THERAPY DOGS BENEFIT DISPATCH CENTERS

TOURNIQUET PROTOCOL STOPS THE BLEED
I DIED.
Your data helped bring me back.

I was at the top of my game when my heart stopped on the track. Your dispatcher coached my coach to do hands-on-chest before it was too late. Because you focused on data and performance using Academy Analytics, I lived to run again.

prioritydispatch.net/AcademyAnalytics
Follow IAED on social media.

The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234; 8,066,638; 8,103523; 8,294,570; 8,335,298; 8,488,748; 8,494,886; 8,712,020; 8,971,501; 9,319,859; 9,516,166. The PPDS is protected by U.S. ... 8,396,191; 8,670,526; 8,873,719. The FPDS is protected by U.S. patent 8,417,533. Other U.S. and foreign patents pending.

Protocol-related terminology in this text is additionally copyrighted within each of the IAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.
Art is a software instructor and IAED-certified EMD-Q® instructor for Priority Dispatch Corp. He has been a fire and EMS dispatcher for 20 years and is a former air medical dispatcher. He currently works at Union County Regional Communications in Westfield, New Jersey (USA).

Jenny has worked at nonprofits around the world. From participating in peace-building efforts in Northern Uganda to working toward the nonproliferation of chemical weapons in The Hague and closing student achievement gaps in the Bronx, Jenny loves learning about and communicating across cultures. Her current role is Community Outreach Coordinator at the IAED™.
Academies of Emergency Dispatch through education, certification, and accreditation. Related research, unified protocol application, legislation for emergency call-center regulation, and strengthening the emergency dispatch community through education, certification, and accreditation.


Academies of Emergency Dispatch®. I introduce people from all organization? Outreach. That’s my job at the International Academies of Emergency Dispatch. I introduce people from all walks of life and careers to emergency dispatch.

Preliminary results from a study at attitudes and barriers toward calling 911 in Salt Lake City (Utah, USA) revealed that many community members are afraid that they will get themselves or others in trouble if they call. Overdoses go unreported for fear of law enforcement. Medical help is delayed because people assume that calling 911 will result in an expensive ambulance ride that they can’t afford. Incidents that happen in a public place go unreported because bystanders assume that someone else has made the 911 call.

Over the past year, I have been attending a wide range of events in Salt Lake City and spreading the good word of emergency dispatch. When to call. Why to call. What to expect when you do call. From running an educational booth at the local refugee farmers market, to joining the mayor’s community health committee, to presenting at the United Nations Civil Society Conference, there is no shortage of venues to educate the public.

I’m not alone in this outreach. The recently organized IAED™ Outreach Committee has representatives from around the world. Our goal is to create an outreach toolkit for agencies to use when pursuing programs in government advocacy, public education, and public relations. If you or your agency want to get involved, reach out by emailing Jenny.Hurst@emergencydispatch.org.

We can exchange contact information—no cheese cubes or dress attire required.
Dr. Clawson inducted into Hall of Fame

Dr. Jeff Clawson is among the EMS standouts, the emergency medicine doctor recognizing the vital role of emergency dispatchers, the emissary of protocols found round the world, and the last person to toot his own horn about anything he has accomplished.

So, we’re going to do it for him.

EMS World inducted Dr. Clawson into the EMS Hall of Fame as announced in the November 2019 issue of the magazine, and he never even saw it coming.

“It was a total surprise to me that EMS World magazine gave me/us a high honor in their latest edition,” said Dr. Clawson, known to many as “the father of modern emergency dispatch.”

And not only is the recognition a plus for Dr. Clawson but, also, further acknowledgment of the dispatch protocol he created 40 years ago.

“The honor goes to all of us in emergency dispatch,” he said. “We are literally the first link, the first responders, providing potentially lifesaving pre-arrival instructions in a medical crisis.”

John Erich, Senior Editor, EMS World, developed the idea for an EMS Hall of Fame to commemorate EMS milestones and introduce the people who built the foundation.

“They are a part of history that helps us understand where we are and how we got here,” he said. “It’s especially important for people entering the profession. These are the pioneers.”

The EMS World Hall of Fame made its debut in the February 2019 issue, with the inaugural salute going to Frank Pantridge, M.D., inventor of the portable defibrillator, and Peter Safar, M.D., known as the father of CPR. In the November 2019 issue, R. Adams Cowley, M.D., shock trauma pioneer, was honored alongside Dr. Clawson.

Erich said the Hall of Fame is well-received and plans call for inducting new members at least through 2020.

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PIONEERS OF PREHOSPITAL CARE

By John Erich

The short history of EMS has been driven by the wisdom, foresight, and innovation of countless individuals. As the field ages into its second half-century and its origins fade to the past, it’s worth commemorating the greatest pioneers of prehospital emergency medical services. This series honors these healers.

JEFF CLAWSON, MD

The father of emergency medical dispatch

Not all emergencies are equal. With his invention of priority dispatch, Jeff Clawson, MD, first gave 9-1-1 a call-taker the ability to triage the urgency of needed responses.

As an EMT and dispatcher in Utah before starting medical school, Clawson realized in the mid-1970s the need for a system of standard, protocol-based caller interrogation. He designed a card-based system of such protocols, alphabetized by chief complaint and containing essential questions to ask callers and prearrival instructions to give them in certain situations. Ultimately these became the Medical Priority Dispatch System (MPDS) and helped turn 9-1-1 communications personnel into the “first first responders” they are today.

MPDS categorizes call levels from alpha (minor) to echo (immediate life threats) depending on patient severity. These values help systems determine appropriate response resources and modes. It offers instructions in cases of immediate dangers like cardiac arrest (e.g., telephone CPR, defibrillator use), choking (the Heimlich maneuver), hemorrhage (bleeding control), and administration of drugs to reverse overdose (naloxone) and anaphylaxis (epinephrine).

Clauson’s system of priority dispatch has been adapted for use by law enforcement, firefighters, and other medical communication and today is integrated into CAD systems worldwide. MPDS products are available through the Priority Dispatch Corp.

In 1988 Clawson established the International Academies of Emergency Dispatch (IAED), which now includes members in 46 countries. Their emergency dispatch protocols are used in some 80 million calls a year. Clawson was also central to development of the IAED’s Naloxonator Conference for emergency dispatchers, as well as the Journal of Emergency Dispatch. He remains active in writing, education, and research related to dispatch issues and currently oversees the development of IAED’s research and educational programs.

R ADAMS COWLEY, MD

Shock trauma care pioneer

R Adams Cowley, MD, was part of the National Research Council committee that produced the 1966 Accidental Death and Disability white paper, but his contributions to emergency medicine predates even that.

He was a pioneer in open-heart surgery, performing operations before widespread use of the heart-lung machine, and known for his innovative procedures. Prolificated that many of his patients died of shock soon after seemingly successful operations, he won a six-figure Army grant to study shock in humans. In 1958 Cowley developed the nation’s first clinical shock trauma unit, which despite being known as the “death lab” saved multiple patients. Since 1985 it has been known as the R Adams Cowley Shock Trauma Center.

Cowley is credited with articulating the “golden hour” concept of speedy care for trauma victims. By 1959 he was having badly hurt patients brought to hospital care by helicopter. This drew the interest of Maryland Gov. Marvin Mandel, who in 1973 created a state Division of Emergency Medical Services with Cowley as director.

The coordinated statewide EMS system Cowley developed, the Maryland Institute of Emergency Medical Services, was the nation’s first, and Cowley fought continually for funding, equipment, helicopters, and anything else it needed.

He additionally founded the Society of Thrombosis Surgeons and National Study Center for Trauma and EMS, enacted in 1966. He invented a surgical clamp that bears his name and a prototype pacemaker used by President Dwight Eisenhower.

Cowley’s CV has ultimately featured more than 400 published professional articles, chapters, books, and white papers, as well as numerous awards and honors, including a Congressional Gold Medal for lifelong commitment to the advancement of trauma care. He died in 2001.
Emergency dispatch has come a long way since the early days of cellphones (mobile phones). Wireless communication married to location technology allows caller locations to display instantly on our mapping systems. But you can’t take out the human element: the emergency dispatcher. If we don’t do our jobs, people can die. Yet we often fail to recognize bad practices that can put people at risk.

Most agencies receive well over half their calls via wireless (mobile) networks. Many are calls with no one on the line. While many of these are accidental “pocket dials,” some are not. Often police are dispatched to investigate these, aided by latitude and longitude data passed from the phone system and displayed on a map. The problem is that even advanced location technology only gives a caller’s approximate location. The “uncertainty factor” may be less than 30 meters (under 100 feet), but it’s approximate nonetheless. In a suburban environment, the caller may be in one of several apartments (flats) or one of several adjoining houses. Think of a circle of probability: The caller is probably inside that circle, you just don’t know exactly where, and there’s no guarantee the caller is even in the circle.

Get ready to enter the danger zone. It happens when an emergency dispatcher gives the street address corresponding to the latitude and longitude coordinates as the location of the call. That’s misinformation, pure and simple. It suggests that someone at that specific address called for help when that might not be the case. If no one is home when police arrive, it may result in a forcible entry to search for a victim who doesn’t exist. Ultimately, it may mean that a real victim isn’t found.

A best practice when dispatching responders to the coordinates of a wireless/mobile call is to advise responders that the cell/mobile coordinates centered on the address shown. Going one step further, provide the “uncertainty factor” displayed by some phone systems. Simply put, that’s how far—in feet or meters from the latitude and longitude displayed—away the caller is likely to be found. This, in turn, may tell responders whether they need to knock on four doors or eight.

For larger properties, where the coordinates are centered on the left rear corner of the property may narrow their search considerably or might broaden it to include the adjacent property or street.

Another good practice to minimize dispatch errors is to identify cellphone/mobile coordinates as such in your CAD system. For a call dispatched to a street address corresponding to a set of coordinates, entering “CELL COORDINATES” in the location name field makes it clear that you don’t yet have a confirmed address. “CELL TOWER” could be the location name in CAD when no coordinates are available and the address of the tower is used. This can avoid incidents like the one that occurred in Deerfield Township, New Jersey (USA), on July 29, 2016.

Late at night, officers were mistakenly dispatched to a call with no one on the line. The tower address was mistaken for the caller’s address and tragically, there was a house on the same property (the owner leased land to the phone company for their cell tower). The resident saw the officers walking around the darkened house and, thinking they were intruders, retrieved his shotgun. The officers, seeing a man with a weapon in the darkened house, opened fire.

If you’re a football player, you maximize your team’s chances of winning when you pass the ball effectively every time. In our jobs, we pass information. Make it accurate and make it count every time.

Art Braunschweiger
What number are you calling from?"

“My cellphone.”

::eye roll:: (Really?)

Follow-up “What is that number?”

Got it. Confirming location: “Where are calling from?”

“(Blank) County, City (not the address you need).”

::head drop:: (almost hit the console with that one)

Telecommunicators are all too familiar with scenarios like these, receiving the dumbest answers to the simplest questions. A telecommunicator’s eye roll is right up there with that of the frustrated parent. When they include the unseen and often added gestures of shaking the head, sighing heavily, grinding the teeth, waving hands … they are the true multitaskers of our profession.

What you do next with the caller falls under customer service. Customer service is a major focus these days. The problem with customer service in an emergency services environment is that most callers are in crisis and have one request: “Send the (pick your poison) a) Fire Department b) Ambulance c) Police,” and they don’t want to answer questions. They want you to magically send them what they want and have it arrive within three seconds after they request it. Unfortunately, you cannot arrange instant arrivals, and this is where your customer service comes into play.

While hanging up on them or yelling back at the caller is what you want to do, it is not what you can do. What you can do is remind yourself that you are a professional (you are getting paid to deal with this person). PS: Yes, please, add more zeroes on the check and increase the pay. Or, maybe, try this: Put yourself in the caller’s position. This is a Big Deal—capital B, capital D—for them to call you. Even the “frequent flyers” have a threshold before they call. Whatever has happened has obviously upset/angered/frustrated/confused them. Now they are dealing with a system they are not familiar with, in an emotional state. While we understand the system, they don’t. This compounds their emotional state and their interaction with you. Consider when you are dealing with your health insurance provider, your bank, or your cable/internet provider. How fast do you get aggravated? Now add a life-threatening situation—someone assaulted, a witnessed cardiac arrest, a bad accident—and it ups the stakes. If you respond with your own poor attitude, or how we sometimes would really like to respond, you will more than likely only deteriorate the situation.

What can you do? Channel your patience. Some callers go into a cursing rant; let them get it out. If you stay professional, they’ll probably calm down and apologize. Even if they do not, your professionalism will keep you out of hot water. No one likes that supervisor conversation discussing their performance or hearing their recording.

What else? Try hard to push your bad day away. This caller isn’t the reason for your already-existing bad mood. They can trigger a bad mood, but then you are giving them power over you. Is it easy? Nope. Ask yourself if that particular caller is worth you getting a write-up. Definitely not.

Always remember, they need help and you are their best and maybe only chance of getting the help they need.

Do not forget that everything is recorded. Positive media is nowhere near as plentiful as when a telecommunicator screws up. Then it is big news. Do you ever want to hear yourself on a national morning talk show or news program the one time you slipped on your customer service? Callers are good at pushing our buttons. Customer service is how we show that they don’t get to us (at least on the recordings). It is a tool, and if used well, it will protect you against complaints. Tone, delivery, word choice—all matter to the receiver’s perceptions. While it may be an annoying “buzzword,” customer service is part of case reviews for quality assurance. Use it as your tool to protect you.
TAKE A BREATH
Tool’s accuracy depends on the count
Audrey Fraizer

The Academy is at it again, seldom stopping to pause for a breath particularly in the evolution of Dispatch Life Support (DLS) tools.

A recent test of the existing Breathing Verification Diagnostic Tool (BVDxT) was provided in the form of a survey (powered by surveymonkey.com) that elicited comments about the ease in getting the breathing count started to achieve optimal results. In other words, is the BVDxT working to the patient’s optimal benefit? Does the caller understand when the counting begins?

Well, that’s what the survey is trying to find out, and results from the first four days of posting indicate that a change is very well on the horizon for the BVDxT. Nearly 1,000 emergency medical dispatchers had accessed the survey to chime in on the opening statement: Okay, I want you to say now every single time s/he takes a breath in, starting immediately.

Apparently, based on the preliminary results, most respondents tend to find the statement lacking specificity in their ranking of the existing statement and of some of the four others developed for the study. Comments added in the space provided in the survey indicated that callers are often unclear on when to start or stop the count, as it’s currently worded.

The phrase “starting immediately” tends to confuse the caller, explained Chris Olola, Ph.D., IAED™ Director of Research and Biomedical Informatics. As shown in respondent rankings, a slight, although more precise, re-wording could improve the tool’s effectiveness in future applications.

Preliminary results (more responses still coming in at this date) favor adding the words “…ready, Go” to the end of the statement. The words “…ready, Go” prepare and tell the caller exactly when to begin in the process. The word clarifies when and grabs the caller’s attention.

Why is this important?

The DLS tools are an integral part of the “seconds count” world of emergency dispatch, and in a nonvisual environment, callers need simple, easy-to-understand “verbal pictures” to follow. During the evolution of bystander CPR, for example, overly complicated and confusing CPR sequential training instructions would cause people to hesitate and, consequently, delay the procedure or simply give up.

A similar concept applies to the BVDxT. Confusion of when to begin counting can confound each subsequent step in determining the correct Chief Complaint, Determinant Code, and use of a PAI.

An EMD uses the diagnostic tool in cases when the caller indicates that an unconscious (collapsed) patient is breathing, but the EMD wants to verify that the reported breathing is effective or the EMD suspects the reported breathing might be AGONAL. It is used to verify effective breathing, not when the breathing appears to be UNCERTAIN or AGONAL.

“... Ready, Go” prepares and tells the caller exactly when to begin.

The tool in ProQA® calculates the patient’s breathing rate based on the time elapsed between each of the four breaths counted. After the fourth breath, the tool calculates the breathing rate (breaths per minute) and provides an answer choice recommendation (slow or normal breathing, for example). If the answer choice is Slow Rate for an unconscious patient, the EMD is instructed to repeat the diagnostic within 60 seconds to confirm effective breathing. ProQA will save the rate value and compare it with the second check. If slower than the first check it will provide Slow Deteriorating Rate (consider AGONAL) choice and then select AGONAL breathing rate (Ineffective Breathing) in Protocols 12 and 31. This will trigger the Key Question answer choice of the same name and will be clinically treated the same as AGONAL breathing.

If you’ve been a certified EMD during the past 15 years, it’s highly likely you’ve used the tool. The DLS Link is available from among the most commonly selected Chief Complaints, Protocol 6: Breathing Problems and Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic)—but can be activated at any time by EMDs.

The high number of responses received a few days into the survey shows the interest “in making the tool even better,” Olola said.

Source

SAFETY NETS
Epigastric pain could mean something else

Brett Patterson

Brett:

My team keeps me on my toes. Here is another question that I would love your take on:

I was reviewing a lesson for Protocol 1: Abdominal Pain/Problems and was curious as to why Rule 1 does not indicate the use of the Aspirin Diagnostic and Instructions Tool. Should we attempt to use the diagnostic from the icon at the top of the ProQA® screen? (Whitney Mercado, EMD)

Thanks for being there,
Teri Best
Chief Communications Officer
CHRISTUS® EMS, Longview, Texas (USA)

Hi Teri (and Whitney):

First of all, if the pain or discomfort described sounds like Heart Attack Symptoms denoted on Protocol 10, use Protocol 10.

The 1-C-5 & 6 codes for abdominal pain are safety nets to make sure we get an ALS, face-to-face evaluation for patients in cardiac age range with epigastric pain (heart attack until proven otherwise). However, we know that the risk of cardiac arrest for these patients is much lower than patients complaining of chest pain.

In the male patients over 34 with abdominal pain, the risk of cardiac arrest is about 0.1%, and females over 44 is about 0.06%, while the cumulative number for the Protocol 10 codes for patients over 34 is 0.27%. So we assume the heart attack risk for the abdominal pain patients is much lower and wait for a more definitive evaluation before aspirin is indicated. Additionally, because abdominal pain may indicate a surgical or hemorrhagic risk, the predicted low risk of heart attack is weighed against a moderate risk of aspirin administration.

While I can tell you the cardiac arrest quotient for these codes, I do not know the frequency of myocardial infarction, and I think this is a very interesting question. I am copying our research team to see if there is any interest among them to look at this more closely.

Thanks for the great question,
Brett A. Patterson
Academics & Standards Associate Chair, Medical Council of Standards International Academies of Emergency Dispatch

Hi Teri (and Whitney):

Two research papers look at the problem in two different ways:

• Of 606 hospital-confirmed AMIs (based on ICD-9 code 410 (Acute Myocardial Infarction)), 261 (43.1%) had been triaged using Protocol 10 (Chest Pain). www.ncbi.nlm.nih.gov/pubmed/29223194

• Of 3,007 cases that we triaged using Protocol 10, only 8.7% (n=261) were AMIs. www.ncbi.nlm.nih.gov/pubmed/28409655

Chris Olola, Ph.D.
Director of Research and Biomedical Informatics, IAED™
**Brett:**
Which Chief Complaint card should be selected when a caller states they had to have brain surgery and their scalp has come unattached at the surgical site and requires reattachment? No injury or cause, no bleeding.

**Kristen Phelps**
Davie County E911 Communications Center 
Mocksville, North Carolina, USA

**Hi Kristen:**
Interesting complaint.
A surgical wound, while purposeful, is traumatic. If the complaint is an issue with the wound and not bleeding, Protocol 30: Traumatic Injuries (Specific) works fine. I will assume the patient’s brain surgery was greater than 6 hours old here, but the Protocol does ask about this—30-A-3 or, if sooner and alert, 30-B-1.

**Brett**

In the past year there have been a lot of fentanyl overdoses. In our center we would go to the Overdose Protocol (Protocol 23) first and then if not breathing go into the PAIs. Panel 4 of the CPR pathway directs Overdose/Poisoning situations to follow the Ventilations 1st pathway. I have two questions about this.

First is, if the caller comes in and finds patient down and not breathing and then advises “I think she/he overdosed” but they do not know how long they have been down, why wouldn't we just go to the Compressions 1st pathway? Even for hanging, for instance, why not just go into compressions if we do not know how long they have been down for?

Also, with fentanyl being big and the different types of fentanyl out there such as fentanyl, carfentanil, and U4, wouldn’t doing mouth-to-mouth ventilations cause a possible issue to where you could have two patients?

I think that if they meet either one or both criteria then we should only do compressions only.

Finally, I think it could be questionable about what path to take—ventilations or compressions—if it is not witnessed and we do not know how long they have been down.

**Name withheld upon request**

**Hi,**
Unfortunately, your agency is not alone with regard to high volumes of narcotic overdose calls. The problem is truly of epidemic proportions. To put things in perspective, have a look at this article from British Columbia, Vancouver, Canada:
dailyhive.com/vancouver/bc-emergency-services-130-overdose-calls-2018

But back to your questions.

**OVERDOSE** is in the Ventilations 1st pathway because the cause of death is likely respiratory in origin and, if in arrest, the patient has likely used up all oxygen reserves and has built up too much carbon dioxide. Your point about time down is noted, but scene estimates are generally unknown or unreliable, which is why we do not discriminate with sudden cardiac arrest patients either. If the cause is likely respiratory in origin, the current standard of care assumes ventilations are needed. And if sudden cardiac arrest is the complaint, the standard assumes oxygenated blood is present and focuses on compressions, at least until advanced airway adjuncts can be applied. In summary, the current standard of care for cardiac arrest of suspected respiratory etiology is ventilations with compressions.

I understand your concern regarding potential contamination when providing Mouth-To-Mouth (M-T-M) in narcotic OVERDOSE cases. However, this concern is anecdotal and unsupported by the evidence. Most of the pushback on this actually comes from providers rather than lay rescuers, who are generally willing to help. And if the rescuer does not want to provide M-T-M, a Refused M-T-M pathway is readily available.

We added some related precautions to v13.1 when paranoia about contamination from fentanyl and its analogs was high but have since removed the instruction to try and administer Narcan without touching the patient. The reason for this is based on evidence that came to light following some rather exaggerated media reports early on. Here’s a link to an article authored by an expert in this field and recently printed in the Journal that details this journey and provides specific references. Please see page 20.

Importantly, after dealing directly with these emergencies for many years now, and also providing M-T-M instructions in the MPDS’ for nearly 40 years, we have never had a report of disease transmission or narcotic contamination with any serious consequence. This fact, when considered with the compelling science, is why the current standard of care continues to be ventilations with compressions when arrest is of suspected respiratory etiology.

**Brett**

*Brett:*
Hello, Katelynn:

Because there are often multiple patients, traffic considerations, and safety concerns, Protocol 29 is a scene-oriented protocol. Rather than prioritize by specific injury, the Protocol evaluates potential injuries by looking at the mechanism of injury and other important scene factors. And because the caller is often looking at the entire scene, asking about obvious injuries, or injuries that may be noted at a glance, serves to include any injuries in at least the BRAVO-1 code, once the DELTA-level has been ruled out. When no injuries are reported, or when a 1st-party caller is the only patient, a more detailed assessment may qualify the ALPHA and OMEGA codes.

Does that help?

**Brett**
Way Down Yonder on the Chattahoochee
ChatComm is a private center handling public response

Becca Barrus

Not very many people can say they have been with their organization since the beginning. Fewer still can say they were specifically recruited to help get the endeavor off the ground. When Shireka Graham moved to the Atlanta, Georgia (USA), area from Mississippi (USA) 10 years ago, that is just what IXP Corporation did.

Since she has been there from the start, she is one of a number of IXP telecommunicators to talk with about the Chattahoochee River 911 Authority—or “ChatComm” for short. Graham, Deputy Director of Operations, has been with ChatComm since the operation was bare bones.

“When I walked in, there was no carpet on the floor, just concrete,” she recalled. Graham started out as a line dispatcher and has moved up through the ranks over the last 10 years. She was promoted to Communications Training Officer (CTO), Supervisor, Training Manager, and then in 2017 she became Deputy Director of Operations.

Graham is passionate both about her role and ChatComm as a multi-agency emergency communication center. With the size and scope of the operation, that’s exactly what ChatComm needs. IXP provides ChatComm with operations technology and technology support as part of a multi-year managed service.

IXP dispatches fire, police, and EMS operations for the northern Atlanta metro area including Sandy Springs and Johns Creek in Fulton County and for police in Brookhaven and Dunwoody in DeKalb County with fire and EMS transfers to the county.

What kind of MPDS® calls does ChatComm get most often? Off the top of her head, Graham said it probably had to be Protocol 17: Falls, which may be due in part to the fact that there are a lot of senior living facilities in the area they serve. And, of course, Protocol 26: Sick Person (Specific Diagnosis) is used often. As for Fire Priority Dispatch System™ (FPDS) calls, it is definitely Protocol 52: Alarms.

Overall, the center handles approximately 400,000 calls a year (most of which are police calls) for an area with 325,000 residents.

Unlike most emergency response centers in the United States, which are owned by the government and funded by tax money, ChatComm is a managed
service delivered by IXP Corporation. In fact, it is the largest privately owned 911 center that currently exists.

What does that mean for the day-to-day practices of emergency dispatchers? “It gives us a little more leeway as far as training goes,” Graham said. “We’re able to focus more on communication. When you’re with a county, you have to cater to different departments.”

Does a privately owned 911 center handle dispatch stress differently than a county 911 center? ChatComm has ongoing training programs tailored to the specific agencies they support. They also have stress-related programs for their employees as part of their benefits program. Center management, supervisors, CTOs, and corporate human resource staff are also educated to monitor each employee’s wellness. Additionally, there is a quiet room in the center where emergency dispatchers can go to catch their breath and get away from the noise. ChatComm also utilizes an Employee Assistance Program (EAP) and has chaplains available from the communities they serve.

ChatComm is a state-of-the-art communication center located in Sandy Springs, Georgia (USA), encompassing approximately 16,000 square feet. The space includes the communication center, training and meeting spaces for the four cities, administrative offices, and supporting technology and telecommunications rooms. ChatComm also hosts the Georgia Crime Information Center (GCIC), which supports offices for Sandy Springs and Johns Creek, and a city Emergency Operations Center (EOC) for Sandy Springs.

IXP’s operation is accredited in both Emergency Medical Dispatch (EMD) and Emergency Fire Dispatch (EFD) through the International Academies of Emergency Dispatch® (IAED®) and is the only privatized center accredited through the Commission on Accreditation for Law Enforcement Agencies (CALEA). Going above and beyond the standard is crucial to both the center and Graham. “It’s definitely important to us that we are processing calls at the highest level of customer standard and care,” Graham said. “ACE gives us the guidance to make sure we’re delivering that kind of customer service.”

Because achieving ACE was a priority, Graham and the emergency dispatchers put in the work to get those results. “You have to start with educating the staff on the importance of ACE,” she said. “That’s where it all starts. You have to tell them what ACE is, what it means, and how we’re going to process it. If the staff is doing everything they need to be ACE, everything else falls into place.”

Graham and ChatComm also got help from Kim Rigden, IAED Associate Director of Accreditation, who spoke with Graham one-on-one and walked her through the best training methods to achieve ACE. Graham also spoke with Angela Burrer, M.S., Communication Chief out of Texas (USA), who acted as ChatComm’s ACE mentor. “She kept me from pulling my hair out,” Graham said of Burrer.

But Graham isn’t the kind of person who sits back while she watches other people work. For example, when she began the re-accreditation process, Graham had no idea that MPDS Protocol 38: Advanced SEND existed. Since ChatComm primarily dispatches police calls, the Protocol proved to be a huge asset to them. Graham had the training manager really focus on Protocol 38, which included having emergency dispatchers take lessons from the IAED’s College of Emergency Dispatch, while Graham completed the trainings herself.

When asked about her most memorable call, Graham immediately mentioned the center’s first active shooter call in 2014. Graham was the supervisor working that day, so she was front and center when the initial calltaker—a trainee—answered the call. It started out as a domestic call, and Graham remembered that everyone in the center had to come together to act as a cohesive unit—every telecommunicator, every firefighter, every EMS medic, every police officer. The call ended badly (both the caller and the suspect died), but the ChatComm team was able to understand that they had done everything they could.

After the call was over, Graham made a point to find the initial calltaker to make sure they were all right. The trainee is still with ChatComm—in fact, she has recently been promoted to a supervisor position. She kept me from pulling my hair out,” Graham said. “My team is amazing,” Graham said. “I’m extremely proud to have such a dedicated team. They put in the work. We’re like family. If one person goes through it, we all do. This accreditation is important to all of us—we achieved something.”
There are any number of reasons tourists flock to the Yukon and why “Yukoners” would never want another place to call home. The desire to capture a spirit of adventure is braided through the past and present and into the future. Answering the call of “gold” in the Klondike during the late 1890s drew thousands daring enough to pick their way to riches up the Chilkoot Trail and White Pass Trail and, to this day, these same trails continue to capture the intrepid spirit. The Yukon will always provide unbridled open space, raw beauty, wildlife, vibrant culture, and time for introspection and challenge away from busy lives and, at the same time, depending on where you settle, a veritable mix of business and industry.

The drawbacks? That depends. Back in the day, Yukon gold rush fever hastened death from hypothermia, among other environmental dangers. Do your survival skills measure up to maintaining proper body temperature despite unpredictable weather, navigating harsh environments, overcoming unforeseen hazards and miscalculation, and all without immediate access to emergency help? If choosing a small town, such as Faro in central Yukon, care for critical and life-threatening injuries requires ground or air (medevac) transport to Whitehorse, 355 kilometers (221 miles) southwest.

But it doesn’t take daring or bravado or living “off the grid.” An accident can happen anywhere, anytime when the outdoors beckons a wandering soul no matter how well-equipped for adventure of life in the Yukon. No matter where your travels lead, slips, trips, and falls are the primary mechanism of injury, and in a remote area where response isn’t a given, minor incidents can escalate quickly into major fiascoes.

**Land of adventure and beauty**

Yukon covers 483,000 square kilometers (186,487 square miles) of the Canadian North and is bordered by Northwest Territories to the east, Alaska to the west, British Columbia to the south, and Beaufort Sea to the north. Yukon is one of the most remote jurisdictions in North America, hosting a population of about 40,000 people (a density less than 0.1 persons/square kilometer).

The geography and an appealing sense of isolation in a crowded world contribute to Yukon as the land of adventuring paradise. There are glacier-fed alpine lakes, the fifth-longest river in North America (the Yukon River), healthy populations of grizzly and black bears, and your pick of climates—desert, arctic tundra, and high-alpine mountainous terrain. Aboriginal Peoples of Northern Canadian Territories offer a fascinating glimpse into culture and what it takes to survive in the harsh environment through the generations.
Yukon is a land of intrigue, a bucket list destination for the spirited, historians, and those seeking the beauty of nature and solitude. It’s possible to take a river or hiking trip and see no one for the duration.

And if it’s cold you’re seeking?

“Yukon is generally considered cold to most other Canadian jurisdictions,” said Gerard Dinn, Clinical Operations, Yukon Emergency Response Coordination Centre (ERCC). “No other place in North America gets as cold as Yukon during its periods of extreme cold.”

In 2017, the Canadian Tourism Research Institute estimated there were 334,000 overnight visitors to the Yukon, an increase of 2.5% over 2016, but even the most astute backcountry traveler cannot afford to ignore the possible misstep. Yukon can kill you a hundred ways. You can slip into a river, freeze to death overnight, fall in a climb, or simply lose your bearings in the vast wilderness. There are few roads and relatively few people in Yukon Territory. Unpaved roads and unpredictable weather preempt schedules and final destinations. An estimated 7,000 grizzly bears call the Yukon home, although, sadly, mortality among the bear population from human and unpredictable weather preempt schedules and final destinations. An estimated 7,000 grizzly bears call the Yukon home, although, sadly, mortality among the bear population from human intervention is higher than vice versa.

Complex EMS environment

Yukon’s emergency service network is as complex as its environment. The Royal Canadian Mounted Police (RCMP) Operation Communication Center in the Yukon screens calls for police, fire, and EMS and forwards them to the appropriate secondary safety answering point.

The ERCC building, off the Alaska Highway, provides the second-highest level of emergency response in Yukon and, in addition to sending medical response to 911 callers, coordinates multi-agency response for situations of a larger magnitude, such as wildfires and air crashes. Response is scaled accordingly.

Although the ERCC is centralized into one facility, response takes coordinating multiple resource management processes throughout the territory. A typical emergency response requires the Emergency Response Coordination Officer (ERCO) to follow a detailed checklist, starting with use of the Medical Priority Dispatch System™ (MPDS) Protocols through a response mode that takes several factors into consideration: adjusting deployment plans for a given response area, notifying allied agencies and receiving hospitals, tracking EMS crew movements and briefing them on the operation, monitoring all radio frequencies, and coordinating whatever else is required.

Not far and few between

Each year, Yukon EMS responds to approximately 6,200 ground service requests in Whitehorse, 1,100 medevac requests, and 1,800 community-based emergency service requests. Remote emergencies (off pavement, off airstrip) account for between 40 and 50 responses each year and can entail—depending on the situation—the Special Operations Medical Extraction Team (SOMET), Yukon Search and Rescue, local fire departments, ground and air ambulance, or the RCMP.

Territorial Search and Rescue (SAR) falls under the Emergency Measures Organization and the RCMP. Parks Canada oversees the three national parks within Yukon’s borders. Medical calls, regardless of location, fall to EMS. Regardless of jurisdiction, emergency response is a shared responsibility and, Dinn said, neighboring agencies frequently cooperate to respond using any suitable vehicle required for access and transport, including fixed wing aircraft, helicopters, all-terrain vehicles, boats, and snowmobiles. EMS responders make their own safety decisions while on location and may go away from their vehicle as long as they remain within visual range.

Caution and preparation are again, the key. Visitors should know emergency numbers and the 10-digit phone number established for satellite phone users in locations cellular phones cannot access emergency services. Long distances, resource limitations, long hours of darkness, and extreme weather conditions can prevent immediate on-scene response to protect the safety of responders, bystanders, and allied responders. Dinn advises backcountry explorers to come prepared to support themselves for extended periods even after emergency service activation.

“Yukon is a beautiful, vast, and remote location,” Dinn said. “Many emergencies can be avoided if travelers understand and anticipate the remoteness of their destinations.”

The same caution applies to Yukoners. Personal preparation and risk prevention are strongly encouraged, especially for those living and traveling in rural or remote areas. Up-to-date first aid training and emergency kits at home and in their vehicles are part and parcel to survival and everyday living.

Yukon is a beautiful, vast, and remote location.

Know before you go

Conditions in the Yukon are harsh and communication with the outside world can be difficult at best. Emergencies handled by today’s ERCC rival the complexity of those from days gone by. Don’t let Yukon fever get the best of you. Know where you’re going and what you might face along the way.

Source

CAREER MOVES
ENP certification will take you there

Audrey Fraizer

John Ferraro took exactly the steps his father advised when facing a challenge. He ate a healthy breakfast. He took a walk. He took a deep breath. With his strategy for test taking in place, he was ready to sit for the Emergency Number Professional (ENP) certification exam offered by the National Emergency Number Association (NENA).

The ENP exam is no easy feat. Not everyone passes the first time around. “It’s not an automatic gimme,” said Ferraro, ENP, Executive Director, Northwest Central Dispatch System (NWCDs) (Arlington, Illinois, USA), and NENA Education Advisory Board member. “Everyone is intimidated in taking the exam.”

But once Ferraro jumped the hurdle, he found the benefits well worth the effort. The credentials are more than a grouping of letters following a name. The certification proves knowledge and experience far beyond the nuts and bolts of emergency communications. It is a sign of competence, dedication, and above all, the willingness to push the envelope of your career. Passing the exam is an achievement and with it comes a huge sigh of relief when the letter announcing you’ve passed arrives in the mail.

Jennifer Kirkland, ENP, RPL, 9-1-1 Operations Administrator, Vail Public Safety Communications Center (Vail, Colorado, USA), and NENA Education Advisory Board member, remembers taking the exam like it was yesterday and not six years ago. “I was terrified,” she said, to the extent that she had considered rescheduling despite the hours spent studying NENA’s exam prep guide, “The Body of Knowledge,” and going in with 12 years’ professional experience. She was convinced to go ahead; after all, the worst scenario was having to prepare a second time if she failed.

Kirkland passed the first time around and, if she hadn’t, it was never even a fleeting thought to forego the exam altogether. “It’s so worth it,” she said. “Certification shows your commitment to the profession and your commitment to learning about the industry.”
Get ready before you go

Prior to taking the exam, NENA Institute Board, which oversees the ENP Certification Program, highly recommends taking advantage of NENA resources. The ENP Reference Manual is a must-read and periodically updated by NENA to reflect recent changes in the profession. Online and webinar-based study courses are available, as well as access to group study in person.

Boot camp is NENA’s short, intensive, and rigorous pre-exam preparation course. The camps are traditionally held at NENA’s annual conference and, in 2020 (for the first time ever), at NAVIGATOR. The workshop starts up slowly with an overview of the ENP application and exam scheduling processes, cruises into pointers in exam-taking strategies, and then revs up to the cram session to get participants on the direct course to passing the exam. The review session covers the major categories and subcategories of communication center operations and management, and questions on exam day vary for each test taker according to random selection of 150 questions from a 900-item ENP bank.

Vicki Pickett, Operations Manager, Jefferson County Communications Center Authority (Jeffcom) (Lakewood, Colorado, USA), studied “like crazy” to prepare for the ENP exam and that was despite 18 years in the profession already under her headset.

“I was so nervous but, at the same time, excited,” she said. “It means so much to me.”

Set your 911 future

ENP certification is the benchmark for emergency number professionals, and the learning doesn’t end after the exam. It’s only the start. The exam is a one-time requirement for certification, although ENPs must show continued learning and contribution to the profession through a process requiring that they earn 24 points to recertify every four years. The points signify professional growth.

NENA Institute Board (NIB) members meet annually to present an exam as dynamic as the people determined to achieve the credentials. Most would consider it a disservice otherwise.

“The exam must keep pace with the rapidly changing profession,” Pickett said.

After all, a static exam wouldn’t reinforce what NENA represents and expects from its ENPs.

Pickett started in emergency dispatch 26 years ago. She is president-elect of the NIB, which depends on expertise and dedication like hers to review and update the questions and synchronize NENA’s resource material. The NIB oversees the ENP exam, question revisions, and other items related to the ENP certification.

But the credentials are more than a personal badge of commitment, she said.

“It’s super important to advance our profession,” Pickett said. “When I started [in emergency dispatch] there weren’t many opportunities to do that. The ENP is a public demonstration that we know what we’re talking about.”

Change is the M.O.

No one can argue the changes since Feb. 16, 1968, when Alabama (USA) Speaker of the House Rankin Fite made the first emergency phone call using the 911 code. Fifty years later, the beginnings are every bit as different as typewriters in the computer age. Technology becomes more sophisticated by the day. Dispatcher-guided pre-arrival instructions, such as CPR and naloxone administration, are an expectation, not a novelty. Emergency dispatchers are the first on scene, no matter their location, working radios and phones to direct response and manage the scene throughout the incident.

Recent steps to advance emergency dispatch status is evident in the push to place them under the same protective service occupation category as police and firefighters. Minimum training standards and continuing education are requirements set by states or by centers in states lacking legislation.

The present and future lead back to achieving the ENP credential, and for anyone interested in a career in public service dispatch, it’s the only way to go.

“Anybody planning a career in 911 needs this,” Ferraro said. “The positives are unbelievable. It’s a validation. It shows you know your stuff. It advances your career.”

Anyone planning a career in 911 needs this.

Ready when you are

The first exam in 1997 drew 115 NENA members, and during the past 22 years, over 2,000 people have tested (with a passing rate of 90%). Sitting for it requires three years of professional experience and accumulating points based on additional experience, education, and professional development and service (such as involvement on NENA boards and conference presentations).

Kirkland said the ENP credential is worth all the pre-exam jitters, plus some.

“Anyone who is eligible should take it,” she said. “The value is immeasurable. Why would anyone not set themselves up for success?”

The boot camp at NAVIGATOR is scheduled for Sunday, April 26, at Disney’s Coronado Springs Resort (Lake Buena Vista, Florida, USA). The exam will not be offered at NAVIGATOR. ENP exams are scheduled four times annually for a two-week period each time—winter, spring, summer, and fall—at computer-based testing facilities throughout the U.S. and Canada.

For more information, go to ena.org/page/enpcertification2017 for an overview of ENP certification, schedules, and application requirements.
CREATURE COMFORTS
Therapy animals in the comm. center

Becca Barrus

While humanity overall is a pretty mixed bag, one of the things we’ve done right is domesticating animals. There’s a reason so many people have pets even though they require the work of care and feeding. Even the most hard-hearted villains would be hard pressed to stay stony in the face of a cheerful dog or a cuddly kitten. If asked to articulate why, most people would simply say that interacting with animals just feels good.
therapy animals | FEATURE

Solly the yellow lab at the Sydney Control Centre
Canines for Christ's Chaplain Ron Leonard and Marilyn Leonard with Molly
Science generally agrees that humans get positive benefits from interacting with fuzzy animals; for example, the simple act of petting an animal releases many hormones in the human body, among which is phenylethylamine, a chemical that heightens mood. Many therapists encourage their mentally ill (depressed, anxious) patients to have a pet, as its presence will produce feelings of comfort and happiness in its owner.

But why do humans like having animals around as sidekicks? One theory—Wilson's biophilia hypothesis is the technical term—claims that early human survival was partly dependent on signals from the animals around them. For example, if rabbits in the brush were stressed, it probably meant that a snake or other predator was nearby. Conversely, if the rabbits were calm, no predators were present, which meant that the humans could relax too. Thus, the biophilia hypothesis suggests that if modern humans see animals at rest or in a peaceful state, this may send feelings of safety, security, and well-being to our brains.

Considering the vast spectrum of humans interacting with animals through history, we've only just begun to recognize the true mental benefits of having animals around. In the last couple decades, therapy animals have been used to alleviate boredom, loneliness, and stress in hospitals and assisted living facilities. It's only been in the last 10 years or so that people have begun figuring out that that kind of therapy can be applied in other settings, such as the emergency communication center.

A growing number of centers are using therapy animals—mostly dogs, although cats, rabbits, guinea pigs, and even horses can be used—to bring a ray of sunshine and a surge of oxytocin to their emergency dispatchers. They have enthusiastically agreed to share about their individual experiences and give advice to anyone looking to start a similar program in their center.

A quick note: Therapy animals and service animals serve different purposes. Service animals typically live with their owners and help them with a specific task (turning on lights, getting medicine, detecting oncoming seizures, etc.), while therapy dogs only interact with patients at a specified time and don't require as much intensive training. Often, therapy dogs work in close conjunction with physical and occupational therapists in hospitals and rehab centers. And while they don't require intensive training, therapy dogs still must be trained not to jump, bite, or pull on their leashes and follow basic commands (such as “sit,” “down,” and “stay”).

Canines for Christ

Larry Randolph didn't even own a dog when he got inspired to begin a dog ministry. In July 2007, he borrowed his sister’s dog and started bringing it to people in need as a hobby that then grew into something bigger. Canines for Christ now has over 900 volunteers bringing over a thousand dogs to veterans hospitals, nursing homes, special needs facilities, and more in 35 U.S. states.

The mission of Canines for Christ is “letting Christ’s love shine through us and our canines as His disciples when we visit people who need love, hope, and compassion that only God’s message can provide. And we want them to know that God loves them. Millions of people have been touched by this saving message as we bring God’s light of love into the darkness.”

Chaplain Ron Leonard, a retired military man, met Randolph in 2012 and trained his dog Molly with the American Kennel Club to be an official therapy dog volunteer. Since then, Molly and Leonard have made over 4,000 visits.

Around 2016, Canines for Christ therapy dogs began visiting 911 centers, starting with one in Nashville (Tennessee, USA). As they continued to visit the center, interest grew and the program began broadcasting their interest in reaching more emergency dispatchers in more centers. In all, Leonard estimates that they regularly visit about 35 emergency response centers in the United States and have a relationship with even more. Leonard, who is based in Tennessee, is a member of the National Emergency Number Association (NENA) and the Tennessee Emergency Number Association (TENA).

Canines for Christ volunteers have provided emotional comfort and aid in the aftermath of notable mass shootings such as the Parkland, Florida (USA), shooting in 2018 and the Dayton, Ohio (USA), shooting in 2019.

K-9’s On Call Support Dogs

K-9’s On Call Support Dogs is a newer program than Canines for Christ, but it began in a similar manner. Duke and Karen Kimbrough began their program in Austin, Texas (USA), in 2017 when Duke retired from working 40 years as an emergency medicine physician in local hospital emergency rooms in Austin and with Austin-Travis County EMS. Karen has done pet therapy work in hospitals for 20 years; she started out in nursing homes, then added children’s and general hospitals and school reading programs. Once Duke retired, he decided to join Karen in her work. One of Duke’s colleagues in EMS heard they were interested in starting a therapy dogs program and got the Kimbroughs in touch with people at the 911 call center.
“We were very, very lucky to have so many people interested,” Karen said. “And we were lucky that Duke had those connections.”

The program began small—just Karen, Duke, and their dog Texsi at first—and grew to include friends and colleagues. Now Karen says that they’re getting a significant increase in volunteers. They try to find people who have backgrounds in either medicine or nursing or people who understand the business of 911 and first responders, like Chris Parker, who, along with her dog Ruby Shoes, has been involved since nearly the beginning.

K-9’s On Call Support Dogs works closely with Austin’s Combined Transportation, Emergency, and Communications Center (CTECC), bringing dogs to visit the emergency dispatchers during their shifts. Karen said that the program operates under CTECC’s rules, policies, and regulations, which include stringent background checks of those who volunteer.

Stephanie McClintock, Acting General Manager of CTECC, works closely with Karen in coordinating visits. The two of them communicate regularly. When McClintock moved into the position two years ago, the visits from K-9’s On Call Support Dogs had already been established by her predecessor.

“It’s been very smooth,” McClintock said, despite rumors in the beginning that someone on the floor was allergic to dogs. McClintock continued to communicate with managers to ensure that everyone was fine; there have been no issues with allergies. McClintock checks in on a regular basis to make sure that the dogs aren’t distracting.

“Overall it’s been a very positive experience for the emergency dispatchers,” McClintock said. “When I’m here and see the dogs on the floor, everybody is nothing but smiles. Sometimes they’re on the floor, crawling around with the dogs, hugging them, telling dog stories.”

The therapy dogs come into the center about two to four times a week, making sure to visit all three shifts, including the night shift. CTECC houses EMS, fire, and law enforcement emergency dispatchers for City of Austin, Travis County, and Capital Metropolitan Transit Authority, as well as the Texas Department of Transportation (TXDOT) and city and county EOC.

What do the emergency dispatchers think of their furry visitors?

“I love dogs,” said Katie Ferrara, CTECC calltaker. “I have a dog, who I obviously can’t bring into work, so therapy dogs are the next best thing.”

Ferrara continued by saying that the dogs help alleviate the stress of taking 911 calls; it’s nice to focus on something else for a minute.

Kathy Yarbrough, a senior dispatcher who has been with CTECC for 25 years, agreed.

“It’s really a little break,” Yarbrough said. “You get two or three minutes where you’re not thinking about the horrible things people do to each other.”

She had good things to say about the volunteers who bring the therapy dogs in as well—she said that they’re sweet and will ask the emergency dispatchers how their day is going. The volunteers are also sensitive to people who don’t necessarily want to be visited at that moment. These are the emergency dispatchers who will say “No thank you” or not turn around when the dogs come walking down the row of consoles.

Currently, the K-9’s On Call Support Dogs aren’t on the call list to be notified after a big event to help emergency dispatchers de-stress. However, if the dogs happen to be in the center the day after a big event or a particularly hard call, they’ll take extra care to spend time with the people involved. Karen also mentioned that they do respond with more frequent visits to the emergency dispatchers during a crisis, like the Austin bomber or when there are flooding issues.

“When the EOC is open, we make sure to visit those folks taking care of the crisis,” she said.

Mayra Toro, Assistant Manager for Austin Police Department (housed in CTECC), said the visits create a different atmosphere for the time they’re there.

“It brings a level of excitement to employees,” she said. “Then, after the dogs walk away, the dispatchers and calltakers are right back to their phones and the next call.”

St John Ambulance (NT) Inc.

Lucy McLennan, Duty Manager Emergency Communications Centre (DMECC) for St John Ambulance (NT) Inc. in Darwin (Northern Territory, Australia), was the catalyst for getting therapy dogs to visit her center. She was aware of some communication centers, hospitals, schools, and other workplaces were starting to introduce therapy options for their staff and thought that it could work for her center. She approached her manager, Craig Garraway, with the idea, and he was immediately supportive, encouraging her to pursue the project. McLennan did her homework and found Kristy Teunissen at Mind Your Paws, who was enthusiastic about the idea.

Similar to CTECC, the issue of allergies was raised, only in this case McLennan was aware of who precisely had the allergy. In the beginning, therapy dog visits had to be arranged around the EMD’s shifts because of her allergy. Later on, the dogs could visit during her
Tatianna Blank with APD Communications greets Texci.
EPO Kate Campbell with Harlow at St John Ambulance.
shift, provided there was no physical contact; the EMD reported no ongoing issues.

Scheduling was also an issue at first. The availability of the dogs and the 24/7 operation of the center meant that some emergency dispatchers missed out. But, like the allergy issue, McLennan and her team worked to find a solution, and all the shifts are visited now.

Despite the teething troubles, the visits are smooth, and the emergency dispatchers are reaping the benefits.

“Staff mention that seeing the dogs help calm them down and cheer them up, especially on stressful days,” McLennan reported.

Harlow (a golden retriever and poodle mix) and Scout (a border collie) are both beloved by the emergency dispatchers and seem to have an intuitive knack to find those who are in need of receiving a cuddle or seeing a fun trick. For example, McLennan recalls a particularly busy day shift when she overheard an emergency dispatcher telling a supervisor about feeling highly anxious. A short time later, the dogs showed up and after a pass around the room, Harlow made a beeline for the emergency dispatcher in question and sat at her feet.

The human component to therapy dog volunteers is crucial in Darwin as well. Teunissen will chat with the emergency dispatchers, talking to them about their own dogs and asking questions related to dog training. She also allayed McLennan’s fears about members of staff having a fear of dogs by saying that Harlow is sensitive to those people and didn’t anticipate any issues. She was correct.

After a highly stressful active shooter incident a couple of months ago, Teunissen contacted McLennan to ask if she and the dogs could make an extra visit for the ambulance and police teams that had been involved.

“There is a visible difference in the center when the dogs walk around and share their time,” McLennan said.

NSW Guide Dogs did a site visit at the Sydney Control Centre where they assessed the organization for suitability and surveyed the type of work and atmosphere of the center and the potential impact it might have on a therapy dog. The center has 160 staff total, with up to 30 employees on shift at any given time, which would not be suitable for a dog more comfortable with smaller crowds.

Solly, a yellow Labrador, was chosen, and he currently visits the center three days a week. What does he do during his visits? He wanders around and interacts with the staff; sometimes he will go for walks with people he’s become comfortable with in the park behind the center. He has also visited state headquarters and some paramedic stations, where he’s spent time with some paramedics who were involved in a traumatic incident.

“His presence seems to just reduce the stress in the room,” Puustinen said.

When he’s at the center, Solly is often the center of attention and very patient with being photographed endlessly. Mindful that he’s a living creature with emotional and physical limits, Puustinen watches Solly carefully and will take him to her office to sleep if he gets exhausted.

**Bring fluffy sunshine to your center**

If you’re interested in utilizing therapy dogs in your center—and why wouldn’t you be?—here are some things to consider:

- Do your homework! Research therapy dog programs in your area and find out how other centers are going about it.
- Check in with management. It helps if you have a proposal put together to show that you’ve considered every angle.
- If allergies are a concern, try to find a therapy dog that is a hypoallergenic breed or take steps to cut down on allergens. K-9’s On Call Support Dogs makes sure its dogs are bathed 24 hours before each visit.
- Make sure your therapy dog organization tests and registers its dogs and provides insurance coverage for the dogs, their teams, and those they’re visiting.
- Communicate with the therapy dog providers about the nature of emergency dispatch. You don’t want the dogs disrupting the work.
- Remember that therapy dogs have personalities and feelings just like humans do; pay attention to how dogs are responding and reacting on a visit. Be attuned to when dogs need a break.
For Laura Spaulding, domestic violence is personal. She became interested in police work in order to protect victims like her sister who had been beaten by her husband while pregnant. Domestic abuse was something Spaulding saw the signs of as a teenager in the Georgia town where she spent her formative years.

Spaulding recalled an incident in 2011 as a Concord (New Hampshire, USA) police officer where she and another officer responded to an apartment in the early morning hours on a report of a domestic disturbance called in by a third-party who heard a scream. While standing on the other side of a locked door, she heard a person come down the stairwell and open the door—running straight into Spaulding, who had her gun drawn. The woman was fleeing from her former boyfriend after he broke into the home, beat her, and tried to strangle her. Seeing this woman and what she had gone through reminded Spaulding of her commitment to help victims of domestic violence.

“One of the reasons I became a police officer was to protect victims, like my sister,” she said. “There are people out there who don’t know that this isn’t OK, that this isn’t normal life and that they don’t have to put up with it.”

Let’s define domestic violence

According to the National Coalition Against Domestic Violence (NCADV), domestic violence is “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats, and emotional/psychological abuse.”

Police Priority Dispatch System™ (PPDS™) Protocol 114: Domestic Disturbance/Violence outlines some additional information about domestic violence. It is “a general term used to cover physical and mental abuse that occurs within the home and family.”

Breaking down the numbers

In 2012, Spaulding applied for a newly created position to become a domestic violence officer in Concord. She got the job and is a solo act, focusing on victim advocacy and community service. Daily, she looks through the police call logs from the past 24 hours identifying incidents when patrol officers documented domestic violence in a
home. Spaulding also keeps a list of calls where children were present so she knows the number of secondary victims needing support services.

Looking through the call logs is no small matter for Spaulding. During each of the past five years, Concord police officers have responded to an average of 700 domestic disturbance calls. And these numbers hold true for more than New Hampshire.

Domestic violence hotlines in the United States receive more than 20,000 calls each day, according to NCADV. Every minute, 20 people on average in the U.S. experience intimate partner physical violence. Each year, there are 10 million victims of domestic violence.

One in four women and one in nine men experience intimate partner contact sexual violence, severe intimate partner physical violence, and/or intimate partner stalking with the impact ranging from fearfulness, injury, use of victim services, PTSD, etc., in the United States. Intimate partner violence victims are most commonly women ages 18–24.

Statistics from UN Women show that an estimated 35% of women throughout the world have experienced physical and/or sexual violence by an intimate partner or have experienced sexual violence by a non-partner (not including sexual harassment) in their lifetime. More than half of the 87,000 women intentionally killed in 2017 throughout the world were killed by family members or intimate partners. This translates into 137 women being murdered every day by a member of their own family.

According to the World Health Organization (WHO), a 2013 analysis estimates that intimate partner violence ranges from 23.2% in high-income countries, to 24.6% in the WHO Western Pacific Region, to 37% in the WHO Eastern Mediterranean Region, to 37.7% in the WHO South-East Asia Region.

Domestic violence victims

As outlined above, women and men of varying ages and family situations experience domestic violence. NCADV says domestic violence exists in every community, affecting people regardless of sexual orientation, gender, age, socioeconomic status, nationality, religion, or race. “The devastating consequences of domestic violence can cross generations and last a lifetime.”

As an emergency dispatcher handling these calls, you might wonder why victims don’t always leave these situations when the violence continues. PPDS Protocol 114 Axiom 1 lists seven reasons why victims of abuse may choose to stay: economic dependence, children, emotional dependence, shame, social isolation, fear of reprisals, and lack of knowledge and access to help.

In her work, Spaulding is all too aware of reasons victims choose to stay quiet. In the case of the woman she helped in 2011, substance abuse was a contributing factor.

“She was so concerned about talking to police because he [former boyfriend] told her he would have her arrested for drug possession,” Spaulding said, adding that she later told the woman, “I don’t care about that when someone’s life is in danger.”

Abusive cycle

According to New Hope, there are three phases of the cycle of abuse.

1. Tension-building phase: The victim senses tension and works to calm the abuser down. He or she may walk on eggshells to avoid a major confrontation.

2. Violent episode: The perpetrator has violent, abusive incidents, attempting to dominate the victim by using violence. This may include physical or other types of abuse.

3. Reconciliation: The abuser offers an apology or shows affection, looking like there is an end to the violence. The perpetrator shows remorse and sadness.

4. The cycle repeats.

Common phrases used by perpetrators include “It wasn’t me; it was the alcohol/drugs,” “You know how to push my buttons,” and “I won’t do it again.”

Deep dive into PPDS

Now that you understand more about what domestic violence is, the cycle of abuse, and how staggering the numbers are, let’s get into using the protocol to process these types of calls.

When someone calls in to report an incident of domestic violence, there are two definitions you need to be familiar with. First, DOMESTIC DISTURBANCE is defined as “Any disturbance where the parties involved are, or have been, in a marriage, domestic partnership, or other intimate relationship, as defined by applicable laws.” FAMILY DISTURBANCE is defined as “Any disturbance where the parties involved share a close family relationship such as parent-child, stepparent-stepchild, siblings, etc.”

Rule 1 on Protocol 114 directs EPDs to use Protocol 113: Disturbance/Nuisance for disturbances not involving persons in a DOMESTIC or FAMILY relationship.

Once you are familiar with the difference between DOMESTIC and FAMILY DISTURBANCE, another thing you need to be aware of is determining whether this call is a COLD CALL. The PPDS defines COLD CALL as “A call for service involving a PAST event that does not require a full interrogation because, by the caller’s assessment, the suspect/person/vehicle is not in the area. Exceptions to this definition must be approved by local agency policy.”

There are people out there who don’t know that this isn’t OK.
Case Entry Question 6 asks, “When did this happen?” If needed, 6a, 6ai, and 6aii can help gather additional information to determine if this is a COLD CALL.

A COLD CALL incident requires only the Key Questions with the blue circle to be asked on Protocol 114. These Key Questions are Key Question 2 “Was the disturbance physical or verbal?” and Key Question 9 “Does anyone need medical attention?”

If the answer to KQ 9 is yes, the EPD will ask, “How many?”

After asking these questions, the EPD will code the call as either 114-B-1 or 114-B-2, depending on the type of situation. There are four—potentially five—Post-Dispatch Instructions the EPD will provide the caller:

a. If it’s safe to do so, separate yourself from her/him and avoid further contact.

b. Lock your door and windows.

c. If the suspect arrives/returns, do not let her/him in.

d. Do not disturb anything at the scene.

e. (Court order) Have all paperwork available for the responding officers.

It's happening now

When an EPD takes a call for a domestic violence incident that’s happening now, the EPD will choose Protocol 114 and ask if weapons were involved or mentioned and more details about the type and location of weapons (if applicable). There are six Determinant Suffixes: C = Club, E = Explosive, G = Gun, K = Knife, M = Multiple weapon types, and O = Other. Rule 3 states that unless the caller says that he or she fears household utensils might be used as a weapon against him or her or someone else, these items should not be considered accessible weapons.

If the incident is verbal and involves a boyfriend and girlfriend, the EPD will send a 114-D-2. If the incident involves two brothers physically fighting, the EPD will dispatch a 114-D-3.

After dispatching, the EPD will return to questioning. Key Question 3 asks, “How many people are involved?” KQ 4 has several parts with the EPD asking where the suspect is now, information about how she or he left, a vehicle description, the direction the person was heading, and if it’s known where the person was going. KQ 5 asks for the suspect’s description. After asking KQ 6, “Are you or anyone else in danger right now?” go to Protocol C: Caller in Danger (CID) if the caller says he or she is in danger. As an EPD, you can work to keep a caller in danger safe.

Protocol C asks questions about if the caller can safely relocate, if the phone can be taken with him or her, if the person can talk freely, and the caller’s exact location. After the EPD follows the panels, depending on the caller’s answers, he or she will stay on Protocol C or return to Key Questioning on Protocol 114.

Something important to keep in mind while working through Protocol 114 is Rule 2: “DOMESTIC and FAMILY violence has the potential for escalation at any time.”

After asking if the disturbance is physical or verbal, the EPD will choose from the available DELTA Determinant Codes and send a response. KQ 7 asks whether children are present and if they are, their ages and where they are now. KQ 8 asks “Has anyone involved been using alcohol or drugs?” KQ 9 finds out if anyone needs medical attention and how many. If needed, a medical response can be sent at this time.

You are a lifeline

The next time you answer the phone, chances are high that it could be a call about a domestic disturbance. While your agency might not have a domestic violence officer like Spaulding going through the call logs, what you do makes a big difference to a caller while he or she is going through a challenging situation. Protocol 114 helps you navigate these situations so you are able to provide a lifeline to a caller who needs your reassuring voice and record-keeping skills while waiting for police to arrive.

Sources
2. See note 1.
3. See note 1.
5. See note 1.
10. See note 4.
T STANDS FOR TOURNIQUET
New Protocol stops the bleed

Audrey Fraizer

The “hero in the cowboy hat” Carlos Arredondo grabbed the first thing he saw that might work to save a spectator collapsed on the ground, unable to stand, his legs shattered to “torn flesh and a length of bare bone” from the bombs detonated at the 2013 Boston Marathon.

“Somebody’s sweater,” Arredondo said, “I tore it apart,” and he placed it around Jeff Bauman’s right leg. Gauze wraps had been tied around his left leg moments earlier by Allan Panter, a physician who had been near Bauman in the crowd.

Tourniquets stopped what could have been fatal bleeding in many victims at the Boston Marathon, and Bauman is quick to credit the two men and the tourniquets they placed for saving his life. Less than a year later, Bauman said as much to responders from 23 agencies attending a tourniquet training course.

“Carlos put the tourniquet around my right leg,” Bauman said, “and someone [Dr. Panter] tied a shoelace [it was actually gauze] around my left leg really, really tight. And doing that right there bought me 10 minutes of my life. Tourniquets saved my life.”

Tourniquets are back in EMS vogue. It’s not because of the Boston Marathon bombing, but instead because they do work as Bauman’s survival indicates. Research dispels some—although not all—reasons why tourniquets fell from medical grace to a device of last resort in hemorrhage control.

Numerous studies supporting the tourniquet’s return have the device counted among the essential gear of fire/EMS systems and stationed alongside AEDs at airports and other potential targets of mass casualty incidents. The U.S. Department of Homeland Security’s Stop the Bleed program is a nationwide campaign to teach bystanders how to provide initial response to stop uncontrolled bleeding in emergency situations. Uncontrolled, life-threatening hemorrhaging is one of the leading causes of preventable death following a traumatic injury, and a person who is bleeding uncontrollably can die from blood loss within five minutes.

The International Academies of Emergency Dispatch (IAED) is a charter member of the Stop the Bleed campaign, and instructions for tourniquet use are available in Medical Priority Dispatch System (MPDS) version 13.2. Protocol T: Tourniquet was developed “from scratch” by an Academy research team that spent the better part of a year...
drafting the proposal and performing pre-testing prior to a volunteer-focused study conducted at four venues in Salt Lake County, Utah (USA), enlisting 246 participants.

The increase in mass casualty and violent attacks in recent years is pushing emergency medical recommendations for public installation of emergency bleed kits and to co-locate the kits next to AEDs. The Salt Lake International Airport, an IAED Accredited Center of Excellence (ACE), placed emergency trauma bleeding control kits next to AEDs for easy and familiar access to the public and airport operations. The bleed kits, assembled specifically for airport use in cooperation with Salt Lake City Fire Department Heavy Rescue Specialists, contain tourniquets, chest seals, trauma bandages, gauze, gloves, markers, and instructions.

Airport operations employees have received Stop the Bleed program training, and since installation of the bleeding control kits, a tourniquet was used in response to a traveler who had fallen down an escalator, according to Heidi Harward, Operations Manager—Safety Programs at Salt Lake City Department of Airports.

**T: Tourniquet**

In ProQA®, DLS Links for Amputation/Severe limb injury with (uncontrolled) SERIOUS hemorrhage will guide the emergency dispatcher to the tourniquet instructions. The DLS Link is incorporated in the following protocols:

3: Animal Bites/Attacks
4: Assault/Sexual Assault/Stun Gun
7: Burns (Scalds)/Explosion (Blast)
17: Falls
21: Hemorrhage (Bleeding)/Lacerations
27: Stab/Gunshot/Penetrating Trauma
29: Traffic/Transportation Incidents
30: Traumatic Injuries (Specific)

Three separate sets of instructions within the PAIs give step-by-step application instructions depending on the type of tourniquet available: commercial (manufactured) with Velcro, commercial without Velcro, and makeshift tourniquets.

The best makeshift tourniquets are between 2 and 3 inches wide and 3 to 4 feet long and made of material pliable enough for inserting a short stick to tighten the material until the bleeding stops. A long-sleeved shirt, bathrobe belt, or necktie can be used as the makeshift tourniquet. The emergency dispatcher should never recommend the use of a clothes belt because, although it may slow some bleeding, the stiff fabric cannot be adequately tightened to compress the arteries. Materials less than 1 to 2 inches wide should also be avoided since they are usually too narrow to cause enough total tissue compression to stop most arterial bleeding and are far more likely to cause tissue and nerve damage.

Each section begins with instructions to place the strap/cloth around the arm/leg at about 2 to 3 inches (5–8 cm) higher on the limb (closer to the shoulder/hip) than the bleeding site. The strap/cloth should never be wrapped around a joint or over the wound. If need be, the strap/cloth can be placed 1 to 2 inches (3–5 cm) away from the joint. It’s OK to lift the arm or leg to get the strap beneath the limb.

The next step involves securing the strap/cloth and then tightening it as hard as possible against the limb and fastening the ends (Velcro to Velcro, buckling or looping the ends in the non-Velcro device, or tying a half-knot with the knot facing up on the limb for a makeshift tourniquet). Finally, the caller is told to keep tightening the strap/cloth until all the bleeding stops. This is done with the rod (windlass) attached to the commercial tourniquets or a stick or rod for the makeshift tourniquet. If no stick is available, the caller is told to tighten the knot as hard as the person is able and to hold it until help arrives.

If the patient complains of pain from the pressure, the emergency dispatcher assures the caller that pain is not uncommon and, above all else, to keep the strap tight. As stated in the Bleeding Control Axiom accompanying the instructions: Adequate control of almost all bleeding is simple if enough pressure is applied to the right place.

**Research**

While the PAIs are easy to follow and the tourniquets seemingly require little more than common sense to apply, the same can’t be said of the process to develop instructions specific to the emergency dispatch setting.

The research team could only observe participants following over-the-phone test instructions in applying a tourniquet to stop a catastrophic bleed for a simulated limb and note where common errors occurred.

At each of the 10 study sites, participants called a simulated 911 line and reported a victim with life-threatening bleeding to the leg, which is identified in the real world as:

- Blood that is spurting out of the wound
- Blood that won’t stop coming out of the wound
- Blood that is pooling on the ground
- Clothing that is soaked with blood
- Bandages that are soaked with blood
- Loss of all or part of an arm or leg

The emergency dispatcher verified the catastrophic nature of the bleed and proceeded in giving the step-by-step instructions while a research team member timed how long it took the “caller” to stop the bleeding with the
tourniquet, according to the control device that indicated when the caller had applied the tourniquet sufficiently to stop the bleeding.

“We could watch how people reacted [in response to the instructions], but we couldn’t step in,” said Chris Olola, Ph.D., IAED, Director, Biomedical Informatics and Research. “It took a lot of testing and revision before adding it to the existing protocol.”

The Tourniquet Protocol doesn’t replace direct pressure in most bleeding situations, cautioned Greg Scott, Operations Research Analyst, IAED. “A tourniquet is the best way to stop the bleeding from catastrophic injury. Direct pressure is still the preferred method for abrasion.”

As in the EMD’s First Law of Safety, the bystander is cautioned against creating “more victims at the scene.” Bystanders must ensure their own safety and provide care to the injured person if the scene is safe to do so. If safety is threatened, the bystander should move from the danger, taking the victim if possible, to find a safe location.

The history of the tourniquet—a word influenced by the French tourner, which means “to turn”—dates back centuries to the Roman Empire when a leather-coated bronze thigh strap was fastened and tightened to save a life in battle, without regard to saving a limb.5

Take a huge leap forward to World War I and the decline of the tourniquet in favor of applied pressure due to noted increases in nerve damage and other medical morbidities when a tourniquet was applied.

The official British manual, republished by the U.S. government in 1918, Injuries and Diseases of War strongly denounced the use of a tourniquet: “The systematic use of the elastic tourniquet cannot be too severely condemned. The employment of it, except as a temporary measure during an operation, usually indicates that the person employing it is quite ignorant both of how to stop bleeding properly and also of the danger to life and limb caused by the tourniquet.”6 It was demanded that the medical officer remove the tourniquet at once.

The wars in Afghanistan and Iraq reintroduced tourniquets to the point where “Combat troops are reportedly going out on dangerous patrol missions with tourniquets already in place on extremities, as they wish to be fully ready to respond to extremity bleeding, if and when the mine or the improvised explosive device (IED) should go off.”7

While a simple tourniquet can save a life, there are also times when not to use one. They should never be used when simple pressure or pressure dressing suffices to control the bleeding, and they should never be partially applied, which fails to occlude the artery and can increase venous bleeding.8

Sources
8. See note 6.
DISPATCH LIFE SUPPORT
A unique standard of care and practice exists

Brett A. Patterson

By the time the following article was published in July 1990, I had been an EMD in Pinellas County, Florida (USA), for about three years and was completely enamored with Dispatch Life Support (DLS). I had been a paramedic for nearly 10 years and had experience in the emergency room, critical care interfacility transports, and emergency ambulance response, but until I experienced that 1987 EMD certification course taught by none other than Dr. Jeff Clawson, I had no concept of nonvisual medicine or the passion it would bring me. The art and science of caring for patients remotely, without the benefit of visual or tactile assessment did, and still does, fascinate and inspire me.

This article, published in JEMS, was groundbreaking at the time and still holds truths unknown to many today. It baffles me to consider that currently—nearly 30 years after this article was published and over 40 years since the citizens of Salt Lake City first benefited from the provision of DLS—so many people bound to the ethical code of public safety still do not understand the uniqueness of our discipline or, horrifically, the value of it. Although we now clearly understand the criticality of early recognition and intervention in cardiac arrest, and a plethora of peer-reviewed literature that supports DLS and ambulance triage for this and all other types of emergencies is available, there are still an astounding number of primary PSAPs in the United States and other civilized countries that do not provide this lifesaving care to their citizens. Those same calls that I astoundingly heard in my EMD class—where the dispatcher simply obtains an address, phone number, and complaint, then disconnects from the terrified caller in need without providing what is clearly an international standard of care and public expectation—are still happening. If I wasn’t on the inside seeing this with my own eyes, I simply wouldn’t believe it.

This article clearly articulated a DLS standard of care that is separate and necessarily distinct from the visually-oriented Basic Life Support practice, and it acknowledged the Academy as the academic body charged with maintaining and evolving DLS. The DLS standard of care is more clearly evident than ever, as is public expectation, and our Protocol has evolved to a sophistication I had not dreamed of those many years ago. However, we have much more to accomplish, and part of that includes a more universal understanding of the unique role of the First, First Responder. Now that we have a sound DLS standard of care, it’s about time that we implement it universally.

J
Dispatch Life Support

Establishing Standards That Work

by Jeff J. Clawson, MD, and Scott A. Hauert, AEMT

In the emergency medical services world of “seconds count,” acronyms help keep things simple and direct. Public acceptance of these shortened versions of names or products is assured when the acronyms can stand by themselves without explanation. EMT is one such example. EMD (Emergency Medical Dispatcher) is still relatively new, in existence less than a decade, having successfully won the battle against EMS-D (Emergency Medical Services Dispatcher), which rolled easily off no one’s tongue and is now obsolete.

A new acronym was recently coined to establish an identity for, and to enhance understanding of, a new key component of EMD. DLS, which stands for Dispatch Life Support, represents the sum of knowledge, procedures and skills used by trained EMDs to provide care via pre-arrival instructions given to callers. It consists of those BLS and ALS principles that are appropriate for use by emergency medical dispatchers. But isn’t this really just basic life support in disguise? The answer is a resounding “no” (see Figure 1, item 1). Each item serves as an example of how these standards relate to the role of the medical dispatcher.

The core of BLS, CPR and ACLS revolves around the standards and guidelines developed by the American Heart Association (AHA), which are tailored for EMS providers (see Figure 1, item 2). Unfortunately, difficulties arise when these guidelines are applied directly to medical dispatching.

The consistency of care and acceptance brought about by these much-needed standards created order from the chaos that previously existed in these areas of EMS. However, to some extent, blind acceptance of the standards, coupled with their limitations in certain situations, has caused significant difficulties when the standards are applied directly to pre-arrival instructions given by EMDs (see Figure 1, item 3).

These problems often surface when medical control physicians adopt and review pre-arrival instruction protocols, and find that they appear to deviate from current guidelines, such as those of the AHA. Actually, the medical director’s real dilemma is in attempting to understand the special limitations that are inherent in the dis-
The consistency of care brought about by the AHA standards created order from the chaos that previously existed in the areas of BLS, CPR and ACLS. But significant difficulties arise when they are applied directly to pre-arrival instructions given by EMDs.

Tonya Johnson, Emergency Medical Dispatcher from Emergicare in Erie, Pennsylvania.

Photo by Patrick A. Moore
of the hazards of neck manipulation if the patient has sustained a significant mechanism of injury. Fortunately, this scenario is less likely to occur, as most callers reporting traumatic incidents have not remained on scene.

cern first surfaced many years ago when the initial process for doing CPR differed in witnessed vs. unwitnessed arrest situations. One might think that people would, if confused, decide immediately that either method was better than doing nothing at all. But this is not always the case, as people sometimes hesitate or, even worse, give up.

Although this cannot be observed firsthand at the scene of an actual citizen CPR case, the fact that it occurs in practice on mannequins supports the contention that it occurs in the confusion of a real crisis. This delaying mental trap has been appropriately termed "paralysis by analysis" (see Figure 1, item 10).

There are several other examples that illustrate the problems of applying BLS training taught in a controlled environment directly to medical dispatching. The following are important concepts that are NOT present in BLS guidelines, but are essential to DLS:

- A seizure or convulsion may be a symptom of the onset of cardiac arrest. Any patient 35 years or older who presents with a seizure as the chief complaint should be assumed to be in cardiac arrest until proven otherwise. This is a statistical probability that occurs with some regularity.
- Cardiac arrest in a previously healthy child should be considered to be caused by a foreign body obstructing the airway until proven otherwise.
- Dispatchers should be trained to...
See, the AHA “Standards” from a Medical Dispatch Perspective

The following are excerpts from the American Heart Association’s “Standards and Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care,” published in the Journal of the American Medical Association on June 6, 1986.

1. Emergency Cardiac Care: Basic life support is that particular phase of ECC that either (1) prevents circulatory or respiratory arrest or insufficiency through prompt recognition and intervention, early entry into the EMS system, or both, or (2) externally supports the circulation and respiration of a victim of cardiac or respiratory arrest.

2. Standards and Guidelines: The 1980 standards and guidelines were intended (1) to identify a body of knowledge and certain performance skills that are commonly necessary for the successful treatment of victims of cardiopulmonary arrest or of serious or life-threatening cardiac or pulmonary disturbance.

3. Standards and Guidelines: The 1980 standards and guidelines were intended (2) to indicate that the knowledge and skills recommended or defined do not represent the only medically or legally acceptable approach to a designated problem, but rather an approach that is generally regarded as having the best likelihood of success in view of present knowledge.

4. Standards and Guidelines: The standards and guidelines were not intended to imply (1) that justifiable deviations from suggested standards and guidelines by physicians qualified and experienced in CPR and ECC under appropriate circumstances represent a breach of a medical standard of care, or (2) that new knowledge, new techniques, or clinical circumstances may not provide sound reasons for alternative approaches to CPR and ECC before the next definition of national standards and guidelines.

5. Basis for Changing Recommendations: In some subject areas, sound data had accumulated, and changes were recommended on that basis. In other areas, while the experimental data were not conclusive, changes were recommended on the basis of clinical evidence or in order to improve educational efficacy.

6. Standards and Guidelines: “Loose constructionists,” while realizing the need for uniformity and consistency, have believed that more flexibility is needed, for two principal reasons: (1) New knowledge and innovation are ongoing, and failure to permit flexibility can result in delay of potentially lifesaving advances; (2) The physician’s prerogative for discretionary action may be threatened by overly rigid standards, particularly because the term has important legal, as well as medical, overtones.

7. Emergency Cardiac Care: Emergency cardiac care is dependent for its success on laypersons’ appreciation of the critical importance of activating the EMS system as well as their willingness to initiate CPR promptly and their ability to provide it effectively.

8. Basis for Changing Recommendations: Final decisions took into account not only which technique or adjunct or therapy was the most correct, but also how the public could best be served, which brought into the decision-making such factors as safety, effectiveness, teachability and ease of sequencing into related maneuvers.

9. Public Education: Other changes for improving retention should include simplification of the sequences of BLS and inclusion of only one method of managing foreign-body obstruction in the adult.

10. Public Education: There are many reasons why lay individuals do not become involved in performing CPR. These include lack of motivation, fear of doing harm, inability to remember exact sequences and poor retention of psychomotor skills.

11. Reasons to Withhold CPR: Few reliable criteria exist by which death can be defined immediately. Decapitation, rigor mortis and evidence of tissue decomposition and extreme dependent lividity are usually reliable criteria. When they...
identify obvious death situations (as defined by medical control), mobilize the response accordingly and give limited pre-arrival instructions (see Figure 1, item 11).

- If the victim is unconscious and breathing cannot be verified by a second-party caller, the victim should be assumed to be in cardiac arrest until proven otherwise.
- EMDs should assume that bystanders have inappropriately placed a pillow under the head of an unconscious victim, until proven otherwise, and ensure that it is removed.
- BLS protocol for choking victims should be modified to reflect that EMDs recommend a specific number of thrusts, rather than stating a range of six to 10 thrusts. The present guidelines contain no basis for deciding during the crisis how many to use. This simplification will eliminate any confusion and subsequent hesitation on the caller’s part.

The Heimlich maneuver should be the primary treatment for infants, children and adults who are choking (see Figure 1, item 9). Many readers will assume that EMDs are aware of these concepts. But most of this information is not directly taught to the majority of EMTs and paramedics and is not covered in the current EMT and paramedic textbooks. Addressing these omissions highlights the need for “dispatcher-specific training.”

The psychology behind pre-arrival instructions is currently undergoing some unique and very useful expansion. As callers’ actions can now be predicted to a reasonable extent, EMD protocols need to reflect these new understandings. There is no question that DLS is different from BLS, just as EMDs are different from EMTs—not better or worse, but different. You don’t get “apples” by training people to be “oranges.” Likewise, you won’t get good guidelines for baking apples by using the recipe for peach cobbler.

The next step in solving this problem seems an obvious one: Medical dispatch experts, line dispatchers and the standard setters must work together in creating sound DLS guidelines.

The AHA has correctly stated that, “Basic life support can and should be initiated by anyone present when cardiac or respiratory arrest occurs,” and, furthermore, “The most important link in the CPR-ECC system in the community is the layperson.”

In the future, every time the requirement of BLS is mentioned in the AHA Standards and Guidelines, it should be preceded by a reference to DLS. And every discussion of the layperson being an important link in the initial provision of emergency cardiac care should emphasize the dispatcher’s role as teacher of that layperson. Until this is accomplished, no standards or guidelines, regardless of how well-intentioned, will best serve people in crisis who need immediate, but realistic, Dispatch Life Support intervention.

References

Jeff J. Clawson, MD, is president of Medical Priority Dispatch, Inc. in Salt Lake City, medical director for the Salt Lake County Fire Department, fire surgeon for the Salt Lake City Fire Department and the medical dispatch consultant for the city of Los Angeles. Clawson originated the Medical Priority Dispatch System, the national standard of medical dispatch care and practice.

Scott A. Hauert, AEMT, is director of training for the National Academy of Emergency Medical Dispatch and Medical Priority Consultants Inc., both in Salt Lake City. He previously worked as a field supervisor and staff development coordinator during 12 years of employment at Gold Cross Ambulance in Salt Lake City and is the recent past president of the Utah Association of EMTs.
ever in a million years would Chloe Porter suggest anything odd about her family. She is the older of two children raised for most of her life by a single mom who is an emergency dispatch professional. Chloe was always aware of a few exceptions, such as the long hours her mom, Christine Bannister, worked and the looked-for quiet space that sometimes precluded conversation after she came home from school.

In relation to her mom’s career, Chloe said, “It just made a few things different for me, but it was just the way it was.”

Chloe, 16, and her brother Egan, 13, grew up in a home not quite synchronized by a regular routine. Bannister is a supervisor at Waukesha County Communications, Wisconsin, USA, and has not only healthily survived the profession but, also, is helping others to do the same.

The “help” goes beyond callers and emergency dispatchers. Bannister is also keen on developing and maintaining healthy relationships within the sphere of their daily influence.

“There are so many things we did without reflecting on the why,” Bannister said. “I didn’t realize the impact on my kids because we never discussed the topic of my work.”

While Chloe holds no grudge against her 911 upbringing, she never truly recognized exactly what her mother did that could cause something unsettling in her mood. Chloe and Egan simply rolled with the long hours, holidays mom was at work and not home, and the hyper-vigilance Bannister asserted on her children.

That was until Chloe attended a wellness conference in which her mom was the opening speaker and spoke about wellness for the first first responder. Bannister hadn’t told Chloe a lot about her profession but figured the conference was the perfect segue to heighten Chloe’s perspective of her emergency dispatch career. Bannister brought up the potential effects of stress on relationships, the importance of recognizing and doing things to remedy the stress, and began her session proudly introducing Chloe as a big part of her “why.”

Chloe hadn’t anticipated the introduction any more than she did the open-armed reception from the audience. Their questions resonated with what Chloe had long accepted although—at the same time—wondered about others in her situation. It was as if the audience was listening to Chloe in reflection of their own personal relationships. They asked Chloe if she was speaking. They wanted to attend.

The response inspired Bannister and Chloe. They had an important message to deliver. Chloe could stand beside her mother in support of the profession and, also, in support of “it’s OK” to bring your family into a conversation about emergency dispatch. Bannister could talk about a journey resonating on several levels.

Their first co-presentation “Growing Up 911” was a big hit at NAVIGATOR 2017 and at the national NENA conference held the same year. Chloe admitted a slight case of jitters when first joining her mother up front, but that didn’t last long. She learned to engage through the honesty of her experience and apparent deep admiration for emergency dispatchers.

Bannister said that they tend to leave their audience in tears from both the laughter in anecdotes of the profession’s “insider” quirks and the acknowledgment that this is a profession requiring the same compassionate help at home as on the phone.

Bannister’s complementary approach to help people who take the calls didn’t exist in a profession she was thrilled to discover 23 years ago. She had found a career path in which she could excel though, at that time, no one discussed the stress associated with one call or accumulated in the span of weeks, months, or years.

The direction their speaking partnership will take from here, Bannister can’t say. “Anything’s possible,” she said. “I wanted to show Chloe how emergency dispatch changes people’s lives, and through all of this she’s inspired me to continue to evolve and change mine.”
TAG-TEAM SAVE
Emergency dispatchers combine efforts to locate, get help for victim

Josh McFadden

Sometimes the most challenging calls require emergency dispatchers to get a little help from their friends.

Co-workers Mike Graves and Christopher (Kit) Willadsen, at Addison Consolidated Dispatch Center (ACDC) in Addison, Illinois (USA), supported one another when a call came into the center from a bicyclist who had come across a non-responsive man.

Willadsen took the call from someone who had been riding on a bike trail at the DuPage County Forest Preserve Salt Creek Marsh in Wood Dale, Illinois. The heavily wooded area is a popular spot for outdoor activities, but it can also be a difficult spot to pinpoint caller locations. It covers 26,000 acres of wetlands, woodlands, and prairies. Fortunately, Willadsen got a hand from the caller and from his teammate Graves.

“The caller gave a good description of where he was,” Willadsen said. “The location where they were made it difficult to pinpoint. [Graves] saw where it was.”

The caller indicated that the man had possibly fallen off his bike. The victim was turning purple, having difficulty breathing, and not responding appropriately. Willadsen reassured the caller that help was already on the way, and he instructed him to lay the man flat on his back. At this point, the victim stopped breathing.

Willadsen didn’t hesitate to confidently give CPR instructions to the caller.

However, because of the urgent nature of the call, combined with troublesome location, Willadsen knew he’d need help sending crews to the right location while he focused on the caller.

“[Willadsen] yelled across the room where the caller was, and I looked at a map in the forest reserve area,” Graves said. “I had to switch to Google Maps to see where the bike path was. [Willadsen] was handling the heavy work; I guided units in and was verifying locations.”

Meanwhile, Willadsen had the responsibility of coaching the caller on administering CPR and keeping him calm.

“The caller was freaked out but attentive; he was ready to go,” Willadsen said. “It’s a little more satisfying when you have callers going with your flow and when you’re able to flow with the protocols and training.”

Narrowing down the exact location in this forest wasn’t easy for Graves, but there were plenty of twists and turns with the caller, too. Willadsen coached him and encouraged him while counting out loud together. Within 90 seconds of the chest compressions, the patient began to breathe. However, while Willadsen conducted the breathing test, the patient stopped breathing again. Willadsen instructed the caller to start compressions again. This time, within 45 seconds the patient started breathing again, and the first fire unit arrived on scene and took over.

Graves played a critical role in getting responders on the scene so quickly. He initially used information from Willadsen and then relied on Vesta 9-1-1 Phone Map and Google Earth to give the appropriate information to responding units. He provided the units with landmarks in the forest to quickly get them to the victim.

“I just found the closest access point,” he said. “It’s easy for us to get within 500 feet, but we got crews within 50 feet.”

Willadsen and Graves acknowledged that this call was unique. Willadsen said he hung up the phone confident that he had done everything right.

“We did the best we could with the info we had at the time and used the tools that were given to us,” Graves said. “Everything fell into place. It doesn’t always happen that way.”

For their outstanding efforts, ACDC Professional Standards Coordinator Sherianne Hermes nominated Willadsen and Graves for the IAED’s Call of the Week.
Recognition comes in many shapes and sizes, but how often do you see the high-five presented in the shape of a leaf? At Manatee County Emergency Communications Center (ECC) (Bradenton, Florida, USA), acknowledgment comes just that way, symbolic of a fresh start and growth in the Tree of Life. A leaf is added to the center’s Tree of Life each time dispatcher-directed PAIs for CPR are closely linked to survival from sudden cardiac arrest (getting a pulse back). The leaf and tree are a celebration in the name of the emergency dispatcher and the profession, in general.

Heather Hedgcock, Manatee ECC, Quality Assurance Coordinator, designed the tree, and from the time of “planting” in January 2019 through July 2019, she has attached 36 laminated green leaves to the tree’s branches signifying the lifesaving force of emergency dispatchers.

“I wanted to do something to display the saves on a regular basis,” said Hedgcock, who reviews the CPR calls prior to awarding a leaf. “The calls must be highly compliant [to protocol]."

The tree, however, is about more than compliance to the Medical Priority Dispatch System® (MPDS®). Foremost, the six-foot stenciled tree in the center’s foyer represents the dedication and hard work of emergency dispatchers that Hedgcock wanted on display for all to see.

“The protocols are wonderful; they save lives,” she said. “But I did the tree for the people here. It’s recognition.”

Hedgcock also considers customer service as a big part of the recognition and, like following protocol, it is second nature to the tri-Accredited Center of Excellence (medical, fire, police). After all, life-threatening situations make for extremely tense and dynamic calls that require the voice of calm and reassurance. Performing to the best of one’s ability—and helping to keep a person alive while waiting for EMS to arrive on scene—easily falls by the wayside or, at least, in terms of recognition fails to attract attention, Hedgcock said. It’s not something emergency dispatchers go around bragging about.

The center receives a high volume of calls requiring CPR related to sudden cardiac arrest, opioid-based drug overdoses, and drowning. Once response is on scene, the emergency dispatcher disconnects and goes on to the next call. It’s not likely the dispatcher will announce what happened, let alone learn the call’s outcome. Most often they don’t know the patient’s status unless they hear it from dispatchers on the radio listening to the traffic between EMS and the hospital.

Senior Telecommunicator Jen Henderson has five leaves to her name. She can’t think of a career path in which she is better suited because of the ability to help people, make a difference during an emergency, and juggle multiple tasks in a fast-paced environment. Recognition might not be a priority on her list of why she is going on her 18th year at the Manatee County ECC, although the Tree of Life is a welcome addition on their walls.

“We don’t always get to know about the calls [other than their own] involving CPR, so it’s a really positive thing to be noticed,” she said. “The recognition is motivating, especially when we’re always striving to do better.”

The leaves aren’t the limit on the Manatee County ECC Tree of Life. Following a suggestion from Kim Rigden, IAED™ Associate Director of Accreditation, the tree will bloom with laminated pink and blue flowers celebrating emergency dispatcher-directed childbirth and delivery.

“Can’t wait to watch the tree grow over the years,” said Hedgcock, who in September reached her 20th anniversary at the Manatee ECC. “Everyone here does an awesome job.”

The Manatee County ECC is the primary 911 center for all wireless callers in Manatee County and landline callers outside of the City of Bradenton jurisdiction. They answer over 400,000 emergency and non-emergency calls per year and dispatch for Manatee County EMS, Manatee County Marine Rescue, and nine fire departments. In addition to the leaf with their name, emergency dispatchers receive a heart pin and certificate commemorating each CPR save.
911 AND OVERDOSE PROTECTION LAWS
Good intentions don’t guarantee effectiveness

Audrey Fraizer

Good intentions don’t always reach the intended audience, and a good example of this are the Good Samaritan Laws (GSL) providing protection to callers and patients in medical crises involving drug overdoses.

Studies show that the fear of arrest for a drug-related crime prevents witnesses from calling 911, particularly if the caller lacks the specifics of state-directed GSL. It’s a relationship that can prove fatal to the people most vulnerable to the consequences the laws are meant to avoid.

A study conducted by the New York City (New York, USA) Department of Health and Mental Hygiene (2005) found that over a 27-month span in the early 2000s, only about one-third of people witnessing an overdose called for medical help, fearing police response if they made the call. In July 2011, New York state became the largest state in the nation to adopt a Good Samaritan Law to fight overdoses.

A second (unrelated) study in 2017 involved participants who had training in opioid overdose rescue and were educated about the state’s GSL. The results are telling:

At the 12-month follow-up, participants had witnessed 326 overdoses. In the overdose events where the participant had correct knowledge of the GSL at the time of the event, the odds of a bystander calling 911 were over three times greater than when the witness had incorrect knowledge of the GSL. This association remained significant after adjusting for age, gender, race of the witness, and overdose setting.

In the second study, researchers concluded that laws protecting overdose witnesses along with public awareness of the law may be “an effective strategy to increase rates of 911 calling in response to overdose events and decrease overdose-related mortality.”

According to the Prescription Drug Abuse Policy System (PDAPS) (2018), 45 states and the District of Columbia have GSLs, and the laws fall into two primary categories. The first encourages calling 911 to seek medical assistance by providing criminal immunity for both the person in need and the person who sought help. The second provides varying levels of criminal or civil immunity for those involved with the prescription, possession, or emergency administration of the opioid antidote naloxone to reverse the effects of the overdose.

Maine, Texas, Kansas, Oklahoma, and Wyoming do not have GSLs.

The Good Samaritan Drug Overdose Act in Canada provides some legal protection for people who experience or witness an overdose and call 911 or their local emergency number for help. The act became law on May 4, 2017, and applies to all controlled substances or illegal drugs.

Good intentions, however, are not the harbinger of effective laws, at least in the United States. A review by the Cincinnati Enquirer indicates many of the laws are ineffective among those most vulnerable. Few states allocate any funding to educate drug users about the GSL protections, making the most likely affected, the least informed.

There’s also confusion about GSL application. Few states have databases showing how many times a GSL has been invoked or whether the laws have impacted 911 call volume. The problem, according to an Ohio state prosecutor, is the difficulty of enforcing on a local level. “The people who drafted it never really considered how we’re going to apply it,” he said.

Sources
3. See note 2.

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