The Netherlands

Go United
Small Country, Big Efforts

Presentation Navigator Washington 2016

Your presenter is Piet-Hein Verhagen

The first time he came into contact with AMPDS/ProQA was in 2010 as a member of a project to explore the possibilities of implementing AMPDS/ProQA in the Netherlands.

Started in 2012 as an EMD /EDQ and became a member of the Dutch Culture Committee.

Piet-Hein is a certified and registered AMPDS/ProQA/Aqua instructor and EFD since 2016.

In 2013, several Dutch EMD visited the United States for their first Navigator in Salt Lake City. The subsequent years, their colleagues also were given the opportunity to visit Navigator. One of them even experienced her own moment of fame, as she was on the cover of the Journal (Navigator 2015)

This presentation, however, is not really about the Netherlands visiting the United States but about how they go United in their own country on National, Regional or Local level.

It’s about cooperation

- Multidisciplinary (Medical, Police and Fire)
- Between Medical and Civilians
- Monodisciplinary Medical
**National Multidisciplinary Cooperation**

A very chaotic rescue during a terrible train incident in 1962 in Harmelen (92 were killed and 52 wounded) lead to the Dutch Government deciding that Dispatching had to be organized in a more efficient and effective way. From that time on, Medical, Police and Fire were forced to work together, resulting in a big reorganization.

The initial 48 Communication Centers for each separate discipline were reduced to 24 multidiscipline Communication Centers in 2004. Next step will be a centralization to 10 Communication centers for the whole country (planned 2018).

Currently, all Communication centers have the same CAD-system in which they can share incidents by sending it to each other. They all have the same Radio-Communication system so it’s possible for a Fireman in the North to speak with a Policeman in the South or Medics in East or West etc.

There is a National server for GPS locations showing the Medical and Police units, including helicopters. As for Fire, only few First Responder-units are using GPS locators.

The most recent Multidisciplinary cooperation is the introduction of the Assailant Shooter Protocol (protocol 136) which is currently used as a standard for Police, Medical and Fire in some Communication Centers. We are trying to introduce it also in non-AMPDS/ProQA using Communication Centers.

Occurring challenges are:

Because there are many features in the CAD system there are different ways of using it in Communication Centers for similar processes. The biggest challenge is to standardize those processes. National meetings for user groups are aimed to achieve this goal.

**National Cooperation between Medical and Civilians**

During each call, the EMD and the caller work together to provide good care to the patient.

For many years, in the event of a cardiac arrest, the Dutch Communication Centers are using a system that automatically alarms CPR-trained volunteers in a range of 400 meters around the victim. In a circle of 1000 meters around the victim the system also alarms AED-trained volunteers.
The CPR-volunteers receive the address and the easiest way to reach the victim on their cellphones. The AED-volunteers also receive notification of the address and route to the nearest AED.

On a special login-screen, the EMD can see how many volunteers have been alarmed.

Currently there are 9000 AED’s and 800.000 volunteers.

(Unfortunately) there are two different types of the abovementioned system in the Netherlands

The color on the map reflects the percentage of trained volunteers per inhabitant. (the grey area is using another system, on which we unfortunately have no recent information)

As we all know, Priority Dispatch Company stands for Quality, so we definitely understood the choice to start collaborating with the Dutch company Heart safe Living (Journal 2015 May/Jun), to globally improve the survival rate of individuals experiencing sudden cardiac arrest.

More information about how this works can be made visible by using this link:

https://www.youtube.com/watch?v=F61f7oNZV8M

**National Cooperation Medical (monodisciplinary)**

In case of a large incident, the dispatcher can use a special application for assistance.

The dispatcher selects the incident on the screen, decides how many external units are needed and, with only one push on the button, he sends a call for assistance to all the other Communication centers’ CAD systems at once.

There is a National agreement that all Communication Centers shall provide 50% of their free capacity for assistance.

Ambulances receive the information about an incident from CAD on their Mobile Data Terminal (MDT). The location is also sent to their navigation system. The paramedics send relevant information about their patient (MIST > Mechanism of injury, Signs Treatment) directly to the hospital’s ER. Only in special cases they will contact the ER by phone.
In the Netherlands there are two Dispatch systems. NTS (Netherlands Triage Standard) and AMPDS/ProQA.
The green area uses AMPDS/ProQA, the yellow uses NTS.

**National Cooperation AMPDS regions**

Directors are M.A.D.

Medical Managers Ambulanceservices (MMA) are N.U.T.S.

EDQ are D.O.P.E.D.

- The M.A.D. Directors Make All-over Descision. Meetings 4 times a year. They approve national policies and other decisions made by Medical Managers. Make financial and strategical descisions (EMA/NEMA)
- The N.U.T.S. Medical Managers Ambulance service (MMA) take care of the National Urgency Table and Specified units. All AMPDS codes are in that table with response (specified units) and modes (urgency). 4 times a year, the MMA reassess the table and adjust it if necesarry. They also make National Policies.
- The D.O.P.E.D. EDQ, maximum 2 per agency 5 times a year they meet for Discussions Of the Protocol (and Performance) of the Emergency Dispatcher . They provide suggestions for national or local policies.

Achievements Directors: Founded an association for Dutch AMPDS users.

Problems: meetings are being cancelled because of other priorities. No decision for EMA/NEMA

Achievements MMA: National Policy > Quick "hands-on-chest" when caller calls for CPR.

National agreement on special definitions protocols 9 and 24

Gather and analyse feedback-data from ambulances and adjust urgencies for AMPDS-codes
Problems: Despite of National agreements there still are local differences > Aspirin, special definitions protocol 9 OBVIOUS DEAD

Achievements EDQ: Multiple PFC’s. Multiple proposes for national policies.

A set of questions to clarify CE-question 3 for choosing the best Chief Complaint Protocol.

Problems: So many people so many opinions. It takes time to make good decisions

**Website**

Recently we started a website on which we can check the meeting reports

Though the website is still under construction, we are planning to introduce a forum and make a database with audiofiles for training purposes.

**Regional Cooperation**

The 3-4 Communication Centers in our region organise training sessions, in which we discuss the most frequently occurring communication problems with protocol compliance. We train with AMPDS card sets and discuss cases with guidance of audiofiles. We talk about Human Factors and how they may influence a call.

Problems: Available time for preparation. EDQ are also EMD; in case of absenteeism in his team, sometimes the EDQ has to work as an EMD.

**Local Teamwork**

EMD and EDQ work together to improve quality. Frequent newsletters with tips and trics 4 times a year, EMD and EDQ schedule person-to-person evaluations

5 card set calls per month (stay competent with back-up system)

Final goal is becoming an ACE.

Problems with becoming an ACE

In AQUA 5 we would be an ACE in Aqua 6 we still struggle with moderate DLS deviations.

Are EMDQ to strict or EMD stubborn ??

**Our Slogan : Let’s stay United**