

Delaware County Regional EMS Automated External Defibrillator Program

I. GOAL

- A. To reduce mortality rates in Delaware County due to cardiac arrest through the implementation of a Prehospital early defibrillation program.

II. BACKGROUND

- A. The overall leading cause of death in Pennsylvania is heart disease. More common than most heart disease is the occurrence of cardiac dysrhythmias, specifically ventricular fibrillation. Ventricular fibrillation results in the immediate cessation of blood and oxygen flow to the brain. Without proper blood flow, irreparable brain damage begins within four to six minutes. Rapid intervention is, therefore, required to restore proper heart functions and blood flow.

With the advent of Automated External Defibrillators (AEDs) and the Pennsylvania Automated External Defibrillator Program, Basic Life Support Prehospital Emergency Medical Services (EMS) systems now have the tools necessary to combat this type of heart malfunction.

III. AUTHORITY

- A. The Delaware County Department of Intercommunity Health Coordination's Regional Emergency Medical Services Office, under the authority granted by the Pennsylvania Department of Health, Bureau of Emergency Medical Services, shall be the agency to authorize and oversee the training, certification, usage and documentation of AEDs by Delaware County EMS units and providers within the Delaware County EMS Region.

IV. SERVICE REQUIREMENTS

- A. Currently it is not mandatory for EMS licensure/certification to be an AED authorized service. This is an optional program that any service may request to be a part. If a service wishes to participate in the Delaware County Regional EMS AED program, the following requirements must be adhered to:
 - 1. Be licensed or certified by the Pennsylvania Department of Health, Bureau of Emergency Medical Services.
 - 2. Apply in writing to, and be approved by, the Regional EMS Office for AED program participation.
 - 3. Have an AED Medical Director approved by the Regional EMS Office.
 - 4. Have an AED Program Coordinator approved by the Regional EMS Office.
 - 5. Use only semi-automatic AEDs that meet the equipment requirements of this program.
 - 6. Provide 24-hour immediate response with AED trained personnel, while in service. When not in service, an ALS unit must respond on all dispatches.
 - 7. Participate in the Regional Quality Assurance/Quality Improvement program.
 - 8. Maintain appropriate record keeping to include at a minimum:
 - a) Training records
 - b) Maintenance records
 - c) Usage reports.
 - 9. Meet the following service training requirements:
 - a) Teach AED providers about their responsibilities as a "higher trained" responder.
 - b) Discuss liability issues, including insurance coverage and potential needs.
 - 10. Any other requirements deemed appropriate by the Regional EMS Office.

V. PERSONNEL REQUIREMENTS

- A. The following personnel requirements must be met:
1. AED Medical Director must be:
 - a) A licensed MD/DO.
 - b) Board certified in emergency medicine, or ACLS provider.
 - c) Approved by Regional EMS Office and Regional Medical Director.
 - d) Roles and responsibilities:
 - (1) Insure AED training requirements are met.
 - (2) Fulfill all quality assurance requirements.
 - (3) Authorize AED providers and maintain a current listing.
 2. AED Program Coordinator must be:
 - a) An AED provider.
 - b) Approved by the service requesting AED authorization.
 - c) Approved by the service AED medical director.
 - d) Approved by the Regional EMS Office.
 3. AED Provider must:
 - a) Be currently certified at the American Heart Association BLS for Healthcare Providers level or equivalent, as approved by the Pennsylvania Department of Health.
 - b) Be authorized by and meet skill maintenance requirements as identified by the service AED Medical Director.
 4. AED Instructor must:
 - a) Be currently certified as an American Heart Association Instructor at the BLS for Healthcare Provider level or equivalent, as approved by the Pennsylvania Department of Health.

VI. REGIONAL REVIEW

- A. Prior to the approval and initiation of an AED program, the Regional EMS Office shall review, at a minimum, the following:
1. AED Medical Director.
 2. AED Program Coordinator.
 3. A list of proposed providers who have completed training requirements for AED usage as outlined above.
 4. Analysis of service capabilities.
 5. Analysis of Service QA/QI program.
 6. Make, model and specifications of equipment.

VII. MANAGEMENT & REPORTING

- A. The AED Medical Director is responsible to insure compliance with the state uniform reporting format (trip sheets).
- B. The AED Medical Director is responsible for an analysis of each AED application. If any deviation from protocol occurs or if there is any AED equipment malfunction, then this analysis, the PA Patient Care Report (PaPCR), and the data record containing the minimum data set must be submitted, in writing, to the Regional EMS Office within 72 hours of this analysis. Otherwise, this analysis should be kept with and for the same period of time as required for the PaPCR.
- C. The AED Program Coordinator is responsible to insure all the AEDs are in safe working condition, ready for immediate use.
- D. The AED Program Coordinator is responsible to insure that all maintenance, routine and otherwise, will be performed and documented with the appropriate records kept.

- E. The AED Program Coordinator is responsible to insure that all training requirements are met, and that the appropriate reports are forwarded to the Regional EMS Office in a prompt and appropriate manner.
- F. The AED Program Coordinator or his/her designee shall participate in all BLS Coordinators' Committee meetings.
- G. If the AED is voice data capable, the tape or mechanism must be submitted for QA purposes to the AED Medical Director for each AED application. It must be kept for at least 30 days.

VIII. EQUIPMENT REQUIREMENTS

- A. Must be FDA approved.
- B. Must be Semi-automatic. (Requires provider action after analysis for shock delivery)
- C. Must have voice prompts for semi-automatic operation.
- D. Must be programmed to meet current Pennsylvania Department of Health Statewide BLS Protocols.
- E. Must be able to give, at a minimum, ten (10) consecutive shocks at maximum energy level plus one hour of monitoring and five minutes of printing on each new battery power.
- F. Must have an alternative power source (charged spare batteries).
- G. Must provide written data record retrievable by the service consisting of the following minimum data set:
 - 1. Incident date
 - 2. Serial number of AED used
 - 3. Time AED was applied to patient
 - 4. Time and ECG for each analysis
 - 5. Shock or No Shock advisories
 - 6. Time each shock delivered and energy delivered for each shock
 - 7. Post shock ECG for each shock delivered
 - 8. AED trouble conditions

**APPLICATION FOR APPROVAL
OF AUTOMATED EXTERNAL DEFIBRILLATION PROGRAM
DELAWARE COUNTY REGION 12**

(Print or Type All information)

NAME/ADDRESS:

<i>Name of Organization</i>	<i>Name of Contact Person</i>
<i>Street Address</i>	<i>P. O. Box/Suite/Apartment Number</i>
<i>City</i>	<i>State</i>
<i>Zip Code</i>	<i>Telephone Number</i>

TYPE OF ORGANIZATION:

- | | | |
|--|--|--|
| <input type="checkbox"/> AMBULANCE SERVICE | <input type="checkbox"/> POLICE DEPARTMENT | <input type="checkbox"/> SECURITY AGENCY |
| <input type="checkbox"/> BUSINESS/INDUSTRY | <input type="checkbox"/> QRS | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> FIRE SERVICE | <input type="checkbox"/> RESCUE | |

MEDICAL DIRECTOR

<i>Name of Medical Director</i>	<input type="checkbox"/> M.D.	<input type="checkbox"/> D.O.
<i>Street Address</i>	<i>P. O. Box/Suite/Apartment Number</i>	
<i>City</i>	<i>State</i>	<i>Zip Code</i>
		<i>Telephone Number</i>

- | | | |
|------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Licensed MD/DO (Attach copy of license) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Copy of Current ACLS Card (Attach) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Copy of Board Certification (Attach) |

* Medical Director must be Board Certified in Emergency Medicine or an ACLS Provider.

AED PROGRAM COORDINATOR:

<i>Name of AED Coordinator</i>			
<i>Street Address</i>	<i>P. O. Box/Suite/Apartment Number</i>		
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>

- | | | |
|------------------------------------|-----------------------------------|------------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | AED Provider |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Approved by Medical Director |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Approved by Service/Company |

Please attach:

1. Copy of Quality Assurance Plan.
2. Skill Maintenance Requirements as identified by the AED Medical Director.
3. Provide a copy of your response procedure to cardiac emergencies.
4. Copies of certifications as requested in application.
5. List of proposed providers and a list of providers who have completed authorized training.
6. Sample of data record retrievable for each AED to be used.
7. List of all AEDs to be used including Brand Name, Model Number, and Serial Number.

If your organization is not a licensed EMS service, please provide a brief description of how your organization will coordinate efforts with the EMS System:

I have reviewed this application and all of the information contained herein, or submitted separately, in support of the application is accurate and complete.

Signature of Organization Representative

Date

I do hereby acknowledge and accept the position and responsibilities as the Medical Director and am in support of this AED application. I have reviewed the attached quality assurance plan and concur with its contents.

Signature of AED Medical Director

Date

I do hereby acknowledge and accept the position as the AED Program Coordinator and am in support of this AED application. I have reviewed the attached requirements and agree to maintain the standards required.

Signature of AED Program Coordinator

Date

Print Name of Individual completing this Application

Title

FOR REGIONAL USE ONLY:

I have reviewed the attached application and information provided. Based on this information the application is:

Approved

Denied

Reason for Denial: _____

Regional Representative

Signature of Regional Representative

Date

Regional Medical Director

Signature of Regional Medical Director

Date

