Print Form

Big Lakes Regional EMS Council

Regional Emergency Medical Services Council

Public Access Defibrillation Collaborative Agreement

It is the intent of _____**(Organization Name)** to provide public access defibrillation (PAD).

This service is being offered in cooperation with _____ **(Physician/Hospital)**.

In accordance with the provision of Chapter 552 of the Laws of 1998 and conditions set forth by Section 3000-B of Article 30 of the Public Health Law of the State of New York, our organization has:

- Identified a physician or hospital knowledgeable and experienced in emergency cardiac care to serve as our Emergency Health Care Provider (EHCP).
- Selected an AED that is in compliance with Article 30, section 3000-B, 1a. The AED will be programmed to the current Emergency Cardiovascular Care (ECC) Guidelines and will be capable of defibrillating both adult and pediatric patients and will comply with the WREMAC cardiac monitor/defibrillation specification policy and procedure **(Attachment 1)**.
- Selected a PAD training course for AED users that has been approved by the Department of Health (Policy #1 below).
- Provided written notice to 9-1-1 and/or the community equivalent ambulance dispatch entity of the availability of AED service at our organization's location **(Attachment 2)**.
- Filed with the Regional Emergency Medical Services Council (REMSCO) serving the area a copy of the "Notice of Intent to Provide PAD" (DOH 4135) along with a signed copy of this agreement.
- Agreed to participate in the required Quality Improvement Program by mailing the requested information each time the AED is used **(Attachment 3)**.
- Agreed to follow the practice protocol for use of the AED as developed with the EHCP.
- Agreed to file a new collaborative agreement with the REMSCO if the EHCP changes; and provide written notice of such change to the named EHCP below.

Policies:

1. It is the policy of our organization that persons providing PAD be properly trained. Therefore, all persons providing PAD shall be certified by the (check all that apply):

☐ American Heart Association	☐ National Safety Council	☐ REMSCO of NYC, Inc
☐ American Red Cross	☐ Emergency Services Institute	☐ EMS Safety Service, Inc
☐ American Safety & Health Institute	☐ Medic First Aid International	☐ State University of NY

2. It is the policy of our organization to ensure the rapid arrival of EMS. Therefore, 9-1-1 and/or the community equivalent ambulance dispatch entity will be called **immediately** when the AED is deployed. Our primary responding ambulance is_____**(Name of Ambulance Company)**.

3. It is the policy of our organization to conform with *NYS Public Health Law* Article 30 section 3(f) by placing a notice or sign at the main entrance of the facility and/or building in which the AED is stored, advising of its location.

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4. It is the policy of our organization to ensure the AED is in a state of readiness at all times. Therefore, all regular maintenance and checkout procedures of the AED will meet or exceed the manufacturer's recommendations. Documentation of such inspections shall be dated and maintained in a secure file for a period of three (3) years. Inspections shall be the responsibility of the agency's PAD Program Coordinator. The agency PAD Program Coordinator shall be _____.

5. It is the policy of our organization to ensure appropriateness in providing PAD. Therefore, our agency shall participate in the required Quality Improvement program as determined by the Regional Emergency Medical Services Council.

6. It is the policy of our organization to provide written notification of AED use to the EHCP and REMSCO within forty-eight (48) hours of the incident. Therefore, our agency shall report, at a minimum, the following information:

- Name of PAD program where AED was used;
- Location of the incident;
- Date and time of incident;
- Age and gender of the patient;
- Estimated time from arrest to CPR and the 1st AED shock;
- Number of shocks delivered to the patient;
- Name of the EMS agency that responded, and
- Hospital to which the patient was transported

Signed in agreement:

PAD Program Coordinator:

_____ _____ _____
Print Sign Date

PAD Agency CEO/Owner/General Manger:

_____ _____ _____
Print Sign Date

PAD EHCP:

_____ _____ _____
Print Sign Date

Attachment 1

Title: WREMAC Cardiac Monitor/Defibrillator Specifications for All New Equipment Purchases	**Effective Date: January 4, 2008** **Page 1 of 2**
Policy # 1997-2	**Revised: May 2004, January 2008**

Policy	All cardiac monitors / defibrillator equipment used in the WREMAC region shall be compliant with the specifications in the attached procedure.
Procedure	Follow attached guidelines
Reference	Western Regional Emergency Medical Advisory Committee (WREMAC) March, 2008 Minutes (approval)

	PROCEDURE:			
	Automated	**PAD/BLSFR/EMT-B**	**EMT-I**	**EMT-CC/P**
	Voice Prompts	Yes	Yes	Optional
	Visual Prompts	Yes	Yes	Optional
	Hands-Free Defibrillation	Yes	Yes	Optional
	Ability to Print Code Summary for Receiving Hospital Within 24 Hours	Optional	Optional	Yes
	Ability to Print Real-time Rhythm Strip	Optional (Device option may be available to CC/P and Credentialed I's only)	Optional (Device option may be available to CC/P and Credentialed I's only)	Yes
	Screen/Display to Monitor Rhythm	Optional (Device option may be available to CC/P and credentialed I's only)	Optional (Device option may be available to CC/P and credentialed I's only)	Yes
	Manual Operation (Adult & Pediatric)	Optional (Device option may be available to CC/P only and must be controlled by lockout/password)	Optional (Device option may be available to CC/P only and must be controlled by lockout/password)	Yes
	Synchronized Cardioversion (Adult & Pediatric)	Optional (Device option may be available to CC/P only and must be controlled by lockout/password)	Optional (Device option may be available to CC/P only and must be controlled by lockout/password)	Yes
	Pacing (Adult & Pediatric)	Optional (Device option may be available to CC/P only and must be controlled by lockout/password)	Optional (Device option may be available to CC/P only and must be controlled by lockout/password)	Yes
	Defibrillation	Yes	Yes	Yes

	(Adult & Pediatric)			
	Bi-Phasic Capabililty	Yes	Yes	Yes
	Waveform Capnography (Adult & Pediatric)	Optional (Device option may be available to I/CC/P only)	Yes	Yes
	12 Lead Monitoring Capability	Optional (Device option may be available to CC/P only and controlled by lockout/password)	Optional (Device option may be available to CC/P only and controlled by lockout/password)	Yes
	Ability to transmit 12-lead EKG	Optional (Device option may be available to CC/P only and controlled by lockout/password)	Optional (Device option may be available to CC/P only and controlled by lockout/password)	Recommended

Attachment 2

SAMPLE 911 or Ambulance Dispatch Letter

CURRENT DATE

JOHN DOE, Senior Dispatcher
XYZ Fire Control
City, State ZIP

To Whom It May Concern:

Please be advised that (NAME OF PAD AGENCY) has engaged in an agreement to provide Public Access Defibrillation (PAD). We are notifying you of this agreement pursuant to the requirements of New York State Public Health Law, Article 30, Section 3000-b and because you will serve as our 9-1-1 public safety answering point.

Our PAD Program Coordinator is Jane Doe and may be contacted by phone at 716-555-1212. Please feel free to call if you have any questions regarding our program.

Thank you very much for your time and attention.

Sincerely,

Jane Doe
PAD Program Coordinator

Attachment 3

UB|MD EMERGENCY MEDICINE EMS DIVISION

Notice of AED Use by PAD Agency

Name of PAD Site: _____

Location of Incident: _____ **City**: _____ **State**: _____ **Zip**: _____

Date of Incident: _____ **Time of Incident**: _____

Age of Patient (in years): _____ (approximate if unknown) **Sex (circle)**: MALE FEMALE

Witnessed arrest (circle): YES NO **Estimated time from arrest to CPR**: _____ **minutes**.

CPR initiated by (circle): BYSTANDER STAFF OTHER (specify) _____

Total number of shocks delivered by PAD agency: _____

Name of transporting ambulance service: _____

Hospital name where the patient was transported: _____

Patient outcome on scene (circle):

Regained pulse **Remained pulseless**

Became responsive **Remained unresponsive**

THIS SECTION IS TO BE COMPLETED BY EHCP for QI

Was code summary reviewed? YES NO If not, why? _____

Were actions appropriate? YES NO If not, why? _____

Was the agency contacted for follow-up? YES NO

Are there any unresolved issues with this incident? YES NO

If yes, what and how will they be addressed? _____

_____

Incident reviewed by: _____ Date: _____

Within 48 hours of AED use, please email this form & downloaded "code summary" to:

UBMD EMS Division
ATTN: Karen Broderick
EMAIL: UBMDEMS@Buffalo.edu

77 Goodell Street, Suite 420 ♦ Buffalo, New York 14203
♦ Phone: (716) 829-5500 Fax: (716) 645-9701
www.ubmdems.com