Medical Advisory Committee

Meeting Minutes

31st May 2018, PHECC office @ 10:00am

Present	Apologies	In attendance
David Menzies (Chair)	David Irwin	Brian Power, PHECC PDO
Jason van der Velde	Shane Knox	Ricky Ellis, PHECC PDO
David Hennelly	Mick Molloy	Margaret Bracken, PHECC Support Officer
Ian Brennan	Niamh Collins	
Eoghan Connolly	Macartan Hughes	
Martin O'Reilly		
Cathal O'Donnell		
Shane Mooney		
Gerard Bury		
Stanley Koe		
Hillery Collins		

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1. Chair's Business

Brian Power informed the meeting that the Chair was delayed due to an emergency call and the Vice Chair was unable to attend. The members elected Jason van der Velde, a member of Council, to Chair the meeting until the Chair arrived. Apologies were noted.

Brian Power relayed that the Director of PHECC has resigned on health grounds and will be leaving the organisation shortly. Hillery Collins wished the Director well on his retirement and thanked him for his service.

2. Minutes from March 2018 meeting

The minutes of the meeting held on 29th March were reviewed.

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 29th March 2018.

Proposed: David Hennelly **Seconded:** Eoghan Connolly

Carried without dissent

2.1 Matters Arising

- Agenda item 4

Gerard Bury, who was not present at the March meeting, requested that his dissent to the resolution regarding paediatric IV Paracetamol administration be noted.

- Agenda item 5.1

At the March meeting the Committee recommended that the PHECC Medication use during pregnancy document be recommended to Council for approval. David Hennelly queried if this document has been formally released by PHECC. Brian Power clarified that, as per Council rules, documents will become

official and action items will come into effect when the minutes are approved and signed by the Chair of Council. He confirmed that the May Council minutes will be signed at the next Council meeting on 14th June.

The Chair of the Quality and Safety Committee advised that the Q&S Committee discussed the issue of action items at their May meeting and agreed that if an item needs actioning immediately it is not necessary to wait for Council approval. The MAC members agreed to recommend to Council that if there is a safety issue items can be actioned immediately.

- Agenda item 9

At the March meeting the role of Medical Directors of licensed CPG providers, the role of Medical Practitioners at planned and unplanned incidents and events, and the relationships between Medical Practitioners and PHECC Registrants was discussed. The members were informed that PHECC were seeking clarification and advice from the Medical Council of Ireland, Medical Insurance Companies, the Nursing and Midwifery Board of Ireland (NMBI), the Irish College of General Practitioners (ICGP), and PHECC's legal advisors. The meeting Chair requested an update and Brian Power clarified that PHECC was in the process of writing to these organisations at present.

3. Clinical Queries

3.1 PR Paracetamol for paramedics

Correspondence from a paramedic to the Vice Chair of MAC, requesting that the MAC discuss the use of PR Paracetamol for use by paramedics was included in the meeting papers. The question of whether paramedics should be permitted to administer medications via the PR route and the appropriateness of this was discussed. What is best practice was stressed as being of prime importance by Stanley Koe. It was noted that PR Paracetamol is currently an AP skill and is not in the training standards or scope of practice for paramedics. It was clarified that PR Paracetamol is on the 7th schedule for paramedic use, thus its introduction was not a legal issue. It was highlighted that if the issue is a training issue and not a safety issue, it could be considered for use by paramedics going forward as a vital treatment. Also, should direction be given by the service provider's Medical Director and the training required for practitioners was explored. The use of alternative non-pharmacological options such as cooling was considered.

Gerard Bury spoke about his concerns regarding potential exposure for practitioners and the need for awareness of patient modesty, which needs to be considered. Also, the perception of risk in a difficult situation may be a concern. It was suggested by some members that these are issues for the service providers. Professor Bury also highlighted his disquiet about using the related CPGs for purely pyrexia situations. He also pointed out that the use of the word 'consider' should be used in the relevant CPGs.

It was noted that the NICE Guidelines strongly direct that Paracetamol should be for limited use. It was commented that having the option for paramedics to administer medications PR only when other routes were not available would be beneficial in the long term.

It was proposed to look at the evidence supporting the administration of an anti-pyretic in these situations with the next evolution of CPGs. Stanley Koe will review where things currently stand with the administration of anti-pyretic medications and report back at the next Committee meeting in July.

Resolution: that the Medical Advisory Committee recommend to Council for approval that the scope of practice for paramedics is extended to permit PR medication administration.

Proposed: Cathal O'Donnell **Seconded:** Stanley Koe
Carried without dissent

4. Correspondence

There was no correspondence for discussion.

5. Clinical Developments

5.1 P/AP recognition of heart block and transcutaneous pacing

David Hennelly provided an overview. There are concerns regarding pacing but not concerns around the act of pacing itself. There are issues regarding the ongoing sedation of patients and what the procedures are if the patient improves. The Vice Chair has drafted a CPG and as he was not in attendance an update will be provided at a later stage.

5.2 Ambulance transport to local injury units

Brian Power advised that the Chair has written to the Emergency Medicine Programme, and as the Chair was delayed for the meeting an update would follow. Cathal O'Donnell informed that the NAS met with the Emergency Medicine Programme, and ambulance transport to a local injury unit will be piloted in Cork City shortly. The practicalities are being worked out and the NAS will use this as a model if considered feasible. Brian Power advised that PHECC and the Chair have carried out some work on protocol and procedures for ambulance transport to LIUs. Cathal O'Donnell requested that the draft LIU document be sent to him for information. Brian Power requested that NAS keep PHECC appraised of developments regarding the LIU pilot, and this was agreed by Cathal O'Donnell.

5.3 IM/SC Epinephrine for life threatening asthma

Brian Power outlined that there is no clinical evidence at present to support IM/SC Epinephrine for life threatening asthma, however it is being used clinically in many settings. The members identified a need to look at the framework for shortness of breath (SOB) and determine if there is a need to update the suite of SOB CPGs. Hillery Collins questioned if Ketamine should be considered as an option for asthma. The meeting Chair noted that IM/SC Epinephrine for life threatening asthma needs to be explored but as there is not a pressing clinical need it will be discussed at a future meeting on the next CPGs.

Resolution: that the Medical Advisory Committee recommend that the shortness of breath (SOB) CPGs be reviewed in the next round of CPGs.

Proposed: Hillery Collins **Seconded:** Cathal O'Donnell
Carried without dissent

* The Chair arrived and joined the meeting. A decision was made that Jason van der Velde would continue chairing the rest of the meeting.

5.4 Pre-hospital sedation

David Hennelly gave a presentation on pre-hospital sedation from the prehospital sedation subgroup.

A discussion followed with feedback from the members.

- A decision needs to be made around what exact sedation tool is used
- MAC need to think as a group about the requirements for sedation
- What is best practice within the prehospital setting?
- What is the basic monitoring standard required to apply and who should be involved?
- It must be carried out safely
- Should there be a new clinical level or division on the PHECC register for this scope of practice?
- Is this for all APs or how do we separate out practitioners going forward?
- How often and where are skills likely to be needed?
- Does the NAS have data on how often these events occur?

Gerard Bury suggested that collecting audit data would be hugely beneficial. He noted that mental health emergencies are very sensitive and can cause difficulties. The issue is regarding practitioners making good clinical judgement, there needs to be a level of confidence that their core skills are current.

The importance of using the correct terminology was stressed with 'procedural sedation and analgesia' given as a suggestion.

Cathal O'Donnell highlighted that clarity must be given that sedation is not a treatment in itself but a procedure that allows for a clinical intervention to occur.

David Hennelly advised that more time is required. The meeting Chair thanked David and requested that a written report be brought back to the Committee.

* Gerard Bury left the meeting.

5.5 Trauma system – Report; implications for PHECC practitioners

The Chair provided an overview as a member of the HSE Trauma Implementation working group who are working on the implications for PHECC practitioners. The issue is should ambulance crews be expected to travel longer distances with very sick patients. Cathal O'Donnell noted that a higher level of practitioner is required, and there are only a small number of practitioners with the required skill set and training, and there is a need to address this. The Chair advised that the issue regarding a higher level of practitioner will be addressed as part of the MAC strategy for 2018-2020.

5.6 2018 Guidelines for the early management of patients with acute ischemic stroke

A report on an exploratory meeting held on 4th May 2018 with Brian Power and the Stroke Clinical Programme following the release of the 2018 Stroke Guidelines was included in the meeting papers. Cathal O'Donnell was representing NAS at the meeting via telephone conference. Brian Power briefed the members and a discussion followed. The meeting Chair posed the question whetheher there was a need for a different approach to the stroke CPGs. The difference to stroke thrombolysis and stroke thrombectomy was discussed and in particular the implications for pre-hospital. It was highlighted that there were only two centres, Beaumont and CUH, that provide thrombectomy for large vein occlusion

(LVO) in Ireland. Cathal O'Donnell advised that it would be a huge challenge for the service providers if patients were transported directly to these hospitals. Brian Power highlighted that the Stroke Programme did not think that this process would be appropriate at this time and that patients should be transported to the nearest appropriate ED and receive thrombolysis followed by a secondary transfer if required. As outlined in the meeting report, there are up to four EDs that do not have stroke thrombolysis available and that local knowledge is important to ensure that stroke patients are not transported to these EDs.

The question was posed in relation to non NAS/DFB providers and how they would be aware of which EDs are not stroke centres. Brian Power advised that the Clinical Care at Events Subcommittee are looking at the process of communications with NEOC under these circumstances. The Chair suggested that PHECC should take a role in enforcing the stroke protocol to ensure that the voluntary and private service providers are also informed. Ricky Ellis noted that an advisory notice could be circulated to all the service providers as part of the Governance Validation Framework.

The question was posed, however, if it was appropriate to identify patients with LVOs in the Dublin and Cork areas and transport them directly to Beaumont and CUH respectively. A discussion ensued on the benefits of a pre-hospital stroke scoring system such as the Los Angeles Motor Scale (LAMS) to achieve this objective. Brian Power referred to the pre-hospital stroke article included in the meeting papers which identified a high sensitivity and specificity for LAMS. David Hennelly questioned whether LAMS should be introduced now and become a baseline for future pre-hospital stroke scoring.

6. CPG Development Process

6.1 Shock from blood loss – Paediatric*
Following agreement at the March meeting amendments were made to CPG 5/6.7.51 Shock from Blood Loss – Paediatric to reflect the Adult CPG 5/6.6.8. A revised draft CPG was included in the meeting papers for approval.

Resolution: that the Medical Advisory Committee recommend that CPG 5/6.7.51 Shock from Blood Loss – Paediatric be recommended to Council for approval.

Proposed: David Hennelly **Seconded:** Hillery Collins
Carried without dissent

6.2 COPD CPG
6.3 Behavioural Emergency CPG
6.4 Sedation CPG

These CPGs are being progressed through subgroups.

7 Clinical Practice at Events

7.1 Clinical Care at Events Subcommittee
Brian Power informed the members that the Clinical Care at Events Subcommittee held a meeting on 20th April and he provided an update. He advised that he recently circulated a spreadsheet to all service providers involved in covering events requesting deidentified patient data, and he is awaiting feedback.

The meeting Chair questioned where practitioners stood in relation to clinical care at events. He noted that the terminology used is confusing, and that clarification and advice which is currently being sought by PHECC from the Medical Council regarding the role of the 'Medical Director' will help to clarify matters. The Chair of the Quality and Safety Committee advised that clinical care at events was discussed at their May meeting and some members expressed concern that an invitation to join the Clinical Care at Events Subcommittee was not extended to all Committees, and they were not aware of the existence of the Subcommittee. Brian Power informed the Committee that a decision was made by MAC to limit the Clinical Care at Events Subcommittee to MAC members initially and to seek consultation with interested parties as proposals emerged. Brian Power informed that a standards document will be drafted and circulated in due course. The Subcommittee will strive to make progress over the next 8 to 12 months.

8 MAC Strategy 2017-2020

A revised and updated report of all the feedback and suggestions arising from the MAC strategy meeting which was held on 3rd May was tabled. The Chair requested the members to identify three main priorities from the list to present to Council for approval, and the remaining items on the list will form part of Council strategy.

The three priorities were agreed as follows:

1. Community Paramedic
2. Critical Care Paramedic
3. Treat and referral

The members discussed the possibility of new clinical levels or divisions on the PHECC register. Jason van der Velde advised that terminology needs to be clearly and accurately defined, and advised that clinical levels as opposed to grades i.e. BLS, ILS, ALS, CCS, as per PHECC scope of practice, is a more accurate use of terminology. The question was asked if new legislation is required for PHECC to change or add clinical levels on the PHECC register. Brian Power advised that there are currently three clinical levels on the PHECC register and sub divisions are there to reflect Interns. These were added without the requirement of legislation and he is confident that the same could apply to any new sub divisions. He also noted that crewing configurations needs to be looked at as this is an issue currently.

The Chair informed that Council are seeking primary legislation re titles, which can have different clinical levels and protected titles.

The Chair will bring the three priority items identified to the next Council meeting in June for approval and dedicated workshops will be organised thereafter. It was also agreed to write to recognised institutions and licensed CPG providers for feedback.

9 External communications, consultation, feedback

There was no correspondence for this agenda item.

10 AOB

10.1 Prior to his departure Gerard Bury noted that at the March MAC meeting there was an agreement in relation to Lidocaine IM in the medication formulary and sought clarification as he was not present at that meeting. He noted his concerns. Shane Mooney advised that practitioners are very aware that Lidocaine IM is to be used as a last option. Jason van der Velde informed that the dose is well below what is considered safe. The meeting Chair thanked and acknowledged Professor Bury for his concern.

10.2 Martin O'Reilly advised that he sent a request to Brian Power to add Lidocaine as a dilutant for Ceftriaxone to the medication formulary. He pointed out the need to inform practitioners in the meantime who are currently using these medications. Brian Power informed the meeting that this has been included in the latest version of the Medication Formulary and the Medication Field Guide.

10.3 Shane Mooney enquired about the current status of the field guide app. Brian Power advised that he does not have an update yet, and the cost of setting up and maintaining the app is proving very costly. Council will be looking at allocating resources for the app.

The next meeting of the Committee will be held on Thursday 26th July @ 10:00am in the PHECC office.

There being no other business the meeting concluded.

Signed: _____ **Date:** 26.7.18

Chair