please also note that although the Axiom provides examples of potentially “Large animals,” this term is not specifically defined in Protocol, as is designated by ALL CAPS definitions like EXOTIC Animal. This allows for some EMD subjectivity about the mechanism of injury, including factors such as the size of the patient as compared to the animal, and the type of injuries, or lack of injuries, sustained.

As you suggest, the software could prompt a code based on the type of animal selected, but this is problematic for a couple of reasons. First of all, the list of animals included is potentially very long, especially considering the subjective term “Large.” Doing this for the few listed in the Axiom simply opens a can of worms regarding the plethora of animals that could potentially inflict serious injury. Second, basing the code on the species alone (other than toxic animals) greatly increases the potential for over-triage, i.e., listed species are very capable of inflicting minor injuries as well, no matter the actual size or species.

Currently, the response code is driven by the injuries sustained, the patient’s condition, the situation (MAULING or multiple animals or Attack in progress), or by the EMD’s subjective selection of a Large or EXOTIC Animal. If the emergency dispatcher is concerned about the mechanism of injury, he or she is free to select codes 3-D-6/7/8/9; this is not compulsory, but based on the EMD’s interpretation of the Chief Complaint Description.

Currently, the animal answer choice options simply provide important additional information for responders, and perhaps heighten the EMD’s awareness of the potential for serious injury: They do not drive a specific response. However, if this is possible in software, the Academy always welcomes suggestions for protocol improvement.

Should you wish to suggest an option for improving this process, please complete a Proposal for Change form, include any supporting documentation, and submit it to the Academy for consideration. I have attached one for your reference.

With regard to Case Entry PDI-a and the Fast Track, thank you so much for bringing this to our attention! I spoke with Irena Weight, who directs the implementation of protocol content into software for Priority Dispatch Corp.™, and she will ensure that Case Entry PDI-a will be included in the Fast Track ProQA® sequence in the next version (MPDS v13.1), which will be available shortly.

Interesting to me is the fact that I did not hear this concern earlier, and this has me wondering if the PDIs omission in the ProQA sequence has been problematic. Have you noticed any heightened caller anxiety or other problems, or did you just notice the inconsistency in the protocol?

Brett

Thank you so much for the thorough explanation. We came across these during our version 13 testing and training preparation. I have forwarded your response onto our QA and Training team for their information, and no further questions have arisen.

Kellie

Founded as a retirement community for Civil War union veterans at the beginning of the 20th century, St. Cloud is one of two cities in Florida’s Osceola County (USA). St. Cloud Communications is the smallest of the county’s three PSAPs and serves St. Cloud’s roughly 50,000 citizens over an area of 9.2 miles (14.8 km).

But don’t let its size fool you—St. Cloud Communications packs a big punch. The center has earned triple-accreditation, a feat that only 10 centers in the entire world have accomplished.

To what does the center owe its success? According to Misael (Mike) Cortez, Communications Manager at St. Cloud Communications, it’s all due to the workers.

“We wouldn’t be there as an agency without them,” he said.

The management team of St. Cloud Communications sets a high bar for employees from the get-go. Nadine Zilke, Records Manager, said that all workers have to make it through a “pretty strict” training program and need to be certified in police, fire, and medical before they even start.

“Our workers are up for the challenge,” Zilke said.

Not only do the workers have to be triple certified, they have to be ready to perform both calltaking and dispatching duties, something that is “unheard of” in their area.

“It takes a unique person to be a dispatcher,” Cortez added. “There’s a lot of skill sets behind it. The ability to be a fire, medical, and police dispatcher all wrapped into one demonstrates incredible skill.”

The 26 (mostly full-time, but some part-time) emergency dispatchers are divided into four squads, working twelve-hour shifts in a rotating schedule that gives them every other weekend off. All of the emergency dispatchers handle all services. They’ll be calltakers for part of the day, processing police, fire, and medical calls, then they’ll dispatch for fire or police for the other part.

According to Zilke, one of St. Cloud’s goals is to get the center fully staffed. Currently they have turnover at about 15

**SIMPLY ST. CLOUD**

Emergency dispatchers have you covered

Becca Barrus
percent—or three or four people—each year. Cortez said that some go to other agencies, and some become police officers, firefighters, or paramedics. “We’re experimenting with some new approaches on processing new hires,” Cortez said.

Right now, it takes six months to a year to get onboard at St. Cloud Communications. The center is doing what it can to get new employees sitting at the console sooner without sacrificing crucial training time.

St. Cloud Communications dispatches for one police department and one fire department, which has three (soon to be four) stations. They field about 67,000 police calls and 63,000 fire and medical calls a year.

Because of their location on the Narcoossee corridor and the fact that a major highway nearby is under construction, they receive a lot of traffic-related calls, both with and without injuries.

A majority of the people the center serves are English speaking. However, about a third of the population is Hispanic, which necessitates translation fairly frequently. There are four or five bilingual dispatchers; some emergency dispatchers have grandparents and parents who speak Spanish and can therefore understand it but aren’t fluent in it. When those resources aren’t available, St. Cloud Communications uses an interpretation line.

In addition to English and Spanish speakers, the center also serves a growing population of Haitians, who speak Haitian Creole.

Another obstacle the center faces is the ever-present issue of stress. They utilize the Employee Assistance Program (EAP), which emergency dispatchers can use for both job-related and personal stress. The program allows them to call anonymously and get help using their city employee number.

For calls that are particularly stressful, like a shooting or a fire that results in a fatality, managers and supervisors provide debriefings for the emergency dispatchers to help process the event. Being fully staffed would also help—Zilke wants to make sure that there are enough people in the center to be able to cover for someone who needs to take a break after a taxing call.

Although it’s not on the coast—it’s roughly 50 miles (80 km) from the shore—St. Cloud still needs to prepare for hurricane season, which spans from June 1st to Nov. 30th. Emergency dispatchers are prepared to report to work even in the most tempestuous weather. Sometimes they have to plan to stay at work for multiple shifts or days at a time, bringing a travel kit that’s packed with spare clothes, snacks, water, and toiletries.

The emergency dispatchers are divided into two shifts—alpha and bravo. The alpha squad works immediately before and also during the storm.

“During the height of the storm,” Zilke said, “the center is generally at its least busy time. Responders are standing by under shelter, and citizens are bracing for the storm.”

When the storm passes, the bravo squad takes over and is deluged with calls from citizens reporting damage to property, roads, telephone lines, and water lines. They also field the kinds of medical, fire, and police calls that come in on normal days.

This rotation between alpha and bravo squads can last for days after the storm, depending on the volume of calls and the need for assistance. Their operational plan is flexible, changing as the storm does.

St. Cloud Communications put its hurricane plan into practice in September 2017 for Hurricane Irma, which was a Category 5 storm with winds up to 185 miles per hour. The emergency dispatchers hiked up their waders (metaphorically) and went to work, doing their best to make the process as seamless as possible for responders and citizens.

So, should your travels ever take you to central Florida and you end up needing emergency help, know that you’ll be in good hands. If you’re ever in the neighborhood, what should you be sure not to miss? Cortez didn’t hesitate for a second before answering.

“You need to hit the Catfish Place,” he said. They sell frog legs and gator tail. What does gator taste like? “I’d say it tastes like chicken, but ...” He laughed, not wanting to use the old cliche. “It tastes kind of like chicken and fish combined.”
SNAP OF THE FINGERS
New Hampshire 911 is nothing short of amazing

Audrey Fraizer

You can’t help but note some really unique features—and, perhaps, stylish quirks—about New Hampshire’s 911 systems.

For starters, the state’s two centralized communication centers—26 miles apart—act as one PSAP (and the emergency dispatchers answer all incoming 911 calls for the state).

Since the sites are compatible in everything they do, one ACE covers both sites, and they’ve recertified four times.

They review 100 percent of their cardiac arrest calls.

They made history as the first 100 percent computer-based 911 system in North America (1995).

The emergency dispatchers snap their fingers and everybody jumps.

“Every day is different,” said David Rivers, PSAP Operations Chief, New Hampshire Bureau of Emergency Communications (BEC).

You learn to roll with the tempest and prepare for whatever comes.

New Hampshire Bureau of Emergency Communications

The BEC oversees 911. A 16-member Enhanced 911 Commission sets bureau policy. In 1995, the bureau activated medical ProQA®. The 58 Emergency Medical Dispatchers distributed between two sites—Concord and Laconia—answer all incoming 911 calls and sort them by type of emergency.

Although separated by a runner’s marathon, “We’re virtually in the same room,” Rivers said.

The 911 calls are answered by the EMD first in queue, regardless of site. The EMD gathers information through ProQA, and, based on the caller’s location and emergency, delegates dispatch to a secondary PSAP. There are 86 secondary PSAPs in New Hampshire, of which three are fire-only dispatch centers.1

The move wasn’t predicated solely on monetary concerns, Rivers explained.

The state known for its climbers’ paradise (the White Mountains) covers 8,968 square miles, and more than a third of the 1.3 million people live in rural areas (496,355). The sheer number of centers answering calls and dispatching responses made for inconsistent service. They were essentially independent operations. The single primary PSAP gives callers the same high-quality service—no matter where the call originates—and pools resources to fund system upgrades.

The BEC, organized in 1994, accomplishes the same goal: standardization. For example, the bureau’s Mapping Unit provides global
positioning and data control to assist towns with address verification and location tracking to coordinate response. A set of recommendations includes standards for street names (such as changing duplicates), address ranges, and road classifications.

**Community support**

The move to a single PSAP for answering calls, and leaving only dispatch up to the local jurisdictions, was met with some resistance. Opponents voiced concern over loss of familiarity. EMDs in Concord and Laconia might not understand the needs of rural New Hampshire. Police and fire officials said the plan would limit their control and compromise quality.

Mark E. Doyle, Director, Division of Emergency Services and Communication, had his misgivings. He was with the Merrimack (New Hampshire) Police Department at the time the single center plan was announced and wasn’t totally sold on the concept until weighing the benefits against an anticipated loss the community might not even notice.

“I was apprehensive,” said Doyle, who retired from Merrimack police in 2017. “Calls would be going somewhere else, but after hearing more about it, I realized the consistency of response would be the same. Training was a real plus. It was something we had not been able to offer."

Buy-in from public safety and the public took outreach, and that’s a job Wanda Bowers continues to this day. She’s been the BEC Informational Representative since 1994 and, in addition to fielding questions about newer technology (such as New Hampshire’s Text to 911), she often finds herself starting back at square one. People don’t understand the process. She said it’s understandable, given the state’s rural complexity and inexperience with 911 (which can be a good thing).

“They haven’t called 911 and until that happens, they don’t know what to expect,” she said. “If they have called, they want to know why all the questions. There’s the assumption we know where they are without asking.”

**Service with a snap**

New Hampshire attacks cardiac arrest on several fronts.

EMS covers tens of thousands of people in at least 29 communities through the HEARTSafe program designed to advance system changes along the Chain of Survival to increase survival rates from out-of-hospital cardiac arrest. To qualify, a community must hold CPR/AED classes, put AEDs in public places, and promote CPR/AED response relative to the size of the community.

State regulations for AEDs were introduced in 1999 and enhanced during the past nearly two decades with Good Samaritan protections, training in CPR and AED use, and a registry available to responders through 911. There are more than 3,500 registered AEDs in the state; there’s at least one in every public school and in the majority of private schools.

The BEC reviews every cardiac arrest call and regularly trains all EMDs on the use of the MPDS® CPR PAIs and modifications in ProQA related to CPR, such as the Fast Track feature for hands-on CPR. This direct link was created in an effort to meet American Heart Association recommendations to reduce the time from discovery of cardiac arrest to “hands-on-chest.”

And that brings us to the snap of the fingers.

“The priority is hands-on-chest [in a suspected cardiac arrest],” Rivers said. “EMDs giving instructions snap their fingers, and someone else on the floor comes and takes over police and fire.”

Doyle said the EMDs’ instincts are remarkable.

“I was flabbergasted to see it happen,” he said. “I admire them. They can work so closely in a challenging environment.”

If it’s a multiple vehicle accident, the fingers don’t snap, but the EMD taking the call makes an announcement because of the incoming calls anticipated.

Rivers calls it “EMD situational awareness.”

“It can boggle your brain what they can do as a team,” he said.

The bureau’s focus on Chain of Survival has not gone unnoticed. Two EMDs were named Dispatcher of the Year (DOY) at consecutive NAVIGATORs.

EMD Stephen Harris was named DOY at NAVIGATOR 2011 and EMD Joyce Jastrem was named DOY at NAVIGATOR 2012. Harris provided CPR instructions to the son of a patient in sudden cardiac arrest, who then relayed them to his stepfather. The patient survived and the family shared the stage with Harris at NAVIGATOR. Jastrem was recognized for her lifesaving CPR instructions during a call lasting 10 minutes and 22 seconds.

One week later, the patient was home recuperating from surgery to implant a stent into a blocked artery. Jastrem is one of the first dispatchers the bureau hired and certified in 1995. ●

**Source**

For 16-year-old Olivia Crooks, navigating at speeds topping 60 miles per hour down a residential street on a breezy October afternoon in 2015 left her with little time to decide what to do. Like a race car on a quarter-mile track, Crooks initially figured she could steer the 2004 PT Cruiser to a cul-de-sac and spin the car around in a circle until the gas tank ran empty. In a tight space away from traffic and pedestrians, she could avoid a collision and possibly injuring someone in her path.

Maybe it was impulse—an instinctive action while in crisis—that made Crooks pick up her phone and call 911. Her car had bolted out of the Southwest High School parking lot in Green Bay, Wisconsin (USA), and onto the roadway. She was not in control, her vehicle was, and she needed help NOW. The heck with a cul-de-sac.

The emergency dispatcher answering Crooks’ call at Brown County Public Safety Communications in Green Bay had an even better solution. Julia Robak had the advantage of a protocol developed by the International Academies of Emergency Dispatch® (IAED™) to override stuck accelerators in both manual and automatic transmissions. They had recently trained on using the protocol.

Robak also had the benefit of a second emergency dispatcher who dispatched response while she provided instructions. Robak determined the car and driver’s location and asked the type of transmission.

“Automatic,” Crooks said.

“Okay, shift into neutral or ‘N’ now,” said Robak, following the “Accelerator Stuck & Can’t Stop Vehicle” instructions. Crooks complied.

Robak next told her to “apply firm, constant pressure” to the brake pedal gradually until coming to a safe stop.

“Don’t pump the brake,” she cautioned Crooks.

Crooks held tight to the steering wheel, her foot on the brake, and guided the car to the side of the road. The car stopped. She got out.

Police responding to the scene put the car in park and turned off the ignition. Crooks was shaken but not injured and by this time—knowing Crooks was stopped and safe—Robak had disconnected and was on to the next 911 call. The incident, from the time the PT Cruiser bolted out of the parking lot to a curbside rest, totaled about two minutes.

Robak and Crooks met face-to-face through a spot on “Good Morning America” filmed in front of the high school. As much as they were both thankful, Robak said she was doubly so.

“It all went so well,” Robak said. “She knew where she was. She focused on what I was saying, and she trusted what I told her. She didn’t question. She just did it.”

Robak backs away from taking full credit. She had the protocol, an attentive caller, and a center that constantly trains and supports its emergency dispatchers. Publicity over the call, she said, showed the positive side of 911, reflecting well on the entire staff and a profession she finds “rewarding” and without the grind of two days ever being alike.

“I went to school for criminal justice,” said Robak, who has been in emergency dispatch for a little more than a decade. “I wanted to be a detective, and 911 isn’t that much different. We’re always looking for information that will help our callers and responders.”

The IAED released the Accelerator Stuck & Can’t Stop Vehicle Protocol in manual card format on March 22, 2010, for use by emergency dispatchers in all three disciplines—police, fire, and medical. The ProQA® version was released two weeks later. The protocol’s instructions revolve around managing the situation—bringing the vehicle to a resting place while securing the safety of the occupants inside.
A crash killing California (USA) Highway Patrol Officer Mark Saylor, his wife, daughter, and brother-in-law became a watershed for a sudden unintended acceleration problem in vehicles manufactured by the Toyota Motor Corporation that first appeared in 2002.

Toyota initiates a recall to correct a possible incursion of a front driver's side floor mat into the foot pedal well, which can cause pedal entrapment.

Toyota initiates a second recall after some crashes were shown not to have been caused by floor mat incursion and halts sales of some of its most popular car and truck models in the U.S., Europe, and China.

IAED releases Accelerator Stuck & Can't Stop Vehicle Protocol in manual card format (tabbed pullout style) that can be used by emergency dispatchers in all three disciplines (police, fire, and medical). Any emergency communication center, whether an MPDS® user or not, can use the printed protocol card under a special limited use license.

Toyota confirms a confidential settlement in the lawsuit involving the 2007 crash of a Camry that severely injured the driver, 76-year-old Jean Bookout, and killed her 80-year-old passenger, Barbara Schwarz.

Chrysler initiates recall of 35,000 Dodge and Jeep models for sticky accelerator pedals.

Brown County Public Safety Communications (Green Bay, Wisconsin, USA) EMD Julia Robak uses the ProQA® Accelerator Stuck & Can't Stop Vehicle Protocol to help 16-year-old Olivia Crooks stop her out-of-control Chrysler PT Cruiser.
what more can i do
WHAT CAN I DO

When there’s nothing I can do?

Becca Barrus

The work of emergency dispatchers cannot be performed by a machine. That might be a no-brainer to some of you—“Of course a machine can’t do what I do every day!”—but have you ever stopped to think precisely why that is? Machines are getting smarter. They can drive themselves, take your order at a fast-food place, and even write poems. Why wouldn’t they be able to assess an emergency and dispatch the correct response?

Two words: emotional labor. Emotional labor is the process by which workers “suppress, exaggerate, or otherwise manipulate their own and/or another’s private feelings in order to comply with work-related display rules.” In other words, emotional labor is what emergency dispatchers do when they put aside their own emotional reactions to a call in order to better serve the caller. It doesn’t mean you turn off your emotions; instead, you regulate them appropriately.
Emotional labor is an essential part of taking and dispatching emergency calls. Not only are you there to administer the practical logistics of helping the caller, such as dispatching an ambulance or giving PDEs or PAIs, you’re there to administer a personal touch as well.

Dr. Jeff Clawson, Medical Director, Research, Standards & Academics, has recordings of multiple calls fielded by Michelle Welch, someone he’s referred to as “the ideal EMD in terms of calm.” One such call was from a woman whose husband went into cardiac arrest on Thanksgiving Day and didn’t survive. Even though the incident had a less-than-ideal outcome, the woman still called Welch back to thank her for the instructions she gave.

After listening to Welch’s other calls in which she gives affirming statements such as “I’ll be on the phone in case you need help” and “You did the best you could,” it’s not hard to imagine that the woman whose husband died was also thanking Welch for how she gave the instructions.

Have you ever had a situation like that? One where, despite all your training and the comprehensiveness of the protocols, there’s nothing you can do for the patient or caller?

What can you do when there’s nothing you can do?

Sometimes all you can do is be the voice of calm in the middle of a stressful or scary event.

Can it be taught?

While whether or not we can teach machines to have emotions is a hotly contested debate (as well as material for a plethora of robot-themed science fiction movies), the answer to whether or not humans can be taught empathy is just as elusive. Is it one of those situations where you either have it or you don’t? Can you teach an emergency dispatcher how to say just what the caller needs to hear or is it entirely instinctual?

“Empathy is hard to teach,” said Christine Barton, Communications Manager and in-house Academy Instructor for Regional Emergency Medical Services Authority (REMSA) in Reno, Nevada (USA). “Some people have a very natural ability, and others struggle with it.”

Cheryl Buchanan, Comm. Center Manager for Hanover County Public Safety Emergency Communications in Hanover, Virginia (USA), agreed. “A lot of it is gut instinct,” she said.

There has to be a natural desire to help. Buchanan, who has worked in public safety for 25 years, noted that dispatch centers used to only invite people with a public safety or emergency background to apply for positions. This meant that, for the most part, the emergency dispatchers were able to visualize the caller’s situation because they had been on the scene of similar calls.

Now young people are coming into the profession with not only a different work background, but a different communication background as well. Buchanan posited that technology—specifically texting—affects one’s ability to connect with other people. This isn’t necessarily a bad thing; it’s just different from how things were done in the past.
Buchanan’s training focuses on teaching new emergency dispatchers how to connect.

How do you teach someone how to have gut instincts? Playing audio recordings of calls is a popular training choice.

Many instructors, including Barton and Buchanan, play recordings of calls for newly hired emergency dispatchers for a couple of reasons. Buchanan said that playing calls creates an experience similar to the one emergency dispatchers will have when they begin answering calls.

In a two-week course after the EMD course called “communication academy,” Barton plays recordings of actual calls and breaks them down into instructional pieces. She asks the students, “Who was the patient in this? Who else is a potential patient?” to get their minds accustomed to thinking of the caller’s situation as a whole. The person who calls might not be the only person on scene who needs help.

And after you teach them all you can? Then it’s up to experience to teach them the rest.

“With experience, you figure out if everything’s being done that can be done,” said Jody Mader, Shift Supervisor, Triple Q Instructor, and ETC-I Instructor for Butler County in El Dorado, Kansas (USA). “Not that taking hard calls gets easier, exactly, but with time you get more experiences that help you figure out how to handle tough situations.”

Serving versus saving
Barry Bagwell, Deputy Director (retired) of Mecklenburg EMS Agency (Medic) in Charlotte, North Carolina (USA), and EMD Instructor for the Academy, isn’t sure if you can teach emergency dispatchers how to have empathy, although you can certainly plant the seed. To do this, Bagwell has his EMD students examine their motivations at the beginning of training.

“If you’re coming into this career to deal with high-acuity patients all the time, you’re going to be disappointed,” he said. Low-frequency, high-acuity situations—such as cardiac arrests and delivering babies—are the exception rather than the rule. Emergency dispatch is a customer service field; emergency dispatchers deal with things that seem minor to them but are still significant to the caller. He suggests that emergency dispatchers ask themselves, “How can I help the caller even when there isn’t a need to save the patient?”

It’s important not to mentally filter calls, internally judging callers for calling 911 when theirs isn’t a life-threatening or even urgent situation. Just because something doesn’t warrant an ECHO or DELTA Determinant Code doesn’t mean it’s not an important call to them.

“We’re here to help our caller regardless of the acuity of the patient,” Bagwell said. “It’s part of who we are.”

Barton encourages emergency dispatchers to revisit their “why” as well.

“There was a reason we all chose this path,” she said. “It’s different. It’s very personal. I tell dispatchers that I don’t want to know your why, but what I want you to remember is that you’re going to have days when you don’t want to do it anymore. On those days, that’s when you need to remember your why.”

In addition to remembering why you’ve entered the emergency response field, it can be helpful to realign your expectations. In her article “The ‘We Save Lives’ Myth,” Kate Dernocoeur points out that, statistically, emergency responders rarely save lives. Rather, you provide a service for the community: to “make them feel less frightened and more reassured” during a stressful and unexpected event in their lives.²

“A child with a broken collarbone is no big deal in the spectrum where ‘we save lives’ is the bottom line,” Dernocoeur wrote. “But if you discard that notion, knowing that your presence made a scary event more manageable should generate a different and lasting sense of accomplishment.”³

One of the emergency dispatchers at Buchanan’s center took a call from a woman who had found her husband unconscious in their yard. He had gone...
outside to work in the shed, and when he didn’t come back in, his wife went out to look for him, not knowing how long he’d been lying there. The emergency dispatcher went through the protocol and, once it became apparent that there was nothing to be done for the husband, asked, “Is there anything else we can do for you?” as outlined in PDI-a of MPDS® Protocol 9: Cardiac or Respiratory Arrest/Death.

The emergency dispatcher then chose to stay on the line with the woman and say “I’m here, I’m here for you,” until the responders arrived. Later the responders called and told the emergency dispatcher that the woman had said that she was so glad she had the voice on the other end of the phone.

“It’s all about customer service,” Buchanan said. “We need to not own the caller’s experience. It’s easy to get caught up in what’s happening and take it personally—the anger or hostility directed toward the situation that the caller is aiming toward you—especially when you get 10 calls in a row like that.

You have to separate yourself from the situation. The emergency is not ours, but we have to be willing to be there for them and support them through it.”

Enhancing, not ad-libbing

For Craig Sturgess, an emergency dispatcher for the Welsh Ambulance Services NHS Trust (Wales, U.K.), the task at hand was clear: get the patient onto his back. The patient’s wife had called 999 when she found him collapsed in the bathroom, wedged between the toilet and tub. He was not conscious and it was unclear as to whether or not he was breathing. The protocol called for Sturgess to instruct the woman to get the patient on his back in order to start CPR.

“Oh, listen to me,” Sturgess told the understandably distraught woman. “I’m going to help you now.”

He instructed her to go find someone to help—a neighbor, a passerby, anyone. The woman was hesitant to leave her husband, but Sturgess reassured her with an unscripted but touching gesture.

“Leave the phone next to him by his head so I can speak to him,” he said.

Once the patient’s wife was gone, Sturgess talked to and reassured him, despite the patient’s unconscious state. He said things like, “Sir, if you can hear me, we are coming as quickly as we can for you, okay?” and “Your wife is coming back,” every minute or so until a couple of neighbors arrived with the wife to help.

Even with the main problem—not being able to get the patient on his back and begin CPR instructions—solved, Sturgess kept looking for little ways to serve those involved in the call. He told the man who was administering CPR, “You’re doing really well there. You’re doing brilliant, okay?” He told the other neighbor to keep an eye on the patient’s wife, suggesting that she step out of the room because he could tell that seeing her husband like that was upsetting her.

The patient did not survive. To someone with a “we save lives” mindset, the endeavor might seem like a failure. However, to someone with a serving mindset, Sturgess had helped the patient’s wife in a profound, compassionate way by offering to talk to her husband while she was gone. He helped by encouraging and checking in with the neighbors, who were not trained in CPR and probably weren’t expecting to be part of a life-or-death situation that day.

There’s no script for what to say to comfort someone in an emergency situation because it’s individually tailored to each experience. Sometimes the perfect thing to say to a caller comes through instinct. Sometimes it comes through experience.

You have to separate yourself from the situation. The emergency is not ours, but we have to be willing to be there for them and support them through it.

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What if nothing comes to mind at that crucial time? You can never say, “Someone is coming; help is on the way” too many times.

The protocol is all about making sure patients get the right help in the right place at the right time, and sometimes that help is your voice telling them that someone is there, that someone is coming, and that they aren’t alone.

There will be times when you can save a patient and that is momentous. But every single time you talk to a caller, you have the opportunity to make a difference by providing comfort. By being a calm, reassuring voice in the vortex of the current moment they’re living in. By filling that big, scary silence with a kind word.

After all, what you do is, in the words of Dernocoeur, “a valuable, worthy, important task.”

Sources
3. See note 2.
4. See note 2.
### Ambulance Services

**1867**
London, England, starts a service to convey smallpox victims to the hospital using six horse-drawn carriages modified to accept specially designed litters to carry patients.  

**1869**
Bellevue Hospital in New York City, USA, started an ambulance service under the direction of Edward Dalton—a former Union Army surgeon. He believed that speed was king. The faster the service the better the patient outcome.

**1867**
Ambulance
/ˈambjuələns/
The term ambulance comes from the Latin word “ambulare,” meaning “to walk or move about.”

**1905**
First gasoline-powered ambulance (Palliser Ambulance), introduced by Maj. Palliser of the Canadian Army, was heavily armored and had a single steering wheel and tracks and designed for military use.

**1928**
The first Flying Doctor took flight in a single engine leased Qantas plane from Cloncurry, Queensland, to provide help to people living in the Australian bush.

**900 AD**
Wagons and carts recorded as means of transporting the sick.

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HERE TO STAY

And that was the goal for Gold Cross founder

Audrey Fraizer
Their similarities are glaring: a push for best practice standards, a focus on training and education of staff, and an emphasis to remember who is keeping you in business. Both have been around EMS for a long time, and their legacies will last far beyond their lives.

Their success, finding root in the late 1960s, comes from drive and a visionary capacity to chart courses where none had existed until that time. Both are dynamic and innovative and arrived at the cusp of a new phase of public safety: EMS.

“Those were early days in EMS,” said Jeff Clawson, M.D., and inventor of the medical, fire, and police protocol systems (MPDS®, FPDS®, and PPDS®). “What he did was a big influence in what I ultimately decided to do.”

Dr. Clawson is referring to R. Gene Moffitt, Founder, President, and CEO of Gold Cross Ambulance in Salt Lake City, Utah (USA). Clawson was an EMT at Intermountain Ambulance and Gold Cross Ambulance early in his medical career.

Gold Cross is a solid medical ACE (three re-accreditations since their initial ACE in 2007) and uses ProQA® Paramount. Moffitt sits on the Academy’s College of Fellows.

“Jeff was always the renegade,” Moffitt said. “He was a great employee. He’s a great friend. We didn’t always agree, but we’ve both always wanted what was best for EMS.”

Gold Cross celebrated its 50th anniversary in business on March 28, 2018.

The International Academies of Emergency Dispatch® (IAED™) turns 30 this year.

Crossing paths
Moffitt was an electronic technician for Utah’s division of Sperry Rand Corp. when periodic layoffs due to adjustment in various programs convinced him to go full time using his electronics background for the city’s sole ambulance service—Intermountain. Dr. Clawson got his first look at emergency services with the same ambulance service where his first call—a cardiac arrest—changed the course of his college education. He went from paleontology to getting accepted to medical school in the spring of 1970.

Moffitt left Intermountain to start Gold Cross Ambulance along with his wife, Julia. She was at home, seated at the couple’s kitchen table, and dispatched responses for emergency medical calls forwarded from the police department (there was no 911). He drove a 1968 Cadillac ambulance to transfer patients between care facilities and to hospitals for emergency care. Gold Cross and Intermountain Ambulance later alternated police call days and, in addition to emergency response, Gold Cross transferred patients between medical facilities.

In the early days, Moffitt’s wife, Julia, sat at the kitchen table and dispatched emergency medical calls forwarded from the police department.

Moffitt’s company grew. He was hiring. Dr. Clawson, by this time a pre-med student at the University of Utah, applied. He had already worked for several months at Intermountain Ambulance.

“My second real job was with his ambulance company,” Dr. Clawson said. “I asked him [Moffitt] after my interview if he hired me because I was applying to med school, and several other good reasons, and he replied, ‘No. You were just the first guy that showed up in a suit and tie.’”

Dr. Clawson went on to medical school in Utah and an emergency medical residency on the LSU Service at Charity Hospital of New Orleans at Louisiana (USA). It was during his first year at the “Big Free” that Dr. Clawson conceived the core of what would become the medical protocol system he later launched after returning to Salt Lake City.

Context of the times
The late 1960s and early 1970s was a pivotal period for the emerging specialty of EMS.

“Death in a Ditch,” published in the May-June 1967 issue of the Bulletin of the American College of Surgeons, introduced responders to concepts for the safe extrication, emergency on-site splinting and bleeding control care, and transport of patients involved in vehicular accidents.1 Written by J.D. Farrington, M.D., then a trauma surgeon in Minocqua, Wisconsin (USA), the article remains one of the most widely requested articles published in the journal.2

A 1972 report by the National Academy of Sciences substantiated the trauma of traffic accidents and inadequate on-scene emergency care. The report showed an estimated 1.5 million people injured in accidents each year, of which 115,000 were killed, and claimed that better emergency treatment could prevent 90,000 of these fatalities.1

The TV show “Emergency!” made the Los Angeles, California (USA), paramedic program the envy of thousands nationwide.
At the time of the National Academy of Sciences report, roughly “half of the country’s ambulance services were provided by 12,000 morticians, primarily because they owned the only vehicle that could at that time accommodate a patient on a stretcher.” Ambulance services, where they existed, were intended to simply transport accident victims to the nearest hospital without providing any ABCs (airway, breathing, and circulation) or stabilizing care. Salt Lake City provided its ambulance service through the police department in a paddy wagon-like vehicle, and, up until 1974, Red Cross first-aid courses were the primary source for training ambulance drivers and attendants.

Two major funding sources helped change EMS in Utah and across the country.

The federal 1973 Emergency Medical Services System Act authorized $160 million over three years for EMS to be divided among states requesting funds. That same year, the Robert Woods Johnson Foundation (RWJF) announced $15 million in grants for developing regionalized emergency medical services ultimately distributed to 44 EMS organizations in 32 states.

Utah scored on both, establishing formal training requirements and regional ambulance services to ensure “central and immediate citizen access” to EMS and creating central control of EMS communications. Interestingly, the RWJF grant encouraged funding for ambulance and dispatch training.

In February 1974, the Utah Board of Health approved minimum ambulance standards including regulations for equipment and mandatory EMT certification. At the same time, the contract between the city and Intermountain Ambulance was due to expire.

Moffitt’s Gold Cross Ambulance assumed the agreement on a five-year renewal basis.

Nowhere to grow but up

Gold Cross took off from there, expanding from a building leased near downtown Salt Lake City to a central campus, west of downtown, accommodating ambulance maintenance and supply and emergency communications (and corporate headquarters located just south of their operations building). The company is under contract with three of the Salt Lake valley’s largest fire departments, which still includes Salt Lake City. Outlying ambulance service areas are stationed in four counties and all are dispatched from the secondary PSAP in Salt Lake City. Staff has skyrocketed to 500 employees under the Moffitt family leadership.

Chris Nilsen started with Gold Cross in 1996 and was hired on as an EMT. Then he completed his paramedic training in 2002 and for several years attended to emergency calls and interfacility transfers. Nilsen began working in dispatch part time in 2004 in addition to working as a paramedic and paramedic supervisor. He has been Communication Director since 2011 and oversees 15 full-time EMDs in three shifts answering 60,000 calls annually.

Nilsen depends on a rigorous training course, which in the classroom takes from six to eight weeks, depending on experience and the ability to pick up on ProQA® (understand the process). New hires and experienced EMDs are paired for on-floor training.

Training is part of the reason the communications department—like most of Gold Cross—is known for longevity of employment.

EMD Sharmaine Solomon wanted a change from dispatching maintenance
services for Delta Airlines five years ago. The experience got her in the door, while her patience and quick learning have made her an invaluable member of the communications team. The transition, however, wasn’t as easy as she first expected.

“We’re in a constant state of readiness,” Nilson said. “We receive calls from all over the state, and many of them direct because they don’t want a fleet of emergency vehicles in front of their house.”

Solomon said she seldom learns the outcomes and prefers it that way.

“Unless it’s in the news, we don’t hear,” she said. “I think that’s better because it keeps things positive. I tell myself ‘they’re going to survive,’ and take the next call without worrying about the last.”

Infinity and beyond

Moffitt keeps his hands immersed in the business. He goes to the office daily, chairs the board meetings, attends staff meetings, and knows just about every employee by name. He is known throughout Utah and much of the country for his contributions to EMS and, in addition to professional posts (such as past President of the American Ambulance Association), he has received innumerable honorariums. In 2017, JEMS presented him with a Lifetime Achievement Award for Outstanding Service in EMS. In 2013, he received the Lifetime Achievement Award from the American Ambulance Association (AAA).

Those are simply two of a much longer list important to Moffitt but, in all honesty, not the reason Gold Cross has remained in business in Utah for 50 years.

“I have a company that is a staple in the community, and I was blessed enough to make that happen,” he said.

It’s similar to what Dr. Clawson intended in 1979 with the introduction of protocol.

“What Jeff did was a wonderful thing,” Moffitt said. “We both have created something that will stay here long after we are gone.”

Sources


2. See note 1.


4. See note 3.

5. See note 3.
By the Numbers

2018
Las Vegas

15 tracks

1,566 attendees

2 dispatcher of the year recipients

130 instructors

16 countries represented

48 exhibitors

29 ace

634,390 steps taken by marcom department

55 re-ace

1,566 attendees

140+ sessions

15 tracks

7,684 square feet of banners
What does NAVIGATOR’s “All In” theme mean to you?

To Nancy Lockhart, “All In” means “going that extra mile every day, doing the research, doing the CDEs, and doing things that inspire your passion.”

Lockhart is the IAED™ mascot for “All In.” She received the Dr. Jeff J. Clawson Leadership Award at the Closing Luncheon of NAVIGATOR 2018, held in Las Vegas, Nevada (USA), and was undoubtedly a most familiar face circulating among the 1,566 attendees at the three-day conference. Her network is vast and that, she finds, is an asset the conference encourages for everyone in the emergency dispatch profession.

“You can have really meaningful and positive conversations and go back to your center and create change,” she said. “It’s tremendous.”

And the really cool thing?

“Once you have attended your first NAVIGATOR, you’re family for life,” Lockhart said.

The conference does draw people over and over again. There’s something for everyone whether it’s to hear about the latest and greatest protocol and software innovation, stroll the exhibit hall, attend any of the 140 educational sessions (in 15 tracks) offered this past NAVIGATOR, participate in research, celebrate ACE or Re-ACE, tour area communication centers, or hobnob with like minds from the many countries the conference attracts.

“We learn a lot here just from rubbing shoulders,” said Christine Bannister, Supervisor, Waukesha County Communications (WCC) Center.

Bannister’s been in EMS for 24 years, with 20 years in emergency dispatch and four trips to NAVIGATOR. Apparently, Bannister’s devotion to the profession has rubbed off on her 14-year-old daughter Chloe (Porter). In 2018, Chloe became the youngest NAVIGATOR presenter ever when she took the floor in the motivational session “Growing up 911.”

“Kids growing up in 911 live with a schedule that’s not always family friendly,” Bannister said. “We’re not always there for the holidays, birthdays, and weekends.”
That’s just fine by Chloe. She understands and admires the profession (and her mom).

“It’s a really cool job,” Chloe said. “When I tell my friends my mom works in 911, I am very proud of that. My mom goes to work to help people.”

It’s not only the callers that emergency dispatchers help. They also help one another, as any of the Las Vegas Fire and Rescue Communication Center personnel will tell you following the evening of Oct. 1, 2017. It was on that night a lone gunman pointed his arsenal at the Route 91 Harvest country music festival, killing 58 people and injuring another 851 people either by gunfire or the ensuing flight from the Las Vegas Strip venue.

“I still don’t know how this has affected me,” said LVFR Fire Communication Specialist Mone Foster during one of eight “Vegas Strong” presentations at NAVIGATOR. “Our phones were ringing off the hook. So many people called needing help. It’s still hard to believe this was real. I’m just glad to have the support of my co-workers.”

And talk about “All in,” emergency dispatchers from Sacramento (California, USA) Regional Fire/EMS Communications Center were on the LVFR floor within 48 hours of the shooting to offer support.

“We sat down and answered 911 calls,” said Kylee Soares, Communication Manager, Sacramento Regional Fire/EMS. “They were very receptive, and we probably got more out of it than they did. It was a moving experience.”

“All In” is also about being part of a broader community and seeing the dedication and passion emergency dispatchers take to their work, no matter their country.

“We give it our all regardless of where we are or what’s happening,” said Kenny Pile, Emergency Ambulance Communications Centre, St John Ambulance, New Zealand. “We’re in this to do our best and give everything our all.”

Then there are those looking forward to giving it their all in the years to come.

Jessica Lindley is certified in ETC, EMD, EPD, and EFD, and NAVIGATOR was held just days before her graduation from Veterans Tribute Career & Technical Academy. VTCTA opened in 2009 to prepare students for careers in public service, and Lindley was drawn to a career in emergency dispatch since her sister died in an accidental drowning at their home 10 years ago.

“We called 911, and the dispatcher gave my mom CPR instructions,” she said. “My sister didn’t make it, but I’ll never forget what the dispatcher did for us. He kept us calm. He was calm. It made me want to do exactly the same thing for other people. I can make a difference.”
Two emergency dispatchers receive DOY award

In a first during the Academy’s 20-year history of presenting the Dispatcher of the Year award, two emergency dispatchers—one from Canada and one from the U.S.—were announced as recipients of the coveted prize.

EMD Margaret Dohrman, Pinellas County Safety and Emergency Services, Largo, Florida, USA, and Kelly Cayer, Calgary 911, Canada, were selected from the 57 individuals nominated by their respective agencies for the award designed to honor emergency dispatchers who represent everything the Academy stands for.

“It’s about taking every call,” said Brian Dale, IAED™ Associate Director of Medical Control and Quality Processes. “It’s about compliance to the protocols. It’s about consistency, and it’s about always doing it right.”

Dohrman, who was unable to attend NAVIGATOR, acknowledged the award in a video played to the packed Opening Session. The “bloodhound,” as she is affectionately called at Pinellas County 911 owing to her tenacity, was commended for her ability to manage multiple lines during a critical situation while also keeping her tone of voice calm and conversational.

“This award is for the team,” said Dohrman, a 28-year veteran of emergency dispatch. “I am privileged to be part of the profession. It’s a rewarding career, and I couldn’t dream of doing anything else.”

Kate Belniak, Dispatch Supervisor, Pinellas County 911, accepted the DOY award on Dohrman’s behalf.

Cayer took the stage, speech in hand, and was admittedly nervous speaking from behind a podium to an audience of more than 1,000 peers.

“I am shaking; my heart is racing,” Cayer said. “I am extremely honored to accept an award that highlights all of us. I found a calling in dispatch. I truly love what I do.”

While the award exemplifies the Academy’s standards for emergency dispatch, the nomination packet includes a call representing the emergency dispatcher’s typical (albeit outstanding) performance. Cayer’s call demonstrated her professional skills in calming a young caller and using repetitive persistence to help him and his mother save their father/husband from choking. Cayer gave Heimlich instructions to dislodge the chicken nugget obstructing the man’s airway and, when that failed, she gave CPR PAIs.

“Each of us takes this type of call and never hears the outcome,” Cayer said. “This time I did, and I’m forever grateful for the outcome. Seconds truly count, and this time, it saved a life.”

The DOY awards were the beginning of the presentations honoring contributions to the profession, including a tribute to the Las Vegas Fire and Rescue (LVFR) emergency dispatchers. The center received hundreds of calls of desperation and panic on Oct. 1, 2017, when a single gunman took aim at an outdoor concert.

“That night our team undeniably had vision,” said Sarah McCrae, LVFR, Assistant Fire Chief, who arrived at the center within the first hour of the incident. “They knew what they were after and what they were about. So despite the fear, the concern, and the confusion, they pressed ahead and provided calm reassurance to our community and to our first responders.”

The LVFR team stood proudly on stage during the audience’s standing ovation at the Opening Session on April 24 at the Las Vegas Aria Resort and Casino.

Other award winners:

**Instructor of the Year:** Christine Waegli, EMD and EMD-Q®, Ticino Soccorso 144, Breganzona, Switzerland (Waegli is a member of the IAED College of Fellows)

**Research Poster contest (two awardees for separate research projects):**
- Dawn Faudere, Operations Supervisor at Johnson County Emergency Communications, Kansas City, Missouri, USA
- Chuck Gipson, Medic EMS, Davenport, Iowa, USA

**The Bill Boehly Emergency Communication Nurse (ECN) of the Year:** Jeff Pierce, RN, REMSA, Reno, Nevada, USA

**Dr. Jeff J. Clawson Leadership Award:**
- Nancy Lockhart, 911 Operations Manager, South Bend, Indiana, USA, and EMD-Q Instructor

In addition to the awards, Christof Constantin Chwojka, Chief Executive Officer, 144 Notruf Niederoesterreich, the Emergency Communication & Coordination Center in Lower Austria, was announced Chair of the IAED Board of Accreditation.

More information about the award recipients and NAVIGATOR 2018—including videos—can be found on the Journal website: iaedjournal.org and Facebook: facebook.com/InternationalAcademiesofEmergencyDispatch/posts
Consider these two scenarios.

A woman dies at home of sudden cardiac arrest (SCA). She is 89 and has been under hospice care for the past several weeks. The woman’s end-of-life plans, including DNR (Do Not Resuscitate) orders, are in place. The hospice nurse, who is familiar with the patient and family, knows whom to call and what to do. She also consoles the woman’s daughter, who, despite expecting her mother’s death from a terminal illness (not from SCA), admits the difficulty of making decisions at the time of her death. With the nurse taking over the more-or-less administrative tasks of her mother’s death, the daughter said she was better able to cope with the immediate loss.

Compare that with the experience of a spouse, whose 63-year-old husband dies of SCA and neither wife nor her husband had discussed their preferences for end-of-life care (advance directives). She calls 911 at the time of his collapse, although she soon realizes the call is too late. The EMD sends an ambulance, and EMTs arriving on scene are legally bound to start resuscitation because there is no DNR order, despite the wife’s objections. The EMS system in their area does not allow non-physicians to pronounce death and stop all resuscitative efforts. Paramedics transport his body to the hospital by ambulance where a doctor later declares her husband dead. The wife said the experience (continuing resuscitation and transporting his body to the hospital) made his death more difficult on the family.

Some EMS systems are authorized to terminate resuscitation out of hospital. In these systems, making a distinction between workable cardiac arrest patients and patients who are unquestionably (and irreversibly) dead is an important function of the EMD. In that respect, communication centers must be certain about local EMS laws regarding death pronouncement and certification and how to take care of the body.

**Ethical considerations**

Paramedic responses to terminally ill patients in cardiac arrest can create ethical problems for EMS personnel, since attempting to resuscitate may not always be what family members and loved ones desire. For most states in the U.S. EMS responders are required to begin resuscitation efforts if the patient or family does not have a current DNR (a physician’s order directing medical personnel to not attempt to revive a patient using CPR or other extraordinary means) at the scene...
when EMS personnel arrive and the patient has a chance of surviving. Any questionable end-of-life circumstances without a DNR must be clarified later, in the hospital after EMS completes its turnover to hospital staff. Even when a DNR order exists and is presented to EMS personnel at the scene, different policies apply in different states and regions. In areas where EMS policy prohibits death certification in the field, EMS responders “are expected to provide BLS and ACLS as part of their professional duty to respond.” There are exceptions:

• When a person has obvious clinical signs of irreversible death
• When attempts to perform CPR would place the rescuer at risk of physical injury
• When the patient or surrogate has indicated that resuscitation is not desired

A physician’s involvement is not universal. For example, in Maryland, EMS providers can halt resuscitation efforts and declare the patient’s death on scene without a medical consult if unable to resuscitate a patient in cardiac arrest after 15 minutes of CPR, according to a protocol issued by the Maryland Institute for Emergency Medical Services Systems (MIEMSS).1

No matter where the arrest occurs, “decisions either to not start CPR or to stop CPR once started are ethically and legally similar, without distinction. Stated more prosaically, ‘withholding resuscitative efforts at the initial collapse’ is ethically and morally equivalent to ‘withdrawing resuscitative efforts at the terminal event.’”

Sudden cardiac arrest (SCA) vs. heart attack (or myocardial infarction, MI)

There is a difference. The heart’s electrical system is affected when SCA occurs. During SCA, the heart stops beating and no blood is pumped to the rest of the body. Survival depends upon turning the electricity back on, typically through electric shock, and in many cases removing the clot from a cardiac artery when the arrest is caused by a heart attack.

An estimated 17.7 million people died from cardiovascular diseases in 2015, representing 31 percent of all global deaths.2 About 40 to 50 percent of all cardiovascular deaths are SCAs, and about 80 percent of these are caused by ventricular tachyarrhythmias,3 which include both ventricular fibrillation (VF or Vfib) and ventricular tachycardia (VT). These deadly heart rhythms are most often caused by a heart attack, typically known as a myocardial infarction (MI). An MI is caused by a blockage in a cardiac artery, interrupting blood flow and causing an area of the heart muscle to die, therefore affecting the heart rhythm. Drug therapy or surgery can restore blood flow if done in time. While heart attacks (MI) are the leading cause of SCA, other conditions can cause the heart to stop suddenly, such as a strong electric shock or a sharp, sudden blow to the center of the chest. Asphyxia, or lack of oxygen in the blood and brain, can also cause the heart to stop over a period of minutes, but asphyxia is generally not considered an SCA, since the physiology is different and typically does not cause ventricular fibrillation.

CPR and early defibrillation double survival chances.

It’s essential to call 911 when an individual experiences an MI or SCA. Immediate hospital transport is essential. SCA requires immediate CPR, treatment with a defibrillator, and hospital transport.

Workable cardiac arrest

Medical Priority Dispatch System™ (MPDS®) Protocol 9: Cardiac or Respiratory Arrest/Death is designed to achieve an ECHO- or DELTA-level Determinant Code rapidly when a cardiac arrest is “workable”—when there is potential to restore a normal heart rhythm—and the patient has not reached the point of irreversible (biological) death. The term “workable” identifies the patient’s condition as potentially responsive to lifesaving procedures such as CPR, the use of an AED, and/or cardiac medications such as epinephrine, vasopressin, and amiodarone.

An American Heart Association (AHA) fact sheet states CPR and early defibrillation with an AED can more than double the chance of survival.7 A hands-on-chest Fast Track was added in MPDS v13.0 and is intended for patients who are initially and obviously described as being in cardiac arrest in the Case Entry sequence.

What the caller knows

In the case where the caller describes an SCA that just happened, Protocol 9 does not have any required Key Questions, since generally the SCA is identified in Case Entry, and getting to Pre-Arrival Instructions for arrest is time critical. In the case where the caller describes a possible expected or obvious death, the EMD begins Protocol 9 Key Questions. The first Key Question on Protocol 9 is essential for appropriately assessing the patient’s condition:

“(Suspected death) Tell me, please, why does it look like s/he’s dead?” Even if the caller responds cynically, the EMD will have a clear description of the patient’s condition to determine the best approach.

In other words, it doesn’t matter what the caller thinks of the questions; what matters is finding out what the caller knows.

MPDS Protocol 9 contains several Determinant Codes for cases of unquestionable death—where the patient is determined to be biologically dead: 9-B-1 “OBVIOUS death unquestionable (a through h)” and 9-G-1 “EXPECTED death unquestionable (x through z).” A DELTA priority-level Determinant Code 9-D-2 “OBVIOUS or EXPECTED death...
questionable (a through h; x through z)" is assigned when the case appears to be a biological death, but the caller is uncertain about the patient being "beyond any help" or is uncertain about the condition of irreversible death.

Because of the caller's uncertainty, the DELTA-level response is necessary as a safeguard to ensure a rapid response with the adequate EMS resources to handle a patient that will likely need resuscitation attempted. The EMD must begin CPR Pre-Arrival Instructions for these cases.

MPDS Determinant Codes for both OBVIOUS DEATH (9-B-1) and EXPECTED DEATH (9-O-1) exist for patients who are clearly and irreversibly dead or have a terminal illness accompanied by written DNR legal orders to forgo lifesaving measures. Medical ACEs interested in reducing over-response can use the OBVIOUS and EXPECTED DEATH Determinant Codes to optimize resource allocation in cases of irreversible death.

Obvious death

The OBVIOUS DEATH definition is very specific in providing identifiers that describe nonviable, “dead patients.” For example, CPR instructions will not be successful in case of a decapitation or with a decomposing corpse.

If the patient's condition matches the local definition for OBVIOUS DEATH, the emergency dispatcher should ask Key Question 1a, “Do you think s/he is beyond any help (resuscitation/CPR)?” If the caller expresses any uncertainty, the EMD provides PDI-c, “I’m sending the paramedics (ambulance) to help you now. Stay on the line and I’ll tell you exactly what to do next,” and proceeds to the DLS Links to provide PAs for life-sustaining efforts.

Key Question 1b, “Are you certain we should not try to resuscitate her/him?” addresses EXPECTED DEATH situations, which may include a patient who has suffered from a terminal illness or who has desired to establish a DNR order. If the caller is certain that the patient’s wishes were to not be resuscitated (as indicated with a DNR order), the EMD may send 9-Ω-1 only if the DNR is unquestionable and the OMEGA is already defined and authorized by Local Medical Control. However, as Rule 1 directs, “if the caller believes the DNR should be ignored or is uncertain if the DNR is valid or in place, an appropriate response and resuscitation attempt should be made.”

These final Key Questions provide the EMD with confirmation that the OBVIOUS DEATH and EXPECTED DEATH determinations are correct.

After completing Key Questions, the EMD initiates an appropriate response and then provides PDIs that best address the situation. For either OBVIOUS DEATH or EXPECTED DEATH situations, the instructions similarly reassure the caller “I’m sending someone to assist you” (the EMD will notify proper authorities) and ask whether the EMD can do anything else for them.

In the case of OBVIOUS DEATH, the EMD also instructs the caller to leave everything as he or she found it, which preserves evidence that may be reviewed in the event of an unexpected death.

Local Medical Control

Prior to any use of the definition or Determinant Codes associated with “OBVIOUS DEATH,” a local medical director/physician must authorize specific conditions that are widely regarded as clearly indicative that the patient has entered a hopeless, nonviable state of being, and the certified EMD must be trained and well aware of the locally defined terms. As stated in the definition of OBVIOUS DEATH:

Local Medical Control must define and authorize any of the patient conditions below before this determinant can be used. Situations should be unquestionable and may include:

a. Cold and stiff in a warm environment
b. Decapitation
c. Decomposition
d. Incineration
e. NON-RECENT death
f. Severe injuries obviously incompatible with life

Local Medical Control may also add situations of unquestionable or expected death in addition to those already listed in the protocol.

MPDS study

The study noted in the introduction examines the MPDS Determinant Codes for OBVIOUS DEATH unquestionable and EXPECTED DEATH unquestionable, along with their associated suffixes, and compares those codes to the responding EMS crews’ determination of the patient’s condition at the scene.

Study results showed that overall, unquestionable death in the priority response classifications of BRAVO- and OMEGA-level codes were coded correctly by the EMD in 98.5 percent of all cases, as indicated by the paramedics’ decision not to transport upon arrival. The reasons for transport included local protocols, inability to locate a DNR, and paramedic intuition.

According to the study’s conclusion, determining the ability of these codes to correctly predict the findings of the responding EMS crews will help system administrators and medical control physicians make better decisions about the use of ALS and rapid response resources to cases recorded by the EMD as unquestionable death.

Sources
2. See note 1.
4. See note 1.
Answers to this quiz are found in the article “Protocol 9: Cardiac or Respiratory Arrest/Death,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. There are no exceptions to the rule that EMS responders “are expected to provide BLS and ACLS as part of their professional duty to respond.”
   a. true
   b. false

2. The heart’s electrical system is affected when:
   a. a heart attack occurs.
   b. an SCA occurs.

3. About 80 percent of all sudden cardiac arrest deaths are caused by:
   a. coronary heart disease
   b. cardiomyopathy (enlarged heart)
   c. ventricular tachyarrhythmias
   d. vascular heart disease

4. A heart attack is typically called a:
   a. sudden cardiac arrest
   b. myocardial infarction
   c. congestive heart failure
   d. coronary artery disease

5. Protocol 9 is designed to achieve an ECHO- or DELTA-level Determinant Code rapidly when a cardiac arrest is:
   a. ruled out
   b. probable cause of a patient’s condition
   c. unavoidable given the situation
   d. workable

6. What priority-level Determinant Code is assigned when the case appears to be a biological death, but the caller is uncertain about the patient being “beyond any help” or is uncertain about the condition of irreversible death?
   a. 9-E-3
   b. 9-D-2
   c. 9-B-1
   d. 9-Q-1

7. If the patient’s condition matches the local definition for OBVIOUS DEATH, the emergency dispatcher should:
   a. ask if a DNR order is in place.
   b. ask Protocol 9 KQ 1a, “Do you think s/he is beyond any help (resuscitation/CPR)?”
   c. provide Protocol 9 PDI-c “I’m sending the paramedics (ambulance) to help you now. Stay on the line and I’ll tell you exactly what to do next.”
   d. ask Protocol 9 KQ 1b, “Are you certain we should not try to resuscitate her/him?”

8. For a terminal illness, if the caller is certain that the patient’s wishes were to not be resuscitated (as indicated with an on-site DNR order), the EMD may send 9-Q-1 only:
   a. if the EMD believes the DNR should be ignored.
   b. when the caller is unable to adequately describe the patient’s condition.
   c. if the EMD cannot verify the existence of a DNR.
   d. if unquestionable and authorized by Local Medical Control.

9. Local Medical Control may also add situations of unquestionable or expected death in addition to those already listed in the protocol.
   a. true
   b. false

10. MPDS Determinant Codes study results showed that overall, unquestionable deaths were coded correctly by the EMD in 98.5 percent of all cases:
    a. in the priority response classifications of BRAVO- and OMEGA-level codes.
    b. when the caller was able to adequately describe the patient’s condition (unquestionable death).
    c. in priority response classification of ECHO-level codes.
    d. when the caller verified a DNR order in place.

To be considered for CDE credit, this answer sheet must be received no later than 08/31/19. 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.
The Charleston Sofa Super Store fire in Charleston, South Carolina (USA) on June 18, 2007, was initially reported to 911 as a trash fire. Perhaps it started that way, but it didn’t stay a trash fire for long. The fire grew and grew until it engulfed the entire furniture warehouse, which contained no fire sprinklers. Sofa Super Store employee Johnny Ray Tyrrell was trapped inside, where he managed to call 911 almost 18 minutes after the first report of the fire. “Please get some help for me,” he said. “I’ve got a wife and kids.”

The emergency dispatcher reassured Tyrrell that help was on the way and instructed him to stay low to the ground. Tyrrell found a hammer and used it to hit the wall as a makeshift homing beacon to help the firefighters find him. Two firefighters, Steven Beasley and Daniel Bilton, used axes to chop through wood and then metal siding on the outside of the building to create a jagged hole just big enough to pull Tyrrell through.

The rescue was a bright spot in an otherwise bleak evening.

Not long after Tyrrell was rescued, the showroom experienced something called a flashover—an explosion due to intense heat—and consequently the roof collapsed with many firefighters still inside. Unfortunately, there was no system that was keeping track of where the individual firefighters were, so it was unclear how many were trapped.

The firefighters did have radios, but there were “16 fragmented distress messages, transmitted by lost or disoriented firefighters who couldn’t be identified, that were either missed or misunderstood due to heavy radio traffic, loud ambient noise on the fireground, and confusion. The term ‘mayday’ was only used one time and was not heard by [...] anyone else at the fire scene. It wasn’t until an off-duty battalion chief who heard the mayday responded and had a face-to-face report with the fire chief that the chief recognized firefighters were in trouble inside the building.”

It took scores of firefighters and three hours to put out the blaze, and by the time the fire was out, nine firefighters had lost their lives: Mike French, Louis Mulkey, Brad Baity, Mike Benke, Melvin Champaign, Earl Drayton, Billy Hutchinson, Mark Kelsey, and Brandon Thompson.

The Charleston Sofa Super Store fire remains one of the deadliest firefighter disasters in American history.

“Prior to that,” said Bill Haigler, Captain of the city of Charleston Fire Department and EFD Instructor for the Academy, referring to the fire, “Charleston Fire Department didn’t have incident command...
structure. The lack of incident command resulted in the tragedy.”

There are several Fire Priority Dispatch System™ (FPDS™) Protocols that may call for the use of incident command, chief among which is Protocol 69: Structure Fire. ECHO-level fire calls accounted for 0.2 percent of calls in a 2014 retrospective study conducted by the International Academies of Emergency Dispatch™ (IAED™). Nevertheless, one should be prepared for a big structure fire call at all times. One of the ways to prepare is by learning more about the system that firefighters use to organize the scene of a large fire incident.

What is incident command?
The scene of any fire emergency—especially one large in scale—is made up of many moving parts. Incident command is the structure in which all the parts of an incident are organized.

“Incident command is a simple way of knowing where everyone is on the fireground and having a list of tasks that need to be checked off in order to call a scene safe,” Haigler said.

The term Incident Command System (ICS) refers to the systematic, on-site management of resources at the location of an emergency. The ICS was developed in California after a severe wildfire in the 1970s as a result of communication and coordination problems of multi-agencies trying to work together to put out the fire. It was adopted by the NFPA in 1987 and remains in force today. The ICS is used in countries like the United States, the United Kingdom, Canada, and Brazil and is recommended as an international standard by the United Nations. There are similar systems across the world: in New Zealand, there’s one called Coordinated Incident Management System (CIMS); in Australia, there’s one called Australasia Inter-Service Incident Management System (AIIMS); and in British Columbia (Canada), there’s one called BC Emergency Response Management System (BCERMS).

The ICS provides a standardized organizational framework during emergencies so that every agency doesn’t have to create its own from scratch and agencies working together can do so more seamlessly. This standardized framework includes incident action plans (IAPs) and an organizational structure of personnel.

IAPs formally document incident goals, operational objectives, and response strategies. They typically include plans to prevent responder injury or illness, a task assignments list (such as primary and secondary search), a communications plan, a logistics plan, and an incident map.

Organizing a fire incident can be accomplished by using either mechanical or manual methods or a mix of both. Fire agencies can use tactical worksheets, dry erase boards, or a simple pen and pad, or they can use software.

The first incident commander
The FPDS priorities in any fire incident, but especially in the event of a structure fire, are: first, life safety (of both civilians and responders); second, incident stabilization (getting the fire under control or put out completely); and third, property conservation (stopping the fire from doing too much damage, if possible).

What is the role of emergency dispatchers in all of this? The emergency dispatcher is the first incident commander, much like the emergency dispatcher is the first, first responder. Emergency dispatchers are the ones who gather pertinent information from the caller, then pass that information along to the responders to prepare them for what they will find at the incident scene. The questions in the FPDS are specifically designed to help the first incident commander (the EFD) let the incoming incident commander know what’s going on.

Remember, it’s always better to overinform than underinform.

Protocol 69 is different from other fire protocols in that it has far more ECHO-
and DELTA-level Determinant Codes than low acuity ones. There are two CHARLIE Determinant Codes, as opposed to the 12 DELTA and 12 ECHO Determinant Codes. (The UKE version of the FPDS has an additional DELTA- and ECHO-level Determinant Code for a total of 13 each.) It takes three (four if a garage is on fire) Key Questions to determine what kind of DELTA response should be sent: “Did you see flames or smoke?”, “What type of building is involved?”, and “How many floors or stories are there?” The answers to these questions and the subsequent Determinant Code will let the firefighters know what kinds of vehicles they should respond to the fire with.

ECHO-level Determinant Codes are assigned at Case Entry, with the Determinant Code being decided by the answer to the question “What type of building is involved?”

If, as in the case with Tyrrell in the Charleston fire, the caller is trapped inside the building, on fire, or otherwise in danger, you will dispatch the Determinant Code, go to DLS, provide all applicable PDIs, and provide any appropriate PAIs from Protocol B (Fire and Hazards Rescue). After you have provided the caller with as many instructions as possible to help them stay safe, return to questioning if possible. A caller who is stuck inside the building may have more information than one would think—does the caller know what type of building it is? How many floors or stories there are? Which floor the fire is on?

Getting as much information as you can from the caller then passing it on is crucial to making certain that the responders go into the dangerous situation with as much knowledge and awareness as possible. If the caller is distressed and unable to answer questions, try to strike a balance between grilling him or her and giving up on questioning completely. If you can, explain to the caller that the answers to your questions will help the responders in putting out the fire and in search and rescue efforts. In addition to helping the responders, it might also help calm the caller down to have him or her focus on a task.

The emergency dispatcher’s job is not always finished when the firefighters arrive on scene. They can also be in charge of dispatching resources such as additional engines or ladder trucks to the scene as directed by the incident commander. “It’s important that emergency dispatchers are active listeners,” Haigler said. “They can’t just sit at the radio; they have to be actively participating at the scene by tracking resources, like the engines and where they’re going.”

When emergency dispatchers are active listeners and use situational awareness, everyone benefits. If the battalion chief doesn’t understand something that’s being said over the radio and the emergency dispatcher does, the emergency dispatcher can type it out and send it to the chief. At that point, the chief reads it back for confirmation, and that’s one more communication kink that’s been averted in a situation where any mistake can be costly.

Fire incidents are often dynamic. The circumstances can change in a flash, sometimes literally. A roof might collapse or an emergency call might come in from someone trapped inside who wasn’t originally accounted for in the ICS. It’s imperative that the emergency dispatcher communicates any incident information updates to responders as quickly as possible.

Contact your local fire agency to see if they would be willing to let emergency dispatchers join them at the next incident command training. The better acquainted emergency dispatchers are with the form and function of incident command, the better they will be able to play their part in the process.

**SOURCES**

2. See note 1.
Answers to this quiz are found in the article “Taken Into Account,” which starts on page 38. Take this quiz for 1.0 CDE unit.

1. ECHO fire calls accounted for what percent of calls in a 2014 retrospective study?
   a. 0.2
   b. 0.9
   c. 11
   d. 16

2. The Incident Command System was developed in California in the 1970s after what kind of natural disaster?
   a. earthquake
   b. flood
   c. hurricane
   d. wildfire

3. What does the acronym IAP stand for?
   a. Incident Action Plan
   b. Interior Accountability Program
   c. Insurance Access Protection
   d. Inter-Agency Personnel

4. What is an example of span of control?
   a. Firefighters get a wildfire under control in under three hours, keeping it from spreading to the neighboring town.
   b. The battalion chief’s jurisdiction doesn’t go beyond the city’s border.
   c. An emergency dispatcher can’t notify the fire chief if a radio message is misheard.
   d. A lieutenant reports to the captain and is in charge of six volunteer firefighters.

5. In ICS, it is recommended that span of control is 12 to 15 people, depending on incident type, the nature of the tasks that need to be accomplished, and safety factors.
   a. true
   b. false

6. Which NFPA standard mandates that fire agencies have some sort of system that keeps track of personnel at a fire scene?
   a. 1221: Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems
   b. 1403: Standard on Live Fire Training Evolutions
   c. 1500: Standard on Fire Department Occupational Safety, Health, and Wellness Program
   d. 1620: Standard for Pre-Incident Planning

7. What is the first FPDS priority in any fire incident, but especially in the event of a structure fire?
   a. incident stabilization
   b. life safety
   c. property conservation

8. What does it mean that the emergency dispatcher is the first incident commander?
   a. The emergency dispatcher gathers information about the incident, then passes it on to the responders so they will be prepared for what they find.
   b. The emergency dispatcher has a broader view of the incident than those on the ground and therefore gives commands that the incident commander doesn’t think of.
   c. The emergency dispatcher is often invited to the fireground’s incident command center to minimize communication errors.
   d. The emergency dispatcher chooses which resources to dispatch to the fire scene and when they should arrive.

9. How many DELTA- and ECHO-level Determinant Codes are there on Protocol 69?
   a. 3 DELTA and 1 ECHO
   b. 6 DELTA and 0 ECHO
   c. 8 DELTA and 6 ECHO
   d. 12 DELTA and 12 ECHO

10. In the event of a caller trapped inside a burning building, you should never return to questioning after providing PDIs and PAIs.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 08/31/19. 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.
In this issue, we are reprinting an editorial response to a research article that was done on the Medical Priority Dispatch System™ (MPDS) in the journal Prehospital and Disaster Medicine in 2010.

The original research that prompted this editorial—a study done by Sporer et al.—looked at the ability of the MPDS priority levels and Chief Complaints to predict an advanced life support (ALS) intervention by EMS responders. The authors studied over 65,000 cases by matching the MPDS priority levels (ALPHA through ECHO) and Chief Complaints with the ALS intervention type provided by attending EMS personnel (ALS/ALS-Stat/ALS-Critical). Their well-documented findings demonstrated a high sensitivity (ability to find the cases needing ALS treatment) for the higher priority levels (CHARLIE, DELTA, and ECHO)—with 100 percent sensitivity for Cardiac Arrest and Breathing Problems and 98–99 percent sensitivity for Chest Pain, Stroke, and Unconsciousness.

Overall, however, because of lower specificity (ability to distinguish the ALS intervention cases from the rest that weren’t) the researchers did not see a high predictive value for ALS care by grouping the three highest priority levels together.

After reviewing this research, a group of IAED™ researchers responded with the following editorial that emphasizes how important it is to look at the predictive ability of the MPDS codes in a more detailed and specific manner—using the final Determinant Code in its entirety.
Predictive Ability of Emergency Medical Priority Dispatch System Protocols Should Be Assessed at the Atomic Level of the Determinant Code

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Web publication: 27 July 2010

We commend Sporer et al for their work in determining predictive ability of the Medical Priority Dispatch System (MPDS™)1,2 in determining eventual Advanced Life Support (ALS)-level interventions in a wide variety of patient conditions.

However, there are some critical flaws. One significant flaw is in the artificial way the data initially were grouped for this study. An incorrect assumption that CHARLIE-level conditions should be placed in the same category of acuity as DELTA-level calls, and the same with ECHO-level problems, hides a great deal of what could have made this study much more valuable in refining the MPDS Protocols based on its findings. Per the National Academies of Emergency Dispatch (NAED) response matrix (Figure 1), each of the six clinical levels in this study represents a different but clinically-related grouping of potential evaluations, treatments, and response types and modes. By also grouping the ALPHA and BRAVO, and apparently the OMEGA level, into a single category, a similar important loss of code level detail occurred.

The CHARLIE level itself is defined as not having necessarily high acuity cases, but ones that the current standard of care and practice requires an ALS scene assessment—not necessarily ALS treatment. Chest Pain in a cardiac age patient (>35 years) is a good example. Many of these patients ultimately are determined as not having Acute Myocardial Infarction (AMI), but no one would say they do not need an ALS-type evaluation down the line. Examination of the general CHARLIE definition in the NAED response matrix shows a COLD ALS response default recommendation.

We also understand that in order to estimate sensitivities, specificities, and predictive values, the authors needed to dichotomize the "priority" levels into a high and low category. However, a better design would include: (1) establishing an overall trend analysis by analyzing association between MPDS priority levels as a categorical variable (ECHO, DELTA, CHARLIE, BRAVO, ALPHA, OMEGA) and each of the Delphi process categories (ALS-Intervention, ALS-Star, ALS-Critical); and (2) taking each pair, (e.g., ECHO vs. DELTA) and assess their respective association with the Delphi process categories used in this study.

In addition, the sensitivity and specificity statements made regarding the general categories (chief complaint groups) such as Abdominal Pain, Falls, and Traffic/Transportation Incidents are unclear. Since each of these groups contains a spectrum of code levels, including four to 14 individual codes, such groupings are not useful to those involved in improving specific areas within the dispatch protocols. This paper lacks a clear message as to what specific determinant codes should be modified in the dispatch protocols, or how. The authors simply conclude that the protocols need modification so as to increase specificity of chief complaints, such as breathing problems, chest pain, and unconscious/fainting. Realistically, the acuity value of an entire "lumped" chief complaint is not of any particular use in formulating responses or urgencies—thus, the specific wide spectrum of the six levels and more than 600 individual codes therein contained in the MPDS. The authors had a great idea on these pertinent issues, but analy-
Editorial Comments

Figure 1—National Academies of Emergency Dispatch (NAED) response matrix

sis to demonstrate the need for the modifications essentially is lacking.

This paper also leaves the reader wondering if some of the low sensitivities and specificities observed in some chief complaints simply could be due to small sample sizes in each chief complaint. As the authors did not provide the sample sizes in each chief complaint, we are not able to verify this issue.

Finally, the conclusion leaves us right where we started by restating the obvious: that the MPDS is more sensitive than it is specific. This is a well-known fact, since this is inherent in its ongoing design to maintain patient safety, especially when things are not clear in the non-visual dispatch environment. Of much more value in “modifying dispatcher protocols to increase specificity” is looking individually at codes within levels in a chief complaint—the “atomic level.” Trying to study the entire dispatch protocol as a whole is akin to trying to study “internal medicine.” By design, dispatch protocols differ significantly from diagnostic tools in their levels of sensitivities, specificities, and predictive values to capture levels of acuity.

Having read and reread this interesting study, we unfortunately failed to find the information necessary to submit any Proposal for Change request documents to the NAED for protocol improvement. Therefore, without analysis at the determinant level, and more specifically, the individual code level, we find no new message in the conclusions of this study. We look forward to further discussion with authors to see what we may have missed and which should be further evaluated.

Nevertheless, we are happy that collaborative dispatch research efforts have been initiated recently. We are aware and grateful that Dr. Sporer has been, and continues to be, a keen proponent of more collaborative efforts to improve medical dispatch protocol study effectiveness and relevance. We truly look forward to working with these dedicated dispatch scientists in the future.

References


Providing CPR in a snowbank isn’t usually someone’s first choice, but it was the best option considering the circumstances for one person calling the Laconia, New Hampshire (USA), PSAP.

It was a snowy Tuesday when Kristin Klin’s mother suddenly slumped forward in the passenger seat during a short drive between care centers, forcing her daughter to pull over to the side of the highway to phone 911. Her mother was unresponsive, and she had stopped breathing in the seconds between Klin placing the call and having it answered by EMD Brittney Elliott.

Given her mom’s condition, Klin and Elliott assumed that she was in cardiac arrest. Giving CPR inside the car was not an option, Elliott said.

“She pulled her out of the car to the side of the road,” Elliott said. “The caller [Klin] was quite frantic, but she was able to do exactly as I told her.”

Klin improvised the repositioning of her mom from inside the car to the uneven field of plowed packed snow outside. She used her coat as a pulley and cradled her mom’s head to minimize the impact. The snow’s depth and angle to the car, however, precluded the ability to pull her completely through the car door.

Her feet remained elevated inside the open car door.

For the next several minutes, Klin provided chest compressions in time to Elliott’s counting. Her mom survived. She was soon back home and recovering.

Five weeks later, on Sunday, Jan. 28, the Laconia PSAP welcomed Klin and her husband, Paul, to a celebration that included the presentation of two lifesaving pins. Klin attributed her mom’s survival to Elliott’s prompt instructions. Elliott was elated to meet them.

“This was the first time I met someone I had talked to over the phone,” she said. “Kristin’s mom was doing well but still unable to travel.”

Elliott went to school in law enforcement with aspirations of working for the state’s fish and game department. Her first job out of school was in the communication center, where she has stayed for the past 10 years. Helping people is the No. 1 reason she stays, but it’s not the only one for the outdoor enthusiast.

“Listening to calls is a much safer environment,” she said.

All 911 calls in New Hampshire are answered by the Bureau of Emergency Communications centers in Concord or Laconia, which operate virtually as one regional hub. Incoming calls go to the next available emergency dispatcher, no matter which center, and they receive a total of about 1,600 calls per day. Once the EMD gathers the information, triages, and categorizes the call appropriately, it is sent to the appropriate dispatch center to send the appropriate resources (EMS, EMS/police, EMS/fire/police), while EMDs at the Concord or Laconia center stay on the line for medical calls to provide the necessary PAIs and PDIs based on the Chief Complaint. Police and fire requests are immediately transferred to the appropriate dispatch center.

Because of the virtual connection, the two centers are a single Accredited Center of Excellence (ACE) through the International Academies of Emergency Dispatch® (IAED®).
ALWAYS THE PLAN
EMD kept sights on health care
Audrey Fraizer

Discovering a CPR mannequin propped up on your pillows and covered by blankets below the head is not something most would expect.

But maybe that’s simply the product of growing up in an EMS dedicated family.

“I always knew I wanted a career in the health profession,” said EMD Alex Hamilton, Emergency Services Telecommunications Authority (ESTA), Victoria, Australia. She just started practicing earlier than most.

Alex is the daughter of Peter Hamilton. Her dad is a PDC™ Australasian Regional Representative, a former emergency dispatcher with Metropolitan Ambulance Service (now part of Ambulance Victoria), and a father who would rather not take credit for his daughter’s career choice.

It’s not because he isn’t proud of what his daughter does or because he’s a bit embarrassed about the mannequins he placed in her bed as a joke only EMS types might find amusing.

“Dad has been very good about me coming to things on my own,” she said. “He tries not to influence me.”

Posting her recent EMD milestone on the EMD Australasia Facebook page happened because he does the same in similar circumstances when the Medical Priority Dispatch System™ (MPDS®) plays a role in a big event. He seldom includes the EMD’s last name, and this time he simply posted a “Congratulations” to Alex.

Alex was elated, not so much by the post but what led to the mention. Six months as an EMD, and she had the good fortune of giving PAIs for a protocol many may start but few get to finish.

“It was so quick,” Alex said. “I heard a woman screaming in the background, and once we got her on the bed, there was no stopping the baby.”

The baby’s dad, who made the triple zero (000) emergency call, followed the remaining PAIs—such as tying off the umbilical cord and using a blanket to keep the mom and baby warm. He kept comforting the mom, Alex said.

“But I was concerned,” she said. “I didn’t hear the baby cry even though the dad kept repeating the baby was crying and breathing. I finally did hear the baby above the noise in the room. I was relieved.”

Ambulance Victoria paramedics arrived and transported the mom and healthy baby girl to the hospital they were unable to reach by private vehicle.

Alex had picked up the call as the last one on her Friday, Jan. 12, shift. It was close to 6 a.m. and while it might be a call she didn’t expect, that’s something she likes about working in the communication center.

“You never know what to expect,” she said. “It’s different every day.”

Alex is a qualified paramedic, having recently finished the Bachelor in Science Paramedic Degree (as required by Ambulance Victoria). She applied to dispatch for the experience it could offer and, despite student paramedic training in the field, the communication center provided a first experience in assisting with childbirth.

“We get lots of these calls, but the paramedics usually get there before the baby arrives,” she said. “It’s been a really good experience.”

According to ESTA’s website (esta.vic.gov.au/background), ESTA provides Victoria’s 24-hour emergency call-taking and dispatch services for police, fire, ambulance, and Victoria State Emergency Service (VICSES). In 2016-17, ESTA answered 2,595,126 calls for assistance, representing a call every 12 seconds or an average of 7,110 a day. This was an increase of 2 percent in the total number of calls taken compared with the previous year. The total number of events dispatched grew to 2,161,706, an average of more than 5,900 each day or one every 15 seconds.
Some emergency dispatchers can go an entire career without assisting in the delivery of a baby. Those who have been through this know how gratifying it can be to give childbirth instructions over the phone to a father or other bystander and to then hear the healthy cry of the infant.

For Garfield County Emergency Communications Authority (Rifle, Colorado, USA) emergency dispatcher Michelle Raymond, her recent baby delivery call was especially emotional.

On Feb. 26, Raymond took a call from a father whose wife was going into labor. The couple hadn’t made it to the hospital, so this delivery was going to happen at home. By the time Raymond began asking the Key Questions, contractions were two to three minutes apart. Plus, this was baby No. 4 for the couple, so Raymond knew time was of the essence.

Raymond remained cool and correctly followed protocol by asking the right questions and giving proper instructions. Within five minutes, a healthy baby boy was delivered.

Raymond’s supervisor, Gena Baker, was so impressed with the way she handled the call that she nominated her for the International Academies of Emergency Dispatch’ Call of the Week. The IAED™ recognized Raymond with the award.

“[Raymond] remained completely calm while speaking with the baby’s father and giving him instructions about preparing for the birth and steps after delivery,” Baker said. “She did an exceptional job, and, after review, her call was scored as High Compliant! We are very proud of how she handled the call and served this family in our community.”

This was Raymond’s first-ever baby delivery call. It’s an experience few of her colleagues have ever had.

“It is very rare to get a call resulting in a baby being born before the paramedics arrive on scene or before the mother is taken to a hospital,” Raymond said.

But Raymond’s case is even more unique. When she took this call, she was seven months pregnant with her first child. This added element did not detract from Raymond’s sense of duty, but she said it did heighten her feelings.

“I believe I would have handled this call with the same amount of care and professionalism whether I were pregnant or not, due to the severity of the call,” she said. “However, after the call I did have overwhelming feelings of accomplishment and joy. I believe being pregnant and helping deliver a baby added to the emotion. I cried for at least 10 minutes while all of my co-workers gathered around. They were tears of pure bliss.”

As part of her Call of the Week award, the IAED pitched story ideas to newspapers and television stations in and around Rifle. The media were intrigued by Raymond’s experience.

In the days and weeks following this call, several publications contacted Garfield County Emergency Communications Authority and interviewed Raymond. Her story was featured on a Denver (Colorado, USA) TV station1 for its morning news. Even the titan news agency Associated Press picked up the story. It was featured in media all over Colorado and even in the Seattle (Washington) Times2 and the national publication U.S. News & World Report.3

**Sources**


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