Post Incident AED Cardiac Arrest Report

Facility Name: _____

Incident Location: _____

Street Address: _____

City, State, Zip Code: _____

1. Date of Incident: _____
2. Estimated time of incident: ____:____ (HH:MM) circle AM or PM
3. Patient Gender: ☐Male ☐Female
4. Estimated age of patient: _____yrs.
5. Did the patient collapse (become unresponsive)? ☐Yes ☐ No
   a) If yes, what were the events immediately prior to collapse? check all that apply: ☐Difficulty breathing ☐ Chest pain ☐ No signs or symptoms ☐ Drowning ☐ Electrical shock ☐ Injury ☐ Unknown
   b) Was someone present to see the person collapse? ☐ Yes ☐ No
      If yes, was that person a trained AED employee? ☐ Yes ☐ No
   c) After collapse, at the time of patient assessment and just prior to the facility AED pads being applied: was the person breathing? ☐ Yes ☐ No
      Did the person have signs of circulation? ☐ Yes ☐ No
6. Was CPR given prior to 911 EMS arrival? ☐ Yes, go to 6a ☐ No, go to 7
   a) Estimated time CPR started: ____:____ (HH/MM) circle AM or PM
   b) Was CPR started prior to the arrival of a trained AED employee? ☐ Yes ☐ No
   c) Who started CPR? ☐ Bystander ☐ Trained AED Employee
7. Was a facility AED brought to the patient's side prior to 911 EMS arrival? ☐ Yes ☐ No
   a) If no, briefly describe why and skip to #15 _____
   b) If yes, estimated time (based on your watch) facility AED at patient's side: ____:____ (HR:MM) AM or PM
8. Were the facility AED pads placed on the patient? ☐ Yes ☐ No
   a) If yes, was the person who put the AED pads on the patient a: ☐ Trained AED facility employee ☐ Untrained AED facility employee ☐ Bystander
9. Was the facility AED turned on? ☐ Yes ☐ No
   a) If yes, estimated time (based on your watch) facility AED was turned on: ____:____ (HR:MM) AM or PM
10. Did the facility AED ever shock the patient? ☐ Yes ☐ No if yes:
    a) Estimated time (based on your watch) of 1st shock by facility AED: ____:____ (HR:MM) AM or PM

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

11. Name of person operating the facility AED: _____

    a) Is this person a trained AED employee? ☐ Yes ☐ No

    b) Highest level of medical training of person administering the facility AED: ☐Public AED trained ☐ First responder AED trained ☐ EMT-B ☐ CRT/EMT-P ☐ Nurse/Physician ☐ Other health care provider ☐ No known training

12. Were there any mechanical difficulties or failures associated with the use of the facility AED?

    ☐ Yes ☐ No If yes, briefly explain & attach a copy of the completed FDA reporting form (required by law):

    _____

13. Did any of the below personal concerns regarding the patient apply? ☐ Vomiting ☐ Excessive chest hair ☐ Sweaty ☐ Water/wet surface ☐ Other concerns not listed above:_____

14. Were there any unexpected events or injuries that occurred during the use of the facility AED? ☐ Yes ☐ No

    If yes, briefly explain: _____

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

    Circulation restored: ☐ Yes ☐ No ☐ Unsure If yes, time restored: ____:____ (HH:MM) AM or PM

    Breathing restored: ☐ Yes ☐ No ☐ Unsure if yes, time restored: ____:____ (HH:MM) AM or PM

    Responsiveness restored: ☐ Yes ☐ No ☐ Unsure if yes, time restored: ____:____ (HH:MM) AM or PM

16. Was the patient transported to the hospital? ☐ Yes ☐ No

    a) If yes, how was the patient transported? ☐ EMS Ambulance ☐ Private vehicle ☐ Other _____

    b) If yes, please provide name of transporting ambulance service and the facility the patient was transported to: _____

17. Other comments/concerns not referenced on this form that may be useful for the medical director?

    _____

Report completed by: _____

Please print name/date: _____

Signature/date: _____

Title/phone: _____

Manufacturer/model of the AED used: _____

PLEASE RETURN TO RISK MANAGEMENT WITH 24 HOURS FOLLOWING INCIDENT