Medical Advisory Committee

Meeting Minutes

27th September 2018, PHECC office @ 10:00am

Present	Apologies	In attendance
David Menzies (Chair)	David Irwin (Vice Chair)	Brian Power, Acting Director
Jason van der Velde	Niamh Collins	Ray Carney, PHECC PDO
David Hennelly	Macartan Hughes	Ricky Ellis, PHECC PDO
Ian Brennan	Mark Dixon	Margaret Bracken, PHECC Support Officer
Shane Knox	Stanley Koe	
Philip Darcy	Shane Mooney	
Lisa Cunningham Guthrie	Peter O'Connor	
Cathal O'Donnell		
Martin O'Reilly		
Hillery Collins (via t/c)		
Mick Molloy (via t/c)		
Eoghan Connolly (part meeting)		

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1. Chair's Business

The Chair welcomed everyone to the meeting. Mick Molloy and Hillery Collins attended the meeting via teleconference. Apologies were noted. Condolences were expressed on the recent death of Ian Brennan's mother and Chair's mother in-law, and also Shane Knox's mother. Brian Power informed the meeting that Council, at their 4th September meeting, appointed Mr Richard Lodge to the post of PHECC Director, and he is due to take up this position on or shortly after 1st November 2018. Ray Carney was introduced as the acting PHECC Programme Development Officer replacing Brian Power, who was appointed at the July Council meeting as PHECC Acting Director pending the appointment of the new Director. The Chair extended an invitation to the new Director to attend the next MAC meeting on 29th November and stated that the Committee are looking forward to working with him. Dr Philip Darcy was welcomed as a new member to the MAC nominated by the Chair.

2. Minutes from July 2018 meeting

The minutes of the meeting held on 26th July 2018 were reviewed.

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 26th July 2018.

Proposed: David Hennelly **Seconded:** Jason van der Velde

Carried without dissent

2.1 Matters Arising from the July 2018 minutes

Agenda item 3 clinical queries

An email from a practitioner regarding the recent clinical directive pertaining to medications and pregnancy, specifically Aspirin, was discussed. It was agreed that PHECC will progress with seeking further advice on the implications and risks involved in the administration of Aspirin during pregnancy by EMTs, call takers and responders, and report back at the September MAC meeting. Ray Carney advised that further advice has been sought and an update will be provided at a future MAC meeting. He informed the members that a letter was received from Prof Kieran Daly, Clinical Lead National ACS Programme, informing that he is stepping down from the role of Clinical Lead at the end of September 2018. Prof Daly expressed his great satisfaction on the work that the ACS programme has done since 2010 and complimented the contribution from PHECC and the working groups to the process. The Chair requested that his gratitude be conveyed to Prof Daly and the National ACS programme.

3. Clinical Queries

3.1 IO Access and Lidocaine

Cathal O'Donnell, Medical Director of the NAS, submitted a request to the MAC to discuss the administration of Lidocaine IO prior to the infusion of fluids/medications in conscious patients. ePCR data received from the NAS on the GCS of patients that had an IO inserted was included in the meeting papers to support the discussion. A separate CPG was proposed, and the Chair suggested developing a clinical practice procedure. Discussion took place regarding a minimum GCS above which Lidocaine would be administered and it was felt that administration would be at the discretion of the practitioner. Jason van der Velde recommended that Lidocaine be administered as the initial flush. While the IO manufacturer guideline states Lidocaine 2% it was agreed that Lidocaine 1% would be the form used as it is already included in the current medication formulary where it is used as a solvent for Ceftriaxone IM.

* Hillery Collins joined the meeting via teleconference.

It was agreed that Ray Carney will draft an adult and paediatric CPG for a future MAC meeting and circulate to the members in advance.

3.2 Ketamine

CPG 4/5/6.2.6 Pain Management and context for discussion was included in the meeting papers. Ricky Ellis briefed the members. At the Pre-Hospital Grand Rounds in SVH 30/7/2018, several cases presented during the evening focused on the pain management and medication choices available to APs when managing pain. During the case presentations practitioners suggested that the current pain management CPG was restrictive in the situation where a practitioner wants to use Ketamine as a first line medication.

One practitioner reported being restricted by the lack of clarity in the CPG which identifies Ketamine as a 3rd line medication if Morphine and Fentanyl are ineffective. However, the CPG does allow for the administration of Ketamine as a frontline medication in cases where a painful extrication or procedure is anticipated. It was perceived that the advice on the CPG was lacking clarity and potentially prevented the 1st line use of Ketamine in situations where it would be the best medication to administer. There was consensus from the attending doctors that APs should have access to a wider dosing regime and that the CPG should provide a less restrictive approach to the administration of Ketamine in recognition of the environments/presentations that pre-hospital practitioners meet.

The members discussed at great length the issues of Ketamine dosing and sequence of medication; whether to increase the dose or leave as it currently is, and whether to allow Ketamine to be administered as a first line analgesic. David Hennelly expressed his concerns regarding Ketamine as a frontline drug and advised looking at other guidelines. He suggested expanding the range based on patient need to achieve analgesic effect and work on dissociative doses as a separate range. Jason van der Velde noted that when practitioners are phoning in they are being reminded of the basic steps involved regarding pain management and to use IV Paracetamol as the first line medication. He advised that we should be pushing for getting the basics right, for practitioners to administer IV Paracetamol in the first instance and then Fentanyl, and it is very rare Ketamine is used as an analgesic option. He believes a repeat dose (once only) puts practitioners at a disadvantage and Ketamine could be used potentially every 10 minutes due to its short half-life. Brian Power advised that the option of phoning in should be the exception rather than the rule and that there may be a training issue in these cases. He stated that we need to trust that practitioners have the necessary skills and are competent enough to deal with these situations. He noted that the issue of privileging is well embedded in licensed CPG providers.

David Hennelly proposed changing the dosing regime of Ketamine from 0.1mg/kg to 0.1mg/kg - 0.3mg/kg at 10 minute intervals prn, to the agreement of the members. Ray Carney will amend CPG 4/5/6.2.6 Pain Management accordingly and a revised draft CPG will be presented for discussion at a future MAC meeting. Brian Power advised that clarity be provided to the recognised institutions in relation to the use of Ketamine.

3.3 Pre-eclampsia

Martin O'Reilly submitted a request to the MAC to discuss the benefits or pitfalls to introducing a CPG for pre-eclampsia for Paramedics and Advanced Paramedics. Obstetrics/Pre-eclampsia CPG from Queensland Ambulance Service was included in the meeting papers for information. He provided some background to the request and informed that he was contacted by a maternity hospital in Dublin regarding a pregnant patient who rang that hospital with a severe headache, the hospital did not determine if this was pregnancy related and it was regarded as a headache. The patient was transported to the nearest ED, after which the patient rang the Obstetrics hospital, who in turn rang the nursing staff in the ED. The patient was sent to the Obstetrics hospital and was subsequently discharged. M O'Reilly expressed his concerns as to a potential near miss if the pregnant patient had pre-eclampsia. He questioned if it is reasonable to expect the ED to manage this situation, and if not, what is the protocol for practitioners. He questioned if there is a need for a pre-eclampsia CPG. Brian Power outlined that the rationale for CPGs is to enable administration of medications or interventions. He questioned if practitioners are required to make the decision whether to bring the patient to the Obstetrics hospital or the ED. The consensus among the members was that if patients declare that they have pre-eclampsia they may be brought to the Obstetrics hospital and if they don't declare this they should be transported to an ED. It was agreed that there was no requirement to develop a pre-eclampsia CPG at this point.

3.4 Nifedipine

Correspondence from a pharmacist regarding Nifedipine and the ongoing supply issues was included in the meeting papers for discussion. Some strengths and formulations are officially discontinued, and others are technically not discontinued but are currently not available. The pharmacist contacted Bayer in Aug 2018 and their reply was included. The pharmacist explained that as Nifedipine is so rarely used cardiology was notified, but not everyone was contacted. CPG 4/5/6.5.5 Umbilical Cord Complications was also included in the meeting papers. Jason van der Velde advised that the CUH pharmacy have

sourced a Nifedipine supply. As requested by Brian Power, Mr van der Velde will provide the pharmacy's contact details to Mr Power, for issuing to licensed CPG providers.

Brian Power informed that he attended a HPRA meeting recently and it was stated that there may be supply issues with medications as a result of Brexit. Ray Carney read out a tabled document from the HPRA notifying of a shortage of Morphine Sulphate 10mg/ml solution for injection.

4. Correspondence

4.1 Letter to Licensed CPG Providers

As agreed at the July MAC meeting, correspondence was sent to all licensed CPG providers from Ricky Ellis, Programme Development Officer, advising them that on the basis of legal advice received by PHECC, and as per Council resolution, the practice of granting exemptions for medications and CPGs will cease, and advising them that any deviation from this is a matter for each organisation in conjunction with their Medical Director. The letter informed that the MAC intend to conduct a process to review all CPGs with the intention of designating CPGs as core or non-core CPGs, and that the Palliative Care CPG and the Treat and Refer CPGs have been designated as non-core CPGs as an interim measure. A copy of the letter was included in the meeting papers for noting.

4.2 Letter to RSA

A copy of a letter to the RSA from Ricky Ellis in response to a recent article in the Irish Independent on 8th August 2018 "RSA EXPERT ADVICE", in which the RSA published clinical advice regarding the actions members of the public should take at the scene of an accident, was included in the meeting papers. The letter informed the RSA that PHECC is the statutory regulator of pre-hospital emergency care and its Medical Advisory Committee determines clinical care in all contexts from first aid to Advanced Paramedic level practice, and PHECC would consider it more appropriate for PHECC to advise in this area. An invitation to meet was offered to the RSA to explore how PHECC and the RSA can work together to increase the protection of the public. The Chair read out a reply from the RSA Communications Manager, who communicated that the RSA would be happy to meet with PHECC. The Chair advised that a meeting will be organised in due course to discuss future collaborations.

4.3 Paramedic 2 entry on website as newsletter item

Following the publication of the PARAMEDIC2 trial it was agreed at the July MAC meeting to issue a statement to all PHECC responders and practitioners. The statement which was uploaded onto the PHECC website as a newsletter item with a link to the PARAMEDIC2 trial was included in the meeting papers for information.

5. Clinical Developments

5.1 Subcommittee report – Sedation

A report on "Agitated Patient Management Summary" in relation to MEDICO Cork was included in the meeting papers for discussion and Jason van der Velde provided an overview. He noted that not all agitation cases are behavioural, and the majority are due to head injury. He stated that practitioners are dealing with very difficult situations in these circumstances. Unless there is a known psychiatric disturbance the underlining cause of a patient's agitation may be difficult to determine, and emergency

sedation is called for in the case of extremely agitated patients in these circumstances. In the case of known head injury an analgesia approach followed by Midazolam is required. Sepsis will be a difficult sub-set of patients due to the side effects of sedation.

There was a robust discussion. David Hennelly advised that practitioners need a formal sedation assessment tool to determine why the decision was made to intervene, and he queried at what practitioner level do we start to introduce formal sedation analgesia. Jason van der Velde stated that agitation is a symptom and suggested a scoring mechanism to decide if pain is a factor and if so to administer analgesia in the first instance.

Brian Power advised that it would be very difficult to add any more information to the existing behavioural emergency CPG as it is already quite detailed. He noted that in prehospital care typically the symptoms are addressed, and the focus is on what case is presented. He suggested that an 'Agitated Patient' CPG be developed. He also suggested adding to other relevant CPGs; is the patient agitated; yes/no; if yes go to Agitated CPG. Hillery Collins suggested changing the Behavioural Emergency CPG to Behavioural/Agitated Emergency. The Chair questioned if the traumatic brain injury CPG contains enough instruction to help manage agitated patients and suggested looking at all core CPGs to determine if any adequately managed agitated patients.

Jason van Der Velde and Ray Carney will develop a package on sedation for consideration of the MAC and Council. David Hennelly will provide the sedation document developed for the subcommittee. The Chair stated that he appreciated all the time and effort of the subcommittee and acknowledged the amount of work involved.

5.2 Paediatric intubation

The members were invited to read a paper by Coleman et al regarding Paediatric airway management and concerns: a survey of Advanced Paramedics in Ireland, published in the Irish journal of Medical Science 2018, which was included in the meeting papers. The Chair read an abstract from the paper to the members.

Brian Power provided the rationale for introducing paediatric intubation. He stated that Sean Walsh from Crumlin Children's Hospital, who was a member of a previous MAC, advised that the outcomes for paediatric arrest is poor and intubation may improve outcomes, he recommended that if an individual practitioner is competent and feels confident to use it they should but are not compelled to. Hillery Collins noted that in his opinion most practitioners would not be comfortable to use intubation in paediatric cases, intubation is no different than any other intervention and practitioners don't frequently deal with paediatrics.

Ray Carney read out correspondence received from Stanley Koe on paediatric intubation. Jason van der Velde observed that very good airway management has become a paramedic skill and is to be applauded. The Chair noted the difference between anaesthetising versus intubating a paediatric and advised that there would be quite a change in practice, and more time for consideration is required.

Shane Knox noted that the paper is reflecting on the opinions of practitioners and there is not enough evidence to change current practice. The Chair noted the report and Stanley Koe's comments. The MAC will look at intubation separately at a later stage.

6. CPG Development Process

6.1 Separation of FAR from Responder CPGs

A proposal to separate FAR CPGs from the Responder CPGs, and a copy of the Responder CPGs, were included in the meeting papers. Ray Carney informed that three issues were identified during preparation of the CPGs. There are no changes to the EFR CPGs, only version changes.

The members discussed with agreement as follows:

1. CPG 2/3.4.21 Hypothermia; application of hot packs to armpits and groin is listed as an EFR skill, however the current skills matrix lists same as a FAR/OFA skill.

   * The MAC agreed to remove hot packs for active rewarming (hypothermia) from the skills matrix for FAR/OFA.

2. Following removal of EFR elements of 2.3.4 Asthma – Adult & 2.3.12 Asthma – Paediatric (≤ 15 years) there are no specific management steps for the FAR.

   * The MAC agreed to remove this CPG and amend the CPG 2.3.2 Abnormal Work of Breathing to remove link to Asthma CPG

3. CPG 1/2/3.6.10 Submersion incident, monitor pulse is listed as an OFA skill, however, the FAR has the same skills matrix as the OFA. It was proposed to remove differentiation line in sequence step box (monitor respirations & pulse).

   * The MAC agreed to amend box 'monitor respirations & pulse' and to remove OFA flag.

4. CPG 2.6.9 Spinal Injury Management, advise patient to remain still is not in keeping with FAR Education & Training Standard which lists as an objective 'Demonstrate how to maintain active spinal motion restriction'. Following discussion, the current instruction is to be retained with the addition of a definition of 'passive spinal motion restriction' to be added to the CPG. It was also proposed to remove the information boxes on high risk factors, spinal injury rule-in considerations and low risk factors.

   * The MAC agreed to remove information boxes on high/low risk factors and rule-in considerations and to add a definition of passive spinal motion restriction.

   * Further amendments were agreed to CPG 2.2.3 Primary Survey – Adult; C-spine control to be changed to passive spinal motion restriction.

It is noted that FAR Education and Training Standards will require updating as the FAR standard does not match the spinal injury management CPG instruction on passive spinal motion restriction.

David Hennelly suggested updating the references on all the responder CPGs however Brian Power advised that there is not a lot to reference at responder level. Shane Knox proposed listing the references at the beginning of the CPGs.

Revised and amended draft CPGs will be included for approval at a future MAC meeting.

7. Clinical Practice at Events

7.1 Clinical Care at Events Subcommittee

7.1.1 De-identified data from Clinical Care at Events

At the July MAC meeting Brian Power advised that he recently circulated a spreadsheet to all service providers involved in covering events requesting de-identified patient data and was awaiting feedback. He informed that to date only two organisations have agreed to share their de-identified data, however they lack the resources to convert the data into an appropriate electronic format for PHECC analysis. This is an issue particularly for the voluntary organisations. To eliminate the resource issue for organisations and to encourage other licensed CPG providers to share their data, the Clinical Care at Events Subcommittee made a recommendation to Council that PHECC employ a data in-putter, on a temporary contract of three months to access the data and input it into a PHECC designed spreadsheet. This funding to be part of the PHECC research budget sub heading.

B Power advised there is no update to report. He informed that Council at their July meeting agreed to employ a data in-putter, on a temporary contract, for up to three months to access de-identified data of care at events in Ireland from licensed CPG providers.

8. MAC Strategy 2017-2020

8.1 Strategic Development Committees

At the July MAC meeting it was agreed that work would start on the preparation of material to support the development areas as identified in the MAC strategic plan and to convene three working groups to explore needs, scope of practice, educational needs and international comparators. It was also agreed that all members of the MAC may contribute to each of the three working groups and that PHECC would send an email out to all MAC members inviting them to participate. This email was sent on 31st July requesting that members of the Committee should contact the working group Chair whose contact details were supplied in the email. Strategic objectives, terms of reference and timeframe were also contained in the email. A copy of the email was included in the meeting papers for information.

Brian Power informed the meeting that Martin O'Reilly was the only nominee to the treat and refer subgroup of which Brian is Chair. At the meeting, Mick Molloy, who attended via teleconference, agreed to be part of the treat and refer subgroup. Mr Power advised that the data collected as part of the PhD will be utilised as a research suite to develop the scope of practice and an update will be provided at a future MAC meeting.

Ian Brennan presented on Critical Care Paramedic with feedback and questions from the members. The Chair thanked Ian. Brian Power explained the background to the different practitioner divisions on the PHECC register and advised of the difficulties of making any changes to these divisions under the current legislation. He explained that within each division there was multiple levels which could accommodate CCP in the short term. Mick Molloy questioned if advice be sought from the DoH. B Power advised that this is not necessary, that competencies are what is important not the label on the individual practitioner. Shane Knox suggested considering Paramedic levels 1, 2, 3, 4 and 5 and suggested to drop EMT level. B Power noted that there is confusion in the general public as to what a paramedic is as internationally a paramedic is an ALS practitioner. He stated that he is opposed to abolishing EMT as it would cause a lot more confusion on clinical capabilities.

David Hennelly presented on Paramedic levels, clinical levels/roles, with further feedback from the members.

* Eoghan Connolly joined the meeting.

The Chair observed that career progression is not tied to clinical progression. He suggested that Ian Brennan and David Hennelly present to the Education and Standards and the Quality and Safety Committees, and to Council. Also, to consult with licensed CPG providers and critical care response teams to determine what the next steps might be. Cathal O'Donnell commended Ian Brennan and David Hennelly on their very interesting and informative presentations. He suggested that employers and trade unions should be involved. Brian Power noted there is a definite need for a higher level of care. The Chair pointed out the need to develop a scope of practice and specific competency list. The Chair requested that Ian Brennan and Ray Carney collaborate and identify requirements going forward.

Strategic Development Committees will be a standing agenda item going forward and an update will be provided at a future MAC meeting.

9. External communications, consultation, feedback

A draft proposal from Childminding Ireland who wish to develop first aid training for childminders was tabled for discussion. This proposal will be discussed further at a future MAC meeting.

The current media discussions regarding the new Helicopter Emergency Medical Service in Cork was mentioned. Cathal O'Donnell advised that in his opinion this was outside the scope of the Medical Advisory Committee.

Ray Carney informed that he has received feedback and requests from practitioners for more information and details regarding the medication formulary and indicating the frequency of symptoms e.g. for Methoxyflurane.

10. AOB

David Hennelly queried if a working group is being formed to decide what should be included in CPGs going forward. The Chair stated that there is a large volume of work involved in reviewing all the CPGs and this will be considered for the next CPG review in 2019.

Brian Power brought attention to the 2018 IAEM conference. He informed the meeting that the IAEM was seeking sponsorship and that it may be possible for MAC members to attend under this sponsorship. He asked the members to let him know in the following few days if they are interested in attending.

David Hennelly questioned if MAC meetings should be increased to monthly meetings. Brian Power explained the resources are not available to facilitate this. The Chair stated that specific extra meetings can be scheduled if required.

The Chair thanked everyone for attending the meeting and conveyed his appreciation. There being no other business the meeting concluded at 13:30pm.

The next meeting of the MAC will be held on Thursday 29th November @ 10:00am in the PHECC office.

Signature: _____ **Date:** 29/11/18

Chair