



2004
Defibrillation Section
Medcontrol Incorporated

Medical Directors Policies/Procedures/Protocols

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Revised: August 25, 2003
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1. On all possible vital signs absent (V.S.A.) calls, bring defibrillator, portable oxygen, bag valve mask (BVM) and suction device.
 2. Confirm ABC's and if patient is VSA, proceed to step 3. If a Second Responder is available to provide assistance, begin CPR, while proceeding to step 3 (give 100% oxygen, assist ventilation's with Bag Valve Mask with airway adjuncts, if available), (or use pocket mask).
 3. Turn AED on, attach electrodes and follow AED unit's visual and verbal prompts. **Clear any bystanders, from the patients' immediate area. Ensure responders are clear.**
 4. If **"Shock advised"** defibrillate at 200 Joules. (*This is the AED units' default settings*)
If **"Shock advised"** defibrillate at 300 Joules.
If **"Shock advised"** defibrillate at 360 Joules.

Check patient vital signs, if still VSA, then do CPR for one minute and follow instructions.

If **"Shock advised"** defibrillate at 360 Joules. (*This is the AED units' default setting*)

If **"Shock advised"** defibrillate at 360 Joules.

If **"Shock advised"** defibrillate at 360 Joules.

Check patient vital signs. If still VSA, resume CPR for one minute and follow instructions.

5. If at anytime during step 4, there is a **"No Shock Advised"**, then check patient pulse. If no pulse, resume CPR for one minute and follow instructions. Continue with these protocols until EMS arrival.
6. If patient has a pulse, follow rescue breathing rates (or hyperventilate with BVM @ 100% oxygen if available, and check vital signs frequently until EMS arrival.
7. If vomiting occurs during any step, clear the airway (finger sweep) or suction patient as needed.
8. After unit completes analyzing or shocking, transfer responsibility to EMS on their arrival. If responder is able to leave work site, provide assistance in patient care enroute to hospital with EMS.
9. Provide a verbal at the time of call to EMS and provide a written Medical Call Report to Medical Director following the call for auditing.



J.C. Fedoruk, B.A., LL.B., M.D.,
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.,
Medical Director

Policy

The provider will continue to treat the patient following established protocols unless the attending physician wishes to deviate from accepted protocols and assumes responsibility for the patient.

Procedure

1. Continue with established protocols while explaining that you are operating under the direction of the Medical Director, and that you are not to deviate from protocols.
 2. If the attending physician requests a deviation from accepted protocols then the provider must request the following information from the physician:
 - i. "Are you a **licensed Medical Doctor** in Ontario?"
If "Yes"
 - ii. "Are you taking **full responsibility** for the patient?"
- If "**Yes**" to all above questions, describe the function of the AED and assist the physician wherever possible. On the Medical Call Report (MCR), documentation of the policy deviation should provide the detail's of the patient care given.
 - If "**No**" to any of the above questions follow your established protocols.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-003

Subject: **Physicians Standing Orders on the Administration of Oxygen**

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Oxygen administered during an emergency is considered a first aid technique. Oxygen for all other purposes is a delegated medical act, requiring delegation.

Administer Oxygen to all patients, who are conscious by means of a non-rebreather Mask @ 100% Oxygen at 12-15 lt. /min. Administer Oxygen to all unconscious patients by means of a Bag Valve Mask (BVM) @ 100% Oxygen at 12-15 lt. /min. Ensure a patent airway is achieved by means of airway adjuncts. Be prepared to remove airway adjuncts and suction if patient vomits. Follow these orders unless any contradictions to the administration of Oxygen are present.

***Health Canada** recommends that any supplemental oxygen devices should be removed from anywhere near the victim's head and chest during the shock protocol.

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J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-004
Subject: **Age and Weight Protocols**
Date –March 01, 2002
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In keeping with the newest Emergency Cardiac Care Guidelines 2000, from the American Heart Association and the Canadian Heart and Stroke Foundation, the new guideline for the use of an AED will be:

NOT less than 8 years of age

With an approximate body weight not less 25 kg (55 lbs).

When dealing with children or small adults, use discretion in deciding to use the AED. For those who are younger than eight years, it is rare that the main source of the arrest is cardiac in nature. Usually, the primary cause of the arrest is trauma or respiratory related.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

1. When responding to a call where the patient is vital signs absent (VSA), the **responders should carefully and jointly assess** the condition of the patient and the circumstances surrounding the emergency call. If in doubt whether patient meets the following criteria follow defibrillation protocol #1-001.

On your initial survey and assessment, if the patient is found to be obviously dead, it is not necessary to begin CPR or attach the Defibrillator. Remain on the scene and report the treatment or circumstances to EMS and/or police.

2. The criteria for obvious death are the following:

- Decapitation
- Transection
- Decomposition /putrefaction
- Gross Rigor Mortis and Lividity (pooling of blood)
- Gross charring
- Gross protrusion of cranial or visceral contents
- Reported VSA for a period greater than 30 minutes from a creditable source, (in cases that no BLS attempts have been made).

In cases of obvious death with suspicious circumstances, contact police, take care to preserve the scene as found so as not to hinder the investigation of the police and or coroner. Documentation is required for these calls, place in comments section of the Medical Call Reports.

Special Cases, which may mimic Rigor Mortis:


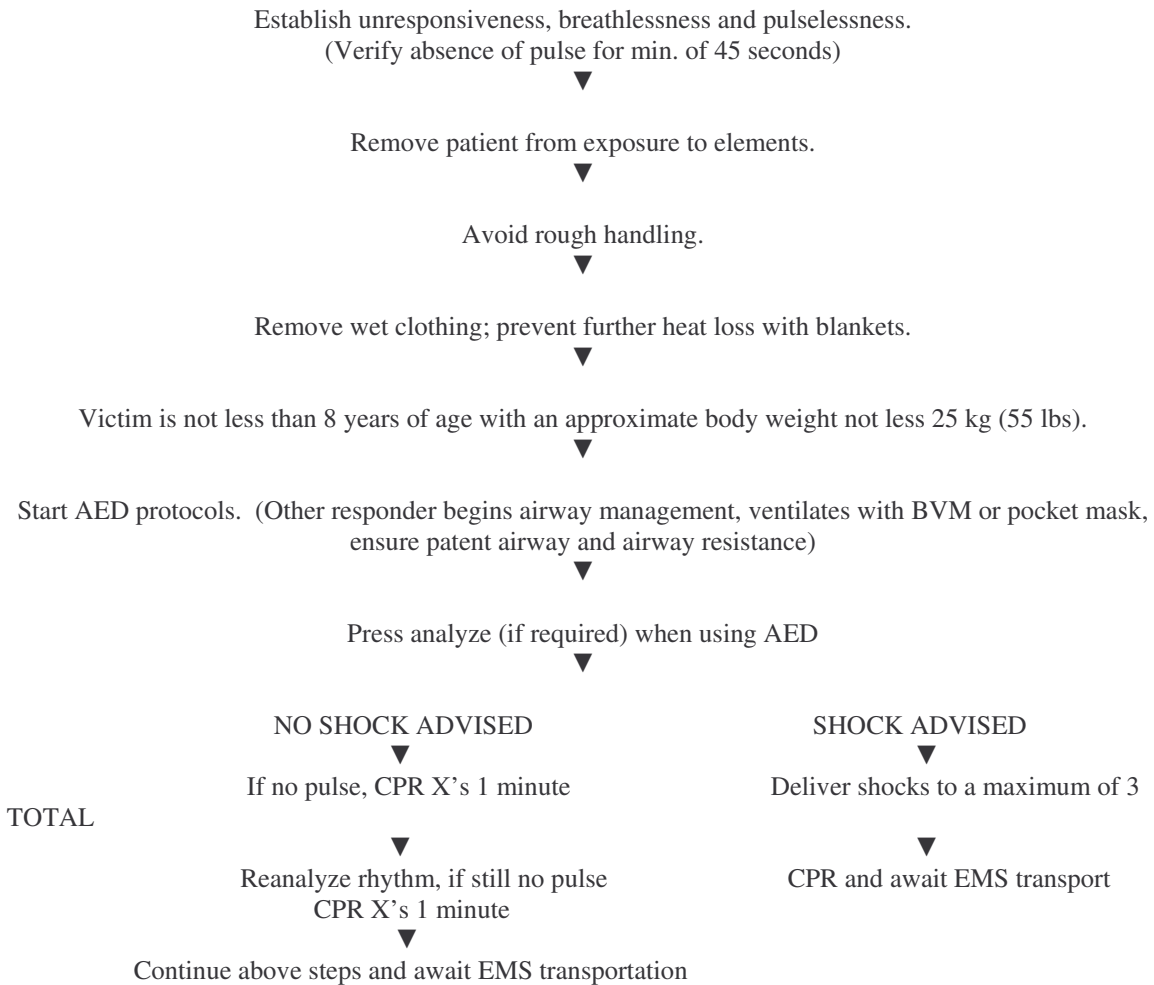
1. The patient is a victim of hypothermia (see #1-006 for treatment).
2. The patient is a victim of electrocution or lightning strike.

Such patients may appear dead, with fixed dilated pupils and stiffening.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

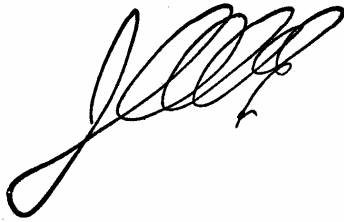
Hypothermia is a condition where a person's core body temperature has cooled to 35 degrees Celsius or less. This protocol refers to severe hypothermic patients. (Example: patient is VSA and is very cold to the touch.)



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-007
Subject: **Defibrillation in Pregnant VSA Patients**
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There is no change in defibrillation protocol for pregnant patients. Proceed as per VSA protocol #1-001
Physicians Standing Orders.

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J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-008

Subject: **Protocol on Do Not Resuscitate (DNR) Patients**

Date –March 01, 2002

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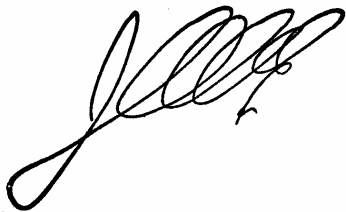
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In some instances you encounter patients who are expected to die (e.g. History of terminal cancer or terminal illness) but who are not obviously dead. Upon arrival credible family members and friends indicate that **no attempt** should be made at resuscitation. Some of these patients may have a written Advance Directive or a Do Not Resuscitation (DNR) order. Others may not have a written order, but the patient may have made their wishes known to family members. (These unwritten DNR orders are also valid.)

In these instances when the responders believe the DNR to be valid, a Basic Life Support assessment should be initiated. BLS procedures include assessing the airway, establishing breathlessness (look for normal signs of breathing only), and establishing pulselessness while awaiting the arrival of EMS. **No invasive procedures, (which includes, ventilating and CPR) will be attempted.** The Emergency Services personnel do not fall under the Ambulance Act but rather the Consent to Treatment Act.

This policy remains intact when assistance in performing invasive procedures is requested. If any issues or concerns arise, advise requesting agency that the Emergency Responders are following the Medical Directors orders.

Documentation will be required. This should include; name and relationship to the patient. This information should be entered into the comments section of the Medical Call Report.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-009

Subject: **Defibrillation on Metal Surfaces, in Standing Water, in Flammable Environments**

Date –March 01, 2002

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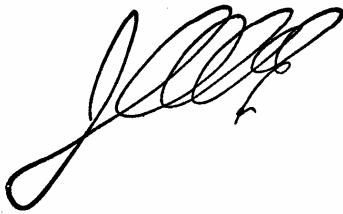
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Defibrillation on metal or conductive surface should be cautioned. Ideally, victims should be treated on concrete surfaces that do not conduct electricity, but metal platforms, grading and stretchers should not pose a risk to responders.

Do not defibrillate victims lying in a pool of standing water. Remove the victim if immersed in water before beginning defibrillation protocols. Even if the ground area is slightly wet or damp it should be safe to start defibrillation protocols.

Defibrillation in flammable areas or in enriched oxygen rooms or areas should not be attempted.

In all these cases, when in doubt move the patient to a safe area where there is no longer, any risk to either the patient or the rescuer.

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J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-010

Subject: **Defibrillation with Pacemakers or Automatic Implantable Cardio Defibrillators**

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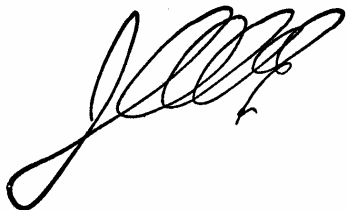
There is no change in protocol for these patients. Avoid putting defibrillation pads directly on the implanted devices. You must place electrodes away from the location site and maintain a space between the two electrodes to avoid electrical arcing. These devices are usually found in the following areas:

- a. Left upper chest
- b. Right upper chest
- c. Left upper abdomen

Implantable pacemakers send electrical impulses to stimulate the heart muscle to contract, when it is below a set rate. Pacemakers are inserted in several locations; you will find them below the left or right collarbones (upper chest area)

The Heart and stroke Foundation of Ontario (HSFO) states when a victim's heart rate exceeds a set rate, the AICD shocks the heart. After a certain number of shocks the AICD shuts itself off and resets. If the AICD is in its shock sequence while you are about to press the shock button, first let the AICD complete its cycle, which takes about 20-30 seconds. You will often be able to tell because you will see minor contractions in the chest area. There is no risk to you if the victims AICD shocks victim while you are doing CPR.

If pacemakers or implanted defibrillators are found on the patient, you should not place the electrode directly on top of the object. Place the electrode approximately 1-2 inches away from the devices and continue with protocol. Documentation of any delays in protocol due to an AICD is required on the MCR.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-011

Subject: **Defibrillation of Patients with Nitroglycerin Patches**

Date –March 01, 2002

Revised:

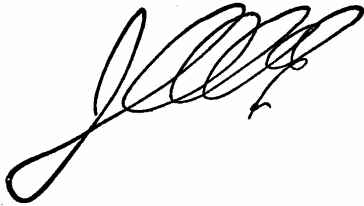
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There have been reports of nitroglycerin patches flaring up after coming into contact with high voltage defibrillation paddles during emergency resuscitation.

Responders should remove medication patches from the chest before attempting resuscitation. After removing, patch or paste, wipe off any residue with a cloth or tissue. Then safely discard it so that no one else is exposed to the substance. (Rescuers must use protective gloves and remove the medication carefully).

Nitroglycerin patches are often placed on the patient's arms and these do not need to be removed. Do not, waste time looking for nitro patches, if they are obvious on the chest remove them.

*Note: Remove all patches on the chest, responders may not be able to identify only nitro patches.

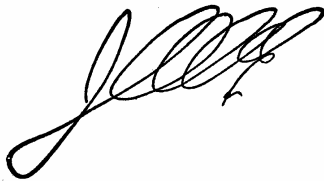
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J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

In all patients who are found to be VSA and trauma is suspected to be the primary cause:

- In the case of patients who have sustained blunt (direct) chest trauma the AED should be applied and the usual protocols should be followed.
- In the case of patients who have sustained only penetrating chest trauma (example-impaled object, knife or gunshot wounds) the patient should not have the AED applied.

Rapid transportation to hospital is the priority in severe multiple body system trauma. (CPR and specific trauma care may have a role in victims care if the victim is pulseless, defibrillation rarely does.)



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-013

Subject: **Treatment of Resuscitation Patients**

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If at any time during your treatment of a cardiac arrest patient, the patient regains a pulse the following should be done:

- Check the patient's respirations (e.g. quality and quantity) and ventilate if necessary.
- Administer oxygen (if available) via the appropriate adjunct
- Take the patient's vitals: pulse, respirations, skin condition.
- If unconscious, put the patient in the recovery position, injuries permitting.
- **MONITOR THE PATIENT'S PULSE AND RESPIRATIONS VERY CLOSELY.**
- Wait for the paramedics to arrive and give them a report of the incident and your actions.
- Complete the Medical Call Report and download LP 500.

If at any time the patient's pulse becomes unobtainable resume protocol #1-001.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-014

Subject: **Transfer of Care from Public Access Defibrillators to First Responders (FR)**

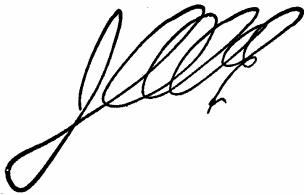
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1. First Responders will identify themselves to PAD Operator.
2. If PAD Operators AED is analyzing or if a “3” shock protocol is in progress, they will be allowed to finish. Responders will assist with protocol, care will be transferred only after a no shock advisory or if CPR is in progress.
3. The on scene AED protocol is now under direction of the First Responder.
4. VSA status is then confirmed by First Responders.
5. First Responders will have the option of having the PAD operator unplug their DISPOSABLE ELECTRODES, and shut their unit off. (First Responders may continue to use the PAD unit or the FR unit must be turned on and immediately ready for use before disconnecting patient from the initial AED.)
6. The First Responder plugs the electrodes into their respective unit and continues protocol. If AED electrodes are not compatible, open and attach electrodes and continue care.
7. The First Responder will replace the disposable electrodes (if applicable) to the PAD operator at the earliest opportunity.
8. The First Responders will download, document and ensure readiness.

Documentation will be required, enter in comments section of Medical Call Report.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-015

Subject: **Transfer of Care from First Responders (FR) to EMS**

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When the first response unit arrives on scene, ensure that EMS has access to driveways, sidewalks, secured entranceways and elevators.

When the fire service has initiated patient care and are waiting for EMS to arrive at patient's side, the first response service shall be prepared to give a full report to the EMS. Information such as the event history and what kind of patient care was given should be relayed to the EMS before they take responsibility for the patient. Once this has taken place, the transfer of care will now be given to the next level of authority.

During V.S.A. calls when an AED is in use, the following steps must be followed:

- If First Responder AED is analyzing or there are "3" shock protocols in progress, they will be allowed to finish. Care will be transferred only after a no shock advisory or if CPR is in progress.
- The on scene protocol is now under direction of the EMS.
- VSA status is then confirmed by EMS.
- EMS will have the First Responder operator unplug their DISPOSABLE ELECTRODES, and shut their unit off. (EMS unit must be turned on and immediately ready for use before disconnecting patient from the initial AED)
- EMS plugs the electrodes into their respective unit and continues protocol.
- First Responders will assist EMS personnel, and if required take over AED protocols if EMS's AED unit fails to work.
- EMS will replace the disposable electrodes (if applicable) to the First Responder operator at the earliest their opportunity.

Documentation of transfer of care should be entered on proper forms.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-016

Subject: **On/Off Duty Healthcare/ Emergency Services Personnel on Scene**

Date –March 01, 2002

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Where an On/Off Duty Healthcare/ Emergency Services Personnel are on scene and willing to assist with patient care, they may be permitted to do so at the discretion of the providers on scene. When EMS arrives, the paramedics on scene are the senior medical authority.

Procedure - No AED equipment in use

- Work co-operatively until the EMS arrives on scene and the transfer of responsibility takes place.
- If the On/Off Duty Healthcare/ Emergency Services Personnel assistance is **not** helpful, the providers on scene will insist that they cease patient care allowing the provider to take over until EMS arrive.

Procedure - AED equipment in use

- Responders will assist; ensuring defibrillation protocols follow safe practices.
- Responders will ask and take over protocols if on/off duty staff equipment breaks down.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #1-017

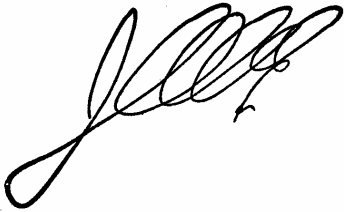
Subject: **Universal Safety Precautions**

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1. Consider all patients' blood and body fluids as bio-hazardous material.
2. Always wash hands after contact with a patient and immediately after contact with any blood any or body fluids.
3. Wear latex/nitrile gloves to prevent contact with blood and/or body fluids at all times.
4. Avoid mouth to mouth contact during resuscitation - have a resuscitation device such as a bag-valve-mask or pocket mask available.
5. Avoid contact with soiled articles such as clothing and linen or bandages. Wrap in plastic and label as bio-hazardous materials.
6. Wear eye and mouth mask, or eye protection to avoid any splashing.
7. Complete documentation of any exposure and follow health and safety guidelines as established by your service.
8. Replace disposable equipment and follow Manufacturers recommendations for deep cleaning of patient care equipment following any contact with any bio-hazardous material.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P.(E.M.), F.A.C.E.P., F.C.L.M.,
Medical Director

Defibrillation Protocol #2-001
Subject: **Data Transfer of SCA Cases**
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Procedures for coordinating and maintaining your LP 500 data are the responsibility of each agency. Information for your defibrillator must be downloaded and sent to your Medical Director. Ways of retrieving this information can be done by instituting the Data Transfer 500 software, direct printer from defibrillator and the code-stat suite. Either way, an electronic or hardcopy of the call information will need to be forwarded to the Medical Director for review.

If any problems are experienced in sending or retrieving the data, after exhausting your agencies resources, contact can be made to M.C.I.

As a reminder, the Medical Call Report (MCR) shall be forwarded at the same time.

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J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #2-002

Subject: **Certification Requirements**

Date –March 01, 2002

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Preamble

Defibrillation is a controlled medical act, (training, retraining, testing and quality assurance fall under the direct responsibility of the Medical Director). A provider may be certified in defibrillation only after successfully completing a training program and a testing process approved and supervised by the Medical Director or his/her Designate. Since providers will be performing defibrillation under the license of the Medical Director any changes to the certification status of a provider will be made at the discretion of the physician. **Certification is valid for one year.**

Definition of terms

Certification:

A provider is certified to perform defibrillation under the license of the AED Medical Director

Decertification:

A provider has his/her certification to perform the act of defibrillation rescinded indefinitely by the Medical Director.

Recertification:

A provider, who was decertified, has his/her defibrillation privileges reinstated. Recertification also refers to the training of providers once they have achieved their initial certification. Recertification must occur every year.

Deactivation:

A provider is temporarily not allowed by the Medical Director to perform defibrillation until otherwise directed.

Reactivation:

A provider is allowed by the Medical Director to resume performing defibrillation.



J.C. Fedoruk, B.A., LL.B., M.D.

C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.

Medical Director

To ensure continuity with Provincial Guidelines the following will be reviewed prior to acceptance into any course programs.

<i>Provider</i>	<i>Instructor</i>	<i>Instructor-Trainer</i>
Anyone who may have access to an AED, current minimum Heart Saver Level A. (One year certification)	Hold current AED provider and BLS CPR Instructor. (Three year certification)	Hold current BLS Instructor Trainer and AED Instructor. (This status is appointed and maintained by the Medical Director)

Guidelines

Course Times

1. First Responder Rapid Defibrillation Program- Initial Certification (8 Hrs). (*expanded content which includes Oxygen Therapy and Airway Management not for PAD programs*)
2. First Responder (Re-cert. 3- 4 Hrs)
3. LP 500 PAD Program (4-6 Hrs)
4. LP 500 PAD Re-cert. (3-4 Hrs.)

Cardiopulmonary Resuscitation (CPR) and Defibrillation Guidelines

Courses will follow the current and accepted Heart & Stroke Foundation of Ontario (HSFO) Guidelines.

Defibrillation

After review of provincial training standards we will continue to authorize course delivery within the above time frames, class size remains unchanged.



J.C. Fedoruk, B.A., LL.B., M.D.
C.C.F.P. (E.M.), F.A.C.E.P., F.C.L.M.
Medical Director

Defibrillation Protocol #2-004
Subject: **Instructor Certification Requirements**
Date –March 01, 2002
Revised: August 12, 2003
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Our policy regarding the minimum prerequisites to become an AED Instructor are:

1. Current CPR BCLS Instructor Certification
2. Current Provider Certification on the LifePak 500 Unit

This policy is considered the accepted standard following the Emergency Cardiac Care guidelines 2000, and the National and Provincial approved guidelines from Heart and Stroke Foundation.

On occasions, instructors may find themselves in a situation where they have missed the date to re-certify. An expired instructor may have the opportunity to re-certify as long as it is within six (6) months of the expiry date as well as they are still current as a CPR instructor. (Documentation of certification is required). The re-certification course may vary in time and content due to deviation/development and changes in the program.

*** Instructor Certification upon completion of initial monitoring will have a three-year period of certification. Within this three-year period a minimum number of six classes must be taught. When offered instructor renewal/update workshops must be attended.**

Defibrillation Protocol #2-005

Subject: **Operators Daily/ Weekly LP 500 Checklists**

Date –March 01, 2002

Revised: August 25, 2003

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The original **LifePak 500 Operator Checklist** indicates turning the unit “on” to perform a self-test daily. This is no longer required since all services are using the lithium battery, and the unit already performs a default self test at 3:00 am every morning. It is therefore only necessary to “power on” the machine **once a week**. Please insure the correct time and date from the established reference source, has been set during this weekly inspection.

Readiness symbol and electrodes expiry dates will be visually inspected daily with staffed services. This corresponds with the manufacturer protocols for lithium batteries. If this policy is adhered to, it will considerably extend the life of the battery.

Please be reminded that service messages and message indicating low battery, replace battery, should be reported immediately. Ensure to refer to the manufacturers’ trouble shooting procedures. Contact manufacturer for replacement of equipment if situation is not remedied. Refer to policy #2-008 for contact information.

Defibrillation Protocol #2-006

Subject: **Save Pin**

Date –March 01, 2002

Revised: August 25, 2003

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➔ **A save pin & certificate will be awarded to Firefighters/First Responders**

If patient was pulseless at any period from the time from arrival at scene to arrival at hospital.
Patient is later defined as a save; all who had direct patient care will receive a pin.

➔ **A certificate will be awarded to Public Access Defibrillation Responders**

If the PAD responders have already restored a pulse and patient maintains a perfusing rhythm to arrival at Hospital; if bystander delivers any shocks; if bystander does any component of CPR:

- Patient is later defined as a save
- The rescuer/PAD responder receives a pin.

Defibrillation Protocol #2-007

Subject: **Medical Call Reports (MCR)**

Date –March 01, 2002

Revised: August 25, 2003

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The following are recommended guidelines to documentation done by first responder agencies on medical assist reports.

- It is the responsibility of defibrillator operators to complete the Medical Call Report (MCR).
- A MCR shall be completed on every medical call that involves any Vital Signs Absent (VSA) patient.
- All reports shall be done in blue or black ink or electronically when available.
- All sections of the form are to be filled out. (any sections that are not applicable (N/A) or “unknown” shall be marked accordingly).
- The hard copy form shall be done by one person and signed by that person.
- Information such as times, ambulance run numbers and benchmarks should be provided by your dispatch centre.
- Once the form is filled out, it becomes a confidential document. Confidentiality of the patient must be respected at all times.
- The Medical Call Reports must be sent to M.C.I. with defibrillator information (if applicable), as soon as possible.
- A procedure will be established for each First Response Agency for the delivery method of the MCR.

Defibrillation Protocol #2-008
Subject: **LifePak Product Technical Service**
Date –March 01, 2002
Revised: August 4, 2003
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PROCESS FOR SENDING UNITS TO BE REPAIRED

Should any LifePak require repair:

- 1) Call 1-800-217-1617 extension 5348, at which point you will inform the technical department at Medtronic Physio Control of the incoming defibrillator and the problem, which has been experienced.
- 2) They in turn will provide you with a return authorization code. After receiving this code, the machine should be priority shipped to:

Medtronic Physio Control

6733 Kitimat Road
Mississauga, ON
L5N 1W3

- 3) Should you need a loaner, inform the company as soon as possible.

Should problems remain unresolved please feel free to contact M.C.I. and we will attempt to facilitate an acceptable resolution.