The Defibrillator Guidelines

International Guidelines for the Proper Deployment of Automated External Defibrillators (AEDs) in Workplaces and Public Spaces

Authored by Dr Don Dingsdag and Dr Graeme Peel

IMPORTANT!

AEDs are critical equipment that should be deployed in accordance with these guidelines. Failure to do so may result in serious harm or death.

October 2022

IMPORTANT INFORMATION

The Defibrillator Guidelines are authored by Dr Don Dingsdag and Dr Graeme Peel and are subject to review from time to time in response to regulatory developments, changing needs and user feedback.

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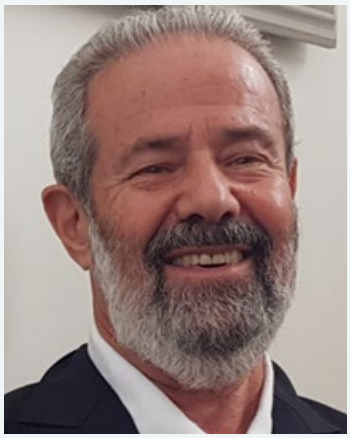
October 2022

About Dr. Don Dingsdag



Since 2006 Don Dingsdag has been instrumental in conducting research into out of hospital sudden cardiac arrest (OHSCA) and providing public and workplace access to defibrillation to improve survival chances of SCA sufferers. He is also Chair and principal researcher of the Cardiac Arrest Survival Foundation (CASF). Throughout his professional life as an academic, researcher and consultant, Don has also been passionate about occupational health and safety (OHS). He was first struck for the need of robust OHS legislation during his BA Honors thesis in 1979 while he researched the Bulli Mining Disaster of 1887, when 81 men and boys died owing to weak mines safety legislation (the 1876 Coal Mines Regulation Act, NSW). This legislation was not properly observed by the Department of Mines inspectorate, the management of the Old Bulli mine, the Miners' Union, nor the miners. The methane gas explosion that caused this needless calamity was catastrophic to the surrounding small mining community as it diminished its male population by about 20%.

For more than 40 years of OHS and related research and industry consultation to the coalmining, construction, energy (electricity and gas supply sectors), transport (bus and train sectors) and food and beverage manufacturing industries, Don has come to the conclusion that even robust and observed legislation is not enough to make workplaces safe, nor to improve safety performance. Much more is needed and as a result for over fifteen years he has become an active advocate for organisational embracing of safety culture and safety leadership to complement and supplement legislative compliance remembering that these approaches are not magic bullets.

His qualifications and experience are:

- BA (Hons) Wollongong University, 1980;
  Thesis: Responses to the Bulli Colliery Disaster of 1887 with Special Reference to the New South Wales Government and the Bulli Coal Mining Company, Department of History, University of Wollongong.
- Ph D Wollongong University, 1989;
  Thesis: The Restructuring of the New South Wales Coalmining Industry 1903-1982, Department of History and Politics, University of Wollongong.
- Expert witness reports, workers' compensation matters, NSW District and Supreme Court;
- Certificate, Investigate WHS Incidents, SAI Global, Sydney;
- OHS Management Systems Lead Auditor, AS/NZS 4801/ OHSAS 18001, Exemplar Global, Sydney;
- WorkCover approved General Induction Trainer, TAFE NSW, Correctional Services NSW;
- Certificate IV in Assessment and Workplace Training, MTS, Sydney;
- Certificate in Confined Spaces Entry Training, MTS, Sydney;

- Certificated Train the Trainer, Drake International, Brisbane;
- Conducting OHS research and development of policies and procedures in the coal mining, construction, energy, transport and food and beverage industries;
- Hazard identification, risk assessments, audits and validations of production lines;
- Lock Out/Tag Out Training (LOTO);
- PC1, PC2 plant, animal, laboratory audits; inspections for PC2 laboratory certification;
- OGTR laboratory inspections and validations;
- Machine Safety risk assessments and training;
- Safety Culture, Safety Leadership training/education for senior management/middle management and blue-collar workers;
- Developing competency safety standards and safety behaviours for universal application across the construction sector in Australia and Hong Kong.

About Dr. Graeme Peel

Dr Graeme Peel is a physician who is a specialist in occupational, environmental, public health and aerospace medicine. He has interests in illness and injury prevention and health promotion, including the efficient and effective deployment of AEDs for public safety. His qualifications are M.B.,B.S; MPH; DAvMed; FAFOEM; FAFPHM; FACAsM.

Graeme served full-time in the Royal Australian Air Force from 1974-2000, primarily in aviation medicine roles in Australia, Malaysia, the United Kingdom and the USA. During this period, he also investigated twelve aircraft accidents and deployed on humanitarian relief and peace monitoring duties.

Graeme was a senior executive with Qantas Airways from 2000-2008, where he firstly developed and then managed the Group's OHS and occupational medicine programs. He concurrently continued his military service as a Group Captain in the Air Force Specialist Reserve, deploying to Sri Lanka following the 2004 Boxing Day tsunami and subsequently to the Middle East.

Graeme is involved in a diverse range of activities, comprising clinical practice, consulting with industries on OHS, advising on fitness for remote deployments, lecturing in aviation medicine at Griffith University, and Air Force Reserve duties. He was an independent member of the NSW Government Mine Safety Advisory Council for eleven years and chaired the Department of Veterans' Affairs Human Research Ethics Committee.

Table of Contents

FOREWORD

The Defibrillator Guidelines (the Guidelines)

Compliance with these Guidelines is voluntary.

Aimed at saving lives, the Guidelines follow recent research which recommends that organisations adopt a 'service-based' approach to heart safety, by clearly defining who has responsibility for monitoring and maintaining AEDs and the training of rescuers.

The first Guidelines were developed by Dr Donald Dingsdag and Dr Graeme Peel in 2012 and launched at Parliament House, Canberra in November 2012. Following consultation with SafeWork Australia, Therapeutic Goods Administration (TGA), defibrillator users, defibrillator manufacturers and other interested parties, a second edition of the Guidelines was released in October 2014

In assembling this edition of the Guidelines, Dr Dingsdag examined current trends and practices in the deployment of AEDs, and reviewed research into use of AEDs in workplaces and public spaces. Broad consultation was undertaken with government, business and professional groups and subject matter experts, and careful consideration given to relevant legislation and regulations.

The Guidelines provide technical specifications for defibrillators, where and how they are to be installed, and instructions for their monitoring and maintenance, as well as stipulation of training standards. Also provided are minimum standards for what should happen during an emergency response, for post-incident support and record keeping, and a process for those wishing to voluntarily register an AED System.

Registering defibrillators within a national database will help to improve access to defibrillators by first responders and emergency service personnel, which in turn will improve the survival rate.

About the Defibrillator Guidelines

The Defibrillator Guidelines were created to improve the standards of AED deployment and use by providing guidance on the selection, location, monitoring and maintenance of AED Systems in workplaces and public spaces, and the inclusion of a voluntary registration program.

Whereas the Australian Therapeutic Goods Administration recognises that, '…some AEDs have been associated with manufacturing problems and some devices have been recalled' and '… in Australia, AEDs are currently classified as Class IIb (medium-high risk) devices.'[1] A limited European Union (EU) pre-market approval model has also been adopted by the TGA along with an extended transitional period.[2] In the USA, under the auspices of the Food and Drug Administration (FDA), AEDs are classified as Class III high risk medical devices owing to the vital role they have in diagnosis and applying therapy, i.e., delivery of a life-saving shock. Accordingly,

[1] Australian Government, Department of Health, Therapeutic Goods Administration, 'Consultation: Potential reclassification of active medical devices for diagnosis and patient therapy.', January 2019, pp. 8, 9.

[2] Australian Government, Department of Health, Therapeutic Goods Administration, Explanatory Statement, Therapeutic Goods Act 1989, Therapeutic Goods (Charges) Act 1989, Therapeutic Goods Legislation Amendment (2019 Measures No.1) Regulations 2019, p. 12

for conformation with the Guidelines and optimal performance, it is strongly recommended that defibrillators deployed in public places and workplaces in Australia have been fully FDA approved for a minimum of two years. In addition, AEDs that are already designated Class IIb classification, or subject to an application for marketing approval that has not been finally determined, when these amendments commence, will have the benefit of a long transitional period (principally, until 1 November 2024) before the new rule begins to apply to them.[3]

Even though the FDA pre-market approval process is demanding, the EU post-market quality management system is also relevant to the post-selection elements of the Guidelines. For example:

> The manufacturer shall establish, document and implement a quality management system as described in Article 10(9) and maintain its effectiveness throughout the life cycle of the devices concerned. The manufacturer shall ensure the application of the quality management system as specified in Section 2 and shall be subject to audit, as laid down in Sections 2.3 and 2.4, and to surveillance as specified in Section 3.[4]

Development of these Defibrillator Guidelines has involved a comprehensive examination of current trends and practices of AED deployment together with extensive research into AED use in the workplace and in public spaces by qualified and experienced people with backgrounds in public health, workplace relations, occupational health and safety, emergency and rescue, quality control and management systems.

[3] *Ibid*. p.12

[4] REGULATION (EU) 2017/745 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 5 April 2017, on medical devices, amending Directive 2001/83/EC, Regulation (EC) No 178/2002 and Regulation (EC) No 1223/2009 and repealing Council Directives 90/385/EEC and 93/42/EEC, Official Journal of the European Union, p. 146

BACKGROUND INFORMATION

Sudden Cardiac Arrest Risk Matrix

It is well known that each year in the USA there are over 350,000 cardiac arrests and in Australia there are approximately 33,000 out of hospital cardiac arrests. What is the likelihood of cardiac arrest across the population?

Risk level in terms of sudden cardiac arrest exposure

Low **Medium** **High** **Extreme**

Workplace Demographic	Likelihood of Cardiac Arrest					
Population; Percentage aged over 50 years old	1 in 5 years	1 in 10 years	1 in 15 years	1 in 20 years	1 in 25 years	< 1 in 25 years
1-9; 20%						X
10-99; 20%						X
100-499; 20%			X			
500-999; 20%		X				
1-9; 30% to 50%						X
10-99; 30% to 50%						X
100-499; 30% to 50%		X				
500-999; 30% to 50%	X					

Important: This matrix is a guideline only and cannot be relied upon to measure potential cardiac arrests. The Public Access to Defibrillation (PAD) study, based at the University of Washington, was a multi-site clinical trial that addressed AED placement. The above matrix is based on the formula that was used in the PAD study to identify higher-risk locations. These figures do not consider visitors, extended hours of occupancy or nature of work. Assumptions are that the area is non-residential and the average number of hours spent at the location each day is eight.

Monitored vs Unmonitored AED Systems

A quantitative risk analysis conducted by a reliability engineer[5] determined probabilities of failure for a leading brand of automated external defibrillator[6] in monitored and stand-alone deployment options.[7] The risk analysis methodology used the Fault Tree Analysis technique and drew upon previous risk and reliability analyses which had established predictions of equipment failure rates and fault diagnostic capabilities.

[5] The analysis was conducted in conjunction with Marcus Punch Pty Ltd

[6] Cardiac Science: see www.cardiacscience.com

[7] Quantified Risk Analysis (QRA) Report, Automatic External Defibrillators (AEDs) in Monitored and Stand-alone Modes, prepared by Marcus Punch Pty Ltd, 12 August 2011

The analysis predicted that the probability of a monitored defibrillator being in a failed state at the time of a deployment was approximately 1-in-800. This figure applied to the best quality defibrillators only. The probability of failure for defibrillators with lesser diagnostic capabilities was predicted to be as high as 1-in-40.

The analysis also predicted that when the same best quality defibrillator is deployed in a stand-alone (unmonitored) mode, the probability of being in a failed state at the time of a deployment could be as high as 1-in-5. This figure depends on the degree of compliance with manufacturers' requirements for daily checking and inspection.

Other defibrillators were also predicted to have a similar result. This figure is consistent with Shah and Maisel's study of defibrillators in the USA in 2006.[8] Monitoring and maintenance neglect are chinks in the armour of defibrillation programs and device deployment. Consequently, it is imperative that organisations intending to introduce AEDs ensure they are effectively managed and checked daily for operability otherwise there is a risk that they will not deliver the life-giving shock for which they were designed.

Monitored AED Systems Save More Lives

Recent research by a leading Australian public health expert, Dr Sue Craig, reiterated Dr Dingsdag's work from 2009, entitled 'Reliability, sustainability and effectiveness of automated external defibrillators deployed in workplaces and public areas,'[9] which concludes that more lives can be saved after sudden cardiac arrest if fully-monitored systems of AEDs are deployed in public areas and workplaces, rather than stand-alone(i.e., unmonitored) defibrillators.

In the study, by Sydney-based researcher Dr Sue Craig, 'Creating a Culture of Heart Safety in Public Facilities',[10] survivors of sudden cardiac arrest were interviewed, Australian and international research were reviewed, and the results of remote surveillance analysed.

Key factors in the successful rescues were that the AED formed part of an integrated system that ensured it was located in a highly visible position, ready when needed with a fully charged battery, and that there were sufficient numbers of trained employees on hand to use it. The research:

- recommends each AED unit be supported by up to ten CPR-trained employees;
- found stand-alone AEDs place an unnecessary burden on managers and can create confusion over who is responsible for the maintenance and operability of the equipment;

[8] Shah, JS and Maisel, WH, "Recalls and safety alerts affecting automated external defibrillators", *Journal of the American Medical Association*, 2006, 296(6); pp., 655-660

[9] Dingsdag, D, "Reliability, sustainability and effectiveness of automated external defibrillators deployed in workplaces and public areas." *Journal of the Occupational Health and Safety Australia and New Zealand 2009*, Vol.25, pp., 351–361

[10] Craig, S, "Creating a culture of heart safety in public facilities", *Journal of Health, Safety and Environment, Australia and New Zealand,* 2014, Vol. 30 (2), pp.,303-314

- recommends organisations move instead to a 'service-based' approach to heart safety, in order to clearly define who has responsibility for monitoring and maintaining AEDs and the training of operators;
- supports that there are long-term cost savings to be achieved through fully monitored AED systems. Indirect costs of failing to mitigate public risk are estimated at 8 to 36 times the direct costs such as loss of key staff, disruption to business, workers compensation and legal liability.

Why Register Defibrillators?

The Guidelines aim to ensure AEDs are properly deployed and always working, which will save lives and avoid fatalities caused by missing or faulty devices.

While reliable data are still scant, some experts in the USA have estimated AEDs are used to help fewer than five per cent of people collapsing from sudden cardiac arrest.[11] This is a statistic that may be exacerbated by lack of information about AED locations and functionality. For example, few public agencies in the USA, including 911 dispatch centres, keep a database of AED locations or systematically check to make sure available devices are in working order.

A University of Pennsylvania crowd-sourcing project called MyHeartMap aimed to map the location of public access AEDs and to better monitor them. Using a smartphone app, more than 300 teams and individuals spent eight weeks knocking on doors, photographing and recording the GPS coordinates of defibrillators wherever they found them. The resulting map pinpointed 1400 AEDs in 500 buildings. The map is now available to 911 despatchers who could provide the location of the nearest AED to an emergency caller.[12]

AEDs in the USA have been subject to numerous recalls for faults. One study of advisories to the FDA between 1996 and 2005 found 21.2 per cent of units distributed during the study period had to be recalled.[13]

Registration of AEDs will serve to eliminate the problems of unknown AED locations and poor functionality.

[11] Winslow, R, "The Device That Saves Lives But Can Be Hard To Find", *The Wall Street Journal,* 12 November 2012, retrieved 21 March 2012 at online.wsj.com/article_email/SB10001424127887324073504578115051054664668-lMyQjAxMTAyMDEwNTExNDUyWj.html?mod=wsj_valettop_email

[12] *Ibid.*

[13] Shah and Maisel, *op. cit.,* p. 655

SECTION 1 – SCOPE AND GENERAL

1.1 Scope

1. This document sets out guidelines on the selection, location, monitoring, maintenance and voluntary registration of AED Systems and is intended to apply to all Workplaces and Public Spaces. The definitions below were developed for the purposes of the Guidelines only and do not relate to any legal requirements under the Model Work Health and Safety (WHS) legislation.

1.2 Definitions

1. The following definitions apply:

AED	is an automated external defibrillator which includes electrodes (pads) and a battery.
AED System	includes: • AED; • AED fault detection; • AED communications network; • AED emergency response; • AED post incident support; • AED enclosure; • AED monitoring, maintenance and support; and • AED training program
Basic Life Support Training	means training in performing cardiopulmonary resuscitation (CPR) and use of an automated external defibrillator in an emergency.
Control Room	is a 24-hour response centre operating 365 days a year.
Defibrillator Data Management System	is a free or commercial defibrillator management software application such as Defibnet.com that enables the recording and management of AED data and provides email alerts based upon the expiry dates of AED electrodes and batteries
Duty Holder	is an organization, entity or individual that has responsibility for an AED System.
Emergency Verification Contact	is a person designated to be contacted by the Control Room in response to an AED being accessed.
Guidelines	are these Defibrillator Guidelines.
Monitoring	is a system to inspect, detect and record the operability of an AED by a remote control room.

Potential Operator	is a person, or persons, relying on the AED System in response to an SCA.
Potential Victim	is a person showing signs of a cardiac arrest.
Premises	is any place, and in particular includes: • any land, building or part of any building; or • any vehicle, vessel or aircraft; or • any installation on land, on the bed of any waters or floating on any waters; or • any tent or movable structure.
Public Space	is a place or a part of Premises that is open to the public.
Regulatory Authority	is the Government authority responsible for regulation of AEDs.
Service Provider	is a third party engaged by a Duty Holder to carry out duties or provide services including, but not limited to, supplying, monitoring and maintaining an AED System.
SCA	is a sudden cardiac arrest event.
Victim	is a person who has a shockable or non-shockable rhythm identified by the AED.
Worker	means: 1. A person is a "worker" if the person carries out work in any capacity for a Duty Holder conducting a business or undertaking, including work as: • an employee; or • a contractor or subcontractor; or • an employee of a contractor or subcontractor; or • an employee of a labour hire company who has been assigned to work in the Duty Holder's business or undertaking; or • an outworker; or • an apprentice or trainee; or • a student gaining work experience; or • a volunteer; or • a person of a prescribed class. 2. The Duty Holder conducting the business or undertaking is also a "worker" if the Duty Holder is an individual who carries out work in that business or undertaking.
Workplace	means the Premises where persons work.

SECTION 2 – TECHNICAL SPECIFICATIONS

2.1 Essential Specifications

1. An AED must:
   a. be of an uncluttered design that enables fast, efficient operation by a Potential Operator in an intense emergency situation;
   b. provide clear rescue prompts or instructions to the Potential Operator so that it is able to be used safely by non-medical personnel in noisy environments;
   c. be easily accessible and be portable (including, whether mounted on a wall, within a vehicle or elsewhere);
   d. be serviceable in both the short and long term;
   e. be IP24 rated;
   f. have an automated self-test facility whereby it performs a daily automated self-test to confirm the operability of the electrodes (pads), cable, battery, and electrical circuitry;
   g. be able to record and store data including usage and cardiac rhythm information for download to a prescribed system or format;
   h. be approved by the Regulatory Authority. In addition, its strongly recommended that the AED has been approved for a minimum of two years by the US Federal Drug Administration;
   i. include:
      i. a first aid pack that contains pocket mask, wipes, razors and scissors; and
      ii. a defibrillator information booklet, instruction and quick reference guide.
   j. have an AED battery supported by the manufacturer of the AED and be operationally warranted.

2.2 Essential Specifications for Monitored AEDs

1. Monitored AEDs must have the ability to send automatic messages and signals from the AED to the Control Room in circumstances where the AED is:
   a. not operable;
   b. removed from its enclosure; and/or
   c. activated.
2. Vehicle mounted or portable publicly accessible AEDs may also include GPS location tracking.

2.3 Non-Essential Specifications

1. Subject to a risk/environmental assessment, the AED should:
   a. have non-polarised and interchangeable electrodes allowing the Potential Operator to place either electrode in the proper position on the body;
   b. be fully automated once deployed and deliver a shock (if required) without requiring the Potential Operator to push a button;
   c. have pediatric capability,
   d. include easy to read backlit electronic text displays and gauges showing:
      i. elapsed rescue time;
      ii. number of shocks administered;
      iii. a CPR countdown;
      iv. battery capacity; and
      v. the operational status of the battery and pad expiry.

SECTION 3 – INSTALLATION AND LOCATION

3.1 Installation

1. Duty Holders must ensure that deployed AEDs are installed strictly in accordance with the manufacturer's instructions and located in the Workplace and/or Public Space in accordance with the requirements of this section.

3.2 Location

1. AEDs must be positioned in a conspicuous and readily accessible location.
2. AEDs must not be located in positions where access could present a hazard to the Potential Operator. Where practicable, AEDs should be located along normal paths of travel and near exits.
3. Reasonable steps must be taken by Duty Holders to ensure that deployed AEDs are located no more than one to two minutes away from a Potential Victim.
4. AEDs deployed on Premises should:
   a. have their positions clearly indicated by placement of a location sign;
   b. have their location clearly indicated and visible to all Potential Operators with the use of appropriate directional signage; and
   c. be mounted at the appropriate height so that the AED enclosure handle and AED are at a maximum height of 1200mm from ground level.
5. The requirements of 3.2(4)(c) may be waived if the accessibility of the AED will be impaired.

SECTION 4 – MONITORING, MAINTENANCE AND TRAINING

4.1 Monitoring

1. The Duty Holder is responsible for ensuring the ongoing functionality of deployed AEDs. A Duty Holder may engage a Service Provider to carry out these responsibilities on its behalf.
2. Duty Holders are responsible for arranging for all deployed AEDs to be checked for functionality daily, 365 days a year in accordance with 4.1(3).
3. Duty Holders with:
   a. 50 or more workers at the Workplace, or where a risk assessment determines that there is high risk in Workplaces with fewer than 50 workers, or where the Workplace is a Public Space and with access to power and communications, should ensure that deployed AEDs are Monitored electronically by a Service Provider operating a Control Room; or
   b. fewer than 50 workers and/or without access to power or communications should ensure that deployed AEDs are manually inspected for operability on a daily basis and that a service log is maintained, in accordance with the AED Daily Inspection Log, which is to be securely stored at the location of each deployed AED.
4. Duty Holders are responsible for ensuring that inspections and maintenance of AEDs are provided in accordance with the manufacturer's specifications. It is essential that deployed AEDs and any accessories are always kept under warranty by ensuring that all parts and consumables do not exceed their warranty period.

4.2 Maintenance

1. Daily checking of AED functionality must be carried out to detect device failure in accordance with 4.1. A Duty Holder may engage a Service Provider to carry out maintenance responsibilities on its behalf.
2. In addition to 4.2(1), both routine and annual on-site maintenance must be arranged by the Duty Holder for all deployed AEDs in accordance with manufacturer's instructions.
3. Duty Holders are responsible for immediately replacing defective AEDs.
4. AED parts and consumables must be replaced:
   a. before their expiry date;
   b. after being used in an SCA;
   c. in accordance with the manufacturer's instructions.

4.3 Training

1. Duty Holders should provide training on an annual basis. A Duty Holder may engage a Service Provider to carry out the responsibilities in this section on its behalf.
2. Training referred to in 4.3(1) should:
   a. meet the guidelines of the national resuscitation peak body;
   b. cover Basic Life Support Training; and
   c. be provided to a minimum of 10 Workers for each AED deployed.
3. Training should be conducted on-site at a time agreed with a Duty Holder's customer site contact or appointee.
4. Trainees should be:
   a. assessed on a theoretical and practical basis by certified trainers;
   b. issued statements of attainment upon successful completion of the training, such statements to be valid for 12 months; and
   c. invited to provide feedback at the end of a training session.
5. A Basic Life Support Training guide should be provided to all Workers who undertake training.
6. Problems, issues and suggestions should be communicated to the Duty Holder's customer site contact or their appointee.

SECTION 5 – EMERGENCY RESPONSE AND POST INCIDENT SUPPORT

5.1 General

1. Duty Holders should ensure that the requirements in this section are met for each AED System. A Duty Holder may engage a Service Provider to carry out these responsibilities on its behalf.

5.2 Emergency Response

1. For monitored AEDs, the Control Room is responsible for providing back-up in response to an SCA and should:
   a. maintain and update details of the Emergency Verification Contact and the correct address for the ambulance service as required;
   b. contact the Emergency Verification Contact upon an AED being accessed. If the emergency is verified, then the Control Room must call an ambulance; and
   c. handle any emergency in accordance with the relevant standard for medical duress alarm response.
2. Notwithstanding the responsibilities of the Control Room in 5.2(1) above, the Duty Holder is primarily responsible for ensuring an ambulance is called directly by the rescuers at the scene of an SCA.
3. Nothing in this section detracts, or is intended to detract, from any legal obligation owed by the Duty Holder or rescuers, including but not limited to, a duty of care owed by the Duty Holder or the rescuers at the scene of an SCA.

5.3 Post Incident Support

1. Each SCA must be overseen by a physician with experience in dealing with cardiac arrest emergencies.
2. The physician referred to in 5.3(1) is not required to provide therapy to the Victim. Their role is to support the Duty Holder or Service Provider in handling of post event matters including consultation and documentation of an SCA.
3. Following an SCA involving use of a deployed AED the Duty Holder must, to the extent allowed by relevant privacy legislation, ensure that:
   a. consultation occurs with the rescuers involved within 24 hours of an SCA where a deployed AED was used;
   b. an ECG report is extracted from the deployed AED; and

c. a Post Incident form is properly completed within 24 hours of an SCA. A sample Post Incident Form can be downloaded from (website to be provided by SWA). Data includes:
    i. Details of the patient
    ii. Details of incident
    iii. Incident Data
    iv. Treatment data
    v. Basic life support (BLS)
    vi. AED use
    vii. Hospital transport
    viii. Police contact
    ix. Outcome data

4. A post-incident debrief of trained rescuers should be arranged by the Duty Holder within 24 hours of an incident where the AED is used.

SECTION 6 – RECORD KEEPING

6.1 Defibrillator Data Management System

1. A Duty Holder or Service Provider may use Defibrillator Data Management System to manage the following key data and records:
   a. AEDS
      i. equipment and consumables;
      ii. manufacturer, model and serial number;
      iii. warranty;
      iv. pads serial number and expiry dates;
      v. spare pads serial number and expiry dates;
      vi. battery serial numbers and expiry dates;
      vii. AEDs under 4.1(3)(a) must have electronic fault monitoring logs;
      viii. AEDs under 4.1(3)(b) must have daily inspection logs in the format set out in Daily AED inspection log.
   b. Training
      i. trained rescuers;
      ii. contact details;
      iii. statements of attainment;
      iv. training expiry dates.
   c. Emergency response:
      i. address or location of SCA for ambulance personnel including the nearest cross street and any special instructions for remote locations without address;
      ii. Emergency Verification Contact details including regular and after hours contact numbers for both a primary and secondary person;
      iii. the location of the AED and any relevant information regarding hours of access to the Premises or access to remote location where the AED is located.

DAILY AED INSPECTION LOG

A Daily AED Inspection Log can be downloaded from (TBC)

Location of AED

Manufacturer of AED	Date of Manufacture of AED
Model Number of AED	Serial Number of AED

Tick box if YES

	MON	TUE	WED	THU	FRI	SAT	SUN
Date of Inspection (MM / YY)	(DD)	(DD)	(DD)	(DD)	(DD)	(DD)	(DD)
AED Condition There must be no dirt, damage or contamination							
Status Indicator Must show device is ready for use							
Supplies: 1 sets of unexpired adult pads that are sealed, undamaged							
1 set of unexpired infant / child pads - sealed, undamaged (if required)							
Ancillary supplies (hand towel, scissors, razor, pocket mask)							
1 installed battery - within expiry date							
Inspected By (Signed Initials)							

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ISBN 978-0-6456409-0-8