Cardiac First Responder Report

National Ambulance Service
(Midland Division)

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Introduction

This report is intended to show where the National Ambulance Service (Midland Division) is in relation to Cardiac First Responder programmes and scheme at the beginning of 2007 and how it has progressed in 2007. The concept of First Responders is rapidly moving forward in many directions with schools, businesses, small and large communities raising money for defibrillators with little or no guidance.

There are many First Responder Programmes throughout the country with different levels of training and expected levels of response.

The National Ambulance Service (Eastern Division) have First Responder schemes where by Responders attend Cardiac Arrests: Adult, Child and Infant, Cardiac Chest pain call and other collapse calls.

In the National Ambulance Service (Western Division) First Responder attend Medical and Trauma calls such as Cardiac Arrests, Cardiac Chest pain, other collapses and Trauma related calls such as Road Traffic Accidents.

In the Midland Division it is envisaged that First Responders would only be called to Adult Cardiac Arrests and Choking calls. Some communities have Public Access Defibrillation Schemes and other have Cardiac Responder schemes which I will discuss more detail later.

Methodology

I have used recommendations contained in the "The Report of the Task Force on Sudden Cardiac Death" as a basis for this report.

The chances of successful defibrillation decrease with each minute that passes. It is now generally accepted that the time to defibrillation is the single most important determinant of survival after cardiac arrest. The ESC Task Force recommended that out-of-hospital defibrillation should be delivered within 5 minutes of receipt of the EMS call. In the hospital setting shock delivery should be within 3 minutes of collapse. The Task Force is of the opinion that the challenges in meeting the ESC targets should be identified and addressed, recognising that it will take some years to achieve them. **"The Report of the Task Force on Sudden Cardiac Death" Page 94**

Definitions & Abbreviations

First Responder – a person trained in minimum in basic life support and the use of an AED, who attends a potentially life threatening emergency. This response may be by the statutory ambulance service or complementary to it. If complementary, first responders can be linked with the statutory emergency services or they can be independent and stand alone. ***"The Report of the Task Force on Sudden Cardiac Death"***

Public access to defibrillation (PAD) means making AED's available in public and/or private places where large numbers of people gather or people who are at high risk for heart attacks live. *"American Heart Association*
http://www.americanheart.org/presenter.jhtml?identifier=3011859
13/02/2007"

Uniformed Responders – personnel who respond to an emergency either on or off duty e.g. fire service personnel, gardaí, EMTs, voluntary and auxiliary organisations, security staff etc. ***"The Report of the Task Force on Sudden Cardiac Death"***

AED – Advisory External Defibrillator
AMPDS – Advanced Medical Priority Dispatch System
APHCO Area Pre Hospital Co-Ordinator
BLS – Basic Life Support
CFR – Cardiac First Responder
Croí – West of Ireland Cardiology Foundation
EMC - Emergency Medical Controller
HSE - Health Service Executive
IHF - Irish Heart Foundation
NAS - National Ambulance Service
PHECC – Pre-Hospital Emergency Care Council
RTA – Road Traffic Accident
RTC - Road Traffic Collision

Brief descriptions of Programme in the Midlands

Community First Responder – AED

This is a responder scheme run in the community. It involves a committee who fundraise and purchase AED's for a pre defined community area. Volunteers are trained by the National Ambulance Service in conjunction with the committee in BLS and use of AED for Adults. The responders then carry the AED and a pager on a rotational basis.

Community First Responder – PAD (Public Access Defibrillation)

In this type of scheme a local committee fundraise to purchase AED's that are then put in cabinets mounted on walls in the community or in buildings. It is expected that when a collapse occurs that someone who is AED trained can go to any of the PAD areas take the AED and use it on the patient.

DARA Scheme – Roosky (not in the Midlands)

In this type of scheme a local committee fundraise to purchase AED's that are then put in cabinets mounted on walls in the community. It is expected that when a collapse occurs, the person after ringing the Ambulance would then ring the GP and then a local PAD trained responder. The Responder would then go and collect the AED before attending the scene of the Cardiac Arrest. Community Instructors would be trained to train AED providers in the area and may act as Responders when the need arises.

Work based AED Programme

This is where an AED is put into a workplace and staff are trained to use the AED in case of a Cardiac Arrest.

NAS Off Duty Responder Programme

This is a new initiative by the National Ambulance Service (Midland Division) where 'Off Duty Staff' carry an AED and pager supplied by the National Ambulance Service. Staff carry the AED and a Pager at all times which will alert the staff in case of a Cardiac Arrest in the Midlands during the day in a pre –defined radius (8 KM) of their home at night.

Fire and Rescue Service Responder Programme

This scheme involves contacting the local Fire service where an ambulance is further than 10 minutes from the scene of a Cardiac Arrest. Where a Fire Station is part of the scheme they will be alerted to the call by their own Control Centre. When Ambulance Control in the Midlands receives a call they will in turn contact the Fire Service Control. Fire Service Control will dispatch an AED resource to the scene. Currently, training is provided by the National Ambulance Service but not the AED.

Active Programmes in the Midlands

Community First Responder – AED

A *Community First Responder* Scheme is usually set up by a local committee of voluntary people. Often a presentation is given by the NAS on all the issues associated with the scheme. Boundaries (area to be covered by the schemes) are agreed and a detailed map sent to the NAS (Midland). Boundaries should be set at 8KM from a central point of where most responders live/work. The objective of this type of scheme is to have trained responder's on-call, on a rota, to be available to attend cardiac arrests and choking calls within the predefined boundaries. Scheme are given a NAS Policy to use as a guideline. They must sign up to the policy where the scheme is linked to the NAS. (Appendix A).

The NAS has provided Instructor training for the volunteer Instructor from the community who in turn provide CPR and AED provider training to volunteer responders. These instructors would also arrange ongoing 90 day re-validation training. Other members of the community would also be trained in CPR and AED though they may not be responders. These Instructors would then become part of the NAS IHF Training Site.
The first of these instructor courses was carried out in May 2007. 9 community instructors were trained from 3 community responder groups. Since then they have trained over 300 providers.

The cost of the scheme is paid for by the committee or local area. They fund and purchase AED's, replacement products (PADS), Face shields, Responder Hi-Vis Jackets, Phone and BLS training equipment. The NAS will provide ID badges, instructor training and co-ordinated activation.

The motivation of these community schemes is very positive however it is an area of concern going forward. Due to these types of schemes being relatively new it is difficult to measure. The concern is that due to the low numbers of calls in a particular scheme and if there were unsuccessful resuscitations that people would become de-motivated. One suggestion for measuring motivation would be to measure the numbers of responders and non responders being trained and re-validated and the turnover of committee members in an effort to measure the motivation.

Activation is by pager or mobile phone. The caller rings Ambulance Control at 112/999. During the call the Computer Aided Dispatch System connects the area of the call and the type of call to a pre defined pager or mobile number. House name, Call type, Address and Phone Number of the caller are automatically sent to the pager or mobile phone.

Pagers have been trialled since early 2007 by Ambulance Officers and Off Duty NAS Responders but have not been made available to communities at present. Sending the information to mobile phones is to be trialled shortly.

One of the issues with the pagers up until recently was that it did not show the patients name and in rural communities this has caused problems in locating the residence of the patient. The procedures on the AMPDS system does not ask the patient name until too late in the call for it to show on the pager. This was a real issue for community schemes as addresses consist of a townlands which can have a radius of several miles. We have recently found a solution for this. The EMC can add in free text into a section of the address. The 'Family Name' of the house from where the patient is now used. It is important to not confuse this with the patient's name as they may not be in their own home or the patient is living with a family member who does not share the same surname.

A system of auditing scheme should be considered to ensure quality, safety and evaluation of scheme types.

Scheme may be audited by

1. Training

    a. The number of providers trained in a year
    b. The number of Responders trained and re-validated
    c. The number of active Responders after 12 months

From this we could assess the value in training instructors in the community. We may also be able to use this as a measure of motivation.

2. Response – How successful was the activation of Responders. What was the difference in response time between the Responders and an Ambulance?

Until Responder Schemes and AED's are common place successful resuscitations will not be a good indicator of the success of a scheme. How activation procedures work and the response time to the patient would be a better indicator to use.

3. Calls – Number of calls by an area should be collated. Attendance at cardiac arrests (Figures held by local committee) would be viewed against this data. The use of the new national CFR Patient Report may help in this area.

4. AED Audit – Where the use of the AED is reported to the National Ambulance Service and the machine's information can be downloaded. Further data could be gained from this, such as times, initial rhythms, conversions and non-conversion of rhythms.

5. Debriefing – As a quality, health and safety measure National Ambulance Service staff should conduct debriefs with all those community responders who attend calls.

To Date:

- While much work has been put into activation by paging system. This has not been implemented for the public schemes. Where public schemes have been activated they have been done so by Paramedics participating in the Off Duty NAS Scheme and also connected with the community scheme.
- Over 300 Providers have been trained by community instructors since May 2007.
- A debrief recently took place after Responders were called out to 3 Cardiac Arrests in the one area.

Presently there are two Community Responder Scheme:

1. In Ballymahon, Co. Longford, there are 3 Teams of 12 Responders who carry an AED & Phone.

2. In Lanesboro and Newtown Cashel, there is 2 Teams, 1 based in each village.

Between both of these Responder Schemes they have up to 10 Public Access AEDs in the community.

PAD (Public Access Defibrillation)

The set up of this type of scheme is similar to that of the *Responder* scheme above, however where it differs is that while they would train the public in CPR and the use of an AED they would not have responders on-call on a rota. Boundaries would have to be set so that the community understand the limits of such as scheme. A 2KM radius of the AED should be used as the boundary. The reason for this is as quoted earlier from the Task Force Report "*defibrillation should be delivered within 5 minutes of receipt of the EMS call".* If a person has to collect the defibrillator and return to the patient in the optimal time then I would suggest one could only travel 4 KM in total to have the defibrillator at the patient's side within 5 minutes.

The NAS has a Draft Policy as a guide for PAD Programmes (Appendix B). Again the NAS will provide instructor training and the instructors would then in turn provide CPR and AED training to the community. These Instructors would then become part of the NAS IHF Training Site. Community training is vital even where there are no responders as it is our experience that some people have not been able to tell if someone is not breathing. By attending CPR classes they should be better able to identify someone not breathing, carry out CPR while waiting for an AED and use the AED where it is available.

The committee or local area would fund and purchase AED's, replacement products (PADS), Face shields, and BLS training equipment.
There would be no need for a pager, ID badge. The NAS would fund instructor training.

The positive and negative points raised in relation to the *Responder programme* above would be similar. The measuring of the PAD schemes would be much more difficult as there would be less links with the NAS. This in turn may accelerate de-motivation. However, if there was a requirement on all Responders to complete the CPR Report and return the bottom copy to the Training Department of the local NAS Division, a follow up could be initiated by the Service.

There are different systems for activation of these schemes. Some encourage the caller to dial 999, the GP and then one of those trained in the use of the AED. Each household may have a list of those trained in their area. In some areas, it is left to the Ambulance Control staff to contact relevant community personnel. Others schemes assume that someone will get the AED to the patient. Some areas ring those on a list of trained persons who would go and collect the AED and then attend the

scene of the Cardiac Arrest.
There is the potential that people would ring the Responders directly and not ring for an ambulance. This maybe discouraged by having NAS personnel from the community involved in the Scheme and also by having community instructors who are taught by the National Ambulance Service.*There is considerable lack of awareness in the community as to the appropriate action to be taken in the event of a collapse. Many people still ring the GP or local hospital in the first instance. The Task Force recommends that the ambulance service should be the first to be contacted. In Ireland the contact number is 999 or 112.* **"The Report of the Task Force on Sudden Cardiac Death"**

The NAS Midland Division is looking at ways where Control staff can advise callers of the location of the nearest PAD to the patient.

Auditing

At present there is no formal links between these types of scheme and the NAS Midland Division. Auditing should be similar to that of the above Responder Scheme.

1. Training - The number of providers trained in a year

2. Response – How often an AED is at scene when the ambulance arrives. What was the difference in response time between the Responders and the National Ambulance Service?

3. Calls – Number of calls by an area should be collected. The use of the new national CFR Patient report form may help in this area.

4. AED Audit - The use of the AED must be reported to the National Ambulance Service and the machine's information downloaded. Further data could be gained from this, such as times, initial rhythms, conversions and non-conversion.

5. Debriefing – As a quality, health and safety measure National Ambulance Service staff should conduct debriefs with all those community Responders who attend calls.

To Date:
Up until recently we were advising groups to work towards the Responder Scheme. The reason for this was that PAD schemes could not be activated and in turn managed in a way that the benefits of the scheme could be measured. The area that could be covered would be far less with a fixed AED than with a Responder.

However in the last year we have recognised two issues:

1) A considerable amount of work/time is required to set up and run a Responder Scheme particularly in the area of administration eg: keeping up to date records on Responders qualifications, re-validation, insurance etc.

2) As of January 2008, we have agreement with all 4 Fire and Rescue Services in the Midlands to act as Responders for Cardiac Arrests.

We now encourage groups to set up PAD systems as a first step to Responder Scheme where there is no Fire Station within 8KM.
Where there is a Fire Station within 8KM we would only encourage PAD systems.

Currently we have 5 PAD only schemes:

Abbeyleix, Co. Laois
Fore, Co. Westmeath
Clonbulogue, Co. Offaly
Rhode, Co. Offaly
Walsh Island, Co. Offaly

Off Duty National Ambulance Service (NAS) Responder

In 2007 we asked Paramedics and other NAS staff if they would volunteer to carry an AED and a pager to attend Cardiac Arrest call in their locality. The response was over whelming with approximately 40 staff (30%) seeking to be involved in the scheme.

The biggest issue was once again, activation. In late 2006, I went to look at the 'Advanced Paging System' being used in Belfast. This system automatically sends data from the Control Centre computer to a pager, during the call taking process. We set about trailing this system with Ambulance Officers and introduced the pagers and AED to Paramedics at the end of the first half of 2007.

Paramedics are required to sign up for the scheme (Appendix C). Initially the pagers were programmed to alert the staff member to a Cardiac Arrest within 8Km of their home 24 hours a day. The scheme was changed early on in the programme as it was recognised that Paramedics maybe away from their home during the day, yet still in the Midland area but would not be aware of a call which they maybe close to. The parameters were changed so that staff would get a page for cardiac arrest in the whole of the Midlands from 0700 to 0000 and 8Km from their home from 0000 to 0700.

The benefits in this type of scheme is that staff do not need additional training nor should they suffer de-motivation as they have a better understanding of the scheme and practical knowledge. The down side is that due to work or other reasons they may not always be able to attend calls.

Paramedics have asked that the scope of the calls they may respond to be extended to include more Medical and Trauma related calls.

i. *Trauma* - If Paramedics attended trauma calls they could give a more clinical perspective on the patient and could advise the Control Centre of the appropriate resources needed. e.g.: how many ambulances are required at an RTC, could they administer aid which may allow the patient then to be brought to hospital in another resource other than an Ambulance. (Recently a patient given IM Glucagon pre hospital by Paramedics was discharged from Emergency Department directly. This early intervention may have negated the need for a bed night.) In light of proposed Discharge CPG's, Paramedics may discharge some patient which would benefit the service with regards its own resources.

ii. *Medical* - As Paramedics are up skilled they will be authorised to administer medications to patients that would stabilise their acute condition before the arrival of an ambulance. Some of these patients may then be able to attend a local GP instead of needing ambulance or to attend the Emergency Department. Again, a more appropriate resource could be allocated to the call, or the patient maybe treated and discharged in line with new CPGs in the future.

As a system of auditing, we document all Responder Scheme calls in particular, to analyse 'time to patient' by a Responder against 'time to patient' by an ambulance. Paramedics are encouraged to contact the Training and Development Department after a call which in it's self a means of auditing any problem.

To Date:

We currently have 13 AED's involving 20 staff. Some of the AED's are shared by staff living in the same area. The number is limited by the number of AED's we could purchase.
To select staff from the 40 applicants we ruled out those who did not live within the Midland area and those who lived in towns that had an Ambulance Station. We prioritised those who were involved with 'Community Responder Schemes', those who were BLS instructors and based on the geographical location of where they lived.

We have had approximately 8 call outs where staff have responded to calls. No successful outcomes have come about yet but due to feedback after each call we are making good progress on activation. In one of the calls the patient turned out to be a Glycaemic Emergency. We have also been made aware of a number of calls where a member of the public thought that someone was breathing but wasn't and that there were Responders in the area. This type of situation maybe averted by Community Instructors teaching Provider BLS courses as it would educate them in the recognition of Cardiac Arrest.

The link between those on this Scheme and involvement in Community Schemes has been nothing short of imperative. The advantages are that Paramedics can bring a lot of common sense to Community Schemes and also reduce the reliance on the Training and Development Department to co-ordinate the Scheme. Paramedics carrying pagers have been able to call Responders involved in their community scheme and request their attendance at the call. At a recent debrief with lay Responders, I was advised that the Paramedic involved in both the Off Duty Staff and

Community Scheme stayed on the phone line with the Responder during the initial stages of the call to encourage the lay Responders.

Fire Service CFR Programme Midland Division

In late 2006, the Training and Development Department of the NAS Midland Division met with the Senior Assistant Chief Fire Officer of Laois Fire and Rescue Service to discuss the potential to have the Fire Service dispatched to Cardiac Arrest Calls. During 2006 we had introduced the Work Based Scheme, started presentations to communities, planning the Off Duty NAS system and so this was another step in implementing the recommendations of the Task Force Report.

R 5.19: A tiered response system should prioritise the training and equipping of rapidly deployable 'uniformed responders' such as:
- retained fire services in rural communities
"The Report of the Task Force on Sudden Cardiac Death" Page 101

It was recognised that other stakeholders in this scheme should be included in the discussions early on in the implementation of the scheme, ie: the Control Centres (Ambulance & Fire). They play a vital role in passing information between the Control Centres and activation. Over the following months, training, deployment and activation procedures were agreed and in March 2007 the First Station (Portarlington in Co. Laois) went live.
A debrief was held after the Fire Service attended a call late in March. It was agreed that the procedures had all worked well but that there was room for improvement.

Again activation is still a critical factor and good co-operation by all stakeholders is leading to great strides taking place in this area. Fire Services are dispatched not just to their fire fighting areas but only to an 8KM radius of their Station. (Appendix D)

The NAS has trained all Fire Fighters to Irish Heart Foundation Healthcare Provider standard as part of the Scheme. There are huge benefits to this scheme:

- Fire Fighters are all ready on-call
- Activation system already in place
- Have an excellent level of training
- Experienced in dealing with traumatic/emergency situations (and can deal with diverse situations)
- Are geographically well placed and are in populated areas away from Ambulance Stations and Hospitals.

There is no issue of motivation as this is seen by Fire Fighters as just a

small extension of their current skills and the utilising of existing qualifications.

The Fire Service are activated when an EMC is taking a call a 'First Responder' icon on the computer system will advise them that the caller is within an 8KM of a LIVE Fire Station. They will then contact Fire Service Control and ask them to dispatch the Fire Service to the scene. As with the activation of all other schemes we are seeking improvement and we are again seeking ways of utilising the automatic paging system between the two Control Centres.

We are auditing by way of documenting all calls responded to by all CFR's. Again the new CFR report will better enable the collection of data on all of these calls.

To Date:

We started off the Scheme with Laois Fire Service and the first Station went live in March 2007. In November 2007, another 2 Stations went live and 1 in Westmeath. In January 2008, Offaly and Longford have agreed to come on board.

In January 2008 2 more Stations in Laois have gone live.

County Council	Number of Stations	Stations with AED's	Stations Live Jan 2008	Stations Live March 2008	Stations Live May 2008
Laois	9	7	5		
Offaly	8	3	0		
Westmeath	4	1	1		
Longford	5	5	0		

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R 5.10: Responsibility for accreditation and monitoring of all BLS / AED training and the maintenance of training records should be assigned to PHECC.
In the absence of PHECC accreditation the NAS Midland Division is a recognised Training Site of the IHF and in doing so all it's instructors are accredited.

R 5.11: Access to defibrillation should be optimised to meet European recommendations. The challenges in meeting the ESC targets should be identified and addressed, recognising that it will take some years to achieve them.
The main aim of this report is to look at what has been happening in this area, in the Midlands over the last year and to review the programmes as the first step in meeting these objectives.

R 5.13: In establishing first responder programmes, priority should be given to programmes, geographic locations and facilities identified as having the greatest need. All such programmes should be coordinated by the HSE Ambulance Service, with best practice guidance from PHECC.
Due to setting up the different programmes we are now in a position to prioritise the programmes and have started doing so.

R 5.14: First Responder programmes must include standardised quality assurance / quality improvement structures (see Section 5.6.8).
By all our Responder programmes being linked to the National Ambulance Service, we can attend debrief sessions after call outs. It may also be better monitored in the future if all programmes are obliged to register with the local Division of the NAS and forward CFR reports to their local Division of the NAS

R 5.16: First Responder programmes outside the voluntary aid organisations should be integrated where appropriate with the statutory ambulance service.
We have created strong links without running the programmes.

R 5.19: A tiered response system should prioritise the training and equipping of rapidly deployable 'uniformed responders' such as:
- full time fire services in urban communities
  Not applicable
- retained fire services in rural communities
  In situ

- the evaluation of the pilot programme of Garda patrol car AEDs should be concluded prior to such programmes being implemented nationally
  Not applicable
- auxiliary and voluntary providers
  Initial talks have taken place
- security personnel at large shopping centres / sports grounds / public amenities, and
  Where there has been interest we have set up schemes
- local first responder programmes should facilitate participation by off-duty trained health services and uniformed personnel.
  In situ

R 5.23: Appropriate support should be available for responders to receive 'critical incident stress debriefing' following a resuscitation attempt.
If support is needed a debrief is provided

R 5.24: The HSE ambulance service should be required to establish structural links to first responder programmes.
Policy's, information document and media communications all encourage a linkage with the NAS. The NAS also endeavours to have NAS personnel on committees where possible.

R 5.32: An AED purchaser should be required to provide the following information at the time of purchase:

- a registration form with all contact details for submission to a central register
- a training form stating that the purchaser understands the responsibility that owning an AED brings and a recommendation that they complete a BLS / AED training course, and
- a community response form notifying their local EMS station that they have an AED and specifying whether they wish to become part of an integrated community response programme, have a limited role in such a response programme or have no role in such a programme.

In the absence of a National Register the NAS Midland Division has a Regional Register of Pre Hospital AED's. (Appendix E)

Recommendations

Community Responder Programmes
These schemes should be continued and expanded. They should be analysed to ensure that the appropriate programme is in place. They should be extended to cover new standards by the PHECC and additional call types.

NAS Involvement
The NAS should take a lead role in co-ordinating and guiding communities with their schemes in the absence of APHCO's, as they are the profession pre hospital acute care service. It is also the link between the different pre hospital service such as GP's, Fire Services and Voluntary Organisations. The National Ambulance Service should play a part in auditing of AEDs as they are extremely familiar with AED. The Service also plays a lead role in Debriefing as they have the day to day experience in these situations themselves and have links to critical incident support where necessary.

Response Times
A system of reporting response times to the Control Centres should be a priority.
Accurate data on response times is of the utmost importance. This information will in future determine the benefit of one scheme over another and the level of response needed in a geographical area. The best practice would be to have a system where the responses times could be captured in the Ambulance Control Centre. The system should give live data to the Control Centre. As an alternative in the mean time, one option may be a texting device that would alert the Control Centre of the status of the Responder.

Inter-agency
There has always been a good relationship in the Midlands between the Fire and Ambulance Services. This scheme has strengthened the relationship further as inter - service training shows what each service has to offer to each other in emergency situations.

Response Times

AED use Reporting
It should be compulsory to report the use of a Pre Hospital AED to the Local PHRTO. In the absence of the PHRTO it should be now seen as Best Practice to report the use of a Pre Hospital AED to the Training and Development Department of the local Division of the NAS.

- *Activation*

Activation should only be through the National Ambulance Service so that the caller is brought through the Advanced Medical Dispatch System this will allow the most appropriate resource to be dispatched. The Control Centre may activate the Fire Service, NAS Off Duty Responders, GP or local Responder Scheme. It will also confirm the chief complaint of the patient so that Responders are not sent to inappropriate calls.

a. Activation by pager or mobile phone be trialled and tested so to encourage caller to call 999 and not the Responders directly. To allow for this, the NAS must have a robust activation system.

Community Responder

b. The National Ambulance Service should look at systems of advising callers of where the nearest AED is located to them. Where there is someone with the caller, they should be advised to collect the AED. Could a link person to the PAD system be contacted to advise them of the call? Could this be done by message to mobile phone?

PAD

c. Activation should only be through the National Ambulance Service so that a co-ordinated and appropriate resource is dispatched. This will also ensure that appropriate Pre Arrival Instructions are given by Ambulance Control and that the Fire Service are only resourced to the appropriate calls.

Fire Service

- *Type of call*

  a. Responders should be trained and encouraged to attend Cardiac Chest Pain and Stroke calls as well as Cardiac Arrest and Choking. This would allow the Responder to attend calls other than possible fatalities which would motivate them. As there are more Cardiac Chest Pain calls than Cardiac Arrest they would also be called out more which would increase confidence and would allow the community to see the benefits of such a scheme

  Community Responder & PAD

  b. Some staff have sought the extension of the Scheme to include more call types. Serious consideration should be given as there are benefits to both the patient and the Service.

  Off Duty NAS Responder

  Payment – while those involved in community schemes have been doing so voluntarily the call volume for Cardiac Arrest and Choking call are very low. If staff are to attend a greater number of calls payment should be discussed early for two reasons 1. Staff are not discouraged by the potential work load, 2. That there are great benefits to the Service as well as patients for this type of schemes.

- *CFR Standard*

  All current community instructors should be up skilled to the new CFR Instructor standard and that they in turn should up skill Responders. The reasons are as mentioned in the recommendation: 'Type of Call (a)'.

  Community Responder & PAD

- *Boundary* – The ESC Task Force on Sudden Cardiac Death recommended that out-of-hospital defibrillation should be delivered within 5 minutes of receipt of the EMS call.

    a. If a Responder has an AED with them when activated, they should be able (traffic and road conditions allowing) be able to travel 5 miles/ 8Km within 5 minutes. As there are many variances that would aid or impede this response, this report suggested a fixed distance of 8KM as a guide for Responders. ***Community Responder***
    b. If some must go to a collect an AED and return to the patient, what distance should be set up? This report recommends 2KM. Where a caller for a Cardiac Arrest is within 2KM of a PAD they would be advised accordingly. This would allow for the time to travel to the AED and return within the recommended time. ***PAD***

- *Training of Instructors* – each Community Scheme should have 4 instructors as two instructors are preferable for each provider course. Schemes should consist of a couple of local areas not only to spread the cost of training equipment but also of AED's as significant savings can be made by bulk purchasing. Each instructor would be requested to give approx 1 course per month. As each instructor would teach 4 providers at a time, each area should train approximately 160 a year. To achieve the goal of having community instructors we should run regular instructor courses with small number. This would allow communities to being instructing sooner rather than later, which would also help gain the support from the community. ***Community Responder & PAD***

- Resources-
    a. There is a lack of IHF Instructor Tutors to do this presently. Approximately 6 to 10 Instructor Tutors are needed within the NAS Midland Division. ***Area Pre Hospital Co-ordinators (APHCO)***
    b. Currently we have no dedicated staff to co-ordinate, audit, advise and seek out best practice in the whole area of AED Responder Schemes. The proposed Area Pre Hospital Co-ordinators should be put in places to carry out these duties at the earliest opportunity.
    c. Even with these APHCO's in place there needs to be a link person within the NAS at Divisional level to continue the co-ordination between communities, the APHCO's and the local division of the NAS.

Conclusion

We have used the *"The Report of the Task Force on Sudden Cardiac Death"* as the driver for our CFR Programmes. We have worked to create a tiered system to create an environment where defibrillators are strategically placed or available as an appropriate resource. We have looked at the various programmes in the Midlands.

The community programmes have been primarily driven by the community themselves and not the NAS. However, our involvement has been in a very cost effective manner while at the same time delivering an optimal service to the public.

The reason for this is that the NAS has not been resourced financially or with the appropriate personnel to guarantee the support of these schemes for the future. We should be encouraging governance by the NAS but independence from the NAS, the schemes should have their own Medical Directors, Insurance and teaching systems.

One of our strategies is that the schemes should be governed, linked and advised by the National Ambulance Service but not run by the Service.

New Positions of Area Pre Hospital Co-Ordinator may take over the need for the NAS to govern these schemes. The APHCO's will give guidance, auditing and co-ordinate the schemes in the future. However it would be important that each Division would have a staff member with responsibility for Pre Hospital AED & CPR.

The reasons for these are:

- To allow for a forum to nurture new initiatives from within or from outside of the NAS in the area of Responder Schemes
- The National Ambulance Service is a major link in the activation of Responders and therefore close ties with the APHCO and schemes are important
- We have also seen that the link at ground level between Paramedics and Communities Schemes has been successful

Community Instructors are one of the great benefits to the Community Schemes. Even if there are no responders, the community at large will see that their contributions have been turned into something tangible and beneficial to the whole community. They also act as a communications network between the NAS and the general public.

Activation is the single most important aspect of all the schemes and this

was acknowledged as a major obstacle at the Resus 2007 by CROÍ. We have taken many steps to create an automatic system. Like any IT system it is prone to problems, software glitches, software compatibility and software to hardware link issues. All practicable steps should be taken to reduce these problems occurring and alternative options should be put in place as back up where possible.

None of these schemes on there own are a solution however, they are all complementary to each other and create not only good inter services relationships but good relationships with the community. I believe this benefit maybe over looked. The community is often critical of the National Ambulance Service; with these schemes they have a better understanding of our abilities and limits and while this will not stop the Service from being criticised it may encourage more educated criticism or informed feedback from the community. Where we are seeking feedback from our service users, this maybe an avenue to explore. It may also be an avenue that maybe used to educate and train the public on new initiatives by the NAS or HSE, i.e.: Recognition of STROKE and actions to take.

With the full range of Schemes, we can use them as back up to each other and also allow us to properly utilise and prioritise resources e.g.: is a full Responder programme necessary, will PAD be adequate, is there a member of staff of the NAS or HSE from the area who could liaise with the groups.

Acknowledgments

I would like to acknowledge the support of the following:

The Chief Ambulance Officer, National Ambulance Service (Midland Division) in the implementation of the programmes above. The acting and permanent Control/Communications Officers for their input and co-operation in the activations system put in place. The Operations and Training Officers for trailing the Paging system. The EMCs some of whom worked on the IT side of things and others who actively implemented changes to provide improved patient care through the activation of different Responder programmes. All the Paramedics who have taken an active part in both Community and Off Duty NAS Staff programmes.

Declan Powers, Senior Assistant Chief Fire Officer, Fire & Rescue Service Laois Co. Council for leading this initiative on behalf of the Fire & Rescue Service. To all the Fire Service personnel who have accepted this initiative with enthusiasm.

To those Community Responders, Committee and Trainers who have all gone beyond their obligations to their own communities.

I would also like to recognise the help I have received from both the Regional and local Hospital Resuscitation Training Officers.

Other organisations which have been a great help have been the PHECC and the IHF.

Appendix A **Community Responder Policy**

Appendix B **Public Access Defibrillation Policy**

Appendix C **NAS Off Duty Responder Application**

Appendix D **Fire Service Responder Policy**

Appendix E **Pre Hospital AED Register**

Appendix A

Policy Title: Community AED Cardiac First Responder Schemes		
1st Draft by:	**Bernie Condron**	**Title: A/Training and Development Officer**
Reviewed by:	**Gearoid Oman**	**Title: A/Training and Development Officer**
Approved by:	**Robert Morton**	**Title: Chief Ambulance Officer**

POLICY STATEMENT:

First Responder schemes comprise members of the public who volunteer to assist their local community by attending emergency calls within an agreed radius of where they live or work and providing basic emergency care whilst an ambulance is en route to the patient.
Primarily, there are four types of First Responder schemes:

Establishment based scheme: Workplaces or sports club, where volunteers operate at or near their normal place of work. Examples include shopping centres, leisure centres, prisons, etc.
Community based scheme: where volunteers operate within the community they live or work and respond to incidents within a pre-defined geographical area such as a village or small town
Fire Service scheme: this scheme provides the Ambulance Service with First Responders who are mobile in an emergency vehicle and able to respond to an area of the Service's operational area.
Off Duty Paramedic Scheme: NAS staff members volunteer to act in a First Responder role in their local community. This policy will also apply to those staff whilst acting as a First Responder.

No First Responder scheme is intended to replace emergency ambulance provision, but to supplement it.

First Responder schemes are a partnership between the local First Responder Groups, local business / commerce and volunteers within the community who are individual members of those Groups. The National Ambulance Service (NAS) is committed to providing initial support and ongoing linkages to such groups, established to provide an appropriate response to areas where an evidence based need exists.

Before being accepted as a First Responder by the Scheme Committee, volunteers should be required to agree to, and abide by the contents of this policy. The Scheme Committee have the authority to suspend or terminate the services of any volunteer, following any breach of this policy.

Document Routing			
1st Draft	**Reviewed**	**Approved**	**Distribution**
Sign: B. Condron Date: 6th Apr 2005	Sign: G. Oman Date: 17th Apr 2007	Sign: R. Morton Date: 17th Apr 2007	Sign: G. Oman Date: 18th Apr 2007

1.0 PURPOSE

1.1 This policy sets out the operating procedures relating to such schemes, developed by the National Ambulance Service to be adopted by those participating in and co-ordinating such schemes. This policy also includes the code of conduct for volunteers who wish to become First Responders and describes the responsibilities of the Scheme and its individual members.

2.0 RESPONSIBILITIES AND ADMINISTRATION

2.1 ROLE OF THE FIRST RESPONDER

2.1.1 To carry an identity card (ID) whenever attending any calls.
2.1.2 To take all reasonable steps to safeguard their own health and safety and that of others who may be affected by their acts or omissions.
2.1.3 To attend local emergency Cardiac Arrest and Choking calls.
2.1.4 To provide emergency care for these patients until the ambulance arrives.
2.1.5 First Responders must be prepared to hand over once more highly qualified help arrives e.g. ambulance crew or General Practitioner (GP). When required, First Responders should provide continuing care under the direction of the ambulance crew.
2.1.6 To have a calm and confident approach. This will provide reassurance both to the patient and their relatives.
2.1.7 To use an Automated External Defibrillator (AED), when indicated, on patients in cardiac arrest and provide effective CPR until help arrives.
2.1.8 To provide a concise verbal hand-over to the ambulance crew on their arrival.

2.2 ROLE OF TEAM LEADER

2.2.1 Organise a rota system to ensure the agreed level of cover, including holidays and sickness.
2.2.2 To represent the Team on the Scheme Committee.

2.3 ROLE OF SCHEME COORDINATOR/LINK PERSON

2.3.1 There should be a Scheme Co-ordinator in each area, who will liaise with the Training and Development Dept.
2.3.2 The Scheme Co-ordinator will be responsible for communication between the Community First Responder Scheme and the NAS.

2.3.3 Wherever possible this route should also be used for general communication in the first instance.
2.3.4 The role and responsibilities of the Scheme Co-ordinator includes:

A. Liaison service between the Scheme and the NAS
B. To assist where appropriate, the provision of training for all Community Responder schemes
C. Co-operate with audit of Community First Responders Schemes
D. Support and motivate their team of Community First Responders and act as focal point for members
E. Arrange regular meetings for the Scheme to provide updates, support and feedback of cases, however patient confidentiality must always be maintained

2.4 ROLE OF SCHEME COMMITTEE

2.4.1 There should be a Scheme Committee in each area, consisting of the Scheme Co-ordinator and Team Leaders.
2.4.2 The Scheme Committee will support the work of the Scheme and the Scheme Co-ordinator.
2.4.3 The role and responsibilities of the Scheme Committee includes:

A. Assist in raising the profile of Community First Responders within the community
B. Ensure an adequate level of stock for consumables
C. To arrange recertification for all Community First Responders
D. Support and motivate their team of Community First Responders and act as focal point for members
E. To check on the Volunteers welfare
F. Ensure that responders are familiar with the Scheme's policies and procedures.

2.4.4 The NAS will encourage local NAS staff to become mentors for volunteers and attend regular review meetings with the local Scheme. This will ensure regular contact between the NAS and each Community First Responder Scheme.

2.5 ROLE OF SERVICE MANAGEMENT

2.5.1 The Assistant Chief Ambulance Officer has overall management responsibility for providing initial support and ongoing linkages to the local Schemes. This responsibility is delegated on a daily basis to the Training and Development Dept.

2.5.2 The Training and Development Dept. is responsible for the management of support and linkages to all First Responder schemes supported by the NAS. The Training and Development Dept. is accountable to the Assistant Chief Ambulance Officer and part of their role is developing a strategy for Schemes and exploring ways in which Schemes can be initially supported and encouraged to develop self-sufficiency while maintaining strong linkages with the NAS. They will also review the use of volunteers on a regular basis and they will be responsible for ensuring the NAS complies with all statutory and mandatory regulations regarding the activation of volunteers by the HSE.

2.5.3 All managerial communications between the NAS and the various schemes which fall within the remit of this policy should, where possible, be co-ordinated by the Training and Development Dept.

2.5.4 The Training and Development Dept. has the authority to terminate the support and activation of any Scheme that breaches the contents of these policies and procedures.

2.5.5 The roles of the Training and Development Dept. and the Assistant Chief Ambulance Officer include the following:

A. Promotion, initial support and effective activation of volunteer schemes by the NAS, in particular Community First Responder schemes
B. Monitor and audit the training of Schemes activated by the NAS including ongoing self sufficiency of training and to ensure it meets and exceeds the standard required
C. Provide advice, support and guidance to volunteers

3.0 DEFINITIONS AND ABBREVIATIONS

C.F.R. – Cardiac First Responder
E.M.F.R. – Emergency Medical First Responder
E.M.T. - Emergency Medical Technician
P.C.R. – Patient Care Report
C.P.G. – Clinical Practice Guidelines
P.H.E.C.C. – Pre Hospital Emergency Care Council

4.0 POLICY/PROCEDURES

4.1 SCHEME CREATION / RECRUITMENT

4.1.1 Using the management information available, the Service may prioritise areas within its operational area which would benefit from the introduction of a First Responder Scheme.

4.1.2 Following initial contact from community groups, they will be asked to submit a detailed map of the area they propose to cover and to discuss this with the Training and Development Department.

4.1.3 the proposed area may need to consider the existence or emergence of other schemes to ensure operational effectiveness.

4.1.4 Volunteers must be over 18 years of age and be physically fit prior to becoming a First Responder.

4.1.5 All Community volunteers are required to complete and submit the following forms, attached to this policy document as appendices, to the local Scheme Committee:

A. Volunteer Confidentiality, Policy and Procedure Agreement, see Appendix B
B. Letter for Insurance Company, see Appendix C

4.1.6 Volunteers at Establishment Based Schemes (i.e. at their normal place of work), will not be required to complete the above. It will remain the responsibility of their normal employer to satisfy themselves that the individual is suitable to undertake these additional duties at their place of work. Therefore, for Establishment Based Schemes, the employer will sign a copy of this policy to confirm that they are aware of their responsibilities under it. The Service will only recognise an establishment level of responsibility up to Basic Life Support and Automated External Defibrillation standards, though it recognises that certain establishments may be equipped to exceed this.

4.1.7 Once volunteers have been accepted onto the scheme they will be invited to attend initial training which will be provided by the National Ambulance Service or other agency. The training will consist of the Irish Heart Foundation Heartsaver AED course in line with national standards.

4.1.8 In the best interests of personal health ad safety, all Community First Responders are advised to be inoculated against Hepatitis B. This can be arranged through their own GP. Should individuals have difficulty obtaining this inoculation, the National Ambulance Service may be able to arrange for the individual to attend the HSE Occupational Health Service facility.

4.1.9 If a Community First Responder wishes to leave the scheme they must inform the Scheme Committee of their intention. They must also return their identity (ID) card, and any equipment issued to them.

4.2 CODE OF CONDUCT

4.2.1 Purpose of Code

To ensure that all volunteers, understand the high standard of conduct that is expected of them whilst they are performing their duties on behalf of the Scheme.

4.2.2 Integrity and Reliability

Must be dependable and can be trusted to work efficiently alone without supervision.

4.2.3 Hygiene and cleanliness

First Responders must have high levels of personal hygiene and cleanliness as they are in close contact with others, especially patients. Also, it is important to minimise risk of cross infection by always wearing gloves and always using the Pocket Mask when dealing with patients and following universal precautions without exception.

4.2.4 Appearance

First Responders are expected to have a clean, smart appearance at all times. Each scheme should have a Hi-Vis Vest which clearly identifies individuals as First Responders, this should be worn at all times when responding to a call.

4.2.5 Effectiveness and efficiency

First Responders must always adhere to and follow agreed policies and procedures.

4.2.7 Conduct towards Patients

Be tactful, reassuring, understanding and sympathetic. Avoid over familiarity and be respectful of different customs, values and beliefs.

4.2.8 Conduct towards Others

Be aware of the needs of patient's relatives, friends or others. Do not be drawn into arguments or disagreements.

4.2.9 Sense of Responsibility

Always respect patient's privacy and dignity. All details regarding patients, including their condition and treatment, are strictly confidential. First Responders are required to sign a Volunteer Confidentiality Form on joining the scheme. Breaches in confidentiality will result in immediate termination of voluntary work for the Scheme and may result in civil legal action being brought against the individual concerned.
Any enquiries from the press / media regarding incidents attended by First Responders must be directed to an Officer of the National Ambulance Service. First Responders must not make any comment to the press. Volunteers are expected to provide care up to but not exceeding the level of their training.

4.2.10Honesty

First Responders enter private homes alone and are therefore in a position of great trust so honesty is paramount.

4.2.11Self-discipline and Loyalty

A high degree of self-discipline and loyalty is required.

4.2.12Complaints and Commendations

Complaints are always thoroughly and fairly investigated in line with the Complaints Policy and Procedure. Community First Responders will be required to co-operate with any investigation into a complaint, adverse incident or legal claim.
All commendations are recorded and the individual concerned will receive a personal letter of thanks and congratulations from the Chief Ambulance Officer.
The Scheme Committee is responsible for ensuring all volunteers adhere to the code of conduct and has the authority to terminate the services of any volunteer who breaches the code.

4.3 TRAINING & ASSESSMENT

4.3.1 The NAS or other approved organisations will provide the initial training. Training courses will be arranged by the Scheme Committee and the NAS Training and Development Dept., who will either provide or co-ordinate the training.

4.3.2 Training course records will be maintained for each Establishment centrally by the NAS if the NAS has provided the training in question, but individual First Responders training records will be maintained by the Establishment itself. If the NAS has not provided training for an Establishment's Responders, then the Establishment is responsible for their training and associated records.

4.3.3 Training records for Community First Responders will be maintained centrally by the NAS, in line with training records for all other operational staff. This will be undertaken by the Training and Development Dept.

4.3.4 Due to the nature of the calls, First Responders are inevitably exposed to stressful and potentially disturbing situations. Whilst informal debriefing by talking to other First Responders, the Scheme Co-ordinator or NAS staff may be sufficient, there may be circumstances where more professional counselling is required. The Training and Development Dept. will assist volunteers in this process. External counselling will be provided if required in line with the NAS Policy – AMBP004 – Advice, Counselling and Critical Incident Stress De-Briefing.

4.4 EQUIPMENT

4.4.1 Each Community First Responder is provided with an official NAS Identity (ID) card, complete with photograph, which must be carried at all times when responding to a call. On leaving the Scheme, Community First Responders are required to return their ID cards and any other property supplied by the Scheme.

4.4.2 The NAS can advise on approved equipment to be used or purchased by the group. The responder kit is comprised of the following:

1. AED with spare defibrillator batteries
2. Disposable pocket face mask
3. Gloves
4. Pager and/or mobile telephone
5. A First Responder high visibility jacket / vest

4.4.3 Only equipment authorised by the Scheme may be used when responding to a call.

4.4.4 Each First Responder is responsible for ensuring that the equipment is fit for operation at the beginning of their duty, that it is cleaned after use (as per training) and then stored correctly. This includes the checking of expiry dates on consumable items of equipment.

4.4.5 Any defective or unserviceable equipment must be withdrawn from use and reported as soon as possible, to the Scheme Co-ordinator, who will arrange for collection of the faulty equipment and provision of a replacement.

4.4.6 Consumables can be replaced by advising the local Scheme Committee that you have attended a call.

4.4.7 Each First Responder Scheme is responsible for ensuring that the AED is maintained as per the manufacturer's instructions. Any AED associated problems should be brought to the attention of the Scheme Co-ordinator.

Clinical Waste

4.4.8 There is a legal requirement for waste to be properly handled, segregated and disposed of. Pocket masks should be disposed off by giving them to Ambulance personnel to put in clinical waste bags. DO NOT dispose of in domestic rubbish.

4.4.9 Clinical Waste is defined as human / animal tissue, excretions, drugs and medical products, swabs and dressings, instruments or similar substances and materials.

4.5 VEHICLES

4.5.1 Where First Responders provide their own transport either using private cars, each Responder must ensure that they have adequate insurance for the vehicle being used. Evidence of insurance cover will be required by the NAS. Each First Responder should ensure that they have informed their insurer of their First Responder activity. This information will be held by the Scheme Co-ordinator/ Committee within the individual's personal file held.

4.5.2 It is the responsibility of each First Responder to maintain their vehicles in a safe and roadworthy condition. The NAS/Scheme will not be held responsible under any circumstances.

4.5.3 Use of blue lights and / or audible warning devices is not permitted.

4.5.4 Transport of patients in a First Responder vehicle is strictly forbidden - any breach in this policy will result in immediate suspension from the Scheme.

4.5.5 The Service will not be held responsible under any circumstances for any vehicle excise duty, NCT, insurance premiums or any other sum payable in respect of the vehicle. (Including any hire purchase or loan repayments in respect of the vehicle).

4.5.6 The vehicle must not under any circumstances be fitted with any permanent or temporary emergency warning devices including but not limited to blue lights, sirens and headlamp flash units.

4.5.7 On route to an incident you have no priority over any other motorist. The manual flashing of headlamps is misleading to other motorists and should be performed only in accordance with the Rules of the Road.

4.5.8 The vehicle must not be fitted with any reflective / non reflective stripes, badges or other signage.

4.5.9 For your own safety, the equipment must be stored and transported in the boot of the vehicle.

4.5.10 Whilst driving to an incident you must concentrate on the standard of your driving.

4.5.11 You must stop in a safe location to undertake other activities such as using the mobile phone or to read a map. You must ensure you park safely and in accordance with the Rules of the Road and any applicable local parking bylaws. Should you need to park in a position that may be considered hazardous, you may display, the vehicles hazard lights to warn other road users of your presence. This should only be used whilst stationary.

4.5.12 Should you be involved in any accident whilst en route to an incident you must stop and provide details in accordance with the Rules of the Road. The accident should be communicated to the NAS/Scheme as soon as possible.

4.5.13 Should you have any concerns as to your safety at scene, remain in your car and if safe to do so, drive on. You must advise Ambulance Control as soon as possible.

4.5.14 There may be occasions when en route to an incident, traffic congestion and the action of other road users will increase stress and anxiety. You must learn to recognise this natural heightened response of the body and maintain control of your actions.

4.6 RESPONDING TO A CALL

4.6.1 All emergency calls will come from Ambulance Control either as a pager message or via the mobile phone. Mobilisation to a call is the sole responsibility of the NAS. First Responders will be mobilised based on pre determined criteria.

4.6.2 Upon receipt of the call, the First Responder on call mobilises to the address given.

4.6.3 Whilst responding to the incident address, drive at normal road speed, obeying all speed limits and in accordance with the current Road Traffic Act and the Rules of the Road.

No exemptions are available for First Responders

4.6.4 When the First Responder arrives on scene they should park up safely and sensibly, allowing access for the ambulance when it arrives. It is acceptable for the First Responder to be accompanied in their vehicle by a relative or friend but it must be remembered that only First Responders are authorised to enter the patient's home or the incident scene.

4.6.5 On arrival at the incident, the First Responder should show their ID card explaining to the patient that the ambulance is en route and that they will provide emergency care until it arrives. The patient's condition is then assessed and appropriate treatment commenced.

4.6.6 First Responders are not authorised to stand-down the ambulance which is automatically dispatched at the time of call.

4.6.7 When the ambulance arrives, the First Responder must gives a concise verbal handover to the crew and offers assistance if necessary.

4.6.8 The First Responder will under no circumstances travel in the back of the ambulance to hospital except in exceptional circumstances and then only at the request of the ambulance crew.

4.6.9 If a First Responder finds themselves in a violent or aggressive situation, leave the incident and inform Ambulance Control via mobile phone. Do not return to collect equipment.

4.6.10 Inform Ambulance Control via mobile phone when clear and available.

4.6.11 First Responders must inform Ambulance Control of any untoward incident or driving offence committed whilst responding to a call as soon as is practicable. The Scheme Co-ordinator and the Training and Development Dept. should also be informed.

Running call

4.6.12 If a First Responder comes across an incident that requires their assistance they should respond appropriately and at the earliest opportunity contact Ambulance Control by dialling 999.

4.6.13 Give the incident address, brief details and render assistance as normal until the arrival of an ambulance.

4.7 LIABILITY

4.7.1 The NAS's insurance cover is provided by the Irish Public Bodies Mutual Ltd.

4.7.2 First Responders, activated by the NAS, are classed as agents of the NAS.

4.7.3 The Service has extended its Employer Liability, Clinical Indemnity Scheme and Public Liability to cover members of First Responder Schemes engaged in **authorized** activities and working within their skill protocols.

4.7.4 In the case of a criminal prosecution, First Responders will be represented by the Clinical Indemnity Scheme, as are all other members of HSE staff including NAS employees.

4.7.5 First Responders must have sufficient car insurance for the purposes of the Scheme and evidence of this will be required by the NAS/Scheme on an annual basis.

4.7.6 You are advised to ensure that by operating as a First Responder you do not invalidate any personal insuring arrangements that you may have, include life or critical illness cover.

4.8 MEDIA POLICY AND FUNDRAISING

Media Policy

4.8.1 For those individuals or organisations authorised by the Scheme to act on its behalf, such as First Responders, all publicity will be coordinated by the Scheme Committee in consultation with Training and Development Dept. following consultation with the HSE Communications Dept.

4.8.2 In particular, the NAS will provide support, advice and final approval for comments addressing all Press enquiries received by those individuals / organisations as mentioned above.

4.8.3 With reference to proactively generated news items e.g. informing the media about a forthcoming initiative, all information must be approved by the HSE Communications Dept. before contact is made with any media. The HSE Communications Dept. will provide support, advice and guidance should it be required.

4.8.4 This policy has been developed to protect patient confidentiality as well as to provide clear guidance on the level of support and involvement in media activity by the NAS/Scheme.

Fundraising

4.8.5 Any fundraising activity, which involves the use of the NAS's name, must be approved by the Chief Ambulance Officer and HSE Communications Dept. prior to its launch. This is to ensure that funds raised are used in a positive and beneficial way to either promote health awareness or to provide equipment such as AEDs for use in the local community.

4.8.6 All funds raised must be accounted for and records must be available for audit. This will be undertaken by the Scheme Committee.

4.8.7 The Training and Development Dept. will assist volunteers in promoting and raising awareness of events aimed at achieving the objectives both of the NAS and of the scheme.

5.0 FREQUENCY OF REVIEW

This policy and procedure will be reviewed informally on an ongoing basis and formally every three years or when necessary following changes in procedures and/or legislation.

6.0 METHOD USED TO MONITOR COMPLIANCE

NAS management will review the clinical effectiveness of each Scheme on a regular basis to ensure that the Scheme is providing maximum benefit to the local community.
The NAS will conduct an annual review of each First Responder Scheme, to ensure its effectiveness both clinically and operationally and to ensure compliance with training requirements.

7.0 REFERENCES

- Community First Responder Handbook
- Policy – AMBP018 - First Responder Patient Care Standards
- P.H.E.C.C. – Patient Care Report Guidelines
- P.H.E.C.C. Clinical Practice Guidelines, Version 2 incorporating Medications Formulary
- P.H.E.C.C. – Clinical Practice Guidelines
- Comments, Enquiries, Complaints and Appeals System
- Data Protection Act 1988 and 2003
- Road Traffic Acts (various)
- Rules of the Road

8.0 APPENDICES

Appendix A – Policy Acknowledgement Form
Appendix B – Volunteer declaration
Appendix C - Letter for Insurance Company

APPENDIX B

NATIONAL AMBULANCE SERVICE
COMMUNITY RESPONDER SCHEME

Volunteer Declaration of Confidentiality, Policy and Procedures Agreement

- Your attention is drawn to the confidentiality aspects of helping in the pre-hospital environment.
- In the course of the pre-hospital service, volunteers may see or hear things of a confidential nature, including information referring to the diagnosis and treatment of patients.
- This information must not be divulged to, or discussed with any person other than relevant ambulance staff. Breaches in confidence will result in the termination of your voluntary work with the Scheme.
- The NAS is not able to support any incident or claim, resulting from the use of a motor vehicle and would wholly be the responsibility of the person operating the vehicle and no secondary claim would be accepted by the NAS.
- I confirm that I will send the enclosed documentation concerning the insurance of my vehicle and will not be attending emergencies until the appropriate endorsement has been received in writing and a copy passed to the Scheme Co-ordinator/NAS Training and Development Dept.
- I also confirm that I will notify my personal insurers of my involvement with the Community First Responder Scheme.

I confirm that I have read and understand the above information and agree to abide by the Scheme's Policies and Procedures.

Name of Volunteer:

Signed: Date:

Scheme Co-ordinator

Signed: Date:

APPENDIX C

NATIONAL AMBULANCE SERVICE
COMMUNITY RESPONDER SCHEME

Dear Sir / Madam

We write to confirm that XXXXX, Policy No XXXXXXXXXX., Has applied for a position in, and has been accepted as a voluntary member of the First Responder scheme.

The Scheme

The First Responder scheme has been developed by the community in consultation with the National Ambulance Service whereby local volunteers are trained to provide emergency care, including defibrillation if necessary to the seriously ill patient whilst an ambulance is en route to the scene. The First Responder scheme is established in a number of areas throughout the state.
All members of the Scheme are volunteers and are not employed by the Scheme and do not receive payment for their services. In return for their assistance, the Scheme provides training in first aid, the storage and use of medical equipment and instruction on the volunteer's obligation to the public. The volunteers are obliged to submit to regular retraining.
Prior to accepting a volunteer into the Scheme, the Scheme undertakes a to abide by a Governing Policy Document of the National Ambulance Service.

Equipment

Each local scheme raises funds to purchase the equipment. The National Ambulance Service provides an approved equipment list. The Scheme also provides detailed training on the safe use and storage of this equipment by volunteers.

Volunteer's role

Each volunteer responds as part of an on call rota within his / her local Scheme. During an on call period, the Responder may be requested by the National Ambulance Service to respond to an emergency in their area. It may be possible that the Responder may walk to the scene of an emergency but this is not always possible. The scheme's volunteers may decide to attend by vehicle (subject to obtaining suitable endorsements on their vehicles insurance policies).

Insurance Cover

The National Ambulance Service would be grateful if you could confirm, in writing to both the volunteer and ourselves that XXXXX will be covered under the terms of his / her existing policy to use his / her vehicle whilst acting as a volunteer. In this regard, we would draw your attention to the following points:

The vehicle will not be equipped with any emergency warning devices (including lights and sirens).
There will be no entitlement for the volunteer to claim any priority over any other motorist.
The volunteer will at all times be expected to observe all applicable road traffic laws.
The National Ambulance Service will not be responsible for any vehicle excise duty, NCT or other sum payable in respect of the vehicle.
The National Ambulance Service will not be responsible for the mechanical condition of the motor vehicle or for any cost of any maintenance or repair.
The National Ambulance Service cannot provide an estimate of the annual mileage the volunteer will undertake in the performance of his / her duties. However, the scheme is designed to operate within an 8 minute travelling time of the volunteer s starting address.
The volunteer will occasionally store his / her first aid equipment, including oxygen cylinders in his / her vehicle. All volunteers have been trained in the safe use and storage of their equipment, and obliged to attend regular re training. All equipment is provided with suitable storage and carriage containers.

A copy of the National Ambulance Service's policy and procedures is available on request. Please forward written confirmation of cover to:

Training and Development Dept.,
National Ambulance Service – Midland Area,
Midland Headquarters,
Midland Regional Hospital,
Tullamore,
Co. Offaly.

Yours sincerely
Training and Development Officer
Ambulance Service

Appendix B

Policy Title: PAD Responder Schemes		
1st Draft by:	**Gearóid Oman**	**Title: A/Training and Development Officer**
Reviewed by:	**Brendan Whelan**	**Title: Training and Development Officer**
Approved by:	**Robert Morton**	**Title: Chief Ambulance Officer**

POLICY STATEMENT:

This Policy is to aid communities to set up life saving Public Access Defibrillation schemes.

Primarily, there are two types of AED schemes:

Public Access Defibrillation (PAD) : schemes are comprised of members of the public who train in the use of a Defibrillator and CPR. They can then carry out CPR, use an AED where it is available whilst an ambulance is on route to the patient

Cardiac First Responder (CFR): This scheme is comprised of members of the public who volunteer to assist their local community. CFR's are on-call within an agreed radius to attend and provide emergency care while and Ambulance is on route.

No scheme is intended to replace emergency ambulance provision, but to supplement it.

1.0 PURPOSE

1.1 This policy sets out the operating procedures relating to such schemes, developed by the National Ambulance Service (NAS) to be adopted by those participating in and co-ordinating such schemes. This policy also includes the code of conduct for volunteers who wish to become First Responders and describes the responsibilities of the Scheme.

3.0 DEFINITIONS AND ABBREVIATIONS

C.F.R. – Cardiac First Responder
C.P.G. – Clinical Practice Guidelines
E.M.F.R. – Emergency Medical First Responder
E.M.T. - Emergency Medical Technician
N.A.S. – National Ambulance Service
P.C.R. – Patient Care Report
P.H.E.C.C. – Pre Hospital Emergency Care Council
PAD – Public Access Defibrillation

RESPONSIBILITIES AND ADMINISTRATION

3.1 ROLE OF THE RESPONDER

2.1.1 To have a calm and confident approach. This will provide reassurance both to the patient and their relatives.
2.1.2 To use an Automated External Defibrillator (AED), when indicated, on patients in cardiac arrest and provide effective CPR until help arrives.
2.1.3 First Responders must be prepared to hand over once more highly qualified help arrives e.g. ambulance crew or General Practitioner (GP). When required, First Responders should provide continuing care under the direction of the ambulance crew.
2.1.4 To keep themselves competent by attending re-validation training.

2.3 ROLE OF SCHEME COORDINATOR/LINK PERSON

2.3.1 There should be a Scheme Co-ordinator in each area, who will liaise with the Training and Development Dept.
2.3.2 The Scheme Co-ordinator will be responsible for communication between the PAD Scheme and the NAS.
2.3.3 Wherever possible this route should also be used for general communication in the first instance.
2.3.4 The role and responsibilities of the Scheme Co-ordinator includes:

A. Liaison service between the Scheme and the NAS
B. To assist where appropriate, in the provision of training for all Community Responder schemes
C. Co-operate with audit of Community First Responder Schemes
D. Support and motivate their team of Responder's and act as focal point for members

E. Arrange regular meetings for the Scheme to provide updates, support and feedback of cases, however patient confidentiality must always be maintained

2.4 ROLE OF SCHEME COMMITTEE

2.4.1 There should be a Scheme Committee in each area, consisting of the Scheme Co-ordinator and Team Leaders.
2.4.2 The Scheme Committee will support the work of the Scheme and the Scheme Co-ordinator.
2.4.3 To register all AED with the NAS
2.4.4 The role and responsibilities of the Scheme Committee includes:

A. Assist in raising the profile of Responders within the community
B. Ensure an adequate level of stock for consumables
C. To arrange Training for the community as a whole in both CPR and AED
D. To arrange recertification for all Responders
E. Ensure that responders are familiar with the Scheme's policies and procedures.

2.4.5 The NAS will encourage local NAS staff to become mentors for volunteers and attend regular review meetings with the local Scheme. This will ensure regular contact between the NAS and each Community First Responder Scheme.

2.5 ROLE OF SERVICE MANAGEMENT

2.5.1 The Assistant Chief Ambulance Officer has overall management responsibility for providing initial support and ongoing linkages to the local Schemes. This responsibility is delegated on a daily basis to the Training and Development Dept.
2.5.2 The Training and Development Dept. is responsible for the management of support and linkages to all First Responder schemes supported by the NAS. The Training and Development Dept. is accountable to the Assistant Chief Ambulance Officer and part of their role is developing a strategy for Schemes and exploring ways in which Schemes can be initially supported and encouraged to develop self-sufficiency while maintaining strong linkages with the NAS. They will also review the use of volunteers on a regular basis and they will be responsible for ensuring the NAS complies with all statutory and mandatory regulations regarding the activation of volunteers by the HSE.

2.5.3 All managerial communications between the NAS and the various schemes which fall within the remit of this policy should, where possible, be co-ordinated by the Training and Development Dept.

2.5.4 The Training and Development Dept. has the authority to terminate the support and activation of any Scheme that breaches the contents of these policies and procedures.

2.5.5 The roles of the Training and Development Dept. and the Assistant Chief Ambulance Officer include the following:

A. Promotion, initial support and effective activation of volunteer schemes by the NAS, in particular Community First Responder schemes
B. Monitor and audit the training of Schemes activated by the NAS including ongoing self sufficiency of training and to ensure it meets and exceeds the standard required
C. Provide advice, support and guidance to volunteers

4.0 POLICY/PROCEDURES

4.1 SCHEME CREATION / RECRUITMENT

4.1.1 Using the management information available, the Service may prioritise areas within its operational area that would benefit from the introduction of a PAD Scheme.

4.1.2 Following initial contact from community groups, they will be asked to submit a detailed map of the area they propose to cover and to discuss this with the Training and Development Department.

4.1.3 The proposed area may need to consider the existence or emergence of other schemes to ensure operational effectiveness.

4.1.4 Participants must be over 18 years of age to be trained in the use of an AED as part of a PAD scheme.

4.1.5 While the NAS may take part in training of participants or training of instructors it is in no way responsible for the running of the scheme and is only represented in an advisory capacity.

4.1.6 In the best interests of personal health ad safety, all Community First Responders are advised to be inoculated against Hepatitis B. This can be arranged through their own GP. Should individuals have difficulty obtaining this inoculation, the National Ambulance Service may be able to arrange for the individual to attend the HSE Occupational Health Service facility.

4.2 CODE OF CONDUCT

4.2.1 Purpose of Code

To ensure that all volunteers understand the high standard of conduct that is expected of them while they are performing their duties on behalf of the Scheme.

4.2.3 Hygiene and cleanliness

First Responders must have high levels of hygiene and cleanliness as they are in close contact with others, especially patients. Also, it is important to minimise risk of cross infection by always wearing gloves and using the Pocket Mask when dealing with patients and following universal precautions.

4.2.5 Effectiveness and efficiency

First Responders should be mindful of the following agreed

4.2.7 Conduct towards Patients

Be tactful, reassuring, understanding and sympathetic. Avoid over familiarity and be respectful of different customs, values and beliefs.

4.2.8 Conduct towards Others

Be aware of the needs of patient's relatives, friends or others. Do not be drawn into arguments or disagreements.

4.2.9 Sense of Responsibility

Always respect patient's privacy and dignity. All details regarding patients, including their condition and treatment, are strictly confidential.

Any enquiries from the press / media regarding incidents attended by PAD schemes recognised by the NAS must be directed to an Officer of the National Ambulance Service. First Responders must not make any comment to the press. Volunteers are expected to provide care up to but not exceeding the level of their training.

4.2.10Honesty

First Responders enter private homes alone and are therefore in a position of great trust so honesty is paramount.

4.2.12Complaints and Commendations

The NAS may be requested to investigate written complaints. Complaints are always thoroughly and fairly investigated in line with the Complaints Policy and Procedure. PAD Responders will be required to co-operate with any investigation into a complaint, adverse incident or legal claim.

The Scheme Committee is responsible for ensuring all volunteers adhere to the code of conduct and has the authority to cease training of any volunteer who breaches the code.

4.3 TRAINING & ASSESSMENT

4.3.1 The NAS or other approved organisations will provide the initial training. Training courses will be arranged by the Scheme Committee and the NAS Training and Development Dept., who will either provide or co-ordinate the training.

4.3.2 Training course records will be maintained for each scheme centrally by the NAS in line with it's record obligation as a training site, if the NAS has provided the training in question, and a copy should be held by the scheme committee. If the NAS has not provided training for an Establishment's Responders, then the Establishment is responsible for their training and associated records.

4.3.3 Due to the nature of the calls, PAD Responders are inevitably exposed to stressful and potentially disturbing situations. Whilst informal debriefing by talking to other First Responders, the Scheme Co-ordinator or NAS staff may be sufficient, there may be circumstances where more professional counselling is required. The Training and Development Dept. will assist volunteers in this process. External counselling will be provided if required in line with the NAS Policy – AMBP004 – Advice, Counselling and Critical Incident Stress De-Briefing.

4.4 EQUIPMENT

4.4.1 The NAS can advise on equipment to be used or purchased by the group. The responder kit is comprised of the following:

1. AED with spare defibrillator batteries
2. Disposable pocket face mask
3. Gloves
4. Pager and/or mobile telephone
5. A First Responder high visibility jacket / vest

4.4.2 Each PAD Scheme Committee is responsible for ensuring that the equipment is fit for operation at all times and that it is cleaned after use and then stored correctly. This includes the checking of expiry dates on consumable items of equipment.

4.4.3 Any defective or unserviceable equipment must be withdrawn from use and reported as soon as possible, to the Scheme Co-ordinator, who will arrange for collection of the faulty equipment and provision of a replacement.

4.4.4 Consumables can be replaced by advising the local Scheme Committee that you have attended a call.

Clinical Waste

4.4.5 There is a legal requirement for waste to be properly handled, segregated and disposed of Pocket masks should be disposed off by giving them to Ambulance personnel to put in clinical waste bags. DO NOT dispose of in domestic rubbish.

4.4.6 Clinical Waste is defined as human / animal tissue, excretions, drugs and medical products, swabs and dressings, instruments or similar substances and materials.

4.5 VEHICLES

4.5.1 This type of scheme does not entail use of a vehicle. Where PAD Responders attends a call in their own transport either using private cars, should be note the following.

4.5.2 Use of blue lights and / or audible warning devices is not permitted.

4.5.3 Transport of patients in a First Responder vehicle is strictly forbidden - any breach in this policy will result in immediate suspension from the Scheme.

4.5.4 The Service will not be held responsible under any circumstances for any vehicle excise duty, NCT, insurance premiums or any other sum payable in respect of the vehicle. (Including any hire purchase or loan repayments in respect of the vehicle).

4.5.5 The vehicle must not under any circumstances be fitted with any permanent or temporary emergency warning devices including but not limited to blue lights, sirens and headlamp flash units.

4.5.6 On route to an incident you have no priority over any other motorist. The manual flashing of headlamps is misleading to other motorists and should be performed only in accordance with the Rules of the Road.

4.5.7 The vehicle must not be fitted with any reflective / non reflective stripes, badges or other signage.

4.5.8 For your own safety, the equipment must be stored and transported in the boot of the vehicle.

4.5.9 Whilst driving to an incident you must concentrate on the standard of your driving.

4.5.10 You must stop in a safe location to undertake other activities such as using the mobile phone or to read a map. You must ensure you park safely and in accordance with the Rules of the Road and any applicable local parking bylaws. Should you need to park in a position that may be considered hazardous, you may display, the vehicles hazard lights to warn other road users of your presence. This should only be used whilst stationary.

4.5.11 Should you be involved in any accident whilst en route to an incident you must stop and provide details in accordance with the Rules of the Road. The accident should be communicated to the NAS/Scheme as soon as possible.

4.5.12 Should you have any concerns as to your safety at scene, remain in your car and if safe to do so, drive on. You must advise Ambulance Control as soon as possible.

4.5.13 There may be occasions when en route to an incident, traffic congestion and the action of other road users will increase stress and anxiety. You must learn to recognise this natural heightened response of the body and maintain control of your actions.

4.7 LIABILITY

4.7.1 The NAS's insurance cover is provided by the Irish Public Bodies Mutual Ltd.

4.7.2 First Responders, activated by the NAS, are classed as agents of the NAS. And are therefore cover by it's insurance cover. However PAD Responders are not activated by the NAS and are therefore not covred.

4.7.3 Further information on insurance can by given by the Training and Development department.

4.8 MEDIA POLICY AND FUNDRAISING

Media Policy

4.8.1 For those individuals or organisations authorised by the Scheme to act on its behalf, such as First Responders, all publicity will be coordinated by the Scheme Committee in consultation with Training and Development Dept. following consultation with the HSE Communications Dept.

4.8.2 In particular, the NAS will provide support, advice and final approval for comments addressing all Press enquiries received by those individuals / organisations as mentioned above.

4.8.3 With reference to proactively generated news items e.g. informing the media about a forthcoming initiative, all information must be approved by the HSE Communications Dept. before contact is made with any media. The HSE Communications Dept. will provide support, advice and guidance should it be required.

4.8.4 This policy has been developed to protect patient confidentiality as well as to provide clear guidance on the level of support and involvement in media activity by the NAS/Scheme.

Fundraising

4.8.5 Any fundraising activity, which involves the use of the NAS's name, must be approved by the Chief Ambulance Officer and HSE Communications Dept. prior to its launch. This is to ensure that funds raised are used in a positive and beneficial way to either promote health awareness or to provide equipment such as AEDs for use in the local community.

4.8.6 The Training and Development Dept. will assist volunteers in promoting and raising awareness of events aimed at achieving the objectives both of the NAS and of the scheme.

5.0 FREQUENCY OF REVIEW

This policy and procedure will be reviewed informally on an ongoing basis and formally every three years or when necessary following changes in procedures and/or legislation.

6.0 METHOD USED TO MONITOR COMPLIANCE

NAS management will review the clinical effectiveness of each Scheme on a regular basis to ensure that the Scheme is providing maximum benefit to the local community.

The NAS will conduct an annual review of each First Responder Scheme, to ensure its effectiveness both clinically and operationally and to ensure compliance with training requirements.

7.0 REFERENCES

- Community First Responder Handbook
- Policy – AMBP018 - First Responder Patient Care Standards
- P.H.E.C.C. – Patient Care Report Guidelines
- P.H.E.C.C. Clinical Practice Guidelines, Version 2 incorporating Medications Formulary
- P.H.E.C.C. – Clinical Practice Guidelines
- Comments, Enquiries, Complaints and Appeals System
- Data Protection Act 1988 and 2003
- Road Traffic Acts (various)
- Rules of the Road

8.0 APPENDICES

Appendix A – Policy Acknowledgement Form
Appendix B – Legal Pre Hospital AED Registration Form
Appendix C – Legal status of those who attempt resuscitation (UK)

Appendix C

Health Service Executive
National Ambulance Service

N.A.S. OFF DUTY RESPONDER SCHEME

Time of scheme 6 Months from ……

I agree to the following conditions as part of Off Duty Paramedic Responder scheme

- The AED is the property of the National Ambulance Service (Midland HQ)
- The AED will be returned to Training and Development Department every 6 months where information will be downloaded and audited. (even if not used)
- When returned, the AED ***may not*** be returned to the same Responder
- Responder must be available by phone and Pager
- Responder must be willing to be contacted 24/7
- It is expected that Responders will only respond to cardiac arrests and choking calls unless other wise agreed
- Daytime radius will cover the Midland 24/7 from 0700 to 0000 unless otherwise agreed with the Training and Development Department.
- Night time radius from home will be 8 KM 24/7 from 0000 to 0700 unless otherwise agreed with the Training and Development Department.
- Willing to become IHF BLS/AED Instructors
- Become involved in local Responder Schemes (As Responder, on Committee or as National Ambulance Service link person)
- To co-operate with auditing of calls and the Responders Scheme
- Advise control that you are at Scene (By phone) and where possible advise control that you are mobile as a responder to a call.
- I have read the SOP on First Responders and agree to its content.

It is recognised by the Ambulance Service that Responders will not be able to respond to every call however all calls made by Ambulance Control maybe audited and Responders MUST co-operate with this,

Responders will be considered on the basis of:

- Geographical location
- Other Responder Schemes
- Demographics
- Being a BLS/AED Instructor

This is a Pilot project, your participation as a volunteer in your community is very much appreciated and we believe that the Off Duty Paramedic Responder will save lives in their own communities.

Signed by: _____ **Date:** _____

Recommended: _____ **Date:** _____
Training Officer

Approved: _____ **Date:** _____
Chief Ambulance Officer

Appendix D

Policy Title: Midland Fire Service Cardiac First Responder Schemes		
1st Draft by:	**Gearóid Oman**	**Title: A/Training and Development Officer**
Reviewed by:	**Draft**	**Title: Draft**
Approved by:	**Robert Morton**	**Title: Chief Ambulance Officer**

POLICY STATEMENT:

First Responder schemes comprise members of the public who volunteer to assist their local community by attending emergency calls within an agreed radius of where they live or work and providing basic emergency care whilst an ambulance is en route to the patient.
Primarily, there are four types of First Responder schemes:

Establishment based Scheme: Workplaces or sports club, where volunteers operate at or near their normal place of work. Examples include shopping centres, leisure centres, prisons, etc.
Community based Scheme: where volunteers operate within the community they live or work and respond to incidents within a pre-defined geographical area such as a village or small town
Fire Service Scheme: this scheme provides the National Ambulance Service (NAS) with First Responders who are mobile in an emergency vehicle and able to respond to an area of the Service's operational area.
Off Duty Paramedic Scheme: NAS staff members volunteer to act in a First Responder role in their local community. This policy will also apply to those staff whilst acting as a First Responder.

No First Responder Scheme is intended to replace emergency medical services provision, but rather to supplement and enhance same.

The Fire Service Cardiac First Responder Scheme is an extension of current partnership between the Fire and Rescue Services in the Midlands and the National Ambulance Service (NAS) Midland Division.

1.0 PURPOSE

1.1 This policy sets out the operating procedures relating to such schemes, developed by the National Ambulance Service and the Fire Services in the Midlands.

Document Routing			
1st Draft	**Reviewed**	**Approved**	**Distribution**
Sign: G. Oman Date: 1st Oct 2007	Sign: Draft Date:	Sign: R. Morton Date:	Sign: G. Oman Date:

2.0 RESPONSIBILITIES AND ADMINISTRATION

2.1 NATIONAL AMBULANCE SERVICE

2.3.1 Scheme Co-ordinator will be the Training and Development Department of the NAS Midland Division. (contact details in Appendix B)
2.3.2 The Scheme Co-ordinator will be responsible for communication with both various Fire Services and Fire Service Control.
2.3.3 Training will be provided by NAS BLS/AED instructors which will consist of the IHF/AHA Healthcare Provider course.

2.2 FIRE AND RESCUE SERVICES

2.2.1 Scheme Co-ordinator will be named in Appendix B.
2.2.2 The Scheme Co-ordinator will be responsible for communication between the Fire Services and the NAS.

2.3 FIRE SERVICE RESPONDERS

2.3.1 To attend local emergency Cardiac Arrest and Choking calls.
2.3.2 To comply with their own Health and Safety Statements.
2.3.3 To provide emergency care for these patients until an EMS response vehicle ambulance arrives.
2.3.4 On arrival of more qualified responder e.g. EMS responders or General Practitioner (GP) a handover should be given. When required, First Responders should provide continuing care under the direction of the higher qualified responder.
2.3.5 To use an Automated External Defibrillator (AED), when indicated, on patients in cardiac arrest and provide effective CPR until help arrives.
2.3.6 To provide a concise verbal hand-over to the higher qualified responder on their arrival.

3.0 DEFINITIONS AND ABBREVIATIONS

NAS	National Ambulance Service
EMS	Emergency Medical Services
EMC	Emergency Medical Controller
IHF	Irish Heart Foundation
AHA	American Heart Association

4.0 POLICY/PROCEDURES

4.1 OPERATIONS SYSTEM

4.1.1 A 8km radius around a Fire Station will be entered onto the Ambulance Control MIS System.

4.1.2 When a call for Cardiac Arrest or Choking is received by the NAS, the Control System will identify if the local Fire Station is part of the responder scheme.

4.1.3 The NAS EMC (Emergency Medical Controller) will contact the relevant Fire Service Control Centre

4.1.4 Contact procedures between NAS Control and CAMP Townsend Street see Appendix D.

4.1.5 Fire Service MUST ONLY respond to Cardiac Arrest/choking calls when dispatched by the National Ambulance Service through their respective Control Centres.

4.1.6 Vehicles:

A. Where there is a 4x4 in the Fire Station, jeep in the fire station the 1st two Fire Fighters will take the AED and go to scene. The rest of the Fire Fighters will attend on a Fire Appliance
B. Where there is no jeep in the Fire Station, Fire Fighters will attend on the Fire Appliance and bring along the AED.

4.1.7 On scene:

Confined area (House, business, etc.))

A. 2 Fire Fighters enter and follow training protocols.
B. On arrival the Fire Officer, they will assess the scene and may rotate the CPR providers

Open area

A. Two Fire Fighters enter and follow training protocols.
B. On arrival the Fire Officer will assess the scene, where there are more than two Fire Fighters available, two should alternate CPR every 30 compressions while two Fire Fighters operate the BVM.

4.1.8 The crew will complete PHECC 'Cardiac First Responder Report' Appendix E and handover to EMS Crew or forward to NAS Coordinator.

4.1.9 After each call out the Station Officer will make contact with their relevant Coordinator who in turn will contact the NAS Coordinator. A Debrief will then be arranged.

4.2 SERVICES PROVIDED BY NAS

4.2.1 MEDICAL DIRECTOR

The Medical Director of the NAS will is the Medical Director of all Responder Programmes co-ordinated by the NAS.

4.2.2 DEBRIEF

The NAS will attend debriefing sessions after the call out of the Fire Service to a Cardiac Arrest patient. This will be to ascertain if any further support is needed for Responders and to review procedures and compliance with procedures.

4.2.3 TRAINING

Training will be provided by NAS BLS/AED Instructors which will consist of the IHF/AHA Healthcare Provider course. This will include:

- CPR and Foreign Body Airway obstruction techniques for Adults, Children and Infants.
- Use of AED and BVM for Adults.
- Use of oxygen (where available) for cardiac arrest situation

4.2.4 USE OF AN AED

AED's must be used in accordance with their training. AED should not be used on children or infants under 8 years of age.

4.2.5 CLINICAL WASTE

There is a legal requirement for the proper handling, segregation and disposal of waste. Pocket masks should be disposed of by giving them to NAS staff to put in clinical waste bags. DO NOT dispose of in domestic rubbish.
Clinical Waste is defined as human / animal tissue, excretions, drugs and medical products, swabs and dressings, instruments or similar substances and materials.

5.0 FREQUENCY OF REVIEW

This policy and procedure will be reviewed informally after each callout of the Fire Service on behalf of the NAS. It will be reviewed formally every 2 years.

6.0 METHOD USED TO MONITOR COMPLIANCE

After each call out, the NAS Co-ordinator will complete the compliance record (Appendix C)

7.0 REFERENCES

- Community First Responder Handbook
- P.H.E.C.C. – Patient Care Report Guidelines
- P.H.E.C.C. Clinical Practice Guidelines, Version 2 incorporating Medications Formulary
- P.H.E.C.C. – Clinical Practice Guidelines

8.0 APPENDICES

Appendix A – Policy Acknowledgement Form
Appendix B – Contact information
Appendix C - Compliance Record
Appendix D – Activation Procedures
Appendix E – Cardiac First Responder Report

APPENDIX B

Contact details

Volunteer Declaration of Confidentiality, Policy and Procedures Agreement

Name	Title	Service	Phone	e-mail	Mobile

APPENDIX C

Compliance Record

Fire Station	Date of Call	Incident number	Date of Debrief	Compliance Yes / No

APPENDIX D

Activation Procedures for Fire Service Cardiac Responder Scheme

Cardiac Arrest within 8KM of Fire Station
(Fire Service Show up as a First Responder on Alert 2000 System).

Procedures Agreed:

Midland Ambulance Control will contact ERCC via 999

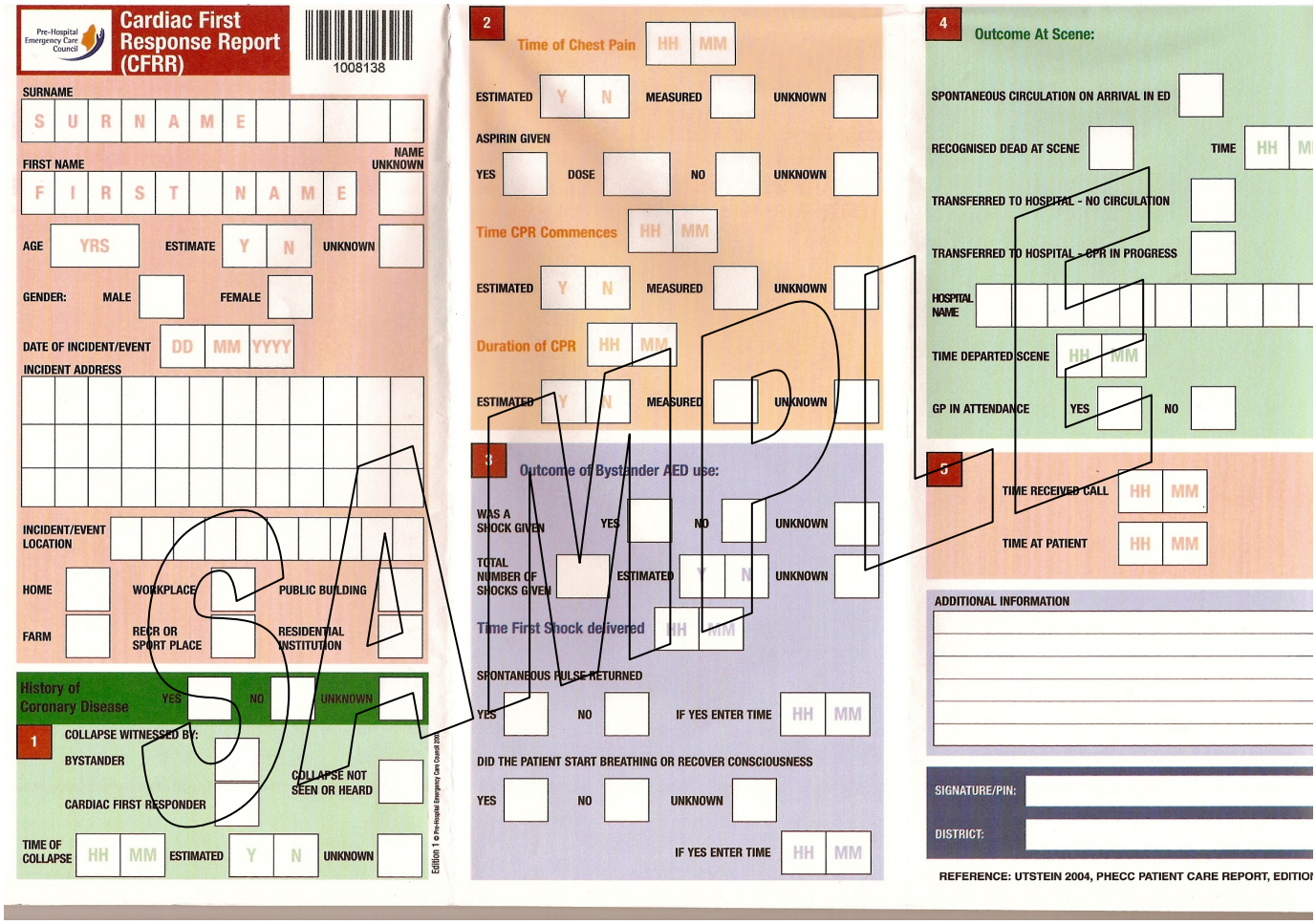
Midland EMC will state:

- **'Midland' Ambulance Control here"**
- **S/S First Responder Cardiac Arrest**
- **9-E-1 Direct Alert**
- **Location of incident**
- **The ERCC Controller will then confirm that the Station has been *Direct alerted* and confirm Midland alert pagers details received, may ask your controller for the address of the incident and any further details**

- **Provide the address/location of the call. Give coordinates from field 3 on Alert System**
- **Provide the phone number of the original 999 caller (Mobile Phone Number)**

DFB WILL HAVE TWO ALERT PAGERS IN THEIR CONTROL CENTRE FROM THE MIDLAND AMBULANCE SERVICE WITH ALL DETAILS.

THIS WILL BE USED TO MOBILE THE FIRE SERVICE IF RECEIVED


Cardiac First Response Report (CFRR)
1008138
SURNAME
FIRST NAME
NAME UNKNOWN
AGE
ESTIMATE
UNKNOWN
GENDER: MALE FEMALE
DATE OF INCIDENT/EVENT
INCIDENT ADDRESS
INCIDENT/EVENT LOCATION
HOME
WORKPLACE
PUBLIC BUILDING
FARM
RECR OR SPORT PLACE
RESIDENTIAL INSTITUTION
History of Coronary Disease
YES
NO
UNKNOWN
1
COLLAPSE WITNESSED BY:
BYSTANDER
CARDIAC FIRST RESPONDER
COLLAPSE NOT SEEN OR HEARD
TIME OF COLLAPSE
ESTIMATED
UNKNOWN
2
Time of Chest Pain
ESTIMATED
MEASURED
UNKNOWN
ASPIRIN GIVEN
DOSE
Time CPR Commences
Duration of CPR
3
Outcome of Bystander AED use:
WAS A SHOCK GIVEN
TOTAL NUMBER OF SHOCKS GIVEN
Time First Shock delivered
SPONTANEOUS PULSE RETURNED
IF YES ENTER TIME
DID THE PATIENT START BREATHING OR RECOVER CONSCIOUSNESS
4
Outcome At Scene:
SPONTANEOUS CIRCULATION ON ARRIVAL IN ED
RECOGNISED DEAD AT SCENE
TIME
TRANSFERRED TO HOSPITAL - NO CIRCULATION
TRANSFERRED TO HOSPITAL - CPR IN PROGRESS
HOSPITAL NAME
TIME DEPARTED SCENE
GP IN ATTENDANCE
5
TIME RECEIVED CALL
TIME AT PATIENT
ADDITIONAL INFORMATION
SIGNATURE/PIN:
DISTRICT:
REFERENCE: UTSTEIN 2004, PHECC PATIENT CARE REPORT, EDITIO
SAMPLE

Appendix E

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Pre Hospital AED Register

National Ambulance Service
(Midland HQ)

Company Information

Company Name _____

Company Address _____

_____

_____

Directions from nearest town _____

Company Phone Number _____

Manager with responsibility for AED _____

Contact person _____ E-Mail _____

Exact Location of AED _____

AED Information

Make _____ Model _____

Serial Number _____ CE Mark _____

Battery out of date _____ Pads out of date _____

Servicing Recommendation _____

Service agreement with _____

Medical Director _____

Updated to 2005 Guidelines Yes No If no date for update _____

Office use:

Received By Training and Development Department: Date _____

Imputed on to Control system Date _____

Grid Ref: _____ _____

Return completed form to: Training and Development Department,
National Ambulance Service, Midland Headquarters, Midland Regional Hospital, Tullamore, Co. Offaly