Department of Veterans Affairs **VHA DIRECTIVE 2008-015**
Veterans Health Administration
Washington, DC 20420 **March 12, 2008**

PUBLIC ACCESS TO AUTOMATED EXTERNAL DEFIBRILLATORS (AEDs): DEPLOYMENT, TRAINING, AND POLICIES FOR USE IN VHA FACILITIES

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy to ensure that VHA has emergency response capability, including access to appropriate resuscitation equipment, to manage cardiac arrests on VHA property.

2. BACKGROUND: Every year about 300,000 Americans die of sudden cardiac death (SCD). For resuscitation to be effective, defibrillation ideally must be applied within three to four minutes of the cessation of normal heartbeats: the sooner a defibrillator is utilized the more likely it is that it will be effective and that a patient will fully recover.

a. In general, for every minute that passes between the event and defibrillation, the probability of survival decreases by 7 to 10 percent. The widespread availability of public access automated external defibrillators (AEDs) has improved survival from cardiac arrest, even when used by non-medical personnel. The importance of rapid access to defibrillation is reflected in the American Heart Association (AHA) "Chain of Survival" concept, designed to optimize a patient's chance for survival of sudden cardiac arrest.

b. VHA is committed to saving cardiac arrest victims through the distribution of public access AEDs, ensuring that personnel are trained in their use, and that appropriate relationships with local Emergency Medical Systems (EMS) are in place. This includes the resuscitation of inpatients, and applies to outpatients, and any other person, including visitors and staff who might suffer a cardiac arrest while at a VHA facility.

c. The manner in which facilities respond to cardiac arrests depends on local expertise and resources, as well as the location of the event.

(1) For example, VHA medical centers with inpatient medical-surgical beds and emergency departments most often use a hospital based "Code-Blue" program, and generally does not need to activate 911 for the resuscitation of inpatients.

(2) However, EMS may serve as the first-line provider for resuscitation for outpatient areas such as free-standing clinics and other out-buildings on the medical center grounds. This is also the case for VHA facilities not having medical-surgical inpatient beds or Emergency Departments, including rehabilitation and psychiatric hospitals, community-based outpatient clinics (CBOCs), domiciliaries, Vet Centers, administrative units, etc. For these facilities the appropriate response to a cardiac arrest generally includes rapid activation of 911, then bystander initiation of Cardiopulmonary Resuscitation (CPR) and application of an AED pending EMS arrival.

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d. VHA strongly recommends that each facility extensively train personnel in the delivery of CPR, including the use of a public access AED. All clinical staff are required to receive CPR training, and in some cases ACLS training, as delineated in the current VHA policy.

e. It is probable that in some cases non-medical personnel may be the first responders, and should this occur, advance knowledge of CPR and public access AED use could significantly improve the chances of survival. ***NOTE:*** *Providing broad training opportunities in CPR and AED use, including non-clinical personnel, is highly encouraged, especially for non-clinical personnel located in areas where clinicians are not routinely on site.*

f. Public access AEDs are approved by the Food and Drug Administration, are available from multiple manufacturers, and are listed on the Federal Supply Schedule.

3. POLICY: It is VHA policy that every VHA Network and facility, (including medical centers, CBOCs, domiciliaries, and administrative units) have a plan and the resources in place to rapidly initiate the appropriate emergency response, regardless of location or time of day, that is inclusive of all veteran patients, visitors, and employees who may suffer a cardiac arrest while in and around the VHA facility.

4. ACTION

a. **Network Director.** Each Network Director is required to ensure that each VHA facility, (including medical centers, CBOCs, domiciliaries, and administrative units) has appropriate emergency response capability, and has written policy and procedures in place.

b. **Facility Director.** Each facility Director is responsible for:

(1) Defining the appropriate response to cardiac arrest for all areas of the facility. This necessitates: determining where a comprehensive ACLS response should be available, (i.e., Emergency Departments and inpatient wards using "code blue" with crash cart), versus public access AED with EMS involvement; installing public access AEDs where appropriate; and, training staff at designated locations, especially those remote to clinical areas.

(2) Ensuring easy access to public access AEDs; this includes placement in high-use areas, such as: lobbies and cafeterias, research buildings, out-buildings, free-standing dialysis units, areas with therapeutic swimming pools, and all satellite buildings.

(a) The decision for placement of public access AEDs should consider areas where there is "a reasonable probability" of one public access AED use in 5 years.

(b) It is strongly recommended that public access AEDs be placed in all VA police cars for use in parking lots and other distant sites. VA police should receive CPR and AED training and maintain current course completion status.

(3) Ensuring CBOCs deploy public access AEDs, and dial 911 in addition to initiating CPR and applying the AED.

(4) Ensuring public access AEDs are clearly identified, accessible, and secured to prevent or minimize the potential for tampering, theft, and misuse.

(a) Responders should be able to rapidly access the device and return to the victim, apply the electrode patches, and still deliver a shock within an acceptable time frame.

(b) Ideally, these devices are installed next to an accessible telephone so that responders can call for help.

(c) The location of AEDs is to be clearly marked for quick identification and access to the AED device and accessories.

(5) Ensuring accessories and Personal Protection Devices are made available where public access AEDs are located. This needs to include, but is not limited to: disposable gloves, disposable CPR facemasks, scissors, paper and pencil to record the events, disposable razors, medical waste plastic bags. and absorbent towels.

(6) Providing facility-wide awareness training to ensure that all staff, on all shifts, are knowledgeable about the placement of the nearest public access AED.

(7) Ensuring hands-on training, including CPR and public access AED, for VA Police and designated response staff in locations where public access AEDs are to be installed, making sure to cover all shifts: this training needs to include contract security services, as well as medical and administrative personnel.

(8) Ensuring that there are established relationships, (and contracts if necessary) that guarantee appropriate EMS responses if called to cardiac arrests on VHA facilities.

(9) Ensuring that a maintenance program for public access AEDs, (including life-cycle replacement plans), is in place. ***NOTE:*** *Manufacturer service documentation must be consulted before designing a maintenance program. Unlike defibrillators found on crash carts, public access AEDs are nearly maintenance free; daily operator testing by charging and discharging the public access AED is typically not required.*

c. **Chief of Staff (COS).** The COS is responsible for:

(1) Determining the best location for public access AEDs throughout the entire parent facility, as well as for all out-buildings, CBOCs, domiciliaries, etc.

(2) Maintaining a roster of all devices and a diagram of public access AED locations for the facility's emergency plan.

(3) Ensuring that each cardiac arrest is reviewed as an important aspect of the facility's quality assurance program. ***NOTE:*** *Public access AEDs are designed with data storage*

capabilities to retrieve actions subsequent to an event. All events are to be reviewed by the parent facility's Code Committee.

(4) Determining who receives what level of training and where.

5. REFERENCES

a. Hallstrom AP, Ornato JP, Weisfeldt M, Travers A, Christenson J, McBurnie MA, Zalenski R, Becker LB, Schron EB, Proschan M; Public Access Defibrillation Trial Investigators. Public-access defibrillation and survival after out-of-hospital cardiac arrest. New England Journal of Medicine. 2004 Aug 12;351(7):637-46.

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c. Friedman FD, Dowler K, Link MS. A public access defibrillation programme in non-inpatient hospital areas. Resuscitation. 2006 Jun;69(3):407-11. Epub 2006 Mar 23.

d. Department of Health and Human Services and General Services Administration "Guidelines for Public Access Defibrillation Programs in Federal Facilities," Federal Register. Vol 66; Number 100, 28495-28511:May 23, 2001, online access via wais.access.gpo.gov;DOCID: fr23my01-89.

6. FOLLOW-UP RESPONSIBILITY: The Assistant Deputy Under-Secretary for Health (10NB), Patient Care Services (11) and Medical-Surgical Services (111A) are responsible for the contents of this Directive. Questions may be addressed to 202-461-7120.

7. RESCISSIONS: None. This VHA Directive expires March 31, 2013.

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

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