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MAY • JUNE 2019 | VOL. 23 NO. 3

THE FOLLOWING U.S. PATENTS MAY APPLY TO PORTIONS OF THE MPDS OR SOFTWARE DEPICTED IN THIS PERIODICAL: 5,857,966; 5,863,366; 5,868,749; 5,893,254; 5,903,364; 5,926,065; 5,937,094; 5,946,419; 5,977,487; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234; 8,066,638; 8,103523; 8,294,570; 8,335,298; 8,488,746; 8,494,086; 8,772,020; 8,971,501; 9,319,859; 9,516,166. THE PPDS IS PROTECTED BY U.S. PATENT 8,396,191; 8,670,526; 8,873,719. THE FPDS IS PROTECTED BY U.S. PATENT 8,417,533. OTHER U.S. AND FOREIGN PATENTS PENDING.


MAY • JUNE 2019 | VOL. 23 NO. 3
Charles is a paramedic and emergency dispatcher with American Medical Response, Jackson, Mississippi (USA), and a volunteer firefighter with the McLain Volunteer Fire Department, McLain, Mississippi. He was supervisor for the 911 service in Jackson County, Mississippi, when Hurricane Katrina hit and part of the FEMA response team responding to the aftermath of Hurricane Michael.

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 ststigler@waukeshaCounty.gov.

Andre is Assistant Executive Director of Communications and Control Centers for Hamad Medical Corporation, the national ambulance service in the State of Qatar in the Middle East. He is a Master Software Instructor and National Q Evaluator for Priority Dispatch Corp., as well as an Adjunct Instructor at Jacksonville State University’s Department of Emergency Management where he earned his BSc, M.S., and M.P.A. He is currently working on a Ph.D.

Kevin is passionate about improving the training and standards required for emergency telecommunicators. A member of the ED-Q™ Council of Standards, his focus is on bringing awareness to the unique stressors that affect public safety dispatchers. Kevin is a NENA certified ENP, an IAED™ Quality Assurance Instructor, and a Lead Evaluator with PDC’s Client Performance Review.
AVIGATOR is over. Summer is upon us. There’s no better time than now to open up this issue of the Journal and enjoy that warm summer breeze.

Speaking of summer weather, Chatham County Communications in North Carolina (USA) recently received its fire accreditation and medical re-accreditation. Chatham’s 22 full-time EMDs/EFDs processed 61,425 calls in 2018 including some for emergencies like Hurricane Florence, Tropical Storm Michael, and Winter Storm Diego. Learn more about Chatham in the ACE Achievers article written by Audrey Fraizer.

Have you ever worked through a natural disaster like the ones mentioned above? Holli Jordan has. While disasters strike everywhere, you might be surprised how many Holli has been through living in southwest Florida. Read about other people working through disasters in the United States in our cover feature.

Across the pond in the U.K., North West Ambulance Services (NWAS) covers people’s emergency response needs in an area that is home to abundant leisure opportunities. Find out how NWAS handles response for 7 million people by reading the Center Piece article written by Becca Barrus.

Maybe you’ve been thinking about how you handle calls for those relying on you and your communication center. Have you ever thought about whether you see yourself working as a job or in a career? If you need help deciding, check out the feature Josh McFadden wrote about that very topic. Also look for resources that you can tap into for personal development within the feature.

Make sure you also tune into our Columns, which feature several guest writers, and the FAQ in Best Practices written by Brett Patterson. Your Space serves up several articles with two babies and a vehicle trapped in floodwater in the mix.

As always, maybe you don’t miss our CDEs—outside weather and fires understanding the completely alert Key Question. We hope you enjoy this issue of the Journal as much as we enjoyed getting it to you. We encourage you to visit iaedjournal.org. You can access Journal content sooner, share as we enjoyed getting it to you. We encourage you to visit iaedjournal.org.
Dear Reader

LIGHTNING NEVER STRIKES TWICE
Or does it?

Becca Barrus

I don’t know about you, but when, at the tender age of five, I first learned that people could get struck by lightning, I was convinced that it would be a bigger threat to my life than it’s ended up being.

Teachers made a big deal of telling us to stay away from trees and bodies of water during thunderstorms and what to do if we were caught in a flat field and couldn’t find cover. While it’s probably better to be overprepared than underprepared—especially when enormous amounts of electricity are involved—no one explained to me that the odds of getting struck in any given year is one in 1,222,000 and only one in 15,300 over a lifetime.1

Even though the odds are low, we are entering the time of year that typically holds the highest number of fatal lightning strikes in the United States. You read that right. The National Weather Service crunched the numbers and found that June, July, and August saw the highest numbers of fatal lightning incidents between 2006 and 2017.2 The study also found that nearly two out of every three lightning-related deaths take place while the victims were taking part in a leisure activity. Fishermen in particular died at a rate three times higher than golfers over the period surveyed, but both sports ought to be avoided during storms.

As with most statistics there are exceptions, and the phrase “lightning never strikes twice” is more of a handy idiom than an established fact. In reality, lightning often strikes the same place twice, especially when geography helps it along. The Empire State Building in New York (USA) and the Sears Tower in Chicago (Illinois, USA) are struck thousands of times per year because they are the highest points in the surrounding areas and because weather patterns repeat themselves in the same geographical areas.3

Weather patterns aside, some people just have rotten luck. Roy C. Sullivan was a park ranger in Shenandoah National Park in Virginia (USA) in the mid-twentieth century. He was also struck by lightning seven times. Some of the strikes could be attributed to geography—Sullivan could for sure have been the highest point once or maybe twice. The first recorded time he was at the top of a fire lookout tower that didn’t have a lightning rod. The rest of the strikes are less easy to explain. One of the safest places to be during a lightning storm is a car or truck because the metal frame will act as a conductor for the strike, guiding it around the occupants and driving the charge into the ground. Not so for Sullivan’s second strike. The lightning hit some nearby trees while Sullivan was driving his truck, and the bolt ricocheted off the trees and through the truck window, hitting him. The five subsequent strikes followed much the same pattern in finding Sullivan wherever he was, regardless of the precautions he took against being hit again. Surprisingly, he never went into cardiac arrest after any of his encounters, although he did suffer from a number of burns, having caught fire more than once.

Oddly enough, Virginia isn’t even on the list of the top 10 places you’re most likely to be struck by lightning in the U.S. The list was compiled with data from the National Oceanic and Atmospheric Administration, the National Lightning Detection Network, Spatial Hazard Events and Losses Database from the United States, and the American Meteorological Society.4

You are most likely to be struck by lightning in Florida (which has double the number of lightning deaths than any other state), followed by Louisiana, Mississippi, Alabama, Arkansas, Texas, North Carolina, Ohio, Colorado, and Tennessee at No. 10.

Stay safe this lightning season and remember: Victims of lightning strikes don’t carry an electrical charge, so it is safe for bystanders to administer CPR right away.

Sources
Doc,

In one of your review comments from the first draft Release Burn of CDE 78b—Protocol 7: Burns/Explosions, you indicated that there was a missed difference between things that were essential in Burn Center care that did not have, or require, the same urgency or care in the prehospital (dispatch and scene evaluation/care) setting. I was unaware of this, so can you explain how to better understand and describe this difference so we get it right in the lesson?

Thanks,
Rory Penman
Multimedia Assistant
Curriculum Department
PDC™

Rory,

“Each year in the United States, burn injuries result in more than 500,000 hospital emergency department visits and approximately 50,000 acute admissions. Most burn injuries are relatively minor, and patients are discharged following outpatient treatment at the initial medical facility. Of the patients who require hospitalization, approximately 20,000 are admitted directly or by referral to hospitals with specialized multidisciplinary programs dedicated to the treatment of burn injuries.”

These are the Burn Centers.

Not so well known is the significant difference in what constitutes important things in caring for burn patients by responders in the prehospital setting vs. what the Burn Center does. While significant burns to the face, hands, feet, genitalia, perineum, and major joints are said to require Burn Center care, this does not mean that our care for these types of burns in the field is any different, or more urgent, for these particular burns vs. other burns. Most prehospital care for burns is supportive and compassionate and includes cooling, flushing, pain medications, fluid replacement for large (> 25%) burns and/or prolonged transports, and trying to keep the burned area relatively clean. Also, preventive measures for hypothermia (especially in children) should be considered. COLD transport is generally recommended.

The main exception is airway involvement usually paired with facial burns or burns incurred within enclosed spaces. That said, perhaps the single most important prehospital area of clinical attention is the consideration of airway burns and the effectiveness of breathing. Significant airway involvement is quite uncommon in the vast majority of burns—even those to the face. There is a higher level of response and care (ALS) as shown by having CHARLIE codes for “Difficulty breathing” and “SIGNIFICANT FACIAL burns,” and DELTA codes for “DIFFICULTY SPEAKING BETWEEN BREATHS” and various decreased levels of consciousness.

The issues of special care (even Burn Center admission) involving significant burns to the face, hands, feet, genitalia, perineum, and major joints, is based on the Burn Center’s ability to preserve physical functionality that is closely related to reducing the ravages of scarring. Surgical intervention, including grafting, is paired with burn healing and infection-preventing processes, followed by rehabilitative and emotional care, which is based on the burn injury severity, disfigurement, and/or loss of functionality aspects of the patient’s overall condition.

In essence, most things done specific to Burn Center care are simply not done, nor can be done, in the prehospital window of basic supportive care provided by emergency dispatchers and responders...

Source
If your 911 center digs are anything like ours, it is probably “governmental,” which is a widely accepted description for “dull,” “boring,” “institutional,” “gray,” and overall ... “blah.” While these words are fitting for the description of a jail where things are not supposed to be cheery, our centers NEED to be sprayed with more goodwill messages and color-infused visuals. In the midst of dealing with people in crisis, we need visual reminders that there is good ... there is color ... and there is joy in what we do and who we are.

Give your creatives “license”

You know the creatives in your center. They love posting anything NOT in black and white. When it comes to designing your center, remember to balance professional “stuffy” and professional “fun.” Inject life and color tastefully without being dressed up like a kindergarten classroom.

Creatives simply need a canvas—a place with unlimited possibility yet a limited scope. Bulletin boards work well for this purpose. In our center, there is a “What’s cooking?” blackboard space where folks can post favorite recipes. Another larger designated wall space serves as the holiday wall used to celebrate themes of the different holidays and seasons. They typically include feedback visuals from staff; for instance, for Thanksgiving there was a big tom turkey display and his “feathers” included individual dispatchers’ responses as to what they were thankful for.

Many centers have an area or bulletin board dedicated to the “attaboy/girl,” which are outstanding items to share with staff. They contribute awareness and motivation to staff—always a good thing!

Naked walls

Do you have bare wall space? There are several inspirational wall posters and framed artwork options depicting 911 themes that are inexpensive yet tasteful and timeless. A quick Google search will lead you to hundreds of options. A long, dull hallway? Consider a mural. If painting a mural is beyond any of your creatives’ capabilities, you may look to a local high school or college. They often look for outside projects for their students, and the price is often right (low or no cost). A mural is like giving the center a tattoo. It’s going to be there for a long time, so think about the design before rushing into the project, making sure it will represent your center appropriately.

Other reminders

Whatever decor you choose should be representative of the mission, vision, and values of your department and of 911 in general. Decor should include diversity, respect, and pride in the workplace. Images of violence or anything of a sexual nature have no place in the center. Humor is good, but it must be tempered. Despite our occasional dark humor in the dispatch world, it should not be displayed in any manner, as it could easily be misinterpreted as insensitive or in bad taste.

Color pulls in the positive

Since our creatives started putting up colorful displays, staff has commented about how great it is to see the center “come alive.” It’s tough not to smile when we see the fun displays, the bulletin board themes, and even the delightful, positive decor that is carefully taped on individual dispatcher lockers when they get signed off on a position.

We all know that attitude is everything. Our disposition, if gloomy, results in mismanaged calls, confusion, and poor customer service. Conversely, if our disposition is sunny, we are more likely to take pride in our work, manage calls appropriately, and provide great customer service. As Allen Klein wrote: “Your attitude is like a box of crayons that color your world. Constantly color your picture gray, and your picture will always be bleak. Try adding some bright colors to the picture by including humor, and your picture begins to lighten up.” If adding a little color therapy to our world will have a positive effect, then I say bring on the crayons!
or those with a medical background, one of the first acronyms learned is “PPE.” Whether gloves, a gown, or eye protection, Personal Protective Equipment is vital for responders and clinicians to reduce their exposure to pathogens and potential hazards. The use of PPE is one of the primary steps taught, and evaluated, during initial certification training assessments as well as all continuing education. It is built so strongly into the culture of EMS that the use of PPE becomes routine and second nature. As emergency dispatchers, what should be built into our culture with the hope that it becomes second nature?

Think back to when you were first hired. The training was probably a blur of industry jargon; geography; CAD, radio, and phone training; as well a phonebook-sized stack of procedures and policies that had to be committed to memory. At some point, you were told that you would receive feedback on your performance through quality assurance (QA) case review and that you were required to accrue continuing dispatch education (CDE) hours. After enduring your marathon of training, where did the topics of QA and CDE get prioritized in your daily responsibilities? Sadly, QA is often dreaded, and CDE is only thought of as our certifications get ready to expire.

The value of continuing education is that it is continuing. Athletes aren’t going to stay in shape or build muscle if they only go to the gym once every two years. Would you want paramedics providing treatment to you or a family member if their only efforts to develop their skills were the bare minimum requirements to remain employed? As certified emergency dispatchers, don’t we too need to value the importance of improving our skills and increasing our ability to provide higher quality service—to both our responders as well as the public? Expecting someone else to provide this for us is not the most effective means of mastering the responsibilities of our job.

We need to change our culture, from day one during initial training, to highlight the value and importance of self-improvement. Personal development. Proactive training. Proactive Personal Education. The emergency dispatcher’s “PPE.”

If only the bare minimum of CDE is completed, are we prepared to take the call from the mother with an unresponsive baby, the caller trapped in her house that is on fire, or the person reporting that he is in imminent danger of being assaulted? If our understanding of QI tells us it’s the supervisor’s job to prompt us to review QA, or that it is our trainer’s job to direct us to review emergency protocols, then we’re learning by trial and error—and often on live calls. This creates needless stress and frustration as we stumble our way through high-acuity and high-emotion calls. At our worst, this increases the probability for poor incident outcomes and potential litigation. The emergency dispatcher’s version of PPE protects telecommunicators from potential hazards and dispatch danger zones by preparing us, ahead of time, to competently and confidently handle difficult or infrequent calls (like the PAI, ECHO, and CID cases referenced above).

Take the initiative to improve your skills. Take an active role in your own development. Be proactive. Listed above are some ways to develop your own PPE.

Proactive Personal Education can reduce stress, compassion fatigue, and fear as we focus on building our abilities and confidence—continually—like athletes building their bodies one gym visit at a time. Just like an EMT shouldn’t need to be told to put on gloves at the scene, emergency telecommunicators should apply their PPE, routinely, as a daily component of learning, growing, and mastering their role in providing emergency service.

Don’t wait for QA. Ask questions after difficult calls or request to listen your calls. Schedule time with your ED-Q to review the IAED™ Performance Standards.

Review the protocol during downtime. Build your confidence by familiarizing yourself with the protocols’ Additional Information panels as well as the various answers displayed in ProQA’s dropdown picklists.

Review your agency approval items and protocol definitions. Do you know what OBVIOUS DEATH conditions have been approved? How many vehicles are defined as a MULTI-VEHICLE Pile-Up? What are the age ranges for AT RISK individuals?

Use the **TEST CASE** feature in ProQA® to practice and role-play calls.

Create a protocol trivia contest in your center. Who is the most knowledgeable EMD/EFD/EPD?

Reference the resources available. These include the Principles of EMD textbook, course manuals, the Journal of Emergency Dispatch, and the College of Emergency Dispatch.
One of my passions for the past 15 years has been helping to raise the awareness of my peers with regard to critical incident stress (CIS): the causes, symptoms, and healthy mitigation techniques. I have dealt with the effects of CIS several times in my career and have luckily been able to eventually overcome it. As a peer support specialist, I have helped many of my brothers and sisters in emergency services deal with their stress over the years.

Many misconceptions exist with regard to CIS. Some of these include the misguided notions that can be summed up by unsympathetic statements such as, “Well, if you can’t take the heat, get out of the kitchen” or “If you can’t handle the stress, perhaps you should consider a career change!” This from professionals where empathy and compassion are supposed to go hand in hand with our stethoscopes and trauma shears. Fortunately, with returning veterans bravely being more outspoken with regard to their struggle with post-traumatic stress, some of the perceived stigma surrounding CIS has also dissipated.

I am a field paramedic of 25 years and now an emergency dispatcher, and believe it or not, the stresses are very, very similar. Being in dispatch doesn’t diminish the stress that we can feel dealing with a critical patient or agitated family member on the telephone.

One of my recent shifts in my emergency dispatch center highlighted this and began with a call from a frantic father who woke up and found his three-week-old son in cardiac arrest. The baby had been sleeping in the bed with his mom, and she had rolled over onto him at some point, suffocating him. Unfortunately, the child was pronounced dead at the scene. Frustration with the caller (who was having issues giving a clear address) coupled with it being a critical pediatric call and the impressively tragic circumstances, culminated in a significant level of critical incident stress.

My day went downhill from there. From that point forward, it was a seemingly unending parade of difficult-to-understand callers, people who couldn’t tell me where they were located, frantic people panicking on the phone, bad phone connections … all combined into a perfect storm of frustration. Soon, feelings of being that “first, first responder” began to evaporate and give way to feelings of irritation and anxiety.

I noticed throughout the day that my usual calm demeanor had cracked and given way to becoming easily frustrated with minor issues. I kept making simple mistakes. When it would get quiet for a few minutes, my mind kept going back to that call or another and the frustration that I had felt. This was culminating in actual stress and anxiety every time the 911 line would ring. Luckily, I recognized my stress and took steps to combat it.

In the short term, I simply took a break! I got up and walked around. I went into the crew room and enjoyed some time with some of the crew members. You could go outside and get some fresh air or go grab a cup of coffee and take a break. Take a few minutes to play a game on your phone or find a quiet place, put on some relaxing music, close your eyes, and think about being in the mountains or on the beach somewhere. If you are really bothered, talk to a close co-worker or supervisor. As peers, we need to be vigilant and be good listeners, especially if a co-worker comes to us stressed or in crisis.

Understand that if you or a colleague experience CIS, you are having a NORMAL reaction to an ABNORMAL situation. Take some time to do those things that make life worth living and relax. It is just as important, in taking care of others, that we take care of ourselves.
The International Academies of Emergency Dispatch® (IAED™) has determined that quality is “conformance to requirements,” according to the Performance Standards 10th Edition, but who determines what is required? Most often, the customer (or community) determines the “standard of care,” and these standards are dependent on circumstances. We define the quality of services, therefore, by listening to the voice of the customer. Why not listen to the voice of the employee to define the quality of employees? This concept, often used in commercial call centers, suggests that job commitment and job satisfaction improve employee engagement and the employee experience and, consequently, improve organizational commitment and operational effectiveness.

Let me explain …

Public safety is of prime importance to our emergency dispatch community. We should be inspired by our community and use that inspiration to make a positive impact on the community’s public safety experience. Every interaction is an opportunity to learn, improve, and impress. But we cannot be empowered if we are not satisfied or committed.

So why are we not satisfied or committed?

Research suggests that a lack of job satisfaction and organizational commitment in emergency dispatch is due to unmet expectations, and the list is not short: benefits, policies, management and supervision, work autonomy and process, opportunity, training, growth and development, teamwork, technology, and even retirement. The unmet expectations lead to non-engaged employees and ultimately affect their well being. How can employees effectively serve if they are unhappy and not part of decisions affecting their career? Research suggests that when employees are less engaged, operational effectiveness diminishes.

This is mostly quantitative research—remember, people do not talk in numbers, so it’s paramount to understand staff needs, wishes, hopes, preferences, and aversions, in their own words.

Public safety telecommunications leaders need to listen to the voice of the employee to create understanding and collaboration. We must ask questions like “How can I help?” or “What do you need?” This is how we gain perspective.

Despite having an organizational mission and vision, employee needs go beyond that in requiring physical, psychological, social, and/or organizational support to achieve work goals. Their feedback must be considered valuable and actionable without a lot of strategic direction.

An employee came to me and said he understood that the calltaker performance was being monitored in terms of answer speed, queue time, duration of calls, and abandoned calls. The employee told me that he became frustrated when callers were not prepared with the information he needed to help, which he felt contributed negatively to how long it took to answer calls, resulting in longer queuing times and more abandoned calls. He suggested adding a voice prompt in the interactive voice response phone system that asked callers to kindly have their patient’s identification information ready in preparation to speak with an agent.

I could have not been more pleased with this suggestion. Even though I originally designed all the scripts and found all types of reasons why the performance indicators were unstable, I never considered this option after more than a year of implementation of the new phone system. In less than 24 hours I added the new script and, in a week, call handling times decreased by 10 seconds. This was a win for both the customers we serve and the employees.

While cakes, cookies, and awards/recognition are good motivators, they are not sustainable mediators of employee well being. When employees have a safe and respectful work environment, evolving best practices, supportive supervision, low cynicism, efficient work processes with non-cumbersome technology, and reasonable job strain with a reasonable work-life balance, there is a greater chance that they will be happy. Happy employees will deliver better service.
PATIENT SYMPTOM FOREMOST
What prompts protocol selection?

Brett Patterson

Brett:
A doctor’s office calls and states: “The patient presented with back pain; however, upon further investigation it was discovered the patient has an abnormal EKG with ischemia.”

My question is, should the abnormal EKG alone prompt the emergency dispatcher to select Protocol 19: Heart Problems/A.I.C.D., or were they correct in choosing Protocol 5: Back Pain (Non-Traumatic or Non-Recent Trauma) since this was the actual symptom given?

Thanks,
Sarah Elliott
Senior Supervisor
Hillsborough County Fire Rescue Emergency Dispatch Center
Tampa, Florida (USA)

Hi Sarah:
This is why we encourage the use of Protocol 33: Transfer/Interfacility/Palliative Care or Protocol 37 for calls from medical facilities; they can usually offer a reliable diagnosis. Both protocols have codes for suspected myocardial infarction.

However, if using the standard protocol, I would hope my EMDs would be familiar with the fact that heart attack symptoms vary, and that back pain with an abnormal ECG and suspected cardiac ischemia is an MI until proven otherwise. My go-to for that would be Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic) where heart attack symptoms are addressed.

However, the fact that we are discussing this now is enough to give the EMD the benefit of the doubt and an opportunity to provide some education.

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

Brett:
I just took a call in which a patient was in arrest after a heroin overdose. Before we were able to get the patient on the ground and commence CPR, the patient started having a seizure. The patient apparently had a history of seizures with heroin overdoses. Since hands were not on chest prior to the start of the seizure, I changed to Protocol 12: Convulsions/Seizures to address the seizures, but this downgraded the response from a 0 to a 1, cancelled EMR, and delayed CPR.

I am aware that on trauma protocols, the calltaker should remain on the trauma protocol if the patient starts having a seizure and use the target icon to provide the appropriate PAIs. However, I am not aware of a similar instruction for patients in arrest, and I’ve had quite a few instances where patients that I’m 99 percent sure are
in arrest have seizures (or seizure-like movements that could be interpreted by the caller as a seizure). Just wanting to confirm there is no instruction to stay on Protocol 9: Cardiac or Respiratory Arrest/Death when a patient is described as having a seizure if CPR/MTM has not been commenced?

Of course, in my scenario, after the seizure stops, we’d go back up to a 0 if the patient is not breathing. In the meantime, the response has been downgraded, EMR cancelled, and CPR delayed until the seizure stops and the breathing detector completed.

The conflicting PAIs made me wonder. If the patient is having a seizure, we don’t do CPR; however, if the patient was in arrest prior to the seizure commencing, we’d want to be doing CPR ASAP.

I understand that seizures may “look like” arrests in that the patient is not conscious and not breathing whilst having the seizure, and that we manage these patients on Protocol 12 so that we’re not doing CPR on patients who are having a seizure and not in arrest. When you’re confident that the patient is in arrest despite the seizure, is there just nothing we can do about it until the seizure has stopped and the breathing detector has been completed?

Just hoping for some clarification around this issue.

Thanks,
Zoe Lethbridge
Emergency Services
Telecommunications Authority (ESTA)
Burwood East, Victoria, Australia

Hi Zoe:

Short answer: If the complaint description and the clinical presentation is, in your mind, consistent with cardiac arrest, go with it. You can always handle the seizure while it’s happening with PDIs from Protocol 12 but get on the chest ASAP. If it turns out to be a generalized seizure, no harm, no foul—the post-ictal patient will likely groan and resist, prompting you to stop compressions.

We know that the cardiac arrest frequency is relatively high in the 12-D-1/2/3 codes due to hypoxic seizure activity being mistaken for generalized seizures. With that said, there are some differences between the two clinical presentations. Here’s a link to an FAQ on the matter that you may find useful: iaedjournal.org/what-is-an-emd-to-do

Let me know if I can help further.

Thanks,
Brett

Hi Kelly:

I have an unwritten rule that states: If the experts need to discuss it, the EMD should get the benefit of the doubt.

It seems to me that the EMD appropriately selected Protocol 27 due to scene safety, and then became concerned about the medical issue and switched to Protocol 6. This is well-intended, and it worked in this case.

The issue with switching protocols here is that it changes the code, which then does not associate the scene safety and response issues. Instead, it is probably best to stay on Protocol 27 and use the Target Tool if PDI/PAI are needed.

Unfortunately, no option is entirely optimal because medical versus trauma versus scene safety all have different priorities. Therefore, we prioritize scene safety and do what we can to address any additional instructions.

Hope that helps.

Brett

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Hope that helps.

Brett
WRAPAROUND CARE
North West Ambulance Service contains multitudes

Becca Barrus

The North West region of England has something for everybody, especially if you’re looking for recreational activities. Are you a sports enthusiast? You’ve got football (that’s soccer to Americans) stadiums and professional teams to spare, including Liverpool, Everton, Manchester City, and Manchester United. If a football match doesn’t tickle your fancy, how about a hike? Cumbria is home to the Lake District, which contains mountains, hills, lakes, and streams that poets have raved about for literally centuries. Not a mountain person but still like the outdoors? No problem. Spend a day at the beach: You’ve got Blackpool, Southport, Formby, Crosby, and more to choose from. And if music is your thing, you’ve come to the right place. Guinness World Records dubbed Liverpool the “World Capital City of Pop.” You can check out some of the local landmarks where the Beatles first played their gigs or tour the museum dedicated to their rise and fall.

Just like the North West has you covered for all your leisure activity needs, the North West Ambulance Service (NWAS) has you covered for all your emergency response needs.

In July 2005, the ambulance trusts of Greater Manchester, Cheshire and Merseyside, Cumbria, and Lancashire consolidated into one entity—the North West Ambulance Service. Over 1,000 emergency and non-emergency vehicles from 109 ambulance stations across the region are dispatched from one of five sites: three Emergency Operations Centres and two patient transport centers. In each of the centers, there is a calltaking suite, in which 999 calls are answered, and a dispatch center, from which the most appropriate and nearest vehicle is dispatched to the patient. Because all of the centers are connected on one virtual system, calls are taken by the first available operator in the region, regardless of where they are based.

Such a massive sprawl of emergency response resources is necessary to keep up with the area’s roughly 7 million inhabitants, who speak a variety of languages from English to Urdu to Polish to Mandarin. NWAS gets 1.4 million calls every year and, on average, sends out emergency resources 4,800 times every single day anywhere over the 14,165 square kilometer (5,469 square mile) coverage area. Due to the huge scale on which the dispatchers operate, they see all sorts of calls, including routine ones about chest pain and not-so-routine ones about active assailants.

However, NWAS doesn’t just receive and dispatch emergency calls—in addition to handling 999 phone lines, there is also a service for non-emergent (but still pressing) medical concerns. Patients can call 111 and be connected with a calltaker who will assess their symptoms and triage accordingly. Sometimes the patient will be referred to a General Practitioner and sometimes an ambulance will be sent.

As if that weren’t enough, NWAS also utilizes a Frequent Caller Team. It does
The goal of NWAS is “to provide the right care at the right place at the right time all the time.”

“Staff are focused on patient care and safety and treat each patient that they deal with in a very professional and courteous manner,” Cashman said, which is one of the things she likes most about her center.

It isn’t only the care of the patient that NWAS is concerned with—they work hard to make sure the members of staff are well supported, too. The North West is no stranger to traumatic events. Two of the most notable in recent history are the Manchester Arena bombing (May 22, 2017) in which 23 people were killed and 139 wounded, and the Cumbria shootings (June 2, 2010) where 12 people were killed and 11 wounded. Programs designed to help first responders process such events, like counseling sessions and colleague support, are available to dispatchers as well as those police officers and paramedics who were on scene.

In particular, Cashman noted that NWAS uses TRiM assessors to check the mental health of staff after a traumatic event, whether it’s an individual call or a more widespread experience. TRiM, which stands for Trauma Risk Management, is a peer support system.

The assessors carry out an interview with the affected person and look for risk factors that increase the likelihood that the person may suffer poor longer term mental health as a result of the incident. The initial interview, which takes place 72 hours after the initial event, assesses the need for further help, and the individual is directed to suitable care. A follow-up interview takes place one month after the first one and, if all goes well, the individual’s TRiM score will have significantly decreased.4

Whether you’re a vacationer, a local, or a member of NWAS itself, NWAS will take care of you whenever you need help.

Sources
Adam Gaines accepted the Quality Assurance (QA) Coordinator position at Chatham County Communications, Pittsboro, North Carolina (USA), nine years into his career in emergency dispatch at the agency.

And kind of like the job of emergency dispatching, he wasn’t sure what he was getting into, but before long he knew he had made the right decision. “I could help the agency as a whole,” he said.

There were a lot of factors playing into accepting the promotion. Gaines takes pride in his profession and Chatham County Communications. Part of it was the challenge of the medical ACE re-accreditation and working toward fire ACE accreditation. Another key factor, however, was a transition that put the emergency dispatcher into a position to help others on the inside. “I didn’t have to prove myself,” Gaines said. “They trust me. I could give consistent feedback because I had been in similar situations. I knew how our call processing worked and could now help to improve it for the future.”

Gaines admits the transition was harder than he had anticipated, which had a lot to do with the ACE process. The medical ACE they achieved in 2015, prior to his promotion, was based on Performance Standards that were seriously overhauled during the intervening three years.

The 2018 release—Performance Standards 10th Edition—provides a single, unified set of standards for emergency dispatchers in the Academies’ three disciplines (medical, fire, and police) and, also, promotes a feedback process using a strengths-based approach. The revision is considered a win-win for ED-Qs and emergency dispatchers because of its focus on performance, not deviations, and fewer cases required for review.

Gaines favors the revised editions and their focus on accentuating performance, although the shift in framing performance did mean starting the medical ACE almost from scratch. Chatham’s medical re-accreditation was approved, and then—this year—their fire accreditation.

“Knowing what was expected made fire easier,” said Gaines, who submitted the application for fire ACE in early December. “My fingers were crossed.”

He was at NAVIGATOR accepting both medical re-accreditation and fire accreditation.

Working from the inside has also shown Gaines the purpose behind a
North Carolina. Although downgraded in response to the expected impact of issued a state of emergency declaration of emergencies, from hurricanes to a busy, this past year has brought its share on the floor.

Nine certification exams before working training, and they’re required to pass hires attend several weeks of classroom control and Jordan Lake State Park. New calls. They also take calls for animal to 6,400 medical calls and 3,500 fire processed 61,425 calls and sent response agencies, including fire, EMS, rescue, (CALEA).

Accreditation for Law Enforcement communications accreditation working toward public safety Agencies (CALEA).

The EMDs/EFDs dispatch for multiple agencies, including fire, EMS, rescue, and law enforcement and, in 2018, they processed 61,425 calls and sent response to 6,400 medical calls and 3,500 fire calls. They also take calls for animal control and Jordan Lake State Park. New hires attend several weeks of classroom training, and they’re required to pass nine certification exams before working on the floor.

And if that isn’t enough to keep them busy, this past year has brought its share of emergencies, from hurricanes to a year’s worth of snow falling in one storm. On Sept. 10, the County Commission issued a state of emergency declaration in response to the expected impact of Hurricane Florence on much of central North Carolina. Although downgraded to a tropical storm, residents were advised to stay put to avoid the risk of travel accidents from flooding and flash flooding on the roads. Historic flooding required keeping in constant contact with residents cut off by the Deep River backing up into the woods. Chatham County was designated a primary natural disaster area among 32 out of 100 North Carolina counties.

One month later, while still recovering from Florence, Tropical Storm Michael ripped across central North Carolina, bringing heavy rain and windy conditions that uprooted trees and damaged and destroyed power lines, poles, homes, and businesses.

Knowing what was expected made fire easier. My fingers were crossed.

“The calls were nonstop that afternoon and evening,” Gaines said. “We were fully staffed on six consoles, and I took turns at [calltaking and dispatch] to give a couple of dispatchers a break.” Florence caused about 200 trees to fall and left about 10,000 without power in Chatham County. Michael felled another 322 trees, with about 16,000 people left without power, some for days.

In December, beginning on a Sunday morning, Winter Storm Diego dumped several inches of snow across North Carolina, toppling trees, closing schools for multiple days, and adding the treacherous elements of snow and black ice to road travel. Tree limbs breaking under the weight of heavy snow pulled down power lines, leaving hundreds in the dark while awaiting snow-hampered crews to fix the broken poles.

Gaines said they train hard to prepare for these types of events. “We’re all about being prepared, but you never know what will happen until it actually happens,” he said.

The 710-square-mile county lies totally within the hilly Piedmont region and occupies a strategic location between two regions that rank as the 29th and 33rd largest Combined Statistical Areas (CSAs) in the nation (2015 U.S. Census Bureau estimates). The Triangle region—the Raleigh-Durham-Chapel Hill and Greensboro-High Point-Winston-Salem CSAs—contributes to population growth predictions. Chatham is predominantly rural (68 percent of the county is forest) and noted for an agricultural industry, though the county has experienced significant residential growth pressure in the northeastern portion.1

The current population of 71,472 (U.S. Census Bureau 2017) represents an 18.5 percent increase over the past decade, and during the next 20 years development is projected to add between 25,000 to 50,000 residents.2 Fifty-five percent of Chatham workers commute for work outside the county.

The 911 center is housed beside the Chatham County Sheriff’s Department and includes the county’s Emergency Operations Center. A Chatham capital improvement plan includes a radio system upgrade, three new radio tower sites, and an expanded EOC and communication center to provide additional console space.

Sources
NOTHING TO DO
BUT STAY
During a natural disaster, there’s not much of a choice

Audrey Fraizer

Nothing says dedication like working through a disaster hoping everything at home stays the way you left it hours or days earlier.

At least Holli Jordan could count on the pine trees.


Holli and Darnell Jordan own a home in southwest Florida, an hour’s driving distance to a Gulf Coast shoreline. Darnell is a retired paramedic, and Holli is an emergency dispatch supervisor at Lee Control, Lee County Emergency Communications Center, Fort Myers, Florida (USA). She’s worked through conditions most of us only read about (fortunately), including hurricanes and wildfires.

“We got a little wind from Hurricane Michael,” she said. “Hurricane Irma seemed to come through fast, and it hit us directly. I left work not knowing what I’d find once I got home.”

Darnell, on the other hand, had a different impression of the storm’s speed, listening to it approach from where he was hunkered down during the worst of it.

The Atlantic hurricane season officially runs from June 1 through Nov. 30 every year, although storms can and do occur outside of that window (about 3 percent). While extended forecasts must be eyed cautiously, a forecast released in December 2018 predicts the Atlantic’s cyclone activity in 2019 at about 80 percent: 8 to 16 tropical storms, with 2 to 8 that could become hurricanes and up to 4 intense hurricanes of Category 3 strength or greater.
Lee County in southwest Florida has had its share of natural disasters, and a teeter-totter is the perfect analogy when it comes to comparing the risk associated with a slew of events. The end that is up in the air holds almost no weight considering the low risk threat of tornadoes or earthquakes. When it comes to hurricanes and storm surge, however, the heavy weight keeps the other end down to the ground.

The danger lies in the county's western edge. The shallow Gulf of Mexico coastline heavily weights the risk for hurricane threats, specifically storm surges, according to “Hurricane Jim” Bjostad, Manager, Emergency Management Program, Lee County Emergency Management; statistically, Lee County will incur a 1-in-11 risk of a hit in any given hurricane season.²

Hurricanes have hit or brushed the county repeatedly, and Holli has worked through at least 10 named hurricanes: Andrew, Category 5, 1992; Charley, Category 4, 2004; Francis, Category 2, 2004; Ivan, Category 3, 2004; Jeanne, Category 3, 2004; Rita, Category 3, 2005; Wilma, Category 3, 2005; Matthew, Category 2, 2016; Irma, Category 4, 2017; and Michael, Category 4, 2018. As an emergency dispatcher, she answers the 911 calls during the event, but is prohibited from sending response units until winds drop below 40 miles per hour, according to Lee County emergency service policy.

Of course, not all hurricanes make landfall and not all hurricanes carry the same impact.

“Irma was the worst,” said Holli, an emergency dispatcher in Lee County for 28 years. “Unbelievable. My husband was home and said Irma sounded like a freight train coming through.”

The Jordan family’s home is in the county’s interior, away from the coast, where Holli said they felt protected from the brunt of storms and storm surge. Yet, because the inevitable does happen, they keep a portable generator ready for hook-up and have added storm weather precautions throughout the house.

“I never thought we’d lose our home,” she said. “I thought maybe a tree would fall on the roof, but nothing more than that.”

Holli went to the county’s emergency dispatch center 24 hours ahead of the time Irma was expected to make landfall (Sept. 10, 2017, in Lee County). She packed a week’s supply of clothes and a sleeping bag, brought in a clothes rack for everyone to share, and planned to stay at work for at least the next 24 to 48 hours.

“I’ve done this so many times, it’s like second nature,” she said. “It’s part of what we do.”

Holli stayed four days. When winds blew down cell towers, she lost the only connection to home that she had. She drove the familiar roads back not knowing what she would find, although a downed mosquito abatement airplane flipped on its side over a home, snapped concrete phone poles, piles of flood debris, and trees lying in the middle of the road gave
her a daunting indication. Some 35,000 Lee County residents and 3,550 of their pets went to 14 shelters, more than any other Florida county.

“I was scared,” she said. “It’s so hard when you’re working and can’t get through to family.”

Holli’s home was spared. Darnell and the couple’s three dogs were safe and unharmed. Despite plans to leave in their RV before the storm hit, he had stayed home corralled in a closet with the dogs.

“It was such a relief when I saw my husband and the dogs,” she said. “I cried.”

A threatened natural disaster activates every emergency dispatcher, according to Chief Casey M. Allo, Program Manager, Lee Control, Lee County Public Safety. It’s policy. During Irma, the schedule was six hours on, six hours off, with four shifts covering a 24-hour period. Tables turned on their side in the center’s conference room afforded individual privacy during the off hours.

Call volume increased considerably during Hurricane Irma and post-storm, from a normal daily number of 225–250 calls made to 911 to 600–700 calls made to 911. Emergency dispatchers did not deviate from the scripted Medical Priority Dispatch System” (MPDS”) Protocol. They followed Case Entry and Key Questions and, when indicated, provided Post-Dispatch and Pre-Arrival Instructions.

The scripted “I’m sending the paramedics to help you now” is where instructions deviated. As approved by local policy and the IAED™, dispatchers informed callers that weather conditions prohibited sending response; help would be sent as soon as conditions permitted. Calls were triaged according to patient severity as assessed through the MPDS. The higher the risk, according to priority symptoms, the higher the Determinant Code (with ECHO and DELTA triaged prior to CHARLIE, BRAVO, ALPHA, and OMEGA). Calls were returned when response could go out, with the patient’s condition at that time establishing the priority level in the triage system. If no one at the number provided answered, the level remained the same as at the time of the initial call.

Dispatchers also took administrative calls for heads of departments monitoring the storm in the separate emergency operations center.

Chief Allo said they train for the worst scenarios. They’re prepared: staffing, schedules, frozen food stocked and ready to cook in microwaves on-site, and, as noted, the conference room converted to bunkers. The center is built to withstand hurricane force winds and surge.

The tough part is knowing what the emergency dispatchers are forced to leave behind, said Chief Allo, and it’s no different for him. “I boarded up the house, pulled out of the driveway, and said good-bye,” he said. “I had sent my family away; I knew they were safe, and it was time I went to work.”

**Katrina scoured Mississippi’s coastline**

Charles Clampett is pragmatic when it comes to mixing business and personal life during extreme weather conditions.

“You come to work and do what is expected,” said Clampett, currently a paramedic and dispatcher for American Medical Response in South Mississippi (USA). “That might sound cold, but I understand. If a storm threatens, you still show up for work.”

Like Holli Jordan, Clampett has the preparation routine down pat. He boards up his house, arranges care for his pets, and hopes for the best when he returns home. The routine was severely tested when Hurricane Katrina reached coastal Mississippi early on Aug. 29, 2005.

Clampett was then a Paramedic Supervisor for Acadian Ambulance and an Emergency Operations Center Pre-Hospital Liaison covering Jackson County—one of the three coastal counties Katrina just about obliterated off the map. Hurricane Category 3 winds (125 miles per hour) and storm surge destroyed large sections of Hancock, Harrison, and Jackson counties. Surge covered almost the entire lower half of Hancock County, and in Harrison County, up to 10 feet of water channeled in downtown Biloxi with about the same in Jackson County. Ninety percent of Mississippi’s easternmost city, Pascagoula, and 100 percent of the low-lying areas in Jackson County were flooded from surge.

Clampett established a communication center with a line dedicated to ambulance dispatch inside Pascagoula’s Singing River Hospital. As a paramedic, he had sat in dispatch and understood the way ProQA® worked and set up a telephone triage system.

During the storm, Biloxi Police Department emergency dispatchers answered calls from people who had not evacuated and were pleading for rescue as rising water flooded their neighborhoods and homes. The dispatchers, unable to send response, provided the only advice...
they could: escape to a place above water (attics, roofs, etc.). The evacuation orders relayed to the public days prior to landfall were every bit as much for the safety of residents as for the safety of responders.

“We circulated the number to municipalities,” Clampett said. “If people needed an ambulance, they’d call this number. We had paramedics wading through eight feet of water in Pascagoula.”

WLOX, a Biloxi news station, won a 2005 Peabody Award for the coverage provided by the 50 employees who stayed at the station the night before Katrina made landfall, the day of, and the 12 days immediately following. Reporters roamed the area donning high boots and hooded trench coats, pointing out Gulf waves crashing into a usually placid coastline, interviewing people who chose not to evacuate, standing under the eaves of their building to show audiences accelerating wind speed and rainfall, and—after it was over—charting the devastation. The coverage was sobering, heartbreaking, and historic.

The damage was inconceivable, Clampett said.

“People remember New Orleans because the levees broke and the water flooded and stayed,” he said. “The water came in and the water went out at the Gulf Coast, but it scoured the surface. It was horrible. People were in shock, milling around in a daze after the storm had passed. It was sweltering, humid and hot. People didn’t know where to go, what they would do.”

Essential to the extreme

Cold weather requires extra layers to stay warm. Cold temperatures plunging below historic lows means you don’t venture out unless, of course, you’re an emergency dispatcher.

Dispatchers are termed essential employees under Waukesha County’s (Wisconsin, USA) emergency conditions policy, meaning that due to the nature of their jobs, they are required to report to work during declared emergency conditions.

Even if that wasn’t county policy, they’d most likely come in, said Waukesha County Communication Center Training and Operations Manager Sherri Stigler.

“Dispatchers know what to expect when they get into this,” Stigler said. “They don’t take their responsibilities lightly.”

The Polar Vortex invading the Midwest during late January shot temperatures to double digits below zero (Fahrenheit) and—adding bone deep cold to frigid air—blasted winds putting people in extreme danger when venturing out in a wind chill of minus 35 to minus 50 degrees in Waukesha, a county in the state’s southeast corner. A day before the cold set in, nine inches of snow fell.

Waukesha County office buildings were closed on Monday, Jan. 28, due to the anticipated snowfall with likely dangerous driving conditions. Waukesha County courthouse and county offices were closed on the coldest days—Wednesday, Jan. 30, and Thursday, Jan. 31. Schools and businesses were closed. No mail was delivered.

The 12 dispatchers that were normally at work during the day shift were increased by one in anticipation of call volume and, sure enough, that’s what happened but not to the extreme you
might expect. Icy, snowblown roads affected local and highway travel. From midnight to 6 p.m. on Monday, Jan. 28, Waukesha County sheriff’s deputies responded to 60 property damage accidents, 14 personal injury accidents, 85 cars in ditches, and 81 disabled vehicles. The 911 calls related to frigid temperatures included frostbite and a house fire possibly related to the use of alternative heating fuel.

The center also hosted 27 Emergency Medical Dispatchers in a three-day certification course taught, ironically, by Barbara Ireland, former Deputy Chief of Communications for New Orleans Emergency Medical Services (NOEMS). Katrina flooded both E911 call centers and all E911 switching equipment. No E911 or regular telephone service was available. She spent five months living out of a suitcase in a small room and on a ship temporarily housing EMS. Each morning they’d report to work.

“We’re not in that same position from the cold,” Stigler said. “We can send. Like every place else, it’s a matter of being prepared and doing the best we can considering the conditions.”

Planning for the worst

Barry Furey is a Public Safety Consultant and Trainer and former Director of Raleigh-Wake Communication Center in North Carolina (USA), a state ranked fifth for homes at risk for natural disasters.

“Murphy was an optimist,” said Furey referring to Murphy’s Law. “Everything will go wrong that can go wrong, but [for emergency services] it will be at the most inappropriate time.”

Nine of Furey’s 45 years in public service was dedicated to Raleigh-Wake (January 2006–December 2014), during which time he directed emergency communications through hurricanes, tropical storms, flooding, winter storms, and tornadoes. His recommendations for natural disaster planning are based on experience managing four 911 communication centers in four states. While written policies and procedures are vital to any operation, he also advocates erring on the side of initiative, common sense, and the willingness to set aside standard operating procedures (SOP).

“There are times you can ignore the SOP,” he said. “What happens when the unthinkable hits at 3 a.m. on a Sunday and the manual doesn’t take the unthinkable into account? You’re lost. You have nothing to go on. I recommend using the manual as general guidance, but you can’t expect people to follow a procedure manual written like it’s for an assembly line.”

Furey can list multiple situations when initiative and preparation in the spirit of Murphy’s Law ruled the day. The issues and their potential varied: natural disasters, technology, power outages, and populations exposed to hazardous manmade elements. He preferred, when able, to use reality-based training similar to other public services.

“It’s easier for a firefighter to raise a 40-foot ladder in a book than in the middle of the night in pouring rain,” he said. “Communications needs more of that.”

His first in on-the-job training at Raleigh-Wake put emergency dispatchers in an off-site backup unit built to accommodate communications in case central operations went down. Problem was, it had never been rigorously exercised.

“The capacity was actually diminished,” Furey said. “Neither the people nor the equipment had been adequately tested. No one likes surprises in communications. Dispatchers have enough to worry about with the next call coming in.”

Furey ran operations from the backup for several days, rotating emergency dispatchers and supervisors through to “exorcise all ghosts from the machines” and create the feeling of second nature when conditions forced a shift in operations. He repeated the training exercise annually for new and seasoned staff.

“You can make any plan you want on paper, but you will never adequately plan unless you practice,” he said.
Furey related an experience from a previous center, when a sudden crash of the CAD system forced familiarity with the MPDS cardset that evolved into standard practice. The “old-timers” didn’t stress without the CAD. They never skipped a beat, automatically pulling out the cards, pens, and paper. The newcomers who had never trained on these procedures “walked around like deer in the headlights,” he said. “That’s when two things hit me,” he added. “First, basic training needs to include both normal and emergency operations. And, secondly, continuity of operations is actually a long-term goal that is heavily dependent upon short-term actions. You have got to successfully transcend that critical minute when the crisis hits in order to be up and running two days later.”

Reporting for duty at the communication center during a natural disaster is second nature. It’s ingrained as part of the job’s responsibilities, Furey said. People arrive early “just in case” and, if they are unable to drive, municipal vehicles provide pick up and drop off. “You never want to place your people in physical jeopardy or expose them to any type of danger,” Furey said. “Yet, it’s been my experience that people come in when not called [voluntarily] rather than refusing to come when called.”

A checklist applies here: accommodations, either at the center or nearby hotel/motel; food; rotations; and a consistent message for callers threatened by conditions jeopardizing field response. Emergency personnel learn the ropes of preparation, such as arrangements for family and pets, and securing their homes, when necessary. “There is a certain amount of dedication that comes with the territory, and dispatchers accept that responsibility,” Furey said. “This is not your typical 9 to 5 job. There are expectations. As much as people don’t like to think about bad things happening, it’s all part of emergency services along with knowing what to do when they do happen.”

Sources
MUCH MORE THAN A JOB
For some people, the place where they go to work every day is simply a job and nothing more. For others, work duties are part of their career. When you think of a job, you may think of coming into the office for eight (or more) hours a day, punching a clock, going through the motions, and doing what you have to do in order to get a much-needed paycheck. A career is different. In a career, you likely have more motivation, more engagement, more passion, and more motivation to continually develop and grow.

In a job, there’s often little hope or even expectation for growth. In a career, the employee has clear goals for advancement and skill development. There’s a defined path for additional future responsibilities and even leadership opportunities.

Some people are content to have a job rather than a career. The workers would rather not increase their accountability or expectations and prefer things to stay the same way. Other people bounce around from job to job for a variety of reasons and never settle on a career.

In the emergency dispatch industry, people can find careers through different positions, skill development, and continuing education. The IAED™ is here to support you in your efforts and provide tools to help you succeed in your career ambitions.

Digging deeper: What are the differences?

Financial expert Trent Hamm, founder of the organization the Simple Dollar, discussed some of the distinguishing characteristics between a job and a career. He wrote, “A job is simply something you do to earn money. Career advancement is not something you’re interested in there, and the work often doesn’t interest you at all. In five years, you’ll likely not be doing anything like your current job. A career is a series of connected employment opportunities, where you build up skills at employment opportunities to move you into higher-paying higher-prestige employment opportunities later on.”

Hamm expounded on the subject with a few other explanations.

A job:
• has minimal impact on future resumes and job applications because it’s completely unrelated to the positions you’ll be applying for.
• is just there to put some easy cash in your pocket.
• offers very few networking opportunities because the people at the job are not people you’ll likely know in a future job.

A career:
• is a series of heavily related jobs that will always be used on future applications and resumes.
• provides the backbone of experiences and learning that will fuel your professional life for years, if not your entire life.
• is loaded with networking opportunities, as most of the people around you are involved in similar careers to yours, and they’ll keep popping up time and time again.

A job can become a career

There are some employment opportunities we typically think of as jobs—temporary stopovers to help make ends meet for a time. For example, fast food cooks and clerks, janitors, grocery store stockers, and pizza delivery drivers...
might not be typical positions that many people expect to work long term.

This doesn’t mean workers have to treat them as jobs. Even these could, in fact, turn into careers.

Hamm points out that a convenience store clerk can certainly show up to work every day, stand behind the counter, and do the bare minimum to keep the job and collect a check. However, ambitious employees may see future growth opportunities, even in a position such as this. Workers may do extra work and may even take it upon themselves to learn about store management, accounting and inventory procedures, or interpersonal communication.

Larry H. Miller, a prominent businessman from Salt Lake City, Utah (USA), worked a series of jobs in his early and mid-20s, eventually securing a position in the parts department of an auto dealer. He treated the position as more than a job and learned everything he could about the business. He was motivated to grow the job into a career and wound up buying a car dealership nine years later. Eventually, he owned the nation’s 10th-largest car dealership, bought a professional basketball team, and saw his net worth soar to more than $400 million.3

Career growth prospects and the link to job satisfaction

Whether you see your current employment situation in emergency dispatching as a job or as a career, it’s important to enjoy what you do. Everyone wants to find at least some sense of fulfillment and satisfaction in what they do for a living. Unhappiness at work can lead to emotional and physical problems, including burnout and depression.

Jacob Morgan, writing for “Forbes,” elaborated on a study conducted by the Society for Human Resource Management, which the organization conducted in 2013.4 In the study, researchers examined the key factors that contribute to job satisfaction. While appreciation for one’s work was No. 1 on the list, learning and career development was No. 6, two places in front of an attractive fixed salary.

Author Brian Hill stated that one of the top six ways to increase an employee’s happiness at work or in a career is the opportunity for advancement. He wrote, “Employees are more satisfied with their current job if they see a path available to move up the ranks in the company and be given more responsibility and along with it higher compensation. Many companies encourage employees to acquire more advanced skills that will lead to the chance of promotion.”5

What can employees do?

When you’re serious about turning your job into a career, or when you want to move to the next level in your advancement, there are resources available. Many companies offer tools and programs to help you progress. In the absence of such assistance, there are still things you can do on your own—at and away from work—to increase your understanding of your profession, gain valuable skills and competencies, and put yourself on a better track for the trajectory you want to go.

Management and organizational development consultant Susan M. Heathfield listed five steps for career growth:6

1. Set goals and create a plan to achieve them.
2. Develop a timeline, including milestones.
3. Utilize company programs (if available).
4. Own your career path (and discuss your ambitions with your boss).
5. Write down your desired path and goals.

In an article for the Harvard Business Review, Herminia Ibarra suggested that advancing in one’s career takes effort and determination. “Those who want to develop themselves must create opportunities. That means coming to understand how your organization works, how it makes money, and who its key people are,” she said.7

Ibarra further said, “Look for roles outside your group or organization that allow you to learn and practice new skills and raise your profile. Teach, speak, or blog on topics relating to your interests. Go to professional gatherings and meet with people from different companies. And, if there isn’t something out there that meets your needs, create your own.”8

We’re here for you

Clearly, the emergency dispatch profession is unique. Your day-to-day tasks are quite different from what most people handle. Though you’re under the headset all day, you never know what type of call you’ll get next. You may think of your time in the comm. center as a stepping-stone, or you may envision a lengthy career. Wherever you stand, the IAED is dedicated to supporting you and the centers where you work.

Our mission is “To advance and support the public safety emergency telecommunications professional and ensure that community members in need of emergency, health, and social services are matched safely, quickly, and effectively with the most appropriate resource.”

In order to achieve this mission, we need to ensure that emergency dispatchers and others in the profession have the right training and knowledge. Not only will this allow you to render the best possible assistance to callers and patients, but it can give you more gratification at work and inspire you to move forward in an enriching career.

With the help of the Academy, you can certify and recertify as an emergency dispatcher. There are also opportunities outside of management such as in quality assurance (EMD-Q®, EFD-Q™, and EPD-Q™) and as an instructor with the Academy.

Laura McConchie, who currently works for St John Ambulance Service in New Zealand as Training and Quality Manager, has seen her career
soar with the help of the IAED and through her own initiative. She began as a call handler in 2006 and advanced to the position of dispatcher within a year. By November 2009 she became the trainer and auditor at her center. Another 6 ½ years later, she became the national manager of the Training and Quality Team for centers in St John: Auckland and Christchurch.

“Most of my learning has occurred by seeking out and being motivating and attending the conferences to network with others to share material, which has proved worthwhile along the way,” she said.

Check out some of the tools and resources we offer to help you learn and grow.

**NAVIGATOR**

This is our signature event of the year. Held annually, NAVIGATOR moves to different locations in the U.S. and brings together some of the brightest minds and most experienced professionals in public safety and emergency dispatching. This three-day event comprises dozens of educational sessions on topics ranging from organizational management, leadership, and technology to stress management, QA, and in-depth instruction on calltaking for medical, police, and fire calls.

NAVIGATOR is the ideal place to network with colleagues and like-minded professionals. Here, you can gain new insights into best practices and share ideas with people from comm. centers around the world. It’s also an occasion where we celebrate greatness and recognize achievements. It’s where we announce the Dispatcher of the Year, Instructor of the Year, the recipient of the Dr. Jeff J. Clawson Leadership Award, and other award recipients.

In 2018, more than 1,500 people attended the event in Las Vegas, Nevada (USA). This is hardly the only NAVIGATOR conference we have, though. Throughout the world, we also hold conferences in the U.K., Ireland, China, Middle East, Australasia, Europe, and Asia. We follow the same format at these events as well.

“Attending NAVIGATOR provides attendees the opportunity to meet with and hear thought leaders within our industry to gain insights and ideas that can be used to further their own commitment to our profession, expand their knowledge base, and help them grow personally and professionally,” said Pam Stewart, IAED Director of Operations. “With over 180 speakers and 11 different educational tracks (at the U.S. event), attendees are sure to learn something that will positively impact their career and set the framework for their future in public safety. And with attendees, sponsors, and exhibitors hailing from 15 different countries, the networking opportunities are priceless.”

McConchie has attended several NAVIGATOR conferences, both the U.S. event and Australasia NAVIGATOR. In fact, she spoke at Australasia NAVIGATOR in 2017 and 2018 as well as at the most recent NAVIGATOR in National Harbor, Maryland (USA), in April. She said making the effort and sacrifice to attend is well worth it.
“NAVIGATOR is extremely worthwhile, as the amount of sessions and the huge networking opportunities are exceptional,” she said. “I always get motivated at these to come back with new ideas, as everyone attending is eager to share, learn off each other.”

The College of Emergency Dispatch

We may not have a football team or even a mascot, but our college is a champion for emergency calltakers and dispatchers. Launched in 2013, the College of Emergency Dispatch promotes learning opportunities for emergency dispatch professionals. This is your best source to access Continuing Dispatch Education (CDE) courses and quizzes.

The mission of the college is “To promote industry-leading educational opportunities to the men and women in the emergency telecommunications profession, and support the emergency industry by empowering those that serve with the knowledge, skills, and abilities necessary to succeed.”

All you have to do is go to learn. emergencydispatch.org and log in using your member ID. You’ll then enter a site full of informative, interactive courses, most of which are in English.

By the end of 2018, members had completed more than 172,000 lessons and logged nearly 122,000 CDE hours on the College. As 2019 began, there were also more than 1,863 users on the College, with 1,662 agencies represented.

“For me, the College has been one of the best innovations in many years,” said Mark Richards, EMD-Q and member of the Board of Accreditation and Medical Council of Standards. “I don’t think it should be a case of ‘should we?’ It should be a case of ‘why wouldn’t we (use the College)?’

McConchie loves the many advanced lessons and quizzes on the College. She points out how easy it is to go at your own pace because you can watch and replay the courses as needed.

Certification and recertification courses

With the help of our partners at Priority Dispatch Corp., we offer a slew of courses where you can certify and recertify in various disciplines. These courses are held both on-site at our corporate headquarters in Salt Lake City, Utah (USA), and in locations across the world. Agencies can even sign up to host their own courses.

Hundreds of courses are available throughout the year. The IAED’s Boards of Curriculum develop all courses, which cover everything from basic information to advanced concepts, and everything else in between. When you successfully complete a course and pass the exam, you are eligible to be certified through the Academy. Your certification is valid for two years.

Instructor training

If you’re interested in expanding your skill set and gaining teaching experience, the Academy can help. We offer instructor training courses to prepare you to impart your knowledge to aspiring emergency dispatchers. You can certify as an EMD, EPD, EFD, or ETC instructor.

Instructors travel to different locations to teach the courses. In the process, they develop friendships, make professional connections, and inspire others in their own professional journeys.

“I enjoy passing on my experiences to other people, knowing that they are gaining knowledge and experience themselves and they will use that experience in ensuring others improve in their own work,” said EMD Instructor James Gummett.

ED-Q™ Instructor Tammy Jewell has glowing reviews of her time in this role.

“I love to travel all over and hear agencies speak proudly of their centers, accomplishments, and goals for the future,” she said. “The commonality among every place I visit is the desire to serve and protect the public. They take their jobs seriously and want to learn how to be better telecommunicators, managers, auditors, etc.”

CCM

The Communication Center Manager Course is an annual training event designed especially for agency leaders. In partnership with Fitch & Associates, this annual course is held in two on-site sessions for a total of two weeks in two different sessions. You also participate online during the course. The next course will be Sept. 8-13 and Oct. 27–Nov. 1 in Little Rock, Arkansas (USA).

The course “provides a comprehensive foundation of management and leadership practices tailored to today’s communication center leaders.” Like NAVIGATOR, it’s also an excellent way to build a network of friends and colleagues in the industry. The course covers many topics, including human resources, customer and media relations, operations, finance and budgeting, and technology.

No matter where you are in your career journey, there are opportunities to expand your skills and knowledge. These could lead to other positions or proficiency in your tasks. Take advantage of what the Academy offers and become the professional you want to be.

Sources


2. See note 1.


8. See note 7.
The most common culprits for all brush, grass, or wildland fires in the United States are:

- **10%**
  - Electrical power or utility line

- **14%**
  - Outside or open fire for waste disposal

- **19%**
  - Intentional, including arson

- **4%**
  - Playing with heat source

- **4%**
  - Lightning

- **10%**
  - Smoking materials

- **3%**
  - Shop tools and industrial equipment, including torches

Timely action is required for fires outside

Josh McFadden

If you like spending time outdoors—whether you enjoy camping, hiking, backpacking, hunting, or just about anything else—you probably love winding down next to a relaxing fire. This does much more than warm you up. There’s something about a crackling, glowing fire that mesmerizes us.

It’s also easy for fires to get out of control.

The Fire Priority Dispatch System™ (FPDS®) covers outside fires in Protocol 67, which includes LARGE OUTSIDE fires, SMALL OUTSIDE fires, and LARGE and SMALL Outside fires with hazardous materials. Version 6.1 of the FPDS also grouped WILDLAND fires and BRUSH/GRASS fires (both large and small) with Protocol 67. Last year, however, with the release of FPDS v7.0, WILDLAND fires and BRUSH/GRASS fires (both LARGE and SMALL) became part of the new Protocol 82: Vegetation/Wildland/Brush/Grass Fire.

Protocol 82 is robust; it has ECHO-, DELTA-, CHARLIE-, BRAVO-, ALPHA-, and OMEGA-level Determinant Codes, in addition to several Determinant Suffixes. Protocol 67 has been trimmed down a bit but still has several Determinant Suffixes. Before we get into the specifics of how to handle common issues with both of these protocols, let’s look at some statistics.

What are the causes?

In the United States, the National Fire Protection Agency studied the causes of fires over a five-year period from 2011 through 2015. Here were the findings of the most common culprits for brush, grass, or wildland fires1:

- Intentional, including arson: 19 percent
- Outside or open fire for waste disposal: 14 percent
- Smoking materials: 10 percent
- Electrical power or utility line: 10 percent
- Garden tools or agricultural equipment: 5 percent
- Lightning: 4 percent
- Playing with heat source: 4 percent
- Agriculture or land management burns: 4 percent
- Fireworks: 4 percent
- Rekindle: 4 percent
- Shop tools and industrial equipment, including torches: 3 percent

Which types are the most common?

During this five-year span, fire departments in the U.S. estimated that there were around 306,000 brush, grass, and forest fires annually. This breaks down to 840 per day. Brush fires or a combination of brush and grass fires led the way with 123,700 of these fires, or 40 percent of the total. Grass fires were right behind at 113,400, or 37 percent. What the NFPA classified as
“Unclassified natural vegetation fires” accounted for 38,300 fires annually, 13 percent of all outside fires. Forest fires, otherwise known as wildland fires, were at 10 percent, with 30,600 fires per year from 2011 to 2015.2

**Final numbers**

The NFPA discovered some other interesting information from its study. Some of the noteworthy findings in the U.S. include the following:
- From 2011–2015, there were 1,330 injuries to firefighters from brush, grass, and forest fires.
- From 2007–2016, 44 firefighters lost their lives while fighting and responding to these fires.
- These fires are most common in March, April, and July.3

**Getting started on Protocol 67**

In Protocol 67, there are nine Determinant Descriptors. The first two Key Questions—“Tell me exactly what is burning” and (if appropriate) “What size of area/structure is burning?” will help determine right off the bat which to choose. As Rule 5 points out, some callers may have a difficult time accurately answering Key Question 2. If this happens, “ask them to relate it to the size of a familiar area (e.g., football field, tennis court, etc.).”

The caller may report that some outside structures are burning. Fire watchtowers, water towers, TV/radio towers, and wind turbines may be considered LARGE ELEVATED structures, and these will be assigned the 67-D-1 Determinant Code. SMALL ELEVATED structures are assigned the 67-C-1 code, the only CHARLIE-level response in this protocol. SMALL ELEVATED structures may be things such as billboards and cellular towers. Your local fire administration or agency must define and authorize for dispatch purposes what constitutes LARGE and SMALL ELEVATED structures based on anything over a set height for LARGE and anything between set heights for SMALL.

It’s critical to determine whether an OUTSIDE fire is LARGE or SMALL, as LARGE ones get a DELTA-level response, but SMALL ones get a BRAVO-level response. The following may be considered LARGE OUTSIDE fires:
- Cardboard (bulk)
- Landfill
- Lumber pallets
- Mulch (bulk)
- Oil pumping units
- Railroad ties
- Recyling yard
- Salvage yard
- Storage containers
- Tire dump (bulk)

Meanwhile, the following may be examples of SMALL OUTSIDE fires, depending on their size:
- Barbecue grill or pit
- Bleachers
- Bonfire
- Doghouse
- Dumpster
- Fence
- Garbage can
- Illegal burning
- Mailbox
- Outhouse/Porta-potty
- Playground equipment
- Poles
- Trash
- Tree house

**Other Key Questions**

While Key Questions 1 and 2 will guide you in choosing the type of fire, the rest of the questions will provide pertinent information to fire crews and will help you determine which DLS link to use.

Key Question 3 instructs you to ask, “Is the fire threatening anything?” This includes people, animals, buildings, or vehicles. Pay attention to Rule 1: “The determination of whether a fire is threatening a building/structure should be based on the caller’s judgment,” as well as Rule 2: “If the caller is unsure, all associated buildings are considered THREATENED.” At this point, if you’ve coded the call as anything DELTA, CHARLIE, or BRAVO, it’s time to send the response and return to the Key Questions. As a matter of reference, Protocol 67 defines THREATENED building/structure as: “Any building/structure that has a potential of catching on fire.

Key Question 4 then asks, “Is anyone trapped or in immediate danger?” If the caller reports that this is the case, send EMS and ask the follow-up questions, “How many?” and “Exactly where are they/you located?” Then, as appropriate, ask Key Question 5, “Are there any electrical hazards?” In Key Question 6, you will ask, “Is the fire spreading?” If the caller indicates that the fire is increasing in size, you’ll need to follow up with, “What direction is the fire spreading?”

You’ll also notify EMS if the caller reports that people are hurt after you ask Key Question 7, “Is anyone injured?” Don’t forget to ask how many people are injured if the caller responds with “Yes.”

**HAZMAT issues**

The presence of hazardous materials can complicate this call. HAZMAT is, “An incident involving a gas, liquid, or solid that, in any quantity, poses a threat to life, health, or property.”
The tricky part here is that “Information about the presence of HAZMAT must be spontaneously provided by the caller,” as stated in Rule 3. You will not ask about HAZMAT during Key Questions unless the caller mentions it at some point. If this does happen, you will end your Key Questions with number 8, “Do you know the warning placard numbers (chemical ID) of the hazardous materials?”

If the call concerns a LARGE OUTSIDE fire with hazardous materials, it will still get a DELTA-level response, but you’ll code it as 67-D-3, whereas LARGE OUTSIDE fires with no HAZMAT issues are coded as 67-D-2. SMALL OUTSIDE fires with hazardous materials get a 67-B-2, while SMALL OUTSIDE fires with no hazardous materials get a 67-B-1.

If hazardous materials are present with any fire, follow the DLS Link to Panel D-1.

**Suffixes**

There are several suffixes to consider with Protocol 67. These will help “delineate what is being threatened by the fire.” These suffixes are:
- T = Trapped
- P = People in danger
- A = Animals
- B = Buildings (non-residential)
- O = Other
- R = Residential
- U = Unknown
- V = Vehicle
- X = Single injured person
- Y = Multiple injured persons

**Other situations**

There is one other BRAVO-level Determinant Code and one ALPHA-level Determinant Code in Protocol 67. If a first-party or second-party caller spontaneously informs you that there has been an extinguished fire, code the call as 67-A-1. An unknown situation gets a 67-B-3 code.

From time to time, fire crews will start controlled burns. In FPDS v6.1, a controlled burn gets an OMEGA response. With the changes in v7.0, there is no longer an OMEGA code on Protocol 67, but there is one for this situation on the new Protocol 82 (82-Ω-1). However, when in Protocol 82, it’s important to keep in mind Rule 6: “Before selecting 82-Ω-1, all questions in Case Entry and Protocol 82 must be asked and answered to ensure that the controlled burn has not escalated into an uncontrolled incident.”

**Over and out**

Give all Post-Dispatch Instructions and link to Panel X-1 unless the caller is in danger but not trapped (B-3), someone is on fire (B-4), or there are dangers present such as HAZMAT (D-1). Also, use the Stay on the Line DLS (X-2), Urgent Disconnect (X-3), or Burn Treatment (X-5) as appropriate.

**A few words about Protocol 82**

The first two Key Questions here are similar to those in Protocol 67: “Tell me exactly what is burning” and (if appropriate) “What size of area is burning?” Key Question 3 is also the same: “Is the fire threatening anything?” If it is, you’ll send the response and return to the Key Questions.

There are nine DELTA-level Determinant Codes on Protocol 82. Three involve LARGE WILDLAND fires, including one with structures involved (82-D-1) and one with structures THREATENED (82-D-2). A SMALL WILDLAND fire with structures involved and a SMALL WILDLAND fire with structures THREATENED are coded as 82-D-4 and 82-D-5, respectively. A LARGE BRUSH/GRASS fire is coded as 82-D-8, while LARGE BRUSH/GRASS fire with structures involved and LARGE BRUSH/GRASS fire with structures THREATENED are coded as 82-D-6 and 82-D-7, respectively. A SMALL BRUSH/GRASS fire with structures involved is also a DELTA-level response: 82-D-9.

Meanwhile, a SMALL WILDLAND fire is coded as 82-C-1, and a SMALL BRUSH/GRASS fire with structure THREATENED and a SMALL GRASS/BRUSH fire get an 82-C-2 and 82-C-3, respectively.

With all sizes of WILDLAND and BRUSH/GRASS fires, the local fire administration/agency must define and authorize for dispatch purposes what constitutes each.

Protocol 82 omits the Key Question about electrical hazards from Protocol 67 but also asks whether people are trapped or are in immediate danger. You’ll also ask, “Is the fire spreading?” (with the follow-up “What direction is the fire spreading?” if the caller answers “Yes”) and “Is anyone injured?” (with the follow-up question “How many?” if there are injured people). The caller must provide HAZMAT information without you asking.

In Protocol 82, there are five Post-Dispatch Instructions, including, “If you feel you are in danger, leave the area immediately and take others with you.” You’ll give this instruction if an evacuation order has not been issued.

**Sources**

2. See note 1.
3. See note 1.
YOU MUST BE FIRE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Spreading Quickly,” which starts on page 32. Take this quiz for 1 CDE unit.

1. With the introduction of FPDS v7.0, which of the following DID NOT move from Protocol 67 to 82?
   a. LARGE BRUSH/GRASS fires
   b. SMALL OUTSIDE fire with hazardous materials
   c. SMALL BRUSH/GRASS fires

2. According to the National Fire Protection Agency, what was the leading cause for brush, grass, or wildland fires in the U.S. between 2011 and 2015?
   a. lightning
   b. fireworks
   c. intentional causes
   d. cigarette butts

3. The NFPA reported that the three most common months for brush, grass, and forest fires in the U.S. are:
   a. February, April, June.
   b. March, April, and July.
   c. June, July, August.
   d. August, September, October.

4. In Protocol 67, SMALL ELEVATED Structures may be things such as billboards and cellular towers?
   a. true
   b. false

5. All of the following could be considered SMALL OUTSIDE fires except:
   a. bleachers.
   b. doghouse.
   c. playground equipment.
   d. mulch (bulk).

6. If the caller answers “Yes” in Key Question 6 of Protocol 67, you must follow up with:
   a. “Is there any water nearby?”
   b. “What direction is the fire spreading?”
   c. “How many people are injured?”
   d. “Can you safely get away from the fire?”

7. What is the significance of Rule 3 in Protocol 67?
   a. It states that the determination of whether a fire is threatening a building/structure should be based on the caller’s judgment.
   b. It states that if the caller is unsure, all associated buildings are considered THREATENED.
   c. It states that any building/structure has a potential of catching on fire.
   d. It states that information about the presence of HAZMAT must be spontaneously provided by the caller.

8. The only ALPHA-level code in Protocol 67, “Extinguished fire (1st/2nd party),” is determined by you asking Key Question 8.
   a. true
   b. false

9. This type of fire does not get one of the nine DELTA-level codes in Protocol 82:
   a. SMALL WILDLAND fire, structures THREATENED.
   b. LARGE BRUSH/GRASS fire.
   c. SMALL WILDLAND fire.
   d. LARGE BRUSH/GRASS fire, structures involved.

10. There are ________ Post-Dispatch Instructions in Protocol 82.
    a. five
    b. four
    c. three
    d. six

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To be considered for CDE credit, this answer sheet must be received no later than 06/30/20. 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.
So, let’s talk about the Key Question (KQ) “Is s/he completely alert (responding appropriately)?” The KQ is among two questions in a majority of the Medical Priority Dispatch System™ (MPDS®) Protocols, with the KQ: “Is s/he breathing normally?” coming in as a close second.

For starters (and the textbook answer), the two KQs are extensions of the information gathered on the Case Entry Protocol, when the mere presence of breathing and consciousness was the focal issue (primary survey). Now, the EMD wants to refine the assessment, depicting the situation more precisely. What is the quality of respiration and level of consciousness (secondary survey)? A higher-level response usually results for not alert patients or those with abnormal breathing.¹

The “Is s/he completely alert (responding appropriately)” KQ is so prolific because of its importance to emergency medical dispatch (EMD). It’s among the Holy Grails of EMD. As MPDS Inventor, Jeff Clawson, M.D., has stated²:

“[…] based on my years of work in the field of emergency medical dispatch, there are several ongoing enigmas to be solved in the attempt to perfect the interrogation and response coding processes at dispatch that will drive much of the most important research as we move forward. These, which we call the ‘Holy Grails’ of EMD, roughly in order, are:

1. Determining true non-alertness and the level of its effects on outcome
2. Determining life-threatening abnormal breathing
3. Determining SERIOUS (life-threatening) bleeding
4. Chest pain (non-traumatic) outcome-based interrogation and coding refinements
5. Detecting strokes that are ‘hidden’ in other Chief Complaints
6. Deciphering more specific information from ‘Unknown Problem’ situations
7. Outcome-based refinements of body area injured and bleeding classification”

Popularity quotient

Just how commonly used is this Key Question, you ask. Well, if you ever took the time to count, you’d find the “completely alert” KQ appears in all but six of the MPDS Protocols. The six exceptions are:

Protocol 9: Cardiac or Respiratory Arrest/Death
Protocol 12: Convulsions/Seizures
Protocol 22: Inaccessible Incident Other Entrapments (Non-Traffic)
Protocol 24: Pregnancy Childbirth/Miscarriage
Protocol 29: Traffic/Transportation Incidents
Protocol 32: Unknown Problem (Person Down)
Protocols 29 and 32 use slightly different variations of the Key Question: “Does everyone appear to be completely awake (alert)” (KQ 4) and “Does s/he appear to be completely awake (alert)” (KQ 1), respectively.

On Protocol 29, there are often multiple patients, making individual assessments problematic. Additionally, this protocol relies more on information about the scene and mechanism of injury, rather than individual patient conditions, to prioritize the call. The third-party nature of Protocol 32 means the caller is likely to be remote from the patient, and a close examination of the patient’s level of consciousness will often not be possible. And it is believed that using the word “awake” will make it easier for the caller to give the EMD a useful answer for such remote incidents.3

Incidentally, the KQ “Is s/he completely alert (responding appropriately)” replaced “Is s/he completely awake (alert)” in MPDS v12.0, which was released in 2008. More about that later.

Changing places

If you were tracking the positioning of “Is s/he completely alert (responding appropriately)?” while reviewing its presence in the Protocol, you would also notice that it does not always appear in the same place on each of the protocols where it is included. Placement varies and here is what we observed. It is listed as KQ 1 in 10 protocols, KQ 2 in five protocols, KQ 3 in two protocols, KQ 4 in five protocols, and KQ 5 in five protocols.

Why the variation? IAED ™ Operations Research Analyst Greg Scott said it has to do with the nature of the Chief Complaint. Key Questions involving safety and scene hazards are almost always listed in the top of the Key Question order sequence, and therefore above the “completely alert” Key Question. A good example of this is on Protocol 4: Assault/Sexual Assault/ Stun Gun, where the safety questions regarding location of the assailant and determining if weapons are involved are the first two Key Questions. On certain other Chief Complaint protocols, Key Questions that relate to injury mechanism, patient extrication, and underlying causes may be placed above the “completely alert” question to sort out these incident-specific circumstances first, so the highest-order DELTA priority codes can be assigned immediately, or to initiate a shunt to another protocol. Protocol 17: Falls is a good example of how placing certain Key Questions ahead of the “completely alert” question can dictate the next immediate action(s) in the protocol.

Clarifying the question

What if the caller doesn’t understand what the EMD is looking for when asking “Is s/he completely alert (responding appropriately)?” Callers sometimes have a difficult time supplying a good answer. They can be ambiguous or hesitant. While the EMD cannot explain the textbook answer (the question is intended to determine if a conscious patient has experienced any decrease in level of consciousness), the KQ is equipped with the clarifier “Is s/he responding appropriately?” identified by parentheses in most versions of the MPDS and by brackets in the U.K.

Use of the clarifier is certainly not unprecedented.

“Unfortunately, callers don’t always give a ‘yes’ or ‘no’ answer,” said Brett Patterson, IAED Medical Council of Standards Chair. “It’s not uncommon to ask, ‘Is she completely alert?’ only to have the caller say something like ‘Well, she’s kind of lethargic.’ That’s the perfect time to use the clarifier. And if you don’t get a ‘yes’ answer, it’s ‘no’ by default. That way you’re being risk averse.”4

According to Universal Protocol Standard 2:

Clarifiers are to be read only when the caller does not understand the original word or phrase (the part not in ( ) or [ ]). It is not acceptable to use both the original text and the clarifier text in the same question at the same time. Such practice creates confusing, compound questions and instructions that are not easily understood by the caller.

Example:

On Protocol 1 in the MPDS, KQ 1 reads “Is s/he completely alert (responding appropriately)?” The first time the calltaker asks the question, it should be read: “Is s/he completely alert?” If the caller does not understand the question, the calltaker may then ask, “Is s/he responding appropriately?” The question should never be read as “Is s/he completely alert, responding appropriately?”

The right path

As the EMD’s First Law of Prioritization states, “The MPDS prioritizes the actions of the dispatcher, not just the response.” In the words of research recently published in the Annals of Emergency Dispatch & Response, “The logic of the MPDS is designed not only to get the information for responders, but to lead the EMD along the most appropriate series of steps.”5

Since alertness (i.e., level of consciousness) is a key indicator of patient status, it is critical for the EMD to determine if the patient is fully alert or not. An incomplete answer on the caller’s part—or an answer the EMD misinterprets—can result in sending the wrong response, rather than leading...
the EMD along the path of choosing the correct Determinant Code (for response assignment). When the "completely alert" KQ is asked and interpreted properly, the not alert patient will most often receive a DELTA-level code, while the fully alert patient may receive a CHARLIE- or even an ALPHA-level code, in the absence of other serious conditions or priority symptoms. In addition to its instrumental role in determining priority level and Determinant Code, the state of alertness can also determine the type of Pre-Arrival or Post-Dispatch Instructions the EMD provides.

For example, after interrogating the caller on Protocol 21: Hemorrhage/Lacerations, the EMD determines that the most appropriate classification is the "not alert" Determinant Code. This is the third of the determinants listed in the DELTA-level, and it results in a 21-D-3 Determinant Code.

As EMDs probably know, the Determinant Codes are set and maintained by the Academy’s Medical Council of Standards according to current clinical standards, user feedback, and expert consensus. However, the actual response assigned to each code is determined by each agency based on available resources and the interpretation of outcome data.

Research
Accepting the challenges associated with remote assessment has always been part of protocol’s development. “We can’t always provide black-and-white choices when we develop these protocol concepts because of the tremendous differences in patient presentations,” Patterson said. “For example, ‘She’s a little lethargic’ is obviously different than ‘She’s semi-conscious.’ To me, the latter means ‘Not alert’ while the former may need the clarifier. My hope is that the Q’s who review these calls will understand the intent of both the process and the EMD and evaluate accordingly. Latitude can be prudent when appropriate.”

Incidentally, the person or people who crack the codes of the seven “Holy Grails” (listed at the beginning of this CDE) are deserving of the Nobel Prize, according to Dr. Clawson, “if such were given in our field.”

Sources
7. See note 1.

THREE RULES IN CASE ENTRY
Three Rules in Case Entry explain the application of scene safety, mechanism of injury, and priority symptoms in choosing the correct Chief Complaint.

1. SCENE SAFETY
If the complaint description includes scene safety issues, choose the Chief Complaint Protocol that best addresses these issues.

2. MECHANISM OF INJURY
If the complaint description involves trauma, choose the Chief Complaint Protocol that best addresses the Mechanism of Injury.

3. PRIORITY SYMPTOMS
If the complaint description appears to be medical in nature, choose the Chief Complaint Protocol that best fits the patient’s foremost symptoms, with priority symptoms taking precedence. Priority Symptoms: abnormal breathing, chest pain, decreased level of consciousness, serious hemorrhage.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Completely Alert?, “ which starts on page 36. Take this quiz for 1.0 CDE unit.

1. What is the purpose of placing “Is s/he completely alert (responding appropriately)” and “Is s/he breathing normally” in Key Questions rather than Case Entry?
   a. Case Entry does not have sufficient space.
   b. The Key Questions refine the assessment for the EMD.
   c. Key Questions offer more flexibility for unstructured interrogation.
   d. “Yes” answers to either question determine immediate lights-and-siren response.

2. KQ “Is s/he completely alert (responding appropriately)” is not listed in how many of the MPDS Protocols?
   a. 18
   b. 12
   c. 6
   d. 3

3. Protocol 29 relies on what type of information to prioritize the call?
   a. patient location
   b. scene and mechanism of injury
   c. whether it’s a second- or third-party caller
   d. close examination of patient’s alertness level

4. On Protocol 32, the KQ “Does s/he appear to be completely awake (alert)” is used rather than the “completely alert” KQ in order to:
   a. limit redundancy of the “completely alert” KQ.
   b. speed up interrogation in remote areas where cellphone coverage is patchy.
   c. promote asking the questions as scripted through variation.
   d. make it easier for the caller to give the EMD a useful answer for such remote incidents.

5. The “completely alert” KQ is always listed in the same position in all Chief Complaints.
   a. true
   b. false

6. What type of Key Questions are almost always listed in the top of the Key Question order sequence, and therefore above the “completely alert” Key Question?
   a. Those involving safety and scene hazards.
   b. Those determining urgent, unscheduled transport of patients.
   c. Those helping the EMD make a diagnosis.
   d. Those asking permission to record the call for training reasons.

7. Clarifiers are to be read only when the caller:
   a. asks the EMD to repeat the question.
   b. does not have an answer that satisfies the original question.
   c. does not understand the original word or phrase.
   d. refuses to answer the question as asked.

8. It is not acceptable to use both the original text and the clarifier text in the same question at the same time.
   a. true
   b. false

9. When the “completely alert” KQ is asked and interpreted properly, the not alert patient will most often receive this level coding:
   a. ECHO
   b. DELTA
   c. CHARLIE
   d. ALPHA

10. Determinant Codes are maintained by the:
    a. Academy’s Council of Standards
    b. Membership consensus
    c. ASTM International
    d. Academy’s College of Fellows

To be considered for CDE credit, this answer sheet must be received no later than 06/30/20. 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.

CDE Quiz Mail-In Answer Sheet

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

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

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

The International Academies of Emergency Dispatch
110 South Regent Street, 8th Floor
Salt Lake City, UT 84111 USA
Attr: CDE Processing
(800) 960-6236 US; (801) 359-6916 Intl.

Please retain your CDE acknowledgement for future reference.

Name ________________________________
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City __________________ St./Prov. _____________
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Academy Cert. # ___________________________
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☐ Instructor
☐ Comm. Center Director/Chief
☐ Medical Director
☐ Commercial Vendor/Consultant
☐ Other

ANSWER SHEET - MEDICAL

May/June 2019 Journal “Completely Alert?“
Please mark your answers in the appropriate box below.

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

Expires 06/30/20

May / June 2019 | THE JOURNAL 39
‘FIRST, DO NO HARM’
First rule of medicine applies to running lights-and-siren

Jeff Clawson, M.D.

Although the issue of limiting use of running lights-and-siren (L&S or HOT) is central to the philosophy of the Priority Dispatch® Protocol Systems, it is an issue that still raises contentious debate whenever the subject is broached in EMS circles.

The Academy has always had as its objective to “send the right thing to the right person in the right way at the right time”—and the research to prove the inefficiency and potential danger of running L&S to all unscheduled calls—so, it surprises us as to why the practice continues as much as it does. Support generally comes in the guise of “because that’s the way it’s always been done” or the unfounded fear of liability for not running HOT and, consequently, endangering a patient’s survival. There are agencies which have failed to implement risk reduction policies in terms of standardizing response as to when L&S should apply, and simply leave it up to the individual emergency apparatus driver to determine the best method of getting to the caller’s location. Lawyers have a term for this. It’s called “arbitrary decision-making.”

The excuses camouflage the risk to patients, responders, and the public.

Research shows that unsafe speed and failure to yield are strong factors in vehicle crashes. The “wake effect” is also a strong factor in accidents involving emergency vehicles using L&S. An emergency vehicle using lights-and-siren creates a type of wave-like avoidance reaction in civilian vehicles as they attempt to get out of the way. Pulling to the side creates more accidents.

The example cited in the accompanying article demonstrates the tragic result of running L&S for a non-emergency (a sprained ankle). The ambulance broadsided a pickup truck, severely injuring the teenage passenger. The impact has had a devastating effect on the woman’s life and the lives of those who have attended her over the past 30 years since the accident occurred.

While many agencies have developed policies to limit HOT responses, others have not or have simply ignored the potential risk and consequent impact on lives. A report released by the National Highway Traffic Safety Administration (NHTSA) (April 2014) provides a staggering overview of an issue that “loyal opposition” should finally concede.

Key findings include:
- There are an estimated 6,500 accidents involving ambulances each year.
- On average, 29 fatal ambulance accidents produce 33 fatalities each year.
- On average, 2,600 people are injured in 1,500 ambulance accidents each year.
- Of those killed in an ambulance accident, 63% were occupants of a passenger vehicle, 21% were passengers in the ambulance, 4% were the ambulance drivers, and 12% were non-occupants.

Remember, the first rule of medicine (and public safety) is “First, do no harm.”
Guest Comment  * by Jeff J. Clawson, MD

RUNNING “HOT”
and the Case of Sharron Rose

Recently, a gentleman from a Michigan EMS system asked me to render my professional opinion regarding his city’s current EMS unit-response philosophy. As I understood from his letter, his system’s medical directors had verbally directed the local ambulance service to respond “emergency status” to all unscheduled calls. I assumed this meant that all ALS units were being dispatched red-light-and-siren (RLS, or “HOT”) to the scene. This mode of dispatch, he said, was based on the medical assumption that such calls represented “presumed life-threatening emergencies.”

After significant thought regarding the possible interpretation of my opinion that might not be appreciated by other members of his system, I decided to respond in writing in the following manner.

The Medical Priority Dispatch System (MPDS) concept was initially developed from 1976 to 1979. Its specific intent was that—from an emergency medical standpoint—the vast majority of people who request mobile aid are not in a life-threatening situation and, in most cases, the aid received at scene does not have a significant effect on the patient’s eventual outcome. Since EMS evolved primarily out of public safety and not out of the medical community, the amount of medical expertise and confidence in medical decision-making in the public-safety community was largely absent. This resulted in the perpetuation of old fire- and police-response traditions in EMS, or the “maximal response disease,” as it has recently been described.

The main objective of MPDS is to “send the right thing to the right person in the right way at the right time.” To my knowledge, not a single article has been published in this century that proves or even strongly indicates that the use of RLS saves lives. I will agree that a strong correlation does exist between early defibrillation of V-fib (in less than 600 seconds) and any time saved in delivering that response. Early reversal of choking and complete airway obstruction also pose good arguments for this practice. A weaker extrapolation can similarly be made for critical trauma patients and the “golden hour.” However, as one official of the American Ambulance Association was once quoted as saying, “Red-lights-and-sirens never saved anyone’s life in the history of the world.” He may be right.

Please do not confuse “saving significant time” with “RLS response,” as no published data prove that RLS response does save significant time. In an unpublished study conducted in Salt Lake City, it was demonstrated that fire...
pumpers and paramedic-staffed engines responding within their initial-response districts in urban or suburban areas experienced a 9-percent to 28-percent reduction in response times. Reductions depended on the time of day and concentration of semaphores, or visual signaling apparatuses, encountered. It was found that the maximum saving occurred during rush hour, when emergency vehicles traveled in the direction of main flow and when there was a traffic light at every block. It is interesting to note that the average time saved in these in-district responses was approximately 30 seconds.

In systems using a comprehensive MPDS, complete with a functioning dispatch quality-assurance program, we are starting to see some fascinating science regarding the appropriateness of sending BLS units “COLD,” or non-emergency status, when there is strict compliance to dispatch interrogation protocols. The City of Houston Fire Department recently submitted an abstract study to the Society for Academic Emergency Medicine on the ability of the city’s MPDS to spare paramedics from non-ALS responses. The city of Los Angeles, one of the largest metropolitan areas in the world, implemented an MPDS in November 1988. And, in March of 1990, Los Angeles implemented a tiered-response system based on the MPDS codes; suddenly, after decades of full RLS response in an EMS system handling approximately a quarter of a million runs each year, 29 percent of those calls were initially dispatched as a solitary responding vehicle “COLD.” I have been working with Los Angeles for more than two years, and, to my knowledge, the city has never received a formal citizen complaint regarding this mode of response. Similarly, neither has the Salt Lake City Fire Department after nearly 12 years of MPDS use.

The use of RLS is not without significant hazard. It has been estimated, for example, that as many as 12,000 emergency-medical-vehicle accidents (EMVs) occur each year in the United States and Canada as a direct result of RLS use. In addition, because of what

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**Editor's Note:** The following news story that appeared on the front page of the Bloomington, Ill., newspaper, The Pantagraph, on Dec. 29, 1989, illustrates just how costly the practice of running red-light-and-siren really can be in terms of lives and dollars.

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**The Pantagraph**

**Friday, December 29, 1989**

**Ambulance involved**

**Tentative settlement reached with crash victim**

**By Scott Richardson**

**Pantagraph Staff**

The City of Bloomington has reached a tentative settlement of nearly $5 million with a former cheerleader who was partially paralyzed in a crash between a pickup truck and a Fire Department ambulance last year.

If the proposal is approved at a scheduled hearing Jan. 10, Sharron Rose Friefburg, 18, of rural Saybrook will get an immediate cash payment of $500,000, according to court papers filed yesterday by her attorney, James Ensign of Bloomington.

She would get three more cash payments, one of $25,000 in 10 years, one of $50,000 in 20 years and one of $100,000 in 30 years.

The proposed settlement also calls for her to get $2,000 each month for the next 10 years and $3,000 per month for each month after that for as long as she lives.

All payments would total $4,975,887 if she lives to her expected life span, Ensign said.

Miss Friefburg is mentally and physically disabled. Using a quadrapod cane, she can walk only a short distance unassisted. She cannot talk and needs more surgery to improve motion of her arms. She is not expected to ever be able to work, Ensign said.

Miss Friefburg was an honor student when she left home March 26, 1988, to attend a movie in Bloomington with Mark Embry. As they were headed south at Center and Locust streets, Embry’s pickup was broadsided by the eastbound city ambulance which was transporting a man with a sprained ankle to Brokaw Hospital.

Miss Friefburg was in a coma until Aug. 1, 1988, and was brought home later that month after the family’s insurance company said it would not pay for any more hospital care because of a policy clause stating the firm would not pay for extended care when a patient has recovered as much as the company’s doctors think likely.

Since early this year, Miss Friefburg has been attending a program that combines education with therapy for the severely disabled.

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we call the “wake effect” of emergency units disrupting, confusing and startling other drivers, up to five times as many accidents are caused by units responding RLS that don’t physically involve the emergency vehicle itself. Does the number 75,000 get your attention? It should, if you, too, believe that the prime rule of emergency medical dispatch—as for medicine itself—should be, “First, do no harm.”

In 1989, I subscribed to a national newspaper clipping service, and for one year, I received so many articles on EMVs that I couldn’t fit them all into a cabinet drawer. And these were just the ones that made the news, such as fatalities, roll-overs, lawsuits and horrible outcomes. Then there was Sharron Rose. Her story caught my eye: In Blooming-ton, Ill., nearly $5 million and the quality of life of a talented, beautiful 18-year-old girl, Sharron Rose Froehling, were lost because of a “sprained-ankle” run (see box on page 12).

In 1983, Salt Lake City’s Fleet Management department reported that the EMVA rate had dropped 78 percent in that city as the result of the MPDS, and it was estimated that the number of EMS vehicles traveling Salt Lake City streets with RLS was safely reduced by 50 percent through use of the system. Were any Sharron Roses saved by these changes? I guess we will never know.

The “loyal opposition” (i.e., attorneys such as Sharron Rose’s) are learning about the “maximal-response disease” and the fact that every ambulance, fire truck and rescue vehicle does not have to respond “HOT.” The blind use of RLS may actually be killing more people than it saves. While we may worry about getting into trouble for not responding or transporting RLS, I predict that, in the not-too-distant future, any use of RLS will be subject to sensible justification and standardization or be considered negligent by the courts.

Finally, after reading about hundreds of unnecessary EMVs, it is my opinion that the medically unjustified, arbitrary or blanket use of RLS is a negligent process that runs contrary to the current medical-dispatch standard of care. In 1989, the National Association of EMS Physicians took the following significant stands in their Position Paper on Emergency Medical Dispatch:

- “Dispatch prioritization is an essential element in any EMS system for it establishes the appropriate level of care including the urgency and type of response.”
- “These priorities must reflect the level of appropriate response including types of personnel (ALS vs. BLS vs. first responder), response configuration (numbers and types of vehicles responding) and mode of response (red-light and siren vs. routine).”
- “The appropriate prioritization of the type, number and manner of responses is essential to effect an appropriate reduction of responding vehicles traveling red-lights-and-siren and therefore unnecessary vehicle accidents.”

In 1990, ASTM, a national standards-setting organization, issued its national document, Standard Practice for Emergency Medical Dispatch, which clearly states:

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

Perhaps these documents should be considered “Plaintiff’s Exhibits #1 and #2,” because that is what they will likely be used for in future EMVA negligence suits.

I believe that the careful, trained and knowledgeable use of the most up-to-date medical priority dispatch protocols results in a safe and efficient dispatch, care and response process for any EMS system. Measured, medically approved, preplanned responses (as opposed to the shotgun, hurry-up-and-wait approach still present in many current EMS systems) has become the new national standard of care.

I left the gentleman from Michigan with the thought that I was confident that his system—as an early leader in EMD training with progressive medical control—would be able to recognize the inevitabilities of response “science” in the near future. Let’s hope his system, as well as many others, realize its importance before it’s too late for the next Sharron Rose.
WHAT’S THAT SOUND?
It’s a first for Currituck County

Audrey Fraizer

The sound of a vehicle in the background came through over the line. Could it be a traffic accident? A suspicious person report?

At first impression, Brandi Leary based what she heard on experience as a night shift Emergency Medical Dispatcher. That changed in less than a New York minute and, in Leary’s case, the time between when she picked up and when she heard a woman’s voice in distress.

“She said the baby’s coming out,” said Leary, EMD and Shift Supervisor, Currituck County Communications, Currituck, North Carolina (USA).

The couple was not going to make it to the hospital, as they had hoped, and the birth was apparently too far along to extend the drive by a very short distance to the nearest fire station. Leary gave dad the PAIs for childbirth and delivery, and their baby—a boy—was born in the front seat at 4:35 a.m. on Jan. 25, 2019.

While Leary was busy providing instructions, EMD Taylor Rolling dispatched an ambulance from Currituck EMS. The crew was at the car within minutes. Dad was about to remove his shoelace to tie off the umbilical cord but not before the sound Leary was anxiously awaiting came through the line.

“I heard the baby cry,” Leary said. “We’ve had calls when the baby’s almost there, but the ambulance arrives before the birth actually happens.”

The baby’s cry was welcome relief. Leary credits the smooth delivery to PAIs in the medical ProQA® and the “amazing” people inside the car.

“They were calm,” she said. “They followed instructions. They were the perfect 911 callers.”

The next voice Leary heard wasn’t at all what she expected.

“Dad had handed mom the phone, and we talked,” she said. “She was calm and told the dad where he could find the blanket for the baby inside the car. I was so happy that everything was going the way it’s supposed to in that moment.”

The moment was particularly eventful for another reason.

Leary’s over-the-phone delivery was the first ever at Currituck County 911. Leary was aware of being “the first” and although the call and outcome were exciting, she didn’t “pay it any mind” until Liz Hodgis, Communications Supervisor, approached her and Rolling to congratulate them.

It was a big deal, Hodgis told them. They had received a call that brought a baby into the world and were remarkably successful at it.

For Leary, it was part of their job in doing the best they can for callers. Standards are high at Currituck County 911 and, aside from that, what could be more satisfying than knowing “you are making a difference in someone’s life”?

Leary has been in a position to help for nearly 19 years (as of September 2019). She worked a total of 14 years in law enforcement at Elizabeth City State University, Elizabeth City, North Carolina (USA), while studying criminal justice and transitioned to full time once she graduated.

In 2014 she went to Currituck County Communications. She said the training is extensive and includes practicing on a specific protocol each month. Before the call in January, there hadn’t been a complete baby delivery, but they sure were prepared for it when it did happen.

“This was our dream call,” Leary said. “Taylor was a huge part of this. We were so ready. We did exactly what we train to do.”

Currituck County Communications provides dispatch services for Currituck Sheriff’s Office, Currituck County Fire and EMS, six volunteer fire departments, North Carolina Forestry, Animal Services and Control, and the public ocean beaches along Currituck County. There are about 500 year-round residents who live along the 20 miles of oceanfront shoreline in Currituck County; in the summer, this number swells to at least 50,000 weekly visitors.
HIGH WATER DANGER
Driver caught in floodwater makes it to safety

Audrey Fraizer

The red car in the photo making the news explains why the driver panicked.

The vehicle rests at an angle perpendicular to water flooding over the gravel road. The front lights are nearly submerged, and the passenger side door—closest to a flooding ditch—is in water up to the window. It’s lucky the person in the car had the time and ample space to climb out the driver’s side window.

“She [the driver] was calm at the start of the call, but she grew a little more frantic as the call went on,” said EMD Lisa Hobbs, Pike County Sheriff’s Office 911, Pittsfield, Illinois (USA).

The woman’s escalating tone of voice was consistent with the water pushing through the bottom edge of the passenger side door. The water was rising from the floor, and the driver was understandably upset at the potential deepening danger.

The woman could not open the door and even if she could have, the rushing water carving a path below and around the vehicle posed an additional threat. She was hesitant about climbing out of the car’s window and onto the roof. Hobbs persisted.

“I asked her name and used that while asking her to listen so I could help,” Hobbs said.

Deputies arriving a few minutes into the call found the woman straddling the car’s roof. The panic of escaping from the inside was now replaced by water slowly pushing the car downstream. The location at a dead-end road complicated rescue, necessitating the use of a road grader able to withstand the increasing pressure of creek water flooding the road. Hadley Creek Road Commissioner Bob Armistead, who was operating the grader, pulled up close to the car and assisted the driver from the car’s roof to the grader’s cab.

The driver was now safe. The car was pulled out of the creek the next day.

The harrowing vehicle trapped in floodwater incident is not uncommon to Pike County emergency dispatchers and response teams.

“The creeks come up,” Hobbs said. “This is not the first time I’ve helped people out of cars.”

The pastoral Pike County, in west central Illinois, is land between two rivers. The Illinois River flows along 30 miles of Pike County on the east side, and the Mississippi River shares a longer stretch on the west side across from the state of Missouri. The county is a farmer’s and fruit-grower’s paradise, owing its fertile land to annual precipitation and the many creeks running serpentine through the predominantly cropland (average 80%) landscape.

During high flood events water seeps through the levees, soaking the fields and overflowing the creek beds. The county keeps a close watch on roads subject to flooding and issues local warnings when conditions threaten to make them impassible.

This spring’s no different. Precipitation was above average over the past winter, and the incident on March 9 coincided with flood warnings issued by the National Weather Service for Pike County due to heavy rain and snowmelt in the Mississippi River Basin.

Despite the above-average chances of receiving such a call, Hobbs enjoys emergency dispatch because of the ability to help people in risky situations. The center uses the Medical Priority Dispatch System™ (MPDS®), which allows her to focus on the caller (calming techniques in particular) while providing the instructions to escape from sinking or flood endangered vehicles.

Public gratitude includes an occasional thank you note or phone call, but that’s not what the profession is about, or the reason Hobbs celebrated her 11th year in dispatch in April 2019.

“It feels good to help someone, and this time everything turned out OK,” Hobbs said.

Pike County Sheriff’s Office 911 averages 9,000 calls annually of which 1,300 are made to 911 for an ambulance, fire, or police response.
HIGH EMOTIONS
Medstar Ambulance experiences highs and lows during trying week
Josh McFadden

From a first-time call to the tragic loss of a colleague, the team at Medstar Ambulance in Sparta, Illinois (USA), saw both ends of the spectrum during one week this past March.

Emergency dispatcher Tori Kelley was in the thick of all of it.

Kelley, who has been at Medstar for two years, has taken a wide range of calls during her tenure but never one like the one she took in early March. When the call was transferred to her, she knew right away that time was of the essence. A mother was in labor on her couch at home, and the baby was already crowning when Kelley jumped into action.

She faced some challenges right away. “When I first came on, I heard a lot of screaming in the background,” Kelley said. “It prepared me and told me we needed to get someone there now.”

Not only was the patient screaming from the pain, but family members were making lots of noise in the background, making it difficult for Kelley to hear what the caller was saying and for the caller to hear her instructions.

To make matters more complicated, the caller was struggling to maintain her composure, even though she was trying to listen and do what Kelley was telling her. Kelley said she used customer service techniques to calm the caller.

“The caller wanted to help, but she was pretty worked up and not sure exactly what to do,” she said. “She was trying to block out the noise too. I had to reassure her and let her know that crews were on the way as fast as they could get there.”

This fast-paced call resulted in the baby coming in less than five minutes after Kelley took over. The baby was completely born by the time crews arrived. Kelley was relieved the baby had been successfully delivered, but she soon turned her attention to other matters.

“The hard part was over, but my next concern was how mom and baby were doing,” she said. “I had to find out if they were breathing or bleeding.”

Though the mother had some bleeding, there were no serious complications.

She and her new bundle of joy were transported to the hospital. Kelley’s last information was that both were doing just fine under doctors’ and nurses’ care.

After ending the call, Kelley had a moment to reflect on the delivery.

“I was excited to know that I got to help bring a life into the world, even though it was nerve-wracking,” Kelley said. “It was a blessing to know that mom and baby were safe.”

Great work runs in her family. Kelley is the granddaughter of Medstar founders Charles and Deb Kelley. Current company Vice President Chuck Kelley and EMT Amy Kelley are her parents.

This call had a happy ending, but it came during a time when employees at Medstar had heavy hearts. That same week, longtime Medstar team member Deon Lee Davis unexpectedly passed away, leaving grieving friends and colleagues in disbelief and sadness.

Davis had been an operations manager and paramedic at the center for 36 years. He was also an EMD-Q®.

“He was one of the very best people you’d ever meet,” said Trecia Hanna, Dispatch Manager at Medstar Ambulance. Like any emergency dispatch center, the Medstar Ambulance comm. center is normally a bustling place with plenty of noise and activity. On the day when everyone learned of Davis’ passing, Tori Kelley said the “silence was unspeakable.”

Davis was much more than a co-worker to Tori Kelley; he was a close family friend. His death hit her hard, but it has given her perspective.

“It’s been challenging for me,” she said. “It makes you realize how precious life is. I’m trying to spend more time with the people I love. Just remember to tell those people close to you that you love them.”
CRISIS INTERVENTION TRAINING
Program trains officers for mental health calls

Becca Barrus

The ability of a police officer to de-escalate a volatile situation is invaluable and, in many instances, lifesaving. It takes training to use discernment to decide which method will work best in a given situation.

That is why Crisis Intervention Training (CIT) was developed. It came about in 1988 in response to police killing a mentally ill person in Memphis, Tennessee (USA). The Memphis Police Department joined with the Memphis Chapter of the National Alliance on Mental Illness (NAMI), the University of Memphis, and the University of Tennessee to organize, train, and implement a specialized unit to respond to calls involving mentally ill people.1

As of 2014, an estimated 2,700 police departments reported using CIT across the U.S.2 A similar program in Toronto (Canada) called Mobile Crisis Intervention Team (MCIT) sends a trained mental health professional with police to scenes involving people with behavioral disorders.3

The training focuses on communication and de-escalation techniques such as: “continuously assessing the threat, being professional, modeling composure, being aware of body language, providing physical space as appropriate, using names and engaging, using calm and clear language, validating the person’s feelings/situation, encouraging relaxation, providing realistic assurances, and remaining patient.”4

The Core Elements of CIT are comprised of Ongoing Elements, Operational Elements, and Sustaining Elements. The program realizes that response to and treatment of mental illness calls go beyond the call and immediate reaction—it involves the community as a whole. It’s a conversation. Having officers with CIT experience is more impactful when coupled with mental health resources where those in need can get the assistance they need. Police departments are encouraged to form partnerships with the mental health advocacy community. Each police agency should have policies that allow officers to refer patients to appropriate services, whether that’s inpatient or outpatient.5

When a crisis call is reported, the nearest CIT officer is sent, much like the nearest responder being sent to an ECHO call.

So what does this have to do with emergency dispatch? Dispatch is part of the Operational Elements of CIT’s Core Elements. The document states that “emergency dispatchers are a critical link in the CIT program” and that their ability to recognize a CIT call and ask questions to give the CIT officer information necessary to respond appropriately are key to the whole process. Emergency dispatchers involved in the CIT program should receive a minimum of 8–16 hours of classroom training and additional in-service training.6

For those who use CIT and the Police Priority Dispatch System™ (PPDS ™), Protocol 121: Mental Disorder (Behavioral Problems) provides a script of research-supported questions and PDIs to de-escalate the situation before an officer even arrives on scene. Such PDIs include speaking softly and calmly to patients, writing down medications and/or drugs that the patient is taking, and protecting patients from themselves if necessary.

Additionally, the International Journal of Law and Psychiatry published a paper in 2011 citing, among other things, the effect that correct coding by the emergency dispatcher has on how the police officer handles the call. The study found that “the manner in which the call was dispatched” (i.e., the Determinant Code) “was, in fact, related to the decision the officers made at scene.”7

Emergency dispatchers need to develop the skill of recognizing which calls are best handled with CIT and/or Protocol 121. Familiarize yourself with the signs and symptoms exhibited by mentally ill callers or patients to give them the best chance to have a positive interaction with the police and to get help.

To find a list of sources, visit iaedjournal.org and look for this article.
HOW LONG DOES IT TAKE YOUR TELECOMMUNICATORS TO GET HANDS ON CHEST?

Do you know?

Quickly directing callers to perform CPR is one of the most important elements in the chain of survival. Knowing how long it takes a telecommunicator to get CPR started is the first step toward improvement. With Academy Analytics™, you can monitor time-to-chest compressions by individual, shift, or the entire communications center. Your team’s current ProQA® performance data is delivered in near real-time directly to your phone, computer, or center monitors. You can review data and give meaningful feedback while the call is still fresh in their minds.

Sign up for our free webinar series at prioritydispatch.net/academyanalytics.