Questions

Question: My concern is about the integration of a No,No,Go or an aggressive T-CPR program when PSAPs are currently using an EMD protocol like Priority Dispatch or Power Phone. We are beginning our journey into improving our EMD / T-CPR program. We have a great partnership with our EMS agency and Medical Director however they seem to favor a No,No,Go approach. NNG is a very different approach than the training of the past and it differs from our current EMD protocols.

Response from Julie Buckingham: The CPR LifeLinks committee was comprised of representatives of Priority Dispatch, PowerPhone, and King County EMD protocol systems. The recommendations found in CPR LifeLinks are protocol agnostic, and a telecommunicators should always follow their prescribed protocols.

Without knowing which protocols are being referred to, it's difficult to fully address this question. However, in almost every protocol the process for identifying cardiac arrest is the same; consciousness assessment followed by a breathing assessment. If the patient is reported as unconscious, breathing is then assessed. If breathing is reported as absent or uncertain, cardiac arrest should be suspected, and T-CPR instructions initiated.

Cardiac arrest is a time critical emergency. Telecommunicators must act quickly and aggressively for the sake of the patient. For every minute a patient is in arrest, their chance of survival decreases by 7% - 10%. CPR stalls the dying process, and it is critical to the patient's chance of survival that it is initiated quickly. Frequently, telecommunicators waste time by over-verifying information that has been reported or clearly stated by the caller. These extra questions, and extra time, come at the expense of the patient and diminish their chance of surviving the arrest.

If telecommunicators are unsure whether a patient is conscious and/or breathing normally, they should start CPR instructions as soon as possible — "when in doubt, there is no doubt." The chance that chest compressions injure adults not in cardiac arrest is very small — *one study found that the chance of injury (e.g., rib fractures) to adults not in cardiac arrest was just 2%.* The study found zero cases where patients sustained any serious injury, such as damage to internal organs.

Response from Petar Hossick: Having a great partnership with your EMS agency and Medical Director is a great start! This truly is a culture shift.

Deschutes County 9-1-1 uses IAED/Priority Dispatch for both EMD (v13.2) and EFD. Over the years, we have worked closely with the Academy and Priority Dispatch and have seen them implement changes to the software that makes getting CPR started quickly easier for our EMDs.

The two changes that were very helpful were the addition of the FastTrack in Case Entry and a change in philosophy around the Breathing Diagnostic tool.

Another very important part of our success has been training. This is where those great relationships you have already established will be essential. Having Captain Hossick come in and explain the Science behind CPR and reassuring our EMDs that if someone is not awake and not breathing, broken ribs is the

least of our concern was huge. He would also come listen to calls and give feedback to the EMDs with me. This was awesome because it closed the loop on information and allowed us to get a more complete picture.

Question: If you already have an EMD program implemented in your dispatch agency, how does this integrate? Is this just additional training as you really can not deviate from the protocols from your EMD program.

Response from Julie Buckingham: To save more lives from out of hospital cardiac arrest, PSAPs need to take a holistic approach to their T-CPR programs. Protocols are just one piece of what makes a successful CPR program. Additional steps that should be taken include incorporating the American Heart Association T-CPR Program and Performance Recommendations, also found in the CPR LifeLinks toolkit, into your PSAPs T-CPR program.

When it comes to training, your education program should discuss the essential role telecommunicators play in the Chain of Survival. Telecommunicators directly contribute to patient care and outcomes. Their ability to act quickly and decisively is essential in these time-critical emergencies.

Initial training should require at least three hours. Another two to three hours should be dedicated to continuing education each year. We recommend a learning program that follows the "Circle of Telecommunicator CPR", and includes the following 5 segments:

- Segment One: Know the Guidelines
- Segment Two: Practice CPR Skills
- Segment Three: Master the Three Stages of T-CPR
- Segment Four: Simulate T-CPR
- Segment Five: Measure & Improve

Response from Petar Hossick: We do use protocols, and training is a huge piece of us. We currently use IAED/Priority Dispatch for both our medical and fire calls. We are on v13.2 for EMD and they now have a FastTrack in case entry so if we know someone is not awake and not breathing we can get to CPR quickly without asking for age, awake, breathing, etc.

Even with that though, training is huge for us. Having Captain Hossick come in and teach us the science behind CPR has helped our EMDs understand the bigger picture. We also changed how we delivered our CPR/First Aid training, so that we could connect the pieces.

Question: Do you recommend pulling data from CARES as an initial step to be able to identify need and show partners current cardiac arrest success (or lack thereof)?

Response from Julie Buckingham: It is often difficult for a PSAP to be able to identify their calls for confirmed cardiac arrest by looking at CAD data alone. If your system reports to CARES, this information will help you to be able to identify these calls, weeding out the false positives that may occur. This data

will also aid you in your recognition program as you may be able to obtain survivor data. However, do not limit your recognition to just those cases where survival occurred. Sometimes, even when a telecommunicator has done everything right, a patient may still not survive. Remember to also focus on that performance which contributes to an increase in survival, such as time to recognition and time to first compression. The American Heart Association T-CPR Program and Performance Recommendations found in the CPR LifeLinks toolkit can easily be incorporated into your QI and recognition program.

Data is often the foundation for building bridges and relationships. Your EMS system may have access to data that you may find valuable in your efforts to improve survival in your community. Likewise, you may have data that your EMS system cannot access, but that they would find of value in their efforts to save more lives from cardiac arrest. Share your data and work together as a system to improve as a system. This collaborative and cooperative approach can lead to significant improvements that ultimately contribute to increased survival from out of hospital cardiac arrest in your community.

Response from Petar Hossick: I absolutely recommend using CARES data to look at times and survival rates. These numbers can be powerful incentives to start conversations. When we first calculated our survival (w/o CARES) we were at about 20 % with the national average in CARES at about 33 %. This is how I got our EMS director to commit hours to cross work at dispatch and additional hours for CPR training.

I think it is important to not weaponize the data. We had some bad numbers on both EMS side and dispatch initially. We concentrated on making them teaching moments versus disciplinary for failure to follow protocol. That helped us get cultural acceptance, but it was not overnight. The culture became a powerful reinforcement of the data after that. People began to seek feedback or brought calls to us to review.