**Calvert County Public Schools**
**1305 Dares Beach Road**
**Prince Frederick, MD 20678**

**Administrative Procedures for Policy #3915 (students) of the Board of Education Regarding Automated External Defibrillators in Calvert County Public Schools**

I. Purpose

To provide Calvert County Public School employees trained in cardiopulmonary resuscitation and the operation and use of automated external defibrillators (AED) with guidelines for the use of AED units in the event of a cardiac arrest emergency

To establish guidelines for the application, location, and maintenance of AED units

II. Definitions

Automated External Defibrillator - A medical heart monitor and defibrillator that is cleared for market by the federal Food and Drug Administration; recognizes the presence or absence of ventricular fibrillation or rapid ventricular tachycardia; determines, without the intervention by an operator, whether defibrillation should be performed; on determining that defibrillation should be performed, automatically charges; and requires operator intervention to deliver the electrical impulse; or automatically continues with delivery of electrical impulse

Automated External Defibrillator Program – a plan for providing AED services which complies with all State of Maryland certification requirements

Employee - an individual whose compensation is paid by the Calvert County Public Schools

III. Roles and Responsibilities

A. Calvert County Public Schools will comply with the Maryland Institute of Emergency Medical Services Systems (MIEMSS) requirement to have a medical advisor for the AED program. The medical advisor has ongoing responsibility for:

1. Providing medical direction for use of AEDs

2. Reviewing each incident in which an AED was operated

B. The Community Resource and School Safety Specialist, with the assistance of the athletic supervisor and school health supervisor, will provide central AED program coordination. Responsibilities include:

1. Selection of employees for AED training and distribution of AED-trained employee lists as required

2. Coordination of AED training for school emergency responders

3. Revision of this procedure as required

4. Monitoring the effectiveness of the AED program

5. Communication with the medical advisor on issues related to the medical emergency response program, including post-event reviews

6. Maintaining the certificate issued by MIEMSS in a place where it is readily available

7. Instituting remedial action as necessary to resolve any issues of compliance with Title 30 MIEMSS Subtitle 06 AED Program

C. The principal/designee of a school equipped with an AED will provide AED program coordination for his/her individual school. Responsibilities include:

1. Encouraging all coaches, physical education teachers, athletic trainers, and any individuals identified by the Community Resource and School Safety Specialist to be AED certified

2. Maintaining required records related to certification

3. Ensuring that all equipment and supplies are present and working correctly

4. Maintaining a file with specifications/technical information sheets for each AED unit assigned to the school

5. Maintaining records related to testing/proper functioning of AEDs and the presence of required equipment as needed if an AED or supplies are used

6. Obtaining maintenance and replacement as needed if an AED or supplies are used

7. Ensuring that all procedures and plans related to the AED are included in the school emergency plan

IV. Location of AEDs

A. AEDs will be located, at a minimum, in each Calvert County public secondary school

B. The principal/designee will determine the location of AEDs in his/her building

C. The location of AEDs should provide optimal accessibility to individuals to operate them and allow staff members to retrieve the device outside of normal school hours if necessary

D. After school hours, an AED should be moved from its designated location by the Athletic Director or coach to support athletic department activities

1. The secondary school principal or designee will ensure that an individual trained in the operation and use of an AED is present at each home s school athletic event

2. If removed from its designated location, the AED must be signed out. Information regarding the responsible person, the time it was removed, the location to which it has been taken, and the estimated time it will be returned must be left in the designated location. (See Attachment 1 – AED Sign Out Sheet)

E. CCPS is not responsible for providing or insuring access to AEDs or AED services to organizations that use the school buildings after school hours.

V. CCPS Designated AED Users

Trained administrators, athletic directors, coaches, physical education teachers, school nurses, safety advocates, and school personnel who have current AED certification are designated to use the AED on school property

VI. Use of the AED

A. The AED should be used on any person (age 8 or above) who displays ALL the symptoms of cardiac arrest. The AED should be placed only after the following symptoms are confirmed:

1. Victim is unresponsive

2. Victim is not breathing, or is breathing ineffectively

3. Victim has no signs of circulation, such as pulse and coughing, or movement

B. The individual using the AED must strictly comply with the directions automatically provided by the unit.

C. It may also be necessary to provide prompt basic life support, such as cardiopulmonary resuscitation, in conjunction with AED use.

D. Someone should be immediately directed to call Emergency Medical System (EMS – 911) if an AED is used.

E. Upon their arrival, the EMS staff assumes care and responsibility for the victim.

VII. Post-Event Review and Quality Assurance Program

A. The principal/designee shall conduct and document the post-event review (See Attachment 3) to learn from the experience following each use of an AED. The principal/designee will complete the Maryland Facility AED Report Form for Cardiac Arrest. (See Attachment 2)

B. All key participants in the event shall participate in the review, including the individual operating or responding with the AED, the Community Resource and School Safety Specialist, and the medical advisor.

C. Included in the review shall be the identification of actions that went well and the collection of opportunities for improvement as well as critical incident stress debriefing.

D. A summary of the post-event review shall be sent to the Community Resource and School Safety Specialist, Principal, Director of Student Services, Deputy Superintendent, and MIEMMS.

E. If the post-event review determines that inappropriate use occurred, the Community Resource and School Safety Specialist will submit a report to the state EMS medical director summarizing conclusions of the review.

F. If the AED fails when operated, the Community Resource and School Safety Specialist will submit the required report to the federal Food and Drug Administration. A copy of this report will also be sent to the state EMS medical director. (Med Watch FDA Safety Information & Adverse Event Reporting Program – see Attachment 4)

G. The Community Resource and School Safety Specialist will maintain a copy of the post-event review summary for seven (7) years.

VIII. Training

A. Initial Training

1. The secondary school health and physical education teachers currently trained to provide Red Cross AED training will provide initial training to all administrators, athletic directors, coaches, and other staff designated by the Community Resource and School Safety Specialist/school principal as part of CPR training.

2. Newly hired administrators, athletic directors, and coaches could be asked to complete an AED training program before assuming responsibilities at athletic events.

3. The athletic director at each school will be responsible for insuring that training takes place. Training will include, but not be limited to:

(a) Assessment of the unconscious person to determine if cardiac arrest has occurred, and the appropriateness of applying an AED

(b) Safety precautions that enable the responder to use the AED without jeopardizing the safety of the patient, the user, or other individuals

(c) Recognizing that the electrical shock has been delivered and that the defibrillator is no longer charged

(d) The use of cardiopulmonary resuscitation (CPR) support in conjunction with the AED as appropriate.

(e) The responsibility to continue care until the arrival of EMS staff

(f) The principal/designee of each school with an AED will maintain training records for each individual in his/her school using the AED Operator Training Recognition Form. (See Attachment 5)

B. Recertification

All administrators, athletic directors, coaches, physical education teachers, school nurses, safety advocates and any school personnel designated by the Community Resource and School Safety Specialist will complete an annual/biannual recertification as part of their CPR certification.

IX. Equipment

A. AEDs that are compatible with local EMS emergency response equipment will be used.

B. Supplemental equipment to be kept with each AED include:

1. Two (2) sets of defibrillator chest pads

2. Disposable, latex-free gloves

3. Maryland Facility AED Report Forms for Cardiac Arrests

X. Equipment Checks and Maintenance

A. All equipment and accessories necessary for support of medical emergency response shall be maintained in a state of readiness.

B. The individual school principal/designee will be responsible for AED checks. AED checks are done weekly 12 months per year. AED checks are to be recorded on the AED Weekly Safety Inspection Record and submitted to the school principal/designee every month. (See Attachment 6)

C. The individual school principal/designee shall be responsible for having regular equipment maintenance performed as necessary.

D. All maintenance tasks shall be performed according to equipment maintenance procedures as outlined in the AED units operating instructions.

E. Following use of emergency response equipment, all equipment shall be cleaned and/or decontaminated as required.

**Attachment 1**

# AED Sign-Out Sheet

| Person Responsible | AED Location | Date & Time Removed | Date & Time Returned |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Attachment 2**

***CONFIDENTIAL***

*For Official Use Only*
M-CAPD #_____
Facility CA Form #_____
MAIS Form #_____

**MARYLAND FACILITY AED REPORT FORM FOR CARDIAC ARRESTS**

To be completed immediately after a cardiac arrest occurs at your facility or the facility AED is put on a patient
Form should be filled out by the main caregiver at the scene & the Facility AED Operator and returned to MIEMSS **within 48 hours**
**Please Return Completed Form with your AED Summary Report and copy of FDA Incident Form (if applicable) to:**
**Maryland Institute for Emergency Medical Services Systems (MIEMSS)**
**653 West Pratt Street Baltimore MD 21201 Attention: Epidemiology / M-CAPD Study**
**Fax: (410) 706-4366**

1.Facility Name: _____

2.Incident Location: _____
*Street address*

_____
*City* *State* *ZipCode* *County*

3. Date of Incident: ____/____/____
*Mo.* *Day* *Yr.*

4.Estimated Time of **Incident**: ____:____a.m. /p.m. 4a.Estimated Time that **911 Call** was placed: ____:____a.m. / p.m.
*Hr.* *Min.* *Hr.* *Min.*

5. Name of Patient: _____
*First* *Middle* *Last*

6. Patient Gender: Male[ ] Female[ ] 7. Estimated Age of Patient: _____Yrs.

8. Did the patient collapse (become unresponsive, i.e., no breathing, no coughing, no movement)? Yes[ ] No[ ]

8a. If Yes, what were the Events immediately prior to the collapse (check all that apply):
Difficulty Breathing [ ] Chest Pain [ ] No Signs or Symptoms[ ] Drowning [ ]
Electrical Shock [ ] Injury [ ] Unknown [ ]

8b.Was someone present to see the person collapse? Yes[ ] No[ ]
If yes, was that person a trained AED Employee? Yes[ ] No[ ]

8c. After the collapse, at the time of Patient Assessment and just prior to the Facility AED pads being applied,
Were there signs of circulation (breathing, coughing, movement)? Yes[ ] No[ ]
Was pulse checked? Yes[ ] No[ ]
If yes, did the person have a pulse? Yes[ ] No[ ]

9. Was CPR given prior to 911 EMS arrival? Yes[ ] Go to #9a No[ ] Go to #10
9a.Estimated time CPR Started: ____:____a.m. / p.m.
*Hr.* *Min.*
9b. Was CPR started prior to the Arrival of a Trained AED Employee? Yes[ ] No[ ]
9c.Who *Started* CPR? Bystander[ ] Trained AED Employee[ ]

10. Was a Facility AED brought to the patient's side prior to 911 EMS arrival? Yes[ ] No[ ]
10a. If No, Briefly describe why and skip to question 17:_____
10b. If Yes, Estimated Time (based on your watch) Facility AED at patient's side: ____:____a.m. /p.m.
*Hr.* *Min.*

**TURN OVER and COMPLETE BOTH SIDES**

Facility Name_____

**Attachment 2 (cont'd)**

## *CONFIDENTIAL*

11. Were the Facility AED Pads put on the patient? Yes[ ] No[ ]

11a. If Yes, Was the person who put the AED pads on the patient a:
Trained AED Facility Employee[ ] Untrained AED Facility Employee[ ] Bystander[ ]

12. Was the Facility AED turned on? Yes[ ] No[ ]

12a. If Yes, Estimated Time (based on your watch) Facility AED was turned on: ____:____a.m. /p.m.
*Hr. Min.*

13. Did the Facility AED ever shock the patient? Yes[ ] No[ ]
If Yes,

13a. Estimated time (based on your watch) of 1st shock by facility AED: ____:____a.m. / p.m.
*Hr. Min.*

13b. If shocks were given, how many shocks were delivered prior to the EMS ambulance arrival? #_____

14. Name of Person operating the Facility AED:_____
*First Middle Last*

14a. Is this person a trained AED employee? Yes[ ] No[ ]

14b. Highest level of medical training of person administering the Facility AED:
Public AED Trained[ ] First Responder AED Trained[ ] EMT-B [ ] CRT/EMT-P[ ]
Nurse/Physician [ ] Other Health Care Provider [ ] No Known Training[ ]

15. Was there any mechanical difficulty or failure associated with the use of the Facility AED? Yes[ ] No[ ]

15a. If Yes, Briefly explain and attach a copy of the completed FDA reporting form (required by Federal law).

_____

_____

16. Were there any unexpected events or injuries that occurred during the use of the Facility AED? Yes[ ] No[ ]

16a. If yes, Briefly explain:_____

_____

17. Indicate the patient's status at the time of the 911 EMS arrival:

| | | | | | *Hr.* | *Min.* |
|---|---|---|---|---|---|---|
| 17a. Pulse restored: | Yes [ ] | No [ ] | Don't Know [ ] | If Yes, Time Pulse Restored: | __ __ | __ __ |
| 17b. Breathing restored: | Yes [ ] | No [ ] | Don't Know [ ] | If Yes, Time Breathing Restored: | __ __ | __ __ |
| 17c. Responsiveness restored: | Yes [ ] | No [ ] | Don't Know [ ] | If Yes, Time Patient Responsive: | __ __ | __ __ |
| 17d. Signs of circulation: | Yes [ ] | No [ ] | Don't Know [ ] | If Yes, Time Circulation Returned: | __ __ | __ __ |

18. Was the patient transported to the hospital? Yes[ ] No[ ]

18a. If Yes, How was the patient transported? EMS Ambulance[ ] Private Vehicle[ ] Other_____

---

Report Completed by:_____
*Please Print Name* *Date*

_____ _____
*Signature* *Date*

_____ _____
*Title* *Office Phone*

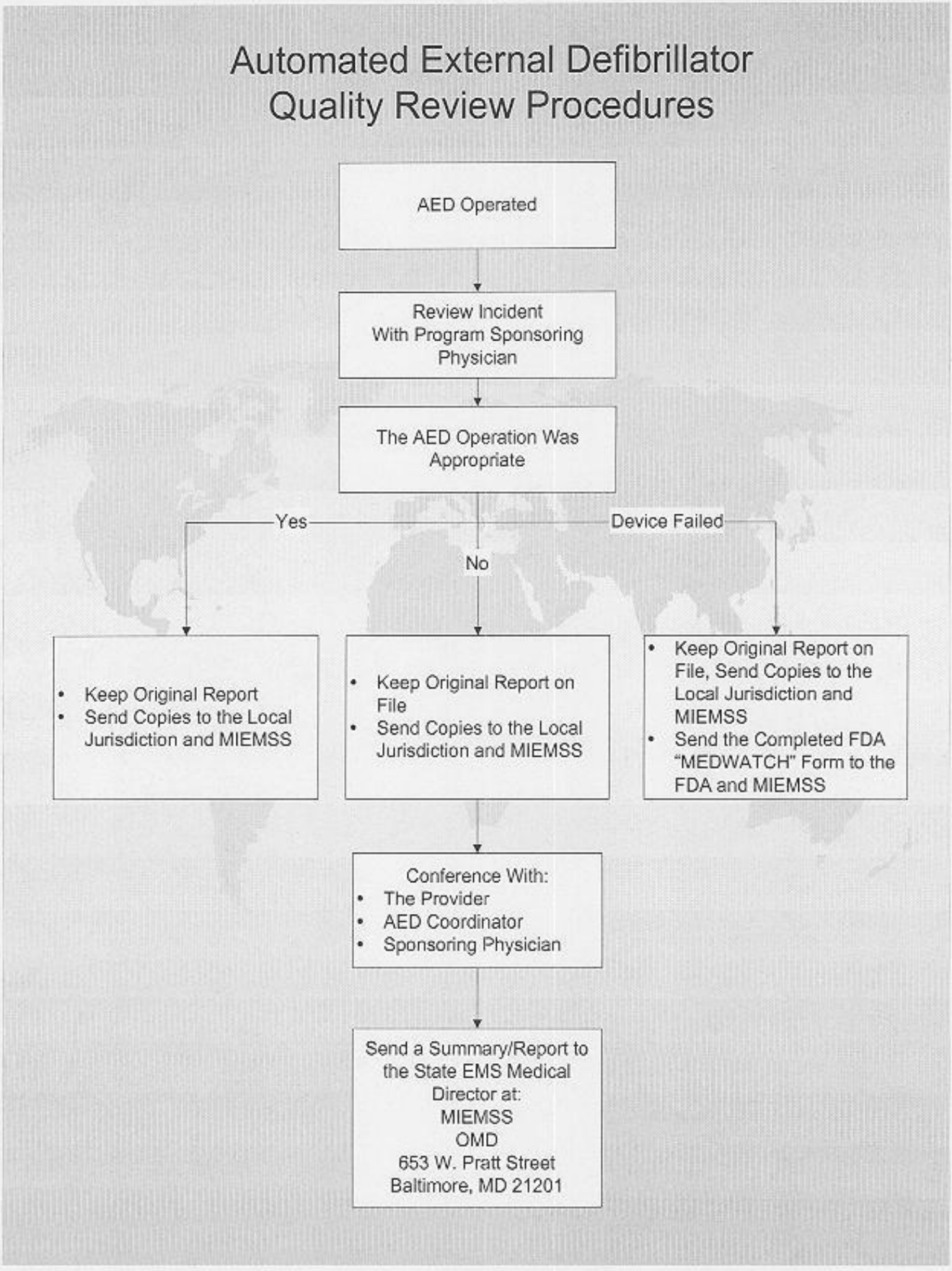
*Make/Model of the Facility AED that was used?*_____
*Manufacturer Make* *Model #*

**Was a Rural Health Grant funded AED used at the scene? (i.e., Was there a MR-AED sticker on the AED?) Yes [ ] No [ ]**
**If yes, by whom? Police Mobile Unit[ ] Emergency Roadside Assist [ ] Public Access Facility [ ]**

**RETURN TO MIEMSS WITHIN 48 HOURS FOLLOWING INCIDENT: FAX (410) 706-4366**
**QUESTIONS? CONTACT MIEMSS Office of Epidemiology at PHONE: (410) 706-4193**

Facility Name_____

**Attachment 3**



**Attachment 4**

Form Approved: OMB No. 09 10-029 1. Expires 12/31/11
See OMB statement on reverse.

U.S. Department of Health and Human Services
Food and Drug Administration

# MEDWATCH

**FORM FDA 3500A (1/09)**

For use by user-facilities, importers, distributors and manufacturers for MANDATORY reporting

Page 1 of ____

MFR Report #

UF/Importer Report #

FDA Use Only

PLEASE TYPE OR USE BLACK INK

## A. PATIENT INFORMATION

| 1. Patient Identifier | 2. Age at Time of Event: or Date of Birth: | 3. Sex | 4. Weight |
|---|---|---|---|
| In confidence | | ☐ Female ☐ Male | ____ lbs or ____ kgs |

## B. ADVERSE EVENT OR PRODUCT PROBLEM

1. ☐ Adverse Event and/or ☐ Product Problem (e.g., defects/malfunctions)

2. Outcomes Attributed to Adverse Event (Check all that apply)

- ☐ Death: _____ (mm/dd/yyyy)
- ☐ Disability or Permanent Damage
- ☐ Life-threatening
- ☐ Congenital Anomaly/Birth Defect
- ☐ Hospitalization - Initial or prolonged
- ☐ Other Serious (Important Medical Events)
- ☐ Required Intervention to Prevent Permanent Impairment/Damage (Devices)

| 3. Date of Event (mm/dd/yyyy) | 4. Date of This Report (mm/dd/yyyy) |
|---|---|
| | |

5. Describe Event or Problem

6. Relevant Tests/Laboratory Data, Including Dates

7. Other Relevant History, Including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

**Submission of a report does not constitute an admission that medical personnel, user facility, importer, distributor, manufacturer or product caused or contributed to the event.**

## C. SUSPECT PRODUCT(S)

1. Name (Give labeled strength & manufacturer)

#1

#2

| 2. Dose, Frequency & Route Used | 3. Therapy Dates (if unknown, give duration) from/to (or best estimate) |
|---|---|
| #1 | #1 |
| #2 | #2 |

| 4. Diagnosis for Use (Indication) | 5. Event Abated After Use Stopped or Dose Reduced? |
|---|---|
| #1 | #1 ☐ Yes ☐ No ☐ Doesn't Apply |
| #2 | #2 ☐ Yes ☐ No ☐ Doesn't Apply |

| 6. Lot # | 7. Exp. Date | 8. Event Reappeared After Reintroduction? |
|---|---|---|
| #1 | #1 | #1 ☐ Yes ☐ No ☐ Doesn't Apply |
| #2 | #2 | #2 ☐ Yes ☐ No ☐ Doesn't Apply |

9. NDC# or Unique ID

10. Concomitant Medical Products and Therapy Dates (Exclude treatment of event)

## D. SUSPECT MEDICAL DEVICE

1. Brand Name

2. Common Device Name

3. Manufacturer Name, City and State

| 4. Model # | Lot # | 5. Operator of Device |
|---|---|---|
| Catalog # | Expiration Date (mm/dd/yyyy) | ☐ Health Professional ☐ Lay User/Patient ☐ Other: |
| Serial # | Other # | |

| 6. If Implanted, Give Date (mm/dd/yyyy) | 7. If Explanted, Give Date (mm/dd/yyyy) |
|---|---|
| | |

8. Is this a Single-use Device that was Reprocessed and Reused on a Patient?
☐ Yes ☐ No

9. If Yes to Item No. 8, Enter Name and Address of Reprocessor

10. Device Available for Evaluation? (Do not send to FDA)
☐ Yes ☐ No ☐ Returned to Manufacturer on: _____ (mm/dd/yyyy)

11. Concomitant Medical Products and Therapy Dates (Exclude treatment of event)

## E. INITIAL REPORTER

| 1. Name and Address | Phone # |
|---|---|
| | |

| 2. Health Professional? | 3. Occupation | 4. Initial Reporter Also Sent Report to FDA |
|---|---|---|
| ☐ Yes ☐ No | | ☐ Yes ☐ No ☐ Unk. |

**Attachment 4 (cont'd)**

# MEDWATCH

**FORM FDA 3500A (1/09)** *(continued)* Page 2 of ____

FDA USE ONLY

## F. FOR USE BY USER FACILITY/IMPORTER *(Devices Only)*

1. Check One ☐ User Facility ☐ Importer
2. UF/Importer Report Number
3. User Facility or Importer Name/Address
4. Contact Person
5. Phone Number
6. Date User Facility or Importer Became Aware of Event *(mm/dd/yyyy)*
7. Type of Report ☐ Initial ☐ Follow-up # ____
8. Date of This Report *(mm/dd/yyyy)*
9. Approximate Age of Device
10. Event Problem Codes *(Refer to coding manual)* Patient Code ___ - ___ - ___ Device Code ___ - ___ - ___
11. Report Sent to FDA? ☐ Yes ____ *(mm/dd/yyyy)* ☐ No
12. Location Where Event Occurred ☐ Hospital ☐ Home ☐ Nursing Home ☐ Outpatient Treatment Facility ☐ Outpatient Diagnostic Facility ☐ Ambulatory Surgical Facility ☐ Other: ____ *(Specify)*
13. Report Sent to Manufacturer? ☐ Yes ____ *(mm/dd/yyyy)* ☐ No
14. Manufacturer Name/Address

## G. ALL MANUFACTURERS

1. Contact Office - Name/Address *(and Manufacturing Site for Devices)*
2. Phone Number
3. Report Source *(Check all that apply)* ☐ Foreign ☐ Study ☐ Literature ☐ Consumer ☐ Health Professional ☐ User Facility ☐ Company Representative ☐ Distributor ☐ Other:
4. Date Received by Manufacturer *(mm/dd/yyyy)*
5. (A)NDA # ____ IND # ____ STN # ____ PMA/510(k) # ____ Combination Product ☐ Yes Pre-1938 ☐ Yes OTC Product ☐ Yes
6. If IND, Give Protocol #
7. Type of Report *(Check all that apply)* ☐ 5-day ☐ 30-day ☐ 7-day ☐ Periodic ☐ 10-day ☐ Initial ☐ 15-day ☐ Follow-up # ____
8. Adverse Event Term(s)
9. Manufacturer Report Number

## H. DEVICE MANUFACTURERS ONLY

1. Type of Reportable Event ☐ Death ☐ Serious Injury ☐ Malfunction ☐ Other: ____
2. If Follow-up, What Type? ☐ Correction ☐ Additional Information ☐ Response to FDA Request ☐ Device Evaluation
3. Device Evaluated by Manufacturer? ☐ Not Returned to Manufacturer ☐ Yes ☐ Evaluation Summary Attached ☐ No *(Attach page to explain why not)* or provide code: ____
4. Device Manufacture Date *(mm/yyyy)*
5. Labeled for Single Use? ☐ Yes ☐ No
6. Evaluation Codes *(Refer to coding manual)* Method ___ - ___ - ___ - ___ Results ___ - ___ - ___ - ___ Conclusions ___ - ___ - ___ - ___
7. If Remedial Action Initiated, Check Type ☐ Recall ☐ Repair ☐ Replace ☐ Relabeling ☐ Notification ☐ Inspection ☐ Patient Monitoring ☐ Modification/Adjustment ☐ Other: ____
8. Usage of Device ☐ Initial Use of Device ☐ Reuse ☐ Unknown
9. If action reported to FDA under 21 USC 360(i), list correction/removal reporting number:
10. ☐ Additional Manufacturer Narrative and / or 11. ☐ Corrected Data

**Attachment 5**

# AED Operator Training Recognition

Please complete and maintain the following information for each AED authorized operator at your facility.

Operator Name: _____

Age: _____ Title: _____

Department: _____ Building/School: _____

Name of AED/CPR Training Program: _____

Date Completed: _____ Refresher Training: ❑ Yes ❑ No

Name of Refresher Course: _____

Date Completed: _____

Signature of Operator: _____ Date: _____

Signature of Coordinator: _____ Date: _____

The above signatures verify that AED operator is currently recognized by a MIEMSS-approved AED Program.

**Attachment 6**

# Weekly AED Safety Inspection Record

Please complete a separate record for each AED. Submit completed form to school principal/designee every month.

AED Serial #: _____ AED Location: _____

Month: _____ Year: _____

| Date | Inspector Initials | Carrying Case Intact | Battery Charged Ready for Use | All Equipment Present |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Battery Expiration date for this unit: _____

Pad expiration date for this unit: _____