

## **Useful Tools for Helping Establish and Manage an AED Program**

**The following pages contain sample AED program forms and checklists**

- 1. AED Site Survey/Planning Document**
- 2. Emergency Responder Training Roster**
- 3. Emergency Response Time Sequences**
- 4. Medical Authorization/Prescription Form**
- 5. SCA/AED Event Review Form *(for use by the Program Manager)***
- 6. SCA/AED Event Report Form *(to be completed by Medical Director)***
- 7. "Annual Checklist" *(for use by the Program Manager)***
- 8. Monthly AED Unit Checklist**
- 9. "Emergency Action Plan" card**
- 10. Drill Checklist**
- 11. Sample Letter to EMS**

**WORKING DRAFT**

**AED Site Survey/Planning Document**

Date \_\_\_\_\_

Site/Company/Agency \_\_\_\_\_

Primary Contact person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

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**About your location/company:**

Total area of occupancy (in sq. ft.) \_\_\_\_\_

Total number of employees (inside facility) \_\_\_\_\_

Is there currently an emergency medical action plan? YES NO

Are there presently AED's at this location?  Yes (*How many* \_\_\_)  No

Are you planning to obtain them? YES NO

How many were you considering purchasing? \_\_\_\_\_

Do you have an AED manufacturer selected? YES NO

If not, would you like assistance in obtaining AED's? YES NO

Where are you planning to place them? \_\_\_\_\_

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Will these locations allow for a 3-minute "drop-to-shock" response? YES NO

How are you planning to train your staff? \_\_\_\_\_

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Would you like assistance in training staff to use AED's? YES NO

Have you developed a protocol for maintaining, checking, and evaluating AED use?  
YES NO

Would you like assistance in developing a AED plan? YES NO

Who will be assigned the task of maintaining the devices? Title: \_\_\_\_\_

Who will be in charge of ordering replacement parts, (i.e. batteries)?

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Title: \_\_\_\_\_

Are other aspects of emergency medical care response with which you need help?

\_\_\_\_\_

**Storage and Accessibility**

Check one  Limited accessibility  Open accessibility

Check one  Secured AED  Unsecured AED

Check one Signage/Location Indicators?  Yes  No

Has your AED ever been used? YES NO Needed but not used? YES NO

How are you evaluating/will you evaluate the success or failure of the unit?

\_\_\_\_\_

What brand of AED do you have/are you considering? \_\_\_\_\_

Are you satisfied with your present device(s)? YES NO

Did your staff receive CPR/AED training? YES NO

How many people on site are CPR/AED trained? \_\_\_\_\_

Did they receive training in emergency medical care response? YES NO

Who provides Medical Direction? \_\_\_\_\_

Who provided training to your staff on AED use? \_\_\_\_\_

On emergency medical care response? \_\_\_\_\_

Are there regular emergency medical care response drills to enhance staff readiness?

YES NO

Would you like help in developing a drill plan? YES NO

What type of emergency response record will be kept? \_\_\_\_\_

\_\_\_\_\_

Who will be in charge of keeping/recording the record? \_\_\_\_\_

\_\_\_\_\_

Who will be providing Medical Control/oversight? \_\_\_\_\_

Supply the prescription for obtaining the AED? \_\_\_\_\_

Physician analyzing the AED data? \_\_\_\_\_

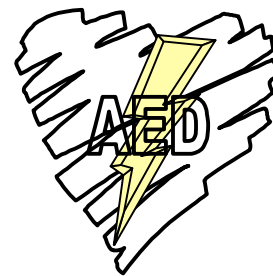
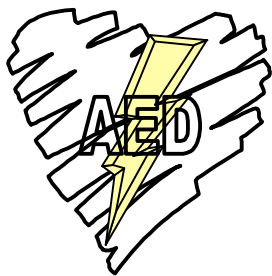
Who will be responsible for managing and supervising the AED program, including notification/interface with EMS? \_\_\_\_\_







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**Medical Authorization/Prescription Form**

Date: \_\_\_\_\_

Company/Agency/Site: \_\_\_\_\_

Location/Address: \_\_\_\_\_

AED Program Coordinator: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Program Manager/AED Management Service: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

AED Program Plan/Operational Protocols in place?  Yes  No

CPR/AED Training Completed?  Yes  No Local EMS Notified?  Yes  No

**Medical Authorization/Direction**

I hereby authorize the above site to acquire/order \_\_\_\_\_ AED(s).

Physician Name (PRINT): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

State: \_\_\_\_\_ License Number: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Post-incident AED Data Analyze will be performed by:

Physician/Service \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**SUDDEN CARDIAC ARREST/AED EVENT REPORT FORM**

**WORKING DRAFT**

Company/Agency/Site: \_\_\_\_\_

Location/Address: \_\_\_\_\_

Date of SCA: \_\_\_\_\_ Time of SCA: \_\_\_\_\_

Patient Age: \_\_\_ Sex: Male \_\_\_ Female \_\_\_ SCA: Witnessed \_\_\_ Not Witnessed \_\_\_

Name(s) of onsite responder(s):

- 1. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_ No \_\_\_
- 2. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_ No \_\_\_
- 3. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_ No \_\_\_
- 4. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_ No \_\_\_

Was CPR given before the AED arrived? Yes \_\_\_ How long? \_\_\_/min. No \_\_\_

Were shocks advised/given? Yes \_\_\_ How Many? \_\_\_ Not indicated \_\_\_ No \_\_\_ (why?)

Any problems/adverse effects encountered on scene?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was CPR continued after AED utilized? Yes \_\_\_ No \_\_\_ Not Needed \_\_\_

*On Scene Outcome...Did victim...*

Regain a heartbeat? Yes \_\_\_ No \_\_\_ Resume breathing? Yes \_\_\_ No \_\_\_ Regain consciousness? Yes \_\_\_ No \_\_\_

*If spontaneous breathing returned*

Was airway maintained after AED utilized? Yes \_\_\_ No \_\_\_ Not Needed \_\_\_

Responding EMS Service: \_\_\_\_\_ Estimated Response Time \_\_\_/min.

Receiving Hospital: \_\_\_\_\_

*Patient Outcome (if known):*

Discharged Alive \_\_\_ DOA at ER \_\_\_ Died in ER \_\_\_ Died within 24hrs. \_\_\_ Died after 24 hrs. \_\_\_  
Other \_\_\_\_\_

**To be completed by medical direction physician only**

- Time AED power on
- Time Pads attached to patient
- Initial Rhythm
- Shock Advised
- Time delivered
- Resulting Rhythm
- CPR Rate & Rhythm (if indicated)
- Impression re appropriateness of AED function
- Impression re appropriateness of responder action

*Physician completing this report:*

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**CPR/AED EMERGENCY RESPONSE DRILL**

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**PLANNING & EVALUATION CHECKLISTS**

**PLANNING CHECKLIST**

- Identify which team members will participate planning session
- Hold an emergency medical care drill planning session
- Determine the date, and time for the scheduled drill.
- Determine who will evaluate the drill
- Determine the nature of the “incident” and location
- Brief the “patient”(s) on the behaviors and “symptoms”
- Identify who will participate in the drill
- Determine who will be designated as the “team leader”
- Make available AED training unit and all appropriate forms
- Conduct the drill as scheduled
- Evaluate drill with all participants
  - What was done properly
  - What could have been better

**CPR/AED EMERGENCY RESPONSE DRILL**

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**EVALUATION CHECKLIST**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Team Leader: \_\_\_\_\_

Participants

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Evaluator \_\_\_\_\_

1. Did the "incident" occur at the scheduled time and place?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Did the "patient" perform as instructed?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Did appropriate person assume scene command?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Were responding the emergency team members assigned to specific duties and tasks appropriately?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Was scene assessed for hazards? Eliminated/controlled?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Was responsiveness/consciousness determined?

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Yes    No      Comments: \_\_\_\_\_

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7. Was EMS/911 “called” immediately?  
 Yes    No      Comments: \_\_\_\_\_

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8. Was AED on scene or immediately sent for?  
 Yes    No      (How long after drill begun? \_\_\_/min.)

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9. Was Airway properly assessed? Maintained?  
 Yes    No      Comments: \_\_\_\_\_

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10. Was Breathing properly assessed? Breaths properly provided?  
 Yes    No      Comments: \_\_\_\_\_

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11. Was Circulation properly assessed? Chest Compressions initiated?  
 Yes    No      Comments: \_\_\_\_\_

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12. Was a team member assigned to “document” the event?  
 Yes    No      Comments: \_\_\_\_\_

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13. Was CPR stopped after AED was powered on?  
 Yes    No      Comments: \_\_\_\_\_

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14. Was “patient” chest properly exposed?    Yes    No

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*if needed...*“cleaned”?  Yes  No

*if needed...*“shaved”?  Yes  No

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15. Were AED pads properly placed?  
 Yes  No      Comments: \_\_\_\_\_

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16. Were AED voice prompts properly followed?  
 Yes  No      Comments: \_\_\_\_\_

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17. After shocks were delivered or if “no shocks advised”, were ABCs properly assessed?  
 Yes  No      Comments: \_\_\_\_\_

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18. If needed, was CPR continued?  
 Yes  No      Comments: \_\_\_\_\_

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19. If breathing and heartbeat returned, was Airway maintained?  
 Yes  No      Comments: \_\_\_\_\_

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20. Was oxygen available on the scene? Administered properly?  
 Yes  No      Comments: \_\_\_\_\_

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21. Were any additional emergency supplies/equipment needed?  
 Yes  No      Comments: \_\_\_\_\_

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22. Did the response team members provide ongoing verbal support

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to the "patient"?

Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Were any inappropriate comments made either to the victim or other team members?

Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Was EMS involved in drill?  Yes  No

*If yes...were there any problems with "handoff"?*  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Did team leader maintain control of scene/team?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

26. Was AED and all equipment recovered, cleaned, and stored properly after the "incident"/drill?

Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

27. Was there a post-drill evaluation session?

Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

28. Which team members participated in the evaluation session?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Were the positive aspects of the drill reinforced?



**WORKING DRAFT**

Company/Agency/Site: \_\_\_\_\_

Location/Address: \_\_\_\_\_

Date of SCA: \_\_\_\_\_ Time of SCA: \_\_\_\_\_

Patient Age: \_\_\_\_ Sex: Male  Female  SCA Witnessed: Yes \_\_\_\_ No \_\_\_\_

**Name(s) of onsite responder(s):**

- 5. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_\_ No \_\_\_\_
- 6. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_\_ No \_\_\_\_
- 7. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_\_ No \_\_\_\_
- 8. \_\_\_\_\_ CPR/AED Trained? Yes \_\_\_\_ No \_\_\_\_

**Responder/Team Interview Questions**

- 1. Did appropriate person assume scene command?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 2. Were responding the emergency team members appropriately assigned to specific duties and tasks?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 3. Was scene assessed for hazards? Eliminated/controlled?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 4. Was responsiveness/consciousness determined?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 5. Was EMS/911 "called" immediately?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6. Was AED on scene or immediately sent for?  
 Yes  No      (How long after event begun? \_\_\_\_/min.)

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7. Was airway properly assessed? Maintained?  
 Yes     No    Comments: \_\_\_\_\_

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8. Was breathing properly assessed? Breaths properly provided?  
 Yes     No    Comments: \_\_\_\_\_

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9. Was circulation properly assessed? Chest compressions initiated?  
 Yes     No    Comments: \_\_\_\_\_

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10. Was a team member assigned to “document” the event?  
 Yes     No    Comments: \_\_\_\_\_

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11. Was CPR stopped after AED was powered on?  
 Yes     No    Comments: \_\_\_\_\_

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12. Was patient’s chest properly exposed?     Yes     No  
*if needed...“cleaned”?*     Yes     No  
*if needed...“shaved”?*     Yes     No

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13. Were AED pads properly placed?  
 Yes     No    Comments: \_\_\_\_\_

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14. Were AED voice prompts properly followed?  
 Yes     No    Comments: \_\_\_\_\_

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15. After shocks were delivered or if “no shocks advised”, were ABCs properly assessed?  
 Yes    No      Comments: \_\_\_\_\_

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16. If needed, was CPR continued?  
 Yes    No      Comments: \_\_\_\_\_

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17. If breathing and heartbeat returned, was airway maintained?  
 Yes    No    Not needed

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18. Was oxygen available on the scene? Administered properly?  
 Yes    No      Comments: \_\_\_\_\_

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19. Were any additional emergency supplies/equipment needed?  
 Yes    No      Comments: \_\_\_\_\_

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20. Was ongoing verbal support provided to the patient?  
 Yes    No      Comments: \_\_\_\_\_

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21. Were any inappropriate comments made either to the victim or other team members?  
 Yes    No      Comments: \_\_\_\_\_

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22. Did EMS arrive?  Yes  No   How long? \_\_\_\_/min.  
If yes...were there any problems with “handoff”?  Yes  No

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Comments: \_\_\_\_\_  
\_\_\_\_\_

23. Did team leader maintain control of scene/team?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_

24. Was AED and all equipment recovered, cleaned, and stored properly after the incident?  
 Yes  No      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Any problems/adverse effects encountered on scene?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***On Scene Outcome...Did victim...***

Regain a heartbeat? Yes\_\_ No\_\_ Resume breathing? Yes\_\_ No\_\_ Regain consciousness? Yes\_\_ No\_\_

Responding EMS Service: \_\_\_\_\_ Estimated Response Time \_\_\_/min.

Receiving Hospital: \_\_\_\_\_

***Patient Outcome (if known):***

Discharged Alive \_\_ DOA at ER \_\_ Died in ER\_\_ Died within 24hrs. \_\_ Died after 24 hrs. \_\_  
Other \_\_\_\_\_

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**Reviewer's Comments:**

*Include plans or suggestions to improve team/responder performance?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Draft Letter to Local EMS Announcing new AED Program

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*Feel free to make needed changes in the following letter and send it to your local EMS Service.*

Dear \_\_\_\_\_:

**We are pleased to inform you that our (*company/organization/church/etc.*) has inaugurated an AED Program at our location. We sincerely appreciate the outstanding emergency medical care that (*local EMS service*) provides to our community and are well aware of your excellent response time. However, we also know that in the event of a sudden cardiac arrest, the victim must receive CPR and early defibrillation as soon as possible in order to have the best chance that he/she will survive.**

**Our AED Program, including training, planning and the acquisition of a (*brand name*) AED was created to enhance our emergency medical preparedness and also help reduce premature cardiac death in our community. We recognize the importance of our role in our community's EMS System and we are proud to work with (*local EMS service*) to help save lives in our (*city/town/county*).**

**We cordially invite officials and/or EMS professionals from your service to pay us a visit in order to inspect our new emergency preparedness program and offer suggestions for how we can best work with EMS to help reduce premature cardiac death. Please call me to arrange a mutually convenient time for your visit.**

**We are truly grateful for your years of dedicated service to and protection of the people in our community. We look forward to working with and supporting (*local EMS service*) in that vital mission.**

**Sincerely,**