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Art is a software instructor and IAED™-certified ED-Q™ instructor for Priority Dispatch Corp.™ He has been a fire and EMS dispatcher for 18 years and works at Union County Regional Communications in Westfield, N.J. Art has been involved in 9-1-1 telecommunicator training and medical quality assurance since 1999.

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

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P
rior to Dec. 1, 2014, I knew next to nothing about the world of emergency dispatch.

Having never worked in the industry or even known anyone who had, all I knew was what I had been taught as a kindergartener. When there’s an emergency, call 9-1-1. I had also figured if there was a fire, if someone had life-threatening injuries or conditions, or if I was involved in or saw a situation where there was danger, I’d simply grab a phone, dial 9-1-1, and the fire department, paramedics, or police would come. My only direct experience with 9-1-1 was when I called after seeing a dumpster fire at my apartment complex shortly after my wife and I had got married.

Little did I know of the intricacies and nuances behind the processes involved in an emergency call.

I came to the Academy last December having spent more than a decade as a writer and editor in fields vastly different than this one. After college, I worked at a local newspaper for eight years—four years as a writer/reporter and four years as an editor. My duties included writing stories on topics ranging from sports to education to business to government.

As newspapers everywhere began to lose subscribers and advertisers due to the online boom, I diversified my skill set and moved on to marketing writing and technical writing, first for a health and wellness company and then for a real estate company. I learned everything I could about nutritional supplements and cellular health and about short sales and title processes. These were educational experiences as I wrote for both internal and external audiences about the companies’ products and services for customers and employees.

But that was nothing compared to the eye-openers I’ve had here.

Through the interview process and in my first few days and weeks, I was amazed and sometimes overwhelmed at the tremendous amount of effort that goes into developing and using the protocols. The knowledge and expertise of the hard-working professionals here and at communication centers display every day is remarkable. It’s clear to anyone that the job of a dispatcher must be challenging, but it wasn’t until I came to the Academy that I truly understood (as much as a non-dispatcher can) what you dedicated men and women face each and every day. It’s inspiring to hear heroic stories of saving lives. It’s moving to learn how you remain calm and collected even when callers are frantically relaying the most harrowing moments of their lives.

I commend all of you for your continued efforts. It’s an honor to play a small role in this profession.

Josh McFadden

S E N I O R  E D I T O R
A report issued in mid-June by the insurance risk firm Verisk estimated that about 128,800 homes in Utah were at high or extreme risks from wildfires. That’s 13.2 percent of the homes in this state. That figure is likely to climb, as 90-degree temperatures in northern Utah threatened to make tinder out of the tall, green grasses in the heavily populated foothills overlooking the Wasatch Front.

Although Utah was 10th on the list as far as number of households at risk, it sounds almost minimal compared to the 2.1 million households at risk in California (15 percent of the total number of homes in the state). Montana—which is new to the wildfire risk analysis—comes in first with the percentage of households threatened (27 percent, or about 130,200 homes). Idaho is second at 25 percent (163,000 homes).

There is no escaping this inevitable scourge of the West.

Wildfire is a natural part of the environment; however, a number of factors, such as hotter and drier summers and persistent drought leading to longer fire seasons, are resulting in larger and more costly wildfires. As of June 19, 12 wildland fires had already burned more than 35,000 acres in Oregon, California, Alaska, and Arizona. During the first five months of 2015, California was up almost 54 percent over the five-year average for the same period.

Wildland fires require an approach different from structural fires. In the case of wildland fires, firefighters direct their efforts toward controlling its spread by creating a gap, or firebreak, across which fire cannot move. Fire crews attempt to stop the fire by several methods: trenching, direct attack with hose streams, aerial bombing, spraying of fire-retarding chemicals, and controlled back-burning.

A fire crew’s desired culture of adventure and hardship are distinguishing characteristics, but the bravado comes with risk. The work is extremely demanding, and according to the Centers for Disease Control and Prevention (CDC), between 2000–2013, nearly 300 on-duty wildland firefighters died from wildfire hazards, with fatalities resulting from burnovers, entrapments, heat-related illnesses and injuries, cardiac arrest, smoke inhalation, and vehicle-related injuries.

That’s where the emergency fire dispatcher’s responsibility is most essential: protecting lives in the field.

Dispatchers do this through system coordination. They disperse fire crews and maintain communication with firefighters, management, and other agencies, such as city fire departments. They track the location of each fire crew and compile statistics involving wildland fires. They operate radios, telephones, and computers and process information on fire weather conditions, forecasts, and wildland fire management activities.

Wildland dispatch is often specialized and divided into tasks and spread among several individuals, such as supervisory, support, and recording dispatchers. Depending on the assigned position, they conduct briefings, set priorities for shifts, and update logs to reflect all significant shift activity. They train local dispatchers on policy and procedure and coordinate expanded dispatch that requires interagency cooperation.

Agencies in wildfire-prone areas also continually modify their approach.

For example, following the 2003 Cedar Fire in San Diego, Calif., the San Diego Fire-Rescue Department put in place a regional cooperative dispatch system that is now used every day, and not just for wildfires. The Cedar Fire destroyed 2,232 residences and 22 commercial properties in southern San Diego County, and it was responsible for the death of 14 people, including one firefighter. The wildfire burned 280,278 acres, including public land in the Cleveland National Forest.

According to the report “Fighting a Wildfire—10 Years After the Cedar Fire,” the system, among many innovations, employs a cooperative approach allowing fire departments to dispatch the nearest available resources regardless of jurisdiction. They go where they’re needed.

The West will never be immune to the wildfire threat. That makes it all the more important for emergency fire dispatchers to provide the dependable first link in these potentially catastrophic events.
It’s almost by triple accident that Lee Van Vleet found research—or the other way around. And during the past five years since getting his master’s in health science, he’s turned into an evidence-based hound for EMS, particularly EMD.

Van Vleet entered a graduate program in 2008 through Western Carolina University (WCU). The degree with an emphasis on emergency medical care was in its first year at the university and required students to make a choice between an education- or research-related project for their thesis. Van Vleet chose the latter and then narrowed the field of concentration.

“There was so little research in EMS relative to other medical science, so that’s the direction I decided to take,” said Van Vleet, District Chief, Wake County EMS, Raleigh, N.C. “EMD is an important component of EMS and one that’s underappreciated.”

The thesis, or rather the previously unknown lure with hands-on research, led to the poster submitted to the IAED™-sponsored contest at NAVIGATOR and—to his astonishment—the poster that took top honors. Van Vleet chose the latter and then narrowed the field of concentration.

“EMD is an important component of EMS and one that’s underappreciated.”

The poster, “Time to First Compression Using Medical Priority Dispatch System™ CPR Pre-Arrival Instructions Does Not Vary With Dispatcher Experience,” quantified the relationship between time to first compression and EMD experience across MPDS versions 11.3 and 12.0 for all calls identified as cardiac arrest.

Van Vleet’s interest in studies involving cardiac arrest survival directly tie into his work and the county’s EMS reputation. Wake County EMS is nationally recognized for its cardiac arrest survival rates. Over the past decade, the survival rate from cardiac arrest has increased substantially due to EMS actions such as continued compressions, cooling patients, not moving patients until pulse is restored, and sending specially trained paramedics to the scene of every cardiac arrest patient.

“Van Vleet’s interest in studies involving cardiac arrest survival directly tie into his work and the county’s EMS reputation.”

Van Vleet is a field paramedic and proficient in providing the county’s EMS initiatives for cardiac arrest survival; his 9-1-1 EMD experience, however, is somewhat limited. Due to state regulations, he was certified in EMD in 1998 when appointed the EMS training officer for neighboring Chatham County.

“I went in to the EMD course with paramedic attitude,” he said. “Why do I need EMD training? I’m a paramedic. I know what to do. My thinking was turned around. The difference between field and phone is apples to oranges.”

Exposure to the communication center, the MPDS, and the EMD program made Van Vleet one—as he says—of the staunchest advocates of protocols and certification. He also found a niche in the link of EMS response and looks forward to future studies that complement EMD.

Van Vleet’s winning poster quantified the relationship between time to first compression and EMD experience across MPDS versions 11.3 and 12.0 for all calls identified as cardiac arrest.

“I like research very much,” he said. “We prove things. We do so much based on what works, without the evidence that it does. That’s not science.”

He’s also looking forward to next year’s research poster contest.

“I’m champing at the bit for the release of MPDS Version 13.0 so I can get started on another EMD project related to protocol,” he said.

The abstract of Van Vleet’s research and winning poster will be featured in the September/October 2015 (Volume 3 Issue 2) Annals of Emergency Dispatch & Response (AEDR).
As a whole, dispatchers are a pretty outspoken group of people. We have opinions on most things and aren’t hesitant to criticize what we don’t like. We also have some definitive ideas when there’s room for improvement. I have yet to meet a dispatcher who didn’t, at one time or another, have an idea on how something could be done better.

This is particularly true for the Medical Protocols. The problem is, we can’t change them, right? Well, if that’s what you thought, you’re mistaken. You and your staff can submit ideas for improvement and should do so. After all, who knows the protocols better?

The Academy is always looking to build a better mousetrap. That expression is uniquely American, and it is part of a quotation by Ralph Waldo Emerson that has turned into a metaphor about the power of innovation. The analogy, as I’ve used it here, is particularly appropriate since the protocols are designed to catch things we can’t see.

In its 143-year history, the United States Patent and Trademark Office has issued more than 4,400 patents for new and improved mousetraps. The Academy has made more than 4,000 changes to the Medical Protocols since their inception in 1979. It surprises many people to find out that the majority of changes come from protocol users: us, the dispatchers. Yet most of us have never heard of how to suggest one of those changes. It’s through a document called a Proposal For Change (PFC for short). It’s the means by which a specific idea for improving the protocols is formally submitted to the Academy. There are PFCs for curriculum changes and other areas; a PFC for protocol change is the focus of this article.

What types of changes are submitted through this process? You can submit anything you think will make the protocols more effective. It might be a different way to word a Key Question, a better way of scripting a Pre-Arrival Instruction, or even adding a new Dispatch Life Support pathway. Your proposal might be based on your experience with a particular aspect of the protocols over time, or you might have had an unusual call that you felt the protocols didn’t adequately handle.

The Academy requires that PFCs go through a formal review and sign off process within your agency, starting with your Dispatch Review Committee and proceeding to your Dispatch Steering Committee. (If you’re not sure who or what these are in your agency, find out.) Then they’re submitted by a designated contact person within your agency (frequently the head of your Quality Improvement Unit). You’ll need to include some supporting documentation, but you don’t need reams of case studies; in many cases, a simple explanation of what you’re proposing and why you feel it will be beneficial is all that’s needed.

The process by which a PFC turns into a protocol change is a multi-step process of review and evaluation within the Academy, followed by beta testing. And it doesn’t happen overnight. Throughout the process, your agency will receive periodic updates. (This is new; in the past an agency typically would not receive any further communication once a PFC had been submitted.)
Our family cottage in northern Wisconsin is my “happy place.” It is a refuge where I can relax with a cool beverage, read to my heart’s content, swim, kayak, and soak up the sun’s warm rays. It is a haven where I can breathe fresh air, take in the beauty of nature, and experience the joy of just being still. I am reminded that nature paints a curious yet accurate portrait of life, even as it is displayed in our own dispatch centers.

This year, I noted an interesting theme among the woodland birds and assorted critters that is particularly significant and absolutely relevant to the care and feeding of our most vulnerable asset: new employees. Too many times, longer-serving staff members looks at new hires as having little value to the organization because they haven’t learned how to do the job.

We are critical of their ability to learn, their work style, motives, mannerisms, and the way they dress. This brings me to the question: Do we truly “eat our young,” or do we nurture and grow them? Do we clip our baby bird’s wings or do we give them wings?

Images at the lake added to my insight.

The pileated woodpecker landed on the suet feeder and was joined by another, much smaller version of the species. The bigger bird peaked at the suet and then turned and carefully placed pieces of the suet inside the smaller bird’s mouth.

Do we extend the same concern to new hires struggling to “gain nourishment” in the dispatch environment? Do we feed them so that they grow and learn, or do we leave them hungry? Do we share our knowledge, experience, and the lessons we’ve learned along the way as seasoned dispatchers, or do we stay silent? Worse yet, do we give them all the answers and never let them make mistakes? It’s not about giving them fish, but rather teaching them to fish. They will never grow hungry.

Outside the front window I saw twin fawns and their mama doe grazing on the grass in front of the cottage. Excited for the photo op, I made a mad dash for my iPhone and stepped outside the front door. The fawns bolted into the woods across the road. The doe walked toward me—stopping within about 50 yards—and proceeded to stomp her front hoof and blow at me angrily as if to scold me for frightening her offspring. After showing her peace, she bounded into the woods to presumably find and console her fawns.

Do we protect our new dispatchers from the things that could potentially harm them? Or do we allow them to make mistakes and encounter risk without warning them?

What can you do to promote the growth of your new dispatchers?

We must encourage longer-serving staff to engage fully and invest deeply in new dispatchers, from a professional and personal level, to help them feel part of the team. We spend a lot of our waking hours within our work community, often more time than we spend with our families at home, making it even more important to create an atmosphere that is caring, supportive, and friendly. There is no place for bullies, no place for impatience.

Plan for success and work through mistakes. Celebrate what was done right, and at the end of the day, your “birds” will either fly or they won’t. This is not failure on your part; this job is not for everyone.

Ultimately, the goal is to equip your new hires from the time they apply to the time they are “fully grown” and working independently in your center.

Your “birds” will either fly or they won’t. Remember: “Clip their wings and they won’t fly. Give them wings and watch them fly.”
PROFESSIONAL LIABILITY INSURANCE

Do EMDs need to carry a policy?

Jeff Clawson, M.D.

Miss Arabella VanBeuge, IAED Membership Services Manager

My name is Jillian Glasgow, and I’m a summer research student in New Brunswick, Canada, working for one of the Regional Health Authorities (RHA). I am currently compiling an estimate of licensure costs for the RHA. Related to my project, I’m also looking specifically at Professional Liability Insurance and was hoping you might be able to answer a quick question for me: Do dispatchers (specifically medical dispatchers) need to carry Professional Liability Insurance?

Any help you can give me is much appreciated.

Thank you,
Jillian Glasgow
Summer Research Student
Organizational Learning
Saint John Regional Hospital
Horizon Health Network Zone 2
Saint John, New Brunswick, Canada

Dear Jillian,

I am in receipt of your most interesting question about liability for Emergency Medical Dispatchers (EMDs). In the Western world, especially the U.S., EMDs are exposed to a variety of critical and fast-moving situations that expose them and their centers, and the EMS systems they serve, to potential and accused liability. More specifically, you queried whether the EMD personally needs such insurance. Let me start by saying that most governmental and private EMS providers carry liability, or errors and omission, insurance for their employees and, as such, the EMD is covered under that umbrella. There have been cases where the actions of the EMD were so willful and wanton that they themselves have been sued. This is rare, however, and usually revolves around some convoluted legal responsibility, employment, governmental statute of limitations, and/or immunity issues.

The bigger question is what is the best prevention for these tragedies that embroil the EMD and their center/system? By far, in my opinion, it is the following:

1) Failure to obtain and verify the caller’s location and phone number correctly
2) Failure to follow established calltaking protocols
3) Failure to provide pre-arrival telephone instructions when possible and appropriate
4) Failure to follow organizational policies and procedures
5) 1st party gone-on-arrival situations assumptions in call cancellation

Ancillary to these is the often associated problem of the calltaker judging the integrity or truthfulness of the caller, which the IAED™ strictly prohibits. This seems to rear its ugly head as a common thread in these lawsuits, and such poor judgment routinely flirts with the above areas as they get off of the straight and narrow professional path. At times, calltakers stray this direction because of unwritten but powerful management pressure about “gate-keeping” to sort the “not-truly-deserving-of-9-1-1-help” out of the system. This is the emperor’s clothes of dispatching.

An interesting fact that you should be aware of is, of all the 3,835 communication centers in 44 countries using the IAED’s Medical, Fire, and Police Priority Dispatch System™ Protocols over the past 36 years, there has never been a formal lawsuit, much less a successful one. Compare that to the medical malpractice count in any one of these countries or even one hospital or clinic. It is a truly amazing record (knock on wood).

Several U.S. emergency ambulance insurers require IAED training, certification, and protocol use to even insure the agency. The IAED program is literally considered an “immunization” against dispatch liability in many quarters.

Of all the 3,835 communication centers in 44 countries using the IAED’s Medical, Fire, and Police Priority Dispatch System Protocols over the past 36 years, there has never been a formal lawsuit, much less a successful one. Compare that to the medical malpractice count in any one of these countries. It is a truly amazing record.
In comparison, one top five-sized city has been involved in at least nine dispatch-related lawsuits in the past 25 years, with several ending in multi-million dollar judgments against them. Not surprisingly, they have shunned the IAED program all this time while continuing their forays into the courts. I must disclose that I have been an expert witness against them 6 different times. One of these, that I was not a part of, was a judgment of 50 million dollars against them.

I also refer to Chapter 11 of the “Principles of Emergency Medical Dispatch” 4th edition textbook on Legal Aspects of EMD that included a number of seminal cases that might be of interest to you in your review of these issues. Please also see Insurance Aspects of EMD in “Principles” 4th edition pages 11.31 & 11.32. Also, see the early article on the Dispatch Danger Zones published in the IAED’s Journal many years ago and accessible on our website (see below).

I hope this initial discussion on these issues might be helpful to you in your work. I am also copying two pre-eminent legal experts in the EMS and dispatch field, Winnie Maggiore and Doug Wolfberg, should you care to contact them also.

Please let me know if further information would be helpful in your endeavors.

Just to be clear, I am not a lawyer, but I did sleep in a Holiday Inn Express recently ... Doc.

Jeff Clawson, M.D.
Division of Research, Standards & Academics

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Dispatch Danger Zones can be found at www.emergencydispatch.org/articles/medicallegal1.pdf
Effective measures in treating severe heart attack earns AHA commendation

In a perfect EMS world, agencies would have standardized protocols to decide where a patient should be transported based on a pre-hospital 12-lead electrocardiogram to detect possible ST Elevation Myocardial Infarction (STEMI).

In addition, EMS would activate the catheterization laboratory team after receiving the transmitted ECG. An ideal system would also foster a coordinated curriculum to teach EMS providers and ED staff to care for STEMI patients and provide feedback on performance and compliance with guidelines.

Apparantly, Austin-Travis County EMS (Texas) has developed that ideal world as designated by the American Heart Association’s (AHA) Gold EMS Agency with the Mission: Lifeline® Program. The achievement recognizes Austin-Travis EMS for its success in applying specific quality improvement measures for treatment of patients who experience the severe heart attack known as a STEMI.

According to the AHA, every year, almost 300,000 people experience a STEMI, which is a type of heart attack caused by complete blockage of blood flow to the heart. Blood flow must be restored as quickly as possible to prevent death.

The Austin-Travis County EMS communication center is an IAED™ medical ACE.

Talking heads, vacuum bottles, and T-shirts are best sellers with a cause

A table overflowing with items designed specifically for the dispatch crowd generated more than $5,000 in contributions to the 911 CARES charitable fund during NAVIGATOR 2015.

The 911 CARES organization celebrated its 14th anniversary in September 2015, having been organized as a one-time helping hand for dispatchers affected by the terrorist attack in New York City, NY, on Sept. 11, 2001. The program was so successful in indicating the willingness of dispatchers to help others in their profession that it continued in order to offer assistance in all types of emergencies.

It’s not only the proceeds from sales (conference and catalog), however, that go into the pool. When notified of accidents, illnesses, and other distressing events, 911 CARES activates alerts that draw contributions from a large pool of followers. In some cases, 911 CARES hooks up with agencies such as the Red Cross to deliver truckloads of donations or sets up a funding page to assist in a massive event, such as during the historic flooding in Texas this past May.

It’s not only money or goods the benefactor or individual is looking for.

“People also look for encouragement,” said Kevin Willett, of Public Safety Training Consultants, who started the 911 Cares program. “Emotional support is every bit as critical.”

Online FEMA course preps dispatchers for deployment

The Federal Emergency Management Agency (FEMA) offers an online Telecommunicator Emergency Response Taskforce (TERT) course designed to reduce stress associated with merging dispatchers from separate PSAPs into the same room to assist during an emergency.

The training is divided into lessons that prepare dispatchers mentally and physically for disaster deployment, encourage interpersonal communication skills, and describe their role in disaster environments.

FEMA personalizes the course with interviews from dispatchers who have been deployed. Mary Dunne, of the Miami-Dade Fire Rescue Department (Fla.), was deployed to Hurricanes Jeanne and Andrew, and Charlottte Theriault, of the Palm Beach Gardens Police Department (Fla.), was deployed to Hurricane Charley.

Theriault said the deployment showed her the importance of camaraderie.

“I was able to help out fellow dispatchers in their time of need just by being there to lend a listening ear,” she said.

There is no cost for the course. Each lesson must be completed to receive dispatch education credit, and FEMA estimates three hours to take the entire course, which includes a final exam.

As a cautionary note, FEMA emphasizes authorization. Self-deployment is neither advocated nor permitted. In addition, according to FEMA, the course is not designed to replace or substitute an agency’s established policies or procedures.
States ban drivers from using cellphones

It’s a well known fact that texting while driving kills, and the numbers are particularly high among teen drivers. In 2012, 11 teens died every day as a result of texting while driving despite acknowledging the dangers of texting and driving, according to the American Automobile Association.

To fight the problem—and save lives—many states have developed laws not only against texting and driving but, also, using a cellphone at all while behind the wheel. A recent rundown (May 2015) from the National Conference of State Legislators details current driving law:

- Hand-held cellphone use ban: 14 states; Washington, D.C.; Puerto Rico; Guam; and the U.S. Virgin Islands prohibit all drivers from using hand-held cellphones while driving
- All cellphone use ban: No state bans all cellphone use for all drivers, but 37 states and Washington, D.C., ban all cellphone use by novice or teen drivers, and 20 states and D.C. prohibit any cellphone use for school bus drivers
- Text messaging ban: 46 states; Washington, D.C.; Puerto Rico; Guam, and the U.S. Virgin Islands ban text messaging for all drivers
- 3 states prohibit text messaging by novice or teen drivers
- 3 states restrict school bus drivers from texting

The number of employees and salaries are not parallel, however, as noted by BLS, which reported that West Virginia had the highest concentration of 9-1-1 dispatchers, with average earnings at $25,270. Other top states in this category were Mississippi, which reported an annual mean salary of $24,370, and Alabama, which reported an annual mean salary of $29,230.

Two states among those with the highest employment level reported annual median salaries above the national average. These were Alaska, which reported a median annual salary of $25,270. Other top states in this category were Mississippi, where the median annual salary was $29,230, and Wyoming, which reported a median annual salary of $37,560.

The top-paying (California metro) salaries were as follows: San Francisco-San Mateo-Redwood City, $72,940; San Jose-Sunnyvale-Santa Clara, $70,910; Santa Barbara-Santa Maria-Goleta, $66,970; Oakland-Fremont-Hayward, $64,700; and Stockton, $64,090.

Stress level parallel for police dispatch and air-trafic controller

Police dispatchers experience the same levels of stress as air-traffic controllers (ATC), according to survey results taken of the two groups at a time when dispatchers didn’t even make the stress radar.

The study, published nearly 20 years ago, showed that as with dispatchers, the ATC is required to direct multiple units in the field, assimilate and dispatch information received from a variety of sources, and is responsible for the lives of others. Both groups were shown to have a higher incidence of heart disease and nervous disorders, compared to the general population, and the stressors causing the health risks were cited as unique to the professions.

Unique factors contributing to police dispatcher stress, according to the same study, were identified as the following: being relegated to a low position on the department’s hierarchy and treated as such; feeling that police officers do not care about them; lack of breaks; shift work; insufficient pay compared to the level of skills necessary to perform the job; lack of uniform certification process; insufficient ongoing training; hyper-vigilance and anticipatory stress; sexism; calls involving abusive or irate citizens, emergency calls, or child abuse calls; and lack of support and positive reinforcement from supervisors and management.

The study concluded that these stressors, if not identified and minimized, might eventually result in job burnout.

Tod W. Burke, an assistant professor at the North Carolina Wesleyan College, Rocky Mount, N.C., and a former Maryland police officer, authored the study available online.
Bill would extend emergency care to service and companion animals

A bill introduced in Ohio would make it easier for first responders to save a pet in an emergency involving a house fire or car wreck called into 9-1-1.

The legislation, introduced by Rep. Tim Ginter, would allow first responders to provide stabilizing treatment—with the exception of administering medication—without first consulting a veterinarian.

Bob Swickard, director of operations for Lifeteam EMS in East Liverpool in northeastern Ohio, had approached Ginter to introduce a bill that would create a “safe harbor” for first responders. If passed, the law would overcome concerns of potential lawsuits for administering basic lifesaving care, such as animal-friendly oxygen.

ACEs already lining up for NAVIGATOR 2016

Communication centers are already lining up for the ACE presentation at NAVIGATOR 2016 to be held in Washington, D.C., and one of the first is Sussex County 9-1-1 in Delaware. The center was notified in May—shortly after the 2015 conference in Las Vegas—that it had achieved its fourth re-accreditation (since its initial ACE in 2001 when it became the 65th EMD ACE in the world). In 2014, the Sussex 9-1-1 center handled a total of 114,208 emergency calls, a nearly 8.5 percent increase from 2011. More than 26,000 of those calls involved medical dispatches.

At NAVIGATOR 2015, in Las Vegas, ACE awards were presented to 22 first-time ACEs and 34 re-accredited centers, bringing the total fire, police, and medical ACE count to 203, spread throughout five continents.

Vaccine could strike blow to sick person calls

A vaccine in the development stages could bolster immune systems against a very contagious and always unpleasant infection from norovirus, resulting in a high number of calls to communication centers reporting abdominal pain, sick person, or possible poisoning.

Infection from norovirus isn’t an enjoyable experience. The virus strikes at least five times in a lifetime and can affect anyone who eats contaminated food, touches contaminated surfaces, or has even minimal contact with an infected person. The symptoms—diarrhea and vomiting—generally last a few days and can be particularly devastating to children and older adults and, according to statistics from the Centers for Disease Control and Prevention (CDC), the nearly 21 million reported instances of norovirus in the U.S. each year contribute to between 56,000 and 71,000 hospital stays and 570 to 800 deaths. In developing countries, it is associated with approximately 50,000 to 100,000 child deaths every year.

The mortality and morbidity rates—particularly in developing countries—were the impetus behind participants from 17 countries on six continents recently meeting through a grant from the Bill and Melinda Gates Foundation. Data about worldwide outbreaks is available from the CDC through the Norovirus Sentinel Testing and Tracking network.

Visit NSTT at www.cdc.gov/norovirus/reporting/norostat/index.html
Two centers receive EENA 112 stamp of excellence

The European Emergency Number Association (EENA) awarded 144 Notruf Niederösterreich PSAP (Lower Austria) and the Centro de Atención ás Emerxencias 112 Galicia–CAE 112 Galicia (Galicia, Spain) Certificates of Quality Standard for their excellent performance following an extensive audit program.

Located in Lower Austria, 144 Notruf Niederösterreich is the first IAED™ ACE (September 2009) in continental Europe. The center answers about 340,000 emergency calls each year and covers a population of nearly 1.7 million people.

Managing Director Christof Chwojka acknowledged his staff in working to achieve the ambitious goal.

“Nocte was awarded this standard is independent proof that our employees do an excellent job, focusing on quality and delivering a high level of professional care,” he said. “We are very proud to be one of the first PSAPs in Europe to receive this outstanding quality award, and we are proud to provide the very best service we can to our patients.”

The EENA 112 Certificate of Quality Standard, launched in June 2013, is a voluntary program designed to measure quality service using criteria that includes staff training, performance management, standardized operating procedures, and handling emergency calls in different languages.

China rules in quest for ACE

Five new ACEs for China were announced on stage during the Opening Session at NAVIGATOR 2015, bringing the total up to six since Wuxi Emergency Center in Wuxi, Jiangsu, was accredited in April 2013.

The pace is expected to continue, according to Jerry Overton, Chair, Board of Accreditation, International Academies of Emergency Dispatch® (IAED™).

“We are finding that the Chinese rightfully view the attainment of ACE as achieving the ultimate goal in dispatch,” Overton said. “They are committed and understand the value. As a result, they initiate a structure that can support the processes of completing the Twenty Points.”

Suzhou Emergency Center, in Suzhou, Jiangsu, was notified of its ACE on April 3, 2015; the four other centers acknowledged at NAVIGATOR became accredited in October 2014. They are as follows: Emergency Center of Yunnan Province, Kunming, Yunnan; Hangzhou Ambulance Center, Hangzhou City, Zhejiang Province; Health and Family Planning Bureau of Huizhou City, Huizhou, Guangdong; and Medical Emergency Center of Qinghai Province, Xining, Qinghai.

In all, 13 centers in China have implemented the Medical Priority Dispatch System™ (MPDS™) using ProQA® and, as of May, two more were in the process. Huludao Emergency Medical Rescue Center, Liaoning, China, was the first to go live with the protocol in March 2011.
Allina Health EMS is everything—and nothing—like the “mom and pop” ambulance service of its founding days.

The “everything” is the organization’s similarity to the lean and hungry philanthropic charm of family-owned establishments. They performed jobs that satisfied all stages of a person’s life. Calls were made from seven-digit numbers posted in the Yellow Pages. Crewmembers kept several overcoats in their office lockers, suited for catering to living and deceased patients and switching jackets depending on whether it was a hospital run or a morgue delivery. They ran hearses and limousines, had a one-seat dispatch center in the same building, and wrote the address of the emergency on a piece of paper handed to the driver. They believed their idealism in putting the patient first would pay off.

It did.

Today, Allina Health EMS—formerly known as Smith-Martin, HealthOne, and HealthSpan—is a division within Allina Health system, which offers a full spectrum of medical care, from clinics and tertiary care hospitals to home health care and hospice serving the Minneapolis/St. Paul area in Minnesota.

The 60 employees when Chuck Kaufman started there in 1976 has multiplied by 10 to a staff of 600, providing assistance to nearly 1.1 million people in 100 communities inside and outside the Twin City metropolitan area. Calls come in to the center in various languages: Hmong, Somali, Spanish, Russian, and English.

Kaufman, who moved through the ranks from “ambulance washer” while in high school to director of the Allina Health EMS communication center, credits the double “p” of care to the company’s continued growth.

“The care is on a much larger scale, but the philosophy hasn’t changed,” he said. “We’ve always been about putting our people and our patients first.”

The secondary PSAP in St. Paul manages 111 EMS vehicles covering a 1,800-square-mile area. They direct ambulances and other support vehicles to the scene of an emergency and, also, the interfacility ambulance transport for highly acute and neonatal transfers. Dispatchers stay in constant contact with EMTs, paramedics, and clinicians navigating crowds on bikes and in golf carts. They do this during large-scale events, such as the popular Prior Lake Music Festival and Twin Cities Marathon.

The communication center is also part of a progressive EMS system exploring ways to treat patients beyond ambulance transport and hospital readmission. The recent move to an ACE is a step toward reaching that goal within the entire Allina Health system.

“We knew ACE was something we had to pursue, but until the past couple of years, we hadn’t made any traction,” Kaufman said. “We started using MPDS”
The communication center is part of the progressive Allina Health EMS plan exploring ways to treat patients beyond ambulance transport and hospital readmission.

Development Director, Mark Rector, flew in from Salt Lake City. Rector encouraged regular review and feedback and suggested performance strategies that resonated with dispatchers, such as sports idioms (put it over the goal line and a slam-dunk, although never throw in the towel or drop the ball).

Rector cautioned leadership of possible consequences. Not everyone might come around. That bothered them.

“We’ve had people working here for a long time,” Kaufman said.

A tips and tricks column for protocol and ProQA went into each Allina EMS newsletter. A three-minute video produced on-site acknowledged the effort ACE required and the hard work toward reaching that goal. Training Supervisor Katie Paulson transformed into a drill sergeant to reinforce complicated pathways during monthly skill-building classes. She developed ways to explain the reasoning behind the protocol standards, devising memory aids to help them remember how they must give instructions.

The EMS Medical Director pitched in, coming into the center to discuss a more aggressive start to CPR.

“He told them they couldn’t hurt people by starting CPR,” Fox said. “He calmed their fears, put them at ease, and said he’d back them.”

The leadership team—Kaufman, Fox, Peckman, and Paulson—advanced new approaches to foster a positive experience, many of which continue.

Signs were posted on lockers to recognize compliant and high-compliant calls and were cleared away at the end of each month to make way for the next month.

“The dispatchers are pretty competitive about it and know exactly how many locker signs they currently have, and who has more or less than them,” Fox said.

“When they were struggling they didn’t care about the locker signs. But the first time they got high compliance and a sign went on their locker, they were grinning ear-to-ear. It’s simple, but it works.”

The high-compliance calls were entered into monthly drawings, and the winner could choose from a $25 Allina-branded clothing item certificate, reserved indoor parking for a shift, or a meal out at a local restaurant of their choice with the leadership team while on duty.

“Every single dispatcher chose lunch out,” Fox said. “They love to debate which restaurant they should go to and flaunt their win as they wave out the door. We enjoy celebrating their good work and getting to know them better.”

Go overboard

Dispatchers delivering babies using the protocol receive a stork pin and a locker sign; the names go on a stork pin board and cake is served in their honor. A cardiac save provides healthier returns—a fruit and vegetable tray—and a locker sign, certificate, Lifesaver pin, and his or her name listed on the Lifesaver board.

A dispatcher accompanied Kaufman and Fox to NAVIGATOR 2015 in Las Vegas to accept the ACE award. Allina Health EMS Dispatcher James Domeier, Specialist First Class with the Minnesota Army National Guard, was awarded IAED™ Dispatcher of the Year and gave his “thank you” and acknowledged the team effort on Skype from his deployment in Sinai, Egypt, as part of the multinational force.

Back home in St. Paul, leadership rolled out the red carpet, complete with an ice sculpture depicting the ACE award figure shown on the certificate. IAED Associate Director Carlynn Page joined

Get into full swing

Three factors created the traction Allina Health EMS needed to achieve ACE in April 2015, just in time to accept the award on stage at NAVIGATOR 2015. The EMS community paramedic program started in 2014 was showing positive gains, and the accreditation paved the way to using the OMEGA response through the Emergency Communication Nurse System™ (ECNS™).

The two are complementary. Community paramedics visit patients in their homes to promote preventive care, while ECNS offers non-acute patient care beginning with the call to 9-1-1.

The second factor was Victoria “Vicki” Peckman, Supervisor, Technology and Emergency Planning. She is the steamroller that took the talk into an action plan.

“We never let ACE fall off the radar,” said Communication Center Manager Angela Fox. “It was a goal we were always serious about, and when Vicki came in full time, it became a push.”

The third was the caliber of staff.

“We have a strong team that provides excellent care,” Kaufman said. “ACE was a way to measure it, prove it, and celebrate the good work they do every day.”

Reality set in. Push became shove on a bumpy road.

Pre-Arrival Instruction compliance was a major obstacle. Dispatchers added extra words and struggled with pathways to take on choking calls and when to start CPR if the patient wasn’t in obvious cardiac arrest. Moving to performance standards version 9a indicated problems in correctly identifying the patient’s Chief Complaint.

Breaking old habits was another, and even tougher, challenge.

“To our more senior staff, the message was they weren’t doing their jobs right,” Fox said. “Actually, they were doing their jobs really well, but we knew there was a better way to do it. We wanted them to be more confident and comfortable when using the protocol.”

Give it your best shot

Kaufman contacted the Academy, and the Academy’s former New Business Development Director, Mark Rector, flew in from Salt Lake City. Rector encouraged regular review and feedback and suggested performance strategies that resonated with dispatchers, such as sports idioms (put it over the goal line and a slam-dunk, although never throw in the towel or drop the ball).

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the celebrations and, along with the leadership team, announced each dispatcher by name on stage in front of families invited to the unveiling of the framed ACE certificate.

“The reception was amazing,” Page said. “They served refreshments, gave toasts with non-alcoholic sparkling grape juice, and brought food over to staff on shift at the center. They really did things top notch.”

Rector’s cautionary advice proved just that—cautionary.

“Mark [Rector] said that it wasn’t unusual to lose dispatchers during the ACE process,” Kaufman said. “I’m proud and happy to say, we did not lose one person.”

**Slam-dunk**

The benefits of accomplishing ACE stand out in a crowd.

“They’re relaxed and comfortable in the protocol and can focus on empathy and compassion instead of wording,” Fox said. “They have pride for their work and confidence in themselves.”

They no longer consider Pre-Arrival Instructions a chore to complete or an obstacle blocking the change during shift to radio dispatch.

Peckman said they’ve become their own best critics.

“They bring calls to my attention,” she said. “They point out issues with the call. They want to do it right so that everyone succeeds.”

**Step up to the plate**

The Allina Health EMS communication center’s journey to ACE taught lessons leadership willingly passes to centers striving toward the same goal.

“Focus on two things, positive recognition and constant explaining/training,” Kaufman said. “Figure out recognition that is highly visible for everyone in the room to see, find something you can do that they care about and really celebrate it. There will be naysayers, do it anyway.”

Fox said never throw in the towel.

“We were 3 1/2 years into this, despite never-ending call reviews, face-to-face feedback, newsletter tips, and CTO training, and I still have dispatchers who all of a sudden get the ‘aha moment,’” she said. “Keep at it; keep explaining what you may think should be obvious by now. Tweak the message each time and keep putting it out there.”

Kaufman said there’s bound to be some anxiety in dispatch no matter the evolution of the center or progression of an individual’s career.

“I was so nervous giving PAIs when the primary PSAP started transferring 9-1-1 callers to us,” he said. “But it’s a feeling that goes away. You’re helping people at their worst moment. You are their lifeline. That compassion is the same today as it was when we started.”

**Keeping the ball rolling**

Allina Health EMS has long recognized the importance diversity brings to their services through several community programs, particularly Freedom House Station 51. Founded by the city of St. Paul, its fire department, the Inver Hills Community College, and Allina Health EMS, Freedom House has provided ongoing financial support for an EMT training program targeting youth of diverse backgrounds.

The company provides grants for purchasing AEDs and placing them in public and private locations, and they offer training for bystander CPR and AED use.

To keep their employees healthy in light of their stressful jobs, they have a chaplain on duty to offer counsel and support following unsettling events, such as an upsetting call or a horrific crash involving Allina health clinicians, and to identify compassion fatigue and burnout. They recently implemented a system that notifies the chaplain if certain keywords are noted by dispatchers during a call.
What could be more important than protecting our children?

Announcing 9-1-1 COMMUNICATION CENTER BEST PRACTICES IN CASES OF MISSING CHILDREN

A missing child is a critically important and high profile event that can rip the fabric of your agency and community if not handled correctly. In terms of urgency, use of resources and potential impact on the community, a missing child requires a level of readiness akin to a disaster. This joint initiative of NAED, APCO, NENA, National AMBER Alert and the National Center For Missing & Exploited Children (NCMEC) was created to:

- Promote awareness of the critical role of the 9-1-1 communication center in handling missing and exploited children calls
- Develop and endorse best practices
- Develop tools for handling incidents of missing and abducted children

Helping to PROTECT OUR CHILDREN is as easy as 1-2-3!


2. Request a copy of the Public Safety Telecommunicator Checklist for Missing Children.

3. Apply to attend NCMEC’s CEO Overview Course in Alexandria, Virginia.

CEO Overview Course

9-1-1 Communication Center Managers and Directors are invited to apply to attend the two-day overview course held at the National Headquarters of NCMEC in Alexandria, VA. Courses are conducted approximately every six weeks at no cost to participants.

For more information, visit www.missingkids.com/911 or email 911@ncmec.org
UNUSUAL MEDICAL CONDITION

Protocol choice depends on Chief Complaint

Brett Patterson

Brett:
While conducting an Emergency Telecommunicator Course (ETC), I had a student inquire about which Medical Priority Dispatch System™ (MPDS®) Protocol would be most appropriate to handle a condition called solar urticaria. In basic terms it appears that the patient would be experiencing an allergic reaction but the resultant reaction manifests itself with burned skin in addition to the urticaria (chronic hives) common in many kinds of allergic reactions.

Should it be coded Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites) or Protocol 7: Burns (Scalds)/Explosion (Blast)? I thought Protocol 7 may be appropriate for the sunburn, but I would rather have you weigh in on it. I appreciate your time.

Lisa S. Ellington EMT-P, EMD, EMD-Q®, ETC-I
System Training Coordinator
Rockingham County 911
Wentworth, N.C., USA

Lisa:
My first bit of advice to an EMD would be to not accept a caller’s "diagnosis" but rather repeat “Tell me exactly what happened” in an effort to obtain signs/symptoms/events that can be classified in the MPDS. This sounds like a hypothetical scenario from a class where that information was available, i.e., solar urticaria was translated to hives caused by sun exposure.

I think it would be unusual for someone to call an ambulance for this disorder, as the patients are usually aware of the problem and know that the condition normally reverses itself rather quickly when the patient gets out of the sun. There are, however, rare exacerbations that include nausea, vomiting, and even fainting, bronchospasm, or tongue/lip swelling.

As we cannot, nor should not, expect an EMD to know the pathophysiology of this disorder, I think we should advise EMDs to instead rely on the Chief Complaint of signs/symptoms/events which, as I mentioned, should be encouraged by repeating "Tell me exactly what happened."

If the Chief Complaint description is simply a rash, Protocol 26: Sick Person (Specific Diagnosis) will rule out Priority Symptoms and handle it well. If it is described as an allergic reaction, as it may well be because it essentially is, Protocol 2 handles any potential difficulty breathing or swallowing or decreased level of consciousness associated with severe reactions. As you mentioned, if it is described as a sunburn, Protocol 7 would work. However, I wouldn’t think the latter complaint would be common because patients know it is not a sunburn; these reactions happen with very brief exposure to the sun and are caused by an antigen-antibody reaction to ultraviolet light rather than actual burns to the skin caused by the ultraviolet light itself.
I’m sorry about the long response, but I think it is an interesting question that deserves a little explanation.

**Brett A. Patterson**
Academics & Standards Associate
Medical Council of Standards Chair

**Brett:**
My question is regarding address verification from wireless callers during Case Entry. We practice asking the address of the caller’s emergency, and then we ask them to repeat the address for verification because ANI/ALI normally shows something different.

The question came up if a second verification was needed if the caller stated the address with the business name (i.e., 3615 Crater Lake Highway, Medford–Wal-Mart) and the dispatcher could visually verify the wireless 9-1-1 call plotted to that location on the map?

Thank you for your time,

**Johnna Pellam**
Performance Manager
Emergency Communications of Southern Oregon
Medford, Ore., USA

**Johnna:**
Thank you for your question; it’s timely, as there seems to be significant confusion on this issue.

First of all, verification policy is locally determined. The Academy strongly recommends that each agency has a written verification policy and that all emergency dispatchers are trained with regard to that policy, and that they receive regular quality improvement feedback to ensure compliance and reduce variation. In the absence of advanced technologies that identify a caller’s location/telephone number, the Academy cautions that repeating an address to a caller as a primary (first line) verification method is potentially inaccurate and litigious, as callers in crisis may accidentally “agree” with even an incorrect address/phone number. Instead, the Academy recommends, as a primary method of verification, asking the caller to repeat the address/phone number. This method is what is taught in initial certification classes that are obviously void of location/phone number identification technologies.

With that said, advanced technologies such as ANI/ALI and now Phase II E9-1-1 have provided opportunities for faster verification of a caller’s address/phone number. This has enabled faster recognition of life-threatening emergencies that enable prompt treatment and improved morbidity and mortality. Many agencies take advantage of these technologies by incorporating them into their verification policies, i.e., verification is completed if the address and/or phone number provided by the caller matches the technology’s displayed information. This policy is sound and effective. Again, what is important is that each agency has a verification policy in place and that everyone follows it. More information can be found in “Principles of Emergency Medical Dispatch,” 4th ed., pages 2.9 and 1110.

**Brett**
Ready & Able
Odds are there’s a protocol to fit the emergency

Josh McFadden & Audrey Fraizer

Not many professions have anything close to the challenge of the instant emotional refueling required in preparation for the next possibly major catastrophic event resulting in a call to 9-1-1. Seldom does anyone outside the profession come in direct or indirect contact with the types of incidents that are part of your daily routine.

Yet, these things happen all the time, and because of the professionalism you provide, callers receive the best prehospital care possible for an amazing variety of medical crises, as demonstrated in the following stories.

As a point of reference, the infographic found in this issue compares the odds of dying from various types of emergencies. Not every calltaker or dispatcher encounters every one of these types of calls, and some might go through an entire career without providing PAIs for more than a handful of these situations. However, as the National Safety Council (NSC) points out, the odds of dying from all possible causes are 1 in 1, so no one is immune from the odds-makers or, for you 9-1-1 dispatchers, the odds of answering a call involving at least one of these emergencies during your career.

And it’s no coincidence that the medical stories are featured in the same issue as the announced pre-release of Medical Priority Dispatch System™ (MPDS®) Version 13.0. The odds of a protocol to fit your caller’s emergency are stacked high in your favor.

The odds
Medical emergencies are dependent on a lot of factors, but it’s often our fears that make the less frequent types of accidents much more frightening. For example, the risk of dying from a shark attack anywhere in the world in 2004 was 1 in 913,200,766. The risk of dying from scalding yourself with a hot water tap in the U.S. in 2004 was 1 in 9,773,050. Doing the math, that means the odds of dying from contact with a hot water tap are 93 times greater than those of dying in a shark attack.

Internationally
Chronic diseases cause increasing numbers of deaths worldwide. Diabetes caused 1.5 million (2.7 percent) deaths in 2012, up from 1.0 million (2.0 percent) deaths in 2000. Lung cancers (along with trachea and bronchus cancers) went up to become the fifth leading cause of death in 2012, killing 1.1 million men and 0.5 million women in 2012. Injuries continue to kill 5 million people each year. Road traffic injuries claimed about 3,400 lives each day in 2012, about three-quarters of whom were men and boys.

Sources
Lifetime **Odds of Dying** from common activities versus those that are commonly feared.

- a motor vehicle crash 1 in 112 vs. a commercial airplane crash 1 in 96,566
- overdosing on opioid prescription painkillers 1 in 234 vs. being electrocuted 1 in 12,200
- falling 1 in 144 vs. a cataclysmic storm 1 in 6,780
- being a passenger in a car accident 1 in 470 vs. a lightning strike 1 in 164,968
- being hit while walking down or crossing the street 1 in 704 vs. a wasp, bee, or hornet sting 1 in 55,764
- complications from surgical or medical care 1 in 532 vs. an earthquake 1 in 179,965

The odds are statistical averages over the entire U.S. population and do not reflect the chances of death for a particular person from a particular external cause, according to the NSC.

*Source*

Teen Hero
Dispatcher helps high school student save boyfriend’s life

In April, Katerin Torres commemorated one year as a dispatcher. During her time fielding 9-1-1 calls and following the Priority Dispatch System™ (PDS™) protocols at Valley Emergency Communications Center (VECC), West Valley City, Utah, Torres has helped numerous callers with a variety of emergency issues. One call that she took this past February stands out.

And two high school seniors will be forever grateful she successfully handled a potentially deadly situation.

At the beginning of February, in the late hours of the day, Torres took a call from Hannah Perkins, an 18-year-old student at Riverton High School in Riverton, Utah. Perkins was with her boyfriend, fellow senior Caleb Barlow, on the front porch of his home when he “fell back” and made “weird gurgling, choking noises.” Barlow’s parents weren’t home, so Perkins got Barlow’s 12-year-old brother, Zach, to help her. Perkins called 9-1-1 and reported the emergency. She said Barlow would take a deep breath and then stop breathing for about 30 seconds before taking another one.

Then he wasn’t breathing at all.
“Then I heard her say, ‘He’s not breathing.’ Before I knew it, I had her doing CPR.”

Fortunately, Perkins had learned how to perform CPR while taking a course with a church group. Still, the real-life situation made things tense.

“At first she was worried and unsure,” Torres said. “But she was more calm once I started asking the questions and once she started doing CPR. I was surprised how calm she was.”

Perkins was doing chest compressions by the time she heard the sirens and saw the flashing lights of the ambulance. Once help arrived, Barlow was breathing again. He was taken by ambulance to a nearby hospital and then flown by helicopter to another. Doctors expected him to make a full recovery.

Though dispatchers don’t always know the outcome of the calls they take, Torres was able to find out about Barlow’s successful revival.

“It makes me feel good to know that I helped someone,” she said. “We have all the right tools to help people survive. Knowing I get to help callers and give customer service is satisfying.”

Like any dispatcher, Torres has taken a multitude of calls where the caller is emotional and where the situation is a life-and-death matter. She’s able to manage the emergencies by staying calm and by reassuring and comforting the caller.

“The key is your level of calmness and showing that you want to help them,” she said. “If I can’t calm the caller down, I’m not satisfied. If I show my compassion and tell them help is on the way, they tend to calm down.”

Barlow is alive today due in large part to Torres’ efforts. But for her, it’s all part of her duties as a dispatcher—duties she’s thankful to have.

“I love my job,” she said. “I love what I do.”
EMD Roxie Davis is a 9-1-1 customer service expert. She doesn’t approach her job as a sales pitch, of course, but she’s firm about keeping the caller on the line, getting to the crisis at hand quickly, and convincing the caller that hers is the voice of reason.

“Roxie is very passionate about her work,” said Annette Ricks, Dispatch Supervisor, Chesapeake Police Department, Chesapeake, Va. “And it clearly shows in her patience and calming presence with each caller.”

When the caller is stumped and frustrated—as is often the case in an emergency—Davis takes the time to reassure the caller and understand exactly what is happening on the other end of the call. She is not known to lose her cool and basically becomes the rock for a caller trapped in a world fast falling apart.

While impossible to single out one call she’s taken over the 10 years working at the police department communication center, she is proud of the bystander CPR instructions she provided to an anxious and upset caller in September 2014.

“Her husband was in cardiac arrest,” Davis said. “She didn’t think she could do CPR right.”

Davis convinced her she could, and for the next seven minutes, even when the caller said she was too tired and far too emotional to continue, Davis stridently and reassuringly kept the caller in the compression mode until paramedics arrived to take over.

“Roxie maintained control, and the caller never quit,” said Ricks, who came to work at the center about the same time Davis did. “She stayed with the caller every step of the way with her calming voice, encouraging words, and assistance.”

That call and others like it, demonstrating Davis’ calming influence in the storm of crisis, were major factors meriting her selection for the Chesapeake Police Department’s 2014 Outstanding Teamwork and Exceptional Performance award.

Other considerations included initiative and performance.

Davis created a PowerPoint presentation on “Protocol Choices” that was used for an in-house training program to help co-workers better navigate ProQA® and—in tandem—she arranged 63 EMD-related terms into a training crossword puzzle. Her EMD compliance always averages above the 95 percent required each month. She is one of two calltakers on the Dispatch Review Committee (DRC) and is also on the Certified Training Officer (CTO) committee.

Davis “loves” calltaking, but if it hadn’t been for a change in center policies in 2005, she might be back building boats or using her customer service skills to sell boating supplies.

“I was afraid I wasn’t going to make it because of the dispatch element,” she said. “I didn’t want to hold anyone up in an emergency and was ready to quit. If I could just handle the phone calls, I knew I’d be a very happy camper.”

A calltaker-only job description happened to be in the making, and Davis was the first to accept the newly designated position. Calltaking is where she plans to stay.

“I like being able to focus on what the caller is saying and watching the screen to make sure I’m following the steps,” she said. “I am helping the person the best I can.”

A job tying her to the same place all day answering calls and giving instructions is a far throw from Davis’ earlier careers. She went from 16 years in banking to boat building and spent over a year on an island in the Caribbean managing a prototype tri-hull charter boat she helped to build locally. The “Wild Thing,” as it was commercially known, turned into a speedboat tourist attraction, although the intention had been a military boat that could move more easily through choppy water because of the hull design. Next, she moved to inside sales at a wholesale boat parts distributor for a number of years, which is when she decided to make her final career move.

“I saw an ad and applied,” she said. “Calltaking is not a job for everyone, and you don’t know if it’s right for you until taking the first call. It’s something I can do and feel good about.”
Cool and Collected
Dispatcher credits 8-year-old’s calmness for helping save father

It’s not every day you hear about a 9-year-old heroically saving her father’s life. But that’s just what happened this past April in Friendswood, Texas, when Victoria Grabowski’s composure helped spare her father from bleeding to death.

And 9-1-1 dispatcher Stephanie Price was honored to play a role in Victoria’s bravery.

Price, a 29-year veteran as a dispatcher, took the call from Victoria after the girl’s father, Mark Grabowski, had severely cut his wrist on a broken glass while washing dishes. Grabowski was bleeding profusely. Later, it was disclosed that he severed six tendons, two nerves, and an artery.

And yet, Victoria remained cool under pressure, though, understandably, she was shaken by the ordeal.

“When I listened to her voice, she sounded sad,” Price said. “But, she was calm and collected. The only time I could tell she was getting upset was when her father was not following instructions (he was about to faint) when she was attempting to get a towel wrapped around his wrist and have him hold the towel in place while she unlocked the door.”

Price walked Victoria through other instructions, and Victoria listened intently. Her attention to detail and instruction likely saved her father from dying of blood loss.

The fact that this strong-willed girl stayed so composed was a huge help, making Price’s job much easier.

“It helps so very much as a dispatcher (when the caller is calm),” Price said. “I understand, as I am sure countless others do, when your caller is calm during a crisis they can get so much more done. A trick that I use on hysterical callers is to tell them, ‘You can fall apart later, but right now, I need you to help me help you prior to the medics/fire/police arriving.’ The majority of the time this has worked and is a very valuable tool.”

Price didn’t have to do too much coaching with Victoria. She was able to give her address and location. She unlocked the door and immediately got the paramedics’ attention when they arrived, ushering them inside the home to where her father was.

Grabowski was rushed to the emergency room, where he was treated and then released. A few days later, he joined his daughter at the Friendswood City Hall as she received recognition for her bravery.

Price is thankful for the experience and that it ended happily.

“It’s wonderfully satisfying when you find out a call ends like this,” she said. “I was so happy to put faces with the names, especially Victoria. She and other kids that handle crisis with such grace are my heroes, along with the whole team of police, fire, EMS, and calltakers.”

Price has been a dispatcher for Friendswood Police for 20 years. She said she takes maybe one or two calls per month from children. Surprisingly, perhaps, she said child callers can often be easier to talk to than some adults.

“They sometimes don’t realize how bad things are or the situation,” she said. “The innocence of the child, in this respect, is such a blessing. Of course, it can—and usually does—break your heart when the situation is being described by this little voice.”

Victoria’s call is one of countless memorable and challenging calls Price has fielded in her dispatch career.

“There are calls that I will never forget, and there are calls I want to forget, but cannot,” Price said. “If you think you know it all or get cocky, chances are, you will be put in your place. There is always something new to learn—be it from someone that has been around for a long time or a new person that is looking at things with a fresh new perspective.”
Ready & Able

**FEATURE**

For a bag-valve mask, firefighters were able to get air into young Santana. Paramedics performed a laryngoscopy, which showed no visible blockage, and rolled Santana on his back.

“He was not breathing well and was almost unconscious,” Ali said. “I hit him real hard four times on the back. Out came the candy.”

Santana was talking by the time the ambulance reached the hospital, and upon his arrival, he was given an exam and reunited with his grandpa. Santana was kept overnight for observation. The next day, according to grandpa, he was ready for a return to the football field, but this time, without hard candy.

“He loves football,” Desjarlais said.

Several months later, Semenchuk and the rest of the EMS crew involved in the incident met Santana and his grandfather at the Winnipeg Celebration of Life Awards Ceremony, where the boy’s love for football did not go unnoticed.

The annual awards ceremony is in conjunction with Winnipeg EMS Week to recognize both EMS achievements and bystander help during an emergency and as part of the 2015 event (on May 28), Santana was presented a signed jersey from the Canadian Football League and tickets to a Winnipeg Blue Bombers game.

Semenchuk was delighted to be part of the celebration.

“It’s so hard when you’re not there and don’t hear what happens,” she said. “So this was really nice to meet the people and know that you’ve been helpful.”

Semenchuk started with WFPS dispatch nine years ago at about the same time the communication center introduced the Medical Priority Dispatch System™ (MPDS®). The instructions, she said, were invaluable, and during the first quarter of 2015, she found them particularly helpful for not only helping Santana but, also, in delivering a baby.

“That happened very fast, but I made it through the instructions,” she said. “I heard the baby cry. I’m sure it went very smooth because of MPDS.”

WFPS is a secondary PSAP. Winnipeg Police Service triages all initial 9-1-1 calls and routes calls to WFPS for fire or EMS assistance in the city of Winnipeg.

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**Hard Candy Goes Down Wrong Pipe**

Winnipeg to the rescue for choking 8-year-old

Grandparents Day celebrations turned out far from anticipated for Dave Desjarlais and his 8-year-old grandson Santana McFayden.

The Sunday afternoon that happened to land on the national day recognizing grandparents (Sept. 14) had started well enough. The two were at the football field, and while grandpa watched the game his older grandson was playing, Santana was playing his own spirited game of skipping up and down the lower bleachers.

While grandpa’s focus was tuned to the field, Santana’s attention was about jumping to the ground and, at the same time, absent-mindedly popping a piece of hard candy into his mouth. The two don’t go together.

“He swallowed the candy,” Desjarlais said.

Santana ran to his grandfather but fell down in a panic of choking from the candy lodged in his windpipe. Desjarlais got up from his seat, saw that Santana was struggling, and ran to his aid. A bystander, noticing the commotion, pulled out a cellphone and called 9-1-1. Winnipeg Fire Paramedic Service (WFPS) EMD Cindy Semenchuk answered.

“The caller told me a young boy was choking,” Semenchuk said. “He was unconscious.”

Semenchuk launched into the PAIs—following Case Entry—and the caller relayed to Desjarlais the instructions for the Heimlich maneuver.

Because Santana was lying down on the ground, Semenchuk had Desjarlais place his hands, one on top of the other, above his grandson’s belly button. Using his weight, Desjarlais pushed into the boy’s stomach.

“I did that for as long as I could,” Desjarlais said. “It may have been two minutes. I don’t know. It seemed like forever.”

Forever, that is, until Winnipeg Firefighter Chris Ducharme and Medical Supervisor Mario Ali arrived on scene within minutes of the call. Using a
Time is Precious
Quick-acting dispatcher and caller save life

Any dispatcher or calltaker will attest that when it comes to emergencies, every second counts. The difference between life and death can be a matter of moments. For one calltaker in Idaho, quick action potentially helped save the life of a 3-year-old boy.

On May 26, Canyon County Dispatch Center (Caldwell, Idaho) dispatcher Doug Ward took a call that he certainly won’t soon forget.

After giving Ward his location and phone number from which he was calling, the man on the other end of the line identified the nature of the emergency: “My son has drowned,” he said.

This wasn’t the first drowning or near-drowning call Ward had taken during his career—he said he takes four or five a year—but he was immediately surprised at how cool under pressure the father was.

“When people call, often the first thing you hear is screaming and shrills,” Ward said. “But he was very calm.”

The father’s calmness was key to the outcome, and his collected demeanor also allowed Ward to quickly determine the protocol to use and the action to take.

The father informed Ward that his son (whose name, at the family’s request, has not been released) was unconscious and not breathing. He was holding the boy in his arms, having pulled him out facedown from a pond. With this information, and armed with ProQA®, Ward had the father on the ground giving his son CPR within 10 seconds of taking the call.

“I immediately clicked on the Drowning tab (in ProQA), and it triggered CPR,” Ward said.

Ward said he believed the father had never done CPR before, but still, he “didn’t miss a beat.”

Because the father and boy were in a rural area, it took emergency responders 20 minutes to get to the scene. Ward instructed the father to continue CPR while they desperately waited for crews to arrive. Due to these efforts, the boy had a faint pulse when paramedics reached him.

The young boy was rushed to the hospital where he was in critical condition. Shortly afterward, he was upgraded to serious condition, and as of June 16, he was in a medically-induced coma but improving daily. Doctors are hopeful but not confident he will come out of the coma and survive. Due to privacy laws, the hospital is not releasing much information about the boy.

Still, to guide the father in getting a pulse and keeping the boy alive this long are encouraging.

“It’s a good feeling to see the child live,” Ward said. “To save a life makes it all worth it.”

As of the middle of June, Ward hadn’t had a chance to meet the boy or his family. He hopes to have the chance, though for the time being the family wishes for privacy.

Ward said drowning and near-drowning incidents are not uncommon in Canyon County, where there are many lakes, rivers, ponds, and canals. Accidents are especially common in the summer when out-of-school children enjoy swimming.

Ward said it’s important to always know where you are and to be extra cautious when playing in or near the water. Not all calls to 9-1-1 end with a happy result.

“They don’t always turn out like this,” he said. “This was like that one good shot in golf that makes up for all the bad ones.”

Without the cooperation and incredible composure from the father, Ward doesn’t believe the child would have been alive when the paramedics arrived. There simply would not have been enough time. Level-headedness allowed Ward and the father to get to work quickly.

“If the father would have been panicking and screaming, and if I would have had to struggle and fight with him, the outcome would have been different,” Ward said. “The way in which a person responds totally makes or breaks the call. Someone who is calm makes it twice as easy for us.”

Ward also praises the ProQA software and the protocols for making his job so much easier.

“I rely on it so much every day,” he said. “It gives me confidence to do my job. When you use it every day, it’s simple to use; it walks you through every scenario. With ProQA, we have all the tools we need. In any given situation, I feel confident I can help the caller.”
Dunlap listened to the audio and was immediately impressed by Cronkhite’s composure and skill in calming the caller and providing Pre-Arrival Instructions, including cautionary advice to avoid taking more victims to the scene.

“I felt such a sense of pride for what Scott did,” Dunlap said. “You hear a lot of bad outcomes from high voltage, and this turned out to be a great outcome.”

Communications Division QA/Training Officer Linda Sapp, EMD-Q®, said everything about the call was perfect.

“He did an excellent job, and his call got a high compliance,” she said.

Buttrill survived and walked out of the hospital 10 days later.

Buttrill’s sister Kayla DuBois said her brother is back to work, fully recovered with only the scars from skin grafts to repair burns to hands, elbows, and shoulder.

“He’s doing great,” she said.

The communication center received the highest honor through an email Dunlap received from DuBois on the day her brother left the hospital. An excerpt from the email reads:

I have a new meaning to come to work and a new meaning to do what I do. I hope each of you know how important your job is, and that you are appreciated. It is easy for us to get complacent in our jobs, but lives really do rely on you and your training. I am thankful for Scottie’s training and calling for this career. Without him, my family would have a giant hole in our hearts. Thank you to each and every dispatcher in this county. You are appreciated.

Cronkhite said it’s not the type of call he’d like to repeat.

“Something like that happens and the blood pressure goes up really quickly,” he said.

Electrocution due to electrical voltage is an obvious and not all uncommon hazard for arborists. The Tree Care Industry Association (TCIA) reviewed 158 occupational tree care accidents reported by the media in 2013. Of these accidents, 79 were fatal, and 12 of the fatalities were due to electrocution.

Electrocution
Fast CPR critical to saving arborist

In an area where boating and swimming accidents are more the norm for 9-1-1, the call Scott Cronkhite answered at the Okaloosa County Emergency Communication Center, on Jan. 28, 2015, was every bit as unexpected as a fatal shark attack in the Choctawhatchee Bay waters bordering the northwestern Florida community.

“Those happen in Pensacola,” said Cronkhite, who joined the department in August 2002 following his retirement from the military. “Not so much here.”

At first, Cronkhite couldn’t make out exactly what the caller was saying. The background was noisy; the scene was obviously chaotic.

“I thought he said someone’s been shot,” he said, “No. I was able to calm down the caller to understand what he was saying. Someone had been shocked.”

Cronkhite immediately went into CPR instructions for the bystander aiding arborist Levi Buttrill, who, by later accounts, had accidentally made contact with a live line at his shoulder or hand while up the tree in a bucket trimming branches to clear distribution lines. Buttrill went down.

The reaction on ground was immediate.

Co-worker Joshua O’Malley lowered the bucket and lifted Buttrill out. At the start of the call to 9-1-1, he told Cronkhite the victim wasn’t breathing.

“He’d been electrocuted, and that doesn’t often turn out well,” Cronkhite said.

Within moments, Ocean City-Wright Fire Control District Deputy Chief Scott Funchess arrived on scene, followed by Ocean City-Wright firefighters Brian Thomas, Blake Good, and Mike Taylor. Firefighters applied an AED to shock Buttrill back to life, while Okaloosa County Paramedic Tom Pocta and EMT Mason Salsgiver got the ambulance ready for his transportation to the hospital. They secured his airway and off they sped, lights-and-siren.

Okaloosa County Public Safety Communication Center Chief Daniel Dunlap was down the hall that morning when he received a call alerting him of the situation.

“The call was from the patient’s sister,” Dunlap said. “She’s a paramedic for the county and didn’t know what happened except that something had happened to her brother.”

Dunlap listened to the audio and was immediately impressed by Cronkhite’s composure and skill in calming the caller and providing Pre-Arrival Instructions, including cautionary advice to avoid taking more victims to the scene.

“I felt such a sense of pride for what Scott did,” Dunlap said. “You hear a lot of bad outcomes from high voltage, and this turned out to be a great outcome.”

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Source

A New Age in Dispatch

Academy releases MPDS Version 13.0

Audrey Fraizer

There’s never been anything like it.

Medical Priority Dispatch System™ (MPDS™) version 13.0 is the newest wonder of the emergency communications world released initially in the North American English (“the Mother” language) version in the fall of 2015, after years of research, testing, and the resolute persistence of the boards and councils of the International Academies of Emergency Dispatch™ (IAED™) and the patience and hard work of the producers at Priority Dispatch Corp.™ (PDC™). Translations into the other 16 language and dialect systems are in the release cascade process as usual.

“This is a moment for the EMS history books,” said Jeff Clawson, M.D., inventor of the MPDS and principal author of the classic dispatch text “Principles of EMD”—now in its fifth edition. “Version 13 captures the best pre-arrival care available to support and improve our proven standards of excellence in caller, bystander, and responder safety.”

MPDS v13.0 brings several new dimensions to EMD since the original release of MPDS in 1979. Now found in 3,000 communication centers worldwide, the latest and greatest version of MPDS enhances an EMD’s role as an integral and critical component in the patient care chain of survival, and the Academy fills the gaps with regard to both dispatch research and the formulation of standards based on expert consensus and actual user input.

MPDS v13.0 is available in cardset form and PDC’s ProQA™ Paramount version 5.1, the software engine of the IAED protocols. However, the MPDS cardset has become increasingly problematic to update and navigate in comparison to software.

“The ability to put all things we think are valuable in protocol is difficult in the cardset,” said Brett Patterson, Chair, IAED Medical Council of Standards. “An increasingly sophisticated protocol complicates manual cardset navigation. It is much more intuitive and simply easier to follow in software.”

All the right stuff

New elements to the protocol system include a Fast Track to “hands-on-chest”; clearer definitions, Rules, and Axioms; and additional patient PAIs and PDIs.

Patterson called the “hands-on-chest” Fast Track a “significant” addition to an EMD’s toolkit, and it’s intended for patients who are initially and obviously described as being in cardiac arrest in the Case Entry sequence. A DLS Link from Case Entry to PAIs was introduced in MPDS v12.2, but the new Fast Track feature in v13.0 has already proven to further reduce hands-on-chest time, which translates into lives saved.

Using the Fast Track, the EMD simply types in an "o" (for “obvious”) in the “Tell me exactly …” field to bypass all remaining Case Entry Questions. The Fast Track immediately recommends a 9-ECHO-1 response activated by a single click followed by a
question about the availability of an AED. The EMD makes sure the patient is flat on his or her back and begins PAIs for chest compressions.

“This is perhaps the single most important change to v13.0,” said Patterson, who has spent the past year traveling around the country promoting getting hands-on-chest faster. “The latest research clearly illustrates the vital role EMDs have in providing lifesaving PAIs to people calling 9-1-1.”

In addition to changes reducing the time to compressions, MPDS v13.0 also limits the use of the AGONAL BREATHING Detector that, according to extensive case review, was clearly being overused.

“While this diagnostic tool was designed to confirm that reported breathing actually is occurring, all too often EMDs were using it to confirm the absence of breathing, which delays time to hands-on-chest,” Patterson said.

Patterson cautions EMDs to use the detector only to confirm reported breathing that the scenario makes questionable, and not to use it when the caller reports UNCERTAIN or absent breathing.

Dr. Clawson simplifies this point by saying: “Use the AGONAL BREATHING Detector when you are unsure, not when the caller is unsure. If the caller is unsure, that’s the same as uncertain, which equals ‘not breathing.’”

Patterson adds, “EMDs should never hesitate to start compressions when they think the patient may be in cardiac arrest. It’s far better to start compressions on a patient who does not need them than to delay compressions for a patient who does. In most cases, the alive patient will object to the compressions, and EMDs need to know that’s OK.”

Patterson said EMDs should never hesitate to start compressions when the status of the patient’s breathing is questionable. “For every minute of delay, the patient’s chance of survival drops 5–10 percent,” he said.

To aid in the quality improvement aspect of rapid intervention for sudden cardiac arrest, MPDS v13.0 includes real-time feedback by displaying hands-on-chest times for the EMD at the end of every cardiac arrest case.

“We know that EMDs appreciate feedback, and this feature not only provides that, it emphasizes the rapid intervention goal we seek,” Patterson said.

Dr. Clawson adds that while efficient protocol is essential to this effort, a cultural change must take place in communication centers worldwide that encourages erring on the side of the patient and starting CPR as soon as possible.

“The goal needs to be rapid recognition of absent or agonal respirations followed by immediate chest compressions,” Dr. Clawson said. “This basic intervention simply improves survival.”

The Academy relies on its members to get the message across.

“The Academy needs your help,” Patterson said. “We rely on patient care-oriented EMDs to spread the word.”

But that’s just the tip of the proverbial protocol iceberg.

MPDS v13.0 also contains a new option for a “Compressions Only” pathway to provide agencies a choice between the current Compressions 1st pathway and the new Compressions Only pathway. Local Medical Control must authorize the option.

Patterson explained that the choice would most likely fall to local demographics.

“We suspect that rural systems with longer response times may elect to continue with the Compressions 1st pathway to provide ventilations at about 10 minutes and beyond after arrest,” he said. “Urban systems with shorter response times may elect to eliminate ventilations altogether and use the new Compressions Only pathway.”

**Take an aspirin**

MPDS v13.0 contains new Axioms for use of the Aspirin Diagnostic & Instruction Tool to clarify true aspirin allergy and whether it is advisable to take expired aspirin or a higher aspirin dosage. “The Principles of EMD” includes a section of frequently asked questions (FAQs) that will be expanded in the book’s fifth edition.

The Aspirin Diagnostic & Instruction Tool has generated more questions than the Academy ever anticipated when it was released.

“Nothing has been more controversial in protocol than this,” Dr. Clawson said. “It’s truly amazing the concerns we’ve had about this. It took us by surprise, since the risks are so small and yet the benefits are so great.”

**More to come**

The work to update the MPDS into version 13.0 was a long process, starting in 2010. The interim release of version 12.2 in September 2012 featured the DLS Link to PAIs and a modified CPR sequence to complement recommendations of the American Heart Association (AHA) for emergency cardiovascular care.
The Academy is so intent on early recognition of breathing status indicating possible cardiac arrest that in addition to these protocol changes in versions 12.2 and 13.0, it has launched a comprehensive program to teach EMDs about prompt recognition of agonal breathing and the importance of prompt and uninterrupted chest compressions. EMD-certified instructors attended several-day courses at both NAVIGATOR 2013 in Salt Lake City and NAVIGATOR 2015 in Las Vegas.

Curriculum materials to complement the version 13.0 release have been in development since the Medical Board of Curriculum met in October 2012, shortly after the release of MPDS v12.2.

Over the past three years, Curriculum & Instructional Design Manager Greg Spencer and his team developed the EMD course manual, EMD certification exams, EMD course PowerPoint presentations, a new Advanced EMD CD, and the Automated Update Guide.

In their world, nothing goes unattended, and Spencer’s group works closely with the Academy’s Medical Board of Curriculum to identify the elements that must be addressed, as well as when they are to be introduced, reinforced, mastered, and extended.

The Academy is also researching protocol outcomes between the new and past version in accredited communication centers to measure the effect of these changes and incorporate the results to further improvement efforts.

Don’t expect the process to come to any sort of standstill. This is a system that relies on internal and external research, technology, expert advice, and—perhaps most importantly—the hundreds of Proposals for Change submitted by the international community of MPDS users.

“Every time we complete a version that we think is perfect, someone finds something else,” Patterson said. “It’s wonderful to have so many people looking at the unified protocol so closely, in so many centers and so many countries.”

Other major enhancements to MPDS include:

- The instructions for taking a pulse have been revised based on published Academy research. Changes include directing the caller to use two fingers, taking appropriate time to detect the pulse, notifying the EMD when s/he has detected it, and counting beats out loud.
- A new Protocol P: Epinephrine (Adrenaline) Auto-Injector Instructions has been added for patients experiencing an extreme allergic reaction or anaphylactic shock. These instructions include positioning the patient, removing the packaging, and using the epinephrine (adrenaline) injector.
- Two new ECHO-level Determinant Codes have been added to Protocol 14: Drowning/Near Drowning/Diving/SCUBA Accident to address drowning victims either currently underwater or just out of the water and in cardiac arrest. In conjunction with these additions, a new Protocol K: Person in Water has been added, which provides instructions for ice rescue, person in water, swift water, and floodwater incidents.
- Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/CBRN and Protocol 25: Psychiatric/Abnormal Behavior/Suicide Attempt now include an Additional Information section on Chemical Suicide. Additionally, new Case Exit Panels X-7a and X-7b have been added to instruct callers and bystanders to avoid (further) contamination at the scene of a chemical suicide.
- Protocol 18: Headache has been modified to address the possibility of stroke or other serious brain conditions. The Stroke Diagnostic Tool has been added to this Protocol.
- Protocols Q: Narcan/Naloxone Nasal Administration Instructions (Panels 1–5) and R: Naloxone Auto-Injector (Evzio) Instructions (Panels 1–4) have been added for patients in need of an antidote for narcotic drug overdose, when available. The EMD will select either Protocol Q or Protocol R depending on the medication device available (nasal spray or auto-injector, respectively). These instructions include preparing the delivery device, administering or injecting the medication, and monitoring the patient to ensure recovery.
- Protocol 24: Pregnancy/Childbirth/Miscarriage has been modified to redefine the range of months/weeks for the 2nd and 3rd TRIMESTERS and the MISCARRIAGE and premature birth definitions. New Rules and Axioms, a DLS Link to F-25, and a specific PAI pathway have been added for patients with cervical cerclage (stitch). The DLS Link for MISCARRIAGE has also been redirected to a new Protocol G: Miscarriage (Panels 1–9). Instructions on Protocol F have also been modified throughout to improve patient care.
- The Sinking Vehicle (1st Party) Protocol has been renamed Protocol L: Vehicle in Water as it now includes additional instructions for a vehicle in floodwater. In addition, the sinking vehicle instructions have been extensively revised to suggest further alternatives for escape and to address other factors such as children in the vehicle.
Drug use and abuse a global problem

Audrey Fraizer

In April, EMD Kyarah Kuykendall answered a call reporting that an adult male passenger in a moving vehicle was not breathing and the driver was not quite sure of where they were.

Kuykendall, of the Cumberland County Department of Public Safety (Pa.), told the driver to pull to the side of the road. She activated mapping technology, and, with the help of the caller identifying landmarks, she was able to pinpoint their location for EMS. For the next 10 minutes, until the crew’s arrival, she provided PAIs for CPR.

The CPR instructions the driver followed lent enough time for emergency crews to administer the emergency medicine naloxone, a prescription drug that reverses respiratory depression caused—as in this medical emergency—by heroin overdose.

Approximately 243 million people, or five percent of the world’s population between the ages of 15 and 64, used an illicit drug in 2012, according to a report by the United Nations Office on Drugs and Crime; globally, there were an estimated 183,000 (range: 95,000–226,000) drug-related deaths (mostly overdoses) in 2012, with opioid overdose comprising the largest category.

The breakdown on an international scale includes the following:

- Drug use in the U.S. resulted in 41,340 deaths in 2011; U.S. overdose deaths have increased for 12 successive years. In 2011, for the fourth year in a row, the number of U.S. citizens whose deaths were drug-related exceeded the number of fatalities in road traffic accidents (33,561). Almost five people per hour died of overdose in the U.S. in 2011.
- There were 485 drug-related deaths registered in Scotland in 2010, 60 (11 percent) fewer than in 2009. However, this was the third-highest number ever recorded—30 (7 percent) more than in 2007 and 193 (66 percent) more than in 2000. The number of drug-related deaths has risen in six of the past 10 years.
- It is estimated that more than 70,000 lives were lost to drug overdoses in European Union countries in the first decade of the 21st century. European Union nations reported 6,100 overdose deaths in 2012.
- Drug-related deaths in Asia are tentative because of poor regional coverage and reporting of mortality data. However, it is estimated that there were between 11,400 and 99,600 drug-related deaths in 2012 in Asia.
What is an overdose/poisoning?  

The Medical Priority Dispatch System™ (MPDS) defines overdose and poisoning differently than commonly used definitions, and the distinction lies with the individual’s intent. MPDS Protocol 23: Overdose/Poisoning (Ingestion) defines OVERDOSE as the “intentional intake of a potentially harmful substance (≥ 2 years old),” and POISONING (ingestion) as the “accidental intake of a potentially harmful substance.” A patient who took a substance with the intent of personal harm should always be classified as an OVERDOSE. A patient who mistook a poisonous substance for food or drink, who accidentally took too much of a drug or medication with no intent to harm himself, or who inadvertently came in contact with a harmful substance in a workplace or household accident should be classified as a poisoning.

For example, a caller reports that her 19-year-old brother overdosed on his pain medication (oxycodone, an opioid). If the caller further reports that the patient had simply forgotten that he had already taken his medicine and took an extra dose by mistake, the case should be classified as a poisoning even though the caller used the word overdose. Clinically speaking, the patient may be suffering from a medication overdose. However, in the dispatch environment, because the patient did not intend personal harm, the case should be treated as a poisoning.

Symptoms to watch

An overdose can occur when a drug or poison overwhelms the body’s ability to process the amount ingested or injected. Signs and symptoms indicating someone has overdosed differ with the type of drug used; a call for emergency help is most likely made when a patient is experiencing any of the following symptoms:

- a seizure
- severe headache
- chest pain
- breathing difficulties

An overdose patient may not have all these signs or symptoms, but exhibiting only a few could mean the individual needs emergency help. Those on scene with the victim are often reluctant to call an ambulance for fear of police involvement; however, police will attend only if there is a fatality or if their presence is requested (e.g., if EMS feels threatened).7

In the MPDS Protocol, for instance, the EMD is prompted to notify the police only if the overdose patient is violent, if she/he has a weapon, or in the case of a volatile/criminal situation. Protocol 23 includes a V suffix the EMD should add to the Determinant Code if the caller reports that the patient is “violent or combative,” as this information is important for responders arriving on scene. In MPDS v13.0, the new suffix “W” has also been added to indicate report of weapons on scene. Be aware that police may need to respond first to secure the scene before medical responders can safely treat a violent patient. After initiating dispatch and providing applicable PDIs, the EMD should provide the caller with safety instructions on Protocol X, Panel 8 (Danger Present – Violent/Combatative Patient), advising the caller to avoid any contact with the patient and to let the EMD know if the patient loses consciousness or leaves the scene.

Protocol 23: Overdose/Poisoning (Ingestion)

Overdosing is a harrowing experience for everyone involved, and that’s no less for the EMD answering the call.

It’s not always obvious when someone has overdosed, and selecting the correct Chief Complaint Protocol for these patients is not always clear. It is critical that the EMD listen carefully to the caller’s response to Case Entry Question 3: “Okay, tell me exactly what happened.” Listen for the primary reason the caller is requesting help. Doing so will help you select the best Chief Complaint Protocol to use for the case.

In most cases, when it is known that a medical symptom is the result of an overdose or poisoning, Protocol 23: Overdose/Poisoning (Ingestion) will be the best Chief Complaint Protocol to use to address potential scene safety concerns. When the caller fails to provide information about a possible overdose or poisoning, the EMD will obviously “Choose the Chief Complaint Protocol that best fits the patient’s foremost symptom, with priority symptoms taking precedence” (Case Entry Rule 5). Likely Chief Complaint Protocols might include: Protocol 1: Abdominal Pain/Problems, Protocol 6: Breathing Problems, Protocol 9: Cardiac or Respiratory Arrest/Death, Protocol 10: Chest Pain/Chest Discomfort (Non-Traumatic), Protocol 12: Convulsions/Seizures, Protocol 18: Headache, Protocol 26: Sick Person (Specific Diagnosis), Protocol 28: Stroke (CVA)/Transient Ischemic Attack (TIA), and Protocol 31: Unconscious/Fainting (Near).

It should be noted that MPDS v13.0 modifies the Narcotics answer choice on Key Question 7 and the 23-C-5 Determinant Descriptor from “Narcotics (heroin)” to “Narcotics (heroin, morphine, methadone, OxyContin™, etc.).” The IAED™ has identified these four drug types to be the most common narcotics associated with overdose in the United States. Listing them in these sections guides the EMD to appropriately address narcotics overdose patients. Similar lists will be provided specific to the country or region where the protocol is used.

Dispatch Life Support

The PDIs on Protocol 23 are quite simple. The first universal instruction tells the caller that help is on the way, instructs her/him to stay on the line and says “I’ll tell you exactly what to do next.” Second is a new PDI-b in MPDS v13.0 that introduces instructions for administering an antidote for heroin or narcotic pain medication overdose (“Narcan/Naloxone help requested”) I’m going to help you give the Narcan to her/him now.”

An EMD must avoid freelance instructions when dealing with overdose and poisoning patients. Many poisoning patients can be effectively treated at home via telephone instructions and follow-up. In fact, calls involving most asymptomatic ingestions (not including antidepressants, cocaine, narcotics, acids, or alkalis) should be referred to the regional Poison Control Center (PCC), when approved and arranged by local medical control (Rule 1). When callers are transferred to a PCC, the Academy advises a complete (verifiable) hand-off. This means not staying on the line with the PCC call evaluator, since three-
way calls can confuse response. This is also one of the few times in the standard Priority Dispatch System™ that callers may not receive an initial prehospital response as an EMS response may not be necessary (Rule 2). If Poison Control’s evaluation indicates the necessity of a mobile response, they will inform Medical Dispatch (Rule 1). Calls back from a Poison Control Center should be coded as a 23-C-8 (Poison Control request for response), unless more severe symptoms warrant a DELTA-level response.

A mobile response should be sent to all overdose patients to provide appropriate intervention and to verify the actual condition of the patient. Because overdose is an intentional act, these patients may need social or psychological intervention and occasional protection from themselves (Axiom 2).

As described in Axiom 6 on Protocol 23, supporting the patient’s breathing is essential in the event of rapid loss of consciousness and respiratory arrest due to a narcotic overdose (heroin, morphine, methadone, OxyContin, etc.). The effects can be treated with naloxone in the prehospital setting, even by callers.

Naloxone is a prescription drug (not a controlled substance) regularly carried by EMS, and it can be administered with little or no formal training. MPDS version 13.0 includes the addition of Protocols Q and R for Narcan/Naloxone administration instructions. Both protocols provide the caller with instructions on how to administer Narcan/Naloxone, which is an antidote for heroin and narcotic pain medications including, but not limited to, Percocet, Lortab, codeine, fentanyl, OxyContin, Dilaudid, and Palladone.

The EMD selects Protocol Q or R depending on the type of medication the caller has on hand. Protocol Q is for nasal spray instructions, and Protocol R is for an auto-injector device called the “Evzio.”

Determined Descriptors

Many newer antidepressants have been designed to be safer and to have fewer side effects. However, older, more dangerous antidepressants are still commonly used because they have proven to be more effective for some patients. An overdose of the oldest class of antidepressant medications, tricyclic antidepressants, can be particularly dangerous. Patients may experience a decreased level of consciousness, cardiac arrhythmias, respiratory failure, seizures, and even death.

Patients poisoned by or who have overdosed on antidepressants should, in the absence of priority symptoms, be sent a 23-C-3 response.

The Determinant Descriptor is different for narcotics.

Once cocaine enters the bloodstream, it causes blood vessel constriction, increased heart rate, and a rise in blood pressure and body temperature. Cocaine-related deaths are often a result of cardiac arrest, stroke, or seizures followed by respiratory arrest.

Because of the significant dangers associated with cocaine, and in the absence of priority symptoms, a 23-C-4 response is always appropriate when cocaine is implicated in an overdose or poisoning case.

Methamphetamine is an addictive stimulant that can cause serious clinical consequences that require Advanced Life Support (ALS) care. The drug can cause a variety of cardiovascular problems, including a rapid, irregular heartbeat, increased blood pressure, and heart attack.

Because of the significant dangers associated with methamphetamine overdose and poisoning, and in the absence of priority symptoms, a 23-C-4 response is always appropriate when methamphetamine is implicated in an overdose or poisoning case.

Sources

6 See note 2.

IAED responds to global heroin and opioid problem

Greg Scott, IAED Medical Council of Standards

In response to the increasing global heroin and opioid drug problem, the International Academies of Emergency Dispatch™ (IAED™) has developed instructions for the delivery of Naloxone (Narcan) for EMRs to provide emergency callers, included in version 13.0 of the Medical Priority Dispatch System™ (MPDS®) Protocol.

Certain bystanders calling for emergency assistance for overdose patients will have ready access to this simple-to-administer, potentially lifesaving treatment.

“Heroin use is increasing at an alarming rate in many parts of society, driven by both the prescription opioid epidemic and cheaper, more available heroin,” said Centers for Disease Control and Prevention Director Tom Frieden, M.D., M.P.H. “To reverse this trend we need an all-of-society response—to improve opioid prescribing practices to prevent addiction, expand access to effective treatment for those who are addicted, increase use of Naloxone to reverse overdoses, and work with law enforcement partners like DEA to reduce the supply of heroin.”

According to the Open Society Foundations’ Naloxone web page, Naloxone is an easy-to-use, lifesaving antidote to overdose from heroin or other opioids. Having been used in hospitals for decades, it has no abuse potential, can be administered with only basic training, and costs around one dollar for a lifesaving dose.3

Naloxone distribution programs have trained drug users, their families, and their friends to identify the signs of overdose, administer the medication, and save lives in countries throughout the world. These efforts have reversed tens of thousands of overdoses, and show that drugs users and their communities can take positive steps for protecting their health.5

One such example is in Vancouver, Canada. After a safer-injection facility opened there, the fatal overdose rate in the surrounding area fell by 35%. In the US, more than 53,000 people have been trained in overdose response, and more than 9,000 rescues have been reported with Naloxone.6

As we roll out version 13.0, we will be working with our user agencies to gather quantifiable data and case studies on the use of Protocols Q and R in order to help us understand how the new protocol instructions are being used, and ultimately help us provide improved service to patients and communities.

Sources

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

Answers to this quiz are found in the article “Overdose/Poisoning Cases,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. Globally, there were an estimated 183,000 (range: 95,000–226,000) drug-related deaths (mostly overdoses) in 2012. Which drug comprised the largest category for overdose?
   a. cardiac medications
   b. opioids
   c. hallucinogens (e.g., LSD)
   d. benzodiazepines

2. In 2011, for the fourth year in a row, the number of U.S. citizens whose deaths were drug-related exceeded the number of fatalities in road traffic accidents.
   a. true
   b. false

3. The MPDS defines overdose and poisoning differently, and the distinction lies with the:
   a. type of drug ingested.
   b. method of administration (ingested, injected).
   c. individual’s intent.
   d. symptoms.

4. If a caller reports that her brother took pills in a suicide attempt, the case should be classified as:
   a. an overdose.
   b. a poisoning.

5. If the patient is violent, the EMD is directed to:

6. When the caller fails to provide information about a possible overdose or poisoning, the EMD will obviously “Choose the Chief Complaint Protocol that best fits the patient’s foremost symptom, with priority symptoms taking precedence.”
   a. true
   b. false

7. The IAED has identified which four drug types to be the most common narcotics associated with overdose in the U.S.?
   a. heroin, methadone, OxyContin, Klonopin
   b. heroin, OxyContin, Lortab, Prozac
   c. morphine, Prozac, methadone, Prilosec
   d. morphine, heroin, methadone, OxyContin

8. A mobile response should be sent to all overdose patients to provide appropriate intervention and to verify the actual condition of the patient.
   a. true
   b. false

9. MPDS version 13.0 includes the addition of Protocols Q and R for:
   a. CPR for an individual suspected of an overdose.
   b. epinephrine administration.
   c. Poisoning Control Center guidelines.
   d. Narcan/Naloxone administration instructions.

10. Patients poisoned by or who have overdosed on antidepressants should, in the absence of priority symptoms, be sent a:
    a. 23-D-2 response.
    b. 23-C-3 response.
    c. 23-C-4 response.
    d. 23-B-1 response.

To be considered for CDE credit, this answer sheet must be received no later than 10/31/16. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.
CLOCK IS TICKING
NFPA 60-second time standard rattles communications

Audrey Fraizer

There’s one piece of information that stands out for communication centers in National Fire Protection Agency (NFPA) 1221 Standard for the Installation, Maintenance, and Use of Emergency Services Communication Systems.

And it’s the first issue Mike Thompson hears about when he travels to various agencies despite the 14 chapters and five annexes making up the standard.

“The 60 seconds is talked about everywhere I go,” said Thompson, Priority Dispatch System™ Program Administrator—Fire and Medical. “Some are chopping it in half. Sixty is good. Thirty is better. Where does the benchmark come from?”

The 60 seconds is referred to in a subsection of NFPA 1221 (2013) 7.4 (Operating procedures):

7.4.2 With the exception of the call types identified in 74.2.2 (see note 1 at end of article) 80 percent of emergency alarm processing shall be completed within 60 seconds, and 95 percent of alarm processing shall be completed within 106 seconds! (See note 2 for revised times effective Jan. 1, 2016.)

Total dispatch transaction time takes into account receipt/pick-up of initial 9-1-1 call, caller interrogation, determinant prioritization/selection, and tone out of resources. Dispatch’s responsibility for the time standard ends at the beginning of Emergency Response Facility (ERF)/Emergency Response Unit (ERU) notification.

“The minute when units are notified, you have satisfied the standard,” Thompson said.

NFPA Standard 1221 is inclusive of all emergency services communications and applies not only to fire service but, also, to law enforcement, emergency medical services, and other responders. According to Annex A of NFPA 1221:

All incoming calls on designated emergency telephone lines should be considered emergency alarms until answered by a telecommunicator. If a telecommunicator determines that the reason for the call is not an emergency, as defined in 33.32, the call should not count against the performance requirements of 7.4.2. A trouble or supervisory signal is not an indication of an alarm.

In the case of an emergency, most communication centers don’t consider the standard a time to beat. The more pressing issues, as various agencies have related to Thompson, a retired career Fire Service Battalion Chief with 24 years of fire service and paramedic experience with the Rapid City (S.D.) Fire Department, is real-world call processing.

For one thing, the one-size-fits-all approach doesn’t accurately reflect the nature of every call (e.g., a structure fire vs. a toaster smoking from burned frosting on pastries); another point is that no validated research exists to support a 60-second dispatch standard.
“We’ve asked the NFPA why the 60 seconds, and we’re told it’s a time that seems reasonable,” Thompson said. “There’s no data, but that’s the best number NFPA has to go on.”

There’s also the question of whether the time element matters.

Again, the data doesn’t exist, Thompson said. There is no data supporting a direct relationship between an established time and positive patient outcomes, fewer property losses, and minimal civilian and firefighter casualties.

The arbitrary time ceiling can also do more harm than good because it can limit information gathering at the point of dispatch.

“Call processing times are important, but you have to maintain perspective on what you’re talking about,” Thompson said. “Where is time most important? Where does time have little effect or a major impact? Good information [given at dispatch] recognizes situations where lifesaving instructions must be provided immediately. The same applies to scene safety. These issues must be recognized early.”

Thompson and Gary Galasso, Priority Dispatch System™ Program Administrator—Fire and Medical, discussed NFPA 1221 7.4.2 at their 60-minute “NFPA Call Processing Time Standard: Is it Valid?” co-presentation during NAVIGATOR 2015. While they questioned the practicability and applicability of the NFPA time stamp, they also commended the NFPA for the standard-setting work that it does.

“NFPA brings a lot to the industry, and their standards are a good thing,” Galasso said. “The problem here is a time standard that should be based on variable data and real-world call processing experience.”

Standard development

Established in 1896, over the past century, the NFPA has gained a reputation as the world’s leading advocate of fire prevention. The NFPA is an international organization with more than 81,000 members. Its individual organizational goals promote lifesaving processes during an emergency through codes and standards, research, training, and education.

The NFPA does not police or enforce standards, said Jay Dornseif, Priority Dispatch System™ Program Adminis-

An arbitrary time ceiling can do more harm than good because it can limit information gathering at the point of dispatch.

trator—Fire. Likewise, the NFPA, as a whole, does not test, evaluate, or verify the accuracy of any information nor the soundness of any judgments contained in its codes and standards. Benchmark times are based on qualitative research, experience, and assumptions.

“The standards are decided by committee consensus,” said Dornseif, who chairs the NFPA 1221 Technical Committee. “The majority wins.”

The 200 NFPA standards and 6,000 volunteers in the NFPA’s assortment of technical committees are heavy hitters.

“The NFPA influences every building process, service, design, and installation in the U.S. and many other countries,” Dornseif said. “They’re taken very seriously.”

Standard time stamps for firefighting—which includes a ceiling for response on scene—are developed to promote an early, aggressive interior attack to limit the spread of a structure fire and the quick arrival of personnel and equipment. NFPA 1221 dates back to 1898 and was originally part of a general standard on signaling systems, and in 1911, municipal fire alarm systems were separated from the general standard. The standard was revised and reissued in 28 issues between 1904 and 2007, with subsequent reissues through 2015.

The time stamps are not confined to communication.

NFPA Standard 1710 specifies a benchmark for career fire departments to place their first ERU en route to an emergency. NFPA 1710, Chapter 5, Subsection 5.2.4.1, sets the arrival time of an engine company within a 240-second travel time to 90 percent of the incidents; initial full-alarm assignment must be deployed within a 480-second travel time to 90 percent of the incidents (subsection 5.2.4.2).

The NFPA, however, also welcomes proposals and comments from the public. Dornseif has consistently encouraged IAED members to review and provide feedback on existing standards, particularly revisions in draft stages prior to a committee’s vote. He also notifies people personally.

“You have the opportunity to get involved,” he said. “It’s up to you to provide your comments. That’s where my time stamp stops.”

A public comment posted as part of the minutes of the 1221 Technical Committee from its Second Draft (of proposals that would go into effect in 2016) meeting in October 2014 echoes concerns voiced by both Galasso and Thompson:

We have just started closely tracking received to dispatch times in our multi-jurisdiction center that serves 11 communities in a heavily populated suburban area, so I don’t have stats to share at this point. However, having looked at the NFPA standard in the past, I find it difficult to believe that a large dispatch center can meet the standard on a regular basis. I would like to see the science behind the determination that 60 seconds is an appropriate time frame. Were the studies (if there were studies) done in the day of enhanced 9-1-1 when all of the calls were coming from landlines? The majority of our calls come from cellphones and making sure that we send units to the correct location in a multi-jurisdictional environment where many of our towns have like street names or the same street runs through four or more of our towns is one of our primary concerns. I contend that thorough address verification can eat up much of your 60 seconds and you haven’t even determined the nature of the problem at that point. Rather than backing into how much time is left over for answer to dispatch based upon how much time they are giving the FD for turnout to arrival—they should do some actual studies in a variety of PSAPs to determine a reasonable standard.
The Academy has never proposed or endorsed a single national standard for call processing times and, up until recently, stayed out of the debate. “We weren’t sure we wanted to jump into that lion’s den, but we’re no longer standing back,” Galasso said. “Our organization [the IAED™] is gathering data today. We’re looking at our own centers to see how long it is taking and not how long it should take.”

Thompson and Galasso emphasized data collection, as well as factoring into the equation primary and secondary PSAPs, the protocol disciplines used at the agency (FPDS®, MPDS®, PPDS®), metro or urban coverage, and other issues that could affect the time stamp. The standard must also apply equally to all agencies, regardless of the agency’s demographics and call volume.

Despite the lack of empirical data to support the time requirements, fire departments have no choice but to meet the 60 seconds 90 percent of the time—or if revised, the current time element—if they plan to pursue accreditation through the Commission on Fire Accreditation International (CFAI).

The required accreditation benchmark was also a factor pushing the IAED into the time stamp fray. “We’re not going to stand here and complain,” Thompson said. “Once we have an idea and better understand the norm, we can travel down that road with some of our partners to help us.”

Galasso and Thompson also urge participation in the NFPA process. “Dispatch controls a relatively small piece of the process, yet it still gets all of the attention,” Galasso said. “Dispatch is easy to pick on. Study the issue. Know what your times are and what they mean. Make sure your process is sound and then meet with fire administration to present and discuss your side.”

Notes
Note 1
• Calls requiring Emergency Medical Dispatch questioning and Pre-Arrival Instructions
• Calls requiring language translation
• Calls requiring use of TTY/TDY or audio/video relay
• Calls of criminal activity that require information vital to safety prior to dispatch
• Hazardous Materials incidents
• Technical rescue incidents

Note 2
The current 7.4.2 revision went into effect in 2013 and, similar to all NFPA standards, remains in effect for at least three years, until the next edition. NFPA did revise 1221 7.4.2 for the edition that goes into effect Jan. 1, 2016. At that time, the standard will read, “90 percent of emergency alarm processing shall be completed within 64 seconds, and 95 percent of alarm process shall be completed within 106 seconds.”

Other revisions in 1221 going into effect Jan. 1 involve incident command dedicating a telecommunicator to an incident—when requested by the incident commander—and establishing operating procedures to identify the circumstances under which the telecommunicator will be assigned and how it will be accomplished.

Sources
3 See note 2.
7 See note 6.
1. The 60 seconds is referred to in which NFPA standard?
   a. NFPA 72 National Fire Alarm and Signaling Code
   c. NFPA 1221 Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems

2. According to current NFPA standards, 80 percent of emergency alarm processing shall be completed within:
   a. 30 seconds.
   b. 45 seconds.
   c. 60 seconds.
   d. 90 seconds.

3. NFPA 1221 applies only to fire service communications.
   a. true
   b. false

4. All incoming calls on designated emergency telephone lines should be considered emergency alarms until the:
   a. ambulance arrives on scene.
   b. supervisor is notified.
   c. caller hangs up.
   d. call is answered by a telecommunicator.

5. NFPA standards are approved by a:
   a. committee consensus.
   b. 100-percent approve or disprove vote.
   c. single NFPA governing board.
   d. membership ballot.

6. NFPA Standard 1710 specifies a benchmark for career fire departments to place their:
   a. traffic control incident manager at the scene.
   b. first ERU en route to an emergency.
   c. fixed water system for fire protection in relation to buildings.
   d. lightning protection systems at the communication center.

7. Initial full-alarm assignment must be deployed within a 480-second travel time to:
   a. 45 percent of incidents.
   b. 60 percent of incidents.
   c. 75 percent of incidents.
   d. 90 percent of incidents.

8. The Academy has never proposed or endorsed a single national standard for call processing times.
   a. true
   b. false

9. Fire departments must meet the 60 seconds 90 percent of the time—or if revised, the current time element—if they plan to pursue accreditation through the:
   a. International Academies of Emergency Dispatch® (IAED).
   b. Commission on Fire Accreditation International (CFAI).
   d. U.S. Fire Administration.

10. For the NFPA edition that goes into effect Jan. 1, 2016, standard 7.4.2 has been revised to “90 percent of emergency alarm processing shall be completed within ______.”
    a. 48 seconds
    b. 64 seconds
    c. 92 seconds
    d. 106 seconds
Much of the early basis for specific aspects of modern EMD practice have their beginnings in Dr. Jeff Clawson’s observations of things most participants in dispatch did not see occurring in plain sight right in front of them. One of these was the “hysteria threshold,” a concept born out of listening to many early cases in which the calltaker was confronted by an out-of-control caller reporting terrible events happening to their family members. On the surface, callers were often said to be “hysterical” and the routine provision of pre-arrival instructions was rare, and since the dispatchers, upon hitting this wall, almost always simply hung up the phone telling the caller that help was coming.

With the early provision of PAIs, there were a few times where he noticed that if the calltaker directly asked for calm, the caller tended to calm down a bit—and later observed to happen only when the calltaker also gave an “adult-learning” relevant reason for this request, and that the request was repeated each time in exactly the same way. These became the elements of success for initial training of EMDs.

Once this was done, it was then observed that the caller hit the edge of this not-so-distant threshold very quickly, and, passing through it, suddenly became a helper rather than a hinder. Calltakers had literally always stopped mere seconds before they would have hit the threshold, thereby never seeing it and never thinking it even existed—obviously believing that callers would never calm down, much less follow instructions by the numbers.

This article described one of the initial breakthroughs in what is now known as the Psychology of Dispatch Life Support. As musical lyricist Leo Robin wrote in 1930, “Beyond the blue horizon, waits a beautiful day ...”
The Hysteria Threshold

Gaining Control of the Emergency Caller

by Jeff J. Clawson, MD

Editor’s note: This is the second of four articles on medical dispatching. Each article will be accompanied by two Utah Treatment Sequence Cards in outline form. These articles and cards will appear in JEMS every other month.

The child in a tantrum, a screaming teenager at a Michael Jackson concert, the ex-spouse in a court custody hearing, and an emergency caller, may all have one thing in common. They’re out of control. They’re hysterical.

The definition of hysteria is listed as “a state of tension or excitement in which there is a temporary loss of control over the emotions.”

Our day-to-day experience leads us to side-step unpleasantness and avoid confrontations which includes the hysterical. It is a process of natural survival. This tendency also exists at the dispatch level and has been a lifesaver there for decades—unfortunately, only the dispatcher.

The caller is too upset (hysterical) to respond accurately, is the common argument. When confronted with a screaming, sobbing, threatening caller, what actually can be done?

In 1976, the Phoenix Fire Department initiated their now renowned program of medical self-help, or pre-arrival instructing, due to a fortunate occurrence in their dispatch center. Some wise soul bothered to make cassette copies of their first recorded successful dispatch interventions and sent them to different agencies along with other requested written information.

After playing the tape over and over, we noticed some consistent occurrences in each of the successful resuscitation cases on the tape. While the caller might have been out-of-control (hysterical) at first, something happened each time that allowed the dispatcher to obtain control of the situation and impact the victim through the caller. The first thing we noticed was ever so simple. The dispatcher didn’t hang up the phone.

Normally, a dispatcher will avoid the confrontation with the hysterical caller. “We’ll send someone right over,” and then hang-up! Review a few dispatch calls where the victim is in dire need of immediate BLS and see what happens.

Next we noticed that the dispatchers in these cases always remained calm but firm. And, faced with an initial disregard to their request to ‘calm down and listen to me,’” they repeated the same request in identical phrasing over and over again. But that process might eventually take 15 minutes, one hour or two days. Maybe, but not very often. We discovered that with “repetitive persistence” the EMD can obtain “control” after usually only two to three repetitions. At this point the caller gives in and becomes a help rather than a hindrance.

But guess what? Thousands of dispatchers have never gotten past this first request and have gone on their careers without reaching the level of control just past the “hysteria threshold.”

Once reached, the caller almost always relinquishes control and becomes not just OK, but begins to follow the dispatcher’s instructions closely, often exactly. Quite a difference from the screaming lunatic that greeted you on the line just minutes before.

There are four simple rules to follow to get past the “hysteria threshold” through the technique of “repetitive persistence”:

1) You must repeat the described request each time in the same identical way. Do not vary the sentence structure (i.e., “Ma’am, you’re going to have to calm down if we’re going to help your baby.” Repeat.) Variation in the spoken format indicates to the caller’s subconscious a weakness in your will, a chink in your verbal armor.

2) People who are out-of-control want people in control to lead them. It’s just that, because they are out-of-control, they never appear that way on the surface. And we fail for it. We agree with, and respond to, their behavior instead of their need.

3) Be firm and in charge. Be generic. Don’t antagonize the caller or they will re-direct their frustration at you, making your argumentative attitude the subject of their displeasure, not the victim’s distressing state.

4) You must believe that the threshold actually exists. And while it may vary between different callers—everyone has one. Mine might be on the next request while yours may be next week. But funny thing—if you don’t task, how will you ever find out?

If we don’t start asking the right questions, we’ll never get the right answers.

The following treatment sequence cards are currently approved by the state of Utah for use by certified EMDs. Any use of these cards outside Utah should be carefully reviewed and approved by local medical control, and the dispatchers using them trained in CPR and the Heimlich Maneuver.
YOU MUST BE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Gaining Control,” which starts on page 42.
Take this quiz for 1.0 CDE unit.

1. In the early days of EMD, routine provision of PAIs was rare and dispatchers were likely to deal with a hysterical caller by:
   a. arguing.
   b. handing the call to the next available calltaker.
   c. simply hanging up the phone, telling the caller that help was coming.
   d. sobbing.

2. Identifying the hysteria threshold and finding a solution is one of the initial breakthroughs in what is now known as:
   a. the Psychology of Dispatch Life Support.
   b. the performance standards of EMD/EPD/EFD.
   c. Case Entry Questions.
   d. Chief Complaints.

3. The definition of hysteria is listed as:
   a. “a state of great happiness and exhilaration at the delivery of good news.”
   b. “a state of tension or excitement in which there is temporary loss of control over the emotions.”
   c. “a state of sadness marked by the inability to act effectively.”
   d. “a state of being bewildered or unclear in one’s mind about something.”

4. Side-stepping unpleasantness and avoiding confrontation is a process of natural survival.
   a. true
   b. false

5. Which fire department, in 1976, initiated its program of medical self-help or pre-arrival instructions?
   a. Salt Lake City Fire Department
   b. Los Angeles Fire Department
   c. Phoenix Fire Department
   d. Chicago Fire Department

6. An EMD can obtain control in a call using a process called:
   a. natural survival.
   b. hysteria threshold.
   c. survival of the fittest.
   d. repetitive persistence.

7. To get past the hysteria threshold, the dispatcher must:
   a. vary the sentence structure.
   b. use a loud voice to silence the caller.
   c. repeat the described request each time in the same identical way.
   d. hang up the phone immediately.

8. People who are out of control want:
   a. people in control to lead them.
   b. to remain out of control.
   c. to find any excuse to remain hysterical.
   d. people out of control to follow them.

9. A dispatcher must be:
   a. evasive.
   b. firm and in charge.
   c. antagonistic.
   d. philosophical.

10. Everyone has a hysteria threshold.
    a. true
    b. false

To be considered for CDE credit, this answer sheet must be received no later than 10/31/16. A passing score is worth 1.0 CDE unit toward fulfillment of the Academy’s CDE requirements. Please mark your responses on the answer sheet located at right and mail it in with your processing fee to receive credit. Please retain your CDE letter for future reference.

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Canada and the United States are similar in some respects but different in others. The country that leads in one category may lag in another. Here are a few examples:...
dispatchers don’t always receive expressions of gratitude for the lifesaving assistance they provide. In fact, such instances can be rare and surprising. But a South Carolina dispatcher recently found out just how much a caller appreciated her timely aid.

And so did potentially many, many others.

On March 10, Charleston, S.C., resident Zan Dietz submitted a letter to the editor to the Post Courier, a Charleston newspaper. The 200-plus-word letter recounts Dietz’s experience the previous August when a dispatcher talked her through the steps of performing CPR on her unconscious husband. Dietz concludes the letter with a sincere outreach of thanks to the dispatcher who helped save her husband after he suffered a heart attack.

“I have not been able to track down 9-1-1 Operator No. 132 who answered my call,” Dietz wrote in the letter. “I sent a thank you note to the head of the 9-1-1 call center, and I hope it was received. She will always be my guardian angel. I have read that 9-1-1 operators often never know the outcome of their incoming calls. I want Operator No. 132 to know that my husband is alive and well and that she is a big reason for that.”

Operator No. 132 is Joselyn May, a two-year veteran with Charleston County Consolidated 911. She calmly and successfully instructed Dietz on how to give CPR to her husband even though Dietz had never been trained in giving CPR or in any medical procedures.

May was pleasantly surprised when she saw the letter in the newspaper. “It feels great,” she said. “With our job, we don’t always get thanks. We don’t always know the outcomes, so it was nice to see this.”

The call came in at 4 a.m. with a frantic Dietz explaining that her husband had collapsed in the hallway of their home on his way from the bathroom. He had no pulse and was gurgling and turning blue. Within moments of calling 9-1-1, May was walking Dietz through the steps of performing CPR.

“I tried to reassure her that help was on the way,” she said. “I was with her until EMS arrived.”

During the conversation, however, Dietz inadvertently dropped her phone, causing the call to end. May called right back and resumed her instruction until EMS arrived. In helping to save the husband’s life, May said she was simply fulfilling her job duties and doing what she loves.

“It felt great to save a life,” she said. “I’ve always had the personality to (want to) help.”

May said there’s never a dull moment in the life of a 9-1-1 dispatcher. The variety of calls and the fact that each day presents new and unique challenges is what she loves about her job. While Dietz did an excellent job of following instructions, some callers have proved difficult. Regardless, May takes it all in stride and focuses on the needs of the person.

“There’s nothing you can do about difficult callers,” she said. “You just try to be a calming voice. There’s a balance between being calm and taking control of the situation. I try to put myself in their shoes.”

SIGN OF APPRECIATION
Caller submits letter of DLS thanks

Josh McFadden
It’s too bad mom wasn’t a backseat driver, literally.

Perhaps if she had been, her daughter, born Feb. 7, 2015, might have experienced a roomier entry into the world compared to the cramped quarters between the front seat and glove box.

“This was not a textbook delivery,” said EMD Erin Jensen, North Central EMS/Coordinated Medical Emergency Direction (CMED), Hartford, Conn.

But it was one for the books.

With a winter warning in effect until 1 a.m., dad was driving his wife to the hospital shortly before 2 p.m. in anticipation of the couple’s second child.

He didn’t have much choice.
Mom was in active labor, and, instead of making a beeline to the hospital, dad had to cut the drive short, exit the highway, and head toward an alternate delivery place on a quieter road.

“He was still driving when he called,” Jensen said. “He was looking for a street sign so he could give a location.”

With the car pulled over to the curb, it was time to get down to the delivery business. Dad positioned his wife as comfortably as possible in the passenger seat of their vehicle and commenced following Jensen’s recitation of the Medical Priority Dispatch System™ (MPDS®) PAIs for childbirth.

“He was great,” Jensen said. “He sounded nervous, but he did really well at listening and keeping it together.”

In moments, a baby girl had made her entrance, but she was not making a sound, and her skin was a faint shade of blue. Jensen gave instructions to rub the baby’s back, according to the protocol, and that brought out a cry.

“That’s all the assurance I needed,” she said. “The baby was going to be fine.”

The ambulance arrived on scene at about the time Jensen was giving instructions to tie the umbilical cord. She was relieved; the outcome was positive.

North Central EMS/CMED Assistant Operations Manager Brian Baldwin credited Jensen for her calming influence and coaching.

“She did a good job getting the caller to pull over and an excellent job coaching the caller through the birth prior to the arrival of EMS,” Baldwin said.

The call will always rank as a commemorative benchmark to Jensen’s part-time job in the dispatch center, as long as she doesn’t get full credit.

“This was really a team effort—from dispatch, EMS, and the Bloomfield Police Department (which had transferred the call from its center),” Jensen said. “Dad was a champ. I was just doing my job the same as anyone else here would have done. We all pitched in for the happy outcome.”

There is one slight downside to the call, Jensen admits. She is also expecting a baby and would prefer the delivery takes place in a more conventional environment. She’s hoping to make it to the hospital on time.

“My heart went out to them,” she said.

North Central EMS/CMED is a nonprofit EMS communication center coordinating patient and resource distribution from the scene of a mass casualty incident to the emergency department (ED) of an acute care hospital. Administered by the North Central Connecticut EMS Council, it is the primary means of communication between prehospital providers in the field and the ED physician for medical direction.

North Central EMS/CMED provides EMD services for the towns of Bloomfield, Canton, East Granby, Granby, Suffield, Wethersfield, and Windsor Locks.

The center processes more than 130,000 emergency medical incidents annually. All North Central EMS/CMED employees are certified EMDs.
Case Exit

WILD BLUE YONDER
Helicopter EMS continues to mature

Audrey Fraizer

LifeLink III Communication Specialist Mike Jacobson sits totally immersed at his CAD directing critical care helicopter flight crew to the nearest Trauma I center for a patient critically injured in a grain elevator blast at a feed mill in northwest Wisconsin. The weather was originally forecast to be good enough to complete the trip, but Mother Nature threw a monkey wrench into the mix as the low pressure system intensified and began moving faster than anticipated. Lowering clouds and rain threatened to block the route.

While flying in rainy, windy conditions is generally not an issue, explained LifeLink III Communication Manager Rob Vawser, lack of visibility can obscure towers and other vertical obstacles along with landmarks necessary to guide the helicopter to the scene and landing.

“The pilot can become disoriented so we stay away from fog and heavy clouds,” said Vawser, who took over the management position in January at the communication center based in Minneapolis, Minn.

At the heart of the incident is Jacobson. He will stay on the call and—if necessary—coordinate ambulance service if the flight is diverted and conditions further deteriorate. He will update the medical crew onboard regarding the situation on scene and communicate with the hospital.

“It’s straight on our shoulder every time we send people out,” Jacobson said. “We have to live with all of our decisions to the end of time.”

In the last 25 years, air medical transport has become an essential part of EMS in Minnesota due, at least in part, to the increasing popularity of the north woods with its stretches of heavy forest and isolated lakes and the distance to a tertiary hospital from a small local access hospital for patients requiring a higher level of care. Nearly 90 percent of LifeLink III’s air transport involves inter-facility transport. The other 10 percent comprises trauma emergencies such as grain elevator explosions or motor vehicle accidents resulting in critical injury; actual helicopter emergency medical service (HEMS) transport depends upon first responders on scene, who also decide the service to call (generally related to proximity) and which hospital to send the patient. Pilots decide whether to fly if the weather is bad.

An explosion at a grain elevator is not uncommon in the rural areas LifeLink III serves; however, for the purposes of this story, the specific incident was dramatized to highlight the intensity of helicopter dispatch, whether for an emergency in a remote setting or an inter-facility transfer. Jacobson has been in dispatch since 2005 (following three years in ground ambulance) and the intensity wrapped into this job is a major reason he wouldn’t trade it for anything else in or out of EMS.

“It’s the excitement,” he said. “We make decisions in a split second. Somebody needs you at that moment and you’re doing all you can possibly do to save that person’s life.”

Jacobson’s dedication earned him a ticket to Shreveport, La., for a beta test of a simulator program designed specifically for HEMS dispatchers by the Metro Aviation Helicopter Flight Training Center. The HEMS Commlab provides scenario-based, hands-on training and evaluation for air medical communication specialists. The helicopter crew and CAD/radio operators are situated within the four walls of the same building, separated by a wall. Together they practice worst-case scenarios that can happen although they do not occur at any great frequency.

“These are major incidents that
require practice because if they happen, it can be tragic,” said Vawser, who helped design the lab prior to moving to Minnesota. “Some of these are incidents that don’t turn out so well and the sim lab allows you to see how you could do it better.”

According to information available from the Metro Aviation website, training includes inter-facility and scene transfers, bird strikes, neonatal transfers, multiple aircraft requests, misinformation and changing landing zones, as well as instrument flight rules (IFR) conditions and instrument meteorological conditions (IMC). Communication specialists sharpen skills for map reading, customer service, radio operations, flight planning and following, and safety-related procedures.

Jacobson spent two days at the HEMS Commlab in Shreveport participating in three practice scenarios and rotating among the CAD, radio, and control desk. Working in a strange environment with people he did not know until the class, and operating unaccustomed equipment, added to the experience, he said.

“This was as real as you can get without being in the communication center,” he said.

Vawser said the Commlab for HEMS communication specialists is a first for the industry and replaces the unannounced drills common to flight dispatch; the lab also falls in line with the type of training flight crews receive and Federal Aviation Administration (FAA) regulations highly recommend.

Today’s world of HEMS is a far cry from a generation ago when Cheryl Pasquarella, registered nurse, started with the company in 1982. Pasquarella wanted a change from the hospital setting and that’s exactly what she found as the nurse on an ambulance helicopter.

“The industry was in its infancy,” she explained. “A supervisor sat at a desk and would page us out when the call came in. We had a flight plan but it was still a daunting task to find the people.”

The air ambulance was equipped with standard hospital equipment—nothing specific to helicopter medical response—which exacerbated the situation.

“We were limited to what we had on the aircraft,” she said.

This was prior to the advent of satellite phones. There was no ground communication. People at the scene might hear the helicopter above but were unable to attract the attention of a flight crew, particularly at places obscured by Minnesota’s thick forests. HEMS was a dangerous mode of rescue, underscored by statistics of the 52 fatalities caused by EMS helicopter crashes between the years 1985 to 1989; the numbers made helicopter flight safety a priority for the National Transportation Safety Board (NTSB) in Washington, D.C.

“We knew the danger involved,” said Pasquarella, LifeLink III Director of Compliance & Quality Assurance. “But we tried not to think about it.”

As a former nurse in a hospital, she was also outside her comfort zone of control. The helicopter did not provide the benefit of good lighting, additional staff, tools and drugs, and space. It was hard to hear anything above the rotor noise.

“We had to figure out what to do with what we had,” she said.

After 15 years in the air, Pasquarella decided she no longer wanted to be standing in a cornfield in the middle of January, watching her breath turn into little clouds in the below freezing weather, while trying to stabilize a patient prior to flight. She switched to HEMS administration and currently oversees the myriad regulations that govern HEMS. She said flight control, safety, and navigation technology has made flights by EMS helicopter crews much safer, as have constant training and subsequent certifications. Studies showed that EMS helicopter safety has improved due to the development of navigational aids such as the Garmin Head-Up Display.

But it’s not only technology. LifeLink III has also heavily invested in research, including studies into noise levels and the use of sophisticated equipment modified for flight, such as the use of ultrasound for diagnosing collapsed lungs. Medical helicopters also commonly carry more drugs than an ALS ground ambulance.

The industry, however, still has its risks and when an accident does occur,

Everything starts with us, and, whatever happens, their safety is our responsibility. This is our family.

—Niki Fortune
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