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HEART ATTACK AND SCA
What’s the difference between a heart attack and sudden cardiac arrest?

A POSITIVE APPROACH
New performance standards make it easier to both give and receive feedback.
Mike, Ph.D., NRP, RN, CCRN, is the EMS Coordinator for Saratoga County, New York (USA), and the Chair of the International Fire Chiefs Association EMS Section. He is a nurse clinician in the cardiovascular surgical ICU at Albany Medical Hospital and a paramedic supervisor for Clifton Park & Halfmoon Ambulance. Mike is the EMS editor for Fire Engineering magazine and lead author of Critical Care Transport.

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

Art is a software instructor and IAED-certified EMD-Q® instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 20 years and is a former air medical dispatcher. He currently works at Union County Regional Communications in Westfield, New Jersey (USA).

MIKE MCEVOY 20 | OPIOIDS

SHERRI STIGLER 10 | LEAN IN

Art Braunschweiger 9 | FROM THE EMD SIDE

Mike, Ph.D., NRP, RN, CCRN, is the EMS Coordinator for Saratoga County, New York (USA), and the Chair of the International Fire Chiefs Association EMS Section. He is a nurse clinician in the cardiovascular surgical ICU at Albany Medical Hospital and a paramedic supervisor for Clifton Park & Halfmoon Ambulance. Mike is the EMS editor for Fire Engineering magazine and lead author of Critical Care Transport.

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**SET YOUR COURSE AT NAVIGATOR**

This issue gets you ready for our biggest event of the year

Josh McFadden

As I write this piece, NAVIGATOR 2019 is about nine weeks away. But by the time you get this issue of the Journal, this huge event will almost be underway.

In addition to networking opportunities and the chance to celebrate accomplishments and successes, NAVIGATOR is the ideal place to learn from the best in the business. We’ve lined up numerous informative sessions to help you develop your skills and improve the work you do every day in your centers.

This year’s NAVIGATOR theme is Set Your Course, and this issue of the Journal offers plenty of columns, opportunities for CDE credit, and thought-provoking feature stories.

One of the most prominent stories in this issue discusses the subject of giving feedback—how to give it, when to give it, and why you should give it. It centers around a new approach Q’s and managers are taking by implementing the principles of strengths-based feedback found in Performance Standards 10th Edition. Read this innovative set of performance requirements is changing the way people interact in the comm. center.

In her feature story, Audrey Fraizer, the Journal’s managing editor, discusses the differences between a heart attack and sudden cardiac arrest. She identifies how the Medical Priority Dispatch System™ (MPDS) addresses these.

We’ve got a pair of Your Space waiting for you. One walks you through the experience of Kay Dove, an emergency dispatcher from Australia who gave CPR instructions and helped turn a potential tragedy into a positive outcome. The other describes the experience of St. Louis, Missouri (USA), emergency dispatcher Angela Grady, who helped save a choking victim.

Check our Research column, as well as Sherri Stigler’s latest Lean In piece where she encourages people to rise to their potential. There’s also a story featuring the U.S. state of Delaware and its five ACE centers, not to mention a Medical CDE and a Police CDE.

Brett Patterson’s FAQ instructs on how to handle overdose calls, as he expertly fields a question from a comm. center professional. His FAQ also discusses the use of a CPAP machine and the challenges in handling CPR and breathing problem calls. Don’t forget to check out Ask Doc and the always popular Blast From the Past.

We hope this issue whets your appetite for even more instruction coming up at NAVIGATOR 2019.
Set your GPS to the International Academies of Emergency Dispatch® for the latest in dispatch education, training, and research.

That’s right! When you need to know what’s going on in the emergency dispatch world, check in with the Academy.

Why should you look to the Academy? Because you’ll find helpful research, Continuing Dispatch Education, and opportunities to attend NAVIGATOR with networking opportunities and access to experts in the field.

NAVIGATOR is a big event for the Academy. It gives us the chance to come together with YOU, whether that’s through the events, sessions, or the Academy’s booth in the Exhibit Hall. As I am writing this in January, preparations are moving forward for a stellar event in April at the Gaylord National Resort & Convention Center in National Harbor, Maryland (USA).

If you come by the Academy booth, you’ll have a chance to snag giveaways, learn more about the College (including the Supervisor Portal), and make suggestions for podcast guests.

One of the things we’re working on right now is a Journal special feature projecting where emergency dispatch is going in the not too distant future. Come get your copy at the booth or in the session “The Future of Emergency Dispatch,” presented by two of our very own editorial members: Audrey Fraizer and Becca Barrus. This special feature has been in the works for months, and we’re excited to get it in your hands.

Not to be outdone, we have other projects we are just as excited to share at NAVIGATOR. So far the Academy has distributed four Research Briefs (stroke, low acuity, CPR barriers, and litigation). These can be found by visiting the AEDR website (aedrjournal.org/research-briefs).

But wait for it … we will have three more at NAVIGATOR including one for fire and one for police. Yes, three more Research Briefs! This means we will have at least one Research Brief available in each of the three disciplines (medical, fire, and police). As always, quizzes will be available on the College for CDE credit (learn.emergencydispatch.org).

But our booth isn’t the only place to connect with us. The Journal editorial staff (in tandem with those on the AEDR Journal staff) are presenting three sessions during the conference including the one about emergency dispatching in the future. Keep reading to find out more.

Please join us at “Stop, Collaborate, and Listen” to learn effective tools to use to reach out to the diverse communities your center serves. After attending this session, you will know how to break down assumptions, connect stakeholders, and implement the findings from a 911 Attitudes Study done by the Academy in 2018. The study included six diverse communities (e.g., Native American community, Hispanic community, and LGBTQ community) and discovered their knowledge, barriers, expectations, and suggestions for improving their experience when calling 911.

Another session to check out is “The Other Side of Science: Translating Evidence into Practice.” You might be wondering how to keep up with the most recent information and evidence in the field of emergency dispatch. But it’s not even just about keeping up; it’s also about communicating, implementing, and training on these best practices in your agency and monitoring progress. Join us for advice on how to stay in the know without giving up all of your other work responsibilities.

And if research is your thing (or you want to give it a shot), make sure to check out the pre-conference IAED™ Research Workshop.

If you are unable to come to NAVIGATOR, please check iaedjournal.org after the conference for the Journal special feature. Make sure to look for our three new Research Briefs on the College along with their quizzes. Don’t forget to keep listening to our podcast.

We hope to see you in April!
FOLLOWING SUIT
Should callers be advised to follow impaired drivers?

Dave Warner

Hi Darren,

Yes, I can help. I know we discussed this briefly with the Bloomington Police Department during our meetings.

The original PDI for over a decade of versions has always been, “Do not continue to follow or make contact with the driver of the other vehicle.” This PDI is only available on Protocol 115: Driving Under the Influence (Impaired Driving) and Protocol 132: Traffic Violation/Complaint/Hazard. We’ve often run into police agencies across the country that are OK with having callers follow suspects in order to obtain current locations of drunk, erratic, or reckless drivers. This, as you know, gives police the chance to locate/intercept and stop the vehicle. Thus, these user agencies haven’t particularly liked the old standing (default) PDI. But as I mentioned before, it was the safe pathway in terms of individuals following others, and it remained in the protocol for years.

With the release of EPD version 6, the Police Council of Standards (COS) re-examined this PDI and determined to make the long-standing “hands-off” approach instruction optional, while also approving a second PDI for protocol use with callers in these situations. This optional PDI states, “Only if safe to do so, continue to follow at a safe distance. Obey all traffic laws and do not make contact with the driver of the other vehicle.” This change had two primary points of focus:

1. To increase the likelihood of apprehension through obtaining current suspect locations for user agencies who dispatch police to intercept.
2. Also, lessons learned from the Denise Amber Lee incident in Florida (USA). The COS felt this procedure would be best addressed at the agency level based on an agency’s resources and historical beliefs as to what is the best practice. In turn, the council wanted the PDI available for callers based on agency practice and police response. This makes the selection up to you for the appropriate PDI your agency wants to provide callers.

You’ll notice Protocol Rule 13 (Case Entry Protocol) states this as needing determination by agency policy. Keep in mind, although the PDI is only on two Chief Complaints, a caller could be following a suspect involved in a theft, hit and run, a robbery, or just about anything. This is the reason for Rule 13 in Case Entry Protocol.

I hope this helps.

Dave Warner
Priority Dispatch Corp.

Dave, Do you have any background on the wording and any legal vetting of the pros/cons of the following statements?

We debated these today at our Dispatch Steering Committee (DSC) meeting.

Thanks,

Darren R. Wolf, ENP
Communications Center Manager
City of Bloomington, Illinois (USA)
Research into the mind and body connection at death raises significant application to administering CPR following cardiac arrest.

A seminal study (Parnia, et al.), commencing in 2008, tracked 2,060 cases of cardiac arrest (CA) in 15 hospitals across three countries. Approximately 40 percent (140) of the 330 patients who survived CA agreed to interviews about their experience. The group of scientists involved in the AWARE study (AWAke during REsuscitation) published their findings in the journal Resuscitation (2014).

According to their results, seven major cognitive themes were prevalent among those who had memories of the experience (fear; animals/plants; bright light; violence/persecution; déjà vu; family; and recalling events post-CA), while a much smaller proportion of the survivors described near-death experiences (NDEs) and actual events related to their resuscitation. That’s where the problem comes in. While CPR-induced consciousness is rare, it does occur, and there is a likelihood that it will increase due to high quality chest compressions and extended CPR times and the availability of newer treatment alternatives. At this point, however, as concluded in the second study, the lack of literature on CPR-induced consciousness adversely limits development of evidence-based management guidelines. Until more research is available, consensus-derived guidelines are the practical solution (such as a clear definition of CPR-induced consciousness and the use of physical and chemical restraints).

The International Academies of Emergency Dispatch® (IAED™) advocates high-performance CPR, a technique that focuses on providing high quality CPR by incorporating minimal breaks in compressions, full chest recoil, adequate compression depth, and adequate compression rate.

As the focus continues, it’s inevitable that we’ll see more of what used to be a rare event, according to Brett Patterson, IAED Academics & Standards Associate and Chair of the Medical Council of Standards. “Patients are showing signs of consciousness during compressions even without any electrical activity or spontaneous contractions of the heart,” Patterson said. “Essentially, the quality compressions alone are circulating enough blood during the resuscitation event to facilitate consciousness.”

Patterson advises that EMDs understand that while a patient resisting CPR (moaning, pushing rescuer away, etc.) is cause for stopping compressions, if the patient then immediately becomes unresponsive when the compressions stop, and is not breathing effectively, CPR needs to be started again immediately.

Sources
HELP WANTED
Dispatchers are tough, to a point
Art Braunschweiger

If I were writing an advertisement for emergency services dispatchers, this is how it would read:

WANTED: Police/Fire/EMS Dispatcher. Must be supremely confident. Must demand perfection of him/herself at all times. Should have an irreverent sense of humor. Must be instantly critical of responders questioning anything the dispatcher says or does. Must be willing to voice an opinion on everything and everyone. Highly developed sense of sarcasm is a plus. Is expected to continually complain about the job while excelling at it and never leaving to seek employment elsewhere.

I have yet to visit a dispatch center that doesn’t have people who fit that description. We are a collection of contrasts. I don’t know of any single group of professionals who can, on the surface, appear to be as indifferent about people’s misfortunes, yet in an instant project a level of empathy and compassion that would have made Mother Teresa proud.

At the Miami (Florida, USA) Police Department, the wall outside the dispatch center is covered with dispatchers’ self-chosen quotations about their jobs. Each is printed on a paper boldly titled “I AM 9-1-1.” Some are very moving. What I haven’t figured out, though, is whether the job makes us, or if we make the job. I do believe this career takes a certain type of person, and that most who excel at it had no idea before they started that they could do what they do so well. And enjoy it. No doubt that’s why so many of us ended up making a career of something we never expected to.

We read about the stress of handling life-threatening calls on a continual basis. There’s no question that we can be impacted by these calls and even experience post-traumatic stress disorder (PTSD). But emergency dispatchers as a whole are incredibly resilient and have well-developed coping mechanisms, not the least of which is an acerbic sense of humor (what my partner Barbara calls being “snarky,” a uniquely North American term).

I firmly believe it’s the workload that often gets to us and not just the work itself. In many centers, chronic understaffing means being forced to work longer hours and extra shifts and having to shoulder heavier call loads with fewer opportunities for breaks. And in centers with separate calltakers and dispatchers, the latter have to handle more phone calls while trying to manage radio traffic at the same time.

Administrators should use hard data to establish staffing minimums. There are ProQA® reports you can run to show how many calls your people are processing per hour of the day and day of the week, how many calls of each Determinant Level each emergency dispatcher is handling, average case open times, and more. The reports you generate can be protocol-specific, such as how many in-progress assault and/or family/domestic violence calls are handled per calltaker per day. The ProQA Reports module is often overlooked or unknown, yet it can provide some of the most valuable data to quantify per-dispatcher workloads. That data can be used in conjunction with other specific measures to determine staffing needs.

Emergency dispatchers are among the most talented people on the planet. We can rise to almost any emergency occasion and—in the words of American songwriter Tom Petty—we won’t back down. We’re very good at drawing strength from within when we have to, but continually compensating for inadequate staffing shouldn’t qualify. Let’s hope a few administrators reading this will take a fresh look at staffing in their centers and do what’s right.
**REACH**

Challenge staff to rise to potential

Sherri Stigler

Spring has sprung, and heck yeah, I’m excited! While it might seem a little “ho-hum” to our southern brother and sister emergency dispatchers, it certainly raises the excitement level in our frigid Wisconsin 911 home. The snow is melting, and soon we’ll see the frozen world come alive as the first greens creep toward the surface, breaking from the depths of the soil and into the warmth of the sun. It’s a difficult and necessary journey, much like the one traveled by staff eager to grow and advance in the profession.

Whenever we start a new class of fledgling emergency dispatchers, our director leads the group through an “icebreaker” activity. He has them stand up and explains the significant effort it will take to be successful in the organization. He asks them to raise their right hands as high as they can. Once all hands are extended skyward, he asks if they can “reach a little higher.” Inevitably, hands extend even farther with fingers wiggling and struggling for a few more inches north. That, he tells them with a smile, is the difference between those who do what is asked and those who reach to their full capacity.

When we look at the “Circle of Life” in dispatch, we tend to understand the universal struggle to attract, hire, and retain great emergency dispatchers. It is an all too common malady faced by nearly everyone in this business. We hear about it at trainings, conferences, and especially at networking opportunities, such as the Fitch & Associates Communication Center Manager (CCM) course. When I attended CCM nearly eight years ago, we discussed the challenges of hiring and retention, finding solace in the realization that most everyone tangled with these issues. Fast forward to this past year, and our latest CCM grad supervisor said that this “broken record” topic was still playing. So how can we break this trend? How do we create an environment where people want to excel, to rise ... to reach? Here are some suggestions.

**Expand the search field**

Attend job fairs, give tours to groups with explicit interest in the profession, such as public safety classes from community colleges and citizen academy classes. We get some of our best applicants from these contacts. Send the posting out to specific job-related trade publications, educational job boards, and especially through social media. Open your doors and allow people to learn about what we do (and how proud we are of what we do).

**Train with purpose**

Develop a well-organized (and memorable) training program. Consider classroom training and training in the operations space. Finally, clarify expectations. Trainees should never have to wonder where they are in the process.

**Support and encourage self-advocacy**

Emergency dispatchers who desire to grow in the organization need to be “fed.” That nourishment comes in the form of training, mentoring, and identifying a path of continual growth and improvement. Without a challenge, these folks tend to leave organizations, so it’s critical to keep them engaged and empowered. Oftentimes, these “rock stars” will find projects and opportunities to improve processes within the department, so we need to allow them to polish and ultimately to shine.

**Embrace feedback and evaluation**

Think of personnel evaluations as quality assurance for the individual. Evaluations are necessary and important conduits for continuous improvement. If we don’t evaluate our calls for service, we can’t determine whether or not we are applying the protocols correctly. The same applies to the general work performance.

**Choose greatness**

Be a place where successes are celebrated and where people feel valued and important. Highlight their extraordinary examples of teamwork. Renew your commitments to them.

Spring has sprung! I challenge all of you to discover and nurture those new sprouts of life in your center. It is time to excel, to rise, and to REACH!
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ACCIDENTAL OR INTENTIONAL?
Purpose behind an overdose

Brett Patterson

Brett: 
Derick Aumann here from New Hampshire. I was looking to clear something up that has been a longstanding policy here.

On Protocol 23: Overdose/Poisoning (Ingestion) Key Question 1, “Was this accidental or intentional?” we have treated the overdose cases as intentional. There is some discussion that these should be treated as accidental. The person intended to get high; they did not intend to overdose.

Just curious on your thoughts.
Thank you,
Derick Aumann, NRP
Quality Improvement Supervisor
New Hampshire Department of Safety Bureau of Emergency Communications
Concord, New Hampshire, USA

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

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

Unfortunately, accidental narcotic overdose is becoming rampant in cities across North America. I suspect this is why this question of intent has become more frequent. After some discussion, the Academy’s Rules Group has proposed some minor protocol modifications to clear up the confusion and make the coding process more intuitive. While I can’t be very specific because the enhancements are in draft form and have not formally been approved, the changes involve adding the intent to harm oneself to the OVERDOSE definition, the ProQA® answer choice, and perhaps to the Key Question itself in the form of a clarifier.

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

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

Hope that helps.

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

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Michael:

I have a continuous positive airway pressure (CPAP) question. If a patient is unconscious and is on a CPAP, how is this addressed? I’ve read the forum, and it has more about vent patients than CPAP patients. Should the calltaker err on the side of the patient and treat as if the patient isn’t breathing? Should they remove the CPAP and check the breathing diagnostic without the CPAP (since sometimes it’s used for sleep apnea)? Start chest compressions whether the CPAP stays on or not?

I’m familiar with the CPAP in the field but not for in-home use. We had a call with a patient on CPAP with a cancer history. The agonal breathing tool was used, and they indicated the patient was breathing normally; however, that wasn’t the case. I’m just wondering what the Academy’s position is on this. I always believe in erring on the side of the patient. This one is a bit tricky. Do you foresee the Academy addressing this in any future updates?

Thanks,

Johnna Howell
Central Emergency Medical Services Fayetteville, Arkansas, USA

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Brian:

I could use a little help from medical direction for this one.

Michael Spath
Chair, ED-Q™ Council of Standards International Academies of Emergency Dispatch

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Johnna:

First of all, I have included Brett Patterson in this email. My knowledge of CPAP is not as complete as his, but I will provide you the basics here and let Brett add or subtract from my comments.

When dealing with CPAP patients, it is important to remember the patient has to be breathing (initiate a breath) for the device to function. It is not a ventilator, so if the person is unconscious but breathing, I would leave the unit in place and functioning. If the patient is not breathing, or the breathing is ineffective, I would remove the device and start CPR as appropriate. If the EMD is not sure if the unit is functioning, or believes the patient is crashing and their breathing is ineffective or agonal, I would remove it and get back to basics. Let’s see what Brett has to say.

Brian Dale
Associate Director of Medical Control and Quality Processes International Academies of Emergency Dispatch

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Michael:

I agree with Brian. If there is any doubt, remove and assess. If there is no doubt, either way, it doesn’t hurt to leave it on. If we know the patient is not breathing and we are doing compressions only, it certainly won’t hurt to leave it on. If we are certain the unconscious patient is breathing effectively, then leave it on. But again, remove and assess if there is any doubt.

Brett

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Hi Brett:

Why isn’t shoulder pain considered a chest pain symptom in addition to other areas of the body such as neck, jaw, upper back, chest, and arms?

Angela Stronach, EMD
Queensland Ambulance Service Brisbane, Queensland, Australia

Hi Angela:

The Heart Attack Symptoms listed in the MPDS® are not strictly limited to exclude the shoulder; it’s just that the areas listed are much more typical for cardiac-related pain. Just as important as the location is the pain description. If a caller reported shoulder pain as heaviness or crushing or aching pain that was non-traumatic, I would certainly err on the side of safety and classify that as a Heart Attack Symptom. However, the shoulder is a complicated joint where musculoskeletal pain with movement is much more common, unlike the more typical pressure-like chest to jaw to upper arm radiating pain associated with cardiac ischemia.

I hope that helps, and thanks for asking.

Brett
The ACEs of Delaware prove that accreditation has nothing to do with fitting a mold but everything to do with doing what’s best for the public and the police, fire, and EMS responders dispatched to the scene.

Delaware is the second smallest state (1,954 square miles or 5,060 km²)—of the 50 states in America—behind Rhode Island (1,214 square miles or 3,144 km²). It ranks 44 in terms of population, although sixth highest in density due to its compact size. The three counties—New Castle, Kent, Sussex—line up in succession from north to south, respectively, and because of temperatures moderated by the Atlantic Ocean and Delaware Bay, the farther south you go, the warmer it gets year-round.

The climate and proximity to beaches and metro corridor says a lot about the people who live year-round or seasonally in the different counties. Rehoboth Beach in Sussex County, for example, tends to be the summer playground for the Florida snowbirds and the place to go for anyone who loves a beachside vacation, while the strip of New Castle County south of the Chesapeake and Delaware Canal is home to the largest number of long-distance commuters in the state, drawing people from across the Northeast Corridor because of amenities outside the urban rush.

As far as emergency communications goes, Delaware requires that all 911 emergency report centers provide emergency medical dispatch, through a contract with the Department of Safety and Homeland Security, including systemized caller interrogation, pre-arrival instructions, and EMD protocols that help determine the appropriate vehicle response and configuration. The law also requires IAED™ medical accreditation.

1. Kent County

The sun was high, temperatures soared into the 80s, and from a stage at the Firefly Music Festival resounded a greeting that needed little reinforcement.

“Stay hydrated. Vodka soda doesn’t count. Stay safe, but definitely get wasted.”

The 2019 (June 21-23) line-up includes headliners Travis Scott, Post Malone, Unknown Mortal Orchestra, and Death Cab For Cutie on multiple stages, beckoning their 60,000 to 90,000 (estimated) fans to dance, crowd surf, and—as so strongly suggested—party.

The Delaware Emergency Medical Services Oversight Council (DEMSOC) oversees the state’s EMS, which has a staff of 1,300 certified first responders; 1,497 EMT-Basics; 317 paramedics; 210 emergency dispatchers; and 8 medical directors.
party, and party some more. In all fairness, the festival receives high marks for its performances, carbon footprint environment, and reputation of going off each year without a hitch. Acts and audiences keep coming back.

Dan McLaughlin hasn’t missed a festival since it started in 2012. Problem is, he never sees or hears the artists perform.

“People tell me how lucky I am to be there,” he said. “I’m in a room without windows for the entire time I’m there. The radio is nonstop. It’s a challenge.”

McLaughlin is a Kent County 911 Supervisor and a Kent County volunteer firefighter. He’s in charge of the seven-member quality assurance team and in addition to dispatching at the PSAP in Dover, he goes to the joint operations trailer during the county’s big events. Firefly is huge and surpasses the NASCAR races held twice a year at Woodlands. The fall NASCAR weekend in October drew about 60,000.

NASCAR has held two NASCAR races each year since Dover International Speedway opened in 1969 and, basically, runs itself, McLaughlin said.

Firefly, however, raises the bar.

Kent County EMS fully staffs Firefly, with New Castle and Sussex counties pitching in for the four-day, 24/7 coverage. Emergency dispatchers answer calls, send response, and watch live streaming video from across the festival grounds to help determine the location of emergencies or potential hazards. Medics travel on foot and use motorized mini-ambulances to transport patients to medical tents and trailers or distribute bandages for the blisters that develop from all of the walking between venues and from campsites inside and outside the race track. Most medical calls involve dehydration, heat exhaustion, or problems related to a party atmosphere.

The festival is a microcosm of Kent County 911 year-round—not the party atmosphere but the people in need of emergency attention. Summer months are particularly busy for the five emergency dispatchers on each of the center’s four shifts. Vacationers flock to the beaches and outdoor events—such as Firefly—that bring in people from all over the country. Commuter traffic jams the roads year-round, and the notorious nor’easter storms create three- to four-foot storm surges above high tide.

Hurricane Sandy in 2012 dumped nine inches of rain in Kent County in a 36-hour period. Hurricane Florence fizzled before reaching the eastern coast.

McLaughlin has been in Delaware most of his life and like most people at Kent County 911, his public safety career began as a volunteer for the fire department. It’s a comfortable fit. They know the lingo and how things are done, which translates into ease in using the medical and fire protocols. They are in the process of implementing the Police Protocols.

2. New Castle

The uncertainty of budget hasn’t stopped Jeffrey P. Miller from pursuing what he believes necessary for the New Castle communication center.

“If I waited for the state to do things involving operations, I’d be an old man sitting in my office not knowing a thing about 911,” said Miller, Chief of the communication center serving the northernmost and largest of Delaware’s three counties.

New Castle was the first center in Delaware to implement all three protocol systems—EMD, EFD, and EPD, in that order—and the only center in the state that entices recruits through free ETC training and certification.

Roll call and free ETC training/certification are “big ticket” items that Miller initiated to complement fire/EMS and police and keep the center fully staffed. Since shifts run in two 12-hour day and two 12-hour night rotations—with four days off in between—catching up on the past days’ events as they happen over the phone could delay the effectiveness of emergency dispatchers coming on shift. Roll call provides briefings on police, fire,
and EMS events that transpired over the previous shift.

“Roll call is huge,” Miller said. “It has value. You can’t go walking into dispatch and expect to do your job like the past four days didn’t happen.”

ETC has cut turnover “significantly,” because, as Miller said, it lets people find out if they’re going to like the job. Those that stay can be certified EMD, EFD, and EPD within six months.

“The program is worth its weight in gold,” Miller said. “We’re not setting people up for failure. They see opportunity for career development.”

**CAD data deployment**

FirstWatch data links emergency communications to New Castle County Police Department’s (NCCPD) TAPS (Targeted Analytical Policing System). Data, based on calls coming into CAD, is used to create predictive maps of hot spots, cold spots, and trending crime that, in turn, determine police resources. Miller attends the weekly “Predictive Policing” meetings and, from the information, directs the prioritization of calls depending on data clusters.

The data-based deployment initiated in 2013 decreased murder and violent crimes. Property crimes fell between 10.9 percent and 37.8 percent, according to a three-year anniversary report, compared to pre-TAPS records (2010–2012).²

“TAPS focuses on hot spots, and we all work together to fix them,” Miller said.

**No second chance**

Securing funds for projects has everything to do with making the process work for emergency dispatchers (92 slotted positions) and the five police agencies and 23 fire and ambulance services in Delaware’s most populous county (over half a million people in 480 square miles). The New Castle center receives more than 50 percent of the state’s 911 calls, averaging 2,000 emergency and non-emergency calls daily.

Miller’s career in public safety goes beyond his 22 years in emergency communications. His start as a volunteer firefighter for Talleyville Fire Company (Wilmington, Delaware) got him interested in 911, and he worked in emergency communications prior to going full time as volunteer fire chief. He went back to 911 and has overseen the implementation of EMD, EFD, and EPD. He is president of the Talleyville Fire Company.

“I’d rather roll my eyes in sand than go through another implementation,” Miller said, in relation to the third rollout (EPD) in 2017. “But it had to be done. The protocols work. Nothing happens without us. There’s no second chance. EMD is so clear and so important, it sounded so wrong not to have police and fire.”

**3. Seaford**

The cities of Seaford and Rehoboth have a lot in common.

They’re both in Sussex County, the southernmost county in Delaware. Their climates are moderated by the Atlantic Ocean, creating mild subtropical weather conditions (hot humid summers and mild winters). Despite seasonal swings in populations, their call volumes are about equal, at least when numbers are ironed out at the end of each year.

“We’re comparable to Rehoboth Beach,” said Anita Bell, Manager, Seaford Police Department communications center. “But we’re busy all year round, while Rehoboth changes with the season. In winter, their calls go way down.”

Rehoboth is the summer escape for Florida snowbirds, and its population goes from about 1,750 permanent residents to upward of an additional 25,000 tourists and part-time residents during the on-season. Seaford’s 7,000 residents are year-round. At one time, Seaford was among the largest chicken-producing areas in a county rated as the largest producer in the world. Dupont chose Seaford as the site of its first nylon plant and although both agriculture and nylon production no longer dominate the economy, employment continues to grow through production and administrative jobs.

Seaford opened the first 911 center in Delaware before 911 was the national number to call for emergency assistance. They used the four-digit number 6644. The center has always been part of the city’s police department.

Bell remembers a time before Delaware became a haven for retirees and before a drive to the beach—about 35 miles east—wasn’t a line of slow-moving traffic during the busy season. She also recalls police dispatch training that relied on payphones and pre-CAD days at the communication center when they used single screens and there was no mapping system available.

The fast-disappearing payphones were part of the early training program for new hires prior to the ANI/ALI system. The dispatcher learned to trace calls made by a police officer who chose a random payphone as part of the
training process. If the payphone had a security camera, police could figure out who made the call by synchronizing the time coded on the camera with the time the call was made.

CAD came to the floor in 2006, just one year after Bell was hired. She took over as manager eight years ago. They upgraded to a newer CAD version in 2016. The mobile data terminals (MDTs) in police cars were not an immediate sell because of the challenges involved, such as watching all the information entered by the dispatcher come up on the screen during a chase scene.

“It’s funny to listen to them now,” Bell said. “If the MDT goes down, their world stops. They can’t do without it.”

Even harder than either CAD or protocol—and they use medical, fire, and police—is getting the fire chief behind the standardized dispatch process. It’s a learning curve for most that is repeated every year because of the annual election of the Seaford Volunteer Fire Department Chief.

“Sure, it’s a big change, I tell them,” she said. “But script makes it easier. Everyone asks the same questions so that the information they receive is consistent.”

Seaford communications went live with fire in late 2018, which is not yet required by Delaware, unlike the medical and police protocols. Her goal is tri-ACE and at this point, she’s confident it’s something well within their reach considering all they have been able to achieve.

“I don’t know where technology will take us,” Bell said. “But it has taken us a very long way in a very short time. Change is something we do well.”

4. Rehoboth

Tammy Ketterman went running on the beach on the November morning she was interviewed for this piece. The exercise is a relaxing start to her day after a 50-mile commute from home to the Rehoboth Police Department communication center. She likes watching the waves come at low tide and doesn’t have to worry about kicking sand onto someone’s towel or tripping over an in-progress sandcastle.

The beauty of an ocean vista and the calm before the storm are reasons Ketterman works in a coastal setting, although, in her case, the calm before the storm has more to with the seasonal tourist trade than it does the chance of a hurricane.

Rehoboth Beach is the snowbird summer capital. From May through September, retirees and sun worshippers of every age and demographic descend upon Rehoboth Beach for the summer, leaving again in late October or early November for their winter hiatus along the country’s southern coastline. Year-round residents, and there are about 1,000, tend to avoid the beach except during the winter, Ketterman said.

“There’s no sand to walk on during the busy season,” said Ketterman, Manager, Rehoboth Beach Police Department 911 center. “You end up walking on other people’s towels. People who live here stay away.”

The waterfront and Boardwalk Plaza are a blanket of tourists on a normal summer day. No curfew is imposed on the mile-long plaza, although the beach closes from 1 a.m. to 5 a.m. each day for health (cleanup) and safety reasons. Festivals, such as Fourth of July fireworks shot over the ocean and the annual Beach Tree Lighting and Sing-Along, draw upward of 50,000 people. As may be expected, calls to 911 quadruple with the majority requiring police assistance for the type of crime large numbers tend to attract (theft makes up 88 percent of total crime).

Violent crime is minimal. The number of full-time officers exceeds state averages by 4:1, and the Rehoboth Beach Patrol is linked to a beach patrol communication center.

The 11 calltakers/dispatchers at the police department headquarters are EMD-, EFD-, and EPD-certified. They dispatch police for the one square mile of waterfront and boardwalk and dispatch fire and EMS for an area covering 36 square miles. Two people cover every shift, except during the busy season when two more come in between 5 p.m. and 2 a.m. They also handle administrative calls and assist people coming into the police station, a short five blocks from the plaza.

Like most public service employees in a resort setting, Ketterman lives outside of Rehoboth Beach. The daily commute, she said, doesn’t bother her, and she’s been doing it for 15 years, same as her husband who commutes 51 miles in the opposite direction each day. She grew up in Pensacola, Florida (USA), so she’s no stranger to popular waterfront destinations. Rehoboth Beach, however, by comparison, she said, is a small town, and it works hard to uphold a family safe environment.

“They want to keep this a nice place,” Ketterman said. “People are bent on being friendly.”
Ketterman is personally bent on making tri-ACE history in Delaware. The Rehoboth Beach 911 center is a medical ACE, and it’s their goal to accredit in police and fire in 2019, which, at this point in time, would make them first in the state to achieve tri-ACE status.

“We’re very proud of what we do,” Ketterman said. “Ask anyone here, and they’ll tell you it’s about helping people, and everybody loves being able to do that.”

5. Sussex

Sussex County used to be the best kept secret in Delaware. The state’s largest county (968 square miles) is now almost the fastest growing in terms of population, with the past several decades producing a notable shift in the reasons why people settle there.

“We live in a beautiful area,” said Sussex County 911 QA Supervisor Debra Jones. “People come here, and they don’t want to leave.”

Sussex County is bordered by the Atlantic Ocean to the east and the Nanticoke River to the west. Maryland is to the south, which means a relatively short commute to Washington, D.C.; Baltimore, Maryland; and Philadelphia, Pennsylvania. For those living in Sussex County, home is an escape from the congestion with its rich farming and coastal landscape and community intent on preserving history.

Southern saltwater and freshwater marshes, Cypress Swamp, and breathtaking ocean views not only attract seasonal tourists but also convince some of them to stay. Agriculture remains a dominant force, bringing in nearly $1.2 billion annually, with Sussex holding first place as the country’s largest producer of lima beans and broiler chickens. Approximately 45 percent of the county’s land is farmed (270,000 acres).

Despite the agrarian dominance, Sussex County’s population increased 11.7 percent during the past six years, which might not sound substantial until you consider the population has quadrupled since 1950 (from 61,000 to 225,000 in 2018). The largest population gains are along the coast and inland bays.

Population increases, tourism (exceeding $850 million in annual revenue), and an ideal location for manufacturing (easy access to water, land, and air) add to the economy. The influx of residents and consequent new construction boosts property tax and real estate transfer tax revenues, keeping the county’s property taxes among the lowest in the region.

Jones has worked in Sussex County public services for 30 years and chairs the Delaware Emergency Medical Dispatch Steering and Aero-Medical Committee. A center opened in 2008 near the Georgetown Airport features the latest state-of-the-art technology, including a GPS tracking system to better pinpoint 911 caller location for wireless devices.

Jones has been in the EOC since 1988 and before that, she worked for a private ambulance service. She oversees quality assurance for the 24 dual-certified (medical and fire) emergency dispatchers.

Does she like the changes Sussex County has experienced during her lifetime?

Relatively speaking, but there’s also a past Jones relishes in modern day.

She’s a huge history buff and active in the annual Sussex County Return Day—a 200-year-old Georgetown event where national and local politicians come together to celebrate the county’s heritage and symbolically bury the hatchet of political differences.

The politics don’t interest her so much as the impact of time on change.

“I think that sometimes looking at that and giving people a perspective of a simple thing, like a garment would have been used or remade or handed down until it was just nothing, and then it was made into a quilt or something,” she said. “Where today, if we get a stain on a shirt, we just go to the store to get a new one. Just bringing those kinds of things to show people how people lived back then, I think, is my greatest passion.”

Sources
It has never been so important for Public Safety to be interconnected as it is today—connecting Police with Fire, officers with information, and departments with the communities they serve. Interconnected technology for Police, Fire, and 911 from CentralSquare, provides innovative technology for the coordinated response needed for today’s most pressing public safety issues.

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**Scene Safety in an Opioid Epidemic**

May be hazardous—but not deadly—to health

Mike McEvoy

**Editor’s Note:** The article “When You Need It Most,” recently published in The Journal of Emergency Dispatch, drew comments asking us to clarify issues involving accidental exposure to fentanyl and its analogs. Mike McEvoy, Ph.D., NRP, RN, CCRN, EMS Coordinator—Saratoga County, New York (USA), offered his expertise from the field safety perspective. While “When You Need It Most” was primarily oriented toward changes to MPDS Protocol 23: Overdose/Poisoning (Ingestion), the Journal welcomed an article that adds to information regarding trained responder safety and expands the information available to lay rescuers and bystanders.

In June 2016, the Drug Enforcement Administration distributed a Roll Call video, “Fentanyl: A Real Threat to Law Enforcement.” The video and subsequent warnings about carfentanil, a more potent chemical analog of fentanyl, was intended to warn law enforcement not to field test confiscated substances because of the potential for exposure. Field testing suspected drugs is dangerous: it involves opening packages and handling unknown liquids and fine powders, something much more safely done in the controlled environment of a laboratory. Yet the wording, printed material, and dozens of stories from law enforcement officers who reportedly became ill after coming in contact with opioid users or their drugs set off a sweeping paranoia that continues today.

Warnings about fentanyl and other opioid products are compelling. Some would have you believe that merely brushing a small amount of opioid-containing liquid or powder against your skin could kill you quickly. Others suggest that touching an overdose victim to provide lifesaving care risks the health and safety of the responder, potentially making them the next opioid overdose victim. Responders have been encouraged to take extreme isolation precautions before entering a scene where opioids may be present or prior to providing care to a suspected overdose victim. Reflecting these concerns, Emergency Medical Dispatch instructions have suggested that dispatchers exercise extra caution and consider discontinuing treatment involving touching a patient if carfentanil is present or the caller questions the safety of touching an overdose patient.1

Toxicologists, who specialize in the study of the effects of drugs and chemicals on the human body, were very quick to respond. The American College of Medical Toxicology (ACMT) and American Academy of Clinical Toxicology (AACT) issued a joint position statement in 2017 disputing many of the warnings and arguing that the dangers of opioid exposures were being hugely overblown.2 There is no doubt that we are in the midst of a major opioid epidemic. More than 130 Americans die each day from opioids.3 But getting opioids into the body is not easy and never has been. In fact, it took years of research and testing to develop a drug delivery system that could miraculously, although very slowly
(3–13 hours), deliver fentanyl through a wearable skin patch.

Once in the body, opioids, even in overdose quantities, do not lead to instant death. The symptoms of an opioid overdose are very predictable and, regardless of whether a person is a chronic or first-time opioid user, take quite some time to kill. Loss of consciousness always precedes respiratory arrest, probably by at least 40 minutes. This time lapse is why bystander or first responder administration of naloxone, an opioid reversal agent, is so effective. People given opioids who are unaccustomed to them become nauseous, often vomit, and get dizzy and euphoric; they do not die instantly and never without plenty of warning.

The actual risk of overdose or adverse health effects from exposure to opioids is quite low for both civilian bystanders and emergency responders. Dermal exposure (absorption though the skin) can occur but takes hours and requires exposure of a large skin surface area. Fentanyl or a fentanyl analog that is observed on the skin (liquid, powder, or pill form) can be very quickly removed by brushing or washing with water and, even if removal is delayed, is very unlikely to be absorbed in any significant quantity. When washing hands or skin, alcohol-based sanitizers should not be used as they may increase absorption through the skin; soap and water are much safer. A single pair of nitrile gloves has been shown to be effective protection while providing care although rarely used today because of the increase in latex sensitivities among patients and responders, may not provide adequate skin protection against opioids.

Mucous membrane exposure (through the eyes, nose, and mouth) is another possible route of absorption of fentanyl and fentanyl analogs. While direct facial contact with opioid containing liquids or powder is unlikely, the tendency to inadvertently rub an eye or touch the face after contact with an unknown substance could potentially lead to exposure.

This includes gloved hands. If there is a high likelihood of splashing liquids or aerosolized powders, an N-95 mask, eye protection, and skin coverage with long sleeves, pants, or paper gowns should be considered. Unless these concerns exist, this additional Personal Protective Equipment (PPE) is unnecessary. If opioid drug particles are suspended in the air, then inhalation exposure could be a concern. While it is very likely that aerosolized carfentanil was used to overcome hostage takers at the Moscow theater in 2002, it is extremely unlikely that such a sophisticated dispersal device would be encountered at any local event. If that were the case, a HAZMAT response would be appropriate.

Based on all the media hype and increasing paranoia, the White House got involved during 2017–2018 in formulating recommendations for emergency responders. In concert with numerous federal partners and emergency responders’ organizations, they produced a poster, “Fentanyl Safety Recommendations for First Responders” and followed up with a downloadable video, “Fentanyl: The Real Deal,” to help subdue the perceived overreaction.

Both are available at whitehouse.gov/ondcp/key-issues/fentanyl. Other organizations also published guidelines and recommendations for emergency responders.

The National Institute for Occupational Safety and Health (NIOSH) Health Hazard Evaluation (HHE) Program is working to better understand workplace opioid exposures and health risks to emergency responders. They have investigated multiple suspected opioid exposures of first responders, many of which have had significant media coverage. In virtually all of these cases, no actual evidence of opioid absorption into the emergency responders was found. The NIOSH reports strongly suggest that an element of anxiety and nervousness, likely stemming from a great deal of misinformation, affected these responders, not an actual opioid exposure.

The most current recommendations regarding opioid exposures were published in Prehospital Emergency Care during 2018, consolidating the best evidence available to date. Overall, the likelihood of an opioid exposure to anyone (civilian or responder) is indeed very low to nearly nonexistent when providing EMD directed care to the routine overdose victim. Exposures can occur when there is significant contamination of the scene.

Again, in such cases, a single pair of nitrile gloves is adequate to protect a friend or family member providing care or administering naloxone to the victim. Nitrile gloves are usually provided in naloxone overdose treatment kits distributed in the community. If gloves are not available, handwashing with soap and water after providing patient care should be more than sufficient to remove any opioid from the hands and prevent an exposure.

Safety of emergency responders and bystanders is critical in this opioid epidemic. Having appropriate resources and sound medical recommendations that allow safe and efficient response to the hundreds of patients that depend on us each day will ensure that our responders and the public they serve are best protected.

Sources
5. See note 4.
HEART ATTACK AND SUDDEN CARDIAC ARREST
One is not like the other

Audrey Fraizer
As an EMD, you undoubtedly know that a heart attack is not the same as sudden cardiac arrest (SCA). However, you might not be aware of the differences and the corresponding Medical Priority Dispatch System™ (MPDS®) Protocols associated with heart attack, SCA, and heart disease.

The following anecdotes illustrate the experiences of a patient—an EMD—who suffered a heart attack followed by SCA and a patient who had a heart attack.

Heart attack and sudden cardiac arrest

Chris Solomons, 51, went about his routine on July 24, 2010, like he always did. He poured a cup of coffee, ate a piece of toast, and smoked his first cigarette of the day before driving to his EMD job at Yorkshire Air Ambulance Service (U.K.).

And that’s when things started to change.

While on his way to work, Solomons felt a pins and needles sensation in his arms and up and down his legs. He began to sweat. A “horrendous” pain in his chest almost forced him to turn the car around but being just five minutes away from the control room, he continued driving despite worsening symptoms. His hands were shaking so hard he couldn’t call for help on his cellphone.

“I realized something was going on,” Solomons later recalled. “This was not any type of indigestion.”

Solomons parked his car and stumbled into the center, where, coincidentally, a BBC camera crew was filming an episode in the series “Helicopter Heroes.” They turned their cameras toward Solomons just as paramedics James Vine and Lee Davison were applying cardiac monitor leads to his chest. The readout was unmistakable. Solomons was having a heart attack, and within seconds he was in cardiac arrest. Vine and Davison laid Solomons on the floor and shocked him twice with a defibrillator. A Yorkshire Air Ambulance transported Solomons to the catheterization lab at Leeds General Infirmary.

He survived.

Although Solomons remembers little aside from the initial pain, he was told that everything happened within two hours of his first signs of pain.

“This is not something I would want to experience again,” he said. “This is not something I’d like anyone to experience.” He calls the paramedics whose quick action saved his life “very special friends.”

Solomons worked as an EMD with the Yorkshire Ambulance Service for 20 years before moving to the patient transport service. He travels worldwide to tell his story of survival from SCA as his way, he said, of giving thanks for the help he received. The BBC crew’s video footage is used—with Solomons’ encouragement—to educate and inspire others on the importance of early intervention.

Heart attack

When Julia Allen, 46, Charlotte, North Carolina (USA), began experiencing chest pains, she stopped at home to leave a key for her kids and make them an after-school snack. Only then did she go to the hospital.

Allen had started her day the way she normally does: groan when the alarm clock rang, get the kids ready for school, and grab a quick breakfast before leaving for work. Only when she arrived at her office did she start feeling sick or, possibly, slow down long enough to realize she was feeling sick. The heartburn she could easily confuse as gas, although it was accompanied by nausea, dizziness, shortness of breath, tightening in her jaw, and pain down her arm.

Heart attack? Of course not. That was totally off her radar. Heart disease happened to other people.
At the hospital, Allen told an ER staff member that she was having a heart attack seconds before collapsing. An angiogram showed that her left ventricle was 80 percent blocked. Surgery was immediate. She survived.

Allen had admittedly ignored the red flags: high blood pressure, increasing weight and cholesterol levels, and a family history of heart disease. She started eating healthier foods, began exercising, and let go of perfectionist standards that contributed to stress.

“If you come to my house now, I guarantee there will be crumbs on the counter and dirty laundry in the basement,” she said. “I just let it go and don’t worry about it.”

Heart attack
A heart attack is a circulation problem.

A blocked artery prevents oxygen-rich blood from reaching a section of the heart. If the blocked artery is not reopened quickly, the part of the heart normally nourished by that artery begins to die.

Symptoms of a heart attack may be immediate and may include intense discomfort in the chest or other areas of the upper body, shortness of breath, cold sweats, and/or nausea/vomiting. More often, though, symptoms start slowly and persist for hours, days, or weeks before a heart attack. Unlike cardiac arrest, the heart usually does not stop beating during a heart attack.

Most heart attacks happen on Monday mornings. In the early morning hours, blood platelets are stickier, a person is partially dehydrated, and stress hormones (such as cortisol) are at their peak.

Most heart attacks are 27 percent more likely to happen around your birthday. They are also most likely to occur on Christmas Day, the day after Christmas, and New Year’s Day.

Women have different heart attack symptoms (nausea, indigestion, and shoulder aches) compared to classic symptoms that men experience (moderate to severe chest pain, radiating pain in arms and chest, dizziness, and shortness of breath).

Cardiac arrest
Cardiac arrest is an electrical problem.

An electrical malfunction in the heart that causes an irregular heartbeat (arrhythmia) can trigger cardiac arrest. With its pumping action disrupted, the heart cannot pump blood to the brain, lungs, and other organs.

Cardiac arrest occurs suddenly and dramatically. A person in cardiac arrest will be unresponsive and will usually stop breathing (or just gasp ineffectively). A cardiac arrest can be lethal within a matter of minutes if the person does not receive CPR and/or cardiac defibrillation.

Most heart attacks do not lead to cardiac arrest. But when cardiac arrest occurs, heart attack is a common cause. Other conditions may also disrupt the heart’s rhythm and lead to cardiac arrest.

Globally, cardiac arrest claims more lives than colorectal cancer, breast cancer, prostate cancer, influenza, pneumonia, auto accidents, HIV, firearms, and house fires combined.

The 2017 Heart Disease and Stroke Statistics state that among the 356,000 out-of-hospital cardiac arrests that occurred, 46 percent received bystander CPR.

A victim’s chances of survival are reduced with every minute that passes without CPR and defibrillation.

Protocols
In the United States, chest pain is the second most common reason for emergency department visits. A patient’s primary complaint of “chest pain” may reflect a broad range of underlying causes; therefore, it is important that emergency medical services (EMS) agencies gain a thorough understanding of these cases, beginning with the initial management of chest pain in the 911 center. The caller’s answer to “Okay, tell me exactly what happened” drives the Chief Complaint. An EMD cannot assume a diagnosis. Three Chief Complaints in the MPDS address conditions of the heart.

• Protocol 9: Cardiac or Respiratory Arrest/Death
• Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic)
• Protocol 19: Heart Problems/A.I.C.D.

For all patients, Case Entry Questions asking if the patient is unconscious and not breathing determines whether cardiac arrest has occurred. The Case Entry Questions also determine the most appropriate level of response. If a cardiac arrest is verified, the EMD gives first responders the Chief Complaint, approximate age, consciousness and breathing status, and the Determinant Code, facilitating preparation for possible use of an automated external defibrillator. Pre-Arrival Instructions in the case of a cardiac arrest would entail dispatcher-assisted CPR.

For a patient with chest pain, additional dispatcher interactions with the caller are recommended to overcome caller or patient denial or to validate that the caller’s descriptions of symptoms and signs may represent the presentation of a heart attack. Specifically, in Key Question 3 of Protocol 10 the EMD asks, “Is s/he changing color?” and in Key Question 4 of Protocol 10, the EMD asks, “Is s/he clammy or having cold sweats?”
Protocol 9: Cardiac or Respiratory Arrest/Death

Cardiac arrest and respiratory arrest are time-critical events, and Protocol 9 serves as a buffer between Case Entry Protocol and Pre-Arrival Instructions. The patient is not breathing and unresponsive. When someone stops breathing, the heart soon stops as the blood oxygen levels decrease and can no longer sustain the heart.

In cases 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. The ECHO Determinant Codes provide EMDs with a way to get a response moving quickly for the patient who is unresponsive and not breathing.

In cases where the caller describes a possible death, the EMD begins Protocol 9 Key Questions. 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 the caller.

Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic)

The Chest Pain Protocol is to be selected by EMDs whenever the caller reports a conscious person with a primary complaint of chest pain (not caused by trauma) or one or more of a defined set of heart attack symptoms, including any of the following: aching pain; chest pain/discomfort (now gone); constricting band; crushing discomfort (heaviness, numbness, pressure, tightness); or (similar) pain present in the arm, jaw, neck, or upper back.4

According to Rule 6 in Protocol 10, “Chest pain due to trauma (current or non-recent) should be handled on Protocol 30.”

Primarily due to the risk of acute coronary syndrome (ACS), the Emergency Medical Dispatcher must consider a complaint of non-traumatic chest pain in conscious adults of cardiac-risk age to be an unstable condition until serious causes can be ruled out, either through on-scene ALS paramedic assessment or further assessment in the hospital emergency department. For this reason, the MPDS places all chest pain patients age 35 and over in the DELTA or CHARLIE priority levels.5

The EMD need not give CPR PAIs unless the heart attack victim goes into cardiac arrest, which means the patient is unconscious and has stopped breathing.

The EMD need not give CPR PAIs unless the heart attack victim goes into cardiac arrest, which means the patient is unconscious and has stopped breathing.

Sources
5. See note 4.
DOING OUR PART TO HELP YOU DO YOURS.

In an emergency, a specially trained OnStar® Advisor is available to help all first responders 24 hours a day. Certified by the International Academies of Emergency Dispatch, our Advisors can provide pre-arrival medical assistance until you arrive.
A POSITIVE APPROACH

New standards guide Q’s to give strengths-based feedback

Josh McFadden
What’s your first thought when you hear someone throw the word “feedback” around? If you’re like many people, you may have a less-than-positive reaction. Though you probably realize it’s important for others to evaluate your work, you may have anxiety over hearing about all the things you did incorrectly.

After all, who likes getting chewed out?

A quick visit to merriam-webster.com reveals that the online dictionary defines feedback as “the transmission of evaluative or corrective information about an action, event, or process to the original or controlling source.”

Say what?

In essence, feedback is generally regarded as a corrective action. Does this make it sound as though when you receive feedback, someone is going to put you in your place so you can get with the program and get up to speed?

Of course, you probably realize that in both professional and personal settings, feedback doesn’t have to be—and ultimately shouldn’t be—a negative concept. It’s possible and preferable to give positive feedback to someone, though this doesn’t always happen.

Writing for the online version of Forbes Magazine, Cord Himelstein suggested, “Positive feedback loops are a fundamental concept in psychology, and the science behind them is simple: Give people feedback about their actions in a timely manner without fear of reprisal, and it gives them a healthy opportunity to work toward better behaviors. Strong feedback loops strengthen relationships on the whole, making them more resilient to change or adversity. [They are] much more effective at encouraging behavior change than giving orders or reprimands.”

Does this make more sense than sitting down with a manager who gives you a long list of all the mistakes you’ve made or who even chides you for all the areas in which you’ve come up short?

After more than two years of studying feedback and evaluation, the International Academies of Emergency Dispatch made some recent changes to the way Q’s evaluate emergency dispatchers in the QA/QI process. These new methods are part of the Performance Standards 10th Edition.

A new era of case review and quality management

In May 2018, the IAED™ rolled out the Performance Standards 10th Edition as the latest set of performance requirements for medical, police, and fire emergency calltaking. Fully integrated into AQUA® Ascent, these standards are used when communication center Q’s review recorded emergency calls for quality.

Perhaps the biggest change to this update and the most significant aspect of the Performance Standards 10th Edition is that case review and quality management are no longer just about deviations from established standards, but allow the reviewer to discuss overall performance with the emergency dispatcher.

This approach does away with anxiety-filled evaluations and introduces a strengths-based way to review calls and provide feedback. What results is a much more positive meeting where the emergency dispatcher can move forward knowing what he or she is doing well in addition to ways in which improvement can come.

Standards in this update are also more succinct and clear. This helps ED-Qs not only review calls more quickly but also more accurately. In fact, this innovative approach cuts down on the total number of cases your center has to review.

Brian Dale, Associate Director of Medical Control and Quality Processes for the IAED, said, “Standards 10 makes it possible for management, ED-Qs, and emergency dispatchers to focus on improving the system, both of the calltakers and the software they’re using.”

Early feedback about the Performance Standards 10th Edition following NAVIGATOR 2018 in Las Vegas, Nevada,
(USA), was overwhelmingly positive, and QA/QI professionals in agencies everywhere continue to heap praise on the new feedback direction.

**Out with the old**

If you’ve ever dreaded meeting with an ED-Q™ to discuss QA/QI, you’re not alone. In the past, it has been common for emergency dispatchers to look at these review sessions with trepidation and nervousness. These case review meetings may have even been painful, leaving you with feelings of failure.

For Q’s, the review process has been challenging as well. The old system required them to point out INSIGNIFICANT errors and call out even the most minor mistakes in calltaking. This made interactions with emergency dispatchers awkward and could even sour relationships with increased tension and negativity. ED-Qs have faced a full plate of thankless assignments and often worked themselves into exhaustion with the frustrating tasks of delivering negative feedback.

Things have changed for the better. The Performance Standards 10th Edition helps foster more positive dialogue between Q’s and emergency dispatchers. Now, these professionals can have a meaningful, productive discussion about the person’s performance without focusing on deviations. The simplified, streamlined standards are clearer and better outline expectations.

**Is negative feedback ever OK?**

An emergency communication center is a unique place, different from most other workplaces. Each day, you speak with emotionally charged callers on the worst days of their lives.

During the course of a typical day, you could experience the lows of knowing a patient didn’t survive despite a caller’s CPR attempts, and you could go through the highs of helping bring a new baby into the world through over-the-phone delivery instructions. Your feelings could move from fear, shock, grief, or pain to elation, relief, or gratitude in a matter of minutes.

You often reach the brink of human capacity when it comes to managing your emotions. It’s one thing to stay on the line with a frantic caller who’s involved in a life-or-death struggle or to take the relentless barrage of verbal abuse that often comes from frightened, angry people. But receiving negative feedback from a supervisor or Q might be the last thing you want to hear in the middle of another challenging day under the headset.

However, in the workplace, there are times when a manager may need to sit down with an employee and discuss the need for improvement. In fact, some people respond well to such direction and use it as a catalyst for positive change.

Houston Chronicle writer Jared Lewis points out, “Other employees not only change their behavior in response to negative feedback, but also feed off the feedback as a source of motivation. Those who are either angered or at least driven to do a better job can use the negative feedback as a means of improvement in terms of performance. Some people approach negative feedback with the attitude that they will show the employer that the feedback he provided was wrong. With these employees, the ‘I’ll show you’ attitude usually prevails.”

Lewis further argues that other workers reflect deeply on negative feedback and allow it to shape their attitudes and govern the way they approach their work going forward.

“Some employees respond to negative feedback in a less emotional and more cerebral manner,” he said. “These employees assess the feedback as an opportunity for self-reflection and a learning opportunity. These eternal optimists see the feedback as an indication that they need to pay closer attention to their own performance and behavior so that they can do a better job in the future. In this sense, negative feedback inspires change.”
The harmful consequences of negative feedback

The effects of negatively focused feedback can be detrimental in the comm. center to Q’s, managers, emergency dispatchers, and to the workplace as a whole.

In a counter-argument to Lewis’ viewpoint, fellow Houston Chronicle business writer Lisa Mooney asserts, “Giving negative feedback to an employee is one way of addressing an issue, but it is often one laden with repercussions that are harmful to your business.”

While it’s true that presenting an employee with a list of things to do or she messed up may think he or she is not capable of fulfilling his or her duties and isn’t fit for the job.

2. Fear: Just because someone made a mistake in handling a call doesn’t mean he or she should be out of a job. But some workers would have these fears if most of the feedback they received was negative. When negative feedback runs rampant through the comm. center, employees may be afraid to talk to managers or Q’s or approach them with concerns.

3. Job satisfaction: It’s no secret that high turnover is a constant challenge in comm. centers across the world. Emergency dispatchers leave agencies or even the profession for various reasons, but job satisfaction is certainly a factor. When managers omit positive comments and fail to point out successes in a person’s work, the employee’s motivation to remain with the company may quickly sour, and he or she will likely shop around for other opportunities.

Diane Alexander, a researcher at the University of Rhode Island, proposed that an employee might lose the desire to contribute to the workplace due to the personal reaction to a negative performance review. She said it’s important for managers to address this worker’s need to be reaffirmed by giving him or her examples in which he or she has excelled at work and assuring the worker that management will acknowledge and appreciate future efforts.

4. Resentment: As a Q or manager, if you give an abundance of negative feedback without discussing strengths and accomplishments, you could inadvertently develop a cold relationship with that employee.

A better way

Thankfully, with the Performance Standards 10th Edition, Q’s and emergency dispatchers alike can avoid many of the challenges other organizations face with evaluations and reviews. While there is certainly no infallible system, the Performance Standards 10th Edition helps remove the barriers to positive communication by recognizing performance more than highlighting mistakes.

The Council of Standards approved this new direction after the IAED received input from members across the globe. In summary, here are the key details of the Performance Standards 10th Edition:

- Simplified and streamlined performance requirements
- The focus is on emergency dispatcher performance, not deviations and errors
- Research based
- Q’s are to review fewer cases
- Built into AQUA 7 Ascent for a faster and easier case review process
- ED-Qs and management can focus on improving system performance
- ED-Qs now look for excellent calls and can give them exemplary status
- Does away with insignificant errors

Work to recognize performance rather than highlight mistakes.

better or with a rundown of all the things he or she does incorrectly can inspire some people, Mooney said this approach won’t produce the long-term impact management ultimately wants.

“While an employer must do what is needed to stop adverse behavior, he should be prepared to provide positive feedback where possible. Giving positive feedback increases the employee’s desire to exhibit more positive behavior—resulting in more productivity and a happier workplace.”

Mooney offers four potential results in an office where negative feedback flows freely: low self-esteem, fear, poor job satisfaction, and resentment.

1. Low self-esteem: Focusing on what the employee is doing wrong could damage a person’s confidence. For example, an emergency dispatcher who only hears how many times he

Sources

3. See note 2.
5. See note 4.
With Academy Analytics you can:

- Monitor your center’s ProQA performance from anywhere!
- Instantly identify outlier cases for review.
- Provide teammates with a dashboard that shows how they are doing on the things that matter.
- Know when there is an increase in aborted or overridden calls.
- Balance the workload to help manage employee stress.
- Coach your team to optimal performance.
- Potentially increase the number of cardiac arrest patients that survive.

For the latest videos, visit: www.firstwatch.net/aa
NOT AN ‘EMERGENCY,’ BUT ...
Even minor calls can be major

Becca Barrus

Imagine, if you will, a family comprised of six children and two parents noisily piling out of a 15-passenger van to spend an evening at a park. A few minutes into the revelries, the parents discover that they are one child short. They leave the playground and head back to the van only to find that their toddler is still strapped in his car seat, the doors locked.

No problem; they’ll just unlock the doors and ... that’s when they see the keys dangling in the ignition.

Speaking as a child from a big family, this happened to my parents fairly often, at least once or twice per child. Sometimes they had another set of keys on them, and sometimes they had to call the locksmith or the local police precinct to come jimmy the locks.

As an Emergency Police Dispatcher (EPD), there are a few Police Priority Dispatch System™ (PPDS™) Protocols that seem minor—at least when compared to an active assailant or robbery—but are hugely important to the callers. In this Police CDE, we will be looking specifically at PPDS v6 Protocol 103: Administrative (Lost or Found Property, Found Unexploded Ordnance, Messages, Transports), Protocol 125: Public Service (Lock-out/Lock-in, Peace, Welfare, Reckless Activity), and Protocol 128: Supplemental.

Protocol 103: Administrative (Lost or Found Property, Found Unexploded Ordnance, Messages, Transports)

At first glance, Protocol 103 doesn’t sound very exciting—the name “Administrative” has one picturing stacks of dull paperwork and being on hold for long amounts of time. The Sub-Chief Complaints are mildly more interesting, if only because “Found UNEXPLODED ORDNANCE” doesn’t seem to fit in with the rest of them. What is an UNEXPLODED ORDNANCE, you may be wondering? The term can encompass anything from a land mine to a grenade to old bullets.

If an UNEXPLODED ORDNANCE is basically an explosive, then what’s the difference between triaging a call as a found UNEXPLODED ORDNANCE and a bomb found? According to Bob Pastula, PDS™ Program Administrator—Law Enforcement, it’s intent.

“An UNEXPLODED ORDNANCE is something that could harm people, but wasn’t purposely put there to harm people,” Pastula said.

For example, the Isle of Guernsey was occupied by Germany in World War II, and it’s not uncommon for the inhabitants to find old German bombs while digging in their yards. Another example is someone finding a souvenir
grenade or bullets when cleaning out his or her grandfather’s attic. The original makers or possessors of the weaponry meant harm, but Grandpa didn’t bring back the grenade from ‘Nam in order to hurt his grandkids. That is why “Found UNEXPLODED ORDNANCE” is on Protocol 103 rather than Protocol 109.

It’s a far better idea for people who find an UNEXPLODED ORDNANCE to call their local precinct and have the proper authorities come dispose of it than it is to bring a box of old grenades into a police department, as one couple in Sunnyvale, California (USA), found out on a hot day in July 2017.

The couple brought a box of “three rocket-propelled grenades and dozens of rounds of rusted ammunition” into the lobby of Sunnyvale’s police and fire and emergency dispatch department headquarters, which caused the whole building to be evacuated until the bomb squad could come dismantle the ordnances.1

The words of Capt. Shawn Ahearn, spokesman for the Sunnyvale Department of Public Safety, apply everywhere, not just California: “If you find anything you believe is an explosive or ammunition, leave it where it’s at. Don’t touch it. Evacuate the area and call 911. We’ll handle it.”2

UNEXPLODED ORDNANCES aside, Protocol 103 has six other fairly self-explanatory Sub-Chief Complaints: Prisoner/Person transport, Blood or organ transport, Escort, Message delivery, Lost/Found property, and Other.

According to Pastula, Blood or organ transport isn’t used as often as it used to be in the PPDS. Before ambulances and medical helicopters were widespread, state troopers would transport organs or blood from one hospital to another or to a research hospital. For instance, there’s an eye institute in Jacksonville, Florida (USA), and if someone had an accident in Miami and needed eyes, the state troopers would relay the organs (in a cooler) from jurisdiction to jurisdiction until they reached the hospital that needed them. And that might still be the case in more rural areas. These days, in Florida at least, a hospital might call law enforcement to pick up an organ or blood transport to take it to the airport, but that’s about the extent of it.

“Message delivery” is a similar concept, except the thing being delivered across jurisdictions is words instead of human viscera. If a person is injured in a car accident three counties away from their home county, the responding police department will send a message to the home county to have a police officer there deliver news of the accident to the person’s family.

Protocol 103: Administrative can also be used to deliver notices of death to next of kin.

Protocol 125: Public Service (Lock-out/Lock-in, Peace, Welfare, Reckless Activity)

“Public Service” handles—you guessed it—calls from the public requesting specific services from the police. Unlike Protocol 103, which deals with a mix of calls from internal and external entities, Protocol 125 solely focuses on calls from external entities, whether the callers are locked out of their house or reporting reckless activity in their neighborhood.

An example of a lock-out/lock-in would be the scenario at the beginning of the article; keys have been locked inside a car and a spare set of keys is not readily available. Whether or not the car is running or a person is in the car will dictate whether the call will be triaged as an URGENT lock-out/lock-in (125-D-2) or a NON-URGENT lock-out/lock-in (125-B-2). URGENT lock-out/lock-in situations are determined by whether or not the situation may be life threatening. For example, if a toddler is accidentally locked inside a car on a blisteringly hot day, it is more urgent than if a toddler is accidentally locked inside a car on a mild day. Chris Knight, Chief of Priority Dispatch® Program Management and Implementations, said that most larger police departments won’t respond to low-acuity lock-out/lock-in calls simply because they don’t have enough resources to do so. Additionally, the departments don’t want to be liable for broken locks or windows. Check to see if your agency responds to lock-out/lock-in calls.

If a child is locked inside a car and there is no adult present, that would be handled under Protocol 102: Abuse/Abandonment/Neglect.
The concept of URGENT versus NON-URGENT carries on to another Sub-Chief Complaint in this protocol: check-the-welfare. As with lock-out/lock-in, a situation's qualification as “URGENT” depends on whether or not the person has not been seen or heard from in a typical period of time or if a situation may be life threatening. An URGENT check-the-welfare warrants 125-D-1. This can include checking the welfare of members of vulnerable populations, such as elderly people and young children, or any call where the caller expresses concern for the person’s welfare. An example of a NON-URGENT check-the-welfare may be a homeless person searching for a place to sleep, as stated by Axiom 3.

Keep in mind that Axiom 2 states that “check-the-welfare calls should be considered crime scenes until proven otherwise.”

The other DELTA-level Determinant Code on Protocol 125 is RECKLESS ACTIVITY. What constitutes reckless activity and how does it differ from, say, a disturbance/nuisance? According to Pastula, a disturbance or nuisance is something that is interrupting someone’s peace—it’s not necessarily dangerous, just annoying.

“Reckless activity is when someone is putting their own life or somebody else’s in danger,” Pastula said. Examples include bridge sitting, car surfing (standing on top of a car when it is moving), and having a sled pulled through the snow by a car. Complaints about skateboarders would be handled on Protocol 113: Disturbance/Nuisance, unless the skateboarders were engaging in dangerous activity, like skateboarding off a roof.

KEEP THE PEACE is not the same thing as sending a police officer to intervene in a disturbance/nuisance or RECKLESS ACTIVITY situation. It is arranged in advance—at least, in cases of ALPHA-level situations—not while the event is happening. Generally it is used to have a police officer standing by while people obtain property or exchange children in cases of shared custody. There are times, however, when someone has stormed out of the abode in the heat of the moment and calls 911 to have a police officer stand by while he or she goes back into the house to get something quickly before leaving again. He or she did not call the police in order to resolve the argument or to report a domestic violence situation; the purpose of having an officer on hand is to avoid escalation.

Protocol 128: Supplemental

Of the three protocols discussed in this article, Protocol 128 seems the most straightforward—it’s only used when someone calls to add further information to an already existing incident report. The kind of additional information can be a suspect description, an evidence description, a weapon description, a vehicle description, or a stolen item description. Not a single Determinant Descriptor on Protocol 128 can receive higher than a BRAVO-level designation.

That does not, however, mean that calls triaged through this protocol are any less important than higher acuity calls.

Due to how the human brain reacts to traumatic situations, it often takes at least two days (two sleep cycles) for a person to process the events of a traumatic incident, such as a car accident, shooting, or sexual assault. Therefore, it is imperative to give people an opportunity to add more information to their cases as it comes to them.

An important thing to remember about Protocols 103, 125, and 128 is that, although there are exceptions, they are “primarily low-acuity events,” Knight said. However, that doesn’t mean that it isn’t important to follow the protocol and do what you can to serve the caller.

Sources
2. See note 1.
Answers to this quiz are found in the article “Not An ‘Emergency,’ But ...,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. Which of the following would NOT fall under the definition of an UNEXPLODED ORDNANCE?
   a. suspicious package
   b. hand grenade
   c. land mine
   d. old bullets

2. What is the difference between a found UNEXPLODED ORDNANCE and a bomb found?
   a. size
   b. intent
   c. location
   d. materials

3. Which protocol would be used to deliver a notice of death to next of kin?
   a. Protocol 103
   b. Protocol 122
   c. Protocol 125
   d. Protocol 128

4. An URGENT lock-out/lock-in warrants a(n)____-level response, whereas a NON-URGENT lock-out/lock-in warrants a(n)____-level response.
   a. ECHO; CHARLIE
   b. DELTA; BRAVO
   c. DELTA; CHARLIE
   d. BRAVO; ALPHA

5. Every agency that uses PPDS must respond to lock-out/lock-in calls.
   a. true
   b. false

6. Which Determinant Code would you use for URGENT check-the-welfare?
   a. 125-A-1
   b. 125-B-1
   c. 125-C-1
   d. 125-D-1

7. A call reporting teenagers skateboarding off a roof would be handled on Protocol 113 and not on Protocol 125.
   a. true
   b. false

8. Which Sub-Chief Complaint on Protocol 125 should be used to send a police officer to stand by while people obtain property or exchange children?
   a. Check-the-welfare
   b. DOMESTIC DISTURBANCE
   c. KEEP THE PEACE
   d. NUISANCE

9. Which protocol is used only when someone calls to add further information to an already existing incident report?
   a. Protocol 102
   b. Protocol 103
   c. Protocol 125
   d. Protocol 128

10. Protocols 103, 125, and 128 are primarily low-acuity events, although there are exceptions.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 04/30/20. 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.
When Emmanuel Negedu fell to the turf after lifting weights with his teammates and winning a race on the indoor football field in 2009, the 20-year-old’s teammates thought he was pulling a prank.1 But when the 6-foot-7-inch University of Tennessee (USA) basketball player didn’t stand up and laugh, things took a serious turn. Senior Associate Athletic Trainer Chad Newman and Director of Sports Medicine Jason McVeigh converged on the scene to help. Newman was unable to find a pulse and asked someone to bring the AED. McVeigh arrived on scene at the same time as the AED.

The machine was set up. It analyzed Negedu’s heart arrhythmia and shocked his heart back into a normal rhythm. Newman administered CPR until Negedu’s heartbeat and breathing stabilized. Negedu had suffered sudden cardiac arrest caused by ventricular fibrillation.

Negedu was transported to UT Medical Center where he stayed for several days before being discharged.

"It was a big shock," he said. "Still now, I don't believe that happened. But it happened. I feel great now, just like I felt before."

What is sudden cardiac arrest vs. a heart attack?

As its name suggests, sudden cardiac arrest (SCA) happens suddenly and often without any warning. It is triggered by an electrical malfunction in the heart, which causes arrhythmia (irregular heartbeat).2 Since the heart’s pumping action is disrupted, this means that the heart is unable to pump blood to the lungs, brain, and other organs. Within seconds, a person loses consciousness and doesn’t have a pulse. If no treatment is started, a person can die within minutes. More than 320,000 out-of-hospital cardiac arrests occur every year in the United States, and a number of those are from a reversible cardiac arrhythmia known as ventricular fibrillation (V-fib). It’s estimated that about 7,000 children suffer sudden cardiac arrest each year.3

A heart attack, on the other hand, takes place when a blocked artery prevents oxygen-rich blood from reaching a section of the heart.4 Unless the blocked artery is reopened quickly, the part of the heart that receives its nourishment from that artery begins to die. The longer the amount of time passes without treatment, the more damage that occurs. The heart usually keeps beating during a heart attack, unlike during sudden cardiac arrest.

Sudden cardiac arrest and heart attacks share a connection. SCA can
happen after a heart attack or during recovery. Heart attacks increase the risk for sudden cardiac arrest, but most heart attacks do not lead to sudden cardiac arrest. When sudden cardiac arrest does occur, a heart attack can often be the cause. But other heart conditions can also disrupt the heart’s rhythm, which can lead to sudden cardiac arrest. These conditions include heart failure, thickened heart muscle, long Q-T syndrome, and arrhythmias, especially ventricular fibrillation.

**What is ventricular fibrillation?**

V-fib is a potentially deadly cardiac rhythm disturbance. Instead of beating (contracting) normally, abnormally electrical activity makes the ventricles (the heart's lower chambers) quiver, or fibrillate. This stops the heart from pumping blood, which causes collapse and cardiac arrest. V-fib is most commonly caused by damage to the heart muscle during a heart attack. It can also be caused by other heart conditions such as cardiomyopathy (heart muscle disease), congenital heart defects, and in some cases, conditions external to the heart including sepsis (severe body infection), drug toxicity, and electric shock.

**What happens for a SCA patient?**

Estimates say that more than 95 percent of cardiac arrest victims die before they reach a hospital. A victim needs defibrillation to stop V-fib, according to the European Resuscitation Council and the American Heart Association. While V-fib makes up only 18.7 percent of all out-of-hospital cardiac arrests (OHCA) in the United States, it is considered a reversible condition when treated immediately with a defibrillator. It is the subject of much attention in emergency medical services (EMS) and emergency dispatch because bystanders can often make a difference before trained responders arrive.

Each minute the brain goes without oxygen, the less likely a patient is to return to a normal life—even if resuscitation happens within 10 minutes. After 10 minutes, most resuscitation attempts are unsuccessful. If a patient receives a defibrillation shock within 5 minutes, he or she has a 50 percent survival rate.

Because of the time-sensitive nature, automated external defibrillators (AEDs) have been and continue to be placed in public places such as schools, casinos, airplanes, and passenger trains. This is why: The average call-to-shock time is nine minutes for a “typical community” according to Cardiac Science’s “Lives Lost—The Case for AEDs in Your Organization.” In a mid-sized urban community, the median response time is 6.6 minutes for EMS. Emergency response may be further delayed in cities during rush hour traffic or with crowded elevators.

**Automated external defibrillators**

An AED is a portable, lightweight device that delivers an electric shock through the chest to the heart. The shock has the potential to stop an irregular heartbeat and allow for a normal rhythm to begin again after SCA.

An AED has a built-in computer that checks the heart rhythm through adhesive electrodes applied to the victim's chest. The computer calculates if defibrillation is needed—a shock is advised only in cases of V-fib or pulseless ventricular tachycardia. When a shock is needed, the AED’s recorded voice tells the bystander to press the shock button on the AED. The shock momentarily stuns the heart and stops the heart’s activity. This gives the heart a chance to resume normal heart rhythm.

AEDs offer a quicker response in a life-threatening situation and allow non-medical personnel to help before EMS arrives on scene.

**Pre-Arrival Instruction selection**

When a caller reports on Case Entry that the patient is Obviously NOT BREATHING and Unconscious (non-traumatic), the EMD codes the call as a 9-E-1, goes directly to Post-Dispatch Instructions, and provides PDI-a. The EMD has several options now. If the patient is an infant who is less than 30 days old, the EMD will go to Protocol N: Airway/Arrest/Choking (Unconscious)—Newborn/Neonate < 30 Days. If the infant is older than 30 days but younger than one year, the EMD will go to either Protocol A: Airway/Arrest/Choking (Unconscious)—Infant < 1 yr or Protocol Ya: Tracheostomy (Stoma) Airway/Arrest/Choking (Unconscious)—Infant < 1 yr.

For patients older than one year, there are four options, depending on age and if the patient has a tracheostomy. For a stoma patient, the EMD will select either Protocol Yb: Tracheostomy (Stoma) Airway/Arrest/Choking (Unconscious)—Child 1-7 yrs or Protocol Yc: Tracheostomy (Stoma) Airway/Arrest/Choking (Unconscious)—Adult ≥ 8 yrs. More often, the EMD will use Protocol B: Airway/Arrest/Choking (Unconscious)—Child 1-7 yrs or Protocol C: Airway/Arrest/Choking (Unconscious)—Adult ≥ 8 yrs.
If the person retrieving the AED has not yet returned, the EMD will use Panel Z-3 to direct the bystander to begin CPR (Panel BC-4). When the AED is on scene, the EMD will go to Panel Z-4 and begin AED administration instructions. The EMD should keep in mind Brock’s Law: The presence of an AED does not ensure its use—the EMD does.

The next series of steps are for setting up the AED. EMDs should be aware of the informational panels (T1–6) that offer troubleshooting in the form of additional information and/or questions to ask the caller. Panel Z-5 says “Undo or remove any clothing from her/his chest. If her/his chest is wet (sweaty), dry it off.” T1 Remove Clothing helps clarify this by offering additional information regarding which clothing can be left on and what should be cut or removed.

Panel Z-6 says “Open the lid, if necessary, and press the ‘on’ button, if there is one.” The EMD follows up by asking if the machine is on. If the caller answers no, the EMD can read T2 Machine not on. Once the AED is ready to go, the EMD tells the caller to find the pads and plug them into the machine if necessary. The caller is then directed to peel off the backing of the pads and apply them to the patient’s bare chest.

T4 directs the EMD to let the caller know to refer to the picture to clear up any confusion about where they should be placed.

Once the pads have been correctly placed, the machine will give instructions. In Panel Z-9, the blue panel (for the EMD) advises that the most likely sequence is analyze and shock. If there are problems with the analysis portion, then the EMD can troubleshoot on T5. If problems arise with the shock portion, the EMD can ask questions located on T6 to better understand what’s happening on scene. If the AED’s analysis doesn’t find a shockable rhythm or if the analyze/shock cycle is given without results, the AED will advise the caller to perform CPR.

Panel Z-10 tells the EMD to go to BC-4 and have the caller perform CPR for two minutes unless interrupted by the AED. Remember, at this point the voice prompts on the AED device are directing the bystander on what specific steps to take. The EMD fills a supportive role here, encouraging the caller to complete the steps advised by the AED device, and when CPR is advised, using the metronome to set the pace of the compressions for the caller/bystander.

After the two minutes have passed, the EMD should return to Panel Z-10; the machine should reanalyze and may administer a shock before advising more CPR.

If the AED does advise more CPR, go to Panel Z-11 where it tells the EMD to go to Protocol C-9/B-8 and have the caller perform CPR for two minutes unless interrupted by the AED. Once the two minutes of CPR are over, the EMD should return to Panel Z-11. Like Panel Z-10, the AED should then reanalyze and may shock again before advising more CPR.

If more CPR is advised, the EMD will give directions from Panel Z-12, which include more CPR from Protocols C-9/B-8 and following the AED’s prompts. The EMD will repeat this panel until help arrives unless the patient begins breathing. In that case, the EMD will continue with Protocol B or C until help arrives.

Sources

4. See note 2.
6. See note 3.
8. See note 3.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

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

1. Sudden cardiac arrest happens suddenly, triggered by a(n) ______ in the heart, causing ______.
   a. electrical malfunction; arrhythmia
   b. blocked artery; damage to heart muscle
   c. electrical malfunction; a blockage

2. How many children suffer sudden cardiac arrest each year?
   a. 1,500
   b. 3,000
   c. 7,000
   d. 10,000

3. The heart usually keeps beating during a heart attack, but it stops beating during sudden cardiac arrest.
   a. true
   b. false

4. Disordered electrical activity makes the ventricles quiver. What are the ventricles?
   a. the heart’s upper chambers
   b. the heart’s lower chambers
   c. bands of muscle in the heart
   d. tendons in the heart

5. Ventricular fibrillation is considered a reversible condition when treated immediately with what?
   a. aspirin
   b. nitroglycerin
   c. defibrillator

6. A patient who receives a defibrillation shock within 5 minutes has a ____ percent survival rate.
   a. 15
   b. 25
   c. 40
   d. 50

7. The AED’s built-in computer checks the patient’s heart rhythm and calculates if defibrillation is needed. A shock is only advised in cases of ventricular fibrillation or pulseless ventricular tachycardia.
   a. true
   b. false

8. Protocol Z: AED Support is used in combination with which other protocols?
   a. Protocols N and Ya
   b. Protocols N, D, and F
   c. Protocols N, Ya, and F
   d. Protocols B, C, Yb, and Yc

9. What is Brock’s Law?
   a. The presence of an AED ensures its use.
   b. The presence of an AED does not ensure its use—the EMD does.
   c. The presence of an AED does not ensure its use—the bystander does.

10. The EMD will repeat Panel Z-12 until help arrives unless:
    a. the patient begins breathing.
    b. the bystander is tired.
    c. the patient turns ashen.

To be considered for CDE credit, this answer sheet must be received no later than 04/30/20. 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.
YOU MAKE ME PROMISES, PROMISES
You should believe this one
Heather Darata

About a decade after EMD came on the scene, the Orlando (Florida, USA) Fire Department implemented EMD.

Then, in September 1990, an article written by Lt. Kathy Keene from the Orlando FD appeared in Emergency Medical Services investigating whether EMD lives up to its promises—is the cost of implementing EMD justified by the “saves”? Lt. Keene reviews the Orlando Fire Department’s goals regarding EMD and two surveys created to see how these goals were being met.

Goal 1: To enhance patient care by achieving a “zero-minute response time”
Goal 2: To reduce dispatcher and field personnel stress
Goal 3: To increase professionalism and cooperation between dispatch and field units
Goal 4: To increase department efficiency by using BLS units for BLS calls

One survey was sent to 25 area dispatchers who were EMD course graduates. Seventeen surveys were completed and returned.

The survey assessing dispatchers’ views found that EMD works for dispatchers. Results were particularly high (80 percent or higher) when it came to the effectiveness of repetitive persistence, providing pre-arrival instructions, callers eagerly following PAIs, EMD procedures enhancing patient care, and EMD procedures allowing for better utilization of EMDs’ training and education.

Another survey was sent to 140 field personnel. Fifty-eight surveys were completed and returned.

The survey assessing field personnel found four points that rang truer (60 percent or higher) than others: EMD procedures increased the reliability of the dispatch information provided, benefits would come from dispatchers spending time in the field and field personnel spending time in dispatch, dispatch was more cooperative with EMD in place (some respondents said dispatch had always been cooperative), and EMD procedures enhanced patient care.

Lt. Keene points out in her article that EMD creates a circle of communication, provides a continuum of patient care, and influences agency employees in positive ways (feeling better about their jobs and knowing patients are receiving better care).

As she points out, “EMD has set up a win-win-win-win situation. Everyone—the caller, dispatcher, field personnel, and patient—benefits.”
any articles have been written over the last few years on emergency medical dispatch—articles extolling the virtues of EMD, promoting canned programs and outlining do-it-yourself approaches. These written pieces promise that EMD enhances patient care, relieves dispatcher stress and improves the efficiency of the overall organization.

Does EMD keep these promises?

There’s no doubt that several dramatic EMQ “saves” have been documented in the literature. But what about the issues of stress and efficiency? Does EMD make a difference to the organization on a day-to-day basis, or is it simply a bill of goods sold on the merits of those few inspiring “saves”? Can the cost of instituting EMD be justified by those “saves”?

Last year, several Central Florida agencies began training dispatchers in EMD procedures. Course development and implementation procedures were reported in this magazine in August 1989. Last January, the Orlando Fire Department began using EMD. As with any new program, it’s important to evaluate its impact on the organization. To do so, we reviewed the program’s original goals:

1. To enhance patient care by achieving a “zero-minute response time.”
2. To reduce dispatcher and field-personnel stress.
3. To increase professionalism and cooperation between dispatch and field units.
4. To increase department efficiency by using BLS units for BLS calls.

Determining how well these goals were met required us to trace EMD from the caller, to the dispatcher and field units, and then back to the caller. We devised two surveys: one directed at the dispatcher and a second for field personnel.

**DISPATCHERS’ VIEWS**

The dispatcher survey consisted of 10 statements, and dispatchers were asked to agree or disagree with each one. Space for comments was also provided.

The survey was sent to 25 area dispatchers, all of whom were EMD course graduates. Seventeen (68%) of the surveys were completed and returned. The raw data were compiled and final results determined by the percentage of “agree” responses.

The following results were obtained:

**Statement 1:** I have found that use of EMD procedures significantly delays (more than 30 seconds) unit dispatch. Forty-seven percent of the respondents disagree that EMD procedures cause any significant delay in dispatch time. While area managers had feared that EMD might delay dispatch, the data gathered from the survey eased their concerns.

**Statement 2:** Callers respond readily to interrogation; thus, information is easily obtained. Sixty-five percent agreed that callers respond readily to systematic interrogation.

**Statement 3:** Repetitive persistence (a hysteresis-controlling technique) works. Eighty-eight percent agreed that repetitive persis-
tence is effective.

Statement 4: I have given pre-arrival instructions. Ninety-four percent have given pre-arrival instructions, which include either treatment-sequence cards or pre-arrival instructions listed with key questions.

Statement 5: Callers are eager to follow pre-arrival instructions. Eighty-eight percent agreed that callers are eager to follow pre-arrival instructions, particularly when they understand units are already on the way. Callers who fail to understand this become frustrated with the key questions and subsequent pre-arrival instructions.

Statement 6: Because everything is written, I feel less stressed by my job. Seventy-seven percent agreed that EMD procedures decreased the stress they feel in their jobs and that stress reduction can be directly attributed to EMD. Entry cards, key questions, and pre-arrival instructions are written so mistakes cannot occur. Dispatchers also feel less stressed because all callers are handled in the same systematic way.

Statement 7: Because of EMD, I feel I am now more a member of the emergency team. Seventy-three percent agreed that EMD procedures made them more a part of the emergency team. Many dispatchers felt they had always been members of the team, but they now believed they were more effective.

Statement 8: Field units are more cooperative now that information provided by dispatch is accurate and more reliable. Seventy-five percent felt that field units were more cooperative and attributed the increase in cooperation to EMD.

Statement 9: EMD procedures enhance patient care. Ninety-four percent agreed that EMD enhanced patient care.

Statement 10: EMD procedures allow me to better utilize all of my training and education. Eighty-eight percent agreed that EMD procedures made better use of their training and education. This was especially true of those dispatchers who work for agencies that require EMT training.

Results indicate that EMD works for dispatchers.

FIELD PERSONNEL SPEAK OUT

Field personnel were also asked to complete a survey. Twelve survey questions focused on the effect EMD has on field personnel and the patient. This time, 140 surveys were randomly sent out, with 58 (41%) completed and returned.

Statement 1: Since EMD procedures were instituted, dispatch information has been more accurate. Forty-five percent agreed that dispatch information has been more accurate since EMD's start.

Respondents frequently commented that the calls they are dispatched to don't always require EMS response. The data indicate that field personnel have unrealistic expectations of dispatch. Dispatchers cannot pick and choose to dispatch units only to those alarms that are favorable to field personnel.

Dispatch policies and procedures are based on organizational goals and objectives, medical direction and community needs. Educating field personnel about dispatch policies and procedures can improve the working relationship between dispatchers and field personnel.

Statement 2: The patient or patient's family is better prepared for your arrival (medications gathered, doctor's name, etc.). Only 18% agreed with this statement. Respondents commented that, due to short response times, callers were often still on the phone with dispatch and had not yet gathered medications as requested. Additionally, some respondents stated that callers were hesitant to leave victims alone while they went to search for medications.

Statement 3: Information provided by dispatch is reliable; a call dispatched as BLS will truly be BLS. Forty-nine percent agreed that dispatch information is reliable. Respondents stated that before EMD began, they were concerned that a dispatcher might miss an ALS call and send only BLS equipment. After only six months of EMD, the majority of respondents trust dispatch information.

Statement 4: I have arrived on the scene and found the caller following the dispatcher's pre-arrival instructions (treatment-sequence cards). Thirty-four percent agreed with this statement. The random selection of participants in the survey included many BLS personnel who respond with ALS units to ALS alarms. ALS personnel frequently are the first to reach the patient and observe the performance of pre-arrival instructions. Since many of the respondents did not observe the performance of pre-arrival instructions, they could not agree with the statement.

Statement 5: If pre-arrival instructions are being followed, they are appropriate to the nature of the injury or illness. Of the 34% of respondents who have handled incidents where pre-arrival instructions are given, 69% agreed that the instructions were appropriate to the nature of the injury or illness. Respondents did, however, express concern that pre-arrival instructions might be performed incorrectly.

Statement 6: Since EMD began, the incident to which I am dispatched is most often the incident I find. Sixty-three percent agreed that EMD procedures have increased the reliability of dispatch information.

Statement 7: Since EMD procedures were instituted, communication with dispatch has been more professional. Forty-four percent agreed that communication with dispatch has been more professional. Respondents who disagreed with this statement felt communication with dispatch had always been professional and EMD didn't change this.

Statement 8: Since EMD procedures began, dispatchers seem to follow up more on calls they have been involved with. Forty-nine percent agreed that dispatchers seem to follow up with patients more frequently than they used to. This may indicate that dispatchers feel more involved with each patient's care.

Statement 9: EMD has helped relieve some job stress and frustration by enabling me to formulate treatment strategies before arriving on the scene. Only 40% of the respondents agreed with this statement. The random selection of participants included many personnel who stated they do not formulate treatment strategies. These individuals would not observe any change in job stress and therefore couldn't agree with the statement.

Statement 10: It would be beneficial to allow dispatchers to spend time in the field and field personnel to spend time in dispatch. Seventy-three percent agreed that it would be beneficial for dispatch personnel to spend time in the field. Respondents commented that it would be less beneficial for field personnel to spend time in dispatch.

One interesting note: Many agencies in the area require dispatchers to be EMT-trained, and such training requires students to spend time in the field. This means that area dispatchers already have field exposure. Field personnel, on the other hand, do not, as a general rule, have dispatch exposure. It's recommended that field personnel be educated in dispatch policies and procedures, and spend time observing dispatchers at the console.

Statement 11: Dispatch is more cooperative now that EMD is in place. Sixty-three percent agreed with this statement. Comments received indicate that some respondents believe information provided after the original dispatch was really available at the time of dispatch, but withhold. This is another indication that field personnel need to be trained in dispatch policies and procedures. Other respondents commented that dispatch has always been cooperative and no changes were perceived.

Statement 12: EMD procedures enhance patient care. Sixty-eight percent agreed. Even respondents who were unaware of dispatch changes perceived a difference in the flow of information.

DISCUSSION

An interesting correlation between organizational structure and the success of an
EMD program was found to exist in the data. Those departments with dispatchers dedicated to EMS/fire dispatch tended to have a more effective EMD program than did those with dispatch centers responsible for multiple, unrelated departments within the organization (see Table I).

It’s clear that dispatchers who must handle varied, unrelated tasks are less impressed with EMD. These dispatchers aren’t relieved of any job-related stress, as indicated by statement #6. Only 20% of the dispatchers from nondedicated dispatch centers agreed that EMD helped relieve job stress, while 100% of the dispatchers from dedicated dispatch centers agreed with the statement.

In comparing the data compiled from field-personnel surveys, we see that the trend continues (see Table II). Field personnel are less trusting of dispatch information, as indicated in statement #3. Only 14% of field personnel with nondedicated dispatch centers agreed that an alarm dispatched as BLS would truly be a BLS alarm. Sixty-one percent of the field personnel with dedicated dispatch centers agreed with this statement.

It’s clear that EMD can be a burden to dispatchers in nondedicated dispatch centers. EMD could become another straw on the already overburdened camel’s back. These agencies must carefully evaluate their dispatchers’ ability to handle the EMD responsibility. This is not to say that EMD shouldn’t be a part of these agencies’ service to the public; rather, agencies with this particular problem must reevaluate their goals. It may be necessary to create a dispatch position dedicated specifically to EMS dispatch. Another option is to contract the dispatch services of a neighboring agency that has a dedicated dispatch center and practices EMD.

Whatever the solution, the level of service provided to the citizen must be foremost in our minds. Simply instituting EMD in a system that cannot properly utilize it only increases the ineffectiveness of the organization and ultimately decreases the quality of care provided.

It’s evident from the survey that EMD creates a circle of communication. The circle begins with the caller and ends with the patient. EMD provides a continuum of patient care. It influences agency employees in positive ways. They feel better about their jobs, believe they’re doing a better job and know the patient receives better care.

Survey results also indicate that further training is needed. It’s not enough to train dispatchers in EMD procedures. Field personnel must also be trained in dispatch and the organizational policies that govern it. The unrealistic expectations that field per- sonnel and managers may hold interfere with communication. The multiple responsibilities of nondedicated dispatch centers may actually prohibit the success of an EMD program.

Overall, EMD has worked very well in our area. The Orlando Fire Department’s first EMD “save” occurred just seven days after EMD procedures were initiated. Returning to the original program goals, EMD procedures have achieved a “zero-minute” response time, as evidenced by field units witnessing the performance of pre-arrival instructions.

Dispatchers and field personnel are beginning to feel some relief from job stress related to dispatch information and procedures. Professionalism and cooperation between dispatch and field units, while never really poor, are improving. An atmosphere of trust and teamwork seems to be developing. Department efficiency is difficult to measure and wasn’t addressed in this survey.

EMD has set up a win-win-win-win situation. Everyone—the caller, dispatcher, field personnel, and patient—benefits. The program isn’t perfect, but it’s getting there!

Lt. Kathy Keene is EMS training coordinator for the Orlando, FL, Fire Department.
On any given day, just about anything can happen in a communication center. A recent call to Ambulance Tasmania in Hobart, Tasmania, Australia, affirms that.

Dispatcher Kay Dove, a two-year veteran of the agency, wasn’t even supposed to handle calls on a particular mid-November (2018) day, but an unusually high call volume pressed her into calltaking duty.

Dove is a mentor at Ambulance Tasmania, which takes care of all 000 calls and dispatching for the entire state. She trains new staff members in both calltaking and dispatching.

When a restaurant employee phoned in to report that a 65-year-old patron was choking, Dove immediately took off her mentoring and dispatching hat and starting following the MPDS®. Dove determined that there was a complete obstruction, so she began giving CPR instructions.

But this was met with some roadblocks. Dove learned that the patient had cerebral palsy and was mostly non-verbal. The caller reported that she was unsure if the patient was awake, as he was unable to give any verbal cues. She also mentioned that his eyes were open and he “looked as though he was trying to breathe.” Regardless of these reports from the caller, Dove instructed her to continue CPR.

Dove gave CPR instructions for 10 minutes before ambulance crews arrived. “Calls like this tend to feel like hours,” she said. “I was very lucky that the dispatcher had a close available crew.” Paramedics later said that while performing a tracheostomy they had removed a large piece of steak from the patient’s throat. Crews then transported the patient to the hospital.

“It was a lucky and very happy result,” Dove said. Dove said that while cardiac arrest and respiratory arrest calls are common in her center, choking calls are rare. She credited her own training and the MPDS for giving her a pathway to success. She called it “the backbone of what we do” and said “It gives you direction in what to say and do when you need it most.”

Like any emergency dispatcher or calltaker, Dove has her share of rough days. However, calls such as this one, where everything ends up positive in the end, make the long shifts and emotional moments worth it all. She also appreciates her close team and the leadership of her manager, Simon Harmsen. “Being an emergency calltaker/discharger is such a rewarding role,” she said. “Remember, you’ve helped somebody during the worst moments of their life, and their memory of how you helped them will stay with them forever. You never know when a call that will impact you will come through, so it’s important to be ready.”

Dove was a winner of the IAED™ Call of the Week Award for her efforts in handling this call.
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HAPPENS IN AN INSTANT
Fast action saves child from choking death

Audrey Fraizer

There are some things you just don’t keep around the house, particularly if it is an item associated with something really scary that has happened.

The “something” the Mosby family of St. Louis, Missouri (USA), avoids is an oval-shaped chip that landed in the hands of their two-year-old toddler in one of those hurried moments between fixing and serving lunch on a weekend.

Mom—Leann Mosby—had left the room briefly and in that instant she heard her daughter—Blaire—gasp. She ran back into the room. Blaire was slumped over. She couldn’t breathe; she couldn’t answer when Leann screamed her name. Blaire was turning blue. The little girl had swallowed the chip, and it was blocking her airway. Leann unstrapped Blaire from the highchair and ran for a neighbor’s home, carrying the unconscious toddler in her arms. “I was screaming for anyone to help,” she said. “I thought I was going to lose her.”

The subsequent 911 call was answered by St. Louis Fire Department EMD Ann Grady. “Mom was frantic,” Grady said. “Her baby was choking.”

The neighbor took the phone while Leann followed Grady’s EMD instructions. She started CPR. In moments, Blaire let out a sigh and opened her eyes. “I knew she was going to be OK,” Leann said.

Leann credits Grady’s professionalism and “stern directness” in saving her daughter. “She was very pointed in what she needed me to do,” she said.1

Grady is a mother of four children, and that experience, combined with her 13 years in emergency dispatch, brought out her stern “no nonsense” voice. “I basically told her what she had to do,” Grady said.

It wasn’t until after the call on Aug. 26, 2018, that Grady learned about an unforeseen affiliation. Blaire is the daughter of St. Louis Fire Department PIO Capt. Garon Mosby. He was away at a conference, and Leann was home alone with Blaire for the weekend. Of course, knowing the connection during the call wouldn’t have changed anything about the help Grady provided. “Finding out it’s one of your own does make it more memorable,” Grady said. “No matter who it is, we do what we’ve got to do to help.”

Although Leann was on an emotional rollercoaster for several days following the incident, Garon convinced her to go public with their story. After all, he is a well-known face and voice of the St. Louis Fire Department, and the experience could encourage a greater awareness of CPR and the importance of emergency communications dispatch. The family hosted an appreciation dinner that included the neighbor, the response team, and first and foremost Blaire and Grady. “Ann is our hero,” said Capt. Mosby, who was an active firefighter prior to accepting the promotion to public information officer. “She is a lifesaver, and we are very grateful for her.”

Grady said her gratification for emergency dispatch comes from the ability to help someone. “I feel good about that,” she said. “I really do.”

The Mosby’s family emergency is not an isolated case. Choking is a leading cause of morbidity and mortality among children, especially those who are three years of age or younger due to the anatomy of a child’s airway and the underdeveloped ability to chew and swallow food; choking on food causes the death of approximately one child every five days in the U.S.

According to a policy statement from the American Academy of Pediatrics: Because it is impossible to prevent all choking episodes among children, cardiopulmonary resuscitation and choking first aid for children should be taught to parents, teachers, child care providers, and others who care for children, particularly children at high risk of choking.2

Sources
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EXPERIENCE COUNTS
Former dispatcher heads 911-linked federal agency

Audrey Fraizer

he young man telephoned from inside a closet. By his side, his mother comforted his younger sister. He breathed rapidly.

“911. What is your emergency?” [the emergency dispatcher] said. He whispered. “There’s someone in our house. Please send help. We’re so scared.”

“He told me his address. I dispatched an officer. I remained on the phone with him through the excruciatingly long minutes until help arrived. He delivered hushed updates over the line as he heard the intruder move through the home. My ears strained listening for telltale background noises, alert for sounds of discovery or of violence."

That call was made many years ago to the Butte County Sheriff’s Office in Oroville, California (USA). Heidi King, the emergency dispatcher who took the call, doesn’t remember if the intruder left before the officer arrived. She delivered hushed updates over the line as he heard the intruder move through the home. My ears strained listening for telltale background noises, alert for sounds of discovery or of violence."

“It’s easy to take for granted the miracle that is our 911 system,” King said. “Almost instantly, it connects people who have never met, and likely will never meet, with lifesaving assistance that can arrive in minutes.”

The job at the dispatch center now gives King a unique and necessary perspective as head of the National Highway Traffic Safety Administration (NHTSA). She was nominated to the position in April 2018 and confirmed one month later to lead an organization tasked with regulating safety standards in the auto industry and transportation.

For those new to emergency dispatch protocol history, NHTSA has long recognized that the strength of our EMS system is dependent on rapid access to a skilled emergency medical dispatcher.

In 1976, NHTSA released a dispatcher training program for emergency medical technicians, which was revised in 1983 and published as Emergency Medical Dispatch: National Standard Curriculum. NHTSA has long recognized that the strength of our EMS system is dependent on rapid access to a skilled emergency medical dispatcher.

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NHTSA houses the National 911 Program. Established in 2005, the program coordinates the migration to a digital, IP-enabled emergency network and adoption and operation of NG911 services and applications.

In 2009, NHTSA and the U.S. Department of Commerce’s National Telecommunications and Information Administration (NTIA) awarded more than $40 million to help 911 call centers across the country improve the ability to locate people calling from wireless and internet-connected telephones.

These projects included $594,000 to Arkansas for the purchase of equipment, hardware, and software to implement Phase II NG911 status for multiple jurisdictions, and $2.7 million to the Florida Department of Management Services, Division of Telecommunications for consulting services and the engineering, equipment, materials, installation, supervision, and training services required for the proper installation and operation of an E911 Emergency Communications Routing System.

In late 2016, the National 911 Program and NTIA received $115 million for the 911 Grant Program from the November 2014 Federal Communications Commission (FCC) AWS-3 spectrum auction.

The 911 Grant Program provides funding to help 911 PSAPs provide optimal 911 services. The grants require cost-sharing, with the federal government covering up to 60 percent of the individual projects.

More information can be found at 911.gov/project_911grantprogram.html along with the opportunity to “sign up to receive email updates as new information is available.” Look for a list of awardees on the Journal website as soon as it becomes available.

Sources
2. See note 1.
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GEOCONEX CORP
BOOTH 505

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

GUARDIAN TRACKING
BOOTH 601

Guardian Tracking helps retain your high-performing employees and coach and counsel your underperformers. Our unique software provides the transparency necessary to see patterns of progress or areas of needed improvement (Early Intervention). GT enables organizations to empower their team and improve employee performance, motivation, and the overall workplace culture.
guardiantracking.com
HigherGround’s Next Generation Capture911 is a cost-effective, multi-channel recording and incident reconstruction solution for critical communications in public safety. Capture911 integrates data from multiple sources into a single, synchronized and holistic view.

Capture911 benefits: capture interactions from any device (telephone, radio, email, chat, video, SMS, GIS, mobile phone and photo); intuitive, easy-to-learn and easy-to-use interface; seamless integration with major console, radio, and telecom systems; exceeds anticipated NENA and APCO NG911 standards; record interactions and associated metadata available for immediate playback; proactive monitoring and notification ensures 24/7 uptime; customized solutions to meet specific needs and requirements; fully upgradable solutions that scale with your system; and secure multi-layer algorithms and encrypted data between client and server. Visit us at: www.higherground.com.

For more information, visit emergencydispatch.org

Iron Horse Seating is designed for 24/7 intensive use for a variety of user statures across multiple environments. As a part of United Group, Inc. the team at Iron Horse prides itself on offering custom seating solutions, delivering quality products and, providing unparalleled customer support.

IronHorseSeating.com

Keystone Public Safety, Inc. is a comprehensive, integrated suite of software applications developed to address the needs of public safety agencies nationwide. Keystone On-Line Public Safety (KOPS) applications include Computer-Aided Dispatch (CAD) for both law enforcement and fire/EMS agencies. Other programs include Police Information Reporting Systems (PIRS), Fire Information Reporting (PIRS), Mobile Computing, Keystone’s Narcotics/Intelligence Tracking System (KNTS), and Civil Process and Jails—our Detention Management/Correctional Facility package.

KeystonePs.com

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

NENA.org

We work with forward-thinking leaders of the largest and most advanced public safety agencies in the world to help them prepare for Next Gen and improve their operations and emergency response. NICE Inform Elite is a comprehensive suite of analytics-enhanced recording and incident management solutions that enables them to uncover critical operational insights and cut the time it takes to complete media requests and Quality Assurance reviews in half. Unlike the legacy logger “boxes” still being pushed by smaller vendors, what sets us apart is the ability to search and report across all siloed multimedia data - from CAD, Radio, Phone and QA - in a single solution to make better decisions faster.

NICE.com

Powered by a 50+ year obsession with perfecting headsets and backed by a worldwide network of services and support, Plantronics audio devices have earned a sound reputation for mission-critical applications. We design headsets for day-to-day wear in demanding environments and our expertise is used to ensure that every product we build meets the highest standards of quality and reliability. Emergency/911 dispatch centers for police, fire, EMT, and other vital first responders, the government, and the military rely on Plantronics for crisp, clear, and reliable communications every time.


Don’t miss out on meeting with the Experts. Experience live demos and learn the do’s and don’ts for Priority Dispatch software. If you have a question, we have the answer. Come on over and meet us!

PriorityDispatch.net
At RapidDeploy, we make public safety leaderships’ CAD headaches go away. Our mission is to reduce response times for all and improve first responder safety by increasing situational awareness. RapidDeploy is an innovative cloud-based calltaking and Computer-Aided Dispatch (CAD) platform serving public safety and other markets. Designed by first responders, RapidDeploy uses leading technologies to solve the key challenges faced by emergency services providers. RapidDeploy simplifies the complexity of emergency dispatch through precise address location, improved situational awareness, allocation of appropriate resources for optimized response, mobile field service apps, and advanced incident management tools. RapidDeploy’s end-to-end solution enables effective coordination of all active resources as well as full audit trails for quality assurance. Founded in 2014, RapidDeploy has built a loyal following of clients and is now launching its solution internationally. RapidDeploy is setting the standard for Mission Critical Dispatch.

rapiddeploy.com

Backed by 25 Years of activity, Regola is a pure software manufacturing company focused on mission-critical technology for Emergency Services, Control Rooms and integrated Command & Control systems, Private Safety & Security Services, IoT-based Intelligent Alerting and Responders Mobilizing, Real-time location and interaction. Our DNA as innovators drives us constantly towards designs of modern end-to-end solutions, being ready and open to smart integrations with 3rd parties and/or pre-existing systems or devices.

With our specialisation we operate as technology suppliers capable of providing all the expertise required by companies that wish to satisfy the standards of excellence set by their markets. Also, Regola is among the very first companies in the world ready in offering Hybrid Public/Private Safety approach, that leaves Customers choosing their preferred environment(s) combination among SaaS, Cloud and on-premise.

regola.it

SAVE Corporation is the leading developer and manufacturer of emergency telecommunicator simulators. Our simulators can be found in call centers and educational institutions throughout the US and abroad. By becoming long term partners with and members of organizations such as: APCO, CALEA, NENA; IAED, ACTE, and countless other worldwide organizations and publications, we continue to provide new technologies by keeping abreast of current technology and training opportunities. “Make Mistakes Without Making Headlines!”

911simulators.com

Schedule Express is the premier, award winning, cloud-based scheduling solution specifically designed and built for Public Safety environments. As a workforce management and scheduling tool, Schedule Express allows you to build and maintain shift-based schedules, while also automating the absence, trade, overtime, training and special assignment processes - from request through approval. This unique capability eliminates paper and man-power costs while substantially reducing errors, omissions and abuse. By automating and validating agency rules, requirements, approval cycles and rotations, Schedule Express helps ensure compliance to federal, state and local regulations. Schedule Express has a consistent ROI of 40%-60% in labor cost reduction.

informersystems.com

Stancil Corporation has been a leader in Radio Recording solutions since 1946. Stancil takes great pride in working with Public Safety agencies, and all branches of the United States military providing secure, logging solutions that stand up to the ‘always on’ requirements necessary to support today’s Emergency Communications center.

stancilcorp.com

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

troopstofirefighters.org

The Healthy Dispatcher offers training classes and consulting services designed to help your center be the best it can be. Founded by a former 911 professional with the Los Angeles Police Department, the tools and perspectives we share can be implemented by your front line staff immediately. Stop by our booth today and find out how we can help you.

thehealthydispatcher.com
In today’s digital world it is more important than ever that public safety data and information be shared among departments, between agencies and across jurisdictions. From initial dispatch through final disposition, Tyler Technologies leads the way in integrated public safety and criminal justice solutions. Only Tyler has the resources, domain expertise and passion to focus on the needs of public safety agencies and provide best-of-breed products.

tyler.com

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

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

Watson Consoles workstations support optimal performance for the operator, IT technician, and facility manager. User-centered features promote focus, health, and comfort. The tech-ready design offers easy access to technology and supports optimal equipment performance. Watson products are designed for 15+ years of active 24/7 duty. Visit www.watsonconsoles.com.

Watsonconsoles.com

Xybix is an industry leader in height-adjustable, ergonomic furniture consoles for public safety professionals. We design, build, and implement furniture solutions for 911 dispatch centers, PSAPs, emergency operations centers, and command centers. Visit our website at www.xybix.com or call 800.788.288 for more information.

xybix.com

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